

**Mississippi's Part C  
State Performance Plan  
2005-2012**



**First Steps**

**Mississippi Department of Health  
Health Services  
Office of Child and Adolescent Health  
Early Intervention Program**

**Revised February 1, 2012**

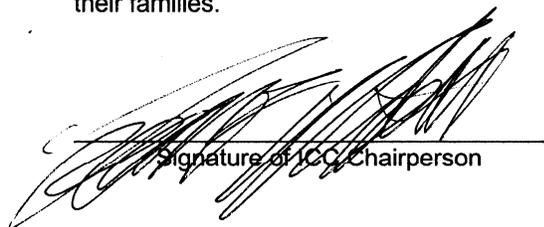
**Mississippi's Part C State Performance Plan (SPP)  
for FFY 2010 – FFY 2012**

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**INTERAGENCY COORDINATING COUNCIL  
CERTIFICATION OF ANNUAL REPORT**

On behalf of the Interagency Coordinating Council (ICC) of Mississippi, I certify that the ICC agrees/ ~~disagrees~~ (\*) with the information in the State's Annual Performance Report for Federal Fiscal Year 2005. The ICC understands that 34 CFR §80.40, of the Education Department General Administrative Regulations, requires that the lead agency prepare an Annual Performance Report containing information about the activities and accomplishments of the grant period, as well as how funds were spent. The ICC has reviewed the Report for completeness of its contents and accuracy.

We submit this Report in fulfillment of our obligation under Section 641(e) of the Individuals with Disabilities Education Act to submit an annual report to the Secretary and to the Governor on the status of the State's early intervention program for infants and toddlers with disabilities and their families.

  
\_\_\_\_\_  
Signature of ICC Chairperson

January 20, 2006  
\_\_\_\_\_  
Date

\_\_\_\_\_  
(\* ) The Council may submit additional comments related to the Lead Agency's Annual Performance Report and append comments to the Report.

## Overview of Part C in Mississippi

The Mississippi Department of Health (MDH) is the designated Lead Agency for the state's early intervention system established under Part C of the Individuals with Disabilities Education Act. First Steps, Mississippi's early intervention program, is administered through nine Public Health Districts throughout the state. Through the nine offices, children and families in every county in Mississippi can access early intervention supports and services. Funds are distributed to these public health district offices annually to coincide with the state fiscal year (July 1-June 30) to ensure statewide implementation of the Part C Early Intervention Program. District Administrators supervise District Coordinators, who are primarily responsible for administering the district early intervention program. District Coordinators supervise Service Coordinators, who are employed or contracted specifically to perform the duties of service coordination. Contracts are executed at the district and state level for services, including evaluation, assessment, Individualized Family Service Plan (IFSP) development, and services to children and families. State and private agencies provide services funded through Part C monies, state funding sources, Medicaid, and insurance.

Department of Health Central Office personnel, who perform the functions of overview, guidance, support, monitoring, training and technical assistance to the public health districts, include the Part C Coordinator, one Branch Director, two Operations Management Analysts Senior, and an Administrative Assistant. Contractual staff reporting to the Central Office includes five Quality Monitors who have been instrumental in providing Technical Assistance and monitoring of our nine districts, and an IT technical assistance provider. Early intervention supports and services are provided in accordance with Part C statute and regulations, and state policies and standards.

The Early Hearing Detection and Intervention in MS (EHDI-M) program is located organizationally under the First Steps Early Intervention System (FSEIS). The Part C Coordinator provides administrative oversight of the EHDI-M program. The EHDI-M director manages the program, updates policies and procedures, and provides periodic trainings for hospital personnel, audiological diagnostic centers, EHDI-M staff, FSEIS staff, and others that collaborate with the EHDI-M program. There are 44 birthing facilities (statewide) that report newborn hearing screening results to the EHDI-M program on a monthly basis. Children that refer (fail) the newborn hearing screening are reported to the EHDI-M program within 48 hours of failure. Annually, approximately 98% of newborns are screened for hearing loss by one month of age before discharge from the hospital. Twenty-six diagnostic centers (statewide) report diagnostic results to the EHDI-M program. Yearly, approximately 60% of newborns that fail the newborn hearing screening receive an audiological diagnostic evaluation by 3 months of age. Over 80% of children that are diagnosed with hearing loss receive early intervention services by 6 months of age. The FSEIS staff and the EHDI staff work together with families of children with hearing loss that are enrolled in the program.

District Coordinators, Service Coordinators, Service Providers, Quality Monitors, and Central Office Staff have participated in several trainings that emphasized play-based assessment and transdisciplinary practices. District, regional and statewide meetings are used to disseminate information, to explain changes, and to provide a forum for stakeholders to ask questions and problem solve. A statewide meeting in October 2010 was used as a forum to update stakeholders on Mississippi's early intervention program. Individuals representing diverse interests attended that meeting. The SPP process was explained in depth at the October meeting. Mississippi has been under an improvement plan since July 2005 to address long-standing non-compliance. Progress on the Improvement Plan was discussed, along with plans for further improvement.

The Mississippi Department of Mental Health has significantly reduced services due to budget restrictions in their agency. This has affected timely multidisciplinary evaluations and service provision in Health Districts V, VI, VII, VIII, and IX.

Hurricane Katrina struck Mississippi on August 29, 2005. District IX, the six southern counties, was most significantly impacted. About one-third of the state suffered tremendous property damage and substantial damage to the infrastructure. The coast is still very much in recovery mode. Staff from OSEP was in Mississippi in November 2005 to assess Mississippi's needs as a result of Hurricane Katrina, and to

evaluate our performance on the Improvement Plan. Due to Hurricane Katrina, paper records, computers, and electronically recorded data were lost in the coastal region. The FFY 2005 data reflect those losses. Starting in July 2005, the First Steps Information System (FSIS) was moved to a centralized system, so data are stored on a server in the Central Office in Jackson. Districts were in the process of “moving” data from the old system, which required saving data on computers and on disks, and importing and exporting data, when the hurricane struck.

District IX, the coastal region, is working to “recreate” electronic and paper data using provider records that were not lost, and data that had been previously supplied to the Central Office. Although raw data were certainly affected, it appears that the percentages for the state are accurate reflections of the system as a whole. Prior to the storm, District IX was one of the most densely populated districts in Mississippi. There were two pilot projects using promising collaborative partnerships with Part B and Department of Mental Health (DMH). Losses to all programs in District IX impacted not only the district, but progress throughout the state. The most significant impact was personal—affecting the lives of children, families, providers and EI staff. According to the State Demographer, based on research done in Florida, it could take five to ten years for the population to return to pre-storm numbers and for the infrastructure to recover.

### **Overview of State Performance Plan Development**

Due to the effects of Hurricane Katrina, Mississippi was given an extension for submission of the SPP. Originally due on December 2, 2005, the SPP deadline was extended to January 30, 2006. On October 25-26, 2005, thirty-one stakeholders representing diverse interests were invited to participate in the development of the framework of Mississippi’s State Performance Plan. Represented were parents and family members, advocates, service coordinators, service providers, district coordinators, monitors, technical assistance and training staff, university training personnel, staff from other state agencies (including Mental Health and the 619 Coordinator from Part B), Comprehensive System of Personnel Development (CSPD) committee members, and Central Office staff, including OMAS, Branch Directors, the Data Manager, and the Part C Coordinator. The makeup of the group reflected geographic, gender, age, and ethnic diversity. Also attending was Betsy Ayankoya, a Technical Assistant from the National Early Childhood Technical Assistance Center (NECTAC), who provided on-site technical assistance for the group.

All invited participants attended the retreat and were active in the process of providing an overview or description of the issue, process, or system; identifying areas in need of improvement; describing activities and strategies for improvement; and setting measurable and rigorous targets. A survey of the stakeholders indicated that the majority of participants felt that the process helped them to better understand the system of early intervention, to contribute to the future of the program, and to have their voice heard.

Once Central Office staff compiled the information from the stakeholder’s meeting, draft versions of the SPP were shared through email distribution with an even wider group of stakeholders, including Department of Health personnel and the members of the SICC. Review and feedback were requested. The State Interagency Coordinating Council met on January 20, 2006, to review the SPP and to make additional recommendations. Recommendations received from contributing stakeholders were incorporated into the final SPP. The final version of the SPP was disseminated electronically for distribution throughout the state. It has been posted to the Mississippi Department of Health’s website at [http://msdh.ms.gov/msdhsite/\\_static/41,0,74,63.html](http://msdh.ms.gov/msdhsite/_static/41,0,74,63.html). In the future the Annual Performance Reports and results of monitoring will be posted to the website. Reports will specify the performance of individual districts, including data disaggregated by indicator.

Currently the state is designated as a “high risk grantee,” and is working to improve performance and compliance on several indicators and other requirements of the grant. Five performance and compliance indicators being reported on a monthly Progress Report Card include “Number of New IFSPs (Child Find),” “45-Day Timeline,” “Timely Provision of Services,” “Natural Environment,” and “Timely and Accurate Data.” Significant improvements have been made in most areas. For the SPP, FFY 2004 data

(July 1, 2004 through June 30, 2005) are reported; however, the discussion of the baseline data includes the latest data from the Improvement Plan Report Card (July 1, 2005 through December 31, 2005). Measurable and Rigorous Targets were set considering both the FFY 2005 baseline data and the current data from the Improvement Plan. Stakeholders considered the activities and strategies developed for the Improvement Plan in writing the SPP.

In September, 2011, Mississippi had the Continuous Improvement Visit (CIV) and Result Focus Presentation with OSEP staff. The CIV portion of the visit was held first, and then MS Early Intervention Program (EIP) held an afternoon Result Focus meeting with stakeholders and SICC members to provide an overview of the Result Focus procedure and to identify Mississippi's focus on improving child outcomes, Indicator 3. (This process is clearly explained and defined under Indicator 3 of MS APR & SPP for FFY2010). On the last day of the OSEP visit, EIP held a work group meeting to identify barriers and establish Improvement Plans (IPs) to implement for this focus result.

EIP is in the process of incorporating IDEA new Part C Regulations into MS policies and procedures for EI staff/providers statewide. EIP has developed a new provider monitoring/audit process and plans to implement these new procedures in FFY 2011. Data review, data verifications, and technical assistance are currently being provided by Quality Monitors in all districts.

## Mississippi's Part C State Performance Plan for 2005-2012

### Monitoring Priority: Early Intervention Services In Natural Environments

**Indicator 1:** Percent of infants and toddlers with IFSPs who receive the early intervention services on their IFSPs in a timely manner.

(20 USC 1416(a)(3)(A) and 1442)

#### Measurement:

Percent = # of infants and toddlers with IFSPs who receive the early intervention services on their IFSPs in a timely manner divided by the total # of infants and toddlers with IFSPs times 100.

Account for untimely receipt of services.

#### Overview of Issue/Description of System or Process:

1. Current training opportunities include research-based practices for multidisciplinary and transdisciplinary teams for evaluation and assessment; IFSP development; service delivery; data collection and analysis; general supervision system; laws and regulations; and the SPP/APR requirements.
2. Fields have been added to the First Steps Information System (FSIS) to capture information regarding timely provision of services in accordance with the newly adopted state definition.
3. The First Steps Early Intervention Program Standards and Procedures, Revised May 2001, Section 7.42, require that the IFSP include the projected dates of initiation of the services listed under early intervention services (to begin as soon as possible after the IFSP meeting), and the anticipated duration of those services. The service coordinator manual directs the Service Coordinator (SC) to include the following: "When will we start? How often? How long? Where will it be done? – Enter actual start date of service. Enter how many times a week service will be provided. Enter how many minutes each session will last. Enter where service will be provided." The Service Provider Report includes this information as well. Attempting to quantify "timely" for the reporting requirement of the Improvement Plan, we identified a need to define timely provision of services, to train on service delivery practices and models, and to address the appropriate use of multidisciplinary and transdisciplinary teams for evaluation/assessment, IFSP development, and service delivery.
4. Locating service providers willing to serve infants and toddlers in natural settings is a challenge in several health districts.
5. In areas where individual providers conduct discipline-specific evaluations, write discipline-specific reports, and make discipline-specific recommendations in isolation from other team members, there is not a true team approach that looks at children and families holistically.

Resulting problems include:

- a. Recommending discipline-specific services that are not integrated and coordinated;
- b. Failure to write goals and outcomes or to identify all supports and services necessary to enhance the family's capacity to meet the developmental needs of the infant or toddler;
- c. Offering services to families in other settings when natural settings are appropriate and available. Many providers use a medical model for evaluations and service provision and

- provide child-centered, direct therapies versus family-centered services that incorporate routines to achieve functional outcomes. Some of our current services address each area of development in isolation from other services (multidisciplinary vs. transdisciplinary);
- d. Scheduling services when and how often the provider is available, or as dictated by Medicaid billing allowances, rather than as indicated on the IFSP and in consideration of the children/families' priorities, resources, concerns, and routines; and
  - e. Creating a waiting list for therapy rather than referring to other providers.
6. Many agencies serving multiple health districts/counties do not offer a variety of services in each of the geographic regions they serve.
  7. Medicaid Issues:
    - a. Waiting for the Treatment Authorization Number (TAN) from Medicaid delays the initial provision of services or continuation of services for some infants and toddlers.
    - b. Medicaid Policies do not allow for multiple providers in a coaching/consultation model to bill for each visit. This affects use of coaching, consultation, and other teaming activities.
    - c. Travel (time or mileage) is not reimbursed.
    - d. Medicaid determines eligibility for reimbursement on "medical necessity" and rehabilitation vs. developmental appropriateness.
  8. Hospitalizations (e.g., NICU), illness and family scheduling issues impact timely provision of initial services. The stakeholder input on October 25-26, 2005, included the need to identify examples of acceptable justifications for delays and to develop a method for qualifying and quantifying justifications in FSIS.
  9. Use of a Primary Service Provider (PSP) as coach model, when appropriate to meet the infant or toddler's (and family's) unique needs, has been a topic in training and is used in some districts. Its use has been limited in most of the health districts. The PSP as coach model focuses on coaching of the identified learners as the primary intervention strategy to implement jointly-developed, functional, discipline-free IFSP outcomes in natural settings with ongoing coaching and support from other team members. The discipline of the chosen PSP(s) is based on the IFSP outcomes, relationships with the learners, and expertise in the areas of support needed by the learners. When implemented appropriately, the model has been well-accepted by families.
  10. Indicators, including Child Find, timely provision of services, services in natural environments, 45-day timelines, and accurate and timely data, are being monitored and reported on the monthly Progress Report Card. Statewide improvements were noted for July through November 2005 with some slippage in December.

**Baseline Data for FFY 2004 (2004-2005):**

Of the 1213 initial IFSPs developed in FFY 2004 (2004-2005), 877 (72%) received their first service in thirty days or less; 336 (28%) received their first service in more than 30 days. All data reported for this indicator were obtained from the FSIS database.

**Discussion of Baseline Data:**

FFY 2004-2005 data used for the baseline are for timely provision of the first service initiated following initial IFSP development. In the past, the database was not configured to capture information about initiation of all services. The data system simply calculated how long it took for the initial service to begin. The data system has been changed, and since July 1, 2005, dates for initiation of all services are being captured.

The data from July 1-December 31, 2005, indicated that 83% of all services began in thirty days or less after development of the initial IFSP; 9% of services began in 31- 45 days; 3% of services began in 46-60 days; and 6% of services began after 60 days. The state did not have a definition

for “timely provision of services” before writing the SPP. The new definition of “timely provision of services” is “within 30 days of the projected initiation date as indicated on the IFSP.”

This definition was not approved by OSEP. The new definition is “‘within thirty days of the parent giving permission for the proposed service,’ unless the team proposes an initiation date of greater than 30 days for developmental and/or therapeutic reasons. If the proposed initiation date is greater than 30 days from the date the parent gives permission for the service, timely is defined as ‘starting on or before the proposed initiation date.’”

Anecdotal reasons most frequently given for failure to initiate services in a timely manner are related to service provider availability. However, there is no field in the data system to enter justifications for this indicator. Therefore, for reporting purposes, justifications could not be quantified. For the data to be reported in February 2007, quantification will be accomplished by adding a field in the database to enter each justification and to qualify and quantify justifications for reporting purposes.

FFY	Measurable and Rigorous Targets for Indicator 1:
2005 (2005-2006)	100% of infants and toddlers with IFSPs will receive the early intervention services on their IFSPs in a timely manner.
2006 (2006-2007)	100% of infants and toddlers with IFSPs will receive early intervention services on their IFSPs in a timely manner.
2007 (2007-2008)	100% of infants and toddlers with IFSPs will receive the early intervention services on their IFSPs in a timely manner.
2008 (2008-2009)	100% of infants and toddlers with IFSPs will receive the early intervention services on their IFSPs in a timely manner.
2009 (2009-2010)	100% of infants and toddlers with IFSPs will receive the early intervention services on their IFSPs in a timely manner.
2010 (2010-2011)	100% of infants and toddlers with IFSPs will receive the early intervention services on their IFSPs in a timely manner.
2011 (2011-2012)	100% of infants and toddlers with IFSPs will receive the early intervention services on their IFSPs in a timely manner.
2012 (2012-2013)	100% of infants and toddlers with IFSPs will receive the early intervention services on their IFSPs in a timely manner.

**Improvement Activities/Timelines/Resources:**

**Activities to commence in the second half of FFY 2005 (2005-2006)**

1. Require the use of this definition of timely provision of services statewide:
  - a. If a later date is specified,
    - i) It cannot be for the primary service(s);
    - ii) The reason(s) for the later date(s) must be stated in writing; and

- iii) The reason(s) for the later date(s) must be based on the child and family's unique needs (e.g. bi-annual hearing follow-ups for children with hearing impairments).
  - b. The additional service(s) with a later initiation date(s) must begin by the initiation date(s) specified on the IFSP for the specific service(s). (See new definition on page 6.)
2. Add fields in the data system to:
  - a. Capture justifications and
  - b. Qualify each justification (e.g. family reasons, provider reasons, MDH staff reasons), which will aid in quantification and program management and improvement.
  - c. Capture information about timely provision of services following IFSP revision.
3. Determine eligibility, write an IFSP, and begin service coordination for families of infants in the Neonatal Intensive Care Unit (NICU) while the infant is still hospitalized. First Steps has a contract with the University of Mississippi Medical Center (UMC) to provide services to hospitalized infants and toddlers. At Forrest General Hospital (FGH) in Hattiesburg, a Service Coordinator is being assigned to work with families and developmental/educational personnel employed by USM/IDS who provide services to babies in the FGH NICU.
4. Explore options for addressing financial issues (e.g. using the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program within Medicaid to fund EI services for Medicaid recipients).
5. Enter into contracts [with state and federal funds and revenue generated from Medicaid through Targeted Case Management (TCM)] to staff early intervention teams in every district. Collaborate with other agencies and utilize providers with the necessary expertise to develop early intervention teams that will:
  - a. Conduct comprehensive multidisciplinary evaluations and assessments, including measuring outcomes;
  - b. Serve on IFSP teams;
  - c. Provide technical assistance and training to Department of Health EI staff and other providers;
  - d. Provide coaching and consultation to families and providers;
  - e. Provide other EI services in natural settings and in a timely manner when other providers are unavailable; and
  - f. Monitor their districts on an ongoing basis and other districts during focus monitoring activities.
6. Improve services to infants/toddlers and their families by:
  - a. Providing service coordinators with training and materials to enable them to:
    - i) Explain the benefits of services in natural settings to parents and service providers;
    - ii) Conduct family assessments that lead to writing effective outcome statements considering priorities, resources, concerns, and routines; and
    - iii) Advocate for the infants, toddlers, and families they serve.
  - b. Presenting research to referral sources and providers on the benefits of implementing family-centered services in natural settings incorporating routines.
7. Provide training on:
  - a. The State's definition of "timely provision of services" and activities to achieve the goal,
  - b. Service delivery models incorporating best practices that support the provision of early intervention services in natural settings, and

- c. Minimum Standards and best practices for Service Coordination.
8. Add “alerts” in the First Steps Information System (FSIS) to remind Service Coordinators (SC) of service initiation timelines.
9. Implement a Primary Service Provider (PSP) as coach model when appropriate to meet the unique needs of the child and family that will lead to timely provision of services, emphasize relationships, empower families to help their children learn and develop, and improve outcomes.
10. Utilize national resources for technical assistance (including OSEP, NECTAC and SERRC) to arrange for high quality training within the state to address the best practice issues.
11. Utilize stakeholders with expertise in each of the above areas to provide training and technical assistance to other stakeholders.
12. Recruit and retain providers who provide services in natural settings.
13. Continue to issue the Progress Report Card related to the Improvement Plan. Work with districts in reviewing their District Work Plans, revising goals, planning and carrying out activities and strategies, identifying resources, and holding people accountable.

**Activities to commence in FFY 2006 (2006-2007)**

1. Evaluate the effectiveness of the above activities and make necessary changes. Utilize broad stakeholder input in this process.
2. Contract with providers willing to implement activities of the SPP and State/District Improvement Plans.
3. Provide training:
  - a. On the new requirements of IDEA’04 and
  - b. To new EI team members on a continual basis to increase the number of effective and efficient teams, addressing inevitable turnover of staff and new findings regarding best practices.
4. Begin revision of the policies and procedures to address changes in IDEA’04 utilizing broad stakeholder input as soon as the final regulations are available.
5. The Service Coordinator manual and necessary forms will be revised to support the changes.
6. The definition of “timely “ was changed to “within thirty days of the parent giving permission for the proposed service, unless the team (including the parent) proposes an initiation date of greater than 30 days for developmental and/or therapeutic reasons. If the proposed initiation date is greater than 30 days from the date the parent gives permission for the service, timely is defined as ‘starting on or before the proposed initiation date.’ This revised definition was accepted
  - a. If a later date is specified,
    - i) It cannot be for the primary service(s);
    - ii) The reason(s) for the later date(s) must be stated in writing; and
    - iii) The reason(s) for the later date(s) must be based on the child and family’s unique needs (e.g. bi-annual hearing follow-ups for children with hearing impairments).”
7. Training and technical assistance will be provided regarding this new definition.
8. Monitoring activities will include determining whether districts were meeting the timelines for “Timely Provision of Services.”

**Revisions, with Justification, to Proposed Targets / Improvement Activities / Timelines / Resources for FFY 2008 (2008-2009), FFY 2009 (2009-2010), FFY2010 (2010-2011), FFY 2011 (2011-2012), and FFY 2012 (2012-2013):**

light pink	Completed
light orange	Continuing
light blue	Revised
light green	New

The tables also include a reference to the improvement category for each activity, as described in the *APR Checklist: Part C State Annual Performance Report*. The improvement categories are:

- A. Improving data collection and reporting
- B. Improving systems administration and monitoring
- C. Providing training/professional development
- D. Providing technical assistance
- E. Clarifying/developing policies and procedures
- F. Program development
- G. Collaboration/coordination
- H. Evaluation
- I. Increasing/adjusting FTE
- J. Other

SC = Service Coordinator

DC = District Coordinator

C.O. staff = Central Office staff , which includes Part C Coordinator, Branch Director, Quality Monitors and other Central Office personnel assisting with particular activities.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Definition of “timely services”</b>				
A, E	<p>1. The definition of “timely” provision of services was changed in FFY 2006, to “within thirty days of the parent giving permission for the proposed service, unless the team (including the parent) proposes an initiation date of greater than 30 days for developmental and/or therapeutic reasons.”</p> <p>In FFY 2011, the definition of 30 days will be changed to 30 working/business days, instead of 30 calendar days.</p>	FFY 2006 through FFY 2012	Part C Coordinator	<p>Revised in FFY 2006</p> <p>Continued in FFY 2007</p> <p>Continued in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Revised in FFY 2011</p>	This definition will be used to improve timely services definition and service delivery due to loss of weekend days and holidays.
A, E, D	<p>2. In FFY 2007, additional guidance was given to service providers and service coordinators regarding when an initial date of service is greater than 30 days from the date the parent/guardian gave informed written consent for the early intervention service(s). The service must start before or on the expected date of service delivery. In FFY 2008, this guidance was revised to require the initial visit to occur within 30 days of the date the parent/guardian gives informed written consent for the early intervention service(s). In FFY 2011, this guidance will be revised to require the initial visit to occur within 30 business days of the date the parent/guardian gives informed written consent for the early intervention service(s).</p>	FFY 2007 through FFY 2012	SC DC	<p>Revised in FFY 2007</p> <p>Revised in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Revised in FFY 2011</p>	The revised guidance and definition of timely services will increase collaboration with consultants. This guidance will continue to be given as needed to improve timely services.
D, A	<p>3. Training on data entry began in FFY 2006.</p>	FFY 2006 through FFY 2012	Data Manager DC SC	<p>New in FFY 2006</p> <p>Continued in FFY 2007</p> <p>Continued in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	<p>Training continues to be offered when there is a change in the database or when requested by staff.</p> <p>A data manual has been developed and been provided electronically for</p>

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
					SC to access it at all times on correct procedures and definitions of each field.
	<b>Database changes</b>				
A	1. In FFY 2007, the system was changed to link service provision changes to an IFSP date, allowing for calculations of “timely” by the data system for all children and all services from July 1, 2007 to current. In FFY 2008, fields were added to allow differentiation between new services and existing services. In FFY 2009, reports were built to facilitate reporting timely services by child’ s name.	FFY 2007 through FFY 2012	Data Manager DC SC	Completed in FFY 2007 Revised in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The database changes continue to facilitate data collection, review, and reporting.
A	2. In FFY 2008, database fields were added for documentation of exceptional family circumstances. Central Office staff determined whether the documentation met the criteria for an exceptional family circumstance. In FFY 2009, district staff began selecting the justification type. When data are pulled for reporting and compliance purposes, Central Office staff check justifications and provide follow up as indicated.	FFY 2008 through FFY 2012	Data Manager DC SC	New in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This process facilitates proper data entry.
A	3. In FFY 2009, database reports were added for district staff to review and correct missing data. District staff access reports that clearly specify the records needing attention (i.e., missing data) and follow up to address issues in a timely manner.	FFY 2009 through FFY 2012	Data Manager DC SC	Completed in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The new reports allow for more efficient data review and data correction.
A	4. In FFY 2010, all forms will be accessed on the tablet PCs. All entries made on the forms will be automatically entered in the database.	FFY 2010 through FFY 2012	C.O. staff DC SC	New in FFY 2010 Continuing in FFY 2011	This will decrease time being spent on data entry and increase time dedicated to service coordination.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Provider Recruitment &amp; Training</b>				
F	1. In FFY 2007, information packets were mailed to SLPs licensed through the Mississippi State Department of Health (MSDH). This activity was not completed in FFY 2010 due to an inadequate amount of staff. This activity will resume when new staff is hired. This activity will be implemented in FFY 2011.	FFY 2007 through FFY 2012	C.O. staff	Completed in FFY 2007 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This activity is an effective tool for recruiting providers and will be re-implemented when additional staff is hired.
F	2. In FFY 2008, a similar packet was sent to OTs and PTs. Ads were developed and published in statewide newspapers in an attempt to recruit therapists into the EIS. In FFY 2010, this activity was discontinued due to a lack of staff at CO. This activity will resume when new staff is hired. This activity will be implemented in FFY 2011.	FFY 2008 through FFY 2012	C.O. staff	New in FFY 2008 Completed in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This activity is an effective tool for recruiting providers and will be re-implemented when additional staff is hired.
F	3. During FFY 2007, the Part C Coordinator requested Human Resources to change therapy rates and structure in an effort to recruit and retain therapists, while managing fiscal resources more effectively. Training rates were added in FFY 2008 and went into effect in FFY 2009. In FFY 2011, therapy rates were reduced due to the economical conditions.	FFY 2007 through FFY 2009	C.O. staff	Completed in FFY 2007 Revised in FFY 2008 Completed in FFY 2009	The therapy rate changes have helped recruitment and retention. Interest in attending training sessions has increased since the training rates went into effect.
F	4. In the last quarter of FFY 2008, a pilot began in Health District IX. This pilot is a nonprofit group, which contracts with providers and facilitates processing of paperwork required for billing of Insurance and Medicaid. The initial provider group began working with this nonprofit pilot in January	FFY 2008 through FFY 2012	Pilot in Health District IX DC	New in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	After the process is in place, tested, refined, and have shown the intended result of increasing the pool of providers, this pilot will expand.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	2010 to alleviate the paperwork barrier for providers.				
	<b>Retention &amp; Recruitment of District Staff</b>				
F	1. In FFY 2007, service coordinator positions were realigned from Health Program Specialist to Health Program Specialist Sr., resulting in a 10% raise.	FFY 2007	C.O. staff	Completed in FFY 2007	Staff turnover has decreased.
F	2. Exploring realignment or reclassification of District Coordinators began in FFY 2008 and the exploration continued in FFY 2009. In FFY 2010, District Coordinator positions have not been realigned. Exploration of this will resume when the economic conditions improve statewide.	FFY 2008 through FFY 2012	C.O. staff District staff	New in FFY 2008 Continued in FFY 2009 Revised in FFY 2010 Continuing in FFY 2011	This activity has been suspended due to statewide budget restrictions and lack of funds.
	<b>Policies &amp; Procedures</b>				
E	1. Due to the new regulation, policies and procedures will be revised.	FFY 2005 through FFY 2012	C.O. staff	New in FFY 2011	Expected impact is program improvement.
E	2. In FFY 2007, revisions were made to the Service Coordinator Manual regarding IFSP directions. This included an emphasis on use of informed clinical opinion in determining eligibility and making recommendations for services. Revisions also included changes in forms.  In FFY 2008, the IFSP instructions were revised to include more details where clarification was needed.  In FFY 2011, the IFSP instructions were revised to include revisions made to the form.	FFY 2006 through FFY 2012	C.O. staff	Revised in FFY 2007 Revised in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Revised in FFY 2011	Expected impact includes an increase in eligibility determinations and continued improvements to the service coordinator manual.  These revisions will also contribute to the quality of IFSP development.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
E	3. In FFY 2007, new forms and procedures were developed to aid in fiscal monitoring, data verification, and resource management. In FFY 2008, the data verification form was revised to allow more information to be entered. In FFY 2009, data verification forms were refined to better capture transition information and other changes. In FFY 2010, this tool was further refined and referred to as the data review/service review tool.	FFY 2007 through FFY 2012	C.O. staff	Completed in FFY 2007 Revised in FFY 2008 Revised in FFY 2009 Revised in FFY 2010 Continuing in FFY 2011	Our data verification process is a very effective tool for identifying training and TA needs. The revisions to the IFSP are expected to be more family friendly and efficient.
E	4. In FFY 2010, changes to the eligibility criteria were considered. This is an ongoing activity.	FFY 2010 through FFY 2012	C.O. staff	New in FFY 2010 Continuing in FFY 2011	Expected impact is a more rigorous definition of developmental delay.
A, E, F	5. In FFY 2010, the IFSP was revised.	FFY 2010 through FFY 2012	C. O. staff	New in FFY 2010	This will make the IFSP more effective, efficient and family friendly.
	<b>Training/TA for staff &amp; providers</b>				
C	1. In FFY 2006, a new service coordinator training was developed. In FFY 2007, these three days sessions were shortened to two days to prevent delays in service coordination. The main content on the third day was IFSP development. IFSP training and follow-up are now provided within the health district.	FFY 2006 through FFY 2012	C.O. staff	New in FFY 2006 Revised in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The revised format is well accepted and continues to be used to enhance service coordination.
C	2. Significant changes to the format of the IFSP were made in FFY 2006. Training on the new format was provided in all health districts in FFY 2006. By FFY	FFY 2006 through	C.O. staff	New in FFY 2006 Revised in FFY 2007	IFSP training within the health districts is open to all service coordinators,

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<p>2007, staff and providers were familiar with the new format. Follow-up training on the IFSP began to be provided within the health districts.</p> <p>IFSP training continues to be provided for each new service coordinator. Follow-up provided within the health districts is individualized and includes coaching.</p> <p>In FFY 2010, the IFSP was revised.</p> <p>In FFY 2011, the IFSP will be reviewed and revised, as needed, to meet the new Part C regulations.</p>	FFY 2012		<p>Continued in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	service providers and affords current staff opportunities to enhance their skills.
C	<p>3. Training/TA on transdisciplinary play-based assessment began in FFY 2007. In FFY 2008, provider training included training on this model. TA continues to be provided for evaluation team members on this model.</p>	FFY 2007 through FFY 2012	C.O. staff	<p>New in FFY 2007</p> <p>Continued in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	Training and technical assistance continue to be offered when requested or needed by staff or providers.
F	<p>4. In FFY 2008, NECTAC and SERRC provided technical assistance on the following topics: changing service delivery models, improving child outcome measurement, and improving transition activities. They continue to provide technical assistance related to these topics and will add the topic of increasing provider awareness of typical child development.</p> <p>In FFY 2009, SERRC provided technical assistance onsite during a focused monitoring visit in which the focus was on timely services. The TA addressed timely service issues and improving our general supervision activities.</p> <p>SERRC and NECTAC continue to link the state with resources to address timely service issues.</p>	FFY 2008 through FFY 2012	C.O. staff	<p>New in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	Technical assistance continues to be requested and provided.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
C	5. Typical Child Development trainings was offered in FFY 2010. It is made available through trainers within each district.	FFY 2009 through FFY 2012	C.O. staff	New in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This training addressed needs identified by stakeholders and through general supervision activities.
C	6. Evaluation tool training (i.e., IDA, DP III, HELP, Sensory Profile, E-LAP) was held in FFY 2009 (January 19-21, 2010), in Oxford, Jackson, and Hattiesburg. Technical Assistance on the administration of these tools continue is an ongoing process.	FFY 2009 through FFY 2012	C.O. staff	New in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This training addressed needs identified by stakeholders and through general supervision activities.
C, F, J	7. In FFY 2009, ARRA funds used for projects at three universities resulted in pre-service and in-service training for staff, providers, and childcare workers on best practices in providing early intervention services. One component addressing assistive technology (AT) awareness and availability include family members in the training opportunities. These trainings are provided in a digital format for staff to use as needed.	FFY 2009 through FFY 2012	University Staff	New in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Training will address needs identified by stakeholders and through general supervision/monitoring of service providers
A, B, C, D	8. In FFY 2010, tablet PCs and portable printers were made available to staff. In FFY 2011, district staff will begin using the tablet PCs and portable printers to facilitate paperwork and service coordination.	FFY 2010 through FFY 2012	District staff	New in FFY 2010 Continuing in FFY 2011	Expected impact includes more effective service coordination and user-friendly data entry.
C	9. In FFY 2009, a designated CO staff member conducted statewide onsite TA related to Medicaid issues.	FFY 2009 through FFY 2010	C.O. staff	New in FFY 2009 Completed in FFY 2010	Current issues/problems specific and unique to each health district were identified and addressed.
C	10. In FFY 2010, Training Modules were developed to cover the First Steps process from enrollment to transition from Part C services. These modules	FFY 2010 through	C.O. staff	New in FFY 2010 Continuing in FFY 2011	The use of these training modules will provide targeted technical

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	continue to be used for targeted TA purposes.	FFY 2012			assistance.
	<b>SICC</b>				
B, G	1. In August 2006, SICC requested the Governor to make new appointments to the SICC. The appointments were made in FFY 2007.	FFY 2007	SICC	Completed in FFY 2007	This resulted in SICC having the required members.
B, G	2. In FFY 2008 and FFY 2009, the SERRC technical assistant to this program assisted in the pre-planning for a retreat for the SICC. The retreat was revised to be a stakeholder meeting and this took place in FFY 2010 (October, 2010).	FFY 2008 through FFY 2010	SICC SERRC	New in FFY 2008 Continued in FFY 2009 Completed in FFY 2010	The stakeholder meeting facilitated addressing current challenges.
G	3. In FFY 2010, a pediatrician was recruited as a member of the SICC. Due to other obligations, he could not continue to serve in this position. Efforts will be made to recruit a pediatrician in FFY 2011.	FFY 2010 through FFY 2012	SICC	New in FFY 2010 Continuing in FFY 2011	This will give us a voice with the medical community, which will help with program requirements related to CMNs or Prescriptions needed for timely service delivery.

**Activities to commence in FFY 2013 (2013-2014):**

1. Evaluate the effectiveness of the above activities in meeting the SPP goals and make necessary changes. Utilize broad stakeholder input in this process
2. Provide training to address compliance and/or performance issues identified in the Annual Performance Reports and through monitoring activities. This training will be ongoing within each health district through coaching, mentoring, and embedded training/technical assistance.

**Resources for Activities and Persons Responsible/Accountable**

1. Database: C.O. staff, data manager, and FSIS User Group
2. Policy and procedural changes and forms: C.O staff with broad stakeholder input
3. Annual Performance Reporting requirements: C.O. staff, district staff, database, general supervision system including monitoring information, and broad stakeholder input
4. Training and Technical Assistance: C.O. staff, district staff, Early Intervention teams, collaborative efforts with DMH and MDE, national resources [e.g. OSEP, NECTAC, SERRC, Infants/Toddlers Coordinators Association (ITCA),Data Accountability Center (DAC)], stakeholders with special expertise, Comprehensive System of Personnel Development (CSPD) Committee members, university training programs, Early Intervention Conference, personnel funded through grants, First Steps Resource Library
5. Monitoring: C.O. staff, Quality Monitors, EI teams, MDH and DMH staff, Parent Advisors, Medicaid, and other stakeholders
6. Early Intervention Teams: personnel will be funded through contracts; collaborative agreements with Part B, Department of Mental Health and other private or public agencies; Part C salaried staff; university programs, training personnel, and practicum students
7. Collaboration: administrative personnel from agencies providing EI services
8. Publicity and Child Find: C.O. staff, MDH staff from the Office of Communications, DCs and SCs
9. Funding sources: state, Part C, and third-party payments; grant monies (e.g. EHDI-M, **GSEG**); and revenue generated by MDH

## Mississippi's Part C State Performance Plan for 2005-2012

### Monitoring Priority: Early Intervention Services In Natural Environments

**Indicator 2:** Percent of infants and toddlers with IFSPs who primarily receive early intervention services in the home or programs for typically developing children.

#### Measurement:

Percent = # of infants and toddlers with IFSPs who primarily receive early intervention services in the home or programs for typically developing children divided by the total # of infants and toddlers with IFSPs times 100.

#### Overview of Issue/Description of System or Process:

1. Current efforts include increasing awareness of the benefits of providing services in the natural environment. Training includes an emphasis on the requirement that early intervention services be provided in natural settings (e.g., the home, child care centers, or other community settings) to the maximum extent appropriate to meet the needs of the child, and on the requirement to provide a justification for services outside the natural environment. Other training includes proper use of different service delivery models such as a Primary Service Provider (PSP) as coach model.
2. Many district staff members have some knowledge of the benefits of providing services in natural settings. Most of these staff members are not comfortable explaining the benefits or legal requirements of natural environment provisions. Enhancing knowledge of all stakeholders and providers should decrease the perception that more services in a clinic are better.
3. The "Step by Step Process of Service Coordination" in our service coordinator manual requires discussing natural environments concept with parents but describes a process more supportive of services provided under a medical model. Parent choice of services is stressed without providing parents with the information needed to make informed choices (i.e., family centered and integrated approaches to address their child's developmental needs).
4. The format used to document service provision (except where the new process has been piloted) does not encourage writing IFSP outcomes to be achieved through natural routines for the infant/toddler and family. In districts VIII and IX, use of a "bubble sheet" emphasizes routines and outcomes in the development of IFSPs. At the December 2005 stakeholders' meeting, a bubble sheet activity was included, with Districts VIII and IX and DMH staff serving as leaders for mock IFSP teams.
5. Team members are unable to identify and write adequate child outcome-based justifications for services outside natural settings. At the December 2005 stakeholders' meeting, the framework for a guiding document was begun.
6. The categories used for natural environment in the FSIS were not clearly defined. Some categories for natural environment did not meet the federal definition of natural environment. Typically since July 1, 2005, categories selected included home, typical, designed, or service provider. "Other" requires a description to determine if it meets the definition for natural environment. Ongoing training and technical assistance regarding natural environments has been provided.

7. Finding service providers willing to serve infants and toddlers in natural environments is a challenge in several health districts.
  - a. In areas where individual providers conduct their evaluations and make discipline-specific recommendations, there is no true team process. Please refer to Indicator 1, overview # 5.
  - b. Many agencies serving multiple health districts do not offer a variety of services in each of the districts they serve.
  - c. In some counties, only special instruction is available in NE. All other services are provided at hospitals and clinics.
  - d. Providers who were unable or unwilling to provide services in the NE have been encouraged to use existing resources in NE or to create programs with typically developing children. The University of Mississippi is piloting a program for Speech/Language and Audiology students to have practicum experiences in NE and to create a typical program in their clinic. These practices have been suggested to other university training programs. Small grants are offered to offset travel expenses. CSPD committee members have been assigned to work with major university training personnel to promote these ideas.
8. Medicaid Issues:
  - a. Medicaid does not reimburse the provider for travel (mileage or time).
  - b. Please refer to Indicator 1, overview # 7 (a, c, and d).
9. Hospitalized infants and toddlers are put in tracking until they are discharged from the hospital.
10. Use of a Primary Service Provider (PSP) as coach model, when appropriate to meet the infant or toddler's (and family's) unique needs, has been a topic in training and is used in some districts. Its use has been limited in most of the health districts; when used appropriately it has been well-accepted by families. Please refer to Indicator 1, Overview # 9 for more details.
11. Agencies are cutting costs by providing clinic-based services and making staff reductions.
12. Increased difficulty finding providers willing to travel to rural areas to provide services.

#### **Baseline Data for FFY 2004 (2004-2005):**

In FFY 2004 of the 1249 infants and toddlers who were initially referred and had initial IFSPs developed and who received early intervention services, 1028 (82%) received early intervention services primarily in the home or community settings with typically developing peers. Although the 618 data were available for reporting on the Child Find indicators, the Natural Environment data are not yet available. Data were obtained from the FSIS database for FFY 2004.

#### **Discussion of Baseline Data:**

Provision of services in home and community settings with typically developing peers has increased while provision of services in clinics, hospitals, design programs or other service provider settings has continued to decrease in the State. Targets were set by considering the FFY 2004 (2004-2005) data as well as the monthly Report Card data. The data from July 1, 2005-December 31, 2005, indicate that 92% of the infants and toddlers with IFSPs received early intervention services primarily in the NE. Data were obtained from the FSIS database. Reasons for services outside NE tend to be based on family choice, service provider availability, and the need for special equipment available only in a clinical setting.

FFY	Measurable and Rigorous Targets for Indicator 2:
<b>2005</b> (2005-2006)	<b>93%</b> of infants and toddlers with IFSPs will receive early intervention services primarily in the home or programs for typically developing children with <b>100%</b> child outcome-based justifications for remaining <b>7%</b> .
<b>2006</b> (2006-2007)	<b>94%</b> of infants and toddlers with IFSPs will receive early intervention services primarily in the home or programs for typically developing children with <b>100%</b> child outcome-based justifications for remaining <b>6%</b> .
<b>2007</b> (2007-2008)	<b>95%</b> of infants and toddlers with IFSPs will receive early intervention services primarily in the home or programs for typically developing children with <b>100%</b> child outcome-based justifications for remaining <b>5%</b> .
<b>2008</b> (2008-2009)	<b>96%</b> of infants and toddlers with IFSPs will receive early intervention services primarily in the home or programs for typically developing children with <b>100%</b> child outcome-based justifications for remaining <b>4%</b> .
<b>2009</b> (2009-2010)	<b>97%</b> of infants and toddlers with IFSPs will receive early intervention services primarily in the home or programs for typically developing children with <b>100%</b> child outcome-based justifications for remaining <b>3%</b> .
<b>2010</b> (2010-2011)	<b>98%</b> of infants and toddlers with IFSPs will receive early intervention services primarily in the home or programs for typically developing children with <b>100%</b> child outcome-based justification for remaining <b>2%</b> .
<b>2011</b> (2011-2012)	<b>98%</b> of infants and toddlers with IFSPs will receive early intervention services primarily in the home or programs for typically developing children with <b>100%</b> child outcome-based justification for remaining <b>2%</b> .
<b>2012</b> (2012-2013)	<b>98%</b> of infants and toddlers with IFSPs will receive early intervention services primarily in the home or programs for typically developing children with <b>100%</b> child outcome-based justification for remaining <b>2%</b> .

**Improvement Activities/Timelines/Resources:**

**Activities to commence in the second half of FFY 2005 (2005-2006)**

1. Clearly define the categories in FSIS used to report natural environment (i.e., natural environment = home or community, and other = any other setting). Change the FSIS field to reflect the federal definition.
2. Provide guiding questions to determine whether the decision to provide a service outside natural environments (“other” in the database) meets the criteria for a child outcome-based justification. Document decisions in FSIS and on the guiding document to be attached to the IFSP.
3. Add fields in the database to indicate that the justification has been reviewed and appropriately qualified by an administrator.
4. Please refer to Indicator 1, **Activities to commence in the second half of FFY 2005**, activities 3, 4, 5, 9, and 13 .

5. Explain the new monitoring process to service providers with emphasis on the following:
  - a. Monitoring activities will be used to identify Program Improvement activities to meet the required targets for the State Performance Plan.
  - b. Monitoring findings and the resulting Improvement Plans at both the state and local levels will be published. To meet targets of the SPP, the Improvement Plans for districts and providers will include district goals, training and technical assistance needs, available resources, activities and strategies, and responsible parties.
6. Please refer to Indicator 1, **Activities to commence in the second half of FFY 2005**, Activity 6.
7. Provide training on:
  - a. Natural environment definition, benefits, and best practices;
  - b. Determining whether the decision to provide services outside natural environments meets the criteria for a child outcome-based justification;
  - c. Service delivery models incorporating best practices that support the provision of early intervention services in natural settings;
  - d. IFSP development incorporating routines to achieve functional outcomes;
  - e. Cultural diversity; and
  - f. Service Coordination.
8. Make changes in the Service Coordinator's Manual to guide personnel in offering more effective services.

**Activities to commence in FFY 2006 (2006-2007)**

1. Please refer to the activities for Indicator 1.
2. Distribute Natural Environment brochures to Service Coordinators, Service Providers, and families explaining the regulations, best practices, and benefits regarding Natural Environments.
3. Place the Natural Environment brochure on the First Steps Early Intervention webpage.
4. In IFSP and service coordinator training emphasize natural routines and functional outcomes. Part of the IFSP training includes using the Natural Environment Guiding Document that is part of the IFSP.
5. Provide technical assistance addressing issues related to explaining the benefits of services in natural environments to providers, referral sources, and parents.

**Revisions, with Justification, to Proposed Targets / Improvement Activities / Timelines / Resources for FFY 2008 (2008-2009),  
FFY 2009 (2009-2010), FFY2010 (2010-2011), FFY 2011 (2011-2012), and FFY 2012 (2012-2013):**

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Natural Environment brochures</b>				
D, F	1. A brochure explaining the benefits of services in the NE was developed in FFY 2006 and has been distributed to families and providers by central office and district staff. This brochure is on the agency website and continues to be used.	FFY 2006 through FFY 2012	C.O. staff District Staff	New in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This brochure continues to be used to explain benefits of services in natural environments.
	<b>Database Changes</b>				
A	1. In FFY 2005, service location categories in the database (FSIS) were changed to report natural environment using the terms in the federal definition.	FFY 2005	Data Manager	Completed in FFY 2005	The same categories continue to be used for reporting purposes.
A	2. In FFY 2006, fields were added in the database to indicate that the justification explanation had been reviewed by an administrator, who determined the type of justification. In FFY 2009, district staff began selecting the justification type. When data are pulled for reporting and compliance purposes, Central Office staff check justifications and provide follow up, as indicated.	FFY 2006 through FFY 2012	Data Manager DC SC	Completed in FFY 2006 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The changes have continued to contribute to more detailed explanations supporting justifications

A	3. In FFY 2008, the NE justification was put on the same record as the early intervention service. This allowed a justification to be entered for each service, if necessary. Prior to this change, only one NE explanation could be entered per child in FSIS. Reports that specify the records needing attention were made available to staff in FFY 2009.	FFY2008 through FFY 2012	Data Manager	<p>New in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	Data entry and review are more user friendly. District staff are utilizing the reports to improve data entry.
D	4. Technical assistance and training about the database changes have been provided since the database changes in FFY 2005. These have been provided in the health districts.	FFY 2005 through FFY 2012	C.O. staff	<p>New in FFY 2005</p> <p>Continued in FFY 2006</p> <p>Continued in FFY 2007</p> <p>Continued in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	Training/TA on data entry and use of the reports are offered within the health district when there are changes in the database or when training/TA is requested.
A, C, D	5. The data manual was not developed in FFY 2008 as planned. Major changes in the database were made in FFY 2008, but the work was not completed. The process of developing the data manual began in FFY 2009. Due to several needed changes in the database, the development of this manual will be continued. In, FFY 2010, the data manual was completed. It includes guidance on entering justifications for services outside of the natural environment and guidance of choosing a justification type. As improvement is made to the database, the manual will be updated accordingly.	FFY 2008 through FFY 2012	Data Manager C.O. staff	<p>New in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	The data manual will facilitate data entry for staff and will be used as a guide for data entry.
A,C,D	6. A committee of one QM and two DCs was formed to address the improvement of reliability of data. Activities involved Central Office providing 10% sampling to be reviewed, 10% of files per staff were reviewed, a QM monitored providers for accuracy and quality and a QM visited DCs to review districts quarterly.	FFY 2011 through FFY 2012	QM, DCs	<p>New in FFY 2011</p>	This activity will improve data by quarterly data report updates. The visiting DC/central office staff will meet with DC and SCs to identify district strengths and concerns, and the

					team of DC, QM will identify provider strengths and weaknesses.
	<b>Provider Recruitment &amp; Training</b>				
F	1. In FFY 2006, contracts were approved to staff early intervention teams in every health district. Health districts continue to contract with providers to form evaluation teams and to provide services.	FFY 2006 through FFY 2012	C.O. staff District Staff	New in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Health districts contract with providers to best meet the specific needs.
D, F	2. Since FFY 2006, subsidies/loans/grants (SLGs) were awarded to university programs to provide pre-service training on services in natural settings.	FFY 2006 through FFY 2012	C.O. staff	New in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009  Continued in FFY 2010 Continuing in FFY 2011	This practice continues and has resulted in some graduates becoming providers for the EIS.
D,F	3. A component of the grants awarded to Universities included a follow up of training on Assistive Technology awareness and availability. The University of Mississippi has established a digital module that provides continuous training on services in the Natural Environment. Mississippi State University has a lending library that provides assistive technology.	FFY 2010 through FFY 2012	University staff	New in FFY 2011	Lending libraries will continue to provide resources for children and families in order to assist in their needs.

D, F	4. SLGs were increased with some regional mental health centers to enable them to contract with additional providers who are willing to provide services in natural settings. Since FFY 2008, two mental health center has an SLG.	FFY 2006 through FFY 2012	C.O. staff District Staff	New in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This SLG allows the mental health center to provide more early intervention services in the NE in their catchment area.
F	5. In FFY 2007, information packets were mailed to SLPs licensed through MSDH. In FFY 2009, this activity was repeated as a tool for recruiting providers. This effort will continue to be used as a tool for recruiting providers. In FFY 2010, this activity was not sent due to shortage of staff. This activity will resume when new staff is hired. This activity will be implemented in FFY 2011.	FFY 2007 through FFY 2012	C.O. staff	Completed in FFY 2007 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This activity is an effective tool for recruiting providers.
F	6. In FFY 2008, a similar packet was sent to licensed OTs and PTs. Ads were developed and published in statewide newspapers in an attempt to recruit therapists into the EIS. In FFY 2009, this activity was repeated as a tool for recruiting providers. This effort will continue to be used as a tool for recruiting providers. In FFY 2010, these packets were not sent due to shortage of staff. This activity will be implemented in FFY 2011.	FFY 2008 through FFY 2012	C.O. staff	New in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This activity is an effective tool for recruiting providers.
F	7 In FFY 2007, the Part C Coordinator requested that Human Resources change therapy rates and structure in an effort to recruit and retain therapists, while managing fiscal resources more effectively. Rate changes went into effect in FFY 2008.	FFY 2007 through FFY 2009	C.O. staff	Completed in FFY 2007 Revised in FFY 2008 Completed in FFY 2009	The therapy rate changes have helped recruitment and retention of service providers. Interest in

	Training rates were added in FFY 2008 and were implemented in FFY 2009. In FFY 2011, therapy rates were reduced due to the economic conditions.				attending training sessions has increased since the training rates went into effect.
F	8. In the last quarter of FFY 2008, a pilot began in Health District IX. This pilot is a nonprofit group, which contracts with providers and facilitates processing of paperwork required for billing of Insurance and Medicaid. The initial provider group began working with this nonprofit pilot in January 2010 to alleviate the paperwork barrier for providers.	FFY 2008 through FFY 2012	Pilot in Health District IX DC	New in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	After this process is in place, tested, refined, and has shown the intended result of increasing the pool of providers, this pilot will likely expand.
F	9. During the last year, several districts have investigated Excel by Five to explore this as a tool for providing services in the natural environment. Excel by Five and the Race to the Top Grant were being developed to give communities an opportunity to pull together all resources available that are child development related to create a certified networking for child development activities. RTT grant was submitted in FFY11 and not approved. A second attempt to develop this activity is being attempted by SECAC to recruit new financial supporters.	FFY 2009 through FFY 2012	District Coordinator	New in FFY 2011	Excel by Five will provide an opportunity for the children in our program to receive services in group settings in the Natural Environment that will enhance their development and provide parents with suggestions as to how to better work with their child.
	<b>Retention &amp; Recruitment of District Staff</b>				
F	1. In FFY 2007, service coordinator positions were realigned from Health Program Specialist to Health Program Specialist Sr. This resulted in a 10% raise.	FFY 2008	C.O. staff	Completed in FFY 2007	Staff turnover has decreased.
F	2. Exploring realignment or reclassification of District Coordinators began in FFY 2008 and the exploration continued in FFY 2009. Exploration will resume when the economic conditions improve statewide.	FFY 2008 through FFY 2011	C.O. staff District staff	New in FFY 2008 Continued in FFY 2009 This activity has been suspended until funds are available.	This activity has been suspended due to statewide budget restrictions and lack of funds.

	<b>Policies &amp; Procedures</b>				
E	1. Due to new regulations, policies and procedures will be revised.	FFY 2005 through FFY 2012	C.O. staff	New in FFY 2011	Program improvement.
E	2. In FFY 2007, revisions in the service coordinator manual were mainly regarding IFSP directions. This included an emphasis on use of informed clinical opinion in determining eligibility and making recommendations for services. Revisions also included changes in forms.  In FFY 2008, the IFSP instructions were revised to include more details where clarification was needed. (Font is different.)  The new service coordinator manual has been completed and can be found on the M drive. The M drive is set up through the First Steps database so that staff can access manuals, forms, documents and instructions for forms and documents.	FFY 2006 through FFY 2012	C.O. staff	Revised in FFY 2007 Revised in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Revised in FFY 2011	Results include an increase in eligibility determinations and continued improvements to the service coordinator manual.  This makes the manual easily accessible for users.
E	3. In FFY 2007, new forms and procedures were developed to aid in fiscal monitoring, data verification, and resource management. In FFY 2008, the data verification form was revised to allow more information to be entered. In FFY 2009, data verification forms were refined to better capture transition information and other changes. In FFY 2010, this tool was further refined and referred to as the data review/service review tool.	FFY 2007 through FFY 2011	C.O. staff	Completed in FFY 2007 Revised in FFY 2008 Revised in FFY 2009 Revised in FFY 2010	The revisions to the IFSP are more family friendly and effective.
	<b>Definition of Natural Environment</b>				
D	1. In FFY 2006, guidance questions were provided to determine whether the decision to provide a service outside natural environments met the criteria for a child outcome-based justification.	FFY 2005 through FFY 2012	C.O. staff	Completed in FFY 2006 Continued in FFY 2007 Continued in FFY 2008	The NE attachment continues to be used. It facilitates complete documentation of the

	Decisions continue to be documented on the IFSP for each outcome. The Natural Environment justification form must be completed whenever the setting for an outcome is not in a natural environment and this attachment becomes part of the IFSP. In FFY 2010, an IFSP was developed which required a justification of why the outcome is addressed outside of the natural environment.			Continued in FFY 2009 Revised in FFY 2010 Continuing in FFY 2011	decision. Documentation of outcomes being addressed outside of the natural environment will be provided through a statement instead of a two page form that is separate from the IFSP.
C	2. Since FFY 2006, training and technical assistance were provided on the following topics: natural environment definition, benefits, and best practices; determining whether the decision to provide services outside natural environments meets the criteria for a child outcome-based justification; service delivery models incorporating best practices that support the provision of early intervention services in natural settings; IFSP development incorporating routines to achieve functional outcomes; cultural diversity; and service coordination.	FFY 2005 through FFY 2012	C.O. staff District Staff	New in FFY2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Training/TA on these topics is incorporated in the service coordinator and provider training. Additional training/TA is provided when requested and when the need is apparent from general supervision activities.
	<b>Training/TA for staff &amp; providers</b>				
C	1. In FFY 2006, a new service coordinator training was developed. In FFY 2007, these three days training sessions were shortened to two days to prevent delays in service coordination. The main content on the third day was IFSP development. IFSP training and follow-up are now provided within the health district.	FFY 2006 through FFY 2012	C.O. staff	New in FFY 2006 Revised in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The revised format is well accepted and continues to be used to enhance service coordination.
C	2. Significant changes to the format of the IFSP were made in FFY 2006. Training on the new format was provided in all health districts in FFY 2006. By FFY 2007, the staff and providers were	FFY 2006 through FFY 2012	C.O. staff	New in FFY 2006 Revised in FFY 2007 Continued in FFY 2008	IFSP training within the health districts is open to all service coordinators and

	familiar with the new format. Follow-up training on the IFSP began within the health districts. IFSP training continues for each new service coordinator. Follow-up provided within the health districts is individualized and includes coaching. In FFY 2010, the IFSP was revised. In FFY 2011, the new IFSP was revised and implemented with Service Coordinators, District Coordinators, and local providers throughout the state. Follow up training/technical assistance will be provided to districts that need assistance.			Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	affords current staff opportunities to enhance their skills.
F	3. In FFY 2008, NECTAC and SERRC provided technical assistance on the following topics: changing service delivery models, improving child outcome measurement, and improving transition activities. They continue to provide technical assistance related to these topics.	FFY 2008 through FFY 2012	C.O. staff	New in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Technical assistance continues to be requested and provided.
C	4. In FFY 2007, the Mississippi EI program held its state conference in collaboration with the Mississippi Early Childhood Association (MsECA) in October 2007. Carol Trivette was a keynote and breakout speaker. Her topic centered on the research regarding coaching families to increase activities during natural routines to improve family and child outcomes. The MsECA and EI plan to continue this collaborative effort, with increased emphasis on serving children with special needs in natural settings and routines. Since FFY 2007, MSDH has been a sponsor of this conference.	FFY 2007 through FFY 2012	MSECA C.O. staff	Completed in FFY 2007 Revised in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	More relevant breakout sessions are needed for those serving the birth to three population. This need has been communicated to those organizing the conference. Provision of more EI sessions have been included in these conferences.
C	5. In FFY 2010, SERRC collaborated with the ECO Center to develop and offer a Typical Child Development training statewide to Service Providers and Service Coordinators within the program. This training provided examples of case studies that emphasized Natural Environment guidelines. Following the trainings, SERCC and ECO selected specific staff to "Train the Trainer". This training gave instructions on techniques to	FFY 2009 through FFY 2012	C.O. staff	New in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This training addressed needs identified by stakeholders through general supervision activities.

	captivate and hold the attention of audiences that require training concerning provision of services on typical child development.				
C, F, J	6. In FFY 2009, ARRA funds were used for projects at three universities resulted in pre-service and in-service training of staff, providers, and childcare workers on best practices in providing early intervention services. One component was assistive technology awareness and availability which included family members in the training opportunities. These trainings are provided in a digital format for staff to use as needed.	FFY 2009 through FFY 2012	University Staff	New in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This training will address needs identified by stakeholders and through general supervision activities. This will continue to impact the knowledge of staff on how to provide family education.
A, B, C, D	7. In FFY 2010, district staff will begin using tablet PCs and portable printers to facilitate paperwork and service coordination. Training and technical assistance were provided for district staff. This procedure was not initiated due to forms not being approved. In FFY 2011, tablet PCs will be used as a mean to complete necessary paperwork during service coordination activities. Revised forms were placed on hold due to release of new Part C regulations. In FFY 2011, these forms will be revised to reflect the new revisions in new regulations.	FFY 2010 through FFY 2012	District staff	New in FFY 2010 Continuing in FFY 2011	Expected impact includes more effective service coordination and efficient data entry.

**Activities to commence in FFY 2013 (2013-2014):**

1. Evaluate the effectiveness of the above activities in meeting the SPP goals and make necessary changes. Utilize broad stakeholder input in this process
2. Provide training to address compliance and/or performance issues identified in the Annual Performance Reports and through monitoring activities. This training will be ongoing within each health district through coaching, mentoring, and embedded training/technical assistance.

**Resources for Activities and Persons Responsible/Accountable:**

Please refer to the resources for Indicator 1, unless otherwise specified.

## Mississippi's Part C State Performance Plan for 2005-2012

### Monitoring Priority: Early Intervention Services In Natural Environments

**Indicator 3:** Percent of infants and toddlers with IFSPs who demonstrate improved:

- A. Positive social-emotional skills (including social relationships);
- B. Acquisition and use of knowledge and skills (including early language/communication); and
- C. Use of appropriate behaviors to meet their needs.

(20 USC 1416(a)(3)(A) and 1442)

#### Measurement:

- A. Positive social-emotional skills (including social relationships):
  - a. Percent of infants and toddlers who did not improve functioning =  $[(\# \text{ of infants and toddlers who did not improve functioning}) \div (\# \text{ of infants and toddlers with IFSPs assessed})] \times 100$ .
  - b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers =  $[(\# \text{ of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers}) \div (\# \text{ of infants and toddlers with IFSPs assessed})] \times 100$ .
  - c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach it =  $[(\# \text{ of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach it}) \div (\# \text{ of infants and toddlers with IFSPs assessed})] \times 100$ .
  - d. Percent of infants and toddlers who improved functioning to reach a level comparable to same-aged peers =  $[(\# \text{ of infants and toddlers who improved functioning to reach a level comparable to same-aged peers}) \div (\# \text{ of infants and toddlers with IFSPs assessed})] \times 100$ .
  - e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers =  $[(\# \text{ of infants and toddlers who maintained functioning at a level comparable to same-})$

aged peers) divided by (# of infants and toddlers with IFSPs assessed)] times 100.

If a + b + c + d + e does not sum to 100%, explain the difference.

- B. Acquisition and use of knowledge and skills (including early language/communication and early literacy):
- a. Percent of infants and toddlers who did not improve functioning = [(# of infants and toddlers who did not improve functioning) divided by (# of infants and toddlers with IFSPs assessed)] times 100.
  - b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers = [(# of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers) divided by (# of infants and toddlers with IFSPs assessed)] times 100.
  - c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach it = [(# of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach it) divided by (# of infants and toddlers with IFSPs assessed)] times 100.
  - d. Percent of infants and toddlers who improved functioning to reach a level comparable to same-aged peers = [(# of infants and toddlers who improved functioning to reach a level comparable to same-aged peers) divided by (# of infants and toddlers with IFSPs assessed)] times 100.
  - e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers = [(# of infants and toddlers who maintained functioning at a level comparable to same-aged peers) divided by (# of infants and toddlers with IFSPs assessed)] times 100.

If a + b + c + d + e does not sum to 100%, explain the difference.

- C. Use of appropriate behaviors to meet their needs:
- a. Percent of infants and toddlers who did not improve functioning =  $[(\# \text{ of infants and toddlers who did not improve functioning}) \div (\# \text{ of infants and toddlers with IFSPs assessed})] \times 100$ .
  - b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers =  $[(\# \text{ of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers}) \div (\# \text{ of infants and toddlers with IFSPs assessed})] \times 100$ .
  - c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach it =  $[(\# \text{ of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach it}) \div (\# \text{ of infants and toddlers with IFSPs assessed})] \times 100$ .
  - d. Percent of infants and toddlers who improved functioning to reach a level comparable to same-aged peers =  $[(\# \text{ of infants and toddlers who improved functioning to reach a level comparable to same-aged peers}) \div (\# \text{ of infants and toddlers with IFSPs assessed})] \times 100$ .
  - e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers =  $[(\# \text{ of infants and toddlers who maintained functioning at a level comparable to same-aged peers}) \div (\# \text{ of infants and toddlers with IFSPs assessed})] \times 100$ .

If  $a + b + c + d + e$  does not sum to 100%, explain the difference.

**Overview of Issue/Description of System or Process:**

In the First Steps Early Intervention Program, evaluations for determining eligibility are completed by teams comprised of two or more of the following: SLPs, PTs, OTs, SIs, and/or early interventionists. These team members are service providers who have a contract with the First Steps program. Entry data for child outcomes is collected after the evaluation and IFSP are completed for each child who is eligible for the First Steps program. The evaluation tools that are used to determine eligibility, in addition to observation and parent or caregiver report, are used to complete the Early Childhood Outcomes Center's Child Outcomes Summary Form (COSF). The evaluation team must complete the COSF on the same day as the evaluation.

After the team determines the COSF ratings, the service coordinator records the ratings in the statewide electronic database. The original copy of the COSF remains in the child's file. Each provider who provides First Steps services is required to have a copy of the COSF.

Within the sixty day period before a child transitions out of the First Steps program, exit COSF ratings must be collected by the primary service provider for each child who received First Steps services for at least six consecutive months. The primary service provider is primarily responsible for collecting the data at exit; however, it is advised to gather progress information from the child's other service providers as well. After the primary service provider has completed the exit COSF, the COSF is given back to the service coordinator. The service coordinator is responsible for recording the ratings and supporting details in the database. If a child transitions out of the program without notice, the primary service provider is required to complete the COSF as soon as notification has been given that the child is no longer in the program.

Exit data reported in this APR is the baseline data. Using the COSF: 7-point version, entry data was collected statewide and child outcome information was summarized for children for whom an initial IFSP was developed between July 1, 2008, and June 30, 2009. Early intervention teams and service coordinators were responsible for completing this process in every health district in FFY 2008. The service coordinators were responsible for ensuring that evaluation team members completed this form at the initial evaluation for all children eligible for the early intervention program. Exit data for FFY 2008 (7/1/2008 - 6/30/2009), was gathered on children exiting the program who had a COSF completed upon entry into the program.

**Procedures/activities/strategies for assessment and measurement of child outcomes:**

- Entry data is collected for infants and toddlers entering the early intervention system whom have an initial IFSP developed within the reporting period (FFY). Teams complete the entry COSF on the day that a child is determined eligible for services.
- Exit will be measured no more than 60 days prior to the child's exit from the early intervention program. Exit data will be collected for infants and toddlers with at least 6 months of consecutive service who are exiting the early intervention system. Mississippi will use the ECO Center definition for "comparable to same-aged peers:" a child who has been scored at a level of 6 or 7 on the COSF.
- Training on measurement of child outcomes; use of the COSF; and related federal and state reporting requirements will be provided to service coordinators and service providers.

**Result Focus**

Mississippi Part C chose Indicator 3C – Child Outcome C: Taking action to meet needs, for its Result Focus. Summary Statement 1: Showed greater than expected growth. Summary Statement 2: Exited the program within age expectations.

To establish procedures on how Mississippi would develop procedures and strategies to improve child outcome, the Result Focus Team, with the assistance of Eric Dickson from the Data Accountability Center (DAC), determined what measurable data and resources were available. The team also established the techniques used to ensure valid data. These resources, strategies, and methods include: Multiple Data Sources (Mississippi FSIS Child Registry, First Steps Child Record, Quality Monitoring, Data Verification Visits) and Data Validation (QM Visits, DATA Aggregation, Analysis for Annual Performance).

Mississippi chose and developed the Result Focus area using the following steps:

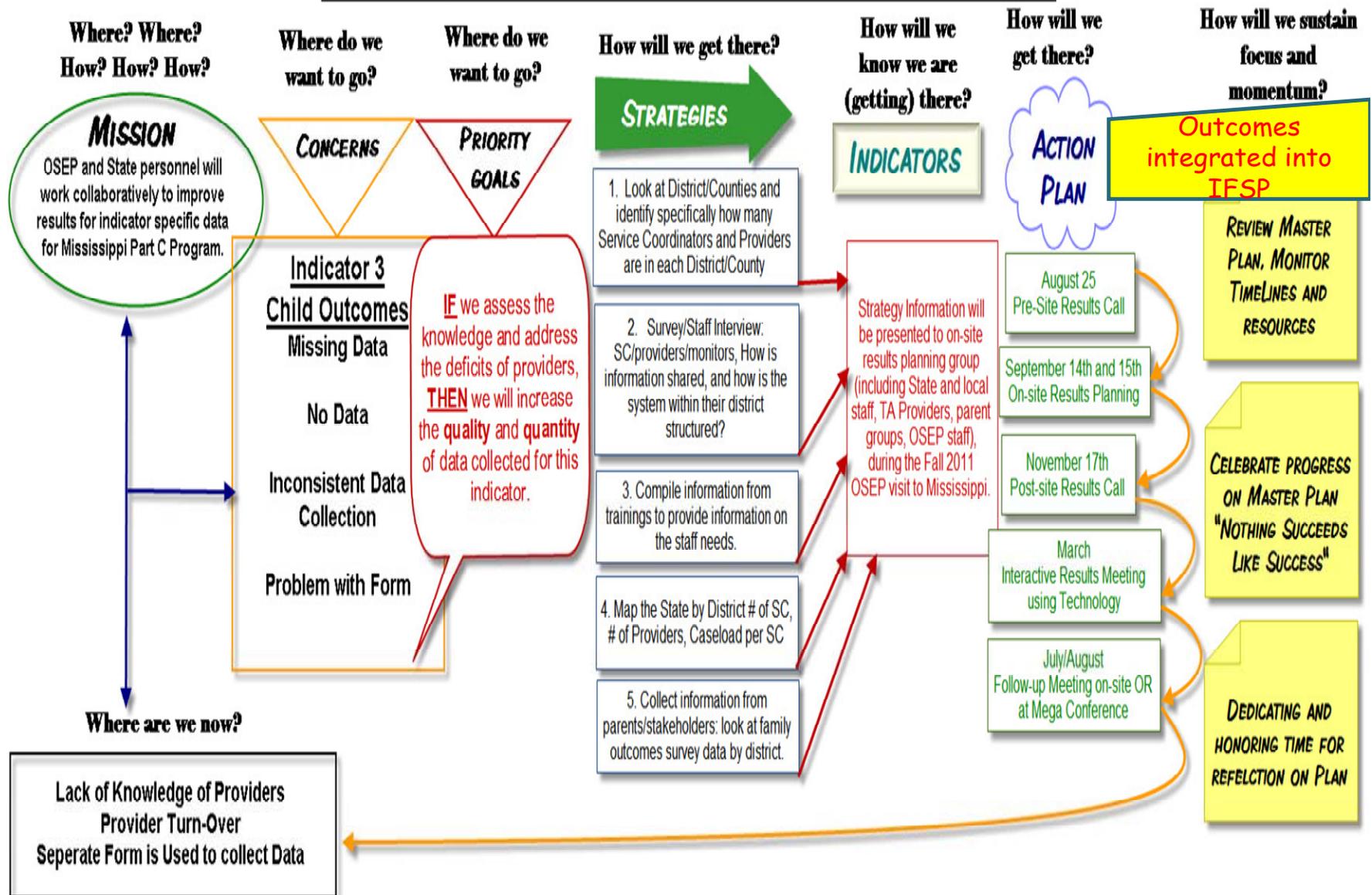
1. A State Interagency Council Committee Board Meeting was held with Grace Kelley (SERRC Consultant) to develop the Result Focus area desired in Mississippi.
2. Once the topic was chosen, a Result Focus Team was established to research and structure procedures and methods to develop the plan.
3. First Steps scheduled a two day training session with Mr. Eric Dickson of the Data Accountability Center (DAC) to assist Mississippi in developing its strategies and procedures. He directed the team to determine, develop, and test its Mississippi's data sources available to carry out the Result Focus chosen. The EIS tested its hypothesis through the SMART process (specific, measurable, accuracy, realistic, timely).
4. The Mississippi team presented a PowerPoint presentation in Washington, DC on August, 2011 for the DAC Focus Result Meeting held with OSEP, SERRC, DAC, and other TA resources.
5. Through extensive discussion and analysis of the Mississippi Early Intervention Program concerns, the team determined its major issues. It was determined that improving the child outcome data was to begin with review of current service providers in the area of service delivery, provider monitoring, fiscal management and handling of provider issues/concerns at the district level.
6. The Result Focus Team members were delegated specific areas from the service provider issues list to research and gather more inclusive information/data to analyze and present at the upcoming OSEP visit for the Result Focus Meeting.
7. An updated Mississippi Result Focus PowerPoint was presented to SICC members and other statewide stakeholders on September 14, 2011 following the OSEP Continuous Improvement visit. During the presentation, SICC members and stakeholders were given the opportunity to assist in identifying issues/barriers and resources available to implement the procedures. Participants were also invited to a Work Group Meeting to be held the following day.
8. The Work Group Meeting on September 15, 2011 was held to create strategies, goals/targets and benchmarks to ensure progress would be made to meet the EIS Result Focus. The three work groups consisted of District Coordinators, Central Office Staff, Mississippi Department of Education Representative, and OSEP staff. Each group worked independently to set up work plans.
9. After review of the work plans, they were consolidated to remove duplicate targets/goals or activities. The revised targets/goals were presented to the District Coordinator/Quality Monitor joint meeting and were assigned to each QM & DC. Target/goal teams were established and strategies/plans with timelines were developed and guidelines on target/goal completed. Progress activities were incorporated in these targets/goals to measure ongoing development and progress.
10. Quarterly reporting on the Result Focus targets/goals will be made to ensure progress activities are occurring to meet benchmarks and also to provide quarterly updates to the SICC board and stakeholders.

Mississippi Result Focus Targets/Goals are:

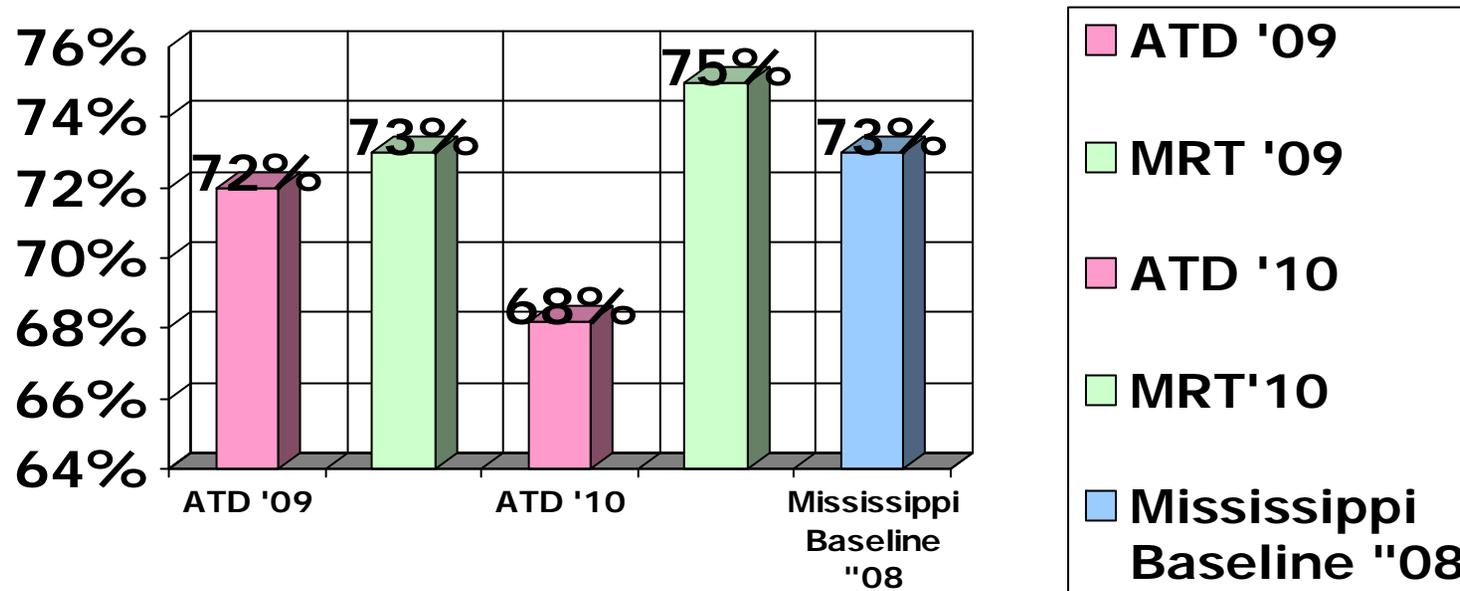
- Increase Service Providers to serve in the Natural Environment
- Connect with colleges to inform students and programs about First Steps
- Increase advertising regarding EI services
- Increase Transition Steps and Services
- Increase Providers use of Assistive Technology through Technology Awareness
- Increase Timely Services
- Increase LEA notification

- Improve State Reliability of Data
- Conduct Child Outcomes Training in Spring 2012
- Educate parents about EI and the benefits of EI for their children
- Increase 45 day timeline

# Mississippi Part C Results Overview Plan 2011



**Accountable:** Mississippi did not meet its target for the last two years.



**Baseline Data for FFY 2008 (2008-2009):**

**Discussion of Baseline Data:**

**Progress Data for Infants and Toddlers Exiting 2008-2009**

A. Positive social-emotional skills (including social relationships):	# of children	% of children
a. Percent of infants and toddlers who did not improve functioning	7	9
b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers	10	13
c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach	9	12
d. Percent of infants and toddlers who improved functioning to reach a level comparable to same-aged peers	47	61
e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers	4	5
Total	N=77	100%
B. Acquisition and use of knowledge and skills (including early language/communication):	# of children	% of children
a. Percent of infants and toddlers who did not improve functioning	7	9
b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers	6	8
c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach	12	15
d. Percent of infants and toddlers who improved functioning to reach a level comparable to same-aged peers	46	60
e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers	6	8
Total	N=77	100%
C. Use of appropriate behaviors to meet their needs:	# of children	% of children
a. Percent of infants and toddlers who did not improve functioning	7	9
b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers	4	5
c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach	10	13
d. Percent of infants and toddlers who improved functioning to reach a level comparable to same-aged peers	46	60
e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers	10	13
Total	N=77	100%

**Baseline Data for Infants and Toddlers Exiting 2008-2009**

<b>Summary Statements</b>	<b>% of children</b>
<b>Outcome A: Positive social-emotional skills (including social relationships)</b>	
1. Of those children who entered or exited the program below age expectations in Outcome A, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	76%
2. The percent of children who were functioning with age expectations in Outcome A by the time they turned 3 years of age or exited the program	66%
<b>Outcome B: Acquisition and use of knowledge and skills (including early language/communication and early literacy)</b>	
1. Of those children who entered or exited the program below age expectation in Outcome B, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	82%
2. The percent of children who were functioning with age expectations in Outcome B by the time they turned 3 years of age or exited the program	68%
<b>Outcome C: Use of appropriate behaviors to meet their needs</b>	
1. Of those children who entered or exited the program below age expectations in Outcome C, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	84%
2. The percent of children who were functioning with age expectations in Outcome C by the time they turned 3 years of age or exited the program	73%

**Discussion of Baseline Data:**

Entry and exit data were collected on seventy-seven children to determine baseline progress data. Seventy-six percent (76%) of children who exited First Steps in FFY 2008 made greater than expected progress in their social relationships while they were enrolled. Eighty-two percent (82%) of children made greater than expected progress in acquiring and using knowledge and skills, including early language/communication. Eighty-four percent (84%) of children made greater than expected progress in taking appropriate actions to meet their needs.

In order to understand why 9% of children for each outcome did not make progress, service coordinators were contacted and the data in the database was reviewed. For Outcomes B and C, this group included children with the most severe disabilities and/or degenerative conditions. For Outcome A, this group included children who had significant developmental delays in all areas of development; one child, who did not receive all necessary services because contact with the family was lost; and one child who moved not being developmentally ready to transition out of the program.

Sixty-six percent (66%) of children who exited First Steps in FFY 2008 were functioning at age expectations in their social relationships by the time they exited the program. Sixty-eight percent (68%) of children were functioning at age expectations in acquiring and using knowledge and skills, including early language/communication at exit. Seventy-three percent (73%) of children were functioning at age expectations in taking appropriate actions to meet their needs at exit.

Technical assistance and training are being provided for new service coordinators, new service providers, and for existing staff and providers, as needed, to refine the procedures for obtaining entry and exit data. In FFY 2009, we expect our exit data to be more representative of the state population receiving early intervention services.

Despite adequate submission of entry data, exit data is lacking. Our baseline exit data does not include many of the children that exited statewide. Factors contributing to the low number of children with exit data include the following: exit ratings not being completed by service providers; exit ratings not entered into the database by service coordinators; failure to implement procedures in a timely manner; lack of understanding of how to correctly rate a child's functioning using the COSF; staff turnover (service coordinators and service providers); lack of resources for evaluations; and limited resources to provide training and technical assistance on the scale required to implement the activities statewide. These barriers will be addressed by conducting a needs assessment to identify particular issues that service providers or service coordinators are having with this process; providing professional development and TA to early intervention teams statewide; and by collaborating with district staff to develop plans to ensure that exit data is collected at the required time and entered in the database in a timely manner. NECTAC and the ECO center staff will provide technical assistance.

FFY	Measurable and Rigorous Target
FFY 2009 FFY 2010 FFY 2011 FFY 2012	Targets for Infants and Toddlers Exiting in FFY 2009 (7/1/2009 to 6/30/2010) , FFY 2010 (7/1/2010 to 6/30/2011), FFY 2011 (7/1/2011 to 6/30/2012), and FFY 2012 (7/1/2012 to 6/30/2013)

Targets for the Summary Statements:	FFY 2009	FFY 2010	FFY 2011	FFY 2012
<b>Outcome A: Positive social-emotional skills (including social relationships)</b>				
Of those children who entered or exited the program below age expectations in Outcome A, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	76%	78%	78%	78%
The percent of children who were functioning with age expectations in Outcome A by the time they turned 3 years of age or exited the program	66%	68%	68%	68%
<b>Outcome B: Acquisition and use of knowledge and skills (including early language/communication and early literacy)</b>				
Of those children who entered or exited the program below age expectations in Outcome B, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	82%	84%	84%	84%
The percent of children who were functioning with age expectations in Outcome B by the time they turned 3 years of age or exited the program	68%	70%	70%	70%
<b>Outcome C: Use of appropriate behaviors to meet their needs</b>				
Of those children who entered or exited the program below age expectations in Outcome C, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	84%	86%	86%	86%
The percent of children who were functioning with age expectations in Outcome C by the time they turned 3 years of age or exited the program	73%	75%	75%	75%

**Improvement Activities/Timelines/Resources:**

**Activities to commence in FFY 2005 (2005-2006):**

Entry data were collected statewide and child outcome information was summarized for 15 children who were referred to the Early Intervention Program and had an initial IFSP developed between July 1, 2005,

and June 30, 2006. The entry status data were based on information gathered at the initial evaluation for eligibility to the Part C early intervention program. That information was completed using the 7 point Child Outcome Summary Form (COSF) developed by the Early Childhood Outcome Center. Due to the limited participation by the local programs in collecting entry measurement of infants and toddlers with IFSPs, changes were made in how this process was phased in throughout the state for the following year. The modified process diverts some of the responsibility from the Service Coordinators while allowing existing providers to take a bigger role in gathering the information needed to measure outcomes.

**Activities to commence in FFY 2006 (2006-2007):**

Using the Early Childhood Outcomes Center Child Outcomes Summary Form: 7-point version, entry data will be collected statewide and child outcome information summarized for children referred to the Early Intervention Program with an initial IFSP developed between July 1, 2006, and June 30, 2007. The Service Coordinator will forward copies of test protocols and evaluation/assessment reports to the Central Office. Personnel with a developmental background will review these documents and complete an Early Childhood Outcome Center 7-point Child Outcome Summary Form. Entry data will be entered into a spreadsheet maintained by Central Office staff.

**Revisions, with Justification, to Proposed Targets / Improvement Activities / Timelines / Resources for FFY 2008 (2008-2009), FFY 2009 (2009-2010), FFY2010 (2010-2011), FFY 2011 (2011-2012), and FFY 2012 (2012-2013):**

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Database Changes</b>				
A	1. In FFY 2006, entry/exit data was entered into a spreadsheet maintained by Central Office staff. In FFY 2008, test fields were added to the database. In FFY 2009, district staff were given the responsibility to enter this data. This effort will continue in FFY 2011.	FFY 2006 through FFY 2012	District staff C.O. staff	New in FFY 2006 Continued in FFY 2007 Revised in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	District staff are responsible for entering data. This is more efficient than sending the Child Outcome form to Central Office.
A	2. In FFY 2008, reports were developed for health districts to use for self check to determine data that have not been entered in the database. These reports will continue in FFY 2011	FFY 2009 through FFY 2012	District staff C.O. staff	New in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The new reports allow for more efficient data review.
	<b>Collection of Data</b>				
A	1. In FFY 2006, service providers began gathering the information needed to measure child outcomes. In FFY 2007, entry data were collected statewide and child outcome information summarized for children referred to the EIS with an initial IFSP developed between July 1, 2006, and June 30, 2007. The SC forwarded copies of test protocols and evaluation/assessment reports to the Central Office. Personnel with a developmental background reviewed these documents and completed a COSF. Entry data was entered into a spreadsheet maintained by Central Office staff.  In FFY 2007, four health districts received COSF training and assumed the responsibility of gathering the entry and exit data. In FFY 2008, the remaining five health districts received COSF training and assumed	FFY 2006 through FFY 2012	Service Providers C.O. staff District staff	New in FFY 2006 Revised in FFY 2007 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Since each health district continues to train staff and providers, the data in the FFY 2010 APR data represents the population receiving early intervention services. Training/TA for new staff and providers will be a continuous and mandatory process to maintain the data requirements for this indicator and to continue

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<p>the responsibility of gathering the entry and exit data. Training on the child outcome process and reporting on child outcomes was provided for new providers and new service coordinators.</p> <p>Training/TA was provided as needed in FFY 2010. Training and TA will continue to be provided in FFY 2011, as needed.</p>				to measure improved child outcomes.
A	<p>2. In FFY 2007, exit data was gathered for children in four health districts after they received COSF training. In FFY 2008, exit data were gathered in the four health districts who received COSF training in FFY 2007 and in the remaining five health districts after they received COSF training. In FFY 2009, child outcomes entry data and exit data were collected in all nine health districts. Child outcome entry and exit data will continue to be collected in all nine health districts.</p>	FFY 2007 through FFY 2012	Service Providers District staff	<p>New in FFY 2007</p> <p>Continued in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	Data collection will result in entry/exit data that represent the early intervention population served in this state.
<b>Training and Technical Assistance</b>					
A, C, D	<p>1. In FFY 2008 and FFY 2009, training/technical assistance was provided for evaluation teams and service providers to measure entry and/or progress levels of a child's development. This training and technical assistance will continue.</p>	FFY 2008 through FFY 2012	District staff C.O. staff	<p>New in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	This practice will continue to maintain the structure needed to measure child outcomes.
A, C, D	<p>2. In FFY 2008, quality monitors began checking for completeness of the outcome data as part of data verifications. In FFY 2009, this process was continued. Observations of the process were done as indicated. This process will continue and it will become a part of general supervision through data reviews.</p>	FFY 2008 through FFY 2012	C.O. staff	<p>New in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	This practice will continue to maintain the structure needed to measure child outcomes.
A, H	<p>3. In FFY 2008, evaluation of data was used to make adjustments needed to the improvement activities. In FFY 2009, the data were used for both reporting</p>	FFY 2008 through	Service Providers District staff	<p>New in FFY 2008</p> <p>Continued in FFY 2009</p>	This practice will result in effective measurement and improved child

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	purposes and making adjustments in the improvement activities. This effort will continue.	FFY 2012	C.O. staff NECTAC & ECO Center	Continued in FFY 2010 Continuing in FFY 2011	outcomes.
A, C, D, F, J	4. Evaluation tool training (i.e., IDA, DP III, HELP, Sensory Profile, E-LAP) was held in FFY 2009 (January 19-21, 2010), in Oxford, Jackson, and Hattiesburg. These trainings are now being provided in a digital format.	FFY 2009 through FFY 2012	C.O. staff	New in FFY 2009 Continued in FFY 2010 Revised in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Improved child outcome measurement is expected.
A, B, C,D	5. In FFY 2010, district staff were given tablet PCs and portable printers to facilitate paperwork and service coordination. Training was done on the new IFSP, which included service coordinators and providers. The new IFSP includes the outcome information within the IFSP document that will eliminate any confusion about rating child outcomes or identifying present levels of development.	FFY 2010 through FFY 2012	District staff	New in FFY 2010 Continuing in FFY 2011	Expected impact includes effective service coordination, user-friendly data entry and more child outcome data developed and entered into database.
	<b>Policies and Procedures</b>				
E	1. In FFY 2007, revisions in the service coordinator manual mainly involved IFSP directions. This included an emphasis on use of informed clinical opinion in determining eligibility and making recommendations for services. Revisions also included changes in forms. In FFY 2008, the IFSP instructions were revised to include more details where clarification was needed. In FFY 2010, revisions were made to the present IFSP to include reporting of Child Outcomes entry/exit data and present levels of development.	FFY 2006 through FFY 2012	C.O. staff	Revised in FFY 2007 Revised in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Results include an increase in eligibility determinations and continued improvements to the service coordinator manual.

**Activities to commence in FFY 2013 (2013-2014):**

In FY 2010 (2010-2011) utilizing the procedures/activities/strategies outlined above, entry and progress data will be gathered on all children meeting the entry and exit criteria described above. Technical Assistance for measuring child outcomes will be provided for all Early Intervention Programs/IFSP teams. Quality assurance and monitoring procedures will be implemented to ensure the accuracy and completeness of the outcome data. Evaluation of the 2009 data will determine whether adjustments are needed in the activities.

**Resources for Activities and Persons Responsible/Accountable:**

Please refer to the resources for Indicator 1, unless otherwise specified.

## Mississippi's Part C State Performance Plan for 2005-2012

### Monitoring Priority: Early Intervention Services In Natural Environments

**Indicator 4:** Percent of families participating in Part C who report that early intervention services have helped the family:

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

(20 USC 1416(a)(3)(A) and 1442)

#### Measurement:

- A. Percent = # of respondent families participating in Part C who report that early intervention services have helped the family know their rights divided by the # of respondent families participating in Part C times 100.
- B. Percent = # of respondent families participating in Part C who report that early intervention services have helped the family effectively communicate their children's needs divided by the # of respondent families participating in Part C times 100.
- C. Percent = # of respondent families participating in Part C who report that early intervention services have helped the family help their children develop and learn divided by the # of respondent families participating in Part C times 100.

#### Overview of the System including changes made in 2006:

First Steps is a program that matches the unique needs of infants and toddlers who have developmental delays with the professional resources available within the community system. Information about family concerns, priorities, and resources is obtained during the initial interview (intake) with the family using the developmental history/family assessment. Families are asked to identify their child's routines, likes, and dislikes; the family's preferred activities; family supports; and siblings' needs. The service coordinator must complete the family assessment form with the family's consent during the intake. The information recorded must be written in a manner that is acceptable to the family for sharing with other early intervention providers. The service coordinator records the family's concerns, priorities, resources and routines on the first page of the IFSP during enrollment.

The Infant/Toddler and Family Rights document is presented to all families at the time of initial intake and with every Written Prior Notice (WPN). A WPN is required when there is an evaluation; an IFSP meeting (including any reviews or annual updates); a transition meeting; a change of agency providing a service; a change of service coordinators; or a change of the child's goals, frequency, duration, or place of service. Families must have multiple opportunities to be informed of their rights. During enrollment, the service coordinator explains due process to the parent using all current documents associated with due process: First Steps Early Intervention Program Complaint Process form, Written Prior Notice, Part C Complaint form, Infant/Toddler and Family Rights, and the Advocacy and Support Information. Parents are given the Part B Procedural Safeguards at the transition meeting.

District monitoring processes include review of the required forms completed in the case file and documentation of dissemination of the Infant/Toddler and Family Rights due process documents as required.

The following activities recommended by the First Steps stakeholder group and additional stakeholders were completed:

1. Use the Early Childhood Outcomes Center Family Outcomes Survey or a similar survey.
2. Maintain consistency statewide in the packets given to parents. The 8/31/2007 revision of the Infant/Toddler and Family Rights document includes their rights, a glossary, the Complaint Process form, a Part C Complaint form, and the Advocacy and Support Information Give parents the following:
  - a. the state toll-free number is in the Infant/Toddler and Family Rights document ; and
  - b. The Complaint Process form has a description of mediation and due process hearing procedures (including who to call and where to write to request relief).
3. The glossary contains clearly define terms used in the provision of EI services.
4. Make all information accessible to all parents (e.g. Braille, written or spoken in the primary language spoken by the parent/guardian, in a format accessible to text readers, an audio file, or sign language).
5. The information necessary for making informal complaints, written signed complaints, requests for mediation, and requesting for due process hearings is included in the Infant/Toddler and Family Rights document.

The following new activity incorporates the stakeholder recommendations and serves to facilitate communication. Communication notebooks were assembled at the statewide meeting on November 1-2, 2006. These notebooks provide a means by which to record and share important information among the caregivers and service providers. The notebooks contain a calendar on which to record service delivery and other important information; the IFSP and subsequent revisions; due process documents and an advocacy list; information about typical development, and other information added to address the unique needs of the child and family. These notebooks are being distributed to new families at the initial IFSP meeting.

The following activities recommended by the First Steps stakeholder group and additional stakeholders are ongoing:

1. Give families the revised Infant/Toddler and Family Rights document. Explain their rights and give them the opportunity to ask questions.

The following activities recommended by the First Steps stakeholder group and additional stakeholders remain:

1. Maintain consistency statewide in the packets given to parents. Give parents the following:
  - a. an ABC process for parents to advocate for their child and
  - b. a description of the responsibilities of all personnel involved in service delivery.
2. Revise the Policies and Procedures and the Infant/Toddler and Family Rights document to address changes in IDEA'04 when the final regulations are available.

The following activity recommended by the First Steps stakeholder group and additional stakeholders was revised. There is no longer a two-page summary of the Family Rights. Parents are given the Notice of Infant/Toddler and Family Rights document, which covers all aspects of due process and provides contact information, and the First Steps Early Intervention Program Complaint Process form, which briefly describes available options when problems arise.

#### **Description of Measurement Strategies Mississippi will use:**

Mississippi's Part C system will attempt to collect information from every family transitioning from First Steps using the Early Childhood Outcomes Center Family Outcomes Survey. The tool will be presented to each family once a year in November. It will be sent to families with a cover letter explaining the purpose of the survey and instructions. Included in the cover letter will be phone numbers and an email address for the families to use if they have questions, concerns, or problems completing the survey. The survey will be presented to families by parent advisors or other trained non-district personnel as a hard

copy in English or Spanish, or presented verbally if needed in another language or via other primary modes of communication (e.g., interpreter) described above. Families will have the option of completing the survey with the parent advisor or independently. The survey will be returned to the First Steps central office in a stamped/self-addressed envelope. Data entry will be accomplished through a scanning process. Future considerations will include contracting with an outside entity to distribute the surveys in a manner accessible to all our parents, and to collect and analyze applicable data.

Data will be reported to OSEP only from surveys completed by families whose children were enrolled for more than six (6) months in First Steps. Survey results from families of children referred to First Steps after 30 months of age or who receive early intervention for less than six months will not be included in the data reported to OSEP, although the data may be used to satisfy other in-state reporting requirements and for monitoring and program improvement activities.

*Who will be included in the measurement?*

The Family Outcomes Survey will be presented to every family whose child or children are currently enrolled in First Steps and have an IFSP. These families will be asked to participate in the measurement of family outcomes.

*What tool(s) will be used?*

Mississippi's Part C system will use the Early Childhood Outcomes Center Family Outcomes Survey. In FFY 2010, the ECO Family Outcomes Survey-Revised: Part C (2010) will be used in place of the original version.

*How will the tool be presented to families? By whom?*

In trainings involving families, present the purpose and results of the survey. The survey will be sent to families with a cover letter explaining the purpose of the survey and instructions. It will be presented in the format needed by the parent/guardian (e.g. Braille, written or spoken in the primary language spoken by the parent/guardian, in a format accessible to text readers, an audio file, or sign language). The person presenting the survey will explain how the participant's confidentiality will be protected to allow the participant to provide the requested information without any fear of repercussions. Results of this survey will be reported at a state level and at a health district level, if this possible while protecting the confidentiality of the respondents.

*When will the measurement occur?*

Measurement will occur in November of each year.

*Who will report data to whom, in what form, and how often?*

Surveys will be returned directly to the First Steps Central Office in stamped/self-addressed envelopes. If district staff or providers are handed a complete survey, they will send it directly to the Central Office. A unique identifying number is assigned to each child to allow comparisons to be made when parents/guardians complete this survey in the future. Aggregate data reports will be generated annually. Data will be reported to OSEP annually in the Annual Performance Report. Reports to OSEP will include data from surveys completed by families whose children were enrolled for more than six (6) months in First Steps. Survey results from families of children referred to First Steps after 30 months of age or who receive early intervention for less than six months will not be included in the data reported to OSEP but may be used to satisfy other in-state reporting requirements and for monitoring and program improvement activities.

*What are the timelines for implementation of data collection and reporting?*

Mississippi's initial baseline data collection occurred in December, 2006, and January, 2007. The survey will be conducted annually in February. Measurable and rigorous targets, improvement strategies, timelines, and resources will be reported to OSEP in the Annual Performance Report due annually in February.

**Description of Sampling Methodology (if applicable):**

Not applicable. Mississippi's Part C system will not use sampling to collect data for Indicator #4.

### **Baseline Data for FFY 2005 (2005-2006)**

Percent of families participating in Part C who report that early intervention services have helped the family:

- |  |     |
|--|-----|
| A. Know their rights:                              | 80% |
| B. Effectively communicate their children's needs: | 81% |
| C. Help their children develop and learn:          | 82% |

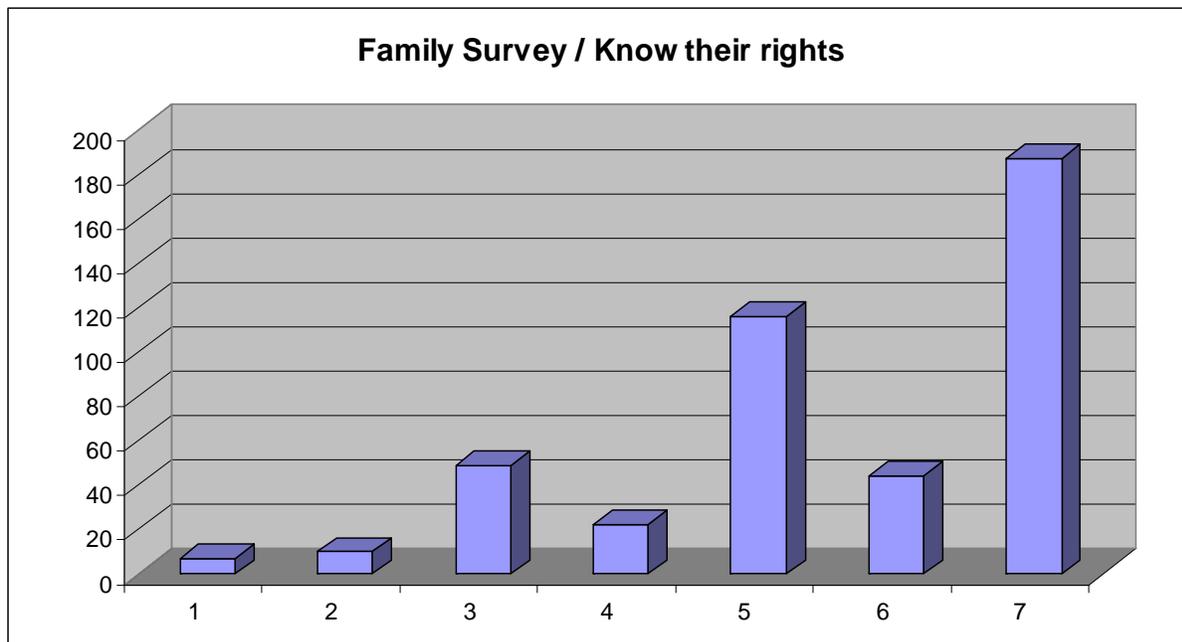
### **Discussion of Baseline Data:**

The following charts and tables contain responses to the items of the survey directly measuring the percent of families participating in Part C who report that early intervention services have helped the family: know their rights; effectively communicate their children's needs; and help their children develop and learn. The results include the number of responses for each point on the likert scale presented both numerically and in a graph, the percentage for each point on the scale, and the percentage of responses within the interval considered to be a positive response. A positive response is defined as a response within the interval of 5, 6, and 7 on the likert scale.

The ECO Family Outcomes Survey (7-point scale) was utilized. (See attached Survey.) Questions 16, 17, 18 correspond to A, B, and C of this Indicator. All other responses on the survey were calculated to assist the program in analyzing training and technical assistance needs. Answers of 5-7 were considered to meet the criteria for "helped the family." Approximately 26% of the 1650 surveys mailed were returned in a format that allowed for calculation of results. This return rate is considered to be adequate. See attached chart for a breakdown of the data by districts and for the state, including raw numbers used in the numerator and denominator for calculating percentages. Completed surveys were tabulated using a scannable form. Surveys that were left blank or were marked with multiple answers for each question were not included in the final results (<10).

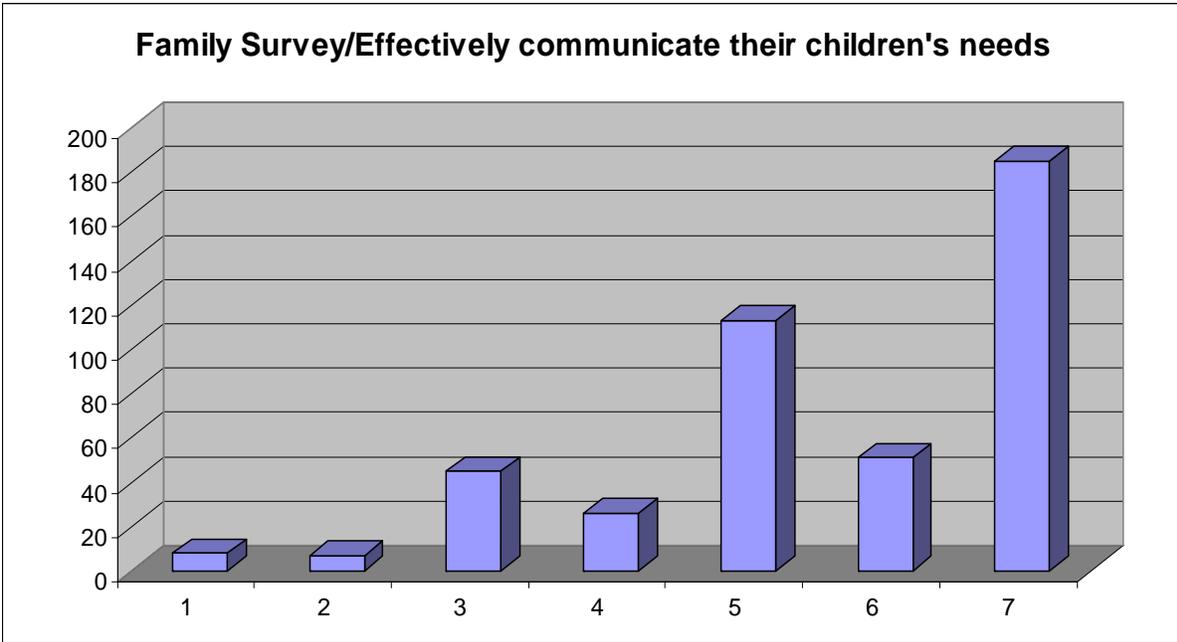
Seventy-six percent (76%) of families out of 1371 received their services on time or were late because of child and family circumstances. Of the 435 families who returned the survey, 80 to 82 % indicated that early intervention helped them know their rights, effectively communicate their children's needs, and help their children develop and learn. The following charts and tables are the results for each part of the indicator by health district.

Health District	# Surveys Sent	% Surveys Sent	# Surveys Returned	% Surveys Returned
I	205	12.18	51	11.72
II	198	11.76	50	11.49
III	177	10.52	52	11.95
IV	126	7.49	25	5.75
V	241	14.32	58	13.33
VI	174	10.34	39	8.97
VII	98	5.82	22	5.06
VIII	201	11.94	59	13.56
IX	263	15.63	63	14.48
ID # blank	0	0	16	3.68
State	1683		435	



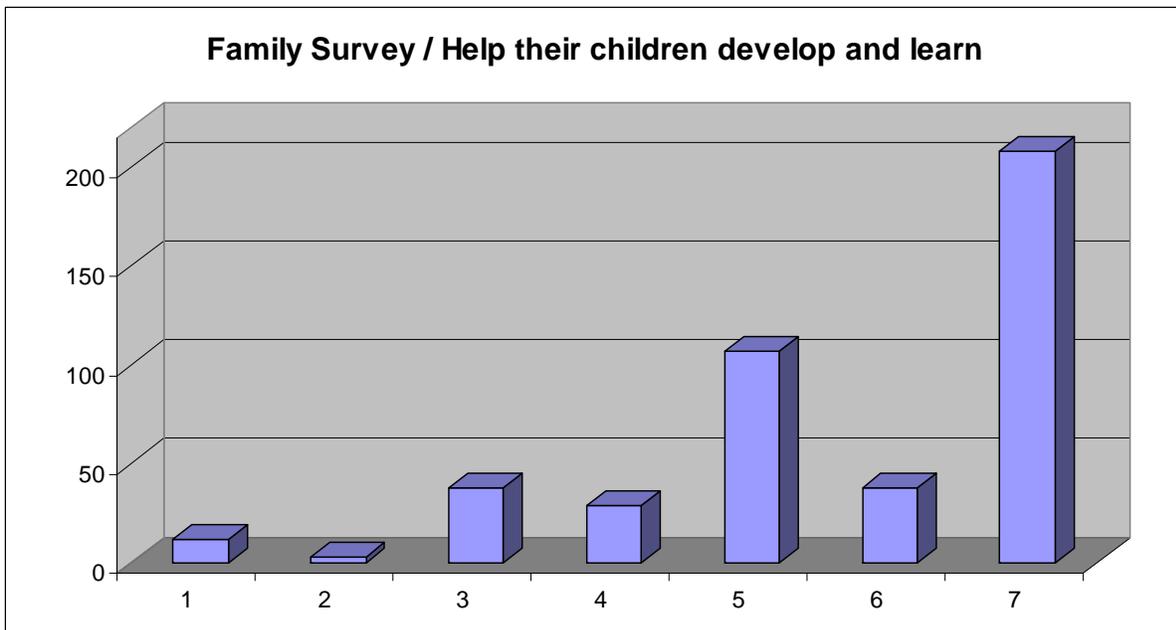
Question 16: To what extent has early intervention helped your family know and understand your rights? Eighty percent (80%) of the returned surveys included a rating of 5, 6, or 7 on this item.

1	2	3	4	5	6	7	Tot:
7	10	49	22	116	44	187	43
1.61%	2.30%	11.26%	5.06%	26.67%	10.11%	42.99%	



Question 17: To what extent has early intervention helped your family effectively communicate your child's needs? Eighty percent (81%) of the returned surveys included a rating of 5, 6, or 7 on this item.

1	2	3	4	5	6	7	Total
8	7	45	26	113	51	185	435
1.84%	1.61%	10.34%	5.98%	25.98%	11.72%	42.53%	



Question 18: To what extent has early intervention helped your family be able to help your child develop and learn? Eighty-one percent (82%) of the returned surveys included a rating of 5, 6, or 7 on this item.

1	2	3	4	5	6	7	Total
12	3	38	29	107	38	208	435
2.76%	0.69%	8.74%	6.67%	24.60%	8.74%	47.82%	

FFY	Measurable and Rigorous Target	
	Percent of families participating in Part C who report that early intervention services have helped the family	<b>Target</b>
<b>2006</b> (2006-2007)	A. Know their rights B. Effectively communicate their children's needs: C. Help their children develop and learn:	83% 84% 85%
<b>2007</b> (2007-2008)	A. Know their rights: B. Effectively communicate their children's needs: C. Help their children develop and learn:	86% 87% 87%
<b>2008</b> (2008-2009)	A. Know their rights: B. Effectively communicate their children's needs: C. Help their children develop and learn:	89% 89% 90%
<b>2009</b> (2009-2010)	A. Know their rights: B. Effectively communicate their children's needs: C. Help their children develop and learn:	92% 92% 92%
<b>2010</b> (2010-2011)	A. Know their rights: B. Effectively communicate their children's needs: C. Help their children develop and learn:	95% 95% 95%
<b>2011</b> (2011-2012)	A. Know their rights: B. Effectively communicate their children's needs: C. Help their children develop and learn:	95% 95% 95%
<b>2012</b> (2012-2013)	A. Know their rights: B. Effectively communicate their children's needs: C. Help their children develop and learn:	95% 95% 95%

**Improvement Activities/Timelines/Resources:**

**Activities to commence in the second half of FFY 2005 (2005-2006)**

1. Provide training and technical assistance on:
  - a. the purpose of collecting this information;
  - b. Parental Rights (for district personnel, service providers, parents and other stakeholders);
  - c. effective service coordination, IFSP development and provision of services to families; and
  - d. appropriate practices that are responsive to diverse cultures.
2. Revise the Policies and Procedures and the Infant/Toddler and Family Rights document to address changes in IDEA'04.
3. Maintain consistency statewide in the packets given to parents. Include the following:

- a. an ABC process for parents to advocate for their child;
  - b. a description of the responsibilities of all personnel involved in service delivery;
  - c. the state toll-free number; and
  - d. a description of mediation and due process hearing procedures (including who to call and where to write).
4. Clearly define all terms contained in parent information materials.
  5. Make all information accessible to all parents (e.g. Braille, written or spoken in the primary language spoken by the parent/guardian, in a format accessible to text readers, an audio file, or sign language).
  6. Revise the FSIS to include data fields for collection and entry of family outcome data elements. The results of individual surveys will not be accessible at the district level. The revisions will include built-in verification and edit functions to prevent avoidable errors.
  7. Facilitate gathering of the family outcome data by:
    - a. Distributing the survey through parent advisors or other trained non-district personnel and using a stamped/self-addressed envelope to return the survey to the First Steps Central office to allay fears that negative ratings will affect services.
    - b. Generating quarterly reports to indicate the number of parents of children within 30 days of transition selecting each potential rating for the five family outcomes. Number of families responding will be compared to number of children who transition from the First Steps system during the same period of time to ensure appropriate implementation and application of this new data collection requirement.
    - c. Making quality assurance calls to districts with low numbers of responses to the Family Outcomes Survey relative to numbers of transitioning children. The purpose of the calls will be to determine reasons for low response rates.
    - d. Providing technical assistance and support as appropriate to address any identified areas of need within district programs.
    - e. Assigning unique ID numbers to each child for purposes of this survey. The number will be placed on both the pre- and post- surveys to allow for the tabulation of the difference between initial and end results. This information will be used to determine training needs.
    - f. Collecting the data used for this indicator in a manner that protects the respondent's identity. This will allow the parent/guardian to respond without concern for how the responses may impact relationships with the service coordinator and other service providers.

**Activities to commence in FFY 2006 (2006-2007)**

1. Provide training and technical assistance on:
  - a. the purpose of collecting this information;
  - b. Parental Rights (for district personnel, service providers, parents and other stakeholders);
  - c. effective service coordination, IFSP development and provision of services to families;
  - d. effective use of the communication notebooks; and
  - e. appropriate practices that are responsive to diverse cultures.

2. When the final Part C regulations are released, revise the Policies and Procedures and the Infant/Toddler and Family Rights document to address changes in IDEA'04.
3. Give communication notebooks to the families of all children at the initial IFSP meeting. The notebook will contain the following materials once they are available:
  - a. An ABC process for parents to advocate for their child;
  - b. An information sheet containing a description of the responsibilities of all personnel involved in service delivery;
  - c. Clear definitions for all terms contained in parent information materials.
  - d. Materials from a compilation of materials already developed and in use in the health districts when appropriate for the family.
4. Continue to make all information accessible to all parents (e.g. Braille, written or spoken in the primary language spoken by the parent/guardian, in a format accessible to text readers, an audio file, or sign language).
5. Revise the FSIS to include data fields for collection and entry of family outcome data elements. The revisions will include built-in verification and edit functions to prevent avoidable errors.
6. Facilitate gathering of the family outcome data by:
  - a. Presenting the purpose and results of the survey in trainings involving families.
  - b. Generating annual reports of the survey results at the state level and the local level, if possible while protecting the confidentiality of the respondents.
  - c. Making quality assurance calls to districts with low numbers of responses to the Family Outcomes Survey. The purpose of the calls will be to determine reasons for low response rates.
  - d. Providing technical assistance and support as appropriate to address any identified areas of need within district programs.
  - e. Collecting the data used for this indicator in a manner that protects the respondent's identity.
  - f. Exploring the possibility of giving the parents the choice to respond electronically, by fax or by phone.
  - g. Exploring means of generating the unique identifying number on each page of the survey to eliminate errors resulting from manually copying the code.

**Revisions, with Justification, to Proposed Targets / Improvement Activities / Timelines / Resources for FFY 2008 (2008-2009), FFY 2009 (2009-2010), FFY2010 (2010-2011), FFY 2011 (2011-2012), and FFY 2012 (2012-2013):**

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Training and technical assistance</b>				
C	1. In FFY 2006, parents, staff, and other stakeholders were given the requirements of collecting family outcomes information. Since FFY 2006, the requirements of the survey are explained each year in a cover letter that accompanies the family survey. The effectiveness of this method will be reviewed and revised, as needed. In FFY 2010, a new Family Survey was implemented.	FFY 2005 through FFY 2012	C.O. staff	Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Revised in FFY 2009 Revised in FFY 2010 Continuing in FFY 2011	There has been an increase of return rate due to ongoing training of this procedure.  A new form was adopted that should be more family friendly to increase survey return.
C	2. Since FFY 2006, training on parental rights (for district personnel, service providers, parents and other stakeholders) has been provided. In FFY 2007, the Service Coordinators began using the Complaint Process form to explain this procedure to parents/caregivers. Service Coordinator were trained to provide this information to families. In FFY 2011, opportunities for parents to receive additional training on their rights and related issues will continue to be increased through collaboration with the Mississippi Parent Training and Information Center (MSPTI) and advocacy groups.	FFY 2006 through FFY 2012	C.O. staff	Continued in FFY 2006 Revised in FFY 2007 Continued in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The expected impact is increasing parents' knowledge of their rights and comfort levels in exercising their rights.
C	1. In FFY 2006, a new service coordinator training was developed. In FFY 2007, these three days sessions were shortened to two days to prevent delays in service coordination. The main content on the third day was IFSP development. IFSP training and follow-up are now provided within the health	FFY 2006 through FFY 2012	C.O. staff	New in FFY 2006 Revised in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010	The revised format is well accepted and continues to be used to enhance service coordination.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<p>district.</p> <p>In FFY 2011 the IFSP was revised, approved and implemented on October 1, 2011. Statewide Service Coordinator and Service Provider training were completed in October 2011 on the new form.</p>			Continuing in FFY 2011	
C	<p>4. In FFY 2008, appropriate practices that are responsive to diverse cultures were included in service provider and service coordinator training. In FFY 2009, more emphasis was placed on addressing these practices.</p>	FFY 2005 through FFY 2012	C.O. staff	<p>New in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	<p>Better rapport with families and improved child/family outcomes were the results of these practices.</p>
C, D	<p>5. In FFY 2008, emphasis was placed on increasing service coordinators', parent advisors', and parents' awareness of advocacy resources. This was done through technical assistance and by encouraging health districts to request training offered by the Mississippi Parent Training and Information Center (MSPTI). Training on advocacy skills for parents and guardians was offered in several health districts by staff from the MSPTI.</p> <p>Since FFY 2008, information about training opportunities offered by MSPTI has been given to district staff for parents. Current training opportunities offered by the MSPTI include onsite training, TA, and webinars.</p> <p>In FFY 2009, the MSPTI and advocacy groups within the state were utilized to provide training to parents, service coordinators and parent advisors. This served to enhance our parents' advocacy skills. The training took place in at least one location in FFY 2009 and continued in FFY 2010.</p> <p>In FFY 2011, MSPTI and First Steps will develop a family guide to early intervention in Mississippi and</p>	FFY 2008 through FFY 2012	C.O staff MSPTI advocacy groups District staff	<p>New in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Revised in FFY 2011</p>	<p>The expected impact is increasing parents' knowledge of their rights and comfort level in exercising their rights.</p> <p>Service coordinators and parent advisors will learn how to better inform and empower parents.</p>

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	incorporate the assistance of MSPTI in the family survey process to assist with assuring all EI families understand the survey and how to accurately answer the questions.				
A	6. In FFY 2007, forms and documents used by the service coordinators to explain due process and complaint procedures to families were included in Infant/Toddler and Family Rights document.	FFY 2007 through FFY 2012	District staff	Completed in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	These documents continue to be disseminated to families to explain the complaint process.
A	7. In FFY 2011, Parent Surveys will be hand delivered to parents by Service Coordinators in an attempt to improve the return rate. Interpreters will be accessed to assist families that use a language other than English. We are establishing a contact for the American Indian families.	FFY 2011 through FFY 2012	C.O. staff District staff	New in FFY 2011	There has been a low percentage of returned surveys. This is an attempt to improve the return rate and have SCs explain how important it is for families to complete and return these surveys..
C, D	9. MSPTI will review identified issues related to low responses from minority groups.	FFY 2011 through FFY 2012	MSPTI	New in FFY 2011	This will increase response rates from minority groups.
<b>Analysis of the Survey Results</b>					
A, F	1. In FFY 2009, we analyzed results by demographics in far greater detail than reported in the 2007 APR to help identify factors contributing to low response rates in population subgroups and to facilitate program improvement. In FFY 2010, a student at Millsaps College and staff continued to assist in this project.	FFY 2008 through FFY 2010	C.O. staff	New in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The impact of Millsaps College involvement is expected to significantly improve data analysis and our activities for program improvement in regards to family

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
					outcomes.
A, F	2. In FFY 2008, we planned to investigate and address factors contributing to the lower than expected survey response rates for the Black or African American and White population subgroups. In FFY 2009, this activity was a priority. A low response rate from our Hispanic population warranted investigation in addition to the other subgroups. In FFY 2010, a student at Millsaps College and staff assisted in this project. In FFY 2011, Spanish interpreters will be used to assist with survey delivery.	FFY 2008 through FFY 2010	C.O. staff District staff	New in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The impact of Millsaps College involvement is expected to significantly improve data analysis and development of improvement activities for program improvement in regards to family outcomes.
A,F	3. In FFY 2007, a "Comment" section was added to the end of the family survey. In FFY 2009, the information given by respondents in the "Comment" section at the end of the survey was to improve the program.	FFY 2009 through FFY 2012	C.O. staff	New in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This information will continue to be used for additional program improvement.
	<b>Policies and Procedures:</b>				
E	1. Due to new regulations, policies and procedures will be revised.	FFY 2011 through FFY 2012	C.O. staff	New in FFY 2011	Expected impact is program improvement.
F	2. In FFY 2007, the Infant/Toddler and Family Rights (I/T & Family Rights) document was put in a parent-friendly format and language. The complaint process form, with directions, a glossary, and a list of resources were put in a single document a new	FFY 2005 through FFY 2012	C.O. staff	Revised in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010	This document continues to be disseminated and explained to families during the enrollment process. This new parent

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	Parent Survey developed by ECO was distributed to families.			Continuing in FFY 2011	survey should give better explanation and answers to questions posed to families and increase the response rate.
F	3. In FFY 2006, there was an effort to make the basic contents of packets given to parents the same. This activity was revised in FFY 2007, to allow district personnel to decide what to include in the packet beyond the I/T & Family Rights document. In FFY 2008, district staff continued to decide what to include beyond the I/T & Family Rights document. In FFY 2009, resources found to be effective in certain health districts were made available in the other health districts. In FFY 2010, resources were available upon request.	FFY 2005 through FFY 2012	District staff	New in FFY 2006 Revised in FFY 2007 Continued in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The expected result is to make our best resources available to all of our parents.
F	4. In FFY 2007, an activity was developed to define all EIS terms contained in the parent information materials. This glossary is included in the I/T and Family Rights document.	FFY 2005 through FFY 2012	C.O. staff	Revised in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This document continues to be disseminated to families during the enrollment process.
F	5. In FFY 2006, there was a renewed effort to translate information to all parents when needed. Translating the I/T and Family Rights and the forms in Spanish were the most recent requests. In FFY 2009, the I/T and Family Rights were translated into Spanish. Interpreters are accessible to families, as needed, in order to assist with reviewing this document.	FFY 2005 through FFY 2012	C.O. staff District staff	Revised in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Increased access to information will improve rapport with parents, increase their involvement and empowerment to advocate for their

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
					children.
F	6. In FFY 2009, the mail out of the Family Outcome Survey was rescheduled to February. This activity was continued in FFY 2010.	FFY 2009 through FFY 2012	C. O. staff	New in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	An increase in the response rate is expected. This change will allow improvement activities directly tied to the survey mail out to be implemented in February rather than waiting until November.
A, B, C, D	7. In FFY 2010, district staff will begin using tablet PCs and portable printers to facilitate paperwork and service coordination. In FFY 2011, all forms will be added to PCs.	FFY 2010 through FFY 2012	District staff	New in FFY 2010 Continuing in FFY 2011	Expected impact includes more effective service coordination for families and user-friendly data entry.
A	8. In FFY 2011, service coordinators will hand deliver the parent surveys and use interpreters as needed.	FFY 2011 through FFY 2012	District staff	New in FFY 2011	The rate of return for parent surveys should increase with better understanding by parents completing the surveys.
	<b>Database Changes</b>				
J	1. In FFY 2009, the Central Directory revisions were initiated to make it web-based and user-friendly. Millsaps College students and staff assisted in this project. Due to technical issues between MSDH and Millsaps College, this project was not completed. However, in FFY 2010, this project was continued. A	FFY 2009 through FFY 2012	Data Manager	New in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Improvements to the Central Directory will be easily accessible and empower our parents, guardians, etc. and

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	revised Central Directory has been added to the website. In FFY 2011, continued updating and monitoring of the Central Directory will occur.				provide a valuable resource to provide ongoing/updated resources.

**Activities to commence in FFY 2013 (2013-2014)**

1. Evaluate the effectiveness of the above activities in meeting the SPP goals and make necessary changes. Utilize broad stakeholder input in this process
2. Provide training to address compliance and/or performance issues identified in the Annual Performance Reports and through monitoring activities. This training will be ongoing within each health district through coaching, mentoring, and embedded training/technical assistance.

**Resources for Activities**

Please refer to the resources for Indicator 1, unless otherwise specified.

## Mississippi's Part C State Performance Plan for 2005-2012

### Monitoring Priority: Effective General Supervision Part C / Child Find

**Indicator 5:** Percent of infants and toddlers birth to 1 with IFSPs compared to:

- A. Other States with similar eligibility definitions; and
- B. National data.

(20 USC 1416(a)(3)(B) and 1442)

#### Measurement:

Percent = [(# of infants and toddlers birth to 1 with IFSPs) divided by the (population of infants and toddlers birth to 1)] times 100 compared to national data.

#### Overview of Issue/Description of System or Process:

1. The DMH is the largest public provider of EI services in Mississippi. In the Spring of 2005, a pilot project between MDH and DMH was implemented in District IX. The goals were to eliminate redundant paperwork, to improve efficiency, and to maximize resources. On April 1, 2006, changes resulting from intense collaboration between the two agencies will be fully implemented. Child Find activities will be a unified effort within the state. The likelihood of children falling through the referral cracks will decrease. Four regional trainings on these changes will take place in January and February 2006, with IFSP training planned for March.
2. Zero to Three is implementing its program in Forrest County through the County and Youth Court system. Stakeholders serving children and families in Forrest County were invited to participate in the initial meeting at which Zero to Three staff presented the program. EI staff from District VIII and the Part C Coordinator participated in the meeting. Follow-up meetings will be scheduled throughout the coming year. Provisions of the **Child Abuse Prevention and Treatment Act (CAPTA)** and IDEA'04 were discussed during the meeting. EI staff expressed interest in collaborating with other agencies to implement the Zero to Three program through Judge McPhail's office. These collaborative efforts should increase referrals to First Steps and EI's ability to better meet the requirements of CAPTA and IDEA'04 for infants/toddlers exposed to abuse and neglect, and the effects of chemical abuse.
3. A unit in the First Steps Central Office (FS-CO) will be designated as the point of referral. Please refer to Indicator 14, **Activities to commence in the second half of FFY 2006**, Activity 2 for more information about the FS-CO central referral unit.
4. Some school districts in each of the nine health districts want to participate in the "transition pilot project," which began in Health District IX. By including Part B staff as multidisciplinary team members and ensuring that evaluations and assessments meet the guidelines for Part B and Part C, eligibility for Part B may be determined soon after the multidisciplinary evaluation/assessment takes place. This project is enhancing the quality of the multidisciplinary evaluations/assessments and is serving to increase awareness of early intervention eligibility criteria and services. The addition of each participating school district increases the number of multidisciplinary team members and the likelihood of a timely and smooth transition.
5. Use of various terms to describe early intervention services (Part C, EI, First Steps, MDH, Infants/Toddlers program, Mental Health EIP) led to confusion over how to access the system. Currently referrals are received on the local level by First Steps and by the Department of Mental Health (DMH). A small number of referrals are sent directly to the First Steps Central Office.

Some referral sources that provide services outside the EI system do not make referrals to First Steps. The agencies providing early intervention services are working to improve communication with and increase collaboration among referral sources and providers.

6. In 2005 new publicity and Child Find materials were developed and printed. New publications include a large poster with the English version on one side and Spanish on the other. Three versions of brochures were developed based on the child's age: 1-12 months, 13-24 months, and 25-36 months. Brochures are available in English, Spanish and Vietnamese. Developmental tear-off sheets are the most popular publications. The tear-off sheets are miniature versions of the poster. Trade show displays were distributed to District Coordinators. One trade show display was purchased for Central Office use. All materials are brightly colored with attractive pictures of babies depicting the activity referenced (crawling, walking, looking at books). The English version includes pictures depicting various ethnic backgrounds. The Spanish and Vietnamese versions include pictures of babies who reflect those cultures. Parent focus groups met to critique the old materials and to express their opinions regarding the development of new materials. The reading level is around fourth grade and includes more laymen's terms and less jargon than previous materials. Having brochures for each year of an infant/toddler's life came out of the parent focus group, as well. Materials are available at no charge for persons with a legitimate need. They will be distributed state-wide through providers, referral sources, and at professional meetings.
7. The number of teams available to conduct comprehensive evaluations and assessments is limited. Delays in evaluations lead to delays in services and reluctance of referral sources to refer infants and toddlers to First Steps. Use of a medical model for evaluations and service provision contributes to the delay. Conducting separate discipline-specific evaluations, writing individual reports, and developing IFSPs from multiple reports is more time consuming than using early intervention teams that conduct comprehensive multidisciplinary evaluations and assessments that facilitate writing IFSPs designed to achieve functional outcomes working in family routines.
8. Difficulty scheduling evaluations and finding service providers led to some service coordinator practices which hinder the process. Some service coordinators wait until after identified providers are available before scheduling the IFSP meeting.
9. Some hospitalized infants are put in tracking until they are discharged from the hospital.
10. While entering records in FSIS, some service coordinators made up ID numbers for infants and toddlers rather than using the SS#, Medicaid #, or phone #. When two children were assigned the same ID number, the database merged the records, reducing the numbers in the data system.

**Baseline Data for FFY 2004 (2004-2005):**

- A. According to the December 1, 2004, Child Count (618 data), in Mississippi 0.74% of infants, birth to one, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, including at risk) whose average was 1.39%.

According to the December 1, 2004, Child Count (618 data), in Mississippi 0.74% of infants, birth to one, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, excluding at risk) whose average was 0.90%.  
According to the December 1, 2005, Child Count (618 data), in Mississippi 0.50% of infants, birth to one, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, including at risk) whose average was 1.39%.

According to the December 1, 2005, Child Count (618 data), in Mississippi 0.50% of infants, birth to one, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, excluding at risk) whose average was 0.90%.

- B. According to the December 1, 2004, Child Count (618 data), in Mississippi 0.74% of infants, birth to one, received services outlined on an IFSP, compared to the national average of 0.92%, which excluded children at risk.

According to the December 1, 2005, Child Count (618 data), in Mississippi 0.50% of infants, birth to one, received services outlined on an IFSP, compared to the national average of 0.92%, which excluded children at risk.

**Discussion of Baseline Data:**

Mississippi is currently serving children birth to one year of age at a rate less than the national average and less than states with similar eligibility criteria. For this comparison, Mississippi used newly developed eligibility criteria rankings provided by OSEP based on the federal 618 Data tables submitted by states on December 1, 2004. Mississippi included our December 1, 2004 and 2005, 618 data since both were available at the time of submission of the SPP. The December 1, 2005, Child Count is considerably lower than the previous year. This drop can be accounted for by the relocation of families outside of Mississippi following Hurricane Katrina

Percentages served annually were calculated based upon the most current U.S. Census population estimates that are available with adjustments for annual state population growth. Comparisons to national percentages and states with similar eligibility criteria were based upon data excluding children at risk.

Although the Child Count raw data indicate that we were serving 207 infants birth to age one on December 1, 2005, during FFY2004 we served 884 infants who had an IFSP before their first birthday.

FFY	Measurable and Rigorous Targets for Indicator 5:
<b>2005</b> (2005-2006)	<b>0.51%</b> of infants and toddlers birth to 1 will have IFSPs.
<b>2006</b> (2006-2007)	<b>0.55%</b> of infants and toddlers birth to 1 will have IFSPs.
<b>2007</b> (2007-2008)	<b>0.60%</b> of infants and toddlers birth to 1 will have IFSPs.
<b>2008</b> (2008-2009)	<b>0.65%</b> of infants and toddlers birth to 1 will have IFSPs.
<b>2009</b> (2009-2010)	<b>0.70%</b> of infants and toddlers birth to 1 will have IFSPs.
<b>2010</b> (2010-2011)	<b>0.75%</b> of infants and toddlers birth to 1 will have IFSPs.
<b>2011</b> (2011-2012)	<b>0.75%</b> of infants and toddlers birth to 1 will have IFSPs.
<b>2012</b> (2012-2013)	<b>0.75%</b> of infants and toddlers birth to 1 will have IFSPs.

**Improvement Activities/Timelines/Resources:**

**Activities to commence in the second half of FFY 2005 (2005-2006)**

1. Create a central referral system at the First Steps Central Office to:
  - a. Eliminate confusion over where or how to make referrals;
  - b. Create and disperse a document depicting the "EI Umbrella;"
  - c. Increase the reliability of data;
  - d. Assign a unique identifying number for each child to be generated automatically by the data system rather than created by service coordinators, eliminating problems with duplication of ID numbers;
  - e. Slightly decrease the amount of time spent entering data at the district level; and
  - f. Give central office staff a clearer picture of the number of referrals from various sources.
2. Collaborate more effectively with referral sources from both the state and local levels.
3. Collaborate with DMH, MDE, and with other departments within MDH to form model evaluation/assessment teams.
  - a. These teams will use best practices when conducting evaluations/assessments.
  - b. New team members will be trained on a continual basis.
  - c. Teams will choose appropriate instruments and team members based on the needs identified prior to the multidisciplinary evaluation and assessment. If new problems are identified, further assessment will be conducted.
  - d. Assessment team members will be trained to act as coaches/consultants.
4. Disseminate new Child Find materials published in 2005 during professional meetings/conferences, by visiting providers and referral sources, and through mass mail outs to referral sources with personal follow-up.
5. Work with the Communications Department at MDH to publicize the EI program through media, including newspapers, newsletters, website information, and their new radio talk show. A five minute radio spot was recorded to air on Public Radio in Mississippi.
6. Visit hospitals and NICUs to discuss processes and procedures for making referrals. Further develop relationships between First Steps and hospital personnel who have contact with infants and their families.

7. attend health fairs, local and state conferences (e.g., Mississippi Chapter of the Academy of Pediatrics, Mississippi Association of Family Practitioners, Mississippi Nurses Association, Nurse Practitioners), and meetings to set up trade show displays; to distribute brochures, developmental checklists and posters; and to answer questions regarding EI.
8. Provide training: Please refer to the training activities for Indicators 1 and 2.

**Activities to commence in FFY 2006 (2006-2007)**

1. Work with each district to form evaluation/assessment teams or maximize effective use of the existing teams.
  - a. These teams will use best practices when conducting evaluations/assessments.
  - b. New team members will be trained on a continual basis.
  - c. Teams will choose appropriate instruments and team members based on the needs identified prior to the multidisciplinary evaluation and assessment. If new problems are identified, further assessment will be conducted.
  - d. Assessment team members will be trained to act as coaches/consultants.
2. Continue the other activities begun in FFY 2005.
3. Please refer to the activities for Indicator 1 and 2.

**Revisions, with Justification, to Proposed Targets / Improvement Activities / Timelines / Resources for FFY 2008 (2008-2009),  
FFY 2009 (2009-2010), FFY2010 (2010-2011), FFY 2011 (2011-2012), and FFY 2012 (2012-2013):**

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Database changes</b>				
A, B, F	1. In FFY 2006, the central referral unit (CRU) at the First Steps Central Office was created to take referrals and enter referral data.	FFY 2005 through FFY 2012	C.O. staff All referral sources	New in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The CRU continues to receive referrals, enter referral data, and notify the health districts of referrals in a timely manner.
	<b>Child Find activities</b>				
G	1. In FFY 2005, a renewed effort to collaborate more effectively with referral sources from both the state and local levels began. Referral sources include: local churches, daycares, clinics, PHRM teams, Head Start Centers, CAPTA and school districts.	FFY 2005 through FFY 2012	All staff	New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The EIS continues to collaborate with the referral sources via child find activities.
E, F	2. In FFY 2005, new child find materials were published. These materials were disseminated at professional meetings and conferences; when visiting providers and referral sources; and through mass mail outs to referral sources with personal follow-up. The year range brochures and tear-off sheets (1-12, 13-24, 25-36 months) are available in English, Spanish, and Vietnamese.	FFY 2005 through FFY 2012	SC DC C.O. staff	New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	These brochures continue to be provided to referral sources upon request and as part of child find activities.
F, G	3. In FFY 2005, the Part C Coordinator worked with the Communications Department at MSDH to	FFY 2005	Part C	New in FFY 2005	A provider newsletter is sent out quarterly to

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	publicize the EI program through media, including: newspapers, newsletters, and the website.	through FFY 2012	Coordinator	Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	providers/agencies within the state to provide child find awareness.
F, G	4. In FFY 2005, an effort was made by both state and local level staff to visit hospitals and neo-natal intensive care units (NICUs) to discuss processes and procedures for making referrals and further develop relationships between First Steps and hospital personnel who have contact with infants and their families. Since FFY 2006, this activity has been carried out by district staff.	FFY 2005 through FFY 2012	SC DC	New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This practice continues at the health district level and serves to increase referrals.
F	5. Since FFY 2005, district and state level staff have attended health fairs, local and state conferences, and meetings to set up displays to distribute brochures, developmental checklists and posters, and to answer questions regarding EIS.	FFY 2005 through FFY 2012	SC DC C.O. staff	New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This practice continues at both the state and local level and serves to increase awareness of the EIS program and the services it offers.
	<b>Evaluation and Assessment</b>				
F, G	1. In FFY 2005, an effort was made to collaborate with the Department of Mental Health (DMH), the Mississippi Department of Education (MDE), and with other department programs within the MSDH to form model evaluation and assessment teams. In FFY 2006, this plan was revised to build evaluation/assessment teams where possible. In FFY 2009, budget constraints and provider	FFY 2005 through FFY 2010	C.O. staff DC	New in FFY 2005 Revised in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010	The development of "model evaluation teams" will contribute to the identification of children who are eligible for EIS.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	shortages prohibited the forming of model teams statewide. However, in FFY 2010, efforts to continue this activity were initiated.			Continuing in FFY 2011	
C, E, F, G	2. In FFY 2007, guidance was given to district staff and providers on use of informed clinical opinion in making eligibility determinations and planning services for premature babies. The guiding document "Guidelines for Premature Infants, PHRM Referrals, and Hearing Loss" was developed and revised in FFY 2007.	FFY 2007 through FFY 2012	C.O. staff DC SC Service providers	New in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This guidance continues to be given to district staff and providers.
<b>Training and Technical Assistance</b>					
C	1. In FFY 2006, a new service coordinator training was developed. In FFY 2007, these three days sessions were shortened to two days to prevent delays in service coordination. The main content on the third day was IFSP development. IFSP training and follow-up are now provided within the health district.	FFY 2006 through FFY 2012	C.O. staff	New in FFY 2006 Revised in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The revised format is well accepted and continues to be used to enhance service coordination.
D, F	2. In FFY 2007, an effort was made through personal contact to increase understanding of providers and potential referral sources of their responsibility to refer all children who may need early intervention services. In FFY 2008, this effort continued.  In FFY 2009, the scope broadened to include increased support of the primary medical providers in making timely referrals; encouraging families to access and use early intervention services; and completing the required paperwork in a timely manner.	FFY 2007 through FFY 2012	SC DC, C.O. staff	New in FFY 2007 Continued in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Renewed efforts to increase support of the primary medical providers are expected to result in more families accepting services and remaining in the program until their child is ready to exit from Part C.
C, D	3. EIS ensures through monitoring, training, and coaching that the multidisciplinary team includes	FFY 2007	C.O. staff	New in FFY 2007 Continued in FFY 2008	This combination of strategies serves to

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	the members needed to identify and address the unique needs of families and children. This activity began in FFY 2007 and continues to date.	through FFY 2012		Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	strengthen the team's skills.
C, D	4. EIS emphasizes through monitoring, training, and T/A an effective use of fiscal resources. This activity began in FFY 2007 and continues to date. EIS follows Health Department and Federal required guidelines on monitoring/auditing of all contracts.	FFY 2007 through FFY 2012	C.O. staff	New in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This combination of strategies serves to increase effective use of fiscal resources. FFY 2010 statewide audits of all providers/contractors was implemented
F	5. EIS increases the number of teams available to perform evaluations and to provide services in a timely manner. This activity began in FFY 2007 and continues to date.	FFY 2007 through FFY 2012	DC C.O. staff	New in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Recruitment of providers occurs regularly at both the state and local levels.
	<b>Policies and Procedures:</b>				
E	1. In FFY 2010, changes to the eligibility criteria were considered. These changes have been put on hold due to publication of new Part C Regulations.	FFY 2010	C.O. staff	New in FFY 2010	Expected impact is a more rigorous definition of developmental delay.
E	2. Due to new regulation, policies and procedures will be revised.	FFY 2005 through FFY 2012	C.O. staff	New in FFY 2011	Expected impact is program improvement. New Part C Regulations will be revised and implemented July 1, 2012.
	<b>SICC:</b>				

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
G	1. In FFY 2010, a pediatrician was recruited as a member of the SICC. Due to other obligations, this individual was not able to fulfill this position. Efforts will be made to recruit a pediatrician in FFY 2011.	FFY 2010 through FFY 2012	SICC	New in FFY 2010 Continuing in FFY 2011	This will give us a voice with the medical community to increase awareness of our EIS program.

**Activities to commence in FFY 2013 (2013-2014)**

1. Evaluate the effectiveness of the above activities in meeting the SPP goals and make necessary changes. Utilize broad stakeholder input in this process
2. Provide training to address compliance and/or performance issues identified in the Annual Performance Reports and through monitoring activities. This training will be ongoing within each health district through coaching, mentoring, and embedded training/technical assistance.

**Resources for Activities**

Please refer to the resources for Indicator 1, unless otherwise specified.

## Mississippi's Part C State Performance Plan for 2005-2012

### Monitoring Priority: Effective General Supervision Part C / Child Find

**Indicator 6:** Percent of infants and toddlers birth to 3 with IFSPs compared to:

- A. Other States with similar eligibility definitions; and
- B. National data.

(20 USC 1416(a)(3)(B) and 1442)

#### Measurement:

**Percent = [(# of infants and toddlers birth to 3 with IFSPs) divided by the (population of infants and toddlers birth to 3)] times 100 compared to national data.**

#### Overview of Issue/Description of System or Process:

Please refer to the overview for Indicator 5. Toddler will be added to any reference to infant in Indicator 5.

#### Baseline Data for FFY 2004 (2004-2005):

- A. According to the December 1, 2004, Child Count (618 data), in Mississippi 1.69% of infants and toddlers, birth to three, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, including at risk) whose average was 2.74%.

According to the December 1, 2004, Child Count (618 data), in Mississippi 1.69% of infants and toddlers, birth to three, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, excluding at risk) whose average was 2.11%.

According to the December 1, 2005, Child Count (618 data), in Mississippi 1.37% of infants and toddlers, birth to three, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, including at risk) whose average was 2.74%.

According to the December 1, 2005, Child Count (618 data), in Mississippi 1.37% of infants and toddlers, birth to three, received services outlined on an IFSP, compared to states with similar eligibility criteria (broad, excluding at risk) whose average was 2.11%.

- B. According to the December 1, 2004, Child Count (618 data), in Mississippi 1.69% of infants and toddlers, birth to three, received services outlined on an IFSP, compared to the national average of 2.24% (excluding at risk).

According to the December 1, 2005, Child Count (618 data), in Mississippi 1.37% of infants and toddlers, birth to three, received services outlined on an IFSP, compared to the national average of 2.24% (excluding at risk).

#### Discussion of Baseline Data:

Mississippi is currently serving children birth to three years of age at a rate less than the national average and less than states with similar eligibility criteria. Mississippi's Part C system falls in the broad eligibility category. Mississippi does not serve children identified as being at risk.

For this comparison, Mississippi used newly developed eligibility criteria rankings provided by OSEP based on the federal 618 Data tables submitted by states on December 1, 2004. Mississippi included our December 1, 2004 and 2005, 618 data since both were available at the time of submission of the SPP. The December 1, 2005, Child Count is considerably lower than the previous year. This drop can be accounted for by the relocation of families outside of Mississippi following Hurricane Katrina. Percentages served annually were calculated based upon the most current U.S. Census population estimates that are available with adjustments for annual state population growth.

Although the Child Count raw data indicate that we were serving 1726 infants and toddlers birth to three on December 1, 2005, during FFY2004 we served 2700 children with an IFSP.

FFY	Measurable and Rigorous Targets for Indicator 6
<b>2005</b> (2005-2006)	1.43% of infants and toddlers birth to 3 will have IFSPs.
<b>2006</b> (2006-2007)	1.53% of infants and toddlers birth to 3 will have IFSPs.
<b>2007</b> (2007-2008)	1.68% of infants and toddlers birth to 3 will have IFSPs.
<b>2008</b> (2008-2009)	1.78% of infants and toddlers birth to 3 will have IFSPs.
<b>2009</b> (2009-2010)	1.88% of infants and toddlers birth to 3 will have IFSPs.
<b>2010</b> (2010-2011)	1.98% of infants and toddlers birth to 3 will have IFSPs.
<b>2011</b> (2011-2012)	1.98% of infants and toddlers birth to 3 will have IFSPs.
<b>2012</b> (2012-2013)	1.98% of infants and toddlers birth to 3 will have IFSPs.

**Revisions, with Justification, to Proposed Targets / Improvement Activities / Timelines / Resources for FFY 2008 (2008-2009),  
FFY 2009 (2009-2010), FFY2010 (2010-2011), FFY 2011 (2011-2012), and FFY 2012 (2012-2013):**

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Database changes</b>				
A, B, F	1. In FFY 2006, the Central Referral Unit (CRU) at the First Steps Central Office was created to take referrals and enter referral data.	FFY 2005 through FFY 2012	C.O. staff All referral sources	New in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The CRU continues to receive referrals, enters referral data, and notifies the health districts of the referrals in a timely manner.
	<b>Child Find activities</b>				
G	1. In FFY 2005, a renewed effort to collaborate more effectively with referral sources from both the state and local levels began. Referral sources include: local churches, childcare centers, clinics, PHRM teams, Head Start Center, CAPTA and school districts.	FFY 2005 through FFY 2012	All staff	New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The EIS continues to collaborate with referral sources via child find activities.
E, F	2. In FFY 2005, new child find materials were published. These materials were disseminated at professional meetings and conferences; when visiting providers and referral sources; and through mass mail outs to referral sources with personal follow-up. The year range brochures and tear-off sheets (1-12, 13-24, 25-36 months) are available in English, Spanish, and Vietnamese.	FFY 2005 through FFY 2012	SC DC C.O. staff	New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	These brochures continue to be provided to referral sources upon request and as part of child find activities.
F, G	3. In FFY 2005, the Part C Coordinator worked with the Communications Department at MSDH to publicize the EI program through media, including: newspapers, newsletters, and the website. In FFY	FFY 2005 through FFY 2012	Part C Coordinator	New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007	A provider newsletter is sent out quarterly to providers/agencies within the state to provide child

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	2011, due to a lack of staff, the quarterly newsletter to providers has been suspended until Spring 2012. At that time, a provider work group will be developed to increase EI awareness and re-implement the provider newsletter.			Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Revised in FFY 2011	find awareness. The development of a provider workgroup will increase EI awareness and be an additional resource to provide EI information and best practice procedures.
F, G	4. In FFY 2005, an effort was made by both state and local level staff to visit hospitals and Neo-natal Intensive Care Units (NICUs) to discuss processes and procedures for making referrals and further develop relationships between First Steps and hospital personnel who have contact with infants and their families. Since FFY 2006, this activity has been carried out by district staff.	FFY 2005 through FFY 2012	SC DC	New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This practice continues at the health district level and serves to increase referrals.
F	5. Since FFY 2005, district and state level staff have attended health fairs, local and state conferences, and meetings to set up displays to distribute brochures, developmental checklists and posters, and to answer questions regarding EIS.	FFY 2005 through FFY 2012	SC DC C.O. staff	New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This practice continues at both the state and local level and serves to increase awareness of the EIS program and the services it offers.
	<b>Evaluation and Assessment</b>				
F, G	1. In FFY 2005, an effort was made to collaborate with the Department of Mental Health (DMH), the Mississippi Department of Education (MDE), and with other department programs within the MSDH to form model evaluation and assessment teams. In FFY 2006, this plan was revised to build evaluation/assessment teams where possible. In FFY 2009, budget constraints and provider	FFY 2005 through FFY 2010	C.O. staff DC	New in FFY 2005 Revised in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010	The development of model evaluation will contribute the identification of children who are eligible for EIS.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	shortages prohibited the forming of model teams statewide. However, in FFY 2010, efforts to continue this activity were resumed.			Continuing in FFY 2011	
C, E, F, G	2. In FFY 2007, guidance was given to district staff and providers on use of informed clinical opinion in making eligibility determinations and planning services for premature babies. The guiding document "Guidelines for Premature Infants, PHRM Referrals, and Hearing Loss" was developed and revised in FFY 2007.	FFY 2007 through FFY 2012	C.O. staff DC SC Service providers	New in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This guidance continues to be given to district staff and providers.
<b>Training and Technical Assistance</b>					
C	1. In FFY 2006, a new service coordinator training was developed. In FFY 2007, these three day sessions were shortened to two days to prevent delays in service coordination. The main content on the third day was IFSP development. IFSP training and follow-up are now provided within the health district.	FFY 2006 through FFY 2012	C.O. staff	New in FFY 2006 Revised in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The revised format is well accepted and continues to be used to enhance service coordination.
D, F	2. In FFY 2007, an effort was made through personal contact to increase understanding of providers and potential referral sources of their responsibility to refer all children who may need early intervention services. In FFY 2008, this effort continued.  In FFY 2009, the scope broadened to include increased support of the primary medical providers in making timely referrals; encouraging families to access and use early intervention services; and completing the required paperwork in a timely manner.	FFY 2007 through FFY 2012	SC DC, C.O. staff	New in FFY 2007 Continued in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Renewed efforts to increase support of the primary medical providers are expected to result in more families accepting services and remaining in the program until their child is ready to exit from Part C.
C, D	3. EIS ensures through monitoring, training, and coaching that the multidisciplinary team includes	FFY 2007 through	C.O. staff	New in FFY 2007 Continued in FFY 2008	This combination of strategies serves to

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	the members needed to identify and address the unique needs of families and children. This activity began in FFY 2007 and continues to date.	FFY 2012		Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	strengthen the team's skills.
C, D	4. EIS emphasizes through monitoring, training, and T/A an effective use of fiscal resources. This activity began in FFY 2007 and continues to date.	FFY 2007 through FFY 2012	C.O. staff	New in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This combination of strategies serves to increase effective use of fiscal resources.
F	5. EIS increases the number of teams available to perform evaluations and to provide services in a timely manner. This activity began in FFY 2007 and continues to date.	FFY 2007 through FFY 2012	DC C.O. staff	New in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Recruitment of providers occurs regularly at both the state and local levels.
	<b>Policies and Procedures:</b>				
E	1. In FFY 2010, changes to the eligibility criteria were considered. These changes are still being considered in FFY 2011. This procedure has been postponed due to new Part C Regulation guidelines.	FFY 2010	C.O. staff	New in FFY 2010 Continuing in FFY 2011	Expected impact is a more rigorous definition of developmental delay.
E	2. Due to new regulation, the policy and procedures will be revised.	FFY 2005 through FFY 2012	C.O. staff	New in FFY 2011	Expected impact is program improvement. These new Par C Regulations will be written and implemented.
	<b>SICC:</b>				
G	1. In FFY 2010, a pediatrician was recruited as a member of the SICC. Due to other obligations, he was not able to fulfill this	FFY 2010 through FFY 2012	SICC	New in FFY 2010 Continuing in FFY 2011	This will give us a voice with the medical community to increase awareness of our EI

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	position. Efforts will be made to recruit a pediatrician in FFY 2011.				program.

**Activities to commence in FFY 2013 (2013-2014)**

1. Evaluate the effectiveness of the above activities in meeting the SPP goals and make necessary changes. Utilize broad stakeholder input in this process
2. Provide training to address compliance and/or performance issues identified in the Annual Performance Reports and through monitoring activities. This training will be ongoing within each health district through coaching, mentoring, and embedded training/technical assistance.

**Resources for Activities**

Please refer to the resources for Indicator 1, unless otherwise specified.

Revised February 1, 2012

**Mississippi's Part C State Performance Plan for 2005-2012****Monitoring Priority: Effective General Supervision Part C / Child Find**

**Indicator 7:** Percent of eligible infants and toddlers with IFSPs for whom an evaluation and assessment and an initial IFSP meeting were conducted within Part C's 45-day timeline.

(20 USC 1416(a)(3)(B) and 1442)

**Measurement:**

Percent = [(# of infants and toddlers with IFSPs for whom an evaluation and assessment and an initial IFSP meeting was conducted within Part C's 45-day timeline) divided by the (# of infants and toddlers with IFSPs evaluated and assessed for whom an initial IFSP meeting was required to be conducted)] times 100.

Account for untimely evaluations, assessments, and initial IFSP meetings, including the reasons for delays.

**Overview of Issue/Description of System or Process:**

1. Activities are being implemented through the State Improvement Plan to address 45-day timelines, timely provision of services, natural environment, Child Find, and accurate data. Activities include training and technical assistance on the appropriate use of multidisciplinary and transdisciplinary teams for evaluation/assessment, IFSP development, and service delivery; the benefits of providing services in natural settings; and on service delivery models incorporating best practices that support the provision of early intervention services in natural environments.
2. Changes resulting from intense collaboration with the Mississippi Department of Mental Health will begin on April 1, 2006. The expansion of the District IX pilot project is enhancing the quality and timeliness of multidisciplinary evaluations/assessments; increasing awareness of early intervention eligibility criteria; improving the quality of IFSPs; and improving timely provision of services.
3. The issues affecting child find include some of the same issues affecting the 45-day timeline and timely provision of services. Improved communication and increased collaboration are needed to more effectively utilize our state's resources. The number of teams available to conduct comprehensive evaluations and assessments is limited. Many providers use a medical model for evaluations and service provision and emphasize child-centered, direct therapies versus family-centered services, routines, and functional outcomes. Current services address each area of development in isolation from other services (multidisciplinary). Evaluations and IFSP development take longer because the multidisciplinary evaluation and the IFSP must be completed using discipline-specific reports. The reports may not aid the development of IFSPs to provide services in natural environments to the maximum extent appropriate to meet the unique needs of the child and family within normal routines.
4. Clarification of data entry requirements and improvements to FSIS render the data more accurate.
5. Frequent turnover of staff in service coordinator positions.

Revised February 1, 2012

**Baseline Data for FFY 2004 (2004-2005):**

Of the 1331 children who were referred, evaluated, and found to be eligible, 959 (72%) had an IFSP meeting in 45 days or less; 372 (28%) had an IFSP meeting in more than 45 days. Late IFSPs were due to lack of service providers to conduct evaluations in a timely manner and difficulty coordinating evaluations with families' schedules. Because the data system was not configured to allow for electronic quantification of the justifications, the number of family-based "justifiable" reasons for missing timelines is not given. Data were obtained from the FSIS database.

**Discussion of Baseline Data:**

Mississippi has an Improvement Plan, which was implemented on July 1, 2005, to address the 45-day timeline requirement. Data taken on December 31, 2005, indicate that from July 1-December 31, 2005, 81% of IFSPs were developed within 45 days of initial referral. Data were obtained from the FSIS database.

FFY	Measurable and Rigorous Targets for Indicator 7:
2005 (2005-2006)	100% of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline.
2006 (2006-2007)	100% of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline.
2007 (2007-2008)	100% of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline.
2008 (2008-2009)	100% of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline.
2009 (2009-2010)	100% of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline.
2010 (2010-2011)	100% of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline.
2011 (2011-2012)	100% of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline.
2012 (2012-2013)	100% of eligible infants and toddlers with IFSPs will have an evaluation and assessment and an initial IFSP meeting conducted within Part C's 45-day timeline.

**Revisions, with Justification, to Proposed Targets / Improvement Activities / Timelines / Resources for FFY 2008 (2008-2009), FFY 2009 (2009-2010), FFY2010 (2010-2011), FFY 2011 (2011-2012), and FFY 2012 (2012-2013):**

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Training/TA for staff &amp; providers</b>				
C	1. In FFY 2006, a new service coordinator training was developed. In FFY 2007, these three days sessions were shortened to two days to prevent delays in service coordination. The main content on the third day was IFSP development. IFSP training and follow-up are now provided within the health district.	FFY 2006 through FFY 2012	C.O. staff	New in FFY 2006 Revised in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The revised format is well accepted and continues to be used to enhance service coordination.
C	2. Significant changes to the format of the IFSP were made in FFY 2006. Training on the new format was provided in all health districts in FFY 2006. By FFY 2007, staff and providers were familiar with the new format. Follow-up training on the IFSP has been provided within the health districts since 2007.  IFSP training continues to be provided for each new service coordinator. Follow-up provided within the health districts is individualized and includes coaching.  In FFY 2010, the IFSP was revised. In FFY 2011, the new IFSP was revised and introduced to DCs, SCs, and service providers throughout the state. The IFSP has been loaded onto the new tablet PC. Follow-up training/technical assistance will be provided to districts that need assistance.	FFY 2006 through FFY 2012	C.O. staff	New in FFY 2006 Revised in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	IFSP training within the health districts is open to service coordinators and affords current staff opportunities to enhance their skills.
C	3. Training/TA on transdisciplinary play-based assessment began in FFY 2007. In FFY 2008, provider training included training on this model. In FFY 2011, TA is being provided as needed for implementation of this activity.	FFY 2007 through FFY 2012	C.O. staff	New in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Training and technical assistance continue to be offered when requested by staff or providers.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
F	4. In FFY 2008, NECTAC and SERRC provided technical assistance on the following topics: changing service delivery models, improving child outcome measurement, and improving transition activities. They continue to provide technical assistance related to these topics and will add the topic of Increasing Provider Awareness of Typical Child Development. TA was provided by NECTAC and SERRC on typical child development and improving child outcome measurement in FFY 2010. This will be continued in FFY 2011.	FFY 2008 through FFY 2012	C.O. staff	New in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Technical assistance continues to be requested and provided.
C	5. A Typical Child Development training was scheduled in FFY 2009 but did not occur until FFY 2010. This training was provided throughout the state to Service Coordinators and service providers. SERCC and ECO Center collaborated to present this training. In FFY 2010, following these trainings, SERCC and ECCO provided EI staff with "Train the Trainer" which gave instructions on techniques to captivate and hold the attention of audiences that require training concerning provision of services. SERRC and the ECO Center will collaborate to provide a child outcomes training to all EI service providers, potentially in FFY 2011.	FFY 2009 through FFY 2012	C.O. staff	New in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This training will address needs identified by stakeholders and through general supervision activities.
C	6. Evaluation tool training (i.e., IDA, DP III, HELP, Sensory Profile, E-LAP) was held in FFY 2009 (January 19-21, 2010) in Oxford, Jackson, and Hattiesburg. Technical Assistance on the administration of these tools continued in FFY 2010. This TA will continue in FFY 2011 as needed.	FFY 2009 through FFY 2012	C.O. staff	New in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This training addressed needs identified by stakeholders and through general supervision activities.
C, F, J	7. In FFY 2009, ARRA funds used for projects at three universities resulted in pre-service and in-service training for staff, providers, and child care	FFY 2009 through	University Staff	New in FFY 2009 Continued in FFY 2010	Training will address needs identified by stakeholders and through

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	workers on best practices in providing early intervention services. One component addressed assistive technology (AT) awareness and availability included family members in the training opportunities. These trainings were provided in a digital format for staff to use as needed in FFY 2011. A digital format of this training is available for staff to access as needed.	FFY 2012		Continuing in FFY 2011	general supervision activities.
A, B, C,D	8. In FFY 2010, tablet PCs were distributed to service coordinators. Statewide training was provided on the use of PCs. The tablet PCs will be utilized in IFSP development and data collection.	FFY 2010 through FFY 2012	District staff	New in FFY 2010 Continuing in FFY 2011	Expected impact includes more effective service coordination and user-friendly data entry.
C	9. In FFY 2009, a designated CO staff member conducted statewide onsite TA related to Medicaid issues. In FFY 2010, staff responsible for this task resigned and have not been replaced. In FFY 2011, a provider workgroup will be established to address Medicaid issues	FFY 2009 through FFY 2012	C.O. staff	New in FFY 2009 Continued in FFY 2010 Revised in FFY 2011	Current issues/problems specific and unique to each health district are identified and addressed.
C	10. In FFY 2010, Training Modules were developed to cover the First Steps process from enrollment to transition from Part C services. Joint training with MDE will be conducted in FFY 2011.	FFY 2010 through FFY 2012	C.O. staff	New in FFY 2010 Continuing in FFY 2011	The use of these training modules will provide targeted technical assistance.
	<b>Database changes</b>				
A	1. In FFY 2008, database fields were added for documentation of exceptional family circumstances. Central Office staff determined whether the documentation met the criteria for an exceptional family circumstance. In FFY 2009, district staff began selecting the justification type. When data are pulled for reporting and compliance purposes, Central Office staff check justifications	FFY 2008 through FFY 2012	Data Manager DC SC	New in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This process facilitates proper data entry and accuracy.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	and provide follow up, as indicated.				
A	2. In FFY 2009, database reports were added for district staff to review and correct missing data. Health district staff accesses reports of records that has discrepancies (i.e., missing data) and follow up to address issues in a timely manner. In FFY 2011, review of data reports will be conducted to implement needed changes and to comply with new Part C Regulations.	FFY 2009 through FFY 2012	Data Manager DC SC	Complete in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The new reports allow for efficient data review and data correction. This should our ability to collect more valued and reliable data and meet new Part C requirements/guidelines.
A	3. In FFY 2010, tablet PCs were disseminated to all Service Coordinators. In FFY 2011, tablet PCs will electronically download data into the child registry for improved timelines and accuracy.	FFY 2010 through FFY 2012	C.O. staff DC SC	New in FFY 2010 Continuing in FFY 2011	This will decrease time being spent on data entry and increase time dedicated to service coordination.
A	4. In FFY 2010, a data collection person will be employed to identify health districts that are not meeting the timelines. This person will also develop a timeline tickler system. This position was temporarily filled. In FFY 2011, EI will continue to pursue a data manager to complete this objective.	FFY 2010 through FFY 2012	C.O. staff	New in FFY 2010 Continuing in FFY 2011	This will allow us to identify areas where service providers are needed to complete timely evaluations. The tickler system will allow SCs to be aware of and meet timelines.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Provider Recruitment &amp; Training</b>				
F	1. In FFY 2007, information packets were mailed to SLPs licensed through the Mississippi State Department of Health (MSDH). In FFY 2009, this activity was repeated as a tool for recruiting providers. In FFY 2010, this activity was discontinued due to a lack of staff at CO. This activity will resume when new staff is hired. This activity will be implemented in FFY 2011.	FFY 2007 through FFY 2012	C.O. staff	Completed in FFY 2007 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This activity is an effective tool for recruiting providers.
F	2. In FFY 2008, a similar packet was sent to OTs and PTs. Ads were developed and published in statewide newspapers in an attempt to recruit therapists into the EIS. In FFY 2009, this activity was repeated as a tool for recruiting providers. In FFY 2010, this activity was discontinued due to a lack of staff at CO. This activity will resume when new staff is hired. This activity will be implemented in FFY 2011.	FFY 2008 through FFY 2012	C.O. staff	New in FFY 2008 Completed in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This activity is an effective tool for recruiting providers.
F	3. During FFY 2007, the Part C Coordinator requested Human Resources to change therapy rates and structure in an effort to recruit and retain therapists, while managing fiscal resources more effectively. Rate changes went into effect in FFY 2008. Training rates were added in FFY 2008 and went into effect in FFY 2009. In FFY 2011 therapy rates were reduced due to economic conditions.	FFY 2007 through FFY 2011	C.O. staff	Completed in FFY 2007 Revised in FFY 2008 Completed in FFY 2009 Revised in FFY 2011	Rate reductions will affect our program by making it more difficult to encourage providers who are willing to work with EIP children.
C	4. Evaluation tool training (i.e., IDA, DP III, HELP, Sensory Profile, E-LAP) was held in FFY 2009 (January 19-21, 2010), in Oxford, Jackson, and Hattiesburg. Technical Assistance on the administration of these tools continued in FFY 2010.	FFY 2009 through FFY 2012	C.O. staff	New in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This training addressed needs identified by stakeholders and through general supervision activities.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
F	5. In the last quarter of FFY 2008, a pilot project began in Health District IX. This pilot is a nonprofit group, which contracts with providers and facilitates processing of paperwork required for billing of Insurance and Medicaid. Processing Medicaid and Insurance is a challenge for many providers that are interested in contracting with the EIS. The initial provider group began working with this nonprofit pilot in January 2010 to alleviate Medicaid and Insurance paperwork barrier for providers.	FFY 2008 through FFY 2012	Pilot in Health District IX DC	New in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	After the processes are in place, tested, refined, and have shown the intended result of increasing the pool of providers, this pilot will likely expand.
C, F, J	6. In FFY 2009, ARRA funds used for projects at three universities resulted in pre-service and in-service training for staff, providers, and child care workers on best practices in providing early intervention services. One component addressed assistive technology (AT) awareness and availability included family members in the training opportunities. These trainings will continue to be made available in a digital format.	FFY 2009 through FFY 2012	University Staff	New in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Training will address needs identified by stakeholders and through general supervision activities.
F	7. In FFY 2009, some health districts used ARRA funds to contract with Service Providers to cover areas which did not have the adequate amount of staff to complete comprehensive evaluations in order to determine eligibility. In FFY 2011 plans are being developed to continue Service Provider coverage.	FFY 2009 through FFY2012	District staff	New in FFY 2009 Continued in FFY 2010 Revised in FFY 2011	This addressed the timely comprehensive evaluation/initial IFSP development needs by employing additional Service Providers.
<b>Retention &amp; Recruitment of District Staff</b>					
F	1. In FFY 2007, service coordinator positions were realigned from Health Program Specialist to Health Program Specialist Sr. This resulting in a 10% raise.	FFY 2007	C.O. staff	Completed in FFY 2007	Staff turnover has decreased.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
F	2. Exploring realignment or reclassification of District Coordinators began in FFY 2008 and the exploration continued in FFY 2009. Exploration will resume when the economic conditions improve statewide.	FFY 2008 through FFY 2012	C.O. staff District staff	New in FFY 2008 Continued in FFY 2009	This activity has been suspended due to statewide budget restrictions and lack of funds.
	<b>Policies &amp; Procedures</b>				
E	1. Due to new regulations, policies and procedures will be revised.	FFY 2011 through FFY 2012	C.O. staff	New in FFY 2011	Expected impact is program improvement.
E	2. In FFY 2007, revisions to the Service Coordinator Manual mainly involved IFSP directions. This included an emphasis on use of informed clinical opinion in determining eligibility and making recommendations for services. Revisions also included changes in forms.  In FFY 2008, the IFSP instructions were revised to include more details where clarification was needed.  In FFY 2010, the IFSP instructions were revised. On the revised IFSP direction, Informed Clinical Opinion is explained in greater detail with improved guidelines given to evaluation teams.	FFY 2006 through FFY 2012	C.O. staff	Revised in FFY 2007 Revised in FFY 2008 Continued in FFY 2009 Revised in FFY 2010 Continued in FFY 2011	Expected impact includes an increase in eligibility determinations and continued improvements to the service coordinator manual.
E	3. In FFY 2007, new forms and procedures were developed to aid in fiscal monitoring, data verification, and resource management. In FFY 2008, the data verification form was revised to allow more information to be entered. In FFY 2009, data verification forms were refined to better capture transition information and other changes. In FFY 2010, this tool was further refined and referred to as the data review/service review tool.	FFY 2007 through FFY 2012	C.O. staff	Completed in FFY 2007 Revised in FFY 2008 Revised in FFY 2009 Revised in FFY 2010 Continuing in FFY 2011	Our data verification process is a very effective tool for identifying training, fiscal and TA needs.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>SICC</b>				
G	1. In FFY 2010, a pediatrician was recruited as a member of the SICC. Due to other obligations, he was not able to fulfill this position. Efforts will be made to recruit a pediatrician in FFY 2011.	FFY 2010 through FFY 2012	SICC	New in FFY 2010 Continuing in FFY 2011	This will give us a voice with the medical community, which will help with program requirements related to CMNs or Prescriptions needed for timely multidisciplinary evaluations.

**Activities to commence in FFY 2013 (2013-2014)**

1. Evaluate the effectiveness of the above activities in meeting the SPP goals and make necessary changes. Utilize broad stakeholder input in this process
2. Provide training to address compliance and/or performance issues identified in the Annual Performance Reports and through monitoring activities. This training will be ongoing within each health district through coaching, mentoring, and embedded training/technical assistance.

**Resources for Activities**

Please refer to the resources for Indicator 1, unless otherwise specified.

## Mississippi's Part C State Performance Plan for 2005-2012

### Monitoring Priority: Effective General Supervision Part C / Effective Transition

**Indicator 8:** Percent of all children exiting Part C who received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday including:

- A. IFSPs with transition steps and services;
- B. Notification to LEA, if child potentially eligible for Part B; and
- C. Transition conference, if child potentially eligible for Part B.

(20 USC 1416(a)(3)(B) and 1442)

#### Measurement:

- A. Percent = # of children exiting Part C who have an IFSP with transition steps and services divided by # of children exiting Part C times 100.
- B. Percent = # of children exiting Part C and potentially eligible for Part B where notification to the LEA occurred divided by the # of children exiting Part C who were potentially eligible for Part B times 100.
- C. Percent = # of children exiting Part C and potentially eligible for Part B where the transition conference occurred divided by the # of children exiting Part C who were potentially eligible for Part B times 100.

#### Overview of Issue/Description of System or Process:

1. Transition services will continue to improve as a result of the collaborative effort with local school districts which began as a "pilot project" in Health District IX. This project has already expanded from most school districts in Health District IX to some school districts in Health District VIII. Meetings are scheduled with school districts within most of the other health districts to explore similar collaborative relationships. In District IX, school districts participating in the pilot project have a representative on one of the early intervention teams that conduct comprehensive multidisciplinary evaluations and assessments. In these school districts, eligibility for Part B is considered concurrently with Part C using the same evaluation and assessment information. The developmental history was revised to meet the requirements for Part C, Part B, and the Department of Mental Health. The bulk of the information is gathered once and updated as needed. Involvement of Part B staff in the multidisciplinary evaluation/assessment for Part C enhances the transition process by increasing Part B's knowledge of their future students.
2. The specifics of the transition process vary among the health districts. Some notify the local school district soon after the child is referred to them while others wait until the transition process must begin. The materials used to inform parents of the transition process vary across the state. The stakeholder group, which met on October 25-26, 2005, recommended making the transition planning and procedures uniform across the state.

#### Baseline Data for FFY 2004 (2004-2005):

- a) Of the 1055 children exiting Part C, transition steps and services were documented 440 times (42%). Children's names were taken from the database, but steps and services were tabulated by hand. The data included all children with birth dates between July 1, 2001, and June 30, 2002, who received EI services during the FFY 2004.
- b) Of the 1015 children exiting Part C who were potentially eligible for Part B, notification to the LEA occurred 329 times (32%). Data were obtained from the FSIS database.

- c) Of the 1015 children exiting Part C who were potentially eligible for Part B, the transition conference occurred 545 times (54%). Data were obtained from the FSIS database.

**Discussion of Baseline Data:**

FSIS does not contain fields for documenting transition steps and services. This information was requested from districts and provided through pencil/paper tabulation. Questions generated by this request indicate that SCs have difficulty determining when, which, and how to enter transition information in the current FSIS fields and the need to clearly define “potentially eligible for Part B.” Addressing the transition questions will result in more accurate recording of the transition activities which are occurring. Potentially eligible for Part B will be defined as “being served with an IFSP until the child’s transition date or until the child is three years old.”

FFY	Measurable and Rigorous Targets for Indicator 8
<b>2005</b> (2005-2006)	A. <b>100%</b> of children exiting Part C will have an IFSP with transition steps and services. B. The LEA will be notified for <b>100%</b> of the children exiting Part C and potentially eligible for Part B. C. The transition conference will occur for <b>100%</b> of the children exiting Part C and potentially eligible for Part B.
<b>2006</b> (2006-2007)	A. <b>100%</b> of children exiting Part C will have an IFSP with transition steps and services. B. The LEA will be notified for <b>100%</b> of the children exiting Part C and potentially eligible for Part B. C. The transition conference will occur for <b>100%</b> of the children exiting Part C and potentially eligible for Part B.
<b>2007</b> (2007-2008)	A. <b>100%</b> of children exiting Part C will have an IFSP with transition steps and services. B. The LEA will be notified for <b>100%</b> of the children exiting Part C and potentially eligible for Part B. C. The transition conference will occur for <b>100%</b> of the children exiting Part C and potentially eligible for Part B.
<b>2008</b> (2008-2009)	A. <b>100%</b> of children exiting Part C will have an IFSP with transition steps and services. B. The LEA will be notified for <b>100%</b> of the children exiting Part C and potentially eligible for Part B. C. The transition conference will occur for <b>100%</b> of the children exiting Part C and potentially eligible for Part B.
<b>2009</b> (2009-2010)	A. <b>100%</b> of children exiting Part C will have an IFSP with transition steps and services. B. The LEA will be notified for <b>100%</b> of the children exiting Part C and potentially eligible for Part B. C. The transition conference will occur for <b>100%</b> of the children exiting Part C and potentially eligible for Part B.
<b>2010</b> (2010-2011)	A. <b>100%</b> of children exiting Part C will have an IFSP with transition steps and services. B. The LEA will be notified for <b>100%</b> of the children exiting Part C and potentially eligible for Part B. C. The transition conference will occur for <b>100%</b> of the children exiting Part C and potentially eligible for Part B.
<b>2011</b> (2011-2012)	A. <b>100%</b> of children exiting Part C will have an IFSP with transition steps and services. B. The LEA will be notified for <b>100%</b> of the children exiting Part C and potentially eligible for Part B. C. The transition conference will occur for <b>100%</b> of the children exiting Part C and potentially eligible for Part B.
<b>2012</b> (2012-2013)	A. <b>100%</b> of children exiting Part C will have an IFSP with transition steps and services. B. The LEA will be notified for <b>100%</b> of the children exiting Part C and potentially eligible for Part B. C. The transition conference will occur for <b>100%</b> of the children exiting Part C and potentially eligible for Part B.

**Revisions, with Justification, to Proposed Targets / Improvement Activities / Timelines / Resources for FFY 2008 (2008-2009), FFY 2009 (2009-2010), FFY2010 (2010-2011), FFY 2011 (2011-2012), and FFY 2012 (2012-2013):**

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Issues related to differences in eligibility &amp; services under Part C and Part B</b>				
F	1. In FFY 2005, Part B staff were encouraged to participate on the multidisciplinary teams to facilitate determining eligibility for Part B concurrently with Part C. This has been ongoing in parts of Health Districts VIII and IX and in other areas of the state.	FFY 2005 through FFY 2012	SC DC C.O. staff Part B staff	New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This practice serves to support seamless transitions.
E, F, G	2. In FFY 2005, collaboration with agencies resulted in the development of forms that meet requirements for Part C and Part B evaluations and assessments. The Department of Mental Health (DMH) EIS and EI have collaborated to revise forms and procedures used for the IFSP development and service provider documentation for the DMH.  In FFY 2010, plans were made to revise the developmental history. Due to the loss of staff, this document was not revised. Efforts to collaborate with DMH and MDE to revise this form will resume in FFY 2011.	FFY 2005 through FFY 2012	C.O. staff	New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Revised in FFY 2010 Continuing in FFY 2011	Collaboration continues to be used to address current issues related to services or documentation.
E, F, G	3. Since FFY 2005, an effort has been made to develop materials that clearly describe the evaluation/assessment procedures, eligibility criteria, service provision, and transition processes for Part B and Part C, (including the differences between Part C and Part B). In FFY 2011, an EI manual will be developed to cover early intervention, detailing the enrollment to transition process. It will also include information concerning	FFY 2005 through FFY 2012	C.O. staff	New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY2011	These materials will explain the "transition" process from Part C and give parents the needed information and advocacy support.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	family rights. A contract was developed with MSTI to produce this product.				
E, F, G	<p>4. Since FFY 2005, a goal with MDE has been to achieve statewide consistency in addressing the transition process, including concerns relating to differences between eligibility criteria, family rights, and services under Part C and Part B. In FFY 2008, Part C participated with MDE in statewide transition trainings designed to increase awareness and enhance Part B/Part C collaboration at the local level. Participation in joint training offered by MDE and EIS increased ongoing collaborative efforts at local levels. In the interagency agreement with MDE signed on 6/15/2009, the roles and responsibilities of Part C and Part B are clearly described. If FFY 2010, joint meetings were continued with MDE to address any policy/procedure changes. In FFY 2011, joint MDE and Part C statewide transition meetings will be initiated. The joint transition meetings will focus on policies/procedures and responsibilities of each agency. Also, new interagency agreements will be developed to incorporate New Part C Regulations.</p>	FFY 2005 through FFY 2012	C.O. staff	<p>New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007 Revised in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011</p>	This collaboration is key to seamless transitions from Part C to Part B.
C	<p>5. Since FFY 2005, training and technical assistance have addressed the transition components. In FFY 2008, the definition for "potentially eligible for Part B" changed in the interagency agreement with MDE. In FFY 2009, the training and TA reflected the current transition requirements.</p>	FFY 2005 through FFY 2012	C.O. staff	<p>New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007 Revised in FFY 2008 Continued in FFY 2009 Revised in FFY 2010 Continuing in FFY 2011</p>	District training/TA for Part C staff is necessary to address local challenges and policy/procedure changes between Part B and Part C.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Definition of “potentially eligible for Part B”</b>				
A,G	<p>1. In FFY 2005, potentially eligible for Part B was defined as “being served with an IFSP until the child’s transition date or until the child is three years old.”</p> <p>In FFY 2006, discussions with MDE regarding the electronic transfer of child find contact information led to changing the definition of “potentially eligible for Part B” to include “children still receiving Part C services after 2 years and 6 months of age who continue to be served with an IFSP until the child’s transition date or until the child is three years old.”</p> <p>In the interagency agreement with MDE signed on 6/15/2009, the definition of “potentially eligible for Part B” was revised to include “children still receiving Part C services after 2 years and 3 months of age who continue to be served with an IFSP until the child’s transition date or until the child is three years old”.</p> <p>The MDE data transfer will continue to occur by the last day of the month for each child who reaches the age of thirty (30) months during the month of submission, who is eligible under Part C, and who has “active” status in the MSDH data system. For children who are referred to Part C after the age of thirty (30) months, MSDH will give data to MDE by the last day of the month in which MSDH received the referral.</p> <p>The transfer of information occurs once a month between the 18<sup>th</sup> and 25<sup>th</sup> of the month from Central Office. In FFY 2011, this procedure will change to reflect New Part C Regulations.</p>	FFY 2005 through FFY 2012	C.O. staff	<p>Completed in FFY 2005</p> <p>Revised in FFY 2006</p> <p>Continued in FFY 2007</p> <p>Revised in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Revised in FFY 2010</p> <p>Revise in FFY 2011</p>	<p>The revision in the definition of “potentially eligible for Part B” allows more time for eligibility determination by Part B and more time to prepare for the transition from Part C services.</p> <p>This will allow our state to adhere to new Part C Regulations</p>

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Parent Advisors</b>				
F	<p>1. In FFY 2008, parent advisors met and began to explore developing a handout which would address the roles of a parent advisor, including their role in transition. This task was difficult because the role of each parent advisor varies depending on the needs of their health district. Due to the lack of parent advisors, this activity did not continue in FFY 2009. However, this activity was supplemented by collaborating with MSPTI.</p> <p>In FFY 2011, collaboration continues with MSPTI to develop this component. Also, an EI manual will be developed to provide parents with needed information concerning their rights and the early intervention process within the state. This also provides parents with resources of advocate groups that can assist them.</p>	FFY 2008 through FFY 2012	C.O. staff	<p>New in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	This tool will educate parents on the resources that are available to help them further their children's development. This will increase parent knowledge and advocacy resources.
	<b>Recruitment of staff</b>				
F	<p>1. In FFY 2005, EI began exploring the possibility of contracting with a parent advisor at the state level for monitoring, coordinating the family outcome activities, linking parents to advocacy groups, and training/technical assistance.</p> <p>In FFY 2008, one of the quality monitors assumed the duties of coordinating the Family Outcome activities, linking parents to advocacy groups, training and technical assistance. This quality monitor also covered two health districts. In late FFY 2008, early FFY 2009, this quality monitor met with staff in each health district to begin assessing needs and planning on how to address</p>	FFY 2005 through FFY 2012	C.O. Staff MSPTI Advocacy Groups	<p>New in FFY 2005</p> <p>Continuing in FFY 2006</p> <p>Continuing in FFY 2007</p> <p>Completed in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Revise in FFY 2011</p>	The expected impact is to prepare parents/guardians for the "transition process" from Part C services. This will increase resource accessibility for parents on support groups/advocacies/parent liaisons.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<p>them. Coordination of training with advocacy groups did not occur in FFY 2009 due to resignation of this quality monitor.</p> <p>In FFY 2010, this activity was restructured to better address the areas of coordinating the family outcome activities, linking parents to advocacy groups, and training/technical assistance. EIS collaborated with PTI to address this area.</p> <p>In FFY 2011, this area was assigned to MSPTI to develop activities for coordination of training with advocacy groups. Current training opportunities offered by the PTI include onsite training, TA, and webinars.</p>				
	<b>Training &amp; Technical Assistance</b>				
C, F	1. In FFY 2008, special emphasis was placed on improving the quality of Transition Steps and Services. This effort continues in FFY 2011.	FFY 2008 through FFY 2012	C.O. staff	New in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This continues to be emphasized in the IFSP and transition trainings.
E	<p>2. In FFY 2006, a training was developed to ensure that families, guardians, caregivers, and providers are knowledgeable on how to advocate for the rights of families of children in need of and eligible for early intervention services. Since FFY 2006, training on parental rights for district personnel, service providers, parents, and other stakeholders has been provided.</p> <p>In FFY 2007, the complaint process form was developed to explain the complaint process to parents. The Infant/Toddler and Family Rights (I/T &amp; Family Rights) document was revised to a family-friendly format and language. The complaint process form, a glossary, and a list of</p>	FFY 2006 through FFY 2012	C.O. staff	New in FFY 2006 Revised in FFY 2007 Continued in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The expected impact is increasing parents' knowledge of their rights and comfort levels in exercising their rights.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	resources were put in a single document. This document has been used since FFY 2007.				
C, D	<p>3. In FFY 2008, emphasis was placed on increasing service coordinators, parent advisors, and parents' awareness of advocacy resources. This was done through technical assistance and by encouraging health districts to request training offered by the Mississippi Parent Training and Information Center (MSPTI). Training on advocacy skills for parents and guardians was offered in several health districts by staff from the MSPTI.</p> <p>Since FFY 2008, information about training opportunities offered by MSPTI has been given to district staff for parents of whom the training was appropriate. Current training opportunities offered by the MSPTI include onsite training, TA, and webinars.</p> <p>In FFY 2009, EI utilized the MSPTI and advocacy groups within the state to provide training to parents, service coordinators and parent advisors. This served to enhance our parent's advocacy skills. The training occurred in at least one location in each health district in FFY 2009. This training will continue in FFY 2011.</p>	FFY 2008 through FFY 2012	C.O. staff MSPTI advocacy groups District staff	<p>New in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	<p>The expected impact is increasing parent's knowledge of their rights and comfort levels in exercising them.</p> <p>Service coordinators and parent advisors will learn how to better inform and empower parents.</p>
C, D	<p>4. In the transition training with MDE, technical assistance offered at district staff meetings included basic instructions on the purpose of the transition conference; the new procedures to address the child and family's unique transition needs, and methods that could be used to document the meeting. In FFY 2009, special emphasis was placed on improving the quality of transition conferences. This training continued in FFY 2010.</p>	FFY 2008 through FFY 2012	C.O. staff	<p>New in FFY 2008</p> <p>Revised in FFY 2008</p> <p>Continued FFY 2009</p> <p>Continued in FFY 2010</p> <p>Revise in FFY 2011</p>	<p>Continued collaboration and improvement in the effectiveness of transition conferences are expected.</p> <p>This revision is a requirement to meet new Part C Regulations.</p>

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	A new training module has been created to include updated federal and state regulations. The new IFSP implemented by First Steps is included in this training with emphasis placed on seamless transition conferences between the two agencies. In FFY 2011, new Part C Regulations will be implemented in policy/procedures and statewide training will be provided.				
A C E,F	5. In FFY 2011, the IFSP was revised and approved in July, 2011. Statewide implementation occurred on October 1, 2011. The new IFSP includes a transition component designed to improve the transition process by providing a detailed guide to document transition steps and services, notification of the LEA and transition conference. Statewide training will continue in FFY 2011.	FFY 2010 through FFY 2012	C.O. staff District staff	New in FFY 2011	The revised IFSP will contribute to meeting transition timelines and impact the goal of a seamless transition process.
A, D	6. In FFY 2009, local staff were instructed to refer all parents who do not want the LEA involved, to Central Office. This has allowed Central Office staff to explain the requirement and allow the service coordinator to maintain rapport with the family. This activity was discontinued and the district staff will direct and guide families through this process.	FFY 20011 through FFY 2012	SC	New in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This will allow more collaboration at the local level.
	<b>Database changes</b>				
A	1. FFY 2005, revisions to the database included fields for transition steps and services and the transition conference. In FFY 2007, FSIS was revised to add calculations for the date the child will be 27, 30, 33, and 36 months and the date that MDE was notified of a child "potentially eligible for Part B."	FFY 2005 through FFY 2012	Data manager	New in FFY 2005 Revised in FFY 2006 Revised in FFY 2007 Revised in FFY 2008 Revised in FFY 2009 Revised in FFY 2010	The database changes continue to provide data collection, review, and reporting. These data base revisions will improve validity and timely data entry.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<p>In FFY 2008, the database was revised to allow entry of justifications, declining LEA involvement, and declining to have a transition meeting. In addition, a report was built to notify the staff of children who will meet the criteria for "potentially eligible for Part B" next month, if their status does not change. This report includes the children referred to Part C after 27 months of age. Reports were built to facilitate entry of missing data.</p> <p>In FFY 2010, these available reports were refined to better serve their purpose.</p> <p>In FFY 2011, the data base will be set up to automatically remind users of upcoming LEA notifications, transition steps/services and transition conferences which are due within 30 days from timeline. Also, new Part C Regulations requirements will be added to the database to ensure implementation of new federal guidelines.</p>			Revise in FFY 2011	
A, G	<p>2. In FFY 2007, work with Part B resulted in revisions that allowed data to be shared electronically between MSDH (FSIS) and MDE (MSIS).</p> <p>In FFY 2008, the process changed to submit data on a monthly basis and not only when requested by the data manager at MDE.</p>	FFY 2005 through FFY 2012	Data manager	<p>Completed in FFY 2007</p> <p>Revised in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	This process continues to be implemented to share data with MDE in a timely manner.
A,F	<p>3. In FFY 2010, a staff member was tasked to monitor data to identify districts that are not meeting the transition timelines. This person had the responsibility of developing a timeline tickler system. In FFY 2011, the database manager will develop this tickler system within the database.</p>	FFY 2010 through FFY 2012	CO staff	<p>New in FFY 2010</p> <p>Continuing in FFY 2011</p>	<p>This process will allow us to identify areas where SC's are not properly implementing the transition process.</p> <p>The tickler system will allow the SCs to know their timelines so that</p>

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
					they can better meet timelines.
A C E,F	<p>4. The IFSP was revised and approved in July, 2011. Statewide implementation occurred on October 1, 2011.</p> <p>The new IFSP includes a transition page(6) designed to improve the transition process by providing a detailed timeline to document transition steps and services, notification of the LEA and transition meeting date. Statewide training occurred in October to include all districts. The tablet pc will help with the transmission of data. In FFY 2011, revisions will be made , as needed, to reflect the new Part C Regulations.</p>	FFY 2011 Through FFY 2012	CO Staff	New in FFY 2011	The new IFSP will help with meeting transition timelines and positively impact the goal of a seamless transition process. Part C to Part B transition process will be updated to follow new Federal Regulations.

**Activities to commence in FFY 2013 (2013-2014)**

1. Evaluate the effectiveness of the above activities in meeting the SPP goals, make necessary changes and utilize broad stakeholder input in this process.
2. Provide training to address compliance and/or performance issues identified in the Annual Performance Reports and through monitoring activities. This training will be ongoing within each health district through coaching, mentoring, and embedded training/technical assistance.

**Resources for Activities**

Please refer to the resources for Indicator 1, unless otherwise specified.

## Mississippi's Part C State Performance Plan for 2005-2012

### Monitoring Priority: Effective General Supervision Part C / General Supervision

**Indicator 9:** General supervision system (including monitoring, complaints, hearings, etc.) identifies and corrects noncompliance as soon as possible but in no case later than one year from identification.

(20 U.S.C. 1416(a)(3)(B) and 1442)

#### Measurement: (beginning with FFY 2005)

Percent of noncompliance corrected within one year of identification:

- a. # of findings of noncompliance.
- b. # of corrections completed as soon as possible but in no case later than one year from identification.

Percent = [(b) divided by (a)] times 100.

For any noncompliance not corrected within one year of identification, describe what actions, including technical assistance and/or enforcement that the State has taken.

#### Overview of Issue/Description of System or Process:

1. The transition to a focused monitoring process will begin in May 2006, after the districts receive training on the changes in the process. The monitoring instruments and training materials are being developed. FSIS data were used to determine the order of the monitoring visits and to determine priorities in conducting the monitoring visit. The focus of each district's monitoring visits will be to investigate and address factors negatively impacting EI services. The factors will be identified through data patterns, the district's self-reviews, informal complaints, findings of the quality monitors, and factors identified in the process of monitoring and providing technical assistance. The monitoring team will work with the district staff to identify and address the factors. The process will be tailored to address the needs in each district. Monitoring goals include identifying, enhancing and utilizing the district's strengths as well as addressing weaknesses. The goal is to have a draft improvement plan developed before the team leader leaves the health district and to provide training and technical assistance as systemic findings and noncompliance are identified.
2. The new monitoring process will replace the current process described in the following sections. The current process has been implemented, but not systematically. Monitoring was primarily conducted as a result of informal complaints and concerns directed to the Quality Monitors or to Central Office staff. Documentation associated with the current approach is not quantifiable.
3. First Steps, Mississippi's Infant and Toddler Early Intervention Program, is a Division of the MSDH Office of Health Services, Bureau of Child and Adolescent Health. The Division is organized into four areas of emphasis. The Division oversees all aspects of Part C implementation. It has programmatic and policy responsibility for the activities of the district early intervention staff. The Division is the primary liaison to all other public and private agencies providing early intervention services (EIS) statewide.

*The Part C Program Integrity Branch* ensures the appropriate use of Part C grant funds throughout the state. The Branch monitors the expenditure of Part C resources by public health districts to ensure availability of necessary resources statewide. The Branch negotiates contracts, monitors contract terms, and supervises the monitoring of quality service delivery of services statewide with the assistance of contractual personnel and public health district staff. The Branch oversees service delivery contracts functioning in multiple public health districts.

*The Part C Services Branch* oversees core implementation activities such as service coordination, child find, evaluation and assessment, individualized family service planning, service delivery, and transition processes. Additionally, the Branch oversees targeted case management (TCM), compliance monitoring activities of the public health districts, training, and technical assistance.

Each of these branches has monitoring responsibilities that overlap at the point of service delivery to the child and family. Each is capable of identifying and correcting isolated or systemic non-compliance. The work of each branch affects training and technical assistance, service delivery, data collection, and other aspects of implementation.

*Early Hearing Detection and Intervention Program in Mississippi (EHDI-M)* oversees the state's universal newborn hearing screening (UNHS) program and hearing intervention activities. This system serves as a significant source of referrals to First Steps. It also promotes personal contact with hospitals with labor and delivery services statewide. The original screening equipment was purchased with Part C funds. All UNHS equipment was replaced in 2004 with funds contributed from third party earnings from other MDH child health programs. Through UNHS greater than 96% of all live births in hospitals are screened and 100% of infants identified with bilateral hearing loss are referred to First Steps. Hearing Resource Consultants (HRCs) work directly with families and providers from screening through treatment. The HRCs are a part of the IFSP team for these children and families. This unit's activities have been reviewed by the Health Resources and Services Administration (HRSA) and received commendations for overall performance.

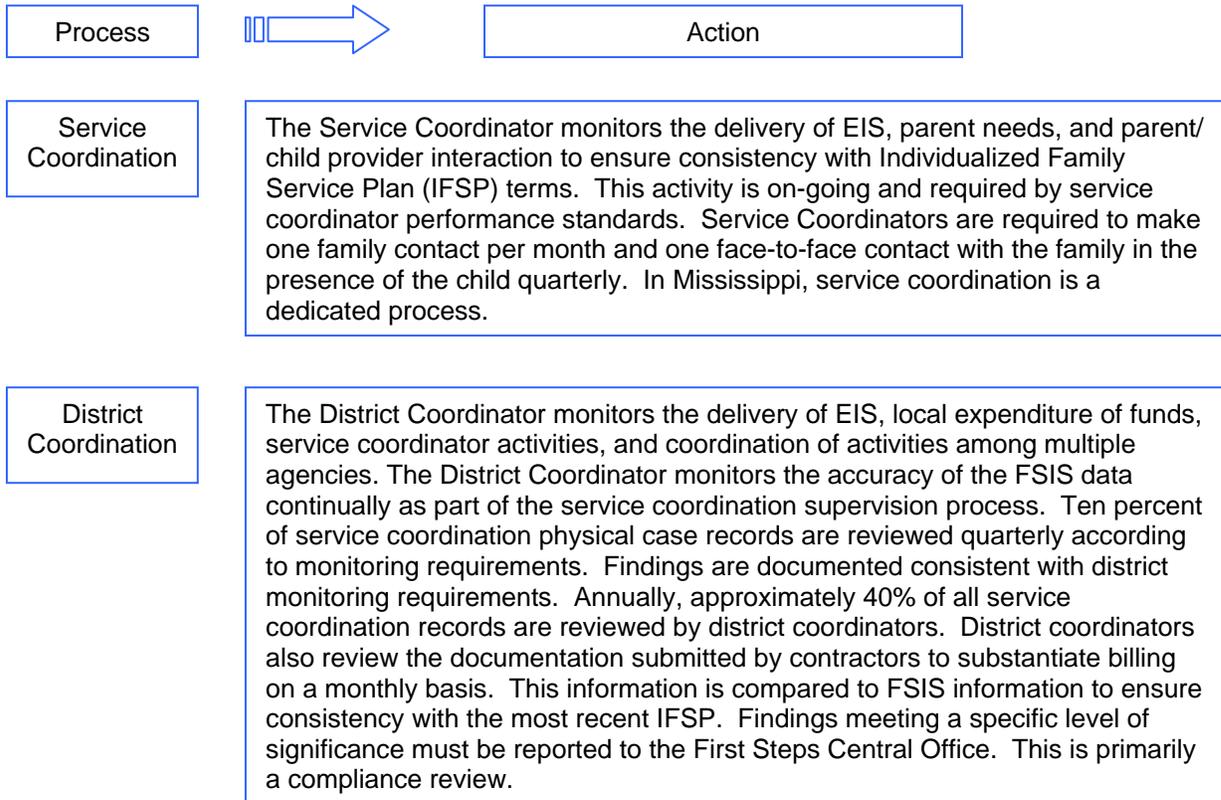
*Information Management* oversees the First Steps Information System (FSIS) and other subordinate data collection and management activities of the division. The FSIS has been under a constant state of development/improvement to allow for the necessary collection of data to meet the 618 data reporting requirements, improve state and local management capacity, address the need to collect outcome oriented data, and to increase service coordination efficiency. Information Management supports statewide staff and provides data analysis, system design, and reports necessary to fulfill all data reporting and programmatic requirements.

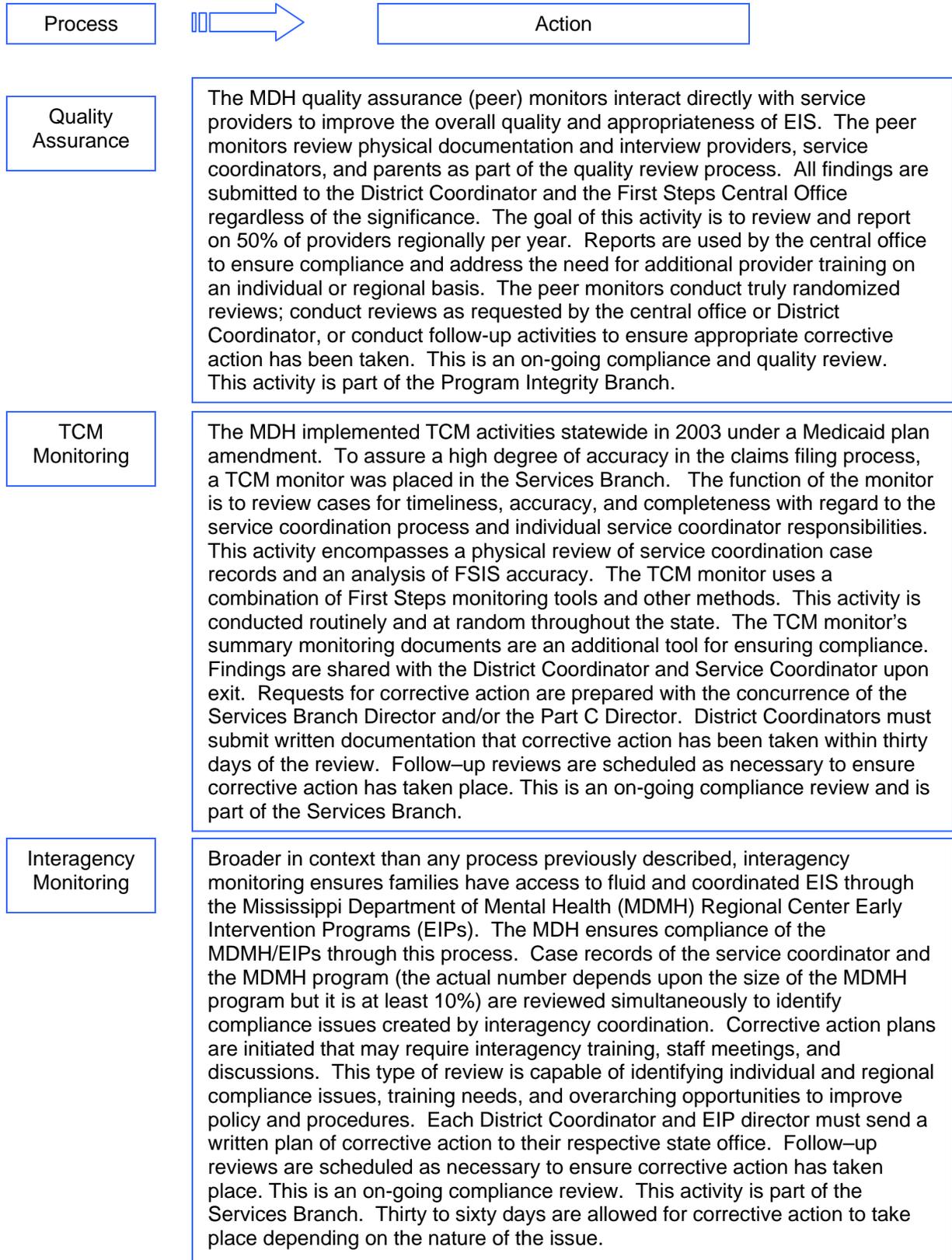
Two programs outside the Office of Health Services assist with monitoring activities. The MDH Office of Finance and Administration, Service Quality and Internal Audit programs (see monitoring Attachment 3), provide additional insight into the activities of the district and field staff. Findings are shared with district and central office staff.

Data from a variety of sources are used to identify isolated and systemic issues. The FSIS has become a formidable tool in identification of isolated and systemic noncompliance. Its utility in this arena continues to be developed. The ability to identify service delivery issues down to the child level and strengthen the integrity of the service coordination, service delivery, and monitoring processes seems to be great. We continue to work toward system enhancement to capture and report child and family outcome data as well. The following diagram depicts the monitoring processes and activities of the MDH as Part C lead agency.

**Lead Agency Primary Monitoring Processes**

The MDH district and county service coordination staff are all employees of the lead agency. Public Health Districts in Mississippi are not autonomous, independently functioning entities.





The implementation of the process described above has led to addressing issues of individual clients and their families but not systemic issues, other than the actions of one agency providing services resulting in termination of the contract. Coordination among the monitoring efforts began in the fall of 2005 between the quality monitors and the OMAS. Within the past six months, District Work Plans have been developed and monitored. The effectiveness of the district self review has depended on the effort of the district coordinator. Review and update of District Work Plans has not occurred on a regular basis.

**Baseline Data for FFY 2004 (2004-2005):**

Various systems for record keeping exist. The combination of systems does not lend itself to electronically quantifiable data regarding complaints on the local or state levels. The numbers recorded below were obtained from District Coordinators who forwarded their data to the Central Office. The current system needs to be redesigned to allow for systematic recording of this information.

- Informal complaints = Not captured in the data system
- Formal signed written complaints = 0
- Mediations = 0
- Requests for Due Process Hearings = 0

**Discussion of Baseline Data:**

There was not a comprehensive system which differentiates between signed and unsigned complaints and complaints reported in writing and orally. Please refer to Indicator 10 for more discussion on complaints; Indicator 11 for more discussion on due process hearing requests that were fully adjudicated within the applicable timeline; and Indicator 13 for more discussion on mediations held that resulted in mediation agreements.

FFY	Measurable and Rigorous Targets for Indicator 9
<p><b>2005</b> (2005-2006)</p>	<p>A. <b>100%</b> of noncompliance related to monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>B. <b>100%</b> of noncompliance related to areas not included in the above monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>C. <b>100%</b> of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) will be corrected within one year of identification.</p>
<p><b>2006</b> (2006-2007)</p>	<p>A. <b>100%</b> of noncompliance related to monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>B. <b>100%</b> of noncompliance related to areas not included in the above monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>C. <b>100%</b> of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) will be corrected within one year of identification.</p>
<p><b>2007</b> (2007-2008)</p>	<p>A. <b>100%</b> of noncompliance related to monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>B. <b>100%</b> of noncompliance related to areas not included in the above monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>C. <b>100%</b> of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) will be corrected within one year of identification.</p>

<p><b>2008</b> (2008-2009)</p>	<p>A. <b>100%</b> of noncompliance related to monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>B. <b>100%</b> of noncompliance related to areas not included in the above monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>C. <b>100%</b> of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) will be corrected within one year of identification.</p>
<p><b>2009</b> (2009-2010)</p>	<p>A. <b>100%</b> of noncompliance related to monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>B. <b>100%</b> of noncompliance related to areas not included in the above monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>C. <b>100%</b> of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) will be corrected within one year of identification.</p>
<p><b>2010</b> (2010-2011)</p>	<p>A. <b>100%</b> of noncompliance related to monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>B. <b>100%</b> of noncompliance related to areas not included in the above monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>C. <b>100%</b> of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) will be corrected within one year of identification.</p>
<p><b>2011</b> (2011-2012)</p>	<p>A. <b>100%</b> of noncompliance related to monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>B. <b>100%</b> of noncompliance related to areas not included in the above monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>C. <b>100%</b> of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) will be corrected within one year of identification.</p>
<p><b>2012</b> (2012-2013)</p>	<p>A. <b>100%</b> of noncompliance related to monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>B. <b>100%</b> of noncompliance related to areas not included in the above monitoring priority areas and indicators will be corrected within one year of identification.</p> <p>C. <b>100%</b> of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) will be corrected within one year of identification.</p>

**Improvement Activities/Timelines/Resources:**

**Activities to commence in the second half of FFY 2005 (2005-2006)**

1. Begin revision of the Policies and Procedures to address changes in IDEA'04.
2. Complaints, Mediation, Due Process Hearings
  - a. Write procedures to address the handling of complaints, mediation, and due process hearings.
  - b. Revise procedural safeguards and develop supporting training materials and information to facilitate exercising of rights.
  - c. Develop necessary forms (for complaints, mediation requests, due process hearing requests, and record keeping of contacts and results).

3. Monitoring:
  - a. Replace the current monitoring activities with a process of focused monitoring, which includes components to identify and address compliance issues
  - b. Develop instruments
  - c. Develop training
  - d. Submit monitoring framework to OSEP, NECTAC, and SERRC for review and feedback
4. Training and technical assistance:
  - a. On Family Rights (what they entail and how to effectively educate parents/guardians and caregivers)
  - b. On Complaints, Mediation, and Due Process Hearings with an emphasis on problem solving to avoid a need for formal, protracted processes to resolve complaints
  - c. On the monitoring process
    - i) The reasons to monitor
    - ii) The process,
    - iii) Effective record keeping and data entry
    - iv) Effective follow-up.
5. Configure the FSIS data base to capture information about:
  - d. written signed complaints
  - e. mediation requests
  - f. due process requests
  - g. correction of non-compliance
  - h. correction of systemic performance problems related to monitoring priority areas and indicators.

**Activities to commence in FFY 2006 (2006-2007)**

1. Continue the changes made in the second half of 2005.
2. Evaluate the effectiveness of the above activities and make necessary changes and utilize broad stakeholder input in this process.
3. Make changes associated with requirements in the federal regulations for Part C of IDEA'04.
4. Contract with providers willing to make needed improvements identified through the General Supervision System.
5. Provide training on:
  - a. The new Policies and Procedures
  - b. The monitoring process.

**Activities to commence in FFY 2007 (2007-2008)**

1. Evaluate the effectiveness of the above activities and make necessary changes and utilize broad stakeholder input in this process.
2. Provide training and technical assistance :
  - a. On improvement activities identified during the monitoring process

- b. For new district staff and service providers. The majority of this training and technical assistance will occur within each health district with follow-up through embedded training, coaching, and mentoring on a continuous basis.
3. Mississippi is working with MSDH administration to develop a matrix of sanctions and enforcement actions that will be used when correction of noncompliance does not occur within the required timeframe.
  4. Data Verification (Beginning January 2008):

**A. Data Reports:** Data pulled for the APR (7/1/06 to 6/30/07) and two progress notes (7/1/07 to 12/31/08 AND 1/1/08 to 4/31/08) will be used to determine if the districts are in compliance with Indicators 1, 2 (child-based justifications), 7, 8, 9, 11, and 14 and performance indicators 2, 5, and 6. When a compliance indicator is not met, the district will be notified of the finding of noncompliance and the time period in which correction must occur. If progress is not being made toward meeting a performance indicator, the district will develop a plan of correction. If expected progress is not evident by the next reporting period, the district will be notified of a finding of noncompliance and the time period in which correction must occur.

**B. Data Verification visits:** Data verification is a joint effort including both central office and health district staff. During each quarter at least the following number of records will be compared to FSIS data. The records reviewed by the district coordinator (DC) and the quality monitor (QM) will not overlap.

Type of case record to review each quarter	DC	QM
active case records with an IFSP	10%	10%
active case records without an IFSP	3	3
inactive case records	PRN	1
tracking case records	PRN	1

The verification involves ensuring:

- critical information is in the child's EI record;
- critical information and FSIS data match;
- documentation suggests good service coordination and EI services that meet the unique needs of the child and their family.
- records for the quality monitors' sample of "active cases with an IFSP" are consistent with billing records.

Errors are corrected immediately. If an activity must occur before the data can be entered, the activity will be scheduled in a timely manner. The quality monitor or other central office staff member will check for correction no later than 30 days from the data verification visit. Technical assistance will be provided when an error is found. If extensive technical assistance is needed, this will be scheduled as soon as possible. Follow-up may involve observations and interviews (e.g., when problems involving multidisciplinary evaluation/assessment, IFSP development, and/or service provision are found). This follow-up will lead to findings if there are at least 3 sources of information and two different methods. Systemic noncompliance will be the finding if the problem occurs throughout the district or regularly in the activities of one or more district staff members or service provider(s). Information from the data verification will be used to determine if the FSIS data and data reports are valid and reliable. As mentioned under data reports, the results of the data reports may result in findings of noncompliance.

**Revisions, with Justification, to Proposed Targets / Improvement Activities / Timelines / Resources for FFY 2008 (2008-2009), FFY 2009 (2009-2010), FFY2010 (2010-2011), FFY 2011 (2011-2012), and FFY 2012 (2012-2013):**

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Monitoring Activities</b>				
B	<p>1. In FFY 2006, the monitoring done in four health districts, which EI called "focused monitoring", was similar to the definition of comprehensive monitoring.</p> <p>During FFY 2007, focused monitoring was done in the remaining five health districts.</p>	FFY 2005 through FFY 2010	C.O. staff	<p>New in FFY 2006</p> <p>Revised in FFY 2007</p> <p>Revised in FFY 2008</p> <p>See # 2 below for current process.</p>	Findings were issued in 7 of 9 Health Districts.
B	<p>2. At the end of FFY 2007, focused monitoring began in three health districts. The health districts chosen were those who would most benefit from focused monitoring soon after the comprehensive monitoring that occurred in all nine health districts in FFY 2005 and FFY 2006.</p> <p>In FFY 2008, the health districts chosen for focused monitoring were those most needing assistance to affect needed changes. This method of selecting health districts for focused monitoring continues to be used in FFY 2009.</p> <p>Focused monitoring occurred in Health Districts VI and III in FFY 2009. Targeted technical assistance occurred in Health Districts IV and V. In FFY 2010, Health Districts II and VIII had focused monitoring visits. Health Districts II and VIII onsite monitoring was in FFY 2010.</p> <p>Targeted technical assistance occurred in Health Districts I, III, IV and V.</p>	FFY 2006 through FFY 2012	C.O. staff and other assigned monitors SERRC ECO	<p>New in FFY 2006</p> <p>Revised in FFY 2007</p> <p>Revised in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Revised in FFY 2011</p>	Selection for focused monitoring shifted to being based on need rather than a rotation schedule. The result is an effective use of available resources for addressing noncompliance. The guidelines for completing a focused monitoring visit will be included in the upcoming General Supervision manual.
B	<p>3. In FFY 2008, we identified a time during the SPP/APR reporting period to review compliance data from the database.</p> <p>In FFY 2009, data pulled for compliance was pulled for a specified period which was less than one</p>	FFY 2008 through FFY 2012	District coordinators and C.O staff	<p>New in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Revised in FFY 2011</p>	The change is expected to result in more timely correction of noncompliance.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<p>year.</p> <p>In FFY 2009, data findings were issued on December 18, 2009.</p> <p>In FFY 2011, data findings will be issued based on a compliance data pull which will cover a 12 month period.</p>				
A, B	<p>4. In FFY 2008, data verification was used as a tool to ensure valid and reliable data to determine TA needs, and to determine if the TA was successful.</p> <p>In FFY 2009, data verification forms were refined to better capture transition information and other changes to facilitate the relevant information.</p> <p>In FFY 2011, data verification forms will be refined to incorporate the new general supervision process.</p>	FFY 2007 through FFY 2012	Quality monitors and other C.O staff SERRC	<p>New in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Revised in FFY 2010</p> <p>Revise in FFY 2011</p>	Our data verification process is a very effective tool for identifying training and TA needs. New forms will be inclusive and will meet the new Part C Regulations/guidelines
B	<p>5. In FFY 2007, potential sanctions and enforcement actions were drafted. In FFY 2009, necessary enforcement actions were determined after the onsite visit. In FFY 2011 a General Supervision manual will be developed and will identify sanctions and enforcement actions. OSEP and SERRC will provide TA for the development of this manual.</p>	FFY2007 through FFY 2012	MSDH administration	<p>New in FFY 2007</p> <p>Revised in FFY2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	More effective use of sanctions/ enforcement actions will result in more timely correction of noncompliance. Correct policy and procedures will be implemented statewide and reflect new Part C Regulations.
B	<p>6. In FFY 2008, one component of verifying correction of noncompliance was based on a review of updated data to determine if the program is correctly implementing the specific statutory or regulatory requirement(s).</p> <p>In FFY 2009, this process continued and was used along with implementation of CAP and accounting for all children involved with the finding. This process continued in FFY 2010.</p>	FFY 2008 through FFY 2012	Monitoring teams	<p>New in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Revised in FFY 2011</p>	The change has resulted in a timely correction of noncompliance.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	In FFY 2011, the process to verify correction of noncompliance and implementation of required procedures will be revised in the upcoming General Supervision manual. OSEP and SERRC will provide TA with the General Supervision manual.				
B	7. In FFY 2008, we identified a time during the SPP/APR reporting period to review compliance data from the database. In FFY 2009, data pulled for compliance was for a specified period that is less than one year. In FFY 2010, this process of pulling data continued. In FFY 2011, this process of pulling data for compliance will be for a specific 12 month period.	FFY 2008 through FFY 2012	District coordinators C.O staff	New in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Revised in FFY 2011	The change is expected to result in a timely correction of noncompliance.
B	8. Service Verification: In FFY 2008, the district coordinators agreed to review the same active case records reviewed for the data verification to determine if the services were being implemented as specified on the current IFSP. In FFY 2009, service verification was redesigned and implemented.	FFY 2008 through FFY 2012	DC	New in FFY 2008 Revised in FFY2009 Continued in FFY 2010 Continuing in FFY 2011	This data verification tool is very effective for identifying training and TA needs.
<b>Training &amp; Technical Assistance</b>					
D	1. Technical Assistance: In FFY 2008, TA was more targeted. In FFY 2009, new reports in the database provided targeted TA. Also, evidence of change must be apparent within a reasonable period of time or additional monitoring activities will be conducted.	FFY 2005 through FFY 2012	Quality monitors, C.O staff, and other resources	New in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Use of the new reports by the quality monitors will facilitate individualized technical assistance.
A,B,D,F	In FFY 2009, SERRC provided technical assistance onsite during a focused monitoring visit	FFY 2009	C.O. staff	New in FFY 2009	This TA helped improve our focused monitoring

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	in which the emphasis was timely services. The TA addressed timely service issues and improving EIS general supervision activities. SERRC and OSEP will assist with developing a General Supervision manual.	through FFY 2012		Continued in FFY 2010 Revise in FFY 2011	process and strategies for addressing timely service issues. Technical assistance will assist in implementing correct Part C procedures/guidelines and will incorporate new federal regulations.
	<b>Database changes</b>				
A	1. In FFY 2008, justification fields were added in the database for service coordinators to document. In FFY 2009, database changes described in Indicator 14 have improved data entry, retrieval, and review.	FFY 2007 through FFY 2012	Data manager District staff	New in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	These changes have facilitated corrective actions within the health districts and improve the data verification process.
A, B	2. In FFY 2009, a general supervision (monitoring) module that allows us to track correction of noncompliance will be developed. This system will allow tracking correction at three levels: local, health district, and state.  The module was developed in August 2010, and will be used with the next compliance data findings and focused monitoring findings.  This monitoring module will be refined in accordance with the new procedures that will be outlined in the General Supervision Manual.	FFY 2009 through FFY 2012	Data manager	New in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This module will facilitate tracking of correction of noncompliance and implementation of new federal regulations.
	<b>Corrective Action Plans</b>				
B, E, H	1. All health districts with findings are now required to submit more detailed CAPs and	FFY 2009	DCs C. O. staff	New in FFY 2009 Continued in FFY 2010	The changes are expected to result in a

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<p>report monthly on their progress. The CAPs must include the following: strategies/activities; expected results; the timeframe including benchmarks (specific sub-goals that will be met by specific dates); and the person(s) responsible for implementing the strategies/activities. The CAP must be submitted to the Central Office by a specified date for approval. Submitted plans will either be approved or corrected by a specified date. Monthly updates on action taken must be documented in the plan.</p> <p>The General Supervision procedures for the CAP and the format of the CAP will be revised.</p>	through FFY 2012		Revise in FFY 2011	timely correction of noncompliance. The revised procedures will better meet the needs of the district and be a more effective tool to measure progress.

**Activities to commence in FFY 2013 (2013-2014)**

1. Evaluate the effectiveness of the above activities and make necessary changes and utilize broad stakeholder input in this process.
2. Provide training and technical assistance :
  - a. On improvement activities identified during the monitoring process;
  - b. For new district staff and service providers. The majority of this training and technical assistance will occur within each health district with follow-up through embedded training, coaching, and mentoring on a continuous basis.

**Resources for Activities**

Please refer to the resources for Indicator 1, unless otherwise specified.

Revised February 1, 2012

**Mississippi's Part C State Performance Plan for 2005-2012****Monitoring Priority: Effective General Supervision Part C / General Supervision**

**Indicator 10:** Percent of signed written complaints with reports issued that were resolved within 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.

(20 U.S.C. 1416(a)(3)(B) and 1442)

**Measurement:**

Percent = (1.1(b) + 1.1(c)) divided by (1.1) times 100.

**Overview of Issue/Description of System or Process:**

When parents are given the Family Rights brochure, they are informed of their right to file complaints and are given the First Steps Central Office toll-free number. Complaints are received on both the local and state levels. Neither the manner in which the complaints are tracked or the forms used to record them are standard. There is not a process for the health districts to systematically report complaints received, action taken, and resolution of the complaint. The only exception is that they are to report to the First Steps Central Office any findings which cannot be resolved at the district level. A significant increase in written complaints was due to the closing of a Department of Mental Health early intervention program, which was the main provider in Health District IX. The closure came with short notice, and services were disrupted until providers were found and put under contract.

**Baseline Data for FFY 2004 (2004-2005):**

Signed written complaints received at the First Steps Central Office = 0

Signed written complaints with reports issued that were resolved within 60-day timeline or a timeline extended for exceptional circumstances = N/A

**Discussion of Baseline Data:**

No signed written complaints have been received at the district or state level in three years. On the state level informal complaints have been handled by central office staff by either addressing the involved parties directly or by conducting a site visit. A main function of the quality monitors has been to investigate informal complaints. On the local level, the DC or DA has addressed complaints. A uniform formal method of documenting complaints needs to be developed for use at both the district and state levels. The database needs to be configured to capture information about signed written complaints.

<b>FFY</b>	<b>Measurable and Rigorous Target for Indicator 10</b>
<b>2005</b> (2005-2006)	100% of signed written complaints with reports issued will be resolved within a 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
<b>2006</b> (2006-2007)	100% of signed written complaints with reports issued will be resolved within a 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
<b>2007</b> (2007-2008)	100% of signed written complaints with reports issued will be resolved within a 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
<b>2008</b> (2008-2009)	100% of signed written complaints with reports issued will be resolved within a 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.

Revised February 1, 2012

<b>2009</b> (2009-2010)	100% of signed written complaints with reports issued will be resolved within a 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
<b>2010</b> (2010-2011)	100% of signed written complaints with reports issued will be resolved within a 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
<b>2011</b> (2011-2012)	100% of signed written complaints with reports issued will be resolved within a 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
<b>2012</b> (2012-2013)	100% of signed written complaints with reports issued will be resolved within a 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.

**Improvement Activities/Timelines/Resources:****Activities to commence in the second half of FFY 2005 (2005-2006)**

1. Develop procedures to ensure that families, guardians, caregivers, providers, and others involved with the provision of early intervention services are knowledgeable and empowered to advocate for the rights of families of children in need of and eligible for early intervention services,
2. Develop communication notebooks, which include among other valuable information procedural safeguards in a user-friendly format; the MDH/EI toll free #; contact information for advocacy groups; forms for filing informal and signed written complaints, requesting mediation, and requesting due process hearings; and sample letters for documenting requests for changes in services, documentation, etc.
3. Training for
  - a. Families on the process, procedures, and forms used to exercise rights and to get relief and remedy;
  - b. District staff on the process, procedures, forms, and materials to teach families about exercising their rights;
  - c. Providers on the process, procedures, forms, knowledge, and skills families need to exercise their rights;
  - d. Advocacy groups and other stakeholders on the process, procedures, forms, and materials provided to families describing their rights and how to exercise them.
4. Explore the possibility of contracting with a Parent Advisor at the state level for monitoring, coordinating the Family Outcome activities, linking parents to advocacy groups, and training and technical assistance.
5. Configure the database to capture information about signed written complaints.
6. Create and distribute a single document for making informal complaints, written signed complaints, requests for mediation, and requests for due process hearings.
7. Please refer to the activities for Indicator 9 **to commence in the second half of FFY 2005.**

**Activities to commence in FFY 2006 (2006-2007)**

Please refer to the activities for Indicator 9.

**Revisions, with Justification, to Proposed Targets / Improvement Activities / Timelines / Resources for FFY 2008 (2008-2009), FFY 2009 (2009-2010), FFY2010 (2010-2011), FFY 2011 (2011-2012), and FFY 2012 (2012-2013):**

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Procedural changes</b>				
E	<p>1. In FFY 2006, the process began to develop procedures to ensure that families, guardians, caregivers, providers, and others involved with the provision of early intervention services are knowledgeable of how to advocate for the rights of families of children eligible for early intervention services. Since FFY 2006, training on parental rights (for district personnel, service providers, parents, and other stakeholders), has been provided.</p> <p>In FFY 2007, the complaint process form was used to explain the complaint process to parents. The I/T &amp; Family Rights document was put revised to a parent-friendly format and language. The complaint process form, a glossary, and a list of resources were put in a single document. This document will continue to be used.</p> <p>In FFY 2011, CADRE will provide TA to assist with the development of more efficient and effective policies/procedures.</p>	FFY 2006 through FFY 2012	C.O. staff	<p>New in FFY 2006</p> <p>Revised in FFY 2007</p> <p>Continued in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	<p>The expected impact is increasing parent's knowledge of their rights and comfort levels in exercising their rights. The revisions will correct previous procedures so that our state complies with new Part C Regulations and the implementation of the new Part C regulations.</p>
C, D	<p>2. In FFY 2008, emphasis was placed on increasing service coordinators', parent advisors', and parents' awareness of advocacy resources. This was done through technical assistance and by encouraging health districts to request training offered by the Mississippi Parent Training and Information Center (MSPTI). Training on advocacy skills for parents and guardians was offered in several health districts by staff from the MSPTI.</p> <p>Since FFY 2008, information about training opportunities offered by MSPTI has been given to district staff for parents. Current training opportunities offered by the MSPTI include onsite training, TA, and webinars.</p>	FFY 2008 through FFY 2012	C.O staff MSPTI Advocacy groups District staff	<p>New in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	<p>The expected impact is increasing parents' knowledge of their rights and comfort level in exercising their rights. Service coordinators and parent advisors will learn how to better inform and empower parents.</p>

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	In FFY 2009, the MSPTI and advocacy groups within the state were utilized to provide training to parents, service coordinators and parent advisors. This will serve to enhance our parents' advocacy skills. The training will continue.				
F	3. FFY 2006, district staff were given materials to develop communication notebooks, which included among other valuable information; procedural safeguards in a user-friendly format; the MSDH/EI toll free number; contact information for advocacy groups; forms for filing informal and signed written complaints, requesting mediation, and requesting due process hearings; and sample letters for documenting requests for changes in services, documentation, etc. Several health districts consider the notebook to be a valuable tool and have continued to use them. This tool continues to be reintroduced to the other health districts by district staff who continues to use them.	FFY 2006 through FFY 2012	DC SC	New in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Families will have access to resources and information related to their child's specific needs.
F	4. In FFY 2006, there was an effort to make the basic contents of packets given to parents the same. This was revised in FFY 2007, to allow district personnel to decide what to include in the packet beyond the I/T & Family Rights document. In FFY 2008, district staff continued to decide what to include beyond the I/T & Family Rights document. In FFY 2009, resources found to be effective in certain health districts were made available in the other health districts. The availability of these resources will continue.	FFY 2005 through FFY 2012	District staff	New in FFY 2006 Revised in FFY 2007 Continued in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Families will have access to resources and information related to their child's specific needs.
F	5. In FFY 2011, technical assistance is being provided by Cadre to assist in developing procedures for dispute resolution, formal/informal complaint, due process, hearing and mediation.	FFY 2011 through FFY 2012	Part C Coordinator	New in FFY 2011	This will clarify, define, and provide MS with a clear and concise a dispute resolution process.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Recruitment of staff</b>				
F	<p>1. In FFY 2005, we began exploring the possibility of contracting with a parent advisor at the state level for monitoring, coordinating the family outcome activities, linking parents to advocacy groups, and training/technical assistance.</p> <p>In FFY 2008, one of the quality monitors assumed the duties of coordinating the Family Outcome activities, linking parents to advocacy groups, and training and technical assistance. This quality monitor was also covering two health districts. In late FFY 2008 and early FFY 2009, this quality monitor met with staff in each health district to begin assessing their needs of planning on how to address them. EIS will continue to coordinate trainings with advocacy groups.</p>	FFY 2005 through FFY 2012	Part C Coordinator	<p>New in FFY 2005</p> <p>Continued in FFY 2006</p> <p>Continued in FFY 2007</p> <p>Completed in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	The expected impact is increased activities to address family outcomes.
	<b>Database changes</b>				
A	<p>1. The database will be configured to capture information about signed written complaints. This procedure did not occur in FFY 2010 as part of the general supervision module described in Indicator 14. This activity is pending due to staff shortage, but will be completed in FFY 2011.</p>	FFY 2010 through FFY 2012	Data manager	<p>New in FFY 2010</p> <p>Continuing in FFY 2011</p>	This module will initiate tracking of complaints.
	<b>Training and Technical Assistance</b>				
C	<p>1. Since FFY 2006, training on parental rights (for district personnel, service providers, parents and other stakeholders) has been provided. In FFY 2007, the service coordinators began using the Complaint Process form to explain this procedure to parents/caregivers. Parent training is provided by service coordinators and/or parent advisors. Service Coordinator training</p>	FFY 2006 through FFY 2012	C.O. staff	<p>New in FFY 2006</p> <p>Revised in FFY 2007</p> <p>Continued in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p>	The expected impact is increasing parents' knowledge of their rights and comfort levels in exercising

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<p>included providing this information to families. Opportunities for parents to receive additional training on their rights and related issues will continue to be increased through collaboration with the Mississippi Parent Training and Information Center (MSPTI) and advocacy groups. The current training for service coordinators on this topic will be reviewed and revised, as needed.</p>			Continuing in FFY 2011	their rights.
C, D	<p>2. In FFY 2008, emphasis was placed on increasing service coordinators', parent advisors', and parents' awareness of advocacy resources. This was done through technical assistance and by encouraging health districts to request training offered by the Mississippi Parent Training and Information Center (MSPTI). Training on advocacy skills for parents and guardians was offered in several health districts by staff from the MSPTI.</p> <p>Since FFY 2008, information about training opportunities offered by MSPTI has been given to district staff for parents. Current training opportunities offered by the MSPTI include onsite training, TA, and webinars.</p> <p>In FFY 2009, we utilized the MSPTI and advocacy groups within the state to provide training to parents, service coordinators and parent advisors. This served to enhance our parents' advocacy skills. These trainings will continue.</p> <p>In FFY 2011, This activity has been enhanced through a contract with PTI. A flyer has been developed to provide families at enrollment with PTI advocacy contact information. An EI Manual was developed from a parent's perspective to describe the EI process; including dispute resolution.</p>	FFY 2008 through FFY 2012	C.O staff MSPTI advocacy groups District staff	<p>New in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Revised in FFY 2011</p>	<p>The expected impact is increasing parents' knowledge of their rights and comfort in exercising them.</p> <p>Service coordinators and parent advisors will learn how to better inform and empower parents.</p>

**Activities to commence in FFY 2013 (2013-2014)**

1. Evaluate the effectiveness of the above activities and make necessary changes and utilize broad stakeholder input in this process.
2. Provide training and technical assistance :
  - a. On improvement activities identified during the monitoring process;
  - b. For new district staff and service providers. The majority of this training and technical assistance will occur within each health district with follow-up through embedded training, coaching, and mentoring on a continuous basis.

**Resources for Activities**

Please refer to the resources for Indicator 1, unless otherwise specified.

## Mississippi's Part C State Performance Plan for 2005-2012

### Monitoring Priority: Effective General Supervision Part C / General Supervision

**Indicator 11:** Percent of fully adjudicated due process hearing requests that were fully adjudicated within the applicable timeline.

(20 U.S.C. 1416(a)(3)(B) and 1442)

#### Measurement:

Percent = (3.2(a) + 3.2(b)) divided by (3.2) times 100.

#### Overview of Issue/Description of System or Process:

We need to put a process in place. There have been no due process hearing requests in the history of EI in Mississippi. This is likely due in part to the fact that the Family Rights two-page summary explained to parents/guardians describes a process for filing complaints but makes no reference to mediation or due process hearings. The section of the two page summary covering this content reads as follows:

*"The right to disagree:* If you disagree with any of the recommendations made for your child or think he/she is not receiving the services needed, you have a right to voice your concerns. If you have a complaint to make, you can call your service coordinator or call the Mississippi Early Intervention Program at 1-800-451-3903.

I, \_\_\_\_\_, parent(s) of \_\_\_\_\_  
verify the above rights and procedures have been explained to me on this date,  
\_\_\_\_\_, and I understand if I have further questions or concerns I may call or write  
for explanation."

The Family Rights brochure given to the parents includes information about due process hearings but the content is not included in the documentation signed by the parent(s). The instructions in the Service Coordinator manual read as follow: "A copy of the detailed Family Rights pamphlet, including a glossary of terms, will be given to the parents, along with appropriate explanations of any of its concerns." Another possible explanation for successful resolution of informal complaints is the way choices have been offered to parents. The policy by and large has been that "Whatever parents want, parents get," whether the team agreed on the appropriateness of the request or it complied with regulations.

#### Baseline Data for FFY 2004 (2004-2005):

Due Process Hearing requests = 0

#### Discussion of Baseline Data:

There have been no due process hearing requests in the history of EI in Mississippi. It is uncertain what percent of parents or guardians know that they can request mediation or a due process hearing. The two page Family Rights handout which must be covered with the parent/guardian mentions complaints but not mediation or due process hearings. Also, the parents have the right to decline some EI services while accepting other EI services. Having this right to decline some EI services makes it less likely that disagreements will escalate to a due process hearing request. The FSIS database needs to be configured to capture information about due process hearings.

FFY	Measurable and Rigorous Target for Indicator 11
2005 (2005-2006)	100% of due process hearing requests will be fully adjudicated within the 30 day timeline.
2006 (2006-2007)	100% of due process hearing requests will be fully adjudicated within the 30 day timeline.
2007 (2007-2008)	100% of due process hearing requests will be fully adjudicated within the 30 day timeline.
2008 (2008-2009)	100% of due process hearing requests will be fully adjudicated within the 30 day timeline.
2009 (2009-2010)	100% of due process hearing requests will be fully adjudicated within the 30 day timeline.
2010 (2010-2011)	100% of due process hearing requests will be fully adjudicated within the 30 day timeline.
2011 (2011-2012)	100% of due process hearing requests will be fully adjudicated within the 30 day timeline.
2012 (2012-2013)	100% of due process hearing requests will be fully adjudicated within the 30 day timeline.

**Improvement Activities/Timelines/Resources:**

**Activities to commence in the second half of 2005 (2005-2006)**

1. Make arrangements to have
  - a. Hearing officers available when needed; and
  - b. Information regarding the forms and process available on the department's website and printed in the languages spoken by our clients' families.
2. Provide training for hearing officers, families, advocacy groups, district staff, First Steps Central Office staff and other stakeholders on Family Rights and Procedural Safeguards.
3. Please refer to the activities for Indicators 9 and 10.

**Activities to commence in FFY 2006 (2006-2007)**

Please refer to the activities for Indicator 9.

**Activities to commence in FFY 2007 (2007-2008)**

Please refer to the activities for Indicator 9.

**Revisions, with Justification, to Proposed Targets / Improvement Activities / Timelines / Resources for FFY 2008 (2008-2009), FFY 2009 (2009-2010), FFY2010 (2010-2011), FFY 2011 (2011-2012), and FFY 2012 (2012-2013):**

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Procedural changes</b>				
E	<p>1. In FFY 2006, the process began to develop procedures to ensure that families, guardians, caregivers, providers, and others involved with the provision of early intervention services are knowledgeable of how to advocate for the rights of families of children eligible for early intervention services. Since FFY 2006, training on parental rights (for district personnel, service providers, parents, and other stakeholders), has been provided.</p> <p>In FFY 2007, the complaint process form was used to explain the complaint process to parents. The I/T &amp; Family Rights document was put in a more parent-friendly format and language. The complaint process form, a glossary, and a list of resources were put in a single document. This document will continue to be used.</p> <p>In FFY 2011, CADRE will provide TA to assist with development of more efficient and effective policies/procedures.</p>	FFY 2006 through FFY 2012	C.O. staff	<p>New in FFY 2006</p> <p>Revised in FFY 2007</p> <p>Continued in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	The expected impact is increasing parent's knowledge of their rights and comfort levels in exercising their rights. The revisions will correct previous procedures so that our state complies with new Part C Regulations and the implementation of the new Part C regulations.
C, D	<p>2. In FFY 2008, emphasis was placed on increasing service coordinators', parent advisors', and parents' awareness of advocacy resources. This was done through technical assistance and by encouraging health districts to request training offered by the Mississippi Parent Training and Information Center (MSPTI). Training on advocacy skills for parents and guardians was offered in several health districts by staff from the MSPTI.</p> <p>Since FFY 2008, information about training opportunities offered by MSPTI has been given to district staff for parents. Current training opportunities offered by the MSPTI include onsite training, TA, and webinars.</p>	FFY 2008 through FFY 2012	C.O staff MSPTI Advocacy groups District staff	<p>New in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	The expected impact is increasing parents' knowledge of their rights and comfort level in exercising their rights. Service coordinators and parent advisors will learn how to better inform and empower parents.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	In FFY 2009, the MSPTI and advocacy groups within the state were utilized to provide training to parents, service coordinators and parent advisors. This will serve to enhance our parents' advocacy skills. The training will continue.				
F	3. FFY 2006, district staff were given materials to develop communication notebooks, which included among other valuable information; procedural safeguards in a user-friendly format; the MSDH/EI toll free number; contact information for advocacy groups; forms for filing informal and signed written complaints, requesting mediation, and requesting due process hearings; and sample letters for documenting requests for changes in services, documentation, etc. Several health districts consider the notebook to be a valuable tool and have continued to use them. This tool continues to be reintroduced to the other health districts by district staff who continues to use them.	FFY 2006 through FFY 2012	DC SC	New in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Families will have access to resources and information related to their child's specific needs.
F	4. In FFY 2006, there was an effort to make the basic contents of packets given to parents the same. This was revised in FFY 2007, to allow district personnel to decide what to include in the packet beyond the I/T & Family Rights document. In FFY 2008, district staff continued to decide what to include beyond the I/T & Family Rights document. In FFY 2009, resources found to be effective in certain health districts was made available in the other health districts. The availability of these resources will continue.	FFY 2005 through FFY 2012	District staff	New in FFY 2006 Revised in FFY 2007 Continued in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Families will have access to resources and information related to their child's specific needs.
F	5. In FFY 2011, technical assistance is being provided by Cadre to assist in developing procedures for dispute resolution, formal/informal complaint, due process, hearing and mediation.	FFY 2011 through FFY 2012	Part C Coordinator	New in FFY 2011	This will clarify, define, and provide MS with a clear and concise a dispute resolution process.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Recruitment of staff</b>				
F	<p>1. In FFY 2005, we began exploring the possibility of contracting with a parent advisor at the state level for monitoring, coordinating the family outcome activities, linking parents to advocacy groups, and training/technical assistance.</p> <p>In FFY 2008, one of the quality monitors assumed the duties of coordinating the Family Outcome activities, linking parents to advocacy groups, and training and technical assistance. This quality monitor was also covering two health districts. In late FFY 2008 and early FFY 2009, this quality monitor met with staff in each health district to begin assessing their needs of planning on how to address them. EIS will continue to coordinate trainings with advocacy groups.</p>	FFY 2005 through FFY 2012	Part C Coordinator	<p>New in FFY 2005</p> <p>Continued in FFY 2006</p> <p>Continued in FFY 2007</p> <p>Completed in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	The expected impact is increased activities to address family outcomes.
	<b>Database changes</b>				
A	<p>1. The database will be configured to capture information about signed written complaints. This procedure did not occur in FFY 2010 as part of the general supervision module described in Indicator 14. This activity is pending due to staff shortage, but will be completed in FFY 2011.</p>	FFY 2010 through FFY 2012	Data manager	<p>New in FFY 2010</p> <p>Continuing in FFY 2011</p>	This module will initiate tracking of corrections.
	<b>Training and Technical Assistance</b>				
C	<p>1. Since FFY 2006, training on parental rights (for district personnel, service providers, parents and other stakeholders) has been provided. In FFY 2007, the service coordinators began using the Complaint Process form to explain this procedure to parents/caregivers. Parent training is provided by service coordinators and/or parent advisors. Service Coordinator training</p>	FFY 2006 through FFY 2012	C.O. staff	<p>New in FFY 2006</p> <p>Revised in FFY 2007</p> <p>Continued in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p>	The expected impact is increasing parents' knowledge of their rights and comfort levels in exercising

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	included providing this information to families. Opportunities for parents to receive additional training on their rights and related issues will continue to be increased through collaboration with the Mississippi Parent Training and Information Center (MSPTI) and advocacy groups. The current training for service coordinators on this topic will be reviewed and revised, as needed.			Continuing in FFY 2011	their rights.
C, D	<p>2. In FFY 2008, emphasis was placed on increasing service coordinators', parent advisors', and parents' awareness of advocacy resources. This was done through technical assistance and by encouraging health districts to request training offered by the Mississippi Parent Training and Information Center (MSPTI). Training on advocacy skills for parents and guardians was offered in several health districts by staff from the MSPTI.</p> <p>Since FFY 2008, information about training opportunities offered by MSPTI has been given to district staff for parents. Current training opportunities offered by the MSPTI include onsite training, TA, and webinars.</p> <p>In FFY 2009, EI utilized the MSPTI and advocacy groups within the state to provide training to parents, service coordinators and parent advisors. This served to enhance our parents' advocacy skills. These trainings will continue.</p> <p>In FFY 2011, this activity has been enhanced through a contract with MSPTI. A flyer has been developed to provide families at enrollment with MSPTI advocacy contact information. An EI Manual was developed from a parent's perspective to describe the EI process; including dispute resolution.</p>	FFY 2008 through FFY 2012	C.O staff MSPTI advocacy groups District staff	<p>New in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Revised in FFY 2011</p>	<p>The expected impact is increasing parents' knowledge of their rights and comfort in exercising them.</p> <p>Service coordinators and parent advisors will learn how to better inform and empower parents.</p>

**Activities to commence in FFY 2013 (2013-2014)**

1. Evaluate the effectiveness of the above activities and make necessary changes and utilize broad stakeholder input in this process.
2. Provide training and technical assistance :
  - a. On improvement activities identified during the monitoring process;
  - b. For new district staff and service providers. The majority of this training and technical assistance will occur within each health district with follow-up through embedded training, coaching, and mentoring on a continuous basis.

**Resources for Activities**

Please refer to the resources for Indicator 1, unless otherwise specified.

## Mississippi's Part C State Performance Plan for 2005-2012

**Monitoring Priority: Effective General Supervision Part C / General Supervision**

**Indicator 12:** Percent of hearing requests that went to resolution sessions that were resolved through resolution session settlement agreements (applicable if Part B due process procedures are adopted).

(20 U.S.C. 1416(a)(3)(B) and 1442)

**Measurement:**

Percent = 3.1(a) divided by (3.1) times 100.

**Overview of Issue/Description of System or Process:**

Not applicable for First Steps because Part B due process procedures have not been adopted by First Steps.

**Mississippi's Part C State Performance Plan for 2005-2012**

**Monitoring Priority: Effective General Supervision Part C / General Supervision**

**Indicator 13:** Percent of mediations held that resulted in mediation agreements.

(20 U.S.C. 1416(a)(3)(B) and 1442)

**Measurement:**

Percent = (2.1(a)(i) + 2.1(b)(i)) divided by (2.1) times 100.

**Overview of Issue/Description of System or Process:**

The First Steps Early Intervention Program Standards and Procedures, May 2001, describe a mediation process. The Family Rights brochure given to parents includes information about mediation, but the content is not included in the documentation explained to parents/guardians by the service coordinator.

**Baseline Data for FFY 2004 (2004-2005):**

Mediations = 0

**Discussion of Baseline Data:**

There have been no mediation requests in the history of EI in Mississippi. It is uncertain whether parents/guardians know that they can request mediation or a due process hearing. The two page Family Rights handout (which must be explained to the parent/guardian) mentions complaints but not mediation or due process hearings. Also, the parents have the right to decline some EI services while accepting other EI services. Having this right to decline some EI services makes it less likely that disagreements will escalate to a due process hearing request. The FSIS database needs to be configured to capture information about mediation.

<b>FFY</b>	<b>Measurable and Rigorous Targets for Indicator 13:</b>
<b>2005</b> (2005-2006)	<b>Based on OSEP guidance, States should not set targets for Indicator 13 unless its baseline data reflect that it has received a minimum threshold of 10 mediation requests.</b>
<b>2006</b> (2006-2007)	
<b>2007</b> (2007-2008)	
<b>2008</b> (2008-2009)	
<b>2009</b> (2009-2010)	
<b>2010</b> (2010-2011)	
<b>2011</b> (2011-2012)	
<b>2012</b> (2012-2013)	

**Improvement Activities/Timelines/Resources:**

**Activities to commence in the second half of FFY 2005 (2005-2006)**

1. Refer to Activity #2 in Indicator 9.
2. Make arrangements to have
  - a. Trained mediators available when needed; and
  - b. Information regarding the forms and process available on the department's website and printed in the languages spoken by our clients' families.
3. Provide training for mediators, families, advocacy groups, district staff, First Steps Central Office staff and other stakeholders on Family Rights and Procedural Safeguards.
4. Please refer to the activities for Indicators 9 and 10.

**Revisions, with Justification, to Proposed Targets / Improvement Activities / Timelines / Resources for FFY 2008 (2008-2009), FFY 2009 (2009-2010), FFY2010 (2010-2011), FFY 2011 (2011-2012), and FFY 2012 (2012-2013):**

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Procedural changes</b>				
E	<p>1. In FFY 2006, the process began to develop procedures to ensure that families, guardians, caregivers, providers, and others involved with the provision of early intervention services are knowledgeable of how to advocate for the rights of families of children eligible for early intervention services. Since FFY 2006, training on parental rights (for district personnel, service providers, parents, and other stakeholders), has been provided.</p> <p>In FFY 2007, the complaint process form was used to explain the complaint process to parents. The I/T &amp; Family Rights document was revised to a parent-friendly format and language. The complaint process form, a glossary, and a list of resources were put in a single document. This document will continue to be used.</p>	FFY 2006 through FFY 2012	C.O. staff	<p>New in FFY 2006</p> <p>Revised in FFY 2007</p> <p>Continued in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	The expected impact is increasing parent's knowledge of their rights and comfort levels in exercising their rights.
C, D	<p>2. In FFY 2008, emphasis was placed on increasing service coordinators', parent advisors', and parents' awareness of advocacy resources. This was done through technical assistance and by encouraging health districts to request training offered by the Mississippi Parent Training and Information Center (MSPTI). Training on advocacy skills for parents and guardians was offered in several health districts by staff from the MSPTI.</p> <p>Since FFY 2008, information about training opportunities offered by MSPTI has been given to district staff for parents. Current training opportunities offered by the MSPTI include onsite training, TA, and webinars.</p> <p>In FFY 2009, we utilized the MSPTI and advocacy groups within the state to provide training to parents, service coordinators and parent advisors. This will serve to enhance our parents' advocacy skills. The training</p>	FFY 2008 through FFY 2012	C.O. staff MSPTI Advocacy groups District staff	<p>New in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	<p>The expected impact is increasing parents' knowledge of their rights and comfort level in exercising their rights.</p> <p>Service coordinators and parent advisors will learn how to better inform and empower parents.</p>

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	will continue.				
F	3. FFY 2006, district staff were given materials to develop communication notebooks, which included among other valuable information; procedural safeguards in a user-friendly format; the MSDH/EI toll free number; contact information for advocacy groups; forms for filing informal and signed written complaints, requesting mediation, and requesting due process hearings; and sample letters for documenting requests for changes in services, documentation, etc. Several health districts consider the notebook to be a valuable tool and have continued to use them. This tool continues to be reintroduced to the other health districts by district staff who continues to use them.	FFY 2006 through FFY 2012	DC SC	New in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Families will have access to resources and information related to their child's specific needs.
F	4. In FFY 2006, there was an effort to make the basic contents of packets given to parents the same. This was revised in FFY 2007, to allow district personnel to decide what to include in the packet beyond the I/T & Family Rights document. In FFY 2008, district staff continued to decide what to include beyond the I/T & Family Rights document. In FFY 2009, resources found to be effective in certain health districts was made available in the other health districts. The availability of these resources will continue.	FFY 2005 through FFY 2012	District staff	New in FFY 2006 Revised in FFY 2007 Continued in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Families will have access to resources and information related to their child's specific needs.
F	5. In FFY 2011, technical assistance is being provided by Cadre to assist in developing procedures for dispute resolution, formal/informal complaint, due process, hearing and mediation.	FFY 2011 through FFY 2012	Part C Coordinator	New in FFY 2011	This will clarify, define, and provide MS with a clear and concise dispute resolution process.
	<b>Recruitment of staff</b>				

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
F	1. In FFY 2005, we began exploring the possibility of contracting with a parent advisor at the state level for monitoring, coordinating the family outcome activities, linking parents to advocacy groups, and training/technical assistance. In FFY 2008, one of the quality monitors assumed the duties of coordinating the Family Outcome activities, linking parents to advocacy groups, and training and technical assistance. This quality monitor is also covering two health districts. In late FFY 2008, early FFY 2009, this quality monitor met with staff in each health district to begin assessing their needs of planning on how to address them. EIS will continue to coordinate trainings with advocacy groups.	FFY 2005 through FFY 2012	Part C Coordinator	New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007 Completed in FFY 2008 Revised in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The expected impact is increased activities to address family outcomes.
F	2. Impartial hearing officers and mediators will be hired to carry out impartial hearings and mediation processes as needed.	FFY 2011 through FFY 2012	Central Office	New in FFY 2011	Trained and knowledgeable hearing officers will be available to carry out appropriate impartial hearing and mediation processes.
	<b>Database changes</b>				
A	1. EI will configure the database to capture information about signed written complaints. This procedure did not occur in FFY 2010 as part of the general supervision module described in Indicator 14. This activity is pending due to inadequate amount of staff, but will be completed in FFY 2011.	FFY 2010 through FFY 2012	Data manager	New in FFY 2010 Continuing in FFY 2011	This module will initiate tracking of complaints.
	<b>Training and Technical Assistance</b>				
C	2. Since FFY 2006, training on parental rights (for district personnel, service providers, parents and other stakeholders) has been provided. In FFY 2007, the Service Coordinators began using the Complaint Process form to explain this procedure to parents/caregivers. Parent training is provided by	FFY 2006 through FFY 2012	C.O. staff	New in FFY 2006 Revised in FFY 2007 Continued in FFY 2008 Revised in FFY 2009 Continued in FFY 2010	The expected impact is increasing parents' knowledge of their rights and comfort levels in exercising

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<p>service coordinators and/or Parent Advisors. Service Coordinator training included providing this information to families. Opportunities for parents to receive additional training on their rights and related issues will continue to be increased through collaboration with the Mississippi Parent Training and Information Center (MSPTI) and advocacy groups. The current training for service coordinators on this topic will be reviewed and revised, as needed.</p>			Continuing in FFY 2011	their rights.
C, D	<p>2. In FFY 2008, emphasis was placed on increasing service coordinators', parent advisors', and parents' awareness of advocacy resources. This was done through technical assistance and by encouraging health districts to request training offered by the Mississippi Parent Training and Information Center (MSPTI). Training on advocacy skills for parents and guardians was offered in several health districts by staff from the MSPTI.</p> <p>Since FFY 2008, information about training opportunities offered by MSPTI has been given to district staff for parents. Current training opportunities offered by the MSPTI include onsite training, TA, and webinars.</p> <p>In FFY 2009, the MSPTI and advocacy groups within the state were utilized to provide training to parents, service coordinators and parent advisors. This served to enhance EIS parents' advocacy skills. These trainings will continue.</p> <p>This activity has been enhanced through a contract with MSPTI. A flyer has been developed to provide families at enrollment with MSPTI advocacy contact information. An EI Manual was developed from a parent's perspective to describe the EI process; including dispute resolution.</p>	FFY 2008 through FFY 2012	C.O. staff MSPTI advocacy groups District staff	<p>New in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	<p>The expected impact is increasing parents' knowledge of their rights and comfort in exercising them.</p> <p>Service coordinators and parent advisors will learn how to better inform and empower parents.</p>

**Activities to commence in FFY 2013 (2013-2014)**

1. Evaluate the effectiveness of the above activities and make necessary changes and utilize broad stakeholder input in this process.
2. Provide training and technical assistance :
  - a. On improvement activities identified during the monitoring process;
  - b. For new district staff and service providers. The majority of this training and technical assistance will occur within each health district with follow-up through embedded training, coaching, and mentoring on a continuous basis.

**Resources for Activities**

Please refer to the resources for Indicator 1, unless otherwise specified.

## Mississippi's Part C State Performance Plan for 2005-2012

### Monitoring Priority: Effective General Supervision Part C / General Supervision

**Indicator 14:** State reported data (618 and State Performance Plan and Annual Performance Report) are timely and accurate.

(20 U.S.C. 1416(a)(3)(B) and 1442)

#### Measurement:

State reported data, including 618 data, State Performance Plan, and Annual Performance Reports, are:

- a. Submitted on or before due dates (February 1 for child count, including race and ethnicity, settings and November 1 for exiting, personnel, dispute resolution); and
- b. Accurate (describe mechanisms for ensuring accuracy).

#### Overview of Issue/Description of System or Process:

1. The validity and reliability of the other indicator measures are dependent on accurate data reported in a timely manner. When monthly reports are run, records with incomplete data and records with illogical combinations of dates are identified. Central Office staff notify DCs and SCs of possible problems. Deadlines are set for staff to follow up to make sure corrections are made or plausible explanations are documented. A more systematic means of checking data accuracy has not been developed. However, new automated reports are available to C.O. staff and District Coordinators through FSIS.
2. On July 1, 2005, the process of transferring data to a centralized network system began. The server is housed at the C.O. Importing and exporting data are no longer required, nor can data be "lost" at the district level.
3. Districts I through VIII have transferred all data to the network system as of December 31, 2005. In District IX, the delay in changing from the old data system to the network system is due to displaced workers, damaged offices, and lost equipment as a result of Hurricane Katrina.
4. Duplicate ID numbers for children have been an issue. Guidance about making up ID numbers has resulted in fewer duplicate numbers and fewer merged records.
5. Issues of accurate and timely entry of data are being addressed at the district level by policies and established deadlines. The state definition of "timely" emphasizes that data will be checked more than once monthly and should be as accurate and current as possible. Frequent data checks and audits have increased the data accuracy and timeliness.

#### Baseline Data for FFY 2004 (2004-2005):

1. State reported data, including 618 data, the State Performance Plan, Annual Performance Reports, and data related to the Improvement Plan are submitted to OSEP on or before due dates. The reports are based on the data reported by the districts and from information from monitoring visits.
2. With each monthly report being generated, the data appear to be more complete, in that fewer data fields are blank. There are fewer instances of illogical dates and the total raw numbers continue to increase at an expected increment.

**Discussion of Baseline Data:**

1. Null reports are a tool available to district staff to use to flag missing data. Lack of time to devote to data entry or waiting for information from a provider were reasons frequently given for missing data.
2. Accuracy of data:
  - a. Reviews of data falling outside of acceptable ranges suggest typing mistakes, problems with interpreting the meaning of data fields, as well as procedural errors in implementing the EI program.
  - b. Because of the dynamic nature of data, all relevant data fields will not be entered for all 60+ Service Coordinators and thousands of cases at a single point in time. However, the data (especially percentages) do appear to represent of the district data and state data as a whole.

FFY	Measurable and Rigorous Targets for Indicator 14:
<b>2005</b> (2005-2006)	a. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be submitted on or before due dates. b. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be accurate.
<b>2006</b> (2006-2007)	a. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be submitted on or before due dates. b. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be accurate.
<b>2007</b> (2007-2008)	a. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance reports will be submitted on or before due dates. b. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be accurate.
<b>2008</b> (2008-2009)	a. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be submitted on or before due dates. b. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be accurate.
<b>2009</b> (2009-2010)	a. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be submitted on or before due dates. b. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be accurate.
<b>2010</b> (2010-2011)	a. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be submitted on or before due dates. b. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be accurate.
<b>2011</b> (2011-2012)	a. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be submitted on or before due dates. b. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be accurate.
<b>2012</b> (2012-2013)	a. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be submitted on or before due dates. b. 100% of state reported data, including 618 data, State Performance Plan, and Annual Performance Reports will be accurate.

**Improvement Activities/Timelines/Resources:**

**Activities to commence in the second half of 2005 (2005-2006)**

1. Define “timely entry of data:” Timely entry of data is the entry of data no later than 10 calendar days after the event occurs. Stakeholders recommended a weekly schedule for data entry by SCs responsible for each case. District personnel will develop local procedures regarding schedules for data entry. When a deadline for a report is approaching, the District Coordinators will be responsible for ensuring that the data report are accurate.
2. A central referral system:
  - a. All initial referrals will be sent to the Central Office,
  - b. Central Office personnel will enter the referral information into the database,
  - c. The database will assign a unique identifying # to each child,
  - d. Central Office staff will notify the District Coordinator (DC) of the referral, as soon as possible, on the date the referral is received. Contact with the district will be documented on the referral form.
  - e. The process used at the FS-CO will be monitored by both self-review within the FS-CO and by contract staff during unannounced monitoring visits.
3. The First Steps Information System (FSIS):
  - a. When FS-CO staff members are in district offices, they will enter data and contact C.O. staff to check the state database for consistency. The staff member in the FS-CO will print out the entered information and the staff member in the district office will do the same. The samples will be compared for consistency,
  - b. District personnel will print null reports and enter missing data at least once weekly,
  - c. Central Office staff and the DC’s will print district reports to check for missing data, 45-day timelines, timely provision of services, services within the natural environment, and justifications. Service Coordinators will be notified of questionable or missing data. Deadlines will be set for “clean up,” with follow up before reports are finalized.
4. Methods of verifying accuracy of data at the district level:
  - a. District Coordinators will be responsible for self-review using available reports and audits of records;
  - b. Focused Monitoring: Systematic checking for data accuracy will be part of the focused monitoring visit to ensure that the data reported reflect the EI activity within the health district. This will occur during:
    - i) Announced monitoring visits,
    - ii) Unannounced monitoring visits, and
    - iii) Follow-up on Improvement Plans.
5. Training on:
  - a. Data entry;
  - b. Self-assessment;

- c. The focused monitoring process for districts and the monitoring team members; and
  - d. Service Coordination and EI procedures effecting data entry and reporting.
6. Central Office staff will continue to work with District IX:
- a. as they recreate their data, including data entry, when necessary;
  - b. by assisting them in continually assessing their needs; and
  - c. by providing man-power, if needed, to assist them as they rebuild the infrastructure of Early Intervention.

**Activities to commence in 2006 (2006-2007)**

Please refer to the activities for Indicators 1.

**Revisions, with Justification, to Proposed Targets / Improvement Activities / Timelines / Resources for FFY 2008 (2008-2009), FFY 2009 (2009-2010), FFY2010 (2010-2011), FFY 2011 (2011-2012), and FFY 2012 (2012-2013):**

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<b>Policies:</b>				
A	1. In FFY 2005, “timely entry of data” was defined as entry of data no later than 10 calendar days after the event occurs. Stakeholders recommended a weekly schedule for data entry by the SC. Health district staff has local procedures for data entry, and the district coordinator ensures that report data are accurate.	FFY 2005 through FFY 2012	District staff	New in FFY 2005 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Entering data soon after the event increases the likelihood that the data will be complete.
A, B, F	2. In FFY 2006, the central referral unit (CRU) at the First Steps Central Office was created to take referrals and enter referral data.	FFY 2005 through FFY 2012	C.O. staff All referral sources	New in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The CRU continues to receive referrals, enters referral data, and notifies the health districts of the referral in a timely manner.
A, B	3. In FFY 2008, data verification was used as a tool to ensure valid and reliable data; determine TA needs; and to determine if the TA was successful. In FFY 2009, data verification forms were refined to better capture transition information and other changes. This process will continue to be used for the purposes listed under FFY 2008.	FFY 2007 through FFY 2012	Quality monitors and other C.O staff	New in FFY 2008 Revised in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Our data verification process is a very effective tool for identifying training and TA needs.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
A, B, D	4. Follow-up to ensure valid and reliable data has been done through phone calls, emails, and other monitoring activities. Since FFY 2007, data review, data verification, and follow-up, when indicated, are tools used to ensure that data are valid and reliable.	FFY 2007 through FFY 2012	C.O. staff	<p>New in FFY 2007</p> <p>Continued in FFY 2008</p> <p>Continued in FFY 2009</p> <p>Continued in FFY 2010</p> <p>Continuing in FFY 2011</p>	Our data verification process is a very effective tool for identifying training and TA needs.
	<b>Database changes</b>				
A, B	<p>1. In FFY 2007, reports were made available to the district staff through the database to check data. In FFY 2009, there were changes in the database to facilitate entry of justifications for late evaluations, services, and transition activities. Significant progress was made at the beginning of FFY 2009. Improvements to the Children 2009 Database include:</p> <p>(a). The tabs were reworked to include all the fields required for reporting related information (e.g., the fields necessary to report the services that a child is receiving are on the provider tab).</p> <p>(b). The formats of the tabs were adjusted to clearly display the information. Some fields were added and some were adjusted to allow one to view all of the information entered.</p>	FFY 2007 through FFY 2012	Data manager	<p>New in FFY 2007</p> <p>Revised in FFY 2008</p> <p>Revised in FFY 2009</p> <p>Continuing in FFY 2010</p> <p>Continuing in FFY 2011</p>	These changes facilitate data input, retrieval, review, and correction.

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<p>(c). The provider tab was adjusted to allow justifications to be entered for <u>each</u> early intervention service for which a justification is needed. Justifications are required for each untimely service and any service delivered outside of a natural environment. Prior to this adjustment, only one justification could be entered for all untimely services and only one justification could be entered for all services outside of the natural environment.</p> <p>(d). The settings of fields were adjusted to allow justifications to be entered before the activity occurred. This is necessary to account for children for whom the multidisciplinary evaluation has not occurred or a service has not been initiated.</p> <p>(e). Two new tabs were added: one tab for entry of data associated with IFSPs and a Summary tab to include information that does not fit into one of the other fields.</p> <p><b>Reports built:</b> For APR indicators 1, 7, and 8 and the 618 data, the reports developed include both reports to identify missing data and reports needed to complete the federal reporting. These reports are available at the local level, health district level, and state level, and serve to facilitate data review and corrections.</p>				

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	<p>Improvements were made in FFY 2009. Each of these report areas is functioning but needs adjustments. EI reports that grow smaller as missing data is entered are preferred over the reports in which the list remains the same length. In FFY 2010, EI improved these reports and built the following reports:</p> <p>(a). An APR report that allows reporting the timeliness of services <u>by child</u>.</p> <p>(b). 618 data reports necessary to report Natural Environment data for a specific date or for a given period of time greater than one day.</p>				
A	2. In FFY 2009, EI began reporting health district level data on the website.	FFY 2009 through FFY 2012	C.O. staff	New in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This is necessary to meet reporting requirements.
A	3. In FFY 2009, EI converted its race/ethnicity data collection to meet the new requirements for the 7 Race/Ethnicity categories. EI identified all the currently active children.	FFY 2009 through FFY 2010	Data manager	New in FFY 2009 Completed in FFY 2009	This was necessary to meet reporting requirements.
A, D	4. In FFY 2009, EI updated the Central Directory to make it web-based and user-friendly. In FFY 2010, the goal is to continue to make it accessible to all persons needing to identify services, support	FFY 2009 through FFY 2010	C.O. staff	Revised in FFY 2009 Continuing in FFY 2010 Completed in FFY 2010	Improvements to the Central Directory will empower our

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
	groups, and other types of resources available at the city, county, health district, or state level.				parents , guardians, etc.
A, B	5. In FFY 2009, EI began the process of developing a general supervision (monitoring) module that allows us to track correction of noncompliance.	FFY 2009 through FFY 2012	Data manager C.O. staff	New in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This module will facilitate tracking of correction of noncompliance.
A, B	6. In FFY 2009, EI built a tickler system for EI service coordinators that serves as a calendar and remind service coordinators of deadlines (e.g., notifying the LEA about a child; 45-day timelines; a deadline for a timely service; a deadline for a child's transition conference) and other activities to occur within the time span the service coordinator selects.	FFY 2009 through FFY 2009	Data manager	New in FFY 2009 Completed in FFY 2009	This tickler system provides reminders needed to facilitate completion of service coordination activities in a timely manner.
A, B, C,D	7. In FFY 2010, tablet PCs and portable printers were made available to Service Coordinators. In FFY 2011, district staff will begin using tablet PCs and portable printers.	FFY 2010 through FFY 2012	District staff	New in FFY 2010 Continuing in FFY 2011	Expected impact includes more effective service coordination and user-friendly data entry.
	<b>Technical Assistance</b>				
D	1. Technical assistance and training regarding database changes continues to be provided for each health district since FFY 2005.	FFY 2005 through FFY 2012	C.O. staff	New in FFY2005 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008	Training/TA on data entry and use of the reports are offered within the health district

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
				Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	whenever there are changes in the database or training/TA is requested.
C	2. Technical Assistance for self-assessment began in FFY 2006 and continues to be provided in FFY 2010 by the quality monitors.	FFY 2005 through FFY 2012	C.O. staff	New in FFY 2006 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	The expected result is program improvement. TA is expected to result in more effective self-assessment and improvement plans.
C	3. Technical Assistance related to the focused monitoring process for health districts and the monitoring team began in FFY 2006. This T/A focuses on reviewing data and on correcting data entry errors and addressing underlying problems.	FFY 2005 through FFY 2012	C.O. staff	New in FFY 2006 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	This is necessary to ensure effective review of the data and correction of data entry errors.
C	4. Technical assistance for service coordination and EI procedures affecting data entry and reporting began in FFY 2006.	FFY 2005 through FFY 2012	C.O. staff	New in FFY 2006 Continued in FFY 2006 Continued in FFY 2007 Continued in FFY 2008	Provision of this TA results in more effective service coordination and more efficient data

Category	Improvement Activity	Timeline(s)	Person(s) Responsible & Resource(s)	Status	Reason/Impact
				Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	entry.
A, D	5. Central Office staff worked with Health District IX staff to rebuild after Hurricane Katrina in FFY 2005 and FFY 2006.	FFY 2005 through FFY 2006	C.O. staff	Completed in FFY 2006	
A, B, D	8. Technical assistance has been provided by phone, in meetings, and through coaching since FFY 2007 for database users.	FFY 2007 through FFY 2012	Data manager C.O. staff	New in FFY 2007 Continued in FFY 2008 Continued in FFY 2009 Continued in FFY 2010 Continuing in FFY 2011	Provision of this TA results in more efficient data entry.

**Activities to commence in FFY 2013 (2013-2014)**

1. Evaluate the effectiveness of the above activities and make necessary changes and utilize broad stakeholder input in this process.
2. Provide training and technical assistance :
  - a. On improvement activities identified during the monitoring process;
  - b. For new district staff and service providers. The majority of this training and technical assistance will occur within each health district with follow-up through embedded training, coaching, and mentoring on a continuous basis.

**Resources for Activities**

Please refer to the resources for Indicator 1, unless otherwise specified.