Resource Toolkit for Programs Serving Infants, Toddlers and Their Families:

Implementing a Research-Based Program Model

the Ounce

June, 2009

McCormick Foundation

The Toolkit was produced with the generous support from the McCormick Foundation.

June, 2009

Dear Program Staff:

Thanks to the generous support of the McCormick Foundation, we are excited to present you with a new, updated version of the Resource Toolkit for Infant and Toddler Programs. It was in 2006 that the Birth to Three Program Quality Workgroup of the Illinois Early Learning Council (ELC) produced the first Resource Toolkit. The original version was created with extensive input over a five-year period from key state funders, program administrators, practitioners, advocates and program model experts. Staff from the Ounce of Prevention Fund's Training Institute, along with many original ELC members and program model experts, have worked over the past year to update the Toolkit. The new Toolkit has been revised from a training and technical assistance perspective. However, this version was created with a deliberate effort to preserve the original intent of those serving on the Early Learning Council and representatives from all major constituencies. While the original work group has since disbanded, the Ounce of Prevention Fund's Training Institute will now continue to update the Toolkit as we move together into the future, navigating the rapidly evolving landscape of support for Illinois families with children birth to three.

You will note that the Resource Toolkit provides in-depth information on a variety of program models, references to additional materials, resources for becoming affiliated with these models, and crosswalks showing how these models map to current program standards for publicly funded programs. Program models addressed in this Toolkit include: Parents As Teachers, Healthy Families, Nurse Family Partnership, Baby Talk and center-based programs for Chicago Public Schools and others that meet criteria as set by NAEYC. The program models presented in the Toolkit are all similar in that they each meet criteria of intensive, comprehensive, research-based models, while taking a slightly different approach to serving infants and toddlers and their families.

Whether your program is applying for Early Childhood Block Grant funding through the Illinois State Board of Education or Chicago Public Schools, the Illinois Department of Human Services or from any other source, this Toolkit will be a valued resource to ensure alignment of your program design with one or more of the program models recognized as eligible for public funding. In some cases, this Resource Toolkit will help you become familiar with several research-based models with infrastructure and support in Illinois and to help you think about choosing a model that is the best fit for your program. Your existing program may be well underway or making a transition to an evidence-based program model. In these cases, this Toolkit can be a good resource of self-assessment of current practice and assist you to determine next steps toward quality improvement. These are just a few of the ways this Toolkit can be useful to you and your staff in progressive achievement of our shared goal for the best possible quality of services for young families through a high degree of model fidelity in program structure and practice.

Consider this version of the Resource Toolkit 'a work in progress' that is reliant on what each of us learns from work with families and their children, implementation of programs by community agencies and practitioners and new research findings. We welcome all feedback that you may have to inform future revisions to the Resource Toolkit for Programs Serving Infants, Toddlers and Their Families.

Sincerely,

The Ounce of Prevention Fund Training Institute

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Purposes for the Resource Toolkit

Agencies who serve Illinois families are becoming increasingly aware that government entities who oversee public funding for birth to three programs are being required by law to fund programs who serve only "the most at risk parents" in Illinois communities. Along with this requirement comes a second requirement that programs only use only an approved research-based model. Therefore, many Illinois agencies are ready to move to a research-based model and began focusing on serving families in the "most at risk" category. The Resource Toolkit is a guide for agencies as they assess the quality of their own programs, and consider the connection between their program's goals and services and the features of a research-based model. The primary purpose of the Toolkit is to aid programs in the decision making process around selecting a model that is best for them and thereby improving the overall quality and value of their program.

Ways the Resource Toolkit May Be Used

As a Technical Assistance Manual: The Toolkit can be used to guide program directors and key stakeholders into specific and detailed answers about program functions and features. As decision makers begin using a logic model to determine what kind of program would best serve their community and agency, the toolkit is a reference for technical information needed to assess the efficacy of those features against the existing program components now being used.

For New or Returning Applicants for Public Funding: Applicants for state or federal grants will need to use very specific language to describe what services they will provide and how they will impact at risk families in their communities. The Toolkit will help applicants be detailed in their language and descriptive in their applications using terms that those reading and scoring applications can readily identify. Applicants will be more prepared to address the specifics required to apply successfully for funding.

For Measuring or Assessing Existing Program Quality: Programs are well served by assessing the current status of their own program quality and identifying specific ways to enhance services they already provide. In other instances, agencies may wish to initiate new programs to serve birth to three at risk children. The Toolkit is useful when developing a set of quality indicators for this purpose because the various crosswalks included describe not only what quality "looks like" within a research-based model, but what it looks like across all models.

For Research-Based Model Determination: If an agency wants to move to serving more at risk families, there must be a rationale for selecting one particular model over another. The features of each of the researched-based model while similar do have very distinctive differences. They also have different requirements for staff, and emphasize different aspects of service delivery such as "outreach" focused vs. curriculum focused. Determining a model is not a random decision, but is based on a careful consideration of all of the models features with an eye toward achieving a good match for the programs mission and vision.

As a Resource Guide: At the genesis of every program as well as many other times in along its history, valuable and accessible resources are needed. The Toolkit contains several resource pages, and can help programs locate other resources for, local, state and federal for data collection, training, research articles, funding and development information, advocacy and public policy. The Toolkit is a valuable asset at the time a program is initiating a family service program, but remains valuable to guide and inform long after services are up and running.

At a Glance:
Profiles of Research-Based Models

In this section you will find a profile for each of the five research-based service models approved for home visiting and center-based birth to three programs. The profiles cover important details regarding each model's purpose and description along with information about the program's key features such as target population and method of service delivery. These "at a glance" profiles should be weighed in consideration against the needs of any specific community and the mission of an agency when considering the most effective way to serve families. Though all of the models have similarities, they all differ in specific requirements. Those involved in the process of selecting a model should consider carefully the distinctions between the models and the features that would serve their community and target population most successfully.

Summary & Comparison of Key Components of Program Models

	Baby TALK	ISBE & CPS Center-Based Infant Toddler Care	Healthy Families (HF)	Nurse Family Partnership	Parents As Teachers (PAT)
Program Purpose & Description	**Purpose** • Baby TALK's mission is to positively impact child development and nurture healthy parent-child relationships during the critical early years. **Description** • Baby TALK is a community system model designed to build collaborations to form a net of support for families in which practitioners provide information, activities and support to expecting parents and families with children from birth to three years.	**Purpose** • To enhance the physical, cognitive, social, and emotional growth of infants and toddlers; to support parents' efforts to fulfill their parental roles; and to help parents move toward self-sufficiency. **Description** • Center-based infant toddler care aims to improve the growth and development of children before they transition to Head Start or Preschool for All by providing early, continuous, intensive and comprehensive child development and family support services on a year-round basis. Children are enrolled in full-day, full year care, and parents receive intensive parenting education and support.	**Purpose** • To promote healthy child development and reduce child abuse and neglect among at-risk families. **Description** • Healthy Families (HF) is a voluntary, intensive home visiting program that reduces family isolation, supports parents as children's first teachers and caretakers, and helps parents develop good parenting skills.	**Purpose**: • Improve pregnancy outcomes by helping women engage in preventative health practices, including obtaining thorough medical care, improving their diet, and reducing their use of alcohol, cigarettes, and illegal substances • Improve child health & development by helping parents provide responsible and competent care for their children • Improve parental economic self sufficiency by helping parents develop a vision for their own future, plan for future pregnancies, continue their education, and find work **Description**: • Nurse Family Partnership is a voluntary program where highly educated nurses visit low-income women in their homes during their first pregnancy and throughout the first 2 years of their child's life to accomplish the above goals. All services are delivered through strength-based and client centered practices.	**Purpose** • To provide the information, support, and encouragement parents need to help their children develop optimally during the crucial early years of life. **Description** • Parents as Teachers (PAT) is a home-based family education and support program for parents with children from the prenatal stage through age 5. Through the program, parents acquire skills that help them make the most of children's crucial early-learning years.

Summary & Comparison of Key Components of Program Models

	Baby TALK	ISBE & CPS Center-Based Infant Toddler Care	Healthy Families (HF)	Nurse Family Partnership	Parents As Teachers (PAT)
Target Population	• All pregnant women and families with children birth through age three, with more intensive services for families who face risk factors. A community collaboration outreach model enables Baby TALK programs to reach every family in a community for identification and service delivery	• Children birth to age 3 who are at high risk for school failure and who need full-day, full-year care due to their parents work or school schedule.	• Families who are at risk of child abuse and neglect. Families are identified during pregnancy or at birth through a structured assessment.	• First time low income mothers	• All families; PAT is a universal access model. Some PAT programs use funding that requires them to deliver services to a very targeted population. PAT also blends with other early childhood programs that target low literacy parents and/or low-income families. Program intensity is modified based on the needs of the families served.
Key Services	**Personal Encounters** • **Newborn Encounters** with every new family either at the hospital when they deliver or in other community settings for support, education and needs assessment for the family to identify the most in need. • **Personal Encounters** in clinical settings which serve low-income families, going where parents and children already are. Visits may include: parent education, parent-child interaction, read-aloud training, support, needs assessment and referrals. • **Intensive home visiting, collaborative case management** and **goal setting** for families targeted for intensive services.	**Child Health & Developmental Services** • Grantees provide screening for developmental, sensory and behavioral concerns as well as linkages to preventive and primary health care and follow-up necessary as a result of screenings. Information from screenings as well as parents is used to determine how the program can best respond to each individual child's characteristics, strengths and needs. Program assures that each child has a "medical home." **Education & Early Childhood Development Services** • Provides opportunities for each child to explore sensory and motor experiences, supports emotional development, encourages trust, self-awareness and autonomy, and promotes the development of cognitive, language and numeracy skills.	• HFI provides voluntary, culturally relevant services to both fathers and mothers. • HFI services include: o Teaching and modeling effective parenting skills; o Providing social support for new parents to reduce social isolation; o Connecting parents to other services in the community; o Removing barriers to services such as lack of transportation or child care; o Monitoring and promoting children's development; and o Supporting parent-child attachment.	Client centered, strength-based, culturally competent services are delivered to the mothers and families using the evidenced based tested NFP Home Visit Guidelines. The Guidelines are structured around the following Home Visit Domains: **Personal Health** • Health maintenance practices • Nutrition and exercise • Substance use • Mental health functioning **Environmental Health** • Home • Work, school, and neighborhood **Life Course Development** • Family planning • Education and livelihood	**Personal Visits** • PAT-certified Parent Educators visit families at their homes on a regular basis. Educators work in partnership with parents to share child development and parenting information using a structured, research-based curriculum. Parents observe their child's skills and interact with their children through developmentally appropriate activities. **Group Meetings** • Group meetings for parents are an opportunity for families to acquire information and gain support from other parents. **Developmental Screening** • All enrolled children receive developmental, hearing, vision, dental, and health screenings at least once each program year.

Summary & Comparison of Key Components of Program Models

	Baby TALK	ISBE & CPS Center-Based Infant Toddler Care	Healthy Families (HF)	Nurse Family Partnership	Parents As Teachers (PAT)
Key Services continued	**Group Encounters** • **Classes for parents** with in a targeted population at community sites. • **Weekly Baby TALK Times Groups** and **Lapsit Groups** for parents at community sites to share support, build parenting skills, and acquire read-aloud training. • Early Intervention services for infants and toddlers who have (or are at risk for) developmental delays and their families. "Warmline" phone service for parents' questions, and developmental newsletters	**Child Health & Safety Services** • Ensures healthy physical development through hygiene, injury prevention, and the proper provision of medication and first aid. **Child Nutrition Services** • Addresses children's nutritional needs through meal service, family assistance with nutrition, and information on food safety. **Child Mental Health Services** • Ensures the mental wellness of every child by: 1) working collaboratively with parents, 2) conducting regular, on-site mental health consultations which include mental health professionals, program staff, and parents, and 3) securing the services of professionals when needed. Support for children's social and emotional development is integrated into all aspects of the program. (See Methods and Approaches for more details.) **Family Partnerships** • Collaboration with parents is fundamental to the model. (See Parent Involvement for more details.) **Community Partnerships** Agencies should assess, collaborate and coordinate with other programs and resources in the community.		**Maternal Role** • Mothering role • Physical care • Behavioral & emotional care **Family and Friends** • Personal network relationships • Assistance with childcare **Health and Human Services** Service utilization	**Connections with Community Resources** • PAT programs connect families to needed resources and take an active role in the community. **Goal Setting** Parent Educators partner with families to establish and achieve child development and parenting goals.

Summary & Comparison of Key Components of Program Models

	Baby TALK	ISBE & CPS Center-Based Infant Toddler Care	Healthy Families (HF)	Nurse Family Partnership	Parents As Teachers (PAT)
Methods & Approaches	• Baby TALK's approach is to "come alongside parents," joining them in the experience of raising their children. • Baby TALK recognizes the parallel processes taking place in building relationships between parent and child and parent and provider. • Baby TALK recognizes that parents are the experts on their children, and facilitates their effective parenting rather than prescribing a parenting approach for them to follow. • Baby TALK values each family's culture and traditions and honors those traditions in program functions. • Collaboration is key. Baby TALK builds a *Trustworthy System of Support* which enables schools, libraries, hospitals, clinics, health departments, literacy programs and community-based agencies to provide resources for strengthening families. • Flexible program design allows communities to apply the model in ways which will meet the needs of local families and take advantage of local resources.	• All programs must have a written plan or curriculum based on developmental principles of how children learn and grow. Curriculum includes 1) the goals for children's development and learning, 2) the experiences through which they will achieve the goals, 3) what staff and parents do to help children achieve goals, and 4) the materials needed to support the curriculum. • Curriculum for infants and toddlers must: o Encourage the development of **secure relationships** by employing a limited number of consistent teachers over an extended period of time. Teachers must demonstrate an understanding of the child's family culture and, whenever possible, speak the child's language; o Encourage **trust and emotional security**; o Encourage each child to explore a variety of **sensory and motor experiences** with support and stimulation from teachers and family members.	• The Healthy Families approach includes the following critical elements: o HF services are initiated **prenatally or at birth**; o HF uses a **standardized assessment** tool to identify families who are most in need of services; o HF services are **voluntary** and HF uses positive, persistent outreach efforts to build trust with families; o HF offers services **intensively** (at least once a week); o HF services should be **culturally competent**; o HF services should **focus on the parent(s)** as well as **supporting parent-child interaction and child development**; o At a minimum, **all families should be linked to a medical provider**; and o Home visitors should have **limited caseloads** (usually no more than 15 families per visitor).	**NFP has Guiding Elements for Service Implementation:** **Client Elements** • Voluntary participation • First-time mother • Low-income • Enrolled early in pregnancy (<28 weeks) **Intervention Elements** • One to one visiting with client and NHV • Client visited in her home • Visits occur during pregnancy and up child's second birthday **Qualities of Nurses and Supervisors** • NHV and supervisors are RN's with BSN training • NHV and supervisors complete NFP NSO core education and deliver the intervention with fidelity to the model **Application of the Intervention** • NHV use professional judgment to individualize guidelines to meet client's needs • NHV apply theoretical frameworks that underpin the program • A full-time NHV carries a caseload of no more than 25 active clients.	• The PAT model is based on the following core values: o All parents deserve **support in their parenting role** and participation is voluntary. o The **home is the child's first and most important learning environment**. o An understanding and appreciation of the **history and traditions of different cultures** is essential in serving families. o Design of the program allows for **intensity and duration of services to match family needs**. o PAT is committed to promoting the **optimal development and school readiness** of each child. o Quality implementation of the PAT program fosters **positive parent-child relationships**, and increases parenting skills. o Local programs adapt the PAT model to meet the **unique needs of the community** being served.

Summary & Comparison of Key Components of Program Models

	Baby TALK	ISBE & CPS Center-Based Infant Toddler Care	Healthy Families (HF)	Nurse Family Partnership	Parents As Teachers (PAT)
Methods & Approaches continued		• Curriculum must also support the **social and emotional development** of infants and toddlers by: o Encouraging the development of **self-awareness**, **autonomy**, and **self-expression**; and o Supporting the emerging **communication skills** of infants and toddlers by providing daily opportunities for each child to interact with others and to express himself or herself freely. • Curriculum must also promote the **physical development** of infants and toddlers by supporting the development of physical skills, including both gross and fine motor skills.		**Reflection and Supervision** • A full-time nursing supervisor supervises no more than eight NHV's • Supervisory activities include 1:1 clinical supervision, case conferences, team meetings and field supervision. **Program Monitoring and Use of Data** • NHV and Nursing Supervisors collect data and use NFP reports to guide practice, monitor implementation, inform clinical supervision, enhance quality and demonstrate fidelity. **Agency Elements** • NFP implementing agency operated by an organization known for successful provision of prevention services to low-income families • NFP implementing agency convenes long-term Community Advisory Board • Adequate support and structure shall be in place to support NHV and nursing supervisors to implement the program and assure data is accurately entered into the data base in a timely manner.	

Summary & Comparison of Key Components of Program Models

	Baby TALK	ISBE & CPS Center-Based Infant Toddler Care	Healthy Families (HF)	Nurse Family Partnership	Parents As Teachers (PAT)
Program Costs	**Costs per participant** **Basic Outreach model to identify at-risk families.** • Outreach/Screening to identify the most-at-risk in your community: • Form collaborations with community agencies already serving your target population. Provide personal encounters with families at these community sites to provide support, education, assessment of needs and tracking of the family's assimilation into the community's system of support. • Possible collaborations: pre-natal clinics hospitals WIC office county health department health clinics • FTE .5 per collaboration (Depending on the si ze of your outreach area and the number of collaborations being formed.) • **Intensive Programming Possibilities** • 1.Provide wrap around services in collaboration with educational programs such as school age parents working on their high school diploma, parents working toward their GED or parents learning English as their second language.	**Cost per participant** • Approximately $9,000 per child in addition to Child Care Assistance funding. (ISBE Model) • Approximately $8,000 per child in addition to Child Care Assistance funding. (CPS Model)	**Cost per participant** • Approximately $3,600 to $4,600 per year (including matching funds from programs) **Start-up costs** • Approximately 25% of a program's annual budget (about $50,000)	• The NFP program costs approximately $4500 per family per year to fund, and can range from $2,914 to $6,463 per family per year. The nurses' salaries are the primary driver that affects variability of costs.	**Cost per participant** • $3,650 per year (weekly visits to one at-risk family, per year) **Start-up costs** • $78,002 per program site for one year for a brand new program (includes training and curriculum, program materials, two part-time parent educators, one supervisor, one clerical support staff person, administrative costs, rent and utilities, and quality assurance and evaluation) • $4,470 for an existing early childhood program to adopt the Parents as Teachers model (includes training and program materials) **Training costs** • $815 per person, including training fee and cost of curriculum

Summary & Comparison of Key Components of Program Models

	Baby TALK	ISBE & CPS Center-Based Infant Toddler Care	Healthy Families (HF)	Nurse Family Partnership	Parents As Teachers (PAT)
Program Costs continued	• This provides opportunities to build a system of support around the families which may include daily parenting class with families at their educational program, home visits, case management, child education classes and opportunities for group activities for all the families enrolled in the program. • Baby TALK Practitioner: • 1.0 FTE for 20-25 families. Because of the daily contact with families in their educational programming, home visits may be less intensive and a provider's case load can be larger. • Child Education Staff: • Follow DCFS guidelines for the age of the children				

Framework for High Quality Services: Criteria for Implementation by Research-Based Program Model

Sections

- Baby TALK
- Center Based Programs
  - Illinois State Board of Education (ISBE)
  - Chicago Public Schools (CPS)
- Healthy Families America for Illinois Programs
- Nurse Family Partnership
- Parents as Teachers

- Full Profile of Program Model
- Crosswalk to Illinois Birth-3 Standards

Contact Information:
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Baby TALK

Full Profile of Program Model

	Baby TALK
Program Purpose & Description	**Purpose** • Baby TALK's mission is to positively impact child development and nurture healthy parent-child relationships during the critical early years. **Description** Baby TALK is an outreach model designed to provide information, activities and support to expecting parents and families with children from birth to three years of age.
Target Population	All pregnant women and families with children birth through age three, with more intensive services for at-risk families. A community collaboration outreach model enables programs to reach all families in a community.
Key Services	Personal Encounters **Newborn Encounters** with every new family either at the hospital when they deliver or in other community settings for support, education and needs assessment to identify the most at-risk. **Personal Visits** in clinical settings which serve low-income families, going where parents and children already are. Visits may include: parent education, parent-child interaction, read-aloud training, support, needs assessment and referrals. **Intensive home visiting, collaborative case management** and **goal setting** for families in need of intensive services. Group Encounters **Classes for parents** within a targeted population at community sites. **Weekly Baby TALK Times Groups** and **Lapsit Groups** for parents at community sites to share support, build parenting skills, and acquire read-aloud training. Early Intervention services for infants and toddlers who have (or are at risk for) developmental delays and their families, which are provided through Baby TALK's innovative STEPS model. "Warmline" phone service for parents of children birth to three, which provides and immediate response to parents' questions and needs. Periodic developmental newsletters to parents during the first three years of their child's life, using volunteers to process the mail.
Outreach & Recruitment	Baby TALK's outreach model allows for identification of at-risk families and delivery of service to them through collaborations with other community organizations. Baby TALK takes services *to* families in a variety of community settings. This concerted system of support provides opportunities for needs assessment, referrals and frequent and intensive services.
Methods & Approaches	**Baby TALK's approach is to "come alongside parents,"** joining them in the experience of raising their children. **Baby TALK recognizes the parallel processes** taking place in building relationships between parent and child and parent and provider. **Baby TALK recognizes that parents are the experts on their children**, and facilitates their effective parenting rather than prescribing a parenting approach for them to follow. **Baby TALK values each family's culture and traditions** and honors those traditions in program functions.

Baby TALK

Full Profile of Program Model

	Baby TALK
Methods & Approaches continued	**Collaboration is key**. Baby TALK builds a *Trustworthy System* of support which enables schools, libraries, hospitals, clinics, health departments, literacy programs and community-based agencies to provide resource for strengthening families. **Flexible program design** allows communities to apply the model in ways which will meet the needs of local families and take advantage of local resources.
Intensity of Services	Families experience Baby TALK differently based on their needs and desires. Families with identified risk factors are served more intensively at schools, clinics, Family Literacy programs, Early Intervention settings and in home visits.
Staff Qualifications & Supervision	<u>Qualifications</u> Baby TALK practitioners should have a bachelor's degree (preferred) or an associate's degree with a high level of experience in education, nursing, or social work. Baby TALK practitioners should display a high degree of empathy, knowledge and willingness to learn about a family's needs and culture. Where possible, Baby TALK practitioners should reflect the culture of communities they serve. Baby TALK practitioners must be certified by Baby TALK through the 4-day Baby TALK certification training. In addition, they must be re-certified annually by Baby TALK, Inc. through the Baby TALK Professional Association. <u>Supervision</u> Individual program should provide supervision of Baby TALK practitioners.
Staff Training	The 4-day Baby TALK certification training includes discussions of child development, building relationships with families, program visits, and collaboration with other professionals. Participants receive training on Baby TALK curricula, including: Newborn Encounter Protocol Personal Encounter Protocol Anticipatory Guidance/Developmental stages Home Visiting Home-made Toys Teen Parenting Parenting Issues Group Encounter Protocol and Curricula Classes for parents Family Fun Times Lapsits Come Sign with Me Early Intervention Family Literacy Developmental Newsletters After attending the training and becoming certified, Baby TALK practitioners receive follow-up communication and technical support from the Baby TALK Professional Association. Baby TALK practitioners must renew their certifications each year by way of an annual report of professional involvement and growth through the Baby TALK Professional Association.
Staff Caseload/ Class Size	Following screening/outreach services, caseloads will be 15-25 families per fulltime staff member depending on the intensity of services. (see program costs)

Baby TALK

Full Profile of Program Model

	Baby TALK
Matching Services to Need	Baby TALK tailors services to the needs of individual families. Families' issues determine the services offered by Baby TALK practitioners. Similarly, Baby TALK curriculum is used in response to families' needs. Based on family needs, participating families receive a variety of services from the following: Newborn encounter Personal encounter Group parenting Home visits Case Management Referrals Parent-child interaction Early Intervention therapies Comprehensive family literacy Evening family events
Coordination of Services	Since Baby TALK programs are collaborative by nature, coordination of services is built into program design. Working side-by side with other professionals in schools, clinics, hospitals and other settings, Baby TALK practitioners are able to make referrals which are natural and immediate. Baby TALK practitioners are knowledgeable about resources beyond program partners and take such referral information with them into each service setting. Children are referred to screening for other educational settings (as appropriate), such as preschool screening for Pre-K or Head Start.
Parent Involvement	Baby TALK practitioners strive to come alongside parents, empowering them to form healthy relationships with their children and to encourage their children's development. Parents' concerns and passions about their children impact Baby TALK's work with their families. Baby TALK works to identify families' strengths and assist parents in using those strengths for the optimal development of their children.
Credentialing or Certification Process	Parent Educations are certified through the 4-day Baby TALK training; certifications must be renewed each year through the Baby TALK Professional Association (see Staff Training above).
Evaluation Requirements	As part of the annual recertification process, Baby TALK practitioners are expected to report their work for the preceding year. They are also expected to participate in evaluation processes as directed by their organization or funding sources.
Program Cost	**<u>Outreach/Screening to identify the most-at-risk in your community:</u>** Form collaborations with community agencies already serving your target population. Provide personal encounters with families at these community sites to provide support, education, assessment of needs and tracking of the family's assimilation into the community's system of support. Possible collaborations: pre-natal clinics hospitals WIC office county health department health clinics FTE .5 per collaboration (Depending on the size of your outreach area and the number of collaborations being formed.

Baby TALK

Full Profile of Program Model

	Baby TALK
Program Cost continued	**<u>Intensive Programming Possibilities</u>** 1.Provide wrap around services in collaboration with educational programs such as school age parents working on their high school diploma, parents working toward their GED or parents learning English as their second language. This provides opportunities to build a system of support around the families which may include daily parenting class with families at their educational program, home visits, case management, child education classes and opportunities for group activities for all the families enrolled in the program. Baby TALK Practitioner 1.0 FTE for 20-25 families. Because of the daily contact with families in their educational programming, home visits may be less intensive and a provider's case load can be larger. Child Education Staff Follow DCFS guidelines for the age of the children 2. Provide intensive services to a targeted group of families who are at risk. Possible targeted groups: Homeless Teens who are parents English Language Learners Parents who have not finished high school Families receiving DCFS services Families mandated by court system Families identified through outreach collaboration as eligible due to risk factors This provides opportunities to support families with intensive home visiting, case management, and group activities for all of the families enrolled in the program. Baby TALK Practitioner 1.0 FTE for 15 families—delivery weekly home visits and semi-monthly group encounters. Because home visits are the primary way of delivering the intensive services, a provider's case load is less. Child Education staff to support planned group activities. Services to each family identified as at-risk, on average = $3,500 per year. **<u>Cost for Parent Educators</u>** Baby TALK certification training = $895, plus travel Annual certification in Baby TALK Professional Association = $40 per year
Supporting Research Citations	Parents who participated in Baby TALK: • Have children who are better prepared for kindergarten and who score significantly higher on test of language development • Tend to miss fewer well child appointments during their baby's first year • Have television on fewer hours per day • Are more likely to visit the public library with their children • Are more likely to be up to date on their child's immunizations (from Summary of Research on Baby TALK Outreach Education Programs)

Baby TALK

Full Profile of Program Model

	Baby TALK
Model-Specific Resources	Baby TALK website: www.babytalk.org Baby TALK Model Standards Baby TALK Curriculum Overview Baby TALK Professional Association (continuing education vehicle for providing resources and annual recertification) Let's TALK Weekly Newspaper Column (available to newspapers to support local Baby TALK efforts) Toll-free phone number for technical support: 1-888-4BT-READ (428-7323)
Initial Point of Contact for Program Model Information	Betsy Osman Baby TALK Headquarters 500 East Lake Shore Drive Decatur, IL 62521-3336 Phone: (217) 475-2234 or 1-888-4BT-READ Fax: (217) 475-2206 Email: betsy@babytalk.org

If you would like a current listing of those Illinois programs that use the Baby Talk, with locations and contact information please contact Deb Weidenhofer (deb@babytalk.org).

ISBE Birth To Three Program Standards & Baby TALK Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	Baby TALK Model Standard	Baby TALK Model Standard Description
SECTION I	**ORGANIZATION**	**AREA I**	**ORGANIZATION**
I.A.	**All birth to three programs must have a mission statement based on shared beliefs and goals.** *Quality Indicator I.A.1.* A mission statement based on shared beliefs is developed cooperatively by parents, staff members, families, and community representatives and is reviewed annually. *Quality Indicator I.A.2.* The mission statement and beliefs are consistent with those of the community. *Quality Indicator I.A.3.* The essence of the mission statement is reflected in all decisions, and a copy is posted and available. *Quality Indicator I.A.4.* The goals stem from the Illinois Birth to Three Program Standards. The program goals are developed by leadership and staff, shared with parents and other stakeholders, and serve as the basis for all planning and program development.	**I.A.**	**Baby TALK's mission is to positively impact child development and nurture healthy parent-child relationships during the critical early years.** *I.A.1.* Baby TALK programs will address how this mission supports their work with families. *I.A.2.* Baby TALK's mission will lead programs to consider the needs of their local communities and families. *I.A.3.* Baby TALK's mission is carried out by all personnel, resource and program decisions. *I.A.4.* Baby TALK program goals are reflective of the real needs of community families and input from service collaborators and serve as the basis for program planning and development.
I.B.	**Scheduling practices and intensity of services are tailored to the individual strengths and needs of children birth to three and their families.**	**I.B.**	**Baby TALK programs are scheduled and delivered in an outreach model, going where parents and children already are in the community, including medical provider clinics, hospitals, libraries, churches, neighborhood centers, schools and homes.** *I.B.1.* Baby TALK programs are scheduled year-round and at various times of the day and week in order to meet the needs of families. *I.B.2.* Families who face increased challenges may be served with greater intensity in Baby TALK programs. *I.B.3.* Baby TALK programs offer both individual and group experiences for families based on the strengths, needs and preferences.
I.C.	**The strengths and needs of the children and families as well as research on best practice determine the ratio of participants to staff and the size of program groups.** *Quality Indicator I.C.1.* Group size and ratios of adults to infants and toddlers are developmentally appropriate in program groups.	**I.C.**	**The strengths and needs of the children and families as well as research on best practices determine the ratio of participants to staff and the size of program groups.** *I.C.1.* Group size and adult-child ratio are developmentally appropriate in program groups.

ISBE Birth To Three Program Standards & Baby TALK Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	Baby TALK Model Standard	Baby TALK Model Standard Description
I.C. continued		**I.C. continued**	*I.C.2.* An appropriate number of families are served by each Baby TALK staff member in accordance with program design and goals, considering location, severity of need, of intensity of service and availability collaborative support.
I.D.	**The program meets the needs of children and families of varying abilities as well as diverse cultural, linguistic, and economic backgrounds.** *Quality Indicator I.D.1*. Qualified staff who demonstrate cultural and linguistic competency are available to effectively interact with families. *Quality Indicator I.D.2*. A variety of activities, strategies, and materials are used to meet the diverse needs of children and families.	**I.D.**	**Baby TALK programs meet the needs of children and families of diverse abilities as well as diverse cultural, linguistic and economic backgrounds.** *I.D.1*. Baby TALK staff will demonstrate cultural and linguistic competency and be available to effectively interact with children and families. *I.D.2*. Baby TALK will use a variety of activities, strategies, program approaches and materials to meet the diverse needs of children and families.
I.E.	**The physical environment of the program is safe, healthy, and appropriate for children's development and family involvement.** *Quality Indicator I.E.1.* The program implements local and state health and safety guidelines. *Quality Indicator I.E.2*. The program décor, furnishings, materials, and resources are appropriate for infants and toddlers and their families.	**I.E.**	**Baby TALK community program environments are safe, healthy and appropriate for the children's development and family involvement.** *I.E.1*. Baby Talk follows local and state health and safety guidelines. *I.E.2*. Baby Talk programs are held throughout the community. Space that is available at clinics and other settings provides important access for families to receive Baby TALK services and resources. "Going where families are" is more crucial to program success than environmental décor.
I.F.	**The administration promotes and practices informed leadership and supervision. The administration participates in and encourages ongoing staff development, training, and supervision.**	**I.F.**	**Baby TALK leadership promotes the notion of continual improvement or "becoming even better."** *I.F.1*. Baby TALK leaders take advantage of opportunities for advanced learning regarding current research and best practices for young children as well as ways of supporting and engaging parents. *I.F.2*. Baby TALK leaders encourage professional growth opportunities in program staff by supporting them in participation in professional organizations, conferences or advanced trainings.
I.G.	**All birth to three programs must follow mandated reporting laws for child abuse and neglect and have a written policy statement addressing staff responsibilities and procedures regarding implementation.**	**I.G.**	**Baby TALK programs must follow mandated reporting laws for child abuse and neglect, and have a written policy statement for addressing staff responsibilities and procedures for implementation.**

ISBE Birth To Three Program Standards & Baby TALK Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	Baby TALK Model Standard	Baby TALK Model Standard Description
I.G. continued	*Quality Indicator I.G.1*. The program leadership familiarizes staff with the Abused and Neglected Child Reporting Act [325 ILCS 5] as well as with the program's policy. This should be included as part of new staff orientation and, at a minimum, be reviewed annually.	**I.G. continued**	*I.G.1*. Baby TALK leaders familiarize staff with the laws regarding child abuse reporting. This should be included as part of new staff orientation and must be reviewed annually. *I.G.2*. Written policies must include procedures for documentation and follow-up of reported abuse.
I.H.	**The program budget is developed to support quality program service delivery.**	**I.H.**	**Baby TALK program budgets support quality program service delivery.** *I.H.1*. Baby TALK budgets include sufficient funds for human resources in order to compensate practitioners with a professional wage. *I.H.2*. Baby TALK budgets include staff development and training. *I.H.3*. Baby TALK budgets include books and materials for quality programming. *I.H.4*. Baby TALK budgets allow for expenditures necessary to enable parents to participate in program activities. *I.H.5*. Baby TALK budgets include funds to support evaluation to determine outcomes and program effectiveness.
SECTION II	**CURRICULUM & SERVICE PROVISION**	**AREA II**	**CURRICULUM & SERVICE PROVISION**
II.A.	**The curriculum reflects the centrality of adult/child interactions in the development of infants and toddlers.** *Quality Indicator II.A.1*. Positive parent/child interactions are encouraged and promoted in all aspects of the program. *Quality Indicator II.A.2*. The curriculum promotes parent/child interactions in the way sessions are designed and conducted by staff. *Quality Indicator II.A.3*. The development of a sense of trust and autonomy among staff, children, and families is a priority. *Quality Indicator II.A.4*. Parents receive education and support to identify and cope with life stressors that may place their family at risk.	**II.A.**	**Baby TALK curriculum reflects the value of parent/child interactions in the development of infants and toddlers.** **II.A.1**. Positive parent/child interactions are encouraged and modeled in all aspects of Baby TALK programming in various environments within the community. **II.A.2**. The development of a sense of trust and autonomy is encouraged between staff and families to enable Baby TALK practitioners to promote the parent/child relationship and the child's development. **II.A.3**. Parents are supported through education and referrals to identify and cope with life stressors that may place them at risk for child abuse and neglect. **II.A.4**. The Baby TALK programming environment is designed to positively impact child development and nurture healthy parent-child relationships.

ISBE Birth To Three Program Standards & Baby TALK Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	Baby TALK Model Standard	Baby TALK Model Standard Description
II.A. continued		**II.A. continued**	**II.A.5**. Baby TALK practitioners share child observations with parents, using the child's behavior as their common language.
II.B.	**The curriculum reflects the holistic and dynamic nature of child development.** *Quality Indicator II.B.1*. A balance of all developmental areas: cognitive, communication, physical, social, and emotional is demonstrated in all activities and service provision. *Quality Indicator II.B.2*. An integrated and individualized program is offered for children in the context of their families. *Quality Indicator II.B.3*. Multiple theoretical perspectives are considered, and developmentally appropriate practices are implemented. *Quality Indicator II.B.4*. A variety of high quality, developmentally appropriate activities and materials are utilized in a safe and supportive environment. *Quality Indicator II.B.5*. An emergent literacy focus is observable in the activities, materials, and environment planned for the child.	**II.B.**	**Baby TALK curriculum reflects all aspects of child development including the typical development of children and the unique development of the individual child.** *II.B.1.* A balance of all developmental areas (cognitive, communicative, motor, health/medical, self-help and social-emotional) is demonstrated in Baby TALK activities and service provision. *II.B.2.* An integrated and individualized program is offered for children within the context of their families. *II.B.3.* Multiple theoretical perspectives are considered, and developmentally appropriate practices are implemented. Baby TALK curriculum is reflective of the most current child development research. *II.B.4.* A variety of meaningful, developmentally appropriate play activities and purposeful materials are utilized in a safe and supportive environment. *II.B.5.* An emergent literacy focus is foundational in the activities, materials, and environment planned for the child. Parents are empowered to facilitate language and relational learning in their children through conversation and book sharing.
II.C.	**The curriculum prioritizes family involvement while respecting individual parental choices.** *Quality Indicator II.C.1*. Opportunities are provided for varied levels of parent participation. *Quality Indicator II.C.2*. Opportunities are provided for parents to increase their levels of program involvement through education and enrichment. *Quality Indicator II.C.3*. The curriculum and activities support family literacy.	**II.C.**	**Baby TALK recognizes that parents understand their own families' needs and honors their participation choices.** *II.C.1.* Opportunities are provided for varied levels of family participation in a variety of locations within the community. *II.C.2.* Opportunities are provided for parents to increase their levels of program involvement through modeling, education, parent handouts and enrichment. *II.C.3.* Recognizing that parents want to do well by their children, Baby TALK provides parents with access to resources and information so that parents are enables to make informed choices concerning their particular family.

ISBE Birth To Three Program Standards & Baby TALK Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	Baby TALK Model Standard	Baby TALK Model Standard Description
II.D.	**The curriculum supports and demonstrates respect for the families' unique abilities as well as for their ethnic, cultural, and linguistic diversity.** *Quality Indicator II.D.2.* Program services are provided in the family's primary language whenever possible.	**II.D.**	**Baby TALK curriculum and service provision supports and demonstrates respect for the families' and children's unique abilities as well as for their ethnic, cultural, linguistic and economic diversity.** *II.D.1.* A variety of cultures are reflected in the activities, material and environment provided. *II.D.2.* Baby TALK services are provided in the family's primary language whenever possible. *II.D.3.* Service provision is comprehensive and convenient regardless of the family's income. *II.D.4.* Baby TALK curriculum and activities support family literacy. *II.D.5.* Baby TALK programming is held "where families are" including health clinics, libraries, schools, churches and occasionally in the home. Programming is conducted in a variety of locations within the community with the intent of reaching each family multiple times and supporting their parenting needs before or as they arise. *II.D.6.* When Baby TALK programs are able to provide Early Intervention services, those services are provided within an inclusive setting using integrated therapies.
II.E.	**The curriculum promotes a framework that is nurturing, predictable, and consistent, yet flexible.** *Quality Indicator II.E.1.* Schedules and routines are familiar and available in print. *Quality Indicator II.E.2.* The program responds to the participant's individual cues and makes accommodations.	**II.E.**	**Baby TALK service delivery is nurturing, predictable and consistent, yet flexible to serve the needs of families in a community.** *II.E.1.* Baby TALK programming schedules are easily accessible for families. Programming is responsive to the needs and schedules of the families served. *II.E.2.* Baby TALK staff and curriculum are sensitive and responsive to the uniqueness of each family. *II.E.3.* Baby TALK program services are responsive to research based on best practices. *II.E.4.* Baby TALK programs are adapted to the unique needs, opportunities and resources in each community.

ISBE Birth To Three Program Standards & Baby TALK Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	Baby TALK Model Standard	Baby TALK Model Standard Description
II.F.		**II.F.**	**Baby TALK's curriculum depends on the establishment of trusting relationships with parents.** *II.F.1.* Baby TALK recognizes parents as experts on their own children. *II.F.2.* Baby TALK celebrates mastery achieved by parents and children. *II.F.3.* Baby TALK practitioners facilitate parental growth in learning from experiences with their children. *II.F.4.* Baby TALK practitioners use Baby TALK's developmental curriculum as a knowledge base but allow families' needs and interests to set the agenda for each encounter. *II.F.5.* Parents' experience of being nurtured in one Baby TALK program setting translates into greater readiness for trust in another Baby TALK program setting.
SECTION III	**DEVELOPMENTAL MONITORING & PROGRAM ACCOUNTABILITY**	**AREA III**	**DEVELOPMENTAL MONITORING & PROGRAM ACCOUNTABILITY**
III.A.	**The program staff regularly monitors children's development.** *Quality Indicator III.A.1.* The staff monitors children's development using a variety of appropriate methods. *Quality Indicator III.A.2.* Developmental monitoring views the child from a holistic perspective within the context of the family and the community. *Quality Indicator III.A.3.* The staff obtains information from different sources and shares the information with parents. The parents are further involved in the interpretation of this information in support of the child's development. *Quality Indicator III.A.4.* Children are referred to the Illinois Early Intervention System when appropriate. *Quality Indicator III.A.5.* Families are informed of appropriate programs in the community by the child's third birthday.	**III.A.**	**The Baby TALK staff regularly monitors children's development.** *III.A.1.* Baby TALK staff participates in the collaborative monitoring of children's development using a variety of appropriate methods. *III.A.2.* Developmental monitoring views the child from a holistic perspective within the context of the child's natural environment. *III.A.3.* Baby TALK staff obtain and share the information from different sources with parents. The parents are further involved in the interpretation of this information in support of the child's development. *III.A.4.* Children are referred to the Early Intervention System when appropriate. *III.A.5.* Families are informed of appropriate programs in the community by the child's third birthday. Transition planning takes place before the child leaves birth to three services.

ISBE Birth To Three Program Standards & Baby TALK Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	Baby TALK Model Standard	Baby TALK Model Standard Description
III.B.	**Leadership conducts regular and systematic evaluations of the program and staff to assure that the philosophy is reflected and goals of the program are being fulfilled.** *Quality Indicator III.B.1*. An annual evaluation is conducted of program quality and progress toward goals. *Quality Indicator III.B.2*. The results of the program evaluation are reviewed annually and are used or considered in making organizational and/or programmatic changes.	**III.B.**	**Baby Talk leadership conducts regular and systematic evaluations of the program and staff to assure that the philosophy is reflected and goals of the program are being fulfilled.** *III.B.1*. A self-evaluation of program quality and progress toward goals is conducted annually. *III.B.2*. The results of the program evaluation are reviewed annually for progress and implementation of program goals. These results are then used or considered in making organizational and/or programmatic changes. *III.B.3*. Baby TALK leadership works in partnership with staff to plan, develop and implement an effective staff evaluation process. *III.B.4*. Baby TALK programs are studied as to impact on children and families.
SECTION IV	**PERSONNEL**	**AREA IV**	**PERSONNEL**
IV.A.	**The program leadership is knowledgeable about child development and best practice for quality birth to three programs.**	**IV.A.**	**Baby TALK leadership is knowledgeable about child development and best practice for quality birth to three programs.** *IV.A.1*. Baby TALK leaders are experienced early childhood professionals with expertise in infant and toddler development and family enrichment. *IV.A.2*. Baby TALK leaders have been through Baby TALK Training and retain current certification through membership in the Baby TALK Professional Association. *IV.A.3*. Baby TALK leaders are supportive of and work to fully implement best practices in birth to three programs.
IV.B.	**The program leadership is effective in explaining, organizing, implementing, supervising, and evaluating birth to three programs.**	**IV.B.**	**Baby TALK leaders are effective in explaining, organizing, implementing, supervising and evaluating the Baby TALK birth to three programs.** *IV.B.1*. Baby TALK leaders are skilled in program management and supervision. *IV.B.2*. Baby TALK leaders model professionalism and convey high expectation of all staff.

ISBE Birth To Three Program Standards & Baby TALK Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	Baby TALK Model Standard	Baby TALK Model Standard Description
IV.C.	**The program leadership hires qualified staff who are competent in working with infants and toddlers and their families.**	**IV.C.**	**Baby TALK leadership hires qualified staff who are competent in working with infants and toddlers and their families.** *IV.C1*. Baby TALK practitioners meet with minimum entry-level requirement/s for their role/responsibilities established by the funding agents. *IV.C.2*. Baby TALK practitioners have formal Baby TALK training. They are able to demonstrate an understanding of how infants and toddlers develop and learn in the context of their families. *IV.C.3*. Baby TALK practitioners demonstrate the ability to come alongside parents and/or the child's primary caregivers to foster meaningful, working relationship in support of parent-child relationships. *IV.C.4*. Baby TALK practitioners demonstrate knowledge of and respect for the unique way in which adults develop skills, learn and change. *IV.C.5*. Baby TALK practitioners demonstrate competence in facilitating the process of parent's learning through trial and error as they raise their children. *IV.C.6*. Baby TALK practitioners have knowledge of and respect for the family's social, cultural and linguistic diversity of the community. *IV.C.7*. Baby TALK practitioners reflect the social, cultural and linguistic diversity of the community.
IV.D.	**The program leadership provides ongoing supervision that promotes staff development and enhances quality service delivery.** *Quality Indicator IV.D.1.* Program leadership creates and maintains an atmosphere that is nurturing and supportive of staff. *Quality Indicator IV.D.3.* The supervisor in partnership with each staff member develops a formative supervision plan.	**IV.D.**	**Baby TALK leadership provides reflective supervision that promotes staff development and enhances quality service delivery.** *IV.D.1*. Baby TALK leadership creates and maintains an atmosphere that is nurturing and supportive of staff. *IV.D.2*. Baby TALK leadership regularly conducts an evaluation process in accordance with the finding sources. *IV.D.3*. Baby TALK leadership develops a goal-setting plan in partnership with each staff member with on-going reflective supervision. *IV.D.4*. Sufficient time for supervision is provided in the Baby TALK leader's schedule.

ISBE Birth To Three Program Standards & Baby TALK Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	Baby TALK Model Standard	Baby TALK Model Standard Description
IV.E.	**The program leadership provides opportunities for ongoing professional growth and development.** *Quality Indicator IV.E.1*. A professional development plan, based on the needs identified through formative supervision and the interests of each staff member, is on file. *Quality Indicator IV.E.2*. Sufficient time and funding are provided for staff to participate in appropriate staff development activities.	**IV.E.**	**Baby TALK leadership provides opportunities for ongoing professional growth and development.** *IV.E.1*. A professional developmental plan, based on the needs identified through goal setting, reflective supervision and the interests of each staff member, is kept on file and reviewed annually. *IV.E.2*. Time and funding are provided for staff to participate in Baby TALK Certification Training and other appropriate staff development activities, such as Touchpoints Training. *IV.E.3*. Baby TALK staff meet on a regular basis for professional growth, debriefing of experiences and exploring approaches for meeting challenges and improving programs. As funding allows staff also participate in local, regional, state and national training and conferences.
IV.F.	**The program leadership promotes continuity in staffing through provision of a supportive work environment, competitive wages and benefits, and opportunities for advancement.**	**IV.F.**	**Baby TALK leadership promotes continuity in staff through provision of a supportive work environment, competitive wages and benefits, and opportunities for advancement.** *IV.F.1*. Baby TALK leadership provides each staff member a schedule appropriate for implementing his/her job responsibilities. Baby Talk staff work in a number of community sites because of Baby TALK's philosophy of "going where the families are." *IV.F.2*. Baby TALK leadership advocates and works to secure a competitive wage and benefit package for personnel commensurate with their professional qualification. *IV.F.3*. Baby TALK leadership provides opportunities for career advancement.
IV.G.	**The program leadership and staff are knowledgeable about programs and agencies in the community that provide services for children and their families.**	**IV.G.**	**Baby TALK practitioners help to build systems in their communities in order to collaborate with programs and agencies that provide services to children and families.** *IV.G.1*. Baby TALK leadership actively seeks to work collaboratively with a variety of agencies in the community that provide educational, social/emotional, medical and other services to children and families. *IV.G.2*. Baby TALK practitioners collaborate and interact with birth to three providers and programs elsewhere in the community as they design and deliver services cooperatively.

ISBE Birth To Three Program Standards & Baby TALK Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	Baby TALK Model Standard	Baby TALK Model Standard Description
SECTION V	**FAMILY & COMMUNITY PARTNERSHIPS**	**SECTION V**	**FAMILY & COMMUNITY PARTNERSHIPS**
V.A.	**The child is viewed in the context of family and the family is viewed in the context of its culture and community.** *Quality Indicator V.A.1*. The program is designed to enhance and support parent/child relationships. *Quality Indicator V.A.2*. Program leadership and staff understand and respect the culture of the families they serve. *Quality Indicator V.A.3*. The leadership and program staff understand that the child's home, community, and cultural experiences impact his/her development and early learning. *Quality Indicator V.A.4*. Materials that promote and support the program emphasize the importance of families in the lives of children. *Quality Indicator V.A.5*. The program leadership and staff communicate with families in their primary language whenever possible. *Quality Indicator V.A.6*. The program assists families in expanding their knowledge of child growth and development and parenting techniques. *Quality Indicator V.A.7*. The program staff recognizes the influence of the community and its characteristics upon the family.	**V.A.**	**Baby TALK's primary purpose is to develop relationships with families that will identify and support family goals.** *V.A.1.* Baby TALK programs provide services that promote family growth and enrichment to identify and build on family strengths. *V.A.2.* In intensive service models, Baby TALK offers parents opportunities to develop and implement a family plan that describes family goals, responsibilities, time tables and strategies for achieving them. *V.A.3.* Baby TALK staff and families regularly review the family plan, document progress toward goals and make revisions when appropriate.
V.B.	**The program leadership and staff seek and facilitate family participation and partnerships.** **Quality Indicator V.B.1. The program leadership assures a system is in place for regular, effective communication and responsive interaction between the program leadership, staff, and families.** **Quality Indicator V.B.2. The program provides opportunities for family involvement and educational activities that are responsive to the ongoing and expressed needs of family members.** **Quality Indicator V.B.3. Families are included in the development and implementation of program activities.**	**V.B.**	**Baby TALK programs exist as collaborative systems between community organizations who are committed to the support of young children and their families. Baby TALK nurtures relationships with families and models this process by nurturing healthy working relationships with collaborators.** **V.B.1. Baby TALK programs are designed to enhance and support parent-child relationships by focusing on the parent-child relationship and utilizing the behavior of the child as the language to guide discussions with families.** **V.B.2. Baby TALK practitioners understand and respect the culture of the families they serve.**

ISBE Birth To Three Program Standards & Baby TALK Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	Baby TALK Model Standard	Baby TALK Model Standard Description
V.B. continued		**V.B. continued**	**V.B.3. Baby TALK practitioners recognize that every experience children have within their home environment, community and culture contributes to development and self esteem and is crucial in children's success of failure.** **V.B.4. Baby TALK serves every family in the community with a child birth to three providing developmental information, encouragement, children's books and activities, and referrals to other helping agencies.** **V.B.5. Baby TALK leaders and staff communicate with families in their primary language whenever possible. Developmental materials are available in Spanish as well as English.** **V.B.6. Baby Talk programs support families with developmental materials and are available to talk through them with the families to support them through each stage of their child's growth and development.**
V.C.	**The program assures that families have access to comprehensive services.** **Quality Indicator V.C.1. Program leadership and staff have a working knowledge of the resources in their community.** **Quality Indicator V.C.2. The program has both a referral and follow-up system to assure that families are able to access services determined appropriate.** **Quality Indicator V.C.3. The program works to address family needs.**	**V.C.**	**Baby TALK practitioners actively seek and facilitate family participation and partnership by going where the families already are in the community.** **V.C.1. Baby TALK practitioners assure a system is in place for regular, effective communication and responsive interaction between leadership, staff and families.** **V.C.2. Baby TALK provides opportunities for family in involvement and educational activities that are responsive to the ongoing and expressed needs of families.** **V.C.3. Baby TALK program delivery design is responsive to feedback and requests from parents.**
V.D.	**The program develops a partnership with families in which the family members and staff determine goals and services.** *Quality Indicator V.D.1.* The program provides services that promote family growth and enrichment to identify and build on family strengths.	**V.D.**	**Baby TALK's collaborative relationships with families and community partners allows for ease and effectiveness in the referral process.** *V.D.1.* Baby TALK practitioners regularly use their working relationships with other providers of service to young families.

ISBE Birth To Three Program Standards & Baby TALK Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	Baby TALK Model Standard	Baby TALK Model Standard Description
V.D. continued	*Quality Indicator V.D.2*. The program offers parents opportunities to develop and implement a family plan that describes family goals, responsibilities, timelines, and strategies for achieving these goals. *Quality Indicator V.D.3*. Program staff and families regularly review the family plan, document progress toward goals, and make needed revisions.	**V.D. continued**	*V.D.2*. Baby TALK programs work to address family needs and have a referral and follow-up system in place to assure that families are able to access services that meet those needs.
V.E.	**The program takes an active role in community and system planning and establishes ongoing collaborative relationships with other institutions and organizations that serve families.** *Quality Indicator V.E.1*. Efforts are made to work in collaboration with other providers of services to families with young children in order to maximize services and resources available in the community. *Quality Indicator V.E.2*. Comprehensive physical and mental health, educational, social, and recreational resources for children and their families are developed and promoted in collaboration with the community. *Quality Indicator V.E.3*. The program leadership recognizes the urgent need for high quality child care for infants and toddlers and participates in community collaboration to identify, locate, and provide access to this service. *Quality Indicator V.E.4*. The program leadership works with the family and community in supporting transitions, respecting each child's unique needs and situation.	**V.E.**	**Baby TALK takes an active role in the community by establishing and maintaining ongoing collaborative relationships with the educational, medical and mental health and social service agencies that serve families.** *V.E.1*. Baby TALK builds collaborations with community partners based on shard goals for families and children. *V.E.2*. Baby TALK builds collaborations into a seamless system which scaffolds families. *V.E.3*. Efforts are made to collaborate and even to co-locate with other providers of services to families of infants and toddlers. *V.E.4*. Community collaborations lead to the development of comprehensive resources for children and families. Baby TALK practitioners serve on a local, state, and national advisory committees to these efforts. *V.E.5*. Baby TALK practitioners recognize the need for high quality child care and participate in efforts to improve, identify, locate and increase access to this service. *V.E.6*. Baby TALK practitioners support and facilitate family transitions between appropriate early childhood programs.

Center Based Programs

- Chicago Public Schools
  - Key Elements of the Center Based 0-3 Program Model
  - Full Profile of the Program Model
- ISBE: Center Based Infant Toddler Care
  - Full profile of Program Model
  - Performance Standards

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Key Elements of the Center-Based 0-3 Program Model
As required by Chicago Public Schools, Office of Early Childhood Education

<table>
<tr><th>Model Requirements</th><th>CPS Center Based</th></tr>
<tr><td>Curriculum</td><td>- Creative Curriculum for Infants, Toddlers and Two's or another formal research based curriculum.</td></tr>
<tr><td>Developmental Screening</td><td>- ASQ-Developmental must be used as the screening tool</td></tr>
<tr><td>Developmental Monitoring</td><td>- All programs must utilize the Creative Curriculum Developmental Continuum online at least two times per year.</td></tr>
<tr><td>Professional Development</td><td><u>Professional Development</u>:
A Professional Development plan must be submitted that includes the PD needs of all staff.</td></tr>
<tr><td>Program Evaluation</td><td><u>Programs must administer an annual evaluation of their classroom environment, child and family goals, and complete an improvement plan based on the findings of the evaluation.</u></td></tr>
<tr><td>Group size and ratio</td><td>Group size and ratios must meet the following requirements:

<table>
<tr><th>Age</th><th>Ratio</th><th>Group Size</th></tr>
<tr><td>6wk – 12mo.</td><td>1:4</td><td>8</td></tr>
<tr><td>12-24 mo.</td><td>1:4</td><td>12</td></tr>
<tr><td>24-36 mo.</td><td>1:6</td><td>12</td></tr>
</table>
</td></tr>
<tr><td>Classroom Staff Qualifications</td><td><u>Education Requirements</u>:
Teachers must hold a BA or AA in Child Development or Early Childhood Education.

Teacher Assistants must have at least 30 college credit hours with at least 15 hours in child development or Early Childhood Education.</td></tr>
<tr><td>Research-Based Parent Education Curriculum</td><td>All programs must utilize a researched based parent education curriculum</td></tr>
<tr><td>Family Support Staff Qualifications</td><td>Family Support Specialist must have a BA/MA in Human Services or other related field.</td></tr>
<tr><td>Case Load</td><td>For Family Support Specialist: 1 FTE for up to 36 families</td></tr>
<tr><td>Frequency of home visits/group services</td><td>- Based on family need; high need families should receive intensive support.
- A minimum of weekly contact is recommended for all families.</td></tr>
<tr><td>Family and Community Partnerships</td><td>- Family Support staff must complete an IFSP with each family
- Programs must have written community partnership agreements</td></tr>
<tr><td>Supervision</td><td>Each site must have an Infant Toddler Specialist with a Level 5 Infant Toddler Credential, Erikson Institute Infant Studies certificate, or 18 hours of infant toddler studies and participation in CPP Professional Development for Infants and Toddlers. The IT specialist interacts with the 0-3 staff in a supervisory capacity.</td></tr>
<tr><td>Contact Information:</td><td>Rebecca Klein
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Center-Based infant Toddler Care
(Based on Early Head Start Standards)
Full Profile of Program Model

	Center-Based Infant Toddler Care
Program Purpose & Description	**Purpose** • To enhance the physical, cognitive, social, and emotional growth of infants and toddlers; to support parents' efforts to fulfill their parental roles; and to help parents move toward self-sufficiency. **Description** • Center-based infant toddler care aims to improve the growth and development of children before they transition to Head Start or Preschool for All by providing early, continuous, intensive and comprehensive child development and family support services on a year-round basis. Children are enrolled in full-day, full year care, and parents receive intensive parenting education and support.
Target Population	• Children birth to age 3 who are at high risk for school failure and who need full-day, full-year care due to their parents work or school schedule.
Key Services	**Child Health & Developmental Services** • Grantees provide screening for developmental, sensory and behavioral concerns as well as linkages to preventive and primary health care and follow-up necessary as a result of screenings. Information from screenings as well as parents is used to determine how the program can best respond to each individual child's characteristics, strengths and needs. Program assures that each child has a "medical home." **Education & Early Childhood Development Services** • Provides opportunities for each child to explore sensory and motor experiences, supports emotional development, encourages trust, self-awareness and autonomy, and promotes the development of cognitive, language and numeracy skills. **Child Health & Safety Services** • Ensures healthy physical development through hygiene, injury prevention, and the proper provision of medication and first aid. **Child Nutrition Services** • Addresses children's nutritional needs through meal service, family assistance with nutrition, and information on food safety. **Child Mental Health Services** • Ensures the mental wellness of every child by: 1) working collaboratively with parents, 2) conducting regular, on-site mental health consultations which include mental health professionals, program staff, and parents, and 3) securing the services of professionals when needed. Support for children's social and emotional development is integrated into all aspects of the program. (See Methods and Approaches for more details.) **Family Partnerships** • Collaboration with parents is fundamental to the model. (See Parent Involvement for more details.) **Community Partnerships** • Agencies should assess, collaborate and coordinate with other programs and resources in the community.
Outreach & Recruitment	• Agencies systematically identify families whose children are eligible for EHS services, inform them of the services available, and encourage them to apply for enrollment in the program.

Center-Based infant Toddler Care
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	Center-Based Infant Toddler Care
Outreach & Recruitment continued	○ Each agency must conduct a Community Assessment of its service area once every three years. This information is used to determine the recruitment area. ○ Strategies used by agencies to recruit families may include: canvassing the community, writing press releases, other advertising, and referrals from currently participating families as well as from other agencies. ○ Agencies should seek EHS applications from as many families as possible. If necessary, programs should help families fill out applications. Programs should seek a greater number of applications than the number of available slots, in order to select children with the greatest need for services.
Methods & Approaches	• All programs must have a written plan or curriculum based on developmental principles of how children learn and grow. Curriculum includes 1) the goals for children's development and learning, 2) the experiences through which they will achieve the goals, 3) what staff and parents do to help children achieve goals, and 4) the materials needed to support the curriculum. • Curriculum for infants and toddlers must: ○ Encourage the development of **secure relationships** by employing a limited number of consistent teachers over an extended period of time. Teachers must demonstrate an understanding of the child's family culture and, whenever possible, speak the child's language; ○ Encourage **trust and emotional security**; ○ Encourage each child to explore a variety of **sensory and motor experiences** with support and stimulation from teachers and family members. • Curriculum must also support the **social and emotional development** of infants and toddlers by: ○ Encouraging the development of **self-awareness**, **autonomy**, and **self-expression**; and ○ Supporting the emerging **communication skills** of infants and toddlers by providing daily opportunities for each child to interact with others and to express himself or herself freely. • Curriculum must also promote the **physical development** of infants and toddlers by supporting the development of physical skills, including both gross and fine motor skills.
Intensity of Services	**EHS Center-Based Services** • Center-based services are provided on a full-day, year-round basis. Center-based services must also provide some home visits to parents. **EHS Home Visiting Services** • Home visiting services are provided on a year-round basis. **EHS Socialization Activities** • EHS provides, at a minimum, two group socialization activities per month for each child (a minimum of 16 group socialization activities per year). These activities are required for both home visiting and center-based services.

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	Center-Based Infant Toddler Care
Staff Qualifications & Supervision	**<u>Qualifications*</u>** *Classroom Teachers:* • Must have an associate's, bachelors or advanced degree in early childhood education or a related field as well as experience working with infants and toddlers. *Each classroom without the above must have at least one teacher with:* • An age-appropriate Child Development Associate (CDA) credential; or • A state-awarded certificate for preschool teachers that exceeds CDA; or • A degree in a field related to early childhood education as well as experience teaching preschool children and a state- awarded certificate to teach in a preschool program. *EHS Home Visitors:* • Must have knowledge and experience in: child development and early childhood education; child health, safety and nutrition; adult learning principles; and family dynamics. • Agencies may require additional qualifications for home visitors, including: a CDA credential, certain college course work, or a particular level of job training and/or experience. *Required staff qualifications are being reviewed and may be changing.

Staff Training	• Agencies must provide an orientation to all new staff, consultants, and volunteers that includes the goals and philosophy of EHS and the ways in which they are implemented by the program. Training opportunities must be informed by the agency's Community Assessment.
	
	• Agencies must implement a structured approach to staff training and development, attaching academic credit whenever possible. This system should be designed to: 1) help build relationships among staff and 2) assist staff in acquiring or increasing job-related knowledge and skills.
	
	• Ongoing training opportunities must be provided and must include:
	  o Identifying and reporting child abuse and neglect; and
	  o Planning for successful child and family transitions to and from the EHS program.

Staff Caseload/ Class Size	**<u>Class Size in EHS Center-Based Programs</u>** • One teacher cannot be responsible for more than four infants and toddlers. No more than eight infants and toddlers may be placed in any one group. **<u>EHS Home Visiting Caseloads</u>** • Each home visitor must maintain an average caseload of 10 to 12 families (maximum caseload is 12 families).
Matching Services to Need	• Agencies must offer parents the opportunity to develop and implement individualized family partnership agreements that identify family goals and responsibilities as well as timetables and strategies for achieving these goals.

Center-Based infant Toddler Care
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	Center-Based Infant Toddler Care
Coordination of Services	• To improve the delivery of services to children and families, agencies must take an active role in encouraging strong communication and cooperation with their community partners, including sharing information in accordance with agency confidentiality policies. • Affirmative steps must be taken to establish ongoing collaborative relationships with other community organizations, including: o Health care providers o Mental health providers o Nutritional service providers o Agencies that provide services to children with disabilities o Family preservation & support services o Child protective services o Elementary schools & other educational institutions o Providers of child care services
Parent Involvement	• Agencies must engage in a process of collaborative partnership-building with parents to establish mutual trust and to identify family goals, strengths, and needed services. This process must be initiated as early after enrollment as possible and must take into consideration each family's readiness and willingness to participate in the process. (Also see Matching Services to Need above.) • Agencies must assist pregnant women in accessing comprehensive prenatal and postpartum care by making referrals immediately after program enrollment. • Agencies must also provide pregnant women (and other family members as appropriate) with prenatal education on fetal development (including risks from smoking and alcohol), labor and delivery, postpartum recovery (including maternal depression), and the benefits of breast feeding.
Credentialing or Certification Process	Not applicable.
Program Monitoring and Evaluation	**Site visits** • EHS federal program officers conduct an on-site program review every three years. **Data collection** • Grantee and delegate agencies must establish and maintain efficient and effective record-keeping systems to provide accurate and timely information regarding children, families, and staff; programs must ensure the confidentiality of this data. Grantees must also provide annual Program Information Reports (PIRs) to EHS federal program officers. **Self-assessment** • At least once each year, agencies must conduct a self-assessment of their progress in meeting program goals and implementing Federal regulations. This process must involve parents and be approved by the Policy Council. Findings from this self-assessment should inform Program Improvement Plans, long-range program goals, and short-term program and financial objectives.

Center-Based infant Toddler Care
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Full Profile of Program Model

	Center-Based Infant Toddler Care
Program Monitoring and Evaluation continued	**Community assessment** • At least once every three years, agencies must conduct a community assessment. This process must involve parents and be approved by the Policy Council. Findings from this assessment should inform Program Improvement Plans, long-range program goals, and short-term program and financial objectives. **Program evaluation** Several national evaluations have been conducted. Individual programs are not required to conduct their own evaluations.
Program Costs	**Cost per participant** • Approximately $9,000 per child in addition to Child Care Assistance funding.
Supporting Research Citations	• Early Head Start's home-based model has been shown to increase children's cognitive and language development, lower children's levels of aggression and promote positive interaction between children and parents. (Love et al., 2002) • Early Head Start parents: o Provide significantly more support for language and learning in their homes o Are more likely to read daily to their children o Are more emotionally supportive of their children o Are less likely to engage in negative parenting behaviors o Report a greater repertoire of appropriate discipline strategies o Are less likely to spank their child (Early Head Start Research and Evaluation Project, 2002)
Model-Specific Resources	• Early Head Start website: www.ehsnrc.org • EHS/Head Start Program Standards • Program Review Instrument for Systems Monitoring (PRISM) • Head Start Bureau Evaluation Handbook
Initial Point of Contact for Program Model Information	Rebecca Klein Center-Based Training Manager Ounce of Prevention Fund Hayes Center 4859 Wabash Ave. Chicago, Illinois 60615 773 373-8670 rklein@ounceofprevention.org

If you would like a current listing of those Illinois programs that use the Early Head Start Center-Based Model, with locations and contact information please contact Rebecca Klein (rklein@ounceofprevention.org).

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	ISBE & CPS Performance Standard(s)	ISBE & CPS Center-Based Infant Toddler Care Performance Standard Description
SECTION I	**ORGANIZATION**		
I.A.	**All birth to three programs must have a mission statement based on shared beliefs and goals.** *Quality Indicator I.A.1*. A mission statement based on shared beliefs is developed cooperatively by parents, staff members, families, and community representatives and is reviewed annually. *Quality Indicator I.A.2*. The mission statement and beliefs are consistent with those of the community. *Quality Indicator I.A.3*. The essence of the mission statement is reflected in all decisions, and a copy is posted and available. *Quality Indicator I.A.4*. The goals stem from the Illinois Birth to Three Program Standards. These program goals are developed by leadership and staff, shared with parents and other stakeholders, and serve as the basis for all planning and program development.	**1304.51(a)(1) (i) - (iii)**	**1304.51:** **(a) Program Planning** (1) Agencies must develop and implement a systematic, ongoing process of program planning that includes consultation with the program's governing body, policy groups, and program staff, and with other community organizations that serve EHS or other low-income families with young children. Program planning must include: (i) An assessment of community strengths, needs and resources through completion of the Community Assessment, in accordance with the requirements of 45 CFR 1305.3; (ii) The formulation of both multi-year (long-range) program goals and short-term program and financial objectives that address the findings of the Community Assessment, are consistent with the philosophy of EHS, and reflect the findings of the program's annual self-assessment; and (iii) The development of written plan(s) for implementing services in each of the program areas covered by this part (e.g., Early Childhood Development and Health Services, Family and Community Partnerships, and Program Design and Management). (See the requirements of 45 CFR Parts 1305, 1306, and 1308.)
I.B.	**Scheduling practices and intensity of services are tailored to the individual strengths and needs of children birth to three and their families.**	**1304.20(f)(1)** **1304.21(a)(1)(i)**	**1304.20:** **(f) Individualization of the program** (1) Agencies must use the information from the screenings for developmental, sensory, and behavioral concerns, the ongoing observations, medical and dental evaluations and treatments, and insights from the child's parents to help staff and parents determine how the program can best respond to each child's individual characteristics, strengths and needs. **1304.21:** **(a) Child development and education approach for all children** (1) In order to help children gain the social competence, skills and confidence necessary to be prepared to succeed in their present environment and with later responsibilities in school and life, agencies' approach to child development and education must:

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	ISBE & CPS Performance Standard(s)	ISBE & CPS Center-Based Infant Toddler Care Performance Standard Description
I.B. continued		**1304.20(f)(1)** **1304.21(a)(1)(i) continued**	(i) Be developmentally and linguistically appropriate, recognizing that children have individual rates of development as well as individual interests, temperaments, languages, cultural backgrounds, and learning styles.
I.C.	**The strengths and needs of the children and families as well as research on best practice determine the ratio of participants to staff and the size of program groups.** *Quality Indicator I.C.1.* Group size and ratios of adults to infants and toddlers are developmentally appropriate in program groups.	**1304.20(f)(1)** **1304.52(g)(3) & (4)**	**1304.20:** **(f) Individualization of the program** (1) Agencies must use the information from the screenings for developmental, sensory, and behavioral concerns, the ongoing observations, medical and dental evaluations and treatments, and insights from the child's parents to help staff and parents determine how the program can best respond to each child's individual characteristics, strengths and needs. **1304.52:** **(g) Classroom staffing and home visitors** (3) For center-based programs, the class size requirements specified in 45 CFR 1306.32 must be maintained through the provision of substitutes when regular classroom staff are absent. (4) Agencies must ensure that each teacher working exclusively with infants and toddlers has responsibility for no more than four infants and toddlers and that no more than eight infants and toddlers are placed in any one group. However, if State, Tribal, or local regulations specify staff: child ratios and group sizes more stringent than this requirement, the State, Tribal, or local regulations must apply.
I.D.	**The program meets the needs of children and families of varying abilities as well as diverse cultural, linguistic, and economic backgrounds.** *Quality Indicator I.D.1.* Qualified staff who demonstrate cultural and linguistic competency are available to effectively interact with families. *Quality Indicator I.D.2.* A variety of activities, strategies, and materials are used to meet the diverse needs of children and families.	**1304.21(a)(1) (i) & (iii)** **1304.51(c)(1) &(2)** **1304.52(h)(1)(i)** **1304.21(a)(1) (i) & (iii)** **1304.51(c)(1) &(2)** **1304.52(h)(1)(i)**	**1304.21:** **(a) Child development and education approach for all children** (1) In order to help children gain the social competence, skills and confidence necessary to be prepared to succeed in their present environment and with later responsibilities in school and life, agencies' approach to child development and education must: (i) Be developmentally and linguistically appropriate, recognizing that children have individual rates of development as well as individual interests, temperaments, languages, cultural backgrounds, and learning styles; and (iii) Provide an environment of acceptance that supports and respects gender, culture, language, ethnicity and family composition.

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	ISBE & CPS Performance Standard(s)	ISBE & CPS Center-Based Infant Toddler Care Performance Standard Description
I.D. continued		**1304.21(a)(1) (i) & (iii)** **1304.51(c)(1) &(2)** **1304.52(h)(1)(i)** **1304.21(a)(1) (i) & (iii)** **1304.51(c)(1) &(2)** **1304.52(h)(1)(i) continued**	**1304.51:** **(c) Communication with families** (1) Agencies must ensure that effective two-way comprehensive communications between staff and parents are carried out on a regular basis throughout the program year. (2) Communication with parents must be carried out in the parents' primary or preferred language or through an interpreter, to the extent feasible. **1304.52:** **(h) Standards of conduct** (1) Agencies must ensure that all staff, consultants, and volunteers abide by the program's standard of conduct. These standards specify that: They will respect and promote the unique identity of each child and family and refrain from stereotyping on the basis of gender, race, ethnicity, culture, religion, or disability.
I.E.	**The physical environment of the program is safe, healthy, and appropriate for children's development and family involvement.** *Quality Indicator I.E.1*. The program implements local and state health and safety guidelines. *Quality Indicator I.E.2*. The program décor, furnishings, materials, and resources are appropriate for infants and toddlers and their families.	**1304.53(a) (1), (7), & (10)** **1304.53(b)(1)-(3)**	**1304.53:** **(a) Head Start physical environment and facilities** (1) Agencies must provide a physical environment and facilities conducive to learning and reflective of the different stages of development of each child. (7) Agencies must provide for the maintenance, repair, safety, and security of all EHS facilities, materials and equipment. (10) Agencies must conduct a safety inspection, at least annually, to ensure that each facility's space, light, ventilation, heat, and other physical arrangements are consistent with the health, safety and developmental needs of children. (NOTE: This standard includes many additional, specific minimum requirements.) **1304.53:** **(b) Head Start equipment, toys, materials, and furniture** (1) Agencies must provide and arrange sufficient equipment, toys, materials, and furniture to meet the needs and facilitate the participation of children and adults. (NOTE: This standard includes many additional, specific requirements for toys, materials, and furniture.) (2) Infant and toddler toys must be made of non-toxic materials and must be sanitized regularly. (3) To reduce the risk of Sudden Infant Death Syndrome (SIDS), all sleeping arrangements for infants must use firm mattresses and avoid soft bedding materials such as comforters, pillows, fluffy blankets or stuffed toys.

ISBE Birth To Three Program Standards & CPS Center-Based Infant Toddler Care Performance Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	ISBE & CPS Performance Standard(s)	ISBE & CPS Center-Based Infant Toddler Care Performance Standard Description
I.F.	**The administration promotes and practices informed leadership and supervision. The administration participates in and encourages ongoing staff development, training, and supervision.**	**1304.52(k)(1)-(3)**	**1304.52:** **(k) Training and development** (1) Agencies must provide an orientation to all new staff, consultants, and volunteers that includes, at a minimum, the goals and underlying philosophy of EHS and the ways in which they are implemented by the program. (2) Agencies must establish and implement a structured approach to staff training and development, attaching academic credit whenever possible. This system should be designed to help build relationships among staff and to assist staff in acquiring or increasing the knowledge and skills needed to fulfill their job responsibilities, in accordance with the requirements of 45 CFR 1306.23. (3) At a minimum, this system must include ongoing opportunities for staff to acquire the knowledge and skills necessary to implement the content of the HS program Performance Standards. (NOTE: This standard also includes additional, specific training requirements.)
I.G.	**All birth to three programs must follow mandated reporting laws for child abuse and neglect and have a written policy statement addressing staff responsibilities and procedures regarding implementation.** *Quality Indicator I.G.1*. The program leadership familiarizes staff with the Abused and Neglected Child Reporting Act [325 ILCS 5] as well as with the program's policy. This should be included as part of new staff orientation and, at a minimum, be reviewed annually.	**1304.52(k)(1)-(3)(i)**	**1304.52:** **(k) Training and development** (1) Agencies must provide an orientation to all new staff, consultants, and volunteers that includes, at a minimum, the goals and underlying philosophy of EHS and the ways in which they are implemented by the program. (2) Agencies must establish and implement a structured approach to staff training and development, attaching academic credit whenever possible. This system should be designed to help build relationships among staff and to assist staff in acquiring or increasing the knowledge and skills needed to fulfill their job responsibilities, in accordance with the requirements of 45 CFR 1306.23. (3) At a minimum, this system must include ongoing opportunities for staff to acquire the knowledge and skills necessary to implement the content of the HS program Performance Standards. This program must also include: (i) Methods of identifying and reporting child abuse and neglect that comply with applicable State and local laws using, so far as possible, a helpful rather than a punitive attitude toward abusing or neglecting parents and other caretakers.
I.H.	**The program budget is developed to support quality program service delivery.**	**N/A**	Not applicable.

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SECTION II	**CURRICULUM & SERVICE PROVISION**		
II.A.	**The curriculum reflects the centrality of adult/child interactions in the development of infants and toddlers.** *Quality Indicator II.A.1*. Positive parent/child interactions are encouraged and promoted in all aspects of the program. *Quality Indicator II.A.2*. The curriculum promotes parent/child interactions in the way sessions are designed and conducted by staff. *Quality Indicator II.A.3*. The development of a sense of trust and autonomy among staff, children, and families is a priority. *Quality Indicator II.A.4*. Parents receive education and support to identify and cope with life stressors that may place their family at risk.	**1304.21(a)(2)(ii) & (iii)** **1304.21(a)(3)(i)(A) & (B)** **1304.21(a)(4)(iii)** **1304.21(b)(1)(i) & (ii)** **1304.21(b)(2)(i)** **1304.40(a)(1)** **1304.40(b)(1)(ii)**	**1304.21:** **(a) Child development and education approach for all children** (2) Parents must be: (ii) Provided opportunities to increase their child observation skills and to share assessments with staff that will help plan the learning experiences; and (iii) Encouraged to participate in staff-parent conferences and home visits to discuss their child's development and education (see 45 CFR 1304.40(e)(4) and 45 CFR 1304.40(i)(2)). (3) Agencies must support social and emotional development by: (i) Encouraging development which enhances each child's strengths by: (A) Building trust; and (B) Fostering independence. (4) Agencies must provide for the development of each child's cognitive and language skills by: (iii) Promoting interaction and language use among children and between children and adults. **1304.21:** **(b) Child development and education approach for infants and toddlers** (1) Agencies' program of services for infants and toddlers must encourage (see 45 CFR for a definition of curriculum): (i) The development of secure relationships in out-of-home care settings for infants and toddlers by having a limited number of consistent teachers over an extended period of time. Teachers must demonstrate an understanding of the child's family culture and, whenever possible, speak the child's language (see 45 CFR 1304.52(g)(2)); and (ii) Trust and emotional security so that each child can explore the environment according to his or her developmental level. (2) Agencies must support the social and emotional development of infants and toddlers by promoting an environment that: Encourages the development of self-awareness, autonomy, and self-expression.

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	ISBE & CPS Performance Standard(s)	ISBE & CPS Center-Based Infant Toddler Care Performance Standard Description
II.A. continued		**1304.21(a)(2)(ii) & (iii)** **1304.21(a)(3)(i)(A) & (B)** **1304.21(a)(4)(iii)** **1304.21(b)(1)(i) & (ii)** **1304.21(b)(2)(i)** **1304.40(a)(1)** **1304.40(b)(1)(ii) continued**	**1304.40:** **(a) Family goal setting** (1) Agencies must engage in a process of collaborative partnership-building with parents to establish mutual trust and to identify family goals, strengths, and necessary services and other supports. This process must be initiated as early after enrollment as possible and it must take into consideration each family's readiness and willingness to participate in the process. **(b) Accessing community services and resources** (1) Agencies must work collaboratively with all participating parents to identify and continually access, either directly or through referrals, services and resources that are responsive to each family's interest and goals, including: Education and other appropriate interventions, including opportunities for parents to participate in counseling programs or to receive information on mental health issues that place families at risk, such as substance abuse, child abuse and neglect, and domestic violence.
II.B.	**The curriculum reflects the holistic and dynamic nature of child development.** Quality Indicator II.B.1. A balance of all developmental areas: cognitive, communication, physical, social, and emotional is demonstrated in all activities and service provision. *Quality Indicator II.B.2*. An integrated and individualized program is offered for children in the context of their families. *Quality Indicator II.B.4*. A variety of high quality, developmentally appropriate activities and materials are utilized in a safe and supportive environment. *Quality Indicator II.B.5*. An emergent literacy focus is observable in the activities, materials, and environment planned for the child.	**1304.20(f)(1)** **1304.21(a)(1)(i)** **1304.21(a)(3)** **1304.21(a)(4)** **1304.21(a)(4)(iv)** **1304.21(a)(5)** **1304.21(a)(5)(i)** **1304.21(a)(6)** **1304.21(b)(2)(i) & (ii)** **1304.21(b)(3)(i)**	**1304.20:** **(f) Individualization of the program** (1) Agencies must use the information from the screenings for developmental, sensory, and behavioral concerns, the ongoing observations, medical and dental evaluations and treatments, and insights from the child's parents to help staff and parents determine how the program can best respond to each child's individual characteristics, strengths and needs. **1304.21:** **(a) Child development and education approach for all children** (1) In order to help children gain the social competence, skills and confidence necessary to be prepared to succeed in their present environment and with later responsibilities in school and life, agencies' approach to child development and education must: (i) Be developmentally and linguistically appropriate, recognizing that children have individual rates of development as well as individual interests, temperaments, languages, cultural backgrounds, and learning styles. (3) Agencies must support social and emotional development.

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	ISBE & CPS Performance Standard(s)	ISBE & CPS Center-Based Infant Toddler Care Performance Standard Description
II.B. continued		**1304.20(f)(1)** **1304.21(a)(1)(i)** **1304.21(a)(3)** **1304.21(a)(4)** **1304.21(a)(4)(iv)** **1304.21(a)(5)** **1304.21(a)(5)(i)** **1304.21(a)(6)** **1304.21(b)(2) (i) & (ii)** **1304.21(b)(3)(i) continued**	(4) Agencies must provide for the development of each child's cognitive and language skills by: (iv) Supporting emerging literacy and numeracy development through materials and activities according to the developmental level of the child. (5) In center-based settings, agencies must promote each child's physical development by: (i) Providing sufficient time, indoor and outdoor space, equipment, materials and adult guidance for active play and movement that support the development of gross motor skills. (6) In home-based settings, agencies must encourage parents to appreciate the importance of physical development, provide opportunities for children's outdoor and indoor active play, and guide children in the safe use of equipment and materials. **(b) Child development and education approach for infants and toddlers** (2) Agencies must support the social and emotional development of infants and toddlers by promoting an environment that: (i) Encourages the development of self-awareness, autonomy, and self-expression; and (ii) Supports the emerging communication skills of infants and toddlers by providing daily opportunities for each to interact with others and to express himself or herself freely. (3) Agencies must promote the physical development of infants and toddlers by: Supporting the development of the physical skills of infants and toddlers, such as grasping, pulling, pushing, crawling, walking, and climbing.
II.C.	The curriculum prioritizes family involvement while respecting individual parental choices. Quality Indicator II.C.1. Opportunities are provided for varied levels of parent participation. Quality Indicator II.C.2. Opportunities are provided for parents to increase their levels of program involvement through education and enrichment. Quality Indicator II.C.3. The curriculum and activities support family literacy.	**1304.21(a)(2) (i) - (iii)** **1304.40(d)(1) - (3)** **1304.40(e)(1) - (4) (i) & (ii)**	**1304.21:** **(a) Child development and education approach for all children** (2) Parents must be: (i) Invited to become integrally involved in the development of the program's curriculum and approach to child development and education; (ii) Provided opportunities to increase their child observation skills and to share assessments with staff that will help plan the learning experiences; and (iii) Encouraged to participate in staff-parent conferences and home visits to discuss their child's development and education (see 45 CFR 1304.40(e)(4) and 45 CFR 1304.40(i)(2)).

ISBE Birth To Three Program Standards & CPS Center-Based Infant Toddler Care Performance Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	ISBE & CPS Performance Standard(s)	ISBE & CPS Center-Based Infant Toddler Care Performance Standard Description
II.C. continued		**1304.21(a)(2) (i) - (iii)** **1304.40(d)(1) - (3)** **1304.40(e)(1) - (4) (i) & (ii) continued**	**1304.40:** **(d) Parent involvement - general** (1) In addition to involving parents in policy-making and operations (see 45 CFR 1304.50), agencies must provide parent involvement and education activities that are responsive to the ongoing and expressed needs of the parents, both as individuals and as members of a group. Other community agencies should be encouraged to assist in the planning and implementation of such programs. (2) EHS settings must be open to parents during all program hours. Parents must be welcomed as visitors and encouraged to observe children as often as possible and to participate with children in group activities. The participation of parents in any program activity must be voluntary, and must not be required as a condition of the child's enrollment. (3) Agencies must provide opportunities for parents to participate in the program as employees or volunteers (see 45 CFR 1304.52(b)(3) for additional requirements about hiring parents). **(e) Parent involvement in child development and education** (1) Agencies must provide opportunities to include parents in the development of the program's curriculum and approach to child development and education (see 45 CFR 1304.3(a)(5) for a definition of curriculum). (2) Agencies operating home-based program options must build upon the principles of adult learning to assist, encourage, and support parents as they foster the growth and development of their children. (3) Agencies must provide opportunities for parents to enhance their parenting skills, knowledge, and understanding of the educational and developmental needs and activities of their children and to share concerns about their children with program staff (see 45 CFR 1304.21 for additional requirements related to parent involvement). (4) Agencies must provide, either directly or through referrals to other local agencies, opportunities for children and families to participate in family literacy services by: (i) Increasing family access to materials, services, and activities essential to family literacy development; and Assisting parents as adult learners to recognize and address their own literacy goals.

ISBE Birth To Three Program Standards & CPS Center-Based Infant Toddler Care Performance Standards

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II.D.	The curriculum supports and demonstrates respect for the families' unique abilities as well as for their ethnic, cultural, and linguistic diversity. Quality Indicator II.D.2. Program services are provided in the family's primary language whenever possible.	**1304.21(a)(1)(iii)** **1304.21(a)(3)(i)(E)** **1304.21(b)(1)(i)**	**1304.21:** **(a) Child development and education approach for all children** (1) In order to help children gain the social competence, skills and confidence necessary to be prepared to succeed in their present environment and with later responsibilities in school and life, agencies' approach to child development and education must: (ii) Provide an environment of acceptance that supports and respects gender, culture, language, ethnicity and family composition. (3) Agencies must support social and emotional development by: (i) Encouraging development which enhances each child's strengths by: (E) Supporting and respecting the home language, culture, and family composition of each child in ways that support the child's health and well-being. **(b) Child development and education approach for infants and toddlers** (1) Agencies' program of services for infants and toddlers must encourage (see 45 CFR 1304.3(a)(5) for a definition of curriculum): (i) The development of secure relationships in out-of-home care settings for infants and toddlers by having a limited number of consistent teachers over an extended period of time. Teachers must demonstrate an understanding of the child's family culture and, whenever possible, speak the child's language (see 45 CFR 1304.52(g)(2)).
II.E.	The curriculum promotes a framework that is nurturing, predictable, and consistent, yet flexible. Quality Indicator II.E.1. Schedules and routines are familiar and available in print. Quality Indicator II.E.2. The program responds to the participant's individual cues and makes accommodations.	**1304.21(a)(3)(ii)**	**1304.21:** **(a) Child development and education approach for all children** (3) Agencies must support social and emotional development by: (ii) Planning for routines and transitions so that they occur in a timely, predictable and unrushed manner according to each child's needs.

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SECTION III	**DEVELOPMENTAL MONITORING & PROGRAM ACCOUNTABILITY**		
III.A.	**The program staff regularly monitors children's development.** *Quality Indicator III.A.3*. The staff obtains information from different sources and shares the information with parents. The parents are further involved in the interpretation of this information in support of the child's development. *Quality Indicator III.A.4*. Children are referred to the Illinois Early Intervention System when appropriate. *Quality Indicator III.A.5*. Families are informed of appropriate programs in the community by the child's third birthday.	**1304.20(b)(1) & (3)** **1304.20(d)** **1304.20(f)(2)(ii)** **1304.40(b)(1)**	**1304.20:** **(b) Screening for developmental, sensory, and behavioral concerns** (1) In collaboration with each child's parent, and within 45 calendar days of the child's entry into the program, agencies must perform or obtain linguistically and age appropriate screening procedures to identify concerns regarding a child's developmental, sensory (visual and auditory), behavioral, motor, language, social, cognitive, perceptual, and emotional skills (see 45 CFR 1308.6(b)(3) for additional information). To the greatest extent possible, these screening procedures must be sensitive to the child's cultural background. (3) Agencies must utilize multiple sources of information on all aspects of each child's development and behavior, including input from family members, teachers, and other relevant staff who are familiar with the child's typical behavior. (4) **(d) Ongoing care**: In addition to assuring children's participation in a schedule of well child care, as described in section 1304.20(a) of this part, grantee and delegate agencies must implement ongoing procedures by which EHS and HS staff can identify any new or recurring medical, dental, or developmental concerns so that they may quickly make appropriate referrals. These procedures must include: periodic observations and recordings, as appropriate, of individual children's developmental progress, changes in physical appearance (e.g., signs of injury or illness) and emotional and behavioral patterns. In addition, these procedures must include observations from parents and staff. **(f) Individualization of the program** (2) To support individualization for children with disabilities in their programs, grantee and delegate agencies must assure that: (ii) Enrolled families with infants and toddlers suspected of having a disability are promptly referred to the local early intervention agency designated by the State Part C plan to coordinate any needed evaluations, determine eligibility for Part C services, and coordinate the development of an IFSP for children determined to be eligible under the guidelines of that State's program. Agencies must support parent participation in the evaluation and IFSP development process for infants and toddlers enrolled in their program.

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III.A. continued		**1304.20(b)(1) & (3)** **1304.20(d)** **1304.20(f)(2)(ii)** **1304.40(b)(1) continued**	**1304.40:** **(b) Accessing community services and resources** Agencies must work collaboratively with all participating parents to identify and continually access, either directly or through referrals, services and resources that are responsive to each family's interests and goals.
III.B.	**Leadership conducts regular and systematic evaluations of the program and staff to assure that the philosophy is reflected and goals of the program are being fulfilled.** *Quality Indicator III.B.1*. An annual evaluation is conducted of program quality and progress toward goals. *Quality Indicator III.B.2*. The results of the program evaluation are reviewed annually and are used or considered in making organizational and/or programmatic changes.	**1304.51(a)(1)(ii)** **1304.51(i)(1)** **1304.52(i)**	**1304.51:** **(a) Program Planning** (1) Agencies must develop and implement a systematic, ongoing process of program planning that includes consultation with the program's governing body, policy groups, and program staff, and with other community organizations that serve EHS or other low-income families with young children. Program planning must include: (ii) The formulation of both multi-year (long-range) program goals and short-term program and financial objectives that address the findings of the Community Assessment, are consistent with the philosophy of EHS, and reflect the findings of the program's annual self-assessment. **(i) Program self-assessment and monitoring** (1) At least once each program year, with the consultation and participation of the policy groups and, as appropriate, other community members, agencies must conduct a self-assessment of their effectiveness and progress in meeting program goals and objectives and in implementing Federal regulations. **1304.52:** **(i) Staff performance appraisals**: Agencies must, at a minimum, perform annual performance reviews of each EHS staff member and use the results of these reviews to identify staff training and professional development needs, modify staff performance agreements, as necessary, and assist each staff member in improving his or her skills and professional competencies.

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SECTION IV	**PERSONNEL**		
IV.A.	**The program leadership is knowledgeable about child development and best practice for quality birth to three programs.**	**1304.52(d)(1)**	**1304.52:** **(d) Qualifications of content area experts:** Agencies must hire staff or consultants who meet the qualifications listed below to provide content area expertise and oversight on an ongoing or regularly scheduled basis. Agencies must determine the appropriate staffing pattern necessary to provide these functions. (NOTE: This standard includes specific requirements for each type of staff position.) (1) Education and child development services must be supported by staff or consultants with training and experience in areas that include: the theories and principles of child growth and development, early childhood education, and family support. In addition, staff or consultants must meet the qualifications for classroom teachers, as specified in section 648A of the Head Start Act and any subsequent amendments regarding the qualifications of teachers.
IV.B.	**The program leadership is effective in explaining, organizing, implementing, supervising, and evaluating birth to three programs.**	**1304.52(c)**	**1304.52:** **(c) EHS director qualifications:** The EHS director must have demonstrated skills and abilities in a management capacity relevant to human services program management
IV.C.	**The program leadership hires qualified staff who are competent in working with infants and toddlers and their families.**	**1304.40(a)(5)** **1304.52(b)(1),(2) & (4)** **1304.52(d)(1)** **1304.52(g)(2)**	**1304.40:** **(a) Family goal setting** (5) Meetings and interactions with families must be respectful of each family's diversity and cultural and ethnic background. **1304.52:** **(b) Staff qualifications - general** (1) Agencies must ensure that staff and consultants have the knowledge, skills, and experience they need to perform their assigned functions responsibly. (2) In addition, agencies must ensure that only candidates with the qualifications specified in this part and in 45 CFR 1306.21 are hired. (4) Staff and program consultants must be familiar with the ethnic background and heritage of families in the program and must be able to serve and effectively communicate, to the extent feasible, with children and families with no or limited English proficiency.

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IV.C. continued		**1304.40(a)(5)** **1304.52(b)(1),(2) & (4)** **1304.52(d)(1)** **1304.52(g)(2) continued**	**(d) Qualifications of content area experts**: Agencies must hire staff or consultants who meet the qualifications listed below to provide content area expertise and oversight on an ongoing or regularly scheduled basis. Agencies must determine the appropriate staffing pattern necessary to provide these functions. (NOTE: This standard includes specific requirements for each type of staff position.) (1) Education and child development services must be supported by staff or consultants with training and experience in areas that include: the theories and principles of child growth and development, early childhood education, and family support. In addition, staff or consultants must meet the qualifications for classroom teachers, as specified in section 648A of the Head Start Act and any subsequent amendments regarding the qualifications of teachers. **(g) Classroom staffing and home visitors** When a majority of children speak the same language, at least one classroom staff member or home visitor interacting regularly with the children must speak their language.
IV.D.	**The program leadership provides ongoing supervision that promotes staff development and enhances quality service delivery.** *Quality Indicator IV.D.1*. Program leadership creates and maintains an atmosphere that is nurturing and supportive of staff. *Quality Indicator IV.D.3*. The supervisor in partnership with each staff member develops a formative supervision plan.	**1304.52(a)(1)** **1304.52(i)**	**1304.52:** **(a) Organizational structure** (1) Agencies must establish and maintain an organizational structure that supports the accomplishment of program objectives. This structure must address the major functions and responsibilities assigned to each staff position and must provide evidence of adequate mechanisms for staff supervision and support. **(i) Staff performance appraisals**: Agencies must, at a minimum, perform annual performance reviews of each EHS staff member and use the results of these reviews to identify staff training and professional development needs, modify staff performance agreements, as necessary, and assist each staff member in improving his or her skills and professional competencies.
IV.E.	**The program leadership provides opportunities for ongoing professional growth and development.** *Quality Indicator IV.E.1*. A professional development plan, based on the needs identified through formative supervision and the interests of each staff member, is on file. *Quality Indicator IV.E.2*. Sufficient time and funding are provided for staff to participate in appropriate staff development activities.	**1304.52(i)** **1304.52(k)(1)-(3)**	**1304.52(i):** **(i) Staff performance appraisals**: Agencies must, at a minimum, perform annual performance reviews of each EHS staff member and use the results of these reviews to identify staff training and professional development needs, modify staff performance agreements, as necessary, and assist each staff member in improving his or her skills and professional competencies.

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IV.E. continued		**1304.52(i)** **1304.52(k)(1)-(3) continued**	**(k) Training and development** (1) Agencies must provide an orientation to all new staff, consultants, and volunteers that includes, at a minimum, the goals and underlying philosophy of EHS and the ways in which they are implemented by the program. (2) Agencies must establish and implement a structured approach to staff training and development, attaching academic credit whenever possible. This system should be designed to help build relationships among staff and to assist staff in acquiring or increasing the knowledge and skills needed to fulfill their job responsibilities, in accordance with the requirements of 45 CFR 1306.23. At a minimum, this system must include ongoing opportunities for staff to acquire the knowledge and skills necessary to implement the content of the HS program Performance Standards. (NOTE: This standard also includes additional, specific training requirements.)
IV.F.	**The program leadership promotes continuity in staffing through provision of a supportive work environment, competitive wages and benefits, and opportunities for advancement.**	**N/A**	Not applicable.
IV.G.	**The program leadership and staff are knowledgeable about programs and agencies in the community that provide services for children and their families.**	**1304.41(a)(1) & (2)**	**1304.41:** **(a) Partnerships** (1) Agencies must take an active role in community planning to encourage strong communication, cooperation, and the sharing of information among agencies and their community partners and to improve the delivery of community services to children and families in accordance with the agency's confidentiality policies. Documentation must be maintained to reflect the level of effort undertaken to establish community partnerships (see 45 CFR 1304.51 for additional planning requirements). (2) Agencies must take affirmative steps to establish ongoing collaborative relationships with community organizations to promote the access of children and families to community services that are responsive to their needs, and to ensure that EHS programs respond to community needs. (NOTE: This standard includes a list of the types of community agencies which EHS programs may collaborate with.)
IV.H.	**The program budget is developed to support quality program service delivery.**	**N/A**	Not applicable.

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SECTION V	**FAMILY & COMMUNITY PARTNERSHIPS**		
V.A.	**The child is viewed in the context of family and the family is viewed in the context of its culture and community.** *Quality Indicator V.A.1*. The program is designed to enhance and support parent/child relationships. *Quality Indicator V.A.2*. Program leadership and staff understand and respect the culture of the families they serve. *Quality Indicator V.A.3*. The leadership and program staff understand that the child's home, community, and cultural experiences impact his/her development and early learning. *Quality Indicator V.A.4*. Materials that promote and support the program emphasize the importance of families in the lives of children. *Quality Indicator V.A.5*. The program leadership and staff communicate with families in their primary language whenever possible. *Quality Indicator V.A.6*. The program assists families in expanding their knowledge of child growth and development and parenting techniques. *Quality Indicator V.A.7*. The program staff recognizes the influence of the community and its characteristics upon the family.	**1304.40(a)(5)** **1304.40(e)(2) & (3)** **1304.51(c)(1) &(2)**	**1304.40:** **(a) Family goal setting** (5) Meetings and interactions with families must be respectful of each family's diversity and cultural and ethnic background. **(e) Parent involvement in child development and education** (2) Agencies operating home-based program options must build upon the principles of adult learning to assist, encourage, and support parents as they foster the growth and development of their children. (3) Agencies must provide opportunities for parents to enhance their parenting skills, knowledge, and understanding of the educational and developmental needs and activities of their children and to share concerns about their children with program staff (see 45 CFR 1304.21 for additional requirements related to parent involvement). **1304.51:** **(c) Communication with families** (2) Agencies must ensure that effective two-way comprehensive communications between staff and parents are carried out on a regular basis throughout the program year. (3) Communication with parents must be carried out in the parents' primary or preferred language or through an interpreter, to the extent feasible.

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V.B.	The program leadership and staff seek and facilitate family participation and partnerships. *Quality Indicator V.B.1*. The program leadership assures a system is in place for regular, effective communication and responsive interaction between the program leadership, staff, and families. *Quality Indicator V.B.2*. The program provides opportunities for family involvement and educational activities that are responsive to the ongoing and expressed needs of family members. *Quality Indicator V.B.3*. Families are included in the development and implementation of program activities.	**1304.40(a)(4)** **1304.40(d)(1) - (3)** **1304.40(e)(1)** **1304.40(f)(1)** **1304.51(b)** **1304.51(c)(1) & (2)**	**1304.40:** **(a) Family goal setting** (4) A variety of opportunities must be created by agencies for interaction with parents throughout the year. **(d) Parent involvement - general** (1) In addition to involving parents in program policy-making and operations (see 45 CFR 1304.50), agencies must provide parent involvement and education activities that are responsive to the ongoing and expressed needs of the parents, both as individuals and as members of a group. Other community agencies should be encouraged to assist in the planning and implementation of such programs. (2) EHS settings must be open to parents during all program hours. Parents must be welcomed as visitors and encouraged to observe children as often as possible and to participate with children in group activities. The participation of parents in any program activity must be voluntary, and must not be required as a condition of the child's enrollment. (3) Grantee and delegate agencies must provide parents with opportunities to participate in the program as employees or volunteers (see 45 CFR 1304.52(b)(3) for additional requirements about hiring parents). **(e) Parent involvement in child development and education** (1) Agencies must provide opportunities to include parents in the development of the program's curriculum and approach to child development and education (see 45 CFR 1304.3(a)(5) for a definition of curriculum). **(f) Parent involvement in health, nutrition, and mental health education** (1) Agencies must provide medical, dental, nutrition, and mental health education programs for program staff, parents, and families. **1304.51:** **(b) Communications - general:** Agencies must establish and implement systems to ensure that timely and accurate information is provided to parents, policy groups, staff, and the general community.

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V.B. continued		**1304.40(a)(4)** **1304.40(d)(1) - (3)** **1304.40(e)(1)** **1304.40(f)(1)** **1304.51(b)** **1304.51(c)(1) & (2) continued**	**(c) Communication with families** (1) Agencies must ensure that effective two-way comprehensive communications between staff and parents are carried out on a regular basis throughout the program year. Communication with parents must be carried out in the parents' primary or preferred language or through an interpreter, to the extent feasible.
V.C.	**The program assures that families have access to comprehensive services.** *Quality Indicator V.C.1*. Program leadership and staff have a working knowledge of the resources in their community. *Quality Indicator V.C.2*. The program has both a referral and follow-up system to assure that families are able to access services determined appropriate. *Quality Indicator V.C.3*. The program works to address family needs.	**1304.40(b)(1) & (2)**	**1304.40:** **b) Accessing community services and resources** (1) Agencies must work collaboratively with all participating parents to identify and continually access, either directly or through referrals, services and resources that are responsive to each family's interests and goals, including: (i) Emergency or crisis assistance in areas such as food, housing, clothing, and transportation; (ii) Education and other appropriate interventions, including opportunities for parents to participate in counseling programs or to receive information on mental health issues that place families at risk, such as substance abuse, child abuse and neglect, and domestic violence; and (iii) Opportunities for continuing education and employment training and other employment services through formal and informal networks in the community. (2) Agencies must follow-up with each family to determine whether the kind, quality, and timeliness of the services received through referrals met the families' expectations and circumstances.

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V.D.	**The program develops a partnership with families in which the family members and staff determine goals and services.** *Quality Indicator V.D.1*. The program provides services that promote family growth and enrichment to identify and build on family strengths. *Quality Indicator V.D.2*. The program offers parents opportunities to develop and implement a family plan that describes family goals, responsibilities, timelines, and strategies for achieving these goals. *Quality Indicator V.D.3*. Program staff and families regularly review the family plan, document progress toward goals, and make needed revisions.	**1304.40(a)(1) - (3)**	**1304.40:** **(a) Family goal setting** (1) Agencies must engage in a process of collaborative partnership-building with parents to establish mutual trust and to identify family goals, strengths, and necessary services and supports. This process must be initiated as early after enrollment as possible and it must take into consideration each family's readiness and willingness to participate in the process. (2) As part of this ongoing partnership, agencies must offer parents opportunities to develop and implement individualized family partnership agreements that describe family goals, responsibilities, timetables and strategies for achieving these goals as well as progress in achieving them. In home-based program options, this agreement must include the above information as well as the specific roles of parents in home visits and group socialization activities (see 45 CFR 1306.33(b)). (3) To avoid duplication of effort, or conflict with, any preexisting family plans developed between other programs and the EHS family, the family partnership agreement must take into account, and build upon as appropriate, information obtained from the family and other community agencies concerning preexisting family plans. Agencies must coordinate, to the extent possible, with families and other agencies to support the accomplishment of goals in the preexisting plans.
V.E.	**The program takes an active role in community and system planning and establishes ongoing collaborative relationships with other institutions and organizations that serve families.** *Quality Indicator V.E.1*. Efforts are made to work in collaboration with other providers of services to families with young children in order to maximize services and resources available in the community. *Quality Indicator V.E.2*. Comprehensive physical and mental health, educational, social, and recreational resources for children and their families are developed and promoted in collaboration with the community.	**1304.41(a)(1) & (2)(i) - (ix)** **1304.41(c)(1) - (3)**	**1304.41:** **(a) Partnerships** (1) Agencies must take an active role in community planning to encourage strong communication, cooperation, and the sharing of information among agencies and their community partners and to improve the delivery of community services to children and families in accordance with the agency's confidentiality policies. Documentation must be maintained to reflect the level of effort undertaken to establish community partnerships (see 45 CFR 1304.51 for additional planning requirements). (2) Agencies must take affirmative steps to establish ongoing collaborative relationships with community organizations to promote the access of children and families to community services that are responsive to their needs, and to ensure that EHS programs respond to community needs, including: (i) Health care providers, such as clinics, physicians, dentists, and other health professionals;

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V.E. continued	*Quality Indicator V.E.3*. The program leadership recognizes the urgent need for high quality child care for infants and toddlers and participates in community collaboration to identify, locate, and provide access to this service. *Quality Indicator V.E.4*. The program leadership works with the family and community in supporting transitions, respecting each child's unique needs and situation.	**1304.41(a)(1) & (2)(i) - (ix)** **1304.41(c)(1) - (3) continued**	(ii) Health care providers, such as clinics, physicians, dentists, and other health professionals; (iii) Mental health providers; (iv) Nutritional service providers; (v) Individuals and agencies that provide services to children with disabilities and their families (see 45 CFR 1308.4 for specific service requirements); (vi) Family preservation and support services; (vii) Child protective services and any other agency to which child abuse must be reported under State or Tribal law; (viii) Local elementary schools and other educational and cultural institutions, such as libraries and museums, for both children and families; (ix) Providers of child care services; and (x) Any other organizations or businesses that may provide support and resources to families. **(c) Transition services** (1) Agencies must establish and maintain procedures to support successful transitions for enrolled children and families from previous child care programs into EHS. To ensure the most appropriate placement and services following participation in EHS, transition planning must be undertaken for each child and family at least six months prior to the child's third birthday. The process must take into account: The child's health status and developmental level, progress made by the child and family while in EHS, current and changing family circumstances, and the availability of HS and other child development or child care services in the community. As appropriate, a child may remain in EHS, following his or her third birthday, for additional months until he or she can transition into HS or another program. See 45 CFR 1304.40(h) for additional requirements related to parental participation in their child's transition to and from EHS.

Head Start Performance Standards Not Included In Crosswalk:		
1304.20 Child Health and Developmental Services (a) Determining Child Health Status (b) *See crosswalk above* (c) Extended Follow-up and Treatment (d) *See crosswalk above* (e) Involving Parents **1304.21 Education and Early Childhood Development** (a) *See crosswalk above* (b) *See crosswalk above* (c) Child Development and Education for Preschoolers **1304.22 Child Health and Safety** (a) Health Emergency Procedures (b) Conditions of Short-Term Exclusion and Admittance (c) Medication Administration (d) Injury Prevention (e) Hygiene (f) First Aid Kits **1304.23 Child Nutrition** (a) Identification of Nutritional Needs (b) Nutritional Services (c) Meal Service (d) Family Assistance with Nutrition (e) Food Safety and Sanitation **1304.24 Child Mental Health** (a) Mental Health Services	**1304.40 Family Partnerships** (b) *See crosswalk above* (c) *See crosswalk above* (d) Services to Pregnant Women who are Enrolled in Programs Serving (e) Pregnant Women, Infants, and Toddlers (f) *See crosswalk above* (g) *See crosswalk above* (h) *See crosswalk above* (i) Parent Involvement in Community Advocacy (j) Parent Involvement in Transition Activities (k) Parent Involvement in Home Visits **1304.41 Community Partnerships** (a) *See crosswalk above* (b) Advisory Committees (c) *See crosswalk above* **1304.50 Program Governance** (a) Policy Council, Policy Committee, and Parent Committee Structure (b) Policy Group Composition and Formation (c) Policy Group Responsibilities - General (d) The Policy Council or Policy Committee (e) Parent Committee (f) Policy Council, Policy Committee, and Parent Committee Reimbursement (g) Governing Body Responsibilities (h) Internal Dispute Resolution	**1304.51 Management Systems and Procedures** (a) *See crosswalk above* (b) *See crosswalk above* (c) *See crosswalk above* (d) Communication with Governing Bodies and Policy Groups (e) Communication Among Staff (f) Communication with Delegate Agencies (g) Record-Keeping Systems (h) Reporting Systems (i) *See crosswalk above* **1304.52 Human Resources Management** (a) *See crosswalk above* (b) *See crosswalk above* (c) *See crosswalk above* (d) *See crosswalk above* (e) Home Visitor Qualifications (f) Infant and Toddler Staff Qualifications (g) *See crosswalk above* (h) *See crosswalk above* (i) *See crosswalk above* (j) Staff and Volunteer Health (k) *See crosswalk above* **1304.53 Facilities, Materials, and Equipment** (a) *See crosswalk above* (b) *See crosswalk above*

healthy families america®

for Illinois Programs

- Full Profile of Program Model
- Crosswalk to IL Birth to Three Standards
- HFA Critical Elements

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Healthy Families

Full Profile of Program Model

	Healthy Families (HF)
Program Purpose & Description	**Purpose** • To promote healthy child development and reduce child abuse and neglect among at-risk families. **Description** Healthy Families (HF) is a voluntary, intensive home visiting program that reduces family isolation, supports parents as children's first teachers and caretakers, and helps parents develop good parenting skills.
Target Population	• Families who are at risk of child abuse and neglect. Families are identified during pregnancy or at birth through a structured assessment.
Key Services	• HFI provides voluntary, culturally relevant services to both fathers and mothers. • HFI services include: o Teaching and modeling effective parenting skills; o Providing social support for new parents to reduce social isolation; o Connecting parents to other services in the community; o Removing barriers to services such as lack of transportation or child care; o Monitoring and promoting children's development; and Supporting parent-child attachment.
Outreach & Recruitment	• HF programs typically work with hospitals, clinics and other agencies who serve pregnant women and/or new mothers to provide assessment services. Assessments enable staff to identify family needs and refer them to supportive services such as HF. • HF makes persistent outreach efforts to those families who are hesitant to accept services, but have not clearly indicated an unwillingness to accept services. HF uses these positive, persistent outreach efforts to build trust with families.
Methods & Approaches	• The Healthy Families approach includes the following critical elements: o HF services are initiated **prenatally or at birth**; o HF uses a **standardized assessment** tool to identify families who are most in need of services; o HF services are **voluntary** and HF uses positive, persistent outreach efforts to build trust with families; o HF offers services **intensively** (at least once a week); o HF services should be **culturally competent**; o HF services should **focus on the parent(s)** as well as **supporting parent-child interaction and child development**; o At a minimum, **all families should be linked to a medical provider**; and Home visitors should have **limited caseloads** (usually no more than 15 families per visitor).
Intensity of Services	• HF services are offered during "critical times" (during pregnancy, at birth, and soon after birth). • Services are offered weekly at the outset, with frequency of contact either increasing or decreasing over time based on family circumstances. • Services should be available from birth through 5 years of age, if needed. Artificial or arbitrary time limits on services should be avoided.
Staff Qualifications & Supervision	**Qualifications** • Varied; HF includes both paraprofessional and professional staff. • Service providers should be selected because of their personal characteristics, their willingness to work in or experience working with culturally diverse communities, and their skills to do the job. • Service providers should have a framework, based on education or experience, to handle the variety of experiences they may encounter when working with at-risk families.

Healthy Families

Full Profile of Program Model

	Healthy Families (HF)
Staff Qualifications & Supervision continued	**Supervision** • Appropriately qualified professional staff should provide supervision. Service providers should receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives; to work with families more effectively; and to express their concerns and frustrations.
Staff Training	• All staff are required to complete the 5-day Healthy Families America Core Training as well as intensive job-specific training. • Assessment workers and home visitors are oriented to the program's goals, services, policies, operating procedures, and philosophy prior to direct work with children and families. • The program provides staff with training on culturally competent practices based on the unique characteristics of the population being served (i.e., age-related factors, language, culture, etc.). • The state system includes a Healthy Families Training Institute that ensures that all staff receive ongoing training specific to each worker's knowledge and skill base.
Staff Caseload/ Class Size	• Home visitors should have limited caseloads so that they can spend adequate time with each family (for most communities, no more than 15 families per visitor).
Matching Services to Need	• See Outreach & Recruitment above. • A service plan specific to each family's needs must be developed. The HF program must work closely with the IDHS' Family Case Management program to develop this plan.
Coordination of Services	• Community participation is required to establish HF programs, with respect to: input into program design, commitment to the operation of the program, and the involvement of health and social service professionals in the community. • Community education programs should be established to inform residents of the nature and extent of child abuse in the community, as well as strategies to reduce and prevent abuse. • The home visitor should work in partnership with the family and other service providers to avoid duplication of home visiting services. • The HF program will collaborate with other home visiting programs, health care providers, and the Family Case Management Program.
Parent Involvement	• Family support workers help foster healthy parent-child interactions by: o Sharing information about child health and development; o Building on the family's natural strengths; o Helping new parents reduce their sense of isolation; and o Linking families to vital community services, including health care providers.
Credentialing or Certification Process	• To become a credentialed Healthy Families America (HFA) program, the following steps must be completed: o Programs complete the **HFA Single Site Application for Affiliation**. Once affiliation is granted, program sites are considered to be provisional. o Within two years of becoming a provisional affiliated site, programs complete the **HFA Credentialing Application**. o Next, programs complete a **Self-Assessment**. o Once the Self-Assessment has been completed and submitted to HFA, a team of at least two external, trained peer reviewers conduct a **site visit**. o The peer review team prepares a **Preliminary Credentialing Report** which is sent first to Prevent Child Abuse America and then to the applicant program. The program has 45 days to respond to the report in writing. o This response is then discussed by the **HFA Advisory Credentialing Panel** and a decision is made. If a site credential is awarded, it lasts for four years.
Evaluation Requirements	• Northern Illinois University, with funding from IDHS, conducted a statewide Healthy Families program outcome evaluation. IDHS-funded Healthy Families programs participated in this study.

Healthy Families

Full Profile of Program Model

	Healthy Families (HF)
Evaluation Requirements continued	• HFI sites located in agencies with access to the IDHS Cornerstone database (e.g., local public health departments) enter participant information into this database. They also submit a narrative quarterly report to IDHS. • HFI sites that do not have access to Cornerstone submit a quarterly report to IDHS with caseload information (number of families served, age, race, and ethnicity) and outcome information (DCFS indicated cases of child abuse and neglect, immunization status, and well-child care).
Program Costs	**Cost per participant** • Approximately $3,600 to $4,600 per year (including matching funds from programs) **Start-up costs** • Approximately 25% of a program's annual budget (about $50,000)
Supporting Research Citations	• Families who did not receive Healthy Families services were reported for abuse or neglect twice as often as families who did receive Healthy Families services. (Daro and Harding, 1999) • Parents who participate in Healthy Families show: o A significant decrease in their overall potential for maltreatment and parental stress o Greater sensitivity to their children's cues o Greater comfort in understanding their children's development o Less overall distress and rigidity o A greater knowledge about alternative forms of discipline (Daro and Harding, 1999)
Model-Specific Resources	• Healthy Families America website: www.healthyfamiliesamerica.org • Healthy Families America Site Development Guide • Healthy Families Critical Elements • Healthy Families Credentialing Standards • Healthy Families Research Folder
Initial Point of Contact for Program Model Information	Mark Valentine Ounce of Prevention Fund 33 West Monroe, Suite 2400 Chicago, IL 60603 312-922-3863 markv@ounceofprevention.org

If you would like a current listing of those Illinois programs that use the Healthy Families Illinois model, with locations and contact information please contact Mark Valentine (markv@ounceofprevention.org).

ISBE Birth To Three Program Standards & Healthy Families Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	HF Critical Element(s)	Healthy Families Standard Description
SECTION I	ORGANIZATION		
I.A.	**All birth to three programs must have a mission statement based on shared beliefs and goals.**	**GA-1**	The program has a written statement of purpose that guides the administration of its services.
I.B.	**Scheduling practices and intensity of services are tailored to the individual strengths and needs of children birth to three and their families.** *Quality Indicator I.B.2*. The intensity of program services is commensurate with the preferences, strengths, and needs of individual children and families.	**4-1**	The program has a well-thought out system for managing the intensity of home visitor services.
I.C.	**The strengths and needs of the children and families as well as research on best practice determine the ratio of participants to staff and the size of program groups.**	**8**	Services should be provided by staff with limited caseloads to assure that home visitors have an adequate amount of time to spend with each family to meet their unique and varying needs and to plan for future activities (i.e., for many communities, no more than 15 families per home visitor; for some communities, less than 10).
I.D.	**The program meets the needs of children and families of varying abilities as well as diverse cultural, linguistic, and economic backgrounds.** *Quality Indicator I.D.1*. Qualified staff who demonstrate cultural and linguistic competency are available to effectively interact with families. *Quality Indicator I.D.2*. A variety of activities, strategies, and materials are used to meet the diverse needs of children and families.	**5-2** **5-2.B.**	**5-2** The program demonstrates culturally competent practices in all aspects of its service delivery. **5-2.B**. The program's materials are reflective of the diversity of the service and target populations.
I.E.	**The physical environment of the program is safe, healthy, and appropriate for children's development and family involvement.**	**N/A**	Not applicable.
I.F.	**The administration promotes and practices informed leadership and supervision. The administration participates in and encourages ongoing staff development, training, and supervision.**	**10.a** **10.b** **11**	**10.a** Service providers should have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families. All service providers should receive basic training in areas such as cultural competency, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and services in their community.

ISBE Birth To Three Program Standards & Healthy Families Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	HF Critical Element(s)	Healthy Families Standard Description
I.F. continued		**10.a** **10.b** **11 continued**	**10.b** Service providers should receive intensive training specific to their role to understand the essential components of family assessment and home visitation (i.e., identifying at-risk families, completing a standardized risk assessment, offering services and making referrals, promoting use of preventive health care, securing medical homes, emphasizing the importance of immunizations, utilizing creative outreach efforts, establishing and maintaining trust with families, building upon family strengths, developing an individual family support plan, observing parent-child interaction, managing crisis situations, etc. **11** Service providers should receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations so that they can see that they are making a difference and in order to avoid stress-related burnout.
I.G.	**All birth to three programs must follow mandated reporting laws for child abuse and neglect and have a written policy statement addressing staff responsibilities and procedures regarding implementation.**	**GA-8**	Program reports suspected cases of child abuse and neglect.
I.H.	**The program budget is developed to support quality program service delivery.** *Quality Indicator I.H.2*. Sufficient funds are allocated to provide staff development and training. *Quality Indicator I.H.5*. Sufficient funds are allocated to support an evaluation process for program effectiveness and outcomes.	**N/A**	Program budget is not addressed in the HF Critical Elements. Funding allocation is addressed on a state level, but not in the HF Critical Elements.
SECTION II	**CURRICULUM & SERVICE PROVISION**		
II.A.	**The curriculum reflects the centrality of adult/child interactions in the development of infants and toddlers.** *Quality Indicator II.A.1*. Positive parent/child interactions are encouraged and promoted in all aspects of the program. *Quality Indicator II.A.2*. The curriculum promotes parent/child interactions in the way sessions are designed and conducted by staff.	**6-4.C.**	Home visitor shares information with families/participants on appropriate activities designed to promote positive parent-child interaction.
II.B.	**The curriculum reflects the holistic and dynamic nature of child development.**	**6** **6-2**	**6** Services should focus on supporting the parent(s) as well as supporting parent-child interaction and child development.

ISBE Birth To Three Program Standards & Healthy Families Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	HF Critical Element(s)	Healthy Families Standard Description
II.B. continued	*Quality Indicator II.B.2*. An integrated and individualized program is offered for children in the context of their families.	**6** **6-2 continued**	**6-2** Delivery of services to families/participants is guided by the Individual Family Support Plan (IFSP) and the process of developing the plan uses family/participant support practices.
II.C.	**The curriculum prioritizes family involvement while respecting individual parental choices.** *Quality Indicator II.C.1*. Opportunities are provided for varied levels of parent participation. *Quality Indicator II.C.2*. Opportunities are provided for parents to increase their levels of program involvement through education and enrichment.	**6-2** **6-2.B.** **GA-3**	**6-2** Delivery of services to families/participants is guided by the Individual Family Support Plan (IFSP) and the process of developing the plan uses family/participant support practices. **6-2.B**. The home visitor and family/participant collaborate to assess family/participant needs and the services which are desired to help address these needs. **GA-3** The program has a mechanism in place for families (i.e., past or present participants) to provide formalized input into the program.
II.D.	**The curriculum supports and demonstrates respect for the families' unique abilities as well as for their ethnic, cultural, and linguistic diversity.** *Quality Indicator II.D.1*. The program provides activities, materials, and an environment that reflect a variety of cultures.	**5-2** **5-2.B.**	**5-2** The program demonstrates culturally competent practices in all aspects of its service delivery. **5-2.B**. The program's materials are reflective of the diversity of the service and target populations.
II.E.	The curriculum promotes a framework that is nurturing, predictable, and consistent, yet flexible.	**N/A**	Not applicable.
SECTION III	**DEVELOPMENTAL MONITORING & PROGRAM ACCOUNTABILITY**		
III.A.	**The program staff regularly monitors children's development.** *Quality Indicator III.A.4*. Children are referred to the Illinois Early Intervention System when appropriate.	**6-5** **6-7**	**6-5** The program monitors the development of participating infants and children with a standardized developmental screen. **6-7** The program tracks target children who are suspected of having a developmental delay and follows through with appropriate interventions (e.g., referrals, follow-up, etc.) as needed.
III.B.	**Leadership conducts regular and systematic evaluations of the program and staff to assure that the philosophy is reflected and goals of the program are being fulfilled.** *Quality Indicator III.B.1*. An annual evaluation is conducted of program quality and progress toward goals. *Quality Indicator III.B.2*. The results of the program evaluation are reviewed annually and are used or considered in making organizational and/or programmatic changes.	**GA-5** **GA-5.D.** **GA-5.E.**	**GA-5** The program monitors and evaluates quality of services. **GA-5.D**. The program has a formal mechanism for reviewing the quality of all aspects of the program (assessment, home visitation, and supervision). **GA-5.E**. The program has a follow-up mechanism to address areas for improvement identified during quality assurance review.

ISBE Birth To Three Program Standards & Healthy Families Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	HF Critical Element(s)	Healthy Families Standard Description
SECTION IV	**PERSONNEL**		
IV.A.	**The program leadership is knowledgeable about child development and best practice for quality birth to three programs.**	**N/A**	Not applicable.
IV.B.	**The program leadership is effective in explaining, organizing, implementing, supervising, and evaluating birth to three programs.**	**N/A**	Not applicable.
IV.C.	**The program leadership hires qualified staff who are competent in working with infants and toddlers and their families.**	**N/A**	Not applicable.
IV.D.	**The program leadership provides ongoing supervision that promotes staff development and enhances quality service delivery.**	**11-1.A.** **11-1.B.** **11-1.C.**	**11-1.A**. The program's policy states that weekly individual supervision is provided to all direct service staff. **11-1.B**. The program ensures that weekly individual supervision is received by all direct service staff. **11-1.C**. The ratio of supervisors to direct service staff is sufficient to allow regular, ongoing, and effective supervision to occur.
IV.E.	**The program leadership provides opportunities for ongoing professional growth and development.**	**11-2.A.** **11-2.B.**	**11-2.A**. The program has supervisory procedures to assure that direct service staff (i.e., assessment and home visitation staff) are provided with the necessary skill development to continuously improve the quality of their performance. **11-2.B**. The program has supervisory procedures to assure that direct service staff (i.e., assessment and home visitation staff) are provided with the necessary professional support to continuously improve the quality of their performance.
IV.F.	**The program leadership promotes continuity in staffing through provision of a supportive work environment, competitive wages and benefits, and opportunities for advancement.**	**N/A**	Not applicable.
IV.G.	**The program leadership and staff are knowledgeable about programs and agencies in the community that provide services for children and their families.**	**7-1** **7-3**	**7-1** Participating family members (as defined by the program) have a medical/health care provider to assure optimal health and development. **7-3** Families/participants are linked to additional services on an as-needed basis taking into account one or more of the following: information gathered in the assessment process, through the development of the IFSP, through home visits, from other service providers, etc.
IV.H.	**The program budget is developed to support quality program service delivery.**	**N/A**	Not applicable.

ISBE Birth To Three Program Standards & Healthy Families Standards

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	HF Critical Element(s)	Healthy Families Standard Description
SECTION V	**FAMILY & COMMUNITY PARTNERSHIPS**		
V.A.	**The child is viewed in the context of family and the family is viewed in the context of its culture and community.** **Quality Indicator V.A.1. The program is designed to enhance and support parent/child relationships.** **Quality Indicator V.A.2. Program leadership and staff understand and respect the culture of the families they serve.** **Quality Indicator V.A.3. The leadership and program staff understand that the child's home, community, and cultural experiences impact his/her development and early learning.** **Quality Indicator V.A.4. Materials that promote and support the program emphasize the importance of families in the lives of children.** **Quality Indicator V.A.5. The program leadership and staff communicate with families in their primary language whenever possible.** **Quality Indicator V.A.6. The program assists families in expanding their knowledge of child growth and development and parenting techniques.** **Quality Indicator V.A.7. The program staff recognizes the influence of the community and its characteristics upon the family.**	**1304.40(a)(5)** **1304.40(e)(2) & (3)** **1304.51(c)(1) &(2)**	1304.40: (a) Family goal setting (6) Meetings and interactions with families must be respectful of each family's diversity and cultural and ethnic background. (e) Parent involvement in child development and education (4) Agencies operating home-based program options must build upon the principles of adult learning to assist, encourage, and support parents as they foster the growth and development of their children. (5) Agencies must provide opportunities for parents to enhance their parenting skills, knowledge, and understanding of the educational and developmental needs and activities of their children and to share concerns about their children with program staff (see 45 CFR 1304.21 for additional requirements related to parent involvement). 1304.51: (c) Communication with families (4) Agencies must ensure that effective two-way comprehensive communications between staff and parents are carried out on a regular basis throughout the program year. (5) Communication with parents must be carried out in the parents' primary or preferred language or through an interpreter, to the extent feasible.
V.B.	**The program leadership and staff seek and facilitate family participation and partnerships.** **Quality Indicator V.B.1. The program leadership assures a system is in place for regular, effective communication and responsive interaction between the program leadership, staff, and families.**	**1304.40(a)(4)** **1304.40(d)(1)-(3)** **1304.40(e)(1)** **1304.40(f)(1)** **1304.51(b)** **1304.51(c)(1) & (2)**	1304.40: (a) Family goal setting (5) A variety of opportunities must be created by agencies for interaction with parents throughout the year.

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	HF Critical Element(s)	Healthy Families Standard Description
V.B. continued	**Quality Indicator V.B.2. The program provides opportunities for family involvement and educational activities that are responsive to the ongoing and expressed needs of family members.** **Quality Indicator V.B.3. Families are included in the development and implementation of program activities.**	**1304.40(a)(4)** **1304.40(d)(1)-(3)** **1304.40(e)(1)** **1304.40(f)(1)** **1304.51(b)** **1304.51(c)(1) & (2) continued**	(d) Parent involvement - general (4) In addition to involving parents in program policy-making and operations (see 45 CFR 1304.50), agencies must provide parent involvement and education activities that are responsive to the ongoing and expressed needs of the parents, both as individuals and as members of a group. Other community agencies should be encouraged to assist in the planning and implementation of such programs. (5) EHS settings must be open to parents during all program hours. Parents must be welcomed as visitors and encouraged to observe children as often as possible and to participate with children in group activities. The participation of parents in any program activity must be voluntary, and must not be required as a condition of the child's enrollment. (6) Grantee and delegate agencies must provide parents with opportunities to participate in the program as employees or volunteers (see 45 CFR 1304.52(b)(3) for additional requirements about hiring parents). (e) Parent involvement in child development and education (2) Agencies must provide opportunities to include parents in the development of the program's curriculum and approach to child development and education (see 45 CFR 1304.3(a)(5) for a definition of curriculum). (f) Parent involvement in health, nutrition, and mental health education (2) Agencies must provide medical, dental, nutrition, and mental health education programs for program staff, parents, and families. 1304.51: (b) Communications - general: Agencies must establish and implement systems to ensure that timely and accurate information is provided to parents, policy groups, staff, and the general community. (c) Communication with families (2) Agencies must ensure that effective two-way comprehensive communications between staff and parents are carried out on a regular basis throughout the program year. Communication with parents must be carried out in the parents' primary or preferred language or through an interpreter, to the extent feasible.

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Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	HF Critical Element(s)	Healthy Families Standard Description
V.C.	**The program assures that families have access to comprehensive services.** **Quality Indicator V.C.1. Program leadership and staff have a working knowledge of the resources in their community.** **Quality Indicator V.C.2. The program has both a referral and follow-up system to assure that families are able to access services determined appropriate.** **Quality Indicator V.C.3. The program works to address family needs.**	**1304.40(b)(1) & (2)**	1304.40: b) Accessing community services and resources (3) Agencies must work collaboratively with all participating parents to identify and continually access, either directly or through referrals, services and resources that are responsive to each family's interests and goals, including: (iv) Emergency or crisis assistance in areas such as food, housing, clothing, and transportation; (v) Education and other appropriate interventions, including opportunities for parents to participate in counseling programs or to receive information on mental health issues that place families at risk, such as substance abuse, child abuse and neglect, and domestic violence; and (vi) Opportunities for continuing education and employment training and other employment services through formal and informal networks in the community. (4) Agencies must follow-up with each family to determine whether the kind, quality, and timeliness of the services received through referrals met the families' expectations and circumstances.
V.D.	**The program develops a partnership with families in which the family members and staff determine goals and services.** **Quality Indicator V.D.1. The program provides services that promote family growth and enrichment to identify and build on family strengths.** **Quality Indicator V.D.2. The program offers parents opportunities to develop and implement a family plan that describes family goals, responsibilities, timelines, and strategies for achieving these goals.** **Quality Indicator V.D.3. Program staff and families regularly review the family plan, document progress toward goals, and make needed revisions.**	**1304.40(a)(1) - (3)**	1304.40: (a) Family goal setting (4) Agencies must engage in a process of collaborative partnership-building with parents to establish mutual trust and to identify family goals, strengths, and necessary services and supports. This process must be initiated as early after enrollment as possible and it must take into consideration each family's readiness and willingness to participate in the process. (5) As part of this ongoing partnership, agencies must offer parents opportunities to develop and implement individualized family partnership agreements that describe family goals, responsibilities, timetables and strategies for achieving these goals as well as progress in achieving them. In home-based program options, this agreement must include the above information as well as the specific roles of parents in home visits and group socialization activities (see 45 CFR 1306.33(b)).

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	HF Critical Element(s)	Healthy Families Standard Description
V.D. continued		**1304.40(a)(1) - (3) continued**	To avoid duplication of effort, or conflict with, any preexisting family plans developed between other programs and the EHS family, the family partnership agreement must take into account, and build upon as appropriate, information obtained from the family and other community agencies concerning preexisting family plans. Agencies must coordinate, to the extent possible, with families and other agencies to support the accomplishment of goals in the preexisting plans.
V.E.	**The program takes an active role in community and system planning and establishes ongoing collaborative relationships with other institutions and organizations that serve families.** **Quality Indicator V.E.1. Efforts are made to work in collaboration with other providers of services to families with young children in order to maximize services and resources available in the community.** **Quality Indicator V.E.2. Comprehensive physical and mental health, educational, social, and recreational resources for children and their families are developed and promoted in collaboration with the community.** **Quality Indicator V.E.3. The program leadership recognizes the urgent need for high quality child care for infants and toddlers and participates in community collaboration to identify, locate, and provide access to this service.** **Quality Indicator V.E.4. The program leadership works with the family and community in supporting transitions, respecting each child's unique needs and situation.**	**1304.41(a)(1) & (2)(i) - (ix)** **1304.41(c)(1) - (3)**	1304.41: (a) Partnerships (3) Agencies must take an active role in community planning to encourage strong communication, cooperation, and the sharing of information among agencies and their community partners and to improve the delivery of community services to children and families in accordance with the agency's confidentiality policies. Documentation must be maintained to reflect the level of effort undertaken to establish community partnerships (see 45 CFR 1304.51 for additional planning requirements). (4) Agencies must take affirmative steps to establish ongoing collaborative relationships with community organizations to promote the access of children and families to community services that are responsive to their needs, and to ensure that EHS programs respond to community needs, including: (xi) Health care providers, such as clinics, physicians, dentists, and other health professionals; (xii) Mental health providers; (xiii) Nutritional service providers; (xiv) Individuals and agencies that provide services to children with disabilities and their families (see 45 CFR 1308.4 for specific service requirements); (xv) Family preservation and support services; (xvi) Child protective services and any other agency to which child abuse must be reported under State or Tribal law; (xvii) Local elementary schools and other educational and cultural institutions, such as libraries and museums, for both children and families; (xviii) Providers of child care services; and (xix) Any other organizations or businesses that may provide support and resources to families.

Illinois Birth-3 Standard	Illinois Birth-3 Standard Description	HF Critical Element(s)	Healthy Families Standard Description
V.E. continued		**1304.41(a)(1) & (2)(i) - (ix)** **1304.41(c)(1) - (3) continued**	(c) Transition services (2) Agencies must establish and maintain procedures to support successful transitions for enrolled children and families from previous child care programs into EHS. To ensure the most appropriate placement and services following participation in EHS, transition planning must be undertaken for each child and family at least six months prior to the child's third birthday. The process must take into account: The child's health status and developmental level, progress made by the child and family while in EHS, current and changing family circumstances, and the availability of HS and other child development or child care services in the community. As appropriate, a child may remain in EHS, following his or her third birthday, for additional months until he or she can transition into HS or another program. See 45 CFR 1304.40(h) for additional requirements related to parental participation in their child's transition to and from EHS.

Healthy Families Critical Elements Not Included in Crosswalk:			
1	**Initiate services prenatally or at birth.**	**2**	**Use a standardized (i.e., in a consistent way for all families) assessment tool to systematically identify families who are most in need of services. This tool should assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes (i.e., social isolation, substance abuse, parental history of abuse in childhood).**
1-1	Program ensures it identifies families/participants in the target population for services either while mother is pregnant (prenatally) and/or at the birth of the baby.	**2-1**	The program uses a tool(s) (e.g., screening tools, assessment tools, etc.) to identify the families/participants within the target population who are most in need of intensive home visitor services.
1-2	The program defines, measures, and monitors the acceptance rate of families/participants into the program in a consistent manner and on a regular basis.	**2-2**	The program ensures that staff and volunteers who use the screening and/or assessment tool(s) have been trained in its use prior to allowing them to administer it.
1-3	The program ensures that, for those who accept home visitor services, the first home visit occurs prenatally or within the first three months after the birth of the baby.	**2-3**	The program uses criteria to identify families/participants in need of service and documents this in its files.
3	**Offer services voluntarily and use positive, persistent outreach efforts to build family trust.**	**4**	**Offer services intensely (i.e., at least once a week) with well-defined criteria for increasing or decreasing intensity of service and over the long term (i.e., three to five years).**
3-1	Services are offered to families/participants on a voluntary basis.	**4-1**	The program has a well-thought out system for managing the intensity of home visitor services.
3-2	The staff uses positive outreach methods to build family/participant trust, engage new families/participants, and maintain family/participant involvement in the program.	**4-2**	The program offers home visitation services intensively after the birth of the baby.
3-3	The program offers outreach under specified circumstances for a minimum of three months for each family/participant before discontinuing services.	**4-3**	The program offers home visitation services to families/participants for a minimum of three years after the birth of the baby.
3-4	The program defines, measures and monitors its retention rate of families/participants in the program in a consistent manner and on a regular basis.		
5	**See crosswalk above.**	**6**	**See crosswalk above.**
5-1	The program has a description of the cultural, racial/ethnic, and linguistic characteristics of all groups within the current service population.	**6-1**	See crosswalk above.
5-2	See crosswalk above.	**6-2**	See crosswalk above.
5-3	The program provides staff training on culturally competent practices based	**6-3**	Before or on the first home visit, the family/participant is informed about their rights, including confidentiality, both verbally and in writing.

Healthy Families Critical Elements Not Included in Crosswalk:	
on the unique characteristics of the population(s) being served (i.e., age related factors, language, culture, etc.) by the program. **5-4** The program regularly evaluates the extent to which all aspects of its service delivery system (i.e., family assessment, service planning, home visitation, supervision, etc.) are culturally competent.	**6-4** See crosswalk above. **6-5** See crosswalk above. **6-6** Those who administer developmental screenings have been trained in the use of the tool before administering it. **6-7** See crosswalk above.
7 See crosswalk above. **7-1** See crosswalk above. **7-2** The program ensures that immunizations are up to date for target children. **7-3** See crosswalk above.	**8 See crosswalk above.** **8-1** Services are provided by staff with limited caseloads to assure that home visitors have an adequate amount of time to spend with each family/participant to meet their needs and plan for future activities. **8-2** The program's caseload system ensures that home visitors have an adequate amount of time to spend with each family/participant.
9 Service providers should be selected because of their personal characteristics (i.e., non-judgmental, compassionate, ability to establish a trusting relationship, etc.), their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job. **9-1** Service providers and program management staff are selected because of a combination of personal characteristics, experiential, and educational qualifications. **9-2** The program actively recruits, employs, and promotes qualified personnel and administers its personnel practices without discrimination based upon age, sex, race, ethnicity, nationality, handicap, or religion of the individual under consideration. **9-3** The program's recruitment and selection procedures assure that its human resource needs are met.	**10 See crosswalk above.** **10-1** The program has a system for assuring that the following trainings are made available for all staff (assessment workers, home visitors and supervisors): orientation, intensive role specific training, additional training within 6 months of hire, additional training within 12 months of hire, and ongoing training topics. **10-2** Staff (assessment workers, home visitors and supervisors), receive orientation (separate from intensive role specific training) prior to direct work with children and families to familiarize them with the functions of the program. **10-3** Staff (assessment workers, home visitors and supervisors) receive intensive training within six months of the date of hire specific to their role within the home visitation program to help them understand the essential components of their role within the program. **10-4** Staff (assessment workers, home visitors and supervisors) demonstrate knowledge on a variety of topics necessary for effectively working with families and children within six months of hire. **10-5** Staff (assessment workers, home visitors and supervisors) demonstrate knowledge on a variety of topics necessary for effectively working with families and children within twelve months of hire.

ISBE Birth To Three Program Standards & Healthy Families Standards

Healthy Families Critical Elements Not Included in Crosswalk:	
	10-6 The program ensures that all program staff receive ongoing training which takes into account the worker's knowledge and skill base.
11 **See crosswalk above.**	**GA-1** **See crosswalk above.**
11-1 The program ensures that direct service staff receive regular and ongoing supervision. (Also see crosswalk above.)	**GA-2** The program has a broadly-based, advisory/governing group (e.g., a voluntary Board, governing body, an advisory committee, etc.) which serves in an advisory and/or governing capacity in the planning, implementation, and assessment of program services. (Also see crosswalk above.)
11-2 Direct service staff (i.e., assessment and home visitation staff) are provided with skill development and professional support and held accountable for the quality of their work. (Also see crosswalk above.)	**GA-3** See crosswalk above.
11-3 The program's Policies and Procedures Manual is used to guide newer service providers in the delivery of services.	**GA-4** The manager (or other program representative) and the advisory/governing group work as an effective team with information, coordination, staffing, and assistance provided by the manager to plan and develop program policy.
11-4 Volunteers and student interns who are performing the same/similar functions as direct service staff are receiving the same type and amount of supervision.	**GA-5** See crosswalk above.
11-5 Supervisors receive regular, ongoing supervision which holds them accountable for the quality of their work and provides them with skill development and professional support.	**GA-6** The program has a policy and procedure for reviewing and recommending approval or denial of research proposals, whether internal or external, which involve past or present participants.
11-6 Program managers are held accountable for the quality of their work and are provided with skill development and professional support.	**GA-7** The program assures participant privacy and voluntary choice with regard to research conducted by or in cooperation with the program.
	GA-8 See crosswalk above.

Healthy Families America Critical Elements
Critical Element #1 Initiate services prenatally or at birth **Critical Element #2** Use a standardized (i.e., consistent for all families) assessment tool to systematically identify families who are most in need of services. This tool should assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes (i.e., social isolation, substance abuse and parental history of abuse in childhood). **Critical Element #3** Offer services voluntarily and use positive, persistent outreach efforts to build family trust. **Critical Element #4** Offer services intensively (i.e., at least once a week) with well-defined criteria for increasing or decreasing intensity of service and over the long term (i.e., three to five years). **Critical Element #5** Services should be culturally competent such that the staff understands, acknowledges, and respects cultural differences among participants; and materials used should reflect the cultural, linguistic, geographic, racial, and ethnic diversity of the population served. **Critical Element #6** Services should focus on supporting the parent(s) as well as supporting parent-child interaction and child development. **Critical Element #7** At a minimum, all families should be linked to a medical provider to assure optimal health and development (e.g., timely immunizations, well-child care, etc.) Depending on the family's needs, they may also be linked to additional services such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters. **Critical Element #8** Services should be provided by staff with limited caseloads to assure that home visitors have an adequate amount of time to spend with each family to meet their unique and varying needs and to plan for future activities (i.e., for most communities no more than 15 families per home visitor on the most intense service level. For some communities the number may need to be significantly lower e.g., less than 10)

Healthy Families America Critical Elements
Critical Element #9 Service providers should be selected because of their personal characteristics (i.e., nonjudgmental, compassionate, able to establish a trusting relationship, etc.), their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job. **Critical Element #10** Service providers should have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families. All service providers should receive basic training in areas such as cultural competency, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and services in their community. **Critical Element #11** Service providers should receive intensive training specific to their role to understand the essential components of family assessment and home visitation (i.e., identifying at-risk families, completing a standardized risk assessment, offering services and making referrals, promoting use of preventive health care, securing medical homes, emphasizing the importance of immunization, utilizing creative outreach efforts, establishing and maintaining trust with families, building on family strengths, developing an individual family support plan, observing parent-child interactions, determining safety of the home, teaching parent-child interaction, managing crisis situations, etc.) **Critical Element #12** Service providers should receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations.

- Full Profile of Program Model
- Crosswalk to Illinois Birth to Three Standards

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Nurse Family Partnership

Full Profile of Program Model

	Nurse Family Partnership
Program Purpose & Description	**Purpose**: • Improve pregnancy outcomes by helping women engage in preventative health practices, including obtaining thorough medical care, improving their diet, and reducing their use of alcohol, cigarettes, and illegal substances • Improve child health & development by helping parents provide responsible and competent care for their children • Improve parental economic self sufficiency by helping parents develop a vision for their own future, plan for future pregnancies, continue their education, and find work **Description:** Nurse Family Partnership is a voluntary program where highly educated nurses visit low-income women in their homes during their first pregnancy and throughout the first 2 years of their child's life to accomplish the above goals. All services are delivered through strength-based and client centered practices.
Target Population	First time low income mothers
Key Services	Client centered, strength-based, culturally competent services are delivered to the mothers and families using the evidenced based tested NFP Home Visit Guidelines. The Guidelines are structured around the following Home Visit Domains: **Personal Health** • Health maintenance practices • Nutrition and exercise • Substance use • Mental health functioning **Environmental Health** • Home • Work, school, and neighborhood **Life Course Development** • Family planning • Education and livelihood **Maternal Role** • Mothering role • Physical care • Behavioral & emotional care **Family and Friends** • Personal network relationships • Assistance with childcare **Health and Human Services** • Service utilization
Outreach & Recruitment Outreach & Recruitment	NFP relies on early enrollment of first-time pregnant, low-income women, no later than the 28th week of gestation realistically by the 25th week. Preferred 16-20 weeks.

Nurse Family Partnership

Full Profile of Program Model

	Nurse Family Partnership
Outreach & Recruitment Outreach & Recruitment continued	In order for programs to be successful in recruiting and engaging this population it is critical for Implementing Agencies to establish and sustain referral partnerships with local entities like: • WIC clinics • Family planning / pregnancy testing centers • Obstetricians and Pediatricians serving low-income/ Medicaid clients • Prenatal care providers: clinics, community based organizations, hospitals • Schools/School Health Nurses • Churches • Self-Referrals During the development and initiation phases of an agency start-up NFP provides intense TA to assist sites in identifying key referral partners, designing a plan to engage and sustain referral partnerships, and to assess regularly that these referral partnerships are working. Included in the planning is 1) identifying the number of referrals a partner can realistically make 2) identifying the early referral process to achieve engagement of participants no later than the 28th week of pregnancy 3) a program plan for timely contact and first home visit to a referred participant and 4) regular contact with referral partners to modify the referral plan as needed for ongoing success.
Methods & Approaches	**NFP has Guiding Elements for Service Implementation:** **Client Elements** • Voluntary participation • First-time mother • Low-income • Enrolled early in pregnancy (<28 weeks) **Intervention Elements** • One to one visiting with client and NHV • Client visited in her home • Visits occur during pregnancy and up child's second birthday **Qualities of Nurses and Supervisors** • NHV and supervisors are RN's with BSN training • NHV and supervisors complete NFP NSO core education and deliver the intervention with fidelity to the model **Application of the Intervention** • NHV use professional judgment to individualize guidelines to meet client's needs • NHV apply theoretical frameworks that underpin the program • A full-time NHV carries a caseload of no more than 25 active clients **Reflection and Supervision** • A full-time nursing supervisor supervises no more than eight NHV's • Supervisory activities include 1:1 clinical supervision, case conferences, team meetings and field supervision. **Program Monitoring and Use of Data** • NHV and Nursing Supervisors collect data and use NFP reports to guide practice, monitor implementation, inform clinical supervision, enhance quality and demonstrate fidelity.

Nurse Family Partnership

Full Profile of Program Model

	Nurse Family Partnership
Methods & Approaches continued	**Agency Elements** • NFP implementing agency operated by an organization known for successful provision of prevention services to low-income families • NFP implementing agency convenes long-term Community Advisory Board • Adequate support and structure shall be in place to support NHV and nursing supervisors to implement the program and assure data is accurately entered into the data base in a timely manner.
Intensity of Services	Services are delivered: • Visits occur during pregnancy and up child's second birthday (Visits are weekly for the first 4-6 weeks upon entering the program; then are biweekly until the birth of the infant; then weekly for 4-6 weeks; then bi-weekly until the child is 21 months; then monthly until the child is two years.
Staff Qualifications & Supervision	**Qualifications** The BSN degree is considered to be the standard educational background for entry into Public Health and provides background for NFP home visiting work. The MSN degree is considered as the preferred standard for the NFP nursing supervisor. It is understood that both education and experience are important. Agencies that may at times find it difficult to fulfill the recommended NFP requirements for hiring and agencies need to consider each individual nurses' qualifications and as needed provide additional professional development to meet the expectations for the roles. Non-BSN nurses should be encouraged and provided support to complete their BSN. **Reflection and Supervision** A full-time nursing supervisor supervises no more than eight NHV's Supervisory activities include 1:1 clinical supervision, case conferences, team meetings and field supervision.
Staff Training	It is the policy of NFP-NSO that all nurses employed to provide NFP services will attend and participate in all core NFP education sessions in a timely manner, as is defined by NFP-NSO policy and the NFP-NSO contract. This is to assure that Nurse Home Visitors and Nursing Supervisors deliver the program with fidelity to the model.
Staff Caseload/ Class Size	**Nurse Home Visitor Caseloads:** • A full-time NHV carries a caseload of no more than 25 active clients
Matching Services to Need	Using the NFP Home Visit Guidelines services are delivered through client centered, strength-based, culturally competent lenses to the mothers and families. NHVs use professional judgment to individualize guidelines to meet client's needs identifying with families their strengths and needs and creating individualized family plans with the family in the lead.
Coordination of Services	An NFP implementing agency is operated by an organization known for successful provision of prevention services to low-income families. The agency builds and maintains community partnerships that provide resources to families. The NFP implementing agency convenes long-term Community Advisory Board that has not only community partners and representatives but includes client representation.
Parent Involvement	**At the Individual Level:** Using the NFP Home Visit Guidelines services are delivered through client centered, strength-based, culturally competent lenses to the mothers and families. NHVs use professional judgment to individualize guidelines to meet client's needs identifying with families their strengths and needs and creating individualized family plans with the family in the lead.

Nurse Family Partnership

Full Profile of Program Model

	Nurse Family Partnership
Parent Involvement continued	**At the Community Level:** The NFP implementing agency convenes long-term Community Advisory Board that includes current and past client representation. At the Linkage & Referral Level: The agency builds and maintains community partnerships that provide resources to families.
Credentialing or Certification Process	NFP Model replication has been just in the last five years. NFP currently has staff who are working on the credentialing/accreditation process that NFP expects to implement in 2010.
Program Monitoring and Evaluation	NFP Monitoring and Evaluation includes but is not limited to: 1. Site visits as needed 2. Data Collection that agencies must establish and maintain in accordance with NSO-NFP agreements. RN HV's and Supervisors enter on a weekly, monthly, quarterly basis and this information is used by NFP Nurse Consultants in regular TA to monitor and to assist sites in success in program implementation. 3. See accompanying slide that show the data collection process:
Program Costs	The NFP program costs approximately $4500 per family per year to fund, and can range from $2,914 to $6,463 per family per year. The nurses' salaries are the primary driver that affects variability of costs.
Supporting Research Citations	The program effects that have the strongest evidentiary foundations are those that have been found in at least two of the three trials: • Improved prenatal health • Fewer childhood injuries • Fewer subsequent pregnancies • Increased intervals between births • Increased maternal employment • Improved school readiness **Positive Program Effects Found in First Trial at Child Age 15** Benefits to Mothers • 61% fewer arrests • 72% fewer convictions • 98% fewer days in jail[2] Benefits to Children at Child Age 15 • 48% reduction in child abuse and neglect • 59% reduction in arrests • 90% reduction in adjudications as PINS (person in need of supervision) for incorrigible behavior[3]
Model-Specific Resources	National Service Office-Nurse Family Partnership 1900 Grant St. Ste. 400, Denver Colorado 80203 www.nursefamilypartnership.org
Initial Point of Contact for Program Model Information	Jeanne Marie Anderson, RN PhD Midwest Program Developer Direct: 303-865-8399 Mobile: 217-722-9944 Email: jeanne.anderson@nursefamilypartnership.org

If you would like a current listing of those Illinois programs that use the Nurse Family Partnership model, with locations and contact information please contact Jeanne Marie Anderson, RN PhD (jeanne.anderson@nursefamilypartnership.org).

ISBE Birth To Three Program Standards & Nurse Family Partnership Standards

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	NFP Model Standard	Nurse Family Partnership Model Standard Description
SECTION I	**ORGANIZATION**	**SECTION I**	**ORGANIZATION**
I.A.	**Standard I.A. All birth to three programs must have a mission statement based on shared beliefs and goals.** **Quality Indicators:** I.A.1. A mission statement based on shared beliefs is developed cooperatively by parents, staff members, families, and community representatives and is reviewed annually. I.A.2. The mission statement and beliefs are consistent with those of the community. I.A.3. The essence of the mission statement is reflected in all decisions and a copy is posted and available. I.A.4. The goals stem from the Illinois Birth to Three Program Standards. These program goals are developed by leadership and staff, shared with parents and other stakeholders, and serve as the basis for all planning and program development.		Nurse Family Partnership has the following Mission Statement: *The Nurse-Family Partnership National Office supports communities in implementing a cost-effective, evidence-based nurse home visitation program to improve pregnancy outcomes, child health and development, and self-sufficiency for eligible, first time parents –benefiting multiple generations.* Local NFP implementing agencies may also have mission statements reflecting the unique characteristics of the community in which they work. The Nurse Family Partnership-National Service Office (NFP-NSO) does not oversee the development, content or use of local agency mission statements.
I.B.	**I.B. Scheduling practices and intensity of services are tailored to the individual strengths and needs of children birth to three and their families.** **Quality Indicators:** I.B.1. The program leadership engages in scheduling practices, including evenings, weekends and summer programming, that respect the individual needs of infants and toddlers and their families in both home visiting and center-based programs. I.B.2. The intensity of program services is commensurate with the preferences, strengths, and needs of individual children and families. I.B.3. The program uses a variety of strategies based on the preferences, strengths, and needs of individual children and their families.	**#7** **#10**	Model element #7 states: *Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current NFP Guidelines.* Based on the experience from the trials, NFP identifies recommended home visit schedules for each of the different phases of the program (Pregnancy, Infancy, and Toddler). Nurse Home Visitors (NHV) have flexibility to adapt the schedule to best meet the needs of individual clients based on their clinical judgment. Model Element # 10 states: *NHV, using professional knowledge, judgment and skill, apply the NFP Visit Guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains.*
I.C.	**Standard I.C. The strengths and needs of the children and families as well as research on best practice determine the ratio of participants to staff and the size of program groups.**	**#13**	Model element #13: *A full-time NHV carries a caseload of no more than 25 active clients.*

ISBE Birth To Three Program Standards & Nurse Family Partnership Standards

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	NFP Model Standard	Nurse Family Partnership Model Standard Description
I.C. continued	**Quality Indicators:** I.C.1. Group size and ratios of adults to infants and toddlers are developmentally appropriate in program groups. I.C.2. A reasonable number of families is served by each service provider in accordance with program design and goals, considering geographic location, severity of need, intensity of services, and training of staff.	**#13 continued**	NFP limits the ratio of NHV to clients to no more than 25 clients to maximize program effectiveness and efficiency. This ratio was determined based on data from the trials. Nursing Supervisors are responsible for assigning caseload among the nursing team to ensure an appropriate distribution of clients in relation to geographic location, and the family's needs.
I.D.	**Standard I.D. The program meets the needs of children and families of varying abilities as well as diverse cultural, linguistic, and economic backgrounds.** **Quality Indicators:** I.D.1. Qualified staff that demonstrate cultural and linguistic competency are available to effectively interact with children and families. I.D.2. A variety of activities, strategies, and materials are used to meet the diverse needs of children and families.	**#1** **#2** **#3** **#4**	The following model elements describe the target population for NFP services based on evidence from the clinical trials showing that this population receives maximum benefit from the program. Model element #1: *Client participates voluntarily in the Nurse-Family Partnership program*. Model element #2: *Client is first-time mother.* Model element #3: *Client meets low income criteria at intake.* Model element #4: *Client is enrolled in the program early in her pregnancy and receives her first home visit by no later than the end of the 28th week of pregnancy.* The model elements allow for diversity of clients and local agencies are encouraged to NFP provide services that meet the cultural and linguistic needs of clients. Registered nurse staff have usually received training in cultural competence and NFP-NSO also covers this topic during new staff training. Local agencies are advised to provide specific training as needed for specific populations groups who they service. At this time, most NFP materials are available in English and Spanish, for clients who speak other languages, local agencies are also encouraged to adapt/translate written materials to meet the needs of other language groups. NFP provides a wide variety of materials that NHV may select from when going into the home. This allows the NHV to tailor the visit to high or low literacy needs as well as teens. NHV may also choose to bring their own materials. NFP also utilizes PIPE curriculum that is participatory and interactive which helps to bridge cultural differences.
I.E.	**Standard I.E. The physical environment of the program is safe, healthy, and appropriate for children's development and family involvement.**	**#6**	According to Model element #6*: Client is visited in her home.*

ISBE Birth To Three Program Standards & Nurse Family Partnership Standards

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	NFP Model Standard	Nurse Family Partnership Model Standard Description
I.E. continued	**Quality Indicators:** I.E.1. The program implements local and state health and safety guidelines. I.E.2. The program décor, furnishings, materials, and resources are appropriate for infants and toddlers and their families.	**#6 continued**	Conducting visits in the home allows the NHV to assess the home environment, better understand the client's context and ultimately provide education and resources to work with the client to create a healthier home environment for herself and her child. Environment is one of the six domains that NHVs routinely address with clients. NFP program guidelines provide various materials for use with clients related to home safety, child development and family involvement. Although it is optimum to have the visit occur in the client's home, nurses and clients can together decide on a different location if there are compelling reasons such as safety issues.
I.F.	**Standard I.F. The administration promotes and practices informed leadership and supervision. The administration participates in and encourages ongoing staff development, training, and supervision.** **Quality Indicators:** I.F.1. The leadership takes advantage of opportunities for advanced learning regarding best practice in the infant/toddler field. I.F.2. The leadership assures that all program staff takes advantage of opportunities for advanced learning regarding best practice in the infant/toddler field.	**#14**	Having a administrative infrastructure to provide leadership and support for the program is a condition of program approval. The role of administrative leadership and support is also articulated in Model Element #18: *Adequate support and structure shall be in place to support NHV and NS to implement the program and to assure that data is accurately entered into the data base in a timely manner.* In addition to agency support, one of the roles of the Nurse Supervisor is assist nursing home visitor staff in professional development planning as described in Model element #14: *Nursing Supervisors provide NHV s clinical supervision with reflection, demonstrate integration of the theories and facilitate professional development essential to the NHV role through specific supervisory activities including 1:1 clinical supervision, case conferences, team meetings and field supervision.*
I.G.	**Standard I.G. All birth to three programs must follow mandated reporting laws for child abuse and neglect and have a written policy statement addressing staff responsibilities and procedures regarding implementation.** **Quality Indicators:** I.G.1. The program leadership familiarizes staff with the Abused and Neglected Child Reporting Act [325 ILCS 5] as well as with the program's policy. This should be included as part of new staff orientation and, at a minimum, be reviewed annually. I.G.2. The written policy must include procedures for documentation and follow-up of reported abuse.		All nurse home visitors and nursing supervisors are Registered Nurses (RNs) and are bound by state nurse licensing requirements to follow laws mandating reporting of child abuse and neglect. As standard of practice, NHV advise clients of their reporting status. Local Agencies are expected to have policies and procedures that guide them in following mandated reporting laws.

ISBE Birth To Three Program Standards & Nurse Family Partnership Standards

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	NFP Model Standard	Nurse Family Partnership Model Standard Description
I.H.	**Standard I.H. The program budget is developed to support quality program service delivery.** I.H.1. Sufficient funds are allocated to support human resources. I.H.2. Sufficient funds are allocated to provide staff development and training. I.H.3. Sufficient funds are allocated for material resources to support quality programming. I.H.4. Sufficient funds are allocated to encourage and support parent participation in all program activities. I.H.5. Sufficient funds are allocated to support an evaluation process for program effectiveness and outcomes.		The requirement for the agency to provide adequate support for administering the program is stipulated in Model element #18: *Adequate support and structure shall be in place to support NHV and NS to implement the program and to assure that data is accurately entered into the data base in a timely manner.* The ability to comply with these requirements is assessed during the application phase. Agencies interested in implementing NFP must complete a program application that includes a Budget Template which identifies all budgeted areas that represent quality program delivery.
SECTION II	**CURRICULUM & SERVICE PROVISION**		
II.A.	**Standard II.A. The curriculum reflects the centrality of adult/child interactions in the development of infants and toddlers.** II.A.1. Positive parent/child interactions are encouraged and promoted in all aspects of the program. II.A.2. The curriculum promotes parent/child interactions in the way sessions are designed and conducted by staff. II.A.3. The development of a sense of trust and autonomy among staff, children, and families is a priority. II.A.4. Parents receive education and support to identify and cope with life stressors that may place their family at risk.	**#11** **#10**	NFP has an extensive curriculum that fosters parent child interactions. This curriculum is theoretically based and individualized by the NHV. These concepts are articulated in the following model elements. Model element #11: *Nurse Home Visitors apply the theoretical framework that underpins the program, emphasizing self-efficacy, human ecology and attachment theories through current clinical methods.* Model element # 10: *NHV, using professional knowledge, judgment and skill, apply the NFP Visit Guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains.* Supplementing NFP curriculum, NHVs receive professional development training to deliver the PIPE (Partners in Parenting Education) model and materials which teach concepts and skills of emotional connectedness between parent and child.
II.B.	**Standard II.B. The curriculum reflects the holistic and dynamic nature of child development.** II.B.1. A balance of all developmental areas: cognitive, communication, physical, social, and emotional is demonstrated in all activities and service provision. II.B.2. An integrated and individualized program is offered for children in the context of their families. II.B.3. Multiple theoretical perspectives are considered, and developmentally appropriate practices are implemented. II.B.4. A variety of high quality, developmentally appropriate activities and materials are utilized in a safe and supportive environment.	**#10** **#11**	The theoretical framework for NFP curriculum is based on the following three theories that together provide a holistic and dynamic approach to child development : Attachment Theory (Bowlby), Self-Efficacy Theory (Bandura), and Human Ecology (Brofenbrenner). According to Model Element 10: *NHV, using professional knowledge, judgment and skill, apply the NFP Visit Guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains.* NFP recognizes 6 program domains that provide a holistic approach to child development, namely: Personal Health, Environmental Health, Life Course, Maternal role, Friends and Family, and Health and Human services. Literacy is one of the topics covered in the guidelines.

ISBE Birth To Three Program Standards & Nurse Family Partnership Standards

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	NFP Model Standard	Nurse Family Partnership Model Standard Description
II.B. continued	II.B.5. An emergent literacy focus is observable in the activities, materials, and environment planned for the child	**#10** **#11 continued**	Additionally, the curriculum (called Visit Guidelines by NFP) provides ideas and materials that can be used or adapted by the NHV for each home visit as described in Model element #11: *Nurse Home Visitors apply the theoretical framework that underpins the program, emphasizing self-efficacy, human ecology and attachment theories through current clinical methods.*
II.C.	**Standard II.C. The curriculum prioritizes family involvement while respecting individual parental choices.** II.C.1. Opportunities are provided for varied levels of parent participation. II.C.2. Opportunities are provided for parents to increase their levels of program involvement through education and enrichment. II.C.3. The curriculum and activities support family literacy.		The primary level of intervention for NPF is with the parents, consequently there is a strong focus on parental involvement. Specifically, the curriculum aims to prepare women to embrace their role as mothers and to continue in their own life course development. Program outcomes of NFP include helping teen mothers complete high school as well as supporting mothers in recognizing and achieving other educational and vocational goals. These outcomes are directly related to improving parental literacy. Whenever feasible, fathers, significant others and/or family members are encouraged to attend the visits. Specific materials for fathers are contained in the curriculum. Many programs have also developed specific outreach efforts for fathers. In all cases, individual clients and families participate in choosing the topics that are most appropriate.
II.D.	**Standard II.D. The curriculum supports and demonstrates respect for the families' unique abilities as well as for their ethnic, cultural, and linguistic diversity.** II.D.1. The program provides activities, materials, and an environment that reflect a variety of cultures. II.D.2. Program services are provided in the family's primary language whenever possible.		The NFP curriculum may be adapted by NHV to meet the unique needs of clients. At this time, NFP-NSO provides materials in both English and Spanish; however, local agencies can translate materials into other languages as needed. Local programs may also supplement NFP materials to better meet the needs of specific clients. To meet the language and cultural needs of clients, local implementing agencies are encouraged to try to hire bilingual staff and/or work with translators to provide services in the family's primary language whenever possible.
II.E.	**Standard II. E. The curriculum promotes a framework that is nurturing, predictable, and consistent, yet flexible.** II.E.1. Schedules and routines are familiar and available in print. II.E.2. The program responds to the participant's individual cues and makes accommodations	**#7**	According to Model element #7: Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current NFP Guidelines. These guidelines provide recommendations for regular scheduled of visits throughout the various phases of the program. All visits are prearranged with the client in accordance with her schedule. The time and date of each visit is written on the visit summary form and left with the client. Individualization of the program to meet client needs is discussed in Model Element 10: *NHV, using professional knowledge, judgment and skill, apply the NFP Visit Guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains.*
SECTION III	**DEVELOPMENTAL MONITORING & PROGRAM ACCOUNTABILITY**	**AREA III**	**DEVELOPMENTAL MONITORING & PROGRAM ACCOUNTABILITY**
III.A.	**Standard III.A. The program staff regularly monitors children's development.** **Quality Indicators:** III.A.1. The staff monitors children's development using a variety of appropriate methods.		As an RN, the NHV has unique training to detect developmental delay. In addition, each implementing agency is required to ensure that their NHV receive professional development in the use of NCAST (Nursing Child Assessment Satellite Training)

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	NFP Model Standard	Nurse Family Partnership Model Standard Description
III.A. continued	III.A.2. Developmental monitoring views the child from a holistic perspective within the context of the family and the community. III.A.3. The staff obtains information from different sources and shares the information with parents. The parents are further involved in the interpretation of this information in support of the child's development. III.A.4. Children are referred to the Illinois Early Intervention System when appropriate. III.A.5. Families are informed of appropriate programs in the community by the child's third birthday.		This training enables NHV to provide regular developmental assessments, to teach parents how to assess for developmental milestones and to facilitate early referrals when concerns are noted.
III.B.	**Standard III.B. Leadership conducts regular and systematic evaluation of the program and staff to assure that the philosophy is reflected and goals of the program are being fulfilled.** **Quality Indicators:** III.B.1. An annual evaluation is conducted of program quality and progress toward goals. III.B.2. The results of the program evaluation are reviewed annually and are used or considered in making organizational and/or programmatic changes. III.B.3. Leadership works in partnership with staff to plan, develop, and implement an effective staff evaluation process.		Implementation Agencies receive regular reports of data which facilitate program monitoring. Data reports include staff performance indicators, fidelity measures and client outcomes. Program monitoring and quality improve efforts are on-going activities for NFP as described by Model element#15: *Nurse Home Visitor and Nursing Supervisors collect data as specified by the NFP NSO and NFP Reports to guide their practice, assess and guide program implementation, inform clinical supervision, enhance program quality and demonstrate program fidelity.* Other methods used for staff evaluation and feedback include: weekly, supervision meetings between each NHV and nurse supervisor, quarterly, observation of home visits by the nurse supervisor.
SECTION IV	**PERSONNEL**		**PERSONNEL**
IV.A.	**Standard IV.A. The program leadership is knowledgeable about child development and best practice for quality birth to three programs.** **Quality Indicators:** IV.A.1. The program supervisor/coordinator is an experienced early childhood professional with expertise in infant and toddler development and family enrichment. IV.A.2. Program leadership is supportive of and works to fully implement best practice in birth to three programs.	**#8**	Both leadership and staff are required to be Registered Nurses as described by Model Element # 8*: Nurse Home Visitors and Nursing Supervisors are registered professional nurses with a minimum of a Baccalaureate degree in nursing.* For Nurse Supervisors, the preferred level of training is a Master's degree. In addition to educational requirements, nursing supervisors must have experience in prenatal and/or early childhood program administration.
IV.B.	**Standard IV.B. The program leadership is effective in explaining, organizing, implementing, supervising, and evaluating birth to three programs. Quality Indicators:** IV.B.1. The program supervisor/coordinator is skilled in program management and supervision.	**#9**	In addition to basic hiring criteria for nursing supervisors, NFP also provides initial nurse supervisor training, on-going consultation and yearly professional development specific to the supervisor's role and responsibilities. Training for NHV and Nurse Supervisors is discussed in Model element#9: *Nurse Home visitors and Nursing Supervisors complete core educational sessions required by NFP NSO and deliver the intervention with fidelity to the NFP model.*

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	NFP Model Standard	Nurse Family Partnership Model Standard Description
IV.B. continued	IV.B.2. The program leadership models professionalism and conveys high expectations for all staff.		
IV.C.	**Standard IV.C. The program leadership hires qualified staff who are competent in working with infants and toddlers and their families.** **Quality Indicators:** IV.C.1. The program staff members meet the minimum entry-level requirements for their role/responsibilities established by the funding agent. IV.C.2. Staff members have formal training in child development theory and practice. They are able to demonstrate an understanding of how infants and toddlers develop and learn in the context of their families. IV.C.3. Staff members demonstrate the ability to establish meaningful, working relationships with parents and other family members. IV.C.4. Staff members demonstrate knowledge of and respect for the unique ways in which adults learn, acquire skills, and adjust to change. IV.C.5. Staff members have knowledge of and respect for cultural and linguistic diversity. IV.C.6. The program staff is knowledgeable of and sensitive to the social, cultural, and linguistic diversity of the community.	**#8**	Minimum qualifications for NHV staff are defined by Model Element # 8*: Nurse Home Visitors and Nursing Supervisors are registered professional nurses with a minimum of a Baccalaureate degree in nursing*. This level of training ensures that staff have a minimum level of education and training in child health and development, therapeutic relationships, providing client education, and cultural competency. Additional education and skill development in these areas is provided through NFP Core education. Core education requirements are discuss in Model element #9: *Nurse Home visitors and Nursing Supervisors complete core educational sessions required by NFP NSO and deliver the intervention with fidelity to the NFP model.*
IV.D.	**Standard IV.D. The program leadership provides ongoing supervision that promotes staff development and enhances quality service delivery.** **Quality Indicators:** IV.D.1. Program leadership creates and maintains an atmosphere that is nurturing and supportive of staff. IV.D.2. Program leadership regularly conducts a self-assessment. IV.D.3. The supervisor in partnership with each staff member develops a formative supervision plan. IV.D.4. Sufficient time for supervision is allotted in the program leader's schedule.	**#14** **#13**	The role of leadership in providing supervision is described by Model element 14: *Nursing supervisors provide NHV clinical supervision with reflection, demonstrate integration of the theories and facilitate professional development essential to the NHV role through specific supervisory activities including 1:1 clinical supervision, case meetings and field supervision.* Nursing supervisors conduct weekly supervision meetings with each NHV. These meetings are documented with a supervision report. Nursing Supervisors attend home visits and provide feedback every 4 months for each NHV. Additional supervision and leadership activities occur during case conferences and team meetings, each of which occurs two times per month with the nursing team. Model element 13 states: *A full time nursing supervisor provides supervision to no more than 8 individual NHVs* . This ensures that the supervisor has adequate time to fulfill her supervisory duties.

ISBE Birth To Three Program Standards & Nurse Family Partnership Standards

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	NFP Model Standard	Nurse Family Partnership Model Standard Description
IV.E.	**Standard IV.E. The program leadership provides opportunities for ongoing professional growth and development.** **Quality Indicators:** IV.E.1. A professional development plans, based on the needs identified through formative supervision and the interests of each staff member, is on file. IV.E.2. Sufficient time and funding are provided for staff to participate in appropriate staff development activities		Nursing supervisors work with NHVs plan professional growth and development. To guide professional growth, the NFP-NSO developed a tool "Guidelines for Growth of Nurse Home Visitors: Building Competency in the NFP Model" that describes the objectives and behaviors associated with each of the NFP core competencies and provides a framework for professional growth planning. A similar tool is available for nursing supervisors. Nurse supervisors are required to attend annual educational meetings sponsored by NFP. Ensuring adequate funding to provide for the educational needs of staff is one of the responsibilities of the implementing agency assumed under Model element #18: *Adequate support and structure shall be in place to support NHV and NS to implement the program and to assure that data is accurately entered into the data base in a timely manner.*
IV.F.	**Standard IV.F. The program leadership promotes continuity in staffing through provision of a supportive work environment, competitive wages and benefits, and opportunities for advancement.** **Quality Indicators:** IV.F.1. The program leadership provides staff members with a workspace and schedule appropriate for implementing their job responsibilities. IV.F.2. The program leadership advocates and works to secure a competitive wage and benefit package for personnel based on their position in the program and their expertise and experience. IV.F.3. The program leadership provides opportunities for career advancement.	**#16** **#18**	The following NFP Model elements describe the required responsibilities of an agency and its leadership regarding support for NFP. Model element 16: *Nurse Family Partnership Implementing Agency is located in and operated by an organization known in the community for being a successful provider of prevention services to low-income families.* Model element 18: *Adequate support and structure shall be in place to support NHV and NS to implement the program and to assure that data is accurately entered into the data base in a timely manner.*
IV.G.	**Standard IV.G. The program leadership and staff are knowledgeable about programs and agencies in the community that provide services for children and their families.** **Quality Indicators:** IV.G.1. The program leadership provides access to information about a variety of agencies in the community that provide social, health, and other services to children and families. IV.G.2. The program leadership arranges for staff members to visit and interact with birth to three providers and programs elsewhere in the community.	**#16** **#17**	Model element 16: *Nurse Family Partnership Implementing Agency is located in and operated by an organization known in the community for being a successful provider of prevention services to low-income families.* In addition, the implementing agency must convene a community advisory group whose role is to help facilitate community support and community involvement as described by Model element #17: *Nurse-family partnership implementing agency convenes a long-term community advisory board that meets at least quarterly to promote a community support system for the program and to promote program quality and sustainability.*

ISBE Birth To Three Program Standards & Nurse Family Partnership Standards

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	NFP Model Standard	Nurse Family Partnership Model Standard Description
SECTION V	**FAMILY & COMMUNITY PARTNERSHIPS**		
V.A.	**Standard V.A. The child is viewed in the context of the family and the family is viewed in the context of its culture and community.** **Quality Indicators:** V.A.1. The program is designed to enhance and support parent/child relationships. V.A.2. Program leadership and staff understand and respect the culture of the families they serve. V.A.3. The leadership and program staff understand that the child's home, community, and cultural experiences impact his/her development and early learning. V.A.4. Materials that promote and support the program emphasize the importance of families in the lives of children. V.A.5. The program leadership and staff communicate with families in their primary language whenever possible. V.A.6. The program assists families in expanding their knowledge of child growth and development and parenting techniques. V.A.7. The program staff recognizes the influence of the community and its characteristics upon the family.	**#11** **#10**	At the agency level, each NFP program must have a community advisory board to help ensure that the program is well integrated into the community. This requirement is expressed by Model element #17 *Nurse-family partnership implementing agency convenes a long-term community advisory board that meets at least quarterly to promote a community support system for the program and to promote program quality and sustainability.* The ecological context in which NFP services occur is also integral to the NFP curriculum. Drawing on the theory of human ecology, the curriculum contains both environment and friends and family domains which cover concepts related to community, culture and their interactions. These concepts are articulated in the following model elements. Model element #11: *Nurse Home Visitors apply the theoretical framework that underpins the program, emphasizing self-efficacy, human ecology and attachment theories through current clinical methods.* Model element # 10: *NHV, using professional knowledge, judgment and skill, apply the NFP Visit Guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains.* Supplementing NFP curriculum, NHVs receive professional development training to deliver the PIPE (Partners in Parenting Education) model and materials which teach concepts and skills of emotional connectedness between parent and child.
V.B.	**Standard V.B. The program leadership and staff seek and facilitate family participation and partnerships.** **Quality Indicators:** V.B.1. The program leadership assures a system is in place for regular, effective communication and responsive interaction between the program leadership, staff, and families. V.B.2. The program provides opportunities for family involvement and educational activities that are responsive to the ongoing and expressed needs of family members. V.B.3. Families are included in the development and implementation of program activities.	**#5**	Since the family is the primary level of intervention for the NFP program, family partnership and participation are assumed in the program model. Model element# 5: *Client is visited one to one, one NHV to one first-time mother/family.* The objectives of NFP include encouraging family support for the client and participation of the father (significant other) of the child whenever feasible.

ISBE Birth To Three Program Standards & Nurse Family Partnership Standards

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	NFP Model Standard	Nurse Family Partnership Model Standard Description
V.C.	**Standard V.C. The program assures that families have access to comprehensive services.** **Quality Indicators:** V.C.1. Program leadership and staff have a working knowledge of the resources in their community. V.C.2. The program has both a referral and follow-up system to assure that families are able to access services determined appropriate. V.C.3. The program works to address family needs.	**#16**	In order to facilitate comprehensive access to services, NFP-NSO requires that implementing agencies have strong community relationships as described in Model element 16: *Nurse Family Partnership Implementing Agency is located in and operated by an organization known in the community for being a successful provider of prevention services to low-income families.* One of the roles of the NHV is to provide referrals to services within the community. Referrals are tracked in the CIS data system and as a standard of practice, NHV routinely follow up with clients on referrals and help to facilitate placements when necessary. Community Services, which includes referrals and resources, is one of the 6 program domains that are covered routinely by the NHV. To better facilitate placement of clients into community services, NFP implementing agencies are encouraged to develop relationships with community service providers.
V.D.	**Standard V.D. The program develops a partnership with families in which the family members and staff determine goals and services.** **Quality Indicators:** V.D.1. The program provides services that promote family growth and enrichment to identify and build on family strengths. V.D.2. The program offers parents opportunities to develop and implement a family plan that describes family goals, responsibilities, timelines, and strategies for achieving these goals. V.D.3. Program staff and families regularly review the family plan, document progress toward goals, and make needed revisions.	**#11**	The theoretical underpinnings of NFP, expressed in Model element # 11: *Nurse Home Visitors apply the theoretical framework that underpins the program, emphasizing self-efficacy, human ecology and attachment theories through current clinical methods*, *emphasize the partnership between client and NHV*. NHV also receive training in motivational interviewing techniques to help facilitate communication with clients to develop partnerships. Client visits teach principles of goal setting, including written documentation of client goals and activities. The educational methods employed emphasize strength based and client centered principles. Regular visits allow NHV to provide follow up and support to help families make progress toward their goals.
V.E.	**Standard V.E. The program takes an active role in community and system planning and establishes ongoing collaborative relationships with other institutions and organizations that serve families.** **Quality Indicators:** V.E.1. Efforts are made to work in collaboration with other providers of services to families with young children in order to maximize services and resources available in the community. V.E.2. Comprehensive physical and mental health, educational, social, and recreational resources for children and their families are developed and promoted in collaboration with the community.	**#16** **#17**	By virtue of the fact that Implementation Agencies must have strong community ties and ongoing community involvement, it is expected that these agencies are also involved in systems planning and continued development of collaborative relationships which will help to strengthen the program and facilitate better integration of services for clients in the community. Model element 16: *Nurse Family Partnership Implementing Agency is located in and operated by an organization known in the community for being a successful provider of prevention services to low-income families.* Model element #17: *Nurse-family partnership implementing agency convenes a long-term community advisory board that meets at least quarterly to promote a community support system for the program and to promote program quality and sustainability.*

ISBE Birth To Three Program Standards & Nurse Family Partnership Standards

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	NFP Model Standard	Nurse Family Partnership Model Standard Description
V.E. continued	V.E.3. The program leadership recognizes the urgent need for high quality child care for infants and toddlers and participates in community collaboration to identify, locate, and provide access to this service. V.E.4. The program leadership works with the family and community in supporting transitions, respecting each child's unique needs and situation.	**#16** **#17 continued**	

Parents as Teachers

- Full Profile of Program Model
- Crosswalk to Illinois Birth to Three Standards
- Parents As Teachers Quality Indicators

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Parents As Teachers

Full Profile of Program Model

	Parents as Teachers (PAT)
Program Purpose & Description	**Purpose** • To provide the information, support, and encouragement parents need to help their children develop optimally during the crucial early years of life. **Description** • Parents as Teachers (PAT) is a home-based family education and support program for parents with children from the prenatal stage through age 5. Through the program, parents acquire skills that help them make the most of children's crucial early-learning years. The program has four goals: • Increase parent knowledge of early childhood development and improve parenting practices • Provide early detection of developmental delays and health issues • Prevent child abuse and neglect • Increase children's school readiness and school success
Target Population	• All families; PAT is a universal access model. Some PAT programs use funding that requires them to deliver services to a very targeted population. PAT also blends with other early childhood programs that target high needs families. Program intensity is modified based on the needs of the families served.
Key Services	**Personal Visits** • PAT-certified Parent Educators visit families at their homes on a regular basis. During visits, Educators work in partnership with parents to share child development and parenting information using the Born to Learn™ research-based curriculum. Parents observe their child's skills and interact with their children through developmentally appropriate activities. **Group Meetings** • Group meetings provide opportunities for parents to acquire additional information about child development, parenting topics, and positive parent-child interactions while gaining support from other parents. Meetings are held at a variety of times that are convenient for families. **Developmental Screening** • All enrolled children receive developmental, hearing, vision, dental, and health screenings at least once each program year. Screening assists parents in identifying a child's strengths as well as areas of concern. Ongoing monitoring by parents is encouraged. **Connections with Community Resources** • PAT programs connect families to needed resources and take an active role in the community, establishing ongoing relationships with other organizations that serve families. **Goal Setting** • Parent Educators partner with families to establish and achieve child development and parenting goals.
Outreach & Recruitment	• PAT promotes its services in the community, recruits and promptly serves the maximum number of eligible families, and facilitates families' ongoing participation in services. o The support of key community persons is enlisted in recruiting families for the program and in promoting the program in the community.

Parents As Teachers

Full Profile of Program Model

	Parents as Teachers (PAT)
Outreach & Recruitment continued	○ Informational materials about the program are distributed in visible locations throughout the areas served by the program. These materials include a full description of PAT services. ○ Recruitment strategies and recruitment materials are culturally sensitive. ○ Families indicating a desire to participate are contacted about participation within two weeks. ○ Program staff annually assesses recruitment activities to ensure that efforts are focused on the most effective strategies.
Methods & Approaches	• The PAT model is based on the following core values: ○ All parents deserve support in their parenting role and participation is voluntary. ○ The home is the child's first and most important learning environment and the family is the unit of learning. ○ An understanding and appreciation of the history and traditions of different cultures is essential in serving families. ○ Design of the program allows for intensity and duration of services to match family needs. Quality programs serve families often enough and maintain families in the program for a sufficient amount of time to meet program and family goals. ○ PAT is committed to promoting the optimal development and school readiness of each child through the use of a curriculum based on child development and neuroscience. ○ Quality implementation of the PAT program fosters positive parent-child relationships, helps parents become astute observers of their child, and increases parenting skills, knowledge of child development, and feelings of confidence. ○ Local programs adapt the PAT model to meet the unique needs of the community being served.
Intensity of Services	**Personal Visits** • Ideally, services should be available before birth (prenatal) to age 5. • The number and frequency of home visits depends on family needs as well as program funding. • Home visits should be completed on at least a monthly basis, and weekly or twice a month for families with children who are at risk of school failure. **Group Meetings** • The number and frequency of group meetings depends on the needs and desires of the families being served. Meetings should be offered at least monthly. Group meetings provide opportunities for parents to acquire information about child development, parenting and positive parent-child interaction.

Parents As Teachers

Full Profile of Program Model

	Parents as Teachers (PAT)
Staff Qualifications & Supervision	**Qualifications** • Parent Educators should possess the knowledge, skills and sensitivity to respond effectively to families' community, cultural, and language backgrounds. • It is recommended that parent educators have a bachelor's degree in early childhood education or a related field. Those with an associate's degree or less must have several years experience working with young children and their families. **Supervision** • It is recommended that supervisors have a college degree in early childhood education, behavioral or social sciences, or a related field. Individual programs may include additional or alternative education requirements. • Individual programs decide upon the frequency and duration of supervision, utilizing the following guidelines: o Individual or group supervision occurs on a regular basis, at least once a month and includes education, administration and support. o At least annually, a supervisor observes each Parent Educator providing a personal visit and facilitating a group meeting. New parent educators are observed more frequently. o Administration of developmental screening is also observed at least every 3 years. Parent Educators receive at least annual written reviews of their performance and progress toward their professional goals.
Staff Training	• To obtain PAT certification, staff must complete a 5-day training institute on early childhood development, effective home visits, facilitation of parent-child interaction, parent group meetings, community resources, services to high-needs families, and red flags in hearing, vision, and health, as well as program recruitment and organization. Staff must also complete an online Follow-Up day after 3-6 months of program implementation. • All supervisors must complete a 2-day introductory supervision training; a one-day advanced training on reflective supervision is also encouraged. • In order to be re-certified, staff must serve a minimum of 5 families and deliver at least 25 personal visits a year. In addition, staff must also complete annual in-service hours: 20 hours (first year), 15 hours (second year), and 10 hours (third year and beyond).
Staff Caseload/ Class Size	• Program staffing adequately supports the program design and goals.All families must receive a minimum of one visit per month. Parent Educators who serve high-risk families with greater needs and who carry additional program responsibilities serve families more frequently:. o A full-time Parent Educator conducting weekly visits serves 12- 14 families. o A full-time parent educator conducting twice a month visits serves 24-25 families
Matching Services to Need	• Local programs adapt the PAT model to meet the unique needs of the community being served. • Design of the program should allow for variations in program intensity and duration to match family needs. o The program curriculum is individualized to address a child's interest and developmental needs as well as parenting issues.

Parents As Teachers

Full Profile of Program Model

	Parents as Teachers (PAT)
Coordination of Services	**Connections with Community Resources Program Component** • Parent Educators are knowledgeable about community resources, including informal networks, local customs, and events. • PAT programs connect families to needed resources and take an active role in the community, establishing ongoing relationships with other institutions and organizations that serve families.
Parent Involvement	• Implementation of the PAT model emphasizes the importance of engaging and building relationships with families through parent empowerment, appreciation of diversity, and partnership. • Recognizing that parents are their children's first and most influential teachers, PAT services are aimed at providing the information, support and encouragement that parents need to help their children develop optimally during their early years.
Credentialing or Certification Process	• Parent Educators are certified through the 5-day training institute; certifications must be renewed each year (see Staff Training above). • The PAT National Center offers a site visit and national commendation program based on a self-assessment in all 8 areas of the PAT Standards.
Evaluation Requirements	**Annual Requirements** • The program annually tracks family enrollment, participation, service intensity and attrition. • Staff annually assesses promotion of PAT services, recruitment activities, and engagement and retention methods to ensure that efforts are focused on the most effective strategies. **Recommendations** • The program conducts a structured, comprehensive self-assessment process at least once every three years. Through this process, an external evaluator provides feedback to staff about program strengths and areas for improvement. • The program annually measures outcomes, including: participant satisfaction, parent knowledge and practices, prevention of abuse, identification of delays, and school readiness. • Program evaluation results are used to modify program goals, revise program design, strengthen program operations, and direct strategic planning.
Program Costs	**Cost per participant** • $3,650 per year (weekly visits to one at-risk family, per year) **Start-up costs (estimated)** • $78,002 per program site for one year for a brand new program (includes training and curriculum, program materials, two part-time parent educators, one supervisor, one clerical support staff person, administrative costs, rent and utilities, and quality assurance and evaluation) • $4,470 per program site for existing early childhood programs to adopt the Parents as Teachers model (includes training and program materials) **Training costs** • $815 per person, including training fee and cost of curriculum

Parents As Teachers

Full Profile of Program Model

	Parents as Teachers (PAT)
Supporting Research Citations	• Children whose families participated in Parents as Teachers are less likely to receive remedial assistance, less likely to be held back a grade in school and half as likely to have Individualized Education Plans as comparable children whose families did not participate in PAT. (O'Brien, Garnett and Proctor, 2002; Drazen and Haust, 1996) • In families with very low income, those who participated in Parents as Teachers were more likely to read aloud to their child and to tell stories, say nursery rhymes, and sing with their child. (Wagner and Spiker, 2001) • Additional citations available at www.parentsasteachers.org.
Model-Specific Resources	• Websites: www.parentsasteachers.org and http://www.opfibti.org/pat/ • The following materials are all available on the PAT website: o Parents as Teachers Standards and Quality Indicators o Supervisor's Manual and Program Administration Guide o "A Closer Look." Parents as Teachers Standards and Self-Assessment Guide o Parents as Teachers Logic Model o Program Evaluation Handbook - Measuring Program Impact o Outcomes Measurement Tool Kit
Initial Point of Contact for Program Model Information	Clare Eldredge Ounce of Prevention Fund State Leader for PAT in Illinois Phone: 217-522-5510 Email: celdredge@ounceofprevention.org

If you would like a current listing of those Illinois programs that use the Parents as Teachers model, with locations and contact information please contact Maureen Brennan (MBrennan@ounceofprevention.org) or Clare Eldredge (CEldredge@ounceofprevention.org).

ISBE Birth to Three Program Standards & Parents as Teachers Standards

There appears to be substantial correspondence between the PAT Standards and Quality Indicators and the Illinois State Board of Education's 0-3 Standards. In addition, the two sets of standards share important similarity in their underlying philosophies. (Note: The examples of correspondence cited in this document are a representative sample and do not represent all the instances of specific correspondence between items in the Illinois 0-3 Standards and the PAT Standards.)

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	Parents as Teachers Standard	Parents as Teachers Standards/Quality Indicators
SECTION I	**ORGANIZATION**	**AREA I**	**ORGANIZATION**
I.A.	**Standard I.A. All birth to three programs must have a mission statement based on shared beliefs and goals.** **Quality Indicators:** I.A.1. A mission statement based on shared beliefs is developed cooperatively by parents, staff members, families, and community representatives and is reviewed annually. I.A.2. The mission statement and beliefs are consistent with those of the community. I.A.3. The essence of the mission statement is reflected in all decisions and a copy is posted and available. I.A.4. The goals stem from the Illinois Birth to Three Program Standards. These program goals are developed by leadership and staff, shared with parents and other stakeholders, and serve as the basis for all planning and program development.	**I.A.**	**PAT Mission Statement:** **To provide the information, support, and encouragement parents need to help their children develop optimally during the crucial early years of life.** **Quality Indicators:** • The program's theory of change is familiar to all parent educators and ideally demonstrated through a logic model. (E11) • The program has clearly defined, written program goals and objectives that are updated when the design of the program and/or the population served by the program changes. (PM 1) • Staff can articulate the program's goals and objectives. (PM 2)
I.B.	**Standard I.B. Scheduling practices and intensity of services are tailored to the individual strengths and needs of children birth to three and their families.** **Quality Indicators:** I.B.1. The program leadership engages in scheduling practices, including evenings, weekends, and summer programming, that respect the individual needs of infants and toddlers and their families in both home visiting and center-based programs. I.B.2. The intensity of program services is commensurate with the preferences, strengths, and needs of individual children and families. I.B.3. The program uses a variety of strategies based on the preferences, strengths, and needs of individual children and their families.	**I.B.**	Design of the program allows for intensity and duration of services to match family needs. Quality programs serve families often enough and maintain families in the program for a sufficient amount of time to meet program and family goals. (GP 1) Quality Indicators: • Parent educators schedule personal visits on a variety of weekdays, evenings, and weekends. (PV1) • Successful PAT programs recognize that all families have strengths and that families' ability to learn and grow is maximized by building on these strengths. (GP V)
I.C.	**Standard I.C. The strengths and needs of the children and families as well as research on best practice determine the ratio of participants to staff and the size of program groups.**	**I.C.**	**Design of the program allows for intensity and duration of services to match family needs. Quality programs serve families often enough and maintain families in the program for a sufficient amount of time to meet program and family goals. (GP IV)**

ISBE Birth to Three Program Standards & Parents as Teachers Standards

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	Parents as Teachers Standard	Parents as Teachers Standards/Quality Indicators
I.C. continued	**Quality Indicators:** I.C.1. Group size and ratios of adults to infants and toddlers are developmentally appropriate in program groups. I.C.2. A reasonable number of families is served by each service provider in accordance with program design and goals, considering geographic location, severity of need, intensity of services, and training of staff.	**I.C. continued**	**Quality Indicators:** • Program staffing adequately supports the program design and goals. (PM 23) • Program staffing complies with state/funder requirements in relation to parent educator qualifications and parent educator to family ratio. (PM 22) • A part-time parent educator (20 hours per week) typically completes 24 visits per month; a full-time parent educator (40 hours per week) typically completes 56 visits per month. Parent educators who carry additional program responsibilities complete fewer visits per month. Group meeting facilities and furnishings are appropriate for the number of families attending, ages of the children, and the type of activity being offered (e.g., size of furnishings, room size, room setup, etc.). (GM 6)
I.D.	**Standard I.D. The program meets the needs of children and families of varying abilities as well as diverse cultural, linguistic, and economic backgrounds.** **Quality Indicators:** I.D.1. Qualified staff that demonstrate cultural and linguistic competency are available to effectively interact with children and families. I.D.2. A variety of activities, strategies, and materials are used to meet the diverse needs of children and families.	**I.D.**	**An understanding and appreciation of the history and traditions of different cultures is essential in serving families. Staff and program practices show a respect for diversity in family lifestyles and child rearing practices. (GP VII)** **Quality Indicators:** • Parent educators possess the knowledge, skills, and sensitivity to respond effectively to families' community, cultural, and language backgrounds. (PM 20) • Parent educators share information about parenting skills and child development in ways that are respectful of families' behaviors and cultural norms. (PV 13) • Group meeting topics and formats are responsive to the special populations or groups served by the program such as teen parents, foster parents, grandparents, non-English speaking parents, etc. (GM 7) • Screening is administered with sensitivity to cultural background and accommodation for the family's primary language. (S 10) • Parent educators demonstrate respect for the cultural background and parenting practices of individual families when connecting families to formal and informal resources. (RN 5) • Recruitment strategies and content of recruitment materials (including language) acknowledge the cultural diversity and cultural norms of the population to be recruited. (RR 5)

ISBE Birth to Three Program Standards & Parents as Teachers Standards

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	Parents as Teachers Standard	Parents as Teachers Standards/Quality Indicators
I.E.	**Standard I.E. The physical environment of the program is safe, healthy, and appropriate for children's development and family involvement.** **Quality Indicators:** I.E.1. The program implements local and state health and safety guidelines. I.E.2. The program décor, furnishings, materials, and resources are appropriate for infants and toddlers and their families.	**I.E.**	**Quality Indicators:** • For presentation-plus and small ongoing group meeting formats, the program provides child care that includes: sufficient adult supervision, developmentally appropriate activities, adequate space, age-appropriate toys and materials, and a clean and safe environment. (GM 5) • Group meeting facilities and furnishings are appropriate for the number of families attending, ages of the children, and the type of activity being offered (e.g., size of furnishings, room size, room setup, etc.). (GM 6) • Program funding and in-kind support (i.e., facility space) is sufficient to provide services to the population it serves. (PM 5)
I.F.	**Standard I.F. The administration promotes and practices informed leadership and supervision. The administration participates in and encourages ongoing staff development, training, and supervision.** **Quality Indicators:** I.F.1. The leadership takes advantage of opportunities for advanced learning regarding best practice in the infant/toddler field. I.F.2. The leadership assures that all program staff takes advantage of opportunities for advanced learning regarding best practice in the infant/toddler field.	**I.F.**	**Staff development supports the professional growth of all staff and increases staff competence in delivering services to children and families. (PD Standard)** **Quality Indicators:** • The immediate supervisor of the parent educators has training and experience in the early childhood field. (PM 21) • The supervisor of the parent educator (s) accesses a minimum of 10 hours of professional development each year. (PD 17) • Parent educators access competency-based professional development and training to promote quality service delivery and maintain annual PATNC certification. • (PD 13)
I.G.	**Standard I.G. All birth to three programs must follow mandated reporting laws for child abuse and neglect and have a written policy statement addressing staff responsibilities and procedures regarding implementation.** **Quality Indicators:** I.G.1. The program leadership familiarizes staff with the Abused and Neglected Child Reporting Act [325 ILCS 5] as well as with the program's policy. This should be included as part of new staff orientation and, at a minimum, be reviewed annually. I.G.2. The written policy must include procedures for documentation and follow-up of reported abuse.	**I.G.**	**Quality Indicators:** • The program follows and annually reviews with staff its policy governing appropriate procedures for addressing child abuse and neglect in alignment with state law. (PM 14)
I.H.	**Standard I.H. The program budget is developed to support quality program service delivery.** **Quality Indicators:** I.H.1. Sufficient funds are allocated to support human resources. I.H.2. Sufficient funds are allocated to provide staff development and training.	**I.H.**	**Quality Indicators:** • Program funding and in-kind support (i.e., facility space) is sufficient to provide services to the population it serves. (PM 5) • Competitive salary, compensation, and benefits are offered to staff. (PM 7)

ISBE Birth to Three Program Standards & Parents as Teachers Standards

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	Parents as Teachers Standard	Parents as Teachers Standards/Quality Indicators
I.H. continued	I.H.3. Sufficient funds are allocated for material resources to support quality programming. I.H.4. Sufficient funds are allocated to encourage and support parent participation in all program activities. I.H.5. Sufficient funds are allocated to support an evaluation process for program effectiveness and outcomes.	**I.H. continued**	• Parent educators access competency-based professional development and training to promote quality service delivery and maintain annual PATNC certification. (PD 13) • At least 5 % of annual program budget is allocated for evaluation, including self-assessment. (E 2) • The program seeks additional funding and in-kind support from a variety of sources to expand services. (PM 6)
SECTION II	**CURRICULUM & SERVICE PROVISION**	**AREA II**	**CURRICULUM & SERVICE PROVISION**
II.A.	**Standard II.A. The curriculum reflects the centrality of adult/child interactions in the development of infants and toddlers.** **Quality Indicators:** II.A.1. Positive parent/child interactions are encouraged and promoted in all aspects of the program. II.A.2. The curriculum promotes parent/child interactions in the way sessions are designed and conducted by staff. II.A.3. The development of a sense of trust and autonomy among staff, children, and families is a priority. II.A.4. Parents receive education and support to identify and cope with life stressors that may place their family at risk.	**II.A.**	**The home is the child's first and most important learning environment and the family is the unit of learning. (GP II)** **Quality implementation of the PAT program fosters positive parent-child relationships, helps parents become astute observers of their child, increases parenting skills, knowledge of child development, and feelings of confidence. (GP XI)** **Quality Indicators:** • Parent educators use the Born to Learn curriculum to deliver personal visits with a focus on child development and parent-child interaction. (PV 18) • Parent educators build and maintain rapport through interaction that is responsive to each family member's interpersonal style. (PV 9)
II.B.	**Standard II.B. The curriculum reflects the holistic and dynamic nature of child development.** **Quality Indicators:** II.B.1. A balance of all developmental areas: cognitive, communication, physical, social, and emotional is demonstrated in all activities and service provision. II.B.2. An integrated and individualized program is offered for children in the context of their families. II.B.3. Multiple theoretical perspectives are considered, and developmentally appropriate practices are implemented. II.B.4. A variety of high quality, developmentally appropriate activities and materials are utilized in a safe and supportive environment. II.B.5. An emergent literacy focus is observable in the activities, materials, and environment planned for the child.	**II.B.**	**PAT is committed to promoting the optimal development and school readiness of each child through the use of a child development, neuroscience based curriculum. (GP X)** **Quality Indicators:** • Personal visit activities and topics are individualized to respect family needs and concerns and in accordance with the child's developmental level. (PV 19) • Parent educators involve the child and parent in an age-appropriate parent-child activity during the personal visits. (PV 27) • Parent educators include a book sharing activity during personal visits. (PV 30) • Parent educators encourage parents to foster literacy in the home environment by modeling reading and writing for their child, engaging their child in literacy activities, and providing literacy materials for their child's use. (PV 31)
II.C.	**Standard II.C. The curriculum prioritizes family involvement while respecting individual parental choices.** **Quality Indicators:**	**II.C.**	**Staff and program practices show a respect of diversity in family lifestyles and child rearing practices. (GP VII)** **Quality Indicators:**

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Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	Parents as Teachers Standard	Parents as Teachers Standards/Quality Indicators
II.C. continued	II.C.1. Opportunities are provided for varied levels of parent participation. II.C.2. Opportunities are provided for parents to increase their levels of program involvement through education and enrichment. II.C.3. The curriculum and activities support family literacy.	**II.C. continued**	• Parent educators schedule personal visits on a variety of weekdays, evenings, and weekends. (PV 1) • Group meetings are offered at times and locations that are convenient for the families served. (GM 3) • Across the program year, the program provides a variety of group meeting formats, including parent-child interaction, presentation-plus, small ongoing groups, and community events. (GM 4) • Parents are used as a resource to identify topics for group meetings, plan and facilitate group meetings. (GM 9) • Parent educators encourage parents to foster literacy in the home environment by modeling reading and writing for their child, engaging their child in literacy activities, and providing literacy materials for their child's use. (PV 31)
II.D.	**Standard II.D. The curriculum supports and demonstrates respect for the families' unique abilities as well as for their ethnic, cultural, and linguistic diversity.** **Quality Indicators:** II.D.1. The program provides activities, materials, and an environment that reflect a variety of cultures. II.D.2. Program services are provided in the family's primary language whenever possible.	**II.D.**	**An understanding and appreciation of the history and traditions of different cultures is essential in serving families. Staff and program practices show a respect for diversity in family lifestyles and child rearing practices. (GP VIII)** **Quality Indicators:** • Parent educators share information about parenting skills and child development in ways that are respectful of families' behaviors and cultural norms. (PV 13) • Group meeting topics and formats are responsive to the special populations or groups served by the program such as teen parents, foster parents, grandparents, non-English speaking parents, etc. (GM 7) • Screening is administered with sensitivity to cultural background and accommodation for the family's primary language. (S10) • Recruitment strategies and content of recruitment materials (including language) acknowledge the cultural diversity and cultural norms of the population to be recruited. (RR 5)
II.E.	**Standard II. E. The curriculum promotes a framework that is nurturing, predictable, and consistent, yet flexible.** **Quality Indicators:** II.E.1. Schedules and routines are familiar and available in print. II.E.2. The program responds to the participant's individual cues and makes accommodations.	**II.E.**	**Successful PAT programs individualize the curriculum to address a child's interests, developmental needs, and parenting issues. (GP XII)** **Quality Indicators:** • Parent educators schedule personal visits on a variety of weekdays, evenings, and weekends. (PV 1) • Parent educators model, individualize, and adjust the parent-child activity to maximize both parent and child success with the activity. (PV 29)

Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	Parents as Teachers Standard	Parents as Teachers Standards/Quality Indicators
II.E. continued		**II.E. continued**	• Personal visit activities and topics are individualized to respect family needs and concerns and in accordance with the child's developmental level. (PV 19)
SECTION III	**DEVELOPMENTAL MONITORING & PROGRAM ACCOUNTABILITY**	**AREA III**	**DEVELOPMENTAL MONITORING & PROGRAM ACCOUNTABILITY**
III.A.	**Standard III.A. The program staff regularly monitors children's development.** **Quality Indicators:** III.A.1. The staff monitors children's development using a variety of appropriate methods. III.A.2. Developmental monitoring views the child from a holistic perspective within the context of the family and the community. III.A.3. The staff obtains information from different sources and shares the information with parents. The parents are further involved in the interpretation of this information in support of the child's development. III.A.4. Children are referred to the Illinois Early Intervention System when appropriate. III.A.5. Families are informed of appropriate programs in the community by the child's third birthday.	**III.A.**	**Quality Indicators:** • All enrolled children receive developmental, hearing, vision, dental, and health screenings at least once each program year. (S 1) • Parent educators use the child's screening results to plan individualized visits and reference the child's screening results in ongoing discussion with parents. (S14) • For particular areas of concern identified through screening, specific recommendations are made by program staff for follow-up activities to support the child's development. (S 15) • When screening results indicate the need for further assessment, parent educators provide recommendations to parents within 5 working days. (S 17) • Program staff work on a regular basis with other local providers of services and programs to address the needs of the population the program serves (e.g., early intervention resources). (RN 10) • Parent educators help families when they transition out of the program providing information and connecting families to community resources that meet their interests and needs. (RN 7)
III.B.	**Standard III.B. Leadership conducts regular and systematic evaluation of the program and staff to assure that the philosophy is reflected and goals of the program are being fulfilled.** **Quality Indicators:** III.B.1. An annual evaluation is conducted of program quality and progress toward goals. III.B.2. The results of the program evaluation are reviewed annually and are used or considered in making organizational and/or programmatic changes. III.B.3. Leadership works in partnership with staff to plan, develop, and implement an effective staff evaluation process.	**III.B.**	**The program produces a written annual report detailing program activities, accomplishments, and challenges that is shared with administrators and/or stakeholders. (PM 40)** **Quality Indicators:** • Evaluation results are used to strengthen program services, operations, and management (e.g., used in strategic planning, revising program design, modifying program goals and objectives, adapting program services, adjusting program operations and management). (E 10) • On an annual basis, parent educators set written professional development goals and evaluate progress toward these goals. (PD 12) • Parent educators receive at least annual written reviews of their performance and progress toward their professional goals. (PM 31)

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Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	Parents as Teachers Standard	Parents as Teachers Standards/Quality Indicators
SECTION IV	**PERSONNEL**	**AREA IV**	**PERSONNEL**
IV.A.	**Standard IV.A. The program leadership is knowledgeable about child development and best practice for quality birth to three programs.** **Quality Indicators:** IV.A.1. The program supervisor/coordinator is an experienced early childhood professional with expertise in infant and toddler development and family enrichment. IV.A.2. Program leadership is supportive of and works to fully implement best practice in birth to three programs.	**IV.A.**	**Quality Indicators:** • The immediate supervisor of the parent educators has training and experience in the early childhood field. (PM 21) • On at least a quarterly basis, the supervisor accesses supervision from an administrator, peer mentor, or other professional. (PM 29) (Also PM 10) • The program supervisor attended the Born to LearnT Institute, ideally for 5 days. (PD 5) • The supervisor of the parent educator(s) accesses a minimum of 10 hours of professional development each year. (PD 17)
IV.B.	**Standard IV.B. The program leadership is effective in explaining, organizing, implementing, supervising, and evaluating birth to three programs.** **Quality Indicators:** IV.B.1. The program supervisor/coordinator is skilled in program management and supervision. IV.B.2. The program leadership models professionalism and conveys high expectations for all staff.	**IV.B.**	**Program Management: The program is carefully designed, well managed, and efficiently operated, incorporating ongoing planning and review of program implementation.** **Quality Indicators:** • Each parent educator participates in relationship-based supervision that occurs on a regular basis, at least once a month. (PM 25) • Individual or group supervision includes the following three components: Education, administration and support. (PM 26) • An effective system of internal communication is maintained among staff, supervisors, and administrators through the use of a variety of communication strategies (e.g., memos, phone calls, e-mail, in-person contact). (PM 30)
IV.C.	**Standard IV.C. The program leadership hires qualified staff who are competent in working with infants and toddlers and their families.** **Quality Indicators:** IV.C.1. The program staff members meet the minimum entry-level requirements for their role/responsibilities established by the funding agent. IV.C.2. Staff members have formal training in child development theory and practice. They are able to demonstrate an understanding of how infants and toddlers develop and learn in the context of their families. IV.C.3. Staff members demonstrate the ability to establish meaningful, working relationships with parents and other family members. IV.C.4. Staff members demonstrate knowledge of and respect for the unique ways in which adults learn, acquire skills, and adjust to change. IV.C.5. Staff members have knowledge of and respect for cultural and linguistic diversity. IV.C.6. The program staff is knowledgeable of and sensitive to the social, cultural, and linguistic diversity of the community.	**IV.C.**	**Quality Indicators:** • Priority is placed on hiring candidates with effective interpersonal skills (e.g., strong communication skills, able to relate to people of diverse backgrounds, outgoing, empathic, non-judgmental, patient, tactful). (PM 19) • The program hires parent educators with a bachelor's degree or beyond in early childhood education or a related field and supervised experience working in the early childhood field. (PM 18) • Parent educators build and maintain rapport through interaction that is responsive to each family member's interpersonal style. (PV 9) • Parent educators apply knowledge of adult learning styles in the delivery of personal visits. (PV 12) • Parent educators possess the knowledge, skills, and sensitivity to respond effectively to families' community, cultural, and language backgrounds. (PM 20)

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Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	Parents as Teachers Standard	Parents as Teachers Standards/Quality Indicators
IV.D.	**Standard IV.D. The program leadership provides ongoing supervision that promotes staff development and enhances quality service delivery.** **Quality Indicators:** IV.D.1. Program leadership creates and maintains an atmosphere that is nurturing and supportive of staff. IV.D.2. Program leadership regularly conducts a self-assessment. IV.D.3. The supervisor in partnership with each staff member develops a formative supervision plan. IV.D.4. Sufficient time for supervision is allotted in the program leader's schedule.	**IV.D.**	**Quality Indicators:** • On at least a quarterly basis, the supervisor accesses supervision from an administrator, peer mentor, or other professional. (PM 29) • The program engages in a structured, comprehensive self-assessment process at least every 3 years. (E 3) • Each parent educator participates in relationship-based supervision that occurs on a regular basis, at least once a month. (PM 25) • On an annual basis, parent educators set written professional development goals and evaluate their progress toward these goals. (PD 12) • Parent educators receive at least annual written reviews of their performance and progress toward their professional goals. (PM 31)
IV.E.	**Standard IV.E. The program leadership provides opportunities for ongoing professional growth and development.** **Quality Indicators:** IV.E.1. A professional development plan, based on the needs identified through formative supervision and the interests of each staff member, is on file. IV.E.2. Sufficient time and funding are provided for staff to participate in appropriate staff development activities.	**IV.E.**	**Professional Development: Staff development supports the professional growth of all staff and increases staff competence in delivering services to children and families.** **Quality Indicators:** • On an annual basis, parent educators set written professional development goals and evaluate progress toward these goals. (PD 12) • Parent educators access competency-based professional development and training to promote quality service delivery and maintain annual PATNC certification. (PD 13)
IV.F.	**Standard IV.F. The program leadership promotes continuity in staffing through provision of a supportive work environment, competitive wages and benefits, and opportunities for advancement.** **Quality Indicators:** IV.F.1. The program leadership provides staff members with a workspace and schedule appropriate for implementing their job responsibilities. IV.F.2. The program leadership advocates and works to secure a competitive wage and benefit package. IV.F.3. The program leadership provides opportunities for career advancement.	**IV.F.**	**Quality Indicators:** • Competitive salary, compensation, and benefits are offered to staff. (PM 7) • In addition to staff time allotted for personal visits, staff time is also budgeted for group meetings, screenings, connecting families to community resources, staff meetings, and professional development. (PM 24) • Written job descriptions for all staff include qualifications and responsibilities that are updated when job requirements change. (PM 17)
IV.G.	**Standard IV.G. The program leadership and staff are knowledgeable about programs and agencies in the community that provide services for children and their families.**	**IV.G.**	**Resource Network: The program connects families to needed resources and takes an active role in the community, establishing ongoing relationships with other institutions and organizations that serve families. (RN Standard)** **Quality Indicators:**

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Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	Parents as Teachers Standard	Parents as Teachers Standards/Quality Indicators
IV.G. continued	**Quality Indicators:** IV.G.1. The program leadership provides access to information about a variety of agencies in the community that provide social, health, and other services to children and families. IV.G.2. The program leadership arranges for staff members to visit and interact with birth to three providers and programs elsewhere in the community.	**IV.G. continued**	• Parent educators are knowledgeable about community resources, including informal networks, local customs, and events. (RN 1) • The program has a comprehensive, annually updated resource network directory that includes health, mental health, education, and social service resources. (RN 2) • The resource network directory is accessible to all parent educators. (RN 3) • Program staff work on a regular basis with other local providers of services and programs to address the needs of the population the program serves (e.g., early intervention resources). (RN10) • PAT staff serves on governing boards or leadership councils of other community agencies that provide services for families with young children. (RN 11) (Also: RN 8,12)
IV.C.	**Standard V.A. The child is viewed in the context of the family, and the family is viewed in the context of its culture and community.** **Quality Indicators:** V.A.1. The program is designed to enhance and support parent/child relationships. V.A.2. Program leadership and staff understand and respect the culture of the families they serve. V.A.3. The leadership and program staff understand that the child's home, community, and cultural experiences impact his/her development and early learning. V.A.4. Materials that promote and support the program emphasize the importance of families in the lives of children. V.A.5. The program leadership and staff communicate with families in their primary language whenever possible. V.A.6. The program assists families in expanding their knowledge of child growth and development and parenting techniques. V.A.7. The program staff recognizes the influence of the community and its characteristics upon the family.	**IV.C.**	**The home is the child's first and most important learning environment and the family is the unit of learning. (GP II) Successful PAT programs build relationships between families and the larger community, especially schools. (GP IX) Personal visits support parents in their parenting role in order to promote optimal child development and positive parent-child interaction. (PV standard)** **Quality Indicators:** • Parent educators share information about parenting skills and child development in ways that are respectful of families' behaviors and cultural norms. (PV 13) • Parent educators build upon and adapt to the home environment, seeking to transfer personal visit activities to daily interactions between parent and child. (PV 23) • Materials commonly found in a home (e.g., towels, spoons, bowls) are used to promote learning during personal visits. (PV 24) • Parent educators partner with families to establish, record and achieve child development and parenting goals that are developmentally appropriate for their children and within the scope of the program. (PV 15)
IV.D.	**Standard V.B. The program leadership and staff seek and facilitate family participation and partnerships.** **Quality Indicators:** V.B.1. The program leadership assures a system is in place for regular, effective communication and responsive interaction between the program leadership, staff, and families.	**IV.D.**	**PAT programs forge partnerships with families based on equality, mutuality, and respect. (GP VIII)** **Quality Indicators:** • Parents are used as a resource to identify topics for group meetings, plan group meetings, and facilitate group meetings. (GM 9) • Stakeholders, including families, are involved in planning and discussing the results of program evaluations. (E 7)

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Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	Parents as Teachers Standard	Parents as Teachers Standards/Quality Indicators
IV.D. continued	V.B.2. The program provides opportunities for family involvement and educational activities that are responsive to the ongoing and expressed needs of family members. V.B.3. Families are included in the development and implementation of program activities.	**IV.D. continued**	• Evaluation results are used to strengthen program services, operations, and management (e.g., used in strategic planning, revising program design, modifying program goals and objectives, adapting program services, adjusting program operations and management). (E 10) • The program gathers and summarizes feedback on participant satisfaction with program activities at least annually. (E12)
IV.E.	**Standard V.C. The program assures that families have access to comprehensive services.** **Quality Indicators:** V.C.1. Program leadership and staff have a working knowledge of the resources in their community. V.C.2. The program has both a referral and follow-up system to assure that families are able to access services determined appropriate. V.C.3. The program works to address family needs.	**IV.E.**	**Resource Network: The program connects families to needed resources and takes an active role in the community, establishing ongoing relationships with other institutions and organizations that serve families. (RN Standard)** **Quality Indicators:** • Parent educators are knowledgeable about community resources, including informal networks, local customs, and events. (RN 1) • The program has a comprehensive, annually updated resource network directory that includes health, mental health, education, and social service resources. (RN 2) • The resource network directory is accessible to all parent educators. (RN 3) • The program has well defined procedures for providing families with information about and helping them access community resources. (RN 4) (Also: RN 5-14) • With family permission, parent educators consult with other organizations serving the family in order to coordinate services and optimally support the family. (RN 8)
IV.F.	**Standard V.D. The program develops a partnership with families in which the family members and staff determine goals and services.** **Quality Indicators:** V.D.1. The program provides services that promote family growth and enrichment to identify and build on family strengths. V.D.2. The program offers parents opportunities to develop and implement a family plan that describes family goals, responsibilities, timelines, and strategies for achieving these goals. V.D.3. Program staff and families regularly review the family plan, document progress toward goals, and make needed revisions.	**IV.F.**	**Parent educators partner with families to establish, record, and achieve child development and parenting goals that are developmentally appropriate for their children and within the scope of the program. (PV 15)** **Quality Indicators:** • Successful PAT programs recognize that all families have strengths and that families' ability to learn and grow is maximized by building on these strengths. (GP V) • Parent educators deliver personal visits from a strengths-based approach, including commenting on strengths of the parent(s) or primary caregiver during each visit. (PV10)

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Illinois Birth-3 Standard	Illinois Birth to Three Program Standards/Quality Indicators	Parents as Teachers Standard	Parents as Teachers Standards/Quality Indicators
IV.G.	**Standard V.E. The program takes an active role in community and system planning and establishes ongoing collaborative relationships with other institutions and organizations that serve families.** **Quality Indicators:** V.E.1. Efforts are made to work in collaboration with other providers of services to families with young children in order to maximize services and resources available in the community. V.E.2. Comprehensive physical and mental health, educational, social, and recreational resources for children and their families are developed and promoted in collaboration with the community. V.E.3. The program leadership recognizes the urgent need for high quality child care for infants and toddlers and participates in community collaboration to identify, locate, and provide access to this service. V.E.4. The program leadership works with the family and community in supporting transitions, respecting each child's unique needs and situation.	**IV.G.**	**Resource Network: The program connects families to needed resources and takes an active role in the community, establishing ongoing relationships with other institutions and organizations that serve families. (RN Standard)** **Quality Indicators:** • PAT staff serves on governing boards or leadership councils of other community agencies that provide services for families with young children. (RN 11) • The program links with organizations that advocate for and support the families and children that the program serves (e.g., local affiliate of La Raza, local chapter of the Association for Retarded Citizens, local mental health associations, etc.). (RN 12) • Program staff participates in advocacy and awareness efforts to promote the program in the local community. (PM 34) • Program staff participates in advocacy and awareness efforts that support early childhood initiatives at the state or national level. (PM 35) • Parent educators help families when they transition out of the program providing information and connecting families to community resources that meet their interests and needs. (RN 7)

Parents As Teachers Quality Indicators Not Included in Crosswalk

Personal Visit Quality Indicators:

- Parent educators involve fathers in personal visits. (PV 3)
- Personal visits are conducted in the home to build on the primary learning environment of the family. When extenuating circumstances exist, personal visits can be delivered in a mutually agreed upon site outside the home. (PV 4)
- Personal visits are completed more than once a month to each family with high needs. (PV 6)
- Parent educators deliver personal visits from a strengths-based approach, including commenting on strengths of the parent(s) or primary caregiver during each visit. (PV 10)
- Parent educators demonstrate a range of communication techniques that are well-matched to the family's communication styles. (PV 11)
- Parent educators understand and maintain professional boundaries in working with families. (PV 16)
- Parent educators integrate the five essential components of a personal visit (rapport, observation, discussion, parent-child activity, and summary) within personal visits. (PV 20)
- Parent educators use shared observation and reflection to help parents become better observers of their children. (PV 22)
- During personal visits, parent educators discuss the following with the parent(s); (PV 25)
    - child development information, including developmental characteristics
    - neuroscience information
    - parenting topics
    - questions and concerns the parent(s) may have
    - information about what to expect regarding child development during the coming months
- Parent educators ask parents about their experience with the follow-up activity and observations of their child's development since the previous visit. (PV 26)
- Parent educators model, individualize, and adjust the parent-child activity to maximize both parent and child success with the activity. (PV 29)
- Parent educators record children's accomplishment of milestones after personal visits. (PV 37)

Group Meeting Quality Indicators:

- The program offers at least monthly group meetings and children or parenting information is provided. (GM 2)
- During group meetings, parents are encouraged to build support networks by talking with each other about common experiences and concerns. (GM 12)
- Across the program year, group meetings address all age groups of children served by the program and all areas of child development. (GM 14)
- Each group meeting includes one or more of the following topics: Parenting, Child Development or Neuroscience, Health, and Community Resources. (GM 15)

Parents as Teachers Quality Indicators Not Included in Crosswalk

- Group meetings assist parents in becoming better observers of their child's development and in understanding their role in their child's development. (GM 16)
- Staff uses group meeting records, informal feedback, parent evaluations, and their own observations to continually improve group meetings. (GM 20)

Screening Quality Indicators:

- When screening is conducted by program staff, the program has written procedures outlining the screening process. When screening is conducted by an outside agency, the program has a written agreement with the outside agency that states results will be reviewed with parents and forwarded to the program. (S 6)
- Screening is scheduled at a time and place that is convenient for families and optimal for the child's performance. (S 8)
- Rapport is established with parent and child prior to administration of developmental screening. (S 9)
- A sample of each parent educator's completed developmental screening protocols is reviewed at least annually by the supervisor or mentor parent educator for accurate administration and scoring. (S 19)
- The program uses screening results to identify developmental needs of the children served and design program services to meet these needs (e.g., a program identifies a number of language delays in children served by the program and designs group meetings, and connects with additional community resources to respond to this issue.) (S 20)
- Screening results are tracked and summarized at the program level. (S 21)

Resource Network Quality Indicators:

- In addition to its core PAT services, the program offers: (RN 9)
  - developmentally stimulating play sessions for children and parents that promote parent-child interaction and parent support networks
  - a lending library of parenting and child development resources
  - a newsletter that includes information regarding activities, events and places of interest to families, developmental information, and parenting tips
  - partial services to families who must be placed on a waiting list
- The process for connecting families with community resources includes documentation and follow-up with the family or organization. (RN 13)

Recruitment and Retention Quality Indicators:

- The support of key community persons and agencies is enlisted in recruiting families for the program and in promoting the program in the community. (RR 2)
- The program's recruitment plan and activities are reviewed and discussed with staff as part of their orientation to the program. (RR 7)
- Enrollment procedures include discussing mutual expectations for participation in PAT services with the family and providing written information about the program so that families have the necessary information to make a commitment to participate. (RR 11)
- As a part of enrollment, both the parent educator and parent sign the written information provided about the program's services, indicating that they have reviewed it. (RR 12)

Parents as Teachers Quality Indicators Not Included in Crosswalk

- Program staff access professional development in recruitment and retention methods and strategies, including strategies to recruit, engage, and retain non-traditional and hard-to-reach families. (RR 15)
- Program staff contacts families that have exited the program to identify strengths, gaps, and weaknesses in the program. (RR 17)
- Program staff annually assesses promotion of PAT services, recruitment activities, and engagement and retention methods to ensure that efforts are focused on the most effective strategies. (RR 17)

Program Management Quality Indicators:

- The program submits required documentation for annual re-certification to the PAT state system leader of PATNC (whichever in applicable) by the required deadline. (PM 12)
- The program ensures that all parent educators and supervisors follow applicable codes of ethics. (PM 13)
- The program follows and annually reviews with staff its procedures to help ensure the personal safety of the parent educators. (PM 16)
- The program accesses consultants (especially mental health consultants) who provide guidance to parent educators regarding their work with families. (PM 28)
- On at least a quarterly basis, the supervisor accesses supervision from and administrator, peer mentor, or other professional. (PM 29)
- The program has a leadership council (e.g., community council, internal coordinating committee, board) with the following characteristics: (PM 32)
    - meets at least every 6 months
    - is composed of community service providers, community leaders, and families
    - reflects the cultural backgrounds of the program's service population
    - provides support for the development and promotion of the PAT program
    - helps identify funding sources
    - provides input into program planning and evaluation
- The program maintains an efficient and comprehensive record keeping system that facilitates accurate and timely completion, submission, filing, and retrieval of essential PAT documents. (PM 36)
- The program supervisor or mentor parent educator reviews a sample of each parent educator's files for accuracy, completeness, and overall quality on at least a quarterly basis. (PM 39)
- The program produces a written annual report detailing program activities, accomplishments, and challenges that is shared with administrators and/or stakeholders. (PM 40)

Professional Development Quality Indicators:

- An orientation process is implemented with new staff, orienting them to the local program's mission, goals, and operations. (PD 1)
- All parent educators complete the Born to Learn™ Institute before delivering PAT services. (PD 4)
- At least annually, a supervisor or mentor parent educator observes each parent educator providing a personal visit. (PD 7)
- First year parent educators receive more frequent personal visit and screening observations, with the first observation taking place within the first 8 weeks of delivering services. (PD 8)

Parents as Teachers Quality Indicators Not Included in Crosswalk

- The program supervisor or mentor parent educator observes each parent educator leading or co-facilitating a group meeting and provides feedback at least annually. (PD 10)
- The program supervisor or mentor parent educator observes each parent educator administering developmental screening and provides feedback at least once every 3 years. (PD 11)
- Program staff access training in the administration and scoring of the screening instrument(s) used by the program. (PD 15)
- Program staff continually builds their knowledge base about the cultures of the families in the communities they serve. (PD 18)

Evaluation Quality Indicators:

- An external evaluator works closely with program staff and provides objective feedback to the program about its strengths and areas for improvement at least once every 3 years. (E 4)
- Discussion of program evaluation activities and results are incorporated into staff meetings at least quarterly. (E 8)
- The program shares evaluation results at least annually with all stakeholders. (E 9)
- Family enrollment, participation, service intensity, and attrition are tracked and summarized each program year, and ideally tracked across program years. (E 13)
- The program measures outcomes for the children and families served, including one or more of the following: (E 15)
    - parent knowledge and practices (e.g., parent competence, parent confidence, parenting skills, parent-child interaction, parent involvement in child's education)
    - prevention of child abuse and neglect
    - identification of child delays
    - child school readiness or school success
- Outcomes for the children and families served are evaluated each year. (E 17)
- The program tracks child outcomes until kindergarten entry, and ideally beyond, to demonstrate the impact of the program on children and families over time. (E 18)

Resources

- Self-Assessment of Current Program Components
- Sample Framework for Logic Model
- "Framework for High Quality Services…"
- ISBE Prevention Initiative: 'Guidelines for "Research Based Program Models"'
- Additional Resources for Useful Information

Self-Assessment of Current Program Components

Information that will help you answer the questions in this self-assessment might be found in:

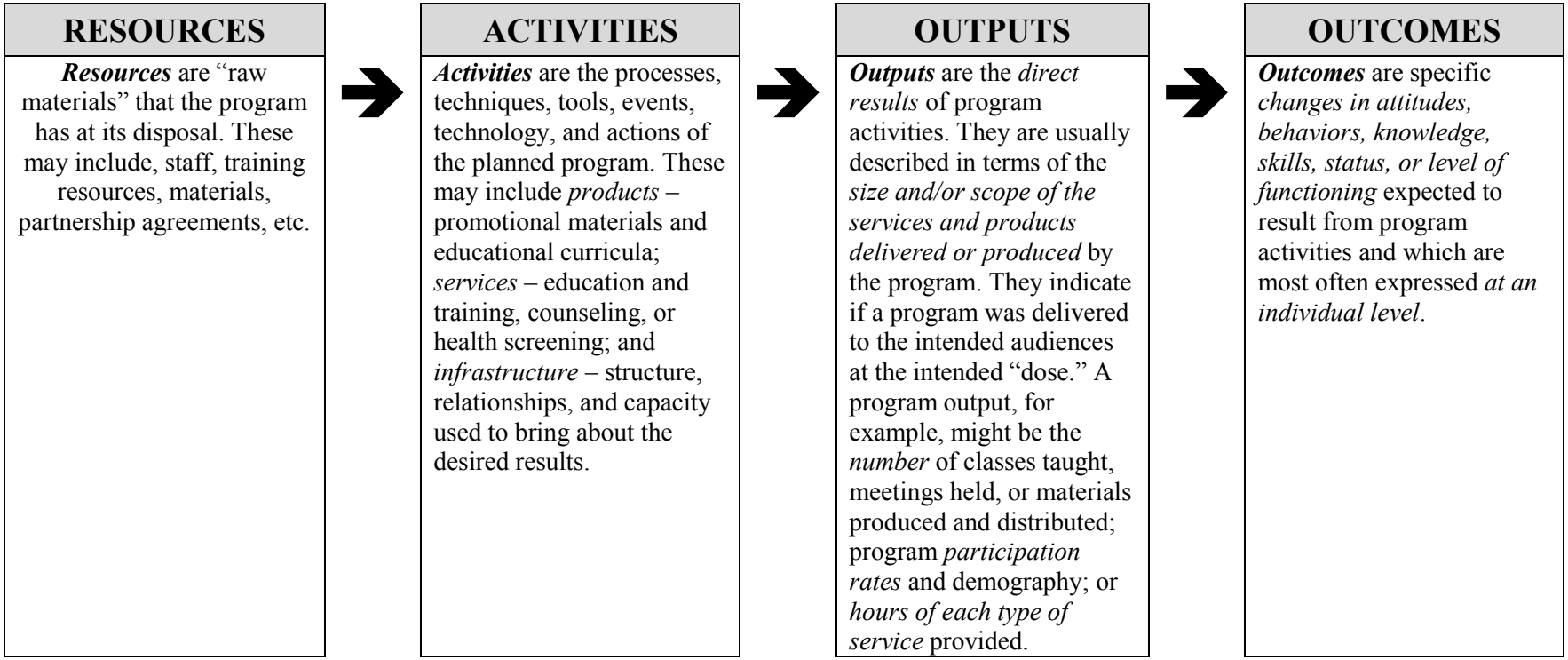
- Your program's mission statement
- Program brochures
- Grant proposals and grant reports
- Other program reports or evaluations

	Your Current Program
Program Purpose & Description	• What is the purpose (or what are the goals) of your program?
Target Population	• Who is your target population (e.g., teens, immigrants, etc.)?
Key Services	• What are the services that your program provides and how do they provide services?
Outreach & Recruitment	• How does your program identify and recruit program participants? • What kind of community outreach do you conduct?
Methods & Approaches	• What are the values or philosophy that your program is based upon?
Intensity of Services	• What is the frequency of contact with program participants? • Does your program provide the same intensity of services to all participants, or does the intensity of service vary with the needs of different participants?

	Your Current Program
Staff Qualifications & Supervision	• What are the qualifications of your program staff (level of education, years of experience, etc.)? • Who provides supervision to your program staff and how regularly does supervision occur?
Staff Training	• What type and amount of training do your program staff receive? Who provides the training? • Do your program staff have opportunities to obtain additional training? If so, please describe. Who provides this additional training?
Staff Caseload/ Class Size	• What is the caseload or class size, on average, per staff member?
Matching Services to Need	• How does your program individualize service provision? • Does your program offer different services to families based on their specific needs?
Coordination of Services	• How does your program coordinate its services with those of other programs or organizations? • How does your program coordinate services for families receiving services from multiple providers?
Parent Involvement	• Does your program involve parents? If so, please describe.

	Your Current Program
Credentialing or Certification Process	• Is your program affiliated with a national or other model?
Evaluation Requirements	• Does your program conduct a self-evaluation, or is it evaluated by an outside entity? If so, what does this evaluation involve?
Program Costs	• What is the average cost of your program per participant? (Average cost = Your cost to run the program divided by the number of participants)
Supporting Research Citations	• Do you have outcome data supporting the effectiveness of your program?
Model-Specific Resources	• Do you use any particular resources or information to help you implement your program?

Sample Framework for Logic Model



Framework for High Quality Services for Expecting Families and Families with Infants and Toddlers through Preschool For All (PFA)

(The following information is an excerpt from the original Toolkit and written as a position paper by the Illinois Early Learning Council: 0-3 Program Quality & Quality Assurance Workgroup. It was written primarily to inform applicants for ISBE & CPS funded 0-3 programs.)

The purpose of the birth to three component of Preschool For All is to improve access to high quality services for expecting families and families with infants and toddlers - both to improve the quality of existing services for at-risk families and to increase the availability of high quality services (increase spaces available). The key to achieving this is to build on existing programs and services with an overriding focus on issues of quality. The approach will take into account parental preferences and needs for a diverse array of care arrangements and service delivery models. The 0-3 Workgroup recommends the following framework for services for families with infants and toddlers through Preschool For All.

I. Program Goal

The goal of prevention services for expecting parents, infants, toddlers and their families is to provide early, continuous, intensive, and comprehensive child development and family support services to help families build a strong foundation for learning to prepare children for later school success.

II. Target Population

The program is intended to benefit children who have been determined at-risk for school failure because their home and/or community environment subject them to language, cultural, economic and like disadvantages. Any pregnant woman or family with children age birth to three meeting income eligibility of less than 50% of the current state median income (current eligibility for the child care subsidy program) will automatically be eligible for the program. Families not meeting income guidelines but with multiple risk factors (e.g. low parental education, language barriers, substance abuse issues, etc.) will also be eligible. Access to services will be phased in over time.

III. Eligible Entities

Any entity demonstrating evidence of existing competencies to provide early childhood education programs may apply for Preschool For All funds.

IV. Guidelines for High Quality Programs

Program models implemented through PFA must be those that are based in research and have shown to improve outcomes for at-risk infants, toddlers, and their families. The models will address the following principles, parameters and best practices:

A. Program Principles

High quality programs for children birth to three and their families must be:

1) **Focused on prevention and promotion of optimal well-being**-programs shall support the promotion of early learning and of health and well-being in the child, parents and family in order to prevent, detect, and address problems at their earliest stages.
2) **Family-centered**-staff and families shall work together in relationships based on respect, and the program shall build on family strengths and support parents as the primary nurturers, educators and advocates for their children.

3) **Intensive and comprehensive**-programs shall offer services of sufficient intensity and comprehensiveness to meet stated goals.

4) **Individualized**-programs shall be flexible enough to meet the needs of individual family members and children.

5) **Relationship-based**-programs shall support and enhance strong, caring relationships which nurture the child, parents, family and care-giving staff, maintaining relationships with caregivers over time and avoiding the trauma of loss experienced with frequent turnover of key people in the children's life.

6) **Culturally responsive**-programs shall demonstrate an understanding of, respect for, and responsiveness to the home culture and home language of every child.

7) **Community-based**-programs should be embedded in their communities and contribute to the community-building process.

8) **Voluntary**-services are offered on a voluntary basis.

9) **Accessible**-services are provided in a way that overcomes potential barriers to participation, such as lack of English proficiency, lack of transportation, and need for non-traditional service hours.

10) **Well coordinated**-families who receive multiple services or who participate in multiple programs should experience a "seamless system of services." Service providers should regularly communicate and coordinate their services on behalf of individual families.

B. Parameters

The specific "best practices" for a program will be determined by its goals. Program structure and activities should be linked to expected outcomes through a "logic model" that is developed for each program. The logic model should include long-term expected outcomes, shorter-term measurable indicators of participant outcomes (including a plan for when and how to measure these indicators), and a description of program activities that are expected to lead to these outcomes. The logic model must be regularly reviewed and updated to reflect current program realities and used to continually improve service provision.

The parameters of a program that should be addressed in a logic model include:

- Target population (who will be served by program)
- Array of services and programs that families will have access to
- Coordination with other services, including outside agencies
- Method and timing of assessment
- How appropriate services will be matched to participant need
- Intensity of services (frequency, duration)
- Staff disciplines, qualifications and training
- Caseloads for staff
- Supervision for staff

C. Common Best Practices

Despite the great diversity among birth to three programs, there are nine best practices that apply to all of these programs and service systems:

1) **Methods and approaches**-the curriculum or approach chosen must reflect the centrality of adult/child interactions in the development of infants and toddlers and the holistic and dynamic nature of child development. The approach should support and demonstrate respect for families'

unique abilities as well as their ethnic, cultural, and linguistic diversity. The approach must address all domains of infant and toddler development including physical, social, emotional, and cognitive development.

2) **Periodic assessment**-because infancy and early childhood are times of such rapid growth and development, assessments (or screenings) must be completed at regular intervals to ensure that children and families are receiving appropriate services.

3) **Inclusion of parents/other family members**-because infants and toddlers are profoundly influenced by their parents and other family members, no services can be provided to the children in isolation from their families.

4) **Transition planning**-transitions from hospital to home, from a prevention program into a more intensive intervention program or from a program for birth to three year olds into a program designed for three to five year olds must be carefully planned to ensure continuity of services for the child and family.

5) **Staff knowledgeable about very young children**-birth to three prevention services must be provided by staff who are knowledgeable about infant and toddler development and who are experienced in working with children this age and their families.

6) **Staff supervision and training**-staff who work with very young children and their families must be provided adequate supervision and on-going training opportunities in this rapidly developing and changing field.

7) **Multidisciplinary coordination**-for families involved with more than one service provider, services (and assessments) must be provided in a coordinated fashion.

8) **Staff/family ratios**-staff must have reasonable caseloads or class sizes to devote adequate time to planning and building strong relationships with children and families.

9) **Intensity of services**-services must be offered on an intensive basis to meet the needs of at-risk families and with increasing or decreasing frequency as appropriate to meet the changing needs of families.

V. Four Approaches for Service Expansion and Improvement

Based on demonstrated community needs and demonstrated competence in delivering programs and services to families with infants and toddlers, eligible entities may apply for PFA funds to accomplish one of the following:

1) Increase availability of high quality prevention programs and services (increase the number of spaces in existing programs using research-based models described below).

2) Raise the quality of existing early childhood programs and services to meet standards outlined in nationally recognized research-based, high quality models (described below).

3) Provide enhanced services to children and families through existing high quality programs already implementing a research-based model.

4) Pilot and evaluate innovative model programs, with basis in research, for expecting parents, infants, toddlers, and their families.

WITHIN ANY OF THESE APPROACHES, PFA FUNDS WILL NOT BE USED TO SUPPLANT EXISTING FUNDING FOR PROGRAMS AND SERVICES TO INFANTS, TODDLERS AND THEIR FAMILIES.

VI. Program Models Funded Through PFA

As the primary goal of this program is to deliver high quality services to very young children at-risk for school failure, programs will only be funded to implement research-based models that have demonstrated positive outcomes. Early Head Start is the premier nationally recognized and widely implemented comprehensive prevention program for very young children and their families. Programs applying for Preschool For All funds are encouraged to progress towards the comprehensive Early Head Start approach for providing services to infants, toddlers and their families. Recognizing the need to address parental preference and needs of different types of families in Illinois, eligible entities may apply for PFA funding to implement research-based infant/toddler program models.

Some research-based, evaluated program models include:

- Baby TALK
- Early Head Start
- Healthy Families
- Parents As Teachers

Enhanced services may include:

- Doula services
- Intensive mental health service
- Others as identified by applicants

As scientifically valid independent research demonstrating positive outcomes on new models becomes available additional models may be funded through PFA.

PFA programs will be required to comply with all standards of the above model they select to implement with the following exceptions and additions:

- Eligible population - PFA funding must be used to serve families meeting the PFA eligibility criteria
- All programs will have mental health consultation available to them (*Early Childhood Group of the Mental Health Task Force model*)

VII. Administration and Infrastructure

Implementing the highest quality programs for expecting families and families with infants and toddlers is of utmost importance for PFA programs. The following recommendations are made to ensure that attention to program quality is built into the foundation from program inception and quality is continually and consistently maintained and improved.

A. Monitoring, Training, Technical Assistance & Consultation

In order to make the best use of scarce resources, this Workgroup recommends using and building on the existing infrastructure and systems of monitoring, training, and support for infant and toddler services in Illinois. This Workgroup recommends working with (possibly contracting with) existing entities that monitor and provide training and technical assistance to approved program models to monitor new programs funded through PFA that are implementing these models, where appropriate.

- There will be **appropriate staff** within the governance structure to coordinate with existing entities conducting monitoring, training, and technical assistance.

- **Funding will be allotted for program start-up** for one-time costs that are incurred as agencies initiate new services.
- More **intensive technical assistance** will be available to new programs just beginning to implement approved program models with intensity decreasing over time so that as new programs are funded they can receive this intensive assistance.
- **Program quality/compliance** will influence funding decisions. Programs must meet standards outlined in this framework. Programs found to be non-compliant will be put on probation and will receive additional technical assistance to create and implement corrective actions within a specified time frame. Programs not implementing corrective actions in a timely manner will be defunded.

B. Resource Development

A system should be developed for addressing resource development in communities with great need but lacking in quality resources or providers e.g., south suburbs, and rural downstate Illinois communities. Again, this should build upon existing structures and mechanisms in place such as Child Care Resource and Referral agencies.

ISBE Early Childhood Block Grant
Prevention Initiative

Guidelines for "Research-Based Program Models"

Background

The Illinois Early Learning Council (ELC) has made a number of recommendations to improve the quality of and coordination among Illinois' early learning programs serving infants, toddlers and their families. Some of these recommendations were implemented by way of statutory change to the Illinois State Board of Education's Early Childhood Block Grant (ECBG) in 2005. Specifically, these changes state that:

1) all new Block Grant funds will be directed to infants and toddlers who are at risk of school failure through the Prevention Initiative program, and
2) that all Prevention Initiative programs must implement voluntary, intensive and comprehensive research-based program models.

When applying for Block Grant funding for fiscal year 2007 (July 2006 - June 2007), both existing Prevention Initiative programs and agencies that apply for new or additional funds to serve infants and toddlers through the Block Grant will need to show that they will implement a research-based program model. This document provides guidelines for determining whether a program model meets the requirement of being "research-based."

Goals of the Prevention Initiative and Program Standards

The aim of the Prevention Initiative is to support the development of infants and children from birth to age 3 years, by providing coordinated services to at-risk infants and toddlers and their families through implementation of an individual family service plan in the context of a comprehensive research-based program model.

All Prevention Initiative programs will be required to comply with the Illinois Birth to Three Program Standards, which provide both Standards and Quality Indicators in the areas of Program Organization, Curriculum and Service Provision, Developmental Monitoring and Program Accountability, Personnel, and Family and Community Partnerships.

Understanding "Research-Based Program Model"

For the purposes of the ISBE Early Childhood Block Grant Prevention Initiative, a "Research-Based Program Model" is defined as a program which meets one of the following criteria:

1) The proposed program is a replication of a program model which has been validated through research and found to be effective in achieving the goals of the Prevention Initiative with a high-risk population. Specifically:
    a) The program model must have been found to be effective in at least one well-designed randomized, controlled trial, or in at least two well-designed quasi-experimental (matched comparison group) studies.
    b) The Prevention Initiative applicant must implement the program as closely as possible to the original program design, including similar caseloads, frequency and intensity of services, staff qualifications and training, and curriculum content.

    Examples of program models that have been identified as meeting these criteria, and for which training and technical assistance will be provided, include Parents as Teachers, Baby TALK, and Healthy Families. The Nurse-Family Partnership is another example of a program model which has been validated through research and found to be effective.

2) The proposed program will comply with all of the standards of a nationally -recognized accrediting organization (e.g., NAEYC) OR the Federal Early Head Start Standards. Specifically:
    a) The program must comply with all standards regarding group size, staff-to-child and/or staff-to-family ratios, staff qualifications and training, and comprehensiveness and intensity of services offered
    b) The program must implement a formal, written curriculum which is comprehensive and is based on research about how infants and toddlers learn and develop (Examples for center-based programs include Creative Curriculum for Infants and Toddlers and the High/Scope Infant-Toddler Curriculum)
3) The program meets all the Illinois Birth to Three Program Standards, has been operating successfully for at least three years, and has a formal, written program model or logic model which identifies the objectives and goals of a program, as well as their relationship to program activities intended to achieve these outcomes. The program model is based on research about what combinations of services have been effective in achieving positive outcomes with at-risk infants, toddlers and their families. The program model should:
    a) Have a formal, written curriculum that is based on research about how infants and toddlers learn and develop and on how parents can be best supported to support their children's development
    b) Have a formal, written plan for conducting family needs assessments and developing individual family service plans addressing their cultural and linguistic background,
    c) Have documented evidence of participant's success in achieving the goals of the prevention initiative (i.e., outcome data)
    d) Provide an intensity of services sufficient to achieve stated goals with a high-risk population (i.e., amount of contact with parents and children). As a guideline intensity of services should be on par with Parents as Teachers, Baby TALK or Healthy Families, or NAEYC or EHS Standards for center-based models
    e) Have caseload sizes that do not exceed those required by Parents as Teachers, Baby TALK, Healthy Families, or NAEYC or EHS Standards for center-based models

<u>Components to Enhance Comprehensive Models</u>

Programs that implement a comprehensive research-based model as described above can be funded to add supplementary program components that are evidenced-based. These services should be based on the needs of the community and population being served. Some examples include doula services or intensive mental health services.

Programs adding enhancement services must:

- Describe the need for the enhanced services in the target population
- Clearly define the outcomes for families and children expected to result from adding these services
- Clearly describe the services that will be provided, including the intensity of services (frequency of contact, caseload size), curriculum content or focus of interaction with parents/children, and the qualifications of the staff that will be delivering the service
- Provide research evidence that the services as they will be provided have been shown to be effective in producing the desired outcomes with populations similar to the program's target population

Additional Resources for Useful Information

Organizations and Agencies

Baby TALK
The National center for Baby TALK, featuring information, requirements and resources regarding the BT Model.
http://www.babytalk.org

Department of Children and Family Services
Timely information about Child Protection, Foster Care, Adoption, Day Care and Services provided by one of the largest state child welfare agencies in the U.S.
http://www.state.il.us/dcfs

Chicago Public Schools Early Childhood Education
CPS-ECE is an early childhood resource for parents, teachers and community members. The mission of the Office of Early Childhood Education is to ensure all children ages birth through age 8 have equal access to comprehensive, high quality program options, and support on a developmental continuum.
http://www.ecechicago.org/

CLAS: Culturally and Linguistically Appropriate Services
The CLAS Institute identifies, evaluates and promotes effective and appropriate early intervention practices and preschool practices that are sensitive and respectful to children and families from culturally and linguistically diverse backgrounds.
http://clas.uiuc.edu/

DCAC – Day Care Action Council
The Day Care Action Council of Illinois is an alliance of individuals and groups committed to advancing the quality and accessibility of child care.
http://www.daycareaction.org/

Early Head Start National Resource Center
The EHS NRC provides training and technical assistance for expectant parents and families with infants and toddlers.
http://www.ehsnrc.org/

Gateways to Opportunity
Gateways to Opportunity is the single statewide support network designed to provide guidance, encouragement and recognition to individuals and programs who serve children, youth and families.
http://www.ilgateways.com/

Geography Matters: Child Well-Being in the States
The state in which a child is born and raised can make an enormous difference to the health and chances of surviving to adulthood, according to a major new report released by the Every Child Matters Education Fund (ECMEF).
http://www.everychildmatters.org/homelandinsecurity/index_geomatters.html

Healthy Families America
The National center for Healthy Families America , featuring information, requirements and resources regarding the HFA Model.
http://www.healthyfamiliesamerica.org

Illinois Association for the Education of Young Children
The vision of the Illinois Association for the Education of Young Children is that every young child in Illinois will have access to the highest quality of care and education.
http://www.illinoisaeyc.org/

Illinois Board of Education
News and information about education in Illinois.
http://www.isbe.state.il.us/

Illinois Department of Human Services
DHS improves the quality of life of thousands of Illinois families by providing an array of comprehensive, coordinated services.
http://www.dhs.state.il.us/

Illinois Early Learning Project Site
The Illinois Early Learning Web site is an effective means of providing evidence-based, reliable information for parents, caregivers and teachers of young child in the state of Illinois.
http://www.illinoisearlylearning.org/

Illinois Head Start Association
Head Start's original and ongoing overall goal is to increase the social competence of children from low income families.
http://www.ilheadstart.org/

Illinois Network of Child Care Resource and Referral Agencies
Illinois CCR&Rs work in partnership with parents, business leaders, government officials and child care providers to make high quality child care available to Illinois families.
http://www.ilchildcare.org/

Mayor Daley's KidStart
"Providing quality activities for children is a year-round commitment. Through our KidStart program, we have put a focus on out-of-school time and interesting and engaging activities for children." – Mayor Richard M. Daley
http://www.chicagokidstart.org/

National Association for the Education of Young Children
Promoting excellence in early childhood education.
http://www.naeyc.org/

National Child Care Association
Serving the private, licensed childhood care and education community.
http://www.nccanet.org/

National Child Care Information Center
A national resource that links information and people to complement, enhance and promote the child care delivery system, working to ensure that all children and families have access to high-quality comprehensive services.
http://www.nccic.org/

National Head Start Association
The only organization dedicated exclusively to the concerns of the Head Start community.
http://www.nhsa.org/

National Institute for Early Education Research
The National Institute for Early Education Research supports early childhood education by providing objective, nonpartisan information based on research.
http://wwwnieer.org/

Ounce of Prevention Fund
The Ounce of Prevention Fund gives children in poverty the best chance for success in school and in life by advocating for and providing the highest quality care and education from birth to age five.
http://www.ounceofprevention.org/

Ounce of Prevention Fund Training Institute
The Ounce of Prevention Fund Training Institute is a primary resource for training and workforce development for staff in programs funded through the Illinois Department of Human Services including Healthy Families Illinois home visiting workforce; the staff of Illinois Parents as Teachers programs; the Illinois State Board of Education, Birth to Three Prevention Initiative staff; and the Chicago Public Schools Prevention Initiative staff. Information regarding classroom and online training and eligibility may be found at this website.
http://www.opfibti.org/training.html

Parents as Teachers
The National center for Parents as Teachers, featuring information, requirements and resources regarding the PAT Model.
http://www.parentsasteachers.org

T.E.A.C.H. Early Childhood Illinois Overview
Through T.E.A.C.H. (Teacher Education & Compensation Helps), funding is available for child care professionals to obtain college credit.
http://www/ilchildcare.org/Providers/TEACH/overview.htm

The American Academy of Pediatrics
The web site is committed to the attainment of optimal physical, mental and social health for children of all ages.
http://wwwaap.org/

The Center for Early Childhood Leadership
The Center for Early Childhood Leadership is dedicated to enhancing the management skills, professional orientation and leadership capacity of early childhood administrators.
http://www.2.nl.edu/twal

the Ounce

US Department of Education
Education Resources: Policies, Grants, Research and Statistics.
http://www.ed.gov/

Voices for Illinois Children
Voices for Illinois Children is a privately funded, non-profit organization that educates, engages and inspires Illinoisans to take meaningful action to improve the lives of all children and their families.
http://voices4kids.org/

Zero to Three
The Nation's leading resource on the first years of life.
http://www.zerotothree.org/