Component #1: Data Analysis

1(a) How Key Data were Identified and Analyzed

A PICTURE OF MONTANA BY NUMBERS:

- Montana is ranked 50th in the nation for children's health.
- Montana is ranked 45th in the nation for children without health insurance.
- Montana is ranked 50th in the nation for teens who abuse alcohol or drugs.
- Montana is ranked 50th for child and teen deaths per 100,000.

(Annie E. Casey Foundation 2014 Data Book, Death Statistics: Vital Statistics Analysis Unit, MT Department of Public Health and Human Resources)

- 1 in 5 Montana children lives below poverty (19%).
- 30% of Montana families with children are single-parent families.
- 30% of Montana families spend more than 30% of their monthly income on housing-related expenses.
- 59% of preschool-aged children are not enrolled in a public or private school.
- 44% of enrolled students participate in free/reduced-price lunch program.
- Between 2010 and 2012, 86 children died in motor vehicle crashes and 40 children committed suicide.

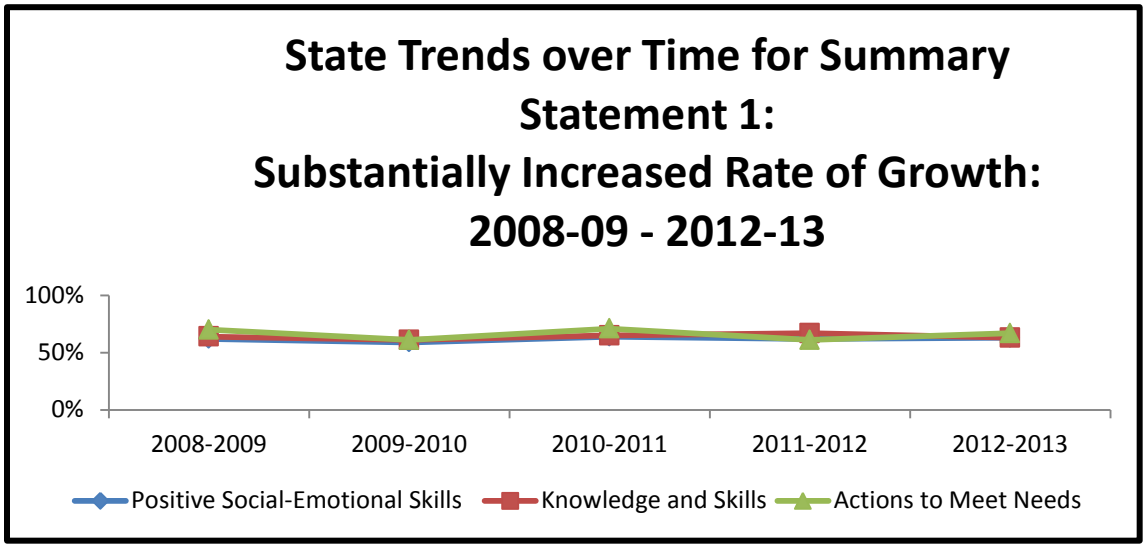
(www.montanakidscount.org)

Montana's core SSIP Stakeholder group, the FSSAC members along with additional support from Marty Blair of the University of Montana Rural Institute, and regional representation from Parents Lets Unite for Kids (PLUK) began the process of developing Phase I of the SSIP utilizing infrastructure analysis and an overview of Montana's reported data components. Montana's Stakeholder group chose to review the FFY 2012 and FFY 2013 APRs in depth noting outcomes data implied a fairly static series of measurements with little increase or decrease over years. Prior to the implementation of the web-based Early Intervention Module (EI Module) in March 2013, few other data sources existed for the Part C program in Montana other than each provider's reporting on required annual performance report indicators including child and family outcomes information. Montana's State Child Outcomes Data Quality Profile was originally reviewed in the fall of 2013 for the FY 2011-2012 profile and again in the fall of 2014 for the FFY 2012-2013 profile. Montana has reported on 28% or more of exiting children

since FY 2008. Trends since 2008 indicate Montana's outcomes data are slightly above average in comparison to the nation and had three peaks: FFY 2010-2011, FFY 2012-2013 and, as noted in the most recent APR, FY 2013-2014. This trajectory mirrored slightly the national averages in each outcome. In conclusion of this review, the evidence did not create a definitive interpretation of the outcomes data to gage need or prevalence of a specific need. State-wide longitudinal data indicated significant increases in the most recent fiscal year.

TABLE 1: Montana: Summary Statement 1						
	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014
Positive Social-Emotional Skills	62%	59%	64%	62%	63%	72%
Knowledge and Skills	64%	61%	65%	67%	63%	72%
Action to Meet Needs	70%	61%	71%	61%	67%	73%

TABLE 2



Additional data analysis was completed reviewing all three child outcomes data and disaggregated based upon individual early intervention providers throughout Montana. See tables below.

TABLE 3: Outcome A, Statement 1

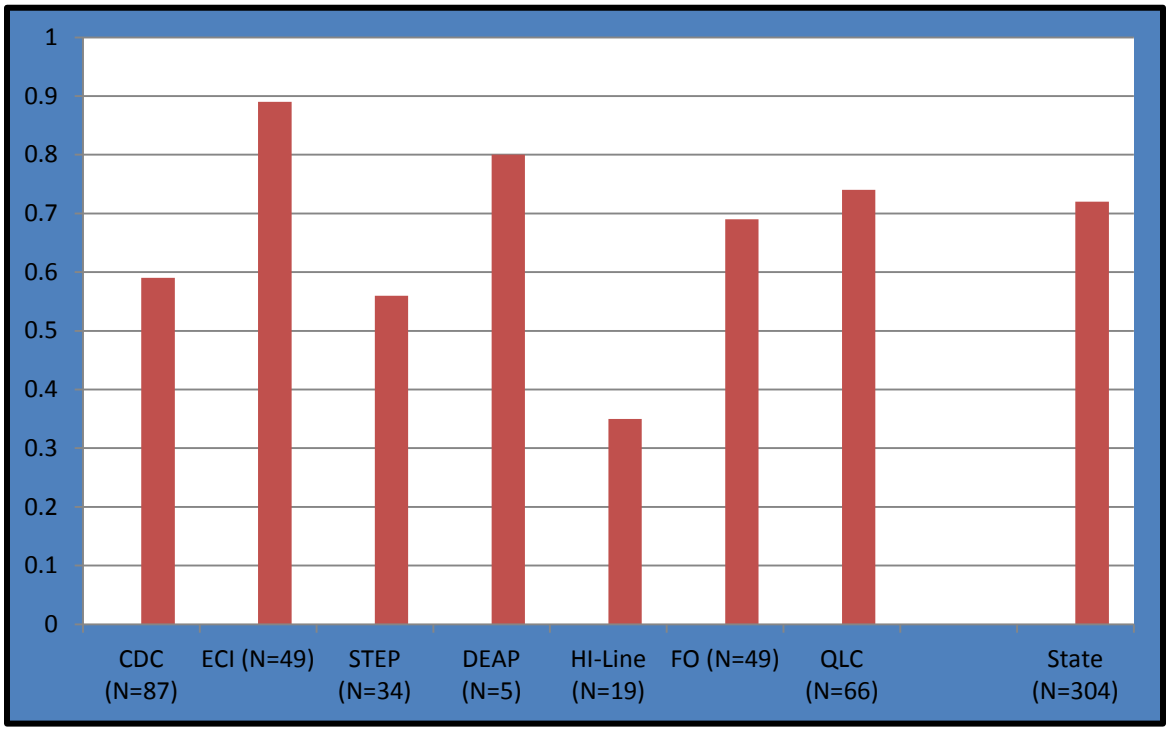


TABLE 4: Outcome B, Statement 1

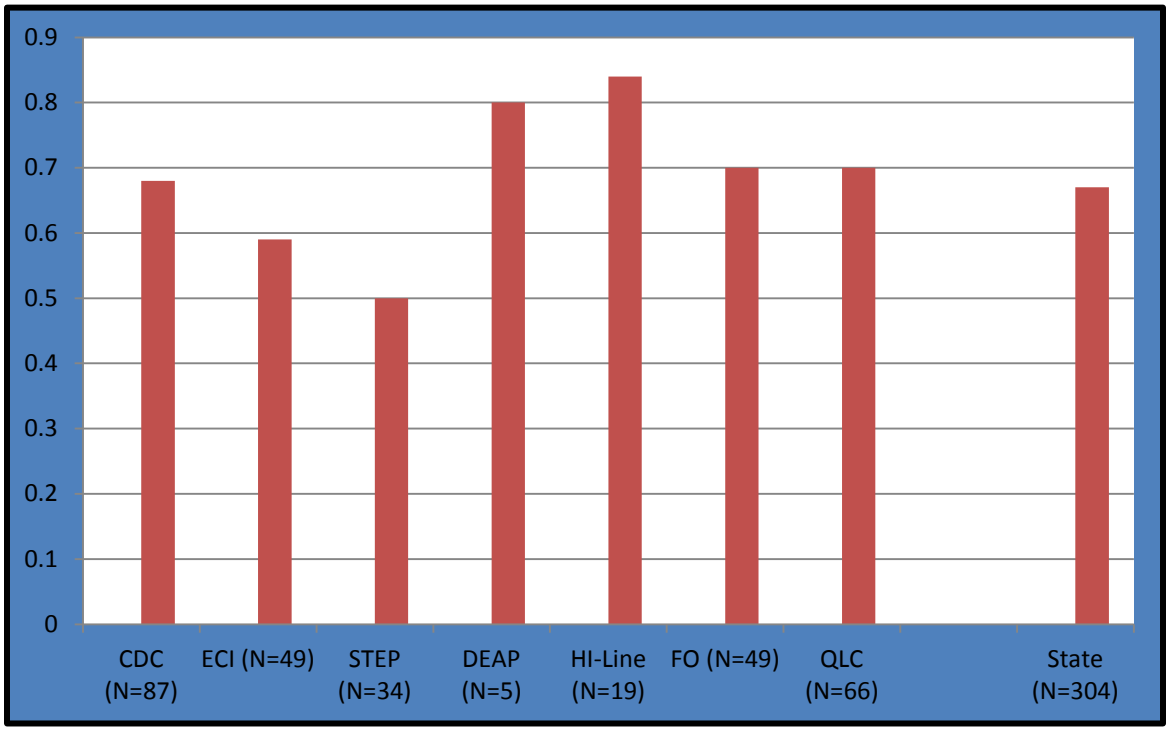
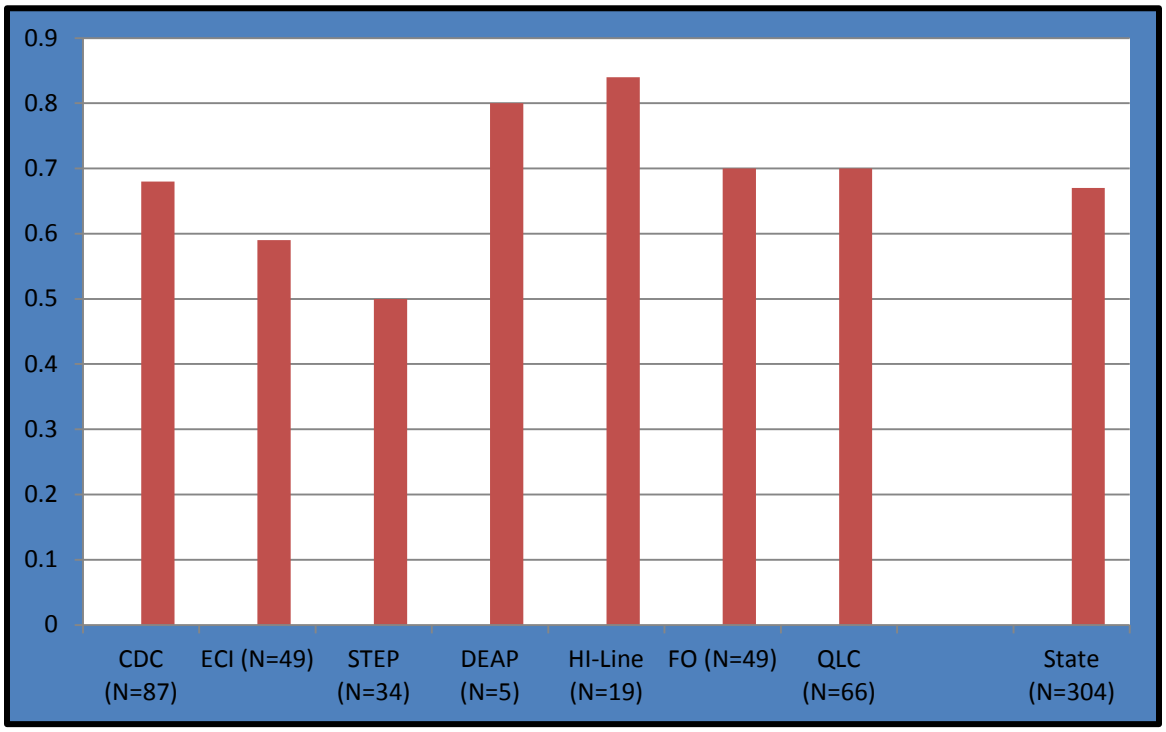


TABLE 5: Outcome C, Statement 1



An unusual pattern was observed once the data was disaggregated by early intervention provider, showing notable differences between providers for each child outcome most notably in Outcome A, Statement 1.

This observation led to inferences about the consistency and reliability of the child outcomes data throughout the State. These inferences were supported by additional qualitative analyses and review of IFSP forms. This review was conducted on approximately 300 Child Outcome Summary forms as part of ongoing efforts to transition to the web-based EI Module for the collection of IFSPs (utilizing a uniform IFSP), Outcomes, Child Count, and Transition data in March 2013. The Part C Coordinator and a provider's coordinator for the Child Outcomes Summary Process worked together to enter the entry and exit scores from the paper Child Outcomes Summary Forms from every provider in the State into the new system in preparation for the FFY 2013-2014 APR.

Through this review process, similarities and patterns were noted in how children were scored upon entry and exit depending upon the local early intervention provider. The ratings of the majority of providers showed consistent intra-provider similarities but inconsistencies in the ways in which outcomes were rated across providers. As noted above, suspicious differences in outcomes percentages existed between providers for each outcome. An example of ten children from a specific provider:

TABLE 6: Baseline and Exit COSF measurement example

	Outcome 1	Outcome 2	Outcome 3		Outcome 1	Outcome 2	Outcome 3	Progress
Baseline				Exit				
Child #1	6	5	4		4	3	3	n
Child #2	5	4	3		4	3	3	y
Child #3	5	3	3		4	3	3	y
Child #4	5	4	3		4	3	3	y
Child #5	6	4	4		6	4	3	y
Child #6	6	6	4		4	3	5	n
Child #7	6	6	4		4	3	3	n
Child #8	3	3	5		3	3	5	y
Child #9	3	3	5		3	3	5	y
Child #10	4	3	3		4	3	3	y

The discovery of differing child outcome rating practices between early intervention providers during the IFSP analysis caused the Stakeholders to inquire more deeply into the validity of the child outcomes ratings and process. To further understand the ratings, the geography and demographics of individual providers and children served as well as to make a more informed decision regarding the State Identified Measureable Result (SIMR), an additional work group was formed in the spring of 2014 consisting of the specific individuals who make up the Child Outcomes Summary Process team at their individual agencies. This group, the Child Outcomes Work Group, was tasked with qualitative analysis of Montana's Child Outcomes Summary Process and providing recommendations for program improvement. Per the Stakeholders instruction, the work group was also charged with recommending the selected SIMR.

The Stakeholders group concur current outcomes data is likely to be limited in its accuracy to aid Montana Milestones Part C/Early Intervention in making data-informed decisions. However, its limited accuracy provides clear direction to the Stakeholder group for the need for systemic and sustainable improvement. The FSSAC developed Montana Milestones Part C/Early Intervention Strategic Plan in the fall of 2013 and created the following initiatives which Montana will build upon throughout the SSIP:

- ✓ Assuring efficiency and effectiveness with processes and requirements so consistency exists across all providers and within the State's monitoring;
- ✓ Developing data collection and analysis to improve outcomes using a singular data system response to DPHHS needs, provider needs, and family needs enabling all providers and DPHHS to use reliable data to make decisions; and
- ✓ Provide an effective professional development system so providers of early intervention services and supports are highly competent and regularly connected across the State.

1(b) How Data Were Disaggregated

All Early Intervention provider agencies agreed to participate in child outcomes quality improvement activities over the course of Montana's SSIP. After discussion with the Stakeholder group and professionals within OSEP, ECTA, and the regional resource and referral agency and based on the limited resources Montana's Part C office can provide, two programs were chosen to implement the improvement plan initially with the remaining five programs scaling up in future years of the SSIP. All seven early intervention providers agree Montana must build a collaborative culture where early intervention providers and all related stakeholders (State, providers, and families) share a common vision and practice in order to increase family and child successes.

Two providers, CDC and DEAP, volunteered to be the pilot sites and undergo thorough scrutiny of their professional development practices, IFSP services and supports, and rigorous, ongoing monitoring of child outcomes with continued drilling down into each child and family's entry and exit Child Outcomes Summary. The two identified early intervention programs will provide data to determine if identified improvement strategies, followed with fidelity, will improve outcomes in two different Montana locations. Through continued analysis of qualitative and quantitative data during the course of the SSIP, Montana Milestones Part C/Early Intervention Program ultimately seeks to determine specific strategies most influential in improving outcomes for children. Analysis indicates the populations served by the two providers are dramatically different due to variety of factors such as geographic differences, varying support services such as medical and dental homes, income, employment, and median ages of the counties.

- Both geographical regions served by the two providers include significant American Indian populations.
- One region, located in western Montana, is more urban containing two communities identified as micropolitan and metropolitan.
- The other, located in eastern Montana, is extremely rural with, at the most, 3 people per square mile.
- Median household incomes vary between both regions with sparsely populated eastern Montana earning more annually.
- Unemployment is higher in western Montana.
- Eastern Montana's median age is older.
- Both early intervention providers are responsible for <u>thousands of miles of territory</u> to provide support and services in the most natural environment.
- Child Outcomes Summary data from the two providers showed the same intra-agency consistencies in rating patterns.

The **Child Development Center** (CDC) is located in western Montana with two communities qualifying as micropolitan or metropolitan, Missoula and Kalispell, both with CDC offices. Counties served are Flathead, Lake, Lincoln, Mineral, Missoula, Ravalli, and Sanders. Missoula and Kalispell witnessed great population growth, over 25% in the past ten years. Unemployment is somewhat higher than in the

eastern part of the State. The region is home to multiple higher education institutions: University of Montana – Missoula, Missoula College – University of Montana, Bitterroot College of University of Montana – Hamilton, Flathead Valley Community College – Kalispell, and Salish-Kootenai College, tribal college located in Pablo.

The Developmental Educational Assistance Program (DEAP) located in vastly rural eastern Montana with offices in Miles City, Glendive, and Colstrip. Counties served are Carter, Custer, Dawson, Fallon, Garfield, Powder River, Prairie, Rosebud, Treasure, and Wibaux. No micropolitan or metropolitan communities exist creating difficulties accessing services and supports. Communities served by DEAP changed dramatically recently due to the oil boom: increasing population, increasing wages, low unemployment rates, and increased crime in targeted areas including a burgeoning methamphetamine trade. As this is being written, the cycle of "boom and bust" is occurring in this region. Due to the recent dip in oil prices, numerous companies are laying off workers and again housing costs and wages will degrade. The region is home to three institutions of higher learning: Little Big Horn College, a tribal college located in Crow Agency, Dawson Community College – Glendive, and Miles City Community College – Miles City.

DEAP is staffed by a director with a long history of leadership at DEAP exclusively. **CDC** is undergoing administrative changes and the retirements of several long employed staff members. Both staff groups meet higher educational requirements for employment as a Family Support Specialist (early interventionist) and participate extensively within Montana's professional development strategic plan. Both agencies note an increasing trend with difficulty recruiting and retaining qualified early interventionists which is likely a root cause for data inaccuracy.

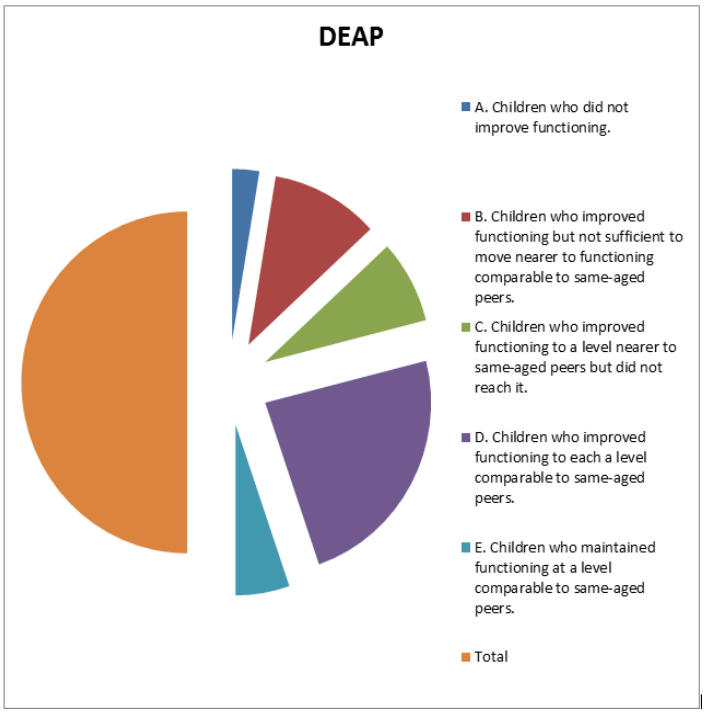
Both agencies are seasoned providers of early intervention in Montana (DEAP since 1976 and CDC since 1975). Additional strengths of pilot agencies:

- Both providers' staff members are participants in Montana Milestones/Part C Early Intervention Program existing strategic improvement plans;
- Both directors of the agencies (Sylvia Danforth and Carolyn Prussen) are key members of the Stakeholders group;
- Members of Outcomes Work Group (Catherine Hafliger, Cassandra Schrockenstein, Sandy Peaslee);
- Employ nationally-certified RBI trainers (Catherine Hafliger and two selected trainees from both agencies participating in national certification in July 2015);
- Employ Master Coaches as trained in *Using a Coaching Interaction Style in Early Childhood* (Sue Holmstrom, Cassandra Schrockenstein, Sherry Taylor);
- Act as community leaders in their identified regions;
- Monitored by experienced Quality Improvement Specialists (Paula Tripp, Paula Sherwood, Connie Wethern, Sandy Carpenter, and Kathleen Kaiser), all members of the Monitoring Tool Work Group;
- Willing and interested in determining if our identified early intervention strategies truly impact and improve a child's social/emotional functioning; and

- Both provider agencies, with the support of the state office of Montana Milestones/Part C Early Intervention Program and Regional Quality Improvement Specialists, have adequate resources to implement strategies and monitor outcomes.

When reviewing actual child outcomes data, graphic illustrations of CDC and DEAP show similarities in their rating percentages creating the hypothesis that the majority of children enrolled in Part C already improved their functioning to a level comparable to same-aged peers.

TABLE 7: Child Outcomes Data from DEAP:



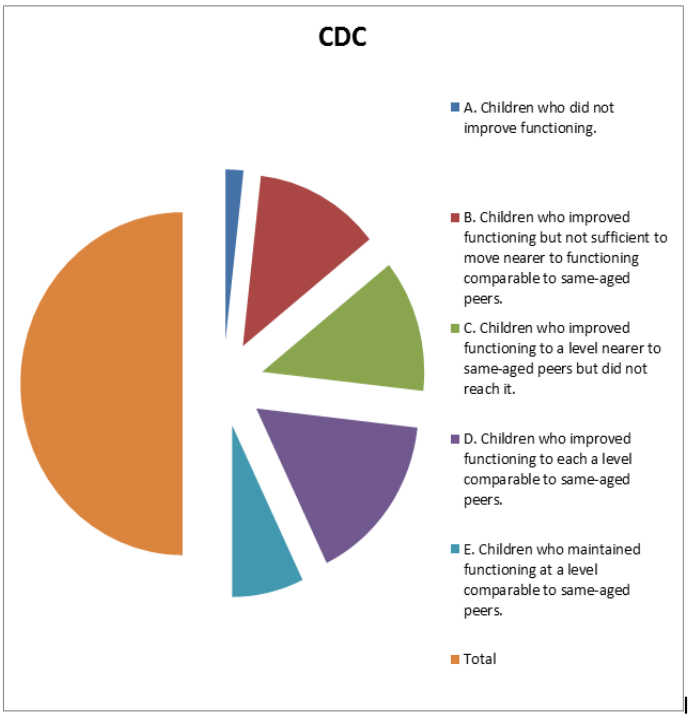


TABLE 8: Child Outcomes Data from CDC

TABLE 9: Comparison of Indicator 3, Outcome A for CDC and DEAP

Indicator 3, Outcome A, Positive Social-Emotional Skills – including personal relationships.	Of those children who entered or exited the program below age expectations in Outcome A, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program.			The percent of children who were functioning within age expectations in Outcome A by the time they turned 3 years of age or exited the program.		
CDC	**Target 59%**	**FFY 2012 Actual 59%**	**FFY 2013 Actual 72%**	**Target 53%**	**FFY 2012 Actual 36%**	**FFY 2013 Actual 64%**
DEAP	**Target 59%**	**FFY 2012 Actual 80%**	**FFY 2013 Actual 70%**	**Target 53%**	**FFY 2012 Actual 67%**	**FFY 2013 Actual 60%**

Initial root cause analysis by both CDC and DEAP points to inaccurate child outcomes ratings for the spikes between FFY 2012 and FFY 2013. CDC and DEAP note difficulties with recruitment and retention of staff pointing to a lack of consistent and systemic professional development informing child outcomes measurements.

TABLE 10: CDC Part C Service Area Demographics:

	Flathead	Lake	Lincoln	Mineral	Missoula	Ravalli	Sanders
Population	93,068	29,017	19,687	4,223	111,807	40,2823	11,363
Households	37,504	11,482	8,843	1,584	38,439	16,933	5,121
Ethnicity							
White	95.4%	68.2%	95.8%	94.1%	92.4%	95.9%	92.0%
Black or African American	0.3%	0.4%	0.3%	0.4%	0.4%	0.4%	0.3%
American Indian or Alaska Native	1.3%	23.4%	1.1%	1.8%	2.9%	1.0%	4.3%
Asian	0.7%	0.5%	0.4%	0.8%	1.4%	0.1%	0.4%
Native Hawaiian or Other Pacific Islander	0.1%	0.1%	0.1%	0.0%	0.1%	0.8%	0.0%
Two or more races	2.2%	7.3%	2.3%	2.9%	2.7%	1.8%	2.8%
Hispanic or Latino	2.6%	4.0%	2.7%	2.7%	2.9%	3.2%	2.6%
Education							
H.S. graduate or higher	93.8%	90.0%	86.0%	89.2%	94.5%	92.1%	87.2%
Bachelor's degree or higher	28.4%	24.8%	18.3%	12.1%	39.1%	24.5%	16.7%
Geography Quick Facts							
Land area in square miles	5,088	1,490	3,613	1,219	2,593	2,391	2,761
Persons per square mile	17.9	19.3	5.4	3.5	42.1	16.8	4.1
Metro or micro area	Kalispell (micro)	None	None	None	Missoula (metro)	None	None
Children under age 5	5536	1890	921	191	6086	1998	504
Median Age	42	42	51	52	35	48	53
Median Household Income	$44,998	$37,274	$30,823	$37,256	$42,887	$43,000	$30,622
Low & Moderate	36.21%	48.62%	51.69%	47.07%	44.32%	38.27%	53.79%

Income Percent							
Percent in Poverty	13 %	18.7 %	19.2 %	15.8 %	14.8 %	13.8 %	17.2 %
Children under age 18 in poverty	20%	31%	32%	28%	17%	25%	38%
Unemploy-ment Rate	7.9%	7.9%	14.5%	9.8%	5.3%	7.4%	12.6%
Births to mothers starting prenatal care during first trimester	77.8%	67.5%	70.3%	69.8%	75.6%	70.9%	64.2%
High School drop-out rate	3.6%	4.6%	3.2%	2.1%	2.5%	2.2%	4.3%
Indian Reservation	Confederated Salish and Kootenai Tribes of the Flathead Nation	Confederated Salish and Kootenai Tribes of the Flathead Nation	no	no	Confederated Salish and Kootenai Tribes of the Flathead Nation	no	Confederated Salish and Kootenai Tribes of the Flathead Nation.

The Flathead Reservation, headquartered in Pablo, is the fourth largest reservation in Montana, encompassing 1,244,000 acres in four counties. The reservation is policed by 19 sworn law enforcement officers.

Sources: US Census Bureau, MT Department of Public Health and Human Services, Bureau of Economic Analysis, MT Department of Labor and Industry, Montana Office of Public Instruction, Montana Department of Transportation, Montana Board of Crime Control, MT Department of Commerce.

TABLE 11: DEAP Part C Service Area Demographics:

	Carter	Custer	Dawson	Fallon	Garfield	Powder River	Prairie	Rosebud	Treasure	Wibaux
Population	1,174	11,951	9445	3,079	1,290	1,748	1,179	9,329	700	1,021
Households	532	5,031	3,749	1,233	532	755	551	3,395	335	457
Ethnicity										
White	98.4%	95.2%	95.1%	96.9%	98.4%	95.9%	95.1%	60.4%	94.9%	98.4%
Black or African American	0.1%	0.5%	0.4%	0.2%	0.2%	0.1%	0.1%	0.3%	0.1%	0.1%
American Indian or Alaska Native	0.9%	2.0%	2.1%	0.8%	0.4%	2.0%	0.4%	35.6%	2.1%	0.9%

Asian	0.1%	0.4%	0.4%	0.7%	0.1%	0.2%	0.8%	0.7%	0.0%	0.0%
Native Hawaiian and Other Pacific Islander	0.0%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Two or more races	0.5%	1.7%	1.9%	1.2%	0.9%	1.8%	3.6%	3.0%	2.6%	0.5%
Hispanic or Latino	0.8%	2.7%	2.6%	1.5%	0.8%	1.7%	2.0%	4.0%	3.3%	0.8%
Education										
H.S. graduate or higher	92.8%	90.9%	89.3%	92.7%	91.7%	93.1%	86.8%	89.1%	86.4%	86.2%
Bachelor's degree or higher	16.4%	19.7%	18.1%	16.1%	13%	19.9%	16.9%	22.3%	21.33%	13.7%
Geography Quick Facts										
Land are in square miles	3,341	3,783	2,372	1,621	4,675	3,297	1,737	5,010	977	889
Persons per square mile	0.3	3.1	3.8	1.8	0.3	0.5	0.7	1.8	0.7	1.1
Metro or micro area	None	None	None	None	None	None	None	None	None	None
Children under age 5	66	755	603	243	86	49	74	756	41	41
Median Age	51	42	41	40	46	51	54	37	54	49
Median Household Income	$35,707	$38,913	$50,752	$52,529	$42,955	$37,685	$34,896	$44,776	$37,969	$38,892
Low & Moderate Income %	47.3%	39.9%	39.4%	35.52%	37.55%	41.21%	41.2%	45.75	48.24%	37.44%
Percent in Poverty	18.1%	15.1%	14.9%	12.5%	21.5%	12.9%	17.2%	22.4%	14.7%	15.3%
Children under age 18 in poverty	26%	19%	15%	12%	26%	16%	26%	26%	20%	14%
Unemploy-ment Rate	3.4%	3.7%	3.5%	2.0%	3.7%	3.7%	4.4%	7.1%	3.9%	3.3%
Births to mothers starting prenatal care during first trimester	78.6%	78.4%	70.5%	76%	77.5%	66.7%	66.7%	53.9%	Value withheld due to low event count.	Value withheld due to low event count.
High School drop-out rate	0.0%	1.7%	3.5%	1.5%	1.6%	.9%	4.3%	5.9%	0.0%	2.0%
Indian Reservation								Northern Cheyenne Tribe	Crow Tribe	

The Crow Reservation in South Central Montana is bordered by Wyoming on the south and by the Northern Cheyenne Reservation on the east. This Reservation is approximately 60 miles wide and 40 miles long, encompassing 1.57 million acres. It is the fifth largest reservation in the US and the largest in Montana. The reservation is policed by 20 sworn law enforcement officers. The Northern Cheyenne Reservation encompasses 445,000 acres between the Crow Reservation and the Tongue River Valley in southeastern Montana. It is policed by nine sworn law officers.

Sources: US Census Bureau, MT Department of Public Health and Human Services, Bureau of Economic Analysis, MT Department of Labor and Industry, Montana Office of Public Instruction, Montana Department of Transportation, Montana Board of Crime Control, MT Department of Commerce.

To perform additional disaggregation by data variables such as ethnicity, gender, or time in service, is severely hampered by the capacity of the Part C office in Montana. However, one improvement strategy will be the continuing enhancement of the web-based Early Intervention Module (implemented March 2013) which has recently been enhanced to provide multiple opportunities for deeper analysis of such specific data both current and longitudinally with implementation date of April 1, 2015.

1(c) Data Quality

Child outcomes data is likely to be limited in its accuracy to aid Montana Milestones Part C/Early Intervention in making data-informed decisions; therefore, the Child Outcomes Work Group was charged with the deeper analysis of child outcomes and, based upon that analysis, recommending improvement strategies and the State Identified Measureable Result (SIMR) for Montana.

The Child Outcomes Work Group met three times during summer and fall 2014 utilizing the qualitative method of investigation of *why* and *how* specific child outcome rating decisions were made in addition to *what*, *where*, *when*. Hence, smaller but focused samples were used to determine the quality of child outcomes ratings. The group discovered a number of systemic problems in the determination of child outcomes ratings and recommended numerous pieces of an overall improvement plan based upon their further investigations using resources currently available from ECTA and technical assistance from ECTA staff members well-versed in outcomes measurement (During the writing of this, Montana Milestones/Part C Early Intervention Program joined the first Child Outcomes Cohort to receive intensive technical assistance around child outcomes). Based upon broad data analysis, inconclusive inferences could be made regarding the strengths of the data reviewed. Each early intervention provider had created a system for rating outcomes using different tools with different work groups. Interviews provided a deeper glimpse into the mechanisms of the Child Outcomes Summary Process. Consistently, each early intervention provider shared the perception the Child Outcomes Summary Process must always show growth for each infant and toddler in all outcome categories. The Child Outcomes Summary Process was introduced to providers in 2006 and no additional targeted outcomes professional development was delivered since that time. Further interviews determined those early interventionists providing documentation to verify outcome ratings did not always understand the processes or use the information gathered for future decision making. Their view of the Child Outcomes

Summary Process was narrow indicating it was a task to complete as it was required by the State, rather than a process for gathering functional assessment data useful for program improvement.

The Outcomes Work Group:

- Utilized qualitative method of investigation of overall Child Outcomes ratings; and
- Used smaller, focused samples to determine quality of Child Outcome ratings.

As the Outcomes Work Group reviewed the data, the methods for collecting data for child outcomes, research about early intervention and its impacts, their discussion led to their recommendation that Montana focus upon improving positive social-emotional skills. They were united in their conviction the child's emerging social-emotional development skills form a critical foundation for learning and wellness that will guide them into adulthood. They further noted the tremendous impact social-emotional development components have for a child with a disability as it prepares children to be self-confident, trusting , empathic, intellectually inquisitive, competent using language to communicate and capable of relating well to others.

The Child Outcomes Work Group noted and recommended the following:

- Positive social, consistent relationships are base from which development potential is possible;
- Actual Outcome A, improving social/motional skills including personal relationships data may or may not be accurate; however, current data does not imply continuous improvement in this Outcome state-wide;
- Interventions with infants and toddlers and their family members must be based on explicit principles, validated practices, best available research, and relevant laws and regulations;
- Professional development provided for early intervention staff addresses service delivery and includes the early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child's and family's preferences, learning styles and cultural beliefs;
- Consistency for writing functional outcomes based upon children's and family's needs and family identified priorities is essential; and
- Consistent measurement of entry and exit child outcomes is compulsory.

1(d) Considering Compliance Data

Analysis of compliance data for the past fiscal year indicated providers continue to meet compliance indicators and were becoming better adept at documenting compliance indicator information. The time-stamping of the electronic database, the EI Module, requires providers to document multiple compliance indicator information including reasons for lateness, explanations of settings, and an ability to monitor complaints.

In addition, the new monitoring tool created by the work group, the Quality Improvement Specialists, with input from the Stakeholders group, is slated to be implemented in May 2015. This tool promotes

quality and compliance as the monitor uses a variety of strength-based methods to determine quality and monitor compliance indicators of individual programs. Personnel development will be monitored closely to determine needs in currently implemented intervention strategies (RBI™, Coaching Interaction Style, RBEI™) and those practices' affect upon social-emotional outcomes. Using family interviews, Quality Improvement Specialists will determine if families have received Procedural Safeguards and the System of Payments including documents identifying a family's insurance provider. Gaging understanding of each of those items will be a component of the interview. The feedback loop will be more consistent as the Part C Coordinator, Quality Improvement Specialist, and provider will conference at a minimum of four times annually to determine and document strategies and practices and their impact. One objective for the monitoring tool is to have quick response to data-driven findings that may signal components lacking quality or compliance. Data drawn from the monitoring tool will be correlated with ongoing outcomes data. With frequent interaction, compliance and quality issues may be quickly remedied. The feedback loop also provides opportunity to offer providers' well-deserved praise for the quality supports and services they are providing infants and toddlers and their families in Montana.

1(f) Stakeholder Involvement in Data Analysis

Montana's ICC, the Family Support Services Advisory Council (FSSAC), is composed of influential members from many parts of Montana State government in addition to a number of family representatives, professionals, and interested observers. Choosing this group to participate as the larger stakeholders group was a natural decision. Their identities are noted in **Section 2(f)**.

This group came together in the summer of 2013 and worked diligently to create the State-wide initiatives for Montana Milestones. Through the creation of the initiatives, members of the group created numerous work groups to support each initiative. This process increased their understanding of early intervention globally and they are a tremendous asset to the Part C office. The group's initial data analysis was a new experience as dissecting data had never been required before. As analysis increased concerns around validity and reliability, many agreed they had been suspicious of the data shared with them via the APR previously. Members are engaged serving on other early childhood councils or panels both state-wide and regionally, and championing the needs of the infants and toddlers and their families. Chairperson Laura McKee was nominated as Montana's Mother of the Year and has been chosen to be Montana's representative nationally culminating in a ceremony in April 2015. It is through her work both professionally and on this Council that she has been recognized for this award. She promises to mention Part C Early Intervention in her acceptance speech.

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

2(a) How Infrastructure Capacity was Analyzed and 2(b) Descriptions of State Systems

Montana's Stakeholder Group convened six times during the course of 2014 analyzing the strengths and weaknesses of Montana Milestones Part C/Early Intervention Program. Broad infrastructure analysis was completed at the first meeting in early spring 2014 using the Infrastructure Analysis Template

developed by the Southeast Regional Resource Center and adapted with input from the Mid-South Regional Resource Center.

The infrastructure analysis and the key data analysis revealed correlations. Lack of systemic professional development and monitoring of child outcomes were likely root causes of poor data quality. Inefficiencies in Montana's systems for collecting data (previously non-existent prior to March 2013) hampered data review and data-informed decision making. Montana's system of monitoring and accountability was insufficient due to the dated tool which was not reflective of current systems or practices. Inconsistency in the application of the tool and any consequences associated with a "finding" of non-compliance were noted in every region of the State. Data had been collected over the years in a variety of formats. Concerns were expressed from all providers that too frequently data collected never seemed to be used for any identifiable purpose. After reviewing outcomes information, all pondered if the data collected was indeed reliable or valid pointing to an incomplete professional development system regarding the value of data and its impact on practices and decision-making. Montana recognized a need for support from IDC and/or DaSy.

Infrastructure analysis inferred Montana's systems for data collection and quality assurance monitoring for the Part C program were inconsistent across the State. Further examination after review of outcomes data, Child Outcomes Work Group information, and Quality Improvement Work Group information, a process was formed to define Montana's expectations for effective collection and use of outcomes data:

- ✓ Expectations for system performance (e.g. targets, benchmarks, indicators) are clearly identified and described in the monitoring system;
- ✓ The monitoring system will use multiple mechanisms for collecting reliable data including surveys, electronic child records, interviews, on-site record reviews, providers' self-assessments;
- ✓ The monitoring system will include identified timelines and processes (to ensure validity and accuracy) for data collection and analysis guiding data-informed decision making;
- ✓ Data collected will address Federal and State requirements and be used to measure performance and identify trends, causes, and improvement strategies State-wide and regionally;
- ✓ Data collected will be scrutinized focusing upon outcomes, supports and services, frequency, intensity, and settings;
- ✓ During the monitoring cycle, procedures will be identified to make any necessary adjustments to implementation strategies as well as revisions to the data collection methods to meet changing circumstances;
- ✓ Data will intentionally be collected on a regular basis;
- ✓ Individuals collecting data will possess the required knowledge and competence in data collection and have ongoing support and training;
- ✓ Part C Coordinator, fiscal staff, providers, and Quality Improvement Specialists analyze data quality, analyze and disaggregate data by differing variables;
- ✓ Data collected meaningfully will aid in making data-informed decisions to increase progress towards intended results; and

- ✓ Using data-informed decisions, resources will be targeted for technical assistance and multiple professional development activities and supports using evidence-based practices to enhance knowledge and skills.

Montana Milestones Part C/Early Intervention Program strengths include the collaborative vision (Part C Coordinator, FSSAC, and seven regional providers) for improvement of Part C early intervention supports and services with emphasis upon systemic, sustainable professional development and the implementation of an electronic system to record IFSPs, services and supports, outcomes, transition information, child counts, and progress reports. Weaknesses noted exist in monitoring and accountability and data collection processes. As one provider noted, "Montana is moving out of the 80s in its methods for collection of data with the electronic Early Intervention module; however, we have a long way to go!"

You can't change the direction of the wind but you can adjust your sails to reach your destination.
Unknown

The infrastructure analysis activity painted a picture of Montana Milestones Part C/Early Intervention Program: the State's systems impact the capacity of regional programs to improve the SIMR; however, the Part C Coordinator connects all systems and provides hands-on leadership for each program. Inspired, the Stakeholders decided this was opportunity to focus completely on the identified specific outcome, build our capacity state-wide and regionally, and implement changes truly impacting the families we serve across the State. Recognizing we can build on our current identified strategic initiatives, professional development implementation plan, and the newly developed electronic data base, the Early Intervention Module, to support improvement and build capacity across all providers, Montana Milestones Part C/Early Intervention Program will utilize the infrastructure with significant noted enhancements that follow to improve results for infants and toddlers with disabilities and their families, particularly their positive social and emotional skills.

2(c) Systems Strengths and Areas for Improvement

Mechanisms are currently in place to facilitate communication, coordination and collaboration between Montana Milestones/Part C Early Intervention Program Coordinator and the seven regional providers of early intervention and include both the following formal and informal methods:

- Quarterly FSSAC meetings
- Bi-annual site visits by Part C Coordinator
- Quality Improvement Specialists
- Annual Summer Institutes
- MT RBI™ Boot Camps
- Master Coaches Community of Practice
- Work Groups
- Fiscal Cohort I

- Targeted professional development such as attendance at the DEC Conference, the National Inclusion Conference and the Siskin Institute for National Certification in RBI™

Professional Development:

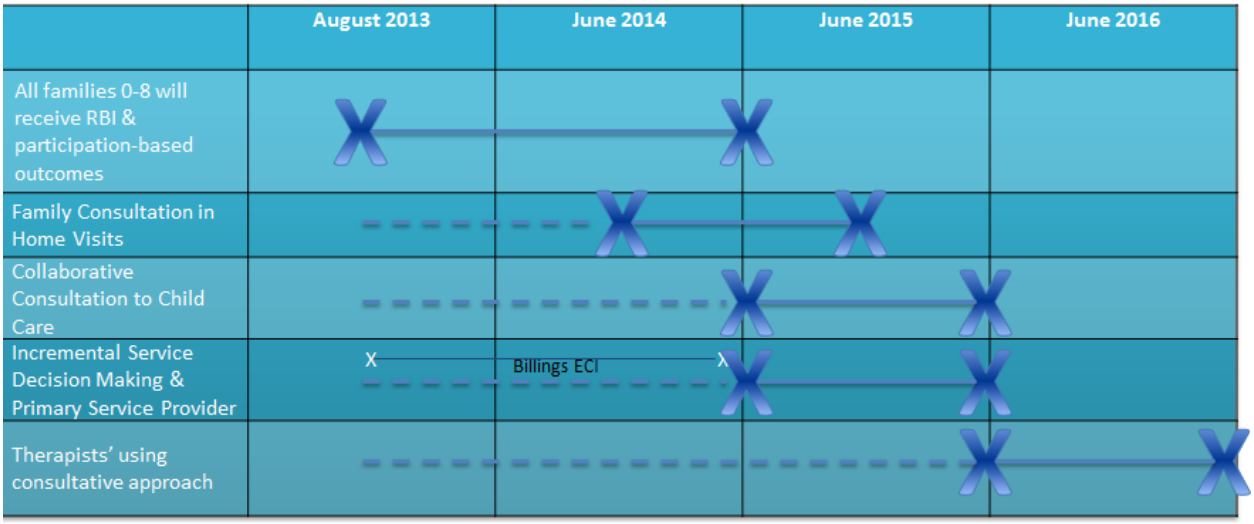
The implementation of professional development opportunities targeting all Family Support Specialists and their supervisory staff members, provider directors, and collaborative partners such as Speech and Language Pathologists, Occupational Therapists, and Physical Therapists is a newly found strength for Montana. Previous professional development opportunities were provided in isolation to provider agencies which led to misunderstandings and various perceptions of the information provided. Consistency of our message relating to RBI™, RBEI™, and Coaching has been successful. The consistent and systemic approaches we have utilized to roll out and sustain those practices serve as the foundation as we address improvement strategies to increase social-emotional skills for our Part C children and families. RBI™, RBEI™, and Coaching are relationship-based and well matched to support positive social relationships in children and their families. As large as Montana is geographically, each provider agency and their staff are isolated and are in dire need of the collaborations and connections that state-wide professional development opportunities and learning communities can provide. Additionally, providing fiscal support to agencies so that numbers of Family Support Specialists may attend national conferences has proved to be influential and energizing to those staff members and their agencies. Montana's Part C Coordinator is reliant on the footwork of Family Support Specialists to glean understanding of the best practices available nation-wide to improve the supports and services to children and families in Montana.

Dr. Robin McWilliam provided three professional development institutes for Montana's Family Support Specialists since 2013 guiding us in Routines-Based Interviewing™ and Routines-Based Early Intervention™ to embed developmental interventions into daily routines thereby Family Support Specialists can support a child's development in every day settings, enhancing their daily functioning at home and in the community. He worked closely with Montana's Stakeholders' group with defining and advancing our implementation timeline. Below is the current timeline for overall implementation of RBEI™ in Montana.

TABLE 12:

Montana RBEI Implementation Timeline

Goal – RBEI practices will be fully implemented in Montana by June 2016
(implementation by FSSs by December 2015)



(*Regarding "*All families 0-8 will receive RBI & participation-based outcomes*," this will apply to children enrolled within the Department of Public Health and Human Services, Developmental Disabilities Program such as Part C, Family Education and Support, the Children's Waiver, and the Children's Autism Waiver.)

At this time, eleven Montana Family Support Specialists are nationally certified in RBI™. An additional two will be attending the upcoming annual Siskin Institute held in Chattanooga in the summer of 2015. In an effort to speed the process of RBEI™ implementation, three MT RBI™ Boot Camps have been held allowing the nationally certified to train groups of 12 – 20 in three regional areas in RBI™ methodology including writing functional outcomes. Montana has 43 Family Support Specialists who have received MT RBI™ Approval following their participation, test, and video review. An additional number of Family Support Specialists have received training from their agency's RBI™ trainer, specifically providers in Missoula and Great Falls. A component of the revised monitoring tool will be to document the status of each agency in the training of the RBI™ methodology to gage need for additional regional Boot Camps. As noted previously, the turnover rate among Family Support Specialists is constant always requiring continued training thus the need for a consistent and systemic way to provide professional development in our chosen practices.

To support the implementation and support of child and family focused functional outcomes in the most natural environment, Montana Milestones/Part C Early Intervention Program turned to Dathan Rush and M'Lisa Shelden to provide specific professional development, *Using a Coaching Interaction Style with Families*, an adult learning strategy. Coaching strengthens and builds the capacity of a parent or

colleague to improve existing abilities, develop new skills, and gain a deeper understanding of evidence-based practices. Following a rigorous two-day Institute for all Family Support Specialists in Montana, Shelden and Rush provided intensive professional development for six months to 16 identified Master Coaches representative of each provider agency in the State thereby creating a Community of Practice. "The early childhood practitioner who uses coaching facilitates a dynamic exchange of information based on the parent's intentions and current level of skills necessary to promote the child's participation in family, community, and early childhood settings" (Bruder & Dunst, 1999; Hanft et al., 2004).

Governance:

Montana Milestones/Part C Early Intervention Program continues to strengthen its collaborative efforts with Early Head Start, Head Start, and Part B/619. Working off of the Part C to Part B transition document, stakeholders from Part C, Part B/619, Early Head Start, Head Start, and Special Education Cooperatives met over the summer of 2014 to develop a guidance document outlining referral procedures for all entities. This document has been presented at Montana's CSPD meetings for their input and evaluation. It will be shared with regional providers of Part C, Part B/619, Early Head Start, and Head Start in a training program developed by Montana's Part C Coordinator and Montana's Office of Public Instruction Part B/619 Monitoring Specialist, Danielle McCarthy, over the summer of 2015. See the document at http://opi.mt.gov/pdf/SpecED/EarlyChildhood/FosteringPartnersHeadStart_IDEA.pdf.

Montana's Part C Coordinator partnered with Dianna Frick of Montana Early Childhood Home Visiting Program during the spring and summer of 2014 to meet regionally with Public Health, Family Support Specialists, Child Protective Services staff, and Best Beginnings Council members (representing regional resource and referral programs) in an effort to develop understanding of each partner's role in early intervention. With this newly identified understanding, the desired outcome is that each program works more collaboratively with each other and avoids duplicative processes for families. These collaborative relationships need continuous attention and it is apparent further attention is required to continue to engage all parties as they are serving infants and toddlers in their communities. A mechanism for ongoing systemic collaboration is needed and is an improvement component for Montana Milestones/Part C Early Intervention Program. A model is currently being piloted in Lewis and Clark County using an online data base to monitor referrals amongst those agencies and/or persons. Montana's Part C Coordinator will be working with the local Best Beginnings Council representative, Drenda Nieman, to determine its effectiveness.

Quality Standards:

After years of absence, Montana's Part C Coordinator is taking an active role in the CSPD. The Montana Digital Academy is a direct link that was provided through collaboration with CSPD. This relationship will continue to be nurtured with the result being technical assistance and professional development modules being more readily available to Family Support Specialists. A pilot of three learning modules will be presented to all Family Support Specialists in the spring or early summer of 2015 via the online learning platform, the Montana Digital Academy. To determine the effectiveness of this collaboration,

Montana's revised monitoring tool will provide data around professional development and ongoing review of child and family outcomes in quarterly meetings with improving social-emotional skills including positive relationships as a primary focus.

Fiscal:

Montana Milestones/Part C Early Intervention Program participated in the Fiscal Cohort I during 2014. Through knowledge gained during the Cohort, Montana is in the process of collecting specific data points from all Part C providers including services and supports provided monthly to infants and toddlers and their families enrolled in Part C along with the intensity and duration of those services and supports. Additionally, providers are documenting funding sources for each service and support. Further analysis of these data pieces will be provided by a contracted individual as Montana explores the Part C rate structure. In the midst of Legislative session, three bills are advancing pertaining to Medicaid funding for Autism Spectrum Disorder, expansion of Children's Health Program, and overall expansion of Medicaid in Montana. Following Fiscal Cohort guidance and targeted professional development, all Part C providers are using Montana's System of Payments with families.

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

The following State-level Improvement Plans and Initiatives promote collaboration in early childhood education in Montana including early intervention for infants and toddlers and their families. Each contains components of improving social-emotional outcomes for children and families which Montana Milestones will leverage and further explore in Phase II.

- **From Early Edge Montana (http://earlyedge.mt.gov/):**

"Montana's Governor Steve Bullock recognizes that our greatest obligation is to the next generation of Montanans. It's with this in mind that he's put together a plan to make voluntary, high-quality early childhood education available to every Montana four year-old entitled *Early Edge Montana*. Montana is currently one of eight states without a publicly funded pre-kindergarten option for four year-olds. Through the Governor's proposal, block grants will be available to every Montana public school district to create or expand high-quality early childhood education programs in their community. School districts will have the option of creating a new program, or partnering with an existing early childhood education program to build on the existing strengths in their community. Participation in these programs will be voluntary, meaning that parents will be able to decide if it is the right option for their child.

Programs will be required to meet high quality standards that:

- Require a lead teacher with an early grades endorsement;
- Sets a teacher to student ratio of 1:10;
- Establishes guidelines for family engagement that ensure family, community and culture are integrated as part of a child's learning both inside and outside the classroom; and
- Sets a process for collaboration with community resources to connect children and families with tools to support health growth and development of children.

- Requires developmentally appropriate curriculum including social and emotional development through play, learning soft skills"

From the Governor's Office, December 2014:
(https://governor.mt.gov/Portals/16/docs/2014PressReleases/121014EarlyChildhoodGrantAwardRelease.pdf)
"Montana has been awarded a $10 million-a-year federal Preschool Development grant from the U.S. Department of Education to increase capacity and expand access to high-quality early childhood education in sixteen high needs communities throughout the State. The grant provides support for school districts in these communities to improve professional and program development, including scholarships for early childhood educators, building Montana's early childhood workforce to ensure they're able to meet the accreditation and licensure standards recently approved by the Montana Board of Public Education. Additionally, grant funds will be used to expand access to publicly funded, high-quality early childhood educational programs in these communities. This competitive grant can be renewed for up to four years, for a maximum of $40 million awarded. More than 6,000 four-year-olds are expected to be served over a four-year period. The grant will build on successful early literacy programs in Montana, and these programs will serve as models and mentors for new programs that are added over the course of the grant. The Office of Public Instruction and the Department of Health and Human Services will provide technical assistance to the grantee communities. The grant complements Bullock's Early Edge initiative, which aims to make voluntary, publicly funded, high-quality early childhood education for four-year-olds available throughout Montana. In his budget, Bullock requested $37 million to fund the initiative."

Montana's Part C Coordinator is a member of the Preschool Grant Assessment Committee representing infants and toddlers with disabilities and their families and is working with partners to further expand Family Engagement within Early Edge Montana.

- **The Montana Project LAUNCH:**

The purpose of Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) is to promote the wellness of young children ages birth to 8 by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. The long-term goal of Project LAUNCH is to ensure that all children enter school ready to learn and able to succeed. Project LAUNCH seeks to improve coordination across child-serving systems, build infrastructure, and increase access to high-quality prevention and wellness promotion services for children and their families.

MT Department of Public Health and Human Services, Children's Mental Health Division, received the Project LAUNCH grant in September 2014. The initiative will engage Montana's early childhood partners to improve systems and access to mental health services for young children and families in our rural state while piloting evidence-based practices in Gallatin and Park Counties.

Interventions to be implemented in Gallatin and Park Counties:

- Universal Screening using the Ages and Stage Questionnaire-3 (ASQ-3TM) and Ages and Stages Questionnaire: Social Emotional (ASQ:SE);
- Integration of behavioral health into primary care settings;
- Mental health consultation in early care and education;
- Enhanced Parents as Teachers home visiting with increased focus on social and emotional well-being; and
- Family strengthening and parent skills training using the *Incredible Years Program*.

Parent representatives from the FSSAC have been asked to participate in a planning meeting with Project LAUNCH coordinators to provide examples and ideas to increase Family Engagement.

❖ **Maternal and Early Childhood Home Visiting:**

Services are offered on a voluntary basis to pregnant women and families with children less than 6 years of age. Visits are intensive, generally occurring every week or every other week, and long-term. Services are focused on families at risk, including those with parents younger than 21, low income, living in at-risk communities, a history of child abuse or neglect, or other factors that can jeopardize healthy child development.

The home visiting models implemented in Montana are all evidence-based and have shown to be effective at improving child development, school readiness, positive parenting practices, and health outcomes. Services provided by the home visitors include health, hearing, vision, and developmental assessments and screenings, connecting families to resources to help improve their self-sufficiency, and providing education and support to parents on healthy pregnancies, overall health, child health and development, school readiness, development-centered parenting, positive parent-child interaction and family well-being.

Linking and sharing resources between Maternal and Early Childhood Home Visiting and Montana's early intervention providers is an objective to improve social-emotional competencies of families.

***Denotes counties where pilot sites for Montana Milestones/Part C Early Intervention Program SSIP implementation**

Services are available in the following counties:
Anaconda-Deer Lodge
Big Horn
Butte-Siler Bow
Cascade
Custer*
Dawson*
Flathead*
Gallatin
Hill
Lake*
Lewis and Clark

Mineral*
Missoula*
Park
Richland
Roosevelt
Yellowstone
Services are also available tin Rosebud County* through Custer County* and Northern Cheyenne Tribe*, on the Crow Reservation through the Big Horn County Program, and on Rocky Boy Reservation through the Hill County program.

Montana Milestones/Part C Early Intervention Program improvement plans:

Several existing improvement plans are ongoing:

- RBI™ – Siskin Institute National Certification
- MT RBI™ Boot Camp
- RBEI™ Implementation
- Coaching – Using a Coaching Interaction Style
- Master Coaches Community of Practice
- Fiscal data collection of supports and services
- Annual Summer Institutes
- Targeted Professional Development

To aid the early intervention providers in Montana, additional enhancements are planned for the electronic Early Intervention Module creating a more a user-friendly data base easily accessed to review supports and services, intervention strategies, outcomes, settings, transitions, intensity and duration of supports and services. Multiple reports have been created and currently a component for documentation of contacts is being designed. This will provide the State and individual providers with accurate fiscal assessments of the cost of providing services and supports to a child and his/her family. Using a continuous cycle of monitoring aimed at improvement, the Part C Coordinator, Quality Improvement Specialists, and providers will be able to make better informed decisions about the trajectory of outcomes, professional development, and staffing patterns.

2(e) Representatives Involved:

The FSSAC, Child Outcomes Work Group, and the Quality Improvement Specialists Work Group were involved in the Phase I SSIP development. Across those groups, stakeholders included representatives from the following organizations and perspectives:

- Early Intervention Regional Providers (4)
- University of Montana – Speech and Language Therapist
- Montana State Legislative Representative
- MT Department of Health and Human Services, Children's Health
- MT Department of Health and Human Services, Quality Improvement Specialist

- Parents (5)
- MT Department of Health and Human Services, Health Resources (Medicaid State Plan)
- Montana School for the Deaf and Blind
- Montana Office of Public Instruction, Part B/619
- MT Department of Health and Human Services, Child and Family Services
- Montana State Auditor's Office (Insurance Commissioner)
- Parents Lets Unite for Kids (PLUK - Montana's Parent Advocacy Group)
- MT Department of Health and Human Services, Children's Mental Health
- MT Department of Health and Human Services, Developmental Disabilities Program
- Montana State University – Early Childhood Professional Development
- Early Head Start
- University of Montana Rural Institute, Promoting Inclusive Communities

Additional Stakeholders Identified:

Going forward to Phase II, Montana identified that a representative from the Montana Early Childhood Project, Early Childhood Practitioner Registry (as a part of the improvement strategy to create a data base of professional development and become the certifying body for Family Support Specialists) is needed as a stakeholder.

For Phase II of the SSIP, Stakeholders will be expected to continue to represent their agencies and specialties providing assistance as Montana implements improvement strategies. Each representative will be advocating ensuring Montana's plan is coordinated among agencies to avoid duplication of processes or procedures. Each representative will be responsible to ensure those within their agency or specialty are part of ongoing monitoring of improved social-emotional skills for infants and toddlers with disabilities and their families within their sphere of influence. Each representative will attend four quarterly meetings regarding SSIP implementation and evaluation. Each representative will attend professional development which most pertains to their role and responsibilities within the Stakeholders' group.

2(f) Stakeholder Involvement in Infrastructure Analysis:

Montana Family Support Services Advisory Council (FSSAC) (Montana's ICC)

The FSSAC worked with the Part C Coordinator to review data, analyze data, direct work groups, set targets, and accept the Child Outcomes Work Group's recommendation to choose improving infants and toddler's social-emotional skills including positive relationships as Montana's SIMR. The group met six times over the course of the past year to develop the content of the SSIP. Recognizing monitoring as a key component of the SSIP, the group commissioned the Quality Improvement Work Group to develop an integrated monitoring tool reflective of Part C Rules and Regulations and Montana's practices. The group will meet again in May 2015.

Early Intervention Regional Providers (4): representatives from four regional providers who are contracted with the State to provide Part C Early Intervention in their defined region (Carolyn Prussen, CDC, David Munson, ECI, Sylvia Danforth, DEAP, Priscilla Halcro, QLC).

University of Montana – Speech and Language Therapist: Dr. Lucy Hart Paulson represents the American Speech and Language Association for Montana as well as the Speech and Language graduate program at the University of Montana.

Montana State Legislative Representative: Representative Jean Price is appointed by the Governor to serve as the Legislative Representative on the Council. She also is a member of the Education Committee within the Legislative Body.

MT Department of Health and Human Services, Children's Health: Heather Racicot represents Children's Special Health Needs.

MT Department of Health and Human Services, Quality Improvement Specialist: Ryane Holzworth represents the monitoring arm of Montana Milestones/Part C Early Intervention Program.

Parents (5): Laura McKee, Rebecca Richards, Bonnie Ramage, Amber Duncan, and Linda Zermeno represent parents of an infant or toddler with a disability.

MT Department of Health and Human Services, Health Resources (Medicaid State Plan): Amber Wells represents Medicaid EPSTD.

Montana School for the Deaf and Blind: Laura Copp represents MSDB as a regional early interventionist for children who are deaf and/or blind.

Montana Office of Public Instruction: Danielle McCarthy represents Part B/619.

MT Department of Health and Human Services, Child and Family Services: Dawn Piazzi represents CFS workers involved with infants and toddlers removed from the family home.

Montana State Auditor's Office (Insurance Commissioner): Ron Herman represents the Insurance Commissioner.

Parents Lets Unite for Kids (PLUK - Montana's Parent Advocacy Group): Lori Gaustad represents the parent organization and Roger Holt is the Executive Director for PLUK.

MT Department of Health and Human Services, Children's Mental Health: Zoe Barnard represents Children's Mental Health focusing upon infants and toddlers with disabilities.

MT Department of Health and Human Services, Developmental Disabilities Program: Tim Plaska represents the administration of the Developmental Disabilities Program.

Montana State University – Professional Development, Early Childhood Education: Dr. Christine Lux represents early childhood professional development at Montana State University.

Early Head Start: Jody Jones represents Salish-Kootenai Early Head Start

University of Montana Rural Institute: Executive Director Marty Blair represents as a promoter of inclusive communities.

Child Outcomes Work Group:

The responsibility of the Child Outcomes Work Group was initially to investigate the Child Outcomes Process and identify areas needing improvement. Their work evolved to developing guidance for completing the Child Outcomes Process, MEISR™ training, and development of training modules for Montana's Child Outcomes Process which will be provided to all Family Support Specialists state-wide, and the determination of the State's Identified Measureable Result based upon their data analysis. The group met three times and will meet again in March 2015.

Child Development Center (CDC): Catherine Hafliger and Cassandra Schrockenstein – Part C Program Coordinators

Quality Life Concepts (QLC): Norma Zelzer and Kari Hoover – Part C Program Coordinators

Hi-Line Home Programs: Denise Herman and Jean Snider – Part C Program Coordinators

Family Outreach: Teri Lilletvedt, Mariah Cantwell-Frank, Jill Ballantyne, Colleen McGee, Katelyn Stewart, Cindy Larson, and Paula Black – Part C Program Coordinators

DEAP: Sandy Peaslee – Part C Program Coordinator

ECI: Christa Tescher – Part C Program Coordinator

STEP: Angela Thompson, Katrina Leligowicz, and Chelsie Guilford – Part C Program Coordinators

Quality Improvement Work Group:

The responsibility of the Quality Improvement Work Group was to investigate monitoring tool examples for Part C Early Intervention and develop a monitoring tool for Montana Milestones/Part C Early Intervention Program reflective of Part C Rules and Regulations and Montana's current practices. Additionally, they created a timeline for monitoring, feedback, and a method to promote quality and plans for remediation. The group met three times and provided presentations to the Stakeholders group to obtain input and make revisions. The monitoring tool is being readied for final review and piloted use in April/May 2015.

Region I Quality Improvement Team: Connie Wethern, Sandra Carpenter, and Kathleen Kaiser

Region 2 Quality Improvement Team: Laura Gebo and Lori Wertz

Region 3 Quality Improvement Team: Shannon Merchen, Troy Kelly, and Ryane Holzworth

Region 4 Quality Improvement Team: Catherine Murphy, Alexis Marthaller, and Joe Beneventi

Region 5 Quality Improvement Team: Paula Tripp and Paula Sherwood

Component #3: State Identified Measureable Result (SIMR)

3(a) SIMR Statement:

Montana has adopted the following State Identified Measureable Result (SIMR) statement:

If Montana Milestones/Part C Early Intervention Program implements specific improvement strategies, we will provide high quality early intervention programs for vulnerable infants and toddlers with disabilities and their families to improve social-emotional skills in an effort to reduce the incidence of future problems in their learning, behavior, and health status.

An increased percentage of infants and toddlers with IFSPs will demonstrate improved positive social-emotional skills, substantially increasing their rate of growth by the time they turn three years of age or exit the program. For Indicator 11, Montana has chosen to focus on Outcome 3, Positive Social-Emotional Skills as our SIMR to pursue over the course of the State-wide Systemic Improvement Plan.

When choosing the SIMR, the Child Outcomes Work Group identified social-emotional skills as the foundation of learning especially important for infants and toddlers with disabilities and their families. Their recommendation is justified by brain development research, as described in more detail below.

Why intervene early?

Decades of rigorous research show that children's earliest experiences play a critical role in brain development. The Center on the Developing Child at Harvard University has summarized this research (Center on the Developing Child at Harvard University, 2010)(Center on the Developing child at Harvard University, 2008):

- Neural circuits, which create the foundation for learning, behavior and health, are most flexible or "plastic" during the first three years of life. Over time, they become increasingly difficult to change.
- Persistent "toxic" stress, such as extreme poverty, abuse and neglect, or severe maternal depression can damage the developing brain, leading to lifelong problems in learning, behavior, and physical and mental health.
- The brain is strengthened by positive early experiences, especially stable relationships with caring and responsive adults, safe and supportive environments, and appropriate nutrition.
- Early social/ emotional development and physical health provide the foundation upon which cognitive and language skills develop.
- High quality early intervention services can change a child's developmental trajectory and improve outcomes for children, families, and communities.
- Intervention is likely to be more effective and less costly when it is provided earlier in life rather than later.

Social and behavioral competence in young children predicts their academic performance in the first grade over and above their cognitive skills and family backgrounds (Raver, C. C. & Knitzer J. (2002), New York: National Center for Children in Poverty, Mailman School of Public Health, Columbia University).

The SIMR is a component within the state-wide initiatives identified under **State-level Improvement Plans and Initiatives.** As noted previously, all Montana Part C providers of early intervention services and supports will be participating in the defined improvement strategies of the SSIP. However, two identified providers will be the focus of increased monitoring with continuous drill down into their data, practices, and Family Support Specialists skills and abilities along with reflection and evaluation of the identified improvement strategies over time. Using these two pilots from two regions to determine the effectiveness of our improvement strategies will guide us as we continue to strive toward continuous improvement for Part C Early Intervention supports and services.

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

The Child Outcomes Work Group identified Summary Statement 1 for Indicator 3, Outcome A as the SIMR. The focus group performed the following tasks before determining the identified SIMR:

- Utilized qualitative method of investigation of overall Child Outcomes ratings; and
- Used smaller, focused samples to determine quality of Child Outcome ratings.

<u>Discoveries:</u>

- Part C providers used individually designed procedures to measure child outcomes with few connections to identified best practices in rating child outcomes.
- Part C providers used a variety of means to formulate their ratings but had lack of understanding of tools provided such as the Decision Tree and formalized assessments.
- Part C providers expressed reluctance to measure child outcomes without always showing growth between entry and exit ratings.
- Part C providers communicated that child outcomes data was not necessarily used for decision-making purposes or monitoring within their agency. Once entry and exit level COS had been completed, no evidence existed that the information was ever reviewed again for any purpose at the local level or at the state level.

Given concerns around the reliability and validity of the child outcomes data presented, the Work Group moved towards identifying the chosen SIMR believing it would have the most impact upon all child outcomes along with their recommendations to improve the child outcomes process. As noted, all Part C providers intend to scale up their practices following the current improvement strategies Montana Milestones/Part C Early Intervention has initiated.

Montana Milestones/Part C Early Intervention Program expects valid and verifiable data available will guide us as we move towards continuous improvement across the State. The data will paint a picture of whether our improvement strategies and implementation truly do increase the percentage of infants

and toddlers with IFSPs who demonstrate improved positive social-emotional skills. As additional data is collected and analyzed and as part of each provider's ongoing monitoring, data-informed decision making will become the norm to determine processes and systems for early intervention in Montana and result in improved outcomes for infants and toddlers.

All State-wide Initiatives include social-emotional components thereby encouraging and, in some cases, requiring the collaboration of local Part C Early Intervention providers and the State office of Montana Milestones/Part C Early Intervention Program.

The Part C Coordinator of Montana Milestones/Part C Early Intervention Program will assist local programs to:

- Increase families and children's access to effective services and programs;
- Provide leadership and support for personnel development and financing effective practice; and
- Engage in collaborative efforts across agencies and resources.

3(c) SIMR as a Child Level Outcome:

Montana chose the child-level outcome to improve social-emotional development of those children who entered or exited the Part C program below age expectations and substantially increase their rate of growth by the time they turn three years of age or exit the program.

Data analysis of this particular outcome indicates addressing problems within the infrastructure across child outcomes measurements may lead to meaningful changes in the percentages of children who substantially increase their rate of growth in positive social-emotional skills. However, using a multi-pronged approach will illustrate both successes and areas for improvement in our child outcomes measurement collection process and the impact of our improvement strategies upon child outcomes.

Our theory for improving the SIMR:

- Positive social, consistent relationships are the base from which development potential is possible;
- Actual Outcome A, improving social/emotional skills including personal relationships data may or may not be accurate; however, current data does not imply continuous improvement in this outcome state-wide;
- Interventions with infants and toddlers and their family members must be based on explicit principles, validated practices, best available research, and relevant laws and regulations.
- Professional development provided for early intervention staff addresses service delivery and includes the early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child's and family's preferences, learning styles and cultural beliefs.

- Consistency for writing functional outcomes based upon children's and family's needs and family identified priorities is essential;
- Consistent measurement of entry and exit child outcomes is compulsory;
- Recurrent monitoring of IFSP promised services compared to IFSP services delivered and outcomes are crucial to determining successful implementation of strategies to improve social/emotional outcomes for infants and toddlers with disabilities and their families.

With the limited personnel resources available within Montana's Part C office, focusing upon two pilot sites to measure the success of our improvement theory is feasible and fiscally responsible. It will provide a template for scaling up practices and supports for all Montana Part C providers throughout the course of the SSIP consistent with the principles of Implementation Science.

3(d) Stakeholder Involvement in Selecting SIMR:

TABLE 13: Stakeholder Group I (FSSAC)
Representatives from the following:

MT DPHHS: Early Childhood Services Bureau	**MT DPHHS:** Child Protective Services	**MT DPHHS:** Children's Mental Health	**MT DPHHS:** Children's Special Health	**MT DPHHS:** Health Resources (EPSTD, Medicaid)	**MT DPHHS:** Developmental Disabilities Program Administrator
Montana Office of Public Instruction: Part B/619 Coordinator	**Montana State Auditor's Office** (Insurance and Securities)	**PLUK** (parent advocacy group)(2 members))	**Parents** (5 members)	**Higher Education Professional Development:** Montana State University	**Higher Education Professional Development:** University of Montana
Early Head Start	**Providers of Early Intervention Services** (4 members)	**Montana School for the Deaf and Blind**	**State of Montana Legislative Representative**	**MT DPHHS:** Quality Improvement Specialist	

TABLE 14: Child Outcomes Work Group

CDC	Catherine Hafliger and Cassandra Schrockenstein
DEAP	Sandy Peaslee
ECI	Christa Tescher
STEP	Angela Thompson, Katrina Leligowicz, and Chelsie Guilford
Family Outreach	Teri Lilletvedt, Katelyn Stewart, Jill Ballantyne, Mariah Cantwell-Frank, Cindy Larson, Colleen McGee, and Paula Black
QLC	Kari Hoover and Norma Zelzer
Hi-Line Home Programs	Denise Herman and Jean Snider

The Stakeholders and Child Outcomes Work Group contributed to the selection of the SIMR through their participation in numerous meetings held throughout 2013-2014 as well as deeper analysis and research into all child and family outcomes before determining the selection of positive social-emotional skills. The choice of the SIMR also reflected the movement of Montana Milestones/Part C Early Intervention Program's approach to the delivery of services based on values and beliefs regarding how professionals interact with and relate to the families they serve, i.e., a family-centered approach using a coaching interaction style in early intervention, Routines-based Interviews™, and Routines-based Early Intervention™.

3(e) Baseline Data and Targets:

TABLE 15: State-wide Baseline Data

Positive Social-Emotional Skills – Summary Statement 1					
2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014
62%	59%	64%	62%	63%	72%
Positive Social-Emotional Skills – Summary Statement 2					
2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014
56%	55%	52%	51%	50%	63%

TABLE 16: Target Data for Identified Pilot Sites: DEAP and CDC

		Positive Social-Emotional Skills – Summary Statement 1					
Baseline		**FFY 2013**	**FFY 2014**	**FFY 2015**	**FFY 2016**	**FFY 2017**	**FFY 2018**
CDC 64%	**DEAP 60%**	**≥59%**	$\geq 59\%$	$\geq 61\%$	$\geq 63\%$	$\geq 63\%$	$\geq 65\%$
		Positive Social-Emotional Skills – Summary Statement 2					
Baseline		**FFY 2013**	**FFY 2014**	**FFY 2015**	**FFY 2016**	**FFY 2017**	**FFY 2018**
CDC 60%	**DEAP 56%**	$\geq 53\%$	$\geq 53\%$	$\geq 53\%$	$\geq 56\%$	$\geq 56\%$	$\geq 59\%$

Deeper analysis into the outcomes data variances among the seven providers raised concerns and led to the creation of an Outcomes Work Group with representation from each of the providers. Based upon the Work Group's investigation and discovery of the systems used by the providers to determine outcomes ratings, the Stakeholders were doubtful that the current baseline data was a true and accurate reflection of outcomes measurements in Montana. Based upon the outcomes data accumulated thus far and the investigation into the reliability and validity of outcomes measurements; the Stakeholders requested Montana Milestones/Part C Early Intervention Program proceed with caution using the previously set targets as our continued targets for 2014-2015 with incremental increases following in 2016-2018. As Montana moves through the SSIP with dedicated focus upon data collection, analysis, and decision-making based upon analysis, our objective is to have valid, reliable data to continue to adjust our targets for continuous improvement as each year progresses.

Component #4: Selection of Coherent Improvement Strategies

4(a) How Improvement Strategies were selected:

The following strategies are interwoven within our theory for improving outcomes for children and families in Montana Milestones/Part C Early Intervention Program. Identified improvement strategies have been in place since 2013 – 2014 and are direct results of the FSSAC fall 2013 strategic planning and Stakeholders meetings to improve Part C in Montana in a systemic and sustainable way. Recognizing the State had not required or encouraged consistent strategies throughout Montana or that it had not measured the results of any strategy in a meaningful way, the strategies were chosen specifically to promote Part C Rules and Regulations of 2011 in addition to improving social-emotional outcomes for children and families. The revision of the monitoring tool and the implementation of service/support data will be keys to measuring the effectiveness of the identified strategies. Those identified as "new" are strategies chosen based upon infrastructure and data analysis as part of development of the SSIP.

TABLE 17: Montana SSIP Improvement Strategies

	Foundational Beliefs	Strategies Currently Being Implemented	New Strategies
Professional Development	• Interventions with infants and toddlers and their family members must be based on explicit principles, validated practices, best available research, and relevant laws and regulations. • Professional development provided for early intervention staff addresses service delivery and includes the early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child's and family's preferences, learning styles and cultural beliefs.	1. Routines-Based Interviews™ certification at the Siskin Institute to develop Coaches able to provide training at MT RBI™ Boot Camps 2. Routines-Based Early Intervention™ 3. Using a Coaching Interaction Style in Early Intervention (families and professionals) with Master Coach component	4. The Montana Digital Academy will be utilized as Montana's online platform for three key learning modules. The Basics of Early Intervention, Introduction to the MEISR™, and Introduction to RBI™ will be presented to all Family Support Specialists in pilot format, spring 2015, for their feedback. 5. Research and writing of Montana Milestones/Part C Early Intervention Program position paper defining early intervention in Montana. 6. To facilitate increased early intervention teaming, Shelden and Rush will present the Primary Service Provider Approach to Teaming along with intensive Master Coaching support

			beginning in July 2015. 7. Develop and implement an early interventionist component for the Montana Early Childhood Practitioner's Registry to monitor and evaluate early interventionists' coursework leading to certification.
Assessment Practices	• Consistent measurement of entry and exit Child Outcomes is compulsory; • Recurrent monitoring of the IFSP promised services compared to IFSP services delivered and Outcomes are crucial to determining successful implementation of strategies to improve social-emotional outcomes for infants and toddlers and their families;	8. Development of Child Outcomes Process Guidance and training of Family Support Specialists to ensure data will be scored correctly and used to improve supports and services provided to infants and toddlers and their families	9. Revised Monitoring Tool 10. Quarterly Outcomes Monitoring 11. Services and Supports data collection by providers 12. Research and identify appropriate functional assessment tools to identify social-emotional needs for infants and toddlers and their families and implement identified tool.
Family Involvement	• Consistency for writing functional outcomes based upon children's and family's needs and family identified priorities is essential.	13. MT RBI™ Boot Camp for MT Approval in RBI™ methodology.	14. Investigate and plan for implementation of an effective model for promoting social-emotional and behavioral outcomes with families, ***Pyramid Model***: ○ Provide families with information on how to develop nurturing relationships with their infant and toddler ○ Provide information to families on practices that may be used to promote their child's healthy

			social-emotional development ○ Provide screening and referral services for mothers who may have maternal depression (Montana has been named a ***Pyramid Model*** Consortium Partner State.)

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

Montana Milestones/Part C Early Intervention Program fundamentals:

Full implementation of Routine-based Early Intervention™ (RBEI™) and use of coaching as an adult learning strategy are existing statewide initiatives in Montana Milestones/Part C Early Intervention. These strategies are expected to have better effects for selected functional outcomes, including social-emotional, than traditional home visit programs. Some critical aspects of RBI™ are as follows:

- The family's role in early intervention is to broaden the children's opportunities for active exploration and learning in daily living activities (Dirks and Hadders-Algra, 2011, Hadders-Algra, 2011, McWilliam, 2010 and Melnyk et al., 2004). The family has the autonomy to identify children's problems according to their own child-rearing perspectives and make decisions about intervention strategies.
- The role of the interventionist changed from being an instructor or a teacher to being a collaborator working with the family (Dirks and Hadders-Algra, 2011 and Hadders-Algra, 2011). Under the context of equal partnership with the family, interventionists now use coaching techniques to empower the family rather than direct instruction to educate them (Dirks and Hadders-Algra, 2011, Hadders-Algra, 2011 and Peterson et al., 2007).

RBEI™ is a recently developed approach focusing on achieving functional outcomes, namely child's independence, enhancement of social relationships with others, and parents' satisfaction with routines, by providing the children with learning opportunities in naturally occurring contexts (i.e., daily routines) and systematically uses collaboration and coaching to set functional goals and implement service plans with the family (McWilliam, 2010).

Routines are defined as activities with regularity (Sytsma, Kelley, & Wymer, 2001), such as those that predictably occur in the same order about the same time each day. These routines reflect the common goals of the family, for example, preparing meals or getting the children ready for bed, and provide a natural learning context.

RBEI™ begins with a Routines-based interview (RBI™) with families and incorporates home visits (McWilliam et al., 2009 and McWilliam, 2010). The Routines-Based Interview™ (RBI™) is an informal

semi-structured method of gathering information about a child and the family's daily routine, which guides the parents or caregivers to report the tasks and the manner the children accomplish these tasks in the routine; it allows the Family Support Specialists to guide parents to determine and prioritize outcomes (McWilliam, 2010). RBEI™ emphasizes children's success in performing routines in the current environment as functional outcomes, which can be identified during RBI™. In comparison to traditional domains that early interventions used as primary outcomes, such as fine motor, gross motor, communication, cognition, and behavior (Blauw-Hospers and Hadders-Algra, 2005, Brooks-Gunn et al., 1994 and Peacock et al., 2013), the functional domains were found to be more meaningful for families and children.

The traditional domains are not completely eliminated in RBEI™, but incorporated within the functional domains. The RBEI™ process includes the current family-centered practices and promotes parental empowerment by incorporating intervention into children's or families' daily routine in the natural home setting. This approach provides the child opportunities to acquire skills repeatedly over time in the natural home environment. The learned skills are expected to sustain in real life for a longer time. Consequently, functional and developmental outcomes are considered to be the primary and secondary outcomes in RBEI™, respectively.

The ***Pyramid Model*** provides the framework for the supports and interventions needed by all families for healthy social emotional development in infants and toddlers. It provides a tiered intervention framework of evidence-based intervention for promoting the social, emotional, and behavioral development of all infants and toddlers, of all abilities. Depending on strong partnerships with families, Family Support Specialists focus on enhancing the families' capacity to support and promote their children's social emotional development within the framework of their routines. They will provide information to families about social-emotional development in context of caregiving relationships and routinely talk about social-emotional milestones as part of development as well as support for families.

Shelden and Rush define coaching is an adult learning strategy in which the coach promotes the learner's ability to reflect on his or her actions as a means to determine the effectiveness of an action of practice and develop a plan for refinement and use of the action in immediate and future situations. For the child, this means being with partners in life who the child wants and needs to be with and doing what he wants and needs to do (Shelden & Rush, 2001). For the learner, coaching develops the competence and confidence to implement strategies to increase the child's learning opportunities and participation in daily life, know when the strategies are successful and making changes in current situations as we are generalizing solutions to new and different circumstances, people, and settings (Bruder & Dunst, 199; Fenichel & Eggbeer, 1992: Flaherty, 1999, Kinlaw 1999).

The Summer Institute 2015, July 20 and 21, 2015, presented by Shelden and Rush will emphasize using a Primary Coaching Approach (PSP as Coach), a family-centered, capacity building method to intervention. Montana's Family Support Specialists, in keeping with Montana's RBEI™ Implementation Timeline, will learn about a primary coach approach to teaming with the assignment of one member of a multidisciplinary team as the primary coach where he or she receives coaching from the other team

members and uses coaching with parents and other primary caregivers to support and strengthen their confidence and competence in promoting child learning and development. This, too, will be followed by six months of more intensive professional development provided by Shelden and Rush to identified Master Coaches from each provider agency. The third day of the Summer Institute 2015, July 22, 2015, will highlight each provider's chosen evidence-based practice and its impact on child and family outcomes.

Several identified improvement strategies have been in place since 2013 – 2014 and are direct results of the FSSAC fall 2013 strategic planning and Stakeholders meetings to improve Part C in Montana in a systemic and sustainable way. The foundation of early intervention in Montana was determined by the previously identified Stakeholders and the strategic plan with its initiatives were developed to promote the consistency and sustainability of the foundation. As time passes, further enhancements will be necessary to continuously improving Part C Early Intervention supports and services in Montana. The Stakeholders and associated work groups focused upon the following: 1. expanding monitoring to inform data-driven decision making; 2. child outcomes guidance including valid and reliable measurement; and 4. investigation and implementation of an effective model, the ***Pyramid Model***, for promoting social-emotional and behavioral outcomes with families as further strategies to improve social-emotional skills and positive relationships for infants and toddlers with disabilities and their families.

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

Montana identified inconsistent data gathering processes and limited focus by local staff on individualized social and emotional needs and development of children as the root causes that lead to selection of the SIMR. Montana's Part C Program stakeholders noted an absence of cohesive direction of the Part C Program in 2012-2013. Following the publication of the Part C Rules and Regulations in 2011, a small number of Family Support Specialists attended a national conference and discovered Dr. McWilliam, who influenced a pivotal change in Part C services and supports in Montana. His approach to interviewing families and developing functional outcomes based upon the child and family's routines inspired them. Following the conference, four Family Support Specialists attended Dr. McWilliam's RBI™ training at the Siskin Institute. After the four became nationally certified following a rigorous training and assessment, Montana brought Dr. McWilliam to Helena to provide a slightly modified version of his Institute. Following that experience, seven Family Support Specialists were certified in RBI™ and the Stakeholders convened to develop an implementation plan for RBI™ and RBEI™ in our state. At this junction, the previous Part C Coordinator resigned resulting in a six month vacancy. When the current Part C Coordinator was hired, drift from RBI™ and RBEI™ already had occurred proving even if an intervention or practices has been demonstrated to be effective by research, if it is not implemented with sufficient fidelity to the established model, it will likely fail.

In an effort to move forward with the implementation plan with fidelity, several strategies were employed quickly:

- Additional candidates were trained at the Siskin Institute in RBI™ and RBEI™

- The MT RBI™ Boot Camp was developed and implemented in specific geographic regions in the state enabling Montana to train large numbers of Family Support Specialists in RBI™ and RBEI™ methodology; and
- The FSSAC developed the Part C Strategic Plan focusing upon state-wide initiatives identified below:
  - ✓ Assuring efficiency and effectiveness with processes and requirements so consistency exists across all providers and within the State's monitoring;
  - ✓ Developing data collection and analysis to improve outcomes using a singular data system response to DPHHS needs, provider needs, and family needs enabling all providers and DPHHS to use reliable data to make decisions; and
  - ✓ Provide an effective professional development system so providers of early intervention services and supports are highly competent and regularly connected across the State.

To create a sustainable and systemic method of delivering professional development and build upon fidelity in our vast state, investigation into the Montana Digital Academy began to determine its ability to develop educational modules around specific early intervention rules, regulations, procedures, and practices necessary for all Family Support Specialists.

In an effort to aid Family Support Specialists in shifting their focus from child-centered interventions to family-centered intervention, Montana provided professional development in *Using a Coaching Interaction Style in Early Intervention* and the creation of an intensively-trained Master Coaching learning community. Additional professional development regarding the Primary Service Provider Approach is planned for July 2015.

Data analysis led the Stakeholders group to look deeply into child outcomes. The ensuing root cause analysis guided the group in developing improvement strategies to build capacity to improve social-emotional outcomes for children among all Part C early intervention providers in Montana.

The existing reliability and validity of the child outcomes measurements data in Montana is questionable. Consequently, several steps are planned to improve consistency, validity and reliability of the state's data.

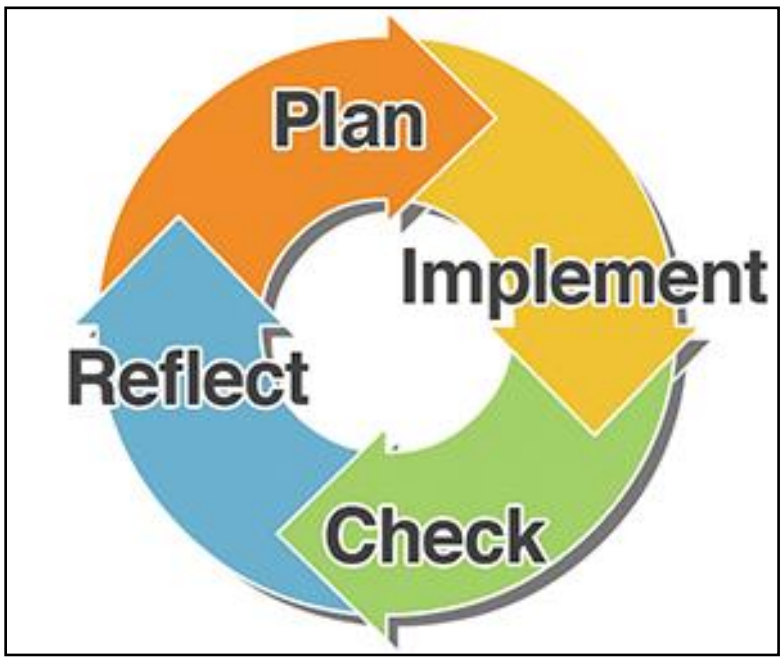
Timely review of accurate data is critical. Therefore, improvement strategies to address this issue are included, Quarterly Child Outcomes Monitoring.

A valuable monitoring tool which drills down into outcomes data is necessary to ensure that improvement strategies are being implemented with fidelity throughout the state.

Montana Family Support Specialists cannot effectively measure social-emotional skills without using functional assessments. Identification of additional evidence-based assessments and practices to focus upon increasing social-emotional skills of infants and toddlers and their families is critical to the successful outcome of this activity.

Finally, a clearly articulated vision for what early intervention is defined as in our State will ensure all Part C early intervention providers are on the "same page."

No improvement strategy is sufficient or sustainable without a continuous cycle of improvement. As noted, the inclusion of specific cycles of monitoring to gage effectiveness will be a component of all improvement strategies. The SSIP provided Montana opportunity to develop new structures to monitor success and draw ideas and strategies from a large, diverse stakeholder group. As Montana's recent history illustrates, implementing practices and procedures, even with gusto, is not enough for the practice/procedure to become embedded within all Part C provider agencies. Learning the value of data and its implications upon our practices and procedures will be a much needed practice included within our ongoing monitoring of the elements of Part C Early Intervention.



4(d) Strategies Based on Data and Infrastructure Analyses:

Analysis of Montana Milestones/Part C Early Intervention Program began with a backwards look at specific improvement strategies in place and led to conjecture about their effectiveness and the fidelity in which they are practiced. Deeper analysis into outcomes data led Montana to review what was perceived to be embedded procedures around the child outcomes process. Each deeper look into a practice, policy, procedure opened our eyes to additional pieces that may have been overlooked or under-utilized.

Focusing upon Montana's strengths and momentum in using Routines-Based Interviewing™ and Routines-Based Early Intervention™ to promote family-centeredness and functional outcomes, the next steps include the continued training of RBI™ trainers by Dr. McWilliam in an effort to promote fidelity of the practice. Likewise, continued training in Coaching practices to aid Family support Specialists as they

work closely with family members to enhance their child's development goes hand in hand with RBI™ and RBEI™.

However, to improve the SIMR at our pilot sites and across Montana, the previously implemented improvement strategies alone were insufficient especially with unreliable data to determine effectiveness. Montana's overall objectives to promote quality and consistency state-wide include the following:

- Systemic and sustainable professional development is required to be readily available to Family Support Specialists to increase their competence in all components of Part C Early Intervention and the measureable results of infants and toddlers and their families;
- Ongoing monitoring of compliance and quality indicators including outcomes, supports and services, are necessary to ensure providers are using data to drive decision-making processes and plan for improvement;
- Investigating and determining appropriate functional assessment methods to identify social-emotional needs of infants and toddlers is necessary. Appropriate interventions to enhance a family's ability to support social-emotional development leading to improved outcomes must be identified; and
- Montana must develop and share with all stakeholders a comprehensive description of Early Intervention in Montana, a roadmap to supports, services, policies, and procedures consistent within each Part C provider agency.

Scaled-up Practices:

- Implementation of RBI™, RBEI™, and Coaching with fidelity;
- Child Outcomes Measurement Guidance and ongoing professional development;
- Quarterly monitoring of outcomes data and services and supports data to determine effectiveness and implementation stages of practices and improvement strategies;
- Professional development in the ***Pyramid Model*** and functional assessment of social-emotional skills;
- Systemic monitoring of all Part C program compliance and quality indicators; and
- Continuous feedback loop to inform decision-making with State office, providers, and Quality Improvement Specialists.

4(e) Stakeholder Involvement in Selecting Improvement Strategies:

Building upon the Montana Part C Strategic Improvement Plan, the **FSSAC** worked with the Part C Coordinator to select and/or continue improvement strategies. The group met six times over the course of the past year to develop the content of the SSIP. The **Child Outcomes Work Group** developed the outline of the Child Outcomes Guidance document, identified the SIMR as well as recommending professional development strategies. Recognizing monitoring as a key component of the SSIP, the group commissioned the **Quality Improvement Work Group** to develop an integrated monitoring tool reflective of Part C Rules and Regulations and Montana's practices.

FSSAC Membership:

Early Intervention Regional Providers (4): representatives from four regional providers who are contracted with the State to provide Part C Early Intervention in their defined region (Carolyn Prussen, CDC, David Munson, ECI, Sylvia Danforth, DEAP, Priscilla Halcro, QLC).

University of Montana – Speech and Language Therapist: Dr. Lucy Hart Paulson represents the American Speech and Language Association for Montana as well as the Speech and Language graduate program at the University of Montana.

Montana State Legislative Representative: Representative Jean Price is appointed by the Governor to serve as the Legislative Representative on the Council. She also is a member of the Education Committee within the Legislative Body.

MT Department of Health and Human Services, Children's Health: Heather Racicot represents Children's Special Health Needs.

MT Department of Health and Human Services, Quality Improvement Specialist: Ryane Holzworth represents the monitoring arm of Montana Milestones/Part C Early Intervention Program.

Parents (5): Laura McKee, Rebecca Richards, Bonnie Ramage, Amber Duncan, and Linda Zermeno represent parents of an infant or toddler with a disability.

MT Department of Health and Human Services, Health Resources (Medicaid State Plan): Amber Wells represents Medicaid EPSTD.

Montana School for the Deaf and Blind: Laura Copp represents MSDB as a regional early interventionist for children who are deaf and/or blind.

Montana Office of Public Instruction: Danielle McCarthy represents Part B/619.

MT Department of Health and Human Services, Child and Family Services: Dawn Piazzi represents CFS workers involved with infants and toddlers removed from the family home.

Montana State Auditor's Office (Insurance Commissioner): Ron Herman represents the Insurance Commissioner.

Parents Lets Unite for Kids (Montana's Parent Group): Lori Gaustad represents the parent organization and Roger Holt is the Executive Director for PLUK.

MT Department of Health and Human Services, Children's Mental Health: Zoe Barnard represents Children's Mental Health focusing upon infants and toddlers with disabilities.

MT Department of Health and Human Services, Developmental Disabilities Program: Tim Plaska represents the administration of the Developmental Disabilities Program.

Montana State University – Professional Development: Dr. Christine Lux represents early childhood professional development at Montana State University.

Early Head Start: Jody Jones represents Salish-Kootenai Early Head Start.

University of Montana Rural Institute: Executive Director Marty Blair promotes inclusive communities

Child Outcomes Work Group Membership:

The responsibility of the Child Outcomes Work Group was initially to investigate the Child Outcomes Process and identify areas needing improvement. Their work evolved to developing guidance for completing the Child Outcomes Process, MEISR™ training, and development of training modules for Montana's Child Outcomes Process which will be provided to all Family Support Specialists state-wide, and the determination of the State's Identified Measureable Result based upon their data analysis. The group met three times and will meet again in March 2015.

Child Development Center (CDC): Catherine Hafliger and Cassandra Schrockenstein – Part C Program Coordinators

Quality Life Concepts (QLC): Norma Zelzer and Kari Hoover – Part C Program Coordinators

Hi-Line Home Programs: Denise Herman and Jean Snider – Part C Program Coordinators

Family Outreach: Teri Lilletvedt, Mariah Cantwell-Frank, Jill Ballantyne, Colleen McGee, Katelyn Stewart, Cindy Larson, and Paula Black – Part C Program Coordinators

DEAP: Sandy Peaslee – Part C Program Coordinator

ECI: Christa Tescher – Part C Program Coordinator

STEP: Angela Thompson, Katrina Leligowicz, and Chelsie Guilford – Part C Program Coordinators

Quality Improvement Work Group Membership:

The responsibility of the Quality Improvement Work Group was to investigate monitoring tool examples for Part C Early Intervention and develop a monitoring tool for Montana Milestones/Part C Early Intervention reflective of Part C Rules and Regulations and Montana's current practices. Additionally, they created a timeline for monitoring, feedback, and a method to promote quality and plans for remediation. The group met three times and provided presentations to the Stakeholders group to obtain input and make revisions. The Monitoring Tool is being readied for final review and piloted use in April/May 2015.

Region I Quality Improvement Team: Connie Wethern, Sandra Carpenter, and Kathleen Kaiser

Region 2 Quality Improvement Team: Laura Gebo and Lori Wertz

Region 3 Quality Improvement Team: Shannon Merchen, Troy Kelly, and Ryane Holzworth

Region 4 Quality Improvement Team: Catherine Murphy, Alexis Marthaller, and Joe Beneventi

Region 5 Quality Improvement Team: Paula Tripp and Paula Sherwood