THE NORTH CAROLINA INFANT-TODDLER PROGRAM

INDICATOR 11: STATE SYSTEMIC IMPROVEMENT PLAN (SSIP)

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SSIP Overview

Description of SIMR

The North Carolina Early Intervention Branch, lead agency for the N.C. Infant-Toddler Program (N.C. ITP), has chosen the following SiMR:

North Carolina will increase the percentage of children who demonstrate progress in positive social-emotional skills (including social relationships) while receiving early intervention (EI) services. A subset of six local lead agencies who are representative of the state will be targeted to begin implementing improvement activities with the goal of expanding to all sixteen local lead agencies for maximum impact.

Therefore, the state is focusing on Child Outcome 3A, positive social-emotional skills (including social relationships), and in particular Summary Statement 1.

Description of State Program

North Carolina's Infant-Toddler Program (ITP) is a system of supports and services for children ages birth to three years who have established health conditions, or developmental disabilities or delays under Part C of the Individuals with Disabilities Act (IDEA). The program serves infants, toddlers, and their families who are referred by community resources or self-referred. The Infant-Toddler Program is implemented by the N.C. Early Intervention Branch in partnership with its 16 regionally-based local lead agencies also referred to as Children's Developmental Services Agencies (CDSAs).

The N.C. Early Intervention Branch State Office is located in the Division of Public Health within the N.C. Department of Health and Human Services. Lead Agency responsibilities are performed on two levels:

- At the state level, the Early Intervention Branch of the Women's and Children's Health Section, in the Division of Public Health, administers, supervises, and monitors programs and activities of the Infant-Toddler Program. The Early Intervention Branch provides oversight for the regionally-based local lead agencies, CDSAs.

- On the local level, the CDSAs provide evaluation services for eligibility determination and perform assessments for service planning. The CDSAs also provide service coordination services for all enrolled children and their families. CDSAs administer, supervise, and monitor programs and activities of the ITP and ensure early intervention services are available through their region, provided by enrolled community service providers. If the CDSA does not have an adequate number of enrolled community service providers to meet the needs of children and their families, the CDSA must provide the service itself while actively searching for and enrolling a qualified service provider.

The N.C. Interagency Coordinating Council (ICC) serves as the designated planning partner for the Early Intervention Branch and the Division of Public Health, advising and assisting them in such substantive activities as child find and public awareness, system needs assessment, system monitoring and evaluation, and professional development.

In Federal fiscal year 2013-2014, census estimates report 356,388 infants and toddlers (zero to-three years of age) were living in N.C. as of July 1, 2014. A total of 18,816 infants and toddlers were enrolled in the

Infant-Toddler Program in FFY 13-14, which is 5.3 percent of N.C.'s population who were younger than three years old.

Process Used for Developing Phase I of the SSIP

The N.C. ITP chose to follow an implementation science framework when planning the SSIP process for the state. The framework was based on several widely-used and accepted implementation science models made available to states through technical assistance (TA) workshops and webinars in early 2014 (the full list of implementation science framework tools examined and utilized can be found in the Appendix page 62). In particular, the Hexagon Tool and the Phase I Activity and Timeline Chart were used to help plan the SSIP process and timeline from early 2014 through April 2015.

The SSIP Planning Team began with a broad data analysis of ITP data to determine if there were clear areas of low performance for any child and family outcomes. Comparisons to national data showed that NC's recent performance in Annual Performance Report (APR) data was similar to other states with comparable eligibility criteria. The State's child and family outcomes data were also analyzed longitudinally to look for trends in performance over time, which showed that the State's outcome data has been very consistent over time. Absent any clear areas of low performance compared to other states, and with consistent performance over time within the State, the following areas were noted:

- Family Outcome 4B – Historically, this was the lowest performing indicator of the three family outcomes. Stakeholders felt that families effectively communicating their children's needs would improve child outcomes over time. However, they expressed concerns about the lack of additional family data, as well as family outcomes data quality.
- Child Outcome 3B – N.C. consistently performed lowest on this indicator for Summary Statement 2, and stakeholders felt that increasing the knowledge and skills of children would lead to improved outcomes. Concerns were presented about using Summary Statement 2, however, as they felt that the "spirit" of EI was more targeted toward Summary Statement 1 (progress) rather than the expectation that children are typically developing by the time they exit the program (which may not be possible for many children).
- Child Outcome 3A – This was the lowest child outcomes indicator for Summary Statement 1, and the stakeholders expressed excitement about aligning social/emotional outcomes with the numerous initiatives already occurring in the State targeting the social/emotional development of children. CDSA directors felt that CDSA staff would benefit from additional training and resources in social/emotional practices.

In parallel with the broad data analysis, the Planning Team performed analyses of the State infrastructure to support the SSIP. Broad and focused infrastructure analysis work pointed to several challenges and potential areas of improvement within the ITP:

- Lack of Community Service Provider Accountability
    - Monitoring for evidence-based practices (EBPs)
    - Absence of data on actual provision of services by community service providers
    - Little structure for communication between community service providers and the EI State Office
    - Limited opportunities for training/TA for community service providers
- Limited professional development opportunities for community service providers, CDSA staff, and EI State Office staff, with particular concern about those providing special instruction
- Resource limitations due to recent budget reductions
- Engagement of families in state system components

- Advocacy
- Program planning & evaluation
- Technical Assistance

The SSIP Planning Team and stakeholders used this information to begin to examine potential focus areas and a SiMR. Initially, it was determined that N.C. should consider choosing a combined focus area, selecting both a child and family outcome. The stakeholders felt that work needed to be done on the family outcomes process, including examining the survey instrument and the dissemination and collection of survey data, as well as exploring other potential methods and data sources for collecting family-level outcomes. The stakeholders also felt strongly that a child outcome focus was necessary given the recent emphasis in N.C. on the child outcomes process and the importance of outcomes for the children served. A combined SiMR, *3A SSI & 4B* or *3B SS2 & 4B*, was discussed with multiple stakeholder groups (as well as with OSEP). Ultimately a single SiMR was selected because it would allow for more direct measurement of the impact of improvement activities on the chosen outcome. The measurement of impact for a combined SiMR would be challenging and concerns were raised by TA consultants and stakeholders that the potential combined SiMRs would be difficult to understand and interpret. The stakeholders agreed that a child outcome should be chosen for the single focus area; however, all internal and external stakeholders were in agreement that a review of the family outcomes process would need to be included as an improvement strategy due to the issues raised with data collection and response rates.

Multiple internal and external stakeholders agreed that the work-to-date pointed to choosing Summary Statement 1 (SS1) for social/emotional skills (3A). The data analysis showed this as the lowest SS1 in the State, and the infrastructure analysis pointed to questions in the State system on community service provider practices addressing social/emotional development. CDSA Directors on the Core Stakeholder Group expressed the need for additional training and tools for their staff around social/emotional development and evidence-based practices and continued work with community service providers in this area. It was also decided that a representative subset of CDSAs would be chosen for implementation due to resource concerns expressed throughout all levels of the infrastructure analysis, allowing for a stepped implementation over time that would eventually include all 16 CDSAs.

Overview of Stakeholder Involvement

The ITP chose a multi-level stakeholder engagement process for Phase I of the SSIP, electing to form several groups throughout the state with the goal of gaining broad and diverse input and feedback. The multi-level stakeholder structure involved the following internal and external groups:

Internal Stakeholder Groups:

- SSIP Planning Team
- ITP State Office staff
- ITP Statewide Leadership Team (including EI State Office leadership and CDSA Program Directors)
- CDSA staff

External Stakeholder Groups

- N.C. Interagency Coordinating Council
- Broad SSIP Stakeholder Group
- Core SSIP Stakeholder Group

A more comprehensive description of these internal and external stakeholder groups can be found throughout the SSIP narrative.

Component #1: *Data Analysis*

In order to plan the Phase I SSIP data analysis, the data team created a Data Analysis Plan which mapped out the steps to take when looking at SSP/APR indicator data, 618 data, and other available data. The plan served as a guide for creating usable datasets, which could then be analyzed to determine performance trends for the ITP. The data team used a "drill-down" approach where larger, broader summary data are used to identify interesting trends or to note unexpected differences, leading to more refined data analysis to identify root causes of the trends and differences noted. Where possible, data were obtained from the N.C. Health Information System (HIS), an Electronic Health Record (EHR) utilized by all sixteen local lead agencies in N.C. All other data sources are noted where relevant.

1(a): How Key Data Were Analyzed

Outcome Data: Child and Family Outcomes

The data team first focused on the Annual Performance Report (APR) Child and Family Outcomes data in order to take a broad look at identifying areas of low performance. North Carolina is using the ECO Child Outcomes Summary Process (COS) as the measurement approach for child outcomes data collection in the State.

Specifically, all children enrolled in early intervention for a minimum of six months receive an entry and exit measurement of their developmental status when compared with same-aged peers. For Family Outcomes, the state uses the National Center for Special Education Accountability Monitoring (NCSEAM) family survey with Rasch analysis, which is distributed at a point-in-time each year to families of children who have been enrolled in the program for six months or longer.

The three Child Outcomes are:

Percent of infants and toddlers with IFSPs who demonstrate improved:

3A. Positive social-emotional skills (including social relationships),
3B. Acquisition and use of knowledge and skills (including early language/communication),
3C. Use of appropriate behaviors to meet their needs.

The two summary statements are:

1. Of those children who entered or exited the program below age expectations in each outcome, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program.
2. The percent of infants and toddlers who were functioning within age expectations in each outcome by the time they turned 3 years of age or exited the program.

The three Family Outcomes are:

Percent of families participating in Part C who report that early intervention services have helped the family:

4A. Know their rights,
4B. Effectively communicate their children's needs,
4C. Help their children develop and learn.

The team based the initial Child and Family Outcome data analysis on the *SSIP Child Outcomes Broad Data Analysis Template* document, created by the Early Childhood Technical Assistance (ECTA) Center

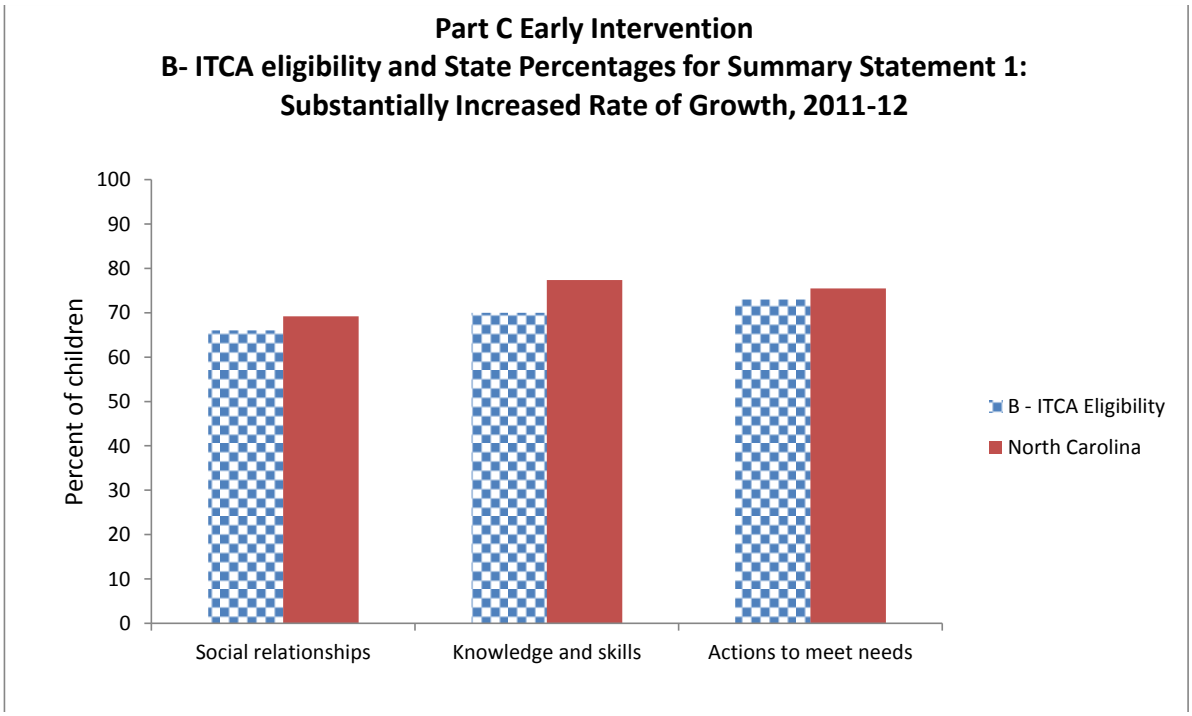
and the Center for IDEA Early Childhood Data Systems (DaSy), which was distributed to the states in 2014. This document outlined a three-step process for broad Child Outcome data analyses:

1. Comparison to National Data
2. Analysis of Trends in State Performance
3. Comparison Across Local Lead Agencies

Comparison to National Data

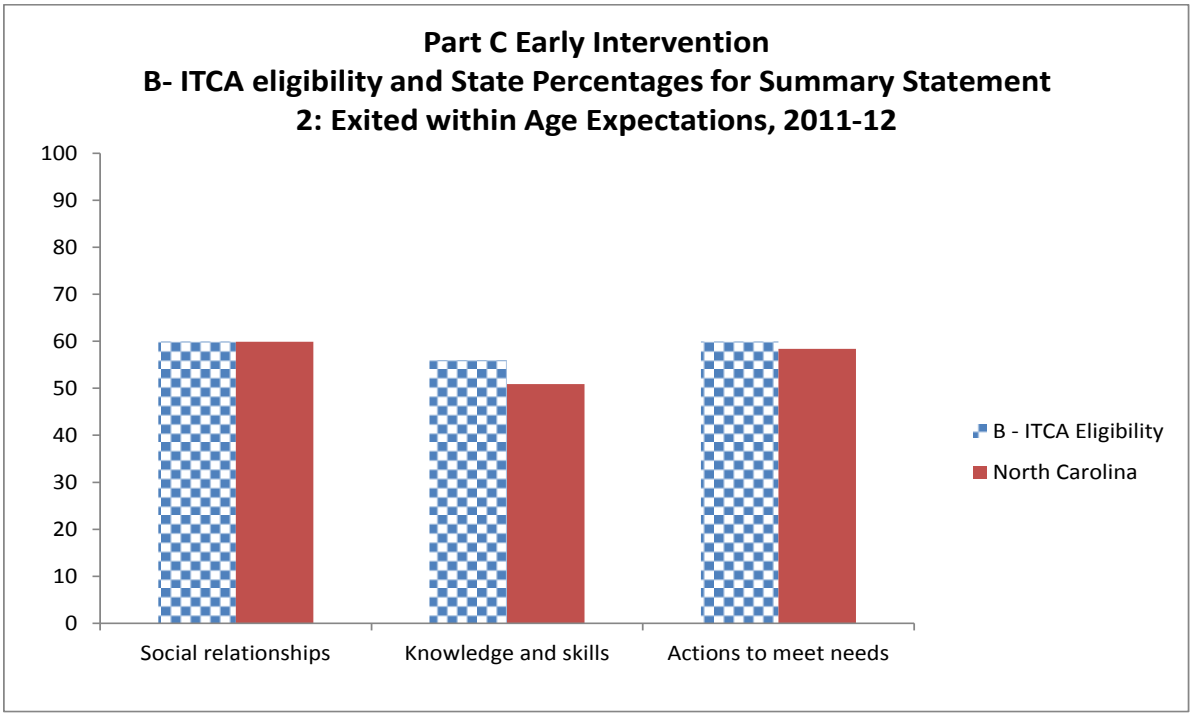
To compare N.C.'s Child Outcomes data to national data, the data team used the *ITCA Eligibility Comparison Graph Creator 2011-12 (FFY 2011).* To ensure that the State's data are compared to other states with similar eligibility criteria for children, N.C. data were compared to the 18 states that fall in category B. Figure 1 below shows FFY 2011 N.C. Summary Statement 1 data for all three child outcomes, while Figure 2 shows the same comparison for Summary Statement 2 data.

Figure 1: Comparison of N.C. Child Outcomes Summary Statement 1 to National Data FFY 2011 for States Using Similar Eligibility Criteria



The figure clearly shows that N.C. data are higher for each of the three Child Outcomes. The magnitude of difference is similar for social relationships (3A) and actions to meet needs (3C), while knowledge and skills (3B) had the largest difference.

Figure 2: Comparison of N.C. Child Outcomes Summary Statement 2 to National Data FFY 2011 for States Using Similar Eligibility Criteria



The data for Summary Statement 2 shows that N.C.'s performance is almost identical to states with similar eligibility criteria for social relationships (3A), while performing slightly lower in the areas of knowledge and skills (3B) and actions to meet needs (3C).

North Carolina data were then analyzed by comparing progress category data for FFY 2011 to national data (Figures 3-5). In addition to looking at the summary statement data, it is important to also look at the progress category data used to calculate the summary statements. The five Progress Categories are listed below (categorized as "a" through "e"):

a. Infants and toddlers who did not improve functioning.
b. Infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers.
c. Infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach it.
d. Infants and toddlers who improved functioning to reach a level comparable to same-aged peers.
e. Infants and toddlers who maintained functioning at a level comparable to same-aged peers.

Figures 3-5: Comparison of N.C. Child Outcomes Progress Category Data to National Data FFY 2011 for States Using Similar Eligibility Criteria

Figure 3: Social/Emotional (3A)

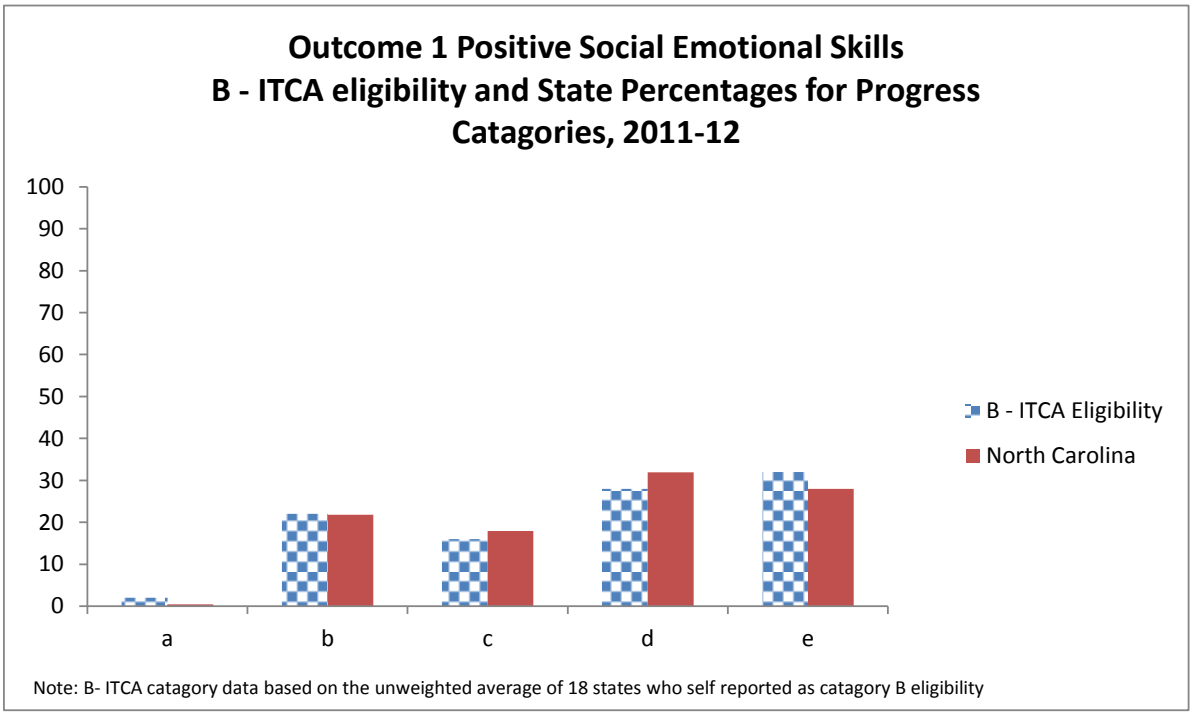


Figure 4: Knowledge/Skills (3B)

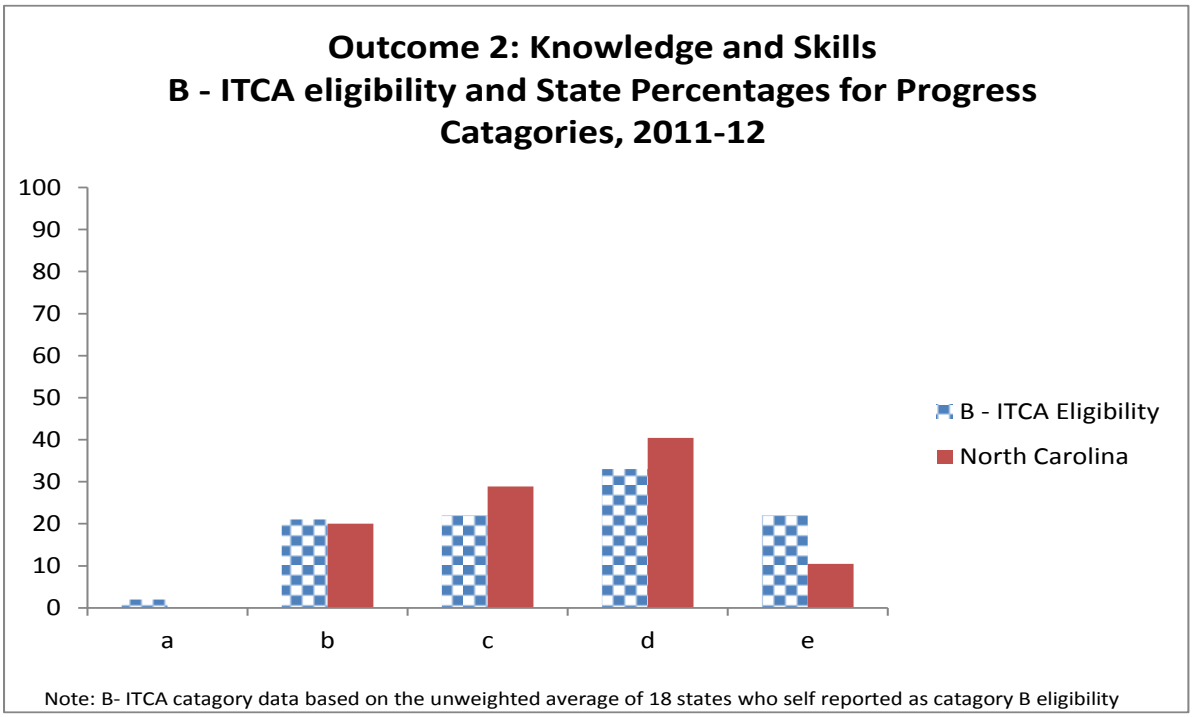
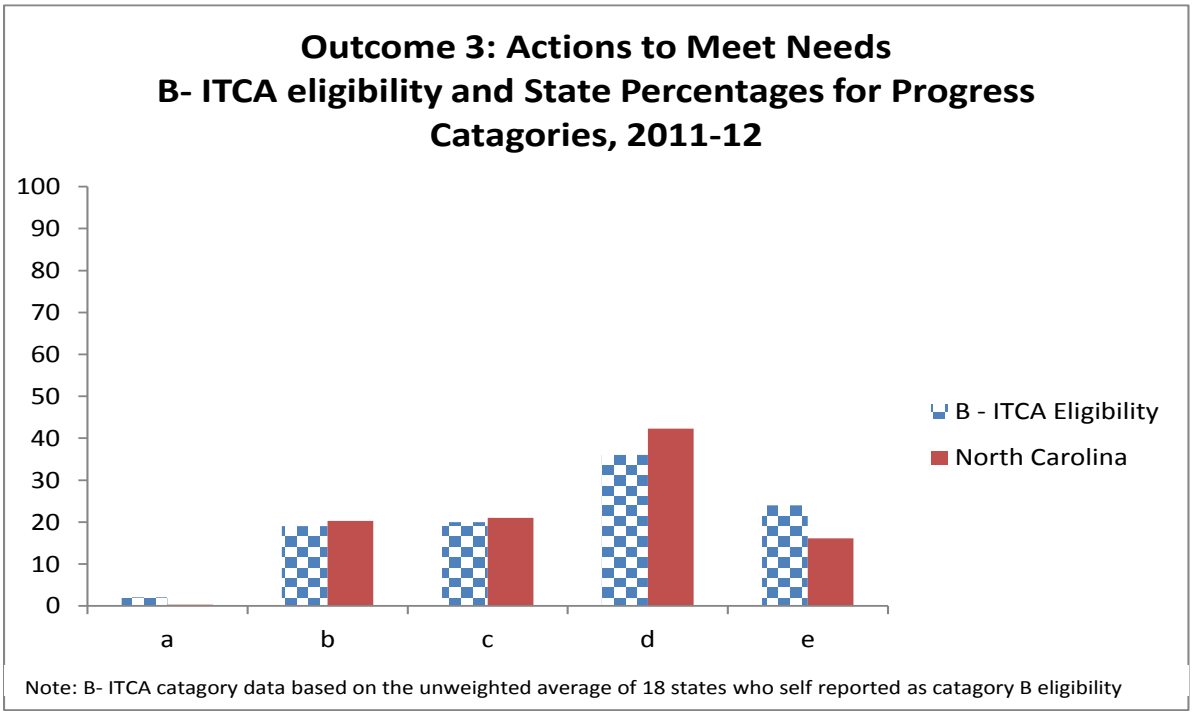


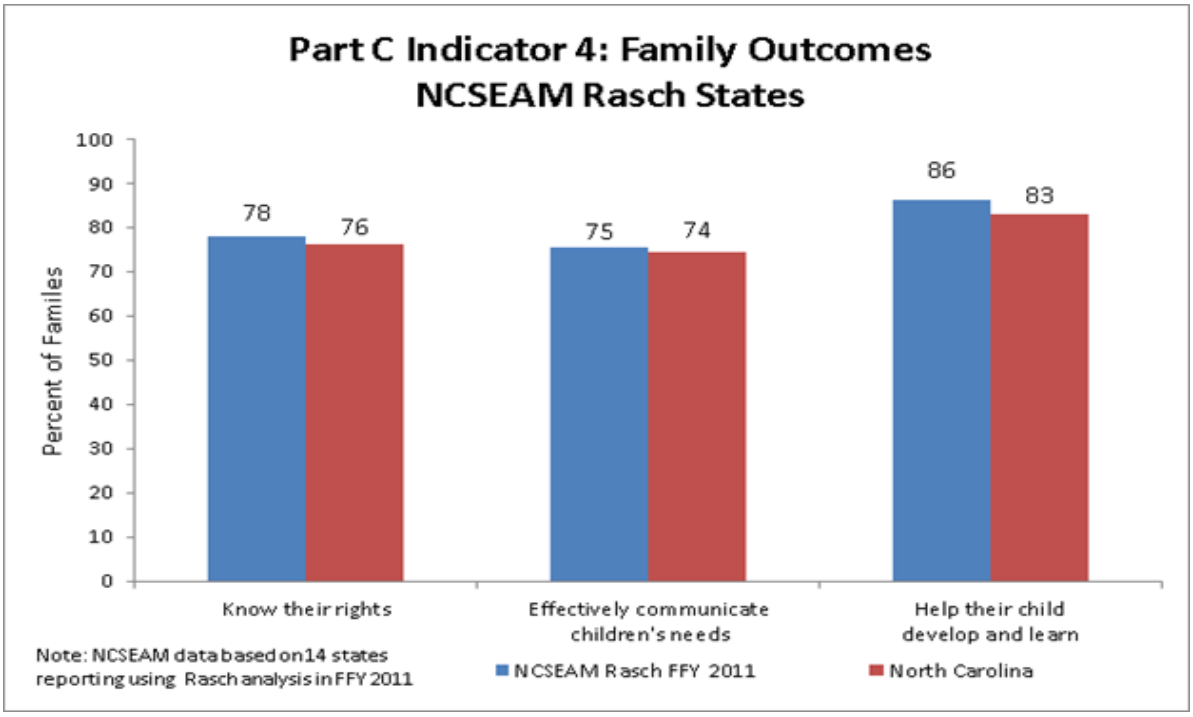
Figure 5: Actions to Meet Needs (3C)



North Carolina's performance was consistently higher for progress category "d" for all three child outcomes in FFY 2011, with the magnitude of difference fairly comparable across the three outcomes. The State had a lower percentage of children in category "e" compared to the rest of the states for all three child outcomes. Finally, the data team noted that N.C. was equal to or greater than the comparison group for categories "b" and "c."

To compare the N.C. family outcomes data to national data, the data team used the *Family Outcomes-State Approaches Calculator (ECTA Center).* Family outcomes data were compared to the mean of the other 14 states that use the NCSEAM survey with Rasch analysis (Figure 6 below). North Carolina's performance in all three Family Outcomes is very similar to the other NCSEAM states with Rasch analysis, although slightly lower for all three outcomes.

Figure 6: Comparison of N.C. Family Outcomes Data to National Data FFY 2011 for States Using NCSEAM Survey with Rasch Analysis



Analysis of Trends in State Performance

The State's child and family outcomes data were then analyzed longitudinally to look for trends in performance over time. The data team created a series of figures to examine each of the two summary statements, as well as the progress categories for all three child outcomes over the previous four years of APR data (from FFY 2009 to FFY 2012 - FFY 2013 data were not available until much later in the Phase I process). Family outcomes data were also graphed over the same time period.

Figure 7 below shows a line graph for each of the three child outcomes and summary statements. The graph shows that the State's APR child outcome data has been very consistent over time. There have been no major fluctuations for any of the child outcomes or summary statements, with most outcomes showing slight improvement from FFY 2011 to FFY 2012. Overall, any observed changes in the lines are in fact very small. **However, the data were very clear that the State had the lowest performance for 3A: social/emotional for Summary Statement 1, while 3B: knowledge/skills was the State's lowest performing outcome for Summary Statement 2.** The *ECTA Meaningful Difference Calculator – Child Outcomes* was used to look for statistically significant change from FFY 2011 to FFY 2012. The results did indicate that the change was statistically significant; however, the SSIP Planning Team agreed that the change did not appear to be clinically significant.

Once it was clear that the State's summary statement data had not varied over time, the next step in the outline was to analyze the APR child outcome data by looking at the progress category data for each of the three child outcomes over time. The data team graphed the State's reported APR progress category data from FFY 2009 to FFY 2012 for each of the three child outcomes to look for any trends over time (Figures 8-10).

Figure 7: State of N.C. Child Outcome APR Data Summary Statements from FFY 2009-2012

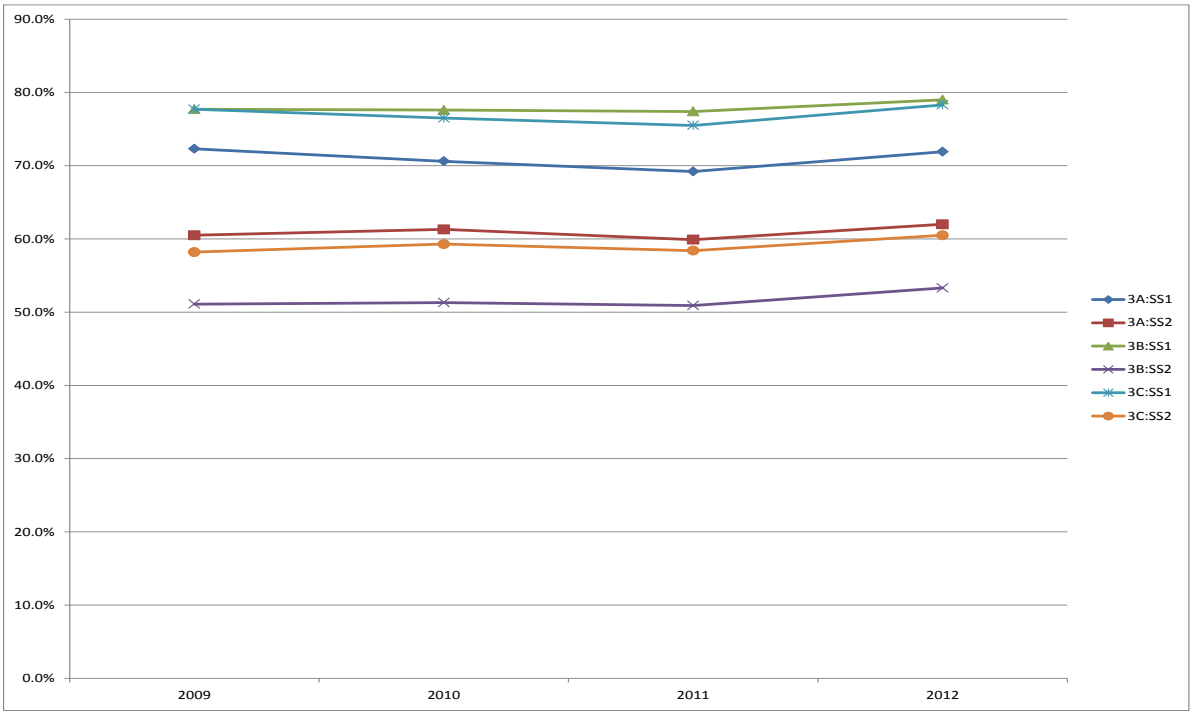


Figure 8: State of N.C. Social/Emotional (3A) Progress Category Data from FFY 2009-2012

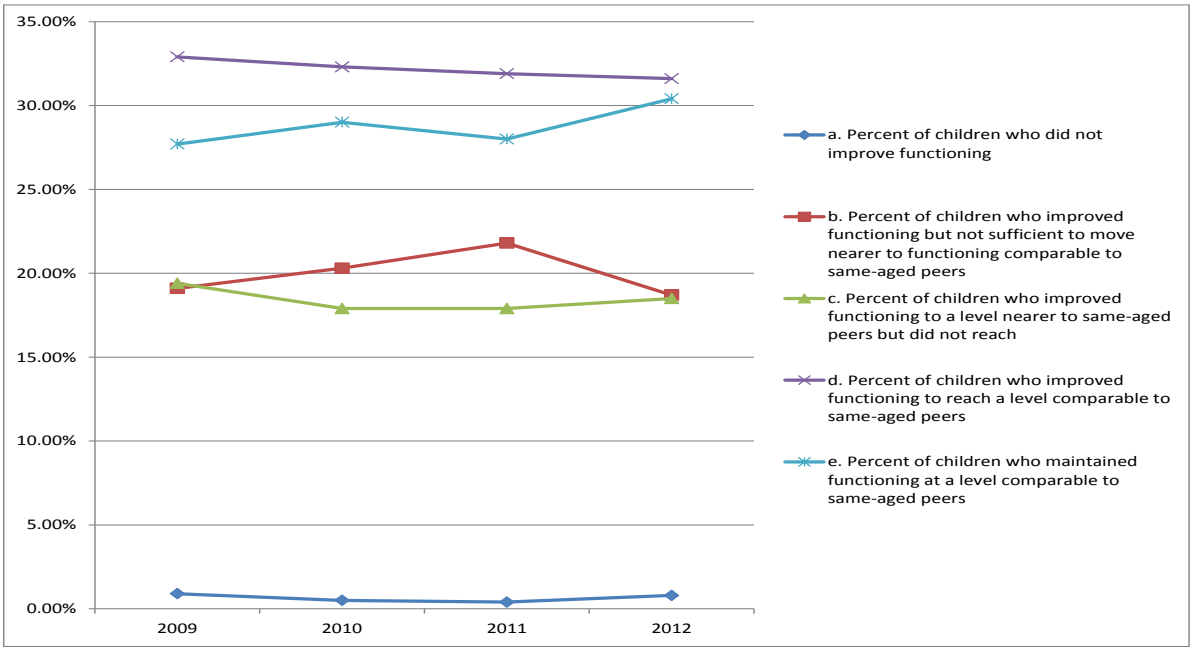


Figure 9: State of N.C. Knowledge/Skills (3B) Progress Category Data from FFY 2009-2012

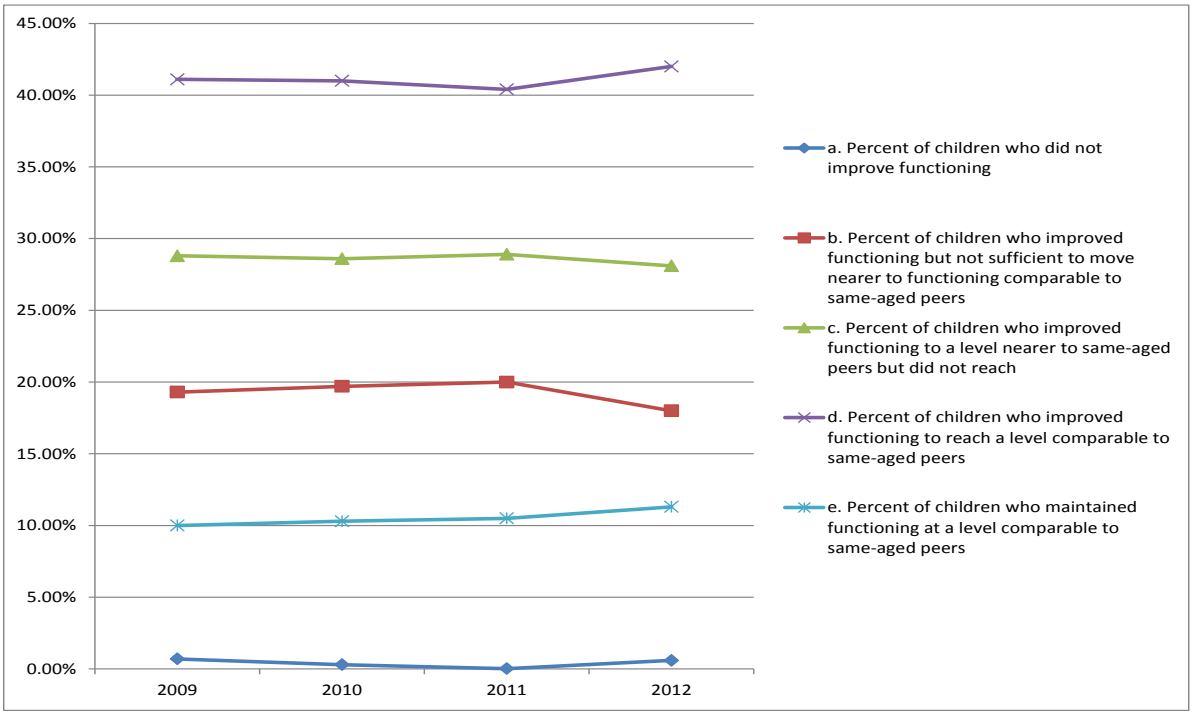
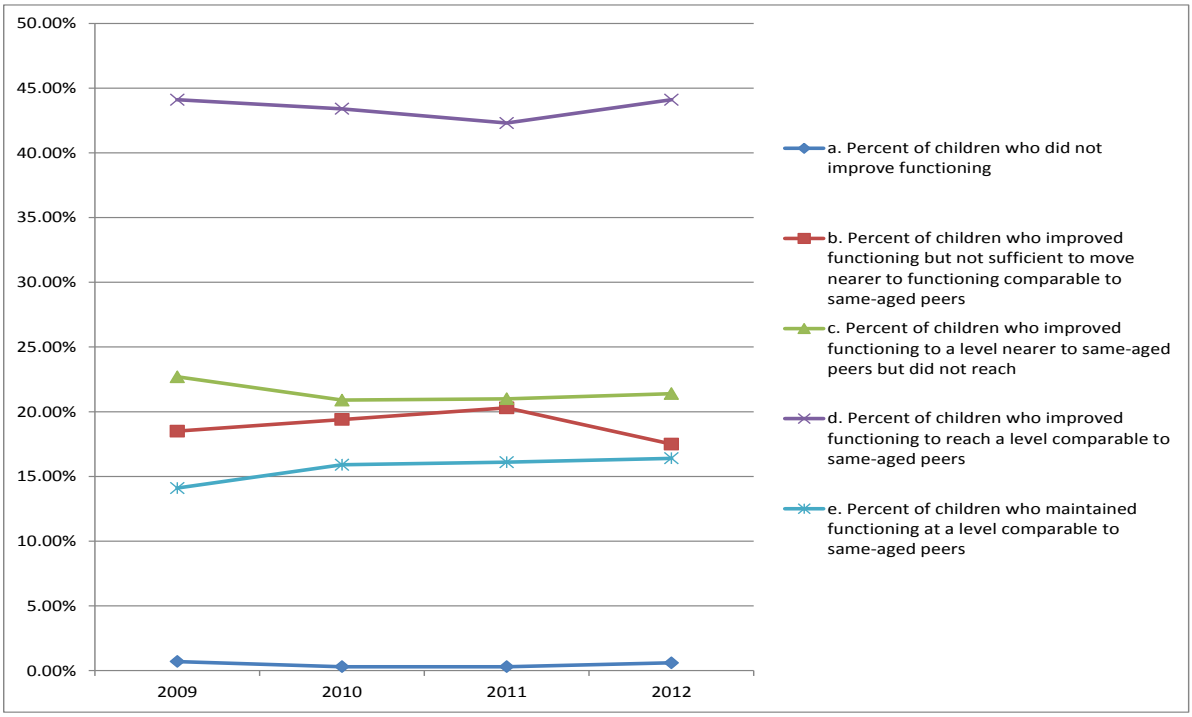


Figure 10: State of N.C. Appropriate Behaviors (3C) Progress Category Data from FFY 2009-2012



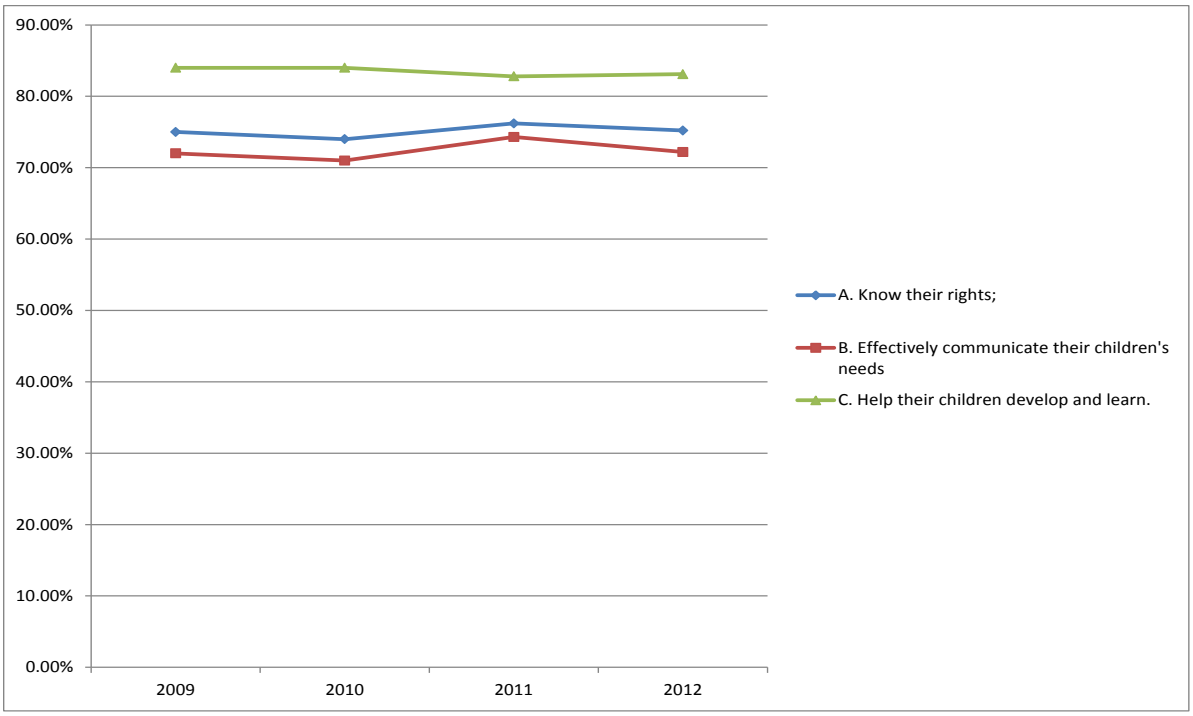
The State's social/emotional data (Figure 8) does not appear to vary over time. Most changes occur year-to-year and are very small. The largest increase over time can be found in the percentage of children in progress category "e," while progress category "d" had the largest decrease. However, when taking into account the scale of the graph (0% - 35%) the data team agreed that any observed differences are small. The team did note the largest percentage of children each year can be found in progress categories "d" and "e." The data team also noted that the percentage of children falling into progress category "b" was higher than progress category "c" until FFY 2012. The data team examined additional data related to progress categories for this indicator, the results of which can be found later in this section.

Figure 9 shows that, similar to the social/emotional data, the progress category data for 3B (Knowledge/Skills) remain consistent over time. Progress category "d" has the highest percentage of children, followed by "c" and then "b."

Child outcome 3C (Figure 10) follows similar trends over time as the other two child outcomes, with data remaining steady through the four years of data examined. In relation to 3C (actions to meet needs), the data team noted that the percentage of children in progress category "d" was much higher than any of the other progress categories. It was also noted that the percentage of children in "b", "c", and "e" were all consistent over time.

Family outcomes data are presented longitudinally below (Figure 11) and show that there has been very little variability over time for the three indicators. The data team noted the lack of additional family outcomes data available for this broad analysis, with the intent of collecting additional data in Phase II (see Section 4).

Figure 11: State of N.C. Family Outcome APR Data from FFY 2009-2012



Comparisons Across Local Lead Agencies

The next step in the broad data analysis was to look at the child and family outcomes data across local lead agencies (CDSAs). North Carolina is a large, geographically diverse state with 16 different local lead agencies in a mix of urban and rural areas. The SSIP Planning Team felt it important to look at the State's performance data by each CDSA to help further analyze data at the local level in order to determine which CDSAs could potentially be targeted for improvement. To accomplish the analysis, the data team synthesized a dataset comprised of all children in N.C. who had received a COS rating at both entrance and exit and had exited the program in FFY 2012 (the most recent data available at the time). An additional family outcomes dataset was created which contained the survey responses from all families who completed the NCSEAM survey in NC in FFY 2012.

As outlined in the Data Analysis Plan, the goal of the local lead agency child outcomes analysis was to look at the CDSAs across:

- Summary statement data – each of the six child outcomes (three areas, two summary statements) were examined by CDSA.
- Progress categories data – each of the five progress categories (a-e) was graphed separately by CDSA to look for differences among the CDSAs.
- Difference scores – the data team decided that it would be important to look at the differences between the entrance rating and the exit rating for each child. A difference score was created for all children in the dataset which was calculated by subtracting exit score minus entrance score. This measure would allow the team to look at the magnitude of change among children at each CDSA beyond the progress categories. The range of difference scores possible was from *-6 to +6*, however, many of the larger differences occurred infrequently or not at all restricting the analysis to *-4 to +4*.
- Child outcome ratings scores data –the percentage of children rated (1-7) at both entrance and exit were compared for all CDSAs.

The conclusions for each of the analyses are presented below:

Local Lead Agency Summary Statement Data – The line graphs of CDSA performance by summary statements showed that there was a diverse range of performance throughout the state. One CDSA (Program A) was consistently the lowest performing CDSA in the state for all six COS summary statements. Two other CDSAs (Program B &Program C) were consistently in the bottom five for all six COS summary statements. There was also a consistent trend where several CDSAs would perform much higher in Summary Statement 1 or 2, but not both. The team drew the conclusion that the data were still too broad and would need to be looked at by progress categories to attempt to explain the differences observed in this step.

Local Lead Agency Progress Category Data – The graphs of performance in the progress categories were very helpful for the SSIP Planning Team, as they elucidated some of the trends seen in the summary statement analysis by CDSA. The CDSA that was identified as being consistently lowest (Program A) in the previous step had the highest percentage of children in category "b" in the State, almost double the state average. For CDSAs that were performing higher in one summary statement versus another, it became clear that the progress category data for those CDSAs varied significantly in categories "d" and "e." Overall, a trend was noted where several CDSAs were much higher than the state average in a particular category. The data team decided that additional analyses of the raw ratings and difference scores were needed to examine these findings.

Local Lead Agency Child Outcome Ratings Difference Scores Data – The calculated difference score from entrance rating to exit rating was then looked at by CDSA for all three child outcomes. The data

team hypothesized that the difference data would show data trends for the CDSAs. These trends would help explain some of the variability in performance observed in the previous two analyses. Some trends that were observed:

- For Child Outcome 3A, two of the CDSAs (Program D & Program E) had less than 1% of children scoring lower on exit than entrance, compared to 5% or greater for the other CDSAs. This was a data quality flag to the data team (see Section 1c below).
- One CDSA (Program D) had the highest percentage of children with a 0 difference score (no change from entrance to exit) for all three child outcomes, and was consistently double the state average.
- Program A, which was consistently the lowest performing CDSA for the summary statements, had the highest percentage of children with *-2* and *-1* difference scores (child scored lower at exit than entrance) for all three child outcomes.
- The percentage of children increasing three or more units from entrance to exit varied greatly among the CDSAs, with a range of 2% to 26% depending on which child outcome was being examined.

Local Lead Agency Child Outcomes Ratings Data – The raw child outcomes scores were looked at by CDSA for entrance and exit scores separately. In this step, the analysis of the scores was to determine whether the trends observed in the previous steps could be explained with the simplest data available (data that has not been summarized). As expected, the raw scores confirmed the following observations:

- The CDSA with the highest percentage of children with a *0* difference (Program D) scored half of children or more a *6* at entrance and exit in all three child outcomes;
- The CDSA with the lowest summary scores in the earlier step (Program A) had the highest percentage of children in the State receiving exit scores of *3* or less. However, the data team noted that this CDSA's entrance scores were not noticeably lower than the other CDSAs. This could indicate that ratings at exit may be an issue with this CDSA; and
- One CDSA (Program F) consistently had the largest number of children rated at *1* at entrance for all three child outcomes. The team noted that this CDSA also had the highest percentage of children with difference scores of *+3* or more in the previous step, which parallels well to children more likely to have a score of *1* at entrance (higher ceiling available).

The final comparison across local lead agencies was to examine our family outcomes survey data from FFY 2012. The data showed the statewide variability in the percentage of families reporting on each of the three family outcomes by CDSA. The data team noted the inconsistency between child outcomes data performance and family outcomes data performance for some CDSAs. For example, Program A has the lowest performance on child outcomes, but is consistently in the top 25% of CDSAs for family outcomes. To further examine this inconsistency, the data team will, in the future, attempt to crosscheck/crosswalk the child outcome data with the family outcome data (discussed in Section 1e).

Comparisons to Targets

The next broad data analysis performed by the data team was to compare N.C.'s performance over time to our State's targets. Each child and family outcome was graphed versus the yearly target for FFY 2009 through FFY 2012. Additionally, summary tables were created by the data team for an "at-a-glance" look at CDSA performance versus targets for FFY 2012 (Tables 1 and 2 below).

Table 1: CDSA Performance Compared to State Targets for Child Outcomes FFY 2012

APR Category	Target	Number (%) of CDSAs At or Above Target	Number (%) of CDSAs Below Target	Range	
				Low	High
3A:Social/Emotional SS1	73.50%	8 (50%)	8 (50%)	49%	84%
3A:Social/Emotional SS2	59.60%	10 (62.5%)	6 (37.5%)	43%	76%
3B:Knowledge/Skills SS1	80.00%	6 (37.5%)	10 (62.5%)	61%	92%
3B:Knowledge/Skills SS2	51.10%	8 (50%)	8 (50%)	36%	74%
3C:Behaviors SS1	78.00%	8 (50%)	8 (50%)	58%	90%
3C:Behaviors SS2	57.80%	8 (50%)	8 (50%)	45%	77%

The data show that:

- half (eight) of the CDSAs are meeting state targets for four of the six categories of child outcomes;
- less than half (six) are meeting state targets for 3B SS1; and
- 10 out of 16 CDSAs are meeting the state target for 3A SS2.

The data team felt that this data did not clearly point to a single indicator for a potential SiMR focus area.

Table 2: CDSA Performance Compared to State Targets for Family Outcomes FFY 2012

Family Outcome	Target	Number (%) of CDSAs At or Above Target	Number (%) of CDSAs Below Target	Range	
				Low	High
4A:Know Their Rights	90%	2 (12.5%)	14 (87.5%)	61%	93%
4B:Effectively Communicate	86%	1 (6.25%)	15 (93.75%)	52%	89%
4C:Develop and Learn	91%	2 (12.5%)	14 (87.5%)	71%	96%

The family outcomes data summary shows that only one or two CDSAs met the State performance targets for FFY 2012, depending on the family outcomes indicator. The data team noted this stark contrast from the similar analysis of child outcome targets and determined that further analysis of the family outcomes data and targets was needed (see Section 1c).

A comparison was also conducted using the *ECTA Meaningful Difference Calculator – Child Outcomes* tool to compare each CDSA's performance to the state mean. The data showed that performance by CDSA varied by child outcome and summary statement. The team could not identify any clear trends from the findings.

Additional Broad Data Analyses

The data team performed additional analyses of the following internal and external data beyond the APR child and family outcomes data to ensure as broad a view as possible of early childhood data that can be used to look for areas of low performance and potential improvement.

- 618 Data – Data on child count, settings, and exit disposition were analyzed to look for trends that could inform the State's focus area/SiMR. There were no major findings of the analysis other than a trend that was observed for children with autism staying in the program longer on average than children without autism.
- APR Compliance Data – See Section 1d
- Other Broad Data Analysis Not Shown: Comparison of performance by CDSA over time (FFY 2009 to FFY 2012) – No clear trends existed other than the data were fairly steady over time at most CDSAs.
- Services Data – Data were analyzed on services added to IFSPs during FFY 2013. The most common service on IFSPs was service coordination, also referred to as Targeted Case Management. Half of children were receiving Speech/Language services, and 45% were receiving Special Instruction. The SSIP Planning Team felt this information was helpful because it showed that almost half of children are receiving some type of social/emotional intervention through special instruction, further reinforcing the choice of focus area for the State.
- N.C. Center for Health Statistics Data
    - N.C. Birth Data (2013)
    - N.C. Birth Defect Data (2010)
    - N.C. Child Health Assessment and Monitoring Program (CHAMP) Survey Data (2011) – N.C. collects data on 19 questions related to Children with Special Health Care Needs through an annual survey. Although the data are not available by county, the summary data for the state is helpful because it can be used as an additional data source to make sure that the ITP is reaching the children in the State who could benefit from EI services.
- United States Census Bureau, American Fact Finder, American Community Survey Data– Data can be obtained on many variables for communities of 65,000 or greater, including income, housing, age, etc. These data will be used in Phase II as we focus on the six CDSAs that are a part of the SiMR and start to drill down into the areas of greatest need in those regions.
- National Center for Education Statistics (NCES) – Data from this survey will be used in Phase II as the ITP begins to look at the children exiting Part C and transitioning to Part 619 services.

Broad Data Analysis Conclusions: While the broad data analysis was being conducted by the data team, the SSIP Planning Team met regularly to discuss the findings and begin to draw conclusions. At the point where the team felt comfortable with the breadth of the broad data analysis, it was decided that the data would be shared with the State's SSIP Broad Stakeholder Group (described in detail in Section 1f). The data were presented to the Broad Stakeholder Group in July 2014 through an interactive meeting where participants were asked to consider a series of questions about the data and to provide feedback. The full summary of questions and comments received from the Stakeholder Group can be found in the Appendix (Page 63-66). To summarize, the Broad Stakeholders provided the following suggestions to the ITP:

- Child Outcome Data
    - Involve parents in COS ratings at the CDSAs
    - Consider the social/emotional well-being of infants and toddlers, as well as family/parent stress, parents' well-being, and supporting family systems
    - Investigate the reliability of Child Outcomes ratings
    - Determine if child outcomes vary by diagnosis or referral source
    - Determine how states include families in the COS process
    - Determine if parents know about and understand the COS process, and if so, how that would affect ratings
    - Compare Adverse Child Experiences (ACE) data in relation to COS data
    - Disaggregate data by race/ethnicity and child's diagnosis

- Family Outcome Data
    - Examine the effectiveness of the current survey instrument, and determine if there are other options
    - Explore other data sources for family outcomes
    - Investigate why most CDSAs are not meeting targets
    - Explore strategies for increasing survey response rate
    - Examine the effectiveness of the current process of collection and dissemination of the survey
    - Share results with families

1(b): How Data were Disaggregated

Following the Broad SSIP Stakeholder Meeting in July 2014, the SSIP Planning Team began meeting to discuss the feedback received from the stakeholders at the meeting. The data team set forth a plan based on the feedback to begin disaggregating the data in various ways to determine root causes for some of the data trends that were observed in the broad data analysis.

Child Outcomes Data

Utilizing the FFY 2012 dataset comprised of all children in N.C. who received a COS rating at both entrance and exit, the data team was able to include the following additional variables in a focused analysis of child outcomes: eligibility category, age at exit from Part C, race, ethnicity, gender, region, contract status, size of CDSA, urban vs. rural CDSA, county, and setting. At the suggestion of the Core SSIP Stakeholder Group (see Section 1e), the following additional variables and combination of variables were analyzed: age at referral, length of time in EI program, urban vs. rural counties, gender & race combined.

In addition to the above variables that were obtainable from the State's data system, the data team decided to include the following variables for further analysis with the child outcomes data if possible: provider data and financial data.

The data team decided that all additional analyses of child outcomes data would be based on the progress categories for children rather than the summary statements. In examining the line-by-line child data to analyze for disaggregation, it became clear that the progress category for each child would be a sufficient indicator of change at exit from the program, since the summary statements are calculated from the progress categories. Therefore, each child's progress category is the outcome measure used in the analyses below. To simplify the presentation of the data, the data team first combined the categories of "c" and "d" to indicate "progress." This combination is logical in that Summary Statement 1 uses "c" and "d" as the numerator for progress. Next, the categories of "d" and "e" were combined to indicate "comparable functioning" for Summary Statement 2. The team used the Pearson Chi-Square test in IBM SPSS Statistics 22 for all categorical data comparisons. The general findings for each variable can be found in Table 3 below, which shows the findings of statistical significance for Summary Statement 1 (Column C) and Summary Statement 2 (Column D). Any noted differences among groups are listed in the notes (Column E), as well as any observable trends (Column F).

Table 3: Findings of Child Outcomes FFY 2012 Data Disaggregation

Column A	*Column B*	*Column C*	*Column D*	*Column E*	*Column F*
Variable	**Groups**	**Findings for c+d (SS1)**	**Findings for d+e (SS2)**	**Notes**	**Observed Trend**
Eligibility Category	Developmental delay vs. established condition	3B: Children with developmental delay more likely to show progress at exit	3C: Children with developmental delay more likely to function at age expectation at exit	Magnitude of difference for Column C is quite large	Children with developmental delay are more likely to show progress for 3B and function at age expectations at exit for 3C
Age at Exit	0 - <1 1 - <2 2 - 3	3A & 3B & 3C: As age at exit group increases, children more likely to show progress	3A & 3B & 3C: 2 – 3 year old age group less likely to function at age expectations at exit	There is an inconsistent relationship between age at exit and outcomes	Younger children are less likely to show progress but more likely to function at age expectations at exit for 3A& 3B
Race	African-American (AA) vs. Caucasian*	3A & 3B & 3C: AA children less to show progress	3A & 3B & 3C: AA children less likely to function at age expectations at exit	The differences observed were consistent among all comparisons of race	AA Children are less likely to show progress and to function at age expectations at exit
Ethnicity	Hispanic vs. Non-Hispanic	None	3C: Hispanic children are more likely to function at age expectations at exit	The observed difference in 3C is small but significant	There does not appear to be a clear effect of ethnicity on outcomes
Gender	Boys vs. Girls	None	3A & 3B & 3C: Girls are more likely to function at age expectations at exit	Column C 3A data were much lower than 3B and 3C for both boys and girls	Girls are more likely to function at age expectations at exit, but there is no difference in progress between the genders
Region	Central Eastern Western	None	None	N/A	Region does not appear to have an effect on outcomes

Column A	*Column B*	*Column C*	*Column D*	*Column E*	*Column F*
Variable	**Groups**	**Findings for c+d (SS1)**	**Findings for d+e (SS2)**	**Notes**	**Observed Trend**
Contract Status	Contract CDSA vs. State CDSA	None	None	N/A	Contract Status (State vs. Contract) does not appear to have an effect on outcomes
Size of CDSA	Small Medium Large**	None	None	N/A	Contract Status (State vs. Contract) does not appear to have an effect on outcomes
Urban vs. Rural CDSA	Urban CDSA vs. Rural CDSA	None	3A & 3B & 3C: Children in urban CDSAs are more likely to function at age expectations at exit	The magnitude of difference, though statistically significant, appears clinically small	Children in urban CDSAs are more likely to function at age expectations at exit
County	100 Counties	N/A	N/A	Number of children in many counties were too small for a comparison	
Setting	Community-Based Home Other	N/A	N/A	Most children receive services in the home, so the number of children in the other groups is too small for a comparison	
Age at Referral	0 - <1 1 - <2 2 - 3	3A & 3B: 0 - <1 age group less likely to show progress at exit 3C: 2 - <3 age group less likely to show progress at exit	3A & 3B: Children referred at an earlier age are more likely to function at age expectations at exit	There is an inconsistent relationship between age at referral and outcomes	Younger children are less likely to show progress but more likely to function at age expectations at exit for 3A & 3B

Column A	*Column B*	*Column C*	*Column D*	*Column E*	*Column F*
Variable	**Groups**	**Findings for c+d (SS1)**	**Findings for d+e (SS2)**	**Notes**	**Observed Trend**
Length of Time in EI Program	6 months – < 1 year 1 year - < 2 years ≥2 years	3B: Children in the program more than 2 years are less likely to show progress 3C: Children in the program less than 1 year are less likely to show progress	3A & 3B & 3C: Children in the program more than 2 years are less likely to function at age expectations at exit	The magnitude of difference between children who stay in the program the longest and the other two groups is quite large for 3C.	Children in the program less than 2 years are more likely to function at age expectations at exit
Urban vs. Rural Counties	14 Urban Counties 86 Rural Counties	None	None	N/A	Urban/Rural status of counties in N.C. does not appear to have an effect on outcomes.
Race*Gender	AA Boys AA Girls Caucasian Boys Caucasian Girls	None	3A & 3B & 3C: AA Boys are least likely to function at age expectations at exit, while Caucasian Girls are most likely to function at age expectations at exit	Relationship observed for Race and Gender for Column D persisted when crossing these variables.	Crossing race and gender does not appear to have a significant difference than looking at race and gender separately.

* All other races were combined into a single group, however the n was too small to use in the analysis
** The 16 CDSAs were divided into three groups based on the number of children served in the previous year

The above data were presented in data tables and graphs to the Core SSIP Stakeholder Group through a series of meetings in late 2014. As data were presented, members of the Core SSIP Stakeholder Group were asked to provide feedback and to suggest alternative analyses that they would like to be presented. When possible, the data analyses suggestions were performed by the data team and brought back to the Group for further feedback. Through this process, it became clear that the ITP would need to begin additional data collection for Phase II of the SSIP, including data on community service providers and parent income (see Section 1e).

The Core SSIP Stakeholder Group was asked to draw conclusions that could be used to guide the State's SiMR, and the following were the observations by the group:

- There appears to be variability in the relationship of age (entrance or exit) to outcomes, indicating that there may be additional differences that need to be examined beyond age.
- Time in EI Program appears to have an impact on outcomes, although inconsistently by outcome.
- There are clear race and gender differences for the Summary Statement 2 data.

- The State is consistently lowest in 3A: social/emotional outcomes for Summary Statement 1 regardless of the variable examined.

Family Outcomes Data

The data team was a bit more limited in the amount and type of data available for disaggregation of the family outcomes data due to data quality concerns related to low response rate and representativeness of the sample (see Section 1c). Additionally, it became clear through the analysis process that the NCSEAM survey responses and Rasch scoring were presented to the ITP with very limited additional variables (only age, race, gender, ethnicity, age at referral and time in program are available). The SSIP Planning Team noted this lack of data, and it will be addressed during Phase II (see Section 1e).

For the data that were available, the data team prepared a table to share with the Core SSIP Stakeholder Group which stratified the data according to the available sub-groups and three family outcomes (Table 4).

Table 4: Findings of Family Outcomes Data Disaggregation

Variable	Category	N	4A: Know rights	N	4B: Communicate	N	4C: Develop and learn
Gender	**Male**	543	75.9%	543	72.7%	543	83.2%
	Female	329	74.2%	329	71.4%	329	83.0%
Race	**American Indian/Alaska Native**	7	100.0%	7	100.0%	7	100.0%
	Asian/Pacific Islander	18	55.6%	18	55.6%	18	66.7%
	African-American	137	70.0%	137	67.2%	137	82.5%
	Hispanic	119	79.8%	119	78.2%	119	87.4%
	Caucasian	570	76.1%	570	72.6%	570	82.8%
	Other	21	66.7%	21	66.7%	21	81.0%
Ethnicity	**Hispanic**	122	79.8%	122	78.2%	122	87.4%
	Not Hispanic	744	74.6%	744	71.5%	744	82.5%
Language	**English**	788	74.7%	788	71.4%	788	82.6%
	Spanish	84	79.8%	84	77.4%	85	88.1%
Age at Referral	**0 - <1**	512	75.6%	512	72.5%	512	83.0%
	1 - <2	291	74.6%	291	71.5%	291	83.5%
	2 - 3	68	75.0%	68	73.5%	68	82.4%
Time in Program	**6 months - <1 year**	78	71.8%	78	69.2%	78	79.5%
	1 year - < 2 years	592	75.2%	592	71.3%	592	83.6%
	2 years - 3 years	202	76.7%	202	76.2%	202	83.2%

The Core Stakeholder Group noted from these results that it appears that there are both race and ethnicity differences observed for all three family outcomes. African-American families are less likely to respond positively for all three categories, while Hispanic families are more likely to respond positively for all three. There appear to be more positive responses from families of children who stay in the program longer as well. However, the SSIP Core Group felt that the patterns observed here may not be accurate due to potential data quality concerns (see Section 1c) and decided that the family outcome survey process would need to be targeted as a part of the SSIP improvement activities (see Section 4).

1(c): Data Quality

Throughout the broad and focused data analyses, the SSIP Planning Team recorded any time a data quality concern was raised internally or by external stakeholders. Data quality is of key importance when planning for the SSIP for two reasons: 1) Low-quality data can lead to false conclusions as to areas of low or high performance when selecting a focus area and SiMR, and 2) Accurate and quality data will be one of the important ways that N.C. can evaluate and track progress toward the SiMR targets and state outcomes.

Early on in the SSIP Phase I process, the ITP received a data quality profile from the Early Childhood Outcomes Center (ECO) and ECTA, *State Child Outcomes Data Quality Profile N.C. Part C* (Appendix, Pages 67-76). This document focused on child outcomes for the State, looking at accepted data quality checks to ensure that N.C. is reporting high-quality data. The report found that:

- N.C. is more than one standard deviation above the national mean for the percentage of exiting children reported on, indicating that the child outcomes data reported to OSEP are well-represented.
- N.C. was within the expected patterns and ranges for progress categories “a” and “e”, meaning that the percentage of children falling into these categories is within the expected ranges.
- N.C. data trends for the three child outcomes and two summary statements have been very consistent with a slight upward trend. The lack of variability year-to-year indicates high quality data.

However, some potential child outcomes data quality issues were noted during the comparison of data across local lead agencies (see Section 1a). In general, the State expects there to be variability in each CDSA in the percentage of children who receive COS ratings *1* through *7* at both entrance and exit, with more children on the lower range at entrance and more children on the higher range at exit. This pattern held true for most CDSAs, except as noted below:

- One CDSA (Program D) consistently rated 50% or more of children a *6* at entrance for all three outcomes, which was much higher than the State average. At exit for all three outcomes, this CDSA also had the highest percentage of children rated a *6* and the lowest percentage in the State for children rated a *7*.
- One CDSA (Program F) had scored more than 20% of children with an entrance 3B: knowledge/skills COS rating of *1*. No other CDSA reported more than 9% of children receiving a *1* at entrance. It was also noted that this CDSA rated children a *2* at entrance at almost three times the state average in the same outcome (3B).
- One CDSA (Program G) had the highest number of children receiving a *7* rating at entrance (22%), while several programs had 3% or less.
- One CDSA (Program A) rated children a *3* at exit more than 12% of the time for 3A: social/emotional, compared to the state average of 5%.

The SSIP Planning Team, after discussing the potential data quality issues listed above, theorized that due to the large number of local lead agencies (16) and the geographic diversity of the State, COS ratings

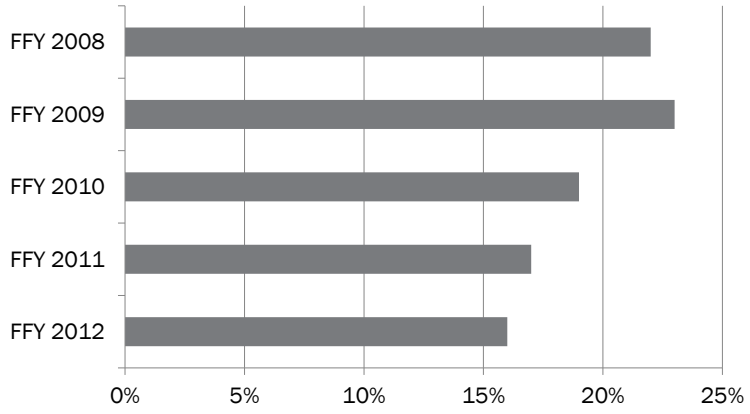
were being performed in numerous and varying ways across the State. Therefore, a more in-depth look at COS ratings was needed as a part of the SSIP process. In particular, the Team and Stakeholders felt that two improvement strategies being implemented in Phase II would address some of the concerns around ratings: *Expanding professional development opportunities and standards*, and *Continued expansion of Child Outcomes integration pilot*. These improvement strategies, once implemented, should serve to reduce the disparity in ratings as the CDSAs are trained to rate in more consistent ways across the State (see Section 4 for additional information on improvement strategies).

The majority of data quality concerns expressed during Phase I, however, involved the State's family outcomes data:

- Targets – It became clear through our work with stakeholders that the targets for our family outcomes data were too high and very few CDSAs were meeting them (see Section 1b). The ITP began using the NCSEAM Family Outcomes Survey with Rasch analysis as the family outcomes measure in the State in FFY 2006. The targets were set in 2005 after one year of data collection using the Early Intervention Services Assessment Scale (EISAS). The EISAS was only used for that one year to set targets, however, the ITP changed surveys the following year to the NCSEAM survey, which yields different results. To correct this issue, the SSIP Planning Team worked with Stakeholders to set new targets for the State Performance Plan submitted in February 2015. The ICC, local lead agencies, community service providers, State Systemic Improvement Plan (SSIP) Planning Team members, and other stakeholders were provided with historical data trends over time, graphic representation of outcomes, analyses related to mean performance, and comparisons to other states and territories. An online survey was distributed broadly to these stakeholders to ask for input on the proposed targets. A total of 21 stakeholder responses were recorded. The majority of stakeholders agreed with the proposed targets. Going forward, the revised targets should be more attainable for CDSAs.

- Response Rate – High response rates for survey administration are very important. The more individuals who respond to a survey, the more likely that the information received will be representative of the larger group you are attempting to survey. Figure 12 shows the response rate by year for the N.C. NCSEAM survey. The response rate was approximately 16% in FFY 2012, down from a high of 23% in FFY 2009. The response rate has been dropping in the State for the previous four years and continued to drop in FFY 2013 (data not shown).

Figure 12: N.C. Response Rates NCSEAM Survey FFY 2008-2012



- Representativeness of Families – In FFY 2012, there was a response rate of 16%. Over 26% of children receiving services in NC are African-American; however, only 16% of respondents were

African-American. Sixty-five percent of respondents were Caucasian while 51% of children receiving services are Caucasian.

As both response rate and representativeness data quality issues are of particular concern due to the State's commitment to collect and report high quality data, Phase II of the SSIP will focus on strategies to address these data quality issues. A more detailed discussion of the root causes for the data quality issues as well as the improvement strategy can be found in Section 4.

1(d): Considering Compliance Data

While the focus of the SSIP is on improving outcomes for children with disabilities and their families, it is important to consider the effect of compliance data on other data that is currently collected, and how it could potentially impact future data that will be collected to evaluate the effectiveness of the State's improvement activities. The SSIP Planning Team examined historical APR compliance data for N.C. from FFY 2008 through FFY 2012 to determine if there were any areas of concern related to the State's compliance data. Table 5 shows the trend in compliance over time for all compliance indicators in the APR.

Table 5: N.C. APR Compliance Data Performance FFY 2008 to FFY 2012

	Indicator 1	**Indicator 7**	**Indicator 8a**	**Indicator 8b**	**Indicator 8c**
FFY 2008	97.21%	97.25%	99.50%	99.54%	98.09%
FFY 2009	95.98%	94.60%	99.82%	99.47%	97.24%
FFY 2010	98.68%	99.77%	100.00%	99.81%	95.24%
FFY 2011	97.85%	99.39%	100.00%	99.83%	98.78%
FFY 2012	98.29%	99.03%	99.83%	99.83%	99.12%

North Carolina's performance for all APR compliance indicators is remarkably consistent over time, with very high compliance statewide. The State consistently meets timelines for IFSP development, timely services, and transition, with all indicators at greater than 95% compliance since FFY 2010. A further examination of the compliance data by CDSA showed that there are no CDSAs that consistently face compliance challenges, with CDSAs consistently above 95% as well (with some minor exceptions). After viewing this data, the SSIP Planning Team did not have any particular concerns with current compliance data. However, a potential future challenge with compliance data was raised by stakeholders during in-depth infrastructure work. There was concern that recent reductions in state CDSA positions due to legislative mandates may over-extend their resources, leading to a reduction in compliance outcomes. The SSIP Planning Team will continue to monitor compliance data to quickly identify potential challenges CDSAs may face and implement strategies for improvement, if necessary.

1(e): Additional Data

Throughout Phase I of the SSIP process, the SSIP Planning Team has been tracking additional data that the ITP will need to collect during Phase II to have as much information as possible when evaluating the impact of improvement activities on outcomes. The list of data to be collected is below, with an explanation of how the SSIP Planning Team plans on gathering the data.

Provider Data – The sixteen CDSAs in N.C. operate on a service model where the majority of services, other than service coordination, are provided by community service providers. Each CDSA enters into

partner agreements with these providers, coordinating with each to share information to ensure that families are receiving comprehensive EI services. Throughout the SSIP Phase I process, it became very clear through internal and external discussions that the ITP did not have enough information on the number and type of community service providers throughout the State. There is not a standard method for collecting provider data and feedback at the state level as each provider network is unique to each particular CDSA. Therefore the plan for Phase II of the SSIP includes additional data collection on community service providers at the state level, including:

- Number and type of providers – All CDSAs will be asked to share provider lists with the SSIP Planning Team, who will compile the number and type of providers by county.
- Provider services – Each CDSA collects data on IFSP planned services, however providers in N.C. bill for services directly when covered by private or public insurance rather than billing through the CDSAs or the ITP. Therefore, it is often difficult to obtain information on services received by children from community service providers. The SSIP Planning Team is in discussions to determine the feasibility of asking providers to report at regular intervals to the CDSAs with which they work the number and types of services provided to children in the ITP. This would allow for analysis of the services children are receiving that are provided by community service providers.
- Provider evidence-based practices (EBPs) – The Phase I process also revealed the State's desire for additional information on provider practices. The SSIP Planning Team will develop a survey using the State's Survey Max online survey software to be emailed to community service providers (after compiling the provider lists in the earlier step). The SSIP Planning Team will then explore new and innovative EBPs that have the potential for statewide replication during the SSIP process.
- Parent income – During focused data analysis discussions with the Core SSIP Stakeholder Team, the question about the effect of parent income on outcomes was discussed. The data team attempted to combine financial billing data with outcomes data, however it was discovered that most CDSAs do not collect parent income data for families who receive Medicaid. The data team, as a part of Phase II, will begin work with the CDSAs to determine if income data can be collected as a part of the intake and assessment process for Medicaid families. If the data cannot be obtained, the variable will be dichotomized into Medicaid Yes or Medicaid No for future analyses.
- Crossing child and family outcome data – When analyzing the NCSEAM family outcomes data for the broad data analysis, the data team was restricted by the number of additional variables available for disaggregation. The ITP partners with an external survey group that manages mailed and online surveys and provides a final de-identified dataset that is received back by the ITP with basic demographic data. Going forward, the State will work with the survey group to ensure that the response data is not de-identified, allowing for matching by child IDs of the family and child outcomes data. This combination of family and child outcomes is of particular importance for the State's improvement activity around incorporating families into the child outcomes rating process. By combining the data, the data team will be able to determine if including parents in the rating process increases family outcomes as well as child outcomes.

1(f): Stakeholder Involvement in Data Analysis

The State of N.C. ITP used a very broad and inclusive stakeholder process in developing Phase I of the SSIP. There were two main goals of stakeholder engagement:

1. To include stakeholders from various backgrounds who support young children and their families in the State; and
2. To ensure that the entire state is represented (geographically) as much as possible.

The ITP chose a multi-level stakeholder engagement process for Phase I of the SSIP, electing to form several groups throughout the state with the goal of gaining broad and diverse input and feedback. The multi-level stakeholder structure involved the following internal and external groups:

Internal Stakeholder Groups:

- SSIP Planning Team
- ITP State Office Staff
- ITP State Leadership Team (including EI State Office leadership and CDSA Program Directors)
- CDSA Staff

External Stakeholder Groups

- N.C. Interagency Coordinating Council
- Broad SSIP Stakeholder Group
- Core SSIP Stakeholder Group

The main internal workgroup for the SSIP, the SSIP Planning Team, consisted of the Part C Coordinator, Part C Data Manager, Team Leader for Statewide Planning and Technical Assistance Team, and several other members of the ITP's Quality Improvement Unit. A subset of this SSIP Planning Team, the data team, was led by the Part C Data Manager along with two ITP planner/evaluator staff who primarily work with data.

The initial stakeholder group for the SSIP was the N.C. Interagency Coordinating Council (ICC). The overall purposes of the ICC are to ensure the development and implementation of a coordinated interagency service system for infants, toddlers, and preschoolers with disabilities or developmental delays and their families and to serve as the major state level advisory board for the lead agency. The Council advises and assists the lead agency in the performance of its responsibilities including assignment of fiscal responsibilities, promoting methods of collaboration, and planning for grant applications.

In April 2014, the SSIP Planning Team presented an overview of the SSIP to ICC members and then conducted a group activity to help identify stakeholders for the SSIP process. ICC members were asked the question: *Who cares about improved results for children and their families in N.C.?* Members provided names of potential stakeholders, their professional or personal affiliation, and their connection to the question being asked. The SSIP Planning Team took the lists of names provided by the ICC and determined the invitation list for membership on the Broad SSIP Planning Team. Individuals on multiple ICC members' lists were the first to be included on the invitation list. The SSIP Planning Team then reviewed the remaining suggested names to determine potential members. After an initial list was compiled, the list was shared with ITP staff, who were asked to provide additional names, if possible.

It was decided early in the process that there would be a single Broad SSIP Stakeholder Group, as recommended by the ICC, which would work on both broad data analysis and broad infrastructure analysis with the ITP. The Team created numerous stakeholder categories (see below) to make certain that all components of the Early Childhood system in N.C. were represented. In total, 55 individuals from throughout the State were sent an invitation to attend a Broad Stakeholder SSIP Meeting in early June 2014, as well as an overview of the SSIP.

The initial Broad SSIP Stakeholder Group met in July 2014, with 35 attendees representing:

- Families – Family Support Program, Family Consultants

- Advocates – N.C. Child, Exceptional Children's Assistance Center (ECAC)
- ICC members
- CDSA Directors
- EI Service Providers
- ITP Staff
- Part B – Early Childhood Division at N.C. Department of Public Instruction
- Early Childhood – Smart Start and the N.C. Partnership for Children
- Referral Sources – WakeMed, Guilford Health
- Researches/Evaluators – Center for Public Health Quality
- Disability Groups -TEACCH
- Individuals with Data Expertise –State Center for Health Statistics
- Local Interagency Coordinating Council (LICC) members
- Professional Development and Technical Assistance – ECTA/DaSY
- Funders – N.C. Division of Medical Assistance

(For a full list of organizations represented in all stakeholder meetings, please see Section 2e).

The Broad SSIP Stakeholder Group meeting was a mix of interactive group activities and PowerPoint® presentations. The goal of the meeting was to receive stakeholder input on the broad data analysis results, as well as an initial infrastructure activity (discussed in Section 2f). The Group was presented with an overview of early intervention in N.C. to provide some background for individuals in the meeting who may not have worked directly with the ITP or CDSAs. Included in the overview were data from the APR, ITP funding, referrals, and enrollment over time. Next participants were given an overview of the SSIP and stakeholder process. The group activities began with presentations of ITP child data (including demographics, enrollment categories, and types of services received by children), child outcome data (explanation of child outcome ratings, progress categories, summary statements, and performance data related to each over time), and family outcome data (explanation of survey process and performance data over time). After each of these presentations, the group was divided into five smaller groups and asked to consider the following five discussion questions:

1. What do you notice? What stands out to you about the data?
2. What questions do you have about the data itself?
3. What do you think the data in this section mean?
4. From the perspective you bring to this meeting, what do you think is contributing to the current results you see?
5. What else would you want to know? (What other kinds of information do you need to better understand this data?)

The smaller groups presented their responses to the larger Group and were asked to submit comments or additional questions the groups had produced. Later, the responses were synthesized into a document that summarized the questions and feedback received during the group activities. Some of the highlights of stakeholder feedback from the meeting were:

- Family outcomes – questions about the survey administration process, return rate, survey instrument and wording as well as incentives.
- Child outcomes – questions about including families in ratings, criteria for being rated, and difference in ratings by eligibility category).
- Referral data – questions about the differences between children who are evaluated and children who are not, types of referral sources.

After the meeting, the Broad SSIP Stakeholder Group members were sent the summary of the meeting, as well as the data presented in the meeting, and were invited to attend a focused infrastructure activity in September 2014 (see Section 2f). The SSIP Planning Team then presented the SSIP overview to the ITP State Leadership Team and other CDSA staff through a series of face-to-face meetings and webinars over the next several months.

A Core SSIP Stakeholder Group was convened in September 2014 to begin working closely with the SSIP Planning Team on the focused, in-depth data analysis. They met five times over the next several months to review both the broad and disaggregated data and to start determining a focus area and SiMR. The Core Group was comprised of members of the Broad SSIP Stakeholder Group, with invitations sent to stakeholders who had expressed an interest and could provide a time commitment to continuing work on the SSIP process. The SSIP Planning Team included four CDSA directors on the Core Group to make certain that the local lead agency perspective was represented in the process. At each meeting, the Core Group was presented with data and asked to provide feedback and comments on any relationships observed between the data and potential focus area. The Core Group quickly focused on three potential areas:

- Family Outcome 4B – Historically, this was the lowest performing indicator of the three family outcomes. The Core Group felt that families effectively communicating their children's needs would improve child outcomes over time. However, the Group expressed concerns about the lack of additional family data, as well as family outcomes data quality.
- Child Outcome 3B – N.C. consistently performed lowest on this indicator for Summary Statement 2, and the Core Group felt that increasing the knowledge and skills of children would surely lead to improved outcomes. Concerns were presented about using Summary Statement 2, however, as the Core Group felt that the "spirit" of EI was more targeted toward Summary Statement 1 (progress) rather than the expectation that children are typically developing by the time they exit the program (which may not be possible for many children).
- Child Outcome 3A – This was the lowest child outcomes indicator for Summary Statement 1, and the Core Group expressed excitement about aligning social/emotional outcomes with the numerous initiatives already occurring in the State targeting the social/emotional development of children. The CDSA directors felt that CDSA staff would benefit from additional training and resources in social/emotional practices.

The Core Group then looked at some of the demographic and local lead agency differences in the broad and disaggregated data and started to draw conclusions about which CDSAs or which particular groups may need to be targeted. Although there were clear race/gender differences in some of the outcomes, the Core Group did not feel that concentrating on a particular race or gender would be feasible. Additional information on the stakeholder process for infrastructure analysis, selection of the focus area and SiMR, and improvement activities can be found in later stakeholder sections.

Component #2: *Analysis of State Infrastructure to Support Improvement and Build Capacity*

2(a) How Infrastructure Capacity was Analyzed

As the SSIP Planning Team began working on broad and focused data analysis, a parallel process was occurring with a broad and focused infrastructure analysis. The broad infrastructure analysis began with the SSIP Planning Team compiling previous ITP documents that described the current infrastructure of the program. In 2011, the ITP worked closely with OSEP on a Critical Elements Analysis process to examine the state system in two areas: general supervision and fiscal policies. As a precursor to the

infrastructure work in Phase I, the Team felt that the final document (the Critical Elements Analysis Guide - CrEAG) provided a very good broad overview of the state system. In particular, the following areas were addressed in the CrEAG process and explained in the document:

- Description of the general supervision system that is reasonably designed to identify noncompliance in a timely manner using its different components.
- A general supervision system that is reasonably designed to ensure correction of identified noncompliance in a timely manner.
- Procedures and practices that are reasonably designed to implement the dispute resolution requirements of the IDEA.
- A data system that is reasonably designed to timely collect and report data that are valid and reliable and reflect actual practice and performance.
- Procedures and practices that are reasonably designed to implement selected grant application requirements, i.e., monitoring and enforcement related to local determinations and interagency agreements, contracts or other arrangements.
- Procedures that are reasonably designed to ensure the timely obligation and liquidation of IDEA funds.
- Procedures that are reasonably designed to ensure allowable use of IDEA funds at the State level.

Although all seven components of a comprehensive infrastructure analysis were not expressly stated in the document, the CrEAG addressed many of the elements. The SSIP Planning Team updated and used this document and other resources, including the *System Framework for Part C & Section 619,* to complete the *SERRC Infrastructure Analysis Guide Broad Data Analysis* document. This guide served as the SSIP Planning Team's initial attempt to ask questions related to the seven components of infrastructure (see Section 2b), focusing on areas within the state infrastructure that are contributing to both low and high performance.

Following this initial attempt at identifying key broad infrastructure questions, strengths and challenges by the SSIP Planning Team, an infrastructure exercise was conducted with the Broad SSIP Stakeholder Group in July 2014. The meeting (described in Section 1f and 2f) was used to gain feedback from the stakeholders on their knowledge and perception of EI in N.C. The infrastructure exercise, conducted with assistance from ECTA and DaSY staff, utilized the *North Central RRC SWOT Analysis Activity-State Infrastructure* outline to ask stakeholders for specific feedback on the general strengths, weaknesses, opportunities, and threats (SWOT) of the state system. The results of the SWOT analysis with stakeholders can be found in Section 2c.

This information was summarized by the SSIP Planning Team, which assigned members of the team specific tasks of collecting additional information requested by stakeholders. These items included questions on existing state initiatives and recent funding changes to the system (discussed in Section 2c). Two months later, the Broad SSIP Stakeholder Group reconvened to continue to work on infrastructure analyses. This meeting in September 2014 was used to conduct an in-depth infrastructure analysis activity with the Group (a "gallery walk"). Participants were first provided with an overview of the seven components of infrastructure set forth in the *System Framework: Components Descriptions – ECTA Center*, as well as an overview of the proposed SWOT format. Stakeholders were divided into four groups, and given a specified time period to review the "definition" of the component and identify strengths, weaknesses, opportunities and threats related to the system component, as well as current state-level improvement plans and early childhood initiatives that might support improving results for children and families. At each station, an SSIP Planning Team member or ECTA/DaSY TA provider recorded the stakeholders' feedback in each of the four SWOT areas for a selected component of infrastructure. The four groups moved from station-to-station until all groups had an opportunity to provide input in each of

the seven areas of infrastructure and on state initiatives. Whenever a new group would repeat feedback provided by a previous group, the note-taker would star the item. Starred items were important during the review process, as they indicated key infrastructure areas that would need to be examined further. Following this activity, the Broad SSIP Stakeholder Group reconvened as a whole group and were asked what they had learned and if they felt this exercise was helpful. The stakeholders expressed that the activity captured vital information and provided a clearer picture of the infrastructure of the ITP.

As a result of the gallery walk activity, the SSIP Planning Team was able to synthesize the feedback provided by stakeholders into a single document separated into the seven components of state infrastructure, current state-level improvement plans, and early childhood initiatives. This document was then condensed into a single one-page summary of the SWOT for the ITP. Both documents can be found in the Appendix, Pages 77-85, and are summarized in Section 2c.

Alignment with Data Analysis

Once both broad and in-depth (focused) infrastructure analyses were completed in September 2014, the Core SSIP Stakeholder Group began meeting regularly. The Core Group was provided with the gallery walk summary, as well as the results of the broad and disaggregated summary, and asked to draw conclusions based on the information collected. In particular, the Core Group found alignment in the following areas:

- Provider network concerns
- Family outcomes data and process concerns
- Interest and concern about the social/emotional health of children
- Interest in increasing the knowledge/skills of children

These areas are explained in greater detail in Sections 3 and 4.

2(b): Description of State System

Utilizing the instruments and tools described in Section 2(a), along with additional TA resources, the SSIP Planning Team was able to accurately analyze and describe the seven state system components of the ITP infrastructure. In this step, the goal of the team was to define each component, rather than to make judgments about their strengths and challenges. A full description of the strengths and challenges of each component identified by stakeholders can be found in Section 2c.

Governance

The EI Branch, which oversees the ITP is organizationally located within the state Department of Health and Human Services (DHHS), Division of Public Health (DPH), Women's and Children's Health Section (WCHS). The EI Branch provides services and supports to children and families throughout N.C. through sixteen regionally-based Children's Developmental Services Agencies (CDSAs). The EI Branch is led by the Branch Head, who acts as the final decision-making authority for all ITP-related decisions not requiring full approval of DHHS or DPH. The Branch Head also serves as the main representative of the EI Branch at both WCHS and DPH leadership meetings, to ensure coordination with other Branches and Sections within DHHS.

The EI Branch's State Office (EISO) is divided into two units: Quality Improvement and Program Support. Their roles are to support ITP services in the state and provide technical assistance and oversight to and monitoring of the local lead agencies, CDSAs. The Quality Improvement Unit has three teams:

Data Management, Regional Consultants, and Statewide Planning and TA. Under the Program Support Unit are the contract development, program operations, and administrative staff.

The CDSAs, as the local lead agencies, provide assessment and evaluation services and also work with community-based service providers who provide EI services through provider agreements. Each CDSA is led by a Program Director responsible for overseeing all staff and compliance with IDEA and N.C. laws and statutes and ITP policies and procedures. Four of the 16 CDSAs are managed through a state contract rather than being directly employed by the State of N.C. In these contract CDSAs, the Program Directors are responsible for compliance with the state contract stipulations and rules.

EI State Office staff participate in numerous local, state and federal early childhood groups and committees, including the following: ITCA, ABCD Project Steering Committee, Smart Start Boards, ECTA Center Learning Communities, N.C. Mental Health Association Workforce Development Project, Department of Public Instruction's Deaf/Blind and Assistive Technology Advisory Councils; Division of Public Health's Children with Special Health Care Needs, Early Hearing Detection and Intervention and Early Childhood Matrix Team Advisory Councils.

The ITP maintains interagency agreements with the N.C. Department of Social Services (DSS) for children referred as a result of the Child Abuse Prevention and Treatment Act (CAPTA) and the Children and Youth Branch of DPH to improve the health of young children with hearing loss. CDSAs have interagency agreements with local Head Start programs for referrals and child find.

The EI Branch has a memorandum of understanding with: the Department of Public Health, Women's and Children's Health Section, Division of Child Development, the Department of Public Instruction and others to ensure quality professional development and coordination of services, as well as the Division of Medical Assistance regarding the sharing of data and the Department of Public Instruction Sensory Support Programs.

Fiscal

The ITP is funded through a mix of Federal Part C funding, state government funding, family fees and Medicaid/other third party payor reimbursements. Systems are in place at the ITP that ensure money is spent according to IDEA and N.C. laws and statutes. The components of the fiscal system are explained below:

Staff - Financial officers (FO's) at each CDSA are responsible for ensuring CDSA billing practices are efficient and comprehensive and for maintaining compliance with ITP, N.C., and OSEP regulations related to Part C funds. These individuals are trained in billing and reimbursement practices through the State at the time of employment and meet weekly as a group and twice yearly with the ITP State Leadership Team for continued trainings and to discuss changes in billing rules/practices and challenges related to new requirements.

Procurement (Contracts, Purchasing) - The EI State Office staff work closely with the State Contract Office and the Purchasing Office in procuring all services and goods. All contracts go through a multi-level departmental review process prior to execution. This ensures that the terms of the contracts are acceptable and the scope of work is in line with the program objectives. Contractors must submit monthly reports to ensure expenditures are being correctly reimbursed. The ITP follows state procurement rules and guidelines for goods and services through the competitive bid process utilizing requests for proposals (RFP), request for quote (RFQ), and invitation for bid (IFB). Competitive grant opportunities are provided through the request for applications (RFA) process. Sole source contracts follow state guidelines regarding waivers of the competitive bid process. All purchases with Part C funds are pre-

approved by the ITP, which is responsible for ensuring appropriate purchases and use. An annual inventory is conducted of fixed assets physically identifies and records all items in the fixed asset system.

Fees, Billing, Reimbursement - The ITP has an established policy which stipulates that Part C funds are the payor of last resort. These funds are not used to pay for services that should be paid by another public or private source. The ITP has a system of payment for early intervention services called the sliding fee scale where each CDSA is responsible for assessing the family's financial status to determine the family's contribution. If the family is enrolled in Medicaid, the provider is required to bill Medicaid for eligible services. If a child or family has private insurance, the ITP provider may bill private insurance with parental consent. After insurance payment or denial, the provider is reimbursed through ITP funding and/or family, as applicable, following procedures outlined in the ITP Manual.

Quality Standards

The ITP bases its high-quality practices on established evidence-based early intervention principles for infants and toddlers with disabilities. Adherence to these principles at the CDSA level is accomplished through consistent implementation of standard eligibility evaluation, assessment, service planning, and service delivery processes. Ensuring procedural safeguards such as obtaining consent, working with families in their native languages, providing prior written notice, and informing families of their rights, also supports the implementation of high-quality practices.

The ITP uses the following child and program level standards that are appropriate for children with disabilities:

- Child Outcome Summary Process to document children's functioning in three outcome areas.
- Standardized/normed evaluation instruments to determine eligibility for children with disabilities.
- Evidence-based assessment instruments to identify the routines, unique strengths and needs of the child and the identification of services appropriate to meet those needs.
- Individualized Family Service Plan, which includes specific child and family outcomes, monitored by the service coordinator regularly.

The following systems and standards ensure high-quality early intervention services:

- Infant-Toddler Program policies and procedural guidance documents provide consistent information to CDSAs and community service providers.
- Each CDSA has a Quality Assurance Coordinator or designated CDSA staff to ensure quality services, provide technical assistance and guidance, and implement improvement strategies, when needed.
- The Regional Consultants provide technical assistance and guidance to the CDSAs regarding implementation of Part C regulations.
- The Child Record Review Tool is a self-assessment instrument which identifies compliance and results on IDEA and ITP requirements implemented at the CDSA.
- EI State Office staff provide oversight of the ITP through self-assessment and focused monitoring processes to ensure these high-quality standards are being implemented. The Regional Consultants provide technical assistance and guidance regarding Part C regulations. The Regional Consultants may assist the CDSAs with correction planning.

The Provider Agreement, Agreement Attachment, and ITP policies and procedures provide necessary information to enrolled community service providers. When a community service provider enters into an Agreement with a CDSA, the provider assures compliance with ITP policy and procedures. The CDSA also has meetings with its enrolled providers to emphasize and clarify policy and procedures and provide

updates and technical assistance, as needed. CDSAs are responsible for monitoring activities with their assigned provider network.

Professional Development

The ITP has a coordinated professional development system with the following components:

- *Recruitment and retention*: For the EI Branch State Office and the majority of the CDSAs (12), recruitment and retention are handled through the Office of State Human Resources. Career opportunities within the EI Branch and its CDSAs are listed under the Department of Health and Human Services. There are four contract CDSAs which follow the recruitment and retention policies and procedures of their respective lead agencies (university, health system, county government, and public health system).

- *Personnel standards and competencies*: The ITP follows the IDEA definition of qualified personnel, which means personnel who have met State-approved or recognized certification, licensing, registration, or other comparable requirements that apply to the areas in which the individuals are conducting evaluations or assessments or providing early intervention services. Licensed professionals must follow the requirements of their licenses. For EI service coordination and special instruction services, the ITP outlines requirements for personnel standards and competencies in the Guidance for Personnel Certification (http://www.beearly.nc.gov/data/files/pdf/ITPGuidePersonnelCert.pdf). ITP certification is awarded based on meeting criteria outlined in this document. Continued education is required yearly, and the ITP verifies certifications through monitoring activities. The guidance also lists education opportunities to maintain competency in early intervention.

- *Professional development strategies*: Continuing professional development is required for all certificate holders. The annual continuing professional development requirement is 10 contact hours (1.0 CEU), to be obtained between January 1 and December 31 of the year. Contact hours/CEU credits must focus on infants and toddlers, with or without disabilities, and their families, and must be obtained from one or more of the education providers listed on www.beearly.nc.gov. Certificate holders must obtain contact hour/CEU credit documentation. Audits requesting documentation from certificate holders may be required at any time from the CDSA or the EI State Office for the previous two calendar years from the date of the audit request. The EI website also has online trainings provided by the ITP on IFSP development, COS ratings, and transition.

- *Needs assessment or evaluation of the professional development system*: The Statewide Planning and TA Team conducts statewide needs assessments regarding training topics, identifies resources for training and technical assistance and develops informational materials to support professional development. As training modules and informational materials are created, they are posted to the EI website and disseminated to CDSAs. The approved continuing education provider list is posted on the EI website and is maintained and reviewed periodically by the EI State Office to ensure that information is current.

The ITP incorporates stakeholder and staff input and data to inform the professional development system through public review and comment. The *Guidance for Personnel Certification* was posted in December 2013 on the EI website (www.beearly.nc.gov) and made available for public review and comment. The posting was also sent to ITP staff for their input. The guidance generated feedback that was reviewed and taken under consideration for revisions to the guidance, which was issued January 2014. Subsequent

proposed revisions to the *Guidance for Personnel Certification* would also be posted for public review and comment. The ITP staff are involved in several workgroups and advocacy efforts throughout the state, helping to promote the importance of EI services in the state.

Data Systems

North Carolina has used a statewide, child-specific data collection system to collect Part C (and previously Part H) data since 1994. From 2005-2010, the State used the web-based Comprehensive Exceptional Child Accountability System (CECAS), which was a data system used jointly by Part C and Part B. Each CDSA was responsible for data entry into CECAS. As of July 2010, all older ITP data were migrated into a new statewide data system, the Health Information System (HIS), which utilizes the Avatar EHR from Netsmart Technologies. Through the Client Services Data Warehouse (CSDW), as well as crystal reports, the EI State Office Quality Improvement (QI) Unit staff monitor monthly data entry and generate reports. The data are maintained at the child level in HIS, which allows for future Early Childhood Integrated Data System (ECIDS) matching with other early childhood data sources. Since the local lead agencies enter child specific data directly into HIS, there is no need to submit 618 summary data to the state office.

At the State level, QI Unit staff use data from the statewide system to generate data for federal reporting. Fields used for reporting from HIS contain consistent dictionaries across CDSAs, so consistent values are used. Each CDSA is expected to complete data entry for a month by the 10th of the following month. The Program Evaluation Team within the QI Unit consists of three staff that provide ongoing technical assistance to CDSAs around data collection and monitor the data system for reporting issues. Annual data-cleaning activities are coordinated by the QI Unit Program Evaluation team. Prior to 618 data submission, data clean-up activities are conducted through the HIS system to ensure the resolution of invalid or missing data issues. The APR is reviewed by multiple staff in the EI State Office, which includes review of data included in the report. Anomalies are identified by the Program Evaluation Team and submitted to CDSAs during the process of monthly data monitoring of HIS data. The CDSAs are given a deadline date for correction.

Additionally, there is a three-year cycle for statewide review of all local lead agencies. During this data verification cycle, six CDSAs are targeted for on-site data monitoring each year. During these visits, the validity and reliability of reported data is confirmed by QI Unit staff. All CDSAs are required to use the statewide data system for reporting 618 data. The data verification process validates that the data entered into the statewide child specific data system are consistent with the data in the child's paper record. These internal processes ensure consistency in review, analysis and reporting.

Technical Assistance

The EI State Office staff provide technical assistance, as part of an effective system of general supervision, which is directly linked to the SPP indicators and to improvement activities. Technical assistance serves multiple functions to assist CDSAs in improving results and compliance. The EI State Office provides CDSAs and their community service providers with a range of assistance to provide information and improve performance from minimal assistance to substantial interventions. EI State Office teams and their TA activities include:

- Regional Consultants: Three consultants are located in the West, Central, and East parts of the state. These consultants provide TA at the CDSA level. TA is provided to CDSA staff as needed on:
    - implementing IDEA regulations and ITP policies and procedures,
    - helping local lead agencies develop effective corrective action or improvement plans based on the data and contributing factors,

    - implementing strategies outlined on corrective action plans,
    - assisting local lead agencies in understanding the data, including factors contributing to noncompliance or performance issues, and
    - providing targeted technical assistance to address specific local needs related to improvement.
- Statewide Planning and TA Team: This team consists of three Planner/Evaluators and one Planner/Evaluator/Supervisor who provide TA on the statewide level by meeting the informational needs of CDSAs, enrolled community service providers, families, federal and state funders, and other EI stakeholders. This Team:
    - develops and disseminates up-to-date statewide information and clarification relating to IDEA Part C and ITP's implementation of these requirements (e.g., IDEA 2011 training, Introduction to EI in N.C., IFSP training, AT Loan System training, Information on Family Outcomes Survey Process),
    - clarifies and communicates statewide program goals and priorities,
    - facilitates pilot implementation (e.g. Child Outcomes Integration Pilot),
    - researches and informs on best practice models, and
    - provides TA to contracted agencies which provide EI services to enrolled infants and toddlers (e.g., AT Loan Program, ECAC).
- Program Evaluation Team: This team consists of two Planner/Evaluators and one Data Manager who provide TA to CDSAs on the electronic medical record and billing system, data entry processes and reports to ensure reliable data that reflect current performance, and inform decisions. Technical assistance is provided at the CDSA and statewide levels.
- Quality Improvement Unit: Various staff of the QI Unit who make up the aforementioned teams also review, revise, disseminate, train and provide CDSA and/or statewide technical assistance on ITP policies and procedures that guide N.C.'s implementation of IDEA.

Technical assistance and capacity-building activities are implemented at varying levels (e.g. leadership, supervisors, EI service coordinators, and community service providers) and through multiple means such as websites, procedural guidance documents, PowerPoint® presentations, coaching, mentoring, training-of-trainers, self-studies, local and/or statewide meetings, and face-to-face training from EI State Office staff and/or from other resources (e.g., ECTA or other TA providers).

Accountability /Monitoring

The ITP has several processes and procedures in place to monitor local lead agency compliance and ensure quality data are maintained on the children and families served in N.C. The ITP's annual self-assessment process allows the state to gather data related to compliance indicators and related requirements through local record review and data inquiry by the CDSAs. Through review and analysis of local self-assessment data and narrative reports, and other monitoring methods, noncompliance may be identified for compliance indicators (e.g., timely services, 45-day timeline, and transition steps/notification/conference). The self-assessment process, desk audits, on-site visits, complaint processes, other monitoring methods inform compliance, overall performance, and areas needing correction or improvement.

North Carolina also uses its database and other data reports to identify instances of low performance on performance indicators (e.g. natural environment, number served birth-to-one and birth-to-three, child outcomes, family outcomes) for each CDSA. If a CDSA's performance is substantially less than the State-established target for any performance indicator, the CDSA may be required to develop an improvement plan. For data verification, six CDSAs are selected randomly to receive an onsite visit per year. Data verification site visits confirm the authenticity of performance and compliance data consistent with internal procedures. When local findings are made, both the Program Evaluation Team and the

Regional Consultants engage in technical assistance activities to ensure the timely correction of non-compliance and to modify any local practices leading to data anomalies. Data verification and self-assessment systems are in place to monitor programmatic weaknesses. Through the corrective action process, improvements are instituted and tracked. The data generated from our system is used to respond to local, legislative and financial data requests. When a corrective action plan (CAP) is issued, the CDSA must show progress as indicated through data. Program Evaluation Team staff may provide the Regional Consultant with data to help inform the decision if the conditions of the CAP have been met. CDSAs participate in monthly child record review exercises to track program performance and compliance. Regional Consultants are present during these record review exercises and also provide technical assistance on an ongoing basis, based on local needs. In addition, Quality Assurance Coordinators are employed by several CDSAs to provide local monitoring at the CDSA level. Data is used for decision making through the regular sharing of monthly statistics on program performance (monthly data reports). In addition, collaboration between Regional Consultants and local lead agencies identifies systemic challenges which are then submitted to the Statewide Planning and TA Team for further analysis and statewide planning. Regional Consultants review data with local lead agencies and help to strategize for improvement.

2(c): Systems Strengths and Areas for Improvement

In addition to the SSIP Planning Team's work on defining the ITP's infrastructure, internal and external stakeholders were provided several opportunities to provide input as to the strengths of and challenges within the system. The first infrastructure activity with the Broad SSIP Stakeholder Group followed a SWOT analysis framework, with input solicited for the ITP as a whole, rather than the seven components of infrastructure. The goal of this broad SWOT analysis was first to gain an understanding of the external view of the general strengths and areas of improvement for the EI system in N.C. The Group provided over 100 different responses in the four areas (strengths, weaknesses, opportunities, threats), with the largest number of responses in the weaknesses and opportunities quadrants. A summary of key points of the respondents can be found below:

Strengths: flexibility of the EI system to change; good at meeting compliance measures; common mission, vision, goals; collaboration with community partners; innovation at CDSAs (particularly around community service providers and supporting families);

Weaknesses: community service provider resources/networks (not enough providers); uneven staffing at CDSAs due to budget cuts; geographic diversity of CDSAs leads to different processes across the State; data on community service providers and provider services; lack of accountability of community service providers; professional development opportunities for staff;

Opportunities: look at Return On Investment (ROI)/economic indicators; working with Part B on similar indicators linking the birth to 21 spectrum; SSIP process; further data analysis, including referral data; examine long-term outcomes to show effectiveness (costs) related to EI services; longitudinal data system across multiple data sources (ECIDS); exchanging ideas and collaborating with other Part C programs;

Threats: finance – loss of positions/$10 million reduction; loss of Medicaid revenue; moving away from compliance toward outcomes; relationships with family due to fewer opportunities to meet face-to-face (less staff, higher caseloads); current staff having to take on additional duties due to lower number of staff; change in leadership.

Some of the major conclusions that could be drawn from this broad analysis were:

- CDSAs – Local lead agencies are innovative with community service providers and families and effective at compliance.

- Community Service Providers - There is concern about the lack of data on providers and provider services, the lack of accountability of providers, and the general need for additional providers.
- Funding – There is concern that recent budget reductions to the ITP program will have an impact on quality and staff.
- There are additional needs for professional development.

The SSIP Broad Stakeholder Group reconvened two months later to participate in a more focused and in-depth infrastructure analysis utilizing a gallery walk activity (See Section 2a). After providing input on the SWOT of the seven components of the ITP, the SSIP Planning Team combined the information received through the activity into a single document (Appendix, Page 86). This document allowed the Team to draw major conclusions for each of the seven state components of infrastructure:

Governance

- Stakeholders felt that the program faced challenges due to the small size of the staff at the EI State Office, which impacted the ability to look at a balance of both compliance and quality of local lead agencies and community service providers.
- Multiple retirements within the governance structure (Branch Head, Section Chief, and vacant CDSA Directors) are a potential threat due to uncertainty.
- Opportunities exist for ITP to work with families on advocacy, and increasing roles of LICCs.

Fiscal

- There are threats to ITP and EI system due to recent loss of 160 positions in the state CDSAs, and concerns for future state budget cuts.
- Current funding/allocation formulas do not support additional costs incurred by community service providers and CDSAs for travel and other expenses, impacting service provider participation in CDSA provider networks.
- There is uncertainty with continued third-party funding due to Medicaid reform and Accountable Care Organization implementation throughout the State.

Quality Standards

- The ITP has recently released additional procedural guidance documents and policies providing more direction to local lead agencies (serves to create uniformity in the system).
- There are concerns about standards for family outcomes, as well as provision of service coordination with families with reduced staff (effects on quality).
- There are concerns about provider quality (no consistent quality standards for special instruction providers), as well as lack of standard training for special instruction providers. There is also a lack of knowledge of evidence-based practices at the provider level, particularly as they relate to special instruction.

Professional Development

- Lack of funds for professional development creates a challenge to continuing education, particularly with service providers who are not reimbursed for trainings and professional development opportunities.
- External resources are available for training, but need to be well-organized and accessible to CDSA staff and community service providers.
- Stakeholders were enthusiastic about making ITP aware of new and existing opportunities for training (UNC-CH School of Social Work, TEACCH, Association of University Centers on Disabilities (AUCD), FRIENDS Resource Center, National Implementation Research Network (NIRN), Carolina Institute of Developmental Disabilities (CIDD) and Smart Start).

Data Systems

- Stakeholders felt that there were several staff at the ITP and within N.C. State Government who understand and can work with/analyze data.
- The ITP data system (HIS) is comprehensive and allows for data reporting, however, additional work is needed to utilize all components of the system.
- Local lead agencies would benefit from additional access to data reports (local and State-level).
- Little to no provider data are centralized for ITP use in supporting CDSAs.

Technical Assistance

- The EI State Office QI Unit employs Regional Consultants and other technical assistance experts who are geographically located in CDSA offices. However, concerns exist about the number of staff (six) for 16 local lead agencies.
- Opportunities exist for more targeted and planned TA to CDSAs, particularly taking advantage of existing TA resources (FRIENDS Resource Center, NIRN), as well as opportunities for local lead agencies to provide TA to one another.
- OSEP provides access to TA resources and personnel for Part C programs. N.C. is fortunate to have local ECTA/DaSY staff in close proximity.

Accountability/Monitoring

- A strong focused monitoring system exists for ITP to work with CDSAs on quality and compliance.
- There is a lack of consistent monitoring of community service providers in the State, leading to reduced understanding of evidence-based programs used.
- Increased data collection has led to increased accountability for local lead agencies. However, often CDSAs have too much data and do not know how to prioritize.

2(d) State-level Improvement Plans and Initiatives

To improve outcomes on a statewide basis for children with disabilities and their families, the existing resources of the early childhood system in N.C. must be leveraged. It would be impossible for a single state program to implement widespread systemic improvement without working with other local, State, and Federal partners. With this knowledge, the SSIP Planning Team began working in mid-2014 to identify existing and upcoming early childhood initiatives throughout the State. Additionally, as a part of the Broad Stakeholder Meeting in September 2014, stakeholders were asked to identify existing local, state and federal early childhood programs and initiatives that could be brought on as partners in the six-year SSIP process. The stakeholders identified over 40 potential partners to add to the SSIP Planning Team's list.

Upon selection of the SiMR, the SSIP Planning Team re-examined the list of initiatives and prioritized the ones that are directly related to social/emotional development of children, would potentially be available in the targeted areas of the State, and were aligned with the improvement strategies the State is going to implement as a part of the SSIP process (See Section 4). The initiatives and organizations the ITP hopes to begin or continue working with are listed below. Of key importance when selecting partners is the consideration that the initiative/organization is aligned to achieve common goals of the SSIP and is addressing the needs of infants and toddlers with disabilities and their families:

The North Carolina Infant Mental Health Association (NCIMHA)– The ITP has been working with this group, which describes themselves as, "the only statewide organization dedicated specifically to the healthy emotional, cognitive and social development of children prenatal to five years old,"

(NCIMHA.org) for several years, with CDSA participation in the Association. The NCIMHA provides resources to local parents, providers, advocates, legislators, and state agencies around the social and emotional health and development of children. The Association has endorsed a new proposal on "Early Childhood Mental Health Workforce Development." The ITP will consult with NCIMHA on evidence-based social/emotional practices for children and core competencies of professionals that support the social/emotional needs of infants and toddlers and their families. The ITP will invite members to participate in Phase II implementation activities. Additional work will be needed from the ITP to strengthen this partnership in Phase II.

Race to the Top/ Early Childhood Integrated Data System (ECIDS) – In 2011 the State of North Carolina received a federal Race to the Top/Early Learning Challenge grant from the federal government. A major goal of this grant was create an Early Childhood Integrated Data System which "integrates early childhood education, health, and social service information from key participating state agencies." (ECIDS Presentation) The focus for the ECIDS will be all children receiving state and federal services from participating agencies within N.C. that serve children ages 0-5 years old. The ITP has been asked to provide data for the ECIDS project, and staff from the ITP are participants on several workgroups at the State level. This initiative aligns well with the State's SiMR because, for the first time, it will allow tracking of children transitioning out of Part C services into other state systems (particularly Part B/619 programs). In order to gauge long-term effectiveness of any intervention, child data must be tracked longitudinally to determine if the intervention worked and if progress was sustained over time. Currently, the ITP has no way of gathering data on outcomes for children who exit Part C services beyond the exit disposition assigned to the child. With ECIDS, the ITP can have access to data which will allow for tracking of children through age five. In particular, Part B/619 entrance and exit Child Outcomes data can be obtained for children who exited Part C, allowing for tracking of social/emotional indicators at several points in time. An additional goal of the ECIDS project is to engage with another longitudinal data system (P20) tracking data for 5-21 year olds, which would allow for data collection on very long-term outcomes of early intervention services.

Exceptional Children's Assistance Center (ECAC) Parent Training and Information Center (PTI) – The Executive Director of ECAC has participated on both the Broad and Core Stakeholder groups and has been a strong voice of families in the SSIP Phase I process. The ITP plans on expanding its partnership with ECAC in Phase II to begin leveraging the PTI Center's resources and personnel. PTI provides education, training, and support to families and professionals who have or work with young children with disabilities. A major improvement strategy for the N.C. SSIP is to evaluate and expand the current work being done that engages and teaches families about early intervention services and outcomes for children with disabilities. The PTI/ITP partnership will provide CDSAs with more access to family resources and support services, which are often challenging at the local level. This was identified earlier through the infrastructure analysis as a potential system weakness.

Child First – "[I]s an innovative, home-based early childhood intervention, embedded in a system of care. *Child First* works with the most vulnerable young children (prenatal through age five years) and families to decrease serious emotional disturbance, developmental and learning problems, and abuse and neglect." (Child First website) N.C. has been working for the past several years to determine the feasibility of implementing this system. Staff from the EI State Office have served on the Child First Key Partner Team for planning. The plan is to have the members of the Child First Key Partner Team transition to the State Implementation Team. The goal of the team will include ongoing cross-system building. The Child First State Implementation Team, which also includes representation from the ITP, will work on state and local integration including building partnerships with other key agencies and organizations that provide social/emotional supports and services to young children and their families.

The Center on the Social and Emotional Foundations for Early Learning (CSEFEL) – This center is funded by the Office of Head Start and the Child Care Bureau, Administration for Children and Families, U.S. Department of Health and Human Services to provide training and technical assistance to selected states, including N.C. Its broad goal is to foster professional development of the early care and education workforce that: 1) enhances knowledge and skills; 2) supports the implementation and sustainability of evidence-based practices; and 3) increases the size of the workforce skilled in supporting the social emotional development of young children (birth – five years old). CSEFEL has developed a conceptual model of evidence-based practices for promoting young children's social and emotional competence and for preventing and addressing challenging behavior. This model is referred to as the Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children. CSEFEL has also developed extensive, user-friendly training materials, videos, and print resources to help N.C.'s communities and programs implement the model. Early Intervention State Office staff have served on the N.C. CSEFEL Planning Team. The initiative in N.C. has included training professionals and implementing demonstration sites. The CSEFEL Pyramid Model concepts are also now included in higher education curricula for child development classes. The ITP plans to strengthen collaboration with the N.C. Part B 619 program, which has provided extensive training and coaching on the CSEFEL Pyramid Model to professionals in their program, to develop strategies for including these concepts in discussions and interventions with families in the ITP.

Global Child Outcome Pilot Program - The ITP piloted successful implementation of global child outcomes integration in 13 counties in N.C. over the past year. An evaluation of the implementation showed that families in the pilot catchment areas are more involved in discussing their children's developmental needs and progress in relation to the three global child outcomes. The evaluation recommends expansion of the implementation to the remaining counties in the state. Recommendations from local and state level stakeholders have included a plan to integrate the expansion of this initiative with the SSIP by incorporating implementation activities for this initiative with the activities in the SSIP, targeting the counties included in the cohort selected for the SSIP focus.

The North Carolina Institute of Medicine: "Growing Up Well: Supporting Young Children's Social Emotional Development and Mental Health in N.C."- This Task Force recommendations include many evidenced-based strategies that could be pursued at the state, county, and local levels. Taken together, they provide guidance on how to create the kind of comprehensive, integrated system that is needed to support the social/emotional development and mental health of all young children. To make a real difference, N.C. needs to engage simultaneously in multiple strategies. Implementation of the recommendations will have a meaningful impact on the lives of N.C.'s youngest children and their families as well as generate large economic returns for the state. ITP will review these recommendations with stakeholders and determine how these recommendations support the state's improvement strategies.

North Carolina Division of Public Health/Children and Youth Branch: Maternal, Infant and Early Childhood Home Visiting Program - The program is designed: (1) to strengthen and improve the programs and activities carried out under Title V; (2) to improve coordination of services for at-risk communities; and (3) to identity and provide comprehensive services to improve outcomes for families who reside in at-risk communities. Based on findings from the comprehensive state-wide needs assessment, the North Carolina Home Visitation (NCHV) program will implement a continuum of evidence-based home visitation services (Nurse-Family Partnerships, Triple P, Healthy Families America) for families with children ages 0-8 that will support each child's physical, emotional, cognitive and behavioral well-being, and will provide children the resilience they need to enter school ready to achieve and on their way to success in life. Outcomes will be achieved by implementing or enhancing evidence-based home visitation (EBHV) programs, replicated with model fidelity, that fill gaps to meet the needs of these families living in high risk communities in the state. The ITP will

collaborate with these programs as a member of the DPH Early Childhood Matrix Team and determine how to integrate strategies across systems.

2(e) Representatives Involved

The following organizations were represented as a part of the SSIP Phase I internal and external stakeholder process:

Role	Organization
Speech Language Pathologist	Carolina Institute for Developmental Disabilities (CIDD)
Program Director	CDSA of Western North Carolina
Supervisor	Concord CDSA
Assistant Director	Concord CDSA
IDC Part C Lead	DaSY/ECTA/IDC
Technical Assistance Specialist	DaSY/ECTA/IDC
Assistant Director, Programs and Educational Services	Division of Child Development and Early Education (DCDEE)
LICC Representative	Durham LICC
Executive Director	ECAC
SSIP Planning Team Supervisor	EI State Office
Branch Head	EI State Office
Part C Coordinator, QI Unit Supervisor	EI State Office
Part C Data Manager	EI State Office
Program Support Team	EI State Office
Program Support Coordinator	EI State Office
Program Support Team	EI State Office
State Implementation Specialist and Data Analyst/ Part B SSIP Coordinator	Exceptional Children's Division at N.C. Department of Public Instruction
Intern/Social Work Student	Family Support Program, UNC
Research Assistant Professor	Family Support Program, UNC
ICC Professional Co-Chair	ICC
Supervisor	Morganton CDSA
Senior Fellow, Health and Safety	N.C. CHILD
Family Planning & Reproductive Health Unit Supervisor	N.C. Division of Public Health
Nutrition Program Supervisor	N.C. Division of Public Health
Program Manager, Center for Public Health Quality	N.C. Division of Public Health
Community Based Programs Administrator	N.C. Division of Social Services
Vice-President	N.C. Infant Mental Health Association
Program Director	New Bern CDSA
Children's Behavioral Health Services Manager, Behavioral Health Section	N.C. Division of Medical Assistance (DMA)
Special Projects Manager	Prevent Child Abuse North Carolina

Role	Organization
Assistant Director	Rocky Mount CDSA
Program Director	Sandhills CDSA
Quality Assurance/Quality Improvement Coordinator	Sandhills CDSA
Health & Family Support Program Officer	Smart Start/N.C. Partnership for Children
Director	State Center for Health Statistics
Assistant Director	TEACCH Autism Program, UNC
Consultant	Title V Parent Consultant (Families)
Physician	Wake County Child Health Clinic
Program Director	Winston Salem CDSA
Program Director, Concord CDSA	ICC Member
Parents (4)	ICC Member
Physician (Provider)	ICC Member
N.C. legislator	ICC Member
Teacher	ICC Member
Prevention & Early Intervention, N.C. Division of Mental Health, Developmental Disabilities, Substance Abuse Services	ICC Member
Provider (2)	ICC Member
Director, Office of Early Learning, NCDPI	ICC Member

Although not all stakeholders and organizations will be able to continue on with Phase II of the SSIP, there is strong support within the early childhood community for collaboration on the SSIP. The Core SSIP Stakeholder Group (described in Section 1f) will continue as the primary stakeholder group for Phase II. However, in Phase II, the Core Group will be expanded to include members with expertise and experience on the social/emotional health of children and families.

2(e) Stakeholder Involvement in Infrastructure Analysis

As discussed earlier in Section 1f, the ITP utilized Broad and Core Stakeholder groups for broad and focused data and infrastructure analysis. Following the first Broad SSIP Stakeholder Group meeting in July 2014, participants were asked to identify others within their organizations or other organizations with experience or interest in infrastructure analysis. A second Broad Stakeholder Group meeting occurred in September 2014 to work on in-depth infrastructure analysis utilizing a gallery walk activity (see Section 2a). The SSIP Planning Team met separately with the Core Stakeholder Group at this time (all members of which were also members of the Broad Stakeholder Group). The SSIP Planning Team felt it was important for consistent stakeholder participation throughout the process, as the level of discussion that was needed to analyze the state system required the background knowledge of the system and process that had been shared in the July 2014 stakeholder meeting.

Component #3: *State Identified Measureable Result (SIMR)*

3(a) SIMR Statement

North Carolina will increase the percentage of children who demonstrate progress in positive social-emotional skills (including social relationships) while receiving early intervention (EI) services. A subset of six local lead agencies who are representative of the state will be targeted to begin implementing improvement activities with the goal of expanding to all sixteen local lead agencies for maximum impact.

3(b) Data and Infrastructure Analysis Substantiating the SIMR

SIMR Based on Data and Infrastructure Analyses

The three main child or family outcomes that stakeholders and ITP staff felt had the potential for improvement based on the data analysis were:

- Family Outcome 4B – Historically, this was the lowest-performing indicator of the three family outcomes. The Core Group felt that families effectively communicating their children's needs would improve outcomes over time. The lack of additional family data concerned the group, as well as the reliance on the current data, with low response rates and uneven representativeness.
- Child Outcome 3B – North Carolina has consistently performed lowest on this indicator for Summary Statement 2, and the Core Group felt that increasing the knowledge and skills of children would lead to improved outcomes. Concerns were presented about using Summary Statement 2, however, since the Core Group felt the "spirit" of EI was more targeted toward Summary Statement 1 (progress) rather than the expectation that children leave typically developing, which may not be possible for many children.
- Child Outcome 3A – This was the lowest child outcomes indicator for Summary Statement 1. The Core Group was excited about aligning social/emotional outcomes with the numerous existing initiatives in N.C. targeting the social/emotional health of children. CDSA Directors also shared that CDSA staff would benefit from additional training and resources in social/emotional practices.

The main findings of the infrastructure analysis were:

- Lack of Community Service Provider Accountability
    - Monitoring for EBP
    - Lack of data on actual provision of services by community service providers
    - No structure for communication between community service providers and the EI State Office
    - Limited opportunities for training/TA for community service providers
- Limited professional development opportunities for community service providers, CDSA staff, and EI State Office staff, with particular concern about those providing special instruction
- Resource limitations due to recent budget reductions
- Engagement of families in state system components
    - Advocacy
    - Program planning & evaluation
    - TA

The Core Stakeholder Group and SSIP Planning Team determined that N.C. should potentially choose a combined focus area, selecting both a child and family outcome. The stakeholders felt that work needed

to be done on the family outcomes process, including examining the survey instrument and the dissemination and collection of survey data, as well as exploring other potential methods and data sources for collecting family-level outcomes. The stakeholders also felt strongly that a child outcome focus was necessary given the recent emphasis in N.C. on the child outcomes process and the importance of outcomes for the children served. A combined SiMR, *3A SSI & 4B* or *3B SS2 & 4B*, was discussed with multiple stakeholder groups (as well as with OSEP). Ultimately a single SiMR was selected because it would allow for more direct measurement of the impact of improvement activities on the chosen outcome. The measurement of impact for a combined SiMR would be challenging and concerns were raised by TA consultants and stakeholders that the potential combined SiMR would be difficult to understand and interpret. The stakeholders agreed that a child outcome should be chosen for the single focus area; however, an improvement strategy of the SSIP process must be to begin working on the family outcomes process.

Multiple internal and external stakeholders agreed that the work-to-date pointed to choosing Summary Statement 1 (SS1) for social/emotional skills (3A). The data analysis showed this as the lowest SS1 in the State, and the infrastructure analysis pointed to questions in the State system on community service provider practices addressing social/emotional intervention. CDSA Directors on the Core Stakeholder Group expressed the need for additional training and tools for their staff around social/emotional development and evidence-based practices and continued work with community service providers in this area. It was also decided that a representative subset of CDSAs would be chosen for implementation due to resource concerns expressed throughout all levels of the infrastructure analysis.

3(c) SIMR as Child or Family-Level Outcome

The chosen SiMR is Child Outcome 3A, positive social-emotional skills (including social relationships), Summary Statement 1 (Of those children who entered or exited the program below age expectations in 3A, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program). The SiMR will improve results for children with disabilities and their families in multiple ways:

- Children exiting Part C will have learned new skills related to interpersonal relationships with both peers and family members.
- Children will be more prepared for the transition to pre-school following exit from Part C. The National Academy of Sciences reports that, “60% of children enter school with the cognitive skills needed to be successful, but only 40% have the social/emotional skills needed to succeed in kindergarten.” (Raver, C. (2002). Emotions matter: Making the case for the role of young children’s emotional development for early school readiness. Social Policy Report of the Society for Research in Child Development, 16 (3), 1-20).
- As families become more involved in the child outcome ratings process they will be better able to understand their children’s needs related to social/emotional development, as well as other skills.

Internal and external stakeholders agreed that implementation of SSIP improvement strategies and activities would begin in a subset of CDSAs rather than all sixteen. Given the resource challenges faced by N.C., as well as the limited number of staff in the EI State Office, it was decided that a focused implementation in six CDSAs would be followed by eventual statewide expansion. The six CDSAs were selected due to their representation of the larger group of programs in the following ways:

- Geographic Diversity – CDSAs have been chosen in the Eastern, Western, and Central parts of N.C., which is consistent with the geographic division of the ITP. One Regional Consultant is

assigned to each geographic region. A mix of CDSAs was chosen that represent both urban and rural counties as well.

- Performance Diversity – CDSAs were chosen that are a mix of low and high performance on Child Outcome 3A, SSI, the SiMR focus. It will be important to look at root causes of success in high-performing CDSAs to determine if there are practices already in place that have proven to be effective in impacting the social/emotional development of children with disabilities. Additionally, several CDSAs who had raised concerns about data quality related to variability of child outcome data during data analysis were chosen (see Section 1).

To determine if initially targeting these six CDSAs (de-identified using the numbers *1* through *6*) would have an impact on statewide data, the data team calculated the percentage improvement in 3A SS1 that would be necessary to allow N.C. to meet our SPP targets for 3A, SS1. Table 6 shows the six CDSAs' APR performance during FYY 2012 and 2013, as well as the number and percentage of additional children who will need to show progress at each CDSA over and above FFY 2013 performance to achieve statewide SPP performance targets. The effect on statewide data is also shown.

Table 6: Impact of six local lead agencies on Statewide Data for Child Outcome 3A, SS1

CDSA	2012 Performance 3A:SS1	2013 Performance 3A:SS1	Number of Children with Exit Ratings	2018 Target %	Number of Additional Children Showing Progress to Achieve Target %	% increase of Children Showing Progress Needed to Achieve Target
1	63.60%	60.70%	141	65.70%	7	5%
2	58.70%	56.20%	533	61.20%	27	5%
3	65.20%	53.30%	131	58.30%	7	5%
4	61.70%	56.00%	297	61.00%	15	5%
5	83.70%	86.40%	535	N/A	0	0%
6	75.10%	81.40%	498	N/A	0	0%
Subgroup Totals	68.00%	65.67%	2135	68.29%	56	2.62%
State Totals	71.90%	73.10%	6250	74.00%	56	0.9%

The four lower performing CDSAs (*1-4*) were all well below the State mean, and were chosen due to 3A, SS1 data decreasing from FFY 2012 to 2013. The two higher performing CDSA (*5-6*) were much higher than the State mean and both showed increasing performance on 3A, SS1 from FFY 2012 to 2013. To set targets for the SSIP, N.C. must choose targets from 2014 to 2018 for the six CDSAs that will be the initial focus of the SSIP. The targets chosen for these six CDSAs must be sufficient so that the improvement (increase) in outcome 3A, SS1 in the six CDSAs will allow the State to increase 0.9% overall by 2018 (the State's SPP target). As only four of the six CDSAs are currently below the State mean, these four programs will have to increase on average 5% each to increase the State average by 0.9%.

<u>3(d) Stakeholder Involvement in Selecting SIMR</u>

Several stakeholder groups were used in helping to determine the SiMR for N.C. The Core SSIP Stakeholder group was presented with numerous different SiMR choices based on the data and infrastructure analysis findings. Due to expressed interest in the combination of a Child and Family Outcome, both single and combined SiMRs were provided as choices. This stakeholder group's opinions

varied on whether the combined SiMRs presented were clear and understandable, but ultimately decided that a combined SiMR may be preferable. This feedback was brought back to the CDSA Directors in January 2015, as well as the EI State Office during an exercise in February 2015. These internal stakeholder groups were presented with two final SiMR choices: the combination of 3A, SS1 & 4B, or 3A, SS1 alone. Both internal groups agreed that the combination SiMR was difficult to understand and implied causality between the impact of one outcome on the other (which would have been difficult to measure in the evaluation process). Therefore, it was concluded that a single SiMR would be chosen, however all internal and external stakeholders were in agreement that a review of the family outcomes process would need to be included as an improvement strategy due to the issues raised with data collection and response rates.

3(e): Baseline Data and Targets

In order to achieve a 5% increase in the four CDSAs by 2018, intermediate targets must be set for all years from 2014 through 2017. The below targets for the subgroup of CDSAs are based on the expectation that the data will not move in the first year of the SSIP due to the start of implementation activities, but will begin increasing in 2015 and again in 2018. Therefore the proposed targets for the SSIP are:

Baseline Data

FFY	2013
Data	65.67%

FFY 2013 – FFY 2018 Targets

FFY	2014	2015	2016	2017	2018
Target	65.67%	66.84%	66.84%	66.84%	68.29%

SSIP targets were shared with both the Core SSIP Stakeholder Group and internal stakeholders via an online survey distributed in March 2015. Respondents were asked whether they agreed with the overall and yearly targets, or if they felt they were too high or too low. Respondents that did not agree were asked to suggest an alternative target percentage. The Core SSIP Stakeholder group also provided feedback on the targets during a meeting in March 2015. Stakeholders were mixed in their opinions about the targets; with some feeling they may be too low for the entire State, while others thought that they were realistic. The SSIP Planning Team explained that although the overall State target may appear low (0.9% increase), the SSIP targets for the subset of six CDSAs (2.62% increase) was fairly aggressive. The stakeholders also had questions about the impact of the SSIP on the entire state, but were reassured that the improvement strategies proposed for implementation in Phase II would be piloted in the subset of CDSAs with the goal of eventual expansion to all sixteen local lead agencies.

Component #4: *Selection of Coherent Improvement Strategies*

4(a) How Improvement Strategies were Selected

Once the initial rounds of data and infrastructure analysis were completed and the SiMR selected, the SSIP Planning Team was expanded to include additional EI State Office staff and an ECTA/DaSY TA staff member. Regional Consultants, whose offices are in the CDSAs and are familiar with their processes, began doing root cause work and developing hypotheses-generating activities. The TA consultant has a deep understanding of N.C.'s early childhood system, having worked with the ITP in several capacities throughout the last decade.

The expanded SSIP Planning Team began meeting to determine if root causes could be found for the conclusions being drawn from the data and infrastructure analysis. Root causes were separated into two major areas: practice issues and infrastructure issues. During an exercise in January 2015 led by the TA consultant, the following six root causes were identified in these two areas, and a resulting hypothesis was generated for each root cause relating it to potential improvement strategies:

1. There is inconsistency in assessment processes across the state that contribute to the types and quality of information that is used for the COS rating process and the development of IFSPs.

Hypothesis: ***If there is consistency in assessment practices across the state, ratings will be more accurate and overall COS data will improve.***

2. The COS rating process is seen as a tag on, not an integral part of the IFSP process, which impacts data quality.

Hypothesis***: If the COS process is an integral part of the IFSP process, ratings will become more accurate and overall COS data will improve***.

3. There is a lack of understanding about what the data mean or how it is used after the ratings are completed.

Hypothesis: ***If staff has improved understanding of the purpose and use of the COS data, ratings will be more accurate and overall COS data will improve***.

4. Staff don't have the expertise in assessment or intervention needed to adequately address social-emotional needs of children in EI.

Hypothesis: ***If staff has training in assessment and intervention, ratings will be more accurate, and children will have appropriate strategies for addressing social/emotional development on their IFSP.***

5. Staff and provider comfort talking with families during assessment, IFSP creation, and intervention about children's social/emotional skills is low and impacts the assessment of social/emotional needs, the writing of the IFSP itself, and securing intervention services for children with social/emotional needs.

Hypothesis: ***If community service providers and CDSA staff have more confidence/competence in talking with families throughout the IFSP process, parents will develop better skills at communicating their child's needs***.

6. Reduced resources (less staff, more families) contribute to fewer conversations that promote family understanding of EI, outcomes, and the IFSP in ways that are meaningful to families.

Hypothesis: ***If community service providers and CDSA staff improve their skills engaging families in the EI process, families will develop better skills communicating their child's needs***.

The next step involved surveying CDSA management staff and direct service staff at the six target CDSAs to determine if the hypotheses were accurate. For each hypothesis a series of questions was crafted to gather additional information on each root cause. Two surveys were distributed in January 2015 via an online survey, each with different questions relevant to the respondents' role: CDSA staff

providing evaluation, assessment, service coordination, and other EI services; and management/administrative staff. The reason for two surveys was to capture the feedback from direct service providers and managers separately to determine if there were varying opinions or a disconnect at the CDSA level between these groups. Furthermore, it was decided that the six CDSAs who would initially be targeted by the SSIP would be surveyed as a representative sample of all programs.

The first survey was sent to over 200 EI service coordinators (EISCs), evaluators, and other direct service staff at each of the six CDSAs. Over 87% of staff responded to the survey. The conclusions drawn from the results of the survey were:

- There are differences across and within CDSAs in the ways in which initial and ongoing assessments are completed.
- There are different tools in use to assess social-emotional development.
- Staff use a mix of guidance materials for the COS ratings process (state and national).
- There is good alignment between the identification of social-emotional needs and IFSP goals for individual children.
- Child Outcome ratings reports are limited to missing data – changes in ratings are not shared regularly.
- There is limited training available specific to social emotional development and assessment of this area.
- The majority of staff are not talking to families about child outcomes, but the majority are talking with families about the family survey.
- Staff are using good practices with families (coaching, open-ended questioning, etc.).

The second survey was sent to 65 supervisors, managers and administrators at each of the six CDSAs, with over 92% responding. The conclusions drawn from the responses received include:

- About half of supervisors report having fewer than three hours of child outcomes training in total.
- Most supervisors don't run Child Outcome Summary reports for their staff or program. Reports that are run are usually about missing data.
- There is a wide range of opinions as to how many social-emotional experts are in each CDSA and in each provider network.
- Almost all CDSAs had at least one supervisor report that there are no social-emotional experts in their catchment area.

The SSIP Planning Team decided that there were sufficient root causes identified to begin crafting improvement activities. The team first reviewed the previous seven N.C. APRs to see which improvement strategies had been included to address areas of slippage or low performance. The EI State Office staff then convened in a full-day workshop in February 2015 to begin selecting improvement activities and strategies based on the data and infrastructure analysis, SiMR selection, and root cause identification work. After being presented with the conclusions of the SSIP Phase I work to date, staff were asked, *"If the SiMR is accomplished in the next five years, what would the N.C. early intervention system look like for children and families; providers; CDSAs; and the ITP?"* The purpose of this exercise was to have the SSIP Planning Team envision the elements of a changed system in order to work backward on what activities/work would need to be accomplished to get there. The staff's vision of the changed system in each of the areas includes:

- Children and Families:
    - Some children will be doing better in school
    - Provision of services would look different – more family/less practitioner-focused

    - Increased IFSP focus on social/emotional skills and outcomes
    - Earlier identification of social/emotional problems

- Community Service Providers:
    - Better prepared to work with children, particularly around S/E skills and needs
    - More choices of tools and practices to work with families
    - More family-focused

- CDSAs:
    - Decreases in amount of services provided at the CDSA (rather than through community service providers)
    - Improved outcomes in multiple areas of development
    - Working with new/different community service providers

- ITP:
    - May have a different role with oversight/monitoring
    - Increased quality
    - More and different types of data collected and analyzed
    - Increased support to CDSAs
    - Expanded collaboration with other organizations including other state agencies
    - Stability and growth

Early Intervention State Office staff members were then divided into groups and asked to brainstorm potential improvement activities and strategies. Each group prioritized the top three to four improvement strategies and presented them to the larger group. Twenty overall improvement strategies were identified and combined into nine broad strategies. The small groups then decided on the potential impact of each strategy, as well as the likelihood of its being implemented. The goal of this likelihood/impact exercise was to choose improvement activities/strategies that would have the greatest impact but were also achievable given the infrastructure challenges at the ITP identified earlier in Phase I. Following this exercise, each EI State Office staff member was asked to select their top three priorities. The top six broad improvement activities were:

1. Centralize and expand provider network
2. Expand professional development opportunities and standards
3. Strengthen the State system for planning and dissemination through use of the Implementation Science model
4. Continue expansion of Integrated Child Outcomes Pilot Project
5. Create an EI service delivery model of clearly defined practice standards for equal access for children and families
6. Overhaul family outcomes measurement process

Three additional broad strategies with lower priority were identified, which the SSIP Planning Team felt were necessary for accomplishment of the SiMR:

7. Disseminate child outcomes data at the CDSA level and investigate additional/alternative data to measure child and family outcomes
8. Explore and implement telehealth options to increase access to social/emotional experts
9. Capitalize on and expand partnerships with other agencies and stakeholders to meet program needs

These broad improvement strategies were brought to the Core SSIP Stakeholder Group in March 2015, who were then asked to provide feedback on how well the strategies were aligned to the SiMR. The stakeholders were in agreement that the chosen improvement activities were comprehensive and would have an impact on the SiMR and address the infrastructure challenges identified through the SSIP process. The stakeholders identified two additional potential areas of improvement to include in Phase II: child find and involvement of families in planning and implementation activities at the local level. The SSIP Planning Team made a note of these suggestions and agreed that they would be included within the improvement activities discussion during Phase II.

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

The SSIP Planning Team agreed that the identified improvement strategies must be practical to implement in addition to having an effect on the SiMR. Additionally, the SSIP Planning Team felt that the strategies must be a part of a continued implementation framework, rather than a series of disjointed initiatives that would be difficult to tie together to measure impact. Beginning with existing initiatives and expanding out to new initiatives, the SSIP Planning Team discussed how each would be implemented and in what way they will lead to improved social/emotional outcomes for children. Below are each improvement activity and its proposed strategies.

1. *Centralize and expand provider network* – internal stakeholders were the most enthusiastic about this improvement strategy, as the majority of them chose this in their top three. The proposed strategies are:

    - Centralize the provider network – The ITP's current de-centralized provider network requires that each provider sign agreements with each individual CDSA. Through this strategy, community service providers that may be able to serve multiple CDSAs will be identified, serving to expand the provider network. Additional providers, particularly in the rural areas of the State, will help those CDSAs that struggle with meeting the service delivery needs of the children and families they serve.
    - Create a provider agreement with a system of accountability, incentives and sanctions that promote evidence-based practices - As the majority of social/emotional EI services provided in the State (>90%) are delivered through community service providers rather than through CDSA staff , the lack of information on provider practices is a challenge to improving social/emotional outcomes. Creating a provider agreement with a system of accountability to standards will help to systematize practices. This would provide the ITP with the ability to ensure that appropriate evidence-based practices are being used, and fidelity is being met where applicable.

2. *Expand professional development opportunities and standards* – stakeholders agreed that to improve social/emotional outcomes, the ITP needed to work on providing additional and varied opportunities for professional growth and knowledge around social/emotional practices.

    - Create standardized and consistent statewide professional development for CDSA staff and community service providers – An existing initiative within the state has been to expand the use of online training for professional development. Currently, only certain CDSA staff are required to take these limited trainings. The number and types of online trainings available will be expanded, and providers will be asked/required to participate in these trainings as well. Consistency of training will lead to consistency of practices by the CDSA and the private provider.

- Modify certification process – The current certification process requires that service coordinators have Infant-Toddler Family Specialist (ITFS) certification. CDSA providers are licensed/certified in their respective disciplines. However, certification at the provider level is maintained by the providers. The goal will be to explore national standards to determine the most effective evidence-based practices for social/emotional services, and incorporate these into the current certification process necessary for both community service providers and CDSA staff.
- Consistent standards for evaluation and assessment – Root cause identification pointed to varied and numerous tools available to CDSA evaluation and assessment staff to rate social-emotional development in infants. Training on the use of a standard set of tools will help to create uniform assessment practices, which will have a direct effect on the quality of Child Outcome ratings.

3. *Strengthen the State system for planning and dissemination* – Although very broad, this improvement activity is of paramount importance in a state system that has recently experienced staff reductions and now has reduced ability to implement new practices and provide technical assistance.

    - Infrastructure strategic planning - The analysis of the current ITP system showed that implementation often occurs through a "top-down" mechanism where changes are made at the EI State Office level, and then implemented down to the CDSA leadership and then eventually CDSA staff. A refined implementation framework would identify best practices and evidence-based practices at the provider and staff level and then scale-up from there. This alternative approach will encourage innovation at the provider level, ultimately leading to an increase in the types of practices that community service providers could choose from to impact social/emotional health and well-being.
    - Change in ITP staff roles - The current ITP personnel structure was created during a time of rapid budget growth and program expansion. Recent budget cuts and position reductions provide the opportunity for the ITP to examine the current structure to determine if it meets the needs of the current EI system particularly around TA and quality standards. Additionally, recent leadership changes at the ITP, including retirements of the Branch Head and several experienced CDSA Directors, could potentially bring new perspectives and knowledge of early childhood system structures. Job duties of all current staff will be examined to identify redundancies, and the ITP budget will be examined to decide if additional resources can be focused toward SSIP implementation activities. In particular, the ITP will explore the use of a staff member to expand and manage the provider network.

4. *Continued expansion of child outcomes integration pilot*–The successful implementation of global child outcomes integration at two CDSAs should be expanded to include all six CDSAs chosen as a subset for the SSIP. In 2011, the ITP created a workgroup to discuss how the child outcome rating process can become more integrated with the entire IFSP process. A few states were already implementing an integrated process, and national early childhood technical assistance contacts were encouraging other states to do the same. The workgroup recommended that the ITP move toward a more integrated process, beginning with a pilot implementation using an Implementation Science framework. By increasing opportunities to involve families and community service providers in global child outcomes observation, tracking, and rating process, the ITP hopes to increase the likelihood that children in the Program will successfully participate and function in home, classroom, and community settings and empower parents to understand their children's functioning related to same age peers and know how to communicate their children's needs and progress. By consistently assuring that entry and exit rating is a team

process, including the parent, and by using tools to increase inter-rater reliability, CDSAs will increase the quality of the rating. Throughout the process, child outcomes rating and tracking become more than just reporting activities; they become opportunities to educate, empower, and encourage parents to take an active role in helping their children to successfully participate across settings and situations during their time in the ITP and beyond.

5. *Creation of an EI service delivery model of clearly defined practice standards for equal access for children and families* – The other SSIP improvement activities are focused on implementing change with the intent of standardizing system components (provider network, professional development, certification/licensure). This activity is intended to define the social/emotional service delivery model for children and families within N.C. as a whole. This broad improvement activity will focus on identifying the most effective early childhood evidence-based practices targeting the social/emotional health of children with disabilities with the intent of determining the feasibility of implementation and expansion of each. Initial steps in this activity will be to work with national TA centers (ECTA, DaSY,) and others) to begin identifying evidence-based practices and best-practice models in delivery of social/emotional services, taking into account the geographic diversity of N.C. Utilizing existing resources for TA, including the Statewide Planning and Technical Assistance Team and the Regional Consultants, as well as external local, State, and Federal training initiatives identified through the SSIP, N.C. will attempt to establish and disseminate a standardized practice model for social/emotional development of young children.

6. *Overhaul family outcomes measurement process* – There was universal agreement among internal and external stakeholders that the current family outcomes process would need to be examined in several areas.

    - Survey instrument – Stakeholders felt that the wording of some questions in the currently used survey (NCSEAM) could be confusing to families, who may not know that they are responding to questions about the ITP rather than specific community service providers. Additionally, some stakeholders felt the survey was too long. A Family Outcomes Workgroup will be convened, led by the Statewide Planning and Technical Assistance Team, which will include members of the State ICC, LICCs, parents, community service providers, and CDSA staff to look at alternative survey instruments to measure family outcomes. A more acceptable survey for parents will lead to a better response rate, which will help make the N.C.'s family outcomes data more representative of the families served.
    - Survey dissemination – Response rates in N.C. have been falling for several years to below acceptable standards. The Family Outcomes Workgroup will be tasked with deciding on strategies to improve response rate, particularly in the area of including the CDSAs more in the survey process. Increased response rates will help with the representativeness of the data and allow for crossing of child and family outcomes data to help determine if global integration activities are successful at impacting family outcomes in addition to child outcomes ratings.

7. *Disseminate child outcomes data at the CDSA level and investigate additional/alternative data to measure child and family outcomes* – Although not selected as a priority for Phase II SSIP implementation, the EI State Office staff felt that the CDSAs should have access to additional data on child outcomes ratings, including summaries by service coordinators, condition, and differences between entrance and exit ratings. Increased knowledge of the ratings being assigned to children at entrance and exit will lead to greater consistency of ratings among staff. Greater

consistency of ratings will lead to more accurate child outcomes data collection, which will allow for better connection between implementation activities/strategies and improved outcomes.

8. *Explore and implement telehealth options to increase access to social/emotional experts* – Exploration of the feasibility of this activity is underway due to immediate provider needs identified in rural areas of the state. Increased access to providers will allow for IFSP service delivery to occur more often as prescribed, which should lead to improved outcomes for children. Additional data will be collected on the number and location of social/emotional providers in the state.

9. *Capitalize on and expand partnerships with other agencies and stakeholders to meet program needs* –Stakeholders felt that, although very broad, this strategy was a continuous activity that the ITP should be undertaking. They decided that including it as an improvement activity made sense since the SSIP process was dependent on leveraging existing partnerships and creating new ones to have maximum impact on the SiMR. In particular, they were enthusiastic about working with the Part B/619 programs within the Exceptional Children's Division in the N.C. Department of Public Instruction (DPI). The ITP has been well-represented in Part B SSIP work as a member of the SSIP Planning Team, as well as Part B/619 on ITP SSIP stakeholder groups. This partnership has led to discussions between the programs on how their SiMRs could be aligned. There is agreement that the work begun with families in EI can lay the foundation for continued parental involvement and advocacy throughout IEP development and special education.

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

The broad improvement activities and strategies were selected in an attempt to address the root causes identified throughout the Phase I process. The table below (Table 7) identifies each root cause, hypothesized mechanism for improvement, and strategies that will address each of the root causes.

Table 7: Connection between Root Causes, Hypotheses, and Improvement Activities that Address Root Causes

Root Causes	**Hypotheses**	**Improvement Activities that Address Root Causes**
There is inconsistency in assessment processes across N.C. that contribute to the types and quality of information that is used for the COS process and the development of IFSPs There is inconsistency and a lack of skill in assessing social-emotional development and positive social relationships across CDSAs	If there is consistency in assessment practices across the state, ratings will be more accurate and overall COS data will improve	2. Expand professional development and Standards 3. Strengthen the State system for planning and dissemination; 5. Creation of an EI service delivery model of clearly defined practice standards for equal access for children and families

Root Causes	Hypotheses	Improvement Activities that Address Root Causes
The COS process is seen as a tag on, not an integral part of the IFSP process, which impacts data quality	If the COS process were an integral part of the IFSP process, ratings will become more accurate and overall COS data will improve	4. Continued expansion of child outcomes integration pilot 7. Disseminate child outcomes data at the CDSA level and investigate additional/ alternative data to measure child and family outcomes
There is a lack of understanding about what the data mean or how it is used after the ratings are completed	If staff has improved understanding of the purpose and use of the COS data, ratings will be more accurate and overall COS data will improve	4. Continued expansion of child outcomes integration pilot 7. Disseminate child outcomes data at the CDSA level and investigate additional/ alternative data to measure child and family outcomes
Staff don't have the expertise in assessment or intervention needed to adequately address social-emotional needs of children in EI	If staff has training in assessment and intervention, ratings will be more accurate, and children will have appropriate social/emotional goals on their IFSP	2. Expand professional development and standards 5. Creation of an EI service delivery model of clearly defined practice standards for equal access for children and families
Staff comfort with talking with families during assessment, IFSP development and intervention about children's social-emotional needs is low and impacts the assessment of social-emotional needs, the writing of the IFSP itself, and securing intervention services for children with social/emotional needs.	If community service providers and CDSA staff have more confidence/competence in talking with families throughout the IFSP process, parents will develop better skills at communicating their children's needs	2. Expand professional development and standards 5. Creation of an EI service delivery model of clearly defined practice standards for equal access for children and families
Reduced resources for service coordination (less staff, more families) contribute to fewer conversations that promote family understanding of EI, outcomes, IFSP in ways that are meaningful to families	If community service providers and CDSA staff improve their skills engaging families in the EI process, families will develop better skills communicating their children's needs	4. Continued expansion of child outcomes integration pilot 6. Overhaul family outcomes measurement process 9.Capitalize on and expand partnerships with other agencies and stakeholders to meet program needs

Root Causes	Hypotheses	Improvement Activities that Address Root Causes
Lack of community service providers in rural areas of N.C. create a resource burden on the CDSAs and affect service delivery of IFSP services	If additional community service providers can be identified or novel treatment approaches can be found, IFSP services will be more likely to be delivered as prescribed	1. Establish and expand provider network 8. Explore and implement telehealth options to increase access to social/emotional experts 9. Capitalize on and expand partnerships with other agencies and stakeholders to meet program needs

Utilizing the Hexagon Tool from the National Implementation Research Network, each of the improvement strategies was assigned a score in six areas: the needs of children served; fit with current initiatives; resource availability; evidence indicating intended outcomes; readiness for replication; and capacity to implement. Although many of the initiatives scored high on needs and fit, there are universal concerns from the scoring related to resource availability and evidence indicating intended outcomes. Additional work will need to be done in Phase II of the SSIP to begin exploring the literature related to the strategies implemented and expected outcomes. To this end, an Evidence-Based Practice Workgroup will be formed to begin looking at the evidence behind all proposed interventions, as well as additional evidence-based practices for social/emotional development. This Workgroup will bring its recommendations for adjustment of the proposed improvement strategies to the SSIP Planning Team and stakeholder groups for consideration.

4(d) Strategies Based on Data and Infrastructure Analyses

Both the Phase I data and infrastructure analysis processes revealed that the ITP had very little to no provider data or information due to each CDSA being in charge of building and maintaining its own provider network.. One of the first tasks of the SSIP Planning Team in Phase II will be to work with the six identified CDSAs on strengthening their provider networks. Lists of community service providers will be centralized and a provider directory will be created with their available services. This directory will be expanded statewide with the goal of creating a single provider network which all CDSAs would have access to. Next steps in Phase II include inventorying provider practices in social/emotional health (and other areas), and collecting information on provider staff certification/licensure.

Data analysis also revealed that additional external data on child and family outcomes beyond the COS ratings and family outcomes survey need to be collected. Leveraging data available from other state agencies, including longitudinal data through the N.C. ECIDS and existing partnerships, the data team will examine other public and private data sources that may be available for crossing with current child and family outcomes data. Additional ways of capturing parent income data from HIS will be explored to stratify the effect of implementation activities across income levels to look for disparities in access and outcomes.

Limited professional development opportunities for community service providers, CDSA staff, and EI State Office staff were identified as a concern through the infrastructure analysis process with internal and external stakeholders. The Statewide Planning and TA Team members have recently begun to expand the professional development activities available through the EI website to CDSA staff and community service providers. This will be further expanded as a major improvement strategy beginning in Phase II of the SSIP. The Statewide Planning and TA Team will seek local, state, and federal partners who can provide low-cost or free trainings given the resource limitations identified during infrastructure analysis.

Additionally, as best practices are developed for assessment and evaluation around social/emotional health and well-being of children, additional training materials on these best practices will be developed.

Engaging families in State system components was also identified as a systems challenge during the infrastructure analysis. Beginning with the expansion of the global outcomes integration in 2015 to the six CDSAs chosen for the SSIP and continuing with the Family Outcomes Workgroup, the ITP will attempt to be more effective at engaging families throughout the EI process. Engagement will include assessment and evaluation, reporting of satisfaction and education about the family outcomes process.

4(e) Stakeholder Involvement in Selecting Improvement Strategies

Multiple stakeholder groups were used in this part of Phase I activities:

- Expansion of the SSIP Planning Team included the Regional Consultants and an external TA provider.
- CDSA evaluation/provider staff were surveyed on hypothesized root causes leading to low performance observed in the data and infrastructure analyses.
- CDSA supervisors were surveyed on hypothesized root causes leading to low performance observed in the data and infrastructure analyses.
- The EI State Office staff were used to help develop broad improvement activities and strategies, the impact/likelihood of each, as well as the capacity and priority for implementation.
- The Core SSIP Stakeholder Group was asked to review the improvement strategies/activities to determine if any major ones were missing and if they felt that the improvement strategies would be effective at impacting the SiMR.

Component #5: *Theory of Action*

See graphic below.

5(a) Graphic Illustration:

North Carolina Infant Toddler Program (ITP) Theory of Action

Strands of Action	If ITP…	Then…	Then…	Then…
Provider Network	…develops a statewide provider network structure with a system of accountability, incentives and sanctions that promote evidence-based practices	…local programs will have greater access to IFSP services for children with disabilities … provider practices will be better understood and will provide the ITP with the ability to ensure that appropriate EBPs are being used, and fidelity is being met (where applicable).	…evaluation and assessment of S/E development will be more consistent at the local programs …families will be more informed about S/E practices that can impact development …provider and CDSA staff will have greater access to best practices and EBPs … ITP will be more capable of supporting local programs for training and TA, particularly around S/E outcomes …ITP will have better quality data on impact of EI on Family Outcomes	…NC will increase the percentage of children who demonstrate progress in positive social-emotional skills (including social relationships) while receiving Early Intervention services
Professional Development & Standards	…expands the current professional development system to include additional and varied opportunities for professional growth and knowledge around S/E practices	… CDSA staff and network providers will have increased access to training and professional development resources …standards in the state for evaluation and assessment of S/E development will be more consistent		
State Planning & Dissemination	…fortifies the state system for planning and dissemination	… the state would better identify S/E best practices and EBPs at the provider and staff level to disseminate across the state …ITP staff roles will be more flexible to support recent changes to the state system		
Family Involvement	…expands child outcomes integration and examines the current Family Outcomes data collection methods	… parents in the program will better understand their child's functioning related to same age peers and know how to communicate their child's needs and progress …data collected from families will more accurately represent the children and families served in EI		
Practice Standards	…creates a system to identify and implement the most effective Early Childhood EBPs targeting S/E development of children with disabilities	…providers and local programs will have clearly defined interventions to use with children and families served in EI		

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

The vision for the ITP is a comprehensive system of early intervention services that has effective professional development and practice standards, which includes families and community service providers, and which will result in improved social-emotional outcomes for the children served. The State's Theory of Action (TOA) clearly outlines the six major categories of improvement strategies which, if implemented, will allow the ITP to have more consistency in social/emotional evidence-based practices, and will provide opportunities for families and community service providers to work together for maximum impact.

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

The Theory of Action (TOA) was developed with input from the SSIP Planning Team and EI State Office staff. The Core SSIP Stakeholder Group was asked to review the TOA graphic for readability and understandability. The goal of stakeholder involvement at this stage was to ensure that the TOA summarized the work done in Phase I in an effective manner and elucidated the relationship between the proposed improvement activities and the intended results/outcomes. Core SSIP Stakeholders felt the TOA was a helpful tool which provided a broad overview of the plan set forth in Phase I. Internal stakeholders were also asked to review the TOA and feedback was affirmative that the graphic was clear.

NC Indicator 11: SSIP Appendix

Implementation Planning Tools

Part C Implementation Guide
Theory of Action logic model form for young children example
AI Hub: Handout8-Communication Protocol Worksheet
Implementation Drivers: Assessing Best Practices - The State Implementation & Scaling-up of Evidence-based Practices Center (SISEP), The National Implementation Research Network (NIRN), Frank Porter Graham Child Development Institute
The Hexagon Tool: Exploring Context - The State Implementation & Scaling-up of Evidence-based Practices Center (SISEP), The National Implementation Research Network (NIRN), Frank Porter Graham Child Development Institute
Tools to Support the Development of a Coherent and Aligned System - The State Implementation & Scaling-up of Evidence-based Practices Center (SISEP), The National Implementation Research Network (NIRN), Frank Porter Graham Child Development Institute
Example: SSIP Phase I Activity and Timeline Chart (Gantt Chart) - ECTA, DaSY
Review of State Context:
Considerations in Identifying Measureable Result for Students/Children with Disabilities as Focus for SSIP – RRCP
State Infrastructure Analysis Tool – Part C Using Implementation Drivers to Tell the Infrastructure Story – RRCP

Data Analysis Tools

Analyzing Child Outcomes Data – Guidance Table
ECO Center - National-State Graph Creator 2011-12 (FFY 2011)
Family Outcomes-State approaches calculator (ECTA Center)
ITCA Eligibility Comparison Graph Creator 2011-12 (FFY 2011)
ECTA Meaningful Difference Calculator – Child Outcomes
ECTA Meaningful Difference Calculator – Family Outcomes
Checking Outcome Data for Quality: Looking for Patterns – ECO Center
SSIP Child Outcomes Broad Data Analysis Template – ECTA Center, DaSY Center
SSIP Child Outcomes Subgroup Analysis Template – ECTA Center, DaSY Center

Infrastructure Tools

SERRC Infrastructure Analysis Guide
North Central RRC SWOT Analysis Activity-State Infrastructure
Local Contributing Factor Tool SPP/APR Results Indicators: C-2, C-4, C-5, C-6 (developed by RCC and NECTAC)
Local Contributing Factor Tool for SPP/APR Indicator C-3/B-7 (developed by RCC and NECTAC)
Hawaii SSIP Infrastructure Component Descriptions (Shared with NC after speaking with Hawaii EI Program)
Initiative Inventory for the State Systemic Improvement Plan - SERRC
System Framework: Components Descriptions – ECTA Center

SSIP Stakeholder Meeting
July 10th, 2014

Summary of Stakeholder Input

General Questions – these are questions that were brought up throughout the day by stakeholders and recorded in the minutes.

1. Are we looking at who declines eligibility determination(s)?
2. What about NICU data? Why does it not appear that there are enough NICU referrals to EI?
3. What about funding cuts (Medicaid cuts)? How will that affect EI?
4. How to calculate potentially eligible children for child find? Research-based data show 12%-13% of children require EI services, however it's 5% in NC (not verified).
5. Should we look at families that decline enrollment or can't be reached?
6. Have we looked at the cultural perspectives about disability?
7. Following giving birth, women may experience depression, however Medicaid services post-birth are less available compared to what the child receives. What is the role of the EI program in maternal depression?
8. Is there a bimodal distribution of those families that decline services? The first mode may be those families that are too early in the process and decline due to being overwhelmed (i.e. child only recently came home from NICU), while the second mode could be those that decline services due to costs (insurance/self-pay).
9. Have we looked at existing initiatives or work around the state that can help to inform outcomes? Example is *Growing Up Well* (IOM).
10. When does the initial referral process start (average age)?
11. Can we examine data from DPH on counties/areas with pediatrician and/or family practitioner shortages and how referrals differ in these counties vs. those that do have access?
12. How many children stay in the program less than six months that are rated a 6 or 7 at entry? Could children be leaving in less than six months with positive outcomes, showing program effectiveness? Suggestion to look at reason for exit among children staying in program for different lengths of time.
13. Why have family survey response rates dropped significantly over time? Can we change the administration of the survey?
14. Cross-check referrals with Birth Defect reporting database/program.

Data Group Discussions – these are the questions/comments that were submitted by the breakout groups on the feedback forms collected at the end of the day. The questions/comments are separated by major data themes presented at the meeting. Questions/comments that were brought up by multiple groups are noted below.

Child Outcomes

- Do states that include families in Child Outcomes ratings process have better outcomes? (2 groups)
- Look at S/E well-being of infants and toddlers as well as family/parent stress, parents well-bring, and supporting family systems. (2 groups)
- Reliability of COS? Bias toward higher scores at exit than entry?
- Do child outcomes vary by diagnosis? Referral source?
- How many states include families in the COS process?
- Do parents know and understand COS? How would that change ratings if they did?
- Can we look at Adverse Child Experiences (ACE) data in relation to COS data?
- How does changing eligibility affect COS ratings?
- Develop tools/processes for infants/children with multiple disabilities.
- Further breakdown of responses by race/ethnicity.
- Child outcomes by diagnosis.
- Do families that self-refer have better outcomes?

Family Outcomes

- Can incentives be used to increase response rate? (3 groups)
- Better collection methods for family survey (more than mass mailing) –ex. hand-deliver? (3 groups)
- Are there other ways of gathering information from families? Can the survey be supplemented with something else? Consider additional data sources. (3 groups)
- Survey seems confusing – ex. Wording on survey may be confusing as to resistance or lack of acceptance their child has a delay. (2 groups)
- Survey has duplicative items – questions seem repetitive. (2 groups)
- Has the survey been presented to families with the opportunity for them to provide feedback? (2 groups)
- Concern that we're not meeting targets for family outcomes.
- Question 1 is too vague – families may feel that this is memorization of rights and not a measure of understanding of rights in practice.
- Does the survey not being anonymous have an impact?

Family Outcomes (continued)

- In what other language(s) is the family survey available?
- Is 17% response rate high enough for good data?
- How are families prepared to answer the survey?
- Is the survey tool asking the correct questions?
- What are the literacy levels of the parents completing the survey?
- What is the proper timeframe to administer the survey? Frequency?
- Can we use a sampling methodology to improve family outcome response rates?
- Do families ever see the results of the survey?
- The survey shows extremes – those that like services and those that are dissatisfied. What about those in between?
- Should the survey be completed at exit by families?

Child/Program Data

- What data do we have on families? (2 groups)
- What is the average age at entry nationwide? (2 groups)
- What is the distribution of age by month?
- What % of services that are recommended don't exist/aren't available?
- What about counties that don't have medical access (i.e. NICU)?
- There appears to be a low amount of referrals from DSS and NICUs – are there data on out of state referrals to NC ITP?
- Is there a disproportionality on hours of services received by race/ethnicity? What about time in Part C?
- Do trends seen in Big B exist in Part C?
- Is 5.1 hours/month sufficient amount of services?
- What is the average age at referral in NC?
- Is there a difference in average age at entry by conditions?
- What role do the CDSAs have in monitoring service providers?
- Why is average age at entry so high?
- Suggestion to look at socio-economic status (SES) as a sub-group.
- Suggestion to look at referral source by age group.
- Suggestion to breakdown NICUs as referral sources (DUKE, UNC, etc.).

- What are the reasons for physician referrals? Are they waiting to see NICU babies before referring (resulting in older referrals)?
- Do we collect information on families that decline or are lost – language, ethnicity, and reasons for decline? Are their patterns?

Child/Program Data (continued)

- What tools are used to measure service gaps? We need additional measures to identify service gaps, needs and develop programs that are truly responsive to child and family needs.
- Suggestion to look at service delivery – actual vs. planned.
- Focus on early referrals to ITP in order to decrease age at enrollment (resulting in an increase to indicator 5)
- Suggestion to collect family level data on parent perspectives, relationships with providers, parent education, reduced family stress, connecting families to sources of data.

Miscellaneous

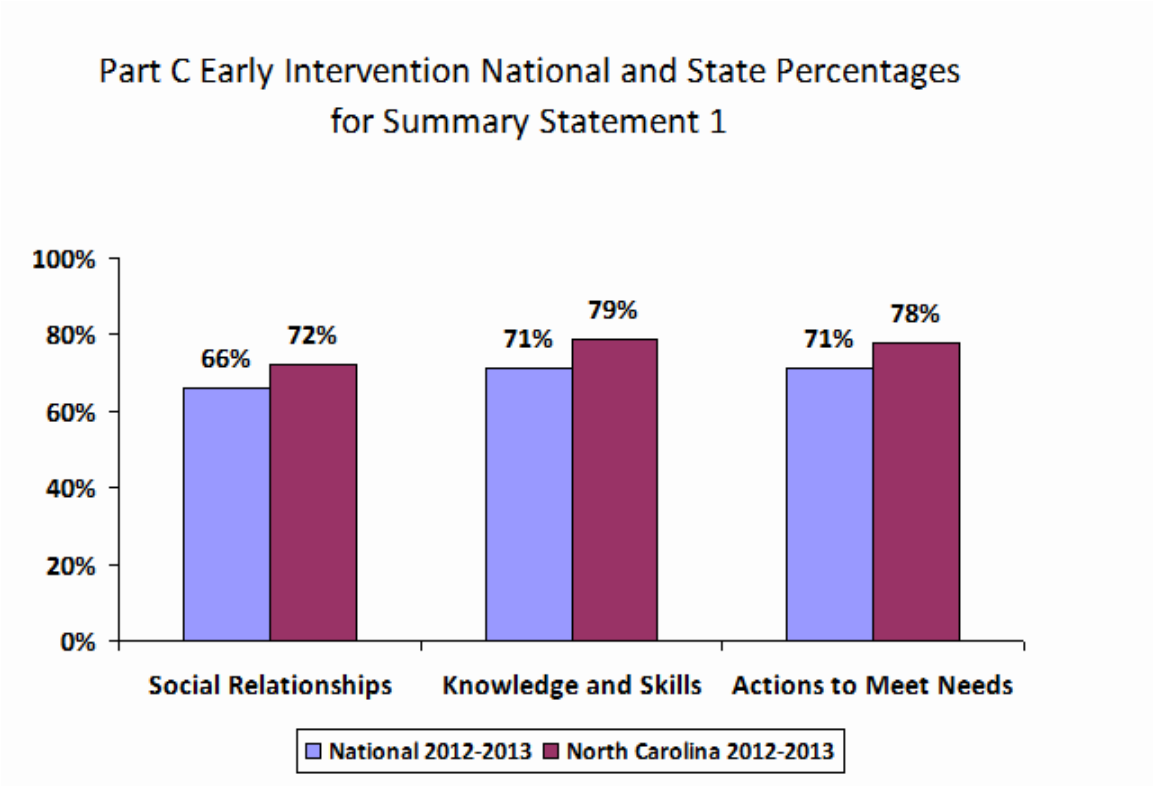
- Continuous Quality Improvement (CQI), professional development, as well as family education are all key for developing programs that meet targets goals of compliance and results.
- Important to have culturally responsive providers and services.
- Suggestion to do this same activity (looking at data) with families.
- How does the community feel about child and family outcomes? Can they see the results?

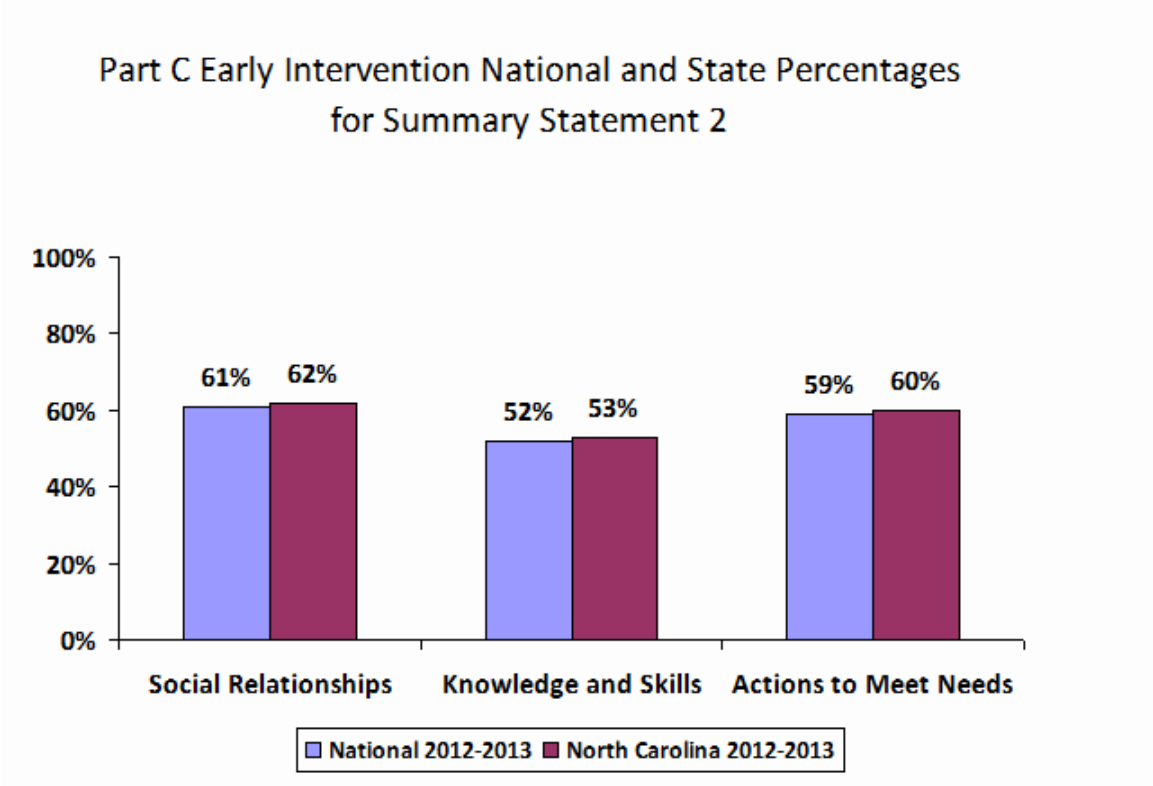
SWOT Analysis – Please see attached SWOT Document

State Child Outcomes Data Quality Profile

North Carolina Part C

Comparison of State and National Data




Part C Early Intervention National and State Percentages for Summary Statement 2
100%
80%
60%
40%
20%
0%
61%
62%
52%
53%
59%
60%
Social Relationships
Knowledge and Skills
Actions to Meet Needs
National 2012-2013
North Carolina 2012-2013

Data Quality

There are several main criteria for identifying states with quality data for inclusion in the national analysis. The first is that the data are complete and that the state reports data on enough children. The second is that the patterns of the progress categories reported by a state are within reasonably expected patterns and ranges.

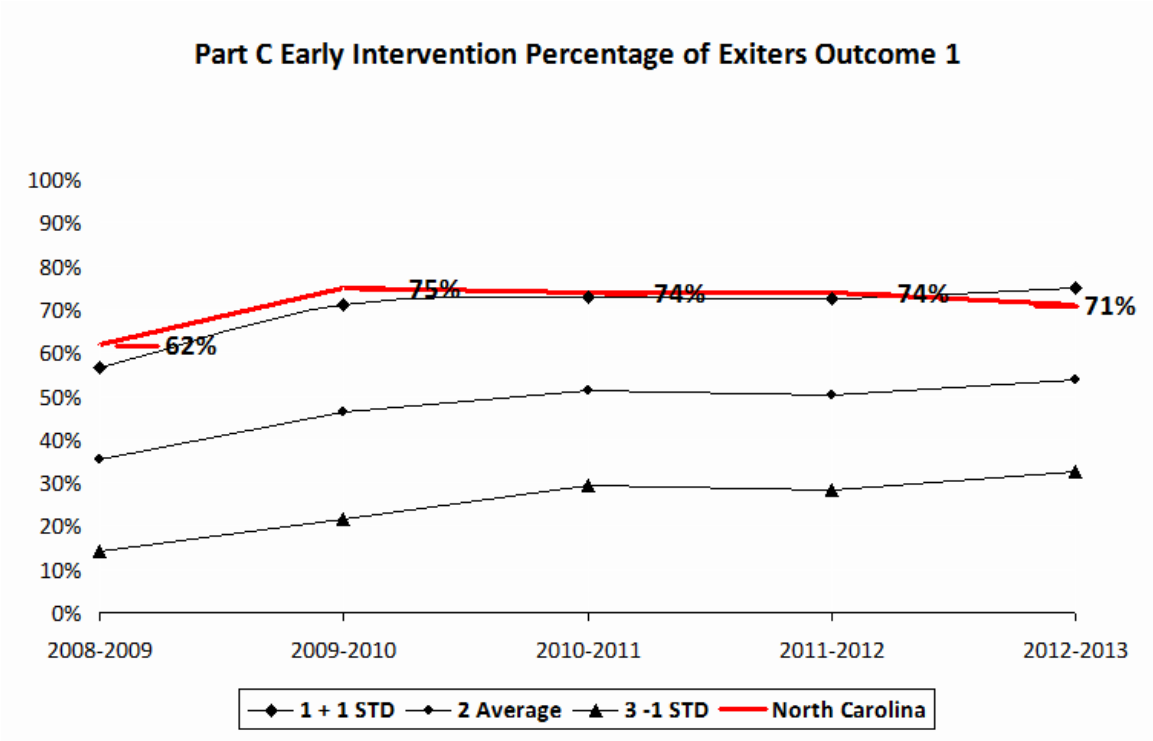
Completeness of Data Trends over Time

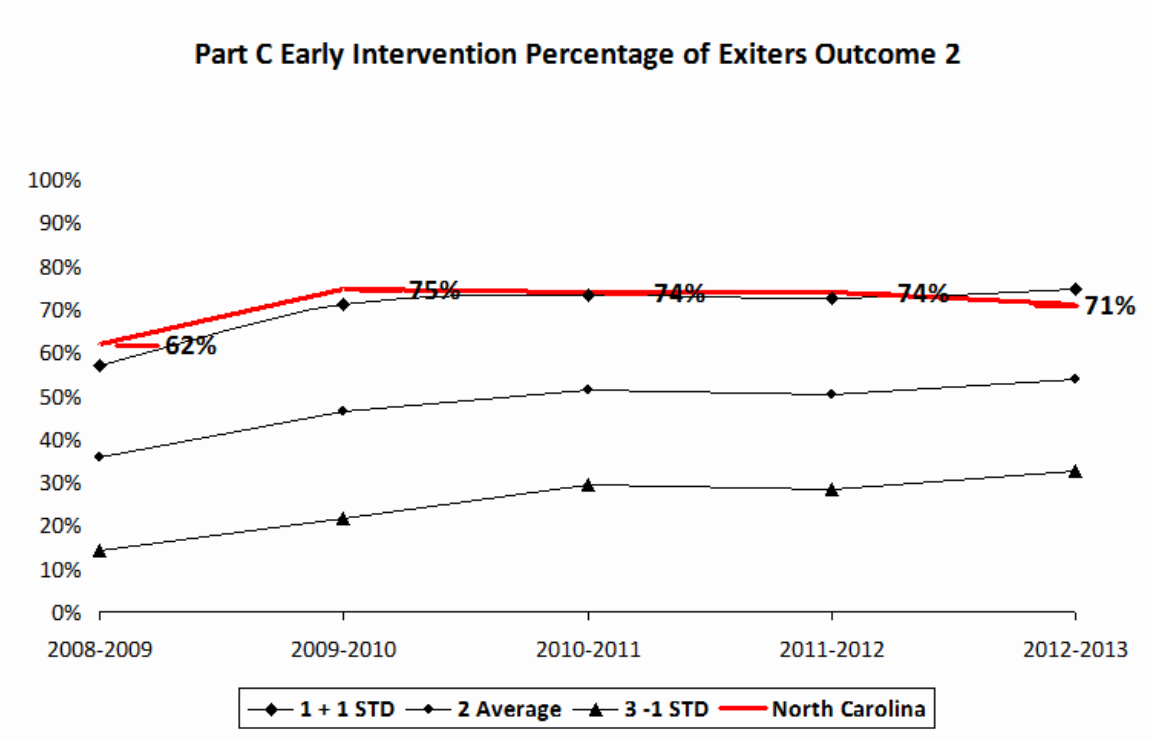
For Part C, at minimum, it is expected that states report data on 28% or more of exiting children.

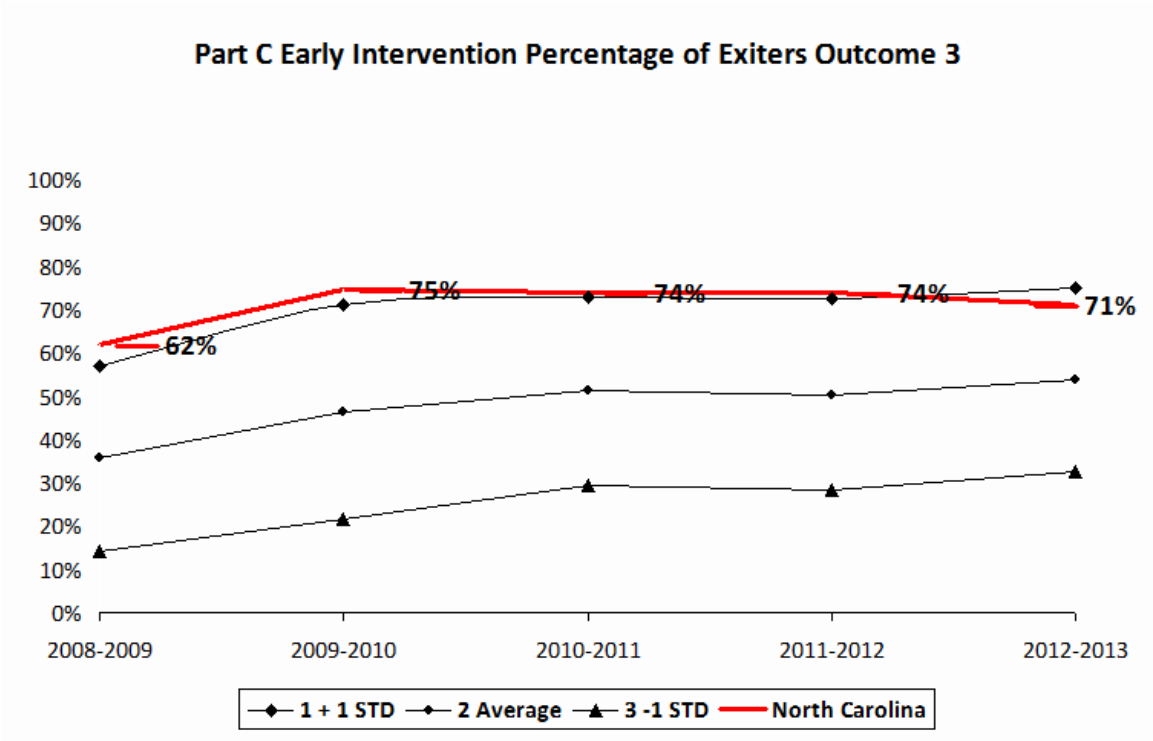
Number of children reported for the outcome / Exiting total

It is important to note that the estimates provided are based upon publicly available information, but some states have established more accurate methods for estimating the number of children receiving services.

The graphs below plot the state's data over time in relation to the national average and one standard deviation (SD) above and below the national average.


Part C Early Intervention Percentage of Exiters Outcome 1
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2008-2009
2009-2010
2010-2011
2011-2012
2012-2013
62%
75%
74%
74%
71%
1 + 1 STD
2 Average
3 -1 STD
North Carolina


Part C Early Intervention Percentage of Exiters Outcome 2
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2008-2009
2009-2010
2010-2011
2011-2012
2012-2013
62%
75%
74%
74%
71%
1 + 1 STD
2 Average
3 -1 STD
North Carolina


Part C Early Intervention Percentage of Exiters Outcome 3
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2008-2009
2009-2010
2010-2011
2011-2012
2012-2013
62%
75%
74%
74%
71%
1 + 1 STD
2 Average
3 -1 STD
North Carolina

Expected Patterns for Progress Categories

The expected patterns and ranges for the progress categories are listed below. As a minimum quality criteria currently used for the national analysis, the values for progress category 'a,' did not improve functioning, are expected to be no greater than 10%. However, we recommend that states use no greater than 5% as an indicator of data quality. The values for progress category 'e,' maintained functioning at a level comparable to same-aged peers, are expected to be greater than 5% and less than 65%.

Category a	Category e
0	<5%
>10%	>65%

State	Outcome	Category A	Category E
NC	Outcome 1	0	0
NC	Outcome 2	0	0
NC	Outcome 3	0	0

1 = out of range for expected pattern; 0 = within expected pattern

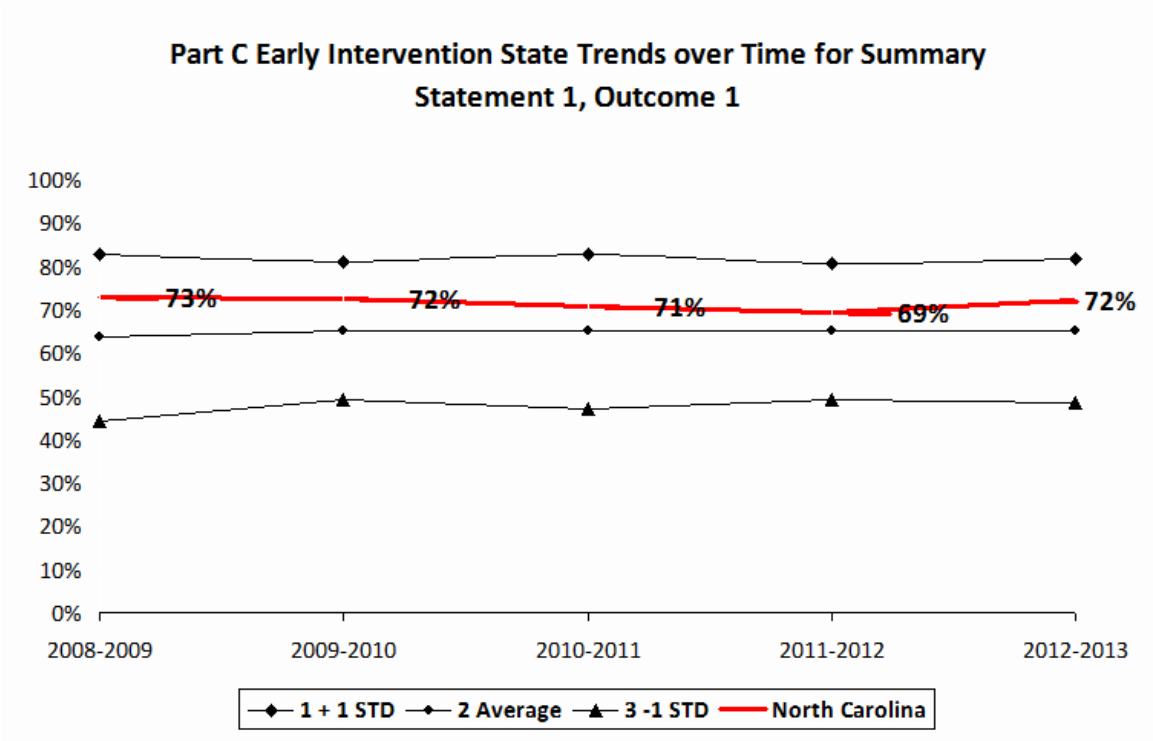
For states or territories that serve a small number of children, these data should be interpreted cautiously as they may be more likely to show unexpected patterns because a single child may represent a larger proportion of the children served.

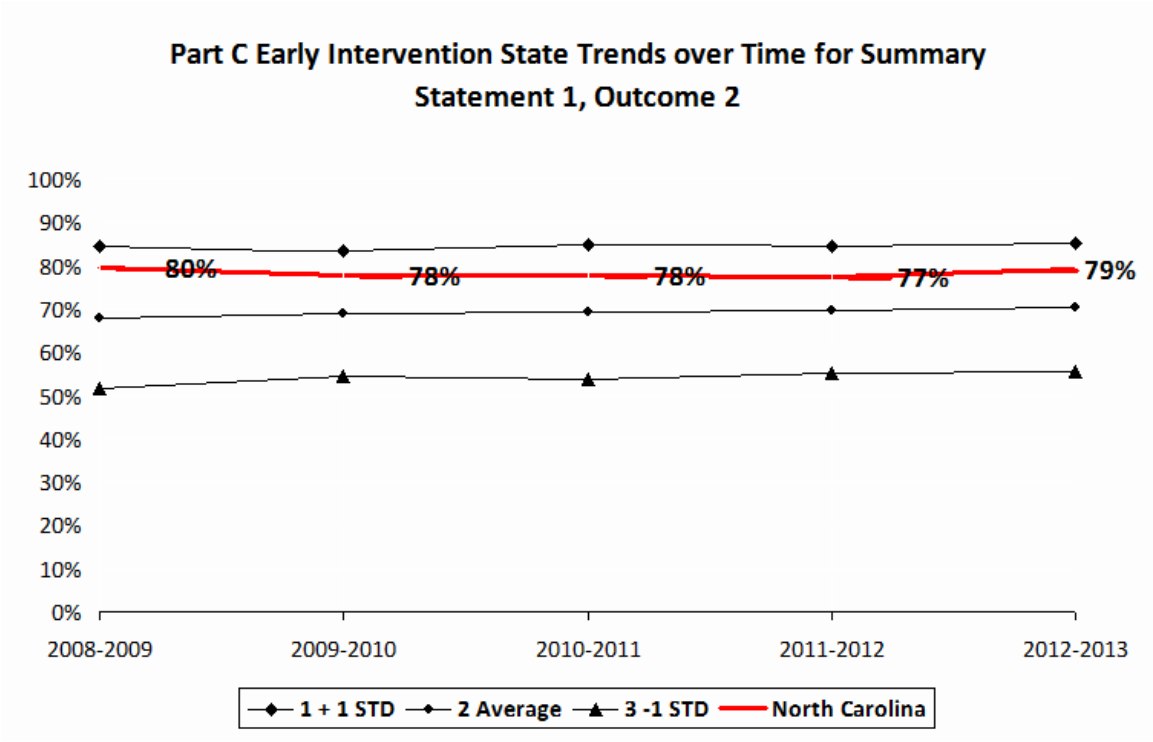
Child Outcomes State Trends over Time

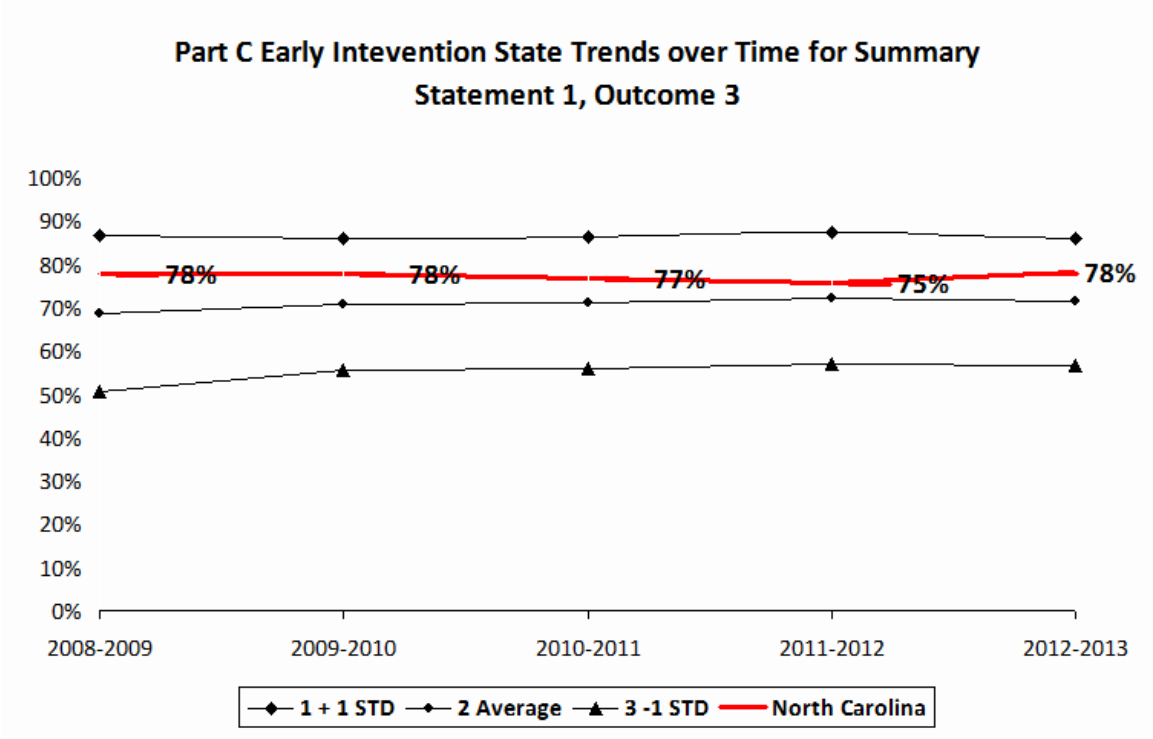
The table below summarizes the main types of change observed over time and possible interpretations.

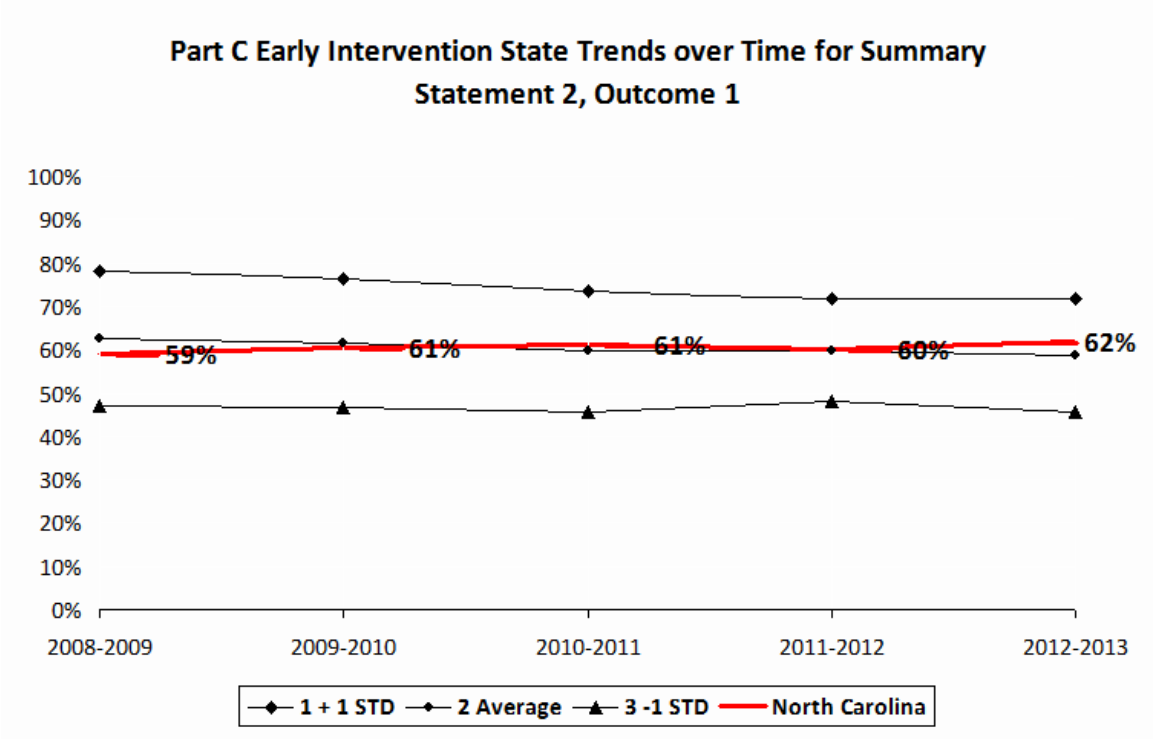
Types of Change	2008-09 → 2011-12
Small variations from year to year are expected	
Large consistent increases are good news particularly when linked to programmatic changes	
Large consistent decreases require explanation (e.g. changing population)	
Large up and down changes are an indicator of questionable data quality and require explanation	

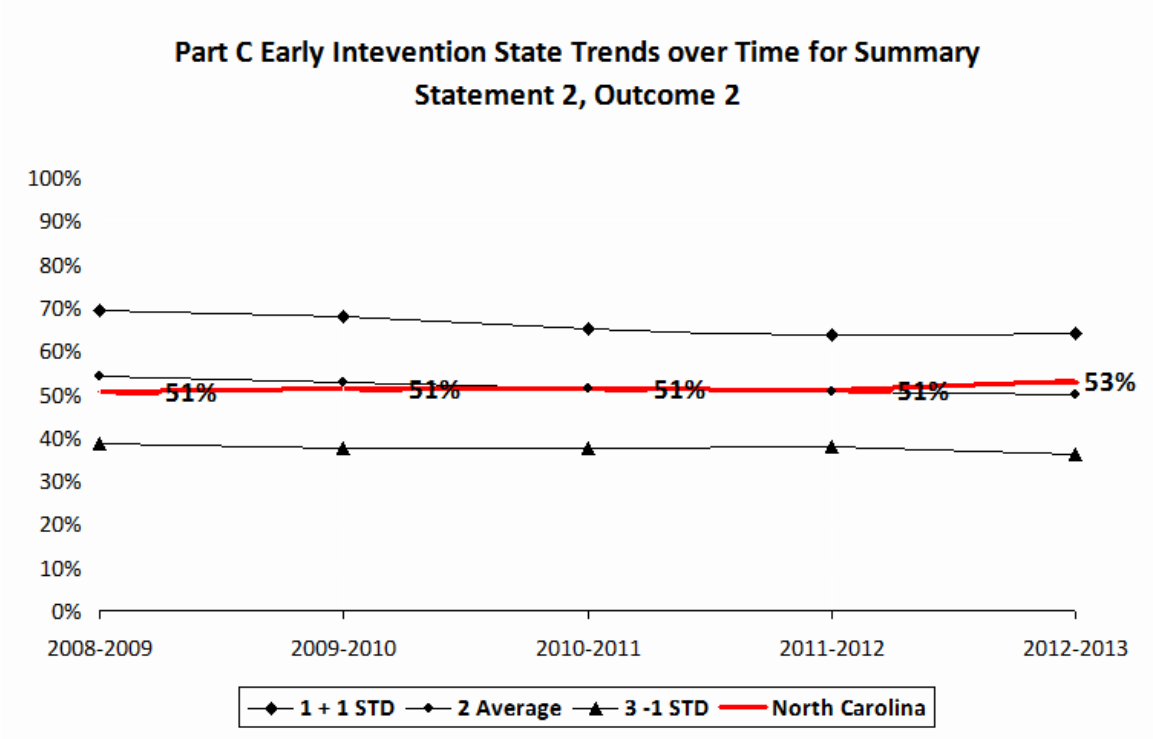
The graphs below plot the state's data over time in relation to the national average and one standard deviation (SD) above and below the national average.

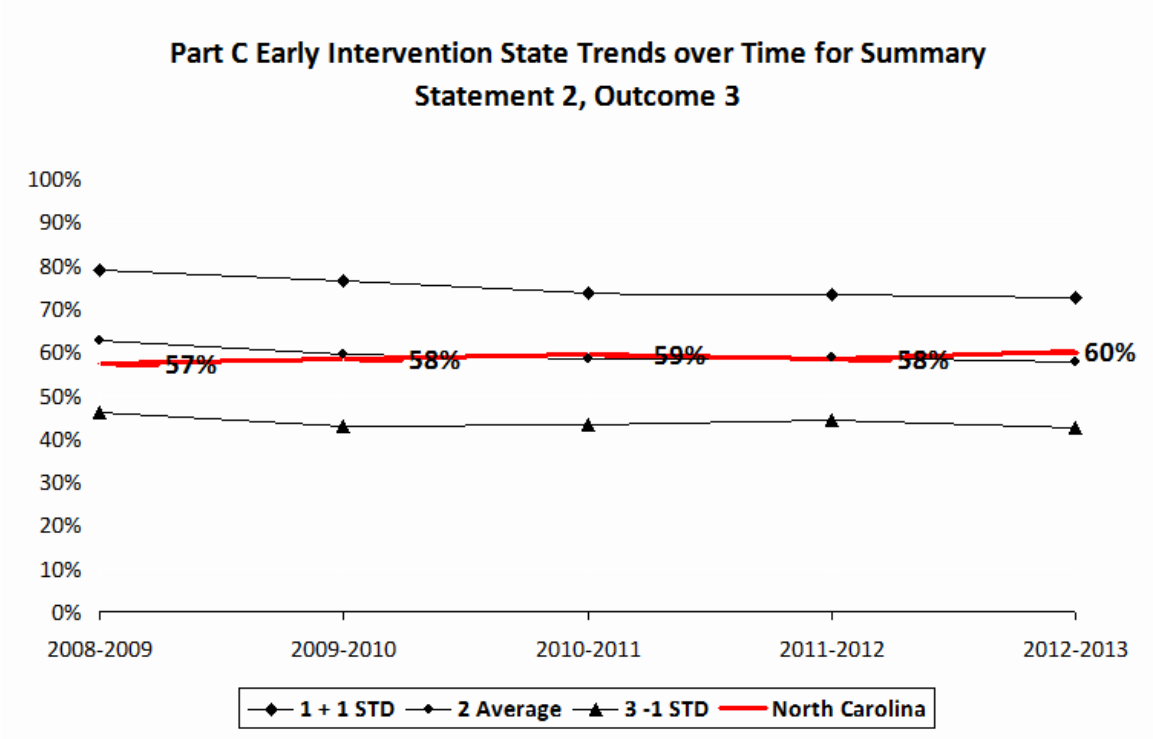

Part C Early Intervention State Trends over Time for Summary Statement 1, Outcome 1
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
73%
72%
71%
69%
72%
2008-2009
2009-2010
2010-2011
2011-2012
2012-2013
1 + 1 STD
2 Average
3 -1 STD
North Carolina


Part C Early Intervention State Trends over Time for Summary Statement 1, Outcome 2
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
80%
78%
78%
77%
79%
2008-2009
2009-2010
2010-2011
2011-2012
2012-2013
1 + 1 STD
2 Average
3 -1 STD
North Carolina


Part C Early Intevention State Trends over Time for Summary Statement 1, Outcome 3
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
78%
78%
77%
75%
78%
2008-2009
2009-2010
2010-2011
2011-2012
2012-2013
1 + 1 STD
2 Average
3 -1 STD
North Carolina


Part C Early Intervention State Trends over Time for Summary Statement 2, Outcome 1
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
59%
61%
61%
60%
62%
2008-2009
2009-2010
2010-2011
2011-2012
2012-2013
1 + 1 STD
2 Average
3 -1 STD
North Carolina


Part C Early Intevention State Trends over Time for Summary Statement 2, Outcome 2
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
51%
51%
51%
51%
53%
2008-2009
2009-2010
2010-2011
2011-2012
2012-2013
1 + 1 STD
2 Average
3 -1 STD
North Carolina


Part C Early Intervention State Trends over Time for Summary Statement 2, Outcome 3
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
57%
58%
59%
58%
60%
2008-2009
2009-2010
2010-2011
2011-2012
2012-2013
1 + 1 STD
2 Average
3 -1 STD
North Carolina

North Carolina Early Intervention Branch
SSIP Stakeholder Gallery Walk Summary

STATE SYSTEM COMPONENT	Strengths	Weaknesses	Opportunities	Threats

GOVERNANCE	• Historical – state office staff to provide direction/leadership
	• Federal/requirements to keep $ in state
	• Very knowledgeable Part C coordinator
	• Department and advocacy comm. very supportive of program
	• Single point of entry (accountability)
		• State office not large enough to be "hands – on"; as a result, CDSAs are different
		• Lack of Medicaid/ Reimbursement expert
		• No supervisor for state CDSA directors
		• Questions about whether the Department understands program disconnect with what happens locally. e.g. contract (quality)
		• Lack of advocacy
		• Lack of flexibility at local lead agency to make decisions (personnel, etc.)
		• Section Chief and Branch Head are exempt positions
			• Regional consultants – provide more EBP TA
			• System to move from compliance focused to results focused
			• Role of LICCS – Define training needs to match needs of program
			• Qualified EC Contract Consultants – due to loss of state office staff
			• Opportunities for families to educate legislators with information/longitudinal data (ECIDs study)
			• Better prepare families for advocacy
			• Use data that clearly defines the program (impact)
				• Medicaid reform
				• Retirements
				  ○ DPH Section Chief
				  ○ DPH EI Branch Head
				  ○ CDSA Directors (Charlotte, Blue Ridge, Greensboro)
				• Continue to be on the radar/ hot seat

MONITORING AND ACCOUNTABILITY	• Existing system for monitoring • Staff that make data more available (i.e.	• Don't consistently monitor providers to determine if EBPs are used • No data on whether or not	• Monitoring minimum for meeting IDEA • Develop knowledge/ standardization about EBPs	• Increased/ continued/enforced monitoring could lead to decreased

STATE SYSTEM COMPONENT	Strengths	Weaknesses	Opportunities	Threats
	state office staff) • APR friendly report for public	services are provided as noted on IFSP • Lack of consistency across the state for mentoring providers • Lack of knowledge/standardization about EBPs • Monitoring minimum for meeting IDEA • Linking educating families with outcomes data (survey) • Monitoring outcomes/accountability • Lack of effective problem – solving methods when presented with data (CDSAs) • Holding providers accountable to provider agreement • Tight fiscal accountability = less flexibility (too rigid)	• Creating consistency across the state for mentoring providers • Creating a QI process that is part of a larger relationship, strengths – based • Sharing effective practices across the state • More access to data (HIS and CSDW) for QI and monitoring • Continue to use/improve HIS • Feedback from families • List of families who are satisfied as advocates - leverage point for quality • Unique ID to track longitudinally (ECIDS) • Increase ability to look at services • Increase Child Find through monitoring of data • Website providing access to data	providers • Increase caseloads = less monitoring of providers • Security of data (confidentiality) • Losing capacity (no dedicated QA staff at some CDSAs) • Time & ability to look at data • Too much data - how to prioritize
TECHNICAL ASSISTANCE	• We have regional consultants who can be dedicated to TA • OSEP and ECTA Center TA resources	• No clear structure for CDSAs to help one another • EI state office staffing has decreased (less opportunity to do TA)	• FRIENDS Resource Center (http://friendsnrc.org/): Peer review tools, evaluating programs • Regional consultants could have planned/scheduled TA (rather than	• Policy makers who don't see value in TA • Lack of money for travel and contracting/hiring TA support

STATE SYSTEM COMPONENT	Strengths	Weaknesses	Opportunities	Threats
	• Utilizing web-based trainings/meetings	• No systematic way of planning TA (using data, targeting areas based on need, matching expertise to need); seems random and reactive • Regional CDSAs do not have decision – making authority re: taking advantage of grant opportunities • Only 3 regional consultants for entire state (don't get to provide TA to "other" CDSAS as much as the CDSA that "houses" them); CDSAs that don't house regional consultants get little TA support	just mostly consultation on request or follow up/reactive) • Take advantage of NIRN framework and resources • CDSA to CDSA support (CDSA intranet) • 2 webinars under development now (Intro to EI and Intro to IFSP) • Could Higher ED offer TA to CDSAs and state office (practice, management, using data for program planning and support, providing TA, supervision, etc.)? • Program doesn't currently take advantage of resources made available through grants • Could CDSAS pursue grants locally? • Using EPB self-checks that are available to help determine targeted TA needs • Directors have various strengths (content and practice expertise, management/operational experience, etc.) that could be utilized for TA from one CDSA to another • Blended TA opportunities (more web based meetings with accompanying planned TA onsite) • Connecting with other programs/states re: practice • Taking advantage of resources the	

STATE SYSTEM COMPONENT	Strengths	Weaknesses	Opportunities	Threats
			contract CDSAs can offer/access (fewer restrictions)	
DATA	• Connection between ITP and State Center for Health Stats. • Multiple people in state office who can analyze data • Universal understanding of need of data - why what we collect is meaningful • HIS more robust than previous systems • Ability to share data with Part B (SSIP) • Use of consistent outcome measure from Part C to Part B (COS) SSIP	• Lack of time/ability to collect additional data or look at existing data • Lack of ability to track longitudinally • Don't have access to provider data • State systems across state don't link - DHHS • Lack of ability to share data across CDSAs • Lack of counts of providers in the state • Family outcomes survey, low response rate too long doesn't ask? we want to know • What happens to children who are not evaluated? • Not having accurate counts of services and individuals served • Lack of standardized process for child outcomes data collection at local level • Lack of incentive(s) for families to return survey • Duplication of effort for data entry (multiple systems) • Consent process impacting data sharing	• Create access to provider data • Link state systems • Consent process impacting data sharing • Ability to measure fidelity to practices (EBPs) • Fix data system to share data from CDSA to CDSA • Programmatic use of data in HIS • Using data to help show need to re-coop lost budget • Additional impact data (process data, services reduced) particularly around outcomes and quality • Use existing data systems to identify children not in the system – how do we identify them? Private schools? Off the data grid • Use of website to share data and reports internally and externally • Use of data to show unmet needs (i.e. child find) • Use data to show info about quality providers (self-referral to services) • Use of SSIP process to improve data systems • ECIDS • Improve data quality/accuracy with data entry multiple systems	• Loss of funding • Loss of data quality/accuracy with data entry multiple systems • Change in admin = changes of priorities • Data does not accurately reflect the need/delivery services child outcomes • Multiple roles (capacity) to look at data of local level - look at data and problem solve

STATE SYSTEM COMPONENT	Strengths	Weaknesses	Opportunities	Threats
		• Additional Medicaid data (funds, billing)		
PROFESSIONAL DEVELOPMENT	• Licensure laws (additional requirements) for certain disciplines are helping staff to be better prepared • Programs collaboration with Higher Ed gives opportunities for higher end course content to match skills/knowledge needed to work in program • EI excellence website (Charlotte CDSA) is a great resource • In house trainings with CDSAs are helpful and utilize the talent/expertise of staff • Specific certification requirement for service coordinators and special instruction providers • Staff is knowledgeable and innovative (great resources) – some longevity, wisdom	• Licensure laws change (additional requirements) may result in shortage of staff • Little/no training on building adult capacity to help their children learn and participate • Funds to support FSN collaboration cut • No staff development funds for staff (registration, travel, etc.) • No web-based training for staff beyond introductory courses • Funds to support professional development contract with UNC cut • No way to train providers in natural environments (only receive orientation, introductory training, and monitoring by CDSAs) • Lack of staff diversity (staff doesn't "match" population served) • Inflexible system (recruitment of providers and staff and lack of incentives) • Inflexible system (classification of positions)	• Identifying existing web-based trainings that can be accessed by staff • Carry – forward money could be used to support training/PD activities • New staff classification system is coming! • More collaboration/consultation with Higher Ed to make sure curricula matches program's focus on child and family outcomes • UNC School of SW – clinical presentations available for staff to access • NCIMH Association training available for staff to access • TEACCH training and AUCD training available for staff to access • More emphasis on family engagement and family leadership (building adult capacity) • FRIENDS Resource Center(Chapel Hill) has training material/support available (http://friendsnrc.org/) • More thought about staff selection (NIRN) and matching expertise to specific needs • Carolina Institute for Developmental Disabilities (CIDD) training resources • Information on Implementation	• Ever decreasing resources for PD • PD resources that are available on the web aren't always specific enough to EI and the population served • Salaries for staff/reimbursement for providers • RttT funding ending (affects program indirectly) • Losing staff (vacant positons lost, retirement, more attractive opportunities) • Culture – some people don't feel responsibility to serve population; don't recognize importance of EI

STATE SYSTEM COMPONENT	Strengths	Weaknesses	Opportunities	Threats
		• Shortage of therapists serving children in natural environments • Disconnect in communication re: priorities of state office; local programs (CDSAs) set their own priorities/initiatives that may or may not be in tandem with priorities of the state office	drivers from NIRN website • Using LICC to help identify PD opportunities locally • Smart Start training available for staff to access • Aligning organization with staff (make the most of staff coaching)	
QUALITY STANDARDS	• Qualified staff in EI – ITFS certification • Global Child outcomes • Meet indicators proficiency- #s good • Last 10 years focused on compliance • Quality standards for childcare • Level of interest in training (working with children w/special needs) • ECAC training for families and providers (supporting families in accessing quality care) (online resources) • Use quality evaluation methods – recent	• Standards for family outcomes • Standards reflect typical development • Little training on incentive to learn to care for children with special needs • Meeting indicators doesn't always = quality • Service provision not always aligned with program philosophy • Don't have enough staff to implement quality services (down time, down time for training) • Know what quality is but can't do it (time) i.e. to engage families • Quality of CBRS providers hit or miss – much more variable than licensed treatment providers	• DPI initiative: Foundations of Learning opportunity to be extended to I/T and preschool • Get more child care standards to reflect children with disabilities • Provide more training on quality standards what should look like for children with special needs • Smart Start and CCR&R programs • More information on building adult capacity (adult learning/teaching adults) • Need a way to measure program quality • Standards for family outcomes	• Quantity threats to quality (availability of providers) • Working towards compliance only threatens quality • Decrease in staffing • Turnover in CBRS providers • Lack of providers means not always getting people w/0-3 experiences and working in natural environments • CDSA capacity to implement • Compliance still takes time • Increased diversity of

STATE SYSTEM COMPONENT	Strengths	Weaknesses	Opportunities	Threats
	improvement (from many to one of 5 valid choices – standardized across state) • More procedural guidance docs/policy providing more direction • Focused monitoring process	• Providing adequate training to the provider field/providers following Part C Regulations		families in NC (w/lack of resources)
FISCAL	• Stability of federal funding • Longitudinal data system (ECIDS) • Fiscal data to analyze	• NC Tracks – providers don't get paid; CBRS? ○ Affecting children being enrolled in Medicaid • Inequity – move positions – reclassifying - % of state and federal positions • Allocation formula – doesn't account for travel, providers, etc.	• Diversify sources, including grants • Private insurance coverage • Create advocacy partners (NC Child, Smart Start) to address budget cuts • Data can be used by advocates • Better prepared leaders/advocates with info and data • Interact and collaborate with larger disability community • Allocation formula has not been revisited in past 10 years • Look at staff and expense practice • Funding – as we restructure	• State office unable to advocate for funding • $10m reduction (160 positions) • IDEA Reauthorization • More budget cuts • Medicaid extrapolated pay backs (CDSAS and providers) • Political nature of Medicaid • Medicaid Reform • Completely capitated – by large companies • ACO- Accountable Care Organization. • Grants – sustain; burden to provide data etc.; match requirements

State Initiatives and Improvement Activities

- NIRN, SISEP
- Local Smart Start partnerships
- UNCG/UNC-C – 5 year OSEP teacher prep programs
- CSEFEL
- Pediatric screening – CCNC
- Autism screening - Pediatric Society, pediatricians
- Autism development disabilities measurement
- Implement 2011 Part C Regulations – site visits for what's next
- Strategic planning - Children and Youth, Women's Health Branches
- 619 data system to improve access to COS data
- Home visiting programs - Nurse/family partnership, parents as teachers, Healthy families
- 2 CDSA's piloting integrating global child outcomes into IFSP
- Child First initiative – intensive parent and child interaction for very at-risk families (SOC approaching collaborative partners – will coordinate screening, referral and treatment
- RttT – ECIDS, KEA
- EC foundation (new – started w/c 6 months) choosing priorities now advocacy foundation – (2000 days) (0-8)
- Medicaid reform
- NCIMH - Grant to increase capacity across the state
- ABCD Project - NCPC/DPI teach screening/referral resources – improving training on B6 childcare
- Research groups at UNC – i.e. Local efforts to support opiate-exposed babies
- CHIPRA (MCH) – oral health
- Family to Family
- Emphasis on CDSAs taking student interns (SLP, OT, PT)
- New MOAs - CDSA's participating in federal/state funded projects (i.e. NICU outcomes, autism)
- CMS – coverage for behaviors treatment for autism –NC in process on determining how will do that (BCBS might)
- EI excellence website – Charlotte CDSA
- Alamance Community (system) of care – focused on S.E., TA to medical practices
- Project Launch (SAMHSA) – behavioral health support
- Triple P (PPP)
- EHS programs across the state

- ADOS 2 training Nov 2014
- MCH NICU coordinators transition NICU –home
- Child treatment program parent/child psychotherapy/ICT 1.8 M legislative funding Dana Hagel Duke/UNC
- FSN – continued funding from DSS PZP/support groups/NICUs
- Essentials for Childhood – task force: NIOM/DPH CDC grant 4 years to look at state systems/infrastructure
- Reauthorization of SCHIP

Gallery Walk Overall Themes

Strengths	Weaknesses	Opportunities	Threats

• State office staff – various strengths and expertise
• State CDSA staff – innovative and knowledgeable
• Data system (HIS)
• Statewide Monitoring System
• Consistent Statewide Outcome Measurement and Reporting System
• Connections with initiatives of other agencies and organizations
	• State office staff resources don't meet needs of local implementation
	  • Leadership change
	  • Key positions vacant and needed
	  • Utilization of Regional Consultants
	• Local Programs (CDSAs) have limited decision-making authority
	  • Local Budget
	  • Local Personnel
	  • Provider Accountability and Incentives
	  • Potential Local Collaborations/Funding opportunities
	  • Program priority-setting
	  • Organize work groups, meetings, trainings, TA, etc. across CDSAs
	• Limited professional development opportunities for providers, CDSA staff, and state office staff
	• Monitoring system focused on compliance with little emphasis on outcomes/results
	• Lack of Provider Accountability
	  • Monitoring for EBP
	  • Lack of Data on actual provision of services by providers
	  • No structure for communication between providers and state office
	  • Limited opportunities for training/TA for providers
	• Challenges with accessing therapists providing services in the natural environment
	• Limited ability to utilize data in HIS for program planning and decision making at the local level (CDSAs) causing CDSAs to utilize multiple local data systems
		• TA by Regional Consultants
		  • Provide more TA on EBP
		  • Plan TA based on program data
		  • More structured/ scheduled TA
		  • Include others (state office staff, CDSA staff, community resources, etc.) in TA opportunities when their expertise meets TA needs
		• Build monitoring/QI process that can balance compliance and results
		• Engage families in state system components
		  • Advocacy
		  • Program planning & evaluation
		  • TA
		• Leverage resources of other organizations/ initiatives
		• Utilize and share data more to identify areas of need and impact
		• Partner more with advocates and larger disability community
			• Loss of funding
			• Loss of personnel
			• Change in administrative/ leadership positions
			• Medicaid Reform
			• Lack of adequate reimbursement/ incentives for providers
			• CDSA lack of capacity to implement EBP