FIRST THINGS FIRST

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PUBLIC NOTICE OF MEETING OF THE

Arizona Early Childhood Development and Health Board

Program Committee

AMENDED

Pursuant to A.R.S. §8-1194(A) and A.R.S. §38-431.02, notice is hereby given to the members of the First Things First - Arizona Early Childhood Development and Health Board, Program Committee and to the general public that the Program Committee will hold a ***Regular Meeting open to the public on Thursday, October 23, 2014 beginning at 10:00 a.m. The meeting will be held at First Things First, 4000 North Central Avenue, Suite #800, Phoenix, Arizona 85012.*** Some members of the Program Committee may elect to attend telephonically.

The Program Committee may hear items on the agenda out of order. The Program Committee may discuss any item on the agenda. The Program Committee may elect to solicit public comment on certain agenda items.

The agenda for the meeting is as follows:

1.	**Welcome and Call to Order**	**Janice Decker, Chair**
2.	**Roll Call**	**Janice Decker, Chair**
3.	**Meeting Minutes, June 16, 2014** **(Review and Possible Approval)**	**Janice Decker, Chair**
4.	**Restructuring of Advisory Committees under Program Committee** **(Discussion and Possible Approval)**	**Karen Woodhouse, Chief Program Officer** **Leslie Totten, Director of Quality First**
5.	**Continuous Quality Improvement for FTF Programs** **(Presentation and Discussion)**	**Karen Woodhouse, Chief Program Officer**
6.	**FY16 FTF Systems Approach Framework for Programmatic Priorities** **(Presentation and Discussion)**	**Karen Woodhouse, Chief Program Officer**
7.	**FTF Program Evaluation Plan** **(Presentation and Discussion)**	**Dr. Roopa Iyer, Sr. Director for Research and Evaluation**
8.	**Adjourn**	**Janice Decker, Chair**

A person with a disability may request a reasonable accommodation such as a sign language interpreter by contacting Cynthia Chavarria, at 4000 North Central Avenue, Suite 800, Phoenix, Arizona 85012, telephone (602)771-5023. Requests should be made as early as possible to allow time to arrange the accommodation.

Dated this 21st day in October 2014

Arizona Early Childhood Development and Health Board

Program Committee

Janice L. Decker, Chair

Arizona Early Childhood Development and Health Board
Policy and Program Committee
DRAFT Meeting Minutes
June 16, 2014

Call to Order, Welcome and Introductions

The Regular Meeting of the First Things First Arizona Early Childhood Development and Health Board Program Committee was held on June 16, 2014 at the Hilton Garden Inn, 4000 North Central Avenue, Payson Conference Room, Phoenix, Arizona 85012.

Chair Decker called the meeting to order at 10:02 a.m.

Roll Call:

Cynthia Chavarria performed a roll call.

Members Present:	Bill Berk, Dr. Randal Christensen, Amy Corriveau, Janice Decker, Naomi Karp, Laurie Smith, Vivian Juan Saunders (P), Mary Ellen Cunningham (P)
Members Absent:	Colleen Day Mach, Toni Harvier, Kenton Laffoon, Dr. Eva Marie Shivers, Alan Taylor, Kim Van Pelt, Brad Willis

Review and Possible Approval of Meeting Minutes

Chair Decker called for a motion to accept the meeting minutes of May 15, 2014. Member Christensen moved to accept the minutes and Member Karp seconded. All in favor, none opposed, Chair voted aye and motion passed.

Program Considerations Related to Fiscal Policy

Chair Decker thanked Committee Members and Stakeholders who have provided valuable input and comments on the Fiscal Recommendations. Chair Decker introduced a one page document of comments e-mailed from Nancy Mongeau, Regional Partnership Council Member. Committee Members reviewed the handout and Ms. Mongeau's comments will be incorporated into the minutes and are attached.

Chair Decker provided a summary of a work session recently held by the First Things First Board (Board). This session was strictly an informative opportunity to relay the discussions on programmatic recommendations related to fiscal policy which is under consideration and no decisions were sought from the Board. At the May 15, 2014 Program Committee meeting, Members requested additional data and this information will be reviewed today. Chair Decker announced that this is the final opportunity for Member's remarks related to the fiscal recommendations.

Karen Woodhouse addressed the chart identifying five potential approaches and options that this Committee can recommend to the First Things First Board and reviewed the additional data that was requested. For each approach, two additional columns were added which show how many Regional Councils would have a certain percentage of funds available to support other strategies and needs in their communities, in addition to funding Quality First.

For option "E", Member Corriveau asked if Regional Councils chose to fund scholarships at whatever level, would the providers still have to be at 3-4-5 stars and this was affirmative. All current policies would remain the same and Ms. Woodhouse reminded the Committee that in Fiscal Year 2016, scholarships will shift to only 3-5 star programs with a waiver possibility for those Regions who don't' have an adequate number of 3-5 star providers. The waiver would allow funding for a 2 star program until providers can move up to a 3-5 star level. The current percentage of Regional Councils who fund scholarships above the required amount is at 60-70%. Most Regional Councils who fund over the baseline are doing so with carry forward funds and with the fiscal decisions being implemented, those carry forward funds will be going away.

Member Smith asked if Quality First is separated from scholarships and the Regional Councils could choose how many scholarships they wanted to fund, is it possible to decrease the reimbursement amounts by a small percentage so they could fill more scholarship slots? Ms. Woodhouse replied yes and Member Smith requested that she'd like this detail be added as an additional point for option "B". Member Corriveau doesn't believe lowering the total reimbursement amounts is going to help with quality because if we're going to decrease or spread out the funding, we're going to lessen quality by that very act. If First Things First has already determined the current price of quality, we can't lessen the rate and expect to keep the same level of quality. Josh Allen, Chief Financial Officer, reminded the Committee that the quality rate wasn't done on a sliding scale; it was based on a market rate and price point per Region. Ms. Woodhouse noted that providers would have a choice to divide a scholarship into two half time positions if they chose to spread out the funding.

Member Christensen voiced the need to first prioritize whether we're recommending that the Regional Councils be free to make funding decisions without First Things First Board (Board) directive or to make their decisions with Board input. Once this is decided we can move to discussing the details of how and on what funds are spent. With revenues dwindling, it is inevitable that quality will be affected. Understanding it will be a difficult decision, he leans toward the Regional Councils having the right to make their own funding decisions. Chair Decker agrees that the Regional Councils need to maintain their autonomy in making regional funding decisions. Member Berk does not agree and believes the Board should provide some input. He believes the Program Committee is making a mistake by choosing one of these options too soon and feels pressured to do so as there has not been enough time allowed to see full results from the Quality First Program as a whole. Chief Executive Officer Sam Leyvas agrees that we need to identify the dynamics on governance. Looking at the statue, we clearly see the intent wasn't to be a "one size fits all model" and there is a natural tension built into this governance system where there must be some compromise. Having carry forward fund balances throughout the years has helped to stall these conversations in the past but this is the point now to make the choices. Mr. Leyvas recognizes Member Berk has some good points on the Quality First model and the need to continue looking at efficiencies and effectiveness of the program.

Chair Decker appreciates Member Berk's and Ms. Mongeau's comments as well as those in a letter received from the Children's Action Alliance. She doesn't disagree with Member Berk's comments but stresses that the Committee can't place this decision on hold until Quality First is fully enacted and all data on the program is available. First Things First can make the model more efficient. We have data to support our work and we've seen an upward progression for providers almost on a monthly basis. We're currently at 38% of our providers at a 3-5 star level compared to 9% of providers four years ago when Quality First began. We see the model and supports are working and need to further focus on those areas that are most indicative of what quality is, measuring those and looking at ways it can scale up.

Member Karp commented that when we talk about Regional Councils vs. First Things First Board (Board) power, we need to remember the children of Arizona don't have this "power" to decide for themselves. From the development of the Proposition 203, Board Member Mathis Basha would say that Arizona needed a system and perhaps the role of the Regional Councils having the freedom to make the decisions based on their community needs was undersold. Whatever the Regional Councils do, they have to look at making decisions and providing options for the bigger picture and Member Karp thinks we've lost sight of this. Member Corriveau voiced she does not know where it was determined that only First Things First should pay for quality and scholarships but somehow we unintentionally arrived to this point. If we're talking about a system as a whole for the state; other agencies and partners need to share the responsibility and be supportive of the system. Member Smith doesn't think having different needs in each region is necessarily bad and can speak for her Region in saying they appreciate the help they're receiving through First things First funding. Member Karp recognizes the different needs but also thinks we need to set some common priorities and everyone needs to contribute to one funding pool, with their remaining funds being spent as they see fits their region.

Member Berk questioned if there still existed a statewide fund for certain programs like Quality First. Ms. Woodhouse clarified that the statewide funding plan pays for the cost of assessments, T.E.A.C.H. Scholarships and some administrative costs of the Quality First initiative. The amount of statewide dollars we used to provide for QF is the same amount, but has now shifted to pay for these Quality First components, and Regional Councils fund the remainder of the cost per provider. Member Berk questioned if with these options could Regional Councils still fund Quality First at a lower level or would they have to provide a certain level? Karen clarified that with options "A" through "D", the Regional Councils would maintain their support of Quality First providers in Fiscal Year 2016. In Option "E", Regional Councils could do whatever they believe was most appropriate with their funding. Member Corriveau questioned if Regional Councils would still have to commit to a three year funding cycle. Michelle Katona, Chief Regional Officer, clarified if the Program Committee recommends one of the options discussed today and the FTF Board approved it the policy would continue for a three year funding cycle so there would be some continuity for providers.

Chair Decker called for other comments. Member Berk favors option "B" and is nervous that with other options, Regional Councils could choose to cut out funding for Quality First completely and believes if this happens, the whole system would suffer and it would be certainly be hard on families.

Ms. Woodhouse reviewed some of the data maps provided to members and reflected that the density of scholarships align with zip codes that have the highest poverty levels in the state. Members were also provided with data charts showing regional zip codes by descending order and it does include poverty levels identified. Review of the maps and data indicates a concentration of high need aligns with geographies where scholarships are being used.

As Member Christensen thinks of Quality First and the research and evaluation data available, he doesn't recommend the Regional Councils use funding as a priority for only Quality First, especially when there are large percentages of programs that have less than 10% of their total funds to decide on what their priorities are. Member Christensen supports option "D". Acknowledging it's a hard

decision to make, Member Smith agrees. The Regional Council has prioritized the School Readiness Indicators, with the first indicator being school readiness, the second being supporting families' confidence and competence, the third is providing access to quality and supporting children with special needs in quality and following with prioritization of oral health and healthy body weight.

Chair Decker again recognizes that this is a difficult decision and encourages the Program Committee that after making a decision today, data can be re-reviewed in the future and revisions made if needed.

Member Christensen reiterates that he supports option "D" as it stands. Member Corriveau supports option "D" as it stands, with the understanding that it would de-couple scholarships from Quality First but maintains QF at the current level. Member Berk reiterates that he supports option "B" as it stands but could support option "D" if the First Things First Board would set a required minimum. The Program Committee understands that option "B" is what Member Berk is describing if he supports option "D" while setting a percentage of funds to QF.

Ms. Katona questions if 1-2 star providers receive incentives but 3-5 star programs receive incentives in the form of scholarships you zero out scholarships through the Regional Councils. How do you then incentivize 3-5 star providers to continue forward with increasing quality? Programmatically something would have to be adjusted to provide for an incentive package.

Ms. Woodhouse stated that if the model includes some type of incentive for 3-5 star programs, and currently the model uses scholarships as an incentive, the payment for it still falls on the Regional Council as part of their unit cost. Regional Councils do this now for 2 star rated programs and will continue to do so in Fiscal Year 2016; however, 2 star rated providers will not be eligible to receive scholarships in Fiscal Year 2016. The incentives 2 star programs receive is used to buy materials and equipment to improve quality. For 3 star providers, if scholarships were replaced with another incentive, be it cash, so providers can maintain their quality, and this would still be an investment on the part of the Regional Council. However, the cost may be less than what a Regional Council had to invest for a scholarship. The other option is that there are no incentives at all for 3-5 star programs which might lead to a bigger de-investment from providers who may think there's no reason to be involved in Quality First at all. Option "B" could set a lower percentage baseline rate, but all of the options allow Regional Councils to fund additional scholarships.

Member Christensen still believes Regional Councils should have the choice, and the case for additional supports should be made to other funders and policy makers. He agrees with Member Karp's comment that somewhere we lost our way in terms of systems changes. First Things First was never meant to be the sole provider of funding for child care and quality. Member Saunders agrees that the bottom line is a decision has to be made and efforts have been made to get participation and comments from all involved. Member Cunningham would vote to support option "D" as well. Member Corriveau again states she's supportive of option "D" but is concerned with lowering the cost of reimbursements but would be comfortable separating Quality First from scholarships and taking out the point of lowering the overall scholarship reimbursement rates by 5% and maintaining the rates as they are now. This option still recognizes what it costs to maintain quality, so the reimbursement rate would remain the same, but option "D" would give Regional Councils the opportunity to decide how many scholarships they're funding.

Ms. Woodhouse returned to a point made earlier that if a Regional Council chose not fund scholarships at all, does the Program Committee recommend that from a policy view, First Things First should come up with a baseline that is paid/made available to a 3-5 star provider as an incentive for quality. If this is the case, would this be in the form of scholarships or cash? Member Christensen asked for background on the number of scholarships awarded as part of an incentives plan. Mr. Allen responded that prior to having a full star rated system, incentives were based on the type and size of provider and was not a cash incentive, it was an in kind/cash value incentive to continue to improve quality. Once Quality First ratings were implemented, incentives were provided as scholarships, with a higher value corresponding to a higher star level rating. Ms. Woodhouse shared that heading into Fiscal Year 2015, 38% of programs are at 3-5 star ratings; the majority of programs are 2 star, and about 12 programs at 1 star. There are an almost even number of scholarships going to 3-5 stars as those going to 2 star programs. Member Christensen again states he fully favors option "D" and supports taking out the point on lowering overall scholarship reimbursement rates by 5%, and that he could support having an incentive plan and suggest that it is some type of scholarship. Chair Decker noted that starting for Fiscal Year 2015, it would only be an incentive for those providers at a 3-5 star level.

Member Smith questioned why a 3-5 star provider couldn't also receive incentives in the form of equipment? Staff responded that when a provider reaches a higher level of quality, they no longer need the same type of equipment and materials to provide a quality environment compared to a provider at 1-2 stars. They might better use some type of cash incentive for staff retention, professional development and increasing employee's educational levels, rather than equipment purchases.

CEO Leyvas is hearing that as a group, the Program Committee supports recommending option "D" with the removal of lower overall scholarship reimbursement rates by 5% and that the Board consider this with the inclusion of an incentive to be determined,

based on First Things First staff determination on what level of funding would be reasonable. Chair Decker believes the nomenclature is better in option "D". Ms. Woodhouse believes it provides affirmation that FTF supports access for low income families. Member Christensen feels it's more than semantics; the philosophy and the model behind it are changing. Member Berk commented that regardless of calling it a stipend vs. scholarship, there's no guarantee that the funds will go to a family in poverty. If we continue to support an option which includes scholarships, there's a certainty that the funds will go toward low income families' access to quality care. Member Berk states that if we change this, it is undoing the current policy made in 2013 and he still believes it's wrong. Chair Decker recapped that she hears overall support for option "D", taking out the 5% reimbursement deduction and that Regional Councils will still have the opportunity to say whether they fund scholarships at all, and the recognition on the part of the Program Committee that First Things First will make a recommendation on the Quality First model to include incentives for 3-5 star programs and that would be a modification to the Quality First model that would be funded through Regional Council dollars and providers could use these funds any way they choose including for scholarships.

Member Corriveau clarified that the cost of scholarships is significantly greater than the cost of a cash incentive and Member Christensen agrees this would be the point, that incentives would costs less than scholarships. CEO Leyvas is hearing the whole premise of choosing option D is confirming that there is trust the Regional Councils will make the best decisions for their communities. If extending the notion that there is trust in the Regional Council Members' decision making, then it has to wrap around all their decisions. They'll also have to consider, if they reduce the scholarships in a region and are only left with an incentives package, then we lose the connection between being able to target those dollars for families in need. Councils will have to grapple with this realization and make decisions that tie best to their communities. Right now, when we talk of Quality First being an incentive, we can say that the cost of each scholarship is around $11,000 annually and this would be equitable to what we would provide for a cash incentive. So a Council could determine if they fund an actual scholarship but with incentive, or a provider could use the funds for whatever they felt was most needed related to maintaining and continuing increasing quality. We could even recommend that the Councils do not loose count of providing access to higher quality whatever option is chosen.

Chair Decker hears that the Program Committee is making the recommendation that we go with option "D, to separate Quality First improvement model costs from scholarship costs" with the following points: 1) Separate improvement model costs from scholarship costs; 2) No further guidance on number of regional scholarships funded and; 3) No reduction to number of providers; 4) removing the point on lower overall scholarship reimbursement rates by 5%; and, 5) Regional Councils will still have the opportunity to choose whether or not they fund scholarships at all.

An additional point to option D will be added to convey the Program Committee recommends that First Things First staff add a component to the Quality First model to include incentives for 3-5 star programs. And this would be a modification to the Quality First model which would be funded through Regional Council dollars and providers could use these funds as needed.

Chair Decker called for a motion on the recommendation to the First Things First Board on the Quality First programmatic approach for Fiscal Year 2016. Member Smith moved that First Things First separate Quality First improvement model costs from scholarship costs, provide no further guidance on number of regional scholarships funded, see no reduction to the number of providers and provide incentives to 3-5 star Quality First programs with First Things First staff to determine the exact amount of those incentives. Member Christensen seconded. All Members in favor except for Member Berk who is opposed and voted nay. Chair in favor and motion passed.

Ms. Woodhouse reviewed language to respond to the formal motion made by Member Decker at the April 8, 2014 Board meeting that the Policy and Program Committee examine programmatic considerations on: 1) How regional councils construct funding plans to align programming to available resources; 2) Whether the Quality First model can be adjusted in ways that preserve the overall design and policy intent; and 3) Other program costs that FTF should research to see if they can be lowered while still preserving the design and policy intent. Chair Decker called for a motion on the recommendation to the First Things First Board on the prefaced statement as outlined: "For First Things First to achieve sustainable progress towards its vision and mission, it is important to strategically fund programs and strategies that are most likely to have positive outcomes for the early childhood system, young children, and their families. Critical to this process is the identification of programs and strategies with research evidence suggesting a greater likelihood they will have the intended positive effect. Such an approach will likely yield greater results from our public investments."

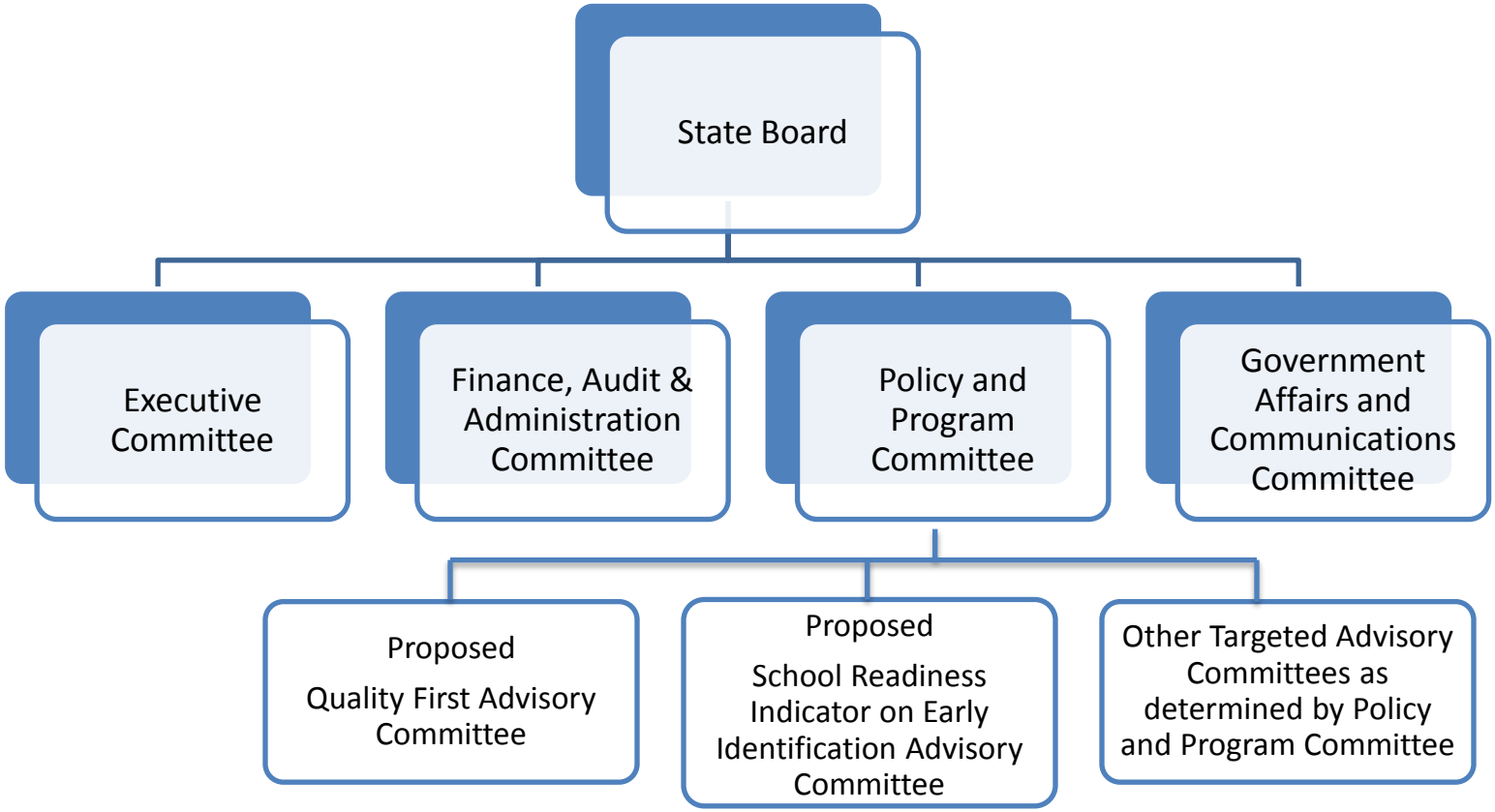
Member Christensen moved that the Program Committee take the prefaced statement as outlined, include the recommendations for Quality First and forward to the Board in July 2014 as the Policy and Program Committee recommendations. Member Karp seconded. All in favor, none opposed, Chair votes aye, motion carried.

Chair Decker thanked everyone for the commitment and work in making these hard decisions.

FY 2015 Meeting Dates:
A survey will be sent to identify dates for the Fiscal Year 15 meetings.

Adjournment:
Chair Decker called for further discussion items or member updates and there being none, adjourned the meeting at 12:00 p.m.

FTF Policy and Program Committee Advisory Committees



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Continuous Quality Improvement (CQI):

Continuous Quality Improvement (CQI) is a process shared by First Things First and grant partners to ensure programs are systematically and intentionally improving services and increasing positive outcomes for children and families. It is proactive, not reactive. It is also a shared process with all partner agencies and organizations toward enhancing the Arizona early childhood system.

CQI is a comprehensive, on-going, data-driven process of review, analysis and synthesis of past performance and current implementation. A CQI environment is one in which data is used to make positive changes—even when things are going well—rather than waiting for something to go wrong.

FTF Model of Change and Logic Models

Three Connected Levels of Continuous Quality Improvement and Related Components

System	Strategy/Program	Grantee
• Context • Components • Connections • Infrastructure • Scale	• Standards of Practice • Evidence Based or Evidence Informed Implementation	• Quality Implementation • Fidelity to Evidence Based or Informed Program Models • Contract Compliance

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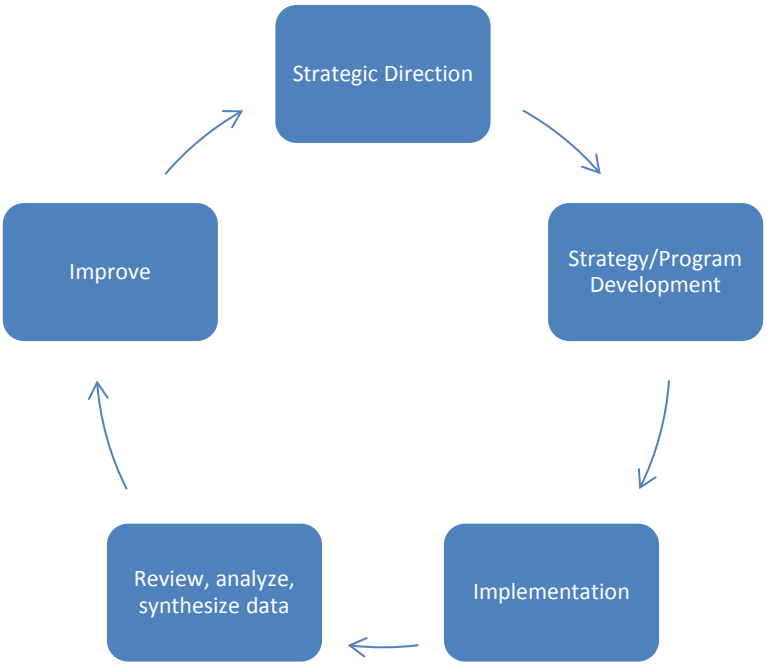
Strategy/Program Level:



Strategic Direction Determine Needs and Assets to Identify priorities for planning	**Strategy/Program Development** Plan evidence based or evidence informed programs to address priorities	**Implementation** Implement programs as intended Quality Assurance Collect grantee data	**Use Data** Review, analyze and synthesize data	**Improve** Improve quality and practice

CQI Inputs:

Needs and Assets Reports
Review of evidence-base in national and local literature and studies
Stakeholder/Partner, Board and Regional Council input and feedback
Standards of Practice
Grantee data (submitted quarterly)
Quality Assurance – desk review, onsite visit and technical assistance
Conduct Evaluation/Research studies
Reports/Results prepared for Board and Regional Councils

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Discussion Questions:

Is FTF's CQI approach clear? What question do you have about the CQI process and the components?

Are there other components that should be added or addressed in FTF's CQI approach?

How should FTF report out information and data obtained through the CQI process?

How should FTF obtain input/feedback for CQI from families, stakeholders and partners?

First Things First Model of Change

If We:	We Create:	Resulting In:	Achieving:
Develop and fund high quality services for children and families that are necessary but not yet available	Coordinated, high-quality service system for young children	**Early Learning** All children have access to high quality, culturally responsive early care & education.	All Arizona's children are ready to succeed in school and in life.
Strengthen already existing high quality services for children		**Family Support/Literacy** All families have the information, services & supports they need to help children achieve their fullest potential.	
Partner to build a system of early childhood services and information for families		**Early Childhood Professional Development** All child care/education & health professionals are well prepared, highly skilled and compensated commensurate with their education & experience.	
		Health All children have access to high quality preventive & continuous health care to promote physical, mental, oral and nutritional health.	
Lead through the synergy of statewide and local strategic planning	Leadership capacity and infrastructure to create and sustain the high-quality service system	**Early Childhood System** The early childhood system is high quality, child & family centered, coordinated, integrated & comprehensive.	
Harness data and technology to build infrastructure and support data-based decision making and accountability			
Shift the brand and awareness of early childhood in Arizona		**Public Awareness** All Arizonans understand the importance of the early years & recognize the influence of early childhood development, health & education on Arizona's economy & quality of life and, as a result, substantially support early childhood development, health, and education both politically and financially.	

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STANDARDS OF PRACTICE

Oral Health

I. INTENT OF THE STRATEGY

The intent of the evidence-based Oral Health Strategy is to provide best practice approaches that enhance the oral health status of children birth through age 5. The expected results are prevention of tooth decay and reduction in the prevalence of early childhood tooth decay and the associated risks for pain and infections that can lead to lifelong complications to health and wellbeing. The approaches for this strategy include: oral health screening for children and expectant mothers with referrals to oral health providers for follow up care as needed; fluoride varnishes for children; oral health education for families and other caregivers; and, outreach to families, other caregivers including early learning and care providers, and oral health and medical professionals.

II. DESCRIPTION OF SIGNIFICANCE

Oral health is an important part of overall health and means more than healthy teeth. Oral health includes the oral, dental, and craniofacial tissues needed for essential human functions, including to:

- Speak, chew, smile
- Smell, taste, swallow
- Convey a world of feelings and emotions through facial expressions
- Protect from microbial infections and are a barrier to other environmental exposures

<u>Young Children</u>

Good oral health and the absence of tooth decay is an essential component of child well-being. Nevertheless, untreated tooth decay is the most common infectious chronic disease among children in the United States; it is five times more common than asthma and seven times more common than hay fever. In the United States, approximately 28 percent of children ages 2 to 4 years have tooth decay experience and 16 percent have untreated tooth decay. Arizona's young children fair worse: an estimated 37 percent of children ages 2 to 4 years have tooth decay experience and nearly one in three in this age group (30%) have untreated decay. Of note, by age 4, more than half (52%) of Arizona's young children have experienced dental decay. National and state studies indicate that the prevalence of tooth decay is higher among children from low income households and some racial and ethnic groups, suggesting particular vulnerability for certain populations of young children.

Untreated tooth decay causes pain and infections that may lead to other serious problems for young children with eating, speaking, playing and learning. More than 51 million school hours are lost each year to dental-related illness. To prevent tooth decay, the American Academy of Pediatric Dentists (AAPD) recommends several strategies for enhancing the oral health of young children including but not limited to: parent/other caregiver education on oral health care (particularly on preventing

transmission of the decay causing bacteria from one person to another, eating healthy nutritious foods and limiting sugars, and caring for gums and teeth); first preventative visit to a dentist within six months of the first tooth erupting and no later than age one, with preventative check-up there-after; a series of topical fluoride applications to children's teeth; and, fluoridated public water supplies. The First Things First (FTF) Oral Health Strategy helps support these recommendations through oral health education of parents and other caregivers, as well as age appropriate education of children; oral health screening, and fluoride varnish application.

Expectant mothers

Oral health is an important focus during the prenatal period. During pregnancy, hormonal changes increase an expectant mother's susceptibility to inflammation of the gums (gingivitis) and gum disease (periodontitis) and morning sickness can cause dental erosion because of increased acid in the mouth.

Poor oral health in pregnancy is associated with premature birth *and* low birth weight. In addition, treating any tooth decay before baby is born is important because decay causing bacteria can be transmitted from mother to child by any mechanism that results in an exchange of saliva. According the Academy of General Dentistry, pregnant women should maintain their regular, semi-annual checkups and consult a dentist if they notice any changes in their oral health. Nevertheless, it is estimated that just 22 to 34 percent of women in the U.S. visit a dentist during pregnancy. The Oral Health strategy supports outreach and messaging regarding the importance of oral health care during pregnancy, as well as oral health screening and referral for pregnant women.

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 Oral Health Program that meets the First Things First accepted definition of evidence based, evidence informed and promising practice models and is designed to address the needs of families with children ages birth to 5 and expectant mothers that a) utilizes evidence based practices for oral health screening and application of fluoride varnish; and b) evidence informed or promising practices for providing oral health education and referral for oral health treatment.
   a. The program will comply with rules issued by the Arizona State Board of Dental Examiners and all rules and practice guidelines for applicable professional bodies.
   b. Oral Health Screening and Fluoride Varnish
      An Oral Health Program will complete oral health screening and applying fluoride varnish as follows**:**
      - Obtain appropriate consent from the parent or guardian.
      - Maintain client confidentiality.
      - Use fluoride varnishes contain a concentrated dose of sodium fluoride (5% NaF) which, when placed on the teeth topically, facilitates re-mineralization of the enamel.
      - Apply fluoride varnish two-four times per year on each participating child according to a child's risk.
      - Develop an electronic system to track children receiving screenings and fluoride varnishes.
      - Provide services within a variety of settings, such as, but not limited to: immunization clinics, physician offices, WIC offices, early care and education centers (Head Start, Early Head Start, pre-schools, and child care facilities) and in private homes for medically compromised patients.
      - During the contact:

- Complete an oral health screening of the child and complete a dental caries risk assessment using best practice tools (See Section IV.B, Resources).
    - Provide anticipatory guidance/oral health education according to findings from the screening and assessment; this may be provided to the child as is age appropriate, or the parent/primary caregiver, or both.
- Complete an oral health screening of the expectant mother and complete a dental caries risk assessment using best practice tools (See Section IV.B, Resources).
    - Provide anticipatory guidance/oral health education according to findings from the screening and assessment.
- Apply fluoride varnish if indicated. (Note: some parents may consent to the screening but not fluoride varnish.)
- Provide written and oral instructions on follow up care, including but not limited to:
    - Care of the oral cavity following fluoride application.
    - Treatment needs; e.g. for tooth decay, and options for dental providers for that care.
    - The importance of establishing a dental home for expectant mothers and children ages birth through 5, and options for dental providers.
- Provide a list of local dental providers, as well as information on the Arizona Children's Dental Network, to encourage connection to a dental home (KidsAZ Dental.org).
- Provide an age appropriate oral health kit (optional).

c. Oral Health Education for Children, Families and Other Caregivers

An Oral Health Program will provide oral health education to children, parents, and other adults that may include providers of early care and education. It is expected that the Oral Health Program will stay current on best practice recommendations for providing oral health education and promoting behaviors that prevent dental decay and other oral health problems.

- The oral health education may be delivered in a group session *or* through an individualized educational session.
    - A group educational session is defined as an instructional opportunity lasting 30 minutes or more and delivered to the group of three or more individuals.
    - An individualized education session is defined as an interactive instructional opportunity with a child, pregnant woman, parent, or other caregiver.
- Programs will use best practice/evidence informed oral health educational materials comprising a curriculum and supporting collateral materials (e.g., brochures, flyers). The curriculum will include information on topics such as:
    - Minimizing saliva-sharing activities (e.g., sharing utensils/silverware) between an infant or toddler and family members or other children in an early care and education setting.
    - Cleaning a young child's teeth if the infant/child falls asleep while feeding.
    - Wiping an infant's gums with a soft wash cloth.
    - Tooth brushing with a soft and age-appropriate sized tooth brush once teeth

emerge using fluoridated toothpaste according to current recommended oral health practice.
    - Flossing between teeth when adjacent tooth surfaces cannot be cleansed by a toothbrush.
    - Providing age appropriate assistance to a child with tooth brushing and flossing.
    - Establishing a dental home and visiting the dentist within six months of emergence of the first tooth and no later than one year.
    - Avoiding caries-promoting feeding behaviors. In particular, parents should be advised that:
        - Infants should not be put to sleep with a bottle containing fermentable carbohydrates (such as milk).
        - Parents should be encouraged to have infants drink from a cup as they approach their first birthday. Infants should be weaned from the bottle at 12 to 14 months of age.
        - Repetitive consumption of any liquid containing fermentable carbohydrates from a bottle or no-spill training cup should be avoided.
        - Between-meal snacks and prolonged exposures to foods and juice or other beverages containing fermentable carbohydrates should be avoided.
    - Education for expectant mothers will include:
        - Increased risk of gum disease and tooth erosion during pregnancy.
        - Basics of proper dental hygiene for adults including brushing, flossing and healthy snacking and meals.
        - Basic oral health preventative care during pregnancy including regular visits to a dental home.
        - Proper care of newborn and infant mouth and teeth to prevent tooth decay.

d. Outreach to Oral Health Program Participants

An Oral Health Program with conduct outreach that engages families of children through age 5 and expectant mothers in opportunities for oral health education, screening and fluoride varnish application (for children).

- To reach the target population, FTF encourages coordination with a) other FTF grantees, such as Family Resource Centers and Quality First early education and care centers, and b) non-First FTF grantees, including WIC offices, immunization clinics, non-Quality First early education and care centers, and other settings where families of young children congregate.
- FTF expects an Oral Health Program to plan service delivery so as not to duplicate or supplant other oral health care that is available in the community.

e. Outreach to Oral Health and Medical Professionals

An Oral Health Program will outreach to medical professionals whose practice includes expectant mothers and young children, as well as to oral health professionals, to emphasize the importance of oral health care for pregnant women and young children. The Oral Health Program may provide professionals with supporting print educational materials as appropriate. When educating Oral Health and Medical Professionals, the educator will:

- Document the purpose, goals and objectives of the Oral Health Program.
- Communicate the purpose and objectives of the activity.
- Identify educational needs/gaps of the learner or target audience.

- Select a format and setting for the activity that are appropriate for the target audience and type of program being implemented.
- Incorporate principles of adult learning into instruction.
- Disclose to learners any relevant financial relationship(s) prior to the beginning of the educational activity.
- Encourage learners to provide regular feedback that will include: whether identified educational needs were met, the overall effectiveness of the program and improvement suggestions.
- Assure that the content/format of activities and materials will promote improvements in quality health care and not specific proprietary business interests or commercial interests.
- Develop a post training evaluation for participant feedback.

Outreach to Oral Health Professionals will also include engaging them as a referral resource for establishing a dental home, and for when expectant mothers and children require follow up care.

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. The literacy learning standard requires grantees to:
   a. Promote and support meaningful early literacy experiences and opportunities for young children in the appropriate context of program implementation.
   b. Support families and caregivers with parenting and child-rearing skills that help increase understanding of early language and emergent literacy development.
   c. Encourage families to use the language in which they are most confident and competent.

   For the Oral Health strategy, this might include providing age appropriate print materials about oral health to families and other caregivers to read to their children, or ways to engage children in other language development opportunities through activities such as tooth brushing.

3. Follow the FTF Child Welfare Policy 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. Coordinate and collaborate with other community partners to communicate aligned oral health messages and approaches.

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.
   c. For the Oral Health strategy, continuous quality improvement may include qualitative and quantitative documentation of change that activities are bringing about. This may include documentation of positive change, no change, and unexpected outcomes to assist the program and Regional Council in redirecting the Oral Health Program as needed to meet local conditions.

6. FTF embraces cultural responsivity 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. Direct service staff for the Oral Health strategy will include:
      - *Oral Health Screening and Fluoride Varnish* – Health professionals provide oral health screenings and apply fluoride varnishes may include:
        - Dentists

    - Dental Hygienists
    - Physicians, physician assistants, registered nurses or licensed practical nurses.
- Health professionals who provide oral health screenings and apply fluoride varnishes must:
    - Have experience in working with young children.
    - Complete training on:
        - The appropriate process to apply fluoride varnish.
        - Approaches to mitigating a child's apprehension about oral health screening and fluoride varnish.
        - Approaches to providing oral health care in a public health setting.
    - Have appropriate training and supervision as required by individual licensing bodies and boards.
    - Comply with all rules and regulations as required by individual licensing bodies and boards.

- *Oral Health Education and Outreach* – For staff providing oral health education and outreach:
    - A bachelor's degree in health education or a public health field is preferred but other allied health professionals may qualify, such as promotoras.
    - Staff are expected to:
        - Reflect the cultural and ethnic experiences and language of the families with whom they work.
        - Complete training in the specific oral health education curriculum and materials being used by the program.
        - Have excellent communications skills and the ability to adjust to the individual learners' needs, both children and adults.
        - Have skills necessary to outreach to and interact with oral health and medical professionals.

2. Supervisory staff
   The Oral Health Program will fall under the purview and supervision of a unit/office/division within an organization such as a county health department, community health center, university or college with experience providing oral health training and/or services.

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 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.

C. Additional Standards

The following are **optional** for an Oral Health Programs:

1. Obtaining Fluoride Varnish Reimbursement
   The Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid agency, allows participating health plans to reimburse for fluoride varnish application to children enrolled in AHCCCS. Rules and regulations apply regarding who may place standing orders for the fluoride varnish and how frequently the varnish can be applied. Oral Health Programs may consider opportunities to obtain reimbursement for fluoride varnish applied to children enrolled in AHCCCS if they are an AHCCCS provider or they contract with the Arizona Department of Health Services, Office of Oral Health to participate in the fluoride varnish reimbursement program if applicable. FTF can work with the program to determine the feasibility of and appropriate mechanisms for obtaining reimbursement. It is expected that reimbursement collected will be reinvested in the program to provide services to additional children after operational cost for billing are taken into consideration.
2. Teledentistry
   Teledentistry is a developing area of dentistry that integrates electronic health records, telecommunications technology, digital imaging, and the Internet to link dental providers and their patients. Teledentistry offers innovative prospects in the delivery of dental care and has the potential to enhance the current practice of dentistry. Through the exchange of clinical information over distances, teledentistry can facilitate the delivery of dental care in areas underserved by dental practitioners, and therefore overcome social and geographic barriers. Teledentistry may be a helpful approach for rural regions to accelerate transmission of oral health screening data to a dental provider to help accelerate follow up care when treatment is needed. FTF can work with the program to determine the applicability and feasibility of, and appropriate mechanisms for, teledentistry.

3. Community of Practice
   FTF encourages an Oral Health Program to participate in a local, regional or statewide community of practice to exchange ideas and best practices for the delivery of oral health education, outreach, and screening and varnishes for expectant mothers and children.

IV. REFERENCES AND RESOURCES

A. References

1. Developing a Thriving Reader from the Early Years: A Continuum of Effective Literacy Practices (available in Fall 2014)
2. FTF Child Welfare Policy (attached)
3. FTF Suspected Child Maltreatment Mandated Reporting Policy (attached)
4. Arizona Early Childhood Career and Professional Development Network Website: azearlychildhood.org (available Fall 2014)
5. U.S. Department of Health and Human Services, National Institute of Dental and Cranofacial Research. *Oral Health in America: A Report of the Surgeon General (2000)* www.nider.nih.gov/DataStatistics/SurgeonGeneral

6. U.S. Department of Health and Human Services, Washington, DC. *Healthy People 2020 (Oral Health)* www.healthypeople.gov/2020
7. American Academy of Pediatrics. *National Summit on Children's Oral Health: A New Era of Collaboration, November 2008* www2.aap.org/commpeds/dochs/oralhealth/SummitOralHealth.html
8. Guarnizo-Herreno CC, Wehby GL. 2012. Children's dental health, school performance, and psychosocial well-being. Journal of Pediatrics 161(6):1153-1159.
9. "Policy on Early Childhood Caries (ECC): Classifications, Consequences, and Preventive Strategies." American Academy of Pediatric Dentistry and the American Academy of Pediatrics. Revised 2008.
10. "AAPHD Resolution on Fluoride Varnish for Caries Prevention." January 2008. American Academy of Public Health Dentistry (AAPHD).

B. Resources

General

1. National Association of State and Territorial Dental Directors (ASTDD) www.astdd.org
2. National Institute of Dental an Craniofacial Research www.nidcr.nih.gov
3. Arizona State Board of Dental Examiners http://azdentalboard.us
4. Arizona Department of Health Services, Office of Oral Health www.azdhs.gov/phs/owch/oral-health/
5. Arizona Department of Health Services, Office of Oral Health: Teledentistry in Arizona www.youtube.com/watch?v=FimWxhGXkqo
6. Arizona Children's Dental Network KidsAZDental.org
7. Collaborative dental practice models in Minnesota www.mchoralhealth.org/mn/collaborative-practice/cdhp/

Screening and Risk Assessment

1. Oral Health Risk Assessment Tool developed by the American Academy of Pediatrics: http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf
2. Caries-Risk Assessment Tool (CAT) developed by the American Academy of Pediatric Dentists, based on a set of clinical, environmental and general health factors: http://www.aapd.org/media/Policies_Guidelines/G_CariesRiskAssessment.pdf
3. Caries Management By Risk Assessment (CAMBRA) developed to assess the child's risk for tooth decay and determine appropriate preventive and therapeutic interventions: https://www.coursera.org/#course/cariesmanagement
4. Caries Risk Assessment Form (Ages 0-6) developed by the American Dental Association as a practice tool for dentists and a communication tool with the parent/guardian: http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/topic_caries_over6.ashx

Oral Health Education

1. American Dental Association: *Smile Smarts!* An oral health curriculum for preschool through grade eight, for students offering flexible, modular lesson plans, support materials, hands-on classroom demonstrations, student activity sheets, and suggestions for further oral

health activities
www.mouthhealthykids.org/en/educators/smile-smarts-dental-health-curriculum/

2. The California Childcare Health Program is a community-based program of the University of California, San Francisco (UCSF) School of Nursing, and Department of Family Health Care Nursing. PDF includes a comprehensive listing of web sites containing educational oral health curriculum.
www.ucsfchildcarehealth.org/pdfs/Curricula/oral_health_11_v6b.pdf
3. *First Smiles* is a statewide initiative in California to address Early Childhood Caries affecting children ages 0-5.
www.first5oralhealth.org
4. Oregon State Early Childhood Cavities Prevention Program http://public.health.oregon.gov/PreventionWellness/oralhealth/Pages/eccp.aspx
5. Partners in Prevention: Getting a Head Start on Oral Health is an infant and toddler oral health continuing education course specifically for Head Start employees and non-dental health professionals.
www.nypartnersinoralhealth.com
6. The National Head Start Oral Health Resource Center assists the national Office of Head Start/Maternal and Child Health Bureau oral health initiative in enhancing the quality of oral health services for pregnant women, infants, and children enrolled in Head Start. http://www.mchoralhealth.org/HeadStart/index.html
Anticipatory guidance to share with parents on infants milestones of development www.mchoralhealth.org/PediatricOH/mod2_6_2.htm
7. National Maternal and Child Oral Health Resource Center www.mchoralhealth.org/toolbox/professionals.html
8. *Open Wide and Trek Inside!* National Institute of Health with the National Institute of Dental and Craniofacial Research, a creative, inquiry-based, active learning instruction program.
www.science.education.nih.gov/supplements/nih2/oral-health/default.htm

Oral Health Activities for Children

1. Colgate-Palmolive Company: www.colgate.com/app/BrightSmilesBrightFutures/US/EN/HomePage.cvsp
2. Oral Health Coloring Books for Children
http://dentalresource.org/resource.html

Oral Health Websites for Families

1. American Dental Association: Mouth Healthy www.mouthhealthy.org/en/
2. Academy of General Dentistry: Know Your Teeth – Your Family's Oral Health www.knowyourteeth.com/family/
3. Academy of General Dentistry: Know Your Teeth – Oral Health During Pregnancy
www.knowyourteeth.com/infobites/abc/article/?abc=P&iid=325&aid=7586
4. American Academy of Pediatrics: Healthy Children – Oral Health
www.healthychildren.org/English/healthy-living/oral-health/Pages/default.aspx

Intersect of Breastfeeding and Children's Oral Health

1. American Academy of Pediatricians: http://www2.aap.org/breastfeeding/familiesResourceGuide.html

2. Academy of Breastfeeding Medicine: http://www.bfmed.org/

FIRST THINGS FIRST

Ready for School. Set for Life.

First Things First Strategic Direction
Systems Approach Framework for Programmatic Priorities
January 2014

Introduction

First Things First's planning and work toward our mission of ensuring a child enters school healthy and ready to succeed typically occurs in three fiscal years at the same time. Currently, FY 2014 implementation of strategies and programs and accompanying data collection is in progress. The Board is also reviewing FY 2015 funding plan recommendations forwarded by Regional Partnership Councils and subsequent grant applications and agreements will be completed in the next six months. Preparation for FY 2016 planning is also beginning with the review of strategy standards of practice, compliance and performance data, evaluation study results, and grantee and partner feedback.

Over the past four years, the work of the First Things First Board, Regional Councils and staff has been strategically guided by recommendations from the Arizona Early Childhood Taskforce, whose members were appointed in January 2010 by Board Chair, Steve Lynn. The Taskforce developed the vision for and elements of a comprehensive early childhood model system, and identified nine priority roles for First Things First, with the explicit understanding that First Things First is only one of many key partners that have an important role in building and sustaining the early childhood system. The nine priority roles include:

1. Quality, access and affordability of regulated early care and education settings
2. Family support and services
3. Professional development system
4. Quality health care and coverage
5. Quality standards, curriculum and assessments
6. Nutrition, physical activity and obesity prevention
7. Comprehensive, aligned and accountable system
8. Adequate and sustainable funding
9. Public awareness and support

The Early Childhood Taskforce recommendations have guided First Things First's strategic direction

The first seven priority roles have a programmatic focus and were the basis of the 10 School Readiness Indicators recommended by the members of the Board's Policy and Program Committee, and the Committee's three Advisory Committees for Early Learning, Children's Health and Family Support and Literacy. The Board approved the 10 recommended indicators In August 2011. The School Readiness Indicators provide a comprehensive composite measure of system progress for young children and were chosen to reflect the effectiveness of funding strategies and collaborations built across communities to improve the lives of children in Arizona and improve their readiness for entering school and subsequently their life long success. They are intended to guide Regional Councils and the Board in making informed priority decisions. (Also see Attachment A).

In October 2012, the board approved the Policy and Program Committee's recommended state level benchmarks for individual School Readiness Indicators for the year 2020. These benchmarks provide First Things First with aspirational, yet achievable targets and will be monitored over time in order to determine progress in reaching systemic improvements for children and families. Regional Councils are now identifying regional level benchmarks for their priority indicators for the year 2020, and these recommendations will be forwarded to the Board in June 2014.

Systems Approach Framework for Priority Roles

As the Early Childhood Task Force identified priority roles for First Things First in 2010, this is also the same year that First Things First funding was invested statewide through Regional Partnership Councils and community grantees. Each year since then, increased capacity and continuous development among all partners has led to improvement and outcomes within Arizona's early childhood system. As strategic planning begins for FY 2016 and beyond, First Things First's focus is on achieving the 2020 benchmarks set for the School Readiness Indicators which will indicate a shift in system behaviors and progress in the priority roles and toward positive outcomes for children and families.

Toward this goal, the Advisory Committees of the Policy and Program Committee, Regional Councils, and First Things First staff have initiated planning discussions using a framework developed by the national BUILD Initiative to evaluate early childhood systems initiatives (Coffman 2007). The framework identifies five connected early childhood system levers: Context, Components, Connections, Infrastructure and Scale. The bullet points for each of the levers are adapted from Coffman's work.

Changing the political environment that surrounds system and affects its success	Establishing high-performing quality programs and services	Creating strong and effective linkage across the system	Developing the supports the system needs to function effectively and with quality	Ensuring the system is comprehensive and works for all children
• Policy changes that expand or enhance systems, strategies and programs • New knowledge and perspectives • Funding streams that are more flexible across systems and programs • Public engagement or mobilization • New advocates or champions	• Expanded program reach or coverage • Continuous improved program quality • Increased operational efficiency • Eliminate duplication and redundancies • New programs or services as needed and only if needed • Maximize use of technology and social media	• Integrated approach across goal areas and strategies • Collaborative approach among and between partners, agencies, regions, and grantees • Coordinated eligibility assessments and applications • Referrals occurring from one program to another • Joint planning across system components • Shared data systems for tracking progress • Outcome data used to drive decision-making	• Consistent and expected standards of quality across the system • Education and training to ensure an appropriately skilled systems workforce • Technical assistance to support systems development • Defined roles and mechanisms for accountability • Infrastructure needed for sustainability	• Employing social innovation and adaptation at regional and statewide levels • Availability of programs and services throughout a geographic region • A comprehensive array of programs and services for system beneficiaries • Long-term financial security to maintain the system over time • Shifts in system ownership, meaning that a broad array of people involved in the system, especially those on the frontlines, assume collective responsibility for maintaining the system

Adapted from: Coffman, Julia. 2007. *A Framework for Evaluating Systems Initiatives*. BUILD Initiative.

This systems framework has been valuable in identifying assets and gaps, guiding discussion, and organizing recommendations across First Things First. At first glance, it is not so different from the approach that First Things First has used in the past; however, application of the framework has caused a shift in intentional, focused thinking and planning about how progress can be made in the priority roles as measured by the School Readiness Indicators. It is intended to impact execution of First Things First system work in the same way.

The Program and Policy Committee and Advisory Committees for Early Learning, Children's Health and Family Support and Literacy have focused on seven powerful initiative areas listed below that align with the priority roles. We propose that the systems framework be used in these initiative areas to inform strategic planning at state and regional levels beginning with FY 2016. As well, our system partners in state agencies, BUILD Arizona, and local community organizations are focused in many of these same areas and First Things First will continue collaborating and coordinating with them to identify the assets, gaps and levers to move forward.

1. Saturate families and communities with information, resources and supports, at the right time along the developmental continuum (including pre-natal), to benefit children. Families are their child's first and most important teacher across all domains of development and school readiness and they are most powerful when they are knowledgeable about how best to support their child's development and health.

2. Build families' capacity to support their child's physical, oral and mental health through a preventative approach.

3. Infuse early literacy throughout all system work, strategies and programs by integrating and leveraging the efforts and resources of Read On Arizona (First Things First is a founding partner) for families, educators, caregivers and decision makers.

4. Expand access to high quality early learning programs and study, refine and expand the Quality First Initiative to efficiently and effectively benefit families, children, and early childhood professionals.

5. Develop and connect components of a comprehensive assessment system that includes universal screening and referral resources, developmental progress assessment, early learning progress assessment and the Kindergarten Developmental Inventory at kindergarten entry.

6. Complete implementation and operation of the early childhood professional development system infrastructure, inclusive of compensation to match degree progression.

7. Collect, utilize and communicate outcome data results to inform transparent and accountable data-driven decisions.

The timeline for FY 2016 strategic planning includes:

January 2014:

- System approach framework presentation and discussion with Board members

February 2014:

- Begin discussions on framework and focused initiatives with regional staff and prepare communication to regional councils
- Begin discussions on improving effectiveness and efficiencies, as well as duplications and redundancies of strategies and programs; begin revisions on Standards of Practice

March 2014:

- Continue staff discussions related to systems approach and strategic planning
- Begin development of First Things First operational strategic plan for FY 2015-2016 (implementation strategies and tactics)

April 2014:

- Continue staff discussions related to systems approach and strategic planning
- Continue development of First Things First operational strategic plan for FY 2015-2016

June 2014:

- Finalize FTF Strategy Toolkit with revised strategy and program information and costs
- Finalize First Things First operational strategic plan for FY 2015-2016
- Preparation for FY 2016 funding planning and financing discussions

July 2014:

- Begin FY 2016 funding plan development

November 2014:

- FY 2016 funding plans completed

January 2015:

- Board approves FY 2016 funding plans and implementation begins

FIRST THINGS FIRST

Ready for School. Set for Life.

First Things First
Research and Evaluation National Advisory Panel
2014 Meeting Summary Report

June 2014

FIRST THINGS FIRST EARLY CHILDHOOD RESEARCH AND EVALUATION NATIONAL ADVISORY PANEL

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Diane Bricker, Ph.D., First Things First
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Kevin J. Brown, Ed.D., Assistant Clinical Professor of Educational Leadership, Northern Arizona University, First Things First, Coconino Regional Partnership Council

Noel A. Card, Ph.D. Associate Professor, Family Studies and Human Development, University of Arizona, John and Doris Norton School of Family and Consumer Sciences

Greg Duncan, Ph.D. Distinguished Professor, Department of Education, University of California, Irvine

Robert M Goerge, Ph.D., Senior Fellow at Chapin Hall at the University of Chicago, Harris School, University of Chicago

Claude Goldenberg, Ph.D. Professor of Education, Stanford University School of Education

Candida Hunter, First Things First, Hualapai Tribe
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David P. Moxley, Ph.D., DPA, Oklahoma Health Care Authority, Medicaid Endowed Professor of Public Health, Professor of Social Work, University of Oklahoma

Pamela Powell, Ed.D. Associate Professor of Literacy and Early Childhood, Northern Arizona University College of Education, First Things First, Board Member

Malia Villegas, Ed.D., Director, NCAI Policy Research Center, Washington, D.C.

Background

Research and evaluation have been a critical component of FTF since its inception. FTF strives for complete transparency and holds itself, and its collaborations with partners, accountable for achieving intended outcomes for children. In 2011, the FTF Board requested a re-examination of FTF's research and evaluation approach, resulting in the creation of the FTF Early Childhood Research and Evaluation National Advisory Panel (Panel) in January 2012. The Panel was convened to provide recommendations to the FTF Board on developing a comprehensive statewide and regional research and evaluation framework and included representation from experts in early childhood research; evaluation design and methodology; Native American early education; placed-based, systems-level evaluation; school readiness, including literacy and language development, cognitive development, and executive functioning; state prekindergarten evaluation; special needs and early intervention; health; and a unique Arizona, state-specific, perspective.

The Panel met three times in the winter and spring of 2012 and produced a report summarizing the Panel's recommendations. The Panel's report was accepted by the FTF Board in 2012. FTF staff produced the 2013-2017 Research and Evaluation Plan to implement the Panel's recommendations and set the research and evaluation direction for FTF. The Research and Evaluation Plan was approved by the FTF Board in October 2012.

One of the goals of this plan was to establish an advisory panel to annually review evaluation and research activities for their soundness and utility and provide feedback on planning activities based on their alignment with the National Panel's recommendations and best practices in research and evaluation. Annual meetings are open to the public and all interested stakeholders, including regional councils, state agency partners, and tribal leaders.

The current Panel responsibilities include:

- Reviewing FTF research and evaluation activities annually to ensure alignment with recommendations of the National Panel and quality standards;
- Reviewing and critiquing approaches for planned research and evaluation activities, e.g., longitudinal data system, Quality First study; and,
- Ensuring FTF undertakes high quality planning, coordination, and implementation of all research and evaluation activities.

  In addition to their annual review of progress and future planning, this panel may serve as an ongoing resource for technical review and advice on evaluation contracting, programmatic monitoring, development of data systems, and reporting and analysis.

Overview

Dr. John Love, Panel Chair, called the meeting to order and introduced the Panel members and FTF staff. Dr. Love has served as the Chairman of the Panel since its inception in 2012. Chairman Love underscored the importance of accountability, transparency, producing valid data and evaluations, and continuously improving efforts to support young children in Arizona as key FTF goals.

Dr. Roopa Iyer, Senior Director, FTF Research and Evaluation, provided the Panel with an update of the progress made to date on key FTF projects and activities outlined in the Research and Evaluation Plan, including those projects completed, in progress, on hold or behind schedule. Sam Leyvas, FTF Chief

Executive Officer, presented the Panel with an overview of the history of FTF, discussed FTFs responsibility to taxpayers for transparency and accountability, and emphasized the importance of quality data and sound evaluation for FTF data driven decision making.

Michelle Katona, FTF Chief Regional Officer, presented an overview of Regional Partnership Council governance and membership structure, and the funding and planning cycles by which they operate. Ms. Katona further explained that Regional Partnership Councils have prioritized FTF Board approved School Readiness Indicators and are in the process of setting benchmarks for 2020 for those indicators for which data is available, noting that FTF cannot meet these benchmarks with FTF efforts alone. It was emphasized that Regional Councils must find opportunities for leveraging funds, building partnerships, and infrastructure and capacity building activities to successfully reach targeted benchmarks.

First Things First Systems Approach

Karen Woodhouse, FTF Chief Program Officer, introduced and reviewed the FTF systems approach that outlines FTF's nine priority roles identified by the Early Childhood Taskforce (2010). These roles are an important part of the vision for and elements of a comprehensive early childhood model system, with the explicit understanding that FTF is only one of many key partners that have an important role in building and sustaining the early childhood system. As strategic planning begins for FY16 and beyond, FTF's is focused on achieving the 2020 benchmarks set for the School Readiness Indicators. The Advisory Committees of the Board's Policy and Program Committee, Regional Councils, and FTF staff have initiated planning discussions using a systems framework developed by Julia Coffman (2007).

As FTF moves forward, decisions must be grounded in robust data and evaluation. Towards this goal, FTF recognizes that gaps still exist in both implementation and outcome data for its funded programs, and that the implementation data required by FTF as part of strategy implementation isn't always adequate to answer whether the program is meeting its intended goal.

The discussion with the panel focused on when and how to collect meaningful implementation and outcome data towards continuous program improvement.

Panel Feedback and Recommendations

Supporting Capacity Building

- Rural communities may face challenges in attempting to collect good data due to variance in grant partner capacity. The need for grantee training with a focus on capacity building was identified.
- A dual tier approach was suggested for implementation data collection, one approach for the urban areas with grantees with greater capacity and another for rural or other communities with limited capacity and resources.
- Provide support to grant partners to initiate or better document the progress being made (e.g. how to demonstrate the needle is moving).
- Identify and provide tools to support all regions in collecting, understanding, and using data.

Efficient and Effective Data Collection

- Tighten standards of practice and selection criteria/rubrics to prioritize evidence-based programs. Create rigorous standards for evidence informed and/or innovative programs.
- Require grant partners to identify how they will comply with the standards of practice.

- Working with systems partners, collect meaningful implementation data and fidelity of implementation data from evidence-based models as part of program requirements.
- Guide grant partners and Regional Council members on what is expected for quality:
  (i) implementation data,
  (ii) short term outcome data, and
  (iii) long-term outcome data.
- Focus on identifying the services FTF funds where quality data are available and at what level (e.g., implementation versus outcome).
- Examine how Regional Councils are meeting community needs using existing data, and provide support for data interpretation towards decision making.
- Audit programs for service and financial data.
- Focus on securing short term outcomes that might begin to address the question of whether funded programs and efforts are meeting the needs of their communities.
- Ensure implementation data is not used in place of data showing real outcomes.
- Collect dosage data (e.g. attendance of children and parents in participating programs), as it can inform impact.
- Identify outcome data that could be secured via an administrative data base versus evaluation studies.
- Conduct cost-benefit analysis to determine how much outcome data should be collected. Annual formal evaluations for all programs may be cost prohibitive, especially for all programs funded by FTF Regional Councils.
- Consider how to go to scale with programs while maintaining quality.
- Consider utilizing local universities and community colleges to collect short term and/or long-term outcome data.
- Maintain the extremely important focus on systems work.

Integrated Data System and FTF Dashboard

Dr. Iyer provided an overview of FTF's progress in implementing an integrated early childhood data system and securing data sharing agreements. While Arizona does not currently have an integrated data system for all early childhood state agency data, FTF will continue working on data sharing agreements with agency partners and focus efforts on building an administrative database to house comprehensive early childhood data. Simultaneously, FTF is focusing on continuously improving its data system to incorporate participant level data for programs funded. Nicole Johnson, Vice President of Operations, provided the Panel with an overview of FTF's data dashboard efforts to date, including the mapping tool. The FTF dashboard will present existing program service data, financial data, census data, and other agency data in new and meaningful ways. The dashboard is planned to be launched in the first quarter of FY15.

Panel Feedback and Recommendations

Ongoing development of the integrated database

- Focus on continuously building the administrative data system and the FTF integrated data system.
- Create a case-management and personnel-management system through which FTF can track service encounters and referrals for individual children and parents.
- Providers need to take attendance and take notes on their cases to improve practice. Very important to strive for identifiable and unduplicated service data.

Tribal Data Considerations

- Use caution when determining whether to consolidate or coordinate available data. Unique indicators for tribal populations may be lost in consolidation (e.g., the difference between unemployment rate versus joblessness in tribal communities and elsewhere).
- Focus on indigenous population identification and how different federal and local agencies define Native American. Many Native Americans are "getting lost" in mixed race classifications and being underrepresented.
- Ensure reciprocal access to data to address the need for transparency and access for tribes' utilization and interpretation of data. .

Review of First Things First School Readiness Indicators and Data Sources

School Readiness (Kindergarten Developmental Inventory)

Ms. Woodhouse provided the panel with an overview of the status of FTF School Readiness Indicators and statewide and regional benchmarking. Only three of the ten indicators were discussed at the meeting, as the focus was to determine the best source of data for the indicators on hold/or under review for revision. An overview was provided for the Panel on efforts to date to implement an Arizona Kindergarten Developmental Inventory instrument (KDI) that is intended as a formative assessment and provide trend data for the FTF indicator of school readiness at kindergarten entry. Arizona is participating in a 10-state consortium led by North Carolina that is developing an assessment system for kindergarten through grade three that includes a Kindergarten Entry Assessment (KEA). The Arizona Department of Education is currently using the Teaching Strategies Gold instrument in public school preschool programs, as do most Arizona Head Start programs. This instrument was discussed as a potential measure for school readiness as well as a child outcome measure for the FTF Quality First validation study.

Panel Feedback and Recommendations

- KDI should include all five critical domains of school readiness identified by the National Education Goals Panel, including numeracy, executive functioning, and social-emotional development. Do not focus solely on literacy, or even just literacy and math in developing the KDI.
- KDI should be a high-quality, multidimensional assessment; FTF should consider using it not only to focus attention on the domains of school readiness but to draw attention to what FTF has accomplished with all its programs.
- KDI has more than one purpose. FTF should ensure that it meets FTF's purpose as an outcome measure for all FTF services that children receive between birth and the time they enter kindergarten.
- Determine what percent of Quality First programs are currently using Teaching Strategies Gold as their assessment tool prior to finalizing a measure.

Developmental Delays Identified in Kindergarten

The Panel was informed that there is no quality data source currently available in Arizona to measure the school readiness indicator related to developmental delay identification — the percentage of children with newly identified developmental delays during the kindergarten year. This was underlined in the findings in the Intervening Early Opportunity Assessment Report by Dr. Charles Bruner. IDEA Part C, which funds services for children birth to age three, is administered through the Arizona Early Intervention Program (AZEIP). When looking at the available data from AZEIP, FTF staff determined that

this is not the best data source given its high eligibility threshold. FTF is reconsidering the language/focus for this indicator and whether it is the best measure of progress of early identification of delays or if there is a more targeted indicator. The intent of this indicator is to accurately screen children with developmental delays and when indicated, refer these children and their families to appropriate services and supports.

The Panel observed the complexity of this issue given that Arizona does not have an integrated early intervention system to address the needs of all children on the continuum of development delays. The Panel further discussed how to identify and serve all children with mild to moderate developmental delays in a coordinated systematic approach. The Panel also highlighted HIPAA (Health Insurance Portability and Accountability Act) restrictions that protect the privacy of a child, but can make it challenging to share data and information with other service providers in the system to more effectively and seamlessly support the child.

Panel Feedback and Recommendations

- Focus to include healthcare providers, such as pediatricians, in conversations related to developmental delays identification as they are often the first to respond to children's issues; also include the state's Child Protective Services Department and their role in working with vulnerable children.
- With respect to early intervention, be mindful of where FTF sets the threshold for screening, due to the risk of false positives, under-diagnosis, and/or misuse of "at-risk" designations.
- Utilize medical professionals to refer children for services in the system (e.g. pediatricians to refer families for home visitation services).

Confident Families (FTF Family and Community Survey)

Dr. Iyer presented the school readiness indicator related to confident families--the percentage of Arizona families that report they are competent and confident about their ability to support their child's safety, health and well-being--and noted that FTF set a statewide benchmark for this indicator in 2013. The Family and Community Survey, conducted every 2 to 3 years, is the proposed data source to measure progress on this indicator. In FY14, data is also being collected from families in FTF tribal regions via focus groups or one-on-one interviews, using the same survey questions. This data collection approach was selected following feedback FTF received from tribal communities suggesting that a phone survey was not necessarily the best method to collect tribal survey data. The information received from the 2012 phone survey is being used as a first effort to set baseline information related to parents' self-report about confidence supporting their children. FTF requested Panel input on:

- Whether other national tools exist to measure parent confidence in supporting their children;
- How to collect population outcome data on this construct; and,
- How FTF family support strategies contribute to the population outcome of increased parental competence and confidence.

The Panel discussed the challenges in getting truly representative survey samples, and even more challenges in ensuring similar representativeness across multiple time points in longitudinal surveys. The panel shared the concern over the current survey items' ability to reliably measure the confident families construct. The Panel noted that it is an enormous effort to collect data for this kind of a construct to be used in benchmarking.

Panel Feedback and Recommendations

- FTF should concretely operationalize the construct when surveying parents about competence and confidence. Define it and determine what measures represent it. Review the National Center for Education Statistics (NCES) survey for guidance.
- Incorporate an additional qualitative approach to collecting data, such as the following items:
  - Asking parents what they think are the most important factors (rank order of importance);
  - Asking what parents are doing to address child development, safety, health and well-being related items; and,
  - Asking questions such as "do you have any concerns regarding your child's development, health etc., and if so, where do you go to for help?"
- Monitor change over time and balance changing methodology with ability to measure this.
- Seek out expert assistance from other states or organizations that have conducted reliable surveys.

Tribal Data Considerations

FTF has several data related policies that address data collection, data approval requirements, data security, and data suppression and dissemination. For each FTF report that will incorporate tribal population data, agreements with the Tribes are secured before gathering data, including primary data collection, secondary data from other public state agencies and tertiary data from existing public reports. FTF is in the process of developing a tribal data policy that will consider long-term data agreements with tribes, data ownership and access to data. The tribal data policy is based on the items raised as part of the 2013 FTF Tribal Consultation with tribal leaders. The Panel suggested tribal data considerations that FTF should deliberate in implementing the Research and Evaluation Plan.

Panel Feedback and Recommendations

Data Collection, Methodology and Reporting

- Share the data collected with tribal leaders and communities in meaningful ways, and specifically pay attention to data presentation format. This was underscored as critical to foster tribes' understanding and feedback as well as in fostering relationships with tribes.
- Continue to support diversity in all evaluation efforts, ensuring respect for the rights and aspirations of Native people.
- Consider culturally responsive measures (e.g. Quality First measures capturing what language a teacher spoke in the classroom; adding an observational component to Quality First assessment measures) and methods for tribal populations.
- Be mindful of challenges related to mobility and sample sizes when handling tribal data. Identify how to track tribal data, what identification number can and should be used.
- Utilize supplemental data sources in addition to census data for tribal populations.
- Look at the community investment as a potential unit of analysis.
- Be clear on definition of American Indian versus Alaskan Native.
- Utilize the United States Department of Education (US ED) guidelines on race and ethnicity definitions (tribal populations are often incorrectly counted in a mixed race or Hispanic category).
- Utilize the National Indian Evaluation Study (NIES) as a resource for setting language in data requests.

Strengthening Ongoing Relationships with Tribes

- Convene an actively involved tribal advisory consultation team to review and provide input for all aspects of FTF's evaluation efforts.
- Continue to honor the government-to-government relationship with tribal nations.
- Focus should not be to 'change the behavior of our Native children and families' but to improve the responsiveness of systems to the children and families being served – this impacts the unit of analysis, choice of indicators, and recommendations.
- Try to inform national policy conversations related to indigenous identification in state data sets, data linkage, the importance of tribal governance in research, and the importance of culture in early childhood policy considerations.
- Support the work of the 10 FTF tribal regions, and where appropriate, work together cross-regionally.

The Panel also recommended that FTF consider culturally responsive measures for other minority populations, such as the Hispanic/Latino population, and review the research literature for best practices in relation to these sub-populations.

Research and Evaluation Studies

Quality First Implementation and Pre-Validation Study

Dr. Iyer and Ginger Sandweg, FTF Senior Director for Early Learning, provided an overview of the Quality First program, Arizona's Quality Improvement & Rating System. Ms. Sandweg also informed the Panel on the cut-off scores on the Environmental Rating Scales (ERS), Classroom Assessment Scoring System (CLASS) tool and FTF Point Scale currently being used to differentiate the star levels of quality early care and education programs. The Quality First Implementation and Validation Study is proposed in the FTF Research and Evaluation Plan to be a three-phase study (or a series of studies) based on Panel recommendations from 2012. Panel members concurred that step 1 of this process will be to validate the Quality First rating scale. The Panel was provided with an overview of the Quality First program components, including how these components are implemented across participating programs, highlighting any model changes that occurred between FY12-14. The Panel was asked to recommend research questions and analysis approaches relevant to the Quality First components based on how these components are currently implemented.

The Panel discussion on research questions and approaches included:

- How many programs access Child Care Health Consultation versus professional development components?
- Is the Mental Health Consultation component linked to Quality First programs?
- What level of professional development do teachers receive?
- Are coaches able to train on curriculum elements effectively?

Panel Feedback and Recommendations

- Identify the standard curriculum that most of the Quality First programs use. Consider the importance of the relationship between early care and education curriculum and Quality First child-level outcomes.
- Focus on strengthening the data elements related to the coaching component of Quality First.
- Operationalize the intent of the coaching component. Given the high coaching expenditures, it is critical to have a good understanding about whether coaching is doing what it is intended to do to impact program quality.

- Focus on the cultural sensitivity aspect in coaching.
- Listen to the national conversation about quality measures and consider the appropriateness of the Environmental Rating Scales measures.
- Continue to focus your efforts around the quality rating system but simultaneously try to assess the fidelity of implementation of the curriculum. FTF needs to show that it has improved the quality of Arizona's preschools.
- Examine what teachers learned and how did that change what they do in classrooms towards program quality improvement and child outcomes.
- Examine each Quality First component's relation to Quality First program sub-measure scores and program rating scores.
- Utilize a KDI to measure child outcomes related to changes in program quality.
- Utilize a cluster analysis approach to examine the relation of quality ratings to type and intensity of Quality First components accessed by Quality First programs, given the variation in services that providers receive based on their star ratings.
- Enroll more programs into Quality First. How can FTF make a difference in the quality of care being provided in Arizona if 73% of providers are not in the Quality First initiative?

Child Care Capacity Study

Due to time constraints, the Child Care Capacity study was not discussed. The Panel determined that members with related content expertize can assist FTF on this topic at a later date.

Considerations for Planning Regional Studies

Panel members were asked to provide guidance on considerations Regional Councils should deliberate when/if they determine to conduct a region-specific program or strategy evaluation study.

Panel Feedback and Recommendations

- Regional Councils should resist the temptation to rush into an evaluation if a program is not yet up to speed. They should wait until the program(s) have been implemented for a while and also look at evaluations across regions and within regions, to identify what elements are contributing to successful outcomes.
- Continue to focus on accessing administrative data with high priority given to participant level implementation data, fidelity of implementation data and data from program participants to begin to capture differential outcomes.
- Utilize a case study approach when appropriate. Case studies can be used for describing packages or bundled programs. However, it is unlikely that they can deconstruct a package/bundle of programs to see what worked and how to spend regional resources. The first step is determining if a particular "bundle" makes a difference; then there is a basis for digging deeper in an effort to discover how the specific programs worked together.
- FTF cannot realistically look at program-level evaluation given the challenge of disentangling all the services in a regional strategic bundle.
- Leverage current regional data to inform regional research questions (e.g. regional needs and assets, school readiness indicators, quarterly data reports).
- Identify whether or not program wait lists exist by strategies.
- Look at statewide studies to capture enough regionally representative samples to inform regions.
- Conduct a thorough literature review to understand what evaluation efforts have been done by others elsewhere.
- FTF should try to be a repository of information to share with regions.

- Apply fidelity of implementation data towards opportunities to help improve program implementation. However, for outcome data, FTF still might need to do an evaluation study.
- Prioritize highly funded FTF strategies/programs to be evaluated for short- term and long-term outcomes. Put some mechanism in place to begin to collect short-term and long-term outcome data.
- Establish a clear set of priorities for strategies with clear, concise rubrics for council members and grantees to follow.
- Ensure that FTF standards of practice clearly demarcate implementation standards and support reduction/elimination of funded program models that aren't evidence-based.
- Think carefully about relying on existing evidence from evidence-based programs especially to the extent FTF may be implementing them under circumstances that differ from those in which the evidence is based. Collect FTF implementation fidelity and impact data because it is difficult to replicate an evidence-based program with fidelity.
- Provide support to Regional Councils that need assistance to make evaluation decisions. Think about evaluation strategies that will help Regional Councils, particularly the smaller ones, do sound evaluations.

Concluding Comments and Future Direction

In addition to the Panel recommendations specific to the annual meeting agenda topics discussed already in this report, the Panel members also provided their concluding comments on FTF's progressing evaluation efforts. The Panel recommendations included:

1. As FTF comes up with solutions to the evaluation challenges in Arizona, think about how these can also advance the field and inform the larger national early childhood research community with respect to measures, evaluation approaches, and data systems.
2. Keep a balanced perspective of what FTF is trying to do with provision of services versus evaluating services.
3. Consider that there are three main goals for evaluation, and think about how to prioritize these:
    a. Providing accountability and quality assurance means measuring the inputs more than outcomes.
    b. Using data to guide ongoing programmatic efforts means evaluating the outcomes, especially with home-grown and/or innovative programs.
    c. Measuring outcomes, even for established evidence-based programs, because FTF needs to justify how the investments and work are impacting children.
4. Continue to advocate for early childhood development programs for all children in Arizona; consider the fact that not all children participate in FTF's strategies and programs, but still can benefit from what FTF is doing throughout the state.
5. FTF should get the best data on fidelity implementation possible.
6. Find ways, where appropriate, to work with other agencies that may be collecting data FTF could use or are implementing studies similar to those FTF is planning.
7. As FTF deals with the many challenges—representative samples, validity of measures, etc.—consider the importance of timing. There will never be the perfect evaluation effort, but getting some results sooner can be better than getting more perfect results much later when policymakers have already moved on.
8. Keep in mind the needs of the Latino population that represents 30% of the Arizona population and approximately 50% of the population under age 6 years.

9. Think of families, not just children. Make sure parents are included in early childhood programs and in evaluations.
10. Consider paring down FTF's ambitious goals; focus on what is considered being the most important goals—the areas needed to generate evaluation data to address the most important questions.