ADMINISTRATIVE PROTOCOL

<table>
<thead>
<tr>
<th>Level:</th>
<th>DHP Division</th>
<th>Policy Number:</th>
<th>DHP-MIECHV 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicability:</td>
<td>MIECHV</td>
<td>Date of Last</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Update:</td>
<td></td>
</tr>
<tr>
<td>Effective Date:</td>
<td>12/13/2013</td>
<td>Approved</td>
<td>12/13/2013</td>
</tr>
</tbody>
</table>

Subject: Maternal Infant Early Childhood Home Visitation Project Outreach to Elgin Families

Policy: The Community System Developer, following the current referral action plan, leads the outreach to families, with the support of MIECHV Coordinated Intake and MIECHV home visiting supervisors and staff.

Purpose: To assure that family outreach is effective and comprehensive so that home visit programs receive appropriate and eligible referrals that meet MIECHV priorities.

Procedure:
1. CSD conducts outreach activities according to current Elgin MIECHV Plan priorities:
   a. Community events, fairs, teen support groups, door-to-door, etc.
   b. Community agencies such as WIC, DHS, DCFS, YWCA, Family Case Management, immigration, pregnancy testing programs, community colleges and training programs, child care centers etc.
   c. Health providers such as physician, mental health, substance abuse
d. Parent groups
e. Convenes group of local outreach workers from Elgin area to develop collaboration in disseminating home visitation brochures and posters
   f. Maintains membership in the Elgin Hispanic Network and conducts promotion of home visiting among other members.
g. Meets with community groups at achieve collaboration
   h. Implements incentive pilot project to increase referrals from select obstetric and social service providers and parent leaders

2. CI leads response for central intake calls that emerge from community outreach supplements outreach activities of CSD and maintains and distributes outreach posters, brochures, and flyers.

3. MIECHV home visitors assist with outreach as their caseloads allow, including door-to-door, agencies, and WIC.

4. Outreach records are completed and maintained:
   a. CSD maintains outreach records for every partner that is invited to participate up and until the first referral is received by CI.
      i. Communication/meeting record—for outreach
      ii. MOU Record—collected for Home Visitation referrals and for AOK

Kane County Health Department
iii. Internal referral process flow chart developed with assistance of CSD for those agencies who submit HV MOU

iv. CSD maintains record of outreach events, number of people she tells about home visiting, and submits referrals obtained at the events.

b. Home Visitors submit outreach reports along with referrals obtained to CI.

5. CI, CSD, and Home Visit staff and supervisors implement incentive projects for family recruitment and retention as needs and resources determine.

6. CI produces monthly referral reports and the MIECHV CI, CSD, and home visitor supervisors conduct analysis in alignment with current outreach activities and take improvement actions as needed.

7. CSD, CI, MIECHV Supervisors and Home Visitors participate in continuous quality improvement.

**FORMS:** Elgin Referral Action Plan, Referral Form, Outreach Record Templates, WIC outreach record template

<table>
<thead>
<tr>
<th>Approved By: (Signature)</th>
<th>Theresa Heaton</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved By: (Name &amp; Title)</td>
<td>Theresa Heaton, CI/CSD Manager</td>
</tr>
<tr>
<td>Date of Approval:</td>
<td>12/13/2013</td>
</tr>
</tbody>
</table>
MIECHV Elgin Community
Referral Action Plan
Revised by Elgin MIECHV Team on September 26, 2013

Goal: Establish and maintain full caseloads for all MIECHV Home Visiting Agencies

Objective 1: Home visitors will be effective in enrolling clients as evidenced by increased enrollments and fewer families we cannot locate or who refuse home visitation.

Activities:
1.1 Q1: Develop a script/talking points—CSD and Home Visitor subgroup — by Sep 30, 2013
1.2 Q1: Train home visitors staff on the script—CSD and supervisors — by Oct 31, 2013
1.3 Q1-Q4: Pair up home visitors for finding hard-to-locate families as needed—HV staff and supervisors — by Oct 31, 2013
1.4 Q2-Q4: Track referral patterns post-training for each program—CI — monthly reports as of 10/2013

Objective 2: Referring agencies will be effective in presenting home visitation to clients as evidenced by referrals increasing.

Activities:
2.1 Q1: Develop a script/talking points—CSD and Home Visitor group - by Sep 30, 2013
2.2 Q2: Train existing referring staff (FCM, WIC, schools, obstetricians, churches, human services) on the script and new staff at time of MOU—CSD — by Oct 31, 2013
2.3 Q2-Q4: Implement drop by “check-in” every 4-8 weeks to the agencies with trained staff to keep the message fresh and remembered...until a referral pattern is established—CSD and HV staff - starting Nov 1, 2013
2.4 Q2-Q4: Track referral patterns post-training for each agency—CI — monthly as of 11/2013
2.5 Q3-Q4: Offer presentations in the community about home visitation—churches doctor offices, human service groups—CSD and MIECHV staff. [need to prioritize which sites will provide the most impact] mental health, obstetricians, housing authority local liaisons, school nurses, DHS Family Community Resource Center, YWCA, WIC, current referral partners with few referrals, pregnancy testing services and pregnancy centers.
2.6 Q1-Q4: Continue weekly emails to referring agencies to ask for referrals and/or to acknowledge referrals—CI

Objective 3: Families will be involved in promoting home visiting in Elgin as evidenced by outreach.

Activities:
3.1 Q1-Q4: Encourage enrolled parents to refer their friends/family—HV staff — design system and/or incentives by Oct 30, 2013; implement starting Nov 1.
3.2 Q1-Q4: Distribute brochures and posters among parent leaders from U-46, from Parent Café’s and COFI trainings, from Circle of Wise Women, and from Housing Authority—CSD and HV staff
3.3 Q1-Q4: Attend outreach events in the community including the library offerings that many parents attend—CSD and parent leader volunteers
3.4 Q2-Q4: Engage home visited families in providing testimony to the teen parents in the high schools and to others through video/audio/or other visuals—CSD and HV subgroup — by what date? December 15, 2013

Objective 4: Enhance our infrastructure for increasing awareness and referrals as evidenced by special projects.

Activities:
4.1 Q1-Q2: Develop, complete, and analyze survey of families that refuse home visitation to understand why they are refusing and use the results to change our scripts for engaging them—CI, CSD, supervisors, home visitors by Oct 30, 2013
4.2 Q2: Develop a website that promotes home visitation—CI, CSD, supervisors, home visitors. January 15, 2014
4.3 Q2: Give WIC staff feedback on all the referrals they make as well as referrals made by MIECHV staff through WIC classes—CI — weekly starting Oct 15 2013.
4.4 Q2: Develop communication with families on the waiting list so they know what is happening—CI and supervisors 1/15/2014
4.3 Q3-Q4: Produce bus or radio ads if budget allows—CI, CSD, supervisors, home visitors — design bus ads by Sep 30, 2013—if igrow is ready. Contact Spanish language radio by October 15, 2013 to set up interview.
Kane County Maternal-Child Home Visitation Programs
Referral Form

Mother's Name: __________________________
Nombre de Mama: ________________________

Child's Name: ____________________________
Nombre de Niño: _________________________

EDC (Due Date): _____/_____/______
Fecha Aproximada del Parto:

Address: ____________________________
Domicilio: _________________________

Street/Calle ________________________

City/Ciudad _________________________
Zip Code /Código Postal _____

Attending School/GED: Y N
Asistiendo a la Escuela/Equivalencia:
Where / Dónde: ________________________

# Years School Completed: _____________

# Años de Estudio: ____________________

Language(s): English Limited English: (Language/Idioma)
Idioma(s): Ínglés Ínglés Limitado

Please Check One/Favor de Marcar Una:

☐ First Time Mother/
Madre Primeriza

☐ Second Time Mother/
Mama por Segunda Vez

☐ Third Time or More Mother/
Mama por Tercera vez o más

I am interested in having a home visitor. I give permission for information from today's assessment to be shared with Kane County Home Visitation Programs/Collaborative through ETO, the Illinois electronic referral system. I understand that this information will be shared only to enable me to have contact with a home visitor, and that all information will be kept confidential by the home visit collaborative/programs and ETO.

Estoy interesada en recibir una visita a domicilio. Doy permiso para que la información de la evaluación del día de hoy se compartan con “Kane County Home Visitation/Collaborative a través del ETO, el sistema electrónico de remisiones de Illinois.” Entiendo que esta información se compartirá solamente para permitirme tener contacto con una persona del programa que me visite en casa y que toda la información se mantendrá confidencial por parte del programa de visitas a domicilio y el ETO.

Client Signature/ Firma del cliente __________________________

Date/ Fecha __________________________

Referral by: ____________________________
Name __________________________________________________________________

Agency ____________________________

☐ FCM ☐ WIC
☐ PIC ☐ Other __________

For MIECHV Agency Only: Told of all HV programs? ☐Yes ☐No

Keeper ☐Yes ☐No

Please fax completed referral forms to the Kane County Health Department at (630) 897-4845

FOR OFFICE USE ONLY

Referred to: ____________________________
Access Excel ETO NFP Faxed

Date Assigned to Home Visitor: ____________
Revised 11/27/12 (North)
Kane County Maternal-Child Home Visitation Programs
Referral Form

Client Name: ____________________________  (Last)  (First)  (MI)

Number of Children: ________

Ages of the Children (please circle)

Newborn  3mos  6mos  9mos  12mos  18mos  24mos  30mos  36mos  3  4  5  6  7

8  9  10  11  12  13  14  15  16  17  18  19  Other  _____

Please place a ✓ by applicable items:

Home Life:

__ No phone

__ Living arrangement:
  __ On own
  __ Spouse
  __ Parents/family members
  __ Partner/boyfriend
  __ Friends
  __ Temporary/short term housing
  __ Homeless

__ Father of baby:
  __ Not involved
  __ Unemployed
  __ Gang involvement

__ No active adult support

__ Inadequate emergency/family contacts

__ Domestic/family violence

__ Partner/family member threaten to hurt/punish

__ Current/former DCFS involvement

__ Child abuse/neglect

__ Client/child at risk of being removed from home, school, or community

__ Crime involvement or arrest record of client, partner, family member

__ Gang involvement

__ Violent crime victim

__ Services received
  __ Food Stamps/SNAP
  __ WIC
  __ TANF
  __ Social Security Income
  __ Social Security Disability

Behavioral Assessment:

__ Substance abuse

__ Smoking: _______/day

__ Beer/wine/liquor: _______/week

__ Parents have a problem with alcohol or drugs

__ Partner have a problem with alcohol or drugs

__ Have felt out of control or helpless

__ In last 2 weeks felt down/depressed/hopeless

__ In last 2 weeks, lost interest in things that used to be fun

__ History of depression, anxiety, or related mental health issue

__ Current diagnosis of depression, anxiety, or related mental health issue

Medical Info:

Medical home: Y or N

Medical home name: ____________________________

__ Last visit to the doctor, where did client go?
  __ Primary physician or OB/BYN
  __ Health Clinic
  __ Emergency Room
  __ Other ____________________________

__ Type of health insurance
  __ Private Insurance (Blue Cross Blue Shield, United Health, CIGNA, etc.)
  __ Public Insurance (Medicaid, CHIP)
  __ No Health Insurance

__ Client has a learning disability

__ Client is developmentally delayed

Prenatal/Infant Care:

__ Date of first prenatal visit: _____/_____/_____

__ Number of prenatal visits

__ Late or no prenatal care, poor compliance

__ Adoption sought/attempted

__ Abortion sought/attempted

__ History of miscarriage/fetal death

__ Risk from EPDS screening: (circle one)
  HIGH  MODERATE

__ At elevated risk for premature delivery/birth complications due to physical/medical condition:
  ____________________________

__ Infant has a NICU admission/high-risk medical diagnosis

Please specify: ____________________________

__ Infant/child is receiving Early Intervention Services

Other: ____________________________
Kane County Maternal-Child Home Visitation Programs
Referral Form

Today's Date: ____________________

Mother’s Name: ____________________
Nombre de Mama:

Child’s Name: ____________________
Nombre de Niño:

EDC (Due Date): _____/_____/_____
Fecha Aproximada del Parto:

Address: ____________________
Domicilio: Street/Calle

City/Ciudad Zip Code /Código Postal

Language(s): English Limited English: ____________________
Idioma(s): Inglés Inglés Limitado (Language/Idioma)

Comment: ____________________

Number of Children: ______

Ages of the Children (please circle below):

Newborn 3mos 6mos 9mos 12mos 18mos 24mos 30mos 36mos 3 4 5 6 7

8 9 10 11 12 13 14 15 16 17 18 19 Other ___

I am interested in having a home visitor. I give permission for information from today’s assessment to be shared with Kane County Home Visitation Programs/Collaborative through Visit Tracker, the Illinois electronic referral system. I understand that this information will be shared only to enable me to have contact with a home visitor, and that all information will be kept confidential by the home visit collaborative/programs and Visit Tracker. Estoy interesada en recibir una visita a domicilio. Doy permiso para que la información de la evaluación del día de hoy se comparta con “Kane County Home Visitation/Collaborative a través del Visit Tracker, el sistema electrónico de remisiones de Illinois.” Entiendo que esta información se compartirá solamente para permitirme tener contacto con una persona del programa que me visite en casa y que toda la información se mantendrá confidencial por parte del programa de visitas a domicilio y el Visit Tracker.

Referrer by: ____________________
Name ____________________
Agency ____________________

For MIECHV Agency Only: Told of all HV programs? ☐ Yes ☐ No Keeper ☐ Yes ☐ No

Please fax completed referral forms to the Kane County Health Department at (630) 897-4845

Referred to: ____________________
Date Assigned to Home Visitor: ____________________

☐ Access ☐ Excel ☐ V.T. ☐ NFP ☐ Fax

Revised 11/8/13 draft (North)
Person Completing this form:

Name: __________________________
Phone #: _________________________
Email: __________________________

MIECHV Partner:  
FF □ VNA □
KK □ U-46 □

Table 1: OUTREACH RECORD MIECHV PARTNERS

Please email to: homevisitation@co.kane.il.us

<table>
<thead>
<tr>
<th>Agency that was Approached</th>
<th>Contact person</th>
<th>Type of Outreach (Marked with the date it took place)</th>
<th>Outcome of the Outreach Attempt</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In Person</td>
<td>Telephone Contact</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Month of October 2013</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well Child WIC Classes - Tally of Classes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Class Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>LM SPANISH</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>PP ENGLISH</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Class Type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Class attendance details are not visible in the image.*