

North Central Infant/Toddler Regional Service Model (RSM)

SECTION 1: Brief summary description of the I/T Child Care Consultation Regional Service Model

Please give a brief (< 150 words) description of your overall service model, including the following elements in your description:

- Your regional funding focus
- Your consultant pool
- The duration and quantity of consultation services and any key details about the content of planned consultation services (e.g., a specific approach or curriculum).

There will be opportunities to describe more details in later sections.

North Central Interdisciplinary Infant-Toddler consultation efforts will focus on both English- and Spanish-speaking providers* in North Central Washington (includes Chelan, Douglas, Grant, and Okanogan Counties). Priority will be given to providers 1) Operating outside of the central marketplace of Wenatchee and 2) have been licensed and providing care for more than five years. Our consultant pool will be comprised of diverse group of public and private sources with proficient working knowledge of infant and toddler growth and development to include early childhood specialists, mental health providers, and registered nurses. Each provider will receive an average of two visits per month with a limit of 40 hours total time available. We expect to work with 20-30 providers at any given time over the course of a year – more will be engaged depending on capacity as we reach the higher end of this caseload.

* For the purposes of the North Central Regional Service Model, the term “provider” will be defined as: A licensed child care staff person in either a child care center or family child care home. A provider receiving consultation services may be a program owner/director or lead teacher but will have authority to make business decisions and/or programmatic changes.

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SECTION 2: Service Delivery Strategy

PART A: Provider Funding Focus Strategies

Please briefly describe the providers that will be your focus.

North Central Interdisciplinary Infant-Toddler consultation efforts will focus on both English- and Spanish-speaking providers* in North Central Washington (includes Chelan, Douglas, Grant, and Okanogan Counties) *outside the central marketplace of Wenatchee.*

Funding Focus Component #1: Please describe why you believe this focus will reach providers that serve a high percentage of vulnerable children (based on DEL’s definition outlined in the accompanying Overview document)?¹

Priority has been given to child care providers in the designated geographic areas because they have an established history of limited resources, high levels of risk, and traditionally underserved populations. Over the past two years, we have continued to expand our recruitment areas to include providers in concentrated pockets of our counties, having begun with most remote (northern Okanogan County, eastern Grant County) and slowly spreading out as these areas are saturated. This progression over the last two years has led to a proposed expansion for the coming biennium into Chelan County by targeting providers in Manson, Chelan, Leavenworth, Orondo, Peshastin, Dryden, and Cashmere.

Within these geographic areas the criteria has been established that providers licensed for more than five years and are in good standing with DEL will be the recipients of I/T Consultation services. Based on a series of Steering Committee conversations in the early stages of developing this project, a consistent theme was the common attitudes, skills, and knowledge that seemed ‘outdated’ among those providers have been licensed more than five years. There have been great advances in the field of early childhood development including brain science, attention to social-emotional development and attachment behaviors, Adverse Childhood Experiences, learning and curriculum. Along with these advances, child care in Washington State has received increased attention and improved regulation and monitoring. It was the consensus of the Steering Committee that these principles were lacking in older programs, and what is now considered quality early care was rare.

¹ Please reference the DEL Funding Focus for Regional I-T Consultation Efforts Memo, specifically page 4, for a description your regional funding focus.

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Funding Focus Component #2: Please describe how your service delivery model will allow you to achieve your expected outputs for the year within your funding focus. What strategies will help you deliver efficient and high quality consultation to providers that serve vulnerable children?

We have accepted that in order to reach the most providers (and children) traveling great distances and large amounts of time will be involved. In recruiting consultants, we must be up front about requirements of time and travel and have been able to develop contracts and a system for compensating consultants in such a way that supports a positive sentiment and strong morale. A consultant's capacity to work independently and in new situations must also be examined as these circumstances are the norm in I-T Consultation in our region.

PART B: Recruitment

Please describe how your regions will recruit new family child care providers and child care centers and teachers into your consultation program.

<p>i. Who will primarily be involved in outreach and recruitment efforts (e.g. leads, steering committee members, community agencies)?</p>	<p>Recruitment will be the responsibility of Lead Consultants. Referrals may also come from Early Achievers Technical Assistants.</p>
<p>ii. What is your primary strategy and anticipated activities to conduct outreach and recruitment?</p>	<p>Based on our experiences over the last couple years we have learned that word of mouth and soft touch marketing has produced the highest volume of response. For this reason, lead consultants use phone calls, on-site visits, and incentives as the primary strategy for recruitment.</p>
<p>iii. What did you find particularly successful or an area you could improve upon from your recruitment in SFY 2012 and SFY 2013?</p>	<p>In 2012-2013, we began reaching out to Spanish-speaking providers. In the initial recruitment of Spanish-speaking providers our strategy involved use of phone calls, mailings and incentives prior to scheduled on-site visits. This proved ineffective. Providers did not engage in services until we scheduled an introductory on-site visit ("meet and greet"). This strategy increased the target audience. These providers were both eager and responsive recruitment and therefore increased our case load. In the same way we will continue to reach out to both Spanish and English speaking providers in new areas of our region.</p>

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PARTS C: Relationship Building and Goal Setting

	Description	Anticipated Outputs
<p>i. Please describe your strategy for building successful relationships with center directors and teachers prior to the start of consultation.</p>	<p>Upon recruitment to participate in services, the lead consultant will schedule a “meet and greet” visit to outline consultation process and services, establish roles and expectations, conduct provider self-assessment and obtain commitment to engage and participate in requested service, assessments and data collection as requested.</p> <p>A second “initial” visit is scheduled to provide an opportunity for the lead consultant and provider to engage in visioning and program reflection. A Quality Improvement Plan (QIP) is created to reflect the provider’s directed needs and a referral to the consultant pool is made. This visit and QIP is provider directed and not influenced by either the lead consultant or an assessment in order to provide a safe and successful relationship based foundation. Successful QIP service will result in continued consultation service and engagement in future assessments.</p>	<p>How many hours do you estimate your consultants and leads will dedicate towards provider <u>assessment and goal setting</u> activities:</p> <p>Average per teacher receiving consultation: <u>16 hours</u></p> <p>Total for SFY 2014: <u>320 hours</u></p> <p>Total for SFY 2015: <u>320 hours</u></p>
<p>ii. What process is in place to establish consultation goals with the consultation recipients (please include name of assessment to establish goals)?</p> <p><i>List your expected hourly outputs on this task in the right hand column.</i></p>	<p>The first Quality Improvement Plan (QIP) is provider directed QIP consultation, informed primarily by the self-assessment. The lead consultant will provide several check-in phone calls or visits with provider and consultant as needed to provide feedback on goal progress. Upon successful completion of provider directed QIP, the lead consultant will schedule a follow-up visit with provider and determine the next best steps in service based on provider readiness. This will either be a co-created QIP by the consultant and provider or based on an ERS assessment.</p> <p>An ITERS (combination of the ITERS/FCCERS for FCC’s) assessment will be done at a minimum within the first six months of service and then again every 6 months while participating in consultation to inform QIPs and service. Other assessments will be conducted as determined by lead consultant and/or consultants based on provider need and individualized QIP.</p> <p>Goals will be framed according to QRIS Quality Standards within the</p>	<p>*This estimation is based on the time expected for pre and post ITERS assessment (4 hours per administration) and an additional 8 hours spread out over the year to review results and set goals.</p>

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	<p>following areas of focus :</p> <ul style="list-style-type: none"> • <u>Child Outcomes</u> including developmental screening, child assessment, identification of red flags in development, alignment to WaKIDS, individualized instruction, mentoring of teaching staff to support increase in teacher-child interactions that support strong attachment and healthy social-emotional development • <u>Facility Curriculum & Learning Environment</u> including use CLASS principles and ERS, mentoring of teaching staff to support improvement in curriculum and teacher-child interactions, classroom quality, inclusion of children with special needs, routines and transitions, and curriculum. • <u>Family Engagement & Partnership</u> including creating welcoming environments for families, improving communication of program activities, child learning, and developmental concerns to families, resources and referrals for families • <u>Professional Development & Training</u> including information and support to address individual or center-wide PD goals and practices that support high quality I/T care. 	
<p>iii. How will your region track consultation goals and progress towards those goals?</p>	<p>Visit Summaries have been created for consultants to use and inform the lead consultant on goal progress. Goal progress is tracked by the lead consultant and data is compiled into a spreadsheet. This data is updated regularly by the lead consultant. Monthly contact (phone or in-person) with providers is conducted by lead consultant to provide feedback on goal progress. At minimum, bi-monthly contact with consultants is maintained to inform goal progress.</p>	

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PART D: Service Delivery Strategy and Anticipated Outputs

<p>Strategies and Related Activities Please describe the service delivery strategies and related activities that will occur in your region. (e.g., initial meetings, classroom based consultation, provider assessments, classroom observations, modeling, culturally and linguistically relevant practices, parent meetings, proposed provider training, etc.) Please be sure that the description explains how your planned activities are related to your funding focus. <i>[See the DEL IT Consultation Hours Policy (Section 1, Part D) outlined in the accompanying “RSM Overview – Phase 2” document and its footnote.]</i></p>	<p>Estimated Outputs (e.g., provide a basic range for consultation hours, teachers/directors served and infant and toddlers reached)</p>
<p>Strategy #1 Goal Setting : Recruitment of eligible providers in areas of focus determined by Steering Committee is conducted by Lead Agency. Upon provider interest, an introductory “meet & greet” on-site visit is scheduled. The purpose of this visit is to inform them of the roles and expectations of the consultation process and service. The provider’s commitment to engage and participate in requested services is finalized. A second “initial” on-site visit to provide an opportunity for the lead consultant and program/provider to engage in visioning and reflection of the program and development of a Quality Improvement Plan (QIP).</p> <p>Strategy #2 : On-site Consultation Consultation is conducted according to each program/provider’s QIP. This service will vary and include, but not limited to: 1) classroom based consultation (coaching, modeling, assessment), 2) one on one or group technical assistance and professional development, and 3) parent engagement and community resources and referrals.</p> <p>Strategy #3 : Professional Development Early into this project, the Lead Agency noted that there are often common themes that appear from the QIP’s. Because of this, the conversation around conducting another level of service with MERIT approved training in a group</p>	<p>Overall Consultation Hours in SFY 2014: 300 – 480 hours total</p> <p>Consultation Hours Per Teacher in SFY 2014: 15 – 24 hours</p> <p>Consultation Hours Per Director in SFY 2014: 15 – 24 hours</p> <p>Anticipated # of Infant and Toddlers Reached in SFY 2014: 175 – 225 infants & toddlers</p> <p>Overall Consultation Hours in SFY 2015: 300 – 480 hours total</p> <p>Consultation Hours Per Teacher in SFY 2015: 15 – 24 hours</p> <p>Consultation Hours Per Director in SFY 2015: 15 – 24 hours</p> <p>Anticipated # of Infant and Toddlers Reached in SFY 2015: 175 – 225 total infants & toddlers</p>

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context has surfaced within our Steering Committee. Therefore, the Lead Agency will begin offering professional development for providers by MERIT approved Trainers/NCIT Consultants, outside of child care hours in each community and link it to on-site consultation services.

Strategy #4

Consultant Recruitment & Professional Development

Consultant recruitment and professional development will be on-going with no closing date. Professional development will be based on individual consultant need, and approved by the Steering Committee. The Lead Agency will conduct bi-annual consultant gatherings. Within the scope of each consultant's contract both, attendance and professional development are required in order to stay on contract for providing these services.

How has your service delivery strategy evolved from SFY 2012 and SFY 2013? What informed those changes (feel free to look back at your previous RSMs)?

Recruitment strategies have shifted based on provider responsiveness. Introductions and program overview via phone, mailings and surveys conducted prior to on-site engagement have been eliminated. Lead consultants contact potential providers and immediately schedule an on-site introductory "meet and greet" visit. This has proven to be most effective.

Consultant recruitment and contracts have changed to meet the diverse needs of our providers. Contracts are sensitive to extensive travel and time required by providers engaged in consultation service. Target providers are in very remote and rural areas and consultants are selected to provide service based on need, not proximity. Providers in these isolated areas have required more duration and frequency of visits, thus requiring contracts to adapt accordingly.

Assessments were conducted based on QIP's and provider readiness. Empowering providers through QIP success and building positive relationships with consultants prior to assessment is critical to our service delivery. Provider readiness for assessment has varied, within the first 6 months of consultation service. Based on this information and our commitment to strengthening our system with outcomes, we will continue to conduct assessments based on QIP's, requiring also that an ERS (ITERS/FCCERS) be conducted within the first 6 months of receiving consultation and every 6 months following until service is deferred or discontinued.

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SECTION 3: Consultant Pool, Coordination and Data Collection

PART A: Consultant Pool

Please describe the background and process for building your interdisciplinary consultant pool.

Consultant Pool	DESCRIPTION Please answer the questions from the first column.
i. Please describe your outreach and process for recruiting consultants?	Based on our successes in past years, consultant recruitment will occur by posting in local newspapers, on craigslist and on the Catholic Charities website. Referrals from I-TCC Consultants and community partners are also actively solicited.
ii. Are the consultants you recruit meeting the qualifications outlined in the I/T Interdisciplinary Child Care Guidelines? To what degree?	The consultants recruited are meeting and exceeding the qualifications outlined in the I/T Interdisciplinary Child Care Guidelines. Consultant “Type” listed below in specific consultant information (education/ social emotional/health) means that they met or exceeded qualifications outlined in guidelines. Listed as content specialist if qualifications not met. Six of the 7 Currently contracted Consultants meet and/or exceed qualifications. (See section iv)
iii. What other qualifications do you expect you will need from your consultants to successfully deliver consultation?	Recruitment of Spanish-speaking consultants as we expand our services is critical.
iv. What type of specialists will you use (e.g. mental health)? How will they be used?	The current consultant pool capacity has met all needs required to meet goals within the QIP’s created in past years. The recruitment and contracting of new consultants is on-going and specific, recruitment will take place as required to meet needs of providers. Consultants in pool have specialized certifications and credentials in addition to the outlined qualifications, including but not limited to; licensed mental health, licensed social worker, registered nurse, CLASS reliable, ASQ and ERS trained. One Consultant was contracted for Spanish-speaking capacity, cultural competency and relationship-based coaching-consultation expertise.
Please list name, phone/e-mail and type (education/health/social emotional) of consultants you already know will be in your pool.	<ol style="list-style-type: none"> 1. Doug Taylor, 509-782-2022/509-393-6828, dougzaylor@yahoo.com, education/social emotional 2. Linda Hibbard, 509-741-0385, msslinda@earlydiscoverieseec.com, education 3. Heidi Collins, 509-679-0943, heidicollins@genext.net, health 4. Mary Craig-Fulk, 509-398-1860, marycf@homenetnw.net, education/social-emotional

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<i>(e.g. John Smith, Health)</i>	<p>5. Jessica Herrejon, 509-449-5098, jessicaherrejon@yahoo.com, education</p> <p>6. Valerie Wright, 360-441-1424, Valerie.wright11@gmail.com, education</p> <p>7. Siliviano Herrejon, 509-449-5098, silvianoherreme@hotmail.com, content specialist</p>
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PART B: Coordination and Data Collection – Staff and Partners

Please articulate how you will coordinate your resources, e.g. consultant pool, point of entry with your service delivery strategies. (This section relates to Core Strategy #2 in the Infant and Toddler Child Care Consultation Logic Model and to Table 7 in the Infant-Toddler Child Care Consultation Guidelines.) Who will be responsible for this, and how will they coordinate the process? Please add rows and columns for additional activities that your region intends to implement.

Category of Coordination	Activities: How will you coordinate this?	Responsibility: Agency and staff person responsible
Engaging Providers - communication, coordination and cross-referral (e.g., linking providers to consultants)	This activity is handled internally. All phone calls, written communication and changes are spearheaded by the Lead Consultants and Project Lead. The program assistant will also support any necessary changes or engagement.	Lead Agency Staff including: Lead Consultant: Cindy Morris Co-Lead Consultant: Carolina Alanis Project Lead: Jessica Frank
Provider recruitment, intake, and assessment (e.g., applying ITERS, QRIS)	<p>A self-assessment (loosely based on the ERS) will be used to allow providers to self disclose areas of concern, need or program deficits and to set initial goals.</p> <p>The ERS (I-TERS and FCCERS) will be used – in whole or in portions – as needed as a tool for setting goals and monitoring progress within the first six months of service delivery.</p> <p>Data from these assessments as well as review of periodic reports will be used to identify infant-toddler trainings needs.</p>	Lead Agency Staff including: Lead Consultant: Cindy Morris Co-Lead Consultant: Carolina Alanis
Training, supervision and support for consultants	Consultants will receive pre-service orientation prior to delivering consultation services. Orientation Agenda includes:	Lead Agency Staff including: Lead Consultant: Cindy Morris Project Lead: Jessica Frank

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	<ul style="list-style-type: none"> • Project background • I-T Consultant Roles and Responsibilities • Quality Improvement – Process and Plans • Documentation • Resource & Lending Library • Q&A • Mandated Reporter Training <p>Infant-Toddler consultants will participate in professional development to ensure current and aligned practices. Consultants are allotted eight hours of professional development per year through a couple different formats. Consultants can engage in STARS training offered by Child Care Aware of Central Washington, submit a request to attend outside training, or engage with focused training opportunities developed in response to the needs of the I-T project. Requests for outside training (to cover the costs of training registration only) will be reviewed and approved by the Infant-Toddler Steering Committee.</p> <p>Child Care Aware of Central WA (Lead Agency) will be the point of contact for all I-T consultants for the purposes of contracts, billing, project documentation and referrals.</p>	<p>PD Coordinator: Lisa Melvin</p>
<p>Data collection and reporting</p>	<p>PROJECT LEAD will:</p> <ul style="list-style-type: none"> • Submit all DEL reports and invoices • Share Quarterly Periodic Reports with I-T Steering Committee • Participate in monthly TA calls • Attend local and statewide meetings as North Central I-T Representative <p>LEAD CONSULTANTS are responsible for the collection, management, quality assurance and compilation of all project documentation.</p>	<p>Lead Agency Staff including: Lead Consultant: Cindy Morris Co-Lead Consultant: Carolina Alanis</p>

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	I-T CONSULTANTS are responsible for completing visit summaries that accurately and comprehensively reflect the on-site activities. Documentation must be submitted within five working days of visit. Any additional information that is relevant to the project must be communicated to the Lead Consultant(s) via phone or email following each visit.	
Other planned coordination activities (add table rows as necessary)	<u>Referral Network</u> – Providers will be connected with additional resources as needed (i.e. available grants, contact information, online resources)	
	<u>Community Resource LENDING LIBRARY</u> Providers receive an informational flier in their Quality Improvement binders and all consultants can access items and promote this resource as a way to obtain new materials for programs facing budgetary limitations. The Lead consultant will make suggestions of items to check out as needed and inform programs of new and available items as updates occur.	

PART C: Curricula and Training

Please list any curricula and training you will support the delivery of high quality consultation services.

PART C: Resources	Description
i. What training, curricula and content experts will be available to support high quality interdisciplinary consultation?	<ul style="list-style-type: none"> • ITERS/FCCERS • CLASS • ASQ (Consultants will use as needed based on QIP) • Washington State Early Learning Guidelines (Providers are given a hard copy. Consultants use as reference if applicable to QIP) • Creative Curriculum (Reference used by Consultants as needed based on QIP) • Second Steps (Consultants will use as needed based on QIP)
ii. What common approaches/methods will your	<ul style="list-style-type: none"> • Identify (and work to balance) the provider's interest and highest needs in the classroom through observation, assessment and dialogue.

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consultant pool utilize related to any training, curricula or other support your region provides?

- Goal-setting that is collaborative (including director and teacher(s) receiving consultation) and data-driven (based on assessment results, documented observations and progress towards goals).
- Encourage and model high quality adult-child interactions that support strong attachment and healthy social – emotional development in all opportunities on-site.
- All new programs will be encouraged to enroll in Early Achievers and supported through their registration and level two process in partnership with TA specialist.
- Solution-oriented, Strengths-based.
- Measure progress through reflective practice

SECTION 4: System Building

PART A: System Building Efforts Description

Please describe your systems building efforts and collaborative regional work to support the unique and diverse needs of infants and toddlers, their families, and the systems and services that support them.

PART A: Please give a brief (< 100 words) description of your system building efforts for infants and toddlers in your region.

It has been formally proposed, moved, and passed by the NCIT Steering Committee to become a part of the North Central Early Learning Collaborative. It is with great intention that the NCIT Project coordinate, collaborate, and braid resources, funding opportunities, and services with those already existing within our communities.

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PART B: Steering Committee Roster and Roles

Please describe your Steering Committee membership and how they reflect your region’s rich geographical, racial, and cultural diversity. List the names, contact information and any role, coordination responsibility and/or representation the individual will have on the committee. Add rows as necessary.

PART B: Steering Committee Member Name	Contact Information	Role, Structure and Representation (coordinating role, responsibility)
Jessica Frank	jfrank@ccyakima.org	CCACW Project Lead
Cindy Morris	cmorris@ccyakima.org	CCACW Lead Consultant
Josie Rutherford	jrutherford@ccyakima.org	CCACW, Coordinator
Kate Young	kate@cdcsa.com	Education Manager, CDCSA
Nancy Spurgeon	nspurgeon@wvc.edu	Wenathcee Valley College, ECE Director
Janelle Bursh	janelleb@ncesd.org	ESD 171, ESIT Director
Judy Bunkleman	Judy.Bunkelman@del.wa.gov	DEL, Licensing Supervisor

PART C: Additional Partnerships

Additional Partnerships you will access for I/T consultation and/or systems building efforts (e.g., Early Learning Regional Coalition). *Add additional rows if necessary.*

PART C: Name of Partnership	Contribution to Work
Early Learning Regional Coalition	
ESIT	Referrals and support

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PART D: Additional Funds

Please list any additional funding sources (funder, in-kind, any additional funding sources you will access for systems building and/or I/T consultation). *Add additional rows if necessary.*

PART D: Funding Source	Amount	Details (activity that it funds, assumptions, etc.)

Please attach a copy of your region's the estimated budget to provide these services on the accompanying budget template.