

Getting Everyone on the Bus!

ILLINOIS

Maternal, Infant, and Early

Childhood Home Visiting

(MIECHV) Program

FY 2017 BENCHMARKS:

Goals, Data, Background and Resources



Benchmark Measurement Period for

HRSA/MIECHV

Oct. 1 2016 - Sept 30, 2017

ILLINOIS MIECHV

Home Visiting

6 BENCHMARK AREAS for FY 2017



- 1. Maternal and Newborn Health (constructs 1-6)**
- 2. Child Injuries, Abuse, Neglect, Maltreatment; and Emergency Department Visits (constructs 7-9)**
- 3. School Readiness and Achievement
(constructs 10-13)**
- 4. Domestic Violence (construct 14)**
- 5. Family Economic Self-Sufficiency (constructs 15-16)**
- 6. Coordination and Referrals for Other Community Resources and Supports (constructs 17-19)**

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BENCHMARK AREA 1

Maternal and Newborn Health



Constructs:

- 1. Preterm Birth**
- 2. Breastfeeding**
- 3. Depression Screening**
- 4. Well-Child Visit**
- 5. Postpartum Care**
- 6. Tobacco Cessation Referrals**

Construct 1: Preterm Birth

Type of Measure: Systems Outcome

Numerator: Number of live births (target child or subsequent children among mothers who enrolled in home visiting prenatally before 37 weeks) born before 37 completed weeks of gestation and after enrollment

Denominator : Number of live births after enrollment who were born to mothers enrolled in home visiting prenatally before 37 weeks

Goal & Rationale: Improvement over time in the number of women who deliver full-term babies.

- ◆ Preterm birth is the birth of an infant before 37 weeks of pregnancy.
- ◆ Babies born before 37 weeks gestation are at risk for a number of health complications, and preterm birth and low birth weight are major contributors to infant mortality.

Data Collection & Measurement Tools:

1. **Who** is included: Prenatally enrolled mothers who enrolled prior to 37 completed weeks of gestation
2. **What** is measured: Number of weeks of gestation as obtained by mother's self report
3. **How** is it measured: MIECHV Data Collection Form is utilized which asks the home visitors to record prenatal mother's service entry date, the child's due date and child's date of birth (DOB).
4. **When** are data collected: At prenatal enrollment/intake visit, ask the prenatal mother "What is your due date?" (**EHS & PAT models:** ask for each new pregnancy)

On home visit after baby is born, ask the postnatal mother "On what date was your baby born?"

Data Entry in Visit Tracker:

- ⇒ Prenatal children are added into Visit Tracker when the pregnant mother is enrolled;
- ⇒ Prenatal Enroll Date should be the same as the guardian enroll date.
- ⇒ Use "Baby" as their first name, and use mom's last name. Enter "P" (for Prenatal) as their sex, and enter the due date.
- ⇒ Only change due date if it's changed by a medical provider
- ⇒ Caution: Do not change due date once baby is born; enter date of birth (DOB).
- ⇒ When baby is born, Under guardian, click on Children page.
- ⇒ Enroll baby using birth date. Add name. Change P to sex of child using M or F

MIECHV Target Child:

For HFI programs: check for youngest child (including prenatal)

For EHS and PAT programs: check for all children (including prenatal)

Benchmark Background and Resources for Preterm Birth

A preterm birth is one that occurs before 37 weeks of pregnancy. Even one or two fewer weeks in the womb can make a big difference in a baby's development. Up to 39 weeks, the brain, lungs, ears and eyes are still growing and developing, and the baby is still learning to suck and swallow, according to the March of Dimes. Elective early deliveries – medically unnecessary deliveries – before 39 weeks don't make health sense, the organization says in its [Healthy Babies Are Worth the Wait](#) campaign.

How can home visitors help mothers prevent preterm births?

To boost a mother's chances of having a full-term pregnancy and healthy baby, encourage participants to do the following:

Seek prenatal care

- 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 did.
- Doctors can spot health problems early when they see mothers regularly. Early treatment can resolve many problems and prevent many others.

Get a flu shot

Women who become ill with the flu are at increased risk for preterm birth.

Quit smoking

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. Get a free "quit kit" and tips to quit at <http://quityes.org/>.

Manage weight gain during pregnancy.

What to Expect website explains weight gain during pregnancy, and weight gain red flags. <http://www.whattoexpect.com/pregnancy/weight-gain/>

Did you know?

- In 2010, the U.S. ranked **24th** in infant mortality among all of the highly developed nations of the world, and had a 9.6 premature birth rate in 2015.
- A preterm birth rate of 8 gives you an "A" in the March of Dimes report card. Currently the state of IL has a "C" at 10.1%. <http://www.marchofdimes.org/materials/premature-birth-report-card-united-states.pdf>

Resources with more information on prenatal care:

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



Construct 2: Breastfeeding

Type of Measure: Systems Outcome

Numerator: Number of infants aged 6-12 months (target child among mothers who enrolled in home visiting prenatally) who were breastfed any amount at 6 months of age

Denominator: Number of infants aged 6-12 months (target child among mothers who enrolled in home visiting prenatally) enrolled in home visiting for at least 6 months

Goal & Rationale: Increase the percent of infants born to enrolled mothers who were breastfed any amount of breastmilk 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 her infant's health.

Data Collection & Measurement Tools:

1. **Who** is included: Infants born during reporting period whose mothers enrolled prenatally
2. **What** is measured: infants breastfed any amount (including with pumped milk) at 6 months
3. **How** is it measured: Parent self-report or WIC records on when the mother starts and stops breastfeeding relative to the child's birth
4. **When** are data collected: At each postnatal home visit until baby is weaned or reaches 6 months of age, whichever comes first

At each home visit, ask mother if child is being fed **any amount** of breast milk.

Note: Mothers who are not recommended to breastfeed due to certain medical conditions should be excluded from this measure. Medical exclusion criteria can be found at <http://www.cdc.gov/breastfeeding/disease/>

Data Entry in Visit Tracker:

- ⇒ Go to **Child** page; click **Health Info** tab
- ⇒ Scroll down to **BreastFeeding Survey** and Click "Add Item"
- ⇒ Fill in date
- ⇒ From drop down menu, select answer :"Yes", "No -weaned/stopped", or "No - never" to question—"Is your child receiving any breastmilk"
- ⇒ Note: To achieve this benchmark, mother must feed baby some amount of breast milk for 6 months.

Benchmark Background and Resources for Breastfeeding

Breastfeeding has many benefits for infants and their mothers:

- ⇒ Human milk is the **ideal food for most infants**. Breastfed infants receive antibodies from breast milk, which protect against infection in the early postpartum period, and breast-feeding 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, death of intestinal tissues, middle-ear infections, leukemia, lymphoma, and sudden infant death syndrome.
- ⇒ Breastfeeding is linked to a lower risk of Type 2 diabetes, Breast cancer, ovarian cancer and postpartum depression in women.
- ⇒ 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."

Breastfeeding Resources:

The National Women's Health Information Center website has **English and Spanish versions of An Easy Guide to Breastfeeding** which can be downloaded and printed. <https://www.womenshealth.gov/publications/our-publications/breastfeeding-guide/>

The Office on Women's Health at the U.S. Dept. of Health and Human Services created "**It's Only Natural**" to offer African American moms the information and support they need to breastfeed. The campaigns aim is to increase awareness of the benefits of breastfeeding to mom and baby while also providing practical "how-to" information. The site includes handouts and video-clips related to overcoming challenges, addressing myths, finding support, and fitting it into your life. It also includes links to fact sheets, and support materials for partners. <http://bit.ly/29xr9EH>

Additional information, support and encouragement for breastfeeding moms can be obtained with referrals to:

- ⇒ Lactation consultants
- ⇒ Breastfeeding support groups
- ⇒ WIC breastfeeding peer counselors

Handout for participants <http://www.dhs.state.il.us/OneNetLibrary/27897/documents/Brochures/4660.pdf>

Information for professionals on the benefits of breastfeeding:

Illinois Physicians' Statement on Breastfeeding
<http://illinoisaap.org/wp-content/uploads/ILPhysiciansStatementOnBreastfeeding.pdf>

Illinois Breastfeeding Blueprint: A Plan for Change
http://www.healthconnectone.org/wp-content/uploads/bsk-pdf-manager/Illinois_Breastfeeding_Blueprint



Construct 3: Depression Screening

Type of Measure: Performance Indicator

Numerator: For those not enrolled prenatally, number of primary caregivers enrolled in home visiting who are screened for depression using the Edinburgh Postnatal Depression Scale (EPDS) within the first 90 days since enrollment; for those enrolled prenatally, the number of primary caregivers screened for depression within 90 days of delivery

Denominator: For those not enrolled prenatally, the number of primary caregivers enrolled in home visiting for at least 90 days; for those enrolled prenatally, the number of primary caregivers enrolled in home visiting for at least 90 days post delivery

Goal & Rationale: Increase the percent of enrolled primary caregivers who are screened for depression at least once during the period from the 3rd trimester up to 90 days post-natal

- ♦ Maternal depression is common and is associated with negative parenting practices, disengagement from the child, and development of psychopathology in the child.

Data Collection & Measurement Tools:

1. **Who** is included: pregnant primary caregivers, and all non-pregnant primary caregivers (**male and female**), and women pregnant with subsequent children **for EHS and PAT models that serve multiple target children**.
2. **What** is measured: Screening for depression within 90 days after delivery or within 90 days of enrollment for those enrolled postnatally
3. **How** is it measured: Home visitor administers the Edinburgh Postnatal Depression Scale (EPDS).
4. **When** are data collected: Screening should be completed at any home visit within 90 days after birth for mothers enrolled prenatally, or within the first 90 days of enrollment for those enrolled postnatally.

Data Entry In Visit Tracker:

- ⇒ Go to Guardian's Assessment page
- ⇒ Click EPDS Enter pertinent information including the date of assessment and total assessment score and save

Note: Scores of **9 and above** on EPDS for women, and **10 and above** for men require a referral. You must screen all caregivers, even if they are already receiving treatment for depression. However, you do not need to refer "again" if they're already receiving services.)

To log a referral,:

- ⇒ Go to guardian **Resource Connection** screen and document the referral there. **Connection Type** must be "Mental Health Services" or "Mothers and Babies."

Benchmark Background and Resources for Screening for Maternal Depression

Why do we screen for maternal depression?

- ⇒ Maternal depression is very common and is treatable.
- ⇒ It most often begins in early adulthood during the childbearing and childrearing years.
- ⇒ It is estimated that more than one-third of women in their childbearing and childrearing years have symptoms of depression.
- ⇒ Maternal depression can disrupt parent-child bonding, critical for healthy child development, by making it difficult for mothers to provide a consistent, nurturing and empathic relationship.
- ⇒ Mothers feeling depressed and overwhelmed may be less likely to breastfeed or will breastfeed for shorter periods of time than non-depressed mothers.

Why are we screening male caregivers?

Depression can disrupt parent-child bonding, and is treatable. A score of 10 or above requires a referral for a male caregiver (and 9 or above for a female caregiver).

What are some common symptoms of depression?

- ⇒ Restlessness or irritability
- ⇒ Extreme sadness and frequent crying
- ⇒ Lack of interest in one's self or children
- ⇒ Feelings of hopelessness
- ⇒ Loss of motivation and interest in normal activities
- ⇒ Changes in sleep patterns and constant fatigue

To learn more about how maternal depression impacts families, watch the video - A Family's Story: Perinatal Depression <http://voices4kids.org/issues/files/perinatdep.pdf>

Resources:

Depression in Mothers: More Than the Blues is a free tool kit produced by SAMHSA, with information and strategies for use in working with mothers who may be depressed. Includes facts about depression; screening tools for more serious depression; and referrals, resources, and handouts for mothers who are depressed.

<http://store.samhsa.gov/product/Depression-in-Mothers-More-Than-the-Blues/SMA14-4878>



Construct 4 : Well-Child Visit

Type of Measure: Performance Indicator

Numerator: Number of children (all target children) enrolled in home visiting who received the last recommended well-child visit based on the AAP schedule.

Denominator: Number of children (target child) enrolled in home visiting

Goal & Rationale: Increase the percent of enrolled children who obtained the last recommended well child visit based on the AAP schedule.

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

Data Collection & Measurement Tools:

1. **Who** is included: All enrolled target children
2. **What** is measured: Well-child visit completion obtained by mother's self report
AAP recommended schedule: 3-7 days, 2-4 weeks, 2-3 months, 4-5 months, 6-7 months, 9-10 months, 12-13 months, 15-16 months, 18-19 months, 2-2.5 years, 3-3.5 years, 4-4.5
3. **How** is it measured: Parent self-report on date of each well-child/baby visit.
4. **When** are data collected: During each home visit. (**EHS & PAT models:** for each target child)

Data Entry in Visit Tracker:

- ⇒ Go to Child Page; click on Health Info tab; find Child Medical Visits
 - ⇒ Click "Child Medical Visits - Add Item"
 - ⇒ Enter Date, Type "Physician", and Reason (which must be "well child")
 - ⇒ Note: To achieve this benchmark, child must have completed last AAP-recommended well-child visit based on child's age.
- OR** Enter on PVR under **Medical Provider Visits** (Note: you do not have to enter in both places)

Benchmark Background and Resources for Well-Child Visit

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

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).

Here is the AAP recommended schedule for well-child visits:

3-7 days, 2-4 weeks, 2-3 months, 4-5 months, 6-7 months, 9-10 months, 12-13 months, 15-16 months, 18-19 months, 2-2.5 years, 3-3.5 years, 4-4.5 years

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.

- ⇒ The [Healthy Children.org](#) site provides the AAP recommended schedule for well-child visits, plus detailed pre-visit questionnaires parents can print out and bring to each doctor visit. This information is also available in [Spanish](#) on this site.
- ⇒ 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).
- ⇒ **Handout:** 2016 [Recommended Immunizations for Children](#) from Birth Through 6 Years Old
- ⇒ The Illinois Dept. of Health and Human Services [website](#) has a variety of healthcare resources, including the All Kids Member Handbook which lists [Well Child Visit and Immunization Schedules](#).

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: <http://www.pamf.org/children/common/development/> has a series of Well-Child Visit Handouts by age group for newborns through age 5. These handouts, **available in English and Spanish**, 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.



Construct 5: Postpartum Care

Type of Measure: Performance Indicator

Numerator: Number of mothers enrolled in home visiting prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery

Denominator: Number of mothers enrolled in home visiting prenatally or within 30 days after delivery and remained enrolled for at least 8 weeks (56 days) after delivery

Goal & Rationale: Increase or maintain the percentage of mothers enrolled in home visiting prenatally who receive a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery.

- ⇒ The American College of Obstetricians and Gynecologists recommends that mothers receive a postpartum care visit 4-6 weeks after delivery.
- ⇒ The postpartum care visit provides an opportunity to assess the mother's current physical health, screen for postpartum depression, provide counseling on infant care and family planning, and discuss breastfeeding.

Data Collection & Measurement Tools:

1. **Who** is included: Female guardians enrolled prenatally or within 30 days of giving birth and remain enrolled for at least 8 weeks postpartum.
2. **What** is measured: Completion of a postpartum care visit by 8 weeks postpartum
3. **How** is it measured: Parent self-report on date of postpartum care visit with a healthcare provider.
4. **When** are data collected: within 8 weeks (56 days) of delivery. (**EHS & PAT models:** for each new pregnancy)

Data Entry in Visit Tracker:

- ⇒ Go to Guardian page; click on Health Info tab; find **Guardian Medical Visits**, click on "Add Item" tab
- ⇒ Enter date or approximate date
- ⇒ From "Type" drop-down list, choose "**physician**"
- ⇒ From "Reason" drop-down list, choose "**postpartum**"

Benchmark Background and Resources for Postpartum Care

The American College of Obstetricians and Gynecologists recommends that mothers receive a postpartum care visit 4-6 weeks after delivery.

Why should new mothers attend postpartum checkups?

- ⇒ The new mother can talk with her health care provider about birth control and pregnancy spacing.
- ⇒ It provides an opportunity to ask questions about any problems experienced during pregnancy, labor and birth. This is the time to talk about how to prevent problems in future pregnancies.
- ⇒ The new mother can share her feelings or concerns about being a new mom, and can be assessed for postpartum depression.
- ⇒ The provider can check on any health conditions, like diabetes and high blood pressure. If the mother had gestational diabetes during pregnancy, the provider may give a blood glucose test to check blood sugar.
- ⇒ A physical exam will be completed where the provider checks blood pressure, weight, breasts and belly.
- ⇒ A pelvic exam will be done to make sure the new mother is healing well after birth.
- ⇒ The provider will make sure vaccinations are up to date, including vaccinations for flu and pertussis.
- ⇒ The provider may use this opportunity to conduct a breast exam and discuss breastfeeding.

For more information on postpartum medical visits and postpartum care, visit the March of Dimes website: <http://www.marchofdimes.org/pregnancy/your-postpartum-checkup.aspx#>



Construct 6 : Tobacco Cessation Referrals

Type of Measure: Performance Indicator

Numerator: Number of primary caregivers enrolled in home visiting who reported using tobacco products or e-cigarettes at enrollment and were referred to tobacco cessation counseling or services within 90 days of enrollment

Denominator: Number of primary caregivers enrolled in home visiting who reported using tobacco products or e-cigarettes at enrollment and were enrolled for at least 90 days

Goal & Rationale: An increase in the percent of primary caregivers referred to tobacco cessation programs within 90 days of enrollment.

- ◆ During pregnancy, women are often motivated to change risky behaviors.
- ◆ Smoking remains the leading cause of preventable death and disease in the U.S.

Data Collection & Measurement Tools:

1. **Who** is included: Primary caregivers enrolled for 90 days who used tobacco products or e-cigarettes at enrollment.
2. **What** is measured: Referrals to tobacco cessation programs of primary caregivers who report using any tobacco products or e-cigarettes.
3. **How** is it measured: Tobacco Use Survey given at enrollment (and updated for all continuing families). At intake, home visitor should ask the primary caregiver whether s/he uses tobacco products or electronic nicotine delivery systems (e-cigarettes). Also ask: Does anyone in the house other than the primary caregiver use tobacco products or e-cigarettes in the home? If yes to any of the "tobacco use survey" questions, a referral to tobacco cessation services should be made.
4. **When** are data collected: At the initial enrollment visit

Data Entry in Visit Tracker:

- ⇒ Go to guardian's **Health Info** screen
- ⇒ Click the **Tobacco Use Survey** "Add Item" tab.
- ⇒ Fill in date and responses to survey questions and click on "Create"

Then...

- ⇒ Go to the guardian's **Resource Connection** screen
- ⇒ Enter Connection Date and choose the appropriate "Connection Type": Tobacco Cessation
- ⇒ Under Family Received Services: Click Yes, No or Unknown to indicate whether guardian completed the referral (received or attempted to receive services)
- ⇒ Follow up with referrals given and update in the designated areas for Connection Follow Up.

OR Enter on PVR under Physical Health "Tobacco Cessation" (Note: you do not have to enter in both places)

Benchmark Background and Resources for Tobacco Cessation Referrals

Refer primary caregivers who use tobacco products to smoking/tobacco cessation programs.

When pregnant women smoke:

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](#))

Additional Resources

CDC- Information for health care health professionals: Preventing Tobacco Use During Pregnancy. This site also provides handouts for clients. <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/tobaccousepregnancy/>

The Illinois Tobacco Quitline is a FREE resource for tobacco users who want to quit for good.

Registered nurses, respiratory therapists, and certified tobacco-treatment counselors are on call 7 days a week to answer all tobacco-related questions and provide the support needed to break the habit. They serve a diverse client base, with Spanish-speaking counselors and live translation services for more than 200 languages.<http://quityes.org/> 1-866-QUIT-YES 1-866-784-8937

Become an EX: for pregnant and postpartum smokers-General information regarding effects of smoking and pregnancy. Site provides some free information to download, and some links to resources that cost.

<https://womensmentalhealth.org/posts/update-smoking-pregnancy-postpartum-period->

Smokefree Women helps you or someone you care about quit smoking by providing quitting advice, tips and support specific to women's needs. <http://women.smokefree.gov/>

American Cancer Society- Information to help stop smoking
<http://www.cancer.org/healthy/stayawayfromtobacco>

TRAINING MATERIALS FOR HOME VISITORS: [Smoking Cessation for Pregnancy and](#)

[Beyond: A Virtual Clinic](#): A free, interactive Web-based program designed for health care professionals to hone their skills in assisting pregnant women to quit smoking.



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BENCHMARK AREA 2

Child Injuries, Abuse, Neglect, Maltreatment; and Emergency Department Visits



Constructs:

7. Safe Sleep
8. Child Injury
9. Child Maltreatment

Construct 7 : Safe Sleep

Type of Measure: Performance Indicator

Numerator: Number of infants (target child aged less than 1 year) enrolled in home visiting whose primary caregiver reports that they are always placed to sleep on their backs, without bed-sharing or soft bedding

Denominator: Number of infants (index child) enrolled in home visiting who were aged less than 1 year during the reporting period

Goal & Rationale: Educate parents on safe sleep practices and increase or maintain the percent of primary caregivers who report that their infants are always placed to sleep on their backs, without bed-sharing or soft bedding.

- ◆ Education and increased awareness about safe sleep and SIDS prevention decreases risks for infants and young children.

Data Collection & Measurement Tools:

1. **Who** is included: Adults with child less than 1 year old at enrollment
2. **What** is measured: Safe sleep practices obtained by parent's self report. Note that safe sleep practices must always occur.
3. **How** is it measured: Parent self-report. Home visitor asks parent the following three safe sleep survey questions:
 - How often is your baby placed to sleep on his/her back?
 - How often does your baby bed-share with you or anyone else?
 - How often does your baby sleep with soft bedding?Answer each question: Always, Never, or Sometimes
Primary caregiver must respond "Always" to back sleeping and "Never" to bed-sharing and use soft bedding questions to receive credit for this benchmark.
4. **When** are data collected: During a home visit, this can be assessed once or more during the reporting period. The most recent assessment is used for reporting purposes. Assess safe sleep on target children less than one year of age during the reporting period. You can reassess to see if bed sharing practices improve after the family is educated about safe sleep practices.

Data Entry in Visit Tracker:

- ⇒ Go to the Child's **Health Info** tab
- ⇒ Scroll down to **Safe Sleep**, click on "Add Item" tab
- ⇒ Enter Date, and select "Always", "Never", or "Sometimes" for each of the three questions.

Note: To achieve this benchmark, Primary caregiver must respond "Always" to back sleeping, "Never" to bed-sharing, and "Never" to the soft bedding question to receive credit for this benchmark.

Benchmark Background and Resources for Safe Sleep

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), mouth or nose 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).

AAP recommendations for a safe sleeping environment that can reduce the risk of all sleep-related infant deaths, including SIDS include the following:

- Always place your baby on his or her back for every sleep time.
- Always use a firm sleep surface. Car seats and other sitting devices are not recommended for routine sleep.
- The baby should sleep in the same room as the parents, but not in the same bed (room-sharing without bed-sharing).
- Keep soft objects or loose bedding (pillows, blankets, and bumper pads) out of the crib.
- Wedges and positioners should not be used.
- Pregnant woman should receive regular prenatal care.
- Don't smoke during pregnancy or after birth.
- Breastfeeding is recommended.
- Offer a pacifier at nap time and bedtime.
- Avoid covering the infant's head or overheating.
- Infants should receive all recommended vaccinations.
- Supervised, awake tummy time is recommended daily to facilitate development and minimize the occurrence of positional plagiocephaly (flat heads).

Additional Resources:

Parent information is available at www.healthychildren.org/safesleep

<http://www.cribsforkids.org/requestacrib/> (resource for free Pack 'n Play cribs)

<http://www.cdc.gov/sids/parents-caregivers.htm> (Grief resources and prevention tips)

https://www.nichd.nih.gov/publications/pubs/Documents/Safe_Sleep_Environment_English.pdf
one page handout

https://www.nichd.nih.gov/publications/pubs/Documents/SafeSleep_AfricanAmerican_2015.pdf (multi-page handout with photos of African-American parents and babies)

<https://www.nichd.nih.gov/sts/campaign/outreach/Pages/activities.aspx>

<https://www.nichd.nih.gov/sts/news/videos/grandparents/Pages/default.aspx>

<https://www.nichd.nih.gov/sts/about/pages/mythsfacts.aspx>



Construct 8 : Child Injury

Type of Measure: Systems Outcome

Numerator: Number of parent-reported nonfatal injury-related visits to the Emergency Room (ER) since enrollment among all target children enrolled in home visiting

Denominator: Number of target children enrolled in home visiting

Goal & Rationale: Decrease the rate of child injury-related visits to the ER.

- ◆ Preventable childhood injuries are a major cause of death and disability for young children.

Data Collection & Measurement Tools:

1. **Who** is included: All target children
2. **What** is measured: Child's Emergency Room visits
3. **How** is it measured: Parent self-report of child's hospital emergency department visits.
4. **When** are data collected: During each home visit ask caregivers about all child medical visits, including ER visits

Data Entry in Visit Tracker:

- ⇒ Go to **Child** Data
- ⇒ Click on **Health Info** tab
- ⇒ Under **Child Medical Visits** click on "Add Item" tab
- ⇒ Enter the **Date** of the visit, identify **Type** of visit as "ER", Identify **Reason** as "Injury" (you can add **Comments** for specificity) and click "**Create**"

OR Enter on PVR under **Medical Provider visits:** Add

(Note: you do not have to enter in both places)

Benchmark Background and Resources for Child Injury

Center for Effective Parenting: Injury Prevention Tips

- ⇒ 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.

RESOURCES:

Home Safety Checklists:

<http://kidshealth.org/en/parents/household-checklist.html>

http://www.safekids.org/sites/default/files/documents/2015_home_safety_checklist_eng.pdf

http://www.ndhealth.gov/injury/publications/home_safety.pdf

Child and Infant Safety Checklist:

<http://www.lewiscenter.org/documents/A&E/Resource%20Desk/Nurses%20Corner/Child%20and%20Infant%20Safety%20Xlist.pdf>

A new [Child Ready Home Safety app](#), developed by the University of New Mexico Health Sciences Center, is designed to help families become aware of hazards in the home. It is currently available on Google Play for Android. An iPhone version is under development.



Construct 9 : Child Maltreatment

Type of Measure: Systems Outcome

Numerator: Number of children (target children) enrolled in home visiting with at least 1 investigated case of maltreatment since enrollment

Denominator: Number of children (target children) enrolled in home visiting

Goal & Rationale: Decrease the percent of children with at least one DCFS investigated case of child maltreatment (child abuse/neglect) following enrollment in the reporting period.

- ♦ Reducing the incidence of child abuse and neglect leads to improved well-being for children and better outcomes for families.

Data Collection & Measurement Tools:

1. **Who** is included: All target children
2. **What** is measured: Investigated reports of child abuse or neglect, regardless of disposition
3. **How** is it measured: DCFS Investigated Reports
4. **When** are data collected: DCFS reports are used for this benchmark. Home visitor does not need to ask about DCFS reports

Data Entry in Visit Tracker:

⇒ N/A. This data will be collected from the Department of Children and Family Services (DCFS).

Benchmark Background and Resources for Child Maltreatment

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/>



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BENCHMARK AREA 3

School Readiness and Achievement



Constructs:

- 10. Parent-child Interaction**
- 11. Early Language and Literacy Activities**
- 12. Developmental Screening**
- 13. Behavioral Concerns**

Construct 10 : Parent-Child Interaction

Type of Measure: Performance Indicator

Numerator: Number of primary caregivers enrolled in home visiting who receive an observation of caregiver-child interaction by the home visitor using the HOME assessment tool

Denominator: Number of primary caregivers enrolled in home visiting with children reaching the target age range

Goal & Rationale: Increase the percent of primary caregivers who receive an observation of caregiver-child interaction using 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.

Data Collection & Measurement Tools:

1. **Who** is included: Primary caregivers with target child(ren) of all ages. Parent and child must both be present to complete the assessment.
2. **What** is measured: Parent-child interaction observation by home visitor
3. **How** is it measured: Home Observation for Measurement of the Environment (HOME) assessment. Use Infant-Toddler (IT) version for children up to age 3. For children 3 or older, use Early Childhood (EC) version of the HOME assessment tool
4. **When** are data collected: Complete the HOME assessment annually for each target child. Complete by 6 months of age for children enrolled prenatally or for children enrolled within the first 6 months of life. Complete within 3 months of enrollment for children enrolled postnatally and after 6 months of age.

Note: For EHS and PAT models, the HOME will need to be completed on each child enrolled

Data Entry in Visit Tracker:

- ⇒ Go to Guardian Assessments screen
- ⇒ Click on the Add New tab and select I/T HOME for child up to age 3, or EC HOME for child 3 or older. Scores are entered under guardian assessments screen
- ⇒ Enter date, choose child from dropdown list if there are multiple target children, and fill in all fields including the subscale and total scores. Then click "Create"

Benchmark Background and Resources for Parent-Child Interaction

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

The HOME (Home Observation for Measurement of the Environment) assessment is designed to be completed in the child's home as a measure of the child's home and family environment. Home Visitors 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. The child should be present at the visit, and awake to complete the assessment.

⇒ The Infant-Toddler HOME, used with children up to age 3, consists of 45 items and covers six subscales:

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 freely 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.

⇒ The Early Childhood HOME is used with children 3 and older and consists of 55 items and 8 subscales. The EC HOME domains differ slightly from those on the IT HOME. EC HOME domains are: **Learning Materials, Language Stimulation, Physical Environment, Responsivity, Academic Stimulation, Modeling, Variety and Acceptance.**

All versions of the HOME assessment are relatively easy to administer and score, and generally take less than an hour to complete.

Parenting Resource:

Get expert advice for common parenting challenges with **Essentials for Parenting Toddlers and Preschoolers**. These free resources give you information for handling the problems and for creating a positive parent-child relationship. Visit <http://www.cdc.gov/parents/essentials> to learn more and to see the tips, videos, and resources.



Construct 11 : Early Language and Literacy Activities

Type of Measure: Performance Indicator

Numerator: Number of children enrolled in home visiting with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with their child, every day.

Denominator: Number of children enrolled in home visiting

Goal & Rationale: An increase in the number of children read to, told stories to or sang to daily.

- ◆ Reading regularly with young children stimulates optimal patterns of brain development and strengthens parent-child relationships at a critical time in child development, which, in turn, builds language, literacy, and social-emotional skills that last a lifetime. (AAP)
- ◆ Daily reading, storytelling and singing with children builds early language skills.

Data Collection & Measurement Tools:

1. **Who** is included: All primary caregivers. **EHS and PAT programs—ask for each child.**
2. **What** is measured: Daily reading, story telling and/or singing to children by any member of the family.
3. **How** is it measured: Parent self-report. Ask caregiver "In a typical week, how many days does a family member read, tell stories and/or sing songs with the child every day?" Note: The measure asks parents to reflect on a typical week and report if at least one of the activities occurred each day during the week. Any combination of these activities done by any family member over the week meets the criteria.
4. **When** are data collected: Screen by 3 months post-enrollment for postnatally enrolled children, or 3 months of age for prenatally enrolled children. Screen each fiscal year.

Data Entry in Visit Tracker:

- ⇒ On Child Health Info page, scroll down to Survey section, find "Literacy Activities" and click "Add Item"
- ⇒ Add date to Literacy Activities Survey and fill in number of days (0-7) to answer the question "In a typical week, how many days does any member of the family read, tell stories and/or sing songs with the child every day?"

Note: Only a response of "**7 days per week**" meets the benchmark. Any one of the listed activities must be done at least once each day over the week to meet the criteria. It does not need to be done by the same family member each day. The survey can be done more than once each year, and the most recent response will be counted for the benchmark.

Rescreen as necessary if family does not practice daily literacy activities at first, but improvement is seen over time.

Benchmark Background and Resources for Early Language and Literacy Activities

Parents play a key role in early literacy

Babies start developing literacy skills from birth, through their relationship with their parents. By talking, reading, telling stories, and singing to infants and toddlers daily, parents provide the foundation their child will need to develop language and reading skills.

Early literacy skills include listening, speaking, reading, and writing. For children of all abilities, the following activities can help young children develop these important skills.

- Read daily to your children from the time they're born
- Respond to your infant's cooing, and talk to your child
- Name things in the child's environment (i.e., body parts, colors, food, and toys)
- Sing songs and recite rhymes daily
- Make sounds of the animals you see in books and in nature
- Give simple directions to your child
- Listen to music, and move or clap to the beat
- Read stories and talk about illustrations
- Ask questions about their day and about stories you read to them
- Explain new vocabulary encountered in books or conversation
- Show interest in what children have to say
- Share storytelling time with your child

Resource: The handout at this link <http://www.pacer.org/parent/php/php-c134.pdf> provides even more ideas to build literacy skills, including for children with disabilities.



Construct 12 : Developmental Screening

Type of Measure: Performance Indicator

Numerator: Percent of children enrolled in home visiting with a timely screen for developmental delays using ASQ-3 (Ages and Stages Questionnaires—3rd Edition)

Denominator: Number of children (target child) enrolled in home visiting reaching the specified time frame during the reporting period

3. **Goal & Rationale:** Increase or maintain the proportion of target children who are screened at the ages of 9-months, 18-months, and 24- or 30-months for developmental delays using the ASQ-3
 - ◆ Early identification of developmental delays offers an opportunity for early intervention to address developmental concerns.

Data Collection & Measurement Tools:

1. **Who** is included: Primary caregivers with target children ages 9 months to 30 months.
2. **What** is measured: Children's development
3. **How** is it measured: ASQ-3 questionnaires
4. **When** are data collected: At a minimum, each target child should be screened at the chronological ages of 9-months, 18-months, and 24- or 30-months. If a child is born prematurely, the version of the screening tool that corresponds with the child's developmental age at that time should be used. (Note: Completion of ASQ-SE (Social-Emotional) screening is encouraged every 6 months, starting at 6 months of age.)

Data Entry in Visit Tracker:

- ⇒ Click on “**Children**” tab; click on “**Screenings**”; click on “**New Screening**”
- ⇒ Enter Screening Date and Screener
- ⇒ Complete all relevant screening information in boxes provided
- ⇒ Under “**Screening Type**” select ASQ-3 (National)
- ⇒ Choose screening result from drop-down list
- ⇒ Enter scores for each domain
- ⇒ Check “Delay/Concern” box next to any domain where there are concerns
*If the screening result identifies a “Concern,” in any area, a referral is required (even if the child is already receiving services for developmental delays).

Note: Children identified with developmental delays, and already receiving services need either the 9, 18, 24 or 30 month screen. Subsequent screens can be skipped.

*If a Concern is noted, scroll to the bottom of the ASQ screening page and enter referral information in Resource Connection section.

- ⇒ Was a connection made as a result of a concern found during this screening? Click “Yes”
- ⇒ Check box for “Developmental” and enter referral information.
You can make multiple referrals, and It is recommended that you always refer internally and offer supportive services during home visits to the family.
- ⇒ Under **Connection Follow Up**, Enter date of Follow up and complete rest of the screen choosing best responses from drop down choices.

Benchmark Background and Resources for Developmental Screening

The first few years of a child's life are an especially sensitive period in the process of development, laying a foundation in childhood and beyond for cognitive functioning; behavioral, social, and self-regulatory capacities; and physical health. Yet many children face various stressors during these years that can impair their healthy development. 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 the ASQ?**

Parent-completed Ages and Stages 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.

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. (www.aappublications.org)

Resources for families:

[Developmental milestone videos](#): This series of videos by the Minnesota Dept. of Education show and explain what parents can expect in their child's development at different ages from newborn to age 5. (allinahealth.org)

[Health and wellness handouts](#): This series of handouts covers typical development and immunizations that may be given at different checkups from birth to 5. (allinahealth.org)

[Physical Development Delays—what to look for.](#) Watch side by side videos of typical and delayed development to see how they differ at different ages. (healthychildren.org)



Construct 13 : Behavioral Concerns

Type of Measure: Performance Indicator

Numerator: Number of home visits where primary caregivers enrolled in home visiting were asked if they have any concerns regarding their child's development, learning and/or behavior

Denominator: Total number of home visits during the reporting period

Goal & Rationale: Increase or maintain the percent of home visits where primary caregivers were asked if they have any concerns regarding their child's development, learning, and/or behavior.

- ◆ Addressing concerns early offers the best opportunity to support families and provide needed education and interventions.
- ◆ Home visitors establish trusting and supportive relationships with families which help caregivers feel safe expressing concerns about child's development and parenting challenges.

Data Collection & Measurement Tools:

1. **Who** is included: All **postnatal** caregivers, regardless of child's age
2. **What** is measured: How often primary caregivers are asked about concerns regarding child's development, learning and/or behavior
3. **How** is it measured: Home visitors document in PVR if they did or did not ask the primary caregiver about developmental, behavioral, or learning concerns . At each visit, Ask: Do you have any concerns regarding your child's or children's development, learning and/or behavior?
4. **When** are data collected: During **every** postnatal home visit

Note: This is the only benchmark question you must ask at each postnatal visit.

Data Entry in Visit Tracker:

- ⇒ Document in the PVR under child info after each postnatal visit
- ⇒ Scroll down to question: Any concerns regarding your child's development, learning, and/or behavior?
- ⇒ Options are Did not ask, No, or Yes
- ⇒ Click on appropriate button next to question (default is "Did not ask")

John Doe Date of Birth: 5/14/2015 Age: 1 yr. 5 months (77 weeks)

Was a ASQ/ASQSE Conducted on this visit? No: (click image to enter screening)

Milestones Reviewed: Birth to 1½ months 1½ to 3½ months 3½ to 5½ months 5½ to 8 months 8 to 14 months
3-4 years 4-5 years 5-6 years

Milestones Reviewed: No

Milestone Comments:

Medical Provider visits: Add

Any concerns regarding your child's development, learning, and/or behavior? Did not ask No Yes

Benchmark Background and Resources for Behavioral Concerns

Home visits 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.

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.

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).



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BENCHMARK AREA 4

Domestic Violence



Construct:

14. Intimate Partner Violence Screening

Construct 14: Intimate Partner Violence (IPV) Screening

Type of Measure: Performance Indicator

Numerator: Number of primary caregivers enrolled in home visiting who are screened for IPV using the Futures Without Violence Relationship Assessment Tool for female caregivers, and the Hurt, Insulted, Threatened with harm, and Screamed (HITS) assessment tool with male caregivers, within 6 months of enrollment.

Denominator: Number of primary caregivers enrolled in home visiting for at least 6 months

Goal & Rationale: Percent of primary caregivers enrolled in home visiting who are screened for intimate partner violence (IPV) within 6 months of enrollment using the Futures Without Violence Relationship Assessment Tool for females or Hurt, Insulted, Threatened with harm, and Screamed (HITS) Assessment Tool for males.

- ◆ Intimate partner 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.

Data Collection & Measurement Tools:

1. **Who** is included: All primary caregivers enrolled in home visiting during their first six months of enrollment (regardless of relationship status or gender).
2. **What** is measured: Whether they receive a screening for IPV using the Futures Without Violence Relationship Assessment Tool or HITS depending on gender
3. **How** is it measured: Futures Without Violence Relationship Assessment Tool or HITS Tool
4. **When** are data collected: During a home visit within the first 6 months of enrollment

Data Entry in Visit Tracker:

- ⇒ On the PVR, Under “**Were any of the following completed?**” check the “Domestic Violence screening” box, and then fill in “**Futures**” (or “HITS” for male caregivers) in “**For any completed, list tool used**” box.
- ⇒ On the “Guardian Assessments” page choose “Add New” and select “Futures” (or HITS)
- ⇒ Complete screen and enter Total Score (10-72)

Note: Scores of 21 or higher on the Futures screen require a referral to domestic violence services. Scores of 11 or higher on the HITS (for males) require a referral.

Note: You must screen all caregivers for IPV and refer for services if a concern is identified, even if they are already receiving IPV services.

If a referral is indicated, also complete a Domestic Violence Safety Plan.

Benchmark Background and Resources for Intimate Partner Violence (IPV) Screening (page 1 of 3)

Intimate Partner Violence is defined as: physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner. An intimate partner is a person with whom one has a close personal relationship that can be characterized by the following: emotional connectedness, regular contact, ongoing physical contact and sexual behavior, identity as a couple, familiarity and knowledge about each other's lives.¹

While women are most often the victims of domestic violence, men can be victims of domestic violence as well. The HITS domestic violence tool is validated for use with male caregivers. HITS stands for Hurt, Insult, Threaten, and Scream. A HITS cut off score of 11 or greater indicates a positive screen for a male participant being victimized.

DV Resources for Home Visitors:

- ⇒ Here's a link to a Futures Without Violence, [Addressing Domestic Violence in Home Visitation Settings webinar](#)
- ⇒ The free [Healthy Moms, Happy Babies Training Curriculum: A Train the Trainers Curriculum on Domestic Violence, Reproductive Coercion and Children Exposed, Second Edition](#) can also be downloaded from the **Futures Without Violence** website. This train the trainer curriculum is specifically geared to the training of home visitors on intimate partner violence, and includes PowerPoint slides with detailed trainers' notes.
- ⇒ A wide range of free training and resource materials are available on **The National Resource Center on Domestic Violence** site: <http://www.nrcdv.org/dvrn/>
- ⇒ The literature which specifically focuses on the impact of violence on children tells us that many young children live in families where their mothers are abused. In 30-60% of families where spousal abuse takes place, there is also child maltreatment and emotional consequences from witnessing violence. **The Child Welfare Information Gateway** website provides information and resources related to Domestic/Intimate Partner Violence. <https://www.childwelfare.gov/topics/can/factors/contribute/family/domviolence/>
- ⇒ **The National Center on Domestic Violence, Trauma and Mental Health** site offers DV trainings and resources <http://www.nationalcenterdvtraumamh.org/trainingta/>. A free [Guide for Engaging & Supporting Parents Affected by Domestic Violence](#) is also available on this site.

¹ Centers for Disease Control and Prevention. Injury Prevention and Control: Division of Violence Prevention, 2015. Retrieved from <http://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html>



Benchmark Background and Resources for Intimate Partner Violence (IPV) Screening (cont'd)

DV Resources for Home Visitors:

- ⇒ If you need to make a referral to a domestic violence shelter, use this site to type in a zip code to locate [Domestic Violence Shelters](#) in your service area. It's helpful to establish points of contact at your local shelters so you can offer a warm hand off to participants when making a referral.
- ⇒ Assist participants with figuring how and when they can leave an abusive relationship by developing a safety plan.
- ⇒ The Domestic Shelters site: www.domesticshelters.org/ provides resources and information on topics such as orders of protection, child custody and escaping violence. Their [Tips on Safety Planning](#) handout lists essentials needed when leaving an abusive partner.
- ⇒ [Home Visitation Booklet](#). This is a comprehensive and practical [resource](#) developed by the Arizona Coalition to End Sexual & Domestic Violence. It covers how home visitors can engage with clients on domestic violence, from starting the conversation and initial screening, through red flags, referrals and documentation. The booklet also includes sections on engaging men and fathers, home visitor safety and self-care.
- ⇒ Information on preventing teen dating violence, resources and training materials designed for professionals working with teens can be found at <http://vetoviolence.cdc.gov/dating-matters>
- ⇒ **A free online course called [Dating Matters](#)®** takes about one hour to complete covers the following topics:
 - Characteristics of healthy and unhealthy teen relationships
 - Early warning signs and factors that may increase a teen's risk for dating violence
 - Statistics, examples, and consequences of teen dating violence
 - Ways to promote healthy relationships and prevent unhealthy and violent ones

DV Resources for Participants:

- ⇒ The National Domestic Violence Hotline can be reached 24-hours a day/7 days a week at 1-800-799-7233.
- ⇒ Call, text or chat Love Is Respect—The National Teen Dating Abuse Helpline: 1-866-331-9474
- ⇒ Domestic violence Safety Tips: <http://www.nrcdv.org/domestic-violence-safety-tips/>
- ⇒ [Understanding Teen Dating Violence](#) fact sheet

Domestic Violence -- A Tip Sheet for Home Visitors

Domestic violence/intimate partner violence (IPV) are among the many sensitive topics that home visitors explore with the families with whom they work. Just as they screen for adverse childhood experiences and maternal depression, home visitors build trusting relationships and apply their observational skills and techniques such as active listening and motivational interviewing in their work with women and families who may be experiencing intimate partner violence (IPV). Here are some tips and resources for home visitors to consider.

Follow a universal approach to domestic abuse screening by using a "safety card." That is, offer safety cards to everyone, for their own possible use or because they may want to share it with a friend or family member. Many programs report using the [Futures Without Violence Safety Card](#) which prompts women to think about whether they are in a healthy or problematic relationship.

- The Arizona Coalition to End Sexual and Domestic Violence reminds home visitors that "using normalizing language and universal education before doing a screening for domestic violence can make it easier for a participant experiencing domestic violence to disclose and can make the conversation more comfortable for both the participants and the home visitor." [1]
- Think about how to approach screening conversations for domestic violence in a way that is respectful and provides an opening for disclosure. If you are a new home visitor, practicing with colleagues, or observing an experienced home visitor can help you feel more comfortable knowing how to start this conversation; for example you can start with open-ended questions, letting the mother know that you ask all families these questions to find out what concerns they may have.
- Discuss confidentiality. Reassure the mother that you will not disclose information that she shares with partners or other family members but be clear too on your role as a mandated reporter. IPV is a possible but not automatic indication of child abuse and neglect.
- Observe and listen. Look for clues; listen for the subtle and understated words that may be cues. Look for signs of emotional abuse, economic abuse, threats, or isolation such as "My boyfriend doesn't like it when I go out with my girlfriends," or "My husband gives me money so I can go grocery shopping."
- Have crisis intervention telephone numbers at your fingertips. The National Domestic Violence Hotline number is 1-800-799-7233 (SAFE); the National Dating Abuse Helpline number is 1-866-331-9474.

Find safe ways to do safety planning. This [handout](#) from Domestic Shelters.org provides concrete information about creating a safety plan. It a helpful resource but be careful not to leave it lying around or to include it in a packet of information without sharing that it is there.

- Visit a domestic violence shelter so you can talk knowledgeably and comfortably about the experience of being in a shelter.
- Take care of yourself. Monitor your own signs of stress. Use your reflective supervision time to get support from your supervisor. Know where to get additional support if your own history may trigger a strong reaction in your work with clients. Create balance in your own life. Find ways to nurture yourself so you can nurture others.
- Take care of your own personal safety as well. Trust your instincts. Know your agency policies and crisis protocols and make sure that if you are working with a family experiencing IPV you know what do if you feel that your own safety is at risk.
- Learn more.

Take a [self-paced online course](#) from the National Resource Center on Domestic Violence for basic background information on domestic violence and an interactive description of the Power and Control Wheel developed by the Domestic Abuse intervention Project in Duluth, MN.

Check out the [Home Visitation Booklet](#) from the Arizona Coalition to End Sexual & Domestic Violence. This comprehensive and practical resource leads home visitors through the process of engaging with clients on domestic violence from starting the conversation and initial screening through referrals and documentation. It includes sections on mandated reporting, engaging men and fathers, and home visitor safety and self-care.

[1] Home Visitation Guidelines on Domestic Violence, Arizona Coalition to End Sexual & Domestic Violence.

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BENCHMARK AREA 5

Family Economic Self-Sufficiency



Constructs:

- 15. Primary Caregiver Education**
- 16. Continuity of Insurance Coverage**

Construct 15: Primary Caregiver Education

Type of Measure: Systems Outcome

Numerator: Number of primary caregivers who enrolled in home visiting without a high school degree or equivalent , who subsequently enrolled in, maintained continuous enrollment in, or completed high school or equivalent (GED) during their participation in home visiting

Denominator: Number of primary caregivers without a high school degree or equivalent at enrollment

Goal & Rationale: Increase the number of primary caregivers who enrolled in home visiting without a high school degree or equivalent who subsequently enrolled in, maintained continuous enrollment in, or completed high school or equivalent during their participation in home visiting.

- ◆ Benefits of a High School Diploma include better job opportunities, higher wages and a positive example for children in the household.

Data Collection & Measurement Tools:

1. **Who** is included: Primary caregivers without a high school diploma or equivalent (GED) at enrollment.
2. **What** is measured: Participants who enroll in or complete high school or a GED program.
3. **How** is it measured: Primary caregivers without a high school diploma or equivalent (GED) at enrollment are asked if they have enrolled in or completed high school or a GED program.
3. **When** are data collected: During a home visit

Note: If a guardian does not complete HS/GED, s/he will remain on your report until s/he completes, even over multiple program years.

Data Entry in Visit Tracker:

- ⇒ Under “Guardian” click on “Goals/Plans.”
- ⇒ If “Education” is a goal area, 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 is tracked over multiple years.

Benchmark Background and Resources for Primary Caregiver Education

Home visitors are in a unique position to encourage and support participant's efforts to complete education goals.

Benefits of a High School Diploma include:

- Better job opportunities
- Allows you to go on to college
- Higher wages
- Sets a positive example to your children

National Center for Children in Poverty

- ⇒ Among children under age 3 in Illinois, 10% are in households with low parental education.
- ⇒ Among children under age 3 in Illinois, 8% are in households with both low income and low parental education.

Illinois awards a **High School Equivalency Certificate** to test-takers who pass the **GED** Illinois test. GED officially means **General Education Development**, but is also known by names such as **Graduate Equivalency Degree**, **General Education Diploma**, or **General Equivalency Diploma**. In Illinois, GED testing is handled by the Illinois Community College Board and the GED exam can only be taken at a local official GED test center.

In addition to the five GED subject tests in math, reading, writing, science, and social studies, GED Illinois test-takers will need to pass the Illinois GED Constitution test, which includes questions about the Declaration of Independence, the United States Constitution, the Illinois Constitution, and the U.S. flag.

The GED testing fee in Illinois is \$50 for all five tests, or \$10 to \$15 per test for retesting. There is no fee for retaking the constitution test. Contact your local [Illinois Official GED Testing Centers](#) for tests available in other languages.

More information on the GED test can be found at [GED FAQ](#) and <http://www.passged.com/IL-GED-Testing.php>



Construct 16: Continuity of Insurance Coverage

Type of Measure: Systems Outcome

Numerator: Number of primary caregivers enrolled in home visiting who had continuous health insurance coverage for at least 6 consecutive months

Denominator: Number of primary caregivers enrolled in home visiting for at least 6 months

Goal & Rationale: Increase in the percent of primary caregivers enrolled in home visiting who had continuous health insurance coverage for at least 6 consecutive months since enrollment in home visiting.

- ♦ Continuous Health Insurance Coverage is defined as having health insurance coverage without any lapses.

Data Collection & Measurement Tools:

1. **Who** is included: Primary caregivers enrolled in program for at least 6 months
2. **What** is measured: Continuous health insurance coverage for at least 6 consecutive months since enrollment
3. **How** is it measured: A series of questions are asked: (1) Is the primary caregiver covered under health insurance? What are the dates? What is the insurance? Parents are asked to report changes to health insurance benefits and continuous coverage is tracked.
4. **When** are data collected: During home visits subsequent to 6 months of program enrollment

Data Entry in Visit Tracker:

- ⇒ Under "Guardian" click on "Health Info"
- ⇒ Scroll down to "Insurance History"
- ⇒ Click on "Add Item" and fill in Date. For History Status field, choose best insurance coverage option from drop-down menu.
- ⇒ Indicate Yes or No for question: Has the primary caregiver had continuous healthcare coverage for the past 6 months?

Note: This information should be entered upon enrollment and then updated quarterly.

Note: In order to achieve this benchmark, insurance coverage must be continuous without any gaps.

Benchmark Background and Resources for Continuity of Insurance Coverage

RESOURCE:

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

BENCHMARK AREA 6

Coordination and Referrals for Other Community Resources and Supports



Constructs:

- 17. Completed Depression Referrals**
- 18. Completed Developmental Referrals**
- 19. Intimate Partner Violence Referrals**

Construct 17: Completed Depression Referrals

Type of Measure: Systems Outcome

Numerator: Number of primary caregivers enrolled in home visiting who received recommended services for depression (and met the conditions specified by the denominator)

Denominator: Number of primary caregivers enrolled in home visiting who had a positive screen for depression within 3 months of enrollment and were referred for services

Goal & Rationale: Increase or maintain the percent of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts

- ◆ Identifying a family's needs allows home visitors to refer family members to appropriate services.
- ◆ If families follow through with referrals, they can receive the help they need.
- ◆ Untreated depression impacts a caregiver's ability to parent.

Data Collection & Measurement Tools:

1. **Who** is included: Primary caregivers who screened positive for depressive symptoms and were referred for services (Scores of 9 or higher for women or 10 or higher for men require a referral)
2. **What** is measured: Whether the referral was given and whether the caregiver received at least one service contact (yes, received services)
3. **How** is it measured: Caregiver self-report and home visitor documentation
4. **When** are data collected: During home visits when appropriate

Note: Per HRSA guidance, this will **not** need to be reported in the presence of subsequent target children

Data Entry in Visit Tracker:

- ⇒ Under "Guardian", click on "Resource Connection"
- ⇒ Enter resource connection information. Connection type should be " Mental Health Services" or Mother's and Babies
- ⇒ If caregiver is already receiving these services, choose "family already receiving services" dropdown option.

Note: In order to achieve this benchmark, caregiver must have been assessed for maternal depression (EPDS, Benchmark 3), receive a referral, and complete one or more service contacts.

While you must screen all caregivers even if they're already receiving treatment for depression, you do not need to refer "again" if they're already receiving services.

Note: Home visitor support offered through use of the Mother's and Babies curriculum counts as services received.

Benchmark Background and Resources for Completed Depression Referrals

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

For completed depression referrals, recommended services include specific techniques and intervention models delivered in the context of client characteristics, culture, and preferences that have shown to have positive effects on outcomes through rigorous evaluations and have demonstrated to achieve positive outcomes for the client.¹

Interpreting the EPDS score

A score of:

0-9 is considered low risk of perinatal depression

10-12—moderate risk of perinatal depression

13-30—high risk of perinatal depression

Note: A score of 0 is considered unusual. It may indicate a reluctance to reveal true feelings or possible literacy issues and requires further discussion with the client

For MIECHV sites, it is recommended that anyone receiving a n EPDS score of 9 or above for female caregivers and 10 or above for male caregivers, should receive a referral.

Read more about the Edinburgh:

The following article has additional details and guidelines for use of the Edinburgh Postnatal Depression Scale (EPDS):

<http://www.pmh.health.wa.gov.au/general/CACH/docs/manual/3%20Birth%20to%20School%20Entry/3.8/3.8.4%20Birth%20to%20School%20Entry%20Resources%20-%20Edinburgh%20Postnatal.pdf>



¹ Home Visiting Collaborative Improvement and Innovation Network.

Construct 18: Completed Developmental Referrals

Type of Measure: Systems Outcome

Numerator: Number of children enrolled in home visiting who a) received individualized developmental support from a home visitor; b) were referred to early intervention services and receive and evaluation within 45 days; OR c) were referred to other community services who received services within 30 days (and met the conditions specified in the denominator)

Denominator: Number of children enrolled in home visiting with positive screens for developmental delays (measured using a ASQ-3)

Goal & Rationale: Increase or maintain the percent of children enrolled in home visiting with positive screens for developmental delays (measured using ASQ-3) who receive services in a timely manner.

- ◆ Tracking referral follow through helps ensure families receive needed services.
- ◆ Early intervention services can change a child's developmental trajectory and improve outcomes for children, families, and communities.
- ◆ Intervention is likely to be more effective and less costly when it is provided earlier in life rather than later.

Data Collection & Measurement Tools:

1. **Who** is included: Index children who screen positive for developmental delays

Note: Children identified with developmental delays, and already receiving services need either the 9, 18, 24 or 30 month screen. Subsequent screens can be skipped.

2. **What** is measured: Family referrals to community resources

3. **How** is it measured: Referral tracking tool used, which gives referral reason, and referral date.

4. **When** are data collected: During a home visit

⇒ Note: In order to achieve this benchmark, families that have been assessed and identified with a positive screen or concern regarding child development (ASQ-3, ASQ-SE), must have been referred to a community resource.

⇒ Note: This benchmark requires that those families that have been screened and identified as needing community services has received a referral for such services to address their needs.
ASQ -3 = at or below cutoff score or parent identifies a concern

Data Entry in Visit Tracker:

If a Concern is noted when entering ASQ screening information, scroll to the bottom of the ASQ screening page and enter referral information in Resource Connection section.

⇒ Was a connection made as a result of a concern found during this screening? Click "Yes"

⇒ Check box for "Developmental" and enter referral information.

⇒ Under **Connection Follow Up**, Enter date of Follow up.

⇒ Did family receive services...? Choose best response from drop down choices.

Referral Follow-up Benchmark also looks at timeframe for referral completion: EI evaluation within 45 days of screen (date family first received services); Community based services started within 30 days of screen (date family first received services); Individualized support from home visitor (date doesn't matter).

Benchmark Background and Resources for Completed Developmental Referrals

When a child receives a positive screen for developmental delays, if the child is younger than 3, the first step for the family is a referral to Child and Family Connections for Early Intervention Services.

To find your local CFC office, call 1-800-323-4769. 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.

For a complete list of EI services, and additional resources for families with young children, visit the Illinois Early Intervention Clearinghouse Web site at <http://eiclearinghouse.org>.

After a referral is made, the family will meet with a team to help them assess your child's development and to determine if the child is eligible for EI services. If the child is eligible, the family will work with a team of professionals to develop a plan for services. The plan is called an Individualized Family Service Plan, or IFSP. It explains what the family wants for their child and how everyone will work together to reach chosen goals. Services might include developmental, speech, occupational, or physical therapy.

The Importance of Early Intervention for Infants and Toddlers with Disabilities and their Families <http://www.nectac.org/~pdfs/pubs/importanceofearlyintervention.pdf>

When there is a waiting list for EI services, home visitors can support the parent's developmental goals for the child with specialized visit plans designed to meet the child's developmental needs.



Construct 19: Intimate Partner Violence (IPV) Referrals

Type of Measure: Performance Indicator

Numerator: Number of primary caregivers enrolled in home visiting who received referral information to IPV resources (and met the conditions specified in the denominator)

Denominator: Number of primary caregivers enrolled in home visiting with positive screens for IPV (measured using the “Futures” for women and obtaining a score of 21 or higher, or the HITS for men and obtaining a score of 11 or higher)

Goal & Rationale: Increase the percent of primary caregivers enrolled in home visiting with positive screens for IPV on the “Futures” (or HITS for male caregivers) who receive referral information to IPV 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 and safety.

Data Collection & Measurement Tools:

1. **Who** is included: Primary caregivers who screened positive for intimate partner violence (IPV)
2. **What** is measured: Referrals to IPV resources. (No timeframe specified but as soon as possible is best practice)
3. **How** is it measured: Referral tracking system has an indicator for referrals for Domestic Violence Services. **Benchmark looks at whether the referral was given. It doesn't matter whether referral was completed, or the date of the referral, as long as it is after the date of the positive screen.**
4. **When** are data collected: after a home visit with a positive IPV screen, referral is entered in Visit Tracker

Note: If a guardian does not receive a referral s/he will remain on your report until s/he receives a referral, even over multiple program years.

Data Entry in Visit Tracker:

- ⇒ Under Guardian, click on “Resource Connection” tab.
- ⇒ Enter Resource Connection: “Connection Type” from the drop down list **must be** “Domestic Violence Services”
- ⇒ Complete all fields and click “Create”
- ⇒ Then click on pencil icon “Add Connection Follow-Up”
- ⇒ Document Follow information with date and using drop down list choices

Complete a Domestic Violence Safety Plan and document on Goal screen—goal type should be “Domestic Violence Safety Plan.” Mark as completed and add End Date when Safety Plan is completed.

Benchmark Background and Resources for Intimate Partner Violence (IPV) Referrals

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.

The State of Illinois Domestic Violence hotline is toll free, confidential, multilingual and open 24-hours.

Call: 1 (877) TO END DV or 1 (877) 863-6338

Domestic Violence Victim Services through the helpline include:

- a 24-hour crisis hotline that provides:
- support
- information
- referral
- counseling
- safety planning
- legal advocacy
- children's services
- temporary food and housing

Visit the Illinois DHS Domestic Violence Helpline website for a list of domestic violence agencies by city: <http://www.dhs.state.il.us/page.aspx?item=31886>



Links to Additional 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](#) Look Through Their Eyes website

⇒ The DCFS SPD searchable online catalog of community-based resources for children and families in IL is available at <https://illinoisoutcomes.dcf.s.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, contact Erik Sandberg at DCFS: Erik.Sandberg@illinois.gov.

⇒ Look up SNAP program **average monthly benefit estimates based on income** at

<http://www.fns.usda.gov/sites/default/files/pd/34SNAPmonthly.pdf>

Dental education for kids and families: <http://cavityfreekids.org/>

Locating dentists: The [Denta Quest Illinois](#) site provides info about dentists that accept Medicaid in IL. Click on the "find a dentist" link or call the phone number.

⇒ **Zika Virus:** The CDC's [Vital Signs](#) presents the latest findings on Zika infection in pregnant women and babies and the importance of prevention and early care.

Visit this page for **Zika Virus Print Resources and Fact Sheets** <https://www.cdc.gov/zika/fs-posters/index.html>



Links to Additional Resources (Cont'd)

Resources from the American Academy of Pediatrics:

SIDS and Other Sleep-Related Infant Deaths. This article provides [updated 2016 Recommendations](#) for a Safe Infant Sleeping Environment from the AAP Task Force on Sudden Infant Death Syndrome (SIDS).

Media and Young Minds. [Updated 2016 Recommendations](#) on media use with infants, toddlers and preschoolers.

Oral Health and Dental Care Resources*:

<https://hvimpact.wordpress.com/2016/12/30/the-role-of-home-visitors-in-promoting-oral-health-a-tip-sheet-for-home-visitors-2/>

Healthy Habits for Happy Smiles is a series of handouts developed by the National Center on Early Childhood Health and Wellness to provide simple tips on oral health issues. The handouts are available in English and Spanish and include the following titles:

- *Brushing Your Child's Teeth* ([English](#) and [Spanish](#))
- *Choosing Healthy Drinks for Your Young Child* ([English](#) and [Spanish](#))
- *Finding a Dental Clinic for Your Child* ([English](#) and [Spanish](#))
- *Getting Fluoride for Your Child* ([English](#) and [Spanish](#))
- *Giving First Aid for Your Child's Oral Injuries* ([English](#) and [Spanish](#))
- *Giving Your Child Healthy Snacks* ([English](#) and [Spanish](#))
- *Helping Your Baby with Teething Pain* ([English](#) and [Spanish](#))
- *Preventing Injuries to Your Child's Mouth* ([English](#) and [Spanish](#))
- *Taking Care of Your Baby's Oral Health* ([English](#) and [Spanish](#))
- *Toothbrushing Positions for Your Child with a Disability* ([English](#) and [Spanish](#))
- *Toothbrushing Tips for Your Child with a Disability* ([English](#) and [Spanish](#))
- *Visiting the Dental Clinic with Your Child* ([English](#) and [Spanish](#))

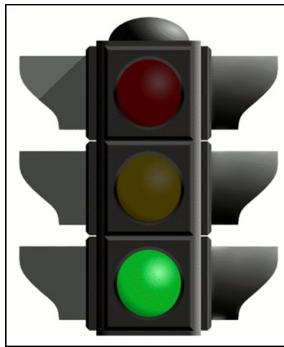
*from HV-Impact Newsletter Dec. 30, 2016 article: The Role of Home Visitors in Promoting Oral Health – A Tip Sheet for Home Visitors by Katrina Holt, MPH, MS, RD, FAND Director National Maternal and Child Oral Health Resource Center Georgetown University

Text-message Service for Parents of Children ages 1-3:

Connect4Tots is a free text-message service that provides parents and guardians of toddlers ages 1 to 3 with information about their child's growth and development, as well as connections to health, education, and public service resources in the City of Chicago.

Please share this resource with the parents and guardians of the children you serve. To join and receive text messages, parents and guardians simply text TO-TOPT5 to 311311 or can use this [online form](#).





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: Illinois-Benchmark-Glossary-FY17-2-23-17.pdf

Suggestions for additions and revisions are welcome!

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