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Maternal Infant and Early Childhood Home Visiting (MIECHV) 5th Annual Benchmark and Outcome Technical Report

FY 2017

The evaluation of the Illinois MIECHV program is funded by the Health Resources and Services Administration to the Illinois Department of Human Services. MIECHV is managed through the Illinois Governor's Office of Early Childhood Development, and the evaluation contracted to the Center for Prevention Research and Development, School of Social Work at the University of Illinois, Urbana.

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Maternal Infant and Early Childhood Home Visiting (MIECHV)
5th Annual Benchmark and Outcome Technical Report
FY 2017

Produced for:
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Contents

Tables and Figures

I. Background and Overview

The Illinois Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program has provided home visiting and doula services in multiple disadvantaged communities across the state for the past six years. During the 2016-2017 program year, FY 2017, Illinois MIECHV was implemented in 32 agencies serving 18 communities across the state. Most notable during the FY 2017 reporting period, which covers the timeframe of October 1, 2016 through September 30, 2017, were the revamping of the program's performance measures by the Health Resources and Services Administration (HRSA). Performance Benchmarks were reduced in FY 2017 from 35 to 19 and they were again changed in FY 2017 to six key measures. The MIECHV system focused on the following areas during the reporting period: 1) Maternal and newborn health; 2) Child injuries, maltreatment, and emergency department visits; 3) School readiness and achievement; 4) Crime or domestic violence; 5) Family and economic self-sufficiency; and 6) Coordination and referrals.

This Annual Benchmark and Outcome Technical Report is produced by the research and evaluation team at the Center for Prevention Research and Development (CPRD), School of Social Work, at the University of Illinois Urbana-Champaign (UIUC). As the external evaluator for the MIECHV initiative, CPRD has completed the fifth full year MIECHV program evaluation, as required by the federal HRSA, reflecting Illinois' submission for Year 6 (FY 2017) Performance Benchmark (PB) data in October 2017, which were reviewed by HRSA in December 2017.

This year's annual report continues to build on prior years' reports related to program implementation, continuous quality improvement (CQI), and several additional sub-studies and outcome analyses that go beyond the HRSA benchmark reporting requirements. The purpose of the added data collection and analysis is to provide Illinois MIECHV leadership with supplemental information and feedback that is used to understand and improve state and community systems and services. MIECHV components are measured and assessed based on empirical qualitative and quantitative data collected by the evaluation team.

HRSA requires that MIECHV programs and services are designed to provide evidence-based services to caregivers and children who are at-risk for a range of adverse outcomes (Michalopoulos, Faucetta, Warren & Mitchell, 2017). Four essential strategies comprise Illinois' proposed approach to the implementation of MIECHV:

1. Expanding or enhancing one of three home visiting models, as well as doula services;
2. Ensuring that home visiting programs are effectively connected to the community-based organizations and services that are required to achieve performance benchmarks, including primary care providers;

3. Providing and participating in comprehensive CQI processes and procedures at the Local Implementing Agency (LIA), community, and state levels, in order to monitor and improve the quality and effectiveness of home visiting and ancillary services; and
4. Developing and strengthening a statewide system of evidence-based and innovative approaches to home visiting, as well as the state and local infrastructure necessary to support effective service delivery.

Adoption and implementation of these strategies include the development and pilot testing of a new system of universal screening, and the redesign and enhancement of the Coordinated Intake Network, and early childhood collaboratives in each target community.

Revisions to MIECHV Reporting Requirements

In late 2015, HRSA announced its intent to revise MIECHV reporting requirements effective October 1, 2016. Over the next year, HRSA announced draft revisions, held listening sessions, provided guidance and technical assistance, and answered endless questions from grantees across the country. The intent of the revision was twofold: to minimize data burden and to standardize data collection across the country. The new set of data requirements was designed to tell a better and more cohesive story about who MIECHV serves and how the lives of those families are improved through MIECHV services.

Under the new system, MIECHV programs continue to report demographic and service delivery data in Form 1 and performance indicators and outcome measures in Form 2. Changes to Form 1 were minimal, whereas Form 2 was almost completely revised. Additionally, there was one overarching change required of programs using home visiting models that serve multiple index children (Parents as Teachers [PAT] and Early Head Start [EHS] in the case of Illinois MIECHV). These programs are now required to report required data on all index children, whereas they previously reported on one target child. The reporting requirement changes are listed below.

Form 1. Demographic data requirements remained fairly constant, with the addition of a handful of data points:

- Guardian housing status
- Child usual source of medical and dental care

Form 2. The overall benchmark areas for Form 2 remain the same:

- Improvement in maternal and newborn health
- Reduction in child injuries, abuse, and neglect
- Improved school readiness and achievement
- Reduction in crime or domestic violence
- Improved family economic self-sufficiency

- Improved coordination and referral for other community resources and supports

Individual constructs, however, were substantially changed:

- HRSA introduced 19 constructs (a reduction from 34 for Illinois).
- Only one of the 19 constructs remained the same.
- Unlike the prior set of constructs, which were each reported once, many of the current constructs are reported each year.

HRSA also categorized the constructs into two groups: performance indicators and systems outcomes:

- Performance indicators are more sensitive to home visiting services and therefore MIECHV grantees are evaluated based on these measures.
- Systems outcomes are influenced more by state or community systems and therefore are less sensitive to change through home visiting services alone. Grantees are required to report these measures but are not evaluated based on them.

A summary of Form 2 constructs is shown in Table 1 below.

TABLE 1: FORM 2 CONSTRUCT SUMMARY

Benchmark Area	Performance Measure		Type of Measure
Maternal and Newborn Health	1. Preterm Birth	Percent of infants (among mothers who enrolled prenatally before 37 weeks) who are born preterm	Systems Outcome
	2. Breastfeeding	Percent of infants (among mothers who enrolled prenatally) who were breastfed at 6 months of age	Systems Outcome
	3. Depression Screening	Percent of caregivers who are screened for depression within 3 months of enrollment or delivery	Performance Indicator
	4. Well-Child Visits	Percent of children who received the last American Academy of Pediatrics recommended visit	Performance Indicator
	5. Postpartum Care	Percent of mothers enrolled prenatally or within 30 days after delivery who received a postpartum care visit within 8 weeks of delivery	Performance Indicator
	6. Tobacco Cessation Referrals	Percent of primary caregivers who reported using tobacco at enrollment and were referred to tobacco cessation services by 3 months post enrollment	Performance Indicator
Child Injuries, Maltreatment,	7. Safe Sleep	Percent of infants that are always placed to sleep on their backs, without bed-sharing or soft bedding	Performance Indicator

and Reduction of ED Visits	8. Child Injury	Rate of child injury/ingestion-related visits to the ED since enrollment during the reporting period	Systems Outcome
	9. Child Maltreatment	Percent of children with at least 1 investigated case of maltreatment after enrollment w/in reporting period	Systems Outcome
School Readiness and Achievement	10. Parent-Child Interaction	Percent of primary caregivers who receive an observation of caregiver-child interaction	Performance Indicator
	11. Early Language and Literacy Activities	Percent of children with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with her/his child daily	Performance Indicator
	12. Developmental Screening	Percent of children with a timely ASQ-3 screen Ages: 9, 18, 24 and 30 months	Performance Indicator
	13. Behavioral Concerns	Percent of home visits where primary caregivers were asked if they have any concerns regarding their child's development, behavior, or learning	Performance Indicator
Crime or Domestic Violence	14. Intimate Partner Violence Screening	Percent of primary caregivers who are screened for IPV by 6 months post enrollment	Performance Indicator
Family Economic Self-Sufficiency	15. Primary Caregiver Education	Percent of primary caregivers who enrolled w/o a HS degree/GED who enrolled in, maintained continuous enrollment in, or completed HS/GED	Systems Outcome
	16. Continuity of Insurance Coverage	Percent of caregivers who had continuous health insurance coverage for at least 6 consecutive months	Systems Outcome
Coordination and Referrals	17. Completed Depression Referrals	Percent of caregivers referred to services for a positive EPDS who receive one or more service contacts	Systems Outcome
	18. Completed Developmental Referrals	Percent of children with positive ASQ-3 screens who receive services within a specific timeframe	Systems Outcome
	19. Intimate Partner Violence Referrals	Percent of caregivers with positive screens for IPV who receive referral information to IPV resources	Performance Indicator

Over time, Illinois MIECHV believes these recent data changes will result in reduced data burden and a more cohesive story of MIECHV program success across the country. However, in the short term the revisions to MIECHV reporting requirements, and the accompanying revisions to Illinois MIECHV's database and program operations, and training and technical

assistance, have been challenging for all MIECHV staff, and the home visitors, who are ultimately responsible for data collection and entry, in particular. In the annual CQI Survey that CPRD conducts to collect direct feedback from the home visiting staff, many open-ended responses addressed issues related to these changes. One respondent said, "The amount of changes occurring in such a short length of time causes a lot of confusion." Another commented, "It is difficult to keep track of PAT, Prevention Initiative (PI), Illinois State Board of Education (ISBE), and MIECHV requirements since they have different guidelines."

Respondents saw both the challenges related to, and the importance of, the revisions to MIECHV reporting. One respondent pointed out: "Sometimes Home Visitors are so focused on data collection or other numbers that is it hard to focus on the parent's needs. I also understand that we need all the data collection in order to show that what we are doing is helping." Another offered: "It would also be helpful if other public funding sources incorporated MIECHV benchmarks, requirements, and a CQI process. It would go far to bolster quality of overall home visiting programs." It is heartening to hear from the field that while challenging, MIECHV program requirements support increased program quality.

Illinois MIECHV Communities

In FY 2017, Illinois MIECHV was comprised of 34 home visiting (HV) programs, housed in 32 agencies, serving 18 disadvantaged communities in 14 counties. A total of 8 programs were new in FY 2017 including Primo Center, Children's Home + Aid Sycamore, Comprehensive Behavioral Health Center, Aunt Martha's Health and Wellness Center Kankakee, Children's Home + Aid Mid-Central Region, Children's Home Association Peoria, and Stephenson County Health Department and Public Health Foundation. Eight of the 34 HV programs also have doula services, which were concluded in FY 2018 (beginning October 1, 2017). A list of the Illinois communities, MIECHV home visiting providers, and model types are provided in Table 2.

TABLE 2: ILLINOIS MIECHV HOME VISITING AGENCIES BY COMMUNITY FY 2017

Community	Agency	Home Visiting Model
Aurora	Family Focus Aurora	Healthy Families / Doula
Chicago	Chicago YMCA	Healthy Families / Doula
Cicero	Children's Center of Cicero-Berwyn	Parents as Teachers
	Family Focus Nuestra Familia	Parents as Teachers
Cook	Primo Center*	Parents as Teachers
DeKalb County	Children's Home + Aid Sycamore*	Healthy Families /Doula
East St. Louis	Comprehensive Behavioral Health Center*	Parents as Teachers
Elgin	Elgin School District U-46	Parents as Teachers
	Family Focus DuPage	Healthy Families
	Visiting Nurse Association Fox Valley	Healthy Families
Englewood/	ChildServ	Parents as Teachers

Southside Cluster	Family Focus Englewood	Healthy Families
	Henry Booth House	Healthy Families
	The Women's Treatment Center	Parents as Teachers
Kankakee County	Aunt Martha's Health and Wellness Center Kankakee*	Parents as Teachers
N Lawndale / E Garfield Park	Family Focus Lawndale	Parents as Teachers / Doula
Macon County	Decatur Public School District 61 (Pershing)	Parents as Teachers
	Macon County Health Department	Healthy Families
	Macon Resources	Parents as Teachers
McLean-Piatt-DeWitt-Woodford	Children's Home + Aid Mid-Central Region*	Healthy Families
Peoria-Tazewell County	Children's Home Association Peoria*	Healthy Families
Rock Island County	Child Abuse Council	Healthy Families / Doula
Rockford	City of Rockford Human Services	Early Head Start
	Easter Seals Chicago	Healthy Families
	YWCA La Voz Latina	Healthy Families
	Rockford Public School District 205	Parents as Teachers
Stephenson County	Stephenson County Health Department*	Healthy Families
	Public Health Foundation*	Healthy Families / Doula
Vermilion County	Center for Children's Services/Aunt Martha's	Parents as Teachers / Doula
	Danville School District 118	Parents as Teachers
	East Central Illinois Community Action	Early Head Start
Waukegan	One Hope United	Doula

*Newly added site in State FY 2017 (July 1, 2016-June 30, 2017)

In addition to home visiting services, 13 communities in FY 2017 provided coordinated intake (CI) services. Three of these agencies have CI services that were in development during FY 2017. A list of the Illinois communities and CI providers are provided in Table 3. Programs are located in high needs communities in diverse areas of the state including the City of Chicago, small to moderate size urban and suburban communities, as well as impoverished rural areas. More information on CI is provided later in this report.

TABLE 3: ILLINOIS MIECHV COORDINATED INTAKE AGENCIES BY COMMUNITY FY 2017

Community	Coordinated Intake Agency
Cicero	Family Focus Nuestra Familia
Cook	Primo Center*
Elgin	Kane County Health Department
East St. Louis	Comprehensive Behavioral Health Center*
Englewood/ Southside Cluster	Children's Home + Aid
Kankakee County	Aunt Martha's Health and Wellness Center Kankakee*
Macon County	Macon County Health Department
Rockford	Winnebago County Health Department
Vermilion County	Center for Children's Services/Aunt Martha's
DeKalb County	Children's Home + Aid Sycamore
McLean-Piatt-DeWitt-Woodford	Children's Home + Aid Mid-central Region (Bloomington)
Peoria-Tazewell County	Children's Home Association Peoria
Stephenson County	Stephenson County Health Department

*Coordinated Intake in development

To provide a statewide visual aid for the distribution of Illinois MIECHV programs, Figure 1 below shows the locations of all Illinois MIECHV home visiting and doula program communities across the state. Further, it demonstrates the expansion to new areas of the state in both 2016 and 2017. In total, Illinois MIECHV's 34 programs and 32 site locations are distributed across 14 counties in the state. Most programs are located in Illinois' more disadvantaged communities as well as several more rural communities on the fringes of metropolitan areas.

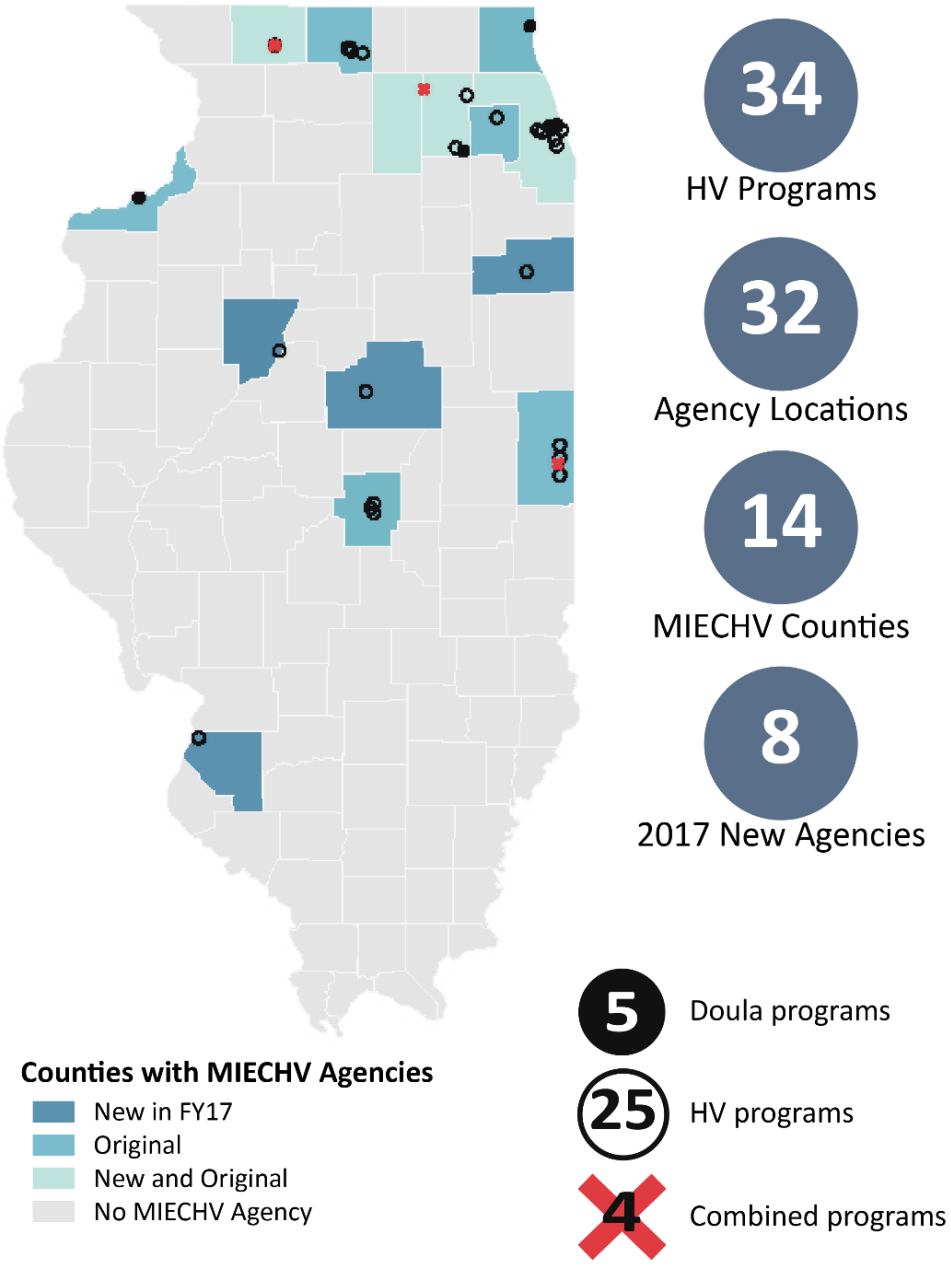


FIGURE 1: ILLINOIS MIECHV SITE LOCATIONS BY COUNTY AND PROGRAM TYPE

II. Participant Demographics, FY 2017

The best way to understand who is served by MIECHV programs is not only to know what services are provided, and where, but it's also important to understand the participating family and children's characteristics and circumstances for children prenatally through kindergarten. The program serves pregnant women and families with children from birth through kindergarten, and is legislatively mandated to prioritize families falling into one or more of the following priority populations:

- Families with low incomes (defined as below the Federal Poverty Levels)
- Pregnant women under 21 years of age
- Families with a history of child abuse or neglect, or interactions with child welfare services
- Families with a history of substance abuse or in need of substance abuse treatment
- Families who have users of tobacco products in the home
- Families who have a child or children with low student achievement
- Families who have a child or children with developmental delays or disabilities
- Families who are serving or formerly served in the Armed Forces

This section of the report presents the socio-demographic characteristics of families served by the MIECHV program in the FY 2017 program year, which ran from October 1, 2016 through September 30, 2017. The terms "caregiver," "participant" and "adult participant" are used interchangeably to refer to the primary guardian or parent enrolled in home visiting services.

Enrollment

In FY 2017, Illinois MIECHV served 1,100 families and 1,088 children. Of the 1,100 families, just under half (47%) were newly enrolled, meaning they enrolled in home visiting services in the 2016-2017 program year (Figure 2). Illinois MIECHV served eleven male caregivers this year, 1% of the total population served. A third of the female caregivers were pregnant at some point during the program year. A higher percentage of newly enrolling participants were pregnant, compared to continuing participants, indicating that many participants are enrolled prenatally and remain in the program.

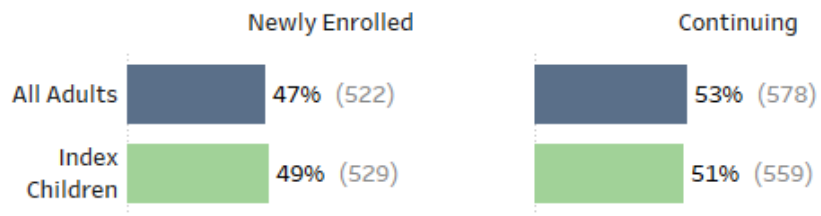


FIGURE 2: ENROLLMENT OF ALL ADULTS AND INDEX CHILDREN IN MIECHV

Just under half (49%) of the children served were newly enrolled this year. Just over half of children served were male (53%) and just under half were female (47%).

Age

MIECHV adult participants ranged in age from 13 to 63 (Figure 3). The majority of adults fell within the 18 to 24 (51%) age range, with very few adults aged 35 or older (11%), or below 18 years of age (9%). The majority of child participants are under one year of age (52%), reflecting Illinois MIECHV's efforts to recruit and enroll participants during pregnancy or soon after birth. Most programs see children through three years of age, which is reflected in the age distribution of children seen in FY 2017.

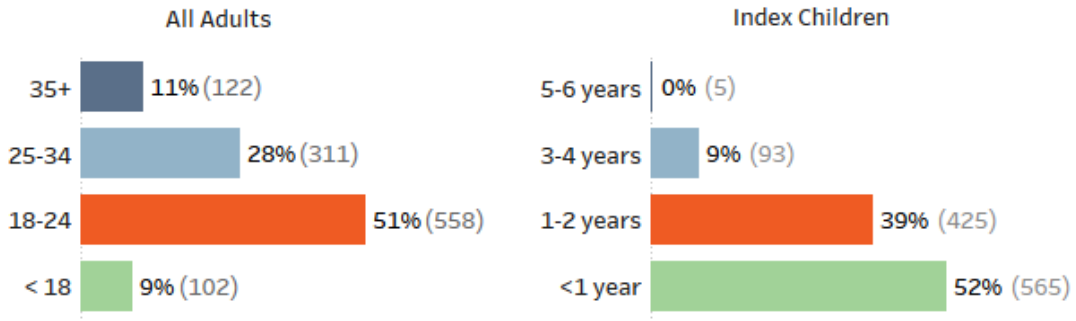


FIGURE 3: AGE OF ALL ADULTS AND INDEX CHILDREN IN MIECHV

Race

In FY 2017, Illinois MIECHV adult participants (caregivers and pregnant women) were 42% white, 39% black, and 19% multi-racial/other, reflecting diverse populations in these communities. When looking at participant race by pregnancy status (Figure 4), more African-American participants were pregnant (48% of the 373 pregnant participants) and more multi-racial/other participants were caregivers (22% of female and male caregivers).

Similar percentages of children served were black (39%) and white (36%) compared to multi-racial children (24%).

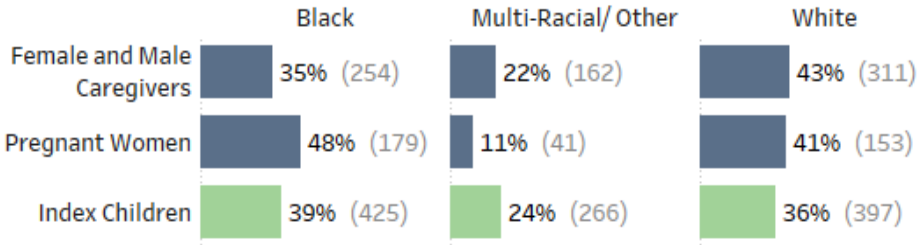


FIGURE 4: RACE OF ALL ADULTS AND INDEX CHILDREN IN MIECHV

Ethnicity

A little over a third (34%) of the 1100 adult participants in FY 2017 were Hispanic or Latino/a. Looking at ethnicity by pregnancy status (Figure 5), more (38%) Latino participants were not pregnant (276 caregivers) compared to 25% (93 women).

A little over a third (38%) of children served were also Latino/a.

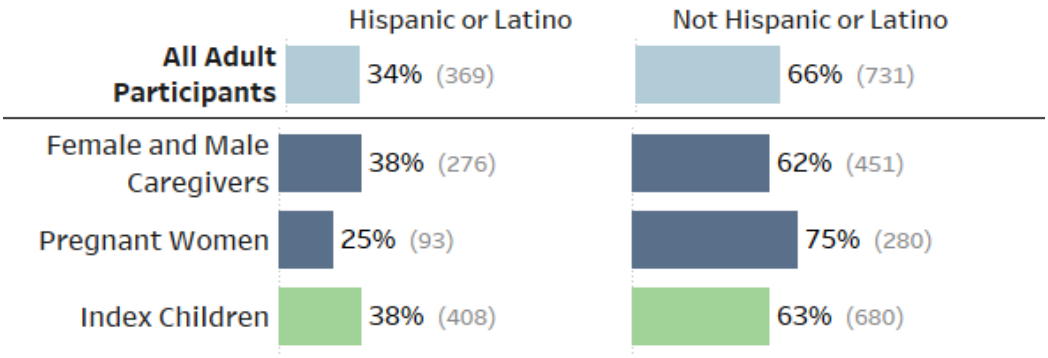


FIGURE 5: ETHNICITY OF ALL ADULTS AND INDEX CHILDREN IN MIECHV

Caregiver Age by Ethnicity and Race

Most adult participants in each racial category fell into the 18 to 24 year age range (Figure 6). African-American participants trended younger than MIECHV participants overall, with 70% below the age of 25. Multi-racial participants served were older than MIECHV participants overall, with over half (55%) above 24 years of age and the highest percent of participants 35 years or older (19%) compared to black and white participants. In this report, the category multi-Racial/other includes those people who self-identify as more than one race, American Indian or Alaska Native, Asian, and Native Hawaiian or other Pacific Islander. These groups are collapsed due to small numbers identifying as these racial categories.

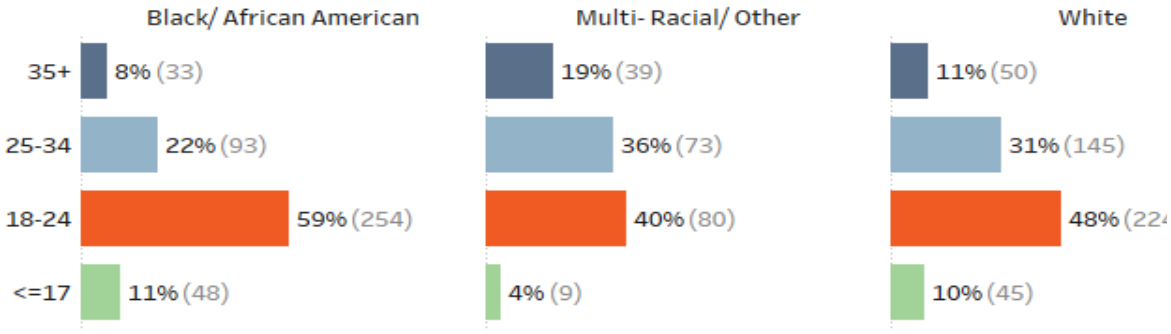
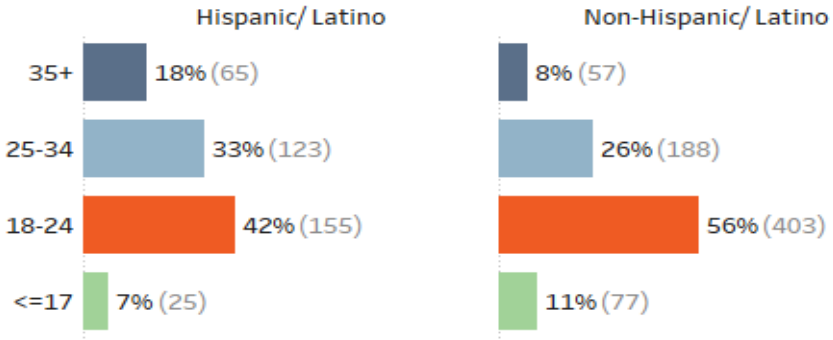


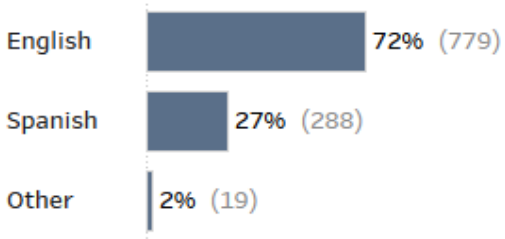
FIGURE 6: AGE OF CAREGIVER BY RACE



As shown in Figure 7 on the left, overall, 34% of participants were Hispanic or Latino/a. These participants were older than non-Hispanic participants, with over half (51%) older than 24 years.

FIGURE 7: AGE OF CAREGIVER BY ETHNICITY

Primary Language



English was the primary language spoken in the homes of almost three quarters (72%) of MIECHV participants in FY 2017 (Figure 8). Just over a quarter of participants (27%) spoke Spanish as their primary language. The remaining languages spoken at home were Arabic, French, Hindi, Telugu, and Vietnamese.

FIGURE 8: PRIMARY LANGUAGE OF INDEX CHILDREN

Marital Status

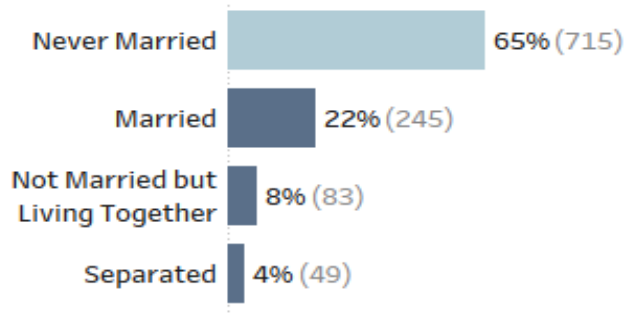


FIGURE 9: CAREGIVERS MARITAL STATUS

The majority of MIECHV participants in FY 2017 reported that they were never married (65%), as seen in Figure 9. An additional 8% were not married, but were living with a partner. Just over 20% were currently married, and 4% were separated.

Education / Employment

Home visiting services not only provide a positive start for children, but also play a key role in supporting parents in completing and advancing their education and careers (Michalopoulos et al., 2017). In FY 2017, 18% of caregivers were students (Figure 10), with 15% of non-pregnant caregivers and 26% of pregnant caregivers currently attending school. Of those currently enrolled in an educational program, almost half (48%) were enrolled in high school and just over a quarter (28%) were enrolled in college. The remaining were enrolled in middle school (3%), GED programs (11%) or technical training programs (9%).

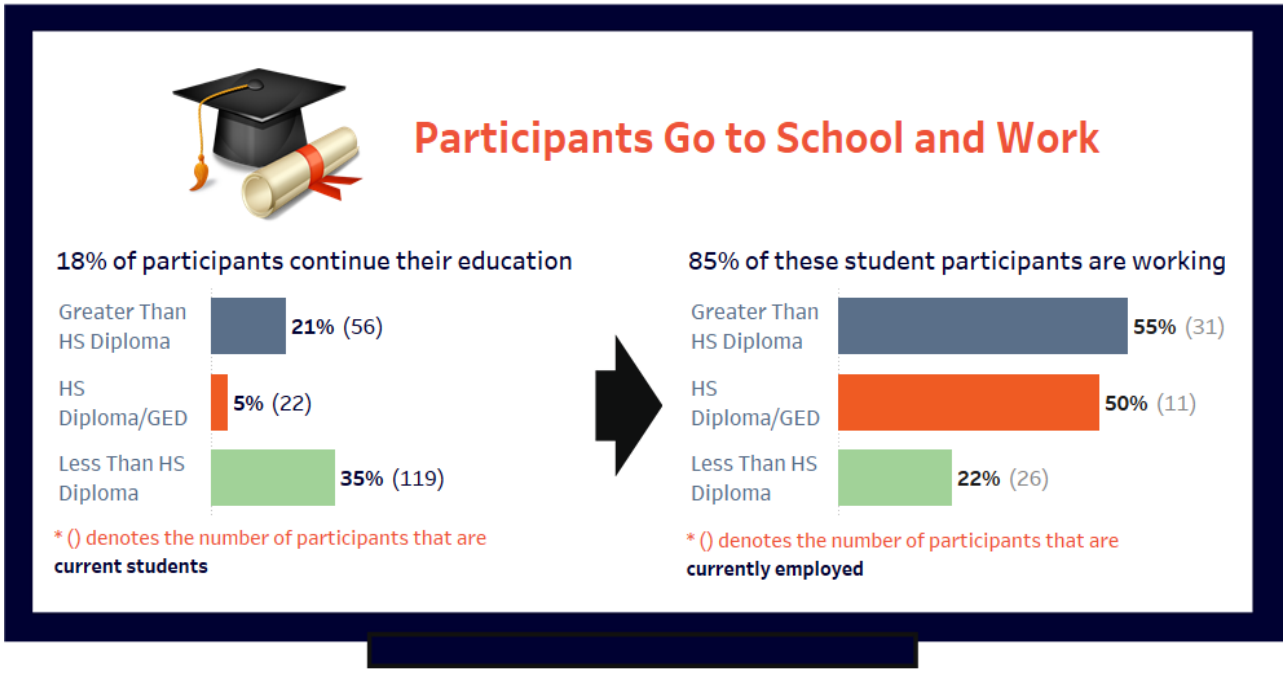


FIGURE 10: CAREGIVERS EDUCATION AND EMPLOYMENT

Over three-fourths of MIECHV caregivers who were enrolled in school in FY 2017 were also working (Figure 10). Over half (53%) of those caregivers who were working and attending school were working full time (averaging 30 or more hours per week).

Housing Status

HRSA required data collection on participant housing status for the first time during the FY 2017 reporting period. Overall, families served by Illinois MIECHV were almost equally likely to rent a home (36%) or live with family (35%), as seen in Figure 11. Far fewer families owned homes (11%), were homeless (8%), lived in public housing (5%) or had some other housing arrangement (4%). Renting a home and living with family were the most prevalent housing scenarios for all racial groups but differences were apparent. More multi-racial and white families rented than lived with family compared to African-American families. These groups were also much more likely to own a home (16%) compared to black families (3%). African-American families were much more likely to classify as homeless (14%) compared to other races (4%) and to live in public housing (10%) than multi-racial (3%) and white (2%) families as well. This is not surprising given the history of residential segregation and redlining in the United States (Mehra, Boyd, & Ickovics, 2017; Aaronson, Hartley, & Mazumder, 2017).

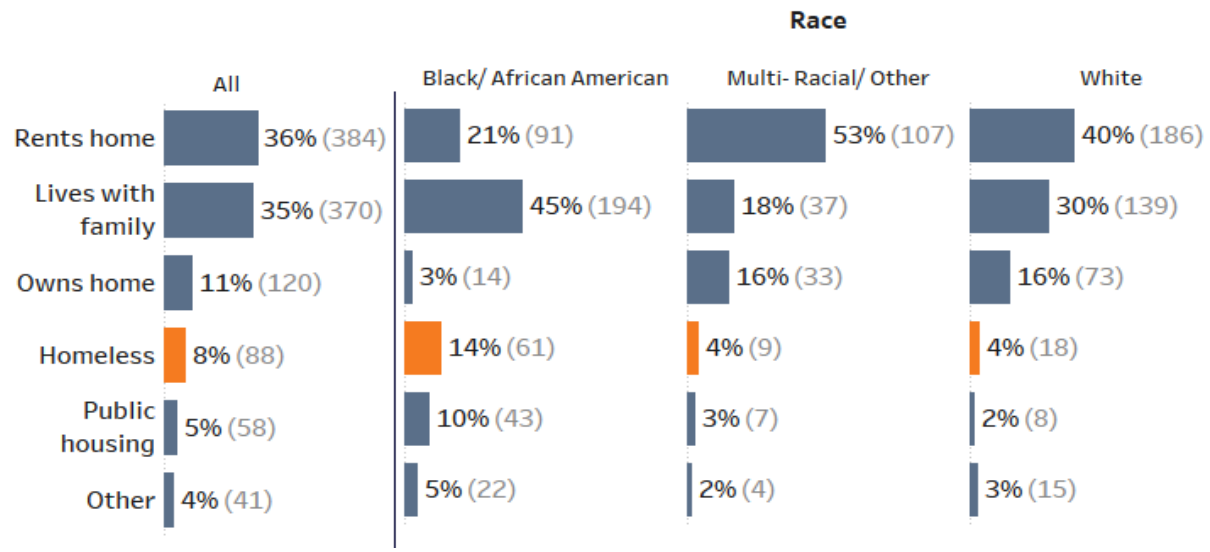


FIGURE 11: HOUSING STATUS BY RACE

Income in Relation to Federal Poverty Level

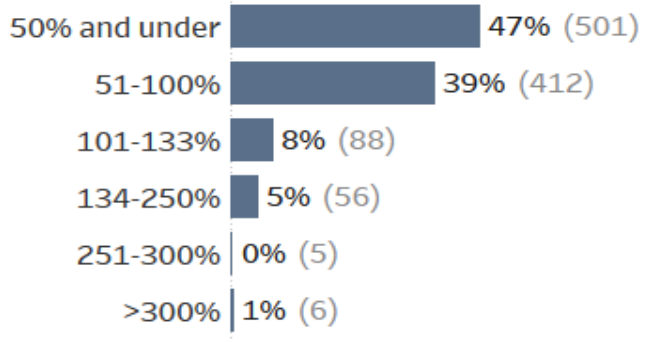


FIGURE 12: INCOME IN RELATION TO FEDERAL POVERTY LEVEL GUIDELINES

As in years past, most families (86%) served by Illinois MIECHV in FY 2017 lived at or below the Federal Poverty Levels (Figure 12), with almost half (47%) living in deep poverty (defined as 50% of the FPL or below). All but six families lived at or below 300% of the FPL.

Priority Populations

In FY 2017, Illinois MIECHV served families that fell into each of the eight legislatively mandated priority populations. The majority (83%) of families served were low income, defined by HRSA as living below the Federal Poverty levels (Figure 13). A quarter of families had someone residing in the home who used tobacco products. Large numbers of participants also faced the challenges of low student achievement, and being pregnant and under 21.

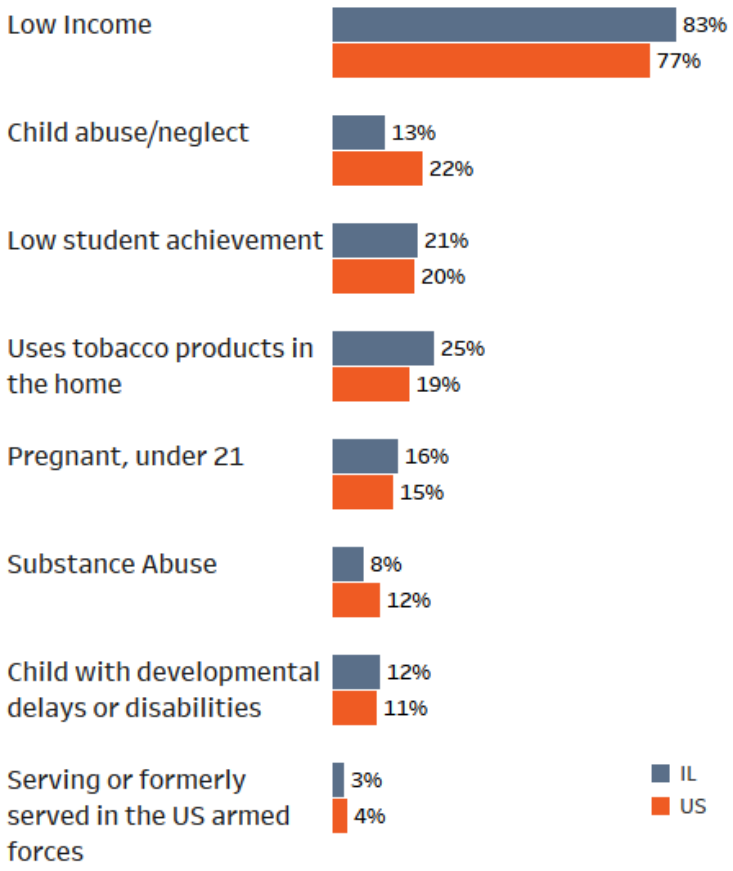


FIGURE 13: COMPARISON OF ILLINOIS AND NATIONAL PRIORITY POPULATIONS

Compared to national MIECHV data, Illinois served higher percentages of low-income families (83% versus 77%) and families who have someone who uses tobacco in the home (25% versus 19%). Illinois served lower percentages of families with histories of child abuse/neglect (13% versus 22%) and substance abuse (8% versus 12%).

Over half of Illinois MIECHV families have multiple risk factors and fall within more than one of these priority populations. Almost 10% meet four or more priority populations.

Insurance Status

Most of the participants served by MIECHV in FY 2017 had health insurance coverage (Figure 14). Very few children (1%) were uninsured. The vast majority (94%) of children were insured through state-based insurance programs (Title XIX or XXI). Most of the uninsured adults served were not pregnant (17%), as opposed to pregnant (3%). Over 90% of pregnant women and almost three quarters (73%) of non-pregnant adult participants were insured through state-

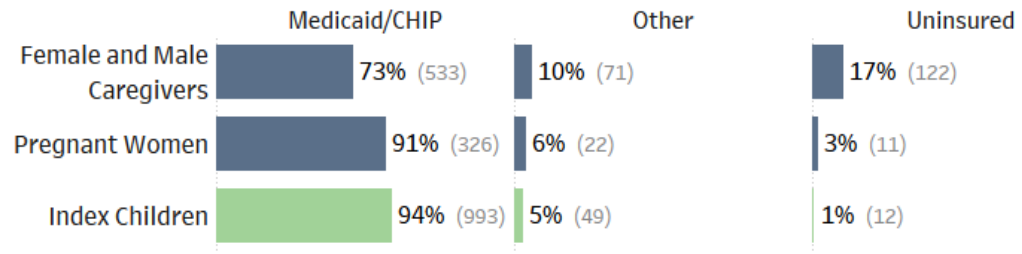


FIGURE 14: INSURANCE STATUS OF CAREGIVERS AND INDEX CHILDREN

based programs. Fewer numbers of participants were insured through private programs or Tri-Care, the insurance program for military families.

Comparing pregnant women's insurance status by ethnicity yields similar breakdowns (Figure 15). Ninety percent of Latinas and 91% of non-Latinas had state insurance coverage, 6% had private insurance, and low numbers were uninsured (4% for Latinas and 3% for non-Latinas). These high levels of insurance coverage are heartening given the importance, high cost and number of visits associated with prenatal, delivery and postpartum care.

However, when comparing the insurance status of non-pregnant people by ethnicity, the story is much different. Insurance coverage for non-Latino/a participants drops off very little – from 97% to 94%, with the vast majority of participants still receiving state-based insurance coverage. Insurance coverage for Latino/a participants drops by over 30% (from 96% to 65%). Over a third (35%) of parenting Latino/a participants are uninsured (compared to 4% of pregnant Latinas).

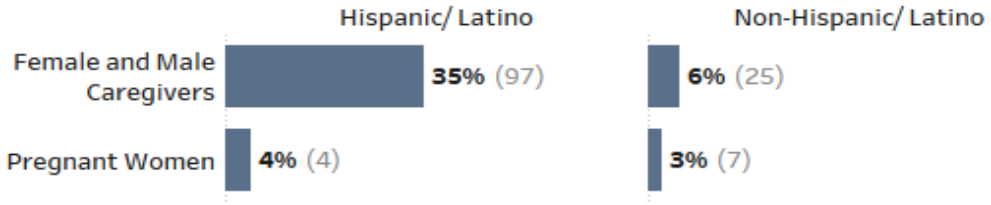


FIGURE 15: UNINSURED CAREGIVERS BY ETHNICITY

These numbers illustrate the significance, and the important limitations, of only providing state-based insurance coverage to non-citizen women when they are pregnant.

Medical and Dental Sources of Care by Index Children

In FY 2017, MIECHV programs nationwide started collecting information about the "usual" sources of medical and dental care for children served by our programs. Over 80% of Illinois MIECHV children regularly received medical care at a private medical office (Figure 16). Most other children (16%) received care at a Federally Qualified Health Center. The remaining few accessed care at one of a number of other options, including at hospitals (either out-patient or at the emergency department) or at retail clinics.

Most children (69%) also had a usual source of dental care (Figure 16). This measure, however, is limited because it was collected on all children, regardless of age, and the American Dental Association recommends initiating dental care six months after a child's first tooth appears or one year of age, whichever comes first. HRSA has revised this data collection point for the coming federal fiscal year to only include children 12 months of age and older.

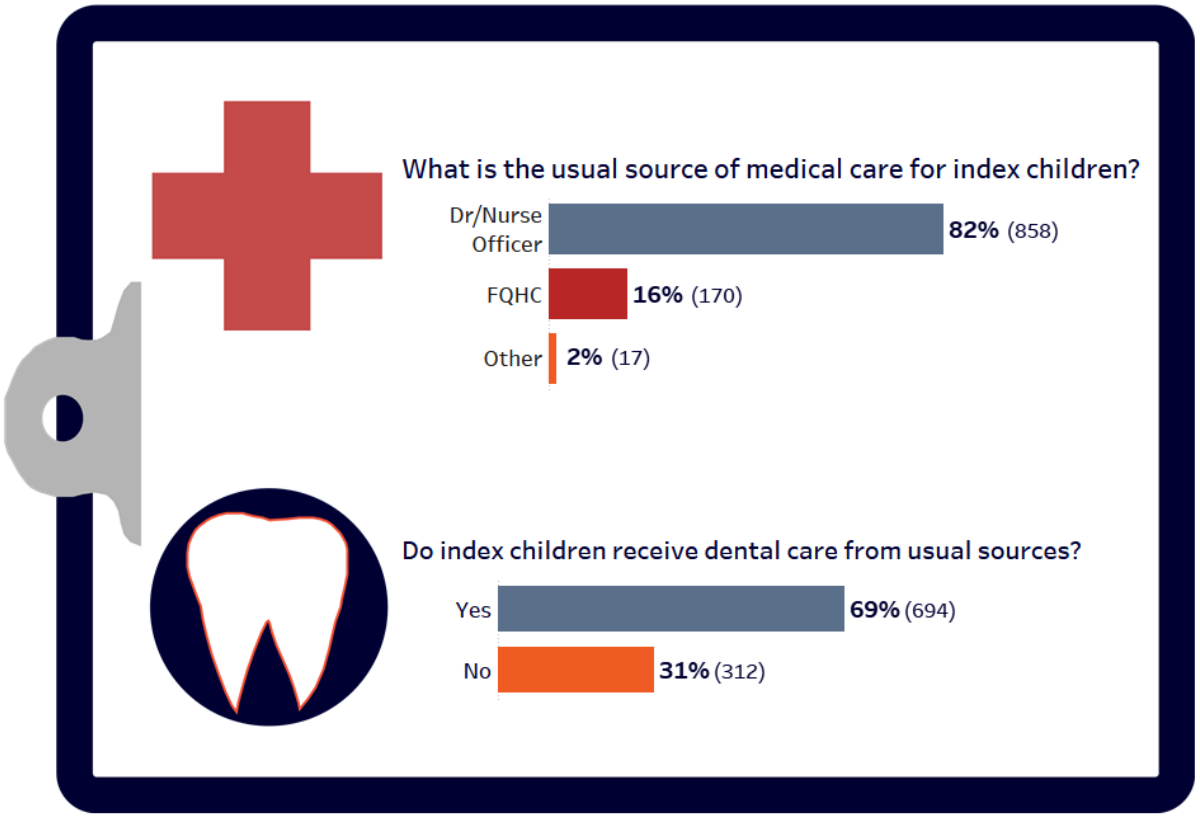


FIGURE 16: MEDICAL AND DENTAL SOURCES OF CARE BY INDEX CHILDREN

Family Engagement

As shown in Figure 17, by the end of the FY 2017 program year, 43% of participants who had been involved in services during the year were still receiving services. Of those who exited the program, more families successfully completed their home visiting services (34%) compared to those who stopped services before program completion (23%). The number of participants who do not complete services remains a continuing challenge for Illinois MIECHV and most other home visiting programs.

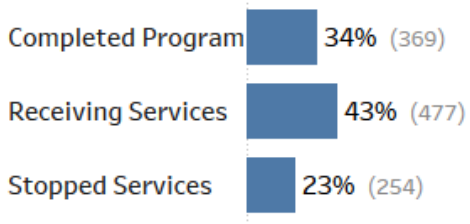


FIGURE 17: FAMILY ENGAGEMENT AND PROGRAM COMPLETION

Households by Program Model

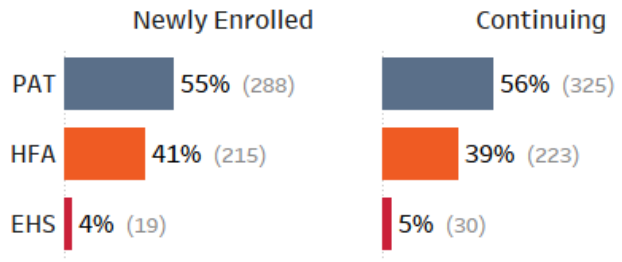


FIGURE 18: PROGRAM MODEL ENROLLMENT BY HOUSEHOLDS

As shown in Figure 18, more families were served by the Parents as Teachers (PAT) model, compared to Healthy Families America (HFA) and Early Head Start (EHS). In FY 2017, only two EHS programs were active in Illinois MIECHV.

Visits and Families Served Over Time

Since 2014, Illinois MIECHV has served more families each program year, increasing from just over 900 in 2014 to 1,100 FY 2017 (Figure 19). However, the number of home visits has not increased in similar fashion (Figure 20). Much of this mismatch can be attributed to difficulties faced by programs in light of a state budget stalemate, significant delays in reimbursement, the delay in reauthorization of MIECHV legislation, and resulting staff furloughs and turnover. Despite these challenges, the total annual number of completed visits to MIECHV families each year has remained in the 12,000 to 13,200 range. With renewed MIECHV and state of Illinois funding, we would anticipate a significant increase over the next 3-5 years.

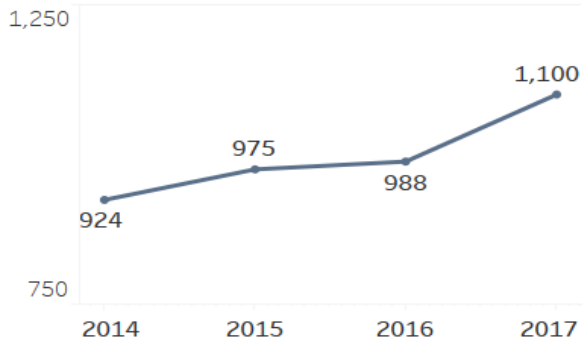


FIGURE 19: ANNUAL NUMBER OF HOUSEHOLDS SERVED

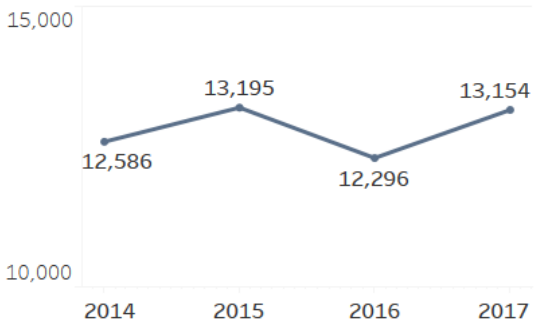


FIGURE 20: ANNUAL NUMBER OF HOME VISITS

III. MIECHV Performance Benchmarks, FY 2017

The MIECHV Performance Benchmarks are both the goals of home visiting in general and the way that MIECHV programs demonstrate success to HRSA, program participants, and other stakeholders. The six benchmark domain areas, illustrated in Figure 21 are:

- Improvement in maternal and newborn health
- Reduction in child injuries, abuse, and neglect
- Improved school readiness and achievement
- Reduction in crime or domestic violence
- Improved family economic self-sufficiency
- Improved coordination and referral for other community resources and supports

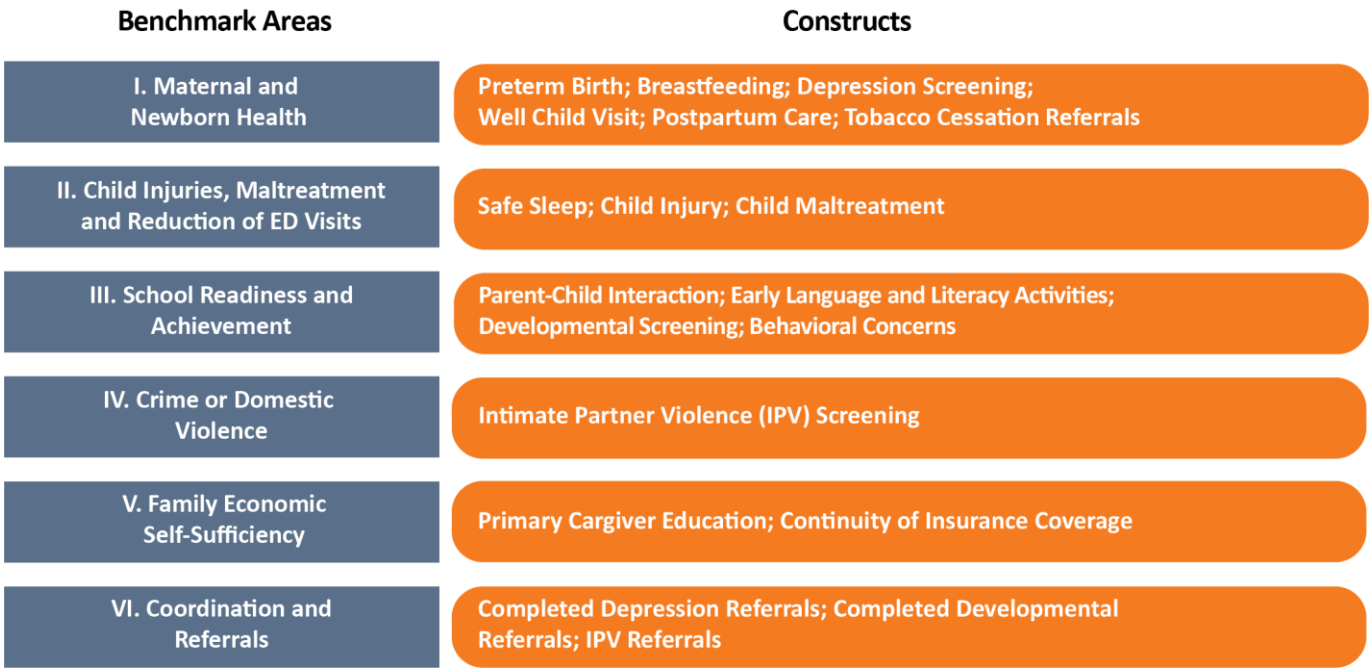


FIGURE 19: MIECHV PERFORMANCE BENCHMARK AREAS AND CONSTRUCTS

Each of these six broad areas contains one to six constructs related to the benchmark. These constructs measure processes and outcomes at the home visitor, home visit, child, and family levels. They are broadly grouped into two categories – performance indicators, which are proximal to home visiting services, and systems outcomes, which are more distal. Most constructs are reported as the proportion (%) of participants who meet the criteria (numerator) among those targeted (denominator). Depending on the way a benchmark is calculated for each construct, a family may or may not "fit" into the construct or "meet the benchmark." For instance, only participants who report using tobacco products would be included in the Tobacco Cessation Referral construct. Only those who received a referral would "meet the benchmark" or contribute toward the outcome, which is significantly fewer in number than all

MIECHV participants. To date, HRSA has not yet issued goals or threshold levels for MIECHV programs. However, grantees must demonstrate measurable improvement in at least four of the six benchmark areas each year. Given that FY 2017 was the first program year the revised benchmarks were implemented, the results shown in Figure 22 below and described in detail in the section below represent Illinois' baseline moving forward. In order to glean a better understanding of the challenges faced by MIECHV families, we have presented data by participant demographics for constructs that measure processes and outcomes that are most in control of or determined by families (as opposed to by home visitors).

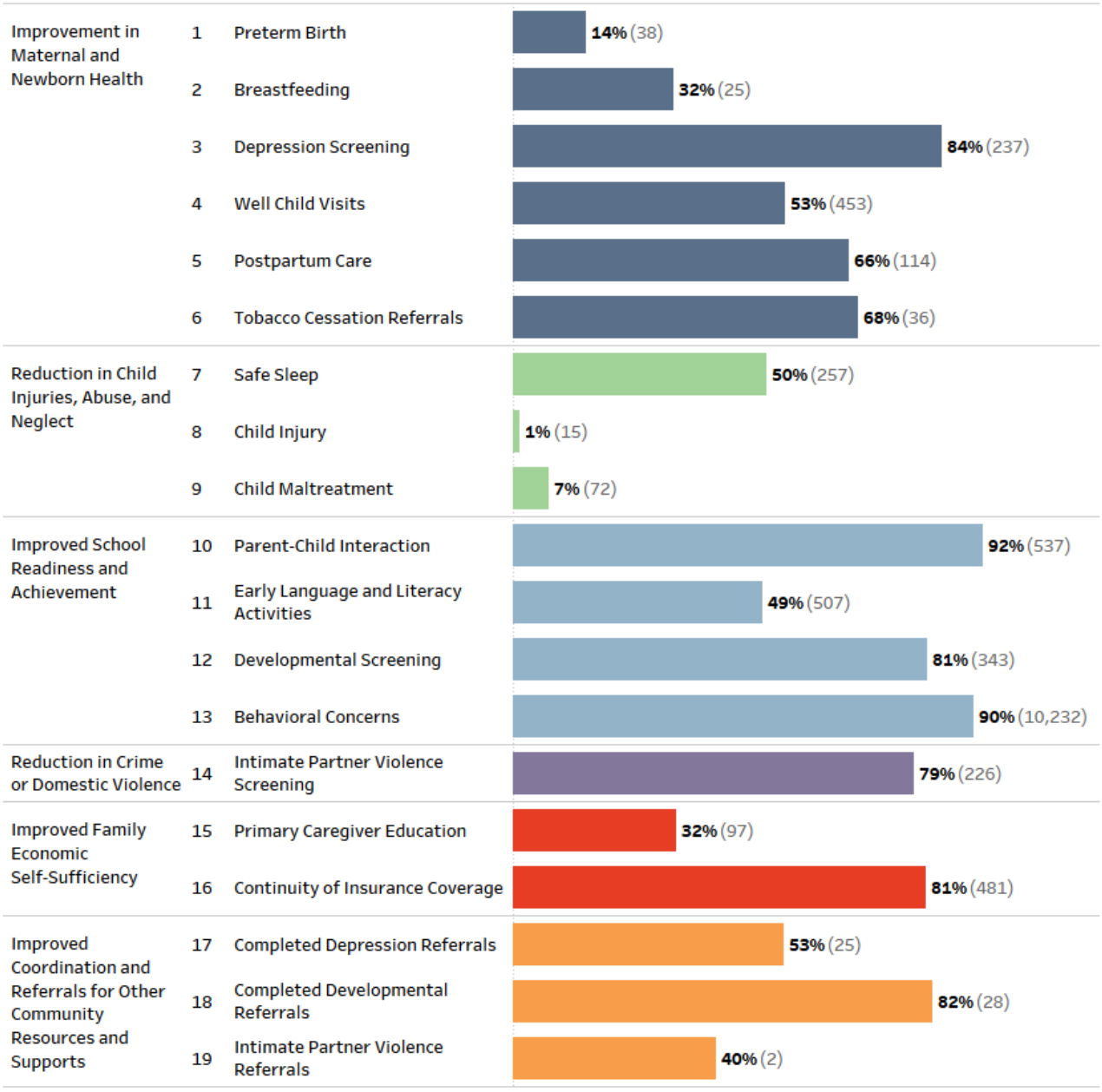


FIGURE 20: 2017 BENCHMARK ATTAINMENT BY CONSTRUCT

Benchmark 1. Improvement in Maternal and Newborn Health
Benchmark 1 contains six constructs related to the health of caregivers and children.

Construct 1. Preterm Birth

looks at whether children born to caregivers who enrolled prior to 37 weeks of pregnancy were born preterm (defined as before 37 completed weeks of gestation). In FY 2017, Illinois MIECHV had 265 babies born to caregivers who enrolled prior to 37 weeks of pregnancy, and 14% were born preterm. Latest data available for Illinois overall indicates that this is higher than the state average of 10.1%, which is not surprising given the higher risk population that MIECHV serves (Illinois Early Childhood Asset Map, 2016).

Construct 2. Breastfeeding

measures breastfeeding at 6 months of age for children whose caregivers enrolled prenatally. Breastfeeding is defined as receiving any breastmilk and includes both exclusive and non-exclusive breastfeeding, as well as feeding with pumped milk. In FY 2017, 32% of Illinois MIECHV children who were enrolled prenatally breastfed through at least 6 months of age, compared to 53% of Illinois children and 58% of US children (Figure 23).

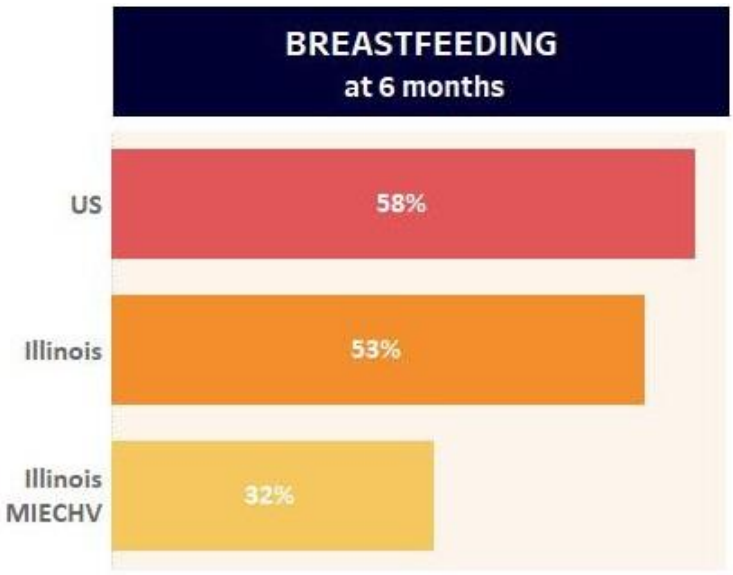


FIGURE 23: PERCENTAGE OF INFANTS BREASTFED FOR 6 MONTHS

Multi-racial parents were much more likely to breastfeed their children through 6 months of age (60%) compared to white parents (34%) and black parents (16%). Latina parents were also much more likely to breastfeed their children through 6 months (52%) compared to non-Latina parents (21%). Additionally, the older the parent and the more education the parent had received, the more likely it was for her to breastfeed her child through 6 months of age.

The breastfeeding construct is the only construct that has remained the same over time, which allows comparison across years. Since 2013, Illinois MIECHV results have ranged from a low of 21% in 2014 to a high of 33% in 2015. This year's result is in line with last year's performance. The Healthy People 2020 baselines for breastfeeding at 6 months (as per 2011 estimates) were 49.4% for the United States as a whole and 47% for Illinois. While a smaller percent of Illinois

MIECHV children achieved this milestone in this program year, compared to state and national data in the recent breastfeeding report card (CDC, 2018), the significant increase in the breastfeeding numbers over years is encouraging.

Construct 3. Depression Screening

shows that 84% of newly enrolling caregivers received a screening for symptoms of depression. Caregivers who enroll prenatally must receive this screening by three months postpartum and all other caregivers must receive this screening within three months of enrolling in home visiting. Historically, Illinois MIECHV home visiting programs screened all prenatally enrolling participants and achieved high levels of coverage (98% or 99% in the prior three years). Home visiting programs were required to screen newly enrolling male and non-pregnant female participants for the first time during FY 2017. The lower level of success for this construct in this program year likely reflects the learning curve associated with the change.

Construct 4. Well Child Visits

measures whether children received their last recommended well child visit based on the recommendations of the American Academy of Pediatrics. In the FY 2017 program year, 53% of MIECHV children received their last recommended well child visit (Figure 24). While this may seem low, there are two important considerations. First, the "last recommended" visit is a moving target. At any given time, a child may have completed a well child visit that was not within the recommended time frame or may have completed several well-timed well child visits but not the *last* recommended visit. Additionally, the frequency of recommended visits is much higher when children are younger (under 2 years of age) as opposed to older, which also increases the likelihood that children in these younger age ranges would miss a

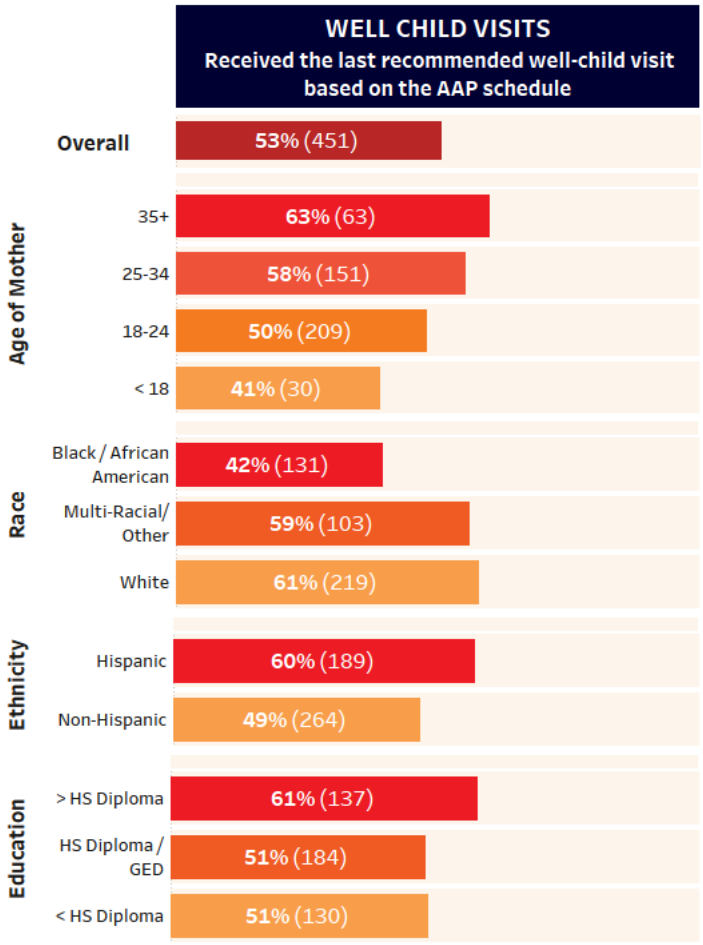


FIGURE 21: WELL CHILD VISITS BY AGE, RACE, ETHNICITY AND EDUCATION

recommended visit. Over 90% of children enrolled in Illinois MIECHV were under 2 years of age in this reporting period.

Hispanic parents were more likely to have children who had received the last recommended well child visit compared to non-Hispanic parents (60% compared to 49%). Parents with more than a high school degree were also more likely to have children who had received the last recommended visit compared to their peers with less education (61% compared to 51%). The older the parent, the more likely their children had received the last recommended visit. Importantly, children of multi-racial and white parents were more likely to have received their last recommended well child visit (59% and 61%, respectively) compared to African-American children (42%). These differences warrant further exploration. Well child visits will continue to remain as a primary focus of Illinois MIECHV's Continuous Quality Improvement work in 2018.

Construct 5. Postpartum Care looks at whether caregivers who enrolled prenatally or within the first 30 days after delivery received a postpartum care medical visit within 8 weeks of delivery. In the FY 2017 program year, 66% of Illinois MIECHV caregivers received a postpartum care visit within this time frame (Figure 25). This is quite a bit lower than the Healthy People 2020 baseline (as per 2012 estimates) of 90.1% for Illinois women during postpartum. However, it reflects the higher risk levels among the population that MIECHV targets. It is also worth noting that a number of MIECHV caregivers did receive a postpartum care visit, but it was outside of the first 8 weeks following delivery.

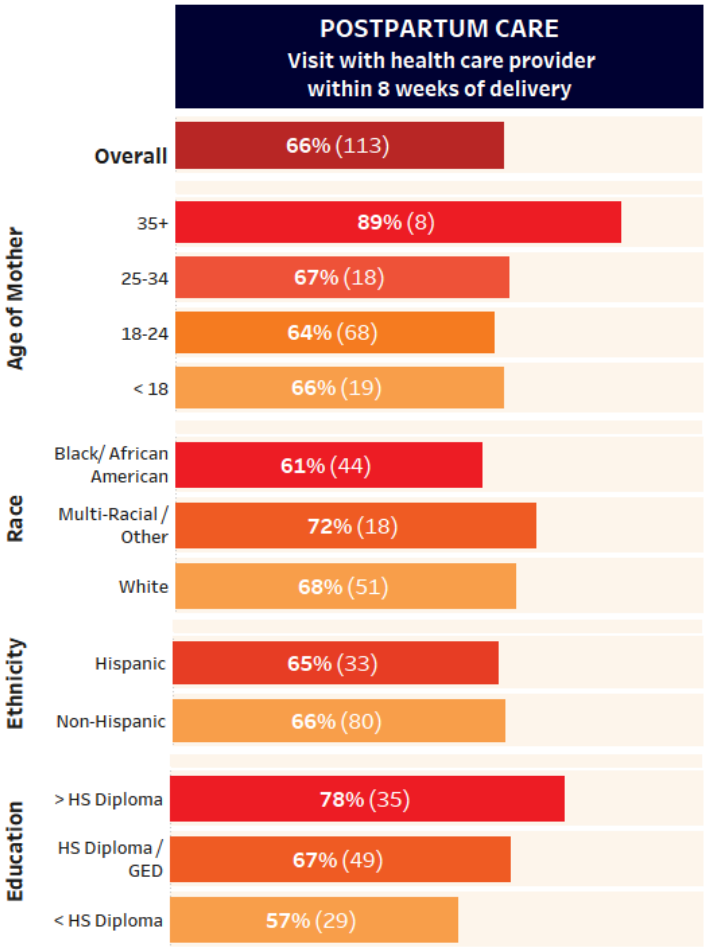


FIGURE 22: POSTPARTUM CARE BY AGE, RACE, ETHNICITY AND EDUCATION

Caregivers who were 35 years or older were more likely than their peers to have received a postpartum care visit within the recommended timeframe when compared to their peers (89% versus 64% to 67%). There were slight differences in visit completion by caregiver race, with multi-racial caregivers most likely to complete the visit within the

recommended timeframe (72%), followed by white caregivers (68%) and black caregivers (61%). The more education the caregiver had received, the more likely she was to complete her postpartum care visit during the recommended timeframe. Almost 80% of caregivers with more than a high school diploma completed the visit compared to 67% of those with a diploma or GED, and 57% of those with less than high school or GED education. Ethnicity did not appear to have an effect on visit completion. This pattern supports how the caregiver's educational attainment significantly increases the parental role in supporting child health, education and well-being (Harding, 2015).

Construct 6. Tobacco Cessation Referrals

Construct 6. Tobacco Cessation Referrals evaluates whether newly enrolled caregivers who report using tobacco products, including e-cigarettes, received a referral to tobacco cessation services from their home visitor within three months of enrolling. Of the 53 participants who reported using tobacco products, 68% received the appropriate referrals within the required timeframe. This was a new area of focus for Illinois MIECHV and it is anticipated that the percent of referrals provided will improve over time.

Benchmark 2. Reduction in Child Injuries, Abuse, and Neglect

Benchmark 2 contains three constructs related to child safety.

Construct 7. Safe Sleep

Construct 7. Safe Sleep shows whether children under the age of one practice safe sleep. Three distinct safe sleep practices are included in this measure: whether the child is placed to sleep on her/his back, whether the child shares a bed, and whether the child uses soft bedding (for instance, a blanket, crib bumpers, etc.). In order to be considered practicing safe sleep, the child must always be placed to sleep on her/his back, must never share a bed, and must never use soft bedding (Task Force on Sudden Infant Death Syndrome, 2016). In the FY 2017 program year, half of MIECHV children under one always practiced all three safe sleep recommendations.

Shown in Figure 26, children of African-American caregivers were much less likely to practice safe sleep compared to their peers (42% compared to 57% for multi-racial parents and 56% for white caregivers). Children of non-Hispanic caregivers were also much less likely to practice safe sleep compared to Hispanic caregivers (45% versus 59%). Caregivers with less education were also much less likely to practice safe sleep. Almost 60% of children whose parents had less than a high school diploma of GED did not practice safe sleep compared to 40% of children whose parents had more than a high school diploma or GED. Illinois MIECHV has partnered with SIDS of Illinois to provide safe sleep related trainings to MIECHV home visitors.

Safe Sleep Practices: Bivariate Analysis. Due to the paramount importance of safe sleep in the well-being of infants, the data for this MIECHV benchmark was more thoroughly examined to identify subgroups of MIECHV caregivers that may need additional education or assistance from the home visitors. The findings of this analysis are similar to those published earlier in a preliminary report on breastfeeding and safe sleep practices (Hussain et al., 2018) and are described as follows. During FY 2017, there were 554 caregivers with infants under 1 year and safe sleep survey was given to 517 (93%). Among the caregivers who took the survey, majority were Black (46%) followed by white (34%) and others (20%). The sample was predominantly non-Hispanic (66%) and had English (79%) as primary language at home. Only about a quarter of the caregivers had education beyond high school (24%). Most participants reported not owning or renting their home or apartment (44%). About a quarter of caregivers reported tobacco use (25%), more than one fifth reported tobacco use at home (22%), and about 8% reported substance abuse. Approximately, 13% of caregivers had a history of child abuse.

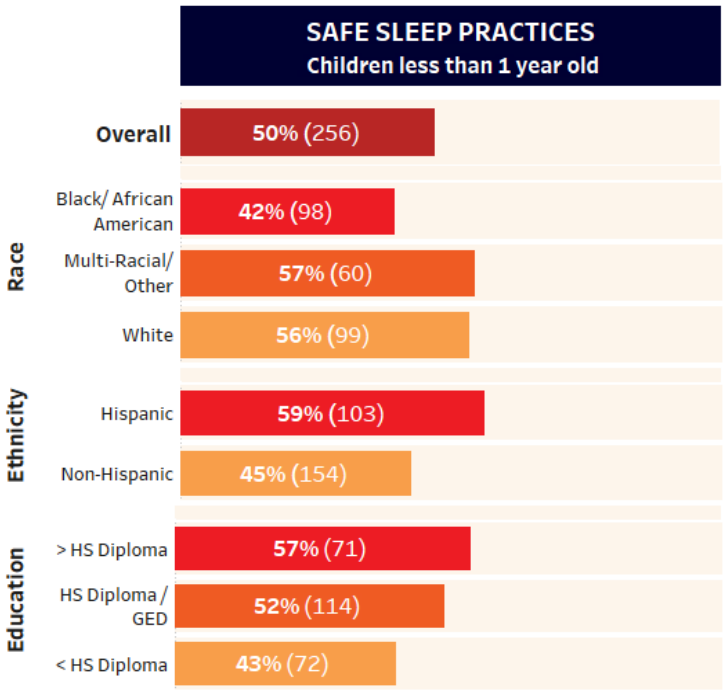


FIGURE 23: SAFE SLEEP PRACTICES BY RACE, ETHNICITY AND EDUCATION

As stated above, overall, 50% of Illinois MIECHV caregivers reported practicing all three safe sleep practices in the FY 2017 program year. A breakdown of each practice shows that at the baseline measurement, 85% of caregivers reported placing infants on their back, 55% reported that they never shared a bed with the infants and about 71% never used soft bedding.

An examination of safe sleep practices by the demographic characteristics of caregivers, as shown in Table 4, reveals several interesting findings. First, safe sleep practices seem to increase with caregiver age. Compared to caregivers who were 25 years or above (>60%), those who were 18 years or below (38%) and those who were in the 18-24 age group (49%) practiced safe sleep less often. Second, caregivers whose primary language is English (46% versus 66%) were less likely to follow the recommendations for safe sleep practices. Other subgroups of caregivers who were also less likely to practice safe sleep practices include: caregivers who were not married (43% versus 67%), caregivers who do not own / rent home or apartment (42% versus 61%), caregivers who reported tobacco use at home (41% versus 52%), and caregivers

who reported low income (48% versus 61%). Surprisingly, caregivers who had a history of child abuse (62%) were more likely to follow safe sleep practices than others (48%).

To summarize, caregivers who are less likely to practice safe sleep, and therefore may need more support from their home visitor to learn about and adopt safe sleep practices are:

- Younger (less than 18 years or between 18 and 24 years);
- Primary language is English;
- Not married;
- Do not own or rent their home;
- Use tobacco at home; and/or
- Low income.

TABLE 4: SAFE SLEEP PRACTICE BY SELECT SAMPLE CHARACTERISTICS

		Sample	Safe Sleep Practice*	
		N	n (%)	P value
Guardian Age	<18	151	57 (37.7%)	<0.001
	18-24	189	92 (48.7%)	
	25-34	139	85 (61.2%)	
	>=35	38	23 (60.5%)	
Race	White	176	99 (56.3%)	<0.001
	Black	236	98 (41.5%)	
	Other	105	60 (57.1%)	
Ethnicity	Non-Hispanic	343	154 (44.9%)	0.002
	Hispanic	174	103 (59.2%)	
Primary Language	Other	109	72 (66.1%)	<0.001
	English	406	185 (45.6%)	
>HS Diploma	No	389	186 (47.8%)	0.08
	Yes	125	71 (56.8%)	
Marital Status	Married	90	60 (66.7%)	<0.001
	Not Married	366	157 (42.9%)	
	Other	51	34 (66.7%)	
Housing	Other Arrangement	261	109 (41.8%)	<0.001
	Owns/Rents	208	126 (60.6%)	
Low Income	No	62	38 (61.3%)	0.058
	Yes	450	218 (48.4%)	
Child abuse	No	448	214 (47.8%)	0.024
	Yes	69	43 (62.3%)	
Low achievement	No	417	200 (48%)	0.104
	Yes	100	57 (57%)	
Developmental delay	No	475	234 (49.3%)	0.495

		Sample	Safe Sleep Practice*	
		N	n (%)	P value
	Yes	42	23 (54.8%)	
Substance abuse	No	474	233 (49.2%)	0.403
	Yes	43	24 (55.8%)	
Tobacco use	No	381	197 (51.7%)	0.208
	Yes	126	57 (45.2%)	
Tobacco use at home	No	387	202 (52.2%)	0.043
	Yes	107	44 (41.1%)	

** Always placing infant on the back, never sharing bed and never using soft bedding*

Construct 8. Child Injury measures child visits to the Emergency Department (ED) due to injury or ingestion. In the FY 2017 program year, only 1% of children visited the ED for these reasons. In prior years, Illinois MIECHV tracked all-cause child visits to the ED. Over the past several years, these have ranged from 12% to 21%. While these results are not directly comparable, it is heartening to see that injury or ingestion account for a small percent of ED visits.

Construct 9. Child Maltreatment measures the percent of children with at least one investigated case of child maltreatment during the year. Investigated cases include both indicated and unfounded cases. Illinois MIECHV collects this data directly from the Illinois Department of Children and Family Services (DCFS). In FY 2017, 7% of enrolled children had an investigated case of maltreatment since enrolling in home visiting. In prior years, Illinois MIECHV collected data only on children enrolled in home visiting for at least one year, and collected suspected cases (reported cases of maltreatment) and substantiated (or indicated) cases. Over the past several years, suspected cases ranged from 6% to 11% and substantiated cases ranged from 1% to 5%. While these results are not directly comparable, they do give some context for the observed proportion during this reporting period.

Benchmark 3. Improved School Readiness and Achievement

Benchmark 3 contains four constructs related to screenings and practices that are linked to school readiness.

Construct 10. Parent-Child Interaction measures the completion of assessments of parent-child interaction using the Home Observation for Measurement of the Environment (HOME) inventory (Caldwell & Bradley, 1984). The HOME is a widely used, validated assessment that captures stimulation both in the child's environment and the parent-child interaction. Home visitors assessed each parent-child dyad using the Infant-Toddler (IT) HOME (for children birth through 3 years of age) or the Early Childhood (EC) HOME (for children aged 3-6 years), depending on the age of the child. Total score for IT-HOME is calculated from 45 items related

to 6 domains- Responsivity, Acceptance, Organization, Learning Materials, Involvement, and Variety. Similarly, total score for EC-HOME is calculated from 55 items related to 8 domains- Learning Materials, Language Stimulation, Physical Environment, Responsivity, Academic Stimulation, Modeling, Variety, and Acceptance. Over 90% of families that had reached a minimum enrollment threshold were screened in FY 2017. In general, most MIECHV caregivers scored well on the HOME inventory. Since the home environment plays a crucial role in the development of the child, the data for this benchmark was examined more thoroughly to understand demographic differences in the scoring patterns. The results are summarized in Table 5 and described below.

The HOME survey was administered on 92% (n=537) of eligible MIECHV caregivers that had reached a minimum enrollment threshold in the FY 2017 program year, and the majority of the surveys were IT- HOME (82%). IT-HOME was administered on 90% (n=432) of eligible caregivers, whereas all caregivers eligible for EC-HOME (n=104) received it.

The maximum possible score is 45 for IT-HOME and 55 for EC-HOME. In the Illinois MIECHV sample, 82% percent of caregivers scored above the reference median (>32 for IT-HOME and >40 for EC-HOME). Caregivers who took IT-HOME (85%) were more likely to score above the respective reference median than those who took EC-HOME (72%). A bivariate analysis of HOME assessment scores by caregiver demographic characteristics highlight several interesting findings. First, caregivers who had a child with developmental delay (73%) were less likely to score above the respective reference median than other caregivers (84%). About 60% of the Illinois MIECHV caregivers scores were in the top quartile (>36 for IT-HOME and >45 for EC-HOME) when compared to reference population. Caregivers who took IT-HOME (64%) were more likely to score above the respective reference 75th percentile than those who took EC-HOME (47%). Additionally, there were other differences in assessment scores by demographic characteristics. When compared to whites (73%), blacks (45%), and other race groups (60%) were less likely to score above the reference 75th percentile. Other subgroups of caregivers that were less likely to score above the reference 75th percentile included: Non-Hispanic caregivers (57% versus 65%), caregivers with English as primary language (57% versus 67%), caregivers with less than a HS Education (57% versus 70%), caregivers who were not married (54%), caregivers who do not own or rent their home or apartment (53% versus 66%), caregivers with a low income (58% versus72%), and caregivers with a history of child abuse (46% versus 63%) (Table 5).

To summarize, caregivers that are less likely to score highest on the HOME assessment are:

- Self-identified with a race of Black or other non-white;
- Non-Hispanic ethnicity;
- English primary language at home;
- Less than a HS education;
- Not married;

- Do not own or rent their home;
- Low income; and/or
- Have a history of child abuse.

TABLE 5: HOME SURVEY SCORE DIFFERENCES BY SELECT CAREGIVER CHARACTERISTICS

		Sample	Score > 50th Percentile		Score > 75th Percentile	
		N	n (%)	P value	n (%)	P value
HOME Survey	IT HOME	477	365 (84.5%)	0.003	275 (63.7%)	0.002
	EC HOME	104	75 (72.1%)		49 (47.1%)	
Race	White	232	183 (85.9%)	0.097	155 (72.8%)	<0.001
	Black	183	130 (77.4%)		76 (45.2%)	
	Other	166	127 (81.9%)		93 (60%)	
Ethnicity	Non-Hispanic	336	257 (82.9%)	0.565	176 (56.8%)	0.042
	Hispanic	245	183 (81%)		148 (65.5%)	
Primary Language	Other	220	165 (80.5%)	0.447	137 (66.8%)	0.017
	English	361	275 (83.1%)		187 (56.5%)	
>HS Diploma	No	427	312 (80.2%)	0.073	220 (56.6%)	0.004
	Yes	152	126 (86.9%)		102 (70.3%)	
Marital Status	Married	184	147 (85%)	0.423	126 (72.8%)	<0.001
	Not Married	320	230 (80.1%)		155 (54%)	
	Other	64	52 (82.5%)		38 (60.3%)	
Housing	Other Arrangement	195	142 (80.2%)	0.227	94 (53.1%)	0.006
	Owns/Rents	347	272 (84.5%)		211 (65.5%)	
Low Income	No	106	85 (87.6%)	0.115	70 (72.2%)	0.008
	Yes	469	350 (80.8%)		249 (57.5%)	
Child abuse	No	501	381 (83%)	0.176	289 (63%)	0.004
	Yes	80	59 (76.6%)		35 (45.5%)	
Low achievement	No	418	317 (83.2%)	0.292	239 (62.7%)	0.09
	Yes	163	123 (79.4%)		85 (54.8%)	
Developmental delay	No	467	366 (84.3%)	0.005	271 (62.4%)	0.051
	Yes	114	74 (72.5%)		53 (52%)	
Substance abuse	No	522	400 (83.2%)	0.056	296 (61.5%)	0.127
	Yes	59	40 (72.7%)		28 (50.9%)	
Tobacco use	No	440	337 (82.8%)	0.38	246 (60.4%)	0.854
	Yes	137	100 (79.4%)		75 (59.5%)	
Tobacco use at home	No	409	310 (82.9%)	0.647	231 (61.8%)	0.27
	Yes	124	94 (81%)		65 (56%)	

Construct 11. Early Language and Literacy Activities looks at the frequency of literacy activities in the home. For this construct, literacy activities consist of reading, singing and/or telling stories with the child, and can be performed by any household member. In FY 2017, 49% of children had a family member practice literacy activities with them daily during an average week (Figure 27). Due to the specific definition of literacy activities, we do not have directly comparable data for this construct. However, Healthy People 2020 reports baselines for children who were read to by a family member every day in the past week, one component of this construct. During 2011-2012, 47.9% of families nationwide and 50.2% of Illinois families reported daily reading. Illinois MIECHV's results (49%) are in this same range.

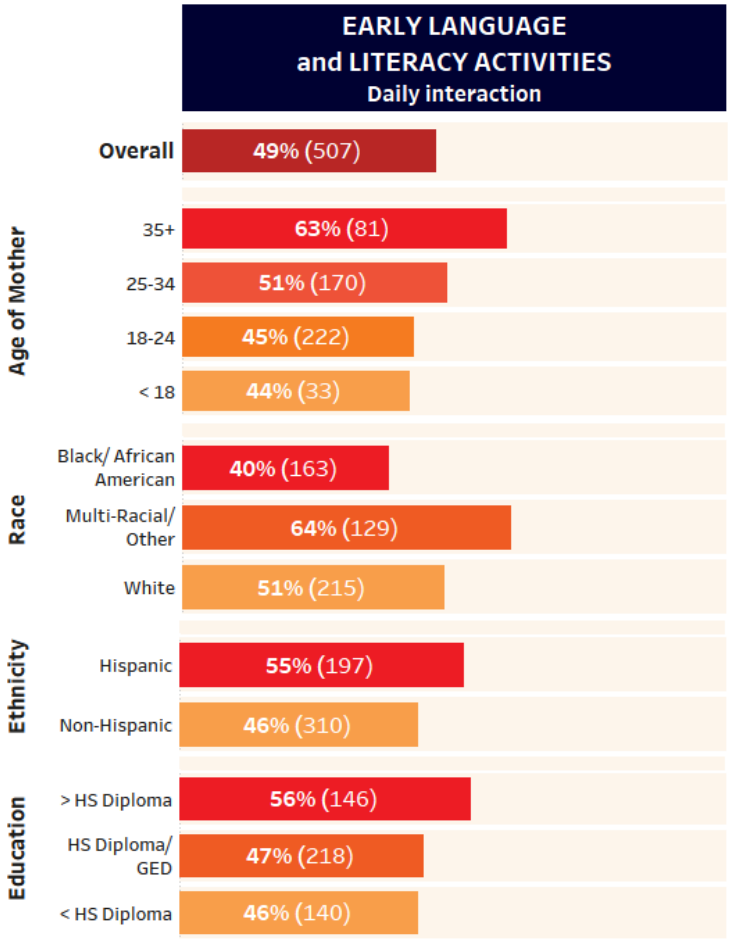


FIGURE 24: EARLY LANGUAGE AND LITERACY ACTIVITIES BY AGE, RACE, ETHNICITY AND EDUCATION

Multi-racial caregivers were most likely of all racial groups to practice literacy daily with their children, with almost two-thirds reporting daily literacy practice compared to half (51%) of white caregivers and just 40% of African-American caregivers. Hispanic caregivers were more likely to practice literacy daily than their non-Hispanic peers (55% versus 46%). The more education a caregiver had, the more likely s/he was to practice daily literacy activities with her/his children (56% for those with more than a high school diploma versus 46% of those without one). Additionally, the older a caregiver was, the more likely s/he was to engage in daily literacy activities.

Construct 12. Developmental Screening measures the completion of developmental screenings using the Ages & Stages Questionnaires (ASQ-3) at the American Academy of Pediatrics recommended ages of 9 months, 18 months, 24 months, and 30 months. In FY 2017, 81% of children reaching these specific ages, received the appropriate ASQ-3 screening. These particular screening timeframes were new to MIECHV home visitors this year. Therefore it is anticipated that these results will improve over time.

Construct 13. Behavioral Concerns tallies the number of postnatal home visits completed and determines at how many of these visits were caregivers asked if they had any concerns about their child's (or children's) development, behavior, or learning. Prenatal home visits are excluded. Home visitors assessed caregivers for concern during 94% of the over 11,000 completed postnatal home visits.

Benchmark 4. Reduction in Crime or Domestic Violence

Benchmark 4 contains one construct, which measures Intimate Partner Violence screening.

Construct 14. Intimate Partner Violence Screening measures the percent of newly enrolling participants who are screened for intimate partner violence (IPV) within six months of enrollment. Female caregivers are assessed with the Futures Without Violence Relationship Assessment Tool (RAT). Male caregivers are assessed with the Hurt, Insult, Threaten and Scream (HITS) assessment tool. Males were added to the assessment requirement in FY 2017, and the assessment timeframe was reduced from one year post-enrollment to six months post-enrollment. Seventy nine percent of caregivers were screened within the required timeframe during this reporting period. This is lower than coverage in recent years (which had ranged from 95% to 100% over the past three years), and is likely due to the revised data collection timetable.

Benchmark 5. Improved Family Economic Self-sufficiency

Benchmark 5 contains two constructs measuring specific educational and health insurance statuses.

Construct 15. Primary Caregiver Education assesses whether caregivers who enrolled in home visiting with less than a high school diploma or GED subsequently enrolled in or completed high school or a GED program. As shown in Figure 28, 32% of caregivers who enrolled in home visiting with less than a HS diploma/GED (and had not already enrolled in or completed a diploma/GED in a prior year), achieved this outcome during this reporting period.

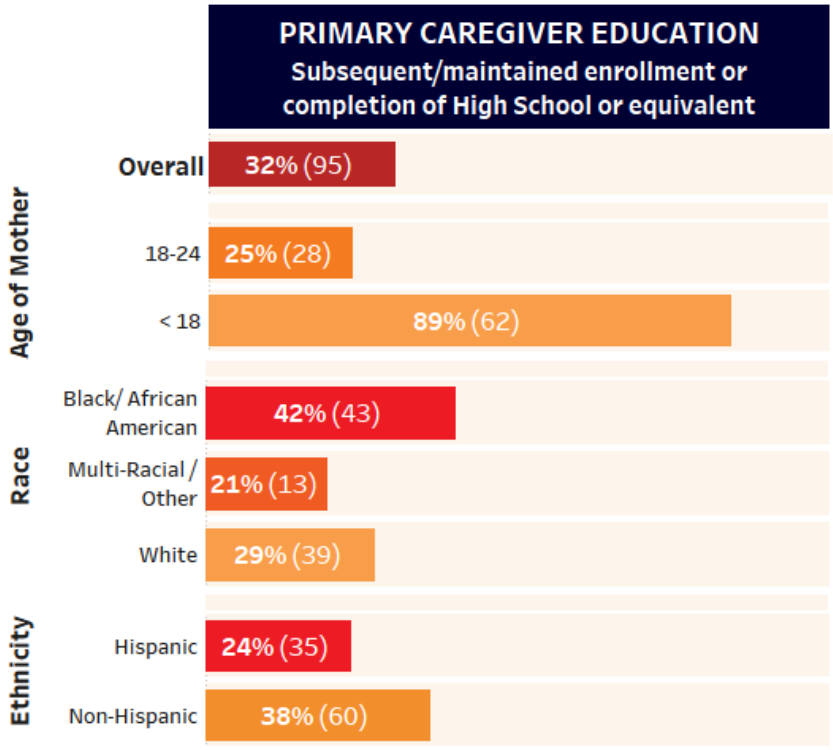


FIGURE 25: PRIMARY CAREGIVER EDUCATION BY AGE, RACE AND ETHNICITY

Caregivers who enrolled in home visiting without a high school diploma or GED and subsequently enrolled in one of these programs in 2016-2017, were substantially more likely to be under 18 years of age (89% versus 32%). This is not surprising because it reflects the standard age range of high school students. Caregivers who enrolled in a high school or GED program in 2016-2017 were also more likely to be African-American (42% compared to 21% of multi-racial caregivers and 29% of white caregivers) and non-Hispanic (38% compared to 24% of Hispanic caregivers).

Construct 16. Continuity of Insurance Coverage

measures the percent of caregivers who have had six months of continuous health insurance coverage. In FY 2017, 81% of Illinois MIECHV caregivers reported having continuous coverage, which is only slightly less than the 87% who reported having health insurance (Figure 29). This indicates a high level of continuity of coverage. It is not known what the barriers to continuous coverage were for participants, although certainly disruption in employment-related coverage seems likely due to the fact that many of these participants are newly pregnant and/or raising small children. Many of Illinois MIECHV's undocumented families also struggle with continuous insurance coverage because they only qualify for Medicaid when pregnant. This is reflected in the much lower percent of Hispanic caregivers who reported having continuous coverage (61%) compared to non-Hispanic caregivers (95%).

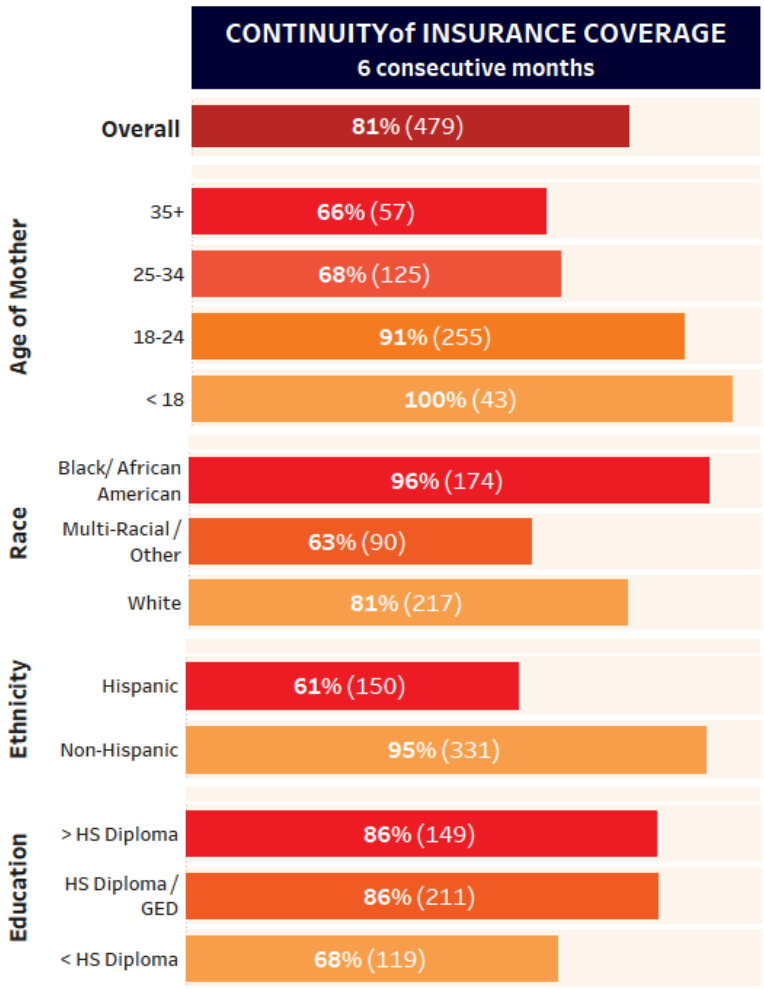


FIGURE 26: CONTINUITY OF INSURANCE COVERAGE BY AGE, RACE, ETHNICITY AND EDUCATION

MIECHV adult participants with less education are less likely to report having continuous health insurance coverage than those with more education (68% versus 86%). Older participants are also less likely to report continuous coverage compared to those under age 25, who may be covered by health insurance plans of their own parents. African-American caregivers are the most likely to have reported continuity of coverage – 96% compared to 81% of whites and 63% of multi-racial caregivers.

Benchmark 6. Improved Coordination and Referral for Other Community Resources and Supports

Benchmark 6 contains three constructs that assess linkages of families with specific needs to services in their communities.

Construct 17. Completed Depression Referrals

links to construct 3, depression screening. This construct measures whether caregivers who had a positive screen (indicating the presence of depressive symptoms) on their initial depression assessment (reported in construct 3), received a referral to mental health services and/or completed that referral. In FY 2017, all but five of the caregivers who reported experiencing depressive symptoms received a referral. Of those that received a referral, 53% accessed services, meaning they completed at least one service contact. To address limited availability of mental health services in some MIECHV service areas, and the stigma some participants associate with seeking mental health treatment, supplemental Mothers and Babies Curriculum, developed by Northwestern University, was approved for this benchmark for use by HVs to provide individualized support to address mental health needs related to identified depressive symptoms.

Construct 18. Completed Developmental Referrals

links to construct 12, developmental screening. This construct measures the percent of children who completed a referral for developmental services for a concern identified on one of the required ASQ-3 assessments (indicating a possible developmental delay). In this case, families must complete one of three types of referrals within specific timeframes in order to be considered as having completed a referral:

- Families must receive individualized developmental support from their home visitor;
- Families must be referred to Early Intervention services and receive an evaluation within 45 days of the ASQ-3 assessment; or
- Families must be referred to a community-based resource and receive services within 30 days of the ASQ-3 assessment.

In FY 2017, 82% of children who had an identified concern (reported in construct 12) received services. Of these, 39% received individualized support from their home visitors and 61% received evaluations from Early Intervention. (An additional two families completed their referrals outside of the required timeframes and thus were not counted as having completed referrals.)

Construct 19. Intimate Partner Violence Referrals

links to construct 14, intimate partner violence screening. This construct assesses whether caregivers who had positive screening results on their initial IPV assessment (indicating the presence of intimate partner violence), received referrals to IPV services. In the FY 2017 program year, 40% of caregivers received referrals. While this may seem low, it is not uncommon for caregivers in these situations to refuse referrals to services. Intimate Partner Violence is a focus of Illinois MIECHV's Continuous Quality Improvement work in the FY 2018 program year as well.

IV. MIECHV Continuous Quality Improvement

The Center for Prevention Research and Development (CPRD) in the School of Social Work at the University of Illinois provides Illinois MIECHV home visiting programs with Continuous Quality Improvement (CQI) supports and services. CQI is the complete process of identifying, describing, and analyzing strengths and challenges, and subsequently testing, implementing, and learning from solutions. It is a vital component of Illinois MIECHV, providing a mechanism to generate meaningful commitments from all levels of the program. Over that past five years, Illinois CQI efforts have worked with LIA's and state staff to demonstrate significant improvements in HRSA benchmarks and other key home visiting indicators (CPRD, Annual Report, 2017). The CQI infrastructure is supported by a CQI Specialist and a Coordinated Intake (CI) Specialist that work with teams at each home visiting and coordinated intake agency, conducting monthly technical assistance calls and providing support in planning, implementing, and evaluating CQI activities.

CQI Plans

The mainstay of CQI activities is the development, implementation and evaluation of CQI Action Plans. Each agency develops plans at least once a year. Plans are developed based on prior performance on the MIECHV benchmarks and aim to improve benchmark performance and overall program quality.

In FY17, coordinated intake programs completed 3 CQI plans. The topics included:

- Increasing referrals into home visiting programs (1 agency)
- Increasing the completion of Memorandums of Understanding (1 agency)
- Assisting families in transitioning from home visiting to other early childhood services (1 agency)

Of the plans completed this year:

- 1 agency surpassed its goal
- 1 agency met its goal
- 1 agency made improvements but did not reach its goal

Home visiting programs completed 14 CQI plans focusing on the revised MIECHV data requirements. The topics included:

- Increasing the frequency of early language & literacy activities (5 agencies)
- Increasing access to dental homes (4 agencies)
- Increasing receipt of recommended well child visits (2 agencies)
- Increasing safe sleep practices (2 agencies)
- Reducing homelessness (1 agency)

Of the plans completed this year:

- 6 agencies surpassed their goals
- 5 agencies met their goals
- 3 agencies made improvements but did not meet their goals

Focus on Early Language and Literacy

Early language and literacy was the construct that most Local Implementing Agencies (LIAs) (6 agencies) chose to work on this year. These CQI plans are detailed in Table 6, below:

TABLE 6: 2017 LITERACY CQI PLANS –SMART AIMS AND RESULTS

SMART Aim	Result	Improved?	Met goal?
Increase the % of families who practice literacy daily from 13% to 30%	64%	↑	✓
Increase the % of families who practice literacy daily from 59% to 65%	61%	↑	
Increase the % of families who practice literacy daily from 57% to 70%	71%	↑	✓
Increase the average # of days/week that families practice literacy from 3.12 to 4.67	Discontinued project due to external factors		
Increase the % of families practicing literacy 3+ times/week from 36% to 85%	44%	↑	
Increase the % of families who read to children 4+ times/week from 75% to 95%	95%	↑	✓

Through the course of their work on these projects, LIAs identified a range of barriers that families faced in attempting to practice literacy activities (defined by HRSA as reading, singing and/or telling stories) with their children. Barriers were related to lack of resources and skills, time conflicts, and factors related to both caregivers and children. These barriers are outlined in Figure 30, below.

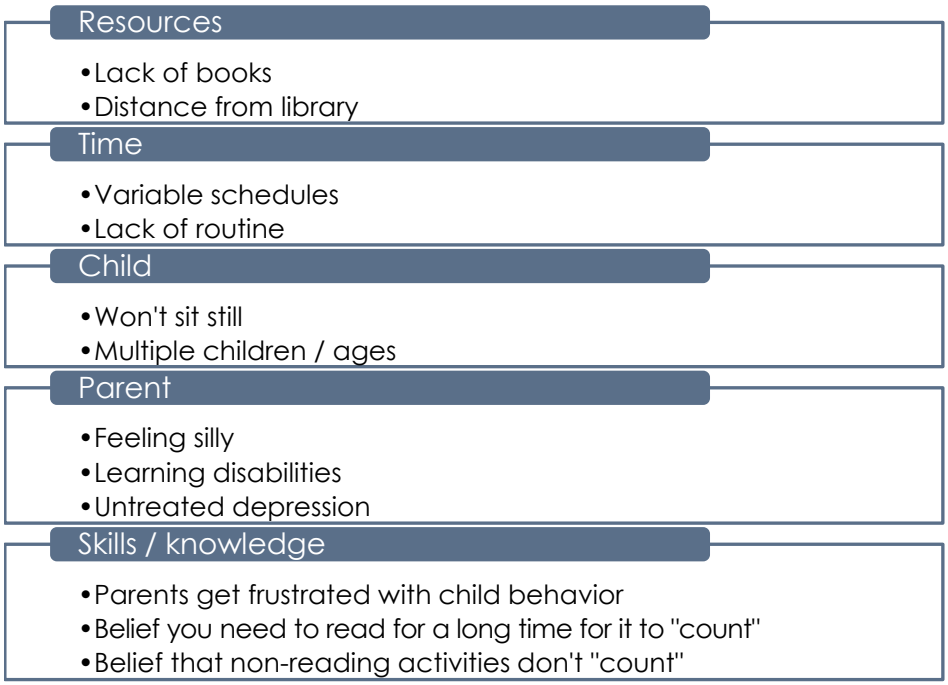


FIGURE 27: LITERACY-RELATED BARRIERS

To address these barriers, home visiting programs tested a number of change ideas, listed in Figure 31:

FIGURE 28: LITERACY-RELATED CHANGE IDEAS, FY 2017

The 2017 Home Visiting and Continuous Quality Improvement Survey (HV/CQI Survey)

As part of the evaluation of CQI and to continue to improve MIECHV systems and services, the evaluation team conducts an annual survey of MIECHV staff to gain insight into and garner staff input on the strengths, weakness, opportunities and threats to the staff experiences, and attitudes, beliefs and practices related to CQI and home visiting more generally. The Home Visiting and Continuous Quality Improvement Survey (HV/CQI Survey) was initially administered in 2013, and has been repeated annually through 2017. The survey has been modified and updated over time to address salient issues related to the workforce, such as salaries, retention, family engagement, and safety. Although the HV/CQI survey does not track individual home visitors over time, it does provide annual reports of key constructs and allows for including new home visiting issues as they surface.

The 2017 survey was sent to all MIECHV providers on June 22, 2017. All MIECHV personnel, which included home visitors, supervisors, and coordinated intake staff, were asked to complete the survey. Three reminder emails were sent and the survey was closed on July 25, 2017. As an incentive, twenty respondents were chosen at random, and each was awarded a $25 Amazon gift card. The survey closed with an 85% response rate.

Home visiting staff attitudes and beliefs regarding CQI practices

Participation in CQI programming is a requirement of the MECHV grant, and each LIA is expected to have a standing CQI team that develops and implements CQI plans focusing on the MIECHV benchmarks or other areas of home visiting quality. A major part of the FY 13—FY 17 HV/CQI survey was to assess the knowledge, beliefs, and implementation of CQI in the MIECHV LIAs. Figure 32 shows the frequency in means and percentages of responses to CQI related questions from FY 13 to FY 17.

Average responses have improved over the five survey years, with some showing significantly larger improvements than others (Figure 32). For example, staff report more favorable responses to adequate team time for CQI, higher quality data, demonstrated benefits of the CQI process, and greater integration of CQI into their programs. These improvements are key factors driving Illinois' improvements achieving the MIECHV benchmarks.

Home visitor safety

Due to the unique nature of home visiting, safety is a particular concern for home visiting programs. MIECHV has targeted high-risk communities across Illinois and, as a result, home

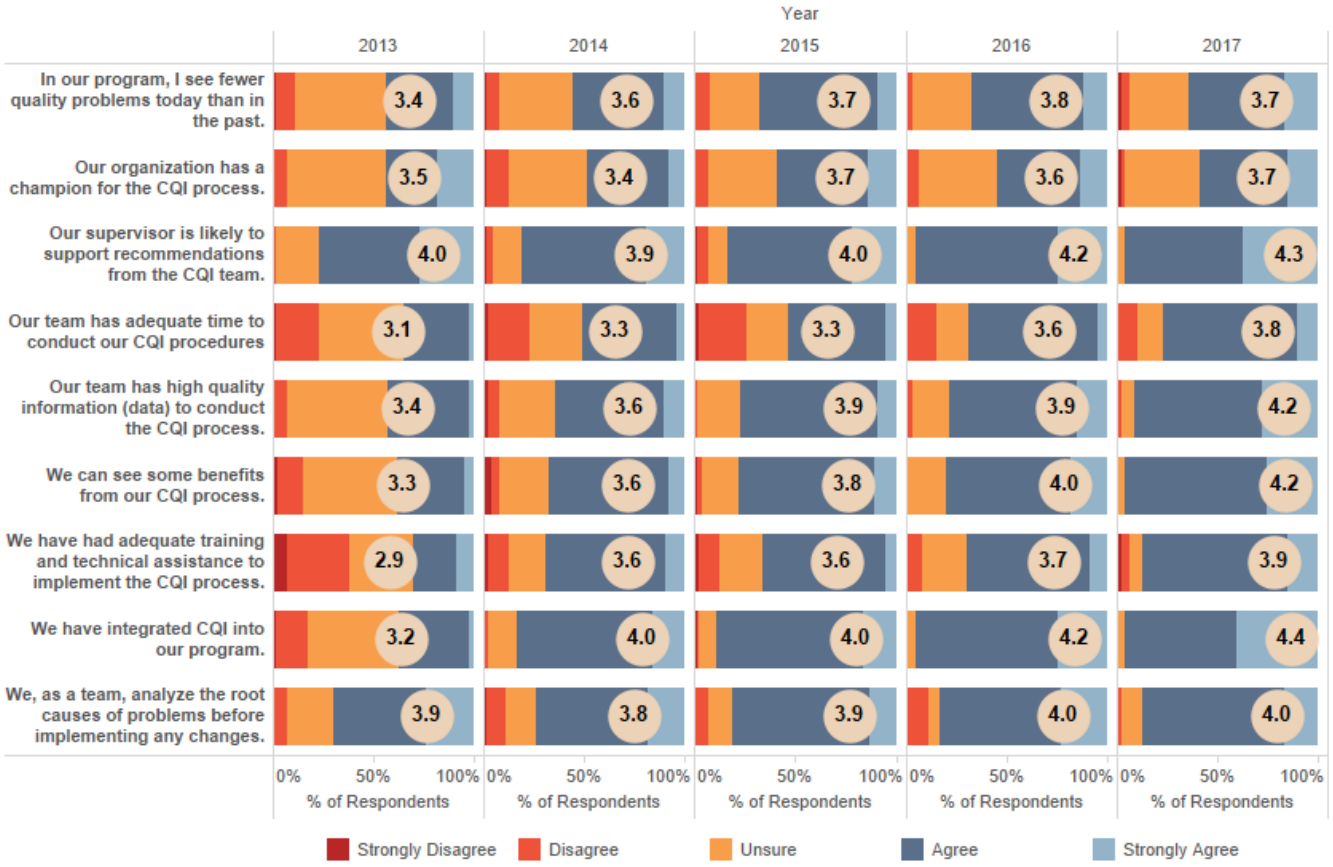


FIGURE 29: RESPONDENT AGREEMENT (AGREE/STRONGLY AGREE) BY SURVEY ITEM, FY 2013- FY 2017

visitors face safety challenges in their day-to-day work. To gain a better understanding of these issues, a series of safety-related questions was added to the 2015 survey. Results indicated that home visiting staff experienced high levels of concern about a number of potential safety issues. However, perhaps because home visiting staff and agencies employed a number of reported safety-related procedures and policies, home visitors reported relatively few unsafe incidents or experiences. In FY 2017, we revisited two components of the safety questions: unsafe experiences, and organizational policies and procedures.

Unsafe experiences

TABLE 7: MIECHV STAFF UNSAFE EXPERIENCES, FY 2015 AND FY 2017

		2015		2017	
		N	%	N	%
Intimidated or harassed in a home	Yes	3	4.1%	5	5.8%
	No	59	79.7%	65	75.6%
Intimidated or harassed in a neighborhood	Yes	6	8.1%	9	10.5%
	No	59	79.7%	63	73.3%
Had something stolen from your property (car, purse) while working	Yes	5	6.8%	3	3.5%
	No	62	83.8%	71	83.5%
Robbed or mugged while working	Yes	1	1.4%	0	0.0%
	No	65	89.0%	76	88.4%
Heard gunshots while working	Yes	23	31.1%	20	23.8%
	No	44	59.5%	54	64.3%
Witnessed violence to others	Yes	18	24.3%	22	25.6%
	No	49	66.2%	54	62.8%
Experienced violence yourself	Yes	1	1.4%	2	2.3%
	No	66	89.2%	74	86.0%

While home visitors reported high levels of concern about safety, it is encouraging that they do not report high levels of unsafe experiences compared to their perceptions of risk. Table 7 shows reported unsafe experiences in 2015 and 2017. Across years, home visitors report very little intimidation or harassment in homes and neighborhoods. While these experiences are especially concerning, home visitors also report experiencing very few incidents of theft, robbery or violence. Modest differences between years are most likely the result of changes in the workforce due to staff experience and turnover.

Agency efforts to reduce risk

In 2015, home visitors were also asked about their agencies' safety practices or policies, to gauge agency safety efforts, as well as home visitor knowledge of those safety efforts. As a follow up to the survey, all agencies with MIECHV home visitors were asked to provide their safety policies, as well as any additional information about safety-related practices not included in their policies. The majority of responding agencies reported not having safety policies or having inadequate or outdated safety policies. In 2016, and again in 2017, we asked home visiting staff to indicate which, if any, safety-related policies or procedures their organization implemented. Table 8 shows results for each year.

TABLE 8: ORGANIZATIONAL SAFETY-RELATED POLICIES AND PROCEDURES, FY 2016 AND FY 2017

		2016		2017	
		N	%	N	%
Provides information about safety during orientation	Yes	52	85.2%	74	87.1%
	No	5	8.2%	8	9.4%
	Not Sure	4	6.6%	3	3.5%
Provides annual safety trainings to all home visitors/CI staff	Yes	42	70.0%	51	60.0%
	No	10	16.7%	21	24.7%
	Not Sure	8	13.3%	13	15.3%
Has a written safety policy or manual	Yes	51	83.6%	73	85.9%
	No	8	13.1%	5	5.9%
	Not Sure	2	3.3%	7	8.2%
Has a standing safety committee	Yes	29	49.2%	44	51.8%
	No	18	30.5%	26	30.6%
	Not Sure	12	20.3%	15	17.6%
Allows staff to cancel/leave a home visit for safety reasons	Yes	59	98.3%	81	96.4%
	No	0	0.0%	1	1.2%
	Not Sure	1	1.7%	2	2.4%
Provides cell phones to home visitors/CI staff	Yes	28	46.7%	53	62.4%
	No	31	51.7%	30	35.3%
	Not Sure	1	1.7%	2	2.4%

Across years, home visiting staff report similar results for safety included in orientation information, organizations having written safety policies or manuals, and agencies having standing safety committees. Fewer staff reported that their agency provided annual safety trainings, however this may be related to the increased number of staff in their first year of

employment, especially given the similar results on the other safety practices. The one main difference between years is that a far greater percent of staff were provided cell phones by their agencies in 2017 compared to 2016. We are not able to determine whether this change was made as a result of safety findings in 2015.

Private funding sources for home visiting

In response to fiscal instability in Illinois, the evaluation team developed a series of questions designed to understand to what extent home visiting programs received private sector funding. These questions were limited to Supervisors or Site Administrators with the assumption that this group would be most likely to have this level of information. However even this group may not have been fully aware of private sector funding at their agencies.

The development of these questions created numerous challenges as to how to ask, understand, interpret, and report this type of information. The first question asked whether or not organizations received private funding for the home visiting programs. Of the 26 individuals who responded, 10 (34.5%) reported their organization received some private funding. Responses are presented in Figure 33 below.

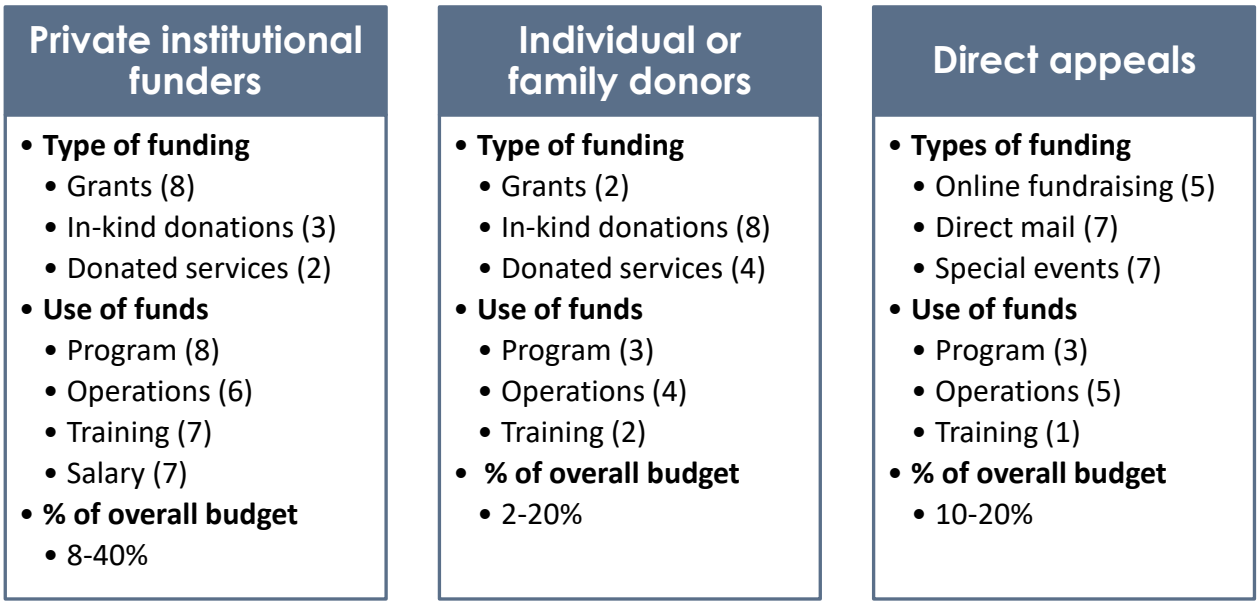


FIGURE 30: PRIVATE FUNDING SOURCES FOR MIECHV HOME VISITING PROGRAMS

Results from this line of questions indicate that home visiting programs do identify and secure funding from multiple private sources and depend on these sources for a wide range of uses. However, these private funds appear to be limited in both amount and contribution to the overall operational budget. Additionally, responses to the CQI Survey's open-ended questions frequently addressed topic in this section, included in seven of the 80 responses. This survey

also indicated that funding was a serious concern for programs. Funding was the third most was completed before MIECHV was reauthorized, and thus funding was front of mind for many. One respondent said: “Advocate for our jobs by informing politicians of the importance of our roles. It’s important to help our most vulnerable by funding programs like this.” This respondent went on to add: “As of June 30th, our agency will lay us off. Families will be without services for an unknown time.”

This response highlights the importance of strong and secure funding for home visiting programs, not just for participants but also for staff and program stability. Funding is an area that merits additional research, especially in light of Illinois’ fiscal instability and many programs’ braided funding structures.

Home visitor workforce capacity and education

Another key set of questions and indicators on the HV/CQI survey are related to the current workforce capacity of Illinois MEICHV home visiting staff. The education, training and support of home visitors is critical for ensuring a high quality, high skilled and effective workforce (Wechsler, 2016). The annual survey contributes to Illinois’ understanding of the workforce development issues.

As illustrated in Figure 34 below, almost all home visitors have completed at least some college, with the majority having a bachelor’s degree or higher. This trend has remained fairly consistent over time, with a slight dip in 2016. During 2016-2017, 58% of home visitors (38 respondents) held a bachelor’s degree, and 16% (6 respondents) an associate degree.

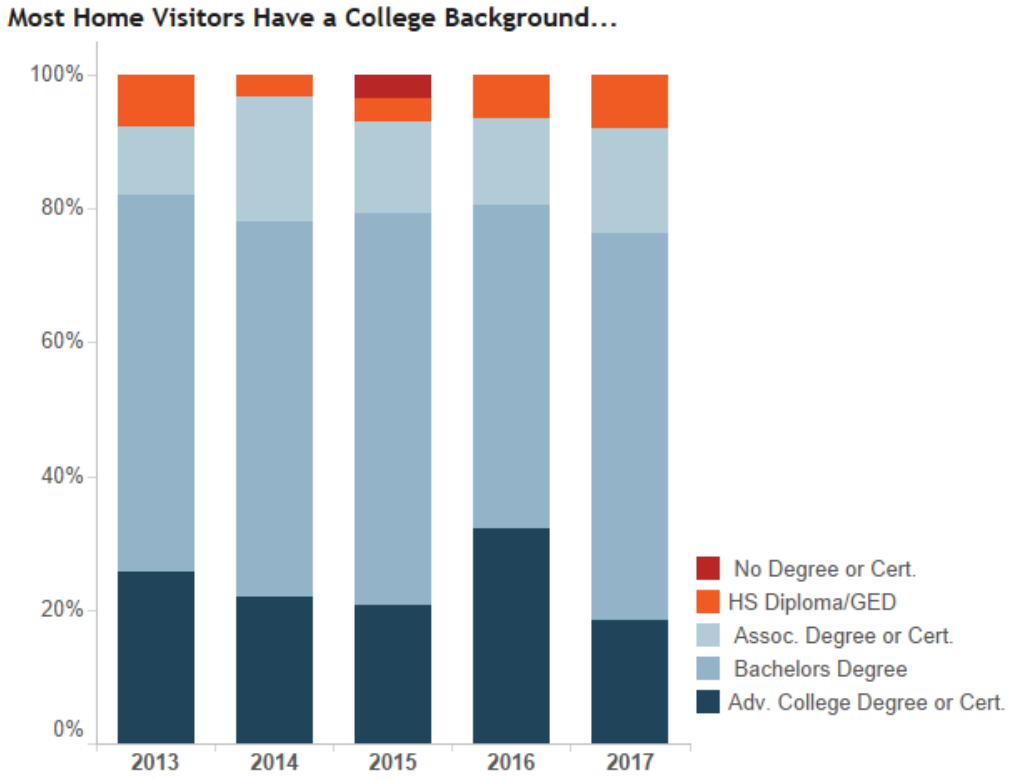


FIGURE 31: HOME VISITING EDUCATION LEVEL, 2013-2017

Home visitor experience

As shown in Figure 35 below, home visitor years of experience in the field have been self-reported on the survey since 2013. Except for the first year of the MIECHV project, most respondents have been at their agency 2-3 years, with 2017 showing an increase in staff remaining at the agency 4-5 years. While this indicates a positive trend

Staff Years at Agency	2013	2014	2015	2016	2017
10+ years	18%	9%	23%	18%	24%
6-9 years	9%	7%	5%	10%	7%
4-5 years	5%	7%	14%	25%	26%
2-3 years	11%	43%	36%	28%	13%
One year or less	57%	33%	22%	18%	30%

FIGURE 32: CURRENT EXPERIENCE

of a steady increase in experience as staff remain with MIEHCV programs over time, staff turnover continues to be a concern (discussed later in this report). In FY 2017 30% of home visitors reported being at their agency less than one year. These higher numbers of less experienced staff in FY 2017 includes the addition of new staff at new MIECHV expansion sites.

Figure 36 shows that most home visitors had one year of experience or less in the field before being hired at their current agency. While this is still the case, the percentage of new hires with a year of experience or less dropped by almost half from 2013, from 58% to only 31% in 2017. The hiring of more experienced staff is a plus for the home visiting programs, and a positive trend to developing and maintaining a highly effective HV workforce.

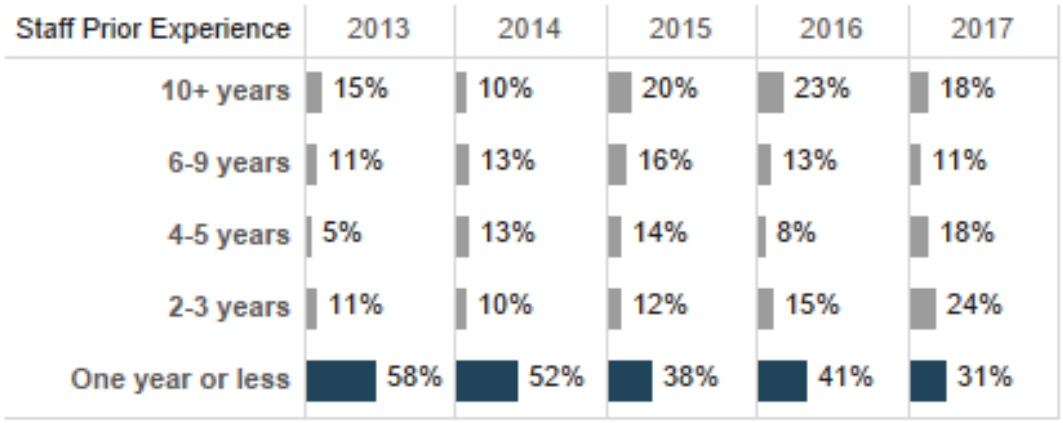


FIGURE 33: STAFF PRIOR EXPERIENCE

Home visitor salaries

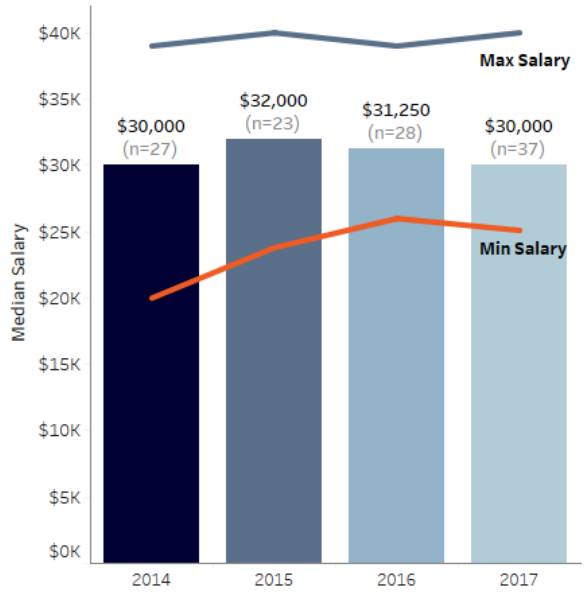


FIGURE 34: HOME VISITING SALARIES 2014-2017

Each year, the CQI survey has asked home visitors to self-report their annual salary. Figure 37 presents HV salaries over time from 2014 through 2017, showing minimum and maximum salaries reported, and the median salary level. While the minimum HV remuneration increased modestly over time, the median salary in 2017 is the same as it was in 2014. This suggests that HV staff may be hired at a slightly higher base rate, but are not receiving raises to substantially increase their wages over time. The drop in FY 2017 may also represent the hiring of a cohort of HV staff to the expansion sites with entry level salaries. As low salaries have been cited as a reason for HV's leaving their position in past CQI surveys, this flat median salary level bears watching (CPRD, HV/CQI Survey, 2017).

The complete MIECHV Home Visiting and Continuous Quality Improvement Survey Report can be found on the CPRD website at http://cprd.illinois.edu/files/2018/02/MIECHV_CQI-SurveyBrief_2017.pdf.

MIECHV Staffing and Staff Turnover

The evaluation team has tracked MIECHV staff turnover for the past four years, to analyze trends and impacts over time. The home visiting workforce is susceptible to turnover due to a variety of factors including relatively low-pay, insecure and unstable funding, and the unique challenges and stresses of providing home-based services to at-risk populations in high-need neighborhoods and communities. Because home visiting is in many ways a relationship-based service, turnover can be especially disruptive to families' progress towards goals, and can influence their willingness to stay in the program after "their home visitor" leaves. As noted in the dropout analysis completed in 2014, "caregivers will often drop out of a program after the loss of their home visitor" (CPRD, MIECHV Parent Dropout Analysis, 2014).

Staffing changes during state fiscal/contract years 2016-2017 reflect not only staff exits/turnover, but also the addition of 23 contracted MIECHV positions, coinciding with the expansion of MIECHV to several new sites as mentioned previously in this report. Staffing levels increased from 111 in SFY 2016 (July 1, 2015-June 30, 2016), to 134 in SFY 2017 (July 1, 2016-June 30, 2017), and included the addition of 8 HVs, and 3 HV supervisors.

For state fiscal year 2017, Illinois MIECHV shows a wide range of turnover, with relatively high turnover in all staffing categories (see Table 9 below). These turnover numbers, based on the number of staff identified in their MIECHV contract with the Office of Early Childhood Development (OECD) for a specific position, range from 30% to 50% per position category, with an average turnover percentage of 36% for July 1, 2016 through June 30, 2017. This is an increase in the overall turnover rate from 2016, which was 22%. However, turnover percentages need to be carefully interpreted because some positions have very few staff (Doula HV = 4, and CI =9), and any reported change may be overstated. Specifically, the largest number of contracted staff were the MIECHV HVs (47 HVs) that reported a 38% turnover last year, which is more than one third of HVs in the past year, and an increase from 31% in the prior year. Staff turnover tables for State FY 2017 (Table 9) and State FY 2016 (Table 10) are provided below for comparison. When including the "Doula HV's" at the doula sites, the HV turnover number for 2017 is even higher, (39%) with an additional 2 HV's leaving their positions. This high turnover may contribute to a number of programmatic issues related to quality, continuity of services, dropouts, and the expense of hiring and training new home visiting staff.

Equally concerning is the length of time positions remain vacant, which ranged from a low of two weeks in SFY 2017, to a high of 4.8 months for CI and 3 months for HV. Overall, the average length of time to fill a position was 2.4 months. Tables 9 and 10 show the average length of employment in years, which again varies by the number of people in a position and job title. Nonetheless, the average length for employment of MIECHV HVs was 2.2 years in State FY 2017, which is a slight increase over 2016's average of 1.8, indicating a positive increase of a few additional months of experience of the HV's who remain in MIECHV programs.

TABLE 9: MIECHV STAFF TURNOVER, SFY 2016 AND SFY 2017

MIECHV Positions	Contracted		Staff Hires		Staff Exits (Turnovers)		% Turnovers		Average Length of Vacancy (months)		Average Length of Employment (years)	
	SFY16	SFY17	SFY16	SFY17	SFY16	SFY17	SFY16	SFY17	SFY16	SFY17	SFY16	S FY17
Coordinated Intake (CI)	5	9	0	6	1	4	20%	44%	5.6	4.8	1.9	2.3
CI Supervisor	5	10	1	8	3	3	60%	30%	0.2	2.0	2.3	2.6
Doula	14	13	8	2	3	4	21%	31%	1.2	1.4	1.9	2.2
Doula Home Visitor	4	4	3	5	3	2	75%	50%	0.4	0.5	1.8	2.2
Home Visitor (HV)	39	47	13	24	12	18	31%	38%	3.6	3.0	1.8	2.2
Other Staff	15	19	1	9	1	7	7%	37%	2.3	1.8	3.2	3.7
HV/Doula Supervisor	29	32	6	8	1	10	3%	31%	1.1	1.4	2.8	3.4
Grand Total	**111**	**134**	**32**	**62**	**24**	**48**	**22%**	**36%**	**2.6**	**2.4**	**2.2**	**2.6**

V. Coordinated Intake

Coordinated Intake (CI) staff and services play a vital role in Illinois MIECHV communities. Local community-based CI workers help at-risk families identify and connect to home visiting, and other services and supports they need, and also support home visiting agencies by helping to maintain caseload capacity with families that best fit their specific eligibility criteria. Knowledgeable and skilled CI staff provide a convenient single point of entry for home visiting, and a variety of other early childhood and family support services. They help empower families by informing them of the range of options available to them, and finding the best match based on their interests, availability, culture comfort, and program criteria. CI workers also assist home visiting programs by promoting home visiting services, conducting outreach activities to help find eligible families, and completing screening and intake assessments which can reduce duplication of referrals and streamline data collection. This coordinated system helps provide more efficient and seamless services, and avoids duplication of efforts related to outreach and recruitment of families. By providing the best fit for families, CI can also assist with the process of family engagement in HV programs, which can lead to better retention in HV programs and ultimately increased positive outcomes for families. Table 11 below lists the CI sites active in Federal FY 2017 (October 1, 2016-September 30, 2017).

TABLE 10: FEDERAL FY 2017 COORDINATED INTAKE SITES

Community	Coordinated Intake Agency
Cicero	Family Focus Nuestra Familia
Cook	Primo Center*
Elgin	Kane County Health Department
East St. Louis	Comprehensive Behavioral Health Center*
Englewood/ Southside Cluster	Children's Home + Aid
Kankakee County	Aunt Martha's Health and Wellness Center*
Macon County	Macon County Health Department
Rockford	Winnebago County Health Department
Vermilion County	Center for Children's Services/Aunt Martha's
DeKalb County	Children's Home + Aid Sycamore
McLean-Piatt-DeWitt-Woodford	Children's Home + Aid Mid-central Region (Bloomington)
Peoria-Tazewell County	Children's Home Association Peoria
Stephenson County	Stephenson County Health Department

*Coordinated Intake in development

Background

In Federal FY 2012, MIECHV initiated CIs in six communities (the Southside Chicago Cluster, Cicero, Elgin, Rockford, and Macon and Vermilion Counties). Additional communities were later added in McLean-DeWitt-Piatt-Woodford Counties, Oak Park-River Forest, Peoria-Tazewell Counties, and Stephenson County. Most recently, East St. Louis and Kankakee have a CI system in the planning/development stages. The original goal was to provide CI services at the local level across the state, to help families access home visiting services that best fit their needs, as well as identify other key supports such as primary health care providers, child care services, early intervention, and preschool programs. Original staffing of CI in each community included a CI worker who screened families for eligibility and referred them to the most appropriate community services, and a Community Systems Development (CSD) worker who focused on relationship building with a variety of collaborative partners. CSD activities included the development of MOU's to formalize working relationships, conducting regular community collaboration meetings to foster ongoing communication among partners, and the organization of community events to promote home visiting and related early childhood services. The final year for MIECHV funding to support the CSD system in the original six MIECHV communities was State FY 2016. This systems change which essentially cut CI staffing in half, has required the HV communities to revisit the community systems and coordinated intake roles.

In addition to CSD staff reductions, the CI system implementation has continued to have challenges due to a variety of factors at the state and local level. Years of state budget crises, CI staff turnover, agency downsizing, leadership changes, contract delays, and program closures due to fiscal constraints have all had a negative influence. Recognizing the many continuing challenges and constraints faced by the CI pilot system, additional efforts by the state MIECHV team and CPRD CQI staff have been made to increase and strengthen supports to the CI system as a whole, with a focus on CI staff support, more coordinated efforts to promote home visiting to potential HV recipients, increasing standardization of CI services across communities such as by aligning intake forms, and refining CI processes, including data collection and reporting.

An essential component of coordinated intake systems that has been reemphasized since the loss of CSD staffing, is recruiting and engaging community partners, and maintaining ongoing, open communication with a variety of early childhood service providers. Coordinating services provides a variety of benefits to all families with young children, especially when they are faced with adversity, complex medical concerns, developmental delays or behavioral concerns (Schlemper, Kapp, Campos, Haq, & Simoes, 2017). Increased efforts over the past year have focused on establishing and expanding collaborative connections with Birth to Three Local Interagency Councils, Early Intervention providers across the state, and the Department of Children and Family Services, to ensure that families with challenges or concerns about their child's development during the early years are connected with supportive services, including home visiting. This relationship building is a process that takes time, and in many cases, relationships that were established early on have had to be rebuilt with referral partners, due to

turnover and disruption in collaborative work. A key step in reestablishing these partnership agreements has been through the development of Memorandums of Understanding (MOUs) to formalize relationship expectations, outline the benefits of participation, and establish specific procedures for sending and receiving referrals. Another effort at better collaborating is being addressed through cross-trainings for home visitors, child welfare workers, and early intervention providers. These trainings, which support cross-system collaboration among early childhood providers, are currently being offered across the state at the local community level.

CI Learning Community Group Meetings

One approach to confer greater understanding of CI challenges and problem solving has been the development of a CI Learning Community. In November 2016, and January 2017, CI Learning Community meetings were convened by video conference from 4 locations across the state. The power of the CI Learning Community became so critically important and compelling to their work that the group decided to convene face to face meetings. In March, in-person quarterly CI Learning Group meetings began, which were held in Bloomington, to provide a central location for the CI staff to assemble. These quarterly meetings replaced the bi-monthly video conference calls which were less effective for group interaction and discussion. The quarterly meetings were established to afford an opportunity for staff delivering CI services to network with, and support each other in their unique roles as coordinated intake providers in their communities.

CI staff report that they find the opportunity to meet face-to-face to talk with fellow CI workers, and to be part of a team, has been extremely beneficial. The group discusses successes and challenges, shares resources and strategies, and provides feedback to leadership related to technical assistance, professional development, and other supports needed. Meeting evaluation feedback on what staff like best about the meetings includes “networking”, “small groups”, “getting to know each other”, “sharing ideas”, “learning from others”, “discussing what we can improve and exchanging ideas”, and “doing the activity in groups with the other CIs.”

Professional development, process standardization and continuous quality improvement (including use of specific CQI tools), are built into every meeting. Resource sharing, and group activities are also components of each gathering. FY 2017 peer learning activities included practice using CQI tools for root cause analysis, writing SMART goals, and peer sharing of site level CQI work. A secure drop box was created for the CIs to share contact information, meeting notes, presentation slides, policy and procedure manuals, recruitment flyers, resource guides, and other useful documents with each other.

To assist programs in clarifying the expectations related to the various aspects of CI, and to expand the pilot systems developed in the original MIECHV communities, a CI “Road Map” document was developed to articulate the objectives/requirements of CI staff.

Key Objectives from the CI Road Map:

1. Learn, engage and collaborate with the key individuals, organizations and ancillary agencies that support maternal, child and family health in your community.
2. Ensure regular and ongoing communication and interaction with community partners and ancillary organizations related to maternal, child and family health systems and services in your community.
3. Know, engage, and collaborate with community partners and ancillary organizations related to enrolling eligible families in home visiting.
4. Demonstrate willingness and capacity to engage and support families in home visiting across communities, cultures, and socio-demographic conditions.
5. Demonstrate professional skills and competencies essential to successful CI work.
6. Regularly lead and facilitate a collaborative meeting with HV partners, or participate in cross-sector collaborative/network meetings (such as AOK and Local Interagency Councils (LICs) with community home visiting programs and other related organizations), to develop and maintain linkages to CI.
7. Participate in monthly CQI calls and quarterly in-person CI Learning Community meetings.
8. Support referrals to all home visiting programs to ensure they maximize a caseload capacity of 85%.

From these objectives/requirements of the position, it is clear that the CI worker role requires a variety of skill sets, including direct service engagement and assessment skills, specialized knowledge of HV program models and local community resources, and also relationship building, networking and collaboration, outreach, presentation and marketing skills.

CI Focus Group

To further understand the needs, skill sets and barriers to high quality CI services in MIECHV communities, CPRD's evaluation team conducted a focus group with persons responsible for coordinated intake (CI) within the home visiting system. The focus group included eight persons, funded by the MIECHV project, responsible for CI in counties or service areas across the state. This focus group was conducted on November 15, 2017.

Two researchers moderated the focus group, which prepared 21 questions covering issues ranging from promoting home visiting and recruiting clients, program referrals, data tracking, caseload capacity, professional development and support, and several other areas. Participants varied in coordinated intake experience from three weeks up to five years. Most CI participants had served in their positions between one and three years, with one individual beginning her CI position within the last month. This range of experience provided developmental and diverse views and experiences particularly considering the unique nature and context of Illinois MIECHV communities.

Takeaways and Lessons Learned:

- CI providers engage in a variety of means of recruiting clients, mostly including getting out into the community. WIC clinics are very productive ground. Less successful experiences came from general advertising, and while Facebook advertising generated some interested inquiries, it did not increase actual referrals. There are no shortcuts for getting out into the community and building trust.
- There are several issues with program referrals, including the different requirements of different programs. An interesting point focused on the need for home visiting services even for parents who are relatively well-off financially. A different issue is language and the need for Spanish-speaking home visitors, as well as challenging issues that arise from lack of transportation.
- Overall, the CI system is good, but participation across local community systems can be a challenge as there is sometimes a competition among service providers for clients. Some agencies say they participate in CI, but only in as much as they receive referrals, but don't share their referrals with others. Some maintain separate wait-lists as opposed to referring clients to other agencies.
- As for data tracking, few CI providers liked the current Visit Tracker system, preferring to track their clients with some combination of spreadsheets they created themselves and post-it notes. The problem with Visit Tracker is its lack of system-wide use, and its limited functionality.
- Few CI providers reported issues with maintaining caseload capacity unless caseload management was impacted by staff turnover.
- There were many professional development needs mentioned focusing on networking and community coalition work. Another gap appeared to be more training on working with fathers. As for training methods, most preferred in-person trainings and some pointed to 'shadowing' home visiting workers as a means of learning about the work that goes on. Others pointed out the need for more sharing opportunities among CI providers such as quarterly meetings.
- Nearly everyone liked the CQI process and seemed to get a lot out of it. Only one participant mentioned the challenge of competing time demands and engaging in CQI.

Overall, CI providers are a key linchpin of a very successful and highly functioning home visiting system. They are committed workers operating under complex circumstances with challenges arising in very different ways within the system. Prior to the development of the CI Learning Community group, many CIs struggled to create a systematic and successful approach to engaging, screening and referring eligible families to MIECHV home visiting services. The CI focus group allowed participants to be heard, to share ideas, and to let new ideas emerge that could be responded to by their peers. It also allowed sharing of frustrations and some

difficulties. Along with the CI Road Map and Community Learning Group, we believe the focus group results will continue to contribute to creating an atmosphere of engagement to learn and guide future systems and service improvements.

The full MIECHV Brief Study Report: Coordinated Intake Focus Group November 2017 can be found on the CPRD website:
http://cprd.illinois.edu/files/2018/05/MIECHV_CI_FocusGroupReport_2017.pdf.

VI. Summary and Recommendations

The completion of the Illinois MIECHV 5th Annual Benchmark and Outcome Report continues to tell Illinois' story of home visiting programs and services. Similar to other states, Illinois has had a long history of supporting and delivering home visiting programs for over 30 years, and MIECHV has significantly increased the standing, capacity and resources to deliver evidence-based home visiting programs and services to more than 1,100 households and 13,000 visits in FY 2017 alone. Unlike other states, Illinois has been constrained by a state government that has not had a legislatively approved a budget over the past two years July 1, 2015, to August 31, 2017 (793 days), which was only officially signed in August 2017. This two-year budgetary stalemate created significant problems with funding, supporting and staffing home visiting, and ancillary services that are not MIECHV funded, but in communities that other state home visiting services are provided. This historical reality (over 2 years) serves as the background and context for Illinois health and human services that are provided to its citizens, particularly those who are disadvantaged and those who serve them. During this time period, agency closings, furloughs, layoffs, contract renewals, staff turnover and low morale were commonplace and exacerbated the quality of programs and services among all the Illinois home visiting organizations and communities, and related services. The July 2017 budget approval began the process of putting Illinois health, education and community programs back on track.

Illinois' needs for home visiting services remain high. MIECHV priority populations continue to be prevalent in Illinois, as reported in the socio-demographic section of this report, with over 83% of families below the 100% FPL level. Use of tobacco in the home, pregnancy under the age of 21, low student achievement, developmental delays, and child abuse and neglect also are the most commonly identified factors that determine eligibility to the MIECHV programs. Nearly 10% of families have four or more priority population risk indicators. The upcoming needs assessment (2019) will assist Illinois MIECHV to better understand whether risk factors (priority populations) have been exacerbated, improved or remained the same. More current census data indicate that Illinois has been losing population over the past five years (U.S Census Quick facts, 2018).

This past year created new opportunities and challenges with the advent of the new and redesigned HRSA benchmarks. A major challenge was the learning, educating and adapting to the new HRSA benchmarks among the home visiting staff, and altering the online data system to receive, calculate, and report data for CQI and benchmark reporting. By contrast, HRSA's new and revised benchmarks, to some degree, simplified key indicators. New indicators include housing status, safe sleep, behavioral concerns, early language and learning activities that provide important new issues, while reducing data collection burden for home visitors and project staff. It should also be noted that the majority of new indicators provide specific actions or tasks that home visitors can do to educate, show, discuss and support the improvement of child and family outcomes. Lastly, the new indicators establish a baseline for future home

visiting services and CQI work. Many multi-year comparisons (trends) were lost as a result of the change in benchmarks or the way the benchmark was calculated.

Continuous Quality Improvement

Illinois MIECHV home visiting programs have now been engaged in continuous quality improvement work for a number of years. Programs were initially trained and oriented on the basic frameworks and tools of CQI when MIECHV was first implemented in Illinois. As new staff joined programs, or new programs joined Illinois MIECHV, individual staff and programs have received one on one training and support.

The field is now at a point where it would be beneficial to increase the formalization of CQI programming, and allow programs an opportunity to interact with one another around CQI and program improvement more generally. For these reasons, it is recommended that Illinois MIECHV develop and implement a group or peer CQI format, which will reinforce the basics of CQI and allow programs to increase their knowledgebase, while learning from one another. CQI efforts will continue to focus on the issues that home visiting staff and programs have the greatest level of control such as screening and referrals, family engagement and safe sleep practices.

Data Requirements

Since October 2016, home visiting staff have worked hard to learn the content of the new MIECHV data requirements, to consistently and accurately implement those requirements, and to document the data correctly and in a timely manner. This has been very challenging given the continuing guidance from HRSA and the ongoing updates to the Visit Tracker database. Much effort was made to assist staff with this transition and it is recommended that additional supports be developed to ease the burden on home visitors and supervisors. These may include additional reports and reminders within Visit Tracker, statewide trainings, individualized technical assistance, and increased recognition of program success. It is also critical that Illinois update and finalize the Visit Tracker database to include the CI system in order to facilitate, understand and report their efforts and actions for reaching key indicators and provide data for quality improvement.

Coordinated Intake

The CI system is an integral part of MIECHV's LIAs and community work to serve high risk families needing comprehensive services. In a sense, a comprehensive, highly engaged CI system provides a community with the knowledge, resources and supports to ensure high quality home visiting services and critical ancillary services needed to address a host of health, medical, education and behavioral problems that are common with young disadvantaged families (Schlemper et al., 2017). Recommendations to continue to develop and strengthen this system include:

- Incorporate and monitor the key objectives from the Road Map to guide CI early childhood services in MEICHV communities
- Continue the support of CI providers through monthly CQI calls and quarterly in-person meetings which include opportunities for peer sharing
- Increase staffing in each CI community to support CI role, such as data entry/follow up staff
- Customize professional development opportunities to address the unique position requirements of CI workers
- Address limitations of Visit Tracker system to better meet the data tracking and referral sharing needs of the CIs
- Enhance supervisory support by providing regular reflective supervision through contracted Mental Health Consultants

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