State of Hawai'i
Department of Health
Early Intervention Section

April 1, 2015

HAWAI'I PART C
FFY 2013 SPP/APR INDICATOR 11: STATE SYSTEMIC IMPROVEMENT PLAN (SSIP), PHASE I

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Overview of the State Systemic Improvement System (SSIP)

State Lead Agency

Hawai‘i Department of Health (HDOH), Early Intervention Section (EIS) is identified as the Part C Lead Agency (LA) and is responsible for developing and implementing a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention (EI) services for infants and toddlers with disabilities and their families as outlined in the Individuals with Disabilities Education Act (IDEA).

Hawai‘i has three State EI Programs and 17 Purchase of Service (POS) EI Programs statewide. Hawai‘i also has fee-for-service contracts to provide additional supports and services to the existing EI Programs. In FFY 2013, 3,588 eligible infants and toddlers and their families received early intervention services.

The SSIP Coordinator (EI System Improvement and Outcomes Unit Supervisor) and the SSIP Data Coordinator (EI Outcomes Coordinator) lead the SSIP Leadership Team to develop and implement the SSIP. The Leadership Team is comprised of EIS Administrative staff that oversees different aspects of Hawai‘i’s EI System, representatives from local EI Programs, infant mental health professionals, representatives from state initiative groups, and parents. (Refer to Attachment A for SSIP Leadership Team Roster).

State Improvement Measurable Result (SIMR)

As a result of broad data analysis and discussions that occurred with the Leadership Team and Stakeholders, it was determined that Hawai‘i’s SIMR is: “to increase the percentage of Hawai‘i’s eligible infants and toddlers with disabilities who substantially increased their rate of growth in positive social-emotional skills (including social relationships) by the time they exit the early intervention program.” The SIMR will be focusing statewide to improve results for all the children eligible for Part C EI services in Hawai‘i.

SSIP Process

The process to develop the SSIP for FFY 2013 included:

1. The HDOH, EIS identified the EI System Improvement and Outcomes (EISIO) Unit (formerly known as the Lead Agency Quality Assurance and Training Team) to be the lead for the planning, development and implementation of the SSIP.

2. The SSIP Coordinator connected with the U.S. Department of Education, Office of Special Education Programs (OSEP)-funded technical assistant center staff (TA consultants) from the Western Regional Resource Center (WRRC), Early Childhood Technical Assistance (ECTA) Center, and the Center for IDEA Early Childhood Data

Systems (DaSy). Anne Lucas and Taletha Derrington are the primary consultants actively working with Hawai‘i and have consulted with other TA consultants as needed.

3. At the recommendation of the consultants, Hawai‘i identified and developed a SSIP Leadership Team to guide the development of the SSIP.

4. An overview of the SSIP was provided to approximately 70 stakeholders at the Annual Stakeholder meeting held in December 2013.

5. Two additional Stakeholder meetings (May 2014 and December 2014) of approximately 70 people were held during Phase I of the SSIP to provide review data analysis, provide input into the selection of the SIMR, participate in infrastructure analysis, identify potential root causes and potential improvement strategies.

6. Quarterly Program Manager Meetings also included the SSIP as an agenda item, beginning in 2014, to be continued throughout the SSIP process.

7. The SSIP Leadership Team met or connected via e-mail at least one time per month.

8. The SSIP SPP/APR Indicator 11, Phase I was:

    a. led and developed by the SSIP Coordinator and SSIP Data Coordinator.
    b. written by the SSIP Coordinator and reviewed by the SSIP Leadership Team and the Children with Special Healthcare Needs Branch Chief.
    c. routed to the Director of Health prior to submission to OSEP to ensure that she is knowledgeable of the status of the Part C Program.
    d. submitted to OSEP as required.
    e. posted on the HDOH website.

<u>Stakeholder Involvement</u>

A broad stakeholder group of approximately 70 people were involved in providing input to Phase I of the SSIP through two meetings that were held in FFY 2013 (December 2013 and May 2014 and one in FFY 2014 (December 2014).

The initial SSIP State Team comprised of EIS Administrative staff and the EI System Improvement Outcome (EISIO) Unit worked with TA consultants beginning in January 2014. After the SSIP Stakeholder meeting in May 2014, the SSIP State Team invited five individuals at the program level and/or with experience in special education, mental health, data analysis, and/or knowledge of community/state initiatives to be part of the SSIP Leadership Team. The invitations were accepted and monthly meetings began in June of 2014. After the December

2014 Annual Stakeholder meeting, four additional members were added to the SSIP Leadership Team: the Public Health Nurse (PHN) Branch Chief and PHN, both of whom are involved with the Hawai‘i Infant Mental Health Association, and two parents who participated in early intervention services.

Members of the Hawai‘i Early Intervention Coordinating Council (HEICC) were invited to the broad Stakeholder meetings that were held in December 2013, May 2014, and December 2014. They were also briefed on the SSIP at their April 2014 meeting and a more comprehensive presentation was done at the October 2014 HEICC meeting.

Component 1: Data Analysis

1a. How Key Data were Identified and Analyzed

The Hawai'i SSIP State Team began working with OSEP funded technical assistance center staff (TA consultants) in January 2014 to begin Phase I planning that included the broad data analysis and planning for stakeholder involvement.

The State Team compiled data from the following sources: 618 data, Child and Family Outcomes Data (APR Indicator 3 & 4), APR compliance indicators, Family Survey, Battelle Developmental Inventory II data, Local Contributing Factor Tools, and the SSIP Provider Survey.

Annual Stakeholder Meeting, December 2013.

A brief overview of the SSIP was provided to approximately 70 broad stakeholders. Stakeholders participated in small group discussions to provide preliminary input based on APR data for Indicator 3 (Child Outcomes) and Indicator 4 (Family Outcomes). Hawai'i elected to focus on child outcomes for the SIMR as described in component 3. Therefore, the summary of the stakeholder discussion below is for Indicator 3 (Child Outcomes).

- What areas are we doing well in?
    - Indicator 3B: Acquisition and use of knowledge and skills (including early language/communication and early literacy)
- What areas should we focus on?
    - Indicator 3A: Positive social-emotional skills (including social relationships)
- What programs are doing well and what programs are not doing well? Possible reasons?
  NOTE: Groups identified provider level instead of program level reasons.
    - Ratings differ from entry to exit due to families having a better understanding of social-emotional development at exit
    - Inconsistency across providers in implementing Child Outcome Summary (COS) process
- What additional questions do you have about the data or what questions would you like answers to?
    - Eligibility/Diagnosis

  - Population of community and cultural effects
  - COS process
  - Availability of community resources
  - Reliability of data

- What else do you want to know about programs before determining a focus area (e.g., total number of children served, staff vacancies, etc.)

  - Is everyone implementing the COS process consistently?
  - Program size
  - Staff vacancies

- Based on the data, what are the top three ideas for Hawai‘i’s potential focus areas? NOTE: Groups identified needs instead of potential focus areas

  - Consistent COS process
  - Training
  - Technical Assistance

SSIP State Team, January 2014 – April 2014.

The SSIP State Team met from January 2014 – April 2014 to prepare for the May 2014 stakeholder meeting. The SSIP Coordinator and the SSIP Data Coordinator gathered data and worked with the TA consultants to analyze the data.

Based on the broad data analysis of child outcome data, the SSIP State Team decided to recommend the focus area be on increasing the percentage of children who exhibit greater than expected growth (SS1), in social-emotional development (including social relationships) based on the following reasons:

- Hawai‘i fell below the national average in 2 of 3 child outcome areas for the percent of children exhibiting greater than expected growth (SS1, and the social-emotional skills outcome area exhibited the lowest percentage and the greatest difference from the national average in comparison to the acquisition of knowledge and skills and taking appropriate actions to meet their needs (Figure 1).

- State trends indicated that greater than expected growth in positive social-emotional skills was below the other two outcome areas and has had a downward trend from FFY 2010 – FFY 2012 (Figure 3).

- Stakeholders and the SSIP Leadership Team decided not to focus on the percent of children exiting at age expectations in social-emotional skills (SS2) because data indicate that this outcome area is one of the highest for Hawai‘i in comparison to the nation (Figure 2) and for state trends over time (Figure 4).

Figure 1. Summary Statement 1

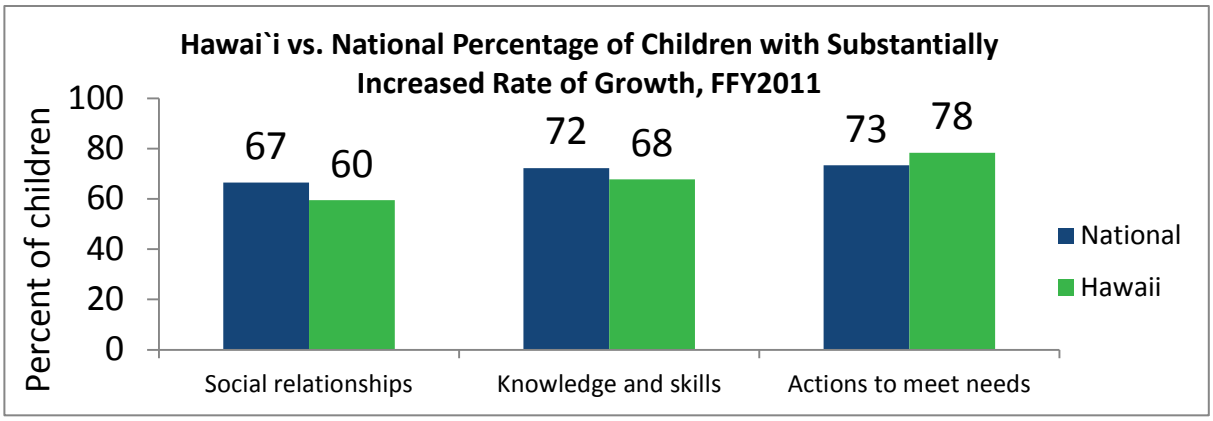
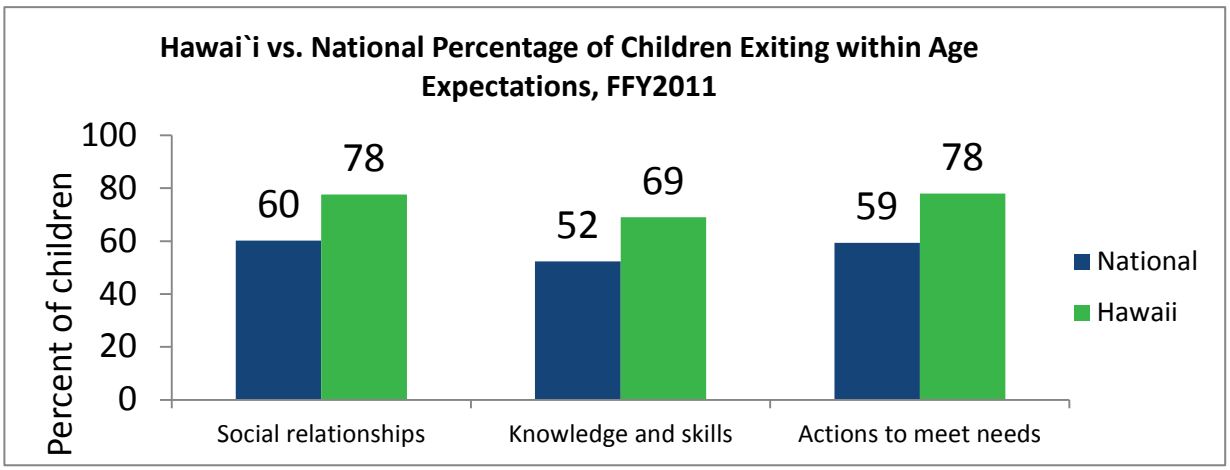
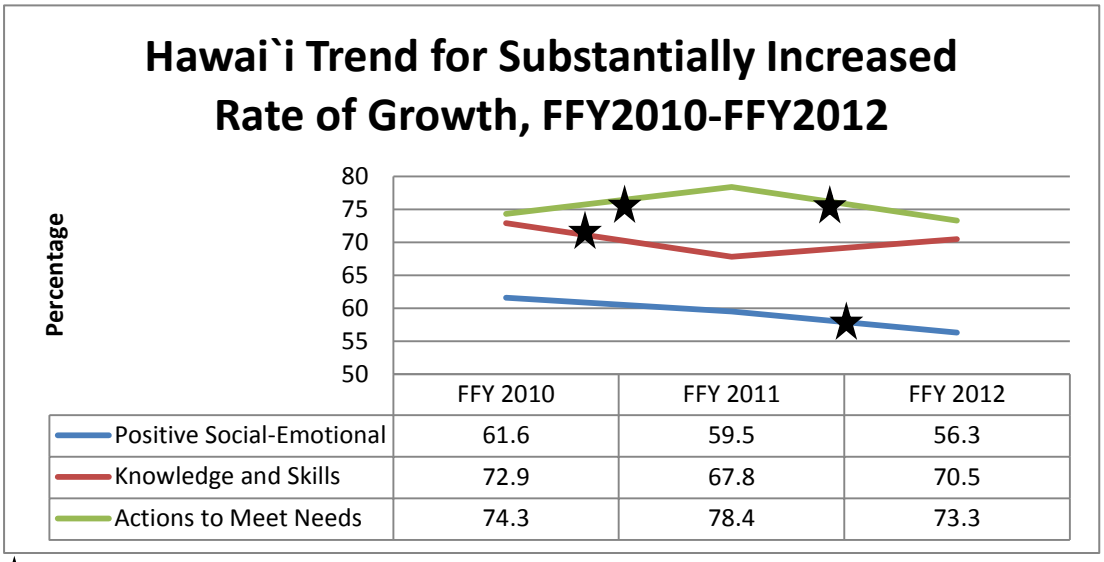


Figure 2. Summary Statement 2



Note: National data based on 33 states with highest-quality data

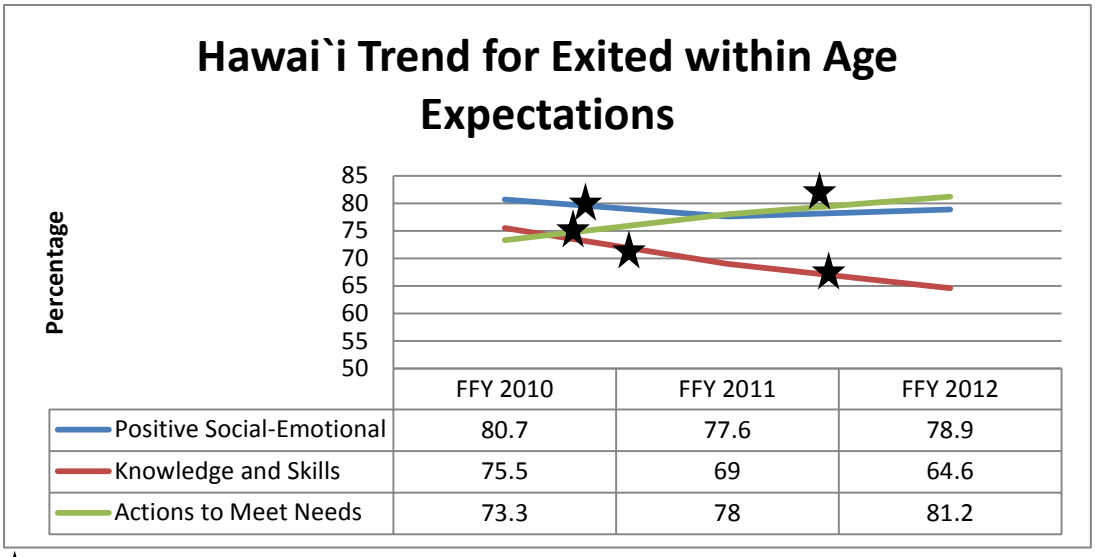
Figure 3. Summary Statement 1



	FFY 2010	FFY 2011	FFY 2012
Positive Social-Emotional	61.6	59.5	56.3
Knowledge and Skills	72.9	67.8	70.5
Actions to Meet Needs	74.3	78.4	73.3

★ Meaningful difference from previous year

Figure 4. Summary Statement 2



	FFY 2010	FFY 2011	FFY 2012
Positive Social-Emotional	80.7	77.6	78.9
Knowledge and Skills	75.5	69	64.6
Actions to Meet Needs	73.3	78	81.2

★ Meaningful difference from previous year

SSIP Stakeholder Meeting, May 15, 2014.

TA Consultants (Anne Lucas, WRRC/ECTA, Kathy Hebbeler, ECTA/DaSy, and Taletha Derrington, DaSy) attended Hawai‘i’s SSIP Stakeholder Meeting in May 2014 to assist Hawai‘i in facilitating the SSIP process.

Stakeholders participated in a small group activity where they were tasked with identifying possible root causes for infants and toddlers achieving less than optimal growth in positive social relationships.

Overall themes that were noted were:

- Family
  - ✓ suboptimal understanding of child development, including social-emotional
  - ✓ suboptimal understanding of primary service provider and coaching model
  - ✓ suboptimal availability and involvement during service delivery
- Providers
  - ✓ Providers have different levels of understanding and ability to implement the primary service provider and coaching model
  - ✓ IFSP outcomes/objectives are not always written in functional terms to address social-emotional skills and at times appear to be more medical or an item from an assessment
  - ✓ May not have the appropriate assessment tools or training to identify social-emotional needs
- Lack of funding/resources
- Need additional Quality Assurance/TA staff to ensure consistent training, mentoring, and support to local programs

<u>Leadership Team Meetings, May 2014 – March 2015</u>

The Leadership Team reviewed compiled information gathered from the broad infrastructure analysis and the broad root cause analysis gathered from the stakeholder meeting. Based on that review, the Leadership Team developed root cause hypotheses, as follows:

1. If a more sensitive/adequate and culturally appropriate assessment tool is utilized, then initial entry Child Outcomes Summary (COS) ratings for social-emotional outcomes will be more accurate, and more functional social-emotional individual child outcomes will be identified.

2. If early intervention (EI) providers: (1) understand their own roles and responsibilities around improving social-emotional development, and (2) understand the roles and responsibilities of other professionals (e.g., infant mental health

clinicians), then providers will be able to deliver appropriate services and develop collaborative partnerships so that families know how to support their child's social-emotional development and children will make progress in their social-emotional skills.

3. If EI providers implement the coaching model and engage parents within the child's daily routines and activities, then individual child outcomes will be achieved and the COS ratings for social-emotional outcomes at exit will be higher.

4. If infants, toddlers and families receive culturally competent services related to social-emotional development, then individual child outcomes will be achieved and higher social-emotional outcome ratings at exit will result.

5. If parents participate in parent support groups, they will be better able to help their child learn and grow which will improve their child's social-emotional outcomes at exit.

6. If EI providers receive more training on appropriate social-emotional development, that includes understanding levels of need, writing functional outcomes, and implementing evidenced based interventions in natural environments, then individual child outcomes will be achieved and the COS ratings for social-emotional outcomes at exit will be higher.

7. If EI providers received more training on appropriate social-emotional development and interventions, then providers will feel more confident and competent in their ability to communicate to the parents about their child's needs in this area and deliver appropriate services and supports that enable the family to support their child's social-emotional development.

8. If EI providers receive more training on the Hawaii COS rating process, including typical child development, then EI providers will be able to explain and the COS rating process to the family and outcome ratings at entry and exit will be consistent and accurate and be used to measure progress of the children's positive social-emotional skills.

9. If a child receives timely and adequate services from highly qualified staff then individual child outcomes will be achieved and higher social-emotional outcome ratings at exit will result.

10. If EI has a high quality web-based database and a data manager/analyst, then data could be collected and utilized for program improvement which will lead to improved individual child outcomes and higher social-emotional outcome ratings at exit will result.

All programs completed the Local Contributing Factor Tool for APR Indicator 3; however, programs left many portions of the tool blank. Therefore, the Leadership Team decided to conduct a SSIP Survey of all providers to collect information on the root cause hypotheses that also included comfort level questions of providers' understanding and/or implementing activities related to social-emotional development. DaSy provided support in the online survey development, tracking, and data compilation on Hawai'i's behalf. Of the 207 surveys distributed, 137 surveys were completed (66%).

Based on this SSIP Provider Survey, Family Outcomes Survey, and data analysis mentioned above, the Leadership Team verified root causes. The confirmed root causes are included in the table below:

#	Confirmed Root Cause	Findings/Justification
1	Parent's understanding of and expectations for child's social-emotional development & growth and cultural beliefs (Roadblocks for Parents)	Although the 2014 Family Outcome Survey data indicates that about nine out of ten of families said they understood their child's delays and/or needs and were able to help their child get along with others, stakeholders identified during the root cause analysis that parental lack of understanding and expectations for children's social-emotional development was a roadblock to identifying social-emotional needs and supporting children's development in this area.
2	Parents need groups to share strategies (Roadblocks for Parents)	On the Family Outcome Survey that goes out every year, only 69.6% (425 of 611 responded) of families responded that they were able to talk with other families who have a child with similar needs.
3	Lack of basic understanding of infant/child development (0-3 and social-emotional development & growth (Roadblocks for Therapists)	Based on the SSIP Provider Survey, staff are less comfortable in understanding age-appropriate social-emotional skills or interpreting functional information about children's social-emotional skills for younger children. One in four staff are not comfortable in understanding age-appropriate social-emotional skills for children birth to three and three in ten staff are not comfortable interpreting functional information; although comfort increases with age, one in five providers are not comfortable interpreting functional information for children ages two-three. However, training was identified as one of the biggest barriers to providing services to address a child's social-emotional needs (Based on the SSIP Provider Survey, 63% of providers wanted training on

#	Confirmed Root Cause	Findings/Justification
		communicating about sensitive issues due to cultural stigma related to mental health services) and most respondents did not complete a Functional Behavioral Assessment (FBA)/Antecedent, Behavior, Consequence (ABC) prior to referring for a psych evaluation.
4	How to write social-emotional goals	Based on the SSIP Provider Survey, the majority of staff feels comfortable with social-emotional development, which would dispute the hypothesized need for training on writing goals in this area. However, the survey identified the need for training in areas related to social-emotional needs and goal-writing: 65% wanted training on ASD; 73% challenging behaviors; 62% on FBA; 63% how to talk to families about sensitive issues; 57% on social-emotional development; 47% on writing functional outcomes. In addition, monitoring and anecdotal information from providers suggests need for training.
5	Not identifying right services/strategies (i.e. behavior vs. sensory delay) (Consistent tool for measuring/goal writing)	Data from SSIP Provider Survey indicate four in ten programs are not implementing evidence-based interventions.
6	Inconsistent Implementation of primary provider and coaching model (Roadblocks for Therapists, Primary provider and coaching model)	Documentation and IFSP service page reviewed during monitoring did not always reflect implementation of Primary provider and coaching model.
7	Not enough training and support for implementation of primary service provider and coaching model, including team members roles (Training)	The SSIP Provider survey data on the need for training suggests that there has not been enough training, and conversations with stakeholders identified the lack of support for implementation of evidence-based practices and the primary service provider model as an issue. Although the SSIP Provider Survey indicated 89% of staff use a coaching model, the gallery walk (described in component 2) suggested otherwise and

#	Confirmed Root Cause	Findings/Justification
		is confirmed by monitoring information from reviews of progress notes in the child's record. If staff are using a coaching model, then why are parents not participating in sessions (leaving therapists and the need for parents to teach their own children)?
8	Not enough training and support for implementation (Training)	The SSIP Provider survey data on the need for training suggests that there has not been enough training, and conversations with stakeholders identified the lack of support for implementation of evidence-based practices and the primary service provider model as an issue.
9	Not enough staff or money for training (Funding)	The majority of SSIP Provider Survey responders noted schedule conflicts (92%) and staff shortages (54%) as barriers to having whole IFSP team present for COS ratings, and as has been noted, staff want more training to address child's social-emotional needs
10	Not enough TA support for EI programs to use data for program improvement, develop and implement strategies to address areas of non-compliance, and to provide evidence-based and quality services.	The infrastructure analysis indicated that programs need technical assistance in using data for program improvement. Stakeholders identified during the infrastructure analysis that there is a lack of staff to provide consistent TA to the EI Programs. Stakeholders identified during the infrastructure analysis that the database needs to be up-graded to include additional data that provides a more complete picture of what is happening at the program level. Program Managers report at Quarterly Program Manager meetings that they frequently gap on-going services (cancel service appointments with families to meet other timeline requirements and/or due to staff shortage/vacancies. This was confirmed via on-site monitoring.

1b. How Data were Disaggregated

Data were disaggregated by reporting year (2011-2013), eligibility type (developmental delay, biological risk, combination), and insurance to determine whether subgroups of children were not performing as well as others that might suggest root causes for overall

state performance and/or a subpopulation to focus on for the SSIP. (Refer to Attachment B for the Hawai‘i Part C SSIP Social-emotional Child Outcomes Analyses)

Summary of analysis:

- Eligibility
  - Almost nine in ten children eligible due to having a diagnosis of a physical or mental condition that the multidisciplinary team determines has a high probability of resulting in developmental delay if early intervention services are not provided (biological risk [BR]) maintained or achieved age-level functioning
  - More children with developmental delays (DD) did not achieve age-level functioning (22%) than the other two eligibility groups, and this group represents the percentage of children with outcomes data (93%)
  - Four in ten children eligible due to both BR and DD were not functioning on par with their peers at exit from EI.
- Insurance:
  - Three in ten children with military insurance did not achieve age-level functioning
  - Two in ten children with Medicaid (QUEST) did not achieve age-level functioning
  - Under two in ten children with private insurance did not achieve age-level functioning

These differences in outcomes for children based on eligibility and insurance will be used in developing improvement strategies for Phase II, but the stakeholders decided that they did not provide strong enough evidence to suggest focusing on a subgroup of children in Hawai‘i for the SIMR

1c. Data Quality

According to the State Child Outcomes Data Quality Profile developed by the ECTA and Early Childhood Outcomes (ECO) Centers, Hawai‘i has met data quality criteria in terms of having <5% of children showing no progress and between 5 and 65% of children entering and exiting at EI age expectations in positive social-emotional skills for the past three years.

However, during the data analysis process, stakeholders expressed concern with the consistency in the COS rating process and felt that it was subjective and that the standardized tools used to assess development are inadequate for the social-emotional area. The COS rating form has been revised to include the decision-making tree developed by the Early Childhood Outcomes (ECO) Center and programs began using the revised form January 1, 2015. Further improvements will be made in SSIP Phase II.

Based on this information, Child Outcome rating scores were compared to the Battelle Developmental Inventory, 2nd Edition (BDI-2) scores to investigate the root cause hypotheses about social-emotional outcomes for children in Hawai'i.

1. Hypothesis 1: COS scores are artificially inflated in comparison to the data from the BDI-2 scores, in particular for the entry rating.
2. Hypothesis 2: Although the BDE-2 measures personal-social development, the BDI-2 is not sensitive enough to pick up delays in this outcome area, again particularly when children are younger.

The quantitative comparison suggested that BDI-2 scores may lack sensitivity at entry (hypothesis 2 supported) and that COS ratings may be inflated at exit (hypothesis 1 not fully supported). Further examination of the records of children with conflicting BDI-2 and COS ratings to determine if there was qualitative evidence to support the difference is required, but the data does suggest the need to improve training related to entry and exit ratings. (Refer to Attachment C for the Hawai'i Part C SSIP BDI-2 and COS Rating Analyses).

1d. Considering Compliance Data

Hawai'i has not met APR compliance indicator 1 targets for timeliness of services and has experienced slippage over the past four years. This is largely due to lack of documentation and staff shortages/vacancies, and also likely affects the capacity of EI services to support children's social-emotional development.

The following APR improvement activities listed below to address possible root causes for Indicator 1 are encompassed in the broad improvement strategies and will be considered when developing Phase II of the SSIP:

- Staff vacancies
  - Improvement activities to collaborate with academic institutions and to explore factors that can improve staff retention will continue.
  - Improvement activity to participate in targeted technical assistance provided by the Early Childhood Personnel Center has been developed.
  - Improvement activity to utilize flip videos has been revised to include exploration of tele-health options.
  - Improvement activity regarding gap report will continue.

- Documentation
  - Improvement activity to develop a mechanism to monitor the quality of documentation has been developed.

1e. Additional Data

Data from Hawai‘i’s home-visiting program will be collected and analyzed by June 2015 and will be used to target improvement strategies/activities in specific geographic areas if applicable.

1f. Stakeholder Involvement in Data Analysis

Stakeholders were presented a summary of the data analysis to support the recommendation that Hawai‘i’s focus area be social-emotional development. Stakeholders had the opportunity to discuss the data and ask questions about the results of the data analysis. The Stakeholders concurred with the Leadership Team’s recommendation to focus on improving social-emotional outcomes.

Taletha Derrington, DaSy TA Consultant hosted a webinar after the Stakeholder meeting for other stakeholders that missed the Stakeholder meeting and those that wanted to hear the results of the data analysis again. Participants were invited to send specific questions in prior to the webinar to ensure that we could address anyone’s questions/concerns. No questions were received prior to the event, but post-webinar feedback was received and participants reported that the webinar helped them understand the data analysis portion of the SSIP.

An SSIP Brief (refer to attachment D) was developed by State Staff and reviewed by the SSIP Leadership Team that explained the SSIP and the data used to identify Hawai‘i’s focus area. The brief was designed to be shared broadly with stakeholders, legislators, key state policy makers and others. The SSIP Brief has been posted on the DOH EIS website.

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

2a. How Infrastructure Capacity was Analyzed

Hawai'i analyzed our infrastructure by conducting a broad analysis of infrastructure strengths, weaknesses, opportunities and threats (SWOT) of each OSEP recommended system component. The compiled information was then broken into themes and determined if it was impacting our focus area, social-emotional development.

SSIP Stakeholder Meeting, May 15, 2014.

TA Consultants (Anne Lucas, WRRC/ECTA, Kathy Hebbeler, ECTA/DaSy, and Taletha Derrington, DaSy) attended Hawai'i's SSIP Stakeholder Meeting in May 2014 to assist Hawai'i in facilitating the SSIP process.

The stakeholders participated in a gallery walk activity, whereby stakeholders rotated in small groups to each of the system components (governance, monitoring/accountability, technical assistance & professional development, data, quality standards, and fiscal) to participate in a facilitated discussion to identify SWOT in each of the components.

The information gathered from the infrastructure SWOT analysis was compiled. The TA consultants helped categorize the information into the 23 themes that were related to specific parts of the infrastructure components (e.g., existing database features and content, specifics about the monitoring procedures/systems, and federal, state, and local policies and procedures).

The Leadership Team then identified issues that were directly or indirectly supporting or hindering improvements in our focus area of social-emotional development. The information was used to confirm root causes. This was shared at the Annual Stakeholder meeting in December 2014 and used to help develop broad improvement strategies.

2b. Description of State Systems

Hawai'i's infrastructure is designed to support the state's implementation of the Part C program and to ensure that children and families receive necessary services and make progress as a result of these services. The various components of the system are aligned with each other and work together to achieve this goal. A description of each of the seven system components is as follows:

Governance

Hawai'i's Part C Early Intervention system is within the Children with Special Health Needs

Branch (CSHNB), Family Health Services Division (FHSD) of the HDOH. The goal of the CSHNB is to assure a comprehensive family centered, community based, coordinated system of services for children with special health needs. This system includes, but is not limited to medical, surgical, nursing, nutrition, social work, dental, physical therapy, occupational therapy, speech-language therapy, assistive technology, hearing services, vision services, psychological services, and care coordination services. The Branch also has an objective to prevent and ameliorate the developmental delays by early identification of children with developmental delays or at risk for developmental delays, by providing a range of early intervention services.

The Early Intervention Section (EIS) is responsible for the implementation of Part C of Public Law 108-446, Individuals with Disabilities Education Act (IDEA), including the identification of children with special needs, coordination and provision of early intervention services within the family's natural environment and daily routines and activities.

Early intervention is guided by the IDEA and Hawai‘i's Administrative Rules. Hawai‘i is in the process of finalizing revised Policies and Procedures, Transition Memorandum of Understanding (MOU) between DOH and Department of Education (DOE), and Medicaid Memorandum of Agreement (MOA) between DOH and Department of Human Services (DHS) to support the implementation of the program. Part C Procedural Guidelines are in place to help local programs implement Part C in adherence to IDEA and Hawai‘i's Administrative Rules.

Monitoring and Accountability

The EIS has an EI Continuous Quality Improvement System (CQIS) to ensure effective implementation of Part C services of the IDEA. Characteristics of the EI Continuous Quality Improvement System (CQIS):

- Continuity – An effective state monitoring system must be continuous, rather than episodic, clearly inked to systemic change, and integrating self-assessment with continuous feedback and response.

- Effective Balance between Process and Improved Results – There should be a balance between procedural compliance (measuring the extent to which legal policies, procedures, programs, and effective structures are in place) and an emphasis on improved child and family outcomes. The emphasis on improved results is to determine:
    - Which early intervention strategies are successful and for whom.
    - Which practices get good results
    - Which early intervention programs consistently show improved results for enrolled infants and toddlers and their families.

- How we can improve results for young children for whom current strategies are unsuccessful.
- How we can support families so they are better able to support their children's development.

Through the gathering and sharing of the above information, improved child and family outcomes can be generalized throughout the State.

- Partnership with Stakeholders – Continuous improvement must occur in partnership between all early intervention personnel, parents/families, and other community providers including families' primary care providers, in the continuous improvement of programs and services. An annual stakeholder meeting is held to review the State's progress in complying with IDEA, Part C regulations and to identify improvement activities to support compliance on required OSEP indicators and State priority areas.

- Linkage with other State Accountability Efforts – State continuous improvement efforts must be integrated with other State accountability efforts. To that end, internal reviews will continue to be an important component of the Early Intervention CQIS. Continuous quality improvement data will also be gathered as an integral part of the overall HDOH's Quality Assurance Process.

- Data Driven – The CQIS is driven by data that focuses on improved results for infants and toddlers. State profile data will provide information at the state and local/community level to support needed management and program improvements.

- Multiple Procedures – The CQIS utilizes multiple procedures, including reviews of quantitative measures, self-assessments, external reviews, focus group discussions, interviews with various stakeholders, program observations, and continuous improvement planning.

- Technical Assistance and Support – Technical assistance, training and mentoring from HDOH will support successful intervention strategies and practices in achieving positive results for infants and toddlers and their families.

The CQIS includes a process to:

1. monitor all Part C Programs statewide for compliance with IDEA Part C requirement and state priorities areas identified by EIS;
2. identify areas of compliance and non-compliance with state and federal (Part C) regulations and requirements based on:
    a. Program data in the EI database

b. 618 data
c. Family Outcome Survey
d. EI Self-Assessment Monitoring Tool
e. Coordinated Service Review
f. Complaints and Due Process Hearings

3. support all Part C Programs statewide in the development and implementation of improvement activities;
4. verify the success of the improvement activities;
5. determine what Part C data must be regularly collected and reported;
6. review and analyze data received;
7. develop and implement a process to validate data reported; and
8. write state and federal reports related to compliance with IDEA Part C requirements.

The monitoring process, identification and correction of non-compliance are described in the State Performance Plan/Annual Performance Report (SPP/APR). The FFY 2013 SPP/APR submitted to OSEP on February 2, 2015 is currently being reviewed. All previous SPP/APRs were accepted by OSEP.

Technical Assistance

Technical assistance (TA) is available to EI Programs statewide. Monitoring, complaints, mediation, and due process data may be used to identify and provide TA. Programs may also request targeted TA.

TA providers work with the Program Manager to address areas of need by exploring factors that may be contributing to low performance or sources of concern and provide guidance in developing an improvement plan that includes strategies to address root causes. TA providers also provide and/or link programs with resources and supports.

Professional Development

All EI Providers are qualified personnel and met the minimum education and state licensure/certification/registration outlined in EIS contracts with providers. Programs are required to submit a personnel tracking form that includes current licensure/certification/registration to the EIS Contracts Unit.

EIS offers a mandatory four day EI Orientation to all new staff. A one-day EI Orientation is mandatory for Fee-For-Service (FFS) providers and they may attend the four day EI Orientation at their own expense.

EIS provides an Annual Refresher course and develops and implements training modules to address areas identified as a need.

Data System

The goal of Hawai‘i Early Intervention Data System (HEIDS) is to improve service delivery for children, assist providers in managing their programs, and provide Hawai‘i Part C administration with data for the purpose of assessing compliance with federal and state reporting requirements. All APR indicator data, with the exception of Indicator 1 (Initiation of Timely Services) and Indicator 4 (Family Outcomes) are obtained via HEIDS. (Refer to the APR under the respective sections for an explanation of how data is gathered for Indicator 1 and 4). HEIDS generates child specific data as well as summary reports.

As part of the annual statewide on-site monitoring, data from the database is validated during the randomly selected record review. EIS selects 10% of children at each EI Program based on the December 1 child count or a minimum of 15 child records to be reviewed. Programs are required to make child specific corrections of data errors and provide evidence of correction to ensure any issue has been resolved.

Quality Standards

Hawai‘i uses the Division for Early Childhood (DEC) Recommended Practices in Early Intervention/Early Childhood Special Education 2014 and the Agreed Upon Practices for Providing Services in Natural Environments as the foundation for practices EI provides should use to improve results for children and families being served. Also resources developed by ECTA are used to develop training modules to support staff in implementing evidence based and quality practices.

The Hawai‘i Early Learning Developmental Standards (HELDS) was created as a supplemental guide to describe the development of children birth to five. The guide for infants and toddlers has three distinct phases of development: Building Security (birth – 8 months), Moving and Exploring (8-18 months), and Discovering Identity (8-24 months). Under the direction of the Executive Office of Early Learning (EOEL) Action Strategy Workgroups, there will be statewide training on the HELDS. EI trainers have been identified to participate in the “train the trainer” trainings so all EI providers can learn to use the HELDS as a resource.

Fiscal

Hawai‘i’s system of payments for early intervention services includes public benefits and insurance and private insurance. It does not include family fees, sliding fees, or use of Part B funds. Families do not incur any costs when using public benefits or insurance (e.g., Medicaid, Children’s Health Insurance Program [CHIP], and military health plan [TRICARE] or private insurance). Co-payments, deductibles or other costs related to use of public

benefits or insurance or private insurance are covered by HDOH. The only cost to parents when using public benefits/insurance or private insurance is the on-going payment of insurance premiums for the public benefits or insurance or private insurance policy.

The HDOH uses federal funds for the administration of the early intervention system and other areas including but not limited to:

- Training/conferences
- Monitoring/Quality Assurance
- Family Survey
- Child Find/Public Awareness
- System Support including equipment and operating expenses
- HEICC activities
- Administrative personnel
- Some direct service personnel and costs

Direct early intervention services are primarily funded through state, local and private sources administered by other state agencies and programs. These funding sources include public insurance/Medicaid (QUEST), and private insurance. Contracted POS EI Programs may also generate funds through donations and fundraising activities.

2c. Systems Strengths and Areas for Improvement

The SSIP Leadership Team reviewed the compiled stakeholder input regarding the infrastructure analysis and identified main strengths and areas for improvement that relate directly to the SIMR (improving social-emotional outcomes).

<u>Governance</u>

A. Strengths

Part C EI Procedural Guidelines are in place regarding evaluation and assessment that include social-emotional development and how to access mental health services, including psychological evaluations to support identification of a child's social-emotional needs.

B. Areas for Improvement

State bureaucracy may hinder timely recruitment of EI personnel, establishing revised policies and procedures and MOAs/MOUs. Long term staff vacancies impacts service delivery, whereby a child and family may not receive all the services and supports they need. This can impact on children not making progress in social-emotional

development. Up-dating policies and procedures so Hawai'i Administrative Rules can be up-dated will ensure that Hawai'i's EI system is in accordance with IDEA. Not having up-to-date MOAs/MOUs can negatively impact collaboration between different agencies providing services to children and families. As a result, infant and toddler's social-emotional needs may not be identified and appropriate services and necessary supports and may not be provided.

Monitoring and Accountability

A. Strengths

EIS monitors randomly selected children as part of the annual statewide on-site monitoring of all EI program and reviews a child's BDI-2 scores that includes social-emotional skills and examines if the child is receiving appropriate services to address identified needs. During the on-site monitoring, COS ratings entered in the HEIDS are validated during the record review to ensure data is accurate and reliable.

B. Areas for Improvement

Stakeholders expressed concerns that the BDI-2 is not sensitive enough to assess social-emotional development, especially in young infants and they question the validity of the COS rating process. If staff and families do not have a clear understanding of the COS rating process then it may result in ratings that do not accurately reflect a child's social-emotional skills.

Technical Assistance

A. Strengths

There is a process in place for EI programs to request and receive TA. The Outcomes Coordinator provides on-site TA when requested in addition to providing training as part of the EI Orientation. The availability TA can be leveraged during implementation of the SSIP to enhance providers' understanding and rating of children's social emotional development for the COS measurement process.

B. Areas for Improvement

Although there is a process to request TA, EIS lost six Quality Assurance positions that provided on-site TA statewide. Therefore, local programs feel guidance is not always consistent and timely and can impact programs ability to implement policies, procedures and practices related to improving social emotional outcomes.

Professional Development

A. Strengths

EI providers meet the qualification standards and have a basic understanding of child development which enables them to complete evaluations and assessments and the COS process. EI providers' basic understand of typical child development can be leveraged to support additional training that will increase their ability to consistently identify children's needs in social-emotional areas and provide accurate social-emotional COS ratings.

B. Areas for Improvement

Lack of funding inhibits providers attending trainings, professional development events, etc. and they have identified a need for training in social-emotional development, understanding and implementing the COS process, identifying and writing functional outcomes/objectives to address social-emotional needs of children, and understanding and implementing the primary service provider and coaching model. This lack of funding impacts on providers not having the time to attend training events or receiving the support they need to implement the things they learn through training events or TA received.

Data System

A. Strengths

EIS and local EI programs have access to the BDI-2 Data Manager which shows children's BDI-2 scores in the social-emotional category. COS rating reports are also available in the HEIDS

Although data is collected via two different data systems, data can be cross-referenced and analyzed to ensure that ratings for positive social-emotional skills are supported by the BDI-2 scores.

B. Areas for Improvement

EIS collects statewide data in an outdated data system (non-web-based). It is recognized that EIS needs to move towards a web-based system and integrate multiple data systems into one. Having one data system reduces possible data entry errors, allows analysis to be done within the one system, increases staff efficiency by having to input data into only one system, allows for "real time" data that can be used for data collection, monitoring and accountability, collaboration between team members, etc.

During the infrastructure SWOT analysis at the Stakeholder Meeting in May 2014, stakeholders reported a concern about the validity of the data if staff collect the COS ratings differently. Stakeholders feel if the ratings are subjective then it may not be accurately depicting how a child may be functioning in social-emotional development. The Child Outcome Summary (COS) form was revised to decrease subjective rating scores; however, programs feel training on the COS process is needed.

Quality Standards

A. Strengths

Providers are aware of the Division of Early Childhood (DEC) Recommended Practices and receive training on implementing evidence based and quality practices through the primary service and coaching model.

Hawai‘i has improved in providing services in a child’s natural environment. The Family Directed Assessment (FDA) has helped providers understand what’s working and not working within the child and family’s daily routines and activities and the family’s natural support system. Having a better understanding of parent-child interactions and the social relationships that different family members have will help identify possible needs to provide appropriate services and supports to enhance a child’s social-emotional development.

B. Areas for Improvement

Despite training efforts, there is still inconsistent understanding and implementation of the primary service provider and coaching model. Having a primary service provider, coached by other team members, allows that family to build a relationship with one provider who will be coaching them on weaving the strategies within their family’s daily routines and activities. The inability to effectively implement the primary service provider and coaching model may interfere with the family receiving support to enhance their skills in supporting their child’s social-emotional development.

Providers report that valuable information is obtained from the FDA; however, they would like more training on how to use that information to develop functional IFSP outcomes and objectives that are meaningful to the family. If outcomes and objectives are functional and strategies are implemented within the daily routines and activities, parent-child interactions will be enhanced which will have a positive impact on a child’s social-emotional development.

Fiscal

A. Strengths

EIS is in the process of revising the existing MOA that is in place with DHS, Medicaid Office to receive reimbursement for some early intervention services. EIS has developed a system to receive reimburse from TRICARE for some early intervention services.

EIS also has a system to conduct fiscal monitoring.

B. Areas for Improvement

Funding has been stagnant and lack of resources continues to be an issue. Staff vacancies and the inability to recruit staff in a timely manner impact the program's ability to provide on-going services on a consistent basis. If a family does not receive the support they need to implement the strategies to address their outcomes and objectives, then progress in a child's social-emotional development may be hindered.

Although fiscal monitoring is in place, programs are using an outdated data system and tracking billing corrections within the current database is not feasible. This may impact EIS' ability to efficiently and accurately monitor corrections which increases staff's time to ensure accurate claims are submitted for reimbursement. Any reduction in funding has a negative impact on staffing and their ability to provide services and supports regarding a child's social-emotional development.

EIS needs to explore expanding reimbursement options from funding sources such as Tricare and Medicaid for early intervention services, including intensive behavioral support services for children with Autism. Increase in funding will support the cost of providing intensive services for children's social-emotional development.

2d. State-level Improvement Plans and Initiatives

As part of the gallery walk during the Stakeholder Meeting in May 2014, stakeholders were asked to identify state initiatives. The SSIP Leadership Team used the Initiative Inventory template to identify current and previously implemented initiatives that relate to social-emotional development.

Based on the analysis, it was determined that the Center for the Social-emotional Foundations for Early Learning (CSEFEL) was a previous initiative in Hawai‘i that should be re-initiated and included in the SSIP. Over 900 early childhood providers statewide were training on the CSEFEL Pyramid Model which was an evidence-based training on promoting social-emotional competencies in infants and young children. The following components

of the CSEFEL initiative can be explored during Phase II of the SSIP to support improving social-emotional outcomes for infants and toddler with special needs:

- Effective training practices to increase participants' knowledge on social-emotional development of infants and toddlers;
- Develop an inventory of social-emotional initiatives to document for the SSIP and identify social-emotional resources for EI providers;
- Conduct a follow up survey to see who is actually using the social-emotional curricula (CSEFEL, Second Step) to provide training to EI providers.

Based on participation in previous initiatives, these two areas must be considered from previous initiatives to potentially enhance the development and implementation of the SSIP:

- Ensure sustainability and create collaborative partnerships to ensure on-going success
- Create a web-based data system to provide up-dates of statewide resources

The following three current state initiatives focus on social-emotional health and development:

- Executive Office of Early Learning (EOEL)

  The EOEL was established by Hawai'i Act 178 in 2012. The creation of the EOEL provides Cabinet-level authority to guide the development of a comprehensive and integrated statewide early childhood development and learning system.

  The mission of EOEL is to coordinate efforts to help ensure a solid foundation for Hawai'i's young children, prenatal to age five, by working with partners, families, and communities, and aligning polices and program in relation to health, safety, and school readiness and success.

  EOEL, in partnership with over 50 private and public partners, identified six critical focus areas as building blocks for the establishment of a comprehensive early childhood system. EOEL's action strategy is operationalized and measured based on how well we are supporting a child's development. The following are the six action strategy workgroups and their broad goals:

  1. Healthy and Welcomed Births
     - ✓ Improve pre- and inter-conception care for women
     - ✓ Improve care during pregnancy and delivery
     - ✓ Decrease infant mortality and morbidity in the first year of life

2. Nurturing and Safe Families
   - ✓ Work with state partners to identify child abuse and neglect prevention and intervention supports and services
   - ✓ Develop Nurturing and Safe Families core competencies and trainings for early childhood practitioners
   - ✓ Advance child abuse prevention public awareness program and community engagement

3. On-track Health and Development
   - ✓ Coordinate with partners, a package of comprehensive screenings for early detection
   - ✓ Create a framework for a screening-referral-utilization of services feedback loop within the medical home model
   - ✓ Establish an early childhood tracking and monitoring system to monitor health and development
   - ✓ Implement health and wellness guidelines in early childhood settings
   - ✓ Promote the social and emotional health of infants, toddlers and preschool age children

4. Equitable Access to Programs and Services
   - ✓ Establish virtual, physical and mobile hubs or one-stop-shops to connect families with services
   - ✓ Improve access to state and federal supports for eligible families
   - ✓ Increase families in accessing care and early learning programs in: Home Visitation programs, Licensed Family Child Care, Family-Child Interactive Learning Programs and Center-Based programs
   - ✓ Improve access and supports for dual -language learner families

5. High-quality Early Learning Programs
   - ✓ Coordinate professional development across all program settings on Hawai'i's Early Learning and Development Standards (HELDS); Family Partnership Guidelines (FPGs); and Formative Assessments
   - ✓ Develop a system of Continuous Quality Improvement across all program settings
   - ✓ Support the development of a qualified early childhood workforce

6. Alignment and Transition Support to K-3

    - ✓ Formalize STEPS infrastructure to support transitions between early childhood environments and kindergarten
    - ✓ Create school-based teams comprised of early childhood and K-3 professionals
    - ✓ Create policies and procedures to share information and supports between early learning programs and kindergarten
    - ✓ Inform the development of an Individual Kindergarten Readiness Assessment system

While all six action strategy workgroups focus on supporting a child's development, action strategy workgroups 2 – 5 have specific goals that will support EIS in developing a system to improve infants and toddler's social-emotional development.

There is an EI representative on each of the action strategy workgroups. The EI representative on the respective action strategy workgroups are also members of the SSIP Leadership Team. This will allow the SSIP Leadership Team to align the SSIP plan with the state initiative work being done via the action strategy workgroups.

- ZERO TO THREE Sharing the Care

  ZERO TO THREE Sharing the Care project developed the following eight topical on-line modules:

  1. Creating Partnerships with Families
  2. Social-emotional Development for Infants, Toddlers and Parents
  3. Building a Healthy Brain
  4. Promoting Well-Being and Preventing Maltreatment of Very Young Children
  5. Culture and Caring for Young Children
  6. Understanding Temperament
  7. Responding to Challenges in Young Children's Behavior
  8. Supporting Staff in Working Effectively with Families

  Hawai‘i was one of six cohorts to participate in the ZERO TO THREE Sharing the Care grant opportunity that allowed Hawai‘i to preview the new Sharing the Care training modules that are inter-disciplinary (child welfare, physical health, mental health, early childhood, and early intervention).

Providers identified wanting social-emotional development training. These modules can be used for new staff of refreshers for experience staff regarding social-emotional development.

- Hawai‘i Association for Infant Mental Health

  The mission of the Hawai‘i Association for Infant Mental Health is to "…promote the social and emotional health of Hawai‘i's youngest by building commitment and capacity to foster nurturing relationships, through partnerships, public education, professional training and advocacy."

  Their primary goals and activities include:

  - Promote the understanding of the nature and importance of first relationships in social and emotional development in the first years of life.
  - Build collaborations by identifying and bringing people together working to strengthen early relationships to share information, ideas and efforts to promote the purpose.
  - Provide education to the general public and policy makers about the emotional needs of young children.
  - Provide and coordinate state of the art interdisciplinary training of service providers to enhance holistic and comprehensive interventions.
  - Promote best practices by identifying, synthesizing, and disseminating research and information of best and promising practices; and convening discussions of community and culturally-based innovations.
  - Advocate for services and promote the development and sustainability of a continuum of evidence-based early childhood services.

  Two members of Hawai‘i's Infant Mental Health Association participate on the SSIP Leadership Team to serve as a resource to develop SSIP improvement strategies that is in alignment with their mission.

  Hawai‘i's Infant Mental Health Association provides training on infant mental health that EI providers can attend to increase their awareness and skills in enhancing infants and toddlers social-emotional development. It will also provide an avenue to collaborate and identify community resources for EI providers and for families in meeting the emotional needs of infants and toddlers.

The core components of the current initiatives that should be incorporated into the improvement strategies in the SSIP during Phase II are:

- A system for on-going Professional Development (trainer quality assurance, training quality assurance, training outcomes);
- A mechanism to gather input from families;
- A plan to ensure sustainability;
- An evaluation process to ensure plan is meeting intended outcomes.

Things that must be considered from current initiatives to potentially enhance the development and implementation of the SSIP:

- Awareness at all levels (policy, administrative, community, and family);
- Account for cultural and linguistic diversity (determine what it means for each culture);
- On-going discussions with EI providers and partners/stakeholders so that everyone is working towards a common outcome.

2e. Representatives Involved

Stakeholders involved in developing Phase I of the SSIP include:

- HDOH Administration
- EIS Staff
- SSIP Leadership Team, including representatives from EI local programs, EIS administrators, early childhood state initiatives, infant mental health association, and parents
- HEICC
- DOE
- EIS service providers, including care coordinators, therapists, and psychologists
- Public Health Nursing
- Early Head Start/Head Start
- Department of Human Services – Medicaid
- Learning Disabilities of Hawai‘i (Parent Training Institute)
- EOEL
- Infant Mental Health Association

Additional stakeholders that will be invited to participate in Phase II include representatives from:

- Hawai‘i Home Visiting Network
- Hui Kupa‘a Early Childhood Workgroup

The two above groups currently conduct the Ages and Stages Questionnaire (ASQ) and ASQ: Social-emotional (SE). The ASQ is a screening tool that covers five domains of development, including personal social domain. The ASQ SE monitors a child's development in behavioral areas. Their participation in the SSIP process will allow for collaboration to ensure that children are being referred to EI and linked with services if found eligible.

The CSHNB Chief, FHSD Chief, and the Director of Health will be invited to all broad stakeholder meetings and invited to have input throughout the SSIP process. Other representatives will be invited as deemed necessary.

2f. Stakeholder Involvement in Infrastructure Analysis

The stakeholders participated in a gallery walk activity at the May 2014 Stakeholder Meeting, whereby everyone had an opportunity to contribute in identify strengths, weaknesses, opportunities and threats in six system components: governance, monitoring/accountability, technical assistance/professional development, data, quality standards, and fiscal. The gallery walk was facilitated by TA consultants and SSIP State Team.

A qualitative analysis of this information (see above) provided data needed to confirm root causes. Confirmed root causes were presented at the Stakeholders Meeting in December 2014. Stakeholders used the information to help identify improvement strategies.

Component 3: State Identified Measurable Result (SIMR)

3a. SIMR Statement

Increase the percentage of Hawai‘i’s infants and toddlers who entered early intervention below age expectation in positive social-emotional skills (including social relationships) and who will substantially increase their rate of growth in social-emotional skills (including social relationships) by the time they exit early intervention (Summary Statement 1). These children move closer to functioning like same-aged peers as reflected in the definition of Summary Statement 1: Those children who entered and exited the program below age expectations in social-emotional skills (including social-emotional skills) that substantially increased their rate of growth by the time they exited.

Hawai‘i will focus on improving social-emotional outcomes for all EI children in the state; therefore, the SIMR is the same as APR Indicator 3A (Child Outcomes, Positive Social-emotional Skills). The same targets will be set for Indicators 3 and 11 (SSIP) and will be used to evaluate progress on the SIMR.

3b. Data and Infrastructure Analyses Substantiating the SIMR

Hawai‘i’s selection of improving greater than expected growth in social-emotional skills (including social relationships) for all children in the state was based on a systematic and iterative processes detailed in previous sections on the analyses of data, infrastructure, state initiatives, survey of service providers, and on the continuous discussions with stakeholders throughout the process.

Based on the broad data analysis of child outcome data, the SSIP State Team decided to recommend the focus area be on increasing the percentage of children who exhibit greater than expected growth (SS1), in social-emotional development (including social relationships) based on the following reasons:

- Hawai‘i fell below the national average in 2 of 3 child outcome areas for the percent of children exhibiting greater than expected growth (SS1, and the social-emotional skills outcome area exhibited the lowest percentage and the greatest difference from the national average in comparison to the acquisition of knowledge and skills and taking appropriate actions to meet their needs.
- State trends indicated that greater than expected growth in positive social-emotional skills was below the other two outcome areas and has had a downward trend from FFY 2010 – FFY 2012.
- Social-emotional skills/infant mental health is a high interest topic area (based on discussions with stakeholders/leadership team).

- There is availability of information and resources to support improvement in social-emotional development (based on discussions with stakeholders/leadership team).
- There would be alignment with State initiatives (based on discussions with stakeholders/leadership team).
- The potential to maximize the impact of costly mental health services.
- Social-emotional skills are critical for overall development (based on discussions with stakeholders/leadership team).

The SSIP Leadership Team recommended this as a focus area, and stakeholders concurred after presentations on the data analysis and the initiatives analysis, which identified considerable leverage points to improve social-emotional skills.

3c. SIMR as Child-Family-Level Outcomes

Hawai‘i SIMR is a child-level outcome. Hawai‘i will implement the SSIP statewide with all 20 EI Programs. Progress demonstrated in the SIMR (Indicator 3A, positive social-emotional skills [including social relationships], Summary Statement 1) will be due to individual children showing growth in their social-emotional skills.

3d. Stakeholder Involvement in Selecting the SIMR

As described in components 1 and 2, the stakeholders were involved in different fact gathering activities. In April 2014, based on the broad data analysis, the SSIP Leadership Team recommended focusing on social-emotional development. Stakeholders received a summary of the broad data analysis at the May 2014 Stakeholder Meeting and the webinar held in July 2014. Stakeholders also provided input into the root cause and infrastructure analyses and were provided summaries of those activities at the December 2014 Stakeholder Meeting. Based on the summary of activities and results, as well as the opportunity for discussion and feedback, the stakeholders concurred with the SSIP Leadership Team’s recommendation of focusing on social-emotional skills for the SIMR, as well as focusing on all children in HI as opposed to a subgroup of children or programs.

3e. Baseline Data and Targets/Description of Measure

For Indicator 3A, positive social emotional skills (including social relationships), Summary Statement 1, data will be collected using the ECO Center’s COS form that Hawai‘i revised based on parent and provider input.

Entry COS ratings are collected on all children at the Initial IFSP meeting and exit COS ratings are collected at the Exit IFSP meeting or within one month of exiting EI.

The COS ratings compares the child's status to typical development and progress is calculated by comparing entry and exit ratings. The rating is based on a combination of the following sources:

- the developmental evaluation and assessments;
- professional opinion;
- parent input; and
- level of achievement of IFSP objectives relevant to the outcome.

In the FFY 2013 APR, submitted to OSEP in February 2015, Hawai‘i, with stakeholder support, requested 53.14% be the revised baseline data for Indicator 3A, positive social emotional skills (including social relationships), Summary Statement 1. See table below for Hawai‘i suggested targets for FFY 2013 – FFY 2016. Stakeholders of EI Program Managers supported this recommendation.

Indicator 3A: Positive Social Emotional Skills (including social relationships)

FFY Year	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018
Target	53.14%	53.14%	53.14%	53.14%	54%	55%

Hawai‘i's targets will be consistent with APR Indicator 3A, positive social emotional skills (including social relationships), Summary Statement 1 and based on input from broad stakeholders at the Annual EI Stakeholder meeting.

Component 4: Selection of Coherent Improvement Strategies

4a. How Improvement Strategies were Selected

Stakeholder Meeting – December 2014

Stakeholders were presented with confirmed root causes and their justifications (refer to table on page 10) based on data analysis, infrastructure analysis, family surveys, and EI provider survey. Stakeholders participated in a group activity and identified approximately 40 possible improvement strategies to address the confirmed root causes.

Program Manager Meeting, December 2014

The list of possible improvement strategies generated by the stakeholders was presented to the Program Managers of the 20 local EI Programs. The Program Managers reviewed the list and were asked to prioritize the list by picking the top three improvement strategies that they felt were doable to address the identified root causes.

Leadership Team Meeting, January 2015

The SSIP Leadership Team reviewed the compiled possible improvement strategies that included the Program Managers top three improvement strategies. The SSIP Leadership Team was given the opportunity to add or delete strategies with justifications.

The SSIP Leadership Team suggested that the SSIP Co-Leaders work with the TA consultants to develop a draft of broad improvement strategies to be used to guide the development of the Theory of Action.

Work with TA Consultants, January – February 2015

The SSIP Co-Leaders worked with TA Consultants to develop broad improvement strategies based on specific improvement strategies generated via stakeholder discussions. The following are the broad improvement strategies designed to improve children's social-emotional skills by assisting providers in identifying appropriate services and implementing evidence-based and quality practices that promote families abilities to support their child's social-emotional development:

1. Community Partnerships: Collaborate with community agencies and other state initiatives to increase access to parent support and education regarding social-emotional skills and social relationships.

2. Professional Development and Implementation of Evidence-based Practices: Enhance the statewide system of professional development to increase early

intervention providers knowledge of social-emotional development, development of functional IFSP outcomes/objectives/strategies and implementation of the IFSP using evidence-based and quality practices.

3. Qualified Personnel: Increase the availability of qualified early intervention providers with infant mental health expertise.

4. Continuous Quality Improvement System: Enhance the current Continuous Quality Improvement System (general supervision) to identify, promote, and support best practices in efforts to improve outcomes for children and families, ensure program effectiveness, measure results on continuous improvement activities, and ensure data is accurate and reliable.

SSIP Leadership Team, March 2015

The broad improvement strategies were shared with the SSIP Leadership Team and they were given an opportunity to provide feedback. The SSIP Leadership Team accepted the broad improvement strategies presented to them in March 2015.

4b. How Improvement Strategies are Sound, Logical and Aligned

The improvement strategies are sound and logical because they were created based on the root cause and infrastructure analyses. The SSIP Leadership Team, with the guidance of the TA consultants, developed broad improvement strategies that encompass the specific strategies that should lead to improvement of children's social-emotional development.

Infusing EIS representatives in other state initiatives will help build community partnerships to support EI providers and families in accessing resources related to social-emotional development and enhancing our professional development system by sharing resources for training and preparing qualified personnel to implement evidence based and quality practices that will lead to improved results. Having a mechanism to identify, promote and support best practices of qualified and trained personnel will improve Hawai‘i's EI system.

Based on the confirmed root causes and supporting data/justifications, four strands of action were identified with a broad improvement strategy to address each strand. (Refer to Attachment E for complete Crosswalk of Confirmed Root Causes and Broad Improvement Strategies).

4c. Strategies that Address Root Causes and Build Capacity

The table below shows the specific root causes that the broad improvement strategies addresses.

Broad Improvement Strategy	Confirmed Root Causes
Community Partnerships Collaborate with community agencies and other State initiatives to increase access to parent support and education regarding social-emotional skills and social relationships	Parents lack solid understanding of and expectations for children's social/emotional development & growth, including the importance of the role their interactions with their children have in promoting it.
	Parents could benefit from groups to share strategies to address their children's needs
Professional Development & Implementation of Evidence-based Practices Enhance the statewide system of professional development to increase early intervention providers knowledge of social-emotional development, development of functional IFSP outcomes/objectives/strategies and implementation of the IFSP using evidence-based and quality practices.	Providers have basic understanding of infant/child development in general and social-emotional development, but need more training in this area, in particular for children ages birth to three.
	Providers are not accurately identifying and writing functional outcomes/objectives to address social-emotional needs of the child
	Providers are not trained in or using appropriate services/strategies (i.e. behavior vs. sensory delay) to address social-emotional needs and promote social/emotional development & growth
	Providers do not consistently implement primary service provider and coaching model
	Providers do not understand their roles within the primary service provider and coaching model and have limited collaborative partnerships with families and other team members
	Providers and programs do not have enough training and support for implementation
Qualified Personnel Increase the availability of qualified early intervention providers with infant mental health expertise.	There is not enough money to hire an adequate number of appropriately qualified staff or to provide needed introductory and on-going trainings
Continuous Quality Improvement System Enhance the current Continuous	Not enough TA staff to provide support for EI Programs to use data for program improvement, to develop and implement strategies to address areas of non-compliance, and to provide evidence-based

Quality Improvement System (general supervision) to identify, promote, and support best practices in efforts to improve outcomes for children and families, ensure program effectiveness, measure results on continuous improvement activities, and ensure data is accurate and reliable.	and quality services.

4d. Strategies Based on Data and Infrastructure Analysis

The table below reflects the data from data and infrastructure analysis, SSIP provider survey, Family Outcome Survey and other qualitative and quantitative that supports the confirmed root causes and was used to develop the broad improvement strategy.

Broad Improvement Strategy	Data/Justification
Community Partnerships Collaborate with community agencies and other State initiatives to increase access to parent support and education regarding social-emotional skills and social relationships	• Although the 2014 Family Outcome Survey data indicates that about nine out of ten families said they understood their child's delays and/or needs and were able to help their child get along with others, stakeholders identified during the root cause analysis that parental lack of understanding and expectations for children's social-emotional development and cultural stigma was a roadblock to identifying social-emotional needs and supporting children's development in this area. • Stakeholders identified during the infrastructure SWOT analysis that parent input into the Child Outcome Ratings varies from initial to exit possibly due to not understanding the COS process and understanding social-emotional development.
	• The 2014 Family Outcome Survey (611 responded) indicated that three in ten families responded were not able to talk with other families who have a child with similar needs.
Professional Development & Implementation of Evidence-	▪ Stakeholders questioned during the infrastructure analysis if providers are

based Practices Enhance the statewide system of professional development to increase early intervention providers knowledge of social-emotional development, development of functional IFSP outcomes/objectives/strategies and implementation of the IFSP using evidence-based and quality practices.	defining social-emotional development the same way. ▪ Stakeholders identified during the infrastructure analysis that not everyone is aware of the Hawai`i Early Learning & Development Standards (HELDS) chart as a resource for understanding typical development. ▪ Based on the SSIP Provider Survey: ▪ Staff are less comfortable in understanding age-appropriate social-emotional skills or interpreting functional information about a children's social-emotional skills for younger children – one in four staff are not comfortable in understanding age-appropriate social-emotional skills for children birth to three and three in ten staff are not comfortable interpreting functional information; although comfort increases with age, one in five providers are not comfortable interpreting functional information for children ages two-three. ▪ 63% of providers wanted training on communicating about sensitive issues due to cultural stigma related to mental health services. ▪ 73% of respondents wanted training on challenging behaviors; 65% on autism spectrum disorders (ASD); and 57% on social-emotional (S/E) development.
	• The data and infrastructure analyses indicated concerns with child outcomes data quality for positive social-emotional skills in terms of accuracy and rating validity/reliability. ▪ Based on the SSIP Provider Survey, the BDI-2 is the most commonly used tool for doing entry (97% of respondents) and exit (69%) ratings, but about half of all respondents felt it was not sensitive enough to pick up social-emotional delays among children under one year of age, and four in ten thought it was not sensitive enough for children ages one to <two years.

	▪ Preliminary evidence from the COS/BDI-2 comparison suggests that BDI-2 scores may lack sensitivity at entry and that COS ratings may be inflated at exit. • Based on the SSIP Provider Survey: ▪ Most of the SSIP Provider survey respondents (70%) did not complete a Functional Behavioral Assessment (FBA)/Antecedent-Behavior-Consequence (ABC) prior to referring for a psychological evaluation ▪ Over 60% of the respondents to the SSIP Provider Survey wanted training on the functional-behavioral assessment (FBA), and almost half wanted training on child outcomes summary (COS) ratings (45%) and writing functional outcomes (47%). • Monitors observed during on-site monitoring that objectives are not always functional (many are copied from the BDI-2 test items) and there are minimal objectives to address social-emotional development. • Stakeholders identified during the infrastructure analysis that more guidance is needed regarding functional assessments and translating functional outcomes into functional objectives that can be measured.
	• Based on the SSIP Provider Survey: ▪ 77% of respondents wanted training on coaching; 72% on evidence based practices in social-emotional development; and 63% how to talk to families about sensitive issues. ▪ four in ten programs are not implementing evidence-based interventions related to social-emotional development
	• Documentation and IFSP service page reviewed during monitoring did not always reflect implementation of primary service provider and coaching model. • Stakeholders identified during the infrastructure analysis that there is no clear, consistent

	understanding of the primary service provider model.
	• Progress notes in the child's record (from monitoring) indicate that: ▪ services are frequently delivered using the medical model instead of coaching model (i.e., parents leave therapists alone with children during therapies. ▪ providers may not understand their role on the team and their notes appear duplicative of each other. • Stakeholders identified during the infrastructure analysis that there is: ▪ a lack of training in understanding their roles when serving as the primary service provider vs. serving as a consultant ▪ an insufficient focus on increasing family capacity to help their child ▪ not enough time to implement coaching model ▪ pattern to "teach to the test" that limits or changes how services are provided ▪ uncertainty regarding role (primary service provider or consultant) makes it difficult to coordinate and collaborate on services
	• Monitoring suggests need for training. • Stakeholders identified during the infrastructure analysis that a limited training/TA and access to opportunities for trainings is a major weakness of the system. • Based on the SSIP Provider Survey, the second most commonly identified barrier to providing services to address a child's social-emotional needs was training (60% identified this as a barrier)
Qualified Personnel Increase the availability of qualified early intervention providers with infant mental health expertise.	• Stakeholders identified during the infrastructure analysis that inadequate funding to address the staff vacancies and hiring of qualified personnel impacts the entire system. • Based on SSIP Provider survey, the majority of responders noted schedule conflicts (97%) and

	staff shortage (57%) as barriers to having whole IFSP team present for COS ratings
Continuous Quality Improvement System Enhance the current Continuous Quality Improvement System (general supervision) to identify, promote, and support best practices in efforts to improve outcomes for children and families, ensure program effectiveness, measure results on continuous improvement activities, and ensure data is accurate and reliable.	• All six Quality Assurance positions have been cut • The infrastructure SWOT analysis indicated that programs need technical assistance in using data for program improvement • Stakeholders identified during the infrastructure analysis that there is a lack of staff to provide consistent TA to the EI Programs. • Stakeholders identified during the infrastructure analysis that the database needs to be up-graded to include additional data that provides a more complete picture of what is happening at the program level. • Statewide data for compliance indicators shows slippage which impacts improving results for children: ▪ Timely Services: 69% to 63% ▪ Timely Initial IFSPs: 94% to 90% ▪ Timely IFSP Reviews: 97% to 95% ▪ Timely Annual IFSPs: 96% to 94% • Program Managers report at Quarterly Program Manager meetings that they frequently gap on-going services (cancel service appointments with families to meet other timeline requirements and/or due to staff shortage/vacancies. This was confirmed via on-site monitoring.

4e. Stakeholder Involvement in Selecting Improvement Strategies

As described above, the broad stakeholders developed improvement strategies to address confirmed root causes and each Program Managers of local EI Programs identified their top three improvement strategies that they believed would have a direct impact on the SIMR. The Leadership Team reviewed and provided input into the stakeholders compiled improvement strategies in January 2015 and reviewed and accepted the four final broad improvement strategies during March 2014.

Component 5: Theory of Action

5a. Graphic Illustration

The Theory of Action (refer to Attachment F) is divided into four strands of action that evolved from the broad improvement strategies to address the confirmed root causes:

1. Interagency Collaboration for Parent Support and Education ("Community Partnership" improvement strategy)
2. Professional Development and Technical Assistance ("Professional Development and Implementation of Evidence-based and Quality Practices" improvement strategy)
3. Fiscal ("Qualified Personnel" improvement strategy)
4. Monitoring and Accountability ("Continuous Quality Improvement System" improvement strategy)

The Theory of Action depicts a flow of action steps from the State EI Lead Agency to the Local EI Programs and Providers, to children and families, to achieving the SIMR.

5b. How Improvement Strategies will Lead to Improved Results

<u>Interagency Collaboration for Parent Support and Education</u>

The rationale behind the Interagency Collaboration for Parent Support and Education strand stems from confirmed root causes related to underdeveloped parent knowledge and skills in young children's social-emotional development. Parental participation in community-based parent support groups that focus on parenting skills and parent-to-parent sharing of strategies to address their child's needs could improve their understanding, appropriate expectations, and their skills in supporting their child's social-emotional development. To achieve this, the State EI Lead Agency will build community partnerships to increase access to these support groups. A state-level requirement for EI providers to identify and develop linkages with community-based parent support groups will lead to systematic inclusion of participation in these groups on IFSPs by EI providers, which will encourage parent participation. The Theory of Action graphic shows the connection between these actions, whereby implementation of this broad improvement strategy at the state level will lead to intended outcomes at the EI provider and parent levels, and ultimately to the improvement in children's social-emotional outcomes.

<u>Professional Development and Technical Assistance</u>

The rationale for Professional Development and Technical Assistance (TA) strand stems from confirmed root causes related to EI providers wanting to increase their knowledge of infant/child development and social-emotional development and delivering services with fidelity for children ages birth to three. Enhancing the professional development system to

address EI provider needs will support them in developing and implementing the IFSP with evidence-based and quality practices using the primary service provider and coaching model to meet the social–emotional needs of the children and families they serve. To achieve this, the State EI Lead Agency will develop and provide training, TA, and on-going support to ensure EI programs are successfully addressing children's social-emotional development. A state-level requirement for EI providers to implement the knowledge and skills they acquire through professional development activities will lead to quality IFSPs and service delivery of appropriate services that will enhance parent and child interactions. The Theory of Action graphic shows the connection between these actions, whereby implementation of this broad improvement strategy at the state level will lead to intended outcomes at the EI provider and parent levels, and ultimately to the improvement in children's social-emotional outcomes.

Fiscal

The rationale for the Fiscal strand stems from confirmed root cause that the level of funding hinders the recruitment of qualified staff to serve all the children and families enrolled in the EI program. Obtaining adequate funding will allow the hiring of appropriate number of qualified staff needed to provide the necessary services and supports for children and families. To achieve this, the State EI Lead Agency will increases funding (e.g., through grant writing, legislative support, etc.) to support recruitment, training, and service delivery. A state-level requirement for EI providers to have an appropriate case load to ensure services and supports provided will address social-emotional development and enhance parent and child interactions. The Theory of Action graphic shows the connection between these actions, whereby implementation of this broad improvement strategy at the state level will lead to intended outcomes at the EI provider and parent levels, and ultimately to the improvement in children's social-emotional outcomes.

Monitoring and Accountability

The rationale for the Monitoring and Accountability strand stems from confirmed root cause that there is inadequate TA support to EI programs for program improvement. If EI programs have support to analyze accurate data, they can improve their program performance based on guidance received through TA. To achieve this, the State EI Lead Agency will develop and maintain a web-based data system and develop a system to use the data to assess program performance and make program improvements. A state-level requirement for EI programs and/or EI providers will be to access and use data to initiate program improvement which will enhance the EI providers ability to implement evidence-based and quality practices to improve children's social-emotional skills. The Theory of Action graphic shows the connection between these actions, whereby implementation of this broad improvement strategy at the state level will lead to intended outcomes at the EI provider and parent levels, and ultimately to the improvement in children's social-emotional outcomes.

5c. Stakeholder Involvement in Developing the Theory of Action

The Theory of Action was developed based on the input stakeholders provided regarding root cause and infrastructure analysis, EI provider survey, and improvement strategies. The SSIP Co-Leaders worked with the TA Consultants to organize the information into a Theory of Action. The draft Theory of Action and Crosswalk of Root Causes and Broad Improvement Strategies were shared with the SSIP Leadership Team for their review to ensure the Theory of Action addressed the improvement strategies and that it flowed from the State EI Lead Agency to EI Programs and/or Providers, to children and families to achieving Hawai‘i’s SIMR . The Theory of Action was finalized in March 2015.

Hawai'i Part C SSIP Leadership Team Roster

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CSHNB: Children with Special Health Care Needs Branch
ECSP: Early Childhood Services Program
EIP: Early Intervention Program
EIS: Early Intervention Section
FHSD: Family Health Services Division
PHNB: Public Health Nurse Branch

Hawai`i Part C State Systemic Improvement Plan (SSIP)
Social-Emotional Child Outcomes Analyses

Report Date 5/14/14

Rationale for Selecting Social-emotional Skills

EI intends to increase the rate of growth of enrolled children so that they "catch up" or do not develop delays. Hawai`i has a lower percentage of children with a substantially increased rate of growth compared to the nation in social-emotional development and knowledge and skills.

Figure 1. Summary Statement 1

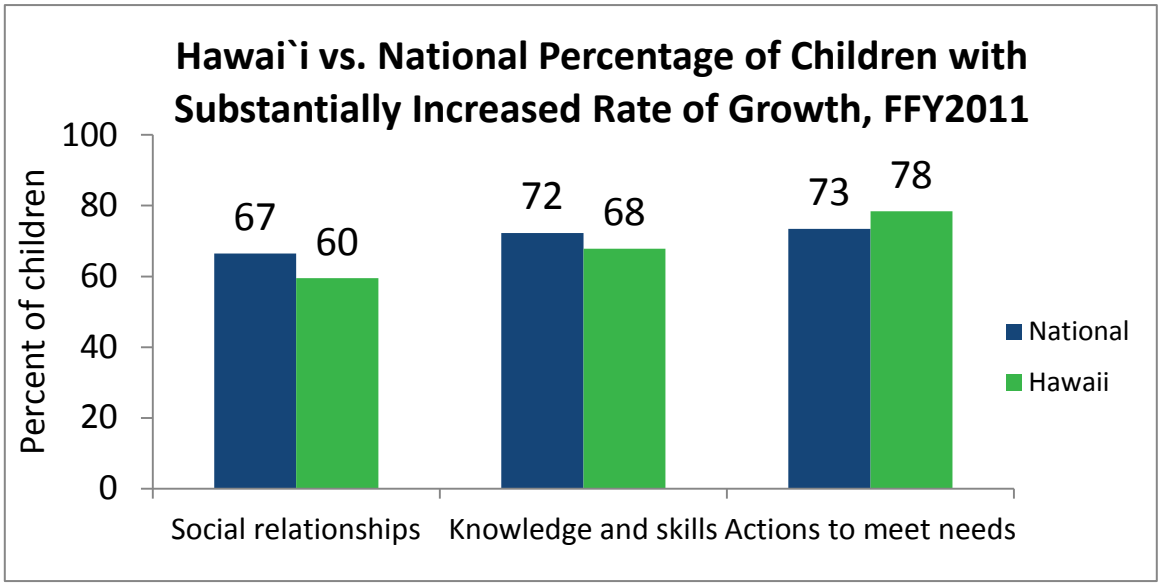
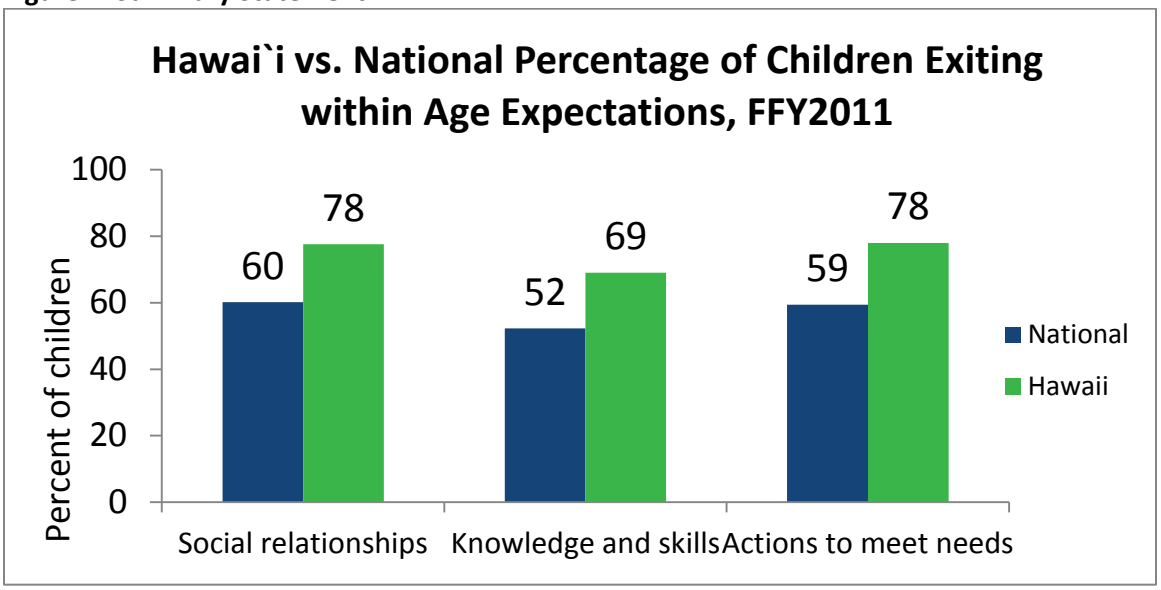


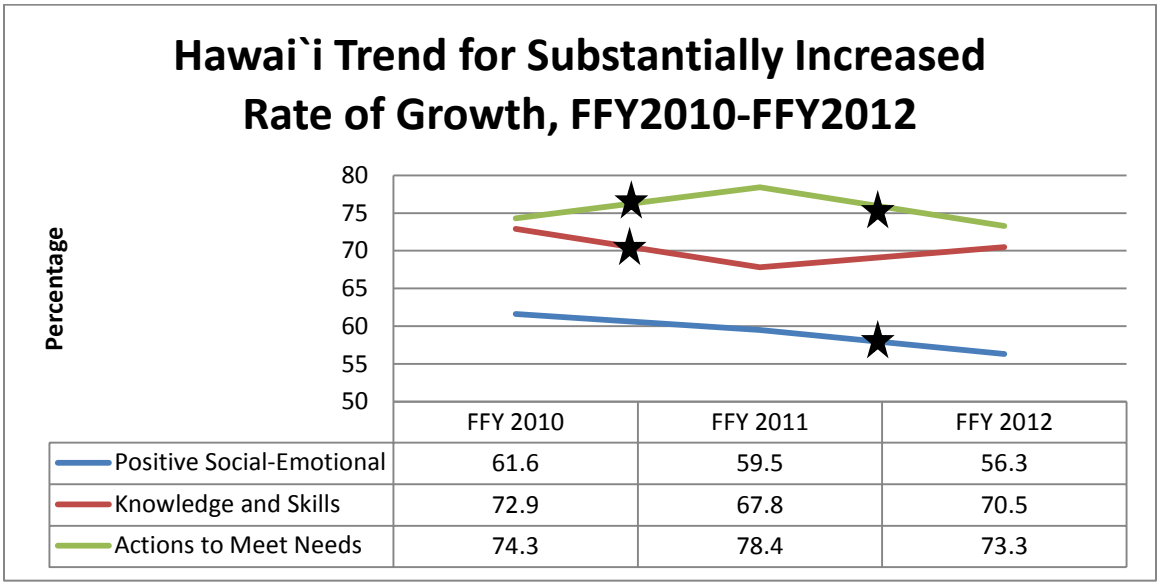
Figure 2. Summary Statement 2



Note: National data based on 33 states with highest-quality data

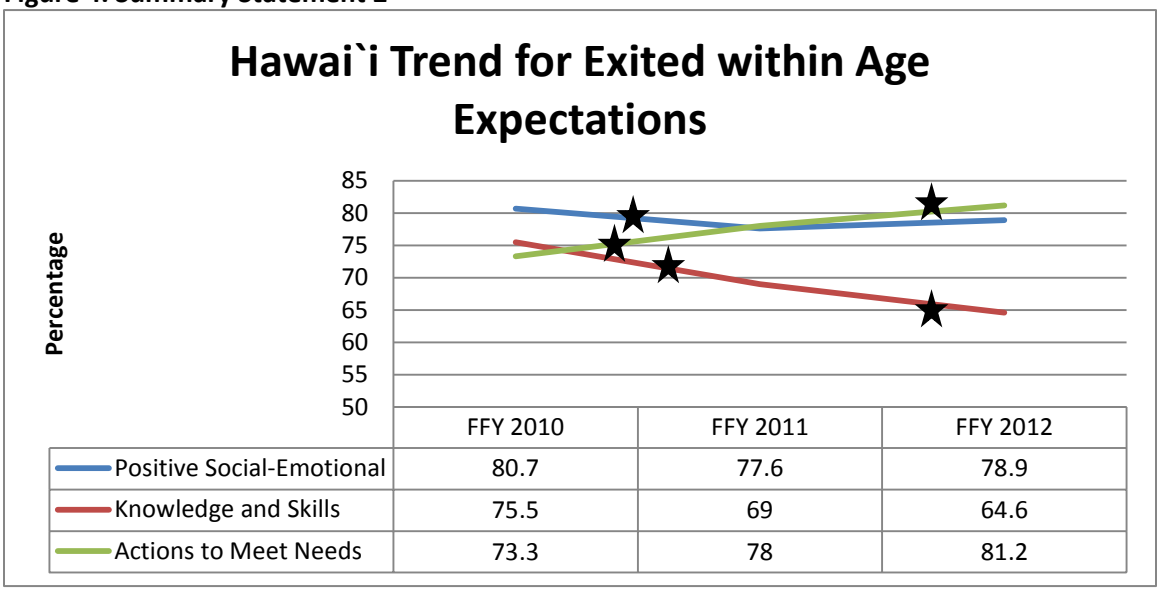
Hawai`i state trends from FFY2010 to 2012 indicate a decline in substantially increased rate of growth for social-emotional development. In addition, there are fewer children with substantially increased rate of growth in the social-emotional area in comparison to the other 2 areas.

Figure 3. Summary Statement 1



	FFY 2010	FFY 2011	FFY 2012
Positive Social-Emotional	61.6	59.5	56.3
Knowledge and Skills	72.9	67.8	70.5
Actions to Meet Needs	74.3	78.4	73.3

Figure 4. Summary Statement 2



	FFY 2010	FFY 2011	FFY 2012
Positive Social-Emotional	80.7	77.6	78.9
Knowledge and Skills	75.5	69	64.6
Actions to Meet Needs	73.3	78	81.2

★ Meaningful difference from previous year

OSEP Progress Categories

#	OSEP Reporting Categories
a	"no" on question a on all ratings
b	"yes" at least once on question a First rating is higher than second rating OR First rating equals last rating, but less than 6 or 7
c	First rating is lower than last rating and lower than 6 or 7
d	First rating is lower than 6 and last rating is 6 or 7
e	First and last rating is a 6 or 7

Reporting Category	Using ECO's COSF
a. % of children who did not improve functioning	Children who are scored lower at exit than entry (or are scored a 1 at both entry and exit) and never received a "yes" on question a.
b. % of children who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers.	Children who are scored a 5 or lower at entry, scored the same or lower at exit and received a "yes" on question a at least once
c. % of children who improved functioning to a level nearer to same-aged peers but did not reach it.	Children who are scored higher at exit than entry but did not reach a 6 or 7.
d. % of children who improved functioning to reach a level comparable to same-aged peers.	Children who are scored a 5 or lower at entry and a 6 or 7 at exit.
e. % of children who maintained functioning at a level comparable to same-aged peers.	Children who are scored a 6 or 7 at both entry and exit.

SUMMARY STATEMENT 1

Of those infants and toddlers who entered or exited
early intervention below age expectations,
the percent who substantially increased their rate of growth
by the time they turned 3 years of age or exited the program.

$$\frac{c+d}{(a+b+c+d)100}$$

SUMMARY STATEMENT 2

The percent of infants and toddlers who were functioning
within age expectation by the time
they turned 3 years of age or exited the program.

$$\frac{d+e}{[(a)+(b)+(c)+(d)+(e)]100}$$

Subgroup Comparisons for OSEP Progress Categories for Social-emotional Skills

Figure 5. OSEP Progress Categories by Federal Fiscal Year

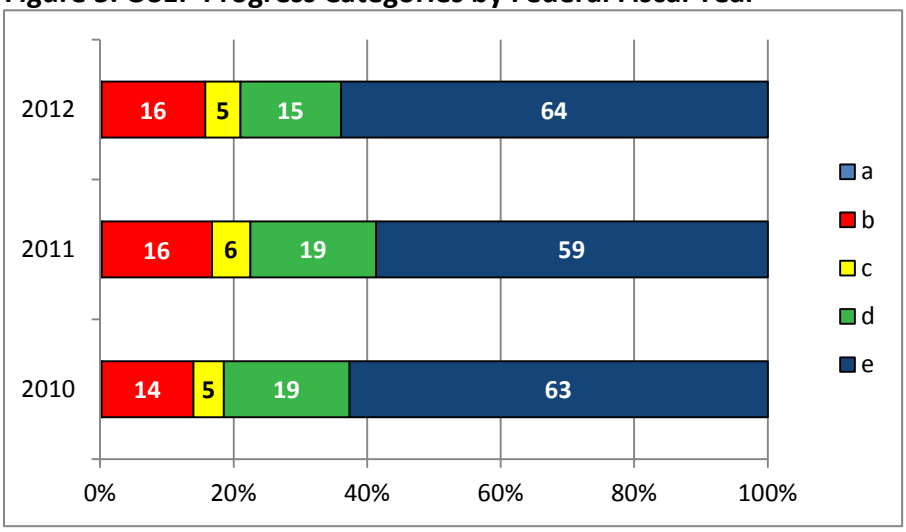
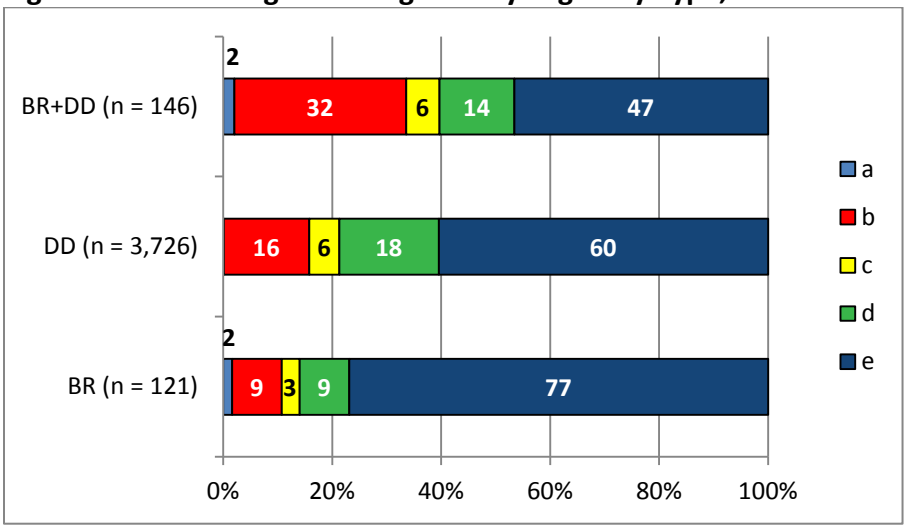


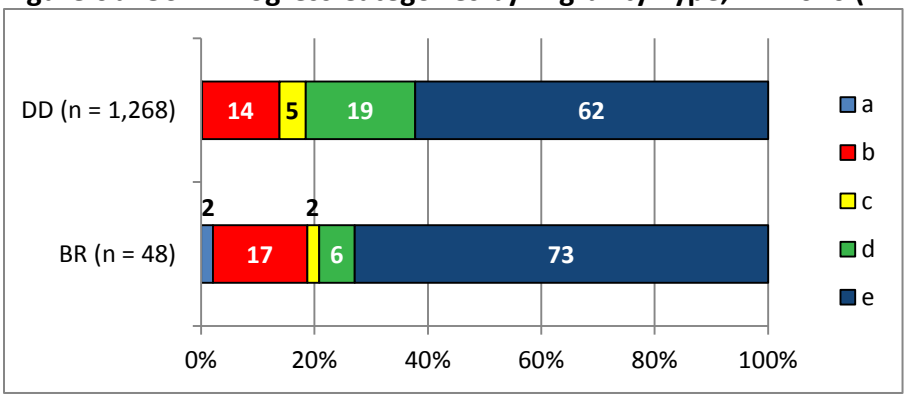
Figure 6a indicates that there is a relationship between OSEP Progress Categories for social-emotional skills and eligibility type. Almost 9 in 10 children eligible due to biological risk (BR) maintained or achieved age-level functioning (d + e). More children with developmental delays (DD) did not achieve age-level functioning (22%), and this group of children represents the largest eligibility category in Hawai`i (93% of children with entry and exit ratings). Almost 4 in 10 children eligible due to biological risk and developmental delay (BR + DD) were not functioning on par with their peers at exit from EI.

Figure 6a. OSEP Progress Categories by Eligibility Type, FFY2010-FFY2012 (N = 3,993)



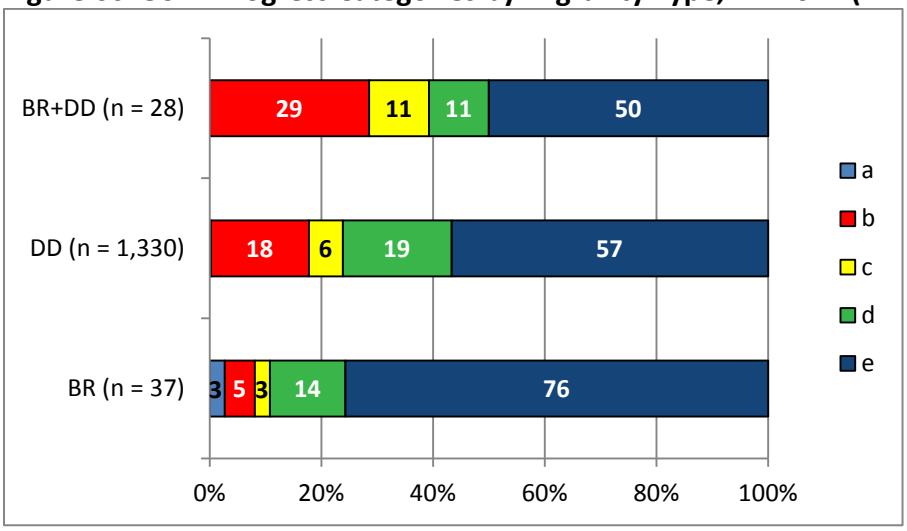
Note: BR = Biological risk; DD = Developmental Delay

Figure 6b. OSEP Progress Categories by Eligibility Type, FFY2010 (n = 1,316)



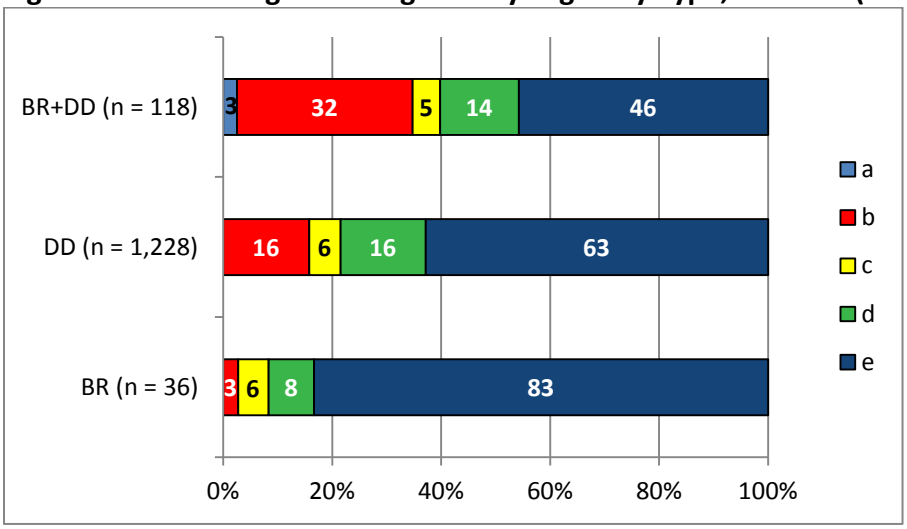
Note: BR = Biological risk; DD = Developmental Delay; BR+DD

Figure 6c. OSEP Progress Categories by Eligibility Type, FFY2011 (n = 1,395)



Note: BR = Biological risk; DD = Developmental Delay; BR+DD

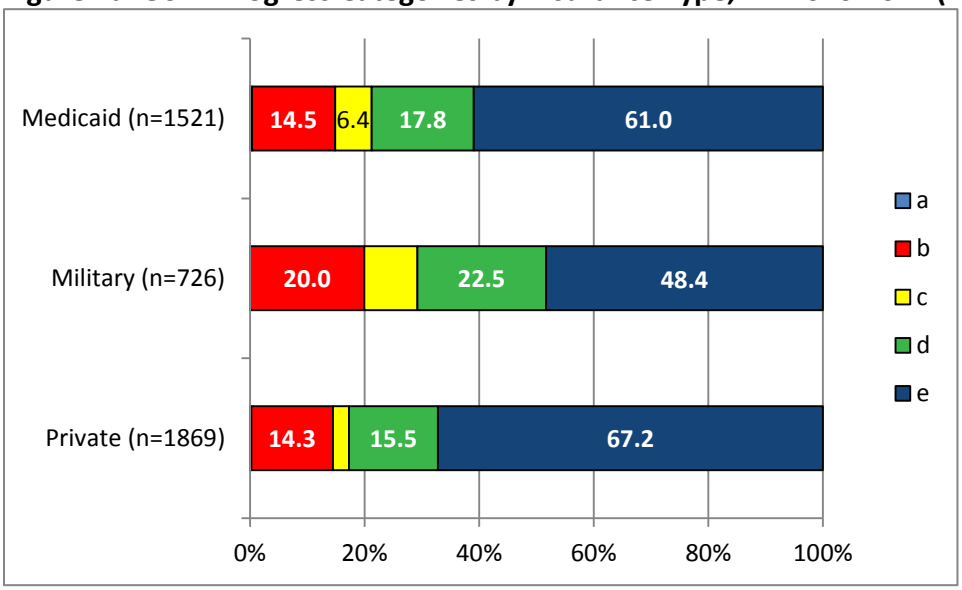
Figure 6d. OSEP Progress Categories by Eligibility Type, FFY2012 (n = 1,282)



Note: BR = Biological risk; DD = Developmental Delay; BR+DD

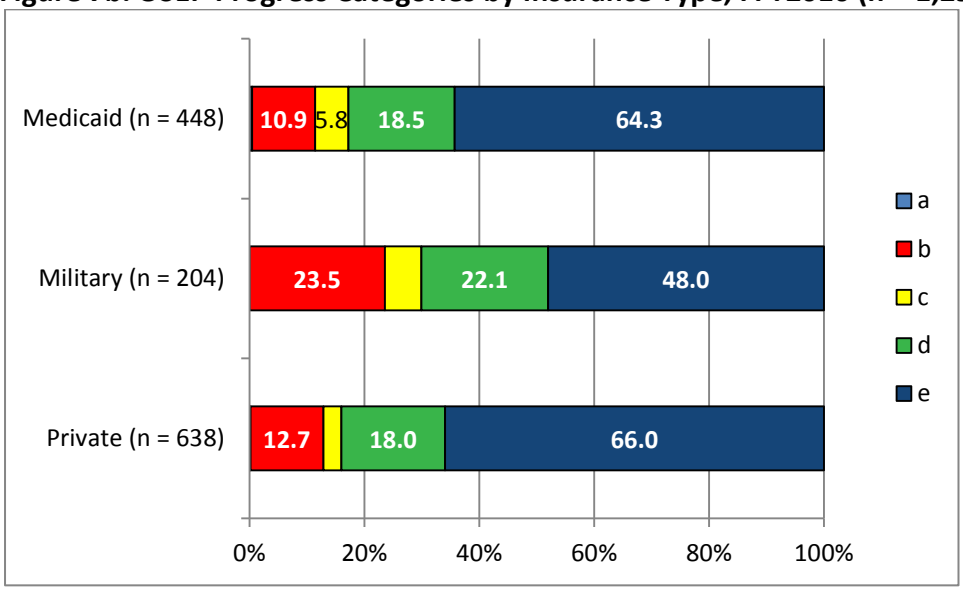
Figure 7a indicates that there is also a relationship between OSEP Progress categories and type of insurance. About 3 in 10 children with military insurance and about 2 in 10 children with Medicaid (QUEST) did not achieve age-level functioning, compared to about 1 in 10 children with private insurance.

Figure 7a. OSEP Progress Categories by Insurance Type, FFY2010-2012 (N = 4,131)



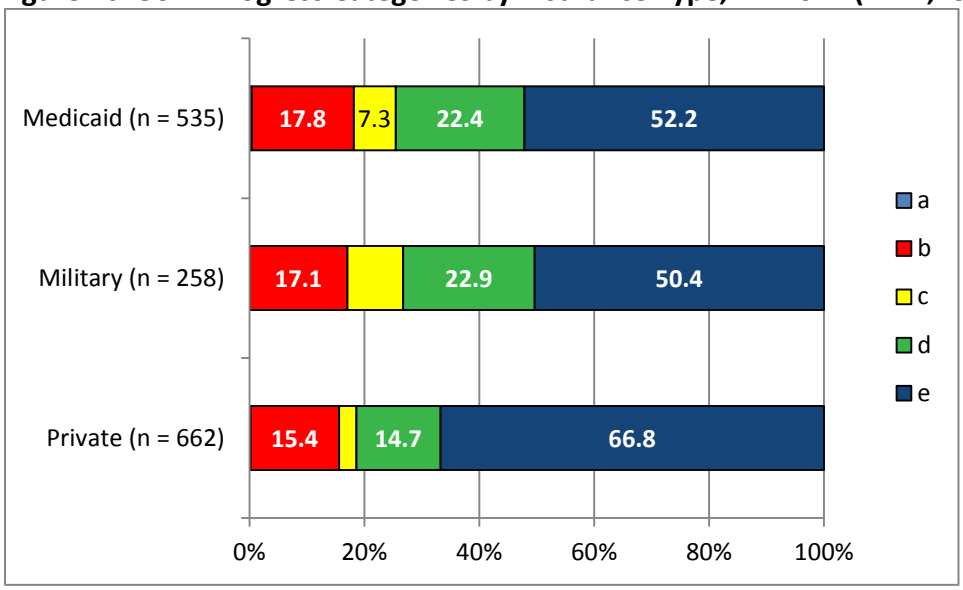
Note: Children with Medicaid (QUEST) and military (TRICARE) or private insurance were classified under Medicaid.

Figure 7b. OSEP Progress Categories by Insurance Type, FFY2010 (n = 1,296)



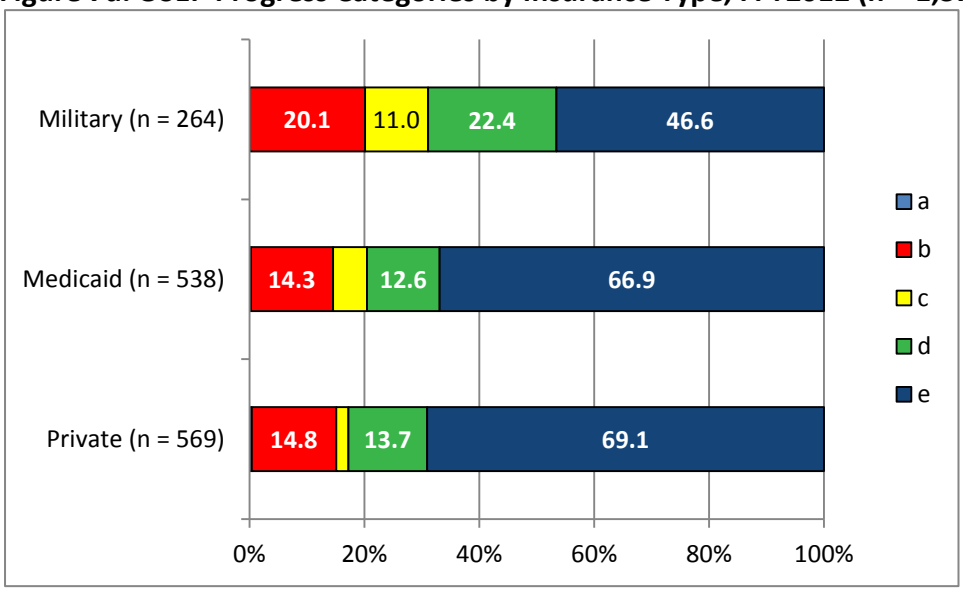
Note: Children with Medicaid (QUEST) and military (TRICARE) or private insurance were classified under Medicaid.

Figure 7c. OSEP Progress Categories by Insurance Type, FFY2011 (n = 1,431)



Note: Children with Medicaid (QUEST) and military (TRICARE) or private insurance were classified under Medicaid.

Figure 7d. OSEP Progress Categories by Insurance Type, FFY2012 (n = 1,374)



Note: Children with Medicaid (QUEST) and military (TRICARE) or private insurance were classified under Medicaid.

Table 1. OSEP Progress Categories and Summary Statements 1 and 2 by Program, Federal Fiscal Year 2012

		a Did not Improve Functioning		b Improved Functioning but not Comparable to Same-Aged Peers		c Improved Functioning Close to Level of Same Same-Aged Peers		d Improved Functioning to Level of Same-Aged Peers		e Maintained Functioning at Level of Same-Aged Peers		SS1 Substantially Increased Rate of Growth	SS2 Exited at Age Expectations
	N	n	%	n	%	n	%	n	%	n	%	%	%
State	1400	3	0.2	218	15.6	74	5.3	211	15.1	894	63.9	56.3	78.9
A	83	0	0.0	9	10.8	0	0.0	13	15.7	61	73.5	59.1	89.2
B	58	0	0.0	11	19.0	2	3.5	5	8.6	40	69.0	38.9	77.6
C	7	0	0.0	2	28.6	0	0.0	3	42.9	2	28.6	60.0	71.4
D	7	0	0.0	1	14.3	1	14.3	0	0.0	5	71.4	50.0	71.4
E	141	0	0.0	22	15.6	8	5.7	19	13.5	92	65.3	55.1	78.7
F	93	0	0.0	12	12.9	7	7.5	16	17.2	58	62.4	65.7	79.6
G	83	0	0.0	9	10.8	3	3.6	15	18.1	56	67.5	66.7	85.5
H	28	1	3.6	13	46.4	0	0.0	6	21.4	8	28.6	30.0	50.0
I	161	1	0.6	22	13.7	11	6.8	18	11.2	109	67.7	55.8	78.9
K	64	0	0.0	8	12.5	0	0.0	4	6.3	52	81.3	33.3	87.5
L	28	1	3.6	4	14.3	3	10.7	5	17.9	15	53.6	61.5	71.4
M	56	0	0.0	7	12.5	3	5.4	9	16.1	37	66.1	63.2	82.1
N	84	0	0.0	20	23.8	11	13.1	11	13.1	42	50.0	52.4	63.1
O	10	0	0.0	2	20.0	0	0.0	0	0.0	8	80.0	0.0	80.0
P	91	0	0.0	12	13.2	8	8.8	20	22.0	51	56.0	70.0	78.0
Q	71	0	0.0	11	15.5	1	1.4	12	16.9	47	66.2	54.2	83.1
R	95	0	0.0	7	7.4	3	3.2	13	13.7	72	75.8	69.6	89.5
S	108	0	0.0	18	16.7	3	2.8	13	12.0	74	68.5	47.1	80.6
T	84	0	0.0	18	21.4	5	6.0	25	29.8	36	42.9	62.5	72.6
U	48	0	0.0	10	20.8	5	10.4	4	8.3	29	60.4	47.4	68.8

The analysis of social-emotional outcomes showed a relationship between outcomes and eligibility type. Programs serve different proportions of children in the three eligibility groups. Differences in outcomes across programs need to be interpreted with regard to the eligibility types of children served.

Table 2. Program by Eligibility Type, Federal Fiscal Year 2012

		Biological Risk		Developmental Delay		BR + DD	
	N	n [a]	%	n [a]	%	n [a]	%
State	1374	40	2.9	1208	87.9	126	9.2
A	89	5	5.6	72	80.9	12	13.5
B	78	5	6.4	66	84.6	7	9.0
C	7	0	0.0	5	71.4	2	28.6
D	7	0	0.0	6	85.7	1	14.3
E	128	2	1.6	113	88.3	13	10.2
F	85	1	1.2	83	97.7	1	1.2
G	61	5	8.2	48	78.7	8	13.1
H	32	2	6.3	4	12.5	26	81.3
I	152	2	1.3	140	92.1	10	6.6
K	59	7	11.9	45	76.3	7	11.9
L	28	0	0.0	27	96.4	1	3.6
M	58	2	3.5	51	87.9	5	8.6
N	80	0	0.0	75	93.8	5	6.3
O	11	0	0.0	11	100.0	0	0.0
P	92	1	1.1	91	98.9	0	0.0
Q	82	1	1.2	75	91.5	6	7.3
R	94	6	6.4	84	89.4	4	4.3
S	105	1	1.0	93	88.6	11	10.5
T	83	0	0.0	78	94.0	5	6.0
U	43	0	0.0	41	95.4	2	4.7

[a] Excludes children with date of entry rating earlier than date of birth & ineligible children.

The analysis of social-emotional outcomes showed a relationship between outcomes and insurance type. Programs serve different proportions of children with different types of children. Differences in outcomes across programs need to be interpreted with regard to the insurance types of children served.

Table 3. Program by Insurance Type, Federal Fiscal Year 2012

		Medicaid [a]		Military		Private		Uninsured	
	N	n	%	n	%	n	%	n	%
State	1466	593	40.5	275	18.8	595	40.6	3	0.2
A	90	20	22.2	4	4.4	66	73.3	0	0.0
B	82	59	72.0	0	0.0	23	28.1	0	0.0
C	7	7	100.0	0	0.0	0	0.0	0	0.0
D	7	5	71.4	0	0.0	2	28.6	0	0.0
E	141	58	41.1	4	2.8	78	55.3	1	0.7
F	87	22	25.3	37	42.5	27	31.0	1	1.2
G	87	23	26.4	4	4.6	60	69.0	0	0.0
H	29	15	51.7	4	13.8	10	34.5	0	0.0
I	163	57	35.0	36	22.1	70	42.9	0	0.0
K	65	37	56.9	0	0.0	28	43.1	0	0.0
L	31	22	71.0	1	3.2	8	25.8	0	0.0
M	61	33	54.1	5	8.2	23	37.7	0	0.0
N	77	21	27.3	33	42.9	23	29.9	0	0.0
O	14	10	71.4	0	0.0	4	28.6	0	0.0
P	98	9	9.2	74	75.5	15	15.3	0	0.0
Q	82	64	78.1	2	2.4	15	18.3	1	1.2
R	97	45	46.4	13	13.4	39	40.2	0	0.0
S	106	35	33.0	5	4.7	66	62.3	0	0.0
T	93	24	25.8	50	53.8	19	20.4	0	0.0
U	49	27	55.1	3	6.1	19	38.8	0	0.0

[a] Children with Medicaid (QUEST) and any other type of insurance (military or private) were categorized as Medicaid.

Entry by Exit Rating Comparisons

Table 4. Entry by Exit Social-emotional Ratings, FFY10-FFY12

State Overall		Exit							Total
		1	2	3	4	5	6	7	
Entry	1	5	6	6	5	6	2	3	33
	2	5	2	23	9	9	10	11	69
	3	3	6	16	32	55	36	36	184
	4	2	4	9	22	63	58	63	221
	5	3	6	22	27	167	212	261	698
	6	1	1	11	23	79	212	433	760
	7	2	8	20	23	129	217	1513	1912
Total		21	33	107	141	508	747	2320	3877

Table 5. Percent of Children Showing Different Patterns of Change in Ratings between Entry and Exit by Federal Fiscal Year

		Extent of Change in Social-emotional Ratings Between Entry and Exit (Percent)				
	Number of children	Decreased by 2 or more (red below)	Decreased by 1 (blue)	No change (yellow)	Increased by 1 (green)	Increased by 2 or more (red above)
FFY10-FFY12	3877	7	9	50	19	15
FFY10	1239	5	8	50	22	15
FFY11	1346	8	10	47	19	16
FFY12	1292	13	9	52	18	7

Note: Only includes children who were at least 6 months old at entry.

Table 6. Percent of Children Showing Different Patterns of Change in Ratings between Entry and Exit by Eligibility for Federal Fiscal Year 2012

		Extent of Change in Social-emotional Ratings Between Entry and Exit (Percent)				
	Number of children	Decreased by 2 or more (red below)	Decreased by 1 (blue)	No change (yellow)	Increased by 1 (green)	Increased by 2 or more (red above)
BR	23	0	4	74	17	4
DD	1087	7	9	51	19	13
BR + DD	72	18	13	38	18	14

Note: Only includes children who were at least 6 months old at entry. BR = Biological Risk; DD = Developmental Delay

Table 7. Percent of Children Showing Different Patterns of Change in Ratings between Entry and Exit by Type of Insurance for FFY12

		Extent of Change in Social-emotional Ratings Between Entry and Exit (Percent)				
	Number of children	Decreased by 2 or more (red below)	Decreased by 1 (blue)	No change (yellow)	Increased by 1 (green)	Increased by 2 or more (red above)
Medicaid	486	7	8	54	19	12
Military	259	9	8	39	23	19
Private	519	6	9	49	14	9

Note: Only includes children who were at least 6 months old at entry. Children with Medicaid insurance (QUEST) and military (TRICARE) or private insurance were classified under public.

Hawai`i Part C State Systemic Improvement Plan (SSIP)
BDI and COS Ratings Analyses

Report Date 12/8/14

The purpose of these analyses is to investigate hypotheses about root causes regarding data on the positive social emotional skills (SE) outcome for children in Hawai`i.

1. Hypothesis 1: COS scores are artificially inflated in comparison to the data from the BDI-2 scores, in particular for the entry rating.
2. Hypothesis 2: the BDI-2 is not sensitive enough to pick up delays in this outcome area, again particularly when children are younger.

Analysis 1: This analysis provides information related to hypothesis 1.

An examination of the means and standard deviations of COS ratings at entry and exit across the 3 COS areas (Table 1) indicates that the SE area has a higher mean entry rating compared to the other 2 areas. The standard deviation (S) for SE at entry is lower than for the other 2 areas, suggesting a narrower distribution of ratings (i.e., more clustered at the higher end). At exit, SE has a slightly lower mean and the same SD as actions to meet needs (AN). The exit means for these 2 areas are higher than knowledge and skills (KS), and the SDs are lower suggesting more clustering at the higher end of the distribution for both SE and AN. This pattern is somewhat consistent with the hypothesis that SE ratings may be inflated in comparison to the other 2 areas. Additional examination of BDI scores and other information used to determine the ratings would be needed to confirm this hypothesis.

Table 1. Means and Standard Deviations of the Three COS Areas at Entry and Exit, Hawai'i (August 2009 to July 2014)

	Positive Social Emotional Skills	Knowledge and Skills	Actions to Meet Needs
Means			
Entry	6.0	4.8	5.6
Exit	6.2	5.8	6.3
Standard Deviations			
Entry	1.4	1.6	1.5
Exit	1.2	1.4	1.2

Analysis 2: This analysis provides information related to hypothesis 1.

The mean of the BDI Personal-Social Z Score was calculated for children grouped by their COS ratings for both entry and exit (i.e., the Z score mean was calculated for all children with a COS rating of 1, the mean was calculated for all children with a rating of 2, and so on). If there is no COS score inflation, we expect to see an increasing stair step pattern where the Z score mean increases with each increase in COS score. The BDI Z score mean for children with COS ratings of 1-2 should be ≤ -1.4, based on Hawai`i's cut point for delay. Because other things can be taken into consideration in assigning the COS scores, the Z score means for children with COS ratings of 3-5 might not be below -1.4 or -1.0, but they should be below 0 (which represents average for the Z score). Children with COS ratings of 6 should have a Z score mean near 0, and it should not be below -1.0. Children with COS ratings of 7 should have a non-negative Z score mean.

Figures 1 and 2 indicate a stair step pattern of increasing Z score means for each increase in COS ratings, and the means are within expected ranges described above. This pattern is not consistent with the hypothesis of COS score inflation at entry or exit.

Figure 1. Entry BDI Personal Social Z Scores by Means COS Entry Social Emotional Skills (Outcome 1)

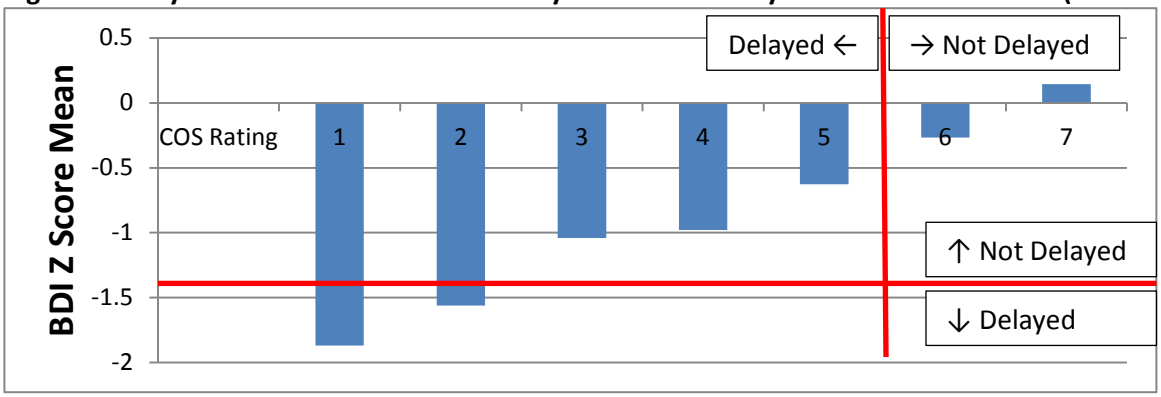
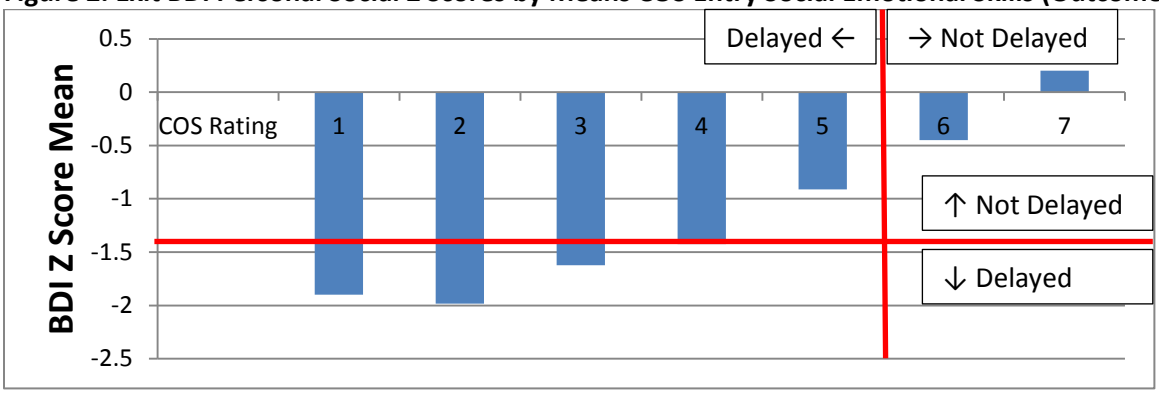


Figure 2. Exit BDI Personal Social Z Scores by Means COS Entry Social Emotional Skills (Outcome 1)



Analysis 3: This analysis provides some information related to hypothesis 1 and 2.

Children were grouped into BDI – age appropriate and BDI – delayed Using Hawai`i's eligibility criteria of BDI Z score ≤ -1.4 as indicative of a developmental delay. The social emotional COS ratings were also grouped into COS – age appropriate (ratings 6 & 7) and COS – delayed (ratings 1-5). A cross-tab of these 2 categories indicates the degree of agreement between the 2 measures. Inflation of COS ratings would be suggested if a relatively high percent (e.g., > 20%) of children were rated as age appropriate on the COS when the BDI indicated they were delayed (purple highlighted cell c, Figures 3 & 4). Conversely, lack of BDI sensitivity in picking up social-emotional needs would be suggested by a relatively high percent of children who were rated as age appropriate on the BDI but the COS indicated delay (peach highlighted cell c, Figures 3 & 4).

Table 3 suggests that the BDI might not be sensitive enough to pick up social-emotional needs, as 21% of the children were rated as age appropriate on the BDI but received a delayed COS rating. Since we do not see this pattern at exit (Table 4), this provides further support for hypothesis 2, that the BDI-2 is not sensitive enough to pick up delays in this outcome area, particularly when children are younger (i.e., at entry).

Table 3. BDI Entry by COS Entry (Hawai`i)

	COS – Age Appropriate (row %)	COS – Delayed (row %)
BDI – Age Appropriate	a. 1033 (78%)	b. 280 (21%)
BDI - Delayed	c. 19 (13%)	d. 122 (87%)

Table 4. BDI Exit by COS Exit (Hawai`i)

	COS – Age Appropriate (row %)	COS – Delayed (row %)
BDI – Age Appropriate	a. 551 (86%)	b. 67 (11%)
BDI - Delayed	c. 24 (28%)	d. 59 (68%)

Table 4 suggests that there may be COS score inflation at exit, as 28% were rated as age appropriate on the COS despite a delayed BDI score.

Although the BDI and COS categorizations are not in agreement for children in cells b and c, we cannot definitively conclude that the COS is inflated or the BDI is not sensitive enough without examining the children's files to consider other evidence that was taken into consideration by the IFSP team (clinicians, providers, and parents). A case review of a sample of children's files in categories c and b might provide additional information to enable a conclusion about COS score inflation or BDI lack of sensitivity.

Tables 5 and 6 present the number and percentage of children in each program, at entry and exit, respectively, with BDI-COS mismatches suggesting potential COS inflation or poor BDI sensitivity.

Table 5. Entry Miss-Matches in COS Ratings and BDI Scores by Program

Program	Entry COS Scores Miss-Matched to BDI Scores Suggesting COS Inflation		Entry COS Scores Miss-Matched to BDI Scores Suggesting Poor BDI Sensitivity		Total Records
	n	%	n	%	
East Sultan Easter Seals	0	0	18	21	87
Hilo Easter Seals	2	3	12	16	76
IMUA Lanai	0	0	2	29	7
IMUA Maui	1	1	21	15	138
Ikaika-Molokai	1	17	4	67	6
Kailua Easter Seals	0	0	13	14	93
Kapiolani Medical Center Central EIP	2	2	16	18	88
Kapiolani Medical Center EIP	1	3	5	17	30
Kapolei Easter Seals	3	2	26	16	159
Kau Child Development Program	0	0	0	0	4
Kauai Easter Seals	3	5	7	11	64
Kona Child Development Program	1	3	10	33	30
Lanakila ECSP	0	0	11	18	61
Leeward ECSP	2	2	19	23	84
North Hawaii Child Development Program	0	0	0	0	13
Parent Child Development Center Wahiawa	0	0	36	38	96
Parent Child Development Center Waianae	0	0	15	19	79
Parent Child Development Center Waipahu	1	1	13	14	95
Sultan Easter Seals	0	0	14	14	103
United Cerebral Palsy Child Development Center	2	2			
Windward ECSP	0	0	11	23	48
Total	**19**		**280**		**1454**

Table 6. Exit Miss-Matches in COS Ratings and BDI Scores by Program

Program	Exit COS Scores Miss-matched to BDI Scores Suggesting COS Inflation		Exit COS Scores Miss-matched to BDI Scores Suggesting Poor BDI Sensitivity		Total Records
	n	%	n	%	
East Sultan Easter Seals	1	2	3	6	50
Hilo Easter Seals	1	3	6	19	31
IMUA Lanai	0	0	1	33	3
IMUA Maui	5	6	3	4	77
Ikaika-Molokai	0	0	0	0	2
Kailua Easter Seals	1	2	2	4	48
Kapiolani Medical Center Central EIP	0	0	3	5	57
Kapiolani Medical Center EIP	1	8	1	8	12
Kapolei Easter Seals	1	2	5	8	59
Kau Child Development Program	0	0	0	0	1
Kauai Easter Seals	2	6	3	9	33
Kona Child Development Program	0	0	2	17	12
Lanakila ECSP	1	3	4	10	39
Leeward ECSP	4	9	5	11	45
North Hawaii Child Development Program	0	0	0	0	4
Parent Child Development Center Wahiawa	0	0	6	18	34
Parent Child Development Center Waianae	0	0	4	13	32
Parent Child Development Center Waipahu	2	5	2	5	43
Sultan Easter Seals	3	5	7	13	56
United Cerebral Palsy Child Development Center	2	5	6	15	39
Windward ECSP	0	0	4	17	24
Total	**24**		**67**		**701**

Part C Early Intervention
State Systemic Improvement Plan
Supporting Infants and Toddlers Social Emotional Development

Brief I, June 2014

Issue:

In the last decade, researchers, policy-makers, educators, practitioners, and families have become increasingly aware of the importance of the emotional and social development of infants and toddlers. Research has shown that development in these early years provides the foundation for the child's future emotional, social, and cognitive development. Research has also indicated that problems that occur in the infant's or toddler's social or behavioral development are likely to be early indicators of more difficult and persistent challenging behavior as the child grows older. (Center for Evidence-Based Practice: Young Children with Challenging Behavior, 2003)

Data:

Early Intervention Programs intend to increase the rate of growth of enrolled children so that they "catch up" or do not develop delays. Hawaii has a lower percentage of children with a substantially increased rate of growth compared to the nation in social emotional development and knowledge and skills (Figure 1). In contrast, Hawaii has a higher percentage of children exiting within age expectations for all child outcomes. However, this data includes children who entered and exited Early Intervention within age expectation (Figure 2).

Figure 1

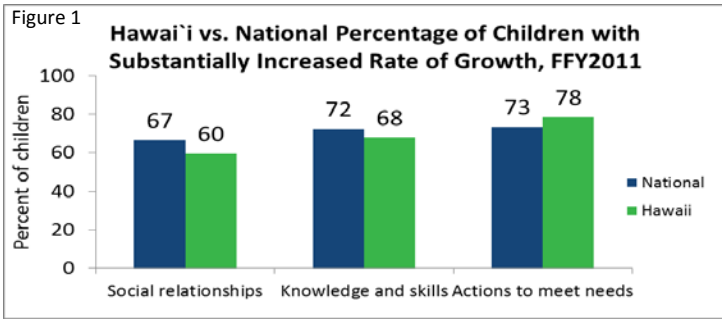
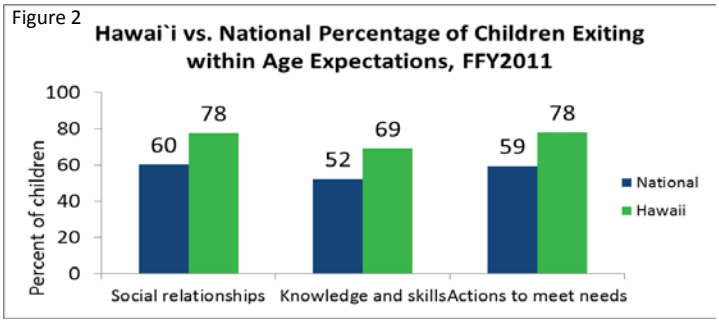


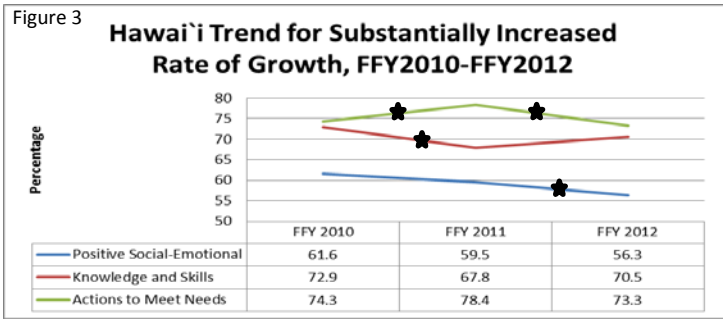
Figure 2



Note: National data based on 33 states with highest-quality data

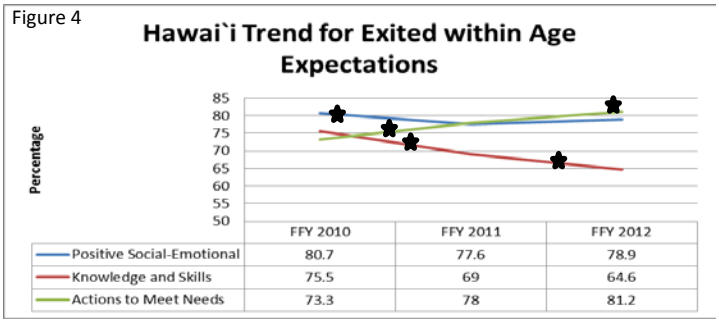
Hawaii state trends from FFY2010 to 2012 indicate a decline in substantially increased rate of growth and fewer children with substantially increased rate of growth in the social emotional area in comparison to the other two areas (Figure 3). For children exiting, there was a significant drop from FFY2010 to FFY2011 for social emotional development and although there was a slight increase during FFY 2012, it was not considered a meaningful difference (Figure 4).

Figure 3



	FFY 2010	FFY 2011	FFY 2012
Positive Social-Emotional	61.6	59.5	56.3
Knowledge and Skills	72.9	67.8	70.5
Actions to Meet Needs	74.3	78.4	73.3

Figure 4



	FFY 2010	FFY 2011	FFY 2012
Positive Social-Emotional	80.7	77.6	78.9
Knowledge and Skills	75.5	69	64.6
Actions to Meet Needs	73.3	78	81.2

★ Meaningful difference from previous year

Target Group:

Infants and toddlers eligible for early intervention services and demonstrate a need for support in social emotional development.

Problem:

Broad data analysis indicated that Hawaii Part C Child Outcomes data for "Positive Social Emotional Skills" was lower than the national average, did not meet Hawaii's target, and declined over the past few years.

Approach:

The State Systemic Improvement Plan (SSIP) is a comprehensive, ambitious, yet achievable multi-year plan for improving results for infants and toddlers with special needs. The SSIP will be part of the federal required State Performance Plan (SPP) and Annual Performance Report (APR) which are viewed as critical components of the Office of Special Education Programs (OSEP's) Results Driven Accountability (RDA) system. OSEP's directive is that it is of utmost importance to improve the results for infants and toddler with special needs by improving early intervention services.

SSIP Purpose:

- Increase capacity of the Early Intervention Programs to implement, scale up, and sustain evidence-based practices.
- Improve outcomes for children with special needs and their families.

SSIP Phases:

Year 1-FFY 2013 Delivered by Feb. 2015	**Year 2-FFY 2014** Delivered by Feb. 2016	**Year 3-6 - FFY 2015-2018** Delivered by Feb. 2017-2020
Phase I - Analysis	**Phase II - Plan**	**Phase III - Implementation and Evaluation**
• Data analysis; • Analysis of infrastructure to support improvement and build capacity; • Measurable result(s) for infants and toddlers with special needs; • Coherent improvement strategies; and • Theory of action	• Infrastructure development; • Support for EI Programs/Providers implementation of evidence-based practices; and • Evaluation	• Implementation; and • Evaluation

Infrastructure: The State is required to identify needed improvements in the State's infrastructure as part of the SSIP and align with existing state initiatives as feasible. The Infrastructure includes seven components:

- Governance
- Personnel Development/Workforce
- Technical Assistance
- Finance
- Quality Standards
- Monitoring and Accountability
- Data Systems

Focus Area/State-Identified Measurable Result(s) (SiMR) for Infants and Toddlers: Social Emotional Development was selected based on:

- Broad data analysis;
- Hot topic in Hawaii;
- Alignment with State Early Childhood Initiatives on social emotional development;
- High cost of early childhood mental health services;
- Positive social emotional skills is critical for overall development of the child.

SSIP Status:

- Provided overview of SSIP to broad stakeholder group - December 2013 and May 2014.
- Conducted broad data analysis - January thru May 2014.
- Identified focus area (SiMR for infants and toddlers with special needs) – May 2014.
- Shared data used in broad data analysis and obtained approval from the broad stakeholder group on the focus area/SiMR – May 2014.
- Conducted infrastructure analysis with broad stakeholder group – May 2014.
- Initiated root cause analysis with broad stakeholder group – May 2014.

Next Steps:

- Webinar on July 1, 2014 from 10:00 a.m. – 11:30 a.m. to share data analysis, results, and reasons for selecting "Social Emotional Development" as the focus area for the SSIP.
- SSIP Leadership Team will meet on a monthly basis and develop, implement and review "SSIP Plan of Action."
- Identify improvement strategies that address issues with the state infrastructure components and the practices that need implementing to improve results.
- Prepare and submit a budget request to ensure improvement strategies can be implemented.

Hawai‘i SSIP Crosswalk of Root Causes and Broad Improvement Strategies

Strands of Action	Root Cause	Data/Justification	Broad Improvement Strategy
Interagency Collaboration for Parent Support and Education	Parents lack solid understanding of and expectations for children's social/emotional development & growth, including the importance of the role their interactions with their children have in promoting it.	• Although the 2014 Family Outcome Survey data indicates that about nine out of ten of families said they understood their child's delays and/or needs and were able to help their child get along with others, stakeholders identified during the root cause analysis that parental lack of understanding and expectations for children's social-emotional development was a roadblock to identifying social-emotional needs and supporting children's development in this area. • Stakeholders identified during the infrastructure strengths, weaknesses, opportunities, and threats (SWOT)analysis that parent input into the Child Outcome Ratings varies from initial to exit possibly due to not understanding the COS process and understanding social-emotional development.	**Community Partnerships** Collaborate with community agencies and other State initiatives to increase access to parent support and education regarding social-emotional skills and social relationships.
	Parents could benefit from groups to share strategies to address their children's needs	• The 2014 Family Outcome Survey (611 responded) indicated that three in ten families responded were not able to talk with other families who have a child with similar needs.	
Professional Development and Technical Assistance	Providers have basic understanding of infant/child development in general and social-emotional development, but need more training in this area, in particular for children ages birth to three.	• Stakeholders questioned during the infrastructure analysis if providers are defining social-emotional development the same way. • Stakeholders identified during the infrastructure analysis that not everyone is aware of the Hawai`i Early Learning & Development Standards (HELDS) chart as a resource for understanding typical development • Based on the SSIP Provider Survey: ▪ Staff are less comfortable in understanding age-appropriate social-emotional skills or interpreting functional information about a children's social-emotional skills for younger children – one in four staff are not comfortable in understanding age-appropriate social-emotional skills for children 0-6 and three in ten staff are not comfortable interpreting functional information; although comfort increases with age, one in five providers are not comfortable interpreting functional information for children ages two to three. ▪ 63% of providers wanted training on communicating about sensitive issues due to cultural stigma related to mental health services. ▪ 73% of respondents wanted training on challenging behaviors; 65% on autism spectrum disorders (ASD); and 57% on social-emotional development.	**Professional Development & Implementation of Evidence-based Practices** Enhance the statewide system of professional development to increase early intervention providers knowledge of social-emotional development, development of functional IFSP outcomes/objectives/strategies and implementation of the IFSP using evidence-based and quality practices.
	Providers are not accurately identifying and writing	• The data and infrastructure analyses indicated concerns with child outcomes data quality for positive social-emotional skills in terms of accuracy and rating	

Hawai‘i SSIP Crosswalk of Root Causes and Broad Improvement Strategies

Strands of Action	Root Cause	Data/Justification	Broad Improvement Strategy
	functional outcomes/objectives to address social-emotional needs of the child	validity/reliability. ▪ Based on the SSIP Provider Survey, the Battelle Developmental Invention, 2nd Edition (BDI-2) is the most commonly used tool for doing entry (97% of respondents) and exit (69%) ratings, but about half of all respondents felt it was not sensitive enough to pick up social-emotional delays among children under one year of age, and four in ten thought it was not sensitive enough for children ages one to <two years. ▪ Preliminary evidence from the COS/BDI-2 comparison suggests that BDI-2 scores may lack sensitivity at entry and that COS ratings may be inflated at exit. • Based on the SSIP Provider Survey: ▪ Most of the SSIP Provider survey respondents (70%) did not complete a Functional Behavioral Assessment (FBA)/Antecedent-Behavior-Consequence (ABC) prior to referring for a psychological evaluation ▪ Over 60% of the respondents to the SSIP Provider Survey wanted training on the functional-behavioral assessment (FBA), and almost half wanted training on child outcomes summary (COS) ratings (45%) and writing functional outcomes (47%). • Monitors observed during on-site monitoring that objectives are not always functional (many are copied from the BDI-2 test items) and there are minimal objectives to address social-emotional development. • Stakeholders identified during the infrastructure analysis that more guidance is needed regarding functional assessments and translating functional outcomes into functional objectives that can be measured.	
	Providers are not trained in or using appropriate services/strategies (i.e. behavior vs. sensory delay) to address S/E needs and promote social/emotional development & growth	• Based on the SSIP Provider Survey: ▪ 77% of respondents wanted training on coaching; 72% on evidence based practices in social-emotional development; and 63% how to talk to families about sensitive issues. ▪ Four in ten programs are not implementing evidence-based interventions related to social-emotional development	

Hawai‘i SSIP Crosswalk of Root Causes and Broad Improvement Strategies

Strands of Action	Root Cause	Data/Justification	Broad Improvement Strategy
	Providers do not consistently implement primary service provider approach	• Documentation and IFSP service page reviewed during monitoring did not always reflect implementation of primary service provider and coaching model. • Stakeholders identified during the infrastructure analysis that there is no clear, consistent understanding of the primary service provider model.	
	Providers do not understand their roles within the primary service provider and coaching model and have limited collaborative partnerships with families and other team members	• Progress notes in the child's record (from monitoring) indicate that: ▪ services are frequently delivered using the medical model instead of coaching model (i.e., parents leave therapists alone with children during therapies. ▪ providers may not understand their role on the team and their notes appear duplicative of each other. • Stakeholders identified during the infrastructure analysis that there is: ▪ a lack of training in understanding their roles when serving as the primary service provider vs. serving as a consultant ▪ an insufficient focus on increasing family capacity to help their child ▪ not enough time to implement coaching model ▪ pattern to "teach to the test" that limits or changes how services are provided ▪ uncertainty regarding role (primary service provider or consultant) makes it difficult to coordinate and collaborate on services	
	Providers and programs do not have enough training and support for implementation	• Monitoring suggests need for training. • Stakeholders identified during the infrastructure analysis that a limited training/TA and access to opportunities for trainings is a major weakness of the system. • Based on the SSIP Provider Survey, the second most commonly identified barrier to providing services to address a child's social-emotional needs was training (60% identified this as a barrier)	
Fiscal	There is not enough money to hire an adequate number of appropriately qualified staff or to provide needed introductory and ongoing trainings	• Stakeholders identified during the infrastructure analysis that inadequate funding to address the staff vacancies and hiring of qualified personnel impacts the entire system. • Based on SSIP Provider survey, the majority of responders noted schedule conflicts (97%) and staff shortage (57%) as barriers to having whole IFSP team present for COS ratings	**Qualified Personnel** Increase the availability of qualified early intervention providers with infant mental health expertise.
Monitoring and Accountability	Not enough TA staff to provide support for EI Programs to use data for program improvement,	• All six Quality Assurance positions have been cut • The infrastructure SWOT analysis indicated that programs need technical assistance in using data for program improvement	**Continuous Quality Improvement System** Enhance the current

Hawai‘i SSIP Crosswalk of Root Causes and Broad Improvement Strategies

Strands of Action	Root Cause	Data/Justification	Broad Improvement Strategy
	to develop and implement strategies to address areas of non-compliance, and to provide evidence-based and quality services.	• Stakeholders identified during the infrastructure analysis that there is a lack of staff to provide consistent TA to the EI Programs. • Stakeholders identified during the infrastructure analysis that the database needs to be up-graded to include additional data that provides a more complete picture of what is happening at the program level. • Statewide data for compliance indicators shows slippage which impacts improving results for children: ▪ Timely Services: 69% to 63% ▪ Timely Initial IFSPs: 94% to 90% ▪ Timely IFSP Reviews: 97% to 95% ▪ Timely Annual IFSPs: 96% to 94% • Program Managers report at Quarterly Program Manager meetings that they frequently gap on-going services (cancel service appointments with families to meet other timeline requirements and/or due to staff shortage/vacancies. This was confirmed via on-site monitoring.	Continuous Quality Improvement System (general supervision) to identify, promote, and support best practices in efforts to improve outcomes for children and families, ensure program effectiveness, measure results on continuous improvement activities, and ensure data is accurate and reliable.

Early Intervention Section

Hawai'i's SSIP Theory of Action

Strands of Action	IF Early Intervention (EI) Lead Agency	Then	Then	Then
Interagency Collaboration for Parent Support and Education	…requires EI providers to identify and develop linkages with community-based parent support groups that are focused on parenting skills and parent-to-parent sharing of strategies to address their children's needs	…EI providers will systematically identify IFSP family outcomes/objectives related to parent participation in community-based parent support groups	…parents will participate in community-based parent-support groups …parents will understand and have appropriate expectations for social-emotional development … parents will gain strategies to address their children's needs	**… infants and toddlers with disabilities will have made greater than expected growth in social-emotional skills (including social relationships) by the time they exit EI**
Professional Development and Technical Assistance (TA)	…develops and provides training, TA, and ongoing supports to ensure accurate assessment and identification of social-emotional needs and full implementation of evidence-based and quality practices to support social-emotional development with fidelity	…EI providers will have improved understanding of child development in general and social-emotional development in particular for children ages 0-3 … EI providers will receive supervision/ support to ensure implementation of training content … EI providers will implement evidence-based and quality practices related to social-emotional development using the primary service provider and coaching model …EI providers will understand their roles, develop collaborative partnerships with families and other team members, identify social-emotional needs of children, write functional social-emotional IFSP outcomes/objectives, and deliver appropriate social-emotional services	…the quality and quantity of parent/child interactions will increase …social-emotional IFSP outcomes will be achieved	
Fiscal	…increases funding (e.g., through grant writing, legislative support, etc.) to hire enough qualified staff, provide introductory and ongoing training, and support service delivery (e.g. tele-health capabilities, equipment availability)	…EI providers will have enhanced capacity to provide appropriate services and supports to children and families		
Monitoring and Accountability	…develops and maintains a web-based data system and builds local program capacity to report accurate data and use data for improvement …analyzes data to monitor program performance and fidelity of implementation and provide feedback to programs	. . . EI programs will review and use child-level data to determine if children are making sufficient progress in their early intervention program, and make program level improvements as appropriate . . . EI programs will use monitoring feedback to provide effective supervision of providers implementation of evidence-based practices …EI providers will have the access and skills needed to use data for program improvement	…social-emotional IFSP outcomes will be achieved	