

Peninsula Infant/Toddler Regional Service Model (RSM)

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

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

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

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

Regional funding focus: The service model for the Peninsula Region focuses on licensed child care providers who care for infants and toddlers, are located in remote and rural areas, and serve families identified as living in these isolated areas of the Olympic and Kitsap peninsulas. Our model supports the development of a collaborative regional perspective on infants and toddlers, their families and the systems and services that support them.

There are two different levels of consultation:

Consultant Pool: The first level of our consultant pool is the Education Consultant (also known as the Infant-Toddler Coordinator), infant and mental health consultants and public health consultants. This first level of consultation provides a supportive system for providers to maximize their abilities to promote positive social and emotional environments that includes engaging in positive attachment relationships to assure optimal learning environments for all children.

The second level of consultation focuses on coordinating with the local infant and toddler services and support systems organized by the Interagency Coordinating Councils in each county. By attending these meetings, we will learn about local systems of support for infant and toddler care, and share the progress of the infant and toddler program to mutually plan how to best engage in this rich bank of local consultation services. Through this approach we will expand our ability to support providers to provide for positive, healthy, and safe environments that promote mental health, social, emotional, attachment, physical, cognitive, motor development. We also feel that this process may also provide resources and support for providers that extend beyond the duration of their participation in this project.

Duration and quantity of consultation services. The Education Consultant provides 2 hours of consultation services per month for 10 months to the 7 new providers and 1 hour per month (or 2 hours every other month) to our 3 existing carry-over providers. She conducts and reviews the ITRS (Infant and Toddler Rating System) assessment, supports the provider in setting goals, and provides on-going consultation to take steps towards achieving goals which links the consultation work together to promote positive outcomes for the provider and ultimately the children.

The Regional Coordinator coordinates consultation services for the mental health consultants, public health consultants and resources and services in cooperation with the Education Consultant.

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SECTION 2: Service Delivery Strategy

PART A: Provider Funding Focus Strategies

<p>Please briefly describe the providers that will be your focus.</p>
<p>So that we will “achieve and sustain positive changes for providers” we chose to work with providers in remote and isolated communities as our priority. These providers will be located in the most rural and isolated areas whenever possible. Additionally, the licensed child care providers will accept child subsidies. Providers that are located in remote areas may not have the ability to access resources. Getting to trainings or having support from project may be impossible because of the geographical distance. As we meet the turnover requirements our focus will continue to be on identifying the most isolated providers.</p>
<p>1. Funding Focus Component #1: Please describe why you believe this focus will reach providers that serve a high percentage of vulnerable children (based on DEL’s definition outlined in the accompanying Overview document)?¹</p>
<p>We believe this focus will reach providers that serve a high percent of vulnerable families because the child care subsidy data and free- and reduced lunch data show that providers are serving low-income families and are located in high need areas. The state child care subsidy data indicates that the percent of licensed child care providers serving children using subsidies is 82.9% in Clallam County, 85.6% in Jefferson County and 64.3% in Kitsap County. These figures show there are a high percentage of families accessing licensed child care that have incomes below 200% of the Federal Poverty Level.</p> <p>The free- and reduced lunch rates also provide evidence of serving high-need populations. As reported in our data summary “the most vulnerable families with infants and toddlers on the Olympic Kitsap Peninsulas include families living in poverty”. The rate of families who qualify for free- and reduced-lunch is 47.1% in Clallam County, 47.0% in Jefferson County, 42.1 in Kitsap County and 58.3% in North Mason County, showing incomes below 185% of the Federal Poverty Level.</p> <p>Additionally, our Coalition has identified our highest need populations to be those living in the more rural, remote and/or isolated areas of our region leading to our focus on child care providers who are located in these areas whenever possible. With positive attachment relationships being very significant to the development of young children’s development, emotional and cognitive capacity, our focus will help to bring these resources to providers and families most in need.</p>

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

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

We have several strategies to assure that we deliver efficient and high-quality consultation to child care providers. Because we are working with child care providers serving families most in need, and are primarily located in the more remote, rural and/or isolated areas of our region, the Education Consultant will plan the visits to the child care programs who are along the same routes as much as daily travel time allows. The second level of consultation services (mental health and public health) will be provided by local consultants (on an as-needed basis) who live closer to the child care providers. When child care providers are located close to each other in proximity, we will plan our work with these providers carefully to both address efficiencies as well as promote provider networking when possible.

We also have efficiencies in the systems that support the consultants who are providing the services. Due to our geographic region, our consultants are continuously on the road or meeting with providers during their project time, requiring a specialized system that assures both communication/support and accountability for reporting. The Regional Coordinator is responsible for the tracking and reporting of all consultation services, and has created efficient systems for consultants to report via email, fax and telephone to reduce drive time. The Education Consultant and Regional Coordinator are located in the same home office, and have regular meetings to assure the timeliness of coordinating monthly and periodic reporting. The program manager who supervises the project is also located in the same office creating continuous availability of support and oversight. The Coalition Infant and Toddler steering committee, who advises the project operations, meets monthly via telephone conference call and provides guidance via email in-between meetings and reports monthly at the Coalition meetings.

PART B: Recruitment

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

i. Who will primarily be involved in outreach and recruitment efforts (e.g. leads, steering committee members, community agencies)?

The primary persons that will be involved in recruiting will be the Regional Coordinator who will actually conduct the outreach and recruitment efforts. The Coalition steering committee will provide advice and guidance to the project, which includes public health, Child Care Aware, early intervention, school district, DEL Child Care Licensing, and community organizations

Child Care Aware is participating by providing names of child care providers who serve infants and toddlers and their locations, by participating on the Coalition steering committee, and by our coordination meetings.

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<p>ii. What is your primary strategy and anticipated activities to conduct outreach and recruitment?</p>	<p>Our primary strategy is multi-pronged. First we will provide two cluster MERIT trainings that are geographically located in the isolated areas to all licensed child care providers to help them gain an understanding of the project and the support that it provides.</p> <p>We will continue to participate in the local Interagency Coordinating Councils to network and to build our connection within the communities and create awareness of the project and identify potential eligible child care providers.</p> <p>Also, from the lists of eligible child care providers received from Child Care Aware, we will directly call providers and meet with them at their locations to review the project and explain the details of participation.</p>
<p>iii. What did you find particularly successful or an area you could improve upon from your recruitment in SFY 2012 and SFY 2013?</p>	<p>We believe we were particularly successful in building new relationships with child care providers who are located in the more remote and rural areas of our region. This is a great accomplishment for us because this project has allowed new resources and support to areas that previously did not have these resources which has also helped the Coalition further expand its priority to bring resources and support to these unique areas.</p> <p>Additionally, the recruitment trainings were very successful in both recruiting the providers for the first 2 years, and for providing information to the general provider populations about our project.</p> <p>There are a total of 172 eligible child care providers in our region with a diverse distribution: 9 providers in north Mason County, 114 providers in Kitsap County, 9 providers in Jefferson County, and 40 providers in Clallam County. We hope to improve on our outreach and expand our recruitment efforts, and to increase our partnership and coordination with Child Care Aware, especially where we are serving the same providers to clarify and coordinate each project's support.</p>

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PARTS C: Relationship Building and Goal Setting

	Description	Anticipated Outputs
<p>i. Please describe your strategy for building successful relationships with center directors and teachers prior to the start of consultation.</p>	<p>The strategy we use for building successful relationships is based on the RIE (Resources for Infant Educators) where we model strong, positive relationships in all of our communication efforts and consultations to support attachment theory and practice with the provider programs. This includes being good listeners at the beginning of our service to learn about the provider’s program, their strengths and the things they are most proud about, and their needs. Another strategy we learned through the first phase of the project is how important it is to meet with both the teacher and director. One has the management of the center and one has the classroom teaching as the priority. Both of these are equally important in the change process.</p>	<p>How many hours do you estimate your consultants and leads will dedicate towards provider assessment and goal setting activities:</p> <p>Average per teacher receiving consultation: <u>22</u></p>
<p>ii. What process is in place to establish consultation goals with the consultation recipients (please include name of assessment to establish goals)?</p> <p>List your expected hourly outputs on this task in the right hand column.</p>	<p>The process for establishing goals happens after the Infant and Toddler Environmental Rating scale has been administered by the Education Consultant early in our consultation schedule, and the ASE:SE has been administered by the provider and the parent. The Education Consultant and provider review the results together and mutually prioritize goals.</p> <p>In this process we listen carefully to the provider and follow their lead in prioritizing the goals that are most important to them and are doable given their time and the project resources available for support. The Education Consultant skillfully helps to adapt and refine goals to both meet the stated needs of the provider and the data shown from the assessment results.</p>	<p>Total for SFY 2014 <u>70-190</u></p> <p>Total for SFY 2015 <u>70-190</u></p>
<p>iii. How will your region track consultation goals and progress towards those goals?</p>	<p>Our Education Consultant will meet with each new provider for 2 hours per month and existing providers 1 hour per month (or 2 hours every other month) to discuss progress towards goals, to scaffold coaching conversations regarding change, and to brainstorm resources and supports. The Education Consultant then records the content of the monthly consultation visits on the Site Visit Form report that includes updates on this progress, and then submits to the Regional Coordinator who tracks this information and creates the monthly and periodic reports for DEL and ORS.</p>	

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PART D: Service Delivery Strategy and Anticipated Outputs

Strategies and Related Activities Please describe the service delivery strategies and related activities that will occur in your region. (e.g., initial meetings, classroom based consultation, provider assessments, classroom observations, modeling, culturally and linguistically relevant practices, parent meetings, proposed provider training, etc.) Please be sure that the description explains how your planned activities are related to your funding focus. <i>[See the DEL IT Consultation Hours Policy (Section 1, Part D) outlined in the accompanying “RSM Overview – Phase 2” document and its footnote.]</i>	Estimated Outputs (e.g., provide a basic range for consultation hours, teachers/directors served and infant and toddlers reached)
Strategy #1 Eighty-one percent of our consultation hours (154 hours) will be provided to new classroom teachers and in some cases new sites. If there is a director, they will join for some of this time. The Education Consultant and the Regional Coordinator will provide an initial meeting/orientation session for the new teachers/directors to explain the program, how our program complements other services they might be receiving, and clarify the scope of work. We will also explain that we may only be working with them for 12 months to prepare them for potential changes at the end of the year. A clear schedule will be provided so the teachers/directors will know what to expect. During the first two meetings, time will be spent developing a relationship with the provider by listening and learning. Our Education Consultant is very skilled in building relationships with providers, and oftentimes builds in emergent consulting in these informal conversations. Each month for 10 months, the Education Consultant will schedule on-site consultation that is individualized for each teacher and their progress in meeting the prioritized goals. After we introduce the ITERS and the ASQ:SE in these initial visits, a schedule for the Education Consultant to administer ITERS will be arranged. The Education Consultant first introduces the ASQ:SE booklet and reviews the administration of the tool, and guides the provider in implementing the tool with parents. The ASQ:SE has different assessments for each 6 month interval of the age of the infant or toddler (6 months, 12 months, 18 months etc.). The providers will complete an ASQ:SE, as will each parent who are also accurate assessors of their young children’s behaviors and development. The ASQ:SE provides a great deal of information about infants and toddlers, including many attachment behaviors such as eye contact between parent and child, how they separate (for example when dropped off at child care), how the baby smiles at others, responses to calming efforts, response when picked up or cuddled, enjoyment of meals times (breastfeeding or bottle feeding), and parent can state things they enjoy about their baby. After the ASQ:SE is completed, the Education Coordinator reviews with the providers and discuss the scores especially if there is a score in the “referral” area.	Overall Consultation Hours in SFY 2014: 70 hours – 190 hours
	Consultation Hours Per Teacher in SFY 2014: 20 hours education for new providers and 10 hours for existing providers; and 2 hours mental health, public health or other consultation resources from ICC professionals. 22 hours x 10 providers and 12 hours x 3 providers
	Consultation Hours Per Director in SFY 2014: 4 hours per year (not additional hours because director is teacher, or director included with teacher in consultation).
	Anticipated # of Infant and Toddlers Reached in SFY 2014: 150
	Overall Consultation Hours in SFY 2015: 70-190 hours (teachers & directors)
Consultation Hours Per Teacher in SFY 2015: 20 hours education for new providers and 10 hours for existing providers; and 2 hours mental health, public health or other consultation resources from ICC professionals. 22 hours x 10 providers and 12 hours x 3 providers	
Consultation Hours Per Director in SFY 2015: 4 hours per year (not additional hours because director is teacher, or director included with teacher in consultation).	

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Then the provider initiates a conversation with the parent as they review both the provider and parent ASQ:SE results to know more about the infant’s development, and plan next steps and scaffolding with the parent for the child’s experience. This process helps to inform the provider’s lesson planning, and helps to identify any early concerns for referral to early intervention programs or other mental health services. We have also found that this process has increased both a parent and provider’s understanding of infant and toddler development.

The ITERS, which is an assessment of primarily the environment, is administered by the Education Consultant. It takes about 2 hours to administer, and is scored in all areas. A complete report is prepared for the provider and then reviewed together. The ITERS provides useful details and strategies for providers to improve their environments.

Nineteen percent of our consultation hours (36 hours) will be provided to teachers already participating in the project. The Educational Consultant will meet with them for one hour per month or for two hours every other month for 10 months. We will conduct a different version of the orientation, building on what the provider knows and then supplementing with what we know we need to improve upon in orienting providers.

Each monthly visit will incorporate an observation and meeting with teacher and/or director to provide feedback help to cooperatively determine the achieved milestones in meeting the goals.

Strategy #2

The Education Consultant, in partnership with the provider, will help to determine if other consultation (such as mental health or public health) is needed as a result of the ITERS, ASQ:SE, observations or provider emergent need. The Education Consultant will then notify the Regional Coordinator who will work with the specific community consultant to schedule the visit. It may not be possible for the Education Coordinator to be at the site at the same time as the community consultant, so there will be communication ahead of time regarding the visit, as well as follow up consultation.

Strategy #3

Our trainings will be based on both individual program ITERS & ASQ:SE and a regional analysis of the ITERS and ASQ:SE of all 10 providers. The Education Consultant will provide 2 MERIT trainings at each of the 10 providers that will be individually designed to maximize the effectiveness of the training. Also, two regional trainings will be provided based on the analysis of the two assessments and common needs/interests which will also serve as recruitment actions by inviting other child care providers.

Anticipated # of Infant and Toddlers Reached in SFY 2015: 150

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Culturally and linguistically relevant practices: There are several ways we are ensuring the services provided are culturally and linguistically relevant. The first is through the Coalition Infant & Toddler Steering Committee that is comprised of many viewpoints including schools, tribes, early intervention, DEL Licensing, Child Care Aware, and community organizations. Second, several steering committee members attend the Thrive By Five Statewide Racial Equity Meetings and are working with the Coalition to expand our understanding of the achievement gap and how to better understand our region’s cultural diversity. For example, our Coalition is co-hosting a regional tribal listening session regarding early learning issues.

We also make sure that all goal setting is led by the provider who knows their community and families the best, and understand the conditions of the community and factors that impact families. They are our best guides in assuring that we are sensitive to the cultural needs and support relevant practices. For example, our Education Consultant recognizes the sensitivities of working with a provider in Forks (far west coastal community) in contrast with working with a rural provider in Kitsap County.

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

We learned a lot in SFY 2012 – 2013 that we are applying to SFY 2013 – 2014. Due to the large geographic area of our region and time travel time involved, we have decided to reduce from 12 providers to 10. The child care providers really liked the consistency of monthly consultation but also expressed need for training to support their monthly consultation. Therefore, we reduced the number of months of consultation from 12 months to 10 months, and added training in for two months. These trainings will be in the provider program so we can maximize benefit to the provider. Also, providers expressed interest in networking with others, so we will provide 2 additional regional trainings.

We learned this last year that our consultation model was confusing and not as effective as it could be. Sometimes the consultants were uncertain about their role and purpose when visiting a provider. As a result we changed this model. This year, the education consultant will be the primary and on-going consultant who develops the monthly relationship with the provider. If additional services are needed, then the education consultant will begin that process. We will provide more clear guidance and expectations of the “specialist” consultants to maximize their expertise and minimize confusion.

Additionally, during this phase of the project we will offer two MERIT trainings that will focus on the needs of the providers in working with infants and toddlers. In the isolated and remote areas of the peninsulas’ region there are few MERIT trainings and even fewer that focus on Infants and Toddlers. Adding these MERIT trainings will serve several purposes, introduce the project to recruit, provide MERIT trainings to our currently enrolled providers and bring together the providers for networking and learning.

Lastly tracking, reporting and preparing the monthly and periodic reports has been challenging given the limited work hours of the Regional Coordinator who manages the data and the Education Consultant who conducts the visits, documents the data and submits reports to the Regional Coordinator. This year we have

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revised the schedule for completion of data documentation each month, and found ways to increase the time that both Regional Coordinator and Education Consultant are in the office at the same time and can meet briefly to coordinate the timely collection of this data and reporting to DEL and ORS.

SECTION 3: Consultant Pool, Coordination and Data Collection

PART A: Consultant Pool

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

Consultant Pool	DESCRIPTION
	Please answer the questions from the first column.
i. Please describe your outreach and process for recruiting consultants?	Our outreach for consultants includes the Infant and Toddler Steering Committee which is composed of members of the Olympic Kitsap Peninsulas Coalition. They helped to identify the mental health and public health consultants from each county so we could provide more local support, and help providers to learn more about the community resources available to them. Also, the interagency coordinating councils in the four counties also help to expand the availability of consultant services into other disciplines.
ii. Are the consultants you recruit meeting the qualifications outlined in the I/T Interdisciplinary Child Care Guidelines? To what degree?	Yes. Each consultant we contract with has the education and experience for their discipline.
iii. What other qualifications do you expect you will need from your consultant to successfully deliver consultation?	We do not have any additional qualification requirements at this time.
iv. What type of specialists will you use (e.g. mental health)? How will they be used?	<p>Mental Health – Consultants may be used to help with AEPS results, or help with child behavior issues, attachment and bonding, parent concerns, preventative suggestions or general well-being of the program. This year this is available to providers as needed, referred by education consultant.</p> <p>Health – Consultants may be used to help with ITERS results, program health concerns, child health concerns, or other health related issues. This is available to providers as needed, referred by education consultant.</p> <p>Interagency Coordinating Council (ICC) – Our intention is to explore with each respective ICC the potential of other</p>

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	supportive consultation services that could be available to a provider in their community, and ways to access those services.
Please list name, phone/e-mail and type (education/health/social emotional) of consultants you <i>already</i> know will be in your pool. (e.g. <i>John Smith, Health</i>)	<ol style="list-style-type: none"> 1. Diane Crabtree 463-4384 cell 426-0075 home DianeCrabtreeRN@aol.com 2. Nancy Schiedermayer 360 461 6741 nschieds@gmail.com 3. Chris Cuneo 360-373-2536 ccuneo@hollyridge.org 4. Lori Zumwalt (360) 337-4823 lori.zumwalt@kitsappublichealth.org 5. Ellen Fetchiet 360-452-4432 Ellen.Fetchiet@elwha.nsn.us

PART B: Coordination and Data Collection – Staff and Partners

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

Category of Coordination	Activities: How will you coordinate this?	Responsibility: Agency and staff person responsible
Engaging Providers - communication, coordination and cross-referral (e.g., linking providers to consultants)	Project Lead, Regional Coordinator (RC) and Education Consultant (EC) will develop and implement recruitment strategies in partnership with the steering committee and Child Care Aware. The RC will be primarily responsible to track the consultants' time and travel, and assure their support. The EC will be primarily responsible to provide education consultation services and coordinate other consultation services.	Lorraine Olsen – Project Lead -OESD 114 Marlaina Simmons – RC – OESD 114 Jessica Felix – EC – OESD 114
Provider recruitment, intake, and assessment (e.g., applying ITERS, QRIS)	Project Lead, Regional Coordinator (RC) and Education Consultant (EC) will work with the steering committee to provide targeted recruitment efforts to licensed child care providers that serve infants and toddlers and are located in remote or rural areas. The Education Consultant or the Regional Coordinator will meet with providers to establish participation in the project. The EC will work with each provider to administer the ITERS and the ASQ-SE.	Lorraine Olsen – Project Lead -OESD 114 Marlaina Simmons – RC – OESD 114 Jessica Felix – EC – OESD 114

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Training, supervision and support for consultants	The consultants will be or have been trained in the tools that are being used in this model including the ITERS and the ASQ: SE. Any other tool or method that the steering committee recommends will require training for consultants so they use it the way it was intended and are valid and reliable.	Lorraine Olsen – Project Lead -OESD 114 Marlaina Simmons – RC – OESD 114 Jessica Felix – EC – OESD 114
Data collection and reporting	The Education Consultant will collect the required data for the project and turn it into the RC in a timely fashion so that it can be reported to DEL. The Regional Coordinator will be at all steering committee meetings and collect the required data for the monthly report. The internal accountant for the OESD will submit the monthly report along with the reimbursement report as required by DEL	Marlaina Simmons – RC – OESD 114 Jessica Felix – EC – OESD 114 Kay Pauley- Accountant – OESD 114
Other planned coordination activities (add table rows as necessary)	<p>We will continue to coordinate with other Coalition members and activities, including early intervention, Early Head Start, and Early Achievers (providers who are participating). Through Coalition outreach efforts, our project can be more visible in the region.</p> <p>We plan to increase our coordination with Child Care Aware so we can support and plan our work together, especially in programs that are participating in the Infant and Toddler Project and the Early Achiever Project.</p> <p>We also will continue attending the local Interagency Coordinating Council meetings to learn more about the needs of each area and plan for additional consultation services to providers as needed.</p>	

PART C: Curricula and Training

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

PART C: Resources	Description
i. What training, curricula and content experts will be available to support high quality interdisciplinary consultation?	<p>The Teaching Strategies Creative Curriculum for Infants and Toddlers serves as the foundational curriculum for our project. This curriculum is developmentally appropriate (it promotes nurturing and learning in ways that match the way children develop and learn) and meets the needs of infants and toddlers for fostering secure attachments, supporting cognition and brain development, and nurturing social, emotional and physical development.</p> <p>Use of the assessment tools such as the ITERS (Infant Toddler Environment Rating Scale) and the ASQ:SE (Ages &</p>

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	<p>Stages Questionnaire: Social Emotional) also serve to provide content area expertise to guide the work of the consultants.</p> <p>In addition to the Education Consultant, other content area experts available to the providers are mental health and public health consultants. In our work with the 4 Interagency Coordinating Councils, we hope to identify additional content experts and consultants. Our Coalition Infant & Toddler Steering Committee also offer expertise technical assistance to the project.</p> <p>We will partner with others to seek training for the Education Consultant, Regional Coordinator and other consultants as opportunities emerge. Training will be classified as MERIT, and will be provided by high quality trainers including the Educational Consultant, experts from infant and toddler programs (such as Early Head Start and early intervention programs). We hope to identify more high quality trainers this next year that focus on infants and toddlers.</p>
<p>ii. What common approaches/methods will your consultant pool utilize related to any training, curricula or other support your region provides?</p>	<p>Our common approaches, as previously mentioned, include the use of the ITERS and ASQ:SE for all providers to serve to understand each provider individually, as well as organize the data by the group. Our overall philosophy is supported by the RIE (Resources for Infant Educators) by Madga Gerber) <i>Authentic Relationships in Group Care for Infants and Toddlers</i>. This approach emphasizes the building respectful relationships between child and adult from birth, supporting healthy, secure attachments that form the foundations for development and learning. Our approach is also based on the Teaching Strategies Creative Curriculum for Infants and Toddlers, and the West Ed Training DVDs for infants and toddler caregiving.</p>

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SECTION 4: System Building

PART A: System Building Efforts Description

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

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

Systems Building:

The systems building over the last two years has well-positioned our project to strengthen these supportive connections and perhaps expand. The system of support for this project is amazing. This is a Coalition-funded project, and the operations are guided by Coalition Infant & Toddler Steering Committee. Our Coalition has chosen this approach to be sure that the Coalition is involved in the day to day operations of Coalition projects and keeps informed in order to make the necessary decisions. The Coalition Infant and Toddler Steering Committee is comprised of members from DEL Child Care Licensing, Child Care Aware, Early Head Start, early intervention, county health departments, child care providers, parenting education, Tribal programs and home visiting programs across the region. This group has vast knowledge across the disciplines of child care, health, infant toddler mental health and infant toddler development and learning to assure that our project is always tied to best practice in infant and toddler development and that we are maximizing our project resources. The steering committee reports monthly to the Coalition, broadening the support and knowledge of the project and identification of potential resources.

The Coalition provides a natural system for expanding and understanding the systemic needs of infants and toddlers. Our Coalition is broadly defined to support Pre-Natal to Grade 3 (P-3) caregiving and educational services for children and support their families. For example, there is a report and discussion at each Coalition meeting where we broaden the knowledge of the project and find ways for our project to benefit from other Coalition efforts. For example, BlockFEST is being expanded to offer more targeted involvement for infants and toddlers. In our Community Momentum grant, we are exploring ways to further coordinate home visiting services which in many cases involves infants and toddlers. Through our Racial Equity work, we have related the needs of providers serving infants and toddlers to assuring cultural diversity and local community relevance.

There are also examples of new, emerging systems from this project. For example, we are attending the four Interagency Coordinating Councils to learn more about the infant and toddler systems of support and resources in each of the four counties, and identify local support systems for child care providers that can last beyond their participation in this project.

Another part of our system development is learning more about state infant and toddler efforts, and noticing how we can possibly coordinate. At each Coalitoin Infant & Toddler Steering Committee meeting we report our regional, state and national efforts to working with infants and toddlers. For example, in August we will report on attending the regional Early Head Start conference in Portland and identify anything that could help us. We are also interested in working more

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with the new Washington Association for Infant Mental Health.

Along with the Steering Committee Members who actively participate in the Coalition, the Regional Coordinator will continue to provide connection between the coalition and the project. An update is provided monthly during coalition meetings and members are given the opportunity to provide input.

PART B: Steering Committee Roster and Roles

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

PART B: Steering Committee Member Name	Contact Information	Role, Structure and Representation (coordinating role, responsibility)
Cynthia Martin	pmf@olypen.com	Early Learning Coalition
Jacki Haight	jhaight@pgst.nsn.us	Tribal, Head Start, Early Head Start
Julia Danskin	jdanskin@co.jefferson.wa.us	Health Department
Lorraine Olsen	lolsen@oesd.wednet.edu	Educational Service District, Head Start, Early Head Start, ECEAP
Suzanne Plemmons	plemms@health.co.kitsap.wa.us	Public Health District
Nita Lynn	nita@olypen.com	Family Support Center, Home Visiting
Robin Williams	robwil@oesd.wednet.edu	Educational Service District, Head Start, Early Head Start, ECEAP
Jody Hitchings	Jody.Hitchings@del.wa.gov	DEL Licensing
April Borbon	aprilborbon@yahoo.com	Isolated populations (immigrants)
Britni Duncan	bduncan@concernedcitizenspnw.org	Isolated Community, Child Care Provider
Susie Albert	susie.albert@qvschools.org	Isolated Community, School District, Tribal
Roxanne Bryson	hrc@hollyridge.org	Mental Health Professionals, Early Support for Infants and Toddlers
Lori Zumwalt	lori.zumwalt@kitsappublichealth.org	Public Health District
Wendy Jackson	wjackson@olycap.org	Head Start, Early Head Start, ECEAP
Tiffany Stutesman	tiffany@ccacwa.org	Child Care Aware, Early Achievers
Marlaina Simmons	masimmons@oesd.wednet.edu	Early Learning Coalition

Peninsula Infant/Toddler Regional Service Model (RSM)

PART C: Additional Partnerships

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

PART C: Name of Partnership	Contribution to Work
Jefferson County Interagency Coordinating Council (Lorraine, Marlaina and Jessica rotate attendance)	Health, Mental Health Professionals, Early Head Start, Head Start, Early Support for Infants and Toddlers, Home Visiting, School Districts, Isolated communities and rural voices, early learning coalitions, parents, Educational Service District
Clallam County Interagency Coordinating Council (Lorraine, Marlaina and Jessica rotate attendance)	Health, Mental Health Professionals, Early Head Start, Head Start, Early Support for Infants and Toddlers, Home Visiting, School Districts, Isolated communities and rural voices, early learning coalitions, parents, Educational Service District
Kitsap County Interagency Coordinating Council (Lorraine, Marlaina and Jessica rotate attendance)	Health, Mental Health Professionals, Early Head Start, Head Start, Early Support for Infants and Toddlers, Home Visiting, School Districts, Isolated communities and rural voices, early learning coalitions, parents, Educational Service District
Mason County Interagency Coordinating Council (Lorraine, Marlaina and Jessica rotate attendance)	Health, Mental Health Professionals, Early Head Start, Head Start, Early Support for Infants and Toddlers, Home Visiting, School Districts, Isolated communities and rural voices, early learning coalitions, parents, Educational Service District

PART D: Additional Funds

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

PART D: Funding Source	Amount	Details (activity that it funds, assumptions, etc.)
There is no additional funding identified at this time.		