

ILLINOIS MIECHV

Getting Everyone on the Bus!

BENCHMARKS: Goals, Data, Background and Resources



Benchmark Glossary for Doula Programs

Benchmark 1(1.1): Prenatal Care Completion

Goal & Rationale

Improvement over time in the proportion of women who obtain at least an “adequate” number of prenatal care visits

- ♦ Women who do not receive prenatal care are 3 to 4 times more likely to die of complications and babies are 6 times more likely to die within the 1st year of life.
- ♦ **Adherence** is a measure that compares the actual number of prenatal visits completed prior to the birth of the child to the 10 visits that are recommended and expected by the American Congress of Obstetricians and Gynecologists (ACOG).

Measurement Tool

MIECHV assessment measure is utilized which asks the home visitors to record at how many weeks pregnant a mother entered service, at how many weeks pregnant a mother gave birth, the mother's service entry date, and the child's DOB. We define adequate prenatal care based on the ACOG recommendations, and utilize the NCQA calculation approach.

Data Collection

1. **Who** is included: Prenatally enrolled mothers
1. **What** is measured: Prenatal visit completion as obtained by mother's self report
2. **When** are data collected: During each prenatal home visit
3. **On each prenatal home visit**, ask the prenatal mother “Approximately when was your last prenatal care medical visit?”

Data Entry: Visit Tracker

- ♦ Prenatal visits are entered under the child (not guardian).
- ♦ Prenatal children are added into Visit Tracker when the pregnant mother is enrolled; Use “Baby” as their name, “P” as their gender, and enter the due date.
- ♦ Indicate the prenatal visit date either on the PVR (in the child section for the prenatal child) or on the health info tab for the child - click on “add medical visits.”
- ♦ Choose “prenatal care” for the reason; the prenatal visit data will not be captured unless “prenatal care” is chosen.
- ♦ Caution: Do not change due date once baby is born; just enter date of birth (DOB).

Benchmark Measurement Periods for HRSA/MIECHV

Year 1: Jan 1 2012 - Sept 30 2012

Year 2: Oct 1 2012 - Sept 30 2013

Year 3: Oct 1 2013 - Sept 30 2014

Year 4: Oct 1 2014 - Sept 30 2015

Year 5: Oct 1 2015 - Sept 30 2016

Illinois Outcome Data

Year 1: 52/213 = 24%

Year 2: 76/316 = 24%

Year 3: 92/207 = 44%

Year 4: 188/299 = 63%

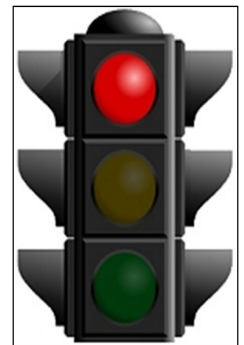
Improvement

Baseline: 49/181 = 27%

Green = 75-100%

Yellow = 65-74%

Red = 0-64%



Numerator = # of women who attend recommended prenatal visits after home visiting program enrollment at the end of the 3rd trimester, based on ACOG guidelines.

Denominator = # of women who gave birth during the reporting period

Improvement is: Increase in the proportion of women who attend recommended prenatal visits after program enrollment (American College of Obstetricians and Gynecologists guidelines) comparing current Federal Fiscal Year (Oct. 1-Sept. 30) to prior Federal Fiscal Year

Benchmark Background: Prenatal Care Completion

⇒ Why are prenatal visits important?

- Each year in the U.S, nearly one-third of pregnant women will have some kind of **pregnancy-related complication**. Prenatal medical care can help keep mom and baby healthy through both treatment and prevention.
- Babies born to mothers who received no prenatal care are 3 times more likely to be born at **low birth weight** and 5 times more likely to die than those whose mothers received prenatal care.
- Doctors can spot health problems early when they see mothers regularly. **Early treatment** can resolve many problems and prevent many others.
- Doctors also can talk to pregnant women about the things that mothers can do to ensure that their unborn babies have a healthy start to life.

⇒ **Did you know?** In 2010, the U.S. ranked only **24th** in infant mortality among all of the highly developed nations of the world.

⇒ What can you do to encourage regular prenatal care?

- Research shows that providing incentives does not overcome barriers to receiving prenatal care. However new pilot projects using **text message reminders** and supportive messages to pregnant moms has shown promising increases in prenatal visit rates.
- **Read more about this strategy:** <http://www.connected-health.org/programs/mhealth/center-for-connected-health-initiatives/encouraging-prenatal-care.aspx>

⇒ Resources with more information on prenatal care:

Prenatal care fact sheet: <http://womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.html>



Benchmark 2(1.2): Parental Use of Tobacco, Alcohol and Drugs

Goal & Rationale

Increase proportion of pregnant mothers who reported using alcohol and tobacco who decreased use between enrollment/onset of pregnancy and delivery

- ◆ Pregnant women who use alcohol, tobacco, or illicit drugs risk their infant's health and development.
- ◆ During pregnancy, women are often motivated to change risky behaviors.

Measurement Tool

Recent and past drug and alcohol use questions are adapted from the 4P's measure to assess substance use risk. These are asked by the home visitor and entered into a MIECHV Assessment form.

Data Collection

1. **Who** is Included: Prenatally enrolled mothers screened and identified as substance users
2. **What** is measured: Parental use of tobacco, alcohol, and drugs
3. **When** are data collected: During prenatal home visits
4. **On prenatal home visits** ask parent: **4P's Plus:**
 - Did either of your Parents have a problem with alcohol or drugs?
 - Does your Partner have a problem with alcohol or drugs?
 - Have You ever drunk beer, wine, or liquor?
 - In the month before You knew you were pregnant, how many cigarettes did you smoke?
 - In the month before You knew you were pregnant, how many beers/how much wine/ how much liquor did you drink?

Data Entry: Visit Tracker

- Go to guardian's health info
- Click the substance abuse survey and click the appropriate yes/no/unknown items

When completing 4P's screening and a positive score is found, we advise the following:

- Go to guardian's assessments
- Click 4 Ps Plus
- Identify by clicking 'Yes' a concern was found as a result of this screening
- Check the appropriate areas of referral received/not received by clicking 'Yes' or 'No' (items included are: tobacco cessation, substance abuse treatment).

Then...

- Go to the guardian's **resource referral**
- Choose the appropriate referral type. Items included are: tobacco cessation, substance abuse treatment.
- Provide the referral reason (given MIECHV Data Collection, 4P's Plus Screening)
- Click 'Yes' or 'No' to identify if the referral was accepted or declined.
- Follow up with referrals given; and update in the designated areas.

Benchmark Measurement Periods for HRSA/MIECHV

Year 1: Jan 1 2012 - Sept 30 2012

Year 2: Oct 1 2012 - Sept 30 2013

Year 3: Oct 1 2013 - Sept 30 2014

Year 4: Oct 1 2014 - Sept 30 2015

Year 5: Oct 1 2015 - Sept 30 2016

Illinois Outcome Data

Year 1: 17/19 = 89%

Year 2: 19/36 = 53%

Year 3: 4/29 = 14%

Year 4: 8/42 = 19%

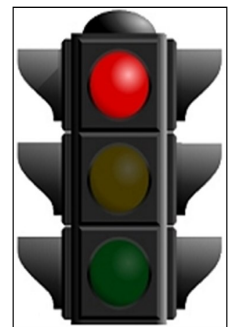
Baseline: 0/84 = 0%

Improvement

Green =

Yellow =

Red =



Numerator = # identified women who decreased substance use between home visiting enrollment and 36 weeks pregnant

Denominator = # pregnant women who were identified as using at home visiting enrollment

Improvement is: An increase in the proportion of women who reduce the use of alcohol, tobacco, and other drugs between enrollment and delivery, comparing current Federal Fiscal Year to prior Federal Fiscal Year

Benchmark Background:

Parental Use of Tobacco, Alcohol and Drugs

- ⇒ Every cigarette smoked narrows the blood vessels in the umbilical cord, reducing the baby's oxygen supply. Just one or two cigarettes a day can increase the risk of **premature delivery**, stillbirth, low birth weight, and other complications. And studies suggest that even light smoking during pregnancy can up your baby's odds for **sudden infant death syndrome** (SIDS) (Babycenter.com).
- ⇒ Smoking during pregnancy **increases the risk** of placenta previa, placental abruption, and SIDS. Infants of smoking mothers are also at an increased risk for prematurity and low birth weight, but mothers who quit smoking reduce these risks.
- ⇒ Smoking has been estimated to contribute to an increase of \$279 in neonatal costs per maternal smoker. Potential neonatal cost savings that could be accrued from women who quit smoking during pregnancy were estimated at \$881 per maternal smoker. ([Ohio Dept. of Health, 2012](#))
- ⇒ Research indicates that among those who use **drugs, polysubstance use is the norm**. In addition, **many women use drugs in combination with alcohol and tobacco**.
- ⇒ Research has also shown that many women who abuse substances have **co-occurring mental health problems** and/or histories of trauma. Most substance users exhibit no signs on physical examination.

Are there any pregnant women who should NOT be encouraged to stop using alcohol or drugs? If so, what is the best approach to use with this population? No.

- Encourage **all pregnant women** to stop using alcohol and drugs. Some women may need additional care from a healthcare provider to be able to safely stop their alcohol or drug use. Stopping use of opiates or pain killers abruptly and without help from a healthcare providers can harm a fetus or threaten a pregnancy.
- Encourage pregnant women who use heroin or are dependent on opioids to switch to methadone with a healthcare providers' help. Refer pregnant women who are taking sustained release opioids for pain (e.g. MS Contin, Oromorph, OxyContin, etc.) to healthcare providers trained in pain management and obstetrics who can monitor their treatment.
- If a woman becomes sick from not drinking alcohol, tell her to immediately seek medical attention to treat alcohol withdrawal symptoms.
- Refer pregnant women who use tobacco products to smoking/tobacco cessation programs. The Illinois Dept. of Public Health operates a Tobacco Quit line at 1-866-QUIT-YES or get a free "quit kit" and tips to quit at <http://quityes.org/>.

Benchmark 3(1.3): Post-Partum Use of Contraception

Goal & Rationale

- ◆ Increase the proportion of enrolled women who initiate use of contraception by 8 weeks postpartum.
- ◆ Initiation of contraception during the postpartum period is important to prevent unintended pregnancy and short birth intervals, which can lead to negative health outcomes for mother and infant.

Measurement Tool

Mothers' self-report of the start and stop date for contraceptive use.

Data Collection

1. **Who** is Included: Enrolled mothers who gave birth during the reporting period
2. **What** is measured: Initiation of use of contraception within 8 weeks postpartum
3. **When** are data collected: During postnatal home visit by 8th week postpartum
4. **On a postnatal home visit before the 8th week postpartum**, ask mother if she has begun the use of contraception.

Data Entry: Visit Tracker

- ◆ Go to Guardian page; click on Health Info tab; find Contraception Use Survey
- ◆ Click on "Add contraception use survey item"
- ◆ Enter date of survey; answer if mother is currently using contraception: Yes or No
- ◆ Note: Contraception use must be initiated within 8 weeks postpartum to achieve this benchmark; the answer to initiating contraception must be "Yes" to meet this benchmark.

Benchmark Measurement Periods for HRSA/MIECHV

Year 1: Jan 1 2012 - Sept 30 2012

Year 2: Oct 1 2012 - Sept 30 2013

Year 3: Oct 1 2013 - Sept 30 2014

Year 4: Oct 1 2014 - Sept 30 2015

Year 5: Oct 1 2015 - Sept 30 2016

Illinois Outcome Data

Year 1: 19/105 = 18%

Year 2: 88/262 = 34%

Year 3: 59/175 = 34%

Year 4: 122/210 = 58%

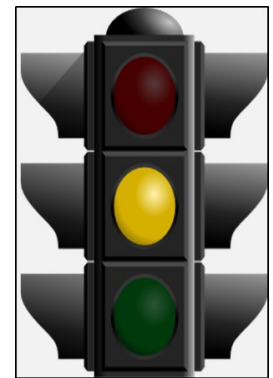
Improvement

Baseline: 69/170 = 41%

Green = 75-100%

Yellow = 65-74%

Red = 0-64%



Numerator = # of women who gave birth during the reporting period who initiate use of contraception within 8 weeks postpartum

Denominator = # of women who gave birth during the reporting period

Improvement is: An increase in the proportion of women who initiate contraception use by six weeks postpartum comparing the current Federal Fiscal Year to the prior Federal Fiscal Year

Benchmark Background:

Post-Partum Use of Contraception

- ⇒ **CDC** recommends that postpartum women not use combined hormonal contraceptives during the first 21 days after delivery due to high risk for venous thromboembolism (VTE). From 21-42 days (6 weeks) postpartum, only women without risk factors for VTE can initiate combined hormonal contraceptives. After 6 weeks, no restrictions on combined hormonal contraceptives apply.
- ⇒ **ACOG: [New Moms Welcome Contraceptive Counseling by Pediatricians at Well-Baby Visit](#)** (May 7, 2013)

Nine out of 10 new mothers would welcome contraceptive counseling by their pediatrician at their well-baby visit, according to research presented today at the Annual Clinical Meeting of The American College of Obstetricians and Gynecologists. Adding contraceptive counseling to the well-baby visit may help reduce unplanned pregnancies, say the researchers.

Lead investigator Tara N. Kumaraswami, MD, MPH, recruited women from obstetric postpartum visits and pediatric well-baby visits at the **University of Illinois Hospital & Health Sciences System in Chicago**. One-hundred women were enrolled in each group. Well-baby visit participants completed a survey followed by contraceptive counseling and a post-counseling survey. Postpartum visit participants were surveyed after their postpartum visit only.

Prior to contraceptive counseling, 83% of well-baby visit participants reported comfort discussing birth control, and 84% stated they would accept contraception advice received at the well-baby visit. Following contraceptive counseling, these women reported significantly increased comfort levels in discussing contraception and their likelihood of using a contraception prescription. Ninety-five percent of women reported that contraceptive counseling at the well-baby visit was convenient, and 90% would prefer if contraceptive counseling were available at that visit.

Previous studies have shown that many women resume sexual intercourse prior to their postpartum visit, putting them at risk for unintended pregnancy. According to Dr. Kumaraswami, up to **44% of women have an unintended pregnancy within the first year postpartum. By reaching women earlier through contraceptive counseling in the pediatrician's office, physicians may help reduce the number of unintended pregnancies.**

RESOURCE: Birth Control Methods Fact Sheet:

<http://womenshealth.gov/publications/our-publications/fact-sheet/birth-control->

Benchmark 4(1.4): Inter-Birth Interval

Goal & Rationale

- ◆ Increase or maintain the proportion of enrolled mothers who receive information by 8 weeks after birth about maternal health risks associated with closely spaced births, and the benefits of adequate inter-birth spacing.
- ◆ Closely-spaced births are those with less than 2.5-3 years between births.
- ◆ According to the CDC, women with short inter-birth intervals are at nutritional risk and are more likely to experience adverse birth outcomes, including low birth weight babies, increased risk of pre-term deliveries, and neonatal deaths.

Measurement Tool

Home visitor fills in a question on the MIECHV Assessment asking if family planning and interpartum interval education was given. This is compared against the target child's DOB.

Data Collection

1. **Who** is included: Enrolled mothers who gave birth during the reporting period
2. **What** is measured: Education on the benefits of an inter-birth interval of at least 18 months
3. **When** are data collected: During postnatal home visit by 8th week postpartum
4. **On a postnatal home visit**, discuss family planning with mother and educate on inter-birth interval risks, and benefits of spacing births at least 18 months apart.

Data Entry: Visit Tracker

- Go to guardian's contact history
- Click the appropriate private contact
- Scroll to the family well-being section within the personal visit record
- Click "I"-information shared, on Inter-Birth Intervals

Benchmark Measurement Periods for HRSA/MIECHV

Year 1: Jan 1 2012 - Sept 30 2012

Year 2: Oct 1 2012 - Sept 30 2013

Year 3: Oct 1 2013 - Sept 30 2014

Year 4: Oct 1 2014 - Sept 30 2015

Year 5: Oct 1 2015 - Sept 30 2016

Illinois Outcome Data

Year 1: 26/61 = 43%

Year 2: 198/262 = 76%

Year 3: 133/175 = 76%

Year 4: 231/244 = 99%

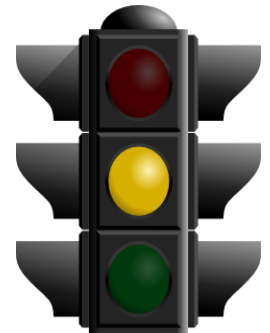
Improvement

Baseline: 139/170 = 82%

Green = 100%

Yellow = 90-99%

Red = 0-89%



Numerator = # of women who receive education within 8 weeks postpartum on family planning and the benefits of an inter-birth interval of at least 18 months

Denominator = # of women who are at least 8 weeks postpartum

Improvement is: Increase or maintain over time the proportion of women who receive information/education on the benefits of inter-birth spacing by six weeks postpartum, comparing current Federal Fiscal Year to prior Federal Fiscal Year

Benchmark Background:

Inter-Birth Interval

What are the risks of spacing pregnancies too close together?

Limited research suggests that a pregnancy within 12 months of giving birth is associated with an increased risk of: The placenta partially or completely peeling away from the inner wall of the uterus before delivery (placental abruption); The placenta attaching to the lower part of the uterine wall, partially or totally covering the cervix (placenta previa), in women who had a first birth by C-section; and [Autism in second-born children](#).

Research also suggests an increased risk of uterine rupture in women who attempt vaginal birth after cesarean (VBAC) less than 18 months after a previous delivery.

In addition, a pregnancy within 18 months of giving birth is associated with an increased risk of:

- Low birth weight
- Small size for gestational age
- Preterm birth

Some experts believe that closely spaced pregnancies don't give a mother enough time to recover from the physical stress of one pregnancy before moving on to the next. For example, pregnancy and breast-feeding can deplete your stores of essential nutrients, such as iron and folate. If you become pregnant before replacing those stores, it could affect your health or your baby's health. Inflammation of the genital tract that develops during pregnancy and doesn't completely heal before the next pregnancy could also play a role.

However, it's also possible that behavioral risk factors, such as failure to use health care services, unplanned pregnancies, stress and socio-economic disadvantage, are more common in women who have closely spaced pregnancies. These risk factors — rather than the short interval itself — might explain the link between closely spaced pregnancies and health problems for mothers and babies.

<http://www.mayoclinic.org/healthy-living/getting-pregnant/in-depth/family-planning/art-20044072>

How does pregnancy spacing affect children?

Every child — and family — is unique. However, research suggests that closely spaced pregnancies can affect children. For example, children who are less than two years apart might experience more conflict than do children who have greater age differences. Spacing siblings more than two years apart also might mean better reading and math scores for the older children. This could be a result of parents spending more time with the older children before having a new baby.

<http://www.mayoclinic.org/healthy-living/getting-pregnant/in-depth/family-planning/art-20044072?pg=2>

Health experts advise women to wait at least [18 months between pregnancies to recover](#) physically and rebuild sufficient nutrients and iron.



Benchmark 5(1.5): Screening for Maternal Depression

Goal & Rationale

- ◆ Increase the proportion of enrolled perinatal women who are screened for maternal depression at least once during the period from the 3rd trimester up to two months post-natal
- ◆ Maternal depression is associated with negative parenting practices, disengagement from the child, and development of psychopathology in the child.

Measurement Tool

Home visitor administers the Edinburgh Postnatal Depression Scale (EPDS).

Data Collection

1. **Who** is included: Enrolled mothers who gave birth during the reporting period
2. **What** is measured: screening for maternal depression during 3rd trimester or 2 months postpartum
3. **When** are data collected: Screening should be completed at any home visit from 3rd trimester to 2 months postpartum.
4. **During 3rd trimester or first 2 months postnatal visit**, screen for maternal depression.

Data Entry (Visit Tracker):

- Go to Guardian's Assessment
- Click EPDS
- Enter pertinent information including the date of assessment and total assessment score
- **Note:** Scores of 13 and above on EPDS require a referral to mental health services, medical services, or medical home. Go to guardian Resource referral screen and document the referral there.

Then...

- Go to "child's screening"
- Choose the appropriate screening type- CESD/EPDS
- Choose "pass" or "concern" as screening result
- Scroll down to the Referral section

Benchmark Measurement Periods for HRSA/MIECHV

Year 1: Jan 1 2012 - Sept 30 2012

Year 2: Oct 1 2012 - Sept 30 2013

Year 3: Oct 1 2013 - Sept 30 2014

Year 4: Oct 1 2014 - Sept 30 2015

Year 5: Oct 1 2015 - Sept 30 2016

Illinois Outcome Data

Year 1: 19/26 = 73%

Year 2: 176/257 = 68%

Year 3: 169/170 = 99%

Year 4: 217/221 = 98%

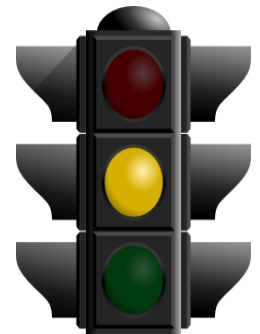
Same

Baseline: 131/153 = 86%

Green = 100%

Yellow = 90-99%

Red = 0-89%



Numerator = # of women who gave birth during the reporting period who were screened for maternal depression at least once during the 3rd trimester or the first 2 months postpartum

Denominator = total # of women in the cohort who gave birth during the reporting period

Improvement is: Increase or maintain proportion of women who are screened for symptoms of depression between 3rd trimester and 2 months postpartum comparing current Federal Fiscal Year to prior Federal Fiscal Year

Data Entry (Continued):

- Choose 'Yes' or 'No' for the question- Was a referral made as a result of a concern found during this screening?
- Choose 'Yes' or 'No' for the question- Was service/intervention received as a result of this referral?
- Choose referral date and agency if there was a positive screen.

Benchmark Background: Screening for Maternal Depression

- ⇒ Maternal depression is associated with negative parenting practices, disengagement from the child, and development of psychopathology in the child.
- ⇒ “Maternal depression negatively affects infants as early as the neonatal period, implicating prenatal effects of maternal depression; as early as birth the infants show a profile of “dysregulation” in their behavior, physiology, and biochemistry which probably derives from prenatal exposure to a **biochemical imbalance in their mothers**” (Preventive Medicine, 1998).
- ⇒ A Family’s Story: Perinatal Depression <http://voices4kids.org/issues/files/perinatdep.pdf>
- ⇒ A study in Minnesota showed that every untreated case of maternal depression was estimated to cost society at a minimum \$23,000 per year in terms of lost productivity for both mother and child.
- ⇒ A review of research and program evaluations suggests that to continue this momentum and effectively reduce the incidence of maternal depression and its impact, the following elements should be in place:
 - ◆ Public awareness of the symptoms of maternal depression and ways to get help,
 - ◆ **Effective early identification of those at risk through screening & referral practices in both health and non-health care settings,**
 - ◆ A two-generation approach to services that addresses the whole family, especially mother and child,
 - ◆ Policies that reduce financial stress on families,
 - ◆ A statewide vision and strategic plan that cuts across state agencies and policy silos to provide a coordinated approach to holistically addressing these issues, and
 - ◆ A system of information collection and reporting that informs practice at the client level and planning and accountability at the state level. ([Children’s Defense Fund of Minnesota, 2011](#)).



Benchmark 8(1.8): Insurance Status for Mother/Child

Goal & Rationale

Increase or maintain the proportion of enrolled women and children who have health insurance at 12 months post enrollment (or at child's 1st birthday for NFP sites).

- ◆ The health of the mother -- before, during, and after pregnancy -- has a direct impact on the health of the child. Both maternal and child health are impacted by access to healthcare and preventive services.

Measurement Tool

Parent Self Report of Maternal and Child Health Insurance Source and coverage period

Data Collection

1. **Who** is included: Women and children who have been enrolled for 12 months (or at child's first birthday for NFP sites)
2. **What** is measured: Health insurance status of women and children
3. **When** are data collected: Upon home visit subsequent to 12 months post enrollment or at child's first birthday
4. **On a home visit at 12 months post enrollment**, ask if mother and child have health insurance.

Data Entry (Visit Tracker)

- Go to Guardian page; click on Health Info tab; find Insurance History
- Click "Add Insurance History Item"
- Enter Date, History Status, and answer "Yes/No" to "Are all family members insured at this time?"
- Go to Child page; click on Health Info tab; find Insurance History
- Click "Add Insurance History Item"; enter Date and History Status
- **Note:** The Family Members Insured question refers to Benchmark 32.
- **Note:** To achieve this benchmark, both mother AND child must have health insurance.

Benchmark Measurement Periods for HRSA/MIECHV

Year 1: Jan 1 2012 - Sept 30 2012

Year 2: Oct 1 2012 - Sept 30 2013

Year 3: Oct 1 2013 - Sept 30 2014

Year 4: Oct 1 2014 - Sept 30 2015

Year 5: Oct 1 2015 - Sept 30 2016

Illinois Outcome Data

Year 1:

Year 2: 219/278 = 79%

Year 3: 170/212 = 80%

Year 4: 148/176 = 84%

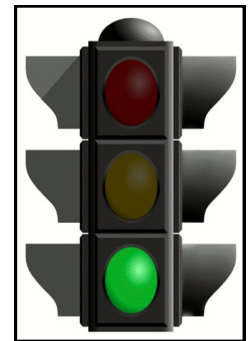
Improvement

Baseline: 190/244 = 78%

Green =

Yellow =

Red =



Numerator = # of women and children who have health insurance at 12 months post enrollment (or at child's first birthday for NFP sites)

Denominator = # of women and children who have been enrolled for 12 months (or at child's first birthday for NFP sites)

Improvement is: Increase or maintain proportion of women and children who have health insurance, comparing current Federal Fiscal Year to prior Federal Fiscal Year

Benchmark Background:

Insurance Status for Mother/Child

Maternal and child health are impacted by access to healthcare and preventive services.

The [Get Covered Illinois website](#) provides information insurance at

Illinois Medicaid, Moms & Babies, or All Kids: Government programs that provide comprehensive coverage for free or little cost.

Insurance programs defined:

Medicaid is a state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The Federal government provides a portion of the funding for Medicaid and sets guidelines for the program.

Moms & Babies is a government program that provides health coverage for pregnant women and their babies. Moms & Babies covers women while they are pregnant and for 60 days after the baby is born. It also provides coverage for the first year of the baby's life if the mother was covered by Moms & Babies when the baby was born. Moms & Babies does not have premiums or co-payments. You can qualify for Moms & Babies if you are pregnant and meet the income requirements. You do not need to be a citizen, legal immigrant, or have a Social Security number to get Moms & Babies.

All Kids is the Children's Health Insurance Program (CHIP) in Illinois. It provides comprehensive health insurance for children up to age 18. Premiums vary on a sliding scale based on household income. All Kids is the Children's Health Insurance Program (CHIP) in Illinois. It provides comprehensive health insurance for children up to age 18. Premiums vary on a sliding scale based on household income.

Affordable Care Act (ACA): The ACA requires that health insurance policies cover the following preventive services for **pregnant women:** prenatal care visits, alcohol misuse screening and counseling; tobacco counseling and cessation intervention; Rh compatibility screening; iron deficiency anemia screening; gestational diabetes screening; infection screening; breastfeeding support, supplies, and counseling.

For **all women**, the ACA requires coverage for contraception and contraceptive counseling; and for domestic violence screening and counseling.

For **newborns**, the ACA requires gonorrhea preventive medication for the eyes; screening for congenital hypothyroidism, hearing problems, phenylketonuria (PKU), and sickle cell anemia.

You can also direct families to www.HealthCare.gov

(Spanish: cuidadodesalud.gov) or visit the website with families during home visits to learn about the Health Insurance Marketplace. **Families may also learn more by phoning the call center** at 1-800-318-2596

(TTY: 1-855-889-4325). Assistance is available 24/7 to answer questions, learn about open enrollment, and sign up for private health insurance.



Benchmark 11(2.3): Dissemination of Safety Information

Goal & Rationale

Increase or maintain the proportion of enrolled caretakers receiving information on injury prevention topics.

- ♦ Education and increased awareness about injury causes and prevention measures improves the quality of life for infants and children.

Measurement Tool

Home visitor checks a box indicating that the parent received child injury prevention education. The date is associated with enrollment.

Data Collection

1. **Who** is included: Adults 3 months post enrollment
2. **What** is measured: Prenatal visit completion obtained by mother's self report
3. **When** are data collected: During each home visit
4. **On a home visit no later than 3 months post enrollment**, discuss injury prevention appropriate to the age of the target child, and document that that discussion has taken place.

Data Entry: Visit Tracker

- In the PVR under "Family Well-being" find "Injury Prevention":
- Document when injury prevention information or referral was made by clicking "I" for Information or "CR" for Community Referral.
- Note: This must be done within 3 months post enrollment to achieve this benchmark.

Benchmark Measurement Periods for HRSA/MIECHV

Year 1: Jan 1 2012 - Sept 30 2012

Year 2: Oct 1 2012 - Sept 30 2013

Year 3: Oct 1 2013 - Sept 30 2014

Year 4: Oct 1 2014 - Sept 30 2015

Year 5: Oct 1 2015 - Sept 30 2016

Illinois Outcome Data

Year 1: 65/207 = 31%

Year 2: 285/684 = 44%

Year 3: 325/351 = 93%

Year 4: 408/420 = 97%

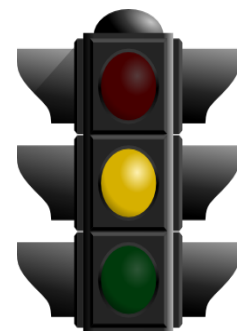
Improvement

Baseline: 154/424 = 36%

Green = 100%

Yellow = 90-99%

Red = 0-89%



Numerator = # of adults participating in home visiting for at least 3 months during the reporting period who receive information about safe sleeping, shaken baby syndrome or traumatic brain injury, child passenger safety, poisonings, fire safety (including scalds), water safety (i.e. drowning), and playground safety

Denominator = total # of adults 3 months post enrollment

Improvement is: Increase or maintain the proportion of parents who receive information/training on prevention of child injuries within 3 months post enrollment, comparing current Federal Fiscal Year to prior Federal Fiscal Year

Benchmark Background: Dissemination of Safety Information

- ⇒ Accidental and preventable injuries in the home among children range from falling down staircases to getting electrocuted by uncovered outlets. Deficits in information, handling stress, and parenting practices are a major cause of home safety related injuries.
- ⇒ According to a study reported in the Journal of Pediatrics, a basic home visit providing home safety information has significantly reduced the number of childhood injuries and showed that the cost per injury prevented was around \$372. ([Ohio Dept. of Health, 2012](#))

RESOURCES:

The Safe Kids website has a wealth of safety and injury prevention information including safety tips, fact sheets, activity pages, safety check lists and other resources. <http://www.safekids.org/safetytips>

A variety of household safety checklists are also available on the [Kids Health website](#). The Women's Health site has information on newborn care and safety available in English and Spanish. Topics include safe sleep and choosing babysitters/child care. [Visit: http://womenshealth.gov/pregnancy/childbirth-beyond/newbon-care-safety.html#](http://womenshealth.gov/pregnancy/childbirth-beyond/newbon-care-safety.html#)



Benchmark 26(4.1): Domestic Violence Screening

Goal & Rationale

Increase or maintain the proportion of enrolled mothers who are screened for domestic violence.

- ◆ Domestic violence is a pattern of abusive and threatening behaviors used by one person in a relationship, typically to control the other.
- ◆ Children in homes where domestic violence is present are more likely to be abused and/or neglected. Most children in these homes know about the violence. Even when the child is not abused awareness of, or witnessing domestic violence can result in emotional or behavioral problems.

Measurement Tool

Futures Without Violence Relationship Assessment Tool

Data Collection

1. **Who** is Included: Women enrolled in home visiting for at least 1 year
2. **What** is measured: Instances of/risk for domestic violence
3. **When** are data collected: During a home visit assessment
4. **During a home visit**, the 4P's Plus assessment is administered by the home visitor; **Domestic violence questions are:**
 - Have you ever felt out of control or helpless?
 - Does your partner threaten to hurt or punish you?

Data Entry: Visit Tracker

- On the PVR, check the appropriate box "DOVE/Futures Without Violence/4 P's" or ...
- Enter a score on the guardian assessments page in the Futures screen.

Note: Scores of 21 or above on the Futures screen require a referral to domestic violence services.

Benchmark Measurement Periods for HRSA/MIECHV

Year 1: Jan 1 2012 - Sept 30 2012

Year 2: Oct 1 2012 - Sept 30 2013

Year 3: Oct 1 2013 - Sept 30 2014

Year 4: Oct 1 2014 - Sept 30 2015

Year 5: Oct 1 2015 - Sept 30 2016

Illinois Outcome Data

Year 1:

Year 2: 153/269 = 57%

Year 3: 196/207 = 95%

Year 4: 168/170 = 99%

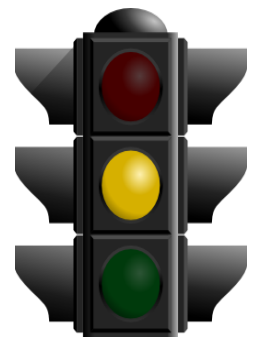
Improvement

Baseline: 174/233 = 75%

Green = 100%

Yellow = 90-99%

Red = 0-89%



Numerator = # of women participating in home visiting for at least 1 year who were screened for domestic violence using the 4P's Plus assessment tool

Denominator = # of women participating in home visiting for at least 1 year

Improvement is: Increase or maintain the proportion of women enrolled in home visiting for at least a year who are screened for domestic violence by comparing current Federal Fiscal Year to prior Federal Fiscal Year

Benchmark Background: Domestic Violence Screening

[Addressing Domestic Violence in Home Visitation Settings webinar:](#) **University of Iowa**

- ⇒ For those young children who experience economic risks and adverse family circumstances—particularly domestic violence, substance abuse, or maternal depression—the possibility of negative outcomes is heightened. These risk factors, either singly or in combination, disproportionately affect low-income adults, particularly women.
- ⇒ A synthesis of research on more vulnerable families finds that although some children do well, many others show some combination of attachment problems (especially for infants and toddlers), developmental delays, learning disabilities, symptoms of post-traumatic stress disorder, difficulty in peer and other caregiver relationships, and later vulnerability to alcohol, tobacco, drugs and substance abuse.
- ⇒ The literature which specifically focuses on the impact of violence on children begins to tell an even more nuanced story. Although much remains to be learned, it is already clear that many young children live in families where their mothers are abused. For example, in a study of police response to 2,400 adult victims of misdemeanor domestic assault in five U.S. cities, more than 80% of the affected households included children; almost half had children under 5 years old.
- ⇒ A study of Head Start families found that 17 percent of parents report that their children have been exposed to domestic violence, and 3 percent of their children have been abused. There is also an intergenerational aspect to the problem. In the last 20 years, the majority of studies have found that between 30 and 60 percent of the children of abused women are themselves maltreated, often by the men who are assaulting their mothers. To make matters even more difficult, some of the children who are exposed to violence at home also witness it on the streets of their communities.



Benchmark 27(4.2): Referrals for Domestic Violence Services

Goal & Rationale

Increase or maintain referrals to appropriate domestic violence services for women experiencing domestic violence.

- ◆ Those who experience domestic violence, including children, need trusted adults to turn to for help and comfort, as well as services to help them to cope with their experiences.

Measurement Tool

Referrals for domestic violence services during home visit screening for domestic violence

Data Collection

1. **Who** is Included: women who have screened positive for domestic violence
2. **What** is measured: Referrals for domestic violence services
3. **When** are data collected: During home visit screening for domestic violence
4. **On a home visit**, referral services are offered to women screening positive for domestic violence.

Data Entry: Visit Tracker

- Scores of 21 and above in the Futures screen require a referral to domestic violence services.
- Indicate a referral was made by clicking the "R" next to Domestic Violence Services on the PVR or go to guardian Resource referral screen and document the referral there.

Benchmark Measurement Periods for HRSA/MIECHV

Year 1: Jan 1 2012 - Sept 30 2012

Year 2: Oct 1 2012 - Sept 30 2013

Year 3: Oct 1 2013 - Sept 30 2014

Year 4: Oct 1 2014 - Sept 30 2015

Year 5: Oct 1 2015 - Sept 30 2016

Illinois Outcome Data

Year 1:

Year 2: 6/7 = 86%

Year 3: 30/32 = 94%

Year 4: 7/7 = 100%

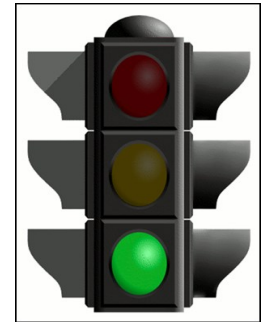
Improvement

Baseline: 9/9 = 100%

Green = 100%

Yellow = 90-99%

Red = 0-89%



Numerator = # of women identified as experiencing domestic violence during the reporting period that are referred for relevant domestic violence services

Denominator = # of women who screened positive for domestic violence

Improvement is: Increase or maintain the proportion of women experiencing domestic violence who are referred to appropriate domestic violence services, comparing current Federal Fiscal Year to prior Federal Fiscal Year

Benchmark Background: Referrals for Domestic Violence Services

[Illinois Department of Human Services - Domestic Violence Victims Services](#)

Domestic violence programs located throughout Illinois provide safety assistance to victims of domestic violence.

Other State Resources:

⇒ [Illinois Coalition Against Domestic Violence](#)

ILCADV provides a variety of local services to survivors of domestic violence and their children including emergency shelter, legal advocacy, counseling, and professional training.

⇒ [Illinois Coalition Against Sexual Assault](#)

ICASA is a state coalition consisting of 33 sexual assault crisis centers and 26 satellite offices. The coalition works to end sexual violence and provide

quality services to victims of sexual assault through counseling, education, and advocacy.

Here's a link to a Futures Without Violence, [Addressing Domestic Violence in Home Visitation Settings webinar](#):



Benchmark 28(4.3): Safety Plan Development

Goal & Rationale

Increase or maintain safety plan development among enrolled women who have been referred to domestic violence services

- ◆ A safety plan for domestic violence victims consists of a list of strategies, resources, and tips which constitute a plan to keep family members safe in the instance of future violence or threats of violence

Measurement Tool

Inquiry regarding the development of a safety plan to mother referred to domestic violence services

Data Collection

1. **Who** is Included: women referred for domestic violence services during reporting period
2. **What** is measured: Development of safety plan in response to occurrence of domestic violence
3. **When** are data collected: During home visit subsequent to positive screening for domestic violence
4. **On a home visit**, inquire regarding the development of a safety plan to mother referred to domestic violence services.

Data Entry: Visit Tracker

- Create a Domestic Violence Safety plan if screened positive on construct 26.
- To do so, from either the PVR Goals section or under the Guardian Goals link on the left, create a "Domestic Violence Safety Plan" Goal.
- Click "Met" to indicate a safety plan was made.

Benchmark Measurement Periods for HRSA/MIECHV

Year 1: Jan 1 2012 - Sept 30 2012

Year 2: Oct 1 2012 - Sept 30 2013

Year 3: Oct 1 2013 - Sept 30 2014

Year 4: Oct 1 2014 - Sept 30 2015

Year 5: Oct 1 2015 - Sept 30 2016

Illinois Outcome Data

Year 1:

Year 2: 2/6 = 33%

Year 3: 9/14 = 64%

Year 4: 7/7 = 100%

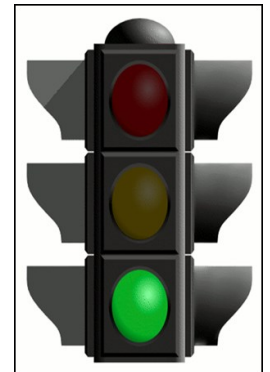
Improvement

Baseline: 6/9 = 67%

Green = 100%

Yellow = 90-99%

Red = 0-89%



Numerator = # of women referred for relevant domestic violence services who develop a safety plan during the reporting period

Denominator = # of women who were referred for relevant domestic violence services during the reporting period

Improvement is: Increase or maintain the proportion of women referred to appropriate domestic violence services who develop a safety plan by comparing current Federal Fiscal Year to prior Federal Fiscal Year

Benchmark Background: Safety Plan Development

⇒ **One in every four women** will experience domestic violence in her lifetime.

[The National Coalition Against Domestic Violence website](#)

has Safety Plans and other resources.

⇒ The domesticviolence.org website has useful tips and information in a [Personalized Safety Plan](#) handbook.

This document includes information on how to stay safe when leaving an abuser, the cycle of violence, and Orders of Protection.

RESOURCES:

⇒ [Illinois Coalition Against Domestic Violence](#)

ILCADV provides a variety of local services to survivors of domestic violence and their children including emergency shelter, legal advocacy, counseling, and professional training.

⇒ [Illinois Coalition Against Sexual Assault](#)

ICASA is a state coalition consisting of 33 sexual assault crisis centers and 26 satellite offices. The coalition works to end sexual violence and provide quality services to victims of sexual assault through counseling, education, and advocacy.

This [Futures Without Violence](#), Addressing Domestic Violence in Home Visitation Settings **webinar** includes information on **safety planning**.



Benchmark 29 (5.1): Household Income and Benefits

Goal & Rationale

Increase household income and benefits from time of one year post-enrollment.

- ◆ Household income influences access to health care, food, quality services, and often indirectly impacts child development.

Measurement Tool

Parents are asked to report their income and benefits, and changes to income or benefits are added to their data file. These changes are checked against date of change for use in this benchmark.

Data Collection

1. **Who** is Included: Families enrolled in program for at least 1 year
2. **What** is measured: Change in family income and benefits over 1st year of enrollment
3. **When** are data collected: During home visit subsequent to 1 year post enrollment
4. **On a home visit**, ask the mother to provide information regarding increases in income and benefits quarterly.

Data Entry: Visit Tracker

- Under "Guardian" click on "Demographics."
- Scroll down to bottom of page to "Family Income History."
- Click on "Add Item" and fill out boxes for Date, Avg. Monthly (average monthly income), #in house (number of household members).
- Use check boxes to indicate "Income Type," clicking on all that apply.
- Note: This information should be entered upon enrollment and then updated quarterly.
- Note: In order to achieve this benchmark, household income and benefits have to have increased.

Benchmark Measurement Periods for HRSA/MIECHV

Year 1: Jan 1 2012 - Sept 30 2012

Year 2: Oct 1 2012 - Sept 30 2013

Year 3: Oct 1 2013 - Sept 30 2014

Year 4: Oct 1 2014 - Sept 30 2015

Year 5: Oct 1 2015 - Sept 30 2016

Illinois Outcome Data

Year 1:

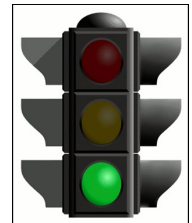
Year 2: 30/274 = 11%

Year 3: 80/204 = 39%

Year 4: 95/170 = 56%

Improvement

Baseline: 0/478 = 0%



Numerator = # of families, whose total household (mother & baby) income and benefits at child's first birthday is greater than it was at the time of enrollment

Denominator = # of families who have participated in the program for one year

Improvement is: An increase from enrollment to one year post-enrollment in total household income and benefits.

Benchmark Background: Household Income and Benefits

National Center for Children in Poverty

- ⇒ Risk factors in relation to child development include poverty, single parent, teen mother, low parental education, unemployed parents, households without English speakers, and large family size.
- ⇒ In Illinois, of 461,000 children under age 3 (2012), 43% live in low income households (below 200% of federal poverty threshold).
- ⇒ In Illinois, of 461,000 children under age 3 (2012), 23% live in poverty-level households (below 100% of federal poverty threshold).
- ⇒ In Illinois, of 461,000 children under age 3 (2012), 11% live in extreme poverty-level households (below 50% of federal poverty threshold).
- ⇒ In Illinois, 40% of children under age 3 experience either 1 or 2 of the risks listed above.
- ⇒ In Illinois, 17% of children under age 3 experience 3 or more of the risks listed above.

RESOURCE:

Illinois WorkNet centers throughout the state assist in finding resources for job searches, career preparation, and work support such as financial aid, child care and more. This is a free service for Illinois residents.



Links to Online Resources (Control + Click)

[Illinois Governor's Office of Early Child Development: MIECHV](#)

The Illinois Governor's Office of Early Childhood Development website has a wealth of information for MIECHV programs including: MIECHV Webinars; Visit Tracker Training Videos; Assessment Tools, Newsletters and other early childhood and home visiting program resources.

[Ounce of Prevention: Home Visiting Programs](#)

[U.S. Dept. of Health & Human Services, Women's Health, Prenatal Care Fact Sheet](#)

[Centers for Disease Control and Prevention \(CDC\): Developmental Monitoring and Screening](#)

[Center for Effective Parenting \(Arkansas\)](#)

[Zero to Three: Behavior and Development](#)

[National Coalition Against Domestic Violence](#)

[National Center for Children in Poverty: State Demographics](#)

[Childhood Trauma Resource](#)

The DCFS SPD searchable online catalog of community-based resources addressing the needs of children and families in Illinois is available at

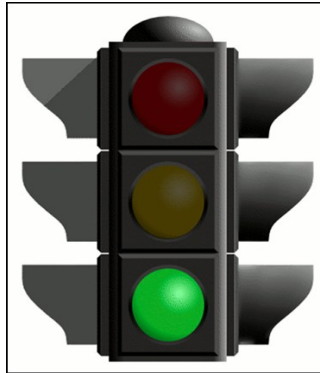
<https://illinoisoutcomes.dcf.illinois.gov/>

Click on **Provider Database**.

Enter your username and password (password is case-sensitive).

If you do not already have a username and password, or if you have an old username and password but have forgotten them, please contact Erik Sandberg at DCFS: Erik.Sandberg@illinois.gov .





Thank you to Great Start Georgia for use of their template to develop this Benchmark Glossary resource for our Illinois MIECHV sites.

Copies of this document are available on the Illinois Governor's Office of Early Childhood website: <http://www.illinois.gov/gov/OECD/Pages/MIECHVP.aspx>. Suggestions for additions and revisions are welcome!

Please direct questions and comments to:

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Updated 11/20/15