Coaching in a Home Based and Combo Setting

March 5, 2014
Session D2: 1:30-4:30pm
Region X Conference

1:30 p.m. – 1:45 p.m.	**Welcome!** • Getting to know you
1:45 p.m. – 2:00 p.m.	**What is Practice Based Coaching** • Formats • Cyclical process for supporting effective practices
2:00 p.m. – 2:30 p.m.	**Shared Goals & Action Planning** • Assessing needs • Set goals • Creating action plan • Review and update
2:30 p.m. – 3:00 p.m.	**Focused Observation** • Gather information through observation • Record information about the observation • Use support strategies for improving or refining practices (i.e., models, prompts)
3:00 p.m. – 3:45 p.m.	**Reflection and Feedback** • Discuss and reflect on observation and progress • Share and consider feedback • Use support strategies for improving or refining practices (i.e., problem-solving conversations, creating materials **Group Discussion**
3:45 p.m. – 4:15 p.m.	**Applying Coaching: Home Visit Observation** • Kaylie, Isaiah and Paige BACKGROUND: This home visit includes both parents and three young children, all of whom are in Early Head Start. Lisa Hall-Schiffbauer is the home visitor. Kaylie, the oldest child, is just about to transition to Head Start. She and her parents attended a Transition Group Socialization earlier in the day. The mother, Gloria, has just started back to work in the evenings recently and her husband, Mike, is the primary caregiver during that time. **Group Discussion**
4:15 p.m. – 4:30 p.m.	**Wrap-Up** • Resources • Sign-Up!

Practice-Based Coaching (PBC)

in EHS home based & combination settings

Head Start National Center on Quality Teaching and Learning

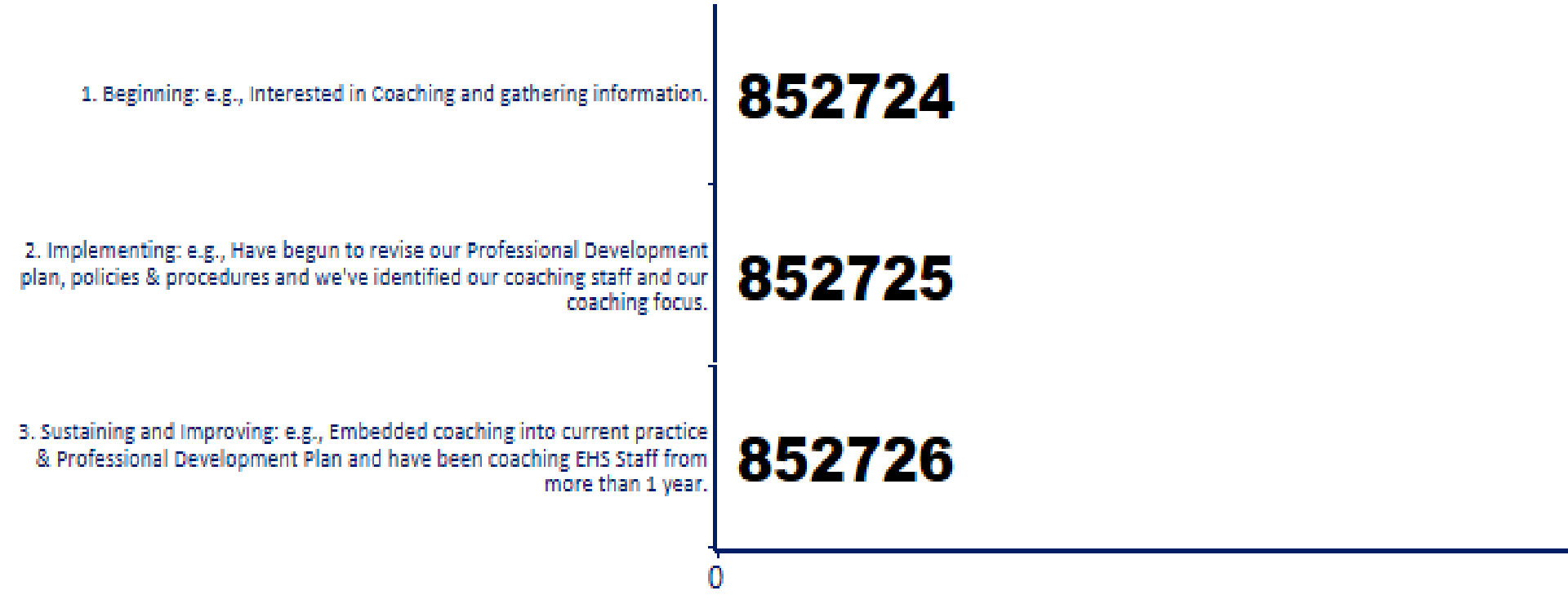
Melissa Bandy, MEd
Katy Keehn, MA
Region X TTA, ICF INTERNATIONAL

Vote With Your Feet

On a scale of 1-3 what level is your program when it comes to using Coaching in EHS?

You may respond at **PollEv.com** when the presenter pushes this poll

Text a **CODE** to **37607**

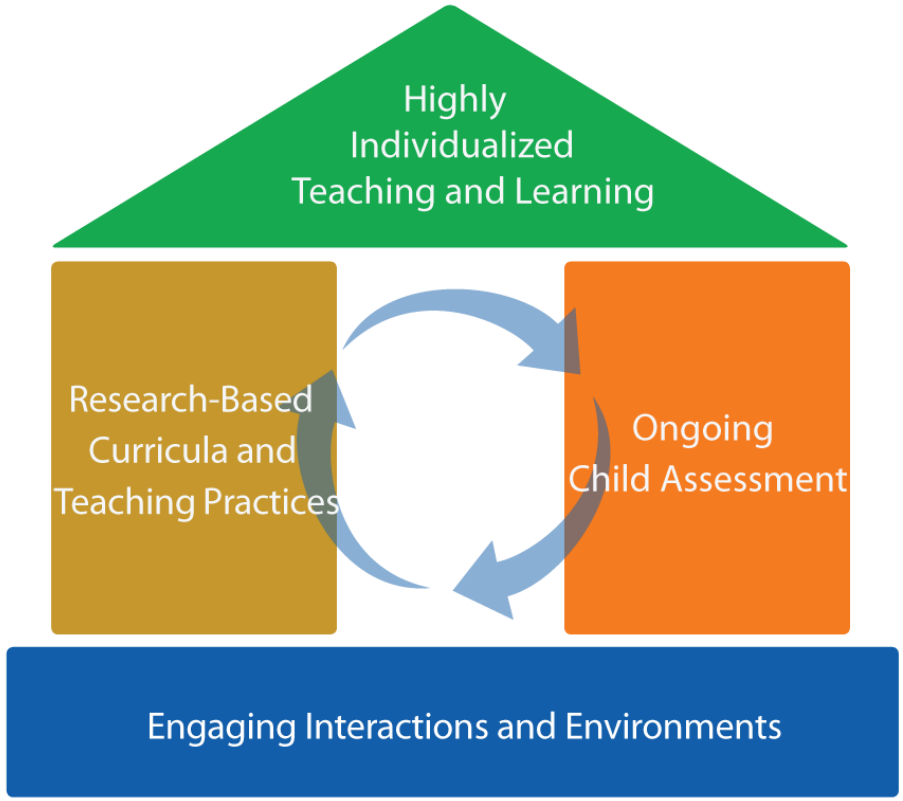


PROFESSIONAL DEVELOPMENT

In what formats can Practice-Based Coaching be provided?

		PARTNER		
		Expert	*Peer*	*Self*
FORMAT	*On-Site*	•Expert comes to the home visit to watch an activity •Expert and Home Visitor arrange a time for a face-to-face meeting	•Peer comes to the home visit to watch an activity •Peer and Home Visitor arrange a time for a face-to-face meeting	•Home Visitor uses self-guided materials to structure an observation of her practices •Home Visitor uses a checklist to examine own video-taped practices
	Distance	•Expert watches video of home visit activity (online or mailed) •Expert shares feedback via website, email, or conference call to provided specific prompts for reflection	•Peer reviews a video of home visit activity the Home Visitor has posted to a discussion board •Peer and Home Visitor arrange a time to discuss observation via Skype	•Home Visitor uses online tutorial to plan an activity to videotape •Home Visitor journals about experiences using a structured online self-coaching tool.

The NCQTL "House" provides the framework for coaching support



FRAMEWORK FOR EFFECTIVE PRACTICE
SUPPORTING SCHOOL READINESS FOR ALL CHILDREN

What is Practice-Based Coaching?

Practice-based coaching is a cyclical process for supporting teachers' use of effective teaching practices that lead to positive outcomes for children.

The cyclical nature of Practice-based coaching emphasizes that expectations, understandings, and desired outcomes of coaching are regularly reviewed and updated.

What is Practice-Based Coaching for Home Visitation?

Practice-based coaching is a cyclical process for supporting Home Visitors' use of effective ***home visiting practices*** *that lead to positive outcomes for children.*

The cyclical nature of Practice-based coaching emphasizes that expectations, understandings, and desired outcomes of coaching are regularly reviewed and updated.

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SHARED GOALS & ACTION PLANNING

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SHARED GOALS AND ACTION PLANNING

- *Assess needs*
- *Set goals for coaching*
- *Create an action plan to guide coaching*
- *Review and update goals and action plan throughout the coaching partnership*

Assess Needs

Information might be gathered about…

- **how often** a practice is used (frequency)
- **how well** a practice is implemented (quality)
- **how confident** you are when using a practice (self-efficacy)
- **what** you believe about how a practice impacts children's learning (beliefs)

When reflecting on your practices…

- Which practice(s) are you most confident using? What makes you feel confident about using this practice?
- Which practice(s) is most difficult to use in your visits or socializations? Why is this practice difficult?
- Which practice(s) do you think would benefit your children the most? How often are you using this practice now?
- Think of a stressful or hectic activity or routine. Which practice might help you in this situation?
- Which practice(s) would you like support to use better or more often in your visits or socializations?

Needs Assessment for Teaching Practices

Teacher Name: _____ Date: _____

Instructions: Each of the questions below relate to effective teaching practices for supporting children's learning.
Read each question and consider how often you do this teaching practice using the 1 to 5 rankings.
Once you have completed the rankings, consider if you would like to do this teaching practice more.
Identify the top 5 teaching practices you would like more support and help to use in the classroom.
Use the notes section to write your initial ideas about what might help you use this practice.

	How Often Do You Use this Practice?							
Teaching Practice	Never	Seldom	Some-times	Usually	Always	Change needed?	Priority (Top 5)	Notes
Engaging Interactions & Environments: Well-Organized Classrooms								
Do you prepare for teaching and instructional activities in advance and have materials ready and accessible?	1	2	3	4	5	Yes No		
Do you use classroom rules to help clarify expectations (what children should do) for specific activities?	1	2	3	4	5	Yes No		
Do you plan the classroom schedule to provide a balanced set of activities and routines?	1	2	3	4	5	Yes No		
Do you provide a visual schedule and use it to help children understand what is currently happening in class and what will happen throughout the day?	1	2	3	4	5	Yes No		

Needs Assessment for Home Visiting Practices

Teacher Name: _____ Date: _____

Instructions: Each of the questions below relate to effective practices for supporting family relationships and children's learning.
Read each question and consider how often you do this practice using the 1 to 5 rankings.
Once you have completed the rankings, consider if you would like to do this practice more.
Identify the top 5 practices you would like more support and help to use on home visits.
Use the notes section to write your initial ideas about what might help you use this practice.

	How Often Do You Use this Practice?							
Home Visiting Practice	Never	Seldom	Some-times	Usually	Always	Change needed?	Priority (Top 5)	Notes
Home Visitor: Responsiveness (adapted from HOVRS –A+)								
Plans next visit with parent, and helps parent decide on activities, materials, & who will provide them.	1	2	3	4	5	Yes No		
Emphasizes parent-selected activities and organizes home visit around them.	1	2	3	4	5	Yes No		
Gets information from open-ended or follow-up questions and uses the information to increase effectiveness of home visit.	1	2	3	4	5	Yes No		
Observes, reacts, and provides reflective feedback, ideas, and developmental information about parent-child interactions or child's development.	1	2	3	4	5	Yes No		

Needs Assessment for Home Visiting Practices Continued…

Teacher Name: _____ Date: _____

Instructions: Each of the questions below relate to effective practices for supporting family relationships and children's learning.
Read each question and consider how often you do this practice using the 1 to 5 rankings.
Once you have completed the rankings, consider if you would like to do this practice more.
Identify the top 5 practices you would like more support and help to use on home visits.
Use the notes section to write your initial ideas about what might help you use this practice.

	How Often Do You Use this Practice?							
Home Visiting Practice	Never	Seldom	Some-times	Usually	Always	Change needed?	Priority (Top 5)	Notes
Home Visitor: Skills (adapted from ZTT Core Competencies Domain #2 Family-Centered Practice- Skills)								
Ensures parents/caregivers are engaged in planning and responding to any health, learning or developmental needs of their child.	1	2	3	4	5	Yes No		
Establishes an ongoing alliance with families that supports their strengths, priorities and parenting practices.	1	2	3	4	5	Yes No		
Uses easily understandable language about social and emotional milestones to help family members promote healthy relationships with each other and with their very young child.	1	2	3	4	5	Yes No		

Set Goals

WHAT IS GOAL SETTING?

- Goal setting is a process that includes selecting home visiting practice(s) for improvement and writing a goal for each practice

- A home visiting practice goal might be taken directly from a needs assessment or might address certain parts of the practice

- Well-written, clearly stated goals facilitate coaching

Set Goals

HOW SHOULD GOALS BE WRITTEN?

- Goals should be specific, observable, and achievable within a defined time frame

- Goals should clearly state
  - what a Home Visitor will do
  - with whom and/or when the Home Visitor will do it

Set Goals

LET'S COMPARE...

- I will support child goals and update them monthly.

I will support each child's learning goals during every home visit and consistently document progress each month in child's learning plan.

- I will promote more parent-to-parent interaction during socialization groups.

I will intently promote at least one opportunity for parent-to-parent interaction during each socialization group by planning for and actively supporting paired learning experiences.

Set Goals

HOW TO GET STARTED…

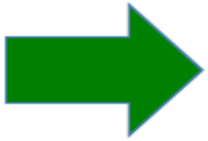
- Goals may reflect how a Home Visitor initially wants to use a targeted practice.
- For example, does the Home Visitor want to:
  - Learn more about the practice and try it out?
  - Do it more often?
  - Do it better?
  - Do it differently?

Set Goals

EXAMPLES OF GOALS…

I will support each child's learning goals by learning more about their individual learning styles, preferences, and family culture.	Learn more and try it out
I will support each child's learning goals during every home visit and consistently document progress each month.	Do it more often
I will support each child's learning goals by providing individualized experiences & appropriate materials during home visits.	Do it better
I will support each child's learning goals by providing opportunities for parents to participate in supportive activities during socialization groups.	Do it differently

Create an Action Plan

GOALS  ACTION PLAN

- After goals are set an action plan is developed to lay a road map for accomplishing the goals throughout the coaching process

WHAT IS AN ACTION PLAN?

- An action plan is a "working" document that describes:
  - Goal(s) that will be the immediate focus of coaching
  - Planned actions or action steps that will be taken to achieve those goals
  - Explicit statement about how you will know when a goal has been achieved
- An action plan might include supports or resources needed and a timeframe for completion

ACTION PLAN FORMAT

Teaching Practice Action Plan			
The goal I will work on in my classroom:			
Steps to achieve this goal:	Resources needed:		
1.			
2.			
3.			
Review Date:_____			
☐ *I know I* **achieved this goal** *because:*		☐ *I am* **making progress** *toward this goal and will keep implementing my action plan*	☐ *I* **need to make changes to my plan** *to achieve this goal by revising the goal or change the action steps*

A COMPLETED ACTION PLAN

Teaching Practice Action Plan	
The goal I will work on in my classroom: *I will change the way I structure my centers so that children interact with more team members during activities.*	
Steps to achieve this goal--	Resources needed:
1. *Learn about another way to structure my centers*	*1 hour after school, websites, training materials*
2. *Meet with team members to discuss new center structure*	*Use regular planning time on Wednesday*
3. *Try it out while video taping, take notes afterwards*	*Video camera, team members to set it up during circle, clipboard for each member to take notes*
Review Date: 9/23	

☐ *I know I **achieved this goal** because:*	☐ *I am **making progress** toward this goal and will keep implementing my action plan*	☐ *I **need to make changes to my plan** to achieve this goal by revising the goal or change the action steps*
My team and I have implemented a structure for centers that allow each of us to interact with all of the children during center time.		

Review and Update

SHARED GOALS AND ACTION PLANNING SUPPORT…

- What the coach will focus on during observations
- What the Home Visitor will do during home visits when the coach is or is not present
- What the Home Visitor and coach will discuss during a debrief meeting (i.e., reflection and feedback)

KEY IDEAS FOR SHARED GOALS AND ACTION PLANNING

- Gather information about how a Home Visitor is currently using effective practices
- Develop goals that are specific, observable, and achievable
- Write an action plan to guide achievement of goals through collaborative coaching partnerships

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FOCUSED OBSERVATION

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FOCUSED OBSERVATION

- *Gather information through observation*
- *Record information about the observation*
- *Use support strategies for improving or refining practices (i.e., models, prompts)*

Gather & Record Information

WHAT MAKES AN OBSERVATION "FOCUSED"?

- Always includes:
  - Gathering information guided by current action plan goal
  - Recording information, being mindful – take notes, reflect, begin to plan feedback

Gather & Record Information

PBC COMPONENT 2: FOCUSED OBSERVATION

- Ways to gather and record
  - Take notes
    - Coaching log / note taking forms
  - Videotape
    - Allows for shared review and reflection
      - Benefit for coach
    - Supports distance viewing

Use Support Strategies

COACHING STRATEGIES

- Model target practices
- Videotape
- Review video
- Provide materials and resources
- Modify environment
- Role-play
- Watch other Home Visitors
- Collect data
- Engage in discussions

KEY IDEAS FOR FOCUSED OBSERVATION

- Includes gathering and recording information
- Observation focus is guided by current action plan
- Might also include providing additional support during home visit or socialization group

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REFLECTION AND FEEDBACK

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REFLECTION AND FEEDBACK

- *Discuss and reflect on observation and progress*
- *Share and consider feedback*
- *Use support strategies for improving or refining practices (i.e., problem-solving conversations, creating materials*

Discuss and Reflect

WHO REFLECTS?

- **Home Visitor**
  - Guided by the coach to reflect on events, activities, efforts, child response, growth in practices, etc.

- **Coach**
  - Observation of Home Visitor effort, behavior, skills, activities and child response, etc.

REFLECTION STARTER PHRASES

- Objective Questions
  - What happen when_____?
  - What have you tried with_____?
- Interpretive Questions
  - Why do you think_____?
  - What do you think would happen if_____?
- Comparative Questions
  - Know that, what would you do next time_____?
  - How did that compare to_____?

Framework for Reflective Questioning

Question Content \ Question Type	Awareness	Analysis	Alternatives	Action
Knowledge/ Understanding (What you know)	What do you know about…? What is your current understanding of (topic, situation)? *Probes (e.g.,):* How did you come to believe this?	How does that compare to what you want to know about…? How is that consistent with (standards, evidence)…? What do you know now after trying…? How does that compare with what you originally thought?	How could you find out about…? What different things could you do to learn more about …? What are other ways to view this for next time?	How do you plan to learn more about…? What option do you choose? Why? How are you going to put that into place? *Probes (e.g.,):* What resources do you have? What supports will you need? Where will you get them?
Practice (What you did)	How are you currently doing…? Why? What kinds of things did you do (have you done so far)? Why? What kinds of things did you try? Why? What kinds of things are you learning to do? What did you do that worked well? *Probes (e.g.,):* What is the present situation in more detail? Where does that occur most often? When did you first notice this?	How is that consistent with what you intended to do (wanted to do)? Why? How is that consistent with standards? Why?	What else could you have done to make practice consistent with standards? Why? What would you do differently next time? How might you go about doing that? What different ways could you approach this? *Probes (e.g.,):* What would it take for you to be able to do…? What would you need to do personally in order to do…?	What do you plan to do? When will you do this? What option did you choose? *Probes (e.g.,):* What types of supports will you need? What resources do you have? What would it take for you to be able to do…? What would you need to do personally in order to do…?
Outcomes (What was the result)	How did that work for you? What happened when you did…? Why? How effective was it to do that? What did you achieve when you did that? What went well? *Probes (e.g.,):* How do you feel about that? What do you think about…? How much control do you have over the outcome?	How did you know you needed to do something else? How did that match (or was different from) what you expected (or wanted) to happen? Why? How do these outcomes compare to expected outcomes based on standards of practice? What *should* happen if you're really doing (practice)? What brought about that result? *Probes (e.g.,):* How do you feel about that? What do you think about…?	What else might happen when you do …? Why? What different things could you have done to get expected outcomes? What might make it work even better next time?	Which option could get the best result? What do you plan to do differently next time? *Probes (e.g.,):* What types of supports will you need? What resources do you have/need? Where will you get them?
Evaluation (What about the process)	What opportunities were useful to you in achieving… (or in learning…)? In what way? How was it useful? Why? What supports were most helpful? What about the supports were most helpful?	How was that consistent with what you expected?	What other opportunities would be useful?	What opportunities do you want to access? How will you access those opportunities? *Probes (e.g.,):* What resources do you need? Where will you get them?

Share & Consider Feedback

FEEDBACK

- Encourage, affirm & acknowledge
  - Strengths-based
  - Direct, specific, and nonattributive
- Conversational & reciprocal
  - But grounded in data/observation
  - Connected to action plan
  - Reflective questions can help

REFLECTION AND FEEDBACK

- Supports the implementation of new practices
- Guides the precision of new practices
- Provides encouragement and support for the adult learner in the movement towards fluency

BENTON FRANKLIN EARLY HEAD START

Brittany Marlow, EHS Coordinator

Nancy Garcia-Olivo, EHS Growth and Development Coach

BY THE END…

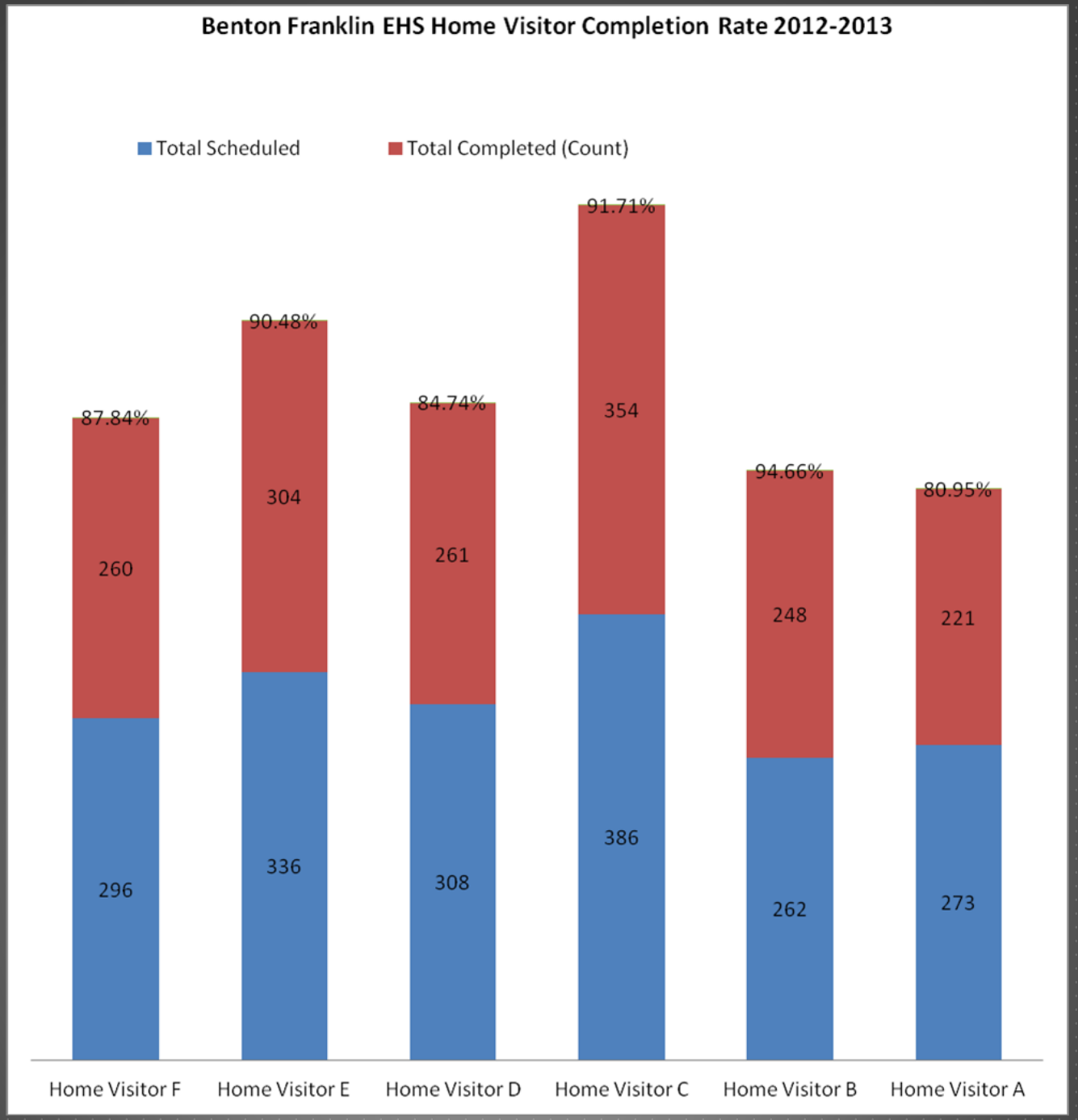
- History of Benton Franklin Early Head Start
- Why we started looking at data
- How EHS is implementing our coach position
- Understand Benton Franklin's data collection process
- Impact of data on Benton Franklin EHS

HISTORY OF BENTON FRANKLIN EARLY HEAD START

Why DATA?

LOOKING AT DATA AS A TEAM

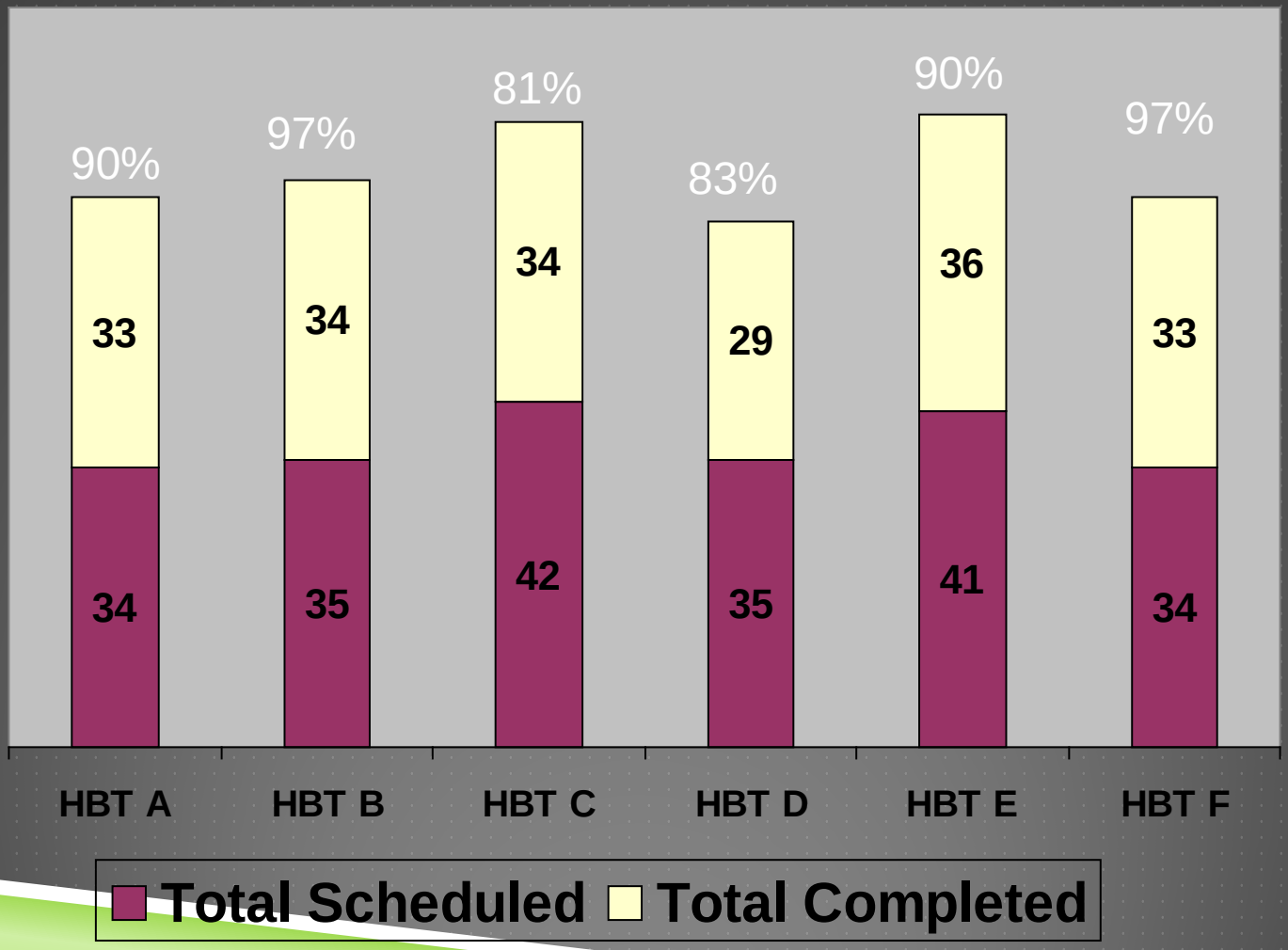
- **HV Completion Rates**
- **Socialization Attendance Rates**
- **Parent Meeting Data**
- **TSG Checkpoints**

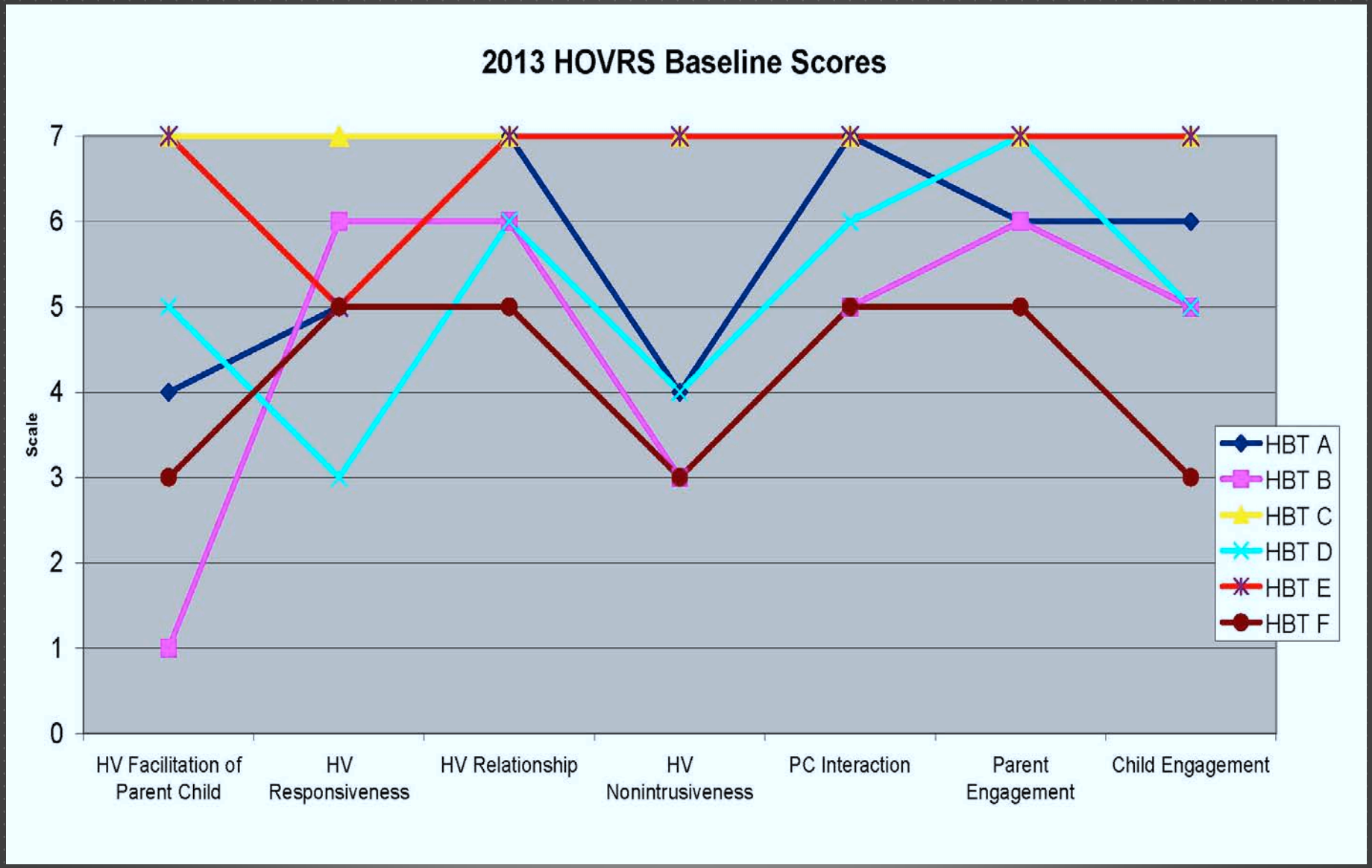

Benton Franklin EHS Home Visitor Completion Rate 2012-2013
Total Scheduled
Total Completed (Count)
87.84%
260
296
90.48%
304
336
84.74%
261
308
91.71%
354
386
94.66%
248
262
80.95%
221
273
Home Visitor F
Home Visitor E
Home Visitor D
Home Visitor C
Home Visitor B
Home Visitor A

SMART GOAL: HOME VISIT COMPLETION RATE WILL BE INCREASED TO 95% BY AUGUST 2014

Activity	Responsible	Resource	Timeline	Follow-Up
Policy and Procedure	Parents, EHS Staff, Admin	Performance Standards, ECLKC and other EHS program policy and procedures	8-31-13	Completed
Training Staff on Policy and Procedure	Admin and EHS Staff	Policy and Procedure, Admin, EHS Staff, ECLKC, Performance Standards	9-15-13	Completed, Case by Case basis
Training and Informing Parents of Policy and Procedure	EHS Staff	Home Visits and Parent Meetings	Sept-Oct 2013	Completed
Monthly Visit Report	EHS Staff	Cap60	Monthly	Continuous, review monthly

Home Visit Completion Rate January 90%




2013 HOVRS Baseline Scores
Scale
7
6
5
4
3
2
1
0
HV Facilitation of Parent Child
HV Responsiveness
HV Relationship
HV Nonintrusiveness
PC Interaction
Parent Engagement
Child Engagement
HBT A
HBT B
HBT C
HBT D
HBT E
HBT F

GROWTH AND DEVELOPMENT COACH POSITION TO SUPPORT HOME VISIT COMPLETION RATES

Benton Franklin Head Start
Early Head Start
Mentoring/Coaching Summary Form

Home-Based Teacher: _____ **Date:** _____

Visit requested by: ☐ HBT ☐ EHSC ☐Planning Team ☐ Coach ☐ Other: _____

Mentoring and Coaching
Home Visited:_____ **This visit was requested by:**_____ **I visited this Visitor to work with them on:**_____
Items Discussed:
Next Steps:
Follow-Up:

Home-Based Teacher's Signature and Date:_____

GDC Signature and Date: _____

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Benton Franklin Head Start
Early Head Start
Mentoring/Coaching Summary Form

Home-Based Teacher: _____ **Date:** _____

Visit requested by: ☐ HBT ☐ EHSC ☐ Planning Team ☐ Coach ☐ Other: _____

Mentoring and Coaching		
Home Visiting Practice I want to change or build upon: **What will it look like when I implement this practice? :**		
Steps to achieve improvement:	**Resources needed:**	**Timeline:**
1.		
2.		
3.		
4.		
Home Visitor will:		
Coach will:		
Comments:		
I know I achieved improvement because:	☐ **I am making progress toward improving and will keep implanting my steps**	**Reviewed Date:**_____

Home-Based Teacher's Signature and Date:_____

GDC Signature and Date: _____

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IMPACT OF DATA ON EHS

- Vested buy in from staff on looking at data
- Data to tell us where we need to take our focus and has identified areas for training
- Evidence based program
- Data to make informed decisions around school readiness

CONTACT INFO

Phone: (509) 735-1062

Emails: EHSC: Brittanym@bfhs.net

GDC: Nancyg@bfhs.net

Home Visit Observation

1. Using the two example tools provided, observe Lisa for competencies and indicators.
    1. HOVRS – A+
        1. Home Visitor Facilitation of Parent-Child Interaction
    2. ZTT P-3 Core Competencies
        1. Domain #1: ECE Core Competency Statements
            1. Knowledge
            2. Skills
            3. Attitudes
2. Share your observation with others at your table.
3. Identify 2 practice areas that are a strength for Lisa and 2 practice areas that would benefit from coaching.

Home Visit Observation

What does research say about Practice-based coaching?

Outcomes for Early Learning Professionals:

Studies that used components of PBC led to a range of positive outcomes for early learning professionals, including

- *implementation of desired practices*
- *changes in early learning professional-child interactions*
- *implementation of practices with fidelity*
- *self-reported changes in knowledge, skills and attitudes about practices*

What does research say about Practice-based coaching?

OUTCOMES FOR CHILDREN

- *Increased participation and engagement*
- *Increased social skills and fewer challenging behaviors*
- *Increased literacy & language skills*
- *Increased skills in logic & reasoning and approaches to learning*

Practice-Based Coaching (PBC)

Head Start National Center on Quality Teaching and Learning

Questions…

Comments…

Next Steps…

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Katy Keehn, MA
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This Practice-based Coaching Overview document was developed from materials provided by NCQTL Coaching to Support School Readiness

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and Learning

HELPING PROGRAM LEADERS CREATE AND SUSTAIN QUALITY COACHING MODELS

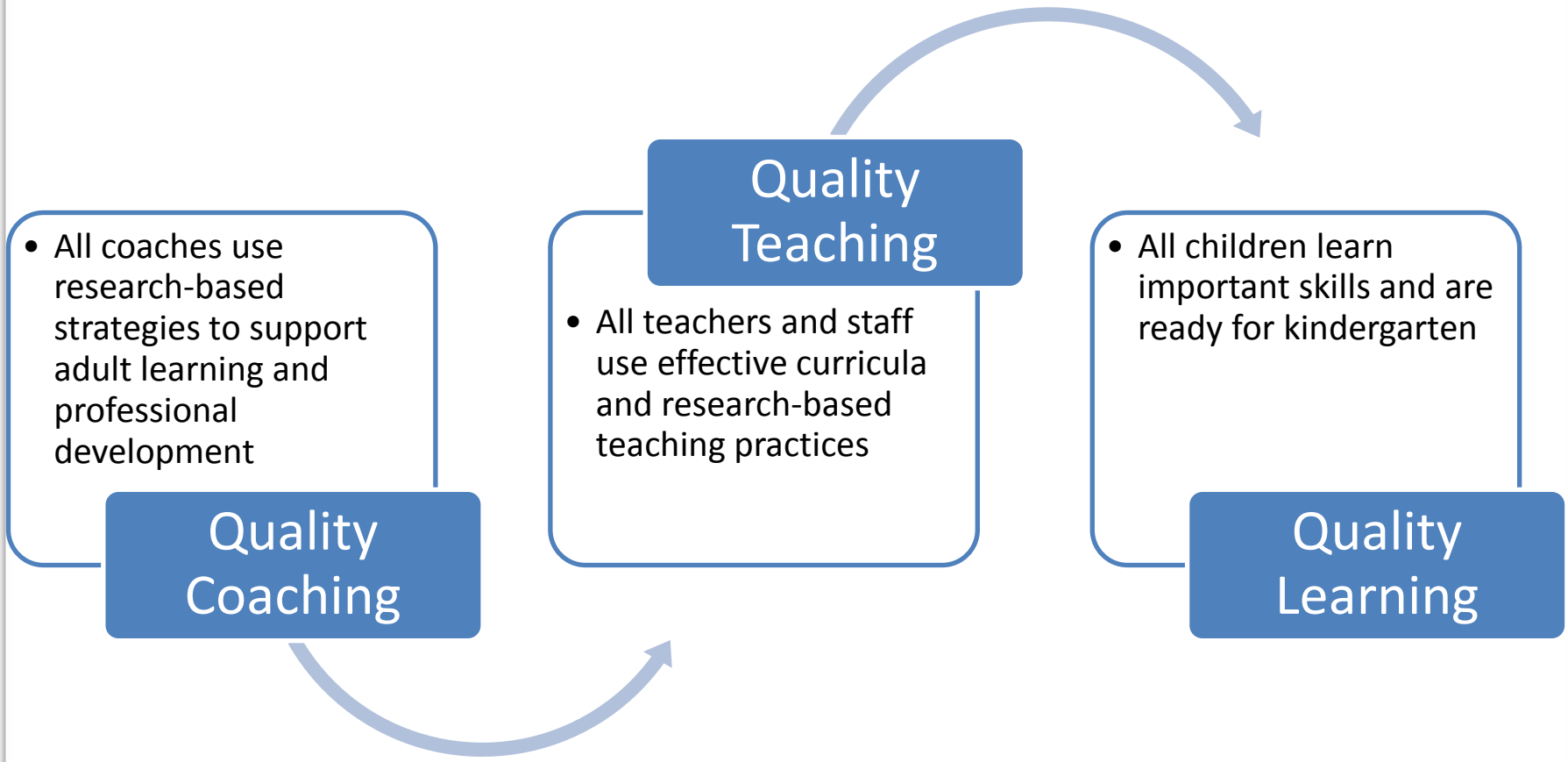
NCQTL

STROLL AND SHARE

- Walk around the room and share your successes and struggles by placing a blank post-it note under a statement that matches your experience (or anticipated experience)!

PROFESSIONAL DEVELOPMENT

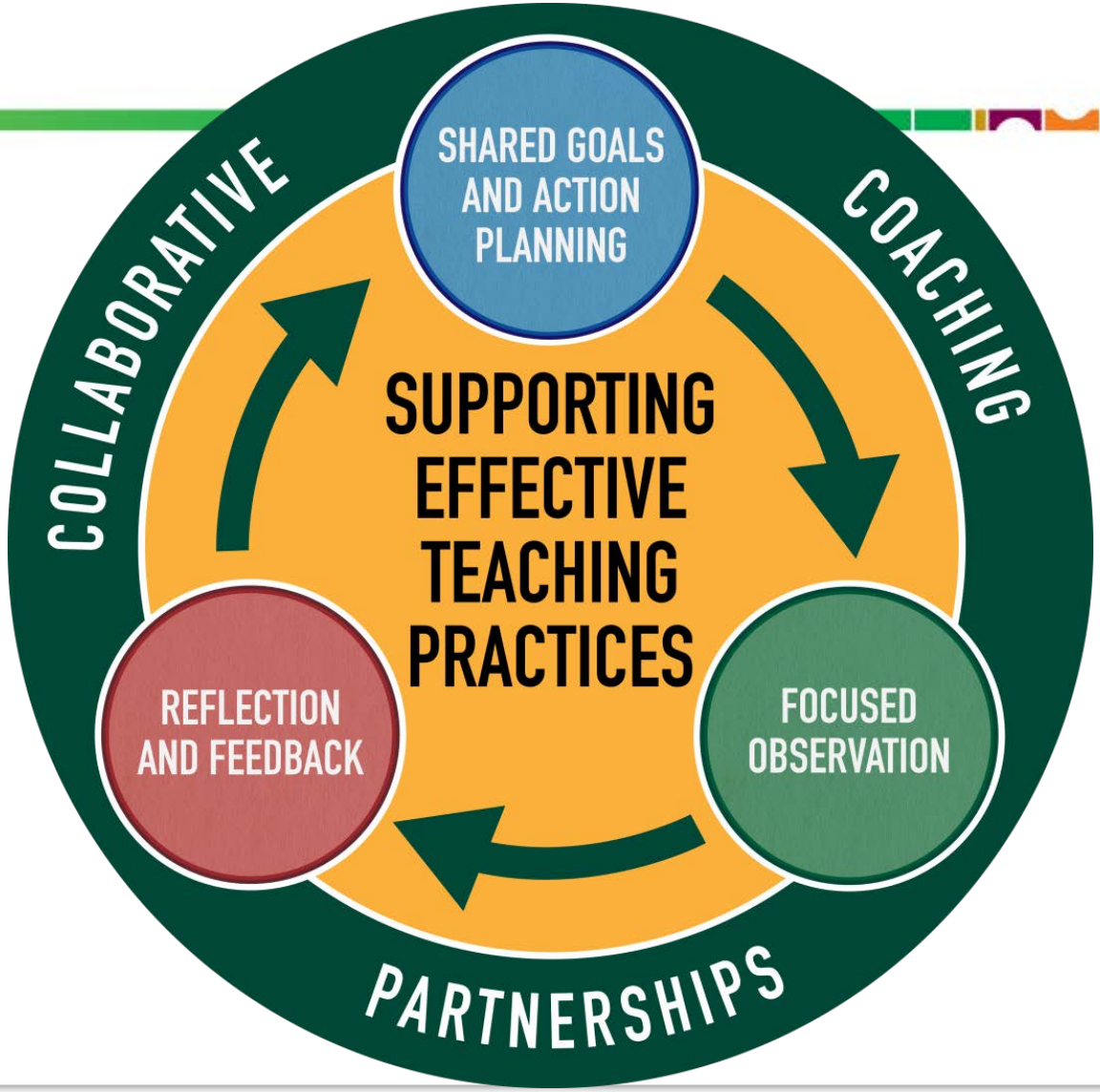
EFFECTS OF QUALITY COACHING



PRACTICE-BASED COACHING

Practice-based coaching is a cyclical process for **supporting** teachers' use of **effective teaching practices** that lead to **positive outcomes for children**

Components of Practice Based Coaching

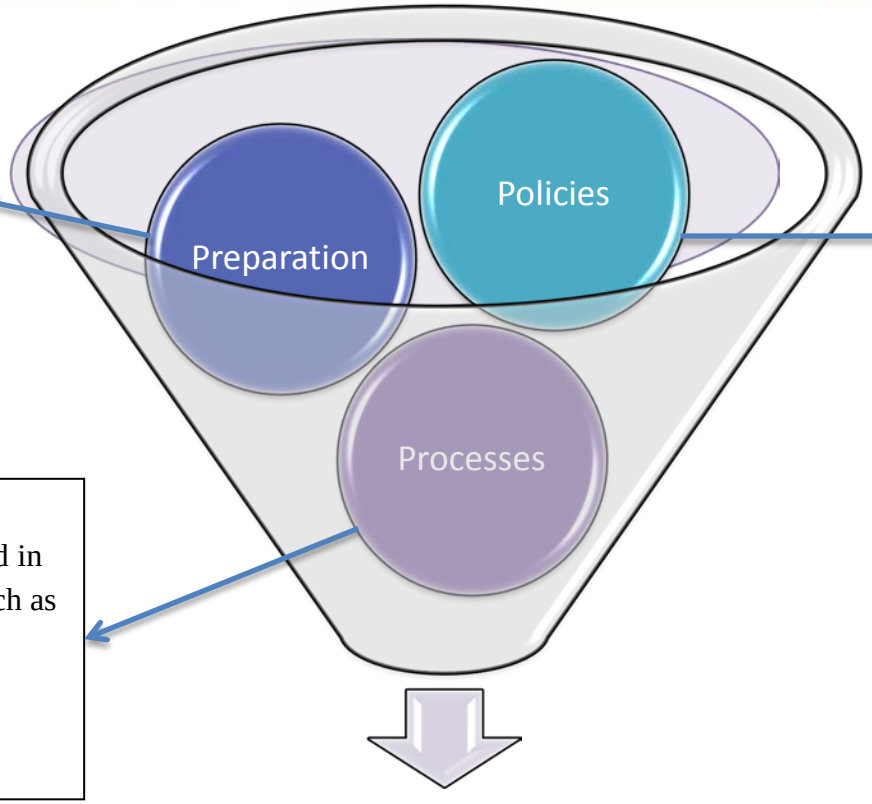


"Adoption of coaching as a form of professional development is a complex endeavor that requires careful planning, system-wide changes, and ongoing support and review."

(Loyd & Modlin, 2012)

THE "3Ps" OF PROGRAMMATIC SUPPORT

Programs must *prepare* to implement coaching and *prepare* coaches and teachers for the coaching process.

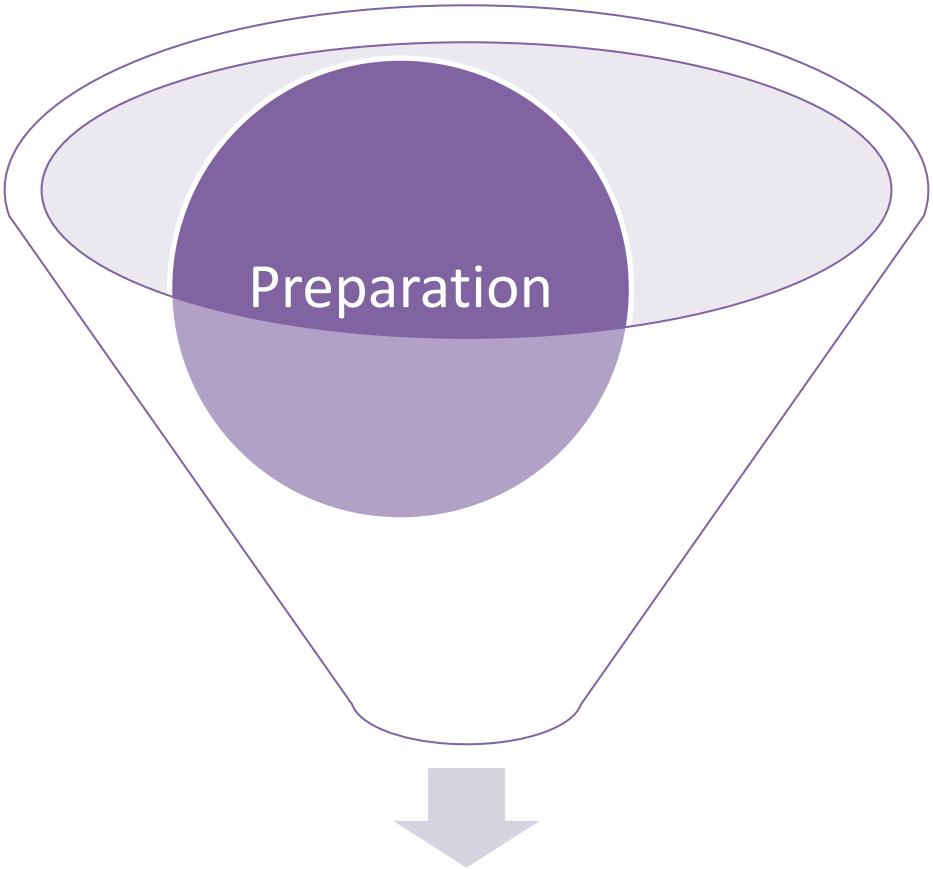


Grantee *policies*, such as providing sufficient time for coaching and training for coaches and teachers, are critical and lay the foundation for effective coaching.

Successful coaching programs are grounded in effective *processes* such as using data to support coaching and connect coaching to child outcomes.

Sustained Quality Coaching

PREPARATION



Practice Based Coaching

PREPARATION: GRANTEE-WIDE

Stakeholders should:

- work together to determine the goals and design of the coaching program.

- agree on the allocation of resources to support and sustain coaching.

PREPARATION: COACHES

- Provide training and ongoing support for coaches
  - Adopt a set of coaching competencies
  - Train coaches in coaching strategies, adult learning principles, administrative tasks and content as needed
  - Community of coaches

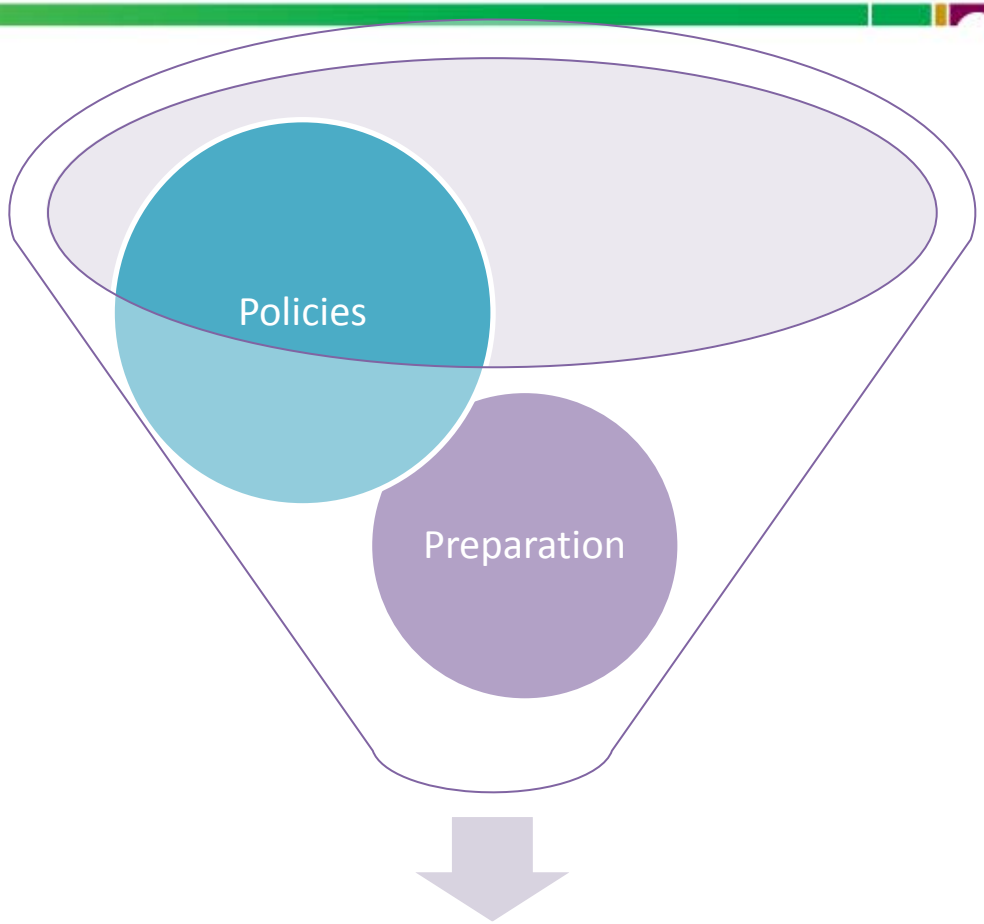
PREPARATION: TEACHERS

- Provide training for teachers and other participants
  - Focus on expectations for coaching
  - Explain coaching procedures and purpose
  - Discuss the teacher's roles and responsibilities in coaching
  - Any specific equipment or documentation needed for the coaching process

PREPARATION: PROGRAMMATIC SUPPORTS

- Coaching Competencies
- Coaching Contracts
- Supervision Policy Statement

POLICIES



Practice Based Coaching

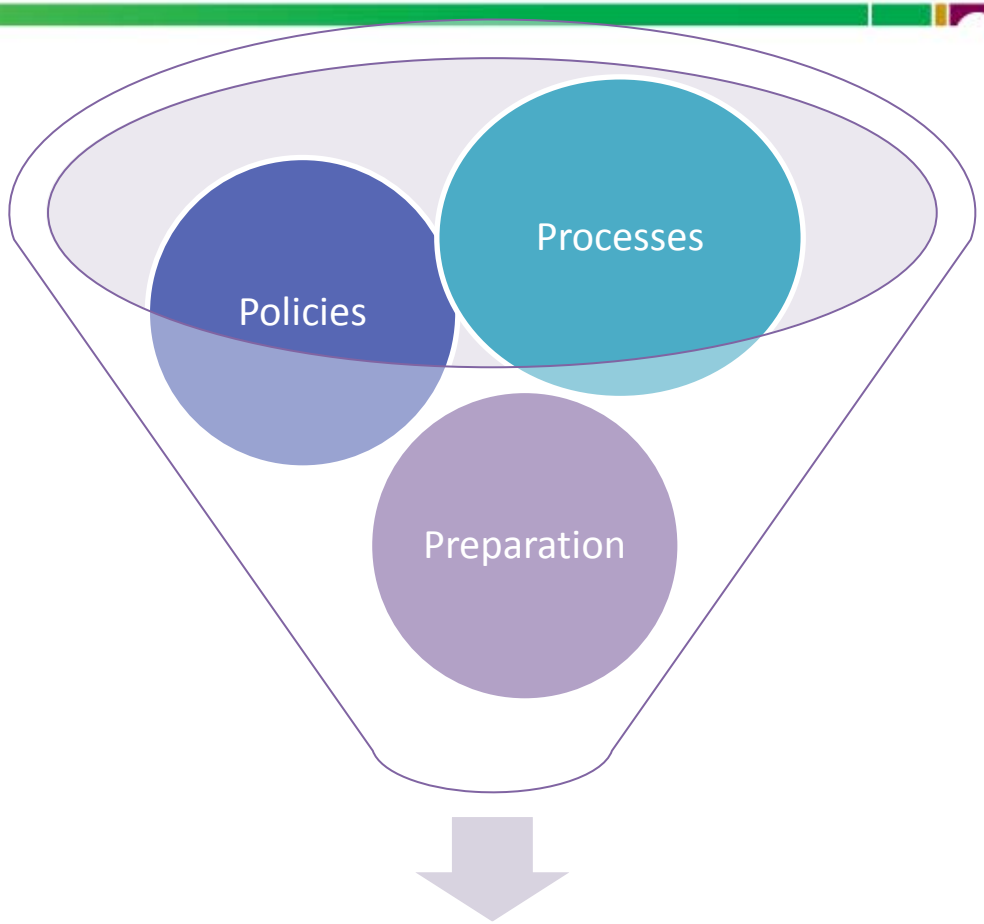
POLICIES

- Establish coaching as a “Safe Place”
  - The teacher is able to try new things, get supportive and corrective feedback, and ask for help in a non-evaluative environment
  - When supervisors serve as coaches, roles are clearly defined
  - Data collected are clearly identified for coaching or for evaluation

POLICIES

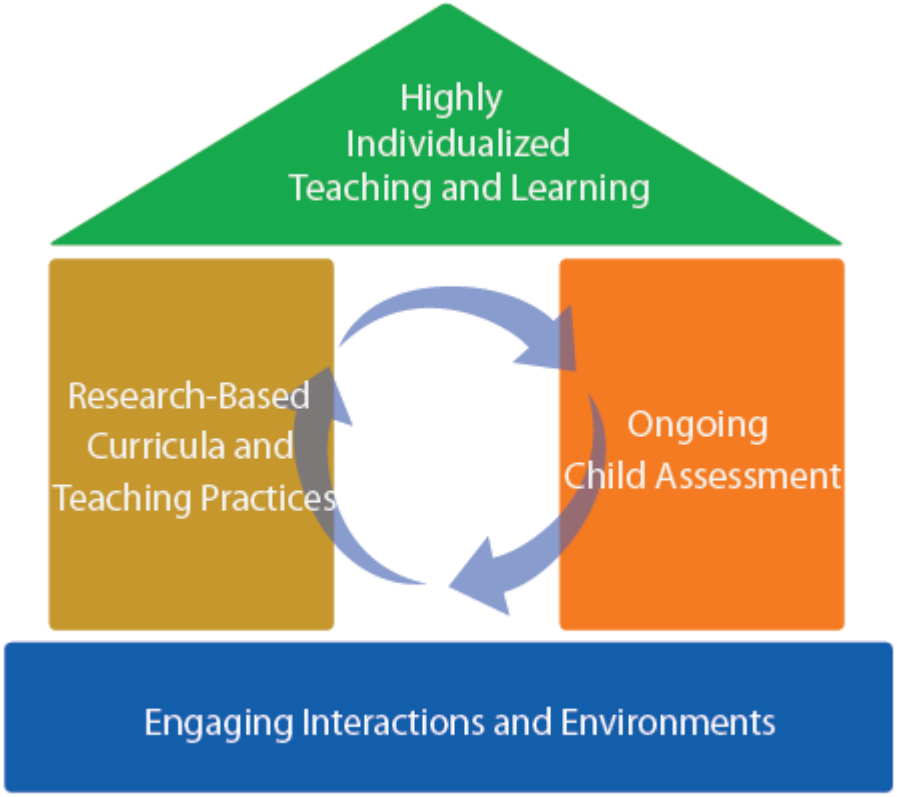
- Provide the time and supports needed for both teachers and coaches
  - Reasonable caseloads
  - Additional personnel for support
  - Time for all aspects of coaching

PROCESSES



Practice Based Coaching

PROCESSES


Highly
Individualized
Teaching and Learning
Research-Based
Curricula and
Teaching Practices
Ongoing
Child Assessment
Engaging Interactions and Environments


DATA

PROCESSES

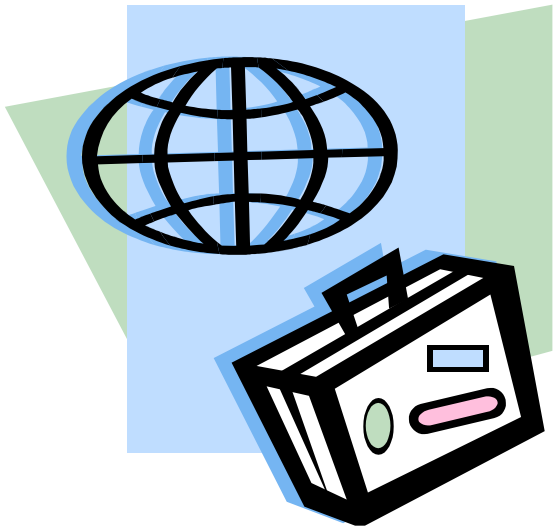
- Data guides coaching
  - At the classroom level
  - At the program level
  - Before, during, and after coaching

PROCESSES

- Gathering information on coaching processes and progress regularly
  - Ensure sustainability by:
    - Review the strengths and needs of the coaching model
    - Gather input from all stakeholders

LET'S TAKE A LOOK AT PROGRAMMATIC SUPPORTS…

- "Unpacking Coaching Success Stories"
- Case Study



PROGRAM LEADERS' GUIDE

- Integrating Feedback
- Refining the Guide

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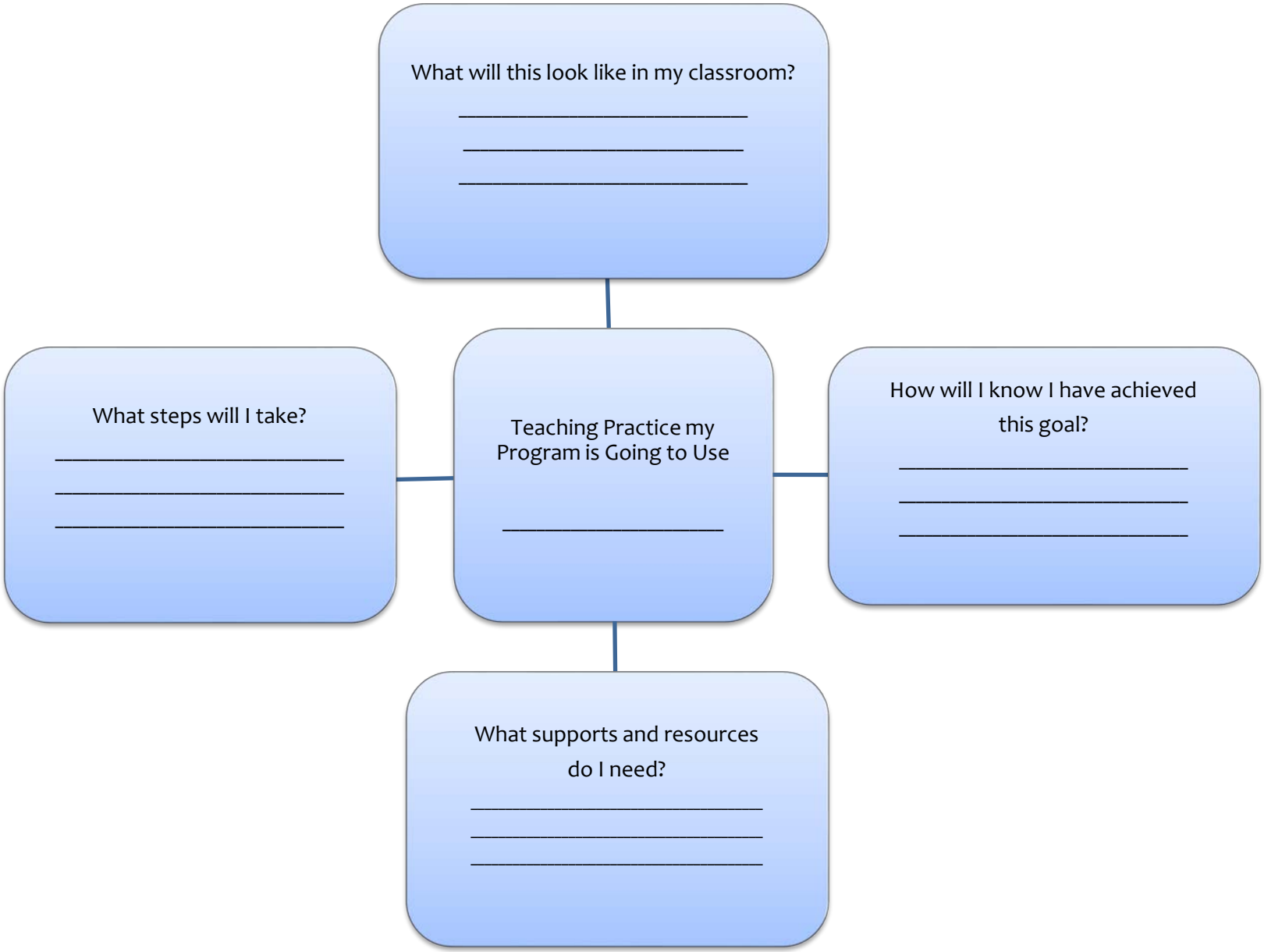
Teacher:_____ # Action Plan Date:_____

Goal		**Goal**	
Goal I want to achieve:		Goal I want to achieve:	
Steps to achieve this goal--	Resources needed:	Steps to achieve this goal--	Resources needed:
1.		1.	
2.		2.	
3.		3.	
Review Date:_____		Review Date:_____	
☐ I know I achieved this goal because: (Way to go! Make a new action plan)		☐ I know I achieved this goal because: (Way to go! Make a new action plan)	
☐ I am making progress toward this goal and will keep implementing my action plan		☐ I am making progress toward this goal and will keep implementing my action plan	
☐ I need to make changes to my plan to achieve this goal by revising the goal or change the action steps		☐ I need to make changes to my plan to achieve this goal by revising the goal or change the action steps	

Coaching to Support School Readiness – April 2012 – Draft Version 1.0

Adapted from: Snyder, P., Hemmeter, M. L., Sandall, S., McLean, M., Rakap, S., Emery, A. K., McLaughlin, T., & Embedded Instruction for Early Learning Project. (2009). *Coaching preschool teachers to use embedded instruction practices* [Manual and Coaching Protocols]. Unpublished guide. College of Education, University of Florida, Gainesville, FL.

Action Plan


What will this look like in my classroom?
_____
_____
_____
What steps will I take?
_____
_____
_____
Teaching Practice my Program is Going to Use
_____
How will I know I have achieved this goal?
_____
_____
_____
What supports and resources do I need?
_____
_____
_____

BriefCASE
Practical Applications of Early Childhood and Family Support Practices
Volume 1, Number 2 January 2008

Tips and Techniques for Effective Coaching Interactions

Dathan D. Rush
M'Lisa L. Shelden

Coaching Characteristics

- Joint planning
- Observation
- Action/practice
- Reflection
- Feedback

INTRODUCTION

This *BriefCASE* contains strategies to assist individuals using a coaching style of interaction to refine their skills when supporting parents, care providers, and colleagues. Coaching is an adult learning strategy that is used to build the capacity of a parent or colleague to improve existing abilities, develop new skills, and gain a deeper understanding of his or her practices for use in current and future situations. Coaching has five research-based practice characteristics that lead to the intended outcomes: (1) joint planning, (2) observation, (3) action/practice, (4) reflection, and (5) feedback. Listed below are 25 tips and techniques designed to address common coaching challenges and ensure effective implementation of the five characteristics of coaching.

TIPS AND TECHNIQUES

1) Always begin a coaching conversation by reviewing the joint plan from the previous visit.

2) At the beginning of the visit, after reviewing the joint plan from the previous conversation, jointly determine the time constraints of the visit and prioritize how to best spend the time.

3) Primarily use open-ended questions rather than closed questions (i.e., questions that can be answered with a "yes" or "no" response).

4) Closed-ended questions that require only a yes/no response should be reserved for situations when you need to ask permission and/or avoid making an assumption. For example, "Would you be comfortable having me watch you feed him?"

5) Become comfortable with a few question stems from the Framework for Reflective Questioning that fit your style or personality. Write these question stems on a note pad that is easily visible during your coaching conversation. If you get stuck during your conversation, then you can quickly refer to your notepad for a few questions you know work. This will help avoid asking too many awareness questions and assist in moving to analysis, alternatives, and the joint plan (action questions).

6) Avoid embedding a suggestion in a question. For example, "What would happen if…? What about…? How about trying…? What do you think about trying…? How would you feel about…?"

7) Avoid asking questions in order to get the person you are coaching to agree with what you are thinking. This often involves the predetermination

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of an answer or idea and a series of questions that lead the person being coached to this predetermined idea or answer.

8) Give the person being coached time to think and respond to the question being asked. Learn to be comfortable with silence. When faced with silence, you should not feel compelled to repeat the question, clarify the question, fill the quiet with talking, or immediately jump to making suggestions or sharing ideas.

9) Learn how to read non-verbal cues. When asking reflective questions, be aware of how the person you are coaching is reacting to the process. If you sense or perceive that the person is uncomfortable or even annoyed, reflect on your coaching skills. For example, are you drilling the person you are coaching, coaxing him/her to answer in the way you want, not allowing for thinking time, or not listening to the person's answers?

10) When the person you are coaching says, "Just tell me what I need to do" or "Don't coach me, just tell me," respond by letting the person know that in order to be most helpful, you at least have to get an idea of what s/he already knows or is doing so you can match the information you will share to his/her interests, needs, lifestyle, etc. People are more likely to act on information if they have a part in developing it and it is tailored to their specific situations, which is what you are trying to do.

11) When the person you are coaching responds to a reflective question by saying, "I don't know," you have two options: (a) If you think the person knows the answer to the question based on previous information the person has shared or an action on his/her part that you observed, then rephrase the question to ensure the person understands or point out the example; or (b) If you do not know the person's level of knowledge related to the question being asked, share information, and then ask the person how that matches his/her current understanding, priorities, ideas, etc.

12) When coaching someone who is really quiet/shy, do not be intimidated or overly concerned by periods of silence. Individuals who are internal processors like to think about what they are going to say before responding. Learn to be quiet and allow silence for the other person to get his/her thoughts together. Be sure to ask open-ended as opposed to yes/no questions. Ask the person to give you specific examples or elaborate on his/her responses.

13) Coaching child care providers and preschool teachers must occur "on the fly" as they are preparing for the next activity, transitioning between activities, or involved in an activity in which you can take part and help with the other children while s/he interacts with the child who is the reason for your support. Since child care providers and preschool teachers are so busy, they must see the benefit of having you in their classroom and working with them.

14) If the person being coached has a tendency to jump from topic to topic, the coach should ask the coaching partner if (a) it would be alright to develop a plan around one topic before moving to the next, (b) he or she is ready to change topics or needs to finish the previous topic before moving on, (c) the coach could write the new topic down and then promise to come back to it upon completion of the previous topic, or (d) he or she prefers to come to resolution and a plan for all topics at the conclusion of the conversation.

15) Coaching through an interpreter requires explaining the process of coaching to the interpreter preferably before the coaching conversation. The interpreter must understand that you need him/her to interpret everything you say to the parent and everything the parent says back to you.

16) Supervisors may use coaching with the people they supervise and a coach can also be the supervisor of a person s/he is coaching. When using coaching, a supervisor must be clear with the other person whether the present conversation is intended to be a coaching or supervisory conversation. Coaching conversations are for the purpose of learning and development, whereas supervisory conversations are about specific job performance in relation to expectations as well as program policies and procedures.

17) Observation of the parent or care provider practicing or using recently discussed ideas and strategies is a critical characteristic of the coaching process and provides an opportunity to promote further reflection and provide feedback. Some questions and comments to prompt an opportunity for observation are: "Let's try it. Can we try that now? Would you mind showing me how you do that? How would that look/how does that look when you do it? How about you try? How about you take a turn? Let's see the two of you do it? Would you be comfortable trying this while I watch?"

18) Modeling a behavior or activity with the child for the parent or care provider may be done to determine how a jointly developed idea or strategy might work or

to show the parent or care provider how what you are talking about might look. Prior to modeling, (a) explain to the parent or care provider what you are going to do and why, (b) give the parent or care provider something specific to watch for or to do, (c) debrief with the parent or care provider what you did with the child, (d) invite the parent or care provider to try what you modeled, (e) reflect on how this worked when the parent did it, and (f) develop a plan for how this can happen when you are not present.

19) Affirmative feedback is non-committal acknowledgement used to let the person you are coaching know that you hear and understand what s/he is saying without agreeing, disagreeing, or making any other type of judgment. Examples of affirmative feedback include, but are not limited to: "I see, I understand, I know what you mean, I hear what you are saying, What I am hearing you say is _____, You seem really (label the emotion you are perceiving)."

20) Evaluative feedback is a judgment of what you see the person doing or hear the person saying. Examples of evaluative feedback may include, but are not limited to: "Great, Good job, That's a good idea, You're really smart to think of that, Excellent thinking, Way to go, mom!, That's just super, I like the way you _____, I would agree with that, That's how I would do it, You are really a good dad." Practitioners should avoid overuse of positive evaluative feedback.

21) Directive feedback involves telling the person what to do in situations where clear and present danger exists

and the coach does not have time to engage the other person in a coaching conversation.

22) Informative feedback is sharing knowledge and information with the person being coached that is directly related to an observation, action, reflection, or direct question. Sharing information prior to reflection may be necessary when you know without a doubt that the person you are coaching has no prior knowledge of the content or situation, thereby has no foundation on which to be coached. In most instances, however, informative feedback follows reflection.

23) The joint plan can be developed either (a) as you proceed through the coaching conversation by noting with the person you are coaching what you each agree to do as a result of a conversation item or (b) at the end of the conversation by reviewing all of the actions, observations, and topics discussed, then determining together what could occur between coaching conversations.

24) Instead of the coach summarizing the joint plan, ask the person you are coaching: "What would you like to focus on between now and our next visit? Based upon all that we've discussed today, what is your plan? What would you like to accomplish between now and the next time we talk?"

25) When the joint plan from the previous session was not the priority of the person being coached, thus not completed between visits, you should first ask yourself if the plan was truly a joint plan or if it was really your suggestion or recommendation. If the former, then you may ask the person at some point during the conversation if the previous plan is still a priority and if so, when/how s/he will go about implementing it. If the joint plan never seems to be a priority for the person being coached, you may need to have an upfronting conversation similar to, "I've noticed that we have developed a joint plan every week for the past three weeks, but so far you haven't been able to implement the plan. Is this still a priority for you? (If so) How can we modify the plan so that it will be useful for you?"

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Take A Closer Look:

Read or download the CASEinPoint on the operational definition of coaching and characteristics of coaching practices at www.fippcase.org: Rush, D. & Shelden, M. (2005). Evidence-based definition of coaching practices. CASEinPoint, 1(6), 1-6.

CASEtools
Instruments and Procedures for Implementing Early Childhood and Family Support Practices

A Framework for Reflective Questioning When Using a Coaching Interaction Style

Dathan D. Rush
M'Lisa L. Shelden
Melinda Raab

This *CASE*tool describes the development and use of the *Framework for Reflective Questioning* for assisting individuals using a coaching style of interaction or adult learning in promoting reflection on the part of another person when using a capacity-building approach. The framework is used to guide the coach in the type and content of reflective questions to ask when assisting another person in reflecting on his or her past, current, and/or future actions. A coach can use the framework for promoting the reflection of a parent, caregiver, or colleague as well as for self-reflection to assess how his or her own practices are consistent with evidence-based practices.

INTRODUCTION

This *CASE*tool includes a description of the development and use of the *Framework for Reflective Questioning*. The framework is useful for assisting coaches in promoting reflection on the part of another person when using a capacity-building approach in early childhood intervention. This article includes an overview of reflection as a component of capacity-building and a characteristic of coaching practices, a description of the framework for reflective questioning, and an explanation of how to use the framework. *CASE*inPoint documents on capacity-building and coaching practices provide more in-depth information on the evidence to support this practice and a more detailed description of the characteristics and indicators of those practices (Rush & Shelden, 2005a; Wilson, Holbert, & Sexton, 2006). *CASE*makers list additional references related to the characteristics and consequences of capacity-building and coaching practices (Rush & Shelden, 2005b; Wilson, 2005).

REFLECTION AS A COMPONENT OF A CAPACITY-BUILDING PROCESS

Reflection is a means of coming to a deeper understanding of what a person already knows/is doing and/or what modifications or new knowledge/skills might be necessary in current and future situations to obtain a desired outcome. Reflection and active participation/engagement on the part of the person being coached are used to strengthen that person's competence related to what he/she knows to do, and build upon current knowledge or skills to acquire new ideas and actions. As a result, the person's confidence is enhanced. This enhanced confidence causes the person to continue to do what works as

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well as try new iterations and evaluate the effectiveness of these actions. The more the person's capacity has been built (i.e., increased confidence and competence), the better the person becomes at more independently achieving his/her desired outcomes now and in the future. The benefits of a capacity-building process are acquisition and use of new knowledge and skills as well as self-attribution related to his/her role in realizing the intended effects (Wilson, Holbert, & Sexton, 2006). The role of a coach is to mobilize experiences, interactions, and opportunities in conjunction with mediating the person's deeper understanding of what is or could be working in order to reach the end goal. This process is consistent with the literature on adult learning by (1) starting with what the person already knows or is doing related to his/her identified priorities, (2) building upon existing knowledge and skills, (3) applying the new information and strategies in meaningful contexts, and then (4) evaluating the effectiveness of his/her actions and generating alternative approaches (Bransford et al., 2000).

COACHING PRACTICES

Coaching is an adult learning strategy that is used to build the capacity of a parent, caregiver, or colleague to improve existing abilities, develop new skills, and gain a deeper understanding of his or her practices for use in current and future situations (Hanft, Rush, & Shelden, 2004; Rush & Shelden, 2005a; Rush, Shelden, & Hanft, 2003). Effective helpgiving includes both participatory (i.e., responsive supports by the helpgiver that promote active involvement by the help receiver in decision-making) and relational (i.e., good interpersonal skills and asset-based beliefs about families by the helpgiver) components, which combined result in family-centered practices (Dunst & Trivette, 1996; Dunst, Trivette, & LaPointe, 1992; Rappaport, 1981; Trivette & Dunst, 1998). In early childhood, coaching may be conceptualized as a particular type of helpgiving practice within a capacity building model to support people in using existing abilities and developing new skills to attain desired child and family outcomes. As part of early childhood practices, coaching promotes self-reflection and refinement by the person being coached on his or her current knowledge and skills. The intended outcome of coaching is competence and mastery of desired skills of the person receiving coaching (Doyle, 1999; Hanft, Rush, & Shelden; Rush, Shelden, & Hanft).

In early childhood intervention programs, coaching builds the capacity of family members to promote the child's learning and development. The key people in a child's life gain competence when a coach supports them in blending new or existing knowledge, skills, and experience to interact with a child in everyday situations, and then assess and perhaps improve upon the results. Early childhood practitioners who use coaching facilitate an interactive information discovery and sharing process based on the parent's intentions and current level of knowledge and skills necessary to promote the child's participation in family, community, and early childhood settings (Bruder & Dunst, 1999; Hanft, Rush, & Shelden, 2004).

The characteristics of an effective coaching process as found in the research literature are: (1) joint planning, (2) observation, (3) action/practice, (4) reflection, and (5) feedback (Rush & Shelden, 2005a). Joint planning occurs as a part of all coaching conversations, which typically involves discussion of what the person receiving coaching supports (i.e., parent, colleague, care provider) intends to do between coaching interactions to use the information discussed or skills that were practiced. Observation generally refers to opportunities when: (a) the coach directly observes an action on the part of the person being coached, which then provides an opportunity for later reflection and discussion, or (b) the person receiving coaching observes modeling by the coach during which the coach may build upon what the person receiving coaching is already doing and demonstrate additional strategies. After modeling occurs, the coach and person being coached discuss how the example matches the intent of the person being coached and/or what research informs us about the coaching topic. The characteristic of action provides opportunities for the person being coached to use the information discussed with the coach or practice newly learned skills during or between coaching interactions. Reflection follows an observation or action and provides the person receiving coaching supports with an opportunity to analyze current strategies and refine his/her knowledge and skills. Feedback occurs after the person being coached has the opportunity to reflect on his/her observations, actions, or opportunity to practice new skills. As part of feedback, the coach may affirm the other person's reflections and/or add information to deepen his/her understanding of the topic being discussed.

REFLECTION AS A CHARACTERISTIC OF COACHING PRACTICES

The coaching characteristic of reflection differentiates the coaching process from basic problem-solving approaches used by practitioners, parents, and other caregivers or a consultative model in which the consultant

asks questions to learn and decide what information he or she can then share with the consultee. Within a coaching approach, reflection is the analysis of existing strategies to determine how the strategies are consistent with evidence-based practices and may need to be implemented without change or modified to obtain the intended outcome(s). Schon (1983, 1987) defines three types of reflection: reflection *in* action, reflection *on* action, and reflection *for* action. The purpose of reflection is to build the capacity of another person in such a way as to promote ongoing self-assessment, planning, and knowledge/skill acquisition by teaching the person receiving coaching supports to be aware of, continually examine, and refine his or her current practices and behavior (Gallacher, 1997; Gilkerson, 2004). When operationalizing the coaching characteristic of reflection, the coach supports the person being coached in building upon what he/she already knows, is doing, has tried, and thinks about within the context of a specific situation as well as generalized to other situations and circumstances. Through a process of reflective questioning and feedback the coach promotes the other person's ability to analyze existing strategies and develop alternatives to build upon current strengths and address identified priorities leading to a plan for action.

THE FRAMEWORK FOR REFLECTIVE QUESTIONING

The capacity-building model and reflection as a characteristic of a coaching interaction style for supporting families and colleagues as part of early childhood intervention (Hanft, Rush, & Shelden, 2004; Rush, Shelden, & Hanft, 2003; Wilson, Holbert, & Sexton, 2006) were used to conceptualize the *Framework for Reflective Questioning.* The four types of reflective questions and types of content were developed based on a review of the literature on capacity-building, coaching, and reflection (Costa & Garmston, 1994; Kinlaw, 1999; Rush, 2004; Schon, 1987; Whitmore, 1996). A pool of questions was identified by a task group of individuals at the Family, Infant and Preschool Program that was examining how coaching could be used to support parents and practitioners in the use of natural learning environment practices. The task group reviewed each question for relevance and to ensure it was stated broadly enough to be used in multiple coaching contexts. Additionally, the task group organized the questions by type and content. Once in a draft format, the framework was then used by the task group members as part of their coaching interactions with families. Feedback was used to make changes and additions to questions on the framework. The *Framework for Reflective Questioning* and instructions for use are included in the Appendix.

The framework consists of four different types of open-ended reflective questions: awareness, analysis, alternatives, and action. *Awareness* questions are used to promote the understanding of what the person being coached already knows or is doing, and how effective the current strategies are (e.g., What have you tried?). Awareness questions may be used initially by the coach to clarify the situation or issue for both the coach and person receiving coaching supports. *Analysis* questions are asked to support the other person in examining how what is currently happening matches what he or she wants to have happen, what we know about child development, and/or evidence-based practices (e.g., How does that compare to what you would like to have happen?). *Alternatives* questions are used to provide the person receiving coaching with an opportunity to consider a variety of possible options to obtain the desired results (What are all the possible options to consider?). *Action* questions assist in developing the joint plan of what the coach and parent, caregiver, or colleague are going to do between coaching interactions as a result of the current conversation (e.g., Who is going to do what before the next time we meet?).

Reflective questions pertain to four different types of content: knowledge/understanding, practice, outcomes, and evaluation. Reflective questions related to *knowledge* and *understanding* are used to assist the person being coached in identifying what he or she currently knows about a particular topic. Questions containing content that focuses on *practice* helps the person explore actually what he or she is doing or has done in the particular situation. Questions about *outcomes* cause the person to think about current or intended results. Reflective questions with content based on *evaluation* ask the person receiving coaching supports to make judgments about the usefulness of opportunities to recognize what he/she already knows or is doing as well as new skills and knowledge he/she desires to learn.

The *Framework for Reflective Questioning* is not designed for use in a linear method. Rather, the questions may be used as they would naturally occur in a conversation and are highly dependent on the questions or comments made by the person receiving coaching supports. During a coaching conversation, the coach generally uses knowledge, practice, and outcomes questions as part of the variety of reflective questions that may be used in a given conversation. A goal of the coach is always to assist the other person in developing a plan for action before

the conclusion of the coaching conversation. While the framework is a guide to the coach for the types of questions to use to promote the other person's reflection, the questions that may be asked during a coaching interaction are not limited to only the questions on the framework. Additional questions used during a coaching conversation can be modeled after questions on the framework based on the intent (type) and content of the question. The majority of questions asked should be analysis and action, and should be open-ended rather than a question requiring only a yes or no response.

USE OF THE FRAMEWORK

Most early childhood practitioners are very familiar with working closely with parents and other care providers of the children enrolled in their programs. The *Framework for Reflective Questioning* is a tool designed to help prepare the coach to streamline the conversation and maximize the potential for building the capacity of the person being coached. This tool assists coaches in having heightened awareness of the types of reflective questions he/she uses as the coach.

The *Framework for Reflective Questioning* may be used in a number of ways. First, the framework may assist an early childhood practitioner or other professional with learning how to use a coaching interaction style (i.e., ask a variety of questions, avoid using closed-ended yes/no questions, ask as few questions as necessary) (see Rush & Shelden, 2008). Second, more experienced coaches may use the framework in preparation for a coaching interaction with a parent, caregiver, or colleague. In this way, the coach can remind himself or herself with a variety of questions or question-stems that may be useful during the conversation. Third, the framework may be used by a person in a coaching role following a coaching interaction to assess and reflect on the types and content of questions asked that promoted parent reflection on his/her knowledge and skills as well as the link between his/her own actions and the desired outcomes. Coaches can then use their own reflections to identify changes they might make to strengthen their reflective questioning skills and to ensure their practices are consistent with the coaching characteristic of reflection. Fourth, the *Framework for Reflective Questioning* may be used by supervisors or peers following observation of a coaching interaction or discussion of a particular situation to assist another person to reflect on his or her use of reflective questioning or coaching practices in general. The supervisor or peer can use the framework as a guide for helping another person reflect on his/her practices against program practice standards or providing feedback related to an observation. Follow-up discussion then assists the supervisee or peer in identifying a plan for changes that would make his or her practices more consistent with the use of the characteristics of a coaching interaction style.

CONCLUSION

The *Framework for Reflective Questioning* can assist coaches in promoting reflection on the part of the person being coached when using a capacity-building approach and coaching interaction style with parents or colleagues. The framework consists of four different types of open-ended reflective questions: awareness, analysis, alternatives, and action. The types of questions may be related to content in four areas: knowledge/understanding, practice, outcomes, and evaluation. The framework may be used by both novice and seasoned coaches prior to or following a coaching interaction with a care provider as well as by supervisors, peers, and the coach himself/herself to reflect on his/her own coaching practices.

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Appendix

Framework for Reflective Questioning

Administration Procedure

The *Framework for Reflective Questioning* is used to assist coaches in promoting reflection on the part of another person when using a capacity-building process and a coaching style of interaction. The framework is used to guide the coach in the type and content of reflective questions to ask when assisting the other person in reflecting on his or her practices. A coach can use the framework for promoting the reflection of a parent, caregiver, or colleague as well as for self-reflection to assess how his or her own practices are consistent with evidence-based practices and program practice standards.

The framework consists of four different types of open-ended reflective questions: awareness, analysis, alternatives, and action. *Awareness* questions are used to promote a person's understanding of what he or she knows or is doing, and how effective the current strategies are. *Analysis* questions are asked to support a person in examining how what is currently happening matches what he or she wants to have happen, what we know about child development, and/or evidence-based practices and program standards. *Alternatives* questions are used to provide the other person with an opportunity to consider all of the options to obtain the desired results. *Action* questions assist in developing the joint plan of what the coach and person being coached are going to do between coaching interactions as a result of the current conversation.

Reflective questions pertain to four different types of content: knowledge and understanding, practice, outcomes, and evaluation. Reflective questions related to *knowledge and understanding* are used to assist the person being coached in identifying what he or she currently knows about a particular topic. Questions containing content that focuses on *practice* helps the other person explore what he/she is actually doing or has done in a particular situation. Questions about *outcomes* cause the person being coached to think about current or intended results. Reflective questions with content based on *evaluation* ask the person being coached to make judgments about the effectiveness of the coaching process.

The *Framework for Reflective Questioning* is not designed for use in a linear method. Rather, the questions may be used as they would naturally occur in a conversation and are highly dependent on the questions or comments made by the person receiving coaching supports. A goal of the coach is to assist the person being coached in developing a plan for action before the conclusion of the coaching conversation. While the framework is a guide to the coach for the types of questions to use to promote another person's reflection, the questions that may be asked during a coaching interaction are not limited only to the questions on the framework. Additional questions used during a coaching conversation can be modeled after questions on the framework based on the intent (type) and content of the question.

The majority of questions asked should be analysis and action, and should be open-ended rather than a question requiring only a yes or no response. Closed-ended questions that require only a yes/no response should be reserved for situations when the coach needs to ask permission and/or avoid making an assumption. Persons using the framework should avoid embedding a suggestion in a question (e.g., What would happen if…? What about…? How about trying…? What do you think about trying…?) or using questions to try and get the person being coached to answer in the way the coach is thinking.

Framework for Reflective Questioning

Question Type / Question Content	Awareness	Analysis	Alternatives	Action
Knowledge/ Understanding (What you know)	What do you know about…? What is your current understanding of (topic, situation)? *Probes (e.g.,):* How did you come to believe this?	How does that compare to what you want to know about…? How is that consistent with (standards, evidence)…? What do you know now after trying…? How does that compare with what you originally thought?	How could you find out about…? What different things could you do to learn more about …? What are other ways to view this for next time?	How do you plan to learn more about…? What option do you choose? Why? How are you going to put that into place? *Probes(e.g.,):* What resources do you have? What supports will you need? Where will you get them?
Practice (What you did)	How are you currently doing…? Why? What kinds of things did you do (have you done so far)? Why? What kinds of things did you try? Why? What kinds of things are you learning to do? What did you do that worked well? *Probes(e.g.,):* What is the present situation in more detail? Where does that occur most often? When did you first notice this?	How is that consistent with what you intended to do (wanted to do)? Why? How is that consistent with standards? Why?	What else could you have done to make practice consistent with standards? Why? What would you do differently next time? How might you go about doing that? What different ways could you approach this? *Probes(e.g.,):* What would it take for you to be able to do…? What would you need to do personally in order to do…?	What do you plan to do? When will you do this? What option did you choose? *Probes(e.g.,):* What types of supports will you need? What resources do you have? What would it take for you to be able to do…? What would you need to do personally in order to do…?
Outcomes (What was the result)	How did that work for you? What happened when you did…? Why? How effective was it to do that? What did you achieve when you did that? What went well? *Probes(e.g.,):* How do you feel about that? What do you think about…? How much control do you have over the outcome?	How did you know you needed to do something else? How did that match (or was different from) what you expected (or wanted) to happen? Why? How do these outcomes compare to expected outcomes based on standards of practice? What *should* happen if you're really doing (practice)? What brought about that result? *Probes(e.g.,):* How do you feel about that? What do you think about…?	What else might happen when you do …? Why? What different things could you have done to get expected outcomes? What might make it work even better next time?	Which option could get the best result? What do you plan to do differently next time? *Probes(e.g.,):* What types of supports will you need? What resources do you have/need? Where will you get them?
Evaluation (What about the process)	What opportunities were useful to you in achieving… (or in learning…)? In what way? How was it useful? Why? What supports were most helpful? What about the supports were most helpful?	How was that consistent with what you expected?	What other opportunities would be useful?	What opportunities do you want to access? How will you access those opportunities? *Probes (e.g.,):* What resources do you need? Where will you get them?

Framework for Reflective Questioning

Question Content \ Question Type	Awareness	Analysis	Alternatives	Action
Knowledge/ Understanding (What you know)	What do you know about…? What is your current understanding of (topic, situation)? *Probes (e.g.):* How did you come to believe this?	How does that compare to what you want to know about…? How is that consistent with (standards, evidence)…? What do you know now after trying…? How does that compare with what you originally thought?	How could you find out about…? What different things could you do to learn more about …? What are other ways to view this for next time?	How do you plan to learn more about…? What option do you choose? Why? How are you going to put that into place? *Probes (e.g.):* What resources do you have? What supports will you need? Where will you get them?
Practice (What you did)	How are you currently doing…? Why? What kinds of things did you do (have you done so far)? Why? What kinds of things did you try? Why? What kinds of things are you learning to do? What did you do that worked well? *Probes (e.g.):* What is the present situation in more detail? Where does that occur most often? When did you first notice this?	How is that consistent with what you intended to do (wanted to do)? Why? How is that consistent with standards? Why?	What else could you have done to make practice consistent with standards? Why? What would you do differently next time? How might you go about doing that? What different ways could you approach this? *Probes (e.g.):* What would it take for you to be able to do…? What would you need to do personally in order to do…?	What do you plan to do? When will you do this? What option did you choose? *Probes (e.g.):* What types of supports will you need? What resources do you have? What would it take for you to be able to do…? What would you need to do personally in order to do…?
Outcomes (What was the result)	How did that work for you? What happened when you did…? Why? How effective was it to do that? What did you achieve when you did that? What went well? *Probes (e.g.):* How do you feel about that? What do you think about…? How much control do you have over the outcome?	How did you know you needed to do something else? How did that match (or was different from) what you expected (or wanted) to happen? Why? How do these outcomes compare to expected outcomes based on standards of practice? What *should* happen if you're really doing (practice)? What brought about that result? *Probes (e.g.):* How do you feel about that? What do you think about…?	What else might happen when you do …? Why? What different things could you have done to get expected outcomes? What might make it work even better next time?	Which option could get the best result? What do you plan to do differently next time? *Probes (e.g.):* What types of supports will you need? What resources do you have/need? Where will you get them?
Evaluation (What about the process)	What opportunities were useful to you in achieving… (or in learning…)? In what way? How was it useful? Why? What supports were most helpful? What about the supports were most helpful?	How was that consistent with what you expected?	What other opportunities would be useful?	What opportunities do you want to access? How will you access those opportunities? *Probes (e.g.):* What resources do you need? Where will you get them?

Home Visit Rating Scales-Adapted & Extended: HOVRS-A+

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Overview:

The *Home Visit Rating Scales-Adapted & Extended* (HOVRS-A+) measure is designed for practitioners and supervisors seeking a ***high level of excellence*** in home visiting practices in programs aiming to help parents to support the early development of their infants and young children. As an extension of HOVRS-A (Roggman, et al., 2010), which was an adaptation of the original HOVRS (Roggman et al., 2008) measure, HOVRS-A+ has the improved ease of use of HOVRS-A along with the full range of rating scores of the original HOVRS. All versions of HOVRS emphasize a developmental parenting support approach that respects each family's strengths and culture. The HOVRS measures were developed with input from practitioners and supervisors in home visiting programs and rate aspects of home visiting quality that are supported by the research literature on various home visiting programs. HOVRS measures have been used to provide feedback to practitioners and supervisors for program improvement.

Description of the HOVRS-A+ Scales

SCALE 1–HOME VISITOR RESPONSIVENESS TO FAMILY

This scale assesses the extent to which the home visitor is (1) prepared for the home visit, (2) attempts to get needed information from the parent, (3) observes and responds to the parent and child during the home visit, and (4) elicits input on the content and activities of the home visit from the parent. A high rating on this scale suggests that the home visitor is frequently engaging in responsive behaviors during the home visit.

SCALE 2–HOME VISITOR-FAMILY RELATIONSHIP

This scale examines the nature of the relationship between the home visitor and the family, as observed during the home visit. It focuses on (1) warmth between the home visitor and parent, (2) parent comfort with the home visitor, (3) positive interactions of the home visitor with the child and other members of the family, and (4) the home visitor's respect and understanding of the family as a whole. A high rating on this scale suggests that the home visitor and family are frequently engaging in warm, positive behaviors during the home visit.

SCALE 3–HOME VISITOR FACILITATION OF PARENT-CHILD INTERACTION

This scale assesses the effectiveness of the home visitor at facilitating and promoting positive parent-child interactions during the home visit. It reflects how much the home visitor (1) encourages the parent's leadership when guiding parent-child interactions, (2) involves and responds to both the parent and the child during interactions, and (3) uses materials available in the home for promoting parent-child interactions. A high rating on this scale suggests that the home visitor is frequently engaging in facilitative behaviors during the home visit.

SCALE 4–HOME VISITOR NON-INTRUSIVENESS/COLLABORATION WITH FAMILY

This scale focuses on the lack of intrusiveness by the home visitor on parent behavior and parent-child interactions during the visit. It assesses (1)

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home visitor control and (2) home visitor flexibility and responsiveness. A high rating on this scale suggests that the home visitor rarely engages in intrusive behaviors during the home visit and that he or she uses effective strategies to collaborate with the parent. A high rating on this scale means the home visitor is non-intrusive in a manner that promotes collaboration with the parent as a partner in supporting the child's development.

SCALE 5–PARENT-CHILD INTERACTION DURING HOME VISIT

This scale examines the nature of the parent-child relationship, as observed during the home visit. It assesses (1) parent-child warmth and physical closeness, (2) parent attentiveness to the child, (3) parent responsiveness to the child, and (4) parent-child joint attention. A high rating on this scale suggests that the parent and child are frequently engaging in warm, positive behaviors during the home visit.

SCALE 6–PARENT ENGAGEMENT DURING HOME VISIT

This scale examines the engagement of the parent and the activities of the home visit. It focuses on (1) parent interest, (2) parent involvement and initiative, and (3) the parent's physical closeness to the home visitor and child. A high rating on this scale suggests that the parent is frequently displaying behaviors that indicate interest and engagement in the home visit activities and discussions.

SCALE 7–CHILD ENGAGEMENT DURING HOME VISIT

This scale focuses on the child's engagement in the activities of the home visit. It focuses on (1) child involvement and (2) child interest. A high rating on this scale suggests that the child is frequently displaying behaviors that indicate engagement and interest in the home visit.

Psychometric properties:

High HOVRS scores reflect high quality home visits and predictive validity is demonstrated by significant correlations with positive outcomes for parents and children in a sample of families from two Early Head Start programs. The new HOVRS-A+ scales have been used reliably, with inter-rater agreement within one point for all scales across 10 observed home visits and scales showing good internal consistency (see below) based on a sample of 83 home visits from various programs. All HOVRS versions include seven rating scales: four for home visiting practices and three for the family engagement and interaction during home visits.

HOVRS-A+ scales (7 scales, *alpha* = .88):

Scales of *Home Visit Process Quality* (4 scales, *alpha* = .84):

- **Home Visitor Responsiveness to Family** (6 items, *alpha* = .69)
- **Home Visitor Relationship with Family** (8 items, *alpha* = .83)
- **Home Visitor Facilitation of Parent–Child Interaction** (6 items, *alpha* = .86)
- **Home Visitor Non-Intrusiveness & Collaboration** (5 items, *alpha* = .69)

Scales of *Home Visit Effectiveness* (3 scales, *alpha* = .74):

- **Parent–Child Interaction during Home Visit** (7 items, *alpha* = .90)

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- **Parent Engagement during Home Visit** (6 items, *alpha* = .83)
- **Child Engagement during Home Visit** (4 items, *alpha* = .91)

Instructions:
Like HOVRS-A, each scale on HOVRS-A+ lists indicators of different levels of quality for a particular home visit process. For each row of scale indicators, check at least one item. Check the item that comes closest to describing the observation even if not an exact match.

Observing either live or from video, the observer checks one indicator item in each row that best matches what is observed. Because the duration of a home visit observation may range from 15 to 90 minutes, it is helpful to check whatever is observed, even at a low level. Then if an indicator of higher quality makes the previous item inaccurate, simply cross out the previously checked item. For example, after observing the home visitor "occasionally gets more information by asking open-ended or follow-up questions," the observer should check that item, but if the home visitor continues to get more information in that way, this item should be crossed out and the higher quality item checked, "frequently gets more information by asking open-ended or follow-up questions."

If child is sleeping for over 75% of the visit, mark N/A ("not applicable") on any item related to interactions or observations involving child.

Scoring:
At the end of the observation, the observer decides on an overall rating, from 1 to 7, based on the pattern of items checked. For example, if most checked items are in the "Good" column, then the rating would most likely be a 5. If, however, items in the "Adequate" column also are checked (and not crossed out), the overall rating would most likely be a 4. If some items are in the 7 column, some in the 5 column, and 1 in another column, the rating would most likely be a 6. Items in the 1 column carry more weight. Multiple items in the 1 column should result in an overall low rating no higher than 2. Do not use items marked N/A to decide the overall rating.

Ratings from the first 4 scales may be summed to provide an index of *Process Quality*. Ratings from the last 3 scales may be summed to provide an index of *Effectiveness Quality*.

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Roggman, L. A., Cook, G. A., Jump Norman, V. K., Christiansen, K., Boyce, L. K., & Innocenti, M. S. (2008). Home Visit Rating Scales. In L. A. Roggman, L. K. Boyce, and M. S. Innocenti, *Developmental Parenting: A Guide for Early Childhood Practitioners* (pp. 209-217). Baltimore: Paul H. Brookes Publishing.

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*Roggman, L. A., Cook, G. A., Innocenti, M. S., Jump Norman, V. K., Christiansen, K., Boyce, L. K., Aikens, N., Boller, K., Paulsell, D., & Hallgren, K. (2010). *Home Visit Rating Scales—Adapted and Extended (HOVRS-A+)*. Unpublished Measure.

1. Home Visitor Responsiveness to Family

Inadequate 1	2	Adequate 3	4	Good 5	6	Excellent 7
Home visitor:		Home visitor:		Home visitor:		Home visitor:
☐ 1.1 does not plan well for the visit. ☐ 2.1 does not have necessary materials for the visit.		☐ 1.3 has a plan for the visit but does not ask for parent input for next visit. ☐ 2.3 is prepared for activities of the home visit (e.g., has necessary materials).		☐ 1.5 asks parents about activities to bring to future home visit(s). ☐ 2.5 brings or does activities selected by parents.		☐ 1.7 plans next visit with parent, **and** helps parent decide on activities, materials, & who will provide them. ☐ 2.7 emphasizes parent-selected activities **and** organizes home visit around them.
☐ 3.1 rarely asks questions to get more information.		☐ 3.3 occasionally gets more information by asking open-ended or follow-up questions.		☐ 3.5 frequently gets more information by asking open-ended or follow-up questions.		☐ 3.7 gets information from open-ended or follow-up questions **and** uses the information to increase effectiveness of home visit.
☐ 4.1 is not attentive to what parent and child are doing. ☐ 5.1 persists with activity that does not meet parent or child's interests or needs.		☐ 4.3 observes parent and/or child but does not always respond or react to what parent and child are doing when necessary. ☐ 5.3 occasionally follows parent and child lead in activities.		☐ 4.5 observes and reacts to parent and child by making comments, providing information, or suggesting activities. ☐ 5.5 frequently follows parent and child lead in activities, changing pace or activities to meet family interests or needs.		☐ 4.7 observes, reacts, **and** provides reflective feedback, ideas, and developmental information about parent-child interactions **or** child's development. ☐ 5.7 follows parent and child lead in activities, **and** acknowledges parent or child interests or needs.
☐ 6.1 directs agenda and activities of home visit or does not set or follow an agenda.		☐ 6.3 allows some input from parent on agenda and activities of home visit.		☐ 6.5 sets agenda and activities for home visit after getting input from family.		☐ 6.7 follows parent-suggested agenda and activities **and** provides additional related information to supplement activities.

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2. Home Visitor-Family Relationship

Inadequate 1	2	Adequate 3	4	Good 5	6	Excellent 7
Home visitor and parent:		Home visitor and parent:		Home visitor and parent:		Home visitor and parent:
☐ 1.1 rarely interact sociably with each other. ☐ 2.1 seem critical, condescending, tense, or detached with each other. ☐ 3.1 do not appear to enjoy visit.		☐ 1.3 occasionally interact sociably with each other. ☐ 2.3 interact with little to no tension but are not overly warm with each other. ☐ 3.3 occasionally appear to enjoy home visit (positive emotions & statements).		☐ 1.5 are relaxed and obviously enjoy interacting. ☐ 2.5 are warm and respectful of each other. ☐ 3.5 obviously enjoy home visit (positive emotions & statements).		☐ 1.7 are at ease, enjoy interacting, **and** readily discuss child's development and parenting. ☐ 2.7 show warmth, respect, **and** appreciation to each other. ☐ 3.7 consistently enjoy the visit **and** show understanding, humor or familiarity.
☐ 4.1 parent appears uncomfortable or uninterested in answering questions or speaking with home visitor.		☐ 4.3 parent answers questions but does not elaborate or initiate discussion.		☐ 4.5 parent shares information, problems, or concerns openly with home visitor.		☐ 4.7 parent shares information **and** initiates discussions on problems or concerns.
☐ 5.1 home visitor ignores family members other than parent and child. ☐ N/A-No other family members present ☐ 7.1 home visitor shows little to no familiarity with family.		☐ 5.3 home visitor interacts with family members other than parent and child but does not involve them in activities. ☐ N/A-No other family members present ☐ 7.3 home visitor shows some familiarity with family but does not ask questions beyond those dictated by home visit.		☐ 5.5 home visitor attempts to involve everyone in the room in activities. ☐ N/A- No other family members present ☐ 7.5 home visitor is interested in what is happening with the family as evident by familiarity with the family as well as by asking relevant questions.		☐ 5.7 home visitor involves everyone in the room in activities **and** with each other. ☐ N/A-No other family members present ☐ 7.7 home visitor asks relevant questions **and** asks how family situations affect child.
☐ 8.1 home visitor does not show respect or acceptance of family system. ☐ 9.1 home visitor brings up issues in an insensitive or disrespectful manner.		☐ 8.3 home visitor appears to be accepting of the family system. ☐ 9.3 home visitor tries to bring up issues in a sensitive or respectful manner but not always effectively.		☐ 8.5 home visitor shows respect and acceptance of the family system ☐ 9.5 home visitor brings up issues in a sensitive or respectful manner.		☐ 8.7 home visitor shows respect, acceptance, **and** talks about family's strengths. ☐ 9.7 home visitor brings up issues respectfully **and** asks questions to help parent reflect on parenting.

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3. Home Visitor Facilitation of Parent-Child Interaction

Inadequate 1	2	Adequate 3	4	Good 5	6	Excellent 7
Home visitor:		Home visitor:		Home visitor:		Home visitor:
☐ 1.1 rarely addresses parent-child interactions. ☐ 2.1 directs parent's interaction with child, telling parent what to do OR rarely addresses parent-child interaction.		☐ 1.3 tries to facilitate interactions, even if not always effectively. ☐ 2.3 supports parent's interactions with child, by commenting on observed parent-child interactions.		☐ 1.5 frequently facilitates parent-child interactions. ☐ 2.5 encourages parent's interaction with child, by discussing how observed interactions support child's development.		☐ 1.7 frequently facilitates parent-child interactions **and** supports interactions as needed without interrupting. ☐ 2.7 promotes parent-child interaction by describing, linking to this child's development, **and** expanding to other ways and places to do something similar.
☐ 3.1 interacts with either parent or child but not both. ☐ 4.1 rarely helps parent respond to child's cues for interaction. ☐ 5.1 does not provide encouragement or reinforcement for positive interactions between parent and child.		☐ 3.3 interacts with both parent & child but occasionally directs attention to only parent or child when there are opportunities to interact with both. ☐ 4.3 observes parent-child interactions & occasionally comments on child's cues or gives feedback to parent for interaction, but misses some opportunities. ☐ 5.3 occasionally provides encouragement or reinforcement for positive interactions between parent and child.		☐ 3.5 frequently interacts with both parent & child, excluding neither. ☐ 4.5 observes parent-child interaction and consistently provides appropriate comments on child's cues, suggestions, feedback, & questions to parent to promote parent-child interactions, rarely missing opportunities. ☐ 5.5 frequently provides encouragement or reinforcement for positive interactions between parent and child.		☐ 3.7 frequently interacts with both parent & child **and** helps sustain engagement of child with parent. ☐ 4.7 uses comments, suggestions, feedback, & questions to promote responsive parent-child interaction **and** expresses child's response by "speaking for child." ☐ 5.7 encourages or reinforces **and** prompts positive parent-child interactions.
☐ 6.1 does not bring or use materials or activities to promote parent-child interaction.		☐ 6.3 brings materials or activities to the home to promote parent-child interactions.		☐ 6.5 uses materials already in the home and/or family routines to promote parent-child interaction.		☐ 6.7 uses home's materials and routines **and** guides parents to identify new uses for household materials to support child's development.

*Roggman, L. A., Cook, G. A., Innocenti, M. S., Jump Norman, V. K., Christiansen, K., Boyce, L. K., Aikens, N., Boller, K., Paulsell, D., & Hallgren, K. (2010). *Home Visit Rating Scales—Adapted and Extended (HOVRS-A+)*. Unpublished Measure.

4. Home Visitor Non-Intrusiveness & Collaboration

Inadequate 1	2	Adequate 3	4	Good 5	6	Excellent 7
Home visitor:		Home visitor:		Home visitor:		Home visitor:
☐ 1.1 often tells parent what to do OR rarely make suggestions for what parent could do. ☐ 2.1 takes over activities or fails to provide guidance for parent-child interaction. ☐ 3.1 plays with or teaches child herself or fails to hand toys or other materials to parent and child.		☐ 1.3 makes suggestions for what parent could do, but not excessively. ☐ 2.3 occasionally guides aspects of parent-child interaction (e.g., provides reinforcement to child). ☐ 3.3 only occasionally hands toys or other materials to child instead of parent.		☐ 1.5 seeks and responds to parent ideas & interests for interactions. ☐ 2.5 sits back when parent-child interaction is ongoing and allows parent to control/direct interaction. ☐ 3.5 frequently hands toys and other materials for child to parent instead of to child.		☐ 1.7 seeks and responds to parent interests for interactions **and** encourages those interactions during home visit. ☐ 2.7 sits back when parent-child interaction is ongoing **and** actively observes, as evident from later reflective comments. ☐ 3.7 consistently hands toys or other materials for child to parent **and** asks how parent wants to use materials.
☐ 4.1 persists with activity too hard for or not of interest to parent or child or fails to respond to parent & child cues by changing pace or activities.		☐ 4.3 occasionally responds to parent &/or child cues (e.g., lack of interest, difficulty with task) by changing pace or activities.		☐ 4.5 frequently responds to parent &/or child cues (e.g., lack of interest, difficulty with task) by changing pace or activities when needed.		☐ 4.7 adapts pace or activities to parent &/or child cues **and** asks parent questions to help parent adapt or enrich interaction or activities with child.
☐ 5.1 is directive and frequently intrudes on or interrupts the parent-child interaction.		☐ 5.3 occasionally intrudes on or interrupts the parent-child interaction.		☐ 5.5 rarely intrudes on or interrupts the parent-child interaction.		☐ 5.7 Does not intrude on or interrupt parent-child interactions.

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5. Parent-Child Interaction During Home Visit

Inadequate 1	2	Adequate 3	4	Good 5	6	Excellent 7
Parent & Child:		Parent & Child:		Parent & Child:		Parent & Child:
☐ 1.1 interaction is minimal, negative, or nonresponsive. ☐ 2.1 have little to no positive physical contact. ☐ 3.1 are positioned away from each other during activities.		☐ 1.3 interact with some warmth (e.g., positive expressions or tone, smiling). ☐ 2.3 occasionally make positive physical contact, but touch may more often be instrumental (i.e., with purpose of accomplishing something like moving child, wiping child's nose, etc.) ☐ 3.3 are occasionally in close physical proximity during activities.		☐ 1.5 interact with a great deal of warmth (e.g., positive expressions or tone, smiling). ☐ 2.5 frequently make positive physical contact. ☐ 3.5 frequently remain in close physical proximity during activities.		☐ 1.7 interact with warmth **and** show appreciation to each other. ☐ 2.7 make positive physical contact during home visit activities **and** contact is helpful or affectionate without being intrusive. ☐ 3.7 remain in close physical proximity during activities **and** readily engage in positive interactions during activities.
☐ 4.1 parent is rarely attentive to what child is doing.		☐ 4.3 parent tries to attend to what child is doing but occasionally does not.		☐ 4.5 parent frequently attends to what child is doing.		☐ 4.7 parent consistently attends to what child is doing **and** sometimes describes child's behavior.
☐ 5.1 parent is not responsive or responds negatively to child's behavior, vocalizations, or emotional expressions during the home visit. ☐ 6.1 parent persists in activities that child is not interested in or when child is looking at or reaching for other things.		☐ 5.3 parent occasionally responds positively to child's behavior, vocalizations, or emotional expressions during home visit. ☐ 6.3 parent occasionally changes pace or activity to meet child's interest or needs (based on where child looks, what child reaches for, emotions child expresses).		☐ 5.5 parent frequently responds positively to child's behavior, vocalizations, or emotional expressions during visit. ☐ 6.5 parent frequently changes pace or activity to meet child's interest or need (based on where child looks, what child reaches for, emotions child expresses).		☐ 5.7 parent typically responds positively to child's behavior, vocalizations, or expressions **and** encourages or supports child's learning and development. ☐ 6.7 parent adapts activities to child's interest or need **and** shows enthusiasm about what child is doing.
☐ 7.1 are rarely engaged in activities together during the home visit.		☐ 7.3 are engaged in activities together on and off during the home visit.		☐ 7.5 are frequently engaged in activities together during the home visit.		☐ 7.7 are engaged together in all the parent-child home visit activities **and** consistently enjoy the

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						interactions.

6. Parent Engagement During Home Visit

Inadequate 1	2	Adequate 3	4	Good 5	6	Excellent 7
Parent:		Parent:		Parent:		Parent:
☐ 1.1 does not indicate interest in material or activities. ☐ 2.1 does not participate in home visit activities; is distracted or involved in another activity. ☐ 3.1 leaves the room.		☐ 1.3 indicates occasional interest in home visit material or activities. ☐ 2.3 occasionally participates in activities. ☐ 3.3 when participating in activities, is more passive than active.		☐ 1.5 frequently appears interested in home visit activities or materials. ☐ 2.5 is an active participant in activities. ☐ 3.5 engages in play and learning activities with child and/or home visitor whenever opportunity is available.		☐ 1.7 is consistently interested in visit activities and materials **and** identifies other activities and materials to try with child. ☐ 2.7 is an active participant **and** maintains focus on home visit topics and activities. ☐ 3.7 actively engages in play and activities **and** shows enthusiasm about doing activities.
☐ 4.1 does not initiate activities or conversations with child or home visitor; home visitor must prompt parent to engage in activities or interactions. ☐ 5.1 rarely asks or answers questions		☐ 4.3 occasionally initiates activities. ☐ 5.3 occasionally asks or answers questions but does not elaborate.		☐ 4.5 frequently initiates activities. ☐ 5.5 frequently asks questions, initiates discussions, or provides information related to topic of discussion.		☐ 4.7 initiates activities **and** bases activities or conversations on child's interests or behavior. ☐ 5.7 initiates conversations and offers information **and** topics that are related to child's development or family well-being.
☐ 6.1 positions self away from home visitor and child.		☐ 6.3 is in proximity to home visitor and child during most of the home visit.		☐ 6.5 remains in close proximity to child and home visitor throughout visit.		☐ 6.7 is in close proximity to child and home visitor throughout visit **and** readily interacts with both.

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7. Child Engagement During Home Visit

Inadequate 1	2	Adequate 3	4	Good 5	6	Excellent 7
Child:		Child:		Child:		Child:
☐ 1.1 does not participate in home visit activities. ☐ 2.1 cries when coaxed to participate in activities or interactions during home visit. ☐ NA for infants under 12 months ☐ 3.1 does not interact with parent and/or home visitor.		☐ 1.3 sometimes participates in home visit activities. ☐ 2.3 requires coaxing to participate in activities or interactions during home visit. ☐ NA for infants under 12 months ☐ 3.3 sometimes interacts with the parent and/or home visitor (including through body language, gaze, gestures, or vocalizations).		☐ 1.5 frequently participates in home visit activities. ☐ 2.5 tries to initiate activities or interactions during home visit. ☐ NA for infants under 12 months ☐ 3.5 frequently interacts with the parent and/or home visitor (including through body language, gaze, gestures, or vocalizations).		☐ 1.7 participates in all the child/parent-child home visit activities **and** actively engages with both materials and parent. ☐ 2.7 initiates activities or interactions **and** initiations are successful and appropriate. ☐ NA for infants under 12 months ☐ 3.7 interacts with parent and home visitor **and** sustains positive interactions.
☐ 4.1 does not appear interested in the home visit activities (for example, through gaze or body language).		☐ 4.3 indicates occasional interest in home visit activities (for example, through gaze or body language).		☐ 4.5 frequently shows interest in home visit activities (for example, through gaze or body language).		☐ 4.7 consistently shows interest in child/parent-child home visit activities **and** shows enthusiasm when doing activities.

Additional comments and considerations:

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Needs Assessment for Teaching Practices

Teacher Name: _____ Date: _____

Instructions: Each of the questions below relate to effective teaching practices for supporting children's learning. Read each question and consider how often you do this teaching practice using the 1 to 5 rankings. Once you have completed the rankings, consider if you would like to do this teaching practice more. Identify the top 5 teaching practices you would like more support and help to use in the classroom. Use the notes section to write your initial ideas about what might help you use this practice.

Teaching Practice	How Often Do You Use this Practice?					Change needed?	Priority (Top 5)	Notes
	Never	Seldom	***Some-times***	Usually	***Always***			
Engaging Interactions & Environments: Well-Organized Classrooms								
1. Do you prepare for teaching and instructional activities in advance and have materials ready and accessible?	1	2	3	4	5	Yes No		
2. Do you use classroom rules to help clarify expectations (what children should do) for specific activities?	1	2	3	4	5	Yes No		
3. Do you plan the classroom schedule to provide a balanced set of activities and routines?	1	2	3	4	5	Yes No		
4. Do you provide a visual schedule and use it to help children understand what is currently happening in class and what will happen throughout the day?	1	2	3	4	5	Yes No		
Engaging Interactions & Environments: Social and Emotional Support								
5. Are your interactions with children responsive and supportive?	1	2	3	4	5	Yes No		

Needs Assessment for Teaching Practices

Teaching Practice	How Often Do You Use this Practice?					Change needed?	Priority (Top 5)	Notes
	Never	Seldom	***Some-times***	Usually	***Always***			
6. Do you identify children's interests and use them to guide interactions and activities with children?	1	2	3	4	5	Yes No		
7. Are you moving around the classroom to interact and engage with children in play and learning activities, including daily routines?	1	2	3	4	5	Yes No		
8. Do you use strategies that promote peer interactions including sharing, cooperation, and play?	1	2	3	4	5	Yes No		
Engaging Interactions & Environments: Instructional Interactions and Materials								
9. Do you arrange classroom activities and materials so that children can practice and learn new skills (e.g., offer limited work materials so children need to share, put high interest materials out of reach so children need to ask, "forget" a key idea so children can "remind" you)?	1	2	3	4	5	Yes No		
10. Are you offering children opportunities to make "choices" within activities?	1	2	3	4	5	Yes No		
11. Are you providing opportunities for children to actively engage, respond, talk, and make meaningful contributions during activities?	1	2	3	4	5	Yes No		

Needs Assessment for Teaching Practices

Teaching Practice	How Often Do You Use this Practice?					Change needed?	Priority (Top 5)	Notes
	Never	Seldom	***Some-times***	Usually	***Always***			
12. Do you use descriptive feedback so children know exactly what is expected and what they are doing well?	1	2	3	4	5	Yes No		
13. Do you vary the level of support children receive during classroom activities and tasks based on their individual abilities?	1	2	3	4	5	Yes No		
14. Are you modeling more complex language, problem-solving skills, and exploration and reasoning skills to expand children's experiences?	1	2	3	4	5	Yes No		
Research-Based Curricula and Teaching Practices								
15. Do you use intentional and systematic teaching procedures to support children's learning during ongoing activities, routines, and transitions?	1	2	3	4	5	Yes No		
16. Do you plan high quality appropriate learning targets for children and use them to guide teaching throughout the day?	1	2	3	4	5	Yes No		
17. Do you observe and record children's skills and progress during naturally occurring activities (i.e., activity-focused assessment) and use this information to inform planning, teaching, and decision-making?	1	2	3	4	5	Yes No		

Needs Assessment for Teaching Practices

Needs Assessment for Home Visiting Practices

Teacher Name: _____ Date: _____

Instructions: Each of the questions below relate to effective practices for supporting family relationships and children's learning.
Read each question and consider how often you do this practice using the 1 to 5 rankings.
Once you have completed the rankings, consider if you would like to do this practice more.
Identify the top 5 practices you would like more support and help to use on home visits.
Use the notes section to write your initial ideas about what might help you use this practice.

	How Often Do You Use this Practice?							
Home Visiting Practice	Never	Seldom	Some-times	Usually	Always	Change needed?	Priority (Top 5)	Notes
Home Visitor: Responsiveness (adapted from HOVRS –A+)								
Plans next visit with parent, and helps parent decide on activities, materials, & who will provide them.	1	2	3	4	5	Yes No		
Emphasizes parent-selected activities and organizes home visit around them.	1	2	3	4	5	Yes No		
Gets information from open-ended or follow-up questions and uses the information to increase effectiveness of home visit.	1	2	3	4	5	Yes No		
Observes, reacts, and provides reflective feedback, ideas, and developmental information about parent-child interactions or child's development.	1	2	3	4	5	Yes No		

Needs Assessment for Home Visiting Practices Continued…

Teacher Name: _____ Date: _____

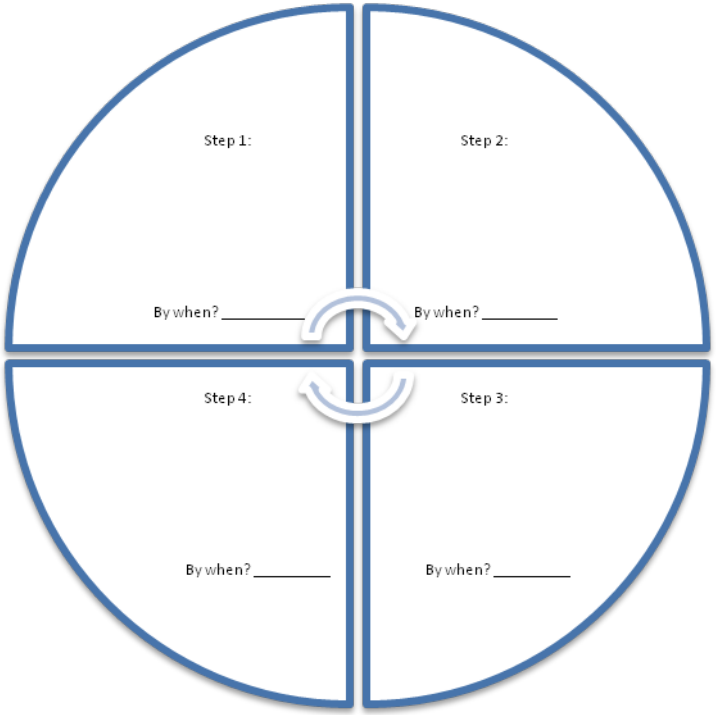
Instructions: Each of the questions below relate to effective practices for supporting family relationships and children's learning.
Read each question and consider how often you do this practice using the 1 to 5 rankings.
Once you have completed the rankings, consider if you would like to do this practice more.
Identify the top 5 practices you would like more support and help to use on home visits.
Use the notes section to write your initial ideas about what might help you use this practice.

	How Often Do You Use this Practice?							
Home Visiting Practice	Never	Seldom	Some-times	Usually	Always	Change needed?	Priority (Top 5)	Notes
Home Visitor: Skills (adapted from ZTT Core Competencies Domain #2 Family-Centered Practice- Skills)								
Ensures parents/caregivers are engaged in planning and responding to any health, learning or developmental needs of their child.	1	2	3	4	5	Yes No		
Establishes an ongoing alliance with families that supports their strengths, priorities and parenting practices.	1	2	3	4	5	Yes No		
Uses easily understandable language about social and emotional milestones to help family members promote healthy relationships with each other and with their very young child.	1	2	3	4	5	Yes No		

Professional Partnership Plan

Professional's Name/Title: _____ Date of Meeting: _____

Goal:



Strengths:

Notes/Comments:

Goal completed? Yes Partially No

Next meeting date:

Note: Date completion of each step in the pie.

Professional's Signature: _____ Mentor/Coach Signature: _____

Assessing Home Visit Quality

Dosage, Content, and Relationships

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A growing number of home visiting program models have been developed and implemented across the country to support parents with young children. Early childhood home visiting programs currently operate in all 50 states, with an estimated 400,000 to 500,000 families receiving services (Stoltzfus & Lynch, 2009). Several programs have been rigorously evaluated and have demonstrated evidence of effectiveness in a range of outcome domains such as parenting, maternal and child health, child development and school readiness, and family economic self-sufficiency (Daro, 2006; Gomby, 2005).

Home visiting is a service delivery strategy, but the content and focus of home visiting, as well as the characteristics of home visitors and the targeted outcomes, vary across program models. A number of models have developed specific fidelity standards and monitoring tools to ensure that families receive the dosage and content of home visiting services intended by program developers. Beyond program-specific fidelity measures, however, more information is needed about similarities and differences in dosage, content, and approaches across programs. Understanding what is common, what is unique, and what the targets of change are for a range of models can support identification of key factors that make home visits effective and inform the development of quality measures for assessing home visits. Program evaluations increasingly include careful documentation of the service delivery process in an effort to understand what is often referred to as the "black box" of service delivery (Chen, 2005; Hebbeler & Gerlach-Downie, 2002).

This article presents information on several characteristics of home visits that may be important for assessing home visit quality across program models, measurement strategies that can be used to assess them, and examples of how quality measures are being used in the field for program development, program management, and research purposes. Examples of measurement tools are presented primarily from three home visiting research initiatives: (a) the Evidence-Based Home Visiting to Prevent Child Maltreatment (EBHV) Cross-Site Evaluation funded by the Children's Bureau, Administration for Children and Families, (b) the Early Head Start Family and Child Experiences Study (Baby FACES) funded by the Office of Planning, Research and Evaluation at the Administration for Children and Families, and (c) formative research conducted to support the development of Partnering With Families for Early Learning (PFEL) sponsored by Thrive by Five Washington.

Abstract

Home visiting is a service delivery strategy, but the content and focus of home visiting, as well as the characteristics of home visitors and the targeted outcomes, vary across program models. Understanding what is common, what is unique, and what the targets of change are for a range of models can support identification of key factors that make home visits effective. This article presents information on several characteristics of home visits—dosage, content, and relationships—that may be important for assessing home visit quality across program models, measurement strategies that can be used to assess them, and examples of how quality measures are being used in the field for programmatic and research purposes.

Home Visit Characteristics That May Influence Quality

Key factors that may influence the effectiveness of home visiting programs include whether (a) the

participants receive the number of visits prescribed by program developers (dosage of services), (b) the expected content of the visits is conveyed, and (c) the relationship quality between the home visitor and the family is strong. Collecting this information is crucial to understanding whether the program developers' vision for conducting the home visits is fulfilled and the extent to which home visitors are able to develop meaningful relationships with families. The sections that follow describe each of these factors and strategies for measuring them.

Dosage of Services

The degree and scope of desired outcomes of home visiting programs usually drives the expected frequency, duration, and length of home visits. For example, Nurse-Family Partnership targets improved pregnancy outcomes, health and development of children, and parent self-sufficiency; it is among the most intensive programs (Olds, Sadler, & Kitzman, 2007). To accomplish program goals, nurses visit a pregnant mother in her home during pregnancy and through the child's second birthday. Nurses conduct weekly home visits for the first month after enrollment and then every other week until the baby is born. Visits occur weekly for the first 6 weeks after the baby is born, then every other week until the baby is 20 months old, and then monthly until the child is 2 years old. Visits typically last from 60 to 90 minutes. Other home visiting programs for parents with more focused outcomes require fewer visits over shorter periods of time. For example, SafeCare, a direct teaching model focused on reducing child maltreatment, works with parents on planning positive and enjoyable activities with their children, responding appropriately to child behaviors, and addressing health and safety issues. It requires weekly 1- to 2-hour visits over 18 to 26 weeks (Edwards & Lutzker, 2008; Lutzker & Bigelow, 2002).

There is evidence that home visiting programs with a range of dosage requirements are effective at improving targeted outcomes (Gomby, 2005; Stoltzfus & Lynch, 2005). Moreover, positive effects have been found even when participants drop out before completing the program (e.g., a Nurse-Family Partnership study found impacts on targeted outcomes even though 38% of families in the program group were no longer enrolled when their children reached age 2 years; Olds et al., 2004). Some studies of home visiting have varied the dosage and found that less exposure yielded outcomes comparable to those found when targeted exposure was greater. For example, a small study of Family Connections found that a group of families randomly assigned to receive 3 months of home visiting had comparable impacts to a group assigned to receive 9 months of services (DePanfilis & Dubowitz, 2005).

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Several ongoing evaluations are collecting data about how the quality of home visits may be linked to child and family outcomes.

Why Measure Dosage? Measuring dosage is important for several reasons. First, measuring dosage will help a program assess the extent to which it is being implemented with fidelity to the program developer's requirements for the intensity of service delivery. In the context of an evaluation, documenting dosage is important for understanding whether a study represents a good test of the program model and for interpreting the evaluation results. For program management and improvement purposes, data on dosage can facilitate identification of implementation issues that prevent home visitors from completing the intended number of visits and aid in the development of solutions. Similarly, dosage data can help programs identify reasons why some families leave the program before completing it.

Strategies for Measuring Dosage. The main method for documenting the dosage of home visits is to require home visitors to maintain a written record of each scheduled visit (completed or not) using a standard format (see box Measurement Tools for Tracking Dosage for two examples). Records could be kept either electronically, as part of a program's management information system, or in paper format. Ideally, paper forms would be entered into a management information system that can produce reports. Individual home visit records can then be

Measurement Tools for Tracking Dosage

For the EBHV cross-site evaluation, home visitors complete a Home Visiting Encounter Form to document (Barrett, Zaveri, & Strong, 2010):

- Whether a scheduled visit was completed
- The length of the visit in minutes
- The location of the visit

A Family/Child Program Exit Form captures:

- The date services ended
- The date of the last home visit
- The primary reason services ended

Baby FACES and the PFEL formative study used a Characteristics and Content Form, adapted from a form used on the Early Head Start Research and Evaluation Project, to record (Boller, Vogel, Chazan-Cohen, Aikens, & Hallgren, 2009; Hallgren, Boller, & Paulsell, 2010):

- The length of visit in minutes
- Percent of time the focus child was awake
- Participants in the visits (not including the home visitor, parent(s), and child), such as an interpreter, Part C provider, other children, other program staff, other health professionals, and other adults
- Language in which the home visit was conducted

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Mothers were more engaged in home visits when the visit focused on child development or family dynamics.

used to create tracking reports that display the dosage of services received by individual families or an average for the caseloads of individual home visitors. In addition, home visitors can use program exit forms to capture the reasons why services ended prior to program completion.

Content of Home Visits

Home visiting content is influenced by whether the program uses a specific curriculum or a more general approach and by the theory of change home visitors use to focus their work with families on targeted outcomes. Many program models and curricula developers, or their technical support offices, provide materials and training for home visitors and supervisors on how to use the approach. The curricula often include tools home visitors can use with families such as assessments of children's developments and families' strengths and needs, visit-by-visit activity plans, and educational materials to leave with families.

Why Measure Content? Systematic documentation of the activities carried out and of the information provided to families during home visits is important for determining both whether the content, as delivered, reflects the program model's guidelines and how content varies over the course of families' enrollment and across families enrolled in a particular program. Although curriculum guidelines and training for home visitors is often provided, research shows that home visiting content is not always delivered as planned. For example, a study of two home visiting programs (Peterson, Luze, Eshbaugh, Jeon, & Kantz, 2007) showed that service content was not consistently delivered across families. Despite being an objective of the program, minimal time was spent facilitating parent–child interactions. Moreover, knowledge of the actual content covered in visits helps researchers identify the particular topics associated with positive parent and child outcomes. For example, Peterson and colleagues found that mothers were more engaged when the home visit focused on child development or family dynamics and less engaged when home visitors discussed community resources and referrals. In addition to measuring what content was covered during a visit, it may also be helpful to assess how well it was covered and how well the parents understood the material.

Strategies for Measuring Home Visit Content. Two primary strategies have been used to measure home visit content: (a) self-reports by home visitors about topics covered during a visit, as well as time allocation across topics and activities, and (b) observations of home visits using a structured coding system during a live observation of a visit or by coding videotapes of home visits (see box Measurement Tools for Assessing Content for specific examples). In addition, a parent questionnaire could be used periodically to assess how well the content is conveyed and understood by home visit participants.

Relationship Quality

The "heart" of home visiting is the relationship between the visitor and the participant (Roggman et al., 2008; Wasik & Bryant, 2001). In clinical and therapeutic settings, the idea of a "working alliance" between the clinician and client means that the helping relationship is rooted in a willing partnership that brings the parties together to address client issues in a respectful way (Horvath, 1994; Santos, 2005). Although home visiting models vary in their recommendations for developing this relationship, a few general principles drawn from social systems, family systems, and empowerment theory provide a foundation for implementing a strengths-based approach—such as developing rapport and trust, assessing strengths and needs regularly, honest and respectful communication, and a focus on empowering clients to identify solutions and actions (Dunst, Trivette, & Deal, 1994; Roggman et al., 2008; Wasik & Bryant, 2001). Many home visiting programs try to match visitors to families on the basis of important characteristics that may support relationship-building. Language is one factor, and some research supports the practice of matching based on characteristics such as race, ethnicity, and age (Wasik & Bryant, 2001).

Measurement Tools for Assessing Content

The EBHV Home Visiting Encounter Form captures (Barrett et al., 2010):

- Topics covered (tailored for specific program models) and the percentage of time devoted to each
- Percentage of planned content covered during the visit

The Characteristics and Content form used by Baby FACES and the PFEL formative study records (Boller et al., 2009; Hallgren et al., 2010):

- Activities conducted during the visit, including: provision of education and information, observation and assessment, goal setting and planning, problem solving, provision of emotional support to primary caregiver, observation of child–caregiver interactions, modeling or demonstrating interactions with the child, evaluation and feedback about child–caregiver interaction, and crisis intervention
- Percentage of time allocated to: child-focused activities, parent–family focused activities, building home visitor–family relationships, parent–child activities, and crisis management
- Topics covered during the visit and whether each was touched on, discussed for at least 10–15 minutes, or a primary focus of the visit: child health and development, parenting, primary caregiver health and well-being, and linkages to community services
- Distractions during the home visit and rating of the extent to which distractions impeded the delivery of content: television, radio, computer games, telephone, visitors, other children, and other adults
- An assessment by the home visitor of the extent to which the visit was conducted as planned, any modifications made to the visit plan, and the reason why modifications were made

Why Measure Relationship Quality? Collecting information about home visitor–family relationships is crucial to understanding how well home visitors are able to develop a meaningful relationship that facilitates the delivery of program content. Some research indicates that higher quality interactions are associated with better outcomes for children (Peterson et al., 2006; Roggman et al., 2006). The quality of the relationship between the home visitor and the parent may influence the effectiveness of care and the extent and quality of parent engagement and involvement in

the program (Korfmacher, Green, Spellman, & Thornburg 2007; Korfmacher,et al., 2008; Roggman et al., 2008). Evidence that higher quality relationships may contribute to outcomes has been found from observations of home visit quality, the study of therapeutic relationships, and, more recently, from home visiting studies (Santos, 2005).

Strategies for Measuring Relationship Quality. Two main strategies have been used to assess the quality of relationships between home visitors and families: (a) observations of home-visitor–family interactions during home visits, and (b) home visitor and participant reports about relationship quality (see boxes Tools for Measuring Relationship Quality: Observation Tools and Tools for Measuring Relationship Quality: Home-Visitor–Participant Report).

Use of Home Visit Quality Measures in the Field

Increasingly, information about the quality of home visits—dosage, content, and relationships—is being used in the field to expand knowledge of home visiting as a service delivery strategy, assess its effectiveness, and continually improve practice. This section provides examples of ways in which the data collection strategies described earlier are being used in the context of research, program development, and program management.

Research

Several ongoing evaluations of home visiting programs are collecting data about the quality of home visits, with the goal of shedding light on what happens inside the "black box" of home visiting and how the quality of home visits may be linked to child and family outcomes.

The EBHV cross-site evaluation is collecting data on several dimensions of home visit quality as part of a fidelity study of home visiting programs being implemented by 17 grantees nationwide. Data collection activities include the use of a Home Visiting Encounter Form (Barrett et al., 2010) to track dosage and content, a Family/Child Program Exit Form (Barrett et al., 2010) to record reasons families drop out of programs before completing them, and periodic completion of the Working Alliance Inventory (Horvath, 1994; Santos, 2005; Tracey & Kokotovic, 1989) by home visitors and families. These data will be used to describe levels of program fidelity and quality both within and across the home visiting programs implemented by participating grantees, as well as to facilitate the identification of barriers to high-quality implementation of home visits and potential strategies for overcoming the barriers.

Baby FACES is conducting observations of a sample of home visits using the Characteristics and Content Form (Boller et al., 2009) and the HOVRS-A (Roggman, et al., 2010) as part of its descriptive study of Early Head Start program quality and of child and family outcomes. The study will document the quality of home visits, as well as the range of activities and topics covered during home visits, the length of the visits, the languages in which home visits are conducted, and the extent of alignment between home visitors' plans for the visits compared to the activities actually carried out in the home.

Formative Input to Program Development

In 2008–2009, Thrive by Five Washington, working with partners in two communities (White Center Early Learning Initiative in White Center, WA, and Ready by Five in Yakima, WA), began developing PFEL, a new home visiting program that draws on elements

Tools for Measuring Relationship Quality: Observation Tools

Home Visit Observation Form (McBride & Peterson, 1993) and **Home Visit Observation Form-Revised** (McBride & Peterson, 1996). These observation tools document the primary interaction partners (e.g., home visitor and parent), the content of the interactions, and the intervention strategies used during home visits. Data are collected during 30-second observation intervals for 10 minutes, taking a 2-minute break and repeating the cycle until the visit is complete or 60 minutes of data have been coded. The Revised form also includes a rating of maternal engagement at 10-minute intervals, using a 6-point scale.

Home Visit Rating Scales-Adapted (HOVRS-A; Roggman et al., 2010). The HOVRS-A was adapted from the Home Visit Rating Scales, a home visit observation measure created by Lori Roggman and her colleagues (Roggman et al., 2008). They originally developed the measure as an observation tool to help staff improve the quality of home visits. Researchers from Mathematica Policy Research adapted the original scales to facilitate their use by observers who do not have home visiting or clinical experience working with families. The scales are divided into two subscales:

1. **Home visitor strategies** comprises four scales that focus on the quality of the home visitor's strategies: (a) home visitor responsiveness to family, (b) home visitor relationship with family, (c) home visitor facilitation of parent–child interaction, and (d) home visitor nonintrusiveness.
2. **Participant engagement** comprises three scales that focus on how engaged the parent is with the home visitor and the child and how engaged the child is with the activities of the home visit: (a) parent–child interaction, (b) parent engagement, and (c) infant engagement.

Each scale has five potential ratings, with 3 anchor points at 1 (*inadequate*), 3 (*adequate*), and 5 (*good*). Lists of indicators are provided under the three anchors to help observers assign a rating. If any indicators listed under anchor 1 are observed, the observer automatically assigns a rating of 1, signifying major problems with the quality of the home visit that outweigh any potential positive aspects. The HOVRS-A was used as part of Baby FACES and the PFEL formative study.

Tools for Measuring Relationship Quality: Home-Visitor–Participant Report

Working Alliance Inventory (Horvath, 1994; Santos, 2005; Tracey & Kokotovic, 1989). This inventory, completed periodically by both the home visitor and the parent(s), assesses how home visitors and participants rate their level of collaboration and the extent to which they have similar goals and similar vision for the home visiting services provided. For example, do they agree on what to work on as part of the home visiting services? Do they share common goals on how to achieve this? Is there trust between the two? The Working Alliance Inventory includes 12 items—such as: parent/home visitor likes me, working towards mutually agreed upon goals, mutual trust, good understanding between us of the kind of changes that would be useful—that are rated on a 7-point scale. This scale is currently being used as part of the EBHV cross-site evaluation.

Helping Relationships Inventory (Poulin & Young, 1997). This inventory was developed to measure the quality of the helping relationship between a social worker and the client through assessment by both parties. Each version, one for the worker and one for the client, contains 20 items measured on a 5-point scale ranging from *not at all* to *a great deal*. Ten items address the structural components of the relationship such as the development of goals and progress being made. The other 10 items address interpersonal components such as whether the worker has an understanding of the family's problems and whether the worker has a calming effect on the family.

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Knowledge of the content covered in home visits helps researchers identify the topics associated with positive parent and child outcomes.

of Partners in Parenting Education (How to Read to Your Baby, 2010) and Promoting First Relationships (Promoting First Relationships 2008). As part of the development process, Mathematica conducted three rounds of home visit observations using the HOVRS-A and the Characteristics and Content Form and provided feedback to PFEL program staff on the results after each round. Program developers used the input to inform both the ongoing development of the PFEL model and the initial discussions about fidelity standards and measures. Although staff felt that these measures could be valuable tools for ongoing monitoring of quality and fidelity, they noted that additional modifications would need to be made, including aligning the Characteristics and Content Form to closely to the PFEL curriculum, determining how to appropriately weight HOVRS-A scales and indicators to align with PFEL, determining appropriate threshold scores for quality, and training staff. In addition, three potential concerns about the HOVRS-A emerged from the observations: (a) the instrument can be challenging to use for families with young infants when assessing interactions involving the child, (b) the HOVRS-A might not account for cultural differences in how parents engage with the home visitor, and (c) the HOVRS-A might not fully differentiate among upper-end scores (Hallgren et al., 2010).

Program Management

Many home visiting programs use reflective supervision techniques to provide oversight and support to home visitors (Eggbeer, Mann, & Seibel, 2007). This type of supervision is typically provided during regular one-on-one and group sessions. An important component of reflective supervision involves attending to the interpersonal nature of the work, including feelings about interactions with families, reflecting on experiences, and discussing the challenges of working with high-need families. Its goals are to provide guidance on content, support the home visitor in strengthening relationships with families, and reduce staff burn out and turnover.

Developing tools and systems to monitor home visit quality for program management purposes can augment the usefulness of reflective supervision by providing managers and supervisors with important information to monitor implementation and also by identifying home visitors who may need additional support and families who are particularly challenging to engage in services. Data collected through home visit records, tracking reports, observations, and self-report tools can be reviewed periodically by home visiting supervisors and managers for several purposes:

- To monitor dosage of home visits received by families enrolled in the program for varying lengths of time
- To monitor the performance of individual home visitors in delivering the intended dosage of services to families in their caseloads
- To identify barriers that prevent home visitors from completing home visits, as well as the characteristics of hard-to-serve families
- To identify families whose participation in home visits is dropping and develop strategies to re-engage them in program services
- To identify reasons why families leave the program prior to completion and strategies that may prevent early program exits in the future
- To monitor the alignment of home visit content to the program curriculum and fidelity standards
- To monitor the quality of home-visitor–family relationships and identify home visitors who may need additional support in developing strong relationships
- To identify barriers to building strong relationships and strategies used by home visitors who have successfully developed strong relationships with families

Conclusion

This article has provided an overview of important dimensions of home visiting quality—dosage, content, and relationships—and provided concrete ideas about how to measure them as well as tools for doing so. It has also provided real world examples about how these tools are being used in the field for research, program development, and program management. As interest in home visiting continues to grow, researchers and practitioners will need tools for understanding more deeply what goes on in the "black box" of home visiting and how to maximize the effectiveness of this service delivery strategy.

Learn More

For more information about the studies described in this article:

Evidence-Based Home Visiting to Prevent Child Maltreatment (EBHV) Cross-Site Evaluation
www.supportingebhv.org

Early Head Start Family and Child Experiences Study (Baby FACES)
www.acf.hhs.gov/programs/opre/ehs/descriptive_study/index.html

Thrive by Five Washington Demonstration Communities
www.thrivebyfivewa.org/demonstrationcommunities.html

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Child Maltreatment evaluation and directing Supporting Quality in Home-Based Child Care, a project funded by Office of Planning, Research and Evaluation at the Administration for Children and Families. She has played a leading role in major studies focused on quality improvement in Head Start, Early Head Start, and child care programs.

Kimberly Boller, *PhD, is a senior research psychologist at Mathematica Policy Research where she plays a key role on several national evaluations including the Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment evaluation, the Early Head Start Family and Child Experiences Survey (Baby FACES), and the child care Quality Rating System Assessment project. She led the development of two compendia of child and family outcome and program quality measures, one for infant and toddler programs and one for prekindergarten through grade 12 settings.*

Kristin Hallgren, *MA, is a human services researcher at Mathematica Policy Research with expertise in early childhood and education research. She has provided formative feedback for front-line staff in Washington State during their piloting of a new home visiting curriculum. She also has helped develop an adapted version of a home visiting quality measurement instrument by authoring an instrument manual, conducting reliability trainings, home visit observations, and analyses of home visit quality.*

Andrea Mraz Esposito, *MSS, is a human services research analyst at Mathematica Policy Research. She has worked on a variety of early childhood education projects including the Home Visiting Evidence of Effectiveness project, a study of a health promotion and obesity prevention enhancement for Head Start programs, and a compendium of child and family outcome and program quality measures.*

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Core Competencies for the Prenatal Through Age Three Workforce

Strengthening the Prenatal Through Age Three (P-3) workforce in Los Angeles County is an essential building block toward achieving First 5 LA's countywide vision of enabling all young children to be healthy, ready to learn and reach their full potential. First 5 LA awarded a $2.8 million contract to ZERO TO THREE (ZTT) in December 2007 to facilitate the Prenatal through Three Workforce Development Project (P-3 WFD Project). The P-3 WFD Project's charge was to:

1. Identify core competencies needed by the P-3 workforce in Los Angeles County;
2. Develop training approaches to support development of these competencies; and
3. Create and field test strategies in selected Los Angeles communities for integrating the core competencies in professional development systems and developing strategies to sustain their use.

ZERO TO THREE served as a resource and facilitator to the Core Competencies Workgroup (Workgroup) . This report captures the Workgroup's consensus on the Core Competencies for the P-3 field and recommendations to First 5 LA regarding the local Prenatal-3 Workforce.

The competencies were created to summarize the basic knowledge, skills and attitudes needed for professionals across the sectors of early care and education, early intervention, mental health, physical health and social services/child welfare working with expectant parents, infants, toddlers and their families. The P-3 WFD Project's intent was to reach agreement on a universal set of core competencies necessary for all P-3 service providers, not to replace existing, discipline-specific competencies. These cross-sector core competencies were designed to facilitate partnership, coordinated service delivery, cross-sector workforce development and more effective and efficient services for expectant parents, infants, toddlers and their families.

The Core Competencies Workgroup membership was diverse in terms of profession and work setting. Its charge was to reach consensus on basic competencies needed by the cross-sector P-3 workforce in order to effectively address the needs of LA County's P-3 population. The Workgroup included experts in workforce development and those with knowledge of the needs of expectant parents, infants, toddlers and their families across Los Angeles communities.

To begin their task of developing cross-sector competencies, Workgroup members identified the following key questions:

- **Who** are the P-3 service providers?
- **What** are the competencies and evidence-based practices that early childhood providers need to carry out their jobs? [1]
- **How** can these competencies be embedded in existing and new training opportunities to build a sustainable P-3 workforce development system? [2]

To address the three questions, ZTT in partnership with First 5 LA:

- Identified and convened community experts in the prenatal and early childhood work sectors of early care and education, early intervention, mental health, physical health and social services/child welfare to form the Core Competencies Workgroup;
- Identified the different P-3 service providers in the five sectors (Appendix D);
- Partnered with national, state and local experts to identify and translate the best available research about professional development into practices that could be implemented locally;
- Conducted a literature review of workforce competencies across the five work sectors and gathered information about existing national, state and local efforts to develop core competencies for the five work sectors involved in this Project (Appendix E);

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[1] V. Buysse and P. Winton, personal communication, November 7, 2007.

[2] National Professional Development Center on Inclusion. (2011). The big picture planning guide: Building cross-sector professional development systems in early childhood, 3rd ed. Chapel Hill: The University of North Carolina, FPG Child Development Institute, Author. http://npdci.fpg.unc.edu/.

- Documented the alignment between the core competency domains with competency statements found for the five work sectors involved in this Project (Appendix F);
- Convened a Training Workgroup and a Sustainability Workgroup to support and complement the development and implementation of the competencies; and
- Assembled a P-3 WFD Project Training Network, to develop and implement cross-sector professional development based on the core competencies and the goals of improved cross-sector collaboration on behalf of the P-3 population.

An evidence-based decision making process guided the project in planning, development and implementation activities. The process involved carefully reviewing and appraising the best available research and integrating it with community, family and professional values and wisdom. [3]

The Workgroup defined the P-3 Workforce as: individuals who work in a public or private setting serving infants, toddlers, their parents or caregivers and/or expectant parents to ensure that children are supported in nurturing environments so that they reach their full developmental potential.

The Workgroup and additional First 5 LA staff created the ***Matrix of Recommended Core Competencies for the Prenatal through Three Field***. This Matrix highlights the eight recommended core competency domains, subdivided into the knowledge, skills and attitudes that comprise them. The competencies are designed for professionals from the sectors of early care and education, early intervention, mental health, physical health and social services/child welfare to use in working with expectant parents, infants, toddlers and their families.

The Core Competencies also inform intentional professional development approaches that ensure that expectant parents, infants, toddlers and their families receive services targeted to their unique developmental needs. Through this project new professional development opportunities were developed and piloted in selected Los Angeles communities to support cross-sector communication and professional development.

For further detail on the Core Competencies Workgroup's process and the competency domains and recommendations generated, please see the following full report. Additional information appears in the Appendices, including a glossary of frequently used terms, a bibliography of references used by the Workgroup and a table comparing the P-3 Workgroup domains to professional competencies identified within the five P-3 work sectors focused on by the Workgroup.

To share your ideas and comments about this report, please contact Tahra Goraya, Director ZERO TO THREE Western Office, or Leticia Sanchez, Program Officer with First 5 LA. ZERO TO THREE's participation in the Workforce Development Project is scheduled to conclude June 30th, 2013.

[3] Buysse, V. & Wesley, P.W.(2006). *Evidence-based practice in the early childhood field*. Washington, DC: ZERO TO THREE.

Core Competencies for the Prenatal Through Age Three Field

The Core Competencies for the Prenatal Through Age Three Workforce were designed to identify the knowledge, skills and attitudes needed by professionals across the early care and education, early intervention, mental health, physical health and social services/child welfare service sectors who are working with expectant parents, infants, toddlers and their families. These cross-sector core competencies are intended to facilitate partnership, coordinated service delivery, cross-sector workforce development and more effective and efficient services for expectant parents, infants, toddlers and their families. The Competencies are not intended to replace existing sector or discipline-specific competencies.

The resulting "Matrix of Recommended Core Competencies for the Prenatal Through Age Three Field" (begins on p. 6) and the recommendations presented in this report are the result of a 5-year process that engaged a Core Competencies Workgroup (Workgroup) comprised of leaders, community partners and family representatives from the five work sectors addressed in the WFD Project. These sectors are: early care and education, early intervention, social service/child welfare, physical health and mental health (P-3 workforce) . National and state-level subject matter experts in the areas of development of workforce competencies and professional development supported the Workgroup. ZERO TO THREE facilitated the Workgroup's efforts by conducting literature reviews, convening and facilitating meetings, and preparing resource materials and reports. The Matrix and the recommendations that follow it present the collective thinking of this diverse and expansive group.

These cross-sector core competencies are intended to facilitate partnership, coordinated service delivery, cross-sector workforce development and more effective and efficient services for expectant parents, infants, toddlers and their families.

Prior to convening the Core Competencies Workgroup, ZERO TO THREE reviewed literature for definitions of the term "competency." Based on this search, a working definition of "competency" was developed and used in an initial survey to Workgroup members' and other stakeholders to gather feedback and comments. The Workgroup reached consensus reached on the following definition: *"**Competencies** for prenatal through three service providers are the basic attitudes, knowledge, and skills needed to demonstrate effective services that meet the needs of expectant parents, infants, toddlers, and their families."*

The three aspects of competence - knowledge, skills, and attitudes - are defined as:

- *Knowledge* – What Prenatal to Age 3 (P-3) service providers need to know.
- *Skills* – What P-3 service providers need to be able to do.
- *Attitudes* – How P-3 service providers should approach their work.

The Core Competencies Workgroup also articulated a number of agreements that serve as an underlying framework for the "Matrix of Recommended Core Competencies for the Prenatal Through Age Three Field":

- The core competencies emphasize ***foundational and basic knowledge, skills and attitudes*** that are essential across the five work sectors of early care and education, early intervention, mental health, physical health and social services/child welfare.
- The core competencies are inclusive and reflective of ***competencies that are common across the five work sectors***.
- The core competencies create a common language and a foundation for ***cross-sector collaboration and professional development*** to deepen and support the work within each the five sectors.

As an initial step in developing the Matrix, ZERO TO THREE conducted a literature review of workforce competencies across the five work sectors. The Core Competencies Workgroup reviewed the Sources for Core Competencies Bibliography (see Appendix E), providing additional information on existing competencies and new competency development efforts in their respective fields.

The Workgroup then prioritized competencies by addressing the question, "What are three to five competencies fundamental to all work sectors and universal for all positions and roles within the work sectors?" This resulted in a comprehensive list of competency statements that varied in levels of specificity. The resulting statements were then grouped into "domains" or clusters of related content and organized to reflect domains found across the five work sectors. Brief descriptions of each domain and related competencies were then drafted by the Workgroup and disseminated for review and feedback by First 5 LA and the Training Workgroup prior to finalizing.

Fundamental Concepts

The Workgroup sought to ensure that the core competencies reflected the following concepts for effective service delivery for expectant parents, infants, toddlers and their families:

- **Unique Developmental Needs Prenatally Through Age Three.** Understanding the unique developmental needs of pre-natal, infant and toddler development is foundational to the core competencies. This includes physical growth from conception on and the child's temperament, but also the emerging capacity of the child to experience, express and regulate a range of feelings, develop satisfying relationships with others, and explore the environment and learn. [4]

- **Development Takes Place in Context of Family and Community.** Family relationships and community resources have direct and profound effect on a child's development. These include factors inherent to the child's relational, social and physical environment that can both support and pose risk to healthy development.

- **Relationship-Based Support and Services.** Just as children grow and develop in the context of supportive relationships within their families and the broader community, P-3 providers must actively build trusting, responsive relationships with families to support their growth and development.

- **Strengths-Based Approach.** Recognizing, leveraging and building family strengths is the most effective way to support families in supporting their child's development.

- **Wellness Promotion.** Health and wellness is an essential component along the continuum of promotion, prevention and intervention/ treatment services.

- **Early Identification and Response.** Early identification and appropriate intervention supports expectant parents, infants, toddlers, and their families are presented with health, developmental or behavioral problems.

- **Inclusion.** Embracing and recognizing the potential of all individuals is crucial to providing effective services for all expectant parents, infants, toddlers, and families including those with disabilities.

- **Culturally Responsive Practice.** Culturally responsive practice respects the diversity of parental goals and related caregiving practices. It leads to effective family partnerships, responsive service delivery and improved prenatal, child and family outcomes.

- **Ethical Professional Practices.** Ethical dimensions, including legal considerations, of working with children and families and the professional standards ensure that services are delivered in an effective manner.

- **Cross-Disciplinary Partnerships.** Awareness of the range of services available to meet the needs of children and families will help ensure families are connected to the information and services that best meet their needs. This awareness establishes connections to other child and family services and recognizes the value of collaborating with other providers within their agency, work sector, and community.

- **Evidence-Based Practice.** Practices reflect the current evidence-base and are subject to revision as new evidence emerges. Evidence-based practice represents the usage of available research evidence, community wisdom and the knowledge gained through their own experiences and reflections to make decisions about work with children and families. [5]

- **Cross-Sector Professional Development.** Typically, pre-service education and in-service training presents knowledge from each competency domain in a discipline-specific way. Understanding is enriched and deepened when information from different sectors is shared across disciplines.

These Fundamental Concepts provide the basis for the *Core Competencies for the Prenatal Through Age Three Workforce.*

[4] National Research Council. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, DC: The National Academies Press, 2000.
[5] For a view of how others have defined and utilized evidence-based practice, refer to: Greenwood, P. (2010, January). *Preventing and reducing youth crime and violence: Using evidence-based practice*. Sacramento, CA: Governor's Office of Gang and Youth Violence Policy. Retrieved from: http://www.nursefamilypartnership.org/assets/PDF/Journals-and-Reports/CA_GOGYVP_Greenwood_1-27-10.

ORGANIZATION OF THE CORE COMPETENCIES FOR THE PRENATAL THROUGH AGE THREE FIELD

The members of the Competencies Workgroup recommended **eight core competency domains** as essential for Los Angeles P-3 professionals working with expectant parents, infants, toddlers and their families:

- **Domain #1:** Early Childhood Development
- **Domain #2:** Family-Centered Practice
- **Domain #3:** Relationship-Based Practice
- **Domain #4:** Health and Developmental Protective and Risk Factors
- **Domain #5:** Cultural and Linguistic Responsiveness
- **Domain #6:** Leadership
- **Domain #7:** Professional and Ethical Practices
- **Domain #8:** Service Planning, Coordination and Collaboration

The eight domains are organized as follows:

- A brief *Description and Key Concepts* introduces each competency domain. This overview of each domain briefly describes key concepts for professionals working with expectant parents, infants, toddlers and their families.

- Each core competency domain is subdivided into sections describing the core **knowledge** (what P-3 service providers should know), core **skills** (what P-3 service providers should be able to do) and core **attitudes** (how P-3 service providers should approach their work).

  The knowledge, skills and attitudes sections are identified by the competency statement numbering system. Knowledge statements are numbered beginning with the letter **"K."** Skills statements are numbered beginning with the letter **"S."** Attitudes statements are numbered beginning with the letter **"A."** *It is important to note that while attitudes themselves are not tangible, the competency statements are written to identify observable behaviors that indicate underlying attitudes.*

- The initial digit of the number associated with each competency statement reflects the domain as numbered above. For instance, statement **K1.1** is the first knowledge competency in the Early Childhood Domain.

- The knowledge and skill competency statements are written as observable behaviors and, where possible as measurable actions. The attitude competency statements either describe observable behaviors that reflect underlying attitudes *or* state essential attitudes that are more difficult to translate into behavioral terms, but nevertheless powerfully influence recipients of services.

The *Fundamental Concepts* described above are intentionally interwoven throughout the core competency domains. The eight competency domains are considered equally important and integrated to build upon and reinforce one another. Therefore, there is some repetition of knowledge, skills and attitude statements across the core domains. Although the core competency statements for each domain are presented discretely, readers will see themes embedded throughout all competency domains.

Matrix of Recommended Core Competencies For The Prenatal Through Age Three Workforce

DOMAIN #1: EARLY CHILDHOOD DEVELOPMENT

Description and Key Concepts:

P-3 service providers have knowledge of key developmental theories and concepts and use this knowledge to support the healthy growth and development of young children. P-3 service providers understand and are able to communicate how development unfolds through the early years from conception through age three years across social, emotional, cognitive, language, physical and motor development. They understand the individual nature of development and that development happens interactively and simultaneously across multiple domains. P-3 service providers respond to support children's development, including monitoring development and connecting the family to developmental screening, assessment, referral and/or intervention as appropriate to the P-3 service provider's role.

Domain #1: Early Childhood Development Core Competency Statements

Knowledge	
K1.1	Understands typical and atypical growth and development from conception through infancy and early childhood according to a general maturational timeline, considering the social, emotional, cognitive, language, physical and motor domains.
K1.2	Refers to the current evidence base on child growth and development and improves understanding of development by observing children.
K1.3	Using current research and professional literature, is able to describe developmental processes and the inter-related influences on development.
K1.4	Recognizes that a child's ability to exercise self-regulation and control over his/her body functions, emotions and behavior emerges over time as a developmental process.
K1.5	Understands the parent's/caregiver's role in supporting the child's development of self-regulation.
K1.6	Understands the impact of physical health on children's social, emotional, cognitive, language, physical and motor development and can describe the conditions that promote optimal health and safety.
K1.7	Describes parent/caregiver interactions with infants and toddlers that reflect a healthy relationship and support social-emotional development. Recognizes indicators of at-risk adult-child relationships.
K1.8	Describes how attachment develops between family members and a child and can recognize signs of healthy attachment and lack of healthy attachment.
K1.9	Is able to discuss the value of breastfeeding for promoting healthy development.
K1.10	Recognizes the strengths and abilities of all very young children, including those with special needs. Supports the practice of inclusion with typically developing peers when inclusive practice would best meet the needs of the child.
K1.11	Promotes acceptance of infants and toddlers with disabilities and special needs as valued and contributing family and community members.
K1.12	Is aware of available resources to support children with disabilities and special needs, including inclusion in family care settings, early education and community settings.
Skills	
S1.1	Discusses development with parents/caregivers to help them recognize their child's individuality and emerging milestones.
S1.2	Applies knowledge of child development and the multiple factors that influence development to observe and understand expectant parents, infants, toddlers and/or families.
S1.3	Makes decisions about services, supports and referrals based upon an understanding of the multiple domains of development and the child's environment, including the array of factors that influence development.
S1.4	Applies knowledge of typical child development, including social-emotional development, to identify early indicators of possible developmental delays or risks to development.
S1.5	Uses screening, observation and/or assessment strategies to inform planning and provision of appropriate services that promote optimal development.
S1.6	Explains early development to parents and caregivers and engages them in monitoring their child's health and development.
S1.7	Recognizes signs of possible child abuse and/or neglect that may appear as behavior problems, developmental delays or ill health and takes appropriate steps to address.
Attitudes	
A1.1	Appreciates the developmental process and the interrelatedness of social, emotional, cognitive, language, physical and motor development of young children.
A1.2	Respects and supports the relationships between children and their parents/ caregivers.
A.1.3	Accepts infants and toddlers with disabilities and special needs and recognizes that they are valued and contributing members of the family and community.
A1.4	Values the strengths, capacities and individuality of all children.
A1.5	Respects the influence of culture on caregiving practices and developmental expectations of children.

Description and Key Concepts:

P-3 service providers understand that services provided to children cannot be separated from family context and the social connections surrounding each child. P-3 service providers effectively partner with families to support health and development and understand that building a positive, supportive relationship with parents/caregivers is central to successful service delivery. P-3 service providers comprehend that family systems are complex, dynamic and unfold developmentally across a variety of relationships (parent to child; parent to parent; parent to provider; etc.). They recognize the family's strengths and vulnerabilities and work to empower families to support the expectant parents', child's and family's health and development. P-3 service providers understand the developmental progression of maturing relationships and use this knowledge to support the child, the family, the caregiver(s) and other service providers connected to the family.

Domain #2: Family-Centered Practice Core Competency Statements

Knowledge	
K2.1	Explains how infants' and toddlers' relationships with a small number of consistent, responsive care providers contribute to health and development.
K2.2	Describes the role of families in supporting very young children's health, learning and development.
K2.3	Describes the individual and cultural meanings and definitions of the term "family" and understands how to appropriately integrate this understanding into providing support and services.
Skills	
S2.1	Ensures parents/caregivers are engaged in planning and responding to any health, learning or developmental needs of their child.
S2.2	Establishes an ongoing alliance with families that supports their strengths, priorities and parenting practices.
S2.3	Applies evidence-based knowledge of the role of families and family dynamics in supporting development when planning and delivering services.
S2.4	Embeds services and supports in the context of each child's family and caregiving routines, as well as within neighborhood and community relationships.
S2.5	Supports families in identifying and achieving their own goals, and in their role as primary decision-makers on issues concerning their child.
S2.6	Supports families to obtain or advocate for the health and/or developmental services their child may need to support optimal development in all areas (social, emotional, cognitive, language, physical and motor).
S2.7	Supports the capacity of family members to meet the needs of infants and toddlers with social-emotional delays, developmental disabilities, health and educational needs.
S2.8	Provides information and guidance to families to assist their understanding of the overt and underlying causes of their child's behaviors and emotions.
S2.9	Assists expectant parents in understanding fetal development and families with infants and toddlers to understand their child's health and development and to anticipate emerging developmental milestones.
S2.10	Uses effective verbal and written communication skills to collaborate with families in an ongoing and positive manner to support each child's health, early learning and development.
S2.11	Uses easily understandable language about social and emotional milestones to help family members promote healthy relationships with each other and with their very young child.
Attitudes	
A2.1	Recognizes and respects the central role of families and parent/caregiver-child relationships in the care, development and well-being of unborn children, infants and toddlers.
A2.2	Explores one's own experiences and biases to understand the family's attitudes and practices.
A2.3	Is open to reflecting on one's own biases and how they might influence guidance, services and supports offered to the family.
A2.4	Respects a family's decisions regarding parenting.
A.2.5	Respects the influence of culture on caregiving practices and family relationships.

Description and Key Concepts:

P-3 service providers understand and value the central importance of relationships in supporting the development of children. They apply this knowledge to assess the quality of relationships children experience and to create constructive and supportive relationships with families. They also apply this knowledge in their working relationships with other service providers. P-3 service providers understand and value the practice of self-reflection and effective communication as tools to develop and maintain positive relationships with children, families and service providers.

Domain #3: Relationship-Based Practice Core Competency Statements

Knowledge	
K3.1	Recognizes that the parent/caregiver-child relationship is the foundation of early development.
K3.2	Describes the importance of early parent/caregiver-child relationships and consistent, responsive interactions in building relationships that promote health, development and learning.
K3.3	Explains why successful work with families requires development of a trusting parent/provider relationship.
K3.4	Recognizes the importance of using evidence-based approaches to support the parent/caregiver-child relationship so that the child's learning, health and developmental needs are met.
K3.5	Recognizes the central role of relationships with other service providers in meeting families' needs.
K3.6	Strives to understand how one's own cultural values and those of the family may affect the development of a trusting relationship between the P-3 service provider and family members.
K3.7	Recognizes how the complexity of family systems requires working collaboratively across departments, agencies and work sectors based on each family's needs.
K3.8	Understands that the nature of relationships among P-3 service providers influences one's own work and relationships with children and families.
Skills	
S3.1	Helps parents recognize the learning that is taking place for a child through their interactions.
S3.2	Uses active listening and observation to identify what is important to families and bases P-3 service delivery upon this knowledge.
S3.3	Communicates effectively with families and with fellow service providers.
S3.4	Seeks and implements ways to communicate effectively with families of linguistic or cultural backgrounds different from one's own.
S3.5	Regularly examines one's own biases, strengths and needed growth to better support the unique needs of each family.
S3.6	Nurtures relationships with families with ongoing communication and respect for family strengths.
Attitudes	
A3.1	Displays openness to the family members' approaches to caregiving and child rearing and seeks ways to build a relationship of trust.
A3.2	Models positive and open attitudes in working collaboratively with service providers from other work sectors.
A3.3	Values the impact that relationships have on outcomes for expectant parents, infants, toddlers and their families
A3.4	Intentionally creates workplace relationships based on respect, consistency and collaboration and supports colleagues in building similar relationships with families and their very young children.

DOMAIN #4: HEALTH AND DEVELOPMENTAL PROTECTIVE AND RISK FACTORS

Description and Key Concepts:

P-3 service providers understand that multiple factors support or impede healthy development and the quality of relationships that support development, to include community, economic, political and cultural influences. P-3 service providers understand that the sources of resilience and risk, from an individual, family and community context, are important to consider in evaluating a child's current and future health and development. Professionals work with families to identify strengths and use these strengths as resources to help manage challenges and reduce risks. P-3 service providers understand that influences on the child and family system are bi-directional and dynamic. As an example, both parents and children influence one another as well as others in their social networks.

Domain #4: Health and Developmental Protective and Risk Factors Core Competency Statements

Knowledge	
K4.1	Understands factors, including community, economic, political and cultural influences that can promote or impede health and development during the prenatal period through age three.
K4.2	Recognizes biological, health and social-emotional factors that impact a child's well-being.
K4.3	Understands prenatal development and potential threats to the mother's and baby's health during the prenatal period.
K4.4	Understands the impact of stress and trauma on a child's development.
K4.5	Recognizes attitudes and cultural context that may impact a mother's decision to initiate or continue breastfeeding.
K4.6	Recognizes attitudes and cultural context that may impact parenting practices.
K4.7	Can cite information from current professional literature and from professional practice about parenting practices, family functioning and parent/caregiver-child relationships and strategies for supporting key relationships.
K4.8	Understands that when the dynamics within a family change when, for example, a new baby arrives. The family may require support to adapt to this change.
K4.9	Understands parenting strengths that support a child's development.
K4.10	Identifies concrete supports that may help families in times of need.
K4.11	Understands the impact the broader health and social service systems (including prenatal and post-delivery health and dental care, mental health, early intervention, early care and education and child welfare) has on supporting a child's health and development during early childhood.
Skills	
S4.1	Uses accurate knowledge of child health and development to identify developmental warning signs.
S4.2	Identifies a potentially at-risk relationship or environment using knowledge of child and family development and social-emotional milestones.
S4.3	Takes appropriate actions to address risks, which may include delivering intervention, referring the family for appropriate services, or reporting concerns to a supervisor or appropriate agency as appropriate to the P-3 service provider's role.
S4.4	Identifies services that may be of assistance to the family and/or connect the family to other needed resources within the community, including but not limited to food, breastfeeding support, shelter, clothing assistance, financial help; or early intervention, physical health, oral health, and mental health services.
S4.5	Addresses attitudes, cultural context, or barriers that may impact a mother's decision to initiate or continue breastfeeding.
S4.6	Seeks and/or recommends supports for the parent/caregiver as well as the child when having identified an at-risk relationship and/or the presence of one or more risk factors.
S4.7	Functions as a team leader or works with a case manager or team to help coordinate the variety of services a family may need in response to the presence of one or more risk factors and/or an at-risk relationship with another family member.
S4.8	Recognizes signs of resilience in the child and family and works with the family to strengthen protective factors.
S4.9	Recognizes the impact of stress and trauma on children and families and supports families in reducing children's exposure to stress.
S4.10	Applies knowledge of factors that promote or impede development to assess risks to development.
S4.11	Applies relationship-based practices and family-centered principles to support the family in reducing risks that may negatively affect child health and development.
S4.12	Takes cultural values into consideration when assessing family strengths and risks.
Attitudes	
A4.1	Appreciates the economic, political and cultural influences that contribute to the family context.
A4.2	Displays willingness to learn about community and other conditions that affect children and families.
A4.3	Recognizes that collaborating and learning across disciplines and work sectors requires an open attitude.
A4.4	Assesses protective and risk factors from a strengths-based perspective.

Description and Key Concepts:

P-3 service providers acknowledge and respond sensitively to cultural differences among families. P-3 service providers seek to integrate culturally responsive methods into their work with expectant parents, infants, toddlers, and their families. P-3 service providers are aware of their assumptions about cultural attitudes and values and check those assumptions with members of the cultural group as well current research on cultural values and differences. Cultural responsiveness requires an ongoing effort to understand current culture-specific information, family preferences and evidence-based practices that support child and family development in the cultural context. P-3 service providers understand that while linguistic and cultural competence are not predicated on being bilingual, appropriate supports and resources matched to the family's preferred language are necessary to enhance the provider's responsiveness and communication with family members.

Domain #5: Cultural and Linguistic Responsiveness Core Competency Statements

Knowledge	
K5.1	Understands that each person's culture shapes his or her values, beliefs and behaviors.
K5.2	Understands that language and/or cultural values and beliefs may be a barrier for families in seeking and/or accessing services.
K5.3	Understands that a family's ability and willingness to access services is impacted by systemic barriers, such as limited resources, lack of cultural sensitivity, immigration status or local/state/federal or program policies.
K5.4	Understands the importance of acquiring language proficiency or using appropriate translation assistance that improves communication with children and families served.
Skills	
S5.1	Discusses and reaches agreement with families about culturally preferred practices to use in child-rearing and group care situations and remains open to accommodations supported by cultural values, the best available resources and practical wisdom so long as the child's safety and health are supported.
S5.2	Recognizes and acknowledges the family's definition of their own culture/cultural affiliation and values.
S5.3	Seeks to learn from members of the cultural group about cultural norms and behaviors and avoids making assumptions about practices.
S5.4	Employs observation and listening skills in order to understand the cultural values of families.
S5.5	Provides appropriate and respectful translation for adults for whom English is not the preferred language, using trained and qualified interpreters if needed.
S5.6	Supports the child's and family's home language and uses resources to communicate effectively with families in their preferred language.
S5.7	Participates in activities designed to improve the cultural competence of services for expectant parents, infants, toddlers and families.
Attitudes	
A5.1	Acts based on current culturally-relevant information and family preferences rather than broad generalities or stereotypes.
A5.2	Demonstrates a willingness to interact with families and P-3 service providers from a cross-section of cultural and ethnic backgrounds.
A5.3	Demonstrates cultural sensitivity by respecting and valuing diverse cultures, values, beliefs and behaviors.
A5.4	Reflects on one's own cultural values and attitudes to understand and appreciate those of others.
A5.5	Recognizes one's own limitations to working with families because of cultural and language differences.
A5.6	Treats others with the respect they would desire for themselves.
A5.7	Demonstrates a willingness to discuss and incorporate new culturally and linguistically relevant ideas and methods into one's practice to support families.
A5.8	Grows in cultural and linguistic responsiveness through a willingness to engage in ongoing education and training to stay current with changing demographics and cultural factors in the population served.

Description and Key Concepts:

P-3 service providers exercise leadership in sharing knowledge and resources with families, colleagues and the general public to promote best outcomes for expectant parents, infants, toddlers and their families. P-3 service providers intentionally express and demonstrate to other providers and clients the optimal practices in working with families and in working as part of a community system. This involves taking actions that assist families in achieving their self-identified goals and objectives. It also involves promoting public awareness of prenatal, infant, and toddler needs and effective ways of supporting expectant parents, infants, toddlers, and families. Seeing the services and connections beyond their own work sector that can support expectant parents, infants, toddlers, and families, enables P-3 service providers to be proactive in obtaining or providing services within their own program or from other programs in support of children and families. P-3 service providers takes a strengths-based approach in working with families in order to ensure that family members are supported in advocating for their child's and family's needs.

Domain #6: Leadership Core Competency Statements

Knowledge	
K6.1	Understands her/his level of leadership responsibility and expected outcomes of action at both the individual and organizational levels.
K6.2	Understands evidence-based and strength-based approaches and strategies for working with expectant parents, infants, toddlers and families of diverse backgrounds.
Skills	
S6.1	Promotes public understanding of children's needs across multiple domains (e.g., health and social, emotional, cognitive, language, physical and motor development).
S6.2	Advocates within the service and health care settings and in the community to identify and remove service delivery barriers for expectant parents, infants, toddlers and/or families in need.
S6.3	Advocates for system improvements to raise the quality of services provided to expectant parents, infants and toddlers and families to promote healthy child and family development.
S6.4	Engages in collaborative problem solving with families and other service providers.
S6.5	Takes appropriate initiative to seek supports and solutions for expectant parents, infants, toddlers and families.
S6.6	Uses self-knowledge and self-reflection in a relationship-based approach both to working with expectant parents, infants, toddlers and families and to working collaboratively with other service providers.
S6.7	Interacts successfully with families and P-3 service providers from a cross section of cultural and ethnic backgrounds.
Attitudes	
A6.1	Believes that each family has strengths and values that support their child's healthy development.
A6.2	Takes ownership for one's own continuing learning and reflection about expectant parents, infants, toddlers, families and service delivery strategies and systems.
A6.3	Respects and appreciates the contribution of individuals such as family or community members as partners in advocacy.

Description and Key Concepts:

P-3 service providers follow and apply the highest quality practices possible that are consistent with the ethical and legal standards, requirements, and obligations of their own work sector. P-3 providers use evidence-based approaches when they are available and appropriate for the children and families they serve. They develop and improve practice based on emerging knowledge on the best approaches to achieving expectant parents' and families' goals for infants and toddlers. P-3 service providers follow the highest standards of ethical behavior and remain current on the laws affecting professional practice.

Domain #7: Professional and Ethical Practices Core Competency Statements

Knowledge	
K7.1	Understands the legal and ethical practices and policies related to serving expectant parents, infants, toddlers and their families.
K7.2	Describes how laws relating to child maltreatment impact professional practice and responsibilities.
Skills	
S7.1	Adheres to the professional and ethical standards of the P-3 service provider's own profession.
S7.2	Takes action to comply with the legal aspects of child protection that pertain to his or her role.
S7.3	Engages in discussion and reflection on how values and standards are demonstrated in one's own work.
S7.4	Maintains written notes and records to monitor progress and document concerns and maintains appropriate confidentiality of these records.
S7.5	Engages in discussion with supervisor and/other service providers to apply ethical solutions to situations encountered in practice.
S7.6	Establishes and maintains relationships of respect, trust, confidentiality, collaboration and cooperation with families, colleagues and service providers from other work sectors.
S7.7	Ensures that all interactions with families, co-workers and related agencies exemplify professionalism and are within the scope and limits of one's own role and competence.
S7.8	Uses appropriate and effective verbal and written communication skills in an ongoing and positive manner to collaborate with expectant parents and families of infants and toddlers.
S7.9	Continuously seeks to improve one's own work-related skills and performance through self-reflection with peers and supervisors and through continuing education to increase knowledge and skills.
S7.10	Provide and/or receive supervision supporting self-reflection, self-assessment and professional growth.
S7.11	Maintain appropriate boundaries in interactions with co-workers, families and other service providers.
Attitudes	
A7.1	Acknowledges the scope of practice of one's own field and welcomes opportunities for cross-disciplinary collaboration to support families' needs for comprehensive services.
A7.2	Maintains responsibility for one's own physical and mental health, recognizing that one's own health impacts interactions with expectant parents, infants, toddlers, families and other service providers.
A7.3	Recognizes that collaborating across disciplines and work sectors requires an open learning attitude.
A7.4	Acknowledges that one's own biases, values and attitudes influence one's decisions, interventions and relationships.
A7.5	Reflects on one's own continuing adherence to the ethics and standards associated with one's work role.

DOMAIN #8: SERVICE PLANNING, COORDINATION AND COLLABORATION

Description and Key Concepts:

P-3 service providers are aware that they are part of a system of services that supports expectant parents', children's, and families' multiple needs. Services provided require planning, including a coordinated effort with other work sector systems and providers. P-3 service providers understand their responsibility to work collaboratively with other P-3 service providers to coordinate services and meet families' and very young children's needs. Seeing the services and connections beyond their own work sector that can support families, enables P-3 service providers to proactively obtain and provide services from within their own program and engage the services of others as needed. P-3 service providers take a strengths- and relationship-based approach in working with families and in collaborating with other service providers.

Domain #8: Service Planning, Coordination and Collaboration Core Competency Statements

Knowledge	
K8.1	Understands the importance of partnering with families to develop goals and connecting with other service provider, as necessary, to support the achievement of goals for the child and family.
K8.2	Understands the importance of clarity and consistency when communicating with expectant parents, families, collaborating team members and other service providers.
K8.3	Understands family strengths and makes important connections with available resources to strengthen the family's ability to protect children and family members from risks.
K8.4	Is aware of available referral processes and available community resources and supports available to address the challenges encountered by the child or family.
Skills	
S8.1	Works collaboratively and flexibly in a team that may include members from multiple departments, agencies and work sectors.
S8.2	Engages with other service providers in a team setting to create and maintain cross-agency and cross-work sector connections to best meet the individual needs of infants, toddlers and their families.
S8.3	Provides feedback on referrals to the original source and fosters collegial relationships across disciplines to share outcomes on the child's well-being.
S8.4	Identifies and remedies barriers to communication in interactions with families and other service providers.
S8.5	Uses evidence-based processes and principles to improve the quality of relationships at all levels of early learning, health and developmental services.
S8.6	Builds trusting relationships with other service providers by recognizing the contributions of each service provider, being responsive and using open communication.
S.8.7	Offers creative solutions to challenging situations to ensure the needs of children and families are met.
Attitudes	
A8.1	Recognizes the importance of being an active team member who contributes knowledge, observations and recommendations to best meet the needs of individual children and families.
A8.2	Recognizes that it may be necessary to initiate collaboration with other service providers and work sectors to support the comprehensive needs of each child and family.
A8.3	Recognizes the limitations of one's own role and responsibilities and is prepared to link the child/family to other providers to obtain appropriate services for the child/family.
A8.4	Respects and appreciates the contribution of individuals such as family or community members as collaborative partners.
A8.5	Is committed to broadening one's own skills in planning and coordination and seeks ongoing learning and improved understanding.
A8.6	Approaches serving expectant parents, infants and toddlers with a creative attitude and open mind.

POLICY AND PROGRAM RECOMMENDATIONS FOR INCORPORATING THE PRENATAL THROUGH AGE THREE CORE COMPETENCIES

The Prenatal through Three Workforce Development Project Core Competencies were intended to create a collective understanding and common language across the work sectors and disciplines and facilitate partnership, coordinated service delivery, cross-sector workforce development and more effective and efficient services for expectant parents, infants, toddlers and their families.

The Core Competencies Workgroup created recommendations to ensure that the identified Prenatal Through Age Three Core Competencies would be incorporated into workforce development efforts in Los Angeles County in alignment with the First 5 LA strategic plan for strengthening families, communities and systems. The Workgroup was asked to develop strategies to promote the development of competent P-3 service providers across the spectrum of promotion, prevention and intervention/treatment as well as policy and practice recommendations. The Workgroup was also asked to identify and prioritize policy and planning efforts, on the practice-, agency-, and systems-levels that may be necessary, to ensure broad dissemination and adoption of the P-3 workforce development core competencies. Further recommendations were generated from a joint meeting with the Core Competencies and Training Workgroups at First 5 LA.

The following recommendations are focused on a) agencies serving the P-3 population b) providers of workforce development efforts c) funders of P-3 workforce development programs, d) systems supporting the P-3 workforce.

A) Recommendations for Agency Practices

The Core Competencies Workgroup developed the following recommendations for P-3 service provider agencies and programs to use the core competencies to strengthen the P-3 workforce along the continuum of promotion, prevention and intervention/treatment:

- Develop training for trainers on the Prenatal Through Age Three Core Competencies so they can effectively integrate the knowledge, skills and values of the Competencies into their existing workforce development efforts.
- Work with providers of professional development to plan P-3 workforce development efforts based on the Prenatal Through Age Three Competencies.
- Work with conference planners to design conferences for the P-3 workforce across sectors and around the Prenatal Through Age Three Competencies.
- Provide the core competencies to staff to help them do a self-assessment of their own knowledge, skills and abilities. Use the results to plan professional development that helps staff focus on the "whole child" when working with children and families by emphasizing the development, health, education, and context of the child (e.g., family culture, environment, individual and family strengths and significant relationships).
- Use the core competencies in designing staff hiring/promotion requirements, orientation, job expectations, and performance appraisals.
- Look for potential hires that see themselves in line with the values, knowledge, skills and attitudes expressed in the competencies.

- Use the domains of the core competencies as a foundation for planning in-service training and professional development activities.
- Educate key personnel on the core competencies; use creative incentives in early efforts to do so.
- Create a video for directors that models training practices related to using the core competencies.
- Create a career pathway plan or matrix tied to the core competencies for use in professional development planning at individual staff and agency levels.
- Promote development of cross-sector resources and expert trainers.
- Engage parents and family members in discussing the desirable competencies of their P-3 service providers. Identify ways families can recognize these competencies in action.

B) Recommendations for Providers of P-3 Workforce Professional Development Efforts

Those who design, develop and implement training and other professional development efforts for the P-3 workforce can play a key role in integrating the Core Competencies into practice. To explore approaches for doing this, ZERO TO THREE worked with the Project's Training Network in creating and field-testing professional development approaches grounded in the Core Competencies and incorporating the best available evidence from the professional development research literature. The Training Network was comprised of expert trainers from the Project's five identified work sectors. Four awareness-raising, cross-sector training sessions were offered focusing on core competency domains 3 (Relationship-Based Practice) and 8 (Service Planning, Coordination and Collaboration). These sessions were followed-up by two individual consultation sessions for each participating individual. After developing a Training Guide, members of the Training Network co-lead sessions and provided consultation to the Field Test One cohort. This Cohort was a cross-sector group of P-3 professionals and program leaders recruited from throughout LA County. The materials used were refined based on feedback collected from a survey of participants in the first cohort and field tested again with a second cohort of P-3 professionals and program leaders based in Long Beach. The final copy of the Trainer's Guide will be available in 2013. Recommendations

emerging from these field tests to those organizations that develop and offer P-3 workforce development opportunities include:

- Develop new trainings that reflect the content of the Prenatal Through Age Three Core Competencies and fill gaps in existing training offerings.
- Clearly define learning goals, objectives and outcomes for existing trainings that reflect the knowledge, skills, and attitudes outlined in the Prenatal Through Age Three Core Competencies.
- Provide opportunities during training for cross-sector groups to come together so that further relationship-building and networking can take place.
- Where possible, use trainers who have been trained Prenatal Through Age Three Core Competencies that are familiar with the community within which the participants are based to offer training on topics relevant to expectant parents, infants, toddlers and their families.
- Develop additional content for a) awareness raising in all eight competency domains; b) in-depth knowledge and skill-building; and c) transformative learning to address underlying attitudes

C) Recommendations for Public and Private Sector Funders of P-3 Workforce Development

Funders from the public and private/philanthropic sectors are particularly well positioned to integrate the Prenatal Through Age Three Core Competencies into workforce development efforts. They can make use of the Core Competencies a requirement of those creating workforce development initiatives. This will assure professional development opportunities will reflect the content of the Core Competencies. Strategies to accomplish this include:

- Requiring the incorporation of core competencies in training for programs supported by First 5 LA.
- Requiring alignment of professional development goals with the Prenatal Through Age Three Core Competencies as a condition of receiving funding for the P-3 workforce professional development efforts.
- Fundraising efforts that foster cross-sector collaboration and use the Prenatal Through Age Three Core Competencies as the guiding document to inform the cross-sector work.
- Requiring conference planners to organize cross-sector conferences for the P-3 workforce that are based on the Prenatal Through Age Three Core Competencies.
- Continue to connect Los Angeles County agency representatives to share ideas and actions related to the core competencies. Engage the Department of Public Social Services (DPSS), Regional Centers and Department of Developmental Services (DDS) and other public and private sector funders in future discussions and applications of the Core Competencies.
- Share the Core Competencies with current statewide program improvement efforts such as the Early Learning Quality Improvement System Advisory Committee (ELQIS), California Comprehensive Early Learning Plan (CCELP), other First 5 Commissions, and other statewide professional development initiatives.

D) Recommendations to Support Systems Change

Workgroup members acknowledged that efforts must also be made to address issues through county-level leadership and in the pre-service professional development activities offered in institutions of higher education in order to improve the quality of the P-3 workforce. For example, the core competencies document could be useful in pre-service education as a guide to cross-disciplinary preparation of the P-3 workforce. While the following recommendations are beyond the scope of this Project, the Workgroup members emphasized that changes must occur within the County's system of higher education in order to improve the P-3 workforce. Their recommendations for changes at the county level and within higher education included:

- Create toolkits for agencies to guide them in incorporating the core competencies into agency practice. For instance, this might include tools to help assess providers' current level of competence, forms for incorporating competencies into personnel expectations and performance appraisals and sample statements of guiding principles.
- Create web-based tools with links to additional resources to educate key stakeholders about the content in the Competencies.
- Create "crosswalks" linking the Prenatal Through Age Three Workforce Development Project Core Competencies and competencies described by other programs, models and higher education (e.g., Early Start Personnel Manual, CA Infant-Family and Early Childhood Mental Health Training Guidelines) to show how the core competencies align in order to build support for the core competencies and to identify gaps in current workforce preparation systems.

- Align the core competencies with accreditation requirements and to promote dialogue among higher education faculty and administrators on the value of the core competencies as a starting point for pre-service education.
- Work with higher education institutions to integrate the use of the Competencies into their Prenatal Through Age Three classes and other professional development offerings.
- Work with higher education institutions to align their coursework with other departments offering degrees in different P-3 sectors.
- Create user-friendly crosswalks with parenting programs and models (e.g., Strengthening Families, Parent Café, Center on the Social and Emotional Foundations for Early Learning [CSEFEL]) to expand usability of the Competencies.
- Be intentional about the field-testing of the training approaches to gather lessons learned for systems change.
- Create tools to help programs and systems elaborate on core competency statements to differentiate levels of competency among entry level, mid-career and advanced professional roles.

STRATEGIES TO PROMOTE AWARENESS OF THE CORE COMPETENCIES

Recommendations were developed that could guide First 5 LA in developing materials to support dissemination of the core competencies and to promote broad understanding of competent P-3 practice.

- Using multiple levels of media to communicate key messages to the larger community to build understanding of the core competencies and on how to identify competent service providers.
- Placing core competencies online for agencies to access.
- Marketing the Competencies as a "lens" for providing effective and high quality services.

The Workgroup members also considered ways in which they could use their own leadership positions to accelerate the adoption of the Prenatal through Three Workforce Development Project Core Competencies in Los Angeles County. Members identified ways they could serve as "ambassadors" for the Competencies and leverage their involvement with state and local advisory councils to communicate information related to the core competencies. Others suggested incorporating the values and discussions from their experience on the Workgroup with other organizations, institutions and projects/initiatives to further link the work. Workgroup members agreed to disseminate and discuss the core competencies with selected early childhood networks and collaboratives and identify additional proactive strategies to apply the principles on multiple levels.

To share your ideas and comments about this report, please contact Tahra Goraya , ZERO TO THREE Western Office Director, or Leticia Sanchez First 5 LA Program Officer. ZERO TO THREE's participation in the Workforce Development Project is scheduled to conclude June 30th, 2013.

APPENDICES

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Project Participants

Appendix B:
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APPENDIX A: PROJECT PARTICIPANTS

ZERO TO THREE wrote this report under contract from First 5 LA. The process of developing this report was collaborative, with many leaders of the prenatal and early childhood field shaping it through their participation, ongoing feedback and final review. This report reflects their thinking and recommendations, focused Los Angeles County's P-3 workforce. The contributions of these individuals are deeply appreciated and their names are acknowledged below. During the course of this multi-year project some of these individuals moved on to new positions and/or new places of employment.

March 2009 –September 2012

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APPENDIX B: GLOSSARY OF KEY TERMS

Collaboration: Exchanging information, altering activities, sharing resources and enhancing the capacity of another for mutual benefit and to achieve a common purpose (Himmelman, 2002, p. 2).

Competency: Competencies of prenatal through age three service providers are the basic attitudes, knowledge and skills needed to demonstrate effective services that meet the needs of expectant parents, infants, toddlers and their families (as developed by the Prenatal through Three Workforce Development Project's Core Competencies Workgroup on April 18, 2009).

Coordination: Exchanging information and altering activities for mutual benefit and to achieve a common purpose (Himmelman, 2002, p. 2).

Cross-disciplinary: A team of professionals representing different work sectors who work collaboratively and share their expertise to resolve an issue or need and reach decisions through consensus.

Cultural Responsiveness: A set of congruent practice skills, behaviors, attitudes and policies in a system, agency, or among those persons providing services that enables that system, agency, or those persons providing services to work effectively in cross-cultural situations (California Department of Health Services, 1999, p. A-6).

Culture: Shared system of meaning, which includes values, beliefs and assumptions expressed in daily interactions of individuals within a group through a definite pattern of language, behavior, customs, attitudes and practices (Maschinot, 2008, p. 2).

Domain: In terms of professional practice "domain" also refers to a specified sphere of activity or knowledge (http://oxforddictionaries.com/definition/american_english/domain?region=us&q=domain).

Development: The sequence of physical and psychological changes that human beings undergo as they grow older (Cole & Cole, 1996, p. 6).

Evaluation: A form of research that involves the systematic assessment of the operation and/or outcomes of a program or policy, compared to explicit or implicit standards, in order to contribute to the improvement of the policy or program (Weiss, 1998, p. 330).

Evidence-based Practice: A decision-making process that integrates the best available research evidence with family and professional wisdom and values (Buysse & Wesley, 2006, p 12).

Family: A group of people who are important to each other and offer each other love and support…[regardless] of life styles, living arrangements and cultural variations (May, 1997).

Family-centered: Views the family as the unit of attention, embraces the concept of family choice and emphasizes the strengths and capabilities of families (Brotherson, Summers, Bruns, & Sharp, 2008, p. 53).

Family Strengths: Characteristics that family members identify as contributing to the growth and development of the child and family. Among the areas of family life that many families identify as strengths are coping strategies, nurturing relationships, communication, religious or personal beliefs, family competence and family/community interconnectedness (Texas Department of Assistive and Rehabilitative Services, 2009, p. 148).

Inclusion: Placement of a child at risk or with special needs in a community program the child might attend if he or she had no special needs (Klein & Gilkerson, 2000, p. 459).

Intervention/Treatment: Targeted and individualized attention to young children and families who are exhibiting symptoms of developmental disturbances. Level 3 of the Promotion – Prevention – Intervention/Treatment continuum (ZERO TO THREE, 2007).

P-3 Service Provider: An individual who works in a public or private setting serving infants, toddlers, their parents or caregivers and/or expectant mothers and fathers to ensure that children are supported in nurturing environments so that they reach their full developmental potential.

P-3 Work Sectors: The Core Competencies Work Group addressed five sectors within which P-3 service providers provide an array of services along the Promotion – Prevention – Intervention/Treatment continuum. These sectors include:

Early Care and Education: Early childhood professionals work in many settings – not just public schools but also child care programs, private preschools and kindergartens, early intervention programs including Head Start and Early Head Start, family support and home-based programs and so on…the professional roles assumed by early childhood professionals…[include] roles as lead teachers, mentor teachers, education coordinators, early childhood trainers, inclusion specialists, resource and referral staff, technical assistance specialists, early childhood technology specialists, early interventionists and home visitors (Hyson, 2003, p. 1).

Early Intervention: Early intervention service provider, or EIS provider, means an entity (whether public, private, or nonprofit) or an individual that provides early intervention services under Part C of the [Individuals with Disabilities Education] Act, whether or not the entity or individual received Federal funds under Part C of the Act and may include, where appropriate, the lead agency and a public agency responsible for providing early intervention services to infants and toddlers with disabilities in the State under Part C of the Act. (b) An EIS provider is responsible for – (1) Participating in the multidisciplinary team's assessment of an infant or toddler with a disability and a family-directed assessment of the resources, priorities and concerns of the infant's or toddler's family, as related to the needs of the infant or toddler, in the development of integrated goals and outcomes for the individualized family service plan (IFSP); (2) Providing early intervention services in accordance with the IFSP of the infant or toddler with a disability; and (3) Consulting with and training parents and others regarding the provision of the early intervention services described in the IFSP of the infant or toddler with a disability (U. S. Department of Education, 2007, p. 26499).

Mental Health: An array of providers touch the lives of young children. Many of these professionals are in positions to promote social-emotional needs and identify and provide intervention for mental health problems. Early care and education providers and primary health care providers often are the frontlines for the majority of children who will interact with one or more such providers during their early years. Therefore, the providers in education and health care are particularly important players in promoting healthy emotional development and identifying early signs of problems. In addition, for a subset of children and families who are at risk or have an identified problem, there are a host of other professionals (Perry, Kaufman, & Knitzer, 2007, p. 100).

APPENDIX B: GLOSSARY OF KEY TERMS

Physical Health: Responsible for the planning, implementing and evaluating of services that address the health priorities and primary needs of infants, mothers, fathers, children and adolescents and their families in Los Angeles County through ongoing assessment, policy development and quality assurance (County of Los Angeles Public Health, n.d.).

A specialty area within the larger field of public health, distinguished by: Promotion of health and well-being of all women, children, adolescents, fathers and families, especially in disadvantaged and vulnerable populations [and a] life cycle approach to theory and practice...focuses on individuals and populations, on health promotion and prevention and on family-centered systems of care in communities (MCH Leadership Competencies Workgroup, 2009, p.8).

Health workers – working in public, private and non-profit entities – deliver essential public services...services include diagnosing and investigating health problems and hazards in the community, educating people about health issues and behavior change and promoting and enforcing laws and regulations that protect health and ensure safety (Perlino, 2006, p. 2).

Social Services/Child Welfare: Home-based services provided to families...with the goal of protecting the child, strengthening and preserving the family and preventing unnecessary out-of-home placement of children, or promoting the return of children temporarily in out-of-home care (Child Welfare League of America, 2003, p. 159).

The professional activity of helping individuals, groups, or communities enhance or restore their capacity for social functions and creating societal conditions favorable to this goal... [to] help people obtain tangible services; counseling individuals, families, or groups; helping communities or groups provide or improve social and health services (Child Welfare League of America, 2003, p. 161).

Child welfare workers...are at the core of the child welfare system, investigating reports of abuse and neglect, coordinating substance abuse, mental health, or supplemental services to keep families intact and prevent the need for foster care; and arranging permanent or adoptive placements when children must be removed from their homes...Caseworkers perform multiple functions from intake to placement on any given case...supervisors help caseworkers perform these functions...assigning cases, monitoring caseworkers' progress in achieving desired outcomes, providing feedback to caseworkers in order to help develop their skills, supporting the emotional needs of caseworkers, analyzing and addressing problems and making decisions about cases (U.S. General Accounting Office, 2003, p. 6).

Prevention: Targeted approach toward children who are at risk of poor developmental outcomes through early identification and intervention strategies. Level 2 of the Promotion – Prevention – Intervention/Treatment continuum (ZERO TO THREE, 2007).

Professional Development: Structured teaching and learning experiences that are formalized and designed to support acquisition of professional knowledge, skills and dispositions, as well as, the application of knowledge in practice (Buysse, deFosset, & Winton, 2007, p. 7).

Promotion: Services aimed at maintaining social, emotional, cognitive, language, physical and motor well-being of all young children and their families and reducing the need for services later on. Level 1 of the Promotion – Prevention – Intervention/Treatment continuum (ZERO TO THREE, 2007).

Promotion-Prevention-Intervention/Treatment Continuum: Services to infants, toddlers, and their families can be described as falling along a continuum of need. Family or child needs may change over time, resulting in moving to different places along this continuum. Some services may straddle these categories, while others may clearly fall within one. Promotion services are universally beneficial and focus on maintaining well being and benefit all very young children and their families. Prevention services are specifically targeted toward very young children and their families when they are part of a group understood to be at greater risk, or when specific risk indicators have been identified. Intervention/Treatment services seek to alleviate suffering and restore healthy functioning and development. (ZERO TO THREE, 2007).

Protective Factors: Attributes that reduce the likelihood or severity of illness or disability and limit its severity (Chan, 2010) or serve as buffers, helping parents who might otherwise be at risk of poor outcomes to find resources and positive coping strategies that allow them to provide nurturing parenting, although they are under stress (Center for the Study of Social Policy, 2007).

Relationship-based: Quality relationships characterized by trust, support and growth exist among and between staff, parents and children; these relationships form the foundation for all the work that's done (Parlakian, 2001, p. 1).

Research: The systematic process of collecting, analyzing and interpreting information to in order to understand a phenomenon (Leedy & Ormond, 2001).

Risk Factors: Characteristics or hazards within the individual, family, community or environment that increase the possibility of the occurrence, severity, duration, or frequency of later disorders (Beckwith, 2000).

Self-regulation: The ability to attain, maintain and change your level of arousal appropriately for a task or situation (ABC Kids Occupational Therapy, 2008).

Self-reflection: Stepping back from the immediate, intense experience of hands-on work to examine one's thoughts and feelings about the work experience and identify interventions that best meet the family's goals of growth and development (Parlakian, 2001).

Sustainability: The continuation, strengthening and/or furthering of impact on the well-being of children and families over an extended period of time (First 5 LA, 2009, p. 8).

Strength-based Approach: Assumes that all families have strengths they can build on and use to meet their own needs, to accomplish their own goals and to promote the well-being of family members. The family-professional relationship starts not from an assessment of problems but from an attempt to fully understand the ways in which the family successfully accomplishes its goals and manages its problems (Powell, Batsche, Ferro, Fox & Dunlap, 1997, p.4).

APPENDIX B: GLOSSARY OF KEY TERMS

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APPENDIX C: PROCESS NOTES AND EVALUATION FINDINGS

OVERVIEW OF METHODOLOGY

An internal evaluation was completed of the Prenatal through Three Workforce Development Project to obtain feedback during the project and to compare perceptions of Workgroup members throughout the project. Four surveys were completed at different points in the project. The surveys included:

- Initial Survey
- Who, What and How Framework Collaborative Meeting Survey
- Mid-Process Survey
- Workgroup Post Survey

The findings included both quantitative results (e.g., using Likert scale ratings) and qualitative feedback. A summary of the results is below, followed by the specific findings from each survey, along with comparisons across surveys where appropriate.

SUMMARY OF RESULTS

The collaborative process generated many lessons and insights about crafting a cross-disciplinary effort to define workforce competencies and put these competencies into practice. Workgroup members reflected on their own experience and identified assets that supported their work. Workgroup members also identified elements that are likely to be helpful to future cross-sector workforce development efforts for the P-3 workforce development in Los Angeles County.

Responses included:

- Remain open to the perspectives of other sectors.
- Separate self from own discipline. Let go of own "professional ego" and sector-specific jargon and terminology.
- Value everyone at the table equally.
- Ensure every work sector is equally considered and valued, particularly since some work sectors are more respected than others by the public and within the early childhood field.
- Set up a process that encourages each work sector to contribute and advocate for the workforce issues and competencies within that sector.
- Identify and address sectors' differences in language used to describe and define competencies in order to develop common language and concepts that are recognized and accepted by all work sectors.
- Keep competency-related language basic without oversimplifying.
- Apply a wellness-based approach rather than an illness/condition/treatment-based approach to frame concepts with jargon-free language.

In comparing pre- and post-responses on a survey of Workgroup participants, the Workgroup members reported they gained useful information from their interactions with other Workgroup members. This information enhanced their professional knowledge, knowledge of other work sectors and understanding of cross-disciplinary collaborative opportunities. The Workgroup process increased the resources, tools and strategies available to them for their own work, including increased connections to professionals outside their own sectors. Several Workgroup members reported that they have already been able to use the Who, What, How Framework and materials provided to the Workgroup in their own work.

SUMMARY OF RESULTS OF EACH SURVEY

Initial Survey

A brief online Initial Survey was administered prior to the Core Competencies and Training Workgroups prior to their first meetings. The survey gathered baseline data across work sectors on the thoughts and knowledge of invited members and others directly involved with the Project. The purpose of this survey was to:

- Learn about participants' current level of understanding related to P-3 competencies and professional development; and
- Identify participants' current thoughts and knowledge on P-3 workforce work sector competencies and professional development approaches and methods.

The Initial Survey was administered online using Zoomerang software's email deployment option that sends the survey link directly to the intended respondents' email addresses. This summary presents responses from those who responded by May 18, 2009. A total of 37 staff and Workgroup members submitted responses, for a response rate of 79 percent.

Definitions. On the Initial Survey "competency" was defined as *"the skill sets and/or knowledge P-3 service providers need to possess in order to provide quality services to infants, toddlers and their families."* Sixty percent of respondents said the definition describes competency to an extent but was not a comprehensive definition. Forty percent thought that it was an accurate and comprehensive definition of competency. Many participants suggested changes or additions to the presented competency definition, several of which addressed disposition, behavior and ability. This indicated that the Core Competencies Workgroup would need to work to reach consensus on an alternative definition of "competency" (see p. 3 of the Summary Report for the revised definition).

Participants were also presented with the working definition of "professional development" as *"structured teaching and learning experiences that are formalized and designed to support acquisition of professional knowledge, skills and dispositions, as well as the application of knowledge in practice."*[1] The majority of respondents (72 percent) agreed that the definition was accurate and comprehensive. Twenty-five percent of participants replied that the definition was not comprehensive and one respondent (3 percent) thought the definition was not accurate. This working definition was ultimately adopted by the Workgroup.

Knowledge of Workforce Work Sectors. To gauge knowledge of the Project's five work sectors, respondents were asked to rate their level of knowledge regarding current efforts to address competencies and to build/strengthen professional development within early care and education, early intervention, mental health, physical health and social services/child welfare at the local, state and national levels on a one-to-four scale ranging from "not at all knowledgeable" to "very knowledgeable." Overall, participants thought they were more knowledgeable at the local Los Angeles County level than at the state and national levels. At the local level, a range of respondents were "somewhat" or "very knowledgeable" of:

- Current efforts to address competencies across work sectors (range: 54 percent for the social services/child welfare sector to 70 percent for the early intervention sector).
- Current efforts to build/strengthen professional development (range: 44 percent in the physical health sector to 64 percent in early intervention).

[1] Definition from: National Professional Development Center on Inclusion. (2007). *New directions and promising approaches to address professional development challenges.* Preconference presented at the International Division for Early Childhood, Niagara Falls, Ontario.

Work Sector Coordination. The survey asked respondents to rate the level at which the identified work sectors are currently coordinating their professional development efforts. Responses indicated that participants believe that work sectors are currently not coordinating professional development efforts, with the majority of respondents indicating the following:

- The Workgroup sectors support and develop competencies at the local (70 percent), state (84 percent) and national (92 percent) levels "a little" or "not at all."
- The Workgroup sectors establish and provide professional development at the local (81 percent), state (86 percent) and national (92 percent) levels "a little" or "not at all."

Impact within Work Sector. Participants were asked how they saw themselves impacting competencies or professional development within their own work sector. With regards to influencing **in-service trainings**, 60 percent of respondents rated they could impact competencies and 61 percent rated they could impact professional development. For **practice** they rated themselves 49 percent on competencies and 50 percent on professional development; on **evaluation** 49 percent and 47 percent, respectively, and on **academia/pre-service training** 49 percent and 44 percent. A sizeable proportion of respondents also indicated that they could have an impact on policy (38 and 42 percent) and research (35 and 39 percent).

Professional Development Approaches. To identify participants' thoughts on the effectiveness of different professional development approaches to building a sustainable approach to professional development for the P-3 workforce, participants rated various approaches on a one-to-four scale ranging from "not at all effective" to "very effective." Of those familiar with the listed approaches, the following approaches were most likely to be rated as "very effective": reflective practice (64 percent), mentoring (63 percent) and modeling (53 percent). Workshops received the lowest rating, with only 14 percent rating this approach as "very effective." Approximately one-quarter of respondents indicated they were unfamiliar with or unsure how to rate the approaches of co-instructing (33 percent) and community of practice (25 percent).

Who, What and How Framework Collaborative Meeting Survey

On April 27, 2009 28 members of the Core Competencies and Training Workgroups, Project subject matter experts and consultants attended a *Prenatal through Three Workforce Development Project Meeting* on the Who, What, How Framework (WWH) (refer to p. 1 of the Summary Report). A paper survey was provided to attendees at the end of the Meeting to determine if meeting objectives were attained and to collect comments and suggestions. The survey form consisted of closed- and open-ended questions. A total of 21 attendees completed and returned the survey, a response rate of 75 percent.

Meeting Objectives and Structure. On a 4-point Likert scale ranging from "strongly disagree" to "strongly agree," survey respondents were asked to rate their level of agreement to a series of meeting objective and structure statements. As shown in Table C1, the majority of respondents agreed or strongly agreed that the meeting had attained its objectives and was well organized.

Table C1: Meeting Objectives Ratings

	Sample Size	Strongly Disagree	Disagree	Agree	Strongly Agree
I better understand the Who, What and How (WWH) Framework.	N=21	5%	0%	43%	52%
The WWH Framework is a useful approach to planning workforce development.	N=20	5%	0%	50%	45%
The WWH Framework is a relevant approach to planning workforce development.	N=20	5%	0%	50%	45%
Overall, the meeting was well organized.	N=20	5%	0%	25%	75%
Overall, the teaching methods utilized during the meeting were appropriate for the audience.	N=20	5%	0%	45%	50%
I feel prepared to apply the WWH Framework to the Project.	N=20	5%	5%	65%	25%
I identified what is needed to move the core competencies and/or professional development work forward.	N=19	0%	16%	69%	16%
I learned planning strategies and examples to assist in the development of cross-sector competencies and professional development related to the Project.	N=18	6%	11%	67%	17%

* Note: percentages do not equal 100 percent due to rounding.

Likes, Suggestions and Comments. The evaluation form included three open-ended questions to gather information about what respondents liked about the meeting, suggestions for future meetings and any other meeting-related comments or suggestions. When asked, "What did you like most about this meeting?" respondents indicated they liked interacting with people from different work sectors, learning about the WWH Framework and appreciated how the meeting was organized. Meeting attendees were asked, "What kind of information would you like to see included at future Project meetings?" Several suggestions concerned narrowing the scope of the Project and providing more examples on the application of the WWH Framework. Respondents were also provided with an opportunity to "share any other comments or suggestions you have regarding this meeting."

Plus/Delta. At the conclusion of most Workgroup meetings, participants were invited to provide feedback on the meeting in accordance with the Plus/Delta format, which is a simple process for gathering oral feedback on positive aspects and areas for change about a meeting. During this process, participants were asked to report on positive aspects of a topic (recorded under the + column on a flip chart or white board) and areas to change or requests for future meetings (recorded under the Δ column). Overall, Workgroup participants were positive about meeting facilitation, receiving information on the "big picture" of the Project and the sharing of information and resources, while areas to change largely addressed logistical concerns. This feedback was used to guide future meetings.

Mid-Process Survey

An online Workgroup Process Survey gathered data to assess how Workgroup members perceived their participation the Project. The information garnered from this survey was used to guide future Workgroup meetings. The survey was adapted from a Communities of Practice Indicators Worksheet developed by the FPG Child Development Institute[2] and is based on the Project approach and short-term outcomes. Workgroup members, consultants and content experts actively participating in the Core Competencies Workgroup at the time of survey dissemination were asked to complete the survey following their third Workgroup meeting and to return it within seven weeks. Of the 17 participants, 82% (14) completed the survey. The following summary demonstrates that at the midpoint the Workgroup, for the most, part adhered to a community of practice structure and the Project approach and was making strides toward short-term outcomes.

Membership. Workgroup participants rated that "all" or "most" of the members represented a variety of work sectors (100 percent) and expertise (97 percent). A slightly smaller proportion of participants reported Workgroup members "displayed most of the time" or "displayed all of the time" a common sense of purpose about their roles in the Workgroup (86 percent). Seventy-nine percent felt that members' responsibility for designing a plan of action to address the Workgroup's purpose was demonstrated "all" or "most of the time."

Process/Activities. The majority of respondents replied that at meetings members engaged in joint activities and discussions "all" or "most of the time" (83 percent) and built relationships with each other (86 percent) suggesting an experience of mutuality and sense of community. The majority of participants responded that learning useful information from interactions with others on the Workgroup had been displayed "all" or "most of the time" at the meetings (92 percent). One hundred percent perceived that members engaged in collaborative reflection on their experiences and concerns "all" or "most of the time." With regard to whether their own level of self-reflection had increased by their participation in the Workgroup, 77 percent responded "all the time," while 23 percent responded "a little."

Knowledge. Seventy-nine percent of respondents reported that members were generating new knowledge as a group through their interaction and had built a shared repertoire of resources, experiences and tools to address the Workgroup's purpose "all of the time" or "most of the time." Seventy-one percent of respondents said "all" or "most of the time of the time the Workgroup's knowledge was successfully translated into practical strategies; however, 29 percent felt this occurred only "a little." Similarly, while 57 percent of respondents replied that members "all" or "most of the time" felt connected with other members in the Workgroup who were outside of their work sector, 43 percent perceived this connection was displayed only "a little."

Project Approach and Short-Term Outcomes. The usefulness of evidence-based practices to the Workgroup's decision-making process was displayed "all" or "most of the time" according to 86 percent of respondents. A slightly smaller percentage of respondents (79 percent) rated that members were addressing issues of culture in the planning of the Workgroup work "all of the time" or "most of the time." The majority of respondents felt "all" or "most of the time" they advocated for and promoted cross-service sector P-3 workforce efforts outside of the Workgroup meetings (93 percent) and that members had a consensus on Project work and deliverables (86 percent).

Workgroup Meeting Comments. Responses to the open-ended question, "What would you keep the same about the Workgroup meetings?" appreciated the preparation, planning and materials developed for the meetings, the sharing of competency information from the different work sectors and the timing of the meetings. Regarding "What changes to the Workgroup meetings would you suggest?" the most common suggestion was to have more time for small group work.

Workgroup Post Survey

The purpose of this survey was to gather post-Workgroup data from active Workgroup participants in order to assess:

- Level of collaboration and cooperation among the Workgroup in accordance with principles of a community of practice;
- Satisfaction with participation in the Project;
- Change in participants' level of cross-sector understanding related to P-3 workforce core competencies and professional development; and
- Current and intended use of Project related resources and information.

The first part of the survey was identical to the questions asked on the Mid-Process Survey. The survey also contained items asked in the Initial Survey with regard to knowledge of different work sectors and perceived level of cross-sector collaboration. In addition, the Post Survey included items related to satisfaction and use of Project resources and information. The Post Survey was administered online. Core Competencies Workgroup participants completed the survey following their last Workgroup meeting and were given approximately three weeks to complete it. Nine Workgroup participants, out of 18, completed the survey for a response rate of 50 percent.

When appropriate, responses between the Initial and Mid-Process Survey and the Post Survey were compared by conducting paired t-tests on the data to determine if there were any differences in responses between the

[2] Winton, P., & Ferris, M. (2008). *Communities of practice indicators worksheet.* Retrieved from: http://community.fpg.unc.edu/resources/planning-and-facilitation-tools/FPG-Community-of-Practice-Indicators-Worksheet-2008.pdf/view

surveys. Six individuals completed both the Initial and Post Surveys and eight individuals completed the Mid-Process and Post Surveys. Statistical difference was set at a significance level of p≤.05 for a two-tailed test. Any differences found are discussed below.

Process: Membership. Workgroup participants rated that "all" or "most" of the members represented a variety of work sectors (100 percent) and expertise (89 percent). There was a statistically significant difference in ratings of work sector variety such that more respondents reported this variety in the Workgroup on the Post Survey than on the Mid-Process Survey. Participants reported Workgroup members "displayed most of the time" or "displayed all of the time" a shared common sense of purpose about their roles in the Workgroup (100 percent); and were responsible for designing a plan of action to address the Workgroup's purpose (89 percent).

Process: Process/Activities. All participants responded that learning useful information from interactions with others on the Workgroup had been displayed "all" or "most of the time" at the meetings (100 percent). With regard to mutuality or sense of community, the majority of respondents replied that members engaged in joint activities and discussions "all" or "most of the time" (89 percent) and built relationships with each other (89 percent). Ratings were significantly more positive on the Post Survey than Mid-Process Survey with regard to engagement in joint activities and building relationships. All of the respondents perceived that members engaged in collaborative reflection on their experiences and concerns at meetings "all" or "most of the time." Concerning whether their own level of self-reflection had increased by their participation in the Workgroup, the majority (89 percent) responded "all" or "most of the time." Ratings were significantly greater on both reflection items on the Post Survey than on the Mid-Process Survey.

Process: Knowledge. All of the respondents reported that members built a shared repertoire of resources, experiences and tools to address the Workgroup's purpose "all" or "most of the time." Eight-nine percent of participants reported that members generated new knowledge as a group through their interactions in the Workgroup. Respondents said that members were successful in turning the Workgroup's responsibilities into practical strategies "all" or "most of the time" (89 percent) and felt connected with others in the Workgroup outside of their work sector (78 percent).

Process: Project Approach and Short-Term Outcomes. All respondents rated that members addressed issues of culture in the planning of the Workgroup work and that members reached consensus on Project work and deliverables "all" or "most of the time." A majority of respondents felt that the usefulness of evidence-based practice to the Workgroup's decision-making process was displayed "all" or "most of the time" (89 percent) and that participants advocated and promoted cross-service sector P-3 workforce efforts outside of the Workgroup meetings (89 percent).

Satisfaction with Participation in Workgroup. To gauge Workgroup participant satisfaction, respondents were asked if they believed their participation in the Core Competencies Workgroup contributed to the early childhood field, was worthwhile and was relevant to their organization on a four-point scale ranging from "strongly disagree" to "strongly agree." All participants "agreed" or "strongly agreed" with the statements, indicating a high level of satisfaction.

Understanding of Work Sectors: Knowledge of Workforce Service Sectors. Similar to the Initial Survey, participants reported being more knowledgeable at the local Los Angeles County level than at the state and national levels. At the local level, for the most part the majority rated that they were "somewhat" or "very knowledgeable" about current efforts to address competencies across service sectors, ranging from a high in the early care and education sector (100 percent) to a low in the mental health sector (44 percent). At the state level, those who rated themselves as "somewhat" or "very knowledgeable" ranged from a high in the early care and education sector (78 percent) to low in the mental health and physical health sectors (33 percent each). Similarly, at the national level the range of "somewhat" or "very knowledgeable" respondents was high in the early care and education sector (67 percent) to a low in the mental health, physical health and social services/child welfare sectors (33 percent each). A statistically significant difference from Initial to Post Survey was revealed at the local level for the early care and education sector such that respondents were more positive in their self-rating of sector knowledge on the Post Survey.

In general, the findings for participant knowledge of current efforts to build/strengthen professional development efforts were lower compared to the knowledge of competencies. Respondents who were "somewhat" or "very knowledgeable" of professional development at the local level ranged from a high in the early care and education sector (100 percent) to a low in the physical health sector (44 percent). Knowledge of professional development efforts at the state and national levels were rated lower. Ratings of "somewhat" or "very knowledgeable" at the state and national levels were highest for the early care and education sector (56 percent) and lowest for the physical health sector (11 percent). There were several differences between Initial and Post Survey: perceived knowledge was rated greater on the Post Survey for the early care and education sector at the local and national levels, early intervention at the national level and mental health at the local level.

Understanding of Work Sectors: Work Sector Coordination. Workgroup members and First 5 LA staff indicated there is a fair amount of coordination among the identified P-3 service sectors. The majority responded that work sectors are coordinating "a lot" or "somewhat" at the local (89 percent), state (78 percent) and national (67 percent) levels. Post Survey ratings of local and state levels reported greater perceived collaboration than was reported on the Initial Survey. A smaller portion of participants indicated that work sectors were coordinating to establish and provide professional development compared to ratings of coordination on competencies. It was reported by the majority of respondents that service sectors were coordinating "a lot" or "somewhat" on professional development at the local level (78 percent), a statistically significant increase in perceived cross-sector coordination compared to ratings on the Initial Survey. However, the majority reported there was still only "a little" or "no" coordination at the state (56 percent) and national levels (67 percent).

Information and Resources. Workgroup participants were asked to report what information and resources received had been useful and relevant to their work. Eighty-nine percent of respondents replied that the Resource Notebook and 56 percent reported the WWH Framework were useful and relevant. Participants identified these as resources they used within their own organizations. Responses to how Workgroup participants planned to use the Project's materials and information to promote cross-sector collaboration indicated that participants were planning to incorporate these materials into organizational protocols and dialogue with other sectors.

The Post Survey concluded by asking respondents for any other ideas, comments, or suggestions related to their participation in the Core Competencies Workgroup. Members expressed a desire to be kept involved in the Prenatal through Three Workforce Development Project.

APPENDIX D: SAMPLE WORK ROLES

Early Care & Education	Mental Health	Early Intervention	Child Welfare	Physical Health
• Aide • Assistant Teacher • Associate Teacher • Early Head Start Home Based Educator • Early Head Start Manager • Family Child Care (FCC) Aide • FCC Network Coordinator • FCC Provider • Family Friend and Neighbor Caregiver/ License-exempt Child Care Provider • Family Literacy Trainer • Family Literacy Coordinator • Master Teacher • Nanny • Program Director • Resource and Referral Specialist • Resource and Referral Trainer • Site Supervisor • Teacher[i]	• Prevention, Intervention/ Treatment • Child Care Mental Health Consultant • Clinical Social Worker • Developmental Psychologist • Early Childhood Mental Health Specialist • Early Interventionist • Licensed Mental Health Professionals • Mental Health Therapist • • Promotion • • Those who focus on supporting healthy development, such as early care and education providers, support group facilitators, parent educators[ii]	• Aide • Assistant • Early Interventionist I • Early Interventionist II • "Qualified personnel who provide early intervention services...: (1) Audiologists. (2) Family therapists. (3) Nurses. (4) Occupational therapists. (5) Orientation and mobility specialists. (6) Pediatricians and other physicians for diagnostic and evaluation purposes. (7) Physical therapists. (8) Psychologists. (9) Registered dieticians. (10) Social workers. (11) Special educators, including teachers of children with hearing impairments including deafness) and teachers of children with visual impairments (including blindness). (12) Speech and language pathologists. (13) Vision specialists, including ophthalmologists and optometrists."[iii]	• Attorney • CASA • Case Worker • Child Protection W orker • Child Welfare Instructor • Child Welfare Policy Advocate • Foster Parents • In-home Aides: Homemaker, parent aide, human service aide, parent educator, family support worker ("all share the common purpose of helping to maintain children in intact families") • Judge • Kinship Caregivers • Permanency Planning Worker • Public Health Nurse • Social Worker[iv]	• Care Coordinator • Certified Lactation Educator • Early Childhood Educator/New Parent Coach • Family Medicine Provider • Health Educator • Hospital Case Manager • Hospital Discharge Planner • Hospital Liaison • Hospital Social Worker • Internal Medicine Provider • Lactation Consultant • Lactation Specialist • Lactation Support Peer Counselor • Nurse Home Visitor • Nurse Midwife • Nursing Staff Supervisor (RN, LCSW, or licensed developmental psychologist) • Nutritionist • Obstetrician • Pediatrician • Pediatric Dentist • Pediatric Nurse Practitioner • Pediatric Office Receptionist • Perinatal Case Manager • Public Health Dentist • Public Health Nurse • Registered Nurse • Social Worker[v]

[i] Insight Center for Community Economic Development (2007). *Early care and education career lattices in Los Angeles.* Oakland, CA: Author.
[ii] Meyers, J. (2007). Developing the workforce for an infant and early childhood mental health system of care. In D. Perry, R. Kaufmann and J. Knitzer (Eds.), *Social and emotional health in early childhood: Building bridges between services and systems.* Baltimore, MD: Brookes.
[iii] Department of Education. Early intervention program for infants and toddlers with disabilities: Proposed rule. *Federal Register,72,* 26456- 26531. 2007.
[iv] Child Welfare League of America (2003). *CWLA standards of excellence for services to strengthen and preserve families with children.* Washington, DC: Author.
[v] Perlino, C. M. (2006). *The public health workforce shortage: Left unchecked, will we be protected?* Washington, DC: American Public Health Association.

APPENDIX E: SOURCES FOR CORE COMPETENCIES BIBLIOGRAPHY

Purpose of this document:
This bibliography identifies resources that informed the work of the Core Competencies Workgroup in formulating core competencies for the prenatal through age three (P-3) workforce. These documents represent information on the P-3 workforce, competencies for the P-3 workforce or competencies developed through the efforts of local, state or national working groups.

General Resources

Annie E. Casey Foundation. (2003). ***The unsolved challenge of system reform: The condition of the frontline human services workforce.*** Baltimore, MD: Author. Retrieved from http://www.caseyfoundation.org/KnowledgeCenter/Publications.aspx?pubguid=%7BA4B76C41-76F0-4ACA-A475-1665F3519663%7D.
This document provides an overview of challenges for the workforce in early care and education, child welfare, early intervention and social services.

Burns, P., Flaming, D., & Economic Roundtable. (2006). ***LA Workforce Investment.*** Los Angeles, CA: Economic Roundtable. Retrieved from http://www.economicrt.org/publications.html.
This document, commissioned by First 5 LA, provides data on the prenatal through five workforce in Los Angeles County.

National Child Care Information and Technical Assistance Center (2009, July). ***The early childhood professional development systems toolkit: With a focus on school-age professional development.*** Fairfax, VA: Author and Child Care Bureau. Retrieved from http://nccic.acf.hhs.gov/pubs/pd_toolkit/index.html.
This document references the role of competencies in the overall development of a comprehensive cross-sector professional development system.

National Professional Development Center on Inclusion. (2008). ***What do we mean by professional development in the early childhood field?*** Chapel Hill, NC: The University of North Carolina, FPG Child Development Institute, Author. Retrieved from http://community.fpg.unc.edu/resources/articles/files/NPDCI-ProfessionalDevelopment-03-04-08.pdf.

Winton, P. J., McCollum, J. A., & Catlett, C. (Eds.). (2008). ***Practical approaches to early childhood professional development: Evidence, strategies and resources.*** Washington, DC: ZERO TO THREE.

Wisconsin Early Childhood Collaborating Partners (n.d.). ***Wisconsin early care and education career guide.*** Retrieved from http://www.collaboratingpartners.com/career_g/WI_IndvPDP.html.
Attempting to unify the early childhood community, provides career guidance covering child care, public education, Head Start, health, mental health, family support, family literacy and early intervention.

ZERO TO THREE. (1990). ***Preparing practitioners to work with infants, toddlers and their families: Issues and recommendations for the professions.*** Washington, DC: National Center for Clinical Infant Programs.

Cultural Competence Resources

Chang, H. (n.d.). ***Getting ready for quality: The critical importance of developing and supporting skilled, ethnically and linguistically diverse early childhood workforce.*** Oakland, CA: Children Tomorrow. Retrieved from http://www.californiatomorrow.org/media/gettingready.pdf.
The document makes recommendations for supporting diversity in the early care and education workforce.

Georgetown University Center for Child and Human Development, National Center for Cultural Competence (n.d.). ***Culturally competent guiding values and principles.*** Retrieved from http://www11.georgetown.edu/research/gucchd/nccc/foundations/frameworks.html#ccprinciples.

National Association for the Education of Young Children (2009, June). ***Quality benchmark for cultural competence project.*** Retrieved from http://www.naeyc.org/files/naeyc/file/policy/state/QBCC_Tool.pdf.

Sareen, H., Vicensio, D., Inkelas, M., & Halfon, N. (2003). ***Cultural proficiency: Applications for a state early childhood comprehensive system.*** Los Angeles, CA: UCLA Center for Healthier Children, Families and Communities; National Center for Infant and Early Childhood Health Policy.

Sareen, H., Vicensio, D., Russ, S., & Halfon, N. (2005, July). ***The role of state early childhood comprehensive systems in promoting cultural competence and effective cross-cultural communication.*** In N. Halfon, T. Rice, & M. Inkelas (Eds.) *Building State Early Childhood Comprehensive Systems Series,* No. 8. Los Angeles, CA: National Center of Infant and Early Childhood Health Policy at UCLA. Retrieved from http://www.eric.ed. gov/.

Developmental Screening Resources

American Academy of Pediatrics (2006). ***Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening.*** *Pediatrics,* 118, 405-420. Retrieved from http://pediatrics.aappublications.org/.

Georgetown Center for Child and Human Development website: http://gucchd.georgetown.edu.
Provides information on a wide range of issues affecting young children. Includes the University Center for Excellence in Developmental Disabilities, National Center for Cultural Competence and National Technical Assistance Center for Children's Mental Health.

Inkelas, M., Martinez, S., Espinosa, L., Zepeda, M., Smith, K., Mackie, J. & Brown, L. (2007, September). ***Policy scan: Desired results and achieving improvement in a system of early identification and intervention in Los Angeles County.*** Los Angeles, CA: Early Developmental Screening and Intervention Initiative. Retrieved from http://www.first5la.org/files/EDSIreport091807.pdf.
A report by the First 5 LA Early Developmental Screening and Intervention (EDSI) Strategic Partnership that identifies key participants in efforts to improve the early identification and intervention system in Los Angeles County.

APPENDIX E: SOURCES FOR CORE COMPETENCIES BIBLIOGRAPHY

Early Care and Education – Publications and Reports

Center for the Study of Child Care Employment. (2008). ***Early childhood educator competencies: A literature review of current best practices and a public input process on next steps for California.*** Berkeley, CA: Author, Institute for Research on Labor and Employment, University of California at Berkeley. Retrieved from http://www.eric.ed.gov.
This report was completed for a project funded by the California Department of Education and presents a review of early childhood educator competency systems developed in other states. It also represents the results of a series of focus groups conducted in California in 2007 to gather input from the field of early care and education on the appropriate direction for developing competencies for early childhood educators in California. There is currently an advisory committee working to take the recommendations of this report and develop specific competencies for early childhood educators under the guidance of WestEd and the California Department of Education.

The Family Child Care Accreditation Project Wheelock College (2005). ***Quality standards for NAFCC accreditation*** (4th ed.). Salt Lake City, UT: National Association for Family Child Care. Retrieved from http://ccrain.fl-dcf.org/documents/-99/631.pdf.
Provides standards for family child care providers seeking accreditation through the national association.

Hyson, M. (Ed.) (2003). ***Preparing early childhood professionals: NAEYC's standards for programs.*** Washington, DC: National Association for the Education of Young Children.
Presents guidelines for early childhood education teacher preparation programs in four-year colleges and community colleges and guidelines developed by the Council on Exceptional Children, Division of Early Childhood for degree programs in Early Childhood Special Education. Guidelines for early childhood education teacher program accreditation are also available at: http://www.naeyc.org/accreditation.

ZERO TO THREE. (2008). ***Caring for infants and toddlers in groups.*** Washington, DC: Author.
Provides standards for programs providing child care for infants or toddlers in group settings such as child care. Available at: www.zerotothree.org.

Early Care and Education – Web Resources

California Curriculum Alignment Project website: http://www.childdevelopment.org/cs/cdtc/print/htdocs/services_cap.htm.
The California Community Colleges Curriculum Alignment Project engaged faculty statewide to develop a lower-division program of study of evidence-based courses designed to be a foundational core for early care and education teacher preparation.

Child Development Division, California Department of Education (2006). ***Infant/toddler learning & development program guidelines.*** Sacramento, CA: Author. Retrieved from http://www.cde.ca.gov/sp/cd/re/documents/itguidelines.pdf.
Provides a variety of materials to provide guidance on quality to programs and individual practitioners, including California Infant and Toddler Learning and Development Program Guidelines; California Infant/' Toddler Learning and Development Foundations; California Child Development Permit: Infant-Toddler Specialist.

National Alliance for Family Friend & Neighbor Child Care, Bank Street College website:
http://www.bankstreet.edu/naffncc/.
Reports, resources and assessment instruments to assess license-exempt child care.

National Infant Toddler Child Care Initiative website: http://nitcci.nccic.acf.hhs.gov/index.htm.
Provides fact sheets, technical assistance papers and issue briefs about building systems of child care designed to support quality care for babies and toddlers.

Program for Infant Toddler Care (PITC) website: http://www.wested.org/cs/we/view/pj/249.
Supports statewide training and technical assistance to improve the quality of early care and education programs for infants and toddlers.

Early Childhood Mental Health Resources

The California Endowment's Mental Health Initiative Case Studies
Fight Crime: Invest in Kids California. (2006). ***From promise to practice: Mental health models that work for children and youth.*** Oakland, CA: Author. Retrieved from http://www.calendow.org/uploadedFiles/FCIK_toolkit.pdf.
The Lewin Group (2006, July). ***Education, resources, empowerment and skills (Project ERES): The challenge of overcoming stigma*** (TCE 0406-2006). Los Angeles, CA: The California Endowment. Retrieved fromhttp://www.calendow.org/uploadedFiles/MHI_calendow_case_education.pdf.
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This document updates recommendations from the California Infant, Preschool & Family Mental Health Initiative on professional competencies for mental health in-service and pre-service training programs.

Georgetown Center for Child and Human Development website: http://gucchd.georgetown.edu.
Provides information on a wide range of issues affecting young children. Includes the University Center for Excellence in Developmental Disabilities, National Center for Cultural Competence and National Technical Assistance Center for Children's Mental Health.

Korfmacher, J., & Hilado, A. (2008). ***The competent early childhood mental health specialist.*** *Herr Research Center for Children and Social Policy at Erikson Institute Research Brief,1,* 1-8. Retrieved from www.erikson.edu/hrc.
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This culturally sensitive, relationship-based state endorsement system has been adopted or used as a model by several other states.

Early Intervention Resources

California Interagency Coordinating Council on Early Intervention (2010, November). ***Early Start Personnel Model: A guide for planning and implementing professional development in support of early intervention services.*** Retrieved from http://www.dds.ca.gov/earlystart/docs/ICC_PersonnelManual.pdf.
This manual presents the recommended personnel competencies updates required by the state's Personnel Model.

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APPENDIX F: ALIGNMENT OF P-3 CORE COMPETENCY DOMAINS WITH WORK SECTOR DOMAINS

Definitions

Core Competencies:

Competencies of prenatal through age three service providers are the basic attitudes, knowledge and skills required to provide effective services that meet the needs of expectant parents, infants, toddlers and their families.

P-3 Service Provider:

An individual who works in a public or private setting serving infants, toddlers, their parents or caregivers and/or expectant mothers and fathers to ensure that children are supported in nurturing environments so that they reach their best developmental potential.

Explanation of Table

The table presented on the following pages was designed to serve as a planning template to guide the Core Competencies Workgroup in the identification of the core competency domains for the Prenatal through Age Three Workforce Development Project.

Column 1 lists the Workgroup recommended core competency domains. Columns 2-6 list domain titles from representative documents from the P-3 work sectors of early care and education, early intervention, social services/child welfare, mental health and physical health.

This table will be updated and revised in 2013.

Column #1	Column #2	Column #3	Column #4	Column #5	Column #6
Prenatal through Three Workforce Development Project **Core Competency Domains**	**Workforce Sector Domain Titles**				
	Early Care and Education[i]	**Early Intervention**[ii]	**Social Services/ Child Welfare**[iii, iv]	**Mental Health**[v]	**Physical Health**[vi]
Early Childhood Development	Child Growth and Development		Apply Knowledge of Human Behavior and the Social Environment	Infant/Toddler and Preschool Development	
Family-Centered Practice	Family and Community		Family-Centered Approach to Child Protective Services	Parenting, Family Functioning and Parent-Child Relationships	
Relationship-Based Practices					Nurse Practitioner-Patient Relationship Teaching – Coaching Function
Health and Developmental Risk and Protective Factors	Family and Community		Effects of Abuse and Neglect on Child Development/ Human Development Family Violence	Parenting, Family Functioning and Child-Parent Relationships Biological and Psychosocial Factors Risk and Resiliency	
Cultural and Linguistic Responsiveness	Cultural Diversity Dual Language		Culture and Diversity in Child Welfare Practice Engage Diversity and Difference in Practice Advance Human Rights and Social and Economic Justice Respond to Contexts that Shape Practice		Cultural Competence

APPENDIX F: ALIGNMENT OF P-3 CORE COMPETENCY DOMAINS WITH WORK SECTOR DOMAINS

Column #1	Column #2	Column #3	Column #4	Column #5	Column #6
Prenatal through Three Workforce Development Project **Core Competency Domains**	**Workforce Sector Domain Titles**				
	Early Care and Education[i]	**Early Intervention**[ii]	**Social Services/ Child Welfare**[iii, iv]	**Mental Health**[v]	**Physical Health**[vi]
Leadership and Advocacy	Administration and Management				Managing and Negotiating Health Care Delivery Systems
Professional and Ethical Practices	Professionalism and Professional Development	Professional and Ethical Practices	Legal Aspects of Child Protection Case Planning and Family-Centered Casework Writing Skills/ Documentation Identify as a Professional Social Worker and Conduct Oneself Accordingly Apply Social Work Ethical Principles to Guide Professional Practice Apply Critical Thinking to Inform and Communicate Professional Judgments	Ethics	Professional Role Monitoring and Ensuring the Quality of Health Care Practice
Service Planning, Coordination and Collaboration		Collaborative Partnerships Transition Planning	Health and Medical Issues DCFS-Specific Issues	Interdisciplinary/ Multidisciplinary Collaboration	

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