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SCHOOL OF SOCIAL WORK

Maternal Infant and Early Childhood Home Visiting (MIECHV)
6th Annual Benchmark and Outcome Report

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)
6th Annual Benchmark and Outcome Technical Report
FY 2018

Produced for:
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I. Background and Overview

The Illinois Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program has provided home visiting services in multiple disadvantaged communities across the state for the past seven years. Many changes and adaptations, documented in detail in prior annual reports, have been implemented since MIECHV services began in 2012, including changes in data systems, new approaches to professional development and continuous quality improvement, and revisions in benchmark requirements. A notable change in the past year (FY 2018), is that the competitive research grant which included funding to doula home visiting programs ended and HRSA has not released a subsequent competitive grant (to adjust to the loss in funding, Illinois MIECHV plans to increase future funding to programs and families). In addition, one home visiting site ended MIECHV services in FY 2018. The number of MIECHV implementing agencies, therefore, reduced from 34 in FY 2017 to 25 in FY 2018, and the number of communities served decreased from the prior year's 18 to 13. Thus, nine fewer agencies, and five fewer communities were supported by MIECHV funding in FY 2018.

> There can be no keener revelation of a society's soul than the way it treats its children. - *Nelson Mandela*

Over the past fiscal year, MIECHV staff have adapted well to the FY 2017 revamping of the program's performance measures by the Health Resources and Services Administration (HRSA). The change has provided a reduced data burden with reporting requirements significantly decreased from 35 to just 19 constructs in six key measurement areas. The MIECHV system has continued its focus on the following areas in FY 2018: 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.

The 2018 Annual Benchmark and Outcome 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 sixth full year MIECHV program evaluation, as required by the federal HRSA, reflecting Illinois' submission for Year 7 (FY 2018) Performance Benchmark (PB) data in October 2018, which were reviewed by HRSA in December, 2018.

This year's annual report, focusing on federal fiscal year 2018 (October 1, 2017 through September 30, 2018), continues to build on prior years' reports related to program

implementation, continuous quality improvement (CQI), and additional sub-studies and outcome analyses that go beyond the HRSA benchmark reporting requirements. MIECHV components are measured and assessed based on empirical qualitative and quantitative data collected by the evaluation team.

Since Illinois MIECHV is committed to advancing racial equity in early childhood systems as described in the Early Learning Council (ELC) Racial Equity definition, this year's annual report also includes breakdown by race and ethnicity for several benchmark constructs when the sample size is large enough and when there are disparities between groups. Illinois MIECHV plans to review these disaggregated data and will work in partnership with IDPH and the Home Visiting Task Force Executive Committee to develop strategies for reducing disparities, culminating in a written plan that will be implemented during FY 2020-21. It is important to note that any racial and ethnic disparities have multiple causes, especially related to systems and structural barriers.

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. Four essential strategies comprise Illinois' approach to the implementation of MIECHV:

1. Expanding or enhancing one of three home visiting models;
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 testing of a system of universal screening and Coordinated Intake, and the enhancement of an early childhood collaborative in each target community.

MIECHV reporting requirements, including any revisions in FY 2018

HRSA substantially revised MIECHV reporting requirements effective October 1, 2016. The intent of the revision was to minimize data burden and standardize data collection across MIECHV sites. 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, with only one of the 19 constructs remaining the same. Also, many of the current constructs are reported each year, unlike the prior set of constructs, which were each reported only once. 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 requisite data on all index children, whereas they previously reported on one target child.

The current constructs are categorized 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. MIECHV FORM 2 CONSTRUCT SUMMARY

Form 2 Construct		Performance Measure	Type of Measure
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

Form 2 Construct		Performance Measure	Type of Measure
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
7	Safe Sleep	Percent of infants that are always placed to sleep on their backs, without bed-sharing or soft bedding	Performance Indicator
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
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
14	Intimate Partner Violence Screening	Percent of primary caregivers who are screened for IPV by 6 months post enrollment	Performance Indicator

Form 2 Construct		Performance Measure	Type of Measure
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
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

Whether your pregnancy was meticulously planned, medically coaxed, or happened by surprise, one thing is certain – your life will never be the same." – *Catherine Jones, Eating for Pregnancy*

Over the past year, the CPRD team and GOECD have worked closely with the data system developers and MIECHV programs to ensure the new data requirements are clear and accurately reported. CPRD also refined monthly "report cards" for the MIECHV sites to assist staff in tracking due dates and timeframes for each of the 19 constructs. The adjustment to reporting on the new benchmark requirements continued to be a challenge this year, especially for the home visitors who are ultimately responsible for data collection and entry. However, overall, sites have adapted to the new reporting requirements, and improvement in performance was seen for most of the benchmark constructs.

In the annual CQI Survey that CPRD conducts to collect direct feedback from the home visiting staff, compared to 2017, fewer of the open-ended responses addressed issues related to these changes than in the initial year the new benchmark constructs were put in place. Three respondents commented on the burden of documentation, and a need to streamline paperwork to avoid duplication of efforts, with one suggesting funders of home visiting

"should come together to look at how they can streamline documentation for Home Visitors." Five commented that there's "too much paperwork."

Respondents noted both the challenges related to, and the importance of MIECHV reporting. One respondent pointed out: "I understand the need to have records, but some things are asked repeatedly/too often" and paperwork "takes time away" from providing direct services that participants need. Other related concerns mentioned were specific timelines, and the burden of data collection that "can be overwhelming sometimes." One respondent noted that timelines for completing assessments and data entry "…can be a challenge, especially when we are working with families who are considered 'at risk'."

Summary of Illinois MIECHV HV and CI communities

Who Provides Services and Where Illinois MIECHV Programs are Located

Home Visiting (HV) Programs: In FY 2018, Illinois MIECHV comprised 24 home visiting (HV) programs serving 12 disadvantaged communities in 15 counties. A list of the Illinois communities, MIECHV HV providers, and model types are provided in Table 2.

TABLE 2. ILLINOIS MIECHV HV AGENCIES BY COMMUNITY AND PROGRAM TYPE, FY 2018

Community	Agency	Home Visiting Model
Cicero	Children's Center of Cicero-Berwyn	Parents as Teachers
	Family Focus Nuestra Familia	Parents as Teachers
DeKalb County	Children's Home + Aid DeKalb /Sycamore	Healthy Families
East St. Louis	Comprehensive Behavioral Health Center	Parents as Teachers
Elgin	Family Focus DuPage	Healthy Families
	Visiting Nurse Association (VNA)	Healthy Families
Englewood/ Southside Cluster	ChildServ	Parents as Teachers
	Family Focus Englewood	Healthy Families
	Henry Booth House	Healthy Families
	The Women's Treatment Center	Parents as Teachers
	Primo Center	Parents as Teachers

Community	Agency	Home Visiting Model
Kankakee County	Aunt Martha's Kankakee	Parents as Teachers
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 (Bloomington)	Healthy Families
Peoria-Tazewell County	Children's Home Association	Healthy Families
Rockford	Easter Seals Chicago	Healthy Families
	YWCA La Voz Latina	Healthy Families
	Rockford Public School District 205	Parents as Teachers
Stephenson County	Stephenson County Public Health Foundation	Healthy Families
Vermilion County	Center for Children's Services/Aunt Martha's	Parents as Teachers
	Danville School District 118	Parents as Teachers
	East Central Illinois Community Action	Early Head Start

*MIECHV funding ended June 30, 2018

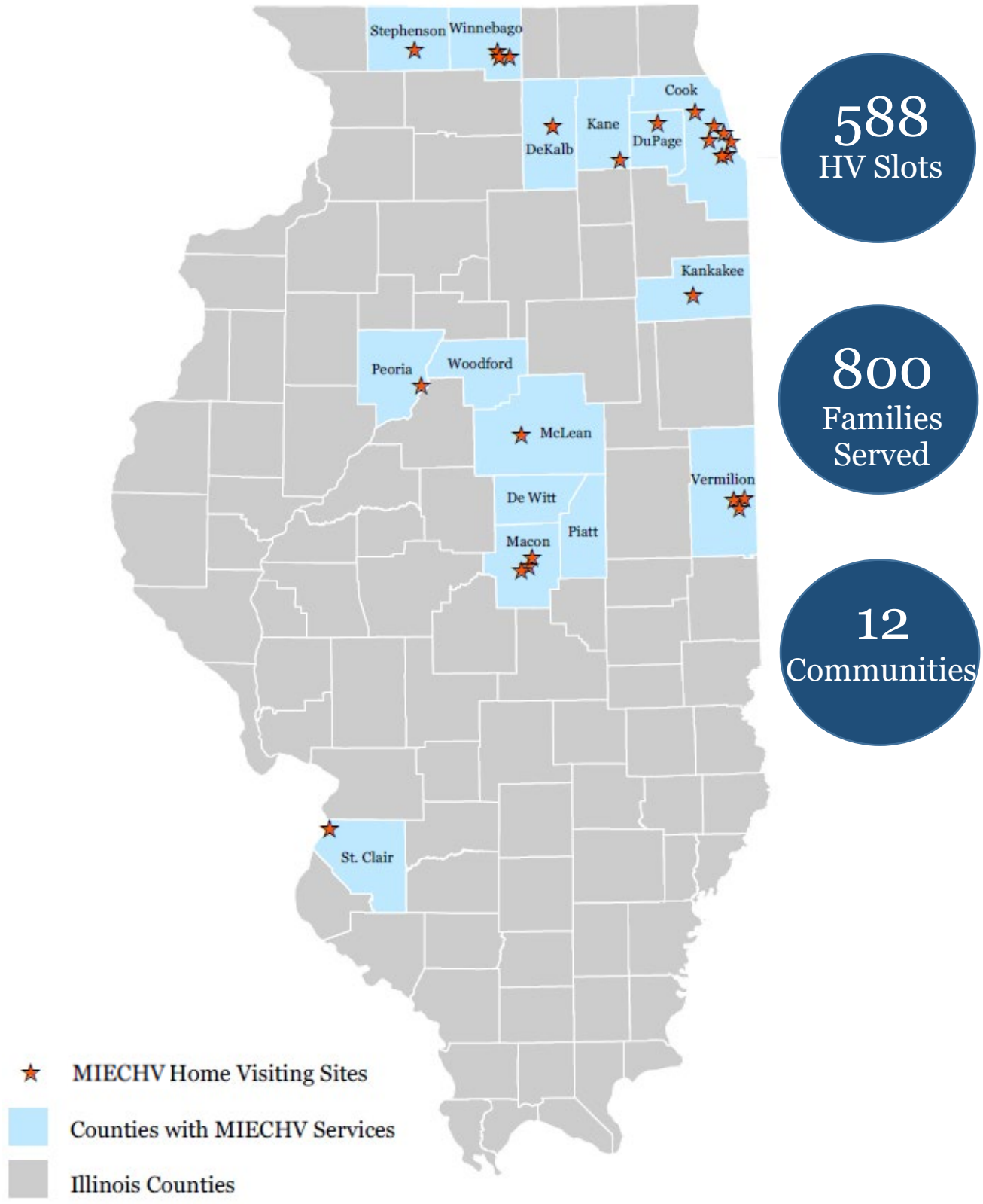


FIGURE 1. **ILLINOIS MIECHV HOME VISITING (HV) SITE LOCATIONS**

Coordinated Intake (CI) sites: A total of 12 sites in FY 2018 provided coordinated intake services. Two of these sites have CI services that were in development during FY 2017 and FY 2018. A list of the Illinois communities and CI providers are below in Table 3. As shown in Figure 2, programs are located in high-needs communities in several areas of the state including small to moderate size cities, as well as rural areas.

TABLE 3. ILLINOIS MIECHV COORDINATED INTAKE (CI) AGENCIES BY COMMUNITY, FY 2018

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

*Coordinated Intake in development

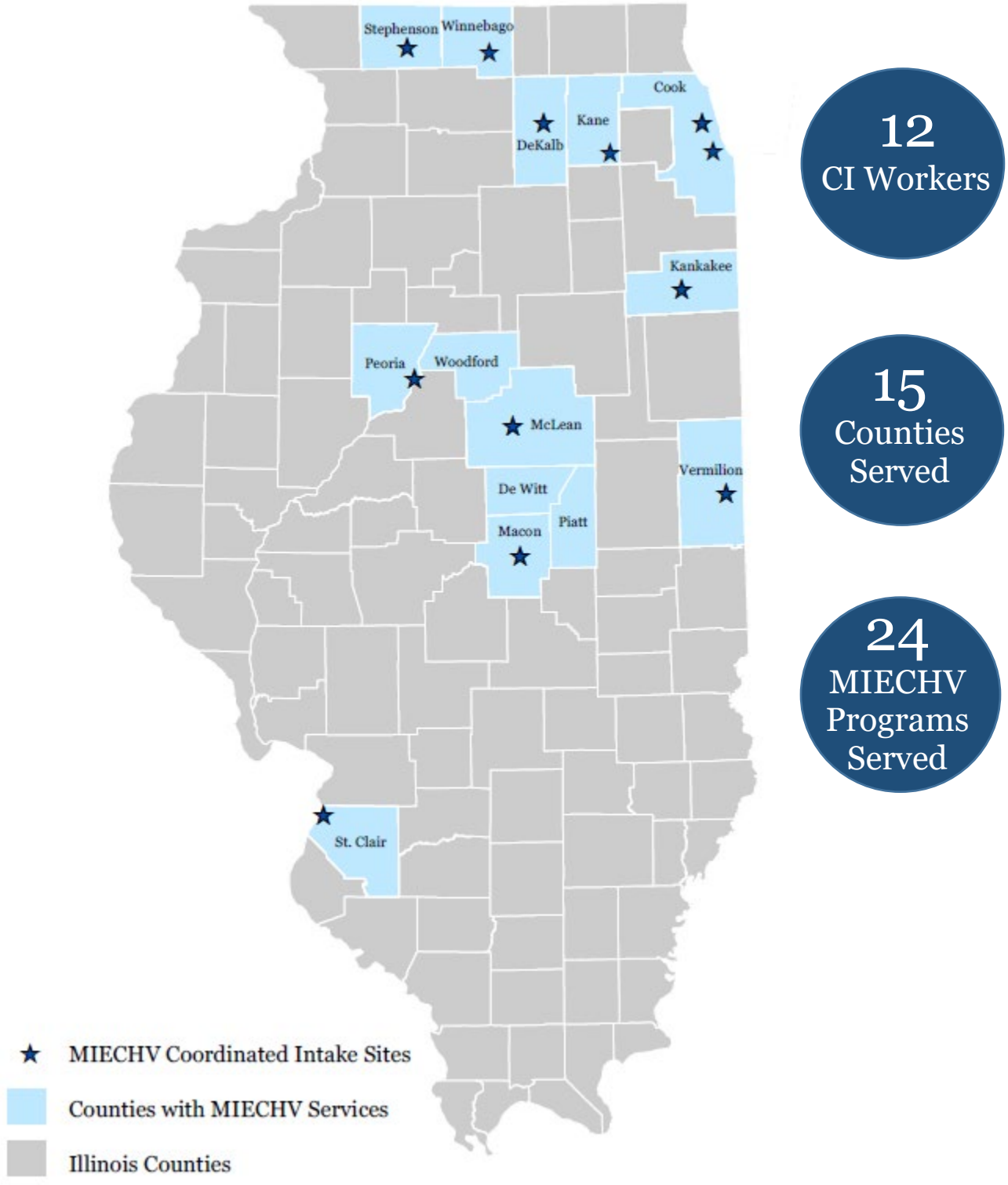


FIGURE 2. ILLINOIS MIECHV COORDINATED INTAKE (CI) SITE LOCATIONS

Data Quality

Since inception of IL MIECHV programs, CPRD in the School of Social Work at the University of Illinois has ensured that data quality and standards are upheld at each site monthly. Support around data quality efforts include: data training, monthly report cards, quarterly data reviews, data resources and technical assistance.

> "The goal is to turn data into information and information into insight." – *Carly Florina*

The purpose of safeguarding the data is to ensure that all information for Form 1 (demographics), Form 2 (HRSA's 19 Benchmarks) and Form 4 [total Personal Visit Records (PVR) and site capacity] are entered into Visit Tracker (VT), the Case Management System (CMS), and there is no missing data for the current fiscal year. Each site is given until the 5th of each month to enter all information into VT before the data is downloaded and complied. Once the data is compiled from each of the forms, it is entered into an agency specific report card (see Figure 3). The main areas of the monthly Report Card are:

- Percentage of Completed Personal Visit Records (PVRs)
- Guardians without any priority population
- Priority Population percentages
- Number of Home Visits and percentage completed
- Inactive guardians and date of last PVR
- Families with no children
- Families without site/fund code
- HRSA Benchmarks outcomes and missing data

REPORT CARD OCT 1, 2018 - OCT 31, 2018

SITE	SAMPLE SITE	IL-TEST
GROUP	ILLINOIS	

REPORTS	STATUS	DETAILS	COMMENTS
FORM 1			
MISSING DATA	YES	14: Priority Population Characteristics: Low income household- Missing 2;	
COMPLETE PVRS	86%	25/29 = 86%	
GUARDIANS WITHOUT ANY PRIORITY POPULATION (GUARDIAN IDS)	1	1/19 = =5% 826141	
PRIORITY POPULATIONS			
HAVE LOW INCOMES	16	16/19 (Total enrollees) = 84%	
PREGNANT WOMEN WHO HAVE NOT ATTAINED AGE 21	0	2/19 (Total enrollees) = 0%	
CHILD WELFARE INVOLVEMENT	8	2/19 (Total enrollees) = 42%	
HX OF SUBSTANCE ABUSE	2	0/19 (Total enrollees) = 11%	
TOBACCO PRODUCTS IN THE HOME	6	0/19 (Total enrollees) =32%	
LOW STUDENT ACHIEVEMENT	4	4/19 (Total enrollees) = 21%	
CHILDREN WITH DEVELOPMENTAL DELAYS	8	8/19 (Total enrollees) = 42%	
MILITARY FAMILIES	1	1/19 (Total enrollees) = 5%	
NUMBER OF HOME VISITS TO DATE	21	21 Visits / Months = 21 visits/ month	
INACTIVE GUARDIANS AND DATE OF LAST PVR (GUARDIAN IDS)	2	931015 - 09/04/2018 931015 - 10/15/2018	-
MAX CAPACITY PERCENT	65%	Total Families (34) / Max Capacity (52)	
FORM 2			
SEE DETAILS AT END (# NEEDS IMMEDIATE ATTENTION)	3	Red (3), Yellow (2), Green (2)	
DATA CHECKS			
FAMILIES WITH NO CHILDREN (GUARDIAN IDS)	4	953765, 956415, 9710831, 974112	
FAMILIES WITHOUT SITE/FUND CODE (GUARDIAN IDS)	0		

NOTES:

1) *The data from this report card was obtained through Visit Tracker and OECD documentation and used for monitoring and compliance purposes. If you see a discrepancy between what is in this report and what you believe to be accurate, contact lesley.schwartz@illinois.gov within 7 days of receiving the report so discrepancies can be addressed and corrected (i.e. if your max caseload does not match what is on the report, if your number of visits should be higher, etc.). If updates were made in Visit Tracker after the report was run for the report card, the report card will not reflect those changes until the following month.*
2) PLEASE REPLY ALL TO REPORT CARD EMAIL WITH ANY COMMENTS YOU WOULD LIKE TO SEE ON REPORT CARD.
3) COLOR CODE: RED-IMMEDIATE ATTENTION, YELLOW-KEEP AN EYE ON, GREEN-GOOD, WHITE-NO RATING
   CODING DETAILS
   FORM 1 AND 2 MISSING DATA IS CODED RED.
   COMPLETED PVRS: GREEN >89%, YELLOW 80-89%, RED <80%
   MAX CAPACITY PERCENT: GREEN >89%, YELLOW 85-89%, RED <85%
4) DETAIL REPORTS USE OCTOBER 1, 2017 AS THE START DATE
5) TO FIND GUARDIANS (OR CHILDREN) BY ID NUMBER, CLICK ON GUARDIAN (OR CHILD) IN VISIT TRACKER AND ENTER THE ID INTO THE SEARCH FUNCTION.

Form 2 Details

Construct	Description	Num	Denom	Outcome	Missing Data	Color Coding Note
3	Depression screening	4	5	80%	0	>89 Green, 80-89 Yellow, <80 Red
4	Well Child Visits	4	6	66%	N/A	>74 Green, 60-74 Yellow, <60 Red
5	Postpartum Care	0	1	0%	0	>74 Green, 60-74 Yellow, <60 Red
6	Tobacco Cessation Referrals	0	0	0%	0	>89 Green, 80-89 Yellow, <80 Red
7	Safe Sleep	0	0	0%	6	Missing data = red
10	Parent-Child Interaction	3	18	16%	N/A	>89 Green, 80-89 Yellow, <80 Red
11	Early language & literacy	12	16	75%	5	Missing data = red
12	Developmental Screening	1	1	100%	N/A	>89 Green, 80-89 Yellow, <80 Red
13	Behavioral concerns	18	20	90%	N/A	>89 Green, 80-89 Yellow, <80 Red
14	IPV screening	0	0		N/A	>89 Green, 80-89 Yellow, <80 Red
15	Primary Caregiver Education	0	2	0%	0	Missing data = red
16	Health Insurance Continuity	0	0	0%	0	Missing data = red
19	IPV referrals	0	0	0%	N/A	>89 Green, 80-89 Yellow, <80 Red

***FIGURE 3*. MIECHV MONTHLY SITE REPORT CARD EXAMPLE**

The same process is repeated for each agency's Quarterly Data Review. All LIA's are required to schedule a review. This review gives LIA's the opportunity to address accuracy, completeness, concerns, plan, and get clarification on any requirements around HRSA's 19 Benchmarks (Form 2) and Demographics (Form 1).

Information missing from Form 1 is simply reported as missing while Form 2 has three indicated color ranges that correspond with outcome percentage and missing data. The three-color code ranges are:

- Red – Immediate Attention and Missing Data
- Yellow – Keep an Eye On
- Green – Good and No Missing Data

The outcome range and missing data does vary from benchmark to benchmark. There are 2 types of measures, Systems Outcomes and Performance Indicators. The goal is to have all LIA's at 85% or higher in outcomes, PVR's, and capacity. Those sites under 85% on capacity and certain benchmarks are given additional supports.

Data quality management is an essential process in making sense of the data. It builds the foundation and establishes a reliable framework to look at the day-to-day operations of the LIA's. It ensures confidence in the upstream and downstream applications that use the data.

II. MIECHV Participant Demographics:

Participant Demographics, 2017-2018

The MIECHV program serves pregnant women and families with children from birth through kindergarten. The program is legislatively mandated to prioritize families falling into these priority populations:

- Families with low incomes (defined as below the Federal Poverty Level)
- 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 use 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 October 1, 2017- September 30, 2018 (FY 2018).

Enrollment

In FY 2018, Illinois MIECHV served 800 families and 844 children. Of the 800 families, just under half (46%) were newly enrolled, meaning they enrolled in home visiting services in the 2017-2018 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.

Just under half (41%) of the children served were newly enrolled this year, with 59% of index children continuing from the previous year.

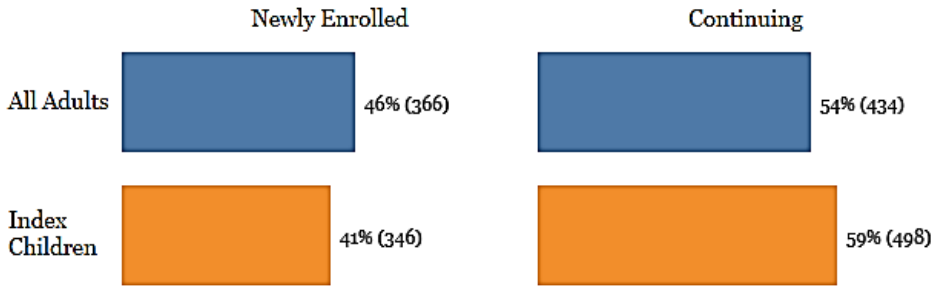


FIGURE 4. ILLINOIS MIECHV NEWLY ENROLLED AND CONTINUING FOR ADULTS AND INDEX CHILDREN, FY 2018

Age

MIECHV adult participants ranged in age from 13 to 63. The majority of adults fell within the 18 to 24 (45%) age range, with very few adults aged 35 or older (13%), or below 18 years of age (10%). 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 serve children through three years of age, which is reflected in the age distribution of children seen in 2018.

FIGURE 5. **ILLINOIS MIECHV ADULTS PARTICIPANTS AND INDEX CHILDREN AGE, FY 2018**

Race

In 2018, Illinois MIECHV adult participants were 44% black/African American, 40% white and 16% multi-racial/other. When looking at participant race by pregnancy status, more African-American participants were pregnant (52% of pregnant participants).

Similar percentages of children served were black (44%) and white (34%) compared to multi-racial children (22%).

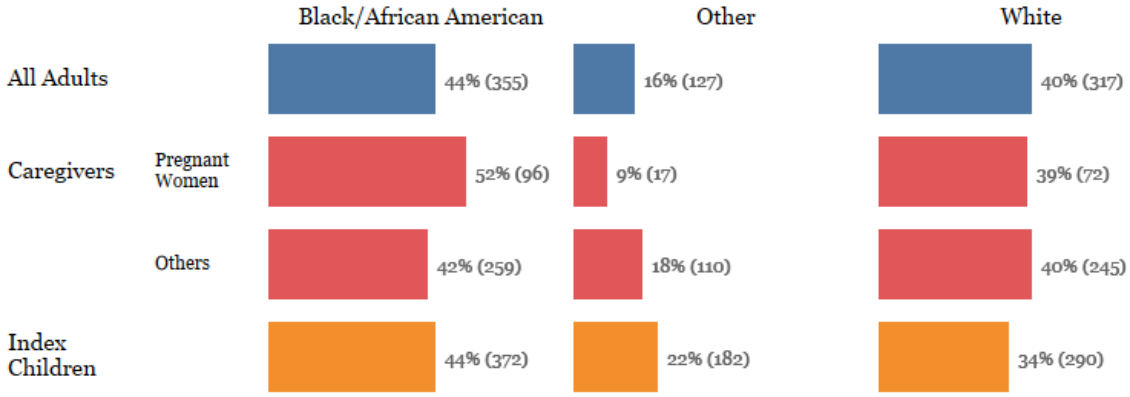


FIGURE 6. **ILLINOIS MIECHV RACE, FY 2018**

Ethnicity

A little under a third (32%) of adult participants in 2018 were Hispanic or Latino/a. Looking at ethnicity by pregnancy status, more Latino participants were not pregnant (22% versus 78%) compared to not Hispanic or Latino.

A little over a third (35%) of children served were also Latino/a while 65% were not.

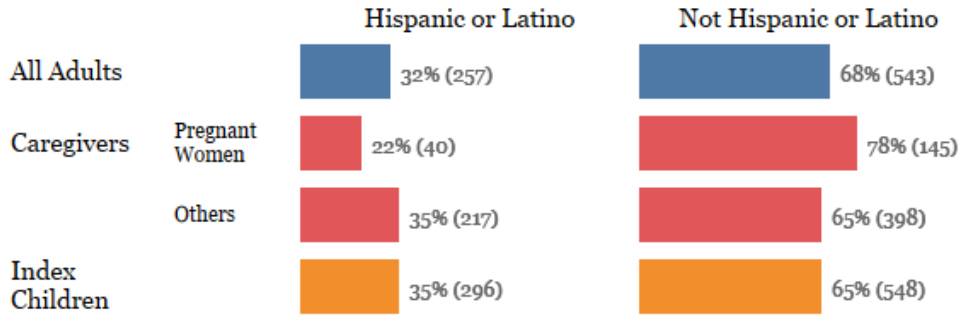
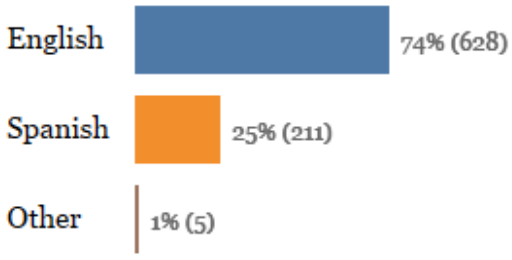


FIGURE 7. **ILLINOIS MIECHV ETHNICITY, FY 2018**

Primary Language



English is the primary language spoken in the homes of almost three quarters (74%) of MIECHV participants in 2018. Just a quarter of participants (25%) spoke Spanish as their primary language. The remaining languages spoken at home were Arabic, French, Hindi, Telugu, and Vietnamese.

FIGURE 8. **ILLINOIS MIECHV PRIMARY LANGUAGE, FY 2018**

Marital Status

The majority of MIECHV participants in 2018 had never been married (61%). An additional 13% were not married, but were living with a partner. This increased by 5% since last fiscal year. Twenty-three percent were currently married and 3% were separated.

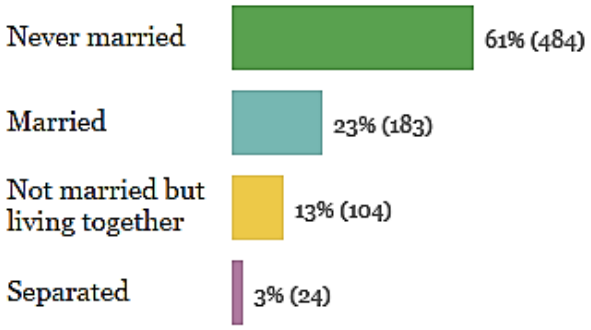


FIGURE 9. ILLINOIS MIECHV MARITAL STATUS, FY 2018

Education / Employment

In 2018, 43% of adult participants had received a high school diploma, with 32% having less than a high school diploma and 25% having higher than a high school diploma.

Employment shows that 62% of adult participants were unemployed, with 22% employed full-time and 16% employed part-time.

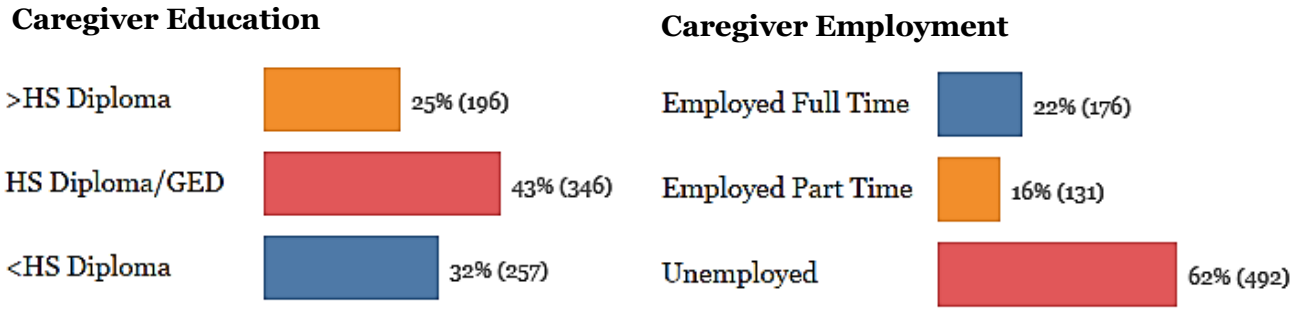


FIGURE 10. ILLINOIS MIECHV EDUCATION AND EMPLOYMENT, FY 2018

Compared to MIECHV national data (HRSA 2018 MIECHV Program Brief), Illinois reported a higher percentage of program participants with a High School Degree or Less (75% vs. 65%).

Housing Status

2017 was the first year that HRSA required data collection on participant housing status. Overall in 2018 the numbers stayed steady; families served by Illinois MIECHV were almost equally likely to rent a home (35%) or live with family (34%). Far fewer families owned homes (15%), were homeless (8%), lived in public housing (6%) or had some other housing arrangement (3%). Renting a home and living with family were the most prevalent housing scenarios for all racial groups. 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 (12%) compared to black families (2%). African-American families were much more likely to classify as homeless (6%) compared to other races (1%) and to live in public housing (6%) than multi-racial (0%) and white (1%) families as well. This is not surprising given the history of residential segregation and redlining in the United States.

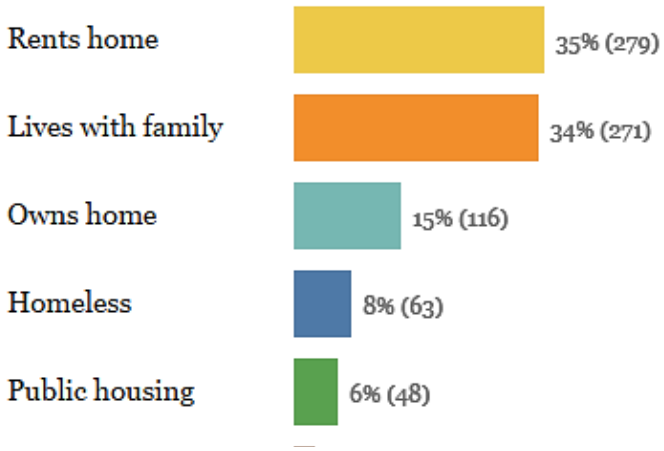


FIGURE 11. **ILLINOIS MIECHV HOUSING STATUS, FY 2018**

Income in Relation to Federal Poverty Level

As in years past, most families (86%) served by Illinois MIECHV in 2018 lived at or below the Federal Poverty Level (FPL), with more than half (51%) living in deep poverty (defined as 50% of the FPL or below). Eight families lived at or above 250% of the FPL. Compared to MIECHV national data (HRSA 2018 MIECHV Program Brief), Illinois reported a higher percent of families below 100% FPL (86% vs. 71%) and 50% FPL (51% vs. 42%).

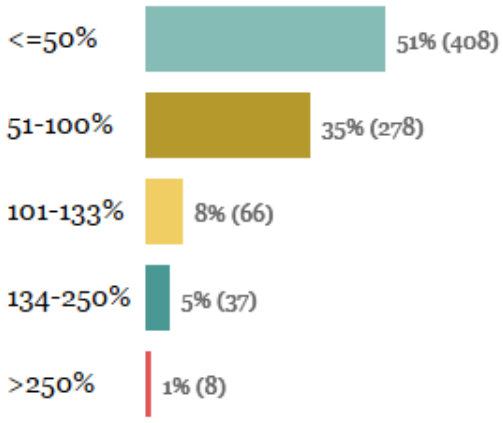


FIGURE 12. **ILLINOIS MIECHV INCOME IN RELATION TO FEDERAL POVERTY LEVEL, FY 2018**

Priority Populations

Illinois served a high percentage of low-income families (86%) and families who have someone who uses tobacco in the home (26%). Illinois served lower percentages of families with histories of child abuse/neglect (13%) and substance abuse (10%).

Over half of Illinois MIECHV families have multiple risk factors and fall within more than one of these priority populations.

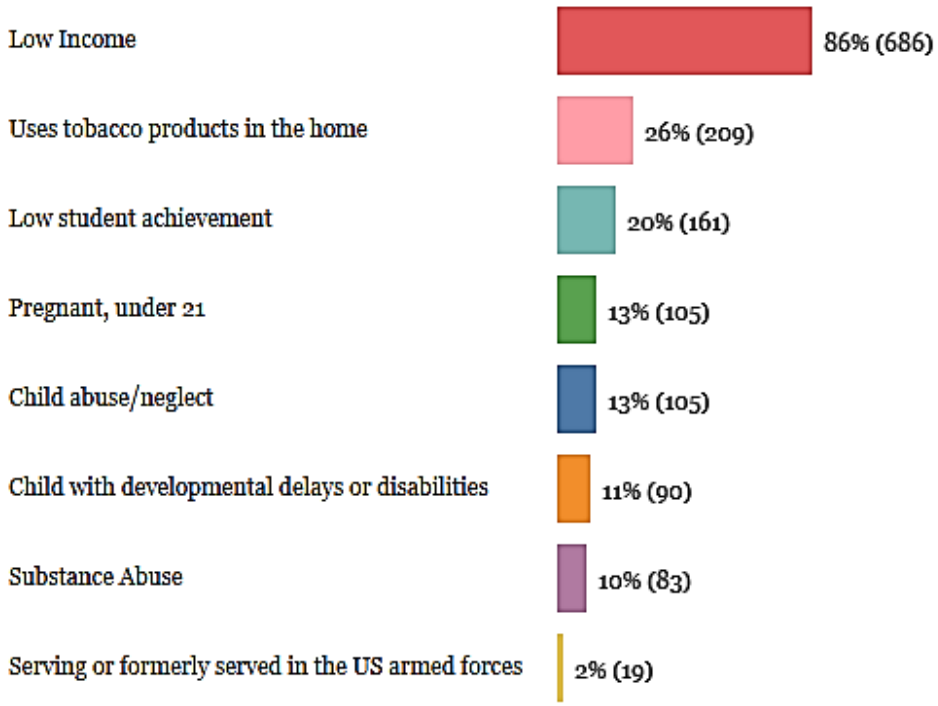


FIGURE 13. **ILLINOIS MIECHV PRIORITY POPULATIONS, FY 2018**

When compared to national MIECHV statistics (HRSA MIECHV Infographic), Illinois had a slightly lower percent (18% vs. 19%) of newly enrolled caregivers with a history of child abuse and maltreatment; same percent (13%) of newly enrolled caregivers with reported substance abuse; and a higher percent of newly enrolled pregnant teens (29% vs. 13%).

Insurance Status

Most of the participants served by MIECHV in 2018 had health insurance coverage. Very few children (2%) were uninsured. The vast majority (95%) 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 over three quarters (76%) of non-pregnant adult participants were insured through state-based programs. Fewer numbers of participants were insured through private programs or Tri-Care, the insurance program for military families.

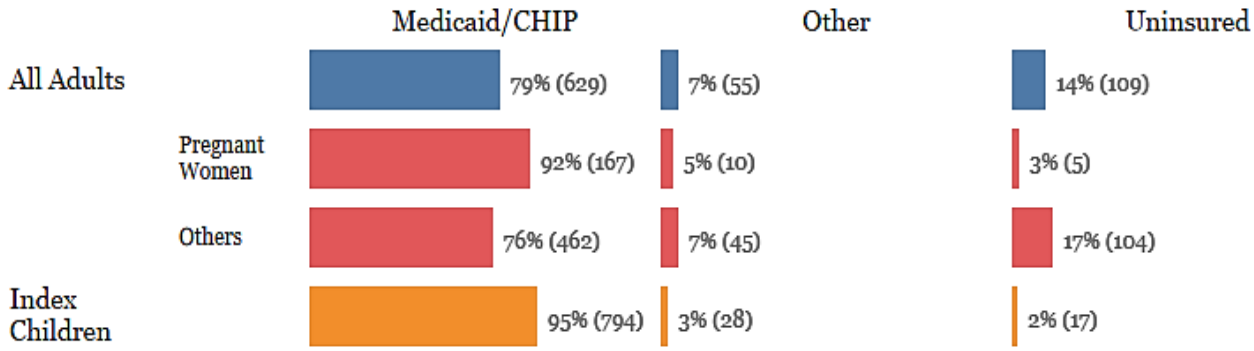


FIGURE 14. ILLINOIS MIECHV INSURANCE STATUS, FY 2018

When compared to MIECHV national data (HRSA 2018 MIECHV Program Brief), Illinois shows a higher percentage of children (95% vs. 76%) on Medicaid or CHIP.

Sources of Medical and Dental Care for Index Children

In 2018, 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. Other children (14%) received care at a Federally Qualified Health Center (FQHC). The remaining 2% 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.

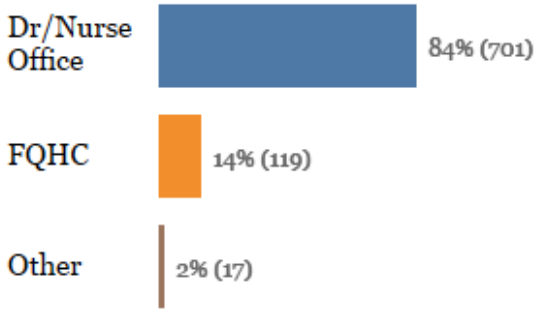


FIGURE 15A. ILLINOIS MIECHV SOURCES OF MEDICAL CARE FOR INDEX CHILDREN, FY 2018

Most children (76%) also had a usual source of dental care. 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.

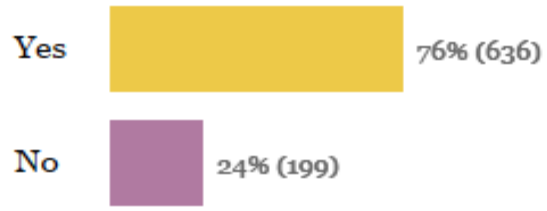


FIGURE 15B. ILLINOIS MIECHV DENTAL CARE FOR INDEX CHILDREN, FY 2018

Family Engagement

By the end of the 2018 program year, 58% of participants who had been involved in services during the year were still receiving services. Fifteen percent of families successfully completed their home visiting services while just over one-fourth (27%) stopped services before program completion.

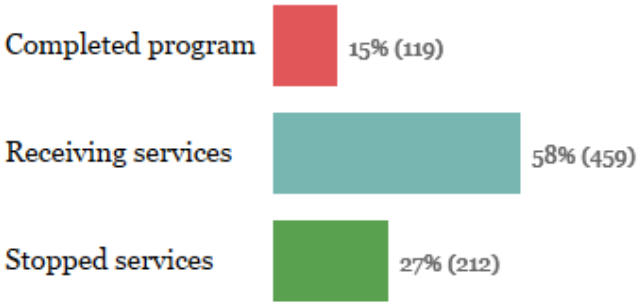


FIGURE 16. ILLINOIS MIECHV FAMILY ENGAGEMENT, FY 2018

During FY 2018, differences in family engagement seemed to exist by race and ethnicity (Table 4). Program completion rates were lowest and stopping services before completion were highest for Blacks (10%, 33%) and non-Hispanics (10%, 30%) when compared to overall estimates (15%, 27%).

TABLE 4. DIFFERENCES IN FAMILY ENGAGEMENT BY RACE AND ETHNICITY, FY 2018

	Receiving services		Completed Program		Stopped services before completion	
	n	%	n	%	n	%
All	459	58%	119	15%	212	27%
Race						
Black or African American	205	58%	34	10%	116	33%
Other	59	46%	38	30%	30	24%
White	200	63%	47	15%	70	22%
Ethnicity						
Hispanic/Latino	144	56%	62	24%	51	20%
Non-Hispanic/Latino	321	59%	57	10%	165	30%

Households by Program Model

More families were served by the Parents as Teachers (PAT) model, compared to Healthy Families America (HFA) and Early Head Start (EHS). In 2018, only one EHS program was active in Illinois MIECHV.

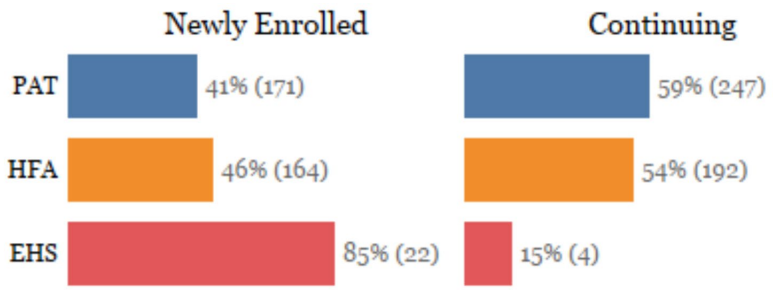


FIGURE 17. ILLINOIS MIECHV HOUSEHOLD BY PROGRAM MODEL, FY 2018

II. MIECHV Performance Benchmarks, FY 2018

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 18 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 referrals for other community resources and support

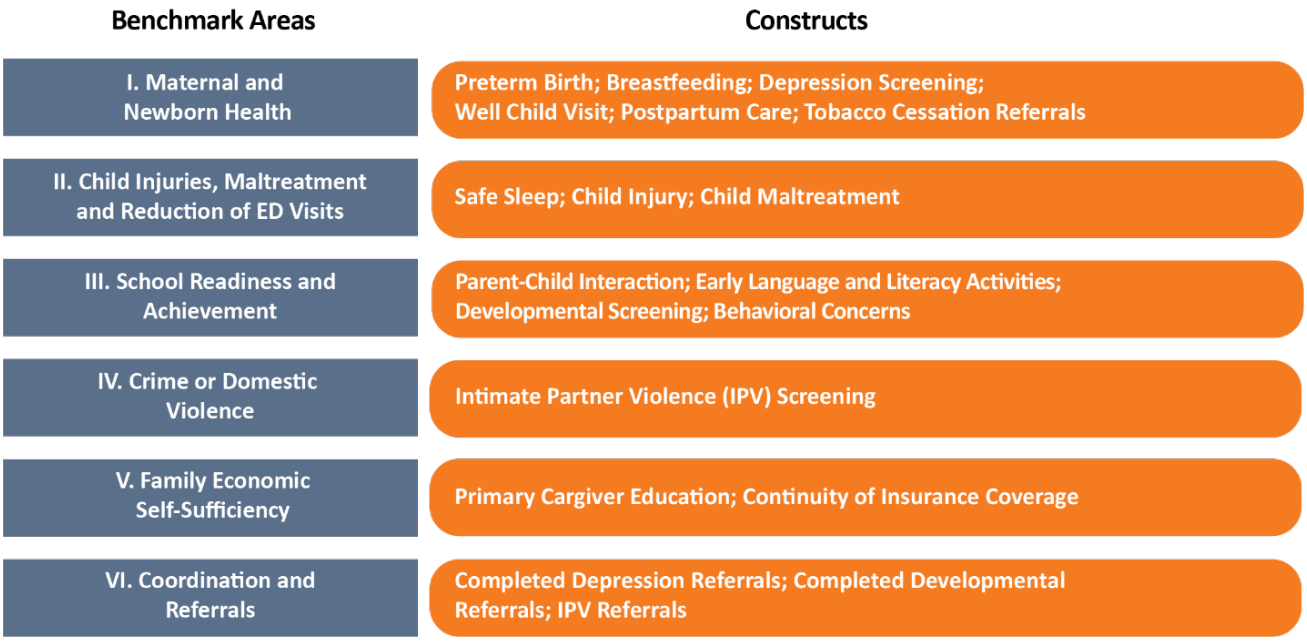


***FIGURE 18.* MIECHV PERFORMANCE BENCHMARK AREAS AND CONSTRUCTS**

"I may not be able to give my kids everything they want, but I give them what they need. Love, time, and attention. You can't buy those things." – *Nishan Panwar*

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. FY 2018 was the second program year with the revised benchmarks and the results are shown in Figure 19 and described in detail in this section.

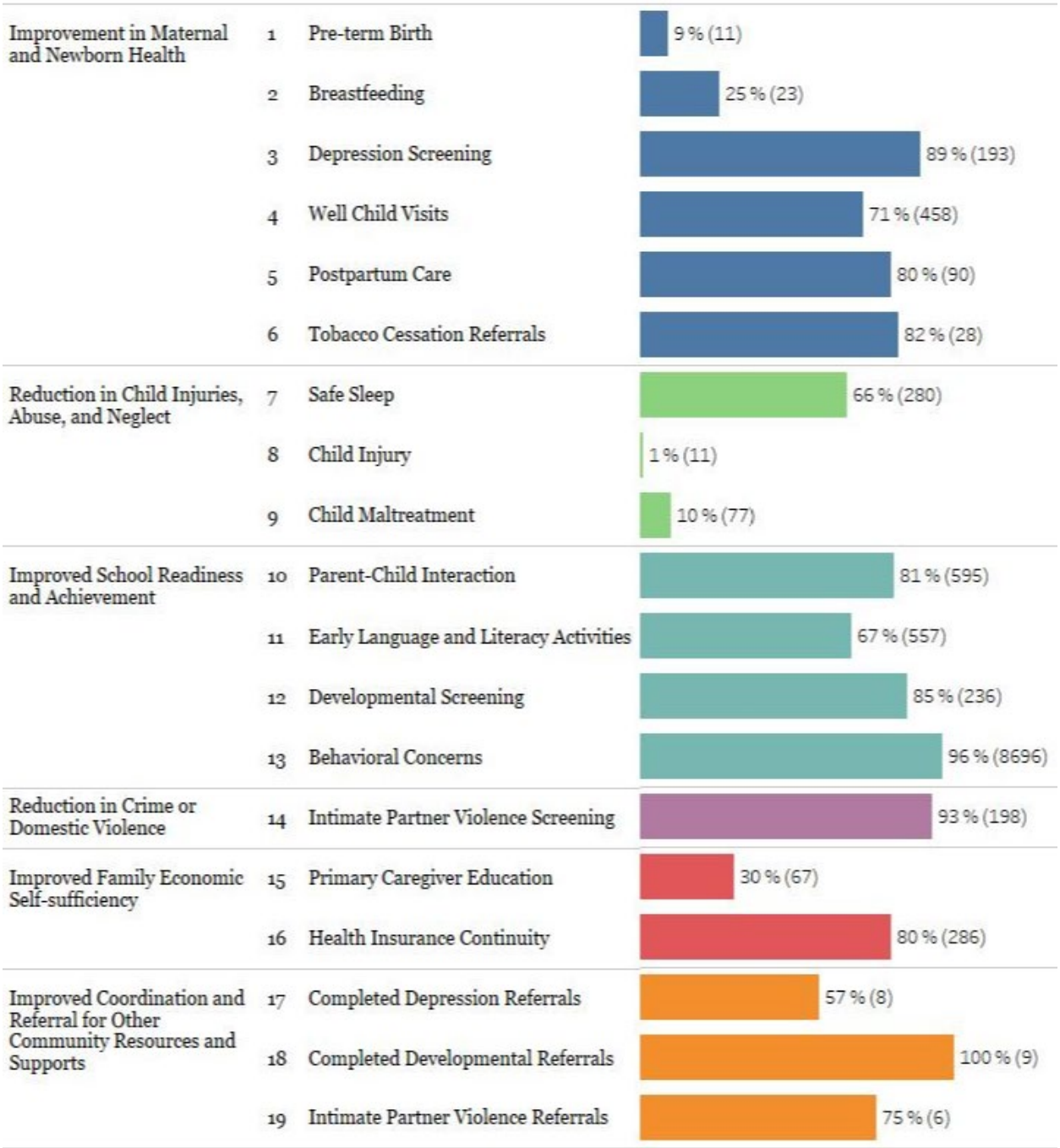


***FIGURE 19.* 2018 ILLINOIS BENCHMARK ATTAINMENT BY CONSTRUCT**

When compared to national benchmark statistics (HRSA 2018 MIECHV Program Brief), Illinois MIECHV had better benchmark performance during FY 2017 and 2018 on depression, developmental screening, behavioral concern inquiries, and IPV screening; and slightly lower performance on early language and literacy activities as shown in Figure 20 below.

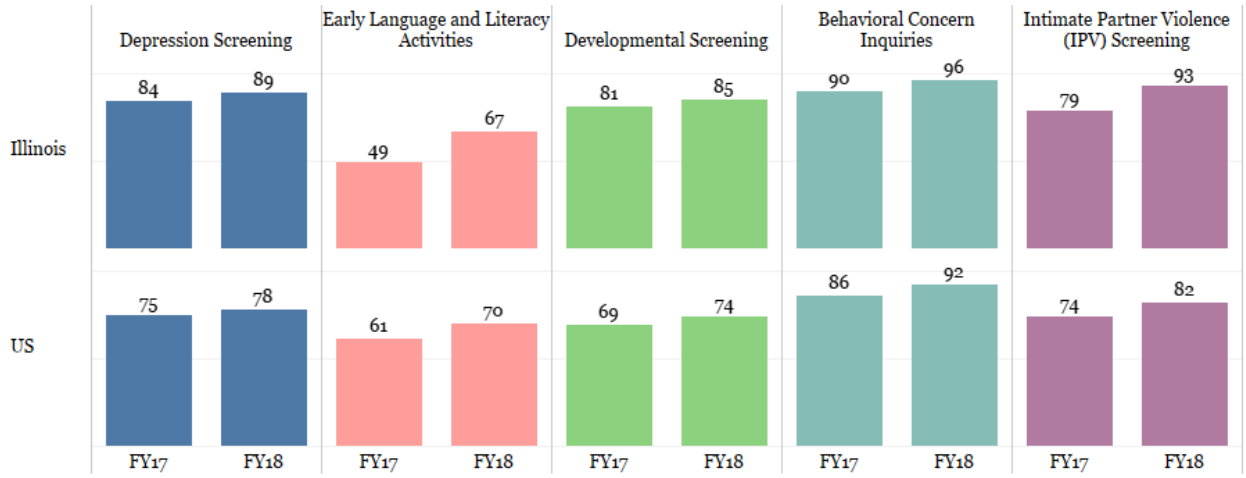


***FIGURE 20*. COMPARISON OF ILLINOIS AND NATIONAL BENCHMARK PERFORMANCE, FY 2017 AND FY 2018**

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 2018, Illinois MIECHV had 123 babies born to caregivers who enrolled prior to 37 weeks of pregnancy, and 9% were born preterm. Latest data available for Illinois overall indicates that this is lower than the state average of 10.1% and a 5% decrease compared to FY2017 is very encouraging.

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 2018, 25% 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 (CDC, 2018).

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 represents a 6% decrease compared to 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. Only a small percent of Illinois MIECHV mothers achieved this milestone in this program year, compared to state and national data in the recent breastfeeding report card (CDC, 2018). This year's results show similar demographic differences like in the previous years. Mothers who are younger than 25 years, non-Hispanic, Black African-American, and have no education beyond high school, need more support and education to breastfeed their children through 6 months of age.

Construct 3. Depression Screening shows that 89% 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 since FY 2017. There was a learning curve associated with the change but a 5% increase in the screening compared to last year shows that agencies have made good progress.

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 2018 program year, 71% of MIECHV children received their last recommended well child visit (Figure 21). There are two important points that need to be considered while reviewing this construct. 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 recommended visit. Over 91% of children enrolled in Illinois MIECHV were under 2 years of age in this reporting period. When compared to the previous year, there is an impressive increase of 18% for this important benchmark construct and that indicates that CQI efforts are paying off.

Hispanic parents were more likely to have children who had received the last recommended well child visit compared to non-Hispanic parents (80% compared to 66%). Parents with more than a high school degree (HSD) were also more likely to have children who had received the last recommended visit compared to their peers with less education (71% with >HSD compared to 67% with <HSD). The older the parent, the more likely their children had received the last recommended visit. African Americans face particular barriers and inequities in the health care system including implicit bias which impacts their ability to access healthcare for themselves and their children, so it is not surprising that children of multi-racial and white parents were more likely to have received their last recommended well child visit (77% and 78%, respectively) compared to African-American children (63%). Well child visits will continue to remain as a primary focus of Illinois MIECHV's CQI work in FY 2019.

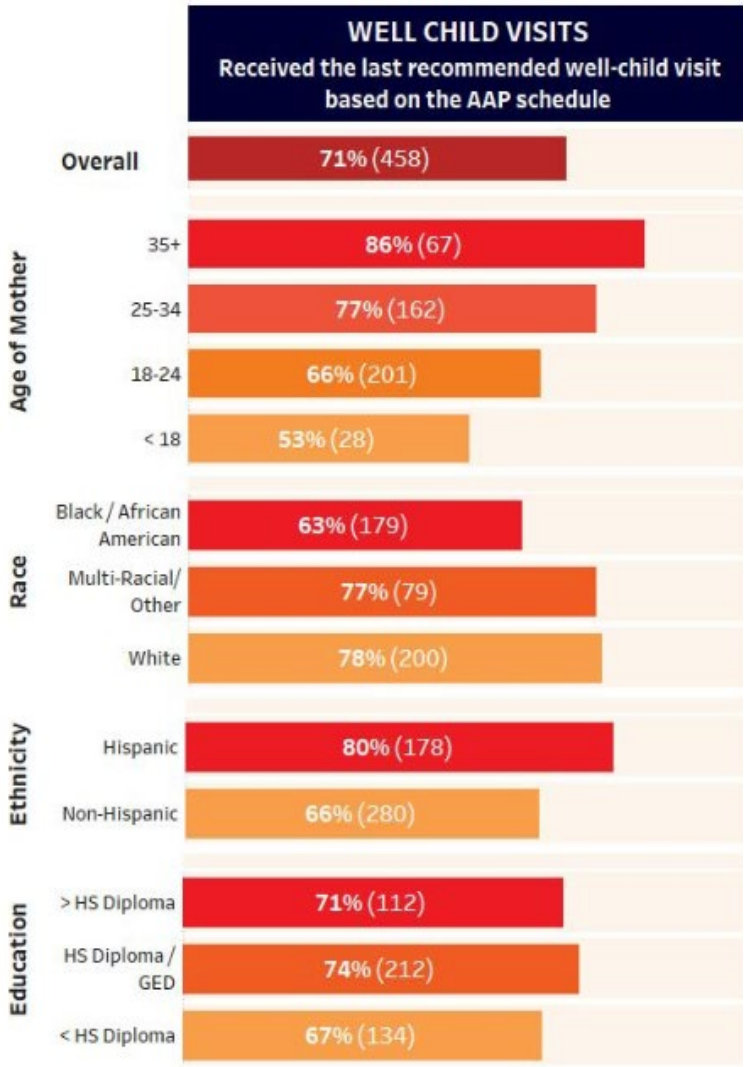


FIGURE 21. **WELL CHILD VISITS BY AGE, RACE, ETHNICITY AND EDUCATION, FY 2018**

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 2018 program year, 80% of Illinois MIECHV caregivers received a postpartum care visit within this time frame (Figure 22). This is a bit lower than the Healthy People 2020 baseline (as per 2012 estimates) of 90.1% for Illinois women during postpartum. However, this reflects a 14% increase from FY 2017, a significant improvement. Caregivers who were 25 years or older were more likely than younger mothers to have received a postpartum care visit within the recommended timeframe. There were slight differences in visit completion by caregiver race, with white caregivers (84%) most likely to complete the visit within the recommended timeframe compared to non-white race caregivers (76%). Since systemic barriers and inequities in the healthcare system impact healthcare access for African Americans, it is not surprising that fewer African American caregivers accessed postpartum care within 8 weeks of giving birth. Hispanics (84%) also show higher visit completion than Non-Hispanics (78%). The more education the caregiver had received, the more likely she was to complete her postpartum care visit during the recommended timeframe. Almost 83% of caregivers with more than a high school diploma completed the visit compared to 80% of those with a diploma or GED, and 77% of those with less than high school or GED education. This pattern supports how the caregiver's educational attainment significantly increases the parental role in supporting child health, education and well-being (Harding, 2015).

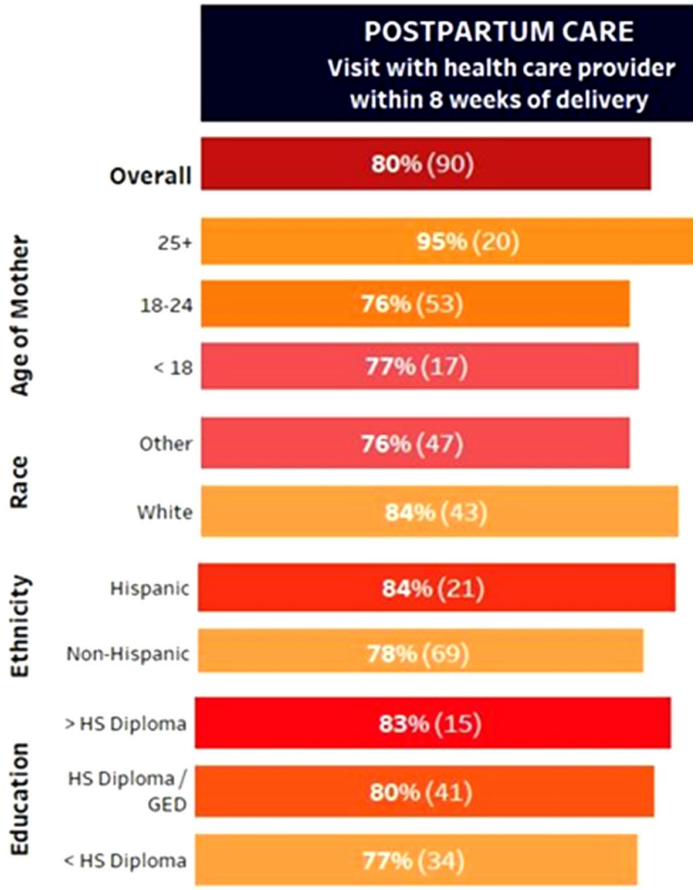


***FIGURE 22.* POSTPARTUM CARE BY AGE, RACE, ETHNICITY AND EDUCATION, FY 2018**

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 34 participants who reported using tobacco products, 28 (82%) received the appropriate referrals within the required timeframe (a 14% increase from last year). This was a new area of focus for Illinois MIECHV starting in FY 2017.

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

Benchmark 2 contains three constructs related to child safety.

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, stuffed animals, pillow, 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 2018 program year, 66% of MIECHV mothers with children under one always practiced all three safe sleep recommendations. This represents a very impressive increase of 16% in safe sleep practices of MIECHV mothers compared to FY 2017.

***FIGURE 23.* SAFE SLEEP PRACTICES BY RACE, ETHNICITY AND EDUCATION, FY 2018**

Shown in Figure 23, children of African-American caregivers were much less likely to practice safe sleep compared to their peers (57% compared to 70% for multi-racial parents and 78% for white caregivers). Children of non-Hispanic caregivers were also

less likely to practice safe sleep compared to Hispanic caregivers (58% versus 83%). Caregivers with high school (64%) or less (66%) education were also less likely to practice safe sleep than those with education beyond high school (70%). Illinois MIECHV has partnered with SIDS of Illinois to provide safe sleep related trainings to MIECHV home visitors.

Construct 8. Child Injury measures child visits to the Emergency Department (ED) due to injury or ingestion. In the FY 2018 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 only 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 2018, approximately 10% 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.

"A child is a child of everyone" -- *Sudanese proverb*

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. Depending on the age of the child, Home visitors assessed the 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). 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. The HOME survey was administered on 81% (n=595) of eligible MIECHV caregivers that had reached a minimum enrollment threshold in the FY18 program year. The decrease in the screenings completed this program year can probably be explained due to changes in data collection and reporting guidelines. Prior to FY18, the benchmark targeted families with babies who had reached 6 months. In 2018, data collection was required at any age after birth. This effectively eliminated the 6 month "grace period" home visitors had to administer the HOME assessment.

> "I love answering questions, especially about my baby. There aren't many people who care to ask a lot of questions about how he's doing or how I'm doing." B.K. – *Home Visiting Program Participant*

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 2018, 67% of children had a family member practice literacy activities with them daily during an average week (Figure 24). 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 (67%) in FY 2018 are much better than state and national numbers and also indicate significant improvement (18%) compared to last year.

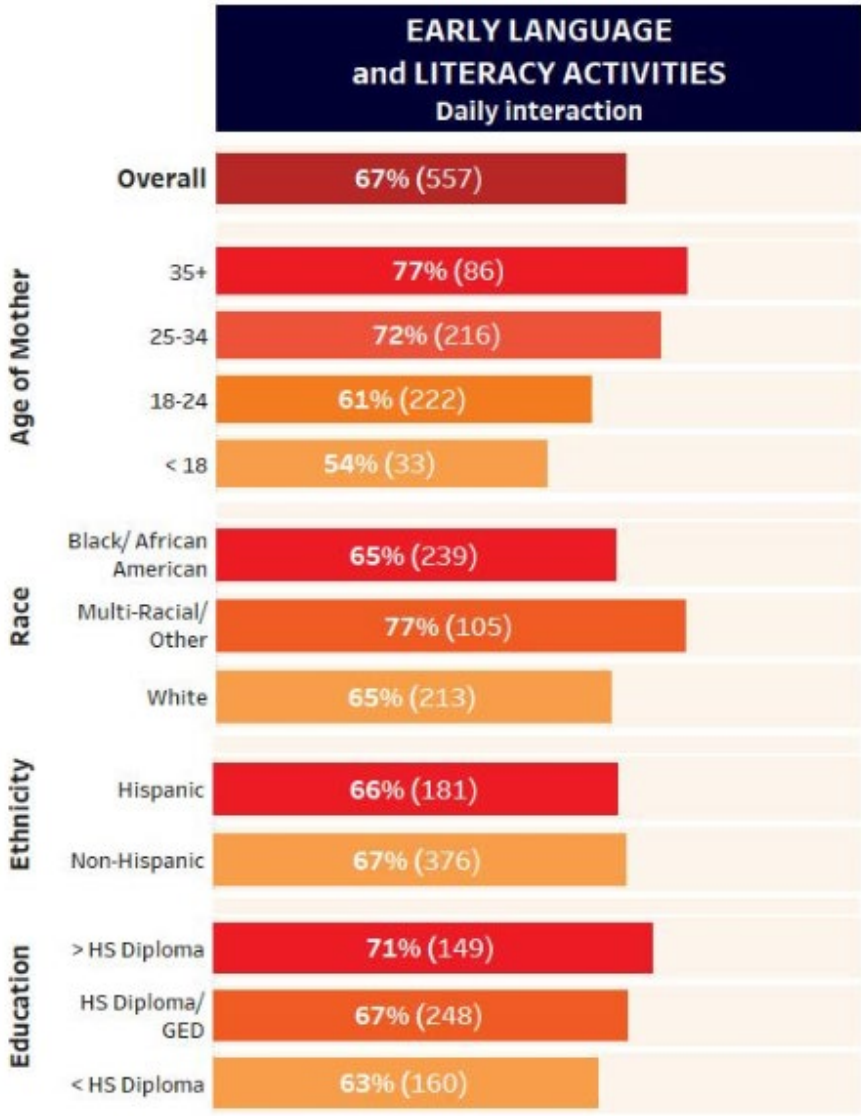


***FIGURE 24.* EARLY LANGUAGE AND LITERACY ACTIVITIES BY AGE, RACE, ETHNICITY AND EDUCATION, FY 2018**

Similar to the previous year, multi-racial caregivers (77%) were most likely of all racial groups to practice literacy daily with their children, with almost two-thirds reporting daily literacy practice compared to 65% of white and African-American caregivers. In this program year, no significant differences were found for this construct between Hispanic caregivers and their Non-Hispanic peers (66% versus 67%). The more

education a caregiver had, the more likely s/he was to practice daily literacy activities with her/his children (71% for those with more than a high school diploma and 67% for those with high school diploma versus 63% 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 2018, 85% of children reaching these specific ages received the appropriate ASQ-3 screening. There is an increase in developmental screening by 4% compared to FY 2017.

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 development, behavior, or learning. Prenatal home visits are excluded. Home visitors assessed caregivers for concern during 96% of the over 8,696 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. Ninety-three percent of caregivers were screened within the required timeframe during this reporting period. CQI activities for this benchmark seem to have resulted in a 14% improvement compared to last year.

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 25, 30% 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.

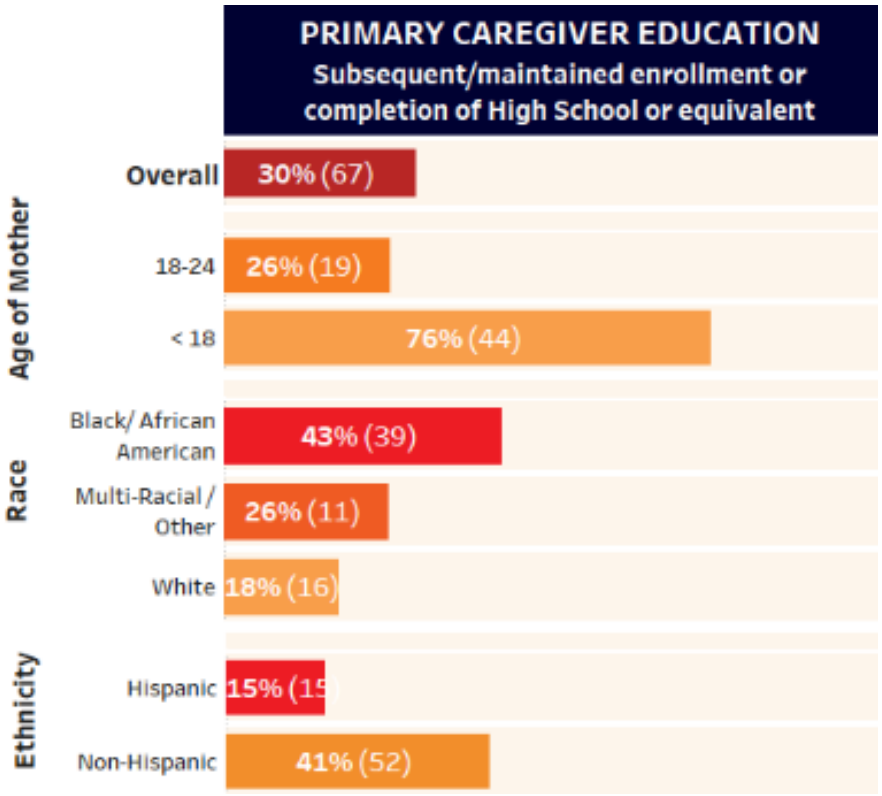


***FIGURE 25.* PRIMARY CAREGIVER EDUCATION BY AGE, RACE AND ETHNICITY, FY 2018**

Caregivers who enrolled in home visiting without a high school diploma or GED and subsequently enrolled in one of these programs in 2017-2018, were substantially more likely to be under 18 years of age (76% versus 26%). 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 2017-2018 were also more likely to be African-American (43% compared to 26% of multi-racial caregivers and 18% of white caregivers) and non-Hispanic (41% compared to 15% 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 2018, 80% of Illinois MIECHV caregivers reported having continuous coverage (Figure 26). This indicates a high level of continuity of coverage similar to the previous program year. 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.

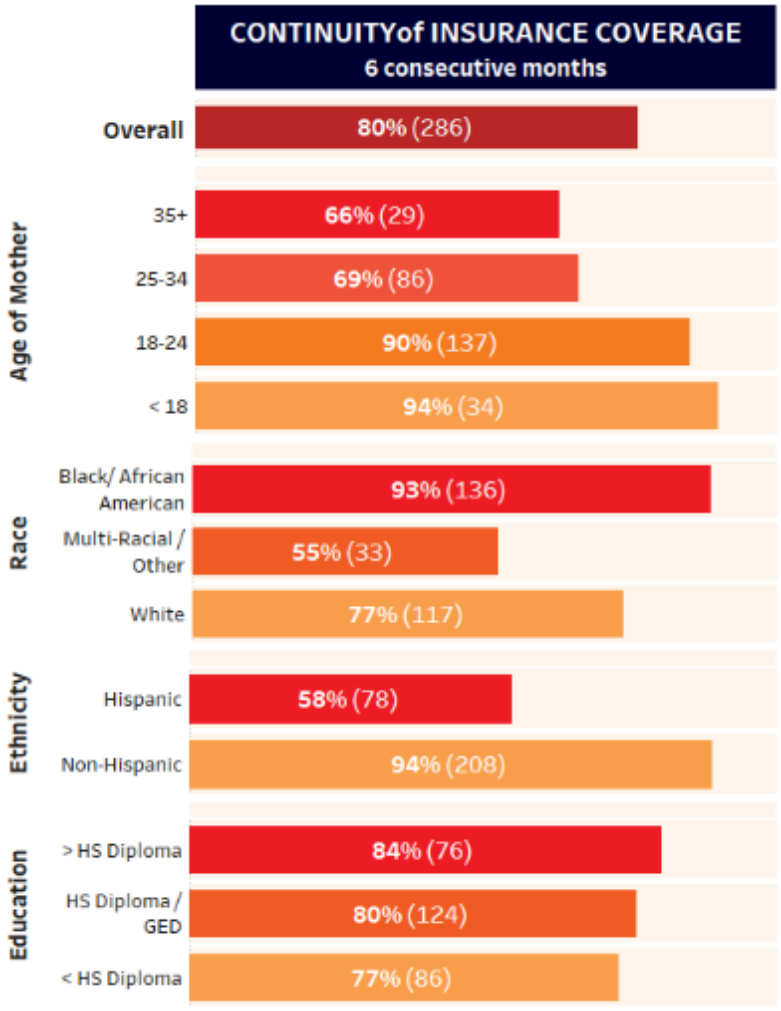


***FIGURE 26.* CONTINUITY OF INSURANCE COVERAGE BY AGE, RACE, ETHNICITY AND EDUCATION, FY 2018**

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 (58%) compared to non-Hispanic caregivers (94%).

MIECHV adult participants with less education are less likely to report having continuous health insurance coverage than those with education beyond high school (77% versus 84%). 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 – 93% compared to 77% of whites and 55% 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 2018, among caregivers who reported experiencing depressive symptoms and received a referral, 57% accessed services, meaning they completed at least one service contact. This represents a 4% increase compared to the previous program year. 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 2018, all (9) children who had an identified concern (reported in construct 12) received services, a 15% improvement compared to the previous year. Of these, 44% received individualized support from their home visitors and 56% received evaluations from Early Intervention.

Construct 19. Intimate Partner Violence Referrals links to construct 14, intimate partner violence (IPV) 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 2018 program year, 75% of caregivers (6 out of 8) received referrals. It should be noted that under-reporting of IPV is common and to be expected. According to the Office for Victims of Crime, "Because the personal nature of these victimizations often influences a victim's decision to report the crime, victimizations by intimate partners are highly underreported." Also, it is not uncommon for caregivers in these situations to refuse referrals to services. Thus, Illinois MIECHV provides universal education of IPV and resources to all participants. IPV was a focus of Illinois MIECHV's Continuous Quality Improvement work in the FY 2018 program year, and resulted in a 35% increase for this important construct.

III. 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. Since 2013, Illinois CQI efforts have worked with LIA's and state staff to demonstrate significant improvements in HRSA benchmarks and other key home visiting indicators. 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 technical assistance calls and providing support in planning, implementing, and evaluating CQI activities. CQI projects unfold over months and aim to improve the quality of service which is measured through performance on MIECHV benchmarks.

In the fall of 2018, MIECHV home visiting staff were asked to classify their community as rural, urban or metropolitan and to list the issues and challenges affecting their community. Although **all** agencies work with "high-risk" populations, families are impacted by the unique characteristics of the communities in which they reside. It is these unique characteristics which often provide LIAs with the essential context and framework to successfully plan and implement a CQI project (see Figure 27).

Rural	Urban	Metropolitan
• Lack staff who are bilingual • Lack of OB care • A lot of mothers with sexual assault/abuse trauma • Limited mental health & health care options • Inadequate child care options • Scarce community resources • Difficult for people to meet basic needs • Doctors are booked-up well in advance • Very high poverty rate • Shootings have gotten a lot worse over the years • Increased violence • Increased gang involvement • Inadequate public transportation • Not all providers accept the medical card • Families lack support systems • Homelessness • High rate of domestic violence	• Younger moms aren't going through WIC • Long waiting lists for mental health services • Inadequate transportation • Long waiting lists for housing • Coordinated Intake-competition between programs • High poverty rate / pockets of deep poverty • High unemployment rate • Large number of undocumented immigrants • Immigration raids • Lack of free mental health services for children • Many families don't drive • Transient population • Lack of accessible employment opportunities • Language barrier exists • Domestic Violence • Mental illness • Drug use • Homelessness is an issue • Violent crime	• High poverty rates • High percentage of undocumented immigrants • Agency pays significantly lower than industry standards • Lack of transitional housing • Lack of sustainable and affordable housing • Gentrification is forcing long-term residents to leave the area • Low-paying jobs • Lack of resources • Everything is far apart • Homelessness and inability to retain clients once they leave a shelter • Clients may be referred through the system (court or DCFS mandated) • Lack access to employment opportunities

FIGURE 27. **COMMUNITY CHARACTERISTICS**

CQI approach

In FY 2018, to enhance communication flow and combat isolation between LIAs, a group approach to CQI work was piloted based on a model provided by Health Resources and Service Administration/ Design Options for Home Visiting Evaluation (HRSA/DOHVE). This approach included group coaching calls, training on CQI tools and methodologies, and organizing agencies into four teams, each focusing on one of three benchmark choices: Intimate Partner Violence (IPV), Completed Depression Referrals, and Well-Child Visits.

CQI includes techniques to:

1. Build an effective CQI team
2. Explore the Cause/Driver behind the problem (Root Cause Analysis, Key Driver Diagrams, Process Mapping)
3. Set SMART goals (Specific, Measurable, Achievable, Relevant, and Time-Bound Aims)
4. Plan and implement intervention strategies (Model for Improvement, Charter, Outcome Measures, PDSA Cycle, PDSA Ramps)
5. Collect, display, and analyze data (Run Chart)

Each step builds on its predecessor. For instance, determining the primary cause of a problem is fundamental to generating a strategic and effective intervention. Although an indeterminate length of time is spent on planning the intervention; implementation itself occurs in successive, systematic, and rapid cycles. Each cycle yields minute improvements that advance goal achievement.

> "FSW's would administer the screening and the women would report that everything was 'wonderful'. Our goal was to give the screening in such a way that we would get honest answers so that moms would get the referrals they need." – *MIECHV HV Supervisor*

To ensure LIA's are able to gauge improvement, each LIA receives a monthly data report and Report Card detailing MIECHV benchmark performance. See Data Quality section of this report for more information. CQI tools are also utilized to measure goal progression and detect the impact of the intervention strategy.

Out of the HV plans completed this year: 9 agencies met or surpassed their goal; 6 agencies showed improvement but didn't reach their goal; 4 were unable to complete their plan due to staff turnover; 2 agencies had no moms test positive on the IPV screening to refer for services; and, 1 agency did not meet or improve on their goal.

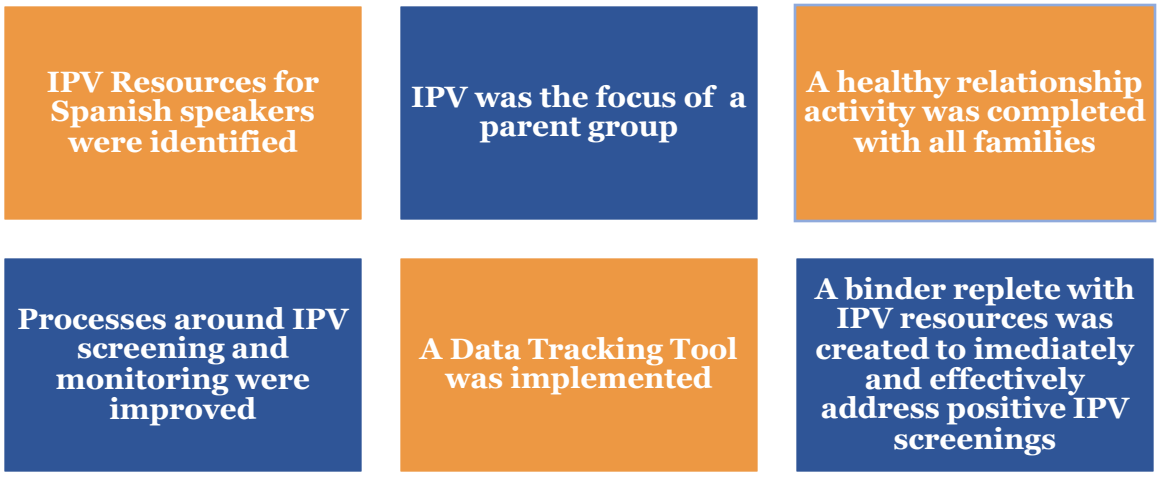
Focus on IPV

Seven (7) agencies chose to focus their CQI work on Intimate Partner Violence. It was chosen as one of the selected construct areas because of challenges identifying IPV and working with caregivers to complete IPV referrals. IPV CQI plans are detailed in Table 5:

TABLE 5. 2018 IPV CQI PLANS –SMART AIMS AND RESULTS

SMART Aim	Result	Improved?	Met goal?
Complete 100% of safety plans with caregivers who have a positive IPV score.	100%	↑	√
Rescreen 100% of participants who verbally disclose active IPV in their relationship but whose IPV screening score is not elevated.	100%	↑	√
100% of participants who screen positive for IPV will complete domestic violence safety plans.	100%	↑	√
Increase referrals from 58% to 100% for parents who screen positive for IPV	No parent screened positive		
100% of participants with a positive Intimate Partner Violence. Screening score will receive a referral and safety plan.	No parent screened positive		
Increase % of annual IPV screening updates from 6% to 40%	44%	↑	√
Increase completion of IPV safety plans from 0% - 100%	Program was unable to complete CQI project due to staff turnover.		

Strategies to combat barriers included:



Focus on Completed Depression Referrals

Eight (8) agencies expressed interest in pursuing this benchmark based on a survey of selected construct areas. By 60 days postpartum, home visitors screen the mothers for depression using the Edinburgh Postnatal Depression Scale (EPDS). Mothers scoring 9 and above are referred for treatment.

TABLE 6. 2018 Completed Depression Referrals CQI PLANS –SMART AIMS AND RESULTS

SMART Aim	Result	Improved?	Met goal?
100% or clients with elevated depression scores will receive a mental health referral.	100%	↑	√
Completed depression referrals will increase from 20% to 50%.	50%	↑	√
Families who complete depression referrals will increase from 0% to 50%.	20%	↑	
80% of mothers who screen positive on the EPDS and complete the 12-week Mothers and Babies (MB) course, will report improved moods by 6/30/18.	66%	↑	
75% of the women who screen positive for depression and access services will report a 25% reduction of symptoms.	100%	↑	√
Increase depression screenings (EPDS) from 60% to 90%	80%	↑	
For women who receive a positive score (9 or more) on the EPDS, increase the number of women accessing treatment from 20% to 50%	74%	↑	√
Increase depression referral completions from 0%-100%	Program was unable to complete a CQI project this year due to staff turnover.		

The reasons reported by programs for "incomplete" referrals were (1) parents refused the referrals, (2) parents had been waitlisted for the services for which they were referred, and (3) mothers did not want to be medicated. The strategies devised to encourage depression completion rates:

Focus on Well-Child Visits

Based on a survey of selected construct areas, 5 agencies selected well-child visits as their focus. CQI projects assisted parents to adhere with the American Academy of Pediatrics (AAP) schedule of well-child visits.

TABLE 7. 2018 IPV CQI PLANS –SMART AIMS AND RESULTS

SMART Aim	Result	Improved?	Met goal?
Increase the number of children who attend their last well-child visit from 76%-78%.	72%	↓	
Increase the percent of children who receive their last recommended well-child visit from 55% to 70%.	86%	↑	√
Increase the completion of last recommended well child visits from 53% to 75%.	58%	↑	
Increase the number of children who attend their last recommended well-child visit from 37% to 50%.	42%	↑	
Increase the percent of children receiving their last recommended well-child visit from 36% to 75%	69%	↑	

Strategies employed to attain project goals included:

- Implemented use of English and Spanish handouts
- Linked developmental assessment and concerns to well-child visits
- Gave families a treat-bag following immunizations
- Had parent schedule well-child visits at the home visit
- Employed role play to assist with effective communication between parent and physician.
- Inquired consistently about well-child visits during all home visits

Without exception, overall benchmark performance improved for all three benchmarks that were the focus of CQI Projects in FY 2018 (see Figure 28).

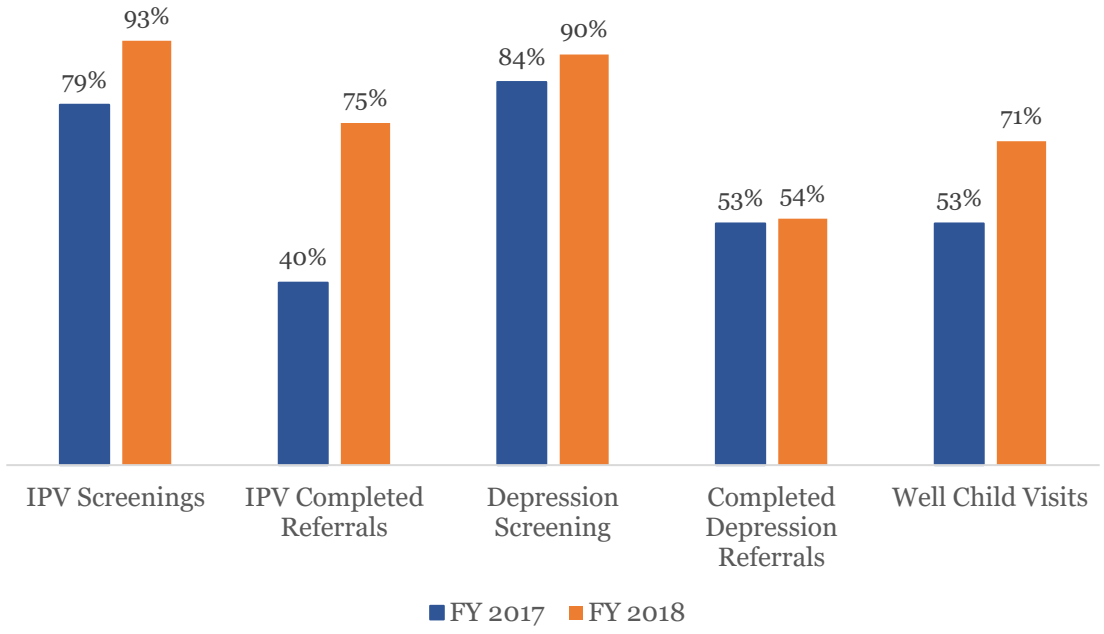


***FIGURE 28.* CQI IMPACT ON OVERALL BENCHMARK PERFORMANCE FROM FY 2017 TO FY 2018**

2018 Home Visiting and Continuous Quality (HV/CQI) Improvement 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. The survey assists with gaining insight into and garnering staff input on the strengths, weakness, opportunities and threats to the staff experiences, attitudes, beliefs, and practices related to CQI and home visiting in general. The Home Visiting and Continuous Quality Improvement Survey (HV/CQI Survey) was initially administered in 2013 and has been repeated annually through 2018. 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 2018 survey was sent to all MIECHV providers on July 23, 2018. All MIECHV personnel, which included home visitors, supervisors, and CI staff, were asked to complete the survey. Three reminder emails were sent and the survey was closed on August 10, 2018. As an incentive, sixteen respondents were chosen at random, and each was awarded a $25 Amazon gift card. The survey closed with an 82% 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 HV quality. Historically, a major part of the HV/CQI survey is to assess the knowledge, beliefs, and implementation of CQI in the MIECHV LIAs and to utilize the feedback to execute future CQI cycles. Figure 29 shows the frequency in means and percentages of responses to CQI related questions from FYs 2016, 2017 and 2018.

Average responses over the last three years are similar and reflect positively on the integration of the CQI process into the programs over time. Very slight decreases in the levels of positive responses were reported this year, with the largest decrease being in the number of staff that feel their team has adequate time to conduct their CQI procedures. This drop from an average of 3.8 in 2017 to 3.2 in 2018 likely reflects the increased emphasis over the past year on group project work, and the added focus on learning to use new CQI tools and techniques. It may also reflect the challenges of new staff requirements to complete a number of foundational trainings in addition to taking on CQI work.

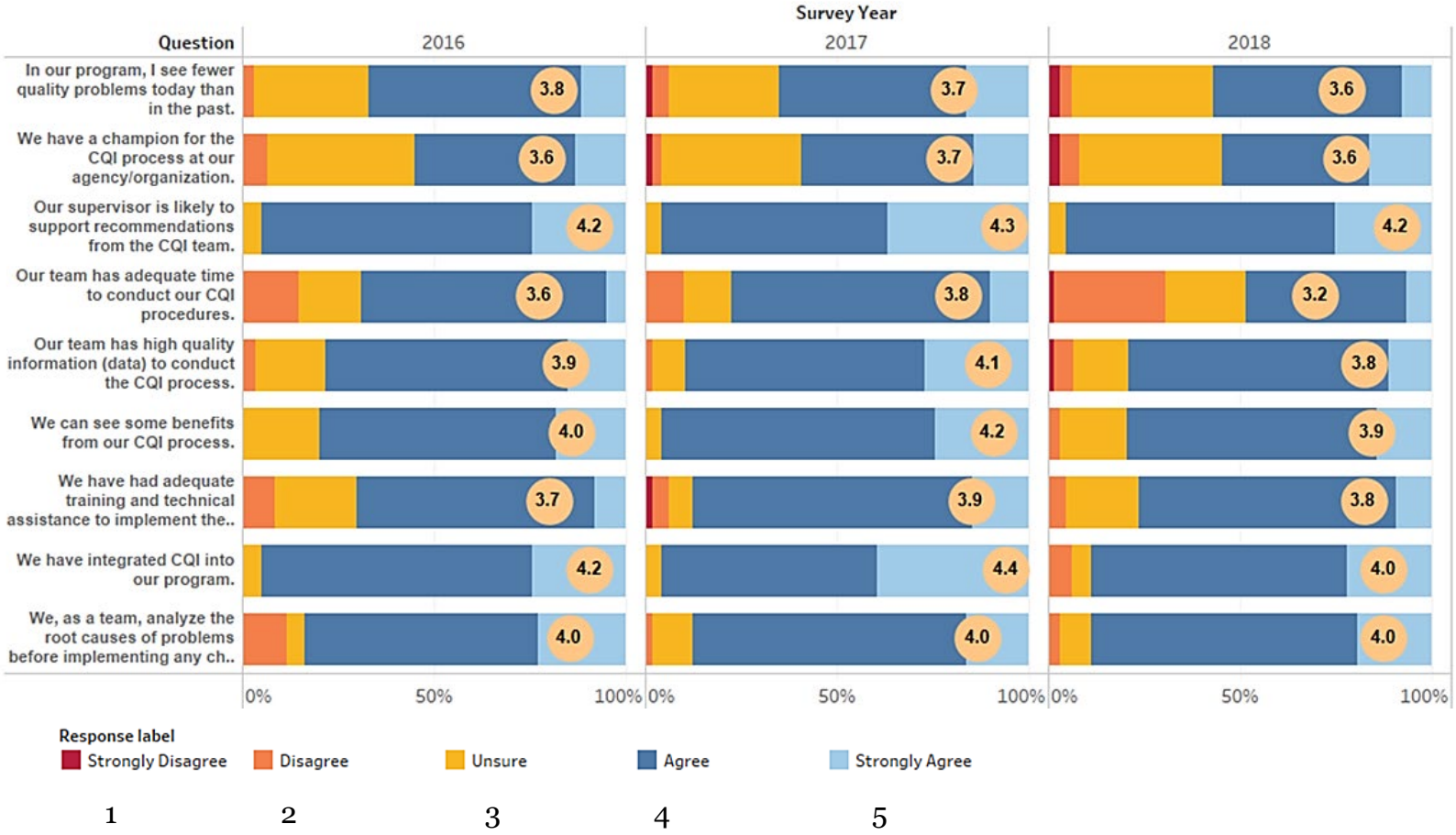


FIGURE 29. **RESPONDENT AGREEMENT (AGREE/STRONGLY AGREE) BY SURVEY ITEM, FY 2016 – FY 2018**

Home visiting CQI group approach pilot

Since 2013, LIAs received individual coaching sessions to assist in the creation and execution of CQI projects. In FY 2018, a new CQI group approach was employed and myriad CQI tools were introduced. LIAs were limited to a choice of 3 pre-determined topics for which to base their CQI projects. Restricted selection supported an effective, operational and cohesive approach to group instruction.

Figure 30 illustrates home visitor feedback on the new process. With the exception of "being grouped with other agencies according to interest and availability", roughly 7 out of 10 participants liked the new process. Respondent comments suggest that discontent over the scheduling process, preference for individual coaching over group instruction, and an ill-fitting group assignment, were the principal factors driving dissatisfaction with the new format.

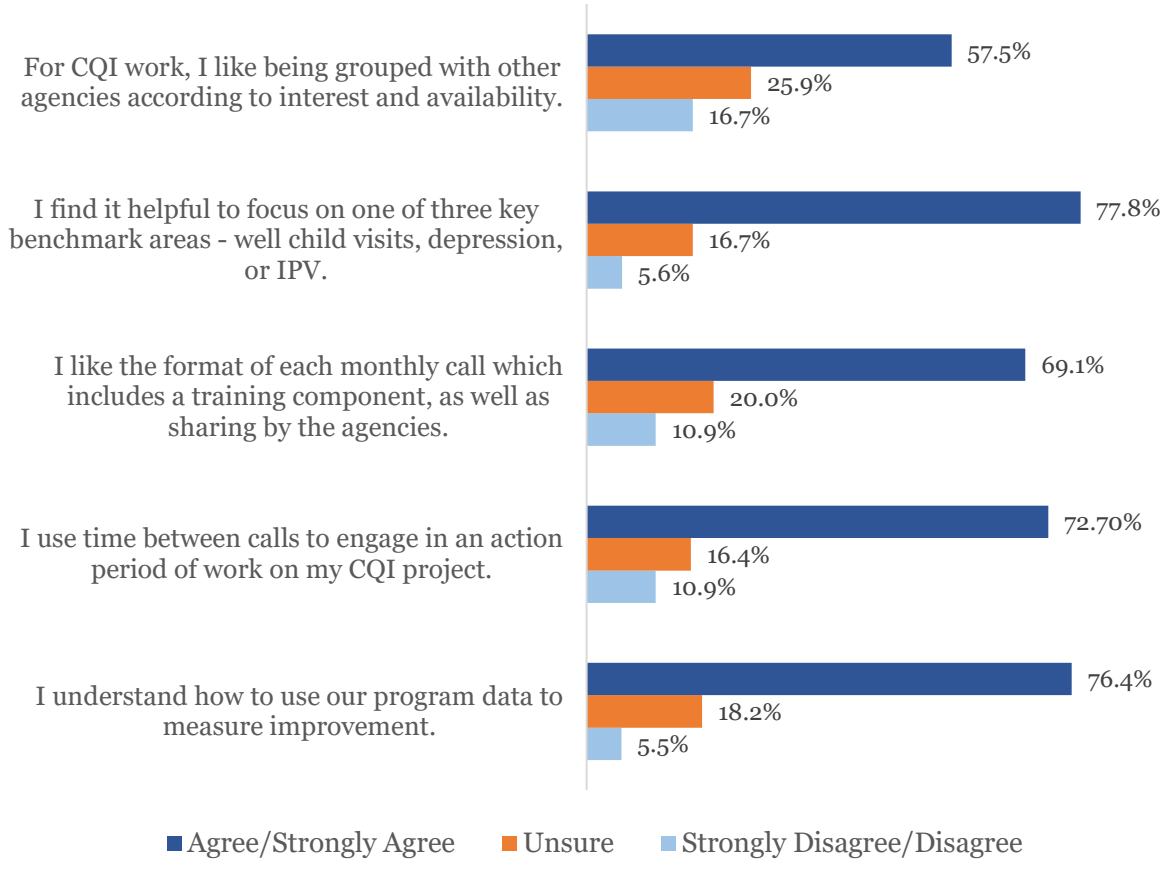


FIGURE 30. NEW GROUP APPROACH TO CQI

Recommendations for FY 2019 CQI Plan

To incorporate feedback from the FY 2018 CQI survey, the following guidelines were utilized to implement the FY 2019 CQI plan.

- Group CQI was piloted with some success (Approximately 57% of respondents from the FY 2018 CQI survey "liked being grouped with other agencies"; 43% either disliked or felt unsure about it). In order to integrate all the feedback into a working model for FY19, both team groupings and individual coaching have been incorporated.
- In FY 2018, teams focused on one of three benchmarks determined by Illinois MIECHV to promote an optimal learning experience for participating teams. Although this proved helpful in the first year implementation of the HRSA/DOHVE CQI Practicum Model (almost 78% of respondents to the FY 2018 CQI Survey found it helpful), sites were allowed to choose the benchmark of their choice in FY 2019 (with guidance from Illinois MIECHV state leads). This has allowed agencies to determine benchmark relevance based on data and the unique attributes of the community and population served.
- In FY 2019, Illinois retained the format of the monthly call which includes a training component and time for discussion (65% of respondents to the statement "I like the format of each monthly call which includes a training component, as well sharing by the agencies"; 3.6% strongly agreed).
- Per FY 2018 MIECHV CQI Survey, 48.4% of respondents agreed or strongly agreed with the statement: "Our team has adequate time to conduct our CQI procedures"; 30.6% disagreed or strongly disagreed; 21% were unsure (more than 1 in 3 respondents disagreed or strongly disagreed with the statement). In FY 2019, to create an intentional CQI workspace and sufficient dedicated time, each monthly coaching call includes a CQI team activity completed or partially completed during the call.
- MIECHV CQI projects (as much as possible) will expand beyond the agency level to embrace community-wide systems change.
- The HRSA/DOHVE CQI Practicum has once again informed the basis for individual coaching calls and instruction.

Socio-demographic characteristics

Results of the FY 2016—FY 2018 CQI surveys are reported below. The socio-demographic factors presented in Table 8 show a predominantly full-time workforce, with the number of CI staff respondents increasing from 8.5% (5 staff) in 2016, to 15% (12 staff) in 2018.

TABLE 8. SAMPLE SOCIO-DEMOGRAPHIC CHARACTERISTICS, FY 2016 - FY 2018

		2016 (n =60)	2017 (n =85)	2018 (n = 80)
Work status	Full-time	93.3%	92.9%	88.6%
	Part-time	6.7%	7.1%	11.4%
Role	Home visitor	55.9%	51.2%	46.3%
	Supervisor or manager of HVs	32.2%	33.3%	33.8%
	Coordinated intake staff	8.5%	9.5%	15.0%
	Other	3.4%	6.0%	5.0%
Years worked at current agency	One year or less	18.3%	29.8%	35.9%
	2-3 years	28.3%	13.1%	21.8%
	4-5 years	25.0%	26.2%	9.0%
	6-9 years	10.0%	7.1%	10.3%
	10 years or more	18.3%	23.8%	23.1%
Prior relevant experience	One year or less	41.0%	30.6%	25.0%
	2-3 years	14.8%	23.5%	26.3%
	4-5 years	8.2%	17.6%	13.8%
	6-9 years	13.1%	10.6%	10.0%
	10 years or more	23.0%	17.6%	25.0%
Highest level of education	No degree	1.6%	0.0%	0.0%
	High School /GED	6.6%	7.0%	7.5%
	Associate's	9.8%	9.3%	8.8%
	Bachelor's	45.9%	54.7%	58.8%
	Bachelor's +	36.1%	29.1%	25.0%

Over the past three years, reports of prior relevant experience of new hires has steadily increased, with only 25% in 2018 reporting one year or less of prior experience compared to 30.6% in 2017, and 41% in 2016. This is a positive trend for workforce development, as more experienced new hires generally require less time onboarding before they are ready to fill their caseloads. These new hires may also be more likely to stay, as they understand the demands of the position and target population prior to

being hired. The percent of staff who have Bachelor's and/or advanced degrees remains in excess of 80% of the survey respondents, another strength of the workforce to be noted (PAT and HFI require Home Visitors to have a high school diploma or equivalent; EHS in Illinois requires an Associate's degree. All programs require supervisors to hold a Bachelor's Degree).

Also shown in Table 7, and below in Figure 31, is the large increase from 2016, in the number of staff reporting they have been at their current agency for one year or less. The number nearly doubled, from just 18.3% reporting a year or less on the job in 2016, to 35.9% in 2018. This uptick may reflect the ongoing struggle HV agencies have had since the Illinois budget impasse (July 1, 2015 – August 31, 2017), which led to layoffs, furloughs and higher turnover, and also an increase in HV staffing levels at a few MIECHV agencies. In 2018, nearly 58% of the MIECHV workforce had been on the job 3 years or less, reflecting a large new workforce. On a positive note, nearly one-fourth (23.1%) have been long-term employees, with ten years or more at their agency.

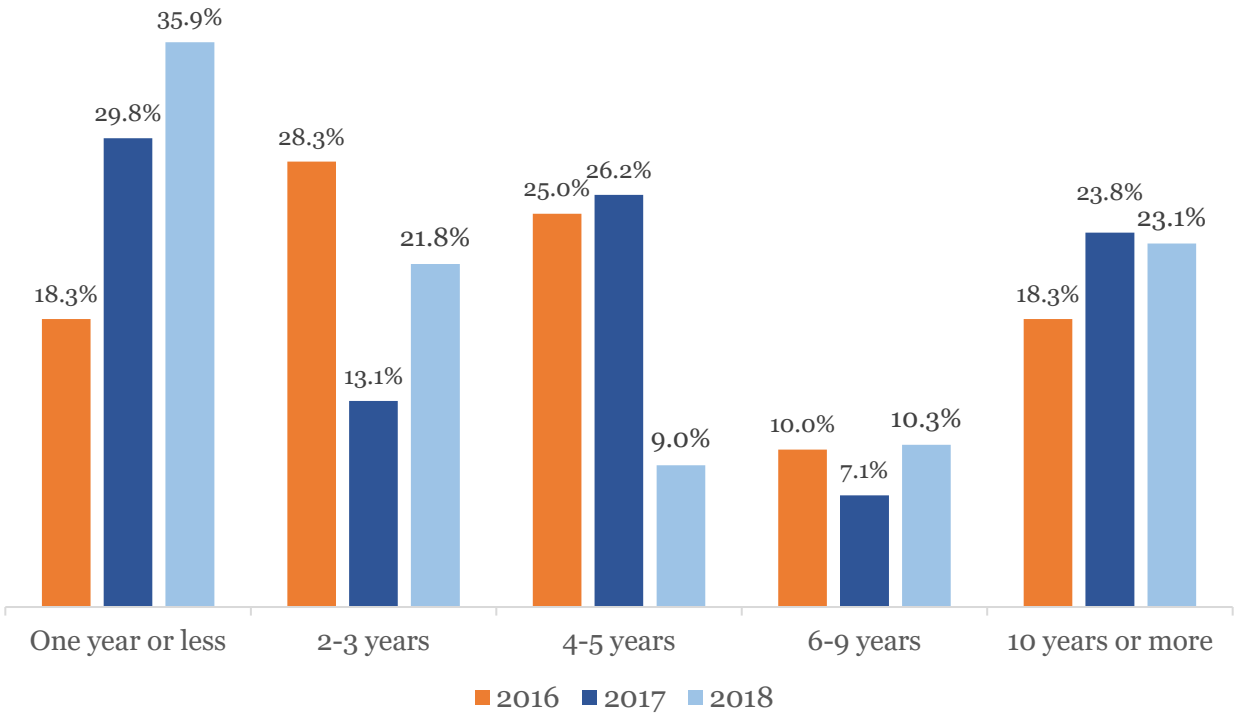


***FIGURE 31.* YEARS WORKED AT AGENCY, FY 2016 - FY 2018**

Home visitor feelings of competency

MIECHV home visitors provide free services to at-risk families who often have complex concerns beyond those related to parenting, including intimate partner violence, lack of resources, and mental health concerns. In their work with families, home visitors must develop trusting relationships and be flexible in their service delivery to meet the unique needs and goals of each family they serve. Knowing that many MIECHV home visitors are fairly new to their positions (36% in FY 2018), a series of items was added in 2018 to measure home visitor's feelings of self-efficacy when providing home visits. Home visitors were asked to rate their level of effectiveness and confidence on a variety of specific home visiting tasks and situations.

***FIGURE 32.* HOME VISITOR SELF-EFFICACY, 2018**

As shown in Figure 32 above, overall, home visitors report they feel they have adequate knowledge and skills to do their jobs well and provide positive outcomes for their participants.

The final item in this section asked home visitors to rate their level of effectiveness on a scale of 1-10, with 10 being the highest. One's belief in their ability to be successful can play a major role in how work tasks and challenges are approached. (Bandura, 1977,

Stajkovic, A. D., & Luthans, F. 1998). Shown in Figure 33 below, of the 36 home visitors who ranked themselves, almost seventy percent (69.5%) rated themselves at 8 or higher on their level of effectiveness as a home visitor. None rated themselves below a 5. Since the first year of the home visitor position involves completing a number of foundational trainings, it may be the case that those home visitors rating themselves in the lower range were newer in their roles.

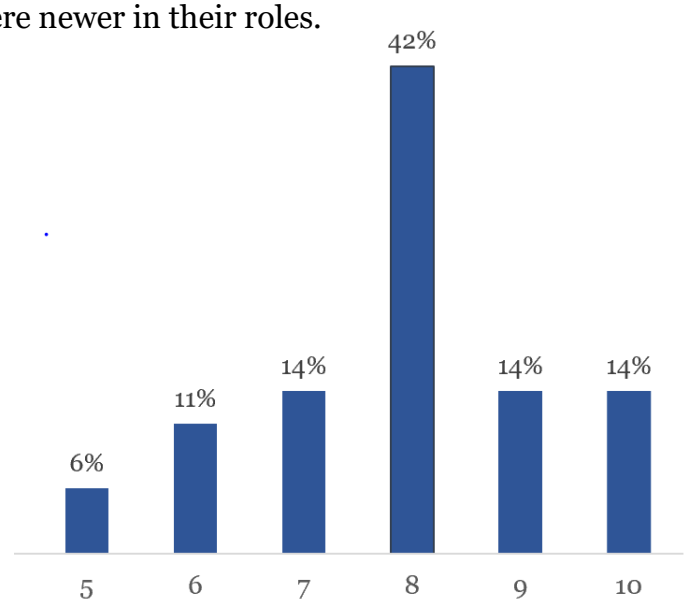


***FIGURE 33.* HOME VISITOR SELF-RATED LEVEL OF EFFECTIVENESS**

Home visitor staff salaries

Again in the 2018 survey, home visitors were asked to report their annual salary. This year, for the 26 staff responding to this question, full-time salaries ranged from $21,600 to $40,000, with a median salary of $31,000. It is interesting to note that home visitors with children aged birth to twelve and with an annual gross income of $31,000, may qualify for public assistance through the IDHS Child Care Assistance Program, as well as other types of public assistance (although family size and other criteria also play crucial factors in determining eligibility). In addition, per Bureau of Labor Statistics CPI Calculator, the median salary reported in July 2014 ($30,000) has a "buying power" of $31,732 in todays' current market; thus, 50% of home visitors who provided salary information in 2018 have less buying power than home visitors had in 2014.

A further analysis of salaries by staff characteristics such as level of education, and years in the profession was conducted. To understand the factors that might contribute to differences, a non-parametric statistical analysis was used to compare these characteristics. As might be expected, Table 9 shows that salaries were higher for staff who have been in the profession longer but did not show an increase beyond 5 years in the field. Higher levels of education yield a graduated increase in salary - particularly an

advanced degree. Almost half of the home visiting staff reporting have been on the job one year or less, earning a mean salary of $29,962. The overall mean salary for home visitors is $31,300. Caution should be used when generalizing due to the small numbers of responses reflecting less than half of the full-time HV workforce. Also, almost half of the sample have been on the job for a year or less, so they are receiving "starting salaries". Nonetheless, from the numbers reported, it is evident that salaries, especially for new staff, remain low for full-time home visitors.

TABLE 9. 2018 HOME VISITOR SALARY BY DEMOGRAPHIC OR EMPLOYMENT CHARACTERISTICS

MIECHV Survey		N	Median	Mean	SD	Min	Max
Current home visiting work experience	One year or less	12	$30,750	$29,962	$3,547	$21,600	$34,000
	2-5 years	11	$32,000	$33,076	$4,506	$25,000	$40,000
	6 years or more	3	$30,500	$30,133	$1,002	$29,000	$30,900
Education	HS/GED/AA	4	$29,250	$29,625	$4,321	$25,000	$35,000
	BA/BS degree	17	$31,000	$31,320	$4,102	$21,600	$40,000
	Beyond college	5	$32,000	$32,568	$3,846	$29,000	$38,840
TOTAL		**26**	**$31,000**	**$31,300**	**$4,019**	**$21,600**	**$40,000**

Illinois non-MIECHV home visiting salaries

CPRD was able to acquire an additional salary data set from the Ounce of Prevention Fund (OPF). However, these data are collected and reported in a slightly different format. Table 10 salaries reflect OPF categories Statewide, Upstate, and Downstate, which appear to be quite comparable, with steady increases from 2014 to 2018. The average MIECHV home visitor salary is similar to the OPF sample (see Table 11). The comparability of both MIECHV and non-MIECHV home visitor salaries is not really surprising as the two systems are often co-located in the same LIAs. It should be noted that the MIECHV survey sample is significantly smaller than the Ounce's data. Their sample represents about 80 (non-MIECHV) home visitors in Illinois. For FY 2018, upstate non-MIECHV home visitors earn an average of 15.72% more than MIECHV home visitors; downstate non-MIECHV home visitors earn 5.64% more.

TABLE 10. OUNCE OF PREVENTION FUND SALARY STUDY – FY 2014, 2016 & 2018

Ounce Survey	2014	2016	2018
Employment characteristics	**Average Salary**	**Average Salary**	**Average Salary**
Statewide	$29,206	$31,012	$35,131
Upstate	$29,286	$31,928	$37,093
Downstate	$29,014	$30,096	$33,169

TABLE 11. OUNCE AND MIECHV HOME VISITOR SALARY COMPARISONS OVER TIME

	2014	2016	2018
	Average Salary	**Average Salary**	**Average Salary**
Ounce	$29,206	$31,012	$35,131
MIECHV	$35,244	$34,604	$31,300

Home visiting staff motivation to remain in or leave their position

The rate of staff turnover is a programmatic factor that plays a critical role in the quality of HV programs. Table 12 and Figure 34 show HV staffing levels and turnovers for the past three state fiscal years (July 1-June 30). The number of home visitor positions increased from 39 in SFY 2016 to a high of 49 in SFY 2018, and turnovers increased as well, with a high of 38% in SFY 2017 and a slightly lower but equally concerning 37% in SFY 2018. To help understand and monitor HV turnover, a series of questions in the HV/CQI Survey were included to capture multiple factors that may contribute to staff leaving or remaining in their positions.

TABLE 12. MIECHV HV STAFFING LEVELS AND TURNOVERS

Year	Positions Funded	New Hires	Exits (Turnovers)	% Turnovers
SFY 16	39	13	12	31
SFY 17	47	24	18	38
SFY 18	49	21	18	37

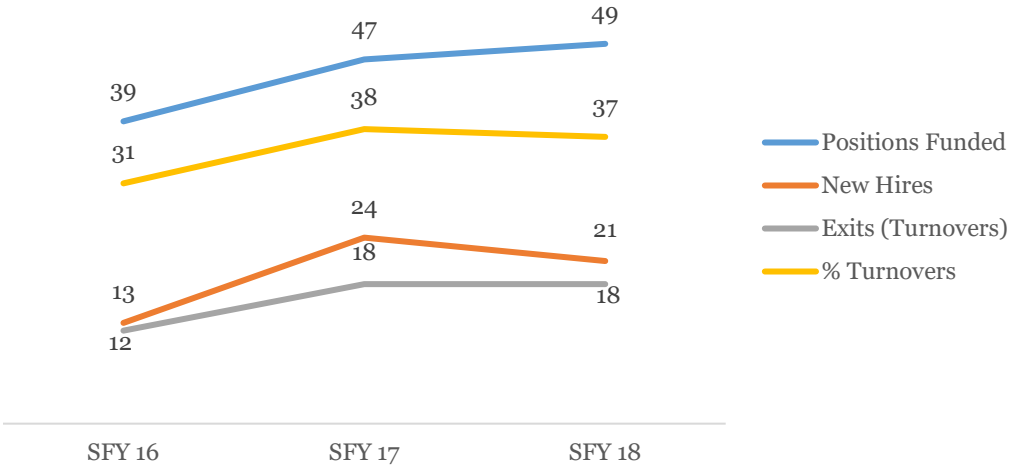


FIGURE 34. **MIECHV HV STAFFING LEVELS AND TURNOVERS SFY 2016-2018**

Figures 35 and 36 summarize the top 3 reasons reported for staying and leaving their positions in FY 2018. Overwhelmingly, making a difference in the lives of others is the highest rated reason (87.3%) for remaining in HV positions. Another top reason, chosen by almost three fourths of home visitors, is the variety and flexibility of the work, which reflects the unique nature of providing home-based early childhood services. A little more than 58% report they stay because of a personal commitment to HV [although there is a downward trend in the percentage of respondents from 2016 (72.1%) to 2018 (58.2%) who indicate "Personal commitment to home visiting" as a reason to stay] and almost half (48.1%) report staying because of MIECHV colleagues in their agency. In contrast, the highest rated factors related to considering leaving HV in FY 2018 was salary (57.5%), with only 16% reporting salary as a reason for staying. The second major reason to consider leaving, chosen by 48%, was the degree to which staff believed funding was insecure. This was a 20% drop from last year's survey (when Illinois did not have a budget passed), but still a reason chosen by almost half of the respondents. The third major reason to leave was opportunity for career advancement in the field (31.6%).

FIGURE 35. **TOP THREE REASONS FOR STAYING IN HV POSITION, 2018**

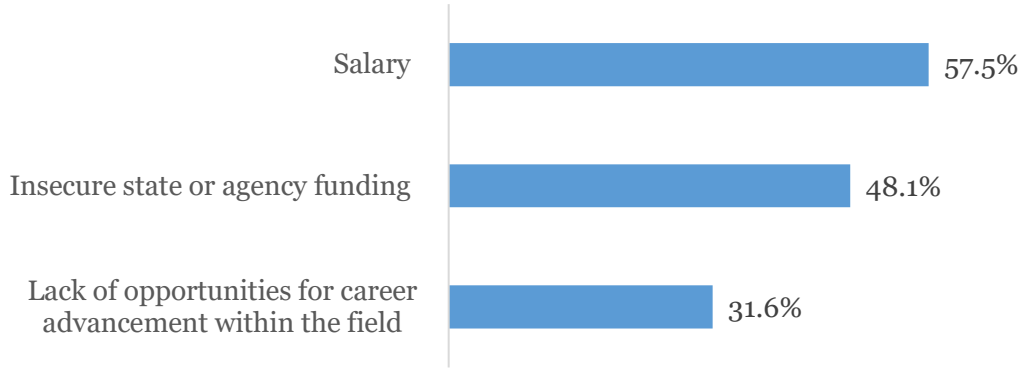


FIGURE 36. TOP THREE REASONS FOR LEAVING HV POSITION, 2018

Table 13 compares the reasons respondents considered staying or leaving from FY 2016 – FY 2018. (Note that the neutral "not a factor in staying or leaving" response, was omitted from the table; numbers will not add up to 100 percent.)

TABLE 13. HV MAJOR AND MINOR REASON FOR CONSIDERING LEAVING OR STAYING, FY 2016-FY 2018

	2016 (n= 33)		2017 (n= 43)		2018 (n= 37)	
	Reason to leave	**Reason to stay**	**Reason to leave**	**Reason to stay**	**Reason to leave**	**Reason to stay**
Salary	65.60%	18.00%	52.90%	23.50%	57.50%	16.30%
Benefits (e.g., healthcare, vacation, sick leave)	16.70%	48.30%	21.20%	48.20%	22.50%	45.00%
Variety and flexibility of work	6.80%	76.30%	1.30%	84.40%	3.80%	73.40%
MIECHV colleagues in my agency	18.30%	41.70%	7.20%	45.80%	13.90%	48.10%
Opportunities for career advancement within the field	45.80%	16.90%	38.60%	19.30%	31.60%	29.10%
Opportunities for career advancement within my agency	49.20%	19.70%	39.80%	20.50%	30.00%	31.30%
Not many other job opportunities where I live or work	6.60%	37.70%	6.00%	29.80%	8.80%	17.50%
Personal commitment to home visiting	0.00%	72.10%	3.60%	61.40%	3.80%	58.20%
Making a difference in the lives of others	1.70%	87.90%	1.20%	84.70%	1.30%	87.30%
Insecure state or agency funding	63.90%	14.80%	67.90%	7.10%	48.10%	7.60%
*MIECHV requirements for assessments and other data collection					29.10%	7.60%
*MIECHV requirements for data system (Visit Tracker) use					25.00%	7.50%
*Number of MIECHV required trainings					7.60%	15.20%
*MIECHV caseload capacity requirements					17.50%	8.80%

*new survey item in 2018

Home visitor safety

Level of concern about potential safety issues:

Due to the unique nature of HV, safety is a particular concern for HV programs. MIECHV has targeted high-risk communities across Illinois and, as a result, home 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 asked. Results indicated that HV staff experienced high levels of concern about a number of potential safety issues. However, perhaps because HV staff and agencies have employed a number of reported safety-related procedures and policies, home visitors reported relatively few actual unsafe experiences. A new question was added to this year's survey related to substance use in the home, an emerging concern. It posed a concern for over 72% of respondents.

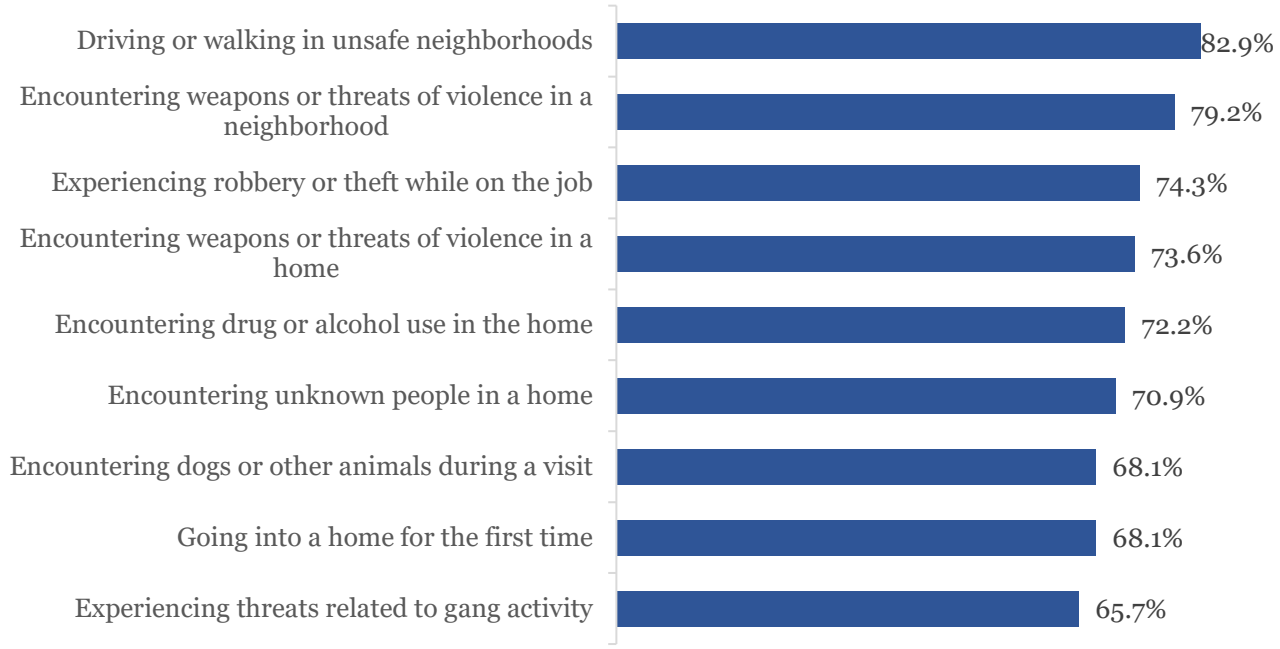


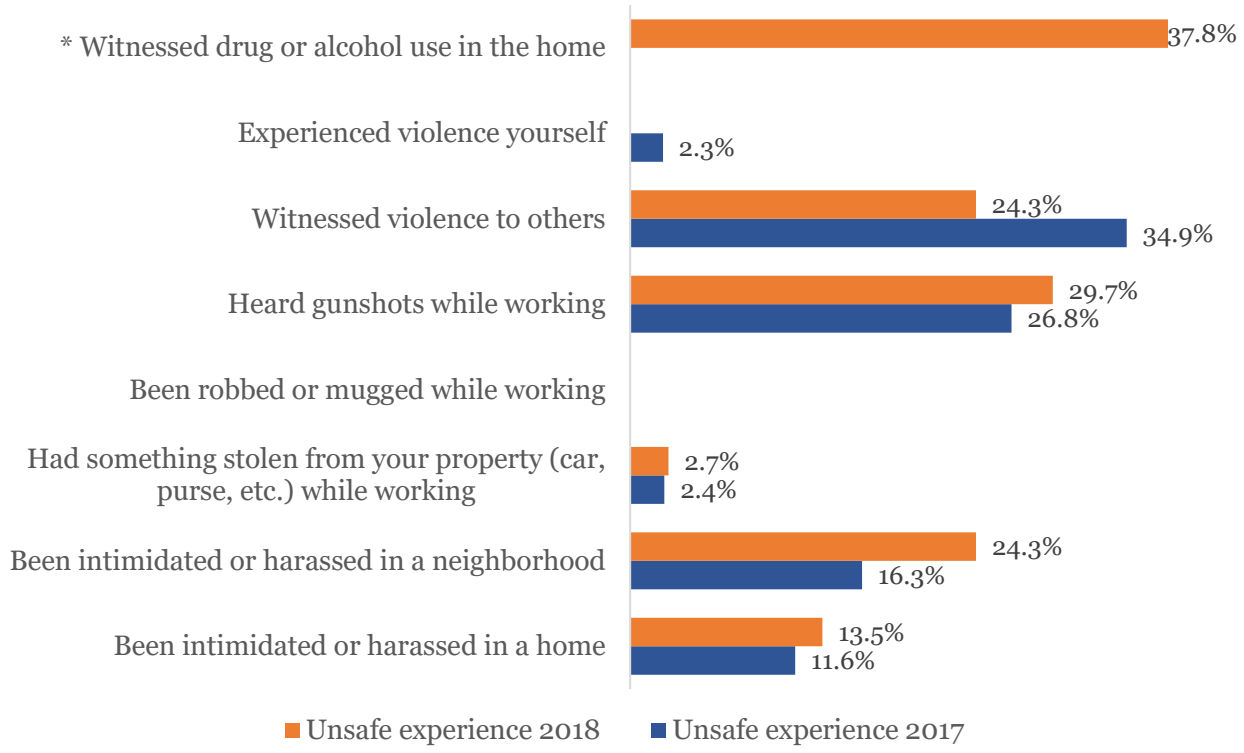
Figure 37. **SOMEWHAT/VERY CONCERNED ABOUT POTENTIAL SAFETY ISSUES, 2018**

Safety concerns and unsafe experiences

While home visitors report high levels of concern about safety, it is encouraging that they do not report high levels of actually experiencing unsafe situations compared to their perceptions of risk. Figure 37 above shows levels of concern, with the top three concerns being: Driving or walking in unsafe neighborhoods (82.9%), encountering weapons or threats of violence in a neighborhood (79.2%), and experiencing robbery or theft while on the job (74.3%). Encountering weapons or threats of violence in a home, and encountering drug or alcohol use in the home were also mentioned as concerns by over 70% of respondents. It is interesting to note that home visitor safety literature

prepared for Idaho MIECHV, THRIVE Washington and Illinois MIECHV state: "Assume that every home has a weapon" and "assume that every client could access a weapon."

Figure 38 shows reported unsafe experiences in 2017 and 2018. A new item was added to the survey this year to address the emerging opioid crisis. Interestingly, over one-third (37.8%) of home visitors report witnessing drug or alcohol use in the home. More than one-fourth reported hearing gunshots while working, with a slight increase from 2017 (26.8%) to 2018 (29.7%). While these experiences are especially concerning, home visitors also report experiencing very few incidents of theft, robbery or personal violence. Modest differences between years may be the result of changes in the workforce due to turnover.



*New item in 2018 survey

***FIGURE 38:* MIECHV HOME VISITOR UNSAFE EXPERIENCES 2017 (N=43) AND 2018 (N=37)**

Agency efforts to reduce risk

In 2015 home visitors were first surveyed about their agencies' safety practices or policies, to gauge agency safety efforts, as well as home visitor knowledge of those safety efforts. At that time, the majority of responding agencies reported they either had no safety policies in place or had inadequate or outdated safety policies. In 2016, 2017, and

2018, to monitor progress toward risk-reduction and safety policies in practice, home visiting staff were asked to indicate which, if any, safety-related policies or procedures their organization implemented. Table 14 shows results for the past three years.

TABLE 14. ORGANIZATIONAL POLICIES AND PROCEDURES, FY 2016 TO FY 2018

		2016		2017		2018	
		N	%	N	%	N	%
Provides information about safety during orientation	Yes	52	85.2%	74	87.1%	64	81.0%
	No	5	8.2%	8	9.4%	10	12.7%
	Not Sure	4	6.6%	3	3.5%	5	6.3%
Provides annual safety trainings to all home visitors/CI staff	Yes	42	70.0%	51	60.0%	55	68.8%
	No	10	16.7%	21	24.7%	13	16.3%
	Not Sure	8	13.3%	13	15.3%	12	15.0%
Has a written safety policy or manual	Yes	51	83.6%	73	85.9%	59	74.7%
	No	8	13.1%	5	5.9%	10	12.7%
	Not Sure	2	3.3%	7	8.2%	10	12.7%
Has a standing safety committee	Yes	29	49.2%	44	51.8%	39	49.4%
	No	18	30.5%	26	30.6%	24	30.4%
	Not Sure	12	20.3%	15	17.6%	16	20.3%
Allows staff to cancel/leave a home visit for safety reasons	Yes	59	98.3%	81	96.4%	73	93.6%
	No	0	0.0%	1	1.2%	3	3.8%
	Not Sure	1	1.7%	2	2.4%	2	2.6%
Provides cell phones to home visitors/CI staff	Yes	28	46.7%	53	62.4%	53	66.3%
	No	31	51.7%	30	35.3%	27	33.8%
	Not Sure	1	1.7%	2	2.4%	0	0.0%

Across years, HV staff report similar results for safety included in orientation, providing annual safety trainings, and agencies have standing safety committees. Fewer staff (74.7%) in 2018 reported that their agency has a written safety policy or manual compared to 2017 (85.9%) and 2016 (83.6%). Since it is likely that an agency with a policy in 2016 and 2017 would still have a written policy or manual in 2018, we expect that this drop reflects a drop in awareness of a written policy.

Notably, for all three years, over 90% of staff report they are allowed to cancel or leave a visit for safety reasons. The one main difference between years is that two-thirds of staff were provided cell phones by their agencies in 2018, compared to less than half (46.7%) in 2016. We are not able to determine whether this change was made as a result of safety findings in 2015. Following the safety study, the Governor's Office of Early Childhood Development recommended that home visitors: "Carry your phone on your person, and keep it charged and programmed with emergency numbers." (Home Visitor Safety Presentation)

"Many referrals want diapers, bills paid, or transportation to appointments"– *MIECHV HV Supervisor*

MIECHV Caseload Capacity

Maintaining a caseload capacity of at least 85% across sites is a MIECHV federal grant requirement. Data from monthly capacity reports show that programs have struggled to keep caseloads full, so questions were added this survey year to gather feedback on the challenges to building and maintaining full caseloads.

Over half (55.6%) of supervisors reported that they received an adequate number of referrals to their HV program, and 84.6% reported the referrals were a "good fit", matching the requirements for their program model. However, of those reporting receiving referrals that were not a good fit, comments included: "many referrals want diapers, bills paid, or transportation to appointments", they received referrals that didn't fit their target population, and "some of the referrals result in actual enrollment, but the majority do not".

It is concerning that 51.9% of supervisors also reported that staff turnover affected their ability to maintain full caseloads over the past year. Additional comments provided speak to an array of impacts staff turnover has on caseloads. These effects include delays in being able to fill caseloads due to an array of training requirements for new staff, and of training not always immediately available when new staff are hired. These challenges are especially difficult when both supervisors and staff are new to MIECHV and program model requirements. Others noted difficulties of families not wanting to switch workers due to the relationship-based nature of the work. Additional challenges noted include "lack of good replacement options" when hiring, lengthy vacancies before positions are filled, and staff out for extended periods.

Coordinated Intake staff were asked if staff turnover at the home visiting agencies they serve presented challenges over the past year. Sixty percent of CI staff reported "Yes". Challenges and concerns noted included delays in providing needed services to families, delays in processing referrals, difficulty of programs finding qualified applicants, long

wait times before newly hired home visitors can fill their caseloads due to extensive onboarding training requirements and losing participants who dropped out of services because they didn't want to change home visitors. Another challenge noted was keeping families on a wait list interested when there is a delay in program's ability to enroll new participants.

New factors impacting recruitment:

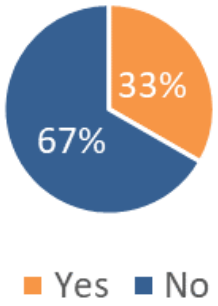


FIGURE 39. **HAVE WIC AND MANAGED CARE CHANGES IMPACTED RECRUITMENT? - 2018**

"People are less likely to want people to come into their homes for many different reasons, and people believe we are connected with government or possible people that will be unkind towards their circumstances."

Questions were added this year to explore new factors that may be impacting recruitment. Respondents were asked if recent changes in managed care and WIC enrollment impacted how families are recruited, and one third (33%) responded yes (Figure 39).

Additional comments provided spoke of challenges and concerns related to these changes, which included lower enrollments in the WIC program, resulting in a lower number of referrals than in the past, and fewer referrals from Family Case Management, which had previously been a reliable referral source.

Others remarked that CI position vacancies also impact referral flow, and that the CI system plays a "critical role" providing a steady influx of families to program.

A question was added this year to assess if the current political environment has had an impact on recruitment of immigrant families. More than a fourth (29%) of supervisors report the current political environment has impacted this specific population (Figure 40). Those responding yes provided further clarification. Challenges noted relate to families being distrustful and unwilling to provide personal information due to fearing deportation.

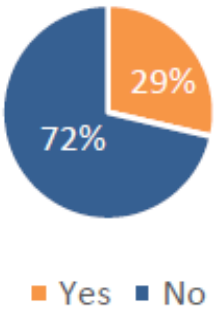


FIGURE 40. **HAS CURRENT POLITICAL ENVIRONMENT IMPACTED IMMIGRANT RECRUITMENT? - 2018**

If there is drug abuse or substance abuse in a household, that family is going to be hesitant to allow anyone into their home …the fear of being reported is real. And sometimes this is the only outlet or release many people in and out of these communities have." – *MIECHV HV Supervisor*

A statewide emerging concern is the opioid epidemic: substance use by family members, and its impact on families' willingness to let HV's in their home. CI staff were asked this year if family substance abuse has had an impact on recruitment. Three of 15 respondents (20%) said yes. Additional comments show staff suspect potential participants are "less likely to want services in their homes due to drug use occurring within their home environment."

MIECHV Staffing and Staff Turnover

The evaluation team has tracked MIECHV staff turnover for the past five years, to analyze impacts and trends over time. 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 low-resource communities can impact staff retention (Alitz, P. J., et al., 2018).

Home visiting is in many ways a relationship-based service and 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 2014 CPRD Dropout Analysis and the 2018 HV CQI survey report, caregivers will often drop out of a program after the loss of their home visitor (CPRD, MIECHV Parent Dropout Analysis, 2014, CPRD, MIECHV 2018 HV CQI survey report).

"Some families choose to not stay in the program because they don't like the change [to a new home visitor]. -- *MIECHV HV Supervisor to a new home visitor* (CPRD, MIECHV 2018 HV CQI survey report).

Staffing changes during the 2018 state fiscal/contract years reflects not only staff exits/turnover, but also the conclusion of MIECHV competitive grant which funded Doula home visitor positions. Overall, contracted positions decreased from 134 in SFY 2017, to 101 staff positions in SFY 2018. This number reflects not only the dropped Doula positions, but also the exit of one HV program from the MIECHV funding stream (Table 15).

TABLE 15. MIECHV STAFFING AND HIRES AND EXITS (TURNOVERS), SFY 2016 - SFY 2018

	Contracted			Staff Hires			Staff Exits (Turnovers)		
MIECHV Positions	**SFY16**	**SFY17**	**SFY18**	**SFY16**	**SFY17**	**SFY18**	**SFY16**	**SFY17**	**SFY18**
Coordinated Intake (CI)	5	9	9	0	6	3	1	4	2
CI Supervisor	5	10	8	1	8	0	3	3	0
Doula	14	13		8	2		3	4	
Doula Home Visitor	4	4		3	5		3	2	
Home Visitor (HV)	39	47	49	13	24	21	12	18	18
Other Staff	15	19	7	1	9	2	1	7	1
HV/Doula Supervisor	29	32	28	6	8	8	1	10	5
Grand Total	**111**	**134**	**101**	**32**	**62**	**34**	**24**	**48**	**26**

For SFY 2018, Illinois MIECHV shows a wide range of turnover, with especially high turnover in HV staffing (see Table 15 above). 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 0% to 37% per position category, with an average turnover percentage of 26% for July 1, 2017 through June 30, 2018. This is improvement in the overall turnover rate from 2017, which was 36%. However, turnover percentages need to be carefully interpreted because some positions have few staff (CI =9, Other Staff = 7), and any reported change may be overstated. Specifically, the largest number of contracted staff were the MIECHV home visitors (49) that reported a 37% turnover last year, which is more than one third of home visitors in the past year, and only a slight decrease from 38% in the prior year. Staff turnover tables for State FYs 2016, 2017 and 2018 (Tables 15 and 16) are provided for comparison (with Doula home visitor positions included in FY 2016 and 2017 only). High home visitor 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 in SFY 2018 from a low of six weeks, to a high of 3.9 months for CIs and 4.5 months for HVs (Table 16). Overall, the average length of time to fill a position was 3.9 months.

TABLE 16. MIECHV STAFF TURNOVER % AND AVERAGE LENGTH OF VACANCY, SFY 2016 - SFY 2018

MIECHV Positions	% Turnovers			Average Length of Vacancy (months)		
	SFY16	SFY17	SFY18	SFY16	SFY17	SFY18
Coordinated Intake (CI)	20%	44%	22%	5.6	4.8	3.9
CI Supervisor	60%	30%	0%	0.2	2	0
Doula	21%	31%	NA	1.2	1.4	NA
Doula Home Visitor	75%	50%	NA	0.4	0.5	NA
Home Visitor (HV)	31%	38%	37%	3.6	3	4.5
Other Staff	7%	37%	14%	2.3	1.8	1.5
HV/Doula Supervisor	3%	31%	18%	1.1	1.4	1.9
Grand Total	**22%**	**36%**	**26%**	**2.6**	**2.4**	**3.9**

Table 17 shows 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 2.4 years in SFY 2018, which is a slight increase over 2017's average of 2.2, indicating a positive increase of a few additional months of experience of the HV's who remain in MIECHV programs.

Table 17. MIECHV Average Length of Employment, SFY 2016 - SFY 2018

MIECHV Positions	Average Length of Employment (years)		
	SFY16	SFY17	SFY18
Coordinated Intake (CI)	1.9	2.3	2.4
CI Supervisor	2.3	2.6	4.7
Doula	1.9	2.2	NA
Doula Home Visitor	1.8	2.2	NA
Home Visitor (HV)	1.8	2.2	2.4
HV/Doula Supervisor	2.8	3.4	3.9
Grand Total	**2.2**	**2.6**	**3.0**

IV. Coordinated Intake

Overview

> My team prefers receiving referrals to recruiting on our own. Referral system [Coordinated Intake] yields equivalent enrollment but is far less time consuming". -- *MIECHV HV Supervisor*

The Coordinated Intake (CI) system in Illinois plays a key role in connecting at-risk families to home visiting services in MIECHV communities. Local community-based CI workers identify and recruit families in need of services and match them to providers that can best meet their needs. This service is vital to helping maintain full caseloads with families that best fit specific program eligibility criteria and are most in need of services. Specially trained CI staff provide a convenient single point of entry for home visiting, and a variety of other early childhood and family support services. They assist families by informing them of the range of options available, 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 in the community and conducting outreach activities to locate and recruit eligible families, thus relieving programs of the burden of finding families to fill their caseloads. Table 2 lists the twelve FY 2018 MIECHV-funded CI agencies and the communities they serve. These CI sites provide referrals to MIECHV and non-MIECHV funded home visiting programs in their service area.

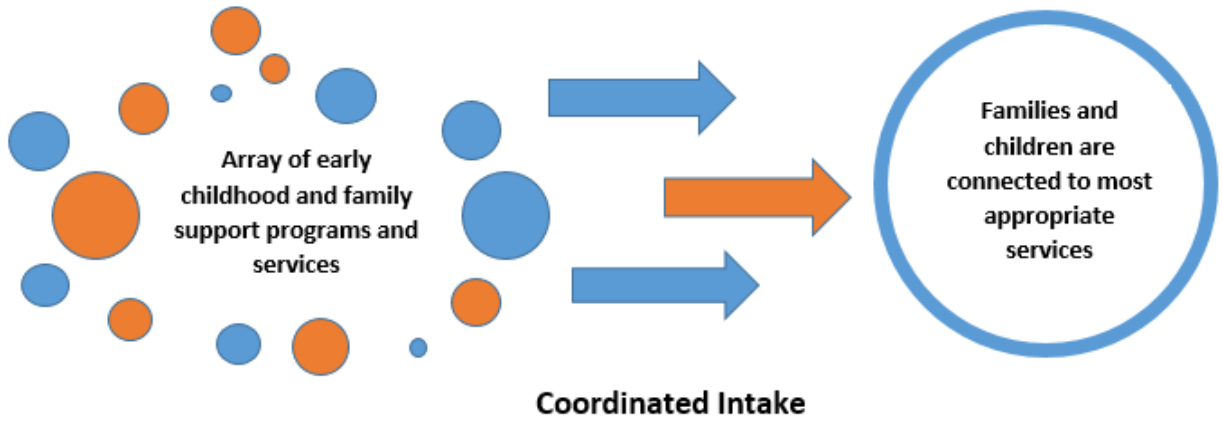


FIGURE 41. **COORDINATED INTAKE CAN BE A CONDUIT TO HELP STREAMLINE A COMPLEX ARRAY OF LOCAL SERVICES FOR YOUNG CHILDREN AND FAMILIES (ADAPTED FROM SEPTEMBER 2018 ISSUE BRIEF ON COORDINATED INTAKE)**

CI Learning Community

Learning Community meetings for CI staff were re-established in FY 2017, using video conferencing from 4 locations across the state. The power and popularity of the meetings among the CI workers led to the development of a quarterly in-person format, with the first face-to-face meeting held in March of 2017.

"I really appreciate the opportunity to get together with team-mates, share ideas, thoughts, concerns, successes." -- *CI worker*

The Learning Community meetings contribute to creating an atmosphere of engagement to learn and develop best practices and guide future systems and service improvements. Resource sharing, professional development, group activities, and continuous quality improvement (including use of specific CQI tools such as process mapping) are built into every meeting. FY 2018 meetings included peer learning activities where staff shared and discussed tools and strategies that work best for them. CI workers shared PowerPoint presentation examples, details of partnership development and favorite family engagement resources. Topics also covered included: Using spreadsheets for data tracking, effective messaging for recruiting families, and MOU development.

"Each day of our lives, we make deposits in the memory bank of our children." – John Wilmot

A secure online Dropbox is used for the CIs to share contact information, meeting notes, presentation slides, policy and procedure manuals, recruitment flyers, tool kits, resource guides, and other useful documents with each other.

All CI staff attending complete evaluation forms after each Learning Community meeting, and feedback is used to inform planning for future meetings. Feedback on the anonymous forms consistently shows that the meetings are helpful and valued by the staff. These sentiments are reflected in the following representative comments "All the information from this meeting is great for what I do."; "Informative and encouraging, lots of great take-aways."; "Love these gatherings"; "It's great to have additional support/ideas."; "Great meeting! A good support system for CI workers."; It's helpful to have a face-to-face meeting to allow everyone to share successes/failures"; "I really appreciate the opportunity to get together with team-mates, share ideas, thoughts, concerns, successes."

Staff are also asked to list barriers or challenges to their community's implementation of coordinated intake, to help guide content for future training. Key challenges noted include:

- Keeping caseloads full
- Using Visit Tracker data system
- Presenting to groups of key stakeholders
- Getting all agencies to participate in CI system; Getting buy-in from agencies, some partners are not "on board"
- Agencies knowing about and understanding the purpose of CI and role of CI staff
- Lack of home visiting programs to refer to, capacity and level of service does not meet the need
- Not all the HV agencies use CI – They have their own CI system
- Not understanding the true purpose of home visiting - agencies giving out incorrect information
- Getting Early Intervention involved
- Getting clients interested enough to sign up, Unaware of service – or they just haven't tried it out yet
- Communication between collaborative partners
- Communication to families, challenges in defining home visits
- Closing the feedback loop
- Reaching families, WIC numbers are decreasing
- Lack of accessibility to key stakeholders at different agencies
- Lack of responsiveness from some HV programs
- Transparency is an issue with some agencies
- Lack of community awareness, lack of marketing, unclear expectations
- Competition between agencies, turfism, lack of trust
- Lack of willingness to refer, do something not required of them
- Agencies scared they will lose referrals, HV agencies not following protocol.

CI CQI Plans for FY 2018

Each CI site creates an annual CQI plan to address an area targeted for quality improvement, The CI team shared CQI plan success stories during a mandatory CI Group call in October 2018. CQI plan activities and successes are also shared quarterly at the Learning Community meetings. FY 2018 CQI plan topics focused on establishing new partnerships, simplifying the referral process for service providers, revising the CIAT screening/intake form to include eligibility point system for risk factors used by some non-MIECHV HV programs, and regularly incorporating questions about other basic needs at time of home visiting intake interview to increase basic needs referrals.

Coordinated Intake (CI) Professional Learning Needs Survey

To help understand and meet the professional development training and technical assistance needs of CI staff and supervisors, CPRD distributed an online survey in February 2018 to 25 current MIECHV CI staff. The survey was closed on March 2nd. Twenty-four surveys were completed, for a response rate of 96%.

Staff rated the degree to which they feel confident with a list of specific CI skills and practices, and then rated which practices they would like to have additional professional learning assistance with. Overall, staff were most confident about:
Engagement and facilitation skills that include trust building, respectful communication, motivational interviewing, cultural awareness; Basic knowledge of child development, maternal child health, and parenting skills; and Comprehensive knowledge of the home visiting models and best practices offered in my community.
The top skills and practices they rated as not at all or slightly confident with were: Survey development; how to display and share data with partners and the community; strengthening communication, understanding, and collaboration with Local Interagency Councils and the Early Intervention system; and ability to design and develop promotional materials such a brochures, flyers, infographics, press releases, social media posts, radio and TV spots.

The three highest ranked responses to training topics, with 11 responses each of "very much" wanted, were: Recruiting and engaging fathers, Ability to design and develop promotional materials such a brochures, flyers, infographics, press releases, social media posts, radio and TV spots, and How to display and share data with partners and the community.

Staff were also asked to list any additional topic areas or specific trainings they felt would be helpful. Responses included: a need for data collection and reporting training, engagement of those exposed to trauma, more training options for reflective supervision, CI use for budgeted dollars, and methods to receive feedback regarding the outcome of CI referrals.

There were 15 different skill areas that 12 or more respondents rated "somewhat" or "very much" interested in for additional training. These cluster into 4 main categories: Marketing and Outreach, Collaboration & Team Building, Recruitment of HV participants/families, and Data use and analysis. Based on feedback from the survey, the Ounce of Prevention training team is working with CPRD and GOECD staff to develop targeted trainings for CI staff.

V. Summary and Recommendations

The Illinois MIECHV 6th Annual Benchmark and Outcome Report continues to tell Illinois' story of home visiting programs and services. Like 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. In FY 2018, MIECHV home visiting served 800 households with 9,852 visits. Unlike other states, Illinois has been constrained by state government budget problems that have had ripple effects since the two-year budgetary stalemate that ended on August 31, 2017 (and lasted 793 days). While the initial impact of agency closings, furloughs, layoffs, contract renewals, staff turnover and low morale are no longer occurring, there are other impacts that remain. For example, staff turnover remains an issue, the challenge of rebuilding caseloads exists, and staff uncertainty remains. These issues effect the quality of programs and services among all the Illinois home visiting organizations and communities, and related services.

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 86% of families at or below the 100% Federal Poverty Level (FPL). 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. Over half of the Illinois MIECHV families served in FY 2018 have multiple risk factors and fall within more than one of the priority populations. An upcoming needs assessment (2019/2020) 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).

Benchmarks

The redesigned HRSA benchmarks (effective October 1, 2016) initially created new opportunities and challenges, including the learning, educating and adapting to the new benchmarks among the home visiting staff, and altering the online data system to receive, calculate, and report data for CQI and benchmark reporting. However, by FY 2018, the new benchmarks were fully implemented, and to some degree, simplified key indicators. As described previously, the six benchmark domain areas 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 support

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.

With the baseline data on the new benchmarks established in FY 2017, an analysis of multi-year trends was possible in FY 2018. Overall, 13 benchmarks constructs improved in FY 2018, one stayed the same, and five benchmarks constructs declined from the prior year. The improved benchmarks constructs include: Preterm Birth, Depression Screening, Well Child Visits, Postpartum Care, Tobacco Cessation Referrals, Safe Sleep Practices, Early Language and Literacy Activities, Developmental Screenings, Behavioral Concerns, Intimate Partner Violence Screening, Completed Depression Referrals, Completed Developmental Referrals, and Intimate Partner Violence Referrals. These improvements should be cautiously interpreted because although priority populations were served in both FY 2017 and FY 2018, the specific households served in FY 2018 are a different sample than the households served in FY 2017.

Continuous Quality Improvement

Illinois MIECHV home visiting programs have now been engaged in continuous quality improvement work for 6 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.

In FY 2018, to enhance communication flow and combat isolation between LIAs, a group approach to CQI work was piloted based on a model provided by Health Resources and Service Administration/ Design Options for Home Visiting Evaluation (HRSA/DOHVE). This approach included group coaching calls, training on CQI tools and methodologies, and organizing agencies into four teams, each focusing on one of three benchmark choices: Intimate Partner Violence (IPV), Completed Depression Referrals, and Well-Child Visits.

The CQI process included techniques to: Build an effective CQI team; Explore the Cause/Driver behind the problem (Root Cause Analysis, Key Driver Diagrams, Process

Mapping); Set goals (Specific, Measurable, Achievable, Relevant, and Time-Bound Aims); Plan and implement intervention strategies (Model for Improvement, Charter, Outcome Measures, PDSA Cycle, PDSA Ramps); and Collect, display, and analyze data (Run Chart). Out of the CQI plans completed in FY 2018, 9 agencies met or surpassed their goal, 6 agencies showed improvement but didn't reach their goal, 4 were unable to complete their plan due to staff turnover, 2 agencies had no moms test positive on the IPV screening, and 1 agency did not meet or improve.

Coordinated Intake

The Coordinated Intake (CI) system in Illinois plays a key role in connecting at-risk families to home visiting services in MIECHV communities. Local community-based CI workers identify and recruit families in need of services, and match them to providers that can best meet their needs. This service is vital to helping maintain full caseloads with families that best fit specific program eligibility criteria, and are most in need of services. Often CI workers connect families to additional early childhood services and basic needs supports and serve as a single point of entry for high risk families needing comprehensive services. 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).

> "If we don't stand up for children, then we don't stand for much."
> *–Marian Wright Edelman*

Data Quality

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.

In FY 2018, support around data quality efforts included: data training, monthly report cards, quarterly data reviews, data resources, and technical assistance. Data quality management is an essential process in making sense of the data. It builds the foundation and establishes a reliable framework to look at the day-to-day operations of the LIA's. It ensures confidence in the upstream and downstream applications that use the data.

Recommendations

The following recommendations are being made for the FY 2019 Federal Fiscal Year.

Continuous Quality Improvement (CQI)

- Incorporate a combined approach to CQI that includes both team groupings and individual coaching and allow sites to choose their benchmark topic individually.
- Work with LIAs to choose CQI projects based on empirical data and observation and set goals based on MIECHV guidelines and recommendations.
- Introduce a statewide CQI focus to encourage system improvement on priority areas across the State.
- Collaborate with interested partners to create a safe sleep environment for all Illinois infants.
- Ensure LIAs create and maintain appropriate CQI project documentation for the program evaluation purposes.
- Continue to conduct the annual CQI survey for MIECHV staff information and feedback.
- Utilize MIECHV Visit Tracker data to identify low-performing benchmarks across the state and explore strategies with LIAs for benchmark improvement.

MIECHV Benchmarks and Data

- Create a training manual providing step-by-step instruction on inputting Form 1 and Form 2 data into Visit Tracker. Provide access to the manual through the igrow website.
- Continue to coordinate with Visit Tracker developers to enhance user supports and adapt to changes in HRSA guidelines.

Coordinated Intake

- Support the continued development and expansion of the coordinated intake system by providing additional staffing to support and expand CI activities. At a minimum, employ one FTE CI worker er MIECHV community.
- Work with Visit Tracker developers to expand the capabilities of Visit Tracker for CI data collection and reporting.
- Develop a coordinated intake strategic plan to help systematically move coordinated intake systems development forward.

Home Visiting and Coordinated Intake Staff Professional Development

- Ensure that professional development for home visitors and coordinated intake staff are available and readily accessible to encourage knowledge of best practices and ensure confidence in their competency to be successful.
- Create a training and technical assistance program for home visitors who are part of a 25% MIECHV-funded Home Visitor Pilot Project. Pilot participants will be responsible for implementing MIECHV procedures and meeting all MIECHV guidelines and requirements.

Staffing

- Identify sources of work related stressors that lead to staff burn-out and turnover and provide targeted supports for MIECHV staff.
- Advocate for increased salaries and benefits for home visitors. As noted in the Full Report of the Early Learning Council's Program Standards and Quality (PSQ) Workforce Compensation Subcommittee, annual average wages for early childhood workers with bachelor's degrees in Illinois are about half of the average wage for members of the general workforce with bachelor's degrees ($53,000, vs. 32,000). (READYNATION, 2015: US Department of Human Services, 2013). Achieving compensation parity is an important element to ensuring a highly qualified and stable home visiting workforce.

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