FIRST THINGS FIRST

Ready for School. Set for Life.

Strategy Toolkit

OCTOBER 2010

Last update January 14, 2011
Goal Area: Professional Development
Additional Guidelines for
Allocating Funds

Updated December 29, 2010

Goal Area: Professional Development
Scholarships T.E.A.C.H.
PCPP and T.E.A.C.H. Compensation

Updated December 14, 2010
Goal Area Family Support/Strong Families
Home Visitation
Family Resource Centers

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I. Purpose

The purpose of the Strategy Toolkit is to provide information to First things First Regional Partnership Councils that will help them to determine strategies that will best address their community assets, prioritized needs and the priorities set by the FTF Board. This Toolkit describes strategies that are currently being implemented through both regional and statewide program funding. However, the list of options provided is not exhaustive, and Regional Partnership Councils may initiate original strategies or adopt proven strategies not included in this document. This Toolkit is an update of the original FTF Strategy Toolkit which was completed in 2008.

II. Description of Toolkit

The Toolkit is organized into the following sections to complement the First Things First Goal Areas:

- Quality, Access and Affordability
- Professional Development
- Health
- Family Support
- Coordination
- Additional Resources

Each Goal Area cover page lists the strategies included in that area, along with the FTF Strategy Workgroup to which each is assigned, and the Policy and Finance Specialists who are responsible for the strategy. Following the Goal Area Cover Page are separate strategy pages which include the goal area, the priority role established by the FTF Board, the evidence base and research for the strategy, considerations for strategy selection and design, and cost of strategy implementation, should a region choose to add or expand it. Additional information to assist in the strategic planning by the Regional Councils include the standard of practice for each strategy, performance measures, the data template and instructions, and additional resources.

The FTF Strategy Toolkit is a continuous work in progress, and information will be added to the Toolkit over time. New models, research and resources will be added to incorporate advances in the fields of early childhood education and health and system-building, and as lessons are learned from FTF's data collection and evaluation activities.

III. Introduction

The starting point for Regional Partnership Councils as they continue to develop Funding Plans is to revisit the assets, gaps and data trends using the 2010 Needs and Assets Reports. The next step is to review current Funding Plans to determine the alignment of strategies with the Needs and Assets Reports and with the FTF Goals and Priority Roles, as recommended by the Early Childhood Education Task Force and approved by the FTF Board at its September 2010 meeting.

The next step is strategy development during which Councils determine which strategies to maintain or discontinue, which to expand and, possibly, which to add. As Regional Partnership Councils determine their strategies, it is critical that they align those strategies with findings from their Regional Needs & Assets Reports and the First Things First Statewide Goals, Measures and Priority Roles.

It is often not a single strategy, but a collection of strategies that help to achieve a desired scope of service or service network which complements the existing assets of a region. It is therefore important for Regional Partnership Council members to leverage and link with existing resources to form a stronger, more capable community to meet the needs of young children and their families. It is this community development that produces "system-building" which can maximize all resources for the benefits of young children.

Regional Partnership Councils should strengthen and build cross agency/organization collaboration and partnerships both within their region and across regions. Partnerships are necessary with city, county, state and tribal departments. Regional Partnership Councils should further ensure coordination through planning and strategy implementation which is coordinated with other FTF Regional Councils and the FTF Statewide Strategies as we work together to build an effective early childhood system.

IV. Explanation of Strategy Toolkit Key Terms (Also refer to the Strategy Toolkit Glossary)

Goal Area – The First Things First five Goal Areas: Quality, Access and Affordability; Professional Development; Health; Family Support; and Coordination. (The goal area of Communication is not included in this version of the Toolkit, but may be added at a later date.)

Goal- Broad measurable statement of intent to set a future direction. Goals indicate **<u>what FTF will do</u>** and accomplish as part of the comprehensive early childhood system.

Each Goal is a piece of a larger picture and is inextricably interrelated and linked with the other Goals.

FTF Priority Role – The eight Priority Roles which were recommended by the ECE Task force and adopted by the FTF Board at its September 2010 Board meeting. Five roles relate to services to children and families, and three are coordination and system-building.

Strategy- A general method or overall approach used to achieve a goal. Strategies provide direction and are globally defined best practices that positively impact the lives of children and families served. Strategies work together and indicate **how we will implement** the Goals. **Note:** The First Things First Statewide Board funded strategies are listed first on each of the Goal Area pages. Additional multi-regional and regional strategies are not listed in any particular order and the list of strategies is not exhaustive.

Key Measures- Key Measures align directly with Goals and indicate **what we want to change.** Key measures are specific, observable, measurable characteristics or changes that represent impact over time and achievement of success. Key measures are what is observed, measured, assessed or monitored in clients or systems to learn if the outcome has been achieved. They are what will be used to "count successes."

Evidence/Research -The level of data or research that supports the value or impact of a strategy for specific target populations. Some strategies in the Toolkit indicate which type of evidence exists, such as:

a. Proven Practice-Study design uses a convincing comparison group to identify program impacts, including randomized-control trial (experimental design) or some quasi-experimental designs. Sample size of evaluation exceeds thirty in both the treatment and comparison groups and the practice must directly impact one of the indicators.

b. Promising Practice- Includes practices that were developed based on theory or research, but for which an insufficient amount of original data have been collected to determine the effectiveness of the practices. Practices in this category may have been studied, but they did not go through rigorous study designs. These practices have been tested but the results are not as clear as those results in the proven category above. Practices that fall in this category are based on some type of research – whether it is theoretical, qualitative, or quantitative – but data have yet to be collected on effectiveness. Promising practices may have been tested under different conditions and, therefore, may

have a research foundation. However, the practices themselves have not been tested using the most rigorous research designs, or were tested in different contexts. The practice must:

- Have a clear focus: have a clearly defined conceptual framework, clear aims, and clear desired outcomes;
- Take account of contemporary research and practice developments in the field;
- Position diversity as key to the development, understanding and delivery of good practice models;
- Have been evaluated as successful

Considerations for Implementation and Cost – These considerations address issues such as capacity for expansion, linkages with other strategies, length of commitment for funding, the timeline for implementing expansion or start-up, the recommended saturation levels, whether the strategy can be taken to scale, and whether there is an administration home infrastructure.

Cost – Includes unit cost for the strategy along with additional information to help Regional Councils to determine a budget for the strategy.

NEED → GOAL AREA → GOAL & PRIORITY ROLE → KEY MEASURE → STRATEGY DEVELOPMENT →STRATEGY IMPLEMENTATION → MONITORING AND EVALUATION

V. Identifying Strategies

How do we know what works or shows promise of working? Research or evidence based strategies along with the social and economic environment of the region should all be considered in determining strategies to pursue. For instance, research tells us that not all home visiting programs are equal. Frequency of visits and staff qualifications are integral in preventing child abuse, better assuring good health and providing stimulating environments for children. A set of criteria is needed to help determine what works (See Additional Resources for an example set of criteria)**.**

It is important that Regional Partnership Councils recognize the cultural diversity and uniqueness in Arizona's children and families and ensure that they have access to culturally and linguistically appropriate services. Effective systems of care respect and make every effort to understand and be responsive to cultural differences.

In addition to recognizing that all families and children bring a unique cultural background with them, effective systems of care also acknowledge and address proactively the disparities in access and treatment that historically have been the

experience of diverse families in traditional systems. Therefore, it is imperative that Regional Partnership Councils strive to build culturally competent systems that serve and advocate on behalf of children and families from traditionally underserved populations.

However, there is a lack of evidence based, best practice strategies for some populations. As a result, it is imperative that strategies be adapted to be culturally responsive and that data be collected to build understanding about the components of strategies that will positively impact these populations.

Regional Councils may need to identify additional "capacity building" strategies which lay a foundation for future high-quality delivery of services or programs. There may be infrastructure, community building, professional development, recruitment or capitol investments necessary before implementation of a successful program can take place. There may also be longer term plans and timelines needed in order to address a priority.

On occasion, a Regional Partnership Council may identify a specific program to implement in the region, after reviewing the data from the region, determining the Goal and Measure of success. A program is defined as a specific approach for implementing the strategy. Should a Regional Council identify a specific program to implement, the research and evidence for implementing such a program should be cited. Councils are not to specify an agency or organization to implement the program.

> *To be effective, system-building processes must pay attention to the impact of culture, ethnicity, race, gender, sexual orientation and class within the process itself, as well as on how systems operate and the ability of families to access and use services. In addition, successful systems' leaders draw on a variety of approaches and strategies employed on an ongoing basis to build cultural proficiency into the system of care.*-from Building Systems of Care: A Primer.

FTF STRATEGY TOOLKIT

GOAL AREA: Quality, Access, and Affordability

FTF Priority: Quality Early Care and Education - Convene partners, provide leadership, and provide funding for increased availability of and access to high quality, regulated, culturally responsive, and affordable early care and education programs.

Goal Area Overview:

First Things First envisions a comprehensive early care and education system that addresses quality, accessibility and affordability. High quality is promoted by Quality First, FTF's signature quality improvement and rating system for regulated early care and education settings. In addition, higher quality programs must be both accessible to all children and affordable for families of every income level. Quality First Scholarships and Prekindergarten strategies promote affordability of a variety of quality early care and education settings, offering families the ability to choose the setting that best meets their needs. Additionally, quality early and education must be accessible to children of all abilities and needs. Some regions have addressed the issue of inclusion of children with disabilities and special health care needs directly through consultation and professional development strategies. While regulated care and education is a FTF prioritized role, in Arizona it is estimated that over 60% of children ages 3 and younger are cared for in family, friend and neighbor (FFN) settings for which there is no public oversight. Some FTF strategies address improving the quality of these settings through education and support groups. It is the intent of FTF to ensure that all early care and education programs actively include children with special needs.

Strategies	Strategy Workgroup and Leads	Policy Staff	Grants and Contracts Specialist
Quality First!	Quality, Access & Affordability Workgroup: Jennifer Johnson and Jill Stevens	Ena Binns Ginger Sandweg	Lyra Contreras
Child Care Scholarships	Quality, Access & Affordability Workgroup: Jennifer Johnson and Jill Stevens	Jill Stevens	Jeanne Weeks
Expansion: Pre-K and Head Start	Quality, Access & Affordability Workgroup: Jennifer Johnson and Jill Stevens	Jill Stevens	Kathy Rice
Expansion: Expand slots and/or capital expense (Expansion: Infant/Toddler)	Jennifer Johnson and Jill Stevens	Jill Stevens	
Inclusion of Children with Special Needs	Early Identification/Special Needs Workgroup: Allison Landy and Shari Elkins	Allison Landy	
Family, Friends, and Neighbors	Quality, Access & Affordability Workgroup: Jennifer Johnson and Jill Stevens	Jill Stevens	

GOAL:

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

STRATEGY SUMMARY	EVIDENCE/RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Quality First is Arizona's voluntary quality improvement and rating system designed to improve the quality of early care and education so that young children can begin school safe, healthy and ready to succeed. **Two types of participation in Quality First:** ▪ **Full Participation:** Includes three years of quality improvement supports *and* receiving a Quality First star rating ▪ **Rating Only Participation:** Includes program assessment, portfolio submission and receiving a Quality First star rating **Eligibility Requirements for participation:** ▪ Provide care to children from birth to age five ▪ Regulated with Arizona Department of Health Services (DHS), Department of Economic Security(DES), Tribal Authority or Military Government ▪ In "Good Standing" with regulatory authority	Research conducted in 5 states with long-term systems and evaluation designs, e.g. CO, NC[1], PA, TN and OK[2], show significant improvement in the quality of participating programs/settings. Locally, the Tucson *First Focus on Quality* pilot program evaluation found significant improvement in 46 centers in key quality components such as physical learning environment, adult-child interactions, school readiness strategies, health and safety, and director and staff qualifications.	Due to program implementation development, year round selection and the Rating Pilot Study there is no capacity for Quality First expansion in FY11. For FY12 planning, it is recommended that Regional Councils review the following considerations for Quality First expansion: ▪ **Multiyear Strategy** - 3 Year Commitment - Year Round Selection Schedule Funding committed to Quality First supports a program during the entire three year improvement process. Quality First programs are enrolled throughout the fiscal year on a ten week selection cycle. The remaining dates and number of programs to be selected for FY11 are: - October 14 50 programs - January 6 52 programs - March 17 52 programs - May 26 52 programs Vacant slots will be refilled in the current fiscal year if a program declines pre enrollment. Slots that are vacant post enrollment will be filled in	The Quality First unit cost includes the cost of quality improvement supports (enrollment incentives, improvement grants, coaching and assessment), child care health consultation and T.E.A.C.H. scholarships. When a Regional Council purchases a Quality First slot, all quality improvements supports and benefits are included in the cost. Regional Councils should use the unit cost below for FY12 funding planning.

Programs are considered to be in good standing when their license/certificate is not in open enforcement action (legal action status), suspended or revoked. **Quality Improvement components include:** **Individualized coaching** ▪ Onsite training and technical assistance ▪ Assistance with goal setting and development of quality improvement plans and expenditure of program improvement grants **Child care health consultation** ▪ Onsite training and consultation on best health and safety practices and requirements ▪ Connections to community resources **Program Assessment** of quality using standardized assessment tools and reliable assessors. **Financial grants and awards** for materials, equipment, professional development and other resources to reach goals in the quality improvement plan. **Professional development** opportunities and access to a T.E.A.C.H. Early Childhood Arizona Scholarships for teachers and caregivers.	[1]Research-based and experiential practices for consideration in activity design; target population; common characteristics of effective activities	the following fiscal year. ▪ **State funded Quality First improvement slots** - At the end of the three year improvement cycle, state funding will be targeted toward administration costs, infrastructure and the rating implementation. - State funding will not be used for funding any additional quality improvement slots. ▪ **Evidence of Demand** - # of current regulated centers/homes ; # of programs on current waitlist; # of accredited programs Regional Councils may want to begin funding *some* additional improvement slots in FY12 due to the number of statewide programs that will be exiting quality improvement in FY13. Councils should strategically consider their long-term plan for financing quality due to the linkage between Quality First and other quality support programs such as Pre K Expansion, Scholarships, FFN and other Professional Development strategies.	**Per Facility Cost for Homes:** QF improvement $15,250 T.E.A.C.H. $2000 CCHC $4000 Total: $21,250 **Per Facility Cost for Centers:** QF improvement $22,500 T.E.A.C.H. $3300 CCHC $4000 Total: $29,800 **Quality First Service Caseload:** Coaching: 1:12 Assessment: 1:20 Child care health consultation: 1:30 **T.E.A.C.H. Early Childhood Arizona Scholarships** T.E.A.C.H specialists are assigned in each regional area to provide assistance with application submission for T.E.A.C.H. scholarships.

[1] LeCroy & Milligan Associates, Inc. (August 2006). *First Focus on Quality: Final Evaluation Report.*

All programs participating in quality improvement will receive an initial **Quality Rating** after two years of receiving improvement supports. **Quality First Outreach/Marketing:** ▪ New Quality First brochures were developed and are available to all regional offices. ▪ There will be a targeted marketing campaign in FY12 to educate parents on identifying quality indicators and selecting early care settings using the Quality Ratings. ▪ Designated contact information for all Quality First external users: Email: qualityfirst@azftf.gov Helpline: (602) 771-5000 Toll Free: 1-877-803-7234		▪ **Rating Only Participation** - In **FY11**, 60 programs will be selected to participate in the rating pilot study. - Programs selected will represent home and center-based, accredited, non accredited, Head Start, for-profit/non-profit, school-based and faith-based programs located throughout the state. All participating programs may choose from four different incentive packages (literacy, math, science, blocks, of infant/toddler) which include both program and staff materials valued at approximately $2500.00. **Pilot Ratings will not be made public.** - In **FY12,** state funding will support 75 programs in an initial Quality Rating. An additional 600+ programs will receive their initial rating through their enrollment in Quality First improvement. - Regional funding opportunities for Quality Ratings in **FY13** will be determined after analyses of the rating pilot study are completed and the rating process and instruments are finalized.	Two T.E.A.C.H. scholarships are available for enrolled center-based programs and one scholarship is available for every two enrolled home-based programs.

Ena Binns, Quality First Coordinator

Ginger Sandweg, Quality First Assistant

1. **Links:** Quality First Workgroup Page **http://ftf/projects/Quality%20First%20Strategy%20Workgroup/default.aspx**
2. **Quality First Workgroup documents include:** QF Reports, QF Implementation Guide, QF Target Service Numbers, QF Application, Rating Pilot Fact Sheet, QF brochure, Quality Rating Systems Comparison to Quality First and other implementation documents

Rationale for Statewide Strategy:

Quality First: Arizona's Quality Improvement and Rating System

The First Things First Board approved funding to design, build and implement the first phase of *Quality First!,* Arizona's Quality Improvement and Rating System (QIRS) for early care and education centers and homes. Because so many of Arizona's youngest children are enrolled in child care, early education and preschool settings, the quality of programs is undeniably important. Just 15% of early care and education centers and less than 1% of family child care homes in Arizona are accredited by a national accreditation system, currently the only measure of high-quality available in the state.

State licensing regulations are considered adequate and minimal and do not include quality determiners, i.e. optimal recommended adult-child ratios, maximum group size, well-qualified personnel, and strong curriculum and environments. Many children are in settings where quality is poor or mediocre[1], and poor quality settings may harm children or may be a barrier to optimal development.

Arizona will now have a system and working model of early childhood care and education quality standards, assessment and supports (financial and other) throughout the state, rather than multiple models, in order to ensure public confidence in its validity and to systematically evaluate outcomes for children.

In order to reach the vision of a coordinated, collaborative QIRS with an infrastructure available throughout the state, FTF is taking the lead in both designing and implementing the statewide baseline model. Regional Partnership Councils may choose to fund additional enrollments for child care homes or centers in their Region to participate in QIRS. (For example, the statewide model may only fund four child care homes in a region, but a Regional Partnership Council may decide to expand that number to ten.)

Arizona's QIRS is a unique model – both in content and process. It combines two models – the "block" and the "points" model into a new hybrid model. It also intentionally rolls out the quality improvement and rating system in distinct phases. The first phase provides support for quality improvement and later phases introduce the "star ratings" for early care and education settings. This innovative model includes core elements which link quality improvement activities, professional development, child care health consultation and family outreach into a comprehensive statewide system.

Quality improvement and rating systems are comprehensive strategies being used throughout the country to improve the quality of early care and education and inform families, providers, funders, regulators and policy makers about quality standards for early care and education. Currently 17 states are operating statewide quality improvement and rating systems, and another 30 states have local pilots or are developing their systems.

Research conducted in five states with long-term systems and evaluation designs, e.g. Colorado, North Carolina[2], Pennsylvania, Tennessee and Oklahoma[3], show significant improvement in the quality of participating programs/settings. Locally, the Tucson *First Focus on Quality* pilot program evaluation found significant improvement in 46 centers in key quality components such as physical learning environment, adult-child interactions, school readiness strategies, health & safety, and director and staff qualifications.[4] A new study of the Colorado's Qualistar Quality Rating and Improvement System by the RAND Corporation[5] suggests that the quality indicators which produce child outcomes measure not only the quality of the environment, but also the quality of interactions, in early care and education settings. Arizona is incorporating this research into its development of *Quality First!*.

[1] Vandell & Wolfe (2002); Cost, Quality and Child Outcomes Study Team; (1995); Helburn & Bergmann (2002); Phillips, (1995)

[2] Bryant.D., Bernier, K., Maxwell K., & Peisner-Feinberg, E. (2001) *Validating North Carolina's 5-star child care licensing system.* Chapel Hill, NC: University of North Carolina, Frank Porter Graham Child Development Center

[3] Norris, D., Dunn, L., & Eckert, L. (2003). *"Reaching for the Stars" Center Validation Study: Final report.* Norman, OK: Early Childhood Collaborative of Oklahoma.

[4] LeCroy & Milligan Associates, Inc. (August 2006). *First Focus on Quality: Final Evaluation Report.*

[5] Zellman, Gail L., Perlman, Michal, Le, Vi-Nhuan, Messan Setodji, Claude (2008). *Assessing the Validity of the Qualistar Early Learning Quality Rating and Improvement System as a Tool for Improving Child-Care Quality.* Rand Corporation.

QUALITY EARLY CARE AND EDUCATION

Our Goal: "Quality" Environments for All Children

Our goal is that every child in Arizona, birth to five, experience environments which promote optimal social, emotional, physical, intellectual and academic growth and development. Specifically,

- Every child is safe and healthy
- Every child has the opportunity to engage in supportive, nurturing interactions with others – both emotionally and instructionally
- Every child experiences a stimulating, relevant and rich physical environment

Child Development Literature

The literature about quality early care and education settings indicate that quality has multiple dimensions, broadly classified as:

- *Structural quality*: group size, child-adult ratios, teacher education and training, curriculum, and health and safety practices. Federal, state and local requirements set minimum standards for most of these features.

- *Process quality:* what happens in the classroom or home care setting, such as teacher-child or child-child interactions, activities in which children engage, group management and use of time, language and literacy development and attention to children's problem-solving skills.

Goal for Quality, Integrated Early Care and Education System

QUALITY FIRST is an essential part of a statewide, integrated and inclusive system of early care and education.

First Things First Quality Fact Sheet 1

Why Should You Care About Early Care and Education?

In many important ways, the preschool years determine our future competitive role in the global economy, the public safety of our communities, the cost-effective investment of public and private dollars, and the success of welfare reform. Child care and education provides a necessary support for families, and the quality of that care is critical to the healthy development of children. If done well, child care benefits us all.

What do we mean when we say early care and education? Historically, child care and early education have been the privately or publicly financed services a child receives in a center or home-based setting when not in the direct care of a parent. Terminology varies for these programs and includes child care, day care, preschool, nursery school, pre-kindergarten, and even "babysitting". Professionals in the field prefer the term early care and education or early childhood education, since all these programs provide care and nurturing, as well as education for young children.
The safe, nurturing environment of quality child and education may support a child's need for early education, a parent's need to work or attend school, or a child's need for a healthy meal and protection resulting from a family crisis.

Research Says:
Children from disadvantaged backgrounds benefit most from high-quality child care and early education programs. (Manhattan Institute, *"Pre-K: Shaping the System That Shapes Children"*, 2006)

Children in higher quality care had more advanced language development. Children in lower quality care became progressively further behind the children in higher quality care on all language measures, especially with vocabulary.
(Frank Porter Graham Child Development Institute at UNC-Chapel Hill, *"Quality of Childcare Affects Language Development",* 2007

How can my Regional Partnership Council use this?

- Background Information
- Press Release
- Public Presentation
- With Business Leaders

First Things First Quality Fact Sheet 2

Why is High Quality Early Childhood Education Important?

Research on brain development scientifically demonstrates how important the first years of life are to a child's later development and readiness for school. High-quality early childhood education is one of the most effective ways to ensure children begin school with the skills they need to succeed. It is associated with higher reading skills, better test scores, and fewer behavioral problems. Low quality early childhood education can have the opposite effect.

Children may spend 30-40 hours per week for as long as 5 years in out-of-home care, before they start kindergarten. Arizona regulates the health and safety of some out-of-home care, but does not measure the quality of that care. Many states are now developing quality improvement and rating systems, which have been proven to improve standards for early childhood providers, as well as to give parents the information they need to select high-quality care. These systems depend upon well trained staff to survey and monitor programs.

- 90% of a child's brain develops by age 5, and stimulating learning experiences during this period of rapid growth lay the groundwork for a lifetime of learning. (Zero-to-Three Brain Wonders)

- More than 40% of America's children are not fully prepared for school when they arrive in kindergarten. *"Set for Success: Building a Strong Foundation for School Readiness Based on the Social and Emotional Development of Young Children,"* Kauffman Early Education Exchange

- Good quality child care is strongly linked to school achievement and the development of social skills that enable a child to grow into happy, productive adults. Such child care has been used successfully to prepare at-risk children for school while poor quality child care can harm children. Their intellectual and social development can be stunted. In extreme cases, children have been harmed physically. *"Good Quality Child Care: A Dramatic Opportunity to Promote Learning and Prevent Damage in Our Youngest Children,"* Child Care Action Campaign, 1996

How can my Council use this:

- Background Information
- Press Release
- Public Presentations
- With Parents

Currently, early childhood education functions in Arizona are spread among multiple state, tribal and local agencies, and no state-level body has authority to promote coordination.

First Things First Quality Fact Sheet 3

What are the Key Indicators of Quality in Early Care and Education?

- **Adult to Child Ratio*:** How many children are there for each adult?
  - Fewer children for each adult is better
  - The younger the child, the smaller the ratio
  - 1:4 (one adult for four infants) and 1:10 (one adult for ten preschoolers) are optimal ratios

- **Group Size**:** How large is each group of children?
  - Smaller groups are better
  - The younger the child, the smaller the group size
  - No more than 8 infants and 20 preschoolers should be in a group

- **Director Qualifications and Leadership:** What knowledge and leadership does the director bring to the program?
  - Philosophy and standards set by the director
  - Administrative skills guide center operations

- **Teacher/Caregiver Qualifications:** What is the caregiver's education and training?
  - Degrees and specialized training result in better child outcomes
  - They should receive continuing education

- **Turnover:** How long have the teacher/caregivers been in their job?
  - Young children need continuous care by trusted adults
  - Children should be with one adult for at least one year
  - Continuity of care is most important for infants and toddlers

- **Curriculum:** Is it developmentally and culturally appropriate, stimulating and intentional?
  - Individual goals and activities planned for each child
  - Reflects all areas of child development: physical, social, emotional and cognitive

- **Accreditation:** Is the program accredited by a national organization?
  - Voluntary standards which are higher than licensing requirements
  - Examples are:
    - National Association for the Education of Young Children (NAEYC)
    - National Association for Family Child Care (NAFCC)
    - National Accreditation Commission (NAC)

- ***Quality First* Rating:** Is the program participating in Arizona's quality improvement and rating system? [Future – what is the program's star rating?]

First Things First Quality Fact Sheet 4

How Do We Ensure High-Quality Early Childhood Programs?

- Advocate for **Quality Child Care Licensing Regulations**, which set the foundation for basic health, safety and well-being of children in out-of-home early childhood programs.

- Set **High Quality Standards** for programs (e.g. *Quality First,* Arizona's quality rating system, national accreditation) and for practitioners (e.g. a credential, degree, license, career lattice).

- Provide **Supports,** such as technical assistance and grants, to help programs and practitioners meet standards.

- Create **Infrastructure** to ensure that programs and practitioners maintain compliance with quality standards.

- Provide **Financial Assistance** linked to meeting standards.

- Build **Understanding and Support** among child care providers about quality.

- Ensure **Consumer Engagement** in selecting high-quality child care by providing information.

- Improve **compensation, benefits, and working conditions** for early childhood practitioners.

- Create **public-private partnerships** to build capacity of local communities to provide quality early childhood education.

- **Coordinate** early childhood functions between state agencies, Head Start and Tribes.

"Improving Child Care Quality: Key Elements", Alliance for Early Childhood Finance

How can my Council use this:

- Promote Ideas
- Funding Plans
- Public Presentations

First Things First Quality Fact Sheet 5

<u>What Should You See in a High-Quality Early Childhood Program?</u>

- ✓ **Teachers / caregivers** who are responsive and engaged with children in conversation, play and interactions.

- ✓ **Indoor and outdoor environments** that are safe, child-centered, stimulating without being overwhelming, and contain a variety of age-appropriate toys and materials available to children.

- ✓ **Daily schedule and routines** which are predictable and have a balance of:
    - child-directed and teacher-directed activities
    - indoor and outdoor time
    - active and quiet activities

- ✓ Well-designed **curriculum** which is research-based, culturally and linguistically sensitive, and aligned with early learning standards (Arizona Early Learning Standards, Head Start Performance Standards).

- ✓ **Ongoing assessment** of children's progress and program effectiveness that support individual children's learning and development, as well as programs' continuous improvement.

- ✓ **Family involvement and educational** opportunities for parents, guardians and other family members.

How can my Council use this:

- Guide for Observation
- Parent Checklist
- Public presentation

Quality First 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 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.

NOTE: **Quality First** is a First Things First administered program. Because of the scope and complexity of the program, there are multiple contacted grantees implementing different portions of the program. The following measurement information is related to the Quality first program overall. Units of service, performance measures, and reporting requirements for Quality First contractors are NOT presented here.

For **Quality First**, the units of service are:

Total number of early care and education home- based providers participating in Quality First
Total number of early care and education center-based providers participating in Quality First

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 Quality First, performance measures are:

Total number of children enrolled in early care and education programs participating in Quality First / proposed service number

Total number of early care and education home- based providers participating in Quality First / proposed service number

Total number of early care and education center-based providers participating in Quality First / proposed service number

Total number and percentage of early care and education programs participating in Quality First with a high level of quality as measured by Quality First / targeted service number

Total number and percentage of early care and education programs participating in Quality First improving their Quality First rating/ targeted service number

Data Reporting Templates

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

Data reporting for **Quality First** is through regular updates in the Quality First data system.

Data Reporting Instructions

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

Data reporting for **Quality First** is through regular updates in the Quality First data system.

Frequently Asked Questions

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

For **Quality First**, the frequently asked questions are:

Data reporting for **Quality First** is through regular updates in the Quality First data system.

GOAL AREA: QUALITY, ACCESS & AFFORDABILITY

STRATEGY NAME: CHILD CARE SCHOLARSHIPS

GOAL:

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

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Early care and education scholarships improve access and affordability of high quality early care and education for low-income families with young children. They provide continuity of care for families who might otherwise be unable to pay for quality care so that child-caregiver relationships are not disrupted. Child Care Scholarships are considered an ongoing commitment to help families afford higher levels of quality care and to support the achievement and maintenance of quality improvements.	Access to high quality early care and education is an important factor in school readiness, and is particularly important for high-risk children living in poverty. Most of the evidence for providing Scholarships rests on what we know about children who cannot access high quality early care and education programs. Without access, these children are less ready to begin and realize success in school and later in life. By providing scholarships, more children will enter school ready to succeed. Data from our longitudinal study will help inform us of the effectiveness of this strategy. Lally, J. R. & Signer, S. M. Introduction to Continuity. Available at: http://www.pitc.org/cs/pitclib/download/pitc_res/360/Introduction%20to%20Continuity.pdf?x-r=pcfile_d Heckman, J.J. 2008. The Case for Investing in Disadvantaged Young Children. In: Big Ideas for Children: Investing in Our Nation's Future. Available at: http://www.firstfocus.net/Download/BigIdeas.pdf Shonkoff, J. P. & Phillips, D.A. (2000). From Neurons to Neighborhoods: the Science of Early Childhood Development. National Academy Press. Washington, DC.	Scholarship rates are determined by median cost by geographic area, provider type and year of child. Scholarships are most often used for full-time care although they can be used for part-time care if a child is receiving 20 hours or less of service per week. Family income is used in determining eligibility and most often may not exceed 200% of the federal poverty level. The administrative home for this strategy – Valley of the Sun United Way - coordinates the program beginning with outreach to providers, contracting and providing monthly funding to providers, data collection, and evaluation. This strategy is easily expanded throughout the state. The current administrative home contract is for FY2011 is renewable for two additional years. Currently, homes or centers must be licensed or certified and enrolled in Quality First or accredited to participate as a provider. There are some exceptions to this rule where providers are on the waiting list for Quality First.	Cost per scholarship varies by region, age of the child and type of provider. The rate is tied to the most recent Market Rate Survey (MRS) and, beginning in FY2013 scholarships are set at the median rate using the formula daily rate X 5 X 50. S

		Regions with this strategy will also need to consider the percentage of their early care and education programs that have applied for and are participating in Quality First, since that is a prerequisite for receiving child care scholarships. Other strategies that may be considered are as pre-kindergarten expansion and/or family, friend and neighbor care. Child Care scholarships will ultimately be available only to programs enrolled in Quality First or rated by Quality First that have achieved an identified star rating level or higher. The particular programmatic components of tying scholarships with quality rating are under development.	

Policy Specialist – Jillynn Stevens

Updated October 2010

First Things First
Quality, Access & Affordability
Quality First Scholarships
Standards of Practice

Quality First Scholarships improve the access and affordability of high quality early care and education for low-income families with children birth though five. Scholarships benefit children, families, the child care industry and communities by offsetting the cost of quality care.

Quality First Scholarships are defined as payments to an early childhood provider, either center- or family-based child care, for the full or partial cost of care based on a per day or week child cost. Quality First Scholarship amounts are determined using data from the most recent "Market Rate" as defined by the Department of Economic Security (DES).[i] These rates indicate the cost of care per age group, setting and attendance status in different districts of the state. Prior to FY2012, Quality First Scholarships were referred to as "Early Care and Education Scholarships" or simply "Child Care Scholarships."

Benefits to Young Children

Access to quality early care and education programs can result in social, developmental and health benefits to young children that help to prepare them for later success in school and in life. Quality early care experiences in stable out-of-home settings help young children develop strong attachments not only to parents but also to caregivers and teachers. These attachments set the stage for future relationships throughout a child's life. Scholarships support continuity of care to children so that previously formed supportive relationships with caregivers can remain in place. Research shows that children thrive in the care of familiar, skilled caregivers who play a significant role in their lives and on whom they count for consistency, feelings of security, belonging and love. Continuity of care is particularly important for infants and toddlers as they are in the developmental stages of building basic trust and a sense of self.[ii] Disruptions in care, particularly those that are abrupt, that result from changes in child care settings can be minimized with the use of Quality First Scholarships.

In addition to promoting continuity of care, Quality First Scholarships can help families to access high quality early care and education with learning environments that meet the developmental needs of young children. Preliminary findings from First Things First parent surveys and individual interviews with families receiving scholarships reveal that even short exposures to quality care result in developmental benefits such as improved language and social skills, and increased recognition of numbers, letters and shapes.

Renowned Professor of Economics, James J. Heckman, advocates strongly for quality early care and education programs that target disadvantaged children. Living in families that are struggling to survive, children in low-income families are particularly vulnerable to insecurity in food, housing and other basic need areas. This lack of supports in turn can impact a young child's development. Without access to stable settings, children from impoverished families often do not receive the cognitive and social supports they need that have been shown to be the determinants of future socioeconomic success. In several reports, Heckman demonstrates that enriching early environments can help to overcome the challenges of being born into a disadvantaged family.[iii]

Benefits to Families

The high cost of early care and education is one of the most difficult obstacles to obtaining and maintaining employment for many low-income single-parent families. Without access to quality care, working families are forced to decide whether to quit their jobs or leave children in the care that is not their primary choice.

Families with incomes less than 200% of the Federal Poverty Guidelines (FPL) may lack the resources necessary to place children with providers offering quality early care and education. Quality child care is costly due to factors such as low staff to child ratios, small group sizes, employment of experienced professionals with early education degrees, higher

wages to pay for education and experience, and early learning environments and curricula designed to maximize the social and developmental needs of children.

Quality First Scholarships support families who are employed, seeking employment or who are improving their skills by participating in training or education to better compete in the market place and who wish to give their children an educational boost. Although families with incomes less than 165% of the FPL would otherwise qualify for child care subsidies through the DES, legislative budget cuts have resulted in a waiting list for subsidies. To date, thousands of children are on the DES waiting list which is only expected to increase as a result of additional budget cuts.

Benefits to the Early Care and Education Industry

Dramatic decreases in enrollment, increasing costs, and decreased DES child care reimbursements have resulted in severe financial pressures experienced by child care providers in both center- and home-based settings. Providers across the state have closed their doors, and many others are threatened with closure without an infrastructure in place to help them stabilize their financial situations. Quality First Scholarships offer a reliable source of income that contributes to the financial stability of regulated providers and allows them to remain operational. With improved financial stability, centers and homes have the increased ability to maintain staff which contributes to the stability of the environment and quality of care to enrolled children. Scholarships also play a strong role in achieving and maintaining high quality care and education.

Benefits to Communities

Early care and education providers serve an important function in communities throughout Arizona. Not only do they provide a safe and nurturing environment for young children, they also play a pivotal role in supporting working parents. The child care industry contributes to the economy by employing some 15,000 individuals in Arizona[iv] thereby contributing to both the local and state tax base. Quality First Scholarships, then, support the healthy development of young children, keep parents working, and support the child care industry – all factors that contribute to the economic viability of communities in Arizona.

Best Practices: Introduction

While scholarships are a growing trend across the nation, the majority of these programs have been developed during the current economic downturn. In addition to Arizona, two states have initiated early care and education scholarships. One program, based in St. Paul, Minnesota, was launched in 2008 as a four-year pilot project funded by foundation dollars. This program targets three-year-olds and supplies a scholarship for two consecutive years per child to support a child's continuity of care with their provider as a means to enhance school readiness. A parent mentoring component is also included. The program serves families at or below 185% of FPL with a total of 171 children enrolled in an early childhood education program during fall 2008. The Minnesota scholarship program is currently being evaluated; no preliminary data is available.[v]

Arizona was the first in the nation to launch a statewide scholarship program through its First Things First Emergency Child Care Scholarships. Implemented in April 2009, the Early Childhood Development and Health Board allocated $23 million to address the sudden economic downturn in the state. Over 10,000 children benefited from the emergency program. In addition, more than one-third of Regional Partnership Councils approved additional funding to continue the scholarship program through the end of FY2010 and many regions funded scholarships in FY2011.

One other state, Tennessee, is using $42 million from the American Recovery and Reinvestment Act to fund scholarships through September 2010 or until funding is exhausted (whichever comes first). Tennessee is making scholarships available to working families with young children including those children up to age 12 in after-school and summer programs. Tennessee anticipates serving a total of 7,000 children. The program is administered by the state Department of Human Services.

Best Practices: Core Principles
Quality First Scholarships are to be used as a strategy to improve both access and affordability to high quality early care and education. These core principles have been developed based on lessons learned during First Things First's initial Emergency Child Care Scholarship program, as well as limited experiences of other states.

Cultural Competency
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.

Early Care and Education Provider Eligibility and Guidelines

1. Early care and education programs participating in First Things First funding quality, access and affordability opportunities are required to be regulated by any applicable State, Federal or Tribal authorities. First Things First (or when applicable, a designated administrative home) has the responsibility for monitoring and verifying that early care and education programs meet the following eligibility criteria for participation:
    A. Provides early care and education services to children with the age range of birth through age five.
    B. Complies with requirements of the appropriate certifying, licensing or regulatory authority or authorities and is in good standing with those authorities, and
    C. Program demonstrates a commitment to quality by one of the following:
        i. Is enrolled as a Quality First participant and actively working towards quality improvement, or
        ii. Is accredited by one of the 6 national accreditations recognized also by ADE and DES, or
        iii. Has applied for Quality First (improvement or rating, when available) and does not decline an opportunity to participate.

    [Approved, FTF Board, as part of the construction policy October 27, 2009]

    Note 1: Those programs who have, previous to this updated policy, declined enrollment in Quality First, can reapply. If Quality First Improvement or Rating opportunity is offered and declined, from here forward, the program will no longer be eligible for funding through FTF.
    Note 2: Programs which decline enrollment in the Quality First improvement program, due to their participation in another approved quality improvement program (Arizona Self-Study, Hands on Quality -United Way Tucson Southern Arizona, and Helios Education Foundation and Valley of the Sun United Way Professional Development Project) may be allowed to participate in FTF funding opportunities. These programs will be expected to participate in the Quality First Rating system, when available.

    [Approved, workgroup 1/24/10]

    D. As the emphasis is that providers ensure continuity of care for young children in a safe, nurturing environment, eligibility determination shall not occur more frequently than every 12 months.
    E. Providers receiving Quality First Scholarships shall not charge more than their usual and customary rate. The scholarship and parental copayment may add up to, but not exceed, the customary rate.
    F. Child care providers shall offer Quality First Scholarships to working families, families looking for work, and families engaged in high school, technical training or postsecondary education.
    G. Providers shall ensure equity in access to Quality First Scholarships and practices that support the full inclusion of children with special needs.

H. In addition to the above listed eligibility criteria, selection for provider participation shall be based on regional priorities.

I. The number of participating providers will, by necessity, be limited due to financial constraints. Each region will set caps to enrollment based on licensure capacity.

   i. At no time shall providers exceed the following numbers of Quality First Scholarships (unless exceptional circumstances exist and a written directive from First Things First is given):

      1. Small Family Homes: 2
      2. Family Group Homes 4
      3. Small Centers 10
      4. Medium Centers 15
      5. Large Centers 20

J. Participating early care and education providers shall determine child eligibility and track certain activities including: attendance, enrollment requirements, and financial information. This information must be maintained in a secure and anonymous manner and be made available to First Things First assignees and designated outside observers of program activities. Random audits shall be conducted by the administrative home to assure fiscal and program accountability.

K. Providers serving families working nontraditional hours are to receive the same scholarship benefits as those working traditional hours with adjustments made to daily rates based on traditional care equivalents.

L. Attendance: In instances of chronic absenteeism by a child, individual circumstances will be assessed and a decision made in conjunction with FTF staff as to whether a scholarship will be terminated or continued due to extenuating circumstances.

Family Eligibility and Guidelines

1. Eligibility for Quality First Scholarships is limited to families with incomes at or below 200% of the most recent Federal Poverty Level (FPL) who have children ages birth through age five and not yet in kindergarten.

   A. Because of limited resources or to align with needs identified in their regional needs and assets report, Regional Partnership Councils may target Quality First Scholarships to subpopulations within the birth through age five population such as infants and toddlers only or preschoolers only.

   B. Families who have children with special needs are eligible and must be given equal access to Quality First Scholarships.

   C. Families shall complete a scholarship application, along with required verification such as proof of family income and proof of citizenship or legal residency of children.

   D. Due to limited resources, families with a parent available to care for their children who are seeking employment are limited to part-time scholarships until they become employed for 20 or more hours per week.

   E. Quality First Scholarships should reduce, not eliminate the parent contribution, by establishing an affordable rate for families that, ideally, would not to exceed 10% of their gross income.

   F. Quality First Scholarships are not available to children in families currently receiving a DES child care subsidy. Families who are the waiting list for DES subsidized child care are eligible for Quality First Scholarships but are required to accept the DES subsidy when offered. Declining the subsidy will result in the loss of any Quality First Scholarships a family receives.

   G. Children enrolled in part-time programs (less than 20 hours per week) may receive part-time scholarships.

   H. The maximum number of Quality First Scholarships available to any given family is two although special circumstances may warrant exceptions.

   I. Quality First Scholarships should accommodate families working non-traditional hours.

Accountability and Documentation

1. An administrative home is used to manage the administration of Quality First Scholarship funds.
2. Cooperation with evaluation requirements is required and includes active collaboration with the First Things First evaluation division.
3. Quality First Scholarships will be provided through a funding formula. Each enrolled provider will be assigned a specific number of Quality First Scholarships targeting particular age groups of children as determined by the funding council. The rate (tied to the DES Market Rate Survey) per scholarship is based on the median cost of care of the most current Des Market Rate Survey. The daily rate is multiplied by 250 (representing 5 days per week multiplied by 50 weeks) for a full 12 month period. Participating providers will be reimbursed for 1/13 of this amount for each child they serve. Quality First Scholarships implemented for less than one year will be prorated to adjust for the number of months services are provided.
    i. Although the rate is based on a set number of days, it is intended that children enrolled in programs under this funding will be enrolled and allowed to attend all of the normal days of operation.
    ii. It is the intention of First Things First to update the funding formula in the future to tie Quality First Scholarship amounts to quality rating.
    iii. By accepting formula funding, providers benefit from receiving regular program to facilitate their day-to-day operations and ability to engage in long-term planning.
4. Participating providers must agree to fill all Quality First Scholarship vacancies and are accountable for maintaining 90% enrollment, at minimum, throughout the contract period. When vacancies occur, the provider must immediately fill the vacancy with an eligible child.
    i. In order to ensure full enrollment, each provider shall develop and maintain a waiting list to assure that eligible children enter the program as vacancies occur. The provider may wish to contact the Child Care Resource and Referral to fill vacant enrollments.
    ii. Providers that consistently fail to maintain enrollment requirements are subject to a reduction in the maximum number of available scholarships assigned to them or they may request to do so through the administrative home.
    iii. Continued underenrollment may result in the discontinuation of program participation and payment.
5. Programs and administrative homes are required to demonstrate practices which maximize existing resources and opportunities, such as federal and state funding.
6. A provider may at no time receive a Quality First Scholarship for more than their customary rate. The Quality First Scholarship amount alone or in combination with a parent copayment cannot exceed the provider's customary rate. Participating providers shall accept the Quality First Scholarship and parent contribution as payment in full.

Quality First Scholarship Levels

Quality First Scholarships shall be set at amounts that combine a balance of the actual cost of providing care with the need to keep child care affordable for eligible families (based on the national standard that family copayments should not exceed 10% of gross family income whenever possible). Please refer to number 3 under Accountability and Documentation.

Appeals process

A fair, equitable and objective appeals process will be available to providers and families in the event of disputes. The appeals process will include 3rd party input and will be conducted in a timely manner.

[i] Market Rate Survey. https://egov.azdes.gov/cmsinternet/appreports.aspx?Category=136&subcategory=426

[ii] Lally, J. R. & Signer, S. M. Introduction to Continuity. Available at: http://www.pitc.org/cs/pitclib/download/pitc_res/360/Introduction%20to%20Continuity.pdf?x-r=pcfile_d

[iii] Heckman, J.J. 2008. The Case for Investing in Disadvantaged Young Children. In: Big Ideas for Children: Investing in Our Nation's Future. Available at: http://www.firstfocus.net/Download/BigIdeas.pdf

[iv] Arizona Workforce Informer. Available at: http://www.workforce.az.gov/admin/uploadedPublications/2790_AzOccProj06-16.pdf

[v] Minnesota Early Learning Foundation. (2009). Summary of Annual Report. Available at: http://www.melf.us/vertical/Sites/%7B3D4B6DDA-94F7-44A4-899D-3267CBEB798B%7D/uploads/%7B3D934F12-4EAA-4BC2-9D87-55CDB858D526%7D.PDF

Child Care Scholarships

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 is 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 Scholarships**, the unit of service is:

Total number of children receiving scholarships

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 Scholarships**, performance measures are:

Total number of early care and education providers offering scholarships/proposed service number
Total number of children receiving scholarships/proposed service number
Total number of families benefitting from scholarships/proposed service number
Total cost for parents/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 **Child Care Scholarships**, the data reporting template is:

In Development

Data Reporting Instructions

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

For **Child Care Scholarships**, 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 with separate data for each Regional Partnership Council area, for each reporting period.

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

Worksheet 1: Service Numbers

General Information

1. **Provider Name:** Your organization's name.
2. **Contract ID:** Your organization's FTF Contract number.
3. **Reporting Period:** Month/Year of data
4. **User completing report:** The name of the person completing the report.
5. **User completing report's email:** The email address of the person completing the report.
6. **Date completed:** The date of when the report was completed.

I. Child Care Providers Scholarship Data Fields

For all Regional Partnership Councils in which you are serving children and families provide a separate row of scholarship summary fields for each unique combination of reporting period and provider type:

7. **Regional Partnership Council:** The name of the Regional Partnership Council in which your organization is serving children & families.
8. **Reporting Period:** The month for which the data is being reported.
9. **Provider Type:** The type of provider: Home or Center Based Child Care Provider
10. **Number of providers offering scholarship or stipends:** The total number of providers that offered scholarship or stipends to families.
11. **Number of NEW families benefitting from scholarship or stipends:** The total number of new families that received a scholarship or stipend during the month.
12. **Number of CONTINUING families benefitting from scholarship or stipends.** The total number of continuing families that received a scholarship or stipend during the month.
13. **Number of DISENROLLED families.** The number of families disenrolled during the month.
14. **Number of NEW Infants (0-12 months) benefitting from scholarship or stipends.** The total number of new infants (0-12 months) that received a scholarship or stipend during the month.
15. **Number of CONTINUING Infants (0-12 months) benefitting from scholarship or stipends.** The total number of continuing infants (0-12 months) that received a scholarship or stipend during the month.
16. **Number of DISENROLLED infants.** The number of infants disenrolled during the month.

17. **Number of NEW Toddlers (13-35 months) benefitting from scholarship or stipends.** The total number of new toddlers (13-35 months) that received a scholarship or stipend during the month.
18. **Number of CONTINUING Toddlers (13-35 months) benefitting from scholarship or stipends.** The total number of continuing toddlers (13-35 months) that received a scholarship or stipend during the month.
19. **Number of DISENROLLED toddlers.** The number of toddlers disenrolled during the month.
20. **Number of NEW Preschoolers (36+ months) benefitting from scholarship or stipends.** The total number of new preschoolers (36+ months) that received a scholarship or stipend during the month.
21. **Number of CONTINUING Toddlers (36+months) benefitting from scholarship or stipends.** The total number of continuing preschoolers (36+ months) that received a scholarship or stipend during the month.
22. **Number of DISENROLLED preschoolers.** The number of preschoolers disenrolled during the month.
23. **Number of NEW children with Special Needs benefitting from scholarship or stipends.** The total number of new children with special needs (0-71 months) that received a scholarship or stipend during the month.
24. **Number of CONTINUING children with Special Needs benefitting from scholarship or stipends.** The total number of continuing children with special needs (0-71 months) that received a scholarship or stipend during the month.
25. **Number of DISENROLLED children with special needs.** The number of children with special needs disenrolled during the month.

Worksheet 2: Out of pocket cost

II. Total out of pocket costs to parents per child per month

For all Regional Partnership Councils in which you are serving children and families provide a separate row of co-pay fields for each unique combination of reporting period, age group, length of day, and provider type:

1. **Regional Partnership Council:** The name of the Regional Partnership Council in which your organization is serving children & families.
2. **Age Group:** The age group of the children benefiting from the stipend: Infants (0-12 months), Toddlers (13-35 months) or Preschoolers (36+ months).
3. **Length of Day:** Half or Full day child care.
4. **Provider Type:** The type of provider: Home or Center Based Child Care Provider.

Please enter the number of children by amount of parent's co-pay:

5. ***$0 co-pay***
6. ***$1-49***
7. ***$50-99***
8. ***$100-149***
9. ***$150-199***
10. ***$200-249***
11. ***$250-299***

12. ***$300-349***
13. ***$350-399***
14. ***$400-449***
15. ***$500 and over***

Frequently Asked Questions

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

For **Child Care Scholarships**, the frequently asked questions are:

In development

GOAL AREA: QUALITY, ACCESS AND AFFORDABILITY

STRATEGY NAME: EXPANSION PRE K AND HEAD START

GOAL:

- **FTF will increase availability and affordability of early care and education settings.**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Pre-kindergarten Expansion is a high quality, part- or full-time, classroom-based early education model. Children are enrolled in schools and community-bases sites, with group size and ratios appropriate to ages, well-qualified professional teachers, curriculum and assessments, health, and parent supports. Target population is children ages 3 and/or 4 years of age from low-income families. Family copayments are kept at an affordable rate. This strategy supports the expansion of programming for those children who may not otherwise have access to high quality early care and education during the two years prior to their kindergarten entry by either increasing the number of hours children participate in a high quality program or by increasing the number of children who can be served. Inherent in this strategy is the principle that all families, regardless of income, children's abilities or other factors have the right to access a high quality early childhood program. Ensuring that all children	There are multiple longitudinal studies showing that investments in high-quality pre-kindergarten programs improve both short- and long-term outcomes for children. Improvements include school success, high school graduation, college attendance and improved earnings. Negative outcomes are reduced such as involvement in the criminal justice system, grade repetition and high school dropout rates. In estimating the costs of early childhood programs, "Meaningful Investments in Pre-K: Estimating the per-Child Costs of Quality Programs," published by the institute for women's Policy Research in 2008. Available at: http://www.iwpr.org/pdf/G718preknow.pdf. [1] Downer, J. (undated). *Successful Kindergarten Transitions: Developing a Community Action Plan* [PowerPoint slides]. Retrieved from Arizona Department of Education [1] Evaluation of the North Carolina More and Four Pre-Kindergarten Program. (2008). Available at:	Six of the seven regions currently funding this strategy use a single administrative home: the Arizona Department of Education. The administrative home coordinates the program beginning with outreach, applications from school districts and partners, community-based partnership assurances, mentoring to build strong collaborations, technical assistance, data collection, and evaluation. The administrative home has made a multi-year commitment to this project. It is strongly advised that regions use the administrative home to implement pre-k expansion strategies to maximize accountability and program oversight to ensure the standard of practice is being followed.	Pre-kindergarten programs under this strategy are reimbursed via formula funding. Full-time slots, defined as a minimum of 5 days a week, 6 hours per day for a total of 30 hours per week are funded at $600 per month per child. Part-time slots, less than 30 hours per week, are funded at $300 per month per child. The cost to administer the strategy through ADE is 10% of the total investment.

have such access requires the use of a "mixed delivery" system of early care and education. In utilizing a mixed delivery system, this strategy supports access to a wide array of program types, including public school programs as well as private, for-profit programs, and non-profit programs. Therefore, this strategy includes methods by which early care and education programs work collaboratively to provide services to preschool aged children in these various settings. A minimum of 20% of total funding going to a school district must be passed through to a community-based provider or providers. Most regions have increased this investment to 40% by the third year of implementation. Typically, the program year for pre-k is similar to a school year although community-based providers and some schools have opted to operate for 10, 11 and even 12 months.	http://www.fpg.unc.edu/~mafeval/pdfs/year_7_key_findings.pdf	The strategy can easily be expanded to any region in the state, assuming that the public or charter school systems are willing to make application. Pre-k expansion providers, both schools and community-based, are required to be rated when rating is available for Quality First. A number of the programs are enrolled in Quality First Improvement. The geography of a particular region may impact how the model is implemented. For example, in remote regions of the state where community child care does not exist, it may not be possible to implement a mixed service delivery model. A recommendation is that a Regional Council first determines the number of children it wishes to serve and then calculate the dollar amount needed to achieve that number. A number of regions have determined that pairing this strategy with child care scholarships targeting infants and toddlers enables them to increase access and affordability to quality early care and education services for the entire birth to age 5 population.	

Policy Specialist: Jill Stevens

STANDARDS OF PRACTICE[1]

Expansion: Pre K and Head Start

I. Strategy Description

First Things First has identified a need to increase the number of children who receive high quality early care and education services in order to improve young children's success in school and beyond. High quality early childhood services have been strongly linked to both academic and life-skills success among children, especially those from families with several risk factors such as low income, low education levels of parents/caregivers, etc. This strategy addresses the identified need by allocating funds for the provision of high quality, early care and education in a center or classroom based setting. Funding will support the expansion of programming for those children who may not otherwise have access to high quality early care and education during the two years prior to their kindergarten entry by either increasing the number of hours children participate in a high quality program or by increasing the number of children who can be served.

Inherent in this strategy is the principle that all families, regardless of income, children's abilities or other factors have the right to access a high quality early childhood program. Ensuring that all children have such access requires the use of a "mixed delivery" system of early care and education. In utilizing a mixed delivery system, this strategy supports access to a wide array of program types, including public school programs as well as private, for-profit programs, and non-profit programs (whose personnel and/or programming are not funded by a public school entity). Therefore, this strategy includes methods by which early care and education programs work collaboratively to provide services to preschool aged children in these various settings.

High quality early care and education programs maintain the following:

- Safe, healthy environments that support children's learning in ways that are stimulating, engaging and developmentally appropriate.
- High quality instructional staff members who have the education, knowledge and expertise to support children's interactions and facilitate their learning.
- Administrative systems that support staff development, retention and collaboration with the community.
- High levels of engagement by families in their child's program.

II. Service Delivery Standards

<u>Intensity of Service Standard</u>

[1] This Standard of Practice must be accompanied by the following Standards of Practice: Developmental Screening Administration; Sensory Screening; Community Based Family Education

Experts in the study of the effects of early childhood on children's development have found several factors as critical in producing positive outcomes for young children. In addition to high staff-to-child ratios and well-qualified staff, programs found to be most effective are those that operate with significant intensity and duration [both number of hours children attend in a day and the length of the program year(s)] (Bowman, Donovan, & Burns, 2000). To address this factor, those programs operating under this funding are required to enroll children for a minimum number of hours per day and for a minimum number of program days per year.

1. To ensure sufficient intensity and duration of program services, children may be enrolled in either a full day or part day of service based on the following definitions and requirements.
   - A full day of services for children is defined as a minimum of 5 days a week, 6 hours per day for a total of 30 hours per week.
   - A part day of services is defined as less than 30 hours per week, but a program must serve children for a minimum of 3 hours per day, 4 days per week or a total of 12 hours per week over at least 3 days in order to receive funding (a 2 day a week program does not meet the requirements of this grant).
2. Program services must be provided for a minimum of 9 months, or a minimum of 170 program days to be funded at the 9 month allocation.
3. A full year program is defined as one that provides services for a minimum of 245 days per year.

Children's Enrollment, Eligibility, and Attendance Standard

Enrollment and eligibility requirements are intended to ensure that services under this grant funding increase children's access to high quality early care and education. Programs are required to leverage funding and ensure non-duplication of services by meeting the following standards of operation:

1. Programs are required to demonstrate that children served are eligible to participate by conducting effective intake procedures that at minimum obtain documentation of age of child, family income, and proof of the child's legal residency.
   - Age Requirements: Children shall be between at least three years of age on or before September 1 of the program year and not yet enrolled in Kindergarten.
   - Financial Enrollment Requirements – child must meet all requirements listed below:

     a. Children participating may not be receiving duplicate programming through other funding available from State, Federal or Tribal sources such as: Department of Economic Security (DES) child care subsidy, Title I, Special Education Programs, or Head Start. Children eligible for these resources but who are currently on waiting lists for these programs are eligible to participate. AND

     b. Family income must be at or below 200% of the Federal Poverty Level (FPL) unless otherwise specified by a Regional Partnership Council. The definition

of poverty is family income at or below 100%; the definition of low-income is family income at or below 200% of FPL.

i. Documentation of family income eligibility must be obtained by program administrator and be maintained on site for at least two years.
ii. Acceptable documentation of income may include any of the following: current pay stubs; written, notarized statement from employer; documentation of current receipt of unemployment insurance; of documentation of receipt of public assistance such as KidsCare, Food Stamps, Free and Reduced Lunch Program, etc. Adjusted Gross Income as listed on the most current federal Individual Tax Form 1040, Form 1099, or W2 forms may also be used for documentation. For those who are self employed, at least one of the tax forms is required.

2. Children's consistent attendance leads to maximum learning opportunities, therefore, attendance policies must support consistency and ongoing participation. When a child has been absent for three consecutive days, the site administrator should contact the family and identify reasons for non-attendance. Programs must put policies in place to determine when children shall be excluded from participation because of non-attendance. These policies must be in writing and given to the families at time of enrollment. Programs must document all decisions regarding children's continued participation.

Funding and Match Standards

Providing a full range of high quality early childhood services requires both appropriate funding levels as well as significant leveraging of program resources. To ensure equity across the state so that all children have access to quality early care and education, a standard allocation rate has been established. These amounts have been determined to be fair and reasonable based on data collected through the Arizona Department of Education, Early Childhood Block Grant programs and national information on the cost of quality care. [i]

1. To be eligible for funding, programs must be located within the Region providing the grant opportunity.
2. The funding formula will be allocated based on the grantee's proposed total (all of grantee and partner entities) service numbers. The grantee must produce a budget for the actual cost of services. If the total per child dollar amount for actual cost of services is less than the allowable allocation, then the rate will be adjusted accordingly so as not to exceed the actual cost of early childhood services. The formula cost per child (to be reviewed annually) will be computed as follows:
   a. An annual per child rate of $7,200 for a full day, full year, 12 month program and $5,400 and for a full day, 9 month school year program will be established, and the

monthly per child rate of $600 per month will be used as a basis for prorating the formula.

b. An annual per child rate of $3,600 for a part-time, full-year (12 month) program and no more than $2,700 per child for a part-time, 9 month program will be established with a monthly per child rate of $300 per month for use in prorating the formula. These rates will be prorated based on the length of the contract and based on the state fiscal year.

3. Startup costs are recognized as a potential expense during a program's first year of expansion. Therefore, up to 20% of the total allocation may be budgeted for startup costs and activities. Up to 5% of a total allocation may be used for startup costs in subsequent grant periods but only under justifiable circumstances (e.g. a classroom must be moved to another community campus).
4. Startup costs may include but are not limited to the following:
   a. Minor repairs or alterations necessary for the safe operation of an early care and education program
   b. Architectural plans or other requirements for licensure
   c. Purchase of classroom equipment and supplies
   d. First time licensing fees
   e. Staff recruitment and marketing
5. A match requirement for total cost of services is as follows: Programs must match funds at a minimum of 20% of the total cost of services. Matching funds may be provided in cash or through in-kind contributions, fairly evaluated, and may consist of, but are not limited to: building space, IDEA Part B funding, Title I, migrant funds, Child and Adult Food Care Program CACFP) funds, and other state, tribal or federal dollars.
6. Programs are expected to braid funding to provide services to the maximum number of children, but shall not supplant any current funding source and shall provide written assurance that the FTF's funding is not supplanting any currently existing funding.
7. Programs may charge families for wrap-around services (time periods before or after the regular school day), but total funding (parent co-pay, FTF, and match dollars) may not exceed the total cost of the program.
8. Parent contributions toward the cost of early childhood education must remain affordable for families and are not to exceed 10% of the gross family income. Parent contributions plus FTF funding and match dollars may not exceed the total cost of care. Families experiencing financial hardship may be excused from the requirement of cash payment (documentation of the hardship must be maintained). In lieu of cash payment, additional parent participation is required. (See Family Involvement Standards for ways in which families may volunteer)

Program Quality Standard

High-quality early care and education improves young children's "…health and promotes their development and learning" (Pediatrics, 2005). Ensuring effective implementation of a comprehensive, high quality early care and education program requires alignment with a variety of nationally recognized quality indicators. Arizona currently enlists several methods to identify early childhood programs with a significant commitment to providing high quality care and education. Participation in this grant funding requires a program's strong commitment to quality by meeting the following:

1. Programs in receipt of the grant funding must meet the following criteria:
    - Early care and education programs participating in First Things First quality, access and affordability opportunities are required to be regulated by any applicable State, Federal or Tribal authority(ies). First Things First (or when applicable, a designated administrative home) has the responsibility for monitoring and verifying that early care and education programs meet the following eligibility criteria for participation:
        - Provides early care and education services to children within the three through five age range.
        - Complies with requirements of the appropriate certifying, licensing or regulatory authority or authorities and is in good standing with those authorities, and
        - Program demonstrates a commitment to quality by one of the following:
            - Is enrolled as a Quality First participant and actively working toward quality improvement, or
            - Is accredited by one of the six national accreditations recognized also by ADE and DES, or
            - Has applied for Quality First (improvement or rating, when available) and does not decline an opportunity to participate.

Curriculum Standard

Research has found that "while no single curriculum or pedagogical approach can be identified as best, children who attend well-planned, high- quality early childhood programs in which curriculum aims are specified and integrated across domains tend to learn more and are better prepared to master the complex demands of formal schooling" (Bowman, 2000). To ensure curricular approaches are used that both meet the individual and developmental needs of children while also providing them with intentionally designed instruction and activities, the following standards are required:

1. Curriculum is designed around children's interests and needs and aligns clearly with the Arizona Early Learning Standards. Nationally recognized models that align with the state standards and incorporate ongoing assessment to determine instructional needs are given priority over packaged curricula with specifically outlined and prescribed lesson plans. Some examples of appropriate curricular approaches include:

    a. The Creative Curriculum for Pre-School (www.teachingstrategies.com)
    b. High Scope Pre-school Curriculum (www.highscope.org)
    c. Project Approach (www.projectapproach.org)
    d. Reggio Emilio (www.reggiochildren.com)

2. Planning for children's learning aligns with the full content of the Arizona Early Learning Standards rather than providing a focus only on language and literacy and/or numeracy development.
3. All programs will follow the most current edition of ADE "Program Guidelines for High Quality Early Education."
4. All program personnel receive training on using the Arizona Early Learning Standards in the development of appropriate curriculum as part of the initial staff development or when staff members are employed who have not previously completed the training activities.

Child Screening and Assessment Standard

Early identification of children with special needs ensures that young children receive the services and supports necessary to maximize their opportunities for healthy development and learning. School districts are required by statute to "…identify, locate, and evaluate all children with disabilities within their geographic boundaries who are in need of special education and related services" (§300.111 Child Find). Screening activities are a first step in the identification process. Therefore, it is imperative that a comprehensive screening procedure be in place to ensure children are identified and receive the supports they need.

1. All children will receive comprehensive developmental and sensory (vision and hearing) screening within the first 45 calendar days of the first day of attendance in the program in accordance with First Things First Developmental and Sensory Screening Standards of Practice.
2. Comprehensive screening must include assessment of children's cognitive, physical, language/communication, social/emotional and adaptive behavior developmental domains. Additionally, more in-depth social-emotional screenings conducted in the context of children's daily activities and routines, along with parental input, are

encouraged to identify possible needs for further supports related to high risks associated with the low-income population

3. All screening will be conducted in partnership with the local school district(s) to ensure coordinated and seamless efforts are maintained.
4. Programs must ensure that any identified program partners such as districts, Head Start programs, or other community based providers have either the training or support they need to ensure that screening takes place within the timeframe and in a developmentally appropriate manner. Screening will be conducted only by those who have been trained to administer screening instruments or methods.
5. Follow up referrals and activities that are initiated to secure appropriate services will be documented and tracked to ensure that families receive the information and/or services necessary.

Ongoing monitoring of children's progress for the purpose of guiding instruction and making curricular decisions is a critical part of high-quality programming. Formative assessment activities, including using observation, collecting work samples, and gathering family input are a requirement of this funding opportunity.

1. All programs participating in this opportunity shall use the data collected to document children's achievement using one of the Arizona State Board of Education approved instruments. It is highly encouraged that all of the providers receiving this funding within a specific region use the same assessment instruments as are currently being used by the local school district. Programs with current County/Type/District/Site (CTDS) numbers will input student assessment data into the Student Accountability and Information System (SAIS) with ADE on the reporting schedule outlined by ADE. For programs without current CTDS numbers, they will be responsible for collecting and maintaining student assessment data and reporting to FTF in quarterly reporting submissions.
2. Public School entities receiving grants directly through this funding are required to enter student data in the SAIS system for their community-based partners until it is technologically possible for the partners to have direct access into the system.
3. Training in appropriate use of the chosen child assessment is required for all staff not previously trained on the selected instrument/s.

Staff-to-Child Ratio and Class Size Standard

According to Bowman et. al. (2000):

> ***Both class size and adult-child ratios are correlated with greater program effects.*** Low ratios of children to adults are associated with more extensive teacher-child interaction,

more individualization, and less restrictive and controlling teacher behavior. Smaller group size has been associated with more child initiations, more opportunities for teachers to work on extending language, mediating children's social interactions, and encouraging and supporting exploration and problem solving.

To ensure maximum learning opportunities are available to children participating in programs funded through this grant, the following group sizes and ratios are required:

1. Classrooms may not exceed a staff to child ratio of one to ten.
2. Class size may not exceed 20 children.
3. A minimum of one lead teacher and one assistant teacher per classroom for classrooms serving more than ten children is minimum staffing required.
4. When classrooms are used for mixed age groups that include three year olds, or as inclusion settings for children with disabilities, ratios and staffing decisions should be adjusted in accordance with the specific disabilities and/or needs of the children present. At a minimum, these groups will maintain a staff to child ratio of no more than one adult per nine children and a maximum group size of 18.

Family Involvement Standard

More so than any other individual, the parent plays a central role as the most influential person in a child's life. With this understanding, engaging in a two-way, reciprocal relationship with families is paramount to successful, comprehensive early care and education programming. Studies have confirmed that involved parents improve children's progress and increase their likelihood for later school and life success (Desmione, 1999). According to Epstein, et. al. (1997), "parents need an array of options that she classifies as 'parent involvement types' "each with specific practices for implementation. Programs receiving funding under this grant must involve families in a variety of ways that support some or all of the following types of family engagement:

- Parenting: assisting families with parenting skills and understanding their child's development
- Communicating: having two-way communications with families about the early childhood program and their children's progress
- Volunteering: offering a variety of ways for families to volunteer in ways that will support the early childhood program and their child's development
- Learning at Home: involving families with expanding their children's learning within the home setting, especially using everyday routines
- Decision-Making: including parents as participants in programmatic decisions, governance and advocacy

- Collaborating with Community: coordinating resources and services for families, children as well as connecting with local businesses, agencies and other local groups

1. To develop strong family involvement connections, programs in receipt of this funding must create and implement plans for family involvement that align with the effective types of family engagement outlined by Epstein et. al (1997). A copy of the written plan shall be available on-site upon request. Activities outlined in the plan may include but are not limited to the following:

    a. Home or community visits (initial and ongoing)
    b. Family conferences
    c. Classroom visits with options for parents to participate
    d. Process for family involvement in decision-making about their own children
    e. Parent satisfaction surveys
    f. Child progress reports
    g. Parent nights with family activities and parent education activities

2. Family engagement activities shall include a focus on involving the family as key decision makers and assessors of the program
3. Family involvement programs that choose to include community based training activities follow the FTF community-based family education standards of practice when delivering family education services.

<u>Kindergarten Transition Standards</u>

1. As part of ensuring effective collaborations with the community and providing children and families with seamless services as they move to school entry, grantees shall create and implement a written Kindergarten Transition Plan that supports the child and family in making a smooth transition into kindergarten. The transition plan shall include a clearly described partnership between the early childhood provider and the kindergarten program into which each child will enter, whether public or private. Kindergarten transition activities support the following:
    - <u>Child-School Connections</u> to increase children's familiarity with the classroom setting and the people within it.
    - <u>Family-School Connections</u> to increase collaboration and involvement with the school and the transition process.
    - <u>School-School Connections</u> to provide children with stable classroom experiences across time[ii]

Community Collaboration Standards[2]

Both community-based, private providers and public schools are critical to the development of a high quality early childhood education system for young children ages three through five. Financing early childhood education programs through a mixed service delivery model ensures that sufficient resources and standards are in place to support high quality through coordinated community efforts. Additionally, "mixed delivery system" promoted in this strategy offers parents choices on where their children can receive quality early childhood experiences, including in programs located in public schools, Head Start programs, tribal programs, for- and non-profit preschools /centers, and faith-based programs. A true mixed delivery model requires equal and equitable access to programs and funding across early care and education settings. For example, in North Carolina's *More at Four Program*, about 50% of enrolled children are served in public school sites, with 30% served in private early childhood settings and smaller proportions in Head Start.[iii]

1. All grantees in receipt of this funding, regardless of program type (e.g. public school entity, Head Start, private provider), must develop and implement a written plan outlining how the program will create financial and non-financial partnerships with other provider types in the region to ensure effective parent choice using a mixed delivery service model. A copy of the written plan and the implementation status is submitted to FTF with the quarterly report and is available during the on-site monitoring visits.
2. When funding is granted directly to a Head Start or public school entity, partnerships are to be established between school districts and community-based providers to implement a mixed model of service delivery. The model requires that public school (including Charters) and Head Start programs develop meaningful financial and non-financial relationships with community based partners and pass through funding at an equitable level for early childhood education services in the community. A specific percentage of funding must be made available to community-based providers as contractually required and may be increased incrementally to reflect deeper investments in the mixed service delivery model.
3. Coordination and collaboration with all FTF grantees is critical to develop a seamless service delivery system for children and families. Services and program cannot be implemented in isolation and coordination and collaboration must occur within a region and across regions. FTF State and Regional Councils will identify opportunities for

[2] Written and signed Memoranda of Understanding or Partnership Agreementd between partners must be submitted as part of a response either to an ISA or RFGA related to this strategy.

collaboration and coordination within the region and across regions. Representatives from each participating school district will be required to attend meetings and workgroups in the region being served to identify, develop, and implement mechanisms around coordination and collaboration.

Early Care and Education Expansion Training and Qualifications Standards

Administration of this grant funding falls under certain statutory requirements. Specifically, Public School entities and their partners in receipt of this funding are bound by Arizona Administrative Code R7-2-612 which requires either a provisional or standard early childhood education certificate for those individuals teaching in early childhood education programs.

> (quoted in part) For the purposes of this rule, public school early childhood education programs are defined as education programs provided by local education agencies, *including their sub-grantees and contracted providers,* for children birth through age 8 for the purpose of providing academically and developmentally appropriate learning opportunities that are standards-based with defined curriculum and comprehensive in content to include all appropriate developmental and academic areas as defined by the Arizona Early Childhood Education Standards or the Arizona K-12 Academic Standards approved by the Board. …Public school early childhood education programs include, but are not limited to, half day and full day kindergarten programs, Early Childhood Block Grant programs pursuant to A.R.S. § 15-1251, Family Literacy Programs for preschool children pursuant to A.R.S. § 15-191.01, and public school-administered early childhood education programs funded in whole or part with federal funds, such as the Head Start or Even Start programs, provided nothing in these rules conflicts with the terms of the federal grant. *Extended day child care programs provided by local educational agencies are not considered early childhood education programs for purposes of this rule unless the program meets the definition of a public school early childhood education program set forth above*

Director/Administrator Education and Qualifications

1. At a minimum, directors/administrators (those responsible for the direct supervision of the program and staff; this may include principals, program coordinators, provider owner/director) must hold a Bachelors degree in Early Childhood, Child Development and Family Studies, or Early Childhood Special Education. OR Hold a principal's certificate through ADE.

2. Areas of knowledge and competencies in:
    a. Curriculum Development and Planning
    b. Administration and Management of Early Care and Education Programs

c. Leadership Development
d. Developmentally Appropriate Practices
e. Children's Health and Safety
f. Arizona Early Learning Standards
g. Arizona Guidelines for High Quality Early Childhood Programs

Teacher Education and Qualifications

1. At a minimum, all primary classroom teachers must hold an Associate's degree in Early Childhood or Child Development, and be currently enrolled in an approved bachelor's degree program leading to early childhood teacher certification.
2. In accordance with ARS cited above, by July 1, 2012, the primary classroom teacher in grantees that are public school entities and their partners must be a teacher who holds an early childhood certificate or endorsement.
3. In accordance with ARS cited above, July 1, 2012, the teaching assistants in grantees that are public school entities and their partners must have a Child Development Associate Credential (CDA) or an Associate's Degree in Early Childhood Education/Child Development.
4. To address cultural competency objectives, early childhood providers shall ensure that children and families receive from all staff members 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. Early childhood providers should receive ongoing education and training in culturally and linguistically appropriate service delivery. Early Childhood providers should develop participatory, collaborative partnerships with other 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.
5. Staff should have the following areas of knowledge and competencies in:
    a. Typical/Atypical child development
    b. Developmentally Appropriate Practices
    c. Classroom Management
    d. Children's developmental expectations
    e. Curricular planning and design
    f. Children's health and safety
    g. Arizona Early Learning Standards
6. All program personnel will participate in continuing education to remain current and update skills and knowledge to meet the requirements of this scope of work.

7. All personnel will have individualized professional development plans specific to their personal goals and the specific needs of the age group with which they work.

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 early childhood program. Program assessment is collaborative and conducted in partnership with the district's Early Childhood Quality Improvement Practices (EQUIP) process.
2. Supervision of program personnel 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.
3. Compensation and benefits are adequate to support the hiring and retention of highly skilled staff.

III. Strategy Implementation Activities

The intent of this strategy is to increase access to high quality, comprehensive early care and education for preschool age children. Implementing a comprehensive early childhood program requires attention to a variety of system components:

- Effective recruitment and enrollment activities that meet the needs of the community.
- Implementation of an appropriate early education curriculum that provides opportunities for children to learn and grow in safe, nurturing and engaging environments.
- Provision of the necessary personnel training needed to implement high quality services.
- Collaboration with the community to ensure families' access to a variety of resources.
- Partnerships with a variety of early care and education providers in the community to ensure parent choice.

Programs funded under this strategy should be ready or near-ready to provide services to children upon application. This strategy is not intended to be used for major construction or renovation projects. Programs with an existing infrastructure requiring minimal startup capital are targeted for this funding. Activities to be conducted include:

Enrollment Activities

1. Conduct ongoing community outreach and recruitment to identify eligible children for services, and to support community awareness and understanding of the financial opportunities.
2. Complete intake procedures that ensure enrolled children are age and income eligible under contract requirements.
3. Implement enrollment procedures that match the contract's priorities of service delivery, (e.g. only 4 year olds, 3 and 4 year olds, children who have never participated in an early childhood program, etc.).
4. Maintain a viable enrollment wait list to ensure required service numbers are sustained throughout the grant period.
5. Enroll eligible children regardless of special developmental or health care needs and promote highly inclusive practices.
6. Develop and implement effective transition activities for children entering the program, moving between program services, and exiting the program.

Implementation Activities

1. Implement a comprehensive early childhood program using a developmentally appropriate practice based curriculum aligned with the Arizona Early Learning Standards.
2. Conduct ongoing, developmentally appropriate, and naturally occurring child assessment for the purpose of monitoring children's progress and making instructional decisions.
3. Provide ongoing staff development to support the implementation of a developmentally appropriate curriculum, effective adult/child interactions and assessments.

Administration Activities

1. Provide appropriate referrals to families for additional evaluation and/or services as needed.
2. Develop and implement a child attendance policy to support children's consistent attendance and participation.
3. Include family involvement and engagement as a component of comprehensive service delivery by providing meaningful opportunities for parents and families to build trusting relationships and be decision-makers in the early childhood program.
4. Develop and implement staff development plans to ensure the ongoing education of program personnel specific to their roles and responsibilities.
5. Conduct ongoing, reflective practices that continuously assess the quality and effectiveness of the implementation of the early childhood program.
6. Collect and maintain child assessment data using an instrument approved by the Arizona Department of Education.
7. Participate in partnership with public schools in their Early Childhood Quality Improvement Practices (ECQUIP) procedures.

Community Collaboration Activities

In order to promote parent choice and a mixed delivery system of early care and education, coordination and collaboration among the various providers within a region are required. Providers incorporated within this system include, but are not limited to, programs located in public schools, Head Starts, tribal programs, for- and non-profit preschools/centers, and faith-based settings. The activities required for successful coordination and collaboration are as follows:

1. Develop and maintain both financial and non-financial relationships across early childhood program settings as well as share resources and professional development opportunities.
2. Conduct outreach with the various local early childhood education providers in the community for the purpose of including them in the provision of services under this funding.
3. Participate in cross-regional and statewide coordination efforts that may include additional workgroups and meetings.

References:

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Date: 2000

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[i] In estimating the costs of early childhood programs, "Meaningful Investments in Pre-K: Estimating the per-Child Costs of Quality Programs," published by the institute for women's Policy Research in 2008. Available at: http://www.iwpr.org/pdf/G718preknow.pdf.

[ii] Downer, J. (undated). *Successful Kindergarten Transitions: Developing a Community Action Plan* [PowerPoint slides]. Retrieved from Arizona Department of Education

[iii] Evaluation of the North Carolina More and Four Pre-Kindergarten Program. (2008). Available at: http://www.fpg.unc.edu/~mafeval/pdfs/year_7_key_findings.pdf

Expansion: Pre-K and Head Start 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 these requirements:

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

The data reporting template is 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 **Expansion: Pre-K and Head Start,** the units of service:

Total number of public school-district Pre-K sites receiving support
Total number of private/public community partner Pre-K sites receiving support

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 **Expansion: Pre-K and Head Start,** performance measures are:

Total number of public school-district Pre-K sites receiving support
Total number of private/public community partner Pre-K sites receiving support
Total number of increased slots for children/proposed service number
Total number of early care and education providers receiving professional development/proposed service number
Total number of professional development sessions conducted/proposed service number
Total number of early care and education providers applying to be regulated through the Department of Economic Security or the Department of Health Services / targeted 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 **Expansion: Pre-K and Head Start,** the data reporting template is:

Pre- K Expansion Data Reporting Template						
Provider Name	The Arizona Department of Education					
Contract ID						
User Completing Report						
User Completing Report Email						
Reporting Period	**Month**	**Year**				
	January	2010				
Regional Partnership Council						
Date Completed						
DATA ENTRY						
Section I: Which of the following Pre-K sites are in your program?						
School District Pre-K sites (Public)	X					
Private Pre-K sites (Community Partners)	X					
Other	X					
Section II: Number of Pre-K sites served during this period:						
	Number of sites served at the beginning of the month	**Number of classroom (within sites) served at the beginning of the month**	**Number of sites newly enrolled during current month**	**Number of classroom (within sites) newly enrolled during current**	**Number of sites disenrolled during current month**	**Number of classrooms (within sites) disenrolled during current month**

				month		
School District Pre-K sites (Public)						
Private Pre-K sites (Community Partners)						
Other						
Reasons for disenrollment						
	No Longer in Business	**No longer eligible**	**Completed program goals**	**No longer wishes to participate/ Discontinued Services**	**Other (please specify)**	
School District Pre-K sites (Public)					Text --> 999	
Private Pre-K sites (Community Partners)						
Other						

Section III: Preschooler Enrollment			
A. Preschoolers (36+ months)	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
Number of FTF funded preschoolers enrolled at the beginning of this reporting period			
Number of FTF funded preschoolers newly enrolled during this reporting period			
Number of FTF funded preschoolers who disenrolled (withdrew) during this reporting period			
B. Preschooler Disenrollment Reasons	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
Family moved out of the area			
Family transportation			
Family change in schedule			
Program cost			
Child moved to another program			
Program terminated child enrollment			
Other (Please specify):_____			
Total number of FTF funded preschooler vacancies (slots) at the end of the reporting period			
Total number of **non-FTF** funded preschoolers enrolled at the end of the reporting period			
C. Special Needs/ Special Health Care Needs	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
Number of FTF funded preschoolers with identified special needs (IEP, other professionally diagnosed educational disability) and/or special health care needs (504 plan or Individual Health Plan by a medical professional) enrolled at the beginning of this reporting period			

Number of FTF funded preschoolers with identified special needs (IEP, other professionally diagnosed educational disability) and/or special health care needs (504 plan or Individual Health Plan by a medical professional) newly enrolled during this reporting period			
Number of FTF funded preschoolers with identified special needs (IEP, other professionally diagnosed educational disability) and/or special health care needs (504 plan or Individual Health Plan by a medical professional) disenrolled during this reporting period			
D. FTF funded Preschooler Disenrollment Reasons (identified special needs and special health care needs)			
	School District Pre-K sites (Public)	**Private Pre-K sites (Community Partners)**	**Other**
Family moved out of the area			
Family transportation			
Family change in schedule			
Program cost			
Family other specified			
Family other unspecified			
Program terminated enrollment			
Other (Please specify):_____			
Section IV. Developmental and Health Screening Information			
A. Developmental Screening (FTF funded preschoolers ONLY)	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
Number of preschoolers screened during this reporting period			
Number of preschoolers referred for follow up Early Childhood Special Education Services			
Number of preschoolers receiving Early Childhood Special Education Services			
B. Hearing Screening (FTF funded preschoolers ONLY)	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
Number of preschoolers screened during this reporting period			
Number of preschoolers referred for follow up hearing services			
Number of preschoolers receiving hearing services			
C. Vision Screening (FTF funded preschoolers ONLY)	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
Number of preschoolers receiving a vision screening during this reporting period			
Number of preschoolers referred for follow up vision screening			
Number of preschoolers receiving vision services			
D. Oral Health Screening (FTF funded preschoolers ONLY)	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**

Number of preschoolers receiving oral health screening during this reporting period			
Number of preschoolers referred for follow up oral health screening			
Number of preschoolers receiving oral health services			
E. Immunization	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
Number of preschoolers up to date on Immunization shots during this reporting period			
Number of preschoolers needing to have immunization during this reporting period			
Number of preschoolers receiving needed immunizations			

Section V. Staff Information			
A. Staff Employment	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
Number of teachers employed at beginning of current month			
Number of new teachers hired during current month			
Number of teachers leaving employment during current month			
Number of assistant teachers employed at beginning of current month			
Number of assistant teachers hired during current month			
Number of assistant teachers leaving employment during current month			
B. Staff Qualifications	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
Associate Degree			
Bachelor Degree			
Master Degree			
Ph.D.			
C. ECE Staff Certification or Endorsement			
Do any of your staff have an Early Childhood Education (ECE) Certification or Endorsement?			
YES or NO	**YES**	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
If **Yes**, how many?			

Data Reporting Instructions

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

For **Expansion: Pre-K and Head Start,** 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 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

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

Worksheet 1: Pre-K Expansion

***Section I*: Which of the following Pre-K sites are in your program?** Mark all that apply and enter the number of sites for each type.

a. School District Pre-K sites (Public)____
b. Private Pre-K sites (Community Partners)___
c. Other___

***Section II*: *Number of Pre-K sites served during this period*.** *Enter data for each type of Pre-K sites by the following variable breakouts.*

	Number of sites using FTF funds at the beginning of the month	Number of classrooms (within sites) using FTF funds at the beginning of the month	Number of sites using FTF funds newly enrolled during current month (receiving FTF $)	Number of classrooms (within sites) using FTF funds newly enrolled during current month	Number of sites using FTF funds disenrolled during current month	Number of classrooms (within sites) using FTF funds disenrolled during current month
School District Pre-K sites (Public)						
Private Pre-K sites (Community Partners)						
Other						

Section III*: *Preschoolers (37+ months) Enrollment Data by Sites

A. *Preschoolers (37+ months): In this table, you will breakout the children enrolled by the total number of preschool aged children (36-72 months enrolled by *School District/Private Pre-K/Other*).

A. Preschoolers (37+ months)	School District Pre-K sites (Public)	Private Pre-K sites (Community Partners)	Other
Number of FTF funded **full time** preschoolers enrolled at the beginning of this reporting period			
Number of FTF funded **half time** preschoolers enrolled at the beginning of this reporting period			
Number of FTF funded **full time** preschoolers newly enrolled during this reporting period			
Number of FTF funded **half time** preschoolers newly enrolled during this reporting period			
Number of FTF funded **full time** preschoolers who disenrolled (withdrew) during this reporting period			
Number of FTF funded **part time** preschoolers who disenrolled (withdrew) during this reporting period			
Total number of approved full time FTF slots			
Total number of full time FTF funded preschooler vacancies (slots) at the end of the reporting period			
Total number of approved half time FTF slots			
Total number of half time FTF funded preschooler vacancies (slots) at the end of the reporting period			
Total number of non-FTF funded preschooler enrolled at the end of the reporting period			

B. *Special Needs/Special Health Care Needs: In this table, you will breakout the total number of children with special needs/special health care needs by school district/private pre-k/other.

C. Special Needs/ Special Health Care Needs	School District Pre-K sites (Public)	Private Pre-K sites (Community Partners)	Other
Number of FTF funded preschoolers with identified special needs (IEP, other professionally diagnosed educational disability) and/or special health care needs (504 plan or Individual Health Plan by a medical professional) enrolled at the beginning of this reporting period			
Number of FTF funded preschoolers with identified special needs (IEP, other professionally diagnosed educational disability) and/or special health care needs (504 plan or Individual Health Plan by a medical professional) newly enrolled during this reporting period			
Number of FTF funded preschoolers with identified special needs (IEP, other professionally diagnosed educational disability) and/or special health care needs (504 plan or Individual Health Plan by a medical			

professional) disenrolled during this reporting period			

Definition of 'Children with Special Needs': Children who have been identified as having a medical, health, or developmental concern requiring additional supports and services and outlined in an Individual Family Service Plan (IFSP), Individual Education Plan (IEP), Individual Health Plan (IHP) written by a medical provider, or 504 Plan.

Section IV: Developmental, Hearing, Vision, Oral Health, Immunization Screenings

A. Developmental Screening (FTF funded preschoolers ONLY)	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
Number of preschoolers screened during this reporting period			
Number of preschoolers referred for follow up Early Childhood Special Education Services			
B. Hearing Screening (FTF funded preschoolers ONLY)	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
Number of preschoolers screened during this reporting period			
Number of preschoolers referred for follow up hearing services			
C. Vision Screening (FTF funded preschoolers ONLY)	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
Number of preschoolers receiving a vision screening during this reporting period			
Number of preschoolers referred for follow up vision screening			
D. Oral Health Screening (FTF funded preschoolers ONLY)	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
Number of preschoolers receiving oral health screening during this reporting period			
Number of preschoolers referred for follow up oral health screening			
E. Immunization	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
Number of preschoolers up to date on Immunization shots during this reporting period			
Number of preschoolers needing to have immunization during this reporting period			
Number of preschoolers receiving needed immunizations			

Section V: Staff Information

a. In this table please enter data on staff employment by school district, pre-k/private pre-k and/or other sites.

a. Staff Employment	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**

Number of teachers employed at beginning of current month			
Number of new teachers hired during current month			
Number of teachers leaving employment during current month			
Number of assistant teachers employed at beginning of current month			
Number of assistant teachers hired during current month			
Number of assistant teachers leaving employment during current month			

b. Child Care/ECE Staff Qualification

***Number of staff with following qualifications:** In this table, please enter the total number of staff with the following credential by school district pre-k/private pre-k/other sites.

b. Staff Qualifications	**School District Pre-K sites (Public)**	**Private Pre-K sites (Community Partners)**	**Other**
High School Diploma/GED			
Child Development Associate Certificate (CDA)			
Associate Degree			
Bachelor Degree			
Master Degree			
Ph.D.			

c. Child Care/ECE Staff Certification/Endorsement

***Does anyone on your staff have an Early Childhood Education (ECE) Credential or Endorsement? YES or NO**

- If **Yes,** How many? by school district pre-k/private pre-k/other sites____

Worksheet 2: Pre-K Parent Education

Training Session data fields

1. **Name of Training Session:** In this data field you will enter the name/topic of the session (e.g. Parenting Skills, Safety, Early Language and Literacy, Child Development)
2. **Number of Trainers:** In this data field you will enter the number of trainers who offered training in this specific session.
3. **Qualifications of Trainer/s:** In this data field please report the highest degree completed by the trainer/s.
4. **Session format:** This data field is a drop down menu. You can choose either **'One on One'** or **'small group'**. If you choose "**Other (please specify)"-** then you need to enter the format of your session in a row added under this field.
5. **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.**
6. **Session venue:** This data field is a drop down menu. You can choose either one of th**e listed** options or the **'other (please specify)**' option. If you choos**e "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.
7. **Session date:** For this data field you will report the date your session took place using the following format: mm/dd/yyyy.
8. **Session location – City:** In this data field you will enter the **City** at which the session took place. Example: City – Phoenix.
9. **Session location – Zip:** In this data field you will enter the zip code of where the training session occurred. For example: Phoenix, Zip Code: 85012

Target Audience

1. ***Number of Parents/Caregivers enrolled in this session:** In this data field you will enter the total number of parents/caregivers enrolled in the training session.
2. ***Number of Parents/Caregivers attending this session:** In this data field you will enter the total number of parents/caregivers who attended the session.

Pre-K Staff Training

DIRECTIONS FOR DATA ENTRY

***Did your school district offer/conduct any Pre-K staff training during this month? Yes/No**, if yes, please fill out the following data fields

Training Session data fields

1. **Name of Training Session:** In this data field you will enter the name/topic of the session (e.g. Positive Guidance and Discipline, Safety, First Aid)
2. **Number of Trainers:** In this data field you will enter the number of trainers who offered training in this specific session.
3. **Qualifications of Trainer/s:** In this data field please report the highest degree completed by the trainer/s.
4. **Session format:** This data field is a drop down menu. You can choose either **'One on One'** or **'small group'**. If you choose "**Other (please specify)"-** then you need to enter the format of your session in a row added under this field.
5. **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.**
6. ***Session venue:** This data field is a drop down menu. You can choose either one of th**e listed** options or the **'other (please specify)**' option. If you choos**e "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.
7. ***Session date:** For this data field you will report the date your session took place using the following format: mm/dd/yyyy.
8. ***Session location – City:** In this data field you will enter the **City** at which the session took place. Example: City – Phoenix.
9. ***Session location – Zip:** In this data field you will enter the zip code of where the training session occurred. For example: Phoenix, Zip Code: 85012

Target Audience

10. **Number of *Public* Pre-K staff enrolled in this session:** In this data field you will enter the total number of public pre-k staff enrolled in the training session based on the type of target audience.
11. **Number of *Public* Pre-K staff attending:** In this data field you will enter the total number of public pre-k staff who attended the session.
12. **Number of Private Pre-K staff enrolled in this session:** In this data field you will enter the total number of private pre-k staff enrolled in the training session based on the type of target audience.

13. **Number of Private Pre-K staff attending:** In this data field you will enter the total number of private pre-k staff who attended the session.
14. **Number of Other Pre-K staff enrolled in this session:** In this data field you will enter the total number of other pre-k staff enrolled in the training session based on the type of target audience.
15. **Number of Other Pre-K staff attending:** In this data field you will enter the total number of other pre-k staff who attended the session.

Frequently Asked Questions

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

For **Expansion: Pre-K and Head Start**, the frequently asked questions are:

In development

Frequently Asked Questions

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

For **Expansion: Increase slots in regulated classrooms/homes and capital expense**, the frequently asked questions are:

In development

Pre-K Staff Training

DIRECTIONS FOR DATA ENTRY

***Did your school district offer/conduct any Pre-K staff training during this month? Yes/No**, if yes, please fill out the following data fields

Training Session data fields

1. **Name of Training Session:** In this data field you will enter the name/topic of the session (e.g. Positive Guidance and Discipline, Safety, First Aid)
2. **Number of Trainers:** In this data field you will enter the number of trainers who offered training in this specific session.
3. **Qualifications of Trainer/s:** In this data field please report the highest degree completed by the trainer/s.
4. **Session format:** This data field is a drop down menu. You can choose either **'One on One'** or **'small group'**. If you choose "**Other (please specify)"-** then you need to enter the format of your session in a row added under this field.
5. **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.**
6. ***Session venue:** This data field is a drop down menu. You can choose either one of th**e listed** options or the **'other (please specify)**' option. If you choos**e "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.
7. ***Session date:** For this data field you will report the date your session took place using the following format: mm/dd/yyyy.
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9. ***Session location – Zip:** In this data field you will enter the zip code of where the training session occurred. For example: Phoenix, Zip Code: 85012

Target Audience

10. **Number of *Public* Pre-K staff enrolled in this session:** In this data field you will enter the total number of public pre-k staff enrolled in the training session based on the type of target audience.
11. **Number of *Public* Pre-K staff attending:** In this data field you will enter the total number of public pre-k staff who attended the session.
12. **Number of Private Pre-K staff enrolled in this session:** In this data field you will enter the total number of private pre-k staff enrolled in the training session based on the type of target audience.
13. **Number of Private Pre-K staff attending:** In this data field you will enter the total number of private pre-k staff who attended the session.

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14. **Number of Other Pre-K staff enrolled in this session:** In this data field you will enter the total number of other pre-k staff enrolled in the training session based on the type of target audience.
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For **Expansion: Pre-K and Head Start**, the frequently asked questions are:

In development

GOAL AREA: QUALITY, ACCESS AND AFFORDABILITY

STRATEGY NAME: EXPANSION: EXPAND SLOTS AND/OR CAPITAL EXPENSE

EXPANSION: INFANT/TODDLER

GOAL: FTF will increase availability and affordability of early care and education settings.

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
First Things First has identified a need to increase the number of children who receive high quality early care and education services in order to improve young children's success in school and beyond in certain areas of the state. High quality early childhood services are strongly linked to both academic and life-skills success among children, especially those from families with several risk factors such as low income, low education levels of parents/caregivers, etc. Regional funding will support the expansion of programming for those children who may not otherwise have access to high quality early care and education in particular neighborhoods or localities where there is a lack of licensed and/or certified providers. While various models exist, most include financial support for planning, facility improvement grants to renovate or expand current settings in order to allow the program to serve more children. It is also possible for regions to provide financial support for capital improvement as long as the FTF capital improvement policy is followed which requires matching funds.	There exist multiple longitudinal studies showing that investments in high-quality pre-kindergarten programs improve both short- and long-term outcomes for children. Improvements include school success, high school graduation, college attendance and improved earnings. Negative outcomes are reduced such as involvement in the criminal justice system, grade repetition and high school dropout rates.	Child care expansion strategies have proven difficult to implement in the current economic environment. System-wide under-enrollment precipitated by fewer children receiving DES subsidies and higher unemployment means that most providers throughout the state have available child care slots. There are sometimes remote areas of the state or underserved neighborhoods where an increase in child care slots is warranted. A thorough analysis should be conducted when considering child care expansion as a strategy to assure that if new slots are developed, that there are families who can afford them or that this strategy is combined with one that insures access such as Quality First Scholarships. Regions may elect to focus on a subpopulation within the birth to five age range such as infants and toddlers or preschoolers.	The cost of this strategy varies according to the specific needs of a region. Major capital expansion is clearly more expensive than facility modification or minor renovation.

Policy Specialist: Jill Stevens

Expansion: Increase slots in regulated classrooms/homes and capital expense Date 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 these requirements:

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

The data reporting template is 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 **Expansion: Increase slots in regulated classrooms/homes and capital expense,** the units of service are:

Total number of home based early care and education providers served
Total number of center based early care and education providers served
Total number of increased slots for participating children

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 **Expansion: Increase slots in regulated classrooms/homes and capital expense**, performance measures are:

Total number of home based early care and education providers served/proposed service number
Total number of center based early care and education providers served/proposed service number
Total number of increased slots for participating children/proposed service number
Total number of early care and education providers receiving professional development/proposed service number
Total number of professional development sessions conducted/proposed service number
Total number of early care and education providers applying to be regulated through the Department of Economic Security or the Department of Health Services / targeted 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 **Expansion: Increase slots in regulated classrooms/homes and capital expense** the data reporting template is:

In development

Data Reporting Instructions

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

For **Expansion: Increase slots in regulated classrooms/homes and capital expense,** the data reporting instructions are:

In development

Frequently Asked Questions

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

For **Expansion: Increase slots in regulated classrooms/homes and capital expense**, the frequently asked questions are:

In development

Expansion: Increase Infant/Toddler 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 these requirements:

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

The data reporting template is 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 **Expansion: Increase Infant/Toddler,** the units of service are:

Total number of home based early care and education providers served
Total number of center based early care and education providers served
Total number of increased slots for participating children

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 **Expansion: Increase Infant/Toddler**, performance measures are:

> **Total number of home based early care and education providers served/proposed service number**
> **Total number of center based early care and education providers served/proposed service number**
> **Total number of increased slots for participating children/proposed service number**
> Total number of early care and education providers receiving professional development/proposed service number
> Total number of professional development sessions conducted/proposed service number
> Total number of early care and education providers applying to be regulated through the Department of Economic Security or the Department of Health Services / targeted 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 **Expansion: Increase Infant/Toddler,** the data reporting template is:

In development

Data Reporting Instructions

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

For **Expansion: Increase Infant/Toddler,** the data reporting instructions are:

In development

Frequently Asked Questions

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

For **Expansion: Increase Infant/Toddler**, the frequently asked questions are:

In development

GOAL AREA: QUALITY ACCESS AND AFFORDABILITY

STRATEGY NAME: INCLUSION OF CHILDREN WITH SPECIAL NEEDS

GOAL:

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

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
This strategy provides a comprehensive, consultative model which provides on-going training, on-site technical assistance, and a variety of staff supports to promote effective, inclusive practices among early care and education settings. Technical assistance is provided based on assessment to support providers' understanding of established goals and objectives of children's Individualized Education Plans (IEPs), Individual Family Service Plans (IFSPs), or medically diagnosed (by a doctor, psychiatrist or psychologist) health condition and how to incorporate them into the program's established curriculum and daily routines. In addition, identification of adaptive materials or program modifications that may be needed to support children's full participation is also a component of an effective consultative model. Referral and support networks are established and maintained with appropriate state agencies such as the Department of Health Services/Division of Children with Special Health Care Needs, community agencies, social services, AzEIP and school systems so that early care and education providers are able to offer families accurate information and appropriate linkages to needed services.	Information on appropriate and effective inclusionary practices can be found in the joint position statement by NAEYC and DEC at: DEC/NAEYC (2009). *Early childhood inclusion: A joint position statement of the Division for Early Childhood (DEC) and the National Association for the Education of Young Children (NAEYC).* Chapel Hill: The University of North Carolina, FPG Child Development Institute	• Providers are often unwilling to serve children with special needs, therefore target numbers should be reasonable and realistic due to likely challenges with outreach and provider enrollment. • Consider whether the region has the capacity to implement the strategy, or will it require seeking contracts outside of the region. • This strategy serves child care providers – not specific children. • As a strategy tied to QAA, eligible providers must meet the requirements of quality indicators • Councils should consider how many consultation models, such as Child Care Health Consultation or Mental Health Consultation, are available in their region currently and ensure coordinated efforts are conducted and managed.	Similar to other consultation models, may be more intense due to the nature of the subject matter. Estimate between 6,500-7,500/ provider served. Include costs for adaptive equipment or environmental materials Additional costs are travel related and administrative

Policy Specialist: Allison Landy

STANDARDS OF PRACTICE

Increasing Inclusion of Children with Special Needs

I. Description of Strategy

As noted in a joint position statement issued by the Division for Early Childhood (DEC) and the National Association for the Education of Young Children (NAEYC), "an ever-increasing number of infants and young children with and without disabilities play, develop, and learn together in a variety of places – homes, early childhood programs, neighborhoods, and other community based settings" (2009). In the broadest sense, "early childhood inclusion embodies the values, policies, and practices that support the right of every infant and young child and his or her family, regardless of ability, to participate in a [wide] range of activities and contexts as full members of families, communities, and society" (DEC/NAEYC, 2009). Embracing the philosophies of inclusive practices and family-centered services results in children and their families feeling a strong sense of belonging, development of positive social relationships, and learning occurring to children's fullest potentials.

Inclusive practices benefit all children – both children with special needs as well as those who are typically developing. Research suggests that including children with special needs with typically developing classmates supports the development of individual abilities, interests, positive social relationships, developmental rates, and learning styles of young children both with and without identified disabilities (National Professional Development Center on Inclusion, 2009). Children with identified disabilities may include those who are being served through an Individual Education Plan (IEP), and Individual Family Service Plan (IFSP), or have a medically diagnosed health condition for which the child would benefit from the development of an Individual Health Plan (IHP).

Parents and professionals alike typically view inclusion as a positive ideal, however, many families often share concerns related to the quality of early childhood settings and the capacity of providers to appropriately care for their child. Therefore, improving the quality of early care and education for young children is critical to the successful promotion of inclusive practices. High quality inclusive programs ensure:

- Access – to materials, environments, and services;
- Participation – in a wide range of activities in which typically developing children also participate; and
- Supports - access to a variety of resources, professional development activities, and funding (DEC/NAEYC, 2009).

To address quality improvements in early childhood programs and further promote effective inclusive practices, First Things First supports the provision of a comprehensive, consultative model which provides on-going training, on-site technical assistance, and a variety of staff

supports based on needs. A successful approach is developed first through assessment of the early care and education staff's knowledge base and expertise related to children with disabilities and general understanding of child development. Based on the assessment of staff, an appropriate plan is developed to address individual and programmatic needs. Technical assistance to an early care and education provider is then provided that includes supporting their understanding of established goals and objectives of children's Individualized Education Plans (IEPs), Individual Family Service Plans (IFSPs), or medically diagnosed (by a doctor, psychiatrist or psychologist) health condition and how to incorporate them into the program's established curriculum and daily routines. In addition identification of adaptive materials or program modifications that may be needed to support children's full participation is also a component of an effective consultative model. Furthermore, referral and support networks are established and maintained with appropriate state agencies such as the Department of Health Services/Division of Children with Special Health Care Needs, community agencies, social services, AzEIP and school systems so that early care and education providers are able to offer families accurate information and appropriate linkages to needed services.

II. Early Childhood Consultation delivery includes the following activities:

Early Childhood consultants will provide services to programs that address the needs of all children identified with developmental (IEP or IFSP) or special health care (medically diagnosed condition) needs rather than just providing a focus on any specific type of disability such as autism.

Early childhood consultation for the purpose of improving inclusive practices focuses on the three areas of high quality inclusive settings: access, participation and supports. Consultants ensure these issues are addressed through a wide variety of training and technical assistance activities. These activities include:

1. **Assessment of Program and Staff:**

- Identification of providers who wish to enroll children with special health care or developmental needs or increase services to children with special health care or developmental needs.
- Assess the environment for space, materials and equipment
- Assess the child development knowledge and belief sets of program staff
- Assess the levels of child participation in all program activities
- Assess the availability of program supports such as community services, funds, and professional development opportunities.

2. **Improving Access:**

- Assist with the identification of any equipment or program modifications (e.g. curricular changes, meal changes, etc.) necessary to ensure full participation of all children.
- Assist staff in designing teaching strategies that effectively promote children's progress toward specific goals and objectives as outlined in their IEP or IFSP

- Educate staff on children's development and identifying developmental red flags

3. Improving Participation:

- Educate staff on use of family centered practices and how to best support staff's development of nurturing, responsive relationships with children and families. Facilitate staff abilities to implement family centered practices to include:
    - **Recognition that the family unit is the focus of attention.**
      Family-centered practice works with the family as a collective unit, insuring the safety and well-being of family members.
    - **Emphasis on strengthening the capacity of families to function effectively**
      The primary purpose of family-centered practice is to strengthen the family's potential for carrying out their responsibilities.
    - **Engagement of families in designing all aspects of the policies, services, and program evaluation.**
      Family-centered practitioners partner with families to use their expert knowledge throughout the decision- and goal-making processes and provide individualized, culturally-responsive, and relevant services for each family.
    - **Connection of families with more comprehensive, diverse, and community-based networks of supports and services.**
      Family-centered interventions assist in mobilizing resources to maximize communication, shared planning, and collaboration among the several community and/or neighborhood systems that are directly involved in the family.

(National Resource Center for Permanency and Family Connections, 2009)

- Directly observe staff and child interactions to ensure all children are included in social interactions
- Conduct individual child observations
- Design and implement program practices responsive to the identified needs of an individual child and program
- Support staff with individual child behavior and classroom management
- Provide on-on-one modeling or coaching for individual child support
- Educate providers and parents on children's developmental and health needs

4. Improving Supports:

- Support staff in providing referrals to parents for early intervention, special education referrals or health care referrals.
- Advise and assist staff in linking to community resources and service, including but not limited to the Arizona Early Intervention Program, local school districts, other state agency services such as the Department of Health Services/Division of Children with Special Health Care Needs, health care providers, health insurance information,

and community services such as library programs, local resource centers and behavioral health services.

- Facilitate meetings, conversations, and collaborations between providers and others who serve the child in various settings, including but not limited to outside therapists, AzEIP providers/support coordinators, local school districts, and health care and behavioral health providers.
- Ensure coordination among all service providers delivering training, consultation, and/or coaching services to a provider. Facilitate team-based planning, discussion, and reflection to ensure consistent information is disseminated and multiple methods are used to enhance learning opportunities for the provider.

III. Service Delivery Standards:

1. Intensity of Services

Consultation services must be of sufficient intensity and duration to generate changes in practices. At a minimum, consultants must meet with providers with face to face contact two times each calendar month. However, providers that may need more intensity of service delivery based on assessment will receive the appropriate consultation activities as determined by their needs. Ratios of consultants to providers should be no more than 1 consultant to 10 providers, but be adjusted when the needs of providers (or other community constraints) require more intensive services.

2. Assessment

All consultation models follow a procedure of assessment, individualized plan development, plan implementation and review of assessment activities. Consultation must begin with assessment to determine the specific needs of an individual provider. The following standards should be met in implementing assessment activities:

- If a specific assessment instrument is used, it must be valid for the population and setting for which it is used
- Assessment activities must align with the goals and activities conducted. In the case of consultation for inclusion, assessment must align with the indicators of inclusive practices: access, participation, and supports.
- Assessment activities include multiple methods which may include, but are not limited to, an assessment instrument or tool, personnel surveys, provider's own observations, etc.
- Assessment is conducted prior to consultation plans being developed

3. Improvement Planning

Individualized planning activities matched to assessment results are developed in partnership with participating providers. The standards of plan development include the following:

- Coordination and confirmation of assessment results with others who provide similar or other consultative services to the provider
- Review of assessment results with a provider

- Prioritize needs and identify three to five goals to be met throughout the service delivery
- For each goal, identify the following:
    - Expected outcomes of plan that are attainable within the service delivery timeline, observable, and measurable.
    - Outline of steps to implementation
    - Expected completion date
    - Possible barriers and plans to overcome
    - Identification of where further supports such as financing would be needed
- Monitor progress toward goal attainment during the course of implementation and assess effectiveness of consultation services
- Adjust consultation activities as determined by ongoing monitoring and assessment of practices

4. Relationship-based/Reflective Practices

Consultation to early care and education providers occurs as a means to assist in the development of family-centered, relationship-based and reflective programs. Relationship-based programs are characterized by "trust, support, and growth… among caregivers, parents, and children (Seibel, Britt, Gillespie, and Parlakian, 2009). Consultation activities are provided in such a way that they support a program's overall growth and understanding of inclusion and its value through a process of ongoing teamwork and reflection. Expected activities by the consultant to promote relationship-based organizational development and reflective practices include:

- Assist the program in identifying shared goals of inclusion
- Facilitate the program's commitment to growth and change through the development of individualized program improvement plans which lead to attainment of program goals and reflect its values.
- Schedule ongoing opportunities for reflecting and discussing staff activities, concerns, and new information
- Maintain and encourage respect among and between staff, families, and children
- Encourage and support open communication to share thoughts, ideas and feedback
- Develop opportunities for staff to discuss their concerns and to examine how attitudes, fears and beliefs affect their work;
- Facilitate the development of high standards and expectations for staff through a program definition of professional excellence

(adapted from the PCAN training curriculum: Seibel, Britt, Gillespie, and Parlakian, 2009)

IV. Training and Qualifications of Early Childhood Consultant Standards

Providing training and onsite consultative services to early care and education providers requires specific education and skills.

- For the purpose of increasing the early childhood professional's capacity to provide inclusive services to children with special needs, consultants should be able to demonstrate the following knowledge and expertise

- Knowledge of inclusionary practices;
- Knowledge of child development and recognizing developmental red flags;
- Knowledge of Arizona Early Learning Standards and developmentally appropriate practices;
- Experience providing care and education for young children with disabilities and who are typically developing;
- Ability to work with adults of varying education and skill levels and knowledge of adult learning principles
- Experience providing training and coaching to adults of varying educational and skill levels;
- Knowledge of the Arizona early care and education industry;
- Experience working with families;
- knowledge of and experience in linking early care and education programs with community resources, state early intervention and special education systems, and health care resources
- Observation, listening, interviewing, and assessment skills;
- Curiosity and respect for differences.

- A bachelor's degree or higher in the following disciplines: early childhood education, early childhood special education, speech/language pathology, occupational therapy, physical therapy, music therapy, social work, marriage and family counseling, educational psychology, or child psychology.
- To address cultural competency objectives, consultants shall ensure that providers, children and families receive from all staff members 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.

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

V. Supervision, Quality Assurance and Evaluation Standards

- Supervision of consultants 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 consultation services utilizes quantitative and qualitative process that includes measures of change within the early childhood environment that accrue due to the consultation process and input from staff, families, program administrators, and community members. Evaluation includes review of the original assessment results, review of the improvement plan activities and re-assessment to determine if consultation made improvements to initial assessment activities.
- Compensation and benefits are adequate for supporting high quality staff and retention of that staff.

Inclusion of Children with Special Needs 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 these requirements:

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

The data reporting template is 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 **Inclusion of Children with Special Needs,** the units of service:

Total number of home based early care and education providers served
Total number of center based early care and education providers served

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 **Inclusion of Children with Special Needs,** performance measures are:

> **Total number of home based early care and education providers served/proposed service number**
> **Total number of center based early care and education providers served/proposed service number**
> Total number of increased slots for children/proposed service number
> Ratio of typically developing children to children with special needs served/target service number
> Total number of early care and education providers receiving professional development training/proposed service number
> Total number of professional development training sessions conducted/proposed service number
> Total number of early care and education providers applying to be regulated through the Department of Economic Security or the Department of Health Services / targeted 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 **Inclusion of Children with Special Needs,** the data reporting template is:

In development

Data Reporting Instructions

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

For **Inclusion of Children with Special Needs,** the data reporting instructions are:

In development

Frequently Asked Questions

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

For **Inclusion of Children with Special Needs,** the frequently asked questions are: In development

GOAL AREA: QUALITY, ACCESS AND AFFORDABILITY

STRATEGY NAME: FAMILY, FRIEND AND NEIGHBOR CARE

GOAL:

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

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Family, Friend and Neighbor Care is a strategy to provide support, training, resources and referral for unregulated providers caring for children in their homes in order to increase quality of care provided. There are several different models and components for delivery of this service: • Group meetings and trainings delivered in a series of sessions (14 weeks, for example) bring home-based providers together with qualified and experienced staff to learn elements of quality care and safety. • In-home visits and the use of an environmental rating instrument (FCERS or CCAT-R) to measure quality improvements. • Financial incentives to help purchase safety and quality improvement equipment/materials.	National estimates suggest that as many as 60 percent of all children need child care due to parent's employment and of these, as many as 50 percent of children ages 5 and under are cared for in home-based settings. In Arizona, home-based child care providers can legally care for 4 children for pay, with a maximum limit of 6 children under the age of 12, including their own. For these homes, there is no licensing or regulatory requirement; therefore, there is no mechanism or support system in place to assist these providers in creating high-quality environments for the children in their care. Child care provided by family, friend, and neighbor caregivers, which is typically home-based child care, is for the most part legally exempt from regulation and, is of growing concern to parents and policymakers to ensure that children are in healthy and safe places with quality care.	Various regions in the state use at least three different models to deliver Family, Friend and Neighbor quality improvement services. Considerations for specific components and the associated costs should be made at the local level. Knowledge of the needs for support, the child and family demographics, provider demographics, geography and current capacity of providers to participate should all be part of determining an appropriate model. Current models being implement in Arizona include: 1. Based on a facilitated group model which brings providers together for professional development and practice sessions, includes 14 weeks of classes. The curriculum includes elements of quality care and safety, which are available in English and in Spanish. An evaluation component comprised of the Child Care Assessment Tool for	The unit costs vary based on the program model and vendor providing the services. The facilitated group model cost is about $25,000 per 14 week session. Groups are generally comprised of around 20 providers for a per provider cost of $1,250.

• Additional resources and financial supports for providers toward certified or licensed.	Evidence suggests that training provided to home-based family, friend, and neighbor caregivers can result in positive outcomes for children. In a study including Arizona home-based providers, impact was noted in the following areas: 1) Safety in the home environment, particularly fire safety; 2) Establishing and maintaining a daily schedule for the children; 3) Encouraging providers to utilize the resources of their local library; 4) Developing a written formalized child care services agreement with parents, and 5) Increased knowledge regarding the Child and Adult Food Program. *(ERIC Education Resource Information Center, ED496388, Strategies for Supporting Quality in Kith and Kin Child Care: Findings from the Early Head Start Enhanced Home Visiting Pilot Evaluation. Final Report, http://eric.ed.gov*)	Relatives (CCAT-R) developed by Bank Street College in New York and a self-report comprise some of the evaluation tools. 2. A second model provides up to 4 in-home visits and the use of an environmental rating instrument (FCERS) to assess quality improvement. This model also includes up to $2000 available to each provider to make quality and safety improvements and an additional $500 is available for becoming regulated. 3. A tribal model includes a college course with 9 sessions and college credit available. Course content includes early childhood development, how to create child-friendly spaces in the home, activities and safety issues. Note: The statewide competitive grant serving Coconino and Yuma regions will expire on June 30, 2011.	The in-home model, which makes small grants available to up to 60 providers, costs nearly $6,000 per provider. The tribal model service target is 35 providers at a unit cost of roughly $2,300 per participant.

Policy Specialist – Jillynn Stevens

Standards of Practice
Family, Friend and Neighbor Care

National estimates suggest that as many as 60 percent of all children need child care due to parent's employment and of these, as many as 50 percent of children ages 5 and under are cared for in home-based settings. Home-based care providers largely do not receive regular access to information, education, or training on children's health, safety and child development. In Arizona, home-based child care providers can legally care for 4 children for pay, with a maximum limit of 6 children under the age of 12, including their own. For these homes, there is no licensing or regulatory requirement; therefore, there is no mechanism or support system in place to assist these providers in creating high-quality environments for the children for whom they provide care. Child care provided by family, friend, and neighbor caregivers – home-based child care that is, for the most part, legally exempt from regulation—therefore, is of growing concern to parents and policymakers.

Nationally, in-home care is the most common type of child care for children under the age of 5 whose parents work (Maher & Joesch, 2005; Snyder, Dore, & Adelman, 2005). Nearly half of all children spend their days – and sometimes their nights – in these types of settings (Boushey & Wright, 2004). Increased availability of information, relevant trainings, and supports for providers who care for children in their homes has been identified by several Regional Councils as a strategy to both improve the quality of care being provided, and increase the over-all professional development of these care providers. Additionally, the strategies include expanding existing services of federal, state, tribal, and community agencies to provide research-based resources, seminars and hands-on training to improve basic parenting/care giving skills, knowledge and understanding.

Evidence suggests that training provided to home-based family, friend, and neighbor caregivers can result in positive outcomes for children. For example, report findings from a national study involving Arizona community partners who provided training and support to family, friend, and neighbor caregivers, showed that 81 percent of providers indicated making specific changes in the care provided to the children as a result of their involvement in the program. The impact was noted in the following areas: 1) Safety in the home environment, particularly fire safety; 2) Establishing and maintaining a daily schedule for the children; 3) Encouraging providers to utilize the resources of their local library; 4) Developing a written formalized child care services agreement with parents and 5) Increased knowledge regarding the Child and Adult Food Program. Participants in this program indicated interest in becoming better providers by providing a higher level of care to the children and families they serve. *(ERIC Education Resource Information Center, ED496388, Strategies for Supporting Quality in Kith and Kin Child Care: Findings from the Early Head Start Enhanced Home Visiting Pilot Evaluation. Final Report, http://eric.ed.gov*)

Research has also been conducted relative to promoting the health and safety of children by increasing the knowledge base of families. In several studies regarding toddler obesity, motor

vehicle restraint usage, and increasing father participation in the child-raising process, group sessions, seminars and trainings have been shown to be effective service delivery methods. In recent years, the question of what types of child care programs best prepare children for kindergarten has emerged as a dominant issue in the early care and education public policy agenda. This has been propelled to the forefront due to the national focus on children's school achievement and the widespread creation of state-funded prekindergarten programs for three and four year old children. Growing awareness of the large number of children in unregulated family, friend and neighbor care settings and concerns about school readiness have generated increasing interest in efforts to support these caregivers and their need for professional development. (Research to Policy Connections No. 5, Assessing Initiatives for Family, Friend, and Neighbor Child Care, March 2007).

Those who operate successful child care programs must meet the following requirements:

- Focus on building collaborative partnerships with existing programs and agencies in order to build upon current revenue and funding sources.
- Enhance and expand current training opportunities to include FFN providers.
- Develop evaluative and monitoring processes that are collaborative, ongoing and that include input from providers, program administrators and staff, families, and community members.
- Include pre and post evaluative activities that involve self-assessment by home-based providers, and opportunities for feedback conversations with their trainer/instructor.
- Identify outreach, engagement and retention practices for home-based care providers.
- Demonstrate program effectiveness by meeting and addressing First Things First performance measures, outcomes and key measures.
- Demonstrate evidence that the Grantee can retain high quality staff whose tenure ensures program integrity and consistency in home-based care provider relationships.

While each First Things First funded community-based professional development program may be uniquely designed, they all have a valuable role to play in meeting the complex needs of early care and home based care providers, families, and communities across the State of Arizona. First Things First focuses on programs and services that provide children with the best opportunities for school and life success.

First Things First funded programs may supplement but not supplant other state expenditures on, and federal monies received for early childhood development and health programs. Funding decisions are based upon a robust process of review to ensure programs are supported by research, value the family and use approaches considered to be best practice.

Qualifications for Trainers/Instructors:

- Instructors should be knowledgeable about and possess experience in working with home care providers, adult learners and young children birth to age five.
- Instructors must have experience in early childhood education, elementary education with a concentration in early childhood, child and family studies, or a closely related

field. Supervisors must meet or exceed these requirements with at least two years of program management experience. If programs experience hardship in recruitment efforts, they must notify and consult with First Things First.

- Instructors should possess appropriate credentials and experience in conducting professional development activities.
- Demonstrated knowledge and skills that reflect current best practices and research that are aligned with Early Childhood Education standards for children and professionals.
- Minimum five years experience working with young children (combination of classroom and supervisory experience). If programs experience hardship in recruitment of qualified trainers/instructors, they must notify and consult with First Things First.
- Experience working with adult learners and diverse cultures.
- Knowledge of diverse populations and languages preferred.

Applicants delivering professional development opportunities to FFN providers will be required to ensure that opportunities are designed and implemented according to the following principles:

- Professional development opportunities to early care and home based care providers are based upon a culture of trust and respect.
    - Clearly define program objectives to ensure comprehension, engagement, and retention.
    - Create opportunities for and act upon formal and informal feedback ensuring that input shapes on-going decision-making.
    - Encourage honest, open communication between participants and instructors.
    - Maintain confidentiality, being respectful of program participants.
    - Is culturally responsive
- Sessions should be based on current research, core areas of competency, and early learning standards.
    - Curriculum should incorporate and reflect the theoretical framework that informs practice in the classroom/home.
- Sessions should be responsive to the needs of the region's early care and home based care providers.
- Experiences should be relevant to the participant's background and as a home based care provider.
- Sessions should involve adult active learning techniques for participants.

Providers of community-based professional development opportunities for early care and home based care providers will:

- Increase the availability of and participation of home based providers in high quality professional development opportunities for those working with or preparing to work with children birth through age five.
- Provide high quality professional development opportunities through innovative and creative approaches.
- Develop outreach and recruitment practices that engage and retain participants.
- Provide resource and referral information to participants on the healthy development of young children; and resources available in the community such as early literacy programs, family support agencies, and physical and oral health resources.

- Provide resource and referral information to participants who indicate an interest in being a regulated provider or obtaining certification or degree related to early childhood education and related fields.
- Identify and coordinate with existing training opportunities within the region.
- Conduct trainings based on best practices and research, giving consideration to:
    - Utilizing subject matter experts (Child Care Health Consultants, local physicians, published authors, researchers, etc.) to enhance training content and delivery
    - The frequency and sequence of training sessions
- Provide professional development sessions that are interactive, model desired behaviors, and address the multiple learning styles of adult learners.
    - Topics should address the core competency areas identified by the National Council for Professional Recognition At a minimum, topics must include:
        - Understanding the five domains of early childhood development (physical well being and motor development, social and emotional development, approaches to learning, language development and cognition and general knowledge), including early childhood special education
        - Observing, documenting, and assessing children's behaviors
        - Ensuring safe and healthy learning environments
        - Understanding ethical and professional issues when working with young children
        - Utilizing developmentally appropriate practices
        - Advancing physical and intellectual competence
        - Supporting social/emotional development and using positive guidance techniques
        - Establishing respectful, positive, and productive relationships with families
        - Ensuring a well-run purposeful program responsive to child and family needs
    - Additional training topics may include, but are not limited to:
        - Sensory integration, behavioral health, and special needs
        - Role of creativity in learning
        - Role of materials in the classroom
        - Role of the arts in cognitive and social emotional growth and development
        - Role of the environment and environmental design in children's learning
        - Role of the teacher/educator as researcher
        - Significance of play
        - Written and oral communication skills of providers
- Maintain flexibility and responsiveness to emerging issues in the community and the early childhood field
        - Recruit staff from the community who has extensive knowledge of community resources
        - Recruit staff that reflect the cultural and ethnic experiences and language of the participants, and integrate their expertise into the program
        - Develop a collaborative, coordinated response to community needs.
        - Be accessible for program participants
- Ensure the provision of high-quality professional development opportunities through experienced and responsive staff.

Programs delivering professional development opportunities to support Family Friends and Neighbor Care will be required to ensure that these opportunities are designed and implemented according to the following principles:

- Create collaborations with and among agencies and other early care and education stakeholders such as Arizona Department of Economic Security (DES), Arizona Department of Health Services (ADHS), Arizona Kith & Kin Project, Child Care Resource and Referral, Regional Libraries, Head Start Programs, School Districts, Child Care Health Consultants, Professional Development Training and Scholarship systems, and other programs working with child-care homes.
- Respond to the diversity among Family Friends & Neighbors (FFN) care providers by addressing the individual needs of home-based care providers.
- Address transportation issues or assist with access to transportation, to and from professional development sessions.
- Provide materials to home-based care providers, including safety equipment and/or safety kits, books, or educational materials that are developmentally appropriate for the children being served.
- Ensure community-based professional development seminars and hands-on training are evidence-based and relevant to the communities in which providers are working, seminars, small group sessions or other methods of gathering home-based providers together so that information and materials can be delivered, peer connections can be made, and opportunities for discussion and group learning can be accessible and available.
- Ensure CPR/First Aid certification, and/or safety training for home-based care providers is part of overall training.
- Ensure a system of support for home-based child care providers that incorporates a mentoring or coaching component, is research-based and proven to improve the quality outcomes for home-based child care, and that can be provided via a variety of service delivery methods.
- "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)

FFN services will include:

- Identification and recruitment of in-home providers caring for children birth through age five.
- Fostering professional, supportive relationships between home-based care givers and community-based coaches or mentors.
- Providing assistance, coaching, mentoring and support, by community-based coaches or mentors, to in-home care providers, as needed and appropriate, to increase the quality of child care that is provided and to help move in-home care providers toward appropriate licensure.
- Creating a program improvement plan with the provider, specific to each provider and the children they care for, that will serve as a roadmap for the provider to move towards higher quality of care and potentially towards licensure.
- Implementing a curriculum that is a strength-based approach based on the providers' needs and recommendations and will focus on safety, brain development, social-emotional developmental needs, positive guidance and discipline, nutrition, parent/caregiver relationships, language and literacy, appropriate learning activities, culture, and health and sanitary practices.
- Developing training materials for providers that identify and utilize available resources.
- Fostering partnerships between existing community agencies and entities so that training, information, services and other supports for in-home care providers can be provided at non-traditional settings and locations, such as public schools, and other "education" settings.
- Coordinating with other First Things First funded programs such as the Kith and Kin Statewide Competitive Grant Program funded through First Things First Statewide Competitive Grant and other programs providing services in the community.

Family, Friend, and Neighbor Care 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 these requirements:

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

The data reporting template is 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 **Family, Friend, and Neighbor**, the unit of service is:

Total number of family, friend and neighbor early care and education providers served

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 **Family, Friend, and Neighbor**, performance measures are:

Total number of family, friend and neighbor early care and education providers served/ proposed service number
Total number of family, friend and neighbor early care and education providers receiving professional development/ proposed service number
Total number of professional development sessions conducted/proposed service number
Total number of technical assistance visits conducted/proposed service number
Total number of family, friend and neighbor early care and education providers applying to be regulated through the Department of Economic Security or the Department of Health Services / targeted 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 **Family, Friend, and Neighbor**, the data reporting template is: 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

FAMILY FRIEND AND NEIGHBOR

GENERAL INFORMATION

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

Services Provided

Please select from the list below the format by which you outreach and provide services as part of your program. You must select at least one.

Service Provisions

- ? Outreach and services provided through traditional training/support sessions
- ? Outreach and services provided via other means
- ? Other (Please Specify)

Number of providers served at beginning of the month *

Number of new providers enrolled during current month *

Did any providers disenroll during the current month? If YES please break out the number disenrolled by following reasons. ○ Yes ○ No

If none, please enter zero

Out of Business

Discontinued Services

Completion

Unknown

Other (Please Specify)

Number of providers disenrolled during current month 0

Number of providers served at end of the month 0

Total number of providers receiving services 0

Does your program collect home based caregivers employment related data? ○ Yes ○ No

If none, please enter zero

Number of home based caregivers employed at beginning of the month

Number of home based caregivers newly hired during current month

Number of home based caregivers leaving employment during current month

Number of home based caregivers employed at end of the month 0

Total number of home based caregivers employed this reporting period 0

Does your program collect child enrollment data? ○ Yes ○ No

If none, please enter zero

Number of infants (birth-12 months) served at beginning of the month

Number of new infants enrolled during current month

Number of toddlers (13-35 months) served at beginning of the month

Number of new toddlers enrolled during current month

Number of pre-schoolers (36-71 months) served at beginning of the month

Number of new pre-schoolers enrolled during current month

Number of children with special needs served at beginning of the month

Number of children with special needs newly enrolled during current month

Newly Regulated/Licensed Providers

Does your program collect regulation related data? ○ Yes ○ No

If none, please enter zero

Number of Providers that applied for licensure

Number of Newly Licensed Providers

Number of Providers that applied for regulation

Number of Newly Regulated Providers

Number of Providers that applied for renewal

Number of Newly Renewed Providers

Did you provide any training sessions as part of your program during the current reporting period? *

Yes No

Name of Training Session	Session Date	Session Location City	Session Location Zip

Data Reporting Instructions

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

For **Family, Friends, and Neighbors**, 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 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

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

Section I: Services Provided

Please select from the list below the format by which you outreach and provide serves as part of your program. You must select at least one.

- Outreach and services provided through traditional training/support sessions
- Outreach and services provided via **"other" means**
  - If other, please specify_____

Section II: Data Fields

Providers

1. ***Number of providers served at the beginning of the month:** In this data field you will enter the total number of providers served at the beginning of the month (carryover from previous month).
2. ***Number of new providers enrolled during current month:** In this data field you will enter in the total number of newly enrolled providers during the month.
3. ***Did any providers disenrolled during current month? Yes or No.** *If YES please break out the number disenrolled by the following reasons:* In this data field enter the total number of providers disenrolled by reason breakout for the month.
    a. No longer in business___
    b. Discontinued services___
    c. Completion___
    d. Other (Please specify):_____

Children Served

4. ***Does your program collect child enrollment data? Yes or No:** In this data field you will answer either **Yes or No**. If YES, please answer the following questions relating to children enrollment. If NO, skip this section.
    a. **Number of infants served at the beginning of the month:** In this data field you will enter in the total number of infants (0 to 12 months) enrolled at the beginning of the month (carryover from previous month).
    b. **Number of new infants enrolled during current month:** In this data field you will enter in the total number of newly enrolled infants (0 to 12 months) during the month.
    c. **Number of toddlers served at the beginning of the month:** In this data field you will enter in the total number of toddlers (13 to 35 months) enrolled at the beginning of the month (carryover from previous month).
    d. **Number of new toddlers enrolled during current month:** In this data field you will enter in the total number of newly enrolled toddler (13 to 35 months) during the month.
    e. **Number of preschoolers served at the beginning of the month:** In this data field you will enter in the total number of preschoolers (36 to 71 months) served at the beginning of the month (carryover from previous month).
    f. **Number of preschoolers enrolled during the current month:** In this data field you will enter in the total number of preschoolers (36 to 71 months) enrolled during the month.
    g. **Number of children with special needs (see definition below) served at the beginning of the month:** In this data field you will enter in the total number of special needs children (0 to 71 months) enrolled at the beginning of the month (carryover from previous month).

h. **Number of new children with special needs enrolled during current month:** In this data field you will enter in the total number of newly enrolled special needs children (0 to 71 months) during the month.

Definition of 'Children with Special Needs': Children who have been identified as having a medical, health, or developmental concern requiring additional supports and services and outlined in an Individual Family Service Plan (IFSP), Individual Education Plan (IEP), Individual Health Plan (IHP) written by a medical provider, or 504 Plan.

Section III: Regulated Program

5. ****Does your program collect regulation related data?*** In this data field you will answer either **YES or NO.** If you answer YES, please fill out the following questions in this section. If NO, skip this section.
   a. Number of Providers that applied for licensure
   b. Number of Newly Licensed Providers
   c. Number of Providers that applied for regulation
   d. Number of Newly Regulated Providers
   e. Number of Providers that applied for renewal
   f. Number of Newly Renewed Providers

Section IV: Training Data

6. ***Name of Training Session:** In this data field you will enter name of the training session. Example: Reading, Writing, Numeracy.
7. ***Topic of Training Session:** This data field is a drop down menu choice fields for a session topic. You can choose more than one topic. If none of the topics lists applies to the training session you are conducting, please choose "**Other (please specify)" box** and enter (type in) the Topic of your training session in the text box provided under the Other (Please Specify)" option.
8. ***Number of Trainer(s):** In this data field you will enter the number of trainers who offered training in this specific session.
9. ***Qualifications of Trainer(s) Please select the highest degree achieved by the trainer(s):** 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.
10. ***Description of Session:** In this data field you will enter a brief description about the training session. Example: For the **Session Name**: 'Reading', the **Description** could be- 'what can Early Literacy and Native Language providers support young children's reading skills'.
11. ***Session Format:** 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 format of your session in the text box provided under the Other (Please Specify)" option.
12. ***Duration of Session:** This data field is a drop down menu. You can choose only one choice that best applies for your session.

13. ***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: Resource center.
14. ***Session date:** For this data field you will report the date your session took place.
15. ***Session Location-City:** In this data field you will enter the **City's** name at which the session took place. For example: City: Scottsdale
16. ***Session Location-Zip:** In this data field you will enter the **Zip code** for the city you entered. Example: City: Scottsdale; Zip- 85259.
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.
18. ***Number of Families Enrolled in this session:** In this data field you will enter the total number families who are enrolled in this session.
19. ***Number of Families attending this session:** 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.)
20. ***Number Child Care Provider/Educator Enrolled in this Session:** In this data field you will enter the total number of Child Care Providers/Educators enrolled in this session.
21. ***Number Child Care Provider/Educator Attended this Session:** In this data field you will enter the total number of Child Care Providers/Educators that attended this session.
22. ***Number Children (0-5 years) Enrolled in this Session:** In this data field you will enter number of children (0-5 years) that were enrolled in this session.
23. ***Number Children (0-5 years) Attended this Session:** In this data field you will enter number of children (0-5 years) that attended this session.
24. **Number of Other Enrolled in this Session:** In this data field you will enter number of other (those that do not fit into previous categories) enrolled in this session.
25. **Number of Other Attended this Session:** In this data field you will enter number of other (those that do not fit into previous categories) that attended this session.
26. ***Did the participants receive equipment as part of the training?** In this data field you will answer either **Yes or No**. If yes, then choose from the drop down list of equipments. For example, smoke detector.

Frequently Asked Questions

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

For **Family, Friends, and Neighbors**, the frequently asked questions are:

In development

FTF STRATEGY TOOLKIT

GOAL AREA: Professional Development

FTF Priority: Professional Development System - Convene partners, provide leadership, and provide funding for the development and enhancement of an early childhood professional development system that addresses availability, accessibility, affordability, quality, and articulation.

Goal Area Overview:

Since research has shown that well-educated and highly skilled early childhood teachers are strongly linked with high quality and optimal child outcomes at entry into kindergarten, First Things First will lead the effort to develop a comprehensive and well-articulated professional development system within Arizona. This system will ensure that more early care and education professionals have access to education and training to achieve degrees, credentials and specialized skills to promote children's cognitive, social, emotional and physical development. As a result of higher educational attainment and specialized in-service training, professional compensation will increase and more staff will remain in the field of early care and education.

Strategies	Strategy Workgroup and Leads	Policy Staff	Grants and Contracts Specialist
Scholarships TEACH	Professional Development Workgroup: Marla Chamberlain and Alicia Smith	Alicia Smith	Russell Spenser
FTF Professional REWARD$	Professional Development Workgroup: Marla Chamberlain and Alicia Smith	Alicia Smith	Jeanne Weeks
Scholarships non-TEACH	Professional Development Workgroup: Marla Chamberlain and Alicia Smith	Alicia Smith	
Community-Based ECE Training	Professional Development Workgroup: Marla Chamberlain and Alicia Smith	Alicia Smith	
Director Mentoring/Training	Professional Development Workgroup: Marla Chamberlain and Alicia Smith	Alicia Smith	
Consultation: Language & Communication	Professional Development Workgroup: Marla Chamberlain and Alicia Smith	Allison Landy	
Recruitment into Field	Professional Development Workgroup Marla Chamberlain and Alicia Smith	Alicia Smith	

GOAL AREA: PROFESSIONAL DEVELOPMENT

STRATEGY NAME: SCHOLARSHIPS T.E.A.C.H.

GOAL:

- **First Things First will build a skilled and well prepared early childhood development workforce**
- **First Things First will increase retention of the early care and education workforce**
- **First Things First will enhance specialized skills of the early childhood development and health workforce to promote the healthy social-emotional development of young children**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Teacher Education and Compensation Helps (T.E.A.C.H.) Arizona is a statewide scholarship program for the early care and education teachers, directors and family child care providers working in licensed or regulated programs. The scholarship requires the employer and the scholarship recipient to each pay 10% of the tuition and course work related fees, and the program, through state or regional funding, to pay 80% of the tuition costs. The T.E.A.C.H. Early Childhood® Scholarship: • funds coursework leading to a degree, certificate of completion or national CDA credential; • supports release time, books, tuition, and a bonus for successful fulfillment of the annual T.E.A.C.H. contract • supports employers (sponsors) with staff retention by obtaining a commitment from scholarship recipients (scholars) to remain with the sponsoring employer for a specified	There is research evidence that higher levels of teacher education and qualification are tied to higher quality care and education. Further, the National Association for the Education of Young Children (NAEYC) is refining its conceptual framework for Early Childhood Professional Development, which identifies key principles of an effective professional development system. The 1993 version may be found at: http://www.naeyc.org/files/naeyc/file/positions/PSCONF98.PDF The Child Care Bureau and the Office of Planning, Research and Evaluation (OPRE), both within the Administration for Children and Families, U.S. Department of Health and Human Services, fund a number of research efforts that address the effectiveness, results, and implications of a variety of early care and education professional development interventions, initiatives, and approaches. Emergent findings and their implications may	• Two T.E.A.C.H. scholarships are available for enrolled Quality First (QF) center-based programs and one scholarship is available for every two enrolled QF home-based programs. • Tuition (courses) and fees (e.g. student program, health and wellness, technology and recreation) at state institutions of higher education are anticipated to increase for the academic 2011-2012 year; the percentage is likely to be announced during the 2011 spring semester. • Capacity at the local institutions of higher education, both in the academic departments and in administration, needs to be considered in choosing to invest in additional scholarships	T.E.A.C.H. is funded by statewide QF, regional expansion QF and regional T.E.A.C.H. only allocations. The cost of QF T.E.A.C.H. scholarship is: • $2000 per family child care home • $3300 per center The cost of a regional TEACH only scholarship is: • $3300

period of time (for successfully attaining the CDA, a scholar must commit to remaining with the employer for 6 months; for coursework leading to/and attainment of the Certificate of Completion and the AA degree, a scholar must commit to remaining with the employer for 1 year) • promotes cooperative partnerships among individuals, employers, and higher education institutions Scholars may not concurrently receive a T.E.A.C.H. and a Professional Career Pathways Project (PCPP) scholarship and must apply for Federal Financial Aid A pilot BA scholarships is being conducted during FY 2011; it will be developed for possible implementation in FY2012 T.E.A.C.H. specialists, assigned to a specified regional area, conduct Outreach and marketing	be found on the NCCIC (National Child Care Information and Technical Assistance Center) website: http://nccic.acf.hhs.gov/poptopics/pd_research_findings.html Despite a substantial body of research evidence on the importance of teacher education on the quality of early learning programs, public policy does not fully recognize the value of well-educated, professional, early education teachers. Policy recommendations include designing programs that enable current early education teachers to get a four-year degree: Barnett, W. S. (December 2004). Better teachers, better preschools: Student achievement linked to teacher qualifications. *Preschool Policy Matters*. Online: http://nieer.org/resources/policybriefs/2.pdf	• Extensive outreach and engagement of scholars and their employers may be needed during recruitment. There is a greater likelihood of a scholar's academic success when a worksite supervisor encourages and supports the scholar. • The current economic climate may present financial barriers to sponsor participation; both financial and administrative waivers are available that release the sponsor from paying the bonus or offering release time to scholars. However, sponsors must pay their 10% of the tuition and course work related fees. The scholar agrees to these modifications to the T.E.A.C.H. scholarship and also to honoring the commitment to remain employed with the sponsoring employer for the required period of time. Regional Partnership Councils do not pay for waived scholarship features.	

Policy Specialist: Alicia Smith

Professional Career Pathways Project	Criterion	T.E.A.C.H. ® Arizona
Available to **any** individual who: • Is currently working with children ages birth – five in a licensed, certified, or tribally regulated center-based program • Is a regulated family group home, or family child care provider • Is an unregulated family care provider or a volunteer; however preference is given to regulated providers • Must identify a Pathway (Goal) and pursue the Early Care and Education (ECE) coursework to accomplish that Pathway • Must complete all courses paid for by the PCPP with a grade of "C" or better to be eligible for continued funding	**Eligibility**	Available to **early care and education teachers, directors and family child care providers** who: • are at least 18 years of age • have a high school diploma or GED • are employed in the state of Arizona or work in an eligible Tribal program where 50% of the children, birth to age 5, are Arizona residents • work in a licensed, certified, or tribally regulated center, family child care home or group home • work a minimum of 30 hours each week directly with young children, birth to age 5, or work as a director of a center that serves children ages birth – 5 (Associates Degree Scholarship) • work a minimum of 20 hours a week directly with young children ages birth – 5 (CDA Assessment Scholarship) • have the sponsorship of the center/program or family child care home/group home which employs them • earn $20.00 or less per hour • must complete coursework with a grade of "C" or better to be eligible for additional scholarship; scholar may have to pay cost of repeating a course
Offered at community colleges throughout Arizona, for Early Childhood Education classes only	**Accessibility**	Offered at community colleges that have early childhood programs that lead to the Associates degree; for Early Childhood Education or Child Development programs of study. All required General Education, and Developmental coursework is covered through the T.E.A.C.H. scholarship
Eligible individuals are able to take **up to 6 credits in Early Childhood Education each semester** and **up to 12 credits per school year**	**Credits**	Scholarship recipients must commit to take a **minimum of nine (9) credits and a maximum of 15 credits hours per year**

Professional Career Pathways Project	Criterion	T.E.A.C.H. ® Arizona
• **All tuition and registration** fees are covered for the approved credits • **CDA applications fee ($325.00) is paid** for eligible participants (who have taken at least one course funded by PCPP), depending on funding source • **CDA Mentor Service for eligible participants,** depending on funding source	**Tuition & Services Offered**	• Early Care and Education **Center Teaching and Administration Director staff –** The **employer (sponsor) and** the scholarship **recipient (scholar) each pay 10% of the tuition and course related fees** and the **T.E.A.C.H. program pays 80%** of the tuition and course related fees • **Family Child Care Providers** – The scholarship **recipient pays 10%** of the tuition and course related fees and the **T.E.A.C.H. Program pays 90%** • **Center and Group Home Owners** – The scholarship **recipient pays 20%** of the tuition and course related fees **and T.E.A.C.H. pays 80%**
Early childhood educators receive a **$10.00 per credit stipend for textbooks**	**Book stipend**	**Scholar pays 10% of the** cost of books and **T.E.A.C.H. program pays 90%; scholar retains all books**
Early childhood educators may use the PCPP Grant **at any local participating** community college	**Usage**	• May be use **at any community college** with an **Early Childhood Associates Degree program and an agreement with T.E.A.C.H.** • At this time there are **no agreements at Dine' College** or **Estrella Mountain, Gateway** or **Chandler-Gilbert Community Colleges**
Early childhood **educators receive advisement in conjunction with enrollment** into the program. A coordinated plan of study is on file for each student	**Advisement**	T.E.A.C.H. Specialists, assigned to a specified regional area, may provide suggestions on course enrollment but **refer scholars to campus advisory and early care and education staff**
Each participating college provides support for the PCPP's implementation at their college. PCPP funding is used for tuition, registration fees, and book stipends. Central Arizona College administers the grant for the Arizona Department of Economic Security – Child Care Administration. **Individual colleges do not receive any administrative dollars; however there is an administrative costs included in the unit costs**	**Administrative costs**	**Administrative costs are included in the unit costs** that have been established for each of the various funding allocations (Quality First statewide, Quality First regional expansion and regional T.E.A.C.H. only)
No commitment to remain with the employer	**Commitment**	Must remain with sponsoring employer for **6-12 months,** depending on the type of scholarship received

Scholarships T.E.A.C.H. Data Reporting Requirements

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

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- Frequently Asked Questions

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Definitions:

NOTE: Because of the scope and complexity of the **Scholarships TEACH** program, there are additional program monitoring requirements for the administrative home. The following measurement information is related to the TEACH program overall, not all monitoring requirements are presented here.

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 **Scholarships TEACH,** the unit of service is:

Total number of participating scholars

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 **Scholarships TEACH,** performance measures are:

Total number of participating scholars/proposed service number
Total number of scholars completing a CDA/proposed service number
Total number of scholars completing AA/proposed service number

Data Reporting Templates

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

Data reporting for **Scholarships TEACH** is through regular updates from the **Scholarships TEACH** data system.

Data Reporting Instructions

Data reporting for **Scholarships TEACH** is through regular updates in the **Scholarships TEACH** data system.

Frequently Asked Questions

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

For **Scholarships TEACH,** the frequently asked questions are:

Data reporting for **Scholarships TEACH** is through regular updates in the TEACH data system.

GOAL AREA: PROFESSIONAL DEVELOPMENT

STRATEGY NAME: FIRST THINGS FIRST PROFESSIONAL REWARD$

GOAL:

- **First Things First will build a skilled and well prepared early childhood development workforce**
- **First Things First will increase retention of the early care and education workforce**
- **First Things First will enhance specialized skills of the early childhood development and health workforce to promote the healthy social-emotional development of young children**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
FTF Professional REWARD$, a compensation and retention strategy for the early care and education workforce, acknowledges and rewards progressive education, educational attainment and commitment to continuous employment at a qualified early care and education setting that provides services to children birth through age 5. The Administrative Home, Valley of the Sun United Way, functions under the direction of FTF to administer FTF Professional REWARD$ in collaboration with the councils funding the awards. The incentives are offered twice each fiscal year, with each enrollment period open to applicants who may have received the incentive previously as well as new applicants. Applicants must meet specific criteria and receive an incentive based upon a tiered reimbursement scale containing 9 levels.	The median hourly salary of Arizona early care and education teachers is $9.75 or $20,280 annually as reported in "A Decade of Data: The Compensation and Credentials of Arizona's Early Care and Education Workforce" (2008). Low wages present a major barrier to encouraging high-quality, well-educated, and well-trained personnel to enter and remain in the field. As described in the report, *Building Bright Futures:*	As a new strategy within the bundle of FTF signature programs, REWARD$ has been well received within the early care and education community. In SFY 2010 and 2011 11 Regional Councils have allocated funding for this strategy; there is capacity within the Administrative Home, Valley of the Sun United Way, to increase the number of awards in the initial 11 Regional Partnership Councils, there is not the capacity to expand to additional Regional areas. In SFY 2012 this strategy could be expanded to new Regional areas. There are eligibility requirements for both the applicant and the applicant's employer. Applicants must work at a program, with children birth to age 5,	**SFY 2011:** Administrative cost-**$290.00** Average incentive award--**$2,000.00** **TOTAL-$2,290.00** **SFY 2012:** Administrative cost-**$350.00** Average incentive award--**$2,000.00** **TOTAL-$2,350.00**

REWARD$ provides enrollment opportunities twice each fiscal year. This means that an individual who is eligible to apply may receive an award during each of the enrollments. Regional Councils should consider this in determining the number of incentive awards to fund, and indicate the total number of awards to be funded inclusive of these two enrollments.	*Arizona's Early Childhood Opportunities* (2009), limited resources are available to assist with wage increases. Financial barriers to improved wages include: lower than market rate DES subsidies, few incentives to hire and retain highly qualified staff, and communities where child care costs are at the limit of what the market can bear.	that demonstrate a commitment to quality by either (1) being an enrolled Quality First participant program working towards quality improvement, or (2) being accredited, by a national organization recognized by either the Arizona Department of Education or the Arizona Department of Economic Security-Child Care Administration, at a level which equals a 3-5 star rating in Quality First, or (3) currently on the waiting list for Quality First participation and never declined participation in the Quality First program. Regional Councils also should be aware that once the **total** number of incentives has been awarded, a balance may still exist in their funded allocation. Additional awards, at that point, would require additional administrative funding.	

Policy Specialist: Alicia Smith

Additional Guidelines for Allocating Funding for FTF Professional REWARD$

Regional Partnership Councils choosing to fund FTF Professional REWARD$ should specify both an allotment (dollar) amount and an approximate number of incentives to be awarded (target service number) during the fiscal year. The total allotment should be calculated based upon the unit cost described below*.

Another factor to be considered is that there are two application periods in a fiscal year: one in the fall and one in the spring. During funding plan development, a Council should determine the number of incentive awards to be made and then specify whether the total number of awards is to be made during the fall application period or whether 50% of the awards are to be made in each of the two application periods (fall and spring) of the fiscal year.

When a Regional Partnership Council still has funds remaining, after the target service number has been reached, the Council may designate this funding for additional REWARD$ incentives. Since the Agreement with the Administrative Home specifies the dollar amount allocated for this strategy, the Regional Partnership Council does not need to take any further formal Council action as:

a. No approval is needed to spend a funding amount that has been initially allocated and approved by the Board, and

b. The Regional Partnership Council may utilize the remaining balance of its allocated funding as carry forward to fund REWARD$ eligible participants during a subsequent application period.

The Regional Partnership Council would determine the number of additional REWARD$ professionals who could be funded from the remaining balance of the initially allocated amount (see Options for Councils Regarding Unexpended Funds for REWARD$).

- The number of additional REWARD$ professionals will be determined by dividing the remaining balance by the unit cost established by FTF Finance.

- The unit cost will include an administrative amount and an incentive award amount for each additional award.

- The Council will specify the number of additional REWARD$ professionals for the current application period and/or the additional number of professionals to be funded during the subsequent application period.

***SFY 2012 UNIT COST: For SFY 2012 the REWARD$ amount for each additional award is $2,350 which includes an administrative cost of $350.00 and an award amount of $2,000**

Options for Councils Regarding Unexpended Funds for REWARD$

When a Regional Partnership Council has reached 75% of its targeted service number during an application period, the FTF Professional REWARD$ Administrative Home will notify the Regional Coordinator in writing, with copies to the Regional Manager, the FTF Senior Policy Specialist, and the appropriate Finance staff.

- The notification will indicate the target service number for the application period, the number and percentage of eligible applications received to date, and the approximate funding amount remaining.
- It will then solicit feedback and direction regarding how the Regional Council wishes to use any anticipated unexpended allocated funds.
- The Regional Council will have three options:

OPTION 1:

Fund additional incentives, beyond the target service number, for the current application period. The Council, via the Regional Coordinator, will specify the number of additional incentive awards (and the calculations for the cost) that is to be made, using the calculations provided by FTF Finance.

OR

OPTION 2:

Apply a specified percentage (i.e., 0 - 100%) of the unexpended funds to the current application period.

OR

OPTION 3:

Apply a specified percentage (i.e., 0 - 100%) of the unexpended funds to the next application period.

Within 5 business days of receipt of the notification, the Regional Coordinator will respond in writing, with a copy to the Regional Manager, the FTF Senior Policy Specialist, and the appropriate Finance staff. The response will specify which one of the three options above the Council has chosen.

FTF Professional REWARD$ 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 these requirements:

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

The data reporting template is 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 **FTF Professional REWARD$,** the unit of service is:

Total number of incentive awards distributed

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 **FTF Professional REWARD$,** performance measures are:

> **Total number of incentive awards distributed/proposed service number**
> Total number of scholars participating in REWARD$/proposed service number
> Total number of scholars at each REWARD$ tier/proposed service number
> Total number of scholars progressing to a higher REWARD$ tier/total participants

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 **FTF Professional REWARD$,** the data reporting template is:

In development

Data Reporting Instructions

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

For **FTF Professional REWARD$,** the data reporting instructions are:

In development

Frequently Asked Questions

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

For **FTF Professional REWARD$,** the frequently asked questions are:

In development

GOAL AREA: PROFESSIONAL DEVELOPMENT

STRATEGY NAME: SCHOLARSHIPS NON-TEACH

GOAL:

- **First Things First will build a skilled and well prepared early childhood development workforce**
- **First Things First will increase retention of the early care and education workforce**
- **FTF will enhance specialized skills of the early childhood development and health workforce to promote the healthy social-emotional development of young children**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Purpose: This strategy focuses on providing scholarships for college-credit coursework as a method for the early care and education workforce to gain access to higher education. The goal of the scholarships is to enable an individual to take coursework leading to credentials and degrees by making it possible for them to afford the expense of going to school. **Strategy Provisions:** • Scholarships can only be awarded to individuals attending an accredited institution of higher education or a Tribal College with authority/authorization to provide services within Arizona (e.g. Navajo Technical College), and that has an established Early Care and Education (ECE) program that **1.** Provides students with academic advisement, by an Early Care and	There is research evidence that higher levels of teacher education and qualification are tied to higher quality care and education. Further, the National Association for the Education of Young Children (NAEYC) is refining its conceptual framework for Early Childhood Professional Development, which identifies key principles of an effective professional development system. The 1993 version may be found at: http://www.naeyc.org/files/naeyc/file/positions/PSCONF98.PDF The Child Care Bureau and the Office of Planning, Research and Evaluation (OPRE), both	**All Scholarships:** • Tuition (courses) and fees (e.g. student program, health and wellness, technology and recreation) at state institutions of higher education are anticipated to increase for the academic 2011-2012 year; the percentage is likely to be announced during the spring semester, 2011 • Two statewide scholarship programs, PCPP and T.E.A.C.H., already exist; they provide a variety of options for teachers and directors, and their employers • Capacity at the local institutions of higher education, both in the academic departments and in administration, needs to be considered in choosing to invest in additional scholarships • Extensive outreach and engagement of scholars and their employers may be needed during recruitment. Outreach will require engaging not only the recipients of the scholarships but their employers, since there is a greater likelihood of scholar's academic success when a supervisor can additionally encourage and support the scholar, especially at the worksite • Ideally will link to retention and compensation	Scholarship costs vary depending upon the institution, the degree program and the type of administration. Private colleges and universities often charge higher fees.

Education faculty or advisor; 2. Offers coursework that leads to a degree in early care and education; 3. Demonstrates that its ECE students are making adequate progress. *of the 21 public community colleges in AZ only **Chandler Gilbert**, **Gateway** and **Estrella Mountain** Community College offer no degree in early care and education; all **three state universities offer degrees in early care and education (NAU offers the BS in Career and Technical Education - Early Childhood Education)** **Professional Career Pathways Project (PCPP):** PCPP is a scholarship program offered at community colleges throughout Arizona for Early Childhood Education classes. Central Arizona College (CAC) is the Administrative Home for PCPP, through funding from the Department of Economic Security-Child Care Administration. To be eligible for PCPP priority is given individuals employed in center-based programs, family child care provider homes or family group homes. While participants may also be volunteers or non-paid workers in an early care and education program, these workers are not given priority. The program pays tuition and registration fees for: • Specific courses in Early Childhood Education, including those leading to the	within the Administration for Children and Families, U.S. Department of Health and Human Services, fund a number of research efforts that address the effectiveness, results, and implications of a variety of early care and education professional development interventions, initiatives, and approaches. Emergent findings and their implications may be found on the NCCIC (National Child Care Information and Technical Assistance Center) website: http://nccic.acf.hhs.gov/poptopics/pd_research_findings.html Barnett, W. S. (December 2004). Better teachers, better preschools: Student achievement linked to teacher qualifications. *Preschool Policy Matters*, Online: http://nieer.org/resources/policybriefs/2.pdf	efforts, such as Professional REWARD$ • Many scholars in the early care and education workforce will need assistance in balancing home, work and school. • Current economic climate may prevent scholars from participating **Professional Career Pathways Project (PCPP):** Capacity for expansion— • Current PCPP staff includes: one Program Specialist, one Office Assistant and one Preceptor. This will not be sufficient to manage a program expansion. If participation in the PCPP increases to more than 3,000 units per year, additional staff will be needed. • The initial development of the "Unit Rate" basis for services did not anticipate some of the necessary IT personnel, as well as marketing, outreach and postage will need to be calculated into the unit cost. • Several colleges have increased their tuition for 2010-2011. Some colleges have added	The unit rate for PCPP services, used by Central Arizona College to calculate cost is currently being revised; see "Considerations for Implementation and Cost."

Child Development Associate (CDA) credential, Community College Certificate of Completion and Associate of Applied Science degree in Early Childhood Education. • PCPP does not pay for the General Education courses required for graduation.		additional "course fees" that the PCPP now pays. These need to be added to the "Unit Rate" calculation. • Contact the Policy Specialist to better understand a "unit" of service and other elements of this program. System Building-- • Participants, who receive another grant or scholarship to attend college or have access to other professional development funds, may not be eligible to use the PCPP Grant. The PCPP contact at each campus has additional information. http://www.centralaz.edu/documents/ECE/CollaboratingColleges.pdf • PCPP recipients must be DES certified. • Participants may not have a TEACH and PCPP scholarship concurrently.	

Policy Specialist: Alicia Smith

FIRST THINGS FIRST
Scholarships other than TEACH
CDA, Associate in Arts and Associate in Science Degrees
Standards of Practice

Research has demonstrated that young children perform better when their teachers have a quality education which includes college coursework in early care and education and are well compensated. In Arizona less than half of all teachers of young children have either two or four year degrees. Of those that do, few have degrees in child development or early childhood education. Early care and education professionals often make little more than minimum wage and receive few or no benefits. Low wages present a major barrier to encouraging high-quality, well-educated, and well-trained personnel to enter and remain in the field. High turnover rates, up to 50 percent in many centers, significantly impact continuity of care and create attachment difficulties for children.

Scholarships for college-credit coursework are one method of creating access to higher education for a low-income workforce that lacks the financial means to afford college. Scholarships enable the early childhood workforce to take coursework leading to credentials and degrees by making it possible for them to afford the expense of going to school.

Scholarships must adhere to the following qualifications:

- Scholarships can only be awarded for an accredited Arizona public institution of higher education.
- The College or University must have an established Early Care and Education (ECE) program that provides academic advisement to its students by an Early Care and Education faculty or advisor, and that offers coursework that leads to a degree in early care and education.
- The college must demonstrate that its ECE students are making adequate progress towards receiving their degrees/certificates. Adequate progress is defined as successfully completing 67 percent of courses enrolled during one academic school year.

Agencies disbursing college credit scholarships will:

- Develop criteria for scholarship awards and establish recruitment processes for potential scholars.
- Ensure scholarship applicants are at least 18 years of age and have a high school diploma or GED, or are high school students currently participating in an early care and education course of study through their high schools.
- Ensure that individuals receiving scholarships either work, volunteer or live in the region.
- Identify outreach and access opportunities for engaging potential scholarship applicants.

- Ensure that every scholarship recipient works with an Early Childhood Education advisor or faculty member to develop an individual professional development education pathway/plan and pursues, at an appropriate rate, the early care and education coursework that accomplishes that pathway/plan.
- Make available financial aid assistance, or utilize financial aid advisors at local colleges and universities to provide financial aid assistance to scholarship recipients.
- Confirm that each scholarship recipient has exhausted other forms of financial aid including completion of Federal Financial Aid Program (FAFSA).
- Ensure official written letters/notices of denial or ineligibility/unavailability of additional educational funding sources are submitted (and on file) by scholarship applicants prior to scholarship award.
- Process requests and distribute funding in a timely manner.
- Ensure that scholarship recipients complete a college placement test.
- Conduct scholarship application reviews and make scholarship award recommendations.
- Ensure that all coursework meet the requirements for either the National Child Development Associate (CDA) credential and/or the certificate of completion or 2-year degree in early childhood education. .
- Ensure scholarship recipients enroll in and complete courses paid for by the scholarship with a grade of "C" or better, and provide documentation of grades received for all coursework paid for through the scholarship in order to remain eligible for continued funding.
- Ensure scholarship recipients must pay for any coursework that must be retaken because of failure to achieve a minimum grade of "C" or for withdrawing after the refundable add/drop period.
- Provide the Regional Partnership Council with reports outlining awards made and written updates for each semester indicating the numbers, and amount of scholarships awarded.
- "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

Scholarships non-TEACH 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 these requirements:

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

The data reporting template is 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 **Scholarships non-TEACH,** the unit of service is:

Total number of participating scholars

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 **Scholarships non-TEACH,** performance measures are:

> **Total number of participating scholars/ proposed service number**
> Total number of participating scholars progressing towards or completing educational goals / number of participating scholars
> Total number of participating scholars completing CDA/ 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 **Scholarships non-TEACH,** the data reporting template is:

In development

Data Reporting Instructions

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

For **Scholarships non-TEACH,** the data reporting instructions are:

In development

Frequently Asked Questions

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

For **Scholarships non-TEACH,** the frequently asked questions are:

In development

GOAL AREA: PROFESSIONAL DEVELOPMENT

STRATEGY NAME: COMMUNITY-BASED EARLY CHILDHOOD EDUCATION (ECE) TRAINING

GOAL:

- **First Things First will build a skilled and well prepared early childhood development workforce**
- **First Things First will increase retention of the early care and education workforce**
- **FTF will enhance specialized skills of the early childhood development and health workforce to promote the healthy social-emotional development of young children**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
The Community-Based ECE Training strategy provides a variety of options for engaging the early care and education workforce in high quality professional development, including: • college coursework • single day and multiple day seminars, workshops or trainings The intent of the professional development is to enhance: • classroom skills • knowledge in the early care and education field • leadership and administration skills Participants may be new employees to the early care and education field requiring basic knowledge and skill	Research demonstrates that the most effective types of professional development approaches include content-based as well as hands-on sessions, and one-on-one mentoring or coaching. An Ohio Department of Education (January 2006) report entitled *Critical Issues in Early Educator Professional and Workforce Development* supports the correlation between teachers/administrators education and training, and program quality. Additionally, research over time has found that formal	There is currently no formalized process for awarding college credit for community-based early care and education training/professional development. This will be an area that will require relationship building at the community college level and could require extensive time to develop. The expectation is that the process would begin during year one of funding and then progress towards award of credit. Trainers/facilitators must meet the qualifications established by the institutions of higher education from which credit will be sought. Credit awarded	Costs will be localized and dependent upon qualifications of trainers, type of training, materials, travel, etc. Examples of the per person costs, depending on the model and approach: • $373 for a model that brings various members in the early care and education community and business leaders together for a comprehensive series of workshops, classes and guest speakers • $440 for a model that includes components such as workshops, training tier levels, mentoring, conferences, guest speakers as well as incentive and reward programs for participating individuals who are eligible to

development through pre-service training or those already in the field looking to improve and expand upon their knowledge through in-service training. To demonstrate that professional practice has been improved as a result of professional development, early care and education community-based models should document participant outcomes through: • a pre and post assessment, • documentation of achievement of milestones, or • a follow-up site visit by a mentor or coach It is expected that Grantees will work with institutions of higher education, that provide services to the regional area, to begin a process during year one funding that will lead to the eventual award of college credits for the community-based training.	professional development is related to increased quality care; however, experience without formal training has not been found to be related to quality care….and the value of applying theory to practice is critical to a successful community-based professional development strategy. Galinsky, E.C., Howes, S., & Shinn, M. *The study of children in family care and relative care.* 1994, New York: Families and Work Institute; Kagan, S.L., &Newton, J.W. Public policy report: For-profit and non-profit child care: Similarities and differences. *Young Children,* 1989, 45, 4-10; Whitebook, M., Howes, C., & Phillips, D. *Who cares? Child care teachers and the quality of care in America* 1989, Oakland, CA: Child Care Employee	should articulate to certificate of completion or the degree requirements. Note that the Standard of Practice for Professional Development Community-based early care and education strategies, contain specific criteria dependent upon the focus of the particular training opportunity offered (i.e. training for early care and education professionals, for mentoring/coaching, and for conference scholarships).	earn college credits for coursework completed • $779 for a model that uses high tech support such as teleconferences and webinars coupled with individual workshops and local area conferences.

Policy Specialist: Alicia Smith

FIRST THINGS FIRST
Community-Based Professional Development for Early Care and Education Professionals
Standards of Practice

Because young children, including infants and toddlers, spend so much time in early care and education settings outside their own homes, it is especially important to ensure that the professionals responsible for their early care and education have the tools and skills to promote learning and healthy social and emotional development, and know how to help when development is not progressing as it should. The preparation and ongoing professional development of early educators is a fundamental component of a high quality early learning system. The education and training of teachers and administrators is strongly related to early childhood program quality, and program quality predicts development outcomes for children.[1]

However, early care and education professionals are often nontraditional learners who benefit from a range of professional development supports. First Things First recognizes the need to provide a variety of options to engage early care and education professionals in professional development. In addition to college coursework, other formats of professional development can encourage individuals who have been away from formal schooling to return to the classroom.

While community-based professional development has not been well evaluated, it does provide another logical stepping stone to more formal and credit bearing professional development. Participants will be encouraged and supported to eventually continue their education through college credit coursework and/or participation in T.E.A.C.H and *Quality First!* All professional development opportunities will be required to show successful outcomes, either through an assessment process, achievement of milestones, or a follow-up visit by a mentor or coach to determine if professional practice has been changed based upon what was learned.

First Things First invites innovative and creative ways to provide high quality professional development to the early care and education workforce in Arizona. The broad nature of this strategy allows stakeholders to collaborate in a variety of innovative and creative ways to increase access to quality community-based professional development opportunities. Models of community-based professional development may focus on enhancing leadership and administrative skills among child care administrators in order to enhance program quality. Additionally, grantees may pursue other approaches to professional development, such as the use of cohorts for participants, single day seminars, or multi-day trainings that are held over the course of several months. While these programs come in different forms, they have a common goal of increasing the level of preparation and skill of early care and education providers, and encouraging them to pursue certification and college degrees in the field.

Research demonstrates that the most effective types of professional development approaches include content-based workshops as well as hands-on, one-on-one mentoring or coaching, also referred to as "consultation."

A national, multi-state evaluation on consulting as professional development concluded that on-site consultation resulted in improvements for both center-based care as well as family child care on factors on Harms' environmental rating scales.[2] Further, formal professional development is related to increased quality care;

[1] Ohio Department of Education (January 2006). *Critical Issues in Early Educator Professional and Workforce Development.* Columbus: OH. This paper was funded by the Department under the Commission of the School Readiness Solutions Group, and was developed by Jana Fleming.
[2] Paulsell et al, 2008, *Lessons for Policy and Programs.*

however, experience without formal training has not been found to be related to quality care. Therefore, the value of applying theory to practice is a key element of community-based professional development. [3]

While each First Things First funded community-based professional development program may be uniquely designed, they all have a valuable role to play in meeting the complex needs of early care and education professionals, families, and communities across the State of Arizona. First Things First focuses on programs and services that provide children with the best opportunities for school and life success.

First Things First funded programs may supplement but not supplant other state expenditures on, and federal monies received for early childhood development and health programs. Funding decisions are based upon a robust process of review to ensure programs are supported by research, value the family and use approaches considered to be best practice.

Applicants in regions that contain federally-designated tribal areas must describe their outreach activities for early care and education providers within tribal communities.

Qualifications for Trainers/Instructors:

- Instructors should be knowledgeable about and possess experience in working with both adult learners and young children birth to age five.
- Instructor must have experience in early childhood education, elementary education with a concentration in early childhood, child and family studies, or a closely related field in order to meet the qualifications of adjunct faculty at the local community college. Supervisors must meet or exceed these requirements with at least two years of program management experience. If programs experience hardship in recruitment efforts, they must notify and consult with First Things First.
- Instructors should possess appropriate credentials and experience in conducting professional development activities.
- Demonstrated knowledge and skills that reflect current best practices and research that are aligned with Early Childhood Education standards for children and professionals.
- Minimum five years experience working with young children (combination of classroom and supervisory experience)
- Experience working with adult learners and diverse cultures
- Bilingual English/Spanish preferred

Community Based Professional Development programs delivering professional development opportunities will be required to ensure that opportunities are designed and implemented according to the following principles:

- Professional development opportunities to early care and education professionals are based upon a culture of trust and respect.
    - Clearly define program objectives to ensure comprehension, engagement, and retention.
    - Create opportunities for and act upon formal and informal feedback ensuring that input shapes on-going decision-making.
    - Encourage honest, open communication between participants and instructors.
    - Maintain confidentiality, being respectful of program participants.

[3] Galinsky, E.C., Howes, S., & Shinn, M. *The study of children in family care and relative care.* 1994, New York: Families and Work Institute; Kagan, S.L., &Newton, J.W. Public policy report: For-profit and non-profit child care: Similarities and differences. *Young Children,* 1989, 45, 4-10; Whitebook, M., Howes, C., & Phillips, D. *Who cares? Child care teachers and the quality of care in America* 1989, Oakland, CA: Child Care Employee Project.

    - Is culturally responsive
- Sessions should be based on current research, core areas of competency, and early learning standards.
    - Curriculum should incorporate and reflect the theoretical framework that informs practice in the classroom.
- Sessions should be responsive to the needs of the region's early care and education professionals.
- Participants should be afforded opportunities for practical application of the theoretical foundation to real-life classroom activities and situations.
    - Experiences should be relevant to the participant's background and current role and provide a pathway leading to a specific goal such as a Child Development Associate (CDA) or other.
- Sessions should involve adult active learning techniques for participants.
- Professional development should include opportunities for on-site technical assistance, mentorship, and/or supervision.
- An assessment should be implemented (either formal or informal) of the outcomes for each participant before a certificate of completion is awarded.

Providers of community-based professional development opportunities for early care and education professionals will:

- Increase the availability of and participation in high quality professional development opportunities for those working with or preparing to work with children birth through age five.
- Provide high quality professional development opportunities through innovative and creative approaches.
- Develop outreach and recruitment practices that engage and retain participants.
- Track individual's progress in obtaining the skills necessary to be qualified to care for children.
- Provide resource and referral information to participants on the healthy development of young children; and resources available in the community such as early literacy programs, family support agencies, and physical and oral health resources.
- Provide resource and referral information to participants relative to degree and certification programs in early care and education (and related fields), and higher education scholarships.
- Identify and coordinate with existing training opportunities within the region.
- Conduct trainings based on best practices and research, giving consideration to:
    - Utilizing subject matter experts (visiting faculty, published authors, researchers, etc.) to enhance training content and delivery;
    - The frequency and sequence of training sessions;
    - Having specific identified outcomes that participants must achieve and assessing those outcomes for each participant before documentation of completion is awarded.
- Provide professional development sessions that are interactive, model desired behaviors, and address the multiple learning styles of adult learners.
    - Topics should address the core competency areas identified by the National Council for Professional Recognition. At a minimum, topics must include:
        - Understanding the 5 domains of early childhood development, including early childhood special education
        - Observing, documenting, and assessing children's behaviors
        - Ensuring safe and healthy learning environments
        - Upholding ethical and professional standards
        - Utilizing developmentally appropriate practices
        - Advancing physical and intellectual competence
        - Supporting social/emotional development and using positive guidance techniques
        - Establishing respectful, positive, and productive relationships with families

        - Ensuring a well-run purposeful program responsive to child and family needs
    - Additional training topics may include, but are not limited to:
        - Sensory integration, behavioral health, and special needs
        - Role of creativity in learning
        - Role of materials in the classroom
        - Role of the arts in cognitive and social emotional growth and development
        - Role of the environment and environmental design in children's learning
        - Role of the teacher/educator as researcher
        - Significance of play
        - Written and oral communication skills of providers
- Design and implement an assessment process to determine the extent to which the training has enhanced the knowledge and professional practice of program participants.
- Ensure that community-based trainings meet requirements of the National Council for Professional Recognition (for the Child Development Associate), and the standard requirements for transfer of credit to a certificate or degree in early care and education (or a related field) at the community colleges. In order to facilitate the process for approval of college credit for community-based trainings, grantees will need to identify one representative to participate in a statewide advisory committee that will inform First Things First regarding the requirements for the approval of college credit. First Things First will create the advisory committee once grantees have been identified. The advisory committee may meet either in person or by other means of communication such as telephonically, live meeting, etc.
- Maintain flexibility and responsiveness to emerging issues in the community and the early childhood field.
    - Recruit staff from the community who has extensive knowledge of community resources.
    - Recruit staff that reflect the cultural and ethnic experiences and language of the participants, and integrate their expertise into the program.
    - Develop a collaborative, coordinated response to community needs.
    - Be accessible for program participants.
    - Ensure a manageable classroom size and appropriate staffing patterns.
- Ensure the provision of high-quality professional development opportunities through experienced and responsive staff.

For those grant opportunities that include mentoring/coaching for administrators/practitioners, grantees will, as applicable, need to:

- Establish a mentoring program that includes effective/proven components of mentoring and that views mentoring as a "core component of professional development-a replacement for less effective training modalities, rather than an additional service." [4]
- Identify selection criteria for mentors/coaches and participating administrators/practitioners
- Include roles, responsibilities, and expectations of mentors/coaches and participating administrators/practitioners
- Develop cohorts of participants
- Create a clear and multi-direction communication system
- Develop individualized professional development plans
- Establish mechanisms that support on-going professional development and support for mentors and participants
- Provide mentoring/coaching, to administrators, that supports leadership development and administrative competency

[4] http://ccf.edc.org/PDF/MentorRG_Eng.pdf

- Provide mentoring/coaching, to practitioners, that supports development of self confidence and self-efficacy in teaching (a belief in one's ability to be effective with children and families)
- Develop on-site or near-site trainings for center administrators that address fiscal administration, systems management, human resource development, and related administrative skills/tasks
- Design an evaluation process to assess system efficacy

For those grant opportunities that include conference scholarships, grantees will, as applicable, need to:

- Ensure that trainings offered at conferences meet requirements of the National Council for Professional Recognition (for the Child Development Associate).
- Include opportunities for providers to meet with each other to develop relationships that will provide support that extends beyond the conference schedule.
- Include innovative methods to remove barriers and increase child care provider participation. This may include scholarship and/or travel stipends to remove financial barriers to attendance.
- Be responsible for reviewing requests and making scholarship/travel stipend awards.

In no way will scholarships or stipends supplant other professional development resources and opportunities that exist in the region.

Providers of community based professional development are expected to partner with First Things First during all stages of planning and implementation, and with local early care and education professionals and other early care and education stakeholders in developing and marketing the program. They will also be required to demonstrate a willingness to work with First Things First Regional Partnership Councils via the Regional Coordinator structure and the systems of communications established by First Things First. In order to document progress towards successful implementation and the achievement of specified goals and outcomes, programs will also be required to function within the framework of First Things First evaluation efforts.

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.

References:

National Association for the Education of Young Children (1993). *A Conceptual Framework for Early Childhood Professional Development.*

Pennsylvania BUILD Initiative (November 2004). *Building an Early Childhood Education and Care Professional Development System: Where are We? What are the Next Steps?* Pennsylvania Department of Education.

Professional Development Community-Based Training Early Childhood Education 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 **Professional Development Community-Based ECE Training,** the unit of service is:

Total number of early care and education professionals receiving professional development

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); the direct services and products delivered by a program (e.g., providing scholarships) and/or the alignment of implementation with FTF standards of practice.

For **Community-Based ECE Training,** performance measures are:

Total number of early care and education professionals receiving professional development/ proposed service number
Total number of professional development sessions conducted/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 **Community-Based ECE Training,** the data reporting template is:

Professional Development- Community Based Training					
User Completing Report					
Reporting Period	Month	Year			
	October	2009			
Regional Partnership Council					
Status					
Date Completed					
DATA ENTRY					
Grantee may add as many columns as there are Sessions in each reporting period					
TRAINING SESSIONS	**1**	**2**	**3**	**4**	**5**
***Name of Training Session**	medium text				

*Topic of Training Session	Advance cognitive competence	To establish and maintain a safe environment	To establish and maintain a safe environment	To establish and maintain a safe environment	To establish and maintain a safe environment
*Number of Trainers	999				
Qualifications of Trainer/s : For each trainer add the following (Note: Nicole, this section is for information on each individual trainer, so they should be able to enter more than one trainer's info)					
*Name of the trainer	medium text				
*Number of years of experience in the following:					
Early childhood education	999				
Elementary education with a concentration in early childhood	999				
Child and family studies	999				
Closely related field in order to meet the qualifications of adjunct faculty at the local community college.	999				
Working with adult learners	999				
Working in diverse cultures	999				
*Minimum 5 years experience working with young children (classroom and/or supervisory)	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
*Bilingual (English/Spanish)	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
*Bilingual (English/Native	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No

Language)					
*Trainer's Degree	Associate's Degree	Associate's Degree	Associate's Degree	Associate's Degree	Associate's Degree
Indicate Major (Nicole- they indicate major for degree chosen)	textbox-medium text				
*State Credentials - (If Yes, name of state and name of credential)	Yes/No				
State	textbox-medium text				
Name of Credential	textbox-medium text				
*Professional Credentials (If Yes, please enter the name of credential)	Yes/No				
Name of Credential	textbox-medium text				
*Description of Session	longer text				
*Session format	Teleconference	Face to Face	Face to Face	Face to Face	Face to Face
*Session duration	1 hour	1 hour	1 hour	1 hour	1 hour
*Session venue	Faith-based organizations	Faith-based organizations	Faith-based organizations	Faith-based organizations	Faith-based organizations
*Date of Session	date				
*Session Location - City	short text				
*Session Location - Zip	drop down of funded RPC				
*Target audience	Family Child Care Providers	Family Child Care Providers	Family Child Care Providers	Family Child Care Providers	Family Child Care Providers

***Number of Participants Enrolled in this Session**	999				
***Number of Participants Attending this Session**	999				
***College credit offered as part of this session**	Yes/No				

Enter data here ONLY if you have more than 1 trainer in the training session held.

****Additional Trainer's Data-- Please enter information here on training sessions that had more than 1 trainer (2nd Trainer).**

***Name of the trainer**					
***Number of years of experience in the following:**					
Early childhood education					
Elementary education with a concentration in early childhood					
Child and family studies					
Closely related field in order to meet the qualifications of adjunct faculty at the local community college.					
Working with adult learners					
Working in diverse cultures					
***Minimum 5 years experience working with**					

young children (classroom and/or supervisory) - Yes/No					
***Bilingual (English/Spanish) Yes/No**					
***Bilingual (English/Native Language) Yes/No**					
***Trainer's Degree**					
Major					
***State Credentials - Yes/No** (If Yes, name of state and name of credential)					
State					
Name of Credential					
***Professional Credentials - Yes/No** (If Yes, please enter the name of credential)					
Name of Credential					

Data Reporting Instructions

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

For **Professional Development Community-Based ECE Training,** 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

***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 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.
3. ***Number of Trainers:** In this data field you will enter the number of trainers who offered training in this specific session.

Qualification of Trainers (for each trainer, please enter the following information):

4. ***Name of the trainer:** In this data field you will enter the name of each trainer(s) at the training session.
5. ***Number of years of experience:** In this data field you will enter in the number of years of experience each trainer has. For example, a trainer has 5 years of experience in early childhood education then the number 5 will be entered here.
6. ***Minimum 5 years experience working with young children (Yes/No)**: you will answer either YES or NO if the trainer has a minimum of 5 years experience working with children in either a classroom and/or supervisory position.

7. ***Bilingual in English/Spanish (Yes/No):** you will answer either Yes or No on whether the trainer is bilingual in English and Spanish.
8. ***Bilingual (English/Native Language):** you will answer either Yes or No on whether the trainer is bilingual in English and Native Language(s).
9. ***Trainer's Degree:** this data field has a multiple choice drop down menu and you can choose more than one from a list of degrees for each trainer and indicate the major. (Associate's, Bachelor's, Master's, Masters in Education, PhD (Doctor of Philosophy).
    - **Degree Major:_____**
10. ***State Credentials (Yes/NO):** this data field is YES or No question, if you answer YES, then you must type in the state and the name of the credential. For example, State: AZ; Credential: Teaching Certificate
    - **State_____**
    - **Name of Credential_____**
11. ***Professional Credentials (Yes/No):** this data field is YES or No question, if you answer YES, then you must type in the name of the credential. For example, Certification in Early Childhood.
    - **Name of Credential:_____**
12. ***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'.
13. ***Session Format:** This data field is a drop down menu. You can choose either **'Face to Face'** or **'Web-based'** or '**Teleconference**' 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.
14. ***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.
15. ***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: Library.
16. ***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).
17. ***Session Location – City:** In this data field you will enter the **City** name at which the session took place. Example: City – Phoenix.
18. ***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.
19. ***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. The choices are Family Child Care Providers, Early Child Care Teachers, Early Child Care Directors and Other.

20. ***Number of Participants enrolled in this session:** In this data field you will enter the total number of participants enrolled in the training session based on the type of target audience. For example: 15 Family Child Care Providers were enrolled.
21. ***Number of Participants attending this session:** In this data field you will enter the total number of participants who attended the session. For example: 15 Family Child Care Providers were enrolled but only 10 attended the session, then the number 10 will be entered here.
22. ***College credit offered as part of this session:** in this data field you will answer either Yes or No on whether college credit was offered as part of the training session.

Frequently Asked Questions

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

For **Professional Development Community-Based ECE Training,** the frequently asked questions are:

In development

GOAL AREA: PROFESSIONAL DEVELOPMENT

STRATEGY NAME: DIRECTOR MENTORING / TRAINING

GOAL:

- **First Things First will build a skilled and well prepared early childhood development workforce**
- **First Things First will increase retention of the early care and education workforce**
- **FTF will enhance specialized skills of the early childhood development and health workforce to promote the healthy social-emotional development of young children**
- **First Things First will improve access to quality early care and education programs and settings***

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
This strategy focuses on enhancing administrative, leadership, and business skills of early childhood education administrators. **Strategy Provisions:** • Mentoring /coaching strategy which views mentoring as a core component of professional development and which supports leadership development and the enhancement of administrative capacities of child care providers • On-site consultation addressing administrative functions, including high quality programming for children and families, staff development and human resources practices, program operations, and community engagement. Engagement with	National Association for the Education of Young Children (1993). *A Conceptual Framework for Early Childhood Professional Development.* This document is currently being revised and updated. http://www.naeyc.org/files/naeyc/file/policy/ecwsi/psconf98.pdf *Building an Early Childhood Professional Development System* (2010) http://www.nga.org/Files/pdf/1002EARLYCHILDPROFESSIONALDEVELOPMENT.PDF Bloom, P.J. & Sheerer, M. (1992).	Various models include: • The Arizona Early Education Emergent Leaders (through Southwest Human Development) • Arizona Directors Academy or AZDAc (through Rio Salado College) A number of communities have local Directors Networks, consisting of regularly scheduled meetings for early care and education program directors and family care providers. Networks, are typically administered by local community agencies such as United Way or Southwest Human Development and exist in the West and East Valleys of Maricopa County; Pinal County; and North, South and Central Pima County. A director's network ("Now and Forever,"also exists in the Osborne School District in Phoenix, for directors at child care centers with children also enrolled in preschool programs in the school district. **System-building issues:**	Costs could range from $9,100 - $10,000, depending on the model and, intensity. Directors Networks are funded through allocations from the local community agency.

national experts in the field of early childhood development and education • Opportunities for early care providers to network, sharing information and experiences, and engaging in dialogue with colleagues • Development and implementation of individualized professional development plans culminating in the presentation of a year-long leadership project • On-going training and support for mentors and participants • Mentoring/coaching to practitioners that supports self-confidence and self-efficacy in early care and education (a belief in one's ability to be effective with children and families) • Facilitation of potential college credits for community-based trainings	The Effects of Leadership Training on Child Care Program Quality. *Early Childhood Research Quarterly, 7,* 579-594. www.cde.ca.gov/sp/cd/re/documents/leadershipmatters.doc Pavia, Louise; Nissen, Hannah; Hawkins, Carol; Monroe, Mary Ellen; Filimon-Demyen, Debra (2003). *Mentoring early childhood professionals*. Journal of Research in Childhood Education.	• This strategy may be a duplication of community based professional development strategies already in place and existing Directors Networks; these however, do not offer college credits. • Given the complexity of ensuring college credit for community-based trainings, this component may not be realized until the second or third year of funding. The focus for this first year should be on the steps to ensure that there are standards for the training sessions that will meet requirements for transfer to colleges and universities. Similarly, trainer qualifications should be in place in the first year to ensure such transfers. • Consideration needs to be given to the education level and qualifications of the trainer in coordination with the institutions of higher education being approached about awarding college credits (generally the higher the level of the coursework –upper division or lower division-- the higher the educational qualifications are for the trainer).	

***NOTE: This goal is from the Quality and Access Goal Area in the FTF Roadmap.**

Policy Specialist: Alicia Smith

FIRST THINGS FIRST
Director Mentoring
Standards of Practice

Researchers and policy makers across the country are beginning to focus more on enhancing leadership and administrative skills among child care administrators in order to enhance program quality. Research has consistently found that having established and effective administrative practices are crucial for ensuring high-quality outcomes for children and families (Bloom 1989, 1996; Whitebook, Howes & Phillips, 1990). Without quality systems in place at the organizational level, high-quality interactions and learning environments at the classroom level cannot be sustained. Research tells us that the Director shapes the work environment for the teaching staff who, in turn, provide the critical link to children's developmental outcomes (Bloom & Sheerer, 1992; Phillips, Mekos, Scarr, McCartney & Abbott-Shim, 2000; Talan & Bloom, 2004). However, there are very few programs in the State of Arizona that provide specialized training and support to child care directors and administrators in a systematic manner. Arizona is not unique in its lack of leadership development programs. Although the call for specialized training for early care and education Directors and Administrators was made several decades ago (Bloom & Sheerer, 1992), many states are only just now beginning, in a systematic way, to include specialized leadership development for directors (NAEYC, 2010).

Goffin and Washington in their book, *Ready or Not: Leadership Choices in Early Care and Education* (2007), argue that in order to resolve the field's ever-shifting challenges, especially in the context of new realities – such as increasing public scrutiny and cut backs in state funding – it is necessary to move beyond reliance on a handful of individual leaders and key stakeholders and toward the creation of a community of diverse leaders.

The target populations that would benefit from successful implementation of these strategies are early care and education directors, family child care providers, and others in program leaderships roles working directly with staff who are working with children birth through age five and their families.

Programs implementing Director Mentoring will:

- Establish a mentoring program that includes effective/proven components of mentoring and that views mentoring as a core component of professional development — a replacement for less effective training modalities, rather than an additional service.
- Identify selection criteria for mentors/coaches and participating administrators/ practitioners.
- Identify roles, responsibilities, and expectations of mentors/coaches and participating administrators/practitioners, including job descriptions, and other written documents.
- Develop cohorts of participants.

- Create a clear and multi-direction communication system between mentors and participants.
- Develop and implement individualized professional development plans that include specific outcomes for the protege.
- Establish mechanisms that support on-going professional development and support for mentors and participants:
    - Provide opportunities for mentors to improve mentoring/coaching skills through readings, peer dialogue and reflective practices and targeted activities that improve practice.
    - Provide mentoring/coaching to administrators that supports leadership development and administrative competency.
    - Provide mentoring/coaching to practitioners that supports and builds self confidence and self-efficacy in teaching (a belief in one's ability to be effective with children and families).
- Develop sessions for center administrators that address fiscal administration, systems management, human resource development, and related administrative skills/tasks.
- Design an evaluation process to assess system efficacy which should include but is not limited to the following evaluation components to ensure quality programming:
    - Pre and post test using measurement scales/questions that have been proven valid, and/or
    - Pre and post qualitative interview with specific questions that show causal relationships, to assist in the assessment of the quality of the services and/or programming
- "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

Qualifications for a Director Mentor will include:

- Demonstrated knowledge and skills that reflect current best practices and research in Early are and Education.
- Possession of the minimum qualifications of adjunct faculty at a community college in early care and education or related field.
- A minimum of five years experience working with young children (with a combination of classroom and supervisory experience).
- Experience in providing adult education and knowledge of adult learning styles.
- Bilingual English/Spanish proficiency is preferred.
- Have demonstrated competencies or training in cultural competency.
- Demonstrated knowledge of the core values spelled out in the NAEYC Code of Ethical Conduct for early childhood adult educators and commit themselves to the following two core values:
    - To respect the critical role of a knowledgeable, competent, and diverse early childhood care and education workforce in supporting the development and learning of young children.
    - To base practice on current and accurate knowledge of the fields of early childhood education, child development, adult development and learning, as well as other relevant disciplines.

Director Mentoring programs delivering professional development opportunities will be required to ensure that opportunities are designed and implemented according to the following principles:

- Materials and sessions should be based on current research, core areas of competency, and early learning standards; and should be responsive to emerging issues in the community and the early childhood field.
- Curriculum should incorporate and reflect the theoretical framework that informs practice in the classroom/program and should including such topics as cultural competence and setting professional goals. Participants should be afforded opportunities for practical application of the theoretical foundation to real-life classroom/program activities and situations. Experiences should be relevant to the participant's background and current role.
- The length of employment and experience/education of staff are reflective of high quality staffing, therefore, instructors/mentors are required to possess:
    - appropriate credentials and experience in conducting professional development activities.
    - Demonstrated knowledge and skills that reflect current best practices and research in Early Care and Education.
    - Experience in early childhood education, elementary education with a concentration in early childhood, child and family studies, or a closely related field in order to meet the qualifications of adjunct faculty at the local community college.

    - A minimum of five years experience working with young children ages birth through five, including a combination of classroom and supervisory experience. Experience working with adult learners and the ability to utilize active adult learning techniques.
    - Bilingual English/Spanish preferred.
    - Supervisors must meet or exceed these requirements with at least two years of program management experience. If programs experience hardship in recruitment efforts, they must notify and consult with First Things First.
- Sessions should engage participants as adult active learners and should employ adult active learning methodologies.
- Professional development should include opportunities for on-site technical assistance, mentoring, and supervision.
- An assessment should be implemented (such as a pre/post assessment) of the outcomes of the individual professional development plan before a certificate of completion is awarded.

References:

Bloom, P.J. (1989). *Early Childhood Job Satisfaction Survey*. Evanston IL: Early Childhood Professional Development Project, National Louis University.

Bloom, P.J. (1996). *Early Childhood Work Environment Survey*. Wheeling IL: National Louis University.

Bloom, P.J. & Sheerer, M. (1992). The Effects of Leadership Training on Child Care Program Quality. *Early Childhood Research Quarterly, 7,* 579-594.

Goffin, S. & Washington, V. (2007). *Ready or not: Leadership choices in early care and education*. NY: Teachers College Press.

NAEYC (2010). Summary of NAEYC-recognized ECE leadership programs. Retrieved January 26, 2010, from http://www.naeyc.org/getinvolved/fellowship/recognized.

National Association for the Education of Young Children (1993). *A Conceptual Framework for Early Childhood Professional Development.*

Pennsylvania BUILD Initiative (November 2004). *Building an Early Childhood Education and Care Professional Development System: Where are We? What are the Next Steps?* Pennsylvania Department of Education.

Phillips, D., Mekos, D., Scarr, S., McCartney, K., & Abbott-Shim, M. (2000). Within and Beyond the Classroom Door: Assessing Quality in Child Care Centers. *Early Childhood Research Quarterly, 15*, 475-496.

Talan, T., & Bloom, P. J. (2004). *Program Administration Scale: Measuring Early Childhood Leadership and Management.* New York: Teachers College Press.

Whitebook, M., Howes, C., & Phillips, D. A., (1990) *Who Cares?: Child Care Teachers and the Quality of Care in America*, Washington D.C.: Center for Child Care Workforce.

Director Mentoring/Training 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 these requirements:

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

The data reporting template is 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 **Director Mentoring/Training,** the unit of service is:

Total number of participating professionals

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 **Director Mentoring/Training,** performance measures are:

> **Total number of participating professionals/ proposed service number**
> Total number of professional development sessions conducted/proposed service number
> Hours of 1:1 mentoring provided/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 **Director Mentoring/Training,** the data reporting template is:

FIRST THINGS FIRST
The right system for bright futures

pgms partner grant management system

Evaluation Report

CONTRACT DATES
9/1/2009
TO
6/30/2010

Address:

Contract ID:

View Reporting Instructions and FAQ

DIRECTOR MENTORING/TRAINING

GENERAL INFORMATION

User Completing Report	AZFTF
Reporting Period	Month 6 Year 2010
Regional Partnership Council	South Phoenix
Status	In Progress
Date Completed	

Director Mentoring/Training Activity

Did you conduct Training Sessions during this reporting period?* (•) Yes ( ) No

If Yes, please enter information about your director mentoring/training activities below. Enter as many as apply.

Session Name	Session Description	Session Date	Session City

Training Session Name*

Topic of Training Session*
Select all that apply.

- [ ] To establish and maintain a safe environment
- [ ] To establish and maintain a healthy environment
- [ ] To establish and maintain a learning environment
- [ ] Advance physical competence
- [ ] Advance cognitive competence
- [ ] Advance communication competence
- [ ] Advance creative competence
- [ ] Support social and emotional development
- [ ] Support and provide positive guidance
- [ ] Establish positive and productive relationships with families
- [ ] Ensure a well-run, purposeful program management
- [ ] To maintain a commitment to professionalism
- [ ] Other (Please Specify)

Description of Session*

Session Format*

( ) One on one training/ Mentoring

Select One

- Small group training
- Other (Please Specify)

Session Duration*
Select One

<Select Session Duratio

Session Venue*
Select One

- School (public, charter, and private)
- Faith-based organizations
- Community Center
- Libraries
- University/College
- Early Childhood Settings
- Community-based Agency (ies)- please indicate the name of the agency
- Other (Please Specify)

Date of Session*

Session Location - City*

Session Location - Zip*

<Select Zip Code>

Target Audience*
Select or Specify

- Early Child Care Directors
- Other (Please Specify)

Number of Directors Enrolled in this Session

Number of Directors Attending this Session

Number of Other (Please Specify) Enrolled in this Session

Number of Other (Please Specify) Attending this Session

Number Of Trainers*

INSTRUCTIONS:

You must SAVE your Training Session entry in order to allow the entry of a Trainer(s).

Validation: The number of Trainers entered must match the Number of Trainers identified in the Training Session in order to set your data template to Completed status to submit to FTF.

To return to the main entry page, click Cancel.

Save Training Session Cancel

Trainer Name		

Data Reporting Instructions

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

For **Director Mentoring/Training,** 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 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.

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

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

Director Mentoring/Training Activity

A. Did you conduct Training Sessions during this reporting period? Yes or No

If Yes, please enter information about your director mentoring/training activities by clicking on + Add Training Session.

Enter the following data fields for each session.

B. Director Mentoring/Training Sessions

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. ***Description of session:** In this text field you will enter a brief description about the training session.
4. ***Session format:** This data field is a drop down menu. You can choose either **'One on One'** or **'small group'**. If you choose "**Other (please specify)"-** then you need to enter the format of your session in a row added under this field.
5. ***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.**
6. ***Session venue:** This data field is a drop down menu. You can choose either one of th**e listed** options or the **'other (please specify)**' option. If you choos**e "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.
7. ***Session date:** For this data field you will report the date your session took place using the following format: mm/dd/yyyy.
8. ***Session location – City:** In this data field you will enter the **City** at which the session took place. Example: City – Phoenix.
9. ***Session location – Zip:** In this data field you will enter the zip code of where the training session occurred. For example: Phoenix, Zip Code: 85012
10. ***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.
11. ***Number of directors enrolled in this session:** In this data field you will enter the total number of directors enrolled in the training session based on the type of target audience. For example: 15 Early Child Care Directors enrolled.
12. ***Number of directors attending:** In this data field you will enter the total number of directors who attended the session. For example: 15 ECC Directors were enrolled but only 10 attended the session, then the number 10 will be entered here.
13. ***Number of "Others" enrolled in this session:** In this data field you will enter the total number of 'Other' enrolled in the training session.
14. ***Number of "Others" attending:** In this data field you will enter the total number of 'Other' who attended the session
15. ***Number of trainers:** In this data field you will enter the number of trainers who offered training in this specific session.

Frequently Asked Questions

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

For **Director Mentoring/Training,** the frequently asked questions are:

In development

GOAL AREA: PROFESSIONAL DEVELOPMENT

STRATEGY NAME: CONSULTATION: LANGUAGE AND COMMUNICATION

GOAL: FTF will build a skilled and well-prepared early childhood development workforce.

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Early educators must possess the appropriate skills and confidence to incorporate effective teaching practices for the children in their care. Not only should early educators be able to employ effective teaching strategies, they should also be prepared to identify possible developmental delays and refer families to the necessary interventions as early as possible. Language and communication consultation programs focus on professional development opportunities for early educators who spend significant amounts of time with young children, including infants and toddlers. This model facilitates appropriate and effective teaching practices that promote children's language and communication development, as well as how early educators identify possible language development delays. The emphasis of this strategy is to enhance language functioning and communication skills in young children, rather than an independent focus on literacy development or therapeutic interventions. The intent of this strategy is to provide education, consultation, and mentoring for teachers and families regarding children's language and communication development. This strategy addresses the issue of increasing professional development among early childhood educators as well as identifying language development problems through ongoing instruction, consultation, and mentoring for teachers in centers and caregivers in regulated homes.	Bloom, P.J. & Sheerer, M. (1992). The Effects of Leadership Training on Child Care Program Quality. Early Childhood Research Quarterly, 7, 579-594. Hart, B. and Risley, T.R. (1995). Meaningful Differences in the Everyday Experience of Young American Children. Baltimore: Paul H. Brookes Publishing Co. National Association for the Education of Young Children (1993). A Conceptual Framework for Early Childhood Professional Development.	This model provides for a consultant to work directly with early care and education staff. As such, councils must weigh the community's interest in adding another consultant to the options currently available. For example, does this region already fund Mental Health Consultation, Special Needs Inclusion Consultation, or Infant-Toddler Consultation. Providers receiving services under this strategy will be required to meet the quality commitment policy of FTF. For example, a provider must be a participant in Quality First, be accredited or demonstrate a commitment to quality as outlined in the policy.	Councils should plan approximately 10,000/provider for a comprehensive strategy to include on-site mentoring, off-site training, and parent education. Minimum recommended amount to cover components, administration and personnel is 100,000.00

Policy Specialist: Allison Landy

FIRST THINGS FIRST
Consultation: Language and Communication
Standards of Practice

Research indicates a strong correlation between early language development and future literacy skills as well as social and emotional development. Specifically, the seminal research study conducted by Betty Hart and Todd R. Risley (1995) highlighted the importance of early language development among young children. Based on their monthly observations of young children from the age of nine months to 36 months, the authors found that the amount of words children hear from a very young age significantly affects their own development in several aspects. Not only do children learn vocabulary and language patterns through interactions with parents and other caregivers, but these interactions also influence their emotional and social development. Infants learn about communication and social skills, as well as develop a sense of security, when their parents sustain social interactions such as smiling and responding vocally.

Hart and Risley also concluded that in addition to the amount of words children hear, the content of these interactions also affects children's social and emotional development. Parents who talk more often to their children use more complex and sophisticated language, which contributes to their children's intellectual development. This "extra talk" also tends to contain more affirmations, which contributes to children's positive self-esteem. Further, the authors found that the children who received exposure to more words and affirming content had larger vocabularies and more sophisticated verbal and literacy skills as measured by third grade tests.

Because many young children, including infants and toddlers, spend so much time in early care and education settings outside their own homes, the professionals who are responsible for their care must possess the tools and skills to promote language and communication development, and know how to assist when development is not progressing as it should. The research literature indicates a strong correlation between the amount of time children speak with a parent or other adult and later literacy skills. In addition, as noted above, the nature of the verbal interactions and the sophistication of the language also influence language development. In turn, the early language and communication skills that children develop influence their future academic achievement. For these reasons, early educators must possess the appropriate skills and confidence to incorporate effective teaching practices for the children in their care. Not only should early educators be able to employ effective teaching strategies, they should also be prepared to identify possible developmental delays and refer families to the necessary interventions as early as possible.

DRAFT

Language and communication consultation programs should focus on professional development opportunities for early educators who spend significant amounts of time with young children, including infants and toddlers. This helps facilitate appropriate and effective teaching practices among early educators, as well as early identification of possible language development delays

Research demonstrates that the most effective types of professional development approaches include content-based workshops as well as hands-on, one-on-one mentoring or coaching, also referred to as "consultation." Critical components of this form of professional development include:

- The use of effective and proven components of mentoring;
- Clear selection criteria for mentors/coaches and participating administrators/ practitioners;
- Identification of roles, responsibilities, and expectations of mentors/coaches and participating administrators/practitioners, including job descriptions, and other written documents;
- A clear and multi-direction communication system between mentors and participants;
- Individualized professional development plans that include specific outcomes for the participant;
- Mechanisms that support on-going professional development and support for mentors and participants:
- Opportunities for mentors to improve mentoring/coaching skills through readings, peer dialogue and reflective practices and targeted activities that improve practice.
- Mentoring/coaching to administrators that supports leadership development and administrative competency.
- Mentoring/coaching to practitioners that supports and builds self-confidence and self-efficacy in teaching (a belief in one's ability to be effective with children and families).

The emphasis of this strategy is to enhance language functioning and communication skills in young children, rather than an independent focus on literacy development or therapeutic interventions. The intent of this strategy is to provide education, consultation, and mentoring for teachers and families regarding children's language and communication development. This strategy addresses the issue of increasing professional development among early childhood educators as well as identifying language development problems through ongoing instruction, consultation, and mentoring for teachers in centers and caregivers in regulated homes.

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Programs implementing Language and Communication Consultation will:

- Facilitate curricular development regarding language and communication development for early care and education providers
- Mentor staff and educate parents in order to enrich language, communication, and literacy growth for all children
- Educate early care and education professionals to identify "red flags" regarding delays in language and communication development
- Provide parent education and facilitate referrals, as needed, for formal state-funded screening and/or intervention services
- Demonstrate a sound understanding of Developmentally Appropriate Practice in early childhood programs and identify how these principles will be incorporated into the proposed program
- Demonstrate a sound understanding of the Arizona Early Learning Standards, particularly those related to language and literacy and d describe how these Standards will be incorporated in the proposed activities
- Demonstrate an understanding of how language and literacy skills apply to the other categories of standards.
- Provide assurance that each person providing direct services has received the Arizona Department of Education approved training in the Arizona Early Learning Standards or describe plans to receive this training
- Ensure staff members possess knowledge and expertise in conducting program assessment, in particular the use of the Classroom Assessment Scoring System (CLASS) to assess language and communication instruction in early childhood settings. Observers are expected to conduct the entire CLASS assessment, but can focus on the Instructional Support Domain (Concept Development, Quality of Feedback, and Language Modeling) when creating service plans with the provider
- Incorporate specific activities that support providers' development of curricula that enhance language and communication skills among young children in their programs
- Create a service plan for each provider based on program assessment that identifies specific activities that will be conducted, frequency and duration of activities, specific areas of focus for each provider and related goals/objectives, and other areas as necessary

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- Provide and implement activities that will target both the providers and families of children in the programs
- Provide a description of how the program assessment will be used to support identification of provider needs in the area of language instruction and how the assessment will be used in the professional development process
- Demonstrate a sound understanding of the principles of effective coaching and mentoring and use of reflection and self-assessment
- Assist providers and parents in making referrals and follow up on those activities when children are identified as having a potential developmental delay through screening and provide support to families when a child is not identified as eligible for services

Program activities should be designed and implemented according to the following principles:

- All program activities should be based upon a culture of trust and respect.
- Clearly define program objectives to ensure comprehension, engagement, and retention
- Create opportunities for formal and informal feedback and act upon it; ensure that input shapes decision-making
- Encourage honest, open communication
- Maintain confidentiality and respect for program participants
- Activities should be based on current research, developmentally appropriate practice, and the Arizona Early Learning Standards.
- Program assessment occurs on an ongoing basis to determine the effectiveness of consulting/mentoring activities, specifically related to improvement in children's language development.
- Personnel providing coaching and mentoring are fully trained and reliable assessors of program strengths and needs.
- Instructors should possess appropriate credentials and experience in conducting professional development activities. Applicants should assure that those providing direct services will hold at a minimum, a bachelor's degree in early childhood development or other closely related field. Related fields include speech language communications, infant-toddler mental health, or early

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childhood special education. Training sessions should involve active learning techniques for participants.

- Instructors should be knowledgeable about and possess experience in working with both adult learners and young children birth to age five.
- Activities should be culturally responsive (e.g. incorporate families' cultural traditions of singing and storytelling as a means for language and communication development).
- Services proposed should be provided with enough intensity and duration to assure that changes are made and sustainable.

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

DRAFT

References:

Bloom, P.J. & Sheerer, M. (1992). The Effects of Leadership Training on Child Care Program Quality. *Early Childhood Research Quarterly, 7,* 579-594.

Hart, B. and Risley, T.R. (1995). *Meaningful Differences in the Everyday Experience of Young American Children*. Baltimore: Paul H. Brookes Publishing Co.

National Association for the Education of Young Children (1993). *A Conceptual Framework for Early Childhood Professional Development.*

Professional Development- Consultation: Language and Communication 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 these requirements:

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

The data reporting template is 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 **Professional Development- Consultation: Language and Communication,** the target service units are:

Total number of early care and education center based providers served
Total number of early care and education home based providers served

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 **Professional Development- Consultation: Language and Communication,** performance measures are:

Total number of early care and education center based providers served/proposed service number
Total number of early care and education home based providers served/proposed service number
Total number of early care and education professionals receiving professional development/ proposed service number
Total number of professional development sessions offered/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 **Professional Development- Consultation: Language and Communication,** 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

CONSULTATION - LANGUAGE AND COMMUNICATION

GENERAL INFORMATION

User Completing Report	AZFTF\mshahi
Reporting Period	Month 7 Year 2010
Regional Partnership Council	State
Status	In Progress
Date Completed	
Please select the type of program(s) you serve:*	○ Center based child care providers ○ Home based child care providers ○ Both
Number of Center based Child Care providers served this period	
Number of Home based Child Care providers served this period	

Number of Children Served by Age Group:*
If none, please enter zero

	Center based child care providers	Home based child care providers
Birth-12 months		
13-24 months		
25-36 months		
37-48 months		
49-60 months		
61-71 months		

Number of children identified for a Child Focus Team Observation by:*
If none, please enter zero

	Center based child care providers	Home based child care providers
Birth-12 months		
13-24 months		

25-36 months		
37-48 months		
49-60 months		
61-71 months		

Number of children identified for a Referral for outside screening by:* If none, please enter zero	Center based child care providers	Home based child care providers
Birth-12 months		
13-24 months		
25-36 months		
37-48 months		
49-60 months		
61-71 months		

Of the children identified, number of children referred for outside screening:* If none, please enter zero	Center based child care providers	Home based child care providers
Birth-12 months		
13-24 months		
25-36 months		
37-48 months		
49-60 months		
61-71 months		

Number of CLASS assessments completed*		
Total number of training sessions held for providers*		
Total number of mentoring sessions held for providers*		
Did your program conduct any training sessions for parents?*	○ Yes ○ No	

If Yes, how many trainings were conducted?

Number of TALK line calls received by:*

If none, please enter zero

Center based child care providers	
Home based child care providers	
Parents	
Other-Please Specify	

Did you conduct any trainings or mentoring sessions this reporting period?* ○ Yes ○ No

If Yes, please enter information about your Training/Mentoring activities below.

Training/Mentoring Activity		

Data Reporting Instructions

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

For **Professional Development- Consultation: Language and Communication,** 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.

DIRECTIONS FOR DATA ENTRY

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

Please select the type of program(s) you serve: Choose Center based child care providers, or Home Based Child Care Providers, or Both.

1. ****Number of providers being served:*** In this data field you will enter the number of programs being served by center-based child care provider and/or home-based child care provider.
2. ****Number of children served by age group:*** In this data field you will enter the number of children birth-5 years of age being served by center-based child care provider and/or home-based child care provider and by age breakouts.
    - ***Birth-12 months***
    - ***13-24 months***

- ***25-36 months***
- ***37-48 months***
- ***49-60 months***
- ***61-72 months***

3. ***Number of Children identified for a:*** In this data field you will enter the number of children (0-5 yrs) identified at the center-based child care provider and/or home-based child care provider for the following by age breakouts:
    a. ***Child focus team observation***
    b. ***Referral for outside screening***
        - ***Birth-12 months***
        - ***13-24 months***
        - ***25-36 months***
        - ***37-48 months***
        - ***49-60 months***
        - ***61-72 months***
4. ***Of the children identified, number referred to outside screening:*** In this data field you will enter the total number of children (0-5 yrs) referred to outside screening at the center-based child care provider and/or home-based child care provider.
5. ***Number of CLASS assessments completed:*** In this data field you will enter the number of CLASS assessments completed by center-based child care provider and/or home-based child care provider.
6. ***Total number of training sessions held for providers:*** In this data field you will enter the total number of training sessions held by center-based child care provider and/or home-based child care provider.
7. ***Total number of mentoring sessions held for providers:*** In this data field you will enter the total number of mentoring sessions held by center-based child care provider and/or home-based child care provider.
8. ***Did your program conduct any training sessions for parents? YES or NO:*** In this data field you will enter either **YES or NO**. If yes, you must answer the following:
    - If **Yes**, how many trainings were conducted? ____
9. ***Number of TALK line calls received by:*** In this data field you will enter the number of TALK line calls received by the following categories:
    - Center based child care providers___
    - Home based child care providers___
    - Parents___
    - Other, (please specify_____) ___

Training/Mentoring Session data fields

Did you conduct any trainings or mentoring sessions this reporting period? YES or NO. In this data field you will enter either **YES or NO**. If yes, please enter information about your training/mentoring activities below.

1. ***Name of Training/Mentoring Session:** In this data field you will enter the name of the training/mentoring session.

2. ***Description of Session:** In this data field you will enter a brief description about the training session.
3. ***Session Format:** This data field is a drop down menu. You can choose either **'One on One'** or **'Small Group'** or '**Large Group**' option. If you choose "**Other (please specify)"-** then you need to enter the format of your session in a row added under this field.
4. ***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.
5. ***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: Library.
6. ***Session Date:** For this data field you will report the date your session took place.
7. ***Session Location – City:** In this data field you will enter the **City** at which the session took place. Example: City – Phoenix.
8. ***Session Location – Zip:** In this data field you will enter the zip of where the training/mentoring session occurred.
9. ***Number of Trainers/Consultants:** In this data field you will enter the number of trainers/consultants in the training/mentoring session.
10. **Qualifications of Trainers/Consultants:** In this data field you will enter the qualifications of trainers/consultants in the training/mentoring session. Please list only the highest degree attained.

***Target Audience:**

11. **Select all that apply:** This data field allows you to select the target audience(s) of the training/mentoring session.
12. **Number of Center based staff enrolled in this session:** In this data field you will enter the total number of center based staff enrolled in the training session based on the type of target audience. For example: 15 parents were enrolled.
13. **Number of Center based staff attending:** In this data field you will enter the total number of center based staff who attended the session.
14. **Number of Home based staff enrolled in this session:** In this data field you will enter the total number of home based staff enrolled in the training session based on the type of target audience.
15. **Number of Home based staff attending:** In this data field you will enter the total number of home based staff who attended the session.
16. ***Number of Early Child Care Directors enrolled in this session:** In this data field you will enter the total number of early child care directors enrolled in the training session based on the type of target audience.
17. **Number of Early Child Care Directors attending:** In this data field you will enter the total number of early child care directors who attended the session.

18. **Number of Parents enrolled in this session:** In this data field you will enter the total number of parents enrolled in the training session based on the type of target audience.
19. **Number of Parents attending:** In this data field you will enter the total number of parents who attended the session.
20. **Other (please specify) enrolled in this session:** If none of the listed audience applies, please choose other and type in your audience for the session here and enter the number enrolled.
21. **Other audience attending:** In this data field you will enter the number of Other audience that attended the training session.

Frequently Asked Questions

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

For **Professional Development- Consultation: Language and Communication,** the frequently asked questions are:

In development

GOAL AREA: PROFSSIONAL DEVELOPMENT

STRATEGY NAME: RECRUITMENT INTO THE FIELD

GOAL:

- **First Thing First will build a skilled and well prepared early childhood development workforce**
- **First Things First will increase retention of the early care and education workforce**
- **FTF will enhance specialized skills of the early childhood development and health workforce to promote the healthy social-emotional development of young children**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
This strategy supports the development of a professional development program for college coursework, by recruiting individuals into the early care and education workforce. By creating a "grow your own" workforce, this scholarship program assists the region in moving toward the creation of a skilled, prepared, more highly qualified child care workforce who would eventually work in Quality First centers and may choose to continue college course work with a T.E.A.C.H. scholarship. Programs target individuals who want to pursue degrees in the early childhood field. Priority may be given to targeted populations based upon regional needs, including Early Childhood Development students; recent high school graduates; non-traditional students who are not working in the early care and education field and do not qualify for T.E.A.C.H. and Professional Career Pathways Project scholarship programs; high school students interested in early childhood education; or teen parents who are completing high school, have their high school diploma or are enrolled in technical school. Scholarships made available to the target population must be used toward early childhood education course work, general education coursework, or developmental coursework. As part of their coursework, participants observe and intern in a	The following sources expand on the correlation between quality child care and wages, education, and retention of teachers: "Staffing Recruiting and Retention in Early Childhood Care and Education and School-Age Care", Minnesota Department of Children, Families and Learning, April 2001 http://www.wilder.org/download.0.html?report=1097&summary=1 "Demographic Characteristics of Early Childhood Teachers and Structural Elements of Early Care and Education in the United States", G. Saluja, D. M. Early and R. M. Clifford, Early Childhood Research and Practice, Spring 2002.	Regional Councils, community colleges, non-profits and local clubs are listed as potential partners in the process of awarding scholarships. Systems to ensure that participants are not concurrently enrolled in the Professional Career Pathways Project and/or the TEACH scholarship program will need to be implemented. In addition, programs administering this strategy are required to confirm that each participant has exhausted other forms of financial aid including completion of application for Federal Financial Aid. Each Council will establish criteria for successful applicants; however, the grantee will conduct the application reviews and make scholarship award recommendations. Preference is given to participants who agree to remain in the early childhood field (preference would be that scholarship recipients work in the classroom) within the regional area for a specified period of time- to	Costs range per scholarship type and region, and may be determined by calculating: • Tuition • Fees • Books • Materials • Supplies • Administration of the program, which may include staff time and related expenses associated with coordinating observation and internship placements.

Quality First or accredited child care setting as determined by their coursework or professional development program. This on-site experience provides an opportunity for participants to see the advantages of working in high quality settings that recognize and reward educational attainment. Another goal of the strategy may be to attract individuals into the field who are highly educated in other areas, but given the present economic recession, are open to exploring career opportunities in the early care and education field. The intent of these recruitment strategies are to encourage those, who are newly recruited, to remain in the field beyond the immediate economic downturn. This strategy also provides opportunities to work with existing regional Career and Technical Education (Tech Prep) Programs/ Consortiums to recruit applicants. Tech Prep is a career-oriented curricular and instructional program that begins in high school and continues through at least two years of postsecondary education at a community college or trade school. Tech Prep incorporates both school-based and work-based instruction in a comprehensive curriculum. Tech Prep also offers students challenging coursework and the ability to relate school activities to future college and workforce requirements. **Strategy provisions:** • Expand access to early childhood courses for non-traditional populations including secondary education students, teen parents, unemployed workers, dislocated workers, displaced homemakers and workforce re-entry adults. • Develop flexible delivery models that build interest, bridge skill gaps, and provide for work-based learning experiences. • Provide workforce education and development services including career advising and counseling, collaborating with Early Care and Education industry/employers to design responsive training and educational	http://www.factsinaction.org/pageone/p1feb03.htm "Low Wages = Low Quality Solving the Real Preschool Teacher Crisis" National Institute for Early Education Research (NIEER), 2003 A Matter of Degrees: Preparing Teachers for the Pre-K Classroom (2010) The US Department of Education has additional information on Tech Prep Education at: http://www2.ed.gov/programs/techprep/index.html	be determined by the Council- following completion of the credential/degree program. Ensuring participants' service time commitment in the identified region after the award may be challenging.	

programming, as well as developing and administering supervised opportunities for participants to observe and interact with children in an early care and education setting such as through an internship and/or apprenticeship program. • Collaborate with employers needing skilled workers, workers in need of retraining, and individuals new to the workforce who need marketable skills. • Collaborate with other scholarship programs such as Teacher Education And Compensation Helps (T.E.A.C.H.) or Professional Career Pathways Project (PCPP) to determine eligible students, ensuring that participants have exhausted other forms of financial aid including Pell grants, PCPP and TEACH scholarships, etc. • Ensure scholarship recipients have taken or commit to take a minimum number of credit hours (to be determined by regional council) within one (1) year at a community college and enter into employment or volunteering for a period of time (to be determined by regional council) at an early care and education program. • Ensure that participants are be required to maintain a grade of "C" or better in order to remain eligible for additional scholarship awards. • Ensure participants agree to service time commitment in the identified region. • Ensure that every participant has an individual plan that advises them into the most appropriate research based educational options and assists them to move through that education at an appropriate rate			

Policy Specialist - Alicia Smith

FIRST THINGS FIRST
Professional Development: Recruitment into the Field
Standards of Practice

Regional Partnership Councils have identified a critical need to encourage new professionals to enter the field of early care and education. Currently programs throughout the state are unable to find substitutes, fill teacher vacancies, and find highly qualified staff. Major factors contributing to the shortage of qualified personnel in the early care and education workforce include low compensation, lack of benefits, and the resulting high turnover rate among staff.

Research strongly suggests that the quality of child care is tied to wages, education, and retention of teachers. [1] Providers with higher levels of education tend to be paid more, and higher-paid teachers tend to remain in the same job for a longer period of time. One way for Arizona to create a more highly qualified early childhood workforce is to recruit a cadre of non-traditional workers into the field who are supported, with scholarships, to achieve higher education in Early Childhood Education (ECE). Scholarships, made available to high school students, recent high school graduates and nontraditional students such as older students, career transitioning and dislocated workers, stay-at-home parents, and returning college students, would be offered as incentives to those who do not qualify for the T.E.A.C.H. ® ARIZONA Scholarship Program or the Professional Career Pathways Project (PCPP), because they are not employed in early care settings already. These individuals would be encouraged to take courses to prepare them to enter the early childhood workforce. As part of their coursework, they would be required to observe and intern in a Quality First or accredited child care setting to be determined by the coursework or professional development program. This recruitment effort provides an opportunity to present, to potential participants, the advantages of working in high quality settings that recognize and reward educational attainment. Another goal is to attract individuals into the field who may be highly educated in other areas but who may be, given the present economic recession, open to exploring career opportunities in ECE. The intent of these recruitment strategies would be to encourage new recruits to remain in the field beyond any immediate economic crisis situation.

In a recent study, researchers at Indiana University explored the link between educational attainment and teacher's beliefs about early childhood education. They found when teachers had a higher education level, regardless of the major area of study; they were more likely to support developmentally appropriate practices. The researchers did find, however, that teachers with course work specific to working with young children were more likely to support child-initiated learning, such as allowing children to select some of their own activities, valuing active exploration in children's learning, and respecting students' individual differences when planning curricula. Based on these findings, researchers have suggested that while it is important to provide specific professional development courses to child care providers, it may be more important to recruit highly-educated individuals to the field. The ability to recruit highly-qualified teachers is strongly tied to the ability to compensate them adequately. [2]

An investment in workforce development that focuses on high quality staff recruitment represents a major first step in ensuring we have an adequate supply of qualified caregivers and teachers who can give our children the early learning boost they need to succeed in school and in life.[3]

Current salaries in early care and education, not only in Arizona, but nationally, do not traditionally support recruitment of highly educated individuals into the field. However, the high unemployment rate resulting from the present economic situation may provide an opportunity to attract those with education in other fields into ECE. At the same time, First Things First wants to recruit recent high school graduates, who are entering the workforce at a very difficult time, to consider careers in early care and education. In order to be successful, recruits should be fully aware and knowledgeable about the requirements and opportunities for continuing educational advancement and they need to have experience in high quality settings with young children.

Workforce Education and Development programs provide options for students to enter the work force or retrain for a new career. Typically they offer short-term certificates and associate degree programs which meet student and employer needs. Many of these programs offer internships that provide experience and valuable career contacts. Programs often have an industry advisory committee which meets periodically during the year to provide input and review programs to ensure that curriculum reflects industry need.

A work-based learning experience course, often called an internship or apprenticeship, provides the opportunity for Workforce Education and Development participants to gain work experience while earning college credits. The goal of an internship is to allow the student to develop employable skills that will benefit their employer from the moment they start the job.

Programs Implementing Recruitment into the Field Strategies will implement the following best practices:

- Develop and conduct recruitment strategies to non-traditional populations including secondary education students, unemployed workers, dislocated workers, displaced homemakers and workforce re-entry adults

- Develop flexible delivery models that build interest, bridge skill gaps, and provide for work-based learning experiences

- Provide workforce education and development services including career advising and counseling, collaborating with Early Care and Education industry/employers to design responsive training and educational programming, as well as developing and administering supervised opportunities for participants to observe and interact with children in an early care and education setting such as through an internship and/or apprenticeship program

- Administer scholarships to the Early Care and Education community

- Collaborate with employers needing skilled workers, workers in need of retraining, and individuals new to the workforce who need marketable skills

- 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

Programs funded by First Things First for the recruitment of professionals into the early care and education field shall perform the following within the region funded:

1. Develop, in collaboration with First Things First, criteria for early care and education workforce development programs and scholarship awards adhering to the best practices indicated above
2. Access labor market information that enables response to changes and opportunities in the Early Care and Education field within the regional marketplace, targeting where there might be shortages within a particular geographic area or area of need
3. Partner with industries to develop new programs, with priority given to collaborative regional strategies for Early Care and Education workforce and economic development.
4. Enhance enrollment through the development of programs that demonstrate the linkages between learning and employment.
5. Provide rapid response to employer requests and or specific needs
6. Develop additional flexible delivery models to meet evolving student, worker and industry needs including:
   - creating a teacher workforce pipeline of new teachers by partnering with colleges to recruit, prepare and retain Early Care and Education teachers; including the recruitment of non-traditional populations such as secondary students, unemployed workers, dislocated workers, displaced homemakers and workforce re-entry adults.
   - developing and implementing "Grow your own" programs which tend to target paraprofessionals and classroom aides already working in child care programs

- working with directors, administrators and owners to tailor preparation programs to the specific needs and resources in their communities.
- raising students' interest in Early Care and Education as a career; building interest and developing strategies to begin teacher recruitment before college through career fairs, education clubs, and early exposure to teacher preparation programs while in secondary school.

7. Develop a recruitment process to identify outreach and access opportunities for potential participants
8. Participate in First Things First programmatic and performance evaluations and data collection efforts
9. Work with other scholarship programs (T.E.A.C.H. Arizona, Professional Career Pathways Project) to determine eligibility , ensuring that participants document that they have exhausted other forms of financial aid including Pell, grants, PCPP and T.E.A.C.H. scholarships, etc.
10. Process applications and award scholarships in a timely manner
11. Ensure scholarship recipients have taken or commit to take a minimum number of credit hours (to be determined by regional council) within one (1) year at a community college
12. Ensure that every participant has an individual educational plan that advises them regarding the most appropriate research based educational options and assists them to move through that education at an appropriate rate
13. Make available financial aid assistance, or utilize financial aid advisors at local community colleges, to provide financial aid assistance to scholarship recipients
14. Provide the Regional Partnership Council with reports outlining awards made and written updates for each semester indicating the numbers, and amount of scholarships awarded
15. Require all scholarship recipients participating in program to participate in an internship or observe in either a Quality First or accredited child care setting within the funding region
    a. Programs are to develop partnerships with regional Quality First programs or accredited child care settings to determine the length and components of the internship/apprenticeship.
    b. All scholarship recipients will be required to participate in this.
16. If appropriate to a specific region's funding strategy, create and implement a monitoring system that tracks recipient's fulfillment of service /internship commitment to the funding region
17. Require scholarship recipients to achieve a grade of "C" or above in approved coursework on their Individual Educational Plans, in order to maintain eligibility. These scholarship recipients, as well as those who withdraw from a course after the add/drop period has ended, will need to re-establish eligibility. To re-establish eligibility, the recipient will be required to take either the same course or another course designated on the educational plan; the course can be of equal or higher credit value; the recipient will be obligated to pay for the course and show course completion documentation of a grade of "C" or above.

When implementing the Scope of Work, programs will:

1. Provide services to students and employers that are based upon a culture of trust and respect
    a. Clearly define program objectives to ensure comprehension, engagement, and retention
    b. Create opportunities for formal and informal feedback; ensure that input shapes program decision-making
    a. Encourage honest, open communications
2. Build collaborative partnerships with employers, students and community colleges to meet the needs of the communities to provide an educated early care and education workforce
3. Programs are expected to partner with First Things First during all stages of planning and implementation, and with agencies and other early care and education stakeholders in developing and marketing the program
4. Coordination and collaboration must occur within a region and across regions utilizing this recruitment strategy. First Things First staff and Regional Councils will identify opportunities for collaboration and coordination with successful applicants who become grantees. Successful applicants will work initially with Regional Coordinators to develop, implement and market the services outlined and to coordinate across regions, as First Things First deems necessary
5. Programs are expected to attend meetings and workgroups in the region being served in order to identify, develop and implement mechanisms related to coordination and collaboration. Successful applicants will also participate in cross-regional and statewide activities that may include additional workgroups and meetings. These meetings should utilize "live meeting," Interactive TV and teleconference technologies, as necessary, to minimize travel and travel costs
6. Programs will also be required to demonstrate a willingness to work with First Things First Regional Partnership Councils via the Regional Coordinator structure and the systems of communications established by First Things First. In order to document progress towards successful implementation and the achievement of specified goals and outcomes, programs will also be required to function within the framework of First Things First evaluation efforts.
7. Develop evaluative and monitoring processes that are collaborative, ongoing, and that include input from students, employers and instructors
8. Demonstrate program effectiveness by meeting and addressing First Things First performance measures, outcomes and key measures
9. Identify outreach, engagement and retention practices for participants and employers
10. Ensure that wages and benefits for own program staff are adequate for supporting and retaining high quality staff, in order to ensure consistency among participant/scholar and program staff/instructor relationships, and program integrity
11. Establish an effective, consistent supervisory process that supports staff members providing services and supports to participating scholars and employers, in order to ensure maximum accountability to scholars, employers, funders and the community

Professional Development- Recruitment into Field 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 these requirements:

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

The data reporting template is 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 **Professional Development- Recruitment into Field,** the unit of service is:

Total number of participating professionals

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 **Professional Development- Recruitment into Field,** performance measures are:

> **Total number of participating professionals/ proposed service number**
> Total number of participating professionals progressing towards or completing educational goals / total number of participants
> Total number of participants completing an individual early education career plan/pathway upon entry into program / total number of participants

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 **Professional Development- Recruitment into Field,** 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

PROFESSIONAL DEVELOPMENT RECRUITMENT

GENERAL INFORMATION

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

Recruitment Activity

Did you recruit any participants during this reporting period?* ◯ Yes ◯ No
If Yes, please enter information below.

Number of participants recruited during reporting period?*
If none, please enter zero.

Number of High School Students	
Number of Volunteers	
Number of Parents	
Number of Home-Based Child Care Providers	
Other(Please Specify)	

Name of program for which you are recruiting participants.*
Enter as many as apply.

Name	Number Of Particpants Enrolled		

Financial Assistance

Did any participants apply for financial assistance during this reporting period?*
If Yes, please enter information below.

○ Yes ○ No

Number of participants applying for financial assistance:
If none, please enter zero.

Number Applying for Federal Aid

Number Applying for State Aid

Number Applying for Tribal Aid

Number Applying for TEACH

Number Applying for PCPP

Other(Please Specify)

Data Reporting Instructions

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

For **Professional Development- Recruitment into Field,** 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 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.

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.**

Data fields

1. **Did you recruit any participants during this reporting period? YES or NO**
    - **Number of Participants Recruited during this reporting period?** In these data fields you will enter the total number of participants recruited based on the type of target audience.
    - The choices are High School Students ____
    - Volunteers____
    - Parents _____
    - Home-based child care providers _____

- Other _____

2. ***Name of program for which you are recruiting participants:** In this text field you can enter the names of the programs for which you are recruiting for. You can enter more than one program.
3. **Number of Participants Enrolled into the Program during reporting period** In this data field you will enter the total number of participants enrolled in each program for recruitment into the field.

4. ***Did any participants Disenroll during the reporting period? YES OR NO**
5. ***Reason for disenrollment:** In this data field, you will breakout the total number of disenrollment by reason for disenrollment. The choices are:
   a. Completion of program___
   b. Transfer to institution of higher education___
   c. Transfer to another program___
   d. Relocated from service area___
   e. Withdrew___
   f. Dropped out__
   g. Reason unknown
   h. Other, please specify____
6. **Number of participants completing an individual early education career plan/pathway upon entry into program:** In this data field you will enter the number of participants completing an individual early education career plan/pathway.
7. ***Does program offer college credit?** In this data field you will choose either **Yes or No** on whether college credit was offered as part of the training session.
8. ***As part of service commitment, are participants volunteering at a child care center?** In this data field you will choose either **Yes or No** on whether participants are volunteering at a child care center. If you answered YES, you must fill out the next data field.
   a. **Number of participants volunteering at a child care center as part of their service commitment:** In this data field, you enter the total number of participants volunteering at a child care center for this reporting period.

9. *** Did any participants apply for financial assistance during this reporting period? Yes or No**
10. ***Number of participants applying for financial assistance:** In this data fields you will breakout the total number of participants applying for financial assistance by type of assistance.
    a. Federal Aid (FAFSA)___
    b. State Aid___
    c. Tribal Aid___
    d. TEACH___
    e. PCPP___

f. Other (please specify)___

Frequently Asked Questions

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

For **Professional Development- Recruitment into Field,** the frequently asked questions are:

In development

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

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 **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:

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 7 Year 2010
Regional Partnership Council	State
Status	In Progress
Date Completed	
Service Provisions *	☐ Community Based Training ☐ Point of Care Training ☐ Home Visitation Training ☐ Other (please specify)

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 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

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

For **Physician Education & Outreach,** 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 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.

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

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

2/12/2010

- 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.

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**

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.

2/16/2010

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

Nutrition/Obesity/Physical Activity

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 **Nutrition/Obesity/Physical Activity,** the units of service are:

Total number of children attending nutrition and recreation training sessions
Total number of adults attending nutrition and recreation 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 **Nutrition/Obesity/Physical Activity,** performance measures are:

Total number of children attending training sessions / proposed service number
Total number of adults attending training sessions / proposed service number
Total number of training sessions conducted/proposed service number
Total number of families receiving referrals for health insurance or health coverage enrollment/ target service number
Total number of 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 **Nutrition/Obesity/Physical Activity,** 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

NUTRITION/OBESITY/PHYSICAL ACTIVITY

GENERAL INFORMATION CONTROL

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

Public Awareness

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 enter zero for any activity that does not pertain to your program.

	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	Number Receiving Info		

Intensive Training Provided * ◯ Yes ◯ No

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

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 **Nutrition/Obesity/Physical Activity,** 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 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

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.*

- Media impression is defined as the number of people reached with media campaigns.
- Provision of written materials is defined as the number of people receiving pamphlets, etc.
- Group meetings.
- 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.
3. ***Description:** In this text field you will enter a brief description about the training session. Example: For the **Name of Information Session**: 'Exercising for a healthier life', the **Description** could be- 'How to incorporate a healthy diet and exercise into your life'.
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. Example: Community center.
5. ***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).
6. *** City:** In this data field you will enter the **City** name at which the session took place. Example: City – Phoenix.
7. *** Zip:** This data field is a drop down menu of zip codes for the funded RPC. You can choose only one zip code.
8. ***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.

9. ***Number receiving Info:** In this data field you will enter the number (approximate) of people that attended the information session and received information.

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 (0-5yrs) 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 (0-5yrs) 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.)

Health Insurance Enrollment Assistance

26. ***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 of the listed health options.
27. ***Number of families served who report they are underinsured:** In this data field, please indicate the number of families that you serve who are underinsured.
28. ***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 number who received enrollment assistance to obtain insurance.

Referrals to Health Care and Low cost Care Providers

29. ***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 number referred to IHS or ITU.
30. ***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 number referred to free or low cost service providers.
31. ***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 number 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 **Nutrition/Obesity/Physical Activity,** the frequently asked questions are:

In development

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.

2/16/2010

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*

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 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 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_____**

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
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- Data should be only reported for services funded by First Things First.
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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.**
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- 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 received referrals 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

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.

2/16/2010

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.		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.	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.
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		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	
Professional Development for Dental		OOH has a media campaign on the importance	

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

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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

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 4 Year 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 Enrollment
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.

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[1] U.S. Census Bureau, Annual Estimates of Population by Sex and Age for States and Fro Puerto Rico, Release data: May 1, 2008. http://www.census.gov/popest/states/asrh/SC-Est207-02.html

Reviewed: 08/26/2010

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.

Reviewed: 08/26/2010

- 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.

Reviewed: 08/26/2010

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

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.

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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.		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 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.		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.	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.
Vision Screening Age appropriate vision screenings for children 1-5 years of age include 1) the use of an objective screening tool		Strategy requires the purchase of equipment and supplies. Staff must	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.

2/12/2010

- 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

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.

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    b. Routines based interviewing practices (see http://www.fpg.unc.edu/~inclusion/RBI.pdf)

    c. Objective child observation

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   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)
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Excerpt from the DES/AzEIP TBM Manual, Chapter 4

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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).

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> **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

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 <u>only</u> 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

FIRST THINGS FIRST

FTF STRATEGY TOOLKIT

GOAL AREA: Family Support/Strong Families

FTF Priority: Supports and Services for Families – Convene partners, provide leadership, provide funding, and advocate for development, enhancement, and sustainability of a variety of high quality, culturally responsive, and affordable services, supports, and community resources for young children and their families.

Goal Area Overview:
First Things First will expand families' access to information, services and resources to support their child's optimal development by increasing the availability, quality and diversity of resources that support children's health, safety, emotional well-being, and language and literacy development. As a result, families who need or want assistance can access a continuum of services, support, and resources in their communities across Arizona to increase their competence and confidence as parents to ensure their children enter school healthy and ready to success. These services and supports will be planned, developed, funded, and delivered in a coordinated and culturally appropriate manner that best meets the needs and preferences of families, leverages available resources, and involves families in the program development and implementation.

Strategies	Strategy Workgroup Leads	Policy Staff	Grants and Contracts Specialist
Parent Education Community-Based Training	Family Support Workgroup: Wendy Sabatini and K. Vilay	K. Vilay	
Home Visitation	Family Support Workgroup: Wendy Sabatini and K. Vilay	K. Vilay	
Family Support – Children with Special Needs	Early Identification/Special Needs Allison Landy and Shari Elkins	Allison Landy	
Food Security	Family Support Workgroup: Wendy Sabatini and K. Vilay	K. Vilay	
Family Resource Centers	Family Support Workgroup: Wendy Sabatini and K. Vilay	K. Vilay	
Community-based Literacy	Family Support Workgroup: Wendy Sabatini and K. Vilay	K. Vilay	
Reach Out and Read	Family Support Workgroup: Wendy Sabatini and K. Vilay	K. Vilay	Chris Cramer
Native Language Enrichment	Family Support Workgroup: Wendy Sabatini and K. Vilay	K. Vilay	

Policy Specialist: K. Vilay

GOAL AREA: FAMILY SUPPORT

STRATEGY NAME: PARENT EDUCATION COMMUNITY BASED TRAINING

GOAL:

- **FTF will coordinate 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.**
- **FTF will increase the availability, quality, and diversity of relevant resources that support language and literacy development for young children and their families.**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
For those families who do not qualify or choose to participate in a home visitation program, community-based family education programs serve as another opportunity for Arizona's parents and families to access education, information and resources. Community based parent education should be offered at times and locations convenient to families of young children. Using a family-centered and strengths-based approach these programs should offer families **a series of classes** that provide information and support in each of the core areas: child development, parenting skills, and resource and referral. Ideally, a parent education curriculum that has an evidence base and a proven track record with the target population is utilized. Successful family education programs facilitate the acquisition of parenting and problem-solving skills necessary to build a healthy family. Effective parenting education develops parent-child nurturing and attachment to support children's social-emotional	Little evidence exists on the effectiveness or impact of community based training for parent-family education. However, research does indicate that programs who involve both parents and children demonstrate a positive impact upon outcomes. The critical element in any parent education program is that parents and families have opportunities to practice newly learned skills with support from parent educators. Some parenting curriculum is more effective with specific target populations and should be researched thoroughy before selection.	Capacity for Expansion Consider expansion of existing community based family education programs to include early childhood development and health topics including parenting skills for families of infants, toddlers and preschoolers. Programs must identify curricula which is evidence-based with plans for implementation for of a birth through five program. Links to Other Strategies This strategy should be implemented in coordination with other family support strategies such as home visitation and/or resource center strategies to ensure optimal programming for each family. FTF funded programs should also support families to use their Arizona Parent Kit, or access the Birth to Five Helpline. Programs should refer families to other FTF or other community resources as a regular part of the curriculum and services.	Costs will vary depending upon program approach: adult-only or adult and child sessions, frequency and duration of each series and class session. Estimates include a range from **$500 to $2000 per family on an annual basis.** Costs may include: Staff Staff Training Outreach and Promotion Curriculum Program Supplies and Materials Incentives. Transportation Child Care Space

development, knowledge of parenting and of child development, parental resilience, and social connections and awareness of support mechanisms available for parents. Family participation in community-based family education services is voluntary and must be provided free of charge to the family.		Timeline for Implementation Establishing a new program may take 3 to 6months prior to emrollment of families due to staff recruitment, training, material development and availability, marketing/ outreach and securing of space/ locations for family education sessions. System-building Issues and Recommended Saturation Level Community based parent education can be a part of a system of family support in a local regional/ community area, especially to provide information to families who may not access or participate in home visitation programs. Many councils build or expand community based parent education into existing resource centers as many families already access other support and services through established resource centers. An ongoing series of classes for parents should take preference over one-shot workshops.	

Policy Specialist – K Vilay

Parent Education Community-Based Training

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 is 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 **Parent Education Community-Based Training,** the units of service are:

Total number of adults attending education 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 **Parent Education Community-Based Training,** performance measures are:

> **Total number of adults attending education sessions/proposed service number**
> Total number of children attending education sessions /proposed service number
> Total number of families receiving referrals for community based services/ target service number
> Total number of education sessions offered/proposed service number

Data Reporting Templates

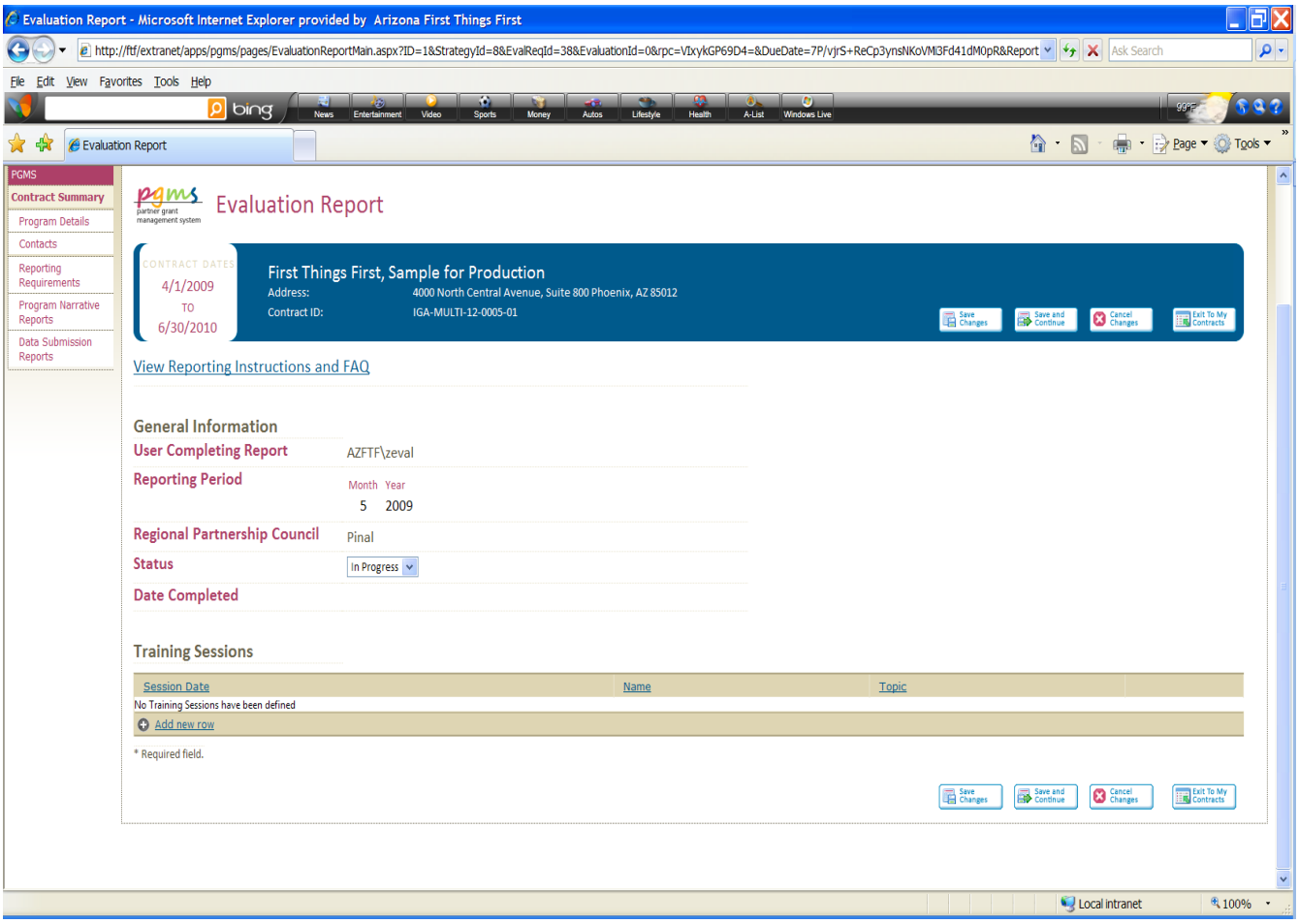
Data reporting templates are the tools utilized to gather data to assess grantee Performance Measures. All FTF grantees submit data on a quarterly basis through designated data reporting templates.

For **Parent Education Community-Based Training,** the data reporting template is:

FIRST THINGS FIRST

The right system for bright futures

Community Based Training Evaluation Report



***Name:** _____

***Topic:**

- ☐ Child Development
- ☐ Parenting Skills
- ☐ Health Support
- ☐ Safety
- ☐ Early Language and Literacy
- ☐ Socialemotional
- ☐ Native Language and Culture
- ☐ Culturally Responsive Practices
- ☐ Community Resources
- ☐ Support Group
- ☐ Other (Please Specify)

*Number of Trainers:

*Qualifications of Trainers:

*Description:

Session Format: Face to face

Session Duration: Less than 1 hour

Session Venue: Library

*Session Date:

Open the calendar popup.

<<< September 2009 >>>

	S	M	T	W	T	F	S
36	30	31	1	2	3	4	5
37	6	7	8	9	10	11	12
38	13	14	15	16	17	18	19
39	20	21	22	23	24	25	26
40	27	28	29	30	1	2	3
41	4	5	6	7	8	9	10

Location:

*City:

*Zip: _____-____

Target Audience: Expectant Mothers

***Adults Enrolled:**	
***Adults Attending:**	
***Children Enrolled:**	
***Children Attending:**	
***Number of families receiving referrals to community services:**	
***Number of families referred who report receiving services from referral:**	
***Number of children receiving referrals to community services:**	
***Number of children referred who report receiving services from referral:**	Required - If none, enter 0

* **Required Field**

Data Reporting Instructions

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

For **Parent Education Community-Based Training,** 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 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

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

1. ***Name of Session:** In this data field you will enter name of the training session. Example: Parenting for Success.

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 lists applies to the training session you are conducting, please choose "**Other (please specify)" box** and enter (type in) the Topic of your training 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: Bachelors Degree, Masters Degree, CDA, Community Leader or Parent.
5. ***Description:** In this data field you will enter a brief description about the training session. Example: For the **Session Name**: 'Parenting for Success', the **Description** could be- 'what can parents expect from their child as an infant, toddler, and preschooler'.
6. **Session Format:** This data field is a drop down menu. You can choose either '**face to face'** 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. Example: small group, large group.
7. **Session Duration:** This data field is a drop down menu. You can choose only one choice that best applies for your session.
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 enter the venue at which your session took place in the text box provided under the Other (Please Specify)" option. Example: Community center.
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. **Location:** In this data field you will enter the **City**'s name at which the session took place and the **Zip code** for the city you entered. Example: City: Scottsdale; Zip- 85259.
11. **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.
12. ***Adults Enrolled:** In this data field you will enter the total number of adults (Example: Parents/caregivers) who enrolled into this session. **Note:** All teenagers who are parents are counted as adults and their children are counted in the children enrolled/attending fields.
13. ***Adults Attending:** 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.)
14. ***Children Enrolled:** In this data field you will enter the total number of children (0-5) who enrolled in this session. **Note:** All teenagers (<18 years of age) who are parents are counted as adults and their children are counted in the children enrolled/attending fields.

15. ***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.)
16. ***Number of Families receiving referrals to community services:** In this data field you will enter only the adult(s) in the family who received a referral. (Example: a pregnant teenager who was referred to prenatal services will be counted here as a family.)
17. ***Number of Families referred who report receiving services from referral:** In this data field you will enter the total number of families that reported they received services from their referral. (Example: 10 families such as pregnant teenagers were referred to WIC services and 5 reported back that they are now enrolled in WIC, the number 5 will be entered here.)
18. ***Number of Children receiving referrals to community services:** In this data field you will enter only the child (birth thru 5) who receives a referral. (Example: a 1 year old baby of a teenage parent who was referred to child care will be counted here.)
19. ***Number of children referred who report receiving services from referral:** In this data field you will enter the total number of children, whose parent(s)/guardian reported they received services from their referral. (Example: 7 children were referred to low cost child care and 3 reported back that they are now enrolled in low cost child care, the number 3 will be entered here.)

Frequently Asked Questions

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

For **Parent Education Community-Based Training,** the frequently asked questions are:

In development

GOAL AREA: FAMILY SUPPORT/STRONG FAMILIES

STRATEGY NAME: HOME VISITATION

GOAL:

- **FTF will coordinate 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.**
- **FTF will increase the availability, quality, and diversity of relevant resources that support language and literacy development for young children and their families.**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Comprehensive Home Visitation programs provide participating families of young children with information and education on parenting, child development and health topics while assisting with connections to other resources or programs as needed. A variety of models exist to address the spectrum of universal needs to targeted or specialized needs of particular populations such as first time parents, teen parents, families at-risk for abuse-neglect, low income families. Home visiting professionals trained in child development and family support make regular, scheduled visits to each family's home -or other natural environments such as the library. Home visitors meet with the family and their infant, toddler or preschooler or with a family expecting a child, to answer questions, provide information and resources, assist parents in their parenting or assist in early detection of any developmental problems in the young child.	Research indicates that home visiting program models have been able to help parents learn parenting skills, increase confidence in their parenting skills, promote appropriate parent-child interactions and increase linkages with community services including health and social services. Home visiting has been shown to be highly effective with regard to promoting effective parenting in the area of preventing abuse and neglect. Specific outcomes and impact of each home	<u>Administrative Home Infrastructure</u> Home Visitation RFGA applicants should include narrative and budget information specific to the activities, responsibilities and related costs to maintain a program's affiliation, accreditation and/or certification. It is the responsibility of the grantee to maintain model fidelity and standing with the administrative home. <u>Timeline for Implementation</u> When establishing a home visitation program new to a region, it can take several months (3 to 6 or more) to ramp up prior to family enrollment and service provision beginning. Activities and timelines and initial costs/ budgeting should be clearly defined in an RFGA application including recruitment of staff, initial training, forms, case management system, data collection and reporting system, etc. <u>Capacity for Expansion and Multi-Year Commitment</u> Prior to the release of an RFGA, needs and assets and other reports should inform each council to the existence and availability of home visitation	Costs vary per program model – typically based upon frequency and duration of visits – and must include model affiliation, accreditation and/or certification costs. Cost per family annually can range from $3,000 to $10,000. If serving families at a frequency of one time per week, the average caseload per home visitor is about 20 families.

Family participation in a home visitation program is voluntary, with no fee for service to families. A family-centered approach is utilized with consideration for each child's present level of development, parent/families knowledge and understanding of child development, current parenting practices, daily routines and interactions, or other information/ instructional needs. A minimum of 3 to 4 home visits annually through a low intensity program model serving families with no or low risk factors should be delivered through a comprehensive program. The greater the needs and risk levels of the family, the greater the frequency and duration of home visits. Some home visitation models provide for weekly home visits, and include parent-child playgroups. National program models such as Nurse Family Partnership, Parents As Teachers and Healthy Families have established administrative homes and must maintain model fidelity. This may include participation in training and evaluation activities mandated by the model.	visitation program is based upon the target population and the program designed to serve that target population. Research suggests that a minimum of 3 to 4 home visits for a non-intensive program model will have some impact upon parent knowledge and awareness.	programs in the region. If possible, information and data on a programs' capacity to expand service provision should be gathered and reviewed. In RFGA applications, the target number of families to be served (existing or newly enrolled), number of existing or new staff needed should be identified, training and program materials needed with estimated costs related to expansion activities. Funding commitments for home visitation should be considered for multi-year investments. <u>Links to Other Strategies and System-Building</u> Home Visitors should support families to ask for a kit upon discharge from the hospital with their newborns and to use their FTF Arizona Parent Kit. They should also inform families of the availability of the Birth to Five Helpline and provide the toll-free number. It will also be important for home visitors to be aware of and refer to FTF funded and other community resources such as quality child care, QF! centers and homes, pre-k options, parenting support groups or classes, food assistance, libraries. <u>Saturation</u> Depends upon the population of the region and family needs and the program model to be implemented. Socio-economic dynamics unique to each regional area must be considered. <u>Target Population</u> Consideration should be given to the age group to receive services. The FTF Home Visitation document recommends home visitation for the birth to age 3 age range.	

FIRST THINGS FIRST
Home Visitation
Standards of Practice

Home visitation programs deliver education, information and support to families where they are - in their homes. Through stand-alone programs or in partnership with center-based services, voluntary home visitation programs educate families and bring them up-to-date information about health, child development and school readiness, and connect them to critical services. Home visitation is a bridge that links the resources of the community with the safety of the home environment, empowering even hard-to reach parents to build a better future for themselves and their children.

A variety of home visitation program models exist and differ in many technical aspects, such as the target population, the experience and credentials of the home visitor, the duration and intensity of the visits, and the end goal or focus of the intervention. Yet, the common ground that unites home visitation program models is the importance placed on infant and child development. Parents play a pivotal role in shaping their children's lives and often the best way to reach families with young children is by bringing services to their front door.

While each First Things First funded home visitation program may be uniquely designed, they all have a valuable role to play in meeting the complex needs of families and communities across the State of Arizona. First Things First focuses on programs and services that provide children with the best opportunities for school and life success. Funding decisions are based upon a robust process of review to ensure programs are supported by research, value the family, use approaches considered to be best practice and are responsive to the specific needs identified in each region. First Things First funded programs shall supplement, not supplant, other state expenditures and federal monies received for early childhood development and health programs.

It is expected that home visitation programs funded by First Things First will be comprehensive for the families they serve and will be offered at no-cost, on a voluntary basis. Programs are also expected to minimize duplication of home visitation services for families. Using a family-centered and strengths-based approach, these programs will also:

- Engage families in assessment of their strengths and needs particularly around the following areas: parental resilience; social connections; knowledge of parenting and child development; concrete support in times of need; and children's social-emotional development.
- Assist families in the development and implementation of a family service plan, which includes specific goals and objectives based upon assessment findings, and future planning for transition from the home visitation program.

- Ensure children receive developmental screening, preferably during well-child visits at 9, 18 and 24 months of age and every six months thereafter, or at any other time there are concerns about developmental delays, for all of the following developmental domains: motor, cognitive, social-emotional, language and self-help. If the home visitor is conducting the developmental screening, the First Things First Developmental Screening Standards of Practice must be followed.
- Assist families in developing skills related to observing and understanding their child's ongoing growth and developmental progress. Connect families with the most appropriate provider and/or agency when developmental or health related concerns are noted.
- Provide resource and 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.

Each family must receive information and support in each of the core areas: Parental resilience, social connections, knowledge of parenting and child development, concrete support mechanisms and children's social-emotional development. Information and support should be tailored to the needs of the family, as identified in the family service plan:

- All domains of child development (cognitive, communication, physical, social/emotional, and adaptive), including understanding when to have concerns related to children's development; and
- Appropriate child-adult interactions and development of parenting skills (i.e. physical touch, positive discipline, early language and literacy experiences and verbal and visual communications); and
- Health (e.g. nutrition; obesity; breastfeeding; physical activity; immunizations; oral health; insurance enrollment; participation in consistent medical/dental homes; participation in prenatal care; safety; developmental health; vision and hearing screening); and
- Identify their natural support systems such as peers.

Programs may also help families:

- Access opportunities to participate in family literacy activities.
- Address issues of substance abuse, domestic violence, mental health, and children with developmental delays or disabilities.
- Facilitate, arrange or organize group activities to further enhance socialization and peer support.

Programs will:

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

    A. 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.

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

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

    D. Encourage open, honest communication.

    E. Maintain confidentiality; be respectful of family members and protective of their legal rights.

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

    A. Encourage family members to build upon their strengths.

    B. Reflect the commitment to effectively serve the identified target population with an emphasis on fathers and grandparent caregivers, through publicity/outreach, literature and staff training.

    C. Help families identify and acknowledge informal networks of support and community resources.

    D. Create opportunities to enhance parent-child and peer relationships.

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

    A. Create opportunities for families of different backgrounds to identify areas of common ground and to accept and value differences between them.

    B. Strengthen parent and staff skills to advocate for themselves within institutions and agencies.

    C. Hire staff who reflect the cultural and ethnic experiences and language of the families with whom they work and integrate their expertise into the entire program.

    D. 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

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

   A. Be accessible for families. Offer extended service hours including weekend/evening hours.

   B. To ensure quality services, caseload size for each staff person is based upon:

      - How many hours per week the home visitor works; and
      - 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); and
      - Where each family lives.

      For example; 20 families 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 visit per week.

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

   D. Develop a collaborative, coordinated response to community needs.

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

   A. Assess home visitors' skills and abilities. Home visitors must be able to engage families while maintaining professional boundaries.

   B. Prior to serving families, staff must have professional training or have participated in development opportunities to ensure a level of competency in service delivery.

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

D. A confidential case file is maintained for each family. This file will include documentation such as contact notes, intake, assessment or screening tools and the service plan. Programs will ensure quality of service provision through regular case file reviews.

E. Provide ongoing staff development/training.

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

6. All First Things First Home Visitation Standards of Practice are modeled in all activities including planning, governance, and administration.

   A. Wages and benefits are adequate for supporting high quality staff.

   B. 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, nursing or a closely related field; unless a specific program model is implemented through lay-persons such as a promotora model of service delivery.

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

   D. Establish supervision as a collaborative process with mechanisms that support staff in difficult situations and provides ongoing opportunities for discussion between staff members and supervisors to reflect and debrief. Supervision will also include observation. It is important that supervisors spend time with 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.

   E. All staff work as a team, modeling respectful relationships.

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

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

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

      1. Activities, as identified by First Things First, include pre- and post- testing, self-assessment and opportunities for feedback; and

      2. Identify outreach, engagement and retention practices; and

      3. Programs must demonstrate mechanisms to assess program effectiveness and to implement quality improvements. Programs must participate in data collection and reporting of performance measures to First Things First.

Home Visitation

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 **Home Visitation,** the units of service are:

Total number of families receiving home visiting 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 **Home Visitation**, performance measures are:

Total number of families receiving home visiting services/proposed service number
Home Visitor caseload /proposed service number
Family attrition/target service number
Home visitor attrition/target service number
Total number of children receiving home visiting services /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 children receiving developmental screening/target service number
Total number and percentage of families reported satisfaction with provided home visitation services/total service number (minimum questions provided by FTF)

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 **Home Visitation,** the data reporting template is:

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

HOME VISITATION OUTCOMES

GENERAL INFORMATION

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

Number of families who received referrals to the following agencies

If none, please enter zero

Community Social Service Provider*

Community Support Group*

Dental Provider*

Early Care and Education (Child Care)*

Early Intervention/Therapy (e.g., Arizona Early Intervention Program, Division of Developmental Disabilities, Special Education Pre-schools, Physical/speech)*

Education – School District (for children)*

Education – Parent (e.g. GED, College)*

Faith Community*

Family Planning*

Financial (Emergency utility/Rent/Food assistance/ Earned income tax credit/Temporary Assistance for Needy Families, Child Care Subsidy)*

Health Insurance (public or private)*

Hospital*

Housing Support (e.g., Shelter Services)*

Job Development/Placement*

Legal (e.g., Child Support Enforcement, Child Custody) *

Mental Health Counseling*

Nutrition (e.g., WIC- Women Infant Children, Food Boxes, Food Stamps)*

Primary Care Physician*

Socialization/Recreation*

Specialized medical*

Transportation*

Native American Indian Center*

Other(Please Specify)

Health Insurance Enrollment Assistance:

Please indicate the number of families that you serve 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*

Home Visitation Program Satisfaction Survey

Did you administer a Home Visitation Program Satisfaction Survey during this reporting period?* Yes No

If yes, please provide the follow data.
If none, please enter zero

Number of participant Satisfaction Surveys Administered

Number of participant Satisfaction Surveys Completed

For each question, enter the total number of respondents who selected A, B, C or D.

	Strongly Agree [A]	Agree [B]	Disagree [C]	Strongly Disagree [D]	
Finding and receiving services was easy.					
Program services were scheduled at convenient times.					
The program fit my family's beliefs, culture, and values.					
My family's experience with the program was very good.					
The program provided the help and services my family and I needed .					
I received high quality services from my home visitor.					
I felt comfortable discussing my concerns with my home visitor.					
The program staff listened to my concerns and acted on them.					
My home visitor did a good job explaining things to me.					
I am satisfied with the information I received.					
As a result of the program, I can support my children better.					
I would recommend this program to others.					

Home Visitation

Data Reporting Instructions

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

For **Home Visitation Implementation,** 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 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

1. *Summary of Families Served*

Enter totals for the reporting period (by month): Summary of families served (caseloads)

a. The first data entry box is the total number of families being served at the beginning of month (carryover from previous month)
b. The next box is the total number of newly enrolled families during that month.
c. Next is the total number of disenrolled families during that month.
d. **Number of families served this month:** this field is calculated by the data system and should be the same as your total number of families being served (caseload) at the end of the month (a+b-c).
e. **Number of families receiving services during the month:** this field is also calculated by the data system it is the total number of families that received services during the month (including those who disenrolled during that period [a+b]).

2. *Family **Disenrollment** Reasons*

Enter totals for the reporting period (by month): Reasons for family **disenrollment**

a. The first data entry box is the total number of families that completed the program per the model.
b. The next box is the total number of families that transitioned to other programs.
c. Next is the total number of families that discontinued services.
d. Next is the total number of families that moved.
e. Next is the total number of families that disenrolled for other/unknown reason.
f. **Total family disenrolled:** this field is calculated by the data system and should be the same as your total number of families disenrolled.

3. ***New** children enrollment by age*

a. In the first data entry box enter the total number of newly enrolled children birth through 12 months old enrolled during the reporting period.
b. In the remaining boxes, enter the total number of newly enrolled children enrolled who were birth through 12 months, 13 months through 24 months, etc, respectively.
c. **Total number of newly enrolled children this month:** this field is calculated by the data system and should be the same as your total number of newly enrolled children enrolled at all eligible ages (0 through 5 years of age or 72 months).

4. ***Total** children served by age at end of month* (includes continuing and newly enrolled)

a. In the first data entry box enter the **total** number of children served/enrolled birth through 12 months old enrolled during the reporting period.
b. In the remaining boxes, enter the **total** number of children served/enrolled who were birth through 12 months, 13 months through 24 months etc., respectively.
c. **Total number of children served this month:** this field is calculated by the data system and should be the same as your **total** number of children served/enrolled at all eligible ages (0 through 5 years of age or 72 months).

5. *Ethnicity of **New** children 0-5 (Only applies to newly enrolled children)*

Note: Please use Parent report of race/ethnicity from enrollment/intake form to determine race/ethnicity of children.

a. In the first data entry box enter the total number of newly enrolled children of African American or Black heritage served/enrolled during the reporting period.
b. In the remaining boxes, enter the total number of newly enrolled children of American Indian or Alaska Native, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, White, Asian, Multi-ethnic (two or more races), or unknown race or ethnicity, respectively.
c. **Total number of Newly enrolled children by Ethnicity:** this field is calculated by the data system and should be the same as your total number of newly enrolled children enrolled at all eligible ages (0 through 5 years of age or 72 months).

6. *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.

a. In the first data entry box enter the total number of children –nine months of age --that were eligible for screening in the reporting month (as determined by age).
b. In the data entry box below the nine month eligibility box, enter the number of eligible children (nine months of age) that received screening in the reporting month.
c. In the data box below the nine month receiving eligibility box, enter the number of children who received screening and for whom a 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.

d. Repeat steps a, b, and c above for children ages 18 months and 24 months.

e. In the column labeled "other" indicate the number of children who received screening and were identified with a delay at ages other than 9, 18, or 24 months.
f. **Total number of children eligible, screened and identified with possible delay:** 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 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.

7. ***Staffing*** *Summary (both Home Visitors and FTE's must be filled out)*
   a. In the first data entry box enter the total number of Home Visitors employed at the beginning of the month.
   b. In the next box enter the total **FTEs** for home visitors employed at the beginning of the month. *Full Time Equivalent (FTE) for example, If you have 5 behavioral specialist staff spending half their time working through FTF funds, they would be recorded as 2.5 FTEs.
   c. In the next box enter the total number of Home Visitors hired during the month.
   d. In the next box enter the total **FTEs** for home visitors hired during the month.
   e. In the next box enter the total number of Home Visitors leaving employment during the month.
   f. In the next box enter the total **FTEs** of Home Visitors leaving employment during the month.
   g. **Total home visitor at the end of the month:** this field is calculated by the data system and should be the same as your total number of home visitors (a+c-e).
   h. **Total FTE at the end of the month:** this field is calculated by the data system and should be the same as your total number of FTEs (b+d-f).
   i. **Average home visitor caseload:** this field is calculated by the data system and should be the same as your average caseload per home visitor.
   j. **Average FTE caseload:** this field is calculated by the data system and should be the same as your average caseload per home visitor FTE.
   k. Total number of HV staff meeting minimum requirement: is the total number of Home Visitors meeting minimum education requirements and should match either total number of persons or FTE's.

Note: Minimum education requirements are prescribed by the First Things First standards of practice, the First Things First scope of work and your contract for home visiting services.

8. *Families Served per Zip Code per month*

Note: For assistance in entering your data electronically, refer to "User Guide for Data Entry: Home Visitation Data Collection Form".

a. The First Things First data system will provide a drop-down of the zip codes within the Regional Partnership Council area(s) you are serving.
b. In the first column of data boxes, for each zip code in which you served families, enter the total number of families served at the beginning of the month.
c. In the next column of data boxes, enter for each zip code in which you served families, the total number of families enrolled during the reporting month.
d. In the next column of data boxes, enter for each zip code in which you served families, the total number of families that have disenrolled services during the reporting month.
e. **Number of families served at the end of the month:** this data field is calculated by the data system and should be the same as your total number of families being served (caseload) at the end of the month, for each zip code.
f. **Number of families receiving services during the month:** this field is also calculated by the data system it is the total number of families that received services during the month (including those who disenrolled during that month), for each zip code.

For **Home Visitation Outcomes,** the data reporting instructions are:

DIRECTIONS FOR DATA ENTRY

Number of families who received referrals to the following agencies: In the data entry boxes enter the number of families who received referrals to the following agencies.

Agency	Number of families who received referrals at the agency
Community Social Service Provider	
Community Support Group	
Dental Provider	
Early Care and Education (Child Care)	
Early Intervention/Therapy (e.g., Arizona Early Intervention Program, Division of Developmental Disabilities, Special Education Pre-schools, Physical/speech)	
Education – School District (for children)	
Education – Parent (e.g. GED, College)	
Faith Community	
Family Planning	
Financial (Emergency utility/Rent/Food assistance/ Earned income tax	

credit/Temporary Assistance for Needy Families, Child Care Subsidy)	
Health Insurance (public or private)	
Hospital	
Housing Support (e.g., Shelter Services)	
Job Development/Placement	
Legal (e.g., Child Support Enforcement, Child Custody)	
Mental Health Counseling	
Nutrition (e.g., WIC- Women Infant Children, Food Boxes, Food Stamps)	
Primary Care Physician	
Socialization/Recreation	
Specialized medical	
Transportation	
Native American Indian Center	
Other(Please Specify)	

Health Insurance Enrollment Assistance.

Please indicate the number of families that you serve 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:** In this data field you will enter the number of families who are not covered by private insurance, AHCCCS, Indian Health Service, or Kids Care.
***Number of families served who report they are underinsured:** In this data field you will enter the number of families who report they are underinsured.
***Number of families served who report lack of insurance or underinsurance who received enrollment assistance to obtain insurance:** In this data field you will enter in the number of families served who report a lack of insurance or underinsurance who received enrolled assistance to obtain insurance.

Home Visitation Program Satisfaction Survey

Did you administer a Home Visitation Program Satisfaction Survey during this reporting period? YES or NO. If yes, please fill out the following:

Number of participant Satisfaction Surveys Administered: In this data field you will enter the number of Satisfaction Surveys that were Administered.
Number of participant Satisfaction Surveys Completed: In this data field you will enter the number of Satisfaction Surveys that were completed.

For each question, enter the total number of respondents who selected A, B, C or D.

	Strongly Agree (A)	Agree (B)	Disagree (C)	Strongly Disagree (D)
Finding and receiving services was easy.				
Program services were scheduled at convenient times.				
The program fit my family's beliefs, culture, and values.				
My family's experience with the program was very good.				
The program provided the help and services my family and I needed .				
I received high quality services from my home visitor.				
I felt comfortable discussing my concerns with my home visitor.				
The program staff listened to my concerns and acted on them.				
My home visitor did a good job explaining things to me.				
I am satisfied with the information I received.				
As a result of the program, I can support my children better.				
I would recommend this program to others.				

Frequently Asked Questions

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

For **Home Visitation,** the frequently asked questions are:

Insert

GOAL AREA: FAMILY SUPPORT

STRATEGY NAME: CHILDREN WITH SPECIAL NEEDS – PARENT COACHING

GOAL:

- **FTF will increase the availability, quality and diversity of relevant resources that support language and literacy development for young children and their families.**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
This strategy specifically targets children who have been screened and referred for evaluation of eligibility for intervention services (either through AzEIP or their local school district), but who are found not to qualify. Although children who do not qualify for state and/or federally funded specialized services, they can still benefit from enhanced support by their families and caregivers. To assist families in developing knowledge and skills to enhance their abilities to help their children reach their fullest potential, First Things First promotes a Parent Coaching and Support model to provide individualized support in coordination with an interactive parent and child together model of services. The core components of the Parent Coaching and Support Services Model include: • Individual Visits: • Ongoing Child Progress Monitoring and Screening: • Parent and Child Interactive Time • Networking and Coordination of Services:	This strategy is a hybrid of the Parents As Teachers home visitation program and Family Literacy education program. Both models have significant evidence of effectiveness in improving families' abilities to support children's development.	Include considerations, such as: • This model is best utilized where strong developmental screening activities are occurring to provide a foundation for recruiting families into the program. • Councils should be aware of the capacity of agencies in their region to implement this strategy, for example: Grantees must have strong understanding of the referral systems in the community; Grantees are best prepared to implement this strategy if they have an understanding of routines based interviewing and other ways to support families in their understanding of children's development. • This strategy is not yet implemented in any region, but is funded in Yuma and White Mountain Apache Tribe.	Based on the Parents as Teachers Model: Unit costs vary depending on service intensity, but at a minimum, require 2500/family for service delivery. Also consider: • travel expenses for highly rural communities, • salary for program personnel responsible for data collection and entry. • Rental fees may need to be considered for parent meeting locations due to the interactive nature of parent groups • Other start up costs such as staff training, parenting materials, children's materials.

Policy Specialist – Allison Landy

STANDARDS OF PRACTICE

Children with Special Needs - Parent Coaching

I. Description of Strategy

Often times when a family has a concern about their child's development they share that concern with the child's health care, child care provider, or school program. Children may then be screened to determine if a further assessment of development is necessary. Evaluation of a child's development by an Arizona Early Intervention Program (AzEIP) provider, a local school district, or other professional, may or may not lead to a determination that the child qualifies to receive state supported intervention services. Reasons vary from the child only demonstrating mild delays in development to misperceptions of what children can do at a particular age. Although children who fall into these categories do not qualify to receive specialized services through state and federal funding, they can still benefit from enhanced support by their families and caregivers.

To assist families in developing knowledge and skills to enhance their abilities to help their children reach their fullest potential, First Things First promotes a Parent Coaching and Support model to provide individualized support in coordination with an interactive parent and child together model of services.

Evidence of effective programs that focus on parenting skills identifies four core components of an effective parent education logic model (Parents as Teachers National Center, Inc., www.parentsasteachers.org). These fundamental, core components of a Parent Coaching and Support Services Model include:

1. Individual Visits[1]: Visits may be conducted in the home or other locations where the family typically frequents and feels most comfortable. Personalized activities center on children's specific needs and family strengths for supporting children's on target development;
2. Ongoing Child Progress Monitoring and Screening: Families are encouraged to develop skills around recognizing how to observe and understand their child's development. Children may be rescreened after specific time periods have passed and no progress is noted;
3. Parent and Child Interactive Time: Families participate in facilitated group activities where they can interact with their children and enjoy opportunities to be connected with other families with similar concerns;
4. Networking and Coordination of Services: Families are provided with information and support in connecting with additional services, navigating referral systems and accessing community resources to improve their natural, concrete support networks

[1] Although home visits are a component of this strategy, they are not intended to be a comprehensive education program, rather specific to the child developmental needs and the individual needs of the family. Therefore, this SOP document is used in place of any additional home visitation standards of practice.

II. Implementation Standards:

Intensity of Services

Intensity of services may vary dependent on the specific needs of the family. Research has demonstrated a clear connection between program intensity and retention of families. The minimum standards for intensity of services for Parent Coaching are as follows:

- Personal Visits – At minimum, one face to face visit for at least one hour will be conducted each month of service delivery. The number of personal visits should be adjusted for families in need of more intensive services, especially recommended for families that may be more isolated from the community, but may not be less than the required minimum.
- Parent and Child Interactive Time – One parent group activity for a minimum of 2 hours will be conducted each month of service delivery.

Conducting Personal Visits

Individualized, personal visits are the core of the Parent Coaching model. During these visits, the family is gaining greater understanding and confidence in their role as the primary teacher of their child. Supporting the parent-child relationship is key to success.

- Prior to conducting personal visits, the grantee uses a standard form or instrument to conduct an "intake" process. The intake process shall include interview of the family, review of other records if available, and information related to child's referral and evaluation to demonstrate eligibility for the parent coaching service and to ensure that duplication of services are not conducted. Intake procedures shall also identify both prior and current resources the family is or has attempted to access.
- Personal visits begin with assessment of family needs, the results of which are used to determine
- Parent coaches shall create a family profile to be reviewed regularly with the family to maitain understanding for the family's routines and ongoing activities.
- Parent coaches implement a structured, research-based curriculum that promotes proven parenting practices that foster children's development.
- Design activities to be conducted during personal visits that are specifically designed around the child's current levels of development and health and ensure that activities are tailored to the individual needs of each family
- Families are fully engaged and are clear partners in the process of monitoring and documenting their child's progress. Families shall be provided with models for writing observations or noting their child'd development and encouraged to keep records of developmental progress to better understand their child's growth.
- In additiona to the individualized topics and activities, visits will address the following skills:
    - Understanding typical and atypical child development
    - Recognizing age appropriate child expectations
    - Identifying developmental milestones and developmental red flags
    - Using strategies for engaging in learning during daily activities and routines specific to the family's lifestyle, background and culture.

    - Maintaining meaningful parent-child interactions
- Visits will be conducted using a family-centered practice model
    - **Recognition that the family unit is the focus of attention.**
      Family-centered practice works with the family as a collective unit, insuring the safety and well-being of family members.
    - **Emphasis on strengthening the capacity of families to function effectively**
      The primary purpose of family-centered practice is to strengthen the family's potential for carrying out their responsibilities.
    - **Engagement of families in designing all aspects of the policies, services, and program evaluation.**
      Family-centered practitioners partner with families to use their expert knowledge throughout the decision- and goal-making processes and provide individualized, culturally-responsive, and relevant services for each family.
    - **Connection of families with more comprehensive, diverse, and community-based networks of supports and services.**
      Family-centered interventions assist in mobilizing resources to maximize communication, shared planning, and collaboration among the several community and/or neighborhood systems that are directly involved in the family.

      (National Resource Center for Permanency and Family Connections, 2009)

Conducting Parent and Child Interactive Group Meetings

Parent and child interactive time is based on the presumption that "all parents deserve and can benefit from support from other parents, research-based information regarding child development, early opportunities to become involved with community and school, and enriched opportunities with [their] child[ren] (Parents as Teachers National Center, Inc., 2004). The goals of the parent and child interactive group times are to remove family sense of isolation and for families to see themselves as support for one another. Additional goals include to support families in recognizing their role as their children's primary teacher as well as give parents opportunities to interact with their children in a learning environment.

- Group meetings occur in family friendly locations that allow for structured activities facilitated by the coach that provide information and promote parenting knowledge.
- Group meetings are held on a schedule convenient for the families participating, including holding events in evenings and on weekends.
- Group meetings include time for parents to meet with and support each other.
- Group meetings are used to reinforce learning occurring during personal visits
- Group meetings provide opportunities for children to play and interact with others outside of the family while parent coaches model and facilitate parent learning.
- Group meetings provide families opportunities to learn by attending activities and events in the community

Training and Qualifications Standards

Providing Parent Coaching services requires specific education and skills.

- Parent Coaches have obtained at minimum an associate's degree in a field related to early childhood education, early childhood special education, child and family studies, social work, or adult education.
- Areas of knowledge and competencies demonstrated in:
    a. Child development
    b. Early intervention/early childhood special education
    c. Availability of community resources and how to access them
    d. Reflective practices
    e. Child observation and ongoing progress monitoring
    f. Family protective factors
    g. Facilation of group learning
    h. Adult education
- To address cultural competency objectives, coaches shall ensure that children and families receive 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. Coaches should receive ongoing education and training in culturally and linguistically appropriate service delivery. Coaches should develop participatory, collaborative partnerships with families 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.

- Parent coaches 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).
- Parent coaches will participate in continuing education to remain current and update skills and knowledge to meet the requirements of this scope of work.

Supervision, Quality Assurance and Evaluation Standards

- Supervision of **XX** 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 consultation services utilizes quantitative and qualitative process that includes measures of change within the early childhood environment that accrue due to the consultation process and input from staff, families, program administrators, and community members. Evaluation includes review of the original assessment results, review of the improvement plan activities and re-assessment to determine if consultation made improvements to initial assessment activities.
- Compensation and benefits are adequate for supporting high quality staff and retention of that staff.

III. Service Delivery Activities:

Parent coaching provides families with the supports they need to ensure their children reach their maximum potential through a comprehensive service delivery model. Coaching focuses on building families' understanding of the primary relationship they have with their children. Coaching is directed toward expanding parent skills and knowledge rather than an intervention service to a child. Such a comprehensive model includes the four components of Individual Visits, Monitoring of Chldren's Progress, Parent and Child Interactive Time, and Networking and Coordination of Services. Each component is devised of the following activities:

1. Individual Visits

- Provide individual coaching to a family in the home setting or other natural setting where a family typically frequents and feels comfortable.
- Build a strong relationship between the coach and family based on respect.
- Include an initial family intake process to determine family and child needs.
- Engage the family in learning about information related to their specific needs as well as the general topics of child development including information on typical and atypical development, age-appropriate expectations, and information on recognizing children's developmental milestones.
- Model, consult, coach parenting practices
- Engage the family in creating a home learning environment, offer ideas for turning daily activities and routines into interactive, relationship-building, learning opportunities.
- Observe the family in parent/caregiver-child interactions.

2. Ongoing Child Progress Monitoring

- Engage the parent/caregiver in conducting ongoing observation of the child's behavior and development across the domains of cognition, language/communication, social-emotional and motor skills.
- Assist the family in understanding the importance of ongoing monitoring of children's progress and development.
- Engage the family in a tangible means to document children's progress and development (e.g. compiling a child portfolio or creating a scrapbook of developmental milestones)
- Discuss with family any ongoing concerns regarding children's development.
- Provide additional screening and/or referral to appropriate health care or educational entities when concerns persist over time.

3. Parent and Child Interactive Group Time

- Facilitate group meetings with families to provide information about parenting skills, child development, child health, adult-child interactions, discussing concerns with professionals and availability of community resources.
- Provide a venue for parents to meet, discuss mutual concerns, support each other, and create parent to parent connections.
- Facilitate interactive learning activities between parents/caregivers and children.

4. Networking and Coordination of Services

- Connect families to fully inclusive community programs, groups, or other opportunities that enrich family and child experiences in settings where children of all abilities are present.
- Provide information and referral supports for medical, mental health, social services, employment etc.
- Assist families in the transition to early intervention, special education or special health care services if a qualifying delay becomes identified.
- Coordinate programming with other service providers also working with the family from other programs or disciplines.

Family Support – Children with Special Needs

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 **Family Support – Children with Special Needs,** the units of service are:

Total number of families receiving parent coaching and support 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 **Family Support – Children with Special Needs,** performance measures are:

> **Total number of families receiving parent coaching and support services/proposed service number**
> Parent coach caseload /proposed service number
> Family attrition/target service number
> Total number of children receiving support services /proposed service number
> Total number of families attending parent and child group activities /proposed service number
> Total number of children attending parent and child group activities /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 **Family Support – Children with Special Needs,** the data reporting template is:

In Development

Data Reporting Instructions

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

For **Family Support – Children with Special Needs,** the data reporting instructions are:

In Development

Frequently Asked Questions

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

For **Family Support – Children with Special Needs,** the frequently asked questions are:

In development

GOAL AREA: FAMILY SUPPORT

STRATEGY NAME: FOOD SECURITY

GOAL:

- **FTF will coordinate 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
Through this strategy, FTF funding can be used to support the distribution of emergency food boxes with a focus on including items and nutritional resources for families with young children. Boxes provide food during an emergency situation. Each box provides a three-day supply of food and serves a family until more permanent assistance is found. Programs which provide food boxes funded through First Things First should work to support families with young children when they lack access to sufficient, safe and nutritious food in order to meet the dietary needs of both young children and parents who care for them. To support families facing food insecurity, and prevent potential long-term negative effects of under-nutrition in young children, the American Academy of Pediatrics has created a general outline of daily feeding schedules for infants, toddlers, and preschoolers. FTF funded food insecurity grantees will follow the AAP guidelines and the other requirements listed in the FTF Standards of Practice.	Scientific evidence suggests that hungry children are less likely to develop into healthy, productive citizens. According to the Center on Hunger and Poverty, inadequate nutrition is a major cause of impaired cognitive development, and is associated with increased educational failure, elevated occurrence of health problems, higher levels of aggression, hyperactivity, and anxiety among impoverished children. Therefore, it is important to support young children and their families in the area of nutrition and healthy eating; especially for those experiencing food insecurity.	<u>Capacity for Expansion</u> A variety of food security providers are well-established in both rural and metropolitan areas of the state. If food insecurity is identified as a priority, it is recommended that the Regional Partnership Council identify the existing providers and develop strategies that expand service provision and/or focus on supporting families with infants, toddlers and preschoolers. Food Bank expansion depends on the following variables; a) capacity for storage, and b) the number of available volunteers. <u>Timeline for Implementation</u> In most cases, distribution of emergency food boxes can begin almost immediately with established providers if food storage and mechanism for serving families is already established. <u>Multi-Year Commitment</u> This is an excellent one-time expenditure to meet immediate needs of families in emergency situations – this does not require a long-term commitment.	Costs vary from provider to provider as some food banks measure in total pounds of food vs. number of food boxes. Approximate cost is $15 to $20 for a 3 day emergency food box which includes food for children ages one through five years. If including infant supplements such as diapers, formula and/or pureed foods, the costs may increase from this range.

FIRST THINGS FIRST
Food Security
Standards of Practice

The American Academy of Pediatrics recognizes that proper nutrition begins at the supermarket with the foods parents buy and continues in the home as parents prepare and serve meals. Giving children a healthy start with good eating habits promotes his or her lifelong health. A variety of foods provides the nutrients that young children need to build strong bodies and stay healthy. Food also supplies the energy that children need to grow normally, play, learn, and explore the world around them. The American Academy of Pediatrics encourages families to think of their nutritional decisions as *health* decisions. Ideally, all young children and families would have access to healthy food and educational information, but recent studies indicate otherwise. For example, in Arizona as many as 1 in 5 children suffer from hunger, and with the continued economic downturn food pantries have seen demand for food boxes continue to rise.

The problem of childhood hunger is not simply a moral issue. Scientific evidence suggests that hungry children are less likely to become productive citizens. According to the Center on Hunger and Poverty, inadequate nutrition is a major cause of impaired cognitive development, and is associated with increased educational failure, elevated occurrence of health problems, higher levels of aggression, hyperactivity, and anxiety among impoverished children. Therefore, it is important to support young children and their families in the area of nutrition and healthy eating; especially for those experiencing food insecurity.

To support families facing food insecurity, and prevent potential long-term negative effects of under-nutrition in young children, the American Academy of Pediatrics has created a general outline of daily feeding schedules for infants, toddlers, and preschoolers. Food Security Programs who provide food boxes funded through First Things First should work to support families with young children when they lack access to sufficient, safe and nutritious food in order to meet the dietary needs of both young children and parents who care for them.

All Food Security Programs must:

- Coordinate, collaborate and communicate with community partners such as universities, local farmers, schools, food banks, State agencies, Tribal entities, faith based community, and private businesses to ensure that families have information about available food assistance providers in the surrounding area.
- Provide information on comprehensive social services and supports available to families.
- Develop a partnership with WIC (Women, Infant and Children) to help ensure that families who may be eligible could also receive WIC services.

Programs may also help families with:

- Financial literacy education to support families toward independence and breaking the constant state of crisis in which families may find themselves. The Food Security Programs need to utilize a positive, family centered, and evidence-based financial literacy curriculum.
- Other resources including diapers, books, clothing and other appropriate items for children birth through five years of age.

Suggested Daily Feeding Schedule for Infants

Food should only be given if the infant is developmentally ready, as recommended by a health provider. Indicators of readiness may include: infants are able to sit up, they open their mouths when they see a spoon coming towards them, they can move the food from the spoon and swallow without pushing it back out of their mouths, they make chewing motions, they have doubled their birth weight, and they have the ability to reject food (turning head and keeping mouth tightly closed).

Following is a general outline suggested by the American Academy of Pediatrics (measures included in the tables below were converted from metric by the Gila River Indian Community's Nutrition office):

Food Group	1-3 Months	4 Months	5 Months	6 Months	7 Months	8 Months	9 Months	10 Months	11 Months	12 Months
Breastmilk	Provides the best nutrition throughout the first year of life. Feed according to baby's hunger cues.									
Formula	18-32 ounces	30-32 ounces	30-32 ounces	30-32 ounces	29-31 ounces	26-31 Ounces	24-30 ounces	22-30 Ounces	20-28 ounces	18-24 ounces
Infant Cereal				4-6 Tbsp.	4-6 Tbsp.	4-6 Tbsp.	¼ -½ Cup	¼ -½ Cup	½ -¾ Cup	½ -¾ Cup
Vegetables				1-5 Tbsp. strained	1-5 Tbsp. strained	¼ -½ Cup strained or mashed	8-10 Tbsp. strained or mashed	½ -¾ strained or mashed	½ -¾ Cup Chopped	½ -¾ Cup Chopped
Fruits				1-5 Tbsp. strained	1-5 Tbsp. strained	¼ -½ Cup strained or mashed	¼ -½ Cup strained or mashed	½ Cup Chopped	½ Cup Chopped	½ Cup Chopped
Crackers, Teething Biscuits, Dry Toast						1 cracker 1 biscuit	1 cracker 1 biscuit	1 cracker 1 biscuit	1 cracker 1 biscuit	2 cracker 2 biscuit
Meat, Poultry, Fish Tofu, Cottage Cheese, Cheese						1-3 Tbsp strained	1-4 Tbsp strained or ground	2-4 Tbsp ground	2-4 Tbsp ground	1 ounce o ¼ cup ground
Egg Yolk (hard cooked)						1 Tbsp mashed	1 Tbsp mashed	2 Tbsp Mashed	1 Egg Yolk	1 Whole egg
Potatoes, Rice, Pasta,						2-4 Tbsp.	2-4 Tbsp.	2-4 Tbsp.	¼ Cup	¼ -½ Cup

Mashed Beans										

Suggested Dietary Needs for Young Children ages 1 through 5

Following is a general outline suggested by the American Academy of Pediatrics:

Food Group	Number of Servings Each Day	Ages 1-2 years	Ages 3-5 years	Example Food Item
Bread, Cereal, Rice, Pasta	6-11	¼ cup dry cereal ½ slice of bread ¼ cup rice ¼ cup pasta	⅓cup dry cereal ½ slice bread ⅓ cup rice or past ¼ cup cooked cere ½ 6" tortilla	Dry Cereal, Whole Grain Bread, Rice or pasta, cooked cereal, 6" tortilla
Vegetables	3-5	1-2 Tbsp.	3-5 Tbsp.	Fresh or frozen, raw, or cooked
Fruits	2-4	¼ -½ apple orange, banana ¼ cup fresh fruit ¼ cup fruit juice	½ apple, orange, banana ½ cup fresh fruit ½ cup fruit juice	Apple, orange or banana, fresh fruit, fruit juice
Milk, Yogurt &Cheese	3 or more. No more than 20 ounces per day	½ cup milk ½ yogurt ¼ cup ice cream 1 oz. cheese	¾ cup milk ¾ cup yogurt ½ cup frozen yogu ice cream 1½ oz. cheese	whole milk, yogurt, frozen yogurt or ice cream, cheese
Meat, Poultry, Fish, Dry Beans, Eggs & Peanut Butter	2-3	¼ cup meat 1oz fish 1oz dry beans 1 egg None-peanut butter	½ cup beans or pe 1 egg 1oz. tuna 2 Tbsp. Peanut bu	Cooked or dried beans or peas, eggs, lean meat (tuna), peanut butter

Infant Food Box: Birth to 12months of age:

Following is a general outline for a 3 day food box for infants only:

Food Group	1-3 Months	4 Months	5 Months	6 Months	7 Months	8 Months	9 Months	10 Months	11 Months	12 Months
Formula	powder formula 1 can →									
Infant Cereal				1 box →						
Vegetables				4 canned or Fresh Vegetables →						
Fruits				4 canned or Fresh Fruits →						
Crackers, Teething Biscuits, Dry Toast						1 box →				
Meat, Poultry, Fish, Tofu, Cottage Cheese, Cheese						½ lb cheese 2 cans of tuna →				
Egg Yolk (hard cooked)						3 eggs →				
Potatoes, Rice, Pasta, Mashed Beans						½ lb. →				

Early Childhood Food Box: 1 through 5 years of age

Food boxes for young children include food for family of 4 with at least one child under 6 years old.

Following is a general outline for a 3 day food box:

Food Group	Options for food items in a food box Ages 1-5 years
Bread, Cereal, Rice, Pasta	Bread one loaf 1 -3 lb bag of rice 2 packs of pasta 1-2 boxes of whole grain cereal 1 pack of yellow corn tortillas
Vegetables	1-2 jars of spaghetti sauce 7 cans of assorted vegetables
Fruits	6 cans of assorted fruits Fresh fruits, 1 quart fruit juice
Milk, Yogurt &Cheese	1 gallon of milk, 40 ounces of yogurt 1 lb of cheese
Meat, Poultry, Fish, Dry Beans, Eggs & Peanut Butter	2 lbs cooked or dried beans or peas 12 eggs 1 jar of peanut butter

Source: "Children's Health Topics: Nutrition Family Community Resources." American Academy of Pediatrics. 2010.

Center on Hunger and Poverty.

GOAL AREA: FAMILY SUPPORT

STRATEGY NAME: FAMILY RESOURCE CENTERS

GOAL:

- **FTF will coordinate 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.**
- **FTF will increase the availability, quality, and diversity of relevant resources that support language and literacy development for young children and their families.**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
Family Resource Centers embedded in local communities provide families with young children access to information and/or education on a variety of child development and health topics. Information about where and when parenting education programs are available should be easily accessible by all interested persons. These centers can also contribute to the community building process as they serve as a central location for engaging local community organizations and local government in the identification and resolution of community concerns. FTF funded Family Resource Centers provide resource and referral information to identify supports and services available to families with young children and	There is little evidence that resource centers in and of themselves have a direct impact on outcomes for young children and their families. However, having "accurate information about raising young children and appropriate expectations for their behavior" has been cited by the Doris Duke Strengthening Families Initiative as one of five key protective factors that improve child outcomes and reduce the incidence of child abuse and neglect (Center for the Study of Social Policy, 2008).	<u>Capacity for Expansion and Links to Other Strategies</u> In addition to providing resource, referral and information services through resource centers, Councils should consider how an existing resource center will enhance the network of agencies supporting families in the region. Family Resource Centers can incorporate and implement other family support strategies, such as community based parent education and serve as a location for FTF grantees and other community service programs and providers to meet on partnership and collaboration activities. It is important to also consider how this strategy targets expansion of those resources to underserved locations within the region, but also allows for the development of new services. FTF funded resource centers should promote use of the Arizona Parent Kit and bring awareness to the availability of the Birth to Five Helpline as well as other FTF statewide strategies such as Quality First! Councils may identify partnerships with cities or other state and local entities in expansion or development of a family resource center. Considerations for implementation should	Costs vary (5,000 to 300,000+ if also providing community based parent education sessions) but must include: • new or additional materials (pamphlets, brochures, books, videos, etc.) that cover the variety of health and development topics and community resources. • Staffing • Marketing/ Outreach If providing community based parent education – costs associated with classroom and/or playgroup sessions should also be included. Refer to Community Based Parent Education Strategy for full details.

provide each family with access to information and support on topics such as parenting skills, early childhood development and health. Community based parent education sessions may also be housed and offered at resource center locations.		include how FTF funded resource, referral and/or community based parent education will be incorporated into existing programming/ services already offered at the center. <u>Multi-Year Commitment and Timeline for Implementation</u> A plan for recruitment and outreach to families and the community must be identified. This can take a considerable amount of time before families actually begin to utilize a resource center (2 to 3 months). <u>System-Building Issues</u> Resource center expansion to engage families with young children should be coordinated and aligned across the community with the other organizations providing services. Resource centers could be 'one-stop' service centers where families have access to early childhood development and health information, identify and locate other family support or parent education programs such as home visitation, parenting classes, food banks, or health insurance enrollment assistance. <u>Recommended Saturation Level</u> It may not be necessary to establish new resource centers to meet the needs of families with young children. Across urban and rural communities, families may already be gathering or coming to established settings such as libraries, WIC or DES offices, non profit or city funded community resource centers. If a council prioritizes this as a need, then the existing gathering places or established resource centers must be identified so that an FTF strategy can build upon these assets to directly serve families. Family Resource Centers can also serve as a hub for other FTF and community funded family support programs to coordinate services for families i.e. home visitation programs could locate the staff office space at the center.	

FIRST THINGS FIRST
Family Resource Centers
Standards of Practice

Based upon Building Bright Futures, regional needs and assets reports, and preliminary information from the Family and Community Survey, we know that Arizona's parents and families with young children need information on child development; to develop parenting skills; and have access to resources. Having "accurate information about raising young children and appropriate expectations for their behavior" has been cited by the Doris Duke Strengthening Families Initiative as one of five key protective factors that improve child outcomes and reduce the incidence of child abuse and neglect (Center for the Study of Social Policy, 2008). All families, regardless of background, can benefit from information or education related to child development and health, as well as access to resources, supports and services. At some point during the course of parenting, all families have questions and seek information. Some families may be searching for nearby family child care providers, while others may be concerned about their child's learning. Families also may be trying to cope with the everyday issues of parenting like toilet training and feeding a picky eater.

While there is no one single support strategy or solution to providing information to families (Daro, 2006), an integral component of an effective family support infrastructure ensures that information is available in a variety of forms and addresses the varying concerns families may have. Information provided must do the following:

- Connect programs across communities
- Be available in a variety of forms
- Be culturally appropriate
- Build on family strengths and knowledge
- Provide accurate information
- Offer opportunities for sharing among and between families through various family and social networks

Although information or education can come in different forms, a common goal is to increase the level of family functioning and promote optimal child development. Family Resource Centers embedded in local communities can provide families with young children access to information and/or education on a variety of child development and health topics. Information about where and when parenting education programs are available needs to be easily accessible by all interested persons. These centers can also contribute to the community building process as they serve as a central location for engaging local community organizations and local government in the identification and resolution of community concerns.

While each First Things First funded Family Resource Center may be uniquely designed, they all have a valuable role to play in meeting the complex needs of families and communities across the State of Arizona. First Things First focuses on programs and services that provide children with the best opportunities for school and life success. Funding decisions are based upon a robust process of review to ensure programs are supported by research, value the family and use approaches considered to be best practice, which are responsive to the needs identified in a specific Region. First Things First funded programs shall supplement, not supplant, other state expenditures on, and federal monies received for early childhood development and health programs.

It is expected that family resource centers funded by First Things First will use a family-centered and strengths-based approach to:

1. Provide resource and referral information to identify supports and services available to families with young children (e.g. quality early care and education programs; family literacy activities; nutrition; obesity; breastfeeding; physical activity; immunizations; oral health; health insurance enrollment assistance; how to access and participate in consistent medical/dental homes; prenatal care; safety; and where to access regular developmental, vision and hearing screenings). ***NOTE: When providing direct health insurance enrollment assistance, programs must follow the First Things First Health Insurance Outreach and Application Assistance Standards of Practice.***
2. Provide each family with access to information and support in each of the core areas: child development and parenting skills.
    - All domains of child development (cognitive, communication, physical, social/emotional and adaptive)
    - Appropriate child-adult interactions and development of parenting skills (i.e. physical touch, showing affection, spending time together, positive discipline, parental monitoring, early reading and language experiences and communication)

    Family Resource Centers may also offer parent education classes at their location. ***NOTE: When providing parent education community based training, programs must follow the First Things First Parent Education Community Based Training Standards of Practice.***

Family Resource Centers will:

1. Provide services to families that are based upon a culture of trust and respect
    A. Create a safe family-centered environment.
        a. Staff are from the community and have extensive knowledge of community resources
        b. Structure activities that are compatible with the family's availability and accessibility

c. Demonstrate genuine interest in and concern for families

d. Services are provided in the family's primary language

e. Clearly define program objectives with the families when they participate: understanding what the program will accomplish helps families become fully engaged in program services.

B. Create opportunities for formal and informal feedback and act upon it; ensure that input shapes decision-making.

C. Encourage open, honest communication.

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

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

   A. Encourage family members to build upon their strengths.

   B. Reflect the commitment to effectively serve the identified target population with an emphasis on fathers and grandparent caregivers, through publicity/outreach, literature and staff training.

   C. Help families identify and acknowledge informal networks of support and community resources.

   D. Create opportunities to enhance parent-child and peer relationships.

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

   A. Create opportunities for families of different backgrounds to identify areas of common ground and to accept and value differences between them.

   B. Strengthen parent and staff skills to advocate for themselves within institutions and agencies.

   C. Hire staff who reflect the cultural and ethnic experiences and language of the families with whom they work and integrate their expertise into the entire program.

   D. 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

4. Programs are flexible and continually responsive to emerging family and community issues.
    A. Be accessible for all families of children ages birth through five in the local community. Family Resource Centers will be located in areas where families routinely congregate (e.g. churches, schools, early care and education centers, libraries, community centers) to provide parenting education, early literacy development, social support opportunities, and/or access to local community resources.
    B. Locations and environments within the location are safe and welcoming for families with young children.
    C. The site will be accessible for persons with disabilities and will be compliant with the American's with Disabilities Act.
    D. Engage families and other community members as partners to ensure that the program is beneficial. Families and community members have regular input and feedback in programmatic planning to meet their needs.
    E. Develop a collaborative, coordinated response to community needs.

5. Family Resource Centers provide ongoing staff development/training to ensure program quality and give staff an opportunity to develop professionally.
    A. Assess staff skills and abilities. Staff must be able to engage families while keeping a professional rapport.
    B. Provide ongoing staff development/training on the First Things First Family Resource Centers Standards of Practice principles.
    C. Supervisors should work with staff to prepare professional development plans.

6. All First Things First Family Resource Centers Standards of Practice are modeled in all activities including planning, governance, and administration.

    A. The length of employment and experience/education are reflective of high quality staff. Staff is required to have a minimum of a high school diploma with knowledge of the surrounding community and the available resources. Supervisors must also meet or exceed this educational and knowledge requirement and, in addition, must also have at least two years of program management experience.

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

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

    D. All staff work as a team, modeling respectful relationships.

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

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

        1. Activities, as identified by First Things First, include pre and post testing, self-assessment and opportunities for feedback

        2. Identify outreach, engagement and retention practices

        3. Programs must demonstrate mechanisms to assess program effectiveness and to implement quality improvements. Programs must participate in data collection and reporting of performance measures to First Things First.

Family Resource Centers

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 **Family Resource Centers,** the units of service are:

Total number of families receiving family resource 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 **Family Resource Centers,** performance measures are:

> **Total number of families receiving family resource services/proposed service number**
> Total number of children receiving family resource services/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 calls received/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 **Family Resource Centers,** 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

FAMILY RESOURCE CENTER

GENERAL INFORMATION

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

Families and Children Served

	In-person/Face to Face	Over Phone
Total Number of families with children (0-5 years) receiving resource and referral information *		

If none, please enter zero

Please report the number of number of families with children (0-5 years) receiving resource and referral information in the following categories

	In-person/Face to Face	Over Phone
Literacy	0	0
Parent Education	0	0
Food	0	0
Health Care (Excluding Indian Health Services (IHS)/Indian Tribal Urban (ITU))	0	0
Indian Health Services(IHS)/Indian Tribal Urban (ITU)	0	0
Health-E-APP	0	0
Housing	0	0

Dental Care	0	0
Child Find	0	0
Child Care	0	0
Mental Health Services	0	0
Other (please Specify)		

Total Number of children (0-5 years) in families receiving resource and referral information *	In-person/Face to Face	Over Phone

If none, please enter zero

Please report the Total Number of children (0-5 years) in families receiving resource and referral information in the following categories

	In-person/Face to Face	Over Phone
Literacy	0	0
Parent Education	0	0
Food	0	0
Health Care (Excluding Indian Health Services (IHS)/Indian Tribal Urban (ITU))	0	0
Indian Health Services(IHS)/Indian Tribal Urban (ITU)	0	0
Health-E-APP	0	0
Housing	0	0
Dental Care	0	0
Child Find	0	0
Child Care	0	0
Mental Health Services	0	0
Other (please Specify)		

Referrals to Services Offered at the Family Resource Center

Total Number of families referred to services at the Family Resource Center *	In-person/Face to Face	Over Phone

If none, please enter zero

Please report the Number of families referred to services at the Family Resource Center in the following categories

	In-person/Face to Face	Over Phone
Literacy	0	0
Parent Education	0	0
Food	0	0
Health Care (Excluding Indian Health Services (IHS)/Indian Tribal Urban (ITU))	0	0
Indian Health Services(IHS)/Indian Tribal Urban (ITU)	0	0
Health-E-APP	0	0
Housing	0	0
Dental Care	0	0
Child Find	0	0
Child Care	0	0
Mental Health Services	0	0
Other (please Specify)		

Total Number of children (0-5 years) in families referred to services at the Family Resource Center *	In-person/Face to Face	Over Phone

If none, please enter zero

Please report the Number of children (0-5 years) in families referred to services at the Family Resource Center in the following categories

	In-person/Face to Face	Over Phone
Literacy	0	0
Parent Education	0	0

Food	0	0
Health Care (Excluding Indian Health Services (IHS)/Indian Tribal Urban (ITU))	0	0
Indian Health Services(IHS)/Indian Tribal Urban (ITU)	0	0
Health-E-APP	0	0
Housing	0	0
Dental Care	0	0
Child Find	0	0
Child Care	0	0
Mental Health Services	0	0
Other (please Specify)		

In Total Number of service providers housed in your Family Resource Center *

If none, please enter zero

Please report the Number of service providers housed in your Family Resource Center in the following categeries

Literacy	0
Parent Education	0
Food	0
Health Care (Excluding Indian Health Services (IHS)/Indian Tribal Urban (ITU))	0
Indian Health Services(IHS)/Indian Tribal Urban (ITU)	0
Health-E-APP	0
Housing	0
Dental Care	0
Child Find	0

Child Care	0
Mental Health Services	0
Other (please Specify)	

Referrals to Services Offered Outside of the Family Resource Center

	In-person/Face to Face	Over Phone
Total Number of families with children (0-5 years) receiving referrals to other agencies *		

If none, please enter zero

Please report the Number of families with children (0-5 years) receiving referrals to other agencies in the following categories

	In-person/Face to Face	Over Phone
Literacy	0	0
Parent Education	0	0
Food	0	0
Health Care (Excluding Indian Health Services (IHS)/Indian Tribal Urban (ITU))	0	0
Indian Health Services(IHS)/Indian Tribal Urban (ITU)	0	0
Health-E-APP	0	0
Housing	0	0
Dental Care	0	0
Child Find	0	0
Child Care	0	0
Mental Health Services	0	0
Other (please Specify)		

	In-person/Face to Face	Over Phone
Total Number of children (0-5years) in families receiving referrals to other agencies *		

If none, please enter zero

Please report the Number of children (0-5years) in families receiving referrals to other agencies in the following categories

	In-person/Face to Face	Over Phone
Literacy	0	0
Parent Education	0	0
Food	0	0
Health Care (Excluding Indian Health Services (IHS)/Indian Tribal Urban (ITU))	0	0
Indian Health Services(IHS)/Indian Tribal Urban (ITU)	0	0
Health-E-APP	0	0
Housing	0	0
Dental Care	0	0
Child Find	0	0
Child Care	0	0
Mental Health Services	0	0
Other (please Specify)		

Health Insurance Enrollment Assistance

Are you providing any Health Insurance Enrollement Assistance as part of your Family Resource Center Services? * ○ Yes ○ 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
If none, please enter zero

Number of families referred to AHCCCS or DES to receive health coverage *

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 *

Data Reporting Instructions

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

For **Family Resource Centers,** 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

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

Section 1: Families and Children Served

1. ***Total number of families with children (0-5 years) receiving resource and referral information:** In this data field you will enter the total number of families with children (0-5 years) receiving resource and referral information in-person/face to face and Over Phone.
    a. ***Please report the number of families with children (0-5 years) receiving resource and referral information in the following categories.***

Table 1A

Category	***In person - face to face***	***Over phone***
Literacy		
Parent Education		
Food		
Health Care (Excluding Indian Health Services (IHS)/Indian Tribal Urban (ITU))		
Indian Health Services (IHS)/ Indian Tribal Urban (ITU)		
Health-E-APP		
Housing		
Dental Care		
Child Find		
Child Care		
Mental Health Services		
Other (please specify)		

2. ***Total number of children (0-5 years) in families receiving resource and referral information:** In this data field you will enter the total number of children (0-5 years) in families receiving resource and referral information in-person/face to face and Over Phone.
    a. ***Please report the number of children (0-5 years) in families receiving resource and referral information in the following categories. Refer to table 1A***

Section 2: Referrals to Services Offered at the Family Resource Center

3. ***Total number of families referred to services at the Resource Center:** In this data field you will enter in the total number of families referred for services at Resource Center in-person/face to face and Over Phone.
    a. ***Please report the number of families referred to services at the resource center in the following categories. Refer to table 1A***

4. ***Total number of children (0-5yrs) in families referred to services at the Resource Center:** In this data field you will enter in the total number of children (0-5) that were referred for services at the Resource Center in-person/face to face and Over Phone.
    a. ***Please report the number of children (0-5 yrs) in families referred to services at the resource center in the following categories. Refer to table 1A***

5. **In total Number of service providers housed in your family resource center.** In this data field you will enter the total number of service providers housed in your family resource center
   a. ***Please report the total number of service providers housed in your family resource center in the following categories.***

Table 1B

Category	***Total number of service providers housed in your family resource center***
Literacy	
Parent Education	
Food	
Health Care (Excluding Indian Health Services (IHS)/Indian Tribal Urban (ITU))	
Indian Health Services (IHS)/ Indian Tribal Urban (ITU)	
Health-E-APP	
Housing	
Dental Care	
Child Find	
Child Care	
Mental Health Services	
Other (please specify)	

Section 3: Referrals to Services Outside of the Family Resource Center

6. ***Total number of families with children (0-5 years) receiving referrals to other agencies in network/region:** In this data field you will enter in the total number of families with children (0-5 years) that received referrals to other agencies in the network/region in-person/face to face and Over Phone.
   a. ***Please report the number of families with children (0-5 years) receiving referrals to other agencies in network/region in the following categories. Refer to table 1A***

7. ***Total number of children (0-5 yrs) in families receiving referrals to other agencies in network/region:** In this data field you will enter in the total number of children (0-5) in families that received referrals to other agencies in the network/region in-person/face to face and Over Phone.
   b. ***Please report the number of children (0-5 years) in families receiving referrals to other agencies in network/region in the following categories. Refer to table 1A***

Section 4: Health Insurance Enrollment Assistance.

Are you providing any Health Insurance Enrollment Assistance as part of your family resource center services? YES or NO. If yes, please fill out the following:

8. * **Number of families referred to AHCCCS or DES to receive health coverage:** In this data field you will enter the number of families referred to AHCCCS or DES to receive health coverage.
9. ***Number of families served who are not covered by private insurance, AHCCCS, Indian Health Services, or Kids Care:** In this data field you will enter the number of families who are not covered by private insurance, AHCCCS, Indian Health Service, or Kids Care.
10. ***Number of families served who report they are underinsured:** In this data field you will enter the number of families who report they are underinsured.
11. ***Number of families served who report lack of insurance or underinsurance who received enrollment assistance to obtain insurance:** In this data field you will enter in the number of families served who report a lack of insurance or underinsurance who received enrolled assistance to obtain insurance.

Frequently Asked Questions

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

For **Family Resource Centers,** the frequently asked questions are:

In development

GOAL AREA: FAMILY SUPPORT

STRATEGY NAME: COMMUNITY BASED LITERACY

GOAL:

- **FTF will increase the availability, quality and diversity of relevant resources that support language and literacy development for young children and their families**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
FTF funded Community Based Literacy Programs: ✓ Provide training for parents that will assist them in improving the skills to be their child's first teacher. ✓ Provide information or education on developmentally appropriate learning opportunities that support early language and literacy development which prepares children for success in school and life. ✓ Make accommodations in curriculum for children and adults with special needs. ✓ Provide "family- friendly" community sites that offer family literacy and parenting education to enable adults to attain proficiency in basic skills. ✓ Offer developmentally appropriate early language and literacy activities for infants, toddlers and preschoolers. Through community based trainings and settings, such as libraries, family resource centers, faith organizations and arly care and education programs, families can learn about activities which support early language and literacy development and can become part of their daily routines. It is critical that families understand the importance of and how to read, talk and sing with their infants, toddlers and preschoolers on a daily basis.	Research indicates that community based family literacy programs which provide learning opportunities for <u>both</u> the young child and his or her parents positively impact young children and their families. (Literacy N. C., 2009) Studies have also shown that shared-reading interventions can have a significant, substantial and positive impact both on young children's oral language skills and on young children's print knowledge, both reading readiness indicators needed for learning to read. Neuman, Copple, and Bredekamp (2000), state that "the single most	<u>Administrative Home Infrastructure</u> Program models, including national program models *Reach Out and Read* and *Raising a Reader*, have established administrative homes. Community Based Literacy RFGA applicants should include narrative and budget information specific to the activities, responsibilities and related costs to maintain a program's affiliation, accreditation and/or certification. Grantees must maintain model fidelity and standing with the administrative home. When considering Family Literacy programs, this type of program may already exist within a school district and/or Head Start program and the administrative oversight should be identified. <u>Capacity for Expansion</u> Regional Partnership Councils should explore and identify opportunities to build upon existing literacy networks, such as public libraries, in order to allow existing programs to serve additional families. In many instances, opportunities also exist for multiple community-based organizations to combine their resources to address complex family needs. First Things	Cost varies ($5,000 to $300,000+ annually) upon program model or programmatic approach. Examples include: <u>Family Literacy</u> Approximately $5,000 per family per year. <u>Reach out and Read (ROR).</u> A unit cost is under development and will be available through the Policy Staff. This cost will include books and equipment, as well as coordination and administration at the regional level

Comprehensive literacy programs that are moderate to high intensity like *family literacy* programs involve both the parent and child in a series of ongoing center based trainings and learning opportunities. Model strategies support serving the needs and concerns of the family rather than serving individual family members in isolation. Other national models are lower intensity programs that engage the parent and child in community settings such as meeting areas in apartment complexes or in pediatric medical practices. **Reach Out and Read**: ROR is a program whose mission is "…to make literacy promotion a standard part of pediatric primary care, so that children grow up with books and a love of reading" (Reach Out and Read Arizona, 2008). The ROR program is delivered through medical practices, and trains doctors and nurses to advise parents about the importance of reading aloud. It also provides books to children at pediatric check-ups from six months to five years of age, with a special focus on children growing up in poverty. ROR health providers, utilize the book to promote age-appropriate literacy skills and as a tool to discuss developmental issues with parents and families. **Raising a Reader**: Raising A Reader's training in community settings helps to develop the capacity of families to create a language-rich environment for young children. The program circulates over 100 high quality children's books into children's homes through an average rotation cycle but helps children and families develop, practice, and maintain the habit of sharing those books ('book cuddling').	important activity for building … skills essential for reading success appears to be reading aloud to children."	First literacy strategies can expand the capacity of established early language and literacy programs to provide supports and services to young children and their families. <u>Links to Other Strategies</u> This strategy is directly linked to Community Based Parent Education – refer to those documents when considering this strategy. This strategy should also be implemented in coordination with other family support strategies such as home visitation and/or resource center strategies to ensure optimal programming for each family. FTF funded programs can support families to use their Arizona Parent Kit, or access the Birth to Five Helpline. Programs should refer families to other FTF or other community resources as a regular part of the curriculum and services. <u>System-Building Issues and Recommended Saturation Level</u> Community based literacy can be a part of a system of family support in a local regional/ community area, especially to provide information to families who may not access or participate in home visitation programs. Many councils build or expand community based parent education into existing literacy programs as many families already access other support and services through established programs. <u>Parent Awareness</u> Parent awareness of the importance of literacy development in young children may be built through lower intensity activities, such as public library programs.	<u>Raising a Reader</u> Estimated at $100.00 per child for program materials and technical assistance; a $2,000 licensing fee—meant to take the project to scale—meaning community wide; and RAR Coordinator travel and hotel costs to attend training provided by Raising a Reader Program. The cost per book in the first year can be as low as $1.00.

FIRST THINGS FIRST

Early Language and Literacy Programs in Home and Community Settings

Standards of Practice

Early childhood stakeholders, families, and communities recognize that when early language and literacy development is optimized, it can be the foundation for a child's later academic success in school. "The years from birth through age five are a critical time for children's development and learning. Early childhood educators understand that at home and in early childhood education settings, young children learn important skills that can provide them with the cornerstones needed for the development of later academic skills..." (Literacy, 2009)

Literacy acquisition encompasses the four domains of language (reading, writing, speaking and listening) and numeracy. Early literacy or precursor literacy skills include the following variables that are consistently shown to predict later literacy achievement:

- alphabet knowledge: knowledge of the names and sounds associated with printed letters
- phonological awareness: the ability to detect, manipulate, or analyze the auditory aspects of spoken language (including the ability to distinguish or segment words, syllables, or phonemes), independent of meaning
- rapid automatic naming of letters or digits: the ability to rapidly name a sequence of random letters or digits
- rapid automatic naming of objects or colors: the ability to rapidly name a sequence of repeating random sets of pictures of objects (e.g., "car," "tree," "house," "man") or colors
- writing or writing name: the ability to write letters in isolation on request or to write one's own name
- phonological memory: the ability to remember spoken information for a short period of time
- concepts about print: knowledge of print conventions (e.g., left–right, front–back) and concepts (book cover, author, text)
- print knowledge: a combination of elements of alphabet knowledge, concepts about print, and early decoding
- reading readiness: usually a combination of alphabet knowledge, concepts of print, vocabulary, memory, and PA
- oral language: the ability to produce or comprehend spoken language, including vocabulary and grammar
- visual processing: the ability to match or discriminate visually presented *symbols*

Programs that support young children's early language and literacy development are a part of the family support system in Arizona. An array of early language and literacy programs and service delivery methods may be implemented to meet the needs of families with young children. Research indicates that family literacy programs which provide learning opportunities for both the young child and his or her parents positively impact young children and their families. (Literacy N. C., 2009) According to Adult Education and Family Literacy Act (AEFLA) standards, the term "family literacy services" means programming that is of sufficient intensity in terms of hours, and of sufficient duration, to make sustainable changes in a family and that integrates all of the following core components:

- ✓ Interactive literacy activities between parents and their children, and
- ✓ Training for parents regarding how to be the primary teacher for their children and full partners in the education of their children, and
- ✓ Parent literacy training that leads to economic self-sufficiency, and
- ✓ An age-appropriate education to prepare children for success in school and life experiences.

Family literacy programs are built on four core principles; 1) the value of education for success in life, 2) the central role of the parent in a child's development, 3) the identification of individual strengths, and 4) the value of experiential learning.

While each First Things First funded early language and literacy program may be uniquely designed, they all have a valuable role to play in meeting the complex needs of families and communities across the State of Arizona. First Things First focuses on programs and services that provide children with the best opportunities for school and life success. Funding decisions are based upon a robust process of review to ensure programs are supported by research, value the family, use approaches considered to be best practice and are responsive to the specific needs identified in each region. First Things First funded programs shall supplement, not supplant, other state expenditures on, and federal monies received for early childhood development and health programs.

It is expected that early language and literacy programs funded by First Things First will be offered at no-cost, on a voluntary basis**. Programs and service can be delivered through home visitation or community based training.** Please, also refer to the First Things First Home Visitation and/or Parent Education Community Based Training Standards of Practice documents.

Using a family-centered and strengths-based approach these programs will:

1. Provide a Focus on Literacy
    A. Inform and educate parents and families on typical early language and emergent literacy development for children ages birth through five.
    B. Literacy coaching and instruction should be woven into the activities of all program components; presented and practiced in contexts that are meaningful to families' lives and needs. If providing literacy services in a community based setting, it is critical that

parents and families are taught to bridge classroom experiences to home environments with their own young children.

C. Training for parents regarding how to be the primary teacher for their children and full partners in the education of their children.

- Actively engage parents in learning how everyday experiences can nurture the literacy development of their children.
- Support parents in maintaining a literacy-rich home environment.
- Assist parents to learn how to advocate for their children within a variety of settings, including school, child care and human service agencies.

2. Use a research-based curriculum and activities to promote learning in contexts which are relevant to the lives of participants.

3. Provide Sufficient Intensity and Duration of Services

- For example, typical frequency and duration of family literacy programs is a minimum of 6 sessions at 2 hours per session.

Programs may also:

- Align with Arizona's Early Learning Standards/Guidelines.
  Family literacy programs across the nation also take into consideration alignment with their state's Early Learning Guidelines which describe the expectations about what children should know (understand) and do (competency and skills) across the different domains of learning. In Arizona, the Department of Education developed Early Learning Standards to provide a framework for the planning of quality learning experiences for all children 3 to 5 years of age. The document can be found here:
  http://www.ade.state.az.us/earlychildhood/downloads/EarlyLearningStandards.pdf
  First Things First is developing Early Learning Developmental Guidelines for infants and toddlers.

- Provide parent literacy training that leads to economic self-sufficiency.
  - Assist adults in raising their literacy levels.
  - Assist adults in gaining the knowledge and skills needed for employment and self-sufficiency.
  - Assist adults who are parents in gaining educational skills they need to be full partners in the educational development of their children.
  - Assist adults in completing their secondary school education or its equivalent (e.g., English language classes, Adult Basic Education, Adult Secondary Education, preparation for the General Education Development (GED) examination, and workplace literacy)

- In community settings, instruction should include a combination of individual and group activities, and encourage cooperative learning.
- Assessment, both formal and informal, should occur on an ongoing basis in order to provide adult learners with feedback about progress they have made toward goals.
- Participants must be actively engaged in the decision-making process with regard to their education.
- Program staff must support adult learners in being self-directed, with understanding that adult education builds upon the knowledge, experiences and roles of participating adults.

All First Things First funded Home Based Early Language and Literacy Programs <u>must also follow</u> the First Things First Home Visitation Standards of Practice.

All First Things First funded Community Based Early Language and Literacy Programs <u>must also follow</u> the First Things First Parent Education Community Based Training Standards of Practice.

March 23, 2010

Community-based Literacy

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 **Community-based Literacy,** the units of service are:

Total number of families attending family literacy trainings or literacy workshops
Total number of children attending family literacy trainings or literacy workshops
Total number of books distributed

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 **Community-based Literacy,** performance measures are:

> Total number of family literacy trainings or literacy workshops conducted/proposed service number
> **Total number of families attending family literacy trainings or literacy workshops /proposed service number**
> **Total number of children attending family literacy trainings or literacy workshops /proposed service number**
> **Total number of books 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 **Community-based Literacy,** the data reporting template is:

In Development

Data Reporting Instructions

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

For **Community-based Literacy,** the data reporting instructions are:

In Development

Frequently Asked Questions

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

For **Community-based Literacy,** the frequently asked questions are:

In development

GOAL AREA: FAMILY SUPPORT

STRATEGY NAME: COMMUNITY BASED LITERACY – REACH OUT AND READ (ROR)

GOAL:

- **FTF will increase the availability, quality and diversity of relevant resources that support language and literacy development for young children and their families**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
FTF funded Community Based Literacy Programs: ✓ Provide training for parents that will assist them in improving the skills to be their child's first teacher. ✓ Provide information or education on developmentally appropriate learning opportunities that support early language and literacy development which prepares children for success in school and life. ✓ Make accommodations in curriculum for children and adults with special needs. ✓ Provide "family- friendly" community sites that offer family literacy and parenting education to enable adults to attain proficiency in basic skills. ✓ Offer developmentally appropriate early language and literacy activities for infants, toddlers and preschoolers. **Reach Out and Read**: ROR is a program whose mission is "…to make literacy promotion a standard part of pediatric primary care, so that children grow up with books and a love of reading" (Reach Out and Read Arizona, 2008). The ROR program is delivered through medical practices, and trains doctors and nurses to advise parents about the importance of reading aloud. It also provides books to children at pediatric check-	Research indicates that community based family literacy programs which provide learning opportunities for <u>both</u> the young child and his or her parents positively impact young children and their families. (Literacy N. C., 2009) Studies have also shown that shared-reading interventions can have a significant, substantial and positive impact both on young children's oral language skills and on young children's print knowledge, both reading readiness indicators needed for learning to read. Neuman, Copple, and Bredekamp (2000), state that "the single most	<u>Administrative Home Infrastructure</u> The *Reach Out and Read* model has an established administrative home – the Arizona Academy of Pediatrics. Community Based Literacy RFGA applicants should include narrative and budget information specific to the activities, responsibilities and related costs to maintain this program's affiliation, accreditation and/or certification. Grantees must maintain model fidelity and standing with the administrative home. <u>Capacity for Expansion</u> For 2012 Regional Partnership Councils can purchase into the statewide contract existing between First Things First and the Academy of Pediatrics. <u>Links to Other Strategies</u> This strategy is directly linked to Community Based Parent Education – refer to those documents when considering this strategy. ROR sites can support families to use their Arizona Parent Kit or access the Birth to Five Helpline. Programs should refer families to other FTF or	<u>Reach out and Read (ROR).</u> A unit cost is under development and will be available through the Policy Staff. This cost will include books and equipment, as well as coordination and administration at the regional level

ups from six months to five years of age, with a special focus on children growing up in poverty. ROR health providers, utilize the book to promote age-appropriate literacy skills and as a tool to discuss developmental issues with parents and families.	important activity for building … skills essential for reading success appears to be reading aloud to children.”	community resources as a regular part of the curriculum and services. <u>System-Building Issues and Recommended Saturation Level</u> Community based literacy can be a part of a system of family support in a local regional/ community area, especially to provide information to families who may not access or participate in home visitation programs. <u>Parent Awareness</u> Parent awareness of the importance of literacy development in young children can be enhanced by involvement of their pediatrician or other health professional.	

Policy Specialist: K. Vilay

FIRST THINGS FIRST

Community Based Literacy - Reach Out And Read

Standards of Practice

Early childhood stakeholders, families, and communities recognize that when early language and literacy development is optimized, it can be the foundation for a child's later academic success in school. "The years from birth through age five are a critical time for children's development and learning. Early childhood educators understand that at home and in early childhood education settings, young children learn important skills that can provide them with the cornerstones needed for the development of later academic skills..." (Literacy, 2009)

Literacy acquisition encompasses the four domains of language (reading, writing, speaking and listening) and numeracy. Early literacy or precursor literacy skills include the following variables that are consistently shown to predict later literacy achievement:

- alphabet knowledge: knowledge of the names and sounds associated with printed letters
- phonological awareness: the ability to detect, manipulate, or analyze the auditory aspects of spoken language (including the ability to distinguish or segment words, syllables, or phonemes), independent of meaning
- rapid automatic naming of letters or digits: the ability to rapidly name a sequence of random letters or digits
- rapid automatic naming of objects or colors: the ability to rapidly name a sequence of repeating random sets of pictures of objects (e.g., "car," "tree," "house," "man") or colors
- writing or writing name: the ability to write letters in isolation on request or to write one's own name
- phonological memory: the ability to remember spoken information for a short period of time
- concepts about print: knowledge of print conventions (e.g., left–right, front–back) and concepts (book cover, author, text)
- print knowledge: a combination of elements of alphabet knowledge, concepts about print, and early decoding
- reading readiness: usually a combination of alphabet knowledge, concepts of print, vocabulary, memory, and PA
- oral language: the ability to produce or comprehend spoken language, including vocabulary and grammar
- visual processing: the ability to match or discriminate visually presented *symbols*

Programs that support young children's early language and literacy development are a part of the family support system in Arizona. An array of early language and literacy programs and service delivery methods may be implemented to meet the needs of families with young children. Research indicates that family literacy programs which provide learning opportunities for both the young child and his or her parents positively impact young children and their families. (Literacy N. C., 2009) According to Adult Education and Family Literacy Act (AEFLA) standards, the term "family literacy services" means programming that is of sufficient intensity in terms of hours, and of sufficient duration, to make sustainable changes in a family and that integrates all of the following core components:

- ✓ Interactive literacy activities between parents and their children, and
- ✓ Training for parents regarding how to be the primary teacher for their children and full partners in the education of their children, and
- ✓ Parent literacy training that leads to economic self-sufficiency, and
- ✓ An age-appropriate education to prepare children for success in school and life experiences.

Family literacy programs are built on four core principles; 1) the value of education for success in life, 2) the central role of the parent in a child's development, 3) the identification of individual strengths, and 4) the value of experiential learning.

While each First Things First funded early language and literacy program may be uniquely designed, they all have a valuable role to play in meeting the complex needs of families and communities across the State of Arizona. First Things First focuses on programs and services that provide children with the best opportunities for school and life success. Funding decisions are based upon a robust process of review to ensure programs are supported by research, value the family, use approaches considered to be best practice and are responsive to the specific needs identified in each region. First Things First funded programs shall supplement, not supplant, other state expenditures on, and federal monies received for early childhood development and health programs.

It is expected that early language and literacy programs funded by First Things First will be offered at no-cost, on a voluntary basis**. Programs and service can be delivered through home visitation or community based training.** Please, also refer to the First Things First Home Visitation and/or Parent Education Community Based Training Standards of Practice documents.

Using a family-centered and strengths-based approach these programs will:

1. Provide a Focus on Literacy
    A. Inform and educate parents and families on typical early language and emergent literacy development for children ages birth through five.
    B. Literacy coaching and instruction should be woven into the activities of all program components; presented and practiced in contexts that are meaningful to families' lives and needs. If providing literacy services in a community based setting, it is critical that

parents and families are taught to bridge classroom experiences to home environments with their own young children.

C. Training for parents regarding how to be the primary teacher for their children and full partners in the education of their children.

- Actively engage parents in learning how everyday experiences can nurture the literacy development of their children.
- Support parents in maintaining a literacy-rich home environment.
- Assist parents to learn how to advocate for their children within a variety of settings, including school, child care and human service agencies.

2. Use a research-based curriculum and activities to promote learning in contexts which are relevant to the lives of participants.

3. Provide Sufficient Intensity and Duration of Services

- For example, typical frequency and duration of family literacy programs is a minimum of 6 sessions at 2 hours per session.

Programs may also:

- Align with Arizona's Early Learning Standards/Guidelines.
  Family literacy programs across the nation also take into consideration alignment with their state's Early Learning Guidelines which describe the expectations about what children should know (understand) and do (competency and skills) across the different domains of learning. In Arizona, the Department of Education developed Early Learning Standards to provide a framework for the planning of quality learning experiences for all children 3 to 5 years of age. The document can be found here:
  http://www.ade.state.az.us/earlychildhood/downloads/EarlyLearningStandards.pdf
  First Things First is developing Early Learning Developmental Guidelines for infants and toddlers.

- Provide parent literacy training that leads to economic self-sufficiency.
  - Assist adults in raising their literacy levels.
  - Assist adults in gaining the knowledge and skills needed for employment and self-sufficiency.
  - Assist adults who are parents in gaining educational skills they need to be full partners in the educational development of their children.
  - Assist adults in completing their secondary school education or its equivalent (e.g., English language classes, Adult Basic Education, Adult Secondary Education, preparation for the General Education Development (GED) examination, and workplace literacy)

- In community settings, instruction should include a combination of individual and group activities, and encourage cooperative learning.
- Assessment, both formal and informal, should occur on an ongoing basis in order to provide adult learners with feedback about progress they have made toward goals.
- Participants must be actively engaged in the decision-making process with regard to their education.
- Program staff must support adult learners in being self-directed, with understanding that adult education builds upon the knowledge, experiences and roles of participating adults.

All First Things First funded Home Based Early Language and Literacy Programs <u>must also follow</u> the First Things First Home Visitation Standards of Practice.

All First Things First funded Community Based Early Language and Literacy Programs <u>must also follow</u> the First Things First Parent Education Community Based Training Standards of Practice.

March 23, 2010

Reach Out and Read

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 **Reach Out and Read,** the units of service are:

Total number of medical practitioners participating in reach out and read model
Total number of books distributed

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 **Reach Out and Read,** performance measures are:

> **Total number of medical practitioners participating in reach out and read model/proposed service number**
> Total number of medical practitioners trained in reach out and read model/proposed service number
> Total funds leveraged for books/ target service number
> **Total number of books 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 **Reach Out and Read,** the data reporting template is:

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

REACH OUT AND READ AZ REGIONAL

GENERAL INFORMATION

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

Physician and Medical Practice Data

If none, please enter zero.

Number of physicians/practitioners trained in Reach Out and Read model during current month *	
Number of newly participating physicians/practitioners during current month *	
Number of physicians/practitioners who discontinued participation during current month *	
Number of participating physicians/practitioners trained at the end of the month	0
Total number of participating physicians/practitioners receiving training	0
Number of participating physicians' offices/clinics trained in Reach Out and Read model during current month *	
Number of newly participating physicians' offices/clinics during current month *	
Number of physicians' offices/clinics who discontinued participation during current month *	
Number of participating physicians'	0

offices/clinics trained at the end of the month

Total number of participating physicians' offices/clinics receiving training 0

During this reporting period were there any training sessions provided by Speech/language pathologist? * ○ Yes ○ No

If Yes, Number of trainings provided by Speech language pathologist during current month *

Other Training Provided

Did your program provide any other training(s) during this reporting period? * ○ Yes ○ No

If Yes,please specify the other training (s) provided during the current month and report the number of training session provided by topic.

Name of Training Session*	Number*		

Summary of Children Served

If none, please enter zero.

Number of children 0-5 years served at the beginning of the month *

Number of new children 0-5 years enrolled during current month *

Number of children 0-5 years disenrolled during current month *

Number of children 0-5 years served at the end of the month 0

Total number of children 0-5 years receiving services 0

Funds Leveraged

If none, please enter zero.

Total other funds leveraged for book distribution *

Total book commitment funds *

Purchase and distribution of Books by Zip Code*

Did you distribute or purchase books in this reporting period? * ○ Yes ○ No

If yes, please enter the following information.

Zip Code*	Number of books distributed during current month*	Total number of books purchased during current month*		

Data Reporting Instructions

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

For **Reach Out and Read,** 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 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

Section 1: Physician and Medical Practice data

1. **Number of physicians/practitioners trained in ROR model during current month:** In this data field you will enter in the total number of physicians/practitioners trained in ROR model during the current month.

2. **Number of newly participating physicians/practitioners enrolled during current month:** In this data field you will enter in the total number of newly participating physicians/practitioners during the month.
3. **Number of physicians/practitioners who discontinued participation during current month:** In this data field you will enter in the total number of physicians/practitioners who discontinued participation during the current month.
4. **Number of participating physicians/practitioners trained at the end of the month: Auto calculated.**
5. **Number of participating physician offices/clinics trained in ROR model during current month:** In this data field you will enter in the total number of participating offices/clinics trained in ROR model during the current month.
6. **Number of newly participating physician offices/clinics during current month:** In this data field you will enter in the total number of newly participating offices/clinics during the current month.
7. **Number of physicians' offices/clinics who discontinued participation during current month:** In this data field you will enter in the total number of offices/clinics who discontinued participation during the current month.
8. **Number of participating physicians' offices/clinics trained at the end of the month: Auto calculated.**
9. **During this reporting period were there any training sessions provided by Speech/Language pathologist?** Choose **YES or NO.** If yes:
   - **Number of trainings provided by Speech/ language pathologist during current month:** In this data field you will enter in the total number of trainings provided by Speech/Language pathologist during current month.

Section 2: Other Training Provided

10. Did your program provide any other training(s) during this reporting period? ***YES* or *NO*.** If **Yes**, please specify the other training(s) provided during the current month and report the number of training sessions provided by topic.
11. **Name of Training Session: In this data field you will enter the names of all training sessions completed**
12. **Number(Attending Training Session): In this data field you will enter the number of individuals attending each session**

Section 3: Children Served

13. **Number of children 0-5 years served at the beginning of the month:** In this data field you will enter in the total number of children 0-5 years served at the beginning of the month (carryover from previous month).
14. **Number of new children 0-5 years enrolled during current month:** In this data field you will enter in the total number of newly enrolled children 0-5 years during the month.
15. **Number of children 0-5 years disenrolled during current month:** In this data field you will enter in the total number of children 0-5 years disenrolled during the current month.
16. **Number of children 0-5 years served at the end of the month: Auto calculated**.

17. **Total number of children 0-5 years receiving services:** **Auto calculated.**

Section 4: Funds Leveraged

18. **Total other funds leveraged for book distribution:** In this data field you will enter the total amount of funds ($) leveraged from all sources excluding FTF funds for book distribution. For example, Pediatric Practice funds donation, other grants, etc.
19. **Total book commitment funds:** In this data field you will enter the total book commitment funds ($) from ALL sources including FTF funds.

Section 5: Purchase and distribution of BOOKs by ZIP CODE

Did you distribute or purchase books in this reporting period? ***YES or NO****. If yes, please enter the following information:*

20. **Zip Code:** In this data field enter each zip code in which books were distributed to physician office/clinics in your regional council. For example, the zip code of the doctor's office.
21. **Number of books distributed during current month**: In the next column, enter for each zip code the total number of books distributed at each site during the reporting period.
22. **Total number of books purchased during current month**: In the last column of data boxes, enter for each zip code the total number of books purchased during the reporting period. If you cannot breakout purchase by zip code please enter the total number of books purchased for the Regional Partnership Council area for the reporting period.

Frequently Asked Questions

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

For **Reach Out and Read,** the frequently asked questions are:

In development

GOAL AREA: FAMILY SUPPORT

STRATEGY NAME: NATIVE LANGUAGE ENRICHMENT

GOAL:

- FTF will coordinate 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.
- FTF will increase the availability, quality, and diversity of relevant resources that support language and literacy development for young children and their families.

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
FTF Native Language Enrichment strategies fund the training of early care and education providers to support native language and cultural aquistion for the the young children of Native American families in child care, early head start/head start or other group settings as part of the regular programming and curriculum.	Native languages throughout the state of Arizona are endangered. Many native languages have been passed from generation to generation orally, and with them, the stories, customs, and life of a people.	<u>Capacity for Expansion and Multi-Year Commitment</u> In most cases, this type of strategy requires the establishment of new programming. Curricula needs to be developed and/or adapted for each Tribe. Significant program development is required. <u>Links to Other Strategies ,System-Building Issues and Recommended Saturation Level</u> Language revitalization initiatives should be interwoven with efforts for family involvement. Once trained through this strategy, early care and education providers should coordinate efforts and activities for native language and culture aquistion with families, the Tribal Council and family support providers such as home visiting programs, community based parent education programs and community resource centers. <u>Timeline for Implementation</u> Expect considerable time for program development, 6 months to 1 year, prior to service to children and families is implemented.	Unit Costs will vary – please consult with Policy Specialist.

Policy Specialis: K. Vilay

First Things First
Native Language Enrichment
Standards of Practice

Native languages throughout the state of Arizona are endangered. Many native languages have been passed from generation to generation orally, and with them, the stories, customs, and life of a people. Native languages are inseparable from cultural identity and spirituality.

Since every community is different, language stabilization and acquisition strategies will also differ from one place to another, allowing them to be consistent with local customs. The concepts of language, identity, culture, and spirituality are highly complex. One can and should ask whose responsibility and privilege is it to teach a native language. The answer may be unclear and likely varies from one context or community to another. Further confusion may be inevitable now that the schools on tribal lands are involved in the teaching of native language and literacy.

A significant factor to revitalize native language is largely dependent on reinforcement in the home. Parents choose, for a variety of valid social reasons, not to teach their children their native tongue or they themselves do not speak their native language. Success of language preservation efforts depends strongly on family support and participation. If family members do not reinforcement and support their children learning their native language, success will be difficult. Therefore, language revitalization initiatives should be interwoven with efforts for family involvement because preservation of native language can not prevail if the leadership does not originate in the home.

Every means possible to promote native language and the virtues of bilingualism must be utilized. For example, use of radio announcements, airing speakers' testimonials, displaying posters or bumper stickers, and wearing T-shirts could all be a part of a community effort to save/maintain a language.

<u>Within each community, native language transmission can occur at different levels;</u>

School level: Schools develop curriculum for mother (family)/child programs. Fluent native speakers teach non-native speaking parents the traditional language. This methodology will ensure that children learn and maintain the language.

Individual level: Native speakers help latent speakers and non-speakers learn the native language by utilizing existing language learning material, taped stories, and by creating new materials.

Family level: Family reunions and family-based summertime and weekend language immersion activities are organized; families are encouraged to limit the intrusion of English-language media; and parental support groups are established to further encourage native language.

Community level: Senior citizens centers are encouraged to have seniors use their native language with young children, for example in "language nests" at local preschools and Head Start centers; community seminars in the native language are promoted; community meetings and conferences about native language are organized, language institutes for families and

communities are held, programs for parents of children in bilingual programs are developed; and "banks" of language learning materials are created and available to all community members.

Tribal Nations level: Elected officials are encouraged to use and promote the native language; networks of Native American language supporters are developed across tribal boundaries.

Communities recognize that lessoning the threat of native language extinctions will mean both individual and group attitudes must be changed. These changes must permeate throughout the entire community.

Within each community, native language early literacy transmission occurs at multiple levels and simultaneously;

It is understood that from birth, all young children are exposed to different languages, cultural values, beliefs and assumptions within the family and in the context of their community. Children absorb powerful messages from people, the environment, and the community that shape their identity, social and cultural values. How infants, toddlers, and young children interact within their environment and respond to experiences is heavily influenced by the values and beliefs of the family and others who care for them.

Because culture has a powerful impact on early learning, early childhood education professionals need competencies in learning about the families, cultures, and languages of children in their care to challenge their own assumptions about differences. Early childhood education professionals must be knowledgeable about their own cultural values and how their experiences can influence learning and development. This will allow them to be better equipped to deliver services in a culturally sensitive manner to all young children, including infants and toddlers.

Children's early experiences with oral and written language, both formal and informal, provide essential foundations for all of their learning. Therefore, it is expected that centers, implementing Native Language early literacy programs will use the following Early Literacy Standards of Practice when teaching young children in center based settings.

Standards of Practice for Early Literacy in Early Childhood Education Settings:

Standard #1: Provide daily opportunities *in the identified Native Language* **for children to develop listening and understanding skills.**

- Provide daily opportunities for children to listen to stories, rhymes, songs and conversations as appropriate for the age group.
- Talk to babies and toddlers with simple language, frequent eye contact, and responsiveness to their cues and language attempts.
- Talk to preschool children using sophisticated vocabulary and sentence structure within the context of the learning environment.

- Tell and retell oral stories to children.

Standard #2: Provide daily opportunities *in the identified Native Language* **for children to speak and practice communicating throughout the day.**

- Engage children in reciprocal (back and forth) conversations about topics that are of interest to them.
- Provide opportunities throughout the day for children to verbally express their thoughts, feelings and understandings.
- Provide for a balance of child and adult conversations.

Standard #3: Provide opportunities *in the identified Native Language* **for children to develop the ability to distinguish between sounds**

- Frequently play with young children by talking to, singing to, and doing finger plays.
- Include books with rhyming words and alliteration in the shared reading experiences.
- Introduce culturally appropriate nursery rhymes to young children by reciting them frequently.

Standard #4: Provide children with daily opportunities to learn about books, their purpose, and how to handle them

- Share age-appropriate books *in the identified Native Language* with children on a daily basis by reading to the child on an adult's lap or together with one or two other children (infants, toddlers and preschool), or in a large group (preschool).
- Allow children, even babies the opportunity to handle books.
- Reread books, especially favorite ones.

Standard #5: Provide children with opportunities to practice using drawing and writing materials

- Provide simple writing materials such as crayons and markers and large paper for toddlers to explore and manipulate.
- Provide ample variety of writing materials that are readily accessible to preschool children throughout the day and throughout the child care setting including outdoor environments.
- Model purposeful writing for children such as making recipe for making traditional foods, lists of traditional foods or materials needed for an activity, making a birthday or get well card for a child or writing a recipe.

Standard #6: Provide opportunities for children to begin to develop alphabet knowledge.

- Use the names of the letters throughout the day within the context of writing children's names or modeling writing for preschool children.
- Incorporate the names of letters into interactive songs and games.

Standard #7: Provide books that are reflective of the child and family's language and culture

- Provide books that are written in the language that is spoken in the child's home.
- Provide books that reflect the child's culture or ethnicity in a non-stereotypical manner.
- Provide books that reflect the child's family structure in a respectful manner.

Additionally, grantees providing native language early literacy training to teaching staff should follow the First Things First **Professional Development Community Based Training Standards of Practice.**

RESEARCH NOTES:

Fishman J, Clarke D, Reyhner J, Christensen R, Wallace L, Zepeda O (1996 & 2007). *Stabilizing Native Languages.* Northern Arizona University.: http://jan.ucc.nau.edu/~jar/SIL/. 67-79.

Bowman, B.T., Donovan, M. S., & Burns, S. S. (Eds.). (2001). *Eager to learn, educating our preschoolers*. Washington, D.C.: National Academy Press, 186-200.

Neuman, S.B., Copple, C., & Bredekamp, S. (2000). *Learning to read and write, developmentally appropriate practices for young children*. Washington, D.C.: National Association for the Education of Young Children.

Native Language Enrichment

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 **Native Language Enrichment,** the units of service are:

> **Total number of early care and education providers receiving professional development in culturally appropriate early literacy practice**
> **Total number of culturally appropriate books distributed**

Total number of families attending culturally appropriate family literacy trainings or literacy workshops
Total number of children attending culturally appropriate family literacy trainings or literacy workshops

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 **Native Language Enrichment,** performance measures are:

Total numbers of early care and education providers receiving professional development in culturally appropriate early literacy practice/proposed service number
Total number of culturally appropriate early literacy professional development sessions conducted/proposed service number
Total number of early care and education providers adding culturally appropriate lending libraries/proposed service number
Total number of families attending culturally appropriate family literacy trainings or literacy workshops in early care and education settings/proposed service number
Total number of children attending culturally appropriate family literacy trainings or literacy workshops in early care and education settings /proposed service number
Total number of culturally appropriate books distributed/proposed service number
Total number of culturally appropriate family literacy trainings or literacy workshops offered/proposed service number
Total number of families attending culturally appropriate family literacy trainings or literacy workshops /proposed service number
Total number of children attending culturally appropriate family literacy trainings or literacy workshops /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 **Native Language Enrichment,** 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

PROVIDER TRAINING II DATA REPORTING TEMPLATE

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

DATA ENTRY

Section I

Does your program serve:

- ? Center Based Child Care Providers *
- ? Home Based Child Care Providers *
- ? Serve Only Native Language Providers *

**** If you are serving only Native Language Providers please skip Sections I through III and proceed to Section IV for data entry**

Section I A

Data Fields	Center Based Child Care Providers	Home Based Child Care Providers
Number of providers served at beginning of the month		
Number of new providers enrolled during current month		
Number of providers disenrolled during current month		
Number of providers served at end of the month	0	0
Total number of providers receiving services	0	0
Provider Disenrollment Reasons		
No longer in Business		
Discontinued Services		
Completion		

Other (Please Specify)		

Section I B

	Center Based Child Care Providers	Home Based Child Care Providers

Does your program conduct intensive training for providers? If Yes, then please complete this section. If No, you can skip Section I B.

○ Yes ○ No

Number of teachers employed at beginning of the month		
Number of new teachers hired during current month		
Number of teachers leaving employment during current month		
Number of teachers employed at the end of the month	0	0
Total number of teachers employed this reporting period	0	0
Number of assistant teachers employed at beginning of the month		
Number of new assistant teachers hired during current month		
Number of assistant teachers leaving employment during current month		
Number of assistant teachers employed at the end of the month	0	0
Total number of assistant teachers employed this reporting period	0	0
Number of infants served at beginning of the month		
Number of new infants enrolled during current month		
Number of infants served at end of the month	0	0
Number of toddlers served at beginning of the month		
Number of new toddlers enrolled during current month		
Number of toddlers served at end of the month	0	0
Number of preschoolers served at beginning of the month		
Number of new preschoolers enrolled during current month		
Number of preschoolers served at end of the month	0	0
Number of children with special needs served at beginning of the month		
Number of new children with special needs enrolled during current month		
Number of children with special needs served at end of the month	0	0

Section II: Lending Libraries

Does your program work with providers (including center based and home based) offering a Lending Library? If Yes, then please complete this section. If No, you can skip this section.

○ Yes ○ No

Number of providers with lending libraries	
Number of providers adding new lending libraries	

Number of providers adding books to their lending libraries

Number of families checking out books

Number of books checked out by families

Section III: Family Enrichment Events

Does your program work with providers (including center based and home based) offering Family Enrichment Events? If Yes, then please complete this section. If No, you can skip this section.

Yes No

Number of family enrichment events provided this month

Total number of children attending family enrichment events this month

Total number of families attending family enrichment events this month

Section IV: Applies only for Programs working with Native Language Providers

Does your program work with Native Language Providers?

Yes No

If Yes, does your program work with the following. If No, you do not have to complete Sections IV- VI

- Center Based Child Care Providers *
- Home Based Child Care Providers *

Data Fields	Center Based Child Care Providers	Home Based Child Care Providers
Section IV A		
Number of providers implementing culturally based literacy and language programs served at the beginning of the month		
Number of new providers implementing culturally based literacy and language programs enrolled during current month		
Number of providers implementing culturally based literacy and language programs disenrolled during current month		
Number of providers implementing culturally based literacy and language programs served at the end of the month	0	0
Total number of providers implementing culturally based literacy and language programs receiving services	0	0
Provider Disenrollment Reasons		
No longer in Business		
Discontinued Services		
Completion		
Other (Please Specify)		

Section IV B	Center Based	Home Based

	Child Care Providers	Child Care Providers
Does your program conduct intensive training for Native language providers? If Yes, then please complete this section. If No, you can skip Section IV B.		
○ Yes ○ No		
Number of teachers employed at beginning of the month		
Number of new teachers hired during current month		
Number of teachers leaving employment during current month		
Number of teachers employed at the end of the month	0	0
Total number of teachers employed this reporting period	0	0
Number of assistant teachers employed at beginning of the month		
Number of new assistant teachers hired during current month		
Number of assistant teachers leaving employment during current month		
Number of assistant teachers employed at the end of the month	0	0
Total number of assistant teachers employed this reporting period	0	0
Number of infants served at beginning of the month		
Number of new infants enrolled during current month		
Number of infants served at end of the month	0	0
Number of toddlers served at beginning of the month		
Number of new toddlers enrolled during current month		
Number of toddlers served at end of the month	0	0
Number of preschoolers served at beginning of the month		
Number of new preschoolers enrolled during current month		
Number of preschoolers served at end of the month	0	0
Number of children with special needs served at beginning of the month		
Number of new children with special needs enrolled during current month		
Number of children with special needs served at end of the month	0	0

Section V: Lending Libraries

Does your program work with providers (including center based and home based) offering Lending Library? If Yes, then please complete this section. If No, you can skip this section.

○ Yes ○ No

Number of providers with lending libraries	
Number of providers adding new lending libraries	
Number of providers adding books to their lending libraries	
Number of providers adding culturally relevant books to their lending libraries	
Number of families checking out books	

Number of families checking out culturally relevant books

Number of books checked out by families

Number of culturally relevant books checked out by families

Section VI: Family Enrichment Events

Does your program work with providers (including center based and home based) offering Family Enrichment Events? If Yes, then please complete this section. If No, you can skip this section.

○ Yes ○ No

Number of family enrichment events provided this month

Total number of children attending family enrichment events this month

Total number of families attending family enrichment events this month

Number of culturally based family enrichment events provided this month

Total number of children attending culturally based family enrichment events this month

Total number of families attending culturally based family enrichment events this month

Data Reporting Instructions

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

For **Native Language Enrichment,** 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 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

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

Section 1

***Does your program serve:** In this data field you will check one of the following choices? *If you are serving only Native Language Providers please skip Sections I through III and proceed to Section IV for data entry*

a. Center Based Child Care Providers (CCP)☐ →go to Center Based CCP column
b. Home Based Child Care Provider (CCP) ☐ → go to Home Based CCP column
c. Both ☐ → enter numbers in <u>both</u> Center and Home Based CCP columns

Data Fields

<u>Service Number</u>

1. ***Number of providers served at the beginning of the month:** In this data field you will enter in the total number of providers served at the beginning of the month (carryover from previous month).
2. ***Number of new providers enrolled during current month:** In this data field you will enter in the total number of newly enrolled providers during the month.
3. ***Number of providers disenrolled during current month:** In this data field you will enter in the total number of providers disenrolled during the current month.
4. **Number of providers served at the end of the month: Auto Calculated.**
5. **Total number of providers receiving services: Auto Calculated.**
6. ***Provider Disenrollment Reasons:** In this data field enter the total number of providers disenrolled by reason breakout for the month. Note: This is the breakout of Q #4.
   a. No longer in business___
   b. Discontinued services___
   c. Completion___
   d. Other (Please specify) -<u>this is a text field (500 characters)</u>

<u>Employment</u>

7. ***Number of teachers <u>employed</u> at the beginning of the month:** In this data field you will enter in the total number of teachers employed at the beginning of the month (carryover from previous month).
8. ***Number of new teachers <u>hired</u> during current month:** In this data field you will enter in the total number of newly hired teachers during the month.
9. *** Number of teachers <u>leaving</u> employment during current month:** In this data field you will enter in the total number of teachers leaving employment during the month.
10. **Number of teachers employed at the end of the month: Auto Calculated.**
11. **Total number of teachers employed this reporting period: Auto Calculated.**
12. ***Number of assistant teachers <u>employed</u> at the beginning of the month:** In this data field you will enter in the total number of assistant teachers employed at the beginning of the month (carryover from previous month).

13. ***Number of new assistant teachers hired during current month:** In this data field you will enter in the total number of newly hired assistant teachers during the month.
14. ***Number of assistant teachers leaving employment during current month:** In this data field you will enter in the total number of assistant teachers leaving employment during the month.
15. **Number of assistant teachers employed at the end of the month: Auto Calculated.**
16. **Total number of assistant teachers employed this reporting period: Auto Calculated.**

Children Served

17. ***Number of infants served at the beginning of the month:** In this data field you will enter in the total number of infants (0 to 12 months) enrolled at the beginning of the month (carryover from previous month).
18. ***Number of new infants enrolled during current month:** In this data field you will enter in the total number of newly enrolled infants (0 to 12 months) during the month.
19. **Total Number of infants served at the end of the month: Auto Calculated.**
20. ***Number of toddlers served at the beginning of the month:** In this data field you will enter in the total number of toddlers (13 to 35 months) enrolled at the beginning of the month (carryover from previous month).
21. ***Number of new toddlers enrolled during current month:** In this data field you will enter in the total number of newly enrolled toddler (13 to 35 months) during the month.
22. **Total Number of toddlers served at the end of the month: Auto Calculated.**
23. ***Number of preschoolers enrolled at the beginning of the month:** In this data field you will enter in the total number of preschoolers (36 to 71 months) enrolled at the beginning of the month (carryover from previous month).
24. *** Number of new preschooler enrolled during current month:** In this data field you will enter in the total number of newly enrolled preschoolers (36 to 71 months) during the month.
25. **Total Number of preschoolers served at the end of the month: Auto Calculated.**
26. ***Number of children with special needs served at the beginning of the month:** In this data field you will enter in the total number of special needs children (0 to 71 months) enrolled at the beginning of the month (carryover from previous month).
27. ***Number of new children with special needs enrolled during current month:** In this data field you will enter in the total number of newly enrolled special needs children (0 to 71 months) during the month.
28. **Total Number of children with special needs served at the end of the month: Auto Calculated.**

Section II – Lending Libraries

29. *** Does your program work with providers (including center based and home based) offering a Lending Library? Yes or No.** In this data field you will answer either **Yes** or **No**. If yes, then please complete this section (a-h). If No, you can skip this section and go section III.
    a. ***Number of providers with lending libraries:** in this data field you will enter in the total number of providers with existing lending libraries.
    b. ***Number of providers adding new lending libraries:** In this data field you will enter in the total number of providers adding NEW lending libraries.
    c. ***Number of providers adding books to their lending libraries:** In this data filed you will enter in the total number of provider Creating lending libraries that circulate culturally relevant children's book.
    d. ***Number of families checking out books:** In this data field you will enter in the total number of families checking out books.
    e. ***Number of books checked out by families:** In this data field you will enter the total number of books checked by families.

Section III – Family Enrichment Events

30. *** Does your program work with providers (including center based and home based) offering Family Enrichment Events?** In this data field you will answer either **Yes** or **No**. If yes, then please complete this section. If No, you can skip this section and go to section IV.
    a. ***Number of family enrichment events provided this month:** In this data field you will enter the total number of family enrichment events provided during this month.
    b. ***Total number of children attending family enrichment events this month:** In this data field you will enter the total number of children attending family enrichment events this month.
    c. ***Total number of families attending family enrichment events this month:** In this data field you will enter the total number of families attending family enrichment events this month.

Section IV – Native Language Program – NOTE: this section is <u>only</u> for those program working with Native Language Providers

31. ***Does your program working with Native Language Providers?** In this data field you will answer either **Yes** ☐ or **No** ☐ . If **yes**, then please check one of the following fields. ****If you answered NO, you do not have to complete section IV & V.****
    a. Center Based Child Care Providers (CCP) ☐ →go to Center Based CCP column
    b. Home Based Child Care Provider (CCP) ☐ → go to Home Based CCP column
    c. Both ☐ → enter numbers in both Center and Home Based CCP columns.

Service Numbers

32. ***Number of provider implementing culturally based literacy and language programs served at the beginning of the month:** In this data field you will enter the total number of provider that are implementing culturally based literacy and language programs that are served at the beginning of the month (continuing programs).
33. ***Number of providers implementing culturally based literacy and language programs enrolled during current month:** In this data field you will enter the total number of providers that are implementing culturally based programs that are newly enrolled during the current month.
34. ***Number of providers implementing culturally based literacy and language programs disenrolled during current month:** In this data field you will enter the total number of providers implementing culturally based literacy and language programs that are disenrolled during the current month.
35. **Number of providers implementing culturally based literacy and language programs served at the end of the month:** **Auto Calculated.**
36. **Total number of centers implementing culturally based literacy and language programs providers receiving services:** **Auto Calculated.**
37. ***Provider Disenrollment Reasons:** In this data field enter the total number of providers disenrolled by reason breakout for the month. Note: This is the breakout of Q #35.
    a. No longer in Business___
    b. Discontinued Services___
    c. Completion___
    d. Other (Please specify) -this is a text field (500 characters)

Employment

38. ***Number of teachers employed at the beginning of the month:** In this data field you will enter in the total number of teachers employed at the beginning of the month (carryover from previous month).
39. ***Number of new teachers hired during current month:** In this data field you will enter in the total number of newly hired teachers during the month.
40. *** Number of teachers leaving employment during current month:** In this data field you will enter in the total number of teachers leaving employment during the month.
41. **Number of teachers employed at the end of the month:** **Auto Calculated.**
42. **Total number of teachers employed this reporting period:** **Auto Calculated.**
43. ***Number of assistant teachers employed at the beginning of the month:** In this data field you will enter in the total number of assistant teachers employed at the beginning of the month (carryover from previous month).
44. ***Number of new assistant teachers hired during current month:** In this data field you will enter in the total number of newly hired assistant teachers during the month.

45. ***Number of assistant teachers leaving employment during current month:** In this data field you will enter in the total number of assistant teachers leaving employment during the month.
46. **Number of assistant teachers employed at the end of the month:** **Auto Calculated.**
47. **Total number of assistant teachers employed this reporting period:** **Auto Calculated.**

Children Served

48. ***Number of infants served at the beginning of the month:** In this data field you will enter in the total number of infants (0 to 12 months) enrolled at the beginning of the month (carryover from previous month).
49. ***Number of new infants enrolled during current month:** In this data field you will enter in the total number of newly enrolled infants (0 to 12 months) during the month.
50. **Total Number of infants served at the end of the month:** **Auto Calculated.**
51. ***Number of toddlers served at the beginning of the month:** In this data field you will enter in the total number of toddlers (13 to 35 months) enrolled at the beginning of the month (carryover from previous month).
52. ***Number of new toddlers enrolled during current month:** In this data field you will enter in the total number of newly enrolled toddler (13 to 35 months) during the month.
53. **Total Number of toddlers served at the end of the month:** **Auto Calculated.**
54. ***Number of preschoolers enrolled at the beginning of the month:** In this data field you will enter in the total number of preschoolers (36 to 71 months) enrolled at the beginning of the month (carryover from previous month).
55. ***Number of new preschooler enrolled during current month:** In this data field you will enter in the total number of newly enrolled preschoolers (36 to 71 months) during the month.
56. **Total Number of preschoolers served at the end of the month:** **Auto Calculated.**
57. ***Number of children with special needs served at the beginning of the month:** In this data field you will enter in the total number of special needs children (0 to 71 months) enrolled at the beginning of the month (carryover from previous month).
58. ***Number of new children with special needs enrolled during current month:** In this data field you will enter in the total number of newly enrolled special needs children (0 to 71 months) during the month.
59. **Total Number of children with special needs served at the end of the month:** **Auto Calculated.**

Section V – Lending Libraries

60. *** Does your program work with providers (including center based and home based) offering a Lending Library? Yes or No.** In this data field you will answer either **Yes** or **No**.

If yes, then please complete this section (a-h). If No, you can skip this section and go section VI.

a. ***Number of providers with lending libraries:** in this data field you will enter in the total number of providers with existing lending libraries.
b. ***Number of providers adding new lending libraries:** In this data field you will enter in the total number of providers adding NEW lending libraries.
c. ***Number of providers adding books to their lending libraries:** In this data filed you will enter in the total number of provider Creating lending libraries that circulate culturally relevant children's book.
d. ***Number of providers adding culturally relevant books to their lending libraries:** In this data field you will enter in the total number of providers that are adding culturally relevant books to their existing lending libraries.
e. ***Number of families checking out books:** In this data field you will enter in the total number of families checking out books.
f. ***Number of families checking out culturally relevant books:** In this data field you will enter the total number of families checking out culturally relevant books.
g. ***Number of books checked out by families:** In this data field you will enter the total number of books checked by families.
h. ***Number of culturally relevant books checked out by families:** In this data field you will enter in the total number of culturally relevant books checked out by families.

Section VI – Family Enrichment Events

61. * Does your program work with providers (including center based and home based) offering Family Enrichment Events? In this data field you will answer either **Yes** or **No**. If yes, then please complete this section. If No, you can skip this section.

d. ***Number of family enrichment events provided this month:** In this data field you will enter the total number of family enrichment events provided during this month.
e. ***Total number of children attending family enrichment events this month:** In this data field you will enter the total number of children attending family enrichment events this month.
f. ***Total number of families attending family enrichment events this month:** In this data field you will enter the total number of families attending family enrichment events this month.
g. ***Number of culturally based family enrichment events provided this month:** In this data field you will enter the total number of culturally based family enrichment events provided this month.
h. *** Total number of children attending culturally based family enrichment events this month:** In this data field you will enter the total number of children attending culturally based family enrichment events.

i. *** Total number of families attending culturally based family enrichment events this month:** In this data field you will enter the total number families attending culturally based family enrichment events.

Frequently Asked Questions

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

For **Native Language Enrichment,** the frequently asked questions are:

In development

FTF STRATEGY TOOLKIT

GOAL AREA: Coordination

FTF Priority: Early Care and Education System Development and Implementation – Convene partners and provide leadership in the development and implementation of a comprehensive early care and education system that is aligned both across the spectrum of settings and with the full continuum of the education system.

Goal Area Overview:

The system goals of First Things First can only be achieved through coordination with both public and private entities in order to leverage funding, ease families' access to services, and maximize optimal results for young children. The overall goal is to facilitate coordination among the federal, state, private and tribal systems related to early childhood development and health to ensure a common understanding of the systems and to share ownership in ensuring access to services for all children. The priority role of FTF is to develop a clear plan for the early care and education system that describes the system, aligns programs and services across all types of settings and with the full continuum of the educational system (P-20), and defines roles and responsibilities of those involved in its implementation. This will result in alignment of the early care and education programs and services, including monitoring for access and quality for those programs and services which are the responsibility of varied early care and education agencies and organizations.

Strategies	Strategy Workgroup and Leads	Policy Staff	Grants and Contracts Specialist
Court Teams	Coordination Workgroup: Gary Arnold and Judy Walruff	Judy Walruff	

GOAL AREA: COORDINATION

STRATEGY NAME: COURT TEAMS

GOAL:

- **FTF will FTF will lead cross-system coordination efforts among state, federal and tribal organizations to improve the coordination and integration of Arizona programs, services, and resources for young children and their families.**

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
The principal goals of Court Teams are to improve outcomes and reduce the recurrence of abuse and neglect for infants and toddlers. These goals are achieved by developing court-community teams led by superior court judges to: • Raise awareness of the developmental needs of maltreated infants and toddlers. • Assure case plans that support the developmental needs of these children • Assure a permanency plan that results in stable placements for children with foster families, relatives, or other caretakers. • Assure continuing focus on child wellbeing when children are returned to parents, relatives, or other caretakers. Court teams promote policies and procedures that will foster a system of care that focuses on meeting the developmental needs of children and supports their healthy development. Court Team implementation involves eight core components: 1. **Judicial Leadership**: Local judges in Court Team communities are the catalysts for the programs that meet the needs of vulnerable children and their families. When beginning a Court Team, a local judge	Established court team pilots outcomes: • A significant increase in the services provided to eligible children and their parents, particularly in health care (100% of the children had at least one pediatric visit) and developmental (Part C) screening for early intervention services (64% of the children received a full developmental assessment and at least 20% of those who had been screened had begun receiving services). • Reductions in the number of out-of-placements. Almost half of the children have remained (42%) in one foster home throughout their time in out-of-home care. • An increase in parent-child visits. Very young	• Extensive planning and research may be required to determine the readiness and resources to implement this strategy. • The strategy requires consent from and collaboration with the presiding juvenile or family court judge of the Superior Court responsible for dependency hearing in the region (County). Children under the jurisdiction of the juvenile court are usually involved with Child Protective Services. • Considerable additional collaboration with Child Protective Services, community based family services, early Intervention and developmental disabilities service providers, and mental health providers is also required. • Court Teams established in regions that include a Tribal area will need to also coordinate with Tribal social services • Multi-year planning and commitment is required. Court systems, especially those in rural areas, may have limited resources to assume costs for court team operations. This is an area for discussion and negotiation during a planning phase. • The implementation of Court Teams is	Cost may vary from region to region depending on the resources available from the state or county. Cost are driven by considerations such as the existence of a team or partial team, available state or county funds, or funding from other public or private sources. Essential staff costs include a coordinator and full or part time of administrative support staff. 2011 allocations from Regions Partnership Councils range from $49,000 to $450,000.

convenes the initial meeting with representatives of community, service providers and other stakeholders to build commitment and cooperation. 2. **Local Community Coordinator**: In each Court Team community, a local Community Coordinator serves as a resource for child development expertise for the court. The Community Coordinator coordinates services and resources in support of infants and toddlers in the court systems. 3. **Court Team**: The Court Team is made up of key community stakeholders who commit to working to restructure the way the community responds to the needs of maltreated infants and toddlers. The makeup of Court Teams varies from community to community, but typically the team includes pediatricians; child welfare workers; attorneys representing children, parents, and the child welfare system; Court Appointed Special Advocates (CASAs); Guardians Ad Litem (GALs); mental health professionals; substance abuse treatment providers; representatives of foster parent organizations and children's advocacy groups; Early Head Start and child care providers; and Court Improvement Project staff. 4. **Monthly Case Reviews**: Each month, all individuals and organizations delivering court-mandated services to infants and toddlers meet together with the judge to review progress on each case. This monitoring process in and of itself can help prevent very young children from falling through the cracks in the child welfare system and ensure that the services they are receiving are effective and age appropriate.	children need to see their parents multiple times each week to develop a trusting relationship for reunification purposes. Prior to the Court Teams Project, visits between parents and their young children in foster care occurred less than once a week. • An increase in relative/kinship placements. Approximately 37% of all placements have been with relatives. Reunification plans often include relatives as an additional support for the child.[1]	enhanced with alignment with other regional strategies such as continuing education for court team members to enhance knowledge and skills related to early childhood development; and parent support strategies such as parenting skills, language and literacy programs, and home visiting. • Court Teams strategies are usually implemented through intergovernmental agreements with the County Superior Court. • Timeline for implementation may range from three to six months. • This strategy is applicable to a continuum of services available to the most at-risk children and should be considered as an enhancement to the child welfare system of the region.	

[1] Zero to Three, *Changing the Odds for Babies: Court Teams for Maltreated Infants and Toddlers,* Fact Sheets. Zero to Three Funded Projects - Court Team.

5. **New Court Order Forms**: Court-ordered service referrals have been expanded in Court Team sites to include a variety of services for children. By focusing attention on the children themselves, it is hoped that children's needs for medical and mental health interventions will be incorporated into resolving the family's child welfare system involvement. 6. **Training and Technical Assistance**: Training and technical assistance to court personnel and community service providers on topics such as being more responsive to, and responsible for, the children's social and emotional development needs; general infant and toddler development; parenting interventions; services available to foster children in the community; and the impact of trauma on children. 7. **Mental Health Treatment**: Ideally each Court Team will have the capacity to refer parents to mental health services which are designed to improve the parent-child relationship by focusing on reading and responding to cues in ways that support child development and to address unmet emotional needs that the parent may have which impacts her/his ability to meet the needs of baby. 8. **Resource Materials**: Access to resource materials including bench books and training videos developed by Zero to Three and other organizations involved with the development of Court Teams.			

Policy Specialist – Judy Walruff

To view a copy of the IGA please contact the Policy Specialist

Regional Partnership Name:

1. Successful collaborations have a shared vision and clarity of purpose.

	Not at this time	*Some progress*	*Moderate Progress*	*Substantial progress*	*Fully Developed*
a. Shared vision. Our collaborating partners have the same vision for young children and agreed upon mission.					
b. Clear purpose. Our work does not duplicate existing efforts, but adds unique value to members of the group and to other related initiatives.					
c. Concrete, attainable goals and objectives. Goals and objectives are clear, measurable and benefit children and families.					
d. Resources are directly linked to the Discovery's goals and objectives. Our resources funding, time, talents, etc. are aligned with our goals and objectives. Do you have enough of the right resources to get the job done?					
e. Members share a stake in both process and outcome. Collaborating partners value the process of engagement as the means to achieve their outcomes.					

2. Successful collaborations are broad-based, include key stakeholders, and reflect the diversity of the community.

	Not at this time	*Some progress*	*Moderate Progress*	*Substantial progress*	*Fully Developed*
a. Appropriate cross-section of members. Our collaborating partners represent each segment of the community who will be affected by the work including parents, health and human service professionals and a range of public/private organizations.					

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b. Mutual respect, understanding, and trust. Our collaborating partners share an understanding and respect for each other and their respective organizations: how they operate, their cultural norms and values, limitations, and expectations.					
c. Continual openness to drawing in new members. Our collaborating partners have the willingness to and a process for widening the circle to include new partners over time.					

3. Successful collaborations promote a community engagement process that builds and continuously renews relationships.

	Not at this time	*Some progress*	*Moderate Progress*	*Substantial progress*	*Fully Developed*
a. Development of clear roles, policy, and operating guidelines. Our collaborating partners clearly understand the roles and responsibilities of being a member of the group and are accountable for implementing specific activities.					
b. Awareness and buy-in among partners. Every level (board, upper/mid management, line staff) within each partnering organization in the group is aware of and buys into our Discovery goals and strategies.					
c. Influence over decisions and resources. Collaborating partners make recommendations about and influence decisions over the work, particularly how funds are used.					
d. Ability to reach consensus. Our collaborating group embodies a spirit of cooperation and has the ability to discuss problems and issues openly. Group members are willing to compromise to achieve the vision and goals of the collaborating group.					
e. Progression from simple to complex activities. Our group has gained confidence through success with smaller projects and, at the appropriate pace, is undertaking more complex issues and tasks.					
f. Open communication. Our collaborating partners interact often and have created formal, planned channels of communication to ensure all necessary information is conveyed to one another and to people outside the group.					

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g. Clear understanding of staff roles and responsibilities. Our collaborating group has determined the level of staff support needed to facilitate the collaborative process, has developed a job description, specified tasks and has a process for participatory evaluation.					
h. Sufficient operating resources. Our collaborating group has an adequate, consistent financial base to support its operations.					
i. Leveraging resources. Our group leverages and influences the allocation of resources to support the community agenda for young children.					

4. Successful collaborations have public visibility and accountability.

	Not at this time	*Some progress*	*Moderate Progress*	*Substantial progress*	*Fully Developed*
a. History of collaboration in the community. Our collaborating partners are aware of and build on prior experience and success with collaboration.					
b. Community awareness of the issue. Our community is aware of the issues facing young children and knows that a focus on early care and education is needed.					
c. Influences the political/social climate. Our collaborative includes and works with political leaders, opinion-makers, persons who control resources, and the general public in our community to improve policies and practices that benefit young children.					
d. Cultivating champions. We engage high-profile community leaders and emerging leaders who can motivate others, to assume leadership roles and promote the vision and work of our Discovery effort.					
e. Communication with diverse constituents. Our collaborating group has developed communication strategies that identify multiple audiences and ways to listen to various constituencies' perspectives and accommodate their points of view.					

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f. Facilitâtes public dialogue. Our collaborating partners facilitate a public dialogue of issues and maintains regular contact with the media.					

5. Successful collaborations are flexible, and have the capacity to adapt to changing community conditions.

	Not at this time	*Some progress*	*Moderate Progress*	*Substantial progress*	*Fully Developed*
a. Systematic gathering of information and analysis of community issues. Our collaborating group assesses the community's strengths and needs by collecting data, and by getting community input and feedback on an ongoing basis.					
b. Adaptability. Our collaborating group uses the information to refine our strategies and has the ability to sustain a community agenda during changes in the environment or among participants.					
c. Seeks and effectively uses technical assistance and training to gain needed skills and knowledge. Our collaborating group seeks out and takes advantage of training to increase participants' skills. Members of our group, including parents, use experts to consult or provide hands-on training.					
d. Partners with organizations outside the community and other communities. Members learn and gain motivation from their peers in other communities within their regions, the state, and elsewhere.					
e. Invests in continuous learning. Our collaborating group creates opportunities to reflect, assess what is learned and apply it to their community change work and within their respective organizations.					

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Scoring:
Not at this time= 0
Some Progress= 1
Moderate Progress= 2
Substantial Progress= 3
Fully Developed= 4

Total Score:
Foundation/Networking level= 0-35
Individuals or organizations come together for relationship building, and information sharing
Moderate/Cooperation level= 36-60
Partners share information only about the subject at hand. Each organization retains authority and keeps resources separate.
Developing/Coordination level= 61-90
More formal relationships and an established mission. More open communication channels between organizations.
Advanced/Collaboration level= 91+
Participants bring separate organizations into a new structure with a formal commitment to a common mission.

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Court Teams

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 **Court Teams,** the units of service are:

> **Total number of Court Team trainings provided**
> **Total number of children with a service checklist within one month of entry into the child welfare system**

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 **Court Teams,** performance measures are:

> **Total number of Court Team trainings provided / proposed service number**
> **Total number of children with a service checklist within one month of entry into the child welfare system / target service number**
> Total number of Court Team meetings held/ proposed service number
> Total number of system improvement measures implemented / 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 **Court Teams,** 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

COURT TEAMS

GENERAL INFORMATION

User Completing Report: AZFTF\mshahi

Reporting Period: Month 7, Year 2010

Regional Partnership Council: State

Status: In Progress

Date Completed:

Number of court team meetings held during current reporting period. *

Did any new children come into the court system during this reporting period? * ◯ Yes ◯ No

If Yes, Number of new children entering the court team program during the current reporting period. *

Number of CONTINUING children served by your Court Team Program during the current reporting period. *

Number of NEW children Served by your Court Team Program during the current reporting period. *

Did any children disenroll from your Court Team Program during the current reporting period? if yes please enter data below. * ◯ Yes ◯ No

REASON FOR DISENROLLMENT:

Returned to parents

Adoption

Unknown Reasons

Other (Please Specify)

Number of children with a Court Team Checklist within one month of entry into the child welfare system? *(e.g. Best for Babies Service, Mohave County Juvenille Court Infant checklist)

How many system improvement measures are being continued during this reporting period? *

Did you implement any NEW system improvement measures during current reporting period? * ◯ Yes ◯ No

If Yes, Number of system improvement measures implemented during current reporting period. *

Did you complete any system improvement measures during current reporting period? *

Yes No

If Yes, Number of system improvements completed during the reporting period.

Number of court team trainings held during current reporting period. *

Did you conduct any court team training sessions this reporting period?*

Yes No

If Yes, please enter information about your training activities below. Enter as many as apply.

Name of Court Team Session	Session Description	Date of Session	Session Location - City

Data Reporting Instructions

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

For **Court Teams,** 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 2009 – Report due October 20
2nd Quarter – October-December 2009 – Report due January 20
3rd Quarter – January-March 2010 – Report due April 20
4th Quarter – April- June 2010 – 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.**

1. ***Number of Court Team meetings held during current reporting period:** In this data field, please enter the number of Court Team meetings held during this current reporting month.
2. **Did any new children come into the court system during this reporting period? YES or NO.**
   If yes, Number of new children entering the court team program during the current reporting period. In this data field, please enter the number of new children entering the court team program during the reporting period.
3. **Number of CONTINUING children served by your Court Team Program during the current reporting period.** In this data field, please enter the Number of CONTINUING children served by your Court Team Program during the current reporting period

4. **Number of NEW children served by your court team program during the current reporting period.** In this data field, please enter Number of NEW children served by your court team program during the current reporting period
5. **Did any children disenroll from your court team program during the current reporting period? Select: YES or NO.** If yes, please enter the reason for disenrollment
   - **REASON FOR DISENROLLMENT: Please enter number of children disenrolled for each listed reason.**
     i. Returned to Parents_____
     ii. Adoption _____
     iii. Unknown Reasons _____
     iv. Other (Please specify)_____
6. ***Number of children with a Court Team Checklist within 1 month of entry into the child welfare system:** In this data field, please enter the number of children that received a Court Team Checklist within a month of entry into the child welfare system.
7. **How many system improvement measures are being continued during this reporting period:** In this data field, please enter the number of system improvement measures being continued during the current reporting month.
8. **Did you implement any NEW system improvement measures during current reporting period? Select: YES or NO.**
   If yes, Number of system improvement measures being implemented during current reporting period. In this data field, please enter number of system improvement measures being implemented during current reporting period.
9. **Did you complete any system improvement measures during current reporting period? Select: YES or NO.**
   If yes, Number of system improvements completed during the reporting period. In this data field, please enter number of system improvement measures completed during current reporting period.
10. **Number of Court Team trainings held during current reporting period:** In this data field, please enter total number of Court Team Trainings conducted during the current reporting month.
11. **Did you conduct any court team training sessions this reporting period? Select: YES or NO. If yes,** *please enter the following training session data variable for each session:*

Court Team Training Session data fields

1. ***Name of Court Team Session:** In this data field you will enter the name of the Court Team session.
2. ***Topic of Court Team 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. ***Session Description:** In this text field you will enter a brief description about the Court Team session.
4. ***Session Format:** This data field is a drop down menu. You can choose **'One on One Training', 'Small Group', 'Large Group', or 'Other.'** 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.
5. ***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.**
6. ***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.
7. ***Date of Session:** For this data field you will report the date on which a Court Team session occurred.
8. ***Session Location – City:** In this data field you will enter the **City** name in which the Court Team session occurred. Example: City – Phoenix.
9. ***Session Location – Zip:** In this data field you will enter the zip code of where the Court Team training session occurred. Example: 85012.
10. ***Target Audience:** In this data field, please enter the number attended by the type of audience from 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 Court Team session on the line provided and enter the number attending.

Target Audience	Number Attended
Child Protective Service	
Court Appointed Special Advocate (CASA)	
Baby Court Appointed Special Advocate (CASA)	
Early Childhood Professionals	
Foster Parents	
Arizona Early Intervention Program (AzEIP)	
Child Welfare Providers	
Attorneys	
Health/Mental Health Care Providers	
Other (Please specify):	

Definitions:

1. **Early Childhood Professionals** – Child Care Providers, Preschool Teachers, Assistant Teachers etc.
2. **Health/Mental Health Care Service Providers** – Medical Professionals, Behavioral Health Providers, Therapists, Social Workers etc.

3. **Child Welfare Providers** – Private social service agencies, etc.

Frequently Asked Questions

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

For **Court Teams,** the frequently asked questions are:

In development

Additional Resources

Decision Making Template

Proven Promising Strategies

Web Site Related Evidence

Systems Development

Strategy Toolkit Glossary

DECISION-MAKING TEMPLATE

EXAMPLE

Following is an example of a set of criteria for selecting strategies. Criteria may be modified to meet specific regional priorities. This type of tool may be used to help prioritize or to eliminate strategies as needed during the strategic planning process.

Decision-making Criteria	Yes or No, Rating 1-5, considerations or comments
Is the strategy an evidence based approach?	
Does the strategy fill an identified gap or need from the Regional Needs and Assets Report?	
Does the strategy have the power to have an impact on positively changing the conditions, skills, attitudes or behaviors of the children and families served?	
Is the strategy child and family focused, collaborative and easily accessible?	
Is the strategy cost effective, affordable and sustainable?	
Does the strategy build upon existing financial resources?	
Is the strategy culturally responsive for children and families?	
Is the strategy one for which data can be collected and analyzed to know if it is working the way it should?	
Is the strategy timely in that it can be acted upon and funded in one to two years?	
Does the strategy build or contribute to a system which supports one or more of the First Things First goal areas, instead of creating a separate, stand-alone program or service?	

PROVEN/PROMISING STRATEGIES

Can quality child care improve future school performance in any meaningful way?

Can home visiting programs have a lasting impact on children?

The urgency of questions like these points to a knowledge gap in the strategies/practices that support children and families. For too long, impartial, results-oriented research information has been a challenge to come by. A funder or practitioner interested, for example, in improving children's health would find it daunting to sort through all the evaluation literature and find strategies whose effectiveness have been soundly demonstrated. Typing "child health policy" into an Internet search engine would yield tens of thousands of responses of wildly varying quality.

There is no question that we could improve our efforts if we had better access to reliable information on effective strategies. As issues of accountability and measurable outcomes increasingly define the development of new social strategies, it is essential that we have an objective picture of what is working (or has the likelihood of doing so). Policymakers and funders must have a foundation of reliable information to make sound investments.

Narrowing this knowledge gap is a goal of the First Things First Strategy Toolkit. The Strategy Toolkit provides a first step for those who ask *"We know where we want to go and what key measures we want to achieve, now what do we do to get there?"*

Every strategy included in the Toolkit, whether "proven," "promising," or "undetermined," has been examined by First Things First Policy Specialists to ensure that strategies reflect credible methodology.

Adapted from The Promising Practices Network (PPN), a group of individuals and organizations who are dedicated to providing quality evidence-based information about what works to improve the lives of children, families, and communities. Further information can be found at promisingpractices.net.

PROVEN/PROMISING STRATEGIES

Evidence Criteria Consideration Process Chart

	Proven	Promising	Undetermined
	Must meet all of these criteria to be listed as "Proven".	Must meet at least all of these criteria to be listed as "Promising".	A practice with these conditions is not yet identified as Proven or Promising.
Type of Outcomes Affected	Must impact one of the key measures.	May impact an intermediary outcome/ performance measure for which there is evidence that it is strongly associated with a key measure.	Intended to impact a key measure, but has not been researched extensively to demonstrate specific impact on FTF key measures.
Measurable Outcomes	Supporting research indicates statistically significant changes in outcomes desired.	Supporting research indicates strong correlations among activity and outcomes though may not show cause/effect relationship due to type of research conducted.	Research is linked to strategy though may not be directly investigated for the impact of the specific strategy.
Research Methodology	Study design uses convincing comparison groups to identify impacts, including randomized-control trial (experimental design) or some quasi-experimental designs.	Study may have comparison groups, but not be strong experimental design. For example, the groups may lack comparability on pre-existing variables. Or, study may not employ an experimental design, but still use quantitative data in its analysis.	Study may not be conducted using a comparison groups or experimental design (i.e. does not result in a cause and effect relationship). Study may use qualitative rather than quantitative data. For example surveys of parent beliefs rather than measurements of their behavior
Sample Size	Sample size of evaluation exceeds 30 in both the treatment and comparison groups.	Sample size of evaluation exceeds 10 in both the treatment and comparison groups.	Sample size of evaluation includes at least10 in the treatment group, comparison group, or study group.
Availability of Evaluation Documentation	Publicly available.	Publicly available.	Publicly available, though limited in scope.

WEB SITES RELATED TO EVIDENCE-BASED PRACTICE

What Works Clearinghouse
http://ies.ed.gov/ncee/wwc/

Child Trends
www.childtrends.org

Harvard Center on the Developing Child
http://developingchild.harvard.edu/

Center for Evidence-Based Practices – Research & Training Center
http://www.researchtopractice.info/whatisebp.php

The Research and Training Center on Early Childhood Development
http://www.researchtopractice.info

The Center on the Social Emotional Foundations for Early Learning (CSEFEL)
http://csefel.uiuc.edu

The Promising Practice Network (PPN)
http://www.promisingpractices.net

National Early Childhood Technical Assistance Center
www.nectac.org

National Center for Research on Early Childhood Education
http://www.ncrece.org/wordpress/

CONNECT: The Center for Research on Early Childhood
Educationhttp://community.fpg.unc.edu/connect

The Campbell Collaboration (C2)
http://www.campbellcollaboration.org/

The Pathways Mapping Initiative
http://www.pathwaystooutcomes.org/index.cfm

Center for Early Literacy Learning
http://www.earlyliteracylearning.org/

Identifying and Implementing Educational Practices Supported by Rigorous Evidence: A User Friendly Guide
http://www.ed.gov/rschstat/research/pubs/rigorousvid/guide_pg4.html#intro

A Policymaker's Primer on Education Research
http://www.ecs.org/html/educationIssues/Research/primer/index.asp

Evidence & Policy
https://www.policypress.org.uk/journals/evidence_policy/

US Dept of Education
http://www2.ed.gov/rschstat/best-practices.html

Adapted from Buysse, Virginia & Wesley, P. (2006). *Evidence-Based Practice in the Early Childhood Field.*
Washington, DC: ZERO TO THREE Press.

SYSTEMS DEVELOPMENT

1. **Stages of Development**. Building a system needs to be done in stages, typically planning, implementation and ongoing management. There are variations on these stages and more specifics in terms of specific activities and outcomes that can be found in many of the resources listed here.

    a. Building an Early Learning System: The ABC's of Planning and Governance Structures – Bruner, Wright, Gebhard & Hibbard, SECPTAN, 2004 - defines an early learning system and shares important "rules of thumb" for creating the planning and governance structures to build it. www.finebynine.org/pdf/SECPTAN_Build_PROOF.pdf
    b. Stages of Systemic Change, by Beverly L. Anderson - defines six developmental stages and six key element of change. http://insites.org/documents/systemic.pdf
    c. Together We Can: A Guide for Crafting a Profamily System of Education and Human Services, A. Melaville and M.J. Blank, US Government Printing Office, 1993. A description of collaborative endeavors across the country and a guide for integrating services including detailed description of the 5 stage process and benchmarks. http://searcheric.org/ericdb/ED357856.htm
    d. The Framework: A Tool to Develop Collective Leadership for Community Change, by Patricia Hughes, developed for The W.K. Kellogg Foundation's Leadership for Community Change Program, 2005 - This document depicts the states of community change and leadership development that can enhance the efforts of any group and is based on the theory of change developed by the two coordinating organizations (IEL and CEL) for this project. The Framework is an operational tool that translates the critical discoveries made during the design and delivery of this program into strategies and practices to help guide other communities toward a sustainable plan for change and improvement. www.iel.org/pubs/klccframework.pdf

2. **Models**. There is no one right model of an early childhood system. Most of the models used for planning and implementing early childhood systems are variations on four types. Below is a chart of the most common models used (From "Organizational Development", ©Dean Clifford)

    Each of the currently operating early childhood initiatives listed below are unique but share some common characteristics of the types listed previously.

a. North Carolina's Smart Start – a public-private partnership, The North Carolina Partnership for Children, supports a statewide, locally-administered, comprehensive approach to early care and education, family support and health services for children 0-5. www.ncsmartstart.org/about/whatissmartstart.htm
b. Iowa Community Empowerment – a state-sponsored early childhood initiative that is focused on 0-5, although not exclusively. The Iowa Empowerment Board is the governing body and its members are appointed by the Governor and the Legislature. It is a partnership between communities (local empowerment areas) and state government for the purpose of creating an integrated and coordinated early care, health and education system. www.empowerment.state.ia.us/common/pdf/community_empowerment_1998_2008.pdf
   Early Childhood Iowa – an alliance of stakeholders in early care, health and education systems that affect children 0-5 and whose purpose is to support the development and integration of early care, health and education system for Iowa. Community Empowerment serves as the infrastructure support for Early Childhood Iowa, but is a partner among equals where leadership is shared. www.state.ia.us/earlychildhood/docs/ECIDescription2.pdf
c. Smart Start Colorado –The Early Childhood State Systems Team leads the development and implementation of the comprehensive early childhood system. The Director is housed in the Office of the Lt. Governor. Local and regional Early Childhood Councils that operate in 30 counties are charged with the creation of a "seamless delivery system of early care and education services."www.smartstartcolorado.org/about/faqs.html
d. South Carolina First Steps – a public-private partnership established to help prepare children to reach first grade healthy and ready to succeed and run by a Board of Trustees whose members are elected at county forums in collaboration with their legislative delegations. County Partnerships plan, coordinate and implement services. www.scfirststeps.org/whoweare.htm
e. Arizona's First Things First – oversight by a new state level board, the Arizona Early Childhood Development and Health Board whose members are appointed by the Governor. There are also Regional Partnership Councils responsible for assessment, planning, implementation and resource and partnership development. The goal is to improve developmental and early learning outcomes for young children ages birth to 5 by building a system to grow and sustain a

coordinated network of early childhood programs and services. Funded by tobacco tax. http://azecdh.gov/ecdh/About_FTF/About_FTF.asp

f. Hawaii's Good Beginnings – a public-private partnership between the State and a private-non-profit corporation, Good Beginnings Alliance, created as a focal point for policy development, disbursement of funds and raising private funds. There are also county Community Councils and a state level Interdepartmental Council. www.goodbeginnings.org/history.htm
g. California's First5 – Funded by cigarette tax and operated by the California Children and Families Commission. Funds are distributed through the state's 58 counties all of which have their own local commissions. www.ccfc.ca.gov/commission/about_us.asp
h. Smart Start Oklahoma - a public-private partnership formed by two entities, the Oklahoma Partnership for School Readiness and its supporting foundation, the Oklahoma Partnership for School Readiness Foundation, to address critical issues surrounding healthy growth and development of young children. Local organizations serve 19 counties. www.smartstartok.org

3. Assessment/Evaluation

States are in different stages of assessment and evaluation of their early childhood initiatives. For those in the early stages of development, there is much benefit to evaluating collaborative efforts and systems work. There is value in continuing to evaluate these areas throughout the life of an initiative, too. While there are not as many tools for assessing these collaboration and systems development as there are for evaluating specific programs or for establishing and measuring indicators, the ones listed below have been tested and should be helpful.

a. Colorado Smart Start's Needs Assessment Toolkit – a web-based data system designed to store and manage a variety of indicator and program data. Takes users through a complete needs assessment process and provides a report and foundation for a strategic plan at the end. www.smartstartcolorado.org/communities/ssc_toolkit.html
b. Charting a Course: Assessing Communities' Strengths and Needs by Charles Bruner, Karen Bell, Claire Brindis, Hedy Chang, William Scarbrough - a review of existing guides to conducting community assessments and selected, effective assessments. Illustrations from specific community assessments show the different ways assessment

results can be used to help shape community actions. www.cfpciowa.org/publications/ccbs/index.htm

c. Together We Can: A Guide for Crafting a Profamily System of Education and Human Services, A. Melaville and M.J. Blank, US Government Printing Office, 1993. (See Appendix A: Checklist 1: Process for Crafting a Profamily System of Education, p. 119, and Human Services and Checklist 2: Indicators of Systems Change, p. 123.) http://searcheric.org/ericdb/ED357856.htm

d. Early Childhood Systems Building Tool: A Framework for the Role of Title V Maternal and Child Health Programs in Early Childhood Systems, Johns Hopkins Bloomberg School of Public Health, 2004 - provides an organizing framework "around which public health agencies can systematically plan for and monitor their unique functions and capacities as part of comprehensive early childhood system building and school readiness initiatives." www.jhsph.edu/wchpc/publications/EC%20Tool%20April%202004%20v3.pdf

4. Lessons Learned

a. North Carolina Early Childhood Systems Study, 2005 – This study looked at North Caolina laws, policies and programs from a "whole system view." It reports findings and recommendations. http://www.childcareservices.org/_downloads/Systems_Study_2005.pdf

b. Sharing the Stories: Lessons Learned from 10 Years of Smart Start, Carolyn K. Kroll and Michele Rivest, 2004, pages 37- 41. Includes a chapter on local partnership perspectives and lessons learned about building comprehensive early childhood systems.
(link directly to this NTAC publication)

c. "Some Concluding Lessons Emerging From Systems Work Across Various States" - ©Dean Clifford *(Create link to this highlighted section below – Attachment 4)*

5. Strategic Planning – Process and Planning Documents

a. Iowa Community Empowerment Board's Strategic Plan for 2006-2009.
www.empowerment.state.ia.us/Common/pdf/strategic_plan.pdf & www.state.ia.us/earlychildhood/docs/StrategicPlanRevisedSpring07.pdf

b. California First 5's Guidelines Document – http://www.f5ac.org/item.asp?id=150

c. Together We Can: A Guide for Crafting a Profamily System of Education and Human Services, A. Melaville and M.J. Blank, US Government Printing Office, 1993. A description of collaborative endeavors across the country and a guide for integrating services including detailed description of the 5 stage process and benchmarks. http://searcheric.org/ericdb/ED357856.htm
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e. The Build Initiative's Theory of Change – this paper "helps to sort out when actions are or are not contributing to meeting overall goals and which actions being posed are more, or less, essential to moving forward. The theories of change presented here are designed to enable that type of learning and continuous improvement." www.buildinitiative.org/docs/TowardaTheoryofChange.doc
f. Pathways Mapping Initiative, developed by Lisbeth B. Schorr at Harvard University, "seeks to collect and organize knowledge based on research and lessons learned with the aim of helping communities think and plan systemically to produce desired community-wide outcomes." www.PathwaysToOutcomes.org
g. Strategic Planning for Nonprofit Organizations: A Practical Guide and Workbook, Michael Allison & Jude Kaye, John Wiley & Sons, 1997 - book/disk set that helps create and implement a strategic plan and is designed for all types of nonprofits. Includes worksheets, checklists, useful tips.

6. Additional Resources

a. National Center for Service Integration – a clearinghouse for resource briefs and other publications about service integration. www.cfpciowa.org/initiatives/national/nsci.htm
b. Child and Family Policy Center – works at the community, state, and national levels on child and family policy issues, with emphasis on developing more asset-based and comprehensive approaches to

helping children and their families succeed. CFPC conducts research, produces research syntheses, facilitates community and state forums on children's issues, and provides technical assistance to state and community policy-makers. www.cfpciowa.org

c. State Early Childhood Policy Technical Assistance Network – a network of experts on early childhood issues available to help state decision makers design early childhood policies. www.finebynine.org/network.html
d. Theory of Change from ActKnowledge and the Aspen Institute Roundtable on Community Change - offers a tool to design and evaluate social change initiatives. www.theoryofchange.org/html/overview.html
e. Iowa Financing Strategy for a Comprehensive Early Childhood System – a checklist of elements that must be addressed in developing and financing an early childhood system - www.state.ia.us/earlychildhood/docs/IowaFinancinStrategyOct04.pdf
f. A Framework for a Coherent Early Care and Education System, Teresa Vast, 2004 – proposes a framework for an efficient and coordinated system of early care and education. www.earlychildhoodfinance.org/handouts/System%20Framework%20essay%20-%202003.pdf
g. Getting from Here to There: To an Ideal Early Preschool System, *Early Childhood Research and Practice*, Gallagher, Clifford & Maxwell, Vol. 6, No. 1, Spring 2004 – proposes the merging of support systems such as personnel preparation, technical assistance and evaluation and specific recommendations for achieving an integrated early childhood system. http://ecrp.uiuc.edu/v6n1/clifford.html

Collaboration

"Collaborations are defined as organizational and interorganizational structures where resources, power and authority are shared and where people are brought together to achieve common goals that could not be accomplished by a single individual or organization independently." – from United We Stand: Collaboration for Child Care and Early Education Services, Sharon L. Kagan, Teachers College Press, 1991.

1. Assessment Tools.

These tools help groups assess how their partnerships are doing in varying stages of the collaborative process.

a. The Wilder Collaboration Factors Inventory – a scale to assess a collaborative. www.cahs.colostate.edu/ccp/PDF/The%20Wilder%20Collaboration%20Factors%20Inventory-Reformat.pdf
b. Thinking Collaboratively: Ten Questions and Answers to Help Policy Makers
Improve Children's Services, Charles Bruner , PhD.- provides checklists to help assess key issues in establishing interagency initiatives, demonstration project and statewide reforms to foster collaboration. www.cyfernet.org/research/thinkco.html
c. Partnership, Alliances and Coordination Techniques (PACT), National Child Care Information Center (NCCIC) - provides checklists for shaping partnerships and for assessing how partnerships are doing. www.nccic.org/pact/index.html#Tools
d. Service and System Integration Matrix, ©Dean Clifford– a tool to assess and rate a partnership's commitment, planning, training, leadership, resource sharing and communication. *(link to this chart – Attachment 5)*

2. Family Involvement

Establishing high quality comprehensive systems of service for young children requires the meaningful involvement of their families at many levels from planning to implementation to governance/oversight.

a. Principles of Family Support – established to provide guidance to health, education, and human service systems and organizations to be more culturally competent, family-focused and strength-based.
b. Involving Families in Early Childhood Systems Work, ©Dean M. Clifford, Ph.D.
c. Bringing the Local Community into the Process: Issues and Promising Practices for Involving Parents and Business in Local Smart Start Partnerships, Frank Porter Graham Child Development Institute publication, 1997. This report describes finding from interviews and case studies about the involvement of parents and business leaders in the Smart Start decision-making process. www.fpg.unc.edu/~smartstart/reports.html

3. Additional Resources

a. United We Stand: Collaboration for Child Care and Early Education Services, Sharon L. Kagan, Teachers College Press, 1991. Discusses the value of collaboration, the process and lessons learned.

b. PACT, NCCIC - publications related to 1) creating, implementing and sustaining partnerships; 2) evaluating partnerships; 3) facilitating the partnership process;
4) financing strategies; and 5) research on the benefits of partnership in the child care and early education systems - www.nccic.org/pact/index.html#Tools
c. NTAC Effective Practices Papers- "Family Support: A Solid Foundation for Children", "Family Support and School Readiness", "Effective Strategies for Integrating Family Support into Early Care and Education"

4. Lessons Learned

"People should expect to spend 6-18 months planning services integration strategies." – William Morrill, National Center for Services Integration

a. Achieving Success in Collaboration: Foundation of Successful Collaborations - ©Dean Clifford *(link to document, pp. 4-5, Attachment 8)*
b. Sharing the Stories: Lessons Learned from 10 Years of Smart Start, Carolyn K. Kroll & Michele Rivest, 2004, pages 25- 29. Background on local NC Smart Start partnership collaborative planning and lessons learned. *(Link directly to this NTAC publication)*
c. Lessons Learned by Established Collaborative Partnerships - ©Dean Clifford, Ph.D.
   - Be patient.
   - Maintain on-going communication and interaction.
   - Seek the support of top leadership and administrators.
   - Provide incentives for participating.
   - Understand that each participant has a different piece of the puzzle.
   - Do not expect equal contributions from all partners.
   - When conflict occurs or things get bogged down, re-focus on the shared vision, mission and long-term priorities.
   - Don't skip steps!

From National Smart Start

GLOSSARY OF FIRST THINGS FIRST COMMON TERMS AND ACRONYMS (12/30/10)	
Term/Acronym	Definition
American Academy of Pediatrics /Arizona Academy of Pediatrics (AAP or AzAAP)	The Arizona Chapter of the American Academy of Pediatrics is a professional membership association comprised of pediatricians, pediatric sub-specialists, academicians, hospital administrators and physicians, nurse practitioners, school nurses and other child health care providers. The AzAAP has built a network among pediatricians and other medical professionals and child advocacy organizations throughout Arizona, working collaboratively to improve the health and well-being of Arizona's children and to further the education of pediatricians and the public in matters pertaining to children's health and well being issues.
Access/Accessibility	Accessibility refers to the ability of a family with young children to find and receive the supports and services they need that meet their specific needs, including location, timeliness and affordability.
Accountability and Monitoring	Accountability and monitoring processes are in place to ensure that services for children and families are carried out efficiently, economically, effectively, ethically and equitably, while achieving desired program outcomes.
American Community Survey (ACS)	The American Community Survey is an ongoing survey that provides data every year – giving communities the current information they need to plan investments and services. A report is provided by the U.S. Census Bureau at www.census.gov.
Affordability	Affordability refers to the ability of a family to access quality child care that is within reach of their family budget. Affordability strategies are those that pay a portion of the cost of child care for low-income parents to offer them more options in choosing a child care provider to meet their needs.
Arizona Child Care Association (ACCA)	The Arizona Child Care Association is a non-profit professional trade organization governed by membership through a representative Board of Directors. ACCA's mission is to represent private, licensed child care centers statewide and to promote affordable, quality early care and education that meets the needs of Arizona's families and children.
Arizona Department of Education (ADE)	The Arizona Department of Education is the state agency responsible for administration and oversight of Arizona's K-12 public schools. ADE also serves as the administrating body for Early Childhood Special Education for children 3 to 5 years old and other early childhood education programs.

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Arizona Department of Administration (ADOA)	The Arizona Department of Administration oversees training, technical assistance, compliance review and monitoring, evaluation, dissemination of information, administration and allocation of funds and recognition of excellence in agencies and branches of Arizona state government. It provides customers, both internal and external, with administrative service in the following areas: Accounting, Human Resources, Budget and Strategic Planning, Procurement, Facilities Management, Grants Management, and Audit Resolution, Contract and Cost Allocations for the Department.
Arizona Department of Economic Security (DES)	The Arizona Department of Economic Security is a state agency whose mission is to promote the safety, well-being, and self-sufficiency of children, adults, and families. Within this state agency, the Child Care Administration is responsible for distribution of federal funds from the Early Childhood Development Block Grant, as well as state funding for child care subsidy.
Arizona Department of Economic Security (DES) Certified Providers	The Arizona Department of Economic Security certifies and monitors some child care home providers, known as DES Certified Child Care Homes, which become eligible to receive child care subsidies. They may care for no more than four children at one time for compensation and up to six children total, including the provider's own children. They may care for no more than two children less than one year of age. DES Certified Home Providers have an Arizona Child Protective Services (CPS) clearance, must pass a fingerprint and criminal background check, and provide proof of current training in CPR and First Aid. Their homes must be inspected to ensure they meet a wide variety of health and safety standards.
Arizona Department of Economic Security (DES) Child Care Subsidy	Subsidies provide eligible families with financial support for a portion of child care costs when parents or caretakers participate in qualified activities, such as employment, or fall into certain categories including receiving public assistance, transitioning from public assistance or referral through Child Protective Services. DES certifies and contracts with family child care homes, with Department of Health Services licensed centers and group homes, and non-certified relative providers to provide child care services for eligible families.
Arizona Department of Health Services (DHS)	The Arizona Department of Health Services oversees a wide array of programs and services designed to protect and ensure the health of the state's diverse population. These include public health, including maternal and child health, disease prevention and control, emergency medical services, emergency preparedness and response, state laboratory services, public health data and statistics and vital records; and the licensing and certification of health and child care facilities.

Arizona Department of Health Services (DHS) Licensed Providers	Early care and education providers who care for more than four children for compensation must be licensed by the Office of Child Care Licensing in DHS. Exceptions include: care on military bases (where care is regulated by the military authorities), care on tribal lands (where care is regulated by the tribal authorities) and care where parents remain on the premises. Child care providers who care for children in their homes can serve up to 10 children for compensation in a DHS Certified Group Home. In DHS Licensed Child Care Centers the total number of children allowed is based on the size of facility and licensed capacity. All must meet regulations which promote children's health, safety and well being.
Arizona Health Care Cost Containment System (AHCCCS)	The Arizona Health Care Cost Containment System is Arizona's Medicaid program, designed to deliver quality managed care for eligible citizens, including young children. AHCCCS contracts with health plans and other program contractors. AHCCCS receives federal, state and county funds to operate.
Assessment	The process of collecting information to measure the progress or performance of a person, group or system.
Arizona Early Intervention Program (AzEIP)	The Arizona Early Intervention Program (pronounced Ay-zip) is a statewide system of supports and services for families of children, birth to three, with disabilities or developmental delays. Children must meet eligibility requirements to receive services. The AzEIP system is a collaboration of activities by the following state agencies: Arizona Department of Economic Security/AzEIP, DES/Division of Developmental Disabilities, Arizona Department of Health Services, Arizona State Schools for the Deaf and the Blind, Arizona Department of Education and AHCCCS.
Benchmarks	A benchmark is a point of reference by which objectives can be measured in the attainment of a defined goal.
Best Practice	Best practice asserts that there is a technique, method or process that is highly effective at delivering a particular outcome. Best practice can also be defined as the most efficient (least amount of effort) and effective (best results) ways of accomplishing a task, based on repeatable procedures that have proven themselves over time for large numbers of people. Best practices are often contained in the standard of practice for a given strategy and are used to describe the process of developing and following a standard way of doing things that multiple organizations (or regions) can replicate and use for management, program implementation, policy and evaluation.

Bureau of Indian Education (BIE)	The federal Bureau of Indian Education, formally known as the Office of Indian Education Programs, oversees educational opportunities from early childhood to adulthood, to assure tribal members' cultural and economic well being in keeping with the wide diversity of Indian tribes and Alaska Native villages as distinct cultural and governmental entities. There are 183 elementary and secondary schools within the BIE system serving approximately 48,000 students. Of these schools, 59 are BIE-operated and 124 are tribally controlled through BIE contracts or grants.
Children's Action Alliance (CAA)	Children's Action Alliance is a non-profit, non-partisan organization dedicated to promoting the well-being of all of Arizona's children and their families through research, publications, media campaigns and advocacy.
Child and Adult Care Food Program (CACFP)	The United States Department of Agriculture Child and Adult Care Food Program is available to public or private child care providers. This program, administered in Arizona by ADE, reimburses providers for nutritious meals served while children are in care and education settings. The CACFP is not a child care program, but an effort to improve nutrition for children and adults. Participating child care providers must be licensed or certified or submit to a fingerprint and background check to qualify for reimbursement.
Child Care Health Consultant (CCHC)	A child care health consultant is a health professional, often a registered nurse, who has specialized training and experience with young children, provides consultation to child care providers to assure the health and safety of children cared for in these settings, and has knowledge of community health resources and regulations.
Child Development Associate (CDA)	CDA is a credential awarded by the National Council for Professional Recognition to professionals working in one of three early care and education settings – child care centers / preschools, family child care and home settings receiving services of a home visitor. There are endorsements associated with particular age groups (infant/toddler or pre-school endorsement), as well as language (bilingual endorsement).
Child Care Resource & Referral (CCR&R)	Child Care Resource and Referral is a statewide program in Arizona that helps families find child care. CCR&R also provides information about community trainings and resources for child care providers and the early childhood community. This program is funded by the Arizona Department of Economic Security, Child Care Administration through federal funding.
Child Health	Child health is a state of physical, mental, intellectual, social and emotional well-being and not merely the absence of disease or infirmity. Healthy children live in families, environments, and communities that provide them with the opportunity to reach their fullest developmental potential.

Children with Special Health Care Needs	Children with special health care needs are those who require health related services beyond those required by children generally. Examples may include severe allergies, assistance with crawling or walking, or dietary restrictions such as requiring gluten free foods.
Coaching	Coaching is an adult learning strategy that incorporates reflective practices to enhance skills and build competencies that support quality services to young children and families. Coaches collaborate with service providers to provide individualized assistance, which may be delivered on-site, through phone or other communication. Coaches facilitate a learning environment in which service providers can analyze current practices through assessment and self-reflection, and then set goals for improvement.
Collaboration	Collaboration is a mutually beneficial and well-defined relationship entered into by two or more organizations or community leaders that requires a commitment to mutual relationships and goals, a jointly developed structure and shared responsibility, mutual authority and accountability for success, and shared resources and rewards.
Consultation	Consultation is a systematic process to help professionals and parents address concerns, identify goals and make improvements. It is an indirect service delivery model in which a consultant (e.g. early childhood educator, therapist, health professional) and a client work together to address an area of concern or a common goal for change.
Coordinate	To coordinate is to plan, determine roles, avoid duplication of services and open communication channels between organizations and individuals. Authority rests with individual organizations; however, responsibility for program outcomes is shared. Procedures and protocols are exchanged and aligned to ease utilization and participation by community members and service customers.
Data Reporting Instructions	Data reporting instructions provide First Things First grantees with information and requirements in order to collect, record and report data using a data-reporting template in the First Things First data system.
Data Reporting Templates	Data reporting templates are the tools utilized by First Things First grantees to report and submit data to assess grantee Performance Measures.
Division for Early Childhood (DEC)	The Division for Early Childhood (DEC) is an international membership organization for those who work with or on behalf of young children with disabilities and other special needs. Its mission is to promote policies and advance evidence-based practices to support the optimal development of young children with special needs

Developmentally Appropriate Practice (DAP)	Developmentally appropriate practice is the term used by The National Association for the Education of Young Children (NAEYC) to describe an approach to education that focuses on the child as a developing human being and lifelong learner. This approach recognizes the child as an active participant in the learning process, a participant who constructs meaning and knowledge through interaction with peers and adults, materials and the environment. The teacher is an active facilitator who helps a child create meaning from the various activities and interactions encountered throughout the day. Developmentally appropriate practices result from the process of professionals making decisions about the well-being and education of children based on at least three important kinds of knowledge related to: 1. Child development and learning 2. The strengths, interests, and needs of each individual child in the group 3. The social and cultural contexts in which children live. Copyright © 1997. All rights reserved. NAEYC Position Statement.
Dental Home	The ongoing relationship between a dentist and patient inclusive of all aspects of oral health care, delivered in a comprehensive, continuously accessible, coordinated and family-centered way.
Developmental Screening	The use of a brief procedure or standardized instrument designed to identify those who may need further assessment to verify developmental and/or other health risks.
Division of Developmental Disabilities (DDD)	Located within DES, the Division of Developmental Disabilities provides services and supports to children and adults with developmental disabilities to assist with self-sufficiency and independence. The division also assists and supports family members and others who are caring for children and adults with disabilities. DDD is also a provider of AzEIP services under DES.
Dynamic Indicators of Basic Early Literacy Skills (DIBELS)	The Dynamic Indicators of Basic Early Literacy Skills are a set of standardized, individually administered assessments of early reading development. They are designed to be short (one minute) fluency measures used to regularly monitor the development of pre-reading and early reading skills such as letter identification.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	The Early Periodic Screening, Diagnosis, and Treatment Program is the child health component of the federal Medicaid program. It is required in every state and is designed to improve the health of low-income children by financing appropriate and necessary pediatric services. EPSDT is a mandatory set of services and benefits for all individuals under age 21 who are enrolled in Medicaid.

Early Care and Education (ECE)	Activities and/or experiences that are intended to effect developmental changes in children prior to their entry into kindergarten. Although ECE can refer to experiences a child has in the home with a parent or primary caregiver, the term is often used to describe preschool or child care programs. Early care and education takes many forms depending on the theoretical and educational beliefs of the educator or parent.
Early Childhood	The period in life which is defined by the profession as the years between birth and age 8, though the statute for First Things First places the focus on birth through age 5 and experiences prior to entry into kindergarten.
Early Childhood Development and Health	For the purposes of First Things First, includes the array of programs, services, and supports in early care and education, health and family support that serve children from birth to age 5 and their families.
Early Childhood Education (ECE)	Often used synonymously with Early Care and Education.
Early Childhood Quality Improvement Practices (ECQUIP)	Early Childhood Quality Improvement Practices is a system for program improvement developed by ADE for schools receiving state funding through the Early Childhood Section of ADE. There are two parts to the ECQUIP process: an annual self-assessment conducted by the local district or charter and an onsite validation visit by ADE every six years.
Early Childhood Special Education	Refers to the identification and service delivery of specialized services such as education, speech, occupational, or physical therapy to preschool age children (3 to 5 years) with identified special needs.
Early Childhood System	Refers to the entirety of early care and education, health, family support, early literacy, and professional development components that serve children birth to age 5 and their families.
Early Intervention (EI)	Typically refers to the specialized services, programs and therapy supports provided to children birth to age 3 who have been identified with special health care or developmental needs.
Early Learning Standards (ELS)	Early Learning Standards are documents that states have produced to describe what children should know and be able to do at certain stages of development before they start kindergarten. In Arizona, the document is known as the Arizona Early Learning Standards. The Arizona Early Learning Standards were developed by the Department of Education and are considered appropriate for all children 3 to 5 years of age. First Things First is developing the Infant and Toddler Developmental Guidelines for use with children birth to age 3. Early care and education professionals and other family service providers use early learning standards as a framework to plan quality learning experiences for young children.

Environmental Rating Scales (ERS) **ECERS-R/ITERS-R/FCCERS-R**	The Environmental Rating Scales are valid and reliable assessment tools that measure indicators of quality in early care and education settings. The ERS tools focus on environmental factors such as the accessibility of learning materials, health and safety procedures, supervision of children and personal care routines. The ERS include three individual assessments: one for center-based preschool classrooms, one for center-based infant and toddler classrooms and one for family child care home settings. The Early Childhood Environmental Rating Scale-Revised measures quality in preschool classrooms, the Infant Toddler Environmental Rating Scale-Revised measures indicators of quality in infant and toddler classrooms, and the Family Child Care Environmental Rating Scale-Revised measures the quality of family child care home settings.
Family	Family includes biological and adoptive parents, grandparents, aunts, uncles, siblings, guardians or other adults, including extended family members, defined by law or custom of the Tribe, country or cultural group, who provide primary care of a child within a household.
Family, Friend, and Neighbor (FFN) Care	Care that takes place in the child's or caregiver's home during the day, evening, or overnight, generally based upon the caregiver's prior relationship with the child and family. The family part of FFN includes older siblings, grandparents, aunts, uncles, and cousins, although research shows the great majority of the family members providing FFN care are grandparents. Friends and neighbors are caregivers unrelated to the child or children in their care. FFN care is usually provided for free or by barter, although a fee may also be paid. Family, Friend and Neighbor care, which is most generally unregulated, is also referred to as Kith and Kin care.
Family Literacy	Various programs and services for families that focus on conducting activities intended to increase parents' knowledge of their children's emerging literacy development, so they can best support their child's development in this area. An example is the Title 1 Even Start/Family Literacy Program which brings together parents and their preschool children within a learning environment. Programs include specific educational objectives for the adult and the children through a comprehensive, intergenerational approach. Existing sites across Arizona are funded and administered through ADE Early Childhood Education and target low income families.
Fidelity	The degree to which a program is implemented according to a specified and proven model.

Financial Incentives	Financial incentives, as used by First Things First, are available through the Quality First program and may be provided to support program improvement, the costs of providing high-quality services, or to reward achievement of quality improvement. Incentives are also tied to other strategies such as those that attract and retain special health providers and reward early education professionals for attaining education milestones.
Goal (FTF)	Broad measurable statement of intent to set a future direction or desired accomplishment. The goal communicates the direction of (more, less, maintain) the result statement. Goals indicate what FTF will do as part of the comprehensive early childhood system. Each Goal is a piece of a larger picture and is inextricably interrelated and linked with the other Goals.
Goal Area (FTF)	First Things First has identified 6 goal areas: Quality, Access and Affordability; Health; Professional Development; Family Support/Early Literacy; Coordination, and; Communications.
Head Start (HS)/Early Head Start (EHS)	Head Start is a comprehensive federal child development program that serves children from ages 3 to 5 and their families. Early Head Start serves children under age 3 and pregnant women. The program is child-focused and has the overall goal of increasing the school readiness of young children in families living at or below the poverty level. Federally funded program grantees and delegate agencies deliver a range of services that encompass all aspects of a child's development and learning.
Health Screening	Brief procedures or tools to determine if further assessment is needed to identify health risks or concerns. Activities include vision, hearing, oral health, or developmental screening, which may occur within a medical home or an educational setting.
High-Quality	First Things First defines high quality early care and education, health, and family support programs as those providing children with the greatest opportunities to reach their maximum potential in life.
Home Visiting / Home Visitation	Home visiting programs are voluntary and provide participating families of young children with information, support and education on parenting, child development, early learning and health within their homes, while facilitating linkages to other resources or programs, as needed. A variety of models exist to address the spectrum of needs, from those that are universal for all families with young children to more targeted, comprehensive interventions for particular populations, such as first time parents, teen parents, parents with premature babies, families at-risk for abuse or neglect, and low income families.

Individuals with Disabilities Education Act (IDEA)	Individuals with Disabilities Education Act is a federal special education law that mandates a free and appropriate public education for all children with disabilities under age 21.
Individual Education Plan (IEP)	An Individual Education Plan is a written plan developed by the family and a school's special education team to specify a child's current levels of development, goals for learning, and the supports to be provided to attain those goals within natural environments, such as the home, child care center or school.
Individual Family Service Plan (IFSP)	An Individual Family Service Plan is completed for families with children from birth to age 3 who are participating in early intervention or other support services. The written plan is developed in partnership between a family and a team of early intervention service providers working with the family, and the IFSP describes a family's priorities and interests related to the child, the outcomes the family would like to experience as a result of early intervention or support services, and how the service providers will support the family in attaining the outcomes. Home visiting and other family support programs may also use the term "Family Service Plan" to indicate the written plan to achieve family and adult goals.
Indian Health Service (IHS)	Indian Health Service is an agency within the U.S. Department of Health and Human Services responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. The IHS is the principal federal health care provider and health advocate for Indian people; its goal is to raise health statuses to the highest possible level. The IHS currently provides health services to approximately 1.9 million American Indians and Alaska Natives who are members of more than 564 federally recognized tribes in 35 states.
Inclusion	Inclusion in early childhood pertains to the values, policies, and practices implemented so that every infant and young child and his or her family, regardless of ability, can fully participate in a wide range of activities within various settings. Inclusive settings should include, but are not limited to homes, Head Start programs, schools, early care and education settings, places of worship, recreational locations (such as community playground and community events) and other settings that all children and families enjoy. (Definition adapted from DEC/NAEYC, 2009).
Indicator	A statistic or data source used to measure current conditions as well as identify trends.
Infant Mental Health Specialist	Infant Mental Health Specialists are early childhood professionals with a set of core beliefs and distinct skills, training experiences, and clinical strategies, who incorporate a comprehensive, intensive and relationship-based approach to working with young children birth through age 2 and their families.

Infant-Toddler Specialist	Infant-Toddler Specialists work with young children from birth through age 3 in a variety of early care and education settings. It is the responsibility of specialists to both nurture and provide developmentally appropriate education for children, as well as build relationships with the child's family members. In fact, working with the families is as important to the specialist as working with the children. The specialist recognizes and honors the culture and needs of the families in all aspects of the program.
Interagency Service Agreement (ISA) / Intergovernmental Agreement	Legal documents describing tasks agreed upon and to be accomplished and/or funds to be paid from one governmental agency (i.e. state, tribal, or other) to another.
Inter Tribal Council of Arizona (ITCA)	Inter Tribal Council of Arizona, Inc. is a private, non-profit corporation that promotes Indian self-reliance through public policy development. ITCA is a membership organization comprised of the senior elected Arizona tribal officials: chairpersons, presidents and governors. The purpose of the corporation is to provide the member tribes with the means for action on matters that affect them collectively and individually, to promote tribal sovereignty and to strengthen tribal governments. ITCA also serves as a united voice for member Arizona tribal governments to address common issues of concerns.
Key Measure	First Things First's Key Measures align directly with FTF Goals and indicate desired change. Many Key Measures listed will indicate whether regular progress toward First Things First Goals will be achieved within three to five years. Other Key Measures listed will provide important data to determine ongoing impact on and progress of the early childhood development and health system.
KidsCare Health Insurance	Arizona's Children's Health Insurance Program provides medical coverage for children who have no health insurance. In order to be eligible, applicants must meet certain age, income and other residency requirements. Children who qualify for Medicaid may not receive benefits through KidsCare. KidsCare is currently unable to approve any new applications, as enrollment has been frozen since January 1, 2010 due to lack of funding for the program. However, families may still apply and, if eligible, must be willing to pay an income-based premium, in order to be placed on the waiting list for participate in the program.
Local Education Agency (LEA)	A Local Education Agency refers to a public school district, or a body that oversees multiple schools. The responsibilities of a LEA may include operating the local public school system, distributing grant money to school projects and contracting for educational services.

Medicaid	Medicaid is the federal program for individuals and families with low incomes and limited resources. It is jointly funded by the states and federal government, and is managed by the states. Among the groups of people served by Medicaid are eligible low-income parents, children, seniors and people with disabilities. Medicaid is the largest source of funding for medical and health-related services for people with limited income.
Medical Home	A model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective. Critical pediatric medical home principles: 1) family-centered partnership that are trusting, collaborative, working partnership with families that respect diversity and recognize that families are the constant in a child's life; 2) community-based system with a family centered- coordinated network designed to promote the healthy development and well being of children and their families; 3) transitions where the provision of high-quality, developmentally appropriate, health care services continues uninterrupted as the individual moves along and within systems of services, and from adolescence to adulthood; and 4) value as demonstrated by the requirement that a high-performance health care system have appropriate financing to support and sustain medical homes that promote system-wide quality care with optimal health outcomes, family satisfaction and cost efficiency (American Academy of Pediatrics).
Mental Health Consultation	Mental health consultation aims to build the capacity (and improve the abilities) of early care and education staff, programs, and families to prevent, identify and reduce the impact of social-emotional development problems among young children. Consultation involves a collaborative relationship between a professional who has expertise in the social-emotional development of young children and an early childhood professional. 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.
Mentor	A one-on-one relationship between two individuals which functions over time to facilitate the transfer of knowledge, skills, attitudes, beliefs, and values between a more experienced individual (called a mentor) and a less experienced individual (called a protégé). The relationship may include coaching, tutoring, training, guiding and self-reflection in order to assist the protégé to advance her/his career, enhance her/his education, build skills and develop professional networks.
Monitoring	A system or process designed to check, record, and track progress of any program, service or organization on a regular basis. Monitoring is generally accomplished by comparing performance to a set of expected standards. Examples in early childhood include licensing regulations, Head Start Performance Standards, and quality improvement and rating systems.

National Association for the Education of Young Children (NAEYC)	NAEYC is a national professional organization for the early care and education field, which also has local affiliates which carry out work at the state and community level to improve the quality of early care and education programs and increase the knowledge and skills of the early care and education workforce.
Needs and Assets Assessment Reports (N & A)	First Things First Needs and Assets reports are produced every other year, alternating between a statewide and a regional focus. Each FTF Needs and Assets report provides a snapshot of the demographic characteristics within the state or region of young children ages birth to five and their families. Also included are the early care, development and health systems, services and other assets available to young children and their families, as well as areas in which the state or region has unmet needs for these systems and services.
Open Meeting Law (OML)	State law which states that meetings of public bodies (which include the FTF Board and Regional Councils and subcommittees) must be conducted openly, and meeting notices and agendas must be provided that contain information as is reasonably necessary to inform the public of the matters to be discussed or decided.
Oral Health Providers	General, pediatric, and specialty dentists (e.g. endodontic, periodontal) and dental hygienists.
Part B/Section 619	Refers to Part B of the Individuals with Disabilities Education Act, which addresses requirements for providing special education services for children (ages 3 through 21 years). Section 619 specifically addresses special education services for preschool aged children (ages 3 to 5 years).
Part C/Early Intervention	Refers to Part C of the Individuals with Disabilities Act. Addresses requirements for family and child education services for infants and toddlers (ages birth to 3 years) with special needs.
Parent's Evaluation of Developmental Status (PEDS)	Parents' Evaluation of Developmental Status is a tool used for early, routine developmental screening to identify a child who may be in need of further evaluation for needed intervention services.
Performance Measures	First Things First's Performance Measures include (1) key indicators of performance (i.e. Units of Service); (2) basic implementation of strategies; (3) alignment of program activities to strategy specific standards of practice, and (4) performance or progress towards 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).

Professional Career Pathways (PCPP)	Professional Career Pathways Project is a scholarship program funded through DES and offered at community colleges throughout Arizona for early care and education coursework only. The recipient must be employed in a DES or DHS regulated home or center-based setting, directly with children birth to age 5. Volunteers may also have limited access to participation in the scholarship program.
Professional Development	Professional development generally refers to ongoing learning opportunities available to professionals to enhance skills, knowledge and career advancement. Early childhood professional development encompasses all types of facilitated learning opportunities, including college coursework, conferences/workshops, observation and practice, coaching/mentoring, communities of practice, lesson study, reflective supervision and technical assistance.
Program Guidelines for High Quality Education: Birth Through Kindergarten, Third Edition	Arizona's *Program Guidelines for High Quality Early Education: Birth through Kindergarten*, revised by the ADE in partnership with First Things First, is a set of recommended practices for programs to use as they strive for excellence in the care and education of young children throughout Arizona. This document is intended to provide guidance by delineating quality and providing a set of indicators that concretely describe what a program will look like when providing high quality early care and education for children birth through age 6.
Program Standards	Program Standards are the recommended practices for early childhood programs that have been identified to be highly effective in supporting young children's growth and learning. High quality program standards are not requirements, such as licensing regulations, but address the similar structural components of quality such as healthy and safe environments, curriculum and instruction, staff qualifications, ratios and group sizes, compensation and retention, and family engagement. Arizona's program standards were developed through a joint effort between First Things First and ADE and are documented in the *Program Guidelines for High Quality Early Education: Birth through Kindergarten, Third Edition*.
Promising Practice	Includes practices that were developed based on theory or research, but for which an insufficient amount of original data have been collected to determine the effectiveness of the practices. Promising practices may also have been tested under different conditions and, therefore, have a research foundation. However, the practices themselves have not been tested using the most rigorous research designs or were tested in different contexts.
Proven Practice	Study design uses a convincing comparison group to identify program impacts, including randomized-control trial (experimental design) or some quasi-experimental designs. Sample size of evaluation exceeds 30 in both the treatment and comparison groups.

Quality Improvement and Rating System (QIRS)	A systematic approach to assess, improve, and communicate the level of quality in early care and education programs. Based upon defined program standards, these systems provide an opportunity to (1) increase the quality of care and education for children; (2) increase parents' understanding of and demand for higher quality care; (3) increase professional development of early childhood providers; and (4) provide information and accountability to policymakers for funding. (National Child Care Information Center.)
Regional Behavioral Health Authorities (RBHAs)	ADHS-Division of Behavioral Health Services contracts with community based organizations, known as Regional Behavioral Health Authorities, to administer behavioral health services throughout Arizona. RBHAs function similarly to health maintenance organizations by contracting with a network of service providers to deliver a full range of behavioral health care services, including prevention programs for adults and children, a full continuum of services for adults with substance abuse issues and general mental health disorders, adults with serious mental illness and children with serious emotional disturbance. The state is divided into six geographical service areas served by four RBHAs.
Regulated Child Care	A general term that covers all forms of rules that are applied to early care and education settings, including building safety approvals, fire safety approvals, licensing, funding requirements, criminal record checks and child abuse and neglect clearances. Informal providers, such as FFN care, are generally not required to be regulated, as long as the provider does not care for more than 4 children for pay.
Research-Based	Research that is based on the neurobiological, behavioral and social sciences that has led to major advances in understanding the conditions that influence whether children get off to a promising or worrisome start in life.
Request for Grant Application (RFGA)	Request for Grant Application is the primary mechanism used by First Things First to solicit proposals and award grant funding to community entities for the implementation of strategies approved in regional or statewide funding plans. Eligible entities respond to an RFGA with a competitive grant application that is reviewed by community stakeholders, with final recommendations for grant awards approved by the FTF Board.
School Readiness	School readiness is a term used with increasing frequency to describe expectations of how children will fare upon entry to kindergarten. Years of research on child development and early learning show that several interrelated domains of development define school readiness—physical wellbeing and motor development, social and emotional development, approaches to learning, language development, and cognition and general knowledge. These domains are interrelated, build on one another, and form the foundation of learning and positive social interaction which lead to success in school and life. Readiness is built upon a foundation of positive early experiences and learning environments in the home and community.

	School readiness is also viewed as the readiness of school systems to provide opportunities for young children of all backgrounds and cultures to succeed after entry into kindergarten.
Specialized Program	A specialized program is one that is specially designed for and serves a specific group of children who may have similar health, developmental, or language needs.
Standards/ Regulatory Standards	All licensing, certification, and approval standards related to early care and education, including those criteria used by state, military and tribal government agencies, and their contracted authorities; inclusive of all professional development standards and teacher certifications. (See also Program Standards).
Strategy (FTF)	A general method or overall approach used to achieve a goal. First Things First strategies provide direction and are globally defined best practices that positively affect the lives of children and families. Strategies work together and indicate how First Things First will implement goals.
Target Service Number	A Target Service Number represents the number of units (e.g. target population) proposed to be served or the number of products/services proposed to be delivered during the contract year.
Teacher Education and Compensation Helps (T.E.A.C.H) Early Childhood ® Arizona	Teacher Education and Compensation Helps is a nationally licensed professional development scholarship program for early care and education professionals. Licensed by the Child Care Services Association in Raleigh, North Carolina, the Arizona program is called T.E.A.C.H. Early Childhood ®ARIZONA. It provides funding for tuition, books, release time and a financial bonus for eligible scholarship recipients who successfully fulfill their annual T.E.A.C.H. contract commitments.
Technical Assistance (TA)	Technical Assistance is a response to a specific need for information, direct instruction, modeling, or a combination of these, or the request of support from an expert. Strategies for the delivery of TA include consultation (on-site or by phone), training and resource sharing. Technical assistance often includes a written agreement between the TA provider and the requesting person or group. TA may also be offered when performance of contracted services does not conform to service specifications.
Training	Training refers to the acquisition of knowledge, skills, and competencies as a result of the teaching of vocational or practical skills and knowledge that relate to specific useful competencies. The objective may be to develop initial or basic qualifications or to maintain, upgrade and update skills with the specific goals of improving capability, capacity, and performance.

Unit of Service	A Unit of Service is a First Things First 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 contractor is expected to provide as part of an agreement.
Unregulated Child Care Homes	In Arizona, child care providers who care for 4 or fewer children at any given time and accept compensation for any of those children do not need to be licensed or certified to provide care. They are defined as unregulated and are not required to have a criminal or Child Protective Services background check.
Women, Infants and Children (WIC) Program	The Women, Infants and Children's program is a federally funded program providing recipients with nutritious food, nutrition education, and referrals. WIC serves pregnant, breastfeeding, and postpartum women, as well as infants and children under age 5, who meet WIC eligibility guidelines.