Prevention Initiative RFP Component One
Screening to Determine Program Eligibility

Goal 1: Illinois' neediest children will be identified and served.

In an effort to identify Illinois' neediest children and families, screening must be conducted to determine their need for services. Screenings are to be conducted on a community-wide basis and be developed and implemented with cooperation among programs serving young children operating in the area to be served (e.g., public schools, licensed child care providers, special education cooperatives, Early Head Start, Early Intervention, Child and Family Connections, Child Find, etc.).

Eligibility requirements are based on local need and those factors identified by research as causing children to be at risk of academic failure. Children who are at risk are defined as those who, because of their home and community environment, are subject to such language, cultural, economic, and like disadvantages to cause them to have been determined as a result of screening procedures to be at risk of academic failure. When programs are enrolling women who are pregnant or infants prior to turning 3 months of age, eligibility determination is based on family and environmental risk factors. When children older than 3 months of age are being enrolled, their developmental status, including social and emotional development, should be additional factors considered to determine eligibility. A weighted eligibility criteria form will need to be developed and implemented by each program to determine that the most at-risk children and their families are being served. Information from the parent interview form plus children's scores from a published, research-based screening instrument indicating risk of academic failure will be used to complete the weighted eligibility form.

Eligibility criteria must be established for Prevention Initiative (PI) programs to enroll pregnant women and children who are most at risk. Programs will need to develop criteria and indicators to use for determining which families to enroll first. These criteria should be weighted. This means that some criteria, as determined by the program and the community's risk factors, are given more weight or more points than other criteria. Some risk factors may be given one point and other factors two, three, or more points each.

Programs will serve those children and families most in need in the community as determined by those having the most points on the weighted eligibility criteria measure. Programs will utilize the individualized weighted criteria system for (a) enrolling families identified as having most points on the weighted eligibility criteria measure; and (b) ensuring families having the most points on the weighted eligibility criteria measure are prioritized on a waiting list (if applicable). After a family is enrolled in the program, it's allowed the opportunity to continue services for the duration of the program (prenatal to age 3). The family may voluntarily leave the program. The eligibility criteria form and screening for eligibility is only completed one time. Programs will develop guidance for staff in a policy and procedures manual.

A *screening* is a general type of assessment that addresses common questions parents and professionals have about the development of young children. Screening assessments are designed to efficiently identify those children who need more thorough and detailed assessment and/or determine a child's eligibility for a given program. The procedures and tests used in screening are developed to be quickly and easily administered without highly specialized training. (Reference from *A Guide to Assessment in Early Childhood: Infancy to Age Eight*. Washington State Office of Superintendent of Public Instruction, 2008.)

A *screening* is a short-administered tool or checklist that identifies children needing further assessment/evaluation or identifies participants for a given program. Screening instruments must be formally validated with evidence that the instrument activities reliably and accurately detect children who are at risk for developmental delays and do not incorrectly identify children disproportionately as being at risk of academic failure.

Examples of broad-based screening instruments for children birth to age 3:
- Ages & Stages Questionnaire ®
- Battelle Developmental Inventory ™
- Brigance ® Early Childhood Screens III

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Comprehensive screening procedures must include:

A. Research-based criteria to determine at what point performance on the screening instrument indicates that children are at risk of academic failure as well as to assess other environmental, economic, and demographic information that indicates a likelihood that the children would be at risk.

B. The weighted eligibility criteria developed by the state should be used to prioritize children who are at most risk of academic failure. These are competitive preference priorities. Additional risk factors selected should reflect the community to be served and are weighted to ensure that the children most at risk of academic failure are enrolled.

Illinois has developed competitive preference priorities around the priority populations that may be most at risk for later school failure based on research.

Highest Priority Populations	Children experiencing homelessness
	Children identified as "youth in care" (involved in the child welfare system)
	Children with developmental delays and/or disabilities
	Children from families identified as

	having incomes below 50% of the Federal Poverty Level (FPL)
Additional Priority Populations	Children from families identified as having incomes below 100% of the Federal Poverty Level (FPL)
	Primary caregiver did not complete high school/No GED or High School Equivalency
	Teen parent at birth of first child
	Child was born outside of the United States or has one or more parent or caregiver born outside of the United States (identified as immigrant or refugee)
	Parent or caregiver primarily speaks a language other than English at home
	Active Duty Military family
	Screening indicates delays in development but no referral has been made to Early Intervention to date
Communities may identify additional risk factors to apply to their weighted eligibility criteria.	

C. Children/Families have multiple risk factors or one highest priority factor according to the weighted eligibility form. The highest competitive preference priority factors are homelessness, child welfare involvement, disability (IFSP/Early Intervention), and family income at or below 50% of the FPL.

D. The program collects and reviews proof of family income to determine eligibility (below 200% FPL) and priority points (50% or 100% of FPL).

E. Screening instruments/activities that are:
   i. Related to and able to measure the child's development in at least the following ways (as appropriate for the age of the child): vocabulary, visual–motor integration, language and speech development, English proficiency, fine and gross motor skills, social skills, and emotional and cognitive development; and
   ii. Formally validated with evidence that the instrument activities reliably and accurately detect children who are at risk for developmental delays do not incorrectly identify children disproportionately as being at risk of academic failure;
   iii. Evidence-based developmentally appropriate screening instruments for children 3 months of age or older (more than one instrument may be needed); and

    iv.   Children, identified through broad-based diagnostic assessments as experiencing a developmental delay, will be referred to the appropriate [Department of Human Services Child and Family Connections](#) office or the appropriate referral in the local community.

F. Written parental permission for the screening.

G. Parent interview (to be conducted in the parents' home language, if necessary) including at least the following;
    i.   A summary of the child's health history and status, including social development and whether the child has an existing disability; and
    ii.   Information about the parents, such as age, educational achievement, income, and employment history.

H. Vision and hearing screening;
    i.   Vision screen (for children 3 months or older, questions embedded within the child developmental screening instrument regarding vision will be sufficient to meet this requirement); and
    ii.   Hearing screen (for children 3 months or older, questions embedded within the child developmental screening instrument regarding hearing will be sufficient to meet this requirement).

I. Where practicable, provision for the inclusion of program staff in the screening process.

J. A provision for sharing the results of the screening with program staff and with the parents of the children screened.

PI programs should be working with other programs in their community serving prenatal women and families with children birth to age 3 to identify and enroll eligible participants for the PI program. Individual communities may be at different places on a continuum of implementing coordination strategies. Ways of coordinating across programs and sectors include, but are not limited to:

A. **Shared or mutual referrals:** participating programs use a shared set of protocols and/or a shared form to refer families to each other's services.

B. **Coordinated Intake**: a collaborative process that provides families with a shared screening process and *coordinated points of entry* for programs serving young children and their families within a defined community. The main components include:
    i.   Coordinated and joint outreach;
    ii.   A shared form and shared procedures for intake or eligibility screening, used by all participating programs;

    iii.   Coordination of Referrals: referrals can come from different entities. Often one entity is identified as a coordinating entity that will collect all intake forms, track and, when applicable, assign referrals and follow-up; and

    iv.   Regular meetings of the participating programs to review progress and to trouble-shoot and improve the referral system.

C. **Referral pipeline**: connects children and families with the highest needs to high-quality early childhood programs, social service providers, medical and dental services, job training programs, and other community resources to meet family needs. These connections are made possible through strong collaboration among community partners, leveraging a shared vision and the places and spaces where families already connect. An effective pipeline may include talking points, tracking systems, and small experiments to engage strong communication and referral linkages between non-Early Childhood programs and Early Childhood programs. Pipelines should be "bi-directional," meaning that non-Early Childhood partners should refer to Early Childhood partners, and Early Childhood partners should refer to non-Early Childhood partners.

D. **Continuous early childhood services:** smooth transitions between early childhood programs (e.g., from 0-3 to 3-5 to kindergarten, etc.), and aligned, high-quality programming in all of those settings, resulting in children's readiness for school and for life. Through enrollment pipelines into continuous early childhood services, children with the highest needs are identified and enrolled in appropriate services as early as possible and continue in high-quality early education through third grade.

The following additional practices are recommended for PI programs:

- Programs will develop weighted criteria based upon the risk factors present in the community and those factors identified by research as causing children and families to be at risk. (e.g., families experiencing poverty; families experiencing homelessness; families and/or children receiving services through the Department of Children and Family Services, including foster families and intact families; teen parent; children experiencing developmental delays and/or have a disability or chronic health condition; parent with disability or chronic health condition; parent with mental illness; linguistically isolated children and/or families; parent with low educational attainment; recent migrant or refugee family, caregiver substance abuse; incarcerated parent(s); children with very low birth weight or children who experienced extreme prematurity or a prolonged stay in the Neonatal Intensive Care Unit (NICU); children with high lead levels; death in immediate family; domestic violence; military family)
- A parent interview (to be conducted in the parents' home/native language, if necessary) is designed and should obtain a summary of the following information:
  - i.   Child's health history, including prenatal history;
  - ii.   Child's social and emotional development;
  - iii.   Parent's education level, employment history, income, age, marital status, and living arrangements;

       iv.   Family's food security or insecurity; and

       v.   Number of children in the household and the number of school-aged siblings experiencing academic difficulty.

- The at-risk factors to determine eligibility are agreed upon by all partners.
- Programs will develop policies and procedures to provide guidance to staff specifically in regard to sharing the results of the screening with applicable program staff and with the parents of the children screened.
- Programs should implement best practices regarding vision screens by collecting the results from a completed vision screen from each child's physician or medical home. Vision screens from a medical provider should be collected when a child is 6 months, then annually thereafter.
- Programs should implement best practices regarding hearing screens by making sure the hearing screen is an objective measure of hearing sensitivity. Hearing screens using an objective measure of hearing sensitivity should be completed when a child is 6 months, then annually thereafter.
- Programs should regularly engage in conversations with each family regarding their child's health, including hearing and vision, and provide referrals as applicable.
- Outreach and recruitment strategies are targeted to reach those families with the greatest number of risk factors (in particular, at-risk families who may not otherwise come to the screening).
- For children determined to be English Learners, it is recommended that the developmental screening take place in the child's home language, whenever possible.
- See these sections of the Birth to 5 Program Standards: I.B.1., III.A.2., III.A.3., V.C.4., V.E.3.

More information can be found on the ISBE EC website, and the Plan Partner Act website.

Prevention Initiative RFP Component Two

Evidence Based Program Model and Research-Based Curricula

Goal 2: Families will receive intensive, research-based, and comprehensive prevention services.

Programs will be designed so that parents will gain knowledge and skills in parenting through the implementation of an evidence-based program model and a research-based curriculum, which will guide the provision of services. The program model needs to be the basis for all other programming so that the Prevention Initiative (PI) program has the ability to serve pregnant women (when applicable) and/or children birth to age 3 and their families (as applicable). Supplemental services must be integrated within the context of an ISBE PI-funded program and complement and align with the evidence-based program model, research-based curriculum, as well as the Illinois Early Learning Guidelines (IELG) and Birth to 5 Program Standards. Supplemental services must not be offered in isolation.

Programs will offer intensive and regular home visits and provide activities requiring substantial participation of and interaction between the parent and child. This is a vital component of effective programs. Activities must be designed to guide and educate parents as they learn new ways of supporting their child's development. Parenting skills must be promoted and supported as parents play an integral role in assisting their child's learning. The program will recognize that parents are their child's primary and most influential teacher. Home visits should be provided in the home. Educational activities may be site-based or home-based. Through coordinated services, parents will become better prepared to provide for the developmental needs of their children. The educational activities and services must adhere to the requirements of the selected program model and be of sufficient intensity and duration to make sustainable changes in a family. Programs will, at a minimum, implement the following:

- Comprehensive services are derived from research supporting successful prevention services with children and families experiencing multiple at risk factors;
- Services are aligned with the Illinois Birth to 5 Program Standards;
- An evidence-based program model and/or or standards with fidelity; and
- A research-based curricula:
    - Home Visiting programs implement a research-based parent/family-centered curriculum for parent education that aligns with the Illinois Early Learning Guidelines for Children Birth to Age Three Years.
    - Child Care Center-Based programs and Family Literacy programs implement a research-based child-centered curriculum for classroom programming and a research-based parent/family-centered curriculum for parent education. Both must align with the Illinois Early Learning Guidelines for Children Birth to Age 3 Years.

All PI programs will adhere to the following program requirements:
- For the purposes of the Early Childhood Block Grant for PI Birth to Age 3 Years Programming, a prevention initiative program must meet at least one of the criteria listed below under Prevention Initiative program.

- Programs will provide guidance to staff regarding implementation of the program model and curricula in a policy and procedures manual.
- Programs must **not** charge fees for program participation. This includes fees for parents and children. In addition, parents who participate in the parental education component may be eligible for reimbursement of any reasonable transportation and child care costs associated with their participation.
- Year-round programming is preferable. Year-round programming is defined as a PI funded program model that is implemented with fidelity through all 12 months of the year. Partial-year programming is defined as a PI funded program model that is implemented with fidelity in fewer than 12 months of the year. If partial-year services must be offered, the following documentation is required to be included with the grant submission:
  - Why partial services must be offered?
  - What services will be offered when programs are not providing services as defined by the program model (limited services)?
  - The duration of the limited services?
  - What months of the year will limited services be offered?
- The program will adhere to the recommendations provided by the chosen program model and/or the best practice guidelines provided. The information below is a general overview of best practice guidelines regarding home visiting caseloads for programs serving children and families experiencing multiple risk factors.
  - 1.0 FTE home visitor serving families weekly has a caseload of approximately 10 to 15 families. (average 12)
  - 1.0 FTE home visitor serving families biweekly has a caseload of approximately 18 to 25 families. (average 20)
- The program uses technology to support parent education, when applicable. PI staff should not take technology into the home with the exception of enhancing parent education or encouraging the use of applications that support parent-child interaction such as: Zero to Three: Let's Play or Zero to Three: Babies on the Homefront.
- PI programs must offer appropriate parent education and/or services that address the eight designated areas of education listed below.
  - Child growth and development, including prenatal development;
  - Childbirth and child care;
  - Child safety and injury prevention (including, but not limited to, lead concerns, safe sleep, car seats, furniture hazards, water safety, etc.);
  - Family structure, function, and management;
  - Prenatal and postnatal care for mothers and infants;
  - Prevention of child abuse;
  - The physical, mental, emotional, social, economic, and psychological aspects of interpersonal and family relationships; and
  - Parenting skill development.

- Parent/Child interactions and/or parent groups and/or workshops are provided <u>at least monthly</u> to foster parent/child relationships and, at a minimum, provide education on the eight designated areas of education (as applicable).
- An emergent literacy focus is observable in the activities, materials, and environment planned for the child. (Birth to 5 Program Standard II.B.5)
- A schedule of program activities, including, but not limited to, parent/child interactions and/or parent education activities is provided at least quarterly.
- The program has a toy/book lending library.
- The program has a parent resource lending library that includes resources that provide information about the eight designated areas of education.
- The program has a newsletter.
- The program is aligned with a birth-through-third grade continuum of services. This is a set of educational experiences and supports for children, families, and the professionals and organizations that serve them. The ISU Birth through Third Grade Continuity Project lists eight areas for potential alignment:
  - Community partnerships;
  - Comprehensive services;
  - Family engagement and parent leadership;
  - Data-driven improvement;
  - Supported transitions;
  - Aligned assessments;
  - Aligned curriculum and instruction; and
  - Joint professional development.

The following additional practices are recommended for PI programs:

- The program offers programming for children and their families from the prenatal period to age 3.
- The program will begin to transition enrolled children and their families to services for children ages 3 to 5 at age 2 years, 6 months. Enrollment of a child into a PI program should occur prior age 2 years, 6 months. Children age 2 years, 6 months or older should be referred to other community resources or the appropriate 3 to 5 program.
- The curriculum is implemented with fidelity and should support all domains of the Illinois Early Learning Guidelines for Children Birth to Age 3.
- The use of supplemental curricula should be based upon the unique needs of the program that necessitate content above and beyond the primary curriculum. Content used from the supplemental curriculum should be based upon research on best practice and should align with the comprehensive curriculum. All supplemental curricula needs to be aligned with the Illinois Early Learning Guidelines for Children Birth to Age 3.
- The program recognizes that both mothers and fathers play an essential role in their children's development.
- The program encourages both mother/female and father/male involvement in the lives of children.

- The program supports literacy by promoting literacy activities with both children and adults. Adults are encouraged to pursue a high school diploma, GED or English Learning classes when applicable.
- The program fosters social connections between families with young children.
- The program connects families to supports in times of need, including community resources.
- The program provides activities that teach parents how to meet the developmental needs of their children, including their social and emotional needs.
- See these sections of the Birth to 5 Program Standards: I.B., I.B.2., I.B.3, I.B.4, I.C., I.C.1, I.C.2, I.D., I.D.1., I.D.2, I.E., I.E.1., I.E.2., II.A.1., II.A.2., II.A.3., II.A.4., II.B.1., II.B.2., II.B.3., II.B.4., II.C., II.C.1., II.C.2., II.C.3., II.D., II.D.1., II.D.2., II.E., II.E.1., II.E.2., II.F.1., II.F.4., II.F.5., II.F.6., V.A.

Prevention Initiative Program

For the purposes of the Early Childhood Block Grant for Prevention Initiative Birth to Age 3 Years Programming, a PI program must meet one of the criteria listed below. A program may choose more than one criterion listed below. However, the program must meet all of the requirements of each criterion chosen. A program will also identify the specific criterion for all children and families served.

A program model is defined as a frame of reference that identifies the objectives and goals of a program, as well as their relationship to program activities intended to achieve specific outcomes. It reflects standard practices that guide the provision of services and determines the parameters delineating the service settings, duration, type of intervention, and ratios of child and/or family served to service provider, etc.

Home Visiting Prevention Initiative Program

- Criterion One
  The program model is evidence-based as defined by the [Department of Health and Human Services' Administration for Children and Families (DHHS) HomVEE](#) and is listed on the DHHS website as meeting all the evidence-based home visiting program model criteria.

- Criterion Two
  The proposed program is a replication of a program model that has been validated through evidence and found to be effective in providing prevention services for families experiencing multiple risk factors. Specifically:
  o 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.
  o The program is implemented as closely as possible to the original program design, including similar caseloads, frequency and intensity of services, staff qualifications and training, and curriculum content.
  o Home visiting program models that have not been designated as "evidence based" by the U.S. Department of Health and Human Services' Administration for Children & Families will provide evidence of how they are taking steps to meet those rigorous evidentiary standards including but not limited to the following:
    ▪ In existence for at least three years;
    ▪ Associated with national organization or institution of higher education;
    ▪ Minimum requirements for frequency of visits;
    ▪ Minimum education requirements for home visiting staff;
    ▪ Supervision requirements for home visitors;
    ▪ Pre-service training for home visitors;
    ▪ Fidelity standards for local implementing agencies;
    ▪ System for monitoring fidelity; and
    ▪ Specified content and activities for home visit.

Examples of Prevention Initiative Home Visiting program models currently being implemented in Illinois include:
[Baby TALK](#) ™
[Early Head Start](#)

[Healthy Families America](#) ®
[Parents as Teachers](#) ™

Examples of supplemental support and/or services to <u>enhance</u> Birth to Age 3 comprehensive services include, but are not limited to:
Doula Services (Please see additional information below.)
Fussy Baby Network ®
Touchpoints ™
[Abriendo Puertas/Opening Doors](#)

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Child Care Center-Based Prevention Initiative Program

- Criterion Three
  The proposed program must comply with all standards regarding group size, staff-to-child and/or staff-to-family ratios, and staff qualifications and must implement formal, written curricula that is comprehensive and is based on research about how infants and toddlers learn and develop. The proposed program will comply with the following:
  - o Provide Center-Based Infant/Toddler Care to improve the growth and development of children before they transition to Preschool for All or Head Start by providing early, continuous, intensive, and comprehensive child development and family support services.
  - o Children will be enrolled in a program that is between 2 ½ to 5 hours long five days a week. The program structure should be similar to a Preschool For All program in a child care center, including set PI program hours.
  - o Maintain the [ExceleRate Illinois](#) Quality Recognition and Improvement System (QRIS) Silver (Compliance) or Gold (Exemplary) Circle of Quality.
  - o All center-based programs must maintain at least ExceleRate Gold Circle of Quality for adult/child ratios.
  - o The program must be embedded in a child care center that is licensed and meets all of the licensing standards of the [Illinois Department of Children and Family Services](#) for center-based child care.
  - o Maintain the ability to access funds that are reimbursable by the [Illinois Department of Human Services Child Care Assistance Program](#).
  - o When applicable, [Early Head Start requirements](#).
  - o Implements an evidence-based program model for parent/family education (as described above, home visiting).
  - o Implements a research-based, child-centered curriculum.
  - o Implements a research-based parent/family-centered curriculum.

  <u>Center-Based Staff</u>

- Director Credentials: Principal Endorsement or [Gateways to Opportunity](#) Illinois Director Credential Level II or higher.
- Teacher Credentials: [Early Childhood Professional Educator License (PEL) Teaching Endorsement](#) (Validity/Age Range: Self-contained general education from birth to grade 3) or a [Gateways to Opportunity](#) Infant Toddler Credential Level 5 or an Early Childhood Credential Level 5
- Other classroom staff are required to hold a [Gateways to Opportunity](#) Early Childhood Education Credential Level 4.
- All personnel must meet Department of Children and Family Services licensing requirements set forth in the [Illinois Administrative Code Title 89: Social Services Chapter III: Department of Children and Family Services Subchapter e: Requirements for Licensure Part 407 Licensing Standards for Day Care Centers.](#)

<u>Parent Education Staff</u>
- Staff must meet the requirements of the chosen home visiting program model.

<u>Nutrition</u>
- The program must provide a snack, in the case of a half-day program, or a meal, in the case of a full-day program, for participating children. The program will provide food service as applicable.
  - Food and beverages provided in programs located in a licensed child care center or other community setting shall meet DCFS standards set forth at 89 Ill. Adm. Code 407.330 (Nutrition and Meal Service).

A center-based child care center will adhere to the requirements above and when there is a discrepancy between the standards and the licensing requirements, the program will comply with the strictest policy or procedure.

A program may be able to provide all of the services, including licensed center-based child care and home visiting services, or the program may need to enter into a joint agreement (school districts), collaboration, or a partnership with another entity or entities to fulfill the requirements of the PI grant.

Family Literacy Prevention Initiative Program

- Criterion Four
  PI programs implementing a family literacy model must include the four components indicated below. Illinois Family Literacy Consortium of State-level Agencies and Offices defines Illinois Family Literacy Programming as the integrated, intensive services for families at risk that must include, but not be limited to:
  - Adult education (literacy instruction for parents);
  - Child education (emergent literacy activities for children);
  - Parenting education (parent group time); and

- Literacy-based, interactive, parent-child activity services in order to improve the literacy skills for families (parent/child interaction group time).

The proposed program must comply with all standards regarding group size, staff-to-child and/or staff-to-family ratios, and staff qualifications and must implement formal, written curricula that is comprehensive and is based on research about how infants and toddlers learn and develop. The proposed program will comply with the following:

- Provide Center-Based Infant/Toddler Care to improve the growth and development of children before they transition to Preschool for All or Head Start by providing early, continuous, intensive, and comprehensive child development and family support services.
- Children will be enrolled in a program that is between 2 ½ to 5 hours long five days a week. The program structure should be similar to a Preschool For All program in a child care center, including set PI program hours.
- Maintain the ExceleRate Illinois Quality Recognition and Improvement System (QRIS) Silver (Compliance) or Gold (Exemplary) Circle of Quality.
- All center-based programs must maintain at least ExceleRate Gold Circle of Quality for adult/child ratios.
- The program must be embedded in a child care center that is licensed and meets all of the licensing standards of the Illinois Department of Children and Family Services for center-based child care.
- Maintain the ability to access funds that are reimbursable by the Illinois Department of Human Services Child Care Assistance Program.
- When applicable, Early Head Start requirements.
- Implements an evidence-based program model for parent/family education (as described above, home visiting).
- Implements a research-based child-centered curriculum.
- Implements a research-based parent/family-centered curriculum.

Center-Based Staff
- Director Credentials: Principal Endorsement or Gateways to Opportunity Illinois Director Credential Level II or higher
- Teacher Credentials: Early Childhood Professional Educator License (PEL) Teaching Endorsement (Validity/Age Range: Self-contained general education from birth to grade 3) or a Gateways to Opportunity Infant Toddler Credential Level 5 or an Early Childhood Credential Level 5
- Other classroom staff are required to hold a Gateways to Opportunity Early Childhood Education Credential Level 4
- All personnel must meet Department of Children and Family Services licensing requirements set forth in the Illinois Administrative Code Title 89: Social Services Chapter III: Department of Children and Family Services Subchapter e: Requirements for Licensure Part 407 Licensing Standards for Day Care Centers

Parent Education Staff

       o   Staff must meet the requirements of the chosen home visiting program model.

   Nutrition
       o   The program must provide a snack, in the case of a half-day program, or a meal, in the case of a full-day program, for participating children. The program will provide food service as applicable.
              ▪   Food and beverages provided in programs located in a licensed child care center or other community setting shall meet DCFS standards set forth at 89 Ill. Adm. Code 407.330 (Nutrition and Meal Service).

A Family Literacy PI program will adhere to the requirements above and when there is a discrepancy between the standards and licensing requirements, the program will comply with the most strict policy or procedure.

A program may be able to provide all of the services, including licensed center-based child care and home visiting services, or the program may need to enter into a joint agreement (school districts), collaboration, or a partnership with another entity or entities to fulfill the requirements of the PI grant.

The program must access funds to provide adult education (e.g., [Illinois Secretary of State Penny Severns Family Literacy Program](#)).

Additional Information

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Curriculum

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The following criteria must be considered by PI programs in evaluating curricula for implementation. Curriculum models should:
- Align with the [Illinois Early Learning Guidelines for Children Birth to Age 3](#);
- Align with the [ISBE Birth to 5 Program Standards](#);
- Include significant content to be taught with intentionality and integration;
- Include child initiation and engagement;
- Use clear research-based content based on a systematic and comprehensive review of research of how children learn;
- Support parent engagement by using curricula that helps build meaningful communication with families;
- Consider the child's linguistic and cultural background;
- Be appropriate for all early childhood staff to implement regardless of their qualifications;

- Be appropriate for children with a wide range of abilities; and
- Provide research/evidence of the curriculum effectiveness.

Programs should adopt a comprehensive curriculum that covers all domains, which should minimize the need for additional supplemental curricula. However, some programs do opt for a supplemental, developmentally appropriate, research-based curriculum, perhaps to support literacy, math, or social and emotional development. If that is the case, supplemental curriculum must align philosophically with the core curriculum (activities/lessons, etc.) and align with the [Illinois Early Learning Guidelines for Children Birth to Age 3](#) and the [ISBE Birth to Five Program Standards](#).

Examples of research-based child-centered curricula aligned with the Illinois Early Learning Guidelines currently being implemented in Illinois include:

> [The Creative Curriculum ® for Infants, Toddlers & Twos](#)
> [HighScope ® Infants &Toddlers Curriculum](#)

Examples of research-based parent/family-centered curricula aligned with the Illinois Early Learning Guidelines currently being implemented in Illinois include:

> [Baby TALK ™ Curriculum](#)
> [Parents as Teachers ™ Curriculum](#)
> [Partners for a Healthy Baby Curriculum](#) (Florida State)

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Additional Information

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Doula

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If your program is considering integrating a doula component into your home visiting program, there is a readiness factor that should to be considered. Supplemental services must be integrated within the context of an ISBE Prevention Initiative-funded program and complement and align with the evidence-based program model, research-based curriculum, as well as, the [Illinois Early Learning Guidelines (IELG)](#) and [Birth to 5 Program Standards](#). Supplemental services must not be offered in isolation of the program model. The program must be able to take on all the roles and responsibilities of doula services. Doula services are not required in an ISBE-funded PI program; however, if your program is considering doula services review the information below:

1. Doula services are integrated and provided concurrently within an ISBE PI-funded evidence-based home visiting program and program model. The home visiting program must be large enough to be able serve most pregnant women who desire a doula. Doula

services ideally commence at the beginning of the third trimester of pregnancy. The program therefore should have MOUs or other mechanisms in place with prenatal clinics, WIC programs, etc. to ensure that pregnant women in the program's target population will be referred by the 26th week of pregnancy.

2. The program must seek doula training and technical assistance through the Ounce of Prevention Fund (OOPF). The OOPF has limited openings in the doula training and technical assistance program. The interested PI program must actively seek an OOPF Doula Services application and go through the preparedness vetting process and be accepted and enrolled into the training and technical assistance program before PI funding may be allocated toward doula services. New doulas must receive pre-service and in-service training from the Ounce of Prevention Training Institute, and are encouraged to pursue credentialing through Doulas of North America (DONA).

3. The ability of doulas to be present during the labor and delivery process is key to the success of this service. Programs must have agreements with local birthing hospitals that ensure that the hospital will allow doulas to attend the births of their participants.

4. In their hiring and scheduling practices, programs need to account for the fact that births often happen outside of normal working hours. This expectation should be made clear to candidates for doula positions, and programs should keep this requirement in mind in deciding how they will grade/compensate doula positions.

5. Because being present during labor and delivery is such a crucial component of doula services, in addition to ensuring that doulas have flexible schedules, programs wishing to implement doula services need to ensure that there is some back-up capacity, so that participants can still receive doula support when their primary doula is on vacation, ill, unable to attend a birth, or for when there are vacancies in the program. This will generally mean having at least two doulas as part of a program's staffing pattern, but back-up can also be achieved by having a supervisor trained as a doula or by having a part-time position in addition to a full-time doula.

6. Because allowances must be made for the time it takes to be with moms during the labor and delivery process, doula caseload sizes are smaller than those for other home visitors. Doulas typically carry a caseload of 9-10 families at any one time. Because the doula intervention is time-limited (generally lasting for about five months), a caseload of 9-10 families at any one point in time would result in a doula serving approximately 22-24 families over the course of a year.

7. Doula services are not intended to be stand-alone services within PI. PI doula services are meant to be an integrated part of a long-term, evidence-based home visiting model. Coordination of services should include articulating how the doula and long-term home

visitor will work together in introducing services to expectant families, and how they will coordinate home visits in the perinatal period to avoid duplication of services while ensuring that the long-term home visitor begins a relationship with the family early enough to ensure a smooth transition from doula/home visitors services to just home visiting services.

8. Because, as described above, a doula will serve more families over the course of a year than will a long-term home visitor, and because the goal is to have doula participants transition into the long-term home visiting program, the ratio of long-term home visitors to doulas needs to be such that there are not doula participants who cannot transition to long-term services because there are not enough home visitors to serve them. Generally, a ratio of at least three (or more) home visitors for every doula will suffice to ensure that there will be enough home visitors to serve participants who are finishing doula services.

9. Prenatal groups offer an efficient way for parents-to-be to learn about prenatal care and the birthing process while connecting with a peer group and continuing to build a relationship with their doula. Generally, about 10% of a doula's time is spent facilitating such groups.

10. In order to support doulas' abilities to better serve participants who may have medically complicated pregnancies, access to a doula clinical consultant is a part of the doula model. These consultants are generally RNs, midwives, or other professionals who have some training in the medical aspects of pregnancy and childbirth, and are generally contracted for about 10 hours per month.

Doula Program Goals:
➢ Promote active engagement of new program families in long-term home visiting services through initial prenatal and intrapatum program experiences;
➢ Promote a parental sense of confidence, competence, and comfort in the mother's physical, emotional, and social transition into parenthood;
➢ Promote positive health practices for developing baby and new parent;
➢ Promote a growing sense of emotional availability, attunement and engagement with the developing and new infant;
➢ Prepare for labor and delivery and provide intrapartum doula support in an effort to bring about positive birth outcomes for infant and parent;
➢ Supporting newborn care and feeding;
➢ Provide seamless transitions from doula to home visiting only services;
➢ Program design calls for a 1.0 FTE doula caseload of 23 over the course of the year;
➢ The doula intervention is limited to a five-month period. A 1.0 FTE doula typically has a caseload of nine to 12 women at any one time. Some of these are pregnant, some are postpartum. Doulas attend approximately two births every month; and

➢ Doulas also organize and facilitate prenatal groups.

More information can be found on the ISBE EC website.

Prevention Initiative RFP Component Three
Developmental Monitoring

Goal 3: Children's developmental progress will be regularly monitored to inform education and to ensure identification of any developmental delays or disabilities.

Infants and toddlers grow and change at remarkable rates. It is important that staff and parents understand what each child is able to do and what developmental skills are challenging for each child. Authentic assessment and data collection must be implemented as PI staff and parents partner to assess a child's development. Authentic assessment through multiple developmentally appropriate methods is important to inform education and to ensure that all children who have a potential developmental delay or disability are identified and referred for diagnostic assessment and appropriate services. The program will implement processes to utilize authentic assessment to guide education and the Individual Family Goal Plan, as applicable.

Programs will collect information regarding a child's health history at screening (if applicable) and annually thereafter update the general health information, including well-child visits and immunizations. When a child is 3 months of age or older, programs will also use a published, research-based tool(s) (at least every six months) to perform developmental screening for all children. The developmental screening will (as appropriate for the age of the child) include:
- Vocabulary;
- Visual-motor integration;
- Language and speech development;

- English proficiency;
- Fine and gross motor skills;
- Social skills;
- Emotional development; and
- Cognitive development.

Developmental and/or educational progress must be assessed and documented to ensure that the program meets the needs of the child and provides a system whereby that child's parents are routinely advised of their child's progress. The research-based tool and procedures to assess progress must align with the Illinois Early Learning Guidelines for Children Birth to Age 3. More than one tool may be needed to ensure a comprehensive evidence-based screening has occurred.

Examples of broad-based general assessments for children birth to age 3 are:
- Ages and Stages Questionnaire
- Brigance Screening (Birth to Three edition)
- Battelle Developmental Inventory

Examples of a broad-based assessments for children birth to age 3 for social and emotional screening are:
- Ages and Stages: Social Emotional Questionnaire
- Devereaux Early Childhood Assessment Program (DECA)

ISBE does not endorse any curriculum, tool, or program model. The examples provided by ISBE do not necessarily reflect the views or policies of the ISBE nor do the mention of trade names, commercial products, or organizations imply endorsement by ISBE.

Assessment Definitions:

- Diagnostic assessment is a thorough and comprehensive assessment of early development and/or learning for the purpose of identifying specific learning difficulties and delays, disabilities, and specific skill deficiencies, as well as evaluating eligibility for additional support services, Early Intervention, and special education. A diagnostic assessment is usually a formal procedure conducted by trained professionals using specific tests. (Reference from *A Guide to Assessment in Early Childhood: Infancy to Age Eight*. Washington State Office of Superintendent of Public Instruction, 2008.)

- Instructional assessment is the process of observing, recording, and otherwise documenting the work children do and how they do it as a basis for a variety of educational decisions that affect the child, including planning for groups and individual children and communicating with parents. This level of assessment yields information about what children know and are able to do at a given point in time, guides "next steps" in learning, and provides feedback on progress toward goals. Assessment-to-

support instruction is a continuous process that is directly linked to curriculum. (Reference from *A Guide to Assessment in Early Childhood: Infancy to Age Eight*. Washington State Office of Superintendent of Public Instruction, 2008.)

- Authentic assessment is an ongoing assessment process that occurs in the individual's natural environment. Authentic assessment refers to the "systematic collection of information about the naturally occurring behaviors of young children and families in their daily routines. Information is collected through direct observation and recording, interviews, rating scales, and observed samples of the natural or facilitated play and daily living skills of children. (Reference from Bagnato, S. (2007). Authentic Assessment for early childhood intervention: Best practices. New York: The Guilford Press.)

It is strongly recommended that program staff partner with parents to ensure children are vaccinated and receive well-child visits as recommended by a physician. Children under the age of 3 have varying levels of communication skills; therefore, screening often for hearing and vision challenges is essential to making sure every child has access to medical resources. The program must screen children for hearing and vision impairment utilizing questions associated with the child's developmental screening instrument when children are 3 months or older then thereafter at least every six months.

Programs will adhere to the chosen program model regarding health, hearing, and vision screening requirements. If there is a discrepancy between the program model and the PI RFP, the program will adhere to the more rigorous recommendations.

Children identified as in need of further assessment are linked to the local Department of Human Services Child and Family Connections or the appropriate community referral. The program will provide follow-up services to ensure the child receives all needed assessments and services.

Supporting positive and constructive parent and child interactions is a cornerstone of PI programming. The predominant changeable factor effecting children's lives is parenting. Supporting warm, responsive, encouraging, and commutative developmental parenting strategies will impact children's learning and development. Assessing parenting can support guiding more nurturing parenting and ultimately improve child outcomes. Programs will implement a research-based tool to assess the parent and child interactions at least twice within the fiscal year, as applicable. The program will implement processes to utilize the information gathered to guide education and the Individual Family Goal Plan, as applicable. The program will develop policies and procedures to support staff and guide implementation.

Examples of tools that assess parenting (parent and child interactions) are:
- Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO™)
- Home Observation for Measurement of the Environment (HOME) Inventory
- KIPS: Keys to Interactive Parenting Scale

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Programs will provide guidance in a policy and procedures manual to support staff as they implement developmental monitoring regarding each child's health, including, but not limited to, general health, immunizations, hearing and vision, as well as physical development, cognitive development, communication, visual-motor integration, social and emotional development. The program will also provide guidance regarding the implementation of a tool to assess parent and child interactions.

The following additional practices are recommended for PI programs:
- The program regularly monitors children's development, using multiple sources, and communicates with parents about the child's development.
- See the following Birth to 5 Program Standards: II.F., II.F.2., II.F.3., III.A., III.A.1., III.A.3.
- Infants and toddlers are referred to the Illinois Early Intervention System, when appropriate. Preschool children are referred to the local Early Childhood Special Education system, when appropriate. (Birth to 5 Program Standard III.A.4.) The program follows up to ensure the child receives all needed diagnostic assessments and services.
- See the following Birth to 5 Program Standards: III.B.1, III.B.2, III.B.3, III.B.4.
- Programs should implement best practices regarding vision screens by collecting the results from a completed vision screen from each child's physician or medical home. Vision screens from a medical provider should be collected when a child is 6 months, then annually thereafter.
- Programs should implement best practices regarding hearing screens by making sure the hearing screen is an objective measure of hearing sensitivity and completed when each child is 6 months old, then annually thereafter.
- Programs should regularly engage in conversations with each family regarding their child's health, including hearing and vision, and provide referrals as applicable.

More information can be found on the [ISBE EC website](#).

Prevention Initiative RFP Component Four
Individual Family Goal Plan (IFGP)

Goal 4: Families will receive services that address their identified goals, strengths, and needs.

An important focus of the Prevention Initiative (PI) program is to help families identify how they want to improve their lives and the steps that will help them reach their goals. Families must be full partners in developing and implementing an Individual Family Goal Plan (IFGP) that identifies the family's goals, responsibilities, timelines, and strategies for achieving these goals, including the services to be provided to the child and to the family. The IFGP will initially be completed within the first 60 days and be reviewed periodically and updated at least every six months. The IFGP guides the delivery of services to ensure families obtain and receive appropriate services to meet their needs.

The PI IFGP is a written plan that maps out the goals of the family and the services the family will receive. It also describes how and when these goals will be achieved and how and when the services will be accessed. Home visitors should take a family-centered approach when developing an IFGP with a family, due to the central concept that supporting a child's family lends itself to supporting the child.

The family is encouraged to take an active role in the development of the IFGP, including participating in setting goals for themselves. PI programs are designed to support family self-sufficiency. Home visitors are encouraged to partner with each family to develop goals for the parent, the child, and parent–child interaction.

The IFGP will be developed in partnership with the family and will be grounded in the information revealed during the Family Centered Assessment (FCA). All programs must utilize a published, research-based FCA with every family served. The FCA will be implemented with

fidelity as recommended by the FCA chosen and be completed initially within the first 60 days of enrollment and reviewed and updated at least every six months.

An FCA is a process of systematically listening to parents with young children while utilizing surveys to capture the family's strengths and needs. It is an outcome and intervention-planning instrument that is helpful in assessing the strengths and needs of families. An FCA is a process designed to gain a greater understanding of how a family's strengths, needs, and resources affect a child's safety, permanency, and well-being. The assessment should be strengths-based, culturally sensitive, individualized, and developed in partnership with the family (or as recommended by the FCA tool developers). The strengths identified will provide the foundation upon which the family can make changes. Examples of FCAs currently being implemented in Illinois are the Life Skills Progression ™ and Baby TALK Assessment.

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Programs will provide guidance in a policy and procedure manual to support PI staff as they partner with each family to develop and implement an Individual Family Goal Plan and create goals for the parent(s), the child, and parent-child interactions.

The following additional practices are recommended for PI programs:
- See the following Birth to 5 Program Standards: V.D., V.D.1., V.D.2., V.D.3.
- The program encourages parents and families to make decisions regarding their parenting and their children's development and engages families in developing Individualized Family Goal Plans.
- The staff uses the Individual Family Goal Plan to guide the services provided to the family.
- The program implements a Family Centered Assessment (FCA) for each family served.
- A comprehensive FCA should contain items that assist staff with understanding families' strengths, resources, and needs. The FCA should include information regarding parenting, family relationships, education and employment, health and access to insurance and medical care, food security, and housing stability.
- The Individual Family Goal Plan includes, but is not limited to, educational and social-economic needs of the family.
- The program should develop an IFGP in collaboration with other agency(s)/district(s) the family is receiving services from to coordinate services.

More information can be found on the ISBE EC website.

Prevention Initiative RFP Component Five
Case Management Services

Goal 5: Families will receive comprehensive, integrated, and continuous support services through a seamless and unduplicated system.

Many of the families participating in Prevention Initiative (PI) programs have multiple needs, some of which cannot be met directly by the program. These may include, for example, adult education, housing, nutrition, health care, and other needs. Programs must form relationships with other service providers in the community to develop a system for referring families into and out of programs. The referral system will address referral procedures as well as follow-up procedures to ensure that families receive the needed services.

The program will develop a referral system that ensures 3-year-old children are placed into other early childhood education programs that meet their specific developmental needs and the services to be provided to ensure a successful transition into those other programs. The program will provide comprehensive transition services to families when a change in provider has been identified or beginning when children are 2 years, 6 months. Transition activities should begin six months prior to any scheduled transition. All transitions are too important to be left to chance. Adjustments to transitions are accomplished more effectively when individuals have adequate and reliable information about what to expect and are provided with the appropriate emotional and social support. The program will develop written transition plans (as a part of or separate from the IFGP) in partnership with the family. The program will help identify other early childhood programs (as needed) and offer support as the family navigates the early childhood system. (Other early childhood providers may include Preschool for All, prekindergarten, Head Start, Early Head Start, Early Intervention, Special Education, Child and Family Connections, Title I, bilingual education programs, etc.)

Programs are encouraged to develop programming that provides for coordination of services and delivers Prevention Initiative services in ways that reflect local needs and resources. Each PI program must demonstrate that the proposed program is not a duplication of services. (for example, home visiting programs may choose to coordinate among themselves to serve

different priority populations such as teen parents or prenatal mothers, or different neighborhoods/ ZIP codes, etc.) Learn more information about community collaboration on the [Partner Plan Act](#) website.

Families participating in PI programs may also have developed goals or service plans with other service providers. The Prevention Initiative program must coordinate the Individual Family Goal Plan (IFGP) or Individual Family Service Plan (IFSP) with plans that other community service providers have developed with or for the family (when applicable).

Programs will formalize collaborations and/or partnerships through memorandums of understandings (MOUs) or letters of intent. Collaborative partnerships must include a direct link between and among the initiatives. The program will develop relationships and formalize agreements with other appropriate community service providers to, at minimum, define a referral and follow-up system, establish a plan for reducing duplication of services, and coordinate IFGP or IFSP (as applicable). The program should take an active role in local community systems development efforts by participating in local collaborations and initiatives, including but not limited to, participating in locally driven data collection efforts and participating in the local efforts to minimize barriers to services for families with children from birth to 5. Programs should share available relevant program-level aggregated data that contributes to community needs assessment, problem identification, and setting a common agenda.

Programs will provide guidance in a policy and procedures manual to support staff as they build relationships with community partners, develop formalized agreements, navigate a referral and follow up system, connect families to community resources, and coordinate IFGP or IFSP.

Community Systems Development

State vision[1]: The early childhood framework is based on the vision of every child entering kindergarten safe, healthy, ready to succeed and eager to learn. We celebrate diversity and partnering with community stakeholders who value a bright future for all young children in Illinois. We are committed to universal access for all children birth to age 8, to high-quality programs and services and to prioritizing children with high needs and families that are hard to reach. When Illinois' vision is realized, we will see all young children's needs being met to include early childhood education, physical and mental health, and family support.

Illinois is committed to:
- Serving the hardest to reach children and families first and providing them access to the highest quality services;
- Ensuring that resources are sufficiently allocated to provide high-quality services to families with pregnant women and children from birth to 5;

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[1] From ELC website as of 3/2/15.

- All children entering school are healthy and ready to learn;
- A holistic approach to family and children's needs;
- Ensuring that family engagement and partnership is integrated and embedded in all early childhood programs and services;
- Striving for an early childhood system that is transparent, easily navigated, and accessed by the families it is intended to serve;
- Ensuring that all children have well-educated and well-compensated teachers; and
- Ensuring that the learning and care continuum from birth to third grade is aligned, allows for smooth and effective transitions, and reflects best practices.

State-funded providers are expected to actively participate in collaborative system-building efforts that:[2]
- Have diverse membership representing multiple systems serving young children and families. These cross system partnerships should include physical and mental health, early care and education, family support, and other service systems[3];
- Organize to bring individuals, community stakeholders, families, professionals, agencies, and organizations together to address and solve existing and emerging challenges that cannot be resolved solely by one group or system;
- Maintain a broadly held shared vision and mission for the community;
- Manage an action plan of data-driven strategies and activities to effect change, including measuring and tracking progress;
- Ensure partnership with families as leaders in building and maintaining the comprehensive birth to age 5 system in the community; and
- Consider the collaboration's strategies and work in the framework of assessing improved outcomes for children and families.

Table I below describes **guidance** for the roles of local community collaborations and direct service providers in relation to key aspects of system building. Local collaborations and direct service providers should support each other and should be well-integrated in order to achieve the state's vision of every child entering kindergarten safe, healthy, ready to succeed, and eager to learn.

Aspects of EC System Building	Column A: Role of Local Collaboration	Column B: Role of Service Provider

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[2] Recommendations on Community Systems Development Rationale, Guiding Principles, Characteristics, and Core Functions, as adopted by the ELC in October 2013.

[3] Examples include local public health department, Child and Family Connections, Early Intervention, Easter Seals, special education services, hospitals and clinics, home visiting programs, Head Start/Early Head Start, mental health providers, domestic violence agencies/shelters, University of Illinois Cooperative Extension, Crisis Nursery, American Heart Association, Red Cross, public libraries, school districts, Child Care Resource and Referral, educational centers, YMCA/YWCA, Boys and Girls Clubs, homeless shelters, public housing, police and fire departments, GED providers, community colleges, universities, English Language Learner programs, professional development providers, Illinois State Police Car Seat Checks, community businesses, substance abuse treatment programs, local DHS office, WIC, IHEAT, child care providers, food banks, and faith-based entities.

Pipeline of services	• Coordinate activities to reduce duplication of effort or intake • Recruit and engage with other local child- and family-serving programs (beyond EC programs, e.g., housing, child welfare) • Develop and implement systems development efforts (such as coordinated intake or pipeline development (0-3 >3-5 >K) • Disseminate state-level templates for consent forms that enable local programs to make "warm referrals" • Adopt referral systems that the improve families' access to services (such as the G3PS system currently being piloted in selected AOK Networks) • Identify any areas of targeted need	• Participate in information-sharing and cross-training across sectors and programs • Assess families' needs and know how to effectively refer them to a range of local comprehensive services • Participate in systems development efforts (such as coordinated intake or pipeline development (0-3 >3-5 >K) • Put in place consent forms and procedures that support a "warm referral system" to make referrals and transitions more successful for families • Engage families in understanding the continuum of services and how to access • Ensure that high-risk families are served and that programs are reasonably full
Systems building	• Bring together local/ organizational leaders from key systems to address barriers and support effective local systems • Hold vision of what local EC system should look like • Develop and implement cross-sector strategies to achieve system outcomes • Diffuse knowledge throughout local cross-sector organizations	• Identify barriers faced by families and providers in trying to obtain comprehensive services for the family • Participate in cross-sector collaboration meetings and workgroups and provide feedback from program experience • Participate in the development of system building strategies

Data sharing and analysis	• Gather and compile locally desired data from local providers and share with stakeholders
	• Use local data to guide local planning and measure collaborative progress
		• Share available aggregated program data and trends with the local collaboration, such as the following service utilization data:
		   o Number of slots available vs. utilized
		   o Number of

		developmental/SE screenings
		○ Number of children referred to E.I. services
		○ Number of IEP recipients at kindergarten that did not receive E.I. services
		○ Number of new Youth in Care
Policy advocacy (feedback loop)	• ↑Communicate local cross-sector experience, concerns, barriers, questions, successes to region/state • ↓Provide accurate and timely information to local providers and others	• ↑Collect and communicate program and system experience, concerns, opportunities, barriers, questions, successes to local collaborations • ↓Provide accurate and timely information to program staff and families
Public and parent engagement	• Participate in developing shared messaging • Engage parents, transmit message to parents • Create and use structures that engage parents as leaders (e.g., parent councils) • Coordinate parent leadership development activities	• Participate in developing shared messaging • Engage parents, transmit message to parents • Engage parents in leadership roles in the program/ agency
Quality improvement	• Bring programs together to discuss their experiences with reflective practice and continuous quality improvement • Communicate promising practices to region/ state	• Implement program with model fidelity and continuous quality improvement • Participate in state efforts such as ExceleRate • Participate in sharing lessons learned and best practices
Resource development	• Leverage the private sector, including community foundations, corporate giving, and United Ways • Coordinate rapid response to funding opportunities or funding cuts	• Participate in collaborative discussions to engage the private sector • Blend and braid available funding to implement services that match families' needs
Workforce development	• Form and support local professional development	• Promote professional development opportunities

	cohorts within sectors (e.g., ExceleRate cohort). • Coordinate local trainings to maximize outreach and minimize duplication of effort	among program staff, supervisors, and administrators and leadership

The following additional practices are recommended for PI programs:

- See the following Birth to 5 Program Standards: III.B.5., V.A.7., V.C., V.C.1, V.C.2., V.C.3., V.D., V.D.1., V.E., V.E.1, V.E.2., V.E.4.
- The program ensures that the services the family receives are coordinated with other services the family is receiving. In particular, the program ensures that the family's IFGP or IFSP is coordinated with plans that other community service providers have developed with or for the family.
- The program creates partnerships to support the development of infants and toddlers by focusing on the child and family through a network of child and family service providers.
- The program develops written transition plans with other early childhood programs as applicable that address the unique needs and situations of families.
- The program establishes partnerships with parents and families and develops shared goals with families based on the families' strengths and needs and the program's objectives.
- The program takes an active role in community and system planning.

More information can be found on the ISBE EC website.

Prevention Initiative RFP Component Six
Family and Community Partnerships

Goal 6: Families will be engaged in the program, and community systems for infants and toddlers will be strengthened.

Families are invited to be full partners in developing and implementing the program. Parents and other family members must be given the opportunity to have input into planning program activities. The program must have a system for regular communication with parents about the program and about their child's progress. The clear intentions of the program should focus on families being invited to actively engage in the program and building community systems to support and strengthen families with infants and toddlers.

Each Prevention Initiative (PI) program must develop and implement a written family engagement plan that is reviewed and updated annually to include, but need not be limited to:
- Written and verbal orientation to the educational program;
- Opportunities for engagement in home-based and/or site-based activities;
- Intensity of the activities and services offered, including home visits, groups, and case management;
- Provision for communication to and from parents about the program;
- Comprehensive written Planned Language Approach (a coordinated, systems, program-wide approach to supporting the school readiness of all children served);
- Refer and follow up with families obtaining additional services or leaving the program;
- Provision for promoting and supporting parenting skills;
- Activities that emphasize and strengthen the role of the parent(s) as the child's primary educator;
- Provision for seeking parents support and engagement in the program; and
- Ensuring parents are full partners in the decisions that affect children and families.

Each PI program must develop and implement a written community collaboration plan that is reviewed and updated annually. The community collaboration plan will provide guidance to staff about the coordination and collaboration efforts the program is engaged in with other providers in the same service area. The plan must describe the agreements made with Head Start, Early Head Start, and other providers in the service area. The plan(s) will specifically identify how programs will:

- Coordinate with other service providers within the same service area concerned with the education, welfare, health, and safety needs of children (prenatally and birth thru third grade/8 years old);
- Coordinate with other early childhood providers to create a system for making referrals, providing follow-up, and explaining how case management services will be used;
- Reduce duplication of services; and
- Coordinate Individual Family Goal or Service Plans.

Programs will provide guidance in a policies and procedures manual to support staff as they implement the family engagement plan and community collaboration plan. The policies and procedures should align with the agreements and formalized plans with other service providers in the area.

The following additional practices are recommended for PI programs:

- See the following Birth to 5 Program Standards: I.A., I.A.2., I.A.3., I.A.4., I.A.5., I.A.6., V.A., V.A.1., V.A.2., V.A.3., V.A.4., V.A.5., V.A.6., V.A.7., V.B., V.B.1., V.B.2., V.B.3., V.B.4.

More information can be found on the ISBE EC website.

Prevention Initiative RFP Component Seven
Data Collection and Evaluation

Goal 7: The evaluation will provide critical data and information that is used for continuous program improvement.

Program evaluation is an ongoing process that culminates in the improvement of program quality. To be successful in this endeavor, programs need to develop systems for observing, recording, and measuring the quality and significance of the program's progress and success toward the implementation of the program model and the [Illinois Birth to 5 Program Standards](#). Likewise, the program needs to develop systems for measuring and analyzing the progress that children and families are making toward their goals. There are three parts to a successful Prevention Initiative (PI) system of Continuous Quality Improvement (CQI) that include a 1) written framework, 2) written Continuous Quality Improvement Plan (CQIP), and 3) written evaluation.

The program must develop a written framework and implement a system for PI CQI and evaluation. The framework developed should include data and information to be collected and the measures, methods, and processes to be used to evaluate specific PI program goals, PI RFP components (1-9), the chosen program model, and the [Birth to 5 Program Standards](#). The data elements, measures, methods, and processes must be specific and consistent with CQI.

The purpose of an annual program CQIP and evaluation is to improve program quality and enhance service delivery to children and families. The CQI and evaluation process is critical for informing program practice. Programs will conduct a self-assessment. This is a method of measuring agency accomplishments, strengths, and weaknesses. Self-assessment allows for the continuous improvement of program plans and service delivery methods, allowing for the enhancement of program quality and timely responses to issues that arise in the community, the program, and among enrolled families. The process also provides an opportunity for involving parents and community stakeholders and for making staff more aware of how the program is viewed by its consumers.

Results of the framework data and other reports from a self-assessment are analyzed by the program leadership and staff, and a written CQIP is generated. The CQIP determines program direction for the year and will, at a minimum, address the following:
- Identifies specific issues that are deficient or areas that the program would like to strengthen;

- Actions to be taken to remedy the deficiencies and, as applicable, the resources and professional development that will be targeted towards improvement efforts; and
- The person responsible and the timelines in which the deficiencies are expected to be corrected.

Self-assessment activities should be ongoing. The impact of proposed changes is reviewed during subsequent self-assessments to ensure that the results of the changes are beneficial to the program and to the children and families served. A written annual evaluation summarizing the results of the framework data, self-assessment, and continuous quality improvement plan must be available, at a minimum, for the program staff, program participants, and ISBE upon request.

The framework, CQI, and evaluation system developed must be guided by written policies and procedures.

The following additional practices are recommended for PI programs:

- See the following Birth to 5 Program Standards: III.C., III.C.1., III.C.2., III.C.3., IV.D.2.
- An annual program self-assessment appropriate for the program model selected is completed to determine whether the program is being implemented as intended, and whether the anticipated outcomes for children and families are being achieved.
- There is a formal process by which the results of the annual program self-assessment (and any other program evaluation data) are used to inform continuous program improvement.
- There is a process for sharing the results with the program staff, program participants, and the community (as applicable).

More information can be found in the [Prevention Initiative Implementation Manual](), Quality Indicator I.A.6., PIIM Pages 15 through 20.

Prevention Initiative RFP Component Eight
Qualified Staff and Organizational Capacity

Goal 8: Staff will have the knowledge and skills needed to create partnerships to support the development of infants and children.

Appropriately qualified personnel who meet the requirements of the evidence-based program model that is to be implemented by the Prevention Initiative (PI) program must be employed and may include but are not limited to: program coordinators/supervisors, home visitors, doulas, early childhood teachers, and infant mental health consultants.

The program must have the organizational capacity to implement all nine PI Request for Proposals (RFP) components and the chosen program model with fidelity, as well as adhere to the Illinois Birth to 5 Program Standards. PI funding is identified as supplemental funding. The provision of state-funded programs provides that only supplemental costs may be charged. Those funds are intended to supplement (i.e., in addition to) and not supplant (i.e., replace) local funds. Programs are expected to maintain multiple funding sources/streams to be eligible to be awarded supplemental funding. If the program receives funds with this FY18 RFP, the entire program will adhere to the FY18 RFP requirements.

The program will maintain a staffing structure that will provide sufficient support to direct service providers, which includes at least one supervisor. PI programs must maintain sufficient enough hours (Full Time Equivalent [FTE]) to maintain a reasonable caseload and be able to interact with children and families long enough to make sustainable changes in the family. Home visiting program must maintain at least 3 FTE home visitors. Home visitors must be at least .50 FTE.

PI Child Care Center-Based program staff salaries need to be proportionate to the number of PI students in the classroom or at the center depending upon the position. Teaching staff salaries should be comparable to local K-12 teaching staff salaries. School district salary scales are publicly available documents and should be consulted to determine the appropriate starting salary for teachers, based on level of education.

The following is an example of what a typical PI Home Visiting Program staffing structure might look like if the program is implementing an evidence-based program model with fidelity. PI programs need to choose one program model for parent education/home visiting (e.g., Baby TALK, Early Head Start, Healthy Families America, Parents as Teachers). Home Visiting Programs must maintain a staffing structure that will include at least:

- Option One
  - One PI supervisor
    - One FTE supervisor for every six FTE home visitors (guidance but not required)
  - At least three FTE PI home visitors paid through PI funds
    - (Three full-time positions or six half-time positions or other FTE that adheres to the ISBE requirement)

    The fiscal agent maintains and implements the PI program.

- Option Two
  - This option occurs when a PI program is attached to an existing Home Visiting Program, paid through other funds like MIECVH or IDHS that has at least two FTE home visitors and a supervisor. PI funds need to be allocated to fund a minimum of one FTE PI home visitor. This means the PI program can fund one full-time position or two half-time positions. Alternatively, of course, more PI staff can be employed if PI funding allows. The PI staff hired need to implement the same program model the existing program is using and be embedded into the larger existing Home Visiting Program.

- Option Three
  - A fiscal agent will maintain joint agreements and/or partnership agreements with other entities to maintain a staffing structure large enough to implement the nine PI RFP components and the program model with fidelity, i.e., employ one supervisor and three FTE home visitors paid out of PI grant funds (home visitors need to be at least .50 FTE) using the same program model.
    - Examples:
      - The fiscal agent is a school district and maintains joint agreements with other school districts to serve families is those other districts. The fiscal agent maintains and implements the PI program.
      - The fiscal agent is a school district and maintains joint agreements with other school districts. The fiscal agent maintains a PI supervisor and enough PI FTE home visitors to serve their school district. The fiscal agent flows funding to the other school districts in which joint agreements are in place. Those districts hire their own PI home visitors to implement the program but are supervised by the supervisor with the fiscal agent. This arrangement takes a lot of coordination and collaboration.

The supervisor should maintain a manageable supervisor to staff ratio in order to be able to be able to participate in local community collaborations to support the local data collection efforts, birth to third grade continuum efforts, maintain a comprehensive understanding of community resources, establish and maintain joint agreements, partnership agreements, or MOU agreements.

Implementing a fiscally responsible grant means that the cost per family aligns with the quality components offered. To determine the cost per family, simply divide the total grant allocation by the number of families served in the program. The cost per family should be at the lower end of the cost continuum if the program is offering home visiting services twice per month to families served and has no other identified quality components. The cost per family may be on the higher end of the cost continuum if the program implements components that have been identified by research to increase quality including, but not limited to, mental health consultation, weekly home visits (intensive services), doula, etc.

The program must follow mandated reporting laws for child abuse and neglect and have written policies addressing staff responsibilities and procedures regarding implementation.

All PI staff must be registered in the Illinois Department of Human Services' "Gateways to Opportunity" registry, unless in the Educator Licensure Information System (ELIS).

Programs will maintain records as identified in the current ISBE State and Federal Grant Administration Policy, Fiscal Requirements and Procedures manual, as applicable. The responsibility for retention and destruction of records is shared between ISBE and the Local Records Commission. Prior to the destruction of any records following the three-year period, a fund recipient must contact the Local Records Commission, Illinois State Archives, Margaret Cross Norton Building, Illinois Secretary of State, Springfield, Illinois 62756 (217/782-7075).

Applicants should note the requirement for staff background checks on the assurances page, program assurance/specific terms of the grant, item 11.

All programs must pursue the chosen program model recognized process for model fidelity and indicating quality. Center-based programs will obtain the necessary licensure through the Department of Children and Family Services, adhering to all requirements set forth in the Illinois Administrative Code Title 89: Social Services
Chapter III: Department of Children and Family Services Subchapter e: Requirements for Licensure Part 407 Licensing Standards for Day Care Centers and participate in ExceleRate™ Illinois.

Policies reflect the "rules" governing the implementation of the program. Procedures represent an implementation of policy. A policies and procedures manual that provides clear guidance on how the program will provide voluntary, continuous, intensive, research and evidence-based comprehensive child development and family support services for expecting parents and families with children from birth to age 3 must be in place. These policies and procedures should support staff as they maintain compliance to the nine components of the PI RFP and fidelity to the chosen program model.

The following additional practices are recommended for PI programs:

- A PI program has the capacity to serve infants and toddlers and provides PI programming for children and their families from the prenatal period through age 3.
- Maintains a staffing that consists of at least one FTE PI supervisor for every six FTE PI staff.
- The supervisor should maintain a manageable caseload of staff and, when applicable, families in order to be able to be able to participate in local community collaborations to support the local data collection efforts, birth to third grade continuum efforts.
- The supervisor should have a comprehensive of community resources and establish and maintain joint agreements, partnership agreements, or Memorandums of Understanding (MOU), etc.
- The administrator and all program staff are knowledgeable about high-quality early childhood programs and are effective in explaining, organizing, and implementing them.
- The program has written personnel policies and job descriptions on file.
- The organization has experience providing services to infants, toddlers, and their families and working with families of similar cultural background as the families to be served.
- The organization has experience administering grants successfully and has appropriate financial systems to ensure that expenditures are properly documented.
- The administrator and all program staff are knowledgeable about high-quality early childhood programs and are effective in explaining, organizing, and implementing them. If applicable, the staff are maintaining or pursuing Gateways to Opportunity Credentials.
- See the following Birth to 5 Program Standards: I.G., I.G.1, I.G.2., I.H., I.H.1., I.H.2., I.H.3., I.H.4., I.H.5., I.I., I.I.1., I.I.2., I.I.3., I.I.4., I.I.5., I.I.6., I.I.7., IV.A., IV.A.1., IV.A.2, IV.B., IV.B.1., IV.B.2., IV.C., IV.C.1., IV.C.2., IV.C.3., IV.C.4., IV.C.5., IV.D., IV.D.1., IV.F., IV.G., IV.G.1., IV.G.2.

Additional Information

Mental Health Consultant (MHC)

Those that decide to include a Mental Health Consultant (MHC) in their budget should consider the following. MHC in PI programs will be hired to support the program staff. For example, they can be hired or contracted to:
- Provide reflective consultation to program supervisors;
- Support reflective supervision in team meetings;
- Join supervisors and direct service providers, like home visitors or teachers, to support reflective supervision;
- Provide professional development to program staff;
- Partner with a home visit to observe a child or family; and
- Partner with PI staff to co-facilitating a group.

Remember the cost of MHC should be proportionate to the needs of the staff and size of the program. The cost of contracting a mental health consultant may range from $75 to $300 per

hour. The program needs to think strategically about when and how to engage the MHC to support the program staff.

Using Mental Health Consultants during a Home Visit:
The program staff need to partner with the MHC to decide the role of the consultant in participating in home visits and identify the benefit to the family. Things to consider before a consultant participates in a home visit:
- How are families identified?
    - Before the consultant begins to participate in home visits, the home visitor, consultant, and supervisor need to meet to clarify the role of the consultant in the visit, and the goal for the consultant's participation. What will be the benefit to the family?
    - How will the consultant support and partner with the home visitor during the visit?
- How is the consultant's participation in the visit explained to a family?
    - Before the consultant participates in the visit, the home visitor needs to engage the family in a discussion about the consultant and talk with the family about the purpose for the consultant's participation in the home visit. Then consent should be received from the family for the consultant to visit.
- What happens after the consultant participates in the home visit? What follow-up is done with the family?

Using Consultants for Co-Facilitation of Groups:
Consultants can be used as a co-facilitator with staff for groups offered to families. This is an opportunity for staff to utilize the early childhood mental health knowledge of the consultant in providing groups for parents. This is also a way to create sustainability of the project by capturing the consultant's knowledge in developing materials that can be used to lead groups in years to come. Things to consider before a consultant participates in a home visit:
- Are there group topics that could be enhanced with consultant co-facilitation of the group?
- What materials for group facilitation or parent handouts could staff develop with your consultant to support early childhood mental health in your programs?

More information can be found on the ISBE EC website.

Goal 9: Staff will continue to gain skills and knowledge based on current research and best practices to improve outcomes for families.

Staff development activities must be implemented and will be used to inform the program's staff development and continuous quality improvement efforts. In order to enable staff to achieve the purpose and goals of the Prevention Initiative (PI) program, staff development needs must be assessed and appropriate ongoing professional development activities provided. All staff will develop a written, individualized professional development plan in collaboration with their PI supervisor. A professional development plan is a written course of action to improve and strengthen a staff member's ability to function effectively in their professional role and meet their responsibility to children and families.

The program will provide PI staff administrative and reflective supervision.

- o Administrative supervision is supervision to oversee performance to assure that the agency's legal and ethical responsibilities are met. Supervision responsibilities include examining the completion of charts and other records, determining that reporting obligations are met, generally ensuring that minimum performance standards are met, and guiding the PI staff to a higher level of performance of these basic duties. The PI supervisor's role is to train, teach, coordinate, monitor, and evaluate, as well as ensure staff has a thorough understanding of the community and institutional resources the program is able to offer families that participate in the program.

- o Reflective supervision is the regular collaborative reflection between a service provider and PI supervisor that builds on the PI staff's use of her/his thoughts, feelings, and values within a service encounter. The significant focus is on attention to the parallel process or on how relationships affect relationships including the ones between the practitioner and PI supervisor, the PI supervisor and the caregiver, and the caregiver and the young child. Dialogue between PI supervisor and PI staff incorporates observation and feedback to improve practice, plan effectively, and foster professional development. Reflective supervision promotes and supports the development of a relationship-based organization and is characterized by reflection, collaboration, and regularity. Reflective supervision will be implemented based on the recommendations of the chosen program model with fidelity. (Reference from Brohk, K. [2010]. *Reflective Supervision in Infant Mental Health Practice*. Michigan Association of Infant Mental Health. Retrieved from http://www.mi-aimh.org: Van Berckelaer

(n.d). Using reflective supervision to support trauma-informed systems for children: A white paper developed for the Multiplying Connections Initiative.)

The following additional practices are recommended for PI programs:

- Staff development needs are assessed on a regular basis.
- Staff in-service training programs are conducted to meet individual staff needs.
- Other appropriate ongoing professional development activities are provided.
- The program offers resources for staff to share and opportunities to consult others in the same role and/or with early childhood experts and regularly.
- See the following Birth to 5 Program Standards: I.F., I.F.1, I.F.2, IV.D.3., IV.D.4., IV.E., IV.E.1., IV.E.2.

More information can be found on the [ISBE EC website](#).