



Nebraska Children and Families Foundation Rooted In Relationships

2014-2015 Evaluation Report December 2015



Interdisciplinary Center For Program Evaluation

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2014-2015 Evaluation Report

Rooted in Relationships (RIR) is an initiative that partners with communities to implement evidence-based practices that enhance the social-emotional development of children, birth through age 8. One part of this initiative supports communities as they implement the *Pyramid Model*, a framework of evidence-based practices that promote the social, emotional, and behavioral competence of young children, in selected family childcare homes and childcare centers. Using the Pyramid Model in these settings is an emerging practice nationally, therefore development of implementation and evaluation processes and procedures is evolving over time. In addition to Pyramid Model implementation, each community establishes a multi-disciplinary stakeholder team charged with developing and implementing a long-range plan to influence the early childhood systems of care in the community and support the healthy social-emotional development of children.

The work of this initiative is focused on the following three goals and critical outcomes:

1. Nebraska has shared principles, definitions, and collaborative practices related to screening, assessment, and adult-child interactions which promote the positive development of the “whole child”. The RIR initiative includes ongoing evaluation for continuous improvement.
2. Early care and education environments meet the needs for all children’s positive social-emotional development.
3. RIR seeks to improve the social-emotional competence of children ages birth through 8

Selected communities engage in three key activities

1. **Community Work:** Stakeholders connect with additional local partners for the development of a long range plan to support the social-emotional development of young children. Such a plan will include community assessment, systems building, and the development of a process for coordination of systems and services.
2. **Implement the Pyramid Model:** The community will identify 9-15 childcare providers from both in-home and center-based early care and education settings to engage in a three year implementation cycle using a train-coach-train approach.
3. **Selection of a Systems Priority:** Communities choose at least one additional system, i.e. health (Pediatrics/OB-GYN), child welfare, early elementary (K-3), to support in the development of a detailed plan to implement evidence based strategies to promote social-emotional development. The community focuses on this chosen system and coordinates in order to move their community forward in meeting needs and improving the overall well-being of children, families, and their community.

RIR is currently supporting six communities (Cohort 1-Dawson, Dakota, and Saline Counties and Cohort 2- Dodge, Hall, and Lancaster Counties) in these efforts. Funding for this project is a partnership between the Buffett Early Childhood fund (beginning in 2013) and Nurturing Healthy Behaviors funding made available through a grant award to Nebraska Children (NC) following a state funding appropriation to the Nebraska Department of Education (NDE) in 2014.

Evaluation Completed to Monitor Progress and Outcomes

Throughout the implementation of the RIR initiative, quantitative and qualitative evaluation data has been collected to monitor progress and measure outcomes on both the Pyramid Model implementation and Systems of Care. At this time only Cohort 1 has a full year of data to analyze. A full analysis of data from Cohort 2 will be presented in the 2015-2016 Annual Report. The evaluation is organized in three major sections: the Pyramid Model and Community Early Childhood Systems of Care Pyramid Model Implementation and Building Statewide Capacity to Support Early Childhood Systems of Care. The results of the evaluation found positive outcomes across all three of the grant components:

Community Early Childhood Systems of Care: Communities completed systems level planning and have initiated community specific strategies including expanding social-emotional screenings of young children, public awareness activities and parent engagement activities. Circle of Security™-P, a strategy implemented by all three communities, was effectively implemented with parents demonstrating significant increases in parenting skills, improved relationships with their children and decreased parenting stress.

Pyramid Model Implementation: Pyramid Model fidelity measures for program-wide implementation and classroom evaluations for quality practices were completed at baseline and approximately 12 months later for Cohort 1 programs. Programs demonstrated improvement in implementing Pyramid Model strategies. A majority of infant/toddler classrooms and a minority of preschool classrooms achieved the quality benchmarks. Providers reported that their skills improved significantly over time and were highly satisfied with their Pyramid Model coach. High percentage of coaches engaged in joint planning with their providers and focused most frequently on supporting the implementation of Tier One Pyramid practices.

Statewide Early Childhood Systems of Care: RIR successfully established cross-agency partnerships to align activities with the goal of building statewide capacity to support young children and their families. For example, RIR has created infrastructure supports, reflective consultation, facilitator networking, and evaluation, to support statewide implementation of Circle of Security™-P and sponsored training that doubled the number of mental health providers certified in Child Parent Psychotherapy (CPP).

Table of Contents

Supporting Community Early Childhood Systems of Care	4
Program Descriptions and Evaluation Findings.....	6
Developmental Screening	6
Parent Engagement	8
Community Awareness.....	14
Pyramid Model Implementation.....	15
Program Descriptions and Evaluation Findings	15
Fidelity to the Pyramid Model for Program-wide Implementation	18
Classroom Outcomes.....	22
Provider Outcomes.....	24
Coaching Strategies	28
Children’s Social-Emotional Screeners and Assessments.....	31
Building Statewide Capacity to Support Early Childhood Systems of Care	34
Collaborative Effort to Align Early Childhood Social-Emotional Initiatives	34
Support of Evidence-Based Practices.....	35
TPOT R and TPITOS R Training	36
Conclusions.....	37

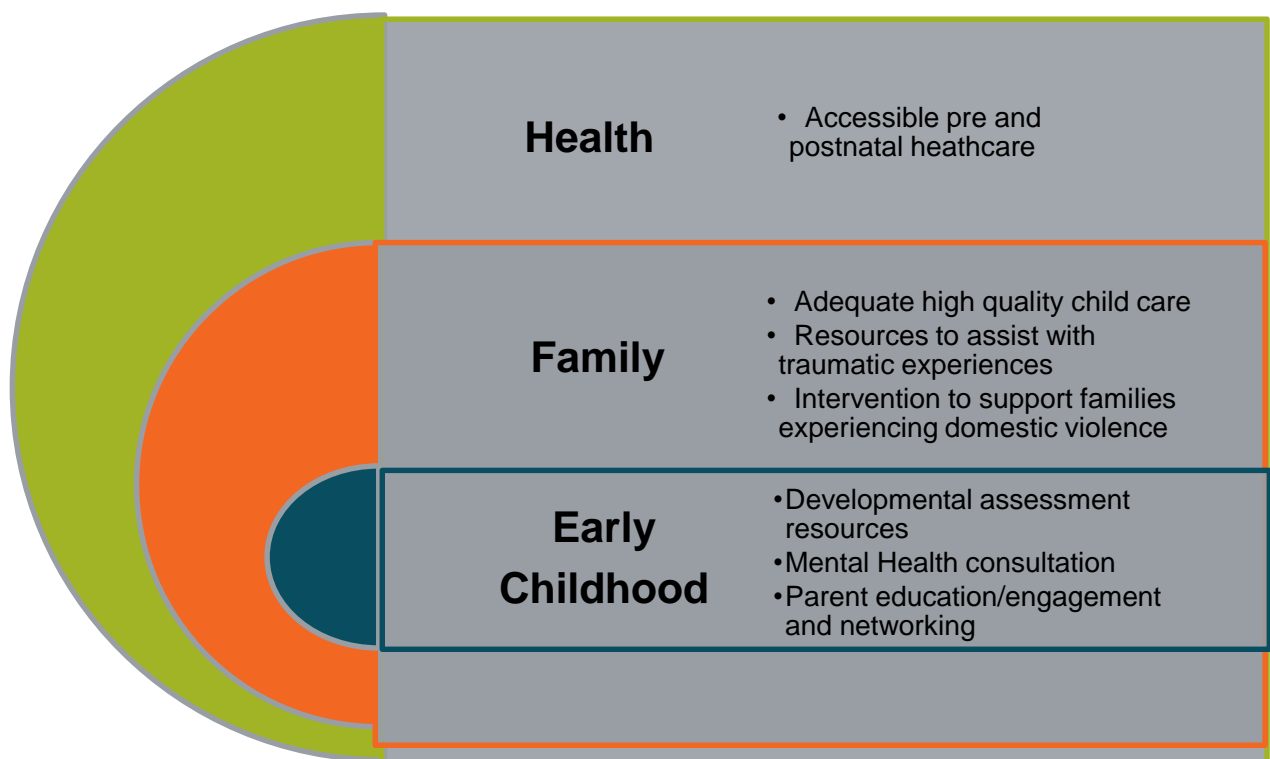
Supporting Community Early Childhood Systems of Care

This report will focus solely on the efforts of Cohort 1 communities (Dakota, Dawson, and Saline Counties) to improve their early childhood systems of care. The communities in Cohort 2 are in the preliminary stages of this work and will be included in the next annual report. In Cohort 1, each community Stakeholder Team was responsible for developing a community plan to strengthen their early childhood systems and supports for social emotional development and child mental health. This planning process included two primary elements, community data gathering and selection of a systems priority.

Early Childhood Systems		
Element of Evidence Based Implementation	Community Data Gathering	Selection of a Systems Priority
Purpose of Activity	To identify strengths, assets, and critical gaps in community services and systems for young children in order to make informed recommendations for action and to build community awareness.	To select a systems priority and implement evidence-based practices that will address the needs identified through community data analysis.
Timeline	Ongoing through the planning period	By the end of Year 1
Who Participates	Community Collaborative Team & Other Stakeholders	Community Collaborative Team

The first step of this planning process was to guide their communities in a systematic process of community mapping using the Early Childhood System of Care Community Self-Assessment (ECSOC) and analyzing other sources of community data. There are four primary areas rated on the ECSOC self-assessment: health, family resource, early childhood mental health services and school. Once communities had gathered all of their existing data and completed the ECSOC this information was then used to develop a long-range plan that would influence the early childhood systems of care in their community and support the healthy social-emotional development of children. The evaluation of the implementation of each community's plan was customized to match the strategy(ies) adopted by that community. This was accomplished through a collaborative effort between the evaluator and community stakeholder team to identify the questions and design the evaluation plan. For strategies that were shared across communities, a common evaluation was developed. This report will describe the mutual priorities that were found across RIR Stakeholder Teams and describe the strategies that communities adopted based on this plan, including any evaluation results.

Common Priority Areas across RIR Community Stakeholder Teams



Program Descriptions and Evaluation Findings

Developmental Screening

Based on the community data gathering and ECSOC process described previously, two RIR Stakeholder Teams, Saline and Dakota, implemented strategies related to developmental screening. The Dakota RIR Stakeholder Team sponsored a community-wide social-emotional screening event. In Saline County, the RIR Stakeholder Team completed a needs assessment to determine the extent to which social-emotional screening was being implemented throughout the county.

What strategies were used in Dakota County to expand social-emotional screening efforts?

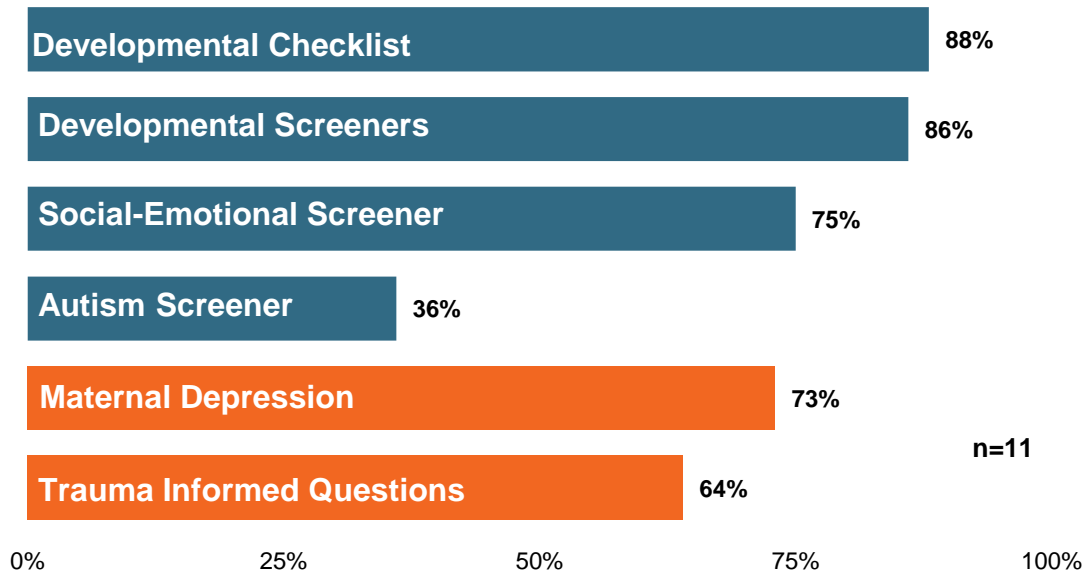
The Dakota County RIR Stakeholder Team implemented a social-emotional screening event in partnership with Parent Child Interaction Therapy (PCIT) therapists, Educational Service Unit #1 and the South Sioux City Schools. Social-emotional screening using the Ages and Stages Questionnaire-Social-Emotional (ASQ-SE) or the Developmental Indicators for the Assessment of Learning (DIAL), was completed as part of the Early Childhood Screening event with 36 children. This community event was successful in finding children in need of further assessment or services. There was one child referred for further assessment in Early Childhood Special Education and an IEP was written. Eight children were referred to receive Parent Child Interaction Therapy (PCIT). Although turnout was lower than expected, the community felt it was a worthwhile event and are determining strategies to increase family participation, such as expanding locations for the screening in the future.

25% of the children screened were in **need of further assessment.**

To what extent are community providers in Saline County implementing developmental screening?

In April 2014, the Saline County Rooted in Relationships Stakeholder Team was interested in determining to what extent community programs, agencies, and clinics were using developmental screening for children birth through age eight. A screening survey was developed and distributed to agencies and private practitioners. A total of 11 surveys were returned with 45% of the respondents associated with public schools. The remainder represented a broad range of programs including private mental health practitioners, community action programs, and physician's clinics. Information was collected from the community providers in February of 2015.

The majority of respondents in Saline County are screening young childrens' development, including social-emotional skills.
 Fewer respondents systematically screen for autism.



The results showed that the majority of the respondents were screening children using developmental checklists or screeners, or social-emotional screeners for children birth to five years. Fewer respondents (36%) were screening for autism in this same age group. There were significantly fewer respondents (< 25%) that had screening practices in place for children over age five. Respondents indicated that a variety of professionals were responsible for the administration of the screeners. The Early Development Network or the school district were the primary referral source for concerns about young children's development.

In Saline County, respondents indicated that the majority of the mothers were screened for depression. Community therapists were the referral source for maternal mental health concerns. In addition, most respondents were asking questions related to trauma.

Following this screening needs assessment, there was interest in the community to pilot a new developmental screener, The Survey of Wellbeing of Young Children (SWYC). This is a comprehensive screening instrument for children under five years of age that covers a broad range of areas including developmental milestones, social-emotional concerns, autism and trauma informed care. Currently, the Saline County RIR Stakeholder Team is working with two sites, a local pediatric clinic and a Sixpence program to pilot the assessment. They are developing a process of implementation and training for the pilot sites. In addition, a decision tree was also developed to guide referrals based on screening results.

Parent Engagement

All of the system of care activities across the three RIR Stakeholder Teams had a component related to parent engagement. These activities range from a variety of awareness activities to a needs assessment to support future planning.

What were the results of the Dakota County RIR Stakeholder Team Parent Engagement Needs Assessment?

The Dakota County RIR Stakeholder Team completed a parent engagement needs assessment to guide efforts on determining parent engagement activities for their community. A total of 501 respondents completed the survey. Nearly all of the respondents (96%) were the mother or the father of the child(ren) and were between 26 and 45 years old (87%). Just over two-thirds were raising their child(ren) in a dual-parent household and 23% were single-parents. Child ages varied, with most respondents noting that they had at least one child in the 6-12 age range. Several key factors emerged as parent preferences for parent engagement activities:

Fun activities with their children

Series of classes

Convenient location and at **low** or **no** cost

Parents identified barriers that may hinder participation:

Time.....Work Schedule.....Cost



The Dakota County RIR Stakeholder Team will use this information in future planning of parent engagement activities.

Circle of Security™-Parenting is an 8-week parenting program based on years of research about how to build strong attachment relationships between parent and child. It is designed to help parents learn how to respond to their child's needs in a way that enhances the attachment between parent and child.

Circle of Security™-Parenting (COS-P)

Each of the Cohort 1 communities sponsored at least one COS-P series in their communities. The three Cohort 1 communities implemented 26 COS-P class series across eight counties. The communities began offering COS-P as a part of their parent engagement systems strategy identified as a priority during the analysis of their community data. Saline County expanded its COS-P efforts to the surrounding counties of Gage, Richardson, Fillmore, Lancaster, and Nemaha. Additionally, COS-P Facilitators throughout the state were offered the opportunity to share their data with RIR. A total of 18 COS-P class series in five counties (Buffalo, Douglas, Lancaster, York, and Red

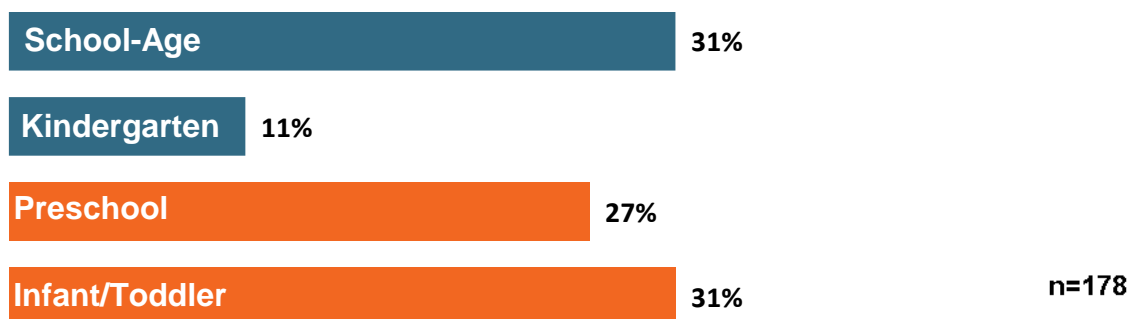
Willow) contributed data. A variety of different supports were made available to increase participant access to COS-P. The data presented in this evaluation report are not representative of all COS-P classes in the state but only those funded (in whole or in part) and/or otherwise supported via technical assistance.

About the COS-P Participants

A total of 190 participants enrolled in COS-P and were supported via funding and/or technical assistance by Rooted in Relationships. Demographic data was completed on the post-survey at the final COS-P session. A total of 178 participants completed the evaluation survey. The following data was based on information from those 178 participants. The majority (89%) of the participants in the COS-P sessions were parents. Other groups represented included: grandparents (3%), unknown (3%), foster parents (3%) and other (2%). These participants were primarily female (85%) and were in the 19-30 (48%) and 31-50 (40%) age groups. The participants on average had two children and ranged from having 0 to 9 children. About half (53%) were eligible for Child Care Subsidy or Free and Reduced Lunch.

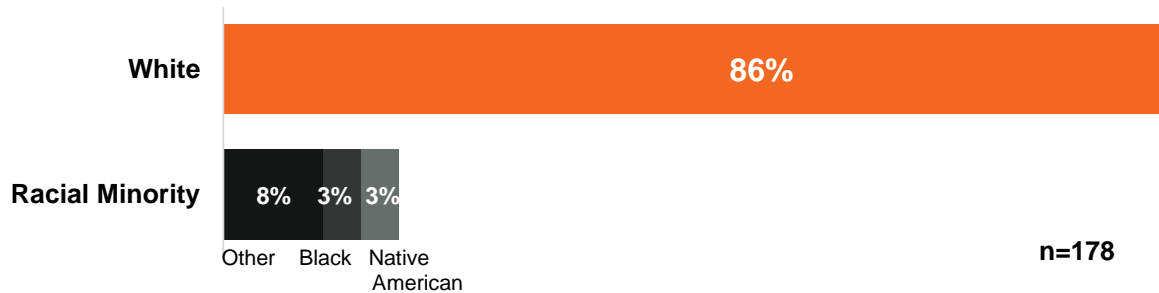
**190 individuals
participated in a
COS-P series.**

The majority of the 285 children of participants were infants/toddlers, preschoolers, and school age



Both the race and the ethnicity of the participants were reported. Most of the participants were white (race); however, of this group, 31% noted their ethnicity was Hispanic. These results suggest that there has been good outreach to the Hispanic population. Only 9% of the state population is Hispanic.

The race of most participants was white.
Of this group, 31% of the participants indicated their ethnicity was Hispanic.



Why did the individuals participate in COS –P?

Participants joined a COS-P class for a variety of reasons. The primary reason was an interest in improving their parenting skills. Several indicated that they had experience with previous parenting classes and were seeking a new approach. Some reported that they joined to learn strategies to specifically address behaviors of their child, e.g., “my child is crying a lot” or “has meltdowns”. Others were there to support other family members, e.g., “to support my wife” or “girlfriend”. A few joined the class based on recommendations.

Program supports were provided to help increase participation. The majority of the sessions provided child care (92%), food (92%) and incentives (83%), which were primarily gift cards. Few programs were able to provide transportation (10%) for the participants. In each COS-P series, Facilitators referred 1-2 participants to additional services, on average.





COS-P Evaluation Measures

Participant Survey

- Nine-item retrospective pre/post survey
- Based on a 5-point Likert Scale with 5=strongly agreed
- Evaluates three areas:
 - Caregiver stress
 - Caregiver-Child Relationship
 - Positive parenting skills (such as responds to child's needs, recognize the behaviors that trigger my negative response to my child)

Parent Educator Survey

- 11 item scale that:
 - Provides a description of the supports provided for the COS-P (such as incentives, child care, refreshments)
 - Determines if the Facilitator participated in reflective consultation and the degree it was helpful.

How did participants evaluate their COS-P experience?

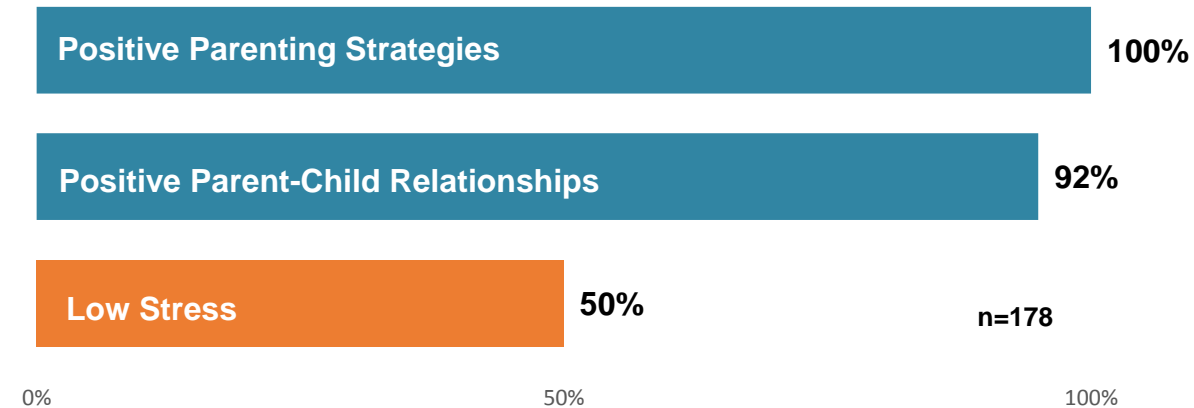
Participants were asked to rate a series of questions that were related to caregiver stress, their relationship with their children, and confidence in their parenting skills. A total of 172 individuals completed the survey. The results of the data were analyzed in two different ways. First a statistical analysis (a paired t-test) was completed to determine if there was a significant change in participants' perception by the end of the COS-P series across the program identified outcomes. There were significant positive differences found between overall scores at the beginning of the group ($M=2.77$ $SD=.73$) and scores at the groups' conclusion ($M=4.29$; $SD=.2$); $t(170)=-25.31$, $p<.001$, $d=1.94$, two-tailed test. These results suggest a strong effect size that is in the zone of desired effects.

The second analysis examined the percent of participants who at the conclusion of the COS-P class series positively rated their skills in three outcomes areas (a rating of agreed or strongly agreed). The results found very high percentages of participants met the program goal of rating their own parenting skills and their relationship with their children very positively by the final session. Only half of the parents reported low stress related to their parenting at the end of the COS-P sessions; however, this was an increase from the pre assessment, where only 15% reported low stress.

35% more parents met the program goal of **low parenting stress** at the end of the COS-P sessions.

Most of the participants met the program goal (rating of agreed or strongly agreed) in adopting positive parenting strategies and positive relationships with their children.

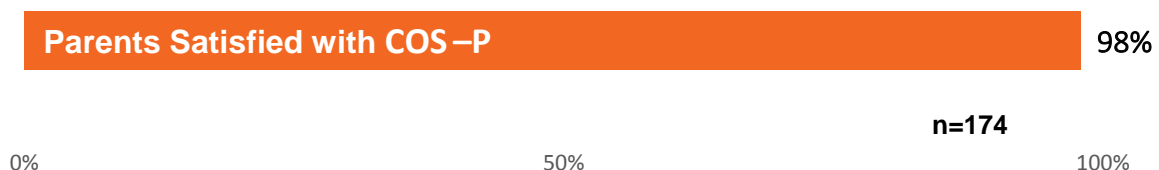
Fewer met the goal of feeling low levels of stress related to parenting.



What did participants and facilitators tell us about their experience?

Participants were very positive about their COS-P experience, using descriptors such as: “wonderful”, “very enjoyable”, and “very helpful”. Many commented on the benefits of participating in the sessions, specifically how the sessions helped them to gain parenting skills and improved their confidence. One commented that it decreased “my stressors and fears about parenting”. Many expressed that their ability to read and respond to their child’s needs had improved and they could better understand their child’s behavior. Increased confidence in parenting was also documented as a benefit. It provided them with a set of tools to use with their children. As one parent said, “I learned so much about myself, my children, and how I can apply these skills into my parenting.” Most importantly they described that they “enjoyed their child” and had a better relationship. Several recommended this group to others, including new parents, divorced parents, grandparents, and fathers. Overall the participants rated the group format (98% agreed or higher) and their facilitator (100% agreed or higher) very positively.

Nearly all of the participants agreed or strongly agreed that the group format was helpful and the COS-P Facilitator did a good job facilitating the group.





“This is the best parenting class I have taken and I have taken a few over the years. It has made a huge difference in ME and how I handle situations with my children.”

A parent evaluates COS-P

What did COS-P Facilitators tell us about their experience?

Facilitators confirmed many of the benefits that the participants described. Not only did participants gain understanding of the concepts discussed in COS-P, many also changed their language and behaviors. As the sessions went on, participants began to open up and share their experiences with others in the group and became more reflective of their own behavior.

Facilitators were asked to describe any challenges or suggestions for improving COS-P sessions. A few facilitators noted that they had some families drop out or attend inconsistently. A few suggestions were made for improvement. One theme emerged: setting more ground rules and/or being clearer about expectations upfront.

COS-P facilitators (n=30) offered the opportunity to participate in reflective consultation as part of their participation in RIR. A total of 43% joined in consultation sessions with a large majority (92%) generally participating one to two times per month. High percentages of the facilitators rated the consultation as helpful (77%). Slightly fewer found the frequency of the reflective consultation to be adequate (62%).

77% of the facilitators viewed **reflective consultation** as a helpful support.

Community Awareness

What were the results of Dawson County's efforts to increase community awareness about early childhood Mental Health?

A goal of the RIR Dawson County Stakeholder Team was to increase parents' understanding of the importance of social-emotional development as part of their children's well-being. Print materials were developed in both English and Spanish and were available to Stakeholder Team members to disseminate to parents. A standing banner was also developed that could be used to display at booths and events to further build awareness of the county's efforts. Two events were implemented to specifically build awareness in their community. During the week of the Young Child, "Being a Friend" was adopted as a theme and a coloring activity and information sheet were distributed to local entities, as well as being posted on a listserv and Facebook page. Building on this friendship theme, a Sizzling Summer Shindig was held. A total of 40 children participated in a "Super Friend" activity that stressed how to be a friend and involved having children make super friend capes. The team also participated in a Community Baby Shower. A total of 35 parents attended. The Dawson County RIR Stakeholder Team hosted this event in Lexington and it involved distribution of gifts through a raffle, including social emotional books, cd's, scarves and toys. Each gift included an attachment with social-emotional information. In addition, the Stakeholder Team sponsored 2 tables at the Lights on Afterschool event with the theme "Even Witches Give Their Friends a Hand to Help".





The Pyramid Model is a framework of evidence-based practices that promote social-emotional competence in young children and prevent and address challenging behaviors (Fox, Dunlap, Hemmeter, Joseph & Strain, 2003). The model is designed as a promotion, prevention, and intervention framework built on the foundation of a high quality workforce. The three tiers of the Pyramid Model include:

1. Nurturing and responsive relationships and high quality learning environments that have positive behavior expectations and predictable routines;
2. The intentional teaching of social-emotional competencies such as play skills and emotional regulation;
3. Individualized interventions for children who need additional supports such as a positive behavior support plan.

Pyramid Model Implementation

Program Descriptions and Evaluation Findings

About the implementation

Rooted in Relationships Pyramid Model implementation was designed to bring Pyramid Model practices to center-based and home-based child care providers. Each provider worked closely with a coach who provided Pyramid Model training and ongoing support for the implementation of Pyramid strategies to promote the children's social-emotional development. Each community coaching team consisted of both early childhood specialists and mental health providers.

During the first 18 months of the project,

20 coaches have supported

82 center and home-based providers in

39 programs impacting over

850 children.

In addition to the training and coaching, providers are eligible to apply for funds to support social and/or emotional development and well-being of the children in their care. The funds are to be used to help the provider reach a specific coaching goal. To date, 31 grants have been distributed totaling \$13,308.87. Providers can purchase materials, equipment, curricula and/or training that will help them reach their coaching goals.

Pyramid Model Implementation

Element of Evidence Based Implementation	Training	Coaching	Coach Consultation	Leadership Team
Purpose of Activity	To share Pyramid Model framework and content to support provider readiness for: implementation of practices, and application of knowledge/skills.	To promote growth and change in provider knowledge and skills to effectively implement and sustain Pyramid Model practices.	To identify the coach's thoughts, feelings and experiences related to how coaching decisions are made and how they affect the coaching relationship.	To promote a community of peer learning which leads to sustainability and continuous quality improvement in practice.
Timeline	4 Trainings (Yr 1) 3 Trainings (Yr 2) 2 Trainings (Yr 3)	2.5 hours/month (Yr 1) 1.5 hours/month (Yr 2) Individualized (Yr 3)	Monthly	6-12 meetings per year
Who Participates	Providers, Directors & Coaches	Providers	Coaches with Rooted in Relationships Coach Consultants	Providers & Coaches

About the programs and the providers

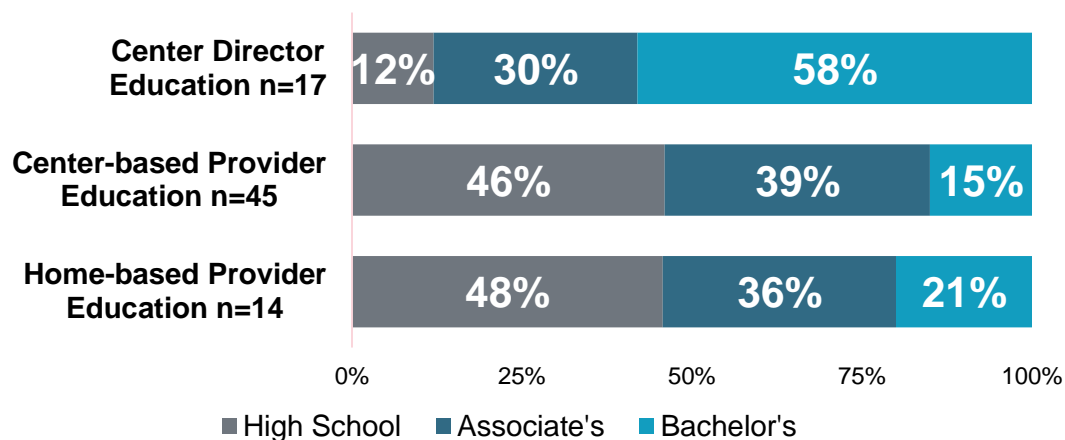
Cohort 1, comprised of Dakota, Dawson and Saline counties, served 18 programs including 10 home-based providers and 8 child care centers. The retention rate for Cohort 1 was 83%, with only three programs withdrawing. Reasons for leaving the Initiative include the closing of one center, the medical concerns of a home-based provider, and the determination that a center needed to develop more readiness prior to participation.

Cohort 2, comprised of Dodge, Hall and Lancaster counties, served 21 programs including 5 home-based providers and 15 child care centers. As of December, 2015, all of the cohort 2 programs had been retained.

Of the 39 programs implementing the Pyramid Model through RIR, 62% are child care centers and 38% are home-based. A total of 82 providers initially enrolled, 40 from Cohort 1 and 42 from Cohort 2. By the end of this reporting period, 10 of the Cohort 1 providers had exited, which is a retention rate of 75%. As of December, 2015, three of the Cohort 2 providers had exited, which is a retention rate of 93%. The rates should not be compared because Cohort 1 providers have been participating in RIR at least six months longer than Cohort 2 providers.

Information was collected about the education of the directors and the home and center-based providers.

The majority of center directors had a 4-year college degree.
The highest degree for nearly half of the home-based and center-based providers was a high school diploma.



Most (81%) of the participants with a 2 or 4 year college degree, majored in early childhood development or elementary education. Other areas of study included agricultural sciences, criminal justice, dental assistance, psychology and social work.

About the children

At the beginning of their involvement in Rooted in Relationships the programs completed a demographic survey about the 850 children they serve.

82% were enrolled in center-based programs

18% were enrolled in home-based programs

24% qualified for a state child care subsidy, an indicator of family poverty

9% spoke a primary language other than English

About the coaches

The coaches supporting providers are highly trained in their field as well as in coaching. Each county had from two to four coaches plus a lead coach to provide additional support and leadership. Coaches had expertise in one of two areas: mental health or early childhood. A total of 11 coaches were mental health providers with a master's degree in either social work or counseling. The remaining 8 coaches were early childhood specialists who typically had experience as classroom teachers, supervisors and administrators. The coaching team for each county was made up of both early childhood specialists and mental health providers.



Measures of Pyramid Model Fidelity

The fidelity measures are reported as a percentage of items meeting fidelity. Quality is considered a score greater than or equal to 75%.

Benchmarks of Quality (BOQ)

Fox, Hemmeter & Jack, 2010.
A center-based self-assessment tool that the leadership team completes.

- 47 items
- 9 subscales plus 1 overall score

Family Child Care Homes Program-wide PBS Benchmarks of Quality (FCCH BOQ) Lentini, 2014.

A self-assessment tool that the home-based provider completes.

- 42 items
- 8 subscales plus 1 overall score

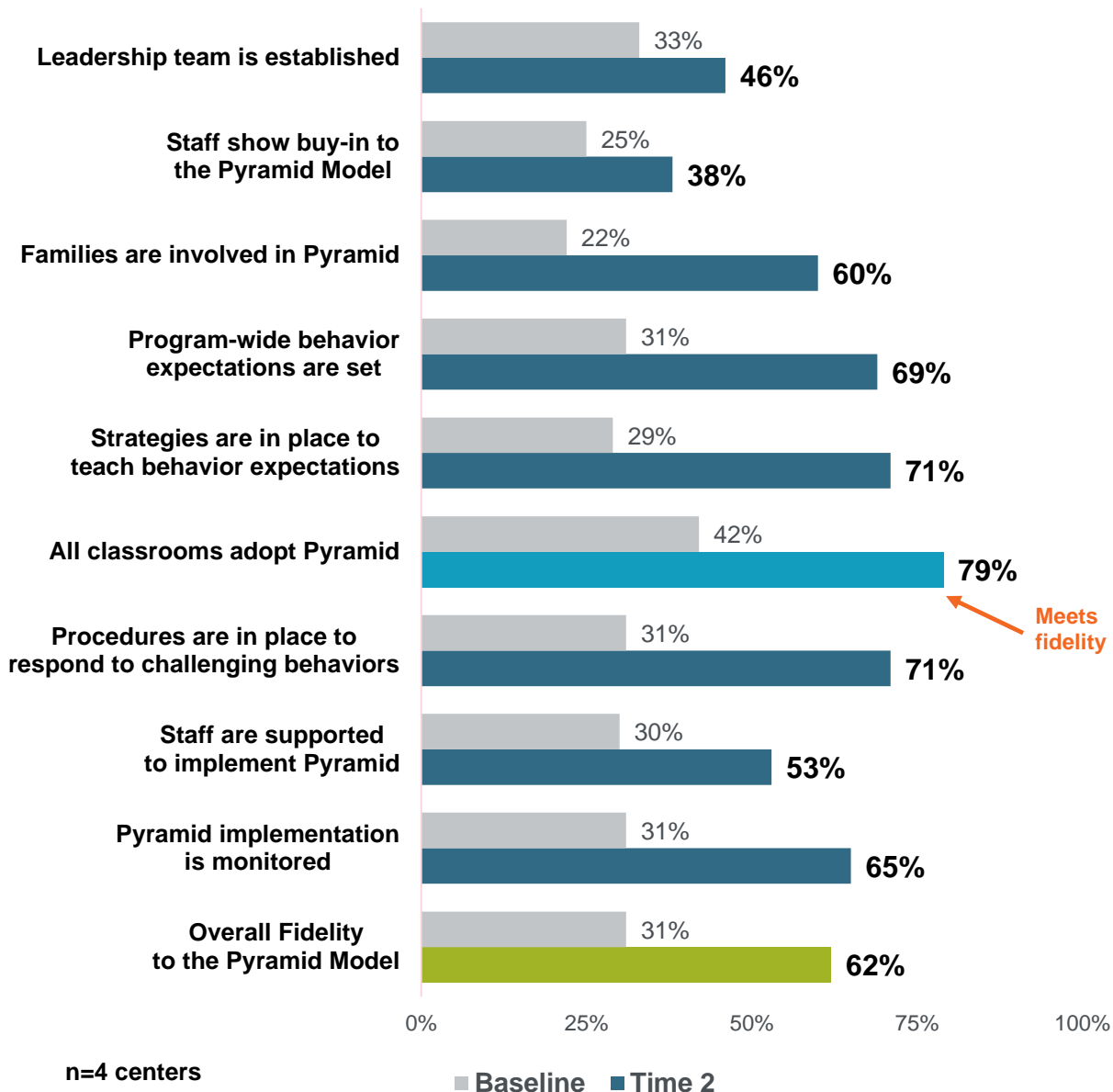
What was the fidelity to the Pyramid Model for program-wide implementation?

The Pyramid Model provides specific guidance for the adoption of evidence-based practices that promote young children's social-emotional development. Program-wide implementation of the model includes a systematic approach to positive behavior supports to ensure consistency and predictability at every level. Parents, care givers and administrators are aligned in promoting these model practices to support social-emotional development. Program-wide implementation of the Pyramid Model includes setting program-wide behavior expectations, involving families in the Pyramid Model, adopting procedures to respond to challenging behavior, and monitoring the implementation of Pyramid practices.

To evaluate the program-wide implementation fidelity to the Pyramid Model, two surveys were utilized. Centers that implemented the model program-wide completed the **Benchmarks of Quality (BOQ)**. Across the six RIR counties, 10 programs – four in Cohort 1 and six in Cohort 2 - chose to do a program-wide implementation meaning that all classrooms in a child-care center were implementing Pyramid Model strategies. All home-based providers, 10 in Cohort 1 and five in Cohort 2, completed the **Family Child Care Homes Program-wide PBS Benchmarks of Quality (FCCH BOQ)**. The side bar provides information about these tools. Providers completed the surveys at baseline and approximately 12 months later. This report does not include Cohort 2 data because they have only collected baseline data at this time.

The following chart shows how the Pyramid practices in the four center-based programs in Cohort 1 who opted to implement the Model program-wide have changed over time. The scores are presented as an average across the programs at baseline and 12 months later. Fidelity is defined by the tool authors as implementing 75% of the practices in a given area.

Centers increased their fidelity to the Pyramid Model in the first year, achieving fidelity in 1 area and approaching fidelity in 4 additional areas. Programs are meeting the fidelity benchmark in the area of "All classrooms adopting Pyramid practices."

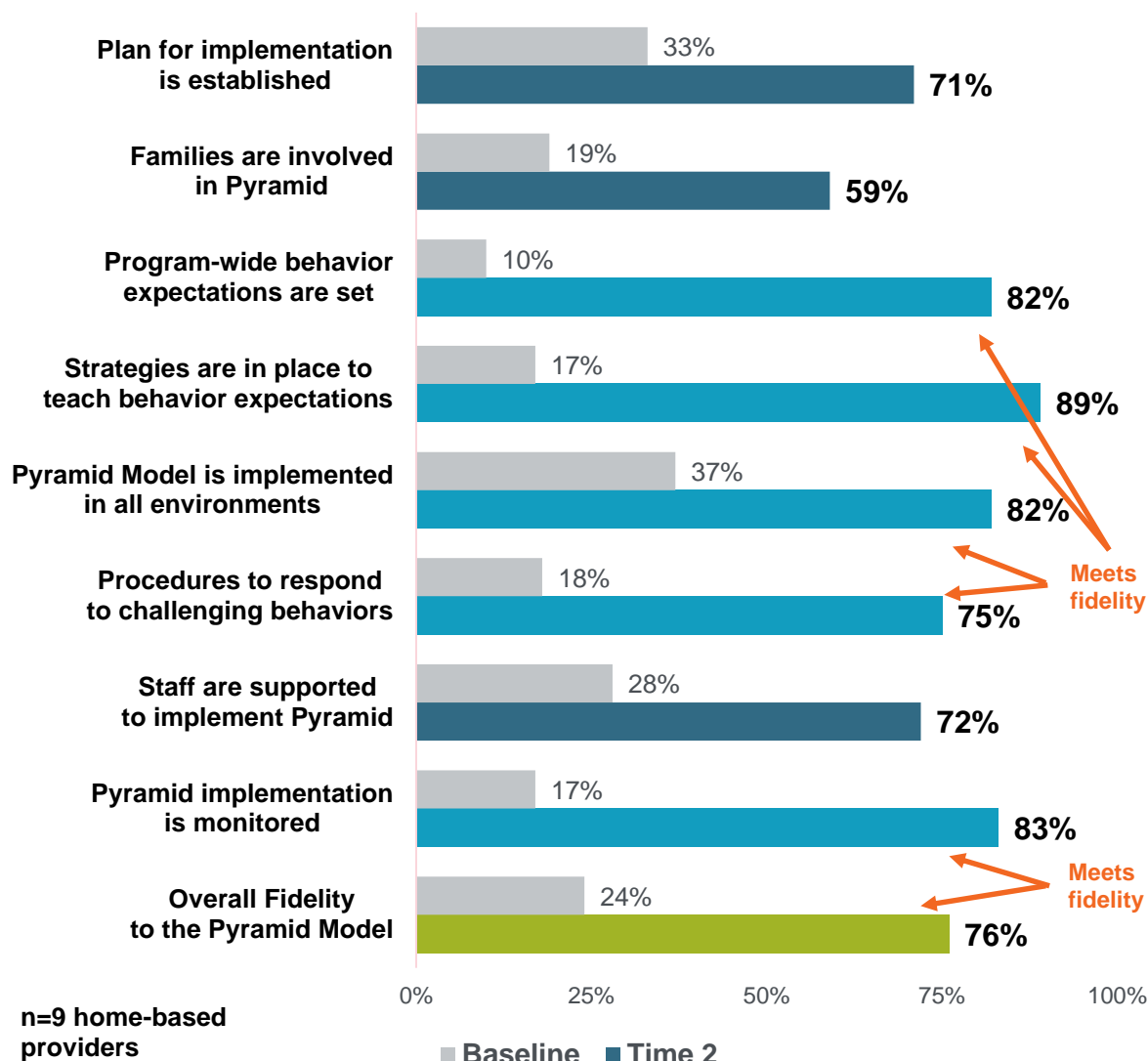


The BOQ survey results indicate that programs are improving in their implementation of the Pyramid Model. There are not enough center-based programs implementing Pyramid Model program-wide to do a statistical analysis to determine if these changes are significant. However, the four programs showed growth in every area. They have reached fidelity in the area of classroom participation in Pyramid. They are approaching fidelity (scores of 65% to 74%) in the areas of setting program-wide behavior expectations, teaching the expectations, responding to challenging behaviors and monitoring the implementation of the Pyramid Model. The areas most in need of support and improvement are increasing staff buy-in to the Pyramid Model and building a leadership team.

The following chart shows how the nine home-based providers in Cohort 1 have changed their practices over time, based on results from the FCCH BOQ. The scores are presented as an average across the providers at baseline and 12 months later. To meet fidelity to the Pyramid Model, 75% of the practices in a given area must be in place.



Home-based providers increased their fidelity to the Pyramid Model in the first year, achieving fidelity in 6 areas.



Home-based providers made great strides in implementing the Pyramid Model. They met fidelity in five subscales and overall. They approached fidelity in two areas: establishing a plan for implementation and supporting staff to implement the Pyramid Model. The area most in need of support and improvement is involving families in the Pyramid Model.



Measures of Center-Based Classroom Practices

Classroom assessments are completed by an outside evaluator. Scores are reported on two scales:

Key Practices examine Pyramid Model strategies. The score is reported as a % of indicators met.

Red Flags signify problem practices in need of immediate attention.

Quality for both tools was defined as meeting 80% of the Key Practices and having NO Red Flags.

Teaching Pyramid Observation Tool, Research Edition (TPOT R) Hemmeter, Fox, & Snyder, 2014.

- **Key Practices** - 14 areas
- **Red Flags** - 17 items

Teaching Pyramid Infant Toddler Observation Scale, Revised (TPITOS R) Carta, 2015

- **Key Practices** - 13 areas
- **Red Flags** - 11 items

What were the outcomes for the center-based classrooms?

To measure the center-based classroom outcomes, outside evaluators completed observations using the **Teaching Pyramid Observation Tool Research Edition (TPOT R)** for preschool rooms and the **Teaching Pyramid Infant/toddler Observation Scale Revised (TPITOS R)** for infant or toddler rooms. Details about the TPOT and TPITOS can be found in the side bar. The TPOT and TPITOS have not been used to collect data in family child care homes as they were not originally designed for this environment. However, RIR is currently piloting the use of these measures in the home-based setting. These tools were developed to measure the implementation of Pyramid Model strategies and focus on four areas of teacher practices: nurturing responsive relationships, creating supportive environments, providing targeted social-emotional supports and utilizing individualized interventions. Practices measured in the **Key Practices** scale include building warm relationships with children, utilizing preventative strategies such as posting a picture schedule and structuring transitions, teaching social-emotional skills, and individualizing strategies for children with behavior challenges. **Red flags** measure negative practices such as chaotic transitions and harsh voice tone.

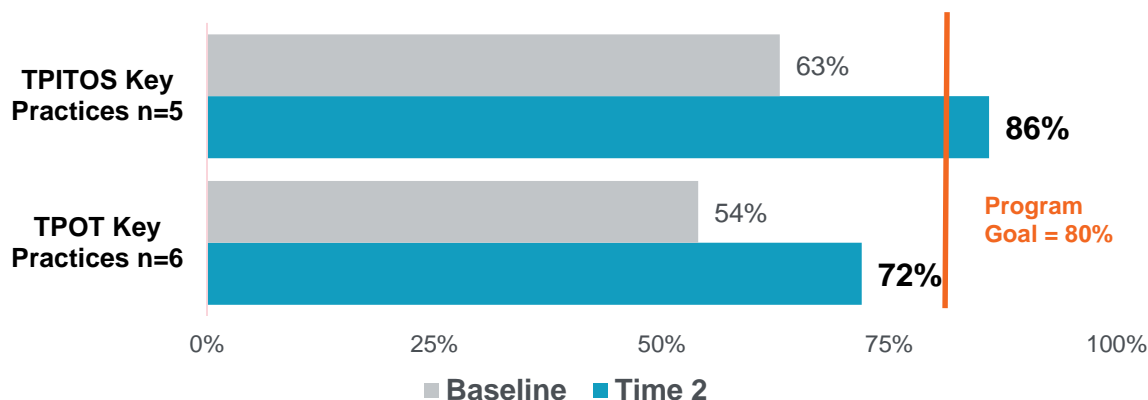
Across the six counties, 36 preschool classrooms had a TPOT R observation at baseline, 9 from Cohort 1 and 27 from Cohort 2. After approximately a year of coaching and training, six Cohort 1 classrooms had an interim observation. The other three classrooms had exited the program.

For the infant and toddler classrooms, there were 18 TPITOS R observations collected at baseline, 9 from

Cohort 1 and 11 from Cohort 2. After approximately a year of coaching and training, five Cohort 1 classrooms had an interim observation. The other two had exited the program.

Classroom Pyramid practices improved in the first year.

On average, infant toddler classrooms met the quality indicator goal by the second observation, but preschool classrooms did not.



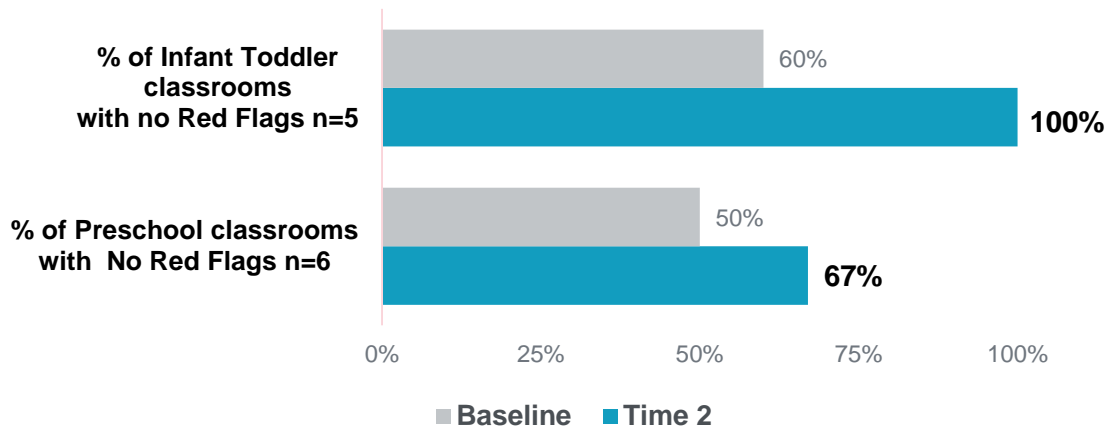
After approximately a year of RIR coaching and training, classrooms showed improvement in the use of Pyramid strategies. Infant/toddler classrooms increased, on average, 23 points in the Key practices scale. Preschool classrooms experienced an average increase of 18 points. At the baseline observation, only one of the infant/toddler classrooms met the program goal of 80%. By the second observation, the majority (three) of classrooms met the goal. For preschool classrooms, none met the goal at baseline; by the second observation, 33% (two) classrooms met the goal.

The following chart presents the incidence of Red Flags at baseline and at the second observation. For both preschool and infant/toddler classrooms, negative practices decreased over time. None of the Infant/toddler classrooms had Red Flags after Pyramid coaching. Most, (67%) of the preschool classrooms had no Red Flags by the second observation. At baseline, the most Red Flags in a single classroom was four. By the second TPOT, the most in a single classroom was three.

At baseline, only **one infant/toddler** classroom and **zero preschool** rooms met the program goal.

After coaching, **three infant/toddler** rooms and **two preschool** rooms met the goal.

After coaching, NONE of the infant toddler rooms had Red Flags.
The majority (67%) of preschool classrooms did not have Red Flags.



What were the outcomes for the providers?

Provider Survey Results

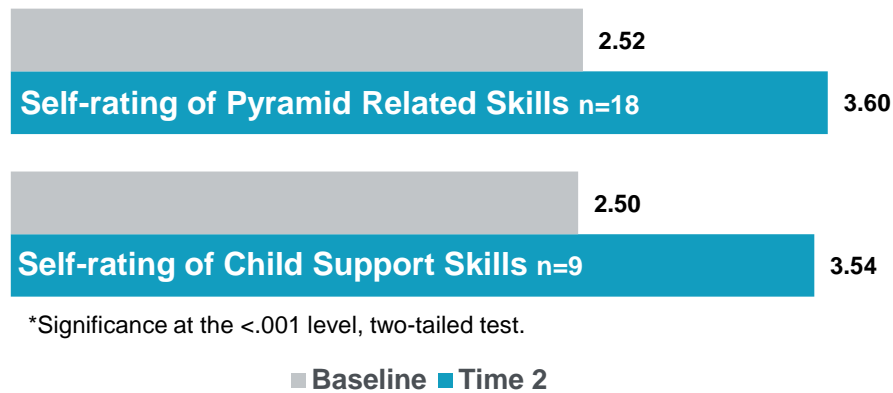
After 12 months of participation in Rooted in Relationships, Cohort 1 providers were asked to evaluate how their ability to support the social-emotional competency of young children changed over time. Providers completed a 22 question pre-post survey to assess their skills in supporting the social emotional competence of all of the children in their program (e.g., I help children problem solve when they have a conflict) and in supporting an individual child who experienced challenges in this area (e.g., I can help this child learn to use positive skills to replace his or her challenging behaviors). The survey is based on a 4 point Likert scale with 1 = almost never and 4 = almost always. There were 19 surveys collected from the 30 Cohort 1 providers, a survey return rate of 63%.

The coach “has taught me to focus on the positive rather than the negative and how to use positive phrases... It’s an excellent program.”

A provider evaluates Pyramid Model coaching



Providers reported a significant* increase in their skills as a result of participation in Rooted in Relationships.



Results of a paired t-test analysis indicate that providers reported significant increases in Pyramid related skills such as creating a positive environment and following a daily routine, as a result of Pyramid Model training and focused coaching. There were significant positive differences found between program skills at baseline ($M=2.52$; $SD=.43$) and at time 2 ($M=3.60$; $SD=.35$), $p<.001$, $d=2.32$, two-tailed test. The results suggest effect sizes within the zone of desired effects.

Providers who focused on implementing child-specific strategies to support individual children struggling with social-emotional competence also noted strong improvement in their skills. Child support skills could not undergo statistical analysis because only 9 providers responded to this portion of the survey. However, providers indicated that they felt more capable of implementing strategies to build children's social-emotional skills and managing challenging behavior because of the Pyramid Model training and coaching offered through Rooted in Relationships.

All of the providers were satisfied or very satisfied with their RIR coach. In reflecting on the degree to which their practices changed while working with their coach, 63% indicated that they made many changes and 37% made some changes.

Focus Group Results

Evaluators conducted focus groups in two counties in Cohort 1 to learn more about the providers' experience with RIR coaching.

Participants

A total of 15 people, including child care providers from both center and home based settings and center directors, participated in the two focus groups. One provider was in her first year in the field. Several had over 20 years of experience. Most of the participants had worked in early childhood for more than eight years.

Structure of Coaching

Providers met individually with their coach for one to two hours each month. All participants mentioned that their coach was available to them by text or email during the work day, in the evening, and on the weekends. They agreed that coaching provided once a month was sufficient to review Pyramid practices, to address questions about challenging behaviors and to set goals for the following month. One provider noted, “There have been a lot of projects to complete as we go along so once a month is good because it gives me a goal to finish before we meet again. If we met more often I might burn myself out.” Having the coach observe in the classroom or home was also helpful.

In addition, the providers meet monthly to network or have short trainings. They also had three all day trainings in the first year. They felt that the trainings have been very practical and they especially liked the make and take workshop where they were able to create materials to use with children such as visual schedules, rules signs, etc.

Coaching Process

The providers appreciated that coaching sessions were individualized so they could work on what was most meaningful to them. One person mentioned that the coach helped her figure out how to improve the transitions at bathroom time. Another valued the coach’s support with materials, handouts for parents, and even bringing in a laminator to create the rules and the picture schedule. A center director noted that the coach was an excellent “sounding board” and that her “wealth of knowledge” made her an excellent resource. The coach’s approach to solving problems with the provider was also helpful.

The coach “doesn’t necessarily come in and give you answers.

She talks you through it....

We have one child who has a lot of aggression. She asks us questions like, ‘Why do you think he’s doing it? When does he do it?’ **She is trying to get you to come up with the answers.”**

A provider reflects on coaching

Strategies to Support Children

The providers valued the Pyramid Model training for helping them to understand child behaviors in new ways. They learned to reframe child behaviors more positively and to appreciate the ways a child is trying to get needs met. Through the trainings they have learned to be more specific with children and explain what makes them feel proud of the children’s good behaviors or actions.

As providers reflected on how the Pyramid Model project has impacted the children and families they serve, they described specific interventions that have worked well. The training and the individualized coaching provided them with strategies to support the children’s social emotional skills. The coach, “helps us find different ways to interact with them that are better.” For example, they discovered ways to help children work out their issues between themselves or learn to share. As one provider said, “There is a big difference where the kids were before and now. One child has learned more self-control. Everything is running smoother than before.”

Several providers mentioned that they discuss and labels feelings more regularly. A few noted that some of the children seem to be repeating a lot of what they hear at school to their parents. One participant explained, “After a weekend, I had one parent come in and say “I learned a lot about you on the weekend.’ I’m like ‘Oh you did?’ The parent replied, ‘I heard when you were frustrated, I heard when you were happy and heard when you were sad!’” Another provider shared, “I had one child go home and his mom did something that made him really mad and he said, ‘Do you see my face Mom? You are making me sad!’”

The providers described many of the characteristics of the coach that contributed to their successful relationship with her. These included: easy to talk to, “I could tell her anything”, trustworthy, non-judgmental, and “she’s been in our shoes.”

Suggestions for Improvement

There were a few suggestions to improve the program. One participant expressed that this opportunity should be available for all new providers, explaining, “I wish I would have had it when I started. I am a new provider and don’t know honestly where I would be without it. She has helped me ... so much.” Others indicated pictures of other programs, “real illustrations, not just the glossy pictures you see in the book”, would be helpful to see how others like them were implementing the Pyramid Model. They also recommended visiting other family child care homes so they could network and share ideas.

Focus Group Summary

Overall, the providers expressed deep satisfaction with their coaches and with the Pyramid Model project. They have appreciated the opportunity to apply for grants, to meet other providers in their community, to improve their skills, and to fulfill professional development requirements. They have enjoyed using new tools with families, including newsletters and the ASQ-SE. One participant summed it up nicely, saying the Pyramid project, “... gave me a purpose throughout the day. I had the tools to deal with situations that I didn’t know how to deal with before. I felt like I was kind of drowning with ten kids in the room by myself. But now... I have the tools ... and I can teach other people in my room what to do.”



What strategies did coaches use to support the providers?

Coaches were expected to meet with providers up to 2.5 hours each month in year one and up to 1.5 in year two. In addition, they were available by phone and e-mail. To monitor the content of the coaching sessions as well as the coaching strategies used, coaches were asked to answer a brief five question survey after each session.

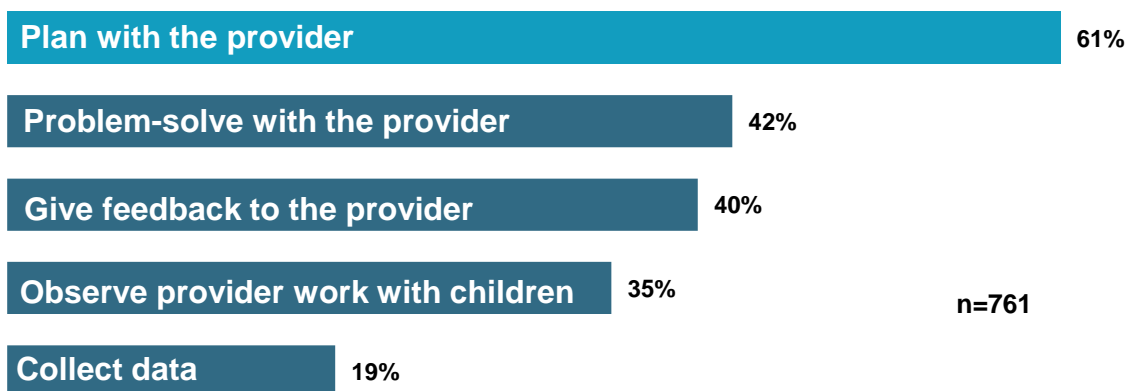
Across the 20 RIR coaches in Cohorts 1 and 2, 772 coaching sessions were logged on the survey. The number of coaching entries varied widely from coach to coach, with the most logging 106 sessions and the least logging 7. It appears that some coaches completed a survey after every session and others rarely logged their visits. The following data should be viewed as an indication of coaching practice trends but not a complete record of RIR coaching sessions.

Which coaching characteristics were used in the classroom or home-based setting?

This data provides information about the coaching characteristics used while the coach was spending time observing and interacting within the center or home based setting. Separate data, shared later, identify the coaching characteristics that were used during the coaching conversations between coach and provider.

The most frequent coaching characteristic used outside of a coach conversation was joint planning with the provider.

Problem-solving, including reflecting on practices, and giving feedback were also frequent coaching activities.



In addition to the above activities, coaches occasionally did focused observations of the provider working with an individual child (15%), modeled Pyramid strategies side by side with the provider (8%), demonstrated a strategy with a child or group of children (4%) and observed the provider working with a parent (2%).

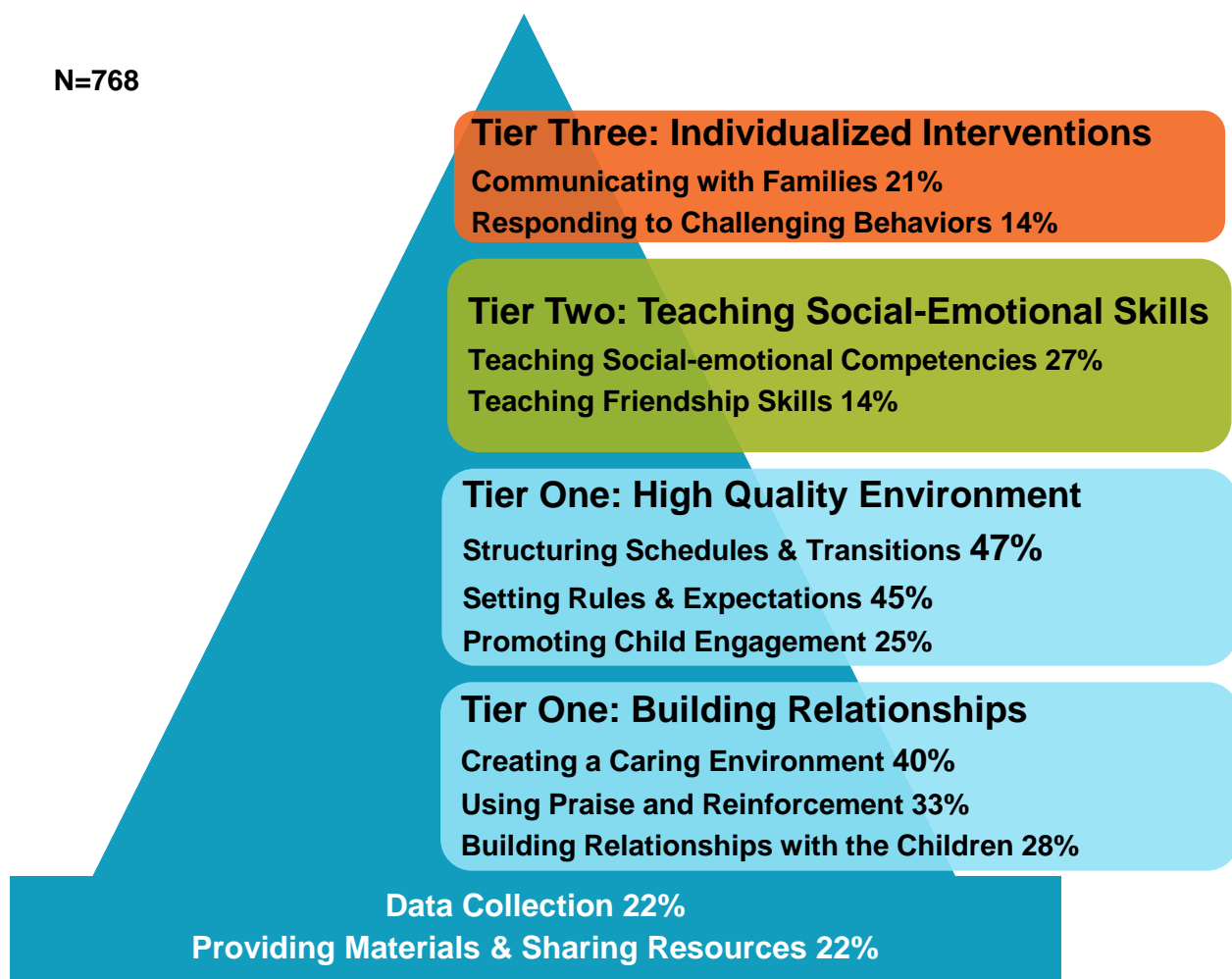
How were coaching characteristics determined?

As reported on 763 coaching logs, the majority (56%) of the time, coaches selected coaching characteristics based on a previous coaching conversation or through joint planning with the provider. Provider requests informed coaching characteristics 18% of the time. Previous observations of the classroom determined coaching characteristics 15% of the time and results from data collection determined coaching characteristics 12% of the time.

What was the content of the coaching sessions?

The content of the coaching sessions can be mapped onto the tiers of the Pyramid Model. The percentage indicated after each item in the graphic below indicates the frequency that the topic was addressed during the coaching sessions.

Coaching sessions focused most frequently on creating predictable routines, setting behavior expectations, and creating a caring environment.

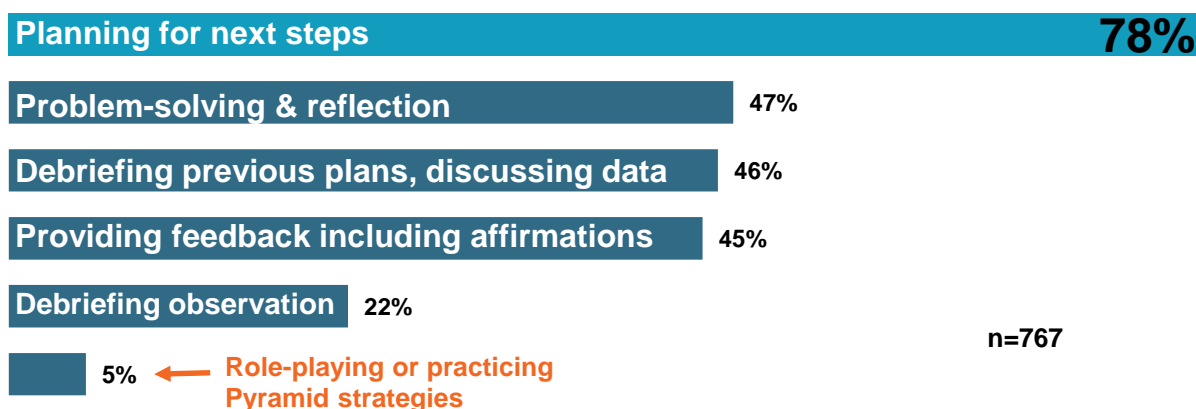


At the base of the Pyramid is building an effective workforce where coaches focused on using data to inform practices. Coaches also brought the providers materials and resources to build their capacity. Coaches and providers were least likely to discuss teaching friendship skills or strategies to respond to challenging behavior.

Which coaching characteristics were used in coaching conversations?

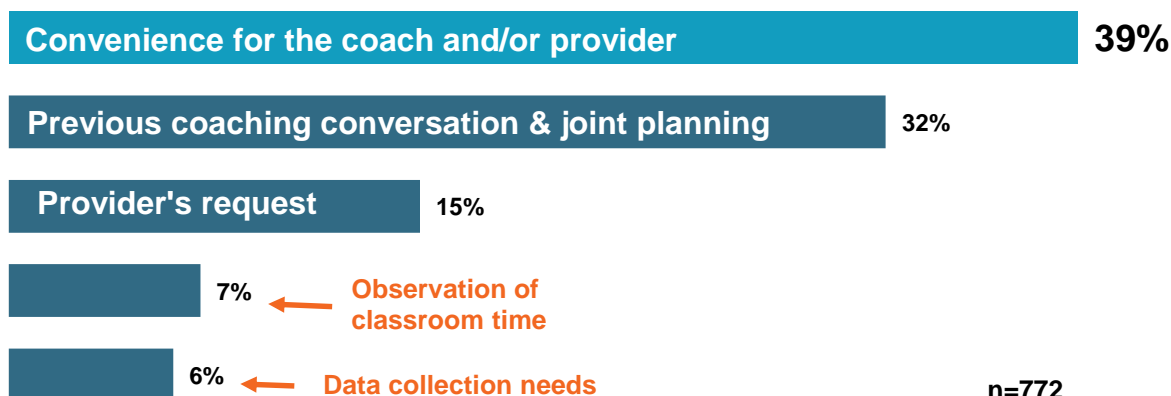
These data provide information about the coaching characteristics used while the coach was debriefing with the provider. Coaches could use multiple characteristics in a single coach conversation.

Coaching characteristics used during 767 coaching sessions included:



How was the timing of the coaching conversation determined?

Decisions about when to meet next or how often to meet, as reported in 772 logs, were determined by:



Summary of the Coaching Logs

Overall, the coaching data indicate that coaches worked closely with providers to plan coaching sessions that focused most frequently on the bottom tier of the Pyramid Model. Given that the providers were in the first or second year of implementation, which focused mostly on Tier One of the Pyramid Model it makes sense that coaches spent more of their coaching sessions focused on topics that fell into this Tier. The Tier Two training and coaching was in its early stages, and Tier Three training has not yet occurred. Once these Tier One practices are firmly in place, it is likely that the focus of the coaching sessions will shift to Tier Two and Tier Three practices. Also of note is the high percentage of coaches engaging in joint planning with their providers, which is the hallmark characteristic of coaching. An examination of coaching logs in year two and three of the project will show the ways in which the coaching content evolves over time.



Social-emotional Measures

Ages & Stages Questionnaire, Social-Emotional (ASQ-SE)

Squires, Bricker & Twombly, 2002. The **ASQ-SE** is a parent-completed 30 item social-emotional screener assessing self-regulation, compliance, affect and interactions. The cutoff score indicates typical development.

Devereux Early Childhood Assessment- Clinical (DECA-C)

LeBuffe & Nagliere, 2002. The **DECA-C** measures **Total Protective Factors (TPF)** and **Total Behavior Concerns (TBC)** based on a 62 item survey completed by parent or provider.

What were the social-emotional needs of the children?

A premise of the Pyramid Model is that as providers use Pyramid strategies to build caring relationships with the children, create positive and supportive environments and directly teach children social-emotional skills, children's challenging behaviors will decrease. However, it is expected that a small number of children (<5%) may still need more individualized, targeted support. The Model includes training and individualized interventions that providers can use in working with children and additional resources are available through RIR to fund more intensive interventions should no other payer source be available.

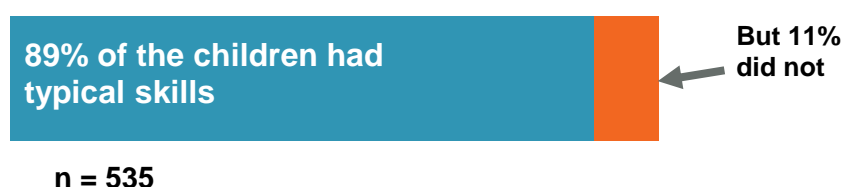
In Rooted in Relationships, coaches worked closely with providers to identify children who have demonstrated persistent challenging behaviors and/or delays in social or emotional development (behaviors in this category are referred to as needing "top of the Pyramid" interventions). Once identified, the coach helped providers select the best strategies to support the child (including bringing in additional supports, if needed).

To assess the social-emotional development of individual children, parents were asked to complete a screener, the **Ages & Stages Questionnaire, Social-emotional (ASQ-SE)**. The ASQ-SE properties are described in the side bar. The ASQ-SE has an age anchored cutoff score. Scores below the cutoff are considered typical. Scores at

or above the cutoff are flagged, indicating that the child's skills are outside the typical range and the child may be at risk for delays in social-emotional development. Since the ASQ-SE is a screener, it is recommended that children who do not score in the typical range receive further evaluation.

Almost all (92%) of the programs across the two cohorts collected ASQ-SE data. However, getting every parent to fill out the ASQ-SE was difficult. Overall about 60% of the parents completed the survey. Across both cohorts, 535 children were screened.

Most children in the RIR Pyramid Model Implementation had typical social-emotional skills.



The screener results indicated that a strong majority (89%) of the children had typical social and emotional competencies. They demonstrated the ability to engage in positive interactions with peers and adults and were able to regulate emotions appropriately for their age. However, a small percentage (11%) of children did not demonstrate typical skills. A total of 59 children, 20 from Cohort 1 and 39 from Cohort 2 were flagged by the ASQ-SE because they did not meet the cutoff score. The screener results suggested that these children may be at-risk for delayed social-emotional development.

To gather more specific information about the children flagged by the screener, it was recommended that the teacher, with parent consent, complete a **Devereux Early Childhood Assessment – Clinical (DECA-C)**. This measure provides more specific information about the child's strengths, as measured by the **Total Protective Factors (TPF)** scale and about the child's challenging behaviors as measured by **Total Behavior Concerns (TBC)** scale. Referrals for additional screening or special education services were also tracked.

In Cohort 1, providers completed DECA-C's for six children who were either flagged by the ASQ-SE (n=20) or had demonstrated challenging behaviors or low emotional competence. Of these, one had already been referred for special education services or additional screening. Only three children had pre and post DECA-C. The DECA-C may not have been completed due to the parent not providing consent, or provider and coach misunderstanding about the need to follow-up with an assessment following a child being flagged on the ASQ-SE.

Because so few children in Cohort 1 were evaluated using the DECA-C, it is not possible to do a statistical analysis or interpret the data in a meaningful way. It is also difficult to analyze if the intervention made an impact on the children. There is minimal information about the intervention, the behavior support plan or the strategies used to support the children who struggled with social-

emotional competencies. Collecting this type of information could be a valuable addition to the evaluation of the RIR Pyramid Model in order to determine individual child outcomes and the efficacy of the coaching focused at the top of the Pyramid.

At the time of this report, Cohort 2 coaches and providers had only just begun reviewing the social-emotional screener results and were planning further evaluation for the children who had missed the cutoff. In the next Rooted in Relationships annual report, DECA-C results for Cohort 2 children will be presented.



Building Statewide Capacity to Support Early Childhood Systems of Care

A primary goal of RIR is to strengthen the system of care at the state level through cross-system collaboration and partnerships to ensure alignment across initiatives and build state infrastructure and capacity. This cross-system collaboration is accomplished through regular RIR Implementation Team meetings and ongoing communication with statewide initiatives that are working towards similar goals. Key areas that were addressed include the establishment of common coaching processes, improved quality of early childhood settings, and collaboration among initiatives.

Collaborative Efforts to Align Early Childhood Social-Emotional Initiatives

Coaching

Pyramid Leadership Team. RIR partners with the Pyramid Leadership Team to work on aligning the statewide efforts with the long term goal of an integrated early childhood system of care for young children and their families. This team, consisting of partners from across various systems (government, universities and private organizations) is working together to implement the Pyramid process consistently in a variety of settings. Common training, evaluation and continuous improvement processes were established.

Coach Coordination Task Force. The newly established Coach Coordination Task Force will continue this work by developing standardized processes for coach training (initial and ongoing), methods of communication among coaches working in a program, strategies for reducing coaching overload, and alignment of coaching processes and practices across initiatives.

RIR collaboration with statewide partners has resulted in **common processes** across initiatives and has **promoted alignment** of cross-agency activities.

Quality Initiatives

RIR staff are working with Step up to Quality, the state's quality rating and improvement system, to incorporate Pyramid Model and other social-emotional strategies into the menu of options. This would allow providers participating in RIR to receive quality points for their participation and enable them to move up in the Steps as a result.

Cross Agency Collaborations

Early Care and Education Groups. RIR staff participate on a number of early care and education groups in order to stay connected at the state and community levels. These include; Early Childhood Interagency Coordinating Council (RIR Coordinator serves as a Technical Assistant to the Governor appointed Council), Early Learning Connection Coordinators (attend quarterly meetings), the Early Childhood Data Coalition and the Toxic Stress Steering Committee.

State Systems Teams. Staff participate on numerous teams at the state systems level to promote cross system supports for Rooted in Relationships and other initiatives. For example, NC provides the “backbone support” to the Prevention Partnership made of up public agency officials from NDE (Commissioner), DHHS CEO and Division Deputies (Health, Behavioral Health, and Children and Family Services), Office of Probation, Supreme Court, along with legislative representation, and private philanthropists such as NC and Sherwood Foundation. Additionally, staff participate in Together for Kids and Families (DHHS-Public Health). This group is working on a variety of statewide projects such as ongoing development and implementation of the Integrated Skills and Competencies for Early Childhood Professionals; recent update of Early Childhood System of Care Community Self-Assessment to include a Parent Survey.

Nebraska Infant Mental Health Association. Rooted in Relationships staff are collaborating to ensure messaging around Infant and Early Childhood Mental Health has continuity and support NAIMH to continue offering professional development opportunities such as the series of webinars offered this past year.

Support of Evidence-Based Practices

Child Parent Psychotherapy (CPP). Nebraska has a shortage of mental health providers and this shortage is further exasperated by the lack of mental health providers trained in early childhood mental health. To address this need, RIR partnered with Project Harmony, Region Six Behavioral Healthcare, and the Nebraska Resource Project for Vulnerable Young children to sponsor a three day introductory CPP training with follow-up consultation in order to increase the number of certified CPP trained therapists. CPP is an evidenced based therapy that was recently approved as a Medicaid reimbursed therapeutic practice for very young children. As a result, the training and consultation process was designed to conform to the requirements of Magellan in Nebraska, so that trainees could expect to be approved upon completion of training and other requirements. A total of 38 individuals who practice across the state were enrolled in the training. To date 20 of these therapists were approved as Nebraska Magellan Providers of CPP, doubling the number of approved CPP providers in Nebraska.

RIR supported training **doubled** the number of approved **CPP mental health providers.**

Circle of Security-Parenting (COS-P). RIR co-sponsored the initial training for Circle of Security™ – Parenting (COS-P), training 114 individuals in September 2014. COS-P classes are facilitated by Registered Circle of Security Parent Educators. A statewide leadership team, led by RIR staff, is working to develop state-level infrastructure supports to ensure the fidelity of the COS-P model and support class facilitators. A web-based document warehouse was developed to house evaluation tools, archived webinars and marketing fliers and brochures that can be accessed by any COS-P Facilitator in Nebraska. Additionally, for 6 months following the initial training, newly trained Facilitators were supported via interactive webinars to help incorporate COS-P into their communities. Facilitators have since been supported via quarterly newsletters and networking phone calls. In December, 2015 RIR, with support from NDE-Part C, began offering reflective consultation to support the work of these Facilitators. RIR staff maintain regular communication and collaboration with Circle of Security International and work closely with them to meet the needs of Facilitators in Nebraska. Additionally, an evaluation template was provided to Facilitators to provide them a mechanism to evaluate their sessions.

TPOT R and TPITOS R Training

Along with partners at the Nebraska Department of Education, RIR provided Teaching Pyramid Observation Tool – Research Edition (TPOT R) training to 25 coaches and early childhood providers in February of 2015. Mastery of this evaluation tool deepened participants' understanding of the Pyramid Model. Most of the training participants chose to complete live reliability to ensure that their scoring was aligned with experienced TPOT R evaluators. As a result of this capacity building effort, the pool of TPOT R reliable evaluators in Nebraska nearly doubled, from 10 to 22. The training also contributed to the geographic distribution of TPOT R expertise in Nebraska. Previously, most TPOT R evaluators were based in the eastern part of the state. Now there are evaluators as far west as Ogallala.

RIR also supported two experienced evaluators to attend a national reliability training for the Teaching Pyramid Infant-Toddler Observation Scale – Revised (TPITOS R) in April of 2015. This was the first national TPITOS R training for the revised tool. Upon return, these evaluators trained five more coaches on the tool, again more than doubling the pool of expert observers.

Conclusions

Community Early Childhood (EC) Systems of Care

- RIR Stakeholder Teams implemented strategies to expand social-emotional screenings of young children in their communities.
- Circle of Security™-Parenting was effectively implemented across communities with parents demonstrating significant increases in parenting skills, improved relationships with their children and decreased parenting stress.
- RIR Stakeholder Teams worked to increase public awareness of the importance of early childhood mental health and social-emotional well-being
- RIR Stakeholder Teams worked to enhance parent engagement with their children to identify the preferences and needs of parents.

Pyramid Model Implementation

- Pyramid Model coaches have supported center and home-based child care programs to implement high quality social-emotional practices.
- Programs participating in RIR for more than a year have demonstrated increased fidelity to the Pyramid Model.
- The majority of infant/toddler classrooms and the minority of preschool classrooms participating for over a year in RIR have reached the quality benchmarks for classroom practices.
- Providers have demonstrated significant improvements in their ability to use Pyramid practices to support children's social-emotional development.
- Most of the children enrolled in the RIR programs have had a social-emotional screener. 11% of the children were identified as needing additional evaluation.
- RIR coaches have worked collaboratively with providers to plan coaching sessions.

Building Statewide Capacity to Support EC Systems of Care

- RIR, through cross agency collaboration, has helped to align activities across statewide initiatives.
- RIR and partners continue to standardize processes for coach training methods of communication among coaches, strategies for reducing coaching overload, and alignment of coaching processes and practices across initiatives.
- RIR has supported the inclusion of social-emotional strategies within the Step Up to Quality menu of options.
- RIR sponsored training and doubled the number of approved Child-Parent Psychotherapy (CPP) certified mental health providers.
- RIR has developed infrastructure supports, reflective consultation, marketing materials, facilitator networking, and evaluation to support statewide implementation of Circle of Security™-Parenting.

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