List of Appendices

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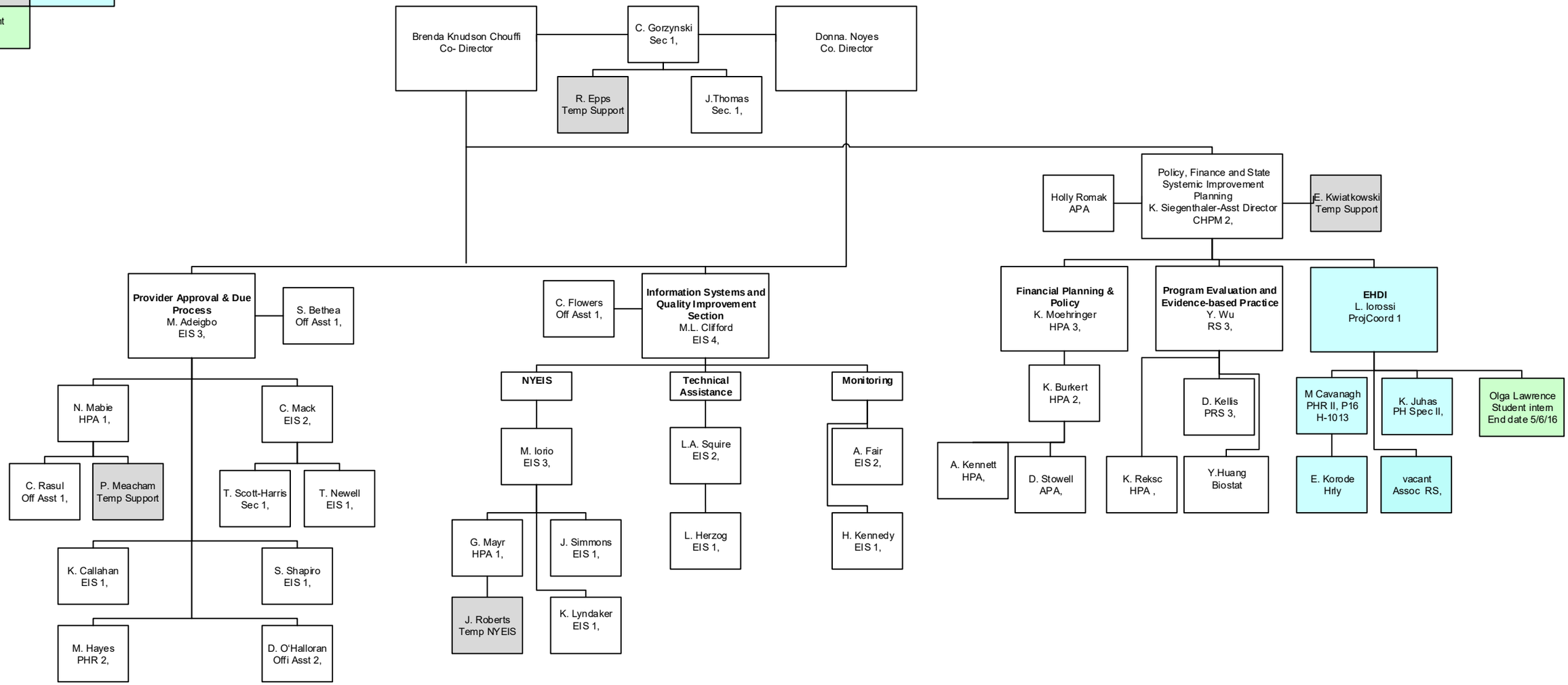
BUREAU OF EARLY INTERVENTION

Vacancy	Pending Vacancy
Temp Staff	HRI
Student	



2/11/2016

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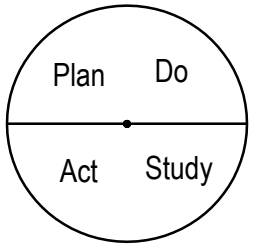
Early Intervention services helped me and/or my family….
connect with parents of children with similar needs.
take part in typical activities for children and families in my community.
cope with stressful situations.
support the needs of other children in the family.
feel welcome in the community.
involve my child's doctor in early intervention services.
cope with the emotional impact of having a child with a disability.
find resources in the community to meet my child's needs.
find information I need.
make changes in family routines, like mealtime or bedtime, that will be good for my child with special needs.
know where to go for support to meet my family's needs.
use services to address my child's health needs.
feel less isolated.
know how to keep my child healthy.
be better at managing my child's behavior.
improve my family's quality of life.
learn how to work on my child's special needs during daily activities like getting dressed.
feel more confident in my skills as a parent.
communicate better with the people who work with my child and family.
have confidence in my ability to care for my child with a disability.
feel that I can get the services and supports that my child and family need.
understand what services my child will get when he/she goes into the preschool special education program.
understand how to change what I'm doing to help my child as he/she grows.
understand the roles of the people who work with my child and family.
help my child to be more independent.
know about my child's and family's rights concerning early intervention services.
be an equal partner in planning my child's services.
feel that my efforts are helping my child.
advocate for my child.
be able to tell how much progress my child is making.
get the services that my child and family need.
understand my child's special needs.
learn how to communicate with my child.
understand how the early intervention program works.
do things with and for my child that are good for my child's development.
help my child learn.

Family-centered Services Scale Items
Someone from the Early Intervention Program went out into the community with me and my child to help get us involved in community activities and services.
My family was given information about ways of connecting with other families for information and mutual support.
Someone from the Early Intervention Program asked whether other children in the family needed help in understanding the needs of the brother or sister with a disability.
My family was given information about community programs that are open to all children.
My family was given information about where to go for help or support if I feel worried or stressed.
My family was given information about opportunities for my child to play with other children.
Someone from the Early Intervention Program asked if I was having any problems getting the services I needed.
My family was given information about how to advocate for my child and my family.
My family was given information about the public school system's programs and services for children age three and older.
My family was given information about what my options are if I disagree with a decision about my child's services.
Someone from the Early Intervention Program asked if the services my family received met our needs.
I was given help in preparing for the IFSP meeting.
The IFSP kept up with my family's changing needs.
My family was given information about activities that I could do with my child in our everyday lives.
My child transitioned from early intervention (birth to 3 program) to preschool special education without a break in services.
My family was given information about the rights of parents regarding early intervention services.
I was given information to help me prepare for my child's transition.
My child received all the supports for transition listed in our IFSP.
I was offered the chance to meet with people from the Early Intervention Program and the committee on preschool special education to plan for my child's transition to preschool special education.
I knew who to call if I had problems with the services and supports my child and family are receiving.
Written information I received was written in an understandable way.
My family's daily routines were considered when planning for my child's services.
I felt part of the team when meeting to discuss my child.



PDSA WORKSHEET

Team Name :	Date of test:	Test Completion Date:
Overall team/project aim:		
What is the objective of the test?		

Please send completed worksheets to:

PLAN:

Briefly describe the test:

How will you know that the change is an improvement?

What driver does the change impact?

What do you predict will happen?

PLAN

List the tasks necessary to complete this test (what)	Person responsible (who)	When	Where
1.			
2.			

Plan for collection of data:

DO: Test the changes.

Was the cycle carried out as planned? ☐ Yes

What did you observe that was not part of your plan?

STUDY:

Did the results match your predictions? ☐ Yes ☐

Compare the result of your test to your previous performance:

What did you learn?

ACT: Decide to Adopt, Adapt, or Abandon.

☐ Adapt: Improve the change and continue testing plan.
Plans/changes for next test:

■ Adopt: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability Display Storyboard in Birth Records Office. Educate new staff through SPDS *"Guidelines for the New York State Certificate of Live Birth & Quality Improvement"*.

☐ Abandon: Discard this change idea and try a different one

TABLE OF CONTENTS

This document provides details about the NYS Early Intervention Program (NYEIP) Quality Improvement Collaborative (the Collaborative). The package is divided into two sections. The first section includes information related to the Collaboratives's recruitment process. The second section includes information to prepare for the Informational Call and first Learning Session.

New York State Early Intervention Program Quality Improvement Collaborative

Part One: Recruitment

Overview of the Collaborative

Purpose and Goals of the Learning Collaborative

This Learning Collaborative is an innovative project designed to enable improvement teams to share, test and implement strategies to improve the family-centeredness of early intervention services provided through the New York State Early Intervention Program (NYEIP). This exciting and challenging project will require that teams engage with energy and a commitment to try new ways of delivering services. Together, we can determine and disseminate strategies that will serve as a model of how to improve the quality of services to fully engage parents and caregivers in their child's care.

The goals of the Learning Collaborative are to:

- Need to add goals.

Early Intervention Officials/Designees, Service Coordinators, Quality Assurance Officers, and Early Intervention Service Providers/Therapists will work together for approximately 12 months to implement more family-centered care. Evidence-based early intervention practices for providing family-centered care will be implemented over the course of the Learning Collaborative. Participants will learn and apply key principles to improve care and implement the core intervention, and associated measures, as the primary focus of work. These core interventions are based on current available scientific evidence. As part of the improvement process, teams will collect or review process and outcome data that are sensitive to the changes they will be testing and implementing to track performance and results over the 12-month period.

The Collaborative will use a learning model, the Institute for Healthcare Improvement's Breakthrough Series (BTS)[1] (**Appendix A**) modified to meet the requirements and unique needs of this topic and context, and a change model, the Model for Improvement (**Appendix C**), that have demonstrated effectiveness in previous New York State Department of Health (NYSDOH) projects. The Collaborative will assist participating teams in embedding strategies to measure and address family-centered care and improved family outcomes throughout the process.

IHI's Breakthrough Series is a vehicle for identifying, testing, and spreading changes that are effective for improving care and outcomes for defined populations.

Collaborative Benefits

Individuals participating in the Collaborative will receive benefits that include:

- Support from national technical assistance centers and regional faculty, including Centers of Excellence for Developmental Disabilities;
- Coaching and technical assistance, including in-person Learning Sessions, regular Coaching Webinars, support to implement and test improvements, and feedback on data to make improvements;
- Opportunities to connect with other teams to share strategies, identify lessons learned, overcome barriers and expedite the implementation of project goals; and

[1] Institute for Healthcare Improvement (IHI), Boston MA

- Building quality improvement knowledge and capacity that can be applied beyond the scope of this project.

The Collaborative will provide a unique opportunity to learn and practice change. The experience can be expected to improve participant's professional satisfaction as well as the quality of early intervention services delivered to families. Higher staff morale and retention should be considered one of the cost benefits of the time devoted to the effort.

Collaborative Planning Group

This planning group will:

- Share evidence-based information and examples of best practices;
- Create and refine the change package of concepts and ideas for improvement;
- Coach teams on improvement methodology;
- Provide communication strategies to keep participants connected to the faculty and their colleagues during the Learning Collaborative; and
- Share tools, forms, and other aides to facilitate implementation of and spread of effective changes.

Overall Structure of the Collaborative

The Collaborative will facilitate the early intervention teams working together for approximately twelve months. Over the course of the Collaborative, representatives from the Learning Collaborative teams will participate in a one-day, in-person Learning Sessions and up to two virtual Learning Sessions. In addition, regular contact with participating teams through e-mail, conference calls and webinars, including routine, monthly coaching webinars, will be facilitated. A project website will be developed which may include journal articles, policies and protocols, and education materials, information on other state initiatives, practice guidelines and quality improvement tools.

Collaborative Expectations

Pre-Work Activities for Teams

Prior to the first Learning Session, teams complete multiple activities that will accelerate the start-up of their improvement efforts and equip them to gain the most from the first Learning Session. These Pre-Work activities include: holding a team meeting; reviewing baseline data; reviewing practices currently in place; developing their own SMART AIM (**S**pecific, **M**easureable **A**chievable, **R**ealistic, **T**ime bounded) aligned with overall project goals and based on a review of baseline data; and preparing a Storyboard to share with other teams.

Learning Sessions

Learning Sessions are the major integrative events where all teams come together in person or virtually for focused content and quality improvement learning. Through plenary sessions, small group discussions and team meetings, attendees have the opportunity to:

- Learn from faculty and colleagues;
- Receive individual coaching from faculty members;
- Gather new knowledge on the subject matter and process improvement;
- Share experiences and collaborate on improvement plans; and
- Problem solve strategies to overcome improvement barriers.

A minimum of three members from each team are expected to attend the Learning Sessions, of which one member should be an Early Intervention Official/Designee. Information regarding the Learning Sessions is forthcoming. Tentative date for this learning session is June, 2016.

Action Periods

In between the in-person Learning Sessions—times called Action Periods—teams will be expected to make changes within their practice/delivery of early intervention services to accomplish the overall project goal of improving family centeredness of early intervention services. They will do so by applying the Model for Improvement, beginning with small changes and increasing in scope and scale.

Initial Learning Collaborative Schedule and Checklist

Action Item	Date and Time
☐ Recruitment and Pre-Work packets sent to prospective participants	
☐ Review the Recruitment materials (pages 1-7)	
☐ Facilities will need to complete a three step process: 1. Review the materials in Part Two: Pre-Work; 2. Read Appendices A and B in detail; and 3. Complete and submit the NYEIS Participant Form (**Attachment 1**) electronically to email account.	
☐ Acknowledgement by NYSDOH of receipt of Participant Form	

New York State Early Intervention Program
Quality Improvement Collaborative

Part Two: Pre-Work

Information that will help prepare you to participate in the
New York State Early Intervention Program
Quality Improvement Collaborative -
Improving Family-Centered Care

Team Preparation Checklist of Pre-Work for First Learning Session

Thank you for joining the New York State Early Intervention Program (NYSEIP) Quality Improvement Collaborative (the Collaborative). We are delighted to have the opportunity to work with your team to make improvement happen together!

This section of the package contains information that will help your team prepare to participate in the Collaborative. This packet includes specific activities that we ask you to complete prior to the first Learning Session, as well as detailed instructions for completing these tasks.

Some technical language used in this packet may be unfamiliar. Please check the glossary (**Appendix F**) for clarification. More detailed explanations will follow at the first Learning Session.

If you have any questions, please contact Kirsten Siegenthaler, New York State Early Intervention State Systemic Improvement Planning Coordinator, at Kirsten.Siegenthaler@health.ny.gov, or by calling (518) 472-7016, option 2.

Please complete the following activities before the first Learning Session. Details on each section can be found in the Appendices and related attachments:

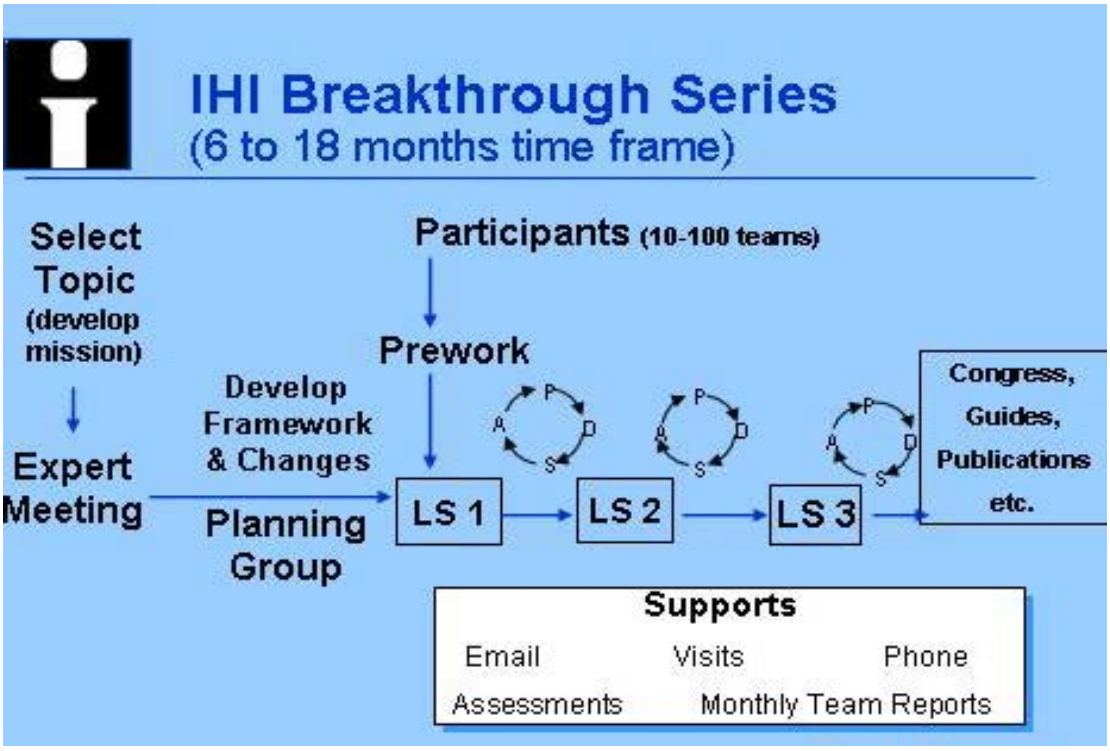
- ☐ Read the Overview of a Learning Collaborative (**Appendix A**) to get an understanding of the Collaborative process.
- ☐ Formalize your team members, keeping in mind team expectations (**Appendix B**). Review Collaborative goals, structure, and expectations with team.
- ☐ Review the Model for Improvement (**Appendix C**).
- ☐ Document the standard practices and procedures for providing early intervention services to families;
- ☐ Complete your team AIM Statement (**Appendix D**).
- ☐ Develop a Storyboard with your team and submit the final product electronically to email address (**Appendix E**).

Appendix A: Overview of a Learning Collaborative

A Learning Collaborative is a time-limited effort by multiple teams/participants that come together with faculty to learn about and create improved processes in a specific topic area. The expectation is that the teams share expertise and data with each other; thus, "everyone learns, everyone teaches." The New York State Early Intervention Program Quality Improvement Collaborative will be approximately 12 months in length.

A Collaborative provides a systematic approach to quality improvement. Each team in the Collaborative will learn quality improvement fundamentals to create small tests of change before a broader organizational rollout of successful interventions. At the same time, each team will collect monthly data on measures and will receive reports from the Department on monthly reporting compliance to track improvements. Learning is accelerated as the Collaborative teams work together and share their experiences through monthly reports, Learning Sessions, conference calls, webinars, and e-mail.

The three phases of the Learning Collaborative are: **Pre-Work**, **Learning Sessions**, and **Action Periods**.



What is Pre-Work?
Collaborative teams will be involved in Pre-Work from the time they join the Collaborative in May 2016 until the first Learning Session in June 2016. The purpose of the Pre-Work is to prepare the participating teams to launch the improvement initiative and prepare for this first Learning Session. During this time, the Collaborative team has several important tasks to accomplish, including: creating an AIM statement[21], documenting current practices and procedures, developing a Storyboard, and participating in one of the Pre-Work calls. A Pre-Work packet, with more detailed information about this phase, is enclosed.

What is a Learning Session?
Learning Sessions bring teams together to become skilled in quality improvement fundamentals through theoretical application with real time coaching. Through plenary addresses, small group discussions and team meetings, attendees have the opportunity to:

- Learn from faculty and colleagues;
- Receive coaching from faculty members;
- Gather new information on the subject matter and process improvement; and
- Share information and create detailed improvement plans.

The Learning Collaborative will include up to two Learning Sessions facilitated by the Collaborative's project team and expert faculty. One of these will occur at the start of the Collaborative, and the other toward the end of the 12-month period. A minimum of three key members from each facility team are expected to attend the Learning Sessions.

What are Action Periods?
The time between Learning Sessions (both in-person and virtual) is called an Action Period. During Action Periods, Collaborative teams work toward major, breakthrough improvements by initiating small tests of change. Although each participant focuses on his/her own practice, and continuous contact with other Collaborative participants and faculty is provided.

Monthly conference calls, regular e-mails and webinars maintain this continuous contact during the Action Period. Each participant collects or reviews data to learn if the tests of change are resulting in improvement. Monthly data is reviewed by each team and then submitted to the Department. Teams are encouraged to include other colleagues in Action Period activities.

[1] An AIM statement is "a specific statement summarizing what your organization hopes to achieve. It should be time specific and measurable." (Institute for Healthcare Improvement, www.ihi.org)

Appendix B: Collaborative and Team Expectations

Form a Team and Review Team Expectations

An appropriate and effective team is a key component of successful improvement efforts. Team members should be selected based on their knowledge of the early intervention system that will be impacted by improvement efforts and their commitment to make the changes encompassed in the Change Package. The complete Change Package will be shared prior to the first Learning Session. Members should include multidisciplinary staff who will work together to achieve the project goals and be impacted by improvement efforts.

Selecting Team Leaders

Team activities will be guided by a Champion and a Day-to-Day Leader/Key Contact. Individuals in these roles will represent the team at the Learning Sessions and share their learning with other team members. Ideally team members should have the following attributes:

Champion

- Is a practicing provider who is an opinion leader and is well respected by peers;
- Has authority to allocate the time and resources needed to achieve the team's improvement efforts;
- Has authority over areas affected by the change;
- Will champion the spread of successful changes;
- Understands the processes of care in the early intervention system;
- Has a good working relationship with colleagues and the Day-to-Day Leader; and
- Wants to drive improvements in the system.

The Champion will be a critical member of the team, and should plan to attend all Learning Sessions.

Day-to-Day Leader/Key Contact

- Drives the project, ensuring that cycles of change are tested and implemented;
- Coordinates communication between the team, Collaborative faculty and other teams;
- Oversees data collection; and
- Works effectively with the Champion.

The Day-to-Day Leader/Key Contact should understand how changes will affect the early intervention system, and should plan to attend all Learning Sessions.

Selecting Other Members

In addition to team leaders, the team should include members from key areas or providers of other services in the early intervention system. These members might include individuals including, but not limited to, early intervention designees, service coordinators, agency quality assurance officers, and early intervention service providers.

Team Members who should attend the Learning Session

Teams should choose a minimum of three individuals who can most effectively work together, learn the methodology and plan for action when returning to their county or region. Different

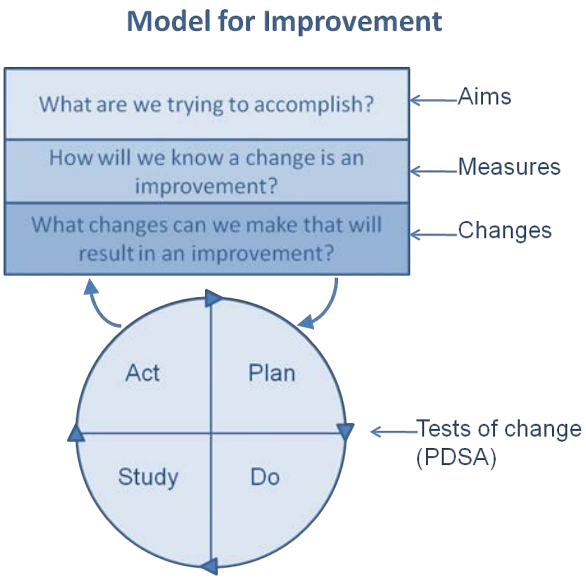
team members can attend the Learning Sessions; however, past teams have found it beneficial to send the same members to the Learning Sessions.

Team Expectations
Teams participating in the Learning Collaborative are expected to:

- Engage with colleagues and other providers to communicate and collaborate in order to promote change and improve processes;
- Select a team of at least # people, including one Champion and one Day-to-Day Leader/Key Contact;
- Complete Pre-Work activities to prepare for the first Learning Session;
- Create and share Storyboards at the first Learning Session. The Storyboard will describe your team and your goals. At the Collaborative Summit, the Storyboard will illustrate your team's efforts and lessons learned;
- Use rapid change cycles (Plan-Do-Study-Act (PDSA) tests) to implement the Change Package;
- Participate in monthly Collaborative Coaching Webinars;
- Regularly communicate with faculty and other teams; and
- Report on the achievement of selected process and outcome measures, including details of changes made and data to support these changes.

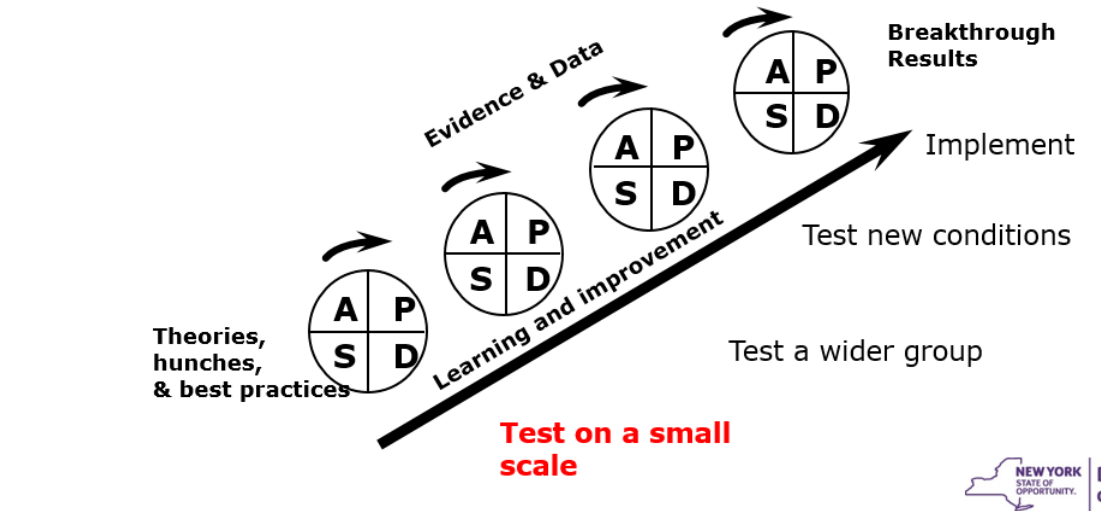
Appendix C: Model for Improvement

The Model for Improvement[3] is a simple yet **powerful strategy for making improvements in the care you provide to families.** Developed by Associates in Process Improvement, the application of the model has two components. First, your team will address three fundamental questions. These questions will guide your team in creating an AIM Statement, measures and specific change ideas. Secondly, your team will use Plan-Do-Study-Act (PDSA) cycles to easily test these changes in your work environment. Successful tests of change pave the way for full scale implementation within your system. A brief synopsis of the model is presented below. More detail is available on the Institute for Healthcare Improvement (IHI) Web site at: www.ihi.org.



Associates in Process Improvement

[3] *The Model for Improvement was developed by Associates in Process Improvement. www.apiweb.org/API_home_page.htm



Three Key Questions for Improvement

1. *What are we trying to accomplish?* ***(AIM Statement)***

When you answer this question, you are creating an AIM Statement – a statement of a specific, intended goal. A strong, clear AIM Statement gives necessary direction to your improvement efforts. Your AIM Statement should include a general description of what your team hopes to accomplish and a specific patient population on which your team will focus. A strong AIM Statement is specific, intentional and unambiguous. It should be aligned with goals and all team members involved in the improvement process should support it.

2. *How will we know that a change is an improvement?* ***(Measures)***

Your team will use a set of defined measures to determine if the rapid cycle changes in care are working. They can also be used to monitor performance over time. These measures are designed to help you know if the changes you are testing are resulting in improvement. This quality improvement measurement strategy should not be confused with the type of measurement used for research. Where research focuses on one fixed and testable hypothesis, the methods for measuring improvement rely on sequential testing using practical measurement strategies. The measures for this Collaborative are based on those used by the NYSDOH and other State Collaboratives; they have been edited for specific use in this project by the Collaborative's project team in partnership with representatives of the early intervention system.

3. *What changes can we make that will result in an improvement?* ***(Best Practices and ideas)***

As with the measures, the collection of evidence-based changes that we will use in this Collaborative are selected from national technical assistance centers and center for excellence with faculty who have expertise in the field. This collection of changes is called the Change Package and includes multiple opportunities for improving family-centered care. More detail on the use of the Change Package will be provided at that first Learning Session.

PDSA Cycles

The PDSA (Plan-Do-Study-Act) cycle is a method for rapidly testing a change - by planning it, trying it, observing the results, and acting on what is learned. This is a scientific method used for

action-oriented learning. After changes are thoroughly tested, PDSA cycles can be used to implement or spread change. The key principle behind the PDSA cycle is to test on a small scale and test quickly. Traditional quality improvement has been anchored in laborious planning that attempts to account for all contingencies at the time of implementation; usually resulting in failed or partial implementation after months or even years of preparation. The PDSA philosophy is to design a small test with a limited impact that can be conducted quickly (days, if not hours!) to work out unanticipated "bugs". Repeated rapid small tests and the learning gleaned build a process ready for implementation that is far more likely to succeed.

Appendix D: AIM Statement

Identify Your Team's AIM

An AIM Statement answers the question, "What are we trying to accomplish?" It is an explicit statement summarizing what your practice plans to achieve during the project. An AIM Statement will focus your team's actions, helping to improve family-centered care in the early intervention program. The AIM Statement should be **time-specific, population specific and measurable**.

When writing your AIM Statement, state your AIM clearly, and use specific numeric goals. Teams make better progress when they have unambiguous, specific goals. Setting numeric targets clarifies the AIM, helps to focus change efforts, and directs measurement activities.

EXAMPLE

We aim to improve . The focus of these efforts over the next 12 months will be to . To accomplish this, we will form a multidisciplinary team, and use one or a combination of evidence-based strategies and will measure change over time to determine if improvement is being achieved.

Our goals include:

1. .

As you begin to develop your team's AIM Statement, be sure to:

- **Involve the senior leaders:** Leadership must ensure the AIM Statement is aligned with the strategic goals of the organization. They should also help identify an appropriate population for initial focus of the team's work.
- **Base the goals in your AIM Statement on existing data or needs:** Examine available information about family-centered practices and feedback from families, and focus on issues that matter most to your families.

- **Revise your original AIM Statement as needed during the first Learning Session.**

Appendix E: Storyboards

In preparation for the opening Learning Session, teams are asked to create a Storyboard to share information.

This Storyboard is an opportunity for teams to briefly describe their team, how early intervention services are provided to families, and what they plan to accomplish during the Learning Collaborative. Storyboards will also be on display for all participants to review during the Learning Session.

Please bring a copy of your Storyboard to post on a display board at the Learning Session (this display board will be provided to you at the Learning Session) and at least one extra copy for use by your improvement team to make revisions or edits during the Learning Session. In addition, prior to the Learning Session, please e-mail an electronic copy of your Storyboard to person and email address.

Your audience will be other participating teams, Collaborative leadership, observers and faculty. Therefore, the Storyboard should be as clear and concise as possible. Detailed instructions and a template are attached to help guide you in completing your Storyboard (**Attachment 2)**.

Here is a sample outline for what you might include in your Storyboard:

- ⇨ Name and location of your organization
- ⇨ Brief description of your county or region (early intervention referral and evaluation process, service models/structure, provider community, staff, community characteristics, etc)
- ⇨ Improvement team (names, titles, affiliations, roles)
- ⇨ Team's improvement AIM for project
- ⇨ Baseline data that shows where you are starting from
- ⇨ Initial ideas for improvement
- ⇨ Other relevant information

Storyboard display tips

- ✓ Use fewer words and more pictures/graphics
- ✓ Use pictures of real people …. at least of your team!
- ✓ Make font size as big as possible
- ✓ Don't worry about making the display fancy
- ✓ Use color to highlight key messages→ If no access to a color printer, use bright highlighters

Appendix F: Collaborative Glossary

Action Period
The period of time between Learning Sessions (in-person or virtual) when teams work on improvement in their home organizations. During this time, teams will be supported by the Collaborative Project Team and faculty, and are connected to other Collaborative team members.

AIM Statement
A written, measurable and time-sensitive statement of the expected results of an improvement process.

Change Package
The Change Package includes a list of high leverage key change concepts or "ideas" for changes in your hospital system and specific strategies for those changes. These changes come from evidence provided by previous research.

Collaborative
A time-limited effort (usually 12 -24 months) by multiple organizations, which come together with faculty to learn about and to create improved processes in a specific topic area. The expectation is that the teams share expertise and data with each other, thus: "Everyone learns, everyone teaches."

Cycle or PDSA Cycle
A structured trial of a process change. Drawn from the Shewhart cycle, this effort includes:
Plan: a specific planning phase;
Do: a time to try the change and observe what happens;
Study: an analysis of the results of the trial; and
Act: devising next steps based on the analysis.

Consecutive PDSA cycles will naturally lead to the plan component of a subsequent cycle.

High Leverage Change Concepts
A high leverage change concept will result in significant improvement in the system of care and result in better care, improved outcomes, reduced hospital stays and lower costs.

Key Changes – Change Package
The list of essential process changes that will help lead to breakthrough improvement, usually created by the leadership team and chair based on literature and their experiences.

Learning Session
A meeting during which participating organizational teams meet with faculty and collaborate to learn key changes in the topic area, including how to implement them, an approach for accelerating improvement and methods for overcoming obstacles to change. Teams leave this meeting with new knowledge, skills and materials that prepare them to make immediate changes.

Measure

Key measures should be focused, clarify the team's AIM Statement and be reportable. A measure guides the ability to track patients for delivery of proven interventions and to monitor their progress over time.

Model for Improvement
An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes.

Pre-Work Packet
A packet containing a complete description of the Collaborative, along with expectations and activities to be completed prior to the first meeting of the Collaborative.

Pre-Work Period
The time prior to the first Learning Session when teams prepare for their work in the Collaborative, including selecting team members, scheduling initial meetings, consulting with senior leaders, preparing their AIM Statement and initiating data collection.

MD Champion
The MD Champion supports the team and controls the resources employed in the processes to be changed. The MD Champion works to connect the team's AIM with the organization's mission, provides resources for the team and promotes the spread of work of the team to others.

Spread
The intentional and methodical expansion of the number and type of people, units or organizations using the improvements. The theory and application comes from the literature on Diffusion of Innovation (Everett Rogers, 1995).

Storyboard
A Storyboard is a display of information to promote sharing across teams at the Learning Sessions. Storyboards usually include demographic information about the hospital team, the team's AIM Statement, data and lessons learned during the Action Periods.

Test
A small scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.

Appendix G: Collaborative Leadership and Faculty

New York State Department of Health

Donna M. Noyes, PhD, Bureau of Early Intervention (BEI) Co-Director

Brenda Knudson-Chouffi, BEI Co-Director

Kirsten Siegenthaler, PhD, BEI State Systemic Improvement Planning Coordinator

Yan Wu, BEI Program Evaluation and Evidence-Based Practice (PEEP) unit

Mary Lou Clifford, Information Systems & Quality Improvement (ISQI) section

Margaret Adeigbo, BEI Provider Approval and Due Process (PADP) unit

Ken Moehringer, Fiscal Planning and Policy section

Kelly Callhan, BEI PADP

Jessica Simmons, BEI ISQI

Katherine Reksc, BEI PEEP

Include DFH QI group?

University Centers of Excellence in Developmental Disabilities

Need to add names and affiliations

Expert Guidance Team

Need to add names of team

For Illustrative Purposes Only
Example Data Collection Tool

Instructions: Each month, review the IFSPs of at least 20 infants. **Only check infants who are <specify criteria>.**

1. Year:_____ 2. Month:_____

NYEIS ID	3. IFSP has goal to provide opportunities for parents to connect with families for information and mutual support. Y or N	4. Documented in IFSP parent support group information was given. Y or N	5. Follow up to make sure parent was able to connect Y or N	6. IFSP was updated to address parent concerns Y or N	7. Reviewer EIOD ISC OSC, etc.	Initials of Reviewer
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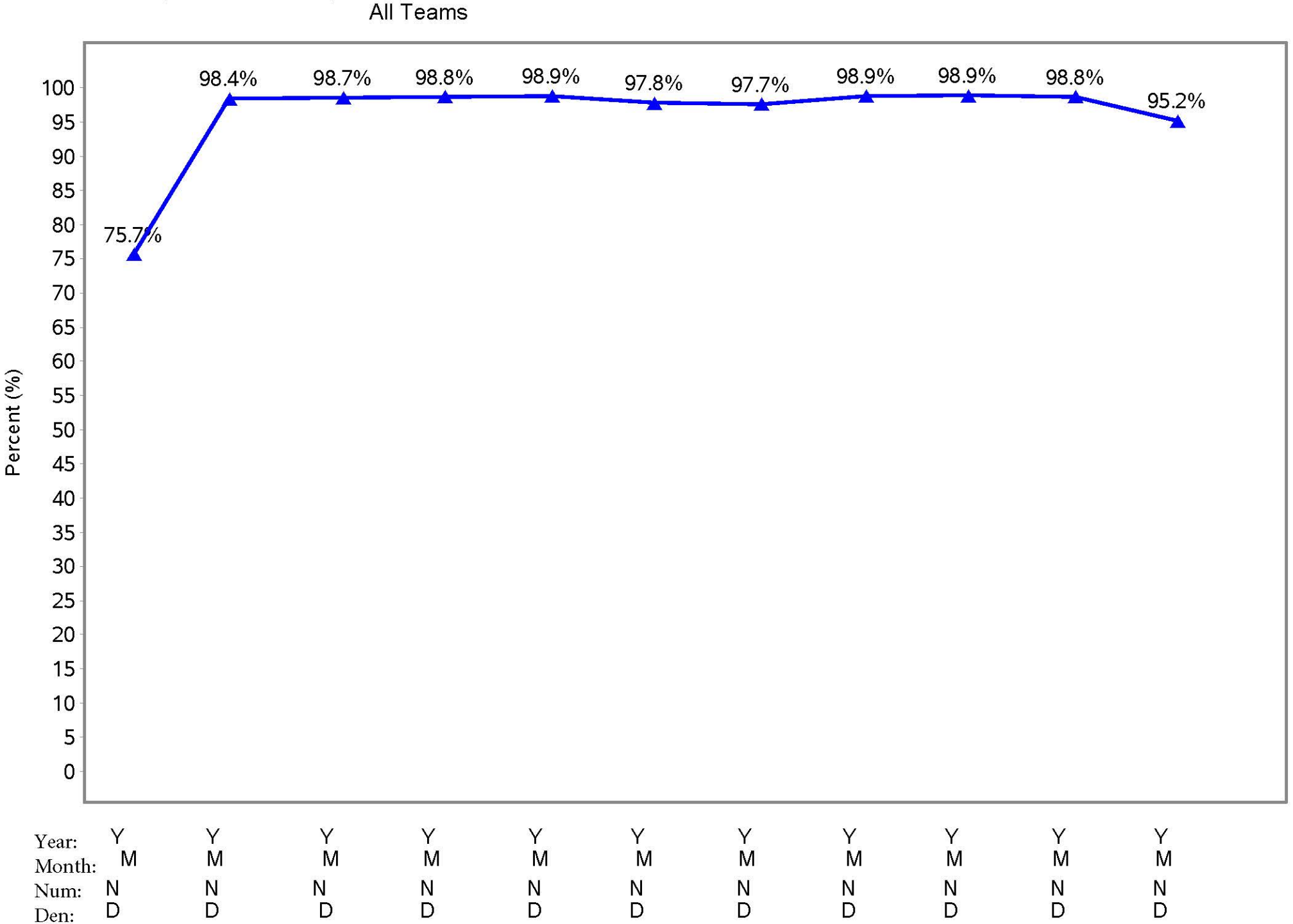
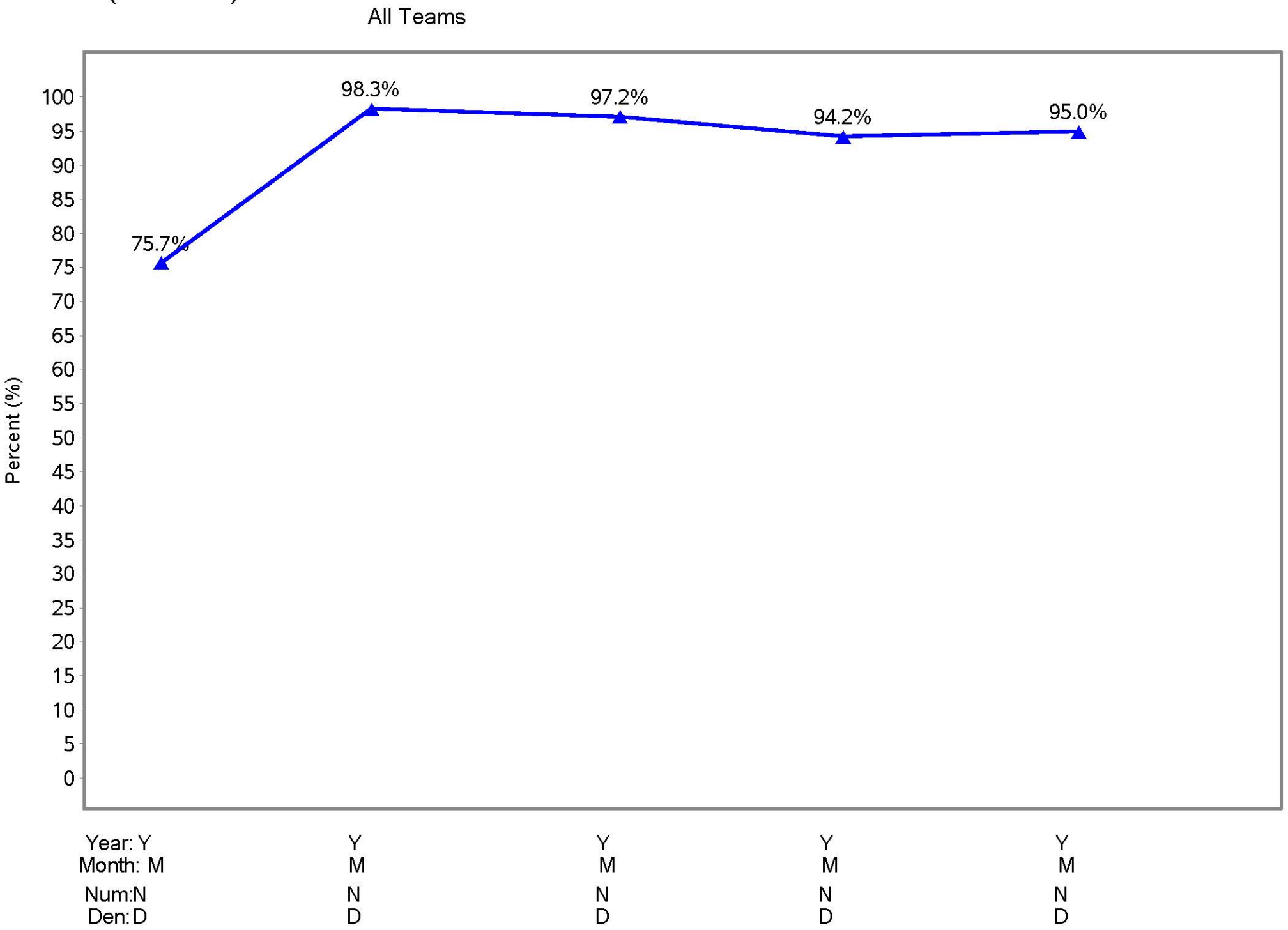
Measure (as of 1/11/16)



Measure (as of 7/13)



State Systemic Improvement Plan

Phase 2

March 15, 2016

State Systemic Improvement Plan

- Comprehensive, Ambitious Achievable
- Improve results for infants and toddlers with disabilities and their families
- Three phases: 2014 to 2020
  - First phase: data analysis and select measure (completed April 1, 2015)
    - Presented Outcome Data and Infrastructure Analysis to EICC in March 2015
  - Second phase: plan to align infrastructure and evaluate (to be submitted on April 1, 2016)
  - Third phase: implementation (report on progress Feb 1, of each year)

State Identified Measurable Result (SIMR)

- NYS selected Family Outcomes
- Percent of respondent families who meet the state's standard on the New York Impact on Family Scale (NYIFS)
- State Standard
  - defined as a measure >=576 on the NYIFS
  - represents the minimum positive impact of Early Intervention Program services on family outcomes considered acceptable for accountability purposes
- Families with a high likelihood of agreement with all the NYIFS items having a location on the scale that is lower than or equal to the item, "***Early intervention services have helped my family use services to address my child's health needs***."

New York State Department of Health

New York State Department of Health
Bureau of Early Intervention
Family Survey

This is a survey for families whose children are leaving the Early Intervention Program. Your responses will help improve services and measure results for children and families. For each statement, please select one of the following responses: very strongly disagree, strongly disagree, disagree, agree, strongly agree, very strongly agree. In responding to each statement, think about your family's experience with early intervention services. You may skip any item you feel does not apply to your child or family.

DIRECTIONS:

- Please use a pencil only.
- Fill in the oval completely.
- Correct mark: ⬭ ⬬ ⬭
- **PLEASE DO NOT FOLD FORM.**

Institute for Child Development

Please return this form in the envelope provided to the Institute for Child Development.

Early Intervention Services for

These statements are about the results of early Intervention services for your family.

Early intervention services have helped me and/or my family:

	Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree
1. understand my child's special needs.	⬭	⬭	⬭	⬭	⬭	⬭
2. make changes in family routines, like mealtime or bedtime, that will be good for my child with special needs.	⬭	⬭	⬭	⬭	⬭	⬭
3. learn how to work on my child's special needs during daily activities like getting dressed.	⬭	⬭	⬭	⬭	⬭	⬭

Hardest for Families to Agree to

State Standard

Easiest for Families to Agree to

Early Intervention services helped me and/or my family….
connect with parents of children with similar needs.
take part in typical activities for children and families in my community.
cope with stressful situations.
support the needs of other children in the family.
feel welcome in the community.
involve my child's doctor in early intervention services.
cope with the emotional impact of having a child with a disability.
find resources in the community to meet my child's needs.
find information I need.
make changes in family routines, like mealtime or bedtime, that will be good for my child with special needs.
know where to go for support to meet my family's needs.
use services to address my child's health needs.
feel less isolated.
know how to keep my child healthy.
be better at managing my child's behavior.
improve my family's quality of life.
learn how to work on my child's special needs during daily activities like getting dressed.
feel more confident in my skills as a parent.
communicate better with the people who work with my child and family.
have confidence in my ability to care for my child with a disability.
feel that I can get the services and supports that my child and family need.
understand what services my child will get when he/she goes into the preschool special education program.
understand how to change what I'm doing to help my child as he/she grows.
understand the roles of the people who work with my child and family.
help my child to be more independent.
know about my child's and family's rights concerning early intervention services.
be an equal partner in planning my child's services.
feel that my efforts are helping my child.
advocate for my child.
be able to tell how much progress my child is making.
get the services that my child and family need.
understand my child's special needs.
learn how to communicate with my child.
understand how the early intervention program works.
do things with and for my child that are good for my child's development.
help my child learn.

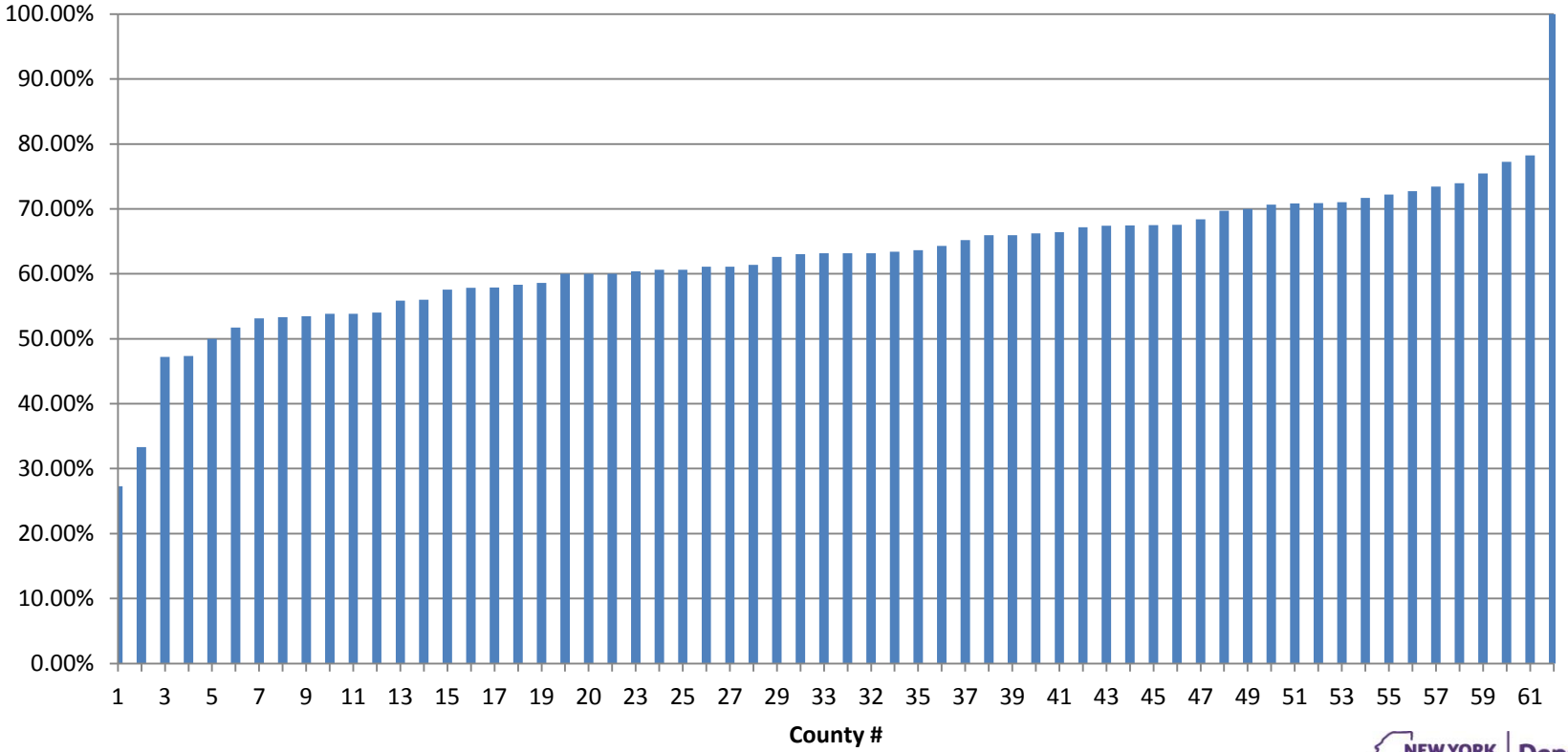
SIMR Baseline and Targets

FFY	2008 - 2013
Of those families who responded to the NYS Family Survey from FFY 2008–FFY 2013, the percent who met the State standard of >=576.	65.09% (4,245/6522)

FFY FFY 2014-2018 Targets	2014	2015	2016	2017	2018
Of those families who responded to the NYS Family Survey in each FFY, the percent who met the State standard of >=576.	65.09%	65.09%	65.50% (+.41%)	66.00% (+.50%)	66.50% (+.50)

NEW YORK STATE OF OPPORTUNITY. Department of Health

Percent of Families Meeting NYIFS State Standard >=576



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How will we improve?

- Family-centered services lead to improved family outcomes
- NYS Family Survey has items about how the families perceived their experience
- Parents who report that their experience was family centered and of high quality are very likely to report positive outcomes

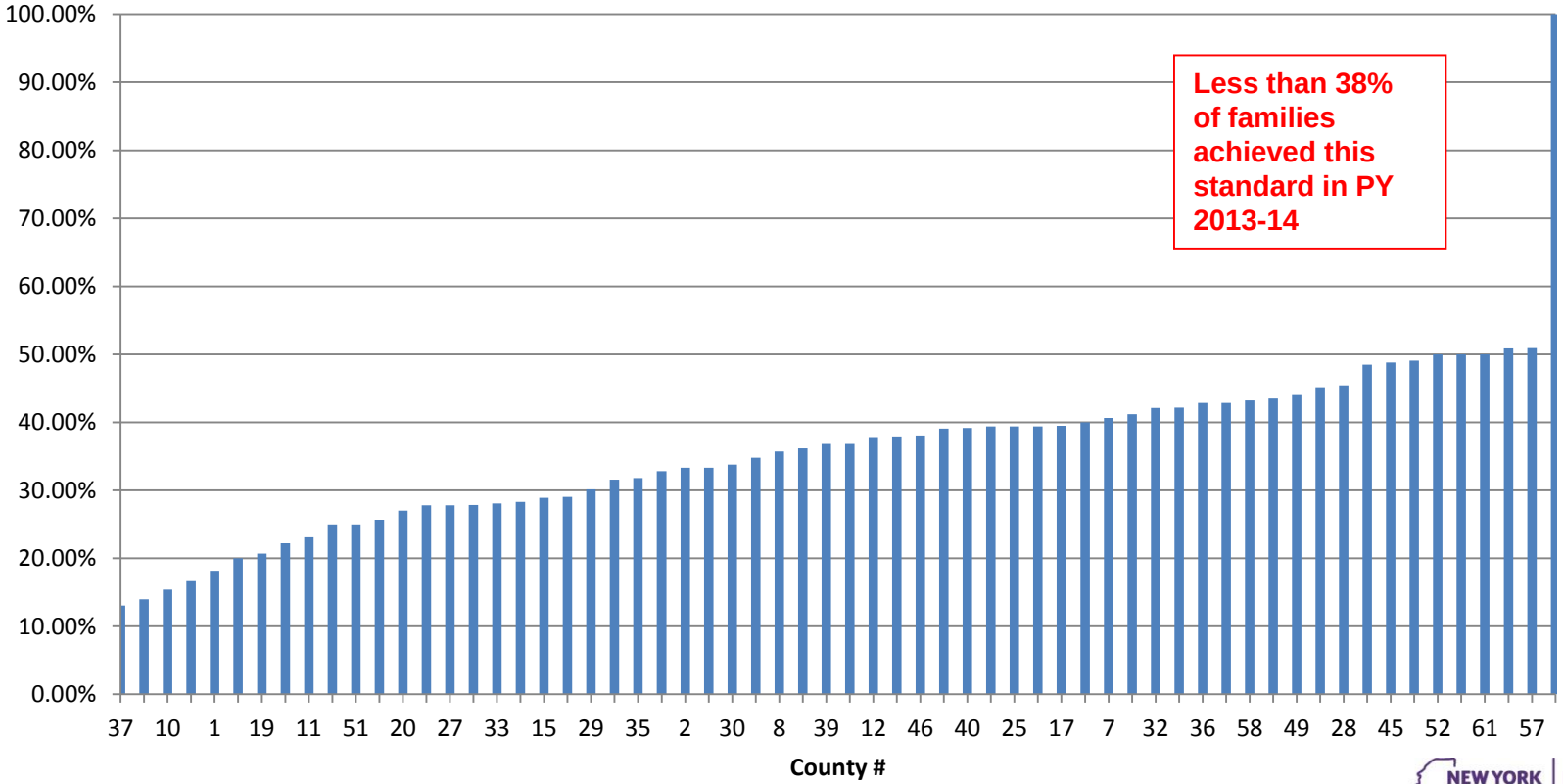
March 15, 2016

Hardest for Families to Agree to

Easiest for Families to Agree to

Family-centered Services Scale Items
Someone from the Early Intervention Program went out into the community with me and my child to help get us involved in community activities and services.
My family was given information about ways of connecting with other families for information and mutual support.
Someone from the Early Intervention Program asked whether other children in the family needed help in understanding the needs of the brother or sister with a disability.
My family was given information about community programs that are open to all children.
My family was given information about where to go for help or support if I feel worried or stressed.
My family was given information about opportunities for my child to play with other children.
Someone from the Early Intervention Program asked if I was having any problems getting the services I needed.
My family was given information about how to advocate for my child and my family.
My family was given information about the public school system's programs and services for children age three and older.
My family was given information about what my options are if I disagree with a decision about my child's services.
Someone from the Early Intervention Program asked if the services my family received met our needs.
I was given help in preparing for the IFSP meeting.
The IFSP kept up with my family's changing needs.
My family was given information about activities that I could do with my child in our everyday lives.
My child transitioned from early intervention (birth to 3 program) to preschool special education without a break in services.
My family was given information about the rights of parents regarding early intervention services.
I was given information to help me prepare for my child's transition.
My child received all the supports for transition listed in our IFSP.
I was offered the chance to meet with people from the Early Intervention Program and the committee on preschool special education to plan for my child's transition to preschool special education.
I knew who to call if I had problems with the services and supports my child and family are receiving.
Written information I received was written in an understandable way.
My family's daily routines were considered when planning for my child's services.
I felt part of the team when meeting to discuss my child.

Percent of Families Meeting FCSS 599+



NEW YORK STATE OF OPPORTUNITY. Department of Health

Phase 2

Must report to OSEP how we will:

- Align state infrastructure to support SSIP
- Evaluate the plan
- National technical assistance

State Infrastructure Changes

- Align Department of Health staff and establish a statewide stakeholder team
- Allocate funding for Centers of Excellence
- Strengthen family outcomes data collection

DOH Staff

- SSIP Team comprised of co-directors, managers and key staff
  - Representing provider approval, due process, family initiatives, professional development and training, policy, and data analysis
- Designated Coordinator
- Implemented routine meetings

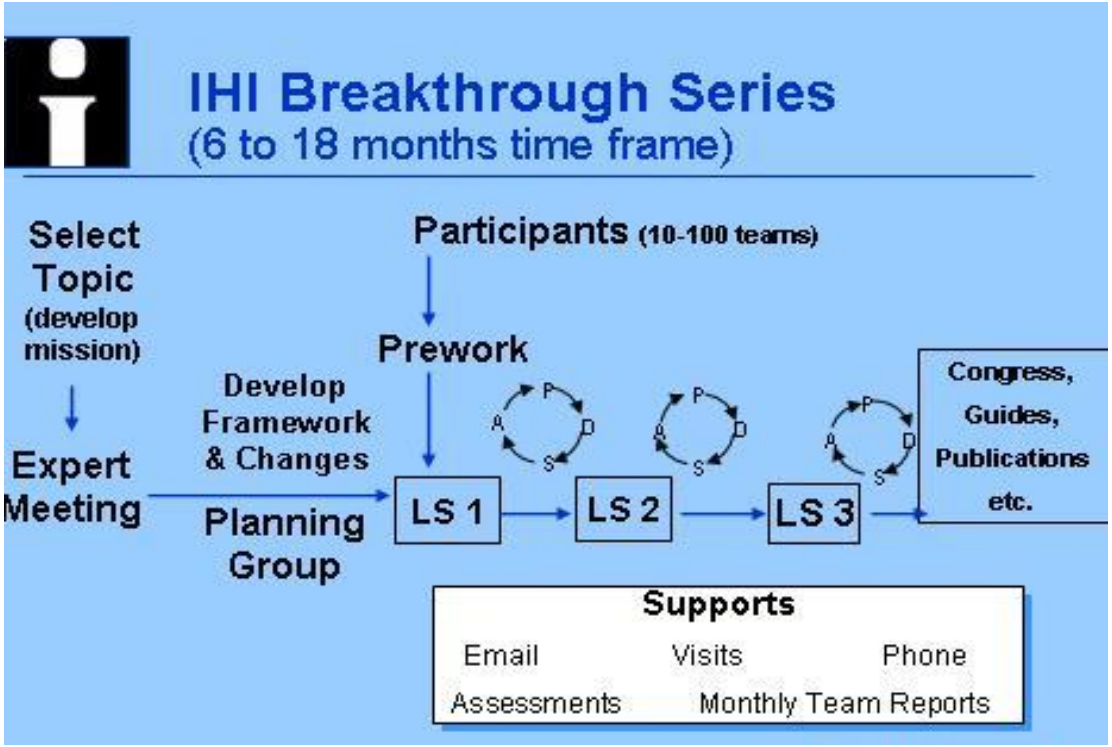
Centers of Excellence

- Develop a centralized repository of evidence-based practices for family-centered services
- Create a website for the evidence-based practices, data collection, and sharing of challenges and successes
- Implement the evaluation plan
- Establish and support the learning collaborative, which will be the framework for improved the family-centeredness of services
- Provide coaching, mentoring, and training for participants in the learning collaborative

NEW YORK STATE OF OPPORTUNITY. Department of Health

IHI Breakthrough Series

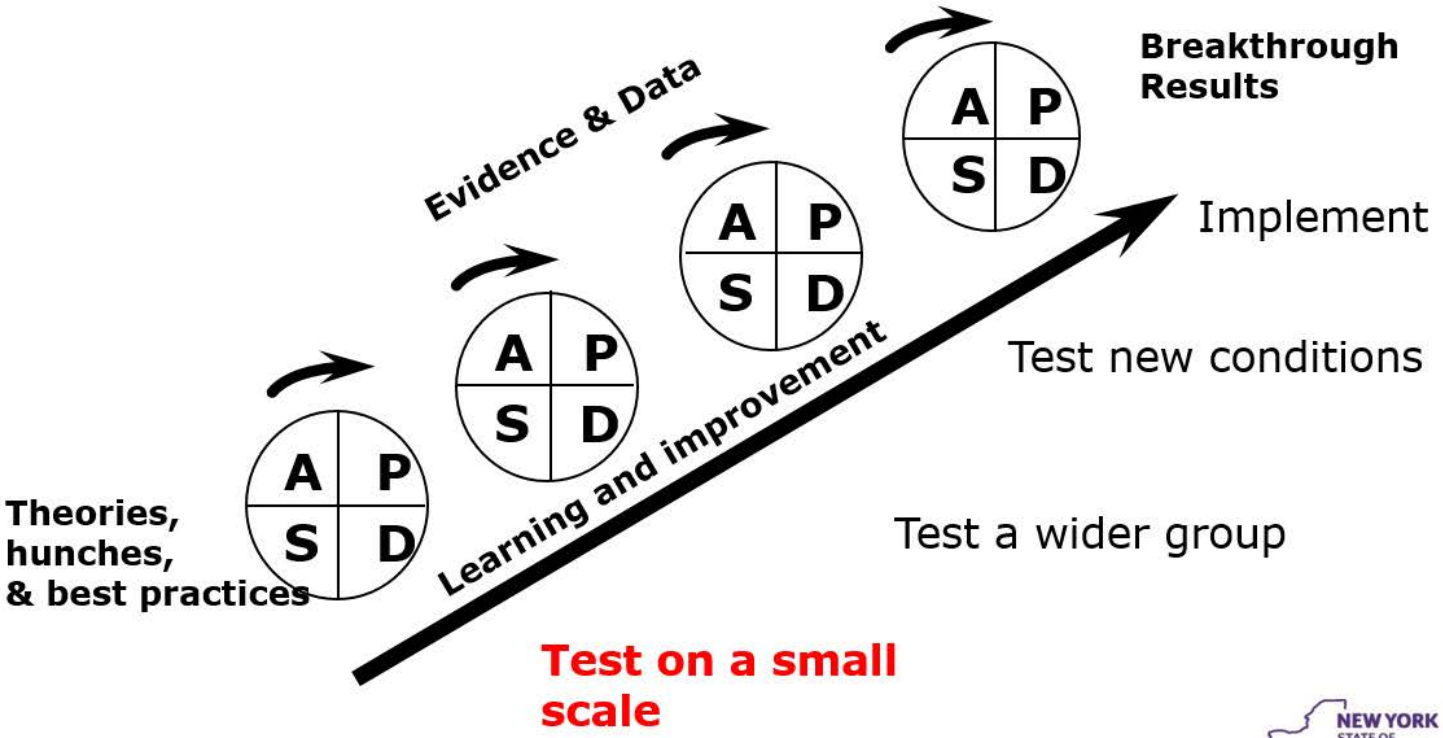
Three phases of the Learning Collaborative: **Pre-Work**, **Learning Sessions**, and **Action Periods**



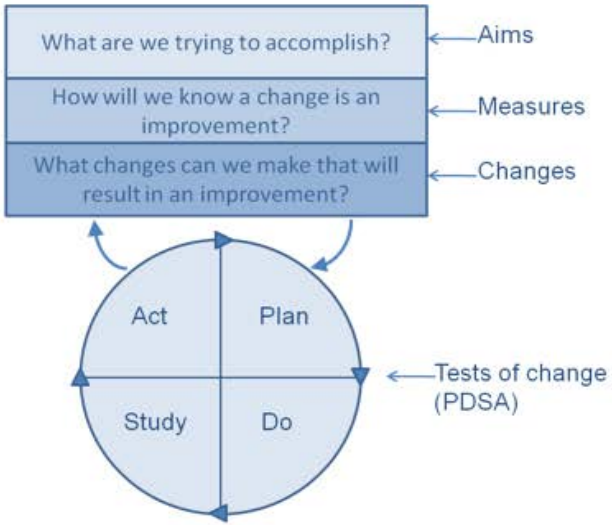
NEW YORK STATE OF OPPORTUNITY. Department of Health

Sequential Building of Knowledge

Includes a Wide Range of Conditions in the Sequence of Tests



Model for Improvement



New York's Model for Improvement

The goal is to improve positive outcomes for families and their infants and toddlers as a result of participating in the New York State Early Intervention Program.

An increased percentage of respondent families participating in Part C will achieve the State's standard (person mean >= 576) on the New York Impact on Family Scale (NYIFS)

The state will improve outcomes for families by:

- Convening a State-level Quality Improvement Advisory Team is established to guide state implementation
- Forming Learning collaboratives/communities of practice
- Using Plan-Do-Study-Act cycles to improve family-centered practices
- Assessing baseline-level of family-centered practices in accordance with State standards and re-assessed periodically,
- Identify evidence-based strategies to improve family-centered services are identified
- Implement family-centered practices by providers in delivering services
- Engaging families as partners and meaningfully involved in promoting their children's development

Timeline

- Learning collaboratives last about 12 months
- Plan is to hold three regionally based collaboratives each year for two years (6)
  - Regions: NYC/LI, Hudson/Capital/NE, Central/Western
  - About 42 teams each year (3 regions * 14 teams/region)
  - Teams have 3-6 participants
- Every county participates

Evaluation Plan

- Implementation: Are we implementing the learning collaborative with fidelity?
- PDSA: Plan, Do, Study, Act
  - Learning Collaborative model is inherently data-driven
  - Process Measures
- NYS Family Survey scales
  - Family-Centered Services Scale (FCSS)
  - Impact on Family Scale (IFS)
  - Outcome Measures

Implementation Milestones

- To what extent were milestones in implementation reached on schedule?
  - Did the statewide quality improvement team convene?
  - Were Centers of Excellence established?
  - How many learning collaborative teams were successfully recruited?
  - How many members were successfully recruited to participate?
  - Were the team members representative (EIO/D/M, parents, service coordinators, therapists, QA personnel at agencies, etc.)?
  - Were the initial in-person or virtual learning sessions held?

Evaluation of Learning Collaborative

The Centers of Excellence with BEI will implement the evaluation plan:

- Process or Short-Term Measures
- Outcome or Long-Term Measures

Evidence-based Practices

- Based on the activities that stakeholders originally identified as being needed to ensure high quality, family-centered EI services:
  - Someone from EI went out into the community with me and my child to help us get involved in community services
  - My family was given information about ways of connecting with other families for information and mutual support
  - My family was given information about opportunities to play with other children
- Common theme is community involvement
- Consistently the hardest items for parents to agree that EI helped their family
- Not intending that every family and child be required to participate in activities in the community, needs to be individualized

PDSA WORKSHEET

Team Name :	Date of test:	Test Completion Date:
Overall team/project aim:		
What is the objective of the test?		

Please send completed worksheets to:

PLAN:

Briefly describe the test:

How will you know that the change is an improvement?

What driver does the change impact?

What do you predict will happen?

PLAN

List the tasks necessary to complete this test (what)	Person responsible (who)	When	Where
1.			
2.			

Plan for collection of data:

DO: Test the changes.

Was the cycle carried out as planned? ☐ Yes

What did you observe that was not part of your plan?

STUDY:

Did the results match your predictions? ☐ Yes ☐

Compare the result of your test to your previous performance:

What did you learn?

ACT: Decide to Adopt, Adapt, or Abandon.

☐ Adapt: Improve the change and continue testing plan.
Plans/changes for next test:

■ Adopt: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability Display Storyboard in Birth Records Office. Educate new staff through SPDS *"Guidelines for the New York State Certificate of Live Birth & Quality Improvement"*.

☐ Abandon: Discard this change idea and try a different one

Data Collection Tool Example

For Illustrative Purposes Only
Example Data Collection Tool

Instructions: Each month, review the IFSPs of at least 20 infants. **Only check infants who are <specify criteria>.**

1. Year:_____ 2. Month:_____

NYEIS ID	3. IFSP has goal to provide opportunities for parents to connect with families for information and mutual support. Y or N	4. Documented in IFSP parent support group information was given. Y or N	5. Follow up to make sure parent was able to connect Y or N	6. IFSP was updated to address parent concerns Y or N	7. Reviewer EIOD ISC OSC, etc.	Initials of Reviewer
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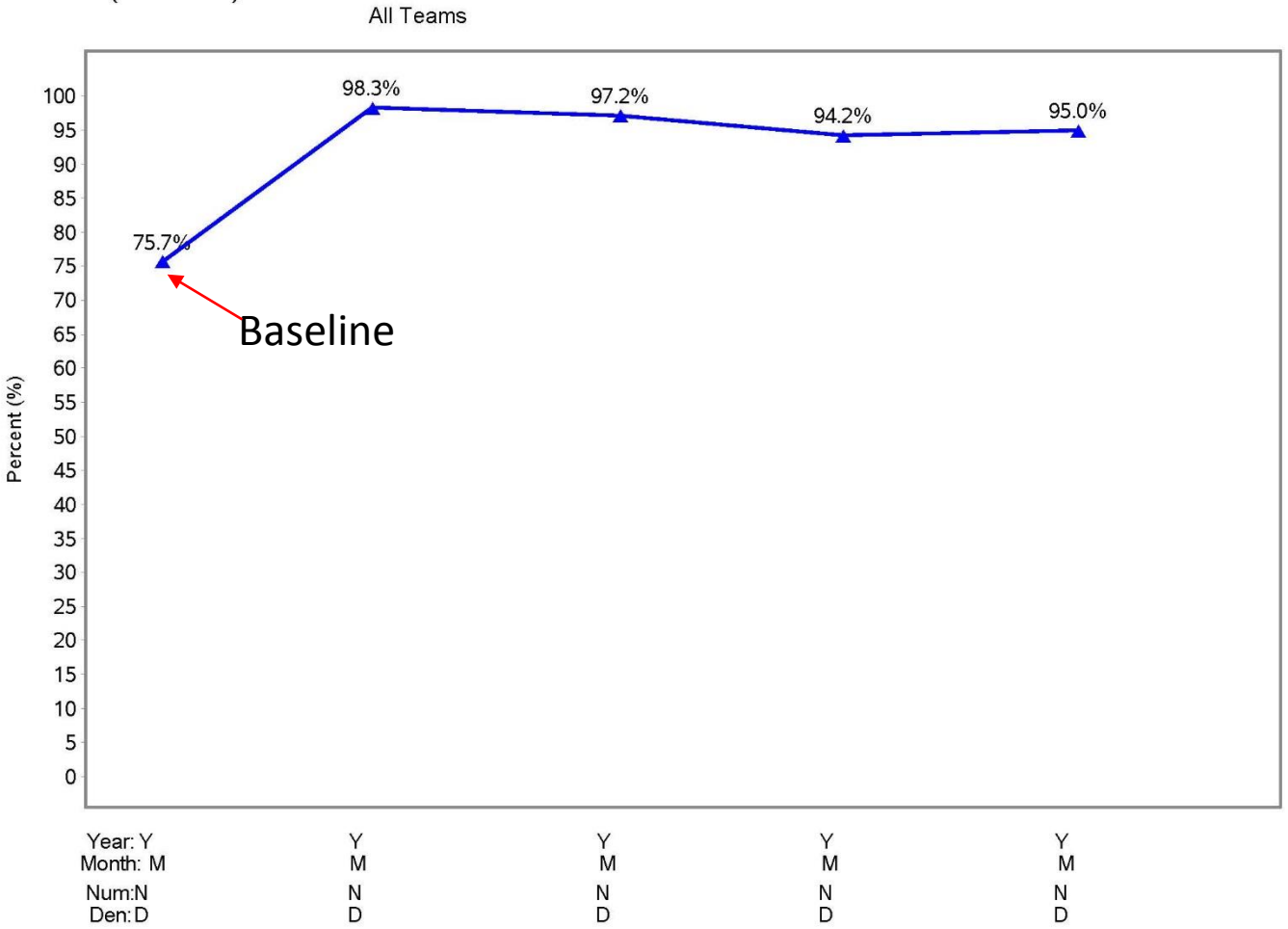
Measure (as of 7/13)

Run Chart after 4 months



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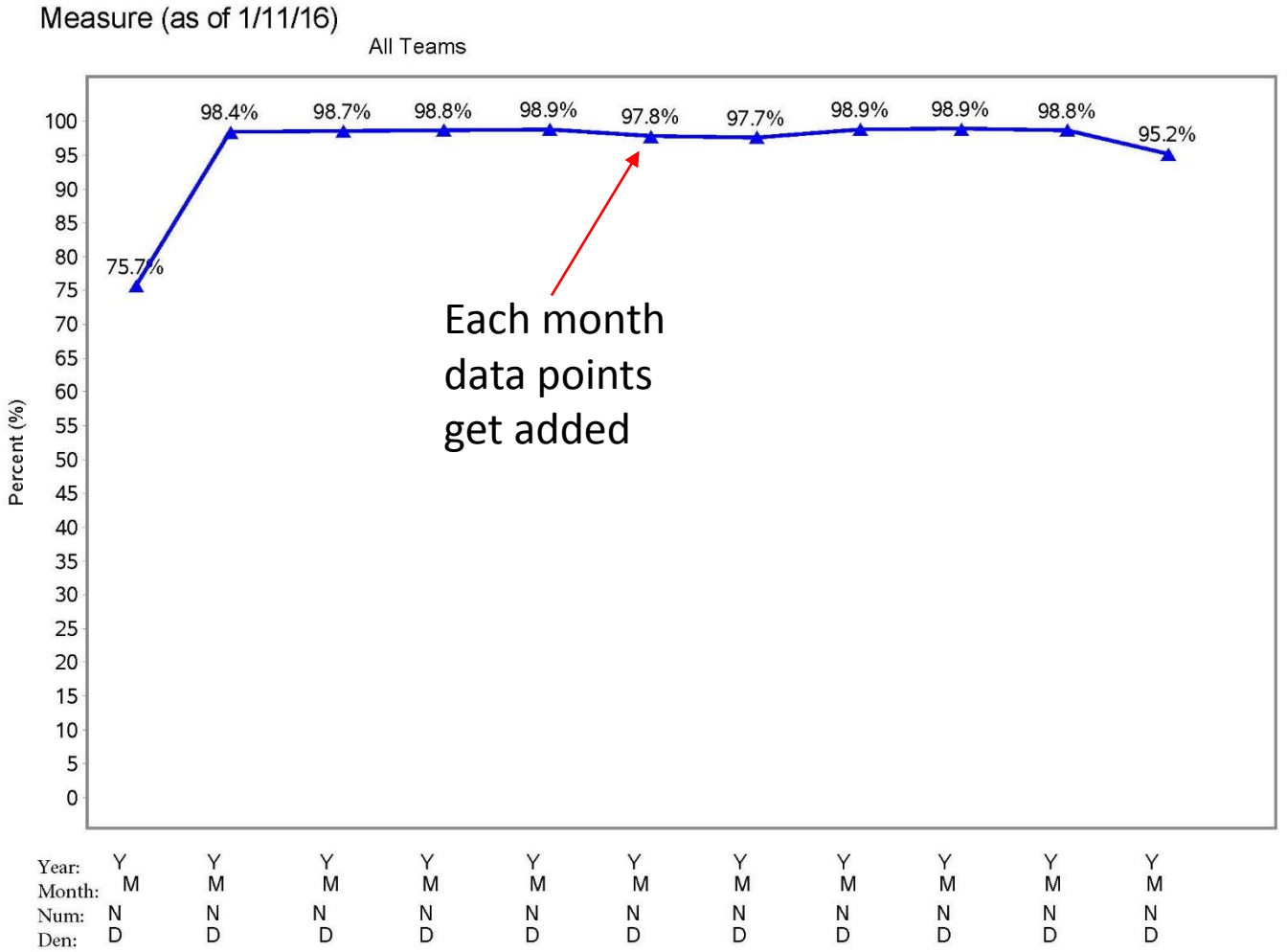
Run Chart after 10 months



Strengthen Family Outcomes Collection

- Send closer to when the family exits (sending two mailings instead of one)
- Geocode addresses to make sure they are valid
- Review and update contact information, work with municipalities, service coordinators
- Increase statewide sample and in some counties invite all with a geocoded address
- Translate into Russian, Yiddish, Chinese, Bengali, and Arabic
- Exploring creating a trifold pamphlet about the importance of providing family centered services and what families should expect
- Reminder letter three weeks after the survey is sent

National Technical Assistance

- Family Outcomes Community of Practice
- National Center for Systemic Improvement
- IDEA Data Center
- Other state part C programs: AR, CT, IA, LA, TX

Next Steps

- Submit Plan to OSEP on April 1, 2016
- Convene statewide stakeholders
- Establish Centers of Excellence
- Recruit Teams
- Implement Learning Collaborative

Questions?

New York State Department of Health

New York State Department of Health
Bureau of Early Intervention
Family Survey

This is a survey for families whose children are leaving the Early Intervention Program. Your responses will help improve services and measure results for children and families. For each statement, please select one of the following responses: very strongly disagree, strongly disagree, disagree, agree, strongly agree, very strongly agree. In responding to each statement, think about your family's experience with early intervention services. You may skip any item you feel does not apply to your child or family.

DIRECTIONS:

- Please use a pencil only.
- Fill in the oval completely.
- Correct mark: ⬭ ● ⬭
- **PLEASE DO NOT FOLD FORM.**

Institute for Child Development

To Serve • To Educate • To Understand

Please return this form in the envelope provided to the Institute for Child Development.

Early Intervention Services for

These statements are about the results of early intervention services for your family.
Early intervention services have helped me and/or my family:

	Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree
1. understand my child's special needs.	⬭	⬭	⬭	⬭	⬭	⬭
2. learn how to be an active member of the Individualized Family Service Plan (IFSP) team.	⬭	⬭	⬭	⬭	⬭	⬭
3. learn ways to help my child make easier transitions between activities.	⬭	⬭	⬭	⬭	⬭	⬭
4. be better able to meet the needs of my child with special needs.	⬭	⬭	⬭	⬭	⬭	⬭
5. be better able to meet the needs of other family members.	⬭	⬭	⬭	⬭	⬭	⬭
6. do things with and for my child that are good for my child's development.	⬭	⬭	⬭	⬭	⬭	⬭
7. become knowledgeable about different treatments/interventions for my child.	⬭	⬭	⬭	⬭	⬭	⬭
8. be able to help my child use new skills in a variety of settings.	⬭	⬭	⬭	⬭	⬭	⬭
9. be better at managing my child's behavior.	⬭	⬭	⬭	⬭	⬭	⬭
10. help my child to be more independent.	⬭	⬭	⬭	⬭	⬭	⬭
11. learn ways to help my child develop social skills.	⬭	⬭	⬭	⬭	⬭	⬭
12. find resources in the community to meet my child's needs.	⬭	⬭	⬭	⬭	⬭	⬭
13. be more involved in community activities with my child.	⬭	⬭	⬭	⬭	⬭	⬭
14. cope with stressful situations.	⬭	⬭	⬭	⬭	⬭	⬭
15. find information I need.	⬭	⬭	⬭	⬭	⬭	⬭
16. use services to address my child's health needs.	⬭	⬭	⬭	⬭	⬭	⬭
17. understand more about my child's delay or diagnosis.	⬭	⬭	⬭	⬭	⬭	⬭
18. feel welcome in the community.	⬭	⬭	⬭	⬭	⬭	⬭
19. take part in typical activities for children and families in my community.	⬭	⬭	⬭	⬭	⬭	⬭
20. communicate better with the people who work with my child and family.	⬭	⬭	⬭	⬭	⬭	⬭
21. be an equal partner in planning my child's services.	⬭	⬭	⬭	⬭	⬭	⬭
22. learn how to use my child's interests in certain activities and objects as teaching opportunities	⬭	⬭	⬭	⬭	⬭	⬭
23. learn how to help my child adapt to new people and environments.	⬭	⬭	⬭	⬭	⬭	⬭
24. know about treatment/intervention options in the community.	⬭	⬭	⬭	⬭	⬭	⬭

DO NOT MARK IN THIS AREA

SERIAL #

(cont.)

These statements are about the results of early intervention services for your family.

Early intervention services have helped me and/or my family:

	Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree
25. be able to explain my child's unique qualities, strengths, and needs to professionals.	○	○	○	○	○	○
26. understand the roles of the people who work with my child and family.	○	○	○	○	○	○
27. know how to keep my child healthy.	○	○	○	○	○	○
28. know about my child's and family's rights concerning early intervention services.	○	○	○	○	○	○
29. think critically and ask questions about service options.	○	○	○	○	○	○
30. feel less isolated.	○	○	○	○	○	○
31. connect with other families of children with special needs	○	○	○	○	○	○
32. learn ways to encourage appropriate play with other children.	○	○	○	○	○	○
33. feel competent in dealing with professionals and agencies.	○	○	○	○	○	○
34. learn strategies to communicate with my child.	○	○	○	○	○	○
35. involve my child's doctor in early intervention services.	○	○	○	○	○	○
36. be able to have my child share in as many family activities as possible.	○	○	○	○	○	○

These statements are about the results of early intervention services for your child.

Early intervention services have helped my child:

	Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree
37. be able to handle unexpected changes in routine.	○	○	○	○	○	○
38. be able to transition from one activity to another.	○	○	○	○	○	○
39. practice safe behaviors (staying close to an adult, responding to "Stop").	○	○	○	○	○	○
40. do more things for himself/herself, like eating, getting dressed, and toileting.	○	○	○	○	○	○
41. function independently in a variety of activities without direct adult assistance.	○	○	○	○	○	○
42. display fewer and less intense problem behaviors (aggression, self-injury, tantrums).	○	○	○	○	○	○
43. be included by his/her peers in playtime and in activities.	○	○	○	○	○	○
44. try different ways of solving a problem.	○	○	○	○	○	○
45. keep going when a task is hard.	○	○	○	○	○	○
46. seek positive interactions with peers.	○	○	○	○	○	○
47. use new skills in different settings.	○	○	○	○	○	○
48. recognize the emotions of others.	○	○	○	○	○	○
49. get along with other children.	○	○	○	○	○	○
50. take part in a group activity.	○	○	○	○	○	○
51. start to learn about books.	○	○	○	○	○	○
52. be able to follow instructions.	○	○	○	○	○	○
53. use toys and objects appropriately in play.	○	○	○	○	○	○
54. learn new words.	○	○	○	○	○	○
55. move from place to place to participate in everyday activities.	○	○	○	○	○	○
56. use language to express himself/herself.	○	○	○	○	○	○
57. use objects as tools.	○	○	○	○	○	○

(cont.)

These statements are about the results of early intervention services for your child.

Early intervention services have helped my child:

	Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree
58. improve joint attention skills (where two people share attention to the same object).	○	○	○	○	○	○
59. learn to give and receive affection.	○	○	○	○	○	○
60. take part in conversations.	○	○	○	○	○	○
61. engage in typical family activities.	○	○	○	○	○	○
62. adapt to new people.	○	○	○	○	○	○
63. acquire learning skills, such as imitating others, exploring, trial-and-error, etc.	○	○	○	○	○	○
64. learn basic concepts, such as colors and shapes.	○	○	○	○	○	○
65. seek help when needed to assist with basic care.	○	○	○	○	○	○

These statements are about your family's experience with the Early Intervention Program.

	Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree
66. I was given help in preparing for the IFSP meeting.	○	○	○	○	○	○
67. The IFSP kept up with my family's changing needs.	○	○	○	○	○	○
68. I knew who to call if I had problems with the services and supports my child and family are receiving.	○	○	○	○	○	○
69. Written information I received was written in an understandable way.	○	○	○	○	○	○
70. My family's daily routines were considered when planning for my child's services.	○	○	○	○	○	○
71. I felt part of the team when meeting to discuss my child.	○	○	○	○	○	○
72. I was given information to help me prepare for my child's transition.	○	○	○	○	○	○
73. I was offered the chance to meet with people from the Early Intervention Program and the committee on preschool special education to plan for my child's transition to preschool special education.	○	○	○	○	○	○
74. My child received all the supports for transition listed in our IFSP.	○	○	○	○	○	○
75. My child transitioned from the Early Intervention Program to preschool education without a break in services.	○	○	○	○	○	○
76. Overall, I am satisfied with the services my child received.	○	○	○	○	○	○
77. Overall, I am satisfied with the services my family received.	○	○	○	○	○	○

My family was given information about:

	Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree
78. activities that I could do with my child in our everyday lives.	○	○	○	○	○	○
79. opportunities for my child to play with other children.	○	○	○	○	○	○
80. ways of connecting with other families for information and mutual support.	○	○	○	○	○	○
81. where to go for help or support if I feel worried or stressed.	○	○	○	○	○	○
82. community programs that are open to all children.	○	○	○	○	○	○
83. how to advocate for my child and my family.	○	○	○	○	○	○
84. what my options are if I disagree with a decision about my child's services.	○	○	○	○	○	○
85. the public school system's programs and services for children age three and older.	○	○	○	○	○	○
86. the rights of parents regarding early intervention services.	○	○	○	○	○	○

Someone from the early intervention program:

	Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree
87. went out into the community with me and my child to help get us involved in community activities and services.	○	○	○	○	○	○
88. asked if I was having any problems getting the services I needed.	○	○	○	○	○	○
89. asked whether other children in the family needed help in understanding the needs of the brother or sister with a disability.	○	○	○	○	○	○
90. asked if the services my family received met our needs.	○	○	○	○	○	○

The early intervention provider(s) that worked with my child:

	Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree
91. did what they said they were going to do.	○	○	○	○	○	○
92. showed a willingness to learn about the strengths and needs of my child and family.	○	○	○	○	○	○
93. were easy for me to talk to about my child and family.	○	○	○	○	○	○

My service coordinator:

	Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree
94. was available to speak with me on a regular basis.	○	○	○	○	○	○
95. was knowledgeable and professional.	○	○	○	○	○	○