



**ISSUE BRIEF ON COORDINATED INTAKE: AN OVERVIEW AND ILLINOIS' EXPERIENCE WITHIN
THE EARLY CHILDHOOD HOME VISITING SYSTEM
September 2018**

EXECUTIVE SUMMARY

Given the multi-faceted needs of families during pregnancy and while raising young children—particularly for those experiencing risk factors, such as housing instability, poverty or geographic isolation—and of various service providers, it can be challenging to navigate the often complex and fragmented constellation of child- and family-serving systems (e.g. health care, education, child care, early intervention, mental health, social services) that impact a child's healthy development, educational attainment, and positive life outcomes. This is critical as research has demonstrated that high-quality early learning experiences and other interventions provided by child- and family-serving systems promote numerous benefits for young children and their parents.

One approach to address the fragmentation and lack of coordination among child- and family-serving systems—and to develop stronger connections and relationships among and within such systems—is the development and use of **coordinated intake**, which can be a conduit to help streamline a complex array of local services for a young child. Coordinated intake provides families with a single point of entry where their needs for support can be assessed and they can then be referred to the local services and programs that best fit the family's needs. Coordinated intake can exist within different child- and family-serving systems.

In Illinois, it is rooted within the state's early childhood home visiting system with referrals made to other services applicable beyond the home visiting system. A number of communities in Illinois are employing coordinated intake as a strategy to increase access to home visiting and other high-quality early childhood services, and to address, in part, the fragmentation and make better connections—at the local level—among service providers and systems. While it is in an early stage of implementation in Illinois, coordinated intake takes a community-centered and -focused approach with support from state infrastructure that is provided by the Governor's Office of Early Childhood Development.



While coordinated intake is not a silver bullet, it is worthy of continued and further exploration as a viable opportunity to address fragmentation, duplication of efforts, limited funding, and the challenges of access to services. It has the potential to strengthen and align key child- and family-serving systems that impact the lives of Illinois' most vulnerable children and to help advance Illinois' vision for early childhood: *Every child enters kindergarten safe, healthy, eager to learn, and ready to succeed*. The purpose of this Issue Brief is to provide a brief overview of coordinated intake and to describe Illinois' unique experience, including what it looks like, how it fits within a larger strategy, and the opportunities and challenges presented.

PREFACE & ACKNOWLEDGEMENTS

This Issue Brief is geared toward a variety of interested parties, including: public and private funders and potential funders of coordinated intake or home visiting; and potential community partners to a coordinated intake system. For more information about coordinated intake in Illinois, please contact:

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The Issue and the Opportunity . . .

All children benefit from high-quality early learning experiences, but the largest impact is for those children who experience risk factors.¹ A large body of research demonstrates that high-quality early learning and experiences promote the healthy development, educational attainment and positive life outcomes of young children, particularly for those who experience risk factors. Most notably, studies indicate that programs for young children and their parents can improve children’s physical health, socioemotional development and mental health, and school readiness skills and academic performance. These benefits have been shown to endure after the end of intervention and to provide a significant return on investment.² Moreover, research has shown a positive impact on parents as well in two-generation interventions, such as early childhood home visiting.³

Undergirding this work is recognition that a child is nested within their family, local community, and a constellation of child- and family-serving systems (e.g. health care, education, child care, early intervention, mental health, social services) that impact their healthy development, educational attainment and positive life outcomes. However, these child- and family-serving systems are often fragmented and may not act or function in an integrated or coordinated manner, and the landscape of child-serving systems is complex and can be challenging to navigate.

Given the multifaceted needs of families during pregnancy and while raising young children—particularly those experiencing risk factors—and various service providers, it can be a challenge to navigate the most appropriate services to best serve families. One approach to address this fragmentation is the development and use of **coordinated intake**.

¹ Within this context, the term “risk factors” consists of the whole spectrum of obstacles that parents, caregivers or guardians may face, such as housing instability, poverty, family violence, language barriers or geographic isolation.

² According to research by Professor James Heckman, a Nobel laureate in economics at the University of Chicago, investing in quality early learning programs is the most efficient way to affect school and life success and to reduce social expenditures later. Read more about Dr. Heckman’s work at heckmanequation.org.

³ Sama-Miller, E., Akers, L., Mraz-Esposito, A., Zukiewicz, M., Avellar, S., Paulsell, D., and Del Grosso, P. (2017). *Home Visiting Evidence of Effectiveness Review: Executive Summary*. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Washington, DC. Retrieved August 28, 2018 from:

https://homvee.acf.hhs.gov/homvee_executive_summary_august_2017_final_508_compliant.pdf

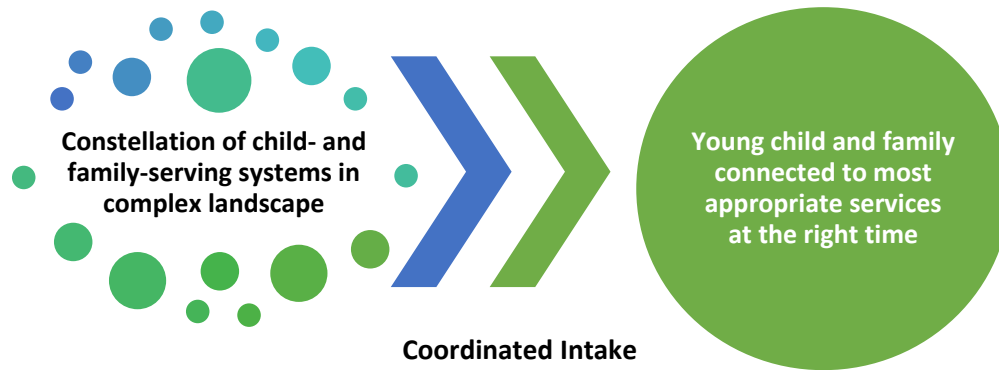


Figure 1. Coordinated intake can be a conduit to help streamline a complex array of local services for a young child.

Coordinated intake offers a central point of entry for determining needs for support and referrals to services, and can exist within different child- and family-serving systems. In Illinois, it is rooted within the state’s early childhood home visiting system with referrals made to other services applicable beyond the home visiting system. While it is in an early stage of implementation, coordinated intake in Illinois takes a community-centered and -focused approach with support from state infrastructure that is provided by the Governor’s Office of Early Childhood Development (GOECD).⁴ A number of communities in Illinois are employing coordinated intake as a strategy to increase access to home visiting and other high-quality early childhood services, and to address, in part, the fragmentation and make better connections—at the local level—among service providers and systems. By virtue of the local approach taken in Illinois, there are variations within the communities depending upon a number of factors (e.g. local collaborations formed or already in existence, number of community partners and their relationships) and each community looks a little different.

While coordinated intake is not a silver bullet, it is worthy of continued and further exploration as a viable opportunity to address fragmentation, duplication of efforts, limited funding, and the challenges of access to services. It has the potential to strengthen and align key child- and family-serving systems that impact the lives of Illinois’ most vulnerable children and help advance Illinois’ vision for early childhood: *Every child enters kindergarten safe, healthy, eager to learn, and ready to succeed.*⁵ The purpose of this Issue Brief is to provide a brief overview of coordinated intake within home visiting and to describe Illinois’ unique experience, including

⁴ To learn more about GOECD and its work, visit its website at:

<https://www2.illinois.gov/sites/OECD/Pages/default.aspx>

⁵ This is the vision of the Illinois Early Learning Council, a public-private partnership created by Illinois Public Act 93-380, that strengthens, coordinates and expands programs and services for children, birth-to-five, throughout Illinois. To learn more about the ELC, visit its website at:

<https://www2.illinois.gov/sites/OECD/EarlyLearningCouncil/Pages/default.aspx>

what it looks like, how it fits within a larger strategy, and the opportunities and challenges presented.

What is Coordinated Intake?

Coordinated intake⁶ provides families with a single point of entry where their needs for support can be assessed and they can be referred to local services and programs that best fit the family's needs.⁷ Coordinated intake staff conducts a brief screen of the family regarding their strengths and needs, and then refers them to the appropriate services based on availability and eligibility requirements of the service.⁸ This can eliminate duplication of services, improve access to services, and provide uniformity across programs since there is only one release of information, one screening process, and one process for referral and data tracking.

Coordinated intake can exist within different child- and family-serving systems. In Illinois, it is rooted within the state's early childhood home visiting system with referrals made to other services applicable beyond the home visiting system.

Coordinating services for families, generally, has demonstrated cost savings per provider, enhanced family engagement, and improved equity among low-income families due to the

Home Visiting is a dual-generation approach that supports parents, caregivers or guardians (as applicable) and children by nurturing strong parent-child relationships, promoting positive parenting practices, supporting parents in achieving life goals (e.g. education, employment), and connecting families to community resources.

Home visitors meet one-on-one with families in their home environment on a weekly basis (or as needed) to enhance parenting skills and support healthy child development. Visits can begin during pregnancy or after the child's birth and continue throughout the child's early years of life, with some models providing visits up to age 5 or kindergarten entry of the child. Families also participate in ongoing socialization activities where children of a similar age and their parents can interact with each other in a group setting.

Documented benefits of home visiting include:

- Improved maternal and child health outcomes
- Increased prevention of child injury and abuse
- Improved early literacy, language, problem-solving, and social-emotional skills
- Better school performance
- Higher high school graduation rates

To learn more about Illinois' home visiting system, see *Appendix A*.

⁶ While there are a number of terms used to describe this concept generally, including "coordinated intake", "central intake", "centralized intake" or "common intake", for purposes of this Issue Brief, the authors are using the term "coordinated intake".

⁷ Maternal, Infant and Early Childhood Home Visiting Technical Assistance Coordinating Center (MIECHV TACC) (2014). *MIECHV Issue Brief on Centralized Intake Systems*. Retrieved August 28, 2018 from https://www.greatstartgeorgia.org/sites/default/files/miechv_issue_brief_centralized_intake.pdf.

⁸ For example, some programs in Illinois use a Coordinated Intake Assessment Tool (CIAT), or some variation of it, when conducting an assessment. The CIAT can be accessed at: <http://igrowillinois.org/about-miechv/coordinated-intake-resources/>.

increased affordability of child care.⁹ Creating partnerships with larger organizations can help to improve program quality by making it easier for small community providers to meet quality standards, gather and report data, and offer a range of needed supports for children and families.¹⁰

Coordinated intake explores how to optimize the aligned interests of child- and family-serving systems through improved linkages between services (e.g. early childhood, health) in order to create better outcomes for the whole child. As a young child is nested within family, community and multiple systems, it is important to be cognizant of the potential benefits of coordinated intake to these multiple levels.



Figure 2. Coordinated intake can provide benefits at multiple levels.

⁹ Bartley, S., Lloyd, A., Dean, E., & Abu-Anbar, R. (2017). Piecing Together: Completing the Early Childhood System Puzzle in the District. DC Action for Children. Retrieved August 28, 2018 from https://www.dactionforchildren.org/sites/default/files/Piecing%20Together_FINAL_0.pdf.

¹⁰ Ibid

Benefits to child- and family-serving systems include:

- Building broader early childhood systems of care to meet comprehensive needs of children and their families; and
- Improved data collection through easier ability to track families and obtain data in order to identify gaps in services and areas of improvement.¹¹

Benefits to local communities include:

- Systematically improving coordination among programs may reduce costs and reduce duplication of effort (e.g. parents enrolled in multiple programs) within a community.¹²

Benefits to home visiting programs include:

- Reducing burden on programs to find participants to fill their caseloads;
- Reducing competition among providers;
- Programs receive families who meet their criteria and may be more likely a good fit for program, so enrollment and retention rates improve, which may help programs meet funding requirements; and
- Better identification of health risks (e.g. interpersonal violence, substance abuse, and maternal depression) which can be addressed either as part of a home visiting intervention or through a simultaneous referral to other services.¹³

Benefits to young children and their families include:

- Provides a central point of entry for families seeking early childhood services, particularly given that the initial engagement of families is critical;
- Helps families navigate an array of services and agencies;
- Helps educate families on what is available within their community; and
- Individual needs are better identified and families are more efficiently matched—in a more direct and expeditious way—to home visiting programs in the community.¹⁴

Certain challenges to achieving a successful coordinated intake system have also been identified, including funding (both at the onset and on-going), the importance of trust and good relationships amongst cooperating parties and providers, a need for training opportunities for coordinated intake staff, and a method to share data.¹⁵

¹¹ MIECHV TACC (2014).

¹² Ibid

¹³ Ibid

¹⁴ Ibid

¹⁵ MIECHV TACC (2014); Early Childhood Iowa – Quality Services and Programs Component Group (QSP Component Group) (2011). *Centralized Intake Best Practices Guide*. Retrieved August 28, 2018 from <http://igrowillinois.org/wp-content/uploads/2015/06/1- Coordinated Intake Best Practices - Iowa.pdf>

The structure and scope of a coordinated intake system may vary and there are some excellent resources on this topic.¹⁶ Some states, such as New Jersey and Delaware, use a statewide approach. Others have taken a more localized approach, including the coordinated intake framework for home visiting in Illinois. One of the reasons that coordinated intake for home visiting varies from state-to-state involves federal legislation and funding. Notably, the federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, which was established in 2010 and required coordinated intake, gave states latitude in deciding how to undertake coordinated intake. Other resources have identified excellent “best practices” related to coordinated intake¹⁷ and the purpose of this Issue Brief is not to duplicate those. Rather, the purpose is to tell Illinois’ story of coordinated intake, which continues to be a work in progress.

What does Coordinated Intake look like in Illinois?

In Illinois, a number of communities are employing coordinated intake as a strategy to increase access to home visiting and other high-quality early childhood services, and to address, in part, the fragmentation and make better connections—at the local level—among service providers and systems. While it is in an early stage of implementation, coordinated intake in Illinois takes a community-centered and -focused approach with support from state infrastructure that is provided by GOECD.

Undertaking coordinated intake in a systematized way came about, in large part, by leveraging federal funding from the MIECHV Program. These funds have been used in Illinois to support coordinated intake by establishing a system of universal screening and coordinated intake in identified at-risk communities throughout the state, which are also referred to as “MIECHV Communities”. These MIECHV Communities, along with a few communities that do not receive funding from MIECHV but have chosen to implement coordinated intake with other funds, use coordinated intake staff, who serve as a hub for home visiting in order to streamline services and increase referrals within their respective community.

When the MIECHV Program was established in 2010, it was a natural leverage point for the use of coordinated intake due to the statutory purposes of the MIECHV Program, which include improving the coordination of services for at-risk communities, and identifying and providing comprehensive services to improve outcomes for families who reside in at-risk communities.¹⁸ In addition, the coordination of home visiting with other community services for families was an

¹⁶ Resources on this topic including the following: (1) National Evidence-Based Home Visiting Model Alliance (NHVMA) (2016). *C-Intake: Lessons Learned & Recommendations*; and (2) MIECHV TAAC (2014), which is cited above.

¹⁷ For a description of best practices related to coordinated intake, see the following: (1) MIECHV TACC (2014), which is cited above; NHVMA (2016), which is cited above; and (3) QSP Component Group (2011), which is cited above.

¹⁸ 42 U.S.C. 711

original, required federal benchmark for the MIECHV Program and a priority of the national Home Visiting Research Agenda.¹⁹

At the outset of the MIECHV Program, state leaders in Illinois agreed that coordinated intake was a high priority and that all six MIECHV Communities (i.e. the Southside Cluster in Chicago, Cicero, Elgin, Rockford, Macon County and Vermilion County) should design their own coordinated intake processes within guidelines provided by the state. Starting in 2012, these six MIECHV Communities began piloting coordinated intake at the local level through the use of MIECHV funding. These communities had flexibility to choose a local coordinated intake agency and the details of implementation. For example, three communities opted to use county health departments while three used non-profit organizations and/or social service agencies as the local coordinated intake agency. In addition, each community determined its own decision tree to pre-determine a variety of possible scenarios (e.g. what happens if a family is eligible for two local programs).

The original staffing of coordinated intake within each MIECHV Community included (1) a coordinated intake worker whose responsibilities included screening families for eligibility and making referrals to appropriate services, and (2) a community systems development (CSD) worker whose responsibilities included building relationships with community partners through developing memoranda of understanding with such partners and facilitating community collaboration meetings.²⁰ In response to new infrastructure spending restrictions from the federal Health Resources and Services Administration (which administers the MIECHV Program

MIECHV Program

The MIECHV Program, established in 2010, was designed to expand voluntary, evidence-based home visiting programs across the United States and improve the outcomes for pregnant women and families, particularly those considered at-risk.

The MIECHV funding provided to Illinois over the last seven years – more than \$50 million – has been a vital part of our home visiting and early childhood systems, and builds on more than two decades of state investment in home visiting to support voluntary, evidence-based home visiting models that partner with families from pregnancy through their children’s first years of life. In addition to using MIECHV funds to expand and improve direct services to Illinois families, Illinois has used MIECHV funds for a variety of innovative projects. MIECHV funding enables Illinois to create laboratories for researching and testing innovative strategies, as well as valuable trainings, tools and approaches that can be applied more broadly, including coordinated intake. MIECHV has also led to a much more integrated home visiting system in Illinois, in part by bringing together the multiple funders of home visiting in Illinois.

The MIECHV Program expired on September 30, 2017 and was reauthorized for five years in February 2018.

¹⁹ Paradis, H., Belknap, A., O’Neill, Kay, Baggett, S., and Minkovitz, C. (2018). Coordination of early childhood home visiting and health care providers. *Children and Youth Services Review* 85: 202-210.

²⁰ Center for Prevention Research and Development, School of Social Work at the University of Illinois, Urbana (CPRD) (2018). Maternal Infant and Early Childhood Home Visiting (MIECHV) 5th Annual Benchmark and Outcome Technical Report FY2017. Retrieved August 28, 2018 from <http://cprd.illinois.edu/files/2018/07/IL-MIECHV-5th-Annual-Report-FY17.pdf>

in collaboration with the federal Administration for Children and Families), after FY2016 the CSD positions no longer received MIECHV funding.

As of the date of this Issue Brief, 13 MIECHV Communities²¹ are actively implementing or using coordinated intake or are actively developing coordinated intake. Each has one or more coordinated intake staff members to identify, recruit, engage, and enroll eligible families and caregivers in local home visiting programs. Additionally, the state – through GOECD – provides guidance and resources, including the Coordinated Intake Assessment Tool (CIAT)²², sample coordinated intake procedures, and a care coordination protocol and forms for connecting families to Medical Homes, along with free training for staff, assistance in connecting to local early childhood coalitions and networks, and inclusion in statewide meetings and trainings. There is also a Learning Community for coordinated intake staff and supervisors led by GOECD.

In addition to the MIECHV Communities that receive funding for coordinated intake staff from the MIECHV Program, there are also a few communities that do not receive MIECHV funding and are undertaking coordinated intake within their communities on a voluntary basis using a funding source other than MIECHV, including Oak Park-River Forest. See *Figure 3* below for maps highlighting where coordinated intake is occurring in Illinois.

By virtue of the local approach taken in Illinois, there are variations within the communities depending upon a number of factors (e.g. local collaborations formed or already in existence, how many partners the coordinated intake has and their relationships) and, as a result, each community looks a little different. Each community and its context is unique with individual strengths and challenges (e.g. size, urbanity, geography, employment, socio-economic factors, race and ethnicity).²³ For example, each community has a unique combination of services, its own history, working relationships and dynamics amongst service providers, and each community provider may have a different approach as to services offered and varying levels of capacity to serve families and provide home visiting services.

²¹ The 13 MIECHV Communities are: Chicago’s Southside Cluster communities; Cicero; Elgin; Rockford; Macon County; Vermilion County; Stephenson County; Peoria County; DeKalb County; McLean-Piatt-DeWitt Counties; East St. Louis; Kankakee County; and Chicago’s Austin community.

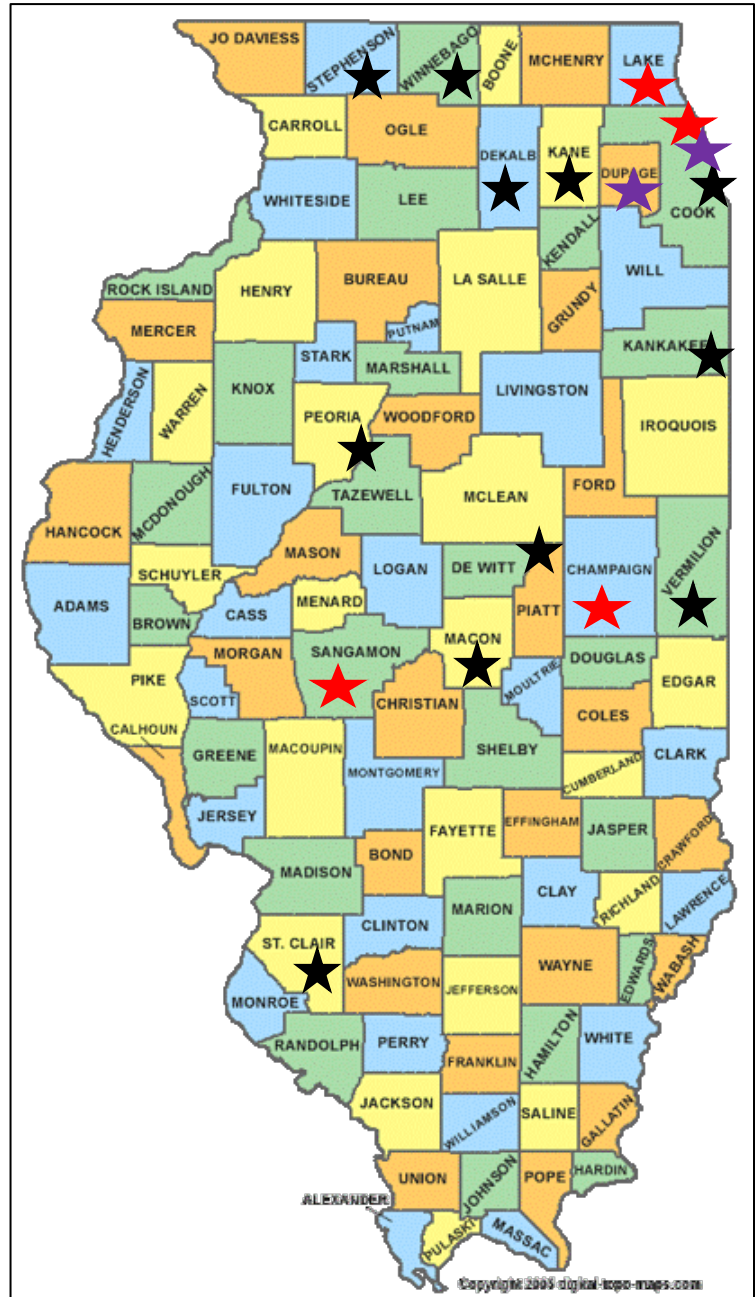
²² The CIAT can be accessed at: <http://igrowillinois.org/about-miechv/coordinated-intake-resources/>

²³ P. Mulhall and M. Wilson (personal communication, October 20, 2017)

Figure 3. Maps highlighting various communities that are either (1) actively implementing or developing coordinated intake (CI) with MIECHV or other funding sources, or (2) exploring the possible use of CI within their community.

KEY

- ★ = Actively implementing or developing CI with MIECHV funding
- ★ = Actively implementing or developing CI with funding from sources other than MIECHV
- ★ = Exploring CI



Source: GOECD

Illinois continues to fine-tune its coordinated intake programs in order to improve alignment with other child- and family-serving systems and to ensure that the efforts of coordinated intake are complementing or supporting other initiatives within the state (as described below under “*What Opportunities does Coordinated Intake offer in Illinois?*”). Resources and support are provided to coordinated intake staff and supervisors by GOECD and the Center for Prevention Research and Development at the School of Social Work at the University of Illinois (CPRD). For example, GOECD and CPRD staff help to facilitate a Learning Community for coordinated intake staff and supervisors that includes a combination of quarterly in-person meetings and monthly conference calls. In addition, CPRD staff offers continuous quality improvement (CQI) through individualized monthly calls with each MIECHV Community. Topics for CQI projects have included: increasing referrals from local obstetricians; increasing connections with more rural parts of a service area; revising the model intake form to better reflect the requirements of other (i.e. non-MIECHV) funders of home visiting; and improving the transition process from home visiting to preschool programs as children age out of home visiting services.

During FY2018, GOECD’s support included a re-evaluation of tools and resources for coordinated intake staff at the MIECHV Communities and other voluntary communities. This work constitutes the next phase of coordinated intake in Illinois – “Coordinated Intake 2.0”. The following highlights the work that is included within the scope of Coordinated Intake 2.0:

- The development of a Roadmap (attached as *Appendix B*) that lays out expectations for coordinated intake agencies and staff;²⁴
- The development of a toolkit that contains revised or new resources to better support coordinated intake staff and supervisors;
- The identification of professional development needs for coordinated intake staff, and the development of specialized curricula and/or assistance connecting to professional development opportunities;
- Each MIECHV Community undertakes an individual CQI project, which includes monthly CQI calls with CPRD staff, and the development of CQI plans based on individualized needs and interests identified by each MIECHV Community; and
- The continuation and enhancement of a Learning Community for coordinated intake staff of MIECHV Communities and non-MIECHV funded communities that are implementing coordinating intake; the Learning Community meets in-person on a quarterly basis and has monthly calls in between the in-person meetings.

Illinois’ long-term vision is to implement coordinated intake for all home visiting programs within communities—possibly, via area or regional networks—across the state.²⁵ For example, one of the action steps resulting from a recent collaboration of the Home Visiting and Early

²⁴ Roadmap for Coordinated Intake (2017).

²⁵ Ibid

Intervention (EI) systems in Illinois is to establish regional points of entry for home visiting building on coordinated intake (as described below). Other objectives of Illinois' long-term vision include: creating better consistency and uniformity across coordinated intake processes; continuing to increase the quality of coordinated intake services and processes; collecting outcome data; and increasing buy-in regarding the use and benefits of coordinated intake by other system partners to make coordinated intake truly a system-wide effort.

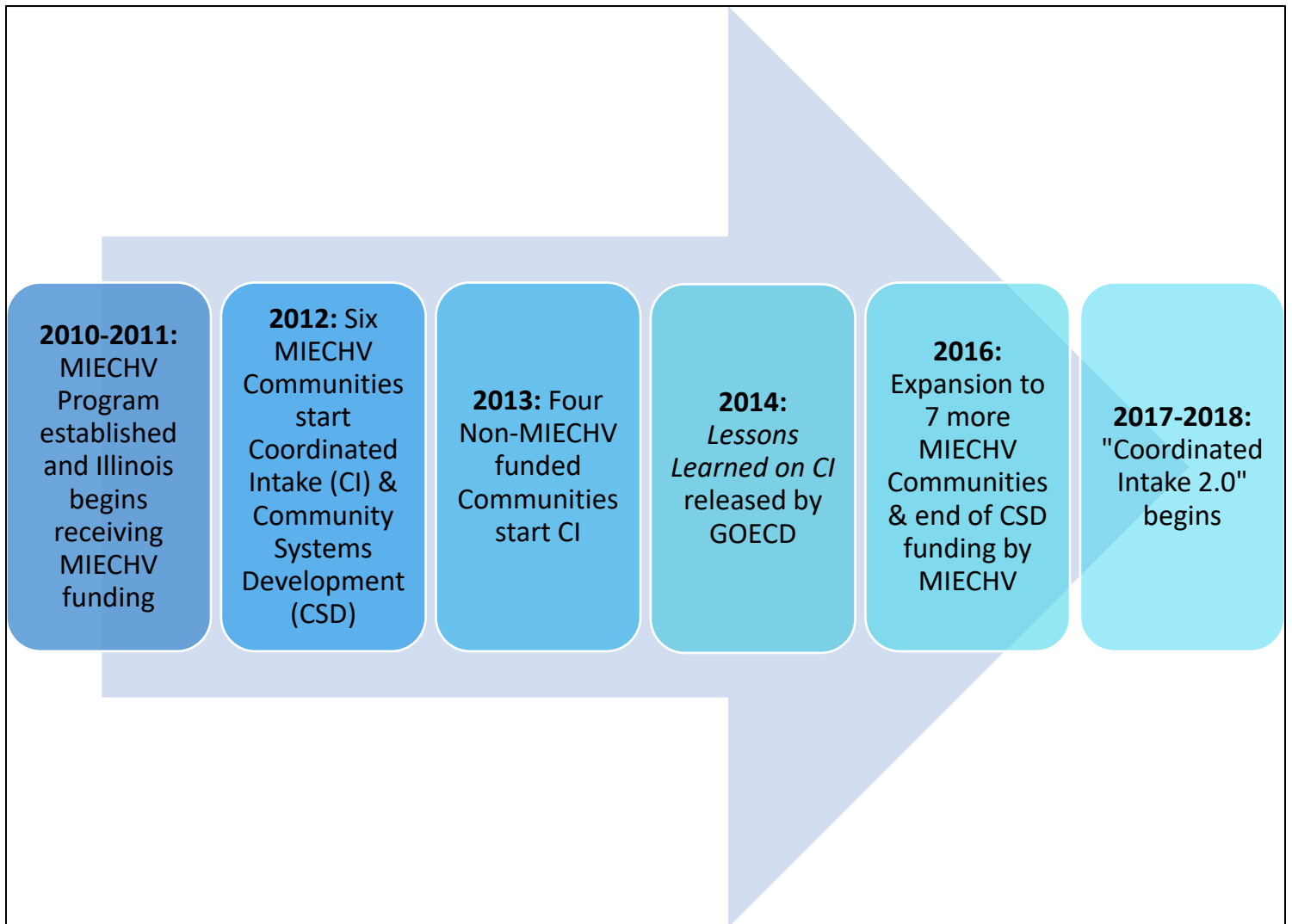


Figure 4: A brief history, to date, of launching coordinated intake for home visiting in Illinois.

How does Coordinated Intake fit into a larger strategy in Illinois?

The use of coordinated intake as a strategy advances the statewide approach and philosophy to home visiting both on a systems-level and family-level. Illinois' home visiting system is structured and funded in such a way as to welcome all evidence-based models to the table, and then allow individual communities and programs to select the model(s) best suited to their specific needs.²⁶ Illinois' home visiting system uses a range of effective evidence-based models, which are funded through the state's *entire* home visiting system, including funding from the MIECHV Program, the Illinois Department of Human Services (IDHS), the Illinois State Board of Education (ISBE), and the City of Chicago through its Department of Family & Support Services (DFSS) (formerly it was through Chicago Public Schools). It is one of the hallmarks of Illinois' home visiting system that communities are allowed to choose a model based on their needs.²⁷ To learn more about Illinois' home visiting system, see *Appendix A*.

On the family-level, a priority of the Illinois home visiting system is to ensure that each family is connected with the home visiting program that best suits its individual needs.²⁸ For example, in the initial meeting with the family, an eligibility screening tool is used that takes into account the family's current needs and geographic considerations. Particularly for Illinois families experiencing risk factors, it is important that a good match is made right from the start because if that does not occur, the family may not continue with the services and programs may lose the opportunity to partner with them during a critical time in their child's development. Coordinated intake staff can also assist families in connecting to other basic resources (e.g. child care, health care, housing, diapers).

What Opportunities does Coordinated Intake offer in Illinois?

There is growing emphasis on the importance of collaboration within and across child- and family-serving systems in Illinois. For example, the re-competition in FY2019 of the Early Childhood Block Grant (ECBG) by ISBE, which has been increased by \$200 million over the last four years, promoted coordination within communities.²⁹

In addition, coordinated intake ***complements or intersects with other efforts*** occurring throughout Illinois as highlighted in the following current initiatives.

- **Universal newborn support system:** Illinois Family Connects (IFC) is a universal system, currently being piloted in the Illinois communities of Peoria and Stephenson Counties, designed to reach all newborns and their parents by offering them a home visit from an IFC nurse, who provides information, supports and resources to strengthen the capacity of parents in meeting their children's needs once the mother and baby are home from

²⁶ Illinois Early learning Council Home Visiting Task Force (HVTF) (2015a). *Overview of Home Visiting in Illinois*.

²⁷ Ibid

²⁸ Ibid

²⁹ See Notice of Funding Opportunity (NOFO) / Request for Proposals (RFP): Fiscal Year 2019 Early Childhood Block Grant-Prevention Initiative for Birth to Age 3 Years. Retrieved August 28, 2018 from https://www.isbe.net/Documents/FY19_RFP_PI.pdf.

the hospital. IFC is grounded in the principle that every family could benefit from some level of support after the birth of a new baby. This universal approach generates outcomes at a larger scale, ensures that the most at-risk are identified, increases engagement with the hardest to reach families, builds broad-based public support, and supports community-level change. Based on an individual family's level of need and personal resources, assistance ranges from providing information/resources on newborn care, breast-feeding, child care, or parent support groups to making referrals to high-intensity services, such as home visiting. In addition to serving families, the IFC teams are strengthening relationships with local hospitals, medical providers, service providers and county health departments in their respective communities. This requires a high level of resource coordination across multiple child-serving systems, such as health care, EI, child care, and home visiting. Before the two pilots were launched, much thought was given to how the referrals within the IFC system would intersect – in a seamless and complementary way – with the (then) existing coordinated intake efforts within Peoria and Stephenson Counties. IFC has been well-received by providers, families, and both communities. Providing IFC services to all families increases the ability to identify and serve those at highest risk and increase the acceptance of more intensive home visiting services. Preliminary findings are promising, including: the program has been positively received by women and families, and families from all socioeconomic backgrounds are utilizing it; 97% of families reported some risk/need across the entire risk/need matrix; 64% of families had at least one area of significant risk/need requiring follow-up and community referral; and the universal nature of IFC has been very positively received resulting in spill-over effects such as increased support for home visiting.³⁰ For additional information on IFC, visit its website: www.ilfamilyconnects.org.

- **Home Visiting, EI, and Child Welfare Cross-Trainings:** A series of cross-systems trainings for home visitors, EI providers and child welfare workers have been and are being undertaken across Illinois and are occurring within local communities. To date, two series have been successfully implemented in Southern Illinois and Central Illinois. These cross-trainings are supporting early childhood providers in better understanding the impact of trauma on child development and how various early childhood programs and services can support children's recovery and developmental trajectory. In addition, cross-training attendees have the opportunity to network, problem solve across systems, and identify community-level planning needs for improved cross-system collaboration and ensuring families can receive the services they need. Learnings from these trainings will be used to drive policy changes that better coordinates child welfare, EI, and home visiting services in order to better meet the needs of infants and toddlers. GOECD has been involved in the planning of these cross-trainings, including connecting home visiting stakeholders to their local planning committees and making sure that coordinated intake staff in MIECHV Communities and non-MIECHV Communities are

³⁰ Handler, A., Zimmerman, K., Dominik, B. & Garland, C. (2018). *Illinois Family Connects Early Evaluation Report*.

aware of these trainings and their importance to breaking down silos among home visiting, EI and child welfare.

- **EI-HV Collaborations:** In 2016, the U.S. Departments of Education (ED) and Health and Human Services (HHS) issued a joint statement on collaboration and coordination between MIECHV and the Individuals with Disabilities Education Act Part C (EI) Programs.³¹ While the home visiting and EI systems may differ in the services they provide, they share the same goal of ensuring the youngest children and their caregivers have a healthy, safe, and strong attachment relationship and healthy development trajectory for the child and child’s family. The joint statement provides eight recommendations compiled from interviews with 10 states that have been working to create strong linkages between MIECHV and EI collaborations. From these federal recommendations, Illinois’ early childhood leaders, including GOECD, the Illinois Early Learning Council (ELC), the Home Visiting Task Force (HVTF; see *Appendix A* for more information), the Illinois Interagency Council on Early Intervention (IICEI), and other Illinois stakeholders convened in 2017-2018 to develop strategies for increasing communication and collaboration between EI and home visiting. An outcomes report was issued that includes recommendations for improved integration between the two systems, including establishing and implementing regional system points of entry across all home visiting programs similar to EI.³² The HVTF and IICEI are convening a Home Visiting/EI Ad Hoc Subcommittee that will focus on implementing several of the recommendations.
- **Home Visiting for Homeless Families Demonstration (HVHF) Project:** Since 2013, the HVHF Project has piloted an innovative approach to help homeless young mothers access stable housing while also providing high-quality home visiting services to promote positive education outcomes for mother and child. Through high-quality home visiting services, the HVHF Project seeks to improve the developmental trajectories (i.e. improvements in breast-feeding rates, developmental screenings, well-child visits and maternal efficacy rates) of children experiencing homelessness in communities throughout Illinois. The HVHF Project’s approach is to train homelessness providers on home visiting, hire a home visitor whose caseload is exclusively homeless families, and provide training to a shelter on implementing the Parents as Teachers home visiting program model. The 8 programs involved in the HVHF Project communicate with one another on a regular basis to coordinate referrals and provision of services. In addition to these community collaborations, there is a statewide advisory group that meets quarterly to discuss systems issues and new ideas. The HVHF Project is collecting data

³¹ HHS and ED joint statement can be accessed at: <https://www2.ed.gov/about/inits/ed/earlylearning/files/ed-hhs-miechv-partc-guidance.pdf>.

³² The outcomes report can be accessed at: <https://www2.illinois.gov/sites/OECD/Events/Event%20Documents/HVEI%20Report%20Full%202023April2018.pdf>

that will indicate impact and inform future efforts. In FY2018, the HVHF Project provided 776 home visits to 64 mothers. The HVHF project is developing connections with coordinated intake communities so that coordinated intake staff are educated on the specific needs of homeless families.

- **Work of ELC’s committee to connect health care and early childhood systems:** The Health Subcommittee of the ELC’s Integration and Alignment Committee are working to create stronger linkages between the early childhood and health care systems to improve children’s health outcomes and well-being. This is important because we know that there are shared goals, values, and objectives of early childhood and health services, but there are barriers and yet unexplored opportunities to better align these two systems—both of which are so critical in a young child’s life. The Health Subcommittee’s work is exploring how to optimize those aligned interests through improved linkages between early childhood and health services in order to create better outcomes for the whole child. This work advances the Health Subcommittee’s new charge: strengthen the relationship between the health and early childhood provider sectors in order to promote increased awareness of and enrollment in high-quality early childhood programs and services. This will be an opportunity for the work of coordinated intake to intersect with and complement the work of the ELC.
- **ACEs-Home Visiting Initiative:** Rush University Medical Center in Chicago, Illinois (“Rush”) is engaging in an initiative to screen pregnant and postpartum women for Adverse Childhood Experiences (ACEs)³³ within certain of Rush’s clinical settings (the “Initiative”). Those women with a cumulative ACE score of 3 or higher, as well as teen mothers, are being linked—through coordinated intake housed within Rush³⁴—with an existing community-based home visiting program within the communities that Rush serves (largely, the west side of Chicago³⁵). The Initiative is one part of Rush’s larger Community Health Implementation Plan (CHIP). The Illinois MIECHV Team³⁶ has been collaborating with Rush since September of 2016 on a variety of issues to help develop the Initiative (e.g. capacity of the community-based home visiting programs, coordinated intake, data collection, and training), and to connect Rush with other programs, researchers and entities whose respective work may intersect or align with that of the Initiative. Rush has memorialized the proposed workflow and logistics for the

³³ The screening tool has been built into Rush’s electronic records system and uses the original ACEs questions that were used in the landmark ACEs research study undertaken by Kaiser Permanente and the Centers for Disease Control and Prevention.

³⁴ The coordinated intake staff is employed by Rush and is part of Rush’s Health Population Team, which provides care coordination for certain of Rush’s other patients.

³⁵ These communities include Austin, West Garfield Park, East Garfield Park, North Lawndale, South Lawndale and Near West Side, and their rates of child poverty, infant mortality, and child abuse and neglect are nearly double or triple national rates of these social determinants of health.

³⁶ The Illinois MIECHV Team includes representatives of GOECD and the Ounce of Prevention Fund.

Initiative, and prepared various resources for parents that will be available in both English and Spanish (e.g. materials about ACEs and resiliency). There will be a research component to evaluate certain outcomes in connection with the Initiative.

Spotlight on Local Coordinated Intake Initiatives

The coordinated intake staff in the MIECHV Community of Kane County has undertaken numerous successful initiatives to increase the capacity of the 15 evidence-based home visiting programs within the County, including:

- Developing and posting videos of mothers talking about home visiting and how it helped them in both English (<http://kanehomevisits.org/stories.htm>) and Spanish (<http://kanehomevisits.org/historias.htm>);
- Developing user-friendly, easy-to-read self-referral forms for parents to use;
- Developing a toolkit for obstetricians in order to increase the number of referrals from obstetricians; and
- Providing feedback reports to referring agencies showing the number of referrals that were sent to coordinated intake staff on a monthly basis and the outcome of the referrals.

What are some of the actual and perceived challenges related to Coordinated Intake in Illinois?

The following focuses on certain challenges that Illinois has experienced with coordinated intake. While earlier in this Issue Brief, challenges generally were identified; here, Illinois' challenges are shared in order to continue telling the state's story.

Effects of the Two Year State Budget Impasse on Illinois' Home Visiting System

On July 6, 2017, the Illinois General Assembly passed a state budget for fiscal year 2018.³⁷ The passage of this budget followed two fiscal years (i.e. 2015 and 2016) without having passed a full-year and fully-funded budget. During this two year period, many services that support young children and families were impacted, but perhaps none more so than home visiting services. The home visiting system was directly impacted by the state's budget impasse as many state-funded programs did not receive funding for services for two years. The reduction in home visiting services was also impacted in two other directions: first, there were fewer referrals to home visiting from traditional sources like Family Case Management since they were experiencing payment issues; and, home visiting was less able to refer to services like EI because of the reduced capacity. Despite their best efforts, many state-funded programs were required to reduce services or close completely and the system experienced a high rate of staff

³⁷ In Illinois, the state's fiscal year starts on July 1 and ends on June 30.

turnover. A 2017 report by the Chicago Foundation for Women noted that “nearly 60 percent of more than 40 home visiting programs surveyed by the Ounce of Prevention Fund indicated staff layoffs, salary cuts, and reductions in the number of families served”.³⁸ While the budget impasse ended, it has taken time for state-funded home visiting programs to rebound from the impasse, including a significant backlog of bills that had built up over the budget impasse period.

Despite these challenges, there have been areas of hope and Illinois’ home visiting system has shown resilience. For example, the system has seen the persistence and commitment of many core players—home visitors, program directors, agencies, and infrastructure. The HVTF and the funders of home visiting in Illinois worked during the budget impasse to determine how to support the sustainability and quality of the *entire* home visiting system during this challenging fiscal environment. While the funding was stable for federally funded programs (such as those that are MIECHV-funded) and as a result most MIECHV-funded programs were able to sustain at their service levels, there was a challenge with state-funded programs (i.e. IDHS-funded) that had to close or reduce services as a result of the budget impasse. Fortunately, certain of the MIECHV-funded programs were able to absorb some of the home visiting staff positions that were previously funded by IDHS. The HVTF continues to engage in an ongoing conversation about what the HVTF can do to support Illinois’ home visiting system in a sustainable way. There has been increased state funding for ISBE’s Prevention Initiative (PI) programs through a discrete statutory set-aside for birth-to-three programs in the ECBG. Families continue to enroll in home visiting services as it is a recognized and evidence-based intervention.

While this last year has represented a period of rebuilding and much work remains to be done to fully advance the envisioned system, the recently-passed FY2019 state budget is a step in the right direction. As an on-time, fully-funded, full-year budget, it not only provides some funding increases, but also represents another year of badly-needed stability for programs, providers, children and their families. Namely, the FY2019 budget includes a \$50 million increase to the ECBG and level funding for home visiting programs within IDHS.

Community Systems Development (CSD) position no longer funded by MIECHV

During the first four years of the MIECHV Program in Illinois, a CSD staff position was funded, but starting in 2016, this position was no longer funded through MIECHV. The hope of the Illinois MIECHV Program was that communities would take what they had learned and leverage other resources to continue this important systems work. Given this shift, Illinois’ MIECHV Program provided MIECHV Communities with written guidance on how to proceed without a specific CSD position.³⁹ However, this loss of the CSD position essentially cut the coordinated

³⁸ Chicago Foundation for Women (2017). *Damage Done: The Impact of the Illinois Budget Stalemate on Women and Children*, p. 3. Retrieved August 28, 2018 from <https://www.cfw.org/app/uploads/2017/08/Damage-Done-CFW-POLICY-PAPER-FINAL-8-2-17.pdf>

³⁹ <http://igrowillinois.org/wp-content/uploads/2018/04/Guidance-for-Continued-Community-Collaboration-Efforts.pdf>

intake staff in half and created extra work for the coordinated intake staff in MIECHV communities; it has required the communities to revisit the CSD and coordinated intake roles, as sustaining community partner relationships are key to the success of coordinated intake.⁴⁰

Recruiting and retaining coordinated intake staff

Finding and retaining coordinated intake workers can be challenging. Coordinated intake staff require varying skill sets for understanding the home visiting model(s) in the community, communicating effectively with multiple community partners, families, and colleagues, and serving as a liaison to referral sources, families, team members, and community agencies.⁴¹ In addition, coordinated intake staff need to possess excellent problem solving skills, good oral and writing skills, and proficiency in database management. Former employees have recommended the need for better training and higher salaries to mitigate high rates of turnover given the required skills and responsibilities of coordinated intake staff.⁴² Retaining staff in coordinated intake (much like with home visiting staff) is particularly important given the relationship building and trust that develop between coordinated intake staff and community partners and the understanding of the different home visiting models that coordinated intake staff develops—all of which are key components to successful referral partnerships. Another related challenge is the length of time that coordinated intake positions often remain vacant.⁴³

Voluntary nature of the local referrals and competition among programs within a community

A benefit of coordinated intake is that it can minimize the duplication of services and reduce competition among providers by increasing the pool of referrals and matching families to programs that best fit their needs. Currently, competition for families is likely due, in part, to changes in birth rates and other options that families may have in the communities.⁴⁴

Replication difficulties

Since programs have flexibility in designing their own version of coordinated intake, there have been obstacles with replicating coordinating intake successfully. Suggestions to mitigate this issue include creating a blueprint for coordinated intake statewide and developing guidelines for when declining referrals can or cannot be allowed along with better documentation on the reasons why.⁴⁵ GOECD has encouraged the sharing of policies and procedures manuals among coordinated intake programs to share best practices and details of effective procedures.

⁴⁰ Ibid

⁴¹ CPRD (2018). MIECHV Home Visiting and Continuous Quality Improvement Survey Report, February 2018. Retrieved August 28, 2018 from https://cprd.illinois.edu/files/2018/02/MIECHV_CQI-SurveyBrief_2017.pdf.

⁴² Ibid

⁴³ CPRD (2017). Illinois Maternal Infant and Early Childhood Home Visiting (MIECHV) 4th Annual Benchmark and Outcome Technical Report FY 2016. Retrieved August 28, 2018 from https://cprd.illinois.edu/files/2017/11/MIECHV_AnnualReport_2016.pdf

⁴⁴ Ibid

⁴⁵ Ibid

Data

Multiple funding streams and numerous state, federal and model requirements have resulted in varying data collection points and data collection policies, and the use of several different data management systems across programs, models and funders in Illinois. These variations make it difficult to aggregate uniform and meaningful home visiting data across the state. GOECD is exploring the use of an existing platform in order to test ways to improve these issues. Currently, coordinated intake data is largely managed through the use of Excel spreadsheets. The MIECHV Visit Tracker system is used for data tracking but it was really designed for case management purposes, and only MIECHV-funded agencies, which are a small percentage of agencies served by coordinated intake, use Visit Tracker.

Another issue concerns data about the child being served. Most notably, it can be difficult to learn the status of referrals outside home visiting as many child- and family-serving systems are not connected for purposes of sharing data.

Others identified in the 2014 Lessons Learned

A report issued by GOECD in 2014 outlined the challenges related to coordinated intake both at the community-level and state-level.⁴⁶

Additional Resources

- *Coordinated Intake in Illinois: Lessons Learned from MIECHV (The Maternal, Infant, and Early Childhood Home Visiting Program)*, October 17, 2014: http://igrowillinois.org/wp-content/uploads/2015/06/6-Lessons_Learned_from_MIECHV_Coordinated_Intake_FINAL.pdf
- Maternal, Infant, and Early Childhood Home Visiting Technical Assistance Coordinating Center (MIECHV TACC) (2014). *MIECHV Issue Brief on Centralized Intake Systems*: https://www.greatstartgeorgia.org/sites/default/files/miechv_issue_brief_centralized_intake.pdf.
- Early Childhood Iowa – Quality Services and Programs Component Group (QSP Component Group) (2011). *Centralized Intake Best Practices Guide*: http://igrowillinois.org/wp-content/uploads/2015/06/1-Coordinated_Intake_Best_Practices_-_Iowa.pdf

⁴⁶ Governor's Office of Early Childhood Development (GOECD) (2014). *Coordinated Intake in Illinois: Lessons Learned from MIECHV (The Maternal, Infant, and Early Childhood Home Visiting Program)* October 17, 2014. Retrieved August 28, 2018 from http://igrowillinois.org/wp-content/uploads/2015/06/6-Lessons_Learned_from_MIECHV_Coordinated_Intake_FINAL.pdf

Conclusion

While Illinois continues to develop coordinated intake, valuable lessons are being learned that will enable improvements at both the local and state level. Illinois is finding that coordinated intake is worthy of continued and further exploration as a viable opportunity to address the fragmentation within and between child- and family-serving systems, and a promising approach to outreach and coordination of services to best meet the needs of families with young children and connect them with programs that best address their needs.



Appendix A

A Brief Primer on Home Visiting in Illinois⁴⁷

In order to tell Illinois' story on coordinated intake, a brief overview on home visiting in Illinois is necessary, including how it is funded and the state's approach.

What does home visiting look like in Illinois?

Illinois has long valued evidence-based home visiting programs as an effective and efficient strategy for improving the life trajectory of expectant and new families who are at risk for poor health, educational, economic and social outcomes.⁴⁸ Over the past three decades, Illinois has reflected this value by developing a robust statewide home visiting system that cuts across agencies and funding streams, reaching from the highest levels of government to the providers on the ground.⁴⁹

What is the statewide approach and philosophy to home visiting?

Illinois follows a "big tent" approach: Illinois' home visiting system is both structured and funded in such a way as to welcome all evidence-based⁵⁰ models to the table, and then allow individual communities and programs to select the model(s) best suited to their specific needs. In Illinois, our home visiting system uses a range of effective models, including Parents as Teachers (PAT), Healthy Families America (HFA), and Early Head Start-home based (EHS)⁵¹. These models are funded through our *entire* home visiting system, which includes funding from federal, state and local sources (as described in more detail below). One of the state's funders of home visiting, ISBE, also supports the Baby Talk⁵² model. It is one of the hallmarks of our Illinois system that we allow communities to choose a model based on their needs.⁵³

On the family level, a priority of the Illinois home visiting system is to ensure that each family is connected with the home visiting program that best suits *its* individual needs. For example, in the initial meeting with the family, an eligibility screening tool is used that takes into account the family's current needs and geographic considerations.

⁴⁷ This Issue Brief is based upon the best information available but reflects limitations associated with the lack of a standard reporting mechanism for home visiting.

⁴⁸ HVTF (2015a)

⁴⁹ Ibid

⁵⁰ For purposes of this Issue Brief, "evidence-based" home visiting programs are defined as those programs that meet the rigorous U.S. Department of Health and Human Services (US DHHS) criteria for evidence of effectiveness as determined by the Home Visiting Evidence of Effectiveness (HomVEE) project. The US DHHS launched the HomVEE Project to conduct a thorough and transparent review of the home visiting research literature. HomVEE provides an assessment of the evidence of effectiveness for home visiting program models that target families with pregnant women and children from birth to age 5. (HomVEE, 2017). See also HomVEE's website for more details: <https://homvee.acf.hhs.gov/>

⁵¹ PAT, HFA and EHS are each evidence-based models as designated by the HomVEE project. (HomVEE, 2017).

⁵² The Baby Talk is a home-grown model.

⁵³ HVTF (2015a)

What is the State’s vision for home visiting?

In 2014, the leaders of home visiting revised the state’s vision for high-quality, intensive home visiting services (the “State Vision”) in order to promote **parent-child attachment**, provide **developmental screening**, monitoring, and referrals, and provide **linkages to community** resources and services.⁵⁴ The guiding principles for the Illinois home visiting system are:

- **Continuum of Services** – Home visiting is an integral part of a continuum of services for families that is well-coordinated and integrated, and begins prenatally.
- **Skilled Workforce** – As early childhood professionals, home visitors should be provided with appropriate professional development and compensation.
- Home visiting services are:
 - **Evidence-based** – Home visiting programs use models and curricula whose effectiveness is supported by research.
 - **Culturally and linguistically responsive** – Home visiting services respect, promote, and build on families’ cultural, racial, ethnic, and other backgrounds and experiences.
 - **Voluntary** – Families are free to choose whether or not to participate.
 - **Accessible** – Home visiting services should be accessible statewide to all families who want these services.
 - **Targeted** – In an environment of limited funding resources, home visiting services should target the children and families who are most at risk.
 - **Aligned** – Home visiting services are aligned with the Illinois Early Learning Guidelines and Illinois Early Learning and Developmental Standards; and
 - **Outcome driven** – The state is able to demonstrate outcomes related to maternal and child health, school readiness, and reduction of child abuse and neglect.⁵⁵

How is Home Visiting Funded in Illinois?

In Illinois, home visiting is supported by a diverse set of funding streams:

- Federal HRSA (Health Resources and Services Administration) MIECHV Program
- IDHS – General Revenue Funds
- ISBE – Early Childhood Block Grant, General Revenue Funds
- Early Head Start – Federal to Local Funding

The funds, which the state directly administers, total approximately \$50M and support a network of over 300 programs across the state serving approximately 17,000 families per year.⁵⁶ The major funders of home visiting in Illinois, which are identified in the diagram below

⁵⁴ HVTF (2015b). *Home Visiting Task Force: Vision for Home Visiting in Illinois*. Retrieved August 28, 2018 from https://www2.illinois.gov/sites/OECD/Events/Event%20Documents/HVTF_HV%20Vision%20for%20IL--FINAL.pdf

⁵⁵ Ibid

⁵⁶ HVTF (2015a)

(the “Funders”), have committed to continuously assessing the needs of the system, to being responsive in addressing the state’s diverse geographic and demographic realities, and to fostering needed innovations.⁵⁷ As home visiting programs have expanded across the state, the public and private stakeholders in Illinois’ home visiting system have sought to ensure the quality and fidelity of the services that are offered to families, and the presence of a skilled workforce.⁵⁸

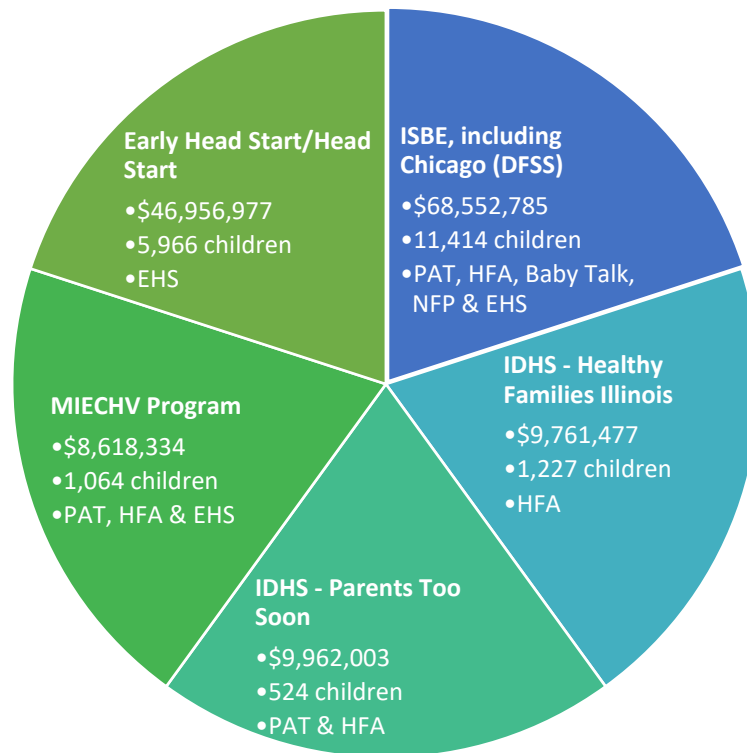
Illinois has invested robustly in the home visiting system for the last 30 years and looks to expand such investments into the future. For example, the home visiting system is exploring a variety of options and opportunities, including a potential state plan amendment which would enable home visiting services to be funded through Medicaid, if approved. Most notably, a proposal to offer home visiting services to families of children born with withdrawal symptoms from opioid addiction was included in the state’s 1115 Medicaid waiver application to the federal Centers for Medicaid and Medicare Services, which was approved in May 2018. In addition, Illinois is in discussions with providers to link home visiting programs with local managed care entities.

The home visiting system in Illinois is complex and diverse. Multiple funding streams and numerous state, federal and model requirements have resulted in varying data collection policies and the use of several different data management systems across programs, models and funders in Illinois. These variations make it difficult to aggregate uniform and meaningful home visiting data across the state. Over the past few years, the Funders of home visiting in Illinois have met to collaborate and share data about their home visiting programs in an effort to provide state-level data for the first time. In order to aggregate home visiting data from multiple sources, some numbers had to be estimated to fit the needs of the state level reports. When this occurred, the numbers provided are the best estimation possible within the current capabilities of the systems. The following chart provides this estimation:

⁵⁷ Ibid

⁵⁸ Ibid

**Major Funders of Home Visiting Services in Illinois
Including: Total Funding, Total Number of Children Served per Funder, and Models Funded
(State Fiscal Year 2017)**



**Across all Funders:
Total Funding = \$134,705,609
Total Children Served = 19,477**

Source: GOECD

How is the quality of home visiting services monitored?

CQI is an integral part of Illinois’ home visiting system for identifying, describing, and analyzing strengths and challenges.⁵⁹ In the early days of MIECHV funding in Illinois, the administrators of the Funders met quarterly as part of a state team (the “State CQI Team”) to improve the alignment of data and program expectations across Funders. The goal of the State CQI Team was to identify strengths and challenges in the system and advocate for policy-level change.⁶⁰

⁵⁹ CPRD (2017)

⁶⁰ For more information about CQI efforts in Illinois’ home visiting system, see the report prepared by the Center for Prevention Research and Development, School of Social Work at the University of Illinois, Urbana: <http://cprd.illinois.edu/files/2018/07/IL-MIECHV-5th-Annual-Report-FY17.pdf>

Beginning in 2016, the Funders and other interested stakeholders, including researchers, evaluators, advocates and training providers, organized the Home Visiting Infrastructure Collaborative, which is a state-wide group that meets quarterly exploring ways to understand home visiting programs and services at an expanded and in-depth level, and to support and strengthen home visiting services.⁶¹

Home Visiting Task Force

The HVTF is a standing committee of the ELC, which works with the GOECD to provide overall leadership in early childhood systems development. The HVTF is a diverse, collaborative group of nearly 200 members drawn from federal, state, and local governments; academia; representatives from national home visiting models; service providers; advocates; parents; and others who are interested in home visiting.⁶² The HVTF serves as a forum to discuss programs, policies, and research that is essential to ensuring that state and federal public policy is informed by the programs on the ground and reflects the research being conducted.⁶³

The HVTF's goals are to expand access to evidence-based home visiting programs for all at-risk children; improve the quality of home visiting services; and increase coordination between home visiting programs at the state and local level, as well as between home visiting and all other publicly-funded services for mothers, infants and toddlers.⁶⁴ Positioning this work under the ELC is one example of how home visiting is connected to the other major early childhood services in Illinois such as preschool, child care and EI Part C services.⁶⁵

The HVTF works with GOECD to continue to advance the quality, quantity, and coordination of home visiting services across the funding streams and relevant departments. The HVTF also serves as the strategic advisory body for the federal MIECHV grant. Since its creation, the HVTF has explored in depth a variety of topics relevant to home visitors. The following are examples of certain of the HVTF's initiatives in recent years:

- *Creating better linkages between home visiting and health systems:* In 2014, the Health Connections Work Group was created and convened to increase connections between home visiting and the medical home.⁶⁶
- *Enhancing Personal Safety of Home Visitors:* In 2015-2016, the Ad Hoc Safety Workgroup was created and convened to address personal safety issues of home visitors based upon requests from the field. The Ad Hoc Safety Workgroup developed a set of resources that are free, easily accessible and high-quality including a set of “best

⁶¹ CPRD (2017)

⁶² HVTF (2015a)

⁶³ Ibid

⁶⁴ Ibid

⁶⁵ Ibid

⁶⁶ The recommendations of the Health Connections Work Group can be accessed at: <http://igrowillinois.org/wp-content/uploads/2015/06/3- FINAL HVTF HC WG recommendations 23 Feb 2015.pdf>

practices”, a template of a safety policy, a safety manual, and numerous other useful materials.⁶⁷

⁶⁷ The white paper prepared by the Ad Hoc Safety Workgroup can be accessed at: <http://igrowillinois.org/wp-content/uploads/2016/05/White-Paper-1.pdf> . Other safety-related resources can be accessed at: <http://igrowillinois.org/programs/>

Appendix B
MIECHV Coordinated Intake (CI) Road Map

Our Vision

Coordinated Intake will be the single point of entry to HV programs within designated CI communities across the state of Illinois.

Overarching Goal

Ensure all Illinois eligible mothers and families who want to voluntarily participate in a home visiting (HV) program acquire access and enrollment in programs that best meet their family needs. A major role of CI staff is to help maintain a minimum 85% caseload capacity for all HV programs, as part of a collaborative community, to help pregnant and parenting families obtain HV and other early childhood and family support services.

Specific Objectives

The CI staff should address the following specific objectives in their targeted community:

Objective 1

Learn, engage and collaborate with the key individuals, organizations and ancillary agencies that support maternal, child and family health in your community. In order to satisfy Objective 1, CI staff must:

- a) Know services and staff members associated with those services in your community, including hospitals, early childhood, early intervention, home visiting, public health, school district(s), child care agencies, domestic violence, housing, food pantries, transportation systems, mental health and substance abuse providers, DCFS, the faith community, TANF, WIC, etc.
- b) Identify a point of contact (person) at each agency and maintain regular contact, and update your contact information when that person changes.
- c) Develop Memoranda of Understanding (MOUs) as testimony to solidify partnership agreements and expectations.

Objective 2

Ensure regular and ongoing communication and interaction with community partners and ancillary organizations related to maternal, child and family health systems and services in your community. In order to satisfy Objective 2, CI staff must:

- a) Participate in monthly collaborative meetings with community partners.
- b) Establish formal and in-formal communication procedures for updating and working with partners.

- c) Develop or design multiple strategies for marketing and communicating home visiting and related services to the community.

Objective 3

Know, engage, and collaborate with community partners and ancillary organizations related to enrolling eligible families in home visiting. In order to satisfy Objective 3, CI staff must:

- a) Identify eligible families in the target community.
- b) Know the eligibility criteria for each HV program (MIECHV and non-MIECHV).
- c) Know the capacity for each HV program (MIECHV and non- MIECHV).
- d) Know the program models well enough to make an appropriate match between family and HV program.
- e) Transition and support the entry into HV programs (warm handoff).
- f) Know the best places, locations, services and organizations for identifying and recruiting likely eligible families.
- g) Collaborate/coordinate with community partners to conduct community-wide screenings to identify at-risk children who could benefit from HV services.

Objective 4

Demonstrate willingness and capacity to engage and support families in home visiting across communities, cultures, and socio-demographic conditions. In order to satisfy Objective 4, CI staff must:

- a) Identify services that best match potential families by age, language, culture, service area and other community demographics.
- b) Become familiar with your community to help you understand the full range of community conditions and early childhood needs and services. Learn the locations of key community settings for at-risk and vulnerable families: public housing, homeless shelters, food pantries, etc.)

Objective 5

Demonstrate professional skills and competencies essential to successful CI work. In order to satisfy Objective 5, CI staff must:

- a) Master engagement and facilitation skills that include trust building, respectful communication, motivational interviewing, cultural awareness, etc.
- b) Master intake assessment skills using the Coordinated Intake Assessment Tool (CIAT).

- c) Develop a working knowledge of community services and resources for referrals and specialized services.
- d) Have knowledge and skills needed to prepare, organize and facilitate community meetings.
- e) Maintain and report on number and types of referrals to HV and other services, including outcome of referrals to HV, and outcome of other referrals as possible.
- f) Promote home visiting to eligible families and to the overall community using a variety of methods.
 1. Develop “elevator speeches” for various audiences (such as parents, doctor’s offices, community leaders), regarding the benefits of home visiting programs.
 2. Design and develop promotional materials such as brochures, flyers, infographics, press releases, social media, radio and TV spots.
- h) Have a basic knowledge of child development, home visiting programs and practices, maternal child health, and parenting skills.
- i) Have a basic knowledge for collecting, organizing and submitting referral reports. Use referral reports and related data for quality improvement.

Objective 6

Regularly lead and facilitate a collaborative meeting with HV partners, or participate in cross-sector collaborative/network meetings (such as AOK and Local Interagency Councils (LICs) with community home visiting programs and other related organizations), to develop and maintain linkages to CI. In order to satisfy Objective 6, CI staff must:

- a) Maintain contact list of key partners and update as necessary.
- b) Prepare for monthly meetings with key HV partners – coordinate communication, location, agenda, meeting minutes, actions and problem solving.
- c) Respond to and follow up on issues as they surface.

Objective 7

Participate in monthly CQI calls and quarterly in-person CI Learning Community meetings. In order to satisfy Objective 7, CI staff must:

- a) Participate in Continuous Quality Improvement activities through monthly calls with the Center for Prevention and Development (CPRD), which include developing individualized CQI plans.

- b) Actively engage in discussions and peer-sharing activities at quarterly Learning Community meetings.

Objective 8

Support referrals to all home visiting programs to ensure they maximize a caseload capacity of 85%. In order to satisfy Objective 8, CI staff must:

- a) Monitor both MIECHV and non-MIECHV HV program capacity levels and send referrals to “best-fit” programs as needed to ensure caseloads do not drop below 85%.
- b) Maintain a waiting list as needed when programs reach maximum capacity.

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