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**Northwest Maricopa Regional Partnership  
Council Meeting Agenda and  
Supporting Documentation  
June 21, 2013**



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## Northwest Maricopa Regional Partnership Council Meeting – 06/21/2013

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## Northwest Maricopa Regional Partnership Council Meeting Agenda

June 21, 2013

9:00 a.m. –

*West-MEC, 5487 North 99<sup>th</sup> Avenue, Glendale, Arizona, 85305*

*Pursuant to A.R.S. § 38-431.03 (A) (1), A.R.S. § 38-431.03(A) (2) and A.R.S. § 38-431.03 (A) (3), the Regional Partnership Council may vote to go into Executive Session, which will not be open to the general public, to discuss personnel items, records exempt from public inspection and/or to obtain legal advice.*

*The Regional Partnership Council may hear items on the agenda out of order. The Regional Partnership Council may discuss, consider, or take action regarding any item on the agenda. The Regional Partnership Council may elect to solicit public comment on certain agenda items.*

**The agenda for the meeting is as follows:**

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| <b>1. Welcome, Introductions, and Call to Order</b>                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Dr. Debbie Pischke, Chair</b>                                              |
| <b>2. Call to the Public</b><br><i>This is the time for the public to comment. Members of the Council may not discuss or take legal action regarding matters that are not specifically identified on the agenda. Therefore, pursuant to A.R.S. §38-431.01(H), action taken as a result of public comment will be limited to directing staff to study the matter, responding to any criticism, or scheduling the matter for further consideration and decision at a later date.</i> | <b>Dr. Debbie Pischke, Chair</b>                                              |
| <b>3. Review and Approval of May 17, 2013 Meeting Minutes</b>                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>Dr. Debbie Pischke, Chair</b>                                              |
| <b>4. Presentation on Quality First Model Changes</b>                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Ginger Sandweg, Sr. Director of Early Learning</b>                         |
| <b>5. Developmental Screening Subcommittee Update</b>                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Ashley Flowers, Council Member</b>                                         |
| <b>6. Discussion and Possible Approval of SFY14 Funding Plan Modifications</b> <ul style="list-style-type: none"><li>a. Developmental Screening Strategy</li><li>b. Parent Education Community Based Training Strategy</li></ul>                                                                                                                                                                                                                                                   | <b>Dr. Debbie Pischke, Chair</b>                                              |
| <b>7. Continued Discussion around Systems Building</b>                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>Dr. Debbie Pischke, Chair</b><br><b>Christina Lyons, Regional Director</b> |
| <b>8. SFY14 Chair and Vice Chair Elections</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Christina Lyons, Regional Director</b>                                     |
| <b>9. Director's Update</b> <ul style="list-style-type: none"><li>a. June 10-11 State Board Meeting Update</li><li>b. Benchmarking Update</li><li>c. Family Resource Center Collaboration Update</li><li>d. FTF Organizational and Staffing Changes</li><li>e. FTF Summit</li></ul>                                                                                                                                                                                                | <b>Christina Lyons, Regional Director</b>                                     |
| <b>10. Council Member Updates and Announcements</b>                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Council Members</b>                                                        |
| <b>11. Adjourn</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>Dr. Debbie Pischke, Chair</b>                                              |



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## ATTACHMENT 1

**Arizona Early Childhood Development and Health Board**

**Northwest Maricopa Regional Partnership Council**

**DRAFT Meeting Minutes – May 17, 2013**



**Arizona Early Childhood Development & Health Board**

**Northwest Maricopa Regional Partnership Council**

**March 15, 2013 – *Draft* Meeting Minutes**

**Call to Order**

The Regular Meeting of the First Things First Northwest Maricopa Regional Partnership Council was held on Friday, May 17, 2013 at West-MEC, Board Room, 5487 North 99<sup>th</sup> Avenue, Glendale, Arizona 85305.

Chair Dr. Pischke welcomed everyone and called the meeting to order at approximately 9:10 a.m.

**Members Present:**

Judith Brengi, Patrick Contrades, Ashley Flowers, Margaret Morales, Dr. Deborah Pischke, Jannelle Radoccia, Stacey Cassidy and Lynda Vescio

**Members Absent:**

Annette Johnson

**Call to the Public:**

Erin K. Jeffreys, Parent, Moms Club - Addressed the importance of the Parents as Partners Early Literacy Program. Ms. Jeffreys is a parent and runs a Moms Club in Litchfield Park which consists of about 42 members and they service about 70 children. The Parents as Partners Early Literacy program has added to their organization and has done a great job providing tools for her mom's group. Ms. Jeffreys read a letter from a parent in her Moms group. Ms. Jeffreys' son has been moved by all the great activities they do and has really come to learn and love the PAP staff. Ms. Jeffreys is saddened that the program is ending and encouraged the Northwest Council to consider refunding the program.

Jennifer Whelan, Former Teacher and Parent - Addressed the importance of the Parents as Partners Early Literacy Program. Ms. Whelan has three children, four, two and eleven months old. Ms. Whelan has been attending the PAP Early Literacy events for more than a year. As a former teacher it is difficult to find a program that offers educational tools for both parents and children. There are centers for children to participate in that collate to the books that they read. Ms. Whelan mentioned that her son is allergic to dogs and the program uses a dog called Max that reads to the kids and this has really helped her son with his reading skills. Ms. Whelan and her family encouraged the Northwest Council to consider refunding the program.

Catherine Otto, Director of Parents as Partners Early Literacy Program, SWI – Ms. Otto shared that she received a very exclusive invitation and in August will be speaking with Dr. Rene Casper from Louisiana State University on behalf of the Family Literacy Program that has been initiated in Arizona. This program has been used in early reading first programs and has been very successful. Ms. Otto read a letter from one of the parents whose children attend the PAP program and mentioned that the parent asked for the Northwest Council to consider refunding the program.

Ms. Kimberly Richards, First Teeth First Program Coordinator, Maricopa County Department of Public Health, Offices of Oral Health. Ms. Richards provided Council with some exciting news about the First Teeth First program. On Monday, the First Teeth First program along with a Dental Sealant program did a day of dental in Aguila and Wickenburg. They saw approximately 24 kids at Aguila Elementary and it went very well. There were 3 urgent children and they worked

with local dentists in the area to provide services to the children. The First Teeth First program is reaching the outlining areas.

**Review and Approval of April 19, 2013 Meeting Minutes:**

Vice Chair Contrades made a motion to approve the April 19, 2013 meeting minutes as written. Motion was seconded by Council Member Radoccia and carried out by unanimous vote.

**Discussion with First Things First CEO, Rhian Evans Allvin:**

First Things First, CEO Rhian Allvin updated Council on First Things First business and where things are on a variety of statewide topics.

Research and Evaluation – First Things First started a longitudinal study with three universities and the study was stopped due to some valid concerns. A National Research and Evaluation Advisory panel was convened last spring and after six months of deliberation the panel came back with a host of recommendations on how to approach research and evaluation. They came up with two categories around collecting and analyzing data, creating an administrative data base and layering on a series of studies on top of that. The intent would be to net these data bases to the Department of Economic Security and the Department of Health Services and the first MOU was signed with the Department of Education. The second piece is to analyze the data and they are in the process of creating data dashboards for communities. The first one goes live in August 2013 and is Quality First. The second bunch of recommendations was on targeted specific studies and the first one is related to quality first and will start with a validation study. Chair Dr. Pischke has agreed to participate on the stakeholders group on the statewide kindergarten developmental inventory. The stakeholders group completed their work and is jointly releasing an RFI request for info with Department of Education to go out to potential vendors and other states. There are several options being looked at and the intent is to pilot by the following school year and is a top priority.

The Regional Boundary Taskforce has concluded their work and CEO Allvin thanked Member Contrades for serving on the Taskforce. The recommendations were to keep everything the way it is with three exceptions; to consolidate North Pima and Central Pima in Tucson, to consolidate Central Maricopa and Northeast Maricopa into one Region and to combine the Phoenix regions from three to two. These recommendations will go to the Board at the June Board meeting.

The Board put together a Taskforce around public private partnerships in the fall and Board Member, Nadine Mathis Basha is chairing that Taskforce. The intent is to figure out how to leverage First Things First dollars to bring in additional federal resources and additional national foundation grants. If regions are interested in doing matching grants or applying for grants to support some of the work they are doing in region the intent is to keep regions from competing. It will be necessary to track all of this to make sure the grants are being administered properly.

Updates to Quality First go to the board in June at the June Board meeting. CEO Allvin facilitated two webinars in the last few weeks explaining the updates. The updates include things such as scoring and parameters around intent on how quickly the centers are expected to matriculate up the star rating scale and reformulating scholarships due to a complicating system on how scholarships are administered. There are 216 rates for scholarships and the proposal narrows that down to 4.

In June we will be getting the final report back from St. Luke's Health Initiatives. First Things First partnered with St. Luke's Health Initiatives to have an analysis done on the Arizona Early Intervention system and the report will come back in June. First Things First has a lot of systems work to do to get the early intervention system to where it needs to be. This will at least start to give First Things First a road map on how we can invest due to struggles with that piece of the system.

Budget – Governor Jan Brewer reinstated childcare on Thursday, May 16, 2013. The Senate and Governors budgets matched which is nine million dollars and this is a huge victory for the children of Arizona. First Things First became the safety net and was funding food boxes because of the economic situation. The Legislature zeroed out home visiting, pre-k, all state funding to childcare and for the last three years, First Things First ended up funding and backfilling all the setbacks. There was no state money going in to match the federal funds for childcare subsidies. First Things First went back to the governor in August of 2012 and laid out all that has happened and the commitments that we have made. In January 2014 nine million dollars will be put back into the budget for childcare.

Chair Dr. Pischke presented CEO Allvin with a gift in appreciation for all her hard work at First Things First.

CEO Allvin has accepted the position of Executive Director of the National Association for the Education of Young Children (NAEYC) and her last day at First Things First will be Wednesday, July 3, 2013. NAEYC is headquartered in Washington, DC and CEO Alvin's position in Washington starts on August 12, 2013. This is an exciting time for the early childhood movement across the country and the chance to be part of that effort through NAEYC is an opportunity that doesn't come along often.

CEO Allvin presented Council Member Cassidy with a one year pin and thanked Ms. Cassidy for all her hard work and the hours she dedicates for the Children of Arizona.

#### **Community Outreach Update:**

Regional Director Lyons announced that Angela Rabago-Mussi has been promoted to First Things First, Senior Director and this will be the last meeting she will attend. Director Lyons thanked Rabago-Mussi for all her hard work and dedication.

Community Outreach, Senior Director, Rabago-Mussi mentioned that it was an honor to have been able to work with the Northwest Maricopa Council for the last three years. There has been great progress and all the support that the Council has always had for Community Outreach and Awareness is greatly appreciated. First Things First is working quickly to fill the vacant position, in the meantime Community Outreach Consultant; Angel Aguirre will be available for both the Northwest and Southwest Regions.

Vice Chair Contrades commented that Senior Director, Rabago-Mussi has done a great job and will be spearheading the statewide community outreach efforts for First Things First.

- Outreach Activities: First Things First Community Book Distribution Project -First Things First partnered with local Rotary volunteers to place a First Things First label and a fact sheet in nearly 3,000 books. The Book project took place on Wednesday, May 15<sup>th</sup> at 6 p.m. at All In The Game Sports Center, 7797 W. Paradise Lane, Peoria. Every library in the West Valley will get books to distribute to children and their parents. Rabago-Mussi thanked Council Member Annette Johnson and Vice Chair Contrades for helping at this event.

#### **Community Awareness Subcommittee Update:**

Chair Dr. Pischke moved the order of the agenda due to timing constraints for Senior Director, Rabago-Mussi.

##### **a. Discussion and Possible Approval of SFY14 Community Awareness Plan**

Council Member Vescio provided Council with an update of the Community Outreach & Awareness Plan that was discussed at the May 8, 2013 Community Awareness Subcommittee meeting. Council Member referred Council to attachment #3 of the meeting packet. The Subcommittee agreed with the proposed budget but changed the allotted total cost for the following:

Books – Increased from \$8,000.00 to \$13,000.00

Event Sponsorship – Decreased from \$35,000.00 to \$30,000.00

If the Subcommittee recommendation is approved by Council it will go to the Board at the June Board meeting for possible approval and funds can be used beginning in July of 2013.

**b. Discussion and Possible Approval of SFY14 Community Awareness Budget**

Senior Director Rabago-Mussi referred to the page 18 and 19 of the meeting packet, Community Outreach & Awareness Plan and shared that in the new year 3 year plan there is a more deliberate focus on engagement and building awareness. The new statewide plan is proposing a three tier system of engagement with three different levels of involvement and engagement including friends, supporters and champions. This plan is flexible and Council can come back to it later to possibly add or adjust it.

Council Member Radoccia made a motion to approve and accept the Recommendations of the subcommittee as presented. Motion was seconded by Council Member Brengi and carried out by unanimous vote.

**Presentation by Teen Outreach Pregnancy Services (TOPS):**

TOPS Outreach Coordinator, Ashley Butler updated Council on the TOPS program. Ms. Butler shared a powerpoint with Council and shared some history on who Teen Outreach Pregnancy Services got started. Some of the services that the program provides include case manager, nurse educator, healthy pregnancy classes and many others. Ms. Butler talked about some of the classes that are offered; healthy pregnancy, childbirth education and proactive parenting and provided outreach and referral information. Ms. Butler shared a success story, talked about some of their special events and provided contact information for the program.

*Chair Dr. Pischke adjourned Council Meeting for a short recess at approximately 10:25 a.m.*

*Chair Dr. Pischke reconvened the Council Meeting at 10:35 a.m.*

**Discussion and Possible Action on SFY 2014 Grantee Agreements:**

Chair Dr. Pischke requested verbal declaration of Conflict of Interest and explained that if any Council Member believes that a Conflict of Interest is present the member must disclose that Conflict using the Member Disclosure Form and must sign the Statement of Disqualification at the bottom of the Disclosure Form. Chair Dr. Pischke asked Council Members to state their conflict into the meeting record. Council Members who had a Conflict of Interest were as follows:

Chair Dr. Pischke disclosed a conflict of interest with Agenda Item #7 Grant Agreement – FRC GRA-RC008-14-0622-01.

Chair Dr. Pischke disclosed that she is an employee of the Peoria Unified School District.

Vice Chair Contrades facilitated this portion of the meeting due to Chair Dr. Pischke had a conflict of interest.

**a. Peoria Unified School District FRC (GRA-RC008-12-0622-01)**

Council Member Vescio made a motion to approve grant agreement #GRA-RC008-14-0622-01 with Peoria Unified School District, addressing regional strategy Family Resource Center, for fiscal year 2014 in the amount of \$50,000.00. Motion was seconded by Council Member Radoccia. Chair Dr. Pischke abstained. Motion was carried.

**b. Pendergast Elementary School District FRC (GRA-MULTI-14-0630-01)**

Council Member Vescio made a motion to approve grant agreement #GRA-MULTI-14-0630-01 with Pendergast Elementary School District, addressing regional strategy Family Resource Center, for fiscal year 2014 in the amount of \$100,000.00. Motion was seconded by Council Member Brengi and carried out by unanimous vote.

Chair Dr. Pischke facilitated the remaining portion of the meeting.

**Director's Update:**

**a. Regional Boundary Taskforce**

Regional Director Lyons informed Council that CEO Allvin addressed the Regional Boundary Taskforce update.

**b. Quality First Model Changes**

Regional Director Lyons would like to bring back materials to have a more in depth discussion around the Quality First Model Changes especially since they will impact the budget. Regional Director Lyons will ask First Things First Ginger Sandweg, Quality First Senior Director to speak about Quality First at the June Council Meeting.

**c. April 8-9, 2013 FTF State Board Summary**

There is a copy of the Board Summary in the meeting packet for Council to review. Regional Director Lyons reminded Council that the Summit is coming up. Administrative Assistant Gandara will provide Council with information on how to register as more information is provided. At the June meeting Council will elect the Chair and Vice Chair. Anyone interested in either position should inform Regional Director Lyons.

**Council Member Updates and Announcements:**

Council Member Radoccia informed Council that she resigned from Apostles Lutheran Church on April 30, 2013, is no longer the Director and no longer has Conflicts of Interest. Council Member Radoccia announced that there is a great opportunity to see some of their children in action. Theatre Works is doing 101 Dalmatians in the Northwest Region at the Peoria Center for the arts on beginning on May 31<sup>st</sup> through June 2<sup>nd</sup>, 2013. Council Member Radoccia's daughter will star in the play.

**Call to the Public:**

Leah Eckley, Program Manager, Smart Support – Mental Health Consultation Program, Southwest Human Development – Ms. Eckley updated Council on some things that are happening in the Northwest Region. There are four full time Consultants and they are always full but due to the summer months there are some transitions and they do have some availability. If anyone knows of a center that might benefit from Mental Health Consultation please give Ms. Eckley a call. One of the four Consultants was promoted to the Supervisor position and they are recruiting for a full time Mental Health position for the Northwest Region. The Early Childhood Mental Health Consultation program in Arizona is the largest throughout the Nation. Because of this success SMART Support has been getting a lot of recognition and has been asked to support other states in the Mental Health Consultation programs. The Professional Journal for Infant Mental Health May Issue (0-3) throughout the Nation has featured three articles on how Early Childhood Mental Health Consultation can help children who are in childcare and in foster care. Ms. Eckley would like to attend a Council meeting at a later date to provide more information and answer any questions that the Council might have.

**Adjournment:**

There being no further business, Chair Dr. Pischke adjourned the meeting at 11:08 p.m.



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## ATTACHMENT 2

**Arizona Early Childhood Development and Health Board**

**Northwest Maricopa Regional Partnership Council**

**Quality First Model Change Updates**

**HOLD FOR SFY15 QF UPDATE (PowerPoint)**



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## ATTACHMENT 3

**Arizona Early Childhood Development and Health Board**

**Northwest Maricopa Regional Partnership Council**

**Developmental Screening Documents**



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### **Northwest-Southwest Maricopa Regional Partnership Councils' Developmental Screening Subcommittee Update and Recommendations**

Throughout the month of June the Northwest-Southwest Maricopa Regional Partnership Councils' Developmental Screening Subcommittee met to analyze information relating to developmental screening activities occurring within the two regions and work together to develop an approach to address identified needs.

After reviewing and analyzing data, the Subcommittee determined that the priority needs of the Regions included: access to comprehensive screening activities that included coordinated linkage to evaluation and intervention services, and access to evidence based parent coaching services for children with delays who did not meet the eligibility requirements for state funded early intervention services (AzEIP/ CRS/ DDD).

Upon prioritizing Regional developmental screening needs, the Subcommittee began to review appropriate strategies to best address said needs. After reviewing a variety of approaches, the Subcommittee came to consensus in identifying two strategies: Care Coordination/Medical Home and Children with Special Needs – Parent Coaching. Both strategies are evidence/research based and have shown significant evidence of effectiveness in promoting adequate/timely developmental screenings and in improving families' abilities to support children's healthy development.

At this time, the Northwest-Southwest Maricopa Regional Partnership Councils' Developmental Screening Subcommittee makes the following recommendations for Regional Partnership Councils' consideration and possible approval:

#### **Recommendation 1:**

**Revise SFY14 Funding Plan to add a *Care Coordination/Medical Home Strategy* in the amount of \$200,000 per 12 month calendar year with the intent of providing services to 600 children.**

The medical home model 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. A medical home addresses well-child care, acute care, and chronic care for all children from birth through their transition to adulthood. A medical home is a building block needed to ensure accessible, patient-centered, and coordinated primary care for children. The medical home model is an approach to providing primary care that is focused on the relationship between the patient and the personal clinician. Championed by the American Academy of Pediatrics, the medical home is broadly defined as primary care that is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."

An important component of a medical home is care coordination to provide linkages for children and their families with appropriate medical services and community resources in a coordinated effort to achieve optimal 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.

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 medical practice to assure that children receive appropriate medical care and developmental screening in a culturally and linguistically appropriate manner.

See attached standards of practice for additional information on Care Coordination/Medical Home Strategy.

Care Coordination/Medical Home is currently being implemented in 4 Maricopa Regions.

Care Coordination/Medical Home addresses the following statewide indicators (bolded are regionally identified priority indicators):

1. **#/% children demonstrating school readiness at kindergarten entry in the development domains of social-emotional, language and literacy, cognitive, and motor and physical**
5. % of children with newly identified developmental delays during the kindergarten year
6. #/% of children entering kindergarten exiting preschool special education to regular education
7. #/% of children age 2-4 at a healthy weight (Body Mass Index-BMI)
8. #/% of children receiving at least six well child visits within the first 15 months of life
9. **#/% of children age 5 with untreated tooth decay**
10. **% of families who report they are competent and confident about their ability to support their child's safety, health and well-being**

#### Recommendation 2:

Revise SFY14 Funding Plan to add a *Children with Special Needs-Parent Coaching Strategy* in the amount of \$200,000 per 12 month calendar year with the intent of providing services to 85 children.

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 model of family support for children with special needs to provide individualized support in combination with an interactive parent and child together model of services that includes families and children with similar experiences living in the community.

The fundamental, core components of a parent coaching and support services model for families with children with special needs include:

1. Individual Visits: Visits are 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. Ongoing developmental screening using standardized screening tools are implemented to monitor and assess the child's developmental progress.

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 and to reduce family isolation.
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.

The purpose of this strategy is to meet the needs of individual families specific to their child's developmental needs when a child is developmentally delayed but found ineligible for Arizona's IDEA programs. Although ineligible for IDEA in Arizona, families and their children with developmental delays can benefit from formal supports, services and resources that promote positive developmental outcomes and school readiness.

See attached standards of practice for additional information on Children with Special Needs-Parent Coaching Strategy.

Children with Special Needs-Parent Coaching is currently being implemented in 2 Maricopa Regions.

Children with Special Needs-Parent Coaching addresses the following statewide indicators (bolded are regionally identified priority indicators):

- 1. #/% children demonstrating school readiness at kindergarten entry in the development domains of social-emotional, language and literacy, cognitive, and motor and physical**
5. % of children with newly identified developmental delays during the kindergarten year
6. #/% of children entering kindergarten exiting preschool special education to regular education
8. #/% of children receiving at least six well child visits within the first 15 months of life
- 10. % of families who report they are competent and confident about their ability to support their child's safety, health and well-being**



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### Standards of Practice Care Coordination/Medical Home

#### I. Description of Health Issue

Data shows that many primary care physicians struggle to fulfill the care-coordination needs of children, youth, and families. The medical home model 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. A medical home addresses well-child care, acute care, and chronic care for all children from birth through their transition to adulthood. A medical home is a building block needed to ensure accessible, patient-centered, and coordinated primary care for children. The medical home model is an approach to providing primary care that is focused on the relationship between the patient and the personal clinician. Championed by the American Academy of Pediatrics, the medical home is broadly defined as primary care that is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective." A medical home does not refer to an actual physical place but to an approach to providing health care that assures that patients have access to care, that their care is well coordinated, and that they are engaged in their care, patient centered care.

An important component of a medical home is care coordination to provide linkages for children and their families with appropriate medical services and community resources in a coordinated effort to achieve optimal 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.

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 medical practice to assure that children receive appropriate medical care and developmental screening in a culturally and linguistically appropriate manner.

The National Committee for Quality Assurance (NCQA) has defined these goals as: improving the patient experience, recognizing clinicians for their efforts and providing confidence for purchasers that their dollars are spent on quality care. Read more at:

[http://www.ncqa.org/Portals/0/Programs/Recognition/2011PCMHbrochure\\_web.pdf](http://www.ncqa.org/Portals/0/Programs/Recognition/2011PCMHbrochure_web.pdf)

#### II. Implementation Standards

##### A. Programs implementing care coordination will:

1. Assist a medical practice or group practice to identify:
  - a. Children with special healthcare needs and establish methods for developmental screening, referral and coordination of medical and social services for children as needed;
  - b. Children with complex social risks that require a care coordinator to assist a family in meeting their needs (includes living in a shelter for family violence or homelessness).
2. Assure that the program intake process assesses the strengths and needs of the child and family by:

- a. Using standardized developmental screening tools;
  - b. Assessing children for social, emotional and behavioral risks and ensure they are enrolled into the program;
  - c. Fully engaging with families in the assessment and planning process.
3. Complete an intake assessment and develop a written care plan with 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. The care planning process must include the following:
    - a. Work with families and health providers to assure the details required and goals of the written plan of care. The intensity of care coordination should vary based upon identified needs/desires of the family;
    - b. Periodically review the care plan with the family and identify completion of goals and additional needs that might be addressed;
    - c. Work with the medical practice or group practice referral staff to identify medical and social service referral needs;
    - d. Ensure completion of referral visits and outcomes of those visits;
    - e. Assist the family in following up with referrals as needed.
  4. Facilitate family access to health insurance as needed:
    - a. Provide assistance in e-Health insurance application process
    - b. Provide information regarding community resources
    - c. Promote family independence by working to develop self-care skills
    - d. Lead, facilitate or participate in early intervention team meetings as appropriate
    - e. Advocate for the family
  5. Participate in quality/performance measurement processes related to the care coordination/medical home model.

**B. Care coordination programs will:**

1. Assure that all program staff has the appropriate experience and education to provide care coordination services.
2. Provide ongoing training to program staff to assure quality implementation.
3. Assure that all patient and family information is handled in a confidential manner.
4. Assure that appropriate consent is obtained for service delivery.
5. Collaborate with local agencies/community partners.

It is recommended that well child visits for children age 0-5 years follow the standards for well child visits based upon Early Periodic Screening Diagnostic and Treatment (EPSDT) guidelines. EPSDT funds well-child visits that provide comprehensive health care through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems for enrolled AHCCCS members less than 21 years of age. Standardized forms and guidelines for all EPSDT providers can be found at:

<http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf>

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.

**II. Training and Qualifications Standards**

**Qualifications for a Care Coordinator include:**

- Minimum of a Bachelor's Degree in health care, social work, nursing 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.
- Have training in using valid developmental and sensory screening assessment tools.

#### V. Cultural Competencies

**Programs will also implement the following best practices and standards related to Cultural Competencies:**

- To address cultural competency objectives, early childhood practitioners /early childhood service providers shall ensure that children and families receive from all staff members and program participants' effective, understandable, and respectful care that is provided in a culturally competent manner. Early childhood practitioners /early childhood service providers should ensure that staff and participants 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>
- Service providers should understand individual Tribes/Nations are distinct and separate communities from other Tribes/Nations and their governmental systems and structures are not reflective of each other. Services to Tribal communities and on reservations must be provided in a manner compatible with the Tribe's/Nation's cultural beliefs and practices, to include the preferred language of the community. Services must also be provided in accordance with the Tribe's/Nation's laws, policies and procedures. The effectiveness of services is directly related to the provider's consideration of the beliefs, customs and laws of the Tribe/Nation.
- Service providers can obtain information about providing services on tribal lands from a variety of sources. These include the FTF Regional Director, Regional Council members, tribal websites and publications, as well as official representatives of the Tribe/Nation such as the governing body, standing committees and authorized departments.
- It is highly recommended that service providers seek guidance from one or more of these sources before initiating services on reservations. Failure to do so could result in contraventions of cultural beliefs, Tribal laws or sovereignty.
- The ideal applicant will demonstrate their ability to operate within these parameters through prior experience working with Tribes/Nations, demonstrating that staff are culturally competent, partnerships with agencies serving Native American families, knowledge of cultural beliefs, customs and laws of the Tribe/Nation or a combination of these elements.
- Related to data collection, evaluation or research activities:
  - 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 data from or related to any early childhood development and health program or activities on the reservation.
  - Any grantee implementing programs in tribal communities must have official tribal permission to collect and utilize sensitive data from or related to any early childhood development and health program or activities. Such data can include but not be limited to:
    - Morbidity and mortality among children 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 beginning at age 2 years and each year after that

## V. Evidence based programs

First Things First is committed to funding programs that use research based practice and data-driven decision making, or Evidence Based Programs (EBP). Our emphasis on evidence-based programs is grounded in the idea that the maximum benefit for children and families is delivered by programs that base their practice in the most current, relevant, and reliable evidence about the effectiveness of the program.

The following are considered when deciding on funding programs:

- Evidence based programs (EBP) are programs that have been validated by documented and *scientific research* and the evidence has gone through a peer review process. Evidence is established through scientific research that has had a comparison between an intervention group and a control group where the intervention group has had a significant impact. Peer review means that someone external to the program or research team has reviewed the methodology and the findings to determine if a standard was met.
- A best or promising practice is defined as an intervention that is based on a theory of change and has had some evaluation of the outcomes. This can be based on one program that has been tested in multiple settings.
  - A promising practice cannot be based on the evaluation of a single program even if it has been done for many years in the community and everyone likes it.
- There are many instances where there is not an evidence based program or a promising practice or a particular strategy. The research or evaluation has not been done specifically on the population being served or a new innovative program design is being used. Adaptations of an EBP or implementation of an extension of an EBP can be proposed with justification.

### **Evidence based or best practice models of care coordination**

There are a number of successful national models, which have demonstrated impressive health outcomes for children ages birth through five by offering high-risk families additional supports to access care. Applicants should use one of the following models to provide care coordination services:

1. **Healthy Steps**: The concept of the integrated Healthy Steps Program is to position early childhood development specialists in primary care clinics. The team approach provides the resources medical providers need to coordinate quality care, and provide parents want and need. The Healthy Steps specialist's office will be located next to clinic rooms for "warm hand offs", as well as provider and patient consultation. The Healthy Steps specialist will support the primary medical provider by bringing more specialized knowledge to bear on problems that the medical provider thinks require additional support. The Healthy Steps specialist is the member of the link between a family and their child's provider.
2. **Pediatric Alliance for Coordinated Care (PACC)** - this is the one evidence based program with some support that replication is possible. It includes having clinics that serve children in a medical home model. There are specific standards to follow that include service coordination by a trained staff member of the team within the clinic with families who require coordination of multiple providers, tests and those who have medically at-risk children.
3. **Community based programs** that assist families with children who have complex medical and health care needs to access needed care are included in this strategy to accommodate regional difference.

### **Elements common to each program should include the following:**

- Routine and ongoing developmental screening
- Parental guidance and education
- Well child visits with immunizations
- Support continuity of care for parents and their children
- Interaction with more than one agencies

- Development of a care plan with the family- parental
- Ongoing evaluation of efforts at reaching the targeted population.

## 7I. References and Resources

Antonelli, R., Stille, C., and Freeman, L. Enhancing Collaboration Between Primary and Subspecialty Care Providers for Children and Youth With Special Health Care Needs, Georgetown University Center for Child and Human Development, Washington, DC, 2005.

Antonelli, R., McAllister, J.W., and Popp, J. (2009, May). Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework, The Commonwealth Fund.

Kurt, C., Stange, K.C., Nutting, P.A., Miller, W.L., Jaén, C.R., Crabtree, B.F., Flocke, S.A. and Gill, J.M. (2010). Defining and Measuring the Patient-Centered Medical Home. *J Gen Intern Med.* 2010 June; 25(6): 601–612. Published online 2010 May 14. doi: 10.1007/s11606-010-1291-3.

McCarthy, D., Nuzum, R., Mika, S. et al. (2008). The North Dakota Experience: Achieving High-Performance Health Care Through Rural Innovation and Cooperation. May 15, 2008 | Volume 93. The Commonwealth Fund. <http://www.commonwealthfund.org/Publications/Fund-Reports/2008/May/The-North-Dakota-Experience--Achieving-High-Performance-Health-Care-Through-Rural-Innovation-and-Coo.aspx>

National Committee for Quality Assurance (NCQA) in 2011. Patient Centered Medical Home. Found at: <http://www.ncqa.org/tabid/631/default.aspx>

National Quality Forum standards for Care Coordination; can be found at: [http://www.qualityforum.org/projects/care\\_coordination.aspx](http://www.qualityforum.org/projects/care_coordination.aspx)

Scholle, S.H., Sampsel, S.L., Davis, N.E.P., (2009). Quality of Child Health Care: Expanding the Scope and Flexibility of Measurement Approaches. The Commonwealth Fund Report. Found at <http://www.ncqa.org/tabid/1402/Default.aspx?q=pediatric+care+coordinantion>

**STANDARDS OF PRACTICE**

**Family Support – Children with Special Needs**

**I. Strategy Description**

The Individuals with Disabilities Education Act (IDEA) is a law ensuring services to children with disabilities throughout the nation. IDEA governs how states and public agencies provide early intervention, special education and related services to more than 6.5 million eligible infants, toddlers, children and youth with disabilities. Infants and toddlers with disabilities (birth-2) and their families receive early intervention services under IDEA Part C. Children and youth (ages 3-21) receive special education and related services under IDEA Part

**B.**

IDEA Part C and Part B are currently implemented in Arizona. The Arizona Early Intervention Program (AzEIP) is Arizona's statewide, interagency system of supports and services for infants and toddlers with developmental delays or disabilities and their families. AzEIP was established and receives funding through IDEA Part C and is the program within the Arizona Department of Economic Security (DES) designated to fulfill lead agency functions and responsibilities for early intervention. AzEIP service providing agencies are those state agencies identified in Arizona law that provide early intervention services under IDEA, Part C and include the Arizona State Schools for the Deaf and the Blind (ASDB); and DES through DES/AzEIP and DES, Division of Developmental Disabilities (DES/DDD). ASDB educates children and youth with hearing or vision loss. DDD provides services and supports to help eligible individuals with developmental disabilities achieve self-sufficiency and independence. DDD also offers supports for family members and other caregivers. Under IDEA Part B, The Arizona Department of Education (ADE) Exceptional Student Services division, receives funding and provides special education services to children three years of age through 21 years of age.

Each of the service agencies, DES/AzEIP, ASDB, DES/DDD and ADE have different eligibility requirements and services are delivered by both public and private providers. The State of Arizona defines eligibility for supports and services through AzEIP as a child between birth and 36 months of age who is developmentally delayed or who has an established condition which has a high probability of resulting in a developmental delay, as defined by the State. A child is considered to be developmentally delayed when they have not reached 50% of the developmental milestones, expected at their chronological age, in one or more of the following areas of developmental: cognitive, physical, communication, social or emotional and adaptive. Established conditions which have a high probability of developmental delay include, but are not limited to: chromosomal abnormalities, metabolic disorders, hydrocephalus, spina bifida, grade 30 or 4 intraventricular hemorrhage, periventricular leukomalacia, cerebral palsy, significant auditory impairment, significant visual impairment, failure to thrive, or severe attachment disorders. The determination that a child has an established condition, and therefore eligible for AzEIP supports and services, is based on diagnosis by a qualified physician or other qualified professional who can provide an informed clinical opinion.

ASDB serves children under the age of three who have a hearing impairment, which is a permanent bilateral loss of hearing acuity, as determined by an audiologist; and/ or a visual impairment, which means a permanent bilateral loss in visual acuity or a loss of visual field, as determined by an ophthalmological evaluation, that interferes with the child's development.

For DDD, a child under the age of six may be eligible for services if there is a strongly demonstrated potential that the child is or will become developmentally disabled as determined by appropriate evaluations. DDD defines developmental disabilities as cognitive disability, cerebral palsy, epilepsy, or autism.

A child who enters the public preschool setting as a student with a disability will need to qualify for special education services based on the results of evaluations and information gathered in seven areas: vision, hearing, cognitive development, physical development, communication development, adaptive development, and social and emotional

development. A child must meet criteria for one of the following special education classifications, described in ARS §15-761: Preschool Moderate Delay, Preschool Severe Delay, Preschool Speech/Language Delay, Hearing Impaired, or Visually Impaired. For the most part, infants, toddlers and preschoolers who are at-risk for developmental delay but do not meet the varying eligibilities do not receive any formal supports or services.

A wide range of referral sources also exist in Arizona. For example, pediatricians, family practice physicians, social workers, hospital personnel, child care providers, local schools (child find), or even families themselves can refer a child for determination of eligibility. When a family has a concern about their child's development they typically share that concern with the child's health care professional, child care provider, or school program. The entity receiving the family's concern may then screen the child to determine if a referral to the Part C or Part B provider is appropriate and send a referral accordingly for evaluation to determine eligibility.

The evaluation process of a child's development by an 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 due to inconsistent or lack of use of standardized screening tools. 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. For example, families may not be aware of the importance of early childhood development, such as the rapid and sophisticated brain development that occurs in the first five years of life and how early experiences and strong, positive relationships set the foundation for later success in school and life. As identified in the *First Things First Family and Community Survey on Early Childhood, A Baseline Report on Families and Coordination 2008*, "While Arizona's parents understand the importance of early brain development, not all are sure what they can do to best support their child's optimal development." For those children who are even mildly developmentally delayed, they can benefit from their parents and families increased competence and confidence to support their development.

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 model of family support for children with special needs to provide individualized support in combination with an interactive parent and child together model of services that includes families and children with similar experiences living in the community.

**The fundamental, core components of a parent coaching and support services model for families with children with special needs include:**

5. Individual Visits: Visits are 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.
6. Ongoing Child Progress Monitoring and Screening: Families are encouraged to develop skills around recognizing how to observe and understand their child's development. Ongoing developmental screening using standardized screening tools are implemented to monitor and assess the child's developmental progress.
7. 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 and to reduce family isolation.
8. 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.

The purpose of this strategy is to meet the needs of individual families specific to their child's developmental needs when a child is developmentally delayed but found ineligible for Arizona's IDEA programs. Although ineligible for IDEA in Arizona, families and their children with developmental delays can benefit from formal supports, services and resources that promote positive developmental outcomes and school readiness.

## **II. Implementation Standards**

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 and the significance of their role as their child's first and foremost teacher. Coaching is directed toward expanding parenting skills and knowledge rather than provision of therapy services to a child. This comprehensive model includes the four components: Individual Visits, Monitoring of Children's Progress, Parent and Child Interactive Time, and Networking and Coordination of Services. 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. Frequency of visits may vary dependent on the specific needs of the family. Research has demonstrated a clear connection between program intensity and retention of families. At minimum, one face to face visit for at least one hour will be conducted each month of program participation. 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. One parent group activity for a minimum of 2 hours will be conducted each month of service delivery.

### **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.
- 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.
- 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.
- 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.
- Parent coaches shall create a family profile to be reviewed regularly with the family to maintain 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.
- Plan 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's development and encouraged to keep records of developmental progress to better understand their child's growth.
- In addition 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(National Resource Center for Permanency and Family Connections, 2009):
  - **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.

## 2. Monitoring of Children's Progress

- 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.
- Empower families to navigate a complex system of service delivery and programs for children with developmental delays.

## 3. 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 supporting families in recognizing their role as their children's primary teacher as well as giving 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.
- Facilitate group meetings with families to provide information about parenting skills, child development, child health, adult-child interactions, opportunities to discuss 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.

### III. Staff Qualifications, Supervision and Professional Development Standards

#### Staff Qualifications

Providing Parent coaching services requires specific education and skills:

- Parent coaches must have at minimum a bachelor's degree in a field related to early childhood education, early childhood special education, child and family studies, social work, or adult education.
- Parent coaches must have areas of knowledge and competencies demonstrated in:
  - a. Child development; typical and delayed 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. Facilitation of group learning
  - h. Adult education
- Supervisors and parent coaching staff (including supervisors, direct service staff, volunteers and sub-grantee or partner personnel implementing the strategy) will have access to and receive training on the utilization of the Arizona Infant and Toddler Developmental Guidelines ( August 2012) and the Arizona Early Learning Standards.
- 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 standard of practice.

#### Supervision, Quality Assurance and Evaluation Standards

- Supervision of 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.
- To ensure quality services, caseload size for each parent coach is based upon:
  - How many hours per week the parent coach 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, 15 families is the maximum caseload for a parent coach providing individual home visits and group meetings. Geographic proximity/ travel time to families served, duration and intensity of visits and documentation requirements should be considered for manageable caseload sizes.
- Evaluation of consultation services utilizes a 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.

#### IV. Cultural Competency

##### **Affirm, strengthen and 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.
- 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.
- 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>
- Service providers should understand individual Tribes/Nations are distinct and separate communities from other Tribes/Nations and their governmental systems and structures are not reflective of each other. Services to Tribal communities and on reservations must be provided in a manner compatible with the Tribe's/Nation's cultural beliefs and practices, to include the preferred language of the community. Services must also be provided in accordance with the Tribe's/Nation's laws, policies and procedures. The effectiveness of services is directly related to the provider's consideration of the beliefs, customs and laws of the Tribe/Nation.
- Service providers can obtain information about providing services on tribal lands from a variety of sources. These include the FTF Regional Director, Regional Council members, tribal websites and publications, as well as official representatives of the Tribe/Nation such as the governing body, standing committees and authorized departments. It is highly recommended that service providers seek guidance from one or more of these sources before initiating services on reservations. Failure to do so could result in contraventions of cultural beliefs, Tribal laws or sovereignty.
- Programs will demonstrate their ability to operate within these parameters through prior experience working with Tribes/Nations, demonstrating that staff are culturally competent, partnerships with agencies serving Native American families, knowledge of cultural beliefs, customs and laws of the Tribe/Nation or a combination of these elements.
- Related to data collection, evaluation or research activities:
  - 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 data from or related to any early childhood development and health program or activities on the reservation.

Any grantee implementing programs in tribal communities must have official tribal permission to collect and utilize sensitive data from or related to any early childhood development and health program or activities.

##### **Developmental and Sensory Screening: Approaches By Region**

Approach: Care Coordination/Medical Home

Summary:

The American Academy of Pediatrics describes a medical home as a model of delivering primary care *that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care*. An important component of a medical home is care coordination to provide linkages for children and their families with appropriate medical services and community resources in a coordinated effort to achieve optimal 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.

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 medical practice to assure that children receive appropriate medical care and developmental screening in a culturally and linguistically appropriate manner.

**Central Phoenix:**

Approach: Purchasing of Sensory Screening Equipment for Providers to Share/Borrow

Summary:

Purchase and maintain costly sensory screening equipment for community partners to share/borrow as needed.

**Central Phoenix / North Phoenix:**

Approach: Providing Sensory Screenings

Summary:

Provide high quality vision and hearing screening for children age birth through five and provides comprehensive follow up to ensure that children with vision and hearing conditions are identified and linked with appropriate services.

**Central Phoenix / Northeast Maricopa:**

Approach: Family Support - Children with Special Needs

Summary:

Expand families' access to the information, services and supports they need to help their young children achieve their fullest potential. To make the best choices, families need access to information that educates them about what their child is learning and doing, how to optimally support early childhood development and child health and what resources or programs are available in their community. Families also need opportunities to connect with other families in their community. The continuum of high-quality services and support will be planned, developed, funded, and delivered in a family-centered, comprehensive, collaborative, culturally and linguistically responsive manner that best meets the needs and preferences of families, leverages available resources, and involves families in the program development and implementation. As a result of First Things First's efforts, families who need or want assistance have the support they need to use language and play throughout their daily routines and interactions, read with their children daily and increase their competence and confidence about their ability to support their child's safety, health and well-being.

**All Regions:**

Approach: Home Visitation



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## ATTACHMENT 4

**Arizona Early Childhood Development and Health Board**

**Northwest Maricopa Regional Partnership Council**

**SFY2014 Funding Plan Implementation Documents**

## Northwest Maricopa: SFY 2014 – 2016 Funding Plan

Allocations and Funding Sources	SYF2014	SFY2015 estimates	SFY2016 estimates
FY Allocation	<b>\$10,288,819</b>	\$10,324,546	\$10,324,546
Carry Forward From Previous Year	<b>\$4,317,215</b>	\$2,991,577	\$948,621
<b>Total Regional Council Funds Available</b>	<b>\$14,606,034</b>	<b>\$13,316,123</b>	<b>\$11,273,167</b>
Strategies	Approved Changes	Proposed Allotment	Proposed Allotment
Quality First	<b>\$1,160,225</b>	\$1,276,134	\$1,276,134
Scholarships TEACH	<b>\$160,000</b>	\$160,000	\$160,000
Child Care Health Consultation	<b>\$171,234</b>	\$170,871	\$170,871
Quality First Child Care Scholarships	<b>\$4,082,420</b>	\$4,329,739	\$4,329,739
Mental Health Consultation	<b>\$492,000</b>	\$492,000	\$492,000
Pre-Kindergarten Scholarships	<b>\$1,446,720</b>	\$1,808,400	\$1,808,400
Nutrition/Obesity/Physical Activity	<b>\$650,000</b>	\$600,000	\$600,000
Oral Health	<b>\$400,000</b>	\$400,000	\$400,000
Scholarships non-TEACH	<b>\$45,945</b>	\$45,945	\$45,945
Recruitment into Field	<b>\$280,000</b>	\$280,000	\$280,000
Recruitment – Stipends/Loan Forgiveness			
Home Visitation	<b>\$500,000</b>	\$500,000	\$500,000
Family Resource Centers	<b>\$725,000</b>	\$725,000	\$725,000
Parent Education Community-Based Training	<b>\$300,000</b>	\$300,000	\$300,000
Food Security	<b>\$100,000</b>	\$100,000	\$100,000
Service Coordination	<b>\$75,000</b>	\$75,000	\$75,000
Community Awareness	<b>\$75,000</b>	\$75,000	\$75,000
Community Outreach	<b>\$77,000</b>	\$77,000	\$77,000
Media	<b>\$200,000</b>	\$200,000	\$200,000
Needs and Assets			
Statewide Evaluation	<b>\$673,913</b>	\$752,413	\$752,413
<b>Total</b>	<b>\$11,614,457</b>	<b>\$12,367,502</b>	<b>\$12,367,502</b>
<b>Total Unallotted</b>	<b>\$2,991,577</b>	<b>\$948,621</b>	<b>(\$1,094,335)</b>

## FAMILY SUPPORT AND LITERACY

### STRATEGY: COMMUNITY BASED TRAINING – PARENT EDUCATION

STRATEGY SUMMARY	EVIDENCE / RESEARCH	CONSIDERATIONS FOR IMPLEMENTATION AND COST	COST
<p>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 <b>a series of classes</b> that provide information and support in each of the core areas: child development, parenting skills, and resource and referral. A parent education program that has an evidence base and a proven track record with the target population should be utilized and implemented. Examples include: The Incredible Years: Parents and Children Training Series, Nurturing Parenting Program and Growing Great Kids.</p> <p>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 development, knowledge of parenting and of child development including social emotional, language and literacy, cognitive, physical and motor development, parental resilience, and social connections and awareness of support mechanisms available for parents.</p> <p>Additionally, families should be supported to understand that daily exposure to verbal and</p>	<p>Research indicates that community based education programs who involve both parents and their young children in a series of classes demonstrate a positive impact upon outcomes. Parent Education programs have <b>the most impact with families of older toddlers and young preschoolers (2.5 years through 3 years of age)</b> as families may naturally begin to seek out opportunities outside of their home environments to reduce isolation. Infants and toddlers, themselves, benefit from the new experiences and environments that community based programming can offer. 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.</p> <p>Some parenting curriculum is more effective with specific target populations and should be reviewed thoroughly before selection.</p> <p>From <b>Evidence-Based</b></p>	<p><u>Capacity for Expansion</u> 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 programs.</p> <p><u>Links to Other Strategies</u> 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. 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.</p> <p><u>Timeline for Implementation</u> Establishing a new program</p>	<p>Costs will vary depending upon program approach: adult-only or adult and child sessions, frequency and duration of each series and individual class session. Estimate <b>\$2000 to \$3000 per family on an annual basis</b>. Costs may include: Staff Staff Training Outreach and Promotion Curriculum Program Supplies and Materials Incentives. Transportation Child Care Space</p>

<p>written language provides young children with the opportunities to begin acquiring a basic understanding of the concepts of <b>literacy</b> and its functions. Through play, children learn to create meaning from language and communicate with others using verbal and non-verbal language, pictures, symbols and print. Environments rich with print, language, storytelling, books, technology, and writing materials allow children to experience the joy and power associated with reading and writing, while mastering basic concepts about print. Programs are respectful and supportive of children’s cultural heritages and home languages while encouraging English language acquisition. The abilities to listen, speak, read, and write emerge interdependently in Environments designed to meet each child’s unique skills, abilities, interests, and needs.</p> <p>Family participation in community-based family education services is voluntary and must be provided free of charge to the family.</p>	<p><b>Parenting Education Programs</b>  <b>Literature Search</b>  September 2005  “Evidence-based parenting education programs are those that have been studied in both controlled, clinical trials and community Settings and have demonstrated specific, expected outcomes. However, the effectiveness of any parent training program will be dependent upon selecting a model that is appropriate for the given population and implemented with fidelity. It is important to note that many programs which lack a formal or “confirmed” evidence base may still produce desired outcomes and improvements for its participants.”</p> <p>Families can learn:</p> <ul style="list-style-type: none"> <li>- parenting skills</li> <li>- non-violent discipline techniques</li> <li>- to support child-directed play</li> <li>- interaction and play techniques</li> </ul>	<p>may take 3 to 6 months prior to enrollment of families due to staff recruitment, training, material development and availability, marketing/ outreach and securing of space/ locations for family education sessions.</p> <p><u>System-building Issues and Recommended Saturation Level</u>  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.</p>	
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Parent Education – Community Based Training addresses the following statewide indicators (bolded are regionally identified priority indicators):

- 1. #/% children demonstrating school readiness at kindergarten entry in the development domains of social-emotional, language and literacy, cognitive, and motor and physical**
- 10. % of families who report they are competent and confident about their ability to support their child’s safety, health and well-being**

**Parent Education / Parent Awareness Activities occurring in Northwest Maricopa**

**General Parent Education:**

Benevilla	Active Parenting: 1,2,3,4, Parents! Active Parenting: 1,2,3,4 Padres! Nurturing Families Salud con Sabor Latino	450 Families
Pendergast FRC	Learning Basket Common Sense Parenting The Incredible Years 1, 2, 3, Magic	250 Families
Glendale Elementary FRC	Learning Basket Parenting Now	200 Families

**Targeted Parent Education:**

Benevilla (Grandparents Raising Grandchildren)	Second Time Around / Powerful Families / Active Parenting: 1,2,3,4 Padres!	250 Families
Teen Outreach Pregnancy Services (Pregnant and Parenting Teens)	TOPS Curriculum	250 Teens
Maricopa County Department of Public Health (Nutrition Education)	Color Me Healthy – Child Nutrition and Physical Activity Promotion/ Child Passenger Safety Training	900 Families
Benevilla (Children with Special Needs)	Nurturing Families – Special Needs and Health Challenges	100 Families

**Parent Awareness / Family Support-Education Activities:**

Benevilla	Parenting Workshops / School Readiness Workshops / Literacy Events / Purposeful Play Groups / Coffee Talks / Songersize / Support Groups	5000 Families
Glendale Elementary	Parenting Workshops / School Readiness Workshops / Literacy and Mathematic Series / English Language Classes / Financial Literacy	400 Families
Pendergast	Parenting Workshops / School Readiness Workshops / Mommy and Me Classes/ Literacy and Mathematic Series / English Language Classes	900 Families
Peoria	Parenting Workshops / School Readiness Workshops / Literacy Events / Nutrition Workshops/ Play Groups / Songersize	300 Families
Public Libraries	Literacy Events	NW Maricopa Regional Partnership Council provided 3000 books to support summer reading
Valley of the Sun United Way	Readiness Basket	100 Families



# FIRST THINGS FIRST

*Ready for School. Set for Life.*

[azftf.gov](http://azftf.gov)

## ATTACHMENT 5

**Arizona Early Childhood Development and Health Board**

**Northwest Maricopa Regional Partnership Council**

**System Building Documents**

# Systems Building: Northwest Maricopa Regional Partnership Council

## Responses to System Building Questions (03/2013)

### Q. What has been accomplished up to this point?

- Service Providers working together to reach similar audiences and piggy backing with other state funded agencies that are not funded with First Things First. Coordination and communication.
- Awareness and increased knowledge of assets in the community and coordination.
- Cooperation knowledge breaking down some of the silos.
- The school district verses private child care conversations and the doors that have opened up. Breaking down schools and private communication, focusing on the child not the program.
- Cross referrals.
- Leveraging dollars.
- Raising awareness of the importance of Early Childhood.
- Breaking down barriers.
- Bringing nontraditional partners to the table.
- Networking and working together to make common goals.
- Shared knowledge, resources and information.
- Working on raising standards.
- Increased importance of quality and disregard for quality.

### Q. Besides the Council, who else is funding early childhood programs in the Northwest Maricopa Region and has any level of partnering occurred with the identified funders?

- Parents
- Faith Community
- Other State Agencies
- Non Profits
- Federal Government
- Mosiac
- Dental Providers
- Health Community
- Public Schools
- Charter Schools
- Higher Education
- Private Businesses

### Q. How has the Council worked or interacted with their Regional Service providers out in the Community?

- They come to us.
- Community Outreach.
- Grantee Meetings.
- Being in community, personal interactions, and networks.

**Q. Who needs to be brought to the table in order for the Council to establish a successful childhood system?**

- Legislators
- Community Leaders
- Policy Makers
- School Boards
- City
- Early Interventionists
- Health and Dental Providers
- Local Chambers
- Small Businesses
- Civic Groups
- ADE
- Philanthropic Community

**Q. What barriers and gaps exist that hinder system building in the Northwest Maricopa Region?**

- Large geographic size of region.
- No sense of urgency.
- First point of contact is not always familiar with First Things First.
- Results take time – nothing is instantaneous.
- No clear definition of what “school readiness” is.
- Political environment.
- Lack of engagement of policy makers. Lack of knowledge among policy makers on the importance of early childhood.
- Limited funding focused on early childhood.