

# ILLINOIS MIECHV

## Getting Everyone on the Bus!

### BENCHMARKS:

## Goals, Data, Background and Resources



# **ILLINOIS MIECHV**

## **BENCHMARKS**



### **YEARS 1-3**

- 1. Maternal and Newborn Health (Benchmarks 1-8)**
- 2. Child Injuries; Child Abuse, Neglect or Maltreatment; and Reduction of Emergency Department Visits (Benchmarks 9-15)**
- 3. Improvement in School Readiness and Achievement (Benchmarks 16-18, 20-24)**
- 4. Domestic Violence and Crime (Benchmarks 26-28)**
- 5. Family Economic Self- Sufficiency (Benchmarks 29-30, 32)**
- 6. Coordination and Referrals for Other Community Resources and Supports (Benchmarks 33-37)**

# **ILLINOIS MIECHV**

## **BENCHMARKS**

### **1. Maternal and Newborn Health**



- 1. Prenatal Visit Completion**
- 2. Parental Use of Tobacco, Alcohol and Drugs**
- 3. Post-Partum Use of Contraception**
- 4. Inter-Birth Interval**
- 5. Screening for Maternal Depression**
- 6. Breastfeeding**
- 7. Well-Child Visit Completion**
- 8. Insurance Status for Mother/Child**

# 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%

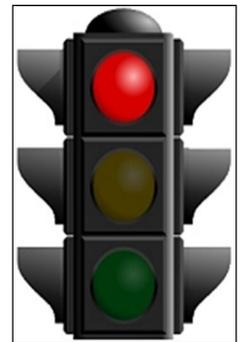
**Improvement**

**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%

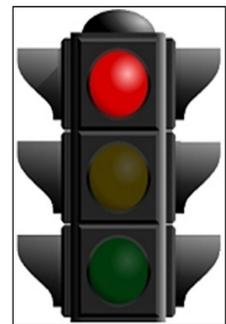
**Baseline:** 0/84 = 0%

**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%

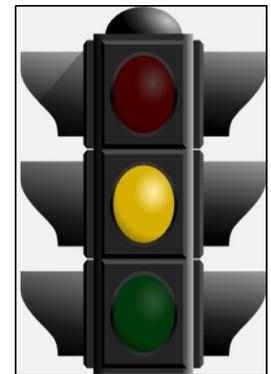
**Improvement**

**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-methods.pdf>

## 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%

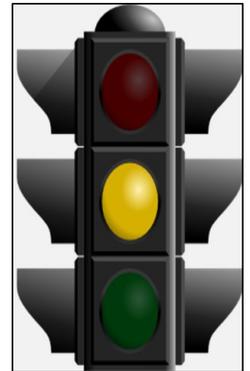
**Improvement**

**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%

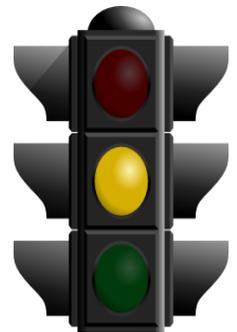
**Same**

**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 3<sup>rd</sup> 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 6(1.6): Breastfeeding

### Goal & Rationale

Increase the proportion of infants born to enrolled mothers who were breastfed for their first 6 months.

- ◆ Breastfeeding offers many benefits to both mother and baby and is viewed as the most highly effective preventive measure a mother can take to protect the health of her infant.

### Measurement Tool

Based on parent self-report or WIC records on when the mother starts and stops breast feeding relative to the child's birth

### Data Collection

1. **Who** is included: Infants born during reporting period
2. **What** is measured: infants breastfed (including with pumped milk) during first 6 months
3. **When** are data collected: During each home visit until 6 months postpartum
4. **On each home visit during first 6 months postnatal**, until the mother's answer is "weaned" or "never," note if the child is being breastfed.

### Data Entry: (Visit Tracker)

- Go to Child page; click Health Info tab; found under Breastfeeding Survey
- Click "Add Breastfeeding Item"
- Fill in date and if breastfeeding is: "Ongoing"; "Never"; "Weaned"
- Add "Total Weeks Breastfed"
- Note: To achieve this benchmark, mother must breastfeed for 6 months.
- Note: This information can also be entered in the PVR—Breastfeeding Survey

### 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:** 39/142 = 27%

**Year 3:** 20/97 = 21%

**Year 4:** 37/112 = 33%

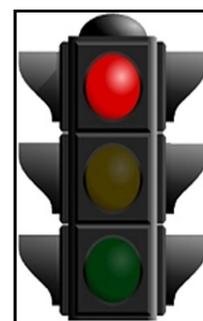
**Improvement**

**Baseline:** 34/106 = 32%

Green = 60-100%

Yellow = 50-59%

Red = 0-49%



**Numerator** = # of infants in cohort who were born during the reporting period who were breastfed for their first 6 months

**Denominator** = # of infants in cohort who were born during the reporting period

**Improvement is:** An increase in the proportion of women who breastfeed their infants for at least six months by comparing current Federal Fiscal Year to prior Federal Fiscal Year

# Benchmark Background: Breastfeeding

- ⇒ Human milk is the **ideal food for most infants**. Breastfeeding benefits infants and their mothers. Breastfed infants receive antibodies from breast milk, which protect against infection in the early postpartum period, and breastfeeding is less expensive than formula feeding. (National Center for Health Statistics, 2008).
- ⇒ Breastfeeding provides antibodies to the baby protecting against diarrhea and pneumonia, which are two of the leading causes of infant mortality.
- ⇒ In addition, breastfeeding has historically been seen to reduce the incidence of bacterial meningitis, bacteremia, death of intestinal tissues, middle ear infections, leukemia, lymphoma, late onset sepsis and sudden infant death syndrome.
- ⇒ Recent research has shown that breastfeeding also contributes to a modest reduction in the risk for overweight and obese adolescents.
- ⇒ According to a 1999 study, "If 90% of families could comply with the medical recommendations to breastfeed exclusively for six months, the United States could save \$13 billion/year and prevent an excess of 91 deaths annually."
- ⇒ Research also points to differences in managed care health costs among children, as children who were never breastfed cost between \$331 - \$475 more in their first year of life.
- ⇒ Additionally, total WIC feeding for exclusive formula costs \$80,085,869 compared with partial breastfeeding costs of \$10,953,651 (**Ohio Dept. of Health, 2012**).

## Breastfeeding Resources:

Refer to lactation consultants, La Leche League groups, and WIC breastfeeding peer counselors to provide information, support and encouragement to breastfeeding moms.



# Benchmark 7(1.7): Well-Child Visit Completion

## Goal & Rationale

Increase the proportion of enrolled children who obtained at least 5 well child visits by 15 months of age.

- As traditional childhood diseases become less prevalent, guidelines have become more focused on encouraging pediatricians to also address the parent/child relationship and other psychosocial aspects of development.

## Measurement Tool

Parent self-report on date of each well-child/baby visit.

## Data Collection

1. **Who** is included: Enrolled children who reached 15 months of age during the reporting period
2. **What** is measured: Well-child visit completion obtained by mother's self report
3. **When** are data collected: During each home visit until 15 months of age
4. **On each home visit**, ask the mother if the child has had a well-child visit with a healthcare provider since the previous home visit.

## Data Entry (Visit Tracker)

- Go to Child Page; click on Health Info tab; find Child Medical Visits
- Click "Add Child Medical Visits Item"
- Enter Date, Type, and Reason (which must be "Well Child")
- Note: To achieve this benchmark, child must have completed at least 5 Well Child Visits by 15 months of age, and have been enrolled in program for 15 months.

## 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:** 2/44=5%

**Year 2:** 9/16=56%

**Year 3:** 82/98 = 84%

**Year 4:** 58/62 = 94%

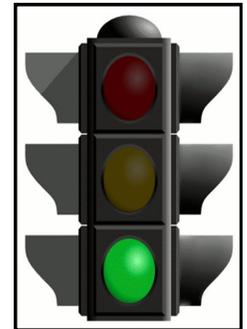
**Improvement**

**Baseline:** 43/55 = 78%

Green = 75-100%

Yellow = 65-74%

Red = 0-64%



**Numerator** = # of enrolled children who obtained at least 5 well-child visits by 15 months of age

**Denominator** = # of children in the program who reached 15 months of age during the reporting period

**Improvement is:** An increase in the proportion of children who obtain at least five well-child visits before reaching age 15 months by comparing current Federal Fiscal Year to prior Federal Fiscal Year

# Benchmark Background: Well-Child Visit Completion

Well-child visits have been shown to significantly increase the number of immunized children and decrease outpatient and emergency department sick visits.

**ROUTINE WELL-CHILD VISIT SCHEDULE** (recommended by the American Academy of Pediatrics)

A visit with a pediatrician *before* the baby is born is important for first-time parents, those with high-risk pregnancies, and any other parent who wishes to discuss common issues such as feeding, circumcision, and general questions.

After the baby is born, the next visit should be 2-3 days after bringing the baby home (for breast-fed babies) or when the baby is 2-4 days old (for all babies discharged from a hospital before 2 days old).

Thereafter, visits should occur at the following points:

- By 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, annually after until age 21

Of course, visits and phone calls to a health care provider should be made any time a baby or child seems ill or whenever the parent is concerned about a baby's health or development

⇒ There is a net saving of \$80.75 per case prevented among infants immunized just against the rotavirus ([Ohio Dept. of Health, 2012](#)).

⇒ Children of mothers who delay prenatal care are at high risk for not receiving adequate numbers of [Well Child Visits](#). Recognition of this marker can allow for targeted interventions to ensure children receive preventive care (Pediatrics, 1999).

## RESOURCES:

You can help parents prepare for upcoming well-child visits by providing information on what to expect at the visit, based on the child's age.

- **The Palo Alto Medical Foundation Sutter Health** website at <http://www.pamf.org/prepare/children.html> has a series of Well-Child Visit Handouts by age group for newborns through age 5. These handouts provide basic information on what is covered at each visit plus information on immunizations, nutrition, typical development, sleep and safety.

• **Centers for Disease Control and Prevention: [Developmental Monitoring and Screening](#)**. Screening should not be just regarded as a point-in-time test, but as an ongoing process, and a key preventive service that parents can expect and anticipate as regularly as immunizations and well-child exams.



# 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%

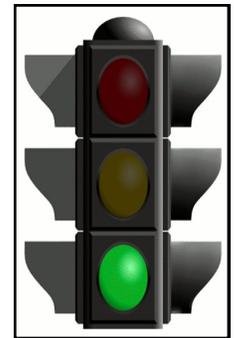
**Improvement**

**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](http://www.HealthCare.gov)

(Spanish: [cuidadodesalud.gov](http://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.



# ILLINOIS MIECHV

## BENCHMARKS

### 2. Child Injuries; Child Abuse, Neglect or Maltreatment; and Reduction of Emergency Department Visits



9. All Cause Child Visits to Emergency Department
10. All Cause Mother Visits to Emergency Department
11. Dissemination of Safety Information
12. Children with Injuries Requiring Medical Treatment
13. Suspected Child Maltreatment Reports
14. Substantiated Child Maltreatment Reports
15. First Time Substantiated Child Maltreatment Reports

# Benchmark 9(2.1): All Cause Child Visits to Emergency Department

## Goal & Rationale

Decrease the proportion of enrolled children who visited the hospital Emergency Room (ER) for any type of care.

- ◆ Studies indicate that low-income persons without a primary care physician are more likely to utilize the emergency department for non-emergency care.

## Measurement Tool

Parents are asked about child's emergency room visits

## Data Collection

1. **Who** is included: Children who are at least 1 year post enrollment (or 1st birthday)
2. **What** is measured: Child's Emergency Room visits
3. **When** are data collected: During each home visit
4. **On each home visit**, ask the mother if the child has visited the Emergency Room since the last home visit.

## Data Entry: Visit Tracker

- Go to **child** data
- Click health info
- In the Visit Note next to the child's name see "medical provider visit" item; click "add"
- Identify the date of the visit
- Identify the type of visit as ER/urgent
- Identify the reason
- Add comments for specificity

## 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:** 32/278 = 12%

**Year 3:** 45/212 = 21%

**Year 4:** 34/180 = 19%

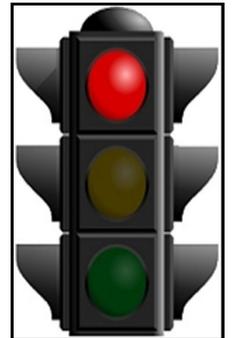
**Improvement**

**Baseline:** 42/244 = 17%

Green =

Yellow =

Red =



**Numerator** = # of participating children who are at least 1 year post enrollment who visited the Emergency Room during the reporting period for care (as determined by diagnosis and procedure codes)

**Denominator** = # of children who are at least 1 year post enrollment (or have reached 1st birthday)

**Improvement is:** A decrease in the proportion of children enrolled in home visiting for at least 12 months attending ER visits comparing the current Federal Fiscal Year to the prior Federal Fiscal Year

## Benchmark Background:

# All Cause Child Visits to Emergency Department

- ⇒ Difficulties in accessing primary health care (setting appointments, longer waiting periods, and short business hours at the primary health care service) are associated with inappropriate ER use.
- ⇒ Decreased unnecessary ER visits may indicate better access to primary health care services and increased confidence of mothers in utilizing those services.
- ⇒ In addition to health ailments, children are often brought to the emergency room either because of abuse, neglect or because the parent is unsure how to access proper care for simple health ailments.
- ⇒ In 2009, 21,444 ER visits across the U.S. were made for those under the age of four. 54.7% were paid by private insurance, 15.8% were paid by Medicaid or Medicare. Per person, this costs \$1,320. ([Ohio Dept. of Health, 2012](#))

Offering resources in a primary care setting to patients who are most likely to use the ED can also reduce the likelihood of an unnecessary ED visit. The [Wisconsin Collaborative for Healthcare Quality](#), which leads the AF4Q effort in Wisconsin, supports an ED Care Coordination Initiative that refers patients in a defined population—those with Medicaid or without health insurance and who are pregnant, are frequent ED users, or have at least one common chronic condition—to a medical home. Case managers at local EDs identify patients in the target population, provide them with educational materials and schedule primary care appointments. Although the program defines clear processes, it allows flexibility across hospitals and provider groups based on internal strategies and cultures. By starting with small interventions targeted to a well-defined population and expanding and adapting as the program progresses, unnecessary visits to local EDs are declining.



# Benchmark 10(2.2): All Cause Mother Visits to Emergency Department

## Goal & Rationale

Decrease the proportion of enrolled mothers who visited the hospital Emergency Room (ER) for any type of care.

- ◆ Studies indicate that low-income persons without a primary care physician are more likely to utilize the emergency department for non-emergency care.

## Measurement Tool

Parents are asked about number of emergency room visits for nonemergency reasons (i.e. cold, flu, etc.)

## Data Collection

1. **Who** is included: Women who are at least 1 year post enrollment (or first birthday)
2. **What** is measured: All visits of mother to Emergency Room
3. **When** are data collected: During each home visit
4. **On each home visit**, ask the mother if she has visited the Emergency Room since the last home visit

## Data Entry: Visit Tracker

- Go to Guardian page; click on Health Info tab; find Guardian Medical Visits, click on "Add Guardian Medical Visits Item" tab
- Enter date or approximate date
- From "Type" drop-down list, choose "ER/urgent"
- From "Reason" drop-down list, choose appropriate reason for visit

## 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:** 22/274 = 8%

**Year 3:** 18/204 = 9%

**Year 4:** 14/170 = 8%

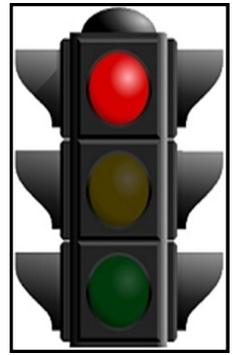
**Improvement**

**Baseline:** 25/236 = 11%

Green =

Yellow =

Red =



**Numerator** = # of mothers who are at least 1 year post enrollment who visited the Emergency Room during the reporting period for care (as determined by diagnosis and procedure codes)

**Denominator** = total # of women who are at least 1 year post enrollment (or first birthday)

**Improvement is:** A decrease in the proportion of mothers enrolled in home visiting for 12 months attending ER visits comparing the current Federal Fiscal Year to the prior Federal Fiscal Year

# Benchmark Background:

## All Cause Mother Visits to Emergency Department

- ⇒ Difficulties in accessing primary health care (setting appointments, longer waiting periods, and short business hours at the primary health care service) are associated with inappropriate ER use.
- ⇒ Decreased unnecessary ER visits may indicate better access to primary health care services and increased confidence of mothers in utilizing those services.

### Benefits of a Medical Home

1. Your **Patient Centered Medical Home** (PC-MH) knows you individually and your medical history each time you visit once your care has started there. You have developed a sense of trust with your PC-MH due to an atmosphere of caring and mutual respect.
2. The medical records at your PC-MH are well organized and used to schedule routine visits needed to meet preventive care guidelines; this is particularly important for children and parents to assure necessary preventive visits and immunizations are given.
3. Your PC-MH medical record includes all information from referral visits or services that you get outside the Medical Home so it has the most complete, up-to-date picture of your child's health possible.
4. Your PC-MH assures your comprehensive service needs are met. They do this by coordinating care with any specialists (an allergist, for example) outside the Medical Home. They also guide you to specialists or services outside the Medical Home to make certain all your medical needs are met.
5. Your PC-MH has set up ways for you to make contacts after regular office hours on a 24 hour/seven days a week basis. This may be done with an answering service, paging service, 24 hour nursesline, or other way to help you know how to handle after hours situations that may or may not require immediate attention.
6. For chronic illness or a special needs child, your PC-MH sets up a plan of care to address ongoing health issues. Your PC-MH's ability to help coordinate and assure comprehensive service needs are met is very important for special needs children who require them. High value PC-MH's will make arrangements to have your special needs child care plan available for immediate access electronically for when you travel or access health records electronically when your child must see other specialists.
7. Your PC-MH treats the whole person and helps assess whether any behavior or emotional issue that concerns you or your child requires special services such as counseling or therapy and refers you, if needed.
8. Your PC-MH helps maintain good health by discussing and checking your health risks related to lifestyle issues. They may have special staff to discuss or provide you with information on many healthy life style topics such as a smoking cessation, special diets, weight loss, and proper car seat use for your young children, etc.



# 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%

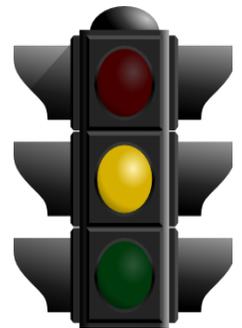
**Improvement**

**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 12(2.4): Children with Injuries Requiring Medical Treatment

## Goal & Rationale

Decrease the proportion of enrolled children with injuries that require medical treatment.

- ◆ Preventable childhood injuries are a major cause of death and disability for young children. Increased supervision and simple safety precautions can greatly decrease the likelihood of such injuries.

## Measurement Tool

Parents are asked about incident and date of injury that required medical treatment, but did not require going to the emergency room. These are then counted.

## Data Collection

1. **Who** is included: Children 12 months post enrollment during reporting period
2. **What** is measured: Children having had injuries that required medical treatment
3. **When** are data collected: During each home visit
4. **On each home visit**, ask the mother if the child has had any injuries that required medical treatment since the last home visit.

## Data Entry: Visit Tracker

- Enter the approx. date and reason on the PVR or on child health information screen.
- **Note:** All medical visits with "injury" notes as the reason will count here.

## 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:** 7/274 = 3%

**Year 3:** 11/204 = 5%

**Year 4:** 3/176 = 2%

**Improvement**

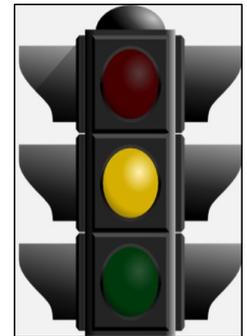
**Baseline:**

9/237 = 4%

Green =

Yellow =

Red =



**Numerator** = # of participating children at least 12 months post enrollment who had injuries requiring medical treatment (based on diagnosis or procedure code) during the reporting period

**Denominator** = # of children participating in home visiting during the reporting period who are at least 12 months post enrollment

**Improvement is:** A reduction in the proportion of children enrolled in home visiting for at least 12 months who receive injuries requiring medical treatment comparing current Federal Fiscal Year to prior Federal Fiscal Year

# Benchmark Background:

## Children with Injuries Requiring Medical Treatment

### Center for Effective Parenting:

- ⇒ Accidental injuries are a leading cause of hospitalization and death for young children. Because many childhood injuries happen in or around the home, it is the parents who must assume responsibility for making the home a safe place.
- ⇒ Injury prevention, like parenting, is an ongoing process. Sometimes, it seems, the job is never done. Parents must constantly be on the lookout for potential dangers in and around the home.
- ⇒ Children are at risk for injury from the moment they are born. Therefore, injury prevention strategies must be implemented even before newborns come home from the hospital. As children grow, they become more mobile. With this mobility comes a greater risk for injury. The more ground children can cover, the more potential dangers they will come into contact with. It is especially important, therefore, for the parents of children who can crawl, toddle, walk, and run to pay close attention to injury prevention.

### Infant Suffocation:

- ⇒ Most injury-related deaths in infants (66 percent) are the result of suffocation. Today, most suffocation deaths occur because infants are placed in sleeping environments that do not meet guidelines for infant safety. A 17-year review of infant suffocation deaths found that the leading causes of suffocation are wedging (between the mattress and wall or bed frame), oronasal obstruction by bedding or a soft sleeping surface, overlaying by another person, head entrapment in a space through which the body had passed, and hanging (e.g., by caught clothing). A descriptive study of infants who died suddenly and unexpectedly found that most infants were found in unsafe sleeping positions (e.g., prone position, head or face covered by soft bedding) or in environments not specifically designed for infants (e.g., adult beds, couches, cushioned chairs, co-sleeping with one or more persons). Both studies concluded that safe sleeping practices may prevent many infant deaths. The American Academy of Pediatrics (AAP) recently stressed the importance of safe sleeping practices in its updated policy on reducing the risk of sudden infant death syndrome (SIDS).



# Benchmark 13(2.5): Suspected Child Maltreatment Reports

## Goal

Decrease the proportion of enrolled families who have reports to DCFS regarding their suspected maltreatment (child abuse/neglect).

## Measurement Tool

DCFS Reports

## Data Collection

1. **Who** is included: Families 12 months post enrollment during reporting period
2. **What** is measured: Suspected child abuse or neglect
3. **When** are data collected: DCFS reports are used for this benchmark
4. **During Home Visits:** No questions are asked by home visitors for this benchmark since reporting comes directly from DFCS on number of reports made for enrolled families. Of course, if the home visitor sees or suspects abuse in the home, she/he should report it to DFCS according to agency/program protocol.

## Data Entry (DCFS)

- N/A. This data will be collected from DCFS.

## 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:** 28/252 = 11%

**Year 3:** 13/204 = 6%

**Year 4:** 18/174 = 10%

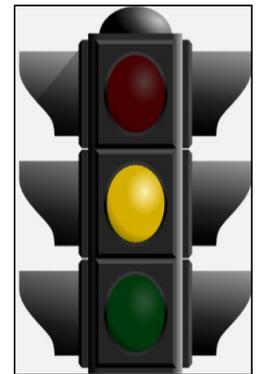
**Baseline:** 9/237 = 4%

**No Improvement**

Green =

Yellow =

Red =



**Numerator** = # of families participating in home visiting who were reported for suspected maltreatment during the reporting period

**Denominator** = # of families participating in home visiting during the reporting period who are at least 12 months post enrollment

**Improvement is:** A decrease in the proportion of families enrolled in home visiting for at least 12 months who were reported for suspected maltreatment comparing current Federal Fiscal Year to prior Federal Fiscal Year

# Benchmark Background: Suspected Child Maltreatment Reports

## Illinois Department of Children & Family Services:

- ⇒ The Department of Children and Family Services is best known for its child protection services. The goal of the Department's child protection program is outlined in the state's Child Abuse and Neglect Reporting Act:
- ⇒ The Department of Children and Family Services shall, upon receiving reports made under this Act, protect the best interest of the child, offer protective services in order to prevent any further harm to the child and to other children in the family, stabilize the home environment and preserve family life whenever possible."
- ⇒ Child abuse is the mistreatment of a child under the age of 18 by a parent, caretaker, someone living in their home or someone who works with or around children. The mistreatment must cause injury or put the child at risk of physical injury. Child abuse can be physical (such as burns or broken bones), sexual (such as fondling or incest), or emotional. Neglect happens when a parent or responsible caretaker fails to provide adequate supervision, food, clothing, shelter or other basics for a child.
- ⇒ Anyone may report suspected child abuse or neglect to the **Child Abuse Hotline** (800) 25-ABUSE (1-800-252-2873). State law mandates that workers in certain professions, including home visiting, must make reports if they have reasonable cause to suspect abuse or neglect. A majority of reports are initiated by calls from mandated reporters.
- ⇒ Online Mandated Reporter training is available on the DCFS website: <https://mr.dcfstraining.org/UserAuth/Login!loginPage.action>
- ⇒ Childhood trauma resources for families and professionals: <http://lookthroughtheireyes.org/>



## Benchmark 14(2.6): Substantiated Child Maltreatment Reports

### Goal

Decrease the proportion of enrolled children who have substantiated ("indicated") DCFS reports of maltreatment (child abuse/neglect).

### Measurement Tool

DCFS Reports

### 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

### Data Collection

1. **Who** is included: Children 12 months post enrollment
2. **What** is measured: indicated (substantiated) allegations of child abuse
3. **When** are data collected: DCFS reports are used for this benchmark
4. **During Home Visits:** No questions are asked by home visitors for this benchmark since reporting comes directly from DCFS on number of reports made for enrolled families. Of course, if the home visitor sees or suspects abuse in the home, she/he should report it to DCFS according to agency/program protocol.

### Data Entry (DCFS):

- N/A. This data will be collected from DCFS.

### Illinois Outcome Data

**Year 1:**

**Year 2:** 10/252 = 4%

**Year 3:** 3/204 = 1%

**Year 4:** 9/174 = 5%

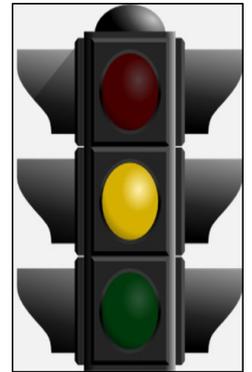
**No Improvement**

**Baseline:** 4/237 = 2%

Green =

Yellow =

Red =



**Numerator** = # of children participating in home visiting who were found to be maltreated (allegations that were "indicated") within 12 months post enrollment

**Denominator** = # of children participating in home visiting during the reporting period who are at least 12 months post enrollment

**Improvement is:** A decrease in the proportion of participating children enrolled in home visiting for at least 12 months who are maltreated, comparing current Federal Fiscal Year to prior Federal Fiscal year

# Benchmark Background: Substantiated Child Maltreatment Reports

A Substantiated or "Indicated Report" means any report of child abuse or neglect made to the Department of Children and Family Services for which it is determined, after an investigation, that credible evidence of the alleged abuse or neglect exists.

## RESOURCES:

⇒ These tip sheets (available in Spanish and English) from *Preventing Child Maltreatment and Promoting Well-Being: A Network for Action 2013 Resource Guide* (Administration for Children and Families, U.S. Department of Health and Human Services) are designed for parents and caregivers to address a particular parenting concern or question. The information is easy to read and focuses on concrete strategies parents and caregivers can use to take care of their children and strengthen their families.

[Keeping Your Family Strong](#)

[Bonding With Your Baby](#)

[Dealing With Temper Tantrums](#)

[Teen Parents ... You're Not Alone!](#)

[Ten Ways to Be a Better Dad](#)

[Raising Your Grandchildren](#)

[Military Families](#)

[Parenting Your Child With Developmental Delays and Disabilities](#)

[Managing Stress](#)

[Helping Your Child Heal From Trauma](#)

⇒ Childhood trauma resources for families and professionals: <http://lookthroughtheireyes.org/>



## Benchmark 15(2.7): First Time Substantiated Child Maltreatment Reports

### Goal

Decrease the proportion of enrolled children who are the first time substantiated victims of maltreatment (child abuse/neglect).

### Measurement Tool

DCFS Reports

### Data Collection

1. **Who** is included: Children 12 months post enrollment
2. **What** is measured: First time indicated (substantiated) allegations of child abuse
3. **When** are data collected: DCFS reports are used for this benchmark
4. **During Home Visits:** No questions are asked by home visitors for this benchmark since reporting comes directly from DFCS on number of reports made for enrolled families. Of course, if the home visitor sees or suspects abuse in the home, she/he should report it to DFCS according to agency/program protocol.

### Data Entry (DCFS):

- N/A. This data will be collected from DCFS.

### 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:** 9/252=4%

**Year 3:** 0/204 = 0%

**Year 4:** 4/174 = 2%

**No Improvement**

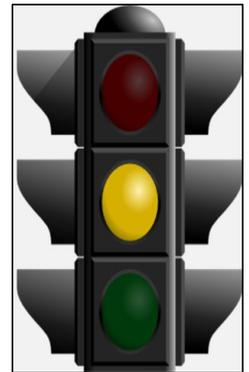
**Baseline:**

1/237 = 0%

Green =

Yellow =

Red =



**Numerator** = # of children participating in home visiting who were found for the first time to have been maltreated within 12 months post enrollment

**Denominator** = # of children participating in home visiting during the reporting period who are at least 12 months post enrollment

**Improvement is:** A decrease in the proportion of children participating in home visiting for at least one year who are first time victims of maltreatment by comparing current Federal Fiscal Year to prior Federal Fiscal Year

# Benchmark Background:

## First Time Substantiated Child Maltreatment Reports

A Substantiated or "Indicated Report" means any report of child abuse or neglect made to the Department of Children and Family Services for which it is determined, after an investigation, that credible evidence of the alleged abuse or neglect exists.

### RESOURCES:

- ⇒ These tip sheets (available in Spanish and English) from *Preventing Child Maltreatment and Promoting Well-Being: A Network for Action 2013 Resource Guide* (Administration for Children and Families, U.S. Department of Health and Human Services) are designed for parents and caregivers to address a particular parenting concern or question. The information is easy to read and focuses on concrete strategies parents and caregivers can use to take care of their children and strengthen their families.

[Keeping Your Family Strong](#)

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- ⇒ Childhood trauma resources for families and professionals: <http://lookthroughtheireyes.org/>



# ILLINOIS MIECHV

## BENCHMARKS

### 3. Improvement in School Readiness and Achievement



16. Level of Support for Child's Learning and Development
17. Knowledge of Child's Development and Developmental Progress
18. Parent Child Relationship
19. (not used)
20. Level of Emotional Well-Being
21. Screening for Developmentally Appropriate Communication Skills
22. Screening for Child's General Cognitive Delays
23. Screening for Self-Regulation
24. Screening for Social-Emotional Delays

## Benchmark 16(3.1): Level of Support for Child's Learning and Development

### Goal & Rationale

Increase the proportion of enrolled parents who obtain a "normal" score on the HOME (Home Observation for Measurement of the Environment) assessment.

- ◆ Children's later success in life is linked with how parents interact with them.
- ◆ Safe and nurturing relationships are critical for children's secure attachment and development.

### Measurement Tool

HOME

### Data Collection is done by U of I Field

#### Data Collectors for this benchmark

1. **Who** is included: All enrolled MIECHV participants
2. **What** is measured: parents' level of support for their child's learning and development
3. **When** are data collected: During a home visit scheduled with a Field Data Collector, assessment is completed within the first few weeks of enrollment and again at one-year and two-years post enrollment.
4. **During a home visit**, the HOME assessment is administered by the Field Data Collector, with the home visitor present.

### Data Entry

**No data entry required for this benchmark.** This information is not recorded in Visit Tracker at this time.

**Note:** While this benchmark looks at parents enrolled for 12 or more months, baseline data is collected using the HOME assessment on all newly enrolled MIECHV participants.

### 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:** 16/274=6%

**Year 3:** 75/204 = 37%

**Year 4:** 108/134 = 81%

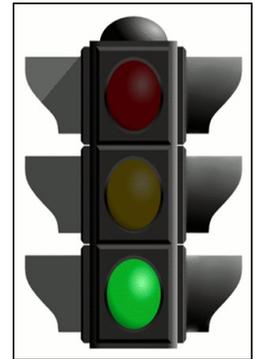
**Improvement**

**Baseline:** 48/237 = 20%

Green =

Yellow =

Red =



**Numerator** = # of parents who obtain a "normal" score on the HOME at 12 months post enrollment

**Denominator** = total # of parents enrolled for 12 or more months

**Improvement is:** An increase in parent support for children's learning and development by comparing current Federal Fiscal Year to prior Federal Fiscal Year

# Benchmark Background:

## Level of Support for Child's Learning and Development

During the early years, home and family constitute the most important environment that exists for most children.

⇒ The Infant-Toddler HOME (**H**ome **O**bservation for **M**easurement of the **E**nvironment) assessment consists of 45 items and covers six main domains:

1. **Responsivity:** the extent to which the parent responds to the child's behavior (offering verbal, tactile and emotional reinforcement for desired behavior and communicating feely through words and actions).;
2. **Acceptance of the Child:** parental acceptance of less than optimal behavior and avoidance of restriction and punishment;
3. **Organization of the Environment:** including regularity and predictability of the environment;
4. **Learning Materials:** provides appropriate play and learning materials;
5. **Parental Involvement:** extent of parental involvement with the child; and
6. **Variety in Experience:** variety in daily stimulation.

This assessment is designed to be done in the child's home as a measure of the child's home and family environment. Field Data Collectors make observations during the home visit while the child is engaged in typical everyday activities, and also conduct an interview with the mother (or guardian) to complete this assessment. Eighteen items on the HOME are based strictly on observation by the Field Data Collector, 15 on interview questions, and 12 on either observation or interview.



## Benchmark 17(3.2): Knowledge of Child's Development and Developmental Progress

### Goal & Rationale

Increase the proportion of enrolled parents who obtain a "normal" score on the KIDI (Knowledge of Infant Development Inventory).

- ◆ When parents understand their child's development they can create reasonable expectations for behavior, and begin to identify which behaviors are normal, when they may need to provide guidance, and when to access early intervention services.

### Measurement Tool

KIDI

### Data Collection is done by U of I Field Data Collectors for this benchmark

1. **Who** is included: All enrolled MIECHV participants
2. **What** is measured: parents' knowledge of child development
3. **When** are data collected: During a home visit scheduled with a Field Data Collector, the KIDI assessment is completed within the first few weeks of enrollment and again at one-year and two -years post enrollment.
4. **During a home visit**, the KIDI assessment is administered by the Field Data Collector, with the home visitor present.

### Data Entry

**No data entry required for this benchmark.** This information is not recorded in Visit Tracker at this time.

**Note:** While this benchmark looks at parents enrolled for 12 or more months, baseline data is collected using the KIDI assessment on all newly enrolled MIECHV participants.

### 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:** 16/181=9%

**Year 3:** 29/148 = 20%

**Year 4:** 44/139 = 32%

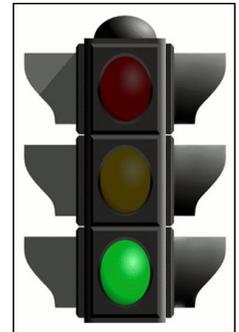
**Improvement**

**Baseline:** 36/163 = 22%

Green =

Yellow =

Red =



**Numerator** = # of parents active in the program who obtain a "normal" score on the KIDI for each observation at 12 months post enrollment

**Denominator** = # of parents active in the program to whom the KIDI was administered for each observation at 12 months post enrollment

**Improvement is:** An increase in parent's knowledge of child development and of their child's developmental progress by comparing scores from current Federal Fiscal Year to prior Federal Fiscal Year

# Benchmark Background:

## Knowledge of Child's Development and Developmental Progress

- ⇒ The **Knowledge of Infant Development Inventory (KIDI)** assesses parents' factual knowledge of parental practices, child developmental processes, and infant norms of behavior. The KIDI is designed to be easily accessible to persons with limited education and to be culturally neutral. This assessment can help home visitors gauge what their participants understand about typical child development, basic safety practices and parenting strategies.
- ⇒ The KIDI was originally developed for research into factors contributing to parents' child-rearing practices, and for evaluating parent education programs.
- ⇒ Participants respond to a series of fifty-eight items on a paper and pencil survey, asking them to agree or disagree with each statement. Starting at item #40, they are asked if they agree, disagree, or if the statement describes an older or younger child.
- ⇒ Research supports the idea that parents' knowledge of child development influences their parental practices, for better or worse. Inadequate and/or distorted information regarding child rearing is associated with practices that hinder normal, positive development and promote negative emotional, cognitive, and social patterns.



## Benchmark 18(3.3): Parent Child Relationship

### Goal & Rationale

Increase the proportion of enrolled parents who obtain a “normal” score on the PICCOLO (Parenting Interactions with Children: Checklist of Observations Linked to Outcomes) assessment.

- ◆ Parents' behavior during a child's early years affects the child's development of social and cognitive abilities.

### Measurement Tool

PICCOLO

### Data Collection is done by U of I Field

### Data Collectors for this benchmark

1. **Who** is included: All enrolled MIECHV participants
2. **What** is measured: parent-child relationship
3. **When** are data collected: During a home visit scheduled with a Field Data Collector, the PICCOLO video assessment is completed within the first few weeks of enrollment (or when the child is three months old) and again at one-year and two-years post enrollment.
4. **During a home visit**, the PICCOLO (video taped) assessment is administered by the Field Data Collector, with the home visitor present.

### Data Entry

**No data entry required for this benchmark.** This information is not recorded on Visit Tracker at this time.

**Note:** While this benchmark looks at parents enrolled for 12 or more months, baseline data is collected using the PICCOLO assessment on all newly enrolled MIECHV participants.

### 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:** 31/181=17%

**Year 3:** 45/119 = 38%

**Year 4:** 61/119 = 51%

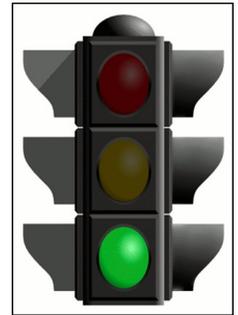
**Improvement**

**Baseline:** 83/141 = 59%

Green =

Yellow =

Red =



**Numerator** = # of parents active in the program who score in the “normal range” range on each administration of PICCOLO at 12 months post enrollment

**Denominator** = total # of parents to whom the PICCOLO was administered at 12 months post enrollment

**Improvement is:** An improvement in parent-child interaction comparing scores from current Federal Fiscal Year to prior Federal Fiscal Year

# Benchmark Background: Parent Child Relationship

- ⇒ A positive parenting attitude, appropriate parent- child expectations, demonstrating sensitivity to infant cues, and providing age-appropriate play material are all important indicators of effective parenting and evidence of infant health promotion.
- ⇒ PICCOLO (Parent Interaction with Children: Checklist of Observations Linked to Outcomes) data provides unique opportunities to assist home visitors to work with participants to improve parent-child interactions.
- ⇒ The PICCOLO includes 29 items designed to measure positive parenting behaviors as parents interact with their infants, toddlers and young children. It assesses four domains: **affection** (closeness, warmth, positive expressions toward child); **responsiveness** (responds to child's actions, emotions, and words); **encouragement** (active engagement and support of child's activities and initiatives); and **teaching**.
- ⇒ The PICCOLO helps us observe a wide range of parenting behaviors that help children develop over time—an approach known as *developmental parenting*.
- ⇒ For this assessment, the Field Data Collectors video record a ten-minute causal, unscripted parent-child interaction activity. Videos are returned to CPRD for review, scoring and analysis.
- ⇒ For more information on Developmental Parenting, see article by Lori Roggman and Mark Innocenti "[Effective Strategies to Engage Parents in Supporting their Child's Development.](#)"



## Benchmark 20(3.4): Level of Emotional Well-Being

### Goal & Rationale

Increase the proportion of enrolled parents who obtain a “normal” score on the Parenting Stress Index (PSI).

- ◆ High parental stress levels have implications for children's trajectory of physical and emotional growth.
- ◆ Chronic parental stress can negatively affect the quality of parents' response to their child, as well as negatively affect parent-child reciprocal interaction.

### Measurement Tool

PSI

### Data Collection is done by U of I Field Data Collectors for this benchmark

1. **Who** is included: All enrolled MIECHV participants
2. **What** is measured: parenting stress
3. **When** are data collected: During a home visit scheduled with a Field Data Collector, the PSI survey is completed within the first few weeks of enrollment and again at one-year and two-years post enrollment.
4. **During a home visit**, the PSI survey is administered by the Field Data Collector, with the home visitor present.

### Data Entry

**No data entry required for this benchmark.** This information is not recorded in Visit Tracker at this time.

**Note:** While this benchmark looks at parents enrolled for 12 or more months, baseline data is collected using the PSI survey on all newly enrolled MIECHV participants.

### 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:** 30/139 = 22%

**Year 3:** 120/122 = 98%

**Year 4:** 133/133 = 100%

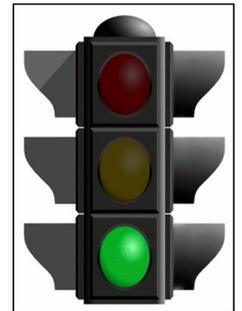
**Improvement**

**Baseline:** 126/143 = 88%

Green =

Yellow =

Red =



**Numerator** = # of parents obtaining a score in the “normal” range on the PSI for each observation at 12 months post enrollment

**Denominator** = total # of parents at 12 months post enrollment for whom the PSI was administered for each observation

**Improvement is:** A decrease in the level of parental stress by comparing PSI scores from current Federal Fiscal Year to prior Federal Fiscal Year

## Benchmark Background: Level of Emotional Well-Being

- ⇒ Parenting stress is associated with maladaptive child rearing as well as disruptive behavioral problems. Increased parental stress can be a risk factor for child maltreatment.
- ⇒ The Parent Stress Index (PSI 4) Short Form is designed to evaluate the magnitude of stress in the parent-child system. Thirty-six items are divided into three domains: Parental Distress (emotional distress in the parenting role); Parent-Child Dysfunctional Interaction (problematic parent-child interactions); and Difficult Child (problematic child behavior or demands); when combined these subscales form a Total Stress scale.
- ⇒ The PSI helps identify the sources and different types of stress that every parent can experience. We know that young children, even infants, pick up on the stress their parents feel and when that stress interrupts their ability to parent in a nurturing way, it can have lasting emotional effects on their child.
- ⇒ “The mothers experiencing a high level of stress were significantly more likely to be younger, first-time parents, lacking a high school degree, and receiving SSI/SSD at the time of intake. Mothers with twins or triplets were more likely to experience a high level of parenting stress.” (Healthy Families of New York, [The Link](#), Spring 2010, p. 5).



## Benchmark 21(3.5): Screening for Developmentally Appropriate Communication Skills

### Goal & Rationale

Increase or maintain the proportion of target children who are screened between 10 and 14 months for developmentally appropriate communication skills.

- ◆ Communication is critical to a child's development. Communication begins at birth with sounds and facial expressions and develops into verbal communication as the child approaches toddlerhood.
- ◆ Parents play an important role in helping children learn to communicate and eventually to learn to read and write.

### Measurement Tool

ASQ-3

### Data Collection

1. **Who** is Included: Children 12 months old for whom the ASQ-3 was administered at between 10 to 14 months of age
2. **What** is measured: Children's developmentally appropriate communication skills
3. **When** are data collected: During a home visit assessment
4. **During a home visit**, the ASQ-3 is administered by the home visitor.

### Data Entry: Visit Tracker

- Click on "Children" tab; click on "Screenings"; click on "New Screening"
- Enter Screening Date; Screening Age, and Screener
- Complete all relevant screening information in boxes provided
- Under "Screening Type" select ASQ-3
- Note: This benchmark is for the 12 month screening and will count if completed between 10 and 14 months of age.

### 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:** 26/42 = 62%

**Year 2:** 114/178 = 64%

**Year 3:** 156/179 = 87%

**Year 4:** 128/141 = 91%

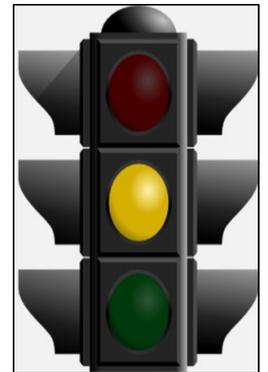
**Improvement**

**Baseline:** 116/160 = 73%

Green = 100%

Yellow = 90-99%

Red = 0-89%



**Numerator** = # of children screened for developmentally appropriate communication skills on ASQ-3 at the 12-month assessment

**Denominator** = # of children who are at least 12 months old

**Improvement is:** Increase or maintain the proportion of target children who are screened for developmentally appropriate communication skills at 12 months of age, comparing current Federal Fiscal Year to prior Federal Fiscal Year

# Benchmark Background:

## Screening for Developmentally Appropriate Communication

The **ASQ-3** is an assessment tool that helps parents provide information about the developmental status of their child across five developmental areas: **communication, gross motor, fine motor, problem solving, and personal-social.**

⇒ **What is it?**

Parent-completed questionnaires that reliably identify children from one month to 5½ years with developmental delays.

⇒ **What age range does it cover?**

1–66 months.

⇒ **How many questionnaires are there?**

21 age-appropriate questionnaires for use at 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, and 60 months of age.

⇒ **How many items are there?**

About 30 items per questionnaire about the child's abilities.

⇒ **How long does it take?**

Each questionnaire takes 10–15 minutes for parents to complete and just 2–3 minutes for professionals to score.

### Signs and symptoms of autism in babies and toddlers:

⇒ If autism is caught in infancy, treatment can take full advantage of the young brain's remarkable plasticity. Although autism is hard to diagnose before 24 months, symptoms often surface between 12 and 18 months. If signs are detected by 18 months of age, intensive treatment may help to rewire the brain and reverse the symptoms.

⇒ The earliest signs of autism involve the absence of normal behaviors—not the presence of abnormal ones—so they can be tough to spot. In some cases, the earliest symptoms of autism are even misinterpreted as signs of a “good baby,” since the infant may seem quiet, independent, and undemanding. However, you can catch warning signs early if you know what to look for.

⇒ Some autistic infants don't respond to cuddling, reach out to be picked up, or look at their mothers when being fed.



## Benchmark 22(3.6): Screening for Child's General Cognitive Delays

### Goal & Rationale

Increase or maintain the proportion of target children who are screened for cognitive delays.

- ◆ Cognitive skills are the basic mental abilities used for thinking, problem-solving, studying, and learning. As children develop cognitively they build capacity for problem solving and retaining knowledge while learning about their environment.

### Measurement Tool

ASQ-3

### Data Collection

1. **Who** is Included: Children 12 months old for whom the ASQ-3 was administered at between 10 to 14 months of age
2. **What** is measured: Children's developmentally appropriate communication, gross motor, fine motor, problem solving, and personal-social skills
3. **When** are data collected: During a home visit assessment
4. **During a home visit**, the ASQ-3 is administered by the home visitor.

### Data Entry: Visit Tracker

- Click on "Children" tab; click on "Screenings"; click on "New Screening"
- Enter Screening Date; Screening Age, and Screener
- Complete all relevant screening information in boxes provided
- Under "Screening Type" select ASQ-3
- Note: This benchmark is for the 12 month screening and will count if completed between 10 and 14 months of age.

### 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:** 26/42 = 62%

**Year 2:** 114/178 = 64%

**Year 3:** 156/179 = 87%

**Year 4:** 128/141 = 91%

**Improvement**

**Baseline:** 116/160 = 73%

Green = 100%

Yellow = 90-99%

Red = 0-89%



**Numerator** = # of children screened for general cognitive delays on ASQ-3 at the 12-month assessment

**Denominator** = # of children who are at least 12 months old

**Improvement is:** Increase or maintain the proportion of target children who are screened for cognitive delays at 12 months of age, comparing current Federal Fiscal Year to prior Federal Fiscal Year

# Benchmark Background:

## Screening for Child's General Cognitive Delays

Developmental screenings provide an opportunity to:

- Obtain information from parents about their child, including strengths and any concerns the parents may have about the child's health, development and behavior.
- Determine whether a child's development is typical for age or is delayed in some regard.
- Talk with parents and involve them more effectively in planning future home visits based on their child's developmental needs.

⇒ Developmental delay is an important problem affecting 10% to 15% of young children, with significantly higher rates among children who live in poverty. [Early detection and intervention for developmental conditions](#) such as autism, speech and language disorders, and cognitive disabilities have been shown to improve long-term academic and behavioral outcomes for affected children; however, many children are not identified until school age, thereby missing treatments that are known to improve outcomes.

⇒ In 2006, the American Academy of Pediatrics (AAP) issued a policy statement recommending systematic developmental screening in primary care by using a validated tool with children 9, 18, and 30 months of age.

⇒ Newer parent-completed screening questionnaires compared with traditional provider-administered screens address a major barrier to screening: provider time. Two such screens, Parents' Evaluation of Developmental Status (PEDS) and **Ages & Stages Questionnaires (ASQ)**, are emerging as the tools of choice in many practices.

⇒ On the basis of their quality and usability in practice, they are on a short list of recommended instruments (Pediatrics, 2009).



# Benchmark 23(3.7): Screening for Self-Regulation

## Goal & Rationale

Increase or maintain the proportion of enrolled children who demonstrate positive self-regulation.

- ◆ Parents and home visitors work together to provide a positive learning environment for children in the home. Parents can encourage creativity, exploration, communication, and inquiry for children to support positive learning experiences for children.

## Measurement Tool

ASQ-3

## Data Collection

1. **Who** is Included: Children 12 months old for whom the ASQ-3 was administered at between 10 to 14 months of age
2. **What** is measured: Children's development of self-regulating behaviors
3. **When** are data collected: During a home visit assessment
4. **During a home visit**, the ASQ-3 is administered by the home visitor.

## Data Entry: Visit Tracker

- Click on "Children" tab; click on "Screenings"; click on "New Screening"
- Enter Screening Date; Screening Age, and Screener
- Complete all relevant screening information in boxes provided
- Under "Screening Type" select ASQ-3
- Note: This benchmark is for the 12 month screening and will count if completed between 10 and 14 months of age.

## 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:** 26/42 = 62%

**Year 2:** 114/178=64%

**Year 3:** 156/179 = 87%

**Year 4:** 128/141 = 91%

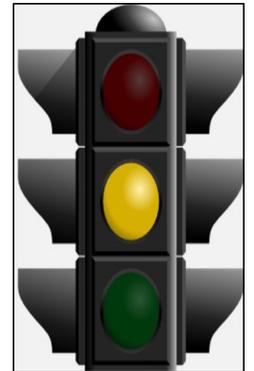
**Improvement**

**Baseline:** 116/160 = 73%

Green = 100%

Yellow = 90-99%

Red = 0-89%



**Numerator** = # of target children who demonstrate positive self-regulation and compliance on the ASQ-3 at the 12-month assessment

**Denominator** = # of children who are at least 12 months old

**Improvement is:** Increase or maintain the proportion of target children who are screened for positive self-regulation and compliance at 12 months of age, comparing current Federal Fiscal Year to prior Federal Fiscal Year

# Benchmark Background: Screening for Self-Regulation

## Zero to Three:

- ⇒ Babies are born with some ability for self-regulation, but they cannot always control their strong emotions. Infants and toddlers who are overwhelmed depend on the outside help, or external regulation, that responsive caregivers provide. Through caring relationships with adults, babies begin to develop their ability to self-regulate, an ability they will continue to work on and need throughout their lives (Beyond the Journal, 2006).

## Beststart.org:

- ⇒ A child's development occurs foremost through the reciprocal interactions with a trusted adult. Usually parents set the foundation for good self-regulation by providing an environment that is warm, nurturing and encourages trust. Parents and later, service providers model the process of self-regulation and provide opportunities to discuss and practice the process. Disruptions in the parent-child relationship through stress from factors such as poverty, poor mental or physical health or maltreatment can adversely affect the development of self-regulation.
- ⇒ Very young children can suffer from developmental and mental health difficulties that may signal the need for referral to an early intervention or mental health professional. Such professionals can diagnose and treat early signs of developmental or mental health difficulty. They also can consult with early care and education professionals to help them support the child and family. Some signs that an infant or toddler may need additional help include behaviors that
- are unusual for the child
  - cause the parents or other caregivers to see the child as “difficult”
  - make it difficult for the child to have satisfying relationships with others
  - are seen in different settings (i.e., at home, in the child care program) by different observers
  - last for a long time

Adapted, from R. Parlakian and N.L. Seibel, *Building Strong Foundations: Practical Guidance for Promoting the Social-Emotional Growth of Infants and Toddlers* (Washington, DC: Zero to Three Press, 2002).



# Benchmark 24(3.8): Screening for Social-Emotional Delays

## Goal & Rationale

Increase or maintain a 95% level of target children who are screened between 10 and 14 months for developmentally appropriate social and emotional behaviors using ASQ-SE.

- ◆ Social-emotional well-being is the capacity to experience, regulate, and express emotions; form close, secure relationships; explore the environment and learn. Parents' emotional health impacts the emotional health of their children beginning at birth and continuing throughout their development.

## Measurement Tool

ASQ-SE

## Data Collection

1. **Who** is Included: Children 12 months old for whom the ASQ-SE (Social Emotional) screening was administered between 10 to 14 months of age
2. **What** is measured: Children's developmentally appropriate social and emotional behaviors
3. **When** are data collected: During a home visit assessment
4. **During a home visit**, the ASQ-SE is administered by the home visitor.

## Data Entry: Visit Tracker

- Click on "Children" tab; click on "Screenings"; click on "New Screening"
- Enter Screening Date; Screening Age, and Screener
- Complete all relevant screening information in boxes provided
- Under "Screening Type" select ASQ-SE
- Note: This benchmark is for the 12 month screening and will count if completed between 10 and 14 months of age.

## 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:** 26/42 = 62%

**Year 2:** 78/178=44%

**Year 3:** 140/179 = 78%

**Year 4:** 122/141 = 87%

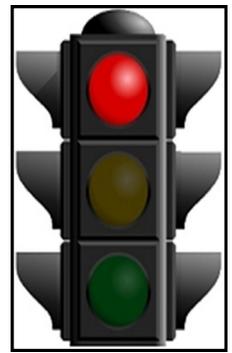
**Improvement**

**Baseline:** 89/160 = 56%

Green = 100%

Yellow = 90-99%

Red = 0-89%



**Numerator** = # of children screened for developmentally appropriate social emotional behaviors on ASQ-SE at the 12-month assessment

**Denominator** = # of children who are at least 12 months old

**Improvement is:** Increase or maintain the proportion of target children who are screened for developmentally appropriate social emotional behaviors at 12 months of age, comparing current Federal Fiscal Year to prior Federal Fiscal Year

# Benchmark Background:

## Screening for Social-Emotional Delays

### Zero to Three:

- ⇒ In their first years of life, children rapidly develop the social and emotional capacities that prepare them to be self-confident, trusting, empathic, intellectually inquisitive, competent in using language to communicate, and capable of relating well to others.<sup>4</sup> Sometimes called early childhood mental health, or infant mental health, healthy social and emotional development refers to a child's developing capacity to:
- Experience, manage and express the full range of positive and negative emotions;
  - Develop close, satisfying relationships with other children and adults; and
  - Actively explore their environment and learn.
- ⇒ Social and emotional development lays the foundation that helps guide a child into adulthood. Early experiences can build a strong foundation or a fragile one, and can affect the way children react and respond to the world around them for the rest of their lives.
- ⇒ Positive parenting practices—including responsive caregiving, positive discipline, supports for language and learning, and playful interactions—promote social and emotional health.



# ILLINOIS MIECHV

## BENCHMARKS

### 4. Domestic Violence and Crime



- 26. Domestic Violence Screening
- 27. Referrals for Domestic Violence Services
- 28. Safety Plan Development

# 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%

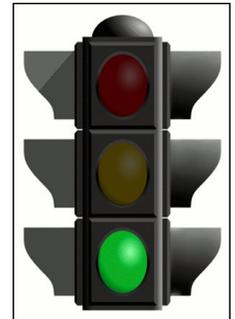
**Improvement**

**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%

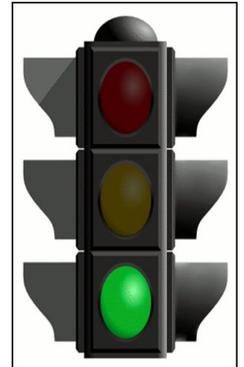
**Improvement**

**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**.



# ILLINOIS MIECHV

## BENCHMARKS

### 5. Family Economic Self-Sufficiency



- 29. Household Income and Benefits
- 30. Employment or Education of Adult Members of Household
- 32. Insurance Status for All Family Members

# 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:**

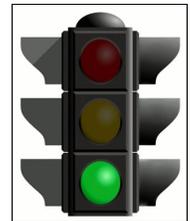
**Year 2:** 30/274 = 11%

**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.



## Benchmark 30(5.2): Employment or Education of Adult Members of Household

### Goal & Rationale

Increase proportion of participants who within 12 months of setting educational attainment as a program goal have an adult in the household who has either completed high school, obtained a GED, or enrolled in post-secondary training.

### Measurement Tool

Parents are asked to identify goals, and if a parent identifies education as a goal and has not completed high school or a GED, this is highlighted in the data system. Those families who then enroll in an education program before the end of their first year are counted.

### Data Collection

1. **Who** is Included: Participants enrolled for at least 1 year who have identified educational attainment goals
2. **What** is measured: Participants who have set educational goals and received a high school diploma or GED, or enrolling in post secondary training or education program
3. **When** are data collected: During a home visit subsequent to 1 year post enrollment
4. **On a home visit**, ask family members regarding their educational achievement and education/training program enrollment.

### Data Entry: Visit Tracker

- Under "Guardian" click on "Goals/Plans."
- If appropriate, enter "Education" as a goal
- If "Education" is a goal, check quarterly to see if goal has been attained.
- If goal has been attained, change status to "Completed" and enter "End Date."
- Note: This benchmark tracks educational goal attainment but not employment.

### 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:**

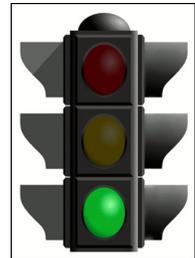
**Year 2:** 27/109 = 25%

**Year 3:** 33/89 = 37%

**Year 4:** 35/77 = 45%

**Improvement**

**Baseline:** 0/198 = 0%



**Numerator** = # of participants in the program who have been enrolled for at least 1 year and who identify educational attainment as part of their goal plan, and who either graduate from high school, obtain a General Equivalency Diploma, or enroll in a post secondary training or education program by the end of 1 year of services

**Denominator** = # of participants who identify educational attainment as part of their goal plan and have been enrolled for at least 1 year

**Improvement is:** An increase in the proportion of families enrolled in home visiting for one year who have achieved an education- or employment-related goal, comparing current Federal Fiscal Year to prior Federal Fiscal Year.

# Benchmark Background:

## Employment or Education of Adult Members of Household

### National Center for Children in Poverty

- ⇒ Among children under age 3 in Illinois, 11% are in households with low parental education.
- ⇒ Among children under age 3 in Illinois, 10% are in households with un-employed parents.
- ⇒ Among children under age 3 in Illinois, 9% are in households with both low income and low parental education.
- ⇒ Among children under age 3 in Illinois, 11% are in households with both low income and low parental education.

### **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.



# Benchmark 32(5.3): Insurance Status for All Family Members

## Goal & Rationale

Increase the number of families with all household members who have health insurance.

- ◆ Both maternal and child health are impacted by access to healthcare and preventive services.

## Measurement Tool

A series of three question sets are asked: (1) Is the mother covered under health insurance? What are the dates? What is the insurance? (2) Is the child covered by health insurance? What are the dates? What is the insurance? (3) Are all other members of the household covered under health insurance?

## Data Collection

1. **Who** is Included: households enrolled for at least 1 year
2. **What** is measured: Families with all household members covered by health insurance
3. **When** are data collected: At enrollment and updated quarterly
4. **On a home visit**, ask mother about the health insurance status of all family members living in the home.

## 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?"
- Note: These steps are related to Benchmark 8.
- Note: Consider primary guardian, other parent only if they live in the home, and all of the primary guardian's children living in the home for 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:**

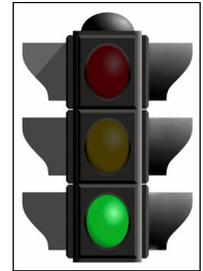
**Year 2:** 195/274 = 71%

**Year 3:** 139/203 = 68%

**Year 4:** 132/170 = 78%

**Improvement**

**Baseline:** 82/236 = 35%



**Numerator** = # of households with all family members covered by public or private health insurance at 1 year post enrollment

**Denominator** = # of households in the program for at least 1 year

**Improvement is:** An increase in proportion of families enrolled in home visiting for one year who have health insurance for all household members, comparing current Federal Fiscal Year to prior Federal Fiscal Year

# Benchmark Background: Insurance Status for All Family Members

The [Illinois Department of Human Services website](#) has health and medical information links, including for [Get Covered Illinois](#) (**Affordable Care Act**).

**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.
- ⇒ For **all children**: immunizations; medical history; blood pressure screening; hematocrit or hemoglobin screening; vision screening; developmental screening; behavioral assessments; height, weight, and body mass index measurements; and obesity screening and counseling.



# ILLINOIS MIECHV

## BENCHMARKS

### 6. Coordination and Referrals for Other Community Resources and Supports



- 33. Identification for Need for Services
- 34. Family Referrals to Community Resources
- 35. Completed Referrals
- 36. Memoranda of Understanding
- 37. Clear Point of Contact

# Benchmark 33(6.1): Identification for Need for Services

## Goal & Rationale

Increase or maintain the proportion of families assessed for child development, maternal depression, or domestic violence.

- ◆ Identifying a family's needs allows home visitors to refer family members to appropriate services.
- ◆ Families are screened for services during the initial screening as well as screenings for tobacco use, maternal depression, child development and domestic violence.

## Measurement Tool

A referral management tool is incorporated into our data system, which includes a reason for referral. Based on the referrals the home visitor makes, we do a count of referrals based on the above mentioned reasons.

## Data Collection

1. **Who** is Included: families enrolled for at least 1 year
2. **What** is measured: Assessment of families' service needs using ASQ-3, EPDS, and Futures Without Violence screening tools
3. **When** are data collected: During home visits when appropriate
4. **On home visits**, assess the family's need for services relating to maternal depression, child development, and domestic violence, based on screening results.

## Data Entry: Visit Tracker

Note: In order to achieve this benchmark, family must have been assessed for either maternal depression (EPDS, Benchmark 5), child development (ASQ-3, Benchmarks 21, 22, 23), or domestic violence (Futures Without Violence and/or 4Ps+, Benchmark 26) by one year post enrollment.

## 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:** 247/274=90%

**Year 3:** 204/204 = 100%

**Year 4:** 170/170 = 100%

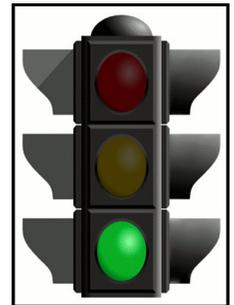
**Improvement**

**Baseline:** 193/236 = 82%

Green = 100%

Yellow = 90-99%

Red = 0-89%



**Numerator** = # of participating families who have been assessed for service needs during the first year of services

**Denominator** = # of families enrolled for at least 12 months

**Improvement is:** Increase or maintain the proportion of families assessed for service needs within year one post enrollment, comparing current Federal Fiscal Year to prior Federal Fiscal Year

## Benchmark Background: Identification for Need for Services

Assessing a family's needs is the first step towards getting the support or services in place that will help the family thrive.

- ⇒ Home visitors work with families to promote the meaningful connections within families and communities to support the development of each child and family. Parents are empowered to ask for help and given the tools to find community and social supports.
- ⇒ Community resources can reduce parental stress and potential information deficits that may lead to child safety issues later on and help enhance parental employment, family housing, and meet family health needs.



# Benchmark 34(6.2): Family Referrals to Community Resources

## Goal & Rationale

Increase or maintain the proportion of families with identified service needs who are referred to available community resources within 1 month of receiving a positive screening.

- ◆ Families are identified as needing services using screenings for tobacco use, maternal depression, child development and domestic violence. Identifying a family's needs allows home visitors to refer family members to appropriate services.

## Measurement Tool

Referral tracking tool used, which gives referral reason, referral date. This can be tracked again screenings and used to quantify.

## Data Collection

1. **Who** is Included: families identified as having a service need
2. **What** is measured: Family referrals to community resources
3. **When** are data collected: During each home visit
4. **On each home visit**, refer families with identified/assessed need to appropriate services.

## Data Entry: Visit Tracker

Note: In order to achieve this benchmark, families that have been assessed and identified with a positive screen or concern regarding either maternal depression (EPDS, Benchmark 5), child development (ASQ-3, Benchmarks 21, 22, 23), or domestic violence (Futures Without Violence and/or 4Ps+, Benchmark 26), must have been referred to community resources.

Note: This benchmark requires that those families that have been screened and identified as needing community services in one of these areas has received a referral for such services to address their needs.

EPDS=14 or above; Futures=21 or above; ASQ -3 = at or below cutoff score or parent identifies a concern

## 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:**

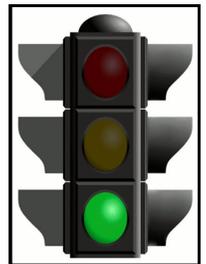
**Year 2:** 7/14=50%

**Year 3:** 28/37 = 76%

**Year 4:** 18/21 = 86%

**Improvement**

**Baseline:** 20/29 = 69%



**Numerator** = # of participating families with an identified service need who are referred to an available community service within one month of positive screening

**Denominator** = # of families identified as having a service need

**Improvement is:** Increase or maintain the proportion of families with identified service needs who are referred to available community resources within one month of receiving a positive screening, by comparing current Federal Fiscal Year to prior Federal Fiscal Year

# Benchmark Background: Family Referrals to Community Resources

A referral constitutes any recommendation made to participating family members, including the target child, for services outside of the home visiting organization that address the physical, emotional, educational, financial or social needs of the family. The referral will be followed up with the family, and/or service provider, if appropriate to determine if the family received the needed services and documented accordingly. (GA Benchmark Glossary)

## **The 2-1-1 Initiative in Illinois**

2-1-1 is an easy-to-remember, non-emergency telephone number that connects people with essential community information and services. 2-1-1 saves time and frustration through specialists who match callers to the right agency based on each caller's need.

The 24-hour line makes it easy for the public to navigate the maze of human service providers and help lines. All calls are free, anonymous and confidential.

Callers can get live assistance with needs such as:

- Food and shelter
- Counseling and mental health services
- Income and employment support
- Help for the elderly and people with disabilities
- Resources for children and families



# Benchmark 35(6.3): Completed Referrals

## Goal & Rationale

Increase proportion of families referred to community resources who complete the referrals by accessing resources.

- ◆ When families indicate need for additional support or intervention services, referrals can be a way to support self-sufficiency, empowerment, and achieving optimal health.

## Measurement Tool

Referral tracking system has an indicator for completion of referral. Home visitors are asked to close referrals when completed. We count the number of closed referrals against all referrals made.

## Data Collection

1. **Who** is Included: Families referred for services
2. **What** is measured: Completed service referrals
3. **When** are data collected: During each home visit
4. **On each home visit**, ask the mother if the family has completed service referral/s.

## Data Entry: Visit Tracker

- Under Guardian find “Resource Referral” tab and locate referral made for this family related to positive screen
- Click on Update icon and answer question for “Family Received Services”: Yes, No, Unknown

Note: “Yes” can include any family that has followed up on the referral, even if they have not received the 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:** 4/7=57%

**Year 3:** 20/28 = 71%

**Year 4:** 10/18 = 56%

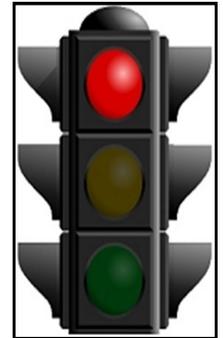
**No improvement**

**Baseline:** 15/20 = 75%

Green = 100%

Yellow = 90-99%

Red = 0-89%



**Numerator** = # of participating families referred to an available community service who complete the service referral

**Denominator** = # of families referred for services

**Improvement is:** An increase in the proportion of families referred for services that complete the referral by comparing current Federal Fiscal Year to prior Federal Fiscal Year.

## Benchmark Background: Completed Referrals

A referral constitutes any recommendation made to participating family members, including the target child, for services outside of the home visiting organization that address the physical, emotional, educational, financial or social needs of the family. The referral will be followed up with the family, and/or service provider, if appropriate to determine if the family received the needed services and documented accordingly. (GA Benchmark Glossary)

Following up on referrals provides an opportunity to make sure the initial referral was appropriate and sufficient, that the contact information was up to date and that the initial referral was sufficient to meet the family's needs.



# Benchmark 36 (6.4): Memoranda of Understanding (Community Systems Development)

## Goal & Rationale

Increase the number of formal agreements with other social services agencies.

- ♦ A Memorandum of Understanding (MOU) establishes a clear understanding of an agreement between parties to outline specific roles and responsibilities in the exchange of resources or information. MOUs may be a helpful tool when fostering collaboration between agencies and defining shared expectations. Families benefit when community service agencies are working together to address the needs of the community.

## Measurement Tool

Ongoing tracking of formal agreements with social service agencies.

## Data Collection

1. **Who** is Included: Agencies with which HV services have a formal MOU
2. **What** is measured: Formal agreements with social service agencies
3. **When** are data collected: ongoing

## 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

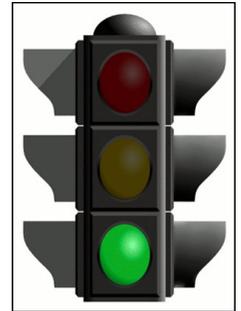
**Year 1:** 40

**Year 2:** 126

**Year 3:** 190

**Year 4:** 231

**Improvement**



**Improvement is:** An increase from prior Federal Fiscal Year to current Federal Fiscal Year in the number of community agencies with which the home visiting provider has established formal memoranda of understanding for the coordination of services and exchange of information.

## Data Entry

- Visit Tracker may be adding a component to track MOUs. For now, your agency will keep a separate list and report a total number of agencies with which you have MOUs.
- **Note:** This is a Community Systems Development (CSD) benchmark.

# Benchmark Background: Memoranda of Understanding

The Goal for Community Systems Development is to establish a system for coordinating maternal, infant, and early childhood services that are comprehensive, culturally appropriate, and high quality. To accomplish this goal, it is crucial to engage all early childhood services, related services, and key stakeholders.

Maternal and Infant Child Health, and Early Childhood Care and Education Services originate from multiple federal, state, and community systems and services. This often results in fragmentation, isolation, and even unneeded competition at the local level. CSD's role is to build leadership capacity for infant and child services that integrate, coordinate and reduce duplication of services and systems, thus improving the availability and quality of services.

One common indicator that provides evidence of the formalization (structures, capacity and high performance) of a CSD is number and types of key Memoranda of Understanding (MOUs). These demonstrate commitments to participating and partnering among a full range of early child community agencies and organizations. A second aspect of a high quality MOU concerns whether and how partnerships and commitments are honored and implemented; that roles and responsibilities are not viewed as pro forma, but are functional. The quality of a MOU can be validated by the CSD with semi-annual or annual reviews of the MOU and the successes and challenges that may have surfaced during its implementation.

MOUs are not legally binding, but serve as a formalized statement of the mutual expectations of two agencies. An MOU represents a signed commitment on the part of two or more parties to conduct interagency business in a specified manner.



# Benchmark 37 (6.5): Clear Point of Contact (Community Systems Development)

## Goal & Rationale

Increase the number of agencies with a clear point of contact for receiving referrals from home visiting providers.

- ◆ Building relationships between organizations enhances a program's ability to collaborate with other community-based groups.

## Measurement Tool

Ongoing tracking of number of community agencies with which the home visiting provider has an identified contact person

## Data Collection

1. **Who** is Included: Agencies serving families with children
2. **What** is measured: The number of agencies in the community which serve families with young children with which the CSD has an identified contact person.
3. **When** are data collected: ongoing

## 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

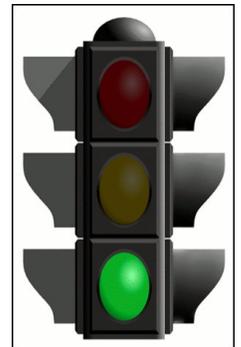
**Year 1:** 53

**Year 2:** 219

**Year 3:** 309

**Year 4:** 402

**Improvement**



**Improvement is:** An increase from prior Federal Fiscal Year to current Federal Fiscal Year in the number of community agencies with which the home visiting provider has an identified contact person

## Data Entry

- Visit Tracker may be adding a component to track community agency contacts. For now, your agency will keep a separate list and report a total number of agencies with which you have coordinated contact people.
- **Note:** This is a Community Systems Development (CSD) benchmark.

# Benchmark Background: Clear Point of Contact (Community Systems Development)

Another key indicator in establishing strong partnerships and functional collaboration with local community based agencies and organizations is the engagement of key personnel into the Community Systems Development (CSD) network; i.e., identifying a **specific contact person** who participates or has knowledge of the CSD's goals, objectives and activities. Ideally, the key contact person will be part of the CSD network, or they will identify a "gatekeeper" to be contacted and/or linked to their services and resources. Many CSD's use directories, websites or meetings to identify and monitor services or **points of contact**. Most importantly, the agency or individual serving as the point of contact must ensure that changes in services, policies and personnel are updated regularly to maintain awareness of currently available services, ensure that communication channels stay open, and enhance continuity of services to home visiting program participants.



# 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

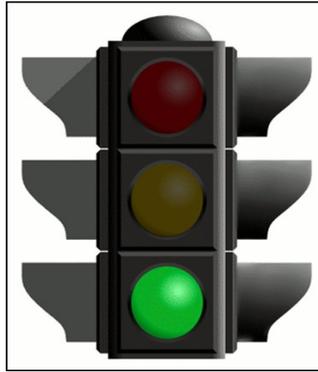
<https://illinoisoutcomes.dcf.illinois.gov/>

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](mailto: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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