

Indicator C11: State Systemic Improvement Plan – Nebraska – Phase II

Monitoring Priority: General Supervision

The State’s SPP/APR includes a State Systemic Improvement Plan (SSIP) that meets the requirements set forth for this indicator.

Baseline and Targets

Baseline Data – C3B Summary Statement 1 - Acquisition and Use of Knowledge and Skills:

FFY	2013
Data	40.2

Performance Data – C3B Summary Statement 1 - Acquisition and Use of Knowledge and Skills:

FFY	2014
Data	50.4

FFY 2013 – FFY 2018 Targets- C3B Summary Statement 1 - Acquisition and Use of Knowledge and Skills:

FFY	2014	2015	2016	2017	2018
Target	40.2	40.5	41	41.5	42.5

Phase II Component #1: Infrastructure Development

Nebraska’s early intervention (EI) system is co-administered by the Nebraska Departments of Education (NDE), Office of Special Education, and Health and Human Services (DHHS), Division of Medicaid and Long-term Care. The NDE and DHHS Part C Co-Coordinator and respective Administrative teams, along with the two Family Partners who serve in an advisory capacity to the Co-Leads, meet monthly to review, plan and make decisions regarding systemic improvements for infants/toddlers and their families who receive EI services. Because Nebraska is a birth mandate state all internal systems are aligned and integrated with the IDEA Part B/SEA infrastructure. Nebraska is able to maximize resources and supports due to this alignment.

The Co-Leads meet monthly with the NDE Program Improvement Team (includes the 619 Coordinator and Part B SSIP Coordinator), Data Team (includes the Part C and B Data manager), Early Childhood Program Administration (includes the State Administrator for preschool services, Child Care State Director and Head Start State Director) and the DHHS Medicaid Waiver teams to engage in extensive planning and implementation of evidence-based practices across state systems to ensure continued improvement of access and service provision for infants/toddlers with disabilities and their families¹.

The Co-Leads established a Results Driven Accountability (RDA) stakeholder committee in January 2014 to assist the state in the planning and implementation of the State Systemic Improvement Plan (SSIP). The members of the committee were formally invited to serve as representatives, and as part of the agreement to

¹ Response to OSEP Evaluation tool item 1 (c & d). Please note that the reference to each footnote refers to all information included from either the beginning of the SSIP or the information written between footnotes. Therefore, all information in the SSIP is referenced.

participate, the individual agreed to serve on the committee throughout all phases of the SSIP. Committee members represent internal and external partners as well as diverse professionals and family members. Representatives include parents, State Interagency Coordinating Council members, local interagency Planning Region Team (PRT) members, EI services coordinators and supervisors, special education directors, early intervention staff, Parent Training and Information Center staff, institutions of higher education, mental health providers, State Child Welfare staff, local and State Head Start Director(s), child care agencies, medical/health agencies, community agencies, and private foundations².

The Co-Leads also obtain input from Nebraska Special Education Advisory Council (SEAC) and the Early Childhood Interagency Coordinating Council (ICC). These councils were established pursuant to federal regulations and as such provide for input from a diverse group of stakeholders. SEAC and ECICC, which regularly discuss the SPP/APR and provide input on the targets and strategies contained within, have reviewed and supported the work of the RDA Stakeholder group. SEAC and ECICC meet quarterly and will continue to be utilized for additional input on the development of Phases II and III of the SSIP³.

The RDA Stakeholder Committee met several times in 2014 and 2015 to assist in the continuous evolution of the SSIP and help provide for ambitious and meaningful change statewide. Stakeholders and early intervention staff were provided additional opportunities to receive information related to RDA Phases I and II and provide input during the Annual Early Development Network Conference in June 2015, the Annual Statewide Results Driven Accountability Meeting in August 2015, the RDA Stakeholder Committee meeting in October 2015, and the Results Matter Child Outcomes Task Force in November 2015. Finally, local-level infrastructure in the SSIP work was enhanced by NDE's statewide conference titled, "Supporting Results Driven Accountability Through Policy, Programs and Practice Conference" held in November 2015 which featured keynote speakers Alan Coulter, Ph.D., the Principal Lead for the TIERS Group, and Senior Manager at the Human Development Center (HDC); and Silvia DeRuvo of the WestEd Center for Prevention and Early Intervention.

Local program providers' knowledge and skills were enhanced by the following topical presentations:

- Evidence Based vs. Compliance Based Strategies
- Implementation Science
- Using Data to Determine Root Cause
- Setting Five-Year Targets

The Stakeholder work is communicated frequently to other NDE and DHHS offices, local EI programs/administrators, parents, agencies and advisory groups. This insures that other interested parties have access to the work of the stakeholder group and an opportunity to provide additional input⁴.

Nebraska's multiple stakeholders selected the following State Identified Measurable Result in response to Results-Driven Accountability:

Increase the number and percentage of infants and toddlers who demonstrate progress in the acquisition and use of knowledge and skills (including early language/communication)
– 3B, Summary Statement 1;

The Stakeholders also selected three coherent improvement strategies to assist in achieving results for infants/toddlers with disabilities and their families:

² Response to OSEP Evaluation tool item 1 (d)

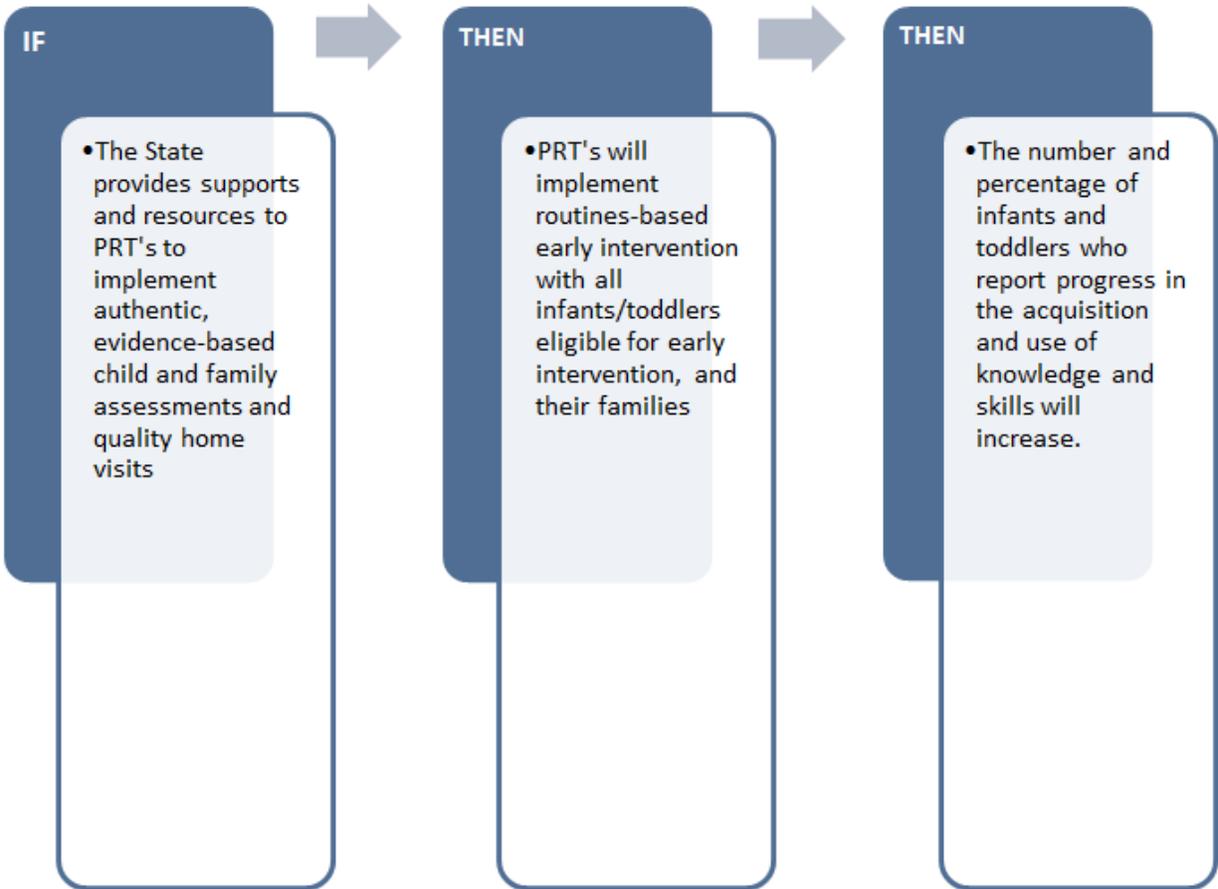
³ Response to OSEP Evaluation tool item 1(d)

⁴ Response to OSEP Evaluation tool item 1 (c & d)

- a. The RBI;
- b. Functional child and family focused IFSP outcomes; and
- c. Quality home visits based on routines.

The improvement strategies, as a unified set, are referred to as a “routines-based early intervention approach,” (RBEI) and have the potential to positively affect Nebraska’s SIMR⁵.

Nebraska’s Theory of Action:



During Phase I, the Co-Leads developed a state-level leadership team in order to strengthen state and local level infrastructure in the implementation of the SSIP work. This leadership team consists of the following experts who are assisting Nebraska in the scaling up and implementation of the RBEI model for the SIMR: Dr. Robin McWilliam, researcher of RAM Institute and founder of RBEI; Dr. Haidee Bernstein, lead analyst from Westat and IDC/ DaSy consultant; Dr. Barb Jackson of UNMC-Munroe Meyer Institute; Dr. Cindy Hankey and Sue Bainter, M.A. Special Ed OTR/L, state EI experts/ coordinators; Connie Shockley, PTI-Nebraska; Mark Smith, M.S. of UNMC-Munroe Meyer Institute serving as a Family Partner to the Co-Leads; Julie Docter, DHHS Part C Co-Coordinator; Amy Bunnell, NDE Part C Co-Coordinator; and Cole Johnson, NDE PRT Coordinator.

⁵ Response to OSEP Evaluation tool item 1(a)

This leadership team meets monthly to continue the planning, scaling up, implementation; evaluation; and data collection processes necessary to achieve results for infants/toddlers with disabilities and their families. This team is responsible for identifying the infrastructure changes critical to implementation of the SSIP, identifying and obtaining the necessary resources to achieve intended outcomes, and developing timelines to complete the infrastructure changes necessary to better support local programs and providers.

The state leadership team is further supported by the assigned state contacts at IDC, DaSy, and ECTAC as well as through our participation at the May 2015 IDC Interactive Data Institute in Chicago, IL and the November 2015 DaSy Topical Meeting on Local Data Use for Program Improvement in San Antonio, TX. Three of Nebraska's state leadership team members attended the IDC Interactive Data Institute in which we had the honor of presenting information to attendees related to our Part C Theory of Action and the selection/implementation of our Phase II coherent improvement strategies. Valuable information was obtained from this Institute related to understanding Phase II evaluation requirements, utilizing implementation drivers, building an effective evaluation team, and developing quality data for evaluation purposes and to drive change⁶.

Two state leadership team members attended the DaSy Topical Meeting on Local Data Use for Program Improvement along with four local EI program administrators in our state. The Nebraska delegation analyzed its current early childhood data systems; supports Nebraska's Early Childhood Programs have available for local districts in regards to data use; and established a plan for future data use and supports throughout the state. While reviewing Nebraska's current data systems and supports for local districts, the delegation analyzed the state's Teaching Strategies GOLD assessment system utilized to obtain Child Outcomes data for all children aged birth-to-five in state-supported early education programs. Since state-wide implementation of the TS GOLD system was established in FFY 2011, Child Outcome scores have varied some, but Nebraska chose to adjust its Child Outcome targets based upon what was thought to be a stabilizing data pattern. However, upon further analysis, it appears that the first year of potentially stabilizing data will most likely be FFY 2014 due to state-wide implementation of the Inter-rater Reliability Certification that was required of all early intervention/educational providers during FFY 2013. It should be noted, however, that Nebraska will need a couple more years of data to be certain that the data has stabilized. Furthermore, based upon the delegation's analysis and conversations regarding the resources and supports that Nebraska has in place for local school districts to utilize and analyze their data, it was felt that a plan would need to be developed to increase understanding and utilization of the data currently available to local programs through the Teaching Strategies GOLD system. Therefore, the state leadership team established a strategic plan to gather more information regarding available data, for children of all ages, across all Department data systems; identify how those other systems compliment or conflict with the Teaching Strategies GOLD system; identify ways that the different systems might be merged to enhance district access to child information for meaningful analysis; and finally, develop training for school district personnel that includes all available data systems and resources that would help local districts/providers better understand and utilize the data that is currently available to them in order to improve outcomes for all children and families. It is anticipated that these local data trainings will occur in 2016-2017, across the nineteen Educational Service Units throughout the state to ensure that all local district providers have access to needed information to make data driven decisions⁷.

In October 2015, three family leaders from Nebraska were selected to participate in the DaSy Family Leadership Data institute in Atlanta, GA which has strengthened our state's infrastructure in the implementation of Results-Driven Accountability. The participants included Mike Adams, Chair of the Nebraska ECICC (also a parent member); Christy Pelton, parent member of the ECICC; and Connie Shockley of the Nebraska Parent-Training Information Center. The main topics covered at the DaSy Conference included:

⁶ Response to OSEP Evaluation tool item 1 (c)

⁷ Response to OSEP Evaluation tool item 1 (a)

- Data 101
- Privacy & Confidentiality of data: What do families need to know?
- SPP/APR – what data are states required to collect and what do they do with it?
- RDA – a focus on improving results for children and families
- The power of linking data – cross-agency/program data system initiatives

The Nebraska participants reported that the topics were presented at varying levels to accommodate the participants' knowledge and elicit insightful questions from the participants. Additionally, the participants were provided with relevant and ongoing resources related to the above-mentioned topics. The participants reported that the sessions garnered great discussion around the big picture of data; including what data is collected by states; what it means to be an effective data systems stakeholder; and developing action plans that can easily apply to the work that the Nebraska ECICC and PRT's are conducting. The Nebraska participants felt that the session on linking data information was very valuable as it demonstrated both the difficulties and benefits of being able to compile and access data across agencies/programs and longitudinally to provide meaningful information in determining policy discussion at all levels. The Nebraska participants have had the opportunity to share the information obtained at the DaSy Institute with the Part C State Leadership team, the Nebraska Part C RDA Stakeholders, the Nebraska ECICC and local PRT's in which the participants are members of. The Part C State Leadership team will continue to utilize these participants' expertise as we continue to move through the phases of the SSIP.

Nebraska has taken multiple steps to further align and leverage the Part C SSIP with other early learning initiatives and programs within our state. The state-level leadership team actively engages with multiple state agency offices to improve overall state infrastructure in order to globally enhance the state's capacity to improve access and service provision to infants and toddlers and families. This work includes the Co-leads serving as active advisory task force members on the following councils:

- Nebraska's Early Hearing Detection and Intervention Task Force (Lead Agency: DHHS – Division of Public Health)
- Early Childhood Comprehensive State Systems State Leadership Team (Lead Agency: Division of Public Health)
- Infant-Toddler Toxic Stress Leadership Committee (Division of Public Health)
- Maternal Child-Health Bureau's Task Force for Children with Special Needs (Division of Public Health)
- Home Visitation Task Force (Division of Public Health)
- Nebraska's Resource Project for Vulnerable Young Children (Lead Agency: University of Nebraska – Children, Families and the Law)
- Impact from Infancy (Lead Agency: Nebraska's Child Advocacy Centers)
- Pyramid Model and Rooted in Relationships State Leadership Team (Co-Lead Agency: NDE and Nebraska Children and Families Foundation)
- Circle of Security Statewide Leadership Team (Lead Agency: Nebraska Children and Families Foundation)
- Nebraska Infant Mental Health Association

The Co-Leads are members of a variety of internal state-level committees in which initiatives and funding across multiple state agencies for infants and toddlers with disabilities is communicated and coordinated. Monthly meetings are held with state-level early childhood program administrators within NDE, DHHS, and other state and private agencies to ensure alignment of services, systems, and funding. These include the Nebraska Head Start State Collaboration Director, NDE Early Childhood

Administrator, NDE Part B/619 coordinator, DHHS Medicaid Waiver Administration, DHHS Child Welfare Administration, DHHS Public Health Administration, University of Nebraska Lincoln (UNL) personnel, University of Nebraska Medical Center (UNMC) personnel, Nebraska Children and Family Foundation Administration, and the Nebraska Buffett Early Childhood Institute Administration⁸.

These partnerships have resulted in several coordinated and collaboratively-funded initiatives and projects designed to strategically align with Nebraska's SIMR to support results for infants/toddlers with disabilities and their families:

1. Nebraska Circle of Security-Parenting (COS-P) - 114 professionals from the fields of early care and education, University Extension, mental health and public health were trained in September 2014 to implement the International Circle of Security Parenting curriculum across the state of Nebraska. New infrastructure that has been identified by the Nebraska Statewide Circle of Security Leadership Team is the development of four Reflective Consultation Coordinators in 2016 that will be assigned to regional areas of the state in order to provide monthly Reflective Consultation to the 114 trained Circle of Security coordinators, as well as the creation of the Nebraska COS-P website (necosp.org);
2. Nebraska Pyramid Model – Several agencies across the state are working together to focus supports for young children on the development of social and emotional competence. To better facilitate their goals, the agencies formed the Pyramid State Leadership Team to promote and direct the statewide implementation of the Pyramid Model. The Pyramid Model is an evidence-based model that promotes social and emotional competence and helps prevent challenging behaviors in young children.

Within the Nebraska Department of Education, the Early Childhood Special Education Department, as one partner on the Pyramid State Leadership Team, began Pyramid implementation in public school preschool programs with several pilot sites in 2009 and 2011. The program was then expanded in 2013 to include a cohort of nine programs/districts, another cohort of 12 programs/districts was added in 2015, and proposals will be accepted in the fall of 2016 for a third cohort of up to 12 more programs/districts. The Nebraska Children and Families Foundation (NCFE) is currently working to provide additional Pyramid Model implementation at the community level. NCFE offers training to childcare programs and homes that wish to implement the Pyramid Model in more rural areas of the state. Additional training in the Pyramid Model is offered for interested people and programs through the University of Nebraska Extension program. Working collaboratively, the various state programs have been able to reach over thirty school and community-based programs across twenty counties to date.

For 2016, the Pyramid State Leadership Team is developing a plan to provide the Pyramid Model Home Visitation Modules to home and community-based providers within the child care and early care/education programs that are already implementing the Pyramid Model. This additional training will allow providers who are working with children aged birth to five in home and community settings to facilitate social and emotional development and decrease challenging behaviors in children who are identified as at risk or verified with a disability. The intent is that once providers have completed the Modules, they will be supported by the internal coaches within each program/district. With all providers birth-to-five trained in the Pyramid Model, their ability to support families and care-providers in addressing any social emotional or behavioral concerns identified during an RBI should be greatly enhanced.

Training modules are also available from the national organization (TACSEI - Technical Assistance Center on Social Emotional Intervention) for "Family Coaching". The authors of the Pyramid

⁸ Response to OSEP Evaluation tool item 1 (b & d)

training modules used interventions which are the same practices as Nebraska's Part C improvement strategies - including the RBI, writing functional outcomes based on the RBI, and using routines during quality home visits through coaching families. Joint planning can occur to utilize the common training practices and promote close collaboration across the work already begun by Part C and the Pyramid Leadership team. Providers who receive training in the Part C RDA improvement strategies, and who are also involved in the Pyramid work in their community or region, can augment their skills to effectively assess social emotional and behavioral challenges expressed by families during the RBI, write functional outcomes about the family routines and activities influenced by the child's difficulties in this area of development, and build family capacity during home visits to help their child participate in home and community activities. Ultimately, entire birth-to-five programs and communities will be working together to address the social emotional and challenging behavior needs of all children within a particular community, and social and emotional child outcomes on the Teaching Strategies GOLD assessment will improve;

3. Tracking Infant Progress Statewide (TIPS) – University of Nebraska Medical Center provides developmental follow-up and referrals to EDN for high-risk infants placed in the seven NICUs across the state. Annual data is collected and analyzed regarding the health and developmental outcomes for infants with a NICU experience;
4. Nebraska Respite Program for children with disabilities, birth through age three housed within the DHHS Division of Children and Family Services, and has aligned funding and training in order to ensure EDN children and families have access to respite care and quality providers statewide;
5. Nebraska Family Care Enhancement Project - provides information, referral and medical/education services and supports to families of infants/toddlers with special health care needs through consultation in pediatric medical clinics. In collaboration with the University of Nebraska Medical Center, Munroe-Meyer Institute, the project began with five pediatric medical clinics in metro Omaha/Lincoln and central Nebraska that house Parent Resource Coordinators (PRC's) to provide care coordination, family support, and timely EDN referrals for infants/toddlers with disabilities. In 2015, new infrastructure and funding was identified and implemented in order to expand this project to three additional rural health clinics that serve large demographic populations of Hispanic, immigrant/refugee, and Native American children and families. Annual data is collected and analyzed regarding the health and developmental outcomes for infants/toddlers being served by the PRC's;
6. Helping Babies from the Bench/CAPTA initiative – renewed emphasis and trainings began in 2015 and will continue into 2016, in partnership with DHHS Children and Family Services division, the UNL - Nebraska Resource Project for Vulnerable Young Children, and Douglas County Juvenile Court Judge Doug Johnson. These trainings are targeted toward child welfare workers, judges, attorneys, EI providers, Head Start personnel, University Extension coordinators and child care providers to develop competencies and skills regarding the impact of toxic stress on the developing brain, as well as quality early care and education programs available to children, ages birth to five, in Nebraska. Nebraska continues to have low EDN verification rates for CAPTA-referred children, thus new infrastructure and training developed in 2015 included trainings to EDN providers within each of the 29 PRT's regarding state regulations related to screening and evaluation procedures. Additionally, the above-named entities agreed to collaboratively plan and fund the Nebraska Young Child Institute in June 2016 in which keynote speakers include Dr. Brenda Jones-Harden, Associate Professor at the University of Maryland, to present information on the development of maltreated foster, prenatally drug-exposed, and other at-risk children; and Dr. Sam Meisels, Founding Executive Director of the Nebraska Buffett Institute and former President of the Erikson Institute, presenting information on the early childhood focus of the Nebraska Buffett Institute in partnership with the University of Nebraska and in alignment with existing state

initiatives/projects. Additional break-out sessions, led by state experts, will focus on the impact of trauma on young children, the importance of attachment and relationship on children's development, the impact of prenatal drug use on the developing child, early brain development, Adverse Childhood Experiences,

Trauma-Informed Care, and evidence-based interventions and supports for young children;

7. Nebraska's Early Childhood Integrated Skills and Competencies for Professionals – in collaboration with DHHS, Divisions of Public Health and Behavioral Health, the Nebraska Children and Families Foundation, and the University of Nebraska Medical Center, this document was developed to reflect the view that the three disciplines of early childhood mental health, education, and home visiting are highly integrated. The document augments existing training and education of service providers from these disciplines throughout the state of Nebraska. Practitioners utilize this tool to support the intentionality of quality service provision and to support cross-training across disciplines;
8. Nebraska Recharge for Resilience Home Visitation Conference – held in October 2015, this statewide conference provided a professional development forum for home visitors from a variety of disciplines to receive pertinent early childhood information and training. One targeted session focused on Ecomap/family assessment training in which EDN providers, migrant educators, University Extension educators and Early Head Start/Head Start staff were in attendance;
9. Home Visitation Training – in collaboration with Nebraska Children and Families Foundation and the NDE Head Start State Collaboration Office, this training was provided to four Early Head Start agencies in Nebraska which focused on routines-based assessment and intervention, promoting positive parent child interaction and building parent capacity through coaching;
10. Promoting social-emotional development in child care settings – this collaboration developed in 2015 with the Nebraska Children and Families Foundation, Rooted in Relationships project, provides training and coaching related to family engagement by using routines-based assessment of challenging behaviors of young children within the childcare setting;
11. Results-Driven Accountability in the University of Nebraska-Lincoln (UNL) Curriculum – in collaboration with UNL higher education faculty, instructional curriculum related to Nebraska's RDA project components was added to UNL Early Childhood Special Education Master's level coursework for students enrolled in the class "Issues in ECSE". This curriculum was added to prepare Nebraska's EDN workforce requirements of RDA⁹.

Phase 1-Building the Infrastructure for Training on the RBI and Functional Child and Family Outcomes

In addition to aligning initiatives with statewide partners during Phase 1 of RDA, Nebraska worked through the implementation stages of exploration and installation, analyzing both existing resources and resources critical for a successful shift toward implementation of the first two improvement strategies. As part of this analysis, Nebraska put into place the following infrastructure characteristics:

- Appointment of, and financial support for, two statewide coordinators whose primary function is to facilitate implementation of quality EI practices in local programs. Of note is the fact that these two coordinators came from the field of EI in Nebraska and are also nationally-certified in the RBI;
- Financial investment in a cadre of 16 certified trainers for the RBI and functional IFSP outcomes who provide and support this training and implementation within their local programs and regions;
- Facilitation of local implementation using a team self-assessment tool targeting readiness for implementation of quality EI practices. The self-assessment discussion includes reflection on action

⁹ Response to OSEP Evaluation tool item 1 (b & d)

and planning needed for key evidence-based practices (including the coherent improvement strategies);

- Formation and ongoing engagement of two EI stakeholder groups who are and continue to be the front-line implementation specialists, providing feedback to the state coordinators and leadership team. Because Nebraska is a local control state, the state-level leadership team relies heavily on these two stakeholder groups to lead implementation change at the local levels – the first group is the ten teams who have been involved in implementation of the RBI and functional IFSP outcomes over the past five years, and the second is the cadre of certified RBI trainers who are working within their own teams/regions but also providing training and coaching in other regions as directed by the state-level leadership team;
- A website for EI services coordinators and providers which serves as a central location for national, state, and local technical assistance tools and documents. The website highlights district/program samples, provides video examples, etc., related to evidence-based EI services.
- Development of a standardized seven component training module, including utilization of coaching to providers, to ensure fidelity of implementation of the RBEI; and
- Development of professional development and technical assistance resources for EDN providers available on Nebraska’s Early Development Network and Department of Education websites. Multiple topics offered in a variety of formats include an orientation to EDN that introduces services coordinators and early intervention providers to EDN cores values and beliefs, laws and regulations governing the program, and their role in IFSP service provision. Both printed and audio mediums are used. Additional training modules target services coordination specifically. Other training topics include home visitation core principles and practices and toxic stress for home visitors. Technical resources available on the website include a guidebook for implementing EDN according to IDEA-Part C, and Nebraska’s Departments of Education and Health and Human Services administrative codes, as well as materials about early childhood transitions and children’s social emotional development birth to five. Materials from EDN’s annual in-person conference are also available on the website. The Department of Education’s website houses extensive materials devoted to evidence-based practices in Nebraska, including routines-based early intervention. The IFSP-web online training modules address all things related to IFSPs, including what an IFSP is, legal requirements of an IFSP, the IFSP process, and subjects addressed in an IFSP, such as family concerns and priorities, child and family strengths, and desired child and family outcomes.

Recognizing a need for additional supports, in August 2015 Nebraska added four (4) Regional Technical Assistance Providers whose primary function is to facilitate implementation of quality EI practices within the 29 PRT’s. The four Regional TA Providers currently work within their own PRT’s as EI providers and are also nationally-certified in the RBI and have agreed to support state and local level infrastructure by assisting PRT’s in the implementation of the RBI. Specific roles for the four TA providers include:

- Scheduling and providing the required seven component training in order for a PRT to implement the RBI, Functional IFSP Outcomes, and Quality Home Visitation practices to ensure ongoing fidelity;
- Facilitating capacity-building in local level coaches;
- Assisting the PRT in appropriate evaluation and data collection; and
- Supporting the PRT in implementation of new practices into the local EI process¹⁰.

Identification of Cohorts 1, 2 and TIP PRT’s

Nebraska is utilizing a cohort approach to scale-up and implement the RBI and functional outcomes through the Planning Region Team (PRT) system.

¹⁰ Response to OSEP Evaluation tool item 1 (a)

In August, 2014 three PRT's were selected as Cohort 1 and agreed to complete the following actions:

1. Establish a local RBEI leadership team;
2. Conduct a data review/analysis;
3. Create action steps related to the PRT Targeted Improvement Plan (TIP);
4. Engage in training of RBEI practices for all EI providers during the first year of implementation;
5. Utilize coaching practices to sustain the RBEI approach to fidelity;
6. Agree to implement additional data collection and evaluation methodologies to ensure fidelity in implementation; and
7. Allow the state to gather needed results data for SSIP reporting requirements.

In August 2015, four (4) additional PRT's were selected as Part C RDA Cohort 2; agreeing to complete the above-stated actions as well. Cohort 2 includes Nebraska's three largest EI programs.

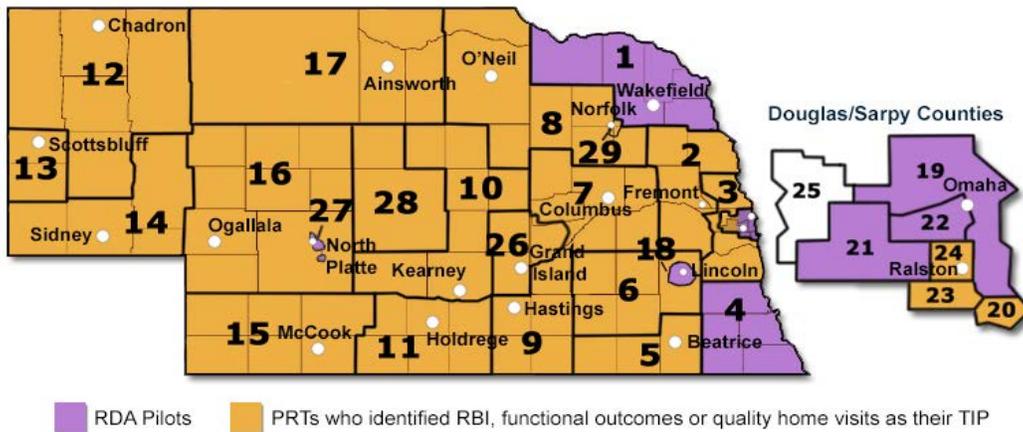
Also in 2015, all 29 PRT's were required to submit a Targeted Improvement Plan (TIP). As a part of this requirement, significant technical assistance was provided to assist the regions in this process. First, PRT's were informed of the Part C State Systemic Improvement Plan. The PRT Lead Agency Assurances were updated to encompass and reflect the added responsibility of the PRT to develop and implement a local TIP in order to improve outcomes for infants/toddlers and their families. In the spring of 2015 a Targeted Improvement Planning webinar was developed and recorded. This webinar walked the PRT's through the TIP process as well as the upcoming expectations. Finally the PRT'S were provided with a TIP Planning Guide and TIP Analysis Checklist. These two documents provided the details and criteria required for TIP approval. All of these technical assistance items were placed on the EDN website and can be found at the following link: <http://edn.ne.gov/cms/products/planning-region-teams>

PRT's were responsible for developing region wide Targeted Improvement Plans. These plans consisted of 5 elements:

1. PRT Data Analysis - Each PRT was required to look at various data systems and analyze their data. This data included SPP/APR indicators, Services Coordination data, EDN referral vs. verification data, and EDN monitoring data to name a few. Each PRT assessed the quality of their data and examined three to five year trend data. The final part of the data analysis included each PRT performing a root cause analysis to address slippage and/or not meeting SPP/APR indicators.
2. Focus for Improvement - Each PRT identified a focus for improvement based on their data review. This focus will drive and help PRT's build capacity to improve measurable results for infants/toddlers with disabilities and their families.
3. PRT Infrastructure Analysis – PRT's were also tasked with an infrastructure analysis. PRT's examined their governance models, fiscal resources, professional development systems, as well as any existing evidence-based practices occurring within their regions. PRT's were also responsible for describing collaborative processes and initiatives within their region that could be tied to improving child and/or family outcomes.
4. Targeted Improvement Plan - Based on the analysis of the PRT data and infrastructure within regions, PRT's then developed comprehensive, multi-year TIP's focused on improving child and family outcomes. These based were required to focus on at least one (1) child or family level indicator. PRT's were responsible for choosing an evidence-based practice to improve results along with a multi-year, implementation timeline.
5. Implementation and Evaluation Plan - Finally, PRT's were responsible for starting their implementation and evaluation plan. They were asked to provide how they would track fidelity within

their implementation as well as how the PRT would track evaluation of their selected evidence-based practice¹¹.

The majority of the PRT's, outside of those in Cohort 1 and 2, selected one or more of the three coherent improvement strategies (including implementation of the Routines Based Interview as their child and family assessment) in order to produce improved results for infants/toddlers and their families.



During the RDA Stakeholder Committee meeting in October 2015 and the SEAC and ECICC meetings in November 2015, the Co-Leads received stakeholder input on effective implementation strategies of the SSIP work within PRT's and how to ensure effective change is occurring statewide; how to ensure the selected evidence-based practices are being implemented to fidelity; and how to effectively evaluate implementation and impact at both a local and state level. The stakeholders made the following recommendations which the Co-Leads will implement during Phase II:

1. Utilize and collect the RBI Implementation Checklist to document ongoing approval scores for individual EI providers within the pilot PRT's;
2. Utilize and collect the IFSP Quality Functional Outcome checklist to document effectiveness of the RBI implementation within the pilot PRT's;
3. Collect parent responses via survey following their participation in the RBI within the pilot PRT's and utilize Westat to analyze these responses; and
4. Collaborate with the University of Nebraska Medical Center – Munroe-Meyer Institute's Data and Evaluation Research Center to develop a home visitation study/checklist to determine the effectiveness of EI home visitors to be utilized within the pilot PRT's.

Additionally, these stakeholders, as well as the Results Matter Child Outcomes Task Force, provided guidance and advice on the Part C Child Outcomes measurement system due to Nebraska's Part C Determination of "Needs Assistance" for the first time ever. These stakeholders recognized that Data Completeness, as well as State and National Data Comparison, is an area that needs improvement for Nebraska. Thus they recommended the following strategies, which will be implemented by the Co-Leads:

1. Provide targeted TA to districts which have a large number of "missing" data in the child outcomes data base;

¹¹ Response to OSEP Evaluation tool items 1 (a) and 3(a)

2. Develop and disseminate additional TA materials/webinars to districts to assist in their understanding and awareness of this issue, of which the first webinar was posted on the EDN website this fall; and
3. Provide training and TA related to improving local-level data infrastructure/capacity.

The stakeholders also recognize that since Nebraska is the only state to utilize the Teaching Strategies Gold system to measure Part C Child Outcomes, it is difficult to determine appropriate improvement strategies related to the national comparison data indicator. Thus, the following recommendations will be implemented by the Co-Leads during Phase II:

1. Work with the Early Childhood Technical Assistance Center (ECTA), DaSy, and IDC to identify factors contributing to the child outcomes data;
2. Work with Teaching Strategies Gold administration to validate the analyses for OSEP data-reporting purposes; and
3. Partner with local EI programs/school districts to improve the data entry/quality.

In Fall 2015 the state leadership team met with Dr. Lisa Knoche and Dr. Chris Marvin of UNL's Children, Youth, Families and Schools; and Dr. Barb Jackson and Dr. Kerry Miller of UNMC, Munroe-Meyer Institute (MMI) to develop additional infrastructure supports related to training and evaluation methodologies for the home visitation coherent improvement strategy. Current planning includes the partnership with UNL to develop and provide early intervention service delivery competencies and skills to EDN providers, as well as the partnership with UNMC-MMI to develop evaluation methodologies and collect/review/analyze data related to the quality of EDN service delivery in natural environments¹².

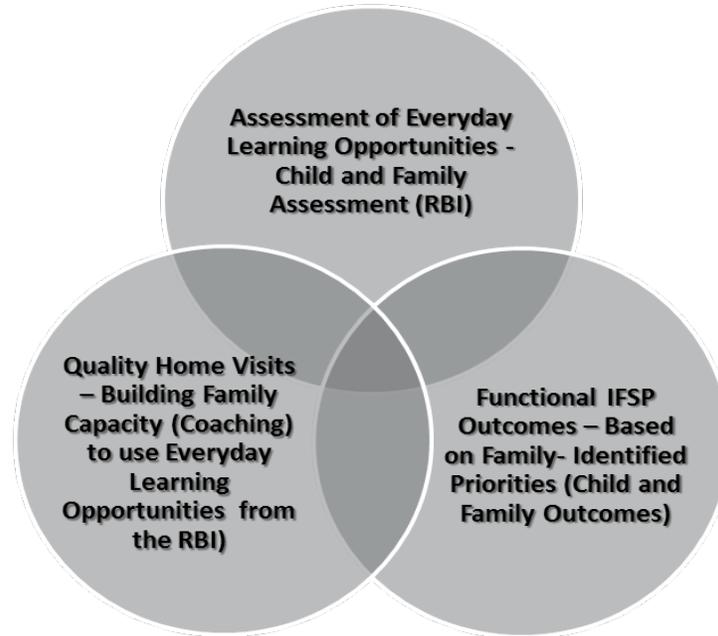
Phase II Component #2: Support for LEA Implementation of Evidence-Based Practices

During Phase I, Nebraska chose three coherent improvement strategies as the plan for positively impacting the state's identified SIMR: Child Indicator 3B. More specifically, the three improvement strategies are grounded in the 2014 Division for Early Childhood (DEC) Recommended Practices (RP) for Early Intervention (EI) and Early Childhood Special Education (ECSE) (<http://www.dec-sp.ed.org/recommendedpractices>). The practices most directly related to the coherent improvement strategies are outlined below:

- 1) The Routines Based Interview (RBI) – DEC RP: A1-A7, and A11, and F1-F3, F6, F8, F9, TC4;
- 2) Functional child and family focused IFSP outcomes – DEC RP A8, F4, F7 INS2; and
- 3) Quality home visits based on routines – DEC RP A9, A10, E1-4, F5-7, INS4-7, INS11, TC 1-

Figure 1: Routines-Based Early Intervention.
Developed by Sue Bainter & Cindy Hankey, 2013

¹² Response to OSEP Evaluation tool items 1(a), 2 (a, b & c)



Nebraska’s coherent improvement strategies are also aligned with key evidence based practices as illustrated in the following:

Why the RBI:

- Based on the evidence about how young children learn; “natural learning opportunities include those practices that support parents of children with disabilities to understand the critical role of everyday activities and child interests as the foundation for children’s learning....the child will be motivated to pay attention longer, resulting in positive benefits related to child learning...given the opportunity to learn and practice new skills multiple times” (Dunst et al., 2000; Raab, 2005);
- Structured to help families identify their priorities; the RBI capitalizes on the research about child learning and provides a means for families to express their priorities and describe their child and family’s everyday activities. In a study of efficacy of the RBI, (McWilliam, Casey, & Sims 2009), families were randomly assigned to either receive the RBI or receive the business as usual and more traditional approach to IFSP development. Those families in the RBI group were more satisfied with IFSP development, and the outcomes written were more functional;

Why functional IFSP outcomes:

- Directly connected to and a result of the RBI, yielding a family-chosen rank ordering of their priorities as expressed during the interview; “A reciprocal process for providing and receiving information while promoting family members’ understanding of intervention in their everyday routines and activities is integral to the development of an individualized family service plan (IFSP)... and results in informal shorthand statements that represent the family’s choice of what to work on.” (Woods & Lindeman, 2008);
- Meaningful because they relate to specific parts of the family’s day; “Child outcomes which describe the context in which the skill is needed so that everyone within the family working on the outcomes understands the desired behavior is not meaningful on its own, but rather in how it helps the child to participate in home, school and community activities.” (Wilson, Mott, & Batman, 2004);
- Articulated by the family and relate to their ability to express their family’s needs in addition to their child needs; “the outcomes and benefits of using resource-based practices for family support

include...improved parenting confidence and competence, increased family satisfaction with resource provision, enhanced parent and family well-being;

Why quality home visits based on routines:

- Meaningful learning opportunities for young children are based on daily routines; “children learn through repeated interactions with the environment distributed across time, better than they do in massed trials” (McWilliam, 2010);
- Inherent to quality home visits is coaching to build the family’s capacity to support their child’s learning; “parents are the major influence on their children’s development even when their children participate in intervention; and effectiveness of intervention is highly associated with parents becoming more responsive with their children...” (Mahoney, 2009); “Capacity building is a process that assists parents in recognizing and taking advantage of everyday activities and situations that have developmentally-enhancing qualities to enhance child learning” (Dunst & Trivette, 2009), “coaching involves asking questions, jointly thinking about what works and what does not, trying new ideas with the child, sharing information, and jointly planning next steps” (Hanft et al./2004; Rush & Shelden, 2011)” (Dunst, 2004)¹³.

Nebraska has piloted the RBI in ten districts or regions within the state since 2009. These teams or regions were the early adopters, generating positive momentum through their results, which demonstrated increased family engagement, more functional IFSP outcomes deemed as “met” by the family and IFSP team, and improved family satisfaction as demonstrated by the annual family survey. However, in order to truly prepare for a statewide scale up, the Part C state leadership team used the work of this early adopter group to inform an implementation plan that targeted Planning Region Teams (PRT’s) as “transformation zones”(referred to as “cohorts” in Phase 1 SSIP). Implementation science literature considers the concept of a transformation zone to be a more effective way to make sustainable change because it can replicate a more real-world approach. Significant change on a large scale requires a simultaneous focus on: 1) establishing the new evidence-based practices (EBP) as regular and routine practice, in conjunction with 2) developing the infrastructure to assure effective use of the EBP in the context of the “working” environment. The PRT’s in Nebraska were the natural and logical choice for organizing RDA efforts as they are point of contact across the state for overseeing Part C efforts and evaluation (see infrastructure section)¹⁴.

The PRT’s selected as cohort 1 had no previous RBI or functional outcome training. In addition, their individual regional characteristics were considered to be representative of the unique make-up of Nebraska’s PRT’s. One was a metro region where the district was also the PRT, another was a rural PRT with 20 or more districts and with staff employed by both the Educational Service Unit and also employees of the districts. The third was a medium sized district (also the PRT) and included contracted EI service providers.

Each of these PRT’S were responsible for building the infrastructure “package” of:

1. Establishing a local leadership team;
2. Conducting a data review/analysis via a self-assessment, and creating action steps;
3. Engaging in training for RBI and writing functional IFSP outcomes for all EI providers and services coordinators during the first year;
4. Identifying, training and utilizing coaches from each PRT to provide a local method for sustaining fidelity to the RBI and writing functional IFSP outcomes;
5. Development of additional data collection and evaluation methodologies to ensure fidelity in implementation and allow the state to gather needed results data for SSIP reporting requirements and ultimately guide scale up efforts for the rest of the state.

¹³ Response to OSEP Evaluation tool item 2(a)

¹⁴ Response to OSEP Evaluation tool item 2 (a & b)

As noted above in #2, prior to training, the three chosen PRT's were required to participate in a facilitated team self-assessment tool targeting readiness and "fit" for implementation of quality EI practices, build buy-in from the region and review state regulations related to Part C. The Nebraska Team Self-Assessment discussion concluded with reflection on action planning crucial for implementation of the RBI and functional IFSP outcome writing. Key action steps identified during the team self-assessment included recognition of the difference between evaluation and assessment according to state and federal requirements, using family expressed needs to guide IFSP outcome writing, and the need for program and team collaboration as a necessary support for initiating and sustaining the new practices¹⁵.

The two statewide coordinators (referenced in infrastructure section) worked closely with the cohort 1 PRT's in Phase I of the SSIP to assist with infrastructure implementation by establishing a communication loop between the local leadership teams and the Part C state leadership team. The Part C leadership team provided ongoing TA and guidance through the stages of planning, training, reflecting, and then acting/adjusting based on the implementation efforts. This PDSA (plan, do, study, and act) process allowed for problem-solving to support the three PRT's and consideration of challenges which could arise with further scale up efforts, allowing the Part C state leadership to develop potential solutions¹⁶.

The state-level coordinators also continue to rely on the ten early adopter teams who have been implementing the RBI and functional IFSP outcome writing for the last few years for anecdotal experience and ongoing problem-solving. These regions are currently helping to develop the annual RBI fidelity process as well as how to best ensure that new staff are trained and approved. Implementation competency drivers are part of the infrastructure development process in each PRT through:

- Selection of competent individuals to serve as local/internal coaches and promote the implementation of the interventions at the PRT level;
- Training that involves actual practice of the interventions with "on the job" coaching and feedback; and
- Annual performance fidelity checks and data analysis.

As referenced in the infrastructure package, the PRT's within Cohort 1 established leadership teams, composed of, at minimum:

- 1) an administrator who is responsible for ensuring that staff stay organized and focused on the desired outcomes, and addressing challenges by creating solutions at all levels;
- 2) the local agency services coordination agency supervisor;
- 3) a PRT chair, and 4) at least one local RBI expert trainer/coach
- 4) one local RBI expert trainer/coach.

Initially the task of the leadership team was to create buy-in with EI providers and services coordinators while also communicating information to local stakeholders about the implementation plan, such as the PRT group and parents. As EI providers are trained, the leadership team oversees the approval numbers and addresses any issues as well as determining professional development plans for staff who enter the local workforce after the initial training, or staff who need a more intense level of support for approval. While training and approval is proceeding, the leadership team uses information from their required self-assessment to take action steps that ensure that the EI delivery process is set up to facilitate successful implementation once a critical mass is trained to approved levels. Essentially the leadership team serves as the point of contact between the local EI teams/programs and their constituents as well as with the Part C state leadership team.

¹⁵ Response to OSEP Evaluation tool items 2(b) and 3 (c)

¹⁶ Response to Evaluation tool item 2(b)

Using what was learned through the Cohort 1 PRT's' implementation experience the Part C state leadership added Cohort 2 which included two PRT's with the largest EI programs in Nebraska, and two additional PRT's who had not had any RBI or functional outcome training. These four new PRT's (Cohort 2) will participate in the same infrastructure and training process as the first three PRT's, i.e. establishing a leadership team, identifying implementation needs through a self-assessment, training and approval in the first year including identification of local coaches, and data collection methodologies for both fidelity and evaluation¹⁷.

¹⁷ Response to Evaluation tool items 2(a) and 3(c)

Overview of Infrastructure and Communication Patterns

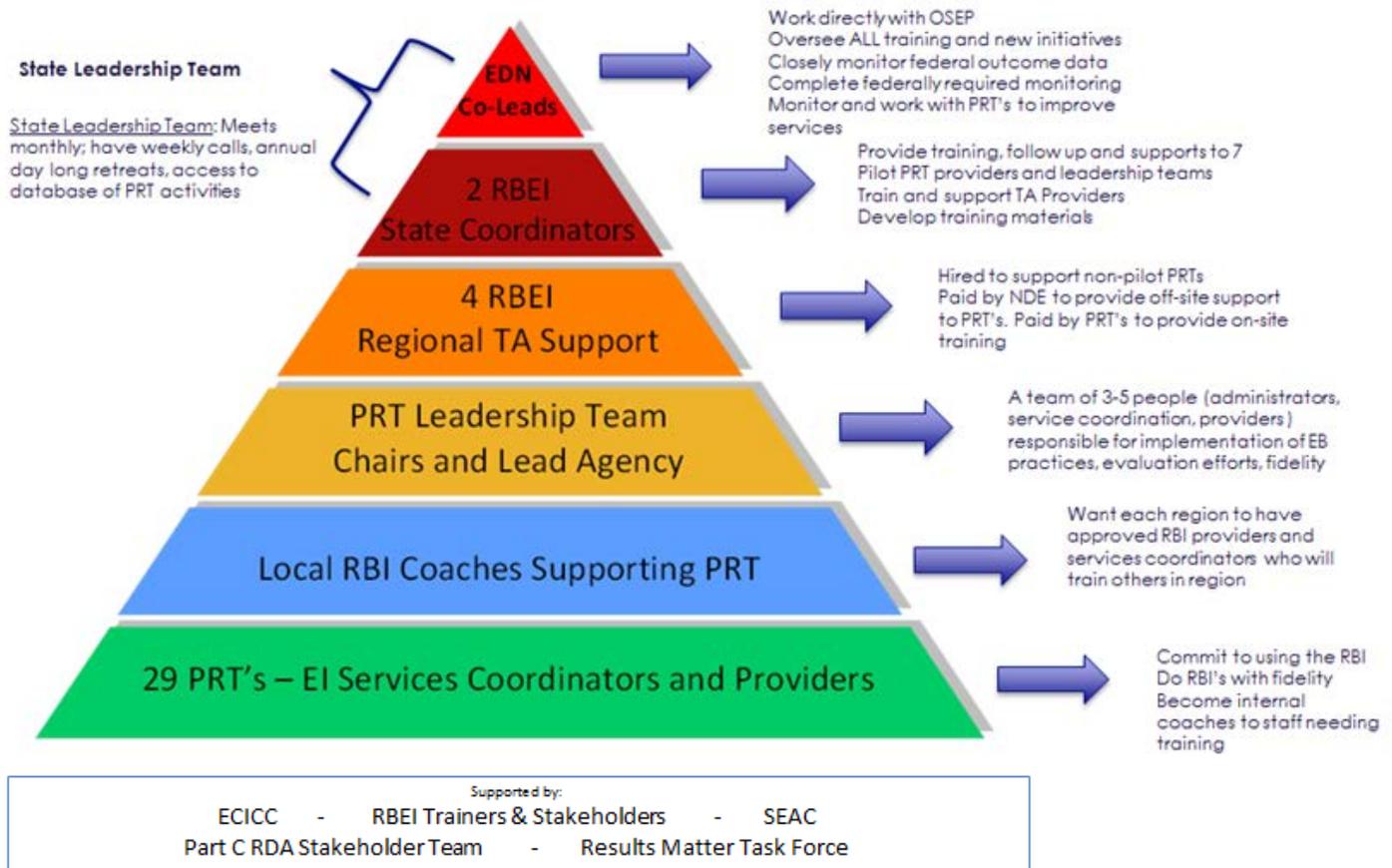


Figure 2: State support for EI programs and providers for RDA scale up. Developed by Part C state Leadership Team, 2016

The overall structure of communication and support is illustrated in Figure 2. Specifically, the Part C Co-leads will communicate with the two state coordinators through monthly meetings and weekly telephone contacts, as well as to the field through email blasts, newsletters and webinars to support PRT infrastructure and data analysis, and monthly calls to SPED coordinators/administrators. The statewide coordinators will have quarterly conference calls with the four regional TA providers to ensure that the TA providers have the information and strategies needed to support the PRT's in their four regions to coordinate training and fidelity events, and data collection for their TIP. An online system is used to track activities the regional TA providers undertake on behalf of their PRT's such that the two statewide coordinators can report to the Part C Co-Leads regularly. Cohorts 1 and 2 are supported directly by the two statewide coordinators and activities are guided and overseen more closely by the Part C state leadership team so that this plan, and any needed adjustments, can become the backbone of the overall statewide scale up efforts¹⁸.

At the most recent Nebraska Part C RDA Stakeholder meeting in October of 2015, the committee was provided with an update of the recent activities related to the RDA plan and the status of the Part C Child Outcome data. Specifically, the group was asked for their input regarding three crucial items which the Part C leadership team deemed important for scale up of the RDA implementation package:

¹⁸ Response to Evaluation tool item 2(b)

1. Shifting from individual district focus to PRT as point of contact;
2. How should newly developed RDA resources be disseminated to the field; and
3. How can the stakeholders be kept informed of implementation data and its impact on child and family outcomes now that Phase II has commenced.

Phase I data collection from statewide monitoring and analysis of federal child and family outcomes, identified barriers to implementation of RBI practices:

- Lack of EI provider knowledge and training needed to use evidence based tools and processes for required child and family assessment and ongoing progress monitoring;
- Misalignment between family expressed priorities and IFSP outcome development; and
- Difficulty in EI provider use of family interactions during ongoing home visits that allow for building parent capacity to influence their child's development and the family's well- being.

To address Phase I barriers, the team self-assessment process has been a required implementation pre-cursor to increase provider knowledge and perceptions. Additionally required for Cohorts 1 and 2 was training related to Part C state regulations to ensure that all EI providers, services coordinators and program administrators understand the regulatory basis for child and family assessment, in particular. Both the team self-assessment and regulation trainings will also be part of the overall implementation package for PRT scale up. This will address the barrier of misalignment between assessment, family expressed priorities, and IFSP outcome development¹⁹.

The RBI and functional outcomes training (known as an RBI Boot Camp) includes hands on practice in real time with families recruited from EI programs. State level coaches assigned to small groups give feedback, using an implementation checklist, about participant implementation skills in order to: 1) determine a state approved level of competency for "approval" after the participant practices in their home district and region; and 2) ensure annual fidelity to those same skills across the local region once everyone involved in child and family assessment are trained. The same RBI checklist is used to provide feedback across all steps of training, approval and ongoing fidelity. In addition, local coaches serve as RBI "experts" who are responsible for organizing ongoing training efforts for new staff and facilitate analyzing fidelity data across districts or the PRT to pinpoint any specific regional training or coaching needs. The regional TA provider has an added layer of knowledge and skill in the RBI and functional IFSP outcome writing as well as feedback strategies and eventually data collection methods to support the local PRT's to make decisions about training and TA needs targeted in their PRT TIP.

A recent review of IFSP outcomes from Cohort 1 revealed a need for additional TA specific to writing functional outcomes. The purpose of the additional training is to prepare the PRT for a data fidelity check of 20% of their IFSPs in Phase II. Similar to the RBI training and follow up, implementation competency drivers have been initiated for IFSP outcomes via the two statewide coordinators and the regional TA providers facilitating a webinar to compare scores and provide feedback for a subset of both child and family outcomes from Cohort 1 PRT's with opportunity for questions and discussion so they can make necessary adjustments.

As Nebraska's RDA plan enters into the initial implementation stage for all the PRT's who chose one or more of the state's coherent improvement strategies, a new barrier identified (see item #1 from October Stakeholder meeting) was the transition from an individual district focus for training, fidelity and data analysis to that of the PRT. All representative districts within a PRT must now come together collectively to develop regional plans for the TIP. The state-level leadership team has been and will continue to offer TA in the

¹⁹ Response to Evaluation tool item 2 (b)

form of webinars, SPED director calls, the regional TA provider system, etc. to address the challenges inherent in moving to this changed group. The lessons being learned from the transformation zone will continue to be vital in creating “implementation teams” aka the PRT leadership teams so that these teams can: 1) ensure collective representation across the PRT to identify and monitor the TIP, 2) set up processes for receiving and analyzing data collection at a PRT level rather than at the individual district level, and 3) build a sustainable infrastructure which oversees the implementation of the improvement strategies while monitoring the data for both fidelity and evaluation. Part C Stakeholders also recommended finding ways to help all representative districts see the benefits of the RBI such as having parents present about their experiences, sharing Family Survey data from PRT’s who have been implementing the RBI for a few years, and finding personal ways to help PRT’s connect with each other.

An additional barrier identified through the continuous improvement cycle from Cohorts 1 and 2 includes inconsistent RBI implementation into local EI process that meet state regulations. This issue is affecting the quality of implementation fidelity and may also be affecting the quality of the federal child and family outcomes data.

To address this barrier, the Part C state leadership team completed an in-depth review of the EI processes used in the ten teams across the state who were early adopters and have been implementing the RBI over the past few years and compared these experiences with the EI state regulations. The result was the development of an EI process technical assistance document and an online orientation for early intervention professionals (<http://edn.ne.gov/cms/orientation-edn-nebraska>) which were recently disseminated across the audiences in the field.

The continuous improvement cycles used to identify this barrier and any other challenges to implementation will continue between all levels of the RDA scale up infrastructure identified in Figure 2²⁰.

²⁰ Response to Evaluation tool item 2 (b) and 3(a & c)

Phase II Component #3: Evaluation Plan

The Phase II Evaluation component is being conducted with both internal and external supports and resources. As described in Component #1, a state-level leadership team consists of the following experts who are assisting Nebraska in the SSIP Evaluation process: Dr. Robin McWilliam, researcher of RAM Institute and founder of RBEI; Dr. Haidee Bernstein, lead analyst from Westat and IDC/DaSy consultant; Dr. Barb Jackson of UNMC-Munroe Meyer Institute; Dr. Cindy Hankey and Sue Bainter, M.A. Special Ed OTR/L, state EI experts/coordinators; Connie Shockley, PTI-Nebraska; Mark Smith, M.S. of UNMC-Munroe Meyer Institute serving as a Family Partner to the Co-Leads; and the Nebraska Co-Lead agencies²¹.

Evaluation Of Nebraska’s SIMR

Nebraska has one SIMR and is using a unified set of 3 coherent strategies to improve child outcomes. Nebraska’s Part C SIMR is to:

Increase the number and percentage of infants and toddlers who demonstrate progress in the acquisition and use of knowledge and skills (including early language/communication) – 3B, Summary Statement 1.

Baseline Data and Targets for the SIMR

Extensive data analyses with stakeholders and advisory councils were conducted on Indicators C3 and C4 to select the specific child and family outcome indicators in which the state will improve results for infants and toddlers with disabilities. After this selection, the stakeholders determined the baseline data and set future targets for the selected indicators. After careful analysis of all of the data, the stakeholders decided to focus on Indicators 3B: Acquisition and Use of Knowledge and Skills Outcome Statement 1 as the SIMR and Indicator 4B: Effectively Communicate Child’s Needs as a benchmark. The tables below outline the baseline data and targets set by the stakeholders for these two indicators:

Target – Indicator C3B – Summary Statement 1 – Acquisition and Use of Knowledge and Skills:

Year	Future Target	Baseline	Performance
2013-14		40.2	
2014-15	40.2		50.4
2015-16	40.5		
2016-17	41.0		
2017-18*	41.5		
2018-19*	42.5		

²¹ Response to Evaluation tool item 2(c)

Benchmark - Indicator C4B – *Families effectively communicate their children’s needs:*

Year	Future Target	Baseline	Performance
2013-14		80.9	
2014-15*	81.00		83.8
2015-16*	81.50		
2016-17*	82.00		
2017-18*	82.30		
2018-19*	82.60		

On-going Measurement toward the SIMR

Each year the stakeholders and advisory councils will review progress toward the state’s performance on the targeted indicators; with a special focus on Indicators 3B: Acquisition and Use of Knowledge and Skills Outcome Statement 1 (as the SIMR) and Indicator 4B: Effectively Communicate Child’s Needs (as a benchmark. Performance results will be shared annually with each of the PRT leadership teams. In turn, each PRT will report progress toward their Targeted Improvement Plans (TIP) via Nebraska’s Grant Management System²².

Nebraska has 29 planning region teams (PRT’s). Cohort 1 is comprised of 3 PRT’s (1, 22, and 27). Cohort 2 has 4 PRT’s (4, 18, 29 and 21). The remaining PRT’s are referred to as Targeted Improvement Plan (TIP) PRT’s.

Evaluating The State Coach Cadre And Cohort 1/Cohort 2

Strategy #1 Routines Based Interview

The RBI is a semi-structured interview used with families, teachers and child care providers. The purpose of the interview is to gather information about how a child participates in everyday activities. At Siskin Institute, McWilliam (2009) developed an RBI Training process, an RBI Protocol and an RBI Implementation Checklist. Participants who go through the training process and achieve 85% or better on the implementation checklist are considered to be “approved” (see Appendix 1 RBI Implementation Checklist).

A. Evaluation of Nebraska’s Cadre of RBI Certified Trainers/Coaches

Over a period of years (2009-2013) Nebraska invited 18 providers to attend the Siskin RBI Training Program, with the intent of strategically placing certified RBI trainers/coaches geographically across the state. These trainers achieved 85% accuracy on the implementation checklist and were certified by the Institute. To document fidelity to the RBI process, this cadre is required to submit an RBI implementation checklist, completed by an approved RBI provider, every 2 years. If 85% accuracy

²² Response to Evaluation tool item 3(b)

is not achieved, providers practice their interview skills with feedback from other approved providers and resubmit videotapes until 85% accuracy is achieved.

Date	Training Activity	Expected Outcome	Evaluation
2009-2013	18 Providers Attended Siskin Institute	Build cadre of State Trainers/ Coaches (Intermediate Outcomes)	Collection of RBI Implementation Checklists every 2 Years

Table 1- Building a Cadre of State Trainer/Coaches

B. Evaluation of RBI Training for Cohort 1 and Cohort 2

Beginning in 2013, Nebraska replicated the Siskin training model and began providing in-state “RBI Boot Camps”, using Siskin certified trainers as coaches. Initially, any provider interested in RBI training could apply for the boot camp. However, with the advent of RDA and the identification of cohorts, the state began to strategically invite participants from specific planning regions teams. In the summer of 2014, the internal coaches for Cohort 1 (PRT’s 1, 22 and 27) were invited to the camp. Once these providers completed the approval process, they functioned as coaches in their local RBI boot camps beginning in January 2015. During the summer of 2015, the internal coaches for Cohort 2 (PRT’s 4, 18, 19 and 21) were trained. Once they completed the approval process, they served as coaches for their local PRT boot camps which began in January 2016. For evaluation purposes, cohort regions are required to submit RBI implementation checklists to the State Co-Leads documenting RBI approval for each provider and services coordinator in the region. They must also provide annual documentation that interviewers maintain fidelity²³. In addition, the state also collects evaluations of the boot camp experience from families and the participants. Boot camp training processes are revised based up the feedback from both groups.

²³ Response to Evaluation tool item 3 (a & c)

Date	Training Activity	Expected Outcome	Evaluation Process
July 2014	2 day RBI Boot Camp for Cohort 1 coaches	Internal cadre of approved RBI coaches in Cohort 1 regions by Dec 2014 (Short-term Outcome)	Collection of Initial RBI Approval Checklist and on-going Annual Fidelity Checks
Jan-Feb 2015	(3) 2 day RBI Boot Camps in each of Cohort 1 regions	All providers and services coordinators in Cohort 1 receive RBI training (Short-term Outcome)	Collection of boot camp evaluations from parents and providers
Mar-July 2015	RBI practice with feedback from coaches	Submit videos. Achieve 85% on RBI Implementation Checklist (Short-term Outcome)	Collection of Initial RBI Approval Checklist and Annual Fidelity Checks
August 2015- Full implementation of RBI in PRTs 1, 22 and 27 (Cohort 1)			
July 2015	2 day RBI Boot Camp for Cohort 2 coaches	Internal cadre of approved RBI coaches in Cohort 2 regions by Dec 2015 (Short-term Outcome)	Collection of Initial RBI Approval Checklist and on-going Annual Fidelity Checks
Jan-Feb 2016	(6) 2 day RBI Boot Camps in each of Cohort 2 regions	All providers and services coordinators in Cohort 2 receive RBI training (Short-term Outcome)	Collection of boot camp evaluations from parents and providers
Mar-Nov 2016	RBI practice with feedback from coaches	Submit videos. Achieve 85% on RBI Implementation Checklist (Short-term Outcome)	Collection of Initial RBI Approval Checklist and Annual Fidelity Checks
December 2016- Full implementation of RBI in PRTs 4, 18, 19 and 21 (Cohort 2)			

Table 2 Cohort 1 and Cohort 2 RBI Training

Strategy #2 Functional Child & Family Outcomes

A. Evaluation of Functional Outcome Training Cohort 1 and Cohort 2

Functional outcomes are defined by McWilliam (2010) as “Goals that 1) reflect the priorities of the family, 2) are useful and meaningful, 3) reflect real-life situations, 4) are free of jargon, and 5) are measurable.” Initial training on functional outcomes is embedded into the RBI boot camps. Additional training is provided individually to each PRT in the form of a Functional Outcome Webinar, facilitated by the state coordinators or TA providers.

²⁴

As a quality indicator, Nebraska worked closely with Dr. McWilliam to develop an IFSP Quality Checklist (Appendix 2 IFSP Quality Outcome Checklist). This checklist is used to measure (a) the total number of high quality outcomes in each IFSP, (b) the total number of family outcomes in each IFSP (prior state data analysis indicated low number of family outcomes as compared with child outcomes), and (c) the quality of the outcomes written. The state expects to see an increase in the number of family outcomes, as well as improvement in the quality of both child and family outcomes on individual IFSP’s.

To evaluate statewide progress toward the implementation of functional child and family outcomes, Nebraska is analyzing 20% of the IFSP’s written annually from each Cohort region utilizing the Quality Outcome Checklist. Feedback and training are/will be provided to each region following the analysis.

Date	Initial Functional Outcome Training	Follow Up Outcome Training Webinar w/ Feedback	Begin Annual Analysis of IFSP’s
Cohort 1	Jan-Mar 2015	Nov-Dec 2015	August 2016
Cohort 2	Jan-April 2016	Dec 2016	August 2017

Table 3 Functional Outcome Training Timeline Cohort 1 and Cohort 2

Strategy #3 –Quality Routines-Based Home Visits

A. Evaluation of Quality Home Visit Training for Cohort 1 and Cohort 2

Once the RBI has been completed with families and high quality functional outcomes are written into the IFSP, Nebraska wants to ensure that home visits are built upon the priorities established by the family during the interview and reflective of the routines and activities of the family. Although quality home visit research is available, the state determined it would be most effective to conduct a small home visit study in order to inform the leadership team regarding the “current” quality of home visits in Nebraska. For example, it is not known exactly how the RBI training influences home visits, and coupled with other training efforts such as primary service provider, coaching and natural learning environment practices, the home visit study could potentially provide data about the most salient features needed by EI providers and programs to implement quality home visits in Nebraska. The descriptive study results were organized into three groups of home visits: 1) those provided by EI providers who have been using the RBI over the past few years, 2) those provided by EI providers who were recently trained in the RBI and have just started implementation, and 3) those provided by EI providers who have not been trained in the RBI. A range of experience and other trainings are factored into the analysis. This study was completed in March 2016 (see Appendix 3 Quality

²⁴ Response to Evaluation tool item 3 (a & c)

Home Visitation Report). The results of the study will be used to inform the content of home visit training for the state. Training is expected to begin in 2017²⁵.

Date	Home Visit Training	Evaluation Process TBD
Cohort 1	Projected Spring 2017	Projected data collection to begin Fall 2018
Cohort 2	Projected Spring 2018	Projected data collection to begin Fall 2019

Table 4 Home Visit Training Cohort 1 and Cohort 2

Training And Evaluation Of Nebraska’s TIP PRT’S

As transformation zones, seven of the 29 PRT’s in the state (Cohorts 1 & 2) committed to the implementation of all three of Nebraska’s improvement strategies. The PRT’s who have submitted their TIP and identified RBI as their improvement strategy are referred to as TIP PRT’s.

It is the responsibility of Nebraska’s 4 TA providers to support the TIP PRT’s with RBI training, using the same 7 step training process and training regime as that of the cohorts. The PRT’s themselves are responsible for evaluating progress toward their TIP and will be reporting their evaluation results via the annual Grant Management System²⁶. The TIP process ensures that each PRT develops an individualized set of targets and specific activities based on their region’s data and infrastructure analysis, thus facilitating consideration of the best fit for how each PRT’s chosen coherent strategy(s) would be implemented, to improve results for infants/toddlers with disabilities and their families. Each year, the TIP is to be reviewed and each PRT required to use their data to report the effectiveness of their plan, their progress and how fidelity is being addressed. Revisions can be then be made in response to the plan evaluation.

Projected Impact of Improvement Strategies On Evaluation Of SIMR

Table 6 (below) provides a summary of the expected implementation dates and projected impact of Nebraska’s three coherent improvement strategies. In addition to the on-going evaluation of the strategies themselves (RBI Implementation checklists, outcome quality ratings and to-be-developed quality home visit checklist), the state is also working to improve data collection of the Federal Child Outcomes (TS GOLD) and the Family Survey (family outcomes). Additional strategies implemented in order to improve federal outcome data include: additional oversight abilities by PRT leadership teams, regional TA webinars regarding TIPS, TS GOLD training for providers and administrators, assistance in reviewing charts, and annual reminders for data submission 2-3 months prior to data deadlines. It is expected that full implementation of the above-listed improvement strategies will result in improved child and family outcome data for Cohorts 1 and 2.

²⁵ Response to Evaluation tool item 3 (c)

²⁶ Response to Evaluation tool item 3 (c)

Year	Implementation Strategies	Expected Impact/ Outcome
2013-14	Baseline	No Impact
2014-15	Cohort 1- RBI and Quality IFSP Outcome Training Initiated	Children and families in Cohort 1 begin to receive quality child and family assessment. (Short Term Outcome)
2015-16	Cohort 1 - full implementation of RBI Cohort 2 - RBI and Quality IFSP Outcome Training Initiated	All children and families in Cohort 1 receive quality child and family assessment. (Short Term Outcome) Children and families in Cohort 2 begin to receive quality child and family assessment. (Short Term Outcome)
2016-17	Cohort 1 & Cohort 2 - full implementation of RBI Cohort 1 - full implementation of quality IFSP outcomes	All children and families in Cohorts 1 & 2 receive quality child and family assessment. (Short Term Outcome) All IFSP's within Cohort 1 contain functional meaningful child and family outcomes. (Intermediate Outcome)
2017-18	Cohort 1 & Cohort 2 - full implementation of RBI, Cohort 1 & Cohort 2 - full implementation of quality IFSP outcomes Cohort 1 & 2 - quality home visit training initiated	All children and families in Cohorts 1 & 2 receive quality child and family assessment. (Short Term Outcome) All IFSP's within Cohort 1 & 2 contain functional meaningful child and family outcomes (Intermediate Outcome) Improvement in Family Outcome Data (C4) and Child Outcome Data (C3, SS1) for Cohort 1 & 2 (Long Term Outcomes)
2018-19	Cohorts 1 & 2 - full implementation of RBI Cohorts 1 & 2 - full implementation of quality IFSP outcomes Cohorts 1 & 2 - full implementation of quality home visits	All children and families in Cohorts 1 & 2 receive quality child and family assessment. (Short Term Outcome) All IFSP's within Cohort 1 & 2 contain functional meaningful child and family outcomes. (Intermediate Outcome) Improvement in Family Outcome Data (C4) and Child Outcome Data (C3, SS1) for Cohorts 1 & 2 (Long Term Outcomes)

Table 6 Projected Impact of Improvement Strategies on Evaluation of SIMR ²⁷

²⁷ Response to Evaluation tool item 3 (a & c)