FIRST THINGS FIRST
Ready for School. Set for Life.

March 20, 2012
First Things First
4000 North Central Avenue, Suite 800
Phoenix, Arizona 85012

MEETING MINUTES & SUMMARY OF DISCUSSION

Developmental Screening Sub-Committee

Committee Members in Attendance	Jacquelyn Power, Chair, Patty Merk, Carlo Saldana and Ginger Ward
Committee Members Attending Telephonically	Karen Applequist, Becky Raabe, and Roy Teramoto
Staff Members in Attendance	Karen Peifer and Sandy Foreman, Leads. Tracey Craig, Cami Ehler, Amy Kemp, Michelle Katona, Kelley Murphy, Elsa Romero, Beverly Russell, K. Vilay and Karen Woodhouse
Telephonic contributor	Leslie Anderson, Leslie Anderson Consulting, Inc.

Call to Order
The regular meeting of the First Things First – Arizona Early Childhood Development and Health Board, Developmental Screening Sub-Committee was held on Tuesday, March 20, 2012 at the First Things First Board Room, 4000 North Central Avenue, Suite 800, Phoenix, Arizona 85012. The meeting was called to order by Chair Jacquelyn Power at approximately 1:35 p.m. A brief welcome was made by Chair Power; everyone in attendance introduced themselves and the organization which they represent.

Review of Sub-Committee Structure and Roles
Karen Peifer, Sr. Director of Children's Health began by reviewing the intent of the meeting which was to begin the conversation around Indicators 5 & 6. Reviewed the timeline for choosing benchmarks with 2020 as the goal.

Developing State Level Benchmarks for School Readiness Indicators

Indicator 5- % of children with newly identified developmental delays during the kindergarten year

1. **WHAT DO WE KNOW ABOUT THE DATA?**

A request was made to Arizona Department of Education (ADE) to identify children who were newly identified with developmental delays during the kindergarten year. The results of this request indicate that 4.5% of children enrolled in kindergarten were newly identified.

Dr. Amy Kemp, Sr. Director of Evaluation Research provided information regarding data from the Department of Education, which does not include data for the Native American population.

Dr. Roy Teramoto, Maternal and Child Health Coordinator, Indian Health Services stated that there are three separate HIS service areas, Phoenix, Navajo and Tucson. The Navajo Nation Service area includes other states which makes difficult to separate data.

Dr. Power, Superintendent of Schools, Bureau of Indian Education (BIE) stated that the Native American population does have a high representation of children in special education services in Bureau schools and that they would not necessarily be represented in the ADE data. She also stated that they know that many children have been incorrectly identified as needing special education in that system. They have begun using a Response to Intervention (RTI) during the early phases of identification of children before making a determination of an actual delay. More serious learning delays are determined by schools with considerable discretion in how to treat.

The BIE does refer children with more serious developmental delays to AZEIP but that many children receive enrichment services through the FACES program. The majority of delays are communication delays.

The FACES program has 20 years of data that includes Head Start, Early Heat Start and BIE schools. She proposed making a connection for FTF to the representative to the FACES data. Screening for hearing is mandatory but vision screening it not.

Migrant education data is also not included in ADE data.

2. **METHODOLOGY FOR DATA**

There was a brief discussion on the data extraction methodology which was acceptable but the limitations of the data were discussed.

3. **IS THIS DATA ADEQUATE FOR SETTING A STATE LEVEL BENCHMARK?**

Dr. Peifer asked what can be determined by the statewide ADE data. Is this an adequate representation of general population and can this be used as starting place in determining a benchmark?

The discussion centered on how there are multiple systems- Part C, Part B, BIE, DES, IHS- and that kindergarten is not mandatory. The timing of the assessment for developmental delays and learning delays that varies during the kindergarten year that makes the wording of this indicator circumspect.

4. **IS THERE A BASELINE OR TREND LINE?**

Will request ADE data for 2009, 2010 and 2011 for the next meeting and information will be provided if possible. Benchmark for year 2020 is goal. Also review data next two years follow trend line. ADE data is data for newly identified children in kindergarten, possible distinction of data may be needed from IHS.

Dr. Peifer mentioned that North Carolina has survey data that is similar to Arizona. (*North Carolina uses the % of children who receive early intervention/special education services at 0-2 and 3-5 years old- they expect the % to increase as a result of more screening- still it misses those who do not meet the EI criteria but have some delays)*

Karen Applequist, Northern Arizona University asked if data from AzEIP would help inform the trend line, eligibility requirements different at AzEIP, preschool and kindergarten.

5. **WHAT ELSE IS NEEDED FROM THE EXISTING DATA SOURCE TO MAKE A STRONG JUSTIFICATION FOR DEVELOPING A BENCHMARK BASED ON THIS DATA?**

Dr. Kemp has responded with the following: Developmental screening – we currently hold (from regional needs and assets requests) counts of Children Referred and Children Receiving Services for AzEIP by county; Head Start grantee level data on total children with IFSP, IEP, screenings, children needing follow-up from screening; and the ADE data for 2010 already shared.

ITEMS FOR FURTHER CONSIDERATION:

Further consideration about the wording of this indicator is needed. Dr. Peifer, Ms. Forman and K Vilay will take this discussion back to the co-chairs of the advisory committees for consideration.

Indicator 6; # of children entering kindergarten exiting Part B special education to regular education.

1. **WHAT DO WE KNOW ABOUT THE DATA?**

The ADE data extraction found that 9868 children exited Part B special education services when they entered kindergarten

The NCSHCN data asked how many children required early intervention services when they entered kindergarten. It assumes that the children had received early intervention services (Part B) and that they continued to need an EI when they entered kindergarten which is different than what our indicator is asking. Also, there was a change from 3.6% in the 2005-6 survey to 10.2% in the 2009-10 survey which is a big jump.

2. **METHODOLOGY FOR DATA**

The data extraction methodology was discussed and accepted however, the meaning behind the actual number was in question.

3. **IS THIS DATA ADEQUATE FOR SETTING A STATE LEVEL BENCHMARK?**

It was suggested that a denominator is needed to calculate a percentage in order to set a baseline for this indicator. The number of children entering kindergarten could be used as a denominator.

4. **IS THERE A BASELINE OR TREND LINE?**

Not yet. More data points are needed from ADE to determine a benchmark for this indicator. If there is a change in the language of the indicator to reflect the number of children who were functioning at a level comparable to same aged peers at the time they exited kindergarten it might be a reasonable place to start setting a benchmark.

The data use useful in setting a bechnmark since it is statewide and school disctrict specfici. It could be used to establish regional behcnmarks as well.

5. **WHAT ELSE IS NEEDED FROM THE EXISTING DATA SOURCE TO MAKE A STRONG JUSTIFICATION FOR DEVELOPING A BENCHMARK BASED ON THIS DATA?**

Additional ADE data is needed to set a benchmark or the language of the indicators should be adjusted to be able to use the existing data.

Adjournment

There being no further business the meeting was Member Merk motioned for adjournment. Member Saldana seconded. Meeting adjourned at approximately 12:00 p.m.

SUBMITTED

Elsa Romero, Executive Staff Assistant

APPROVED

Karen Peifer, Sr. Director of Children's Health

COMMITTEE APPROVAL

Jacquelyn Power, Chair