



**Coordinated Intake in Illinois: Lessons Learned from MIECHV
(The Maternal, Infant, and Early Childhood Home Visiting Program)
October 17, 2014**

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Coordinated Intake in Illinois: Lessons Learned from MIECHV

Executive Summary

October 17, 2014

The Illinois home visiting system embraces the State's early childhood vision of every child entering kindergarten safe, healthy, ready to succeed, and eager to learn. The overall goals of Illinois home visiting are to promote positive parenting and healthy child growth and development, and to prepare young children for school success.

As authorized by the Affordable Care Act, Illinois is receiving federal MIECHV funds to:

- Expand or enhance one or more **federally-recognized evidence-based home visiting models**;
- Ensure that home visiting is **effectively connected** to community based organizations and services;
- Establish a system of **universal screening** and **coordinated intake** in target areas;
- Enhance or establish an **early childhood collaborative** in target areas.

Six communities (the Southside Cluster, Cicero, Elgin, Rockford, and Macon and Vermilion Counties) have been piloting Coordinated Intake for home visiting since February of 2012, and four additional "voluntary" communities (McLean-DeWitt-Piatt-Woodford Counties, Oak Park-River Forest, Peoria-Tazewell Counties, and Stephenson County) began planning for Coordinated Intake starting in July of 2013. While the State provided general guidelines to these communities, they had flexibility regarding the selection of the local Coordinated Intake agency as well as the details of implementation, including the decision tree for determining the flow of referrals.

Since 2012, the MIECHV State Team has learned a great deal from the pilot and "voluntary" communities. Local communities have established some strong models and innovations, and the challenges that they have reported have helped us to identify and act on areas for infrastructure-building and policy improvements. Best practices have been identified with regard to family engagement, sustainability and integration, public awareness, and professional development and support. In addition, there were challenges regarding a fixed point of entry as well as partnerships with some DHS programs, medical providers, and non-MIECHV-funded home visiting programs.

In response, state funders of home visiting have been meeting to develop a unified vision and common goals and outcomes, and to address these barriers at the state systems level. The MIECHV State Team also recommends two targeted "universal" strategies for reaching vulnerable families prenatally or shortly after the baby's birth.

1. **"Universal" prenatal strategy: WIC/FCM/BBO as an intake point for home visiting**

We recommend the universal screening of prenatal WIC/FCM/BBO families for home visiting (with dual enrollment during a transition period or when otherwise appropriate).

2. **"Universal" post-natal strategy: birthing hospitals and centers as an intake point for home visiting**

Since we know that not all vulnerable parents will seek out WIC/FCM/BBO programs, we also recommend coordinated outreach to families through birthing hospitals and centers.

In addition to the above "universal" strategies, we recommend that home visiting providers continue to take an **"All Families Served"** approach to outreach that includes partnering with a wide spectrum of organizations and associations, using resources such as the iGrow materials and [video testimonials](#) developed by MIECHV providers. When implemented with these strategies, Coordinated Intake can be an important mechanism for linking together a **continuum of services** from birth to eight, and ensuring that **seamless transitions** are made, including transitions between home visiting and high quality early learning programs.

We thank the Coordinated Intake pilot agencies and "Voluntary" communities for their dedication to improving outcomes for Illinois children, and for their ongoing contributions to building our state home visiting system.

MIECHV Overview

As authorized by the Affordable Care Act of 2010, Illinois is receiving federal MIECHV funds to:

- Expand or enhance one or more **federally-recognized evidence-based home visiting models**;
- Ensure that home visiting is **effectively connected** to community based organizations and services;
- Establish a system of **universal screening** and **coordinated intake** in target areas;
- Enhance or establish an **early childhood collaborative** in target areas.

The six Illinois communities receiving MIECHV formula funds are:

- Southside Chicago cluster (Englewood, West Englewood, and Greater Grand Crossing)
- Cicero
- Elgin
- Rockford
- Macon County
- Vermilion County

In each of these pilot communities, a collaboration of agencies is funded to implement MIECHV. These providers use the following evidence-based home visiting models: Early Head Start (EHS), Healthy Families Illinois (HFI), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT). Key staff roles include: Home Visitors, Coordinated Intake (CI) workers, and Community Systems Developers (CSDs) and all of their respective supervisors.

For all six communities, key components of the Illinois MIECHV program include:

- **Strong Foundations training** for home visiting staff on **domestic violence, substance abuse, maternal depression, and development delays** (provided by the Ounce of Prevention Fund and others).
- **Linkages to medical homes** (coordinated by the Illinois Chapter of the American Academy of Pediatrics).
- **Infant Mental Health consultation** (provided by the Illinois Children’s Mental Health Partnership, housed at Voices for Illinois Children).
- **4P’s Plus substance abuse and other risk screening** (training and support provided by Dr. Ira Chasnoff).
- **Sustainability strategies** (beyond the MIECHV grant period).

Research, evaluation, and continuous quality improvement are vital components of MIECHV, which has 6 federal benchmarks with 37 constructs. Illinois MIECHV has three main research and data components:

- **Illinois benchmark evaluation** led by the Center for Prevention Research and Development (CPRD) at the University of Illinois at Urbana-Champaign.
- **MIHOPE, a federal research project** including randomized control trials in the Southside Cluster, Elgin, Macon County and Vermilion County, led nationally by MDRC and conducted in Illinois by Mathematica Policy Research. (In the randomized trials, eligible families are either referred to MIECHV home visiting services or another type of social service that does not include home visiting.)
- **CQI (continuous quality improvement)** at the state and local levels, coordinated by CPRD.

In state Fiscal Year 2014, MIECHV started supporting four additional “voluntary” Coordinated Intake communities to plan and implement Coordinated Intake among their local home visiting programs. These communities are:

- McLean, DeWitt, Piatt, and Woodford Counties
- Oak Park – River Forest
- Peoria and Tazewell Counties
- Stephenson County

For more information about MIECHV, please see [Appendix A – HRSA MIECHV Overview](#).

Coordinated Intake Overview

At the outset of the program, the State provided guidance to the MIECHV pilot communities regarding Coordinated Intake, as summarized below:

What is Coordinated Intake?

- Coordinated Intake is a collaborative process that provides families with a single point of entry for home visiting programs within a neighborhood, community, city, town, suburb, or county.
- Trained Coordinated Intake workers serve as a hub for home visiting, assessing families' needs, referring them to an appropriate home visiting program, and tracking what happens to the referrals.

What are some benefits of Coordinated Intake?

- Families have a single point of entry for a variety of local home visiting services.
- Home visiting programs will be able to collectively track what happens to each family and can minimize duplication of services.
- Some or all of the recruitment and intake functions can be transferred from home visiting programs to Coordinated Intake workers.

Who are the key partners that are involved in Coordinated Intake?

- Local home visiting programs.
- A designated Coordinated Intake agency (this can be an agency with home visiting programs or without home visiting programs).
- Other early childhood and social service programs that can refer families to home visiting.

Why is Illinois promoting Coordinated Intake?

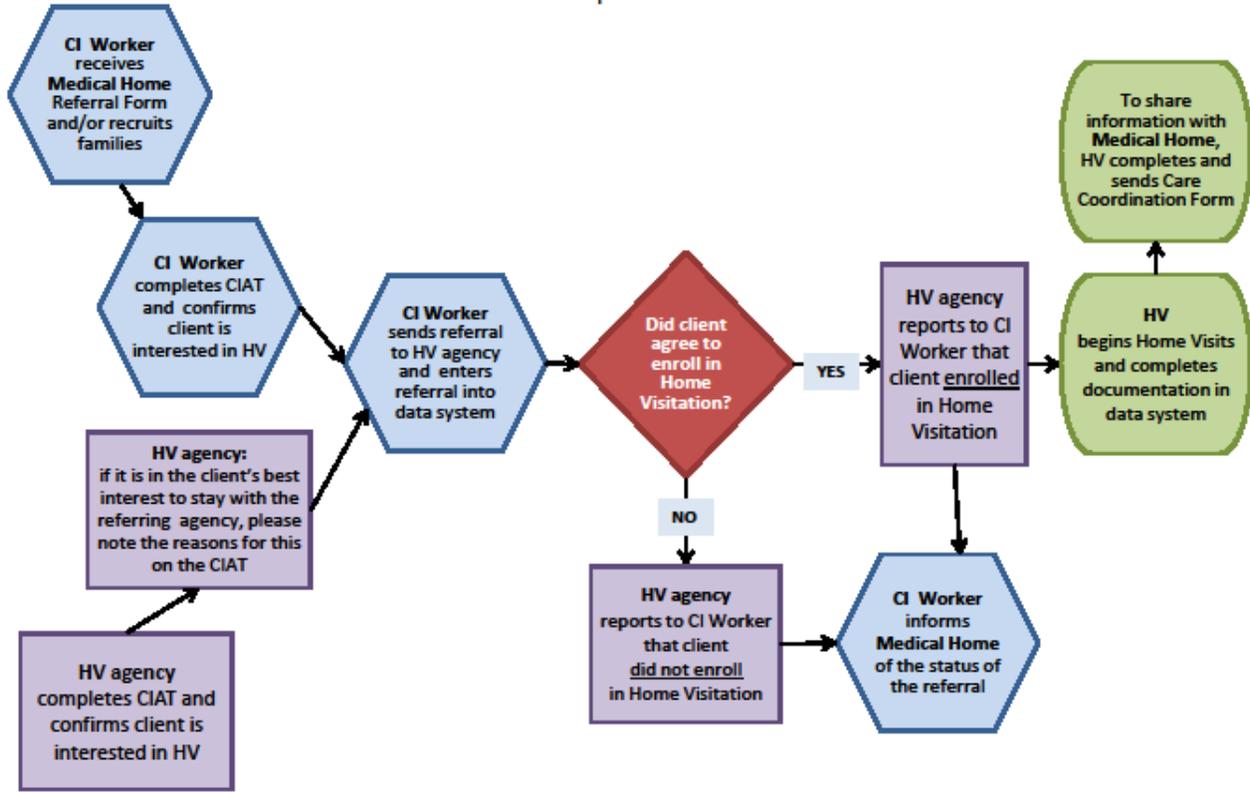
- Indications are that Coordinated Intake will be part of future federal home visiting funding streams.
- The State's long-term vision is for Coordinated Intake to act as the single point of entry for all home visiting programs statewide.
- The State has piloted Coordinated Intake in six communities funded by MIECHV, and is seeking to expand Coordinated Intake into other communities who are willing to participate on a voluntary (unpaid) basis.

Coordinated Intake and the Home Visiting Referral Process

- Coordinated Intake workers should serve as the repository for all home visiting intakes, and should track what happens to each referral.
- Referrals to home visiting can be generated from Coordinated Intake workers, from home visiting providers, or from other service providers and programs.
- To determine a family's eligibility for home visiting programs, we worked with the University of Illinois' Center for Prevention Research and Development to create the Coordinated Intake Assessment Tool (CIAT), which includes screening for a variety of risk factors. (The CIAT can be modified to include additional information as needed.)
- Agency self-referrals are allowed: a home visiting program may generate a referral to its own program, as long as it completes the CIAT and sends the CIAT to the Coordinated Intake worker for processing.
- Referrals can be generated solely through Coordinated Intake workers, through each home visiting agency (including internal or self-referrals), or through a combination of the two (see "Coordinated Intake Flow Chart" on the following page).
- Regardless of the originating source, all referrals must be processed by Coordinated Intake.
- All referrals received by Coordinated Intake workers should be sent to the appropriate home visiting program within two business days.

Coordinated Intake Flow Chart for Illinois Home Visiting Programs

April 2013



Role of Coordinated Intake Workers

- The role of Coordinated Intake workers is to assist families by determining the services and supports that are best suited for the family's particular needs, based on self referrals and referrals from other sources such as primary care providers, hospitals, child care providers, and other service providers.
- The Coordinated Intake agency should convene or participate in regular meetings of a community collaborative to discuss challenges, barriers, and successes of Coordinated Intake. The community collaborative can be a pre-existing coalition or network, and should include home visiting agencies and other stakeholders who refer families to home visiting, such as early childhood programs, health care providers, and social service agencies.
- A level of trust is inherent for the Coordinated Intake worker to develop and promote their role within the community and home visiting system. While input into this role should be discussed by the collaborative, day-to-day functions of both positions are overseen by their agency's chain of command, not by the collaborative.

Coordinated Intake Expectations

- The Coordinated Intake process should have full buy-in and support from all levels of management.
- Agencies are expected to support families that are already enrolled in another home visiting program by not making attempts to enroll them in their own home visiting programs.
- We expect that all participating agencies and programs will act in the spirit of full and transparent collaboration, with no holding back of referrals or unfairly distributing cases across agencies.

Recommended requirements for Coordinated Intake workers include:

- A basic understanding of the home visiting models in the community
- Ability to communicate effectively with multiple community partners, families and colleagues
- Must be able to serve as a liaison to referral sources, families, team members, and community agencies
- Excellent problem solving skills
- Good oral and writing skills
- Proficiency in computer programs, such as Microsoft Office (Word, Excel)
- Proficiency with database management

Please also see the following Appendices:

- *Appendix B: Coordinated Intake Assessment Tool (CIAT)*
- *Appendix C: Sample Coordinated Intake Worker job description*

Coordinated Intake: Community Level Implementation

While each of the pilot communities was provided with the guidance described in the previous section, they were given flexibility in implementation. The table below summarizes the key features, successes, and challenges for each community that is currently implementing Coordinated Intake (a few other communities are in the planning process, but have not yet begun implementation).

Community	CI Agency	Key Features	Successes	Challenges
Southside Cluster	Children's Home + Aid	<ul style="list-style-type: none"> • One of the CI workers has previous experience as a direct service provider. • HV agencies and CI workers recruit families. • COFI has trained parent ambassadors who also refer families to CI. • Referring agencies fill out basic eligibility information and send to CI worker. • CI also completes intakes in person (at community events and program sites, including health care provider offices) and on the phone. 	<ul style="list-style-type: none"> • Referrals are coming in from medical providers and parent ambassadors. • HV programs are usually at least 85% full, depending on case weights. 	<ul style="list-style-type: none"> • MIHOPE randomization has discouraged some medical providers from referring. • Barriers in partnering with WIC, FCM, other DHS/MCH providers, who are scattered throughout the area.
Cicero	Family Services Mental Health Center	<ul style="list-style-type: none"> • CI workers are master's level therapists. • CI workers complete all intakes in person, including health care provider offices and the families' homes. • CSD actively supports CI and HVs in directly finding referral options for families with needs beyond HV services. 	<ul style="list-style-type: none"> • HV programs are usually at least 85% full. • Referrals are coming in from medical providers. • Agency is experimenting with CI conducting mental health assessments (when a need is indicated), and billing Medicaid. 	<ul style="list-style-type: none"> • Agency is in the process of expanding CI outreach to reach more participants. • School District has been slow to collaborate, citing its prior involvement with a teen parenting program.
Elgin	Kane County Health Dept	<ul style="list-style-type: none"> • HV agencies, other agencies, and CSD worker recruit families. • CSD has trained parent ambassadors who will also refer families to CI. • Referring agencies fill out basic eligibility information and send to CI worker. • CSD (a former EHS HV) also completes some intakes in person at various community locations. 	<ul style="list-style-type: none"> • From the outset, CI referred to non-MIECHV and MIECHV HV programs. • Detailed monthly CI transparency reports provide data on incoming and ongoing referrals to each site. 	<ul style="list-style-type: none"> • Elgin is using multiple strategies to overcome barriers in reaching prenatal participants, including iGrow ads, video testimonies, and referral incentives. • HV turnover at some sites. • Barriers in partnering with some WIC/FCM/DHS sites, which are scattered throughout the area.

Community	CI Agency	Key Features	Successes	Challenges
Rockford	Winnebago County Health Dept	<ul style="list-style-type: none"> • CI worker is cross-trained to screen for WIC, FCM, and other state-funded MCH programs as well as home visiting. • CI worker sees all new WIC families and completes intakes in person at the HD. • MIECHV and non-MIECHV HVs from all partner agencies were cross-trained to recruit prenatal and parenting clients following WIC classes led by the CI worker. 	<ul style="list-style-type: none"> • Successful integration of CI with WIC, FCM, and DHS MCH programs. • Opportunity for HVs to have direct contact with families and answer questions prior to enrollment. 	<ul style="list-style-type: none"> • Home visitors are not always available for all WIC nutrition classes; there are missed opportunities. • The collaboration is developing alternative strategies to reach prenatal participants who do not come to the HD, including Latina teens.
Macon County	Macon County Health Dept	<ul style="list-style-type: none"> • CI worker is a former HV (HFI model). • CI worker receives weekly referral list from WIC/FCM. • CI worker conducts intakes in person and over the phone. 	<ul style="list-style-type: none"> • Creation of “iGrow” materials has raised the local profile of home visiting; other MIECHV communities have adopted the iGrow brand and materials. • Partnership with WIC/FCM has resulted in a constant large influx of referrals. • Participation in the collaborative has greatly improved the lines of communication between partnering agencies. 	<ul style="list-style-type: none"> • Challenges in engaging WIC/FCM families –the large volume means that a lot of these contacts are on the phone rather than in person, and the HD is experimenting with in-person CI intakes at various points during WIC appointments. • Barriers in engaging some school districts that do not want to acknowledge teen pregnancy. • HV turnover rate is high. • High rate of turnover at one of the funded home visiting agencies posed a particular challenge for referring partners.
Vermilion County	Aunt Martha’s/ Center for Children’s Services	<ul style="list-style-type: none"> • CI worker completes all intakes in person, at various program sites, community events, and at families’ homes. 	<ul style="list-style-type: none"> • Strong connections with local health care sites. • CI regularly refers families to a wide variety of programs in the county (not just HV). 	<ul style="list-style-type: none"> • Transitions in the CSD agency contributed to difficulties in coordination and communication. • Need to expand outreach and referral relationships to reach rural areas of the county and nontraditional partners.

Community	CI Agency	Key Features	Successes	Challenges
McLean, DeWitt, Piatt, and Woodford Counties	Children’s Home + Aid	<ul style="list-style-type: none"> • In the planning phase. • Workers in each participating HV agency use the CIAT to complete intakes in person at various program sites. 	<ul style="list-style-type: none"> • Most home visiting programs and other key partners, including the Health Department, are consistently coming to the table. 	<ul style="list-style-type: none"> • Some programs remain unsure why Coordinated Intake would be better than having each program recruit their own families. • Some rural school districts have not yet been able to actively participate.
Oak Park – River Forest	Parenthesis	<ul style="list-style-type: none"> • The CI agency also is the sole provider of HV services in the area. • Additional fields were added to the CIAT in order to better determine which HV program would be the best fit for the family. 	<ul style="list-style-type: none"> • Key referral partners, including a broad range of social service and safety net providers, are meeting monthly to review referrals and give feedback. 	<ul style="list-style-type: none"> • Starting up without an electronic data system has presented some challenges to tracking referrals.
Peoria and Tazewell Counties	Children’s Home Association	<ul style="list-style-type: none"> • In the planning phase. • It is envisioned that HVs will complete CIATs and send them to the CI worker to make referrals to HV and track data. • County HDs are discussing a possible online process that would send referrals to the CI worker. 	<ul style="list-style-type: none"> • Key partners are meeting monthly to plan for CI. • County Health Departments are actively supporting this process. • Marketing with the iGrow “brand” is underway. 	<ul style="list-style-type: none"> • Decision-makers from some local HV programs are not yet fully engaged.
Stephenson County	Stephenson County Health Dept	<ul style="list-style-type: none"> • Three Family Case Managers have been trained to conduct the CIAT and are screening all pregnant women and those with a new infant (through initial WIC appointments and FCM appointments). 	<ul style="list-style-type: none"> • Helps families become aware of program choices in the community. • Partners with the AOK Network by referring interested parents to Parent Cafes. 	<ul style="list-style-type: none"> • Manual data entry and reporting is a challenge. There is interest in following up with families who declined services to find out why.

Effective Practices

We have identified the following as best practices from our work with the pilot MIECHV communities:

- **Family Engagement**
 - Hiring Coordinated Intake Workers with previous home visiting experience and putting the Coordinated Intake Worker in close engagement with local home visitors led to more effective engagement and clearer communication with families.
 - Conducting in-person intakes (rather than over the phone) was more effective in building rapport with families.
- **Sustainability and Integration**
 - Cross-training Coordinated Intake Workers to screen for home visiting as well as other MCH programs (such as Family Case Management, WIC, and Better Birth Outcomes) was an efficient way of integrating Coordinated Intake within Health Departments.
 - Having appropriately trained Coordinated Intake Workers conduct mental health assessments (for families with the indicated risk factors) and billing Medicaid for these assessments is one promising practice to support sustainability.
- **Public Awareness**
 - The iGrow “brand” and clear, positive messaging about home visiting have increased public awareness among families, referral partners, and other community providers.
 - Video testimonies by families who have “graduated” from home visiting are another promising means for dispelling myths and normalizing home visiting services.
- **Professional Development and Support**
 - Regular Learning Communities for Coordinated Intake Workers and Community Systems Development Workers provided important avenues for peer support and the sharing of best practices and problem-solving approaches.
 - Housing the Coordinated Intake and Community Systems Development positions in the same agency and/or having joint supervision meetings with the two staff has led to stronger coordination of work with the partner agencies.

Year Two Data

Screening and Enrollment:

During the second Federal Year of MIECHV (October 1, 2012 through September 30, 2013), 2,552 families were screened for home visiting in the six formula grant-funded communities, and 528 of these families were subsequently enrolled in home visiting services during that year.

We did not ask agencies to provide a detailed breakdown of the reasons why the remaining families were not enrolled. Anecdotally, these reasons included: some families declined home visiting, some families were randomized into the MIHOPE control group, a few families may not have been eligible for local programs (due to geographic or other reasons), and in some cases, slots were full and families were added to the waitlist.

Characteristics of MIECHV families served during Year Two include the following:

- 50% of families enrolled in home visiting prenatally;
- 41% of primary caregivers were African Americans, 34% were Hispanic, and 29% were white;
- 90% of pregnant enrollees and 69% of other female caregivers were covered by Medicaid;
- 99% of families are at or below 100% of the federal poverty level;
- 73% of primary caregivers had a high school diploma/GED or less; and
- 72% of primary caregivers were unemployed.

Caseloads:

On June 30, 2014, the MIECHV caseload statewide was 85% full, with variations across communities and programs.

Referral agencies:

Between Year One and Year Two, the pilot communities increased the total number of referral agencies from 93 to 148, an increase of 59%. As defined in the MIECHV benchmarks, referral agencies are agencies for which a specific contact person has been identified for the purpose of making referrals. During the same period, the pilot communities increased the number of signed MOUs with referral partners from 35 to 103, an increase of 194%.

Limitations of the data and the previous data system

Unfortunately, the State's initial MIECHV data system did not meet our needs, and in the spring of 2013, months before our second annual federal report was due to HRSA, we switched to Visit Tracker. Our first priority with Visit Tracker was to fully build out the MIECHV benchmarks for home visiting and the required federal reports (which did not include implementation details of Coordinated Intake). Now that these tasks have been largely completed, the data contractor is in the process of building out Coordinated Intake, which is a wholly new function of the database, and has required more time than originally anticipated. Meanwhile, the State has established an interim form for tracking referrals to and from of Coordinated Intake (please see [Appendix D](#), which is a work in progress).

Initial Implementation Barriers

During the start-up phase, there were some initial barriers that were addressed as follows:

Barrier	Action
<p>Some Coordinated Intake workers did not have a background in early childhood or home visiting.</p>	<p>The MIECHV State Team worked with communities to ensure that the Coordinated Intake workers had the opportunity to meet with each local home visiting program, “shadow” local home visitors (with advance permission from the home visitor and family). Coordinated Intake workers were invited to enroll in the same trainings that were required of home visitors.</p> <p>Coordinated Intake workers are also encouraged to attend bi-monthly Learning Communities to share information and best practices with their Coordinated Intake and Community Systems Development peers. Co-facilitated by the Ounce and members of the State Team, the Learning Communities included sessions that enabled Coordinated Intake workers to share how they approach families and to receive constructive feedback from their peers.</p>
<p>In some communities, local turf issues led to questions about whether Coordinated Intake agencies were fairly referring families to all HV partners.</p>	<p>The MIECHV State Team provided sample monthly transparency reports (first developed by the Elgin community) for Coordinated Intake agencies to use, showing how many referrals came in from and out to each agency. The MIECHV State Team also helped facilitated some dialogues between the partner agencies to open up communication.</p>
<p>Some communities were hesitant to collect sensitive risk factor information from families at the outset (questions that are on the CIAT), especially when parents were involved in recruitment.</p>	<p>MIECHV is allowing these communities to use a shortened version of the CIAT (essentially the first page of the current CIAT form). When the CIAT and the Coordinated Intake function are built into the MIECHV electronic data system (Visit Tracker), we will re-standardize the use of the CIAT and will re-train community providers.</p>
<p>MIHOPE randomization presents a barrier to partnering with outside agencies; if an agency refers families to home visiting and the family is randomized into the control group (does not receive home visiting services), the agency may decide it is not worthwhile to refer additional families.</p>	<p>The MIECHV State Team has shared this concern with the MIHOPE researchers. MIHOPE has made online videos and other materials available to help communities explain MIHOPE and its importance to our community partners. While this is an important barrier, there may be little that Illinois can do to ameliorate this situation. Illinois was selected as a MIHOPE State, and four sites in our state are required to participate in MIHOPE as a condition of our receiving federal funding.</p>

Current Challenges and Strategies

Current barriers, along with program- and systems-level strategies to address them, are described below.

Challenges	Program Level Strategies	System Level Strategies
<p>Communities with a primary, fixed single-entry point for Coordinated Intake (such as WIC/FCM) are missing families who do not choose to use these services or who may be hesitant to seek services from a governmental agency (due to immigration status or other concerns).</p>	<p>The MIECHV State Team is recommending a mixed approach at the community level that not only includes key points of entry, but also includes active outreach through creative venues (religious institutions, ethnic associations, park districts, libraries, outreach events, etc.).</p>	<p>Macon County’s home visiting partners worked with a local marketing firm to develop the “iGrow” brand for home visiting, which was used in a widespread marketing campaign including posters, brochures, outdoor and indoor banners, billboards, and transit ads. The iGrow campaign has since been expanded to include other MIECHV communities.</p>
<p>Communities whose Coordinated Intake workers are not housed in WIC/FCM provider agencies are having difficulty partnering with these programs (which have the potential to refer many at-risk families to home visiting).</p>	<p>DHS administrators directly contacted a few local MCH providers to assure them that this level of collaboration was both desired and supported; a more systemic policy solution is needed to address this situation statewide.</p>	<p>OECD continues to work in partnership with DHS MCH program administrators to streamline transitions between MCH and home visiting programs, and to clarify expectations and requirements at the provider level. Pilot programs are being explored in selected communities.</p>
<p>One community (Elgin) was experiencing particular challenges in recruiting and engaging prenatal families for its NFP and HFI programs.</p>	<p>The Elgin MIECHV team conducted a survey of families who declined home visiting and found that 50% of respondents did not feel they needed home visiting services. In response, the Elgin group created video testimonials from English and Spanish speaking parents who had graduated from home visiting. DVDs are being shown to referral partners, and are available for playback in waiting rooms and other venues.</p>	<p>While part of this issue reflected a need for improved public awareness about home visiting, it may also reflect an overlap of multiple programs serving the same target population. State funders of home visiting are working on a statewide map of the areas currently served by home visiting, and the funders have agreed to work together to improve future joint planning of services statewide.</p>
<p>Some communities have had challenges in developing partnerships with local home visiting programs that are not funded by MIECHV.</p>	<p>In one community, the Coordinated Intake Worker and the non-MIECHV home visiting program piloted joint visits with eligible families to introduce them to home visiting. The Community Systems Development Worker facilitated a subsequent meeting with all of the home visiting programs to clarify program descriptions and eligibility.</p>	<p>The state funders of home visiting are continuing to work together on better aligning their requirements and expectations of providers, so that a unified message can be shared with all home visiting programs, regardless of state funding source. This process is starting with a shared vision statement and guiding principles to be released in fall 2014.</p>

Challenges	Program Level Strategies	System Level Strategies
<p>Across the board, communities have had difficulty getting MOUs or otherwise partnering with birthing hospitals, even though this would be a natural point of entry for home visiting.</p>	<p>We are recommending that communities go through hospitals' medical social work departments as an initial point of contact.</p>	<p>Through the MIECHV Technical Assistance Coordinating Center, we know that some other states have been successful in building strong partnerships with hospitals. Through the Home Visiting Task Force's Sustainability Work Group, we are identifying the best ways to reach hospital administrators and managed care Accountable Care Entities, to make the case that home visiting will help reduce their costs. We are also exploring partnerships through DHS MCH programs that are already working with selected hospitals.</p>

In summary, the experience of MIECHV pilot and "voluntary" Coordinated Intake communities has led to:

- improved guidance from the State Team;
- local best practices which have been shared with other communities; and
- identification of systems issues which are being addressed by state agencies and state funders of home visiting.

We consider this part of our continuous quality improvement cycle that uses data and feedback from our sites to improve both the MIECHV program and our state systems as a whole.

Recommendations

Two years of Coordinated Intake efforts and innovations at the community level has shown us that each community has stronger connections with some service providers and weaker connections with others. We have found that the quality and depth of these connections depend largely on the level of buy-in of individual organization or program directors rather than an intentionally unified statewide approach. In response, GOECD recommends two targeted “universal” strategies for reaching vulnerable families prenatally or shortly after the baby’s birth.

1. **“Universal” prenatal strategy: WIC/FCM/BBO as an intake point for home visiting**

We recommend the universal screening of prenatal WIC/FCM/BBO families for home visiting (with dual enrollment during a transition period or when otherwise appropriate). OECD and DHS have already been discussing possible strategies along these lines and would like to see pilot projects develop in this direction, with the aim of making improvements statewide.

2. **“Universal” post-natal strategy: birthing hospitals and centers as an intake point for home visiting**

Since we know that not all vulnerable parents will seek out WIC/FCM/BBO programs, we also recommend coordinated outreach to families through birthing hospitals and centers. We recognize that there are barriers to developing such partnerships with hospitals, and we also realize that new parents are already inundated with overwhelming amounts of information immediately after a baby’s birth. OECD recommends that a Work Group be convened to address this strategy.

In addition to the above “universal” strategies, we recommend that home visiting providers continue to take an **“All Families Served”** approach to outreach. Even if the above prenatal and postnatal strategies are fully implemented, there will still be some vulnerable families who are missed (for example, those who do not seek out WIC and leave the hospital without reading or receiving information about home visiting). To maximize the opportunity to reach these families, there must be an additional community strategy that includes a wide spectrum of organizations and associations. To this end:

- a. We support the ongoing work of the Race To The Top--Early Learning Challenge’s Consortium for Community Systems Development. The Consortium is developing a strategic plan to develop infrastructure, guidance, and technical assistance for local community collaborations, which should include home visiting programs as well as a wide variety of community providers, parents, and other stakeholders, so that early childhood messages permeate local communities as widely as possible.
- b. We encourage all collaborations to use and disseminate iGrow materials and home visiting video testimonials in addition to utilizing other public awareness strategies.

When implemented with these strategies, Coordinated Intake can be an important mechanism for linking together a **continuum of services** from birth to eight, and ensuring that **seamless transitions** are made, including transitions between home visiting and high quality early learning programs.

For more information, please contact:

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APPENDIX A: The Affordable Care Act

MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) (P.L. 111-148). It authorized the creation of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, which facilitates collaboration and partnership at the federal, state, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

The program is designed to (1) strengthen and improve the programs and activities carried out under Title V of the Social Security Act; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

MIECHV includes grants to states and six jurisdictions; and grants to Indian Tribes, Tribal Organizations, and Urban Indian Organizations. The legislation requires that grantees demonstrate improvement among eligible families participating in the program in six benchmark areas:

- Improved maternal and newborn health;
- Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits;
- Improvement in school readiness and achievement;
- Reduction in crime or domestic violence;
- Improvements in family economic self-sufficiency; and
- Improvements in the coordination and referrals for other community resources and supports.

MIECHV is an evidence-based policy initiative and the authorizing legislation requires that at least 75 percent of grant funds be spent on programs to implement evidence-based home visiting models. Currently, thirteen home visiting models meet the HHS criteria and are eligible for the 75 percent funding. Additionally, up to 25 percent may be spent on promising approaches that must be rigorously evaluated. (For more information on the evidence-based models, please see <http://homvee.acf.hhs.gov/>.)

The MIECHV program includes \$1.5 billion in funding during Fiscal Years 2010-2014, including a three percent set-aside for grants to tribal entities and a three percent set-aside for research and evaluation, including a required national evaluation: \$100 million in FY 2010; \$250 million in FY 2011; \$350 million in FY 2012; \$400 million in FY 2013; and \$400 million in FY 2014. Grants to states are subject to the condition that the state gives service priority to families residing in at-risk communities as identified by the statewide needs assessment. The program is administered by the Maternal and Child Health Bureau, Health Resources and Services Administration, and the Administration for Children and Families (ACF).

The Tribal MIECHV program, administered by ACF, mirrors the state program to the greatest extent practicable. The goal of the program is to support the development of happy, healthy, and successful American Indian and Alaska Native children and families through a coordinated home visiting system.

Priority populations were identified as those eligible families that: (A) reside in communities in need of such services, as identified in the statewide needs assessment; (B) have low-income; (C) include pregnant women who have not attained age 21; (D) have a history of child abuse or neglect, or those who have had interactions with child welfare services; (E) have a history of substance abuse, or need substance abuse treatment; (F) have users of tobacco products in the home; (G) have a history of, or have children with low student achievement; (H) have children with developmental delays or disabilities; and (I) include members of the military.

For further information on the MIECHV program, please visit: <http://www.mchb.hrsa.gov/programs/homevisiting> and <http://www.acf.hhs.gov/programs/occ/initiatives>. To learn more about the Affordable Care Act, visit www.HealthCare.gov.

The Health Resources and Services Administration (HRSA), part of the U.S. Department of Health and Human Services, is the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. For more information about HRSA and its programs, visit www.hrsa.gov.

With the mission of promoting social and economic well-being, the Administration for Children and Families (ACF) administers more than 60 programs with a budget of more than \$51 billion, making it the second largest agency in the U.S. Department of Health and Human Services. Our broad range of programs--which include family assistance, Head Start, child welfare and other programs for families and children--share an overarching goal: to help people in need achieve the American dream of prosperity, good health, independence, and bright futures for their children. For more information, please visit <http://www.acf.hhs.gov/>.

Appendix B: Illinois Home Visiting Coordinated Intake Assessment Tool (CIAT)

A Home Visiting program uses trained home visitors to provide direct services to pregnant women or children from birth to age 5. Home Visiting services are free and voluntary. Home Visitors are professionals who have received background checks as well as extensive training in subjects *related* to child development and family strengthening. All Home Visiting services are confidential.

Parent's level of interest in home visiting: Very Interested Interested Unsure

Today's Date: _____

Name of Person completing CIAT: _____

Agency Name: _____

Phone Number: (____) _____ - _____

Fax Number: (____) _____ - _____

Email Address: _____

PARENT INFORMATION

First Name: _____ Last Name: _____ MI: _____

Date of Birth: ___/___/___ Age: _____ Gender: Female Male

Street Address: _____ Apt. #: _____ City/State/Zip: _____

Home Number: (____) _____ - _____ Work Number: (____) _____ - _____

Mobile Number: (____) _____ - _____ **May we text your mobile phone?** Yes No

Email Address: _____

Best time to reach by phone: Morning (8am-12pm) Afternoon (12-5pm) Evening (5-8pm)

Primary language spoken: English Spanish Other: _____

Who can we contact if we cannot reach you using the above contact information?

Name: _____ Phone Number: (____) _____ - _____

Relationship: _____ Alt. Phone Number: (____) _____ - _____

<p>If client is pregnant: Date of expected delivery: ___/___/___ Number of weeks pregnant: ___ wks Current trimester: <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd Is she a: <input type="checkbox"/> 1st time <input type="checkbox"/> 2nd time <input type="checkbox"/> 3rd+ time mom Start date of prenatal care: ___/___/___</p>	<p>If client has an infant/child: Child's Name: _____ DOB: ___/___/___ Age: _____</p>
<p>Client's ethnicity: Is client Hispanic or Latina/o? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Client's race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> More than one race</p>	<p>Client's highest grade of school completed: _____</p> <p>Health insurance coverage: <input type="checkbox"/> None <input type="checkbox"/> Military (TriCare) <input type="checkbox"/> Public (Medicaid, Medicare, AllKids) <input type="checkbox"/> Private (e.g. HMO)</p>
<p>Plan of Care: (please check ALL that apply) <input type="checkbox"/> Referral to Home Visitation <input type="checkbox"/> Referral to other services: _____</p>	<p>Services client is receiving: <input type="checkbox"/> WIC/ SNAP/ TANF <input type="checkbox"/> SSI/ SSD <input type="checkbox"/> FCM/Better Birth Outcomes</p>

I agree to release information between the following agencies in order to assist in providing the most appropriate services for my family: _____ . I understand that I may be contacted if more information is needed. If referrals are needed under the Plan of Care section above, I give my permission to share my information with programs that provide those services and I understand I may be contacted by staff from those programs.

 Signature Date

OPTIONAL: Family and Household Information

The next few questions will ask for some more information about your family and household. This will help us identify the program that could best fit your needs.

1. Total number of children: 1 2 3 4 5 or more

- a. The target child/ youngest child’s DOB, age, and name are listed on page 1 (do not list this child again here).
- b. 2nd child DOB: ___/___/___ Age: _____ Name: _____
- c. 3rd child DOB: ___/___/___ Age: _____ Name: _____
- d. 4th child DOB: ___/___/___ Age: _____ Name: _____
- e. 5th child DOB: ___/___/___ Age: _____ Name: _____

2. Level of involvement of the children’s father:

- Very involved Somewhat involved Not involved

- 3. CUSTOM FIELD 1 (optional - as designated by the VT Site Administrator, per the agreement of that community)
- 4. CUSTOM FIELD 2 (optional - as designated by the VT Site Administrator, per the agreement of that community)
- 5. CUSTOM FIELD 3 (optional - as designated by the VT Site Administrator, per the agreement of that community)
- 6. CUSTOM FIELD 4 (optional - as designated by the VT Site Administrator, per the agreement of that community)
- 7. CUSTOM FIELD 5 (optional - as designated by the VT Site Administrator, per the agreement of that community)

Appendix B: Illinois Home Visiting Coordinated Intake Assessment Tool (CIAT)

STRONGLY RECOMMENDED: Screening Assessment

The next few questions may be sensitive. We are asking these questions so that we can determine the best possible services for you and your family. Many parents have experienced these issues, and we have been able to refer them to home visiting or other services to help support them. This information is confidential and will only be shared with any referral agencies that we contact on your behalf. You may decline to answer any of these questions. May I continue?

	Priority Population Categories	Risk Factor ?	Declined to answer	Did not ask
1	Transportation barriers: <i>How do you usually get to appointments or errands?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	No regular source of health care: <i>Do you have a regular clinic or doctor that you go to for health care?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	First time mother: <i>see page 1 (VT: auto-fill from page 1)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Teen mother (under age 21): <i>see page 1 (VT: auto-fill from page 1)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Low income: <i>see page 1 - does client receive public benefits?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Family with current or former military members: <i>Has anyone in your household served in the military?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	<u>User of tobacco products in home:</u>* <i>Does anyone in your household smoke cigarettes?*</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Low student achievement: <i>Do you perceive yourself or any of your children as having low student achievement?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Any child in the home with developmental delays or disabilities: <i>In school, did you or any of your children have an Individual Education Plan (IEP) for special education services?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	<u>History of alcohol or substance abuse or need for treatment:</u>* <i>A lot of families struggle with alcohol or substance abuse. Is this something that is a concern for you, either now, or in the past?*</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	History of child abuse/neglect or involvement with child welfare services: <i>Some families have been contacted by the Department of Children and Family Services (DCFS) due to worries about their children's welfare. Has this ever happened to your family?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Housing instability: <i>Many families are worried about having stable housing. Is this a concern for your family?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	<u>Depression/anxiety or mental health concerns:</u>* <i>Things can be stressful for families, especially for new parents and young parents. Have you been feeling down, depressed, or hopeless?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Lack of support system: <i>Do you have friends or family who would be able to help out if needed?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Relationship or family problems: <i>How is your relationship with your family or your husband/boyfriend/partner?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	<u>Domestic or family violence:</u>* <i>One out of four women in the U.S. report ever experiencing physical or sexual violence, and pregnant women are especially vulnerable. May I ask if your husband, boyfriend, or partner has ever threatened to hurt you or punish you?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

***If any of these four underlined risk factors are checked, if the client is pregnant or recently post-partum, and if you have been trained to deliver the 4P's Plus screening and intervention, please do so if appropriate, and attach a copy of the completed 4P's to this form.**

Appendix B: Illinois Home Visiting Coordinated Intake Assessment Tool (CIAT)

For Office Use Only:

Evidence-Based Home Visiting (HV) Options	Eligibility Criteria	Family Eligibility
Early Head Start- Home Based	Pregnant or child under 2 years and low income	☐ Y ☐ N
Healthy Families	Pregnant or within 2 weeks postnatal and a yes on a behavioral question or meets a priority population	☐ Y ☐ N
Nurse Family Partnership	1 st pregnancy, low income, and less than 28 weeks pregnant	☐ Y ☐ N
Parents as Teachers	Prenatal or a child up to age 3	☐ Y ☐ N

IF REFERRAL IS GENERATED FROM AN AGENCY OTHER THAN CI: FOR REFERRING AGENCY ONLY (Optional): Which Home Visiting program would you recommend and why? (We recognize that families may be eligible for more than one program. In order to help us understand your decision, please provide the rationale for recommending a specific home visiting program for this family: e.g., they met the criteria listed above, another family member is also being served by the program, or other reasons.):

FOR COORDINATED INTAKE ONLY: Which program was the family referred to, and why?

Appendix C: Sample Coordinated Intake Worker Job Description

Effective, collaborative community development and coordinated intake are essential components of the MIECHV structure for ensuring the best possible match of home visiting to meet the needs of families. As the first point of contact with families and other community agencies, the Coordinated Intake Worker (CIW) is responsible for representing the MIECHV community agencies, building relationships with potential program families and other families, and accurately referring families to the most appropriate community service.

The CIW provides a single point of entry for access, assessment and referral in a local area to family support services. The CIW gathers a brief screen from the family regarding their needs and strengths as well as the information necessary for referral. This enables the CIW to refer the family to the most appropriate support service based on their needs and the availability and requirements of the service.

Required Skills

- Minimum of [] years appropriate experience required
- Proficiency in computer programs, such as Microsoft Office (Word, Excel)
- Proficiency with database management
- Knowledge of the MIECHV requirements and a basic understanding of the evidence-based home visiting models associated with MIECHV
- Excellent problem solving skills
- Ability to communicate effectively with multiple community partners, families and colleagues
- Must be able to serve as a liaison to referral sources, families, team members, and community agencies
- Good oral and writing skills

Primary Job Responsibilities

- Accurately complete screening with families
- Interpret screens that are submitted by referral sources
- Track home visiting program capacity by agency (MIECHV & non-MIECHV)
- Utilize DCFS Service Provider Data Bases
- Maintain weekly contact with WIC Clinics and Family Case Management
- Refer 100% of positive screens to the most appropriate (for the client) home visiting provider within 24 hours and ensure screen is received by provider. If all home visiting providers are at capacity, refer to appropriate community resources and place client on waiting list for home visiting services. Waiting list clients will receive a minimum of a monthly contact to monitor availability of services and eligibility of client.
- Provide immediate referrals to community resources for 100% of clients presenting with emergency needs
- Refer 100% of negative screens to other community and parenting services as indicated
- Coordinate bi-weekly meetings of all participating home visiting agencies to ensure families received the best option for services, reduced duplications, consistent messaging, and a contingency plan for emergency referrals. This emergency service contingency plan

Appendix C: Sample Coordinated Intake Worker Job Description

will be included in the Memorandum of Understanding between the Home Visiting agencies and the Coordinated Intake agency.

- Conduct a minimum of 20 screens per month or 75% of target population, whichever is higher.
- Provide outreach to a minimum of four referral sources per month.
- On a quarterly basis, market home visiting services to all local junior high and high schools, local obstetricians and birthing centers, and prenatal clinics.
- Facilitate and organize quarterly collaborative meetings, including ATOD, mental health, domestic violence, basic need service providers, as well as service providers to parents with development delays, to discuss service referrals and follow through. Record and maintain agendas, attendance, and meeting minutes.

Appendix D: Coordinated Intake Monthly Referral Report Form

Coordinated Intake Monthly Referral Report Form
Updated 8/1/14

MONTH: _____ AGENCY NAME: _____

Type of Program	Name of Provider/Source	Program model, description, or name, if applicable	# of Referrals IN				# of Referrals made to HV	# of Referrals OUT							
			# of CIATs or referrals sent by the agency/ program to CI	# of families who could not be reached for follow-up	# of families who declined HV services	# of families who were not eligible for any known local HV program		TOTAL # of referrals made by CI to Home Visiting	# enrolled in MIECHV-funded HV slots	# enrolled in Non-MIECHV-funded HV slots	# referred but not enrolled (pending, etc.)	# added to HV Waitlist	TOTAL # of referrals to non-HV services (ESL, parenting classes, etc.)		
							this column will auto-calculate								
Home Visiting	Children's House	HFI					0								N/A
Home Visiting	School District 11	PAT					0								N/A
Home Visiting	Family Center	EHS					0								N/A
Home Visiting	Community Services	NFP					0								N/A
Home Visiting	Families Together	Baby TALK					0								N/A
HV SUBTOTAL:			0	0	0	0	0	0	0	0	0	0	0	0	0
CI/CSD Outreach/Activities															
Adult Education/ ESL	Children's House						0								N/A
DHS Local Office (FCRC)	DHS Office Name						0								N/A
Developmental Disab/ Del	Early Intervention provider						0								N/A
Domestic Violence	Safe House						0								N/A
Faith-Based Institution							0								N/A
Food Pantry							0								N/A
FCM/WIC	Local Health Dept						0								N/A
Health Care	Dr. Smith						0								N/A
Health Care	Access Community Health Center						0								N/A
Health Care	County Hospital						0								N/A
Health Care	Teen clinic						0								N/A
Homeless Service Provider							0								N/A
Housing	Housing Authority						0								N/A
Mental health							0								N/A
Parenting Classes	Family Center						0								N/A
PreK	School District 11						0								N/A
Schools							0								N/A
Families							0								N/A
Other Types of Referral Pa	Add any specific agencies here						0								N/A
Referrals made out of serv	All Out of Area Referrals						0								N/A
OTHER SOURCES SUBTOTAL:			0	0	0	0	0	0	0	0	0	0	0	0	0
GRAND TOTAL			0	0	0	0	0	0	0	0	0	0	0	0	0
			# of CIATs or referrals sent by the agency/ program to CI	# of families who could not be reached for follow-up	# of families who declined HV services	# of families who were not eligible for any known local HV program	# referrals made to HV								
			TOTAL # of referrals made by CI to Home Visiting	# enrolled in MIECHV-funded HV slots	# enrolled in Non-MIECHV-funded HV slots	# referred but not enrolled (pending, etc.)	# added to HV Waitlist								TOTAL # of referrals to non-HV services (ESL, parenting classes, etc.)