Learning Innovations
20 Winter Sport Lane
Williston, VT 05495
Phone 802.951.8218
FAX 802.951.8222

EVALUATION REPORT
FOCUSED MONITORING (FM) IN THE CONNECTICUT BIRTH TO THREE SYSTEM: A KALEIDOSCOPE OF PERSPECTIVES

Prepared by
Kristin Reedy, Ed.D. and Vicki Hornus, M.S.,
Learning Innovations at WestEd

December 2008

Table of Contents

BACKGROUND 1

MONITORING REQUIREMENTS UNDER IDEA 1

PURPOSE 2

EVALUATION QUESTIONS 3

METHODS 4

HISTORY OF FOCUSED MONITORING IN CONNECTICUT 5

DESCRIPTION OF CONNECTICUT'S FOCUSED MONITORING SYSTEM ... 6

FINDINGS 7

- ICC and Focused Monitoring Stakeholders Group 8
- Focus Groups with Providers 8
- Interviews with Focused Monitoring Peer Team Members 15
- Interviews with Focused Monitoring Parent Team Members 18
- Interviews with DDS Staff and Other State Level Stakeholders 20
- State DDS Manager Interviews 23
- Observation of the Focused Monitoring Process 26
- Interviews with National Special Education Accountability Monitoring (NCSEAM) Consultants 27

SUMMARY AND REFLECTIONS 29

- Themes 30
- Strengths: Leadership, Process, and Impact 31
- Areas for Improvement 33

COMMENDATIONS 35

RECOMMENDATIONS **36**

Process **36**

Design **36**

Professional Development and Technical Assistance **37**

CONCLUSION **37**

REFERENCES **38**

APPENDICES

Appendix 1: Resumes of Evaluation Team

Appendix 2: Self-Assessment: Focused Monitoring Implementation Checklist (FMIC) Revised March 2005

Appendix 3: State Interagency Coordinating Council

Appendix 4: Connecticut Part C Focused Monitoring Program Groups Using The Size of the Program Based on Children with IFSPs on July 1, 2007

Appendix 5: April 14, 2008 – ICC and Focused Monitoring Stakeholders Group Meeting – Input on FM Evaluation Questions and Methods

Appendix 6: Interview Protocols

Appendix 7: Case Example of the Process: Focused Monitoring Review

LIST OF TABLES

Table 1: Focus Groups: Perceived Purpose of the Focused Monitoring System **9**
Table 2: Focus Groups: Perception of Degree of Involvement **10**
Table 3: Focus Groups: Understanding of the Selection Process **11**
Table 4: Peer Team Members: Perceived Purpose of the Focused Monitoring System **16**
Table 5: Peer Team Members: Perception of Intended Outcomes of the Focused Monitoring System **16**

Table 6: Parent Team Members: Perceived Purpose of the Focused Monitoring System..... 18
Table 7: Parent Team Members: Perceptions of Intended Outcomes of the Monitoring System 19
Table 8: State Level Stakeholders: Perceived Purpose of the Focused Monitoring System..... 21
Table 9: State Level Stakeholders: Perception of Intended Outcomes of the Focused Monitoring System..... 21
Table 10: Perceived Strengths of Connecticut's Birth to Three Focused Monitoring System 31
Table 11: Perceptions of What Could be Improved 34
Table 12: Range of Program Compliance on Priority Area Indicators 2007 35

Evaluation Report
Focused Monitoring (FM) in the Connecticut Birth to Three System: A Kaleidoscope of Perspectives

Prepared by Kristin Reedy, Ed.D. and Vicki Hornus, M.S.
Learning Innovations at WestEd
December 1, 2008

BACKGROUND

The Connecticut Department of Developmental Services (DDS) contracted with Learning Innovations at WestEd to conduct an external evaluation of the Connecticut Birth to Three Focused Monitoring System (the CT FM System). Given the multiple stakeholders that have been involved in both the development and the implementation of the CT FM System and the multiple audiences to whom the findings and recommendations of the evaluation will be directed, the Learning Innovations Evaluation Team has taken a collaborative approach to identifying evaluation questions, determining methodology, co-interpreting the data and developing recommendations. Our evaluation plan was designed to collect information from multiple perspectives and sources of data in order to capture a complete and accurate picture of Focused Monitoring in Connecticut that will provide a basis for ongoing review and continuous improvement, resulting in improved outcomes for Connecticut's young children with disabilities and their families.

Learning Innovations at WestEd is a not-for-profit education, research, development, and technical assistance organization located in Woburn, Massachusetts and Williston, Vermont. Learning Innovations is a program of WestEd, headquartered in San Francisco, California, with a total of 16 offices nationally and over 500 employees.

The Evaluation Team included Kristin Reedy, Ed.D. and Vicki Hornus, M.S. both employees of Learning Innovations at WestEd. Kristin and Vicki are career special educators with experience at the local, state, and federal/national level. Kristin is currently the director of the federally funded Northeast Regional Resource Center (NERRC), which provides technical assistance and support to state agencies in the northeast region with regard to the implementation of the Individuals with Disabilities Education Act (IDEA). Vicki is a NERRC Senior Program Associate with particular expertise in Focused Monitoring, state-to-local monitoring systems, and General Supervision. Resumes are included in Appendix 1.

MONITORING REQUIREMENTS UNDER IDEA

Under IDEA, states are responsible for ensuring compliance with the statute and providing General Supervision of all programs providing Part B (3-21) and Part C (0-3) services. A state's system of General Supervision is responsible for monitoring and enforcing IDEA requirements and ensuring a process that will lead to continuous improvement (National Center for Special Education Accountability Monitoring-

NCSEAM, 2007). As stated in IDEA 2004, Section 616, "The primary focus of Federal and State monitoring activities… shall be on—(A) improving educational results and functional outcomes for all children with disabilities and (B) ensuring that States meet the program requirements under this part, with a particular emphasis on those requirements that are most closely related to improving educational results for children with disabilities."

"Focused Monitoring" has been defined as: "A proactive approach which includes a purposeful selectio1`n of priority areas to examine for compliance/results while not specifically examining other areas in order to maximize limited resources, emphasize important requirements, and increase the probability of improved results." (NCSEAM, 2007). Focused monitoring activities of the Lead Agency for Part C should be designed and implemented to improve educational results and functional outcomes for infants and toddlers with disabilities and their families.

A state's system of General Supervision is comprised of several components that should work together in an integrated manner to ensure overall compliance with the IDEA. Focused Monitoring is one component of Connecticut's system of General Supervision for the Part C Birth to Three Early Intervention Program. Other components include: the State Performance Plan (SPP) and Annual Performance Report (APR); (2) State to Local Determinations; (3) statewide monitoring through the Biennial Performance Report (BPR) self-assessment process; (4) statewide policies, procedures and service guidelines; (5) Memoranda of Understanding with other agencies and programs; and (6) the due process and dispute resolution system including complaints, mediation, and due process hearings. The General Supervision system is managed through state policies and procedures, informed by data on processes and results, supported with technical assistance and professional development, and includes fiscal management and enforcement procedures to ensure compliance. The focus of this current evaluation was on the Focused Monitoring component of Connecticut's Birth to Three General Supervision system.

PURPOSE

The evaluation was engaged to accomplish the following general purposes:

- To promote broader awareness, increased capacity, sustainability, and stakeholder "buy in" of the Connecticut Birth to Three Focused Monitoring System.

- To gather useful and timely formative evaluation data and information about the CT FM System that will validate the breadth and scope of the system, obtain information regarding client satisfaction, solicit feedback on the effectiveness of the program and inform future program planning.

- To facilitate broad sharing of the evaluation findings and to collaboratively develop data-based recommendations for CT FM System improvement and development.

Throughout the Spring 2008, the Evaluation Team held several conversations with officials at DDS to plan the evaluation. These meetings helped to (1) identify issues and concerns that the Department wanted to address; (2) identify the documents that would be reviewed; (2) determine what individuals and groups the Evaluation Team would interview; (3) schedule the on-site Focused Monitoring inquiry visit to be observed; and (4) schedule focus groups with providers. In April 2008, the Evaluation Team attended the Connecticut Interagency Coordinating Council (ICC) and Focused Monitoring Stakeholders Group meeting to present the purposes and plans for the evaluation and to solicit input and obtain confirmation of the evaluation purposes and questions to be addressed.

EVALUATION QUESTIONS

The evaluation questions were designed to solicit perceptions from a variety of stakeholder perspectives and to assess the match between what was described in state documents and by state staff as the process of Focused Monitoring with what was actually occurring during the on-site visit(s). In others words, the evaluation (1) explored the degree of commonality or discrepancy in stakeholder perceptions and understandings of the process and (2) assessed the degree of fidelity with which the process is being implemented. The CT FM System was also evaluated against the standards set forth in the NCSEAM Focused Monitoring Implementation Checklist (2005), Appendix 2.

The following overarching questions were addressed in the evaluation and incorporated into the interview and focus group protocols.

1. To what extent is there a clear understanding by local programs, parents, ICC members, and other stakeholders of the purposes, processes and intended outcomes of the CT FM System?

2. To what extent and in what ways are stakeholders involved in the development of the process, the identification of priority areas, and evaluation of activities?

3. What are the primary components of the CT FM System and how are they being implemented?

4. How do these components integrate with the state's overall system of General Supervision?

5. To what extent and in what ways have the professional development needs for Focused Monitoring Teams been assessed and addressed? To what extent is ongoing professional development provided?

6. To what extent do the Focused Monitoring Teams use a coherent approach, a common language, similar strategies and consistent implementation?

7. What data sources are used for Focused Monitoring and how are they systematically gathered, analyzed and reported to determine Focused Monitoring activities?

8. How are monitoring results used for local program improvement, technical assistance, professional development, corrective action and/or enforcement?

9. To what extent and in what ways do local program staff find the Focused Monitoring system to assist in their local program improvement efforts?

10. What impact is the Focused Monitoring system having on the quality of local program services and on child and family outcomes?

11. What challenges in implementation of the Focused Monitoring system are faced by the Department and local programs/providers?

12. To what extent and in what ways are the Focused Monitoring data used to inform other Department initiatives and reported to the local programs, other stakeholders and to the public?

METHODS

A range of evaluation activities was conducted to obtain information on the functioning of the CT FM System and of stakeholder perceptions and opinions, providing multiple sources of data and perspectives so that a comprehensive picture of the Focused Monitoring System was obtained. The variety of data sources provided a multi-lens look at Focused Monitoring as it is being implemented for the Birth to Three program in Connecticut; a kaleidoscope of lenses through which to view the system.

Evaluation Activities	**Time Frame**
Conducted meeting of Focused Monitoring Stakeholders Group to obtain input and agreement on evaluation questions, methodology and instrumentation.	April 14, 2008
Reviewed FM documents, protocols and reports, examples of corrective action plans, etc.	Spring 2008
Reviewed guidance documents from NCSEAM.	Spring 2008
Reviewed Verification Letter (2006) and Determination Letter and Response Table (2008) from the U.S. Office of Special Education Programs (OSEP).	Spring 2008
Conducted 2 focus groups with local providers in East Hartford and Shelton, CT. Number of participants: 18 representing 17 of 38 of local programs.	June 19-20, 2008
Conducted in-depth telephone or face-to-face interviews with local program providers, DDS and other state level staff, Parent and Peer Focused Monitoring Team Members, the ICC Chair and other "key informants." Total of 18 interviews conducted.	Summer-Fall 2008
Participated as an observer on one three-day on-site FM Visit.	Summer 2008
Conducted telephone interviews with two representatives from the National Center for Special Education Accountability Monitoring (NCSEAM).	Fall 2008

HISTORY OF FOCUSED MONITORING IN CONNECTICUT

Focused Monitoring in Connecticut began in 2003 with consultation from the Northeast Regional Resource Center (NERRC) and the National Center on Special Education Accountability Monitoring (NCSEAM). NERRC is funded by the U.S. Office of Special Education Programs (OSEP) to support states in the implementation of IDEA. Focused monitoring was one of the OSEP-designated priority areas for technical assistance. NCSEAM, a national center also funded by OSEP, was charged with helping states to establish their systems of Focused Monitoring and to provide leadership and support to improve the effectiveness of state accountability systems. Connecticut's Part C Director, Linda Goodman, was invited to serve as a member of the NCSEAM's Advisory Board and Connecticut was chosen as one of the original NCSEAM "partner" states. NCSEAM guidance documents including the *NCSEAM Self-Assessment: Focused Monitoring Implementation Checklist (FMIC)* were utilized to design Connecticut's Birth to Three Focused Monitoring System.

Working with the Focused Monitoring Stakeholders Group, DDS identified three priority areas for Focused Monitoring: Child Find, Service Delivery, and Transition. These areas were selected, in part, because valid and reliable data on these three indicators were readily available. Programs were sorted into small, medium, and large groupings for Focused Monitoring selection based on the size of the program. Measures were defined for program ranking and selection using statewide data available on all local programs.

To date, 26 of 38 local early intervention programs have received an on-site Focused Monitoring review.

- 4 programs in Spring 2005
- 5 programs in Fall 2005
- 4 programs in Spring 2006
- 5 programs in Fall 2006
- 4 programs in Spring 2007
- 3 programs in Fall 2007
- 1 program in Summer 2008

Each program was selected and reviewed in one of the three priority areas. To date, priority areas across programs have included:

- Child Find – 9 programs
- Service Delivery – 7 programs
- Transition – 10 programs

DESCRIPTION OF CONNECTICUT'S FOCUSED MONITORING SYSTEM

Focused Monitoring is one component of Connecticut's system of General Supervision for Part C of the IDEA. Stakeholders identify priority areas. Programs are selected for an on-site monitoring review based upon a ranking of performance in priority areas. Monitoring reports originally included findings of noncompliance and required corrective actions.

Purpose of Focused Monitoring in Connecticut: As described in the Connecticut *IDEA Part C Quality Assurance Manual (2007),* the purpose of Focused Monitoring is "…not to compare programs to each other but to support low performing programs by helping them to identify effective strategies for improvement" (p.28).

Stakeholder Involvement: According to the description of Focused Monitoring in the Connecticut *IDEA Part C Quality Assurance Manual* (2007), the State ICC serves as the base for the Focused Monitoring Stakeholders Group, with the addition of parents, a representative from the Part B Focused Monitoring staff (Connecticut State Department of Education), and a special education director from a local school district who is also on the Part B stakeholders group. The stakeholders group is responsible for advising DDS, the Lead Agency for Part C, on priority areas, indicators and measures to be monitored each year as well as reviewing progress on the priority areas for the state as a whole. (See list of current ICC Members, Appendix 3.)

Priority Areas: The Focused Monitoring Stakeholders Group annually reviews aggregated statewide data provided by DDS and determines the priority area(s) to be addressed in the coming year. As indicated above, since beginning Focused Monitoring in Connecticut, the three priority areas have been Child Find, Service Delivery and Transition. In some years, more than one priority area may be selected but an individual program will not be monitored in more than one area at a time. These areas were selected initially because valid and reliable data on all local programs were readily available.

Indicators and Measures: For each priority area, an indicator is identified and how it will be measured to what criterion is defined. For example, in the priority area "transition," the *indicator* is that "children and families have a smooth transition at age three." The *measure* of that indicator is the date of the child's transition conference, and the *criterion* is that "100% of transition conferences will be held at least 90 days before age three."

Grouping, Ranking and Selection: As indicated above, programs are grouped by size (small, medium, and large), based on enrollment. The rationale for program groupings, as explained in the Connecticut *IDEA Part C Quality Assurance Manual* (2007), is to provide a basis of comparison to other similarly sized programs. Programs have been grouped as follows: small sized programs 0-59, medium sized programs 60-149, and large programs 150 or more. (See Appendix 4 for an example of *Connecticut Part C*

Focused Monitoring Program Groups Using the Size of the Program Based on Children with IFSPs on October 1, 2007.)

Within their size group, programs are ranked according to their level of compliance with the targeted indicator. For example, for the priority area, "transition," programs are ranked based on the percentage of transition conferences that meet the specified criterion. Based on this ranking, the lowest ranking programs within each group are selected for on-site Focused Monitoring. Procedures provide that even if a program is the lowest ranked in their size grouping on more than one indicator, only one priority area will be focused on in the Focused Monitoring review. Additionally, if a program has already received an on-site visit, the next lowest program will be selected. Programs may also be selected at random if all other programs are meeting criterion for the chosen indicator. As the *Quality Assurance Manual* indicates, "Once a program has been selected for an on-site visit, they will not be selected for an on-site visit using data in another priority area until the program no longer has an active improvement plan for measures in that priority area" (p. 28). Programs are selected in January and July. Once selection is made, programs are notified by phone and by letter.

Focused Monitoring Team: The team conducting the on-site Focused Monitoring visit(s) is comprised of the DDS Part C Accountability and Monitoring Manager, three Parent Team Members who are employed by DDS, a director of a local Birth to Three program in another part of the state who serves as a Peer Member and other DDS staff, as appropriate or needed.

Focused Monitoring Process: The process for Focused Monitoring is explained thoroughly in the Connecticut *IDEA Part C Quality Assurance Manual* (2007). Components include: (1) pre-planning calls with the selected program; (2) a parent input letter mailed to all families of children enrolled in the program; (3) a "desk audit" of state compiled data on the program prior to the visit at which data from multiple sources are reviewed and hypotheses generated by the Monitoring Team to guide the on-site inquiry visit; (4) the on-site inquiry visit which includes record reviews and interviews with program staff and parents; (5) the on-site exit meeting and drafting of the preliminary report which includes notification of any finings of noncompliance; (6) the final summary report; (7) improvement and corrective action plan development and (8) technical assistance and/or professional development related to the improvement or corrective action plan. It is important to note that the program director and staff from the selected program are closely involved in the planning of the on-site visit from the point of notification of selection, through the on-site visit, including the opportunity to provide input into the hypotheses generated during the desk audit and the discussion of the verification of hypotheses at the exit meeting.

FINDINGS

Findings from each of the data collection activities are described and summarized below. Each section provides a different lens through which to view the CT FM System from the perspective of seven different groups: the ICC and Focused Monitoring

Stakeholders Group, providers of early intervention services at the local level, Parent and Peer Focused Monitoring Team Members, DDS staff and other state level stakeholders, DDS Managers, and external consultants from the National Center for Special Education Accountability Monitoring (NCSEAM). In addition, this section includes a report of an observation of an on-site Focused Monitoring visit, conducted in August 2008.

ICC and Focused Monitoring Stakeholders Group

A meeting with the ICC and Focused Monitoring Stakeholders Group was held on April 14, 2008. At that meeting, the purposes of the evaluation were explained, over-arching evaluation questions were shared and the Department provided an overview of Connecticut's Birth to Three system of General Supervision. The group provided a number of suggestions for evaluation questions that they wanted to see addressed in the evaluation. Issues raised by the group included the difference between quality versus compliance as the intent of the Focused Monitoring reviews, the cost of implementing the system, how Connecticut's system compares to that used in other states, how the Biennial Performance Report (BPR) and the CT FM System complement each other and how the CT FM System contributes to improved family and child outcomes. Questions included: Is Focused Monitoring focusing on the "right " programs? Is Focused Monitoring worth the cost? Are we getting information that will help in program improvement? A complete listing of the ICC and Focused Monitoring Stakeholders Group comments and suggestions is included in Appendix 5.

Focus Groups with Providers

This section summarizes the responses from focus groups with Birth to Three local program directors. Sections are organized to correspond to the Focus Group protocol used by the Evaluation Team (Appendix 6). Two focus groups were held: one on June 19 and the other on June 20, 2008 in East Hartford and Shelton, Connecticut. Focus groups were two hours in duration. One Evaluation Team member served as the facilitator of the group while the other recorded responses on a laptop computer. Responses to the predetermined focus group questions are summarized below. All providers of Birth to Three Programs were invited to participate in the focus group of their choice through direct emails to each program and via monthly newsletters from DDS. There were ten participants in East Hartford and seven in Shelton for a total of 17. One additional provider who was not able to attend either focus group requested an opportunity to speak with the Evaluation Team. She was subsequently interviewed by telephone and her comments incorporated with the comments from other participants. In summary, a total of 18 providers were involved representing 17 out of 38 programs in the state. Participants included providers who had participated in a Focused Monitoring on-site inquiry visit as a Peer Team Member and others who had not. Participants also included providers who had experienced an on-site visit when their own program was selected for a review. The focus groups provided one lens through which to view CT's FM System—through the eyes of local providers, some of whom had been recipients of an on-site visit, had participated as a Peer Team Member, or both.

Purpose, Process and Intended Outcomes: The first cluster of focus group questions asked providers to explain their understanding of the purposes, processes and intended outcomes of the CT FM System. Providers differed in terms of whether (1) they perceived the purpose to be to improve compliance with IDEA and state regulations, (2) to improve the quality of the program and services to children and families or (3) to serve both purposes. As one provider put it, "I wish could say it is really to improve programs. Seems like the idea is to be in 100% compliance with federal guidelines and if the program improves, that's great, but that doesn't seem to be the goal."

On the other hand, other providers saw a dual purpose of quality *and* compliance: "It's a way for people to see how we are in compliance with requirements and [the Team] will also make suggestions for improvement and how we are overall serving children and families." Other purposes expressed by providers included: "to look good to the feds," "get more money," "consistency across programs," "equity," and "to learn from one another." Several providers acknowledged that "quality is hard to measure," but when probed about *how* to measure program quality, few had suggestions to offer. They did note that "looking good" based on compliance data is not necessarily an indicator of the quality of the program. One provider reported that there is a lack of understanding across the system of "why we are doing this" and that there are "a variety of ideas about why it is happening." And another explained, "One purpose is quality assurance and providing TA to improve quality of programs. But …the real purpose is for the state to demonstrate to the feds that they have a system of General Supervision of the programs." Table 1 shows the breakdown of responses to this question. The majority of comments indicated that the perceived primary purpose of Focused Monitoring is to improve compliance. Fifty-seven percent of comments related the purpose to compliance while another 14% saw it as both compliance and quality.

Table 1 Focus Groups: Perceived Purpose of the Focused Monitoring System

	Quality	Compliance	Both Quality & Compliance	Did not rate	Total
# of comments	0	12	3	6	21
% of comments	0	57%	14%	29%	100%

Note: Responses coded "did not rate" did not relate directly to the question.

Involvement in the Process: When asked about their involvement in the development of the CT FM System, providers again differed in their responses. Some indicated that they remembered being asked for input on priority areas and measures, e.g. timely services, that provider comments were incorporated into the proposed process, and that they had input into the family survey. Others perceived the process as a "top down" requirement from the federal government or the state: "I was not involved in the development. It felt like it came down from the state….we don't typically argue with state issues." And another, "I don't know how they decided to pick and measure the priority areas." Table 2 shows the breakdown of responses to this question. Twenty-three percent of comments indicated involvement in the process.

Table 2 Focus Groups: Perception of Degree of Involvement

	Yes	No	Did not rate	Total
# of comments	3	5	5	13
% of comments	23%	38%	38%	100%

Note: Responses coded "did not rate" did not relate directly to the question.

Understanding of the Selection Process: Most providers understand the selection process for Focused Monitoring to be data-based; that the *reason* programs are selected is due to their data or percent of compliance on the targeted indicator. Others, however, noted that while the program's rate of compliance may be the reason that the program was selected, once on-site, the review is comprehensive and addresses issues that go beyond the specific compliance indicator. This comment expresses the perceptions of a number of providers: "When they do select you, they also look at everything. That was a surprise to me. They interviewed staff, interviewed families, not just the item that we didn't do well on. Reviewed 10% of the charts. Went to all three of our sites and interviewed all staff. We had to shut down for several days... Asked staff about parent rights, etc. It wasn't just about timely services."

Others questioned the criteria being used for selection, again raising the quality versus compliance dichotomy: "[The process]… does it truly identify programs that need help? When fixed, they have never told me anything that I didn't know." Still others questioned the time and effort being put into the Focused Monitoring process, given what was perceived as relatively minor compliance violations: "To come out for two days because someone is next on the list. The punishment does not fit the crime. There should be levels of intervention – seems like there is one approach for all programs even though you may have already solved the problem. We do have

legitimate issues and problems that we would like help with. The levels of response and intervention need to fit the situation." Table 3 shows the breakdown of responses regarding on what criteria the selection of programs is based. Fifty-four percent of comments reported selection based solely on data while another 23% reported data along with other factors.

Table 3 Focus Groups: Understanding of the Selection Process

	Data	Data and Other Factors	Other	Did not Rate	Total
# of comments	7	3	1	2	13
% of comments	54%	23%	8%	15%	100%

Note: Responses coded "did not rate" did not relate directly to the question.

Overall System of General Supervision: When asked how Focused Monitoring is integrated into the Connecticut Birth to Three Program's system of General Supervision, responses indicated a general lack of understanding of what "General Supervision" is and how Focused Monitoring is a part of a more comprehensive process. There also seemed to be some confusion among providers as to how the BPR, a self-assessment required of all programs every two years, fits with or relates to Focused Monitoring. One mentioned the overlap between the BPR Improvement Plan and what she referred to as the "Focused Monitoring Plan": "It's almost like you are in a perpetual state of chart review….the timelines make it confusing…I thought you could put them together into one report but I felt like I had to do two separate ones."

Others expressed frustration with the combination of processes which were perceived to be duplicative, too compliance focused, and too time consuming, taking resources away from service delivery and potentially reducing rather than improving quality. Several mentioned the complaint resolution system as a component of General Supervision and one provider was concerned that when the program called the Department with a question it was counted as a parent complaint. Others expressed frustration with the data reporting system.

Two participants commented positively: "Focused monitoring fits in very well. Some programs are afraid of it but I welcomed it. …Every program needs that kind of support. The state has been very helpful with our new director in terms of providing her support." And, "I'm fine with having the state come in. I think the process has improved the

program." When asked about the relationship of Focused Monitoring to the BPR, one participant commented, "The BPR thing is coming up…it's different from Focused Monitoring, right? Now they are not coming this year…they are just checking two things. I think it's a great program…"

Provider Descriptions of the On-site Visit: Those participants who had experienced an on-site Focused Monitoring visit were very clear about why their program was selected, confirming that selection was based on their program's compliance data on the chosen indicator. With few exceptions, most participants felt that they were well prepared for the on-site visit in terms of what to expect and in terms of the development of the on-site schedule.

Involvement in the desk audit was perceived differently. Some providers would have preferred to be physically present at the desk audit meeting, rather than participating by phone. One didn't feel that her input was taken seriously ("Because I was a new director, it was the state's hypothesis.") but most confirmed that they had an opportunity to participate in the generation of hypotheses during the desk audit.

Several providers commented on what they saw as inconsistency across monitoring team members, particularly between Parent Team Members and between Parent or Peer Team Members and the DDS Team Leader. For example, "The parent representatives were on opposite ends of what their job was. One explained how she would give the center the benefit of the doubt. The other parent was a stickler. The Focused Monitoring Team is not necessarily on the same boat as central office. One thing that I was specifically told was a good thing at a monitoring visit, three months later I was told it was wrong [by the state]."

Another commented on what she perceived as a discrepancy between the concerns raised at the exit meeting in the draft report and the final report: "I feel that the report is too casual. There is a difference between the verbal presentation and the written one. The exit meeting is much too casual for the effort that goes into it from the program."

Providers commented as well on the technical assistance they received to assist with program improvement after the site visit. Several were able to give specific examples of technical assistance provided: "We had another visit on services to children with autism…it turned our program around because of all the help that we got from the state." Others, however, either didn't receive what they perceived as technical assistance or they could not remember receiving it or the support they received didn't measure up to what may have been unrealistic expectations: "They tell you that you are going to be getting TA – that was not as easy as they thought it was going to be. I'm thinking that they are going to be calling me, sending resources. I didn't have enough staff. I was hoping that they were going to help us in ways to acquire that staff. The reality was very different from the promise."

Impact on Program Improvement, Program Quality and Child and Family Outcomes: This issue again relates back to the quality versus compliance dichotomy.

Participants commented that Focused Monitoring has improved their compliance data. One program director indicated that the process resulted in her being able to hire additional staff and provided the impetus to focus specifically on particular compliance requirements at the local level. One comment sums up the feeling of the majority of the group participants: "I don't know about quality, but certainly it has made our staff really aware of the federal requirements. Don't know if it has changed the quality of their care, but certainly the data looks impeccable." And another: "I can't say that Focused Monitoring improves the quality of care. It improves our documentation." Another acknowledged that the Focused Monitoring process resulted in closing a program that, in her view, was of poor quality. On the other hand, another director indicated, " My staff and I feel that we have reduced quality of services because the emphasis is more on compliance."

Too Much for Too Little—the "Overkill Factor": Throughout the focus group interviews, comments reflected a perception that the while the Focused Monitoring process has strengths and may be necessary in order for the state to address compliance, it may be too much effort for too little effect and/or be a level of intervention that is not warranted given the relatively minor levels of noncompliance that many programs are beginning to demonstrate. For example, one provider commented that her program was the lowest in her size grouping with a level of compliance at 90%. She questioned the validity of a process that was identifying a program for a highly intrusive, time and resource intensive process for only "minor" violations. The following comments capture what seemed to be commonly held perception of the group:

- "I think it's a lot of manpower and money to find out…"

- "It was overkill in my opinion….the director knew the problems prior to the visit, and could have corrected them. Didn't need the visit. I think that it did not require that much infusion of time and personnel to prove the hypothesis. In my case we had three data entry errors. We knew that before they arrived."

- "It comes down to having a very complex process to look at something that is relatively simple. If a signature is not there…to say that we have a hypothesis is overdoing it. It assumes that there could be multiple reasons. If the signature is missing, you don't need a hypothesis. The provider made a mistake – didn't get it. It's overkill. Staff already know that they need the signatures. You could say that we will train the staff. You have to go through the motions. What can you do to 'make them know' again."

- "It's a big hammer for something that could be fixed with a tack."

Strengths/Benefits: Participants voiced the following strengths of the Focused Monitoring process:

- Uses a data-based process

- Improves compliance at the local level
- Improves compliance at the state level
- Provides a rationale and support for staff increases or other improvements
- Provides opportunity for participation from the local program director in the process of generating hypotheses and recommendations
- Provides data demonstrating improvement in services for Birth to Three
- Enhances Connecticut's reputation as a "national leader" in Part C

To some, Focused Monitoring is a "necessary evil." Providers acknowledged "there has to be some sort of monitoring to look at what kind of services people are providing." One commented that "the steps involved are totally reasonable…" but she had issues with the selection process: "Everything they do makes sense…they are just selecting the wrong people."

Below is a sampling of positive comments about the Focused Monitoring system:

- "The parents [team members] were actually wonderful. A lot was really nice about it. You did hear a lot of good things about your program."

- "They gave us a lot of positive feedback – charts were organized so they could go through quickly. It was fairly painless as far as the whole process goes. I was new and was able to learn the whole process."

- "I thought it was positive. I remember getting upset in the meeting because of some of the results…but I knew that the purpose was to make things better. "

- "They were very open to the director's hypothesis of why it was going on. We took results of the monitoring; we took the info and did something with it. The team was open-minded."

Suggestions for Improvement: Participants had a number of thoughtful suggestions that are categorized as follows: Overall Process, Selection Process, Data Issues, Time/Effort/Cost, Quality vs. Compliance, and Professional Development.

Overall Process: Overall suggestions related to simplification, making the process less threatening for providers with more emphasis on program strengths, providing more upfront guidance on what to expect during the visit, and connecting Focused Monitoring more directly with the BPR.

Selection Process: Providers recommended a focus on programs that demonstrated significant noncompliance in the targeted indicator(s). If programs are at high levels of compliance, statewide, they suggested that it might be time to choose another indicator(s). An alternative but related recommendation was to use differentiated levels of monitoring or intervention based on the degree of noncompliance demonstrated by the data.

Data Issues: The data collection and reporting system and the technology to support it could be improved, according to a number of participants. Reduction in the numbers of indicators and measures was suggested. However, one recommendation as for the Department to conduct further training with providers to stress the importance of valid and reliable data for the overall system.

Time/Cost/Quality: Time, effort, and cost of implementing the Focused Monitoring system have increased the burden at the local level and providers recommended that be acknowledged and supported with additional resources and more efficient use of technology. To increase focus on program quality, participants recommended using the parent interview process to probe parent perceptions about and satisfaction with the quality of the services they were receiving.

Summary: Not unexpectedly, the local Birth to Three program providers who participated in the two focus groups were somewhat negative in their descriptions of the Connecticut Focused Monitoring System. The process is time intensive and intrusive for them and their staff and carries with it high stakes in terms of determinations of program compliance. However, further probing and the opportunity to generate strengths and recommendations brought out acknowledgement of the necessity of a compliance monitoring system and the effort that the DDS has made to make the process clear, consistent, predictable, participatory, transparent and above all, data-based. The general perception is that the process has helped to improve compliance at the local level. However, there are fundamental concerns about an over emphasis on compliance at what many feel is at the expense of program quality and strong interest in revising the selection process so that it targets the "right" programs. The focus groups provided one lens through which to view CT's FM System—from the perspective of those who are the recipients of the process and who know from first hand experience all that it entails.

Interviews with Focused Monitoring Peer Team Members

Each Focused Monitoring Team includes a director of a local Birth to Three Program in another part of the state who serves as a "peer member" of the team. Six Peer Team Members were interviewed by telephone by the Evaluation Team in the Summer, 2008. Four of the six had received a review of their own program and two had not. Peer Team Members who had also experienced a Focused Monitoring visit, tended to respond to interview questions from their own experience-base as a recipient of an on-site visit. (The Peer Team Member interview protocol is included in Appendix 6.) This lens takes a look at the CT FM System from the point of view of participants in the process.

Purpose and Intended Outcomes: When asked about the purpose of the CT FM System, Peer Team Members focused on the use of data to improve compliance and to determine what a program needs to do to improve. One peer said that the "purpose is to direct more concentrated energy on the area of insufficiency…as opposed to being a comprehensive program overview. It doesn't stay as tightly encapsulated as one would think, but they try to stay on track…it's the domino theory …one thing leads to another.

It can get more bulky than what was anticipated." Another peer said, "When they come out they want to see if we are doing what we need to do. It was still a full program review." In response to intended outcomes, comments ranged across three areas: compliance, quality, and both quality and compliance. Tables 4 and 5 summarize responses.

Table 4 Peer Team Members: Perceived Purpose of the Focused Monitoring System

	Quality	Compliance	Both Quality & Compliance	Total
# of comments	1	3	3	7
%of comments	14%	43%	43%	100%

Table 5 Peer Team Members: Perception of Intended Outcomes of the Focused Monitoring System

	Quality	Compliance	Both Quality & Compliance	Total
# of comments	2	4	3	9
% of comments	22%	44%	33%	100%

Preparation and Training: There was consensus among peers that they did not need, nor did they receive much training on the process prior to the visit, but that the DDS Accountability and Monitoring Manager (Team Leader) or other Team Members were available to field their questions "on the job." One person suggested that her/his role was to "offer emotional support to the director and to give ideas/strategies that would work for her program. People appreciate having that perspective…people who have walked in their shoes." Peer Team Members seemed confident that their own experience as local directors was adequate preparation for serving on the Focused Monitoring Team.

Focused Monitoring Process from Start to Finish: Since four of the peers interviewed had received an on-site visit of their own program some of their responses were based more on that experience rather than when they served as a Peer Team Member. They each described the use of data for selection of programs for on-site

visits, the desk audit, hypothesis framing, record review, on-site interviews, and exit meeting with the program director. Several mentioned that their involvement, while very useful to them (they learned new information) and the program being monitored, was a considerable drain on their own company's resources. One peer commented, "It's not compensated. It's above and beyond." There were also comments about whether the current method of selection was identifying the "right" programs.

Ability to Influence the Report and Recommendations: With one exception, each of the peers felt that they were able to influence the report and recommendations. One person commented, "I felt that I was listened to and that I could be honest with the local program."

Impact on Quality of Local Program Services and Child and Family Outcomes: As reflected in the sample below, the majority of comments expressed the view that Focused Monitoring is more about good data and compliance rather than program quality.

- "It makes you aware of the compliance issues…but I don't think it gets at quality."
- "Federal data doesn't address quality of direct service provision. Quality assurance and focused monitoring of data are two different things."
- "[Focused Monitoring] is …improving the quality *of the data*…We're learning to put in the data they way they like it."
- "Monitoring is about data input and the data system…not about quality."
- "I think it's a little tricky…there are some programs that are not the best quality, but they have good data so they look good. But how else would they pick a program? The data is what they have to use."

Strengths/Benefits: Peers voiced the following strengths of the Focused Monitoring System:

- Improves compliance at local and state level
- State leadership for Birth to Three
- Having parents and peers involved
- Helps us to look good as a state
- Helps to leverage resources for local programs

Areas for Improvement:

- Streamline the process and provide opportunity to "fix" some problems without having to have a complete Focused Monitoring on-site visit.
- Demonstrate more generosity of spirit, be more user friendly and collaborative.
- Develop a strategy to identify those programs that have good data but remain "under the radar."
- Match Focused Monitoring with the BPR and timelines for correction.
- Assure that all Parent Team Members have the same and ongoing training so there is consistency in how they perceive their role and how they rate the data collected.

Other Information: All Peer Team Members interviewed suggested more emphasis on the quality of programs, but none were confident in the best way to measure it. On-site observations and videotaping were mentioned as possible means to assess the quality of provider-family-child interaction.

Interviews with Focused Monitoring Parent Team Members

Each Focused Monitoring Team includes three Parent Team Members. The three currently employed Parent Team Members were interviewed individually in person on June 19 and 20, 2008. Parent Team Members are employed by DDS and serve on all on-site visits, providing consistency across programs. Parent Team Members are individuals who have had a child participate in the Connecticut Birth to Three program, either presently or in the past. They are not assigned to on-site visits within their own region. All three work very part time with Birth to Three. One individual joined the program within the past year and had been on only two site visits at the time of the interview. (The Parent Team Member interview protocol is included in Appendix 6.) This lens reflects the parent perspective from "inside" the process. It is colored by the interviewees' experiences as parents of children with disabilities who received Birth to Three services and by their participation in the process of Focused Monitoring, itself.

Purpose and Intended Outcomes: Parent Team Members were unanimous in their view that the purpose of Focused Monitoring is to ensure that all families and children receive the highest quality services possible. They also described being able to "connect the dots" between what the chart (IFSP) specifies and what the family and service providers report is actually happening. "Families may not realize what they could/should be getting….even though they could be happy, ignorance is not bliss."

Parent Team Members reported that intended outcomes were improvement in both compliance and quality: "Ultimately the outcome is that children get the best possible services that they can get" and "The goal is 100% compliance on all protocols in 100% of the programs." They also noted that identifying needs for technical assistance from DDS and making connections between program directors as an important means for networking and peer-to-peer support. Tables 6 and 7 show the breakdown of Parent Team Members responses regarding purpose and intended outcomes.

Table 6 Parent Team Members: Perceived Purpose of the Focused Monitoring System

	Quality	Compliance	Both Quality & Compliance	Total
# of comments	0	2	3	5
% of comments	0	40%	60%	100%

Table 7 Parent Team Members: Perceptions of Intended Outcomes of the Focused Monitoring System

	Quality	Compliance	Both Quality & Compliance	Total
# of comments	1	0	6	7
% of comments	14%	0	86%	100%

Preparation and Training: Parent Team Members reported that those involved from the beginning of the CT FM System's development had extensive training: "About a week long, very intensive, very informative." However, the newest member reported little training other than meeting with other Parent Team Members. Others indicated that new members received on-the-job training from them. They all indicated that they may request additional training and support, as needed, but that there is no ongoing, scheduled training plan.

Focused Monitoring Process from Start to Finish: Parent Team Members described the process fully and consistently with more emphasis on the point where they "come in" during data review and hypothesis setting. Two individuals also applauded the process of developing a TA plan for the program at the exit meeting.

Ability to Influence Report and Recommendations: All three Parent Team Members expressed their belief that they were "taken seriously" and that they were "all partners and equals" in the process. They also explained that while the DDS Accountability and Monitoring Manager writes the report, any differences in opinion are reflected in the written document.

Impact on Quality of Local Program Services and Child and Family Outcomes: There was consensus that the CT FM System has a very positive impact on the quality of services and outcomes as reflected in the following sample of Parent Team Member comments:

- "Even the programs who were concerned about us coming... they were happy to get the input and will do something about it."
- "If they learn they are doing something wrong they can quickly fix it."
- "Programs don't want to have an on-site visit so they are motivated to improve and do better."
- "The data is put out publicly on the Internet for parents and peers to see –that also serves as a motivator."

Strengths/Benefits: Parent Team Members voiced the following strengths of the CT FM System:

- The DDS Accountability and Monitoring Manager (Team Leader) was perceived as an asset. "Her experience, background, knowledge and relationships…"
- Well organized and individualized for each program
- Peer Team Members provide a needed perspective
- Focusing on only one priority area

Areas for Improvement:

- Develop a training manual or guide to study, refer to, help clarify what the Team Members should be looking at.
- Visit more programs, perhaps doing data verification visits, which could be less intensive than a Focused Monitoring visit.
- Schedule more days on-site to talk with families.

Interviews with DDS Staff and Other State Level Stakeholders

Face-to-face interviews were conducted with DDS and other state level staff or stakeholders in June 2008. A total of 18 interviews were conducted, including the ICC Chair, representatives from the Connecticut Department of Education, and the Executive Director of the Connecticut Parent Advocacy Center (CPAC). (The interview protocol used with state level personnel and stakeholders is included in Appendix 6.) This lens captures the views of those who helped to design the CT FM System and are helping to implement it at the present time.

Purpose and Intended Outcomes: These individuals listed multiple purposes including compliance with IDEA, improvement in quality and services, opportunities for training and technical assistance and improvement in the overall Birth to Three system. Some added that monitoring and quality assurance are part of the DDS contractual relationship with providers. When describing outcomes, both compliance and quality measures were identified. Below is a sampling of comments from interviewees.

- "As a result of the comprehensive review we actually improve their workflow and their system and clarify expectations and requirements."
- "To identify needs for technical assistance."
- "Compliance with policies and procedures."
- "To improve results for children – the data helps them reflect on what is happening so they can correct it."
- "[Focused Monitoring is]…a way to gather more from families' perspectives, especially about how services need to change or evolve."

Several individuals mentioned improvement in compliance data on the transition indicator and improvement in services as a result of Focused Monitoring. One individual also expressed concern about unintended consequences: "Could the focus on

quantitative data, which is readily available, mask some of the quality issues? Numbers don't necessarily demonstrate the quality." Tables 8 and 9 below summarize state staff perceptions of the purpose and intended outcomes of the CT FM System.

Table 8 State Level Stakeholders: Perceived Purpose of the Focused Monitoring System

	Quality	Compliance	Both Quality & Compliance	Did not Rate	Total
# of comments	1	2	5	0	8
% of comments	13%	25%	63%	0	100%

Note: Responses coded "did not rate" did not relate directly to the question.

Table 9 State Level Stakeholders: Perception of Intended Outcomes of the Focused Monitoring System

	Quality	Compliance	Both Quality & Compliance	Did not Rate	Total
# of comments	3	3	7	4	17
% of comments	18%	18%	41%	24%	100%

Note: Responses coded "did not rate" did not relate directly to the question.

Stakeholder Involvement: All of those interviewed complimented the DDS Accountability and Monitoring Manager's work to prepare for and engage stakeholders, resulting in a high level of stakeholder involvement – both in the initial planning process and on an ongoing basis. "[The DDS Manager]…has set up things so that everybody can be actively engaged. We took our charge seriously…broad stakeholder group, different spectrum of families." "[It is]…a tribute to DDS that we have been able to engage them in the process. " "They take very seriously trying to gather info from a

variety of sources from a variety of ways to be sure that programs are meeting the needs of children and families. "

Interviewees explained that stakeholders are presented with ranked program data in the priority areas. Data are reviewed, priority areas identified for the coming year and programs selected for on-site visits. However, there was some concern that because of the way that the data are presented, conclusions or decisions driven by the data are almost "predetermined." "Because the system is compliance driven – we have the data points and cut scores, rather than a qualitative decision. I think that they could do a more qualitative decision. "

While the stakeholder group is diverse, members often seem to serve as affirmers rather than analyzers and advisors. One individual stated, "Stakeholders oversee the process but don't actually make the choices about ranking and visits." She also wondered if use of the ICC as the stakeholder group might be supplemented by a focus group of local program directors, not just the "chosen few" on the ICC.

Primary Components of the Focused Monitoring System: Interviewees could identify all the primary components of the CT FM System, including opportunity to request technical assistance. Some also mentioned how the BPR integrated with Focused Monitoring within the overall system of General Supervision. Their perception was that the BPR gives programs an opportunity to report on program performance and compliance in many more areas than are addressed in an on-site Focused Monitoring visit.

Integration with General Supervision: Nearly everyone mentioned the General Supervision "puzzle pieces" (NCSEAM, 2007) explaining that Focused Monitoring is one component of a system that includes the BPR, information from complaints, mediation, and due process, the SPP/APR and state to local determinations. One individual explained that the state level program responsible for General Supervision was previously referred to as "Quality Assurance." In response to provider input, the title was recently changed to "Accountability and Monitoring."

Impact on Quality of Local Program Services and Child and Family Outcomes: Overall, this group of state level staff and stakeholders expressed the view that the CT FM System has had a very positive impact on the quality of services for children and families. Example comments included:

- "Being out in the field to see what is in records and what families are saying leads to guidance and training where it is needed."
- "Transition conferences have improved greatly."
- "It has raised the bar in terms of how programs are run."
- "We have hard data to show that families are getting timely services."
- "We have identified programs that were not serving families appropriately and we were able to go deeper, including the elimination of one program."

Strengths/Benefits: State level staff and stakeholders voiced the following strengths of the CT FM System:

- Data: "Website presents the information well, comparative data, transparent…"
- State Staff: "Strong, experienced staff who make it all seem easy and have a commitment to having families involved."
- Local Staff: "Have become better informed, more knowledgeable, connect with one another for support."
- "More interactive with people at the program level than the prior system."
- "Families are getting quality services."
- "Focus is on building capacity."

Areas for Improvement:

- "Report general findings and strengths to stakeholders and providers so the work becomes more useful to everyone in the system."
- "Look at stronger programs to see what they are doing, share best practices across programs."
- "There needs to be a component of looking at quality. "
- "Provide training for new members of ICC/Focused Monitoring Stakeholders Group."
- "Monitor the balance of parent representatives on the stakeholder group – include low income, children with a variety of needs…"
- "Include evaluation of ourselves and how we support providers, how we could improve services beyond Focused Monitoring."

Other Information:

- Providers would like to be recognized for quality as well as areas for improvement.
- Providers would like a way to offset the costs of their monitoring experience.
- For some indicators, procedural compliance is not enough. "For example with transition, the procedures may have been followed but the parents are still unhappy – didn't know what to expect, didn't get to visit the school, and didn't know what to ask during the school visit."
- "The team is working hard to make this a positive experience, a learning opportunity."

State DDS Manager Interviews

Individual face-to-face interviews were conducted with the Birth to Three System Director and the Accountability and Monitoring Manager, June 2008. These two DDS administrators were the primary developers of the current CT FM System. The Accountability and Monitoring Manager is also the Team Leader for all of the on-site Focused Monitoring visits. She served as the overall architect, including the actual

development of the data system, hiring and training of staff and team members, and development of the *IDEA Part C Quality Assurance Manual.* Interview protocols are included in Appendix 6. This lens captures the perspective of the individuals responsible for the development and implementation of the system. They are also the state officials who are accountable to the federal government for the implementation of Part C of the IDEA in Connecticut.

Technical Assistance (TA) and Support: DDS Managers affirmed the influence that early planning and technical assistance from OSEP-funded TA providers had on their conceptualization and design of the CT FM System. The DDS Part C Director was a member of the NCSEAM Advisory Board. Connecticut served as a NCSEAM "partner state" and participated in the joint NERRC/NCSEAM Focused Monitoring Regional Conference held in September 2003. NCSEAM staff worked closely with Birth to Three state leadership to support their planning efforts. Prior to 2003, Connecticut used a three-year cyclical on-site monitoring process. The Birth to Three Director reported that her role on the NCSEAM Advisory Board provided ready access to materials and strategies, which were shared with others in the state and informed the design of the CT FM System.

Perceptions of Local Providers and Stakeholder Understanding of the CT FM System: Both DDS Managers agreed that the Focused Monitoring Stakeholders Group has the clearest understanding of the entire CT FM System. They acknowledged, however, that local programs may still view the process as just "monitoring" and that while the BPR is another component, there may not be a clear understanding of how the different components inter-relate to make up the overall system of General Supervision. They noted that local programs vary depending on whether or not they have actually experienced an on-site monitoring visit. Both concurred that parents of children served through Birth to Three and local providers who have not experienced an on-site visit probably understand the CT FM System the least because they are not directly involved or impacted by it. ICC members are perceived to understand the process and its purposes very well.

Stakeholder Involvement: Both DDS Managers reported that at the outset stakeholders were heavily involved in "defining what they wanted the system to measure," reviewing data sources and selecting the indicators and measures. They also had input into the protocols that are used for each indicator area.

Primary Components of CT FM System: DDS Managers' descriptions of the CT FM System were highly consistent with (1) what is written in the *IDEA Part C Quality Assurance Manual* and (2) with other interviewees' accounting of the process. Some components of the process are perceived as more difficult than others for local providers to understand. For example, generating unique hypotheses for each selected program and designing the on-site visit to confirm or refute those hypotheses results in an on-site review that is tailored to the individual program. Although the basic process is the same across programs, not all visits address the same hypotheses. Highlights of the process that were noted by DDS include:

- The participatory nature of the process, including input from the program director into the hypotheses: "We want the providers to be comfortable with the hypotheses."
- Summary meetings at the end of each day with the program director "…to make sure that we are on the right track…."
- Record Reviews: "If we see a trend, we bring them [the program director] in right away to check in with them. In the old system, we'd sequester ourselves and not let them know until the final report. Also give them a chance to clarify or check on things on-site. "
- A preliminary written report is developed on the final day and given as a draft at the exit interview, which includes notification of findings of noncompliance.
- Feedback from providers at the exit interview: "…to get their feedback as well as a fill out a written survey. For example, someone asked that we include a strengths section…we modify the Focused Monitoring process based on the feedback to the team from the program that has gone through it."
- The final report is sent with a cover letter and posted publicly on the Birth to Three Website.

Integration of CT FM System Components with the overall system of General Supervision: As described on page 2, there are multiple components of the Connecticut Birth to Three system of General Supervision including the BRP self-assessment, the complaint and due process system, the SPP/APR, state to local determinations and on-site focused monitoring. "We think it fits together fairly well and results in programs having only a single improvement plan." When asked about connection to program quality and "Quality Assurance," a DDS Manager reported, "We have acknowledged that this is accountability and monitoring, not quality assurance, but programs can call for TA assistance or receive it as a result of a monitoring visit." DDS Managers also pointed out that the initial selection of compliance indicators for Focused Monitoring was made based on the availability of valid and reliable data on these indicators for all local programs. These indicators provided an objective, data-based method for program selection. They acknowledged the emphasis on compliance but noted, "Now that we have three years of family outcome and child outcome data available, we can shift the Focused Monitoring lens to look at true outcome data…" while continuing to include compliance measures in the on-site reviews.

Use of Monitoring Results: DDS Managers use the results of Focused Monitoring to:

- Revise procedures and forms
- Report on the APR
- Identify programs most in need of technical assistance
- Modify the overall system of General Supervision
- Keep in touch with the parent perspective
- Sanction programs where needed

Assistance for Local Programs in Improvement Efforts: When asked about how the CT FM System assists in local program improvement, DDS Managers had somewhat different views. One commented, "It provides an outside perspective and helps bring

things to their attention so they can address them." The other suggested, "It assists them to improve in the areas we identify…though they may not put stock in the area." She added, "OSEP priorities aren't necessarily their priorities."

Impact on Quality and Outcomes: Interviewees reported greater levels of compliance across programs in the state but noted that improved compliance may not translate into higher quality. For example, the statewide level of compliance on the transition indicator is now very high, "…but that doesn't mean that it is a smooth transition." Monitoring results may provide a program with information to leverage support from the local administrator or to advocate for increased resources which could affect quality at some level." Both mentioned using the CT FM System as leverage to close a particularly ineffective program.

Challenges, Strengths and Needed Improvements: DDS Managers identified challenges related to the costs and resources needed to implement the program, how to transition to new priority areas and how to explain the process to local programs so that they see it as supporting program improvement. The ability to target low performing programs using a data-based approach is considered to be a strength. The program is also described as "user-friendly" with a high level of involvement from providers throughout process, includes parents and peers on the on-site review teams and links well to the BPR and SPP/APR components of the General Supervision system. DDS Managers look to the possibility of streamlining the system and reducing duplication with the BPR as areas for improvement or adjustment as well as reconsideration of the priority areas and ways to increase local provider understanding of the process.

Is it worth it? When asked if the time, money and other resources used in the implementation of the CT FM System were worth the investment, both DDS Managers agreed unequivocally, "Yes it is!" "Yes, totally, especially when compared with the former system of cyclical monitoring." Their perspective provides a lens that is colored by their responsibility to implement the IDEA and to be, as a state, in compliance with the federal statute.

Observation of the Focused Monitoring Process

For the purposes of this external evaluation, a member of the Evaluation Team observed the Focused Monitoring Team for a three-day on-site visit of a selected program during the Summer 2008. As a participant observer, the key questions to be addressed from the Evaluator's perspective were (1) what was the process in actuality and (2) how did what was observed compare to the description of the process as articulated in the Connecticut *IDEA Part C Quality Assurance Manual.* A detailed description of the on-site Focused Monitoring visit observed during the external evaluation is included in Appendix 7.) This lens provides a report of the actual implementation of the process from an external, neutral perspective. It is informed by how the process was described, both in written documents and by interviewees, as well as by the guidance provided by NCSEAM through the Focused Monitoring Implementation Checklist.

For the most part, the observation of the on-site visit confirmed the Focused Monitoring process as described in the Connecticut *IDEA Part C Quality Assurance Manual* (2007). The process was implemented with fidelity to what had been described in writing and confirmed by those who were interviewed as well as focus group participants.

The following are some general observations of the process:

- The reasons for selection of the program and the items that would be addressed on-site were made clear to the program from the outset.
- The desk audit meeting provided an opportunity for the team (and the program) to come together, review data and generate hypotheses about what factors may be contributing to the result that triggered the program's selection.
- The report format and process for developing it is short, concise and efficient, enabling the Team to leave the site visit on the final day with an almost-final document, which includes written notice of findings of noncompliance.
- Protocols for record reviews and interviews with staff and parents are aligned with the BPR and with each other, providing a triangulated approach to data collection that is consistent with the overall Birth to Three performance and compliance indicators.
- The site visit team process was participatory and gave all Team Members the opportunity to contribute.
- The Team reached consensus on the hypotheses, findings and recommendations.
- The three Parent Team Members provided a strong "parent voice" throughout the process.
- All Team Members demonstrated first hand knowledge and deep understanding of the issues and constraints that influence service delivery in Birth to Three programs.
- The participation of a Peer Team Member provided an excellent opportunity for professional development for the peer and offered the perspective of a fellow program director that understands the day-to-day realities of managing an early intervention program.
- Program personnel are asked to provide direct feedback and/or complete a feedback form.
- The Team Leader is a constant throughout the on-site visits ensuring consistency in the process. Her organizational and communication skills enabled the visit to go smoothly and the time to be used efficiently. Her thorough understanding of the entire General Supervision system in Connecticut and state and federal requirements, made her a valuable technical assistance resource to the program. Her sense of humor and energy helped to make the process upbeat and congenial.

Interviews with National Special Education Accountability Monitoring (NCSEAM) Consultants

The Evaluation Team sought the input and national perspective from NCSEAM through interviews with two staff members in the Fall 2008. Both had supported Connecticut in the initial development and design of their system and bring experience from working

with states across the U.S. Their perspective provided a final lens through which to view Connecticut's approach.

Involvement in the Development of CT's FM System: CT was one of the original NCSEAM partner states for both B and C and one of the first states to agree to collaborate with NCSEAM. In the first few years, NCSEAM staff met frequently with the Focused Monitoring Stakeholders Group and then returned again for the more recent OSEP Verification Visit (2006). NCSEAM also completed a "case study" of Connecticut system of General Supervision, December 2006.

Purpose and Intended Outcomes of Focused Monitoring: NCSEAM Consultants described Focused Monitoring as "… a tool that is used to result in improvement and correction where it is needed… It should be different from state to state depending on their needs and decisions." In their view, the primary purpose of Focused Monitoring is to *focus* attention on areas where improvement is most needed and will have the greatest impact on children and families. "It's important to use your scarce on-site monitoring resources well, by going places that can benefit from an on-site visit and that have the maximum ability to benefit from improvement." Another commented, "It depends on why you are doing it….there are a number of potential outcomes." Possible outcomes suggested by NCSEAM Consultants included: to increase correction and improvement of identified areas of noncompliance and to improve quality of services to children and families. Things to consider: "What is your standard of compliance versus quality? We all have our own opinions on the role that compliance plays in quality. Set your purpose first, then underneath that you can have sub-purposes but one of them should be to demonstrate 100% compliance on all the compliance indicators."

Stakeholder Involvement in Other States: NCSEAM Consultants reported that while it varies greatly, in the most effective states stakeholders are involved in all the processes: system development, priority area identification, and evaluation. But because Focused Monitoring is still new for many states, stakeholder groups have not been involved in evaluation of the system. "Connecticut is out front on this." One interviewee mentioned, "Selecting the priority areas can become almost pro forma since the data are telling you what you need to focus on."

Comparison with Focused Monitoring in other States: One individual summed it up: "CT has taken the premises of Focused Monitoring and done a better job designing it so that it makes sense for them…" "They are a classic example of what was envisioned by the NCSEAM stakeholder group originally, including all of the things that were deemed important—data, peers, parents, confirming or not confirming the hypotheses, record reviews, all of the pieces that are on the FM checklist."

However, the NCSEAM Consultant perspective is that "There is no rule; NCSEAM has a model, but when we start working with a state, we encourage people to evolve the model to what makes sense for to them …it changes. The idea is that it's a set of really good principles…but how states choose to use those principles…can be very informative. We have never felt that it needed to be a certain set of rules…or an ironclad

model. States are using different terms or ways of doing 'focused monitoring'. How they are using the term, what their purpose is depends and changes."

Integration with General Supervision and Quality Assurance: Regarding General Supervision, NCSEAM staff indicate that it can be a challenge for states to "…really understand General Supervision and how all the pieces fit together." They noted that in Connecticut, the BPR provides additional data, but speculated that it may not be clear to all stakeholders how the BPR fits into the overall General Supervision system. One reminded, "You can't do focused on-site monitoring unless you have a comprehensive system of General Supervision. It can't stand alone, you have to have all the pieces."

Impact of Focused Monitoring on Quality and Child and Family Outcomes: Interviewees agreed that across the country they see the potential of Focused Monitoring to impact quality and outcomes. One reported that local programs and team members indicate that they "…learned more about what is going on in this local program than we ever did with a traditional approach; it allows you to drill down to the deep systemic issues and components." "Focused Monitoring gets you in the door, but once in you uncover deeper, systemic things that will result in improvement across the board."

Strengths of Connecticut's System:

- Qualifications and understanding of DDS Managers
- Data-based approach
- BPR is a strong process, electronically based
- System is designed to generate solutions and improvement strategies
- Rapport with stakeholders
- Responsive and "makes sense"
- Exemplifies an effort to continue to evolve and improve

Suggestions for Improvement: NCSEAM Consultants indicated that, based on the case study conducted in 2006, Connecticut should consider (1) improving tracking correction of noncompliance identified through the BPR and Focused Monitoring and (2) continuing to explore development of a wider range of sanctions or actions to be taken when programs do not correct noncompliance within one year.

SUMMARY AND REFLECTIONS

This external evaluation of Connecticut's Birth to Three Focused Monitoring System was designed to provide a multi-lens look at the process and procedures, components, effectiveness and impact of the system using multiple sources of data. Document reviews, interviews, focus groups, and an extensive on-site observation provided a kaleidoscope of perspectives from which to look at Connecticut's approach, from the points of view of those responsible for creating the system, to those who are on the "receiving end," to those who view Focused Monitoring from a wide national lens, to those who narrowly focus in from a local provider or parent perspective. The following section summarizes overarching themes that emerged for the Evaluation Team from the

totality of data collected. Themes are followed by a section on strengths and suggested considerations for improvement.

Themes

Quality vs. Compliance: An overall theme that emerged from the comments from both the focus groups with providers and the State and Monitoring Team Member interviews related to the issue of program quality versus program compliance. Was the Focused Monitoring System intended to do one or the other or both? Was it accomplishing one or the other or both? Local providers who had been the recipients of an on-site Focused Monitoring review tended to perceive the process as heavily compliance oriented and that program quality was neither addressed nor improved as a result. State level staff and Monitoring Team Members, however, tended to see the process as a focus on compliance *as a means* to improve program quality and that improved services to children and families was the ultimate goal. Whether or not that goal is being achieved, remains a matter of degree and difference of opinion.

Cost vs. Impact: A second theme that surfaced particularly from the Focus Group participants (providers) was (1) acknowledgement of the time, effort, and resources put into the process from both the state and local level and (2) questioning whether that investment was justified. In other words, "Is it worth it?" If the process is simply resulting in improved record keeping at the local level with no connection to improved services and results, then the outlay of resources and the intrusiveness of the process are perceived as excessive. If, on the other hand, the process is improving compliance as well as increasing capacity at the local level and resulting in improved quality and ultimately outcomes for children and families, the return is worth the cost. Because "program quality" and long-term impact are difficult to document using the current indicators and measures, whether the return is worth the investment remains largely a matter of perspective, informed by anecdote and personal experience.

Validity—Identifying the "right" programs: A third theme questioned the validity of the process. Providers noted that the current procedure of categorizing programs by size and then ranking programs within their size group has tended in recent years to identify programs that may be the lowest scoring in their group, but are still demonstrating high levels of compliance. On the other hand, providers commented that there might be programs that "…are good at putting in their data…so they look good…but they are not the best quality." "Some people have good data so they stay under the radar." This raises issues of validity in the program selection process and whether there might be other, less intrusive ways to address relatively low or isolated instances of noncompliance. This concern also points to the areas of priority or focus for Focused Monitoring which, to date, have included Child Find, Service Delivery and Transition. A question implied by many of the interview comments is, "Do these continue to be the 'right' priority areas?"

Strengths: Leadership, Process, and Impact

Leadership: Providers of programs that were monitored acknowledge the expertise and deep understanding of Part C that DDS leadership brings to the Focused Monitoring process as well as to the overall administration of the Birth to Three System in Connecticut. Observations of the on-site visit confirmed that the effectiveness of the process could be credited to a large degree to strong leadership and direction from the DDS Team Leader.

Process: Table 10 shows a comparison of the strengths of the Focused Monitoring system as perceived by three groups: providers, state level staff and stakeholders, and Focused Monitoring Team Members. Perceived strengths of the process included strong leadership from the Department of Developmental Services, a process that is well organized, consistently implemented, data-based and which incorporates multiple sources of data and a variety of perspectives. Team members clearly feel that their opinions and input are taken seriously and that they have a genuine opportunity to influence the outcome.

The Evaluation Team's review of the process aligns with stakeholder perceptions. The on-site visit that was observed in the Summer 2008 indicated that, in fact, the process that is being implemented follows the description in the *IDEA Part C Quality Assurance Manual* and confirms the descriptions given in interviews with Focused Monitoring Team Members and state level staff, all of whom have a common understanding of how the process is intended to be implemented.

Based on the observation of the on-site review, the process is very participatory beginning with the desk audit and generation of initial hypotheses, to the on-site interviews with the local program director and staff, to the exit meeting at which findings are reviewed and hypotheses disproved or confirmed. The process is also highly efficient in terms of use of staff time and resources. The work that the team does prior to the on-site visit ensures that time spent on-site is used effectively. The model of generating draft hypotheses based on data prior to the on-site visit enables the Monitoring Team to target their inquiry and to probe for evidence of particular concerns and contributing factors. The parent perspective is clearly reflected in the structure of the monitoring teams as well as the degree to which parent views are affirmatively solicited in the on-site interview process.

Impact: Impact on local program improvement, program quality and on child and family outcomes is difficult to measure and needs to be addressed over time. The diverse perceptions described above indicate that the degree to which program quality is improved as a result of the Focused Monitoring process is a matter of opinion, position, and point of view. Data, however, show high levels of compliance for the state as a whole. A review of Connecticut's 2008 Annual Performance Report (APR) indicates that levels of compliance on the State Performance Plan (SPP) compliance indicators are

Table 10 Perceived Strengths of Connecticut's Birth to Three Focused Monitoring System

Monitoring Team Members	State Level Staff or Stakeholders	Providers/Program Directors
Leadership and expertise from DDS.	Leadership and expertise from DDS.	
Provides support to leverage resources at the local program level.		Provides support to leverage resources at the local program level.
Peer membership on the team.	Peer membership on the team.	
	Provides a good training vehicle for the peer member and helps to make program-to-program connections.	
Parents' perspective and membership on the team.	Parents' perspective and membership on the team.	
Provides a means to address compliance.	Provides a means to address compliance. Assists with tracking of correction of noncompliance.	Improves compliance at the local and state level.
Uses a data-based process from which to make program decisions.	Uses a data-based process that allows comparisons across programs. Well developed website with publicly available data. Transparent process.	Uses a data-based process. Provides data demonstrating improvement in services for Birth to Three.
Uses multiple measures and reflects multiple perspectives.	Uses multiple measures and reflects multiple perspectives.	
Uses a supportive, problem-solving approach.	Makes connection between forms & paperwork, compliance & program quality.	Participation of local program director in process of generating hypotheses and recommendations.
Focus on strengths as well as areas for improvement.	Vehicle for staff training—increases local capacity.	
Well-organized, consistent process.	Well-organized, fair, consistent process.	
		Enhances Connecticut's reputation as a "national leader" in Part C.
Tailored to the individual program; unique hypotheses.		

close to the required target of 100% compliance. As summarized in the 2008 OSEP Determination Letter and accompanying Response Table (June 2008), Connecticut is reporting 97% compliance for timely services (Indicator C-1), 97% compliance for timeliness of the Individual Family Services Plan (IFSP) (Indicator C-7) and 99.9%, 100%, and 99.4% compliance for early childhood transition (C-8 A, B, and C respectively). In addition, Connecticut reported 99% for children receiving early intervention services in the home or for programs for typically developing children, and high child find/identification rates for infants and toddlers with disabilities (Indicators C-5 and 6). Based on this data, it appears that Connecticut as a whole is performing well on indicators of both compliance and performance. It is not possible to conclude, however, that these high levels of compliance are directly linked to the CT FM System. Rather, the entire General Supervision system as a whole, including the BPR and Focused Monitoring, are most likely contributing to the high levels of compliance that Connecticut is able to demonstrate.

The following are examples of stakeholder and state staff comments regarding the positive impact that Focused Monitoring is having at the local level:

- "There is impact for children and families. We have identified programs that were not serving families appropriately and [the process] enabled us to go deeper and we eliminated one program."

- "The process really makes programs look at themselves and want to be better."

- "The level of accountability and systematic focus on holding people accountable is making a big difference."

- "We talk to families, and we think that transitions are going smoother, start earlier; data shows that more kids are getting FAPE at three, on time. And more kids have access…families weren't really accessing their right to an evaluation in the transition to the school districts."

- "Yes, [there is impact] on the quality of program services…it forces you to have an internal review. Any time an external agency comes in to evaluate your system, you are going to spend a period of time evaluating your own system prior to that so it's positive in that regard. Plus it provides a chance for state to offer suggestions for improvement."

- "The general feeling from some is that it's a waste of money and time…but the bottom line is are we improving services to families and I think we are. Families are benefiting."

- "More timely services….*babies can't wait*. Families are getting timely services and we have hard data to show that."

Areas for Improvement

Table 11 shows a comparison of the suggestions for improvement in the Focused Monitoring system offered by three groups: providers, state level staff and stakeholders, and Focused Monitoring Team Members.

Connection to Quality: Based on input from the provider focus groups, it appears that the process could be improved by finding a way to address program quality more directly. Now the use of rates of compliance for particular indicators for program selection and the focus on compliance, particularly though the record review process during the on-site visit, give the impression that procedural compliance is the "bottom line" and that procedural compliance in and of itself will also ensure program quality. To continue the "buy in" needed to justify the investment of substantial resources to the process, it will be important to make a more explicit connection between compliance, quality, and ultimately child and family outcomes.

Program Selection: Selection of programs for the on-site Focused Monitoring visits is currently based on rates of compliance in priority area indicators, using a rank ordered listing of programs, categorized by size of the program. This provides the perception of equity across programs and allows for comparisons between programs of similar size. However, due to the relatively high rates of compliance that are currently being demonstrated by local programs on the identified priority area indicators, selection using the current method may result in programs being targeted which are already demonstrating high levels of compliance, even though the program may be the lowest ranked on the priority indicator within its size grouping. Although any incidence of noncompliance with state or federal requirements must be identified, addressed and corrected, as overall compliance on priority indicators improves, statewide, this may result in the identification of programs for which the investment of resources in the on-site review is not warranted. There may be other, less intrusive ways to address noncompliance in these programs. Alternatively, there may be other areas of noncompliance or performance that need to be more fully addressed, implying the need to review priority areas, indicators and measures. Table 12 shows the range of compliance ratings for the three Focused Monitoring priority area indicators from which programs were selected for an on-site visit 2007-08.

Table 11 Perceptions of What Could Be Improved

Monitoring Team Members	State Level Staff or Stakeholders	Providers/Program Directors
Address quality as well as compliance.	Address quality as well as compliance.	Address quality as well as compliance.
Review/revise selection criteria to find the "right" programs.		Make the process "friendlier" and emphasize what you are doing right.
Make the process more "streamlined."		Simplify the process. Coordinate with the BPR self-assessment. Use fewer indicators/measures.
Make interview protocols available to program directors.	Provide greater levels of policy guidance and TA.	Provide program guidance on what to expect.
	Look at the strong providers and what can be learned from them; not just the weaker programs. Share best practices across programs.	Match programs with needs in a particular area with another program that is strong.
		Develop different levels of monitoring, differentiated levels of review.
Increase/improve training for new members of the Monitoring Teams.	Provide training for new members of the ICC on the general supervision system including focused monitoring.	Provide training to local staff on why paperwork, compliance are important and how data is used.
		Address issues in data reporting and the data system.
	Include TA providers as part of the on-site visit.	Include program director in desk audit meeting, face to face.
	Provide more diversity among parent team members.	
Provide opportunities for programs to "self-correct."		
	Evaluate the services we (DDS) provide to providers.	

Table 12 Range of Program Compliance on Priority Area Indicators 2007

Priority Area	Range of Percent Compliance		
	Small	**Medium**	**Large**
Transition	75-100%	93.33-100%	85.92-100%
Child Find	92.31-100%	83-100%	96.60-100%
Service Delivery	50-100% *	91.80-100%	90-100%

Note: The 50% compliance rating was based on 1 out of 2 cases out of compliance.

Impact: As noted above, many interviewees and as well as state level personnel expressed the opinion that the Focused Monitoring process was more about compliance than quality. However, as also noted above, many stakeholders and DDS staff perceive that the system is having an overall positive impact on both. Nevertheless, it will be important for local program directors as well as parents and other stakeholders to see a connection between the CT FM System, the investment in resources required for implementation and improved program quality and services to children with disabilities and their families. As suggested above, it may be appropriate to revaluate the priority areas and to choose those more closely tied to child and family outcomes or to pursue other means to measure program quality. It may also be time to explore appropriate methods and measures of impact on children and families. The family and child outcome indicators on which Connecticut will report in the Annual Performance Report, may be appropriate measures and data sources.

COMMENDATIONS

- The Department of Developmental Services is commended for seeking expert technical assistance prior to beginning the Focused Monitoring process, primarily from the National Center for Special Education Accountability Monitoring (NCSEAM) so that the system that was developed reflected best-accepted practice in the field.
- The Department is also commended for initiating the external evaluation of the system.
- The Department has developed and implemented a comprehensive, integrated system of General Supervision of which Focused Monitoring is one component.
- The process of Focused Monitoring was developed with authentic stakeholder involvement, is consistently implemented, data-based, and grounded in principles of equity, quality, and utility.

- The involvement of parents as members of the Focused Monitoring Teams as well as the extensive outreach and interviews with parents ensures that the parent perspective is reflected throughout the process.
- The leadership provided by DDS Accountability and Monitoring staff is exceptional and models the high standards to which local programs are also held.

RECOMMENDATIONS

Process

- Consider including more than one Peer Team Member on the Focused Monitoring Team to create a better balance between parents and peers and to maximize the opportunity for other program directors to contribute their knowledge and experience as well as to benefit from the process.
- When new team members join the team, consider providing explicit training on the record review process prior to the on-site visit to address consistency across the record reviews.
- For the on-site visit, consider delaying the formal, written notice of findings of noncompliance until the final written monitoring report is issued. This will (1) provide time for reflection and adjustment after the visit, (2) give more time for programs to correct identified noncompliance, (3) give DDS more time to verify correction of noncompliance by the close of the 12-month correction timeline, and (4) give the program an opportunity to immediately correct noncompliance before the formal notification is received.
- Publicize general findings and "lessons learned" from all of the visits completed in a given year, so that every program can benefit from the experience of a few.
- The Team Leader is key to a successful on-visit, and to the overall Focused Monitoring process. It may be advisable to train additional DDS staff to take on the Team Leader's role so that there are others who know the process and could be called upon to lead a visit if needed.

Design

- Review the priority areas and criteria for program selection with the Focused Monitoring Stakeholders Group and consider a focus on new or additional priority areas based on Connecticut's State Performance Plan and Annual Performance Report. Increase the emphasis on quality and outcome measures and consider new ways of measurement in addition to data analysis, record reviews and interviews.
- Given the high rates of compliance demonstrated on the measures for the three priority areas, re-evaluate the identified priority areas or consider differentiated levels of response based on level of noncompliance demonstrated by the program.
- Consider whether other factors might be used to "trigger" or select programs for a Focused Monitoring on-site visit.

- Develop measures of program quality and include them in the CT FM process and/or the BPR self-assessment. One suggestion is to convene a group of stakeholders to develop quality indicators for Birth to Three programs and include them in both the Focused Monitoring process and the BPR self-assessment.
- Reduce the complexity of the system and simplify the IDEA Part C Quality Assurance Manual so that it is easily understood by providers and parents.
- Review the relationship between the BPR and the CT FM System to reduce redundancy and to ensure alignment.
- Consider the development of a consolidated Improvement Plan or Corrective Action Plan that incorporates findings from the BPR, on-site Focused Monitoring, and due process/complaint system.
- Use Data Verification to verify correction of noncompliance after implementation of a local Improvement or Corrective Action plan.
- Increase diversity (race/ethnicity, socio economic status, and disability categories) across the Parent Team Members and the ICC and Focused Monitoring Stakeholders Group.

Professional Development and Technical Assistance

- Provide additional professional development to local programs on the overall system of General Supervision in Connecticut and ensure that the relationship between the various components is clear to all stakeholders.
- Clarify appropriate expectations for the technical assistance that is available to local programs and how that assistance might be accessed.
- Provide additional training and ongoing support to Parent Team Members.
- Carry out a Technical Assistance Needs Assessment to identify areas for focused TA.

CONCLUSION

In summary, leadership, consistency, and efficiency along with high levels of participation, use of data from multiple sources and perspectives, and data-based generation and confirmation of hypotheses have made the Connecticut Birth to Three Focused Monitoring System an excellent example of how a focus on priorities can improve levels of compliance, strengthen local capacity and, to some degree, impact program quality at the local level. This external evaluation has attempted to capture the multiple viewpoints of a diverse group of constituents by presenting a kaleidoscope of lenses through which to view Connecticut's system. It provides a prism offering a range of colorful perspectives, reflecting well on Connecticut's ability to implement and ensure compliance with Part C of the IDEA.

REFERENCES

Brackett, A. & Hurley, N. (2004). Collaborative Evaluation Led by Local Educators: A Practical, Print- and Web-Based Guide*. Newton, MA: Education Development Center, Inc. Retrieved November 5, 2008 from www.neirtec.org/evaluation.*

Connecticut Department of Developmental Services. (2007). IDEA Part C Quality Assurance Manual. *Hartford, CT: Author.*

Luster, J. (2006). Case Study: The Connecticut Part C System of General Supervision*. New Orleans, LA: National Center for Special Education Accountability Monitoring (NCSEAM).*

National Center for Special Education Accountability Monitoring (NCSEAM). (2005). *Focused Monitoring Implementation Checklist (FMIC)*. New Orleans, LA: Author.

National Center for Special Education Accountability Monitoring (NCSEAM). (2007). *Developing and Implementing an Effective System of General Supervision: Part C.* New Orleans, LA: Author. Retrieved November 5, 2008 from http://www.monitoringcenter.lsuhsc.edu/General%20Supervision.htm

U.S Department of Education, Office of Special Education and Rehabilitative Services (2008). *Connecticut FFY 2006 Determination Letter and Response Table.* Washington, DC: Author.

APPENDIX 1

Resumes

KRISTIN MYERS REEDY

SUMMARY OF RELATED EXPERIENCE

Kristin Myers Reedy is the Director of the Northeast Regional Resource Center (NERRC) for Learning Innovations at WestEd. NERRC helps state education agencies improve their systems of early intervention, special education, and transition services through the development and implementation of policies, programs, and practices to enhance educational results for children and youth with disabilities. Dr. Reedy is responsible for the overall management of the center. Her areas of expertise and interest include special education reform, special education policy, program evaluation, finance, regular education reform, and early childhood special education.

Dr. Reedy has 20 years of experience in special education as a classroom teacher, consultant, and administrator. Prior to joining WestEd, she served as a consultant and manager at the Vermont Department of Education and as the Director of Special Services for two Vermont school districts.

EDUCATION

1995	Ed.D., Educational Leadership and Policy Studies, University of Vermont
1984	Certificate of Advanced Study, Educational Administration and Planning, University of Vermont
1979	M.Ed., Special Education, University of Vermont
1972	M.Ed., General Education, University of Massachusetts, Amherst
1970	B.A., English, Denison University, Granville, OH

PROFESSIONAL EXPERIENCE

1999–Present *Director,* Northeast Regional Resource Center (NERRC) Learning Innovations
WestEd, Williston, VT
Responsibilities include leadership and management of one of six federally funded regional resource centers in the U.S., providing technical assistance and support to the eight northeastern states with regard to special education policy and practice.

1992–1999 *Director of Special Services*
Barre Supervisory Union, Barre, VT
Responsible for the administration of special education, Title I, 504, ESL, and alternative programs pre K–12. Supervised a staff of 30 professional and 50 paraprofessionals. Established new initiatives in supported employment, early childhood, alternative education for students with emotional-behavioral disabilities, and inclusion.

1988–1992 *Director, Special and Compensatory Education Programs*
Washington Northeast Supervisory Union, Plainfield, VT

Directed the overall administration of district-wide programs. Supervised a staff of 10 professionals and 13 paraprofessionals. Developed and managed special and compensatory education budgets; completed state and federal required applications; and developed grant proposals. Established new initiatives in early childhood, staff development, program evaluation, and policy development.

1987–1988 *Acting Chief,* Special Education Unit, Division of Special and Compensatory Education**,** Vermont Department of Education, Montpelier, VT
Managed the day-to-day affairs of the Special Education Unit, including the direct supervision of 14 program consultants and 7 support service staff. Assisted in budget negotiations with school districts and acted as Unit liaison to the State Interagency Team. Participated in the development of policy, legislation, and long-range plans. Supervised monitoring and program evaluation activities. Represented the Unit in contacts and cooperative activities with the State Legislature, State Board of Education, Governor's Office, state agencies, local education agencies, and advocacy groups.

1984–1987 *Essential Early Education Consultant,* Division of Special and Compensatory Education, Vermont Department of Education, Montpelier, VT
Provided consultation, technical assistance, and training to Essential Early Education (EEE) programs statewide. Served as a project coordinator of federal early childhood state planning grants; supervised preschool grant project assistant and subcontracted grant staff; and directed all activities involved in a statewide early childhood special education planning effort including needs assessment, interagency agreements, and state plan development. Served as regional general special education consultant to 10 supervisory unions in southeastern Vermont; chaired the Department of Education's Early Childhood Project Team; and developed an EEE Parent Handbook, EEE Best Practice Guidelines, and various other resource documents for practitioners and parents.

1982–1984 *Consulting Teacher/Learning Specialist*
Moretown Elementary School, Moretown, VT
Directed the special education and compensatory education programs. Managed the consultation and inservice training to regular classroom teachers, supervision and evaluation of support service paraprofessionals, assessment of students, design and supervision of Individual Education Plans, consultation with families, and direct instruction to students in individual and small group settings.

1979–1982 *Preschool and Family Therapist,* Children and Youth Services
Washington County Mental Health, Montpelier, VT
Developed and implemented a demonstration project designed to provide service to childcare centers for behaviorally "at-risk" children, ages 3–6. Conducted individual and group therapy with clients, counseling with families, parent training, consultation and inservice training for childcare providers. Consulted with Children's Service staff in additional Vermont community mental health centers where the project was to be replicated; consulted with Head Start staff and families; supervised Vermont College human services student practica.

1975–1978 *Special Instructor*, Speech and Language
Green Mountain School, Montpelier, VT
Conducted individual speech and language therapy with learning impaired children, ages 6–21.

1973–1974 *Teacher*
Vermont State Hospital, Waterbury, VT
Developed and implemented a pilot program for class of autistic children, ages 6–12. This project, which stressed socialization and language development, continued as GRASP (Group Activities School Program) at the Vermont State Hospital.

1973 *Developmental Day Care Specialist*
Monson State Hospital, Palmer, MA
Provided direct instruction to multi-handicapped and developmentally disabled children and young adults.

SELECTED PROFESSIONAL ACTIVITIES

- State Board Appointee, Vermont Special Education Fiscal Review Panel, 1998–present

PROFESSIONAL AFFILIATIONS

- Council for Exceptional Children (CEC), Vermont Chapter
- Vermont Coalition of Disability Rights, Education Subcommittee

VICKI CLEMENTS HORNUS

SUMMARY OF RELATED EXPERIENCE

Vicki Clements Hornus, a Senior Program Associate with the Northeast Regional Resource Center (NERRC), provides technical assistance to state departments of education in the areas of focused monitoring, Least Restrictive Environment, access to the general education curriculum, Communities of Practice, and using data to support special education programs and services. She brings a long history of leadership in special education at the local and state levels in Vermont. Ms. Hornus joined the Vermont Department of Education in the fall of 2000 as the Special Projects Coordinator for Act 117, an Act to Strengthen the Capacity of Vermont's Education System to Meet the Educational Needs of All Vermont Students. Prior to then, she spent 28 years in Vermont schools as a director of special services and elementary school counselor. Before moving to Vermont, she taught Educational Psychology and Child Development at Miami University and Hudson Valley Community College. Ms. Hornus has served as president of the Vermont Association for Special Education Administrators and the Northeast Coalition of Educational Leaders and was an officer and board member of the Howard Center for Human Services. She has also served as an adjunct instructor at Trinity College and Champlain College and has presented at numerous conferences and workshops. She participated in a Sino-American Seminar on Educational Leadership, making presentations on "Maximizing the Achievement of Special Needs Students" to Chinese educators in Beijing and in Huhehot, Inner Mongolia. Recently, she presented at several conferences on "Students with Special Needs in the NCLB Spotlight" and was co-director of the Massachusetts Special Education Leadership Academy in 2004.

EDUCATION

1975	Graduate study, School Administration, University of Vermont
1968	M.S., School Psychology, Miami University, Oxford, OH
1966	B.A., Elementary/Special Education, Purdue University

PROFESSIONAL EXPERIENCE

2002–Present *Program Associate*, Northeast Regional Resource Center
Learning Innovations at WestEd, Williston, VT
Provides technical assistance to state departments of education in the Northeast to improve the quality of education and life opportunities for children with disabilities and their families. Provides technical assistance and consultation to educators and school districts to improve the outcomes for all students, including those with special needs.

2000–2002 *Act 177 Special Projects Coordinator*
Vermont Department of Education, Montpelier, VT

Responsible for leading implementation of Act 117, an Act to Strengthen the Capacity of Vermont's Education System to Meet the Educational Needs of All Vermont Students, including development and implementation of a comprehensive plan to implement Act 117; development of informational materials for school personnel, and presentations and workshops for school personnel, professional organizations, school boards, and department personnel. Also responsible for communication with the state board of education and the state legislature, and for leadership, supervision, and support of consultants on the Special Education Monitoring Team, the Educational Support System Team, and the Special Education Auditing Team.

1985–2000 *Director of Special Services*
Burlington School District, Burlington, VT
Leadership, administrative, and managerial responsibilities for Special Education, Compensatory Education, English as a Second Language. These included implementation of federal and state regulations for students with special needs; recruitment, hiring, training, supervision, and evaluation of staff; budget development, monitoring, and implementation; and coordination of all district student support services. Developed new programs for students with limited English proficiency; implemented changes in delivery models of all student support services; chaired the district's community Advisory Committee on Diversity; initiated a comprehensive program review; and initiated a Parent Advisory Committee.

1995–1998 *Adjunct Instructor*
Champlain College, Burlington, VT
Taught courses on Children with Special Needs, Human Behavior in Social Environments, and Behavior Management.

1995–1996 *Adjunct Instructor*
Trinity College, Burlington, VT
Taught a course on Teaching in an Integrated Setting.

1978–1985 *Director of Special Education Services*
Springfield School District, Springfield, VT
Leadership, administrative and managerial responsibilities included organization of the first special education department; development of policies and procedures to implement federal and state regulations; recruitment, hiring, training, supervision, and evaluation of staff; and budget development, monitoring, and implementation. Coordinated all district student support services and participated in contract negotiations and management.

1972–1978 *Elementary School Counselor*
Springfield School District, Springfield, VT
Provided counseling, consultation, and coordination for students, parents, and teachers. Conducted educational evaluations and planned programs and parent study groups, and developed and implemented a preschool screening clinic.

1971–1972 ***Instructor*, Early Childhood Education**
Hudson Valley Community College, Troy, NY

1970–1971 *Guidance Director*
Emma Willard School, Troy, NY

1968–1970 *Instructor*, Educational Psychology
Miami University, Oxford, OH

SELECTED PUBLICATIONS AND PRESENTATIONS

Hornus, V. (2005, February). *Students with Special Needs in the NCLB Spotlight*, Presentation at Research for Better Schools 2005 Regional Conference: Improving Mathematics and Science Achievement: Resources to help all students reach high standards of performance. Philadelphia, PA.

Hornus, V. (2005, February). *Supporting Special Educators and Developing Their Leadership*, Presentation to Chittenden/Franklin County Special Education Administrators. Burlington, VT.

Hornus, V. (2004, October). *Students with Special Needs in the NCLB Spotlight*, Presentation at New England Comprehensive Assistance Center School Improvement Planning network Institute. Westborough, MA.

Hornus, V. (2004, August). *Access to the General Education Curriculum*, Presentation at Massachusetts Special Education Leadership Academy. Auburn, MA.

Hornus, V. (2004, August). *Leadership and Administration*, Presentation at Massachusetts Special Education Leadership Academy. Auburn, MA.

Hornus, V. (2004, August). *Program Models and Service Delivery: Educational Support Systems and Circles of Support*. Presentation at Massachusetts Special Education Leadership Academy, Auburn, MA.

Hornus, V. (2004, June). *LRE-Part B Community of Practice*. Presentation at Region 1 Parent Technical Assistance Center Regional Conference. Mystic, CT.

Hornus, V. & Reedy, K. (2004, June). *LRE and Inclusion: Strategies and Tools for Collaboration between Parent Centers, States, and Local School Districts.* Presentation at Region 1 Parent Technical Assistance Center Regional Conference, Mystic, CT.

Hornus, V. & A. Smith. (2004, May), *LRE-Part B Community of Practice*, Presentation at National Institute for Urban School Improvement Synergy Meeting. Washington, DC.

Hornus, V. & A. Smith. (2004, May), *LRE-Part B Community of Practice*, Presentation at Office of Special Education Programs (OSEP) Leadership Conference. Washington, D.C.

Hornus, V. (2004, March). *What is Focused Monitoring?* Presentation to Massachusetts Program Quality Assurance Services Staff. Malden, MA.

Hornus, V. & Morgan, P. (2004, March). *Vermont's Higher Education Collaborative for Special Education: A Statewide Model for Preparing and Retaining Highly Qualified Special Education Teachers.* Presentation at 2004 Office of Special Education Programs Joint Personnel Preparation/State Improvement/Comprehensive System of Personnel Development Conference, Arlington, VA.

Hornus, V. (2003, August). *Special Education for All Teachers.* Presentation/Workshop at Project Across: Alternative Certification Routes with On-Going Support Systems, Attitash Bear Peak, NH.

Hornus, V. & Morgan, P. (2003, June). *Vermont's Higher Education Collaborative for Special Education: A Strategy for Preparing and Retaining Highly Qualified Special Education Teachers in Vermont.* Presentation at the IDEA Partnerships 2003 Summit: National Summit on Shared Implementation of IDEA, Arlington, VA.

Hornus, V. (2002). *Educational support systems.* Guest lecture to the Vermont School Boards Association, Killington, VT.

Hornus, V. (2002). *Understanding Act 117, Strengthening the Capacity of Vermont's Education System to Meet the Needs of All Students*. Guest lecture for the Vermont School Boards Association interactive TV series, Waterbury, VT.

Hornus, V. (2000, April). *Maximizing the achievement of special needs students.* Presentations sponsored by the Sino-American Seminar on Educational Leadership to Chinese educators in Beijing and in Huhehot, Inner Mongolia.

Hornus, V. (1995–2000). *Special Education testing and evaluation for classes in tests and measurement in counseling graduate program.* Guest lectures in the Graduate Counseling Program at the University of Vermont, Burlington, VT.

Hornus, V. (1995, 1997, 1999). *How to interview for a teaching position.* Guest lectures in the Department of Education at Trinity College of Vermont, Burlington, VT.

Hornus, V. (1997). *Alternative educational programs.* Guest lecture to the Vermont Association of Special Education Administrators, Stowe, VT.

Hornus, V. (1997). *Public school programs of special services for children.* Guest lecture in the Education Department at the Community College of Vermont, Montpelier, VT.

Hornus, V. (1995). *What principals need to know about special education*. Guest lecture in Educational Administration at St. Michael's College, Colchester, VT.

SELECTED PROFESSIONAL ACTIVITIES AND AWARDS

- Heart of Education Award, Burlington Education Association, 2000
- Gregory Packan Children's Advocacy Award, Community Network for Children, Youth and Families, 2000
- Gail Lynk Administrator of the Year Award, Vermont Association of Special Education Administrators, 1994
- Professional Recognition Award, Chittenden Child Protection Network, 1992
- Vermont Fiscal Review Panel, 1998–2000

- Vermont Education Coalition, 1998–2000
- Board of Directors, Avery Foundation, 1995–1999
- Special Education Funding Task Force, 1997–1998
- Northeast Coalition of Educational Leaders, President 1985-1987
- New Americans Committee, 1990–1992
- Chittenden County Local Interagency Team, 1989–1992
- Board of Directors, Howard Mental Health Services, 1985–1991; Secretary, 1989–1991
- Child Protection Network, 1985–1988
- Staff, Vermont Leadership Academy, 1985
- Board of Directors, Big Brother/Big Sister of Springfield
- Board of Directors, Consumer Controlled Community Child Care
- Board of Directors, Lincoln Street, Inc.
- Board of Directors, Planned Parenthood of Southern Vermont

APPENDIX 2

NCSEAM Focused Monitoring Checklist

Self-Assessment: Focused Monitoring Implementation Checklist (FMIC)
REVISED MARCH 2005

Purpose

The Focused Monitoring Implementation Checklist is a means by which states/lead agencies and local programs/districts can assess

- the comprehensiveness of their data system and activities,
- the involvement and participation of stakeholders in the development, implementation, and evaluation of the monitoring system, and
- the monitoring procedures within a focused monitoring process.

Assumptions

To have a viable, useful, and effective focused monitoring system, states/lead agencies and local programs/districts must be able to collect, examine, evaluate, and report data at the child/student level. States/lead agencies and local programs/districts must involve and actively seek participation from persons who represent the diverse interests involved in ensuring that *IDEA* is being effectively implemented to produce results for children/students and compliance with legal and regulatory requirements in the evaluation of data and designation of priorities.

States/lead agencies and local programs/districts must use monitoring procedures that focus attention on specific areas of program performance that can be related to federal/state compliance as identified through an analysis of data. Monitoring procedures are to include reviews of data, determinations of specific indicators of compliance/noncompliance, data analysis, comparison, hypothesis development, on-site visitations/investigations, reporting, along with planning for corrective actions and feedback to produce results for children and youth and compliance.

The FMIC provides a general overview of the state or local program in the areas of

- data collection, analysis, reporting, and use;
- stakeholder involvement and participation;
- monitoring procedures; and
- feedback for improvement, and correction.

The FMIC is to be used as a starting point for identifying the state/lead agency and the local program/district need for technical assistance on focused monitoring. Additional, directed questions related to focused monitoring are used in assisting the state/lead agency and the local program/district in identifying specific needs. From the needs or concerns information gathered, desired results can be framed and used in the cooperative development of work plans aimed at meeting the identified needs.

Preparation of this tool was supported by a grant (H326Y02001) from the U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs. The content does not necessarily reflect the position or opinions of the U.S. Department of Education or offices within it.

SELF-ASSESSMENT: FOCUSED MONITORING IMPLEMENTATION CHECKLIST

Part C Part B

Contact name: _____ Completion date:_____

Agency name:_____ Contact email: _____

1: Data System

	ANSWER: **Yes** or **No**	**Comments/Notes**
1.1 Data: Collection		
1.1.1. Is there an individual child/student record database system which includes children a) Birth through 2 years of age? b) 3 through 5 years of age? c) c) 6 through 21 years of age?		
1.1.2. Are individual child/student data in this system updated at least quarterly?		
1.1.3. Does this system maintain historical data?		
a) 1.1.4. Does this system b) interface or communicate with other systems within the state/lead agency? c) interface or communicate with other systems across agencies? d) eliminate most paper reporting?		
1.1.5 Does the state/lead agency have a systematic method to collect data regarding a) family involvement? b) family perspectives?		
1.2 Data: Compilation and Reporting		
1.2.1. Are a) routine reports generated? b) ad hoc reports possible?		
1.2.2. **Are local program or district profiles or report cards with data about IDEA** a) disseminated to the programs/districts at least annually? b) made available to the public through print or electronic publication?		
1.2.3. Are aggregated data available for export?		
1.3 Data: Verification and Improvement		
1.3.1. Is verification conducted annually for randomly selected data?		

	ANSWER: **Yes** or **No**	**Comments/Notes**
1.3.2. Are data calculation methods evaluated?		
1.3.3. Is there a plan in place specifying a) regular reviews to the data system? b) regular updates to the data system?		
1.4 Data: Decision Making		
1.4.1. **Are data analyzed to evaluate the status of services for children in the state?**		
1.4.2. **Are data analyzed to determine the progress students are making?** *(Part B only)*		
1.4.3. **Are data analyzed to determine progress toward priority goals?**		
1.4.2. **Are data trends examined at the** **a) state level?** **b) local program/district level?**		
1.4.3. Are local program/district data compared to data in similar programs/districts to identify similarities or differences?		

2: Stakeholder Process

	ANSWER **:** **Yes** or **No**	**Comments/Notes**
2.1 Stakeholder Process		
2.1.1. **Does the Monitoring Stakeholder Group include** **a) parents?** **b) advocates?** **c) service providers/coordinators/educators?** **d) individuals with disabilities?** **e) parent organizations?** **f) advocacy organizations?** **g) g) policy makers?**		
2.1.2. Does the Monitoring Stakeholder Group meet at least annually?		
2.1.3. Does the Monitoring Stakeholder Group a.1. determine priority goals for state-wide performance improvement in early intervention/special education? **OR** **a.2 participate in the determination of priority goals for state-wide performance improvement in early intervention/special education?** b.1 designate indicators of each goal? **OR** **b.2 participate in the designation of indicators of each goal?**		

	ANSWER **: Yes** or **No**	**Comments/Notes**
c.1 designate targets for each goal? **OR** **c.2 participate in the designation of targets for each goal?** d.1 designate a trigger for each goal? **OR** **d.2 participate in the designation of triggers for each goal?** **e. identify indicators for selection for on-site monitoring?** **f. reconsider/review selection indicators annually?**		

3: Organizational Structure for Focused Monitoring

	ANSWER **: Yes** or **No**	**Comments/Notes**
3.1 Focused Monitoring Procedures		
3.1.1. **Are local programs/districts ranked on selection indicators?**		
3.1.2. **Is local program/district selection for on-site monitoring based on performance on the selection indicators?**		
3.1.3. Do standards exist to determine compliance for each goal?		
3.1.4. **Do protocols (objective measures) evaluating the extent of compliance for each selection indicator exist?**		
3.1.5. **Are local programs/districts not selected for on-site monitoring, monitored for Continuous Improvement?**		
3.1.6. Is the monitoring process integrated into other state/lead agency administrative supervision components?		

4: Focused Monitoring of A[g]encies

	ANSWER **: Yes** or **No**	**Comments/Notes**
4.1 Team Composition/Training		
4.1.1. **Does the On-Site Monitoring Team include** a) parents? b) local program/district personnel? c) peers from other local programs/districts? **d) state/lead agency personnel?**		

	***ANSWER* : Yes** or **No**	**Comments/Notes**
4.1.2. **Is there annual training for On-Site Monitoring Team members?**		
4.1.3. Is the reliability of On-Site Monitoring Team members' ratings examined?		
4.2 Site Visit Activities		
4.2.1. **Is there a pre-visit examination of the selected local program/district to examine** **a) data in addition to that for selection?** ***b)* the program/district Self-Assessment or Self-Review documents? *(NA if not available)*** **c) parent/family participation and involvement?** **d) complaints/previous monitoring information?** **e) performance data from general education(such as the achievement of typical peers)?** *(Part B only)*		
4.2.2. **Does the On-Site visit focus on areas specific to the indicator on which the local program/district was selected?**		
4.2.3. **Does the on-site visit include** **a) an open meeting or focus group with parents?** ***b)* a focus group with students?** *(Part B only)* **c) interviews with individual parents?** ***d)* analysis of parent survey data?** *(NA if not available)* **e) Interviews with graduates or exiters or with their parents?**		
4.3 Reporting and Follow-up		
4.3.1. **Is a post-staffing meeting conducted with the On-Site Monitoring Team?**		
4.3.2. **Does the state/lead agency have prescribed timelines for report dissemination?**		
4.3.3. **Is the written report issued by the state/lead agency within prescribed timelines?**		
4.3.4. Does the state/lead agency report on the timeliness of report dissemination?		
4.3.5. **Are written monitoring reports available to the public through print or electronic publication?**		
4.3.6. **Do corrective actions have** **a) measurable results directly related to noncompliant areas?** **b) timelines for completion established?** c) **connections to changes in child/student/family results data?**		
4.3.7. **Are technical assistance needs incorporated into local agency corrective action plan?**		
4.3.8 **Is technical assistance available in all known areas of noncompliance?**		

	***ANSWER* : Yes** or **No**	**Comments/Notes**
4.3.9. **Is corrective action follow-up tracked to ensure progress toward correction?**		
4.3.10. Is an on-site follow-up conducted to verify results?		
4.3.11. **Are the results of the corrective action plan verified?**		

5: Incentive and Sanction Process

	***ANSWER* : Yes** or **No**	**Comments/Notes**
5.1 Incentives		
5.1.1. Are incentives included for improvement of performance on priority goals?		
5.1.2. Have incentives been implemented as part of the focused monitoring process?		
5.1.3 Has the effectiveness of various incentives been evaluated?		
5.2 Sanctions		
5.2.1. **Do explicit written procedures exist regarding the imposition of sanctions?**		
5.2.2. **Does a range of sanctions exist for violations?**		
5.2.3. **Have sanctions been applied according to the written procedures?**		
5.2.4. Has the effectiveness of various sanctions been evaluated?		

6: Enhancement of Focused Monitoring

	***ANSWER* : Yes** or **No**	**Comments/Notes**
6.1 Research and Evaluation		
6.1 .1. Is an independent or third party evaluation of the monitoring system conducted at least biannually?		
6.1.2. Are the results of the independent or third party evaluation used to make changes in focused monitoring system/processes?		
6.1.3. Are studies conducted to determine effectiveness of separate focused monitoring components?		

Preparation of this tool was supported by a grant (H326Y02001) from the U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs. The content does not necessarily reflect the position or opinions of the U.S. Department of Education or offices within it.

DEFINITIONS[1]:

Baseline - Starting point or initial level of the goal's indicator measure against which future levels will be compared. A baseline may be a single data point, or a set of measures over time. (See definition of "trend" below.)

Data Analysis - Comparing present levels of system performance to baseline & targets in order to draw conclusions, identify strengths & weaknesses & areas for improvement by systematically examining why levels of performance were or were not reached.

Goal - Statement of the measurable condition(s) desired for the population of children with disabilities.

Hypothesis – an "educated guess" of causes of events or observed data based on an analysis of specific data

Indicator - Statement that helps quantify the goal and signals whether the goal is being achieved. There may be multiple indicators for a single goal. OSEP has issue the State Performance Plan document that delineates 19 indicators related to Part B Priority areas (see definition below) and ___ indicators related to Part C Priority areas.

Progress - Performance that exceeds baseline and is in the direction of the target.

Priority areas – key elements of the *IDEA.* These include:

Part B:

1) Effective State Supervision
   a) Child Find
   b) Dispute resolution and monitoring
   c) c) Public Input
2) Meaningful and Effective Family Involvement
3) Development and Performance of Outcomes for Children, and Youth with Disabilities
4) Inclusion of Children, and Youth with Disabilities in Typical Community and School Settings with their Non-disabled Peers with Needed Supports
5) Effective Transitions:
   a) for Infants and Toddlers, with Disabilities to Preschool
   b) for Children and Youth with Disabilities to Adult Life

1 Where applicable, definitions of terms as proposed by the Performance Measurement Workgroup in the Drafts (Parts C/B) of 4/20/2004 are used or adapted.

6) Enhanced Social, Emotional and Academic Development for Children and Youth with Disabilities through the use of positive behavior supports and strategies and improved school climate.

Part C:

1) Effective State Supervision
   Child Find - All eligible infants and toddlers are appropriately identified
2) Meaningful and Effective Family Involvement
3) Development and Performance of Outcomes for Infants and Toddlers with Disabilities and their Families
4) Embedding Early Intervention Services in Families' Daily Routines and Typically Occurring Community Activities
5) Effective Transitions for Infants and Toddlers with Disabilities—Transition to Part B

Target - The desired level of each indicator to be reached within a time period. A target may be long or short term.

Trend - A summary of past performance over time that may be used to display progress toward a goal, maintenance and/or compliance.

Trigger - The numeric or other point at which something a predetermined action is taken.

Technical Assistance Work Plan Development

The State/Local program personnel and Center staff jointly develop work plans that include

a. Description of need(s)/concern(s)
b. Prioritization of these need(s)/concern(s)
c. Statements of the desired results
d. Statements of how the accomplishment of the desired results will be observed/measured
e. Follow up evaluation includes
    i. Annual re-administration of self-assessment FMIC (14 to 18 months after implementation of the work plan)
    ii. Evaluation of progress and accomplishments

A format similar to the one below will be used.

National Center on Special Education Accountability Monitoring Work Plan

State/District:_____

Date Developed: _____ Date for Review_____

Description of Concern/Need:	**Priority Ranking:**
Desired Results:	**Data/Information Sources & Description:**
Measurement of Results:	**Measurement Review Dates:**

Work Plan Developers:

Names: Titles/Agencies:

APPENDIX 3

Interagency Coordinating Council

Connecticut State Interagency Coordinating Council

- Timothy Bowles, Department of Social Services
- Kathy Bradley, Department of Children and Families
- Mary Beth Bruder, Melissa Van Buren, Alternate, UConn Center for Excellence
- Jose Centeno, Office of Protection & Advocacy
- Dona Ditrio, Early Head Start
- Rita Esposito, REACHOUT, Inc. (provider)
- Richard N. Fisher, State Insurance Department
- Linda Goodman, Department of Mental Retardation
- Mark A. Greenstein, M.D., Physician
- Clara Gutierrez, Parent
- Jeanette Haines, Board of Education and Services for the Blind
- Cindy Jackson, Children's Therapy Services (provider)
- Robert LaCamera, M.D., Am. Academy of Pediatrics, CT
- Joseph McLaughlin, McLaughlin & Associates, LLC (provider)
- Elise Minor, Parent
- Deborah Pagano, Parent
- Lolli Ross, Chair, Greenwich ARC (provider)
- Maria Synodi, Alternate. George Coleman, Department of Education
- Louis Tallarita, SDE – Coordinator of Education for Homeless Children
- Elayne Thomas, Vice Chair, Parent
- Rep. John W. Thompson, CT Legislator
- Robin Tousey-Ayers, Department of Public Health
- Myra Watnick, Rehabilitation Associates (provider)
- Diane Wixted, Commission on the Deaf and Hearing Impaired

APPENDIX 4

Program Groups 7-1-07

Connecticut Part C Focused Monitoring Program Groups
Using the Size of the Program Based on Children with IFSPs on July 1, 2007

Group 1 – Small Programs 0-59 n=15		Group 2 – Medium Programs 60-149 n=11		Group 3 – Large Programs 150+ n=10	
Program	**Total**	**Program**	**Total**	**Program**	**Total**
Building Bridges, LLC	1	Cooperative Educational Services	69	LEARN-Birth To Three	153
NE Center for Hearing Rehabilitation	9	Children's Therapy Services	71	CREC Birth to Three	165
Ahlbin Centers for Rehabilitation Medicine	22	Child and Family Network	72	Reachout, Inc.	194
CREC Soundbridge	22	Hill Health Corp.	77	Early Connections North Region	201
Therapy Solutions Center	25	Early Connections West Region	92	Family Junction	204
Danbury Public Schools	28	SARAH, Inc.	102	McLaughlin & Associates, LLC	205
American School for the Deaf	29	Early Connections South Region	129	Greenwich ARC	210
Cheshire Public Schools	32	Education Connection	133	HARC	238
Wheeler Clinic	36	Jane Bisantz & Associates, LLC	141	Easter Seals of CT / RI, Inc.	425
St. Vincent's Special Needs Center	42	Project Interact, Inc.	146	Rehabilitation Associates of CT	437
East Hartford Birth-To-Three	50	Easter Seal Rehab Cntr of Grtr Wtby	147		
STAR Rubino Center	50				
TheraCare	51				
Key Service Systems	53				
Kennedy Center	56				

This information is based on information available from the Connecticut Birth to Three data system as of August 8, 2007.

APPENDIX 5

ICC and Focused Monitoring Stakeholders Group Comments 4-14-08

April 14, 2008

ICC and Focused Monitoring Stakeholders Group Meeting-Input on FM Evaluation Questions and Methods

What are the outcomes that you would like to see from the Focused Monitoring Evaluation?

- Is the system too focused on quantity vs. quality? Ex. Transition
- Efficiency of the system-cost-benefit analysis
- How we compare to other states?
- What aspects of current system are successful/weakness?
- Families have understanding how system can help child?
- Omissions in system?
- Family outcomes?
- Additional resources based on results of FM system evaluation.
- Focus on something important! Ex. Transition-specific timing
- Quality of the program vs. transition date
- Determine factors considered in FM review
- How do BPR and FM complement each other?
- Difference between quantity vs. quality- consider measures
- Looking at family outcomes & child outcomes
- Ongoing practices become a part of the QA system-more of a seamless process

What questions do you have that you would like to see addressed in the evaluation of the FM System?

- What information that is already being measured on the BPR and are they being repeated in FM?
- Are we doing the best we can to make sure children and families are being best served?
- Families offer the best feedback on the system and service.
- Is the FM process giving us the information? We need to know?
- What's the purpose of FM? Is it just info for the Fed. Govt?
- Develop overall comprehensive state system vs. acting in silo. Referring back to legislators.
- How are monitoring results used to improve the B23system, Dept. of Ed. as well as other state agencies?
- Is FM helping programs that need help, is it identifying the right programs to monitor?
- Coordinated efforts? Use of stakeholders? FM teams? How do they contribute to the process? Defining terminology……
- How much money is being put into the system from the provider standpoint as well as by the Department? And is it worth it?

APPENDIX 6

Interview Protocols

Learning Innovations at WestEd

Connecticut Birth to Three Focused Monitoring System Evaluation

Focus Groups with Birth to Three Providers

June 19th, 9:30-11:30 East Hartford DDS Office, 255 Pitkin Street, Conference Room 2A
June 20th, 9:30-11:30 Shelton Town Hall, 54 Hill Street, Auditorium/Meeting Room.

Purpose

Learning Innovations at WestEd has been asked by the Connecticut Department of Developmental Services to conduct an external evaluation of the CT Birth to Three Focused Monitoring System. The evaluation will provide information to inform and improve the Focused Monitoring System. We are convening these Focus Groups as a one component of our comprehensive evaluation effort. We want to solicit input and comments from Birth to Three Providers on how the Focused Monitoring process is working, your perceptions of its intent, value, and outcomes, and your suggestions for improvement. We understand that the participants in the Focus Groups will include providers who have participated in a Focused Monitoring on-site inquiry visit as well as those who have not. We encourage all providers to attend the Focus Group in their region(s). We would like to have the opportunity to hear the perspectives and impressions from everyone, whether or not your program has had a Focused Monitoring on-site visit.

Questions

1. From your perspective, what is your understanding of the purposes, processes and intended outcomes of the Focused Monitoring System?

2. To what extent and in what ways have Birth to Three providers been involved in the development of the Focused Monitoring process, the identification of priority areas, and evaluation of activities?

3. What is your understanding of the selection process and criteria for on-site visits?

4. What are the primary components of the Focused Monitoring System and how are they being implemented?

5. How do these components integrate with the state's overall system of general supervision and quality assurance?

6. For those of you who have been through an on-site Focused Monitoring visit:

    a. What is your understanding of why your program was selected?
    b. What kind of preparation did you receive prior to the visit?
    c. How were you involved in the “desk audit” prior to the visit?
    d. Describe the process from your experience. What was it like?
    e. What feedback did you receive during the visit?
    f. Describe what followed after the visit?
    g. To what extent and in what ways has the Focused Monitoring system assisted in your local program improvement efforts? Has it helped you to improve the quality of your program’s service delivery?
    h. What was the most important insight or learning that you gained from the Focused Monitoring Process?

7. For those of you who have not been through an on-site Focused Monitoring visit…

    a. What is your impression of how your program is monitored?
    b. How has the Focused Monitoring system impacted what you do?

8. What impact is the Focused Monitoring system having on the quality of local program services and on child and family outcomes?

9. What are the strengths/benefits of the current the Focused Monitoring system?

10. What suggestions would you make to improve the Focused Monitoring process?

CT Part Birth to Three Focused Monitoring Evaluation
Parent Team Member

Name of Member:_____

Position:_____

Date:_____ **Interviewer:**_____

Explain the purpose of the FM evaluation. Indicate that the interviewee will not be identified by name in the evaluation report. Notes from the interview will remain the property of Learning Innovations/WestEd and will not be shared with the Department of Developmental Services.

1. Tell me about your involvement in the Focused Monitoring process.

2. What would you say is the purpose of the FM system?

3. What would you describe as the intended outcomes of the FM system?

4. What preparation/training did you receive as a Focused Monitoring Team Member? Before, during, after the visits? Ongoing training needs? Communication with the Department?

5. Describe the FM process, start to finish.

6. As an FM Team Member, to what degree do you feel you were able to influence the report and recommendations that the Department made to the program?

7. What impact is the FM system having on the quality of local program services and on child and family outcomes?

8. What are the FM system's strengths?

9. What about the system or process could be improved?

10. Is there any other information you would like to share?

CT Part Birth to Three Focused Monitoring Evaluation
Peer Team Member

Name of Member:_____

Position:_____

Date:_____ **Interviewer:**_____

Explain the purpose of the FM evaluation. Indicate that the interviewee will not be identified by name in the evaluation report. Notes from the interview will remain the property of Learning Innovations/WestEd and will not be shared with the Department of Developmental Services.

1. Tell me about your involvement in the Focused Monitoring process.

2. What would you say is the purpose of the FM system?

3. What would you describe as the intended outcomes of the FM system?

4. What preparation/training did you receive as a Focused Monitoring Team Member? Before, during, after the visits? Ongoing training needs? Communication with the Department?

5. Describe the FM process, start to finish.

6. As an FM Team Member, to what degree do you feel you were able to influence the report and recommendations that the Department made to the program?

7. What impact is the FM system having on the quality of local program services and on child and family outcomes?

8. What are the FM system's strengths?

9. What about the system or process could be improved?

10. Is there any other information you would like to share?

CT Part Birth to Three Focused Monitoring Evaluation
State Agency Staff and Other State Level Stakeholders

Name of Member:_____

Position:_____

Date:_____ **Interviewer:**_____

Explain the purpose of the FM evaluation. Indicate that the interviewee will not be identified by name in the evaluation report. Notes from the interview will remain the property of Learning Innovations/WestEd and will not be shared with the Department of Developmental Services.

1. Describe how you are or were involved in the development of CT's Focused Monitoring System/Process.

2. What would you say is the purpose of the FM system?

3. What would you describe as the intended outcomes of the FM system?

4. To what extent and in what ways are stakeholders involved in the development of the process, the identification of priority areas, and evaluation of activities?

5. What are the primary components of the FM system?

6. How do these components integrate with the state's overall system of general supervision and quality assurance?

7. What impact is the FM system having on the quality of local program services and on child and family outcomes?

8. What are the FM system's strengths?

9. What about the system or process could be improved?

10. Is there any other information you would like to share?

Tailor additional questions/probes to the particular individual being interviewed.

CT Part Birth to Three Focused Monitoring Evaluation
Accountability and Monitoring Manager & Part C Director

Name of Member:_____

Position:_____

Date:_____ **Interviewer:**_____

Explain the purpose of the FM evaluation. Indicate that the interviewee will not be identified by name in the evaluation report. Notes from the interview will remain the property of Learning Innovations/WestEd and will not be shared with the Department of Developmental Services.

1. Describe how planning for the CT FM System got started.

2. What resources, TA or support did you receive as you began to plan your FM system?

3. What was your role in setting the system up?

4. To what extent is there a clear understanding by local programs, parents, Interagency Coordinating Council (ICC) members, and other stakeholders of the purposes, processes and intended outcomes of the FM System?

5. To what extent and in what ways are stakeholders involved in the development of the process, the identification of priority areas, and evaluation of activities?

6. What are the primary components of the FM System and how are they being implemented?

7. How do these components integrate with the state's overall system of general supervision and quality assurance?

8. How were the members of the on-site FM teams selected? How are they involved in the process?

9. What data sources are used for Focused Monitoring? How are data collected, analyzed and used in decision-making?

10. How are monitoring results used?

11. To what extent does the FM system assist in local programs in their improvement efforts? In compliance? In performance?

12. What impact is the FM system having on the quality of local program services and on compliance, performance, and on child and family outcomes?

13. To what extent and in what ways are the FM data used to inform other Department initiatives and reported to the local programs, other stakeholder and to the public?

14. What challenges do you face in implementing the FM system?

15. What are the FM system's strengths?

16. What about the system or process could be improved?

17. Given the time, effort, funds and resources that are put into the FM Systems, from your perspective, is it worth it?

18. Is there any other information you would like to share?

Tailor additional questions/probes to the particular individual being interviewed.

CT Part Birth to Three Focused Monitoring Evaluation
NCSEAM Staff

Name of Member: _____
Date: _____ **Interviewer: _____**

Explain the purpose of the FM evaluation. Indicate that the interviewee will not be identified by name in the evaluation report. Notes from the interview will remain the property of Learning Innovations/WestEd and will not be shared with the Department of Developmental Services. Interviewees will not be quoted in the report without permission.

1. Describe how you were involved in the development of CT's Focused Monitoring System/Process.

2. What would you say is the purpose of FM (in general… not CT's system)?

3. What would you describe as the intended outcomes of FM?

4. Based on your experience in other states, to what extent and in what ways are stakeholders involved in the development of the process, the identification of priority areas, and evaluation of activities?

5. Review the main components of the CT FM System. How does what CT does compare to other states that you have worked with?

6. How do FM components typically integrate with states' overall systems of general supervision and quality assurance?

7. Across the country in the states that you have worked with, what impact is the FM system having on the quality of local program services and on child and family outcomes?

8. In terms of Focused Monitoring across the country, where should we be going?

APPENDIX 7

On-Site Case Study

Case Example of the Process: Focused Monitoring Review

Prior to the Desk Audit

- The program was selected based on a review of statewide data according to indicators on Service Delivery, the Focused Monitoring focus area for 2008-09.
- The program was selected because the program was the lowest of its size group of Birth to Three Programs. Its rate of compliance was 90% on SPP Indicator 1 Timely Services: Children for whom all new services began within 45 days from the IFSP meeting.
- Date for Site Visit: August 4-6, 2008
- 7/10/08: Peer Team Member notified of Desk Audit and on-site visit dates.
- 7/14/08: Program Director received copies of letters that will be sent to all eligible families two weeks prior to the visit.
- Documents Reviewed:
  - Service Delivery Protocol Preparation Checklist
  - Form letter to parents informing them of the on-site visit and invitation to schedule interview with the Monitoring Team
  - IDEA Part C Quality Assurance Manual
  - Birth to Three Monitoring: Services Delivery Protocol Summary Form
  - Focused Monitoring Summary Report Form
  - Program's Focused Monitoring Report March 2005 (Transition)
  - Record Review Form for Services Delivery-Families
  - Focused Monitoring: Service Delivery-Records Protocol

Desk Audit Meeting with the Team July 21, 2008

- Team Members present:
  - Alice Ridgway, DDS, Manager, Accountability and Monitoring and Team Leader
  - Pam Kelly, Parent Team Member
  - Jo Rossi, Parent Team Member
  - Deborah Pagano, Parent Team Member (new)
  - Donna Cimini, Peer Team Member (new program/provider), Creative Development Programs
  - Deb Resnick, DDS, Main Contact for the Program (Day 3 only)
  - Kristin Reedy, Learning Innovations/WestEd External Evaluator as participant observer

Description of the Meeting: Approximately two hours including call with Program Director(s)

The Team Leader reviewed the process for the Desk Audit and for the site visit with Team Members and also provided background information and history on the Program. She reviewed the schedule for the three-day on-site visit with the Team Members and

clarified the goals of the meeting and reminded members that the Program Directors would be joining the meeting by phone to review hypotheses and provide input to the process.

Goal of the Desk Audit Meeting: To form hypotheses that will be the "lens" through which the Team will look at the program.

Clarified the reason the Program was selected for Focused Monitoring 2008: Programs were ranked on timely services indicator using data from May 2008. This Program was the lowest in its size grouping.

Discussed/explained the record review process and how multiple sources of data will be used to triangulate the data: record reviews, interviews with families, statewide data collection, etc.

Team Members were given time to review packets of information. Documents available for the Team Members at the Desk Audit:

- the Program's Biennial Performance Report (BPR)/Self-Assessment, 9/07.
- the Program's Improvement Plan (based on the BPR)
- Raw Data including IFSPs by child, services by service coordinator, "dash board" data.

Reviewed prior rankings of the Program to see trends in levels of compliance on this indicator.

December 05: 96%
June 06: 94%
December 06: 99%
June 07: 97%
September 2007 BRR: 57% reported by the program
June 08: 90%

Team Members shared their observations based on the review of the data presented in the packets. Aileen McKenna, DDS, reviewed information on complaints received at the Department from families served by the Program.

Generation of Hypotheses: Based on the history, background information, current and trend data review and overall knowledge of the program including changes in leadership in recent months, the Team generated hypotheses that would be tested during the site visit. There was a good deal of discussion and speculation about how staffing changes were influencing the program's service delivery, relationships with families, and compliance.

The Team Leader addressed with the Team how to write up reports, cautioned about the way the reports were written and reminded members about the possibility that their notes could be made public if requested. Also addressed possible conflict of interest.

Conference Call with Program Director(s)

Prior to making the call to the Program Director(s), the Team Leader gave the Team the opportunity to generate any questions that they wanted to clarify on the call. The Team Leader began by introducing the Team Members. She described how the on-site visit will be conducted and what the three-day schedule will include. She clarified the focus area for the visit: service delivery, and referred them to the Services Delivery Protocol Summary Form so that they could see exactly what the Team will be looking for and where they will look for the data (Appendix 12 in the QA Manual).

The Team Leader posed the following overall question: “Given everything that you [the Program Director(s)] have been through, what can we do to help?” She reminded them that this visit is not just to find what’s wrong (with the program) but also to identify the program’s strengths and how can it be improved. Used the metaphor of a “swamp” to describe Focused Monitoring. “We are looking for orchids but also looking for alligators.” The hypotheses will help the Team to focus on underlying issues that may be contributing to data on the timely services indicator.

Program Director(s) were given the opportunity to describe the current status of the program and raise issues that they wanted the Team to address. Program Director(s) speculated themselves on what was contributing to the current situation.

The Team Leader reviewed the Team’s draft hypotheses and asked Program Director(s) for feedback. The process was interactive and participatory. The discussion turned to strategies for addressing the problems identified in the hypotheses. For example, one hypothesis was that the program should have an “independent assessment” or external review to confirm the program’s self-assessment in the BPR and to “help the program prioritize TA and training needs.” The Team Leader also began to indicate to the Program Directors what potential “findings” would be, but clarified that she was not using the word “finding” to indicate a finding of noncompliance.

Desk Audit Hypotheses for the Program

1. Recent staff turnover including the program director and a number of staff who all left at the same time, some without notice, has resulted in difficulty providing services and high levels of confusion regarding Birth to Three requirements.

2. The previous program manager completed the program's Biennial Performance Report so an independent assessment of the program's performance will help the new leadership set priorities for improvement.

3. The program is in the process of redefining the role of staff as service coordinators, which may help families fully benefit from the support this role offers.

4. Staff are not clear about the requirement to begin all new IFSP services within 45 days from the meeting.

5. Most recent complaints related to challenges in communication with families and professional staff relationships.

Program Director(s) confirmed that they were in agreement with the hypotheses as the Team Leader described them.

The Team Leader ended the call by reviewing the on-site process again and indicated that the Team would do the first record review with the Program Director(s) so that they can see what the Team will be looking at in the record review. The Team Leader also asked Program Director(s) to have July visit notes available in case those had not yet been entered into the record. At the conclusion of the call, the Team Leader encouraged Program Director(s) to review Appendix 12 and to email her if they had any other issues that they wanted the Team to address. Program Director(s) indicated their enthusiasm about the visit and seemed to have a positive attitude toward it, seeing it as an opportunity for improvement.

On-Site Focused Monitoring Visit August 4-6, 2008

Day 1

Team Members present:

- Alice Ridgway, DDS, Manager, Accountability and Monitoring
- Pam Kelly, Parent Team Member
- Jo Rossi, Parent Team Member
- Deborah Pagano, Parent Team Member (new)
- Donna Cimini, Peer Team Member (new program/provider)
- Kristin Reedy, Learning Innovations/WestEd as participant observer

Orientation/Overview: The Team Leader reviewed the purpose of the on-site visit with the Program Director(s) and selected staff. She provided a “draft” of the Focused Monitoring report (using the standard form) to show them what it would include and listing the hypotheses that had been generated at the Desk Audit meeting. Explained that once final, the report will be posted on the DDS website. The Team Leader explained the purpose of the visit, the priority area (service delivery) that was the area of focus, why the program was selected, etc. She acknowledged the progress that the program had made since the last on-site visit, which had focused on transition. She explained how the selection process is the “flag” or “trigger” that results in the visit but that once there, the Team will address any/all areas that have to do with service delivery. Explained that the Team will do record reviews, interviews with staff and parents, etc. “Compliance is what brings us to the door.”

Interview with Program Director: The Team Leader interviewed the Program Director using the standard protocol. Two other EI staff were present. Other Team Member

observed. They were given the opportunity to ask questions at the conclusion of the interview. No one asked any additional questions. The protocol addresses issues related to cultural, linguistic, racial and economic diversity.

Record Reviews: Twenty-two records were selected for review. Rather than a random sample, a purposeful sample of records was chosen to get representation across a number of variables including a range of service coordinators assigned to the families, town of residence, Department of Children and Families (DCF) involvement, and socio-economic levels. Also, if DDS had received a call or complaint from a parent, that child's record was selected. As an orientation/training activity, more senior Team Members were paired with the new Team Member to do the first record review using the record review protocol. The initial record review was very time consuming. The protocol is very detailed and aligned with specific items on the Focused Monitoring Service Delivery Protocol Grid, Appendix 12 in the Quality Assurance Manual. Timelines for evaluations, periodic developmental reviews, and written prior notice dates in the record are crosschecked with data from the statewide data system to verify accuracy. A list of attendance and contacts generated for Medicaid billing is also cross checked with case notes in the record to determine if the service was in fact provided on the billing date. The Team Leader conducted her first record review with the Program Director. As she went through the record, she explained what she was finding, what she was specifically looking for and why she rated the item as she did. She also used the record review to explain or clarify requirements so it was a teaching/learning/ technical assistance opportunity for the Program Director as well. She also pointed out aspects of the record or forms that were done well, e.g. the Missed Visit form.

During this process, other Team Members were present in the room and were able to ask the Team Leader for clarification/interpretation as they went along. Some records were very extensive and required a good deal of hunting or searching for the correct documents. A good deal of interpretation is also required of the record reviewer in order to respond to the items on the protocol. Although Team Members were reviewing individual records, they were able to talk with each other and ask questions of the Team Leader as they worked. No end-of-day summary meeting was held with the Program Director(s) at the end of Day 1 since they needed to leave the office before the Team had finished for the day.

Staff Interviews: Direct service staff were individually interviewed by Team Member using a standard protocol. Interview questions were aligned with the items on Focused Monitoring Service Delivery Protocol Grid, Appendix 12 in the Quality Assurance Manual and with the items on the record review protocol. Three interviews were observed as they were conducted, one with the Team Leader and two with one of the Parent Team Members. Interviewers took notes on the interview protocol. Interviews were not recorded.

Each interview began with an explanation of the purpose of the visit and the intent of the interview and addressed confidentiality of information. Interviewers followed the protocol but also asked follow-up questions. If an interviewee asked for feedback (e.g. "What am

I doing wrong that needs to be corrected?") the Team Leader deferred and responded that the Team was not ready to give that type of feedback yet. One interviewee raised a concern that she reportedly had brought to the attention of the Program Director(s) which had not been addressed to her satisfaction. The interviewer asked her if she would like to have that mentioned as a recommendation/consideration in the report and she agreed.

Day 2

Record Reviews: Continued and completed on Day 2 for a total of 22 records.

Staff Interviews: Continued by phone.

Parent Interviews: Parents were contacted by phone by Team Members. Parents were selected based on responses to the letter of invitation for an interview during the visit, parents whose children's records were selected for review, parents from whom the Department may have received a phone call or complaint, as well as randomly selected "cold calls". The intent was to interview roughly 15-20 of the program's parents (approximately 10%). A standard interview protocol was used for parent interviews. Interview questions were aligned with the items on Focused Monitoring Service Delivery Protocol Grid, Appendix 12 in the Quality Assurance Manual and with the items on the record review protocol.

The Evaluator was able to observe/listen in on three parent interview calls. One interview was done with a Spanish-speaking parent using the Language Line interpreter. Others were done in English. Team members adhered to the script and protocol in their interviews. Team members demonstrated an informal, reassuring style when speaking with families, were respectful of family schedules, cultural differences, and preferences and clearly conveyed the intent to elicit honest feedback from parents on services that they were receiving. One parent was particularly dissatisfied with the services she was receiving. The Parent Team Member interviewing her remained neutral in her tone of voice, reflecting the parent's concerns and encouraged her to make a list of her questions and issues that she could discuss with the Program Director.

Data Entry: The Team Leader entered the yes/no ratings from the record reviews into a database on her computer and calculated the percentages for each item.

Wrap-up Conference for Day 2: At the close of Day 2, the Team Leader debriefed with the Program Directors, providing an overview of strengths that had been noted in the record reviews and interviews, giving them the initial findings from the record review process, informed them of the scores for each item on the record review protocol, and the areas where there was identified noncompliance where a formal finding of noncompliance would be made. (There were five findings.) The criteria for "substantial compliance" with a requirement is 95%. Any record review percentages that fell below 95% were considered to be out of compliance. The Team Leader also reported on the

record review scores for items that were “quality measures” but not compliance requirements. “The main goal for being here is not compliance…we are looking for quality.” Program Directors had the opportunity to ask questions and the Team Leader was helpful in explaining the reasons for the ratings, the patterns that the Team observed in the record review process as well as staff and parent interviews. She also provided suggestions for addressing some of the areas in need of improvement. She clarified that any items that fell below 50% of the standard for quality measures on the BPR (standard = 85%) were required to be addressed in the program’s Improvement Plan. Program Directors were very receptive to this informal, preliminary feedback.

Day 3

Staff and Parent Interviews: Continued and completed. A total of 15 parent interviews were conducted and 15 out of 33 staff interviews.

Record Review Summary of Comments: One Parent Team Member reviewed all of the record review protocol forms for comments from the reviewers and summarized the strengths, weaknesses, and concerns that were noted by the reviewers on the forms.

Parent Interview Summary of Comments: Two Parent Team Members reviewed all of the parent interview forms for comments that were noted and summarized the strengths, weaknesses, concerns that were noted by the interviewers on the forms.

Staff Interview Summary of Comments: Team members also reviewed all of the staff interview forms for comments that were noted and summarized the strengths, weaknesses, concerns that were noted by the interviewers on the forms.

Data Entry: The Team Leader entered the yes/no ratings from the record reviews and interview protocols into a spreadsheet on her computer and calculated the percentages for each item.

Development of the Report: The standard two-page form was used. It includes the Priority Area being addressed (Service Delivery), the reason for selection, the hypotheses generated at the Desk Audit meeting, the findings based on the site visit, strengths of the program, space for measures in “need of significant improvement” to be included in the Improvement Plan and areas of noncompliance. (Note: When this process started, one of the Team Members was out of the room, finishing an interview.)

The Team Leader began to lead Team Members in a discussion of the hypotheses and what evidence they had collected to support or refute each. As they talked, she typed comments into the report form, beginning with Hypothesis #5. She reported to the Team the data for parent interviews. Team Members discussed the information and provided their own interpretations based on the record reviews and interviews that they had done.

Next, they discussed Hypothesis #3, service coordination. An example of the type of comment recorded on the form: “In both records and during family interviews, it was noted that service coordinators did not react to parent requests for outside services.” Then the Team Leader went into the spread sheet/database to look for supporting quantitative data. For example, 38% of families reported that service coordinators assisted them in accessing service outside of EI and 38% reported that they know what their service coordinator can do for them. Eighty percent of records had documentation of other services. Staff interviews produced some different information. For example, 92% of staff reported that they knew what the role of the service coordinator is. The Team Leader looked across the different sources of data for information to support/refute the hypotheses. She also referred back to the Program’s most recent BPR to compare the self-assessment ratings with what the Focused Monitoring Team found.

The Team Leader reported that four “quality measures” need to be improved on and addressed in the Improvement Plan. She asked the Team, “Based on review of records and interviews, are those the top quality measures?” These were areas that weren’t addressed in any of the hypotheses. Team Members discussed these areas. “Some of the staff work for 0-3 and other outpatient clinics, and that might impact how they communicate with families.” This also relates to the service coordination issue, Hypothesis #3. Other issues and challenges were raised related to this hypothesis.

For Hypothesis #4, the Team Leader questioned the percentage that was reported on the record reviews for a particular compliance item. The results at 80% were unexpectedly high. She questioned Team Members about how they rated this item. There was a good deal of discussion about the factors that may be contributing to this hypothesis.

This process continued for the other hypotheses. In some cases, the hypotheses were reworded. Team Members contributed to the wording of comments and findings reported in the document.
Team Members demonstrated their first hand knowledge and deep understanding of the issues and constraints that influence service delivery in Birth to Three programs. The Team Leader cautioned Team Members about recommending specific improvement strategies in the report, as it is the program’s role to develop those strategies and the role of the Department’s TA provider who would follow-up with the program after the Focused Monitoring visit.

Then the Team Leader asked Team Members to offer strengths that they observed from record reviews and interviews. She sometimes questioned wording but recorded observations from each Team Member, checking to be sure that she captured what they intended to convey accurately. She also checked their observations against data from the record reviews and interview protocols and did not include one strength offered by a Team Member because the interview protocols only showed 80% for that item. The minimum criterion is 85%, which is consistent with the criterion in the BPR.

The Team Leader also reviewed the results from the record reviews and interview data for strength areas (85% or better).

At the conclusion of this process, the Team Leader printed drafts of the report for all Team Members to review.

The Peer Team Member was asked to sign a confidentiality statement but because Parent Team Members are subcontractors of the Department, they were not required to do so.

Exit Interview with Program Directors

The Team Leader presented the report and indicated that the conversation at the exit interview would not address improvement strategies. She went over the components and data collection strategies, being specific about how many interviews were conducted, number of records reviewed, etc. She noted the revisions to the original hypotheses, clarifying the issues that the Team addressed. She then reviewed the findings, which were presented according to each of the five hypotheses.

During the presentation, the Program Director(s) made specific requests for TA as follow-up. They also asked for clarification on a number of procedural issues and for suggestions to address them. The Team Leader responded to these as she went forward with the presentation so that technical assistance actually was imbedded into the exit interview.

The Team Leader reviewed the timelines for correction of findings of noncompliance and the relationship between the Focused Monitoring findings and the BRP Improvement Plan. The program will need to create a new Improvement Plan to address the new findings of noncompliance and other measures in need of improvement. She also explained the relationship to the state-to-local determinations process.

The exit interview included a review of the strengths that the Monitoring Team identified and concluded with a review of the findings of noncompliance. There were five items where noncompliance was demonstrated. Two of the items were also in the program's BPR from September 2007 where the timeline for correction was one year from the BPR date. For that reason, the program will need to address those issues as soon as possible. The other three items newly identified will have 12 months to demonstrate correction of noncompliance. For three consecutive months, the program will sample up to 10% of the current records of eligible children and demonstrate that the noncompliance has been corrected. The program needs to keep a list of the records that were reviewed so that they are available for data verification.

The Team Leader asked the Program Directors for feedback on the process as compared to their prior Focused Monitoring visit. The Program Director was positive, indicating that this visit "was completely different." "I felt very relaxed this time…I wasn't

really worried about it. Saw it as a positive thing…I was excited about you coming. I got phone calls from a couple of families …indicating that they were going to request an interview…it's a good thing. But the first week of the month is not a good choice of dates..." due to evaluations and billing. Feedback from staff was also positive. "I also felt not threatened because you do a really good job in helping us to not feel threatened." "It validates what we are saying to staff and helps us."
Ultimately if benefits children and families.

The program will receive the final report shortly and they will have the opportunity to review it again. Overall the exit interview was upbeat, cordial and the findings well received by the Program Directors who are clearly interested and motivated to improve programs and services to children with disabilities and their families.

Strengths of the Process

- The report format and process for developing it is short, concise and efficient, enabling the Team to leave the site visit on the final day with an almost-final-report, which includes formal, written notice of findings of noncompliance.
- Protocols for the record reviews and interviews with staff and parents are aligned with the BPR and with each other, providing a triangulated approach to data collection that is consistent with the overall Birth to Three performance and compliance indicators.
- Site visit Team process is participatory and gives all Team Members the opportunity to contribute.
- The Team reaches consensus on the hypotheses, findings and recommendations.
- Having three Parent Team Members provides a strong "parent voice" throughout the process.
- Team Members demonstrated their first hand knowledge and deep understanding of the issues and constraints that influence service delivery in Birth to Three programs.
- The three Parent Team Members are actual contracted employees and participate in the entire Focused Monitoring visit, which provides consistency in approach and reduces the need for ongoing professional development/training.
- The participation of a Peer Team Member (a director from another Birth to Three program) provides an excellent opportunity for professional development for the peer as well as providing the perspective of a fellow program director that understands the day-to-day realities of managing an early intervention program.
- The Team Leader is a constant throughout the on-site visits ensuring consistency in the process. Her organizational and communication skills enable the visits to go smoothly and the time to be used efficiently. Her thorough understanding of the entire General Supervision system in Connecticut, state and federal requirements, makes her a valuable TA resource to the program(s). Her sense of humor and energy are an asset.
- The reason for selection of the program and the items/indicators that would be addressed on-site are made clear to the program being reviewed from the outset.
- The Desk Audit meeting provides a great opportunity for the Team (and the program) to come together, review data and generate hypotheses about what

factors are contributing to the data result that triggered the program's selection for the on-site visit.

Suggestions for Improvement

- Consider including more than one Peer Team Member on the Focused Monitoring Team to create a better balance between parents and peers and to maximize the opportunity for other program directors to contribute their knowledge and experience as well as to benefit from the process.
- When new Team Members join the Team, consider providing explicit training on the record review process prior to the on-site visit.
- Review the focus areas and criteria for program selection with the Focused Monitoring Stakeholders Group and consider a focus on new/additional priority areas based on Connecticut's State Performance Plan and Annual Performance Report. Increase the emphasis on quality and outcome measures and consider new ways of measurement in addition to record reviews and interviews.
- Separate the generation of strategies to address problem areas and discussion of potential findings from the Desk Audit process. Postpone discussion of findings and strategies until the conclusion of the on-site review.
- The Team Leader is key to a successful on-visit, and to the overall Focused Monitoring process. It may be advisable to train additional DDS staff to take on the Team Leader's role so that there are others who know the process and could be called upon to lead a visit if needed.