



**ARKANSAS' PART C PROGRAM
FIRST CONNECTIONS**

State Systemic Improvement Plan



FIRST CONNECTIONS

Department of Human Services

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

P. O. Box 1437 Little Rock, AR 72203

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OVERVIEW of ARKANSAS' PART C SSIP:

Description of State Identified Measurable Results (SIMR)

Phase I work for the development of the State Strategic Improvement Plan (SSIP) culminated in the selection of the following SiMR as the Lead Agency's area of focus for improving results for infants and toddlers with disabilities:

Increase the percent of families participating in Part C who report that early intervention has helped them help their child develop and learn.

[Family Outcome 4/C]

A subset of programs/providers from each of five regions will be selected to participate in intensive TA on evidenced-based practices in the initial implementation.

Description of the State's Part C Program [First Connections]

To understand the SSIP, it is relevant for the reader to understand Arkansas' Part C or First Connections Program. Arkansas' "lead agency" in charge of administering the program is the Department of Human Services, Division of Developmental Services (DDS). The lead agency collaborates with other related agencies through Intra or Inter-Agency Agreements.

The lead agency provides early intervention using a state-wide network of EI providers contracted through voucher agreements. A restructuring of the Part C Program in 2013 removed center-based early intervention services offered through Developmental Day Treatment Centers from the state's Part C program into a separate Children's Services program under the Division of Developmental Disabilities Services. According to the latest child count data reported, First Connections serves 1,378 children birth to three years of age.

The lead agency's "central office" staff includes the Part C Coordinator and a five-member management team responsible for the major system components including:

- Data Manager
- Fiscal Manager
- Program Manager
- Comprehensive System of Personnel Development Coordinator
- Quality Assurance/Monitoring, Licensure and Certification Manager

Arkansas' Part C staff participates on the Infant and Toddler Coordinators Association (ITCA) professional development committee.

Process Used for Developing Phase I of the SSIP and Overview of Stakeholder Input

For information about Timeliness for SSIP Work, please see Appendix 3.

The team leaders and the Part C Coordinator formed the Core SSIP Team to identify stakeholders, lead small group analyses, and guide conversations about specialty areas to report back to the larger stakeholder group.

The Arkansas Interagency Coordinating Council (AICC) meets quarterly to advise and assist the lead agency and was involved in the development of the SSIP.

An SSIP Stakeholders Group was created to assist the lead agency in SSIP development with representatives of agencies and organizations that collaborate with Part C as well as parents of children with disabilities and Institutes of Higher Education (IHEs).

Internal and external stakeholders were involved in all components of Phase I of the SSIP: Core SSIP Team (lead agency staff), SSIP Stakeholders Group, the AICC, and ECTA Center staff.

For a list of membership and/or agencies represented in the SSIP Stakeholders Group, please see Appendix 2.

Stakeholders participated in development of the SSIP through face-to-face workgroup meetings, Webinars, phone conferences, and e-mail to identify concerns related to performance areas and potential barriers to high performance or impact on low performance for infant and toddlers with disabilities. Stakeholders, through large and small group meetings, worked with the Core SSIP Team to complete the steps in the Phase 1 process:

- data analysis
- broad and in-depth infrastructure analyses
- identifying related state initiatives
- formulating theories of possible causes
- identifying and recommending the measureable result (SiMR)
- identifying root causes
- developing improvement strategies to address the SiMR
- crafting a Theory of Action and the Theory of Action graphic

The Core SSIP Team and the Part C Coordinator, in collaboration with ECTA initially invited stakeholders to participate in conference calls to provide an overview of the SSIP requirements and timelines and to describe the role of stakeholders in the development of the SSIP. After individuals accepted the invitation to participate on the stakeholder group, they participated in a two-day face to face workshop.

Data presented/analyzed:

- 1. Family Outcomes Data**
 - 2. Indicator 2 / “Natural Environment”**
 - 3. Child Count and Exit Data**
 - 4. Child Outcomes Data**
1. Arkansas collects Family Survey data for the State Performance Plan / Annual Performance Report (SPP/APR). Arkansas uses the family survey developed by the Early Childhood Outcomes (ECO) Center, an instrument in which parents rate the extent to which First Connections has helped them achieve specific outcomes. The survey is distributed by mail; however, families have the option of completing the paper copy and sending it by mail, using a link to complete it online, by phone, or during a visit with the providers.

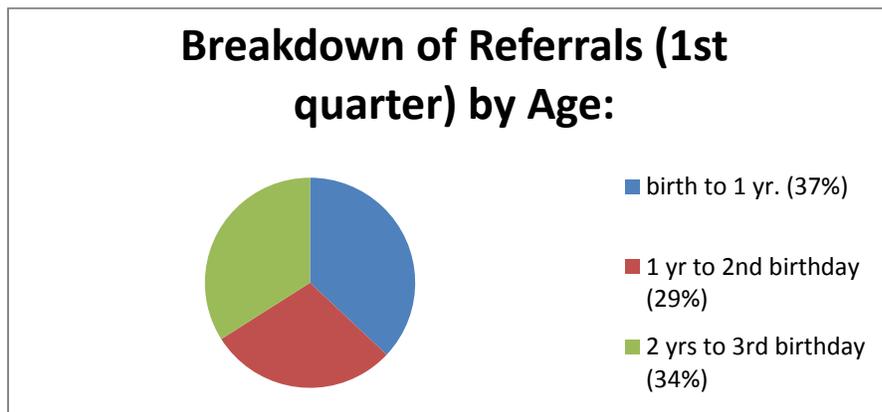
Average ratings for survey items for 2012-2013 were below the national average.

The percent of families participating in Part C who report that early intervention has helped their families compared to the national average:

- A. **Know their rights (68%) versus 87% nationally**
- B. **Effectively communicate their children’s needs (71%) versus 88% nationally**
- C. **Help their child develop and learn (75%) versus 90% nationally**

Stakeholders were concerned that 25-32% of parents self-reported that they don’t know how to help their children, communicate their needs, or know their rights. Stakeholders agreed that we wanted families to benefit more from early intervention and improvement in this area would look like an increase in these percentages.

- 2. “Natural Environment” has long been a program weakness, or an opportunity for improvement, in Arkansas. Analysis of data around 2012 APR data on service setting reported 33% of children in Arkansas were served in the natural environment. Currently 74% of children in Arkansas are served in natural environments. Current APR data shows improvement in this area, but not to the level of performance stakeholders would like to see for the state, especially when compared to national data. Nationally, 51 states reported that at least 90% of children are served in natural environments.
- 3. 2013 Referral data reveals that over one-third of new referrals to the program are for children over age two, a factor that directly affects child outcomes (COSF ratings) gathered as part of transition. The breakdown of referrals by age may indicate a need for better Child Find and public awareness activities, physician and other referral source education and better “marketing” of the program to increase the likelihood that infants and toddlers experiencing a developmental delay will be referred for Part C earlier to improve child outcomes. First Quarter (2014) referral data shows the breakdown of the 1274 referrals as follows:



- 4. Arkansas uses the Child Outcome Summary Form (COSF) developed by the Early Childhood Outcomes Center. Arkansas recently adopted (in 2014) tools to assist IFSP teams in completing initial and exit COSF ratings for all infants and toddlers who received EI services for six months or more. These tools are an “Age Anchor” (*ND Early Childhood Outcomes Process Age Expectation Developmental Milestones by Age Groups*, June 2010) developed by North Dakota, and a slightly modified version of the “Decision Tree” tool developed by the Early Childhood Outcomes Center (ECO. 5/19/09), modified by Arkansas’ Part C program with direct service provider input.

After an extensive analysis of both the state's child outcome summary (COS) data and national comparisons, the SSIP Stakeholders Group and Core SSIP Team determined that Arkansas' child outcomes have plateaued over the past several years with no significant improvement. Stakeholders agreed that as a state, we should work toward the broad goal of "improving child outcomes." The stakeholder group discussed how best to accomplish this goal.

Face to face meetings enabled stakeholders to work in smaller groups to come up with ideas, possible causes, and possible solutions and report these ideas back to the group as a whole during large group discussion. Each workgroup considered questions to guide their work (see Component 1(a) for more information) and reported back their answers to the large group.

Identifying and Recommending a Feasible SiMR

Information from the first face to face workgroup meeting with the SSIP Stakeholder group was shared with the AICC for discussion and feedback. Another face to face day-long workshop was convened with the Core SSIP Team and the SSIP Stakeholders group to narrow the focus and identify and recommend a feasible State-identified Measureable Result (SiMR).

When Child Outcomes, Natural Environment data, and Family Survey data were looked at together, there appeared to be a link between stagnant growth in child outcomes, inability to provide intervention within everyday child and family activities and the comparable number of families reporting that early intervention has helped them help their child develop and learn.

In a full SSIP Stakeholders Group discussion led by one of Arkansas' national TA partners, Core SSIP Team members working in collaboration with the full stakeholder group considered the question:

"What would happen if we can increase the percent of families who can say that early intervention has helped them to help their child develop and learn?"

The group's answers helped the team narrow the focus of the SiMR:

- If we increase Family Outcome area "c," then we increase "b" and "a" also (because if parents can help their child develop and learn, they can express their child's strengths and needs and advocate for their child)
- If parents improve in Family Outcome area "c," then children learn more effectively, so child outcomes A-C improve
- Parents get more and better support and education from EI
- Parent better understands their role in EI and the roles of providers and other EI team members
- Engaged, competent, capable parenting possibly results in a reduction in abuse/neglect of children with disabilities (reduction in CAPTA referrals)
- Parent involvement in learning may result in children more prepared for kindergarten and beyond resulting in improved educational outcomes for children with disabilities
- Generational change: nurtured children become better parents themselves

After considering the group's responses and principles of early learning, the group identified that "more therapy" isn't "better intervention," because therapy sessions out of context and without parent

coaching is not going to yield lasting results for infants/toddlers with disabilities. Three hours a week of therapy won't enable the family to help the child learn and won't help the child learn functional skills within typical activities in order to be a more active participant in home and community life. Families may ask for "more" because they aren't seeing results, but more therapy isn't the answer . . . more intervention is!

Infrastructure Analysis

Subcommittees led by lead agency managers were formed to complete the infrastructure analysis. The AICC formed a subcommittee from their membership to complete the analysis of the governance component. Once completed, each component was shared and discussed at the next stakeholder meeting where stakeholders identified additional strengths and needs.

For more information on infrastructure analysis and stakeholder involvement in the process, see: Component 2(a), Components 4(c-d and e). For more

COMPONENT #1: DATA ANALYSIS

Arkansas was one of seven “framework states” selected by the Center for IDEA Early Childhood Data Systems (DaSy) to participate in developing a framework for a high quality early childhood data system. This project was funded by the Office of Special Education Programs (OSEP) and involved intensive work over a period of 14 months with input from Part C and Part B 619 staff. Involvement in developing the framework provided an opportunity for evaluation and assessment of the First Connections current data system. It was determined, based on the frameworks, that the Comprehensive Data System (CDS) reflects the framework for a high quality early childhood data system. All components are in place and required data is being collected to report to OSEP. Information is collected at the child level from the time of referral to the time the child leaves the program. The strongest areas of CDS are receiving the referral, creation of IFSPs to ensure all required elements are included, and creating the prior authorization for the services indicated on the IFSP. Data system (CDS) areas of weakness include: the quality of the IFSP, documenting delivered services, steps for transition as shown in compliance data (i.e. Indicator 8/Effective Transition).

State’s Expectation for Effective Data Use

The lead agency expects the various units within the Part C program to use data across areas to inform and guide program administration for data-based decision making. The units within the Part C program are expected to collaborate with one another and share data and their unit’s perspective on data to inform the work of other units. To accomplish this, the Part C unit managers (team leads) meet quarterly to share information and data and make decisions about program administration. For example, when QA/Monitoring identifies issues with the IFSP or documentation, TA and professional development efforts might focus on increasing IFSP quality or provider’s use of the data system to document accurately. Program managers observations in the field (qualitative data) inform needed changes in the Data system and identify needs for training and TA. Materials developed as a result of data analysis include:

- Data Unit: guides for using CDS linked in the data system
- Q/A Monitoring: TA on site or by phone and share a list of online courses by topic
- CSDP: self-study guides and PowerPoints on identified issues

Component 1 (a) How Key Data Were Identified and Analyzed:

Data collection included reviews of APR/SPP data from previous years, reviews of local program data, review of local policies and procedures, review of child records, interviews with parents and program coordinators and providers, and direct observation of IFSP meetings.

Data used to begin the work were 2012 APR/SPP data pulled for FY 2013 reporting and data from previous years’ APR/SPP reporting (Indicators 2, 3, 4, 8, and Child Count) as well as trend data from multiple years. This data was shared with the Core SSIP Team working with national TA partners to prepare for presenting data to the SSIP Stakeholders Group. The team wanted data to be presented in an understandable and useful way to “tell our story” -- “what we do” and “how we’re doing.” The Core Team provided input to the Data Unit on formatting the data for the presentation to share with the SSIP Stakeholders Group.

As work progressed with the SSIP Stakeholders Group, the most recent APR/SPP data (2013) was pulled and analyzed, specifically:

- Child Count Data
- FY 12-13 and FY 13-14 Settings, Exit, and Outcomes Data
- Child Outcomes (Indicator 3)
- Family Involvement (Indicator 4)
- Natural Environment (Settings)
- Timeliness of Services (Indicator 1)
- 45-Day Timeline (Indicator 7)
- Transition (Indicator 8)
- Kids Count Data

For information on data analysis timelines, please see Appendix 3 “Timelines for SSIP Work.”

In theory, early intervention should enable more children to exit the program functioning at or near age level when they leave the Part C program. However, the data shows there is still work to be done based on the number of children leaving the program and not reaching a level of development closer to their same-aged peers.

Quantitative data (Child Count, Exit, and Compliance Indicators) as compared to the qualitative data (Child Outcomes scores and Family Survey results) yielded variations between the number of children served in various locations and those who exited for various reasons and at various ages. This data was compared to the number of children who received services in the natural environment in comparison with the number of child outcomes summary forms completed and the observation that child outcomes scores have not changed very much over the years.

Questions that guided data analysis of both quantitative and qualitative data were developed by the Core SSIP Team with suggestions and input from ECTA:

- *To what degree has the data presented around this results area demonstrate a need?*
- *To what extent are we satisfied with our performance in these areas?*
- *What other initiatives in AR support this results area?*
- *Give two reasons why this should be included in our state identified measurable result.*

The process used for collecting and analyzing data and methods for the broad and in-depth analyses included a review of and analysis of existing and the most current data that was already pulled to satisfy 618 Data and the APR and a comparison of this data with the previous year’s data. Stakeholder groups working with the Core SSIP Team and national TA partners worked together to make inferences around the data, trying to determine what could cause it to look like it does. Stakeholders shared their input around using and understanding the data and practices for data collection.

The Data Manager and a subcommittee of volunteers from the SSIP Stakeholders Group began with a SWOT analysis to determine strengths, weaknesses, opportunities, and threats regarding the Part C data system and data collection practices (*see Component 1 (f) for additional information*).

The SSIP Stakeholders Group, the Core SSIP Team, and national TA partners worked collaboratively throughout the Phase I process. After identifying issues through data analyses (listed below as “potential issues”), the broad group met to identify potential causes (*root causes – see Appendix 1*).

Potential issues identified in an earlier work group meeting were reviewed, with opportunities to amend ideas or add to the list. Identified areas included:

1. Low parent participation in annual family survey: data unit had to phone 500 + parents to get enough responses to be representative of the families served
2. Still too high a percentage of children receiving services outside of their natural environment and typical activities and without caregiver participation
3. Percent of parents who say EI helped them help their child develop and learn below national averages
4. “Late referrals” a high percentage of children are not referred until they are over two years old, maybe the program needs better public awareness/Child Find in order to increase percentage of 0-1 referred to Part C
5. Too many children who received services for six months or more do not get exit COSF ratings as part of the transition/exit process
6. Possible low quality entry COSF ratings due to inconsistency in how ratings are generated
7. Children whose time in EI helped them achieve a level of functioning closer to that of their typically developing peers lower than what stakeholders would like to see for children and below national averages

After reviewing the list of previously identified “potential issues” as a team and discussing them, the large group divided into table work groups to brainstorm root causes (*See Appendix 1 for Contributing Factors Questions and Discussion*).

Stakeholder identification of “potential issues” and possible causes/contributing factors moved the group easily into the next steps – determining what the statewide comprehensive early intervention network would need in order to support change to reach identified goals that improve outcomes for children and families through infrastructure analysis.

For more information on infrastructure analysis and stakeholder involvement in the process, see: Overview of this report, “Infrastructure Analysis,” Component 2(a), Components 4(c-d and e). For more information about Contributing Factors, please see Appendix 1.

Quantitative Data:

618 Child Count Trend Data (2007-2014)

Year	Total Served	0-1	1-2	2-3
2014	1144	137	379	628
2013	1378	169	486	723
2012	3130	382	1077	1671
2011	3140	327	1070	1743
2010	3222	367	1085	1770
2009	2720	247	982	1491
2008	2878	273	982	1623
2007	2838	294	941	1603

Review of Child Count Trend Data indicates that historically, the program experiences a significantly lower percentage of referrals in the 0-1 age range. Stakeholder groups offered ideas on contributing factors/possible causes as part of data analysis.

The 2013-2014 Child Count data reflects a decrease in the number of children served within previous years as a result of a reorganization beginning July 1, 2013 in which center-based Developmental Day Treatment Centers (specifically designed for children with disabilities) were moved from under the administration of Part C to a different section of DDS-Children's Services. FY 2013-2014 was the first year of reporting that reflects the changes of Reorganization.

FY 12-13 Settings, Exit, and Outcomes Data

- **Natural Environment:**

33% of the children were served in the Natural Environment and 67% were served in other settings such as the Clinic and Developmental Day Treatment Centers.

- **Exit and Child Outcomes Data**

In the 2012-2013 data, 1463 children exited First Connections and were also reported to have received services for more than six months. Their Child Outcomes Survey calculated and summarized entry and exit scores show:

- A. Positive Social Emotional Skills:**

- Summary Statement 1:** 59% of children who entered the program below age expectation in the outcomes area substantially increased their rate of growth by the time they exited the program

- Summary Statement 2:** 22% of children were functioning within age expectations in the Outcome area by the time they exited the program.

- B. Acquisition and Use of Knowledge and Skills (including early language/communication):**

- Summary Statement 1:** 60% of children who entered the program below age expectation in this outcomes area has substantially increased their rate of growth by the time they exited the program

- Summary Statement 2:** 21% of children are functioning within age expectations in this outcome area by the time they exited the program.

- C. Takes Appropriate Action to Meet Needs:**

- Summary Statement 1:** 58% of children who entered the program below age expectation in this Outcome area substantially increased their rate of growth by the time they exited the program

- Summary Statement 2:** 23% of children are functioning within age expectations in the Outcome area by the time they exit the program.

FY 13-14 Settings, Exit and Outcomes Data

- **Natural Environment:**

74% of infants and toddlers were served in the natural environments (home and community programs like daycare), and 26% were served outside of the natural environment, primarily through outpatient services in clinic settings; which is an increase from previous years.

- **Exit Data FY 13-14**

Out of the 3230 children who exited First Connections (Part C Program) during the FY '14, 1806 (56%) met the criteria of receiving services for more than 6 months ***and should have*** completed COSF ratings on an exit Child Outcomes Summary form. The total number of children for whom the Child Outcomes form was completed was 1690. 116 children met the criteria, but did not receive the exit COSF rating before they left the program. This includes children in the range of the following ages .8 percent of 0-1 year olds; 14% of 1-2 year olds, and 41% over 2 year olds.

- **Child Outcomes Data:**

In the 2013-2014 data, 1690 children exited First Connections and also reported to have received services for more than six months. Their Child Outcomes Survey calculated and summarized entry and exit scores to measure progress closer to age appropriate skills in the three outcome areas shown below:

Child Outcome Areas and Summary Statements 1/2	Numerator	Denominator	% of children who substantially increased their rate of growth by the time they exited the program.
<p>[A] Positive Social Emotional Skills: <u>Summary Statement 1:</u> Of those children who entered or exited the program below age expectations in Outcome A, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program <i>Expected calculation: (665 + 321=996) /60+406+675+321=1462)</i> <i>996/1462= 68%</i></p>	996	1462	68%
<p>[A] Summary Statement 2: The percent of infants and toddlers who were functioning within age expectations in this Outcome by the time they turned 3 years of age or exited the program <i>Expected calculation: (321+228)/(60+406+675+321+228)</i> <i>549/1690=33%</i></p>	549	1690	33%

<p>[B] Acquisition and Use of Knowledge and Skills: <u>Summary Statement 1:</u> Of those children who entered or exited the program below age expectations in Outcome B, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program Expected calculation: $(651+348)/(71+388+651+348)$ $999/1458=69\%$</p>	999	1458	69%
<p>[B] Summary Statement 2: The percent of infants and toddlers who were functioning within age expectations in this Outcome by the time they turned 3 years of age or exited the program Expected calculation: $(348+232)/(71+388+651+348+232)$ $580/1690=34\%$</p>	580	1690	34%
<p>[C] Takes Appropriate Action to Meet Needs: <u>Summary Statement 1:</u> Of those children who entered or exited the program below age expectations in Outcome C, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program Expected calculation: $(618+343)/(88+401+618+343)$ $961/1450$</p>	961	1450	66%
<p>[C] Summary Statement 2: The percent of infants and toddlers who were functioning within age expectations in this Outcome by the time they turned 3 years of age or exited the program Expected calculation: $(343+240)/(88+401+618+343+240)$ $583/1690=35\%$</p>	583	1690	35%

Targets in each outcome area A-C were met as follows:

A. Positive Social Emotional Skills:

Summary Statement 1: The Target was 56%, which was met.

Summary Statement 2: The target was 25%, which was met.

B. Acquisition and Use of Knowledge and Skills (including early language/communication):

Summary Statement 1: The target was 53%, which was met.

Summary Statement 2: The target was 21%, which was met.

C. Takes Appropriate Action to Meet Needs:

Summary Statement 1: The target was 56.75%, which was met.

Summary Statement 2: The target was 23%, which was met.

Even though most children are served in their natural setting at this time, the data shows that not enough children exit the program functioning within age expectations when compared to other states nationally, though the 2013-2104 data does reflect a slight increase in scores in the Child Outcome areas.

The increase in Child Outcome scores could be influenced, at least in part, by collaboration between the Data Unit and the CSPD Unit to develop and to provide more intensive training in the last couple of years around Child Outcomes and to train the EI professionals on the IFSP team in the use of tools to standardized children’s COSF entrance and exit ratings (Age Anchor and Decision Tree tools – for more information, see “Data Analysis” section of SSIP Overview and Program Initiatives section of Component 2(d)) so that (1) more child outcomes data is being entered into the data system and collected and (2) child entrance and exit ratings are better representations of child’s level of functioning in each outcome area.

Family Survey Disaggregated Data

Race Categories	Percentage Child Count Population Represented by Race	Percentage of Returned Family Survey Represented by Race
American Indian or Alaska Native	.4%	.4%
Asian or Pacific Islander	.3%	1.4%
African-American	37%	23%
Hispanic	7%	0%
White	53%	68%
Multi-Racial	2%	.8%
Race not reported	0	6%

FFY 2012: Indicator 4 / Family Survey Data Disaggregated by Race

The Lead Agency reported in the 618 Child Count for November 1, 2012 that a total of 3130 infants and toddlers were served in the Arkansas Part C program. Family survey response was received from all 75 counties in Arkansas. Analysis of the responses showed a representation by most race categories throughout the state and all geographic areas of the state. Arkansas’ data review shows an increase in representation from the American Indian/Alaska Native and Multi-Racial families. Analysis shows a decrease in the response rate of Asian or Pacific Islander, African –American and Caucasian families. There were no surveys received from families reporting their ethnicity as Hispanic even though surveys are sent in Spanish.

Family Survey Data Captured after July 1, 2014:

Surveys are sent out at the end of the Fiscal Year. Using the CDS (data system) to create labels, surveys are sent to families via mail, and families have the option of completing the survey electronically on the First Connections Web site or by return mail. Surveys received in the mail are entered into the database by state staff personnel. The survey database was created to capture, hold, and analyze the survey data. Scores are calculated by counting satisfaction relating to scores of 5, 6 and 7 on a scale of 1-7. The calculation is designed by Northrop Grumman contractors based on the information suggested by the Survey Designers (ECO). Survey responses are accepted from July 1 through the end of the year .Out of 1,400 surveys distributed through multiple distribution methods, only 287 completed surveys were

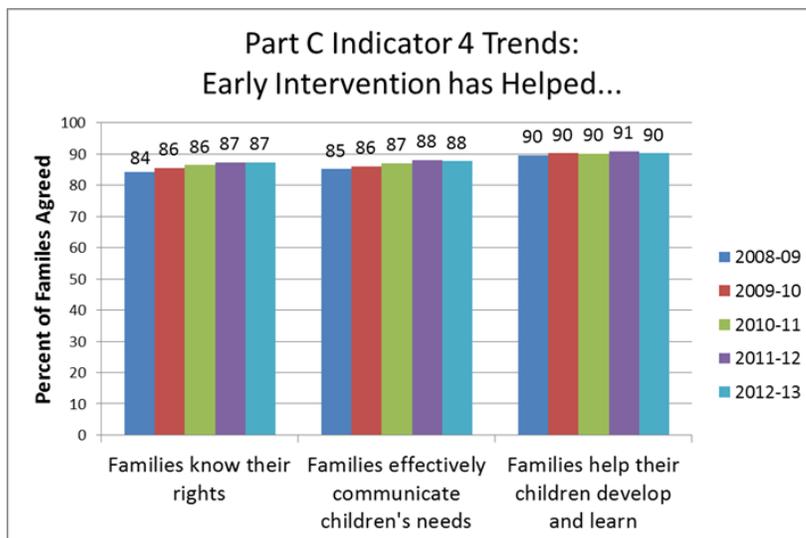
received (21% rate of return). To increase the number of families surveyed, phone surveys were conducted to ensure a representative number for data collection purposes. Completed surveys were representative of racial makeup of the state and geographical regions of the state.

As a result of low participation, the family survey was shortened and reformatted to make it less intimidating in response to SSIP Stakeholder Group. These changes were employed in the hopes that more families will complete and return Family Outcome surveys.

Data from the Family Survey shows:

- a. 215 (75%) Know their rights
- b. 232 (81%) Effectively communicate their child's needs
- c. 229 (80%) Help their child develop and learn

When compared with other states, Arkansas' parents who self-report that early intervention empowered them to help their child develop and learn are approximately 10% below the average (nationally).



Possible reasons for a lower than national average score in this Family Outcome area were suggested by Core SSIP Team with input from SSIP Stakeholders Group:

- (1) Small percentage of families returned the Family Survey
- (2) 36% of children served receive EI services in clinic outpatient settings (non-natural environment)
- (3) Limited number of families participate in the therapy sessions
- (4) Services provided in daycare settings rarely involve caregivers as children participate in "pull out therapy sessions"
- (5) Early intervention is child-focused and "therapy based" rather than family-focused "intervention" to build functional child skills.
- (6) EI services are not linked to typical child and family activities even when provided in the child's typical setting.
- (7) Child outcomes on the IFSP are not functional and not tied to the three outcome areas

Kids Count (2014) Data:

According to Kids Count (2014), Arkansas ranked 41 overall 16 indicators of child well-being and in four domains: (1) economic well-being (ranked 42), (2) education (ranked 36), (3) health (ranked 34), and (4) family and community (ranked 45). The report also indicated that 29% of children live in poverty, 53% of children aged 3 and 4 are not in preschool. http://www.aecf.org/m/databook/2014KC_profile_AR.pdf

Arkansas Advocates for Children summarized the Kids Count findings:

“The number of kids attending pre-K has remained steady, despite a lack of added funding from the state budget. Funding for the state’s pre-K program has not increased in seven years (effectively it’s been cut if you consider inflation and cost of living increases). The initial investment the state made in pre-K after the Lake View case was a good start. However, Arkansas would greatly improve in this category with extra state funding. Arkansas made gains in health coverage and education over the last year, but the child poverty rate went up to 29 percent. Those ups and downs are consistent with national trends. “We now know more than ever before about how to give children a good start and help them meet major developmental milestones throughout childhood,” says Rich Huddleston, executive director of Arkansas Advocates for Children and Families. “On several fronts, we’ve seen the difference that smart policies, effective programs and high-quality practice can make in improving child well-being and long term outcomes. We should all be encouraged by the improvements in many well-being indicators in the health, education, and safety areas, but we must do much more.”

http://www.aecf.org/m/databook/2014KC_newsrelease_AR.pdf

IFSP Quality Ratings

Monitoring of IFSP quality is scheduled to begin July 1, 2015, therefore it was determined that starting point data would be useful to compare to subsequent data in order to measure progress towards improving the functionality of child outcomes on the IFSP. IFSP quality will be measured by monitoring staff trained to use the IFSP-OAT rating tool.

(For more information about the tool and rating system, see “Additional Data that May Be Needed for Subsequent SSIP Phases” and Component 2(c)).

Starting point data was obtained in this manner:

- IFSP quality ratings were completed in March of 2015 (prior to monitoring for compliance and quality but after training and initiative had begun to require IFSP teams to improve the quality and functionality of IFSP outcomes)
- Core SSIP Team members determined that monitoring staff would pull IFSPs created during the last six months (after training initiative began)
- 25 IFSPs would be randomly pulled (5 from each of five regions) to obtain data to determine “where we are at”
- Each monitoring team member would rate five random IFSPs: (2) from state staff, (2) from center-based providers contracted with Part C, (1) independent service provider
- Ratings from the five monitoring team members would be averaged to get an average rating for the state’s Part C program. Rating quality level is determined by the guide provided on the IFSP-OAT tool where: a score of 0-17 is “lacking quality;” scores in the range of 18-31 show “elements of quality;” and ratings between 32-51 are “high quality IFSPs.”

Monitor 1	Monitor 2	Monitor 3	Monitor 4	Monitor 5
(a) score (7) lacking quality	(a) score (18) IFSP has elements of quality	(a) score (0) IFSP lacking quality	(a) score (34) IFSP high quality	(a) score (20) IFSP has elements of quality
(b) score (6) lacking quality	(b) score (21) IFSP has elements of quality	(b) score (23) IFSP has elements of quality	(b) score (12) IFSP lacking quality	(b) score (17) IFSP lacking quality
(c) score (31) IFSP has elements of quality	(c) score (10) IFSP is lacking quality	(c) score (18) IFSP has elements of quality	(c) score (24) IFSP has elements of quality	(c) score (17) IFSP lacking quality
(d) score (0) IFSP lacking quality	(d) score (50) IFSP high quality	(d) score (22) IFSP has elements of quality	(d) score (19) IFSP has elements of quality	(d) score (30) IFSP has elements of quality
(e) score (23) IFSP has elements of quality	(e) score (4) IFSP is lacking quality	(e) score (26) IFSP has elements of quality	(e) score (14) IFSP lacking quality	(e) score (3) IFSP is lacking quality
Total for 5 IFSPs: 67 Average rating: 13.4	Total for 5 IFSPs: 103 Average rating: 20.6	Total for 5 IFSPs: 89 Average rating: 17.8	Total for 5 IFSPs: 103 Average rating: 20.6	Total for 5 IFSPs: 87 Average rating: 17.4

Statewide Average (all 5 monitors/areas) = 17.96

The IFSP Outcome Assessment Tool (OAT) indicates that scores of 0-17 are IFSPs “lacking quality” while scores in the range of 18-31 are IFSPs showing “elements of quality.” The IFSP OAT specifically rates IFSP outcomes on the level to which they enable parents and other caregivers to implement learning strategies within typically occurring activities. With a rating that borders between “low quality” and the lowest end of “showing elements of quality,” First Connections IFSPs demonstrate a lower level of quality and functional child goals/objectives than what is needed to reach the SiMR based on a representative sampling of 25 IFSPs created in the past six months and randomly pulled by monitors for review/rating. Breakdown by area is shown in the chart above. State-wide overall rating in March of 2015 is “elements of quality” (18-31) with the state-wide average coming in at the low end of the rating scale for this category. The initial improvement target is set at raising the state-wide average IFSP quality rating to 25 in the next fiscal year.

For additional information regarding timelines for data analysis, please see Appendix 3 “Timelines for SSIP Work.”

Component 1 (b) How Data Were Disaggregated:

Data was collected and pulled from the Comprehensive Data System (CDS).

Child Count Data disaggregated:

- By EIS provider
- By child
- By county
- By region
- By child’s gender, race, age, and ethnicity
- By EI service
- By EI service settings
- By IFSP Date
- By Referral Date

Family Survey Data disaggregated:

- By geographical region (county)
- By race
- By provider

Exit Data disaggregated:

- By EIS Provider
- By child’s date of birth, age, race
- By county
- By IFSP Date
- By exit date
- By transition date
- By date of LEA Notification
- By steps included in a Transition Plan (Yes/No)
- By reason for exit
- By reason for Delay if transition not completed at least 90 days prior to third birthday
- By measurement for Timely/Late (how many days)

Reason for Exit	Male	Female	Total
1. No longer eligible for Part C prior to reaching age three.	143	108	251
2. Part B eligible, exiting Part C.	720	415	1135
3. Part B eligible, continuing in Part C	0	0	0
4. Not eligible for Part B, exit with referrals to other programs.	155	135	290
5. Not eligible for Part B, exit with no referrals.	62	50	112
6. Part B eligibility not determined.	141	58	199
7. Deceased.	2	1	3
8. Moved out of state.	14	12	26
9. Withdrawal by parent (or guardian).	116	87	203
10. Attempts to contact unsuccessful.	34	17	51
Total number of infants and toddlers exiting by gender.	1387	883	2270

Since Child Outcomes (COSF ratings) are a part of exit/transition, this data was analyzed closely and disaggregated by age when it was discovered that not every child who had received EI services for at least six months (or more) received an exit COSF rating.

Exit data revealed that out of the 3,230 children who exited First Connections during the FY 2014, 56% of those children (1,806) received services for more than 6 months and should have received an exit COSF rating (IFSP team completing the Child Outcomes Summary form). But, the total number of qualifying children exiting the program (out of 1,806) for whom the exit rating was accomplished was 1,690. Child Outcomes data was not completed, gathered, or recorded for 116 children.

Disaggregation of that data by reason for exit determined that exit outcomes are more likely to be recorded for children exiting the program at the age of transition (shortly before the third birthday) than for children exiting the program “for other reasons.” When the exit data was also disaggregated by age, the results verified the assumption made from the previous disaggregated analysis. Analysis of the COS exit rating data by age of children exiting the program who received services for six months or more showed:

- 0-1st birthday -- .8% had the COSF exit rating completed
- 1-2nd birthday -- 14% had the COSF exit rating completed
- 2-3rd birthday -- 41% had the COSF exit rating completed

Conclusions made from the disaggregated data analysis were:

- Exit Child Outcomes (COSF ratings) are not being completed for all children who exit the program and received services for at least six months.
- Children who transition to Part B or other appropriate services are more likely to have their exit COSF rating (final Child Outcomes) completed as part of transition.
- Children who exit the program for “other reasons” are less likely to have their exit COSF rating (final Child Outcomes) completed.
- Children who exit at or near the age of transition are more likely to have their exit COSF rating (final Child Outcomes) completed.
- Children exiting the program prior to the age of transition are highly unlikely to have their exit COSF rating (final Child Outcomes) completed.
- Age at transition and where the child transitions to affects whether or not child exit outcomes are recorded (when they’re not recorded, this affects child outcomes data).
- IFSP teams are possibly viewing “transition” only as an event that affects toddlers approaching the third birthday, so transition steps and final child outcomes are not being completed for children who exit the program at other times and for other reasons.

For additional information root causes see Component 4(c). For more information on how data analysis led to the narrowing and final selection of the SiMR, see *Overview “Identifying and Recommending a Feasible SiMR;” Component 1(a-f); Component 2(f); Component 3(b and d).*

Component 1 (c) Data Quality:

As highlighted above, the quality of data is impacted by missing exit scores. This concern must be addressed along with provider knowledge about typical child development and appropriate use of assessment information and other evidence to support child outcome ratings.

Data goes through a series of clarification, verification, and corrections processes to ensure accuracy and quality. This process involves pulling data from our state-wide EI data system, sending it out to each provider for corrections and approval, and then returning corrected data to be cleaned, counted, and reported. Therefore, the data is scrubbed intensively before it is reported to OSEP. In some cases, what is entered into the data system is not what gets reported due to changes being made at reporting time.

The validation and verification process for the CDS system is that there are specific data fields that are “required fields” and must be entered or the system will not allow the section to close; and it provides

error messages until errors are corrected. The design of the CDS system is such that all required data needed in the Data Collection process is in place and can't be overlooked. There are specific system designs in place that allows for measuring timelines for specific reports; such as Timeliness of Services, Timely IFSP, and Effective Transition. The Data Manager works with the system developers (Northrop Grumman) to create business rules and calculating formulas to determine whether or not children's services are provided in a timely manner using OSEP's measuring calculations (within 30 days from parent signature on the IFSP).

For information on timeliness for data analysis, please see Appendix 3 "Timelines for SSIP Work."

State's Support of EIS Programs/Providers in Effective Data Collection and Use

With the implementation of the CDS data system in 2011, there were immediate program improvements in the way data was collected and used, but there were also difficulties in getting a state-wide network of EIS providers and service coordinators to use the live system "in real time" and to use it consistently and appropriately. The state has various strategies in place to support EIS providers and programs in effective data collection and use:

- First Connections Data Unit operates a call in center for Technical Assistance and guidance regarding how to use the Comprehensive Data System.
- First Connections Data Unit created user guides for the various user identities/roles and has them linked in the system for easy access.
- First Connections Data Unit offers on-site training and/or TA when requested.
- First Connections Data Unit offers quarterly "train the trainer" workshops so that providers can learn the system and go back and train others on their team/staff.
- First Connections CSPD Unit revised all certification courses and workshops, ongoing professional development trainings, and training materials to include use of the system
- First Connections Quality Assurance/Monitoring uses the CDS system to remotely monitor providers and programs and can provide TA on use of the system in addition to the Data and CSPD Units and issue sanctions for programs that fail to use the system consistently.

How Data Quality Supports the SiMR

Quality data supports the SiMR in that data shows the percentage of children exiting Part C at or near a level close to that of same-aged peers is below national averages, the percentage of families reporting that early intervention helped them help their child develop and learn is also below national averages, and the percentage of children who receive early intervention in the natural environment is far below even the lowest performing states.

2013 – 74% served in the NE (may or may not be served using natural environment learning practices like coaching and embedded intervention)

2012 – 46% served in the NE (may or may not be served using natural environment learning practices like coaching and embedded intervention)

2011 – 32% served in the NE (may or may not be served using natural environment learning practices like coaching and embedded intervention)

Component 1 (d) Considering Compliance Data:

Part of work on the SSIP involved an analysis of Compliance Indicators and whether those data negatively impact performance on the SiMR and/or present potential barriers to improvement. Compliance Indicators reviewed and analyzed:

- Indicator 1 (Timeliness of Services)
- Indicator 7 (45-Day Timeline)
- Indicator 8 (Transition)

Compliance data disaggregated by provider was reviewed and analyzed by the Core SSIP Team and is used for program improvement planning, for provider determinations, and to inform TA and training needs and in which regions.

The analyses of Compliance data are closely linked with the SiMR. Timeliness of services and 45 day timeline areas did not seem to contribute to child and family outcomes. However, Transition was determined to directly impact child outcomes data; as the final outcome rating captured in the data system is embedded within the transition conference – which isn't happening for children who exit the program prior to age three (see Component 1(b) for additional information).

Failure to complete Transition and final child outcomes (COSF ratings) for all children exiting the program who received services for at least six months affects data on child progress.

While it's not compliance, early intervention provided outside of the child's and family's natural environment affects both child and family outcomes, specific impacts include:

- (1) Whether or not the parent is present and/or actively involved (Family Outcomes and Child Outcomes)
- (2) Whether or not natural learning environment principles are being practiced: caregiver coaching and embedded interventions (Family Outcomes and Child Outcomes)
- (3) Whether or not the child is learning, playing, and growing alongside typically developing peers (Child Outcomes)

Compliance related to timely transition conferences has a definite impact on the data quality (missing exit ratings for children). While not a compliance indicator, the percent of children in segregated settings create a barrier to family ability to help their children develop and learn. Improvement efforts in this area (Natural Environment) could positively impact the state's capacity to improve results.

Component 1 (e) Additional and Related Data:

To continue work with stakeholder groups on subsequent phases, related data may be reviewed (a and c) and additional data may be needed to measure progress towards reaching the SiMR (b).

Additional and Related Data that May Be Needed for Subsequent SSIP Phases:

(a) KidsCount Data

KidsCount data is provided annually and will be reviewed with Stakeholder groups as part of subsequent phases of SSIP planning, development, and progress evaluation.

(b) Revised Method of Collecting Family Outcome Data

The state currently collects information based on a family survey (developed by ECO) and uses the results to report outcomes data in the SPP/APR. When analyzing the data from the survey, the team reviewed families' perceptions about how helpful early intervention under Part C has been. To monitor progress towards achieving the SiMR, Part C must have a method of measuring what parents are doing differently as a result of EIS providers coaching them to implement intervention strategies to help their child learn within typical child and family activities. During Phase II the State plans to develop an instrument to measure how families think and act differently as a result of participation in First Connections. This will provide additional data about how practices are being implemented as a precursor to measuring actual outcomes and progress towards achieving the state's measurable result as described in the sections that follow. The timeline for collecting this data would align with annual family surveys and be incorporated into annual family survey methods.

(c) IFSP Quality (IFSP-OAT) Ratings

IFSP quality (functional child outcomes on the IFSP) will be rated/determined by the First Connections Quality Assurance/Monitoring Unit as part of a current initiative to improve the quality of IFSPS (particularly functional child outcomes). The team will use the IFSP-OAT Outcome Assessment Tool (2014) developed by Witwer, A.N., Saltzman, D., Appleton, C., & Lawton, K. in collaboration with the Ohio State University Nisonger Center and Ohio Colleges of Medicine Government Resource Center. IFSP quality rating monitoring is tentatively scheduled to begin July 1, 2015 and will be an ongoing process. QA/Monitoring Unit will provide average rating scores to Stakeholder groups involved in subsequent phases of SSIP planning, development, and progress evaluation annually.

Component 1 (f) Stakeholder Involvement in Data Analysis:

The SSIP Stakeholders Group represents multiple internal and external stakeholders and was patterned after IDEA requirements for SICC membership to include IHEs, parents of children with disabilities, state and local agencies that pay for EI services, Parent Advocacy Group members, Part B (ECSE), EIS providers, AICC members, representatives of related initiatives (*for more information, see Appendix 2 "Stakeholder Representation"*).

Agencies/organizations invited to collaborate selected a representative from their agency/organization with knowledge of early childhood (0-5 initiatives) to serve as stakeholder. Two state staff service coordinators were selected to serve on the SSIP Stakeholders Group, based on their quality indicator scores (from APR data reports). ECTA provided support in data analysis as external stakeholders.

The SSIP Stakeholders Group identified "areas of improvement" and the Data Unit identified what types of existing data was linked to these areas. In a face-to-face workgroup style meeting, SSIP Stakeholders and the Core SSIP Team reviewed data tied to suggested areas of improvement as well as other data provided by the Data Unit that gave a picture of "who we serve and what we do."

Ongoing meetings were conducted via teleconference, in person workshops, small group breakout sessions, and focus groups. As work on the SSIP continued, Stakeholders had opportunities to compare Arkansas data with national data, to go back to review data previously presented in light of new information gained from Root/Cause Analyses.

A subset of the large SSIP Stakeholders Group worked to complete the Data section of Infrastructure analysis. This workgroup was formed of volunteers from the large stakeholder group who felt that this area best represented their interest, knowledge, and/or skills. The Data Analysis Stakeholder Workgroup met via conference calls to complete a broad infrastructure analysis of the state data system and data. The workgroup used the SWOT method of analysis and found that Arkansas has a very strong Data System (CDS) that collects a number of data fields/areas that could be useful to guide and monitor various improvement decisions. Information from all data analysis activities conducted with the SSIP Stakeholders Group and Data Analysis Workgroup was shared with the AICC for comment and input.

COMPONENT #2: ANALYSIS of STATE INFRASTRUCTURE to SUPPORT IMPROVEMENT and BUILD CAPACITY

Component 2(a) How Infrastructure Capacity was Analyzed:

Throughout the year, First Connections team leaders (unit managers) held monthly meetings to discuss issues identified in their particular program area as well as general program requirements.

- The Quality Assurance, Licensing and Certification Unit assures program quality and compliance and supports EIS providers by offering targeted technical assistance upon request.
- The Comprehensive System of Personnel Development (CSPD) Unit guides program staff and EIS providers in processes related to improving results for infants and toddlers, conducts outreach TA with related agencies, and conducts public awareness activities and information sharing with families and family advocacy groups.
- The Program Manager supports lead agency regional program coordinators in meeting requirements for service coordination under Part C of IDEA and supports staff in helping parents become advocates for their children who understand their role as partners in early intervention.
- The Data Unit gives EIS providers, agency, and program staff information about the quality of data, quality of service provision and compliance, and an opportunity to receive direct guidance regarding the collection and reporting of data.
- The Fiscal Unit communicates with EIS providers on a daily basis to ensure the appropriateness of payment for services. Reports are reviewed weekly to guide the submission of authorizations. Upon request, the fiscal unit manager meets with the Assistant Director and DHS\DDS Financial Services staff to assist in the maintenance/management of Part C finances.

The strong collaborative working relationship of the various units and the staff meetings to regularly share information, data, and ideas guides and informs policy, procedures, and improvement efforts.

To analyze the current infrastructure to support improvement and build capacity in EIS programs/providers, First Connections (FC) established a State Systemic Improvement Plan (SSIP) Stakeholders Group (*for more information about composition of this group, see the Overview section of this report*). The state Interagency Coordinating Council (AICC), the advisory group to the lead agency, also provided guidance as a separate stakeholder group for the development of the SSIP.

First Connections used the System Framework developed by the ECTA Center to describe and analyze the infrastructure. For each infrastructure component, the subcommittee chairperson led members through a review process that provided the group with valuable knowledge regarding the assigned area. Face to face and web based meetings were held several times throughout the examination period to ensure that subcommittee (or “work group”) members were supported to understand and complete the process within specified timelines. The Core group discussed findings and recommendations from each of the subcommittees and shared this information with the larger stakeholder group and the AICC.

Information from the broad and in-depth infrastructure analyses guided the Core SSIP Team and the SSIP Stakeholders Group in narrowing down the focus to select the SiMR. For additional information on the narrowing of the focus and the final selection of the SiMR, see *Overview “Identifying and Recommending a Feasible SiMR;” Component 1(a-f); Component 2(f); Component 3(b and d)*.

State's Role in Increasing the Capacity of EIS Programs/Providers to Improve Results

The State has a responsibility and a desire to support programs and to build the capacity of EIS programs and providers to improve results for infants and toddlers with disabilities and their families. The CSPD Unit determines training and professional development needs in collaboration with other units through data analysis. The CSPD Unit also conducts annual needs assessment and develops TA self-study materials/guides as well as workshop style trainings to address provider TA/PD requests. First Connections is committed to developing trainings and guides to support providers in addressing need areas to incorporate best practices and to better serve children and families within IDEA guidelines. Before a training is launched, staff from each Part C unit review the training course content and provide input in the areas of their expertise. Final approval of training course content comes from the Part C Coordinator with guidance from national technical assistance partners like ECTA, ITCA, DaSy, SERRC.

In addition to the CSPD Unit, other units provide training and technical assistance in their specialty areas to support providers, and each has developed tools to assist contracted providers in understanding the system, their requirements in the program. Each unit has developed technical assistance materials (guide to completing the Family Assessment, guide to IFSP development, guide for using the data system, a guide for submitting requests for prior authorization of payment, transition checklist/guide, etc.) as well. The lead agency plans to expand the development of support materials, particularly video and Web-based trainings to increase the capacity of EIS providers.

Component 2(b) Description of the State Systems:

Governance

As described in the overview of this report, Arkansas's lead agency in charge of administering the Part C Early Intervention Program is in the Department of Human Services within the Division of Developmental Disabilities Services. The Part C Coordinator reports directly to the Assistant Director of Children's Services. In Arkansas all of the Part C systems are housed within the lead agency except the EIS providers who are statewide and under contract to serve selected counties.

Within the lead agency there are 5 leadership teams which report directly to the Part C Coordinator. They are:

- Data Manager
- Fiscal Manager
- Program Manager
- Comprehensive System of Personnel Development Coordinator
- Quality Assurance, Licensure and Certification

The Arkansas Interagency Coordinating Council (AICC) is the advisory group composed of individuals selected by the governor to serve terms on the AICC to represent agencies and organizations that collaborate with Part C and individuals with a vested interest in early intervention for infants and toddlers with disabilities and their families. Part C leadership works closely with the AICC and other state agencies such as Arkansas Department of Education, Division of Children and Family Services, Division of Early Childhood Education, Arkansas School for the Deaf, and the Division of Medical Services.

Licensure and Certification

Providers/programs are not licensed through First Connections; programs/providers are licensed by DDS Quality Assurance.

First Connections is committed to quality services to families and their children. Direct service providers are certified through the program on an annual basis. Training through the lead agency assists providers in maintaining quality standards and updating their certification requirements. The lead agency contracts with 75 Early Intervention Providers (EIS) around the state. The Lead agency contracts assure that programs are held accountable through regular off site and on site monitoring. Technical assistance is provided upon request through Early Intervention monitors, data staff, and/or training staff.

New programs interested in participating in the State's Part C program contacts Certification Unit to obtain a copy of Quality Standards, Certification Policies, and an application to be reviewed by Certification and QA staff. Approved applications receive an initial 90-day temporary certification to provide the service or services contracted to provide. During the temporary certification, Quality Assurance/Monitoring reviews their performance (review of child files) to move them from a temporary certification to regular certification. Open enrollment is currently closed.

Quality Standards

Standards for early intervention services have been established in accordance with Administrative Rules and Regulation Sub-Committee of the Arkansas Legislative Council. Arkansas has policies and procedures, including personnel standards, approved by the Office of Special Education Programs (OSEP) and aligned with IDEA, Part C regulations. The policies and procedures give guidance to all levels of the system on intake, evaluation, assessment, IFSP development and review, child and family rights, transition planning, and dispute resolution.

The Arkansas Framework for Infant and Toddler Care was established for program trainers, directors, and parent educators to use as they work with caregivers and parents to ensure quality care for infants and toddlers. This framework guides the design and implementation of local early childhood programs caring for infant and toddlers. The framework is aligned with the Arkansas Early Childhood Education Framework and the Arkansas Department of Education Frameworks for kindergarten. First Connections uses the Arkansas Frameworks for Infants and Toddlers and requires that elements of the IFSP be linked to the standards set forth in state frameworks to ensure a standard of care for all children served.

The Division of Child Care and Early Education has revised child care regulations for Child Care Centers, Child Care Family Homes, Registered Child Care Family Homes, Out-of-School Time Facilities and FBI Background Check Form. These requirements were developed to ensure the safety and wellbeing of children in out of home care.

Better Beginnings: Arkansas Quality Rating Improvement System is available to every licensed and registered child care facility in Arkansas. The system is designed to help programs improve their day to day environment for children, and to establish proven administrative practices.

The Arkansas Better Chance (ABC) program rules set the general guidelines for the operation of early childhood programs funded under the Arkansas Better Chance for School Success Program. The ABC Program services educationally deprived children birth through 5 years.

Fiscal

The lead agency ensures that funds provided through the IDEA Part C grant and the State Medicaid program are available to reimburse early intervention programs for all required Part C supports in accordance with federal and state requirements, e.g., IDEA payor of last report. In addition, insurance is billed by early intervention providers to offset program costs. The fiscal department responsibilities are to issue prior authorizations to the contracted providers, conduct fiscal reporting, budget projections, expenditure tracking and monitoring.

Professional Development

First Connections' Comprehensive System of Personnel Development (CSPD) collaborates with the data unit, fiscal unit, and quality assurance/monitoring and certification/licensure unit to identify areas of training and professional development need. The CSPD unit is also involved in policy update/revision (as needed) and in developing trainings and quarterly newsletters around policy to keep the state-wide network of EI providers well informed.

The CSPD unit researches best practices in early childhood education and develops trainings for ongoing professional development in the areas of IFSP development, methods of family assessment, writing functional child outcomes, routines-based early intervention, and family engagement.

The lead agency has representatives from the Arkansas Department of Education (ADE) on its advisory panel (AICC). Joint/collaborative professional development trainings between the ADE and Part C on the topic of transition from Part C to Part B have been provided on a limited basis.

Data

The Part C web-based data system (CDS) is easily accessed for programs to utilize to enter data on all referrals, evaluations, IFSPs, and fiscal management. First Connections relies heavily on the data that is entered at the program level. The CDS was designed around quality data system frameworks to ensure compliance with IDEA requirements for the IFSP and most data elements are required fields with error checking rules (*for more information, see introduction to Component #1*).

Data reports can be run from CDS so that individual service coordinators and direct service providers can self-monitor progress. Data from the system is used for program management, completing the APR, and making IDEA determinations. Quality Assurance can access the data system to remotely monitor programs and data is also used for offsite and onsite verification visits and relaying data to providers as needed.

The Comprehensive Data System (CDS) includes a training calendar component to inform EIS providers, service coordinators, administrators, and clerical of PD/TA opportunities and where they may self-register.

Technical Assistance

Programs and/or providers reported for non-compliance or identified by monitors or data unit as struggling in areas of compliance are offered technical assistance/professional development either through the CSPD program or by their regional monitoring staff.

PD/TA to support local improvement efforts are guided by:

- data analysis
- IFSP reviews and consultation with monitoring and QA staff
- EIS provider identified need
- state staff identified need
- research on EI best practices

TA is also provided by the Data Unit on appropriate use of the data system. Data Unit staff provide “on call” TA surrounding CDS user issues, on-site staff training on use of the data system, and quarterly “train the trainer” workshops.

CSPD collaborates with institutes of higher education that prepare professionals to enter the field of early childhood education. Students enrolled at Henderson State University (HSU) and University of Central Arkansas (UCA) may register and attend Part C professional development workshops at no cost, and Part C presenters also provide training at these campuses.

Henderson State University collaborated with Part C administrative staff to develop the curriculum for their Masters of Early Intervention program. HSU also partnered with Part C administration to revamp the DT educational program to align with EI best practices and changes in the State’s Part C program; collaboration with IHEs will be ongoing as part of continual improvement strategies.

Accountability/Monitoring

Monitoring and general supervision for Part C in Arkansas includes multiple components including identifying and correcting non-compliance with policies and procedures, fiscal management, and data on processes and results, complaints and dispute resolution.

Part C conducts annual general supervision activities for each EI program to monitor the implementation of the IDEA and identify possible areas of noncompliance and low performance. Annual activities include:

- Identifying and issuing findings of noncompliance and verifying correction
- Collection and verification of data for the SPP/APR
- Public Reporting of APR data
- Determinations about how local programs are meeting the requirements of the IDEA

On-site monitoring of EIS programs are completed on a three year cycle resulting in plans with timelines for correction if needed. Service to billing monitoring has been initiated to address the use of federal and/or state funds as well as the timeliness and accuracy of billing the lead agency, parents, and third party payers.

Focused Monitoring is conducted by the lead agency based on identified area of issue. A Focused monitoring visit includes off-site activities such as desk audits and in-depth review of available data, on-site monitoring activities such as file reviews, and interviews with families and staff, and additional activities as determined necessary based on the identified issues. Reports may include findings of noncompliance, strengths and/or improvement plans.

Arkansas' Part C program, First Connections, is in the process of adopting an IFSP Quality Rating Scale which is designed to be used by the Part C program for accountability and monitoring purposes, specifically for measuring performance standards and to have a method for measuring progress in the program's goal to improve the functionality and quality of IFSPs.

As a result of all monitoring activities, Part C state staff provides technical assistance to all EIS programs as needed or requested.

Component 2(c) System Strengths and Areas for Improvement:

SSIP Infrastructure Workgroups conducted systemic evaluation including a strengths, weaknesses, opportunities and threats (SWOT) analysis as an opportunity to examine strengths and areas for improvement. The ability of the system to achieve the SiMR is dependent on a number of unknown variables. The following summary analysis of system strengths and opportunities for improvement is only a snapshot of the current status of the components under the current lead agency with the current Medicaid billing rules. Infrastructure and program changes will require that this analysis be repeated and modified over time. Broad and in-depth infrastructure analyses conducted with Core SSIP Team, SSIP Stakeholders work groups, and the AICC identified the following system component strengths and areas for improvement:

Governance

Strengths:

MOUs and Interagency agreements with other state agencies and partners outline roles and responsibilities for effective collaboration.

The AICC provides advice and assistance with the Part C Early Intervention Program. Subcommittees of the AICC address specific need areas/issues related to Part C guidelines, practices, etc. The AICC meets quarterly and encourages public participation and comments at their meetings.

Updated publications and a new mission and principles publication reflect EI best practices and our program's core values, mission, and principles. Our mission and principles, publications, and revised trainings (public statements) are aligned with IDEA.

State Part C Policy and Procedures approved by OSEP provide oversight and guidance for the state's Part C program and align with IDEA and other federal and state mandates. Policy and Procedures are developed with input from stakeholders (public policy hearings, regional TA support and input from other states, OSEP TA guidance and OSEP approval).

Areas for Improvement:

- Part C does not have the opportunity to provide quarterly updates/reports to the general assembly or lead agency administration in the way that most states do.
- Provider understanding of roles and responsibilities is an area in need of improvement and a focus of CSPD.

- Implementing methods of improving parent participation in the family survey to get additional “family voice” on the program’s effectiveness.
- DHS (lead agency) has a formal policy governing written communications that outlines multilevel strategies for how information is shared and responses given. In many ways this benefits the program, but in some ways hinders the program’s public awareness and Child Find activities (inability to create a Part C FaceBook page as part of Child Find due to regulations of lead agency).
- Public statements of vision, mission, and principles will be clearly understood by staff, local program administrators, referral sources, families, and direct service providers as part of our ongoing reorganization work.
- Voucher/vendor/provider agreement reflective of those public statements

Fiscal

Strengths:

The lead agency ensures that funds provided the IDEA Part C grant and the State Medicaid program are available to reimburse Early Intervention programs for all required Part C supports. In addition, insurance is billed by EI providers to offset program costs. The fiscal department responsibilities are to issue prior authorizations to the contracted providers, fiscal reporting, budget projections, expenditure tracking and monitoring. Fiscal data are linked to programmatic data (e.g., birth rate, number of referrals, referral source, child count, units of service) to allow for analysis of the amount of funds spent. Fiscal data is another source of information that drives program improvement efforts.

Part C and Section 619 state staff conduct a cost-benefit analysis of potential funding sources and develop clear, detailed financing strategies, specifying which funding stream(s) would be most beneficial to pursue for what purpose/service or function.

Part C partners with other state/local agencies to provide contracts and grants for advanced training (UAMS – CoBALT) and for due process facilitation (UALR – Bowen School of Law).

Areas for Improvement:

- Arkansas receives no state allocations for funding.
- The allocation process is not designed to support and fund the implementation of evidence-based practices (e.g., inclusion, coaching, teaming).
- Alternate funding allocation to eliminate short falls at specific time of the year; some providers unable to manage their allocations throughout the entire fiscal year, resulting in available provider shortages.
- The PA process is cumbersome; there have been discussions of how to improve this component.

- To improve quality of early intervention services and strategies, First Connections is considering implementing a method of documenting justification of need (completed by the IFSP team) as many other states have done.

Quality Standards

Strengths:

The state requirements for professional certification, child care licensing, tiered rating system for child care, frameworks for infants and toddler care specify quality child level standards. Policies and procedures guide the work of the quality assurance and monitoring work. Arkansas maintains highly qualified and skilled staff through our personnel standards.

Areas for Improvement:

- EI trainings for certification/licensure: A recent review of EI coursework requirements for licensure and certification revealed an absence of requirements for training on evidence based practice, Program's vision, mission, and key principles. Changes in coursework requirements for certification and licensure, however, would impact the CSPD Unit.
- Evaluation and assessment and report writing guidance is needed to improve narrative quality and recommendations sections of reports to make them more useful for families. Improved guidance will help assure that, from the very beginning, parents will have the language they need to be able to describe their child's development and next steps. Families need to understand early on that they have the central role as participants and decision makers.
- Resources are needed to publish the updated family handbooks, though paper products and PDFs on a website may not be the most effective way to communicate information to young parents and opportunities exist to improve in this area.
- Opportunities exist to increase in collaboration with DCCECE who sponsors the Arkansas Better Chance programs and Arkansas Department of Education with the Arkansas Framework for Infant and Toddler Care. Working with both of these programs would increase our ability to provide quality standards TA/PD to our providers.

Professional Development

Strengths:

Comprehensive Technical assistance/professional development based on collaborative planning and data analysis is strength of this infrastructure area. Professional development needs are determined through collaboration with QA/Monitoring, Data, Fiscal, and Certification/Licensure units as these team leaders meet regularly to discuss identified issues and plan how to address these issues through ongoing professional development.

Multiple strategies exist for ongoing professional development, including a quarterly newsletter to share information about policy, EI best practices, and online trainings available to Part C staff and contracted providers.

Areas for Improvement:

- Resources for implementing statewide or regional professional development or technical assistance.
- A method to require EIS providers to attend professional development or technical assistance trainings, possibly via contract authority.
- A method to evaluate the effectiveness of professional development activities (training, coaching, mentoring) to impact provider performance.
- The lead agency needs to offer more online training as CSPD Unit faces staff shortage (limiting training opportunities) and as EIS providers cannot easily free up staff.
- Trainings on providing early intervention within typical child and family activities.
- EIS programs implementing evidence-based practices (EBP) with fidelity including natural learning environment practices, coaching as a style of interaction with families, and use of primary service provider approach to teaming.
- There continues to be a misunderstanding in the State about the mission and purpose of Part C. The reality of Part C as a system of supports for families is still being described to families by many as a way to get therapy for the infant/toddler to fix the child's development. A marketing plan is needed to align the SiMR with the primary referral sources.
- The system can enhance how families are involved in professional development, perhaps through collaboration with parent advocacy groups.
- EIS providers, early childcare providers, and families need more guidance about how to understand and support their child's challenging behaviors.
- There are separate organizations providing professional development to specific groups (TAPP for teachers, MidSOUTH for DCFS workers, ASU for DCCECE workers, APEN for Home Visiting Network) but there is not a unification of these channels to work together.

Data

Strengths:

Arkansas participated with the DaSy Center to help develop the "Framework" for high quality early childhood data systems and has a Comprehensive Data System aligned with quality frameworks and IDEA requirements.

The Part C web-based data system is easily accessed and programs use it for collecting data on referrals, evaluations, IFSPs, and fiscal management. First Connections relies heavily on the data that is entered at the program level. Data from the data system is used for program management, completing required reports for APR, and making IDEA determinations. Data is also used for offsite and onsite verification visits and relaying data to providers as needed.

Areas for Improvement:

- Developing a way to measure the functional outcomes data which will help the program to know what is working and what areas could be improved. Improving this area could be beneficial to the provider in measuring the outcomes data needed for reporting.
- The state needs a better way to determine more than just “service setting” to monitor improvement efforts in increasing the percentage of children served using natural learning environment practices.
- The state needs a way to measure the effectiveness of the evidence-based practices with how families interact with their children and participate as decision makers.
- The state needs a way to measure changes in caregivers’ parenting as a result of EI coaching to implement learning strategies within typical child and family activities.
- Better data sharing with the Arkansas Department of Education data systems with regard to longitudinal data analysis is a potential improvement area.
- Having a designated developer as part of the Part C staff is a critical component to responding quickly to required data system changes and offers an area of potential improvement.
- Providers are unable to articulate specific needs/problems due to lack of familiarity with CDS, despite continuous availability of trainings and TA
- Providers are not familiar with the data and having conversations centered around data to make program changes; therefore not sure how to read the data and know what it means or how to use it effectively
- Providers are still resistant to using the CDS system to document delivery of sessions and transition which makes the data more cumbersome to collect manually
- Some providers do not understand the child outcome summary process; therefore the quality of the data is suspect.
- Provider may enter data without parent included in the assessment process measuring child progress
- IFSP child goals/objectives are linked to specific areas of development and not to 3 OSEP outcomes areas. We’re working on domain-specific learning and then measuring child progress in global child outcomes – possibly the data does not reflect what is actually occurring with the child

Technical Assistance

Strengths:

There have been recent collaborative outreach/TA trainings between Part C and: CASA, DCFS, Family2Family, Title V, ARC, students enrolled in OT and DT programs at IHEs, and pediatric residents at UAMS.

Programs and/or providers reported for non-compliance or identified by monitors or data unit as struggling in areas of compliance are offered technical assistance/professional development either through the CSPD program or by their regional monitoring staff.

Areas for Improvement:

- PD/TA to support local improvement efforts could be improved by better collaboration between IHEs, LEAs, and other state-wide organizations providing PD/TA.
- Allocate more resources for implementing statewide or regional professional development and technical assistance.
- Part C does needs a procedure or method of requiring EIS providers to attend professional development or technical assistance trainings in areas of low performance/non-compliance.
- Staff providing TA to EIS programs about evidence-based practices (EBP) including natural learning environment practices, coaching as a style of interaction with families, and supporting families and other caregivers in methods to help children who exhibit challenging behavior use appropriate behavior to get their needs met need time and experience to ensure implementation with fidelity.

Accountability/Monitoring

Strengths:

Quality Assurance Monitors are trained to use the IFSP-OAT Outcome Assessment Tool (2014) developed by Witwer, A.N., Saltzman, D., Appleton, C., & Lawton, K. in collaboration with the Ohio State University Nisonger Center and Ohio Colleges of Medicine Government Resource Center. IFSP quality (functional child outcomes on the IFSP) will be rated/determined using this tool and IFSP-OAT rating scores will be collected from Quality Assurance Monitors as qualitative data to measure improvement in the quality of IFSPs as part of ongoing improvement strategies. Accountability data is posted on the First Connections Web site and is useful for programming as well as opportunities for improvement.

Areas for Improvement:

- Resources to enhance the capacity of the accountability/monitoring unit are needed.
- Approval of and implementation of the revised sanctions matrix.
- A method for assuring compliance and holding programs accountable for non-compliance is needed.
- The voucher agreements between the lead agency and EIS programs do not adequately assure that programs are accountable.
- Developing a method of self-assessment for EIS programs to measure how evidence-based practices (EBP) including natural learning environment practices and coaching as a style of interaction with families is a potential area of improvement.

Component 2(d) State-level Improvement Plans and Initiatives:

KidsCount data demonstrates that more than half of Arkansas toddlers (3-4) do not attend preschool and that, over a period of seven years, this trend has worsened not improved.

Children Ages 3 To 4 Not Attending Preschool (Number & Percent)

Location	Data Type	2006 - 2008	2007 - 2009	2008 - 2010	2009 - 2011	2011 - 2013
United States	Number	4,381,000	4,387,000	4,234,000	4,325,000	4,428,000
United States	Percent	54%	53%	53%	54%	54%
Arkansas	Number	41,000	42,000	40,000	42,000	44,000
Arkansas	Percent	52%	52%	51%	52%	55%

As the state of Arkansas works to improve educational outcomes for all children (and all ages), more and more focus is placed on the youngest learners and initiatives at improving early learning outcomes are plentiful. Various organizations and lead agencies are working on the same goal of improving learning outcomes for pre-school children, but there is a noticeable lack of strong collaboration, especially in the form of shared resources (fiscal, personnel, physical space, training, etc.) as various organizations serving similar populations are often unaware of the work of other groups trying to reach the same or similar results. Teamwork to better serve families and to leverage available resources is an area of potential improvement statewide.

“I believe the projects, programs, and stakeholders across the state are working to achieve common goals by participating in multi-organizational workgroups . . . that represent state agencies, community-based organizations, individuals, families, etc. This regular sharing of information allows us to better understand each other’s goals, hopefully prevent duplication of efforts (and use of funding), and better work to improve early intervention outcomes across the system, rather than within individual silos. . . . As far as leveraging resources, I believe this is being done in the same manner as aligning common goals. With workgroup-type interaction, the group members are promoting each other’s programs and initiatives, using this information to help prevent duplication of effort/funding, and to provide means for data sharing, program collaboration, sharing of best practices, and quality improvement initiatives, etc. The importance of communication across all these stakeholders cannot be overstated. We cannot achieve common goals with other organizations and programs, nor best leverage available resources, if you are not aware of these programs/projects. Communication is the first and most important step in achieving the level of collaboration needed to bring about true systemic change and improvement.”

-- Bryan Cozart, Director, Family-2-Family Health Information Center of Arkansas [SSIP Stakeholder]

Agency and State Initiatives:

Part C/agency initiatives:

- **TA: IFSP Team Initial and Final COSF Ratings:** beginning in 2013, this technical assistance initiative supporting EIS providers and service coordinators to arrive at COSF ratings jointly as a team using standardized tools and based on a variety of sources of information.

- **TA: Planning and Writing Functional Child Outcomes:** current technical assistance initiative supporting EIS providers and service coordinators to plan and to write of functional outcomes with families, which began in 2014 as a collaboration between First Connections' CSPD unit and ECTA to present TA Webinars and to create a self-study guide on writing functional child outcomes with examples and planning sheets included. Quality Assurance/Monitoring will support this initiative by using a standardized rating tool to rate the quality of IFSPs in regard to functional child outcomes on the IFSP to provide data on quality rating improvements for ongoing progress monitoring and a method of evaluating the effectiveness of training and TA efforts in this area.
- **Unlimited Potential (UP):** a new initiative in its initial stages (program/site selection) to support EIS providers and programs in implementing evidence-based practices to improve child and family outcomes as part of Intensive TA provided to the State's Part C program from ECTA.

Part C collaborates with and contributes to initiatives of other agencies that serve families of children 0-3 (and beyond the third birthday) to improve educational outcomes for all children. Currently, Part C serves as a stakeholder on the following initiatives/grants/associations:

- **Arkansas Association for Infant/Toddler Mental Health (AAIMH):** AAIMH hosts monthly meetings for members and non-members and seeks to improve inter-agency collaboration to better serve families of young children and to educate parents, the public, and professionals of the importance of healthy social emotional development of young learners. AAIMH conducts an annual conference for professionals on topics of interest in behavioral health and how it impacts our youngest learners.
- **Co-BALT Program (UAMS Pediatrics):** The **Community-Based Autism Liaison and Treatment (CoBALT)** Project seeks to build state-wide capacity to more quickly triage children to appropriate diagnosis (DD, SLI, Sz, HL, ASD) and into individualized services before the age of 6. CoBALT teams around the state provide in-depth, autism specific screenings for children suspected of experiencing ASD. Teams refer children under three to Part C. Collaborative trainings between CoBALT and Part C.
- **Autism Implementation Grant:** The grant's goals are to reduce the age at first ASD screening for children in Arkansas (all children screened by age 2) and to ensure that young children with ASD concerns receive appropriate follow up and in-depth assessment so that families of children affected by autism spectrum disorder are routed to appropriate supportive services. Part C serves as a stakeholder and partner in the planning of the ASD grant and collaborative training and screening endeavors.
- **LAUNCH Grant (Linking Actions for Unmet Needs in Children's Health):** The over-arching program goal is to promote social-emotional development and behavioral health to improve educational outcomes for Arkansas children 0-8 by providing trained teams to assist existing agencies within the state via collaboration and/or consultation with home visiting programs, ECSE, and school districts/LEAs throughout the state. Part C serves as a stakeholder in this program's grant planning and is exploring joint trainings and other opportunities to partner.

- **Safe Babies Court Team (Pulaski County pilot through Zero to Three):** The Arkansas Safe Babies Court Team is a pilot project under way in the 10th Division Circuit Court in Pulaski County. Approximately 4,000 children are in the custody of the Arkansas Department of Human Services (DHS) Division of Child and Family Services, including 500 children awaiting adoption. Pulaski County is home to the state capitol and most populous city, Little Rock.
- **Governor's Developmental Disabilities Council:** The Council's main objective is to improve the independence and productivity of people with developmental disabilities and to ensure their integration and inclusion into the community. The DDC's belief is that persons with disabilities and their families are the decision-makers in all matters affecting their lives and that this philosophy is best demonstrated when people with disabilities are given viable choices of where they live, work, play, learn, worship and participate in daily life experience. The Council works to assist individuals experiencing a developmental delay in self-advocacy and to educate legislators and local officials about the needs and concerns of the DD community and how policies will affect individuals experiencing developmental delay.
- **Parent Advisory Council (PAC):** The mission of the PAC is to serve as a liaison between the families of children with special health care needs (CSHCN) and existing resources. PAC brings issues that impact the lives of these children and families with appropriate recommendations to representatives of service agencies within the state. PAC has a teaching responsibility to the families they represent, service agencies, and the professionals who serve the children.

Other state initiatives affecting children 0-5 that the lead agency is involved with (but not an active Part C involvement, though Part C may contribute) include:

- **Preschool Expansion Grant:** The U.S. Secretary of Education announced that Arkansas was one of thirteen states awarded a significant expansion grant to expand and improve the state pre-kindergarten program called Arkansas Better Chance (ABC) through the Department of Human Services' Division of Child Care and Early Childhood Education (DCCECE). The expansion is designed to improve services for roughly 1,670 children per year in the state and add 2,240 new pre-kindergarten slots in Arkansas. The Preschool Development/Expansion Grant, administered by the U.S. Departments of Education and Health and Human Services, is worth nearly \$15 million per year for four years and will improve and expand pre-kindergarten services in 10 of the state's highest-need, most underserved counties: Craighead, Crittenden, Jefferson, Lonoke, Miller, Pulaski, St. Francis, Searcy, Union, and Washington Counties. Arkansas will receive the money in 2015.

"We are excited to be selected to receive this expansion opportunity. The announcement acknowledges Arkansas' existing commitment to high quality pre-k by allowing additional 4 year olds to be served and by making improvements to the existing program."-- Tonya Williams, director of DCCECE

- **The Assuring Better Child Health and Development (ABCD) Program:** The ABCD Screening Academy's primary focus was to increase use of a general developmental screening tool as a part of health supervision during well-child care provided by primary care providers who act as young children's medical homes, as recommended by the AAP. Five states, including Arkansas, were to develop lasting policy and systems improvements and practice improvements to build

and strengthen linkages between primary care providers and other child and family service providers, thereby improving the quality of care for children with or at-risk of developmental delay.

- **Home Instruction for Parents of Preschool Youngsters HIPPY:** Arkansas has the largest HIPPY home visitation program in the county and is also home to the national office of HIPPY USA, one of the country's most widely implemented, evidence-based home visiting programs. Home visiting programs are an important part of the state's early care and education system with nearly 6,700 children and their families being served by the state's evidence-based home visiting programs. Given how rural the state is, Arkansas provides a home-based option for its pre-Kindergarten program using the HIPPY and Parents as Teachers (PAT) home visiting models in addition to the programs funded through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.
- **University of Arkansas: Welcome the Children:** state-wide training, TA, and PD program supports Arkansas' early childhood providers, providing training and resources at no cost to programs. Welcome the Children collaborates with Family2Family on a series of focus groups for Hispanic families of children with special health care needs in the early intervention age range, among many other projects.
- **Following Baby Back Home (Arkansas Children's Hospital):** a home visiting program for high-risk newborns and their families referred through NICU or a physician across the state of Arkansas. Home visits are conducted by registered nurse/social worker teams in coordination with the local primary health care providers and specialty providers to assure continuity of care. Program goals include: working with families to encourage timely immunizations and adherence with follow-up care appointments and reduction of preventable hospitalizations and ED visits; identifying local resources to meet the needs of the baby; building the family's skills and confidence in providing a safe, nurturing home for their baby.
- **UAMS Project PLAY (Positive Learning for Arkansas' Youngest):** offers classroom, program, or child specific consultation and matches early childhood mental consultants with early care and education providers in Arkansas at no cost to the early care program to offer innovative techniques proven to positively impact the social and emotional development of children.
- **UAMS Project REACH (Reaching Educators and Children):** provides a six-month training partnership with follow-up coaching to eligible child care programs at no cost to the program. Goals of the partnership are to reduce staff stress by equipping care providers with successful strategies to support children's social-emotional development and reduce challenging classroom behaviors while nurturing positive relationships with young learners.
- **UAMS Project WISE (We Inspire Smart Eating):** WISE educators provide support, materials, and training to equip programs and educators to have a positive impact on children's nutritional choices. Another component of the project impacts children by teaching families to discover fresh, locally grown vegetables and fruits and provides nutritional tips in a family newsletter.
- **DCFS Implementation of Evidence-Based Family Assessment Tools:** The Department of Human Services' Division of Child and Family Services began training Family Service Workers in 2015 to use evidence-based screening tools to assess families' strengths, needs, concerns, priorities, and

preferred activities using the CANS and FAST instruments. Other program initiatives aligned with the CANS and FAST include DCFS staff trained to provide parent coaching/mentoring to improve outcomes for families.

- **UAMS, The Arkansas Network for Early Stress and Trauma (NEST):** Funded 2021-2016, NEST provides culturally competent, client-centered, family-focused, evidence-based assessment and treatment—including Parent-Child Interaction Therapy (PCIT) and Child-Parent Psychotherapy (CPP)—to 340 traumatized children between the ages of birth to five referred by child welfare professionals, early childhood educators, military partners and/or child advocates. NEST also offers training and coaching to approximately 70 mental health professionals to implement evidence-based interventions targeting young children while developing and disseminating training materials and other tools to enhance trauma-informed practices for professionals working with young children.

Component 2(e) Representatives Involved:

The lead agency worked with various internal and external stakeholders representing agencies that collaborate with Part C and that fund EI services as well as parents of a child with a disability and members of parent advocacy groups. Three primary stakeholder groups were involved in Phase I analysis:

- Core SSIP Coordinating Team
- SSIP Stakeholders Group
- AICC - Arkansas Inter-agency Coordinating Council members appointed by the governor

For a list of the agencies represented/membership of each group, please see Appendix 2 "Stakeholder Representation."

Expected Roles of Stakeholders in Phase II

An additional stakeholder group was identified to assist with identification of improvement activities and to build governance infrastructure by participating in the review of existing policies, guidelines, and forms. The newly identified stakeholder group is the Community of Practice made up of representatives from each of the UP Sites. This group of EIS providers and program administrators will also assist the lead agency in determining best methods of supporting EIS programs/providers in the implementation of EBPs and will assist the lead agency in determining methods of evaluating the effectiveness of improvement methods.

Stakeholders who were involved in Phase I of SSIP work will participate in a workgroup meeting to overview the work of Phase II, "Planning to Build State Capacity." Throughout Phase II SSIP work, previous stakeholders will assist the lead agency in building on the data and infrastructure analyses, coherent improvement strategies, and the theory of action developed in Phase I to move forward in developing a plan that outlines the activities, steps, and resources required to implement the coherent improvement strategies to reach the State-identified Measurable Result(s) for infants and toddlers with disabilities and their families.

Component 2(f) Stakeholder Involvement in Infrastructure Analysis:

Lead agency team leaders, each presiding over a different area, headed up small work groups of volunteers from the larger SSIP Stakeholders Group to complete broad infrastructure analyses in the area they oversee:

- Data Manager – Data Infrastructure Analysis and assist with TA Analysis
- Fiscal Manager – Fiscal Infrastructure Analysis
- Program Manager – Governance Infrastructure Analysis
- Comprehensive System of Personnel Development Coordinator – PD and TA Infrastructure Analyses
- Quality Assurance/Monitoring and Licensure/Certification Coordinator – Quality Assurance Infrastructure Analysis and Accountability/Monitoring Infrastructure Analysis and assist with TA Infrastructure Analysis

Subsets of the large SSIP Stakeholders Group worked to complete all sections of Infrastructure analyses except for Governance. These workgroups were formed of volunteers from the large stakeholder group who felt that this area best represented their interest, knowledge, and/or skills. Some members worked on one than one small workgroup. Each Stakeholder small work group was headed up by the Core SSIP Team Lead for that area (or areas).

Governance was completed by a subcommittee of the AICC who submitted their analysis to the Part C Coordinator.

Work groups met via conference call, e-mail lists, and face to face meetings to complete broad infrastructure analyses using the SWOT method to determine: strengths, weaknesses, opportunities, and threats. Information from the broad analyses was reported back to the SSIP Stakeholders Group as a whole and shared with the AICC. Broad infrastructure analyses information supported these same workgroup teams in moving forward to complete in-depth infrastructure analyses using the tool provided by

Workgroup teams are as follows:

AICC Subcommittee Completing Governance Infrastructure Analysis (lead by Part C Program Manager):

- Arkansas School for the Deaf, Outreach Coordinator
- Provider/Friendship Community Care
- Provider: Faulkner County Day School
- AR Dept. of Education, Office of Special Education
- Provider Payment Agency

Professional Development and Technical Assistance Analyses (lead by Part C CSPD Coordinator):

- IHE, Henderson State University
- Direct service provider (KidSource)
- Licensure/certification Unit
- Service Coordinator
- Two quality assurance monitors

Fiscal Analysis (lead by Part C Fiscal Manager):

- PA unit staff
- Service Coordinator
- AICC Member: DHS/DDS, Assistant Director, Children's Services
- Part C Coordinator

Data Analysis (lead by Part C Data Manager):

- Two direct service providers (HRS Associates and Little Bitty City)
- Parent of a child with a disability
- Two quality assurance monitors
- Two service coordinators

Quality Assurance and Accountability/Monitoring Infrastructure Analyses (lead by Part C Quality Assurance Manager):

- Educational Consultant
- Two AICC members
- Direct Service Provider (Friendship Community Care)
- Licensure/certification Unit
- CSPD trainer
- Monitoring staff

For a list of the agencies represented/membership of each stakeholder group, please see Appendix 2 "Stakeholder Representation."

COMPONENT #3: SiMR

To identify the SiMR, the goal is to select a SiMR for the SSIP that can make a significant impact on results for children with disabilities and their families.

To confirm or narrow the SiMR, Arkansas:

- Used the information from in-depth data and infrastructure analyses
- Obtained input/feedback from SSIP Stakeholders group and the AICC
- Evaluated whether the SiMR is a measureable result
- Evaluated whether the SiMR is feasible to implement and aligned with other initiatives

Component 3(a) SiMR Statement:

Proposed State-identified Measureable Result:

Increase the percent of families participating in Part C who report that early intervention has helped them help their child develop and learn.

Arkansas' SiMR is aligned to SPP/APR indicator 4/C:

The percent of families participating in Part C who report that early intervention has helped their families:

- A. Know their rights
- B. Effectively communicate their children's needs
- C. Help their child develop and learn**

Stakeholders and Part C leadership were in agreement that improving outcomes for infants and toddlers with developmental delay and improving outcomes for families were desired goals of improvement efforts. Through discussions in workgroup meetings, it was determined that improving parents' and other caregivers' ability to help their child develop and learn would likely result in and impact other APR/SPP Indicators:

- families' improved ability to describe their child's abilities and challenges (Indicator 4/B)
- improved learning and development for infants/toddlers (Child Outcomes Data Indicator 3/A-C)
- a higher percentage of children served within the natural environment (Indicator 2)

The rationale for choosing one of the three family outcomes became clear – making changes in this one area of the program would not only have a significant effect on families, but empowering families to assist their child's learning and development would have a significant impact on children now and in the future.

"To get significant improvement in child outcomes, we might need to remember who has the biggest influence on their behavior and learning. What are we doing with families during home visits and through our preschool services? Are our supports to families specific and relevant enough to sustain families implementing interventions as part of parenting?" Robin McWilliam. "It's a Family Affair." Siskin Institute. Sept. 2011.

Explanation for Selecting a Subset of Programs

Infrastructure analyses revealed opportunities and potential threats that could be considered barriers to state-wide implementation of improvement strategies. Some identified potential barriers included:

- limited CSPD resources to prepare EIS providers to work with parents and other caregivers in a coaching relationship or to embed intervention strategies in typical child activities
- no method for program to evaluate effectiveness of professional development in changing provider practice
- lack of available resources to offer incentives for programs to implement improvement strategies
- many children still being served in outpatient clinic settings
- limited QA/Monitoring resources to ensure compliance with selected improvement strategies
- no method to require programs to implement improvement strategies
- low provider buy-in in some areas of the state
- “culture shift” needed as there is still a misunderstanding about the mission of First Connections internally and externally; Part C is still being described to families as a way to get therapy to fix the child’s development
- lack of resources for “marketing” the program’s mission and principles
- inability of fiscal system to support provider teaming practices used by many other states’ Part C programs effectively

When regarding the threats and opportunities in several infrastructure areas as potential barriers to state-wide implementation of SSIP improvement strategies, it was determined available resources to change infrastructure were not accessible, and that implementation in a focus area, group, or region would be needed.

National TA partners worked with the Core SSIP Team to determine strategies for selecting a subset. The subset (or focus area) will be determined through application process. Currently contracted EI providers/EI programs interested in implementing evidence-based practices, DEC recommended practices, and identified improvement strategies have been invited to submit applications to be partner programs, called Unlimited Potential (UP) sites:

“This effort includes inviting interested EI Professionals to partner with us to learn and grow to reach our unlimited potential and to assist children and families in doing so as well. Selected applicants become part of an Arkansas network of Unlimited Potential (UP) Sites partnering with the Part C program to implement evidence-based practices as part of the State’s Systemic Improvement Planning. UP Sites receive professional development, technical assistance, feedback, and support to implement evidence-based and best practices and to serve as demonstration sites for other EI providers.” *from the UP Application Packet, First Connections, DHS:DDS. 2015.*

From completed applications submitted, the Core SSIP Team along with an SSIP Stakeholder Work Group, Other EC partners, and National TA partners will select programs/providers from each of 5 regions of the state: central, NW, NE, SW, SE. UP Sites are selected based on their interest as expressed in the submitted application, as well as an analysis of the following program data/records:

- Natural Environment data
- Outcomes data
- Use of CDS (the data system)
- Determinations (monitoring)
- Quality of IFSPs (functional child outcomes)

By recruiting programs already strong in the above listed categories, the Part C program can use limited resources to boost their ability to implement evidence-based practices and identified improvement strategies to build on the work they’re already doing. In addition, the Part C program will have a smaller subset of provider data (from these sites) to measure progress and to make more rapid adjustments, as needed. Additionally, these EI providers/programs can then serve as demonstration sites, trainers, and mentors as improvement strategies are scaled up to state-wide implementation – increasing the State’s capacity to support change.

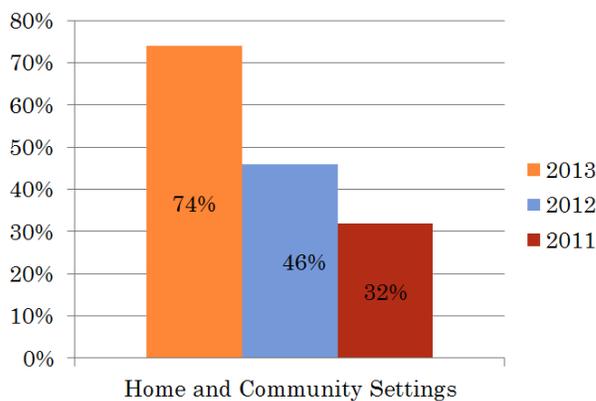
Component 3(b) Data and Infrastructure Analyses Substantiating the SiMR:

The State-identified Measurable Result(s) for infants and toddlers with disabilities and their families must be:

- (a) Clearly based on the data and state infrastructure analyses
- (b) Aligned with current agency initiatives or priorities
- (c) Selected through a systematic process

Clearly based on the data and state infrastructure analyses:

NATURAL ENVIRONMENT TRENDS

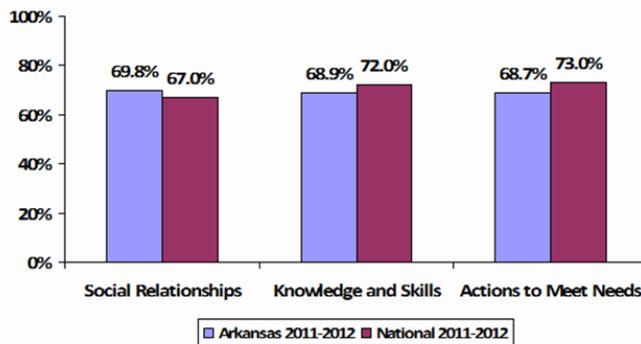
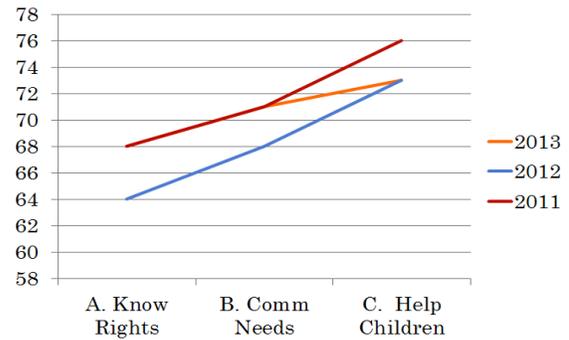


Data demonstrates that 74% of children are receiving services in the home or community based setting. While this number is an improvement, it means that 36% of children receive services in clinic or center based programs for children with disabilities. The proposed state identified measurable results is consistent with First Connections efforts to increase the percentage of children served in natural environments within typical child and family activities or routines by collaborating with families to provide them with the supports and skills needed to support the development of their children.

Analysis of the most recent Family Survey data indicate that 25-32% of parents self-reported that they don't know how to help their children, communicate their needs, or know their rights, but improving outcomes for families has been a program goal and concern based on results of multi-year trend data which shows that the percentage of families self-reporting that involvement with Part C has helped them help their child develop and learn has dropped in 2012 and in 2013 from the percent reported in 2011.

TREND DATA AROUND FAMILY SURVEY

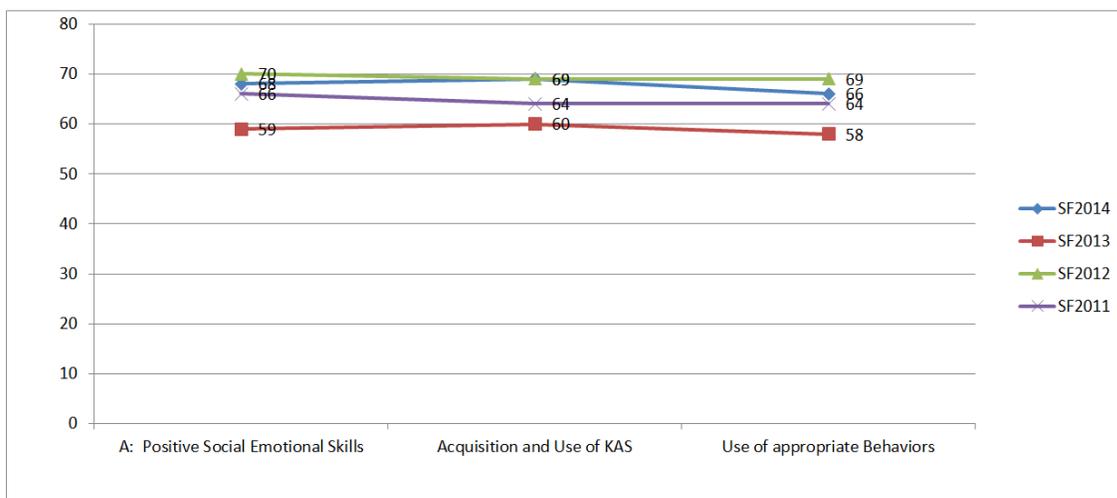
STATE TARGET: A. KNOW RIGHTS 80%
 B. COMMUNICATE NEEDS 70%
 C. HELP CHILDREN LEARN 87%



Data revealed that Child Outcomes Data met targets, but child outcomes still trend behind the national level (with only a slight exception regarding social-emotional relationships)

Of more concern is trend analysis that shows Arkansas' Child Outcomes Data is at a standstill in spite of revised/updated professional development and additional training and technical assistance provided in the areas of completing initial and exit COSF ratings as a team and on writing functional child goals/objectives linked to the three outcome areas.

CHILD OUTCOMES (SUMMARY STATEMENT 1) TRENDS



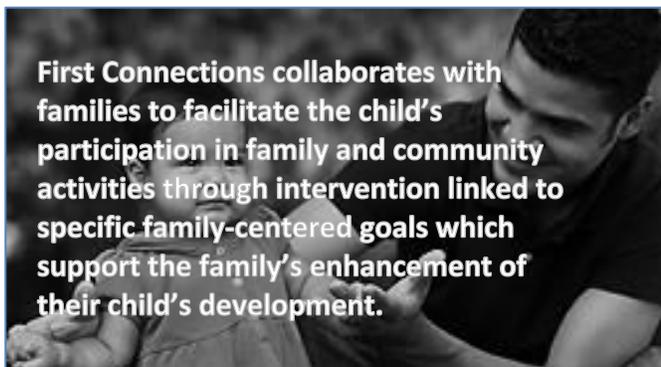
Summary Statement 1: The percent of the children who entered the program below age expectation in the Outcomes Areas, the percent who substantially increased their rate of growth by the time they exited the program. (Calculation: $c+d/a+b+c+d$)

Stakeholders and program administration universally agreed that to continue doing what we've been doing would result in a continuation of child outcomes below national averages, showing little to no improvement, and below where we'd like them to be.

Please refer to the following sections for more detail on Data and Infrastructure Analyses Substantiating the SiMR: Overview; Component 1(a-f); Component 2(a-c); Component 3(a)

Aligned with current agency priorities and initiatives:

The SiMR aligns with First Connections' Mission and Key Principles:



Key principles:

- Parents and family members are a child's first teachers; with supports and resources all families can enhance their child's learning and development.
- Infants and toddlers learn best in their natural environment through every day experiences and interactions with familiar people in familiar contexts with typically developing peers.
- All children, no matter what their physical, cognitive, or emotional level of development, need meaningful opportunities to develop skills, establish a sense of self, and lay a foundation for life-long learning.
- All children learning together fosters the potential of every child; children with disabilities have the right to play and learn alongside children without disabilities.
- The family and IFSP team collaboratively plans and writes strategies/activities, services, and supports to enhance the child's participation and learning in natural environments and every day activities, using the child's and family's strengths to overcome challenges and to accomplish goals that reflect family priorities for their child's development.
- Active family/caregiver participation in the early intervention process is critical to a child's development with support and training from qualified early intervention service providers.
- Early intervention is designed to meet the needs of infants and toddlers who have a developmental delay or disability while offering supportive services to the family, like parent education/training to help parents understand their child's developmental abilities in order to promote their child's development.

The SiMR builds upon the current technical assistance initiatives to support EIS providers and service coordinators in the IFSP team's selection of initial and exit COSF ratings using standardized tools (2013) and to plan and to write functional outcomes with families (2014). As one of five states selected for Intensive TA, Arkansas will have the additional resources and capacity to support intensive training and TA on the implementation of natural environment learning practices with families from the very first contacts, evaluation and assessment, using strengths and interests to inform IFSP planning, and writing functional outcomes on the IFSP and to:

- (1) support intensive training to the regionally selected providers (UP Sites, see 3(a) above) on collaborative coaching of parents and other caregivers to jointly develop strategies for learning opportunities within the child's typical activities
- (2) operationalize training objectives into measureable outcomes for changes in practice.

Selected through a systematic process:

The Core SSIP Team, after attending regional meetings and national Webinars on preparing for SSIP, began the process by reviewing data from previous APR/SPP reports and going over 2013 data to identify areas in need of improvement to share with Stakeholders.

Stakeholders were provided with an overview of the SSIP process and basic requirements and presented program data. From the data and team discussions, a wide variety of issues were identified as a "problem" needing fixing or "low performance" needing improvement.

The SSIP Stakeholders Group considered the following:

- FFY2013 Part C State Performance Plan (SPP)/Annual Performance Report (APR) as well as trend data from previous years' APRs
- Input from the Interagency Coordinating Council (ICC) parent members
- Information gathered from family phone surveys

Over the course of several meetings, root causes were identified which informed the focus on family outcomes. The SiMR was developed by the entire stakeholder group in December 2014.

Please refer to the following sections for more detail: Overview; Component 1(a-f); Component 2(f); Component 3(d)

Component 3(c) SiMR as Family-Level Outcome:

The SiMR is a family-level outcome as opposed to a process or compliance outcome with the ultimate result of improving outcomes for infants/toddlers with disabilities and their families.

"As an early childhood mental health therapist I tell families I am going to train them to be their child's therapist because while I may be the mental health specialist, they are the expert on their young child and the most important person in his or her life. They will spend most time with them to affect the most change. I then coach them in behavioral strategies – most all sessions are dyadic with some parent-only sessions for teaching skills and when sensitive issues arise that would be best not to discuss with child present. We do this because the research tells us this approach brings about the most positive outcomes. I wonder if EI services could be more engaging of families like this."

-- Early Childhood Mental Health Therapist, UAMS [SSIP Stakeholder]

The selection of a family-level SiMR ties into the original intent of early intervention as outlined in the 1986 IDEA legislation, "to enhance the capacity of families to meet their child's needs" and supports the over-arching goal of early intervention (Part C) and early childhood education (Part B/619):

“Early intervention and early childhood special education support young children with disabilities **and their families**. For children, the ultimate goal of this support is to enable young children to be active and successful participants during the early childhood years and in the future in a variety of settings – in their homes with their families, in child care, preschool or school programs, and in the community. **For families, the ultimate goal is to enable families to provide care for their child and have the resources they need to participate in their own desired family and community activities.**” *“Family and Child Outcomes for Early Intervention and Early Childhood Special Education.” ECO. Apr. 2005.*

The decision to focus on families of children experiencing developmental delay stemmed from the belief that being able to assist in their child’s learning and development impacts parents across all socio-economic and educational backgrounds and bolsters the family’s ability to be actively involved in their child’s learning in the preschool years and beyond, an identified “protective factor” resulting in improved educational outcomes for school aged children.

“All the intervention with the child occurs between specialists’ visits . . . children do not learn in massed trials. They learn over time. . . . Children are therefore learning throughout the day, whether we want them to or not! That’s where the learning opportunities occur, so what should the relatively infrequent and short visits by professionals be concentrated on?” *Dr. R. A. McWilliam. “Early Intervention in Natural Environments: A Five-Component Model.” Dec. 2004.*

Just over one-third of all children referred to First Connections are in their last year of eligibility (2nd birthday to third birthday), while 29% are referred after their first birthday. In our short time together with children and families, helping children reach a level of development closer to their typically developing peers is possible, but the biggest impact early intervention can have is changing the trajectory for the entire family by impacting how families think about and act with their child. Stakeholders hold strongly to the evidence base for Part C that positive family outcomes will impact child development more than changes in child outcome ratings in that “. . .parents’ use of intervention techniques resulted in child acquisition of behaviors” (Bruder, M. *Parents as teachers of their children and other parents.* JEI, 9 (2) 136-150. 1985).

Please refer to the following sections for more detail: Component 3(a-b) and Component 4(c)

Component 3(d) Stakeholder Involvement in Selecting the SiMR:

The SSIP Stakeholders Group’s early work on the SiMR focused on identified areas of need after data and infrastructure analyses:

1. low Indicator 2 scores (natural environment) as an area in need of improvement and areas base on broad stakeholder input started with two key issues:
2. percent of families who indicate EI has helped them know their rights, communicate their child’s needs, can help their child develop and learn lower than desired and below national averages
3. child outcomes data below national averages
4. Plateaued child outcomes data within Arkansas’ Part C program over a period of years

All of these were areas that stakeholders felt were “worthy of improvement.” As work continued with infrastructure analyses and identifying root causes, members of both the SSIP Stakeholders Group and the Core SSIP Team saw that these issues were all linked. It was hypothesized that if more children were served in their natural environment, more parents would be involved in early intervention and receive the coaching needed to implement learning strategies in their typical day to help their child develop and learn (and then child outcomes would improve). In order for the program to get the most improvement from improvement efforts, it was determined that primary caregivers have the most influence on their child’s behavior, learning, and development and that families should be the focus. This hypothesis is supported by research on early learning and parent involvement.

Please refer to the following sections for more detail: Overview; Component 1(f); Component 2(f) For a list of membership/representation on each stakeholder group, please see Appendix 2 “Stakeholder Representation.”

Component 3(e) Baseline Data and Targets:

First Connections collaborated with the SSIP Stakeholders Group, the AICC, and national TA partners to review family outcomes data and the process the state has in place to gather information from families. Historical Data from 2006-2012 showed a gradual 8% improvement in 4(a) “parents know their rights” though the target was not met for this outcome. This same data showed little improvement from baseline data set in 2006 in 4(b) “parents effectively communicate their children’s needs” and 4(c) “parents help their child develop and learn.” Though targets were met in these two areas, there was only a 1% improvement in the six years’ reporting period for 4(b) and only a 4% improvement over six years for outcome 4(c).

Historical Data

Baseline Year	FFY	2005	2006	2007	2008	2009	2010	2011	2012	
A	2006	Target ≥				77.00%	78.00%	80.00%	80.25%	80.25%
		Data		59.00%	62.00%	65.10%	65.00%	67.90%	64.20%	68.00%
B	2006	Target ≥				67.00%	68.00%	70.00%	70.25%	70.25%
		Data		70.00%	67.50%	70.30%	69.00%	71.30%	67.90%	71.00%
C	2006	Target ≥				84.00%	85.00%	87.00%	87.25%	87.25%
		Data		71.00%	70.80%	72.80%	73.00%	75.90%	73.20%	75.00%

Key: Gray – Data Prior to Baseline Yellow – Baseline Blue – Data Update

The lead agency consulted with the AICC to set new targets for Family Outcomes A-C.

FFY 2013 - FFY 2018 Targets

FFY	2013	2014	2015	2016	2017	2018
Target A ≥	80.00%	82.00%	84.00%	86.00%	88.00%	90.00%
Target B ≥	80.00%	82.00%	84.00%	86.00%	88.00%	90.00%
Target C ≥	80.00%	82.00%	84.00%	86.00%	88.00%	90.00%

For a list of membership/representation on each stakeholder group, please see Appendix 2 “Stakeholder Representation.”

COMPONENT #4: SELECTION of COHERENT IMPROVEMENT STRATEGIES:

In Phase I of the SSIP, states must demonstrate that improvement strategies were selected in a systematic way with the input of key stakeholder groups and that such strategies are feasible and logical in leading to a measurable improvement in the State-identified Measureable Result (SiMR) for infants and toddlers with disabilities and their families.

Component 4(a) How Improvement Strategies Were Selected:

Many of the improvement strategies were selected based on review of data from CDS and from Quality Assurance/Monitoring unit which indicated consistent issues with:

- Child outcome summary percentages of children improving to a level closer to that of typically developing peers below national averages
- Many children served outside of the natural environment
- Percent of parents reporting that early intervention helps them help their child develop and learn below national average
- Failure of IFSP teams to complete final COSF ratings for many children exiting the program prior to third birthday
- Low quality of IFSPs in regard to functional child outcomes
- High reliance on child-focused therapy and a low level of application of natural environment practices (even for those children served in their natural environment)
- Coaching with families and other caregivers not widely used

This data was supported by interviews with families, staff, and program directors from various programs throughout the state.

The process used to select improvement strategies included:

- Broad SSIP Stakeholders Group meetings
- Interviews with Quality Assurance/Monitoring staff
- Core SSIP Team monthly meetings
- Core SSIP Team and SSIP Stakeholders Group collaboration with national technical assistance partners
- Review of CSPD trainings, materials, and capacity
- Review of forms, policies, procedures, and guidelines
- Input from physician groups
- Strategies Work Group of volunteers from existing SSIP Stakeholders Group and AICC representing:
 - Parent Advocacy (director and 2 regional directors)
 - Parents of a child with a disability
 - IHEs (Henderson State University and University of Arkansas for Medical Sciences)
 - Part C program coordinator
 - Service coordinator
 - AICC member/EI service provider
 - ECSE (Part B/619)
 - DBHS
 - DCCECE

In large SSIP Stakeholders Group meetings, Core SSIP Team monthly meetings, and through interviews with Quality Assurance/Monitoring staff and regional Part C program coordinators, a lack of consistent

understanding and implementation of natural environment practices including coaching interactions with parents was identified as a potential root cause of data indicating that a significant percentage of parents self-report (in the annual family survey) that early intervention did not help them help their child develop and learn. Collaborative Coaching as a style of interaction with parents is a prominent evidence-based strategy for increasing a parent’s ability to interact with their child in ways that will promote learning in everyday activities (routines-based early intervention) and effect change over time, improving both family and child outcomes.

Additional improvement strategies were identified through:

- Physician Input: a meeting with physicians at the Medical Home Workgroup and with physicians at Dennis Developmental Center
- Review of CSPD training and technical assistance offerings
- Review of Part C forms, policies, procedures, and guidelines
- Field observation (observing IFSP meetings)

Proposed broad improvement strategies

Broad improvement strategies to improve outcomes for families and for children receiving early intervention and to implement evidence-based practices with fidelity are grouped into four main areas:

- (a) **Knowledge** (*parents, referral sources, providers*)
- (b) **Training** (*public/referral sources, providers, parents*)
- (c) **Policy** (*forms, policy, procedures and guidelines*)
- (d) **Quality Assurance/Monitoring** (*TA, measuring and evaluating implementation and progress, compliance*)

Broad improvement strategies gathered from stakeholder input, data and infrastructure analyses identifying areas of “needs improvement,” and linkage with current initiatives will be described in greater detail in Phase II of the SSIP (due February 2016) and will include the implementation framework and reasons each strategy was ultimately selected.

Overview of Proposed Coherent Improvement Strategies by Broad Improvement Area (above):

(a) Knowledge: *Parents, Referral Sources, Providers*

- Educate parents about their role as partner with First Connections and the program’s goal of increasing their confidence and competence in being able to help their child develop and learn.
- Family Handbooks revised to correctly describe what early intervention is and the caregivers’ role as partner in intervention
- Make revised Family Handbooks more accessible to a generation of parents that read on smartphones, tablets, and other e-readers.
- Partner with families to develop family stories that highlight the benefits of being able to implement intervention strategies into daily activities to promote their child’s learning and development.
- Develop a “marketing plan” to educate referral sources on mission and principles of early intervention, what that “looks like,” and the benefits of natural environment practices including coaching interactions with parents
- Offer parent training that each family would receive as a part of the Part C/EI service package – early brain development, importance of interacting with young children, what kind of

environments support healthy development, how parent mental health, substance abuse, trauma and/or neglect can result in delays, etc. AND that children can catch up if intervention occurs early, and if parents support the interventions... i.e., those gains for young children are achieved within relationships with their caregivers, and therefore their ability to progress depends on parent education and involvement.

- Offering training at HSU for families, providers, and DT students regarding functional IFSP's to ensure useful and meaningful goals and objectives.
- Educate EIS providers on the importance of family participation in the family survey and have a provider group brainstorm ways of increasing the percent of families who report.
- Market this initiative to EIS providers so they understand the importance of maximizing everyday learning opportunities to enhance caregivers' ability to meet their child's needs.

(b) Training: *Public/Referral sources, Providers, Parents*

- Enhance the CSPD Unit to be able to provide more regional trainings, more Web-based TA and trainings, and develop and disseminate trainings to support EIS providers in implementing evidence-based practices that will support the SiMR
- Create Web-based training for referral sources that clearly defines early intervention, what it "looks like" and why natural environment learning practices are a benefit to children and families.
- Operationalize training objectives into measurable outcomes for changes in practice.
- Part C collaboration with IHEs to revise degree program/course content to include EBPs for early learning so that future providers receive pre-service training that aligns with the SiMR (already in place at Henderson State University).
- Consider collaborative trainings with DCCECE to include training for early childcare professionals on their role in early intervention under Part C as part of certification/licensure training for early childcare professionals.
- Consider collaborative trainings with DBHS and/or MH providers to initiate a training program to help EI direct service providers incorporate dyadic techniques into their work as parent coaches.
- Consider revision of annual professional development requirements and pre-service training requirements for direct service providers to include CSPD courses linked to the SiMR.
- Continue to provide targeted technical assistance (TA) on completion of the COSF rating as an IFSP team at entrance and at exit.
- Continue to provide targeted technical assistance (TA) about the writing of functional outcomes and objectives with families and other topics as identified through the general supervision of programs.
- Intensive training for an initial cohort of programs (UP Sites) on implementing with fidelity evidence-based practices (EBP) including natural learning environment practices, coaching as a style of interaction with families, writing functional outcomes on the IFSP, and developing strategies for learning opportunities within the family's or care provider's existing routines.
- Establish and support a Community of Practice (CoP) for EIS program leaders in the initial cohort (UP Sites) about the implementation of EPBs.
- Provide training for EIS providers/programs on how to support staff implementing EBPs and increase knowledge of practices that support achievement of SiMR while scaling up the implementation of the EBPs with the remaining programs statewide.
- Offer a video and/or online training module for parents to highlight the benefits of being able to maximize everyday learning opportunities to help their child develop and learn.
- Orient service coordinators in the use of the video or online parent training module as part of the intake process.

- Consider a “parent development” program – running alongside the “child development” program – emphasizing that parents are also developing toward their own goals, and their development impacts the child’s development. The family service package could include an expression of support of those parent goals.
- Personnel development: Collaborative trainings held at HSU for DT’s to emphasize the importance of working with parents/primary caregivers in the child’s natural environment.
- Pre-service personnel development: HSU coursework for DTs regarding embedding intervention into typical activities (HSU has adopted new textbooks to try and meet the needs within the classroom and coursework, *Early Intervention Every Day!* Crawford, Merle and Weber, Barbara.

(c) Policy: Forms, Policy, Procedures and Guidelines

- Complete the DaSy Center and ECTA Center Framework self-assessments to inform the changes.
- Implement use of the Parent Participation Agreement Form.
- Require parents or other caregivers be present for all or a number of sessions with the child, involve them in the teaching tasks by demonstrating, then coaching the parent to engage the child in the tasks.
- Revise, as needed, the annual Family Survey to increase response rate.
- Meet quarterly with EBP Community of Practice (from UP Site cohort group) to review policies and procedures and forms and to discuss issues such a billing and the system of payments policy to streamline processes to make providing EBPs cost effective.
- Include a Natural Environments Service Guideline in procedural manual to include caregiver coaching in the home and/or early care and education settings to support primary caregivers’ ability to embed learning strategies (intervention) into typical child and caregiver routines.
- Develop a Natural Environment Provider Treatment Provision Agreement or include this provision in exiting voucher agreements.
- Develop an Evaluation/Assessment and Report Writing Guidelines (manual) to address the pivotal role of the parent as decision-maker and part of the EI Team through suggested wording of the written report to support the family’s ability to enhance their child’s learning and development and to use information from report to develop age-appropriate learning goals for their child.
- Work with the EBP Community of Practice to develop requirements for EIS providers to make ongoing assessment results available to and utilized by parents in order to educate parents on next steps in development to facilitate parent participation in early intervention, in updating goals and objectives on the IFSP, and in implementing intervention strategies into their typical activities.
- Work with national TA partners to create a (or implement an existing) coaching checklist to be used by EIS providers in their work with parents and other caregivers.
- Consider developing or implementing an existing rating tool (SHoRE or FINESSE) to measure parent’s ability to help their child develop and learn within typical child and family activities to measure program progress in reaching the SiMR.
- Consider creating an (or implementing an existing) self-assessment tool to be used by EIS providers/programs for self-reflection on how EBPs are being implemented.
- Revise voucher agreement as needed to support the provision of Evidence–based Practices (EBPs) such as caregiver coaching in natural learning settings.
- Collaborate with Medicaid to create an FAQ booklet for Part C providers implementing EBPs and writing functional outcomes to answer common questions.

- Collaborate with Medicaid to determine methods of maximizing revenue as required by the state while assuring that the EBPs are main drivers for Part C services.
- Include an environmental assessment of child’s typical environment with the goal of supporting developmental outcomes.

(d) Quality Assurance/Monitoring: TA, Measuring-Evaluating Implementation/Progress, Compliance

- Establish regularly occurring collaborative meetings between Data Unit and QA/Monitoring Unit to share information and to evaluate/measure progress on implementation.
- Consider enhancing the Part C data system to collect ongoing indicators of how the EBPs are being implemented.
- Ensure that the CDS includes critical indicators related to the SiMR for Part C.
- Align priority areas, rankings, and visit protocol for Focused Monitoring with the SiMR.

Component 4(b) How Improvement Strategies Are Sound, Logical, and Aligned:

Arkansas’ various stakeholder groups determined that the improvement strategies suggested in early analysis and planning for Phase I of the SSIP are logical, sound and aligned with each other and with the SiMR. The state is poised for a number of changes described in the overview and infrastructure assessment that make selecting firm strategies challenging in the early planning stages of Phase I, so stakeholders understand that planning and strategizing is ongoing and fluid. Strategies can be modified and more can be added.

All of the strategies listed above converge to ensure that referral sources, providers, and families understand the importance of increasing caregiver confidence and competence in being able to help their child develop and learn. The suggested strategies also consider potential barriers to implementation and recommend ongoing evaluation of policies and procedures in an EBP Community of Practice. The currently proposed broad strategies and strategy overviews (section 4(a) above) support the program on a variety of systemic levels all leading to improvements in family partnership with EI so that parents benefit from participation in Part C by gaining the ability to help their child develop and learn. Procedure and policy changes, knowledge-based trainings and information sharing, and current state initiatives are inter-related and multi-tiered, supporting a systemic approach to addressing the SiMR.

The improvement strategies will be supported primarily by allocations from the Part C grant as described in the federal Part C application and through Arkansas’ participation in Intensive TA as part of a two-year state assistance opportunity. EIS programs participating in the cohort group (UP Sites) also support these strategies by making staff available to attend professional development activities. The regional EIS providers/programs in the first cohort of this intensive training agreed to commit the time and resources needed to develop the capacity to implement the EBPs. The initiative supports scaling up of EBPs in the cohort group through webinars, on-site training and TA, and workshops to support cohort practitioners in implementation of natural learning environment practices, coaching as a style of interaction with families, and writing functional child outcomes with the family in the IFSP meeting.

Wherever applicable improvement strategies will be aligned with other state initiatives such as the LAUNCH grant and the Autism Implementation Grant (AIG) and other efforts as they are identified:

- The LAUNCH grant provides training to EI and ECSE providers and consultation to Part C and Part B to assist families and other caregivers of children with challenging behavior in promoting social-emotional development and better understanding and supporting children.
- The AIG provides training to EI professionals to address families' concerns about their child's development and/or suspected ASD. Collaboration with AIG enables 0-3 providers and service coordinators to provide ASD screenings to all children by the second birthday and training in "next steps" for children who fail screenings to route families of children suspected of being affected by ASD to the appropriate early intervention supports to improve the early detection and support of children with ASD.

Component 4(c) Strategies that Address Root Causes and Build Capacity and Component 4(d) Strategies Based on Data and Infrastructure Analysis:

Root causes of the issues identified through data analyses and the threats and opportunities discovered in infrastructure analyses with stakeholders as well as additional issues identified by: stakeholders, Arkansas Medical Home Workgroup, physicians at Dennis Developmental Center, QA/Monitoring staff, area program coordinators, and Data Unit can be grouped into broad, inter-related topic areas:

(a) Mission/Goal and Principles of Part C Program:

What needs to happen: In order to achieve buy-in, appropriate and timely referrals, and full-scale implementation of improvement strategies to achieve the SiMR, the Part C program must be effectively represented by referral sources and providers and understood by families, referral sources, and the providers that make up the system.

Where we are: A failure to appropriately "market" early intervention under Part C as a parent education and support program has resulted in the idea that EI = "therapy for babies." Referral sources, parents, and EIS providers are, to a large extent, still focused on Medicaid guidelines that promote individual therapy for infants/toddlers, rather than supporting families as decision makers to be able to incorporate intervention into their typical activities to promote their child's learning and development.

Contributing factors or root causes:

- * *El under Part C historically grouped together with center-based day habilitation programs until the Reorganization in 2013 and a need to "re-market" the program*
- * *Low rate of referral in 0-1 age group possibly tied into a PCP lack of understanding of Part C as different from center-based options for families of infants/toddlers experiencing developmental delay resulting in low physician referral rate*
- * *Mission/principles developed in 2013 not thoroughly "marketed" or incorporated into procedures for contracted providers to embrace them*
- * *Interpretation of Medicaid guidelines as non-supportive of best practices in early learning and clarification for EI providers not readily available*
- * *Referral sources and EIS providers creating an initial impression of Part C Program as therapy where parents are passive recipients of services*
- * *Referral sources refer directly to local providers who may or may not be part of the state-wide Part C program*
- * *Programs not meeting natural environment requirements*
- * *Noncompliant programs/providers have years to make changes under the current sanctions matrix, so there is little incentive to comply*
- * *Lack of resources in the QA/Monitoring Unit make enforcing sanctions difficult*

** Providers in silos not willing to team in order to develop the “whole child” and “scope of practice” fears, misunderstandings, and short-sightedness*

For more information about proposed improvement strategies to address this area, see Component 4(a) “Proposed broad improvement strategies:”

(a) Knowledge: Parents, Referral Sources, Providers

(d) Quality Assurance/Monitoring: TA, Measuring-Evaluating Implementation/Progress, Compliance

(b) Child and Family Outcomes:

What needs to happen: The purpose of early intervention under Part C of IDEA is to improve developmental outcomes for children 0-3 and the capacity of families receiving services to enhance typical learning activities in order to promote their child’s learning and development. To reach the SiMR, program changes will ultimately result in an improvement in child outcomes as a result of increasing the percentage of families who report that participation in early intervention under Part C enhanced their capacity to help their child develop and learn.

Where we are:

Arkansas’ Child Outcomes Data demonstrated that though previous targets were met, the percentage of children participating in Part C who improved their level of functioning closer to that of their typically developing peers lags behind national averages and that despite efforts to improve outcomes for infants/toddlers receiving early intervention, outcomes have plateaued over the past several years.

The percentage of families responding to the family survey, though representative of the demographics and regions of the state as a whole, is very low (21% response rate). *(For more information about the Family Survey, see 1(e)).* Of those completing the survey, the percentage of families reporting that early intervention helped them help their child develop and learn is approximately 10% below national averages in this outcome area.

The Data Unit shared with stakeholders an identified issue from Child Exit/Child Outcomes Data that many children who exit the program and received services for at least six months do not receive an exit child outcome rating (which affects child outcomes data). Disaggregation of that data shared with stakeholders determined that exit outcomes are more likely to be recorded for children exiting the program at the age of transition (shortly before the third birthday) than children exiting the program “at other times” and/or “for other reasons.” This determination was made by analysis of the COS exit rating data by age (children who received services for six months or more and who exited the program for any reason, including transition to Part B):

- 0-1st birthday -- .8% had the COSF exit rating completed
- 1-2nd birthday -- 14% had the COSF exit rating completed
- 2-3rd birthday -- 41% had the COSF exit rating completed

For more information on how data was disaggregated, please see Component 1(b)

Expanding on contributing factors or root causes:

** Despite revised trainings and collaboration between Data and CSPD Units, persistent misunderstandings about “transition” and that transition occurs not only when a child approaches three, but whenever a child leaves the program*

- * *Data system allows user to close the child's file/exit the child without requiring the user to enter COSF ratings in the system in order to proceed*
- * *IFSP teams not completing exit COSF ratings when a child exits the program and received services for six months or more*
- * *IFSP teams possibly not accurately completing initial and/or exit COSF ratings as a team and using tools provided to standardize the process*
- * *"Lost child outcomes ratings for the 116 children eligible but who were not rated," possibly represent children who improved to a level equal to or closer to the level of functioning of their typically developing peers*
- * *Low parent participation in the survey possibly a result of the DHS return address on the envelope; DHS logo on the letters repellant to some families*
- * *Low parent participation in the survey due to lack of program name recognition – parent is familiar with the name of their therapy provider but may not connect that name with EI under Part C -- First Connections*
- * *Parent misinterpretation of survey*
- * *"Snail Mail" out of touch with parents' needs and the times. . . families may respond better to a state app or mass text message to families with link to survey*
- * *Low participation from minority, second language, rural families possibly connected to length of survey and wording*
- * *How the program markets the family survey to EIS providers – do providers understand how important the survey is, what the data is used for?*

For more information about proposed improvement strategies to address this area, see Component 1(a) and Component 4(a) "Proposed broad improvement strategies:"

(b) Training: Public/Referral sources, Providers, Parents

(c) Policy: Forms, Policy, Procedures and Guidelines

(d) Quality Assurance/Monitoring: TA, Measuring-Evaluating Implementation/Progress, Compliance

(c) CSPD:

What needs to happen: The shift from being a therapist who "works with babies" to being a coach who helps adult learners plan, implement, and assess the effectiveness of intervention strategies to promote learning within typical child activities is at the very core of the SiMR.

Where we are: Despite a total overhaul of First Connections training materials and course content beginning in 2012, provider practice has not significantly changed and natural learning environment practices are not implemented as provider and public misunderstandings surrounding implementation of natural learning environment principles still exist in a state culture of "more is better" in regards to hours of child-focused therapy.

Contributing factors or root causes:

- * *Lack of provider experience/training on how to coach caregivers and how to create intervention strategies to reach functional goals within typical child activities*
- * *Lack of resources to support necessary CSPD functions or to expand capacity*
- * *Shortage of RBEI trained interventionists and trainers in the state*
- * *Natural environment learning practices not a required pre-service training for certification or post-*

service training for ongoing PD for direct EIS providers, only for service coordinators

- * EIS providers not required to implement natural learning environment practices*
- * Lack of daycare provider participation in intervention (daycare provider not involved and/or therapist not including the daycare provider)*
- * Daycare provider not included on the IFSP team*
- * Daycare provider not informed of their role in EI (DCCECE doesn't include training to daycare providers on their role in early intervention under Part C)*
- * Therapist not trained to coach/include the daycare provider*
- * "Pull out sessions" and "outpatient therapy" employed more than natural learning environment practices*
- * Pre-service: state licensure for specialty areas (SLP, OT, PT) doesn't require 0-3 experience, education, or training and the internship rarely involves infants/toddlers and families*
- * Pre-service: college pre-service therapy students complete internship at large centers near the university and don't complete observation/internship in the NE -- students choose their own location but faculty approves the placement; better collaboration with both universities as well as daycare networks around the state could ensure an internship experience that better prepares future EI professionals to work with families.*

For more information about proposed improvement strategies to address this area, see Component 4(a) "Proposed broad improvement strategies:"

(a) Knowledge: Parents, Referral Sources, Providers

(b) Training: Public/Referral sources, Providers, Parents

The suggested improvement strategies listed in Component 4(a) were selected with input from the Strategies Workgroup, other stakeholders, the AICC, and national TA partners. Potential improvement strategies have been suggested to address identified address root causes, to affect systemic change where necessary to remove barriers to implementation, and to support implementation of and eventual scale up of evidence-based practices to reach the SiMR.

Over the next year during Phase II of the SSIP development, the suggested strategies in Component 4(a) will be analyzed using an implementation framework to be determined as work on Phase II progresses. The implementation framework selected for completion of Phase II will assist the lead agency and stakeholder participants in determining the following:

- 1) which strategies are "doable"
- 2) the impact of implementing each strategy on the system, programs/providers, and families
- 3) the most logical order in which to implement improvement strategies
- 4) methods of evaluating strategies



Though the implementation framework's fleshing out comes in later phases of SSIP work, the coherent improvement strategies suggested in this Phase I report address improvement efforts needed in each area of the implementation framework:

- **Competency drivers:** activities to develop, improve, and sustain providers' and programs' ability to 1) put strategies and EBPs into practice to 2) benefit the children, parents, and other caregivers. The four competency drivers include: selection, training, coaching and performance assessment.
- **Organization drivers:** areas of improvement needed to intentionally develop the supports and infrastructures needed to create a hospitable environment for new programs and innovations, specifically, Decision-Support Data Systems; Facilitative Administration; and Systems Interventions or strategies to work with external systems or levels of the EI network.
- **Leadership drivers:** areas of improvement needed in the governance infrastructure area to support knowledgeable and engaged leadership.

Improvement strategies suggested in Component 4(a) address potential changes in policy, forms, procedures and guidelines to support implementation of evidence-based practices to support the Part C program in reaching the SiMR and methods for measuring and evaluating implementation and progress to ensure compliance [competency drivers/organization drivers]. Component 1(e) discusses additional data that may be needed to complete work in future SSIP Phases and suggests the improvement strategy of adopting a different method of surveying families so that what we're seeking to improve (caregiver's ability to implement intervention in typical activities) is what we're measuring [organization drivers].

Other strategies proposed in Component 4(a) also address the knowledge and training needs of the public (primarily referral sources and the medical community), parents, and EIS providers [competency drivers]. Specific strategies to increase parent participation in the family survey are also suggested [organization drivers]. Methods to better market early intervention under Part C to increase knowledge of referral sources, the medical community, parents, providers, and the Arkansas general assembly and lead agency administration about the benefits to families of EI working collaboratively with caregivers in a coaching capacity to enhance caregivers' ability to assist in their child's learning and developments are included in the proposed list of strategies in Component 4(a) [leadership drivers/organization drivers].

Marketing methods concentrate on areas that the lead agency and EIS programs can have a direct impact on in order to reach the goal, which includes implementation of the Parent Participation form, expanding on current guidelines for report writing to make reports more family friendly, making the Family Handbook more readily available to families, and recruiting family participation in developing family stories as part of outreach to share the mission and vision of First Connections. Collaboration with other partners such as IHEs, DCCECE, DBHS, and the state Department of Education is also suggested as part of ongoing improvement strategies, and more partnerships may be identified as new relationships are formed and new initiatives are introduced within the state.

The Unlimited Potential (UP Site) initiative is one method of using existing infrastructure and resources to begin improvement strategies with a target group. Designed to support programs already strong in functional outcomes and natural learning environment principles and begin implementation with a cohort group of providers/programs that are already early adopters and comfortable with natural learning environment practices, coaching as a style of interaction with families, and writing functional child goals/objectives, this initiative will boost the capacity of the Part C program to scale up EBPs statewide by using the cohort group to affect change as providers/programs in the first cohort will assist over time. The Scale UP plan will be addressed in greater detail in Phase II and III of the SSIP.

Component 4(e) Stakeholder Involvement in Selecting Improvement Strategies:

Taking information from various stakeholders groups, parent and program coordinator interviews, information from physician meetings and meetings with QA/Monitoring and suggesting coherent improvement strategies was the task of the Strategies Work Group created from volunteers from the broader SSIP Stakeholders Group, the AICC, and the Core SSIP Team.

The Strategies Work Group reviewed work previously completed by the SSIP Stakeholders Group and suggested improvement strategies to address root causes (identified earlier in the root/cause analysis), to align with other state initiatives (identified during a large group meeting), and to help the Part C Program reach the SiMR (previously proposed by the large stakeholder group). Members of the Strategies Work Group are listed in Component 4(a), page 49.

Strategies Work Group members independently reviewed previously completed work and, using a strategies crosswalk tool provided by ECTA, generated at least one feasible solution for each identified root cause and submitted them to the SSIP Coordinator to compile all suggestions into one document. Three work group members (two IHEs and Parent Advocacy Group) enlisted the participation and assistance of staff members who had not previously been involved as stakeholders but who had a vested interest in improvement strategies affecting early learners).

The document of all submitted suggestions was re-distributed to work group members to rank the suggestions based on:

- (1) “goodness of fit” (alignment with SiMR, program values, mission, and vision, and other state initiatives)
- (2) feasibility (in consideration of results of infrastructure analysis)

The work of this group was shared with the SSIP Stakeholders Group as a whole and with the AICC for comment and input.

COMPONENT #5: THEORY OF ACTION:

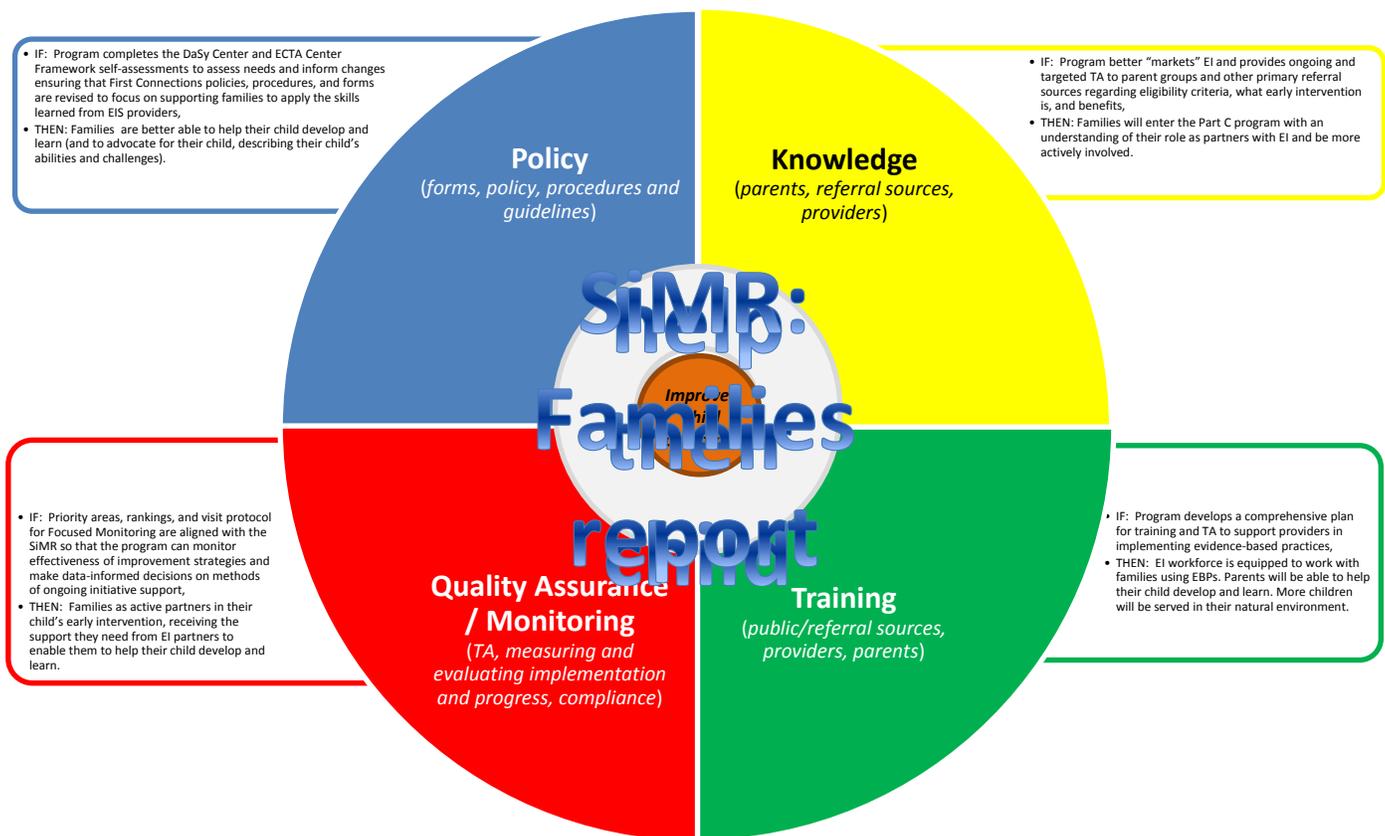
The goal of the theory of action is to illustrate how implementation of coherent improvement strategies and evidence-based practices will demonstrate the State’s capacity to lead meaningful change in the Part C program to achieve improvement in the SiMR.

In Phase I of SSIP work, broad improvement strategies to address root causes and overcome barriers were gathered from stakeholder input through a systematic process outlined in previous sections of this report. Subsequent phases of SSIP work will describe improvement strategies in greater detail and will include the implementation framework and reasons each strategy was ultimately selected.

Component 5(a) Graphic Illustration:

THEORY OF ACTION GRAPHIC

4 Broad Focus Areas to Reach SiMR



Description of Graphic:

The First Connections Theory of Action graphic representation illustrates the interrelated nature of the four broad areas of improvement and how each supports the other to achieve the SiMR (larger middle circle) of *increasing the percentage of families who report that early intervention helped them help their child develop and learn*. The innermost circle represents the anticipated long-term outcome that will result from improvements in helping families incorporate learning strategies into the child’s and family’s typical day: **improved outcomes for children**.

For each broad improvement area, the graphic presents one currently feasible strategy to support its implementation (represented in the color-coordinated box on the outskirts of each improvement area as an “IF” statement). The graphic also represents anticipated goals or results as “THEN” statements in the color-coordinated boxes on the outskirts of each improvement area. The four broad improvement areas and potential improvement strategies for each area are discussed in detail in Component 4(a) of this report.

Component 5(b) How Improvement Strategies Will Lead to Improved Results:

The theory of action graphic depicts the belief that if our program implements improvement strategies in the broad and inter-related areas of knowledge, training, policies/forms, and quality assurance/monitoring, we can achieve the intended to result – to increase the percentage of families reporting that early intervention helped them help their child develop and learn (SiMR):

We believe that active family/caregiver participation in the early intervention process is critical to a child’s development with support and training from qualified early intervention service providers.

If we “re-market the program” to build a shared understanding about the true purpose of early intervention among parents and primary referral sources . . .

families will enter the Part C program with an understanding of their role as partners with EI and be more actively involved.

We believe that infants and toddlers learn best in their natural environment through every day experiences and interactions with familiar people in familiar contexts with typically developing peers.

If we enhance training and TA to create an EI workforce of professionals prepared to coach and to support the child’s caregivers to employ learning strategies within daily child and family activities . . .

parents will be able to help their child develop and learn and more children will be served in their natural environment.

We believe that parents are a child’s first teacher and that all families with the necessary supports and resources can help their child develop and learn.

If we assess needs and analyze policies, procedures/guidelines, and forms to ensure that First Connections policies and forms are revised to focus on supporting families to apply the skills learned from EIS providers will result in . . .

families being better able to help their child develop and learn (and to advocate for their child, describing their child’s abilities and challenges).

We believe that early intervention is designed to meet the needs of infants and toddlers who have a developmental delay or disability while offering supportive services to the family, like parent education/training to help parents understand their child's developmental abilities in order to promote their child's development.

If we change the focus of Quality Assurance/Monitoring efforts to align with the SiMR, the program can monitor effectiveness of improvement strategies and make data-informed decisions on methods of ongoing initiative support which will result in . . .

families are active partners in their child's early intervention, receiving the support they need from EI partners to enable them to help their child develop and learn.

Component 5(c) Stakeholder Involvement in the Theory of Action:

The Strategies Work Group used a tool provided by ECTA to determine the “ifs” needed to reach the “then” (results) that the large SSIP Stakeholders Group had identified as improvement goals or results they'd like to see (for more information on composition of the group and work of the group, refer to Components 2(e) and 4(e)).

Strategies Work Group members used improvement strategy suggestions submitted during earlier SSIP work to guide them in completing a Theory of Action tool independently or with members of their staff at the agency they represent who were not members of any previous stakeholder group. The independent or staff work of the Strategies Work Group members was submitted to the SSIP Coordinator to compile all ideas into one document to re-distribute to work group members for feedback and input before sharing the work group's ideas with the SSIP Stakeholders Group as a whole and with the AICC for comment and input.

For representation on the Strategies Work Group, see Component 4(a).

For more information about stakeholder involvement, see Overview section of this report; Component 1(f); Component 2(f); Component 3(d); Component 4(e). For information on Timelines for SSIP Work, see Appendix 3.

Appendices:

Appendix 1: *Contributing Factors Questions and Discussion (Component 1(a))*

Appendix 2: *Stakeholder Representation (Component 2(e))*

Appendix 3: *Timelines for SSIP Work (Phase I)*

Appendix 1

Contributing Factors Questions and Discussion (Component 1(a))

Questions the table work groups considered regarding contributing factors included:

- **Why do we have the problem?**
- **How can this problem be addressed?**

Answers: What could be causing the problems (identified above)?

- “Disconnect” between the Part C program and the “providers” (3), (5), (6), (7)
- Survey is too long (1)
- Survey may be worded at a level above some of Arkansas’ families (1)
- No name recognition could contribute to low parent participation as parents recognize the name of their provider/program but not the name of the state’s Part C program “First Connections” (1)
- Parent communication between providers and parents is inadequate (1), (2), (3), (7)
- Program failure to appropriately educate parents (many parents record NA in the blank when asked about their child’s disability because they do not feel or potentially have not been told that their child has a disability) (1), (2), (3), (7)
- Parent misinterpretation of survey, what it’s for, who it’s from, etc. (1)
- “Snail Mail” out of touch with parents’ needs and the times. . . the family may respond better to a state app or mass text message to families with link to survey (1)
- DHS logo on the letters repellant to some families (1)
- Low participation from minority, second language, rural families – failure to “connect” and “engage” these families (1), (2), (3), (7)
- How do we educate EIS providers about the survey – do providers understand how important the survey is, what the data is used for? (1)
- A state “culture” that favors a medical model and “therapy for babies” over an educational, parent education and training program (2), (3), (7)
- IFSP teams not using approved tools to arrive at a COSF entrance and/or exit rating based on various sources of information and typical developmental milestones in each of the three outcome areas (3), (6), (7)
- Child outcome areas on the COSF may be “poorly defined” (i.e.: do all parents understand what it means to “use appropriate behaviors to get needs met” at their child’s age and developmental level?) (3), (6), (7)
- Low referral rates from PCPs who don’t understand the difference between Arkansas’ center based day habilitation program and Part C (3), (4), (7)
- EI providers and service coordinators failure to complete COSF as part of exit strategies, particularly for children who leave the program prior to the age of transition (5), (7)
- Dropping off children for therapy (2), (3), (7)
- Clinic outpatient service providers suggest parents are a distraction to the child during therapy and ask parents to leave the children (2), (3), (7)
- Parents are told that children perform better one-on-one with therapists (2), (3), (7)
- Services based on medical model of service delivery (2), (3), (7)
- Lack of participation piece for parents to play a role in services (1), (2), (3)

DESIRED OUTCOMES/GOALS:

After generating a list of possible “causes of the problems,” the broad group brainstormed goals/outcomes they’d like to see from future improvement efforts. The list of desired improvements included:

- More families to participate in survey
- Higher percentage of families reporting that they can help their child develop and learn (C outcome)
- Higher percentage of families reporting that they can communicate their child’s needs and advocate for their child (A and B outcomes)
- More children reaching a level of development equal to or closer to the level of their typically developing peers
- Improved natural environment scores more in line with national averages

Stakeholders then identified potential barriers to reaching the above identified goals:

potential barriers to reaching desired goals:

- *need for more collaboration with other agencies around the state
- *recruitment doesn’t focus on core knowledge areas or an accurate representation of what EI is and what the providers’ role looks like
- *pre-service personnel cannot access trainings in CDS
- *open enrollment is now closed (no more recruitment)
- *poor definition/clarification of “teaming” and the definition of team
- *geographical barriers in rural AR affecting teaming
- *more than a test at the end of a training is needed -- need some method of observation, measure of application (no method of evaluating effectiveness of training/PD/TA)
- *following the mission isn’t a top priority
- *little or no use of mentoring
- *college pre-service therapy students not doing their observation/internship in the NE (doing center-based) -- students choose their own location but faculty has to approve this. We need better collaboration with both universities as well as daycare networks around the state
- *despite use of a train the trainer model, those who attended CDS don’t go back and train the others; many providers are not using the system appropriately and are out of compliance with data entry requirements
- *providers in silos not willing to team in order to develop the “whole child” and “scope of practice” fears, misunderstandings, and short-sightedness
- *more CDS training/practice needed, including CDS training on how to enter a PA, de-obligate, etc
- *lead agency does not have opportunities to communicate with, inform, or report to lead agency administration or the Arkansas general assembly
- * no AICC personnel committee
- *state licensure for specialty areas doesn’t require 0-3 experience, education, or training and the internship rarely involves infants/toddlers and families
- *lack of understanding of “scope of practice” of specialty areas
- *lack of core knowledge area training requirement
- *core areas of knowledge not identified

- *certification doesn't require certain core knowledge training, required PD doesn't require it either
- *not necessarily using available staff in the most effective ways
- *high staff turnover
- *understaffed training unit and monitoring unit
- *lack of personnel in general
- *lack of available resources, particularly Part C staff positions that were once available
- *lack of state contribution/funding for EI under Part C
- *no method of imposing sanctions or holding providers to their agreements/requirements
- * Medicaid payments/guidelines are a barrier
- * Travel, costs and travel time are a barrier (reimbursement)

Appendix 2

Stakeholder Representation (Component 2(e))

(a) Core SSIP Team -- The lead agency's "central office" staff contains five team leaders, each presiding over a different area who report to the Part C Coordinator and who make up the Core SSIP Coordinating Team:

- Data Manager
- Fiscal Manager
- Program Manager
- Comprehensive System of Personnel Development Coordinator
- Quality Assurance/Monitoring, Licensure and Certification Coordinator

(b) SSIP Stakeholders Group -- An SSIP Stakeholders group was developed by requesting collaboration and partnership with representatives of agencies, organizations, and backgrounds similar to the makeup of the AICC with representatives from:

- Institutes of Higher Learning:
 - Henderson State University, *Assistant Professor of Special Education*
 - University of Arkansas for Medical Sciences, *Young Child Wellness Specialist*
- Parent(s) of a child with a disability
- Parent Advocacy Group:
 - Family2Family, *Director*
- Medicaid, (RN) *Utilization Review Supervisor*
- DCFS, *Specialized Services Unit*
- DCCECE, *Program Manager*
- DBHS, *LCSW – Children's Treatment Coordinator*
- DDS Children's Services, *area manager*
- DDS Waiver Services, *intake and referral coordinator*
- AICC members
- Educational Consultant, *SLP - Consultant*
- EI Service Coordinators
- Title V, *Registered Nurse/Nurse Manager CMS*
- Part B (ECSE), *Early Childhood Coordinator*
- Part C direct service providers:
 - KidSource, *Director and DT*
 - Itty Bitty City, *Director and DT*
 - Friendship Community Care, *Pediatric Services*
 - HRS Associates, *Executive Director*
- Other Home Visiting Programs
 - Arkansas Home Visiting Network, *Program Coordinator*
 - DCFS Family Support/Specialized Services

(c) **AICC** - Arkansas Inter-agency Coordinating Council members are appointed by the governor. The current AICC members represent:

- Provider Payment Agency
- DCFS Payment Agency
- Provider: Faulkner County Day School
- General Assembly Member
- DHS/DDS Asst. Director, Children's Services
- Insurance Governance
- Parent of a child with a disability
- AR School for Deaf Outreach
- Counseling Associates Family Support
- AR Dept. of Health/Infant Hearing
- Parent of a child with a disability
- AR Dept. of Education, Office of Special Education
- McKinney-Vento Coordinator
- DHS/DHS Personnel Preparation
- Provider/Friendship Community Care
- DHS/Medicaid Payment Agency
- DHS/Dept. of Early Childhood

Appendix 3

Timelines for SSIP Work (Phase I)



Although information in the report appears in a linear fashion, the process of developing Phase I of the State Systemic Improvement Plan (SSIP) was non-linear. Various groups including the Core SSIP Team, the SSIP Stakeholders group, and the Arkansas Interagency Coordinating Council (AICC) worked in large and small groups to undertake data analysis, broad and in-depth infrastructure

analyses, formulating theories of possible causes, proposing a Measureable Result (SiMR), developing improvement strategies to address the SiMR, and crafting a Theory of Action and the Theory of Action graphic. These activities occurred simultaneously with each activity informing the other.

Work began with a regional SERRC meeting in November of 2013 to share information and tools related to beginning the SSIP work. The Part C Coordinator and SSIP Coordinator convened the unit managers (team leaders) on 11/7/2013 to share information learned at the regional meeting and formed the Core SSIP Team.

Core SSIP Team reviewed data pulled for the APR/SPP during the first quarter of 2014 (January – March)

By February 2014, the Core SSIP Team had identified related and/or collaborating agencies and organizations that needed to be part of the SSIP work and drafted a stakeholder invitation and brief overview of the SSIP and by mid-March of 2014, the invited ambassadors (representatives) formed the SSIP Stakeholders Group.

The Core SSIP Team participated in a series of Webinars presented in the spring of 2014 by the RRCP with DaSy, ECTA and IDC to prepare teams to work with stakeholder groups to complete various components of Phase I:

- SSIP Overview – Thursday, March 6th
- SSIP Data Analysis -Tuesday, April 8th
- SSIP Infrastructure Analysis -Thursday, May 1st

The first stakeholder meeting to introduce the group and to present the overview of SSIP work was held (via Webinar) Tuesday, April 8, 2014. Stakeholders completed the initiative inventory by the end of April, 2014.

A full-day stakeholder workshop (face-to-face) was conducted May 19, 2014. The outcomes for this workday are as follows:

- Have a basic understanding of the purpose and requirements of the State Systemic Improvement Plan (SSIP).
- Gain a basic understanding of the process used to identify potential State Identified Measureable Results and some of the key data that substantiate these selections.

- Identify concerns related to performance areas and potential barriers to high performance or impact on low performance for infant and toddlers with disabilities.
- Provide recommendations to the State on which potential State Identified Measureable Result is most feasible and doable for the State.
- Understand next steps and when stakeholder input will be essential in future activities.

Core SSIP Team met to review work of SSIP Stakeholders Group on May 29th and to organize this information into a summary to present to the AICC.

Work with the SSIP Stakeholders group on the Infrastructure Analysis began with a conference call to overview the areas of infrastructure and tools teams would use to complete the broad infrastructure analysis (Wednesday, June 11, 2014 and a follow up call on June 24, 2014). The ECTA Center System Framework was identified and used to understand infrastructure components.

August/September of 2014 team leaders led small workgroups of stakeholders in broad infrastructure analysis of the area of infrastructure most closely related to the unit they oversee. The five workgroups set their own work timelines and methods of meetings that included face-to-face meetings, teleconferences, and Webinars.

September 2014. Core SSIP Team met to review each small workgroup's first draft of infrastructure analyses to create a summary to share with the AICC and SSIP Stakeholders Group.

September 2014. The Data Unit requested from system developers a data pull to show broad data on number of families served in various socioeconomic strata to determine how a proposed family participation (sliding fee) scale would impact families. Specifically analyzed were: how many families would participate in cost participation and whether or not the income generated would offset fiscal collection and management costs to make the proposed change feasible. This information was shared with stakeholders as part of data-driven decision making/improvement planning.

October 2014. Core SSIP Team met to go over finalizing Phase 1 work and to determine if any additional data were needed to complete the process. Members of the core team also participated in the Improving Data, Improving Outcomes conference and gained additional information.

November 12, 2014: Core SSIP Team participated in National Center for Systemic Improvement (NCSI) TA Webinar to support early intervention programs in improving educational results and functional outcomes for children with disabilities.

November 20, 2014: Core SSIP Team teleconferenced with national TA partner to discuss improvements to in-depth analyses and sharing results with various stakeholder groups.

Early December 2014: Complete in-depth infrastructure analyses and summaries and presented to AICC and review additional sources for data and information on related initiatives – including data from Kids Count, Child Welfare, RTT-ELC application, MCH.

December 9, 2014: Day-long face to face workshop to review root causes, devise a theory of action, discuss other state initiatives stakeholders are involved with or are aware of and ensure that the SiMR and broad improvement strategies are aligned with other initiatives, program values and mission, and elements from analyses completed as part of SSIP work.

January 15, 2015: Part C team leaders met with administration to propose a revision to the QA/Monitoring Sanctions matrix to align compliance requirements with SiMR.

Core SSIP Team reviewed data pulled for the APR/SPP during the first quarter of 2015 (January – March)

January 21, 2015: Program administration shared information about SSIP work with the AICC.

February 25, 2015: Core SSIP Team with Part C Coordinator and national TA partner met via conference call to assess progress towards completion of SSIP Phase I report and to discuss “next steps” as the team prepares to work with stakeholders on Phase II.

March 2015: Strategies Work Group formed from SSIP Stakeholders Group and AICC to share various agency perspectives and to review root causes and suggested improvement strategies. Work group members were able to refine and/or propose additional improvement strategies, when deemed necessary and rank strategies (*for more information, see Component 4(e)*). Strategies Work Group, using the Theory of Action tool provided by ECTA, submitted theories of action based on suggested strategies to address root causes and to achieve the SiMR. Ideas of the group were incorporated into the graphic (Component 5(a)) designed by the Core SSIP Team.