New Jersey Early Intervention System

SPP/APR FFY 2013 (SFY 2014)

Indictor 11-Attachment

State Systemic Improvement Plan

Submitted: April 1, 2015

Overview

The New Jersey Department of Health (DOH) is the designated State Lead Agency for the Early Intervention System (NJEIS) established under Part C of the Individuals with Disabilities Education Act. As such, DOH is ultimately responsible for implementing its general supervisory authority to ensure the availability of appropriate early intervention services for eligible infants, toddlers and their families.

New Jersey (NJ) is a geographically small northeastern state with a diverse population of 8,938,175 according to the July 1, 2014 estimate by the U.S. Census Bureau. Despite its small geographic size NJ ranked first as the most densely populous state in the country (1,185 residents per square mile). New Jersey is divided into three geographic regions they are: North Jersey, Central Jersey and South Jersey. The state has a twenty-one county governmental structure and is the only state that has had every county deemed "urban" as defined by the Census Bureau's Combined Statistical area.

The U.S. Census bureau estimates that NJ's median household income for the year 2013 was $71,629. The 2013 U.S. Census estimates include 320,132 children that are under three years of age. The US Census Bureau reported for 2009-2013 that 17.9% of NJ's children under the age of five were below the federal poverty level. In SFY 2014 the NJEIS had 19,026 referrals to the program.

NJ was one of the last states to receive an Office of Special Education Program (OSEP) verification visit which required the identification of a results topic. At that time (2011) trend data from the previous Annual Performance Reports (APRs), showed that NJEIS was not meeting performance targets for Indicator 3A. As part of the efforts related to the OSEP verification visit and the ensuing results work, the DOH assembled Stakeholders to identify, develop and implement activities and strategies to improve the social and emotional outcomes for participating children. Between 2011 and 2013 the NJEIS provided training opportunities for Service Coordination Units on the Ages and Stages Screening tools, surveyed the service coordinators about their knowledge of social and emotional development and worked with national technical assistance providers to drill into the data for potential root causes and/or patterns. NJEIS learned that there were no similarities or patterns by age or region in either FFY 2009 or FFY 2010 that would have indicated a root cause at that time. NJEIS conducted a survey among service coordinators which revealed the service coordinators enrolled in the system reported being confident in their knowledge about social and emotional development and their ability to work with families on this developmental area.

By the time of the annual Part C Steering Committee meeting in January 2014, DOH was aware of the intentions of OSEP to shift focus in the SPP/APR to include greater emphasis on Results Driven Accountability, and what would eventually be finalized and released as Indicator C11: the State Systemic Improvement Plan (SSIP). Therefore, in addition to the review and discussion of the compliance and performance indicators at this meeting, the DOH presented preliminary information about Results Driven Accountability to the Stakeholder group. The membership of the NJEIS Part C Steering Committee has been very consistent for several years and therefore

each member has a strong working knowledge of the APR indicator data and the strengths and challenges for the NJEIS. When presented with the possibility of an intensified and sustained attention to results as a component of the SPP/APR, the Part C Steering Committee agreed that the DOH consider Indicator 3A; the percentage of infants and toddlers with IFSPs who demonstrate improved positive social and emotional skills including social relationships.

Beginning the SSIP

The earliest phases of the SSIP began with the selection of a Lead Agency Leadership Team referenced in this report as the SSIP Leadership Team to coordinate its development and eventual execution. The SSIP Leadership Team includes the Part C Coordinator, Results Accountability Coordinator, Monitoring Coordinator, CSPD Coordinator and Central Management Office Coordinator.

The selection of Stakeholders began with the members of the established NJEIS Part C Steering Committee which included the membership of the State Interagency Coordinating Council (SICC). The Part C Steering Committee therefore includes advocacy agencies, parents, early intervention provider agencies, and other state department agency representatives, members of the pediatric medical community, higher education, Regional Early Intervention Collaborative (REIC) staff and staff from the lead agency. The DOH then identified and offered an invitation to additional specific individuals and public and private agencies to join the Part C Steering Committee and participate in the SSIP development. The additional invited Stakeholders included persons that represent NJEIS Targeted Evaluation Teams (TETs), the Infant Mental Health Community, additional family support staff and advocates for families and state partners that support infants and young children through the child welfare system and other state initiatives. The complete list of Stakeholders involved and their affiliation is attached to this submission.

The state team, with Stakeholder input, spent one full year collecting and *Analyzing Data,* completing an *Infrastructure Analysis,* determining *Root Causes,* developing *Coherent Improvement Strategies* and finalizing a *Theory of Action.* These efforts are detailed here in Phase One of the SSIP and are intended to support the implementation of the State Identified Measureable Result (SIMR):

To substantially increase the rate of children's growth in their development of positive social and emotional skills by the time they exit the program, as defined by the targets established for Indicator 3A, Summary Statement 1 in each of the years, FFY 2014-2018.

Component #1: Data Analysis

Measuring Child Outcomes in NJ

The NJEIS uses the Battelle Developmental Inventory 2nd edition (BDI) to report on child outcomes by using the developmental scores a child received upon entry into the program compared with the developmental scores of the child upon exit from the program. NJEIS business rules use the Standard Score of the BDI (mean =100, standard deviation of 15) as the primary data point for assigning children to a progress category. To ensure that even the smallest progress is captured, measured and reported, the NJEIS business rules also factor in changes in raw scores for each child. The NJEIS set the "with peers" standard using the Standard Score of 80 or above on the BDI in each of the five (5) domain areas assessed by the instrument. NJEIS uses the Personal-Social Domain of the BDI to report on Indicator 3A, the Cognitive and Communication Domains to report in 3B, and the Adaptive and Motor Domains to report on Indicator 3C.

NJ's Processes to Identify, Select, and Analyze Data

Throughout the development of this SSIP over the past year, the DOH utilized all available data to inform each of the processes outlined in Indicator C11. Where feasible and as indicated, data sets were analyzed by state level performance and local (County) level performance. Specific data sets are presented later in this section. In addition to the available NJEIS APR data, the DOH:

- Considered additional data sets recommended by Stakeholders;
- Consulted and collaborated with other Part C states that utilize the BDI for child outcome measurement;
- Consulted with other Part C states that were considering Indicator 3A as their SIMR;
- Considered other data sets related to young children and their families; and
- Reviewed the data previously gathered via the results work

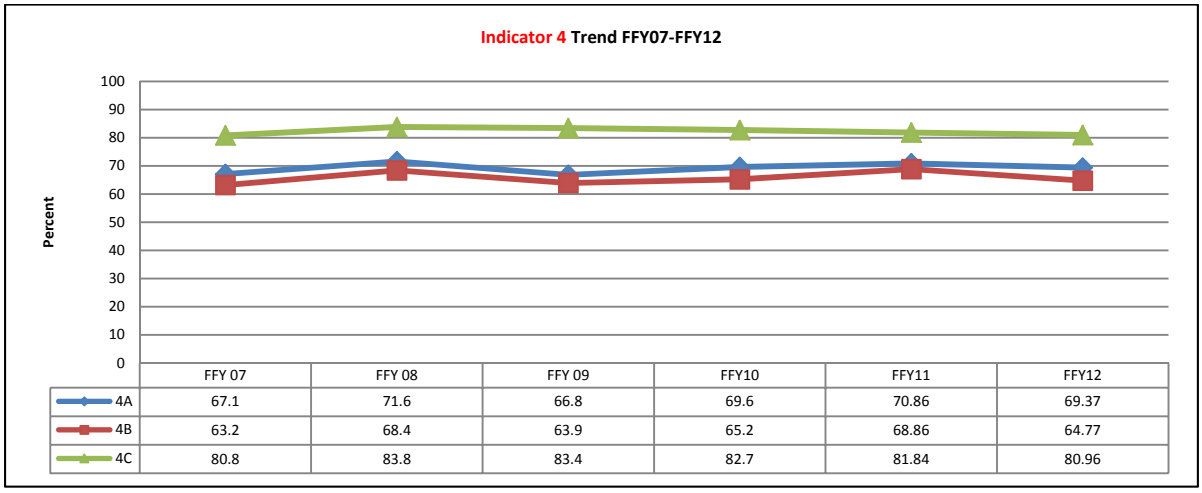
Broad Analysis

Broad data analysis and consideration of a SIMR officially began with the state team reviewing all state 618 (Federal Child Count) and 616 (APR) data including evaluating the performance data in both child and family outcomes. Trend compliance data for C1, C7 and 8A-C were reviewed. NJEIS has strengths in these indicators and compliance is within 95%- 100%. There are several counties that have, in some years, had a slip in performance on an individual compliance indicator. However, there is no discernable pattern that would suggest barriers to implementation strategies for this SIMR based on compliance data.

The DOH was in a unique position to consider both child and family outcomes as possible choices for a SIMR having previously invested in continuous quality improvement efforts related to Indicators 3A and 4A, 4B and 4C prior to the SSIP requirement. Child Outcomes (3A) in social and emotional development became the focus of improvement strategies in conjunction with the OSEP Results visit in October 2011. At about the same time, NJEIS initiated data-informed improvement work in family outcomes based on the APR Indicator 4 performance.

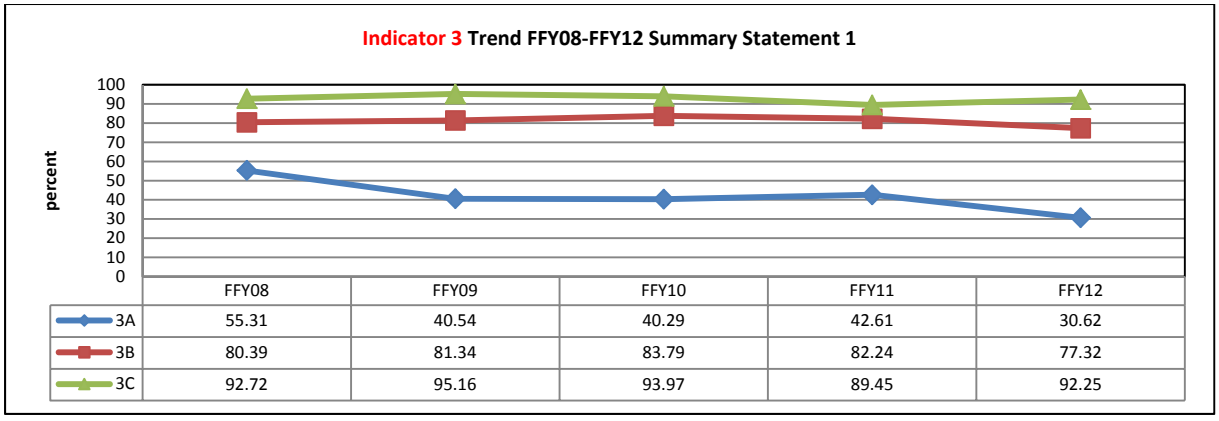
This work has been ongoing in four targeted counties utilizing the survey data and resources and skills of the REICs.

NJEIS obtains performance data on family outcomes through the use of the NCSEAM family survey. Indicator 4A, 4B and 4C statewide trend data were consistent and stable. Individual counties that have been implementing data-informed improvement strategies with the REIC were maintaining those activities into FFY 2013.

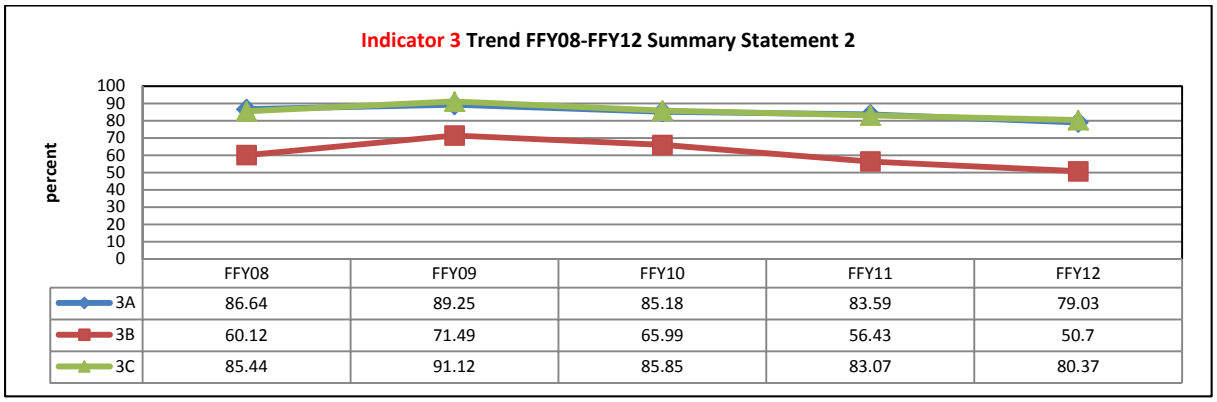


	FFY 07	FFY 08	FFY 09	FFY10	FFY11	FFY12
4A	67.1	71.6	66.8	69.6	70.86	69.37
4B	63.2	68.4	63.9	65.2	68.86	64.77
4C	80.8	83.8	83.4	82.7	81.84	80.96

Trend Data for Indicator 3 FFY 2008-FFY 2012

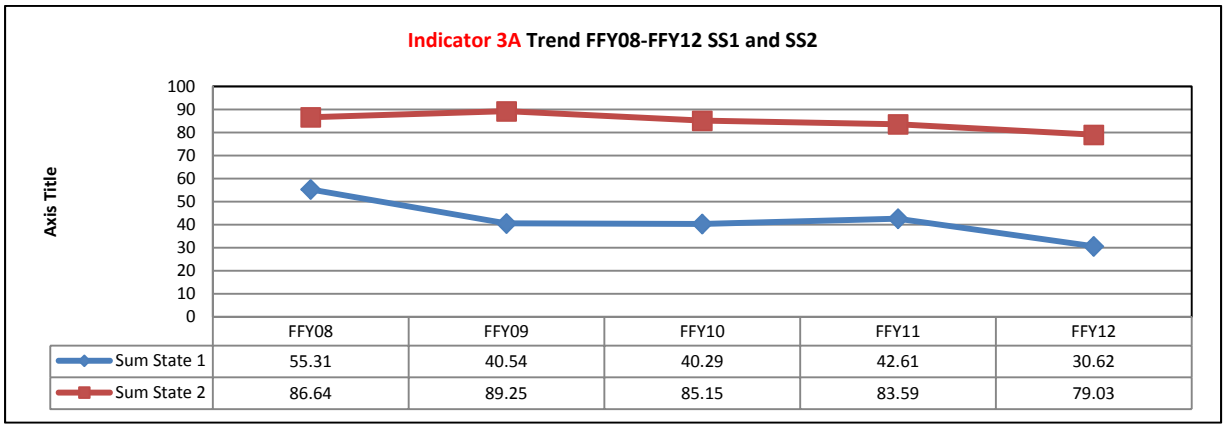


	FFY08	FFY09	FFY10	FFY11	FFY12
3A	55.31	40.54	40.29	42.61	30.62
3B	80.39	81.34	83.79	82.24	77.32
3C	92.72	95.16	93.97	89.45	92.25



	FFY08	FFY09	FFY10	FFY11	FFY12
3A	86.64	89.25	85.18	83.59	79.03
3B	60.12	71.49	65.99	56.43	50.7
3C	85.44	91.12	85.85	83.07	80.37

Trend performance data for each sub-indicator and each Summary Statement were discussed. Indicator 3A showed a trend of slippage in performance and overall low performance compared to 3B and 3C. Indicator 3A Summary Statements 1 & 2 were as follows:



	FFY08	FFY09	FFY10	FFY11	FFY12
Sum State 1	55.31	40.54	40.29	42.61	30.62
Sum State 2	86.64	89.25	85.15	83.59	79.03

After consideration of the trend data in C3 and C4, DOH concluded that the performance in C4 did not merit a five year "systemic improvement plan" whereas child outcomes and specifically children's social and emotional development would significantly benefit from an intensive plan.

***Stakeholder Input*: May 16, 2014**

On May 16, 2014, the finalized SSIP requirements were brought to the SICC along with the data described above as had been reviewed by DOH. The SICC members were presented with state FFY 2008-FFY 2012 performance trend data, regional performance data for FFY 2012, and the National Data Quality Standards for each reporting category. SICC members agreed that DOH should proceed with pursuing an SSIP based upon Indicator 3A.

Stakeholder Input: July 25, 2014

A full day SICC retreat meeting was held on July 25, 2014, that included an open invitation to other members of the Part C Steering Committee and additional invited Stakeholders. At this meeting the Stakeholders were presented a data package created by DOH that included:

1. Preliminary Indicator 3 data for FFY 2013;
2. Trend data on Indicator 3 for FFY 2008-FFY 2012;
3. Published national data on Indicator 3 compared with NJ performance;
4. NJ's data quality compared to the proposed National Data Quality Standards
    a. For data completeness,
    b. For progress categories a-e; and
5. Preliminary NJEIS BDI fidelity data collected through observations and the BDI *Fidelity Checklist* which will be covered in more detail later under this component.

The Stakeholders asked questions about the data and provided input into further lines of inquiry. After endorsing the working SIMR, the Stakeholders used this data package as reference to conduct the Infrastructure Analysis to address the proposed SIMR.

At the end of the meeting, an invitation was extended to all participants to attend the next SICC meeting scheduled for September 19, 2014 to continue the good work of this Stakeholder group. At this point, these stakeholder groups collectively joined together to become the designated Part C Stakeholder group for SPP/APR including the SSIP, hereafter for the remainder of this report are referred to as the "Stakeholders".

In-depth Analysis

After the July meeting, the DOH focused on final data clean-up for FFY 2013 Indicator 3 prior to any disaggregation for SSIP purposes. The following sections each describe a point in time that updated data were presented to various groups for their consideration.

Stakeholder Input: September 19, 2014

On September 19, 2014, the DOH updated the Stakeholders on its data clean-up. A sub-group was formed to examine the additional data sets once the FFY 2013 data were finalized and able to be disaggregated.

Stakeholder Input: September 25, 2014

On September 25, 2014 the SSIP leadership team presented data that were gathered and analyzed on BDI fidelity to the DOH Commissioner and her senior staff including the Deputy and Assistant Commissioners as part of the DOH's Continuous Quality Improvement efforts. The senior staff of the DOH provided comments including ideas for next steps in utilizing the data.

Stakeholder Input: October 20, 2014

On October 20, 2014, the DOH met with the NJEIS Targeted Evaluation Teams (TETs) and Service Coordination Units (SCUs) and provided for their review, a data package that focused specifically on data quality. As the TETs and SCUs have primary responsibility for ensuring the data is both collected and properly entered into the appropriate databases, their understanding

of the SSIP and any data quality issues is vital to needed improvements. The group was provided specific data on the following:

1. NJ's Data Completeness for Indicator 3
    a. By state
    b. By county
2. Proposed National Data Quality Standards for Indicator 3
    a. By performance category (a-e)
    b. For data completeness
3. Indicator 3 preliminary performance data
    a. By state
    b. By county; and
4. BDI fidelity data
    a. Quantified ratings of fidelity
    b. Qualitative data on patterns of error

Stakeholder Input: November 21, 2014

On November 21, 2014, the Stakeholder data sub-group had the opportunity to review and provide input into the DOH preliminary disaggregation of Indicator 3A. The Stakeholders reviewed the following data sets:

1. Preliminary state performance for FFY 2013 on Indicator 3;
2. Preliminary county performance for FFY 2013 on Indicator 3;
3. Preliminary performance on 3A Summary Statement 1 by primary language of the parent (State);
4. Preliminary performance on 3A Summary Statement 1 by age at entry into the NJEIS (State);
5. Preliminary performance on 3A Summary Statement 1 by length of time in the NJEIS (State);
6. Preliminary performance on 3A Summary Statement 1 by Home/Foster Care (State);
7. Preliminary county performance on data completeness; and
8. Preliminary state and county data quality for FFY 2013 in Indicator 3A reporting categories (a) and (e).

By November 2014, the data for FFY 2013 Indicator 3, while not finalized, was more stable and provided a more accurate indication of the state's performance and what would be reported in the February 2015 APR submission. These data were presented to the Stakeholders at this regularly scheduled SICC meeting. The DOH used the SICC meeting to review the option of selecting a smaller SIMR with the Stakeholders. The DOH moved forward from this meeting with agreement that DOH could consider a smaller targeted SIMR based on the final data analyses.

Stakeholder Input January 16, 2015

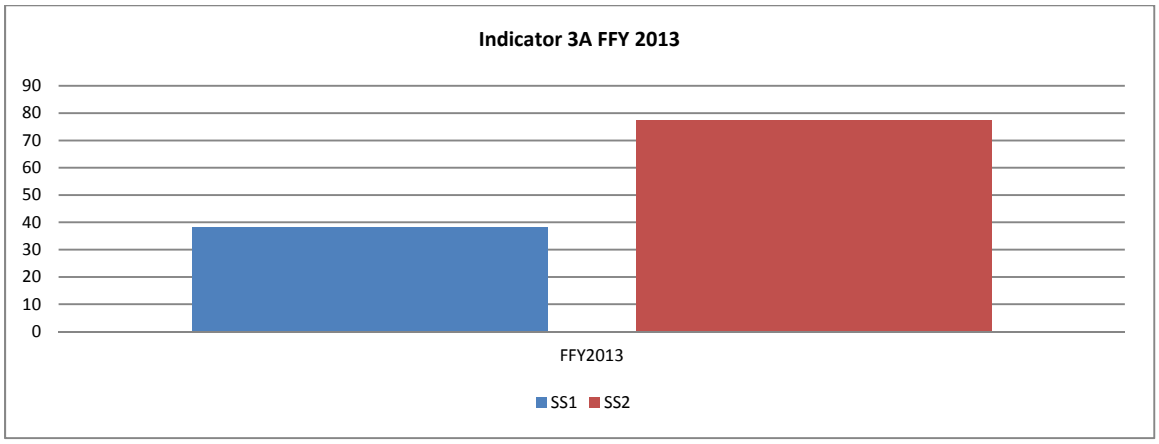
On January 16, 2015, the data for Indicator 3 and all other APR indicators were finalized and presented to the Part C Stakeholders Group. In relationship to the SSIP, this meeting represented a full year of work toward data collection, broad data analysis, identification of additional lines of inquiry, and finally targeted data analysis. At the January 2015 meeting, the Stakeholders set targets for FFY 2013-FFY 2018. A final review and SICC certification of a draft FFY2013 APR SPP/APR was completed at the January 23, 2015 SICC meeting.

Stakeholder Input: February 24, 2015

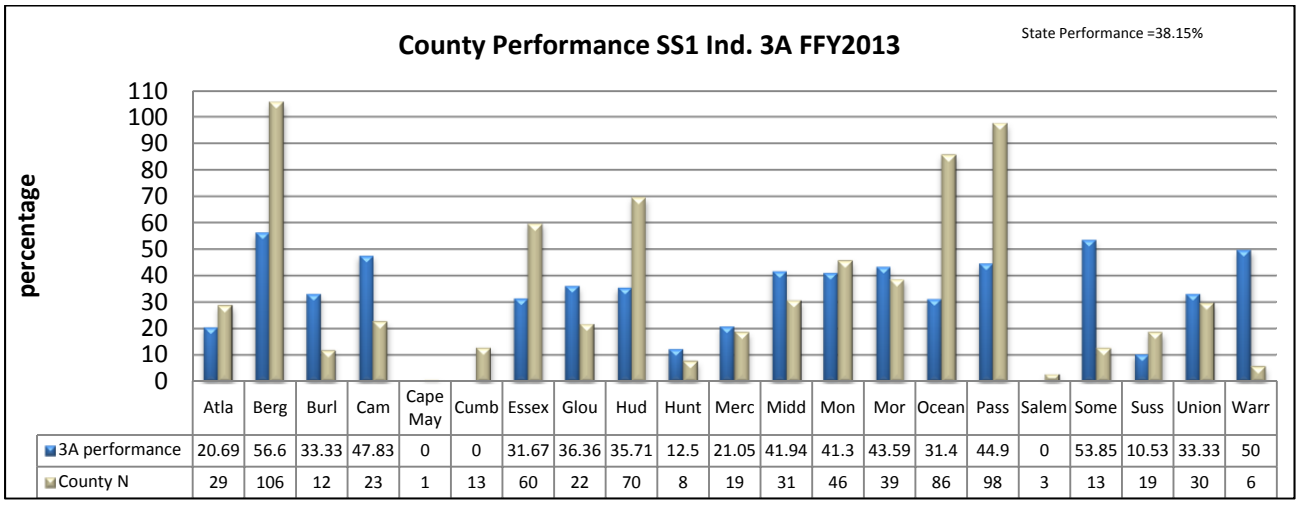
In a final look at disaggregated data, the Stakeholders met again on February 24, 2015 to review the data, confirm their agreement with a SIMR and identify the root causes contributing to the NJEIS performance in Indicator 3A Summary Statement 1. Data sets included performance data which is presented here and data quality which is presented in the next section. In all, the Stakeholders considered:

1. State performance for FFY 2013 on Indicator 3A;
2. County performance for FFY 2013 on Indicator 3A;
3. County performance for FFY 2013 on Indicator 3B and 3C
4. Performance on 3A Summary Statement 1 by primary language of the parent (State);
5. Performance on 3A Summary Statement 1 by age at entry into the NJEIS (State);
6. Performance on 3A Summary Statement 1 by length of time in the NJEIS (State);
7. County performance on data completeness;
8. State and County data quality for FFY 2013 in Indicator 3A reporting categories (a) and (e).
9. County drill down for 1 county (Sussex) that had outlier data in reporting category “a”

State performance for FFY 2013 on Indicator 3A:

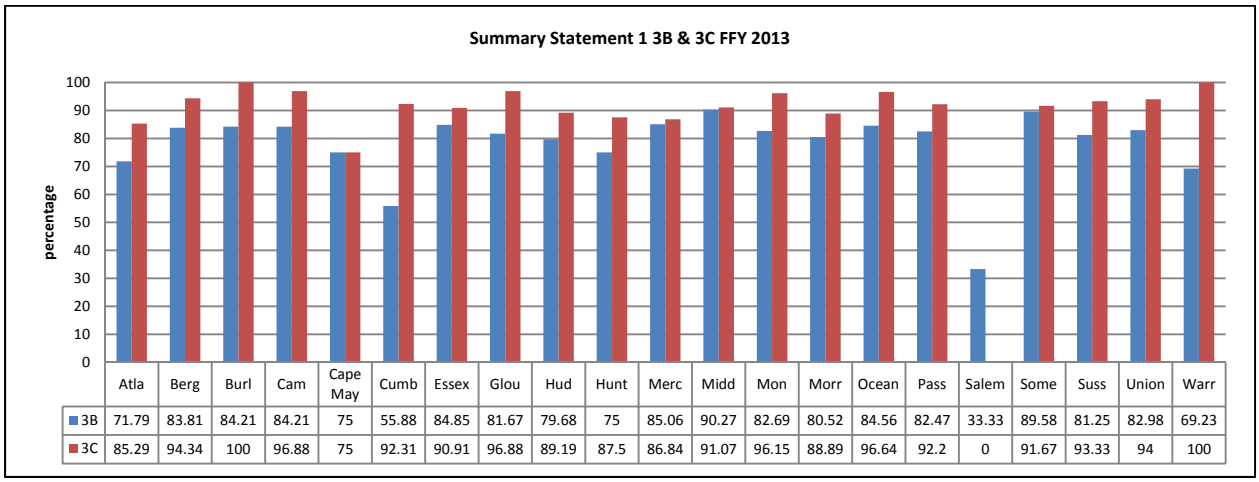


Cape May, Cumberland, and Salem counties had N’s that resulted in performance of zero percent for Summary Statement 1 in 3A. Each of these counties is small, however these results along with the poor data completeness, indicate potential target counties for improvement strategies.



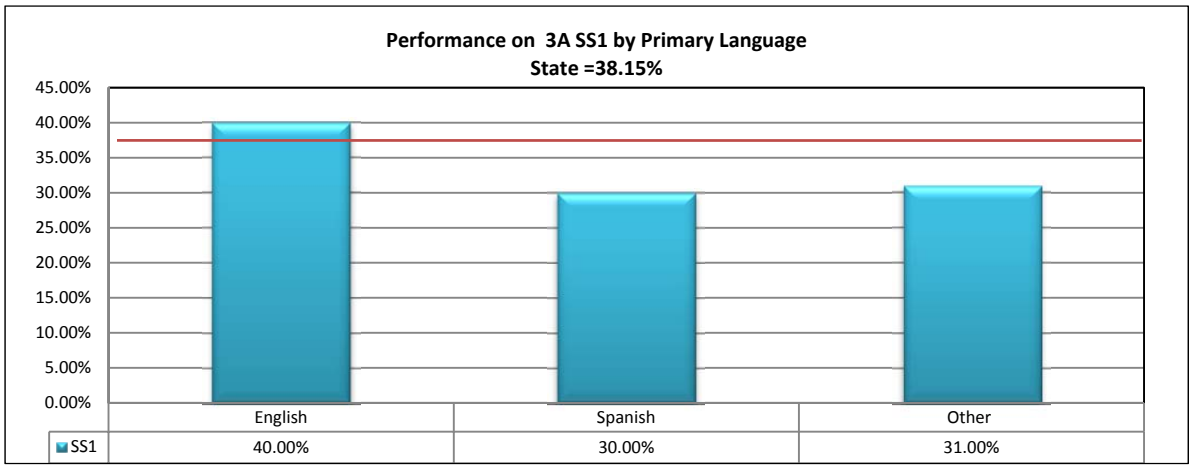
	Atla	Berg	Burl	Cam	Cape May	Cumb	Essex	Glou	Hud	Hunt	Merc	Midd	Mon	Mor	Ocean	Pass	Salem	Some	Suss	Union	Warr
3A performance	20.69	56.6	33.33	47.83	0	0	31.67	36.36	35.71	12.5	21.05	41.94	41.3	43.59	31.4	44.9	0	53.85	10.53	33.33	50
County N	29	106	12	23	1	13	60	22	70	8	19	31	46	39	86	98	3	13	19	30	6

For comparison county performance in 3B and 3C were:



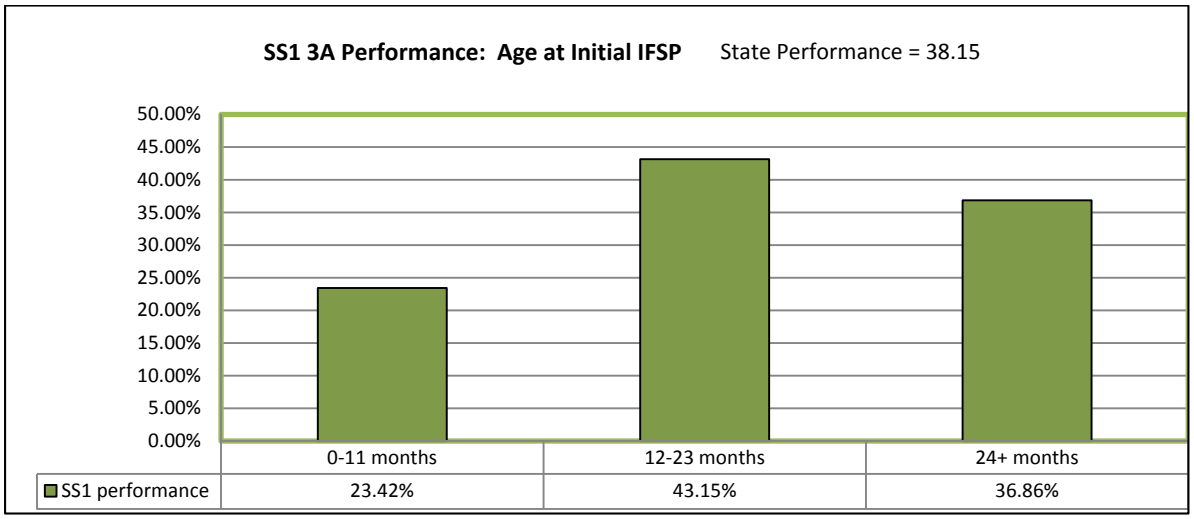
	Atla	Berg	Burl	Cam	Cape May	Cumb	Essex	Glou	Hud	Hunt	Merc	Midd	Mon	Morr	Ocean	Pass	Salem	Some	Suss	Union	Warr
3B	71.79	83.81	84.21	84.21	75	55.88	84.85	81.67	79.68	75	85.06	90.27	82.69	80.52	84.56	82.47	33.33	89.58	81.25	82.98	69.23
3C	85.29	94.34	100	96.88	75	92.31	90.91	96.88	89.19	87.5	86.84	91.07	96.15	88.89	96.64	92.2	0	91.67	93.33	94	100

The DOH and Stakeholders considered children's performance in 3A based on the primary language spoken in their home.



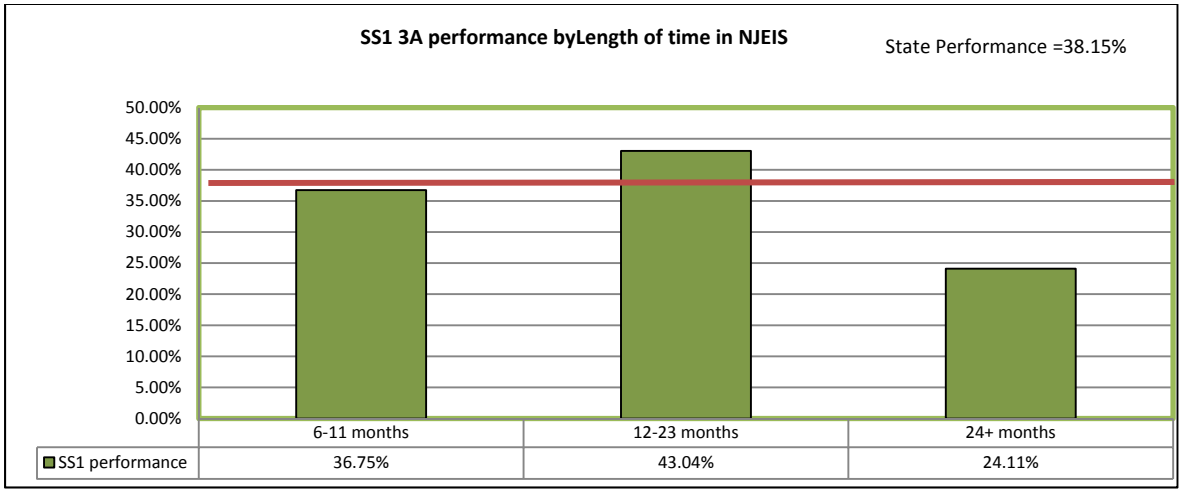
	English	Spanish	Other
SS1	40.00%	30.00%	31.00%

Next, the DOH investigated the age at initial IFSP development for Indicator 3A Summary Statement 1 for children that had an IFSP prior to age 12 months, between 12-23 months and at 24 months or later.

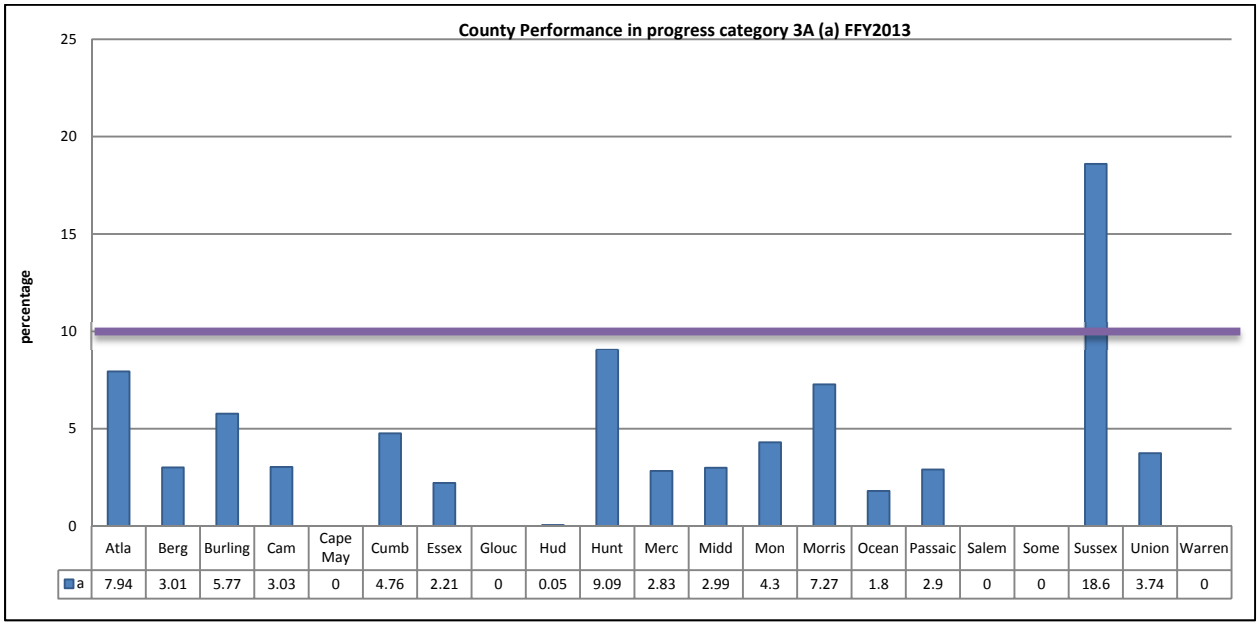


Data indicate that children who begin the program after 12 months demonstrate performance above the state performance of 38.15%, whereas children who enter the NJEIS between 0-11 months have low performance that is statistically significantly when compared to state performance. The children aged 0-11 months were also more likely to have delays in their social-emotional skills identified by their initial BDI evaluation given the percentage in 3A (e) for this group is at 65% (see chart on page 14). The results of this data provide potential root cause and opportunity for improvement strategies with this sub-population of children.

The NJEIS reports child outcome data on children that participate in the system for at least 6 months. Performance data for 3A was investigated by the length of time children spent in the NJEIS program.



DOH examined the children whose progress category was 3A (a) for FFY 2013 as shown below:



	Atla	Berg	Burling	Cam	Cape May	Cumb	Essex	Glouc	Hud	Hunt	Merc	Midd	Mon	Morris	Ocean	Passaic	Salem	Some	Sussex	Union	Warren
a	7.94	3.01	5.77	3.03	0	4.76	2.21	0	0.05	9.09	2.83	2.99	4.3	7.27	1.8	2.9	0	0	18.6	3.74	0

The data for FFY 2013 show data quality of less than 10% in progress category (a) for all but one county: Sussex. Therefore, drill down into specific children was conducted to discern patterns. Eight (8) children were investigated: all 8 had English as their primary language, and had diagnoses of "delayed milestones". Seven of eight (87%) had their first IFSP after the age of 24 months, and seven of eight (87%) had the same EIP providing their IFSP services.

The preliminary performance on 3A Summary Statement 1 by children in out-of-home foster care in the state yielded no significant information and therefore was not included in the final data package reviewed by Stakeholders on February 24, 2015.

Based on the in-depth data analysis, no significant patterns emerged that would justify a smaller targeted SIMR. The Stakeholders reviewed and agreed that the SIMR should be inclusive of all twenty-one counties and elected to not focus on one specific targeted NJEIS population. The NJEIS SIMR:

To substantially increase the rate of children's growth in their development of positive social and emotional skills by the time they exit the program, as defined by the targets established for Indicator 3A, Summary Statement 1 in each of the years, FFY 2014-2018.

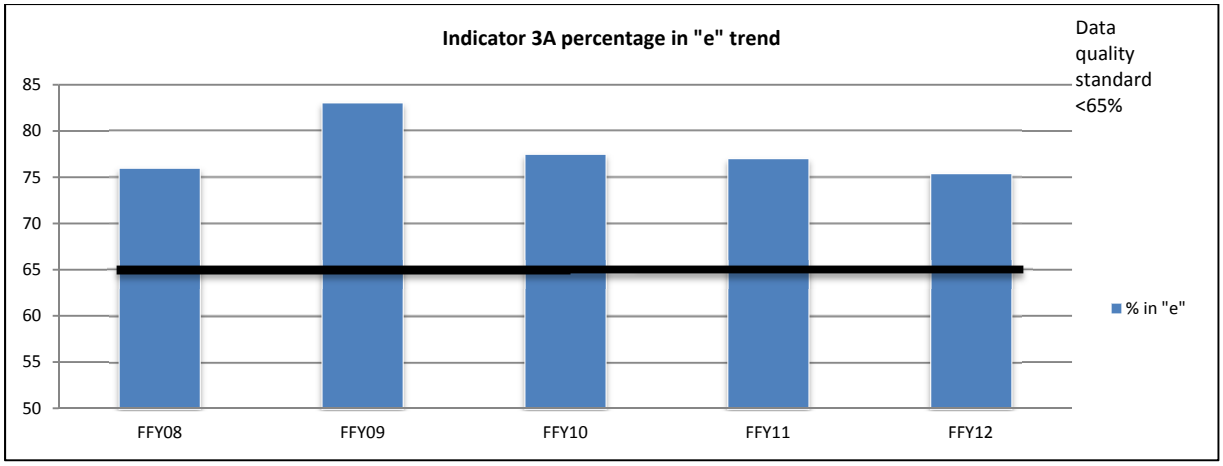
Data Quality in Child Outcomes

Since the introduction of child outcomes into APR reporting, DOH has engaged in continuous efforts to improve the quality of the data at all levels of input and use. For example, the creation of business rules for merging of the BDI data set with the comprehensive NJEIS Central Management Office data; the adoption of the electronic scoring and storing of BDI data; and the

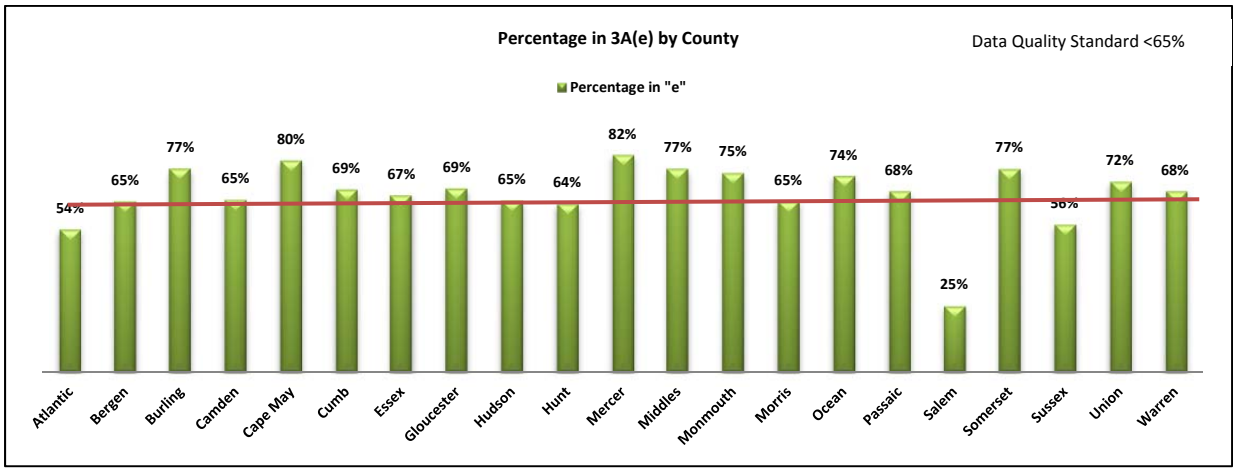
creation of internal protocols to ensure matching of child records; contribute to ensuring clean and unduplicated data for reporting.

Patterns in Progress Categories

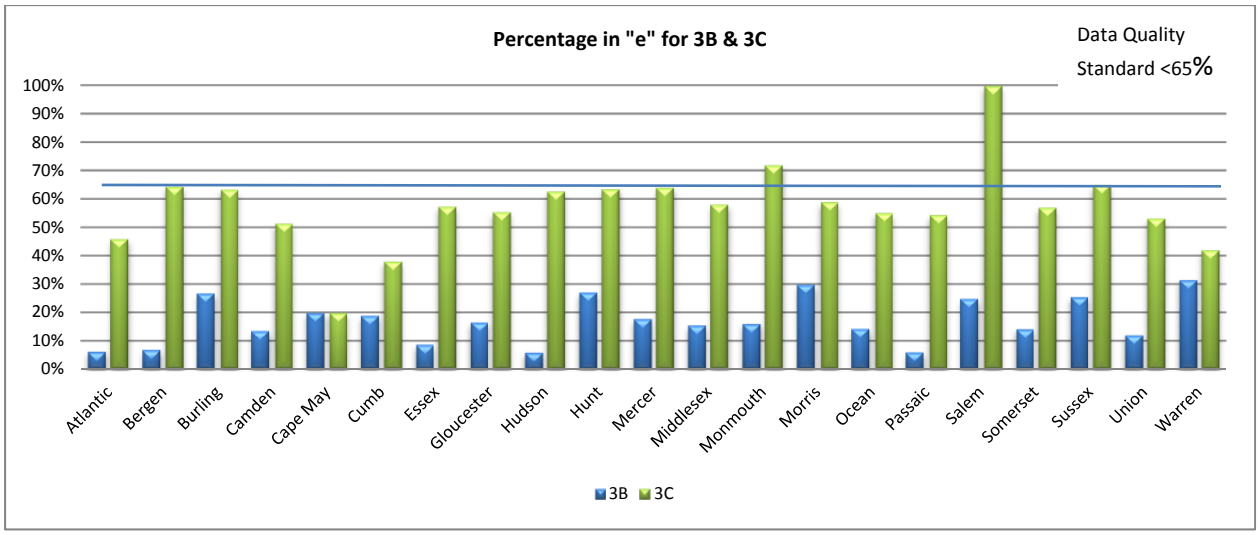
DOH used the Child Outcomes Data Quality Profiles prepared by the Early Childhood Outcomes Center/Early Childhood Technical Assistance Center (ECTA) for FFY 2011 and FFY 2012 to examine the NJEIS data results in each of the progress reporting categories a-e. A potential issue in progress category (e) was identified. Trend data shows that the NJEIS has not met the National Data Quality Standard of <65% for category "e" in Indicator 3A for several years. The chart below illustrates this.



DOH then disaggregated the current FFY 2013 performance in 3A (e) by county. The chart below indicates the percentage of children that entered and exited the system with a Standard Score of 80 or above on the BDI Personal-Social Domain indicating these children did not have delays in their social and emotional skills.

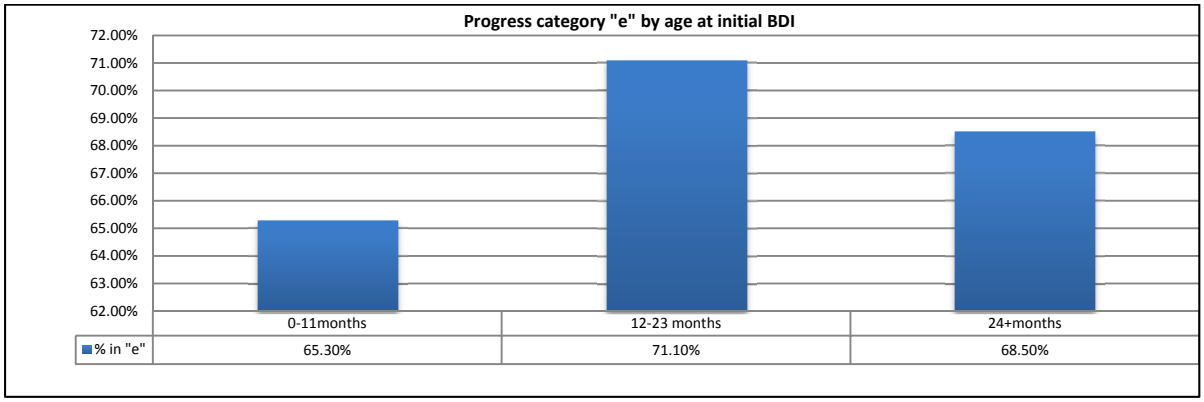


Eleven of 21 Counties (52%) have performance data that exceeds the maximum national quality standard of 65%. This phenomenon does not consistently appear in either Indicator 3B or 3C. The FFY 2013 statewide percentage in "e" for Indicator 3B is 12.95% and 58.78% for 3C. The outlier performance of Salem County is likely due to a very small n which also identified a "completeness" data quality issue for that county.



The Personal-Social Domain on the BDI consists of 3 sub-domains: Adult Interaction, Self-Concept and Social Role and Peer Interaction. The Peer Interaction sub-domain is administered to children aged 24 months or older and contains an additional set of developmental skills to evaluate. Therefore it was hypothesized that children evaluated at age 24 months or older would be less likely to enter "with peers" and therefore would not be reported in progress category (e) than those who were evaluated before 24 months.

The data chart below shows the results of analysis by age at initial evaluation with BDI disproving the hypothesis.



Fidelity of BDI Administration

Concern for data quality in progress categories generated collaboration with other states that utilize the BDI for measuring child outcomes to investigate if other BDI states had similar results. One area of concern was the fidelity of the administration of the Personal-Social domain of the BDI by NJEIS Targeted Evaluation Team (TET) members. The Personal-Social domain differs from the other four domains on the BDI as the use of structured interview with the caregiver is used more often to obtain the child's scores, whereas the other domains require more structured tasks and/or direct observation to be properly scored according to the test's manual.

On March 16-17, 2014 the Part C Coordinator, Results Accountability Coordinator and the Executive Director for one REIC met with colleagues from two other Part C states and national TA staff to review BDI administration procedures and review and compare data from observations of BDI fidelity that was collected during January and February 2014 in NJ with the other states' data. At this meeting, it was identified that the NJ patterns of errors in fidelity were consistent with other states' findings. Therefore, the DOH moved forward to collect additional data. Based on preliminary observations in NJ and discussions with partner states, it was hypothesized that the NJ TETs lack fidelity of administration of the BDI for the Personal Social domain, (which NJEIS uses to report in Indicator 3A).

The NJ BDI *Fidelity Checklist* was developed for the purpose of assessing evaluators throughout the state. The NJEIS utilized the resources of the REIC Training and Technical Assistance Coordinators (TTAs) from May–July 2014 to conduct fidelity observations and score the TETs using the checklist. Eighteen (18) observations were conducted for a total of twenty (20) children. Evaluator fidelity for each of the 18 observations was summarized and assigned an overall "Fidelity Score". State and REIC staff met in July 2014 to review both the fidelity data and the effectiveness of the *BDI Fidelity Checklist.*

The collected sample generated preliminary results that indicate fidelity of administration of the Personal-Social domain is an area in need of improvement. Consistent patterns of fidelity error in the sample included:

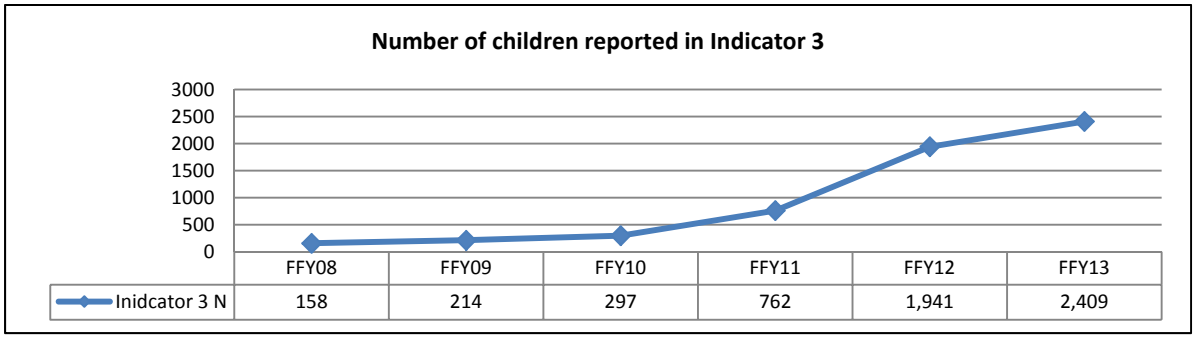
1. 76% of the teams did not consistently maintain fidelity to the manual's questions; and
2. 94% did not consistently ask the qualifying questions prior to scoring.

In addition to the data reported above, the TTAs reported that the Personal-Social Domain was often administered last in the sequence of items and not always reviewed with the family at the conclusion of the evaluation which indicates that it was "not a priority" in the evaluation process.

At the October 20, 2014, meeting with the TET and SCU administrative staff, these errors of fidelity were presented along with the BDI *Fidelity Checklist*. Administrators were instructed to conduct further observations using the *Fidelity Checklist* to establish a baseline for each evaluation practitioner in their agency. This baseline data will be used as a part of the coherent improvement strategies to improve data quality that will be developed in Phase 2 of the SSIP.

Data Completeness

From FFY 2008 through FFY 2011, NJEIS used an approved sampling plan to report child outcomes. Through collaborations with national TTA staff, the NJEIS began to recognize the usefulness of the data set for Indicator 3 was limited by its data quality, specifically the data completeness resulting from the use of a sampling plan instead of gathering full statewide information. As a result, the NJEIS decided to make a financial and workforce investment and moved from the sampling plan to statewide collection of exit data for children that participated in the system for at least 6 months effective July 1, 2012. The NJEIS also moved to require an annual BDI evaluation for all children prior to the development of their annual IFSP and developed business rules to use the annual BDI as the exit evaluation if conducted within 4 months of the child's exit date. As indicated in the chart below, these efforts resulted in an increase in the reported n for FFY 2012 and FFY 2013 and improved the stability of the performance data.

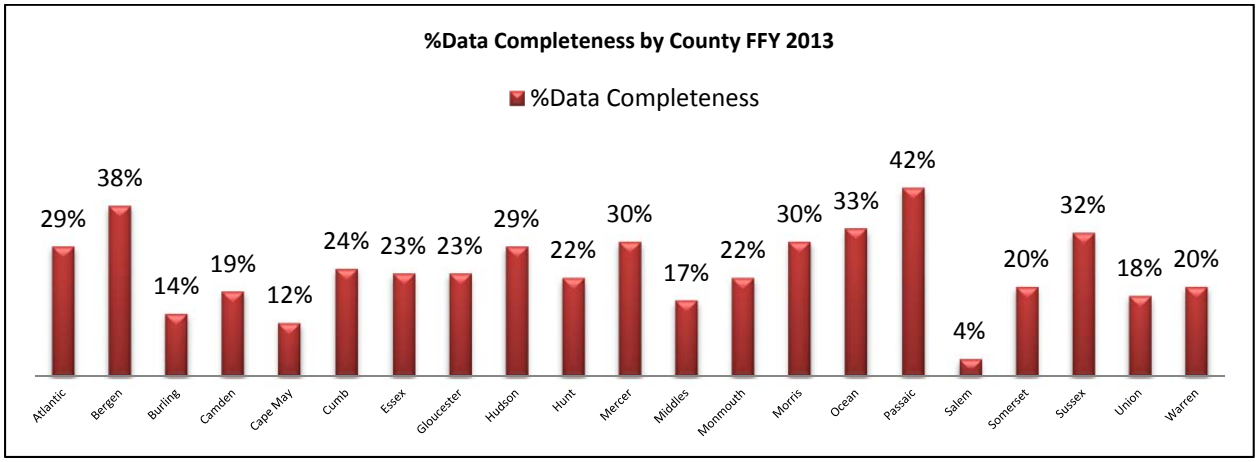


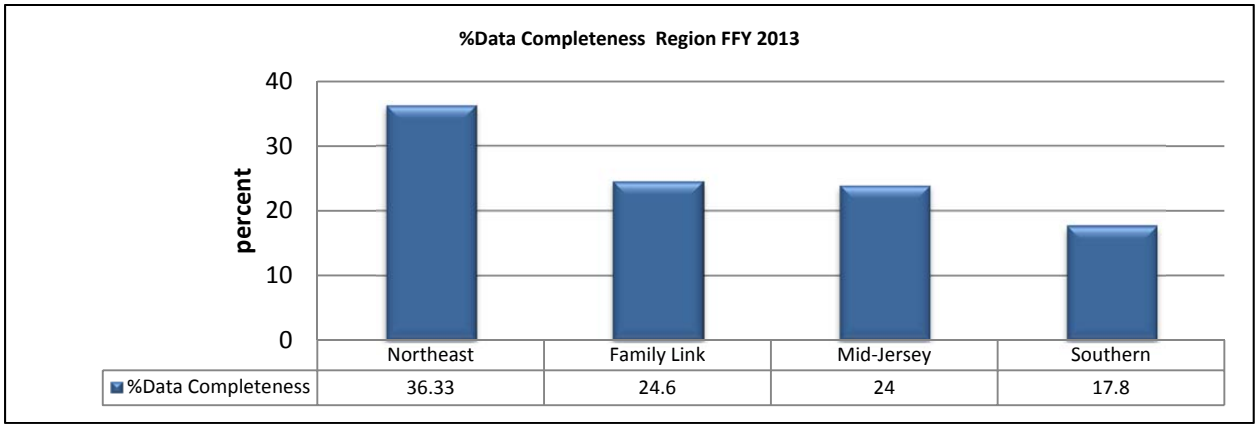
The NJEIS is reporting a data completeness of 23.27% based on the NJEIS Child Outcomes Data Quality Profile prepared by ECTA when calculating the number of children reported in child outcomes, Indicator 3 divided by the exiting total reported in the same year. NJEIS data completeness improves to 30.92% when the NJEIS business rule of excluding children that exited prior to 6 months is applied.

Number of children reported in Indicator 3 =2409	Number of children exited from NJEIS = 10,352	Percent "Data Completeness" = 23.27%

Number of children reported in Indicator 3 = 2409	**Adjusted Number children exited = 7,791**	**Percent "Data Completeness" =30.92%**

The data completeness information below was disaggregated by region and county and reported to the local TET and SCU administrators at the October 20, 2014 meeting.





Summary

The in-depth data analysis described in this section and infrastructure analysis described in the next section, occurred simultaneously to finalize a decision on NJ's Part C SIMIR and the root causes affecting the performance in 3A.

As a part of Phase 2, NJEIS is collecting additional data from two sources.

1. **Family Interview:** Specific to the issue of data completeness, the SICC Family Support Committee developed a plan to interview families about their experience with the BDI evaluation. As the BDI is a standardized evaluation tool and the administration of such requires parental consent, the NJEIS needs to understand the reasons why families are consenting and/or not consenting to an exit BDI evaluation as they leave the program. Additionally, the family interview is reviewing the methods of communication and established protocols employed by the SCUs and TETs to inform and encourage families to participate in a formal developmental evaluation prior to transition.

2. **Fidelity of TET Evaluators:** The issue of fidelity of evaluators, particularly with children aged 0-11 months, is being addressed beginning with the collection of baseline data on TET evaluators that currently use the BDI. The use of the *Fidelity Checklist* to measure baseline began in November 2014 and will continue through 2015, when the DOH will analyze the results for each TET agency and use those results to inform the implementation of professional development strategies in Phase 2.

Stakeholders

As described in this section, Stakeholder involvement in the data analysis has been consistent and frequent throughout Phase 1 of the SSIP process. By utilizing the established resources of the SICC, the Part C Steering Committee and augmenting the group with invited participants, the NJEIS has assembled a substantial coalition with which to plan and implement the SSIP.

Component# 2:

Analysis of State Infrastructure to Support Improvement and Build Capacity

ECTA Framework Components

Governance

Data Systems

Accountability/Monitoring

Quality Standards

Finance

Personnel/ Technical Assistance

Broad Infrastructure Analysis Process

Two meetings were conducted to complete a broad infrastructure analysis.

***Stakeholder Input*: July 25, 2014**

The SICC Retreat/Stakeholder meeting in July 2014 was an opportunity for each of the Stakeholders that had previously provided input to the DOH at various junctures on the issue of children's social and emotional development to come together for a full-day working meeting focused solely on SSIP development. After discussion of the SSIP requirements and review of the most currently available data, the Stakeholders endorsed a working SIMR which was available for reference during the infrastructure analysis processes.

NJEIS Working SIMR: To substantially increase the rate of children's growth in their development of positive social-emotional skills by the time they exit the program, as defined by the targets established for Indicator 3A, Summary Statement 1 in each of the years FFY 2014-2018.

The Stakeholders took part in a "gallery walk" activity to develop a list of strengths, weaknesses and opportunities for the NJEIS in each of the components in relationship to achieving the working SIMR. The Early Childhood Technical Assistance Center (ECTA) system framework definitions of system components were used as a guide for analysis of the NJEIS Infrastructure.

At the beginning of the infrastructure analysis portion of the day, the full group was lead in a discussion of the *Governance* component. Working as a large group provided the opportunity for the group to understand the intended outcome that would be generated in small groups for the remaining components. The intended outcome of the day was to identify the strengths and weaknesses in each of the system components as related to improvement in child outcomes as defined by the working SIMR. Before moving into small groups, the Stakeholders also identified initiatives currently in NJ that could be helpful to the SSIP process and achievement of the SIMR. These Statewide initiatives were identified:

- Race to the Top Early Learning Challenge – NJ is a grantee;
- NJ Council for Young Children (NCYC);
- Early Learning Standards published by NJCYC;
- "Keeping Babies and Children in Mind" (Infant Mental Health Field Workshops);
- American Academy of Pediatrics Physician Partnership;
- Infant Mental Health Endorsement now available in NJ;

- "Grow NJ Kids": a Quality Rating Improvement System (QRIS) designed for early care and education programs providing incentives such as training and program materials and will communicate program level of quality to the public in the future;
- Children with Disabilities Committee;
- Pyramid Model; and
- Community of Care Consortium.

Participants were then assigned to several small groups that included a strategic combination of individuals from different affiliations. Each group rotated through 5 designated areas to address each component, which provided each participant the opportunity to provide input into each component. The strengths, weaknesses and opportunities for each area related to the system's ability to achieve the SIMR were recorded. A facilitator guided the discussion at each location, reviewing briefly for each new group what the previous group(s) had identified. The members of each group could:

1. Agree with a previously recorded strength/weakness/opportunity;
2. Disagree with a previously recorded strength/weakness/opportunity; or
3. Generate and add new ideas.

After working through each infrastructure component, the large group reassembled and reported and discussed their collective work. Stakeholders then concluded the day with a discussion of the potential "Threats" to the successful implementation of the SSIP. These include:

1. Funding challenges specific to Part C and/or SSIP implementation;
2. Resource challenges for people, time and skill sets for activities that will be needed;
3. Competing Priorities on the part of the DOH;
4. Discussions by officials considering the pros and cons of pulling out of Part C;
5. Failure to keep in touch with Stakeholders at all levels and at all points in the process;
6. Overall care and trends in healthcare in the state;
7. Increased accountability requirements that may create rigidity or limit ideas in moving the SSIP forward; and
8. General state economy

Given the feedback regarding the potential threats identified by the Stakeholder team, the DOH leadership reflected upon those that are wholly within NJEIS control and took note that within the process of the development and implementation of the SSIP, these potential threats can be minimized with due diligence by the DOH:

1. Maintaining relationships with Stakeholders;
2. Guarding against rigidity and encouraging creativity;
3. Certain resource acquisitions and allocations; and
4. Setting clear priorities and articulating those to Stakeholders and to those in authority.

Other potential threats are within limited control of the NJEIS leadership team at DOH but require vigilance to monitor for potential effect on the NJEIS as a whole.

Lead Agency Staff Input: **August 12, 2014**

On August 12, 2014, the DOH NJEIS staff participated in an exercise similar to the one the Stakeholder group completed at the July retreat and provided input into the strengths and areas in need of improvement as related to the achievement of the working SIMR. The SSIP Leadership Team identified the benefit of conducting this analysis separate from the Stakeholders, as the state team experience the system from a broader perspective and could contribute additional institutional knowledge of system components.

Broad Infrastructure Analysis Results

The feedback and input from both Stakeholder and lead agency staff meetings are compiled below. The inclusion of an item in this broad Stakeholder analysis does not imply consensus or agreement on the part of the individuals and/or groups; rather all comments by participants were accepted and included in the data. Presented below are brief descriptions of the NJEIS Infrastructure components and the identified strengths, weakness and opportunities for each.

Governance

P.L.1993, Chapter 309, enacted on December 23, 1993, established the Department of Health (DOH) as the Governor appointed lead agency for early intervention in conjunction with the Departments of Education (DOE) and Human Services (DHS). Since the 1993 enactment a new Department of Children and Families (DCF) was split off from the Department of Human Services.

In 2010, the New Jersey Council for Young Children (NJCYC) was created by Executive Order to serve as the Governor's State Advisory Council for Early Education and Care. On October 18, 2011, Executive Order 77 established an Early Learning Commission as part of NJ's Race to the Top Early Learning Challenge (RTTT-ELC) grant application as a part of the governance structure to improve supports for families and their infants and young children. The Commission was charged with recommending improvements to the "quality of, and access to, early learning and development programs in the state by coordinating early childhood education, health, and development programs across departments and expanding New Jersey's Quality Rating Improvement System (QRIS). The Commission is chaired by the Commissioner of Education and includes the Commissioners of DOH, DHS, and DCF. Ultimately, the Commission makes the final decision about funding allocations and significant policy decisions.

In addition to the NJCYC, NJ established an Interdepartmental Planning Group (IPG) that consists of the administrators from each of the state's departments with oversight of programs and services for children from pregnancy to age eight. This IPG is charged with considering the feasibility of recommendations and plans for implementation. The Part C Coordinator is a member of the NJCYC and IPG. NJEIS state, regional and local staff work with committees and/or on RTTT-ELC implementation activities.

The NJEIS governance has system point of entry for referral of children and families through four Regional Early Intervention Collaboratives (REICs) that cover the state's twenty-one counties. Grants/Contracts are executed annually to the REICs and fourteen Service Coordination Units (SCUs) that provide ongoing service coordination for the twenty–one counties. Direct early Intervention services are provided by 64 Early Intervention Program (EIP) provider agencies through contracts with the DOH. EIPs are contracted to serve as a comprehensive agency, a service vendor agency and/or a targeted evaluation team (TET). Comprehensive agencies are expected to serve as an early intervention program for a child and family by providing the identified services on the IFSP. Individual practitioners must be enrolled with the NJEIS Central Management Office through one of the contracted EIPs. Policies and procedures are disseminated statewide and posted on the NJEIS website.

The REICs are also responsible to facilitate family and community involvement in the NJEIS and assure that local resources are coordinated to assist families to meet the needs of their infants and toddlers with developmental delays and disabilities. The REICs are responsible for ensuring that families have an active voice in decision-making through REIC Boards/Councils. Each of the four REICs employs at least one full-time Training and Technical Assistance (TTA) Coordinator and one full-time Family Support Coordinator. The Family Support Coordinator positions are required to be staffed by a parent of a child with a disability.

The governance of the NJEIS has essential strengths that allow for the system to operate on a daily basis and from which a sustainable SIMR can be achieved. There are weaknesses and opportunities for the governance structures of the NJEIS which may need to be addressed as a part of achieving the SIMR.

The charts below highlight the strengths and weaknesses as reported by Stakeholders. A full list of the strengths and weaknesses generated by the Stakeholders can be found attached to the SSIP.

Strengths of the NJEIS in Governance	
The NJEIS has a vision, mission and purpose to serve infants and toddlers with disabilities and their families which is known to the workforce and which is reinforced at the Regional and Local level.	The system maintains a training and technical assistance team (CSPD) consisting of 4 professionals that work from the REIC offices. A state-level staff person is assigned to oversee and support the regional TTA staff.
The NJEIS has updated policies and procedures that are in effect and disseminated to ensure the rights of families and the needs of children are met in accordance with Part C of the IDEA.	The DOH invested in and supports the BDI as a standardized evaluation tool for system use and has committed the financial resources to maintain its use.

The structure of the NJEIS has different levels of administration at the local, regional and state level which can support initiatives (such as the SSIP).	The NJEIS consistently meets or exceeds the state's target of 99.5% for Indicator 2 – Children receive services primarily in natural environments. This evidence based practice provides opportunities for practitioners to work directly with the caregivers in a child's life.
The state has designated Targeted Evaluation Teams (TETs) with supervision at the local level. The TETs provide specialized expertise in evaluation and assessment, which contributes to the development of IFSPs and to the data collected and reported in Indicator 3.	The NJEIS utilizes a state-created Family Directed Assessment (FDA) which provides service coordinators the opportunity to talk with families prior to IFSP development about their concerns priorities and resources.
Weakness and/or Opportunity for NJEIS in Governance	
There is no current procedure and/or policy to annually review the TET Letters of Agreement and performance.	There are areas in the state that have challenges with adequate practitioner coverage.
An ongoing and formalized Continuous Quality Improvement strategy for the TET teams is needed.	The Regional Early Intervention Collaborative structure may be underutilized, particularly the family support personnel.
Communication strategies from DOH to multiple agencies about initiatives need improvement.	The state office has vacant positions and lacks redundancy in responsibilities which creates a vacuum of knowledge when a position is vacated.
Strategies for communication with families about the importance of social-emotional development need improvement.	The NJEIS structure does not have EIP agencies that would provide identified services, attend the initial IFSP meetings.

Data System

The NJEIS has a sophisticated and extensive system for collecting and analyzing data for multiple purposes. NJ collects the required demographic information on each child and family referred to the system including race/ethnicity, family size, and municipality of residence, gender, diagnosis and family income. As a fee-for service-state, NJ maintains a database of all services that are authorized on an IFSP and an accurate accounting of the actual delivery of services, including type of service, length of service, the provider agency and the individual practitioner who provided each service. Local data managers at the REICs are charged with ensuring the input of data is accurate and complies with policies and procedures and can alert the DOH to any specific data issues that may appear in a child's file.

Since 2006, NJEIS has been using an electronic scoring and storing system for all BDI data known as the BDI Data Manager and Mobile Data Solution (MDS). All evaluation team members are licensed to utilize a laptop BDI application of the MDS which records and scores the results of the BDI for children in real time as the evaluator administers the items on the tool. This information is then uploaded to the BDI Data Manager which provides timely access to the

score reports for use at the local level in addition to state-level access. The use of electronic scoring has shown to reduce calculation errors in scoring and chronological age determinations and produces fewer basal and ceiling errors.

The state office has created procedures to import BDI evaluation information from the stand-alone BDI Data Manager system with the DOH's comprehensive central management data in order to query and analyze relevant data and factors. The DOH has implemented data quality checks and reports which are designed to match children in the two databases and check for errors such as ID number, date of birth, name spelling and exit date from the system. These data checks improve the accuracy and completeness of the data set when reported.

The charts below highlight the strengths and weaknesses in the Data System as reported by the Stakeholders. A full list of the strengths and weaknesses generated by the Stakeholders can be found attached to the SSIP.

Strengths of the NJEIS in Data System	
NJEIS has leadership (state and regional) that values data and the use of data to inform decisions.	DOH has financial and ongoing technical support of hardware and software for BDI, SCU and REIC systems.
NJEIS collects and has available a wealth of data. Service data, practitioner data, financial data, child and family outcome data, etc. is available to DOH which has the ability to create and run various types of reports.	DOH has a new staff person to assist with data and data visualization and a seasoned staff person with skills to manage complex queries.
NJEIS leadership shares and explains data to Stakeholders regularly through SICC and Steering Committees and other formal meetings.	NJEIS regularly posts information on- line. This can be a helpful venue for the activities and information related to SSIP.
Weakness and/or Opportunity for NJEIS in Data System	
There is an opportunity for professional development at all levels on the use of data for planning and intervention.	Funding is needed to update equipment and maintain hardware and software in the field.
NJEIS has available an abundance of data which has limits: Not all data are available in "real time"; Data systems have been developed for different purposes by different developers and ease of integration is limited.	Data analysis is limited by: 1) Lack of statistician to help interpret the data in context; 2) Time available to analyze data due to competing priorities and staffing patterns; and 3) Use of multiple data systems to meet different needs (SPOE, BDI).
There is the opportunity to improve communication and inclusion of "informal" Stakeholders in the dissemination of data.	General I.T. challenges such as maintaining and replacing equipment. Ongoing challenge of changing technology and securing data.

Accountability/Monitoring

A significant component of the NJEIS general supervision system is the performance desk audit process that was developed and implemented using data compiled through the NJEIS System Point of Entry (SPOE) database. The purpose of the SPOE data desk audit is to: 1) ensure data in SPOE are accurate; 2) to identify noncompliance and areas for improvements; and 3) to verify correction of non-compliance in accordance with federal requirements in OSEP. The SPOE database is an electronic central data system that:

- Ensures an unduplicated count for federal reporting;
- Verifies data;
- Established and provides trend data for improvement planning;
- Identifies potential areas of non-compliance that are then targeted for follow-up by telephone, record submission or site visit; and
- Allows tracking of required corrective actions.

SPOE data desk audits review compliance and performance data for selected priority indicators for all counties/provider agencies. An inquiry response format has been developed and implemented to verify accuracy of data, request missing information and determine if barriers are appropriately addressed to correct performance issues. As needed, findings and corrective action plans are issued and verification of correction is completed in accordance with federal requirements.

On-site focused monitoring is an important component of the NJEIS general supervision system. NJEIS selects EIPS or SCUs whose performance data and/or history of uncorrected noncompliance suggest an onsite visit if necessary. Improvement plans and revised corrective action plans are issued, as necessary, as a result of onsite visits. Onsite visits are conducted to verify correction or to determine the need for additional sanctions such as designation of high-risk or at-risk status when correction is not timely.

The charts below highlight the strengths and weaknesses in the Accountability/Monitoring as reported the Stakeholders. A full list of the strengths and weaknesses generated by the Stakeholders can be found attached to the SSIP.

Strengths of the NJEIS in Accountability/Monitoring	
The monitoring process and team provides feedback to the system on how well we are doing –or not doing in a given area and uses data to provide the feedback.	There is public reporting at the agency provider level which contributes to accountability of the agency.

There are agencies that write appropriate outcomes based on social emotional issues	EIPSs have used self-assessment previously and may be able to apply that strategy to monitor child outcomes and social emotional development.
The Family Directed Assessment (FDA) has helped to identify issues. The FDA summary can be helpful to families as they participate in the IFSP**.**	The federal regulations provide for specific criteria from which to monitor and hold providers accountable.
Data can be drilled down to the practitioner level.	The current monitoring team can conduct onsite visits for corrective action plans.
Weakness and/or Opportunity for NJEIS in Accountability/Monitoring	
Currently there are no agency reports per county about how families' and children's concerns are being addressed.	There could be greater accountability imposed on "low performers". There are no sanctions for those that refuse to participate in voluntary training.
NJEIS is not currently able to address the quality of IFSPs.	There is no periodic review of the LOA for provider agencies which impacts recruitment, retention of staff and FTE status.
There is concern that not all service coordinators and other NJEIS staff understand the FDA and its purpose and benefits.	The opportunity exists to add requirements for general supervision with annual reporting to DOH, and meaningful self-correction.
There exists the opportunity to increase the availability of local level data regarding social emotional development.	There is an opportunity to develop an auditing system that focuses on quality in addition to compliance.

Quality Standards

The DOH is responsible for ensuring that state and federal legal requirements are fully implemented statewide. The NJEIS developed six modules on procedural safeguards and requires every individual enrolled with NJEIS to successfully complete the modules as a condition of their ongoing ability to provide early intervention services. The roll-out to the over 4,600 existing practitioners began in May 2014 and will continue until each individual demonstrates the successful completion of the six modules. Sanctions are applied for non-compliance with completing the modules within established timelines. In addition, effective July 1, 2014, NJEIS requires completion of the modules for any individual prior to their enrollment and authorization to provide early intervention services in the NJEIS.

The NJEIS is partnering with early care and education initiatives around the state to align and make useful child level and program standards. In 2013, NJ became a Race to the Top Early Learning Challenge (RTTT-ELC) state, receiving $44.3 million to focus on the quality of

programs and services from pregnancy to age eight. The grant award reflects the work of the Departments of Children and Families (DCF), Education (DOE), Health (DOH), Human Services (DHS) and the NJ Council for Young Children (NJCYC). At the heart of the RTTT-ELC is "Grow NJ's Kids" which is NJ's Quality Rating Improvement System and the establishment of an early Childhood Training Academy to align early childhood workforce preparation. The Commissioners of DOE, DOH, DHS, and DCF co-signed and distributed a letter of endorsement for the *NJ Birth to Three Early Learning Standards* which was provided to early childhood professionals in the state.

Although the NJ DOE is the lead agency executing the RTTT-ELC grant, state Commissioners (including the Commissioner of Health), regional and local NJEIS personnel are at the table and fully invested in the successful implementation and collaborations possible through RTTT-ELC.

The charts below highlight the strengths and weaknesses in the Quality Standards as reported the Stakeholders. A full list of the strengths and weaknesses generated by the Stakeholders can be found attached to the SSIP.

Weakness and/or Opportunity for NJEIS in Quality Standards	
There is an opportunity to make all early learning standards a part of scope of practice and to utilize the parent guide to the early learning standards.	There needs to be improved access and opportunities for peer interaction. Finding low or no cost options can be a challenge.
NJEIS needs a consistent definition of social emotional development.	There is the opportunity to look at documentation during periodic reviews to see how meeting the social emotional outcomes on an IFSP.
There are no uniform program standards that are implemented statewide.	There are not state defined standards for direct practitioner supervision including team meetings, mentoring and communication.
Strengths of the NJEIS in Quality Standards	
The Early Learning Standards are available in NJ and there are national information and resources that can be used in the work.	
NJEIS has data to build upon. We already have some data around social emotional practice.	
Riverside provides face to face training for BDI which promotes consistency	
NJEIS uses a standardized and standard assessment tool in BDI.	
Procedural Safeguards modules are required to be completed by all NJEIS personnel	

Finance

The NJEIS budget is comprised of funding from a state line item appropriation, federal Part C, Medicaid recovery, and family cost participation recovery. The NJEIS has a history of strong support from the NJ Legislature and the Governor's office. The Governor's proposed budget for SFY 2016 includes a 3.414 million increase for SFY 2016 to meet the projected increasing needs of the program. The current SFY 2015 state appropriation is $85,973,000. The state appropriation and family cost participation (FCP) funds are used for the direct early intervention services to children and families.

NJ implements a fee-for–service pay and chase contract with the Early Intervention Program (EIP) provider agencies. This means that EIPs submit claims for the early intervention services provided and the state issues payment every two weeks and then chases the Medicaid and FCP recovery. The Central Management Office (CMO) data including referral, evaluation, and eligibility, services authorized under an IFSP, claims payments, and fund recovery authorization are used to issue monthly and quarterly budget updates and financial forecasts to the Commissioner's office and state Office of Management and Budget.

The NJEIS Family Cost Participation (FCP) system is a progressive co-payment per hour based on family income and size for eligible direct services provided in accordance with an IFSP. Families at or above 300% of the federal poverty level are subject to FCP. NJEIS recognizes that some families may choose to decline some services or chose to only receive services provided at public expense as a means to reduce or eliminate their FCP. NJEIS closely monitors the effect of the FCP on families and their services. A monthly report is prepared documenting the number of families that are approaching or had services been suspended due to non-payment of their FCP over 60 days past due or declare that they exited the program due to the family cost participation. On average, about 33% of families have a FCP and 12% of the families suspended for non-payment remain suspended.

Current state insurance legislation, P.L. 2009 c.115 provides limited potential coverage for some families receiving early intervention services but did not improve the state's ability to recover the cost of early intervention services from private insurance companies. The legislation requires that certain health benefits plans provide coverage for medically necessary therapies for the treatment of autism and other developmental disabilities. However, the law only requires carriers to provide benefits for coverage of the out of pocket FCP incurred by covered persons under an IFSP. The NJEIS cannot require that a family utilize their insurance benefit and has no mechanism to bill insurance companies directly should a family consent to the use of their private insurance

The charts below highlight the strengths and weaknesses in Finance as reported the Stakeholders. A full list of the strengths and weaknesses generated by the Stakeholders can be found attached to the SSIP.

Strengths of the NJEIS in Finance	
Financial commitment from the state budget to the NJEIS and consistent support of EI by Office of Management and Budget.	
Monitoring and accountability via data systems.	
The SICC service delivery committee is using the ECTA system framework to develop recommendations for a competitive EIP RFP.	
The Central Management Office has data and procedures in place to recoup revenue from Family Cost Participation and Medicaid.	
Weakness and/or Opportunity for NJEIS in Finance	
Opportunity to leverage funds from other sources related to hurricane Sandy, NJ Association of Infant Mental Health, Race to the Top initiative etc.	There is an opportunity to re-look at how the role of family support and CSPD can be used to support this project.
Funds for infrastructure are needed to s*u*pport an increase in DOH and regional staff to support the SSIP and to hire additional service coordinators to reduce large caseloads.	There is limited ability to advocate at the legislative level for an adequate budget to meet the needs and goals.
There is an opportunity to consider a new cost study.	There is the opportunity to ensure that EPSDT is fully utilized.
The NJEIS cannot access private insurance of families that participate.	Lack of funding to support training and supervision of practitioners

Personnel Development and Technical Assistance

The NJEIS has established personnel standards for all practitioners that provide early intervention services. These standards are monitored for all early intervention practitioners, requiring education background and licensure as appropriate for each position in the state. The Central Management Office is responsible for verifying practitioner credentials including licensure, certifications and degrees with ongoing verification that licensure is in good standing. Individual practitioners must be enrolled with the NJEIS through one of the contracted EIPs that are accountable for ongoing supervision.

The NJEIS Comprehensive System of Personnel Development (CSPD) provides training for a variety of early intervention practitioners, including service coordinators and paraprofessionals; families and primary referral sources. The CSPD ensures that training relates specifically to understanding the basic components of early intervention services, federal and state requirements and how to coordinate transition services for infants and toddlers with disabilities. The REICs provide monthly provider meetings and regional ongoing targeted training and

technical assistance to program administrators, service coordinators, and service providers to address areas in need of improvements as well as areas of noncompliance as identified through general supervision activities.

The DOH, NJEIS identified a continuing need to expand to on-line training to meet the training and education needs of NJEIS personnel. Mercer County Community College (MCCC) is contracted to provide NJEIS with a Learning Management System (LMS). The contract includes: tracking of training/technical assistance modules/webinars; tracking of constituent participation and awarding of CEUs; and support Webinars for up to 500 individuals at the same time; and sending email blasts to communicate updates and hot topics to every enrolled practitioner/administrator. Live webinars are conducted by NJEIS staff members with MCCC providing the IT support for each session. Webinars are recorded and accessible to practitioners through the LMS.

With the additional capabilities now available through the LMS, the NJEIS has real-time access to providing information directly to practitioners in order to provide technical assistance on general system issues. NJEIS now requires that every practitioner enrolled with the NJEIS have an active email account to ensure that the NJEIS can communicate information down to the direct service practitioner. In the past, communications were sent through provider agency administrators with no assurance that the agency passed information down to their practitioners.

The NJEIS employs 4 regional TTAs that provide technical assistance to local SCU and EIPs as needed. Each TTA is readily available by phone, email and at the monthly regional provider meetings, to answer questions, provide clarification and to troubleshoot individual family case issues with the local providers.

The charts below highlight the strengths and weaknesses in Personnel/Technical Assistance as reported by the Stakeholders. A full list of the strengths and weaknesses generated by the Stakeholders can be found attached to the SSIP.

Strengths of the NJEIS in Personnel/TA	
There is an established Comprehensive System of Personnel Development (CSPD).	The NJ Infant Mental Health Endorsement is taking hold. Some NJEIS personnel are working towards their endorsement.
The personnel standards are actively enforced and are currently under review as part of ensuring a qualified workforce.	National programs have developed material that can be used to address and identify social emotional concerns and or challenging behaviors.

Weakness and/or Opportunity for NJEIS in Personnel/TA	
Training needs are extensive. Personnel at all levels need training on 1) Social emotional development 2) Data use and analysis.	The opportunity exists to develop materials to support the dissemination of information related to social emotional development.
There is a need for a personnel standard for Targeted Evaluation Team members.	There is a need to increase the number of Regional TTA staff to meet training needs. The REIC spend significant time addressing issues child by child instead of looking at systemic needs and working towards a larger goal.
Concern that web-based training will be the only method for learning and dissemination of information.	There is a need to strengthen relationships with higher education in order to facilitate more personnel development around social emotional development.
Current TTA staff who are responsible for training are utilized for other purposes limiting time spent on personnel development needs.	Weaknesses related to service coordinators included: 1) High caseloads; 2) Need for more training opportunities for service coordinators; and 3) Need to address turn-over of SCU personnel

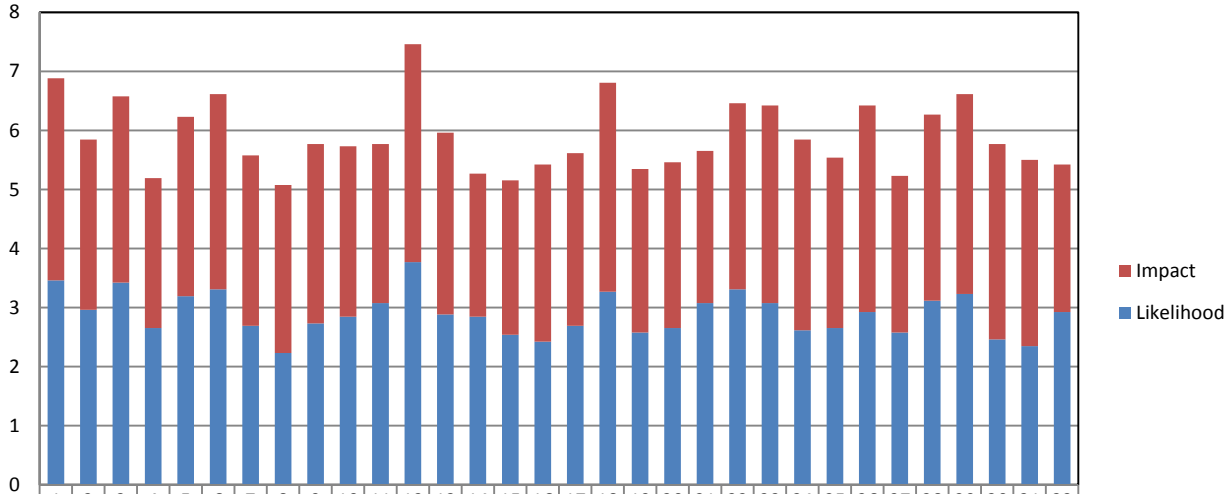
In-depth Infrastructure Analysis Process

NJEIS used the results of the broad infrastructure analysis described above to further analyze components of the system that could be enhanced and thus contribute to statewide implementation of evidence-based practices designed to improve child outcomes. A *Likelihood/ Impact* survey tool was used to prioritize those efforts that would have the greatest likelihood of success and those that would generate the highest impact on the achievement of the SIMR. The full *Likelihood/Impact* survey tool is attached to this SSIP.

The identified system weaknesses and opportunities from the broad infrastructure analysis were compiled and rewritten into 32 possible strategies that could contribute to the achievement of the SIMR. DOH asked each Stakeholder and each lead agency staff to complete the survey indicating for each of the 32 items: 1) the likelihood that the strategy/effort can be achieved within the next 3 years and 2) the impact that effort would have on the SIMR if it were achieved. A Likert scale of 1-4 was used for responses.

The initial results of the *Likelihood and Impact Scale* were compiled and analyzed and provided back to the group as part of the SICC meeting on September 21, 2014.

Stakeholder responses: Items #1-32
Likelihood & Impact Scale November 2014



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
Impact	3.4	2.9	3.2	2.5	3	3.3	2.9	2.8	3	2.9	2.7	3.7	3.1	2.4	2.6	3	2.9	3.5	2.8	2.8	2.6	3.2	3.3	3.2	2.9	3.5	2.7	3.2	3.4	3.3	3.2	2.5
Likelihood	3.5	3	3.4	2.7	3.2	3.3	2.7	2.2	2.7	2.8	3.1	3.8	2.9	2.8	2.5	2.4	2.7	3.3	2.6	2.7	3.1	3.3	3.1	2.6	2.7	2.9	2.6	3.1	3.2	2.5	2.3	2.9

The Stakeholder group recommended at this meeting to take initial action on Item 12 on the *Likelihood and Impact Scale* as it was rated the highest from all respondents:

> *Item #12: Determine the usefulness of supplemental tools to assess social emotional needs.*

A small sub-group was recruited from the larger Stakeholder group to begin work on item #12 for Phase 2. This item suggested investigation into an additional tool to help measure social and emotional development as a method to improving data and intervention practice.

The final results of the survey with items plotted according to likelihood and impact were brought to the Stakeholders on February 24, 2015. The Stakeholders discussed contributing factors (both data and infrastructure) to the current performance in the SIMR. The Stakeholders identified three (3) additional root causes related to the infrastructure that are believed to impact improvement in the SIMR. In all, they reached agreement on the following four root causes:

1. Need for improved data quality in the measurement of child performance in social and emotional development including improved data completeness and consistent fidelity in the administration of the BDI.
2. Need for enhanced professional development that would ensure practitioners have the necessary knowledge and skills to use evidence-based practices to support young children and their families in enhancing the child's social and emotional development.

3. Need for statewide use of evidence-based practices to support families' capacity to enhance their child's social emotional development.
4. Need for all levels of the system to endorse and reinforce the value of social and emotional development as key to the overall healthy development of infants and toddlers.

Lastly, working from the root causes and survey results, the Stakeholders reached agreement on 15 items that were considered to have a high likelihood of being achieved and a high impact on improvement in the SIMR. These items were clustered according to possible strands for the Theory of Action and provide the basis for the development of Coherent Improvement Strategies. The chart on the next page shows these items.

Systemic Actions (Improvement areas that will have impact on SIMR)	Cluster
Provide training for service coordinators to utilize the Family Directed Assessment (FDA) as an opportunity to talk with families about social emotional development.	Professional Development
Analyze the existing role and responsibilities and skills of social workers and "teachers" in the NJEIS for consideration as potential resources in the development of children's social emotional development.	Professional Development
Collect data on the practices used by practitioners to address children's social emotional outcomes.	Social and Emotional Development
Develop a plan to integrate the *NJ Early Learning Standards* into the scope of practice in NJEIS.	Social and Emotional Development
Analyze the business rules of the BDI and the methods for reporting child outcomes for possible revisions.	Data quality
Improve the implementation of BDI assessment by the TETs, including the fidelity of evaluators.	Data quality
Determine the usefulness of supplemental tools to assess social emotional needs (Ages and Stages Social Emotional or other tools).	Data quality
Make available various types of professional development for practitioners on social emotional development including on-line, face to face, reflective practice opportunities etc.	Professional Development
Establish competency-based components and requirements for practitioners working in NJEIS.	Professional Development
Develop a general supervision/monitoring system that focuses on quality in addition to compliance, including methods to evaluate and address quality of IFSP and service delivery.	Social and Emotional Development
Develop communication strategies from DOH to agencies, practitioners, families and public about social emotional development and SSIP activities.	Social and Emotional Development
Learn about models of parent engagement related to EI. Develop a system to measure "family engagement".	Family Engagement
Define family engagement models of related to provision of EI services and develop a system of family engagement.	Family Engagement
Analyze the utilization of the NJEIS service of Family Training for consideration as a potential resource in the development of children's social emotional development.	Family Engagement

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

The NJEIS SIMR resulted from the investigation into the data trends, infrastructure analysis and a strong Stakeholder commitment to the content area of social and emotional development in young children. The NJEIS SIMR is:

To substantially increase the rate of children's growth in their development of positive social and emotional skills by the time they exit the program, as defined by the targets established for Indicator 3A, Summary Statement 1 in each of the years, FFY 2014-2018.

Baseline and Target Data

The Baseline and Target Data for the NJEIS SIMR are the same as the baseline and targets reported in Indicator 3A Summary Statement one in the FFY 2013 APR.

FFY2013	FFY2014	FFY2015	FFY2016	FFY2017	FFY2018
38.15%	38.15%	39.85%	41.55%	43.25%	45.00%

Component #4 Selection of Coherent Improvement Strategies

During Phase 1 of the SSIP, the NJEIS completed each of the required steps of data and infrastructure analysis to discern root cause(s) for current performance in Indicator 3A. This information was then used to identify Coherent Improvement Strategies and develop the Theory of Action for the SIMR. Discussions of improvement strategies were enriched by taking a closer look at other early care and learning state initiatives identified during the Infrastructure Analysis that could provide resources and potential partners. The NJEIS SIMR addressing the social and emotional needs of young children complements several projects already underway in the state and which are included in the applicable Coherent Improvement Strategy described below.

The Stakeholders reviewed the Data and Infrastructure Analysis to identify four root causes that affect current performance in the SIMR. The results of the *Likelihood and Impact Scale* had identified possible strategies for consideration that were likely to occur and likely to impact the SIMR. After discussion, deliberation and debate, the Stakeholders agreed to a final list of 15 possible strategies (see chart in previous section #2 on Infrastructure Analysis) from which Coherent Improvement Strategies were identified. These strategies were determined by the Stakeholders to be sound, logical, aligned with the SIMR and capable of building capacity for systemic change. The Stakeholders also emphasized the importance of ensuring these strategies, and their related activities are based on available evidence-based practice. Stakeholders reviewed and discussed OSEP's model Theory of Action, focusing on how efforts at the federal, state and local level can contribute to the improvement of child and family outcomes. Using the "if-then" framework, they recommended logical sequences of action and the expected results beginning with state activity to provider agency to practitioner action to

outcomes at the child and family level. Working in small groups, the Stakeholders considered each possible Coherent Improvement Strategies and the impact of these strategies on provider and practitioner actions and the effects of these actions on ultimate improvement in the SIMR.

Three of the four identified root causes relate to clinical application of evidence-based practice which can benefit from alignment with two specific initiatives already underway in the state.

1. NJ is a Race to the Top Early Learning Challenge (RTTT) state focused on the quality of programs and services from pregnancy to age eight. A critical piece of the RTTT is the NJ-Early Learning Training Academy (NJ-ELTA). The NJ-ELTA will establish a statewide training academy with regional satellite venues to coordinate and align the preparation of early childhood professionals, including the delivery of high-quality professional development to facilitate the implementation of the highest standards for the education and care of children throughout the state. The NJ-ELTA is expected to expand its outreach to become a lead provider and authoritative clearinghouse for state-sponsored early childhood training. NJEIS is a RTTT partner and is invested in contributing to and benefitting from the development and access to resources of the NJ-ELTA for the professional development of NJEIS practitioners.
2. Montclair State University developed and has implemented a series of seven workshops in Infant and Early Childhood Mental Health in the ten (10) counties affected by Superstorm Sandy. The trainings, “Keeping Babies and Children in Mind”, are offered at no cost to the participants who were from all sectors of public and private infant/child/school and family programs. NJEIS has had a number of practitioners and personnel from the regional and local level attend some or all of the workshops. The DOH has been in conversation with the leadership of this project to investigate methods to utilize this established series for the professional development needs of the NJEIS.

Root Cause: #1 Professional Development

The need for an enhanced Professional Development system that will ensure practitioners have the necessary knowledge and skills to use evidence-based practices to support young children and their families in enhancing the child’s social and emotional development.

Coherent Improvement Strategy#1

NJEIS will enhance its Professional Development System to provide learning opportunities focused on practitioners’ knowledge and skills in evidence-based practices to support the social and emotional development of young children.

Stakeholders have advised these activities for development and execution under Phase 2:

- Make available professional development opportunities to practitioners on social emotional development including on-line, face to face, reflective practice opportunities etc.
- Collect data on the practices currently used by practitioners to address children’s social emotional outcomes.

- Utilize the resources of the NJ Race to the Top (RTTT) ELTA and the Montclair State "Keeping Babies and Children in Mind" program to meet some of the professional development needs of the system.
- Provide additional training opportunities for service coordinators to utilize the Family Directed Assessment (FDA) as an opportunity to talk with families about social and emotional development.

Root Cause: #2 Family Engagement

The need for statewide use of evidence-based practices to support families' capacity to enhance their child's social emotional development.

Coherent Improvement Strategy #2

The NJEIS will develop, implement and monitor a process that defines and enhances quality family engagement as a core expectation of early intervention.

Stakeholders have advised these activities for development and execution under Phase 2:

- Investigate evidence-based practice on parent engagement related to Early Intervention and social emotional development.
- Develop a system that can measure change in a family's capacity to help their child in their social and emotional development.

Root Cause: #3 Social and Emotional Development

The need for all levels of the system to endorse and reinforce the value of social and emotional development as key to the overall healthy development of infants and toddlers.

Coherent Improvement Strategy #3

The DOH will effectively communicate to all practitioners enrolled with the system the fundamental importance of social emotional development to young children's success and the expectation that IFSP teams should consider this developmental area.

Stakeholders have advised these activities for development and execution under Phase 2:

- Develop communication strategies from DOH to agencies, practitioners, families and public about social emotional development and SSIP activities.
- Develop a plan to integrate the *NJ Early Learning Standards* into the scope of practice in NJEIS.
- Develop a general supervision/monitoring system that focuses on quality in addition to compliance, including methods to evaluate and address quality of IFSP and service delivery

The fourth root cause addresses data quality which is instrumental to the valid and reliable measurement of child outcomes.

Root Cause #4 Data Quality

The need to improve data quality in its measurement of child performance in social and emotional development including improved data completeness and consistent fidelity in the administration of the BDI.

Coherent Improvement Strategies #4

1. The NJEIS will provide targeted technical assistance to all TETs based on the specific errors in fidelity that are identified.

Stakeholders have advised these activities for development and execution under Phase 2:

- Complete observations of fidelity for all TET evaluators that administer BDI.
- Assess the knowledge and skill of TET evaluators for evaluating children's social and emotional status when they enter the system between 0-11 months at age.

2. The NJEIS will develop, implement & monitor new statewide procedures for obtaining exit BDIs.

Stakeholders have advised these activities for development and execution under Phase 2:

- Develop a new set of procedures that articulate, at each point in the system, responsibility for the collection of exit data (SCU, TET, regional data personnel and DOH staff).
- Collect and analyze information from interviews with families to find systemic opportunities to increase the consent rate of families for the exit BDI.

Component #6: Theory of Action

The results of this work are captured in the Theory of Action graphic on the next page of this SSIP. This graphic illustration shows the logic of how implementing the coherent improvement strategies will lead to change in provider behavior and result in the achievement of improved results in children's social and emotional development. Phase 2 work has already begun putting the Theory of Action into motion.

The final Theory of Action graphic was presented to the Part C Stakeholders on March 27, 2015.

Action Strands	If the State……	Then providers…..	Then	Result
Data Quality	…provides targeted TA to TETs based on identified errors in fidelity … …develops, implements & monitors statewide procedures for obtaining exit BDIs	*…will address individual skills that need improvement thereby improving fidelity of BDI administration* *…increase the number of exit BDIs that are completed and reported*	Quality of child outcome data will improve statewide IFSPs will reflect appropriate outcomes and strategies to include Social/Emotional Families will be better able to support and enhance their child's overall development including social emotional	*Infants and toddlers with disabilities will substantially increase their rate of growth and development of positive social emotional skills by the time they exit the program*
Social & Emotional Development	…effectively communicates: the fundamental importance of social emotional development to young children's success; and the expectation that IFSP teams should consider this developmental area.	…will understand the value of social and emotional development will result in increased support to families and caregivers around enhancing children's social and emotional development.		
Family Engagement	…develops, implements and monitors a process that defines and enhance quality family engagement as a core expectation of Early Intervention.	…will support families to increase their capacity to help their child grow and learn.		
Professional Development	…enhances the Professional Development System to provide learning opportunities focused on practitioners' knowledge and skills in evidence-based practices to support young children's social and emotional development.	…will apply evidence-based practice when working with children and their families that enhances the child's social and emotional development and their family's capacity to enhance their development		

NJEIS Stakeholders & Affiliation	
Amy M. Smith	Autism NJ
Barbara Tkach	NJ Department of Education/SICC member
Catherine Noble Colucci	Rutgers University/SICC member
Chanell McDevitt	NJ Department of Banking & Insurance/SICC member
Stacy Schultz	Early Intervention Provider Agency
Claire Wieczerak	Autism NJ
Cynthia Newman	Mid-Jersey Early Intervention Collaborative
Dan Keating	ABCD
Danielle Anderson Thomas	NJ Department of Education/SICC member
K. David Holmes	Consultant/ABCD
Desiree Bonner	Helpful Hands Early Intervention Collaborative
Diana MTK Autin	Statewide Parent Advocacy Network/PTI
Fran Gallagher	NJ AAP
Gerald Theirs	ASAH
Jennifer Buzby	Southern NJ Early Intervention REIC

NJEIS Stakeholders & Affiliation	
Jennifer Blanchette-McConnell	Mid-Jersey Early Intervention REIC
Joseph Holahan	Pediatrician/SICC member
Joyce Salzberg	Early Intervention Provider Agency /SICC member
Steve Weiss	Parent/SICC member
Lorri Sullivan	Montclair State University
Maria Emerson	Early Intervention Provider Agency
Mary Ciccone	Disability Rights NJ
Mary Remhoff	Monmouth County Service Coordination Unit
Michele Christopoulos	Early Intervention Provider Agency/SICC member
Michele Safrin	NJ Department of Children & Families
Patti Ciccone	Northeast Regional Early Intervention Collaborative
Rachel Badalamenti	Parent/SICC member
Rosemary Browne	NJ Department of Children Families/SICC member
Ericka Williams	Department of Children & Families
Susan Marcario	Family Link Regional Early Intervention Collaborative
Shawn Rebman	Early Intervention Provider Agency

SSIP Leadership Team (DOH)	
Terry Harrison	Part C Coordinator
Susan Evans	Results Accountability Coordinator
Oliver Giller	Central Management Coordinator
Christine Nogami-Engime	Monitoring Coordinator
Karen Melzer	CSPD Coordinator

Sharon Walsh National Consultant

Governance Strengths		
The NJEIS has a vision, mission and purpose to serving infants and toddler with disabilities and their families which is known to the workforce and which is reinforced at the Regional and Local level.	The DOH invested in training on the Ages and Stages screening tools for service coordinators to increase their knowledge of social-emotional development and about screening tools for young children.	The State Interagency Coordinating Committee (SICC) is available to assist with opportunities to strengthen family involvement and understanding of social-emotional development.
The NJEIS has updated policies and procedures that are in effect and disseminated to ensure the rights of families and the needs of children are met in accordance with Part C of the IDEA.	The DOH invested in and supports the BDI as a standardized evaluation tool for system use and has committed the financial resources to maintain its use.	The NJEIS utilizes a state-created Family Directed Assessment (FDA) which provides service coordinators the opportunity to talk with families prior to IFSP development about their concerns, priorities and resources.
The structure of the NJEIS has different levels of administration at the local, regional and state level which can support initiatives (such as the SSIP).	The system maintains a training and technical assistance team (CSPD) consisting of 4 professionals that work from the Regional offices. A state-level staff person is assigned to oversee and support the regional TTA staff.	NJEIS consistently meets or exceeds the state target of 99.5% for Indicator 2 – “children receive services primarily in natural environments”. This evidence based practice provides opportunities for practitioners to work directly with caregivers in the child’s life.
The state has designated Targeted Evaluation Teams (TET) with supervision at the local level. The TETs provide specialized expertise in evaluation and assessment, which contributes to the development of IFSPs and to the data collected and reported in Indicator 3.	The Procedural Safeguards Office offers a structure for families to voice concerns which assists the NJEIS with identifying areas for continuous quality improvement efforts.	The four REICs have established local connections and staff which provide an opportunity and structure that can be used to strengthen family’s knowledge of social emotional development in the execution of the SSIP.

Governance Weaknesses/Opportunities		
There are no current procedures and/or policies to annually review the TET Letters of Agreement and performance.	An ongoing and formalized Continuous Quality Improvement strategy for the TET teams is needed.	Personnel at all levels (regional, agency and practitioner) need training on interpreting and understanding policy and how it is to be applied to their role within the system.
The Regional Early Intervention Collaborative structures may not be familiar to families.	Communication strategies from DOH to multiple agencies about initiatives need improvement.	Strategies for communication with families about the importance of social-emotional development need improvement.
The REICs maybe underutilized, particularly the family support personnel.	The NJEIS system structure does not support time for collaborations with team about social-emotional and other topics.	The NJEIS structure does not have EIP agencies that will provide identified services attend the initial IFSP meetings.
There are areas in the state that have challenges with adequate provider coverage.	The strategic plan for improving social emotional needs to be tied with the overall strategic plan for the system.	The state office has vacant positions and lacks redundancy in responsibilities which creates a vacuum of knowledge when a position is vacated.

Data System Strengths		
NJEIS collects and has available a wealth of data. Service data, practitioner data, financial data, child and family outcome data, etc. is available to DOH which has the ability to create and run various types of reports.	DOH financial and ongoing technical support of hardware and software for BDI, SCU and REIC systems.	The Ages and Stages Questionnaire is being used by multiple initiatives and groups and has been considered by DOH/NJEIS.
NJEIS has leadership (state and regional) that values data and the use of data to inform decisions.	Ability to work with Riverside for improvements to BDI or other new tools.	NJEIS regularly posts information on line – this can be helpful venue for the activities and information related to SSIP.
NJEIS leadership shares and explains data to stakeholders regularly through SICC and Steering Committees and other formal meetings.	Improvements in hardware and software used by NJEIS has the ability to positively affect; Team communications; Use of data among teams; Outcome progress monitoring; and Monitoring ability of DOH.	A web-based system for IFSPs is being planned.

NJEIS has a positive relationship with Riverside to manage and use the BDI both the hardware/software and the clinical interpretation of the data.	DOH has a new staff person to assist with data and data visualization and seasoned staff person with skills to manage complex queries.	

Data System Opportunities		
There is an opportunity for professional development at all levels on the use data for planning and intervention.	The opportunity exists to inform social-emotional practices for practitioners. Data can be "non-judgmental", provides opportunity to present information clearly to state, regional and local staff.	The opportunity exists to utilize data, about social emotional development and evidence based practice, to affect policy and potential funding.
There is the opportunity to improve communication and inclusion of "informal Stakeholders in the dissemination of data.		

Data System Weaknesses		
Data analysis is limited by: 1) Lack of statistician to help interpret the data in context; 2) Time available to analyze data due to competing priorities and staffing patterns; and 3) Use of multiple data systems to meet different needs (SPOE, BDI).	Additional reports and queries could be made available to regional and local staff for program planning and improvement.	General I.T. challenges such as maintaining and replacing equipment. Ongoing challenge of changing technology and securing data.
NJEIS has available an abundance of data which has limits: Not all data are available in "real time"; Data systems have been developed for different purposes by different developers and ease of integration is limited.	Data sharing between outside groups, others involved in the care of the child is cumbersome and not easily achieved.	There is no current procedure to capture in a data set the evidence based practices that are employed by practitioners to address social-emotional delays.
There are certain systems or components available only to certain staff (REIC or SCU or DOH) which limits local use.	Funding for equipment to update, and maintain hardware and software in the field.	The BDI web-based data system has limited functionality.

A web-based system has not been implemented.	Front-line practitioners (including service coordination) lack of understanding for the importance of data and overall system accountability.	There is no system or structure or data system that can measure "family engagement."
Providers and regional personnel are limited in their use of more complex data to that which is provided by DOH.	Data reliability is dependent on the quality of the information input into the system.	

Accountability/Monitoring Strengths		
The monitoring process and team provides feedback to the system on how well we are doing – or not doing and use data to provide the feedback.	There are agencies that write appropriate outcomes based on social emotional issues.	The Family Directed Assessment (FDA) has helped to identify issues. The FDA summary can be helpful to families as they participate in the IFSP.
There is public reporting at agency provider level which contributes to accountability of the agency.	The current monitoring team can conduct onsite visits for corrective action plans.	DOH reviews policies and procedures when issues are raised.

Accountability/Monitoring Opportunities		
There is an opportunity to achieve more consistency and add quality checks on the administration and use of the FDA.	There is an opportunity to develop and auditing system that focuses on quality in addition to compliance.	The opportunity exists to engage families in the self-assessment of an agency.
The opportunity exists to look at the family survey to ascertain if there is social emotional information that can be useful.	There exists the opportunity increase the availability of local level data regarding social emotional development.	The opportunity exists to add requirements for general supervision with annual reporting to DOH, and meaningful self-correction.

Accountability/Monitoring Weaknesses		
Currently there are no agency reports per county about how families and children's concerns are being addressed.	NJEIS is not currently able to address the quality of IFSPs.	Data quality is an ongoing challenge.

There could be greater accountability imposed on "low performers". There are no sanctions for those that refuse to participate in voluntary training.	There is variability in the types and amount of services provided.	There needs to be a consistent statewide improvement plan.
Clearer standard and criteria for selecting and evaluating the TETs is needed.	There is no periodic review of LOA for provider agencies which impacts recruitment, retention of staff and FTE status.	There is no standard way to measure performance in social emotional development in the children in NJEIS.
There is concern that all service coordinators and other NJEIS staff understand the FDA and its purpose and benefits.	It is unclear what evidence-based practice is implemented on a regular basis.	It is unclear if there are continuous quality improvement efforts at the EIP and SCU level.

Quality Standards Strengths		
Riverside publishers provides face to face training for BDI.	NJEIS has data to build upon. We already have some data around social emotional practice.	The Early Learning standards are available in NJ and there are national information and resources that can be used in the work.
NJEIS uses a standardized and standard assessment tool in BDI.	Procedural Safeguards modules are required to be completed by all NJEIS staff.	

Quality Standard Opportunities		
There is an opportunity to make all early learning standards a part of scope of practice and to utilize the parent guide to the early learning standards.	There is the opportunity to look at documentation during periodic reviews to see how EI is meeting the social emotional outcomes on an IFSP.	There is an opportunity to have additional education and training of BDI administration and other tools.
There is the opportunity for NJEIS to determine if the use of supplemental tools to assess social emotional needs is helpful.	There is the opportunity for NJEIS assess family's perception of a child's status and family's ability to address social emotional development.	There is the opportunity to refine and promote the screening process for resource families within EI and address their social emotional needs.

Quality Standards Weaknesses		
NJEIS needs a consistent definition of social emotional development.	There are no uniform program standards that are implemented statewide.	There are no standards for team meetings, support and mentoring and communication among team members.
Feedback is needed from TETs to inform DOH if the training provided is appropriate or if gaps exist.	There are concerns about BDI sensitivity, parent feedback process and administration.	There is standard method to capture information from biological family and resource family around children's social emotional development.
Weakness in the standard implementation of the key principle of "family involvement" throughout NJEIS.	There needs to be improved access and opportunities for peer interaction. Finding low or no cost options can be a challenge.	Limited knowledge about the program standards.
There could be an inconsistent and lack of implementation of national standards and evidence based practice.	There is a lack of opportunities for education on quality early intervention and that can include social emotional development.	Lack of time to get to know families better, effectively administering the FDA.

Finance Strengths		
Financial commitment of state budget and DOH to the NJEIS and there is consistent support of EI by the Office of Management and Budget.	Monitoring and accountability via data systems.	The Central Management Office has data and procedures to recoup revenue from Family Cost Participation and Medicaid.
	The SICC service delivery committee is using the ECTA system framework to develop recommendations for a competitive EIP RFP.	

Finance Opportunities		
There is an opportunity to re-look at how the role of family support and CSPD can be used to support this project.	There is an opportunity to re-look at reorganizing the use of family training and social workers in the system.	Opportunity to leverage funds from outer sources related to hurricane Sandy, NJ Association of Infant Mental Health, Race to the Top initiative etc.
There is the opportunity for the REICs to fundraise.	There is an opportunity to consider a new cost study	There is the opportunity to ensure that EPSDT is fully utilized.

Finance Weaknesses		
Funds for infrastructure are needed to support an increase in DOH and regional staff to support the SSIP process and to hire additional service coordinators to reduce large caseloads.	Fiscal structures the system is unable to analyze how funds are being utilized and limited accountability in general.	Consistent review of LOAs for accountability is needed.
Lack of funding to support training and supervision of practitioners.	No data utilization review is being conducted which could inform how current funding is used	Many EIP programs do not hire FTEs rather the workforce is predominantly per-diem.
Underutilization of teachers in the provision of direct services and over-reliance on discipline specific services.	There is limited ability to advocate at legislative level for adequate budget to meet needs and goals.	Family cost share may limit families participation whose child may have social emotional needs.

Personnel Development/Technical Assistance Strengths	
There is an established Comprehensive System of Personnel Development (CSPD).	The NJ Infant Mental Health Endorsement is taking hold. Some NJEIS personnel are working towards their endorsement.
The personnel standards are actively enforced and are currently under review as part of ensuring a qualified workforce.	National programs have developed material that can be used to address and identify social emotional concerns and or challenging behaviors.

Personnel Development/Technical Assistance Opportunities	
There is the opportunity to strengthen relationships with higher education in order to facilitate more personnel development around social emotional	The opportunity exists to develop materials to support the dissemination of information related to social emotional development.
There is the opportunity to reach more direct service practitioners through the Mercer County College Learning management system (webinars, e-blasts, modules)	There is the opportunity to train current T&TA staff responsible for training in the Learning Management System and new technologies for training.
There is the opportunity to partner with other Part C states working on Social and Emotional development.	There is the opportunity to partner with other states that use the BDI for child outcome reporting to address fidelity issues.

Personnel Development/Technical Assistance Weaknesses	
Weaknesses related to service coordinators included: 1) High caseloads; 2) Need for more training opportunities for service coordinators; and 3) Need to address turn-over of SCU personnel	Current T& TA staff responsible for training utilized for other purposes limiting time spent on personnel development needs.
There is a need for a personnel standard for Targeted Evaluation Team members.	Concern that web-based training will be only method for learning and dissemination of information.
Training needs are extensive. Personnel at all levels need training on 1) Social emotional development 2) Data use and analysis.	There is a need to increase the number of Regional TTA staff to meet training needs. The REIC spend significant time addressing issues child by child instead of looking at systemic needs and working towards a larger goal.

SICC & Stakeholder

Infrastructure Analysis Part 2
September 2014

As a part of the NJEIS State Systemic Improvement Plan (SSIP), the Department of Health (DOH) obtained and compiled comments and input from SICC members, invited Stakeholders and DOH staff regarding the strengths, weaknesses, and opportunities within the system's framework that can potentially impact the achievement of the State Identified Measureable Result (SIMR). The identified system weaknesses and opportunities were rewritten as possible strategies that could contribute to the achievement of the SIMR.

To utilize resources effectively and efficiently, the DOH must prioritize those efforts with the greatest likelihood of success and those that will generate the highest impact. DOH is requesting that stakeholders contribute their opinion as to 1) the likelihood that a strategy/effort can be achieved within the next 3 years and 2) the impact that effort would have on the SIMR if it were achieved.

These responses will assist the DOH with setting priorities and the development of coherent strategies for submission in Phase one of the State Systemic Improvement Plan (SSIP).

Instructions: For each item:

1) **Circle the "Likelihood" of the strategy/effort being achieved within the next 3 years; and**
2) **Circle the "Level of Impact" achieving the item will have on the SIMR**

Stakeholder Identified Possible Strategies **1= not likely, low impact** **4= highly likely, high impact**	**Likelihood of Achievement** 1 2 3 4	**Level of Impact on SIMR** 1 2 3 4
1. Provide training for service coordinators to utilize the Family Directed Assessment (FDA) as an opportunity to talk with families about social emotional development	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
2. Analyze the roles and responsibilities of the REIC staff and the potential adjustment of assignments to incorporate SSIP work.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
3. Develop communication strategies from DOH to agencies, practitioners, families and public about social emotional development and SSIP activities (e.g. FAQ, manual, topical briefs, webinars, website and other materials)	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
4. Identify & support low and no cost options for including peers into regular routines of children and families	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
5. Analyze the business rules of the BDI and the methods for reporting child outcomes for possible revisions	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
6. Improve the implementation of BDI assessment by the TETs, including the fidelity of evaluators	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
7. Provide incentives to practitioners to facilitate team collaborations, interest and participation in training including exploring providing CEUs.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
8. Fill more staff positions at DOH that can be assigned to SSIP (e.g. statistician, clinical staff)	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

Stakeholder Identified Possible Strategies **1= not likely, low impact 4= highly likely, high impact**	**Likelihood of Achievement**				**Level of Impact on SIMR**			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
9. Institute professional development (practitioner level) on **data use** for intervention and progress monitoring to improve practitioners' regard for and knowledge and skills in the use of data and overall system accountability	☐	☐	☐	☐	☐	☐	☐	☐
10. Provide training to provider agency administrators on the use of data to conduct their own continuous quality improvement activities.	☐	☐	☐	☐	☐	☐	☐	☐
11. Improve dissemination of NJEIS data in user friendly formats to practitioners, families, service coordinators and the public.	☐	☐	☐	☐	☐	☐	☐	☐
12. Determine the usefulness of supplemental tools to assess social emotional needs (Ages and Stages Social Emotional or other tools)	☐	☐	☐	☐	☐	☐	☐	☐
13. Collect data on the practices used by practitioners to address children's social emotional outcomes	☐	☐	☐	☐	☐	☐	☐	☐
14. Analyze the NCSEAM survey for items that may provide additional data for the NJEIS work on social-emotional development and if families feel early intervention helped them in this area.	☐	☐	☐	☐	☐	☐	☐	☐
15. Utilize available data about social emotional development and evidence based practice to attract external additional funding achieve the SIMR	☐	☐	☐	☐	☐	☐	☐	☐
16. Improve hardware and software systems so that all levels of the NJEIS have compatible and comparable systems	☐	☐	☐	☐	☐	☐	☐	☐
17. Integrate data systems used by NJEIS to improve ease of analysis for SSIP (BDI, SPOE)	☐	☐	☐	☐	☐	☐	☐	☐
18. Make available various types of professional development for practitioners on **social emotional** development including on-line, face to face, reflective practice opportunities etc.	☐	☐	☐	☐	☐	☐	☐	☐
19. Learn about models of parent engagement related to EI. Develop a system to measure "family engagement	☐	☐	☐	☐	☐	☐	☐	☐
20. Define family engagement models of related to provision of EI services and develop a system of family engagement	☐	☐	☐	☐	☐	☐	☐	☐
21. Use the resource of SPAN to connect with families to support families understanding of social emotional development	☐	☐	☐	☐	☐	☐	☐	☐
22. Develop a plan to integrate the *NJ Early Learning Standards* into the scope of practice in NJEIS.	☐	☐	☐	☐	☐	☐	☐	☐

Stakeholder Identified Possible Strategies **1= not likely, low impact 4= highly likely, high impact**	**Likelihood of Achievement**				**Level of Impact on SIMR**			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
23. Establish competency-based components and requirements for practitioners working in NJEIS	☐	☐	☐	☐	☐	☐	☐	☐
24. 24. Increase the number of Mental Health professionals in the NJEIS	☐	☐	☐	☐	☐	☐	☐	☐
25. Strengthen relationships with higher education to facilitate more personnel development around social emotional development	☐	☐	☐	☐	☐	☐	☐	☐
26. Develop a general supervision/monitoring system that focuses on quality in addition to compliance, including methods to evaluate and address quality of IFSP and service delivery	☐	☐	☐	☐	☐	☐	☐	☐
27. Analyze child outcome data to determine if the social emotional needs of children in Resource homes are different from children that are not in resource homes.	☐	☐	☐	☐	☐	☐	☐	☐
28. Analyze the utilization of the NJEIS service of Family Training for consideration as a potential resource in the development of children's social emotional development	☐	☐	☐	☐	☐	☐	☐	☐
29. Analyze the existing role and responsibilities and skills of social workers and "teachers" in the NJEIS for consideration as potential resources in the development of children's social emotional development	☐	☐	☐	☐	☐	☐	☐	☐
30. Decrease the caseloads of Service Coordinators to allow for greater opportunity to focus on social emotional development and information in the FDA	☐	☐	☐	☐	☐	☐	☐	☐
31. Increase funding to agency providers to support training and supervision of practitioners	☐	☐	☐	☐	☐	☐	☐	☐
32. Conduct utilization review to determine how current funding is used	☐	☐	☐	☐	☐	☐	☐	☐