FIRST THINGS FIRST
Ready for School. Set for Life.

FTF STRATEGY TOOLKIT

GOAL AREA: Health

FTF Priority: Access to Quality Health Care Coverage and Services – Collaborate with partners to increase access to high quality health care services (including oral health and mental health) and affordable health care coverage for young children and their families.

Goal Area Overview:

First Things First will improve children's access to health care by increasing the number of children with continuous medical, mental health and dental insurance coverage, expand access to medical and dental homes, increase medical professionals' use of best practice guidelines for preventive medical, oral and mental health care, expand use of early screening to identify children with developmental delays, and increase accessibility to needed treatment services identified through screening.

Strategies	Strategy Workgroup Leads	Policy Staff	Grants and Contracts Specialist
Recruitment – Stipends/Loan Forgiveness	Early Identification/Special Needs Workgroup: Shari Elkins and Allison Landy	Allison Landy	Kristen Martin
Physician Education and Outreach	Health Workgroup: Christina Lyons and Kelley Murphy	Kelley Murphy	Chris Cramer
Child Care Health Consultation	Health Workgroup Christina Lyons and Kelley Murphy	Kelley Murphy	Teri Lippens
Mental Health Consultation	Health Workgroup: Christina Lyons and Kelley Murphy	Judy Walruff	Lindsay Kaid
Nutrition/Obesity/Physical Activity	Health Workgroup: Christina Lyons and Kelley Murphy	Kelley Murphy	
Prenatal Outreach	Health Workgroup: Christina Lyons and Kelley Murphy	Kelley Murphy	
Injury Prevention	Health Workgroup Christina Lyons and Kelley Murphy	Kelley Murphy	
Oral Health	Health Workgroup: Christina Lyons and Kelley Murphy	Judy Walruff	
Health Insurance Enrollment	Health Workgroup:	Kelley Murphy	

	Christina Lyons and Kelley Murphy	
Care Coordination/Medical Home	Health Workgroup: Christina Lyons and Kelley Murphy	Kelley Murphy
Developmental & Health Screening Sensory Screening	Health Workgroup: Christina Lyons and Kelley Murphy	Kelley Murphy
Developmental & Health Screening Play-Based Mobile Early Education	Health Workgroup: Early Intervention Shari Elkins and Allison Landy	Allison Landy
Developmental & Health Screening Coalition Building	Health Workgroup: Early Intervention Shari Elkins and Allison Landy	Allison Landy
Developmental & Health Screening Community Based Screening	Health Workgroup: Early Intervention Shari Elkins and Allison Landy	Allison Landy

GOAL AREA: HEALTH

STRATEGY NAME: WORKFORCE RECRUITMENT – STIPENDS AND LOAN FORGIVENESS

GOAL:

- **FTF will collaborate with existing Arizona early childhood health care systems to improve children's access to quality health care**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Provider Loan Repayment ***and/or*** Stipend Program provides financial incentives for the purpose of recruiting and/or retaining therapists and other intervention professionals to work in underserved communities where access to therapeutic services are limited. Providers commit to a time of service obligation in return for the financial benefits. The first component of the program is established to pay off portions of education loans. The program additionally provides recruitment incentives to agencies to support the hiring and retention of professionals. The strategy is administered through the Department of Health Services which provides the following: • Oversight and management of the distribution of loan repayment funds to financial institutions on behalf of eligible clinicians as well as distribution of stipend payments. • Outreach and recruitment of potentially eligible clinicians. • Oversight and maintenance of service obligations attached to funds distribution	The therapist program is modeled after the National Health Service Corp program which provides loan repayment to doctors and other health care professionals. The US Department of Health and Human Services Health Resources and Services Administration reports that over 28,000 primary health care providers have participated and of them, over 70% of NHSC clinicians stay working in underserved areas after they complete their service commitment (http://nhsc.hrsa.gov/loanrepayment/nhsclrpaib.pdf)	• The strategy is administered through a contract with the Arizona Department of Health Services. Currently 9 regions are participating in the contract and there is capacity for DHS to expand. • The infrastructure costs are to administer the program itself, provide oversight of the loan payments, and conduct marketing and outreach. • Councils should consider approximately 23% of total budget to cover program administration (13%) and indirect costs (10%) of implementation. • Implementation is standardized across regions and councils may choose to fund loan repayment, stipends, or both. • Therapists receiving funds must commit to a 2 year service obligation, the council must plan for 2 year's worth of funding ***up front in a single fiscal year***. For example, if an SLP earns a 25,000 loan payment per year, the council must fund each SLP at 50,000 to cover both years of service obligation. A way to think about this is to compare the funding to creating an escrow account for a mortgage. • 3rd and 4th year continuation funding for each therapist is optional. • This strategy provides an appropriate use of carry forward dollars because the funding is put in up front for the 2-year period. The only subsequent year funding needed would be to cover the administration costs of the program during that period.	**Loan repayment** costs for therapists: SLP/OT/Psychologists: Year 1 of service, $10,000; Year 2 of service, $15,000 (total of $25,000 per funding plan year per therapist) PT: Year 1 of service $15,000; Year 2 of service $ 20,000 MH Specialist/Family Counselor: Year 1 of service $5,000; Year 2 of service $7,500 **Stipend** costs may include: Moving Expenses: $3,000. Sign On & Retention Bonuses: $3,000/sign on; $5,000 for Year 1 service completion; $7500 for Year 2 service completion Professional Conference/license fees: up to $2,500 **Indirect and Admin – 23%**

Policy Specialist: Allison Landy

Recruitment – Stipends/Loan Forgiveness

First Things First reporting requirements and progress monitoring are aligned with First Things First Goals, Key Measures, and Standards of Practice. The purpose of First Things First data submission and monitoring is to determine the extent to which each program has accomplished the stated goals, key measures, targeted service number, and activities outlined in the standards of practice.

Grantees will be provided with data reporting requirements by First Things First. There are five main components to data reporting:

- Unit of Service
- Performance Measures
- Data Reporting Template
- Data Reporting Instruction
- Frequently Asked Questions

The data reporting template captures the set of data the grantee submits on a quarterly basis; the instructions support that data submission. Units of Service and performance measures outline how the quarterly data submissions will be evaluated according to the contracted deliverables and standards of practice for that contract. Frequently asked questions present answers to common reporting, evaluation, policy, and performance questions.

Definitions:

Unit of Service and related Target Service Number

A Unit of Service is a FTF designated indicator of performance specific to each FTF strategy. It is composed of a unit of measure and a number (Target Service Number).

A Unit of Measure/Service can be a target population and/or a service/product that a grantee is expected to serve as part of an agreement. Target Service Number represents the number of units (e.g. target population) proposed to be served or number of products/services proposed to be delivered during the contract year.

For example, for the FTF strategy Home Visitation the FTF Unit of Service is “number of families served” and a Target Service Number of 50 represents the number of families the program proposes to serve during the contract period. All FTF applicants must clearly state in the proposal a target service number for each strategy specific Unit of Service.

For **Recruitment – Stipends/Loan Forgiveness**, the units of service are:

Total number of therapists receiving loan forgiveness
Total number of therapists receiving stipends

Performance Measures

Performance Measures measure (1) key indicators of performance (i.e. Unit of Service); (2) basic implementation of strategy; (3) alignment of program activities to strategy specific standards of practice, (4) performance or progress toward pre-established strategic goals. Performance measures may include the level or type of program activities conducted (e.g. serving families/children through home visits) and/or the direct services and products delivered by a program (e.g., providing scholarships).

For **Recruitment – Stipends/Loan Forgiveness,** performance measures are:

Total number of therapists receiving loan forgiveness/proposed service number
Total number of therapists receiving stipends/proposed service number

Data Reporting Templates

Data reporting templates are the tools utilized to gather data to assess grantee Performance Measures. All FTF grantees submit data on a quarterly basis through designated data reporting templates.

For **Recruitment – Stipends/Loan Forgiveness,** the data reporting template is:

Loan Forgiveness & Stipends - Data Reporting Template			
Provider Name			
Contract ID			
User Completing Report			
User Completing Report Email			
Reporting Period	**Month**	**Year**	
		2010	
Regional Partnership Council			
Date Completed			

Data Entry		
Section I: For this Regional Partnership Council, are you providing loan forgiveness contract? (Please enter Yes or No in the yellow box)	**Yes**	**If No, please skip this section and go to Section II.**

1. How many therapists signed loan forgiveness contracts for this region during the reporting period?

Types of Therapists	Number
Speech Language Pathologists (SLP)	
Occupational Therapists	
Physical Therapists	
Mental Health Specialists	
Psychologists	

2. Of the total number of therapists with loan forgiveness contracts, how many are in which year of service?

Types of Therapists	First Year of Service	Second Year of Service	Third Year of Service	Fourth Year of Service	
Speech Language Pathologists (SLP)					
Occupational Therapist					
Physical Therapist					
Mental Health Specialist					
Psychologist					

Section II: For this Regional Partnership Council, are you providing stipends? (Please enter Yes or No in the yellow box)	**Yes**	**If No, please skip this section. Go to section III**

3. How many therapists received stipends for this region during the reporting period?

Types of Therapists	Number
Speech Language Pathologists	
Occupational Therapists	
Physical Therapists	
Mental Health Specialists	
Psychologists	

4. Of the total number of therapists receiving stipends during the reporting period, how many therapists (by type) received stipends from the following category list and the total funding spent by category type?

Categories	Speech Language Pathologists (SLP)	Occupational Therapist	Physical Therapist	Mental Health Specialist	Psychologist
Total number of therapists receiving stipends for Moving Expenses					
Total funding ($) spent on Moving Expenses					
Total number of therapists receiving stipends for Continuing Education Units/ Professional Development Fees					
Total funding ($) spent on Continuing Education Units/ Professional Development Fees					
Total number of therapists receiving stipends for Licensing and Professional Affiliation Fees					
Total funding ($) spent on Licensing and Professional Affiliation Fees					

Total number of therapists receiving stipends for Sign On/ Retention Bonuses					
Total funding ($) spent on Sign On/ Retention Bonuses					
Total number of therapists receiving stipends for One Year Service Completion					
Total funding ($) spent on One Year Service Completion					
Total number of therapists receiving stipends for Two Year Service Completion					
Total funding ($) spent on Two Year Service Completion					
Total number of therapists receiving stipends for Other (Please specify)					
Total funding ($) spent on Other (Please specify_____)					

Section III: Of the total number of therapist, how many received both loan forgiveness and stipends?

Types of Therapists	Number
Speech Language Pathologists (SLP)	
Occupational Therapists	
Physical Therapists	
Mental Health Specialists	
Psychologists	

Data Reporting Instructions

Data reporting instructions support data submission through the data reporting template.

For **Recruitment – Stipends/Loan Forgiveness,** the data reporting instructions are:

Loan Forgiveness & Stipends Data Reporting Instructions

INFORMATION

Your data report is always due on the 20th day of the month following the end of each quarter. Each quarterly submission will include information for the entire quarter broken out by month. Each data report submitted will include information for the entire preceding quarter.

1st Quarter – July-September – Report due October 20
2nd Quarter – October-December – Report due January 20
3rd Quarter – January-March – Report due April 20
4th Quarter – April- June – Report due July 20

- Data should be only reported for services funded by First Things First.
- Data should be reported separately for each Regional Partnership Council area in which contracted services are provided. For example, if your program is contracted to provide services in both Central Maricopa and Northeast Maricopa regions, two separate reports must be submitted.
- For each quarter, **data should be tallied for each month of service.**
- Your final data submission for the quarter cannot be completed until you complete all monthly reports.

DIRECTIONS FOR DATA ENTRY

Section I: ***For this Regional Partnership Council, are you providing loan forgiveness contract/s? Yes/No,*** In this data field you will enter either yes or no. If Yes, go to #1. If No, skip to section II.

1. **How many therapists signed loan forgiveness contracts for this region during the reporting period?** For this question, please breakout the number by types of therapists that signed loan forgiveness contracts for this reporting period.
    a. **Speech Language Pathologist (SLP)___**
    b. **Occupational Therapists___**
    c. **Physical Therapists___**
    d. **Mental Health Specialists___**
    e. **Psychologists___**

2. **Of the total number of therapists with loan forgiveness contracts, how many are in which year of service?**

	First Year of Service	Second Year of Service	Third Year of Service	Fourth Year of Service
SLP				
Occupational Therapist				
Physical Therapist				
Mental Health Specialist				
Psychologist				

Section II: **For this Regional Partnership Council, are you providing stipends? *Yes/No*,** in this data field you will enter either yes or no. If Yes, go to #3. If No, your data entry in complete.

3. **How many therapists received stipend bonuses for this region during the reporting period?** In this data field you will enter the number of therapists broken out by type that received stipend bonuses for this regional council during the reporting period.

	Number
Speech Language Pathologists	
Occupational Therapists	
Physical Therapists	
Mental Health Specialists	
Psychologists	

4. **Of the total number of therapists receiving stipends during this reporting period, how many therapists (by type) received stipends from the following list and the total funding spent for each category?** In this data field, please enter the total number of therapists (by types) receiving stipends and the funding ($) spent for each category for this reporting period.

	Speech Language Pathologists (SLP)	Occupational Therapist	Physical Therapist	Mental Health Specialist	Psychologist
Total number of therapists receiving stipends for Moving Expenses					
Total funding ($) spent on Moving Expenses					
Total number of therapists receiving stipends for Continuing Education Units/ Professional Development Fees					
Total funding ($) spent on Continuing Education Units/ Professional Development Fees					
Total number of therapists receiving stipends for Licensing and Professional Affiliation Fees					
Total funding ($) spent on Licensing and Professional Affiliation Fees					
Total number of therapists receiving stipends for Sign On/ Retention Bonuses					
Total funding ($) spent on Sign On/ Retention Bonuses					

Total number of therapists receiving stipends for One Year Service Completion					
Total funding ($) spent on One Year Service Completion					
Total number of therapists receiving stipends for Two Year Service Completion					
Total funding ($) spent on Two Year Service Completion					
Total number of therapists receiving stipends for Other (please specify)					
Total funding ($) spent on Other (please specify_____)					

Section III: Of the total number of therapists, how many received both loan forgiveness and stipends? Enter the total number of therapist (by type) who received both loan forgiveness and stipends.

Types of Therapists	Number
Speech Language Pathologists (SLP)	
Occupational Therapists	
Physical Therapists	
Mental Health Specialists	
Psychologists	

Frequently Asked Questions

Frequently Asked Questions present answers to common reporting, evaluation, policy, and performance questions.

For **Recruitment – Stipends/Loan Forgiveness,** the frequently asked questions are:

In development

PHYSICIAN OUTREACH AND EDUCATION
STATEWIDE STRATEGY

All young children come into contact with a variety of health care professionals in the first few years of life. These interactions range from preventative well child visits to hospitalization, acute and ongoing care for the seriously ill child. All health professionals receive extensive initial training to assure competency in their practice, but information specific to early childhood is often limited. In addition, in many health professions, education and training is focused on acute or emergency care instead of primary or preventative care.

According to the U.S. Department of Health and Human Services, neurobiological, behavioral, and social science research has significantly advanced our appreciation and understanding of the importance of early life experiences on early brain development and human behavior. The potential to improve developmental and other health outcomes in children through planned interventions is now well established.

More recent evidence indicates that primary care for children is best delivered in a medical home setting. For many years, the term "Medical Home" has been used in various ways by various individuals and groups. At a basic level, it is used to address access to health care. In this context, the term 'medical home' implies a primary care relationship between a patient and a health care provider, and one marker is if a family or patient can identify a practice or provider by name as their usual source of care. At a more complex level, the term "Medical Home" has been used in various ways to define the type of primary care practice, particularly in the context of care for children with special health care needs.

The American Academy of Pediatrics describes the medical home as a model of delivering primary care *that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and* culturally effective care.

The concept of the Medical Home is currently being promoted as an approach to providing comprehensive primary care for children, youth, and adults. There is now considerable discussion at the public policy level about the benefits of the medical home, accompanied by an emerging understanding of the need to pay physicians and other primary care providers appropriately to provide the services necessary to create a quality medical home.

Because of this movement, and the need for ongoing training and education of physicians, First Things First developed the Physician Outreach and Education program.

Physician outreach and education is a quality improvement strategy with the goal of assisting physicians in identifying the health system and practice procedures that need to change or be implemented that would result in consistent quality care for children. Physicians involved in a quality improvement strategy engage in activities that include assessment of their health care delivery systems and develop a plan for improvement. They receive technical assistance and coaching as well as materials to support clinical practice improvement. Additional support may also be provided through the formation of collaborative learning groups that commit to the quality improvement process.

This strategy is particularly important to strengthening early identification of developmental delay and timeliness of intervention. Pediatricians and family physicians receive technical assistance related to procedures and best practices to elicit parents' concerns and perceptions through developmental screening using a standardized, validated tool. Additional support and education is provided around the development of systems that track children a physician refers for evaluation. Support is also provided to assist practices in identifying community resources that support child development based on the individual needs of the child and family. The importance of this component of the education and outreach strategy is heightened due to the current economic situation. As services change and the intervention system evolves, physicians will need support in understanding those changes and how to best provide information to families.

A key benefit of the physician outreach and education strategy is that it supports a medical home model of care. Through development of high quality assessment and follow up activities, physicians fully integrate practices that provide strong continuity of care for children and families..

GOAL AREA: HEALTH

STRATEGY NAME: PHYSICIAN OUTREACH AND EDUCATION

GOAL:

- **Increase the number of health care providers using a medical/dental home**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Physician outreach and education **)** is a practice improvement strategy. Coaches assist physicians (pediatricians and/or family practice) who serve children 0-5 to complete a self assessment of their office practices. They work together to identify areas that might benefit from changes. Practices then have the option to participate in a self study or much more intensive learning collaboratives to improve the quality of care they provide.	Evidence based Rresearch has shown that there are effective quality improvement techniques that physicians can use. Links are provided below to websites that have additional information	• **Best Care For Kids** is the FTF funded statewide physician outreach and education program administered through the Arizona Academy of Pediatrics. Regional expansion will be conducted through this statewide administrative home • Participating in practice improvement is voluntary for physician practices • There may be significant costs to participating practices due to non-billable time dedicated to these activities • Outreachto recruit practices into the program is difficult with no guarantee that practices will participate in the program. • Cost for improvement varies depending upon several factors including size of practice, number of physicians, geography,current office practices, level of improvement participation (self study vs. learning collaboratives)	Cost is approximately $6,500.00 per practice

		• The health or hospital system in which a physician practice operates may impact costs and level of participation • Length of participation varies for each practice based upon its individual needs and identified goals • Regions considering expansion should discuss any specific regional issues with policy specialist and grantee prior to allocating funds to this program	

Policy Specialist – Kelley Murphy

LINKS TO:

Health - Physician Outreach - What is Quality (Nichq)

Health - Physician Outreach - Quality Improvement (AAP)

Health - Physician Outreach - IHI

Health - Physician Outreach - Medical Home Improvement

Physician Education & Outreach

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For example, for the FTF strategy Home Visitation the FTF Unit of Service is “number of families served” and a Target Service Number of 50 represents the number of families the program proposes to serve during the contract period. All FTF applicants must clearly state in the proposal a target service number for each strategy specific Unit of Service.

For **Physician Education & Outreach,** the units of service are:

Total number of participating practices

Performance Measures

Performance Measures measure (1) key indicators of performance (i.e. Unit of Service); (2) basic implementation of strategy; (3) alignment of program activities to strategy specific standards of practice, (4) performance or progress toward pre-established strategic goals. Performance measures may include the level or type of program activities conducted (e.g. serving families/children through home visits) and/or the direct services and products delivered by a program (e.g., providing scholarships).

For **Physician Education & Outreach,** performance measures are:

Total number of participating practices/proposed service number
Total number of practices in practice improvement/proposed service number
Total number of practices in self-study/proposed service number
Total number of practices in a learning collaborative/proposed service number

Data Reporting Templates

Data reporting templates are the tools utilized to gather data to assess grantee Performance Measures. All FTF grantees submit data on a quarterly basis through designated data reporting templates.

For **Physician Education & Outreach,** the data reporting template is:

FIRST THINGS FIRST
The right system for bright futures

pgms partner grant management system

Evaluation Report

CONTRACT DATES
7/1/2010
TO
7/31/2010

TEST PRODUCTION AGENCY (APPS)

Address: Parter Address Agency Details
Test City, AZ 85032

Contract ID: GRA-STATE-10-0218-01

View Reporting Instructions and FAQ

PHYSICIAN EDUCATION OUTREACH

GENERAL INFORMATION

User Completing Report AZFTF\zeval

Reporting Period

Month	Year
7	2010

Regional Partnership Council State

Status In Progress

Date Completed

Service Provisions *

Please select from this list, the services you deliver as part of your program. You can select as many services as applicable.

- ☐ Community Based Training
- ☐ Point of Care Training
- ☐ Home Visitation Training
- ☐ Other (please specify)

Community Based Training Sessions

Did you provide any Community Based Training Sessions as part of your program THIS REPORTING PERIOD? *

○ Yes ○ No

If Yes, please enter information about your Community Based Training Sessions below. You may add as many sessions as needed.

Name	Date	City	ZipCode		

Point of Care Training

Did you provide any point of care training as part of your program THIS REPORTING PERIOD?*

○ Yes ○ No

If YES, please indicate for clients that you serve the numbers that received point of patient care or clinic based training.

If none, please enter zero

Number of Residents/Physicians Trained*

Number of clinical care visits in which training occurred*

Home Visitation Training

Did you providing any home visitation services as part of your physician/resident training THIS REPORTING PERIOD?* ○ Yes ○ No

If YES, please indicate for clients that you serve the numbers that received home visitation training.

If none, please enter zero

Number of Residents/Physicians receiving home visitation training *

Number of home visits completed*

Data Reporting Instructions

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For **Physician Education & Outreach,** the data reporting instructions are:

INFORMATION

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- Data should be only reported for services funded by First Things First.
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OVERVIEW

- For each quarter, **data should be tallied for each month of service.**
- Your final data submission for the quarter cannot be completed until you complete all monthly reports.

DIRECTIONS FOR DATA ENTRY

***Any data field with an asterisk mark is required; you cannot skip it.**

Section I: Service Provisions

Please select from the list, the services you deliver as part of your program. You can select as many services as applicable. *After a service type is selected, please complete Data Entry into data fields related to the services. Please skip any service delivery choices that do not pertain to your program.*

- Community Based Training
- Point of Care Training
- Home Visitation Training
- Other (please specify):

Section II: Community Based Training Sessions

Did you provide any community based training sessions as part of your program THIS REPORTING PERIOD? Select YES or NO

If yes, please enter information about your community based training sessions below. You can add as many sessions as needed.

Training session data fields

1. ***Name of Training Session:** In this data field you will enter the name of the session.
2. ***Topic of Session:** This data field has drop down menu. You can choose more than one topic, if you do so, then please add a row and copy the drop down box and choose another topic. If none of the topics applies to the training session you are conducting, please choose "**Other (please specify)"** and add a row below this field and enter (type in) the topic of your session.
3. ***Number of Trainers:** In this data field you will enter the number of trainers who offered training in this specific session.
4. ***Qualification of Trainers:** This data field has drop down menu. You can choose more than one qualification, if you do so, then please add a row and copy the drop down box and choose another choice. If none of the topics applies to the training session you are conducting, please choose "**Other (please specify)"** and add a row below this field and enter (type in) the topic of your session.
5. ***Description of Session:** In this text field you will enter a brief description about the training session. For example: for the **Name of Training Session**: ''Why won't they sleep? Developmental & Environmental Strategies for Nap Time" the **Description** could be- 'Share difficulties and challenges that providers may have getting children to settle down for nap time, develop strategies for making nap time pleasant for you and the children. Discuss the benefits of rest and the recommended amount of rest-time that you children require. '
6. ***Session Format:** This data field is a drop down menu. You can choose either **'Individual'** or **'small group (2-5)'** or '**large group (5+)**' option. If you choose "**Other (please specify)"-** then you need to enter the format of your session in the row added under this field.
7. ***Session Duration:** This data field is a drop down menu. You can choose only one choice that best applies for your session. The choices are: **less than an hour, 1 hour, 2 hours, 3 hours, or more than 3 hours.**
8. ***Session Venue:** This data field is a drop down menu. You can choose either one of the **listed** options or the '**other (please specify)**' option. If you choose "**Other (please specify)"-** then you need to add a row under this field enter the venue at which your session took place for this specific session.
9. ***Session Date:** For this data field you will report the date your session took place using the following format: *mm/dd/yyyy*.
10. ***Session Location – City:** In this data field you will enter the **City** at which the session took place. Example: City – Phoenix.
11. ***Session Location – Zipcode:** In this data field you will enter the zip code of where the training session occurred. For example: Phoenix, Zip Code: 85012

12. ***Target Audience:** This data field is a drop down menu. You can choose either one of the **listed** options or the '**other (please specify)**' option. The choices are: **Residents, Hospitalists, Clinic/Private Practice Physicians**
13. ***Number of Residents enrolled in this session:** In this data field you will enter the total number of residents enrolled in the training session based on the type of target audience. For example: 15 Residents were enrolled.
14. ***Number of Residents who attended this session:** In this data field you will enter the total number of residents attending the training session based on the type of target audience. For example: 15 Residents were enrolled but only 10 attended the session, then the number 10 will be entered here.
15. ***Number of Hospitalists enrolled in this session:** In this data field you will enter the total number of hospitalists enrolled in the training session based on the type of target audience.
16. ***Number of Hospitalists who attended this session:** In this data field you will enter the total number of hospitalists attending the training session based on the type of target audience.
17. ***Number of Clinic/Private Practice Physicians enrolled in this session:** In this data field you will enter the total number of Clinic/Private Practice Physicians enrolled in the training session based on the type of target audience.
18. ***Number of Clinic/Private Practice Physicians who attended this session:** In this data field you will enter the total number of Clinic/Private Practice Physicians attending the training session based on the type of target audience.
19. **Number of Other Participants enrolled:** In this data field you will enter the total number of participants enrolled in the training session.
20. ***Number of Other Participants attending:** In this data field you will enter the total number of participants who attended the session.

Series/Sessions Questions

21. ***Is this a series of training sessions? Yes or No:** In this data field you will choose either yes or no from the drop down menu. If you answer **YES,** you must fill out the following question.
    a. **If YES, This is session_____ in a series of_____.**
22. ***Is this the final session in the series? Yes or No:** In this data field you will choose either yes or no from the drop down menu. If you answer **YES,** you must fill out the following question.
    a. **If YES, How many participants completed the entire series? ____.**

Section III: Point of Care Training

23. ***Did you provide any point of care training as part of your program THIS REPORTING PERIOD? Yes or No:** In this data field you will choose either yes or no from the drop down menu. If Yes, please indicate for clients that you serve the numbers that received point of care or clinic based training.

a. **Number of Residents/Physicians Trained____**
b. **Number of clinical care visits in which training occurred____**

Section IV: Home Visitation Training

24. ***Did you provide any home visitation services as part of your physician/resident training THIS REPORTING PERIOD? Yes or No:** In this data field you will choose either yes or no from the drop down menu. If Yes, please indicate for clients that you serve the numbers that received home visitation.
    a. **Number of Residents/Physicians receiving home visitation training____**
    b. **Number of home visits completed____**

Frequently Asked Questions

Frequently Asked Questions present answers to common reporting, evaluation, policy, and performance questions.

For **Physician Education & Outreach,** the frequently asked questions are:

In development

Rationale for Statewide Strategy:

Child Care Health Consultation

Child Care Health Consultation (CCHC) has been shown to promote healthy and safe environments for children in child care and encourage child care settings (centers and family child care homes) to implement the highest standards of health and safety on behalf of the children in their care. CCHC has been shown to be an essential element in achieving high quality early care and education programs and in maintaining the quality gains made over time.

State licensing regulations do not include child care consultation. Research data shows that when child care facilities receive health consultation the health and safety of the facility is improved as follows:

- Reduction of hazards and risky practices in child care settings related to:
  - Safe active play
  - Emergency preparedness
  - Nutrition and food safety
  - Utilization of safe sleep practices and SIDS risk reduction
- Reduction of infectious disease outbreaks
- Reduction of lost work time for parents
- Improved written health policies
- Increased preventive health care for children[1]
- Data from the Tucson *First Focus on Quality* pilot project of a quality improvement and rating system shows improved health and safety practices in child care settings related to child care health consultation.[2]

A Child Care Health Consultant (CCHC) is a health professional with specialized knowledge of early childhood development, child care and child care regulation, community health and social services. In addition to their professional credentials as nurses or other health professionals, Child Care Health Consultants receive 60 hours of instruction on:

- Health consultation skills
- Quality in early child care programs and how to measure quality
- Caring for children with special needs
- Infectious diseases and caring for children who are ill or temporarily disabled
- Injury prevention in the child care setting
- Oral health in the child care setting
- Mental health and supporting social and emotional development in the child care setting
- Nutrition and physical activity in the child care setting
- Skill building to work with child care providers and families

CCHC's assist child care providers in achieving high standards related to health and safety of the children cared for daily in child care centers.[3] CCHC's offer periodic, consistent monitoring visits and consultation as well as responding to emergent requests to provide assistance regarding the health of a specific child in care.

CCHC's also provide expert information and consultation on working and communicating with families of children enrolled in child care and provide referral and follow-up for needed community based services.

[1] Ramler, M., Nakatsukasa-Ono, W., Loe, C., Harris, K., (2006). *The Influence of Child Care* Health *Consultants in Promoting Children's Health and Well-Being: A Report on Selected Resources*, Educational Development Center, Newton, Ma.

[2] *First Focus on Quality: Final Evaluation Report United Way of Tucson and Southern Arizona, Tucson, Arizona, August 2006,* United Way of Tucson

[3] Ramler, M., Nakatsukasa-Ono, W., Loe, C., Harris, K., (2006). *The Influence of Child Care* Health *Consultants in Promoting Children's Health and Well-Being: A Report on Selected Resources*, Educational Development Center, Newton, Ma.

GOAL AREA: HEALTH

STRATEGY NAME: CHILD CARE HEALTH CONSULTATION

GOAL:

- **FTF will improve access to quality early care and education programs and settings**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Child Care Health Consultation (CCHC): Nurse consultants are trained to support early care and education programs with health and safety issues during on-site visits and through referrals to community agencies. Specifically, they: • Support and improve children's health, and safety in child care settings, based upon a common set of standards for health, safety and positive child development; • Address social-emotional development of children by promoting positive interactions between teachers and children; and • Increase early identification of developmental concerns. CCHCs are part of the Quality First model. Each Quality First participant receives support from a nurse consultant. Some regions have funded	Proven Practice There are more than 21 published outcomes studies and 58 additional evaluations, presentations and monographs that validate the impact of CCHC on early childhood education programs.[4] A meta-analysis of research shows a reduction of hazards and risky practices in child care settings related to: -Safe active play, emergency preparedness, nutrition and food safety, utilization of safe sleep practices, and SIDS risk reduction. -Reduction of infectious disease outbreaks, reduction of lost work time for parents, improved	All CCHC's operate within the statewide infrastructure for child care health consultation. There is a statewide administrative home for training and technical assistance for this program. Quality First participants automatically get CCHCs as part of the program, and QF coaches work closely with CCHCs. Contracts with health agencies exist for most FTF regions. The exceptions are: Outreach for programs outside of the Quality First program is time consuming. Caseloads will not be full immediately, as specific efforts to publicize the program with early	$120,000 per full time CCHC for FY 2011-2012 Each FTE can carry a caseload estimate of 30 centers or homes.

[4] Ramler, M. Nakatsukasa-Ono, W., Loe, C., Harris, K. The Influence of Child Care Health Care Heatlh Consultants in Promoting Children's Health and Well-Being: A Report on Selected Resources. (August 2006).

additional consultants for early care and education programs not participating in Quality First. Carefacts is the statewide web based software program that is utilized by CCHC. It allows data collection and evaluation. Currently 17 states are operating statewide quality improvement and rating systems, and another 30 states are at various stages in the development process.	written health policies, increased preventive health care for children[5] Data from the Tucson, Arizona pilot Quality Improvement and Rating system (*First Focus on Quality*) shows improved health and safety practices in child care settings related to child care health consultation.[6] The evaluation found significant improvement in 46 centers in quality components of health & safety.	care and education programs will require time Expansion of CCHCs outside of Quality First may be limited, based upon the capacity of the grantee within a regional area. The program is experiencing some capacity issues currently with some CCHC positions going unfilled in rural and Tribal regions. One solution In some situations has been for grantees hire one RN to supervise additional consultants who do not meet the qualifications set by the standard of practice.	

Policy Specialist: Kelley Murphy

LINKS TO:

Pima Health

[5] Ramler, M., Nakatsukasa-Ono, W., Loe, C., Harris, K., (2006). *The Influence of Child Care* Health *Consultants in Promoting Children's Health and Well-Being: A Report on Selected Resources*, Educational Development Center, Newton, Ma.

FIRST THINGS FIRST
Child Care Health Consultation
Standards of Practice - Final

Child care providers are entrusted with young children for hours every day. While providing early education services, they must also keep children safe and protected from injuries and potentially serious infectious diseases. Child care staff also work with parents to promote good social, emotional and physical health for children—all generally without benefit of medical expertise. Center staff may have to call multiple resources to answer health related questions.

Child Care Health Consultants (CCHC's) are experts in child health available to support child care providers to assure that children in their care are safe, healthy and ready to succeed.

CCHCs help child care staff to improve health and safety in child care facilities. They also provide advice on the well being of a single child, with the view toward training child care staff to prevent and intervene appropriately in future occurrences. CCHCs provide a one-stop health resource through:

- Onsite and telephonic guidance and consultation
- Staff training on health and safety best practices and requirements
- Reviews of & assistance to develop health, safety, and nutrition policies & practices
- Linkages and referrals to community resources
- Developing and providing information for parents

CCHC's have specific training following the National Training Institute (NTI) Child Care Health Consultation curriculum. They are prepared to train child care staff to talk with families about health topics such as oral health, nutritional eating and weight control, developmental screening, and the value of physician well-child exams and immunizations.

Qualifications for a Child Care Health Consultant include:

Registered Nurse (RN) with a current Arizona license, Advanced Practice Nurse with a current Arizona license and certification as an Advanced Practice Nurse (APN), a Physicians Assistant with a current Arizona license or a Physician licensed to practice in the State of Arizona.

Must have complete the sixty (60) hour National Training Institute (NTI) for Child Care Health Consultants curriculum program PRIOR to the beginning work as a CCHC.

A minimum of one year experience in a public health setting.

The Child Care Health consultant must have experience in providing consultation to and interacting with child care settings including family child care.

Knowledge of the following:

- Child development and family dynamics
- Immunization Schedules
- ADHS Child Care Licensure
- Accreditation Systems

- Quality Indicators
- Adult Learning
- Community Resource
- Injury Prevention
- Recognition and Reporting requirements for child abuse and neglect
- Health Care Systems in the service area

Developed Skills in the following:

- Interpersonal Communication
- Training of Adult Learners
- Facilitation
- Consultation Strategies
- Collaborative Problem Solving
- Cultural Responsiveness
- Team Process
- Computer Data Entry

Programs implementing Child Care Health Consultation will:

Provide health consultation services by Child Care Health Consultants to regulated child care providers (centers and homes) enrolled in Quality First, the quality improvement and rating system created by the First Things First.

Provide health consultation services to regulated child care providers that are not participants of Quality First, if appropriate.

Provide day to day supervision, salary and benefits, practice liability protection and any other employee-related services comparable to other employees in the same employee classification.

Support the Child Care Health Consultant to participate in technical assistance/mentoring visits from the First Things First designated statewide support and quality assurance agency. Receive, review and resolve quality performance issues.

Assure the CCHC remains current with professional licensure/ certifications which qualify the CCHC to perform services related to this contract.

Provide and maintain an adequate workspace for the CCHC and provide telephone and internet access.

Provide a multimedia projector and laptop computer.

Support local travel and instate travel to serve designated child care centers and homes within the region and to attend Quality First-required meetings and training sessions. Provide an agency vehicle or mileage reimbursement for miles traveled in the CCHC's insured personal vehicle.

Support CCHC to attend continuing education provided by First Things First's statewide administrative entity.

To address cultural competency objectives, early childhood practitioners /early childhood service providers shall ensure that children and families receive from all staff members effective, understandable, and respectful care that is provided in a culturally competent manner- a manner compatible with their cultural beliefs and practices and preferred language. Early childhood practitioners /early childhood service providers should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. Early childhood practitioners/early childhood service providers should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and family-centered involvement to ensure that services are delivered in a manner that is consistent with the National Standards on Culturally and Linguistically Appropriate Services and/or the National Recommendations on Cultural and Linguistic Competence for the National Association for the Education of Young Children. To view the http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 ; http://www.naeyc.org/positionstatements/linguistic

Child Care Health Consultants will:

If applicable, participate with other team members such as the Quality First coach and contractors to implement the program improvement plan and assist child care providers to meet the health and safety objectives outlined in the approved plan.

Either join the Quality First coach or schedule an initial meeting with the child care center director or child care home provider to be introduced; to provide an overview of the CCHC program; review health and safety issues identified in the assessment; provide guidance documents such as the Arizona Health and Safety Policy Manual for child Care Centers and other guidance documents that may be identified by Quality First; and plan for ongoing consultation.

For those not enrolled in the Quality First program, and if appropriate schedule a meeting with the child care center director or child care home provider to introduce themselves: provide an overview of the CCHC program; provide guidance documents such as the Arizona Health and Safety Policy Manual for Child Care Centers and other guidance documents; and the plan for ongoing consultation.

For those not enrolled in the Quality First program, complete an assessment of the child care center or home to identify priority areas to be addressed.

Provide additional review of child care facility and/or staff needs that may include:

- Indoor health and safety hazards to children and child care staff;
- Injury prevention and Safe, Active Play;
- Health and safety practices of child care staff (i.e. hand washing, sanitation, dental health, physical fitness, nutrition; Serve as a resource to other agencies, organizations and educational institutions which provide consultation, monitoring or resources to child care programs.
- Measures and practices to prevent, recognize, and report communicable diseases, including staff and parent education;
- Procedures for documenting and reporting children's immunizations;
- Health and safety polices, illness and injury logs;

- The status of child care provider' inclusion of children with special needs;
- Emergency preparedness plan;
- Communication among the child care provider, parent, and primary care provider;
- Medication administration, recording, and storage;
- Health insurance and health care access; and other identified child health and safety concerns.
- Guidance, support, referrals and access to care coordination for families and child care providers to access mental health consultation and educational services for the family, children, or child care providers.
- Educate children, their families and child care providers about child development, mental and physical health, safety, nutrition and oral health issues.

This initial consultation visit protocol may be repeated when the director of a facility has changed.

Provide additional consultation, problem solving by telephone.

Provide additional education and training in group settings off site in conjunction with Quality First Coaches or other FTF funded program staff.

Document activities and services utilizing the computerized documentation system designated by Quality First including:

- Attend training on the Omaha System of Documentation and the CareFacts computerized charting system.
- Be prepared to have the CareFacts software installed on the laptop provided by the contractor at the CareFacts training.
- Keep all charting of visits and activities current within 5 working days of performance.
- Maintain a signed, printed record of information and activities as the legal chart.

Participate in CCHC systems development and marketing activities within the local community.

- Participate in First Things First systems development meetings, regional council meetings, and other events as appropriate.
- Provide community presentations regarding the role of child care health consultation in improving the status of health and safety in child care programs.
- Collect/report data, surveys, evaluation reports or other elements requested by FTF or quality assurance personnel.

The CCHC shall NOT provide direct clinical services (i.e. injections, blood tests, health examination).

Child Care Health Consultation

First Things First reporting requirements and progress monitoring are aligned with First Things First Goals, Key Measures, and Standards of Practice. The purpose of First Things First data submission and monitoring is to determine the extent to which each program has accomplished the stated goals, key measures, targeted service number, and activities outlined in the standards of practice.

Grantees will be provided with data reporting requirements by First Things First. There are five main components to data reporting:

- Unit of Service
- Performance Measures
- Data Reporting Template
- Data Reporting Instruction
- Frequently Asked Questions

The data reporting template captures the set of data the grantee submits on a quarterly basis; the instructions support that data submission. Units of Service and performance measures outline how the quarterly data submissions will be evaluated according to the contracted deliverables and standards of practice for that contract. Frequently asked questions present answers to common reporting, evaluation, policy, and performance questions.

Definitions:

Unit of Service and related Target Service Number

A Unit of Service is a FTF designated indicator of performance specific to each FTF strategy. It is composed of a unit of measure and a number (Target Service Number).

A Unit of Measure/Service can be a target population and/or a service/product that a grantee is expected to serve as part of an agreement. Target Service Number represents the number of units (e.g. target population) proposed to be served or number of products/services proposed to be delivered during the contract year.

For example, for the FTF strategy Home Visitation the FTF Unit of Service is “number of families served” and a Target Service Number of 50 represents the number of families the program proposes to serve during the contract period. All FTF applicants must clearly state in the proposal a target service number for each strategy specific Unit of Service.

For **Child Care Health Consultation,** the units of service are:

> **Total number of home based early care and education providers served by a Child Care Health Consultant**
> **Total number of center based early care and education providers served by a Child Care Health Consultant**

Performance Measures

Performance Measures measure (1) key indicators of performance (i.e. Unit of Service); (2) basic implementation of strategy; (3) alignment of program activities to strategy specific standards of practice, (4) performance or progress toward pre-established strategic goals. Performance measures may include the level or type of program activities conducted (e.g. serving families/children through home visits) and/or the direct services and products delivered by a program (e.g., providing scholarships).

For **Child Care Health Consultation,** performance measures are:

Total number of home based early care and education providers served by a Child Care Health Consultant /proposed service number
Total number of center based early care and education providers served by a Child Care Health Consultant /proposed service number
Total number and percentage of early care and education programs served by a Child Care Health Consultant with a high level of quality as measured by Quality First / targeted service number
Total number and percentage of early care and education programs served by a Child Care Health Consultant improving their Quality First rating/ targeted service number
Total number and percentage of early care and education programs served by a Child Care Health Consultant with a high level of quality as measured by an ERS / targeted service number
Total number and percentage of early care and education programs served by a Child Care Health Consultant meeting Quality improvement goals/ targeted service number

Data Reporting Templates

Data reporting templates are the tools utilized to gather data to assess grantee Performance Measures.

Data reporting for **Child Care Health Consultation** is through regular updates in the Child Care Health Consultation data system

Data Reporting Instructions

Data reporting instructions support data submission through the data reporting template.

Data reporting for **Child Care Health Consultation** is through regular updates in the Child Care Health Consultation data system

Frequently Asked Questions

Frequently Asked Questions present answers to common reporting, evaluation, policy, and performance questions.

For **Child Care Health Consultation,** the frequently asked questions are:

Data reporting for Child Care Health Consultation is through regular updates in the Child Care Health Consultation data system

GOAL AREA: HEALTH

STRATEGY NAME: MENTAL HEALTH CONSULTATION

GOAL:

- **FTF will improve access to quality early care and education programs and settings.**
- **FTF will collaborate with existing Arizona early childhood health care systems to improve children's access to quality health care.**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Early childhood mental health consultation (MHC) builds the capacity of early care and education providers to nurture the social-emotional development of young children, as well as to prevent, identify, and reduce the impact of mental health problems among children from birth to age 6 and their families.[1] MHC requires a collaborative relationship between a professional consultant who has mental health expertise and an early care and education professional. In program-focused mental health consultation the intent is to improve the overall quality of the classroom environment as well as to provide strategies to build early care and education staff capacity to address problem behaviors or organizational problems within the setting that may be affecting one or more of the children, families, or staff. Specifically, early child care mental health consultants accomplish these goals by providing the following supports:	Early childhood mental health consultation (ECMHC) is emerging as an effective strategy for supporting young children's social/emotional development and addressing challenging behaviors in early care and education (ECE) settings. Growing evidence supports its efficacy in reducing problem behaviors and the risk of preschool expulsion, as well as improving early care and education provider	• This is a multi regional strategy with an administrative home infrastructure. (MHC are regionally hired and supervised through regional sub-contracts). • A multi-year commitment is required. • It is a support strategy for Quality First and also serves non Quality First providers. • Costs include funding to support capacity building through tuition reimbursement to qualified applicants. • When considering adding or expanding this strategy and the number of MHC positions to be funded, a council should consult with the policy specialist for the mental health consultation strategy and the statewide administrative home to establish a MHC staffing plan for the	$125,000 per consultant includes costs for consultant time and expenses, administration, and tuition reimbursement program. Target is 5 centers: 2 Homes per consultant. Targets are established based on review of best practices & recommendations of national experts in the field of mental health consultation.

[1] Cohen, E., & Kaufmann, R. (2000). Early childhood mental health consultation. Rockville, MD: Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration and the Georgetown University Child Development Center.

2 Brennan, E., Bradley, J., Allen, M.D., & Perry, D. F. (2008). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing staff and program outcomes. *Early Education & Development, 19*(6), 982-1022.

• On-site consultation services to child care teachers and other care staff to build their competence in forming responsive relationships, using curriculum for intentional teaching of social emotional competence, and understanding working with families in collaborative partnerships. • Training activities for teachers, other child care staff and families that focus on social-emotional development of young children and enhance staff ability to support the emotional well-being of children. • Conduct screening and assessments within the context of the early care and education setting for children identified as potentially needing more intensive services. • Family consultation, including facilitating communication between teachers and families. • Referrals to clinical and assessment services to children and families, such as therapeutic groups, neurodevelopment assessment and dyadic child-parent psychotherapy. Occasionally, requests for mental health consultation may arise as a result of concerns related to a specific child or classroom. Once established, however, the consulting relationship expands to include center assessment and a plan to improve the staff's capacity to support the mental health of young children in their care.	skills and ECE program quality (Duran, et al., 2009[2]).	region that may be achieved within the first three months of the contract period. . • Depending on capacity in a region, councils may also consider extending this service to providers of home visiting services. Consultation to support a home visitation strategy and increase home visitors' capacity to support young children's social-emotional development and health is the identified need when considering this option. However, first priority for this service is early care and education programs. • The timeline for establishing the service in a region not previously served is a minimum of 60 days. Staff recruitment and hiring could be up to 90 days depending on the number of staff to be recruited. • Coordination and collaboration with Quality First, child care health consultants and any other quality improvement programs that serve early care and education providers is essential; and is an expectation of the administrative home and subcontractors for this program.	

Policy Specialist – Judy Walruff

[2] Duran, F., Hepburn, K., Irvine, M., Kaufmann, R., Bruno, A., Horen, N., Perry, D. (2009). What works? A study of effective early childhood mental health consultation programs. Center for Child and Human Development: Georgetown University.

FIRST THINGS FIRST
Mental Health Consultation
Standards of Practice - Final

Child care mental health consultation aims to build the capacity (and improve the abilities) of child care staff, programs, and families to prevent, identify, and reduce the impact of social-emotional development problems among young children (Cohen & Kaufmann, 2000).

Consultation involves a collaborative relationship between a professional who has expertise in the social-emotional development of young children and a child care professional. Specifically, child care mental health consultation is a service made available to an early care and education provider—not a therapeutic service delivered directly to a child or family (Brennan, Bradley, Allen, & Perry, 2008). Innovative ways to improve the quality of early care and education are necessary to effectively enhance the experiences young children have in various child care settings. In particular, researchers, policy makers and practitioners are searching for strategies that effectively promote children's healthy social and emotional development.

Whatever the child care setting, it is the quality of the relationships between the adults and the children that either significantly enrich or detract from a child's experiences. Although relationships are important in most professions, relationships in child care directly shape young children's growth and development – for better or worse. As more young children, especially infants and toddlers spend longer hours in child care, it is critical that their relationships with caregivers are positive, nurturing and responsive in order to promote their healthy social and emotional development. Child care mental health consultation works to enhance all of the relationships in an early care and education program, with special attention paid to those between caregivers and children.

Research also tells us that investing in very young children's social and emotional health is an effective strategy in preparing them for success in both school and in life (Raver & Knitzer, 2002). Mental health consultation is one of the valuable investments many states are making in order to decrease negative outcomes, such as preschool expulsion, and increase positive outcomes, such as being competent problem solvers and confident learners.

Teachers and other child care professionals often cite children's problem behavior as one of the most challenging issues with which they are presented (Center for Evidence Based Practices, 2005; NICHD Early Child Care Research Network, 2006). The alarming statistics on preschool expulsion rates provide compelling evidence that child care staff need increased assistance in addressing children's healthy social and emotional development (Perry, Dunne, McFadden, & Campbell, 2007). Preschool expulsion is one of the strongest indicators that a child is on a developmental pathway that could lead to negative outcomes later in life (Moffitt, 1993; Patterson, DeBaryshe, & Ramsey, 1989). Early, unaddressed behavior problems may be an indicator of a larger concern which in turn may lead to serious juvenile delinquency in the adolescent years and evolve into a stable pattern of adult offending (Moffitt, Caspi, Dickson,

Silva, & Stanton, 1996).

Two recent studies provide data on what can happen when child care providers are not equipped to cope with the growing demands of young children with challenging behaviors (Gilliam, 2005; Gilliam & Shahar, 2006). Gilliam and Shahar (2006) examined expulsion rates and predictors of expulsion from preschool programs in the State of Massachusetts. More than one-third of the teachers reported having expelled at least one preschool child in the past 12 months; Head Start teachers, who often have access to mental health consultation, were less likely than for-profit or non-profit child care centers to have expelled at least one child. Teachers with high levels of job stress or depressive symptoms were more likely to expel children while teachers with a high sense of work satisfaction were less likely to expel children. One of the most surprising findings was that the rate of expulsion from preschool in Massachusetts was more than 34 times the State's rate for expelling school-aged children K-12.

Access to mental health consultation was also found to be associated with lower rates of expulsion. Programs that reported on-site access to a psychologist or social worker expelled 5.7 children per 1,000; occasional access to a mental health consultant was associated with a somewhat higher expulsion rate; and the programs that lacked access to mental health consultation expelled children at the highest rates (10.8 per 1,000).

In *program-focused mental health consultation* the intent is to strengthen the adult-child relationships and improve the overall quality of the classroom environment in order to meet each child's needs and promote healthy development. This includes efforts to build staff capacity to (1) develop positive, meaningful relationships with each child and family, (2) create high quality environments where children learn the skills they need to be competent and confident learners (3) enhance instructional practices that promote children's social-emotional competence (4) recognize when child behaviors require more targeted and intensive interventions and work with families to develop effective support plans.

Early childhood mental health consultants accomplish these goals by providing the following supports:

1. On-site consultation services to child care teachers and providers to build their competence around forming responsive relationships, using curriculum to teach, provide for intentional teaching of social emotional competence, and understanding working with families in collaborative partnerships.
2. Training activities for teachers, other child care staff, and families that enhance care givers' capacities to attend to the emotional well-being of children.
3. Conduct screening and assessments within the context of the early care and education setting of children identified as potentially needing more intensive services.
4. Family consultation – including facilitating communication between teachers and families.
5. Provide referrals to clinical and assessment services to children and families, such as therapeutic groups, neurodevelopment assessment, and dyadic child-parent psychotherapy.

The success of consultation depends on the consultant's ability to develop an alliance with child care teachers, providers and families. Within this alliance, they work to understand what children need and how best to provide it. A hallmark of the effort is respect for the teacher, children and families. However, forming such an alliance takes time and depends on the establishment of a predictable, protective atmosphere of learning. Not only must the mental health consultant understand concerns about particular children or programs, but also strive to understand the child care provider's experience and appreciate the stresses experienced by staff members, their readiness to engage in the learning process, and their particular professional and cultural views about childrearing.

Training and Qualifications

The early childhood mental health (MH) consultant must have an understanding of social-emotional development of children in the early years of life and issues they may lead to more serious mental health concerns. Second, the MH consultant must be knowledgeable of child development and caring for young children in group settings, including knowledge of curriculum development, developmentally appropriate instructional practices, formative child assessment strategies and the Arizona Early Learning Standards. Finally, the MH consultant must be fluent in the delivery of effective consultation. Johnston and Brinamen (2006) identify Specific skills critical to effective mental consultation in early care and education settings include

1. Self-awareness;
2. Knowledge of infant mental health principles;
3. Experience working with parents;
4. Familiarity with typical child development;
5. Group facilitation skills;
6. Observation, listening, interviewing, and assessment skills;
7. Ability to work with adults and knowledge of adult learning principles
8. Understanding of cultural differences (cultural competence);
9. Appreciation of group care; and
10. Curiosity and respect for differences.

A master's degree or higher in the following disciplines: early childhood education, early childhood special education, social work, marriage and family counseling, educational psychology, psychology, clinical nursing with a mental health focus, or infant family practice.

Mental Health Consultation Delivery includes the following:

- Assess the center or learning environment.
- Directly observing children and the care giving environment.
- Develop an approach to strengthen the quality of the program related to providing for children's social emotional competence including staff development plans.
- Develop opportunities for staff to discuss their concerns and to examine how stress affects their work.

- Educate staff on children's development of social emotional competence Providing a forum to explore cultural difference and workplace conflicts.
- Educate staff on and support them in developing nurturing, responsive relationships with children and families.
- Support staff in designing teaching strategies that effectively promote children's development of specific social emotional skills (such as turn-taking, friendship skills, problem-solving, etc.).
- Providing a "safe" space in which staff member can identify, examine and discuss their feelings about their relationships with children and families.
- Conduct individual child observations.
- Design and implement program practices responsive to the identified needs of an individual child.
- Provide crisis intervention series for staff regarding a child's behavior.
- Support staff with individual child behavior and classroom management.
- Provide on-on one modeling or coaching for individual child support.
- Provide support for reflective practices.
- Advise and assist staff in linking to community resources and services.
- Educate providers and parents on children's mental health issues.
- Facilitate staff providing referrals to parents for community mental health services.

To address cultural competency objectives, early childhood practitioners /early childhood service providers shall ensure that children and families receive from all staff members effective, understandable, and respectful care that is provided in a culturally competent manner- a manner compatible with their cultural beliefs and practices and preferred language. Early childhood practitioners /early childhood service providers should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. Early childhood practitioners/early childhood service providers should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and family-centered involvement to ensure that services are delivered in a manner that is consistent with the National Standards on Culturally and Linguistically Appropriate Services and/or the National Recommendations on Cultural and Linguistic Competence for the National Association for the Education of Young Children.
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 ;
http://www.naeyc.org/positionstatements/linguistic

Mental Health Consultants Supervision and Continuing Education.

- Consultants receive training and information regarding mandatory reporting. Arizona law requires home visitation staff who suspect that a child has received non-accidental injury or has been neglected, to report their concerns to Child Protective Services or local law enforcement (ARS §13-3620.A).

- Early Childhood Mental Health Consultants will participate in continuing education to remain current and update skills and knowledge to meet the requirements of this scope of work.

- Additional continuing education as may be required to remain current on the literature and research related to the social emotional development of young children and the methods and approaches to providing mental health consultation in child care settings.

Supervision and Evaluation

All Standards of Practice are modeled in all activities including planning, governance, and administration.

- Establish supervision as a collaborative process with mechanisms that support staff in challenging situations and provides regular discussion to reflect and debrief. Supervision will also include observation, feedback and opportunities for peer consultation.
- Teamwork is valued and modeled on all levels of the consultation system.
- The supervisory approach values a collaborative approach that is implemented as planned and demonstrates that the well-being of families and children is a priority.
- Evaluation of mental health consultation services utilizes quantitative and qualitative process that includes measures of change within the child care environment that accrue due to the consultation process and input from staff, families, program administrators, and community members.
- Compensation and benefits are adequate for supporting high quality staff and retention of that staff.

Mental Health Consultation

First Things First reporting requirements and progress monitoring are aligned with First Things First Goals, Key Measures, and Standards of Practice. The purpose of First Things First data submission and monitoring is to determine the extent to which each program has accomplished the stated goals, key measures, targeted service number, and activities outlined in the standards of practice.

Grantees will be provided with data reporting requirements by First Things First. There are five main components to data reporting:

- Unit of Service
- Performance Measures
- Data Reporting Template
- Data Reporting Instruction
- Frequently Asked Questions

The data reporting template captures the set of data the grantee submits on a quarterly basis; the instructions support that data submission. Units of Service and performance measures outline how the quarterly data submissions will be evaluated according to the contracted deliverables and standards of practice for that contract. Frequently asked questions present answers to common reporting, evaluation, policy, and performance questions.

Definitions:

Unit of Service and related Target Service Number

A Unit of Service is a FTF designated indicator of performance specific to each FTF strategy. It is composed of a unit of measure and a number (Target Service Number).

A Unit of Measure/Service can be a target population and/or a service/product that a grantee is expected to serve as part of an agreement. Target Service Number represents the number of units (e.g. target population) proposed to be served or number of products/services proposed to be delivered during the contract year.

For example, for the FTF strategy Home Visitation the FTF Unit of Service is “number of families served” and a Target Service Number of 50 represents the number of families the program proposes to serve during the contract period. All FTF applicants must clearly state in the proposal a target service number for each strategy specific Unit of Service.

For **Mental Health Consultation,** the units of service are:

> **Total number of home based early care and education providers served by a Mental Health Consultant**
> **Total number of center based early care and education providers served by a Mental Health Consultant**

Performance Measures

Performance Measures measure (1) key indicators of performance (i.e. Unit of Service); (2) basic implementation of strategy; (3) alignment of program activities to strategy specific standards of practice, (4) performance or progress toward pre-established strategic goals. Performance measures may include the level or type of program activities conducted (e.g. serving families/children through home visits) and/or the direct services and products delivered by a program (e.g., providing scholarships).

For **Mental Health Consultation,** performance measures are:

Total number of home based early care and education providers served by a Mental Health Consultant /proposed service number
Total number of center based early care and education providers served by a Mental Health Consultant /proposed service number
Total number of early care professionals receiving professional development/ proposed service number
Total number of professional development sessions offered/proposed service number
Total number of programmatic and individual action plans implemented/target service number
Total number of children referred for clinical and assessment services/target service number
Total number of tuition scholarships distributed/proposed service number

Data Reporting Templates

Data reporting templates are the tools utilized to gather data to assess grantee Performance Measures. All FTF grantees submit data on a quarterly basis through designated data reporting templates.

For **Mental Health Consultation,** the data reporting template is:

In development

Data Reporting Instructions

Data reporting instructions support data submission through the data reporting template.

For **Mental Health Consultation,** the data reporting instructions are:

In development

Frequently Asked Questions

Frequently Asked Questions present answers to common reporting, evaluation, policy, and performance questions.

For **Mental Health Consultation,** the frequently asked questions are:

In development

GOAL AREA: HEALTH

STRATEGY NAME: NUTRITION/OBESITY/PHYSICAL ACTIVITY

GOAL:

- **FTF will coordinate and integrate with existing education and information systems to expand families' access to high quality, diverse and relevant information and resources to support their child's optimal development.**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
This strategy include a variety of public health education programs and curricula delivered in diverse settings. Examples provided below describe different options to address childhood obesity including curricula on healthy eating, reducing screen time and increasing physical activity. These do not represent an exhaustive list.		If working within child care programs, need to coordinate with other strategies (QF, CCHC etc.) Costs will vary depending upon curriculum and service delivery method.	Impacted by type of professional used to deliver program. If known, curriculum costs are included below
Comprehensive programs for child care environments, staff and/or parents to improve nutrition and physical activity • *Nutrition and Physical Activity in Child Care (NAP SACC)* Strategy includes child care center self assessment on nutrition and physical activity practices, goal setting, technical assistance provided by trained child care health consultant, evaluation, revision, repetition. Information provided to parents	Effective practice based intervention	Considerable resources are available on the web. These resources include all staff training power point presentations, implementation manual, parent handouts and online training for those who will implement. All CCHC's funded by First Things First have been trained on this program.	$4,000.00 per center if delivered by a CCHC (cost 120,000 carrying a caseload of 30 centers/homes)
• *I am moving, I am learning (IM/IL) Head Start Obesity Prevention Program* Program allows staff to integrate obesity prevention practices into daily practices. A key feature of IM/IL is that it flexible, allows programs to tailor and individualize strategies and activities to meet local program needs. Requires Head Start teachers to attend a 2 ½	Research to practice initiative, presently being evauated, promising practice	Costs unknown due to lack of data outside of Head Start programs.	Unknown

day training, where they participate in interactive workshops and develop strategies for program implementation.			
• *Hip-Hop to Health Jr.* Targets three- to five-year-old minority children enrolled in Head Start programs with the aim of reducing the tendency toward overweight and obesity in African American and Latino preschool children. The intervention presents a developmentally, culturally, and linguistically appropriate dietary and physical activity curriculum for preschoolers, and a parent component.	Evidence Based	Evaluated in Head Start settings not in family home settings. Costs unknown due to lack of data outside Head Start Programs	Unknown
• *Healthy Start* Modification of childcare food service menus and recipes. Outcome: decrease in fat and calories of meals resulting in a reduction in total serum cholesterol.	Evidence Based	This is an intervention for child care settings with in house food service programs.	Unknown, dependent upon type of professional hired to implement.
• *Color Me Healthy/Color Me Healthy* Preschool/childcare center Curriculum that promotes eating fruits and vegetables and being active	Evidence Based	Materials available in English and Spanish. Curriculum contains parent newsletters.	$80 per kit +$25 for Spanish materials. $100 for trainers manual. Addition $ required for professional to provide training to child care staff
	Best Practice, reduced screen time linked to reduced BMI Evidence Based	Not tested in family child care homes; difficult to implement in rural areas without preschools and child care centers.	Will vary depending upon professional hired to deliver program.

FIRST THINGS FIRST
Community Health Education w/Obesity Prevention
Standards of Practice - Final

A great deal of public health research indicates that Arizona's children are not as healthy as they could be. Increased rates of obesity, diabetes, and asthma; paired with poor nutrition, a sedentary lifestyle, and a variety of economic and social factors are all contributing to a poor environment of physical, mental, and oral health for many children. Even more alarming is recent news published in the New England Journal of Medicine that life expectancy for children born today may actually be less than that of their parents. Though we have made significant progress in addressing health issues that affect children through immunization and other public health interventions, many problems remain. The unique geography and population of the state complicate addressing these health concerns.

Health educators work with individuals and communities to provide information and education on how to improve health and health outcomes. They "work to encourage healthy lifestyles and wellness through educating individuals and communities about behaviors that can prevent diseases, injuries, and other health problems" (U.S. Department of Labor, December 2009). There are many health education programs, on a variety of topics, designed to provide individuals and communities with the information they need to improve their health status.

In order to leverage resources and educational efforts, community health education efforts may be integrated into other public health and health programming. For example, community health education can be addressed through other early childhood programs and services, such as home visitation, parenting education or by child care providers.

First Things First Regional Partnership Councils have identified a number of health needs and disparities specific to their individual regions. To address some of these needs, they have chosen to fund community based health education programs in multiple settings. Any grantee implementing community health education on any topic must meet the following requirements:

QUALIFICATIONS FOR A COMMUNITY HEALTH EDUCATOR INCLUDE:

Minimum of a Bachelors Degree in Health Education, or another allied health profession.

Completion of training in the specific curriculum/materials being used.

Excellent communications skills and the ability to adjust to the individual learners' needs.

Have knowledge and skills in:

- Assessing individual and community needs for health education.
- Planning, implementing and administering health education strategies, interventions and programs.

- Serving as a health education resource person.
- Communicating and advocating for health and health education

PROGRAMS IMPLEMENTING COMMUNITY HEALTH EDUCATION WILL:

Address a documented health need within the target population of children birth through age five.

Choose or develop curriculum based on recognized educational principles.

Assure that the content/format of activities and materials will promote improvements in health not specific proprietary business interests of a commercial interest.

Build upon, enhance and coordinate with existing community based health education efforts in the region.

To the extent possible, work in partnership with other early childhood initiatives that provide services to the same target population.

Hire staff who reflect the cultural and ethnic experiences and language of the families with whom they work.

Hire staff with the appropriate qualifications to deliver the specific services in the scope of work.

Assure that staff receive specific training to carry out community based health education activities.

Provide ongoing staff development on diversity issues.

Establish an effective, consistent supervisory system that provides support for all staff members and ensures accountability to participants, funders and the community.

Assure that evaluation and monitoring is a collaborative, ongoing process that includes feedback from staff, families and community members.

Assure that the content/format of activities and materials will promote improvements in health not specific proprietary business interests of a commercial interest.

Develop a post training evaluation for participant feedback if providing a series of sessions.

Programs implementing best practice models for community health education must adhere to the standards of the model, unless permission to deviate from the model has been obtained from the appropriate source.

Recognize that certain populations have health disparities due to cultural, linguistic, geographic and socioeconomic factors, and tailor interventions/curriculum and programs to address various populations.

Collaborate with existing community resources to reinforce health education messages.

Maintain confidentiality of all information obtained as part of the community based health education program.

In the United States, Native American Tribes are considered autonomous nations with all of the rights and responsibilities of a nation. Understanding this, Native American Tribes are charged with protecting the health and safety of their people. To this end, Tribes have full ownership over any data collected within their reservation boundaries. This means that Tribes can allow or not allow any program to collect health data on the reservation.

Any grantee implementing programs in tribal communities must have official tribal permission to collect and utilize sensitive health data. Such data can include but not be limited to:

- Morbidity and mortality among members of their communities
- Information regarding child safety and welfare
- Information regarding children in foster care
- Infectious and chronic disease information among members of their communities
- BMI and healthy weight information

"To address cultural competency objectives, early childhood practitioners /early childhood service providers shall ensure that children and families receive from all staff members effective, understandable, and respectful care that is provided in a culturally competent manner- a manner compatible with their cultural beliefs and practices and preferred language. Early childhood practitioners /early childhood service providers should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. Early childhood practitioners/early childhood service providers should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and family-centered involvement to ensure that services are delivered in a manner that is consistent with the National Standards on Culturally and Linguistically Appropriate Services and/or the National Recommendations on Cultural and Linguistic Competence for the National Association for the Education of Young Children."
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 ;
http://www.naeyc.org/positionstatements/linguistic

COMMUNITY HEALTH EDUCATORS WILL:

Develop a written program plan that includes:

- Program goals, intended audience
- Measurable objectives
- Appropriate activities to meet objectives, including timelines and responsibilities for implementation
- Description of resources necessary to conduct the program
- Comprehensive evaluation plan to measure the impact of a program, make future improvements and make decision about similar future programs

Communicate the purpose and objectives of the activity to the learner before 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.

Implement the health education program based on activities and timelines developed in the written program plan.

Utilize a variety of skills in delivering strategies, interventions and programs including effective use of instructional technology.

Incorporate demographically and culturally sensitive techniques when promoting programs.

Assess the effectiveness of the program plan and make appropriate modifications.

Maintain confidentiality of all health information obtained as part of the community based health education program.

ALL PROGRAMS IMPLEMENTING OBESITY PREVENTION STRATEGIES WILL:

Include strategies to address both improving eating habits and increasing physical inactivity.

Align program goals, objectives, and strategies with the goals, objectives, and strategy recommendations identified in the Arizona Nutrition and Physical Activity State Plan. Information on the Arizona Nutrition and Physical Activity State Plan is available on line at: http://www.eatsmartgetactive.org/pdf/opp6.pdf

Understanding the influence that parents and caregivers have on the behaviors of young children, all programs must provide obesity interventions that influence the healthy eating and physical activity behaviors of adults as well as children.

Collaborate with existing community resources/partners to communicate the healthy weight and physical activity message. For example, encourage child care centers and home care providers to participate in the Arizona Department of Health Services' "Empowerment Pack" program. Information on the Arizona Department of Health Services' Empowerment Pack is available on line at http://www.theempowerpack.org/

Programs targeting child care centers and home care providers will actively promote participation in the USDA Child and Adult Care Food Program to potentially eligible centers/providers. Information on the USDA Child and Adult Care Food Program is available online at http://www.fns.usda.gov/cnd/care/

Recognizing that certain populations are at greater risk, resulting in disparities in the prevalence of obesity, interventions/curriculum/programs need to be tailored appropriately for various populations and incorporate cultural, linguistic, geographic and socioeconomic factors.

References:

National Commission for Health Education Credentialing (NCHEC), Responsibilities and Competencies of Health Educators. 2008. Available at http://www.nchec.org/credentialing

California Conference on Local Directors of Health Education (CCLDHE), Standards of Practice for Public Health Education in California Local Health Departments. October, 2008. Available at www.ccldhe.org

United States Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, 2010-2011 edition. December, 2009. Available online at www.bls.gov/oco/ocos063.htm

Reducing Screen (TV) Time • *Brocodile the Crocodile – now part of NY state wide Fit 5 Kids curriculum* Seven sessions with messages to reduce TV viewing incorporated into creative lessons in language arts, math, movement and song, arts and crafts, health and science	Promising Practice	This curricula can also be built into home visitation programs such as Parents as Teachers.	
Obesity Prevention in the primary care setting • *High Five for Kids* Implemented by nurse practitioners or other professionals trained in Motivational Interviewing with parents with goal to change child's behavior.	Spark PE for children older than 5 is evidence based		$2700-$4700 for up to 40 staff- includes training, curriculum and follow up. Equipment is an additional $1700
Increase physical activity • *Spark PE Early Childhood* SPARK EC provided children ages 3-5 with high activity, academically integrated, enjoyable movement opportunities that foster social and motor development and enhance school readiness skills. SPARK EC activities are age-appropriate, engaging, rhythmical, and fun. Curriculum, training, equipment, and support are provided to implement an effective physical activity program. • *CATCH Early Childhood* Physical education/activities, specifically aimed at increasing moderate-to-vigorous physical activity while at preschool. Lesson plans and activities, combined with music, hand puppets and other stimulating visuals, create an environment where physical activity, health, education, and healthy eating behaviors are valued and taught	CATCH school age is evidence based		Kit costs $375 each, Includes teachers manual, parent tip sheets and lession plans. Additional costs might be incurred to train staff on implementation.

Policy Specialist – Kelley Murphy **LINKS TO: NAP SACC** Health - Intervention NAP SACC **SPARK** Health - Sparkpe, Early Childhood **CATCH** Health - Catch Info **Color Me Healthy** Health - Color Me Healthy

GOAL AREA: HEALTH

STRATEGY NAME: PRENATAL OUTREACH

GOAL:

- **Collaborate with existing early childhood health care systems to improve children's access to qualiy health care**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Prenatal outreach strategies address health and development of the infant prior to birth. They do the following: • Increase access to and awareness of the importance of early prenatal care for pregnant women and women of childbearing age. • Provide culturally appropriate support and information to at-risk pregnant women facilitating access to prenatal care. • Reduce unhealthy behaviors such as smoking, alcohol use during pregnancy and encourage healthy behaviors among at risk pregnant women. • Establish or expand a comprehensive prenatal/postnatal outreach, suport and information program for pregnant women through a home visiting program using nurses or paraprofessionals such as promotora's or lay health workers.	Evidence Based Child health policymakers and practitioners have implemented many programs both to prevent low birth weight and to improve the life chances of low birth weight babies, especially in the areas of school readiness and achievement. To the extent that the programs succeed, they could help narrow racial gaps in school readiness by as much as 3 to 4 percent. Poor birth outcomes can have negative consequences for children's health and development and have been associated with increased risk formaltreatment. Preterm and low birth weight (LBW) babies face an elevated chance of early mortality,health problems, and developmental delays. LBW infants are twice as likely as their normal-weight peers	Costs vary depending upon the service delivery method. Costs can include, but are not limited to personnel, ERE, training, curriculum, transportation, printing, materials, media, and incentives for program participants. Costs for direct health care are not included. Applicants should consider additional transportation costs when serving remote or rural regions. If choosing home visitation, is this strategy linked to other home visitation in the region? Is there existing capacity in the region that can be expanded?	Home visitation costs range from $1,000-$4,000 per family depending on the range of services provided and the model approach—whether using lay health workers or a team approach such as Health Start that includes multiple levels of providers with a range of credentials of personnel providing the services. Materials and Supplies: $200 per family

	to be placed in foster care and to be maltreated over their early years of life The American College of Obstetricians and Gynecologists recommends that women receive at least 13 prenatal visits during a full-term pregnancy and the first visit occurs during the first three months of pregnancy. Education and preconception counseling for all women about the need for early, continuous prenatal care are essential to healthy births.		

Policy Specialist – Kelley Murphy

See also Health Insurance Outreach SOP

Sources: Nancy E. Reichman. **"**Low Birth Weight and School Readiness." The Future of Children, Spring 2005. The Woodrow Wilson School of Public and International Affairs at Princeton University and The Brookings Institution.

John L. Kiely, Ph.D.,1 and Michael D. Kogan, Ph.D., M.A. "Prenatal Care." Centers for Disease Control. Health - Prenatal Outreach - CDC, Reproductive Health

"Preexisting Factors, but Not Logistical Barriers, Inhibit Timely Use of Prenatal Care." Family Planning Perspectives
Volume 32, Number 5, September/October 2000. Alan Guttmacher Institute.

FIRST THINGS FIRST
Prenatal Outreach, Promotora
Standards of Practice - Final

Partnerships between informal systems of care involving indigenous community health workers and formal care networks is a promising practice in connecting women to prenatal care and improving birth outcomes.

Use of promotoras (community health workers) in Latino communities (especially in rural communities) has shown promise when connecting women to prenatal care. For example, La Clinica del Cariño in Hood River County, Oregon has shown success in increasing access to early prenatal care. The clinic, which serves a predominantly rural Latino population, including many seasonal farm workers, began its Perinatal Health Promoter Program in 1987. In this program, *promotoras* are recruited from the community served by the clinic and are trained to both communicate the need for and to provide basic clinical prenatal services. The *promotoras* work in the communities and in the clinic. Their knowledge of, and integration within, the communities ensures that they are aware of nearly all pregnancies that occur within their communities. Nearly all pregnant women are or eventually become aware of the *promotoras,* who then become case managers for these women by providing prenatal counseling and by facilitating access to the clinic, which is a federally qualified health center. In addition to prenatal services, the *promotoras* provide early postpartum care and family planning services. They work closely with physicians in the clinic and discuss all cases, particularly high-risk pregnancies. Records from the clinic have shown that more than 85 percent of Latina mothers who accessed services at the clinic received prenatal care within the first trimester of pregnancy. (American Journal of Public Health, 2004)

First Things First is interested in implementing the promotora outreach model in rural, Latino communities as a means of improving birth outcomes. Specifically, Applicants who become successful grantees would:

Qualifications for a Promotora include:

Promotoras, who are lay practitioners, should be members of the communities in which they work and must be deeply familiar with their communities.

Have received training, formally or informally in maternal and child health.

Have excellent communication skills.

Programs implementing Prenatal Outreach/Promotora Model will:

Hire staff who reflect the cultural and ethnic experiences and language of the families with whom they work.

Hire staff with the appropriate community knowledge to deliver the specific services in the scope of work.

Assure that staff receive specific training to carry out prenatal outreach/promotora model activties.

Provide ongoing staff development on diversity issues.

Establish an effective, consistent supervisory system that provides support for all staff members and ensures accountability to participants, funders and the community.

Assure that evaluation and monitoring is a collaborative, ongoing process that includes feedback from staff, families and community members.

In the United States, Native American Tribes are considered autonomous nations with all of the rights and responsibilities of a nation. Understanding this, Native American Tribes are charged with protecting the health and safety of their people. To this end, Tribes have full ownership over any data collected within their reservation boundaries. This means that Tribes can allow or not allow any program to collect health data on the reservation.

Any grantee implementing programs in tribal communities must have official tribal permission to collect and utilize sensitive health data. Such data can include but not be limited to:

- Morbidity and mortality among members of their communities
- Information regarding child safety and welfare
- Information regarding children in foster care
- Infectious and chronic disease information among members of their communities
- BMI and healthy weight information

"To address cultural competency objectives, early childhood practitioners /early childhood service providers shall ensure that children and families receive from all staff members effective, understandable, and respectful care that is provided in a culturally competent manner- a manner compatible with their cultural beliefs and practices and preferred language. Early childhood practitioners /early childhood service providers should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. Early childhood practitioners/early childhood service providers should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and family-centered involvement to ensure that services are delivered in a manner that is consistent with the National Standards on Culturally and Linguistically Appropriate Services and/or the National Recommendations on Cultural and Linguistic Competence for the National Association for the Education of Young Children."
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 ;
http://www.naeyc.org/positionstatements/linguistic

Promotoras will:

Engage at-risk pregnant women in prenatal services early, preferably in the first trimester of pregnancy.

Ensure pregnant women are aware of and access formal prenatal care services.

Engage pregnant women and their families in assessing their status using research supported tools to identify strengths and needs. Programs will identify the tools currently used in practice or use the Life Skills Profile.

Help pregnant women and families develop and implement a family service plan based upon assessment findings and goals and objectives identified with the family.

Connect eligible pregnant women to public health coverage as needed and to prenatal care services available. Provide transportation to prenatal doctor visits, as needed.

Monitor and encourage continued access to prenatal care throughout a woman's pregnancy.

Encourage healthy prenatal behaviors, and connect women to available services that mitigate unhealthy behaviors such as smoking cessation or drug or alcohol treatment.

Discuss preconception health issues.

Engage and empower members of the community in fostering support of pregnant women, preserving within the community the traditional Latino cultural context that appears to confer positive health effects. Organize community members to provide social support systems for pregnant mothers, such as those that exist in most areas of Latin America.

Connect pregnant women to nutrition services such as the federal Women, Infants and Children (WIC) Nutrition Program as needed.

Provide education on Newborn Screening and the importance of follow up.

Provide resource & referral information. Identify services available to families and the subsidies to which they may be entitled; help them to fill out the forms to gain those services, and help the families to follow-through to ensure service delivery as needed.

Provide service coordination with other community resources to make an effort to minimize duplication and to ensure that families receive comprehensive services as needed.

Partner with lay midwives (*parteras*), health providers, and caregivers who provide support during labor and the postpartum period (*doulas*), educating women on parenting skills, the health needs of the young child, and child development.

FIRST THINGS FIRST
Prenatal Outreach, Home Visitation
Standards of Practice - Final

Home visitation programs deliver education, information and support to families where they are - in their homes. Home visiting programs have also shown positive effects in improving birth outcomes. A 2004 study of home visiting programs found that mothers visited by paraprofessionals experienced better mental health, and fewer miscarriages and fewer low birth weight newborns. Mothers and children visited by paraprofessionals displayed greater responsiveness to one another and in some cases had home environments that were more supportive of children's early learning.

The same study found that nurse-visited women reported more time between births of first and second children and lower domestic violence rates. Nurse-visited children of mothers with low psychological resource levels at onset had homes more conducive to early learning when compared with controls, more advanced language, better executive functioning and better adaptive behavior during testing. (Pediatrics, 2004)

A prenatal home-visitation program with focus on social support, health education, and access to services holds promise for reducing LBW deliveries among at-risk women and adolescents. Psychosocial support appears to be an important element of such programs. Indeed, research has indicated that the rate of LBW for black mothers is associated with aspects of the social environment that are amenable to change, including social support and neighborhood characteristics. Other important elements appear to be linkages to medical providers and health and nutrition resources, and encouraging healthy prenatal behaviors. (American Journal of Preventive Medicine, February 2009)

A variety of home visitation program models exists. They differ in many technical aspects, such as the experience and credentials of the home visitor, and the duration and intensity of the visits. Yet, common aspects unite home visitation program models focusing on improved birth outcomes, including psychosocial support for the at-risk pregnant woman, encouragement of healthy prenatal behavior, linkages to community services such nutrition and medical services, and parent education and support related to infant and child development.

Qualifications for a Prenatal Home Visitor Include:

Home visitors are required to have a minimum of a Bachelors degree in nursing, allied health, early childhood development, education, family studies, social work or a closely related field; or staff is extensively trained and can demonstrate competency in service provision (Programs must provide complete documentation).

Programs implementing Prenatal Outreach/Home Visitation will:

Conduct background checks on all staff prior to hiring, including finger printing and three professional references

Hire staff who reflect the cultural and ethnic experiences and language of the families with whom they work

While ensuring model fidelity, programs are flexible and continually responsive to emerging family and community issues

- Be accessible for families. Offer extended service hours including weekend/evening hours.
- To ensure quality services caseload size for each staff person is based upon:
    - How many hours per week the home visitor works
    - Family need and intensity of services provided (for example, for families with high risk or multiple risk factors, frequency and intensity of programming can increase to allow for more time to build relationships, modify maladaptive behaviors or attitudes or practice newly learned parenting skills)
    - Where each family lives

    For example; 20 is the maximum caseload for a home visitor working entirely in homes with families assessed as high risk or with multiple risk factors at one time per week. However, adjustments may occur (in consultation with First Things First) based on unique community or client needs.

Engage families as partners to ensure that the program is beneficial. Families have regular input and feedback in programmatic planning to meet their needs.

Develop a collaborative, coordinated response to community needs

Home visitors receive ongoing staff development/training to ensure program quality and give staff an opportunity to develop professionally

- Assess home visitors' skills and abilities. Home visitors must be able to engage families while keeping a professional rapport.
- Prior to serving families, staff must have professional training or have participated in development opportunities to ensure a level of competency in service delivery.
- Provide ongoing staff development on diversity issues

Staff will receive training and information regarding mandatory reporting. Arizona law requires home visitation staff who suspect that a child has received non-accidental injury or has been neglected, to report their concerns to Child Protective Services or local law enforcement (ARS §13-3620.A).

Provide ongoing staff development/training

Supervisors should work with home visitation program staff to prepare professional development plans

All Standards of Practice are modeled in all activities including planning, governance, and administration

- Wages and benefits are adequate for supporting high quality staff
- The length of employment and experience/education are reflective of high quality staff. Home visitors are required to have a minimum of a Bachelors degree in early childhood development, education, family studies, social work or a closely related field; or staff is extensively trained and can demonstrate competency in service provision (Programs must provide complete documentation). If programs experience hardship in recruitment efforts, they must notify and consult with First Things First to determine if alternative education or experience is permitted.

Establish an effective, consistent supervisory system that provides support for all staff members and ensures accountability to participants, funders, and the community

Establish supervision as a collaborative process with mechanisms that support staff in difficult situations and provides regular discussion to reflect and debrief. Supervision will also include observation. It is important that supervisors spend time with home visitors in the field to have a sense of how the service is being delivered. This will help supervisors and staff to identify coaching and mentoring opportunities.

All staff work as a team, modeling respectful relationships of equality

Build a team of staff who is consistent with program goals and whose top priority is the well-being of families and children

Structure governing bodies so that they reflect the diverse constituencies of the community and are knowledgeable about community needs

Evaluation and monitoring is a collaborative, ongoing process that includes input from staff, families, program administrators, and community members

- Activities, as identified by First Things First, include pre and post testing, self-assessment and opportunities for feedback.
- Identify outreach, engagement and retention practices
- Must demonstrate program effectiveness mechanism. Programs must participate in data collection and reporting of performance measures.
- "To address cultural competency objectives, early childhood practitioners /early childhood service providers shall ensure that children and families receive from all staff members effective, understandable, and respectful care that is provided in a culturally competent manner- a manner compatible with their cultural beliefs and practices and preferred language. Early childhood practitioners /early childhood service providers should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. Early childhood practitioners/early childhood service providers should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and family-centered involvement to ensure that services are delivered in a manner that is consistent with the National Standards on Culturally and Linguistically Appropriate Services and/or the National Recommendations on Cultural and Linguistic Competence for the National Association for the Education of Young

Children." http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 ; http://www.naeyc.org/positionstatements/linguistic

Prenatal Outreach Home Visitors will:

Engage at-risk pregnant women in home visiting services early, preferably in the first trimester of pregnancy.

Engage pregnant women and their families in assessing their status using research supported tools to identify strengths and needs. Programs will identify the tools currently used in practice or use the Life Skills Profile

Help pregnant women and families develop and implement a family service plan based upon assessment findings and goals and objectives identified with the family

Connect eligible pregnant women to public health coverage as needed and to prenatal care services available

Monitor and encourage continued access to prenatal care throughout a woman's pregnancy

Encourage healthy prenatal behaviors, and connect women to available services that mitigate unhealthy behaviors such as smoking cessation or drug or alcohol treatment

Connect pregnant women to nutrition services such as the federal Women, Infants and Children (WIC) Nutrition Program as needed

Provide home-visiting services post-partum for at least twelve months, supporting the mother in understanding and addressing needs and development of their infant

Refer pregnant and postpartum women for depression, using a standardized or criterion-referenced tool. Connect women to mental health resources as needed.

After the birth of a child, conduct regular developmental screenings using a standardized or criterion-referenced tool. Provide evidence that staff administering any developmental tool have received the required professional training to administer the instrument. Depending on the duration of the home visiting intervention, **s**creenings may occur at 9, 18 and 24 months of age for all of the following developmental domains: cognitive, language, social-emotional and motor skills

Provide resource & referral Information-Identify services available to families and the subsidies to which they may be entitled; help them to fill out the forms to gain those services, and help the families to follow-through to ensure service delivery as needed

Provide service coordination with other community resources to make an effort to minimize duplication and to ensure that families receive comprehensive services as needed

Encourage and support retention of pregnant and postpartum women to follow-through with and continue involvement with family support services that support family stability and child development.

Each family must receive information and support in each of the core areas: parenting skills, prenatal health and healthy prenatal behaviors, family planning/spacing of birth of children, child health and developmental needs, resource and referral and service coordination. Information and support should be tailored to the needs of the pregnant women and family, as identified in the family service plan.

Child development includes all domains (physical, cognitive, social, emotional, language, sensory)

Parenting skills should involve age-appropriate child-adult interactions and address multiple facets of parenting skills such as physical touch, positive discipline, early reading experiences and verbal and visual communications

Support for the health of the pregnant woman and young child should include information and connection to resources related to the following: proper nutrition and available nutrition resources for pregnant women and young children; obesity prevention; breastfeeding; physical activity; immunizations; insurance enrollment; participation in consistent medical/dental homes; participation in prenatal care; family planning; safety; developmental health; vision and hearing screening)

Prenatal Outreach Home Visitors may also help families:

- Identify their natural supports such as peer support and natural helping networks in their neighborhoods or community.
- Access opportunities to participate in family literacy activities and reinforce reading to the child from birth.
- Address issues of substance abuse, domestic violence, mental health, and children with developmental delays or disabilities

Provide services to families that are based upon a culture of trust and respect

Create a family-centered environment

- Home visitors are from the community and have extensive knowledge of community resources
- Structure activities compatible with the family's availability and accessibility.
- Demonstrate genuine interest in and concern for families
- Respect the culture and heritage of the family

Clearly define program objectives with the families upon enrollment; understanding what the program will accomplish helps families become fully engaged in program services

Create opportunities for formal and informal feedback regarding services delivered and act upon it; ensure that input shapes decision-making

Encourage open, honest communication

Maintain confidentiality, being respectful of family members and protective of their legal rights

Support the growth and development of <u>all</u> family members; encourage families to be resources for themselves and others

- Encourage family members to build upon their strengths
- Publicity/outreach, literature and staff training reflect the commitment to effectively serve fathers
- Help families identify & acknowledge informal networks of support and community resources

- Create opportunities to enhance parent-child and peer relationships

Affirm, strengthen & promote families' cultural, racial and linguistic identities and enhance their ability to function in a multicultural society

- Create opportunities for families of different backgrounds to identify areas of common ground and to accept and value differences between them
- Strengthen parent skills to advocate for themselves within institutions and agencies

Sources:

Nancy E. Reichman. **"**Low Birth Weight and School Readiness." The Future of Children, Spring 2005. The Woodrow Wilson School of Public and International Affairs at Princeton University and The Brookings Institution.

John L. Kiely, Ph.D.,1 and Michael D. Kogan, Ph.D., M.A. "Prenatal Care." Centers for Disease Control. http://www.cdc.gov/ReproductiveHealth/Products&Pubs/DatatoAction/pdf/rhow8.pdf

"Preexisting Factors, but Not Logistical Barriers, Inhibit Timely Use of Prenatal Care." Family Planning Perspectives. Volume 32, Number 5, September/October 2000. Alan Guttmacher Institute.

Ian T. Hill. "The Role of Medicaid and Other Government Programs in Providing Medical Care for Children and Pregnant Women." The Future of Children, Winter 1992**.** The Woodrow Wilson School of Public and International Affairs at Princeton University and The Brookings Institution.

Michael S. McGlade, PhD, Somnath Saha, MD, MPH, and Marie E. Dahlstrom, MA. "The Latina Paradox: An Opportunity for Restructuring Prenatal Care Delivery." American Journal of Public Health, December 2004.

Olds DL, Robinson J, Pettitt L, Luckey DW, Holmberg J, Ng RK, Isacks K, Sheff K and Henderson CR. "Effects of Home Visits by Paraprofessionals and by Nurses: Age 4 Follow-up Results of a Randomized Trial." Pediatrics, December 2004.

Eunju Lee, PhD, Susan D. Mitchell-Herzfeld, MA, Ann A. Lowenfels, MPH, Rose Greene, MA, Vajeera Dorabawila, PhD, Kimberly A. DuMont, PhD. **"**Reducing Low Birth Weight Through Home Visitation A Randomized Controlled Trial." American Journal of Preventive Medicine, February 2009.

Jane Knitzer, Suzanne Theberge, Kay Johnson. "Reducing Maternal Depression and Its Impact on Young Children Toward a Responsive Early Childhood Policy Framework" Project Thrive, Issue Brief Number 2. National Center for Children In Poverty, January 2008.

FIRST THINGS FIRST
Community Health Education
Standards of Practice - Final

A great deal of public health research indicates that Arizona's children are not as healthy as they could be. Increased rates of obesity, diabetes, and asthma; paired with poor nutrition, a sedentary lifestyle, and a variety of economic and social factors are all contributing to a poor environment of physical, mental, and oral health for many children. Even more alarming is recent news published in the New England Journal of Medicine that life expectancy for children born today may actually be less than that of their parents. Though we have made significant progress in addressing health issues that affect children through immunization and other public health interventions, many problems remain. The unique geography and population of the state complicate addressing these health concerns.

Health educators work with individuals and communities to provide information and education on how to improve health and health outcomes. They "work to encourage healthy lifestyles and wellness through educating individuals and communities about behaviors that can prevent diseases, injuries, and other health problems" (U.S. Department of Labor, December 2009). There are many health education programs, on a variety of topics, designed to provide individuals and communities with the information they need to improve their health status.

In order to leverage resources and educational efforts, community health education efforts may be integrated into other public health and health programming. For example, community health education can be addressed through other early childhood programs and services, such as home visitation, parenting education or by child care providers.

First Things First Regional Partnership Councils have identified a number of health needs and disparities specific to their individual regions. To address some of these needs, they have chosen to fund community based health education programs in multiple settings. Any grantee implementing community health education on any topic must meet the following requirements:

QUALIFICATIONS FOR A COMMUNITY HEALTH EDUCATOR INCLUDE:

Minimum of a Bachelors Degree in Health Education, or another allied health profession.

Completion of training in the specific curriculum/materials being used.

Excellent communications skills and the ability to adjust to the individual learners' needs.

Have knowledge and skills in:

- Assessing individual and community needs for health education.
- Planning, implementing and administering health education strategies, interventions and programs.

- Serving as a health education resource person.
- Communicating and advocating for health and health education

PROGRAMS IMPLEMENTING COMMUNITY HEALTH EDUCATION WILL:

Address a documented health need within the target population of children birth through age five.

Choose or develop curriculum based on recognized educational principles.

Assure that the content/format of activities and materials will promote improvements in health not specific proprietary business interests of a commercial interest.

Build upon, enhance and coordinate with existing community based health education efforts in the region.

To the extent possible, work in partnership with other early childhood initiatives that provide services to the same target population.

Hire staff who reflect the cultural and ethnic experiences and language of the families with whom they work.

Hire staff with the appropriate qualifications to deliver the specific services in the scope of work.

Assure that staff receive specific training to carry out community based health education activities.

Provide ongoing staff development on diversity issues.

Establish an effective, consistent supervisory system that provides support for all staff members and ensures accountability to participants, funders and the community.

Assure that evaluation and monitoring is a collaborative, ongoing process that includes feedback from staff, families and community members.

Assure that the content/format of activities and materials will promote improvements in health not specific proprietary business interests of a commercial interest.

Develop a post training evaluation for participant feedback if providing a series of sessions.

Programs implementing best practice models for community health education must adhere to the standards of the model, unless permission to deviate from the model has been obtained from the appropriate source.

Recognize that certain populations have health disparities due to cultural, linguistic, geographic and socioeconomic factors, and tailor interventions/curriculum and programs to address various populations.

Collaborate with existing community resources to reinforce health education messages.

Maintain confidentiality of all information obtained as part of the community based health education program.

In the United States, Native American Tribes are considered autonomous nations with all of the rights and responsibilities of a nation. Understanding this, Native American Tribes are charged with protecting the health and safety of their people. To this end, Tribes have full ownership over any data collected within their reservation boundaries. This means that Tribes can allow or not allow any program to collect health data on the reservation.

Any grantee implementing programs in tribal communities must have official tribal permission to collect and utilize sensitive health data. Such data can include but not be limited to:

- Morbidity and mortality among members of their communities
- Information regarding child safety and welfare
- Information regarding children in foster care
- Infectious and chronic disease information among members of their communities
- BMI and healthy weight information

"To address cultural competency objectives, early childhood practitioners /early childhood service providers shall ensure that children and families receive from all staff members effective, understandable, and respectful care that is provided in a culturally competent manner- a manner compatible with their cultural beliefs and practices and preferred language. Early childhood practitioners /early childhood service providers should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. Early childhood practitioners/early childhood service providers should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and family-centered involvement to ensure that services are delivered in a manner that is consistent with the National Standards on Culturally and Linguistically Appropriate Services and/or the National Recommendations on Cultural and Linguistic Competence for the National Association for the Education of Young Children."
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 ;
http://www.naeyc.org/positionstatements/linguistic

COMMUNITY HEALTH EDUCATORS WILL:

Develop a written program plan that includes:

- Program goals, intended audience
- Measurable objectives
- Appropriate activities to meet objectives, including timelines and responsibilities for implementation
- Description of resources necessary to conduct the program
- Comprehensive evaluation plan to measure the impact of a program, make future improvements and make decision about similar future programs

Communicate the purpose and objectives of the activity to the learner before 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.

Implement the health education program based on activities and timelines developed in the written program plan.

Utilize a variety of skills in delivering strategies, interventions and programs including effective use of instructional technology.

Incorporate demographically and culturally sensitive techniques when promoting programs.

Assess the effectiveness of the program plan and make appropriate modifications.

Maintain confidentiality of all health information obtained as part of the community based health education program.

References:

National Commission for Health Education Credentialing (NCHEC), Responsibilities and Competencies of Health Educators. 2008. Available at http://www.nchec.org/credentialing

California Conference on Local Directors of Health Education (CCLDHE), Standards of Practice for Public Health Education in California Local Health Departments. October, 2008. Available at www.ccldhe.org

United States Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, 2010-2011 edition. December, 2009. Available online at www.bls.gov/oco/ocos063.htm

Frequently Asked Questions (FAQ's) on Pre/Post Natal

Data Submission Requirement

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1. When are reports due to First Things First?

All evaluation data reports (Financial forms for reimbursement can be submitted at any time) are due on the 20th of the month following the preceding month for example, May 1- May 30 data report due on June 22, 2009. Also, if the due date falls on a non-work day, then the following work day will become the due date. For example June 20, 2009 falls on a Saturday, then the actual due date for data would be June 22, 2009.

NOTE: Starting on July 1, 2009, all data collected will be reported quarterly.

1st Quarter – July-September – Report due October 20
2nd Quarter – October-December – Report due January 20
3rd Quarter – January-March – Report due April 20
4th Quarter – April- June – Report due July 20

2. If my organization has more than one Regional Partnership Council, how many reports do I submit?

Reports are to be completed for each Regional Partnership Council area in which services are provided. For example, if a program is contracted to provide services in both Central Maricopa and Northeast Maricopa regions, two separate reports must be submitted.

3. Where is data submitted? And who do I initially contact for questions?

Data is submitted online (AZFTF's extranet) at www. azftf.gov

Contact: your grant specialist
Finance Division
First Things First (FTF)
4000 N. Central Ave., Suite 800
Phoenix, AZ 85012
(602) 771-5100

4. How do you define underinsured?

An individual is considered underinsured if the individual has health insurance coverage that does not pay the entire cost for care AND the incurring of the additional health care expense(s) will be a burden on the consumer to the extent that the individual has to choose between paying for care or paying for other necessities.

5. I am offering Pre/Post Natal Community Based Services/Programs in region X, but I am serving participants from regions X, Y and Z. Do I report data for only region X or for all regions? Should I report of the home zip codes of service recipients?

Please report Pre/Post Natal Community Based Services/Programs on the region in which the service/program is conducted. If a notable number of participants are from another region, please make note of that in your narrative report. You are not required to report the home zip code of service

recipients, report only on the location where the Pre/Post Natal Community Based Service/Program is provided.

*Please note, this is for Community Based Pre/Post Natal Programs only. Grantees funded for Pre/Post Natal Home Visitation Services are required to report home zip codes where service recipients reside and receive services.

6. **When should the Pre/Post Natal Community Based Training Performance Measure and Data Reporting Template be used, and when should the Pre/Post Natal Home Visiting Performance Measure and Data Reporting Template be used?**

You should submit Pre/Post Natal Community Based Training data requirements only if you have a First Things First funded contract to provide Pre/Post Natal Community Based services. Vice versa, submit Pre/Post Natal Home Visiting data requirements only if you have a First Things First funded contract to provide Pre/Post Natal Home Visiting services.

7. **What is the measure of "Delay Identified?" Does this mean they were delayed enough to be referred to other programs (AzEIP, DDD, etc.) or any delay in any area?**

Report data related to the number of children found to have a possible delay based on screening, rather than referral to services. If screening tools indicate any level of possible delay in any domain/ area, the child and family should be referred to the appropriate system: AzEIP for birth to three – this process includes determination of eligibility for Division of Developmental Disabilities (DDD); or public schools and/or Division of Developmental Disabilities for families with children three to five years of age. Report this information in data related to referrals.

8. **Can you please provide clarification on how "teen" is defined?**

A teen is defined as any individual who has not reached his or her 20th birthday. For example, an individual who is 19 years, 11 months, and 29 days is categorically considered a teen. Any individual greater than, or equal to, 20 years of age is categorically considered an adult. For example, an individual who is 20 years and 3 days is categorically considered an adult.

9. **Under the section "Home Visiting Services Provided", the only service options listed include maternal depression screening and family service plan. If "other" home visitation services are provided, where should those services be reported?**

Any home visitation service outside of the creation of a family service plan or maternal depression screening, or any "other" services offered during a home visit (i.e. providing an emergency food box, providing transportation, etc.) should be reported, as appropriate, in the quarterly narrative report.

Prenatal Outreach

First Things First reporting requirements and progress monitoring are aligned with First Things First Goals, Key Measures, and Standards of Practice. The purpose of First Things First data submission and monitoring is to determine the extent to which each program has accomplished the stated goals, key measures, targeted service number, and activities outlined in the standards of practice.

Grantees will be provided with data reporting requirements by First Things First. There are five main components to data reporting:

- Unit of Service
- Performance Measures
- Data Reporting Template
- Data Reporting Instruction
- Frequently Asked Questions

The data reporting template captures the set of data the grantee submits on a quarterly basis; the instructions support that data submission. Units of Service and performance measures outline how the quarterly data submissions will be evaluated according to the contracted deliverables and standards of practice for that contract. Frequently asked questions present answers to common reporting, evaluation, policy, and performance questions.

Definitions:

Unit of Service and related Target Service Number

A Unit of Service is a FTF designated indicator of performance specific to each FTF strategy. It is composed of a unit of measure and a number (Target Service Number).

A Unit of Measure/Service can be a target population and/or a service/product that a grantee is expected to serve as part of an agreement. Target Service Number represents the number of units (e.g. target population) proposed to be served or number of products/services proposed to be delivered during the contract year.

For example, for the FTF strategy Home Visitation the FTF Unit of Service is “number of families served” and a Target Service Number of 50 represents the number of families the program proposes to serve during the contract period. All FTF applicants must clearly state in the proposal a target service number for each strategy specific Unit of Service.

For **Prenatal Outreach,** the units of service are:

Total number of pregnant/postpartum women attending training sessions
Total number of pregnant/postpartum women receiving home visitation services

Performance Measures

Performance Measures measure (1) key indicators of performance (i.e. Unit of Service); (2) basic implementation of strategy; (3) alignment of program activities to strategy specific standards of practice, (4) performance or progress toward pre-established strategic goals. Performance measures may include the level or type of program activities conducted (e.g. serving families/children through home visits) and/or the direct services and products delivered by a program (e.g., providing scholarships).

For **Prenatal Outreach *Community Based Training and Home Visitation,*** performance measures are:

Total number of pregnant/postpartum women attending training sessions / proposed service number
Total number of pregnant/postpartum women receiving home visitation services / proposed service number
Total number of clients receiving home visits/proposed service number
Total number of training sessions offered/proposed service number
Total number of families receiving referrals for health insurance or health coverage enrollment/ target service number
Total number of families receiving referrals for community based services/ target service number
Total number of awareness sessions offered/proposed service number
Total number of people reached by awareness sessions/proposed service number
Total number of children receiving developmental screening/target service number

Data Reporting Templates

Data reporting templates are the tools utilized to gather data to assess grantee Performance Measures. All FTF grantees submit data on a quarterly basis through designated data reporting templates.

For **Prenatal Outreach,** the data reporting template is:

FIRST THINGS FIRST
The right system for bright futures

pgms partner grant management system

Evaluation Report

CONTRACT DATES
7/1/2010
TO
7/31/2010

TEST PRODUCTION AGENCY (APPS)

Address: Parter Address Agency Details
Test City, AZ 85032

Contract ID: GRA-STATE-10-0218-01

View Reporting Instructions and FAQ

PRENATAL HOME VISITATION

GENERAL INFORMATION

User Completing Report	AZFTF\mshahi
Reporting Period	Month 7 Year 2010
Regional Partnership Council	State
Status	In Progress
Date Completed	

Types of Services Delivered

Please select from the list below the services you delivered as part of your program this reporting period. You can select as many services as needed. For service types selected, please complete data entry into the data fields related to the service selected. Please skip any service deliver section that does not pertain to your program.

- ☐ Public Awareness Activities
- ☐ Home Visiting (Nurse Home Visiting)
- ☐ Home Visiting (Promotora or Lay Health Worker Program)
- ☐ Health Insurance Enrollment Assistance
- ☐ Referrals to Health Care and Low Cost Care Providers
- ☐ Community Based Referrals
- ☐ Other (please specify)

Public Awareness Activity

Please select from the list which activities you conduct as part of your program and report the number of people reached through the selected activities. Refer to the instructions for a definition of each activity type. Please skip any activity that does not pertain to your program.

If none, please enter zero

Activity	Number of people reached
Media Impressions	
Provision of written materials	
Group meetings	
One to one interactions	

Home Visiting

Number of Clients served by Home Visiting Program

Please enter the number of clients served by your home visiting program during this reporting period.

If none, please enter zero

	Number of Clients Served at the beginning of the month	Number of Clients Newly Enrolled during Current Month	Total Number of Clients Disenrolled during the Month	Total Number of Clients Served at the End of the Month	Total Clients Served
1st Trimester					
2nd Trimester					
3rd Trimester					
Postnatal (0 - 6 months)					
Postnatal (6 - 12 months)					
Postnatal (12+ months)					

Reasons for Disenrollment

Please enter the reasons for disenrollment for any clients disenrolled during this reporting period. The Total Disenrollment below should equal the Total Number of Clients Disenrolled in the previous table.

If none, please enter zero

	Program Completion per Model*	Appropriate Transition to other Model*	Refused Service*	Moved*	Other/Unknown*	Total Disenrollment*
1st Trimester						
2nd Trimester						
3rd Trimester						
Postnatal (0 - 6 months)						
Postnatal (6 - 12 months)						
Postnatal (12+ months)						

Number of Infants/Toddlers Receiving Development Screening

Please provide the number of infants/toddlers who received developmental screening during this reporting period.

If none, please enter zero

	9 Months	18 Months	24 Months	Other Age	Total
Eligible					
Received					
Possible Delay Identified					

Home Visiting Services Provided

Please provide the number of Home Visiting Sevices provided by client. You can enter as many other services as needed.

Service	1st Trimester	2nd Trimester	3rd Trimester	Postnatal (0 - 6 months)	Postnatal (6 - 12 months)	Postnatal (12+ months)	
Number of Family Service Plans Planned	0	0	0	0	0	0	Edit
Number Screened for Depression	0	0	0	0	0	0	Edit

Health Insurance Enrollment Assistance

Please indicate for families that you serve the numbers that are uninsured or underinsured and those who received enrollment assistance to obtain insurance.

If none, please enter zero

Number of Families Served Who Are Not Covered by Private Insurance, AHCCCS, Indian Health Services or Kids Care	
Number of Families Served Who Report They Are Underinsured	
Number of Families Served Who Report Lack of Insurance or Underinsurance Who Received Enrollment Assistance to Obtain Insurance	

Referrals to Health Care and Low Cost Care Providers

Please indicate for families that you serve the numbers that received referrals to the following agencies.

If none, please enter zero

Number of Families Referred to Indian Health Servicces (IHS)/Indian Tribal Urban (ITU)

Number of Families Referred to Free or Low Cost Care Service Providers

Number of Families Referred to AHCCCS or DES Health to Receive Health Coverage

Community Based Referrals

Please indicate for clients that you serve the number who received community based referrals. Please enter as many rows as needed.

Name*	Service*	Number of Referrals*

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Evaluation Report

CONTRACT DATES
7/1/2010
TO
7/31/2010

TEST PRODUCTION AGENCY (APPS)

Address: Parter Address Agency Details
Test City, AZ 85032

Contract ID: GRA-STATE-10-0218-01

View Reporting Instructions and FAQ

PRENATAL COMMUNITY BASED TRAINING

GENERAL INFORMATION

User Completing Report	AZFTF\zeval
Reporting Period	Month 7 Year 2010
Regional Partnership Council	State
Status	In Progress
Date Completed	

Types of Services Delivered

Please select from the list below the services you delivered as part of your program this reporting period. You can select as many services as needed. For service types selected, please complete data entry into the data fields related to the service selected. Please skip any service delivery section that does not pertain to your program.

- [ ] Public Awareness Activities
- [ ] Community Based Training (Including Promotora Programs)
- [ ] Health Insurance Enrollment Assistance
- [ ] Referrals to Health Care and Low Cost Care Providers
- [ ] Community Based Referrals
- [ ] Other (please specify)

Public Awareness Activity

Please select from the list which activities you conduct as part of your program and report the number of people reached through the selected activities. Refer to the instructions for a definition of each activity type. Please skip any activity that does not pertain to your program.

Number of People Reached Through Media Impressions	
Number of People Reached Through Provision of Written Materials	
Number of People Reached Through Group Meetings	
Number of People Reached Through One to One Interactions	

Community Based Training Sessions

Please enter any community based training sessions.

Name	Topic	Date	City	Zip		

Health Insurance Enrollment Assistance

Please indicate for families that you serve the numbers that are uninsured or underinsured and those who received enrollment assistance to obtain insurance.

Number of Families Served Who Are Not Covered by Private Insurance, AHCCCS, Indian Health Services or Kids Care

Number of Families Served Who Report They Are Underinsured

Number of Families Served Who Report Lack of Insurance or Underinsurance Who Received Enrollment Assistance to Obtain Insurance

Referrals to Health Care and Low Cost Care Providers

Please indicate for families that you serve the numbers that received referrals to the following agencies.

Number of families referred to Indian Health Servicces (IHS)/Indian Tribal Urban (ITU)

Number of families referred to Free or Low Cost Care Service Providers

Number of families referred to AHCCCS or DES Health to Receive Health Coverage

Community Based Referrals

Please indicate for clients that you serve the number who received community based referrals. Please enter as many rows as needed.

Name*	Service*	Number of Referrals*		

Data Reporting Instructions

Data reporting instructions support data submission through the data reporting template.

For **Prenatal Outreach,** the data reporting instructions are:

Pre/Postnatal Community Based Training Instructions

INFORMATION

Your data report is always due on the 20th day of the month following the end of each quarter. Each quarterly submission will include information for the entire quarter broken out by month. Each data report submitted will include information for the entire preceding quarter.

1st Quarter – July-September – Report due October 20
2nd Quarter – October-December – Report due January 20
3rd Quarter – January-March – Report due April 20
4th Quarter – April- June – Report due July 20

- Data should be only reported for services funded by First Things First.
- Data should be reported for each Regional Partnership Council area in which contracted services are provided. For example, if your Pre/Postnatal community based training program is contracted to provide services in both Central Maricopa and Northeast Maricopa regions, two separate reports must be submitted.

OVERVIEW

- For each reporting period, enter all data for all Regional Partnership Council areas served into the First Things First web-based evaluation report. Your "Evaluation Report" screen will automatically show you how many reports to submit.
- For each quarter, **data should be tallied for each month of service.**
- Your final data submission for the quarter cannot be completed until you complete all monthly reports.
- When you have completed your data entry (or want to save and return at a later time) click "Save Changes" in the data system.
- If you make an error, and want to change a piece of information, don't forget to click "Save Changes" for your correction to be saved.
- **Do not forget to change the status of your report from 'in progress' to 'completed'. A COMPLETED status notifies FTF that your data report is ready for review.**

DIRECTIONS FOR DATA ENTRY

Types of Service Delivery:

Please select from the list below the services you deliver as part of your program. You can select as many services as needed. After a service type is selected, please complete data entry into data fields related to the service selected. Please skip any service delivery choices that do not pertain to your program.

- ☐ Public Awareness Activities
- ☐ Community Based Training (including Promotora programs)
- ☐ Health Insurance Enrollment Assistance
- ☐ Referrals to Health Care and Low Cost Care Providers
- ☐ Community Based Referrals
- ☐ Other (Please Specify) _____

Public Awareness Activity

1. Please select from the list the activities you conduct as part of your program. Select as many activities as needed. After an activity type is selected, please report the number of people reached through the specific activity. You **may skip** any activity that does not pertain to your program.
    a. Media impression is defined as the number of people reached with media campaigns.____ *(Number of people reached)*
    b. Provision of written materials is defined as the number of people receiving pamphlets, etc.____
    c. Group meetings.____
    d. One to One interactions.____

Community Based Training

Training Sessions (Education Sessions) is defined as a curriculum based program or formal trainings.

To begin data entry click "Add Training Session," this will bring up the data entry page.

***Any data field with an asterisk mark is required, you cannot skip it.**

Training Session data fields

1. ***Name of Training Session:** In this data field you will enter the name of the session.
2. ***Topic of Session:** This data field has multiple choice fields for a session topic. You can choose more than one topic. If none of the topics applies to the training session you are conducting, please choose "**Other (please specify)"** box and enter (type in) the topic of your session in the text box provided under the Other (Please Specify)" option.
3. ***Number of Trainers:** In this data field you will enter the number of trainers who offered training in this specific session.

4. ***Qualification of Trainers:** This data field is a text box. You will enter the range of qualifications your trainers had. Example: Health Educator.
5. ***Description of Session:** In this text field you will enter a brief description about the training session. Example: For the **Name of Training Session**: 'Newborn care', the **Description** could be- 'Learning to care for your newborn'.
6. ***Session Format:** This data field is a drop down menu. You can choose either **'Individual'** or **'Small group'** or '**Large community event**' option. If you choose "**Other (please specify)"-** then you need to enter the format of your session in the text box provided under the Other (Please Specify)" option.
7. ***Session Duration:** This data field is a drop down menu. You can choose only one choice that best applies for your session. The choices are: *less than an hour, 1 hour, 2 hours, 3 hours, or more than 3 hours.*
8. ***Session Venue:** This data field is a drop down menu. You can choose either one of the **listed** options *(hospital or health clinic, school, other community setting)* or the '**other (please specify)**' option. If you choose "**Other (please specify)"-** then you need to enter the venue at which your session took place in the text box provided under the Other (Please Specify)" option. Example: Library.
9. ***Session Date:** For this data field you will report the date your session took place. You can either enter a date directly into the data field or chose a date from the calendar (icon is next to the box).
10. ***Session Location – City:** In this data field you will enter the **City** name at which the session took place. Example: City – Phoenix.
11. ***Session Location – Zip:** This data field is a drop down menu of zip codes for the funded RPC. You can choose only one zip code.
12. ***Target Audience:** This data field is a drop down menu. You can choose one of the **listed** options [Expectant mothers, expectant teens, postnatal mothers, postnatal teens, expectant mothers (>18 years), Other(please specify)*]*. For example, a pregnant woman is considered a teen if she is 19 years, 11 months and 29 days and younger.
13. ***Number Enrolled:** In this data field you will enter the total number of participants (all expectant/postnatal mothers) who are enrolled in this session.
14. ***Number Attending:** In this data field you will enter the total number of participants who attended the session. (Example: 15 enrolled but only 10 attended the session, then the number 10 will be entered here.)

Health Insurance Enrollment Assistance

2. *Please indicate for families that you serve the numbers that are uninsured or underinsured and those who received enrollment assistance to obtain insurance.*
    a. ***Number of families served who are not covered by private insurance, AHCCCS, Indian Health Services, or Kids Care____**

b. ***Number of families served who report they are underinsured_____**
c. ***Number of families served who report lack of insurance or underinsurance who received enrollment assistance to obtain insurance_____**

Referrals to Health Care and Low cost Care Providers

3. *Please indicate for families that you serve the numbers that <u>received referrals</u> to the following agencies.*
    a. ***Number of families referred to Indian Health Services (IHS)/Indian Tribal Urban (ITU)____**
    b. ***Number of families referred to free or low cost care service providers____**
    c. ***Number of families referred to AHCCCS or DES to receive health coverage_____**

Community Based Referrals

4. *Please indicate for clients that you serve the numbers that received the following community based referrals.*

Number of clients referred to:						
	Home visiting services	Services to promote health such as smoking cessation, drug or alcohol treatment	Family planning services	Nutrition services (e.g. WIC)	Mental health services	Other referrals provided (Please specify)- medium text field to specify other referrals
Expectant Mothers						
Expectant Teens						
Post-partum women						

Pre/Postnatal Home Visiting Instructions

INFORMATION

Your data report is always due on the 20th day of the month following the end of each quarter. Each quarterly submission will include information for the entire quarter broken out by month. Each data report submitted will include information for the entire preceding quarter.

1st Quarter – July-September – Report due October 20
2nd Quarter – October-December – Report due January 20
3rd Quarter – January-March – Report due April 20
4th Quarter – April- June – Report due July 20

- Data should be only reported for services funded by First Things First.
- Data should be reported for each Regional Partnership Council area in which contracted services are provided. For example, if your Pre/Postnatal Home Visiting program is contracted to provide services in both Central Maricopa and Northeast Maricopa regions, two separate reports must be submitted.

OVERVIEW

- For each reporting period, enter all data for all Regional Partnership Council areas served into the First Things First web-based evaluation report. Your "Evaluation Report" screen will automatically show you how many reports to submit.
- For each quarter, **data should be tallied for each month of service.**
- Your final data submission for the quarter cannot be completed until you complete all monthly reports.
- When you have completed your data entry (or want to save and return at a later time) click "Save Changes" in the data system.
- If you make an error, and want to change a piece of information, don't forget to click "Save Changes" for your correction to be saved.
- **Do not forget to change the status of your report from 'in progress' to 'completed'. A COMPLETED status notifies FTF that your data report is ready for review.**

DIRECTIONS FOR DATA ENTRY

Types of Services Delivered:

Please select from the list below the services you deliver as part of your program. You can select as many services as needed. After a service type is selected, please complete data entry into data fields related to the service selected. Please skip any service delivery choices that do not pertain to your program.

- ☐ Public Awareness Activities
- ☐ Home Visiting (Nurse home visiting)
- ☐ Home Visiting (Promotora or Lay health worker program)
- ☐ Health Insurance Enrollment Assistance
- ☐ Referrals to Health Care and Low Cost Care Providers
- ☐ Community Based Referrals
- ☐ Other (Please Specify) _____

Public Awareness Activity

I. Please select from the list the activities you conduct as part of your program. You can select as many activities as needed. After an activity type is selected, please report the number of people reached through the specific activity. You may skip any activity that does not pertain to your program.

e. Media impression is defined as the number of people reached with media campaigns. ☐ *- Number of people reached.*

f. Provision of written materials is defined as the number of people receiving pamphlets, etc. ☐

g. Group meetings. ☐

h. One to One interactions. ☐

Home Visiting Programs

Number of clients served by Home Visiting Program:

1. ***Number of clients served at the beginning of the month by trimester/postnatal age breakout:** In this data field (column A) you will enter the total number of clients served at the beginning of the month (carryover from previous month) by 1st, 2nd, 3rd trimester breakout of expectant mothers and/or by Birth to 6 months, 6 months to 12 months, or 12 months and over age breakout of postnatal mothers.
2. ***Number of clients NEWLY enrolled during the current month by trimester/postnatal age breakout:** In this data field (column B) you will enter the total number of clients NEWLY Enrolled by 1st, 2nd, 3rd trimester breakout of expectant mothers and/or by Birth to 6 months, 6 months to 12 months, or 12 months and over age breakout of postnatal mothers during the current month.
3. ***Total number of clients disenrolled:** In this data field (column C) you will enter the total number of clients DISENROLLED by 1st, 2nd, 3rd trimester breakout of expectant mothers and/or by Birth to 6 months, 6 months to 12 months or 12 months and over age breakout of postnatal mothers during the month.
4. **Total number of clients served at the end of the month:** This data field is shaded grey and you do not need to report in this data field. It will be automatically calculated, so please do not enter any numbers in data field.

5. **Total clients served:** This data field is shaded grey and you do not need to report in this data field. It will be automatically calculated, so please do not enter any numbers in data field.

	Number of clients served at the beginning of the month	Number of clients newly enrolled during current month	Total number of clients disenrolled during the month	Total number of clients served at the end of the month	Total clients served
1st trimester				System Calculated	System Calculated
2nd trimester				System Calculated	System Calculated
3rd trimester				System Calculated	System Calculated
Postnatal (0-6 months)				System Calculated	System Calculated
Postnatal (6-12 months)				System Calculated	System Calculated
Postnatal (12+ months)				System Calculated	System Calculated

6. ***Reasons for Disenrollment (C):** In this data field enter the total number of clients disenrolled by trimester/postal age breakout and the reason breakout for the month.

Number of clients disenrolled for the following reasons	Program completion per model	Appropriate transition to other model	Refused service	Moved	Other/ unknown	Total disenrollment
1st trimester	NA					System Calculated
2nd trimester	NA					System Calculated
3rd trimester	NA					System Calculated
Postnatal (0-6 months)						System Calculated
Postnatal (6-12 months)						System Calculated
Postnatal (12+ months)						System Calculated

Number of Infants/Toddlers receiving Developmental Screening:

Note: Screening for developmental delays should be completed within 30 days of the required ages. A child is deemed to be eligible in that month if it is feasible to do the screening in that month. For instance a child that turns nine months in the last week of the month would be consider eligible the following month as that is the first scheduled visit after reaching nine months.

7. ***9 months/18 months/24 months eligible:** In the first data entry box enter the total number of children –nine/eighteen/twenty-four months of age --that were *eligible* for screening in the reporting month (as determined by age).
8. ***9 months/18 months/24 months received:** In the data entry box below the nine month eligibility box, enter the number of eligible children (nine/eighteen/twenty-four months of age) that *received* screening in the reporting month.
9. ***9 months/18 months/24 months possible delay identified:** In the last row, enter the number of children who received screening at nine/eighteen/twenty-four months of age and for whom a *possible delay was identified* (based on the standardized screening tool). Note: This total is the number of children whose assessment scores indicate a delay, rather than those that are eligible for specific services or programs.

10. ***Other age:** In the column labeled "other age," enter the number of children who received screening and were identified with a possible delay at ages other than 9, 18, or 24 months.
11. **Total:** The "total" columns are calculated by the data system and should be the same as your total number of children who were eligible for screenings, who received screening and who were identified with a possible delay, respectively.
    Note: Screening at 9, 18, and 24 months is recommended by the American Academy of Pediatrics and aligns with the standards of practice for home visiting identified by First Things First.

	9 months*	18 months*	24 months*	Other Age*	Total*
Eligible*				N/A	System Calculated
Received*					System Calculated
Possible Delay Identified*					System Calculated

Home Visiting Services Provided:

12. ***Number of Family Service plans developed:** In this data field you will enter the number of family service plans developed by 1st, 2nd, 3rd trimester breakout of expectant mothers and/or by Birth to 6 months, 6 months to 12 months, or 12 months and over age breakout of postnatal mothers. (See HV Services table below)
13. ***Number screened for depression:** In this data field you will enter the number of women screened for depression by 1st, 2nd, 3rd trimester breakout of expectant mothers and/or by Birth to 6 months, 6 months to 12 months, or 12 months and over age breakout of postnatal mothers. (See HV Services table below)
14. **Other services provided:** In this data field you will enter Other services provided (please specify) of women by 1st, 2nd, 3rd trimester breakout of expectant mothers and/or by Birth to 6 months, 6 months to 12 months, or 12 months and over age breakout of postnatal mothers. (See HV Services table below)

Service	1st trimester	2nd trimester	3rd trimester	Postnatal (0-6 months)	Postnatal (6-12 months)	Postnatal (12+ months)
# Family service plans developed*						
# Screened for depression*						
Other services provided (please specify)-						

Health Insurance Enrollment Assistance

II. *Please indicate for families that you serve the numbers that are uninsured or underinsured and those who received enrollment assistance to obtain insurance.*

d. ***Number of families served who are not covered by private insurance, AHCCCS, Indian Health Services, or Kids Care____**
e. ***Number of families served who report they are underinsured_____**
f. ***Number of families served who report lack of insurance or underinsurance who received enrollment assistance to obtain insurance_____**

Referrals to Health Care and Low cost Care Providers

III. *Please indicate for families that you serve the numbers that <u>received referrals</u> to the following agencies.*

d. ***Number of families referred to Indian Health Services (IHS)/Indian Tribal Urban (ITU)____**
e. ***Number of families referred to free or low cost care service providers____**
f. ***Number of families referred to AHCCCS or DES to receive health coverage_____**

Community Based Referrals

IV. *Please indicate for clients that you serve the numbers that received community based referrals to following services.*

Number of clients referred to:						
	Home visiting services	Services to promote health such as smoking cessation, drug or alcohol treatment	Family planning services	Nutrition services (e.g. WIC)	Mental Health Services	Other referrals provided (Please specify)- medium text field to specify other referrals
Expectant Mothers						
Expectant Teens						
Post-partum women						

Frequently Asked Questions

Frequently Asked Questions present answers to common reporting, evaluation, policy, and performance questions.

For **Prenatal Outreach,** the frequently asked questions are:

In development

Frequently Asked Questions

Frequently Asked Questions present answers to common reporting, evaluation, policy, and performance questions.

For **Prenatal Outreach,** the frequently asked questions are:

In development

GOAL AREA: HEALTH

STRATEGY NAME: INJURY PREVENTION

GOAL:

- **FTF will coordinate and integrate with existing education and information systems to expand families' access to high quality, diverse and relevant information and resources to support their child's optimal development.**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Expand or enhance community based injury prevention and education efforts aimed at parents and providers caring for young children in a variety of community based settings. Programs should have, at a minimum an educational component. Safety equipment may also be provided.	Several national and local programs are evidence based. Generally speaking programs are delivered by individual topic area. Sixty-six percent of preventable child deaths in Arizona in 2003 were due to unintentional injury (accidents), according to the Child Fatality Review Board. Between 2004 and 2007, there were about 184,000 nonfatal unintentional injuries resulting in visits to emergency departments or inpatient hospitalizations among children birth to 5 years old. One in five of the child passengers who died in motor vehicle accidents in 2003 were using a restraint and almost half were sitting in the right front passenger seat. Over 10 percent of Arizona's children ride unrestrained and more than 80 percent of child safety seats are installed, placed, or	Costs will vary due to the service delivery model and curriculum being used. Provision of safety equipment (smoke detectors, car seats etc.) should be accompanied by clear instruction for parents on its use. Staff time (salary, ERE, teaching time), outreach, materials, giveaways should factor into cost estimates. Injury prevention outreach may include but is not limited to: Motor vehicle crashes, drowning, suffocation/choking, fire/burn injury, firearm injury, poisoning, sudden infant death syndrome, home accidents/home safety.	• Program costs range from $30 to $277 per client • A reasonable estimate to fund a comprehensive home safety project described above would be $150 – 250 per family • Child car seats: $60 per item • Smoke Detectors: $50 • Child Gates: $30 • Cribs for Kids: $100/infant • Printing of educational materials • Staff time

	used incorrectly. In 2003, the Arizona Child Fatality Review Board identified that 25 children (most between 1 and 4 years of age) died of preventable drowning accidents. While children age 1-4 make up only 6 percent of the population in Arizona, they accounted for 15 percent of hospitalizations and 17 percent of emergency department visits due to fire/burn-related injuries in 2003. In 2006, there were 90 unexpected infant deaths in Arizona, which accounted for eight percent of all child deaths, 23 caused by suffocation and 28 deaths were identified as SIDS In 90 percent of unexpected infant deaths, unsafe sleeping environment was identified as a contributing preventable factor, and unsafe sleeping position was a factor in 50 percent of unexpected infant deaths.		

Policy Specialist – Kelley Murphy

CDC National Center for Injury Prevention **CDC Gov, Injury**

FIRST THINGS FIRST
Community Health Education
Standards of Practice - Final

A great deal of public health research indicates that Arizona's children are not as healthy as they could be. Increased rates of obesity, diabetes, and asthma; paired with poor nutrition, a sedentary lifestyle, and a variety of economic and social factors are all contributing to a poor environment of physical, mental, and oral health for many children. Even more alarming is recent news published in the New England Journal of Medicine that life expectancy for children born today may actually be less than that of their parents. Though we have made significant progress in addressing health issues that affect children through immunization and other public health interventions, many problems remain. The unique geography and population of the state complicate addressing these health concerns.

Health educators work with individuals and communities to provide information and education on how to improve health and health outcomes. They "work to encourage healthy lifestyles and wellness through educating individuals and communities about behaviors that can prevent diseases, injuries, and other health problems" (U.S. Department of Labor, December 2009). There are many health education programs, on a variety of topics, designed to provide individuals and communities with the information they need to improve their health status.

In order to leverage resources and educational efforts, community health education efforts may be integrated into other public health and health programming. For example, community health education can be addressed through other early childhood programs and services, such as home visitation, parenting education or by child care providers.

First Things First Regional Partnership Councils have identified a number of health needs and disparities specific to their individual regions. To address some of these needs, they have chosen to fund community based health education programs in multiple settings. Any grantee implementing community health education on any topic must meet the following requirements:

QUALIFICATIONS FOR A COMMUNITY HEALTH EDUCATOR INCLUDE:

Minimum of a Bachelors Degree in Health Education, or another allied health profession.

Completion of training in the specific curriculum/materials being used.

Excellent communications skills and the ability to adjust to the individual learners' needs.

Have knowledge and skills in:

- Assessing individual and community needs for health education.
- Planning, implementing and administering health education strategies, interventions and programs.

- Serving as a health education resource person.
- Communicating and advocating for health and health education

PROGRAMS IMPLEMENTING COMMUNITY HEALTH EDUCATION WILL:

Address a documented health need within the target population of children birth through age five.

Choose or develop curriculum based on recognized educational principles.

Assure that the content/format of activities and materials will promote improvements in health not specific proprietary business interests of a commercial interest.

Build upon, enhance and coordinate with existing community based health education efforts in the region.

To the extent possible, work in partnership with other early childhood initiatives that provide services to the same target population.

Hire staff who reflect the cultural and ethnic experiences and language of the families with whom they work.

Hire staff with the appropriate qualifications to deliver the specific services in the scope of work.

Assure that staff receive specific training to carry out community based health education activities.

Provide ongoing staff development on diversity issues.

Establish an effective, consistent supervisory system that provides support for all staff members and ensures accountability to participants, funders and the community.

Assure that evaluation and monitoring is a collaborative, ongoing process that includes feedback from staff, families and community members.

Assure that the content/format of activities and materials will promote improvements in health not specific proprietary business interests of a commercial interest.

Develop a post training evaluation for participant feedback if providing a series of sessions.

Programs implementing best practice models for community health education must adhere to the standards of the model, unless permission to deviate from the model has been obtained from the appropriate source.

Recognize that certain populations have health disparities due to cultural, linguistic, geographic and socioeconomic factors, and tailor interventions/curriculum and programs to address various populations.

Collaborate with existing community resources to reinforce health education messages.

Maintain confidentiality of all information obtained as part of the community based health education program.

In the United States, Native American Tribes are considered autonomous nations with all of the rights and responsibilities of a nation. Understanding this, Native American Tribes are charged with protecting the health and safety of their people. To this end, Tribes have full ownership over any data collected within their reservation boundaries. This means that Tribes can allow or not allow any program to collect health data on the reservation.

Any grantee implementing programs in tribal communities must have official tribal permission to collect and utilize sensitive health data. Such data can include but not be limited to:

- Morbidity and mortality among members of their communities
- Information regarding child safety and welfare
- Information regarding children in foster care
- Infectious and chronic disease information among members of their communities
- BMI and healthy weight information

"To address cultural competency objectives, early childhood practitioners /early childhood service providers shall ensure that children and families receive from all staff members effective, understandable, and respectful care that is provided in a culturally competent manner- a manner compatible with their cultural beliefs and practices and preferred language. Early childhood practitioners /early childhood service providers should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. Early childhood practitioners/early childhood service providers should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and family-centered involvement to ensure that services are delivered in a manner that is consistent with the National Standards on Culturally and Linguistically Appropriate Services and/or the National Recommendations on Cultural and Linguistic Competence for the National Association for the Education of Young Children."
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 ;
http://www.naeyc.org/positionstatements/linguistic

COMMUNITY HEALTH EDUCATORS WILL:

Develop a written program plan that includes:

- Program goals, intended audience
- Measurable objectives
- Appropriate activities to meet objectives, including timelines and responsibilities for implementation
- Description of resources necessary to conduct the program
- Comprehensive evaluation plan to measure the impact of a program, make future improvements and make decision about similar future programs

Communicate the purpose and objectives of the activity to the learner before 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.

Implement the health education program based on activities and timelines developed in the written program plan.

Utilize a variety of skills in delivering strategies, interventions and programs including effective use of instructional technology.

Incorporate demographically and culturally sensitive techniques when promoting programs.

Assess the effectiveness of the program plan and make appropriate modifications.

Maintain confidentiality of all health information obtained as part of the community based health education program.

References:

National Commission for Health Education Credentialing (NCHEC), Responsibilities and Competencies of Health Educators. 2008. Available at http://www.nchec.org/credentialing

California Conference on Local Directors of Health Education (CCLDHE), Standards of Practice for Public Health Education in California Local Health Departments. October, 2008. Available at www.ccldhe.org

United States Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, 2010-2011 edition. December, 2009. Available online at www.bls.gov/oco/ocos063.htm

Injury Prevention

First Things First reporting requirements and progress monitoring are aligned with First Things First Goals, Key Measures, and Standards of Practice. The purpose of First Things First data submission and monitoring is to determine the extent to which each program has accomplished the stated goals, key measures, targeted service number, and activities outlined in the standards of practice.

Grantees will be provided with data reporting requirements by First Things First. There are five main components to data reporting:

- Unit of Service
- Performance Measures
- Data Reporting Template
- Data Reporting Instruction
- Frequently Asked Questions

The data reporting template captures the set of data the grantee submits on a quarterly basis; the instructions support that data submission. Units of Service and performance measures outline how the quarterly data submissions will be evaluated according to the contracted deliverables and standards of practice for that contract. Frequently asked questions present answers to common reporting, evaluation, policy, and performance questions.

Definitions:

Unit of Service and related Target Service Number

A Unit of Service is a FTF designated indicator of performance specific to each FTF strategy. It is composed of a unit of measure and a number (Target Service Number).

A Unit of Measure/Service can be a target population and/or a service/product that a grantee is expected to serve as part of an agreement. Target Service Number represents the number of units (e.g. target population) proposed to be served or number of products/services proposed to be delivered during the contract year.

For example, for the FTF strategy Home Visitation the FTF Unit of Service is “number of families served” and a Target Service Number of 50 represents the number of families the program proposes to serve during the contract period. All FTF applicants must clearly state in the proposal a target service number for each strategy specific Unit of Service.

For **Injury Prevention,** the units of service are:

Total number of adults attending injury prevention training sessions

Performance Measures

Performance Measures measure (1) key indicators of performance (i.e. Unit of Service); (2) basic implementation of strategy; (3) alignment of program activities to strategy specific standards of practice, (4) performance or progress toward pre-established strategic goals. Performance measures may include the level or type of program activities conducted (e.g. serving families/children through home visits) and/or the direct services and products delivered by a program (e.g., providing scholarships).

For **Injury Prevention,** performance measures are:

Total number of children attending injury prevention training sessions / proposed service number
Total number of adults attending injury prevention training sessions / proposed service number
Total number of injury prevention training sessions conducted/proposed service number
Total number of injury prevention materials distributed/proposed service number
Total number of injury prevention information sessions conducted/proposed service number
Total number of people reached by information sessions/proposed service number

Data Reporting Templates

Data reporting templates are the tools utilized to gather data to assess grantee Performance Measures. All FTF grantees submit data on a quarterly basis through designated data reporting templates.

For **Injury Prevention,** the data reporting template is:

FIRST THINGS FIRST
The right system for bright futures

pgms partner grant management system

Evaluation Report

CONTRACT DATES
7/1/2010
TO
7/31/2010

TEST PRODUCTION AGENCY (APPS)

Address: Parter Address Agency Details
Test City, AZ 85032

Contract ID: GRA-STATE-10-0218-01

View Reporting Instructions and FAQ

INJURY PREVENTION

GENERAL INFORMATION

User Completing Report AZFTF\mshahi

Reporting Period Month 7 Year 2010

Regional Partnership Council State

Status In Progress

Date Completed

Public Awareness Activity

Are you conducting any public awareness activities as part of your program? ○ Yes ○ No

If yes, please select from the list which activities you conduct as part of your program. Select as many as needed, and report the number of people reached through the specific activities. Refer to the instructions for a definition of each activity type. Please skip any activity that does not pertain to your program.
If none, please enter zero

Activity	Number of People Reached
Media impressions	
Provision of written materials	
Group meetings	
One to one interactions	

Educational Presentation

Please fill out the following sections based on whether your program provided Information Session and/or Intensive Training during this reporting period. Please refer to the instructions for definitions.

Information Sessions Provided ○ Yes ○ No

Name	Topic	Venue	Date	City

Intensive Training Provided ◯ Yes ◯ No

Name	Topic	Venue	Date	City	Adults Attending this Session	Children (0-5yr) Attending this Session		

Distribution of Materials

Please select from the list the materials you distribute as part of your program. After a material is selected, please report the number distributed. You can select as many materials as needed.

Distribution of Materials Provided ◯ Yes ◯ No

Material	Number Distributed		

Data Reporting Instructions

Data reporting instructions support data submission through the data reporting template.

For **Injury Prevention,** the data reporting instructions are:

INFORMATION

Your data report is always due on the 20th day of the month following the end of each quarter. Each quarterly submission will include information for the entire quarter broken out by month. Each data report submitted will include information for the entire preceding quarter.

1st Quarter – July-September – Report due October 20
2nd Quarter – October-December – Report due January 20
3rd Quarter – January-March – Report due April 20
4th Quarter – April- June – Report due July 20

- Data should be only reported for services funded by First Things First.
- Data should be reported for each Regional Partnership Council area in which contracted services are provided. For example, if program is contracted to provide services in both Central Maricopa and Northeast Maricopa regions, two separate reports must be submitted.

OVERVIEW

- For each reporting period, enter all data for all Regional Partnership Council areas served into the First Things First web-based evaluation report. Your "Evaluation Report" screen will automatically show you how many reports to submit.
- For each quarter, **data should be tallied for each month of service.**
- Your final data submission for the quarter cannot be completed until you complete all monthly reports.
- When you have completed your data entry (or want to save and return at a later time) click "Save Changes" in the data system.
- If you make an error, and want to change a piece of information, don't forget to click "Save Changes" for your correction to be saved.
- **Do not forget to change the status of your report from 'in progress' to 'completed'. A COMPLETED status notifies FTF that your data report is ready for review.**

DIRECTIONS FOR DATA ENTRY

Public Awareness Activity

*** Are you conducting any public awareness activities as part of your program?** In this data field you will choose either Yes or No.

If **YES:** Please select from the list the activities you conduct as part of your program. You can select as many activities as needed. After an activity type is selected, please report the number of people reached through the specific activity. You may skip any activity that does not pertain to your program.

a. Media impression is defined as the number of people reached with media campaigns.
b. Provision of written materials is defined as the number of people receiving pamphlets, etc.
c. Group meetings.
d. One to One interactions.

Educational Presentation

*Please fill out the following sections based on whether your program provided **Information Session provided** and/or **Intensive Training provided** during this reporting period*

- ***Information Session*** is defined as an outreach at health fairs, brief conversations, etc.
- ***Intensive Training*** is defined as a curriculum based program or formal trainings.

To begin data entry click "Add Information Session" or "Add Training Session," this will bring up the data entry page.
***Any data field with an asterisk mark is required, you cannot skip it.**

Information Sessions data fields

1. ***Name:** In this data field you will enter the name of the session.
2. ***Topic:** This data field has multiple choice fields for a session topic. You can choose more than one topic. If none of the topics applies to the information session you are conducting, please choose "**Other (please specify)" box** and enter (type in) the Topic of your session in the text box provided under the Other (Please Specify)" option. **Note:** all text boxes allow up to 500 characters.
3. ***Description:** In this text field you will enter a brief description about the training session. Example: For the **Name of Information Session**: 'How to install a car seat correctly', the **Description** could be- 'How to install a car seat correctly in a vehicle'.
4. ***Venue:** This data field is a drop down menu. You can choose either one of the **listed** options or the '**other (please specify)**' option. If you choose "**Other (please specify)"-** then you need to enter the venue at which your session took place in the text box provided under the Other (Please Specify)" option.
5. ***Number Attending Information Session:** In this data field you will enter the number of people that received information.
6. ***Date:** For this data field you will report the date your session took place. You can either enter a date directly into the data field or chose a date from the calendar (icon is next to the box).
7. ***City:** In this data field you will enter the **City** name at which the session took place. Example: City – Phoenix.

8. ***Zip:** In this data field is a drop down menu of zip codes for the funded RPC. You can choose only one zip code.
9. ***Target Audience:** This data field is a drop down menu. You can choose either one of the **listed** options or the '**other (please specify)**' option. If you choose "**Other (please specify)"-** then you need to enter the target audience of your session in the text box provided under the Other (Please Specify)" option. Example: Children 0-5.

Intensive Training data fields

10. ***Name:** In this data field you will enter the name of the session.
11. ***Topic:** This data field has multiple choice fields for a session topic. You can choose more than one topic. If none of the topics applies to the training session you are conducting, please choose "**Other (please specify)"** box and enter (type in) the topic of your session in the text box provided under the Other (Please Specify)" option.
12. ***Description:** In this text field you will enter a brief description about the training session. Example: For the **Name of Training Session**: 'Exercising for a healthier life', the **Description** could be- 'How to incorporate a healthy diet and exercise into your life'.
13. ***Venue:** This data field is a drop down menu. You can choose either one of the **listed** options or the '**other (please specify)**' option. If you choose "**Other (please specify)"-** then you need to enter the venue at which your session took place in the text box provided under the Other (Please Specify)" option. Example: Community center.
14. ***Date:** For this data field you will report the date your session took place. You can either enter a date directly into the data field or chose a date from the calendar (icon is next to the box).
15. ***City:** In this data field you will enter the **City** name at which the session took place. Example: City – Phoenix.
16. ***Zip:** This data field is a drop down menu of zip codes for the funded RPC. You can choose only one zip code.
17. ***Target Audience:** This data field is a drop down menu. You can choose either one of the **listed** options or the '**other (please specify)**' option. If you choose "**Other (please specify)"-** then you need to enter the target audience of your session in the text box provided under the Other (Please Specify)" option. Example: Teen mothers.
18. ***Number of Trainers:** In this data field you will enter the number of trainers who offered training in this specific session.
19. ***Qualification of Trainers:** This data field is a text box. You will enter the range of qualifications your trainers had. Example: Bachelors Degree, Masters Degree, CDA, Community Leader or Parent.
20. *** Session Format:** This data field is a drop down menu. You can choose either **'Individual'** or **'Small'** or '**Other**' option. If you choose "**Other (please specify)"-** then you need to enter the format of your session in the text box provided under the Other (Please Specify)" option.

21. ***Session Duration:** This data field is a drop down menu. You can choose only one choice that best applies for your session. The choices are: less than an hour, 1 hour, 2 hours, 3 hours, or more than 3 hours.
22. ***Adults Enrolled in this session:** In this data field you will enter the total number of adults (Example: Parents/caregivers) who enrolled into this session
23. ***Adults Attending this Session:** In this data field you will enter the total number of adults who attended the session. (Example: 15 enrolled but only 10 attended the session, then the number 10 will be entered here.)
24. ***Children Enrolled in this Session:** In this data field you will enter the total number of children (0-5) who enrolled in this session.
25. ***Children Attending this session:** In this data field you will enter the total number of children (0-5) who attended the session. (Example: 10 children were enrolled but only 5 attended the session, then the number 5 will be entered here.)

Distribution of Materials

26. ***Did participants receive any materials as part of the training:** In this data field you will choose either **Yes or No.**

If **YES:** *Please select from the list the materials you distributed as part of your program. You can select as many materials as needed. After a material is selected, please report the number distributed.*

a. Child car seats____
b. Smoke detector or fire safety equipment ____
c. Home safety equipment____
d. Cribs or mattresses____
e. Gun locks____
f. Pool barriers____
g. Other (please specify): _____

Frequently Asked Questions

Frequently Asked Questions present answers to common reporting, evaluation, policy, and performance questions.

For **Injury Prevention,** the frequently asked questions are:

In development

GOAL AREA: HEALTH

STRATEGY NAME ORAL HEALTH

GOAL:

- **Collaborate with exisiting early childhood systems to improve childrens' access to quality health care**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
This strategy Increases children's access to preventative dental care. Methodologies may include: **Public Health Insurance Enrollment** Provide health insurance enrollment assistance, educate that dental care is a covered benefit, stress the importance of early oral health care and share expectations of a dental visit. **Data Collection and Recruitment** Work with Arizona Department of Health Services Bureau of Health Systems Development to ascertain Health Professions Shortage Area (HPSA) status. Work with (HSD) toward placement of a dentist through the federal loan forgiveness program or with the National Health Service for placement of a Dentist **Professional Development for Dental**		Councils would Identify locations where AHCCCS enrollment could take place and supplement staffing if needed Health plans employ case managers to assist clients in obtaining needed dental care. The Office of Oral Health (OOH) is currently convening workgroups throughout the state to develop regional strategic plans based on HPSA designations. Work with these groups and utilize the knowledge of the members to determine the best strategy for the region OOH has a media campaign on the importance	Cost varies depending on number of children to be covered, amount per visit and how many components of the program are adopted. See Health Insurance and Outreach strategy page.

Professionals on management techniques for very young children, application of fluoride varnish and how to educate parents. First dental visit by age one is recommended by the American Dental Association and many other professional organizations. Site to hold continuing education varies with community, with some occurring in provider offices		of the first dental visit by age one targeting dentists and physicians (mailing) and messages print ready for newspapers. All have been approved by ADHS, Arizona Academy of Pediatrics and the Arizona Dental Association. There are other examples of dental health professional training models.	Cost may include: Presenter fees $40.00 - $50.00 per hour; print materials; staff time; and training site costs
Train Medical Professionals to screen for urgent dental needs, apply fluoride varnish, make appropriate dental referrals and educate parents. Education may occur in medical provider offices.		Dental professionals to conduct training must be available. Many online courses are available to dental and medical professionals on early childhood oral health including one developed by the Office of Oral Health. OOH could train key dental professional in regions to be regional trainers, and in-person CEs could be delivered in regions.	Presenter fees $40.00 - $50.00 per hour; print materials; staff time
Fluoride Varnish Application, when properly applied to young, high-risk children, is a proven intervention to reduce the incidence of dental caries (tooth decay). Determination of high-risk for a population is low-income; for an individual child it is determined by a dental risk assessment	Evidence Based	Hygienists employed by a public health agency and hygienists who have an Affiliated Practice Agreement with a dentist can apply fluoride varnish without prior exam by a dentist. Medical providers can choose to apply fluoride varnish; training is available through Office of Oral Health or online. AHCCCS has approved medical reimbursement for this service pending available funding. However, there are currently no funds for this service. Must be coordination with local dental health providers to serve as resources for referral, follow-up and treatment. Consider whether there is an adequate dential workforce in the	Usual fees for hygienist $35-$45 per hour Supplies: approx. $2.00 / per application Approx. 6-7 children per hour: includes, review of health history and parent consent, screening, recording findings, writing referral and

		region. See Workforce Development strategy page. Application requires coordination and agreements with child care providers and parents to assure compliance with legal requirements and permission to screen and provide preventive services to minor children	application of varnish, Trainer fees are $35-45 per hour
Child, Parent and Provider Educational Programs focus on correct toothbrushing and the importance of healthy eating. Thes programs are typically delivered in preschool and child care centers, though may also occur in home visitation programs. The Office of Oral Health (OOH) has material that has been focus tested and is available in the referenced forms (billboards, radio spots and brochures) in both English and Spanish. There are a variety of curricula and programs available. Train-the trainer materials for child care providers have been developed by OOH, and materials for participants are available at no cost to regions.	Evidence Based Carbohydrates are needed for the tooth decay process. Diets high in sugar or with a frequent intake of foods high in sugar are a risk factor.	Sustainability may be an issue if the strategy is not embedded. Frequent training and education in early care and education settings due to turnover among staff. Community Based Education will vary geographically depending upon fluoridated water supply, resources In the community, number of providers available etc.	Toothbrushes cost about $3.00 per child with bulk purchase for 3 toothbrushes through the year Tooth paste cost

Policy Specialist – Kelley Murphy

FIRST THINGS FIRST
Oral Health Care for Children Ages 0-5
Standards of Practice - Final

The American Academy of Pediatric Dentistry recognizes that caries is a common, complex, chronic disease resulting from an imbalance of multiple risk factors and protective factors over time. To decrease the risk of developing caries, a potentially devastating infectious disease, the AAPD encourages professional and at-home preventive measures including age-appropriate feeding practices that do not contribute to a child's caries risk.

According to the Centers for Disease Control, one in five children aged 2-5 years have untreated dental caries That number jumps to 33.5% in children aged 2-11 years who are living at less than 100% of the Federal Poverty Level. There are other risk factors that increase the likelihood of dental caries in children such as limited access to routine oral healthcare, poor oral hygiene, increased consumption of certain foods and sugar sweetened beverages and some medical conditions.

To prevent dental caries among young children, the AAPD recommends several strategies including but not limited to: parent information on oral health care, first dental visit by age one, fluoridated public water supplies and topical fluoride application. First Things First Regional Partnership Councils will fund a variety of oral health strategies to improve the oral health status of children birth through five.

ALL PROGRAMS IMPLEMENTING ORAL HEALTH STRATEGIES WILL:

Hire staff who reflect the cultural and ethnic experiences and language of the families with whom they work.

Hire staff with the appropriate qualifications to deliver the specific services in the scope of work.

Assure that staff receive specific training to carry out oral health activities.

Provide ongoing staff development on diversity issues.

Maintain confidentiality of all information obtained as part of the oral health program.

Establish an effective, consistent supervisory system that provides support for all staff members and ensures accountability to participants, funders and the community.

Assure that evaluation and monitoring is a collaborative, ongoing process that includes feedback from staff, families and community members.

"To address cultural competency objectives, early childhood practitioners /early childhood service providers shall ensure that children and families receive from all staff members' effective, understandable, and respectful care that is provided in a culturally competent manner- a manner compatible with their cultural beliefs and practices and preferred language. Early childhood practitioners /early childhood service providers should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service

delivery. Early childhood practitioners/early childhood service providers should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and family-centered involvement to ensure that services are delivered in a manner that is consistent with the National Standards on Culturally and Linguistically Appropriate Services and/or the National Recommendations on Cultural and Linguistic Competence for the National Association for the Education of Young Children."
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 ;
http://www.naeyc.org/positionstatements/linguistic

The following sections apply to specific strategy types.

PARENT EDUCATION

Qualifications for parent education

Health professionals with appropriate and relevant training and experience can provide parent education regarding the oral health of children ages birth through five.

Have excellent communication skills.

Have a comprehensive understanding of community, social and governmental resources available to support the oral health care of families.

Programs implementing a parent education component in an oral health strategy will:

Provide information on the following topics:

- The importance of dental treatment for pregnant and postpartum women. Reducing the mother's/primary caregiver's/sibling(s).
- Minimizing saliva-sharing activities (e.g., sharing utensils) between an infant or toddler and his family/cohorts.
- Implementing oral hygiene measures no later than the time of eruption of the first primary tooth.
- The importance of cleaning a young child's teeth if an infant falls asleep while feeding.
- The importance of tooth brushing of children twice daily with fluoridated toothpaste and a soft, age-appropriate sized toothbrush. Parents should use a 'smear' of toothpaste to brush the teeth of a child less than 2 years of age. For the 2-5 year old, parents should dispense a 'pea-size' amount of toothpaste and perform or assist with their child's tooth brushing.
- The importance of initiating flossing when adjacent tooth surfaces cannot be cleansed by a toothbrush.
- The need to establish a dental home within 6 months of eruption of the first tooth and no later than 12 months of age
- The importance of 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).

- At-pleasure breast-feeding should be avoided after the first primary tooth begins to erupt and other dietary carbohydrates are introduced.
- 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.

FLOURIDE VARNISH/ORAL HEALTH EXAM

Qualifications for applying fluoride varnish:

- Health professional including: dentist, dental hygienist, physician and physician assistants.
- Have appropriate experience in working with young children.
- Have completed training on the appropriate process to apply fluoride varnish.

Programs applying fluoride varnish or completing oral health screening will:

- Obtain appropriate consent from the parent or guardian.
- Maintain client confidentiality.
- Make every attempt to apply varnish 2-4 times per year on each participating child.
- Provide services within a variety of public health settings such as, immunization clinics, physician offices, WIC offices, Head Start, Early Head Start, schools, child care facilities and in private homes for medically compromised patients.
- Complete a brief exam of the child noting any potential problems.
- Complete a dental caries risk assessment.
- Apply fluoride varnish.
- Provide instructions on follow up care.
- Provide any necessary referrals.

Sources:

"Policy on Early Childhood Caries (ECC): Classifications, Consequences, and Preventive Strategies." American Academy of Pediatric Dentistry and the American Academy of Pediatrics. Revised 2008.

AAPHD Resolution on Fluoride Varnish for caries prevention, January 2008. American Academy of Public Health Dentistry (AAPHD).

Frequently Asked Questions (FAQ's) on Oral Health

Data Submission Requirement

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1. **When are reports due to First Things First?**
   - All evaluation data reports (Financial forms for reimbursement can be submitted at any time) are due on the 20th of the month following the preceding month for example, May 1- May 30 data report due on June 22, 2009. Also, if the due date falls on a non-work day, then the following work day will become the due date. For example June 20th, 2009 falls on a Saturday, then the actual due date for data would be June 22, 2009.
   - **NOTE:** Starting on July 1, 2009, all data collected will be reported quarterly.

     1st Quarter – July-September – Report due October 20
     2nd Quarter – October-December – Report due January 20
     3rd Quarter – January-March – Report due April 20
     4th Quarter – April- June – Report due July 20

2. **If my organization has more than one Regional Partnership Council, how many reports do I submit?**
   - Reports are to be completed for each Regional Partnership Council area in which services are provided. For example, if a program is contracted to provide services in both Central Maricopa and Northeast Maricopa regions, two separate reports must be submitted.

3. **Where is data submitted? And who do I initially contact for questions?**
   - Data is submitted online (AZFTF's extranet) at www. azftf.gov

     Contact: your grant specialist
     Finance Division
     First Things First (FTF)
     4000 N. Central Ave., Suite 800
     Phoenix, AZ 85012
     (602) 771-5100

4. **How do you define underinsured?**
   - An individual is considered underinsured if the individual has health insurance coverage that does not pay the entire cost for care AND the incurring of the additional health care expense(s) will be a burden on the consumer to the extent that the individual has to choose between paying for care or paying for other necessities.

5. **I am offering Oral Health Services/Programs in region X, but I am serving participants from regions X, Y and Z. Do I report data for only region X or for all regions? Should I report of the home zip codes of service recipients?**
   - Please report Oral Health Services/Programs on the region in which the service/program are conducted. If a notable number of participants are from another region, please make note of that in your narrative report. You are not required to report the home zip code of service recipients, report only on the location where the Oral Health Service/Program is provided.

Oral Health

First Things First reporting requirements and progress monitoring are aligned with First Things First Goals, Key Measures, and Standards of Practice. The purpose of First Things First data submission and monitoring is to determine the extent to which each program has accomplished the stated goals, key measures, targeted service number, and activities outlined in the standards of practice.

Grantees will be provided with data reporting requirements by First Things First. There are five main components to data reporting:

- Unit of Service
- Performance Measures
- Data Reporting Template
- Data Reporting Instruction
- Frequently Asked Questions

The data reporting template captures the set of data the grantee submits on a quarterly basis; the instructions support that data submission. Units of Service and performance measures outline how the quarterly data submissions will be evaluated according to the contracted deliverables and standards of practice for that contract. Frequently asked questions present answers to common reporting, evaluation, policy, and performance questions.

Definitions:

Unit of Service and related Target Service Number

A Unit of Service is a FTF designated indicator of performance specific to each FTF strategy. It is composed of a unit of measure and a number (Target Service Number).

A Unit of Measure/Service can be a target population and/or a service/product that a grantee is expected to serve as part of an agreement. Target Service Number represents the number of units (e.g. target population) proposed to be served or number of products/services proposed to be delivered during the contract year.

For example, for the FTF strategy Home Visitation the FTF Unit of Service is “number of families served” and a Target Service Number of 50 represents the number of families the program proposes to serve during the contract period. All FTF applicants must clearly state in the proposal a target service number for each strategy specific Unit of Service.

For **Oral Health,** the units of service are:

Total number of participants receiving oral health screenings
Total number of adults participating in oral health trainings
Total number of oral or other health professionals participating in trainings/proposed service number

Total number of fluoride varnishes applied

Performance Measures

Performance Measures measure (1) key indicators of performance (i.e. Unit of Service); (2) basic implementation of strategy; (3) alignment of program activities to strategy specific standards of practice, (4) performance or progress toward pre-established strategic goals. Performance measures may include the level or type of program activities conducted (e.g. serving families/children through home visits) and/or the direct services and products delivered by a program (e.g., providing scholarships).

For **Oral Health,** performance measures are:

Total number of participants receiving oral health screenings/proposed service number
Total number of oral health kits distributed/proposed service number
Total number of adults participating in oral health trainings/proposed service number
Total number of children participating in oral health trainings/proposed service number
Total number of oral or other health professionals participating in trainings/proposed service number
Total number of child care providers participating in oral health trainings/proposed service number
Total number of fluoride varnishes applied/proposed service number
Total number of complete fluoride varnishes series applied/proposed service number
Total number of oral health information sessions offered/proposed service number
Total number of people reached by information sessions/proposed service number
Total number of families receiving referrals for health insurance or health coverage enrollment/ target service number
Total number of families receiving referrals for treatment/ target service number

Data Reporting Templates

Data reporting templates are the tools utilized to gather data to assess grantee Performance Measures. All FTF grantees submit data on a quarterly basis through designated data reporting templates.

For **Oral Health,** the data reporting template is:

FIRST THINGS FIRST
The right system for bright futures

pgms partner grant management system

Evaluation Report

CONTRACT DATES
4/10/2009
TO
7/9/2010

First Things First Sample for Production
Address:
Contract ID: IGA-MULTI-12-0005-01

View Reporting Instructions and FAQ

General Information

User Completing Report AZFTF\zeval

Reporting Period

Month	Year
4	2009

Regional Partnership Council Cochise

Status In Progress

Date Completed

Service Delivery

Are you providing any of the following services as part of your program?* ○ Yes ○ No

From the list of activities below, please report the number of people reached through the specific activity delivered as part of your program. Please refer to the instructions for a definition of each activity type. Please skip any activity that does not pertain to your program. You can report information for as many activities as needed.

Service Delivery	Number of People Reached
Oral Health Screening	0
Expectant Mothers	
Children 0-12 Months	
Children 13-24 Months	
Children 25-36 Months	

Children 37-48 Months	
Children 49-60 Months	
Children 61-72 Months	
Flouride Varnish Application	0
Children 0-12 Months	
Children 13-24 Months	
Children 25-36 Months	
Children 37-48 Months	
Children 49-60 Months	
Children 61-72 Months	
Oral Health Kits	0
Expectant Mothers	
Children 0-12 Months	
Children 13-24 Months	
Children 25-36 Months	
Children 37-48 Months	
Children 49-60 Months	
Children 61-72 Months	

Public Awareness Activity

Are you conducting any public awareness activities as part of your program?* ○ Yes ○ No

If yes, please select from the list below the activities you conduct as part of your program. You can select as

Activity	Number of People Reached
Media impressions	

many activities as needed. After an activity type is selected, please report the number of people reached through the specific activity. Please refer to the instructions for a definition of each activity type. Please skip any activity that does not pertain to your program.

Provision of written materials	
Group meetings	
One to one interactions	

Educational Presentation

Please fill out the following sections based on whether your program provided Information Session and/or Intensive Training during this reporting period. Please refer to the instructions for definitions.

Did you provide any Information Sessions this reporting period?

◯ Yes ◯ No

Name	Topic	Venue	Date	City	Number Receiving Info		

Did you provide any Intensive Training Sessions this reporting period?

◯ Yes ◯ No

Name	Topic	Venue	Date	City		

Referrals to Treatment Providers and Services Received

Please indicate for families (expectant mothers and children) that you serve the numbers receiving referrals to the following types of treatment providers and those receiving services. If none, please enter zero.

Type of Treatment Provider	Expectant Mothers Referred	Expectant Mothers Reporting Receiving Services	Children (0-5yrs) Referred	Children (0-5yrs) Reporting Receiving Services		
Dentist					Edit	
Pediatrician					Edit	
Community Health Center (CHC)					Edit	
Indian Health Services (IHS) / Indian Tribal Urban (ITU)					Edit	

Health Insurance Enrollment Assistance

Please indicate for families that you serve the numbers that are uninsured or underinsured and those who received enrollment assistance to obtain insurance. If none, please enter zero.

Number of Families Served Who Are Not Covered by Private Insurance, AHCCCS, Indian Health Services or Kids Care*	
Number of Families Served Who Report They Are Underinsured*	
Number of Families Served Who Report Lack of Insurance or Underinsurance Who Received Enrollment Assistance to Obtain Insurance*	

Referrals to Health Care and Low Cost Care Providers

Please indicate for families that you serve the numbers that received referrals to the following agencies. If none, please enter zero.

Number of Families referred to Indian Health Services (IHS)/Indian Tribal Union (ITU)*	
Number of Families referred to free or low cost care service providers*	
Number of Families referred to AHCCCS or DES to receive health coverage*	

Data Reporting Instructions

Data reporting instructions support data submission through the data reporting template.

For **Oral Health,** the data reporting instructions are:

INFORMATION

Your data report is always due on the 20th day of the month following the end of each quarter. Each quarterly submission will include information for the entire quarter broken out by month. Each data report submitted will include information for the entire preceding quarter.

1st Quarter – July-September – Report due October 20
2nd Quarter – October-December – Report due January 20
3rd Quarter – January-March – Report due April 20
4th Quarter – April- June – Report due July 20

- Data should be only reported for services funded by First Things First.
- Data should be reported for each Regional Partnership Council area in which contracted services are provided.
- Each Regional Partnership Council area receiving services should receive a data report. For example, if your community based training program is contracted to provide services in both Central Maricopa and Northeast Maricopa regions, two separate reports must be submitted.

OVERVIEW

- To access and enter your data electronically, refer to "User Guide for Extranet Registration".
- For assistance in entering your data electronically, refer to "User Guide for Data Entry: Data Reporting Form" and "Instructions for Data Entry".
- For each reporting period, enter all data for all Regional Partnership Council areas served into the First Things First web-based evaluation report. Your "Evaluation Report" screen will automatically show you how many reports to submit.
- For each quarter, **data should be tallied for each month of service.**
- Your final data submission for the quarter cannot be completed until you complete all monthly reports.
- When you have completed your data entry (or want to save and return at a later time) click "Save Changes" in the data system.
- If you make an error, and want to change a piece of information, don't forget to click "Save Changes" for your correction to be saved.
- **Do not forget to change the status of your report from 'in progress' to 'completed'. A COMPLETED status notifies FTF that your data report is ready for review.**

DIRECTIONS FOR DATA ENTRY

Service Delivery:

1. **Are you providing any of the following services as part of your program**? In this data field you will choose either **Yes/No**

   If **Yes:** *Please select from the list below the services you deliver as part of your program. You can select as many services as needed. After a service type is selected, please select the target audience for the service and report the number of individuals receiving this service. Please skip any service delivery choices that do not pertain to your program.*

   ☐ Oral Health Screening
   - ☐ Expectant Mothers (Number receiving oral health screening) _____
   - ☐ Children ages 0 thru 5 (Number receiving oral health screening by age groups)
     - ☐ 0 to 12 months___
     - ☐ 13-24 months____
     - ☐ 25-36 months____
     - ☐ 37-48 months____
     - ☐ 49-60 months_____
     - ☐ 61 thru 72 months___

     Total (system calculated)

   ☐ Fluoride Varnish Application
   - ☐ Children ages 0 thru 5 (Number receiving Fluoride Varnish Application by age groups)

     (Breakout children # by age – see above)

   ☐ Oral Health Kit
   - ☐ Expectant Mothers (Number receiving oral health kits)
   - ☐ Children ages 0 thru 5 (Number receiving Oral Health Kit by age groups)

     (Breakout children # by age – see above)

Public Awareness Activity

2. *** Are you conducting any public awareness activities as part of your program?** In this data field you will choose either **Yes or No.**

   If **YES:** Please select from the list the activities you conduct as part of your program. You can select as many activities as needed. After an activity type is selected, please report the number of people reached through the specific activity. You may skip any activity that does not pertain to your program.

   a. Media impression is defined as the number of people reached with media campaigns.
   b. Provision of written materials is defined as the number of people receiving pamphlets, etc.

c. Group meetings.
d. One to One interactions.

Educational Presentation

*Please fill out the following sections based on whether your program provided **Information Session provided** and/or **Intensive Training provided** during this reporting period*

- ***Information Session*** is defined as an outreach at health fairs, brief conversations, etc.
- ***Intensive Training*** is defined as a curriculum based program or formal trainings.

To begin data entry click "Add Information Session" or "Add Training Session," this will bring up the data entry page.
***Any data field with an asterisk mark is required, you cannot skip it.**

Information Sessions data fields

1. ***Did you provide any information sessions this reporting period? YES or NO***
2. ***Name of Information Session:** In this data field you will enter the name of the session.
3. ***Topic of Information Session:** This data field has multiple choice fields for a session topic. You can choose more than one topic. If none of the topics applies to the information session you are conducting, please choose "**Other (please specify)" box** and enter (type in) the Topic of your session in the text box provided under the Other (Please Specify)" option. **Note:** all text boxes allow up to 500 characters.
4. ***Description of Session:** In this text field you will enter a brief description about the training session. Example: For the **Name of Information Session**: 'Training/Educating Families on Oral Health', the **Description** could be- 'The importance of brushing and flossing for children and adults for a lifetime'.
5. ***Session Venue:** This data field is a drop down menu and you can choose only one. You can choose either one of the **listed** options or the '**other (please specify)**' option. If you choose "**Other (please specify)"-** then you need to enter the venue at which your session took place in the text box provided under the Other (Please Specify)" option.
6. ***Number attending Information Session:** In this data field you will enter the number of people that attended the information session.
7. ***Date of Session:** For this data field you will report the date your session took place. You can either enter a date directly into the data field or chose a date from the calendar (icon is next to the box).
8. ***Session Location – City:** In this data field you will enter the **City** name at which the session took place. Example: City – Phoenix.
9. ***Session Location – Zip:** This data field is a drop down menu of zip codes for the funded RPC. You can choose only one zip code.
10. ***Target Audience:** This data field is a drop down menu. You can choose either one or more of the **listed** options or the '**other (please specify)**' option. If you choose "**Other (please specify)"-** then you need to enter the target audience of your session in the text box provided under the Other (Please Specify)" option. Example: Teen mothers.

Intensive Training data fields

11. ***Name of Training Session:** In this data field you will enter the name of the session.
12. ***Topic of Topic Session:** This data field has multiple choice fields for a session topic. You can choose more than one topic. If none of the topics applies to the training session you are conducting, please choose "**Other (please specify)"** box and enter (type in) the topic of your session in the text box provided under the Other (Please Specify)" option.
13. ***Description of Session:** In this text field you will enter a brief description about the training session. Example: For the **Name of Training Session**: 'Need for establishing a dental home', the **Description** could be- 'How important it is for children to have a dental home'.
14. ***Session Venue:** This data field is a drop down menu. You can choose either one of the **listed** options or the '**other (please specify)**' option. If you choose "**Other (please specify)"-** then you need to enter the venue at which your session took place in the text box provided under the Other (Please Specify)" option. Example: Community center.
15. ***Session Date:** For this data field you will report the date your session took place. You can either enter a date directly into the data field or chose a date from the calendar (icon is next to the box).
16. ***Session Location – City:** In this data field you will enter the **City** name at which the session took place. Example: City – Phoenix.
17. ***Session Location – Zip:** This data field is a drop down menu of zip codes for the funded RPC. You can choose only one zip code.
18. ***Target Audience:** This data field is a drop down menu. You can choose either one of the **listed** options or the '**other (please specify)**' option. If you choose "**Other (please specify)"-** then you need to enter the target audience of your session in the text box provided under the Other (Please Specify)" option. Example: Teen mothers.
19. ***Number of Trainers:** In this data field you will enter the number of trainers who offered training in this specific session.
20. ***Qualification of Trainers:** This data field is a text box. You will enter the range of qualifications your trainers had. Example: Dentist, Hygienist, Health Educator or Other.
21. *** Session Format:** This data field is a drop down menu. You can choose either **'Individual'** or **'Small'** or '**Other**' option. If you choose "**Other (please specify)"-** then you need to enter the format of your session in the text box provided under the Other (Please Specify)" option.
22. ***Session Duration:** This data field is a drop down menu. You can choose only one choice that best applies for your session. The choices are: less than an hour, 1 hour, 2 hours, 3 hours, or more than 3 hours.
23. ***Professionals Enrolled:** In this data field you will enter the total number of oral health providers (Example: Dentists/Hygienist) who enrolled into this session
24. ***Professionals Attending:** In this data field you will enter the total number of oral health professional who attended the session. (Example: 15 enrolled but only 10 attended the session, then the number 10 will be entered here.)
25. ***Families Enrolled:** In this data field you will enter the total number of families (Example: Parents/caregivers) who enrolled into this session

26. ***Families Attending:** In this data field you will enter the total number of families who attended the session. (Example: 15 enrolled but only 10 attended the session, then the number 10 will be entered here.)
27. ***Children Enrolled:** In this data field you will enter the total number of children (0-5) who enrolled in this session.
28. ***Children Attending:** In this data field you will enter the total number of children (0-5) who attended the session. (Example: 10 children were enrolled but only 5 attended the session, then the number 5 will be entered here.)

Referrals to Treatment Providers and Services Received

Please indicate for families (expectant mothers and children) that you serve the numbers receiving referrals to the following types of treatment providers and those receiving services.

3. Types of Treatment Providers	*Number of Expectant Mothers referred*	*Number of Expectant Mothers reporting receiving services*	*Number of Children (0 – 5yrs) referred*	*Number of Children (0 – 5yrs) reporting receiving services*
Dentist				
Pediatrician				
Community Health Center (CHC)				
Indian Health Services (IHS)/ Indian Tribal Urban (ITU)				
Other Provider (please specify)- **medium text field**				

Health Insurance Enrollment Assistance

4. ***Number of families served who are not covered by private insurance, AHCCCS, Indian Health Services, or Kids Care:** In this data field, please indicate for the families that you serve the numbers that are not covered by any insurance here.
5. ***Number of families served who report they are underinsured:** In this data field, please indicate for the families that you serve the numbers who are underinsured here.
6. ***Number of families served who report lack of insurance or underinsurance who received enrollment assistance to obtain insurance:** In this data field, please indicate

for the families that you serve the numbers who received enrollment assistance to obtain insurance.

Referrals to Health Care and Low cost Care Providers

7. ***Number of families referred to Indian Health Services (IHS)/Indian Tribal Urban (ITU):** In this data field, please indicate for the families that you serve the numbers that are referred IHS or ITU.
8. ***Number of families referred to free or low cost care service providers:** In this data field, please indicate for the families that you serve the numbers that are referred to free or low cost service providers.
9. ***Number of families referred to AHCCCS or DES to receive health coverage:** In this data field, please indicate for the families that you serve the numbers that are referred to AHCCCS or DES.

Frequently Asked Questions

Frequently Asked Questions present answers to common reporting, evaluation, policy, and performance questions.

For **Oral Health,** the frequently asked questions are:

In development

GOAL AREA: HEALTH

STRATEGY NAME: HEALTH INSURANCE ENROLLMENT

GOAL:

- **Collaborate with existing early childhood heatlh care systems to improve children's access to quality health care**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
This strategy provides provides assistance to families to maintain and expand health insurance coverage. It may occur in a variety of settings; personal contact with parents is often made through physician's offices, schools, faith communities, etc. Specifically, assistance to families may include: • Explaining the options available • Completing and submitting the application. • Completing the reapplication Community based media messages may also be used to improve parents' awareness of public insurance options.	Insured children are more likely to have a usual source of health care for preventive care and when they are ill. Families without health insurance experience high out of pocket cost when their children lack coverage. Lack of health insurance can threaten families' economic security.[1] When insured and receiving appropriate health care services, children experience fewer absences from early care and education due to delayed treatment of illness.[2]	The strategy is most effective when linked to national or state level marketing campaigns. Messages must be culturally relevant to the targeted community, which should be clearly defined through regional needs and assets reports and community health surveys and data. When considering this strategy Councils should review the rate of uninsured children within their region. Currently, KidsCare is not enrolling new children. Highes success rates come when combining this strategy with other programs which have direct contact with families. Coalitions which include known and trusted community based organizations are essential to ensuring that information is delivered to families in a variety of settings. The strategy may not work in all areas - esp. in rural areas. Radio appears to be an effective way to reach parents, especially working parents. Current collaborations include organizations that have provided outreach and enrollment assistance, such as community health clinics, hospitals, social service and behavioral health organizations. Additional partners	Television is very expensive Costs vary depending on scope of work. Considerations for cost may include personnel, employee related expenses, materials and supplies, and mileage. Organizations can become contracted community partner

[1] Miller, M., Vigdor, E.R., Manning, W.G. (2004). *Covering the uninsured: What is it worth?* Health Affairs. Retrieved 2/12/08 from http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.157v1.pdf

[2] Getting Ready, Findings from the National School Readiness Indicators Initiative, Rhode Island KIDS COUNT, February 2005, p. 28.

	Research has shown that health insurance coverage is linked to improved health. Insured children are: • More likely to access primary health care services to keep them well. • More likely to receive timely immunizations. • More likely to have medical home.[3]	include faith based service providers and churches, United Ways, and county health departments. Outreach information and resources are available from the Arizona Health Care Cost Containment System (AHCCCS) at: http://azahcccs.gov/community/ Children's Action Alliance (CAA) provides information and resources regarding KidsCare and Medicaid outreach and enrollment activities. http://www.azchildren.org/display.asp?pageId=119&parentId=16 At the regional level, outreach and enrollment assistance should be developed to reflect needs and assets data and be aligned with any outreach and enrollment assistance conducted by other community based efforts.	organizations for a small subscription fee, but it is not a requirement (fee varies) What does this mean?

Policy Specialist: Kelley Murphy

LINKS TO:

AHCCCS http://azahcccs.gov/community/

CAA http://www.azchildren.org/display.asp?pageId=119&parentId=16

Seid M, Stevens GD, and Varni JW, "Parents' Perceptions of Pediatric Primary Care Quality: Effects of Race/Ethnicity, Language, and Access," *Health Services Research*, Vol. 38, No. 4, August 2003, pp.1009–1031.

Seid M and Stevens GD, "Access to Care and Children's Primary Care Experiences: Results from a Prospective Cohort Study," *Health Services Research*, Vol. 40, No. 6, Part I, December 2005, pp. 1758–1780.

[3] Ku, L., Lin, M., Broaddus, M. (2007). *Improving children's health: A chartbook about the roles of Medicaid and SCHIP.* Center on Budget and Policy Priorities. Retrieved from http://www.cbpp.org/schip-chartbook.htm

Yu H and Seid M, “Uninsurance Among Children Eligible for the State Children’s Health Insurance Program: Results from a National Survey,” *Managed Care Interface*, Vol. 19, No. 5, May 2006, pp. 31–39.

Stevens GD, Seid M, Mistry R, and Halfon N, “Disparities in Primary Care for Vulnerable Children: The Influence of Multiple Risk Factors,” *Health Services Research*, Vol. 41, No. 2, April 2006, pp. 507–531.

Stevens GD, Seid M, and Halfon N, “Enrolling Vulnerable, Uninsured but Eligible Children in Public

Health Insurance: Association with Health Status and Primary Care Access,” *Pediatrics*, Vol. 117, No. 4, April 2006, pp. e751–e759.

FIRST THINGS FIRST
Health Insurance Outreach and Application Assistance
Standards of Practice - Final

Many children living in low income families qualify for publicly funded health insurance. Across the nation, as many as half the children who are uninsured qualify for publicly funded health insurance coverage (such as KidsCare or the Arizona Health Care Cost Containment System also known as AHCCCS). In Arizona, it is estimated that 16 percent of children lack health care coverage[1]. For children birth through age five this represents 80,000 children. Health insurance outreach and application assistance is a proven practice for improving and increasing health coverage in public programs. Community application assistance occurs nationally and in Arizona in a wide variety of settings, such as health clinics, child care settings, social service agencies, recreation centers, and homeless shelters. Reports based on national as well as Arizona experience indicate that such assistance can make a difference in getting children covered.

In Arizona, AHCCCS implemented an electronic application for services to make applications more accessible to families. The universal application, known as Health-e-Arizona, allows families to apply for and renew health coverage, as well as other family support programs such as Temporary Assistance for Needy Families (TANF) cash assistance, and nutrition assistance, directly over the internet.
While this application promises to make enrollment in public coverage programs for young children easier, barriers still exist. Many families are not aware of available publicly funded health insurance programs for which they may be eligible. Community-based organizations and families may be unfamiliar with the new application, and may need assistance in completing it. Other families do not have access to a computer or an internet connection. In addition, families who are applying for coverage for the first time are required to submit original documentation to an Arizona Department of Economic Security (DES) office or a community-based agency that is "certified" by AHCCCS to accept such documentation. Families may find going to a DES office intimidating or difficult due to hours of operation (8-5), long wait times or travel distance. Currently, a limited number of community organizations use the Health-e-Arizona application to enroll children in health coverage, including some community health centers and hospitals.

There are several approaches to reducing the number of children who lack health insurance coverage such as increasing awareness of available publicly funded health insurance programs; increasing awareness of and access to the Health-e-Arizona online application; and reducing barriers in the public health insurance application process.

[1] U.S. Census Bureau, Annual Estimates of Population by Sex and Age for States and Fro Puerto Rico, Release data: May 1, 208. http://www.census.gov/popest/states/asrh/SC-Est207-02.html

Programs implementing health insurance outreach and enrollment assistance will:

- Build upon, enhance and coordinate with existing health insurance outreach and enrollment assistance efforts occurring within a region.
- Demonstrate connections to community-based organizations in the region that serve families and/or community-based organizations where the uninsured are likely to congregate or seek other services.
- Provide ongoing staff development on diversity issues.
- Be accessible for families. Some examples include offering extended service hours including weekend/evening hours or operating in locations where public transportation is accessible or where families with young children already congregate.
- Engage families as partners to ensure that the program is reaching eligible families.
- Assure that staff receive specific training to carry out outreach and enrollment activities.
- Provide ongoing staff training as necessary.
- Maintain confidentiality of all information obtained as a part of the outreach and enrollment process.
- Establish an effective, consistent supervisory system that provides support for all staff members and ensures accountability to participants, funders, and the community.
- Assure that evaluation and monitoring is a collaborative, ongoing process that includes feedback from staff, families, and community members.
- Establish a system to ensure that families are informed of all of their health insurance enrollment options and assist families in choosing the appropriate plan to meet their individual family/child's needs.
- "To address cultural competency objectives, early childhood practitioners /early childhood service providers shall ensure that children and families receive from all staff members effective, understandable, and respectful care that is provided in a culturally competent manner- a manner compatible with their cultural beliefs and practices and preferred language. Early childhood practitioners /early childhood service providers should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. Early childhood practitioners/early childhood service providers should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and family-centered involvement to ensure that services are delivered in a manner that is consistent with the National Standards on Culturally and Linguistically Appropriate Services and/or the National Recommendations on Cultural and Linguistic Competence for the National Association for the Education of Young Children." http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 ; http://www.naeyc.org/positionstatements/linguistic

Individuals providing outreach and enrollment assistance will:

- Be adequately trained on the Health-e- Arizona application procedure, the health insurance enrollment process, and the different insurance plan options.
- Seek out families that are eligible but not enrolled in public health insurance and provide assistance for these families to enroll.
- Introduce and provide technical assistance to potential enrollees so that they have the skills to apply for services utilizing the Health-E-Arizona application.

- Provide information that parents can use about the importance of taking their children to well child and preventive health check-ups on a regular basis to receive timely, preventative health care for their children.
- Establish and maintain partnerships/relationships with local or regional AHCCCS and DES offices to remain current on eligibility or enrollment requirements that will maximize enrollment and renewal of public health insurance.
- Maintain confidentiality of all information obtained as part of the outreach and enrollment process.
- Include opportunities for feedback from families into outreach and enrollment activities.

Health Insurance Enrollment

First Things First reporting requirements and progress monitoring are aligned with First Things First Goals, Key Measures, and Standards of Practice. The purpose of First Things First data submission and monitoring is to determine the extent to which each program has accomplished the stated goals, key measures, targeted service number, and activities outlined in the standards of practice.

Grantees will be provided with data reporting requirements by First Things First. There are five main components to these requirements:

- Unit of Service
- Performance Measures
- Data Reporting Template
- Data Reporting Instruction
- Frequently Asked Questions

The data reporting template captures the set of data the grantee submits on a quarterly basis; the instructions support that data submission. Units of Service and performance measures outline how the quarterly data submissions will be evaluated according to the contracted deliverables and standards of practice for that contract. Frequently asked questions present answers to common reporting, evaluation, policy, and performance questions.

Definitions:

Unit of Service and related Target Service Number

A Unit of Service is a FTF designated indicator of performance specific to each FTF strategy. It is composed of a unit of measure and a number (Target Service Number).

A Unit of Measure/Service can be a target population and/or a service/product that a grantee is expected to serve as part of an agreement. Target Service Number represents the number of units (e.g. target population) proposed to be served or number of products/services proposed to be delivered during the contract year.

For example, for the FTF strategy Home Visitation the FTF Unit of Service is “number of families served” and a Target Service Number of 50 represents the number of families the program proposes to serve during the contract period. All FTF applicants must clearly state in the proposal a target service number for each strategy specific Unit of Service.

For **Health Insurance Enrollment,** the unit of service:

Total number of families receiving enrollment assistance for health insurance

Performance Measures

Performance Measures measure (1) key indicators of performance (i.e. Unit of Service); (2) basic implementation of strategy; (3) alignment of program activities to strategy specific standards of practice, (4) performance or progress toward pre-established strategic goals. Performance measures may include the level or type of program activities conducted (e.g. serving families/children through home visits) and/or the direct services and products delivered by a program (e.g., providing scholarships).

For **Health Insurance Enrollment,** performance measures are:

Total number of awareness sessions offered/proposed service number
Total number of people reached by awareness sessions/proposed service number
Total number of families receiving enrollment assistance for health insurance / proposed service number
Total number of families receiving referrals for health coverage enrollment/ target service number

Data Reporting Templates

Data reporting templates are the tools utilized to gather data to assess grantee Performance Measures. All FTF grantees submit data on a quarterly basis through designated data reporting templates.

For **Health Insurance Enrollment,** the data reporting template is:

Health Insurance Enrollment Assistance Data template		
Grantee Name		
Contract ID		
User Completing Report		
User Completing Report's Email		
Reporting Period	Month	Year
	May	2010
Regional Partnership Council		
Date Completed		
Data Entry		
1. Public Awareness Activity		
Are you conducting any public awareness activities as part of your program?	◉ Yes ○ No	
	You must select yes or no. If yes, please choose one or more activities below.	

Activity	Number of People Reached	
☐ Media impressions		If selected, please provide number of people reached.
☐ Provision of written materials		If selected, please provide number of people reached.
☐ Group meetings		If selected, please provide number of people reached.
☐ One to one interactions (include promotional items given)		If selected, please provide number of people reached.

2. Health Insurance Enrollment or Renewal Assistance

Please indicate for families that you serve the numbers that are uninsured or underinsured and those who received enrollment assistance to obtain insurance.

a. Number of Families Served Who Are Not Covered by Private Insurance, AHCCCS, Indian Health Services or Kids Care

Required.

b. Number of Families Served Who Report They Are Underinsured

Required.

c. Number of Families Served Who Report Lack of Insurance or Underinsurance Who Received Enrollment Assistance to Obtain Insurance (new enrollment)

Required.

d. Number of Families Served Requesting Assistance with an AHCCCS or KidsCare Renewal (renewal assistance)

e. Number of families that received information about public insurance opportunities and the process to apply.

Required.

f. Number of families referred to other providers of low-cost or no-cost health care such as community health centers, Indian Health services, or county public health clinics.

Required.

3. Family Income Demographics:

Family Income Breakdown of the Families who Received Enrollment Assistance:

a. Greater than 200% FPL	
b. 134-200 % FPL	Required.
c. 0 to 133% FPL	Required.

Data Reporting Templates

Data reporting templates are the tools utilized to gather data to assess grantee Performance Measures. All FTF grantees submit data on a quarterly basis through designated data reporting templates.

For **Health Insurance Enrollment,** the data reporting instructions are:

INFORMATION

Your data report is always due on the 20th day of the month following the end of each quarter. Each quarterly submission will include information for the entire quarter broken out by month. Each data report submitted will include information for the entire preceding quarter.

1st Quarter – July-September – Report due October 20
2nd Quarter – October-December– Report due January 20
3rd Quarter – January-March – Report due April 20
4th Quarter – April- June – Report due July 20

- Data should be only reported for services funded by First Things First.
- Data should be reported for each Regional Partnership Council area in which contracted services are provided. For example, if your community based training program is contracted to provide services in both Central Maricopa and Northeast Maricopa regions, two separate reports must be submitted.

OVERVIEW

- For each quarter, **data should be tallied for each month of service.**
- Your final data submission for the quarter cannot be completed until you complete all monthly reports.

DATA ENTRY

***Any data field with an asterisk mark is required, you cannot skip it.**

Public Awareness Activity

1. *** Are you conducting any public awareness activities as part of your program?** In this data field you will choose either **Yes or No.**
   If **YES:** Please select from the list the activities you conduct as part of your program. You can select as many activities as needed. After an activity type is selected, please report the number of people reached through the specific activity. You may skip any activity that does not pertain to your program.
   a. Media impression is defined as the number of people reached with media campaigns.
   b. Provision of written materials is defined as the number of people receiving pamphlets, etc.
   c. Group meetings.
   d. One to One interactions.

Health Insurance Enrollment or Renewal Assistance

2. ***Number of families served who are not covered by private insurance, AHCCCS, Indian Health Services, or Kids Care:** In this data field, please indicate for the families that you serve the numbers that are not covered by any insurance here.
3. ***Number of families served who report they are underinsured:** In this data field, please indicate for the families that you serve the numbers who are underinsured here.
4. ***Number of families served who report lack of insurance or underinsurance who received enrollment assistance to obtain insurance:** In this data field, please indicate for the families that you serve the numbers who received enrollment assistance to obtain insurance.
5. *** Number of Families Served Requesting Assistance with an AHCCCS or KidsCare Renewal (renewal assistance) :** In this data field, please indicate for the families that you serve the numbers who requested assistance with AHCCCS or KidsCare Renewal (renewal assistance)
6. *** Number of families that received information about public insurance opportunities and the process to apply.** In this data field, please indicate for the families that you serve the numbers who received information about public insurance opportunities and the process to apply.
7. *** Number of families referred to other providers of low-cost or no-cost health care such as community health centers, Indian Health services, or county public health clinics.** In this data field, please indicate for the families that you serve the numbers who were referred to other providers of low-cost or no-cost health care such as community health centers, Indian Health services, or county public health clinics.

Family Income Demographics

Family Income Breakdown of the Families Who Received Enrollment Assistance

List the breakdown of income of the families who received assistance for enrollment.

a. Greater than 200 % FPL _____
b. 134-200% FPL _____
c. 0 TO 133% FPL _____

Frequently Asked Questions

Frequently Asked Questions present answers to common reporting, evaluation, policy, and performance questions.

For **Health Insurance Enrollment,** the frequently asked questions are:

In development

GOAL AREA: HEALTH

STRATEGY NAME: HEALTH COORDINATION/MEDICAL HOME

GOAL:

- **Increase the number of health care providers using a medical/dental home**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Implement a variety of strategies to support and encourage use of a "medical home" model of care. For many years, the term "medical home" has been used in various ways. At a basic level, it is used to address access to health care. In this context, the term 'medical home' implies a primary care relationship between a patient and a health care provider, and one marker is if a family or patient can identify a practice or provider by name as their usual source of care. At a more complex level, the term "medical home" has been used to define the type of primary care practice, particularly in the context of care for children with special health care needs. The American Academy of Pediatrics describes the medical home as a model of delivering primary care *that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and* culturally effective care. The concept of the medical home is currently being promoted as an approach to providing comprehensive primary care for children, youth, and adults. There is now considerable			Costs vary depending upon the model of service delivery.

discussion at the public policy level about the benefits of the medical home, accompanied by an emerging understanding of the need to pay physicians and other primary care providers appropriately to provide the services necessary to create a quality medical home. Regions wishing to address the broad concept of medical home may wish to address one or many points along this continuum. Families and children face access to care issues, including access to health insurance coverage. But coverage alone does not guarantee the relationship and provision of health care that many envision when using the term "medical home." **Care Coordination** 1. *Provide resources (usually funding) to the practices that they can use to pay for care coordination.* Rhode Island Medicaid, for example, pays providers participating in its PCCM (Primary Care Case Management) program who have a nurse case manager more than those who do not have a nurse case manager. 2. *Pay for care coordination through a separate system (or contract) that is designed to support the Primary Care Physicians and is linked to their practice.* Oklahoma, for example, has dedicated state staff who accept referrals from PCPs (and others) and are tasked with assisting providers and program participants in accessing and coordinating care.	**Evidence Based**	Several models for care coordination exist, but practices will likely be comfortable with one particular model. Models include: • Care coordinator employed by practice; located in practice • Care coordinator employed by practice; shared between practices; located outside of practice or PT within practice • Care coordinator employed by outside entity; located at outside entity; shared between practices • Others… The size and type of practice will influence preferred model of care coordination. Practices may have medicolegal concerns about care coordination provided by	$100,000 per care coordinator is a rough estimate to include salary, ERE etc. This cost estimate will vary depending upon caseload, size of medical practice, geographic location

Support Sensory Screening within medical home Work with primary care practices to update sensory screening tools/equipment/techniques to improve quality and frequency of sensory screening **Support Developmental Screening within medical home** Support primary care practices through referral/evaluation process when a screen shows potential delay Fund/create programs that create in-house or community resources to help families whose children are at-risk for delay		external organizations without contractual relationship to practice. In order to decide what type of care coordination strategy a council might use it is helpful to consider the following questions. What equipment/techniques are currently used in area? What are cost factors allowing/inhibiting practices ability to update screening capabilities? What information tracking and referral streams are available; could this be a target for funding?	Cost dependent upon service delivery model and equipment used: Otoacoutstic Emissions~$4000 Typanometry ~$2500 Audiometer ~$2000 Annual calibration ~$150 per piece of equipment Opthalmoscope $200 Photoscreener or Autrefractor $4500-$12,000 Automated/Computerized Eye Chart $1250+, plus annual software license renewal fee and supplies Annual calibration for photoscreening of $175 per piece of equipment

Support primary care practices to achieve National Committee on Quality Assurance (NCQA) certification for Medical Home Financial incentive to practice to work toward/achieve NCQA certification. This is a time- and labor-intensive process that will yield support for FTF principles Encourage practices to use well-child care provision and developmental screening as two of the three required conditions in quality monitoring. Offer financial support to practices to employ or work with a care coordinator.	Scientific evidence supporting the NCQA criteria does not yet exist. However, NCQA focuses on processes and procedures in primary care offices that support medical home principles, including establishing policies and procedures on making critical referrals and laboratory testing results, emphasis on the patient as central to care, and quality improvement activities.	NCQA certification has three levels. Practices that do not use electronic medical records will not be able to achieve Level 3 certification. Level 1 certification represents substantial progress toward FTF goals of care coordination NCQA certification will require the primary attention of the practice for a period of 3-8 months. It may not be realistic to expect the practice to incorporate other substantial change efforts within that time frame.	Data recording, management and reporting is built –in when using EyeSpy 20/20. Annual software license renewal fees apply (cost dependent on number of screenings performed range $.25-$50 per screen) Puchase into **Best Care For Kids,** the FTF funded statewide physician outreach and education program, at approximate cost of $6500 per practice. For exact regional costs work with the policy specialist. See also Physician Outreach and Education strategy page.

Policy Specialist – Kelley Murphy

LINKS TO:

SOP SOP - Health Coordination/Medical Home

Additional research and information

Antonelli - Making Care Coordination Critical

Mental Health Practice Based CC-Workbook

Health/Primary Speciality Collaboration

FIRST THINGS FIRST
Care Coordination
Standards of Practice - Final

The medical home represents a standard of primary care where children and their families receive the care they need from a family physician, pediatrician or healthcare professional that they trust. Healthcare professionals in partnership with the family work with appropriate community resources and systems to achieve the child's maximum potential and optimal health. A medical home addresses well-child care, acute care, and chronic care for all children from birth through their transition to adulthood.

An important component of a medical home is service coordination and case management to provide linkages for children and their families with appropriate services and resources in a coordinated effort to achieve good health. According to the Medical Home Practice-Based Care Coordination Workbook (McAllistar, Presler, Cooley); "It has been suggested that you cannot be a strong medical home without the capacity to link families with a designated care coordinator.

Effective care coordination begins with recognizing the relationship between the family, the health care provider and the care coordinator. It enhances access to needed services and resources, promotes optimal health and functioning of children, and supports improved quality of life. Data shows that primary care physicians struggle to fulfill the care-coordination needs of children, youth, and families. Care is coordinated and/or integrated across all elements of the complex health care and social services systems (e.g., subspecialty care, hospitals, home health agencies, home visitation services) and the patient's community (e.g., family, schools, childcare, public and private community-based services,). Care coordinators will enhance the abilities of the physician and practice to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Qualifications for a Care Coordinator include:

Minimum of a Bachelors Degree in health care, social work or related field and have experience working with children birth through five and their families.

Have excellent communication and organizational skills that promote efficiency in care coordination.

Have a comprehensive understanding of community, social and governmental resources available to support families.

Programs implementing care coordination will:

Assure that all program staff have the appropriate experience and education.

Provide ongoing training to program staff to assure quality.

Assure that all patient and family information is handled in a confidential manner.

Assure that appropriate consent is obtained for service delivery.

Assure that the intake process assesses the strengths and needs of the child and family by utilizing standardized methods and procedures.

Collaborate with local agencies/community partners.

"To address cultural competency objectives, early childhood practitioners /early childhood service providers shall ensure that children and families receive from all staff members; effective, understandable, and respectful care that is provided in a culturally competent manner- a manner compatible with their cultural beliefs and practices and preferred language. Early childhood practitioners /early childhood service providers should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. Early childhood practitioners/early childhood service providers should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and family-centered involvement to ensure that services are delivered in a manner that is consistent with the National Standards on Culturally and Linguistically Appropriate Services and/or the National Recommendations on Cultural and Linguistic Competence for the National Association for the Education of Young Children."
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 ;
http://www.naeyc.org/positionstatements/linguistic

In the United States, Native American Tribes are considered autonomous nations with all of the rights and responsibilities of a nation. Understanding this, Native American Tribes are charged with protecting the health and safety of their people. To this end, Tribes have full ownership over any data collected within their reservation boundaries. This means that Tribes can allow or not allow any program to collect health data on the reservation.

Any FTF grantee implementing programs in tribal communities must have official tribal permission to collect and utilize sensitive health data. Such data can include but not be limited to:

- Morbidity and mortality among members of their communities
- Information regarding child safety and welfare
- Information regarding children in foster care
- Infectious and chronic disease information among members of their communities
- BMI and healthy weight information

Care Coordinators will:

1. Assist the practice to identify children with special healthcare needs and establish methods for tracking and follow up of these children.
2. Assist the practice to identify other children potentially in need of care coordination services.
3. Complete an intake assessment, with participation of the family. This assessment (including strengths and weaknesses) should consider medical status, developmental stage of the child and a variety of family protective factors such as parental resilience, social connections, knowledge

of parenting and child development, concrete support in times of need and children's healthy social emotional development.

4. Review that intake assessment with the family and identify needs that might be addressed via care coordination.
5. Work with families and health plan, if appropriate, to develop a written plan of care. The intensity of care coordination should vary based upon identified needs/desires of the family.
6. Be able to, as appropriate but not limited to:
    a. Work with the office referral staff to identify service referral needs, ensure completion of referral visits and outcomes of those visits
    b. Assist the family in following up with referrals
    c. Educate families on the importance of follow up
    d. Assure access to care (insurance or social services)
    e. Provide information regarding community resources and linkage to those services
    f. Promote family independence by working to develop self care skills
    g. Lead or facilitate team conferences
    h. Support care transitions
    i. Advocate for the family
7. Monitor the status of the care plan, making any necessary adjustments and communicating changes to the family.
8. Seek out feedback from families on the coordination processes and decisions of the providers serving the child.
9. Participate in quality/performance measurement processes related to the care coordination/medical home model.
10. Care Coordinators will NOT be responsible for performing medical procedures or treatments, giving medical advice, writing reports generally prepared by physicians or nurses and performing routine bookkeeping, clerical or billing functions.

Care Coordination/Medical Home

First Things First reporting requirements and progress monitoring are aligned with First Things First Goals, Key Measures, and Standards of Practice. The purpose of First Things First data submission and monitoring is to determine the extent to which each program has accomplished the stated goals, key measures, targeted service number, and activities outlined in the standards of practice.

Grantees will be provided with data reporting requirements by First Things First. There are five main components to data reporting:

- Unit of Service
- Performance Measures
- Data Reporting Template
- Data Reporting Instruction
- Frequently Asked Questions

The data reporting template captures the set of data the grantee submits on a quarterly basis; the instructions support that data submission. Units of Service and performance measures outline how the quarterly data submissions will be evaluated according to the contracted deliverables and standards of practice for that contract. Frequently asked questions present answers to common reporting, evaluation, policy, and performance questions.

Definitions:

Unit of Service and related Target Service Number

A Unit of Service is a FTF designated indicator of performance specific to each FTF strategy. It is composed of a unit of measure and a number (Target Service Number).

A Unit of Measure/Service can be a target population and/or a service/product that a grantee is expected to serve as part of an agreement. Target Service Number represents the number of units (e.g. target population) proposed to be served or number of products/services proposed to be delivered during the contract year.

For example, for the FTF strategy Home Visitation the FTF Unit of Service is “number of families served” and a Target Service Number of 50 represents the number of families the program proposes to serve during the contract period. All FTF applicants must clearly state in the proposal a target service number for each strategy specific Unit of Service.

For **Care Coordination/Medical Home,** the units of service are:

Total number of children receiving care coordination services
Total number of written care plans

Performance Measures

Performance Measures measure (1) key indicators of performance (i.e. Unit of Service); (2) basic implementation of strategy; (3) alignment of program activities to strategy specific standards of practice, (4) performance or progress toward pre-established strategic goals. Performance measures may include the level or type of program activities conducted (e.g. serving families/children through home visits) and/or the direct services and products delivered by a program (e.g., providing scholarships).

For **Care Coordination/Medical Home,** performance measures are:

Total number of children receiving care coordination services/proposed service number
Total number of written care plans/proposed service number
Total number of families receiving referrals for health insurance or health coverage enrollment/ target service number
Total number of families receiving referrals for health and human service providers/ target service number

Data Reporting Templates

Data reporting templates are the tools utilized to gather data to assess grantee Performance Measures. All FTF grantees submit data on a quarterly basis through designated data reporting templates.

For **Care Coordination/Medical Home,** the data reporting template is:

Care Coordination Data template		
Grantee Name		
Contract ID		
User Completing Report		
User Completing Report's Email		
User Completing Report's Phone Number		
Reporting Period	Month	Year
Regional Partnership Council		
Date Completed		
Data Entry		
1. Care Coordination Service:		**Number**
Please indicate the total of number of children referred for services and the total number of children receiving care coordination services.		
a. Total number of children (0-5yrs) referred for care coordination services		

b. Total number of children (0-5yrs) receiving care coordination services in this reporting period.	
c. Total number of intake assessments completed.	
d. Total number of written care plans developed/initiated in this month.	
e. Total number of written care plans completed/achieved in month.	
2. Health Insurance Enrollment Assistance:	
Please indicate for families that you serve the numbers that are uninsured or underinsured and those who received enrollment assistance to obtain insurance.	
a. Number of families served who are not covered by private insurance, AHCCCS, Indian Health Services, or Kids Care.	
b. Number of families served who report they are underinsured.	
c. Number of families served who report lack of insurance or underinsurance who received enrollment assistance to obtain insurance.	
3. Referrals to Health Care and Low cost Care Providers:	
*Please indicate for families that you serve the numbers that received **referrals** to the following agencies:*	
a. Number of families referred to Indian Health Services(IHS)/Indian Tribal Urban (ITU)	
b. Number of families referred to free or low cost health care service providers	
c. Number of families referred to AHCCCS or DES to receive health coverage	
4. Referrals to Health and Human Services Providers:	
*For the children receiving care coordination, please indicate for children that you serve the numbers that received **referrals** to the following types of health & human services providers:*	
a. Primary Health Care Services	
b. Oral Health Care Services	
c. Mental Health Care Services	
d. Specialty Health Care Provider	
e. Community Social Service Program	
f. Early Intervention Program	
g. Prescription Drug / Pharmacy Assistance Program	
h. W.I.C. Supplemental Nutrition Program	
i. Non W.I.C. Nutrition Education Program	
j. Support Groups	
k. Other (please specify_____)	

Data Reporting Instructions

Data reporting instructions support data submission through the data reporting template.

For **Care Coordination/Medical Home,** the data reporting instructions are:

INFORMATION

Your data report is always due on the 20th day of the month following the end of each quarter. Each quarterly submission will include information for the entire quarter broken out by month. Each data report submitted will include information for the entire preceding quarter.

1st Quarter – July-September – Report due October 20
2nd Quarter – October-December – Report due January 20
3rd Quarter – January-March – Report due April 20
4th Quarter – April- June – Report due July 20

- Data should be only reported for services funded by First Things First.
- Data should be reported for each Regional Partnership Council area in which contracted services are provided. For example, if your program is contracted to provide services in both Central Maricopa and Northeast Maricopa regions, two separate reports must be submitted.

OVERVIEW

- For each quarter, **data should be tallied for each month of service.**
- Your final data submission for the quarter cannot be completed until you complete all monthly reports.

DIRECTIONS FOR DATA ENTRY

Care Coordination Service

Please indicate the total of number of children referred for services and the total number of children receiving care coordination services in the following data fields.

1. **Total number of children (0-5yrs) referred for care coordination services**- For this data field please indicate the total number of children (0-5yrs) referred for care coordination services
2. **Total number of children (0-5yrs) receiving care coordination services in this reporting period:** In this data field please indicate the total number of children (0-5yrs) receiving care coordination services in your program this reporting period.
3. **Total number of intake assessments completed:** In this data field please indicate the total number of intake assessments completed this reporting period.

4. **Total number of written care plans developed/initiated in this month.** In this data field please indicate the total number of written care plans developed/initiated in this reporting period.
5. **Total number of written care plans completed/achieved in month.** In this data field please indicate the total number of written care plans completed/achieved in this reporting period.

Health Insurance Enrollment Assistance

I. *Please indicate for families that you serve the numbers that are uninsured or underinsured and those who received enrollment assistance to obtain insurance.*

a. **Number of families served who are not covered by private insurance, AHCCCS, Indian Health Services, or Kids Care____**
b. **Number of families served who report they are underinsured_____**
c. **Number of families served who report lack of insurance or underinsurance who received enrollment assistance to obtain insurance_____**

Referrals to Health Care and Low cost Care Providers

II. *Please indicate for families that you serve the numbers that received referrals to the following agencies.*

a. **Number of families referred to Indian Health Services (IHS)/Indian Tribal Urban (ITU)____**
b. **Number of families referred to free or low cost care service providers____**
c. **Number of families referred to AHCCCS or DES to receive health coverage_____**

Referrals to Health and Human Services Providers

III. ***For the children receiving care coordination, please indicate for children that you serve the numbers that received referrals to the following types of health & human services providers:***

1. **Primary Health Care Services:** For this data field please indicate the total number of children that you serve who received referrals to Primary Health Care Services. For example, pediatricians, family practitioners, etc.
2. **Oral Health Care Services:** For this data field please indicate the total number of children that you serve who received referrals to Oral Health Care Services. For example, dentist or hygienist.
3. **Mental Health Care Services:** For this data field please indicate the total number of children that you serve who received referrals to Mental Health Care Services. For example, behavioral therapists, psychologists, etc.
4. **Specialty Health Care Provider:** For this data field please indicate the total number of children that you serve who received referrals to a Specialty Health Care Provider.

5. **Community Social Service Program:** For this data field please indicate the total number of children that you serve who received referrals to a Community Social Service Program.
6. **Early Intervention Program:** For this data field please indicate the total number of children that you serve who received referrals to an Early Intervention Program. For example, Arizona Early Childhood Intervention Program (AzEIP).
7. **Prescription Drug / Pharmacy Assistance Program:** For this data field please indicate the total number of children that you serve who received referrals to a Prescription Drug / Pharmacy Assistance Program.
8. **W.I.C. Supplemental Nutrition Program:** For this data field please indicate the total number of children that you serve who received referrals to a W.I.C. Supplemental Nutrition Program.
9. **Non W.I.C. Nutrition Education Program:** For this data field please indicate the total number of children that you serve who received referrals to a Non W.I.C. Supplemental Nutrition Program.
10. **Support Groups:** For this data field please indicate the total number of children that you serve who received referrals to Support Groups.
11. **Other (please specify_____):** For this data field please indicate the total number of children that you serve who received referrals to Other (please specify_____)

Frequently Asked Questions

Frequently Asked Questions present answers to common reporting, evaluation, policy, and performance questions.

For **Care Coordination/Medical Home,** the frequently asked questions are:

In development

GOAL AREA: HEALTH

STRATEGY NAME: SENSORY SCREENING

GOAL:

- **Expand the use of early screening in health care settings to identify children with developmental delay**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
In a variety of community based or other settings, provide age appropriate vision and hearing screening, education regarding the importance of regular screening and, when necessary, link children to appropriate follow up care. **Hearing Screening** Age appropriate hearing screenings for children 1-5 year of age are done using an Otoacoutstic Emissions (OAE) device, a Typanometry or audiometer. Training is provided to assure accurate and appropriate results. **Vision Screening** Age appropriate vision screenings for children 1-5 years of age include 1) the use of an objective screening tool		The type of service delivery model and equipment used impacts cost of implementation. Equipment cost estimates are provided under "cost" but this list is not exhaustive. The cost of outreach must be included. Hearing screening requires the purchase of equipment. Staff using equipment must be trained in the use and maintence of equipment. The choice of equipment depends upon the age of the child. Chosen equipment should be based upon the age and developmental status of the child. Children under the age of 2 who fail a hearing screening must be reported to ADHS. Training is available through the T3 program but other resources exist. Strategy requires the purchase of equipment and supplies. Staff must	Otoacoutstic Emissions~$4000 Typanometry ~$2500 Audiometer ~$2000 Annual calibration ~$150 per piece of equipment T3 training ~$500 per day with 1-2 days of training per staff member. Can do up to 12 in a group for training. Additional costs for reporting, data tracking, software etc. Opthalmoscope $200 Photoscreener or Autrefractor $4500-$12,000 Automated/Computerized Eye

such as a photoscreener or autorefractor, or 2) a subjective assessment incorporating a monocular distant visual acuity screening, or 3) a professional eye examination**.**		be trained on the use and maintenance of the equipment. Training is available through the T3 program but other resources exist. There is wide disparity in the costs for equipment, but also wide disparity in how quickly and how many children can be screened. Chosen equipment is based upon the age, and developmental status of the child.	Chart $1250+, plus annual software license renewal fee and supplies Annual calibration for photoscreening of $175 per piece of equipment T3 training ~$500 per day with 1-2 days of training per staff member. Can do up to 12 in a group for training. Data recording, management and reporting is built –in when using EyeSpy 20/20. Annual software license renewal fees apply (cost dependent on number of screenings performed range $.25-$50 per screen)
Professional & Parent Education Plan should be developed to educate physicians on importance of early identification, checking for screening outcomes on back of immunization label, and what next steps are for referring families for follow-up. Education should include which kids need ongoing monitoring, testing and when it should occur. They should be knowledgeable about early intervention, parent support and local community resources. Culturally competent educational materials and community resources should be developed for physicians to provide to families.		Costs will vary depending the scope and resources available. Local specialists such as the AAP chapter Champion and audiologist may be available for periodic workshops. Larger scale education may include regional conferences, grand rounds, webinars, teleconferences etc.	

Policy Specialist – Kelley Murphy

SOP **SOP - Health - Sensory**

T3 Training **Health - Sensory - Arizona T3 Child Care Training Collaborative**

AzDHS Sensory Program **Health - Sensory - Az Department of Health Services, Sensory**

FIRST THINGS FIRST
Sensory Screenings
Standards of Practice - Final

Training and Qualifications

- Maintain certification and current training for staff on the methods and tools used in screening activities throughout their contract, attending re-certification training courses at the state-approved intervals.
- Grantees may use varying methods to ensure training of staff provided they match the requirements of the tool or instrument developer/manufacturer. Grantees may incorporate use of videos, screening training kits, or interactive web training as a method of training screeners.

Screening Locations

- While screening can occur in wide variety of settings, screenings that are conducted in environments where families maintain ongoing connections (such as child care centers) are preferred. The administration of screening at such locations will facilitate the follow up process, and ensure that routine screenings occur at recommended intervals. Screenings should ideally first occur in a medical home setting.
- Screenings should occur in a quiet, well-lighted, non-distracting environment.
- Screenings optimally should occur in settings that are closely aligned to a child's natural environment (for example: where children typically are such as a home or child care center or other location with which the child has familiarity and is comfortable).

Screening Delivery and Referral Procedures

- Screenings activities and their results must be kept confidential. Parent or guardian consent to screening is required before screening can occur. If a referral is necessary based on screening results, parental consent must be provided before results may be forwarded to another provider or agency.
- Screening must be conducted in the child's primary language.
- Grantees must maintain awareness and knowledge of local systems and available services to which children and families may need to be referred for additional evaluation or support.
- A parent or other designated guardian must be present during all screening procedures.

Screening Tools

- Screening instruments should be sensitive enough to identify problems, and specific enough to prevent unacceptable over referrals.
- Screening tools should be designed to capture and hold a child's interest at an age appropriate level while minimizing distraction from other stimuli.
- Screening tools used must be age appropriate, meeting the cognitive and motor skills required for participation.
- Screening tools should be designed to actively engage a young child, giving the tester the opportunity to observe and interact with the child during the screening process.

- Screening tools must be free from bias and appropriate to the population on which they are used.

Specific Standards Related To Types of Sensory Screening

Hearing

- Hearing screening should be performed using age appropriate, standardized screening tools, equipment and/or assessments.
- Hearing screenings require a quiet environment with ambient noise levels on average of less than 50 dBSPL. Although the space requirement is minimal, it is important that the hearing screenings be conducted in a room separate from the rest of the screening.
- Audiometers, if used, should be equipped with a full headset (two earphones), while audiometers equipped with only one earphone utilizing a handled method should be avoided.
- Hearing and vision screeners should have additional, child friendly manipulatives available to help elicit results beyond the use of hardware and charts.
- All devices to test hearing shall have periodic testing for accuracy and proper functioning and include any required certificates stating that these standards have been met.

Vision

- Vision screening would be performed using age appropriate, standardized screening tools and/or assessments.
- Vision and gross motor skills screenings should be conducted in areas that have minimal distraction, are well lighted, and have space appropriate for the test being used.
- Hearing and vision screeners should have additional, child friendly manipulatives available to help elicit results beyond the use of hardware and charts.

STANDARDS OF PRACTICE[1]

Developmental Screening Administration Practices

I. Description of Strategy

As part of a comprehensive system of services to families, some strategies may include the administration of a developmental screening to assist parents and other caregivers in identifying children who may be in need of additional intervention or support services. Developmental screening activities are an integral component of a larger early childhood system and only provide a small snapshot of children's abilities. Though brief, screening is comprehensive in that it includes a review of children's development in the cognitive, communication, physical, social-emotional and adaptive domains.

First Things First has adopted the following guidance to align with the recommended practices and support the system as a whole.

II. Developmental Screening Administration includes the following activities:

- Obtainment of parental consent.
- Administration of a developmental screening instrument.
- Observation of children in their natural setting where they are comfortable and involved in typical activities and routines such as meals, interactions with siblings, etc.
- Discussion with parents regarding their child's development.
- Interpretation and analysis of screening, observation and discussion results.
- Review of screening results with families.
- Referrals made as necessary to AzEIP, local schools, health care providers, behavioral health professionals, or other community resources.
- Coordination of services with other providers (health professionals, AzEIP providers, etc.) to ensure non-duplicative, collaborative activities.

III. Developmental Screening Administration Standards:

Screening Locations

- Screenings optimally occur in settings that are closely aligned to a child's natural environment (home, child care center, etc).
- Screening is conducted where there are minimal distractions (e.g. no television or radio playing), but in a setting where the child can be observed while participating in naturally occurring activities and routines.

[1] [1] The Developmental Screening Administration Standards of Practice includes supplemental standards to address the unique activities of a Mobile Play Based Family Outreach program inclusive of developmental screening activities. The appropriate supplemental standards should be attached along with the general standards.

Screening Tools

- Screening tools used may be either criterion or norm-referenced, but chosen because they are the most appropriate option for use with the child and/or population being screened.
- If using standardized tools (with children ages three – five), instruments must demonstrate at least a .80 reliability level.
- Screening tools used must be age and individually appropriate, ensuring that the cognitive and motor skills required for participation appropriately match the age of the child.
- Screening tools are comprehensive and assess children in all developmental domains: cognition, communication, physical, social-emotional, and adaptive.
- Screening tools for children three to five are designed to capture and hold a child's interest at an age appropriate level while minimizing distraction from other stimuli (approved tools for birth – three are parent report instruments).
- Screening tools used with children birth to three must be approved for use by DES/AzEIP (see Attachment A).

Conducting Screening

- Screening is conducted only after determining that no other screening has occurred within the last three months.
- Parent or guardian consent to screening is required before screening can occur.
- A procedure is in place to assess what other services are being received by the family and to coordinate screening with other providers that may be responsible for the same or similar activities.
- Screening is conducted only if no other entity has conducted a screening within the last three months.
- Screening must include soliciting parent and/or caregiver input beyond use of simple questionnaires.
- Screening must occur in the child and family's primary language.
- Screenings should be combined with additional confirmatory information (parent input, observations, etc).
- A parent or other designated caretaker is present for all screening procedures conducted through home visitation or mobile screening activities.

Referral Services

- When children's screening results indicate they are suspected of having a delay, parents must be informed immediately.
- Families are provided with the contact information of the appropriate referral designation (AzEIP, health care provider, school district).
- If screening is conducted as a component of home visitation, home visitors follow up with families during each subsequent visit to track progress of referral.
- If barriers arise for the family to access additional evaluation services, the home visitor or other program specialist assesses the family needs and assists the family in identifying ways to remove such barriers.

Training and Qualification Standards

Conducting developmental screening requires specific education and skills.

- Educational level: minimum of a bachelor's degree in child development, nursing, early childhood education, child and family studies, or closely related field is ***preferred.***

- All individuals conducting developmental screening will obtain and maintain certification and/ or required training on all of the chosen methods and tools used in screening activities and attend re-certification or additional training courses as required by the tool, the instrument developers, and as it is determined necessary through supervision.

- Personnel who do not meet the preferred education level or are newly trained in developmental screening activities, may only administer developmental screening under the direct supervision of an individual who does meet the training and qualifications standards until it can be documented that the person conducting screening can do so in a reliable manner. This level of supervision is above and beyond the regular supervision activities required in the First Things First Home Visitation or other Standards of Practice. The supervisor will participate with the home visitor or program specialist in conducting screenings and review all completed screening instruments until the home visitor or program specialist is able to consistently conduct screening in a reliable manner. This can be documented in staff's personnel file and family files.
- Areas of knowledge and competencies must be demonstrated in:
    a. Typical and atypical child development
    b. Routines based interviewing practices (see http://www.fpg.unc.edu/~inclusion/RBI.pdf)
    c. Objective child observation
    d. Appropriate assessment of young children

- Individuals conducting screening will participate in continuing education to remain current and update skills and knowledge regarding developmental screening procedures and child development to meet the requirements of this scope of work.

- To address cultural competency objectives, programs shall ensure that providers, children and families receive from all personnel effective, understandable, and respectful services that are provided in a culturally competent manner- a manner compatible with their cultural beliefs and practices and preferred language. Consultants should receive ongoing education and training in culturally and linguistically appropriate service delivery. Consultants should develop participatory, collaborative partnerships with providers and their communities and utilize a variety of formal and informal mechanisms to facilitate community and family-centered involvement in designing and implementing the National Standards on Culturally and Linguistically Appropriate Services.

- Individuals conducting screening receive training and information regarding mandatory reporting. Arizona law requires early care and education staff who suspect that a child has received non-accidental injury or has been neglected, to report their concerns to Child Protective Services or local law enforcement (ARS §13-3620.A).

Supervision, Quality Assurance and Evaluation Standards

- Supervision of individuals who administer developmental screening activities is conducted as a collaborative process with mechanisms that support them in challenging situations and provides ongoing and regularly scheduled (no less than monthly) opportunities for discussion to reflect and debrief. Supervision will also include observation, feedback and opportunities for peer consultation.
- Evaluation of home visitation and developmental screening services utilizes quantitative and qualitative process that includes measures of how effectively children are being identified as early as possible for additional intervention and/or support services.
- Compensation and benefits are adequate for supporting high quality staff and retention of that staff.

Supplemental Implementation Activity Standards for Mobile Play-Based Outreach, Education, and Screening Programs

1. Activities presented by the mobile unit are conducted using parent and child interactive learning opportunities and provide a range of developmentally appropriate materials to support children's comprehensive development in the physical, cognitive, language/communication, social-emotional, and adaptive skills domains.
2. Mobile units maintain schedules that are consistent, predictable, and planned so that families know when and where to expect the mobile unit to arrive.
3. Locations of mobile units are the same throughout the service delivery period. For example, the unit may be available at the local library every third Tuesday of the month. Both the location and the time remain consistent.
4. The mobile unit focuses on interactive learning and also provides opportunities for children to receive developmental screening before or after the planned play activities are conducted. Exceptions for conducting screening during the course of play activities are when screening includes use of observations of children in naturally occurring activities and play situations.
5. Families are provided educational opportunities regarding children's developmental milestones and age appropriate expectations.
6. Information on child development and ways to support that development through play and daily activities and routines is provided as a component of the curriculum.
7. Additional community information (e.g. location of local support groups, library programs, Quality First participating programs, etc.) is made available to parents and caregivers as needed and/or requested.
8. Families who require a referral based on developmental screening results are provided with assistance in locating and accessing sensory (hearing and vision) screening as part of the referral process.

Attachment A

Approved Tools for Screening Children Birth-Age Three

1. The core team uses screening processes, as appropriate, with an AzEIP-approved screening tool. The following screening tools are approved to determine whether a child is suspected of having a developmental delay:
   a. PEDS (Parents Evaluation of Developmental Status)
   b. Ages and Stages Questionnaire
   c. Ages and Stages Questionnaire: Social Emotional Scale (this tool would need to be supplemented by another tool to ensure all areas of development are covered)
   d. Battelle Developmental Inventory Screening Test.

Excerpt from the DES/AzEIP TBM Manual, Chapter 4

Developmental & Health Screening

First Things First reporting requirements and progress monitoring are aligned with First Things First Goals, Key Measures, and Standards of Practice. The purpose of First Things First data submission and monitoring is to determine the extent to which each program has accomplished the stated goals, key measures, targeted service number, and activities outlined in the standards of practice.

Grantees will be provided with data reporting requirements by First Things First. There are five main components to data reporting:

- Unit of Service
- Performance Measures
- Data Reporting Template
- Data Reporting Instruction
- Frequently Asked Questions

The data reporting template captures the set of data the grantee submits on a quarterly basis; the instructions support that data submission. Units of Service and performance measures outline how the quarterly data submissions will be evaluated according to the contracted deliverables and standards of practice for that contract. Frequently asked questions present answers to common reporting, evaluation, policy, and performance questions.

Definitions:

Unit of Service and related Target Service Number

A Unit of Service is a FTF designated indicator of performance specific to each FTF strategy. It is composed of a unit of measure and a number (Target Service Number).

A Unit of Measure/Service can be a target population and/or a service/product that a grantee is expected to serve as part of an agreement. Target Service Number represents the number of units (e.g. target population) proposed to be served or number of products/services proposed to be delivered during the contract year.

For example, for the FTF strategy Home Visitation the FTF Unit of Service is “number of families served” and a Target Service Number of 50 represents the number of families the program proposes to serve during the contract period. All FTF applicants must clearly state in the proposal a target service number for each strategy specific Unit of Service.

For **Developmental & Health Screening,** the units of service are:

Total number of children screened for developmental delays
Total number of children receiving vision and hearing screening

Performance Measures

Performance Measures measure (1) key indicators of performance (i.e. Unit of Service); (2) basic implementation of strategy; (3) alignment of program activities to strategy specific standards of practice, (4) performance or progress toward pre-established strategic goals. Performance measures may include the level or type of program activities conducted (e.g. serving families/children through home visits) and/or the direct services and products delivered by a program (e.g., providing scholarships).

For **Developmental & Health Screening,** performance measures are:

Total number of children screened for developmental delays/proposed service number
Total number of children receiving vision and hearing screening /proposed service number
Total number of awareness sessions conducted/proposed service number
Total number of people reached by awareness sessions/proposed service number
Total number of families receiving referrals for health insurance or health coverage enrollment/ target service number

Data Reporting Templates

Data reporting templates are the tools utilized to gather data to assess grantee Performance Measures. All FTF grantees submit data on a quarterly basis through designated data reporting templates.

For **Developmental & Health Screening,** the data reporting template is:

Data Reporting Instructions

Data reporting instructions support data submission through the data reporting template.

For **Developmental & Health Screening**, the data reporting instructions are:

INFORMATION

Your data report is always due on the 20th day of the month following the end of each quarter. Each quarterly submission will include information for the entire quarter broken out by month. Each data report submitted will include information for the entire preceding quarter.

1st Quarter – July-September – Report due October 20
2nd Quarter – October-December – Report due January 20
3rd Quarter – January-March – Report due April 20
4th Quarter – April- June – Report due July 20

- Data should be only reported for services funded by First Things First.
- Data should be reported for each Regional Partnership Council area in which contracted services are provided. For example, if your community based training program is contracted to provide services in both Central Maricopa and Northeast Maricopa regions, two separate reports must be submitted.

OVERVIEW

- For each reporting period, enter all data for all Regional Partnership Council areas served.
- For each quarter, **data should be tallied for each month of service.**
- Your final data submission for the quarter cannot be completed until you complete all monthly reports.

DIRECTIONS FOR DATA ENTRY

Public Awareness Activity

1. *** Are you conducting any public awareness activities as part of your program?** In this data field you will choose either **Yes or No**. *If **YES**: Please select from the list the activities you conduct as part of your program. You can select as many activities as needed. After an activity type is selected, please report the number of people reached through the specific activity. You may skip any activity that does not pertain to your program.*
    a. Media impression is defined as the number of people reached with media campaigns.
    b. Provision of written materials is defined as the number of people receiving pamphlets, etc.

c. Group meetings.
d. One to One interactions.

Service Provisions Venue: *select the venue of where developmental screenings occurred*

2. **Please select from the list below the venue of where developmental screenings occurred.** *You can select as many venues as applicable*.
   - ☐ Mobile play based unit
   - ☐ Center based Child care/ Home based child care
   - ☐ Other Community Setting
   - ☐ Community Health Clinic/ Hospital
   - ☐ Schools (charter or district)
   - ☐ Other (please specify): _____

Service Delivery: Number of children receiving the following screenings

Please indicate for children that you serve the numbers of that received screenings, referrals and follow ups in the following types of tests by age breakout.

3. **a. Hearing - Screening:** In this data field, you will enter the number of children that were screened for hearing by age breakout of birth thru 12 months, 13 to 24 months, 25 to 36 months, 37 to 48 months, 49 to 60 months, and 61 to 72 months.

   b. Results forwarded to medical home: In this data field, please enter the number of children whose results were forwarded to a medical home (physician of record) by age breakout.

   c. Referred for follow up: In this field, enter the number of children that were referred for follow-up by age breakout.

   d. Number of families reported being referred and having received an additional evaluation: In this field, please enter the number of families that reported being referred after initial screening and having received an addition evaluation by the children's age breakout.

Hearing	*Screened*	*Results forwarded to medical home (physician of record)*	*Referred for follow-up*	*Number of families reported being referred and having received an additional evaluation*
0 -12 months				
13-24 months				
25- 36 months				
37-48 months				
49-60 months				

61-72 months				

4. **a. Vision - Screening:** In this data field, you will enter the number of children that were screened for vision by age breakout of birth thru 12 months, 13 to 24 months, 25 to 36 months, 37 to 48 months, 49 to 60 months, and 61 to 72 months.

   b. Results forwarded to medical home: In this data field, please enter the number of children whose results were forwarded to a medical home (physician of record) by age breakout.

   c. Referred for follow up: In this data field, please enter the number of children that were referred for follow-up after being screened by age breakout.

   d. Number of families reported being referred and having received an additional evaluation: In this field, please enter the number of families that reported being referred after initial vision screening and having received an addition evaluation by the children's age breakout.

Vision	*Screened*	*Results forwarded to medical home (physician of record)*	*Referred for follow-up*	*Number of families reported being referred and having received an additional evaluation*
0 -12 months				
13-24 months				
25- 36 months				
37-48 months				
49-60 months				
61-72 months				

5. **a. Developmental Screening:** In this data field, you will enter the number of children that were screened for developmental delay by age breakout of birth thru 12 months, 13 to 24 months, 25 to 36 months, 37 to 48 months, 49 to 60 months, and 61 to 72 months.

   b. Results forwarded to medical home: In this data field, please enter the number of children whose results were forwarded to a medical home (physician of record) by age breakout.

   c. Referred for follow up: In this field, please enter the number of children that were referred for follow-up after being screened by age breakout.

   d. Number of families reported being referred and having received an additional evaluation: In this field, please enter the number of families that reported being

referred after initial screening and having received an addition evaluation by the children's age breakout.

Developmental Screening	*Screened*	*Results forwarded to medical home (physician of record)*	*Referred for follow-up*	*Number of families reported being referred and having received an additional evaluation*
0 -12 months				
13-24 months				
25- 36 months				
37-48 months				
49-60 months				
61-72 months				

Health Insurance Enrollment Assistance

6. **Are you providing Health Insurance Enrollment Assistance as part of your program?** In this data field you will choose either **Yes or No.** *If **YES**, please indicate for families that you serve the numbers that are uninsured or underinsured and those who received enrollment assistance to obtain insurance.*
    a. ***Number of families served who are not covered by private insurance, AHCCCS, Indian Health Services, or Kids Care____**
    b. ***Number of families served who report they are underinsured_____**
    c. ***Number of families served who report lack of insurance or underinsurance who received enrollment assistance to obtain insurance_____**

Referrals to Health Care and Low cost Care Providers

7. **Are you providing Referrals to Health Care and Low cost Care Providers as part of your program?** In this data field you will choose either **Yes or No.** *If **YES**, please indicate for families that you serve the numbers that received referrals to the following agencies.*
    a. ***Number of families referred to Indian Health Services (IHS)/Indian Tribal Urban (ITU)____**
    b. ***Number of families referred to free or low cost care service providers____**
    c. ***Number of families referred to AHCCCS or DES to receive health coverage_____**

Frequently Asked Questions

Frequently Asked Questions present answers to common reporting, evaluation, policy, and performance questions.

For **Developmental & Health Screening,** the frequently asked questions are:

In development

FIRST THINGS FIRST
The right system for bright futures

pgms partner grant management system

Evaluation Report

CONTRACT DATES
7/1/2010
TO
7/31/2010

TEST PRODUCTION AGENCY (APPS)

Address: Parter Address Agency Details
Test City, AZ 85032

Contract ID: GRA-STATE-10-0218-01

View Reporting Instructions and FAQ

GENERAL INFORMATION

User Completing Report AZFTF\mshahi

Reporting Period Month 7 Year 2010

Regional Partnership Council State

Status In Progress

Date Completed

Public Awareness Activity

Are you conducting any public awareness activities as part of your program?* ○ Yes ◉ No

If yes, please select from the list which activities you conduct as part of your program. Select as many as apply, and report the number of people reached through the selected activities. Refer to the instructions for a definition of each activity type. Plese skip any activity that does not pertain to your program.

Activity	Number of People Reached
☐ Media impressions	
☐ Provision of written materials	
☐ Group meetings	
☐ One to one interactions	

Service Provisions Venue:

Please select from the list, the venue of where developmental screenings took place. You can select as many venues as applicable.

- ☐ Mobile play-based unit
- ☐ Center based Child care/ Home based child care
- ☐ Other Community Setting

- ? Community Health Clinic/Hospital
- ? Schools (charter or district)
- ? Other (please specify)

Service Delivery:

Please report the number of children receiving the following screenings.

Hearing:

	Screened	Results forwarded to medical home (physician of record)	Referred for follow-up	Number of families reported being referred and having received an additional evaluation
0-12 months				
13-24 months				
25-36 months				
37-48 months				
49-60 months				
61-72 months				

Vision:

	Screened	Results forwarded to medical home (physician of record)	Referred for follow-up	Number of families reported being referred and having received an additional evaluation
0-12 months				
13-24 months				
25-36 months				
37-48 months				
49-60 months				
61-72 months				

Developmental Screening:

	Screened	Results forwarded to medical home (physician of record)	Referred for follow-up	Number of families reported being referred and having received an additional evaluation
0-12 months				
13-24 months				
25-36 months				
37-48 months				
49-60 months				
61-72 months				

Health Insurance Enrollment Assistance

Are you providing Health Insurance Enrollment ○ Yes ○ No

Assistance as part of your program?

If Yes please indicate for families that you serve the numbers that are uninsured or underinsured and those who received enrollment assistance.

Number of Families Served Who Are Not Covered by Private Insurance, AHCCCS, Indian Health Services or Kids Care

Number of Families Served Who Report They Are Underinsured

Number of Families Served Who Report Lack of Insurance or Underinsurance Who Received Enrollment Assistance to Obtain Insurance

Referrals to Health Care and Low Cost Care Providers

Are you providing Referrals to Health Care and Low cost Care Providers as part of your program? ○ Yes ○ No

If Yes, please indicate for families that you serve the numbers that received referrals to the following agencies.

Number of families referred to Indian Health Servicces (IHS)/Indian Tribal Urban (ITU)

Number of families referred to Free or Low Cost Care Service Providers

Number of families referred to AHCCCS or DES Health to Receive Health Coverage

GOAL AREA: HEALTH

STRATEGY NAME: DEVELOPMENTAL SCREENING: PLAY-BASED MOBILE EARLY EDUCATION

GOAL:

- **FTF will expand use of early screening in health care settings to identify children with developmental delay**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Mobile unit brings play-based activities to serve as parent educational outreach, facilitated family support, and child development screening to local communities and neighborhoods. Sets up a traveling classroom or play experience where caregivers and children come together in a park or community center and includes therapists or other professionals who are available to provide child development questionnaires or screening activities. Also provides for facilitated family support on building caregivers' abilities to support children's optimal growth and development. Information on child development and play supports are provided to parents and caregivers, and social service connections/referrals are made when necessary. Additional community information (e.g. location of local play groups, library programs, or Quality First! participating child care centers/homes) is available to parent and caregivers as desired.	This strategy is modeled after a successful Hawaii program serving homeless families along the island beach areas. The current programs address highly isolated families and may work well for highly rural communities of Arizona. For more information see: Ka Pa'alana Program in Hawaii	Include considerations, such as: • An initial cost may include the purchase of a vehicle and would require an initial year budget significantly greater than the renewal year budgets. • Additional startup costs would include materials and small items of furniture that would then be used through the duration of the grant period. Therefore, future funding may be reduced. • Appropriate groups to administer such a program must have a significant connection and understanding of the available community resources and early intervention/IDEA Part B services. • Requires attachment of both the Developmental Screening Standards of Practice along with the Play Based Mobile Unit Supplemental Activities attachment.	Purchase of a vehicle may be needed and require between $90-100,000.00 dollars initially. Additional startup costs would include materials for the play-based/preschool activities of the program. Materials could run around $50,000.00 $100,000-$150,000 per year for service delivery

Policy Specialist: Allison Landy

STANDARDS OF PRACTICE[1]

Developmental Screening Administration Practices

I. Description of Strategy

As part of a comprehensive system of services to families, some strategies may include the administration of a developmental screening to assist parents and other caregivers in identifying children who may be in need of additional intervention or support services. Developmental screening activities are an integral component of a larger early childhood system and only provide a small snapshot of children's abilities. Though brief, screening is comprehensive in that it includes a review of children's development in the cognitive, communication, physical, social-emotional and adaptive domains.

First Things First has adopted the following guidance to align with the recommended practices and support the system as a whole.

II. Developmental Screening Administration includes the following activities:

- Obtainment of parental consent.
- Administration of a developmental screening instrument.
- Observation of children in their natural setting where they are comfortable and involved in typical activities and routines such as meals, interactions with siblings, etc.
- Discussion with parents regarding their child's development.
- Interpretation and analysis of screening, observation and discussion results.
- Review of screening results with families.
- Referrals made as necessary to AzEIP, local schools, health care providers, behavioral health professionals, or other community resources.
- Coordination of services with other providers (health professionals, AzEIP providers, etc.) to ensure non-duplicative, collaborative activities.

III. Developmental Screening Administration Standards:

Screening Locations

- Screenings optimally occur in settings that are closely aligned to a child's natural environment (home, child care center, etc).
- Screening is conducted where there are minimal distractions (e.g. no television or radio playing), but in a setting where the child can be observed while participating in naturally occurring activities and routines.

[1] [1] The Developmental Screening Administration Standards of Practice includes supplemental standards to address the unique activities of a Mobile Play Based Family Outreach program inclusive of developmental screening activities. The appropriate supplemental standards should be attached along with the general standards.

Screening Tools

- Screening tools used may be either criterion or norm-referenced, but chosen because they are the most appropriate option for use with the child and/or population being screened.
- If using standardized tools (with children ages three – five), instruments must demonstrate at least a .80 reliability level.
- Screening tools used must be age and individually appropriate, ensuring that the cognitive and motor skills required for participation appropriately match the age of the child.
- Screening tools are comprehensive and assess children in all developmental domains: cognition, communication, physical, social-emotional, and adaptive.
- Screening tools for children three to five are designed to capture and hold a child's interest at an age appropriate level while minimizing distraction from other stimuli (approved tools for birth – three are parent report instruments).
- Screening tools used with children birth to three must be approved for use by DES/AzEIP (see Attachment A).

Conducting Screening

- Screening is conducted only after determining that no other screening has occurred within the last three months.
- Parent or guardian consent to screening is required before screening can occur.
- A procedure is in place to assess what other services are being received by the family and to coordinate screening with other providers that may be responsible for the same or similar activities.
- Screening is conducted only if no other entity has conducted a screening within the last three months.
- Screening must include soliciting parent and/or caregiver input beyond use of simple questionnaires.
- Screening must occur in the child and family's primary language.
- Screenings should be combined with additional confirmatory information (parent input, observations, etc).
- A parent or other designated caretaker is present for all screening procedures conducted through home visitation or mobile screening activities.

Referral Services

- When children's screening results indicate they are suspected of having a delay, parents must be informed immediately.
- Families are provided with the contact information of the appropriate referral designation (AzEIP, health care provider, school district).
- If screening is conducted as a component of home visitation, home visitors follow up with families during each subsequent visit to track progress of referral.
- If barriers arise for the family to access additional evaluation services, the home visitor or other program specialist assesses the family needs and assists the family in identifying ways to remove such barriers.

Training and Qualification Standards

Conducting developmental screening requires specific education and skills.

- Educational level: minimum of a bachelor's degree in child development, nursing, early childhood education, child and family studies, or closely related field is ***preferred.***

- All individuals conducting developmental screening will obtain and maintain certification and/ or required training on all of the chosen methods and tools used in screening activities and attend re-certification or additional training courses as required by the tool, the instrument developers, and as it is determined necessary through supervision.

- Personnel who do not meet the preferred education level or are newly trained in developmental screening activities, may only administer developmental screening under the direct supervision of an individual who does meet the training and qualifications standards until it can be documented that the person conducting screening can do so in a reliable manner. This level of supervision is above and beyond the regular supervision activities required in the First Things First Home Visitation or other Standards of Practice. The supervisor will participate with the home visitor or program specialist in conducting screenings and review all completed screening instruments until the home visitor or program specialist is able to consistently conduct screening in a reliable manner. This can be documented in staff's personnel file and family files.
- Areas of knowledge and competencies must be demonstrated in:
    a. Typical and atypical child development
    b. Routines based interviewing practices (see http://www.fpg.unc.edu/~inclusion/RBI.pdf)
    c. Objective child observation
    d. Appropriate assessment of young children

- Individuals conducting screening will participate in continuing education to remain current and update skills and knowledge regarding developmental screening procedures and child development to meet the requirements of this scope of work.

- To address cultural competency objectives, programs shall ensure that providers, children and families receive from all personnel effective, understandable, and respectful services that are provided in a culturally competent manner- a manner compatible with their cultural beliefs and practices and preferred language. Consultants should receive ongoing education and training in culturally and linguistically appropriate service delivery. Consultants should develop participatory, collaborative partnerships with providers and their communities and utilize a variety of formal and informal mechanisms to facilitate community and family-centered involvement in designing and implementing the National Standards on Culturally and Linguistically Appropriate Services.

- Individuals conducting screening receive training and information regarding mandatory reporting. Arizona law requires early care and education staff who suspect that a child has received non-accidental injury or has been neglected, to report their concerns to Child Protective Services or local law enforcement (ARS §13-3620.A).

Supervision, Quality Assurance and Evaluation Standards

- Supervision of individuals who administer developmental screening activities is conducted as a collaborative process with mechanisms that support them in challenging situations and provides ongoing and regularly scheduled (no less than monthly) opportunities for discussion to reflect and debrief. Supervision will also include observation, feedback and opportunities for peer consultation.
- Evaluation of home visitation and developmental screening services utilizes quantitative and qualitative process that includes measures of how effectively children are being identified as early as possible for additional intervention and/or support services.
- Compensation and benefits are adequate for supporting high quality staff and retention of that staff.

Supplemental Implementation Activity Standards for Mobile Play-Based Outreach, Education, and Screening Programs

1. Activities presented by the mobile unit are conducted using parent and child interactive learning opportunities and provide a range of developmentally appropriate materials to support children's comprehensive development in the physical, cognitive, language/communication, social-emotional, and adaptive skills domains.
2. Mobile units maintain schedules that are consistent, predictable, and planned so that families know when and where to expect the mobile unit to arrive.
3. Locations of mobile units are the same throughout the service delivery period. For example, the unit may be available at the local library every third Tuesday of the month. Both the location and the time remain consistent.
4. The mobile unit focuses on interactive learning and also provides opportunities for children to receive developmental screening before or after the planned play activities are conducted. Exceptions for conducting screening during the course of play activities are when screening includes use of observations of children in naturally occurring activities and play situations.
5. Families are provided educational opportunities regarding children's developmental milestones and age appropriate expectations.
6. Information on child development and ways to support that development through play and daily activities and routines is provided as a component of the curriculum.
7. Additional community information (e.g. location of local support groups, library programs, Quality First participating programs, etc.) is made available to parents and caregivers as needed and/or requested.
8. Families who require a referral based on developmental screening results are provided with assistance in locating and accessing sensory (hearing and vision) screening as part of the referral process.

Attachment A

Approved Tools for Screening Children Birth-Age Three

1. The core team uses screening processes, as appropriate, with an AzEIP-approved screening tool. The following screening tools are approved to determine whether a child is suspected of having a developmental delay:
   a. PEDS (Parents Evaluation of Developmental Status)
   b. Ages and Stages Questionnaire
   c. Ages and Stages Questionnaire: Social Emotional Scale (this tool would need to be supplemented by another tool to ensure all areas of development are covered)
   d. Battelle Developmental Inventory Screening Test.

Excerpt from the DES/AzEIP TBM Manual, Chapter 4

Developmental & Health Screening Data Reporting Requirements

First Things First reporting requirements and progress monitoring are aligned with First Things First Goals, Key Measures, and Standards of Practice. The purpose of First Things First data submission and monitoring is to determine the extent to which each program has accomplished the stated goals, key measures, targeted service number, and activities outlined in the standards of practice.

Grantees will be provided with data reporting requirements by First Things First. There are five main components to data reporting:

- Unit of Service
- Performance Measures
- Data Reporting Template
- Data Reporting Instruction
- Frequently Asked Questions

The data reporting template captures the set of data the grantee submits on a quarterly basis; the instructions support that data submission. Units of Service and performance measures outline how the quarterly data submissions will be evaluated according to the contracted deliverables and standards of practice for that contract. Frequently asked questions present answers to common reporting, evaluation, policy, and performance questions.

Definitions:

Unit of Service and related Target Service Number

A Unit of Service is a FTF designated indicator of performance specific to each FTF strategy. It is composed of a unit of measure and a number (Target Service Number).

A Unit of Measure/Service can be a target population and/or a service/product that a grantee is expected to serve as part of an agreement. Target Service Number represents the number of units (e.g. target population) proposed to be served or number of products/services proposed to be delivered during the contract year.

For example, for the FTF strategy Home Visitation the FTF Unit of Service is “number of families served” and a Target Service Number of 50 represents the number of families the program proposes to serve during the contract period. All FTF applicants must clearly state in the proposal a target service number for each strategy specific Unit of Service.

For **Developmental & Health Screening,** the units of service are:

Total number of children screened for developmental delays
Total number of children screened for vision and hearing

Performance Measures

Performance Measures measure (1) key indicators of performance (i.e. Unit of Service); (2) basic implementation of strategy; (3) alignment of program activities to strategy specific standards of practice, (4) performance or progress toward pre-established strategic goals. Performance measures may include the level or type of program activities conducted (e.g. serving families/children through home visits) and/or the direct services and products delivered by a program (e.g., providing scholarships).

For **Developmental & Health Screening,** performance measures are:

Total number of children screened for developmental delays/proposed service number
Total number of children screened for vision and hearing/proposed service number
Total number of awareness sessions conducted/proposed service number
Total number of people reached by awareness sessions/proposed service number
Total number of families receiving referrals for health insurance or health coverage enrollment/ target service number

Data Reporting Templates

Data reporting templates are the tools utilized to gather data to assess grantee Performance Measures. All FTF grantees submit data on a quarterly basis through designated data reporting templates.

For **Developmental & Health Screening,** the data reporting template is:

FIRST THINGS FIRST
The right system for bright futures

pgms partner grant management system

Evaluation Report

CONTRACT DATES
7/1/2010
TO
7/31/2010

TEST PRODUCTION AGENCY (APPS)

Address: Parter Address Agency Details
Test City, AZ 85032

Contract ID: GRA-STATE-10-0218-01

View Reporting Instructions and FAQ

GENERAL INFORMATION

User Completing Report AZFTF\mshahi

Reporting Period Month 7 Year 2010

Regional Partnership Council State

Status In Progress

Date Completed

Public Awareness Activity

Are you conducting any public awareness activities as part of your program?* ○ Yes ◉ No

If yes, please select from the list which activities you conduct as part of your program. Select as many as apply, and report the number of people reached through the selected activities. Refer to the instructions for a definition of each activity type. Plese skip any activity that does not pertain to your program.

Activity	Number of People Reached
☐ Media impressions	
☐ Provision of written materials	
☐ Group meetings	
☐ One to one interactions	

Service Provisions Venue:

Please select from the list, the venue of where developmental screenings took place. You can select as many venues as applicable.

- ☐ Mobile play-based unit
- ☐ Center based Child care/ Home based child care
- ☐ Other Community Setting

- ? Community Health Clinic/Hospital
- ? Schools (charter or district)
- ? Other (please specify)

Service Delivery:

Please report the number of children receiving the following screenings.

Hearing:

	Screened	Results forwarded to medical home (physician of record)	Referred for follow-up	Number of families reported being referred and having received an additional evaluation
0-12 months				
13-24 months				
25-36 months				
37-48 months				
49-60 months				
61-72 months				

Vision:

	Screened	Results forwarded to medical home (physician of record)	Referred for follow-up	Number of families reported being referred and having received an additional evaluation
0-12 months				
13-24 months				
25-36 months				
37-48 months				
49-60 months				
61-72 months				

Developmental Screening:

	Screened	Results forwarded to medical home (physician of record)	Referred for follow-up	Number of families reported being referred and having received an additional evaluation
0-12 months				
13-24 months				
25-36 months				
37-48 months				
49-60 months				
61-72 months				

Health Insurance Enrollment Assistance

Are you providing Health Insurance Enrollment ○ Yes ○ No

Assistance as part of your program?

If Yes please indicate for families that you serve the numbers that are uninsured or underinsured and those who received enrollment assistance.

Number of Families Served Who Are Not Covered by Private Insurance, AHCCCS, Indian Health Services or Kids Care

Number of Families Served Who Report They Are Underinsured

Number of Families Served Who Report Lack of Insurance or Underinsurance Who Received Enrollment Assistance to Obtain Insurance

Referrals to Health Care and Low Cost Care Providers

Are you providing Referrals to Health Care and Low cost Care Providers as part of your program? ○ Yes ○ No

If Yes, please indicate for families that you serve the numbers that received referrals to the following agencies.

Number of families referred to Indian Health Servicces (IHS)/Indian Tribal Urban (ITU)

Number of families referred to Free or Low Cost Care Service Providers

Number of families referred to AHCCCS or DES Health to Receive Health Coverage

Data Reporting Instructions

Data reporting instructions support data submission through the data reporting template.

For **Developmental & Health Screening**, the data reporting instructions are:

INFORMATION

Your data report is always due on the 20th day of the month following the end of each quarter. Each quarterly submission will include information for the entire quarter broken out by month. Each data report submitted will include information for the entire preceding quarter.

1st Quarter – July-September – Report due October 20
2nd Quarter – October-December – Report due January 20
3rd Quarter – January-March – Report due April 20
4th Quarter – April- June – Report due July 20

- Data should be only reported for services funded by First Things First.
- Data should be reported for each Regional Partnership Council area in which contracted services are provided. For example, if your community based training program is contracted to provide services in both Central Maricopa and Northeast Maricopa regions, two separate reports must be submitted.

OVERVIEW

- For each reporting period, enter all data for all Regional Partnership Council areas served.
- For each quarter, **data should be tallied for each month of service.**
- Your final data submission for the quarter cannot be completed until you complete all monthly reports.

DIRECTIONS FOR DATA ENTRY

Public Awareness Activity

1. *** Are you conducting any public awareness activities as part of your program?** In this data field you will choose either **Yes or No**. *If **YES**: Please select from the list the activities you conduct as part of your program. You can select as many activities as needed. After an activity type is selected, please report the number of people reached through the specific activity. You may skip any activity that does not pertain to your program.*
    a. Media impression is defined as the number of people reached with media campaigns.
    b. Provision of written materials is defined as the number of people receiving pamphlets, etc.

c. Group meetings.
d. One to One interactions.

Service Provisions Venue: *select the venue of where developmental screenings occurred*

2. **Please select from the list below the venue of where developmental screenings occurred.** *You can select as many venues as applicable*.
   - ☐ Mobile play based unit
   - ☐ Center based Child care/ Home based child care
   - ☐ Other Community Setting
   - ☐ Community Health Clinic/ Hospital
   - ☐ Schools (charter or district)
   - ☐ Other (please specify): _____

Service Delivery: Number of children receiving the following screenings

Please indicate for children that you serve the numbers of that received screenings, referrals and follow ups in the following types of tests by age breakout.

3. **a. Hearing - Screening:** In this data field, you will enter the number of children that were screened for hearing by age breakout of birth thru 12 months, 13 to 24 months, 25 to 36 months, 37 to 48 months, 49 to 60 months, and 61 to 72 months.

   b. Results forwarded to medical home: In this data field, please enter the number of children whose results were forwarded to a medical home (physician of record) by age breakout.

   c. Referred for follow up: In this field, enter the number of children that were referred for follow-up by age breakout.

   d. Number of families reported being referred and having received an additional evaluation: In this field, please enter the number of families that reported being referred after initial screening and having received an addition evaluation by the children's age breakout.

Hearing	*Screened*	*Results forwarded to medical home (physician of record)*	*Referred for follow-up*	*Number of families reported being referred and having received an additional evaluation*
0 -12 months				
13-24 months				
25- 36 months				
37-48 months				
49-60 months				

61-72 months				

4. **a. Vision - Screening:** In this data field, you will enter the number of children that were screened for vision by age breakout of birth thru 12 months, 13 to 24 months, 25 to 36 months, 37 to 48 months, 49 to 60 months, and 61 to 72 months.

   b. Results forwarded to medical home: In this data field, please enter the number of children whose results were forwarded to a medical home (physician of record) by age breakout.

   c. Referred for follow up: In this data field, please enter the number of children that were referred for follow-up after being screened by age breakout.

   d. Number of families reported being referred and having received an additional evaluation: In this field, please enter the number of families that reported being referred after initial vision screening and having received an addition evaluation by the children's age breakout.

Vision	*Screened*	*Results forwarded to medical home (physician of record)*	*Referred for follow-up*	*Number of families reported being referred and having received an additional evaluation*
0 -12 months				
13-24 months				
25- 36 months				
37-48 months				
49-60 months				
61-72 months				

5. **a. Developmental Screening:** In this data field, you will enter the number of children that were screened for developmental delay by age breakout of birth thru 12 months, 13 to 24 months, 25 to 36 months, 37 to 48 months, 49 to 60 months, and 61 to 72 months.

   b. Results forwarded to medical home: In this data field, please enter the number of children whose results were forwarded to a medical home (physician of record) by age breakout.

   c. Referred for follow up: In this field, please enter the number of children that were referred for follow-up after being screened by age breakout.

   d. Number of families reported being referred and having received an additional evaluation: In this field, please enter the number of families that reported being

referred after initial screening and having received an addition evaluation by the children's age breakout.

Developmental Screening	*Screened*	*Results forwarded to medical home (physician of record)*	*Referred for follow-up*	*Number of families reported being referred and having received an additional evaluation*
0 -12 months				
13-24 months				
25- 36 months				
37-48 months				
49-60 months				
61-72 months				

Health Insurance Enrollment Assistance

6. **Are you providing Health Insurance Enrollment Assistance as part of your program?** In this data field you will choose either **Yes or No.** *If **YES**, please indicate for families that you serve the numbers that are uninsured or underinsured and those who received enrollment assistance to obtain insurance.*
    a. ***Number of families served who are not covered by private insurance, AHCCCS, Indian Health Services, or Kids Care____**
    b. ***Number of families served who report they are underinsured_____**
    c. ***Number of families served who report lack of insurance or underinsurance who received enrollment assistance to obtain insurance_____**

Referrals to Health Care and Low cost Care Providers

7. **Are you providing Referrals to Health Care and Low cost Care Providers as part of your program?** In this data field you will choose either **Yes or No.** *If **YES**, please indicate for families that you serve the numbers that received referrals to the following agencies.*
    a. ***Number of families referred to Indian Health Services (IHS)/Indian Tribal Urban (ITU)____**
    b. ***Number of families referred to free or low cost care service providers____**
    c. ***Number of families referred to AHCCCS or DES to receive health coverage_____**

Frequently Asked Questions

Frequently Asked Questions present answers to common reporting, evaluation, policy, and performance questions.

For **Developmental & Health Screening,** the frequently asked questions are:

In development

GOAL AREA: HEALTH

STRATEGY NAME: DEVELOPMENTAL SCREENING – COALITION BUILDING

GOAL:

- **FTF will expand use of early screening in health care settings to identify children with developmental delay; FTF will advocate for timely and adequate services for chidren identified through early screening.**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
This strategy supports community coalition building in an effort to enhance and improve early identification systems for children birth through age five and their families. Effective coordination and collaboration activities take careful planning and a significant investment of time. Before establishing a community coalition, assessment of the collaborating partners' readiness and determination of specific program objectives should occur. Various tools can be used to assess readiness to collaborate. Among the items evaluated in a readiness assessment are: • existence of a shared vision and coalition objectives; • inclusion of key organizational and individual stakeholders; and • leadership capacity. Coalition strategies may also include capacity building that increases the readiness of individuals, organizations, and communities to engage in meaningful collaboration efforts.	We will be gathering evidence as this strategy is implemented in the two regions currently funding it.	• A grant agreement is in development with the Arizona Department of Education to provide administration of coalition development among districts and other stakeholders in the local communities. • Councils may consider entering into the agreement with ADE or they may go with a more grassroots and local effort. To determine which direction the council wishes to go, consider the following: how well organizations, community agencies and school districts work together in the region. Also, consider whether ADE has a strong relationship with districts in the region and would be welcomed as a group facilitator. Finally, consider whether this could be forwarded as a grant agreement or a competitive process.	Requires staffing of the coalition by a coordinator – salary and ERE. May require costs for marketing materials and advertisement. May require costs for consultants or other facilitators Minimum recommended amount 150,000.

Policy Specialist: Allison Landy

FIRST THINGS FIRST
Coalition Building
Standards of Practice[1]

Every community experiences gaps in services to young children, often around the areas of prevention and intervention of developmental and health problems. Identifying and addressing those problems can happen in a variety of ways both formally and informally. Sometimes a gap may be identified through a formal community assessment, other times members of the community themselves begin to see a problem developing and want to intervene proactively. Often, multiple service agencies in a given community offer parent education, health education, prevention information and other interventions aimed at addressing the identified community concerns. Many times these agencies may be providing services to the same populations, or working to address the same problems. Though good work is being done, by collaborating together, more might be accomplished. Historically, when addressing community level problems, coalitions have been an effective way to organize and leverage resources. According to the Prevention Institute, "A coalition is a union of people and organizations working to influence outcomes on a specific problem. Coalitions are useful for accomplishing a broad range of goals that reach beyond the capacity of any individual member organization. These goals range from information sharing to coordination of services, from community education to advocacy for major environmental or policy (regulatory) changes." The benefits of forming and maintaining effective coalitions include; reducing duplication of services, leveraging resources, strengthening bargaining power, and getting "buy in" from community members.

First Things First is interested in supporting community coalition building in an effort to enhance and improve support systems for children birth through age five and their families. Specifically, First Things First would like to support coalitions working toward the improvement of prevention, intervention, and other family supports.

II. Coalition Building Standards

A variety of coalition building models and guides exist. Though they may differ in their specific steps, they do have many common guidelines that may assist those interested in forming and maintaining a coalition to be successful. The development of preventive health and/or child find coalitions involves both coordinated and collaborative efforts. As outlined in the First Things First Coordination and Collaboration Standards of Practice, these two, integral characteristics of effective coalitions are defined as follows:

Coordination: Involves more formal relationships in response to an established mission. Coordination involves some planning and division of roles and opens communication channels

[1] The Coalition/Collaborative Building Standards of Practice includes supplemental standards to address the specific types of coalitions and/or collaborations being established such as Child Find or Preventive Health. The appropriate supplemental standards should be attached along with the general standards.

between organizations. Authority rests with individual organizations, however, risk increases. Resources are made available to participants and rewards are shared.

Collaboration: A more durable and pervasive relationship marks collaboration. Participants bring separate organizations into a new structure with often a formal commitment to a common mission. The collaborative structure determines authority. Risk is greater. Partners pool or jointly secure resources, and share the results and rewards.

Coalition Planning Standards

Effective coordination and collaboration activities take careful planning and a significant investment of time. Before establishing a community coalition, assessment of the collaborating partners' readiness and determination of specific program objectives should occur. Various tools can be used to assess readiness to collaborate. Among the items evaluated in a readiness assessment are:

- existence of a shared vision and coalition objectives;
- inclusion of key organizational and individual stakeholders; and
- leadership capacity.

Having a clear understanding of the factors that impact successful collaboration will help direct initial collaboration efforts. In fact, coalition strategies may also include capacity building that increases the readiness of individuals, organizations, and communities to engage in meaningful collaboration efforts.

Coalition Recruitment

Including the people who both have the skills and the knowledge of the coalition goals as well as the capacity to effectuate change is a key component to successful coalition development. FTF coalition members will be recruited to ensure a broad membership of local level, community individuals as well as those who represent a wide array of service providers and service types. It is important to convene people with diverse perspectives who can then create a vision and clarify coalition expectations, including small neighborhood-based organizations which often help families navigate complex and fragmented service delivery systems. Coalitions should identify both the organizations and the individuals who would be best suited to the work in considering appropriate recruitment.

Establishing Coalition Objectives

Meaningful objectives and activities developed by the coalition are ones that satisfy both the community needs as well as the needs of the participating individuals and agencies. Objectives shall be established by the coalition to set direction and should arise from the shared beliefs of the group. Objectives should include both long-term goals and short-term benchmarks.

Convening a Coalition

Coalition activities shall be conducted in a way that each members' participation is valued and appreciated.

1. Members should all understand the purpose of the coalition
2. Members should understand each of their roles as participants in the coalition
3. Members should understand what resources they bring to the coalition to meet the group's goals and objectives

Structure of the Coalition

Determining how the structure of the coalition is established and maintained is integral to the coalition's success. Coalition members must agree and commit to several structural elements of the coalition. FTF funded coalitions will outline their intended structure as part of the initial planning process. The structural components included in the planning and design of coalitions are:

1. Life expectancy of the coalition: Determining a specific timeframe during which a coalition must conduct its work leads to more successful action and task completion. Coalitions determine their life expectancy based on their group's goals and desired outcomes.
2. Location, frequency and duration of meetings: Meetings occurring at locations seen as "neutral" or not belonging to a particular representation of the coalition adds to the sense of collaboration and openness among members. Coalitions should convene at locations where all members feel a sense of equity. The frequency of meetings is to be determined by the coalition, but may not be less than quarterly. Coalitions that choose to meet more than quarterly, must consider how frequency of meetings may affect members' commitment to the work. Duration of meetings should also be determined by the coalition with the consideration that members will need enough time to accomplish the work in the strategic plan developed.
3. How new members are included: Coalitions should invite and recruit members following the recruitment standards. However, no member should be excluded who shows an interest in the coalition's work and goals.
4. Decision-making processes and procedures: Decisions within the coalition should be made by consensus whenever possible. Recognizing that all members of a coalition may not always agree, coalitions will need to establish how action will be handled when consensus cannot be reached (e.g. by vote, choose not to take action, etc)
5. Meeting Agendas: Establishing meeting agendas in advance provides for structure and direction of meetings. Each meeting will require a clear agenda to be developed and distributed to coalition members in advance of meetings.
6. Participation between meetings: To move long-range goals forward quickly, sub-committees of the coalition may be established. Creating sub-committees will add to the

Ensuring Continuous Progress

To ensure the coalition's success, a process of ongoing self-assessment of the group's work should be used. Conducting a process of reflection throughout the coalition's activities allows the group to adapt and make decisions about elements that may not be working as effectively as desired. This process of monitoring of one's own progress is essential to maintaining the group's productivity and ensuring timely and effective actions.

III. Coalition Coordinator Qualifications Standards

1. Requirements of the Coalition Coordinator must hold a Bachelors degree in a field related to the purpose of the coalition (e.g. if a Child Find Coalition, degree would be in child development, early childhood special education, or other related field; if a Health Prevention Coalition, degree would be in public health, nursing, or other related field) OR have documented work experience conducting the activities of leading a coalition such as member recruitment, strategic planning, facilitation of groups and group dynamics, and evaluation OR a combination of education and experience that meets the necessary knowledge and expertise of the position.
2. Coalition Coordinators should have expertise and knowledge in the following:
    a. Community building and development;
    b. Knowledge of human services systems;
    c. Principles of advocacy and social marketing;
    d. Experience in facilitation of coordination and collaboration; and
    e. Knowledge of and experience with tools and resources to assess systems coordination.

3. To address cultural competency objectives, early childhood practitioners /early childhood service providers shall ensure that children and families receive from all staff members effective, understandable, and respectful care that is provided in a culturally competent manner- a manner compatible with their cultural beliefs and practices and preferred language. Early childhood practitioners /early childhood service providers should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. Early childhood practitioners/early childhood service providers should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and family-centered involvement to ensure that services are delivered in a manner that is consistent with the National Standards on Culturally and Linguistically Appropriate Services and/or the National Recommendations on Cultural and Linguistic Competence for the National Association for the Education of Young Children."

IV Supervision, Quality Assurance and Evaluation Standards

1. Effective programs recognize that building and maintaining quality requires an ongoing and iterative process. Participants and their respective partners shall conduct ongoing, reflective practices that continuously assess the quality and effectiveness of the implementation of the coalition.
2. Supervision of program personnel coordinating the efforts of the coalition is conducted as a relationship-based process with mechanisms that support them in challenging situations and provides ongoing and regularly scheduled (no less than monthly) opportunities for discussion to reflect and debrief**.** Supervision will also include observation, feedback, and opportunities for peer consultation.
3. Compensation and benefits for the personnel coordinating the efforts of the coalition are adequate to support the hiring and retention of highly skilled staff.

V. Coalition Building Implementation Activities

Stakeholders in any coalition building effort will:

1. Establish the overall objectives of the coalition
2. Develop a leadership structure
3. Develop a membership structure
4. Establish a membership recruiting plan
5. Determine the specific activities the coalition will participate in
6. Assess the collective resources of the group
7. Establish a plan to communicate with members, stakeholders and the community
8. Develop a plan of accountability for members
9. Develop a brand
10. Plan to address conflict between members
11. Monitor progress through evaluation and make any necessary changes

Supplemental Implementation Activity Standards for Child Find Coalitions

1. Identify partners necessary to create a comprehensive coalition to include community early childhood programs, AzEIP providers, Head Start programs, any tribal programs within the community, health care providers, and other community based organizations that serve young children and/or families.
2. Identify current activities in the community (asset mapping) that address public awareness and marketing campaigns for locating children who may be in need of additional services.
3. Identify current screening opportunities and procedures among the districts and AzEIP providers within the region.
4. Identify any other sources of screening or public awareness and education activities occurring in the community
5. Identify remaining gaps in the public relations/marketing and screening activities occurring in the region.
6. Identify the needs around informing and educating families in the typical development of children, the availability of developmental and/or sensory screening, and the processes for referral.
7. Based on identified gaps and community needs, develop and implement a plan to address parent awareness and understanding of children's typical development and where to access screening and identification services, enhanced screening services, and/or marketing and public relations related to availability of screening and intervention services.
8. Engage local health care providers of family services such as physicians, hospitals, etc. in building their understanding of the importance of and availability of developmental screening and the process for referral.
9. Engage local early care and education providers in the process of recognizing children's developmental red flags, increasing their knowledge of developmental screening activities, and understanding the process for referral.
10. Develop strategies for transitions between and across district attendance boundaries.
11. Develop and implement recommendations for public relations activities and screening activities that increase the communities' access to services for young children.

GOAL AREA: HEALTH

STRATEGY NAME: DEVELOPMENTAL SCREENING: COMMUNITY BASED SCREENING

GOAL:

- **FTF will expand use of early screening in health care settings to identify children with developmental delay**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Through this strategy, developmental screening is made available to children birth through age five, with an emphasis on early identification of children birth-age three. Screening activities must align with current state systems, AzEIP and IDEA Part B administered through ADE. Screening is conducted in local, easy to access community locations, but not in isolation of the larger medical and educational community as a whole.	Little evidence of the success of community based screening activities exists. Instead information supports improving the coordination of IDEA early identification practices through school-based and early intervention programs.	Include considerations, such as: • While many children may get screened through community based programs, little follow-up and/or comprehensive services are typically available. This creates a service conducted in isolation rather than through a system. In addition, duplication of services is more likely under this strategy. To address this: o Community based programs need to demonstrate knowledge of the greater system as a whole and how services will be coordinated with local medical providers, AzEIP providers, and school-based programs. o A more rigorous level of monitoring from FTF would be required. • This strategy is effective/appropriate only in highly rural communities, though it is recommended that councils consider other methods to improve coordination first, such as the coalition-building strategy in S. Phoenix and NW Maricopa regions. • Capacity to conduct screening may be hindered by the lack of skilled individuals to effectively screen children.	Majority of cost is in administration and travel through rural communities. Actual cost of screening is minimal. Considered costs for: • Screening Tool purchase (cost dependent on tool) • Travel expenses at state rate. • Salary for program administrator and screening administrators

Policy Specialist: Allison Landy

STANDARDS OF PRACTICE[1]

Developmental Screening Administration Practices

I. Description of Strategy

As part of a comprehensive system of services to families, some strategies may include the administration of a developmental screening to assist parents and other caregivers in identifying children who may be in need of additional intervention or support services. Developmental screening activities are an integral component of a larger early childhood system and only provide a small snapshot of children's abilities. Though brief, screening is comprehensive in that it includes a review of children's development in the cognitive, communication, physical, social-emotional and adaptive domains.

First Things First has adopted the following guidance to align with the recommended practices and support the system as a whole.

II. Developmental Screening Administration includes the following activities:

- Obtainment of parental consent.
- Administration of a developmental screening instrument.
- Observation of children in their natural setting where they are comfortable and involved in typical activities and routines such as meals, interactions with siblings, etc.
- Discussion with parents regarding their child's development.
- Interpretation and analysis of screening, observation and discussion results.
- Review of screening results with families.
- Referrals made as necessary to AzEIP, local schools, health care providers, behavioral health professionals, or other community resources.
- Coordination of services with other providers (health professionals, AzEIP providers, etc.) to ensure non-duplicative, collaborative activities.

III. Developmental Screening Administration Standards:

Screening Locations

- Screenings optimally occur in settings that are closely aligned to a child's natural environment (home, child care center, etc).
- Screening is conducted where there are minimal distractions (e.g. no television or radio playing), but in a setting where the child can be observed while participating in naturally occurring activities and routines.

[1] [1] The Developmental Screening Administration Standards of Practice includes supplemental standards to address the unique activities of a Mobile Play Based Family Outreach program inclusive of developmental screening activities. The appropriate supplemental standards should be attached along with the general standards.

Screening Tools

- Screening tools used may be either criterion or norm-referenced, but chosen because they are the most appropriate option for use with the child and/or population being screened.
- If using standardized tools (with children ages three – five), instruments must demonstrate at least a .80 reliability level.
- Screening tools used must be age and individually appropriate, ensuring that the cognitive and motor skills required for participation appropriately match the age of the child.
- Screening tools are comprehensive and assess children in all developmental domains: cognition, communication, physical, social-emotional, and adaptive.
- Screening tools for children three to five are designed to capture and hold a child's interest at an age appropriate level while minimizing distraction from other stimuli (approved tools for birth – three are parent report instruments).
- Screening tools used with children birth to three must be approved for use by DES/AzEIP (see Attachment A).

Conducting Screening

- Screening is conducted only after determining that no other screening has occurred within the last three months.
- Parent or guardian consent to screening is required before screening can occur.
- A procedure is in place to assess what other services are being received by the family and to coordinate screening with other providers that may be responsible for the same or similar activities.
- Screening is conducted only if no other entity has conducted a screening within the last three months.
- Screening must include soliciting parent and/or caregiver input beyond use of simple questionnaires.
- Screening must occur in the child and family's primary language.
- Screenings should be combined with additional confirmatory information (parent input, observations, etc).
- A parent or other designated caretaker is present for all screening procedures conducted through home visitation or mobile screening activities.

Referral Services

- When children's screening results indicate they are suspected of having a delay, parents must be informed immediately.
- Families are provided with the contact information of the appropriate referral designation (AzEIP, health care provider, school district).
- If screening is conducted as a component of home visitation, home visitors follow up with families during each subsequent visit to track progress of referral.
- If barriers arise for the family to access additional evaluation services, the home visitor or other program specialist assesses the family needs and assists the family in identifying ways to remove such barriers.

Training and Qualification Standards

Conducting developmental screening requires specific education and skills.

- Educational level: minimum of a bachelor's degree in child development, nursing, early childhood education, child and family studies, or closely related field is ***preferred.***

- All individuals conducting developmental screening will obtain and maintain certification and/ or required training on all of the chosen methods and tools used in screening activities and attend re-certification or additional training courses as required by the tool, the instrument developers, and as it is determined necessary through supervision.

- Personnel who do not meet the preferred education level or are newly trained in developmental screening activities, may only administer developmental screening under the direct supervision of an individual who does meet the training and qualifications standards until it can be documented that the person conducting screening can do so in a reliable manner. This level of supervision is above and beyond the regular supervision activities required in the First Things First Home Visitation or other Standards of Practice. The supervisor will participate with the home visitor or program specialist in conducting screenings and review all completed screening instruments until the home visitor or program specialist is able to consistently conduct screening in a reliable manner. This can be documented in staff's personnel file and family files.
- Areas of knowledge and competencies must be demonstrated in:
    a. Typical and atypical child development
    b. Routines based interviewing practices (see http://www.fpg.unc.edu/~inclusion/RBI.pdf)
    c. Objective child observation
    d. Appropriate assessment of young children

- Individuals conducting screening will participate in continuing education to remain current and update skills and knowledge regarding developmental screening procedures and child development to meet the requirements of this scope of work.

- To address cultural competency objectives, programs shall ensure that providers, children and families receive from all personnel effective, understandable, and respectful services that are provided in a culturally competent manner- a manner compatible with their cultural beliefs and practices and preferred language. Consultants should receive ongoing education and training in culturally and linguistically appropriate service delivery. Consultants should develop participatory, collaborative partnerships with providers and their communities and utilize a variety of formal and informal mechanisms to facilitate community and family-centered involvement in designing and implementing the National Standards on Culturally and Linguistically Appropriate Services.

- Individuals conducting screening receive training and information regarding mandatory reporting. Arizona law requires early care and education staff who suspect that a child has received non-accidental injury or has been neglected, to report their concerns to Child Protective Services or local law enforcement (ARS §13-3620.A).

Supervision, Quality Assurance and Evaluation Standards

- Supervision of individuals who administer developmental screening activities is conducted as a collaborative process with mechanisms that support them in challenging situations and provides ongoing and regularly scheduled (no less than monthly) opportunities for discussion to reflect and debrief. Supervision will also include observation, feedback and opportunities for peer consultation.
- Evaluation of home visitation and developmental screening services utilizes quantitative and qualitative process that includes measures of how effectively children are being identified as early as possible for additional intervention and/or support services.
- Compensation and benefits are adequate for supporting high quality staff and retention of that staff.

Attachment A

Approved Tools for Screening Children Birth-Age Three

1. The core team uses screening processes, as appropriate, with an AzEIP-approved screening tool. The following screening tools are approved to determine whether a child is suspected of having a developmental delay:
   a. PEDS (Parents Evaluation of Developmental Status)
   b. Ages and Stages Questionnaire
   c. Ages and Stages Questionnaire: Social Emotional Scale (this tool would need to be supplemented by another tool to ensure all areas of development are covered)
   d. Battelle Developmental Inventory Screening Test.

Excerpt from the DES/AzEIP TBM Manual, Chapter 4

Developmental & Health Screening Data Reporting Requirements

First Things First reporting requirements and progress monitoring are aligned with First Things First Goals, Key Measures, and Standards of Practice. The purpose of First Things First data submission and monitoring is to determine the extent to which each program has accomplished the stated goals, key measures, targeted service number, and activities outlined in the standards of practice.

Grantees will be provided with data reporting requirements by First Things First. There are five main components to data reporting:

- Unit of Service
- Performance Measures
- Data Reporting Template
- Data Reporting Instruction
- Frequently Asked Questions

The data reporting template captures the set of data the grantee submits on a quarterly basis; the instructions support that data submission. Units of Service and performance measures outline how the quarterly data submissions will be evaluated according to the contracted deliverables and standards of practice for that contract. Frequently asked questions present answers to common reporting, evaluation, policy, and performance questions.

Definitions:

Unit of Service and related Target Service Number

A Unit of Service is a FTF designated indicator of performance specific to each FTF strategy. It is composed of a unit of measure and a number (Target Service Number).

A Unit of Measure/Service can be a target population and/or a service/product that a grantee is expected to serve as part of an agreement. Target Service Number represents the number of units (e.g. target population) proposed to be served or number of products/services proposed to be delivered during the contract year.

For example, for the FTF strategy Home Visitation the FTF Unit of Service is “number of families served” and a Target Service Number of 50 represents the number of families the program proposes to serve during the contract period. All FTF applicants must clearly state in the proposal a target service number for each strategy specific Unit of Service.

For **Developmental & Health Screening,** the units of service are:

Total number of children screened for developmental delays
Total number of children screened for vision and hearing

Performance Measures

Performance Measures measure (1) key indicators of performance (i.e. Unit of Service); (2) basic implementation of strategy; (3) alignment of program activities to strategy specific standards of practice, (4) performance or progress toward pre-established strategic goals. Performance measures may include the level or type of program activities conducted (e.g. serving families/children through home visits) and/or the direct services and products delivered by a program (e.g., providing scholarships).

For **Developmental & Health Screening,** performance measures are:

Total number of children screened for developmental delays/proposed service number
Total number of children screened for vision and hearing/proposed service number
Total number of awareness sessions conducted/proposed service number
Total number of people reached by awareness sessions/proposed service number
Total number of families receiving referrals for health insurance or health coverage enrollment/ target service number

Data Reporting Templates

Data reporting templates are the tools utilized to gather data to assess grantee Performance Measures. All FTF grantees submit data on a quarterly basis through designated data reporting templates.

For **Developmental & Health Screening,** the data reporting template is:

FIRST THINGS FIRST
The right system for bright futures

pgms partner grant management system

Evaluation Report

CONTRACT DATES
7/1/2010
TO
7/31/2010

TEST PRODUCTION AGENCY (APPS)

Address: Parter Address Agency Details
Test City, AZ 85032

Contract ID: GRA-STATE-10-0218-01

View Reporting Instructions and FAQ

GENERAL INFORMATION

User Completing Report AZFTF\mshahi

Reporting Period Month 7 Year 2010

Regional Partnership Council State

Status In Progress

Date Completed

Public Awareness Activity

Are you conducting any public awareness activities as part of your program?* ○ Yes ◉ No

If yes, please select from the list which activities you conduct as part of your program. Select as many as apply, and report the number of people reached through the selected activities. Refer to the instructions for a definition of each activity type. Plese skip any activity that does not pertain to your program.

Activity	Number of People Reached
☐ Media impressions	
☐ Provision of written materials	
☐ Group meetings	
☐ One to one interactions	

Service Provisions Venue:

Please select from the list, the venue of where developmental screenings took place. You can select as many venues as applicable.

- ☐ Mobile play-based unit
- ☐ Center based Child care/ Home based child care
- ☐ Other Community Setting

- ? Community Health Clinic/Hospital
- ? Schools (charter or district)
- ? Other (please specify)

Service Delivery:

Please report the number of children receiving the following screenings.

Hearing:

	Screened	Results forwarded to medical home (physician of record)	Referred for follow-up	Number of families reported being referred and having received an additional evaluation
0-12 months				
13-24 months				
25-36 months				
37-48 months				
49-60 months				
61-72 months				

Vision:

	Screened	Results forwarded to medical home (physician of record)	Referred for follow-up	Number of families reported being referred and having received an additional evaluation
0-12 months				
13-24 months				
25-36 months				
37-48 months				
49-60 months				
61-72 months				

Developmental Screening:

	Screened	Results forwarded to medical home (physician of record)	Referred for follow-up	Number of families reported being referred and having received an additional evaluation
0-12 months				
13-24 months				
25-36 months				
37-48 months				
49-60 months				
61-72 months				

Health Insurance Enrollment Assistance

Are you providing Health Insurance Enrollment ○ Yes ○ No

Assistance as part of your program?

If Yes please indicate for families that you serve the numbers that are uninsured or underinsured and those who received enrollment assistance.

Number of Families Served Who Are Not Covered by Private Insurance, AHCCCS, Indian Health Services or Kids Care

Number of Families Served Who Report They Are Underinsured

Number of Families Served Who Report Lack of Insurance or Underinsurance Who Received Enrollment Assistance to Obtain Insurance

Referrals to Health Care and Low Cost Care Providers

Are you providing Referrals to Health Care and Low cost Care Providers as part of your program? ○ Yes ○ No

If Yes, please indicate for families that you serve the numbers that received referrals to the following agencies.

Number of families referred to Indian Health Servicces (IHS)/Indian Tribal Urban (ITU)

Number of families referred to Free or Low Cost Care Service Providers

Number of families referred to AHCCCS or DES Health to Receive Health Coverage

Data Reporting Instructions

Data reporting instructions support data submission through the data reporting template.

For **Developmental & Health Screening**, the data reporting instructions are:

INFORMATION

Your data report is always due on the 20th day of the month following the end of each quarter. Each quarterly submission will include information for the entire quarter broken out by month. Each data report submitted will include information for the entire preceding quarter.

1st Quarter – July-September – Report due October 20
2nd Quarter – October-December – Report due January 20
3rd Quarter – January-March – Report due April 20
4th Quarter – April- June – Report due July 20

- Data should be only reported for services funded by First Things First.
- Data should be reported for each Regional Partnership Council area in which contracted services are provided. For example, if your community based training program is contracted to provide services in both Central Maricopa and Northeast Maricopa regions, two separate reports must be submitted.

OVERVIEW

- For each reporting period, enter all data for all Regional Partnership Council areas served.
- For each quarter, **data should be tallied for each month of service.**
- Your final data submission for the quarter cannot be completed until you complete all monthly reports.

DIRECTIONS FOR DATA ENTRY

Public Awareness Activity

1. *** Are you conducting any public awareness activities as part of your program?** In this data field you will choose either **Yes or No**. *If **YES**: Please select from the list the activities you conduct as part of your program. You can select as many activities as needed. After an activity type is selected, please report the number of people reached through the specific activity. You may skip any activity that does not pertain to your program.*
    a. Media impression is defined as the number of people reached with media campaigns.
    b. Provision of written materials is defined as the number of people receiving pamphlets, etc.

c. Group meetings.
d. One to One interactions.

Service Provisions Venue: *select the venue of where developmental screenings occurred*

2. **Please select from the list below the venue of where developmental screenings occurred.** *You can select as many venues as applicable*.
   - ☐ Mobile play based unit
   - ☐ Center based Child care/ Home based child care
   - ☐ Other Community Setting
   - ☐ Community Health Clinic/ Hospital
   - ☐ Schools (charter or district)
   - ☐ Other (please specify): _____

Service Delivery: Number of children receiving the following screenings

Please indicate for children that you serve the numbers of that received screenings, referrals and follow ups in the following types of tests by age breakout.

3. **a. Hearing - Screening:** In this data field, you will enter the number of children that were screened for hearing by age breakout of birth thru 12 months, 13 to 24 months, 25 to 36 months, 37 to 48 months, 49 to 60 months, and 61 to 72 months.

   b. Results forwarded to medical home: In this data field, please enter the number of children whose results were forwarded to a medical home (physician of record) by age breakout.

   c. Referred for follow up: In this field, enter the number of children that were referred for follow-up by age breakout.

   d. Number of families reported being referred and having received an additional evaluation: In this field, please enter the number of families that reported being referred after initial screening and having received an addition evaluation by the children's age breakout.

Hearing	*Screened*	*Results forwarded to medical home (physician of record)*	*Referred for follow-up*	*Number of families reported being referred and having received an additional evaluation*
0 -12 months				
13-24 months				
25- 36 months				
37-48 months				
49-60 months				

61-72 months				

4. **a. Vision - Screening:** In this data field, you will enter the number of children that were screened for vision by age breakout of birth thru 12 months, 13 to 24 months, 25 to 36 months, 37 to 48 months, 49 to 60 months, and 61 to 72 months.

   b. Results forwarded to medical home: In this data field, please enter the number of children whose results were forwarded to a medical home (physician of record) by age breakout.

   c. Referred for follow up: In this data field, please enter the number of children that were referred for follow-up after being screened by age breakout.

   d. Number of families reported being referred and having received an additional evaluation: In this field, please enter the number of families that reported being referred after initial vision screening and having received an addition evaluation by the children's age breakout.

Vision	*Screened*	*Results forwarded to medical home (physician of record)*	*Referred for follow-up*	*Number of families reported being referred and having received an additional evaluation*
0 -12 months				
13-24 months				
25- 36 months				
37-48 months				
49-60 months				
61-72 months				

5. **a. Developmental Screening:** In this data field, you will enter the number of children that were screened for developmental delay by age breakout of birth thru 12 months, 13 to 24 months, 25 to 36 months, 37 to 48 months, 49 to 60 months, and 61 to 72 months.

   b. Results forwarded to medical home: In this data field, please enter the number of children whose results were forwarded to a medical home (physician of record) by age breakout.

   c. Referred for follow up: In this field, please enter the number of children that were referred for follow-up after being screened by age breakout.

   d. Number of families reported being referred and having received an additional evaluation: In this field, please enter the number of families that reported being

referred after initial screening and having received an addition evaluation by the children's age breakout.

Developmental Screening	*Screened*	*Results forwarded to medical home (physician of record)*	*Referred for follow-up*	*Number of families reported being referred and having received an additional evaluation*
0 -12 months				
13-24 months				
25- 36 months				
37-48 months				
49-60 months				
61-72 months				

Health Insurance Enrollment Assistance

6. **Are you providing Health Insurance Enrollment Assistance as part of your program?** In this data field you will choose either **Yes or No.** *If **YES**, please indicate for families that you serve the numbers that are uninsured or underinsured and those who received enrollment assistance to obtain insurance.*
    a. ***Number of families served who are not covered by private insurance, AHCCCS, Indian Health Services, or Kids Care____**
    b. ***Number of families served who report they are underinsured_____**
    c. ***Number of families served who report lack of insurance or underinsurance who received enrollment assistance to obtain insurance_____**

Referrals to Health Care and Low cost Care Providers

7. **Are you providing Referrals to Health Care and Low cost Care Providers as part of your program?** In this data field you will choose either **Yes or No.** *If **YES**, please indicate for families that you serve the numbers that received referrals to the following agencies.*
    a. ***Number of families referred to Indian Health Services (IHS)/Indian Tribal Urban (ITU)____**
    b. ***Number of families referred to free or low cost care service providers____**
    c. ***Number of families referred to AHCCCS or DES to receive health coverage_____**

Frequently Asked Questions

Frequently Asked Questions present answers to common reporting, evaluation, policy, and performance questions.

For **Developmental & Health Screening,** the frequently asked questions are:

In development