Maryland Family Support Center Manual

MARYLAND FAMILY NETWORK

MARYLAND FAMILY NETWORK
Leading Maryland's Family Support Centers

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Using This Manual

As a staff member of one of Maryland's Family Support Centers, you have been entrusted with one of the most important jobs in the State - ensuring the healthy development of our next generation. Maryland Family Network (MFN) has developed this manual to support you in your work. The manual includes standards basic to all state funded Family Support Centers and federally funded Early Head Start (EHS) Centers as well as suggestions for making your Center even more effective.

MFN understands that occasionally the policies of a sponsoring agency will differ with the guidelines presented herein. In those instances, please consult with the sponsoring agency and Maryland Family Network for guidance.

At various places in this manual, you will see the Early Head Start logo (). The appearance of the logo indicates that the information may apply differently to Early Head Start Centers. A footnote with the logo will give you further information for Early Head Start.

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Introduction

The Family Support Initiative in Maryland

Maryland Family Network and the Maryland network of Family Support Centers represent the pursuit of a vision: To address some of the State's most pressing social problems and to put in place a prevention mechanism, a front end, to the State's crisis-oriented human services delivery system. The first four Family Support Centers and Maryland Family Network were established in 1986, after a group of parents, State and local leaders, child care and adolescent pregnancy advocates, child development specialists and leaders in the foundation community met and planned for nearly two years.

The specific catalysts for the effort were the State's skyrocketing reports of child abuse and neglect and resulting foster care placements, its high teenage pregnancy rate and growing recognition of the relationships between adolescent parenting and long-term welfare dependency. Additional catalysts were limited success in education and job attainment and negative outcomes for the children of teenagers.

Since its beginning, the network's goal has been to provide comprehensive, culturally-sensitive, community-based, preventive services to families who live in neighborhoods that show high concentrations of a variety of risk factors known to be predictive of long-term welfare dependency and poverty.

In 1995, Maryland Family Network applied successfully for Early Head Start funding and MFN was awarded funding for two of the first EHS programs in the country. Currently MFN serves as the grantee for twelve delegate agencies providing a locally designed center based Early Head Start model. The model builds on the strengths of the family support approach combined with best practice as laid out by the Head Start Program Performance standards.

The State of Maryland has invested in many programs, from the Maryland Model for School Readiness to credentialing and accreditation for child care providers to Family Support Centers, Judy Centers, and Head Start to improve the early experiences of the State’s children. These programs have the potential to move the State toward the achievement of one of its foremost goals – that all children arrive at school with the skills and competencies they need to succeed in school. Family Support Centers often are the first institution on the continuum of school readiness as they play a critical role in the educational development of both the child and the parent.

Maryland's coordinated network of community-based Family Support Centers is strongly supported by the Governor, the Maryland General Assembly, public (state, local and federal) agencies, private funders, and communities.

Philosophy and Mission of Family Support Centers (FSCs)

Family Support Centers are child-centered, family-focused programs that serve young parents together with their children aged birth through three years. These prevention oriented, early intervention programs are offered in welcoming, home-like settings.

Centers strive to:

- Promote the full development and general competence of children and reduce the occurrence of emotional, physical, or social handicaps through appropriate preventive services.
- Enhance the quality of parent-child and family interactions in order to improve the competence of parents in their role as caregivers and families as functioning units.
- Provide, or be a link to, services necessary for greater parental self-support and self-sufficiency.
- Serve as a community Center where parents with young children can experience support and establish wholesome connections with others.
- Reduce the incidence of additional pregnancies among young parents and first pregnancies among other adolescents in the community.

Maryland's Family Support Centers:

- Welcome families regardless of income marital status, race, religion, degree of need or other characteristics which might serve to stigmatize them.
- Are planned in full cooperation with community members and reflect a close, cooperative partnership between families and the program staff.
- Believe in the strengths and importance of families and seek to build on those strengths.
- Invite voluntary participation by offering activities in which parents want to participate.
- Empower families to approach life's challenges proactively.
- Emphasize strong peer, as well as professional, supports.
- Reflect the premise that all families need support at some time and sources of support should be available in neighborhoods and local communities.
- Believe parents who feel competent in other areas of their lives are more likely to be better parents.
- Assume pre-teens and teens who can achieve academic, avocational, and vocational success and who are optimistic about their futures are more likely to delay parenthood.
- Are multi-disciplinary in approach and staffing to reflect a holistic approach to family needs and circumstances.

All of the programs target teen parents since they and their children are more vulnerable to the stresses that can affect all families. The Centers' overriding goal is to interrupt the cycle of poverty among young parents and their children by preventing additional pregnancies, encouraging, and whenever possible, empowering young people to complete their education, acquire job skills, and be more effective parents. To create a program that will achieve this goal, participants and staff plan a combination of structured

and unstructured activities. At the core of all the services is a focus on enhancing infant/toddler development and parent-child relationships.

Maryland Family Network and the network of Family Support Centers are built on the family support principles. They are:

- A commitment to families and their individual members becoming empowered so they can help themselves to realize their own goals;
- An acknowledgment of the universal need for family support services, leading to programs without eligibility or 'needs-based' requirements;
- A recognition of the necessity to actively involve program participants and community service providers as equal partners in the design and implementation of services; and
- A commitment to understanding the individual parent and child within the context of the larger family, neighborhood, community, city, state and nation, recognizing the need to affect all of these environments.
- A commitment to the Strengthening Families approach and to building on the five Protective Factors that all families need:

Parental Resilience

Social Connections

Concrete Support in Times of Need

Knowledge of Parenting and Child Development

Social & Emotional Competence of Children

Early Head Start (EHS) participants MUST meet Federal poverty guidelines.

CENTER FOR THE STUDY OF SOCIAL POLICY'S
strengthening families™
A PROTECTIVE FACTORS FRAMEWORK

Strengthening Families Protective Factors

- Parental Resilience
- Concrete Support in Time of Need
- Social Connections
- Knowledge of Parenting and Child Development
- Social and Emotional Competence of Children

FSC Core Services	Strengthening Families Protective Factors
Self Sufficiency Programming	Parental Resilience, Concrete Support in Times of Need, Social Connections
Parent Education	Parental Resilience, Knowledge of Parenting & CD, Social Connections, Social and Emotional Competence of Children
Infant Toddler Program	Parental Resilience, Knowledge of Parenting and CD, Social & Emotional Competence of Children
Service Coordination	Parental Resilience, Concrete Support in Times of Need, Social Connections
Health Education	Parental Resilience, Concrete Support in Times of Need, Knowledge of Parenting and CD, Social & Emotional Competence of Children
Home Visiting	Parental Resilience, Concrete Support in Times of Need, Social Connections, Knowledge of Parenting and CD, Social & Emotional Competence of Children
Participant (Parent) Support and Involvement	Parental Resilience, Social Connections, Knowledge of Parenting and CD
Outreach, Collaboration and Resource Development	Parental Resilience, Concrete Support in Times of Need, Social Connections, Knowledge of Parenting and CD, Social & Emotional Competence of Children

The Role of Maryland Family Network (MFN)

Maryland Family Network's charge is to administer and coordinate the operation and expansion of the Maryland Family Support Center network by providing training, technical assistance, monitoring, contract management and quality assurance services. Through our work, it is our hope that families and their young children, FSC staff, and their community partners will confidently embrace their roles as a child's earliest teachers and will strive to do all that they can to meet needs of the children in their care by supporting and encouraging them along the continuum of learning. Maryland Family Network's staff members have expertise in infant and early childhood development, adult education, employment readiness, adolescent pregnancy, parent education, social work, counseling, substance abuse, grantsmanship, community organization, program management and administration.

The staff's skills are made available to the Family Support Centers through ongoing, regularly-scheduled training and targeted on-site technical assistance. Each Family Support Center is assigned a Program Consultant who provides overall technical assistance, training and guidance in program management, child development programming, service delivery and staff development. The Program Consultant also is responsible for assuring the quality of the programs. On-Site Progress Reports, ITERS reports, and monthly individual Center Management Information System (MIS) Summary Reports are objective reports used by the Program Consultant and the Program Department in the quality assurance process. The MFN Program Monitor visits each Center at least once a year and prepares an On-Site Progress Report Form of the visit. The Infant Toddler Environment Rating Scale (ITERS) is administered at each Center once a year by a two-person team.

MFN maintains a participant database to collect information for preparing required reports for funders, for analyzing program effectiveness, for public relations and for future planning. Centers are encouraged to enter data on site so the information is immediately accessible for program management. All Centers receive training and software to generate reports that will assist them in managing their programs.

The staff of Maryland Family Network provides structured and responsive opportunities for frequent information exchange and peer learning. In-service workshops and staff development conferences, which reflect the needs and interests of Center staff members as well as best practices information, are held regularly and are open to all Center staff, but are required of full-time staff. Full-time staff are also required to complete a set of core competency training modules within a specific time frame after being hired. These modules are provided on a regular basis by Maryland Family Network, and may differ for various positions in a Center. To foster better communication among Centers, MFN holds a mandatory Directors' meeting every other month beginning with the month of July on the third Tuesday of the given month. (For MFN Training Requirements, see Appendix 2).

In order to achieve our mission, Maryland Family Network engages in advocacy activities including public policy advocacy. Maryland Family Network may take positions on public policy issues that meet at least one of these four criteria:

- Affects Maryland Family Network's ability to work toward its mission;
- Affects the nonprofit status or operations of Maryland Family Network;
- Affects the quality of early childhood education programs and services; or
- Affects the status of the Maryland Family Support Center network and its program participants.

Maryland Family Network conducts its advocacy work through coalitions and networks such as the Alliance of Statewide Family Resource and Support Programs, the Child Welfare League of America, Maryland Children's Action Network, the Maryland Coalition for Healthy Mothers/Healthy Babies, the National Family Support Network, and the Maryland Head Start Association.

In Maryland Family Network's work with coalitions and associations, Maryland Family Network may take part in the advocacy work of a group provided the work is not in conflict with our mission or the position taken by our Ad Hoc Public Policy Committee.

Maryland Family Network's Board and staff members represent a broad cross-section of the political spectrum. Maryland Family Network does not support one candidate over another and does not support any political parties. Maryland Family Network works with both political parties in making and implementing public policy and in all legislative matters. If one candidate for office is asked to speak at Maryland Family Network events or conferences an invitation is extended to all opposing candidates.

Technical assistance and monitoring differ for EHS Centers.

Section I
Family Support Center Services/Program

Core Services

Because each Center is responsive to its community and involves its participants as partners in program development and execution the array of services at each Center may look different. At the heart of the Family Support Center philosophy is the idea of service coordination, interdisciplinary teamwork, and viewing parents and their young children together as a total unit. Parents utilizing the Family Support Centers are required to attend the Centers with their children. Family Support Centers are not licensed to provide childcare. Parents utilizing the Early Head Start Centers have the option of having their children attend the program without their presence as the Early Head Start programs are licensed to provide childcare.

Each Family Support Center and those Early Head Start Centers providing full programming to both parents and their children will provide on-site or by referral the following core services as listed in the RFP promulgated by Maryland Family Network:

Self- Sufficiency Programming

Educational services such as adult education, family literacy and employment readiness activities that may include job related skill development and computer literacy.

Parent Education

These services are designed to enhance parenting skills for mothers and fathers and include: formal parent education classes, parenting enhancement activities, informal interactions, role modeling and peer education.

Infant/Toddler Program

Infants and toddlers are provided with developmentally appropriate and individualized programming to maximize the child's development and foster positive parent/child relationships that lay the foundation for success in future settings. Quality developmental care supports the positive growth of children as parents attend activities at the Center.

Service Coordination

The coordination of services and service linking support parents to identify strengths, set goals and choose steps that will affect positive change for their families.

Health Education

Primary and prenatal health care education, family planning counseling, substance abuse counseling, nutrition and other related health education and screening services. These services assist participants in making informed and responsible choices related to their family's general and reproductive health care. Included in this core service is mental health consultation and the related provision of services.

In-Home Intervention

Family Support Centers provide home visiting to enhance the services provided to parents. This is an avenue to reach families that may not readily engage in the FSC but want to work toward participation in the Center. The model of Home Visiting used by the FSCs is In-Home Intervention. 

Participant (Parent) Support and Involvement

Skills and relationships that will carry over outside the Family Support Center. Basic life skills, recreation and opportunities to develop leadership and advocacy skills.

Outreach, Collaboration and Resource Development

Outreach activities in the local community serve to ensure awareness, acceptance and involvement in planning and participation in the Family Support Center. Collaboration and resource development are necessary for a Family Support Center to grow and thrive.

In EHS, home visiting services may be a program option appropriate for the family's needs or part of their Center participation.

Self-Sufficiency Programming

Educational services such as adult education, ESOL classes, and family literacy are provided at FSCs. Employment readiness provides job related skill development, including computer literacy, which will aid the participants in planning for, securing and maintaining employment.

Adult Education/Family Literacy

Educational services should include classroom and individual instruction to accommodate learning levels of third through twelfth grade (ABE, pre-GED, GED) levels, high school completers in need of "brushing up" or completion of specific academic skills, adult learners interested in family literacy and tutoring. Linkages with agencies which provide tutorial services for non-readers or speakers of other languages should be established if the service is not offered on-site. There should be revolving, open-ended enrollment and services should be non-threatening and self-paced, provide daily successes, promote esteem-building and be highly individualized.

Family literacy activities include adult literacy and education, parent child activities (PACT) focusing on literacy, parent education to maximize their role as their child's first teacher and quality developmentally appropriate child care. Sustainable changes in families occur when these services are fully integrated and occur daily.

ASSESSMENT AND TESTING

Every participant enrolled in adult education will receive a placement test using the CASAS (Comprehensive Adult Student Assessment System) or TABE (Test of Adult Basic Education) at entry. The CASAS or TABE will be administered after every 60 hours of instruction to document grade gains and academic achievements. Centers have the option of using this benchmark based on student attendance and their adult education funding source. The GED practice test should be administered to all GED students prior to them taking the official test. The practice test will serve as an indicator of student readiness and validate progress of a student.

REQUIREMENTS

- CASAS or TABE placement test for each student with documentation of reading and math scores.
- Adult Education classes are to be revolving and open-ended allowing participants to begin receiving services at enrollment.
- Individual files documenting student goals on an Individual Learning Plan, pre/post test scores, Learner's Registration/Enrollment Form and monthly progress notes should be kept in a secure file cabinet.
- Classroom instruction offered for sufficient number of hours so that individual students can attend for a minimum of 10 hours per week.
- Computer-assisted instruction as a secondary method of instruction using an approved assessment tool for 15 minutes daily or 1 hour weekly per student.
- Contextual learning activities facilitated daily.
- Individual, self-paced instruction.
- Staff/student ratio of 8 - 12 adult learners per instructor.
- Weekly plan that includes daily lessons.

- Administration of post-test after 60 hours of instruction and every 60 hour period of instruction thereafter.
- Administration of the GED practice test prior to registering for the official GED test.
- Service coordination and support services are provided to FSC eligible participants.

DOCUMENTATION

The following documentation must be compiled into individual student files for each learner:

- Documentation of CASAS or TABE reading and math scores for placement and pre/post tests on Learner's Registration/Enrollment Form, as well as the Maryland Family Network Management Information System Quarterly Milestones Form.
- Completion of Individual Learning Plan which contains student's learning goals.
- Completion of monthly progress notes.
- Completion of MFN-MIS Center-based Family Activity Form (Refer to MIS glossary for coding).
- Completion of the MFN-MIS Quarterly Milestone Form with the original being given to the Service Coordinator and a copy placed in the student file.
- Documentation of contextual learning activities placed in the student file or in a centrally located binder of all contextual learning activities.
- Documentation of GED practice test scores placed in student file.
- Documentation of family literacy activities by progress note or activity form.
- Samples of student's class work.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- In situations of in-kind or contractual staff with the Board of Education or other educational institution, make sure that there is a written agreement in place stipulating employment information, as well as the instructor's ability to participate in FSC/MFN training activities, reporting/training expectations of the employer and FSC/MFN, instructional and reporting requirements for the instructor.
- When hiring an instructor, be sure that he/she has experience and is committed to incorporating computer-assisted instruction.
- All Adult Educators should be trained to use the CASAS and/or TABE screening tools as an approved web-based instructional program. "Flexible High School" or high school students attending FSCs to complete high school academic courses are not to use a web-based instructional program. Instructional staff should immediately coordinate with the Service Coordinator regarding unexplained or chronic absenteeism or any other issue that negatively affects educational progress or goal attainment.

Employment Readiness

Employment readiness services include job related skill development which will aid the participant to plan, secure and maintain employment. These services consist of individual and group activities and result in the following outcomes for participants, whether enrolled in adult education or not: an assessment of career interests, values and skills; an increased awareness of career clusters as they relate to assessment results; and the development of tangible employment readiness skills. The results of the assessment includes educational and training goals, steps to job readiness and steps necessary for a job search which will culminate into a career plan for each participant. At least 30% of participants should receive employment readiness services.

REQUIREMENTS

- **Career Exploration** – Administration of a standardized career assessment tool to assist participants to identify their interests, values and skills as they relate to job clusters and the world of work. Examples of standardized tools used in the field are: VISIONS/DISCOVER, Holland Self-Directed Search, Career Exploration Inventory, and Harrington O'Shea
- **Job Readiness** – Enhancing participant's interpersonal skills related to securing and maintaining employment such as the ability to cope with anger and conflict, time management, stress management, working as a team member, effective communication skills and selecting quality child care.

Employment readiness skills must be provided to all EHS participants if a GED is a goal on the Family Partnership Agreement.

- **Job Search Skills** – Providing program activities which develop specific competencies in the areas of seeking and gaining employment, such as: completing a job application, writing a resume, mock interviews and cover/thank you letter writing.
- **Job Retention Support** – Extending services to participants who are currently working in an effort to support continuation of employment and prevent unwanted or unnecessary termination of employment.
- Provision of referrals to specialized community services related to employment.
- All participants receiving adult education services and everyone with employment as a goal on their Family Partnership Agreement should receive employment readiness services.

DOCUMENTATION

- A copy of the completed career assessment to be placed in each enrolled participant's file.
- A checklist or documentation, to be placed in participant's file, denoting completion of activities.
- Documentation of employment readiness activities on the participant's goal sheet.
- Copies of referrals to outside sources.
- Completion of MFN-MIS Center-based Family Activity Form (Refer to MIS glossary for coding).
- Completion of MFN-MIS Quarterly Milestone Form upon completion of all employment readiness activities.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- Employment readiness activities can include group workshops, individual sessions, panel discussions, presentations by guest speakers and successful former/current participants, field trips and video taping of mock interviews.
- For information on how to actively involve fathers, please see Appendix 5 – Fatherhood Services.

EHS programs should refer to
and the Head Start Act of 2007 for specific requirements.

Parent Education

The adults (parents and grandparents) who live with and care for infants and young children play an important role in laying the foundation and setting the stage for learning success. Parent education services are designed to enhance parenting skills for mothers and fathers and include: formal parent education classes, parenting enhancement activities, informal interactions, role modeling and peer education. EHS parents are expected to follow all expectations outlined in the Core Services.

Parent education is provided formally in groups and individual sessions, and informally during the myriad of opportunities that present themselves throughout the course of the day. All Centers are required to provide parenting activities through formal parent education based on an evidenced-based parent education curriculum focused on children between the ages of birth through three and approved by MFN. Examples of evidence based curricula include Nurturing Parent Education Program, Circle of Security, and Chicago Parenting Program. Centers are also required to provide informal parent education (informal interactions, role modeling and peer education). Activities should be designed to attract and include fathers (For information regarding Fatherhood Services, see Appendix 5).

Parent education is a strong component of family literacy and when it is integrated daily with adult literacy, PACT and quality developmentally appropriate child care services sustainable changes occur in families.

Parent education services and activities should:

- Enhance parents' knowledge of the developmental phases and expectations for their child's growth.
- Increase parents' understanding of "school readiness" as it relates to early development.
- Promote the parents' role as the child's first and most important teacher.
- Empower parents so they may provide for their own and their children's needs.

This core service has two components: Formal parent education and informal parent education. These two components support each other in reinforcing parenting skills.

Formal Parent Education

This is a course offered to parents throughout the year. Formal parenting must consist of an evidenced-based curriculum approved by MFN. Examples of evidence based curricula include Nurturing Parent Education Program, Circle of Security, and Chicago Parenting Program. Curriculum components are selected based on desired outcomes for parents and feedback from previous parent education courses and certified parent instructors.

Formal Parent Education will address:

- Appropriate expectations and developmental milestones to include, but not limited to, toilet training, issue of "spoiling," TV/movies, and sleeping patterns.
- Infant and toddler health/nutrition information.
- Behavior management techniques.
- Parents' role as the child's first teacher and advocate.

REQUIREMENTS

- The approved evidenced based curriculum must be offered with guidelines as to successful completion of the course; i.e. number of weeks or sessions inclusive of the amount of time per session.
- Course offered throughout the year.
- Clearly defined goals and objectives for the course.
- A minimum of 23 parents annually must complete a formal parent education series based on the approved curriculum.

DOCUMENTATION

- Notes in participant folders.
- MFN issued certificate for parents who have met all requirements at end of the formal evidenced-based program.
- Completion of MFN-MIS Code P-13 for Formal Parenting Education Program.
- Completion of the MFN-MIS Quarterly Milestone upon completion of the Formal Parenting Education Program.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- Be sure to provide an atmosphere where parents have the opportunity to support and learn from each other. Remember, an individual who is a parent is also a person with his/her own identity, needs and agenda. Parents need praise and lots of it. Parents love to hear positive/fun things about their children.
- Formal Parent Education must only be provided by a person who has been trained in the approved evidenced-based curriculum of choice. Informal Parent Education

Informal parent education occurs daily throughout the Center through modeling, informal interactions, and conversations with parents. Since behavior is learned from what is observed and through practice, promoting positive parenting is the responsibility of the entire Family Support Center staff. Informal parenting also occurs through parent support groups where parents get together to discuss common concerns. Informal parent education supports and reinforces the information shared in formal parent education. As such, there should be coordination between these two components.

REQUIREMENTS

- All Center programming is planned to include the role, responsibilities and perspective of parents.
- Observations of informal parenting occurs throughout the Center by all staff.

DOCUMENTATION

- Completion of MFN-MIS Code P-12 for informal parent education.
- Note in participant files.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- Informal parent education is a way to meet parent concerns and needs around a specific issue. These might include regularly scheduled parent support groups.
- Since parents may be experiencing stress and low self-esteem, every effort should be made to facilitate growth in parenting skills through small groups, experiential and interactive sessions and activities with parents, children and staff. Suggested activities might include: holding weekly special events and/or workshops with guest speakers; establishing a monthly "make and take" session where parents can make developmentally appropriate toys for their children; inviting parents to cook dinner together.
- Opportunities for "teachable moments" for informal parenting include: field trips, meal time, drop-off and pick-up times and informal recreation.
- To be counted as a P-12 activity (Informal Parenting) a session/discussion/modeling with a parent needs to be at least **10 minutes** in length.
- Informal parent education is a contextual activity in adult education.
- For information on how to actively involve fathers, please see Appendix 5 – Fatherhood Services.

EHS programs should refer to
and Early Head Start Act of 2007 for specific requirements.

Infant/Toddler Program

Overview

Infants and Toddlers are provided with developmentally appropriate and individualized programming to maximize the child's development and foster positive parent/child relationships. Quality developmental care supports the positive growth of children as parents attend activities in the Center.

Children are born with tremendous potential and capacity for learning across all developmental domains: physical, cognitive, emotional, language, and social development. The first three years of life represent a critical time for development. It is a time when the child is developing a template for relating to the world and determining whether the world is a safe, worthwhile and trustworthy place. The best way to protect and foster healthy development is through consistent, dependable, nurturing caregivers. During this period it is critical that attachment relationships are formed to provide a secure base from which children can explore the world and develop trust, empathy, self-esteem and confidence. The Child Development (CD) room should be an emotionally warm, safe and welcoming environment for parents and children. Parents are an integral part of the program and respected as the experts on their children.

By providing developmentally appropriate experiences for both parents and children which strengthen parental and caregiver attachment in a safe, nurturing environment, child development staff is promoting the optimal physical, social, emotional, language and cognitive development of young children while supporting the needs of families. Sustainable changes in families occur when adult literacy, parent education, PACT and quality developmentally appropriate child care services are fully integrated and occur daily.

Family Support Centers offer children with an IFSP a nurturing environment and developmentally appropriate experiences to further their IFSP goals, and offers their parents support and guidance in navigating the early intervention system and in understanding their child. Family Support Centers are encouraged to recruit and enroll these families.

EHS programs should refer to Performance Standards 1304, Subpart B - Early Childhood Development and Health Services. EHS programs must use standardized screening tools for development and behavior within the first 45 days of entry to the program and annually thereafter. Ongoing assessment is a different tool.

REQUIREMENTS

- Full-time Child Development Specialist employed at each Center.
- CD room to be open and available when parents and children are on site.
- Use of the Creative Curriculum for Infants, Toddlers and Twos, Second Edition, Revised.
- Use of Teaching Strategies Gold to conduct observations of children
- Use of ASQ-On Line to provide developmental screenings of children
- Passing score of 6.0 on yearly Infant Toddler Environmental Rating Scale (ITERS) and MFN Early Literacy Observation.
- For further information, reference Section II, Program Operations. A. The Setting.
- See Appendices 3 and 4 for further information and sample forms.

DOCUMENTATION

- Completion of MFN-MIS Intake Form, Part II: Eligible Child Survey, upon enrollment.

- Completion of MFN-MIS Code C- 190 (with time noted).
- Completion of MFN-MIS Code P-13 Formal Parenting.
- Completion of MFN-MIS Code P-12 for Informal Parenting, when appropriate.
- Completion of MFN-MIS Code P-11-PACT (for both parent and child).
- Completion of MFN-MIS Code C-191, C-192, C-193, C-194, C-195, 0-302 when appropriate with documentation and/or reports in child's folder.
- Completion of MFN-MIS Quarterly Milestones by required programs to note Ages and Stages Questionnaire (ASQ) and immunization completion as well as outside program referrals.
- Daily schedule and weekly lesson plans, posted in classrooms, for infant and toddler groups.
- Documentation of observations using Teaching Strategies GOLD tool, individualization in each child's folder and in weekly lesson plans, including progress notes/observations.
- Written plan for parental involvement in routine care.
- Evidence of Informal Parent Education in CD room.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- The CD room is only available to children whose parents are on-site. A parent cannot under any circumstances leave a child at the Family Support Center, nor can a child attend with a non-custodial adult, unless the Center is licensed.
- The CD room is not available for children of staff, volunteers or any non-participant.
- It is a challenging task to provide quality early childhood education in a setting as informal as a Family Support Center. Since the age range of children in the CD room can be so varied and since a different number of children and group of children may arrive each day, staff members need to make flexible plans for activities, snacks and schedules.
- The Child Development Specialist is selected jointly by the FSC Director and the MFN Program Consultant.
- Staff should consult "Everything You always Wanted To Know about the ITERS but Were Afraid to Ask," MFN, July 2012 for more information regarding the ITERS and ITERS clarifications updated yearly.

Program/Curriculum

It is expected that the Family Support Centers will use the Creative Curriculum for Infants, Toddlers and Twos, Second Edition, Revised in planning their programs. This developmentally appropriate curriculum provides for all areas of a child's development through an integrated approach that emphasizes learning as an interactive process. Learning should be real, relevant and increasingly more complex and challenging. Adults facilitate children's engagement with materials and activities and extend the child's learning by asking questions, making suggestions and encouraging play choices that promote children's thinking and language.

The Family Support Centers use the Infant Toddler Environmental Rating Scale (ITERS) as a guide to the setting up and functioning of the classroom. The learning environment should be designed so children

learn through active exploration and interaction with adults and other children, and a variety of materials, equipment and experiences.

CD rooms offering an exciting, age-appropriate curriculum for infants and toddlers are providing and promoting the necessary "school readiness" skills important for the later development of formal reading and math skills.

The daily schedule and activities in the CD room should be flexible, child-centered and developmentally appropriate. Infants should have a schedule that includes some planned activities in all the developmental areas as well as flexibility in meeting their own individual schedules for sleep, play and eating. These routines are an integral part of the learning environment. Toddlers are ready for more organized activities to include structured and unstructured play as well as individual and small group play. All children should go outside daily, except in extreme weather conditions. Above all, the atmosphere of the Infant/Toddler room must be emotionally supportive and enhance the social-emotional development of children and their parents.

Classroom management should be handled with an approach that begins with: nurturing and responsive relationships with children; responsive routines, environments and strategies to support social-emotional development and an intentional approach to teaching. Timeouts are not appropriate to use in our programs. Redirection, offering choices, providing a quiet time and/or removal from an activity are appropriate learning approaches.

REQUIREMENTS

- Weekly lesson plans and schedules for both the infant and the toddler areas are posted in the room and are based on Creative Curriculum for Infants, Toddlers and Twos, Second Edition, Revised.
- Evidence of individualizing for each child through observations, screenings and assessments.
- Classroom set up to meet Creative Curriculum guidelines and ITERS expectations.
- Evidence of a "literacy rich" classroom based on the Early Literacy Strategies.
- Children will go outside daily for 30 minutes except in extreme weather. There must be a protocol in place to support consistent decision making for outside play.

DOCUMENTATION

- Completion of MFN-MIS Code C- 190 with time noted.
- Daily schedule and weekly lesson plan posted in classroom.
- Documentation of individualizing in each child's folder and in the weekly lesson plan.
- Weekly observations in each child's folder.
- Written weather policy for CD staff regarding outdoor play.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- It is important that the CD room reflect developmentally appropriate practice as it relates to "school readiness" for infants and toddlers. The use of dittos, drilling and group lessons in learning to recognize letters and numbers, required practice using worksheets, prescribed craft/art activities, coloring books and writing names are inappropriate activities unless initiated by the child.

- It is recommended that the ITERS be utilized by CD Specialists as a tool for training staff. For information on how to actively involve fathers, please see Appendix 5 – Fatherhood Services.

Early Literacy (EL)

(Adapted from "Essentials of Early Literacy Instruction," Roskos et al, Young Children, Mar. 03).

Early Literacy refers to the knowledge and skills that precede learning to read and write in the primary grades. This is a process by which infants and toddlers form reading and writing concepts and skills, learning the relationship between the two. When teachers and parents talk to and read aloud to infants, engage in conversation with toddlers, encourage scribbling and "reading" the marks, point out words and letters in signs, encourage toddlers to hold a book and turn the pages, they are helping children understand the connection between printed words, speech and real experience. Infants and toddlers' early reading and writing learning is embedded in a larger developing system of oral communication.

There are three important areas of learning in early literacy: oral language and comprehension, phonological awareness (awareness of sounds of language) and print knowledge.

Developmentally appropriate settings, materials and experiences in the classroom will encourage early forms of reading and writing to flourish and develop into conventional literacy. Infants need rich conversation, daily listening to books and experience with the sounds of words. Toddlers are ready for these and additional activities encouraging early writing and active interaction with book reading. Early literacy and play should be linked so that activities are fun and enjoyable for infants and toddlers and developmentally appropriate for the individual child.

The seven Early Literacy strategies are:

1. Rich teacher talk
   CD staff will engage children in rich conversations in large group, small group and one-on-one settings.
2. Storybook reading-individual
   CD staff will offer materials and activities to support children's individual reading experiences at least once or twice a day.
3. Phonological awareness activities (awareness of the sounds of words)
   CD staff will provide children with phonological awareness materials and activities that increase children's awareness of the sounds of language.
4. Alphabet/Number activities
   CD Staff will engage children with materials and activities to increase their understanding of the letters of the alphabet, numbers and their direct use.
5. Support for emergent reading
   CD staff will provide children with materials and activities, which support and encourage their attempts to "read."
6. Support for emergent writing
   CD staff will provide children with materials and activities which support and encourage their use of emergent writing and their understanding of its importance.
7. Shared book experiences-group
   CD staff will offer at least one planned small group shared book experience daily to support children's understanding of early literacy. These will include text-related

experiences and extensions to the classroom learning areas through related materials, props, and activities

REQUIREMENTS

- Three different EL strategies observed *daily* through specific planned and/or spontaneous activities. This does not include rich teacher talk, since it is expected that such rich conversation will occur all through the day.
- Variety of EL materials present in four or more areas of classroom on a daily and ongoing basis.
- Daily, staff encourage children to use EL materials in learning areas (four or more instances observed).
- Weekly lesson plans show all EL strategies through eight detailed planned EL activities, as well as EL materials added to the classroom for the week.
- Each child receives two or more individual or small group reading experiences daily.

DOCUMENTATION

- Weekly lesson plans for infants and toddlers include: planned EL strategies; detailed EL activities; and EL materials present in the classroom for the week.
- Observations in classroom and individual observations documented in child's file.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- "Variety" means at least five different materials present, two of which must be labels and books.
- See Early Literacy Observation Form in Appendix 3 (completed annually by MFN) for details.

Staffing

The CD room needs to be fully staffed with continuous, consistent and qualified staff managed by a full-time Child Development Specialist. Because of the inherent inability to predict the number of children using the CD room, both parents and staff must be willing to share the child care responsibility. There will be times when CD staff will require the support of their colleagues or increased participation of parents.

Classroom staffing is based on the National Association for the Education of Young Children (NAEYC) guidelines. The required staffing ratios are:

6 weeks through 14 mos.	1 Adult to 3 Children
15 months through 47 months	1 Adult to 4 Children

If a CD room is state-licensed for child care, the required ratios may be different and supersede those here.

Volunteers in the child development room can be a great adjunct to our programs, as they provide those extra set of hands often necessary in offering warm, nurturing environments for young children. Foster Grandparents receiving a stipend are considered volunteers. While the characteristics and skills of volunteers serving in a child development room are closely aligned to those of paid staff, it is important to remember that volunteers:

- are paid staff and can never be left in the room or any individual area of the room alone. At all times child development rooms and individual areas of the rooms, as well as outdoor play space must include at minimum of one paid staff.
- should be expected or required to engage in any personal care routines, i.e. diaper changing or toileting.

All potential volunteers must be interviewed by the Child Development Specialist prior to a decision to accept that person into the child development room in order to determine goodness of fit, physical ability to care for young children, and willingness to accept family support philosophy and core principles for working with young children.

All volunteers must undergo a criminal background check and fingerprinting.

Before starting in the child development room, all volunteers must be provided with a description of duties and successfully complete an orientation and training process. Training and orientation should include and not be limited to the following:

- Training on philosophy of Family Support and related principals
- Definition of developmental childcare and the services provided
- Family Support and Early Head Start Centers as school readiness programs
- Universal precautions
- Health and safety procedures including hand washing, etc.
- Safe sleep procedures
- Confidentiality procedures and in-Center referrals and/or exchange of information procedures
- The role of parents in the lives of their children
- Discipline techniques for young children

All Centers have been provided with a Volunteer Manual. This also should be used as a reference tool in engaging and incorporating volunteers into your program.

If the classroom is *not* licensed, volunteers may be counted in determining ratios. Parents, on the other hand, may *not* be counted as an "Adult" for purposes of ratios, unless they are in the CD room that day working as a volunteer with all the children.

EHS programs may never have more than eight children in a group; volunteers may never be counted in determining ratios. EHS must follow child care licensing regulations.

REQUIREMENTS

- Qualified staff have completed required MFN training, had background checks and fingerprinting. Please see job descriptions in Appendix 1 for minimum educational and experience requirements. 
- Volunteers in the classroom receive an orientation to the Family Support Center and are trained in best practices related to early childhood education. Background checks and fingerprinting are required of volunteers.
- Required ratios are maintained
- There is a written plan for staffing the CD room when a CD staff member is absent.

- The CDS provides direction and training to the child development staff and meets with individual staff at least monthly, providing supervision

DOCUMENTATION

- Evidence of appropriate staff qualifications in personnel files.
- Evidence of fingerprinting, background check and completion of required training for all staff and volunteers.
- Documentation of monthly supervision by CDS.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- There may be times when overcrowding, safety concerns and insistence on quality care for very young children may necessitate limiting the number of families who can use the child development room at any one time.

Refer to Head Start Act of 2007 for staff qualifications.

Parents

Parents are expected to spend time in the CD room participating in their child's play and routine care so the children experience nurturing interactions with their parents. Learning to trust is the infant's primary task during the first year of life. Trust provides the foundation for further development and forms the basis for self-confidence and self-esteem. The role of the FSC is not to substitute for parents but to support the primacy of the parent/child relationship. When FSC parents are in scheduled Center activities CD staff will perform necessary diaper checks, changing and feeding, unless otherwise indicated by the parent.

The activities in the CD room are an important opportunity for informal parent education and should provide opportunities for parents to see how others interact with children. As parents participate in the program, the child development staff can model adult-child interactions and parents can learn effective child rearing techniques.

When parents enter the CD room with their child they should be asked about their child's day, including the child's mood as well as anticipated eating, diapering and sleeping needs over the next few hours. In addition, when parents pick up their child, this is an important time to share how the child's day has gone in the CD room. This can be a verbal and/or written exchange for toddlers. A written exchange is required for infants.

REQUIREMENTS

- Evidence of informal parent education in CD room.

DOCUMENTATION

- Completion of MFN-MIS Code P-12 for informal parent education.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- Staff may ask parents to change and feed their child before leaving the CD room in the morning.
- To be counted as a P-12 activity (Informal Parenting), a session/discussion/modeling with a parent needs to be at least 10 minutes in length.

Parents and Children Together (PACT) Activities

PACT experiences are an opportunity for engagement between the parent and the child, allowing parents to spend time in the CD room with their child. These experiences enable parents to observe their child at play and, through engagement in this play, gain a better understanding of their child's developing skills.

PACT activities are:

- A daily, developmentally appropriate planned activity for parents and children focusing on the parent offering the child two choices for play and following the lead of their child.
- To allow parents and children to have fun and enjoy each other.
- To provide a link to other core services, the monthly theme of the Center or a parenting/ developmental issue.
- To show an experience which can be easily replicated at home.
- A time when parenting skills are practiced, modeled and integrated into the activity.
- Approximately 10-15 minutes.

The role of the CD staff member during the PACT activity is to:

- Present the prepared, planned activity for parents to complete with their
- child. Help the parent recognize what the child is saying/showing/doing.
- Support the parent in engaging with and responding to the child.
- Offer the parent clear and specific positive feedback.
- Act as a support and/or coach for the parent.

REQUIREMENTS

- Daily, developmentally appropriate planned PACT activity for all parents and children.
- Staff support and praise the parent/child engagement in the activity
- Staff praise parents' increasing skills in responding to their child in a positive manner.

DOCUMENTATION

- Completion of MFN-MIS Code P-11(for both parent and child).

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- Expectant parents can participate in PACT activities to observe parent/child interaction and modeling from CD staff, other parents, as well as assist parents who have more than one child in the CD room.
- The 2008 PACT Activities notebook developed by MFN is an excellent resource.
- For information on how to actively involve fathers, please see Appendix 5 – Fatherhood Services.

Observation, Assessment and Individualization

Observation and assessment of each child in the CD room are important responsibilities of the CD staff and provide them with information on the child's growth and development and the child's relationships with children and adults. Individualized responsive programming is made possible by observations and ongoing assessments. The Ages and Stages Questionnaire On-Line is used in all centers to screen for possible developmental delays and, in Family Support Centers, to support planning for the individual child. The Ages and Stages Questionnaire- Social Emotional On-Line is required to screen for possible social-emotional concerns.

Observations have several purposes: 1) the sharing of information with parents, 2) planning for the classroom, and 3) planning for individual children's needs. Observations are ongoing and should be recorded in the child's folder at least weekly. Through consistent observations, both formal and informal, staff can best plan for each individual child *within* the group.

Family Support Centers and Early Head Start have differing requirements for screenings, assessments, observations and individualizations.

FAMILY SUPPORT CENTERS

The ASQ On –Line is used as an assessment tool with children enrolled in Family Support. The initial ASQ On-Line is completed annually by the 3rd visit to the program. The ASQ On-Line is completed with the parent in the home or in the center. The ASQ-SE (to screen for social-emotional and/or behavioral concerns) is conducted in the same manner as above. The ASQ-SE may only be administered by a staff person who has completed a MFN approved ASQ-SE training.

Observations using Teaching Strategies GOLD must be completed on each enrolled child weekly to include observations in each of the four domains (language, cognition, social-emotional, gross motor/fine motor). CD staff will use the results of the ASQ On Line 3 and classroom observations to plan at least two individual learning goals (from the developmental domains of language, cognition, social-emotional and gross motor/fine motor). These must be established in partnership with the parent.

FSC REQUIREMENTS

- Observations include a minimum of one observation in each of the four developmental domains for each child weekly.
- ASQ On-Line completed annually with the parent.
- Two individual learning goals, based on the ASQ On-Line and observations, are developed in partnership with the parent(s).
- Progress notes must be completed as needed. Examples include, but are not limited to information on: referrals, attendance issues, conversations with parents, behavioral issues, etc.

EARLY HEAD START REQUIREMENTS

EHS child development staff must complete the screening tools, ASQ On –Line ~~3~~ and the ASQ-SE On-Line, within 45 days after the child is enrolled, and yearly after the initial screening. These tools are completed with the parent in the home or in the center.

CD staff must complete sufficient observations weekly using to meet the requirements of the ongoing assessment, Teaching Strategies GOLD. This assessment will be completed and shared with parents every three months. At this time, the parent and CD staff will set individual learning goals for the next quarter based on their child's TS GOLD assessment.

EHS REQUIREMENTS

- ASQ On-Line ~~3~~ and ASQ-SE On-Line completed within 45 days of enrollment.
- Sufficient observations completed weekly in all domains to meet the needs of TS GOLD.
- Individual learning goals set every three months, at a minimum, in partnership with the parent(s).
- Progress notes must be completed as needed. Examples include, but are not limited to information on: referrals, attendance issues, conversations with parents, behavioral issues, etc.

DOCUMENTATION

- MFN-MIS Quarterly Milestones completed.
- Completion of MFN-MIS Codes: C-190, C-191, C-192, C-193, C-194, 0-302.
- Referrals for additional service made as needed, and noted in file.
- Progress notes, observations, completed ASQ's and individual learning goals are noted in the child's file.

Possible Developmental Delay

When there is an indication of possible developmental delay through observation, ASQ or parental concern, a referral for further evaluation should be considered. If the child is new to the program, has limited experience in group care, had a score very close to the cut off, and/or was screened in a less than ideal situation, staff and the parent may agree to develop an action plan rather than complete an immediate referral to Infant and Toddlers. This plan might include offering specific activities in the classroom and continued observation but must include a re-screen in a specific period of time, no longer than two months. If this re-screen still shows a delay, a referral must be made.

After discussion by the CD Specialist with the parent and an explanation of the process, the referral will typically be made to the local Infant and Toddlers Program. It is ideal that the parent complete the referral phone call or letter him/herself with the support of Family Support Center staff. All referrals and follow-ups should be documented in the child's folder. If the child is found to have a disability and an Individualized Family Service Plan (IFSP) is generated, with the parent's permission a copy should be kept in the child's folder. In addition, it is important to work closely with Infants and Toddlers to assure the CD room is providing the most appropriate experience for the child in implementing the IFSP. Staff should support the parent by attending IFSP meetings and evaluations. It is not unusual for Infants and Toddlers to provide early intervention services on-site at a FSC. This practice is encouraged as appropriate and should be determined on a case by case basis.

REQUIREMENTS

- As appropriate, the implementation of IFSP through individualization in the classroom and consultation with service providers for the child.
- Timely referrals made to the local Infant and Toddler program or other service provider, as needed.

DOCUMENTATION

- Completion of FOF-MIS Codes: C-190, C-191, C-192, C-193, C-194, 0-302.
- Referrals for additional service made, as needed, and noted in file.
- Progress notes, observations and individual learning goals are noted in child's file.
- IFSP in child's folder.
- Individualization in child's folder notes support for appropriate classroom IFSP goals.
- Follow-up to concerns on screenings noted in file.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- If the IHI/FA has a developmental concern with a child, he/she should consult with the CD Specialist before making a referral for evaluation.
- For information on how to actively involve fathers, please see Appendix 5 – Fatherhood Services.

EHS programs have different requirements for screening and assessment tools.

General Health and Safety Issues

It is required by MFN that all staff working in the CD room have current Child CPR/First Aid certificates, training in universal precautions and child abuse and neglect reporting.

Refer to MFN ITERS Information and Clarification Notebook titled "Everything You Always Wanted To Know about the ITERS But Were Afraid To Ask" (July 2012) for more complete information on classroom requirements including health and safety information.

In addition, "Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Third Edition" found online is an excellent resource for many health and safety questions. This is a joint project of American Academy of Pediatrics, American Public Health Association and National Resource Center for Health and Safety in Child Care and Early Education. The ITERS bases its updates and clarifications on this document, which is updated yearly.

Diaper Changing

Diaper changing is an important issue in the CD room. See Appendix 4 for a Diaper Changing Procedure for staff and parents to follow. This should be posted. Diapers must be checked every hour by smell and by feeling through the cloth as well as visually inspected every two hours. Staff are to change diapers while parents are involved in program activities. Exceptions can be made on a case-by-case basis as determined by the parent and CDS.

First Aid

There should be a First Aid Kit in each CD room. See Appendix 4 for a listing of items to be included. This kit should be checked monthly for required contents and expiration dates. A list of items in kit and a card noting these checks needs to be kept in the First Aid Kit.

Safe Sleep/Back to Sleep

All Infants up to 12 months must be put to sleep on their back in a crib with a tight fitting sheet and nothing in the crib. This includes no blanket in the crib. If the child is 6 months of age or older and when put down to sleep on their back turns them self onto their stomach, they may be allowed to stay in this position for their nap. An infant may have a pacifier in their crib to support his/her transition to sleep. See Appendix 4 for a fact sheet on such to be posted above cribs. Cribs should be used by only one child (with a name card posted on the crib) until the sheets are changed and the crib cleaned and sanitized.

Children should not be left to sleep in car seats or other infant equipment. Children 12 months and above may nap on a cot or mat unless the parent asks to have the child sleep in a crib.

Parents should be taught to put their children to sleep in cribs on their backs and to be sure there are no soft items in the sleeping area. Staff should be sure SAFE SLEEP information is a part of parent workshops and/or orientation to the CD room.

Sippy® Cups

Sippy® cups are often used in Centers by parents as well as child development staff. Although the intent of Sippy® cups is to transition children from the use of a bottle to a regular cup, often the Sippy® cup simply takes the place of the bottle. It is the expectation that no child will use a Sippy® cup in the CD room after the age of eighteen months.

Using regular cups in Center programs minimizes pediatric dental concerns, encourages fine motor skills and promotes independence in children. In addition Centers provide an important model for parents. By offering children a regular cup instead of a Sippy® cup we are encouraging them to learn, through practice, an important developmental skill.

Additional information:

1. Begin this transition to learning to drink from a cup when the child is sitting up and starting to eat solid foods.
2. Use a Sippy cup® as a transition only.
3. Children should never be allowed to walk or play with cups or bottles in the classroom
4. Share with parents the nutritional and health risks of Sippy® cups. Help them with suggestions to teach their child to use a cup and discuss appropriate times to use a Sippy® cup.

Sunscreen

When weather conditions warrant, staff should apply spray sunscreen of at least SPF 30 to children older than six months prior to going outside. Children under six months of age should not be in the direct sun. The directions on the individual sunscreen should be followed. Permission for this application of a specific sunscreen should be added to the program's general parental permissions. Programs may allow parents to provide their own brand of sunscreen and need to develop an appropriate permission if this is done. If a parent does not want sunscreen used on their child, the child needs to wear clothing outside which covers his /her exposed skin as well as a hat. See Appendix 4 for supporting information on young children and sunscreen.

Infant Equipment

It is the expectation that each infant area will have no more than 1 or 2 infant seats to use when staff are very busy with routine care for other children. The seat must be placed near a staff person. Other

equipment such as swings, walkers, ExerSaucers® and Bumpo® seats are not allowed in the program. They represent potential safety hazards and/or may encourage staff to leave children unengaged for periods of time.

Car Seats

It is expected that all children will use appropriate car seats when using program transportation. Please refer to KISS (Kids In Safety Seats) for current state regulations regarding the use of car seats as well as information on installation. Parent Education and support should be provided to parents so they understand and use car seats to transport their children safely.

EHS has additional car seat safety standards.

Foot Covers

To ensure that the floor/rug in all infant rooms remains clean, staff, parents and visitors are to be required to remove or cover their shoes when they enter the infant room. Bare feet (adults) are not allowed.

Food

It is important for the health of our families that all food provided by the centers is nutritious and that meals and snacks model healthy eating practices. This means: offering fresh foods whenever possible; offering water and/or milk for children to drink; limiting the provision of juice at snack and if juice is offered, only offering 100% juice. Programs are encouraged to consider USDA guidelines when deciding types and quantities of food to serve.

Sanitizing

Toys mouthed by children must be sanitized daily. Bins or aprons for mouthed toys must be easily accessible to teachers in classrooms. Tables for eating and changing table surfaces must be cleaned and then sanitized before use. Cribs must be cleaned and sanitized before they are used for another child. All surfaces in the room should be sanitized weekly. See Appendix 4 for additional information on sanitizing and/or disinfecting.

Hand Washing

Hand washing policies and procedures must be followed by staff, parents and children and visitors to the classroom. See Appendix 4 for Hand Washing Procedure and Policy.

Immunizations

It is important to ensure that each child is fully immunized. Part II of the Eligible Child Survey asks for documentation regarding up to date immunizations when the child is enrolled. It is the responsibility of CD staff to be sure parents keep their child up to date with immunizations and to know the COMAR (Code of Maryland) immunization schedule. These immunizations are documented in the MFN-MIS and recorded in the child's folder.

Allergies

Allergies should be noted at intake. A dated note stating which children have allergies and/or a note stating that "no children currently have allergies" must be posted near the eating area and updated monthly.

REQUIREMENTS

- First Aid Kit in classroom with required items. Items must be checked monthly, including expiration dates. Kit includes list of required items. See Appendix 4 for a current Maryland Child Care Administration listing of required items.
- Health policies documented.
- Emergency procedures documented.
- Diaper changing procedure posted and followed. See Appendix 4.
- Safe Sleep procedure posted and followed. See Appendix 4.
- Hand washing policy and procedure posted and followed. See Appendix 4
- No child above the age of 18 months uses a Sippy® cup in the center.
- All children up to date with immunizations.
- All CD staff CPR and First Aid certified.
- Written parental permissions obtained for walking trips, photos and administration of sunscreen. See Appendix 4.

DOCUMENTATION

- Completion of MFN-MIS Quarterly Milestones.
- Completion of MFN-MIS Code C-195.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- Licensed centers will be required to follow licensing regulations regarding necessary parent permissions.
- Young children cannot consistently communicate their thirst needs. Children should be offered drinks of water at regular intervals throughout the day.
- One source for immunization schedules is Maryland Department of Health and Mental Hygiene (http://www.EDCP.org and link to Immunization / Schedule for Immunizations.)
- It is expected parents will provide routine care for their children during breaks from their planned program activities. When parents are engaged in these activities CD staff will provide routine care for their children.
- For information on how to actively involve fathers, please see Appendix 5 – Fatherhood Services.

EHS programs should refer to Head Start Program Performance Standards and Other Regulations and the Head Start Act of 2007 for specific requirements.

Service Coordination

Service coordination is an integral component of family support services. It provides the mechanism for families to maximize their potential. It is not an isolated function, but one that is performed in conjunction with all other staff. The central figures in the service coordination process are the parents. It is parent driven and delivered according to the parents' expressed needs and requests. Service coordination is ideally performed by one identified full-time staff.

Service coordination is the identification of strengths and goals, assessment of need(s) and related services, service linking/referral and, most importantly, follow through. The above efforts are completed via the initial interview, ongoing face-to-face contacts with participants and collaborations with Center staff as well as outside agencies that have involvement with the participant and his/her family.

Service coordination begins with the receipt of the initial referral. Orientation into the Center is part of the service coordination process and represents a component of the assessment phase and request for services. All service coordination activities are documented in a participant file on the required forms as listed below. Also included in this process are regular case meetings. Service coordination ends when a family is no longer engaged with the Center and there has been appropriate follow-up activity.

Case Meetings (Case Reviews)

Case meetings bring together staff who are involved with the families to discuss their progress towards goal attainment. Case meetings are an opportunity for staff to share their work with families, receive suggestions concerning families and work as a team to move the family toward self-sufficiency. The focus is on strengths and the identification of any barriers that may impede goal attainment. The final outcome is a written plan for use of Center resources to facilitate the participant's progress towards goal attainment and self-sufficiency. Case meetings ideally should be held weekly. Every family must be reviewed at least monthly. Due to varying enrollment numbers, EHS may review families on a different schedule.

FORM COMPLETION AND DOCUMENTATION REQUIREMENTS

Each participant is required to have a file that includes the following:

- MFN-MIS Applicant Initial Contact Form: to be completed in its entirety at time of entry into the program. This activity is not coded on the MFN-MIS Center-based Family Activity Form.
- MFN-MIS Applicant Initial Contact Form (Appendix A): to be completed when there is a name change, birth of a child, etc.
- MFN-MIS Intake Form (Parts I and II): to be completed by the third visit. Completion should be done in an interview format and is used for the purpose of identifying strengths, assessing needs and assisting participants with establishing goals or an action plan.
- Pregnancy Survey (Parts I and II): Part I of this form is completed upon learning that a participant is pregnant and gathers information regarding the pregnancy, the receipt of prenatal care and the expected delivery date. Part II is focused on the outcome of the pregnancy and the health of the newborn.
- Family Partnership Agreement (FPA): formal goal setting process as a result of the intake interview and subsequent contacts. The focus is what the *participant* identifies as a goal. The initial Family Partnership Agreement is completed within 45 days of completion of the Initial Contact Sheet. Subsequent FPAs are repeated every three months. The goals and objectives are short term in nature and should be achievable within a three-month period of

time. Participant signs off and receives a copy as a standard part of the process. It is required that at least one goal pertain to the child(ren).

Family Partnership Agreements (FPA) must be completed within 90 days of enrollment in EHS programs.

- MFN-MIS Quarterly Milestone Form: to be completed for each quarter the participant attends the Center. This includes both adult and child participants.
- Progress Notes: completed to document the initial interview, subsequent contacts with Center and agency staff involved with the participant, referrals, crises and related follow-up activity. Progress notes are completed at least twice per month and are required to include progress toward goals with a note being completed to document every significant contact. In addition, a closing summary is completed and placed in the progress notes section of the file once it is determined a participant will no longer attend the Center.
- Participant Files: are considered legal documents. All progress notes are required to be dated and signed with full signatures. Mistakes are to be corrected with a single line drawn through the error and the writer's initials written above the correction.

MINIMAL REQUIREMENTS

- Orientation process upon entry into the program.
- Intake interview and completion of MFN-MIS Intake Form on or around the time of the third visit.
- Review, update and complete a Family Partnership Agreement every three months. Include at least one goal for the child (ren) and documentation of progress toward goals.
- Completion of the Life Skills Progression tool by the second visit and then every six months thereafter.
- A minimum of bi-monthly entries into the progress notes written in ink.
- Documentation of crises, attendance patterns, appropriate referrals and follow-up conducted.
- Completion of MFN-MIS Quarterly Milestones form for each quarter that a participant is in attendance in the Center.
- Weekly case meetings with related documentation on all participants reviewed.
- Maintenance of organized participant files in a locked and secure file cabinet.
- Documentation substantiating that file has been reviewed on a monthly basis by the Director or supervisor of the Service Coordinator.
- Inform members of the team about lack of attendance or any other barriers that may affect a participant's success or the Center's ability to meet contractual obligations. Provide and document appropriate follow-up to re-engage participants according to the Center's recruitment retention plan.

DOCUMENTATION

- Completion of MIS Codes: O-300, O-302, O-303, O-304.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- Lapsed attendance and efforts to re-engage the participant must be documented. Activities to re-engage families include telephone calls, home visits, and contacts with emergency contact persons. Letters are sent as a last resort and copies are maintained in the participant file.
- If the participant has not been to the Center for a period of three months, in spite of repeated efforts to re-engage them, the file can be closed. A MFN-MIS Quarterly Milestones form is completed and a closing summary is prepared and included in the progress notes. The file is then moved from active to closed files. An inactive file is considered closed and requires documentation to that effect.
- MFN-MIS forms are completed by staff and in conjunction with the participant. A blank form is never given to a participant to complete.
- The Service Coordinator is selected jointly by the FSC Director and the MFN Program Consultant.
- For information on how to actively involve fathers, please see Appendix 5 – Fatherhood Services.

EHS programs should refer to Head Start Program Performance Standards and Other Regulations and the Head Start Act of 2007 for requirements including the EHS-specific attendance policy. EHS programs not receiving state funds do not complete MFN-MIS Quarterly Milestones.

Health Education

Health Education is a vital component of a Family Support Center. Issues related to optimal health touch every aspect of one's life. Health Education includes those topics related to the physical as well as the emotional well being of parents and their children. The focus is primary healthcare and/or prevention. However, it can include topics related to secondary health. The broad spectrum of health education topics includes, but is not limited to, generalized health, proper diet and nutrition, substance abuse, disease prevention, family planning and pregnancy prevention, prenatal care, child and adult mental health, stress management, domestic violence, healthy relationships, etc. Health Education is provided primarily in a group format but opportunities to provide information on an individual basis can be utilized. Groups can be one time only workshops or a weekly series covering several aspects of one topic. In addition, the service can include health screenings, assessments, health fairs, cooking classes and visits to healthcare facilities. The use of speakers is encouraged as well as partnerships with healthcare providers.

Required Topics

- **Substance abuse education** - Offerings may include the use and abuse of illicit drugs, co-dependency issues, signs and symptoms of drug use, etc. Substance abuse topics are to be offered quarterly.
- **Reproductive health education** - Especially related to pregnancy prevention. This can take the form of workshops, a seminar series or individual counseling. Offerings should include contraceptive updates, gynecological care, STD's, family planning as it relates to managing one's fertility, decision making and optimizing family life. Reproductive health topics are to be offered quarterly.
- **Proper and preventive healthcare** - Practices include the use of universal precautions. Topics include, and are not limited to, issues related to generalized wellness, proper diet and nutrition. The focus is on adult and children's health issues. Cooking classes, speakers, screenings and health screenings are encouraged. Proper and preventive healthcare topics are to be offered quarterly.

Other Topics and Ideas

- Prenatal care sessions can be done individually or in a group.
- Newborn classes in which the focus can be on the care of the new baby. Topics may include but not be limited to, infant development, feeding and nutrition, diaper rash, common illnesses, when and how to call the doctor, being the parent of a newborn, etc.
- Stress, depression and other topics associated with mental health.
- Promoting healthy self esteem and emotional well being.
- Domestic violence.
- Healthy relationships.
- Cooking classes with nutrition as the focus.
- Health fairs.
- Dental health and related information for both parents and children. Demonstrations of proper brushing techniques for both parents and children and the dissemination of toothbrushes.

REQUIREMENTS

- Services are offered once a week for at least an hour.
- Focus is on primary/preventive and secondary healthcare.
- A wide variety of issues/topics are covered.
- Reporting communicable diseases to local health authorities and to all Center families. This includes childhood diseases and adult illnesses such as head lice, infectious hepatitis, scarlet fever, etc.
- Systems Coordination - During the intake process and subsequent participant contacts, efforts are made to ensure that parents and their children have a healthcare provider and maintain regular visits. These efforts also include maintaining a current record of children's immunizations on file. If parents or their children do not have a healthcare provider, efforts are made to link them to one.
- Provision of mental health consultation via contract with a mental health professional. Services can include and are not limited to attendance at case meetings to provide consultation to staff on mental health issues related to the parents and/or their children, group activities with parents, observations of the child development room operation in relation to mental health, and individual meetings with parents.

DOCUMENTATION

- Documentation of services is required on the monthly calendar.
- MIS Documentation – use MFN-MIS codes F-70, F-71, M-110, R-90, R-91, SU-130, SU-131 or as specified in Glossary of services for Maryland's network of Family Support Centers.
- Attendance records of group activities/presentations.
- Documentation in progress notes as warranted

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- To substantiate health education is offered it must be included on the monthly calendar. Also, an attendance sheet should be completed for the activity.
- Staff are encouraged to make referrals for actual physical and/or mental health services beyond that which can be accommodated by the mental health consultant. This does not include screenings or assessments.
- WIC on-site does not count as health education. However, it is encouraged, as it is a great retention and marketing tool for the Center.
- It is not required that cases of HIV be reported to the local authorities. However, if a participant or staff are potentially exposed to the virus while in the Center, it is urged the person(s) be referred for immediate testing. The use of universal precautions is encouraged at all times so as to limit this type of exposure.
- For information on how to actively involve fathers, please see Appendix 5 – Fatherhood Services.

EHS programs should refer to Head Start Program Performance Standards and Other Regulations and the Head Start Act of 2007 for specific requirements.

Home Visiting

Family Support Centers provide home visiting to enhance the services available to parents. This is an avenue to reach families who are willing but may not yet be ready to engage in the FSC. The home visiting program in FSCs is In-Home Intervention. All In-Home Interventionists (IHIs) are trained in the evidenced-based Parents as Teachers (PAT) home visiting model.

The overall goals of In-Home Intervention are to support families through home-based services and recruit parents to actively participate in the FSC. Intensive home-based services are focused on the expressed needs and wants of parents and children. In-Home Intervention helps parents enhance the quality of parent, child and family interaction. Parenting and health education are the focal points with the parent/child relationship being the primary focus. Visits include a mandatory parent/child activity and development-centered parenting discussion. The IHI models or facilitates appropriate parent/child interactions. Family well-being discussions are integrated into each visit to help keep children safe and build strong families. The In-Home Interventionist may recommend additional resources or support the family in accessing community-based resources that will help them achieve their goals.

Each IHI will serve at least 35 families over the year with an intensive negotiated caseload of 15 families monthly. Families are required to be visited a minimum of three times each month, although weekly is highly recommended to maintain momentum. Each visit should last 60 – 90 minutes. The average length of the home visiting intervention is six months except in extenuating circumstances. After six months, each family should be re-evaluated for continuing service. Families should be linked to outside resources when the need is warranted or requested.

Dual Services (Center-based and IHI) to Families

(EHS program options and participation requirements differ.)

Center-based services will be made available to IHI participants based on the collaborative decision following regular service coordination meetings.

Examples of families eligible for dual services include the following

- Special needs families (parent or child).
- Families mandated or court-ordered to participate with services.
- Families with children with behavioral concerns.
- Families who are completing their goal of transitioning to the Center.

No more than 25% of the IHI caseload should receive dual services. IHI negotiated caseload will remain the same. Center required participation levels and home visit intensity will remain the same.

REQUIREMENTS

The IHI will provide home visits to assist families with any or all of the following services:

- **Infant/Toddler Program:** Ages and Stages Questionnaires On-Line (ASQ-On Line) should be completed on all children annually. The initial ASQ On-Line must be completed on or around the third visit. Referrals to Infants and Toddlers should be coordinated with the Child Development Specialist. The IHI will coordinate the referral process by working with the parent and the CDS.

  IHI will be responsible for home safety checks.

IHI will monitor immunization status and well child medical visits on a regular basis.

IHI will be responsible for completing Parts I and II on the Intake Form.

- **Self-sufficiency:** Parents set realistic short-range goals they expect to attain in a three-month period. The IHI may assist parents in locating and accessing educational programs, homework and tutoring programs, and finding adequate child-care. When ready, the IHI helps the parent transition into the FSC for adult education, employability services, and/or other services in which they have requested to participate.
- **Employment:** The IHI helps parents explore career options, develop systems for household management, arrange child care and establish emergency plans for sick-child care and access to transportation. The IHI encourages parents to utilize FSC services to obtain education and/or employability skills needed to move into the workforce.
- **Parent Education:** The IHI promotes positive parent/child relationships and understanding of child development through the use of the Parents as Teachers curriculum and/or other parent education resources.
- **Health Education:** The IHI encourages parents to access medical care for themselves and their children. The parent(s) and IHI discuss family planning and general prenatal health. Parents are encouraged to keep well baby appointments and maintain immunization records. Home safety checks are to be completed quarterly with every family.
- **Mental Health:** The IHI's role is to provide support and to appropriately refer parents to resources. The IHI does not provide counseling or therapy. The IHI may utilize the services of the mental health consultant as needed.
- **Social Support:** The IHI encourages the parents to attend FSC events whenever possible. FSC events can be part of the process of transitioning into the Center. When this is not possible, the IHI problem solves with parents to establish linkages with community resources or friends and family. The IHI is not the social support system for isolated families.
- **Service Coordination:** The Service Coordination process is an essential core service for both center-based and home-based families. Each family should have a service coordination plan that may include a transition plan. The IHI should regularly attend and participate in Center-based case meetings. Referrals for child development or access to supports for family well-being may be coordinated by the IHI. Service coordination promotes a parallel support process among families, the IHI and Center staff.

The Director or immediate supervisor meets at least monthly with the IHI for reflective supervision. Monthly supervision culminates with the completion of the IHI Caseload Review Checklist.

IHIs may facilitate a weekly life-skills group in the Center for IHI participants and Center participants.

Home Visit Structure – A 4 Step Model (60 – 90 minutes)

1. Connect, Reflect, Agree – 10 minutes

   Introductions and program description or review of activities and observations since last visit; review the agreed upon agenda for the visit. Agree on adjustments for individualization for this visit.

2. Family Well-Being – 20 minutes

   Begin or continue with goal-setting and attainment (i.e. checking progress on specific steps set on previous visit) based on parents' interests, strengths and concerns. Assist parents with planning and developing problem-solving skills.

3. Parent/Child Activity and Development-Centered Parenting– 20 minutes

   Developmentally appropriate activities for parent and child facilitated by the IHI and then practiced by parent and child with the IHI observing. Discussion of how child development influences parenting and strategies for enhancing the parent/child relationship.

4. Planning for the next visit – 10 minutes

   Review highlights of the visit. Engage the parent in planning the focus for the next visit.

DOCUMENTATION

IHIs should maintain a separate file, in a secured file cabinet, for each participant containing the following:

- Completed PROMIS Part I – Adult & Family.
- Completed PROMIS Part II – Child Survey.
- Completed ASQ On-Line for each eligible child, 0-3 years
- Home safety checklist (completed quarterly).
- Immunization record updated regularly according to the COMAR (Code of Maryland) immunization schedule.
- Family Partnership Agreement completed within 45 days of enrollment and updated every 3 months with ongoing documentation to record progress.
- Completion of the Life Skills Progression tool by the second visit and then every six months thereafter.
- Home Visit Record (HVR) for each visit.
- Copies of referrals to outside resources.
- Copies of PROMIS Quarterly Milestone Reports to be filed in the record with the original being submitted to the data entry staff when due.

The following documents should be completed and submitted to MFN:

- PROMIS Adult & Family Survey (Part I)
- PROMIS Child Survey (Part II)
- PROMIS Family Activity Form (Refer to PROMIS glossary for codes).
- PROMIS IHI Caseload Review Checklist.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- The IHI is not a substitute when other positions are vacant nor should the IHI perform other duties that will take him/her away from providing services to families on the home-based caseload.
- The IHI is selected jointly by the FSC Director and the MFN Program Consultant.

- Accurate coding of where a service takes place is important. Home visits must be conducted in the home and last at least 60 minutes.
- Transportation is not a service provided by the IHI.
- Too many services performed during a home visit could confuse or frustrate the family in their attempt to attain their goals. To help families experience frequent success, break down large or complex goals into smaller steps for subsequent visits and code each service accordingly. Some services overlap and can be combined under one code.

For information on how to actively involve fathers, please see Appendix 5 – Fatherhood Services.

EHS programs should refer to Head Start Program Performance Standards and Other Regulations and the Head Start Act of 2007 for specific requirements. Home visits must be at least 90 minutes and include the full range of Head Start services: PAT, screenings, ongoing assessments, tracking health requirements, health, nutrition, mental health, parent education, crises management, self-sufficiency, employment readiness, home safety checklist or similar document and clearly identified and attainable goals. EHS Home Visitors are called Family Advocates.

Participant (Parent) Support and Involvement

Participant (Parent) Support and Involvement activities are designed to develop the wide range of skills, strengths, and interests of participants. Family Support Centers provide programming that is comprehensive and well-rounded in nature. Services are delivered from a holistic approach, developed to promote balance in participants' lives and delivered within the cultural context of those served.

It is important to empower participants with skills and relationships that will carry over outside of the Family Support Center. Not only does this include basic life skills and recreation but also provides excellent opportunities for participants to develop leadership and advocacy skills. These skills are very important in the growth and development of parents attending the Center. It is important that opportunities be offered regularly to promote the development of these skills. In addition, once these skills are learned it is important that opportunities to practice these skills are provided on a regular basis.

Staff's role is to promote independence and self-reliance and not to foster an over-reliance on the Center for families' social and recreational needs. Although peer support activities may sometimes look like fun and recreation on the surface they are in reality intentional and purposeful.

REQUIREMENTS

- Parent Advisory Group meets at least monthly. This group plans activities and serves as a vehicle for participant input. Agenda and minutes are required and are kept on file. The group is lead by participants with staff serving in a supportive capacity.
- Peer support and recreational activities occur at least weekly and parents are involved in the planning and execution.
- Activities to develop parent leadership and/or advocacy skills occur at least quarterly.
- The Center Advisory Board membership includes two parents.

SUGGESTED ACTIVITIES

- Peer support and recreational activities planned by parents may include: celebrations of holidays, birthdays and special cultural observances, special group sessions to meet a need or enhance personal growth, table games, athletic events, arts and crafts sessions, sewing and cooking classes,
- Activities to develop parent leadership and/or advocacy skills may include decision making, active listening, community awareness, public speaking, meaningful participation in meetings, how to be assertive, etc.
- Field trips that are age appropriate for very young children.

DOCUMENTATION

- MFN-MIS Documentation on a Family Activity Log: Codes SS 170, SS-173

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- Peer Support activities can be for parents only with the purpose of parents taking care of themselves as an enhancement to their parenting role.
- As Family Support Centers are generally non-licensed facilities, parents and children must remain together at all times whether this is on trips or on-site at the Family Support Center.
- For information on how to actively involve fathers, please see

Participant (Parent) Support and Involvment activities provided weekly. Parent and Policy Committee meetings count toward this requirement. EHS programs should refer to and the Head Start Act of 2007 for specific requirements.

Outreach, Collaboration and Resource Development

Family Support Centers cannot exist without outreach, collaboration and resource development. These activities provide the foundation upon which the program is built and thrives. The sponsoring agency's and community's vision and plans for the Family Support Center are clearly described in the proposal and were critical to the funding of the proposal. Those who wrote the proposal are typically the people who designed the program and negotiated and formed the original collaborations. The Director and program staff must become familiar with the proposal and use it as a guide to build their program.

Outreach services are targeted at local organizations, families, youth and others to ensure community awareness, acceptance and involvement in planning and participation in Family Support Center activities. A Family Support Center can hire the best staff, create the warmest environment, and plan to provide the most needed services, but they are all meaningless if community members do not come in and utilize the Center.

Each Center is expected to have a written Recruitment and Retention Plan. Each center is expected to "work" the plan and document the activities as they are completed. The plan should be reviewed and refined as necessary, but at a minimum annually.

The best way to bring participants in the door is for staff members to walk out of the door -- and into the community. Outreach is salesmanship and more. It is letting potential and current participants know the Family Support Center is a place where they can find people who genuinely care about them and where they can find services and programs to meet their needs. It is contacting community organizations and social service agencies to make them aware of Center activities and programs, to stimulate a two-way referral system and to establish formal linkages. Relationships should be established with area:

Infant and Toddler Program	Housing authorities
High schools	Civic organizations
Community colleges	Mental health facilities
Neighborhood associations	Health clinics and hospitals
Churches	Head Start and child care facilities
Business people	Recreation departments
Legislative representatives	Literacy programs
Government officials	Public school systems
Health departments	Private social service agencies
Police departments	Homeless shelters
Departments of Social Services	Food banks

The following are suggested means of communication, in order of effectiveness:

- Person to person, face to face (home visits, street work, meetings with individuals who could make referrals, meetings with agency Directors, etc.).
- Person to group (hosting special events, speaking at churches, schools, conferences, clinics, community groups, social service agencies, etc.).
- The internet (Center website, emails, social networking sites, etc.)
- Telephone (calling participants and potential participants -- have each staff member call a certain number of participants each week, individuals who could make referrals, agency

Directors, etc.). Make sure the telephone system in your Center is user friendly.

- Writing to an individual (letter-writing, birthday and get-well cards).
- Using the media (brochures, flyers, a monthly Center newsletter including a calendar, press releases and public service announcements sent to newspapers, radio and television stations, posters, appearances on talk and news programs).

Visiting, calling, and writing to participants should not be considered intrusions to their privacy. Remember - an individual cannot become independent until they have first had the opportunity to develop trusting relationships.

The most important thing to remember about *outreach* is that it is a *continuous, everyday* process. Visiting a new mother once is not enough. Informing the counselors at an agency that the Center exists is not enough. The Center needs to constantly remind and educate. All of the techniques above and more should be tried and retried. When working with agencies and community groups, individuals on every level (from the Executive Director to the Counselors or from the President to the Members) should be contacted regularly.

Collaboration means working together to reach common goals, sharing resources, communicating openly and breaking down barriers in order to create opportunities for families with very young children. The Family Support Network in Maryland is a model of partnering and collaboration. Although collaboration can be tiring, frustrating and confusing, it produces more meaningful, responsive and effective services for families. Collaboration occurs at local, regional, state and national levels. Directors need to be fully aware of ongoing relationships and collaborations and to be constantly looking for new ones. Sponsoring agency representatives and Center documents like the original proposal and the Program Services Proposals are good places to gather this basic information. Maintaining collaborations and relationships means that Directors need to spend time outside the Center. Directors will be exposed to fresh ideas, new connections and new opportunities; it is time well spent.

Directors need to balance their time between direct program management and growing their program through collaborations and resource development. The sponsoring agency contact is the first step to gathering information about current resources, the development history of the agency and the Center itself and the agency's fund raising policies and practices. The sponsoring agency may have fund development staff and not expect the Director to actively seek funds or write grants. However, all resource development for the Center may rest solely with the Director.

In either case the Director must be vigilant, creative and assertive in assuring that the Center remains vital and responsive.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

- Outreach, collaboration and recruitment are part of every staff member's job description, not just the Director or Home Visitor. All staff members may be asked to participate in community meetings, attend fairs and conferences to distribute information and contact or speak with other organizations.
- If there are not enough families participating in the program *all* staff members are expected to work the recruitment and retention plan until contractual participation levels are reached.
- The recruitment and retention plan should specify how staff will participate in this function.
- For information on how to actively involve fathers, please see Appendix 5 – Fatherhood Services.

Section II
General Guidelines for Program Operations

Family Support Center Service Philosophy

A Family Support Center (FSC) environment is more like a home than an agency. Families should feel welcome and services should be easy to access. A family's first contact with a Center, whether it be face to face or via phone, is critical. As in a family, parents are always responsible for and are seen as the expert for their own children. Staff will support both the parent and the child as they access Center services. Services should feel more like help from a partner than like therapy from a counselor or instructions from an authority.

All services must reflect the family support principles. The services must:

- Show respect for both parents and children as individuals;
- Build on strengths, not search for deficits;
- Serve the best interests of children birth through three;
- Involve participants and the community in planning and implementation;
- Be offered at convenient times in accessible locations for a minimum of 35 scheduled hours of service to families each week; and
- Be provided in coordination with other agencies.

Expectations of Sponsoring Agencies

General Contract Compliance:

- As the local partner the sponsoring agency coordinates compliance with the contract among all those in their organization responsible for contract fulfillment (FSC Director, agency's administrative/program and financial representatives supporting the FSC program).
- Provides and maintains an appropriate facility/location suitable for operating a community-based Family Support Center.
- Review all agency administrative policies and procedures for compliance with the requirements of the contract.
- Fully comply with all local, state and federal laws and regulations, especially those involving employee protections, payroll and tax filings.
- Practice no discrimination in relation to employees, volunteers and program participants. MFN encourages the use of Women and Minority Owned Business Enterprises for the purchasing of services and supplies.
- Apprises MFN promptly of any issues, concerns or conditions that may alter contract compliance.

Supporting the FSC and the Director

- MFN contracts with the sponsoring agency. At times there may be competing agendas that create confusion or complications for the FSC Director. All parties must remain alert for this and be ready and willing to communicate closely to clarify the mission and vision to help the Director prioritize effectively. It is especially incumbent upon the contracting parties to remain vigilant to these potentially conflicting situations. Often these occasions become opportunities to enhance the overall operation of the Center.
- Assist the Director to maximize the potential of the sponsoring agency's administrative services. Work to fill vacant positions as quickly as possible.
- Identify and where possible, eliminate administrative and compliance obstacles so the Director can focus on program operations
- Involve the Director actively in the budgeting process and the ongoing financial management (including review of monthly expenditure reports) for the FSC within the sponsoring agency.
- Provides leadership, direction and resources to the FSC Director for the purpose of raising additional program funds.
- Work with the FSC Director to develop, maintain and support collaborations and/or partnerships with other community providers in order to enhance the FSC operations and/or array of family support services.

Contractual Operating Standards

State funded Family Support Centers

Contractor will be required to ensure the Family Support Center targets young families with children from birth through 47 months of age (0-3 years).

A major goal for the program will be to serve at least thirty-two (32) families with children 0-3 years intensively each month and at least one hundred (100) families with children 0-3 years intensively per year.

In addition, the program will serve thirty-two (32) children ages 0-3 years intensively each month and at least one hundred (100) children ages 0-3 intensively per year.

For this purpose the following definitions will be used:

- Family - a parent, or legal guardian, and all of the children she/he brings to the Center. MFN will monitor this count by checking the "Parents Total" entry on the monthly "Participation Summary Report."
- Intensity - Five (5) or more visits per month. The intensity level will be determined by dividing the total number of visits made to the Center in the "parents" category by the "Parents Total."

In addition, the Family Support Center will be expected to recruit new participants, at a minimum, on an average of 4-5 per month. MFN will monitor this count by checking the number of "Intakes" completed each month.

The In-Home Interventionist is required to serve 35 families a year, maintaining a caseload of 15 at any given time. Families counted on a caseload are expected to receive intensive services (defined as face to face contact at least three times a month).

Early Head Start Centers

Each Early Head Start Center has a negotiated funded enrollment standard and attendance/participation requirements that must be maintained at all times.

Target Service Populations

Primary Service Populations

A. State funded Family Support Centers
   1. Children birth through three years of age and their mothers and fathers or those recognized as the primary caregivers. **
   2. Young parents, being defined as parents 19 years of age and under.
   3. Expectant parents.

B. Early Head Start Programs
   1. Children birth to three years of age and pregnant women who meet income guidelines.
   2. Children birth to three with disabilities.

** Primary caregiver is defined as one who has legal custody or guardianship. Therefore, children may only attend the Center in the presence of their primary caregiver.

Recommendations for Secondary Service Populations

In order to fulfill the existing mission and better support each family as a total unit, the next phase of services should focus on providing program activities to a sub-group of the mandated population. Since extended family members greatly impact individuals in the target group, programming should be considered when additional funding is available for the following (not listed in any order of priority):

- Expanded services to fathers focusing on activities specific to male parents.
- Siblings of the children birth through three years.
- Parents of parenting teens.
- Parents and children four years of age who are making the transition to other Pre-school/Head Start programs.

Variations in Programming within Family Support Center Network

Further variations in programming or services to be offered beyond the populations outlined above should be discussed with Maryland Family Network Program Consultants. Maryland Family Network will consider proposed variations if the following conditions exist:

- The service is based upon a need that is reflected by the community served by the Family Support Center.
- The variations do not infringe upon the Family Support Center philosophy and/or the Center's daily operations.

The Setting

Location

The most effective and successful Center locations are:

- Accessible to prospective participants (neighborhood settings are effective).
- Convenient to public transportation.
- Accessible to other community services.
- Convenient to parking.
- Accessible to usable outdoor space.
- Handicapped accessible.
- Easily visible and clearly identified by a prominent outdoor sign.

The Center Building

The Center should be homelike and be a clean, attractive, safe and welcoming atmosphere. A sense of participant ownership should be evident in the individualized decor and display of participant projects and memorabilia. Centers must be large enough to accommodate the concurrent activities that are part of FSC programming.

When determining space utilization, the child care areas should take priority as their requirements are the most specific. The child development room is required to be two thousand square feet of contiguous child care space. Consult the MFN Program Consultant at the beginning of the planning process.

Be sure to consider the need for staff to have work space that will provide privacy for counseling sessions and phone calls. Plans for regular, reliable, and thorough maintenance of the entire facility should not be overlooked. The building should have sufficient accessible restrooms and should be inspected for hazards such as stairwells, floor grates for furnaces, low glass windows, lead paint, etc. Emergency evacuation routes should be identified from all areas. Evacuation plans should be posted in all rooms and all exits should be clearly marked. Smoke detectors and fire extinguishers are essential. Participants must know and practice evacuation procedures.

Do not neglect visibility of your facility to the community. A large, well designed and well placed sign is essential and required.

Space Requirements for Family Support Centers

It is required that a Center be located in a space of at least 5000 square feet. The following list of designated areas will be helpful for all Centers in planning effective space utilization:

The Child Development Room(s)

At least 2000 square feet of contiguous space (usable floor space). Running water, natural light, refrigeration and telephone service are needed in the children's area. A washer and dryer and a defined storage area for coats, diaper bags and strollers should be located in or adjacent to the child development room. Dimmer switches, windows to the floor, multi-level built-ins, half doors, half walls, child sized plumbing and an automatic dishwasher for daily disinfecting of toys are highly recommended.

EHS programs should refer to and the Head Start Act of 2007 for specific requirements.

Large Lounge/Multi-purpose Room

This room should be large enough to accommodate a sofa, comfortable chairs, coffee table, television, book shelves, etc. This area can double as a participant lounge, group meeting area and/or conference room where formal parent education sessions, tutoring, groups and other sessions are held. Because of privacy issues this cannot be used as a walk through area.

Kitchen/Dining Area

The space should be large enough to accommodate 10 - 15 people including small children. This area can easily be used for nutrition and cooking classes. The Center's kitchen needs to be maintained in a homelike atmosphere. This includes basic safety measures for very young children.

Bathrooms (2)

One bathroom is required in the CD area and one is required for adults.

Reception/Waiting Area

The reception/waiting area should serve as a place to greet and make participants feel welcome. Ample seating should be provided. In addition, the reception desk should provide a secure and permanent space for a telephone and computer. Consider the participant and prospective participant when selecting the phone system. Complicated, automated systems are off-putting to families and providers.

Education Center

A large room with tables, chairs, and a chalk/white board is needed for adult education classes. A separate area, but in close proximity to the classroom, is required to accommodate four or more computers and at least one printer.

Offices (minimum)

- Director
- Counseling room (may also be used for testing purposes)
- Child Development Specialist
- Service Coordinator/IHI

Large general staff room is acceptable as long as each staff person has his/her own desk or work space. Offices should be large enough to accommodate locked files for confidential information. It is important that the Center be designed with space that is comfortable, flexible and large enough to accommodate a variety of program activities and provide for adequate storage.

Listed below are additional suggestions for rooms given the availability of space. These rooms will allow for flexibility in the program, enabling activities to be performed simultaneously as well as providing space for crowded occasions.

Conference Room

This room can be used for formal parent education sessions, tutoring, typing class, sewing class, participant meetings, advisory council sessions and staff meetings.

Small Lounge

This area should be large enough for a couch, comfortable chairs and a small table. It can also be used for small informal groups and respite for parents.

Storage Area

There should be a designated locked area for FSC supplies (food, emergency supplies, office supplies, audio visual equipment, education materials, out-of-season equipment and materials).

Maximizing Collaborations and Community Support

The initial stages of organizing a family support program are important because they provide the foundation upon which the program will be built. The Sponsoring Agency's and Community's vision and plans for the Family Support Center are clearly described in the proposal and were critical to the funding of the proposal. Those who write the proposal are not often the ones who implement the program. The FSC must link with its community if it is to be vital and productive. It is essential the Director and program staff get to know their community well and develop a clear understanding of its strengths, needs, issues, and resources. This means walking the community, meeting people, listening to them, meeting with collaborators and partners regularly. It is also essential that the Director and program staff become familiar with the proposal and use it as a guide to build their program.

Just as community input is an important part of the decision-making process in site selection, it is also an important part of program development and assuring the quality of ongoing operations and relevancy of services. During any point in a Center's development, the organizers may want to reach out to the community through forums and surveys. Information gathered during the application process should prove invaluable as plans become realities. More specific information regarding target populations and community resources may need to be collected as the program develops. Community forums and carefully designed surveys can be effective tools for these purposes.

Community assessments are required of EHS programs and must be completed every three years and updated annually.

The Advisory Board

FSC programs are required to develop community advisory boards to provide advice on every aspect of Center operations. FSC advisory boards are essential to the success of each Center. An advisory board can help assure ongoing community input into a program's development and can help maintain the program's responsiveness to community needs. In addition, an advisory board can help disseminate information about FSC services to other agencies and institutions, and can identify and advocate for necessary community resources for parents and children.

The advisory board is comprised of at least two participants, community residents and leaders, and representatives of private local agencies and businesses who meet at least quarterly with the Director. It is advisable to include members whose professional expertise is varied and who can be called upon to offer creative solutions to problems and challenges. Members should be enthusiastic and actively supportive of the Center and its activities. As the advisory board evolves it will need to develop a detailed delineation of the board's responsibilities and authority in conjunction with the sponsoring agency.

EHS programs are required to develop Policy Committees and Parent Committees. Refer to the and the Head Start Act of 2007 for specific requirements.

Program Development

Programs should continue to monitor data on the nature and severity of community problems, the availability of existing community resources and information on services and program variations that have been effective in other Family Support Centers and elsewhere. Local community-based programs are affected just as much by local conditions as they are by changes regionally, state-wide or nationally (e.g. welfare reform, economic recession).

The most successful programs are flexible and approach program development as an ongoing process. MFN Program Consultants can assist in this process. Opportunities for growth and development occur when:

- Communities experience population shifts.
- Participant needs and interests change.
- Resources are not consistently available.
- New funds become available.
- Staff members change.
- Staff skills and interests develop and horizons broaden.
- Advisory board's characteristics and agendas vary.

Service Delivery

Program Services in the FSC should include a mixture of both formal and informal activities. The following issues will need to be addressed as you develop programming for your Center:

Confidentiality

Confidentiality is an essential and highly-valued "right" in the delivery of service and support to participants. In the informal atmosphere of a FSC, it is often difficult to guarantee confidentiality; therefore, development of policies, design of adequate private space for meetings, telephone conversations and administrative duties and instillation of appropriate attitudes in all staff members must be priority tasks for all Directors. Staff and volunteers should receive training in the importance of maintaining confidentiality and an agreement to this effect should be signed at the time of hiring. This policy should be shared with parents.

The following areas of concern should be addressed and reinforced regularly:

- Records should be kept under lock and key at all times. A record should never be left unattended once it has been removed from the files.
- Staff members should never discuss one participant with another.
- Staff members should never discuss participants with other staff members unless the discussion is professional and will serve to enhance service or support.
- Discussions of a counseling or information gathering nature with a participant should be held in private.
- Staff members should use the telephone in private if the conversation is of a confidential nature.

- Staff members leading group sessions with participants in which sensitive information may be disclosed should make sure that the parameters include the guarantee of confidentiality. It will be necessary to remind the group of this at least in the beginning of each session.
- When counseling a participant never guarantee complete confidentiality as you never know the nature of the information to be disclosed (e.g., the intent to harm oneself or another). It is better to let the individual know they will have to trust you will deal with the information in their best interest and that otherwise they can choose not to share the information with you at this time.
- All requests for information from other agencies or the media about the Center, its program, or its participants must be referred to the Director. It is necessary to have signed permission forms on file for all minors whose names and/or pictures will be used in any public way.
- When requesting information about a participant from another agency or when another agency requests information from Center files on a participant, it is necessary to have a signed release of information form in the file before any information is exchanged.

Realizing that many crises in interpersonal relationships are caused by gossip and exchanging inaccurate information, and that staff members in the FSC are to be role models for the participants, it is clear that ensuring confidentiality and respecting the privacy of individuals will have many benefits.

Role Modeling

Staff need to remember they are viewed as role models and every interaction with a participant (including children) and/or other staff members is important.

Role modeling is an effective, non-threatening tool for presenting alternative modes of behavior i.e. parenting, conflict resolution, goal setting, maintaining confidentiality and task completion.

Information and Referral

Every Center should have an information and referral file which contains information on public and private agencies that serve families in the community. Each listing of an agency should include:

- Agency name, website, and email address of contact person.
- Hours of operation.
- Contact person and telephone number.
- Brief description of services.
- Any restrictions about the types of individuals served.
- Fees, methods of payment/reimbursement.
- Sample forms, procedures (if applicable).
- Information on accessibility to bus/metro lines.

Examples of community resources include:

Department of Social Services
Housing Authority
Health care clinics
Family counseling
Child and spousal abuse intervention

- Substance abuse counseling and rehabilitation
- Legal Aid
- Emergency shelters
- Pediatric clinics
- Mental health services
- WIC (Women, Infants, and Children)
- Family planning clinics
- Employment services
- Educational services
- Day care centers
- Home child care providers
- Maryland Infant and Toddler Programs
- Head Start
- Energy assistance and weatherization
- Food bank
- Consignment shops
- Lead abatement

The information can be presented to staff and parents on bulletin boards, notebooks, open files, card files, etc. In addition, directories of community services published by local agencies should be made available.

Information about community services should be updated at least twice a year. The most effective linkages occur when relationships have been formed with individual staff members at their agencies. This is time consuming but invaluable.

Referral is an important service which includes assessment of need, exploration with the participant of available resources and assessment of the participant's ability to obtain services independently or level of assistance that may be needed. Timely follow-up is an essential step in this process. Advocacy may be a part of the referral process. Most communities have regular collaboration or networking sessions where all agencies can meet and exchange information.

Once referrals are made it is essential that follow-up is conducted to ensure that effective service provision occurs and is documented in participant files.

Home Visiting

Home visits may be used as a means to recruit new participants and maintain contact with active participants. Some FSCs try to visit every new referral in order to assess the type of service needed (Center or home-based). There are times when staff other than the In-Home Interventionist may make home visits to encourage continued participation, to visit newborns, to visit incapacitated participants or to further evaluate or enhance parent/child relationships. Most home visits are made by the In-Home Interventionist and meet the expectations of this core service component.

All EHS programs have a home-based component. All enrolled families receive home visits.

Parent Involvement

A major tenet of the Family Support philosophy is programs are planned in full cooperation with community members and reflect a close, collaborative relationship between families and program staff. We all know experiences are more valuable and meaningful when the participants are invested in them. Involving parents in as many decisions as possible regarding planning activities and Center operations gives parents opportunities to experience success in a safe environment, accept responsibility, learn the many steps necessary to bring a project to fruition, work collaboratively, become familiar with different points of view, learn effective negotiating skills and develop increased self-confidence.

While meaningful parent involvement can reap many benefits it is a delicate art and progress can be uneven. Children thrive when their parents are confident and can advocate for themselves and

their families. These are attributes of families that are self-sufficient. Active empowered participants are the best advocates for their Centers and the family support movement. MFN believes strongly in the power of parent involvement and provides Parent Leadership training throughout the state whenever funds are available.

EHS programs are required to develop Policy Committees and Parent Committees. Refer to and the Head Start Act of 2007 for specific requirements.

Meal Provision and Nutrition

- Creates a more home-like atmosphere.
- Is fun and creates an atmosphere conducive for making friends.
- Provides participants with balanced meals.
- Allows for informal sharing of nutritional information as well as discussions on menu planning, marketing, food preparation and storage.
- Provides the opportunity to teach household budgeting.

Daily meals and snacks should be well balanced, nutritional and economical. Centers should promote, through role modeling and menu planning, the use of healthy snacks. Parents should eat with their children whenever possible. The serving of "junk foods" is prohibited.

EHS programs should refer to and the Head Start Act of 2007 for specific requirements.

Personnel Policies and Procedures

Family Support Center staff are employees of the Sponsoring Agency and so are covered by the sponsoring agency's personnel policies and procedures. Because of the special nature of the Family Support Center program in some cases the sponsoring agency may have to develop additional policies and procedures specific to certain aspects of the operation of the FSC. In these cases the MFN Program Consultant assigned to the FSC should be consulted. Personnel policies and procedures should be readily accessible to staff at the FSC.

Staffing

Staff positions in each Center may vary and each granting organization will have its own detailed personnel policies and procedures. The following are presented as minimal guidelines for staffing a Center:

- Prior to hiring, detailed job descriptions must be prepared that include FSC philosophy, job duties and qualifications (see FSC manual), as well as sponsoring agency specific information such as salary range, job benefits, etc. The necessity for flexibility and open-mindedness in meeting the daily needs of the Center's programs and participants are essential qualities for any successful candidate for any position.
- All positions are advertised to the general public, as well as posted in house, and care should be taken that Equal Employment Opportunity standards are followed.
- Keep all resumes received on file. Develop a standard process for all candidate interviews. Candidates should be interviewed by more than one person.

- Keep all written notes prepared by the interviewers with each resume. Be sure to involve the Advisory Board in the development of this process.
- MFN will be involved in the selection process for the Director. Resume and Chart Form of Job Description for each candidate must be submitted to MFN prior to joint interviews for review.
- The MFN Program Consultant will be involved in the selection process for the Director, In-Home Interventionist, Service Coordinator, and Child Development Specialist. Resume and Chart Form of Job Description for each candidate must be submitted to MFN prior to joint interviews for review.
- MFN is available for consultation in the hiring of personnel for all other positions and should be notified of any new hires.
- The final decision for new hires should be documented and kept on file for future reference. Keep all reference checks.
- A standard employment application should be prepared and completed for each employee and kept on file. Be sure to include a section to document reference checks.
- All new employees must attend a MFN orientation to the network within six months of hire.
- Center specific orientation for all new staff members should be conducted by the Director immediately upon hire. The orientation should cover the FSC philosophy, personnel policies, procedures for evaluation and data collection and expectations for job performance and accountability.
- This manual contains valuable information and should be kept in a place where it is easily accessible to all staff at all times.

In EHS, MFN is involved in the selection of Family Service Coordinators.

Volunteers

Volunteer power can be an invaluable resource to Centers. Volunteers can supplement staff resources and expertise. Involving volunteers is also an effective way to demonstrate community support, increase collaboration, bolster development efforts, and assist participants with self-help efforts.

Advisory Board members who volunteer regularly, as well as individuals who help briefly with one event, enrich a Center's program. Planned orientation and training sessions will assist volunteers to work with competence and to understand the impact and importance of their responsibilities. Orientation sessions will also help volunteers to view themselves as part of the staff team and to understand the Center's policy that prohibits workers from bringing their children to work.

Participants should also be encouraged to contribute their services to the Center and its programs to promote ownership of the program, enhance self-esteem, learn marketable skills, earn references and increase self-sufficiency.

The Volunteer Program Management Manual, which outlines the basics of volunteer management, is a separate manual available through Maryland Family Network. This reference guide includes sample program materials; tips for recruitment, screening, recognition; interacting with young children; and strategic planning checklists.

For specific information regarding Volunteers in Child Development Rooms, see Section I, Page 16.

Supervision

Effective supervision of staff is the key to a successful, well-run program. Supervision is time consuming and critical. Job expectations and responsibilities should be clearly delineated and adhered to as closely as possible. All staff should understand the chain of command. Flow charts are very helpful. Supervision should be provided at least monthly, in a positive manner, and with specific concrete goals established prior to the end of the session. Staff meetings should include all part time staff and be held on a regular basis to solve problems, share information, provide support, set goals and plan for the future.

In-service training for all staff should be provided to meet their needs as perceived by the Director and staff members.

In the event a staff member's performance is not meeting clearly stated expectations, disciplinary action may be indicated. It is necessary to document the following: (1) specific problems with examples; (2) efforts made to alleviate problem behaviors (supervision, additional training, meeting employees' stated reasonable needs, consultation with MFN, etc.); and (3) any actions taken.

Data Collection and Evaluation

Data Collection

Family Support Centers gather demographic data on participants at time of enrollment. Data is recorded on a daily basis to document services provided to participants, progress on outcomes and any changes in a participant's status, which is gathered quarterly. The data collected in this effort can be used to provide service coordination services and to document outcome measures for the network and for individual Center use. The data also provides an objective means by which current and potential public and private funders can make funding decisions.

The MFN MIS is a customized, web-based version MyHeadStart. Information is compiled on a monthly basis to provide feedback to program Directors, staff and MFN program staff. This system works well because of the family-focused, child-centered orientation of the network's Family Support and Early Head Start Centers. The flexibility of the many information and service tracking features of MyHeadStart allows MFN to customize reports and data collection as circumstances and requirements change. Many Centers compile this information in-house with the software provided by MFN, enabling them to produce reports more quickly and more specific to their immediate needs. MFN manages and maintains the centralized database of information for all sites.

Data collection and evaluation procedures and forms must be integrated into everyday Center routines. The MFN MIS Department is responsible for all management information system functions for the participant database. Periodic training in documentation, data entry and generating reports from the database is provided by the MIS Department. MFN provides technical support for the software; it is each sponsoring agency's responsibility to provide technical support for the hardware and to make sure that it is compatible, accessible and operating at all times.

Evaluation

Evaluating family support programs is challenging and complicated. The very principles of family support embrace respect for individuals and families to meet their needs. However, the service design is a poor match for the principles of good research and evaluation that focuses on rigorous, standardized treatment and the use of control groups. MFN is committed to moving both agendas ahead respectfully as we work to accomplish the following outcomes:

- Children are immunized on time.
- Children meet age-appropriate child development milestones and developmental delays are identified early. Children with developmental delays are linked with appropriate services.
- Primary caregivers develop good parenting skills.
- Families advocate their interests and negotiate systems to obtain needed services.
- Parents make educational gains and develop employment skills.
- Families progress toward a 40-hour per week non-subsidized employment.
- Adults plan subsequent pregnancies. Adolescents delay additional pregnancies until the age of majority.

Purpose

Family Support Centers gather data on a daily basis to document the activities of participants and the Center. The data collected in this effort can be used to provide service coordination services and fulfillment of Program Service Proposal information for each Center. The data also offers an objective means by which current and potential public and private funders can make funding decisions based on the following criteria:

- Are the FSCs providing the services they said they would provide?
- How often are the services being utilized?
- How many people are serviced by FSCs?
- Who, categorically (i.e. parents, pregnant women, children, etc.), is utilizing FSCs and what services do they use?
- Are new participants being identified and served?
- What other agencies are the Family Support Centers working with to serve the targeted populations?

This information is compiled on a monthly basis to provide feedback to program Directors, staff and MFN technical advisors. Many Centers compile this information in-house with the software provided by MFN, enabling them to produce reports more quickly and more specific to their immediate needs.

Recordkeeping, evaluation procedures, and forms must be integrated into everyday office routines. Maryland Family Network trains Center Directors and staff members in recordkeeping to facilitate coordination of services to participants and management of program services. All of the recordkeeping, evaluation procedures and forms can be used to serve these purposes.

Public Relations and Fundraising

Public relations (PR) and fundraising activities are critical to the success of your Family Support Center. Continuous fundraising and public relations efforts will increase the number of participants, build community spirit and involvement and address needs not previously anticipated.

Public Relations

Public relations is everything sent out from the Center electronically or on paper, the behavior of every staff person, the way people are greeted in person or on the telephone (how user friendly is the Center's telephone system?), the way the building looks, and the daily delivery of all of your program services and components.

Look at the messages you are sending to the community: Are they consistent? Is the Center's name and logo always visible? Is the Family Support Center Network logo on all appropriate materials? Is your address and telephone number on printed materials? Are staff and volunteers pleasant when answering the telephone? Do the Center's written materials reflect that it is warm and welcoming? Are printed materials neat and well organized? Do promotional materials target your audience? As specified in the contract, ensure the Family Support Center's name and logo is prominently displayed on all stationary.

Public relations is also working with the media. Here are a few things to keep in mind:

The media needs to be cultivated. Invite them to your Center even when you don't have a story. Get to know them and their interests. Let them get to know you as well. Ideally, you want to be known as an "expert" the media can call on in the community. When the time comes for you to need them, you will have a much easier time pitching your idea if you know the face that goes with the name. Learn how to write a press release and find out the proper person to send it to at your local paper. When you have a story to tell, give the media a call. Ask yourself before calling: Is this event photogenic? Is it newsworthy? How can I personalize the story to the paper?

- Always have a PR crisis plan. Your sponsoring agency will help you develop one. To protect your Center from looking disorganized during a crisis:

  Gather the facts before answering questions.

  Appoint one spokesperson and let the entire staff know who it will be.

  Refer press calls to that person.
- Ensure that you always have a backup spokesperson.
- Tell the truth.
- PR must be ongoing. People have short attention spans. You must keep the name of your Center in front of the public frequently so that your Center is in the front of everyone's mind.
- Think about your general plans for the year. Are there upcoming events, programs that you could target for the media? Are there new staff appointments? Do you need volunteers? Always make sure you announce your event approximately two weeks in advance. Also make sure that each announcement lists a contact person and telephone number and email address, if possible.

Fundraising

There are many funding sources (foundations, corporations, individuals, special events) and there is also a lot of competition. Planning is an important part of raising money. What do you need funded? What are some realistic sources? What are the less time consuming ways of raising the money? Which ways raise awareness or attract volunteers? What are the local businesses in your community? What are their interests? What can you give them as recognition?

A few rules to remember:

- People give to people. The most effective technique is face to face solicitation. People give to people who they know, whether in person, by telephone, or by mail. Involve board members, staff members and volunteers in fundraising.
- Ask. People can only say no. State clearly what is needed -- a contribution of cash or in-kind donations of goods or services. Be up-front about it.
- In proposal writing keep in mind who will be reading it. Are they familiar with your Center? What are their interests? What have they given to in the past? The more research you do before writing the proposal the more successful you'll be. Follow the instructions or guidelines as carefully as possible. Invite others to read your proposal especially someone not in your program.
- Make sure you thank your donors -- immediately! Add your donors to your newsletter list. A recognized and informed donor is more likely to continue giving.

EHS programs should refer to Head Start Program Performance Standards and Other Regulations and the Head Start Act of 2007 for specific requirements on fundraising.

Visiting Dignitaries

From time to time, your Center will have visitors. It is important to impress upon all members of your staff the success of the visit. Make sure all of your staff has been alerted to the visit. From the initial greeting at the front door to the final good-bye, the staff must reflect the philosophy of a Family Support Center by being warm and welcoming. Pay close attention to your guests. What are they responding to? Make sure that the visit is more than just a tour of rooms. For example, use the time in the kitchen to talk about participants taking part in nutrition, budgeting, and shopping activities. Involve participants as much as possible in the tour. They are your best marketing/public relations/public education asset.

Before visits, go through the following check list to see if you are ready for a visit:

- Front-door greeter, friendly, waiting and prepped.
- Tour guide ready and prepped.
- Center is clean and neat -- inside and outside.
- All staff aware of visit and visitors.
- Television off.
- Bulletin boards up to date.
- Children properly supervised.
- Rooms to be visited unlocked.
- Packet of information on your Center prepared.

- Know your staff and volunteers' names for introductions.
- Scheduled or requested programming in progress.

Remember, it does not matter if a visitor sees something unexpected or perhaps not perfect -- as long as you explain the reason for it. For instance, if you don't have any participants in the building during the visit, explain the difficulty in attracting young parents or how your families tend to visit in the morning. Visitors notice everything! It is better to address an issue right up front. And finally, build some time into the visit so that your guests have time to ask questions.

Legal Issues

While it is impossible to produce a complete, exhaustive list of legal issues that require consideration, the following list will be helpful when developing policies and procedures:

- Insurance: property, personal and professional liability, vehicle operation, board, volunteer, bonding, health and life.
- Confidentiality: participant records, reporting of child abuse, information shared by participants.
- Health and safety conditions on the premises.
- Parental permission for Center activities, publicity and health releases.
- Identification of persons who can execute contracts, sign checks, etc.
- Parental permission for outdoor play, walks and use of outdoor play equipment.
- Young children not permitted on premises without parents unless child development program is licensed.

Finances

The financial management and reporting system must have, at a minimum, the following:

- The ability to identify and report revenue and expenses (including individual salaries), by funding source. Ten to fifteen days following the close of the month or quarter is considered to be timely.
- The flexibility to accept additional awards and to quickly establish and integrate financial system modifications, during a fiscal year or contract period, for new awards, for changes in existing awards or ward extensions across multiple fiscal years.
- The ability to maintain and to report annually the information about furnishings and equipment required in the contract for a Family Support Center. In general the information is contained in any good fixed asset management system:

  Property description

  Manufacturer's serial number

  Acquisition date and cost

  Source of the property (vendor name, etc.)

  Source of funding for purchased property

  Current location, use and condition of the property

An annual inventory of all listed furnishings and equipment is made to update this information and reconcile it, as appropriate, to the financial system before the required annual report is made to Maryland Family Network.

- The provision for an annual, entity-wide sponsoring agency audit that includes the financial audit of the financial and related program compliance activities of the Family Support Center and is performed according to both government auditing standards **(T=the "Yellow Book")** and generally accepted auditing standards. The audit must be made by an independent accountant licensed or registered in the state of Maryland. When appropriate, the audit must include supplementary information related to federal financial assistance (an "A-133 Audit"). Three (3) copies of the audit report and all related supplementary information, including any management letter issued, is sent to Maryland Family Network within nine (9) months of the sponsoring agency's year end. The contract for a Family Support Center provides more specifics.
- The establishment of a petty cash fund or ability to easily access sums of money between $50.00 and $200.00 for program activities at the Family Support Center.

Sponsoring agencies should coordinate discussion of and compliance with the contract for a Family Support Center among all those in their organization responsible for contract fulfillment. At a minimum that would include the Family Support Center Director and the agency's responsible administrative/ program and financial representatives supporting the Family Support programs.

Each sponsoring agency is expected to comply with all state and federal laws and regulations, especially those involving employee protections, payroll and tax filings. Private not-for-profit sponsoring agencies must file the annual Internal Revenue Service Form 990 Information Return and register with the Maryland Secretary of State, as appropriate.

Each sponsoring agency is expected to practice non-discrimination in relation to employees, volunteers and program participants.

Maryland Family Network encourages the use of Women- and Minority-Owned Business Enterprises for purchasing services and supplies.

Center Name: _____

Recommended* Job Description for

Director

Educational Qualifications and Experience

Master's degree in Human Services or Human Development preferred. Bachelor's degree accepted in the same field with a minimum of four years of experience in program development and management in the program(s) serving populations similar to FSC populations. Minimum of two years supervisory experience required.

General Qualifications

The successful staff person must:

- Understand and be committed to the overall philosophy of Family Support.
- Work cooperatively with consultants from Maryland Family Network who are responsible for the implementation and evaluation of the Family Support Center program.
- Maintain respect for the confidentiality of information divulged by or on behalf of participants.
- Possess the ability to relate to people of diverse educational, cultural, and economic backgrounds.
- Be willing and able to do aggressive outreach and recruitment.
- Model appropriate interaction with young children and parents.
- Have the ability to work independently and as a team member and leader.
- Be willing to submit to a criminal background investigation.
- Have current medical evaluation, including a tuberculosis screen within six months before the individual begins work in the Center.

Specific Qualifications

Management Skills should include:

- Ability to speak and write effectively.
- Ability to plan and organize the use of resources effectively.
- Ability to keep accurate records.
- Ability to establish and implement goals.
- Ability to establish priorities.
- Ability to oversee financial matters and prepare budgets with multiple sources of income.
- Ability to garner additional funding when necessary.

Supervisory skills should include:

- Ability to hire and terminate staff, as needed.
- Ability to delineate and monitor staff responsibilities.
- Ability to evaluate staff performance effectively.
- Ability to recognize and utilize the expertise of others.
- Ability to establish firm, fair, and objective practices with staff.
- Ability to recognize areas of concern and staff weaknesses.
- Ability to encourage staff development.

Community relations and networking skills should include:

- Thorough knowledge of the community.
- Demonstrated ability to mobilize and utilize community resources.
- Demonstrated ability to attract and retain volunteers.
- Demonstrated ability to form effective networks.
- Knowledge of Board structure, its function and Agency/Board relationships.
- Ability to form and work with a Board effectively.
- Public speaking ability.

Leadership Skills should include:

- Ability to gain staff support.
- Modeling the expectations, standards that he/she requires of others.
- Interest in self development through continued education and training.
- Ability to make sound decisions.
- Ability to clearly articulate expectations and to consistently follow through.
- Ability to build an effective team.
- Having played a leadership role in the community in the past and still being actively involved.
- Creativity, vision and flexibility.
- Ability to share vision with staff and to motivate them.
- Always looking to improve all aspects of the program.
- Good problem solving skills.
- Ability to objectively listen and respond to staff concerns.

Job Responsibilities

- Oversees all aspects of program development, supervision of staff, budget, money management, fundraising, enrollment, and facilities.
- Facilitates the smooth flow of the program, and ensures its adherence to stated philosophy.
- Oversees the care, safety, and well-being of staff, participants, and volunteers.
- Coordinates staff meetings, staff orientation and training, and encourages professional development.
- Helps participants to identify needs.
- Networks with the community by coordinating community outreach.
- Prepares monthly, quarterly and annual statistical and programmatic reports.
- Attends sponsoring agency, MFN Directors' and FSC Advisory Committee meetings.

*Recommended job description's duties/responsibilities may be revised to suit each Center's specific needs; however, educational and general qualifications and experience are not to be compromised.

Director - Early Head Start/ Family Support Center

Review of Qualifications

Candidate: _____ Date: _____

Center: _____ Completed by: _____

Requirements	Candidate's Qualifications
Education *Preferred:* Master's Degree in Human Services, Human Development, Social Work, Education, or related field. *Minimum to Hire:* Bachelor's degree in same fields with four years of experience in program management and development.	**Education** Degree/ Year: _____ School: _____ _____ Other Education: _____ _____ Transcript / Diploma / Certificate obtained and reviewed? Yes ☐ No ☐ ***Copy of transcript and diploma required. Please attach along with resume & other supporting documentation to this form when submitting.**
Experience Experience in program management and development in programs servicing low-income families and young children.	**Experience** – Where/ Position/ How long? 1. _____ 2. _____ 3. _____ 4. _____
Supervisory Experience Minimum of two years supervisory experience required.	**Supervisory Experience** – Where/ Number Supervised/ How long? 1. _____ 2. _____ 3. _____ Other? _____

MFN must interview before hire.

A review of this Candidate's qualification was completed by _____ at Maryland Family Network on _____.

This Candidate ☐ is qualified ☐ is not qualified for this position.

Comments: _____

_____

Center Name: _____

Recommended* Job Description for

Child Development Specialist

Educational Qualifications and Experience

Master's degree in Early Childhood Education preferred. Bachelor's degree in Early Childhood Education, Special Education, Child Development, or related field accepted. Must have experience working with young children from birth to three years old. Minimum of 1-year supervisory experience required.

General Qualifications

The successful staff person must:

- Understand and be committed to the overall philosophy of Family Support.
- Maintain respect for the confidentiality of information divulged by or on behalf of participants.
- Possess the ability to relate to people of diverse educational, cultural, and economic backgrounds.
- Be willing and able to do aggressive outreach and recruitment.
- Model appropriate interaction with young children and parents.
- Have the ability to work independently and as a team member and leader.
- Be willing to submit to a criminal background investigation.
- Have current medical evaluation, including a tuberculosis screen within 6 months before the individual begins work in the Center.

Specific Qualifications

This staff person must:

- Have a thorough knowledge of child growth and development of the first years of life from birth to three years of age.
- Have a thorough knowledge of community resources related to the needs of young children and a willingness to help families access them.
- Demonstrate sensitivity and understanding when relating to parents' situation and feelings.
- Possess basic management skills to include:
    - Effective written and verbal communication skills.
    - Knowledge and ability to design and maintain an appropriate environment for infants and toddlers.
    - Ability to plan and implement activities for children individually and as a group.
    - Ability to maintain records and reports on young children.
    - Ability to reinforce health and safety standards in the child development room.

- Possess supervisory skills related to childcare management, which include:
    - Demonstrated ability to supervise and evaluate child development personnel and volunteers.
    - Ability to make sound decisions related to interactions between staff, parents, and children.
    - Ability to provide guidance and direction to staff in curriculum planning and implementation and planning children's activities.
    - Ability to model team leadership skills on issues of child development.
    - Ability to model/teach parents and staff on how to nurture and interact with babies and young children.

Job Responsibilities

- Oversees the health, safety, and well-being of all the children.
- Plans and implements a developmentally appropriate program for infants and toddlers, including screenings, assessments, and development of children's individual classroom plans.
- Demonstrates sound knowledge of good teaching practices and of child growth and development.
- Participates in program staff meetings and training provided by MFN or sponsoring agency.
- Reports directly to Center Director concerning the Child Development Program and other job responsibilities.
- Functions as a member of the Center program management team.
- Provides parents with information and support in their parenting role.
- Ability to lift up to 50 lbs.
- Ability to get up and down off of a floor.
- Complete all required paperwork.

*Recommended job description's duties/responsibilities may be revised to suit each Center's specific needs; however, educational and general qualifications and experience are not to be compromised.

CD Specialist - Early Head Start/ Family Support Center
Review of Qualifications

Candidate: _____ Date: _____

Center: _____ Completed by: _____

Requirements	Candidate's Qualifications
Education *Preferred:* Master's Degree in Early Childhood Education, Child Development, or related field. *Minimum to Hire:* Bachelor's degree in Early Childhood Education, Child Development, or related field.	**Education** Degree/ Year: _____ School: _____ Other Education: _____ _____ Transcript / Diploma / Certificate obtained and reviewed? Yes ☐ No ☐ Related degree includes six 3 credit (18 credits) ECE college classes? Yes ☐ No ☐ (All ECE courses must show a grade of C or above) ***Copy of transcript and diploma required. Please attach along with resume & other supporting documentation to this form when submitting.**
Experience Classroom experience, working with children birth through three years of age required.	**Experience** – Where/ Position/ How long? 1. _____ 2. _____ 3. _____ 4. _____
Supervisory Experience Minimum of one year supervisory experience required.	**Supervisory Experience** – Where/ Number Supervised/ How long? 1. _____ 2. _____ 3. _____ Other? _____

MFN must interview before hire.

A review of this Candidate's qualification was completed by _____ at Maryland Family Network on _____.

This Candidate ☐ is qualified ☐ is not qualified for this position.

Comments: _____

_____

Center Name: _____

Recommended* Job Description for

Service Coordinator

Educational Qualifications and Experience

Masters degree in Human Services, Human Development or Social Work with two years experience providing direct service to families preferred. Bachelor's degree in same fields acceptable with a minimum of four years experience. Must have experience providing direct service to individuals and experience facilitating groups. Familiarity with issues of young parents, infants and toddlers, issues of poverty, and linking with community resources desirable. Minimum of one year direct staff supervision. For EHS, FSC supervises Family Advocates and therefore must have supervisory experience.

General Qualifications

The successful staff person must:

- Understand and be committed to the overall philosophy of Family Support.
- Maintain respect for confidentiality of information divulged by or on behalf of participants.
- Possess the ability to relate to people of diverse educational, cultural and economic backgrounds.
- Be willing and able to do aggressive outreach and recruitment.
- Model appropriate interaction with young children and parents.
- Have the ability to work independently and as a team member and leader.
- Be willing to submit to a criminal background investigation.
- Have current medical evaluation, including a tuberculosis screen within six months before the individual begins work in the Center.

Specific Qualifications

This staff person must:

- Have effective written and verbal communication skills.
- Have excellent planning and organizational skills.
- Have excellent service coordination skills.
- Have the ability to establish and implement goals.
- Have the ability to establish priorities.
- Be able to make assessments and appropriate referrals.
- Have problem solving skills.
- Have the ability to provide individual, family and group counseling.
- Have knowledge of community resources and how to access them effectively.
- Be able to advocate effectively for families.
- Have the ability and willingness to make home visits.

Job Responsibilities

- Meets with new Center participants to familiarize them with the Center and the services available and completes all required paperwork.
- Ensures that new families feel welcomed and are integrated into the Center programs and activities.
- Provides assistance and supportive counseling to families as needed.
- Conducts aggressive outreach and recruitment activities.
- Ensures that all participant files are complete and accurate at all times.
- Ensures the confidentiality of all records and appropriate communications about and with participants.
- Conducts regular case meetings with all appropriate staff to assess progress on participant goals and services.
- Maintains contact with key individuals in community agencies to facilitate referrals; makes referrals as necessary and follows up on all referrals.
- Provides recruitment and retention services, including home visits to families.
- Provides informal and formal parenting education to families addressing specific developmental needs of their children.
- Facilitates groups to optimize participant self-esteem and potential.
- Works with Center staff to ensure that Center services are meeting participant needs
- Serves as member of Center management team and as such, provides leadership to Center staff as requested by Director.
- Attends trainings and meetings as required by sponsoring agency and MFN.

*Recommended job description's duties/responsibilities may be revised to suit each Center's specific needs; however, educational and general qualifications and experience are not to be compromised.

Service Coordinator - Early Head Start/ Family Support Center

Review of Qualifications

Candidate: _____ Date: _____

Center: _____ Completed by: _____

Requirements	Candidate's Qualifications
Education *Preferred:* Master's Degree in Human Services, Human Development, Social Work, or related field. *Minimum to Hire:* Bachelor's degree in Human Services, Human Development, Social Work, or related field.	**Education** Degree/ Year: _____ School: _____ _____ Other Education: _____ _____ Transcript / Diploma / Certificate obtained and reviewed? Yes ☐ No ☐ ***Copy of transcript and diploma required. Please attach along with resume & other supporting documentation to this form when submitting.**
Experience Experience providing direct service to adults and group facilitation. Familiarity with issues of young parents, infants and toddlers, issues of poverty and experience linking to community resources.	**Experience** – Where/ Position/ How long? 1. _____ 2. _____ 3. _____ 4. _____
Supervisory Experience Minimum of one year experience in direct supervision.	**Supervisory Experience** – Where/ Number Supervised/ How long? 1. _____ 2. _____ 3. _____ Other? _____

MFN must interview before hire.

A review of this Candidate's qualification was completed by _____ at Maryland Family Network on _____.

This Candidate ☐ is qualified ☐ is not qualified for this position.

Comments: _____

_____

Center Name: _____

Recommended* Job Description for

Child Development Staff/EHS Teacher

Educational Qualifications and Experience

Associate degree in Early Childhood Education or Child Development preferred. Infant/Toddler CDA acceptable. 90 hour Child Care Certificate and 45-hour Infant-Toddler Certificate required for MSDE licensed facilities. Minimum of one year supervised classroom experience with children age zero through three years.

General Qualifications

The successful person must:

- Understand and be committed to the overall philosophy of Family Support.
- Maintain respect for the confidentiality of information divulged by or on behalf of participants.
- Possess the ability to relate to people of diverse educational, cultural, and economic backgrounds.
- Be willing and able to do outreach and recruitment.
- Model appropriate interaction with young children and parents.
- Have the ability to work independently and as a team member.
- Be willing to submit to a criminal background investigation.
- Have current medical evaluation, including a tuberculosis screen within 6 months before the individual begins work in the Center.

Specific Qualifications

This staff person must:

- Have the ability to participate in training classes pertaining to child development, children at risk, special needs, etc.
- Have the ability and desire to work with infants and toddlers, and be willing to work with preschoolers.
- Have the ability to accept supervision.
- Have the ability to communicate effectively with parents.
- Have the ability to provide support and education to parents in a positive, non-judgmental manner.
- Have the ability to respect participants' communications as confidential and discuss pertinent information with Child Development Specialist.
- Have the ability to involve the parent in working with his/her child.
- Have the ability to follow through on instructions as they pertain to nursery management.
- Have the ability to implement the activity plans for infants, toddlers, and preschoolers.
- Have the ability to model/teach parents how to nurture and interact with their babies.
- Have the ability to effectively enhance the development of children.

- Have the ability to write observations of children.
- Have the ability to lift up to 50 lbs.
- Have the ability to get up and down off of a floor.

Job Responsibilities

- Assists with the care, safety, and well-being of all of the children.
- Assists with the implementation of a developmentally appropriate program for infants and toddlers.
- Provides informal parenting education to participants in the Center.
- Attends training required by sponsoring agency and MFN.

CD Staff / Early Head Start Teacher

Review of Qualifications

Candidate: _____ Date: _____

Center: _____ Completed by: _____

Requirements	Candidate's Qualifications
Education *Preferred:* Associate Degree in Early Childhood Education or Child Development. *Minimum to hire:* H.S. Diploma and For **EHS** Infant/Toddler Child Development Associate (CDA) credential. For **FCS** – 90 hour Child Care Certificate. **90 hour Child Care Certificate and 45 Hours Infant-Toddler Certificate required for MSDE licensed facilities.**	**Education** Degree/ Year: _____ School: _____ Other Education: _____ _____ Transcript / Diploma / Certificate obtained and reviewed? Yes ☐ No ☐ Related degree includes six 3 credit (18 credits) ECE college classes? Yes ☐ No ☐ (All ECE courses must show a grade of C or above) ***Copy of transcript and diploma required. Please attach along with resume & other supporting documentation to this form when submitting.**
Experience Minimum of one year supervised classroom experience with children birth through age three.	**Experience** – Where/ Position/ How long? 1. _____ 2. _____ 3. _____ 4. _____

A review of this Candidate's qualification was completed by _____ at Maryland Family Network on _____.

This Candidate ☐ is qualified ☐ is not qualified for this position.

Comments: _____

_____

Center Name: _____

Recommended* Job Description for

In-Home Interventionist (FSC)/Family Advocate (EHS)

Educational Qualifications and Experience

Must possess a Bachelors degree in Human Services or Human Development with experience in home visiting, counseling, working with families with young children and/or advocacy.

General Qualifications

The successful person must:

- Understand and be committed to the overall philosophy of Family Support.
- Maintain respect for the confidentiality of information divulged by or on behalf of participants.
- Possess the ability to relate to people of diverse educational, cultural, and economic backgrounds.
- Be willing and able to do aggressive outreach and recruitment.
- Model and facilitate appropriate interaction with young children and parents.
- Have the ability to work independently and as a team member.
- Be willing to submit to a criminal background investigation.
- Have current medical evaluation, including a tuberculosis screen within six months before the individual begins work in the Center.

Specific Qualifications

The staff person must:

- Have the ability and willingness to reach out to participants identified as needing in-home intervention.
- Be willing to spend a majority of the time out of the Center, working in people's homes.
- Be positive, persistent and persuasive.
- Be willing to offer limited support as needed to parents around parent-child issues and/or interpersonal difficulties.
- Be familiar with and able to discuss early childhood and parent development.
- Develop and maintain an effective referral network of local community resources.
- Be comfortable dealing with families in crisis by helping them problem solve and making referrals where necessary.
- Understand the difference between empowerment and enablement and be willing to practice empowerment.
- Encourage participants to utilize Center-based services.
- Ability to lift up to 50 lbs.
- Ability to sit on the floor for at least 25 minutes at a time.

Job Responsibilities

- As specified in the contract, IHIs work with 35 families a year and maintain a home visiting caseload of 15 families at any one time.
- Actively reach out to participants identified as needing in-home intervention. These referrals may come from the Family Support Center staff or other community agencies. Referrals may be for expectant parents, with preference given to parents of young children.
- Provide parenting education to participants in their home, addressing the specific developmental needs of the child.
- Assist enrolled parents in assessing family needs and the strength of the parent-child relationship.
- Provide limited assistance to families in their daily functions.
- Provide coaching as needed to parents around parent-child issues and/or interpersonal difficulties.
- Maintain contact with key persons in community agencies to assist with referrals and make referrals to appropriate agencies.
- Attend all scheduled training at MFN.
- Work cooperatively with consultants from Maryland Family Network who are responsible for the implementation and evaluation of this aspect of Family Support Center programming.
- Lead or co-lead a weekly group of parents in the FSC.
- Meet all requirements for the collection of statistical material needed by FSC and MFN.
- Meet all personnel requirements of FSC.
- Maintain records on all families in accordance with FSC and MFN standards.

EHS caseload/program requirements differ. See *Head Start Program Performance Standards* and Head Start Act of 2007 for more information.

*Recommended job description's duties/responsibilities may be revised to suit each Center's specific needs; however, educational and general qualifications and experience are not to be compromised.

In-Home Interventionist (FSC)/ Family Advocate (EHS)

Review of Qualifications

Candidate: _____ Date: _____

Center: _____ Completed by: _____

Requirements	Candidate's Qualifications
Education Bachelor's degree in Human Services, Human Development, Early Childhood Development, Social Work, or related field.	**Education** Degree/ Year: _____ School: _____ Other Education: _____ _____ Transcript / Diploma / Certificate obtained and reviewed? Yes ☐ No ☐ ***Copy of transcript and diploma required. Please attach along with resume & other supporting documentation to this form when submitting.**
Experience Experience in home visiting, counseling, working with families of young children, and/or advocacy.	**Experience** – Where/ Position/ How long? 1. _____ 2. _____ 3. _____ 4. _____

MFN must interview IHI candidate before hire.

A review of this Candidate's qualification was completed by _____ at Maryland Family Network on _____.

This Candidate ☐ is qualified ☐ is not qualified for this position.

Comments: _____

_____

Center Name: _____

Recommended* Job Description for

Receptionist/Secretary

Educational Qualifications

High School Diploma with at least three years of full time related experience.

General Qualifications

The successful staff person must:

- Understand and be committed to the overall philosophy of Family Support.
- Maintain respect for confidentiality of information divulged by or on behalf of participants.
- Possess the ability to relate to people of diverse educational, cultural and economic backgrounds.
- Be willing and able to do aggressive outreach and recruitment.
- Model appropriate interaction with young children and parents.
- Have the ability to work independently and as a team member.
- Be willing to submit to a criminal background investigation.
- Have current medical evaluation, including a tuberculosis screen within six months before the individual begins work in the Center.

Specific Qualifications

This staff person must:

- Have ability to disseminate general program information to the public.
- Have a good telephone manner.
- Have ability and willingness to learn basic child development skills.
- Have sensitivity to families with very young children.
- Have ability to be welcoming and personable.
- Have ability to make independent decisions.
- Have good secretarial skills, which include the following:
    - Word-processing, data entry and other basic computer skills.
    - Ability to develop a good filing system.
    - Effective verbal and written communication skills.
    - Ability to organize administrative office.
    - Good record keeping skills.

Job responsibilities

- Handles Center related communications (verbal and written).
- Disseminates program information to the public.
- Greets the public.
- Maintains and updates files.
- Handles FSC program and activity registrations.
- Participates in community outreach.
- Collects and enters statistical data for reports to sponsoring and funding agencies.
- Other secretarial duties as assigned.

*Recommended job description's duties/responsibilities may be revised to suit each Center's specific needs; however, educational and general qualifications and experience are not to be compromised.

Center Name: _____

Recommended* Job Description for

Adult Education Instructor

Educational Qualifications and Experience

B.A. degree in Education or other related fields; experience in working with populations similar to those served by MFN using nontraditional teaching methods preferred.

General Qualifications

The successful staff person must:

- Understand and be committed to the overall philosophy of Family Support.
- Maintain respect for confidentiality of information divulged by or on behalf of participants.
- Possess the ability to relate to people of diverse educational, cultural and economic backgrounds.
- Be willing and able to do aggressive outreach and recruitment.
- Model appropriate interaction with young children and parents.
- Have the ability to work independently and as a team member and leader.
- Be willing to submit to a criminal background investigation.
- Have current medical evaluation, including a tuberculosis screen within six months before the individual begins work in the Center.

Specific Qualifications

The staff person must:

- Have knowledge of various methods for instruction, which are sensitive to the various learning styles and learning levels of adult students.
- Demonstrate knowledge and familiarity with educational assessment tools specific to adult learners.
- Demonstrate general awareness of learning disabilities and the special needs of the adult learner and be familiar with potential referral sources for diagnosis and treatment plans.
- Be aware of adult education resource materials, which would benefit adult learners and the staff of the FSC.
- Be willing to incorporate computer-assisted instruction as a secondary method for classroom instruction.
- Possess skills necessary to set-up and maintain a positive classroom environment for adult learners who are parents of young children.
- Possess supervisory skills related to volunteer and paid classroom assistants and tutors.

- Have the ability to motivate and sustain enthusiasm of adult learners in attaining their educational goals.
- Have the ability to facilitate classroom instruction in a manner so as to demonstrate sensitivity to personal issues the adult learner may bring into the educational setting and be able to incorporate parenting and employment readiness information relevant to the participant into the classroom instruction.

Job Responsibilities

- Maintain a professional classroom, making recommendations to the Director for the purchase of resource materials and classroom supplies necessary for adult learners.
- Provide educational assessments, using MAPP and other diagnostic tools to place the participant in the appropriate level of instruction.
- Maintain appropriate educational files and student portfolios for each participant which include, but are not limited to:
    - Placements tests/scores.
    - Post-test scores.
    - Samples of participant's work and educational goals.
- Incorporate computer assisted instruction in teaching methodologies.
- Maintain appropriate records for all funding sources, including the Family Support Center, Maryland Family Network, and Literacy Works.
- Provide classroom instruction to participants whose basic skills range from the third to twelfth grade level.
- Work with FSC program staff to incorporate contextual learning practices and activities into the Center program.
- Develop and implement retention strategies for adult education participants in conjunction with other FSC staff members so as to ensure positive attendance rates and greater completion of participant goals.
- Maintain attendance records which capture participant's daily attendance and number of hours of instruction received, sharing with appropriate Center staff when a participant is absent, having attendance problems, or should be recognized for positive attendance.
- Engage in appropriate professional development opportunities within the fields of adult education and family support, and facilitate in-service training when appropriate.

*Recommended job description's duties/responsibilities may be revised to suit each Center's specific needs; however, educational and general qualifications and experience are not to be compromised.

Center Name: _____

Recommended* Job Description for

Career Development and Employment Readiness Specialist

Educational Qualifications and Experience

Bachelor's degree in Counseling, Social Work, Human Services, Vocational Rehabilitation or other related fields. Experience facilitating group activities, providing career assessments and individual counseling preferred.

General Qualifications

The successful staff person must:

- Understand and be committed to the overall philosophy of Family Support.
- Maintain respect for confidentiality of information divulged by or on behalf of participants.
- Possess the ability to relate to people of diverse educational, cultural and economic backgrounds.
- Be willing and able to do aggressive outreach and recruitment.
- Model appropriate interaction with young children and parents.
- Have the ability to work independently and as a team member.
- Be willing to submit to a criminal background investigation.
- Have current medical evaluation, including a tuberculosis screen within six months before the individual begins work in the Center.

Specific Qualifications

This staff person must:

- Demonstrate knowledge and awareness of various resource tools in the area of career exploration and employment readiness, including standardized assessment tools and computer software programs.
- Be capable of facilitating group discussions and workshops related to career decisions and employment development activities.
- Be knowledgeable of various counseling techniques to engage participants in establishing long and short-term education, training, and career goals with measurable objectives and action steps, assessing barriers, monitoring progress toward goal attainment, and modifying goals and plans as needed.
- Be able to maintain accurate participant files and documentation of service delivery and service coordination on behalf of FSC participants.

Have a working knowledge of teachable skills necessary to seek, secure and maintain employment.

- Be willing to network with potential employers within the community so as to develop more learning opportunities for participants.

Job Responsibilities

- Provide individual career assessments which provide the participant with career choices related to outcomes of the assessment processes.
- Provide individual counseling sessions for the purpose of, but not limited to:
    - Assessing interests, values, and skills.
    - Identifying appropriate career clusters related to assessment results.
    - Establishing participant driven goals, identifying barriers, developing actions steps with time lines.
    - Reviewing and documenting progress toward goal attainment.
    - Modifying goals and action plans as required by participant.
- Provide group sessions in areas promoting career exploration and the development of job readiness skills.
- Maintain case files, including narrative description of ongoing participant/staff interactions, participation in service activities and goal attainment.
- Recommend relevant resource materials for purchase to the Family Support Center Director.
- Interact with other family support center staff, particularly Counselors, Educators, Child Development Specialists and Parent Educators so as to integrate multi-discipline information into daily career and employment readiness activities and to facilitate joint team planning approaches to service delivery.
- Participate in appropriate professional development activities.

*Recommended job description's duties/responsibilities may be revised to suit each Center's specific needs; however, educational and general qualifications and experience are not to be compromised.

Appendix 2 Training Requirements

Family Support Network Staff Training Requirements

ALL STAFF (training required for all staff as indicated and recommended for any other staff)

- *All full-time (30+ hours/week) FSC staff and all EHS staff will complete the 2 day Family Support Network Orientation within 6 months of hire.*
- *All full-time staff will attend the fall and spring Conferences, if offered.*
- *All staff who work 15+ hours per week will complete annual training or have current certification in:*

✓ CPR****** ✓ First Aid****** ✓ Universal Precautions****** ✓ Child Abuse and Neglect******

- *All staff who transport participants, under insurance provided by the Center or Sponsoring Agency, will complete basic car seat safety training within 12 months of hire and at least every 5 years thereafter.*******

CHILD DEVELOPMENT STAFF

- *All child development staff (full- and part-time) must complete annual training or have current certification in:*

✓ CPR****** ✓ First Aid****** ✓ Universal Precautions****** ✓ Child Abuse and Neglect******

- *All full-time child development staff will complete the following within 6 months of hire:*
  - ✓ Caring for Infants and Toddlers in our FSC/EHS Center – 1 day
  - ✓ Understanding and Using the ASQ-3/ASQ:SE****** (through on-site training and mentoring)
- *And the following within 1 year of hire:*
  - ✓ Early Childhood Best Practices (ECBP), including Observations with Young Children – 4 days
  - ✓ Language and Literacy Development in Young Children – 1.5 - 2 hours
  - ✓ Children's Mental Health – 1.5 - 2 hours
- *CD Specialists only will complete the following within 1 year of hire:*
  - ✓ Supervision of the Child Development Program – 4 hours (2 in training, 2 in application)
  - ✓ ASQ-3/ASQ:SE Training of Trainers – 2 - 3 hours

DIRECTORS

- *All directors will complete the following within 6 months of hire:*
  - ✓ Process of Service Coordination and Goal Setting using the Life Skills Progression – 1 day

HOME VISITORS

- *All home visitors will complete the following within 6 months of hire:*
  - ✓ Process of Service Coordination and Goal Setting using the Life Skills Progression – 1 day
  - ✓ Observations with Young Children – 1.5 - 2 hours
  - ✓ Understanding and Using the ASQ-3/ASQ:SE****** (through on-site training and mentoring)
- *And the following within 1 year of hire:*
  - ✓ Adult Mental Health: Signs, Symptoms and Procedures – 1.5 - 2 hours
  - ✓ Language and Literacy Development in Young Children – 1.5 - 2 hours
  - ✓ Children's Mental Health – 1.5 - 2 hours
  - ✓ Parents as Teachers*- both Foundational & Model Implementation training

SERVICE COORDINATORS

- *All service coordinators will complete the following within 6 months of hire:*
  - ✓ Process of Service Coordination and Goal Setting using the Life Skills Progression – 1 day
- *And the following within 1 year of hire:*
  - ✓ Adult Mental Health: Signs, Symptoms and Procedures – 1.5 - 2 hours
- *EHS Family Service Coordinators will complete the following within 1 year of hire:*
  - ✓ Parents as Teachers*- both Foundational & Model Implementation training
  - ✓ ASQ-3/ASQ:SE Training of Trainers – 2 - 3 hours

DATA ENTRY STAFF

- *Staff doing data entry will complete the following within 1 year of hire:*

Appendix 2 Training Requirements

- ✓ PROMIS Data Entry and Reports Training – 6 hours
- ✓ Each Center doing data entry must have 3 staff trained in the most recent version of PROMIS at all times.

VAN/BUS DRIVERS

- *All van drivers will complete annual training or have current certification (to be monitored by PC) in:*
  - ✓ CPR**** ✓ First Aid**** ✓ Universal Precautions**** ✓ Child Abuse and Neglect****
  - ✓ Car Seat Safety -The Basic Course (every 2 years)**** ✓ Child Safety Seat Installation (every 2 years)****

**** *Items marked with a double asterisk are not offered as part of regularly scheduled MFN Family Support Network training.*

Staff whose position includes the duties of more than one job category need to complete requirements for both.
Part-time staff attending a training activity will participate in those workshops which are required for their position.

Appendix 3
Program Evaluation and Quality Assurance

Maryland Family Network, as an intermediary, is charged with providing quality assurance services for the network. MFN believes that all intermediary services are focused on assuring that families receive high quality, meaningful services everyday at every Family Support Center. Monitoring, evaluation, training, technical assistance/mentoring, self-assessment, and peer sharing are components of the quality assurance process. Quantitative information provided by the MIS is also used to get as complete a picture as possible of each Center and its performance. In a sense, we live by the "Quality Assurance as a Process" chart, which follows.

Monitoring - Maryland Family Network's Program Monitor conducts an on-site review at each site in the network each year. Results of these monitoring visits (On-Site Report) are submitted in writing to the Program Consultant and then to the Center Directors who prepare program improvement plans if necessary. The completed On-Site Reports are then sent to the sponsoring agency representatives and to the MSDE Program Manager. The results of the monitoring visits are used to:

- Document quality service provision;
- Ensure that health and safety standards are being maintained;
- Identify local program strengths;
- Maintain quality over time; and
- Inform program staff at Maryland Family Network and at the Centers of common situations that may help identify trends or patterns emerging network wide.

Peer Sharing - Once a year, all Centers participate in a peer sharing process as part of the quality assurance process. The Director, Child Development Specialist and the Family Service Coordinator/Family Advocate from each Center form a peer sharing team to visit another Center for the purpose of learning, observing, sharing ideas, and dialoguing about what's working at the Center and where there might be opportunities to strengthen programming. Each Center makes a visit and each Center hosts a visit. Each team completes the peer sharing tool and forwards the summary to the Center and to Program Consultants at MFN. Directors report that the time spent with their own management team traveling together and visiting another program and then discussing the visit, planning, strategizing and gathering new ideas is very productive.

ITERS - All Family Support Centers receive an ITERS (Infant/Toddler Environment Rating Scale, Revised Edition) review annually. Review teams are composed of a two member team contracted to perform the annual review.

EHS programs are monitored in a different way and using a different tool.

Quality Assurance as a Process

	Monitoring	Evaluation	Training	Technical Assistance/ Mentoring	Self-Assessment	Peer Sharing/ Learning
Purpose	Ensure programs are meeting requirements	1) Ensure programs are achieving outcomes and making a difference 2) Identify successful programs/models	Provide information and/or skill-building for professional development or program improvement.	Provide programs with one-on-one assistance to help them improve services and/or meet requirements	Provides programs with opportunity to self-examine in relation to their priorities and core values. Focuses on self-improvement	Share best practices; highlight program strengths; problem solve
Typically Involves	Someone knowledgeable in funding regulations visits program to review reports/documents	A trained evaluator visits a program and/or reviews evaluation data	Program staff come to central location to receive the same training	TA provider-mentor helps program in person or via phone	Cross functional, internal team from organization	Programs share strengths and weaknesses; problem-solve re: challenges
Benefit to programs	Motivation for improved performance	Increased use of data for program improvement	Staff feel valued; improved program performance	Program specific, targeted assistance	Enhances understanding of quality assurance	Builds trust; builds learning and teaching skills
Consequences for Programs	Funding in jeopardy	Loss of funding; loss of program credibility	Not punitive	Not punitive	Not punitive	Not punitive
Challenges of Involving Peers*	Ensuring impartiality when peers compete for funds	Need expertise in evaluation techniques	Highlighting one program over another could cause bad feelings	Ensuring quality	Leads to Peer Review	Voluntary; extensive commitment of time

**** Peer in this chart is defined as someone from another program in the network who provides similar service.***

DIAPERING AND HANDWASHING

Diapering Procedure

1. Before beginning the diapering procedure, clean your hands by using proper hand hygiene (handwashing or use of hand sanitizer according to directions).
2. To minimize contamination, prepare for diapering by getting out all of the supplies needed for the diaper change and placing them near, **but not on**, the diapering surface, for example:
    - Enough wipes for the diaper change, including cleaning the child's bottom and wiping the teacher's and child's hands before putting on the clean diaper (wipes must be taken out of their container)
    - A clean diaper
    - A plastic bag for soiled clothes and a set of clean clothes (if soiled clothing is anticipated)
    - Non-porous gloves (if used)
    - A dab of diaper cream on a disposable paper towel (if used)
    - Changing table paper (if used) to cover the table from the child's shoulders to feet (in case it becomes soiled and must be folded over to create a clean surface during the change)
3. Place the child on diapering table. Remove clothing to access diaper. If soiled, place clothes into a plastic bag.
4. Remove soiled diaper and place into a lined, covered, hands-free trash container.
5. Use wipes to clean child's bottom from front to back (one wipe per swipe) and throw away into trash container. The diaper can also be left open under the child during the cleaning step and then discarded with the soiled wipes before continuing with Step 6. If gloves are used, they must be discarded at this time.
6. Use a wipe to remove soil from your hands and throw into trash container.
7. Use another wipe to remove soil from child's hands and throw into trash container.
8. Put on clean diaper and redress the child.
9. Wash the child's hands following the proper handwashing procedure. Return the child to the play area without touching any other surfaces.
10. Clean the diapering surface by spraying it with a soapy water solution and drying with a paper towel or by wiping it with a water-saturated paper towel or wipe.
11. Disinfect the diapering surface by spraying it with disinfectant-strength bleach-water solution (½ – ¾ cup bleach per gallon of water) and wait at least 2 minutes before wiping (or allow to air dry). Another EPA approved disinfectant, used according to directions, can be used instead of bleach and water.
12. Clean your hands by using proper hand hygiene.

Handwashing Procedure

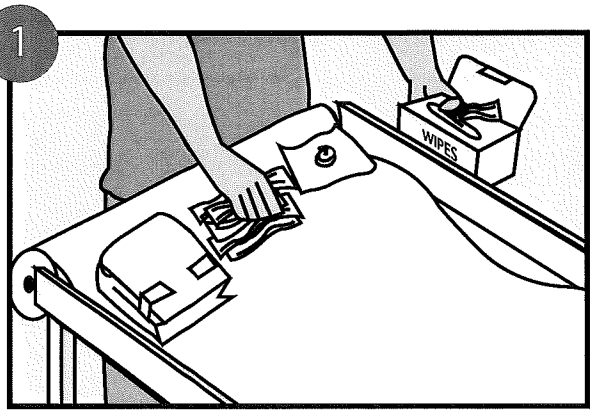
1. Moisten hands with water and use liquid soap.
2. Rub hands together away from the flow of water for 20 seconds.
3. Rinse hands free of soap under running water.
4. Dry hands with a clean, disposable paper towel or air dry with a blower.
5. Turn off faucet using paper towel.
6. Throw the used paper towel into a hands-free trashcan.

Information taken from *Caring for Our Children: The National and Safety Performance Standards for Out-of-Home Care, 3rd edition*, American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Childcare (2011).

Diapering

This poster is based on *Caring for Our Children, 3rd Edition*, a publication of the American Academy of Pediatrics, American Public Health Association, and the NRC for Health and Safety in Child Care and Early Education; created by CCA Global with guidance from the PA Chapter of the AAP.

1



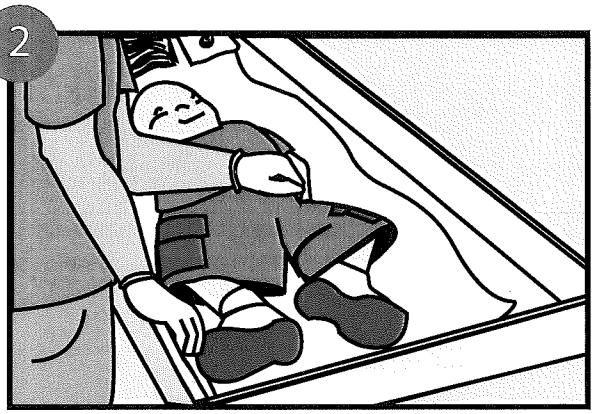
Cover table surface with disposable paper.

Remove from containers and place on diapering surface **away from child's reach**:

- Wipes
- Clean diaper
- Dab of diapering cream on facial tissue [if needed]
- Plastic bag for soiled clothes [if needed]

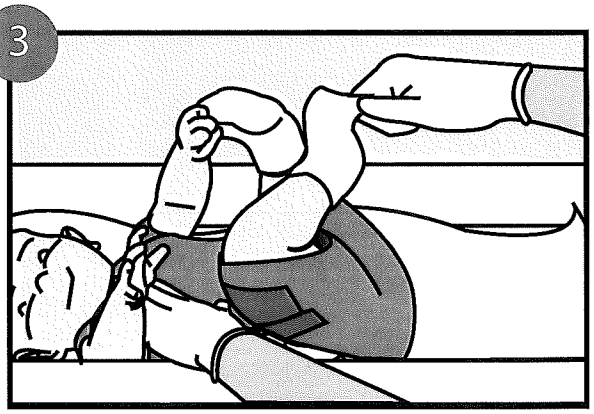
Put on gloves [if using.]

2



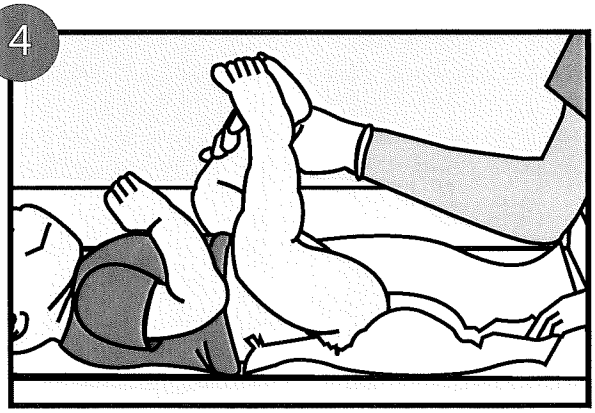
Place child on diapering surface. Always keep a hand on the child.

3



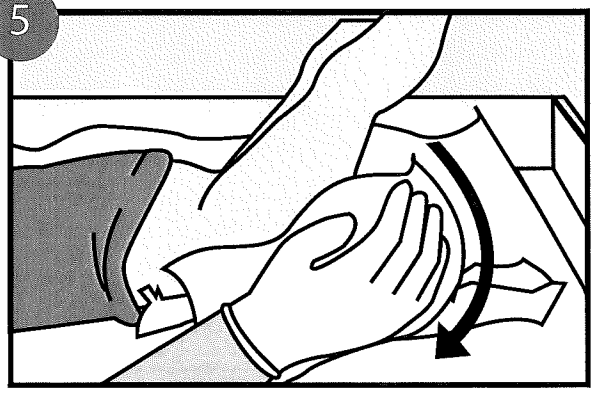
Remove bottom clothing including shoes & socks if feet cannot be kept from contacting soiled skin or surfaces. [If clothing is soiled, remove and place in plastic bag.]

4



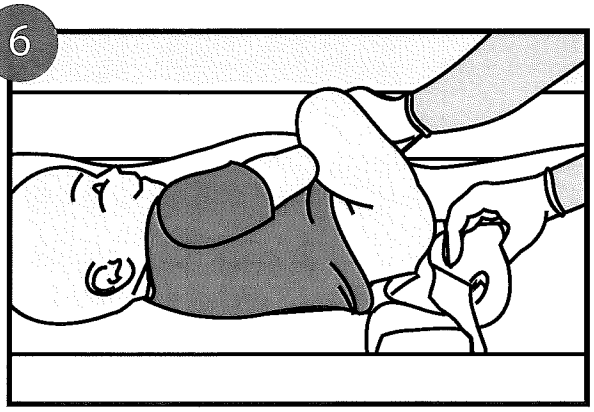
Unfasten diaper but keep soiled diaper under child's bottom.

5



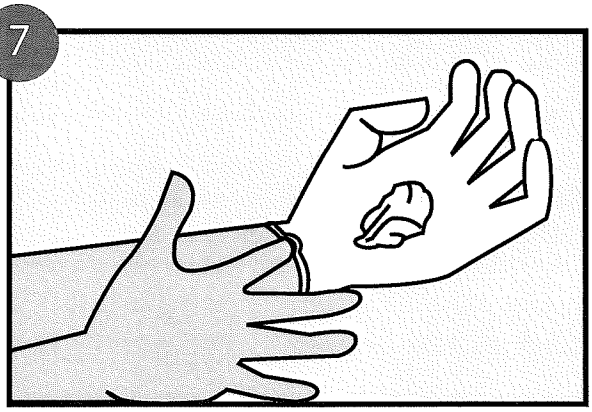
Lift child's legs and clean bottom from front to back. Use fresh wipe each time.

6



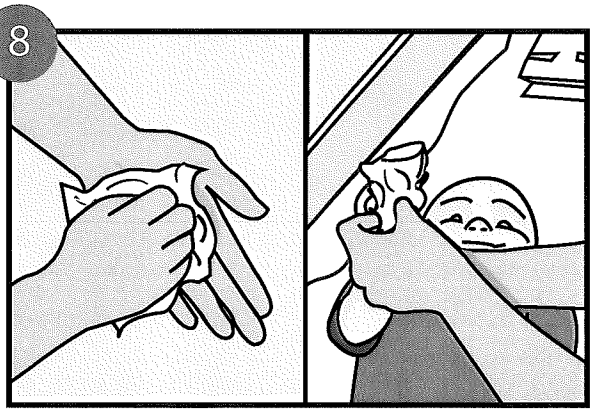
Put soiled wipes in soiled diaper. Then remove diaper and dispose in plastic-lined hands-free covered can.

7



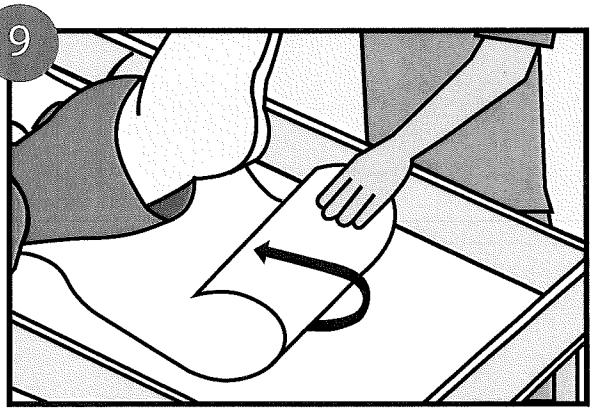
Remove gloves.
Dispose in hands-free can.

8



Use separate fresh wipe on adult's and child's hands. Dispose in hands-free can.

9

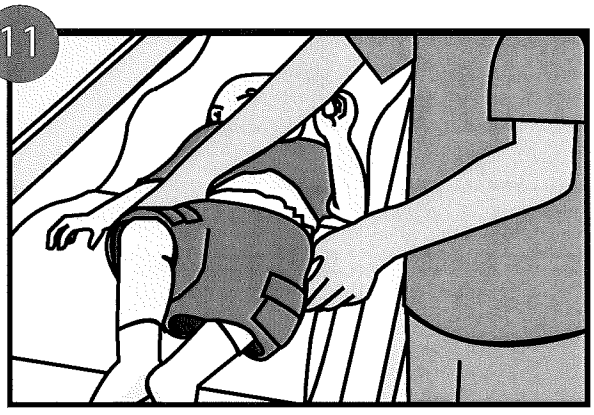


If paper is soiled, fold clean side of paper back under child's bottom.

10

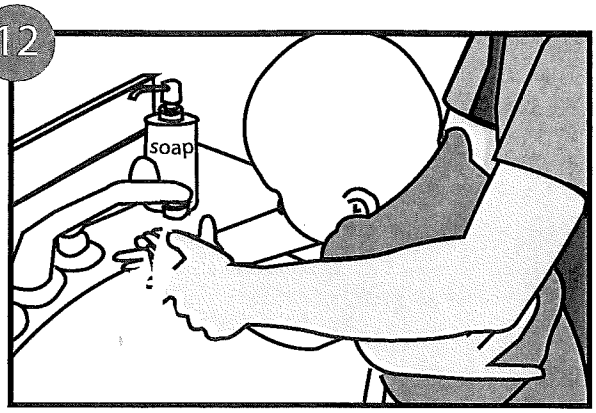
Put clean diaper under child's bottom. [If using diaper cream, apply with facial tissue.]

11



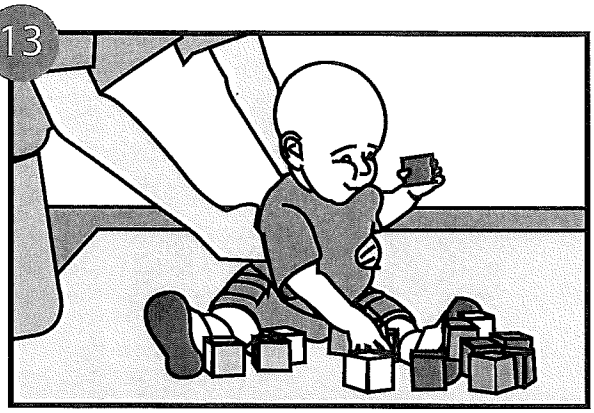
Fasten diaper and redress child.

12



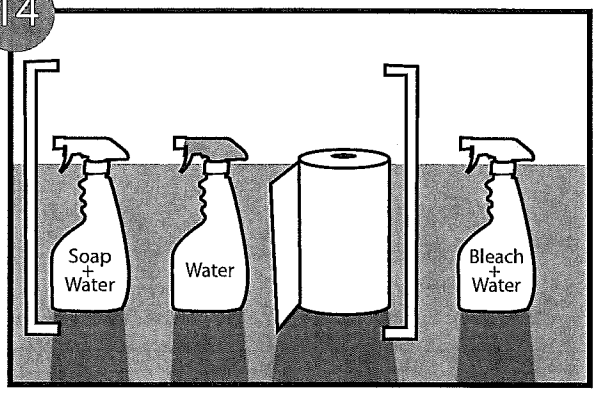
Wash child's hands at sink.*

13

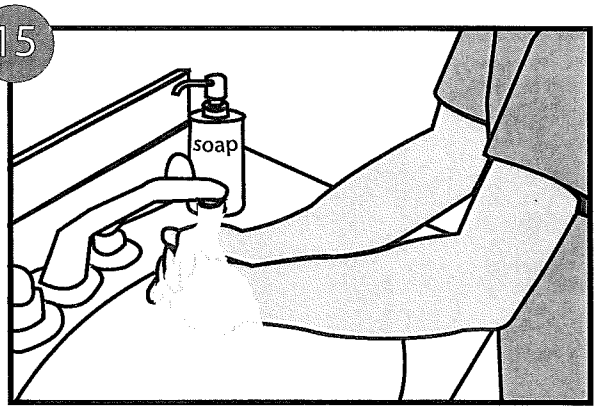


Return child to supervised area.

14



15



16

Clean and Disinfect

a. Dispose of changing table paper.

b. **Clean all the diapering surfaces:**
   - Wash surfaces with detergent, water and paper towels.
   - Rinse surfaces with water.

c. Wet all diapering surface with disinfectant solution.

d. Leave solution on for required contact time.

e. WASH HANDS

f. If diapering surface is wet after required contact time, dry with clean paper towel before next change.

Record in Daily Report form for family (if used)

- Time of diaper change
- Diaper contents
- Any problems such as loose stool, skin irritation, etc.

Hand Washing

According to the CDC, hand washing, when done correctly is the single most effective way to prevent the spread of communicable diseases. Good hand washing technique is easy to learn and can significantly reduce the spread of infectious diseases among both children and adults.

Children and adults must wash hands with soap and water as follows:

- After using the bathroom, toileting.
- After blowing a nose or coughing, handling any bodily fluid – blood, mucus, vomit, etc.
- Before and after eating, serving or preparing food.
- When entering a room from another room or outside.
- After touching pets or animals.
- After playing in water or sand.
- After cleaning or handling garbage.

Use of latex or plastic gloves does not eliminate the need to wash hands.

It is recommended that non-mobile infants' hands be washed by an adult. Follow appropriate hand washing procedures.

If a water source is not readily available, such as when on a playground, field trip, etc., the use of wipes is a temporary and acceptable substitute. Hands need to be washed with water as soon as possible.

Wipes are recommended as a substitute over gel sanitizers when a water source is not available. Gel sanitizers contain alcohol, which may remain on a child's hands and then be ingested, and are therefore not to be used with children.

NOTICE

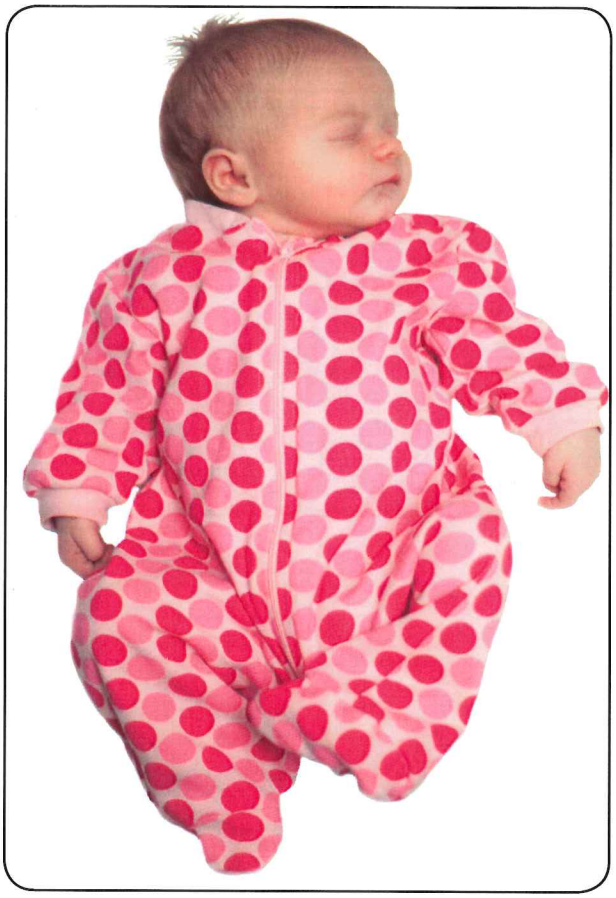
(To be posted near cribs)

Infants up to 12 months must
always be placed
on their
BACK
for sleep.

Stuffed toys and blankets must
never be used in the cribs.

Cribs must have a firm mattress
with a tight fitting sheet.

Safe Sleep Practices and SIDS/ Suffocation Risk Reduction



Applicable Standards from:

Caring for Our Children:

National Health and Safety Performance Standards;
Guidelines for Early Care and Education Programs
Third Edition

A Joint Collaborative Project of

American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove Village, IL 60007-1019

American Public Health Association
800 I Street, NW
Washington, DC 20001-3710

National Resource Center for Health and Safety in Child Care and Early Education
University of Colorado, College of Nursing
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Aurora, CO 80045

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Available at http://nrckids.org.

The National Standards are for reference purposes only and shall not be used as a substitute for medical or legal consultation, nor be used to authorize actions beyond a person's licensing, training, or ability.

Design & Typesetting: Betty Geer, Diane Malk, Lorina Washington

INTRODUCTION

Why Safe Sleep Practices are Important

Early care and education caregivers/teachers touch the lives of young children and their families in many important ways. One of the most important ways to reduce infant deaths in child care settings is for caregivers/teachers to implement (and model for parents/guardians and families) safe sleep practices in their programs. Safe sleep practices include placing infants on their backs to sleep; using safe cribs and equipment for sleeping, prohibiting smoking, and training caregivers/teachers on appropriate safe sleep practices.

The rate of Sudden Infant Death Syndrome (SIDS) in the U.S. has dropped by more than 50 percent since the issuance of the American Academy of Pediatrics (AAP) statement advising side/back sleep positions for infants in order to reduce the risk of SIDS in 1992 and the launch of the even safer Back to Sleep Campaign (side sleeping was found to still contribute to SIDS deaths) in 1994 (1). More safe sleep actions have been identified such as the use of pacifiers, not using strollers or car safety seats as a sleep setting, and the use of no blankets, bumpers, and extraneous bedding in the sleeping area. For child care programs, swaddling is not recommended.

These recent recommendations are supported by the American Academy of Pediatrics (AAP) and can be found in *SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment (AAP, 2011).* Caregivers and teachers need to continue this educational and implementation effort because there are still approximately 2,250 SIDS-related deaths per year in the U.S. (3). Putting into practice the standards outlined in this document can help to lower these numbers and reduce the risk to infants in care.

Overview of Content

This document is a compilation of 27 nationally recognized health and safety standards from *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd Edition, 2011 (CFOC3)** on safe sleep and reducing the risk of Sudden Infant Death Syndrome (SIDS)/suffocation in child care and early education settings.
Standards are listed in order of relevance to the topic. For this reason, the 27 standards are not necessarily in numerical order as they are presented in *CFOC3.* Throughout the document there are references to other standards contained in the full edition of *CFOC3.* For example, in Standard 5.3.1.1: Safety of Equipment, Materials, and Furnishing, the Related Standards section refers to Standard 3.4.6.1: Strangulation Hazards (which is not provided in this document, but can be found in the full edition at http://nrckids.org/CFOC3).

The intended audiences for this document are:

child care and early education caregivers/ teachers who can implement these strategies, many of which are cost free, to provide safe sleep environments and reduce the number of SIDS/ suffocation related deaths in child care and early education settings;

state regulators and policy makers who can promote the adoption of safe sleep practices and SIDS/suffocation risk reduction methods in their state licensing standards;

health consultants, trainers and other health professionals who can promote and teach these strategies to child care and early education caregivers/teachers; and

parents/guardians who can demand the use of these strategies and practices in their child's child care and early education setting.

As with all areas in health, new research comes forth and we recommend that users continue to visit the following web sites for the most up-to-date information on Safe sleep practices and policies and SIDS/suffocation risk reduction measures:

American Academy of Pediatrics
http://www.aap.org and http://www.healthychildcare.org

American Public Health Association
http://www.apha.org

American SIDS Institute
http://www.sids.org

Association of SIDS and Infant Mortality Programs http://www.asip1.org/

Consumer Product Safety Commission
http://www.cpsc.gov

First Candle
http://www.firstcandle.org

National Institute of Child Health and Human Development
http://www.nichd.nih.gov/sids/

National SUID/SIDS Resource Center
http://www.sidscenter.org/

For questions or assistance on these standards or *CFOC3,* please contact:
National Resource Center for Health and Safety in Child Care and Early Education (NRC)
Toll-free Hotline: 1-800-598-KIDS (5437)
Email: info@nrckids.org
Website: http:/nrckids.org

REFERENCES

1. National Institutes of Health, Eunice Kennedy Shriver National Institute of Child Health and Human Development. Back to Sleep Public Education Campaign. http://www.nichd.nih.gov/sids/
2. American Academy of Pediatrics, Task Force on Sudden Infant Death Syndrome. 2011. SIDS and other sleep-related infant deaths: Expansion of recommendations for a safe infant sleeping environment. *Pediatrics* 128:1030-1039.
3. Centers for Disease Control and Prevention. Sudden Unexpected Infant Death and Sudden Infant Death Syndrome. http://www.cdc.gov/sids/.

ACKNOWLEDGEMENTS

Thanks to the ***CFOC3* Standards Review Council**: Danette Swanson Glassy, MD, FAAP; Barbara U. Hamilton, MA; and Marilyn Krajicek, Ed.D., RN, FAAN for reviewing this compilation of Safe Sleep Practices and Reducing the Risk of SIDS/Suffocation standards. We would also like to thank all those individuals who contributed to *CFOC3*. A listing can be viewed at: http://nrckids.org/CFOC3/PDFVersion/PDF_Color/CFOC3_acknowledgments.pdf.

Also, a special thanks to Rachel Moon, MD, FAAP, of the American Academy of Pediatrics, Task Force on Infant Positioning and SIDS, for reviewing the standards to ensure alignment with the 2011 AAP Policy, and to Erin Reiney, MPH, CHES, Public Health Analyst at the Maternal and Child Health Bureau, for reviewing the Introduction.

* The full edition is available on the National Resource Center for Health and Safety in Child Care and Early Education (NRC) web site at http://nrckids.org/CFOC3. Print copies can be purchased from the American Academy of Pediatrics (www.aap.org) and the American Public Health Association (http://www.apha.org/publications/bookstore/).

Safe Sleep Practices

STANDARD 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction

Facilities should develop a written policy that describes the practices to be used to promote safe sleep when infants are napping or sleeping. The policy should explain that these practices aim to reduce the risk of sudden infant death syndrome (SIDS) or suffocation death and other infant deaths that could occur when an infant is in a crib or asleep.

All staff, parents/guardians, volunteers and others approved to enter rooms where infants are cared for should receive a copy of the Safe Sleep Policy and additional educational information and training on the importance of consistent use of safe sleep policies and practices before they are allowed to care for infants (i.e., first day of employment/volunteering/subbing). Documentation that training has occurred and that these individuals have received and reviewed the written policy should be kept on file.

All staff, parents/guardians, volunteers and others who care for infants in the child care setting should follow these required safe sleep practices as recommended by the American Academy of Pediatrics (AAP) (1):

a) Infants up to twelve months of age should be placed for sleep in a supine position (wholly on their back) for every nap or sleep time unless the infant's primary care provider has completed a signed waiver indicating that the child requires an alternate sleep position;
b) Infants should be placed for sleep in safe sleep environments; which includes: a firm crib mattress covered by a tight-fitting sheet in a safety-approved crib (the crib should meet the standards and guidelines reviewed/approved by the U.S. Consumer Product Safety Commission [CPSC] and ASTM International [ASTM]), no monitors or positioning devices should be used unless required by the child's primary care provider, and no other items should be in a crib occupied by an infant except for a pacifier;
c) Infants should not nap or sleep in a car safety seat, bean bag chair, bouncy seat, infant seat, swing, jumping chair, play pen or play yard, highchair, chair, futon, or any other type of furniture/equipment that is not a safety-approved crib (that is in compliance with the CPSC and ASTM safety standards) (4);
d) If an infant arrives at the facility asleep in a car safety seat, the parent/guardian or caregiver/teacher should immediately remove the sleeping infant from this seat and place them in the supine position in a safe sleep environment (i.e., the infant's assigned crib);
e) If an infant falls asleep in any place that is not a safe sleep environment, staff should immediately move the infant and place them in the supine position in their crib;
f) Only one infant should be placed in each crib (stackable cribs are not recommended);
g) Soft or loose bedding should be kept away from sleeping infants and out of safe sleep environments. These include, but are not limited to: bumper pads, pillows, quilts, comforters, sleep positioning devices, sheepskins, blankets, flat sheets, cloth diapers, bibs, etc. Also, blankets/items should not be hung on the sides of cribs. Swaddling infants when they are in a crib is not necessary or recommended, but rather one-piece sleepers should be used (see Standard 3.1.4.2 for more detail information on swaddling);
h) Toys, including mobiles and other types of play equipment that are designed to be attached to any part of the crib should be kept away from sleeping infants and out of safe sleep environments;
i) When caregivers/teachers place infants in their crib for sleep, they should check to ensure that the temperature in the room is comfortable for a lightly clothed adult, check the infants to ensure that they are comfortably clothed (not overheated or sweaty), and that bibs, necklaces, and garments with ties or hoods are removed (clothing sacks or other clothing designed for sleep can be used in lieu of blankets);
j) Infants should be directly observed by sight and sound at all times, including when they are going to sleep, are sleeping, or are in the process of waking up;
k) Bedding should be changed between children, and if mats are used, they should be cleaned between uses.

The lighting in the room must allow the caregiver/teacher to see each infant's face, to view the color of the infant's skin, and to check on the infant's breathing and placement of the pacifier (if used).

A caregiver/teacher trained in safe sleep practices and approved to care for infants should be present in each room at all times where there is an infant. This caregiver/teacher should remain alert and should actively supervise sleeping infants in an ongoing manner. Also, the caregiver/teacher should check to ensure that the infant's head remains uncovered and re-adjust clothing as needed.

The construction and use of sleeping rooms for infants separate from the infant group room is not recommended due to the need for direct supervision. In situations where there are existing facilities with separate sleeping rooms, facilities should develop a plan to modify room assignments and/or practices to eliminate placing infants to sleep in separate rooms.

Facilities should be aware of the current recommendation of the AAP about pacifier use (1). If pacifiers are allowed, facilities should have a written policy that describes relevant procedures and guidelines. Pacifier use outside of a crib in rooms and programs where there are mobile infants or toddlers is not recommended.

RATIONALE: Despite the decrease in deaths attributed to SIDS and the decreased frequency of prone (tummy) infant sleep positioning over the past two decades, many caregivers/teachers continue to place infants to sleep in positions

or environments that are not safe. Deaths in child care facilities attributable to SIDS continue to occur at an alarming rate, with a majority occurring in the first day or first week that an infant starts attending a child care program (2,3). Many of these deaths appear to be associated with prone positioning, especially when the infant is unaccustomed to being placed in that position (2,4).

Infants who are cared for by adults other than their parent/guardian or primary caregiver/teacher are at increased risk for dying from SIDS. Recent research and demonstration projects (2) have revealed that:

a) Caregivers/teachers are unaware of the dangers or risks associated with prone or side infant sleep positioning, and many believe that they are using the safest practices possible, even when they are not;
b) Although training programs are effective in improving the knowledge of caregivers/teachers, these programs alone do not always lead to changes in caregiver/teacher practices, beliefs, or attitudes;
c) Caregivers/teachers report the following major barriers to implementing safe sleep practices:
    1) They have been misinformed about methods shown to reduce the risk of SIDS;
    2) Facilities do not have or use written "safe sleep" policies or guidelines;
    3) State child care regulations do not mandate the use of supine (wholly on their back) sleep position for infants in child care and/or training for infant caregivers/teachers;
    4) Other caregivers/teachers or parents/guardians have objections to use of safe sleep practices, either because of their concern for choking or aspiration, and/or their concern that some infants do not sleep well in the supine position;
    5) Parents/guardians model their practices after what happens in the hospital or what others recommend. Infants who were placed to sleep in other positions in the hospital or home environments may have difficulty transitioning to supine positioning at home and later in child care.

Training that includes observations and addresses barriers to changing caregiver/teacher practices would be most effective. Use of safe sleep policies, continued education of parents/guardians, expanded training efforts for child care professionals, statewide regulations and mandates, and increased monitoring and observation are critical to reduce the risk of SIDS and other infant deaths in child care (3).

Loose or ill-fitting sheets have caused infants to be strangled or suffocated (8).

COMMENTS: Background: Deaths of infants who are asleep in child care (whether attributable to SIDS, suffocation, or other causes) may be under-reported because of the lack of consistency in training and regulating death scene investigations and determining and reporting cause of death. Not all states require documentation that clarifies that an infant died while being cared for by someone other than their parents/guardians.

Although the cause of SIDS is not known, researchers believe that some infants develop in a manner that makes it challenging for them to be aroused or to breathe when they experience a life-threatening challenge during sleep. Although some state regulations require that caregivers/teachers "check on" sleeping infants every ten, fifteen, or thirty minutes, an infant can suffocate or die in only a few minutes. It is for this reason that the standards above discourage toys or mobiles in cribs and recommend direct, active, and ongoing supervision when infants are falling to sleep, are sleeping, or are becoming awake. This is also why *Caring for Our Children* describes a safe sleep environment as one that includes a safety-approved crib, firm mattress, firmly fitted sheet, and the infant placed on their back at all times, in comfortable, safe garments, but nothing else – not even a blanket.

When infants are being dropped off, staff may be busy. Requiring parents/guardians to remove the infant from the car seat and re-position them in the supine position in their crib (if they are sleeping), will reinforce safe sleep practices and reassure parents/guardians that their child is in a safe position before they leave the facility.

Challenges: National recommendations for reducing the risk of SIDS or suffocation and other infant deaths are provided for use in the general population. Most research reviewed to guide the development of these recommendations was not conducted on children in child care. Because infants are at increased risk for dying from SIDS in child care (5) and because caregivers/teachers are liable for their actions, they must err on the side of caution and must provide the safest sleep environment for the infants in their care for liability and other reasons.

When hospital staff or parents/guardians of infants who may attend child care place the infant in a position other than supine for sleep, the infant becomes accustomed to this and can have a more difficult time adjusting to child care, especially when they are placed for sleep in a new unfamiliar position.

Parents/guardians and caregivers/teachers want infants to transition to child care facilities in a comfortable and easy manner. It can be challenging for infants to fall asleep in a new environment because there are different people, equipment, lighting, noises, etc. When infants sleep well in child care, adults feel better. Placing personal items in cribs with infants and covering or wrapping infants with blankets may help the adults to believe that the child is more comfortable or feels comforted. However, this may or may not be true. These practices are not the safest practices for infants in child care, and they should not be allowed. Efforts to educate the public about reducing the risk of SIDS and suffocation and promoting the use of consistent safe sleep practices need to continue.

Special Care Plans: Some facilities require staff to place infants in a supine position for sleep unless there is documentation in a child's special care plan indicating a medical need for a different position. This can provide the caregiver/

teacher with more confidence in implementing the safe sleep policy and refusing parental demands that are not consistent with safe sleep practices. It is likely that an infant will be unaccustomed to sleeping supine if his or her parents/guardians object to the supine position (and are therefore placing the infant prone to sleep at home). By providing educational information on the importance of consistent use of safe sleep policies and practices to expectant parents, facilities will help raise awareness of these issues, promote infant safety, and increase support for proper implementation of safe sleep policies and practices in the future.

Use of Blankets: AAP recommendations state that blankets may be hazardous, and use of blankets is not advisable.*

Use of Pacifiers: Caregivers/teachers should be aware of the current recommendation of the AAP about pacifier use to reduce the risk of SIDS. While using pacifiers to reduce the risk of SIDS seems prudent (especially if the infant is already sleeping with a pacifier at home), pacifier use has also been shown to be associated with an increased risk of ear infections. Keeping pacifiers clean and limiting their use to sleep time is best. Using pacifiers in a sanitary and safe fashion in group care settings requires special diligence.

Pacifiers should be inspected for tears before use. Pacifiers should not be clipped to an infant's clothing or tied around an infant's neck.

For children in the general population, the AAP recommends:

a) Consider offering a pacifier when placing the infant down for nap and sleep time;
b) If the infant refuses the pacifier, s/he should not be forced to take it;
c) If the infant falls asleep and the pacifier falls out of the infant's mouth, it should be removed from the crib and does not need to be reinserted. A pacifier has been shown to reduce the risk of SIDS, even if the pacifier falls out during sleep (1);
d) Pacifiers should not be coated in any sweet solution, and they should be cleaned and replaced regularly;
e) For breastfed infants, delay pacifier introduction until fifteen days of age to ensure that breastfeeding is well-established (7);
f) Written permission from the child's parent/guardian is required for pacifier use in the facility.

Swaddling: Hospital personnel or physicians, particularly those who work in neonatal intensive care units or infant nurseries in hospitals may recommend that newborns be swaddled in the hospital setting. Although parents/guardians may choose to continue this practice at home, swaddling infants when they are being placed to sleep or are sleeping in a child care facility is not necessary or recommended. See Standard 3.1.4.2 for more detailed information.

Concern about Plagiocephaly: If parents/guardians or caregivers/teachers are concerned about positional plagiocephaly (flat head or flat spot on head), they can continue to use safe sleep practices but also do the following:

a) Offer infants opportunities to be held upright and participate in supervised "tummy time" when they are awake;
b) Alter the position of the infant, and thereby alter the supine position of the infant's head and face. This can easily be accomplished by alternating the placement of the infant in the crib – place the infant to sleep with their head facing to one side for a week and then turning the infant so that their head and face are placed the other way. Infants typically turn their head to one side toward the room or door, so if they are placed with their head toward one side of the bed for one sleep time and then placed with their head toward the other side of the bed the next time, this changes the area of the head that is in contact with the mattress.

A common question among caregivers/teachers and parents/guardians is whether they should return the infant to the supine position if they roll onto their side or their tummies. Infants up to twelve months of age should be placed wholly supine for sleep every time. In fact, all children should be placed (or encouraged to lie down) on their backs to sleep. When infants are developmentally capable of rolling comfortably from their backs to their fronts and back again, there is no evidence to suggest that they should be re-positioned into the supine position.

The California Childcare Health Program has available a Safe Sleep Policy for infants in child care programs at http://ucsfchildcarehealth.org/pdfs/forms/SafeSleep_policy1108.pdf (6). AAP provides a free online course on safe sleep practices at http://www.healthychildcare.org/sids.html.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

RELATED STANDARDS:
Standard 3.1.4.2: Swaddling
Standard 3.1.4.3: Pacifier Use
Standard 3.1.4.4: Scheduled Rest Periods and Sleep Arrangements
Standard 3.6.4.5: Death
Standard 4.3.1.1: General Plan for Feeding Infants
Standard 4.5.0.3: Activities That are Incompatible With Eating
Standard 5.4.5.1: Sleeping Equipment and Supplies
Standard 5.4.5.2: Cribs
Standard 6.4.1.3: Crib Toys

REFERENCES:
1. American Academy of Pediatrics, Task Force on Sudden Infant Death Syndrome. 2009. Policy statement: The changing concept of SIDS: Diagnostic coding shifts, controversies regarding the sleeping environment, and new variables to consider in reducing risk. *Pediatrics* 123:188.
2. Moon R. Y., T. Calabrese, L. Aird. 2008. Reducing the risk of sudden infant death syndrome in child care and changing provider practices: Lessons learned from a demonstration project. *Pediatrics* 122:788-79.

*This represents a change from the printed version of *CFOC3* based on the AAP's new policy statement on SIDS and other sleep-related infant deaths (http://pediatrics.aappublications.org/content/early/2011/10/12/peds.2011-2284). This change is also noted in the html and PDF formats of *CFOC3* (http://nrckids.org/CFOC3).

3. American Academy of Pediatrics, Back to Sleep, Healthy Child Care America, First Candle. 2008. *Reducing the risk of SIDS in child care*. http://www.healthychildcare.org/pdf/SIDSfinal.pdf.
4. ECELS, Healthy Child Care Pennsylvania. 2007. Car seats and swings are not safe for sleeping. *Health Link Online* 18:1-2. http://www.ecels-healthychildcarepa.org/content/3-27-07 April-May 2007 HL Online.pdf.
5. Leonard, V. 2009. *Health and safety notes: Reducing the risk of SIDS for infants in our care*. Berkeley, CA: California Childcare Health Program. http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/SIDS_en1009.pdf.
6. California Childcare Health Program (CCHP). 2008. *Safe sleep policy for infants in child care*. Berkeley, CA: CCHP. http://ucsfchildcarehealth.org/pdfs/forms/SafeSleep_policy1108.pdf.
7. Jenik, A. G., N. E. Vain, A. N. Gorestein, N. E. Jacobi, Pacifier and Breastfeeding Trial Group. 2009. Does the recommendation to use a pacifier influence the prevalence of breastfeeding? *J Pediatrics* 155:350-54.
8. National MCH Center for Child Death Review. Sudden infant death syndrome (SIDS)/Sudden unexplained infant death (SUID): Fact sheet. http://www.childdeathreview.org/causesSI.htm.

STANDARD 3.1.4.2: Swaddling

In child care settings, swaddling is not necessary or recommended.

RATIONALE: There is evidence that swaddling can increase the risk of serious health outcomes, especially in certain situations. The risk of sudden infant death is increased if an infant is swaddled and placed on his/her stomach to sleep (4) or if the infant can roll over from back to stomach. Loose blankets around the head can be a risk factor for sudden infant death syndrome (SIDS) (3). With swaddling, there is an increased risk of developmental dysplasia of the hip, a hip condition that can result in long-term disability (1,5). Hip dysplasia is felt to be more common with swaddling because infants' legs can be forcibly extended. With excessive swaddling, infants may overheat (i.e., hyperthermia) (2).

COMMENTS: Most infants in child care centers are at least six-weeks-old. Even with newborns, research does not provide conclusive data about whether swaddling should or should not be used. Benefits of swaddling may include decreased crying, increased sleep periods, and improved temperature control. However, temperature can be maintained with appropriate infant clothing and/or an infant sleeping bag. Although swaddling may decrease crying, there are other, more serious health concerns to consider, including SIDS and hip disease. If swaddling is used, it should be used less and less over the course of the first few weeks and months of an infant's life.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

RELATED STANDARDS:
Standard 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction

REFERENCES:
1. Van Sleuwen, B. E., A. C. Engelberts, M. M. Boere-Boonekamp, W. Kuis, T. W. J. Schulpen, M. P. L'Hoir. 2007. Swaddling: A systematic review. *Pediatrics* 120:e1097-e1106.
2. Franco, P., N. Seret, J. N. Van Hees, S. Scaillet, J. Groswasser, A. Kahn. 2005. Influence of swaddling on sleep and arousal characteristics of healthy infants. *Pediatrics* 115:1307-11.
3. Contemporary Pediatrics. 2004. *Guide for parents: Swaddling 101*. http://www.aap.org/sections/scan/practicingsafety/ToolkitResources/Module1/swadling.pdf.
4. Richardson, H. L., A. M. Walker, R. S. Horne. 2010. Influence of swaddling experience on spontaneous arousal patterns and autonomic control in sleeping infants. *J Pediatrics* 157:85-91.
5. Mahan, S. T., Kasser J. R. 2008. Does Swaddling Influence Developmental Dysplasia of the Hip? *Pediatrics* 121:177-78.

STANDARD 3.1.4.3: Pacifier Use

Facilities should be informed and follow current recommendations of the American Academy of Pediatrics (AAP) about pacifier use (1-3).

If pacifiers are allowed, facilities should have a written policy that indicates:

a) Rationale and protocols for use of pacifiers;
b) Written permission and any instructions or preferences from the child's parent/guardian;
c) If desired, parent/guardian should provide at least two new pacifiers (labeled with their child's name using a waterproof label or non-toxic permanent marker) on a regular basis for their child to use. The extra pacifier should be available in case a replacement is needed;
d) Staff should inspect each pacifier for tears or cracks (and to see if there is unknown fluid in the nipple) before each use;
e) Staff should clean each pacifier with soap and water before each use;
f) Pacifiers with attachments should not be allowed; pacifiers should not be clipped, pinned, or tied to an infant's clothing, and they should not be tied around an infant's neck, wrist, or other body part;
g) If an infant refuses the pacifier, s/he should not be forced to take it;
h) If the pacifier falls out of the infant's mouth, it does not need to be reinserted;
i) Pacifiers should not be coated in any sweet solution;
j) Pacifiers should be cleaned and stored open to air; separate from the diapering area, diapering items, or other children's personal items.

Infants should be directly observed by sight and sound at all times, including when they are going to sleep, are sleeping, or are in the process of waking up. The lighting in the room must allow the caregiver/teacher to see each infant's face, to view the color of the infant's skin, and to check on the infant's breathing and placement of the pacifier.

Pacifier use outside of a crib in rooms and programs where there are mobile infants or toddlers is not recommended.

Caregivers/teachers should work with parents/guardians to wean infants from pacifiers as the suck reflex diminishes between three and twelve months of age. Objects which provide comfort should be substituted for pacifiers (6).

RATIONALE: Mobile infants or toddlers may try to remove a pacifier from an infant's mouth, put it in their own mouth,

Revised SIDS Prevention Recommendations

Despite major decreases in the incidence of Sudden Infant Death Syndrome (SIDS) over the past decade, SIDS is still responsible for more infant deaths beyond the newborn period in the United States than any other cause of death during infancy. Revised prevention recommendations have been issued by The American Academy of Pediatrics (AAP) and include the following tips:

- Back to sleep. Infants should be placed for sleep in a supine (wholly on back position) for every sleep. Side sleeping is not considered a safe alternative to sleeping lying on the back. Studies have found that the side sleep position is unstable and increases the chances of the infant rolling onto his or her stomach. Every caregiver should use the back sleep position during every sleep period.
- Use a firm sleep surface. A firm crib mattress, covered by a sheet, is the recommended sleeping surface.
- Keep soft objects and loose bedding out of the crib. Pillows, quilts, comforters, sheepskins, stuffed toys and other soft objects should be kept out of an infant's sleeping environment.
- Do not smoke during pregnancy. Also avoiding an infant's exposure to second-hand smoke is advisable for numerous reasons in addition to SIDS risk.
- A separate but proximate sleeping environment is recommended such as a separate crib in the parent's bedroom. There is growing evidence that room sharing (infant sleeping in a crib in parent's bedroom) is associated with a reduced risk of SIDS. However, bed sharing during sleep is not recommended. Infants may be brought into bed for nursing or comforting, but should be returned to their own crib or bassinet when the parent is ready to return to sleep.
- Consider offering a pacifier at nap time and bedtime. Research now indicates an association between pacifier use and a reduced risk of SIDS. The pacifier should be used when placing infant down for sleep and not be reinserted once the infant falls asleep. In addition, if the infant refuses the pacifier, it should not be forced. If you are breastfeeding your child, it is recommended that a pacifier not be used until your child is one month old, after breastfeeding has been established.
- Avoid overheating. The infant should be lightly clothed for sleep, and the bedroom temperature should be kept comfortable for a lightly clothed adult.
- Avoid commercial devices marketed to reduce the risk of SIDS. Although various devices have been developed to maintain sleep position or reduce the risk of rebreathing, none have been sufficiently tested to show efficacy or safety.
- Do not use home monitors as a strategy to reduce the risk of SIDS. There is no evidence that use of such home monitors decreases the risk of SIDS.
- Avoid development of positional plagiocephaly (flat back of head). Encourage "tummy time" while the baby is awake and observed. Avoid having the infant spend excessive time in car-seat carriers and "bouncers." Place the infant to sleep with the head to one side for a week and then changing to the other.

Assure that others caring for the infant (child care provider, relative, friend, babysitter) are aware of these recommendations.

(Source: American Academy of Pediatrics)

FIRST AID SUPPLY LIST

REQUIRED ITEM	USE TO
Band Aids (assorted sizes)	To cover and protect cuts or open wounds.
Flashlight (operable, may be small	To check eyes, inside nose, throat and ears.
Gauze pads (2'x2" or 4"x4")	To clean, cover and protect cuts or open wounds.
Gauze pad (large, thick size) or sanitary napkin	To control bleeding or cover large wounds.
Gauze, flexible rolls (2 rolls)	To hold gauze bandages in place.
Gloves (disposable vinyl-latex gloves are acceptable, but they may cause a skin reaction for the wearer)	To protect person administering aid.
Ice Bag or Chemical Ice Pack	To control swelling when filled or activated.
Paper Towels	To clean up spills (then discard).
Safety Pins	To secure sling in place.
Scissors (blunt tip)	To cut gauze and bandages to size.
Soap (liquid, fragrance-free)	To clean injured area.
Tape (hypo-allergenic)	To hold gauze bandages to size.
Thermometer (non-glass, non-mercury) or fever strip	To take body temperature. Do not take rectally.
Triangular bandage (pre-made or 40"x40"x64" piece of clean cotton cloth	To immobilize body parts as a sling or a tie for a splint; To hold dressing on large wounds.
Tweezers	To remove splinters.
Wash cloths (disposable)	To clean injured area.
If you suspect that a child has been poisoned, call Poison Control **immediately!** Follow all instructions given by Poison Control. Do not induce vomiting unless instructed to do so by Poison Control. **POISON CONTROL: 410 529-7701 (Metropolitan Baltimore) or 1-800-222-1222 (Maryland only, toll-free)**	

Note: First aid supplies are to be kept in a location which is convenient and easily accessible. First aid supplies are to be available at the child care facility and on all field trips.

Medication

All prescription medication, required to be administered during the time the child/parent are in the program, should be given by the parent. Parents should be asked to notify the program of any medication a child is taking.

Staff may not administer ***any*** non-prescription medication. This includes over-the-counter products such as aspirin, cough medicine, petroleum jelly, chapstick, burn creams, wound creams or lotions/creams of any kind.

If such prescribed medication has to be administered by a staff member:

- Medication must be in the original pharmacy container and labeled with child's name, date, reason for use and dosage:
- There must be written permission from the parent/guardian detailing the medication, time of administration, dosage;
- The ***first*** dosage of a prescribed medication may never be given by the parent/guardian or staff member ***on site in the center***;
- A written medication record must be maintained showing name of child, medication, dosage, time given, observation of the child after receiving the medication and the medication and signed by staff member administering the medication.

All medication must be stored as directed by health provider or label. If refrigeration is needed, medication containers must be stored in a tightly sealed container, labeled and placed inside refrigerator. The refrigerator must not be accessible to any enrolled children.

3.4.5 Sun Safety and Insect Repellent

STANDARD 3.4.5.1: Sun Safety Including Sunscreen

Caregivers/teachers should implement the following procedures to ensure sun safety for themselves and the children under their supervision:

a. Keep infants younger than six months out of direct sunlight. Find shade under a tree, umbrella, or the stroller canopy;
b. Wear a hat or cap with a brim that faces forward to shield the face;
c. Limit sun exposure between 10 AM and 2 PM, when UV rays are strongest;
d. Wear child safe shatter resistant sunglasses with at least 99% UV protection;
e. Apply sunscreen (1).

Over-the-counter ointments and creams, such as sunscreen that are used for preventive purposes do not require a written authorization from a primary care provider with prescriptive authority. However, parent/guardian written permission is required, and all label instructions must be followed. If the skin is broken or an allergic reaction is observed, caregivers/teachers should discontinue use and notify the parent/guardian.

If parents/guardians give permission, sunscreen should be applied on all exposed areas, especially the face (avoiding the eye area), nose, ears, feet, and hands and rubbed in well especially from May through September. Sunscreen is needed on cloudy days and in the winter at high altitudes. Sun reflects off water, snow, sand, and concrete. "Broad spectrum" sunscreen will screen out both UVB and UVA rays. Use sunscreen with an SPF of 15 or higher, the higher the SPF the more UVB protection offered. UVA protection is designated by a star rating system, with four stars the highest allowed in an over-the-counter product.

Sunscreen should be applied thirty minutes before going outdoors as it needs time to absorb into the skin. If the children will be out for more than one hour, sunscreen will need to be reapplied every two hours as it can wear off. If children are playing in water, reapplication will be needed more frequently. Children should also be protected from the sun by using shade and sun protective clothing. Sun exposure should be limited between the hours of 10 AM and 2 PM when the sun's rays are the strongest.

Sunscreen should be applied to the child at least once by the parents/guardians and the child observed for a reaction to the sunscreen prior to its use in child care.

RATIONALE: Sun exposure from ultraviolet rays (UVA and UVB) causes visible and invisible damage to skin cells. Visible damage consists of freckles early in life. Invisible damage to skin cells adds up over time creating age spots, wrinkles, and even skin cancer (2,4).

Exposure to UV light is highest near the equator, at high altitudes, during midday (10 AM to 4 PM), and where light is reflected off water or snow (5).

COMMENTS: Protective clothing must be worn for infants younger than six months. For infants older than six months, apply sunscreen to all exposed areas of the body, but be careful to keep away from the eyes (3). If an infant rubs sunscreen into her/his eyes, wipe the eyes and hands clean with a damp cloth. Unscented sunblocks or sunscreen with titanium dioxide or zinc oxide are generally safer for children and less likely to cause irritation problems (6). If a rash develops, have parents/guardians talk with the child's primary care provider (1).

Sunscreen needs to be applied every two hours because it wears off after swimming, sweating, or just from absorbing into the skin (1).

There is a theoretical concern that daily sunscreen use will lower vitamin D levels. UV radiation from sun exposure causes the important first step in converting vitamin D in the skin into a usable form for the body. Current medical research on this topic is not definitive, but there does not appear to be a link between daily normal sunscreen use and lower vitamin D levels (7). This is probably because the vitamin D conversion can still occur with sunscreen use at lower levels of UV exposure, before the skin becomes pink or tan. However, vitamin D levels can be influenced significantly by amount of sun exposure, time of the day, amount of protective clothing, skin color and geographic location (8). These factors make it difficult to apply a safe sunscreen policy for all settings. A health consultant may assist the program develop a local sunscreen policy that may differ from above if there is a significant public health concern regarding low vitamin D levels.

EPA provides specific UV Index information by City Name, Zip Code or by State, to view go to http://www.epa.gov/sunwise/uvindex.html.

A good resource for reading materials for young children and parents/guardians can be found at Healthy Child Care Pennsylvania's Self Learning Module "Sun Safety" at http://www.ecels-healthychildcarepa.org/content/Sun Safey SLM 6-23-10 v5%20.pdf.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

RELATED STANDARDS:

Standard 3.4.5.2: Insect Repellent and Protection from Vector-Borne Diseases

Standard 3.6.3.1: Medication Administration

Standard 6.1.0.7: Shading of Play Area

REFERENCES:

1. American Academy of Pediatrics. 2008. Sun safety. http://www.healthychildren.org/english/safety-prevention/at-play/pages/Sun-Safety.aspx.

2. American Academy of Dermatology. 2010. Skin, hair and nail care: Protecting skin from the sun. Kids Skin Health.

http://www.kidsskinhealth.org/grownups/skin_habits_sun.html.

3. Kenfield, S., A. Geller, E. Richter, S. Shuman, D. O'Riordan, H. Koh, G. Colditz. 2005. Sun protection policies and practices at child care centers in Massachusetts. J Comm Health 30:491-503.

4. Maguire-Eisen, M., K, Rothman, M. F. Demierre. 2005. The ABCs of sun protection for children. Dermatology Nurs 17:419-22,431-33.

5. Weinberg, N., M. Weinberg, S. Maloney. Traveling safely with infants and children. Medic8. http://www.medic8.com/travel/child-safety.htm.

6. Yan, X. S., G. Riccardi, M. Meola, A. Tashjian, J. SaNogueira, T. Schultz. 2008. A tear-free, SPF50 sunscreen product. Cutan Ocul Toxicol 27:231-39.

7. Norval, M., H. C. Wulf. 2009. Does chronic sunscreen use reduce vitamin D production

to insufficient levels? British J Dermatology 161:732-36.

8. Misra, M., D. Pacaud, A. Petryk, P. F. Collett-Solberg, M. Kappy. 2008. Vitamin D deficiency in children and its management: Review of current knowledge and recommendations. Pediatrics 122:398-417.

What is safe and effective use of bleach?

EPA Standard Definitions

Clean	The process that physically removes debris from the surface or area by scrubbing, washing and rinsing. It may be accomplished with soap or detergent and water.
Sanitize	Product that kills 99.9% germs identified on its label
Disinfect	Product that kills nearly 100% of germs identified on its label.

When used appropriately, much of the risk of harm from bleach can be reduced.
Follow these steps when preparing and using bleach to sanitize:

To safely prepare bleach dilutions:

- Dilute bleach with cool water and do not use more than the recommended amount of bleach.
- Make a fresh bleach dilution daily; label the bottle with contents and the date mixed.
- Wear gloves and eye protection when diluting bleach.
- Use a funnel.
- Add bleach to the water rather than water to bleach to reduce fumes.
- Make sure the room is well ventilated.
- Never mix or store **ammonia** with bleach or products that contain bleach.

To safely use bleach solutions:

- Apply the bleach dilution *after* cleaning the surface with soap or detergent and rinsing with water.
- Allow for a two-minute contact time or air dry.
- Sanitize with bleach when children are not present.
- Ventilate the room and allow the surfaces to completely dry before allowing children back into the area.
- Store all chemicals in a secure area, out of reach of children and in a way that they will not tip and spill.

Recommended Bleach Dilutions

For food contact surface sanitizing (refrigerators, freezers, plastic cutting boards, stainless cutlery, dishes, glassware, countertops, pots and pans, stainless utensils, toys that have been mouthed, high chair trays)	**1 Tablespoon of bleach to a gallon of water.** **Let stand for 2 minutes or air dry.**
For nonporous surface sanitizing and disinfecting (bathroom surfaces and fixtures, sinks, tile, glass, stainless steel, enamel, hard plastic, porcelain, doorknobs)	**1/4 cup of bleach to one gallon of water or 1 tablespoon per quart.** **Let stand for 2 minutes or air dry.**

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3.3 Cleaning, Sanitizing, and Disinfecting

STANDARD 3.3.0.1: Routine Cleaning, Sanitizing, and Disinfecting

Keeping objects and surfaces in a child care setting as clean and free of pathogens as possible requires a combination of:

a) Frequent cleaning; and

b) When necessary, an application of a sanitizer or disinfectant.

Facilities should follow a routine schedule of cleaning, sanitizing, and disinfecting as outlined in Appendix K, Routine Schedule for Cleaning, Sanitizing, and Disinfecting.

Cleaning, sanitizing and disinfecting products should not be used in close proximity to children, and adequate ventilation should be maintained during any cleaning, sanitizing or disinfecting procedure to prevent children and caregivers/ teachers from inhaling potentially toxic fumes.

RATIONALE: Young children sneeze, cough, drool, use diapers and are just learning to use the toilet. They hug, kiss, and touch everything and put objects in their mouths (1). Illnesses may be spread in a variety of ways, such as by coughing, sneezing, direct skin-to-skin contact, or touching a contaminated object or surface. Respiratory tract secretions that can contain viruses (including respiratory syncytial virus and rhinovirus) contaminate environmental surfaces and may present an opportunity for infection by contact (2-4).

COMMENTS: The terms cleaning, sanitizing and disinfecting are sometimes used interchangeably which can lead to confusion and result in cleaning procedures that are not effective (3).

For example, a spray bottle containing a mixture of bleach and water might be incorrectly used as the "first step" to clean a soiled diaper change table or a table surface after a meal. The solution in the spray bottle cannot be used as a "first step" because the purpose of the bleach and water solution is to sanitize (it is not designed to clean and is not effective as a disinfectant on dirty surfaces). In this example, cleaning with detergent and water, and then rinsing the surface with water, should occur before spraying the surface with the bleach and water solution (5).

Each term has a specific purpose and there are many methods that may be used to achieve such purpose.

Task	Purpose
Clean	To physically remove all dirt and contamination. The friction of cleaning removes most germs and exposes any remaining germs to the effects of a sanitizer or disinfectant used later.
Sanitize	To reduce germs on inanimate surfaces to levels considered safe by public health codes or regulations.
Disinfect	To destroy or inactivate most germs on any inanimate object, but not bacterial spores.

Note: The term "germs" refers to bacteria, viruses, fungi and molds that may cause infectious disease. Bacterial spores are dormant bacteria that have formed a protective shell, enabling them to survive extreme conditions for years. The spores reactivate after entry into a host (such as a person), where conditions are favorable for them to live and reproduce (6).

Only U.S. Environmental Protection Agency (EPA)-registered products that have an EPA registration number on the label can make public health claims that can be relied on for reducing or destroying germs. The EPA registration label will also describe the product as a cleaner, sanitizer, or disinfectant. It is important to use the least toxic cleaner, sanitizer and disinfectant for the particular job. Products that are labeled as "green" sanitizers and disinfectants should be EPA-registered. Products must be used according to manufacturer's instructions.

Employers should provide staff with hazard information, including access to and review of the Material Safety Data Sheets (MSDS) as required by the Occupational Safety and Health Administration (OSHA), about the presence of toxic substances such as, cleaning, sanitizing and disinfecting supplies in use in the facility. The MSDS explain the risk of exposure to products so that appropriate precautions may be taken.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

RELATED STANDARDS:
Standard 3.3.0.2: Cleaning and Sanitizing Toys
Standard 3.3.0.3: Cleaning and Sanitizing Objects Intended for the Mouth
Standard 5.2.1.6: Ventilation to Control Odors
Appendix K: Routine Schedule for Cleaning, Sanitizing, and Disinfecting

REFERENCES:
1. California Childcare Health Program. 2009. Sanitize safely and effectively: Bleach and alternatives in child care programs. *Health and Safety Notes* (July). http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/SanitizeSafely_En0709.pdf.
2. Thompson, S. C. 1994. Infectious diarrhoea in children: Controlling transmission in the child care setting. *J Paediatric Child Health* 30:210-19.
3. Butz, A. M., P. Fosarelli, D. Dick, et al. 1993. Prevalence of rotavirus on high-risk fomites in day-care facilities. *Pediatrics* 92:202-5.
4. Grenier, D., D. Leduc, eds. 2008. *Well beings: A guide to health in child care.* 3rd ed. Ottawa, Ontario: Canadian Paediatric Society.
5. North Carolina Child Care Health and Safety Resource Center. Diapering procedure poster. http://www.healthychildcarenc.org/training_materials.htm.
6. Microbiology Procedure. Sporulation in bacteria. http://www.microbiologyprocedure.com/microorganisms/sporulation-in-bacteria.htm.

STANDARD 3.3.0.2: Cleaning and Sanitizing Toys

Toys that cannot be cleaned and sanitized should not be used. Toys that children have placed in their mouths or that are otherwise contaminated by body secretion or excretion should be set aside until they are cleaned by hand with water and detergent, rinsed, sanitized, and air-dried or in a mechanical dishwasher that meets the requirements of Standard 4.9.0.11 through Standard 4.9.0.13. Play with plastic or play foods, play dishes and utensils, should be

closely supervised to prevent shared mouthing of these toys.

Machine washable cloth toys should be used by one individual at a time. These toys should be laundered before being used by another child.

Indoor toys should not be shared between groups of infants or toddlers unless they are washed and sanitized before being moved from one group to the other.

RATIONALE: Contamination of hands, toys and other objects in child care areas has played a role in the transmission of diseases in child care settings (1). All toys can spread disease when children put the toys in their mouths, touch the toys after putting their hands in their mouths during play or eating, or after toileting with inadequate hand hygiene. Using a mechanical dishwasher is an acceptable labor-saving approach for sanitizing plastic toys as long as the dishwasher can wash and sanitize the surfaces and dishes and cutlery are not washed at the same time (1).

COMMENTS: Small toys with hard surfaces can be set aside for cleaning by putting them into a dish pan labeled "soiled toys." This dish pan can contain soapy water to begin removal of soil, or it can be a dry container used to bring the soiled toys to a toy cleaning area later in the day. Having enough toys to rotate through cleaning makes this method of preferred cleaning possible.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

RELATED STANDARDS:
Standard 3.3.0.1: Routine Cleaning, Sanitizing, and Disinfecting
Standards 4.9.0.11-4.9.0.13: Dishwashing
Appendix J: Selecting an Appropriate Sanitizer or Disinfectant
Appendix K: Routine Schedule for Cleaning, Sanitizing, and Disinfecting

REFERENCES:
1. Grenier, D., D. Leduc, eds. 2008. Preventing infections. In *Well beings*. 3rd ed. Ottawa, Ontario: Canadian Paediatric Society.

Developing Effective Fatherhood Services

Consider these questions:

- Do you have policies and procedures and a budget that support a fatherhood program?
- Do fathers see the agency as relevant and welcoming to them?
- Does strong organizational support for father involvement already exist?
- Do you have a fatherhood coordinator who is male?
- When a mother doesn't want the father of her children to be involved, are efforts made to resolve any conflicts, gain her support and involve the father?

Key characteristics to look for when hiring key staff:

- Commitment to children and families.
- Passionate about the role of men in the lives of their children.
- Empathy, respect and high expectations for fathers regardless of their background.
- Ability to build bridges between men and women, mothers and fathers.
- Ability to build rapport and develop helping relationships with men from diverse backgrounds.
- Knowledge of and connections to the community.
- Willingness to go above and beyond the call of duty (this is not a 9 to 5 position).

The goal for parent involvement in Family Support Centers is that both mothers and fathers view the agency as a resource for the family.

This means:

- Both parents are recognized, regardless of the family's living arrangements.
- If the father lives outside of the child's home, information is gathered on him and he is included in the family partnership process.
- The physical and emotional environment of the agency is male friendly.
- Family workers, and all staff, expect fathers to be involved in the process and have the skills and comfort to provide services relevant to his needs.
- Relationships are forged with community partners such as employment training centers and CPS.
- All parenting activities are relevant to mothers and fathers and include both.
- Support is given to couples to help strengthen their families, including romantic relationships, marriage, and/or co-parenting relationships.

EHS programs should include fatherhood/male involvement activities as a part of parent involvement plan. Participation must be documented.

50 Strategies to Increase Male Participation in Head Start Programs

by Shelley R. Hinojosa, M.S.

It is important to recognize that barriers must be addressed in order to successfully get males involved in the Head Start Program. The following are fifty (50) strategies to encourage and facilitate increased male involvement:

1. Administrative leadership and staff support needs to be established for success.
2. Administration and staff orientation and training in a fatherhood program's mission, vision, goals and objectives needs to be considered.
3. Administration and staff needs to examine their attitudes towards never married fathers, and men in general.
4. Fatherhood programs not only target fathers but extended family members such as uncles, grandfathers, significant others and older siblings that are involved in the child's life.
5. Fatherhood program classes are more effective if they are for males only. (Survey results indicate that men are more comfortable to discuss family concerns in the presence of men only).
6. In order to assure male preferences a survey should be conducted to collect the following data: date of preference, time, meals, topics, presenters, door prizes, and the needs and interest of the fathers and men.
7. Classes need to be time appropriated and scheduled after work in the evenings or on Saturdays at a convenient location.
8. Provide a hearty and healthy meal. (Fathers usually come to class after work and are hungry).
9. Meetings should be informal, and educational. Provide a relaxed atmosphere to facilitate verbal participation from the group.
10. Create a father-friendly environment to encourage men to share their feelings and experiences and find out what men want and recognize their hidden fears.
11. Child care should be provided if needed. (Many men are custodians of their children).
12. Agencies need to evaluate their efforts in attracting more male employees.
13. Presenters need to utilize adult learning strategies, such as humor, experiential and interactive activities.

14. When selecting male guest speakers it is helpful if they represent the dominant culture and are able to relate to the participants. (Speakers in a leadership or authority position are good role models).
15. Ask male participants to help select dynamic speakers.
16. Incentives should be male dominant. Children's educational toys and games are also welcomed.
17. Fatherhood programs should address and support the child support enforcement system.
18. Expect male participation on the fatherhood advisory committee. Schedule the meetings at a convenient time for working fathers.
19. Make an effort to involve all male participants in the parent trainings the agency has to offer.
20. Recognize and honor male participation by taking their pictures and placing them in their child's classroom, (with their written consent).
21. Encourage male staff from the sponsoring agency to be involved in the weekly sessions or activities.
22. Design and distribute a fatherhood program newsletter with male participants' input.
23. Everyone should be personally greeted and made to feel welcomed, wanted and worthwhile (W.W.W.).
24. Establish a Male's/Father's Volunteer Day at the agency.
25. Males should be encouraged to volunteer in the children's activities at least once during the year.
26. Make your agency more "male friendly." This would include assessing the expectations of staff.
27. Provide a place for males to meet.
28. Ask men to participate in teaching at the agencies (as opposed to stereotypical "handy man" activities). Men must feel a sense of "ownership" in the programs, without threatening women.
29. Promote male "super activity," such as attending a basketball game, a fishing trip or out of town workshop to reward 100% participation.
30. Transportation should be provided to the classes and activities.
31. Invite male participants who complete the program to act as role models and mentors.
32. Establish a volunteer mentoring program for future fathers.

33 Elicit the support and involvement of mothers to insure the success of the fathers' program.

34. Encourage, support, and teach young never-married mothers to build a relationship with the father of their children.
35. Provide children's meal coupons from McDonald's, Burger King, etc. (give moms a night off from cooking dinner and both mom and children are happy that dad attends).
36. Have an equivalent “mothers only" component (so that women do not feel left out).
37. Provide a lending library that encourages and teaches males the importance of reading to their children.
38. Incorporate family-outing activities. (Holiday parties, picnics and outings encourage day-fun family time).
39. Develop a parenting education curriculum specifically addressing male issues that are culturally sensitive with input from the fathers program.
40. Provide specific parenting activities that dads can implement with their children to reinforce the topic of the class.
41. Get the men to encourage other men to become involved in programs. In addition, encourage children to invite their fathers, grandfathers, etc. to attend special activities where they can show what they are learning or doing.
42. Carefully look for ways to reduce the barriers to male involvement. How are men made to feel, for example, during enrollment, parent conferences, interviewing, etc? Does your staff really expect men to be involved? When scheduling parent conferences, are fathers included?
43. All efforts are made to assure that fathers are present or asked to be present during family partnership agreement sessions.
44. Classes address the cultural and emotional influence that shape men's attitudes toward fatherhood.
45. Male participants need to know exactly what will be expected of them.
46. The fatherhood program has the opportunity to engage young fathers to become positively involved in the lives of their children at an early stage.
47. Provide fathers job training.
48. Recruit males to attend local, state and national family service conferences.
49. Sponsor local, state and regional all male conferences.
50. Partner with local, state and national existing fatherhood and male Initiatives.

MARYLAND
FAMILY
NETWORK

GLOSSARY OF SERVICES

FOR MARYLAND'S NETWORK OF FAMILY SUPPORT CENTERS

Rev. 07/12

Self Sufficiency Program

ADULT EDUCATION

FSC	IHI	Service Definitions
*		**A-30. ESL (English as a Second Language):** When a participant attends formal ESL classroom instruction *in the Center.*
*		**A-31. ABE (Adult Basic Education):** When a participant attends formal ABE classroom instruction *in the Center.*
*		**A-32. GED (Graduate Equivalent Diploma):** When a participant attends formal GED classroom instruction *in the Center.*
*		**A-33. Alternative HS:** When a participant attends formal Alternative HS classroom instruction *in the Center.*
*	*	**A-34. Locating and Accessing Education Programs:** Assisting a participant with identifying, locating, or registering for ***out-of-center*** education programs. This *does not* apply to parenting education or any other non-academically oriented education programs.
*	*	**A-35. Goal-Setting for Educational Needs:** Assisting a participant in identifying *and* establishing educational goals based on participant needs. This service can be used to document a session in which the Goals Sheet is used. *Do not use* this code and #O-302 (Strength and Needs Assessment/ Goal Setting) interchangeably.
*		**A-36. Assessment of Educational Needs through Testing:** When a participant, in a formally administered session, *completes* an educational testing tool(s).
*		**A-37. Tutoring/Homework Assistance:** Assisting a participant *in the Center* with homework and/or educational-related studies.
*		**A-38. External Diploma Class:** When a participant attends formal External Diploma classroom instruction *in the Center*.

EMPLOYMENT READINESS

FSC	IHI	Service Definitions
*	*	**E-50. Career Counseling:** Coded when a FSC staff member assists a participant in identifying and clarifying the participant's work history, particular employability strengths, needs or desires.
*		**E-51. Computer Literacy:** Coded when a FSC staff member assists a participant in developing computer-related skills and an understanding of particular software programs used *in the Center* to prepare a participant for employment.
*	*	**E-52. Job Readiness (resume writing, interviewing):** Coded when a FSC staff member assists a participant in developing employment-readiness skills such as resume writing, interviewing.
*		**E-53. Job Development with Employers and a Participant:** Coded when a FSC staff member assists a participant with arranging a meeting or interview with a prospective employer.
*	*	**E-54. Activities for Job Opportunities:** Coded when a FSC staff member assists a participant with activities for job opportunities such as searching the want ads, searching for employment from businesses in the community and other employment-related activities not otherwise covered in E-52.
*		**E-55. Job Training, Work Experience, Skill Development:** Coded when a FSC staff member assists a participant in performing skill-building activities for the purpose of enhancing the participant's "work experience." This code covers activities outside of skills related to E-51 (Computer Literacy).

Parent Education Program

PARENTING

FSC	IHI	Service Definitions
	*	**P-10. P.A.T. Session with Parent and Child:** Coded when an In-Home Interventionist conducts a P.A.T. session with a family *in the home.*
*	*	**P-11. Parent/Child Activity:** A specific, planned activity designed to further a parent's understanding of child development and/or parenting which requires interaction between the parent and eligible child. P-11 sessions can be attributed to *both* parent and child.
*	*	**P-12. Informal Parent Education:** A session or activity designed to increase a participant's knowledge of parenting practices and skills resulting in improved demonstrated skills. Such sessions are conducted on an informal basis individually or in group settings and may include parent support groups.
*		**P-13. Nurturing Program/PIRC:** Coded when parent attends and completes an MFN-MIS-approved Nurturing Program session. This formal parenting course is of a specific length and participants are expected to complete between 10 and 12 sessions for documentation on the Milestone Form.

BASIC LIFE SKILLS

FSC	IHI	Service Definitions
*	*	**B-150. Basic Life Skills:** When a FSC staff member assists a participant in the center or at home in developing and enhancing the performance of skills essential to everyday living. This service is coded when the activity is not otherwise specified in this glossary of service definitions *and* involves budgeting, banking, food shopping, housekeeping, making and keeping appointments, food preparation and storage, etc.

Service Coordination Program

OTHER

FSC	IHI	Service Definitions
*	*	**O-300. MFN-MIS Intake Form Completed:** The MFN-MIS Intake Form is divided in two (2) Parts. Part I was designed to collect information on the Applicant and the family. Part II is the Child Survey. The Child Survey (Part II) *must be completed on every eligible child.* Completion of service #O-300 Part I is attributed to the Adult Participant and completion of service #O-300 Part II is attributed to the Eligible Child(ren).
*	*	**O-301. MFN-MIS Quarterly Milestone Form Completed:** This code is entered into the MFN-MIS System when a staff member completes AND submits a Milestone Form for *each adult parent or expectant participant* (whether or not they have completed a milestone). Documentation of this code on the Daily Service Log is NOT necessary as completion and submission of the Milestone Form itself serves as service documentation. Milestone Forms are completed and submitted to MFN-MIS by the 5th of every October, January, April and July.
*	*	**O-302. Strength and Needs Assessment/Goal Setting:** Assisting a participant in identifying personal and/or familial strengths and needs resulting in formal goals (use of the FSC Goal Sheet recommended) that will guide the participant through specific programs, activities and services offered by the Center. *If the nature of this session focuses on the participant's educational needs and goals, then the session is coded as A-35(Goal Setting for Educational Needs).*
*	*	**O-303. Service Linking and Follow-Up for a Participant/Family:** Referring participants or family members or a whole family for services outside the scope of services offered at the Center and following up on the referral. This service can be coded once when the referral is made to the participant/family, and again as a follow-up *if the participant/family is successfully engaged in the referred service.*
*	*	**O-304. MFN-MIS Pregnancy Survey Completed:** The Pregnancy Survey *must be completed on every expectant participant and/or expectant parent participant* within the month that the Center learns of the participant's pregnancy.

Health Education Program

FAMILY HEALTH

FSC	IHI	Service Definitions
*	*	**F-70. Family Health Education:** Assisting a participant to develop an understanding of family health issues such as: immunizations, general illnesses, first aid and illness prevention, etc. This code *does not include* pregnancy prevention, prenatal care or substance abuse.
*	*	**F-71. Direct Health Service for Family Member 4yr.+:** When a FSC staff member assists a participant in *receiving* a "direct health service." Direct health services include but are not limited to: doctor's appointments, flu shots, checkups and examinations, etc. This code *does not include* immunizations or direct health services for eligible children (0-3).

MENTAL HEALTH

FSC	IHI	Service Definitions
*	*	**M-110. Counseling, Not Otherwise Specified:** Assisting a participant to develop an understanding of general mental health issues such as: self-esteem, depression, and relationships, etc., *and* develop options to resolve problems or crises. Sessions can be conducted individually or as a group, in a *formal* setting. A unit of service is delivered when there is *a strategy developed to resolve a conflict or cope with a particular problem*. This code *does not include* post-partum depression or substance abuse.

REPRODUCTIVE HEALTH

FSC	IHI	Service Definitions
*	*	**R-90. General Prenatal Health:** Assisting a participant with *all* prenatal health issues including but not limited to: keeping prenatal checkups and appointments, prenatal education, childbirth preparation, fetal growth and development, new baby care, breast and bottle feeding, and contraception, etc. This code *does not include* post-partum depression or substance abuse.
*	*	**R-91. Family Planning:** Assisting a participant with developing *strategies* for pregnancy prevention, adolescent pregnancy prevention, repeat pregnancy prevention, unwanted pregnancy prevention, delaying first intercourse, coping with post-partum depression, and education on the use of condoms and other contraceptive methods as well as human sexuality education. Direct application of these strategies can include but are not limited to *activities* that: enhance self-esteem, maintain school attendance, expand life options, pursuits and leisure time.

SUBSTANCE USE

FSC	IHI	Service Definitions
*		**SU-130. AA/NA/CDA/ACOA/Other Support Group:** Coded for participant attendance at a 12-Step meeting held at the Center or as a referral to 12-satep meetings outside the Center.
*		**SU-131. General Substance Abuse Program:** Assisting a participant in developing an understanding of substance abuse and/or alcoholism and related issues (abuse prevention, co-dependency). Sessions are held in a formal setting with individuals or in a group

Participant (Parent) Support and Involvement

SOCIAL SUPPORT

FSC	IHI	Service Definitions
*	*	**SS-170. Recreation/Peer Activity: A specific planned activity designed to expose participants to recreation and socially supportive activities. Parents are involved in the design and execution of the activity.**
*	*	**SS-171. Youth Program: A specific planned group activity designed to expose teenagers to positive means and experiences of socially supporting one another.**
*	*	**SS-172. Parent Advisory Group: Parent Advisory Group Meeting**
*	*	**SS-173. Parent Leadership/Advocacy Skill Development Activity: A specific activity designed to develop parent leadership and/or advocacy skills.**

Infant/Toddler Program

CHILD HEALTH AND DEVELOPMENT

FSC	IHI	Service Definitions
*		**C-190. Developmental Child Care: Coded when an FSC-eligible child age 0-3 spends time in the Center's Child Development room. The total time the child is in the child development room is captured on the MFN-MIS Family Activity Form. Do not count time used as breaks for snacks or mealtime *outside* the child development room.**
*	*	**C-191. ASQ (non-SE): Coded when an ASQ Screening is completed on any FSC-eligible child age 0-3 (or P.A.T. child when screened by In-Home Interventionists).**
*		**C-192. Referral for Developmental Delay: Coded when a Participant and the FSC-eligible child age 0-3 are referred for assessment, diagnosis and/or intervention pertaining to a developmental delay the child is suspected to be experiencing.**
*	*	**C-193. Referral for Pre-School Services: Coded when a Participant and the FSC-eligible child age 0-3 are referred for registration to pre-school program(s) for the child.**
*	*	**C-194. Service Linking and Follow-Up for Child 0-3: Coded when a Participant and the FSC-eligible child age 0-3 are referred for and engaged in any other service(s) other than developmental delay or pre-school programs. This service is coded once a follow-up to the referral reveals that the Participant has engaged the eligible child in the service.**
*	*	**C-195. Direct Health Service for Child 0-3: Assisting a Participant and the FSC eligible child age 0-3 in obtaining a health service for the child, such as immunizations, doctors visits, nurse consultations, etc,**
*	*	**C-197. MFN-MIS Quarterly Milestone Form Completed: This code is entered into the MFN-MIS System when a staff member completes AND submits a Milestone Form for *each FSC eligible child age 0-3* (whether or not they have completed a milestone). Documentation of this code on the MFN-MIS Family Activity Form is NOT necessary as completion and submission of the Milestone Form itself serves as service documentation. Milestone Forms are completed and submitted to MFN-MIS by the 5th of every October, January, April and July.**
*	*	**C-198. ASQ-SE: Coded when an ASQ-SE Screening is completed on any FSC-eligible child age 0-3 (or P.A.T. child when screened by In-Home Interventionists).**

EHS-Specific Activities

EHS	EHS IHI	Service Definitions
*	*	**Nutrition: Assisting a participant to develop an understanding of the nutritional needs for his/her child and/or family. This could be accomplished in individual discussions or in a group setting. Cooking and food preparation with participants is also acceptable.**
*	*	**Policy Council Committee: Assisting a participant to attend Policy Council Committee meetings and/or to carry out their duties as a member of the Policy Council Committee. This could include transporting, editing minutes and/or preparing reports in conjunction with a participant.**
*	*	**Transition: Assisting a participant with all issues related to transitioning from the program. This could include searching for another Head Start program or child-care placement, assistance completing applications, site visits with a participant and exploring ways to prepare the child for the transition.**

Appendix 7 Maryland Family Support Centers

ENSURING CHILDREN HAVE STRONG FAMILIES

BALTIMORE CITY

Bon Secours Family Support Center
26 N Fulton Ave
Baltimore, MD 21223
tel 443.388.3678 fax 410.362.3649
email Andrea_Person@bshsi.org
Director Andrea Person
Sponsor Bon Secours of Maryland Foundation, Inc

Coppin State University Child Development Center
2500 W North Ave
Baltimore, MD 21216
tel 410-235-0555 fax 410-366-7720
email mclemence@goodwillches.org
Director Meagan Clemence
Sponsor Goodwill of the Chesapeake, Inc

MFN/Dukeland Early Head Start
2803 N Dukeland St
Baltimore, MD 21216
tel 443-835-7701 x132 fax 443-873-5830
email fmiller@marylandfamilynetwork.org
Director Faith Miller
Sponsor Maryland Family Network, Inc

Our House Early Head Start
2707 Sethlow Rd
Baltimore, MD 21225
tel 410.396.8469 fax 410.350.0212
email Claudia.Ray@habc.org
Director Claudia Ray
Sponsor HABC/Division of Family Support Services

PACT: Helping Children with Special Needs Therapeutic Nursery Early Head Start
1114 N Mount St
Baltimore, MD 21217
tel 410.982.0845 x201 fax 410.982.0844
email cosgrove@kennedykrieger.org
Director Kimberly Cosgrove
Sponsor PACT: Helping Children with Special Needs

St. Vincent de Paul Early Head Start at Arlington Elementary School
3705 W. Rogers Ave.
Baltimore, MD 21215
tel 410.578.0244 fax 410.367.1927
email shainna.ashe@vincentbaltimore.org
email olutunde.clarke@vincentbaltimore.org
Interim Director Shainna Ashe
Direct Supervisor Olutunde Clarke
Sponsor St. Vincent de Paul of Baltimore

St. Vincent de Paul Early Head Start – Arundel
2400 Round Rd.
Baltimore, MD 21225
tel 410-659-7701 x132 fax 443-873-5830
email shainna.ashe@vincentbaltimore.org
email olutunde.clarke@vincentbaltimore.org
Interim Director Shainna Ashe
Direct Supervisor Olutunde Clarke
Sponsor St. Vincent de Paul of Baltimore

St Vincent de Paul Early Head Start-Pimlico
4330-D Pimlico Rd
Baltimore, MD 21215
tel 410.578.0244 fax 410.367.1927
email shainna.ashe@vincentbaltimore.org
email olutunde.clarke@vincentbaltimore.org
Director Olutunde Clarke
Sponsor St Vincent de Paul of Baltimore

Southeast Baltimore Early Head Start Center
The Harry and Jeanette Weinberg Early Childhood Center at Commodore John Rodgers School
100 N Chester St
Baltimore, MD 21231
tel 443.923.4300 fax 410.563.2725
email webers@kennedykrieger.org
Director Susan Weber
Sponsor Kennedy Krieger Family Center

United Way at Excel Academy
1001 West Saratoga Street
Baltimore, MD 21223
tel 410.547.8000 fax
email michelle.macer@uwcm.org
Director Michelle Macer
Sponsor United Way of Central Maryland

Waverly Early Head Start Center of Goodwill
829 Montpelier St
Baltimore, MD 21218
tel 410.235.0555 fax 410.366.7720
email mclemence@goodwillches.org
Director Meagan Clemence
Sponsor Goodwill Industries of the Chesapeake, Inc

Harry & Jeanette Weinberg Early Childhood Center
Henderson Hopkins School
2100 Ashland Ave
Baltimore, MD 21205
tel 443.642.4103 fax 410.522.1032
email tracyh@dbcckids.org
Director Tracy Harris
Sponsor Downtown Baltimore Child Care, Inc

ALLEGANY COUNTY

Cumberland Family Support Center
205 Baltimore Ave
Cumberland, MD 21502
tel 301.724.5445 fax 301.724.0642
email janicefsc@msn.com
Director Janice Cannon
Sponsor Cumberland YMCA

ANNE ARUNDEL COUNTY

Annapolis Family Support Center
80 West St
Annapolis, MD 21401
tel 410.269.4460 fax 410.974.2139
email Karen.Nissly@maryland.gov
Director Karen Nissly
Sponsor Anne Arundel Co Dept of Social Services

Anne Arundel Early Head Start
PO Box 1212
Edgewater, MD 21037
tel 410.832.0536 fax 410.626.1918
email mjarboe@aaccaa.org
Director Peg Jarboe
Sponsor AA Co Community Action Agency

ENSURING CHILDREN HAVE STRONG FAMILIES

maryland's family support centers (continued)

BALTIMORE COUNTY

Center for Family Success
201 Back River Neck Rd
Baltimore, MD 21221
tel 410.853.3860 fax 410.686.5479
email juanita.ignacio@maryland.gov
Director Juanita Ignacio
Sponsor Baltimore Co. Dept. of Social Services

CAROLINE COUNTY

Caroline County Family Support Center
100 N 6th St
Denton, MD 21629
tel 410.479.3298 fax 410.479.3789
email french.tearesa@ccpsstaff.org
Director Tearesa French
Sponsor Caroline County Board of Education

Federalsburg Judy Hoyer/EHS Center
323 S University Ave
Federalsburg, MD 21632
tel 410.754.2467 fax 410.754.7091
email french.tearesa@ccpsstaff.org
Director Tearesa French
Sponsor Caroline County Board of Education

Ridgely Early Head Start
2 N Maple Ave Unit 3
Ridgely, MD 21660
tel 410.634.2231 fax 410.634.2236
email french.tearesa@ccpsstaff.org
Director Tearesa French
Sponsor Caroline County Board of Education

CARROLL COUNTY

Carroll County Family Support Center
10 Distillery Dr
PO Box 489
Westminster, MD 21158
tel 410.876.7805 fax 410.386.6675
email jtierney@hspinc.org
Director Joyce Tierney
Sponsor Human Services Program of Carroll County

CECIL COUNTY

Family Education Center
200 Road B Hollingsworth Manor
Elkton, MD 21921-6623
tel 410.287.1100 fax 410.392.9548
email lwoodside@mrdc.net
Director Lynda Woodside
Sponsor Maryland Rural Development Corporation

DORCHESTER COUNTY

Dorchester County Early Head Start Center
824 Fairmount Ave
Cambridge, MD 21613
tel 410.901.2015 fax 410.901.2836
email cwooten@shoreup.org
Director Cherry Wooten
Sponsor SHORE UP!, Inc

FREDERICK COUNTY

Family Partnership
8420 Gas House Pike Ste EE
Frederick, MD 21701
tel 301.600.2774 fax 301.600.2209
email bmay@frederickcountymd.gov
Director Barbara May
Sponsor Frederick County Government

KENT COUNTY

Kent Family Center
115 S Lynchburg St Ste B
Chestertown, MD 21620
tel 410.810.3790 x 7608 fax 410.810.2674
email lmazingo@kentgov.org
Director Lisa Mazingo
Sponsor County Commissioners of Kent County

MONTGOMERY COUNTY

Family Discovery Center
1010 Grandin Ave
Rockville, MD 20851
tel 301.424.2989 fax 301.251.7865
email shari.waddy@sheppardpratt.org
Director Shari Waddy
Sponsor Family Services, Inc

PRINCE GEORGE'S COUNTY

Adelphi/Langley Park Family Support Center
8908 Riggs Rd
Adelphi, MD 20783
tel 301.431.6210 fax 301.431.6212
email ncoward@pgcrc.org
Director Nathalie Coward
Sponsor Prince George's Child Resource Center

QUEEN ANNE'S COUNTY

The Family Center of Queen Anne's County
103 N Linden St
Sudlersville, MD 21668
tel 410.438.3182 fax 410.438.3806
email jennifer.crossley@qacps.org
Director Jennifer Crossley
Sponsor Queen Anne's Co Board of Education

SOUTHERN MARYLAND

Family Support Center of Southern Maryland
8395 Old Leonardtown Road
Hugesville, MD 20637
tel 301.290.0040 fax 301.290.0050
email dfranklin@thepromisecenter.org
Director Demia Franklin
Sponsor The Promise Resource Center

TALBOT COUNTY

Talbot County Early Head Start
215 Bay St Ste 1
Easton, MD 21601
tel 410.820.6940 fax 410.820.6958
email wendy.deale@maryland.gov
Director Wendy Deale
Sponsor Talbot County Health Department

WASHINGTON COUNTY

Washington County Family Support Center
221 McRand Court Ste 300
Hagerstown, MD 21740
tel 301.790.4002 fax 301.790.4007
email dori.yorks@maryland.gov
Director Dori Yorks
Sponsor Washington Co. Dept. of Social Services