



FIRST THINGS FIRST

ARIZONA EARLY CHILDHOOD DEVELOPMENT & HEALTH BOARD

Yavapai Regional Partnership Council

Draft Meeting Minutes

Call to Order

A Regular Meeting of the First Things First - Arizona Early Childhood Development and Health Board was held on Wednesday, January 28, 2015 at 9:00 a.m. The meeting was held at the Yavapai County Cottonwood Annex, Board of Supervisors Room, 10 S. 6th Street, Cottonwood, Arizona 86326.

Chair Birch called the meeting to order at approximately 9:08 a.m.

Members Present:

Sherry Birch, Chair
Dr. Kathy Watson, Vice Chair
Ophelia Tewawina
Olga Morris
Anne Babinsky
Angela Bradshaw Napper (via telephone)
Morgan Dubs

Members Absent:

Patricia Bryant
Juanita Setzer
Jim Howard

Conflict of Interest

Chair Birch asked Council Members if there were conflicts of interest regarding items on this agenda. There were none at this time.

Call to the Public

There were no members of the public who requested to speak at this time.

Review and Approval of Meeting Minutes

Vice Chair Dr. Kathy Watson made a motion to approve the minutes of the December 10, 2014 Regular Meeting of the Yavapai Regional Partnership Council, as corrected. The motion was seconded by Council Member Anne Babinsky and passed unanimously.

First Reading of Governance Policy

Lisa Blyth, Regional Director, presented the governance policy for review. Council Members were asked to review any edits that were made in the governance policy pertaining to the order of the meeting with regard to Council officers and their duties, meetings of the council, meeting procedures, call the public, committee and subcommittees, conflicts of interest, and lobbying and campaigning.

SFY15 Quarter 1 Data and Narrative Reports

Lisa Blyth, Regional Director, provided updates pertaining to the SFY15 Quarter one Data Report, and Narrative Reports.

Review of SFY16 RFGA Process Timeline

Lisa Blyth, Regional Director, provided an overview of the SFY16 RFGA process timeline. Council Members were requested to participate in the RFGA review committee.

Discussion and Possible Approval of New Date for May 2015 Yavapai Regional Council Meeting

Lisa Blyth, Regional Director, requested that the Regular May meeting date be changed from May 27, 2015 to May 20, 2015 to accommodate the RFGA approval timelines. Council Member Anne Babinsky made a motion that the Yavapai Regional Partnership Council May meeting date be changed from Wednesday May 27, 2015 to Wednesday May 20, 2015. The motion was seconded by Vice Chair Dr. Kathy Watson and passed unanimously.

Community Outreach Implementation Plan

Community Outreach Coordinator Jennifer Hernandez provided updates pertaining to Outreach activities for the months of November and December, earned media, learning and celebrations across the region, the Business Fact sheet, Outreach Collateral and a Video Challenge, and upcoming events.

Regional Director's Report

Lisa Blyth, Regional Director reported on a number of updates including: Scope of Work Development for SFY2016 RFGA's; Yavapai Apache Nation partnership; Verde Valley Calendar; and Community Meetings. Administrative Assistant Cindy Pemberton provided updates pertinent to the release of the 2015 Big and Little Kids Books. erde CHIP; Quad city CHIP; Child Care Coalition; Big and Little Kids Book production; Faith Forum; 2015 Yavapai Regional Partnership Council Meeting. Council Member Anne Babinsky requested additional information pertaining to the February retreat.

Regional Council Member Updates and Report

Council Member Anne Babinsky announced that the Framing the Future Luncheon is occurring on Monday March 30, 2015 at the Yavapai College Performance Hall from 10:30 a.m. to 1:00 p.m. Chair, Sherry Birch announced that the Church was awarded a bid to expand their property where the Sonshine Learning Center will be located. Chair, Sherry Birch also shared about the presentation of the funding plan to the State Board.

Next Meeting

A Special Meeting will be conducted on February 25, 2015 in Prescott. The next Regular meeting will be held on March 25, 2015 at Prevent Child Abuse, Conference Room, Prescott Valley, Arizona.

Adjourn

There being no further discussion, the meeting was adjourned at approximately 10:40 a.m.

Telephone Procedures

The Board Room telephone was used for members participating by telephone. Members on the telephone were identified when they spoke for the benefit of those physically present at the meeting.

Sherry Birch, Chair



FIRST THINGS FIRST

ARIZONA EARLY CHILDHOOD DEVELOPMENT & HEALTH BOARD

Yavapai Regional Partnership Council

Draft Meeting Minutes

Call to Order

A Special Meeting of the First Things First - Arizona Early Childhood Development and Health Board was held on Wednesday, February 25, 2015 at 9:00 a.m. The meeting was held at the Gardens at Willow Creek Club House, 1171 Lilac Way, Prescott, Arizona 86305.

Chair Birch called the meeting to order at approximately 9:10 a.m.

Members Present:

Sherry Birch, Chair
Dr. Kathy Watson, Vice Chair
Ophelia Tewawina
Olga Morris
Anne Babinsky
Angela Bradshaw Napper
Morgan Dubs
Patricia Bryant
Juanita Setzer
Dr. Jim Howard
Dr. Paul Tighe (member elect)

Members Absent:

Introductions and Ice Breaker

Council Members participated in a story telling activity to learn more about each other.

Legislative Update

Benjamin Altener, Sr. Director of Government Affairs provided an overview of legislative reports including bills of interest and addressed questions from the Council pertaining to Early Childhood Development and Health. Ben Altener provided examples of ways local citizens including Council Members could advocate for early childhood as well as recommended ways for engaging our legislative representatives. Council Members shared things they have done here and in other states to engage Government officials in their efforts.

System Building Discussion

Lisa Blyth, Regional Director engaged the Council Members in a system building overview and activity to discuss System Building. Council Members were asked brainstorming questions

- 1.) What does the phrase "system building" mean to you?
- 2.) What is your understanding of the system building we are doing the Yavapai Region or of our unfunded strategies?
- 3.) What do you envision as important system building efforts?

Council Members generated a list of ideas for number three that will be included in the Outreach Implementation Plan as well as the work of the Council in the next year. Council Members were provided core message outreach items to distribute amongst their personal and professional connections to further the First Things First message in the Yavapai Region.

Yavapai Region Strategies Standards of Practice Review

The Yavapai Regional Partnership Council tabled the agenda item.

RFGA Process Review

The Yavapai Regional Partnership Council tabled the agenda item.

Messaging Training – Early Childhood Everyday

Community Outreach Coordinator, Jennifer Hernandez provided a power point presentation on effective messaging for First Things First. Jennifer provided each Council Member with a list of outreach efforts asking them to return the form identifying ways in which they are willing to assist with outreach in the region.

Team Building

The Yavapai Regional Partnership Council tabled the agenda item.

Next Meeting

March 25, 2015 at Prevent Child Abuse, Conference Room, Prescott Valley, Arizona

Adjourn

There being no further discussion, the meeting was adjourned at approximately 1:00 p.m.

Sherry Birch, Chair

FY 2015 Yavapai Contract Detail



Attachment 3

| | Grantee Name | Contract Number | Contract Period | Allotment | | YTD Expense | Expense Variance | Award Expended % of Award Expended | Allotment Expended % of Allotment Expended | Reimbursement Activity | | |
|---|---|-------------------------|----------------------------|---------------------------|--------------------|--------------------|------------------|------------------------------------|--|------------------------|---------------------|-----------------|
| | | | | Total Allotment | Awarded | | | | | Pending | Paid (Last 30 Days) | |
| Community Awareness | Community Awareness Strategy | | | Strategy Subtotal: | | \$6,000 | \$6,000 | \$1,626 | \$4,374 | 27.1% | 27.1% | |
| | First Things First (FTF-Directed) | PSC-STATE-15-0723-01 | 07/01/2014-06/30/2015 | | | \$6,000 | \$1,626 | \$4,374 | 27.1% | | | |
| | Community Outreach Strategy | | | Strategy Subtotal: | | \$80,000 | \$80,000 | \$30,798 | \$49,202 | 38.5% | 38.5% | |
| | First Things First (FTF-Directed) | PSC-STATE-15-0724-01 | 07/01/2014-06/30/2015 | | | \$80,000 | \$30,798 | \$49,202 | 38.5% | | | |
| | Media Strategy | | | Strategy Subtotal: | | \$50,000 | \$50,000 | \$20,224 | \$29,776 | 40.4% | 40.4% | |
| First Things First (FTF-Directed) | PSC-STATE-15-0726-01 | 07/01/2014-06/30/2015 | | | \$50,000 | \$20,224 | \$29,776 | 40.4% | | | | |
| | | | Goal Area Subtotal: | | \$136,000 | \$136,000 | \$52,648 | \$83,352 | 38.7% | 38.7% | | |
| Coordination | Court Teams Strategy | | | Strategy Subtotal: | | \$66,500 | \$66,500 | \$25,199 | \$41,301 | 37.9% | 37.9% | |
| | Prevent Child Abuse Arizona | FTF-MULTI-13-0362-02-Y3 | 07/01/2014-06/30/2015 | | | \$66,500 | \$25,199 | \$41,301 | 37.9% | | | |
| | Service Coordination Strategy | | | Strategy Subtotal: | | \$0 | - | - | - | 0.0% | 0.0% | |
| | | | | | | - | - | - | 0.0% | | | |
| | | | Goal Area Subtotal: | | \$66,500 | \$66,500 | \$25,199 | \$41,301 | 37.9% | 37.9% | | |
| Evaluation | Needs and Assets Strategy | | | Strategy Subtotal: | | \$0 | - | - | - | 0.0% | 0.0% | |
| | Arizona Board of Regents acting for and on | ISA-STATE-14-0643-01-Y2 | To Be Determined | | | - | - | - | 0.0% | | | |
| | Statewide Evaluation Strategy | | | Strategy Subtotal: | | \$219,344 | \$219,344 | \$219,344 | - | 100.0% | 100.0% | |
| | First Things First (FTF-Directed) | PSC-STATE-15-0732-01 | 07/01/2014-06/30/2015 | | | \$219,344 | \$219,344 | - | 100.0% | | | |
| | | | Goal Area Subtotal: | | \$219,344 | \$219,344 | \$219,344 | - | 100.0% | 100.0% | | |
| Family Support | Family Support Coordination Strategy | | | Strategy Subtotal: | | \$4,500 | \$4,500 | \$1,921 | \$2,579 | 42.7% | 42.7% | |
| | First Things First (FTF-Directed) | PSC-STATE-15-0744-01 | 07/01/2014-06/30/2015 | | | \$4,500 | \$1,921 | \$2,579 | 42.7% | | | |
| | Home Visitation Strategy | | | Strategy Subtotal: | | \$880,000 | \$815,535 | \$407,030 | \$408,505 | 49.9% | 46.3% | \$52,001 |
| | Arizona Department of Economic Security | ISA-MULTI-14-0636-01-Y2 | 07/01/2014-06/30/2015 | | | \$9,515 | \$4,766 | \$4,749 | 50.1% | | | |
| | Arizona's Children Association | FTF-RC022-13-0372-03-Y3 | 07/01/2014-06/30/2015 | | | \$273,752 | \$121,332 | \$152,420 | 44.3% | | \$19,563 | |
| | Yavapai County Community Health Services | FTF-RC022-13-0372-05-Y3 | 07/01/2014-06/30/2015 | | | \$255,000 | \$133,226 | \$121,774 | 52.2% | | \$13,295 | |
| | Yavapai Regional Medical Center | FTF-RC022-13-0372-02-Y3 | 07/01/2014-06/03/2015 | | | \$277,268 | \$147,706 | \$129,562 | 53.3% | | \$19,144 | |
| | Parent Education Community-Based Training Strategy | | | Strategy Subtotal: | | \$197,500 | \$197,500 | \$81,442 | \$116,059 | 41.2% | 41.2% | \$12,165 |
| | Community Counts (formerly Youth Count) | FTF-RC022-13-0384-01-Y3 | 07/01/2014-06/03/2015 | | | \$150,000 | \$55,377 | \$94,623 | 36.9% | | \$12,165 | |
| | Yavapai College | FTF-RC022-15-0488-01 | 07/01/2014-06/30/2015 | | | \$47,500 | \$26,065 | \$21,435 | 54.9% | | | |
| Parent Outreach and Awareness Strategy | | | Strategy Subtotal: | | \$10,000 | \$10,000 | \$10,000 | - | 100.0% | 100.0% | | |
| First Things First (FTF-Directed) | PSC-STATE-15-0736-01 | 07/01/2014-06/30/2015 | | | \$10,000 | \$10,000 | - | 100.0% | | | | |
| | | | Goal Area Subtotal: | | \$1,092,000 | \$1,027,535 | \$500,393 | \$527,142 | 48.7% | 45.8% | \$64,166 | |
| Health | Child Care Health Consultation Strategy | | | Strategy Subtotal: | | \$169,290 | \$169,290 | \$94,455 | \$74,834 | 55.8% | 55.8% | \$9,753 |
| | First Things First (FTF-Directed) | PSC-STATE-15-0722-01 | 07/01/2014-06/30/2015 | | | \$8,783 | \$8,783 | - | 100.0% | | | |
| | Maricopa County Department of Public Health | GRA-STATE-14-0631-01-Y2 | 07/01/2014-06/30/2015 | | | \$3,011 | \$422 | \$2,589 | 14.0% | | | |
| | Pima County Health Department | GRA-STATE-13-0525-01-Y3 | 07/01/2014-06/30/2015 | | | \$5,476 | \$2,485 | \$2,991 | 45.4% | | \$223 | |
| | Yavapai County Community Health Services | GRA-STATE-13-0511-01-Y3 | 07/01/2014-06/30/2015 | | | \$152,020 | \$82,765 | \$69,255 | 54.4% | | \$9,530 | |
| | Mental Health Consultation Strategy | | | Strategy Subtotal: | | \$307,500 | \$307,500 | \$148,979 | \$158,521 | 48.4% | 48.4% | |
| | Southwest Human Development | FTF-STATE-13-0344-01-Y3 | 07/01/2014-06/30/2015 | | | \$307,500 | \$148,979 | \$158,521 | 48.4% | | | |
| | | | Goal Area Subtotal: | | \$476,790 | \$476,790 | \$243,434 | \$233,355 | 51.1% | 51.1% | \$9,753 | |

| Professional Development | | FTF Professional REWARD\$ Strategy | | Strategy Subtotal: | \$27,000 | \$27,000 | \$20,470 | \$6,530 | 75.8% | 75.8% | |
|--|-------------------------|--------------------------------------|--|--------------------|--------------------|--------------------|--------------------|--------------|--------------|-----------|------------------|
| Valley of the Sun United Way | FTF-STATE-13-0346-01-Y2 | To Be Determined | | | - | \$239 | (\$239) | | 0.0% | | |
| | FTF-STATE-13-0346-01-Y3 | 07/01/2014-06/30/2015 | | | \$27,000 | \$20,231 | \$6,769 | | 74.9% | | |
| Scholarships TEACH Strategy | | Strategy Subtotal: | | \$0 | - | - | - | 0.0% | 0.0% | | |
| | | | | | - | - | - | 0.0% | | | |
| Goal Area Subtotal: | | | | \$27,000 | \$27,000 | \$20,470 | \$6,530 | 75.8% | 75.8% | | |
| Quality and Access | | Family, Friends & Neighbors Strategy | | Strategy Subtotal: | \$30,000 | \$30,000 | \$14,421 | \$15,580 | 48.1% | 48.1% | \$2,795 |
| Association for Supportive Child Care | FTF-MULTI-13-0406-01-Y3 | 07/01/2014-06/30/2015 | | | \$30,000 | \$14,421 | \$15,580 | | 48.1% | \$2,795 | |
| Quality First Strategy | | Strategy Subtotal: | | \$0 | - | - | - | 0.0% | 0.0% | | |
| | | | | | - | - | - | 0.0% | | | |
| Quality First Academy Strategy | | Strategy Subtotal: | | \$35,720 | \$35,720 | \$14,888 | \$20,832 | 41.7% | 41.7% | \$1,355 | |
| Southwest Human Development | FTF-STATE-14-0431-03-Y2 | 07/01/2014-06/30/2015 | | | \$35,720 | \$14,888 | \$20,832 | | 41.7% | \$1,355 | |
| Quality First Assessment Strategy | | Strategy Subtotal: | | \$0 | - | - | - | 0.0% | 0.0% | | |
| | | | | | - | - | - | 0.0% | | | |
| Quality First Child Care Health Consultation Warmline Strategy | | Strategy Subtotal: | | \$2,679 | \$1,918 | \$722 | \$1,196 | 37.6% | 26.9% | | |
| University of Arizona Cooperative Extension | GRA-STATE-14-0629-01-Y2 | 07/01/2014-06/30/2015 | | | \$1,918 | \$722 | \$1,196 | | 37.6% | | |
| Quality First Coaching & Incentives Strategy | | Strategy Subtotal: | | \$470,606 | \$470,340 | \$352,452 | \$117,888 | 74.9% | 74.9% | | |
| Valley of the Sun United Way | FTF-STATE-14-0427-02-Y2 | 07/01/2014-06/30/2015 | | | \$470,340 | \$352,452 | \$117,888 | | 74.9% | | |
| Quality First Inclusion Warmline Strategy | | Strategy Subtotal: | | \$7,770 | \$6,854 | \$3,292 | \$3,563 | 48.0% | 42.4% | \$492 | |
| Southwest Human Development | FTF-STATE-13-0426-01-Y3 | 07/01/2014-06/30/2015 | | | \$6,854 | \$3,292 | \$3,563 | | 48.0% | \$492 | |
| Quality First Mental Health Consultation Warmline Strategy | | Strategy Subtotal: | | \$7,992 | \$7,992 | \$4,366 | \$3,626 | 54.6% | 54.6% | \$583 | |
| Southwest Human Development | FTF-STATE-13-0344-02-Y3 | 07/01/2014-06/30/2015 | | | \$7,992 | \$4,366 | \$3,626 | | 54.6% | \$583 | |
| Quality First Scholarships Strategy | | Strategy Subtotal: | | \$1,735,048 | \$1,735,047 | \$1,303,790 | \$431,258 | 75.1% | 75.1% | - | \$429,093 |
| First Things First (FTF-Directed) | PSC-STATE-15-0738-01 | 07/01/2014-06/30/2015 | | | \$15,565 | \$15,565 | - | | 100.0% | | |
| Valley of the Sun United Way | FTF-STATE-15-0484-01 | 07/01/2014-06/30/2015 | | | \$1,719,482 | \$1,288,225 | \$431,258 | | 74.9% | \$429,093 | |
| Quality First Warmline Triage Strategy | | Strategy Subtotal: | | \$4,332 | \$4,332 | \$2,489 | \$1,843 | 57.5% | 57.5% | \$340 | |
| Southwest Human Development | FTF-STATE-13-0351-02-Y3 | 07/01/2014-06/30/2015 | | | \$4,332 | \$2,489 | \$1,843 | | 57.5% | \$340 | |
| Goal Area Subtotal: | | | | \$2,294,146 | \$2,292,203 | \$1,696,418 | \$595,786 | 74.0% | 73.9% | - | \$434,658 |
| Overall Total: | | | | \$4,311,780 | \$4,245,372 | \$2,757,905 | \$1,487,467 | 65.0% | 64.0% | - | \$508,577 |

Instructions for interpreting data report fields:

*Quarterly Data Submission Status

Quarterly Data Submission Status is not a strategy-specific data field. This is a FTF designated field in a report that indicates within a quarter the number of months of data that were submitted for a single contract out of the three mandatory months for the quarter.

0 = 0 months out of 3 months of data for this quarter were submitted.

Note:

No strategy-specific data fields will be displayed for a contract with a "0" Quarterly Data Submission Status

1 = 1 month out of 3 months of data for this quarter were submitted

2 = 2 months out of 3 months of data for this quarter were submitted

3 = 3 months out of 3 months of data for this quarter were submitted

**Contracted Service Units

Contracted Service Units only appear for a contract's lead strategy

Instructions for reading null and zero as data field values:

Blank data field = A null data field appears if the grantee selected "NA (Not Applicable)" when given a YES/NA option on their data reporting template indicating the specific data field(s) are not a part of their contract

0 = Grantee selected "No" in a YES/NO option on their data reporting template indicating the specific data field(s) were not collected for the quarter

0 = Grantee reported "0" on their data reporting template indicating the specific data field(s) were not collected for the quarter

Data Reports by Regional Partnership Council

Council: Yavapai

Fiscal Year: 2015

Court Teams

| Contract Number/ Grantee Name | Data Field | Contracted Service Units** | First Fiscal Quarter (July-Sept) | Second Fiscal Quarter (Oct-Dec) | Third Fiscal Quarter (Jan-Mar) | Fourth Fiscal Quarter (Apr-Jun) | Fiscal YTD Total |
|-----------------------------------|--|----------------------------|----------------------------------|---------------------------------|--------------------------------|---------------------------------|------------------|
| FTF-MULTI-13-0362-02-Y3 / Prevent | Quarterly Data Submission Status* | | 3 | 3 | | | |
| | Number of court team meetings conducted | | 2 | 3 | | | |
| | Number of children newly served by Court Team Program | | 42 | 37 | | | |
| | Number of children served | 100 | 245 | 282 | | | 282 |
| | Number of children at the end of the quarter (subtracting disenrolled) | | 245 | 282 | | | |
| | Number of children with a court team checklist within one month of entry into the child welfare system | | 42 | 37 | | | |
| | Number of system improvement measures continuing to be implemented | | 16 | 19 | | | |
| | Number of system improvement measures newly implemented during the quarter | | 2 | 3 | | | |
| | Number of trainings conducted | | 4 | 3 | | | |
| | Number of participants attended | 400 | 53 | 40 | | | 93 |
| | Number of professionals attended | | 29 | 31 | | | |
| | Number of Court Appointed Special Advocates (CASA) attended | | 24 | 9 | | | |
| | Number of Baby Court Appointed Special Advocates (Baby CASA) attended | | 0 | 0 | | | |
| | Number of parents attended | | 2 | 0 | | | |

Home Visitation

A data field is flagged in grey for a SFY quarter:

Home visitor caseload for the quarter – when the ratio of home visitors to families served is above 1:20.

Staff turnover for the quarter – when the staff turnover is above 20% (from one quarter to the next).

Client turnover for the quarter - when the client turnover is above 20% (from one quarter to the next).

Clients disenrolled due to moving - when the percent of clients disenrolled due to “moving” is above 20%.

Clients disenrolled due to unable to locate - when the percent of clients disenrolled due to "unable to locate" is above 10%.

| Contract Number/ Grantee Name | Data Field | Contracted Service Units** | First Fiscal Quarter (July-Sept) | Second Fiscal Quarter (Oct-Dec) | Third Fiscal Quarter (Jan-Mar) | Fourth Fiscal Quarter (Apr-Jun) | Fiscal YTD Total |
|---|---|----------------------------|----------------------------------|---------------------------------|--------------------------------|---------------------------------|------------------|
| FTF-RC022-13-0372-02-Y3 / Yavapai Regional Medical Center | Quarterly Data Submission Status* | | 3 | 3 | | | |
| | Number of families newly enrolled during the quarter | | 13 | 8 | | | |
| | Number of families served | 70 | 75 | 83 | | | 83 |
| | Number of families at the end of the quarter (subtracting disenrolled) | | 72 | 79 | | | |
| | Number of families continuing to receive services who have moved out of the region during the quarter | | 0 | 0 | | | |
| | Number of families disenrolled during the quarter | | 3 | 1 | | | |
| | Number of full time equivalent (FTE) home visitors at the end of the quarter | | 2.0 | 2.0 | | | |
| | Homevisitor caseload for the quarter | | 36.0 | 39.5 | | | |
| | Staff turnover for the quarter | | 0 | 0 | | | |
| | Family turnover for the quarter | | 0 | 0 | | | |
| | Families disenrolled due to moving | | 0 | 100.0% | | | |
| | Families disenrolled due to unable to locate | | 0 | 0 | | | |
| | Number of children newly enrolled during the quarter | | 14 | 9 | | | |
| | Number of children served | | 135 | 144 | | | |
| | Number of families who received community based referrals | | 74 | 77 | | | |

| YRMC SCREENINGS | | Quarterly Data Submission Status* | 3 | 3 | | | |
|--|---|-----------------------------------|----------------------|---------------|----------------------------|-----------------------------|------------------|
| | Number of hearing screenings conducted | | 0 | 0 | | | |
| | Number of hearing results forwarded to medical home | | 0 | 0 | | | |
| | Number of families referred and having received an additional evaluation | | 0 | 0 | | | |
| | Number of children received hearing screening | | 0 | 0 | | | |
| | Number of vision screenings conducted | | 0 | 0 | | | |
| | Number of vision results forwarded to medical home (physician of record) for | | 0 | 0 | | | |
| | Number of families that report being referred and having received an additional | | 0 | 0 | | | |
| | Number of children received vision screening | | 0 | 0 | | | |
| | Number of developmental screenings conducted | | 6 | 8 | | | |
| | Number of developmental screening results forwarded to AZEIP, Part B or a | | 0 | 0 | | | |
| | Number of children referred for developmental delay follow-up | | 0 | 1 | | | |
| | Number of children received developmental screening | | 6 | 8 | | | |
| | Number of children receiving screening (children may have received 1-3 types | | 6 | 8 | | | |
| YRMC Health Insurance Enrollment | | Quarterly Data Submission Status* | 3 | 3 | | | |
| | Number of families provided New Enrollment Assistance to AHCCCS/ Medicaid | | 1 | 0 | | | |
| | Number of families provided New Enrollment Assistance to private health | | 0 | 0 | | | |
| | Number of families provided Renewal Assistance to AHCCCS/Medicaid | | 1 | 1 | | | |
| | Number of families not eligible for public insurance (e.g. AHCCCS or IHS) | | 0 | 0 | | | |
| | Number of families referred for new enrollment assistance to AHCCCS/ | | | | | | |
| | Number of families referred for new enrollment assistance to private health | | | | | | |
| | Number of families referred for renewal assistance to AHCCCS/Medicaid | | | | | | |
| | Number of families not eligible for public insurance (e.g. AHCCCS or IHS) | | | | | | |
| | Number of families served | | 2 | 1 | | | |
| Contract Number/ Grantee Name | Data Field | Contracted Service Units** | First Fiscal Quarter | Second Fiscal | Third Fiscal Quarter (Jan) | Fourth Fiscal Quarter (Apr) | Fiscal YTD Total |
| FTF-RC022-13-0372-03-Y3 / Arizona's Children Association | | Quarterly Data Submission Status* | 3 | 3 | | | |
| | Number of families newly enrolled during the quarter | | 5 | 5 | | | |
| | Number of families served | 80 | 60 | 65 | | | 65 |
| | Number of families at the end of the quarter (subtracting disenrolled) | | 52 | 44 | | | |
| | Number of families continuing to receive services who have moved out of the region during the quarter | | 0 | 0 | | | |
| | Number of families disenrolled during the quarter | | 8 | 13 | | | |
| | Number of full time equivalent (FTE) home visitors at the end of the quarter | | 4.0 | 4.0 | | | |

| | | | | | | |
|---|---|--|----------|----------|--|--|
| | Homevisitor caseload for the quarter | | 13.0 | 11.0 | | |
| | Staff turnover for the quarter | | 0 | 0 | | |
| | Family turnover for the quarter | | 5.5% | 15.4% | | |
| | Families disenrolled due to moving | | 25.0% | 15.4% | | |
| | Families disenrolled due to unable to locate | | 0 | 7.7% | | |
| | Number of children newly enrolled during the quarter | | 7 | 8 | | |
| | Number of children served | | 165 | 173 | | |
| | Number of families who received community based referrals | | 97 | 90 | | |
| AzCA SCREENINGS | Quarterly Data Submission Status* | | 3 | 3 | | |
| | Number of hearing screenings conducted | | 7 | 4 | | |
| | Number of hearing results forwarded to medical home | | 1 | 1 | | |
| | Number of families referred and having received an additional evaluation | | 1 | 1 | | |
| | Number of children received hearing screening | | 7 | 4 | | |
| | Number of vision screenings conducted | | 6 | 4 | | |
| | Number of vision results forwarded to medical home (physician of record) for | | 1 | 1 | | |
| | Number of families that report being referred and having received an additional | | 1 | 1 | | |
| | Number of children received vision screening | | 6 | 4 | | |
| | Number of developmental screenings conducted | | 22 | 15 | | |
| | Number of developmental screening results forwarded to AZEIP, Part B or a | | 0 | 1 | | |
| | Number of children referred for developmental delay follow-up | | 0 | 1 | | |
| | Number of children received developmental screening | | 17 | 11 | | |
| | Number of children receiving screening (children may have received 1-3 types | | 21 | 14 | | |
| AzCA Health Insurance Enrollment | Quarterly Data Submission Status* | | 3 | 3 | | |
| | Number of families provided New Enrollment Assistance to AHCCCS/ Medicaid | | | | | |
| | Number of families provided New Enrollment Assistance to private health | | | | | |
| | Number of families provided Renewal Assistance to AHCCCS/Medicaid | | | | | |
| | Number of families not eligible for public insurance (e.g. AHCCCS or IHS) | | | | | |
| | Number of families referred for new enrollment assistance to AHCCCS/ | | | | | |
| | Number of families referred for new enrollment assistance to private health | | | | | |
| | Number of families referred for renewal assistance to AHCCCS/Medicaid | | | | | |
| | Number of families not eligible for public insurance (e.g. AHCCCS or IHS) | | | | | |
| | Number of families served | | 0 | 0 | | |

| Contract Number/ Grantee Name | Data Field | Contracted Service Units** | First Fiscal Quarter (July-Sept) | Second Fiscal Quarter (Oct-Dec) | Third Fiscal Quarter (Jan-Mar) | Fourth Fiscal Quarter (Apr-Jun) | Fiscal YTD Total |
|--|---|----------------------------|----------------------------------|---------------------------------|--------------------------------|---------------------------------|------------------|
| FTF-RC022-13-0372-05-Y3 / Yavapai County Community Health Services | Quarterly Data Submission Status* | | 3 | 3 | | | |
| | Number of families newly enrolled during the quarter | | 17 | 10 | | | |
| | Number of families served | 50 | 57 | 67 | | | 67 |
| | Number of families at the end of the quarter (subtracting disenrolled) | | 54 | 60 | | | |
| | Number of families continuing to receive services who have moved out of the region during the quarter | | 0 | 0 | | | |
| | Number of families disenrolled during the quarter | | 3 | 4 | | | |
| | Number of full time equivalent (FTE) home visitors at the end of the quarter | | 2.0 | 2.0 | | | |
| | Homevisitor caseload for the quarter | | 27.0 | 30.0 | | | |
| | Staff turnover for the quarter | | 0 | 0 | | | |
| | Family turnover for the quarter | | 0 | 0 | | | |
| | Families disenrolled due to moving | | 33.3% | 0 | | | |
| | Families disenrolled due to unable to locate | | 33.3% | 25.0% | | | |
| | Number of children newly enrolled during the quarter | | 0 | 7 | | | |
| | Number of children served | | 31 | 38 | | | |
| | Number of families who received community based referrals | | 70 | 91 | | | |
| SCREENINGS | Quarterly Data Submission Status* | | 3 | 3 | | | |
| | Number of hearing screenings conducted | | 0 | 0 | | | |
| | Number of hearing results forwarded to medical home | | 0 | 0 | | | |
| | Number of families referred and having received an additional evaluation | | 0 | 0 | | | |
| | Number of children received hearing screening | | 0 | 0 | | | |
| | Number of vision screenings conducted | | 0 | 0 | | | |
| | Number of vision results forwarded to medical home (physician of record) for | | 0 | 0 | | | |
| | Number of families that report being referred and having received an additional | | 0 | 0 | | | |
| | Number of children received vision screening | | 0 | 0 | | | |
| | Number of developmental screenings conducted | | 16 | 27 | | | |
| | Number of developmental screening results forwarded to AZEIP, Part B or a | | 0 | 1 | | | |
| | Number of children referred for developmental delay follow-up | | 0 | 0 | | | |
| | Number of children received developmental screening | | 16 | 27 | | | |
| | Number of children receiving screening (children may have received 1-3 types) | | 16 | 27 | | | |

| Contract Number/ Grantee Name | Data Field | Contracted Service Units** | First Fiscal Quarter (July-Sept) | Second Fiscal Quarter (Oct-Dec) | Third Fiscal Quarter (Jan-Mar) | Fourth Fiscal Quarter (Apr-Jun) | Fiscal YTD Total |
|---|---|----------------------------|----------------------------------|---------------------------------|--------------------------------|---------------------------------|------------------|
| YCCHS Health Insurance Enrollment | Quarterly Data Submission Status* | | 3 | 3 | | | |
| | Number of families provided New Enrollment Assistance to AHCCCS/ Medicaid | | | 1 | | | |
| | Number of families provided New Enrollment Assistance to private health | | | 0 | | | |
| | Number of families provided Renewal Assistance to AHCCCS/Medicaid | | | 1 | | | |
| | Number of families not eligible for public insurance (e.g. AHCCCS or IHS) | | | 0 | | | |
| | Number of families referred for new enrollment assistance to AHCCCS/ | | 3 | 2 | | | |
| | Number of families referred for new enrollment assistance to private health | | 2 | 0 | | | |
| | Number of families referred for renewal assistance to AHCCCS/Medicaid | | 0 | 0 | | | |
| | Number of families not eligible for public insurance (e.g. AHCCCS or IHS) | | 0 | 2 | | | |
| | Number of families served | | 5 | 4 | | | |
| FTF-RC022-13-0430-01-Y3 / Verde Valley Medical Center | Quarterly Data Submission Status* | | 3 | 3 | | | |
| | Number of families newly enrolled during the quarter | | 8 | 4 | | | |
| | Number of families served | 40 | 8 | 12 | | | 12 |
| | Number of families at the end of the quarter (subtracting disenrolled) | | 1 | 2 | | | |
| | Number of families continuing to receive services who have moved out of the region during the quarter | | 0 | 0 | | | |
| | Number of families disenrolled during the quarter | | 7 | 3 | | | |
| | Number of full time equivalent (FTE) home visitors at the end of the quarter | | 2.5 | 2.5 | | | |
| | Homevisitor caseload for the quarter | | 0.4 | 0.8 | | | |
| | Staff turnover for the quarter | | 0 | 0 | | | |
| | Family turnover for the quarter | | 0 | 0 | | | |
| | Families disenrolled due to moving | | 28.6% | 0 | | | |
| | Families disenrolled due to unable to locate | | 14.3% | 33.3% | | | |
| | Number of children newly enrolled during the quarter | | 8 | 4 | | | |
| | Number of children served | | 8 | 12 | | | |
| | Number of families who received community based referrals | | 171 | 150 | | | |

Data Reports by Regional Partnership Council

Council: Yavapai

Fiscal Year: 2015

Parent Education Community-Based Training

A blank for a quarter indicates that the grantee answered “no” on the data template to “Did any Program Models complete a series during the month?” which means that no program model series were completed during this quarter.

| Contract Number/ Grantee Name | Data Field | Contracted Service Units** | First Fiscal Quarter (July-Sept) | Second Fiscal Quarter (Oct-Dec) | Third Fiscal Quarter (Jan-Mar) | Fourth Fiscal Quarter (Apr-Jun) | Fiscal YTD Total |
|---|---|----------------------------|----------------------------------|---------------------------------|--------------------------------|---------------------------------|------------------|
| FTF-RC022-13-0384-01-Y3 / Community Counts (formerly Youth Count) | Quarterly Data Submission Status* | | 3 | 3 | | | |
| | Total number of program model completing a series during this reporting period | | 4 | 10 | | | |
| | Total number of adults enrolled in program models across all completed series during this reporting period (duplicated) | | 33 | 64 | | | |
| | Number of adults who completed 100% of the sessions in the completed program models | | 13 | 30 | | | |
| | Number of adults who completed between 75% and 99% of the sessions in the completed program models | | 6 | 21 | | | |
| | Total number of adults who completed a program model series | 360 | 19 | 51 | | | 70 |
| | Total number of adults who did not complete the program model series | | 14 | 13 | | | |
| Contract Number/ Grantee Name | Data Field | Contracted Service Units** | First Fiscal Quarter (July-Sept) | Second Fiscal Quarter (Oct-Dec) | Third Fiscal Quarter (Jan-Mar) | Fourth Fiscal Quarter (Apr-Jun) | Fiscal YTD Total |
| FTF-RC022-15-0488-01 / Yavapai College | Quarterly Data Submission Status* | | 3 | 3 | | | |
| | Total number of program model completing a series during this reporting period | | | 5 | | | |
| | Total number of adults enrolled in program models across all completed series during this reporting period (duplicated) | | | 126 | | | |
| | Number of adults who completed 100% of the sessions in the completed program models | | | 43 | | | |
| | Number of adults who completed between 75% and 99% of the sessions in the completed program models | | | 32 | | | |
| | Total number of adults who completed a program model series | 375 | | 75 | | | 75 |
| | Total number of adults who did not complete the program model series | | | 51 | | | |

Data Reports by Regional Partnership Council

Council: Yavapai

Fiscal Year: 2015

Quality First Scholarships

| Contract Number/ Grantee Name | Data Field | Contracted Service Units** | First Fiscal Quarter (July-Sept) | Second Fiscal Quarter (Oct-Dec) | Third Fiscal Quarter (Jan-Mar) | Fourth Fiscal Quarter (Apr-Jun) | Fiscal YTD Total |
|--------------------------------------|--|----------------------------|----------------------------------|---------------------------------|--------------------------------|---------------------------------|------------------|
| FTF-STATE-15-0484-01 / Valley of the | Quarterly Data Submission Status* | | 3 | 3 | | | |
| | Number of center based providers served | | 30 | 31 | | | |
| | Number of center based providers at the end of the quarter (subtracting disenrolled) | | 28 | 27 | | | |
| | Number of home based providers served | | 4 | 4 | | | |
| | Number of home based providers at the end of the quarter (subtracting disenrolled) | | 4 | 3 | | | |
| | Number of children receiving scholarships at the end of the quarter | | 244 | 263 | | | |
| | Center based providers: Number of infants receiving scholarships | | 17 | 19 | | | |
| | Center based providers: Number of infants receiving scholarships at the end of the quarter (subtracting disenrolled) | | 8 | 6 | | | |
| | Home based providers: Number of infants receiving scholarships | | 1 | 2 | | | |
| | Home based providers: Number of infants receiving scholarships at the end of the quarter (subtracting disenrolled) | | 0 | 1 | | | |
| | Center based providers: Number of toddlers receiving scholarships | | 86 | 103 | | | |
| | Center based providers: Number of toddlers receiving scholarships at the end of the quarter (subtracting disenrolled) | | 53 | 53 | | | |
| | Home based providers: Number of toddlers receiving scholarships | | 6 | 7 | | | |
| | Home based providers: Number of toddlers receiving scholarships at the end of the quarter (subtracting disenrolled) | | 4 | 5 | | | |
| | Center based providers: Number of preschool aged children receiving scholarships | | 232 | 268 | | | |
| | Center based providers: Number of preschool aged children receiving scholarships at the end of the quarter (subtracting disenrolled) | | 163 | 186 | | | |

| | | | | | | |
|--|--|-----|-------|-------|--|-------|
| | Home based providers: Number of preschool aged children receiving scholarships | | 9 | 9 | | |
| | Home based providers: Number of preschool aged children receiving scholarships at the end of the quarter (subtracting disenrolled) | | 5 | 5 | | |
| | Center based providers: Number of children with special needs receiving scholarships | | 5 | 6 | | |
| | Center based providers: Number of children with special needs receiving scholarships at the end of the quarter (subtracting disenrolled) | | 2 | 1 | | |
| | Home based providers: Number of children with special needs receiving scholarships | | 0 | 0 | | |
| | Home based providers: Number of children with special needs receiving scholarships at the end of the quarter (subtracting disenrolled) | | 0 | 0 | | |
| | Number of Infant (0-12 months) slots filled end of the quarter | | 8.0 | 4.5 | | |
| | Number of toddler (13-35 months) slots filled end of the quarter | | 54.5 | 54.0 | | |
| | Number of preschooler (36 months - 5 yrs) slots filled end of the quarter | | 128.5 | 146.0 | | |
| | Number of slots filled with children (0-5 yrs) end of the quarter | 234 | 191.0 | 204.5 | | 204.5 |
| | Number of FTF slots vacant for children (0-5 yrs) | | 88.0 | 74.5 | | |

First Things First

- Regional Needs and Assets Report

School Readiness Indicators (SRI's)

- RPC Prioritizes regional needs in alignment with School Readiness Indicators.
- RPC allots funding to Strategies that align with School Readiness Indicators

Scopes of Work (SOW)

- RPC identifies regionally specific requirements for selected strategy SOW's.
- Regional Director, Program Specialist, and Fiscal Specialist develop SOW to be included in RFGA.

RFGA's (Request For Grant Application)

- RFGA's are released in the region seeking applicants to implement programming that complies with the Standard of Practice for a given strategy and the regional requirements identified by the RPC.
- Review committees selected (RPC members + community members)
- Review committee training

RFGA responses

- Applicants turn in their responses to the RFGA's
- Internal Technical Review
- Committee Review
- Committee Recommendations to RPC in Executive Session
- RPC recommendations to State Board

Awards

- State Board approves or denies regional recommendations
- Award and rejection notices sent to all applicants no later than early June

Implementation

- Awarded grantees begin implementation of programming as described in their RFGA applications

Accountability & Continuous Quality Improvement (CQI)

- Quarterly data submission
- Quarterly narrative reports
- QA site visits
- Grantee presentations to RPC

YAVAPAI RFGA TIMELINE

| Strategy | Reviewers | Release date | Pre App conf | Close date | Technical Review | Training for review committee | Committee Review | Clarification | RPC meeting | State Board |
|-----------------------|---|--------------|-----------------|-------------------|-------------------|-------------------------------|-------------------|---------------------------------------|-------------|-------------|
| Home Visitation RFGA | Olga Kathy Barbara André (Community) | 2.2.15 | 2.11.15 1pm | 3.16.15 9:30am | 3.26.15 12:30p | 3.18.15 11am | 3.31.15 9a-1p | Within 5 days of review committee mtg | 4.22.15 | 5.19.15 |
| Parent Education RFGA | Sherry Morgan Barbara Jorgensen (Community) | 2.2.15 | 2.11.15 9am | 3.30.15 9:30am | 4.8.15 9a | 4.1.15 11am | 4.10.15 9a-1p | Within 5 days of review committee mtg | 4.22.15 | 5.19.15 |
| Court Teams RFGA | Anne Angela | 3.2.15 | 3.11.15 10am | 4.13.15 10am | 4.21.15 10am | April 16 10am | April 30 9a-1p | Within 5 days of review committee mtg | 5.20.15 | 6.8.15 |



Home Visitation

I. INTENT OF STRATEGY

The intent of the evidence based Home Visitation strategy is to provide personalized support for families with young children, particularly as part of a comprehensive and coordinated system. Expected results that are common to home visitation programs include: improved child health and development, increase in children's school readiness, enhancement of parents' abilities to support their children's development; decreased incidence of child maltreatment; and improved family economic self-sufficiency and stability (US Department of Health and Human Services, 2014).

II. DESCRIPTION OF SIGNIFICANCE

The early years of life present an important opportunity for parents to lay the foundation for the healthy development of their children. Parents and families play a pivotal role in shaping their children's lives and preparing them for school. Often the best way to reach families with young children is by bringing services to their home. Home visiting programs have diverse goals, but they share a common focus on the critical role parents play in shaping the lives of their children. These programs typically send individuals into the homes of families with young children to gain an understanding of the families' needs. Services are tailored to those needs and seek to improve family health and well-being by providing parenting information; access and connection to broad-based health, economic, and/or social service resources; and support for parents throughout the child's first few years. Home visiting programs can range in intensity and vary with respect to the age of the child, the risk status of the family, the background and training of the home visitor, and the range of services offered.

Decades of research and evidence demonstrates that home visitation can be an effective method of delivering family support and child development services (Mathematica, 2014). A variety of evidence-based models exist to address the spectrum of universal, targeted, or specialized needs of particular populations such as first time parents, teen parents, families at-risk for abuse-neglect, or low income families. The experience and credentials of the home visitor, the duration and intensity of the visits, and the end goal or focus of the intervention are critical to implementation and intended impacts. Yet, the common ground that unites home visitation program models is the importance placed on infant and toddler development. Comprehensive, evidence-based home visitation programs provide participating families of infants and toddlers with information, education and support on parenting, child development and health topics while simultaneously assisting with connections to other resources or programs as needed. Having a portfolio of high-quality home visiting programs is beneficial for serving the diverse needs of Arizona's children and families.

An evidence-based home visitation program is implemented in response to findings from a needs assessment that includes home visiting as a primary service delivery strategy (excluding programs with infrequent or supplemental home visiting) and is offered on a voluntary basis to families expecting a baby or families with infants or toddlers. Home visiting is defined as a voluntary enrollment program in which early childhood and health professionals (such as nurses, social workers) or trained and supervised paraprofessionals repeatedly visit - over a period of at least six months - the homes of pregnant women or families with children birth to age 5 who are born with or exposed to one or more risk factors.

III. IMPLEMENTATION STANDARDS

A. Program Standards

First Things First (FTF) is committed to funding programs that are evidence based or evidence informed. The emphasis on evidence-based programs is grounded in the idea that the maximum benefit for children and families is delivered by programs that base their practice in the most current, relevant, and reliable evidence about the effectiveness of the program. For some programs, an evidence-informed or best practice, or a promising practice model is appropriate. The following criteria are considered by FTF when determining to fund programs:

- **Evidence based programs** are programs that have been validated by documented and scientific research and the evidence has gone through a peer review process. Evidence is established through scientific research that has had a comparison between an intervention group and a control group where the intervention group has had a significant impact. Peer review means that someone external to the program or research team has reviewed the methodology and the findings to determine if standards were met.
- **Evidence informed** is a program or service that has a clearly articulated theory of change (logic model) and has had some evaluation of the outcomes. This can be based on one program or service model that has been evaluated in multiple settings. An evidence informed program cannot be based on the evaluation of a program in only one setting, even if it has been done for many years in a community and everyone likes it.
- **Promising practice** is a program or service that has a clearly articulated theory of change (logic model) with specified implementation and operational processes (activities) and program outcomes. A promising practice program is *informed* by at least one of the following:
 - Evidence based practices of a similar program or service delivery system, but does not have complete fidelity to that model because of justifiable need to change factors such as staffing or written materials in order to adapt to geographic or cultural variation.
 - A similar program or service delivery model that is generally accepted as appropriate for use with the target population to achieve the program outcomes but has yet to be established as evidence based.
 - Culturally responsive practices that are known to contribute positively to program outcomes.

A promising practice must have no evidence that the program or service will cause any harm to recipients. Additionally, a promising practice program is committed to building evidence of program or service effectiveness through ongoing continuous quality improvement activities.

1. Implement an evidence based program that meets the First Things First accepted definition of that model:
 - a. Implement an evidence based home visitation program model. Examples of commonly implemented evidence-based program models and their characteristics include:
 - **Nurse Family Partnership (NFP)** aims to improve pregnancy outcomes, child health and development, maternal life course development, and the economic self-sufficiency of the family. Specially trained, registered nurses with bachelor's degrees (master's degrees preferred) provide ongoing home visits that start while the mother is pregnant and continue until the child reaches age 2. Guidelines are provided for each visit, but nurses use a variety of developmental screenings and diagnostic tools to tailor the program to the specific needs of each family. Willing participants must be low-income, first time mothers willing to receive their first home visit by the 28th week of pregnancy. These mothers initially receive home visits every week for the first month after enrollment and then every other week until the baby is born. Once the baby is born, families receive visits weekly for the first six weeks, and then every other week until the baby is 20 months. The last four visits are monthly until the child is 2 years. These visits typically last 60 to 75 minutes, but the schedule may be adjusted to meet client needs. During these visits, nurses help ensure that mothers receive the care and support they need to have a healthy pregnancy, provide responsible and competent care for their children, and become economically self-sufficient.
 - **Healthy Families America (HFA)** targets at-risk families to help them cultivate and strengthen parent-child relationships, promote healthy child development, and enhance family functioning by reducing risk, building protective factors, and focusing on building strengths rather than correcting weaknesses. To receive services, families must be enrolled while the mother is pregnant or shortly after birth, and they must complete a comprehensive assessment to ascertain the presence of risk factors. Individual providers determine other criteria for enrollment, such as being a single parent or suffering from substance abuse or mental health issues. Visits are initiated prenatally or within the first three months of birth and include weekly visits until the child is 6 months old, at which point the visits may become less frequent depending on the needs of the family. Services can continue until the child is 3 to 5 years old.
 - **Parents As Teachers (PAT)** aims to increase parenting knowledge of early childhood development, improve parenting practices, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness and school success. Parents receive one-on-one home visits from degreed professionals and paraprofessionals who have previous

experience working with children or families. Parents also have access to monthly group meetings, developmental screenings, and information about other resources available to their family. The PAT curriculum provides structure (e.g., personal visit plans and guided planning tools), but it also can be individualized to meet the diverse needs of families.

- **Family Spirit** is designed for Native American mothers and their children. It aims to promote mothers' parenting, coping, and problem-solving skills to address factors such as demographic challenges, family-of-origin problems, and personal stressors. The curriculum, which incorporates traditional tribal teachings, consists of 63 independent lessons in six domains. When the full curriculum is appropriate, Family Spirit recommends initiating the program with weekly visits at 28 weeks gestation and tapering to bimonthly visits until the child's third birthday. Paraprofessional Health Educators conduct the visits, which are typically 45 to 90 minutes in duration. Family Spirit recommends that Health Educators come from the participating community and have familiarity with the tribal culture, traditions, and language.
 - **Home Instruction for Parents of Preschool Youngsters (HIPPY)** aims to: (a) prepare children for success in school and all aspects of life, (b) empower parents to be their child's first teacher, and (c) provide parents with the skills, confidence, and tools needed to successfully teach their child in their home. The ultimate goal is to help parents provide educational enrichment for their preschool child (aged 3 to 5) and promote children's school readiness. HIPPY targets parents who are primarily in at-risk communities and lack confidence in their own abilities to instruct their children, perhaps because these parents struggled academically, do not speak English, and/or did not graduate high school. HIPPY services include weekly, hour-long home visits for 30 weeks a year, and two-hour group meetings monthly (or at least six times a year). The HIPPY curriculum uses role play as the method for teaching parents the skills needed to implement the curriculum with their child. Parents receive 30 weeks of activity packets and storybooks to use with their children. Parents work on these activities with their children during the home visits and also are instructed to spend 15 to 20 minutes a day completing the activities.
 - **Early Head Start-Home Visiting (EHS)** aims to: (a) promote healthy prenatal outcomes for pregnant women, (b) enhance the development of young children, and (c) stimulate healthy family functioning. EHS can be offered in a center-based or home-based based format. In the home-based format referred to in the remainder of this report, EHS home visitors have a Child Development Associate (CDA) credential plus knowledge and experience in child development and early childhood education, principles of child health, safety, and nutrition, adult learning principles, and family dynamics. EHS services include a weekly, 90-minute, home visit and two group socialization activities per month for parents and children. However, there is no set curriculum for EHS visits. Each site determines the curriculum used.
- b. Maintain good standing and current affiliation with the national organization or institution for the home visiting program model.

- c. Ensure fidelity to model requirements regarding program implementation:
- Frequency and duration of services;
 - Staffing ratios and caseload management (in cases where the program model does not specify a maximum caseload per home visitor, adhere to FTF's maximum caseload for a home visitor of 20 families);
 - Developmental and sensory screenings conducted according to the schedule in the program model for the developmental domains: social emotional, language and communication, cognitive, physical, and motor development as identified by the American Academy of Pediatrics (2008). If program model does not indicate a schedule for screening, use at minimum, the schedule recommended by the American Academy of Pediatrics (recommended age intervals of 9, 18 and 30 months and annually thereafter). Home visitors conducting the developmental and sensory screenings must adhere to the FTF Developmental and Sensory Screenings Standards of Practice (see attached).
 - Participation in evaluation and quality assurance (including fulfillment of data reporting requirements as per program model);and,
 - Professional development and staff education requirements.
- d. Offer information, education and coaching to parents and families in all of the core areas of family support:
- **Expand the parent's knowledge of child development and behavior** – Provide education and learning opportunities to families around all the domains of child development (i.e., social and emotional, language, general knowledge, physical and motor development, and approaches to learning); understanding typical and atypical child development; recognizing age appropriate child expectations; and identifying developmental milestones and developmental red flags.
 - **Support positive parenting practices** – Provide education and learning opportunities to families around appropriate parent and child interactions; development of parenting skills; positive discipline; warm, sensitive and responsive caregiving.
 - **Improve child safety** – Provide education and learning opportunities for families to increase their awareness of prevention of injuries in the child's environment and removing them or making adjustments (e.g., safe sleep, choking hazards, and use of car seats).
 - **Improve child health** – Provide education and learning opportunities for families around nutrition; obesity prevention; breastfeeding; physical activity; immunizations; oral health; insurance enrollment; participation in consistent medical/dental homes; participation in prenatal care; preventative services such as well child visits; developmental health; vision and hearing screening.
 - **Contribute to family stability** – Provide information about supports to families that improve their stability and functioning; meet their basic needs; parental functioning and mental health (e.g., warmth, emotional availability, and stimulation); promote stable relationships among caregivers, positive parenting, and family cohesions.

- **Promote strong family relationships** – Provide information about supports aimed at increasing the support network and community involvement of the family.
- e. Actively involve and engage families in all aspects of service delivery:
- Conduct awareness, outreach and enrollment activities for eligible families who are expecting or parenting a child 5 years and younger.
 - Provide the family with a program handbook upon enrollment. The program handbook includes the following information:
 - Program philosophy and goals;
 - Program calendar;
 - Attendance policy;
 - Confidentiality policy;
 - Use of family-centered practices;
 - Expectation for parent/family participation; and
 - Ways families can promote learning at home and within the community to help their child be successful in an early education environment.
 - Engage families in assessing their strengths and needs around the core areas of family support using a standardized assessment form and maintain a record of the assessment in the confidential child and/or family file.
 - Develop a written family service plan that includes specific goals, objectives based upon the strengths and needs assessment and other program tools, timeframe for task completion, periodic reviews (at least quarterly), and future planning for transition from the home visitation program as appropriate. Provide the family with a copy the family service plan including updated plans. Maintain a record of the family service plan in the confidential child and/or family file.
 - Assist families in developing skills related to observing and understanding their child’s ongoing growth and developmental progress. This includes the parent’s understanding and ability to read their infant’s cues and developmentally appropriate expectations for infant and toddler behavior.
 - Ensure families receive information about developmental and sensory screening results, and appropriate referral if needed.
 - Connect families with the most appropriate provider and/or agency when developmental or health related concerns are noted.
 - Provide resource and referral information and assist families by linking them to needed and available services. Document in the case record where families received the referred services. Maintain a record of the referrals made on behalf of the family in the confidential child and/or family file.
- f. Incorporate family-centered practice into service delivery including the following components of family-centered practice:
- Involve families in the planning, development and implementation of the program. Activities and services are developed in response to the needs and interest of the family.

- Structure activities compatible with the family’s availability and accessibility. Home visiting programs will offer non-traditional hours of operation including extended evening and weekend visits if needed for family participation.
 - Structure activities compatible with the parent or caregiver’s limitations or special needs.
 - Support the growth and development of all family members; encourage families to be resources for themselves and others.
 - Strengthen parent’s capacity to advocate for themselves within institutions and agencies.
 - Periodically, but no less than once a year, create both formal and informal opportunities for families to offer feedback about services delivered. Take action based on family’s feedback and ensure that feedback is considered in future systemic decision making.
 - Make reasonable efforts to include all household members (as appropriate) – including fathers, grandparents, and children.
- g. Incorporate strength-based approach to service delivery, which focuses on the family’s abilities, assets, needs and interests. Include the following components of strength-based practice:
- Staff members work with family members in relationships based on equality and respect to identify their strengths, resilience and resources.
 - Encourage family members to build upon their strengths by enhancing their capacity to understand and promote their own optimal cognitive, social, emotional, and physical development.
 - Assist families to learn how to advocate for their children within a variety of settings including early education, health services, and human services agencies.
 - Help families identify and acknowledge informal networks of support and community resources.
2. Literacy learning in early childhood provides the foundation for future literacy success and is rooted in exposure to rich language experiences and engaging activities that build knowledge, understanding and speaking, expands vocabulary, and supports a child’s ability to become a successful independent reader.
- a. Promote and support meaningful early literacy experiences and opportunities for young children in the appropriate context of program implementation.
- Provide education and learning opportunities for parents to learn about early language and emergent literacy development.
 - Inform parents about pre-literacy skills needed for literacy: print concepts, phonological awareness, vocabulary development, comprehension, analysis of the content and structure of text, and making meaning through drawing and writing.
 - Provide information to increase parents’ awareness of the use of languages to communicate, respond to and elaborate on child’s vocalizations (e.g., daily storytelling, talking, singing to infant and child).

- b. Support families and caregivers with parenting and child-rearing skills that help increase understanding of early language and emergent literacy development.
 - c. Engage families in meaningful, day to day two-way communication about how a child develops language and early literacy skills.
 - d. Encourage families to use the language in which they are most confident and competent.
 - e. Encourage parents and families to learn how to observe, guide, promote, and participate in everyday language and literacy development of their children at home, early care, and in their communities.
 - f. Encourage parents and families to advance their own learning interests in language and literacy development through education, training, and other experiences that support their parenting, careers, and life goals.
 - g. Encourage parents and families to support and advocate for their child's learning and development as they transition to new learning environments.
3. Follow the FTF Child Welfare Policy (attached) when working with children and families enrolled in services provided by the Arizona Department of Child Safety to promote non-duplication and coordination of child welfare services.
4. FTF recognizes the importance of collaborative partnerships among community partners that utilize a variety of formal and informal mechanisms to facilitate coordination of services in the community. The Coordination and Collaboration standard requires a grantee to:
 - a. Develop and implement a plan to understand and make connections with other initiatives, strategies and efforts in the region or state that support the early childhood system.
 - b. Develop processes that ensure staff implementing FTF funded strategies understand the connections between this strategy and the early childhood system to avoid duplication of services and promote collaboration between other services and supports offered to children and families in the regions.
 - c. Link families to other supports and services in the community by offering referrals to available providers as needed.
 - d. Provide service coordination with other home visiting programs and community service resources to minimize duplication and to ensure families receive comprehensive services as needed.
 - e. Utilize community reports (e.g. Regional Needs and Asset Reports) to develop a collaborative and coordinated response to community needs (i.e., establish a plan that addresses how the home visitation program will address the needs and utilizes the strengths of the community).
5. Continuous Quality Improvement
 - a. Adopt a process of continuous self-monitoring and reflection to improve program practices that is articulated in a written policy.
 - b. In the written policy, the following should be addressed:

- How data is used to assess the progress and outcomes of program implementation; and
 - How data collection is used to improve staff performance.
6. FTF embraces cultural responsiveness as an intentional life long journey that holistically explores, honors, and values the diversity of the human experience.
- a. Offer programs and services congruent with the needs of diverse children and families.
 - b. Offer programs and services that are responsive to the impact of cultural factors such as histories, traditions, values, family systems and structures, social class, and religion and spiritual beliefs.
 - c. Create a learning environment conducive to and includes all children and families no matter their ethnic, cultural, or linguistic backgrounds.
 - d. Use the cultural knowledge, prior experiences, frames of reference, and performance styles of diverse children and families to make learning more appropriate and effective for them.

B. Staffing Standards

1. Direct Service Staff
 - a. Hire staff who reflect the cultural and ethnic experiences and language of the targeted population with whom they work with and integrate their expertise into the entire program.
 - b. Ensure that staff at all levels receives initial and ongoing professional development in culturally and linguistically responsive service delivery.
 - c. Employ well-trained and competent staff and provides continual relevant professional development opportunities.
 - d. Home visitors are required to have a minimum of a bachelor's degree in early childhood development, education, family studies, human development, nursing, social work or a closely related field. Home visitors without a related bachelor's degree must meet the educational requirements prescribed by the program model.
 - e. Wages and benefits are adequate for supporting highly qualified and bachelor level staff.
 - f. Prior to serving families, staff must have professional training or have participated in development opportunities to ensure a level of competency in service delivery.
 - g. The home visitor's knowledge, skills and abilities must be assessed prior to independent work with families.
 - h. Home visitors must receive ongoing staff development and training to ensure program quality and give staff and an opportunity to develop professionally.
 - i. Prepare and implement a professional development plan for all home visitors and supervisors.
 - j. Provide staff with initial training on the FTF Home Visitation Standards of Practice principles and other required Standards of Practice as appropriate. Staff includes supervisors, direct service staff, volunteers, and sub grantees or partner personnel implementing the strategy.

- k. All staff including direct service staff, supervisors, volunteers, sub grantee or partner personnel implementing the strategy must receive professional development on the utilization of the Arizona Infant and Toddler Developmental Guidelines through the Arizona Department of Education.
 - l. Ensure staff receive training and information regarding the mandatory reporting of child abuse and neglect. (See Section C. Additional Standards, and the attached FTF Suspected Child Maltreatment Mandated Reporting Policy.)
2. Supervisory Staff
- a. Establish an effective, consistent supervisory system that provides support for all staff members and ensures accountability to participants, funders, and the community.
 - b. Ensure home visitors have access to regular supervision. Establish supervision as a collaborative process with mechanisms that support staff in difficult situations and provides ongoing opportunities between staff members and supervisors to reflect and debrief. Supervision must include observation of in-home service delivery. It is important that supervisors spend time with home visitors in the community to have a sense of how the service is being delivered. This assists the supervisor and staff identify coaching and mentoring opportunities.
3. The Arizona Early Childhood Workforce Registry (Registry)
- The Registry is a component of the newly developed Arizona Early Childhood Career and Professional Network (Network). The Network is a comprehensive system designed to meet the professional development needs of Arizona’s early childhood professionals working with or on behalf of children birth-8 years of age.
- a. Staff employed at the administrative home and any sub-grantee who are working directly with or on behalf of children birth – age 8 as a part of the implementation of this strategy must enroll in the Registry by June 30, 2016.
 - b. All participants of this strategy are expected to enroll in the Registry by June 30, 2016.

C. Additional Standards

- 1. Arizona law (ARS §13-3620.A) requires early childhood program staff who suspect that a child has received non-accidental injury or has been neglected, to report their concerns to the Arizona Department of Child Safety or local law enforcement. All staff, grant partners, consultants and participants of this strategy must receive training and adhere to these requirements (see attached FTF Suspected Child Maltreatment Mandated Reporting Policy).
- 2. Developmental and Sensory Screening is a required secondary strategy associated with the Home Visitation strategy. See the Developmental and Sensory Screening Standard of Practice (attached).

IV. REFERENCES AND RESOURCES

- A. US Department of Health and Human Services. (2014). Home Visiting Evidence for Effectiveness, Outcomes. Retrieved from: <http://homvee.acf.hhs.gov/outcomes.aspx>

- B. Mathematica Policy Research. (rev. 2014). Home Visiting Evidence of Effectiveness Review: Executive Summary. Retrieved from:
<http://www.mathematica-pr.com/earlychildhood/evidencebasedhomevisiting.asp>
- C. American Academy of Pediatrics. (2008). Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, 3rd Ed.: Promoting Child Development. Retrieved from: http://brightfutures.aap.org/pdfs/guidelines_pdf/3-promoting_child_development.pdf
- D. Developing a Thriving Reader from the Early Years: A Continuum of Effective Literacy Practices (available in Fall 2014)
- E. FTF Child Welfare Policy (attached)
- F. FTF Suspected Child Maltreatment Mandated Reporting Policy (attached)
- G. Arizona Early Childhood Career and Professional Development Network Website: azearlychildhood.org (available Fall 2014)
- H. Arizona Department of Education
Trainings <http://www.ade.az.gov/onlineregistration/SelectEvent.asp?viewall=%22yes%22&GroupID=31>
- I. ZERO TO THREE National Center for Infants, Toddlers and Families.
(2014). <http://www.zerotothree.org/public-policy/infant-toddler-policy-issues/home-visit.html>
- J. US Department of Health and Human Services. Maternal Infant Early Childhood Home Visiting Programs. (2014). <http://mchb.hrsa.gov/programs/homevisiting/>



Parenting Education

I. INTENT OF STRATEGY

The intent of the evidence informed Parenting Education strategy is to offer learning activities designed to increase the knowledge and skills of parents and families to promote positive parenting practices that result in enhanced child health and development when utilized by parents and caregivers. The expected results of effective parenting education programs are increased parental knowledge of child development and parenting skills, improved parent and child interactions, and more effective parental monitoring and guidance, decreased rates of child maltreatment, and better physical, cognitive and emotional development in children (Samuelson, 2010).

II. DESCRIPTION OF SIGNIFICANCE

All children need caring parents and adults who provide nurturing and stable relationships for optimal developmental outcomes and success in school and life. “But even the most educated parents cannot provide all of the learning tools children need, and many parents have not been prepared with an understanding of how children learn and develop” (Tangible Steps toward Tomorrow, 2007). Evidence exists that some types of parenting education programs can help parents and caregivers do a better job of parenting. According to Bavolek (2002), parenting runs along two continuums: abusive and nurturing. Nurturing parenting behaviors equate to less incidence of abuse. Teaching parents and caregivers how to be supportive, set boundaries, and have appropriate expectations for children can help enhance the nurturing behaviors.

Based upon the Index of Arizona’s Early Childhood Opportunities (Building Bright Futures 2013), it is known that Arizona’s parents and families with young children need more information on child development to develop parenting skills and have access to resources that support them in their role as parents and their child’s most important teacher. Recognizing that parents and families play the most critical role in shaping their young child’s readiness for school and potential for success in life, it is important to invest in a continuum of family support strategies, which include parenting education, to support parents and families. Evidence-based parenting education provides Arizona’s families with access to information about optimal child development and positive parenting practices.

Parenting education works to enable families to build on their own strengths and capacities to promote the healthy development of children. Evidence-based parenting education programs are those that have been studied in both controlled clinical trials and community settings and have demonstrated specific, expected outcomes. However, the effectiveness of any parenting education

program will be dependent upon selecting an evidence-based model that is appropriate for the given population and implemented with fidelity (Meeker, 2005).

Parenting education programs maintain a clear and consistent focus on parenting skills and child development information. They work to strengthen family level protective factors through emphasizing family strengths. Successful parenting education programs facilitate the acquisition of parenting and problem solving skills necessary to strengthen families. Effective parenting education programs help parents and families understand the importance of developing nurturing, positive and strong relational bonds with their young child to support children's social-emotional development, provide information on parenting and child development, increase parent resilience and social connections, and provide connections to concrete assistance to families in times of need (Zepeda, Varela & Morales, 2004).

Effective parenting education programs are offered in a series consisting of a prescribed number of sessions. Parenting education programs that include regular and repeated exposure to a concept or a skill helps parents to integrate the skill into their everyday parenting habits. It is essential to follow tested and proven program design with fidelity in order to maximize parent education program effectiveness. For example, condensing an evidence-based program to a shorter time period or providing all of the course material at once in a mailing rather than at each class session as recommended is likely to undermine the overall effectiveness of a program.

Parenting education program models must dedicate a portion of each session to focus on parent and child interaction. Fundamental to the program model is the engagement of parents and caregivers with their children in developmentally appropriate activities that encourage parent bonding, early literacy, and school readiness. Parenting education programs may offer child care while family members participate in adult-only segments of the session. Parenting education programs that offer on-site child care must adhere to the First Things First (FTF) Requirements for On-Site Child Care (attached).

Parenting education programs funded by FTF will be offered to families of young children at no-cost and on a voluntary basis.

III. IMPLEMENTATION STANDARDS

A. Program Standards

FTF is committed to funding programs that are evidence based or evidence informed. The emphasis on evidence-based programs is grounded in the idea that the maximum benefit for children and families is delivered by programs that base their practice in the most current, relevant, and reliable evidence about the effectiveness of the program. For some programs, an evidence-informed or best practice, or a promising practice model is appropriate. The following criteria are considered by FTF when determining to fund programs:

- ***Evidence based programs*** are programs that have been validated by documented and scientific research and the evidence has gone through a peer review process. Evidence is

established through scientific research that has had a comparison between an intervention group and a control group where the intervention group has had a significant impact. Peer review means that someone external to the program or research team has reviewed the methodology and the findings to determine if standards were met.

- **Evidence informed** is a program or service that has a clearly articulated theory of change (logic model) and has had some evaluation of the outcomes. This can be based on one program or service model that has been evaluated in multiple settings. An evidence informed program cannot be based on the evaluation of a program in only one setting, even if it has been done for many years in a community and everyone likes it.
- **Promising practice** is a program or service that has a clearly articulated theory of change (logic model) with specified implementation and operational processes (activities) and program outcomes. A promising practice program is *informed* by at least one of the following:
 - Evidence-based practices of a similar program or service delivery system, but does not have complete fidelity to that model because of justifiable need to change factors such as staffing or written materials in order to adapt to geographic or cultural variation.
 - A similar program or service delivery model that is generally accepted as appropriate for use with the target population to achieve the program outcomes but has yet to be established as evidence-based.
 - Culturally responsive practices that are known to contribute positively to program outcomes.

A promising practice must have no evidence that the program or service will cause any harm to recipients. Additionally, a promising practice program is committed to building evidence of program or service effectiveness through ongoing continuous quality improvement activities.

1. Implement an evidence-based model that meets the FTF accepted definition of this program model:
 - a. Implement one or more of the parenting education evidence-based models from the following list of FTF accepted program model list.
 - **1-2-3 Magic** targets all parents and caregivers with children two to 12 years of age. 1-2-3 Magic is taught in a group format and delivered in three 2-hour sessions. 1-2-3 Magic divides the parenting responsibilities into three straightforward tasks: controlling negative behavior, encouraging good behavior, and strengthening the child-parent relationship. The program seeks to encourage gentle, but firm, discipline without arguing, yelling, or spanking.
 - **Active Parenting** targets all parents and caregivers with children one to 12 years of age. The program was found effective with families from diverse cultural backgrounds and living in urban, suburban, rural communities. Active Parenting (4th Edition) is conducted in one 2-hour session per week for 6 weeks. **1,2,3,4 Parents!** program and video series is specifically for parenting children one through four years of age. 1,2,3,4 Parents! is implemented in three 90 minute sessions and a

participant must complete all three sessions. The program teaches parents how to raise a child by using encouragement, building the child's self-esteem, and creating a relationship with the child based upon active listening, effective communication, and problem solving. It also teaches parents to use natural and logical consequences and other positive discipline skills to reduce irresponsible and unacceptable behaviors.

- **Common Sense Parenting** targets all parents and caregivers with children two to five years of age. Common Sense Parenting is a group-based series for parents comprised of seven weekly, 2-hour sessions led by a credentialed trainer who focuses on teaching practical skills to increase children's positive behavior, decrease negative behavior, and model appropriate alternative behavior.
- **Early Childhood Systematic Training for Effective Parenting** targets all parents and caregivers with children birth to six years of age. The program was found effective with families identified as at-risk for parenting problems and child maltreatment. Systematic Training for Effective Parenting (STEP) provides skills training for parents dealing with frequently encountered challenges with their children that often result from autocratic parenting styles. STEP is presented in a group format taught in 7 weekly, 1.5-hour sessions facilitated by a counselor, social worker, or individual who has participated in a STEP workshop. The parent educator teaches lessons to parents on how to understand child behavior and misbehavior, practice positive listening, give encouragement (rather than praise), explore alternative parenting behaviors and express ideas and feelings, develop their child's responsibilities, apply natural and logical consequences, convene family meetings, and develop their child's confidence.
- **Eating Smart, Being Active** targets low income pregnant and parenting mothers with children birth to five years of age. The curriculum consists of eight core sessions, each 60 to 90 minutes long, designed to be taught in a series. The teaching techniques in the program model of Eating Smart, Being Active are based on the adult learning principle, dialogue-based learning or learner-centered education.
- **The Incredible Years** targets all parents and caregivers with children birth to 12 years of age. The program was found effective with families identified as at-risk for parenting problems and child maltreatment. The parent, child, and teacher training interventions that comprise Incredible Years are guided by developmental theory on the role of multiple interacting risk and protective factors in the development of conduct problems. There are separate parenting series for infants (0-1 year), toddlers (1-3 years), preschoolers (3-5 years) and school age children (6-12 years). The parenting series focus on strengthening parent-child interactions and attachment, reducing harsh discipline and fostering parents' ability to promote children's social, emotional, and language development.
- **Nurturing Parenting Program** targets all parents and caregivers with children birth to 18 years of age. The program was found effective with families identified as at-risk for parenting problems and child maltreatment. There are separate parenting series for infants (0-1 year), toddlers (1-3 years), preschoolers (3-5 years) and school

age children (6-12 years). The parenting series focus on strengthening parent-child interactions and attachment, reducing harsh discipline and fostering parents' ability to promote children's social, emotional, and language development. Parents and their children meet in separate groups that meet concurrently. The Nurturing Parenting Programs are family-based programs utilized for the treatment and prevention of child abuse and neglect.

- **Raising A Reader** targets all parents and caregivers with children two to eight years of age. Raising A Reader helps parents develop the habit of sharing books through RAR's train the trainer model. It offers agencies who work with families the opportunity to build a positive connection with families to help them learn family friendly versions of research-based practices that will support book sharing at home.
- **Strengthening Families Program** targets all parents and caregivers with children three to five years of age. The program was found effective with families identified as at-risk for parenting problems and child maltreatment and families from diverse cultural backgrounds and living in urban, suburban, rural communities.) Strengthening Families Program is a two hour, 14-session, parenting skills, children's life skills, and family life skills training program specifically designed for high-risk families. SFP is widely used also as a universal primary prevention intervention and builds on protective factors by improving family relationships, parenting skills, and improving the children's social and life skills.
- **Triple P** targets all parents and caregivers with children birth to 16 years of age. The program was found effective with families identified as at-risk for parenting problems and child maltreatment and families from diverse cultural backgrounds and living in urban, suburban, rural communities. Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. It incorporates five levels of intervention on a tiered continuum of increasing strength for parents of children and adolescents from birth to age 16.
- **Tuning in to Kids** targets all parents and caregivers with children 18 months to 18 years of age. The program was found effective with families identified as at-risk for parenting problems and child maltreatment. Delivery options range from a 6-session program with the general community through to a 10-session program for clinical/high need participants. Tuning in to Kids is a parenting program that focuses on emotions and is designed to assist parents to establish better relationships with their children. The program teaches parents simple emotion coaching skills: how to recognize, understand, and manage their own and their children's emotions.

- b. Maintain good standing and current affiliation with the national organization or institution for the parenting education program model being implemented.
- c. Ensure fidelity to model requirements regarding program implementation; adhere to program model in all areas including:
 - Intensity and dosage for achieving the intended outcomes of the program model;

- Staffing ratios and class size (the maximum number of participants is 25 per class session);
 - Series length (number of sessions in a series and length of each session may not be altered without consultation from model developers);
 - Participation in evaluation and quality assurance (including fulfilment of the data reporting requirements as per program model); and
 - Training and professional development of program staff.
- d. Know the target population and their specific strengths and needs
- Select program models for implementation based on the needs of the community, feedback from families and key informants
 - Select program models for implementation consistent with the program model developer's recommended target age and stage of child development.
- e. Implement parenting education program models that focus on parenting and child development for prenatal and parenting families with children birth to 5 years of age and addresses at least one of the core areas of family support:
- **Expand the family's knowledge of child development and behavior**
 - Provide learning opportunities for families in all domains of child development (i.e., social, emotional, language, and physical and motor development); understanding typical and atypical child development; recognizing age appropriate child expectations; and identifying developmental milestones and developmental red flags.
 - **Support positive parenting practices**
 - Provide learning opportunities for families on appropriate parent and child interactions, development of parenting skills, positive guidance practices, and warm, sensitive and responsive caregiving.
 - **Improve child safety**
 - Provide learning opportunities for families to increase their awareness of prevention of injuries in the child's environment (e.g., safe sleep, choking hazards, and use of car seats).
 - **Improve child health**
 - Provide learning opportunities for families on nutrition, obesity prevention, breastfeeding, physical activity, immunizations, oral health, insurance enrollment, participation in consistent medical/dental homes, participation in prenatal care, and preventative services such as well child visits, and developmental, vision and hearing screening.
 - **Contribute to family stability**
 - Support families to improve their stability (e.g. meet basic needs), functioning, and mental health (e.g., warmth, emotional availability, and stimulation), and promote stable relationships among caregivers, positive parenting, and family cohesion.
 - **Promote strong family relationships**
 - Support families to increase their support network and community involvement. Provide community specific resources at all class sessions that are relevant to

the session topic. For example, during a session covering oral health topics, parents should be provided with a list of dental providers in the community that serve children 5 and under.

- f. Conduct local awareness, outreach, and enrollment activities for eligible families and their young children birth to 5 years of age:
 - Provide up-to-date information about where and when parenting education programs are available using means appropriate for the target population and community (e.g., social media, agency website, printed materials).
 - Provide the family with a program handbook upon enrollment. The program handbook includes the following information:
 - Program philosophy and goals;
 - Program calendar;
 - Attendance policy;
 - Confidentiality policy;
 - Use of family-centered practices;
 - Expectation for parent/family participation; and
 - Ways families can promote learning at home and within the community to help their child be successful in an early education environment.
- g. Reach families at the appropriate age and stage of their child so that participants acquire the developmental knowledge necessary for parenting that is age appropriate. Create a family-centered environment:
 - Structure activities compatible with the family's availability and accessibility.
 - Offer extended service hours including weekend and evening hours.
 - Create opportunities for formal and informal feedback (e.g., feedback surveys, suggestion box) regarding programmatic planning and service delivery and take action based on the families' feedback. Ensure that families' feedback and input is shared for consideration in decision making.
- h. Support the strengths of families:
 - Engage parents and families of young children in assessing their strengths and needs particularly in the following areas: parental resilience, social connections, knowledge of parenting and child development, need of supports, and social-emotional competence of the child. Provide a written assessment (e.g. pretest, survey or inventory) and retain a copy of the assessment in the family's confidential case file.
 - Encourage families to build upon their strengths.
 - Provide resource and referral information based on the identified services needed and available to families.
 - Support the growth and development of all family members by offering information and referrals to other needed services.
 - Encourage families to advocate for themselves in getting their needs addressed.
- i. Actively engage participants:
 - Utilize interactive approaches to learning and skill building (e.g., role playing and encouraging participants to practice skills with their children).

- Provide opportunities throughout the class session for participants to practice and apply their new knowledge or skills.
- j. Conduct retention activities to promote ongoing participation and program completion:
 - Consider incentives for participation and program completion.
 - Offer to participants make-up sessions that adhere to program model requirements.
 - Maintain frequent and ongoing contact with families, also providing reminders for upcoming sessions.
 - k. Ensure manageable classroom size and appropriate staffing patterns. Determine what is manageable and appropriate using the following factors:
 - Program model requirements
 - Space, square footage
 - A maximum of 25 participants per class session (including children)
 - l. Parenting education programs that offer on-site child care must adhere to the First Things First (FTF) Requirements for On-Site Child Care (attached).
2. Literacy learning in early childhood provides the foundation for future literacy success and is rooted in exposure to rich language experiences and engaging activities that build knowledge, understanding and speaking, expands vocabulary, and supports a child's ability to become a successful independent reader.
 - a. Promote and support meaningful early literacy experiences and opportunities for young children in the appropriate context of program implementation.
 - Provide learning opportunities for families to learn about early language and emergent literacy development.
 - Provide information to increase families' awareness of the use of language to communicate, and respond to and elaborate on child's vocalizations (e.g., daily storytelling, talking, singing to infant and child).
 - Inform families about pre-literacy skills: concepts of print, phonological awareness, vocabulary development, comprehension, analysis of the content and structure of text, and making meaning through drawing and writing.
 - b. Support families and caregivers with parenting and child-rearing skills that help increase understanding of early language and emergent literacy development.
 - c. Engage families in meaningful, day to day two-way communication about how a child develops language and early literacy skills.
 - d. Encourage families to use the language in which they are most confident and competent.
 - e. Encourage parents and families to learn how to observe, guide, promote, and participate in everyday language and literacy development of their children at home, early care, and in their communities.
 - f. Encourage parents and families to advance their own learning interests in language and literacy development through education, training, and other experiences that support their parenting, careers, and life goals.
 - g. Encourage parents and families to support and advocate for their child's learning and development as they transition to new learning environments.

3. Follow the FTF Child Welfare Policy (attached) when working with children and families enrolled in services provided by the Arizona Department of Child Safety to promote non-duplication and coordination of child welfare services.
4. FTF recognizes the importance of collaborative partnerships among community partners that utilize a variety of formal and informal mechanisms to facilitate coordination of services in the community. The Coordination and Collaboration standard requires a grantee to:
 - a. Develop and implement a plan to understand and make connections with other initiatives, strategies and efforts in the region or state that support the early childhood system.
 - b. Develop processes that ensure staff implementing FTF funded strategies understand the connections between this strategy and the early childhood system to avoid duplication of services and promote collaboration between other services and supports offered to children and families in the regions.
5. Continuous Quality Improvement
 - a. Adopt a process of continuous self-monitoring and reflection to improve program practices that is articulated in a written policy.
 - b. In the written policy, the following should be addressed:
 - How data is used to assess the progress and outcomes of program implementation; and
 - How data collection is used to improve staff performance.
6. FTF embraces cultural responsiveness as an intentional life long journey that holistically explores, honors, and values the diversity of the human experience.
 - a. Offer programs and services congruent with the needs of diverse children and families.
 - b. Offer programs and services that are responsive to the impact of cultural factors such as histories, traditions, values, family systems and structures, social class, and religion and spiritual beliefs.
 - c. Create a learning environment conducive to and includes all children and families no matter their ethnic, cultural, or linguistic backgrounds.
 - d. Use the cultural knowledge, prior experiences, frames of reference, and performance styles of diverse children and families to make learning more appropriate and effective for them.

B. Staffing Standards

1. Direct Service Staff
 - a. Hire staff who reflect the cultural and ethnic experiences and language of the targeted population with whom they work with and integrate their expertise into the entire program.
 - b. Ensure that staff at all levels receives initial and ongoing professional development in culturally and linguistically responsive service delivery.

- c. Employ well-trained and competent staff and provides continual relevant professional development opportunities.
 - d. Family educators must have a minimum of a bachelor's degree in early childhood development, education, family studies, nursing, social work or a closely related field.
 - e. Family educators must have participated in required program training to achieve affiliation or accreditation to deliver the parenting education program model selected to be implemented.
 - f. Family educators are from the community and have extensive knowledge of community resources.
 - g. Model respectful relationships with all staff working as a team.
 - h. Build a team of staff who are consistent with program goals and whose top priority is the well-being of children and families.
 - i. Assess staff skills and ability prior to independent work in the community. Staff must maintain professional boundaries and build a healthy rapport with families.
 - j. Provide staff with initial and ongoing professional development consistent with the program model(s) recommendation on topics and frequency.
 - k. Supervisors and staff (including direct service staff, volunteers and sub-grantee or partner personnel implementing the strategy) must receive training through the Arizona Department of Education on the utilization of the Arizona Infant and Toddler Developmental Guidelines, the Early Learning Standards and the Program Guidelines for High Quality Early Education: Birth through Kindergarten as a regular part of practice. All staff will have ongoing access to guideline materials.
 - l. Provide all staff with initial and annual professional development in the FTF Parenting Education Standards of Practice and other applicable Standards of Practice and FTF policies.
 - m. Provide training to all direct service staff and supervisors on child maltreatment mandatory reporting policies and procedures (see Section C. Additional Standards and attached FTF Suspected Child Maltreatment Mandatory Reporting Policy).
2. Supervisory Staff
- a. Supervisors must work with direct services staff to prepare and implement professional development plans.
 - b. Establish an effective, consistent supervisory system that provides supports for all staff members and ensures accountability to participants, funders and the community.
 - c. Establish supervision as a collaborative process with mechanisms that support staff in difficult situations and provides ongoing opportunities for discussion between staff members and supervisors to reflect and debrief. Supervision will also include observation. It is important that supervisors spend time with family educators in the community to have a sense of how service is being delivered. This will help the supervisor and staff identify coaching and mentoring opportunities.
3. The Arizona Early Childhood Workforce Registry (Registry)

The Registry is a component of the newly developed Arizona Early Childhood Career and Professional Network (Network). The Network is a comprehensive system designed to meet the professional development needs of Arizona’s early childhood professionals working with or on behalf of children birth-8 years of age.

- a. Staff employed at the administrative home and any sub-grantee who are working directly with or on behalf of children birth – age 8 as a part of the implementation of this strategy must enroll in the Registry by June 30, 2016.
- b. All participants of this strategy are expected to enroll in the Registry by June 30, 2016.

C. Additional Standards

1. Arizona law (ARS §13-3620.A) requires early childhood program staff who suspect that a child has received non-accidental injury or has been neglected, to report their concerns to the Arizona Department of Child Safety or local law enforcement. All staff, grant partners, consultants and participants of this strategy must receive training and adhere to these requirements (see attached FTF Suspected Child Maltreatment Mandated Reporting Policy).

IV. REFERENCES AND RESOURCES

- A. Samuelson, A., (2010) Best Practices for Parent Education and Support Programs. What Works, Wisconsin – Research to Practice Series.
- B. Zepeda, M., Varela, F. and Morales, A. (2004) Promoting Positive Parenting Practices Through Parenting Education
- C. Developing a Thriving Reader from the Early Years: A Continuum of Effective Literacy Practices (available in Fall 2014)
- D. FTF Child Welfare Policy (attached)
- E. FTF Suspected Child Maltreatment Mandated Reporting Policy (attached)
- F. FTF Requirements for On-Site Child Care (attached)
- G. Arizona Early Childhood Career and Professional Development Network Website: azearlychildhood.org (available Fall 2014)
- H. <http://whatworks.uwex.edu/Pages/2parentsinprogrameb.html>
- I. Evaluation and Quality Improvement Tools and Resources
- J. Standards of Quality for Family Strengthening & Support: <http://www.cnfsn.org/standards-of-quality.html>
- K. Arizona Department of Education Trainings <http://www.ade.az.gov/onlineregistration/SelectEvent.asp?viewall=%22yes%22&GroupID=31>



Court Team

I. INTENT OF STRATEGY

The intent of the evidence-informed Court Team strategy is to improve outcomes for infants and toddlers and their families involved in the child welfare system in order to reduce or prevent future court involvement. The expected result is that informed local communities can strengthen the support and care for infants, toddlers and their families in the Juvenile Court system. This is accomplished through training, shared planning, systems improvement and regular consultation of those agencies working with a child and family. Court Team implementation may include recommending and referring infants, toddlers and families for services, but does not directly provide these services.

First Things First (FTF) supports implementation of the evidence-informed Court Team model. When an FTF Regional Partnership Council prioritizes the needs of infants and toddlers who have been removed from their home and the Court Team strategy is identified for implementation, the council identifies opportunities for partnership with the child welfare/ Juvenile Court system and other community partners and what role the council will play to support the overall implementation of the evidence-informed model through coordination and collaborative efforts.

II. DESCRIPTION OF SIGNIFICANCE

When young children experience abuse or neglect, family violence, poor nutrition, housing instability and infrequent health care, their ability to learn and succeed is severely compromised. According to Harvard University's Center on the Developing Child, research on the biology of stress shows that major adversity can weaken developing brain architecture and permanently set the body's stress response system on high alert. Science also shows that providing stable, responsive environments for children in the earliest years of life can prevent or reverse these conditions, with lifelong consequences for learning, behavior and health.

Infants are the largest group of children to enter, remain and re-enter the child welfare system. They are at the greatest risk for compromised development. They are six times more likely than the general population to have developmental delays that if left untreated will compromise their ability to have healthy productive lives. Although the developmental impact of child abuse and neglect is greatest among the very young, research confirms that the early years present an unparalleled window of opportunity to intervene effectively with these young, at-risk babies.

Effective and developmentally appropriate interventions and services can change the odds for infants and toddlers and lead to significant cost savings over time through reduction in child abuse and neglect, school failure, criminal behaviors, welfare dependence, substance abuse, medical care

for the illnesses (both physical and mental) that are common among adults who were maltreated as children. When maltreated young children show-up in Juvenile and Family Courts, judges are faced with making difficult decisions that may have long-term implications for their emotional, developmental and physical health.

Recommendations to achieve a comprehensive system of care for infants and toddlers involved in the child welfare system include:

1. Enhancing system capacity of partners including judges, health and mental health care providers, early intervention specialists, foster parents, family members, parent aids, attorneys for children and parents, Court Appointed Special Advocates (CASAs), child welfare caseworkers, adoption specialists, home visitors and others working with young children under the Juvenile Court's jurisdiction to understand developmentally appropriate practices to meet the needs of infants, toddlers and their families involved in the child welfare system through professional development and training for all types of providers;
2. Providing access to programs and services such as quality child care, preventive medical, dental, or mental health services, parenting and other family support programs;
3. Ensuring earlier identification of and intervention for developmental delays in infants, toddlers by providing child and family practitioners with screening and assessment tools.

The Court Team model works to increase awareness among all those who work with maltreated infants and toddlers about the negative impact of abuse and neglect on very young children and to increase the implementation of best practices when working with families of infants and toddlers involved in the Juvenile Dependency system. The Court Team model promotes policies and procedures that will foster a system of care that focuses on meeting the developmental needs of very young children and supports their healthy development.

Research by the national organization, Zero to Three, on the outcomes for very young children under the jurisdiction of Juvenile Courts that implement the Court Team approach has shown:

- A significant increase in the services provided to eligible children and their parents, particularly in access to health care and early intervention services.
- Decrease in the number of foster home moves for infants and toddlers.
- An increase in parent-child visits.
- An increase in relative/kinship placements.

The evidence-informed Court Team model includes the following core components (adapted from ZERO TO THREE Safe Babies Court Teams: 10 Core Components 2014):

- **Judicial Leadership:** Each Court Team requires the leadership of a local judge who, because of their unique position of authority in the processing of child welfare cases, is a catalyst for change.

- **Local Community Coordinator:** In each Court Team community, a local Community Coordinator serves as a resource for child development expertise for the court. The local Community Coordinator can also serve as a team lead to facilitate collaboration and coordination amongst the court, child welfare agencies, service providers and other stakeholders to develop a cohesive system of services and resources in support of infants and toddlers and their families in the court systems.
- **Community Court Team:** The Court Team is made up of key community stakeholders who commit to working to restructure the way the community responds to the needs of maltreated infants and toddlers. The makeup of each Court Team varies from community to community, but typically the team includes pediatricians; child welfare workers; attorneys representing children, parents, and the child welfare system; Court Appointed Special Advocates (CASAs); Guardians Ad Litem (GALs); mental health professionals; substance abuse treatment providers; representatives of foster parent organizations; children's advocacy groups; Early Head Start and child care providers; and Court Improvement Program staff.

The Court Team focuses on the "big picture" of early childhood system building. The Court Team meets at least monthly to learn about the services available in the community, to identify gaps in services, professional development/training needs of team members and to discuss issues raised by the cases that members of the Court Team are monitoring.

Initial and ongoing recruitment is necessary to achieve the broad multidisciplinary participation critical to a Court Team's effectiveness. The community coordinator takes the lead in continually scanning the community for new service providers and relevant stakeholders to incorporate into the Court Team.

- **Target the Population of Infants and Toddlers in Out-of-Home Care:** Infancy and toddlerhood are critical periods in human development. Focus investments on intervention services and prevention programming for these very young children can have the greatest impact while reducing long term costs. Infants and toddlers need comprehensive developmental, medical and behavioral health services to ensure their well-being and developmental outcomes.
- **Monthly Case Review Meetings:** Each month, individuals and organizations delivering services to infants and toddlers meet together to review progress on family cases. This monitoring process in and of itself can help prevent very young children from falling through the cracks in the child welfare system and ensure that the services they are receiving are effective and age appropriate.
- **Placement and Concurrent Planning:** To reduce placements, the Court Team uses concurrent planning, a technique which requires the quick identification of, and placement

with, caregivers who are willing to become the child's permanent family if reunification becomes impossible.

- **Frequent Parent-Child Contact:** Research shows frequent visitation increases the likelihood of reunification, reduces time in out-of-home care, and promotes healthy attachment. (Smariga, 2007). The Court Team focuses on increasing visitation by expanding the opportunities (e.g. doctor's appointments) and the locations (e.g. the foster home, the birth parents' home) for parent-child contact.
- **Medical, Developmental and Mental Health Services:** Infants, toddlers and families involved with the Juvenile Dependency system are provided with referrals and resources to access and participate in regular preventive medical care to ensure child health and developmental screenings to identify and address developmental delays. Each Court Team will also have the capacity to refer parents to mental health services which are designed to improve the parent-child relationship by focusing on reading and responding to cues in ways that support child development and to address unmet emotional needs that the parent may have which impacts her/his ability to meet the needs of their child. It is equally important for young children to participate in mental health services with practitioners experienced in meeting the unique needs of infants and toddlers involved in the child welfare system.
- **Training and Technical Assistance:** Training and technical assistance to court personnel, system partners and community service providers on topics such as being more responsive to, and responsible for, young children's social and emotional development needs; general infant and toddler development; parenting interventions; services available to foster children in the community; and the impact of trauma on children. Through training and technical assistance, Court Team members have access to resource materials including bench books and training videos developed by Zero to Three and other organizations involved with the development of the Court Team model.
- **Evaluation** Methods for standardized data collection and analysis must be established and implemented to measure the impact of Court Team approaches. Ongoing evaluation activities can further lead to continuous quality improvement and professional development opportunities for Court Team members.

The Regional Partnership Council must define its role in supporting the implementation of the Court Team strategy. The role may range from building initial capacity for establishing a Court Team to supporting specific elements of the full evidence-informed model that works to increase and/or improve implementation to supporting the maintenance of the ongoing implementation of a fully established model within a region. Successful implementation, not dependent on the role identified by the regional councils, is achieved through a collaborative and coordinated process of identification, development and operationalizing of action plans to address needs, gaps and barriers in the system that functions under the jurisdiction of the court. While the role and area of focus of a regional council may vary by region, the number of children served by the implementation of the

Court Team model and the number of trainings provided are the required service units for all grant partners implementing the FTF Court Team strategy. In addition, grant partners are also required to report on the number of Court Team meetings held as performance measures. FTF does not fund nor provide direct service for infants, toddlers and their families involved in the child welfare system such as direct health or mental health care.

III. IMPLEMENTATION STANDARDS

A. Program Standards

First Things First (FTF) is committed to funding programs that are evidence based or evidence informed. The emphasis on evidence-based programs is grounded in the idea that the maximum benefit for children and families is delivered by programs that base their practice in the most current, relevant, and reliable evidence about the effectiveness of the program. For some programs, an evidence-informed or best practice, or a promising practice model is appropriate. The following criteria are considered by FTF when determining to fund programs:

- **Evidence based programs** are programs that have been validated by documented and scientific research and the evidence has gone through a peer review process. Evidence is established through scientific research that has had a comparison between an intervention group and a control group where the intervention group has had a significant impact. Peer review means that someone external to the program or research team has reviewed the methodology and the findings to determine if standards were met.
- **Evidence informed** is a program or service that has a clearly articulated theory of change (logic model) and has had some evaluation of the outcomes. This can be based on one program or service model that has been evaluated in multiple settings. An evidence informed program cannot be based on the evaluation of a program in only one setting, even if it has been done for many years in a community and everyone likes it.
- **Promising practice** is a program or service that has a clearly articulated theory of change (logic model) with specified implementation and operational processes (activities) and program outcomes. A promising practice program is *informed* by at least one of the following:
 - Evidence based practices of a similar program or service delivery system, but does not have complete fidelity to that model because of justifiable need to change factors such as staffing or written materials in order to adapt to geographic or cultural variation.
 - A similar program or service delivery model that is generally accepted as appropriate for use with the target population to achieve the program outcomes but has yet to be established as evidence based.
 - Culturally responsive practices that are known to contribute positively to program outcomes.

A promising practice must have no evidence that the program or service will cause any harm to recipients. Additionally, a promising practice program is committed to building evidence of program or service effectiveness through ongoing continuous quality improvement activities.

1. Programs that support the implementation of the evidence-informed Court Team program model must demonstrate adherence and fidelity to the evidence-informed Court Team model. Successful implementation of all 10 of the core components of the evidence-informed model as identified by ZERO TO THREE, Safe Babies Court Team is required.
 - a) When initially establishing the Court Team model, consideration is taken to engage community leaders, specifically judicial leadership, to build the support and partnerships for the formation of a Court Team. This includes effective outreach to engage judicial leadership on the importance of early childhood development with a focus on the unique needs of infants and toddlers who have been removed from their homes, obtaining commitment to the model, and support for the implementation of all core components of the model. Once commitment and support from judicial leadership is obtained, it is necessary to develop an action plan to operationalize the other core components. It is recognized that establishment of the Court Team model takes time and timelines may vary region by region.
 - b) When support is provided to establish the Court Team model, there must be demonstration that all 10 core components of the model are fully planned for, put into practice and operationalized. FTF supports the implementation of this evidence-informed model, however, it does not fund direct services to young children and families involved in the child welfare or Juvenile Court system such as direct health or mental health care.

2. Provide Training and Technical Assistance

Training and technical assistance provides support for the establishment and ongoing implementation of the evidence-informed Court Team model and the professional development needs of Court Team members such as judges, health and mental health care providers, early intervention specialists, foster parents, family members, parent aids, attorneys for children and parents, Court Appointed Special Advocates (CASAs), child welfare caseworkers, Tribal social service and child protection caseworkers, Indian Child Welfare Act (ICWA) Coordinators, adoption specialists, home visitors and others working with children under the Juvenile Court's jurisdiction. Based on the role determined by the regional council, training and technical assistance may include:

- Initial outreach and training on the importance of early childhood development, the long term impact of adverse childhood experiences and the need for developmentally appropriate approaches for young children and their families involved in the child welfare system;
 - Ongoing series of training and technical assistance activities that ensure alignment and scaffolding of knowledge between all the components utilized for this strategy.
- a) Providers of training and technical assistance must:

- i. Provide information and technical assistance on best practices for the successful implementation of the evidence-informed Court Team model;
 - ii. Conduct professional development based on best practices and research, ensuring that subject matter experts (visiting faculty, published authors, researchers, etc.); materials and sessions are based on current research, core areas of skills, knowledge and competency, and are responsive to emerging issues in the community and the early childhood field;
 - iii. Maintain individualized learning seminar attendance records for participants including the hours each participant attended;
 - iv. Provide written resource and referral information to participants on the healthy development of young children and resources available in the community such as medical care, developmental screenings, mental health programs and resources, quality child care, parenting and other family support programs and services. These resources must be updated at a minimum annually and gathered from trustworthy, reliable sources.
 - v. Maintain flexibility and responsiveness to emerging issues in the community and the early childhood field:
 - Develop a collaborative, coordinated response to community professional development needs;
 - Implement continuous quality improvement by reviewing written feedback from program participants collected after every learning session; and
 - Ensure appropriate staffing in order to effectively respond to participant questions or thoughts during the seminar series.
 - vi. Clearly define, document, and share program objectives with participants to ensure comprehension, engagement, and retention.
 - vii. Encourage honest, open communication between participants and instructors;
 - viii. Maintain confidentiality, being respectful of program participants;
 - ix. Take into consideration emerging needs or topics of research as identified by the participating early childhood professionals and be responsive to professional development needs of the participants;
 - x. Include professional development opportunities for follow-up such as on-site technical assistance, consultation, and/or coaching.
3. FTF recognizes the importance of collaborative partnerships among community partners that utilize a variety of formal and informal mechanisms to facilitate coordination of services in the community. Coordination and collaboration among early childhood service providers is critical to developing a seamless service delivery system for children and families. Coordination and collaboration is described as two or more organizations working together in the delivery of programs and services to a defined population.

As a result of coordination and collaboration, services are often easier to access and are implemented in a manner that is more responsive to the needs of the children and families. Coordination and collaboration may also result in greater capacity to deliver services because organizations are working together to identify and address gaps in service, which results in higher quality services and cost efficiency.

Successful applicants must demonstrate capacity to work with and participate in coordination and collaboration activities occurring within the First Things First region being served. Applicants should plan the appropriate staffing and budget to support travel to and attendance at meetings within the regional area or at statewide meetings, as appropriate.

This may include but is not limited to:

- Engaging with other partners delivering the same or similar programs and services;
- Clarifying target populations and outcomes;
- Defining processes and plans to reach desired outcomes.
- Attend local or statewide collaborative meetings, as noted in the Scope of Work.

The Coordination and Collaboration standard requires a grantee to:

- a) Develop and implement a plan to understand and make connections with other initiatives, strategies and efforts in the region or state that support the early childhood system.
- b) Develop processes that ensure staff implementing FTF funded strategies understand the connections between this strategy and the early childhood system to avoid duplication of services and promote collaboration between other services and supports offered to children and families in the regions.
- c) Coordinate with all other regional and statewide professional development providers including institutes of higher education.
- d) Providers of professional development are expected to partner with FTF during all stages of planning and implementation, and with local early care and education professionals and other early care and education stakeholders, including higher education institutions, in developing and marketing the program.
- e) Demonstrate pre-existing relationships and develop new partnerships with local organizations, agencies and community networks that offer professional development opportunities and professional memberships.

5. Continuous Quality Improvement

This may include evaluation, quality assurance and performance monitoring and is a collaborative, ongoing process that includes input from staff, families, program administrators, and community members. Activities may include pre- and post- testing, self-assessment and opportunities for feedback. Programs must demonstrate mechanisms to assess program effectiveness and to implement quality improvements.

- a) Adopt a process of continuous self-monitoring and reflection to improve program practices that is articulated in a written policy.

- b) In the written policy, the following should be addressed:
 - How data is used to assess the progress and outcomes of program implementation; and
 - How data collection is used to improve staff performance.
6. FTF embraces cultural responsiveness as an intentional life long journey that holistically explores, honors, and values the diversity of the human experience.
- a) Offer programs and services congruent with the needs of diverse children and families.
 - b) Offer programs and services that are responsive to the impact of cultural factors such as histories, traditions, values, family systems and structures, social class, and religion and spiritual beliefs.
 - c) Create a learning environment conducive to and includes all children and families no matter their ethnic, cultural, or linguistic backgrounds.
 - d) Use the cultural knowledge, prior experiences, frames of reference, and performance styles of diverse children and families to make learning more appropriate and effective for them.

B. Staffing Standards

If the Regional Partnership Council’s role is to provide funding for one or more Local Community Coordinators, then FTF funded Local Community Coordinators shall meet the following staffing standards:

1. Supervisory Staff

Supervisors must meet or exceed the requirements below with the addition of at least two years of program management experience in a Juvenile or Family Court, child welfare or other related early childhood setting.

2. Local Community Coordinator(s)

a) Education requirements:

Preferred:

Master’s Degree in Social Work, Psychology, Education or Early Childhood Development, AND three (3) years of relevant, progressively responsible experience in social services, Juvenile/Family Court programs, or programs that serve families with young children under the age of five, experience in cross-disciplinary program development, coalition building, and service integration.

OR

Bachelor’s Degree with closely related experience that includes (5) years of management and/or supervision OR any equivalent combination of experience and/or education from which comparable knowledge, skills or ability have been achieved may substitute for a Master’s Degree. Presents evidence of proven success in program implementation, grant management, and data collection and reporting for program

b) Experiential requirements:

- i. Coordinators are reflective of the cultural and ethnic experiences and language of the targeted population with whom they work with and integrate their expertise into the entire program,
- ii. Experience with ensuring that Court Team members receive initial and ongoing professional development in culturally and linguistically responsive service delivery,
- iii. Be knowledgeable about and possess experience in conducting professional development activities, working with adult learners, including learners from diverse cultures,
- iv. Have a minimum of five years' experience working directly with infants and toddlers and their families in the child welfare system,
- v. Have general knowledge of infant and toddler mental health practices such as screening, assessment, evaluation and practices and/or have an Infant/Toddler Mental Health Coalition of Arizona (ITMHCA) endorsement;
- vi. Have experience with facilitation of team meetings to conduct and/or convene the monthly Court Team meetings, monthly Case Review meetings, training and technical assistance and system level service coordination meetings.
- vii. Demonstrate proficiency in the language(s) of the participants or have an alternate and effective procedure for communication,
- viii. Have extensive knowledge of community resources for Court Team members to
 - access professional development opportunities;
 - be aware of additional services that children and families they work with might want/need to access.
- ix. If programs experience hardship in recruiting personnel with these qualifications, notify and consult with FTF.

IV. REFERENCES AND RESOURCES

- A. ZERO TO THREE. Changing the Odds for Babies: Court Teams for Maltreated Infants and Toddlers. Fact Sheets. Zero to Three Funded Projects - Court Team. Retrieved from: http://main.zerotothree.org/site/DocServer/Court_Teams_Final_Fact_Sheet.pdf?docID=3881
- B. ZERO TO THREE. (2014). Safe Babies Court Teams: 10 Core Components. Retrieved from: <http://www.zerotothree.org/maltreatment/safe-babies-court-team/safe-babies-court-teams-10-core-componets.html>
- C. Smariga, M. (2007). Visitation with Infants and Toddlers in Foster Care: What Judges and Attorneys Need to Know. Washington, DC: American Bar Association Center on Children and the Law and ZERO TO THREE Policy Center.

Yavapai Regional Partnership Council
Director's Report: February & March 2015

UPDATES

- A. Non FTF funded Strategy Update
 - 1. ECLC – 2/21/15
 - a. Learning Consortium held 2/21/15
Dr. Loren Thomas, Director of Teacher Preparation at Prescott College
Lauren Zbyszinski – Arizona Department of Education
 - b. Launched website 11/30/14
 - 2. PIECE – Higher Education Round Table Scheduled for 3/25/15
- B. Yavapai Apache Nation partnership
 - 1. Attended Wellness Committee Meeting 2/20/15
 - 2. Meeting with Chairman Beauty on 3/10/15
 - 3. Contributing give away to Earth Day celebration on 4/25/15
 - 4. Have developed an outreach and engagement plan
- C. Verde Valley Calendar
 - 1. Recruiting participants and identification of web host
 - 2. Transfer of leadership
- D. First Things First work groups
 - 1. Data Portal Committee
 - 2. Court Teams
 - 3. Faith Forum
- E. Council member activity
 - 1. RFGA review committees –
Olga, Kathy, Sherry, Morgan, Anne, Angela
 - 2. Early Learning Summit Session reviewer – Kathy Watson
 - 3. Quality First Advisory Sub-Committee – Anne Babinsky

COMMUNITY MEETINGS

- A. Faith Forum – 2/4/15
- B. Best For Babies (Court Teams) – 2/6/15
- C. Raising a Reader – 2/9/15
- D. Prescott Networking Lunch – 2/10/15
- E. Verde Valley Networking Lunch – 2/17/15
- F. Verde CHIP meeting - 2/1/15
- G. YAN Wellness Committee – 2/20/15
- H. Best For Babies Seminar – 2/27/15
- I. Quad City CHIP – 3/5/15

ADDITIONAL INFORMATION

This section will provide updated information about events or topics taking place between the posting of the meeting notice and the Regional Partnership Council meeting.