



Illinois Statewide Strategic Plan

Preschool Development Grant Birth Through Five

FEBRUARY 2020

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We also extend a very special thank you for the input of a wide range of stakeholders across the development of this plan, including parents and service providers. A full list of stakeholders involved appears in Appendix B.

Executive Summary

The Illinois strategic plan is based on the underlying principle that its mixed-delivery system should provide universal supports as well as targeted interventions to help children reach their optimal outcomes. We envision Illinois as a place where every young child—regardless of race, ethnicity, income, language, geography, ability, immigration status, or other circumstance—receives the strongest possible start in life so that they grow up safe, healthy, happy, ready to succeed, and eager to learn.

Based on this vision, Illinois' mission is to provide access to a continuous, equitable, and high-quality early childhood system that enables children, with the support of their families and communities, to grow up safe, healthy, happy, and ready to succeed. , Illinois has a long history of continuous improvement in its early childhood care and education (ECCE) mixed-delivery system. It values coordination and collaboration across administrative systems to provide a cohesive and comprehensive set of programs and services to young children. As a result of a commitment to improve the ECCE mixed-delivery system and realize its vision and mission, Illinois was awarded a federal Preschool Development Grant Birth Through Five (PDG B-5) by the Administration for Children and Families at the U.S. Department of Health and Human Services and the U.S. Department of Education. The strategic plan shared in this document reflects a central activity of Illinois PDG B-5 grant informed by another PDG B-5 activity, a statewide needs assessment, and stakeholder input.

The process of developing a statewide strategic plan included five major activities: (a) findings from a statewide needs assessment, (b) input from the Illinois Early Learning Council ad hoc strategic plan workgroup, (c) input from the Illinois Governor's Office of Early Childhood Development focal planning workgroups, (d) reviewing existing statewide strategic plans, and (e) collecting input from constituents and stakeholders. Illinois has prioritized 23 strategic goals that are categorized in four topic areas or domains—access, quality, coordination, and workforce—to advance the state's B-5 system, as outlined in Exhibit ES1. Exhibit ES2 presents a crosswalk of the strategic plan with the findings of the needs assessment report, as required by the PDG B-5 grant.

Exhibit ES1. Illinois Prioritized ECCE Access Strategic Goals

Strategic focal area	Prioritized ECCE strategic goals
Access	1. Ensure that families with children from prenatal to kindergarten entry age have access to ongoing preventive health care and all appropriate well-child care, health screenings, development and social-emotional supports, immunization, and mental health services and supports.
Access	2. Expand universal newborn supports for all births to connect families with local community services and resources based on individual needs and family wishes.
Access	3. Expand access to home visiting for all eligible families to achieve desired saturation and take innovation models to scale.
Access	4. Ensure that all low- and middle-income families have access to high-quality, affordable infant and toddler care programs that meet their families' schedules and needs.
Access	5. Ensure that all low- and middle-income families have access to high-quality, affordable preschool early childhood programs that meet their families' schedule and needs.
Access	6. Ensure that all infants and toddlers in early intervention receive individualized family service plan (IFSP) services in a timely manner.
Access	7. Ensure that all young children with special needs receive special education services in inclusive settings within the mixed-delivery service model.
Access	8. Increase family and parent knowledge, choice, and engagement within the ECCE system.
Access	9. Eliminate racial/ethnic disparities for children participating in all programs that contribute to school readiness and life success by addressing racial disparities in enrollment in preschool for 3- and 4-year-olds and in prenatal to age 3 services.
Coordination	10. Ensure that Illinois' early childhood practice and policy decisions are driven by a culture of data use that supports strong, equitable outcomes and engages stakeholders.
Coordination	11. Establish and sustain a defined state/regional/local infrastructure for Illinois' early childhood system to implement efforts to improve outcomes for young children.
Coordination	12. Support systems building and improve cross-system connections among programs to ensure that every community has a system for helping families access the coordinated supports they need.
Quality	13. Implement a funding mechanism that is timely, transparent, and sustainable that service providers can access to deliver high-quality ECCE, meet evidence-based performance standards, and provide adequate compensation to all ECCE staff.

Strategic focal area	Prioritized ECCE strategic goals
Quality	14. Modify standards and strengthen support systems so that programs move to higher levels of the Quality Rating and Improvement System (QRIS; ExceleRate) and children achieve kindergarten readiness.
Quality	15. Improve the quality of home-based settings by providing appropriate supports and incentives, including funding for family childcare networks.
Quality	16. Ensure that investments and policies for early childhood mental health efforts are (a) carried out within the framework of equitable promotion, prevention/intervention, and treatment; (b) embedded in the Illinois comprehensive early childhood system; (c) designed to meet the needs of all children and their families with a focus on the most vulnerable; and (d) organized to demonstrate accountability.
Quality	17. Expand the number of ECCE programs implementing the Pyramid Model.
Workforce	18. Increase compensation for providers in the ECCE workforce.
Workforce	19. Eliminate racial and ethnic disparities in the early childhood workforce.
Workforce	20. Enhance early childhood professional development to expand access as well as service offerings, such as mentoring and coaching.
Workforce	21. Restructure and integrate workforce data systems to better allow linkage, analysis, research, sharing, exporting, and use.
Workforce	22. Provide the higher education supports necessary to produce a qualified, competent, diverse, and representative ECCE workforce, including the development of a competency-based preparation and qualifications system and higher education supports for educator candidates.
Workforce	23. Increase opportunities for the early childhood workforce to better support the development of children from culturally, racially, and linguistically diverse backgrounds.

Exhibit ES2. Strategic Plan Alignment to the Needs Assessment

Alignment with needs assessment domains	Corresponding page number(s)
Focal populations for the grant	5, 10, 22
Quality and availability	15, 16
Gaps in data on quality and availability of programming and supports for children and families	16
Quality and availability of programs and supports	17
Gaps in data/research to support collaboration in programs/services and maximize parental choice	5, 6
Measurable indicators of progress	10, 13
Issues involving ECCE facilities	8
Barriers to the funding and provision of high-quality ECCE services and supports and opportunities for more efficient use of resources	16, 17, 23
Transition supports and gaps	14, 15
System integration and interagency collaboration	23

Illinois Strategic Plan: Our Values, Vision, and Mission

The Illinois strategic plan builds on the value that its mixed-delivery system should provide universal supports and targeted interventions so that every child receives the supports they need to reach their optimal outcomes.

- *We envision Illinois as a place where every young child—regardless of race, ethnicity, income, language, geography, ability, immigration status, or other circumstance—receives the strongest possible start to life so that they grow up safe, healthy, happy, ready to succeed, and eager to learn.*
- *Illinois' mission is to provide access to a continuous, equitable, and high-quality early childhood system that enables children, with the support of their families and communities, to grow up safe, healthy, happy, and ready to succeed.*

With this central value, vision, and mission, Illinois has a long history of promoting continuous improvement of its early childhood care and education (ECCE) mixed-delivery system. Illinois values coordination and collaboration across administrative systems to provide a cohesive and comprehensive set of programs and services to young children. A demonstration of the state's commitment to continuous improvement, the Illinois Governor's Office of Early Childhood Development (GOECD), was created to serve as a coordinating body for the state agencies that administer ECCE programs; support the system building of ECCE programs throughout the state; and promote the work of the state's statutory advisory council, the Illinois Early Learning Council (ELC). The ELC is a public-private partnership created under Public Act 93-380 to coordinate existing programs and services for children from birth to age 5. The ELC is the leading advisory body for Illinois' early childhood system. Its membership includes public agency representatives, service providers, private funders, advocates, and family organizations.

The ELC, supported by the GOECD, created a strategic framework to guide the state's ECCE system improvements. This Preschool Development Grant Birth Through Five (PDG B-5) initiative offers the opportunity to build on the ELC's foundational strategic framework, as well as several other system improvement efforts in the state. Although the goals described in this document are to benefit all children from birth to age 5 in the state, it is important to note that the goals also were guided by a recent needs assessment of children of vulnerable or underserved populations.

The PDG B-5 Federal Grant

As a result of a commitment to improve the ECCE mixed-delivery system and realize its vision and mission, Illinois received a federal Preschool Development Grant Birth Through Five from the Administration for Children and Families at the U.S. Department of Health and Human Services and the U.S. Department of Education. The overall purpose of the grant is to improve the effectiveness of Illinois’ ECCE mixed-delivery system by executing the following activities: (a) conducting a statewide needs assessment, (b) developing a statewide strategic plan, (c) increasing opportunities for parent choice and knowledge about high-quality ECCE, (d) sharing best practices among early childhood service providers, and (e) improving the overall quality of ECCE services. The strategic plan shared in this document reflects the second activity of Illinois PDG B-5 grant, which is informed by the first activity—the PDG B-5 needs assessment.

In aligning Illinois’ values, vision, and mission for its ECCE mixed-delivery system, the state has prioritized 23 strategic goals categorized in four strategic focus areas—access, quality, coordination, and workforce—to advance the state’s B-5 system. These 23 goals are described in detail in this document, along with strategic and progress indicators. Before detailing each goal, we first provide background on the strategic planning process and the needs assessment findings that led to the prioritized 23 goals for Illinois.

Strategic Planning Process

To inform the strategic plan, Illinois contracted with the American Institutes for Research (AIR) to lead a comprehensive, statewide needs assessment of the Illinois ECCE mixed-delivery system and its strategic planning effort.¹ The process of developing a statewide strategic plan included five major activities: (a) findings from a statewide needs assessment, (b) input from an ELC ad hoc strategic plan workgroup, (c) input from GOECD focal planning workgroups; (d) a review of existing statewide strategic plans,



¹ Additional organizations contracted by Illinois for the needs assessment included Northern Illinois University and the University of Illinois at Urbana-Champaign.

and (e) input from constituents and stakeholders. This section provides details on each activity in the strategic planning process.

- **Statewide needs assessment.** The statewide needs assessment included: (a) a review of existing needs assessments and other resources, (b) a literature review, and (c) facilitation of stakeholder focus groups. In addition, AIR received additional information from other contracted organizations to address some of the needs assessment domains.
- **Illinois strategic plan workgroup.** The Illinois strategic plan workgroup included representatives from state entities that serve B-5 families, such as GOECD, the Illinois State Board of Education (ISBE), the Illinois Department of Human Services (IDHS), Illinois Head Start, the Illinois Department of Children and Family Services (DCFS), ELC members, key partners in the nonprofit and philanthropic ECCE sectors, and other ECCE stakeholders (see Appendix B). The strategic plan workgroup met two times during the strategic planning process to prioritize and finalize the 23 strategic goals, develop metrics, and give input on action steps and strategies. This group will continue to work to refine and update the strategic plan in 2020 and subsequent years.
- **Focal planning workgroups.** Illinois, under supervision by the GOECD, contracted with organizations to lead focal strategic planning activities on the following topics: (a) aligning and coordinating ECCE professional development; (b) home visiting and early intervention for children in child welfare, (c) inclusion of children B–5 with disabilities in community-based early childhood programs, and (d) kindergarten transition.
- **Reviewed existing strategic plans.** Illinois had several existing strategic plans, ELC committee work plans, and other strategic planning initiatives to draw on to inform the development of strategic goals and action steps (see Appendix D for a list of these plans). In addition, we collected active strategic planning activities being conducted by other ECCE groups in the state to develop a strategic policy agenda and implementation plan focused on prioritizing the expansion of high-quality services to infants and toddlers from low-income households and their families.
- **Collected input from constituents and stakeholders.** AIR worked closely with the GOECD to engage and collect input from a range of stakeholders (see Appendix B). These activities included communicating with and/or attending ELC committee and subcommittee meetings; coordinating with other strategic planning activities; conducting three focus group interviews with parents and service providers; and creating a public online Web portal survey and input form. Please see the next section for a summary of input received from engaging stakeholders.

Stakeholder Engagement Summary

A final draft of the strategic plan was released publicly for three different stakeholder engagement activities: (a) We conducted focus group interviews with parents and service providers; (b) we disseminated the plan to ELC committee chairs and co-chairs; and (c) we uploaded the strategic plan document on GOECD's website for public input. This section summarizes the stakeholder feedback received on the strategic plan. (See Appendix C for additional information collected from these stakeholder engagement methods.)

- **Focus group interviews with parents and providers.** The purpose of the focus group interviews was to receive input from parents and providers about the strategic plan's four focal strategic areas. A total of 33 participants (8 parents, 25 service providers) participated in the three Illinois focus group interview sessions (one in Chicago, one in the Chicago suburbs, and one in the southern part of the state). There was great interest in these focus groups. Each group had nine to 12 participants, and two of the three groups had waiting lists. Overall, participants agreed with the four strategic focus areas for the state's strategic plan and felt that they were all important for the state to focus on for improving the ECCE system. However, there was a range of ideas about strategies and action steps needed to realistically make improvements in the four strategic areas. (See Appendix C for more details on the focus group discussion.)
- **ELC committee member input.** ELC committee members who provided feedback felt that the four strategic focus areas accurately represented the needs of the state. In particular, those providing input on the strategic plan appreciated the emphasis on equity and that the plan addressed eliminating disparities for both children and ECCE professionals. In addition, the strategies to increase mental health services for young children were supported given the limited amount of resources currently available to communities and schools. Respondents also had many thoughts about ways to improve the plan moving forward, including additional strategies and action steps for consideration. These suggestions included the need to put a greater emphasis on securing additional funding, identifying barriers to uptake in services and creating strategies to address these, and ensuring that the strategic targets are realistic and attainable. See Appendix C for additional information about additional feedback and suggested strategies.
- **Website for public input.** We received 14 responses from the online website portal. Input from the public website portal suggested that all four strategic focus areas were important, with workforce being the top priority of the four strategic focus areas (13 respondents), followed by access (11 respondents) and quality (11 respondents). Eight respondents noted that coordination is a priority area in their community. Overall, we received feedback that the strategic plan has the right priorities and focus

areas. Specific comments related to how the strategic plan could be improved and updated are in Appendix C.

The Needs Assessment Findings

The needs assessment was informed by 42 existing needs assessments and related documents; stakeholder focus groups with providers, parents and caregivers, and community partners (37 total focus group participants); a literature review; and analysis and administrative data exports from other GOECD contactors. Exhibit 1 presents the domains covered in the needs assessment report.² As we discuss the 23 strategic goals in the following sections, we will summarize relevant findings from the Illinois statewide needs assessment.

Exhibit 1. Needs Assessment Domains

Needs assessment domains
Focal populations for the grant
Quality and availability
Gaps in data on quality and availability of programming and supports for children and families
Quality and availability of programs and supports
Gaps in data/research to support collaboration in programs/services and maximize parental choice
Measurable indicators of progress
Issues involving ECCE facilities
Barriers to the funding and provision of high-quality ECCE services and supports and opportunities for more efficient use of resources
Transition supports and gaps
System integration and interagency collaboration

² Garcia-Arena, P., Hodgman, S., Jones, K., and Howard, E. (2020). *Illinois Preschool Development Grant Birth through Five Needs Assessment Final Report*, Unpublished report.

Strategic Plan Goals



This strategic plan builds on the foundation that Illinois has maintained for years, which is set forth in the ELC’s strategic framework: to make an impact so that more children, particularly those in vulnerable and underserved populations, have greater access to high-quality ECCE programs and services. The 23 goals in this strategic plan are organized into four strategic focus areas—access, quality, coordination, and workforce—that arose from the strategic planning process. For each strategic focus, we summarize relevant needs assessments, provide strategic targets, and list progress indicators.³ Each strategic goal includes a detailed list of action steps. Although each strategic focal area stands alone, the focal areas and goals overlap. A glossary of terms related to the strategic plan is in Appendix A.

Strategic Focus 1: Access—Expanding Equitable Access to ECCE Services

- **Needs Assessment Finding:** *Access to high-quality ECCE services is not uniform across the state across a range of social, economic, racial, and ethnic groups.*

The needs assessment findings indicated that the availability of ECCE has increased in recent years, but access to high-quality services is not uniform across Illinois. Many state-led initiatives are in place to help ensure that children from vulnerable or underserved populations have access to the support services they need, but many parents may lack awareness of these supports and resources. The findings also indicated a disruption (e.g., loss of services or delay in services) between enrollment in early intervention and special education services on entry into formal schooling (i.e., ages 3 years and up). Rural areas, in particular, were found as places where disruption and demand for special education services were the greatest.

³ The University of Illinois at Urbana-Champaign developed all the strategic goal progress indicators.

Access Strategic Targets

Home Visiting and Infant/Toddler Supports

- By 2025, increase the number of new high-quality home visiting slots by 13,000 (based on fiscal year (FY) 2019 level).
- By 2025, increase the number of new high-quality infant-toddler slots by 5,000 (based on FY19 level) and ensure that slots that meet Early Head Start and/or Prevention Initiative Center-Based quality standards.

Preschool

- Ensure that 80% of the low-income children entering kindergarten have at least 1 year of high-quality preschool and 70% of the children have 2 years of high-quality preschool by 2023.

Early Intervention/Special Education

- By 2025, increase the number (or percentage) of preschool-aged children receiving inclusive special education services across the state by 2 percentage points.

Goal 1: Provide Access to Ongoing Preventive Health Care

GOAL: *Ensure that families with children from prenatal to kindergarten entry age have access to ongoing preventive health care and all appropriate well-child care, health screenings, development and social-emotional supports, immunization, and mental health services and supports.*

Strategies/Action Steps

- Set state-level ECCE system performance outcomes/indicators to measure progress.
- Prioritize baseline data for the targeted health disparities.
- Provide training for staff, partners, and the public regarding health disparities.
- Develop ongoing benchmarks for priority health disparities.
- Establish a legislative agenda and partnerships to support health disparity reduction targets.
- Develop traditional and nontraditional funding streams to support health disparity reduction programs and processes.
- Establish voluntary universal prenatal and postpartum connections/visits that provide referral services.
- Expand funding and access to doulas.
- Increase funding for perinatal support.
- Expand access to primary health care, dental care, immunization

- K. Improve data sources to identify gaps in local mental health services, developmental screenings, and social-emotional screenings by conducting outreach.

Goal 2: Expand Newborn Supports for All Births

GOAL: *Expand universal newborn supports for all births to connect families with local community services and resources based on individual needs and family wishes.*

Strategies/Action Steps

- A. Identify and charge an existing workgroup to oversee, develop, and participate in the action steps and finance mechanisms needed for this goal.
- B. Inventory the availability, access, quality, and equity of newborn supports throughout the state.
- C. Identify communities ready for the next phase of the statewide expansion of universal newborn supports.
- D. Identify a source of sustainable funding for statewide universal newborn supports expansion (not to supplant funding for existing evidence-based home visiting).
- E. Plan for the alignment and coordination of all ECCE providers and universal newborn supports to strengthen the referral process from newborn supports to ECCE providers.
- F. Plan for the alignment and coordination of coordinated intake for home visiting and universal newborn supports to strengthen referral processes for home visiting and ensure prenatal outreach to families before universal newborn supports through coordinated intake for home visiting.

Goal 3: Expand Home Visiting

GOAL: *Expand access to home visiting for all eligible families to achieve desired saturation and take innovation models to scale.*

Strategies/Action Steps

- A. Increase funding to home visiting programs, targeting expansion to communities with the greatest gaps in available service slots.
- B. Increase awareness of the benefits and availability of intensive home visiting services to increase uptake of home visiting services by eligible families.
- C. Institutionalize successful home visiting innovations, such as child welfare home visiting, to increase access to targeted services among priority population families.

Goal 4: Ensure Affordable Infant and Toddler Care

GOAL: *Ensure that all low- and middle-income families have access to high-quality, affordable infant and toddler care programs that meet their families' schedules and needs.*

Strategies/Action Steps

- A. Increase the Early Childhood Block Grant funding for the Prevention Initiative and funding from other sources.
- B. Conduct a gap and needs analysis about the affordability of high-quality infant and toddler care.
- C. Expand the communities that are able to successfully apply for Early Childhood Block Grant funding to include more low- and middle-income communities.
- D. Implement strategies for increasing the number of high-quality childcare opportunities for infants and toddlers from low-income households and improve the quality of existing childcare for infants and toddlers.
- E. Increase the capital grant funding for supporting infant and toddler programs.
- F. Expand eligibility and lower co-pays for the Childcare Assistance Program (CCAP).

Goal 5: Ensure Affordable Preschool Early Childhood Programs

GOAL: *Ensure that all low- and middle-income families have access to high-quality, affordable preschool early childhood programs that meet their families' schedules and needs.*

Strategies/Action Steps

- A. Significantly close gaps in full funding by increasing the Early Childhood Block Grant funding for Preschool for All (PFA) and target funding to communities with the biggest service gaps.
- B. Expand the communities that are able to successfully apply for Early Childhood Block Grant funding to include more low- and middle-income communities.
- C. Increase the capital funds to build facilities in areas with low access to high-quality, affordable preschool early childhood programs.

Goal 6: Provide Timely Early Intervention Services

GOAL: *Ensure that all infants and toddlers in early intervention receive individualized family service plan (IFSP) services in a timely manner.*

Strategies/Action Steps

- A. Implement access to billable, telehealth early intervention services, especially for those families experiencing delays in receiving any of the recommended IFSP services.
- B. Explore and resolve transportation-related barriers that would potentially allow families to access early intervention services (with improved transportation options) in their natural environments.
- C. Establish specialized teams that are uniquely equipped to provide services to bilingual or multilingual families.

- D. Establish specialized teams that are uniquely equipped to provide services to children experiencing homelessness, living in rural areas, and who are in the child welfare system by focusing efforts and supports on particular Child and Family Connections (CFC).

Goal 7: Provide Timely Special Education Services

GOAL: *Ensure that all young children with special needs receive special education services in inclusive settings within the mixed-delivery service model.*

Strategies/Action Steps

- A. Expand access and increase funding to ensure that more high-quality programs are in place to improve services and access to high-quality inclusive childcare.
- B. Increase childcare capacity to provide high-quality inclusive childcare through technical assistance and professional development.
- C. Revise the quality standards related to inclusion within ExceleRate.
- D. Improve continuity between Individuals with Disabilities Education Act (IDEA) Part C (birth to age 2) and Part B (ages 3 to 21) services.
- E. Create and implement guidance with administrators of local education agencies (LEAs), community-based organizations (CBOs), Head Start directors, early intervention professionals, and other ECCE programs to provide inclusive opportunities for serving young children with disabilities across the state.
- F. Elevate models of successful collaboration between LEAs, early intervention providers, CBOs, and other ECCE programs to serve children with disabilities with supports and services within CBOs.
- G. Ensure that state rules and regulations are in place to allow LEAs flexibility to provide services and supports and CBOs flexibility to collaborate with LEAs.
- H. Build infrastructure to support early intervention providers and ECCE providers (Prevention Initiative, Early Head Start, childcare) to provide services with the intent to maximize inclusive opportunities for infants and toddlers with disabilities and their families.

Voice of an Illinois ECCE Parent:

"I am a parent of three children of disabilities. They need to have parents at the table. When you only have educators and providers at the table, you're missing out on a whole perspective."

Goal 8: Increase Family Engagement

GOAL: Increase family and parent knowledge, choice, and engagement within the ECCE system.

Strategies/Action Steps

- A. Provide opportunities for parent leadership and parent supports in all program, community, and state-led advisory bodies.
- B. Increase family access to resources pertaining to parenting, inclusion, homelessness, and linguistic isolation.
- C. Provide training to staff to support families.

Voice of an Illinois ECCE Provider:

“Some parents ‘don’t know what they don’t know’ and are, therefore, discouraged from taking leadership positions.”

Goal 9: Eliminate Racial/Ethnic Disparities in ECCE Services

GOAL: Eliminate racial/ethnic disparities for children participating in all programs that contribute to school readiness and life success by addressing enrollment of the currently priority populations in preschool for 3- and 4-year-olds and in prenatal to age 3 services.

Strategies/Action Steps

- A. Establish and implement concrete work plans and accountability measures for the ELC racial equity plan.
- B. Align and standardize race/ethnicity data collection and reporting (collect, analyze, and report by race/ethnicity and English learner status).
- C. Evaluate and identify whether processes for distributing resources, such as agency contracting, exacerbate racial disparities.
- D. Determine the extent of disparities by income, race, ethnicity, and language ECCE enrollment and participation data, across a range of services and ExceleRate quality ratings.
- E. Produce an annual report on the progress to date on this goal.
- F. Identify a racial equity assessment tool for ECCE programs to use.
- G. Prioritize state ECCE funding and investments in priority populations and create resources to develop capacity in geographic areas with the greatest racial/ethnic disparities.
- H. Create pilots for a comprehensive neighborhood system of care collaboratives (a collaboration of multiple programs and agencies) to ensure that the state is meeting a range of family needs (such as housing or rent assistance, transportation, food, employment).
- I. Develop strategies to integrate families of all backgrounds, including those with mixed immigration status, families without permanent housing, families who are justice involved, caregivers who work nontraditional hours, and others into ECCE services.

Access Key Progress Indicators

- Data from all progress indicators by income, language, race, and ethnicity
- Number of enrollment slots in ExceleRate Illinois Silver- and Gold-rated programs serving all eligible children
- Number of children entering kindergarten who have access to at least 1 year in an ExceleRate Illinois Silver- and Gold-rated publicly funded preschool
- Number of enrollment slots designated for home visiting programs
- Number of enrollment slots designated for infants/toddlers in licensed childcare programs
- Number of children enrolled in early intervention and special education programs
- Number of children enrolled in early intervention programs and special education programs receiving services in community settings

Special Education and Inclusion Indicators

- Number and percentage of preschool-aged children receiving special education services across the state
- Number and percentage of preschool-aged children receiving special education services within public preschool programs (e.g., Head Start, PFA) across the state
- Number of preschool-aged children receiving self-contained special education services across the state
- Number of children enrolled in early intervention receiving services in community settings
- Number of early childhood programs in which special education services are delivered (e.g., Head Start, PFA, childcare)
- Characteristics of children receiving special education services across the state (e.g., race, ethnicity, age)
- Number and percentage of general ECCE settings with an ExceleRate Gold rating in which young children with disabilities receive special education services
- Number and percentage of children with special needs enrolled in general ECCE settings in which young children with disabilities receive special education services
- Number and percentage of general ECCE settings with an ExceleRate Silver rating in which young children with disabilities receive special education services
- Number and percentage of general ECCE settings (serving children receiving special education/early intervention services) with Outstanding Practices in Inclusion awards
- Number of classrooms that implement at high quality as determined by tools, such as the Illinois Inclusion Guidelines or Inclusive Classroom Profile

Strategic Focus 2: Coordination—Enhancing Coordination and Collaboration Across Multiple Types of ECCE Services

- **Needs Assessment Finding:** *A challenge to system integration and interagency collaboration is a lack of consistency in data reporting and collection.*

The needs assessment found that coordination between service providers as well as among state agencies and other organizations, particularly coordination related to the definition of terms, data collection, reporting and analysis, transition supports, and cost modeling is a major challenge to system coordination and collaboration. The central barrier is a lack of consistency in the definitions and the use of key ECCE system terms. The definitions of terms such as “low-income” families, “quality” ECCE, and “access to” or “availability of” ECCE varied across reports. Transition supports (between preschool, kindergarten, home visiting, and/or different types of care) also were found in the needs assessment as a challenge to improving coordination. For children who are vulnerable or underserved, trauma-informed support that follows the children as they transition between types of care (e.g., home- to center-based childcare or preschool to kindergarten) also was identified as a need.

Coordination Strategic Targets

- By 2023, increase the number of state-funded community collaborations to 75–100 (that are accountable to the defined roles and responsibilities).
- By 2025, there will be 75–100 highly functioning community collaborations (that are accountable to the defined roles and responsibilities).

Goal 10: Improve Data Usage

GOAL: *Ensure that Illinois’ early childhood practice and policy decisions are driven by a culture of data use that supports strong, equitable outcomes and engages stakeholders.*

Strategies/Action Steps

- Improve the public reporting of relevant data, including but not limited to dashboards measuring progress on key indicators.
- Strengthen the capacity of all stakeholders to use data effectively, at both the state and community levels.
- Strengthen the ability of agencies to share data while protecting individual privacy.
- Improve the ability of the state to share data with research partners.
- Streamline data collection and support new technology platforms that reduce the burden on providers.
- Where needed, create streamlined processes to obtain consent from families.

- G. Build the state’s capacity to conduct research and evaluation to study and learn from the implementation of all strategies and support the capacity needed to use the results of that research and evaluation to improve policy and practice.

Goal 11: Define an Infrastructure to Implement Comprehensive Systems-Building Efforts

GOAL: *Establish and sustain a defined state/regional/local infrastructure for Illinois’ early childhood system to implement efforts to improve outcomes for young children.*

Strategies/Action Steps

- A. Build and fund state-level infrastructure and readiness to support access to data and support community-level planning at the regional and local levels in identified high-need communities (e.g., priority and underserved).
- B. Support local community collaborations in successfully completing and improving the community systems development benchmark survey.
- C. Provide funding to increase the number and percentages of communities using coordinated intake.
- D. Develop a database to track the procedural steps, families, and referrals in the coordinated intake process.

Goal 12: Strengthen Program Coordination

GOAL: *Support systems building and improve cross-system connections among programs to ensure that every community has a system for helping families access the coordinated supports they need.*

Strategies/Action Steps

- A. Improve alignment between home visiting, childcare, preschool, and other systems—such as early intervention, child welfare, mental health, and health care—to improve the ease of referrals and access to a continuum of services for families.
- B. Streamline access for families by establishing eligibility requirements on a continuum and/or creating a common intake procedure.
- C. Incentivize and support implementation of kindergarten transition plans through coordination between early childhood collaborations and local public schools.
- D. Build our existing and new cross-sector partnerships to support holistic wraparound and coordinated supports for children and families for ECCE services and other services.

Voice of an Illinois ECCE Provider:

“There isn’t a set standard for demonstrating collaboration in a practical way so that multiple districts can implement [programming] and connect.”

Coordination Key Progress Indicators

- Number of community collaborations established in identified high-need communities
- Percentage of local community collaborations completing the community systems development benchmark survey

Expanded Coordinated Intake in Home Visiting Programs Performance Metrics

- Home visiting
 - Increase the total number of home visiting program slots filled by coordinated intake.
 - Increase the total number of referrals processed by coordinated intake.
 - Improve the ability to track the source and status of referrals to home visiting. Track the status of any additional referrals made to other entities and agencies.
- Coordinated intake process
 - Improve the ability to track the number of priority populations of families participating in coordinated intake as measured by income, language, race, and ethnicity.

Kindergarten Transition Performance Indicators

- Increase the number of LEAs partnering with ECCE providers on kindergarten transition plans, including the use of local transition leadership teams, developing a plan to share student information between ECCE programs and kindergarten, professional development activities, and curricula alignment plans.

Strategic Focus 3: Quality—Improving the Quality of ECCE Services

- **Needs Assessment Finding:** *Access to high-quality ECCE services is not uniform, and no standard definition is used for quality across the full range of ECCE services serving children prenatal to age 5—and their families—in the system.*

The needs assessment findings indicated that access to high-quality ECCE services is not uniform across Illinois. Also, a consistent definition of what quality means for ECCE systems is lacking across organizations. Although a few common themes emerged (developmentally appropriate curricula, teacher qualifications, inclusion of specific populations, family engagement, and compliance with state and federal standards), not every element appeared in every definition of quality used in the Illinois ECCE system.

Quality Strategic Targets

- Increase the number of ExceleRate Illinois Silver- and Gold-rated licensed center and home-based programs from 839 to 1,510 by 2023.
- Increase the number of children birth to age 5 years served in high-quality care that includes comprehensive family supports by 5,000 by 2023.
- Increase the number of trained and practicing early childhood mental health consultants from 100 to 300 by 2023.
- Increase the number of ECCE programs receiving Pyramid Model implementation support from a process coach by 50% (currently 42 programs) by 2023.

Goal 13: Implement an Improved Funding Mechanism

GOAL: *Implement a funding mechanism that is timely, transparent, and sustainable that service providers can access to deliver high-quality ECCE, meet evidence-based performance standards, and provide adequate compensation to all ECCE staff.*

Voice of an Illinois Parent:

“Funding is the number one issue to how our kids are learning.”

Strategies/Action Steps

- A. Implement the Funding Commission’s recommendations for the mechanisms for funding distribution.
- B. Develop childcare contracting models.

- C. Execute a PDG pilot for transforming the funding of childcare and other ECCE services.
- D. Integrate lessons learned into the current system and bring to scale.

Goal 14: Modify QRIS Standards and Strengthen Support Systems

GOAL: *Modify standards and strengthen support systems so that programs move to higher levels of the Quality Rating and Improvement System (QRIS; ExceleRate) and children achieve kindergarten readiness.*

Strategies/Action Steps

- A. Finalize revisions to QRIS standards.
- B. Engage ISBE, IDHS, DCFS, and Head Start in planning for support aligned with the revised standards.
- C. Adapt the contracts and funding for the Childcare Resource & Referral and other program support systems needed to execute the revised standards.
- D. Build ECCE programs' and staff capacity to include and serve children from priority populations, through strengthened policies and supports.

Goal 15: Improve the Quality of Home-Based Childcare Settings

GOAL: *Improve the quality of home-based childcare settings by providing appropriate supports and incentives, including funding for family childcare networks.*

Strategies/Action Steps

- A. Engage the ExceleRate subcommittee to establish a tiered funding/tiered QRIS ladder for family childcare homes to improve quality in steps to higher ExceleRate circles of quality.
- B. Fund family childcare networks and support services.
- C. Fund resources to family childcare homes to improve physical environments to attain higher ExceleRate circles of quality.

Goal 16: Expand Early Childhood Mental Health Efforts

GOAL: *Ensure that investments and policies for early childhood mental health efforts are (a) carried out within the framework of equitable promotion, prevention/intervention, and treatment; (b) embedded in the Illinois comprehensive early childhood system; (c) designed to meet the needs of all children and their families with a focus on the most vulnerable; and (d) organized to demonstrate accountability.*

Strategies/Action Steps

- A. Identify and allocate public and private funding to create a fiscal map of current public investments in early childhood mental health promotion, prevention/intervention, and treatment services and supports to determine how to allocate resources more effectively.
- B. Collect data on gaps in services and inequities in resource allocation as well as funding limitations that may reflect gaps in service.
- C. Fund an increased number of mental health consultants across the state.
- D. Expand the number of ECCE programs across child and family serving systems implementing the Illinois Mental Health Consultation Model.
- E. Measure progress toward identified outcomes to understand the impact of investments and establish a process for data development and tracking.
- F. Develop state agency policies related to the provision and integration of early childhood mental health promotion, intervention/prevention, and treatment services and supports.

Goal 17: Expand Use of the Pyramid Model

GOAL: *Expand the number of ECCE programs implementing the Pyramid Model.*

Strategies/Action Steps

- A. Increase the number of process coaches trained in the Pyramid Model.
- B. Increase the number of programs that have process coaches.
- C. Provide more funding for programs to access process coaches and training.
- D. Expand opportunities to bring more people into the Master Cadre (training, coaches).

Quality Key Progress Indicators

- Number of ExceleRate Illinois Silver- and Gold-rated licensed centers and homes and publicly funded early childhood programs
- Number of children enrolled in ExceleRate Illinois Silver- and Gold-rated licensed centers and homes and publicly funded early childhood programs
- Number of early childhood mental health consultants
- Number of early childhood programs receiving the Pyramid Model implementation support from a process coach

Strategic Focus 4: Workforce—Addressing Recruitment, Retention, Compensation, Equity, and Professional Development of the ECCE Workforce

Voice of an Illinois ECCE Provider:

“Some people are there just for the paycheck and not necessarily passionate. You want people who are going to stay up with trends, make sure lessons are developmentally appropriate, who are willing to do what is best for the students. You want people who want to be there.”

- **Needs Assessment Finding:** *There is a need to attract and retain qualified staff, as well as provide more extensive training, professional development, and preparation to educators and providers to improve quality and racial equity.*

Workforce needs emerged as a critical topic in the needs assessment findings. For example, the findings indicated a need to provide more extensive training and preparation to teachers and staff who serve the children we have defined as vulnerable or underserved to expand access to quality ECCE services. The needs assessment also indicated that there is frustration in the ECCE system related workforce compensation and the ability to attract and retain highly qualified ECCE workforce. The ECCE workforce includes home visitors, educators, teachers, caregivers, consultants, and other practitioners or staff employed in ECCE programs.

Workforce Strategic Targets

1. Award 6,000 Gateways Credentials and/or Professional Educator Licenses (PELs) with early childhood education endorsement in the first 3 years.
2. Increase the average community-based wage of early childhood educators by 50% by 2025.

Goal 18: Increase Compensation for ECCE Workforce

GOAL: *Increase compensation for providers in the ECCE workforce.*

Strategies/Action Steps

- A. Develop and approve guidelines for home visiting and doula compensation; submit to home visiting and doula funders for implementation.
- B. Increase CCAP reimbursement rates, with accountability structures that ensure increases lead to staff compensation increases.

- C. Pilot CCAP contracts that include designated compensation funding.
- D. Require compensation parity in Early Childhood Block Grant grants.
- E. Increase CCAP eligibility to allow for increased compensation without decreasing private-pay affordability.
- F. Create an early childhood wage scale.
- G. Increase public funding for ECCE and designate funding increases for compensation increases.

Goal 19: Eliminate Workforce Racial and Ethnic Disparities

GOAL: *Eliminate racial and ethnic disparities in the early childhood workforce.*

Strategies/Action Steps

- A. Collect comprehensive workforce data on race and ethnicity.
- B. Applying a racial equity lens, develop strategies to link policies for workforce compensation to appropriate education levels to support the vision of a racially and culturally diverse, educated, and professional workforce for early childhood across all sectors (ELC, 2019).⁴
- C. Support efforts to develop new, alternative, and innovative ways for teachers to become qualified.
- D. Expand efforts for friend, family, and neighbor childcare providers to be reached.
- E. Offer targeted higher education pathways and job-embedded professional development supports to educators of color and existing members of the early childhood workforce.
- F. Increase compensation for family childcare providers and teacher assistants.
- G. Recruit professionals who are ethnically, culturally, and linguistically representative of the families and children served.

Goal 20: Expand Professional Development

GOAL: *Enhance early childhood professional development to expand access as well as service offerings, such as mentoring and coaching.*

Strategies/Action Steps

- A. Include professional development as a key component of the work addressed by the Illinois Early Childhood Interagency Team.
- B. Develop policies and provide adequate funding for high-quality, job-embedded professional development for all early childhood practitioners, regardless of ECCE program type.

⁴ Illinois Early Learning Council. (2019). *Four racial equity priorities from 2019 retreat*. Springfield, IL: Author.

- C. Create a cross-sector early childhood professional development leadership team to work on cross-sector alignment activities.
- D. Create and distribute print materials that outline and explain the various parts of the early childhood professional development system and how they relate to one another.

Goal 21: Restructure and Integrate Workforce Data Systems

GOAL: *Restructure and integrate workforce data systems to better allow linkage, analysis, research, sharing, exporting, and use.*

Strategies/Action Steps

- A. Rationalize, standardize, and align workforce data systems across state agencies.
- B. Build the systems architecture necessary to link and analyze workforce data across state agencies.
- C. Construct an early childhood workforce participation data set.
- D. Develop an early childhood workforce research agenda.

Goal 22: Provide Higher Education Supports

GOAL: *Provide the higher education supports necessary to produce a qualified, competent, diverse, and representative ECCE workforce, including the development of a competency-based preparation and qualifications system and higher education supports for educator candidates.*

Strategies/Action Steps

- A. Increase knowledge and understanding of Gateways Credentials and the competencies-based system within higher education institutions and among public and private employers of providers in the ECCE workforce.
- B. Embed Gateways Credentials in state systems (e.g., DCFS, childcare licensing standards, Early Childhood Block Grant standards/rules, ExceleRate Illinois).
- C. Expand cohort-based postsecondary supports in institutions of higher education across Illinois and targeted to specific areas of study within early childhood.
- D. Pilot modularization of competency-based coursework, including the implementation of assessments of prior learning.
- E. Increase funding for Gateways Scholarships, Gateways Credential fee waivers, and tuition reimbursement for early childhood educators, educator candidates, home visitors, and other ECCE providers.

Goal 23: Strengthen Workforce to Better Support the Development of Children Who Are Culturally, Racially, and Linguistically Diverse

GOAL: Increase opportunities for the early childhood workforce to better support the development of children from culturally, racially, and linguistically diverse backgrounds.

Strategies/Action Steps

- A. Develop and pilot model program(s) for individuals with a Bachelor of Arts degree and an Illinois Gateways ECE Level 5 Credential to earn a PEL.
- B. Develop and pilot model program(s) for individuals with an Illinois Educator License with Stipulations in transitional bilingual education to earn an Illinois PEL with an endorsement in ECCE.
- C. Develop and implement endorsement programs for individuals with existing non-ECCE PELs to add a secondary endorsement of ECCE.
- D. Increase offerings of Gateways to Opportunity Multilingual Credentials at Illinois institutions of higher education.
- E. Map opportunities for shared professional development across funding streams and program models on core topics and special training related to priority populations.

Workforce Key Progress Indicators

- Number of Gateway credentials and/or PELs with early childhood education endorsement awarded
- Number of special education endorsements or letters of approval awarded to providers in the ECCE workforce
- Number of bilingual or English as a second language Gateways Credentials or endorsements awarded to providers in the ECCE workforce
- Statewide average compensation for assistant teachers, lead teachers, directors, home visitors, doulas, and other providers in the ECCE workforce
- Number of early childhood programs receiving the Pyramid Model implementation support from a process coach

Professional Development Alignment Indicators

- Development, publication, and implementation of a public statewide, cross-agency professional development calendar that aligns all professional development opportunities from entities such as Gateways, STAR NET, and the Early Childhood Center of Professional Learning

- Creation of a statewide website dedicated to professional development that enables users to learn about early childhood professional development opportunity options
- Number of participants attending aligned professional development opportunities
- Role and/or affiliation of participants attending the aligned professional development opportunities
- Percentage of early childhood programs with “protected time” for professional development
- Number and percentage of childcare programs offering protected time for professional development

Potential Barriers to Goals

Several barriers could pose a threat to the state’s ability to achieve some of its strategic goals. These barriers include limited financial resources, limited workforce capacity, and limited program capacity.

Barriers to Achieving Strategic Focus 1 (Access)

The needs assessment indicated that issues related to the precise definition of important topics (e.g., populations served, quality in ECCE across a range of programs) and inconsistent data sources to track the ECCE system are prevalent. The Illinois Early Childhood Asset Map grappled with the definition of high needs and how best to quantify it. The ELC All Families Served Subcommittee has developed priority population recommendations for the state, which have provided some guidance in attempting to quantify children with high needs plus priority and vulnerable populations. However, the definition for high needs depends on the funding source, so tracking and defining who is getting access to what services also varies greatly, even though financial resources and funding for ECCE services and programs to meet the needs are limited. Along with this, a lack of clarity and awareness exists in what funding may be available to support service providers as well as the uncertainty and confusion regarding grant funding.

Barriers to Achieving Strategic Focus 2 (Coordination)

The needs assessment revealed that several practices are in place because of legislative orders reflecting effective and supportive interagency collaboration supporting young children and families (e.g., Illinois ELC, GOECD, ExceleRate Illinois, the interagency team, and the Illinois Longitudinal Data System). Recently, legislation passed by the state’s General Assembly, such as Public Act 100-0645, has served as a lever to incentivize greater interagency collaboration in ECCE. However, as much as the state has put effort into improving collaboration and coordination across the ECCE mixed-delivery system, establishing meaningful, sustaining

partnerships can be difficult. Leadership may change, whether because of changes in administration or in leadership within organizations; it is increasingly more difficult to work together toward the common goal of improving early childhood services in the state. In addition, given the difficulty to coordinate across organizations and services, there have been missed opportunities to connect families, particularly those with the highest needs, to the appropriate services. Barriers include the lack of appropriate and identified data to measure coordination and collaboration, capacity issues within state agencies for sharing available and pertinent data, and even the actual wording of the operational definition of the developed metrics (i.e., high-quality early learning). The ongoing data sharing and communication challenges across agencies and programs may be one of the largest barriers for the state.

Barriers to Achieving Strategic Focus 3 (Quality)

Beyond the need for additional financial resources, another issue is the schedule of funds for those programs relying on Illinois Early Childhood Block Grant funding. The funding from the Block Grant, which is cyclical in nature, is not released until several months into the fiscal year, thereby which largely eliminating CBOs from receiving this money because they cannot afford to wait. As a result, those CBOs may have difficulty improving their quality. Also lacking is the availability and definition of data sources that can support the development and monitoring of quality improvement initiatives.

Barriers to Achieving Strategic Focus 4 (Workforce)

Another major issue is the limited availability of a highly qualified workforce. Returning to the earlier discussion of a lack of funding, lower salaries discourage students from pursuing a path in ECCE from the outset and makes recruitment to the field more challenging. In addition, diversity is lacking among teachers, teachers have inadequate preparation for dealing with children and families who have experienced trauma, and teachers and service providers have few resources once they are in their positions.

Appendix A. Glossary of Terms

Term	Definition
Childcare Assistance Program (CCAP)	This program assists low-income families in paying for childcare.
Childcare and Development Block Grant	This grant supports families by increasing the availability, affordability, and quality of childcare in the United States.
Childcare Resource and Referral	Community organizations that track childcare supply and demand; provide training, technical assistance, grants, and resources to early childhood practitioners; recruit new providers; and administer the CCAP.
Child and Family Connections (CFC)	These privately contracted agencies work as a part of a statewide system to ensure that all referrals of children under 3 years old to the Early Intervention Services System receive a timely response.
Doula	A community health worker who provides skilled continuity of care throughout the childbearing year.
Early Childhood Block Grant	This grant provides funding for establishing early childhood education programs, including preschool education and prevention initiatives for children at risk from birth to kindergarten and their families.
Early Childhood Center for Professional Learning (ECPL)	The Early Childhood Center for Professional Learning provides free professional learning and resources that support ISBE-funded programs in implementing practices that improve outcomes for young children and their families.
Early Head Start	This program provides support to low-income infants, toddlers, pregnant women, and their families.
English Learner	Any student in prekindergarten through Grade 12 whose home language background is a language other than English. The student’s proficiency in speaking, reading, writing, or understanding English is not yet sufficient to provide the student with the ability to meet the state’s proficient level of achievement on state assessments or achieve success in classrooms where the language of instruction is English.
ExceleRate Quality Ratings and Improvement System	The QRIS gives providers a process to pursue quality efforts that will help them learn more, do better, and improve developmental skills among the children they impact. ExceleRate Illinois provides standards, guidelines, resources, and supports for providers to make changes that lead to better quality outcomes. The comprehensive system includes licensed childcare centers, PFA programs, Head Start programs, and licensed childcare homes.
Illinois Longitudinal Data System	The Illinois Longitudinal Data System enables state agencies to link early childhood, education, and workforce data to answer questions in areas that are important to Illinoisans and critical to understanding the state’s future education needs.
Inclusive Classroom Profile	This observational tool assesses practices with the strongest research base for supporting the education and development of young children.

Term	Definition
The Kindergarten Individual Development Survey (KIDS)	KIDS is a research-based observational assessment tool for teachers to document and reflect on the learning, development, and readiness of all children in kindergarten.
Preschool for All (PFA)	PFA is a free program of the ISBE that is committed to serving children at risk and families in Illinois, with the goal of serving all 3- to 5-year old children whose families choose to participate.
Prevention Initiative (PI)	The Prevention Initiative provides grants to home-based and center-based programs to expand access to the Early Head Start model as well as other birth to 3 models (center and home based). The goal is to serve additional children birth to age 3 and help grantees increase program quality.

Appendix B. Stakeholders Engaged

Exhibit B1. Illinois Early Learning Council Strategic Planning Advisory Group Members

Name	Title	Organization
Karen Berman	Assistant Director of Illinois Policy	Ounce of Prevention Fund
Phyllis Glink	Executive Director	Irving B. Harris Foundation
Cornelia Grumman	Director of Education	Robert R. McCormick Foundation
Dan Harris	Executive Director	Illinois Network of Childcare Resource and Referral Agencies
Theresa Hawley	First Assistant Deputy Governor, Education	Governor’s Office
Nakisha Hobbs	Associate Director, Office of Early Childhood	DHS
Carisa Hurley	Director of Early Childhood	ISBE
Janice Moenster	Director of Early Childhood Services	Children’s Home & Aid
Lauri Morrison-Frichtl	Executive Director	Illinois Head Start Association
Edna Navarro-Vidaurre	Manager of Family Engagement	Office of Early Childhood Education, Chicago Public Schools
Cristina Pacione-Zayas	Associate Vice President of Policy	Erikson Institute
Sylvia Puente	Executive Director	Latino Policy Forum
Teresa Ramos	Vice President of Public Policy and Advocacy	Illinois Action for Children
Diana Rauner	President	Ounce of Prevention Fund
Elliott Regenstein	Consultant	Foresight Law + Policy
Trish Rooney	Director of Early Childhood Initiatives	Fox Valley United Way
Jesse Ruiz	Deputy Governor for Education	Governor’s Office
Sara Slaughter	Executive Director	W. Clement & Jesse V. Stone Foundation
Cynthia Tate	Executive Director	GOECD
Dawn Thomas	Principal Investigator, Illinois Early Childhood Asset Map (IECAM)	Early Childhood Collective, Department of Special Education, University of Illinois at Urbana-Champaign
Yolanda Williams	Parent Representative	Community Organizing & Family Issues (COFI)

Exhibit B2. State Leadership

Name	Title	Organization
Jesse Ruiz	Deputy Governor for Education	Governor’s Office
Theresa Hawley	First Assistant Deputy Governor, Education	Governor’s Office
Cynthia Tate	Executive Director	GOECD
Jamilah R. Jor’dan	Deputy Director	GOECD
Iris Hildreth	Family Engagement Manager	GOECD
Deborah Hwang	PDG B-5 MIECHV (Maternal, Infant, and Early Childhood Home Visiting) Coordinated Intake Strategy Manager	GOECD
Maggie Koller	Director of Communication & Dissemination	GOECD
Tom Layman	QRIS (ExceleRate) Policy Director	GOECD
Artiya Nash	Project Director	GOECD
PhoungY Nguyen	Business Manager	GOECD
Lori Orr	Policy Director Cross-Systems Professional Development & Program Enhancements	GOECD
Bethany Patten	Workforce Policy Director	GOECD
Lesley Schwartz	Project Director (MIECHV)	GOECD
Joanna Su	Manager of Strategic Planning (MIECHV)	GOECD

Exhibit B3. Early Learning Council Leadership

Name	Title	Organization
Jesse Ruiz (Council Co-Chair)	Deputy Governor for Education	Governor’s Office
Phyllis Glink (Council Co-Chair)	Executive Director	Irving B. Harris Foundation
Karen Berman	Assistant Director of Illinois Policy	Ounce of Prevention Fund
Kristy Doan	Principal Consultant, Early Childhood & Illinois Section 619 Coordinator	ISBE
Shauna Ejeh	Vice President of Quality and Workforce Development	Illinois Action for Children
Gaylord Gieseke	Consultant	Illinois Children’s Mental Health Partnership
Tasha Green Cruzat	President	Voices for Illinois Children
Cornelia Grumman	Director of Education	Robert R. McCormick Foundation

Name	Title	Organization
Dan Harris	Executive Director	Illinois Network of Childcare Resource and Referral Agencies
Carisa Hurley	Director of Early Childhood	ISBE
Kimberly Mann	Deputy Director of Research & Child Wellbeing	DCFS
Cristina Pacione-Zayas	Associate Vice President of Policy	Erikson Institute
Sylvia Puente	Executive Director	Latino Policy Forum
Diana Rauner	President	Ounce of Prevention Fund
Linda Saterfield	Interim Associate Director	IDHS
Sara Slaughter	Executive Director	W. Clement & Jesse V. Stone Foundation
Teri Talan	Michael W. Louis Chair of McCormick Center for Early Childhood Education	National Louis University
Cynthia Tate	Executive Director	GOECD
Maria Whelan	President & Chief Executive Officer	Illinois Action for Children
Josie Yanguas	Director	Illinois Resource Center

Exhibit B4. Early Learning Council Committee Chairs and Co-Chairs

Name	ELC Title	Organization (if applicable)
Jesse Ruiz	Early Learning Council Co-chair	Office of the Governor
Phyllis Glink	Early Learning Council Co-chair	Irving Harris Foundation
Dan Harris	Quality Committee Co-chair	Illinois Network of Childcare Resource and Referral Agencies (INCCRA)
Teri Talan	Quality Committee Co-chair, ExceleRate Subcommittee Co-chair	National Louis University
Toni Porter	ExceleRate Subcommittee Co-chair	INCCRA
Maria Whelan	Access Committee Chair	Illinois Action for Children
Carie Bires	All Families Served Subcommittee Co-chair	Ounce of Prevention Fund
Marquinta Thomas	All Families Served Subcommittee Co-chair	Illinois Action for Children
Tracy Ocomy Crowder	Family Engagement Implementation Subcommittee Co-chair	COFI
Karen Berman	Integration & Alignment Committee Co-chair	Ounce of Prevention Fund
Shauna Ejeh	Integration & Alignment Committee Co-chair	Illinois Action for Children
Elliot Regenstein	Data, Research, and Evaluation Subcommittee Chair	Foresight Law + Policy
Chelsea Guillen	Inclusion Subcommittee Co-chair	EI Training Program

Name	ELC Title	Organization (if applicable)
Kristy Doan	Inclusion Subcommittee Co-chair	ISBE
Kathy Waligora	Health Subcommittee Co-chair	EverThrive
Kathy Chan	Health Subcommittee Co-chair	Cook County Health and Hospitals System
Trish Rooney	Community Systems Development Subcommittee Chair	Fox Valley United Way
Gaylord Gieseke	Home Visiting Task Force Co-chair	Illinois Children’s Mental Health Partnership & Consultant
Diana Rauner	Home Visiting Task Force Co-chair	Ounce of Prevention Fund
Ireta Gasner	Sustainability Subcommittee Co-chair	Ounce of Prevention Fund
Deb Daro	Universal Newborn Support Ad Hoc Work Group Chair	Chapin Hall

Exhibit B5. Focus Group Interview Participants

Name	Title	Organization (if applicable)
Linda Wang	Provider	HANA Center
Toni Williams	Provider	Tots House
Mary Ottinot	Parent	N/A
Rebeca Oyoque	Provider	First Steps to Learning Inc
Rebeca Frausto	Provider	Little Rascals
TeeNeka Jones	Program Director	CCC Society
Allison Perkins-Caldwell	Owner	Allison’s Infant
Lannon Broughton	Grandparent	N/A
Tiffany Carter	Director of ED	Children and Home Aid
David Quiroz	Parent/Provider	District 88
Vivi Luna	Prenatal-3	District 131
Maria Magaña	Parent	District 131
Noemi Perez	Parent	District 131
Yusdivia Gonzalez	Parent/teacher	District 124
Liliana Olayo	Parent leader	District 131/COFI
DeeDee Buscher	Preschool Program Supervisor	FVDP
Sara Gonzalez	Organizer	COFI
Stefany Valencia	Parent	District 131
Katie Cox	Director of Early Childhood	District 131
Kassia Eide	Family Engagement Coordinator	SPARK
Gene Howell	President/Chief Executive Officer	Riverbend Head Start & Family Service Madison County (Early Head Start/Head Start)

Name	Title	Organization (if applicable)
Robert Jackson	Parent	N/A
Jake Jacob	Infant/Early Childhood Mental Health Consultant	N/A
Terri Mussatto	CFC 21 DM	EI Program Manager
Gloria Hicks	Parent Ambassador	Parents United for Change
Becky McLean	Director	Southern Illinois University–Edwardsville Early Childhood Center PFA
Benda Crisp	Director	UniPres Kindercottage Childcare Center
Robin Dermody	Coordinator	Harmony 175 School District 118 (PI, PFA, PFAE) Military Families
Janice Moenster	Director of Early Childhood Services	Children’s Home & Aid
Rachael Liebermann	Vice President	Smart Start Learning Center
Heidi Elliot	Provider Services Coordinator	Children’s Home & Aid
Jill Andrews	President	SIECAT
Samantha Weidner	Early Childhood Development Director	Clay & Effingham Co. Health Dept.

Exhibit B6. Public Website Constituents

Name	Role	Organization (if applicable)
Angela Searcy	Educational Consultant, coach, and adjunct college professor	Simple Solutions Educational Services
Larissa Vander Kuur	Provider/Educator/Practitioner	Family Childcare Group Home
Cathryn Abraham	Provider/Educator/Practitioner	Consultant
Amber Peters	Early Childhood Collaboration	Elgin Partnership for Early Learning
Mary Haley	Local Collaboration Leader	Metropolitan Family Services
Donna Emmons	Advocate	Illinois Head Start Association
Tammy Wrobbel	Program Administrator	Education
Argelia Luna	Program Administrator	EA District 131 Jumpstart Program
Julia Marynus	Program Administrator	Stephenson County Health Department
Trish Rooney	Community Collaboration Leader and Co-Chair of the Community Systems Development Subcommittee	Fox Valley United Way—SPARK Early Childhood Collaboration
Jon Korfmacher	Researcher	Erikson Institute
Laurie Roxworthy	Program Specialist providing technical assistance and support to program	Ounce of Prevention Fund
Stacie Kirk	Provider/Educator/Practitioner	Southern Illinois University–Edwardsville
Yolanda Williams	Parent/Guardian	COFI/POWER-PAC IL

Appendix C. Stakeholders Engagement Input

This appendix summarizes the input from the stakeholder engagement activities. The feedback is organized by the four strategic focal areas (Exhibits C1, C2, C3, C4, and C5).

Exhibit C1. Access Focus Group Interview Data (Strategic Focal Area 1)

Topical input areas	Paraphrased summary statements
Communication	Parents need to know what is happening in the classroom to be able to work with educators and support children in the home context.
Parent education	Parents need to be educated on the importance of early childhood.
Engagement	There is a need to reach low-income parents who send their children to daycare centers and find ways to share information with these parents about programs.
Barriers to access	Parents feel unclear on eligibility requirements. Many geographical access barriers for services providers in reaching families exist in rural areas.
Suggested action steps or strategies	
<ul style="list-style-type: none"> • Create a decision tree to identify families’ needs (e.g., transportation) when considering early childhood services and programs. • Focus on increasing the role of parents and parent engagement within early childhood services. • Communicate and widely disseminate information from governing bodies regarding the importance of early childhood education. 	

Exhibit C2. Coordination Focus Group Interview Data (Strategic Focal Area 2)

Topical input areas	Paraphrased summary statements
Data and data systems	There is a big learning curve when it comes to providers navigating different data systems.
Collaboration	There is no common understanding for collaboration and what that looks like when it is achieved. There is a fear of losing financial support from collaborators (e.g., losing Head Start dollars).
Communication	It works well to have coordinated intake processes and communication with other providers such as Head Start.
Suggested action steps or strategies	
<ul style="list-style-type: none"> • Increase support for those responsible at the program level for data entry. • Improve coordinated intake so it is supported by teams of individuals. • Create a unique identifier to help coordination efforts between programs. • Develop strategies and frameworks to guide coordination efforts. • Assign responsibility to an entity to monitor collaboration among community programs and with K–12 schools. • Create a campaign that helps parents identify local home-based childcare and early childhood advocates. 	

Exhibit C3. Quality Focus Group Interview Data (Focal Area 3)

Input areas	Paraphrased summary statements
Defining quality	There needs to be an agreed-on definition and measurement approach of quality.
Standardization of early care program and training requirements	The different ECCE agencies have different requirements related to teaching certifications.
Gaps in early childhood services	It is unclear what services should be provided to children through special education versus other mechanisms. There is an increase in mental health issues among children, yet a higher demand placed on children that is preventing them from getting support.
Funding	The allocation of funding for services and programs across the state is inconsistent.
Assessment and data use practices	It is problematic to track and compare children who have had experience in centers and programming versus those who have been at home only. Early childhood educators should know what the expectations are for kindergartners to ensure that they are prepared for first grade and the rest of their schooling.
School readiness	Teachers are having to spend much of their time addressing behavioral issues and are not able to support learning and bolster readiness.
Suggested action steps or strategies	
<ul style="list-style-type: none"> • Increase parent involvement in key conversations about funding and services. • Prioritize funding and resources for zero to three—the most important period of development for children. • Provide funds for marketing or recruitment (e.g., having something with the program’s name or logo would help get the word out to parents about programs). • Provide continuous support for the upkeep of buildings. • Give access to KIDS assessment training for home-based providers to help them prepare children for kindergarten. • Support teacher training to ensure that their observations of children are objective. 	

Exhibit C4. Workforce Focus Group Interview Data on Workforce (Strategic Focal Area 4)

Theme	Paraphrased statements
Compensation	There is a need to increase teacher compensation to attract qualified individuals to the workforce.
Dual-language learners	There is a need for teachers who are qualified to teach and speak more than one language. There is not enough funding and training to send professional staff to obtain qualifications to support dual-language learners.
Teacher education and training	Credentials alone do not make someone qualified to function well in the classroom and teach.

<p>Suggested action steps or strategies</p> <ul style="list-style-type: none"> • Increase funding to support children with special needs. • Increase benefits and compensations for early childhood service providers. • Increase in classroom supports for teachers versus mentoring outside the classroom. • Ensure that higher education supports align with the standards of the industry. • Offer ECE at all the city colleges of Chicago. • Create a unified definition of “quality staff.”
--

Exhibit C5. ELC Committee Chairs Input

Domain	Feedback
Access	Additional strategies suggested for increasing access include the following: increase the number of health care and mental health providers that can serve bilingual families, increase access to hearing and vision screenings, increase transportation innovations, make services easier for families to navigate by increasing coordination, increase outreach to families in rural areas, address food insecurity, analyze the effectiveness of current programs, and pilot successful innovations with priority populations.
Coordination	Additional strategies suggested for improving coordination efforts include the following: clearly define community collaborations, provide professional development for improved data usage to increase organizations’ capacity, and introduce a universal application for parents for any services they may need.
Quality	Additional strategies suggested for improving quality include the following: increase parent voice and conduct a cost-benefit analysis of ExceleRate levels to understand the costs associated with achieving each level.
Workforce	Additional strategies suggested for strengthening the ECCE workforce include the following: conduct an impact study of increasing the minimum wage, expand Gateway registry requirements, increase professional development opportunities, and introduce strategies to ensure that the workforce is educated on trauma-informed practices.

Exhibit C6. Public Website Input by the Strategic Plan Focus Areas

Access
Use wording such positive behavior supports (“PBIS” or “PBS”) because this would allow the inclusion of many positive behavior support models.
Focus on access needs to consider why existing programs are not serving the full number of families that they could.
Include other types of ECCE parent support beyond home visiting.
Offer more social services and dedicated workers to families, meeting them where they are.
Develop community capacity.
Increase emphasis on coordination and collaboration in the strategic plan.
Include special education and inclusive environments with qualified support workers and targeted supports.
Collaboration
Fund early childhood collaborations that help with coordination, initiatives, and connections.
End supplanting of Head Start and Early Head Start funding.
Sustain funding and support for local community collaborations.

Develop community capacity.
Coordinate systems at the state level.
Define “community collaborations” and what is a “high-functioning” collaboration.
Provide greater focus on trauma-based clinical support (early childhood mental health).
Focus on transition from ECE to kindergarten.
Quality
Provide more emphasis on the quality of home visiting programs.
Focus on the collaboration and transitioning of services.
Continue with the ExceleRate push but make it worth it for centers and family care providers. At this point, their view is that ExceleRate hasn’t helped them fill their seats, but it also requires a lot of work to receive this status.
Please do not tie money in with ExceleRate. Directors already have far much to do and often are subbing in classrooms because of staff shortages.
Workforce
Link employee compensation in with higher state childcare payments.
Provide skills, jobs, and training to the entire community at all levels of planning and implementation.
Include budget line items for ECCE staff recruitment.
Add an “inclusion clause” where there would be an increase of employees that are from the communities that are served.
Emphasize coaching ECCE workforce staff over training.
Provide ongoing professional development related to trauma-informed practice, mental health training, and implicit bias training.
Other comments
Would have liked to see the needs assessment before the plan came out.
Reduce the number of goals; some of the goals could be combined.
Add focus on research and evaluation of new and existing services.
Add greater focus on equity.

Appendix D. Existing Strategic Plans Reviewed

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- Illinois Prenatal to Three Initiative. (2019a). *Childcare and development workgroup. October 16, 2019.* Chicago, IL.
- Illinois Prenatal to Three Initiative. (2019b). *PN3 master agenda.*
- Illinois State Board of Education. (2019). *Early childhood block grant logic model.*
- Illinois Task Force on Employment, & Economic Opportunity for Persons with Disabilities. (2017). *Employment and economic opportunity for persons with disabilities recommendations 2017.*
- Illinois United for Youth, A Systems of Care Initiative. (2017). *Pathways: Illinois' strategic plan for children's mental health.*
- Inter Agency Team. (2017). *Illinois early childhood working framework.*
- Irving Harris Foundation. (2016). *Illinois action plan to integrate early childhood mental health into child- and family-serving systems, prenatal through age five.*
- Kindergarten Transition Advisory Committee. (2018). *Final report: Kindergarten transition advisory committee.*
- Professional Development Advisory Committee. (2017). *Professional development advisory committee strategic plan phase VIII, 2018–2021.*
- Illinois Home Visiting Task Force Committee. (2019). *State home visiting vision and priorities.*
- Quinn, P., & Gregg, B. (2019). *Child and family services plan: Federal fiscal years 2015–2019.* Illinois Department of Children and Family Services.

Appendix E. Focal Planning Workgroup Final Documents

1. Deborah Hwang and Joanna Su, Governor’s Office of Early Childhood Development—Plan for coordinated intake and home visiting
2. Ann Kremer and Bernie Laumann, Early CHOICES—Plan for inclusion of young children with disabilities in early care and education settings
3. Sara J. Beach, consultant—Plan for Illinois professional development system alignment
4. FaKelia Guyton and Jaclyn Vasquez, DuPage Early Childhood Collaboration—Plan for kindergarten transition pilot implementation
5. Andria Goss, Erikson Institute - Department of Children and Family Services (DCFS) Early Childhood Project —Lessons learned/Best practices From the Erikson DCFS Early Childhood Project: Early intervention and child welfare
6. Dr. Kimberly A. Mann, Dr. Robin LaSota, and Andria Goss, Erikson DCFS Early Childhood Project: Home Visiting and Child Welfare: Home Visiting Proposal

Coordinated Intake and Home Visiting

Deborah Hwang and Joanna Su, GOECD

Illinois Strategic Plan for Coordinated Intake and Home Visiting December 2019

Deborah Hwang

Governor's Office of Early Childhood Development (GOECD)

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The author would like to especially thank the following for their time and contributions as thought partners in developing a statewide system that increases access to early childhood services and resources for Illinois' families and children. Please see *Appendix A* for a full listing of individuals who participated in key informant interviews and the Coordinated Intake for Home Visiting Work Group.

Coordinated Intake Communities and Community Collaborations

All Our Kids (AOK) Networks
Champaign County Home Visiting Consortium
Collaboration for Early Childhood (Oak Park)
DuPage Home Visiting Network
Lake County Health Department
Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Coordinated Intake workers
North Lawndale
Southside Early Learning Network
SPARK (Aurora)

Early Childhood Service Providers

Asian Human Services
Carole Robertson Learning Center
City of Rockford Head Start Program
HANA Center
Ina Maka "Mother Earth" Family Program
National Urban Indian Family Coalition

Stakeholder Groups

Community Systems Development Subcommittee of the Early Learning Council (ELC)
Coordinated Intake for Home Visiting Work Group
Home Visiting Task Force of the ELC

State Partners

Center for Prevention Research and Development (CPRD), University of Illinois
Governor's Office of Early Childhood Development (GOECD)
Illinois Department of Human Services
Illinois Department of Public Health
Illinois Early Childhood Asset Map (IECAM)
Illinois Head Start Association
Illinois Network of Child Care Resource & Referral Agencies (INCCRRA)
Illinois State Board of Education

Other States and Localities

Education Development Center
First 5 LA
Indiana State Department of Health
New Jersey Department of Children and Families
New Jersey Department of Health
Philadelphia Department of Public Health, Division of Maternal, Child, and Family Health
University of Kansas Center for Public Partnerships & Research
William Penn Foundation

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Cynthia Tate, Lesley Schwartz, Michelle Esquivel, and Joanna Su, GOECD

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Acronyms

AHS – Asian Human Services

AOK Network – All of Our Kids Early Childhood Networks Initiative

CBO – Community-based organization

CCR&R – Child Care Resource and Referral

CFC – Child and Family Connections

CI – Coordinated Intake

CIAT – Coordinated Intake Assessment Tool

CIHV – Coordinated Intake for Home Visiting Work Group

CSD – Community Systems Development

CQI – Continuous Quality Improvement

DCFS – Department of Child and Family Services

ECCE – Early Childhood Care and Education

E/HS - Early/Head Start program

EI – Early Intervention

ELC – Early Learning Council

FC – Family Connects

FFY – Federal Fiscal Year

GOECD – Governor’s Office of Early Childhood Development

HV – Home Visiting

HVTF – Home Visiting Task Force

IDPH – Illinois Department of Public Health

IMHC – Infant Mental Health Consultation

INCCRRA – Illinois Network of Child Care Resource and Referral Agencies

IRIS – Integrated Referral and Information System at the University of Kansas

MFHV – Major Funders of Home Visiting

MIECHV – Maternal, Infant, and Early Childhood Home Visiting

MOU – Memorandum of Understanding

NOFO – Notice of Funding Opportunity

OB/GYN – obstetrician/gynecologist

PDG B-5 – Preschool Development Grant Birth through Five

PI – Prevention Initiative

PN3 – Prenatal to Three Initiative

RFP – Request for Proposal

RPE – Regional Points of Entry Workgroup

SAMHSA – Substance Abuse and Mental Health Services Administration

SFY – State Fiscal Year

TA – Technical Assistance

WIC – Special Supplemental Nutrition Program for Women, Infants, and Children

Preface

Illinois is home to one of the largest and most diverse populations in the U.S. It has the largest community of Asian Americans in the Midwest as well as the one of the largest Latinx communities.¹² More than 14% of its population are immigrants. Its geography ranges from having the third most urban city in the U.S. to being covered mostly by rural landscape.

This rich diversity is reflected in Illinois' early childhood population under age five, which composes 7.5% of the state's overall population.³ In this age group, almost half of the children come from communities of color while 1 in 4 parents of children in this age group are immigrants.⁴ Most of the children (47.5%) reside in suburban areas; 42% reside in urban settings; and 10.5% reside in rural communities. These are just a few characteristics of the rich and varied range of identities, cultures, and experiences of Illinois' children and their families.

The early childhood population in Illinois is not without challenges and barriers for children to “grow up safe, healthy, happy, and ready to succeed.”⁵ The *Illinois Risk and Reach Report of Spring 2019* indicates that 81.4% of Illinois counties were reported to have at least one indicator of risk factors that affect early childhood well-being. In 2016, 21.5% of children age five and under live in families below poverty, which is often associated with risk factors such as inadequate nutrition, maternal depression, and trauma.⁶ Racial and ethnic inequities persist in communities of color, while rural communities remain under-resourced. In the context of rapidly changing immigration landscape and policies, immigrant families and children lack access to culturally and linguistically responsive services to adequately support them in their experiences.

Research shows that the first three years of a child's life are critical to laying the foundation and trajectory of a child's developmental, socioemotional, cognitive, and physical wellbeing, as well as educational and socioeconomic opportunities. Home visiting (HV) services are some of the earliest childhood supports that families can access, starting from pregnancy until when a child is age five. For the context of this plan, HV is defined as an evidence-based, intensive two-generation approach that addresses the child's and caregiver's health and wellbeing, development, school readiness, positive child-parent relationships, family economic self-sufficiency, and family functioning.⁷

¹ https://www.americanimmigrationcouncil.org/sites/default/files/infographics/illinois_infographic_2018.png

² Asian American Center for Advancing Justice. (2012). *A Community of Contrasts: Asian Americans, Native Hawaiians and Pacific Islanders in the Midwest*. Retrieved from: https://www.advancingjustice-chicago.org/wp-content/uploads/2015/08/Community_of_Contrasts_Midwest_2012.pdf

Pew Research Center. (September, 2016). Ranking the Latino population in the states. Retrieved from: <https://www.pewresearch.org/hispanic/2016/09/08/4-ranking-the-latino-population-in-the-states/>

³ Erikson Institute, Illinois Early Childhood Asset Map (IECAM) of University of Illinois at Urbana-Champaign. (Spring, 2019). *Illinois Risk and Reach Report*. Illinois. Retrieved from <https://www.erikson.edu/policy-initiatives/risk-reach/>

⁴ Ibid

⁵ Vision of the Early Learning Council. Retrieved from: <https://www2.illinois.gov/sites/OECD/EarlyLearningCouncil/Pages/default.aspx>

⁶ Erikson Institute, Illinois Early Childhood Asset Map (IECAM) of University of Illinois at Urbana-Champaign.

⁷ National Home Visiting Resource Center. (2018). *Home Visiting Primer*. Arlington, VA: James Bell Associates and the Urban Institute. Retrieved from: https://www.nhvr.org/wp-content/uploads/NHVR_C Primer_FINAL.pdf

While HV programs are well-positioned to build on the strengths of Illinois' diverse families to meet their needs, they constitute a major sector of the state's mixed-delivery early childhood care and education system (ECCE) that does not have statewide coordinated points of entry for screening and enrollment of families. The variation in program models, eligibility criteria, priority populations, funding requirements, data systems, intake processes, and referral mechanisms creates unintentional systemic barriers for families in accessing HV services.

A statewide coordinated intake system for HV services directly addresses these challenges by creating a streamlined intake and referral process that removes the burden from families of having to navigate complex ECCE systems, facilitating their enrollment in programs that are the best fit for their strengths and needs. It creates a more cohesive statewide system of HV services that have historically been siloed. It also positions HV programs to be connected to the rest of the early childhood systems, supporting the creation of a seamless continuum of services for families prenatal to age five.

The strength of Illinois' children and families is their wealth in diversity and experiences, making them strong, resilient, resourceful, and knowledgeable about what is best for their families and children in overcoming barriers to thrive in society. This strategic plan focuses on the expansion of a statewide CI system for Illinois to further empower families by increasing family access and choice of HV programs that best fit their interests, strengths, and needs.

Executive Summary

Illinois is committed to ensuring equitable access to high-quality ECCE services in a mixed delivery system for all children birth to five. The Illinois Early Learning Council's (ELC) vision for Illinois is that it is "a place where every young child – regardless of race, ethnicity, income, language, geography, ability, immigration status, or other circumstance – receives the strongest possible start to life so that they grow up safe, healthy, happy, ready to succeed, and eager to learn."⁸ The Governor's Office of Early Childhood Development (GOECD) holds the ELC's vision and "leads the state's initiatives to create an integrated system of quality, early learning and development programs to help give all Illinois children a strong educational foundation before they begin kindergarten."⁹ As a member of the BUILD Initiative—which provides support to state leaders in developing a strong early childhood system—Illinois also implements a racial equity approach in its efforts to create equitable access to services and programs for all children and families throughout the state.

Illinois seeks to strengthen systems alignment and to lay a strong foundation for scaling a high-quality, efficient ECCE system that is responsive to families' strengths and needs. Thus, one of Illinois' focus areas in year one of the Preschool Development Grant Birth through Five (PDG B-5) is to develop a plan for coordinating and improving family navigation of its robust HV system, which annually serves approximately 17,000 families from prenatal to age five and includes a network of over 200 programs throughout the state.¹⁰

To develop this strategic plan for CI expansion, GOECD staff conducted conversations with community level providers and collaborations as well as state level administrators, convened public and private stakeholders through the Coordinated Intake for Home Visiting (CIHV) Workgroup, sought feedback through the Home Visiting Task Force (HVTF) and other subcommittees of the ELC, and spoke with representatives from other states and localities. The vision and principles of the ELC, HVTF, GOECD, Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, the 2018 Early Intervention and Home Visiting Summit, and the BUILD Initiative have collectively guided the work of the plan.

In Illinois, HV is a mixed delivery system that draws on various funds, resulting in many programs blending and braiding revenue streams and implementing more than one HV model. Yet HV does not have coordinated points of entry for screening and enrollment across the state. Multiple entry points, different program eligibility requirements, and varying levels of HV saturation in communities create unintentional systemic barriers in an already complex and fragmented landscape of HV programs. For underserved families who are already facing challenges involving access to reliable transportation, adequate work with fair pay, health care, public benefits, linguistically and culturally responsive services,

⁸ Vision of the ELC. Retrieved from:

https://www2.illinois.gov/sites/OECD/Documents/Report%20of%20the%20Illinois%20Early%20Childhood%20Strategic%20Visioning%20and%20Planning.080619_Draft.pdf

⁹ Governor's Office of Early Childhood Development. Retrieved from:

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

¹⁰ Illinois Home visiting, Governor's Office of Early Childhood Development. Retrieved from:

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

and immigration status, among others, navigating the constellation of HV services is especially challenging.

To address these barriers, Illinois has been implementing coordinated intake (CI) in select communities across the state through a variety of initiatives. CI is a streamlined intake and referral process that increases access to local HV and early childhood services for families through coordinated points of entry. It aligns different systems of CI staff, local HV programs, early childhood resources, and community services through coordination and strengthened connections to reach Illinois' underserved children and families. It requires relational, trust-based, and collaborative work across all systems to meet the diverse interests, strengths, challenges, and needs of families throughout Illinois. The largest current funder of CI initiatives is the MIECHV program, which supports 12 CI communities. There are five additional CI communities that are publicly and privately funded as well as volunteer-based.

Illinois has learned a great deal from the CI communities. MIECHV has developed a coordinated intake assessment tool, CI communities have developed local decision trees to assist with eligibility and intake, and learning communities have been created to support CI professionals. The benefits of CI span across different systems, as follows:

- For children and families, it removes the burden of navigating complex systems of early childhood supports. It increases options, access, and awareness of early childhood services and resources that are best suited for a family's strengths and needs.
- For HV programs, it facilitates collaboration to increase the impact of HV agencies as well as easing the burden of outreach and participant recruitment. It allows HV programs to redirect their efforts from recruitment to working directly with families.
- For early childhood and community providers and resources, it increases coordination, thereby maximizing the impact and delivery of services.
- For state systems of early childhood services, it addresses fragmentation in Illinois' mixed delivery system by creating a more cohesive HV system that is connected to the broader early childhood system. It provides a continuum of comprehensive care and support for families prenatal to age five, thereby "strengthen[ing] and align[ing] key child- and family-serving systems that impact the lives of Illinois' most vulnerable children and to help advance Illinois' vision for early childhood."¹¹

For more information on the cross-systems benefits of CI, see *Appendix B*.

While there are implementation challenges, there is merit in the CI model, and the time is right to pilot test CI at the regional level, as a step toward comprehensive prenatal to five coordination. As part of the PDG B-5 renewal grant proposal, the first year of the pilot will include three Child Care Resource and Referral (CCR&R) programs and two Early/Head Start (E/HS) programs in southern, central, and northern Illinois, including rural areas. The site selection process will involve gauging programs' interest, capacity, and readiness to implement CI in their regions, as well as the level of HV saturation and concentration of

¹¹ Gallagher, R., Gandana, N., Marable, B., Potere, A., & Wilson, M.A. (September, 2018). Illinois. *Issue Brief on Coordinated Intake: An Overview and Illinois' Experience Within The Early Childhood Home Visiting System*.

risk factors. The Integrated Referral and Intake System (IRIS) software will be used to carry out the CI distribution and tracking of referrals.

Tools to be developed in the first year include a universal assessment tool and a universal decision tree template for referrals. Additional supports will be explored, including a hotline and strategic partnerships with child and family serving systems. The CI pilot will be scaled across the three years of the PDG B-5 renewal grant. It will also include racial equity considerations and actions by collecting data on race, ethnicity, and languages of families to assess the impact of CI on underserved communities.

A statewide CI system would minimize the navigation burden for families by taking on the role of matching families with services that are the best fit for them. Systemically, CI would also increase coordination and collaboration among HV programs and other services, resulting in increased and more equitable access for families and communities, thereby strengthening the ECCE system in Illinois.¹² The MIECHV CI communities have provided much of the understanding of the challenges to CI work as well as strategies to overcome these barriers; the lessons learned from current CI communities are discussed in the plan and are integrated into the design of the CI pilot and its planned statewide expansion.

¹² Gallagher, R, Gandana, N, Marable, B, Potere, A, & Wilson, M.A.

The Early Childhood and Home Visiting Landscape in Illinois

Illinois is committed to ensuring equitable access to high-quality ECCE services in a mixed delivery system for all children birth to five. It seeks to strengthen systems alignment and to lay a strong foundation for scaling a high-quality, efficient ECCE system that is responsive to families' needs.

One of its focus areas is to prioritize supports for infants and toddlers by expanding CI to connect more families to HV and other ECCE services. HV services are among the earliest early childhood supports that families can access to ensure that they have a strong start to a healthy and promising future. While all families can benefit from HV services, programs can provide targeted supports to families experiencing risk factors such as poverty, substance use, maternal depression, and first-time or adolescent parenting.¹³ HV services “strengthen the parent-child relationship, model positive-parenting skills, encourage economic self-sufficiency, support child development, promote learning and school readiness, and/or provide early detection for developmental delays and health issues.”¹⁴

In Illinois, HV is a mixed delivery system that draws on various funds, resulting in many programs blending and braiding revenue streams and implementing more than one HV model. The Major Funders of Home Visiting (MFHV) is a collaboration between two federal funding streams (MIECHV and Early/Head Start) and two state funding streams (Illinois Department of Human Services and Illinois State Board of Education Prevention Initiative).

The Prenatal to Three Initiative's Home Visiting Work Group estimated that 17,270 families were served by HV in FY17. However, based on poverty data and home visiting uptake rates, the Ounce of Prevention estimates that there are 32,000 families with children birth to three who are eligible for and likely to engage in intensive HV services.¹⁵ There remains a significant number of families and children in the early childhood population that have yet to be reached and benefit from HV services, but systemic barriers often prevent families from connecting to programs.

Evidence-based HV is a sector of the state's mixed-delivery ECCE system that does not already have coordinated points of entry for screening and enrollment across the state. In many locations, HV programs are siloed from one another and/or may lack strong connection to the rest of the early childhood system. Multiple entry points, different program eligibility requirements, and varying levels of HV saturation in communities create unintentional systemic barriers in an already complex and fragmented landscape of HV programs. For underserved families who are already facing challenges involving access to reliable transportation, adequate work with fair pay, health care, public benefits, linguistically and culturally responsive services, and immigration status, among others, navigating the constellation of HV services is especially challenging.

A statewide CI system would minimize the navigation burden for families by taking on the role of matching families with services that are the best fit for them. Systemically, CI would also increase

¹³ Erikson Institute, Illinois Early Childhood Asset Map (IECAM) of University of Illinois at Urbana-Champaign.

¹⁴ Ibid.

¹⁵ The Ounce of Prevention Fund. (October, 2019). *Home Visiting Cost Model Narrative*

coordination and collaboration among HV programs and other services, resulting in increased and more equitable access for families and communities, thereby strengthening the ECCE system in Illinois.¹⁶

¹⁶ Gallagher, R, Gandana, N, Marable, B, Potere, A, & Wilson, M.A.

A Brief History of Coordinated Intake in Illinois

In Illinois, CI communities have developed from federal initiatives, organically-grown HV collaborations, and state funding incentives. They are supported through a combination of public and private funding, and some are volunteer-driven.

Formal national and state recognition of the importance of CI for HV programs began around 2010 when the MIECHV federal program was first established and included CI in its original requirements.¹⁷ By 2012, Illinois' MIECHV program implemented CI in six communities and has since expanded to 12 sites. Much of the understanding of how CI operates in Illinois—including best practices and challenges—has been informed by the direct experiences and insights of CI workers, as well as through the Technical Assistance (TA) at the Ounce of Prevention Fund and Continuous Quality Improvement (CQI) at the University of Illinois at Urbana-Champaign's Center for Prevention Research and Development.

Several non-MIECHV communities have also implemented CI processes. For example, the DuPage Home Visiting Network was established over 10 years ago when local HV service providers independently came together to work collaboratively. The Network implements its CI process through the DuPage County Health Department; however, referrals were shared in the HV community even before the establishment of the Network.

As a part of the SFY17 Request For Proposals/Notice Of Funding Opportunity (RFP/NOFO), the Illinois Prevention Initiative (PI) began to support CI work, to incentivize HV collaboration across programs. This led to local providers establishing the Champaign County Home Visitors Consortium and developing interest in incorporating CI into their network. The collaborative has since received consultation around CI from the Community Systems Statewide Supports Program through Illinois Action for Children, and it is currently seeking funding to support these efforts.

In 2017, the Collaboration for Early Childhood Care and Education in Oak Park also facilitated a process to officially establish its CI initiative, as a part of their efforts to develop a strong ECCE system to serve families in the Oak Park-River Forest communities.

Other CI communities have been more recently established (2019) with private support. In North Lawndale, Illinois Action for Children and the Steans Family Foundation have launched a CI process in the community in response to needs expressed by HV providers. The Steans Family Foundation has also supported the recent launch of Lake County Health Department's CI initiative as a part of its health equity work.

In addition, several communities are using the IRIS referral software to carry out CI and referrals, and others have expressed interest. This demonstrates that interest in CI and referrals is increasing among ECCE providers throughout Illinois. For a map of Illinois CI communities, see *Appendix C*.

¹⁷ Ibid.

How Coordinated Intake Works

CI involves multi-directional “warm” referrals that pass through the system before they are passed onto HV programs and early childhood services.¹⁸ Referrals come from a diverse range of sources such as CI workers, HV programs, early childhood services, other child and family support services, friends, and families.

In MIECHV communities, when a CI worker recruits a family, they conduct intake and screen for the family’s interest in services, strengths, and needs. When the CI worker receives a referral, they review the family’s information to ensure all basic information is provided and that there is no duplication in service provision before the referral is entered into the database system. The CI staff cross-references the referral with current capacity, availability, program focus, and eligibility requirements of local HV programs to determine services that are the best fit for the family. Families are then provided with options before they are referred and matched with services and resources. Once the family is referred to a program, the CI worker monitors the status and outcome of the referral (i.e., enrolled, waitlisted, or declined) to close the loop on the intake process.¹⁹ See the diagram below for more information on how referrals flow through in a CI process.

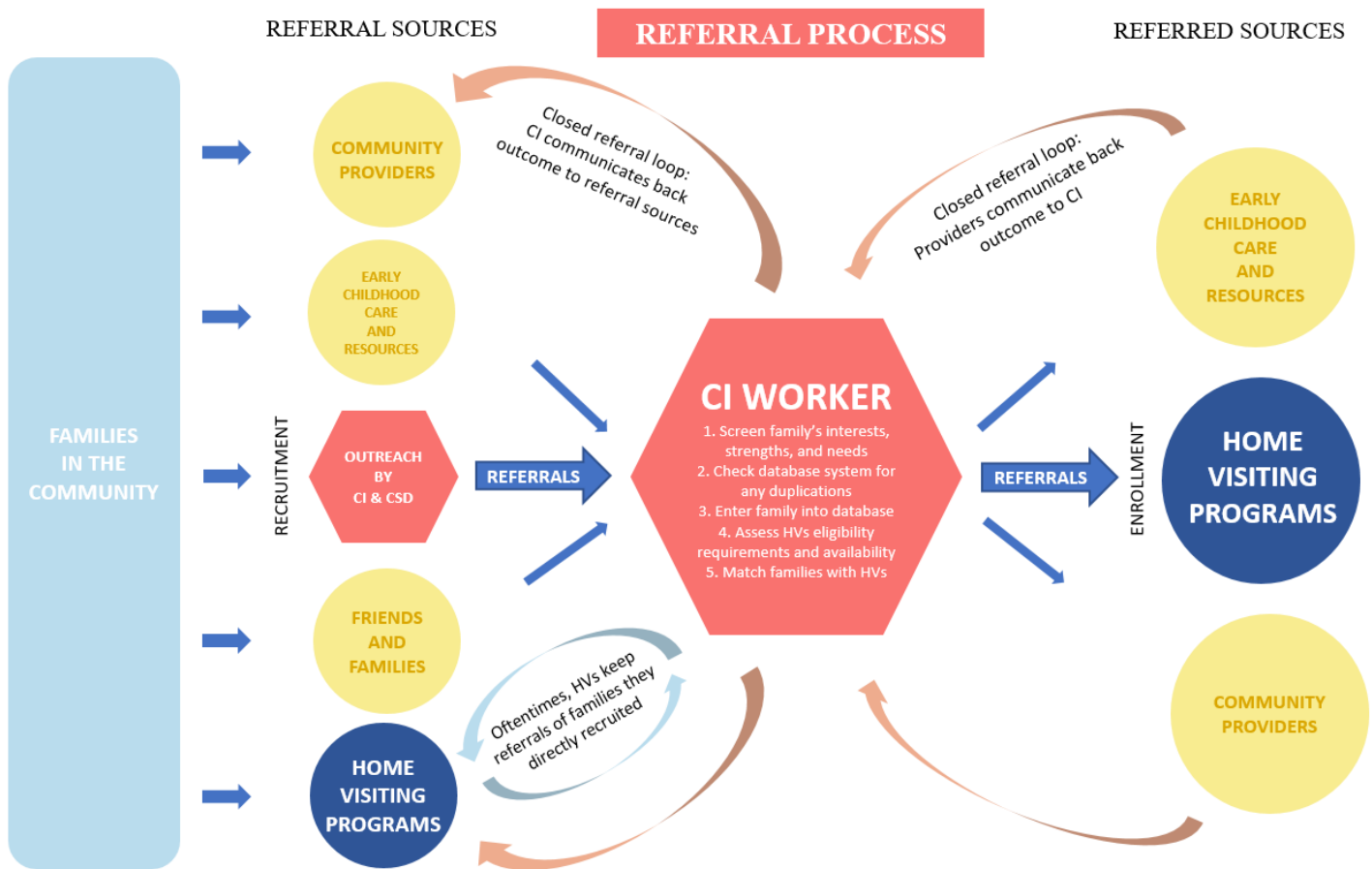
Essential to the function of CI is the participation and collaboration of local HV programs. They can control the flow of referrals in the system by providing and responding to referrals, thereby facilitating a robust system. Their level of participation and communication also determine how well-informed the CI worker is of the capacity of local programs, which is necessary for matching families with services.

To maintain a strong relationship with HV programs, MIECHV CI staff regularly convene and organize collaborative meetings. Collaborative work includes the development of Memoranda of Understanding (MOU) around participation in CI, sharing of information and updates on individual programs, developing shared decision-making trees for the distribution of referrals, and receiving referral reports from the CI staff.

¹⁸ Warm referrals are when service providers or CI workers serve as conduits between participants and the system such as by contacting programs on behalf of the family, facilitating access to services by informing participants about the existence and functions of the services, interpreting complicated policies, imparting skills that can be used to pursue needed services in the future, and providing emotional support throughout, as described in “Coordinated home visiting and early care and education referrals can help families get the services they need” and “Getting to the Warm Hand-Off: A Study of Home Visitor Referral Activities.” Retrieved from: <https://www.childtrends.org/coordinated-home-visiting-and-early-care-and-education-referrals-can-help-families-get-the-services-they-need> and

<https://link.springer.com/article/10.1007/s10995-018-2529-7> respectively.

¹⁹ Center for Prevention Research and Development at the School of Social Work at the University of Illinois at Urbana-Champaign. (2019). Maternal Infant and Early Childhood Home Visiting (MIECHV 6th Annual Benchmark and Outcome Report FY 2018. Illinois: Champaign. Retrieved from: <https://cprd.illinois.edu/files/2019/08/IL-MIECHV-6th-Annual-Report-FY18.pdf>



The CI staff also conduct outreach in the community to increase referral sources beyond the HV community. Some examples of outreach partnerships include collaborations with local health departments, weekly outreach at Illinois Department of Human Services Family and Community Resource Centers, an MOU with the local Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) office, and informational workshops at obstetrician-gynecologist (OB/GYN) clinics as well as other early childhood sites such as Early Intervention's (EI) Child and Family Connections (CFC) agencies.

CI workers are multi-systemic and multi-skilled workers whose roles and responsibilities require strong understanding of multiple state programs and systems, interpersonal and relational skills in interacting with families in a thoughtful and strengths-based manner; community organizing and effective communication in working with HV and community partners; critical and strategic thinking for impactful outreach; and analytical and data-informed decision-making. Their roles and responsibilities are summarized in the following table.

ROLES AND RESPONSIBILITIES OF A CI WORKER

SCREENING	<ul style="list-style-type: none"> • Accurately complete screening with families
REFERRAL	<ul style="list-style-type: none"> • Review screens received from referral sources • Provide program options and refer families to most appropriate HV program, early childhood care and education, and/or other social services as needed
RECRUITMENT OF FAMILIES	<ul style="list-style-type: none"> • Outreach in recruiting family participants directly (independently or collaboratively with HV programs) • Use various outreach strategies to inform families about HV
HV PARTNERSHIPS	<ul style="list-style-type: none"> • Convene and facilitate HV collaboration (develop vision, MOUs, shared decision-making tree for referrals, etc.) • Communicate community HV program capacity and status of referrals to all HV partners • Follow up on status of referrals to HV and/or social service programs • Monitor HV program capacity in the community • Share referral summary report
COMMUNITY PARTNERS	<ul style="list-style-type: none"> • Facilitate, organize or participate in meetings with community partners
OUTREACH	<ul style="list-style-type: none"> • Develop and maintain relationships and formalize agreements with other community service providers • Outreach local social service agencies and families to connect HV and CI with broader community social service system • Plan and implement community outreach events to identify potential families to enroll in HV • Develop and implement social media outreach strategy to raise awareness of HV
DATA TRACKING AND REPORTING	<ul style="list-style-type: none"> • Enter referral data • Monitor availability of all HV slots in the community • Regularly review referral data and communicate information to HV partners • Complete reports required by funder • Analyze recruitment trends (strongest referral sources, average number of referrals processed, referral outcomes, etc.)

Most of the information on how CI works is provided by the *Issue Brief on Coordinated Intake: An Overview and Illinois Experience Within the Early Childhood Home Visiting System, September 2018*; see *Appendix I*.

Stakeholder Engagement in Statewide Coordinated Intake Expansion

Since the establishment of the MIECHV CI communities in 2012, earlier state-level interest in strengthening community and intake systems throughout Illinois was stalled by the two-year state budget impasse (SFY15 to SFY16). HV and other ECCE programs were adversely impacted by the impasse, which resulted in reduced services as well as a decrease in referrals flowing from other sectors.²⁰

In 2017, interest in a statewide CI system regained momentum among state-level stakeholders. The U.S. Department of Education and Department of Health and Human Services released a joint statement calling for a stronger partnership, collaboration, and coordination between MIECHV and the Individuals with Disabilities Education Act Part C EI programs.²¹ Specifically, the statement asked states to *establish and implement regional system points of entry across all of HV programs similar to EI to support shared enrollment and referrals across systems and a “warm hand off.” Consideration should be given to regional system points of entry that are aligned across HV and EI or at least parallel geographic areas.*²² In response, a group of diverse stakeholders convened the 2018 EI-HV Summit and produced *Recommendations for Improved Collaboration and Coordination Across HV and Early Intervention in Illinois* which included action steps and questions to consider for a statewide CI system. These recommendations provided the foundation for the development of this strategic plan.

A subgroup of these stakeholders formed the RPE Workgroup of the HVTF to strategize around implementing the recommendations. The RPE Workgroup was composed of representatives from Illinois’ HV system, EI, GOECD, ELC, HVTF, and the Illinois Interagency Council on Early Intervention. The RPE Workgroup met several times in late 2018 and early 2019.

In 2018, informed by the work of the RPE Workgroup, the GOECD developed Illinois’ proposal for the PDG B-5. The proposal focused on building systemic efforts to expand coordination across Illinois’ mixed delivery system to increase access to ECCE services for families and children. The proposal included the expansion of CI for HV services under *Activity Two: B-5 Strategic Plan*. After GOECD received PDG B-5 year one funding, the RPE Workgroup was reconvened as the CIHV Workgroup and met in September and October 2019, respectively, to gather stakeholder input on the strategic plan.

The first meeting focused on ways to scale the CI system by looking at boundaries of existing systems of early childhood services and networks – EI CFCs, the CCR&Rs, community collaborations such as the All Our Kids Early Childhood Networks (AOK Networks), E/HS programs throughout Illinois, as well as other child/family serving systems. The main takeaways were as follows:

²⁰ Gallagher, R, Gandana, N, Marable, B, Potere, A, & Wilson, M.A.

²¹ U.S. Department of Education & U.S. Department of Health and Human Services. (Jan., 2017). Collaboration and Coordination of The Maternal, Infant, and Early Childhood Home Visiting Program and The Individuals With Disabilities Education Act Part C Programs. Retrieved from: <https://sites.ed.gov/idea/files/ed-hhs-miechv-partc-guidance.pdf>

²² Regional Points of Entry Workgroup. (April, 2018). Recommendations for Improved Collaboration and Coordination across Home Visiting and Early Intervention in Illinois.

- The regional boundaries of existing systems seemed to be arbitrarily determined and did not align with one another; no single existing system was necessarily best for reaching families.
- While existing HV collaboratives and other EC community collaborations do not provide statewide coverage, they are key partners in connecting families and service providers at the local level.
- Building a statewide CI system through the Illinois Department of Public Health (IDPH) would not be feasible due to their loose governance relationship with county and local health departments. However, county health departments have served as some of the strongest sites for CI and remain integral to the scaling of the system.
- Several stakeholders across different systems expressed support for the CCR&Rs in engaging with the CI system. They are well-positioned to connect CI to the rest of the early childhood system and have strong infrastructure to support CI.

The second meeting provided guidance on two of the largest challenges to scaling Illinois' CI system—establishing a coherent referral database system and identifying funding sources beyond PDG B-5. The recommendations are as follows:

- Stakeholders recommended either utilizing existing early childhood database systems or exploring the use of IRIS which is already launched in four counties in Illinois.
- As for potential funding sources, stakeholders recommended holding conversations with the MFHV, the Title V program in the IDPH, and county-level funding as described later in the funding recommendations section of this document.

Coordinated Intake Challenges and Recommendations

While there are many systemic benefits to CI, there are challenges as well. This section identifies barriers as well as recommendations to address them, as summarized in the table below:

Barriers	Recommendations
Lack of Awareness of Home Visiting	Increase Awareness and Understanding
Difficulty Engaging and Enrolling Families	Streamlined Referral Process
CI Staff Turnover	Increase Positions, Salary, and Investment in CI workers
Overcoming Competition and Securing HV Collaboration	Neutral Entity, Referral Reports, and Funding Incentives for Collaboration
Disconnected Data System and Data Collection Process	Integrated Referral and Intake System (IRIS)
Sustainable Funding for a Statewide CI System	Explore Viability of Funding Sources

The information on challenges and recommendations to CI intake is greatly informed by the work in *Coordinated Intake in Illinois: Policy Recommendations for the Current System*; see Appendix D and J for more information.

Barrier: Lack of Awareness of Home Visiting

One significant challenge is the minimal awareness, understanding, and marketing of HV services among families, ECCE providers, and other systems of child and family supports. One reason is that HV services have only recently received national recognition and support in the last two decades. In 2000, the first National HV Forum convened, while in 2009, the U.S. Department of Health and Human Services launched Home Visiting Evidence of Effectiveness (HomVEE).²³ As CI is being initiated as a coordinating system for HV, any challenges or lack of understanding around HV services also impact awareness and support for CI.

In addition to minimal awareness and understanding of HV, families may also have misunderstandings and stigmatized ideas about HV services, leading to reluctance or resistance in participating in CI. Indeed, the Pew Charitable Trusts surveyed prospective family participants on language around HV and found that participants responded negatively to the name “home visiting.”²⁴ CI workers shared that families often associate home visits with the Illinois Department of Children of Family Services (DCFS) and removal of children from the family home. In immigrant and refugee communities, HV services may not exist in their country of origin, may be incongruent to their culture of family systems, or even pose a sense of danger for those who have experienced systemic and institutionalized oppression.

²³ National Home Visiting Resource Center.

²⁴ The Pew Charitable Trusts. (October, 2015). *Family Support and Coaching Programs: Crafting the message for diverse stakeholders*. Retrieved from: <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2015/10/family-support-and-coaching-programs>

As a result, both ECCE and non-ECCE service providers may be unaware of HV services in their community or may not recognize the value of these services. For example, although the RPE Workgroup provided recommendations for stronger alignment between EI and HV systems, one CI community reported difficulty in engaging their local EI providers to be part of their referral system. In some CI communities, programs have expressed difficulty in connecting with their local WIC offices. This creates difficulty in establishing partnerships and increasing referral sources to HV programs, thereby maintaining a fragmented and siloed mixed delivery system of ECCE services.

Recommendation: Increase Awareness and Understanding

Currently, CI workers are doing Community Systems Development (CSD) work to increase awareness around HV services to families and child/family service providers, as well as the benefits of CI to HV programs. Below are additional recommendations to increase understanding of HV in hard-to-reach communities.

- **Partnerships with community-trusted community-based organizations (CBOs)**: In underserved communities that may be reluctant to participate such as immigrant, undocumented, and refugee communities, CI workers can identify and build partnerships with local social service agencies that work closely and are trusted by the community. These CBOs have the knowledge, skills, and relationships that can be leveraged in increasing understanding around HV services.

An example of such collaboration is the partnership between RefugeeONE, Illinois' largest refugee resettlement agency, and BabyTALK, an Illinois HV program, who have co-located their services for refugee families.²⁵ A similar approach for CI, such as partnering with immigrant service providers and conducting intake on-site, would increase connections to hard-to-reach groups as well as providing local CBOs with a connection to local HV supports.

- **Leveraging families' interests**: CI workers can create greater marketability of HV services by leveraging services that families may be already seeking. For example, Asian Human Services (AHS), a social service agency serving Chicago's predominantly refugee and immigrant community in West Ridge, recognized that a priority interest for clients is to increase their English proficiency. In leveraging this interest, AHS offers ESL classes jointly with their HV programs, meeting their clients' needs while also increasing awareness and enrollment into HV services.
- **iGrow website**: Managed by GOECD, the Illinois iGrow HV website continues to gain exposure as more HV services and CI communities are listed on the website directory as well as use the brand to market their programs and systems. The website features video testimonials of families who have received HV services, courtesy of the Kane County Health Department. A similar approach can be taken for the CI system by gathering interviews from communities that have benefited from CI and how they have come to adopt the system.
- **Collaboration with existing parent groups**: As CI expands statewide, connecting with existing parent groups will also be strategic to inform communities about CI and HV services, as well as

²⁵ Park, M., & Katsiaficas, C. (August, 2019). (August, 2019). Leveraging the Potential HV Programs to Serve Immigrant and Dual Language Learner Families. Retrieved from: <https://www.migrationpolicy.org/sites/default/files/publications/NCIIP-HomeVisiting-Final.pdf>

gathering feedback on how to improve the system. For example, the CCR&Rs have Referral Specialists whose responsibilities are to inform parents about local services as well as make referrals to those services. E/HS programs have parent committees that provide input to local programs.

Barrier: Difficulty Engaging and Enrolling Families

Families—especially those from under-resourced communities—face various challenges and barriers to engaging in CI and enrolling in HV programs. Families may not have access to transportation, communication methods (e.g., cell phones, internet), or time to go through the intake process, as they may be working multiple jobs to financially sustain their family. As mentioned earlier, the lack of linguistically and culturally responsive providers can also serve as an additional barrier for families to participating in CI.

CI workers must often make multiple attempts through different approaches to contact a family. One MIECHV CI worker reported contacting families up to three times over the course of several weeks, through texts, calls, and emails.²⁶ Despite these efforts, families still may drop off at any point in the referral process. In some MIECHV CI communities, only 10-25% of referrals resulted in enrollment in a HV program.²⁷

Recommendation: Streamlined Referral Process

In the current context, where there is a low-level of awareness and understanding of HV services as well as stigma, it is essential to ensure that family trust and interest is maintained throughout the CI process. A streamlined referral process would minimize the number of touches that a family has with service providers, decreasing the length of the intake process and thereby increasing the family's interest and likelihood in enrolling in HV. Families would participate in intake once and share only the most essential information needed to determine program eligibility and services that are the best fit for them based on their needs and strengths. Streamlining takes a trauma-informed approach, as it prevents families from being re-traumatized by having to share intimate personal information with multiple providers. Ultimately, this should help to decrease or mitigate potential initial mistrust in CI, HV, and ECCE services.

- **CI and HV joint outreach:** One example of a streamlined process is when CI workers partner with HV providers at outreach events to engage with families. The CI worker conducts the intake process and the home visitor schedules the first appointment with the family. This allows for an immediate warm handoff between the CI worker and home visitor for the families, as well as completing the CI process right away.
- **Direct recruitment of families by HV:** Another approach is to allow HV providers to contact families, conduct the intake process, and enroll families into HV services. This allows the HV program to collect detailed eligibility information at the outset. The HV program would then share the family's contact information with the CI worker, who would enter the referral into the data system to check for any duplication of services.

²⁶ Interview with MIECHV CI Worker

²⁷ Marable, B. (2019). Coordinated Intake in Illinois: Policy Recommendations for the Current System.

Barrier: CI Staff Turnover

Similar to other positions in early childhood, CI sites can experience high-turnover rates of workers, due to the nature of the work, the entry-level salary, and the isolated nature of the position. In most CI communities, the work is done by a single worker. When the MIECHV program initially began, each CI site had two full-time staff: a CI worker to work with families and process referrals and a CSD worker who conducted outreach and community organizing to develop and maintain referral partnerships. In 2016, the MIECHV program no longer funded the CSD position and, as a result, the role and responsibilities of the CSD was assumed by the CI worker.

Within the MIECHV program between SFY16 – SFY18²⁸, the following occurred:

- The percent of turnover ranged from 20%-44%
- Average length of vacancy was 3.9 to 5.6 months
- Average length of employment was 1.9 to 2.4 years

Currently, the average salary of a CI worker in Illinois is \$33,000; this is low considering the educational requirements and responsibilities of the position.

Finally, CI is a fairly recent system and not a readily easy concept to understand. It requires extensive relationship-building to increase awareness and gain buy-in from HV programs and early childhood providers who may be initially reluctant to participate in the system. As the only full-time staff in this role, CI workers can feel isolated in constantly addressing barriers and advocating for CI to different service partners.

The turnover rate of the CI worker also influences the sustainability of CI, as it is essentially built on relationships and trust with HV partners. It takes a significant amount of time to recruit, hire and train a new CI worker, and to rebuild the relationships with HV programs before the CI initiative is functioning at full capacity again. The high turnover rates among home visitors also create instability.

Recommendation: Increase Positions, Salary, and Investment in CI workers

- **Two full-time positions:** Each CI site should have two full-time workers dedicated to conducting CI and CSD work. The positions' responsibilities may be distinctly separated or they may be shared across positions, as the CI and CSD responsibilities often blend together. The addition of another staff person would create a team approach, increasing peer support within the CI initiative.
- **Increased compensation:** To adequately compensate the work and qualifications required for CI workers, the recommendation for a fair salary would be \$41,650 for CI workers downstate and \$52,000 for Cook and Collar Counties, which are more than a 25% and 55% increase in pay, respectively.²⁹

²⁸ Center for Prevention Research and Development at the School of Social Work at the University of Illinois at Urbana-Champaign.

²⁹ The Ounce of Prevention Fund.

- **Strong supports:** Overseeing and supporting the CI workers is a supervisor who holds a strong understanding of the value of CI and the importance of the work, along with dedication to supporting the CI staff through a reflective supervision approach. The MIECHV CI workers also receive infant mental health consultation (IMHC) to strengthen their socioemotional capacity to work with families. One CI worker shared that IMHC has been one of the most beneficial supports that they receive in their work.
- **Professional development:** Strong investment in professional development is also key to the growth and sustainability of CI. For the Ina Maka Family Program at the United Indians for All Tribes Foundation in Washington, the program has maintained nearly all of their original staffing since their start 9 years ago. Katie Hess, the program director, shared that their significant investment in staff satisfaction has been key to having one of the highest workforce retention for home visitors. A similar approach can be applied to CI workers, who have expressed interest in expanding their skills in areas such as data analysis and reporting as well as marketing.³⁰
- **Peer Learning Communities:** Learning Communities provide a strong sense of community and support for CI workers who are often isolated in their work. The MIECHV program facilitates gatherings on a quarterly basis and they focus on resource sharing, professional development, group activities, and CQI. CI workers also participate in annual CQI projects and regular monthly calls with their support through CPRD to further develop their skills.

Barrier: Overcoming Competition and Securing HV Collaboration

A major challenge across all CI communities is the full active participation of HV partners. The function of CI is to track all HV referrals and enrollment slots in the community, but if HV partners are not fully sharing referrals and information on their open slots, the system cannot function at its fullest capacity.

Some of the barriers to participating in CI are that HV programs feel pressure to meet funder requirements to maintain a certain enrollment capacity (e.g., MIECHV programs are required to maintain 85% filled capacity). This expectation, coupled with HV programs often being siloed from one another, can create a sense of competition among HV providers, and, in some cases, a history of distrust between programs.

In one CI community, the CI worker brought all HV partners to the table and regularly convened collaborative meetings where all partners attended and participated. Even then, referrals did not readily come through the system, illustrating that trust and collaboration takes time and patience.

Recommendation: Neutral Entity, Referral Reports, and Funding Incentives for Collaboration

- **Neutral entity to house CI:** Housing the CI initiative in a neutral agency or organization that does not provide HV services to the community would remove potential conflicts of interest that could deter HV agencies from participating in the initiative. It also mitigates doubts from programs that the CI staff is not acting as a neutral broker in the gathering and distribution of referrals to programs. While a neutral CI entity is strategic in overcoming challenges to a HV

³⁰ Center for Prevention Research and Development at the School of Social Work at the University of Illinois at Urbana-Champaign.

collaboration, it is still possible to maintain a CI initiative if the CI entity also provides HV services, as is the case for a few MIECHV CI communities. In these situations, CSD work will be all the more essential in ensuring trust, transparency, and communication with HV and community partners.

- **Transparent referral reports:** It is also best practice for CI staff to provide reports on referrals to the HV collaboration to maintain transparency on the distribution of referrals.
- **Funding incentives for collaborations:** At a larger systems level, the MFHV can encourage or facilitate the development of collaboration between HV programs by incentivizing collaboration in their RFP. This has proven effective in two communities through the Prevention Initiative funding opportunity that awarded points for HV agencies working together or utilizing a CI approach. In the FY20 Illinois State Board of Education's NOFO/RFP for the Early Childhood Grant-Prevention Initiative for Birth to Age 3 Years, the funder outlines ways of coordinating across programs and sectors through shared or mutual referrals, CI, a referral pipeline, continuous early childhood services, and MOUs.³¹

In one MIECHV CI community, the ISBE PI grant language provided the impetus for bringing together HV agencies to work collaboratively despite an extensive previous history of distrust and strong competition.³² In Champaign, the ISBE PI funds also helped facilitate the development of the Champaign County Home Visitors Consortium, which comprises of more than five programs. Currently, the Consortium is interested in developing a CI process in their community as well as funding to support this work.³³

Barrier: Disconnected Data System and Data Collection Process

A variety of different software programs (data systems) are used across CI communities while some do not use one at all. Most of the MIECHV CI communities use Visit Tracker, which also serves as a HV case management system. The communities often use supplemental methods (e.g., email, fax, or calls) to communicate referrals, while the CI at Rush University Medical Center also uses NowPow. The use of different data systems creates challenges for participating HV programs. The lack of a single coherent and consistent data system to receive and send referrals as well as interface with different HV programs is one of the most significant and complex challenges to building a statewide CI system. Related to this issue, it is also challenging to encourage service providers to utilize another data system when early childhood systems already utilize multiple data systems, each with its own set of challenges.

As a result, there is also a lack of comprehensive and consistent data to assess the impact of CI on families, communities, and providers, and to identify priorities for resource allocation and CQI.

³¹ Illinois State Board of Education. (2019). Notice of Funding Opportunity (NOFO) / Request for Proposals (RFP): Fiscal Year 2020 Early Childhood Block Grant-Prevention Initiative for Birth to Age 3 Years. Retrieved from: <https://www.isbe.net/Documents/FY20-PI-RFP-NOFO.pdf>

³² Interview with MIECHV CI Worker

³³ Memorandum of Understanding (MOU) Between Champaign County Birth to Three Home Visiting Programs, provided by the Champaign County Home Visitors Consortium

Recommendation: Integrated Referral and Intake System

The Integrated Referral and Intake System (IRIS) is a web-based community referral system developed by the Center of Public Partnerships and Research at the University of Kansas that meets the requirements of a well-functioning CI database system as follows:

- a single platform that can be used by different service providers
- capability to easily incorporate new providers
- send, receive, and close loop on referrals
- provide enrollment capacities of HV and ECCE services
- capture data on referrals, families, service providers, and communities
- generate reports to inform decision making on CI in community and state levels

A user-friendly, simple, and customizable platform allows service providers to easily be integrated into CI, meaning that all HV partners will be able to participate in electronic intake regardless of their case management software program. In the future state of CI that is connected to all ECCE systems, IRIS would be able to easily incorporate new providers into its system.

IRIS also creates a streamlined process of intake and referral as well as mechanisms for closing the loop on referrals. It captures each activity and time throughout the referral process, as well as current capacity of service providers. This allows the CI worker to know the status of all referrals received through the system.

The program can also easily generate reports at the community-level for providers as well as at a state-level. For providers, reports can help identify strong referral sources, referral trends, and potential partners in providing comprehensive connections to services for families. At a state level, IRIS can help identify strengths and needs across communities, provide input on allocating resources, and measure the growth of community collaborations throughout Illinois.

Currently, there are several communities utilizing IRIS. It is actively used in Stephenson, Carroll, Rock Island, and Cook counties, while four counties are in the process of implementation. In addition, nine counties are inquiring about IRIS. These trends demonstrate that IRIS is gaining traction throughout Illinois and could position the CI system well to connect with these communities for future coverage.

For a map of all communities implementing, launching, and inquiring about IRIS, see *Appendix E*.

Barrier: Sustainable Funding for a Statewide CI System

Funding of the statewide CI system remains a significant challenge. The minimum cost estimates for a statewide system of CI regions is \$3.5 to \$6 million.³⁴ Currently, the MIECHV program remains the largest funder of CI communities in Illinois, while other sites have received private support to implement their system or are operating on a voluntary basis. Recently, state funders of HV have encouraged and supported CI. As mentioned earlier, ISBE PI began supporting CI work in FY17.³⁵ As a part of their FY20

³⁴ Figures listed in the “Home Visiting Cost Model Narrative” and information from the MIECHV program were used to calculate the cost range of the CI system by CCR&R regions, CFC regions, and LIC coordinators.

³⁵ Illinois State Board of Education.

RFP, the Illinois Department of Human Services includes participation in a network of community partners as a part of family recruitment strategies.

As mentioned previously, in DuPage County the CI community is functioning without funding support despite a large HV collaborative that has worked together for over 10 years. The CI worker, who supervises two early childhood programs, volunteers time to process and pass referrals onto HV agencies. The Champaign County Home Visitors Consortium is currently seeking funding for CI.

While private support from the Steans Family Foundation has helped to launch CI in two communities, private funders have expressed their view that support for a statewide CI system should come from the public sector.

Recommendation: Explore Viability of Funding Sources

- **Blending and Braiding Funding – MFHV:** As the main initial beneficiaries of the CI system, the MFHV is a natural consideration for supporting and sustaining CI. One approach to encourage funders to plan in future budgets for the statewide CI system is to compile a list of HV communities that are independently implementing and/or interested in CI.
- **Illinois Department of Public Health:** Several county health departments are serving as CI sites and have expressed strong support for the CI system in CIHV meetings. Following the 2018 *State of Illinois' Maternal Mortality and Morbidity Report*, multiple partnerships are currently being explored between the Title V Maternal and Child Health Services Block Grant and HV, and the MIECHV Project Director now serves on the IDPH Maternal Mortality Review Committee. These partnerships can open the door to discussions of CI funding.
- **County Sources:** Potential funding sources should be explored at the local county level to sustain CI sites. For example, in Los Angeles County, *First 5 LA* draws funds from local tobacco tax revenues. A similar strategy could be considered for Illinois.

Piloting a Statewide Coordinated Intake System

Current CI initiatives cover less than 20 communities, leaving the majority of the state without regional points of entry to HV. Thus, in most of the state, families or social service providers who are seeking to connect to HV are left to their own devices in lieu of systematic referral points. As a result, HV slots may go unfilled, while at the same time, families from priority populations have difficulty finding their way to HV. These conditions lead to inefficient use of resources.

Illinois envisions a future in which there are coordinated points of entry throughout the state for HV as well as other ECCE services. As an initial step toward this vision, a pilot is planned to test CI for HV services on a regional level. Funding to support the pilot and expansion is included in the PDG B-5 renewal grant proposal, which covers three years. Lessons learned from the first year of the CI pilot will inform the scaling out of the system in the second year, as well as any modifications or adjustments needed to the system. The second year will inform the expansion in the third year.

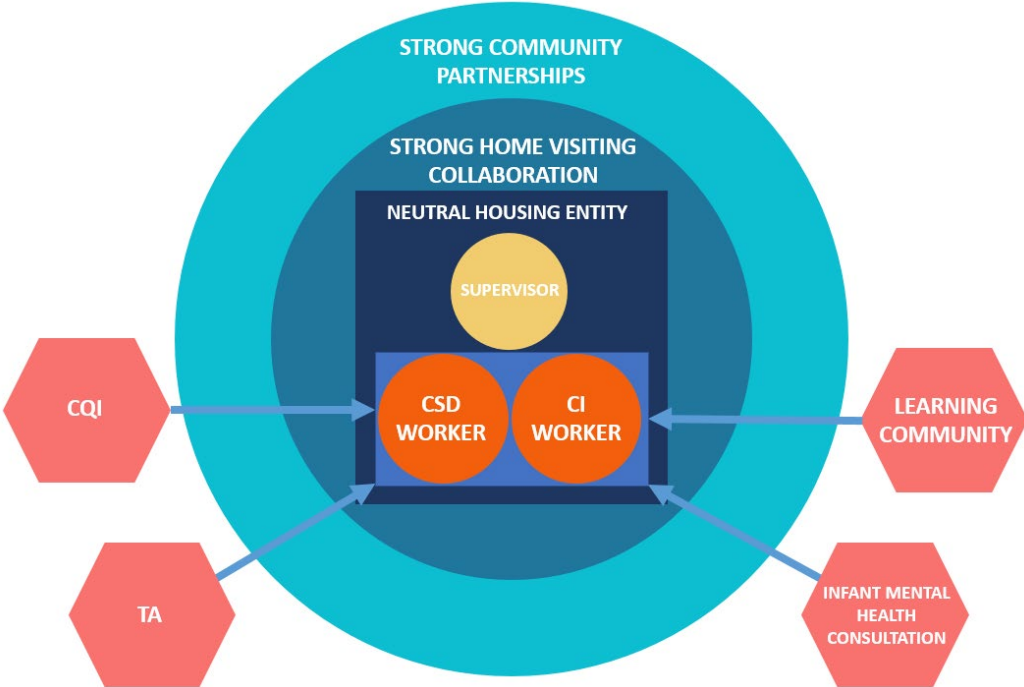
Year one of the CI pilot will involve five regions in southern, central, and northern Illinois, including rural areas. The first year of the pilot will begin July 2020, to align with the state’s fiscal year. The CI pilot and expansion will not duplicate current CI efforts or upend existing CI communities. Instead, it will leverage current efforts and initiatives to ensure that CI is reaching all families that can benefit from HV services. For example, if the CI pilot region comes across families who reside in a catchment area of an existing CI community within the region, the CI pilot site will refer the families to the existing CI community worker rather than duplicate that function.

Each of the pilot sites will include the following:

Pilot Component	Summary Description
CI site staffing	CI worker, community systems development (CSD) worker, supervisor
Professional development	Onboarding training, TA, infant mental health consultation, peer learning communities, and coaching will be provided through the MIECHV CI TA system.
Eligibility assessment tool and referral procedures	The MIECHV CI Assessment Tool (CIAT), referral decision trees, and sample procedures with timeframes for “closing the loop” will be used as templates. The CIAT includes eligibility information for multiple HV models (such as income, age of child/stage of pregnancy, whether this is mom’s first pregnancy, etc). Sites will be required to work with local HV programs to adapt the templates as appropriate.
Family engagement	Prior to rollout, sites will be required to gain parent input on the above templates, through existing mechanisms such as E/HS Policy Councils and Parent Committees. Ongoing family input will guide CQI.

Data system	Data on HV capacity, families engaged, referrals made, status of referrals and source of referrals will be collected using IRIS, a web-based application developed by the University of Kansas for these purposes. IRIS is already used in four counties in Illinois, with expansion planned for four additional communities this year.
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Organization of a Strong CI Site



GOECD and the CIHV Workgroup reviewed a number of systems and entities for consideration in serving as the CI pilot sites. While no entity was a perfect candidate for housing CI, CCR&Rs and E/HS sites rose to the top.

The CCR&Rs’ infrastructure and public awareness of their connection to early childhood services position them well as potential CI pilot sites:

- Their current outreach efforts to families and child care providers is well established and can be extended to prenatal families and HV services.
- Their child care resource directory is updated on an annual basis; the same process can be replicated for HV, enabling CI staff to monitor the capacity of local HV programs.
- CCR&Rs are a neutral entity with regard to child care, and can serve as a neutral entity for HV.
- CCR&Rs Referral Specialists work directly with families in informing them about local services and resources as well as making referrals. Current CCR&R contract language already includes making enhanced referrals to MIECHV HV services as well as other early childhood services and resources beyond child care. This position can be leveraged to inform families and service providers about HV services and to make referrals to HV.

- Several CCR&R directors have expressed and initiated interest in exploring CI, which is essential for a system that is based on collaboration. The Illinois Department of Human Services, which oversees CCR&Rs, have also expressed their support of this pilot.
- While CI will initially focus on building a referral system to HV services, being housed in the CCR&Rs will also enable the CI to be connected to child care and other early childhood services.

In the year one PDG B-5 proposal, E/HS programs were included as a potential consideration for serving as CI hubs. Several components of E/HS position them well to take on a CI role, as follows:

- While E/HS grantees are not located in every county, their services cover every county in Illinois.
- Community engagement is a core part of the E/HS Program Performance Standards, mirroring the vital role of CI in connecting to families, HV services, and early childhood service providers.
- E/HS programs already have Eligibility, Recruitment, Selection, Enrollment, and Attendance coordinators whose work parallels those of CI workers, facilitating the addition of the CI role into E/HS.
- In addition to HV services, E/HS programs provide comprehensive early childhood support to families (medical, dental, nutritional, and family support services, among others). The CI pilot would build onto these existing E/HS connections by adding other HV programs to the mix.
- The Illinois Head Start Association has expressed strong interest in the CI system since year one of the PDG B-5 grant, and they have contributed input throughout the development of the plan.

To test the viability of these sectors, the pilot sites will consist of 3 CCR&Rs and 2 Early/Head Start (E/HS) providers. The selection process will involve gauging the programs’ interest, capacity, and readiness to implement CI in their communities, as well as the level of HV saturation and concentration of risk factors. For a map of CCR&R boundaries and E/HS sites overlaid with HV saturation, see *Appendix F* and *Appendix G*.

It must be noted that E/HS programs and some CCR&Rs that also provide HV services are not viewed as “neutral entities” with regard to HV. For any pilot sites that fall into this category, special efforts will be made to ensure neutrality and transparency in the distribution of referrals. For more information, see the section “Recommendation: Neutral Entity, Referral Reports, and Funding Incentives for Collaboration.”

The pilot sites will use the IRIS data system. They will collect baseline data on CI, including information on racial equity, to identify areas of strength and improvement in the system as well as the impact on communities and service providers. The pilot will also develop a replicable data collection process for use by future CI sites. Some of the data points to be captured are as follows:

Families	<ul style="list-style-type: none"> ▪ priority families enrolled in HV by CI, such as teen mothers and families below poverty ▪ racial equity: race, ethnicity, native language, country of origin, and level of English proficiency ▪ factors influencing family decision regarding enrollment in HV services
Referrals	<ul style="list-style-type: none"> ▪ ideal caseload capacity (i.e., number of HV slots to fill) for a CI worker ▪ strength of referral sources

	<ul style="list-style-type: none"> ▪ outcome of referrals ▪ average time of the CI process and families on waitlist ▪ medium of sent referral
Outreach	<ul style="list-style-type: none"> ▪ effective outreach and community systems building strategies
HVs	<ul style="list-style-type: none"> ▪ number of HV slots filled before and by CI ▪ HV capacities in the communities ▪ number of HVs using CIAT
Workforce	<ul style="list-style-type: none"> ▪ CI position turnover rate

The design of the data collection, analysis, and reporting process will be informed by practices and lessons learned from the MIECHV CI communities. For SFY20, the MIECHV CI communities have a CI Referral Analysis CQI Project to strengthen their data collection and analysis of trends regarding effective outreach strategies, strong referral sources, and outcomes for families.

Universal Coordinated Intake Assessment Tool

To support the CI pilot, stakeholders in the CIHV Work Group recommended that a universal coordinated intake assessment tool be developed. Currently, MIECHV CI communities are using the Coordinated Intake Assessment Tool (CIAT) for referrals to HV programs, which includes fields on the family, risk factors, and focus on priority populations. Because the pilot will include a variety of HV program models supported by different funders, the CIAT will need to be updated accordingly. This can be achieved by convening workgroups of providers who are currently implementing the CIAT as well as other HV programs and representatives from MFHV.

Universal Decision Tree Template for Referrals

MIECHV CI workers use community-specific decision trees to guide HV eligibility determination and identify which programs may be a good fit for each family. These sample templates will be discussed with stakeholders including the MFHV to incorporate information on any additional priority populations and requirements. This information will support the development of a universal decision tree template that can be customized, to help guide CI pilot sites in the distribution of referrals to local HV programs.

Hotline Exploration

State level administrators from several sectors, including child welfare and health care, have expressed interest in making systematic referrals to HV services, but Illinois currently lacks a statewide mechanism to meet these needs. In the *2018 State of Illinois’ Maternal Mortality and Morbidity Report*, IDPH identified the need for coordinated referrals to HV services in addressing maternal mortality. The *2019 Proposal for HV Expansion in Illinois Child Welfare* by Illinois DCFS also describes the need to create an internal structure for managing HV referrals, due to the complexity of the mixed delivery HV system.

As the pilot is initiated and scaled up, large areas of the state will remain without CI coverage. A hotline is one possible mechanism to provide an efficient entry point to HV programs in those areas, while the CI system is still being scaled up. Currently, Indiana and Philadelphia are exploring this approach. In Indiana, the State Department of Health Maternal and Child Health Division is launching their MOMS Helpline in November 2019 and scaling throughout 2020 for statewide coverage. The helpline is developed through the health department's 2-1-1 database where CI workers or "OB Navigators" help families connect to local HV services. Philadelphia's model allows families to access information about HV services online and connect with a CI worker who uses a database system to match and refer families to available programs.

Feasibility research on the hotline model, including lessons learned from Indiana and Philadelphia, will be conducted during the first year of the CI pilot.

Strategic Partnerships

Several strategic partnerships will be fostered to ensure that the CI system will reach as many eligible families as possible during the pilot and expansion, and to link CI to comprehensive ECCE services.

Existing CI Communities

Current CI communities, whether MIECHV or non-MIECHV funded, will serve as key partners to the pilot regions. These communities have established history, experience, and knowledge in working with families, their respective communities, local HV programs, and early childhood providers in their catchment areas. The CI pilot regions and the future statewide CI system will not seek to duplicate or replace those efforts. Instead, they will rely on the CI communities' local expertise by directing families that reside in the catchment area to these existing local CI initiatives. Similarly, pre-existing CI communities will be asked to refer families who live outside their catchment area to the CI pilot sites.

Community Collaborations and Networks

For several CI communities, local community collaboratives have played a significant role in supporting or facilitating the implementation of CI. For example, in several MIECHV CI communities, the local AOK Network coordinator helped CI workers connect to HV programs and develop a local HV collaborative.

It will be important for the CI pilot and expansion sites to connect with these collaborations to ensure the sustainability of the CI system, increase awareness around HV services and CI, have greater reach, and ultimately become a linkage point to the broader early childhood system. The Community Systems Statewide Supports program maintains a listing of early childhood collaboratives in Illinois, and a listing of HV collaboratives which was developed through the CIHV Work Group. These resource lists will be used to support the CI pilot and expansion sites in connecting with community collaborations.

To view a map of HV and early childhood community collaborations in Illinois, see *Appendix H*.

WIC Program

In several MIECHV and non-MIECHV CI communities, the local WIC office has served as the strongest source of referrals. In some cases, CI workers have successfully leveraged this connection to increase CI buy-in and to mitigate the sense of competition between HV programs. During the development of the strategic plan, GOECD had an initial conversation with the WIC Director regarding the proposed CI pilot and scaling, as well as potential connection points with WIC. While WIC is not able to systematically participate in the year one pilot due to their upcoming data system replacement, follow-up conversations will be pursued to explore future linkages.

Early Childhood Systems

The following efforts should be linked to the CI pilot and expansion:

Early Intervention

In 2018, stakeholders conducted surveys with EI and HV providers to guide the development of policies and procedures to strengthen collaboration between the two systems. Recommendations from this undertaking were as follows: to increase pre-service training for providers on their respective systems; provide shared professional development opportunities; share eligibility criteria and service locations; and convene funders of the two systems to review and improve referral procedures and forms as well as information sharing between the two systems.³⁶ These recommendations are now in the process of being fleshed out and implemented. A similar approach is recommended for the CI pilot sites, to gather information on their interaction with other ECCE systems and identify ways to facilitate collaboration and systems alignment.

Child Welfare

As a part of the initial PDG B-5 grant, the Erikson/DCFS Early Childhood Project focuses on connecting at least child welfare-involved families to evidence-based HV services. This work is implemented by a full-time HV specialist who is coordinating services involving child welfare case managers, Erikson DCFS Early Childhood Development Specialists, and Infant Mental Health Consultants. Meanwhile, DCFS has also submitted a *Proposal for Home Visiting Expansion* for Family First funds to connect Intact Families (prenatal through 6 months) to evidence-based HV. As mentioned earlier, the proposal outlines the need for a referral mechanism in the HV system for DCFS to make referrals to HV services, which further highlights the need for a statewide CI system for HV.

³⁶ Department of Human Services and the Governor's Office of Early Childhood Development. 2018. Survey of Child and Family Connections Managers, Service Coordinators and LIC Coordinators; Home visitor Survey Results; and Early Intervention (EI) Provider Survey Results.

Healthcare Providers

Healthcare providers are key partners for CI in reaching families during pregnancy, to identify those who are interested in receiving HV support. Below are several examples of current efforts in place that can be replicated and/or furthered through the CI pilot and expansion.

- **OB/GYN Offices:** In Elgin, the MIECHV CI site focused on outreach with local OB/GYN offices as a part of their CQI plan. Efforts consisted of educating physicians on HV services and referrals, as well as providing them with prenatal toolkits to help them engage with patients. The CI staff also developed a patient referral form tailored specifically for health care providers.
- **ACEs-HV Initiative:** Rush University Medical Center in Chicago (“Rush”) has partnered with MIECHV CI to connect patients to HV services. For mothers with a cumulative Adverse Childhood Experiences (ACES) score of 3 or higher and for all teen mothers, the Rush CI worker connects patients to local HV programs in the communities that Rush serves, mainly on the west side of Chicago. This collaborative work is part of Rush’s larger Community Health Implementation Plan.
- **Family Connects:** MIECHV has piloted Family Connects (FC), a universal newborn screening and referral model, as a strategy to engage high-risk families with newborns in Peoria and Stephenson County. In both communities, FC nurses refer families to HV services through the local MIECHV CI coordinators.³⁷
- **ConnecTeen:** In Lurie’s Children’s Hospital of Chicago, ConnecTeen connects pregnant and parenting youth in Chicago to local HV services. The program allows for a single point of entry for the youth to access support from health, social service, and child development professionals.
- **Medicaid Coverage:** For families that receive Medicaid coverage, CI staff will connect with the family’s MCO Care Coordinator, who will ensure that the family’s health and behavioral health needs are also covered. Currently, one MCO has launched a pilot with MIECHV HV programs in DeKalb and East St. Louis for data sharing and coordination of services for families who are enrolled in HV as well as the MCO.

³⁷ Maternal Infant Early Childhood Home Visiting and Illinois Governor’s Office of Early Childhood Development. August 2019. Family Recruitment for Home Visiting – Lessons Learned from the Family Connects Illinois Pilot.

Equity Considerations for the Coordinated Intake System

As previously described, the proposed statewide CI system is a part of the ELC's broader vision of a strong and robust ECCE system in Illinois that equitably serves all children and families throughout the state regardless of race, ethnicity, income, language, geography, ability, immigration status, or other circumstances. As one of the first touchpoints that prenatal to five families may come in contact with, the CI system must be prepared to provide services equitably. To meet and serve families that are historically underrepresented and underserved, the following are additional recommendations to implement in the statewide CI system.

Support Immigrant Families

CI can be leveraged to bridge the gap between HV services and immigrant families who stand to greatly benefit from the services. In Illinois, 1 in 4 parents of children under the age of 5 are immigrants, meaning that a significant portion of Illinois' early childhood population come from multilingual and multicultural households.³⁸ This diversity is an invaluable resource as research demonstrates that multilingualism has cognitive and socioemotional developmental benefits for young children.³⁹

At the same time, immigrant families face more systemic barriers than their U.S.-born family counterparts in the healthy development of their children. For example, they are more likely to:

- come from low-income households
- have parents with low-levels of education attainment, which is strongly correlated with children's future educational outcomes
- have parents who have limited English proficiency or live in a linguistically isolated household, which acts as a barrier to accessing services: children of dual language learners and/or immigrants are less likely to be enrolled in pre-K services
- be exposed to stressors and trauma related to their immigration experiences, including post-settlement experiences, racism, discrimination, and economic stressors, all of which can greatly impact the parent-child relationship and child development⁴⁰

CI can help to overcome these barriers and increase access to services for immigrant families. As mentioned in the "Roles and Responsibilities of a CI Worker" section above, CI workers are deeply embedded and connected to early childhood and child/family serving programs in the community. They can provide families with referrals to systems of support specific to their immigrant experiences.

In addition, Illinois is home to one of the largest undocumented communities in the U.S. Cook County is the third largest county with undocumented residents, while Illinois is the fifth largest state.⁴¹ Families who are undocumented and/or mixed-status, may be reluctant to share personal and contact

³⁸ Erikson Institute, Illinois Early Childhood Asset Map (IECAM) of University of Illinois at Urbana-Champaign.

³⁹ National Academies of Sciences, Engineering, and Medicine. 2017. Promoting the Educational Success of Children and Youth Learning English: Promising Futures. Washington, DC: The National Academies Press. <https://doi.org/10.17226/24677>.

⁴⁰ Park, M., & Katsiaficas, C.

⁴¹ Gelatt, J. & Zong, J. (November, 2018). Settling In: A Profile of the Unauthorized Immigrant Population in the United States. Retrieved from:

https://www.migrationpolicy.org/sites/default/files/publications/UnauthorizedData-FactSheet_FinalWeb.pdf

information with a CI worker. Further, HV services may be new to families, as similar programs may not exist in their country of origin. A best practice for CI workers in working with undocumented families is to focus on empowering the family's decision making throughout the intake process. This means meeting families where they are at, both figuratively and literally. As recommended under "Challenges to Coordinated Intake," CI workers can partner with trusted local CBOs that families frequent, thereby meeting families where they feel safe rather than outside of trusted networks. Also, the recommendation for a streamlined referral process will be even more important to implement, as it decreases the risk of re-traumatization as well as potential deterrence from services.

To summarize, home visitors and CI workers can do the following to overcome barriers faced by immigrant families:

- partner with trusted local CBOs that families frequent, thereby meeting families where they feel safe
- encourage parents to foster their children's home language development and multilingualism
- provide families with information on additional social support and resources, such as linguistically and culturally responsive programs or those specialized in addressing trauma and stressors related to their immigration experience
- respect privacy boundaries of undocumented and mixed-status families and use available information to match the family with services; HV providers can resume gathering needed information throughout the development of their relationship with the families

Collect Data on Race and Ethnicity

While racial equity is a priority of the Illinois ELC, early childhood data on race and ethnicity are not always collected consistently. For example, at the November 2019 Illinois Prenatal to Three Initiative (PN3) Coalition meeting, representatives from the Erikson Institute commented on the consolidation of Asian American, Alaska Native, Native Hawaiian, Pacific Islander, and multiracial groups into a monolithic "Other, Non-Hispanic" racial category in the *Illinois Risk and Reach Report of Spring 2019*. Together, these groups compose a significant portion of early childhood families in Illinois, and the Erikson Institute noted their intention to disaggregate the data in the next issue of the report.

Janeen Comenote, the Executive Director of the National Urban Indian Family Coalition, illuminated the significance of the paucity of data on Indigenous communities. She noted that the "biggest single issue that American Indians have is *invisibility*" in understanding how and to what degree indigenous children are served by HV.⁴² Along the same lines, there is also a lack of data on Asian Americans despite the fact that they are the fastest growing racial group in Illinois and compose a significant portion of the undocumented community.⁴³

In addition, there are vast differences in needs and access to services along ethnic lines, even within a racial group. For example, in 2015 in the Asian American population, only 2.38% of the Thai community

received benefits from the Supplemental Nutrition Assistance Program while 67.30% of the Bhutanese community received benefits. This large disparity demonstrates the importance of disaggregated data and information on ethnicities of children and families served.⁴⁴

Currently, the lack of comprehensive data on the racial and ethnic demographics of families served by CI communities creates difficulty in determining the equitable impact of CI. It is unknown what the reach of CI is in families and communities of color in Illinois. Baseline figures do not exist to assess the function, development, and improvement of CI, as well as identifying CQI targets for serving underrepresented communities. It also creates barriers to identifying the on-the-ground needs of families from diverse racial and ethnic groups across communities, information that is essential for developing an equitable system.

For the CI pilot and expansion, the intake forms will include fields to collect the following demographic information:

- Race
- Ethnicity
- Primary and secondary language
- Level of English proficiency
- Country of origin (as aforementioned in the equity considerations for serving immigrant families)

Including the aforementioned data in the CIAT for the CI pilots will establish a statewide baseline data on CI reach and impact on underrepresented communities, provide a model for CI communities in data collection protocols, strengthen ECCE programming by identifying communities that are served as well as their needs and experiences, and help advance Illinois' ECCE system in its racial equity efforts. This information can be used to highlight the priority needs of immigrant families in Illinois to stakeholder groups such as the All Families Served Subcommittee of the ELC Access Committee.

Hire Coordinated Intake Staff from Local Communities

The Migration Policy Institute recommends hiring of diverse staff and providing professional development on cultural responsiveness and importance of multicultural language development as a strategy in overcoming barriers to equitably serve immigrant and multilingual families.⁴⁵ Similarly, the Home Visiting Work Group of the Illinois PN3 Coalition identified increasing the availability of linguistically and culturally responsive programming to serve dual language learner families as a strategy

⁴⁴ In-person interview

⁴⁴ Interview with Janeen Comenote;

Asian American Center for Advancing Justice; and

American Immigration Council. (2017). Immigrants in Illinois. Retrieved from:

<https://www.americanimmigrationcouncil.org/research/immigrants-in-illinois>

⁴⁴ Urban Institute. (June 2018). Asian Americans are falling through the cracks in data representation and social services. Retrieved from: <https://www.urban.org/urban-wire/asian-americans-are-falling-through-cracks-data-representation-and-social-services>

⁴⁵ Park, M., & Katsiaficas, C.

to increase the number of families who enroll and are retained in HV services. The Work Group also recommended increased cultural sensitivity and diversity of the HV workforce as a strategy to increase quality and equity in service delivery.

The CI system should adopt these strategies to ensure that CI is able to equitably reach and serve families from all backgrounds. Hiring diverse CI staff who come from the communities that they serve, represent the communities that they serve, and/or are culturally and linguistically responsive to families in the area can advance equitable services as well as increase the recruitment of underserved families into HV programs. Having a match in linguistic, cultural, and racial background can increase family trust and willingness to participate.

Use a Trauma-Informed Approach

As trauma is common in ECCE priority populations, CI staff should be trained to take a trauma-informed approach when working with families. This will help to do the following: 1) bolster the resilience and strength of families in seeking services; 2) avoid re-traumatization of children and families; and 3) mitigate resistance and stigmatization of services in a context where significant barriers already exist.

Utilizing the Substance Abuse and Mental Health Services Administration principles of trauma-informed approaches, below are recommendations for CI⁴⁶:

- Safety – CI workers should establish a sense of physical and socioemotional safety for the children and families that they are working with during the intake process. For example, CI workers should meet families at a location of their designation.
- Empowerment, Voice, and Choice – CI workers should seek to empower families in shared decision-making and choice in selecting a HV program to enroll in. A best practice would be to provide families with all options of HV programs for which they are eligible.
- Cultural, Historical, and Gender Issues and Trauma – CI workers should have an awareness of and are continuously learning about the different cultural, historical, gendered, racial, ethnic, immigrant, and geographic experiences and trauma of the communities that they are working in. For example, CI workers should seek local peer-led professional development learning communities on trauma-informed approaches.

In addition to these recommendations, a streamlined referral process is also part of a trauma-informed approach. Intake processes may involve sensitive topics such as mental health concerns, family violence, and substance use. Undocumented or mixed-status families are often unwilling to provide contact information in the absence of previously established trust. These factors can make the intake process intrusive and interrogative as well as trigger re-traumatization. A streamlined referral process would minimize the number of times that families are required to give sensitive information to multiple providers.

⁴⁶ SAMHSA's Trauma and Justice Strategic Initiative. July, 2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. Retrieved from: <https://store.samhsa.gov/system/files/sma14-4884.pdf>

Maximize Family Choice

As mentioned previously, maximizing family choice is integral to the empowerment and wellbeing of families as well as successfully engaging families in HV programs. For example, the Chapin Hall evaluation study of the “Home Visiting for Pregnant and Parenting Youth in Care” pilot found that a major factor influencing young people’s decision to engage in HV services was having a choice to enroll. Indeed, a core characteristic of HV services is that they are voluntary. This distinguishes them from many of the services that youth in foster care receive. Most of the parent participants appreciated being able to choose whether or not to participate in the program, and that this decision was not made on their behalf by a caseworker or judge.⁴⁷

Underrepresented and underserved families who experience systemic forms of oppression and/or trauma “historically have been diminished in voice and choice and are often recipients of coercive treatment.”⁴⁸ By providing families with options to choose from and giving them the ability to make a choice, CI workers can bolster recruitment of families to HV as well as sustain their engagement in the programs.

Conclusion

Illinois boasts one of the most diverse populations in the U.S., with children and families from across different racial, cultural, socioeconomic, and immigrant backgrounds in rural, suburban, and urban communities. At same time, these children and families also face a diverse array of systemic challenges and barriers in accessing support and resources to thrive in society. The focus of the CI strategic plan is to increase and streamline equitable access to quality early childhood services and resources that are the best fit for each individual family. Through the CI pilot, Illinois will test a regional system for connecting families to HV and other services. The plan seeks to empower and strengthen Illinois’ families during the early years of child development, so that they may establish a strong foundation for a promising future and continue to enrich the state of Illinois.

⁴⁷ Dworsky, A., Gitlow, E., & Ethier, K. (2019). Home visiting for pregnant and parenting youth in care: Final report. Chicago: Chapin Hall at the University of Chicago.

⁴⁸ SAMHSA’s Trauma and Justice Strategic Initiative.

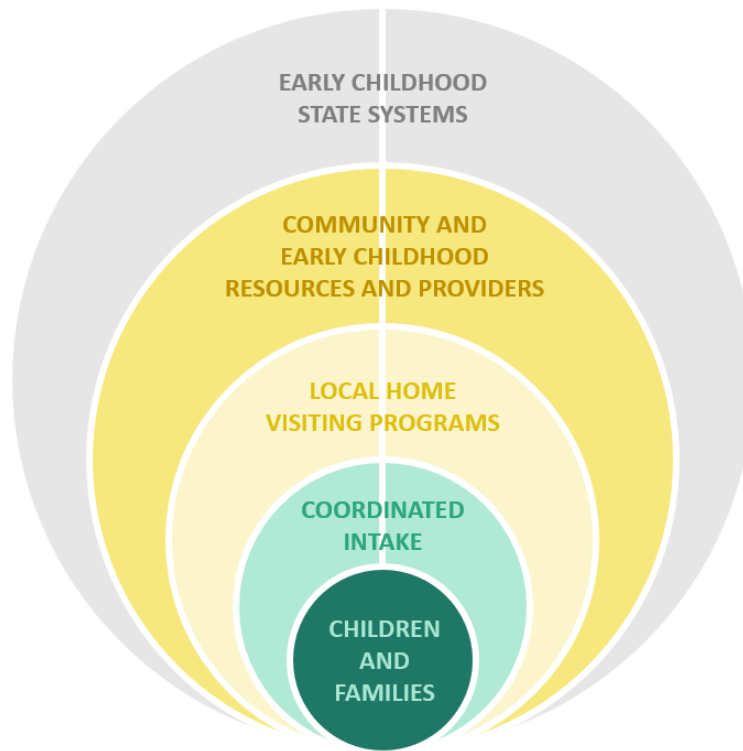
Appendix A

Acknowledgments Continued

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Delreen Schmidt-Lenz	Karen Rios	Misty Krippel	
Diana Careaga	Karen Berman	Nakisha Hobbs	
		Niah Hamilton	

Appendix B

BENEFITS OF COORDINATED INTAKE



CHILDREN AND FAMILIES

- Single point of entry to early childhood services
- Burden removed of navigating complex array of services
- Increased awareness of available early childhood resources and services in community
- More efficiently and effective enrollment in services as well as increased options for services

LOCAL HOME VISITING PROGRAMS

- More home visiting partnerships resulting in improved programming
- Reduced burden to conduct outreach and recruit participants
- Decreased competition and facilitates collaboration between home visiting programs
- Increased enrollment of families into programs of best fit, leading to higher retention rates of participants
- Improved identification of interests, strengths, and needs of families
- Uniformity across programs in intake, screening, and referral process

COMMUNITY AND EARLY CHILDHOOD RESOURCES AND PROVIDERS

- Reduced costs and duplication of efforts through systematic coordination

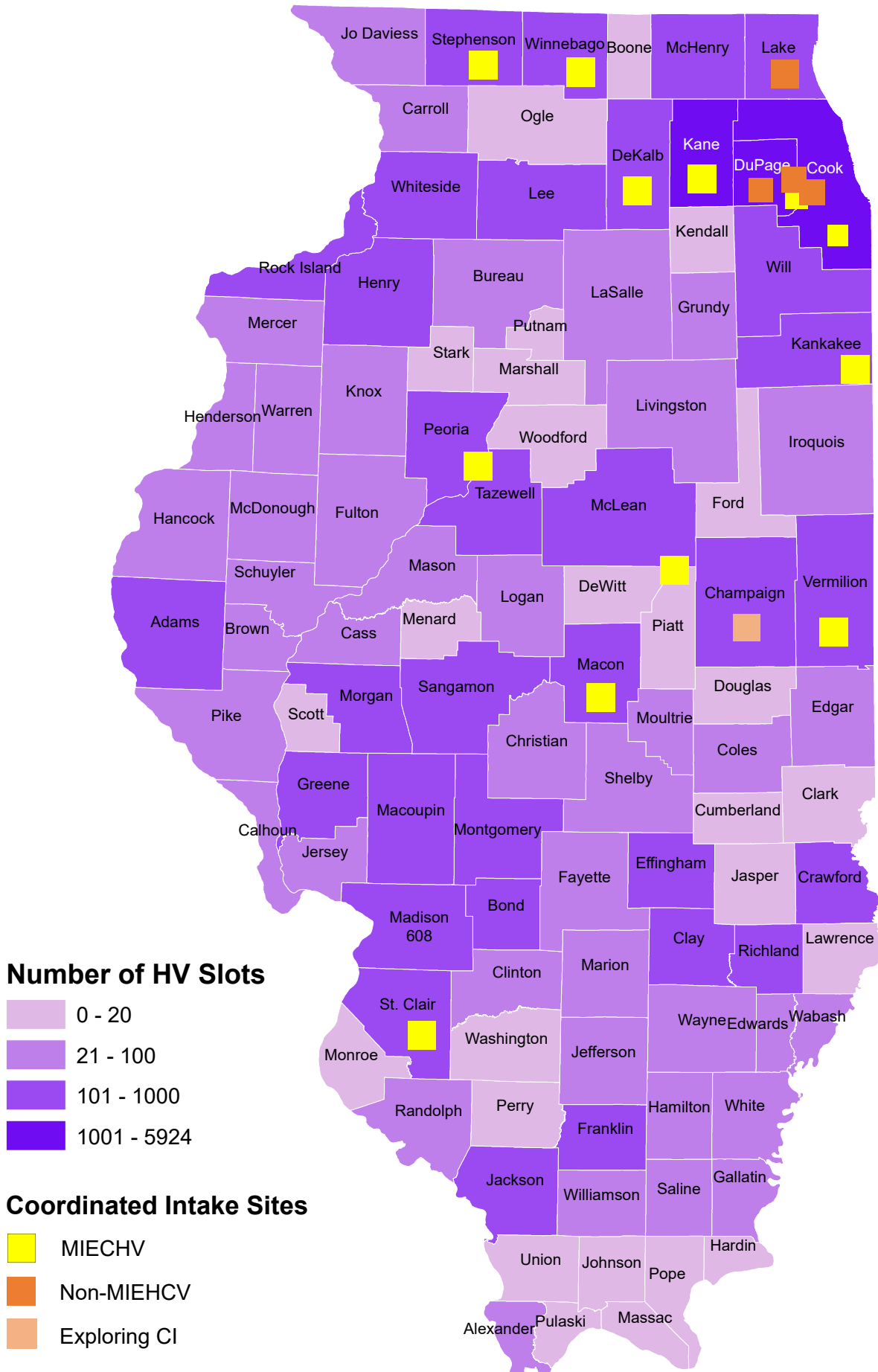
EARLY CHILDHOOD STATE SYSTEMS

- Increased awareness of strengths and needs families in Illinois
- Identification of gaps in services, areas in need or oversaturated with services, and collaborations in home visiting and early childhood provider communities to further strengthen and leverage
- Continuum of care for families prenatal to age five by connecting home visiting to broader early childhood systems

Graph includes information from "Coordinated Intake in Illinois: Policy Recommendations for the Current System" and "Issue Brief on Coordinated Intake: An Overview and Illinois' Experience Within the Early Childhood Home Visiting System, September 2018"

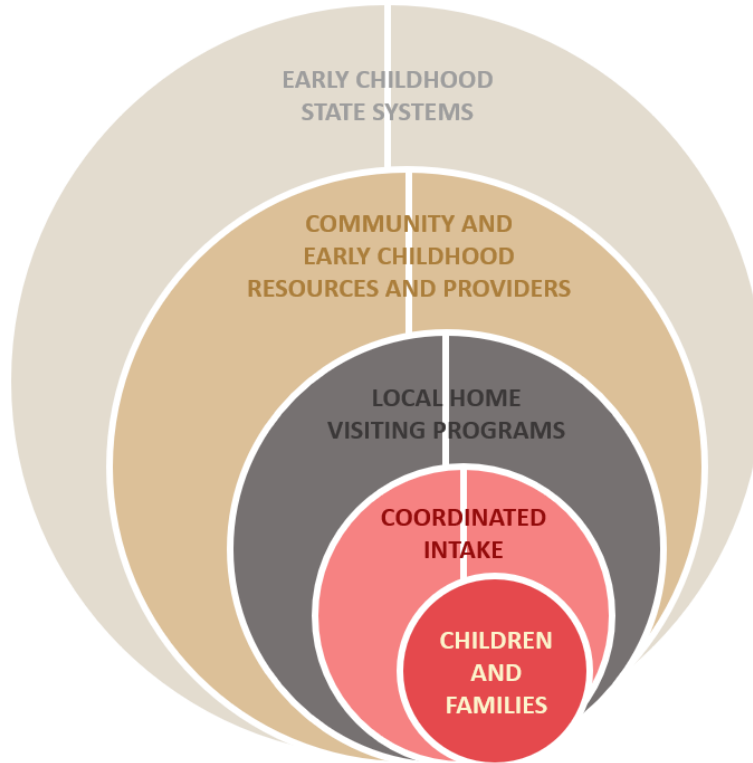
Appendix C

Illinois Coordinated Intake Communities 2019



Appendix D

CHALLENGES TO COORDINATED INTAKE



CHILDREN AND FAMILIES

- Minimal or no awareness of home visiting services or coordinated intake
- Stigmatized ideas around home visiting
- Lack of culturally and linguistically responsive services and providers for families
- Sensitive nature of questions in intake process
- Multiple contact with service providers and coordinated intake staff throughout recruitment to enrollment process

COORDINATED INTAKE

- Understaffed coordinated intake sites
- Recruitment and retention of coordinated intake staff
- Disconnected data system and data collection process

LOCAL HOME VISITING PROGRAMS

- Voluntary nature of local referrals and competition amongst programs within communities
- Sense of competition between different providers, leading to weak buy-in into coordinated intake

COMMUNITY AND EARLY CHILDHOOD RESOURCES AND PROVIDERS

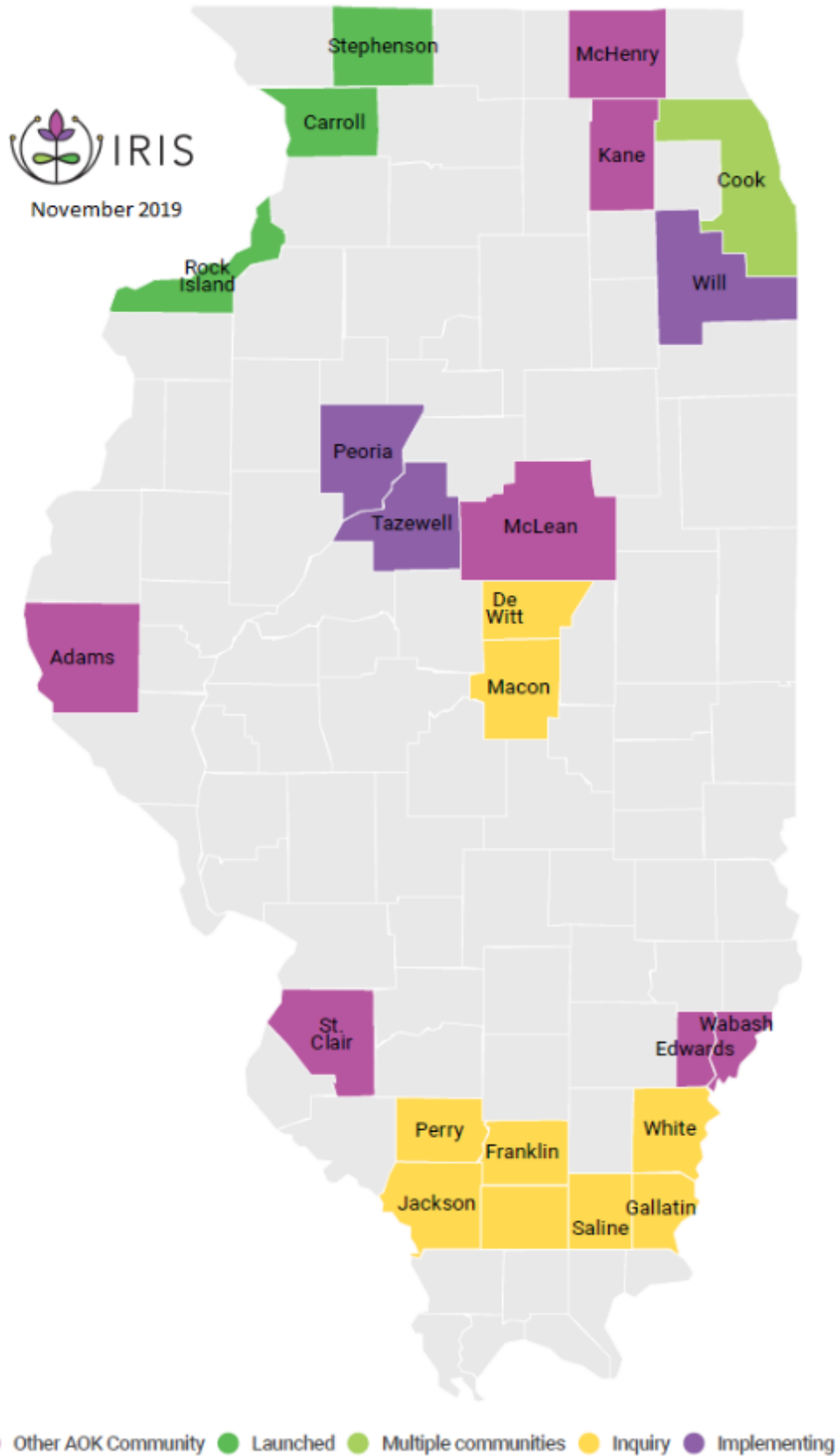
- Lack of awareness and understanding of home visiting programs and coordinated intake

EARLY CHILDHOOD STATE SYSTEMS

- Two-year Illinois budget impasse
- MIECHV CSD position no longer funded
- Need for sustainable funding for a statewide CI system

Graph includes information from “Coordinated Intake in Illinois: Policy Recommendations for the Current System” and “Issue Brief on Coordinated Intake: An Overview and Illinois’ Experience Within the Early Childhood Home Visiting System, September 2018”

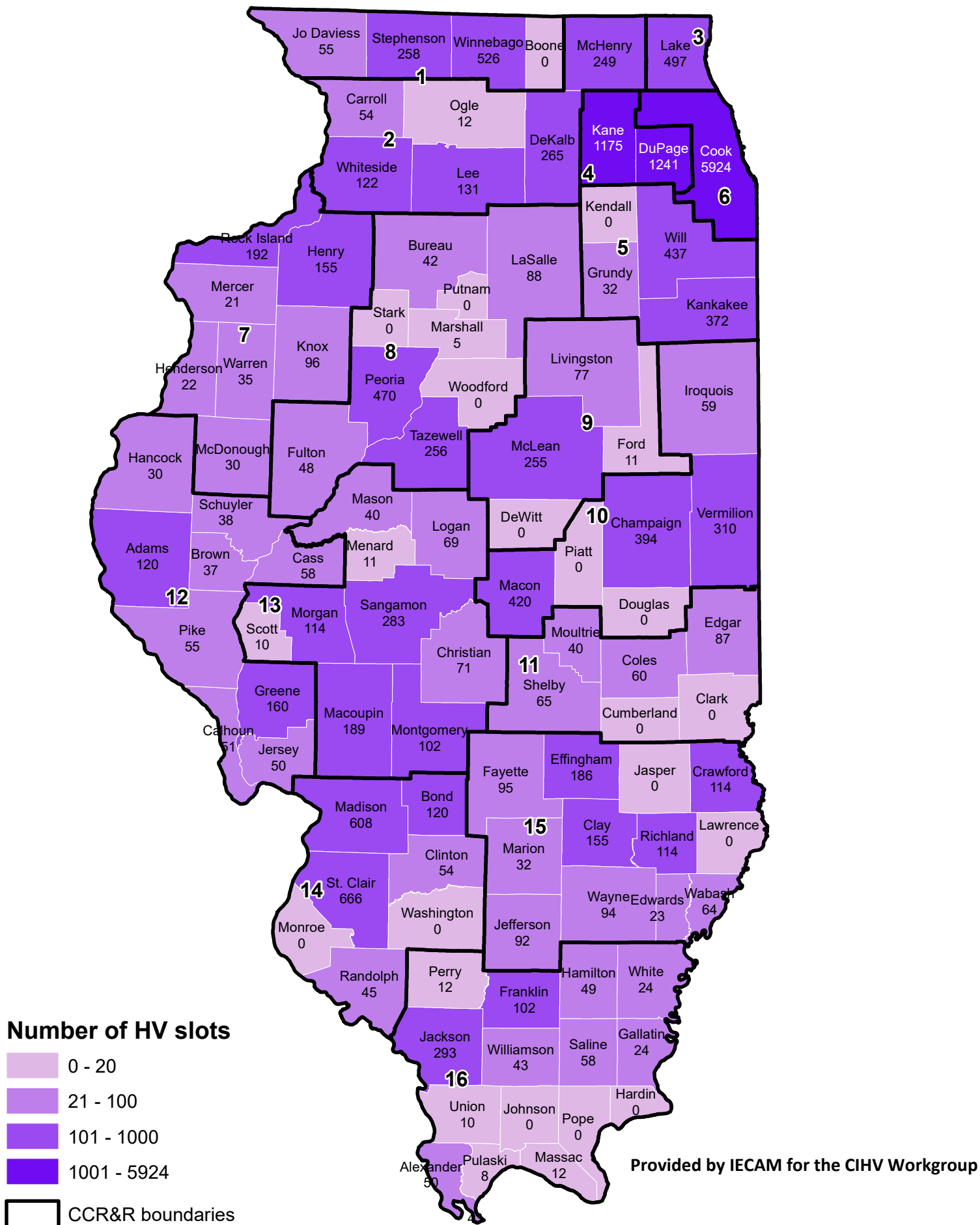
Appendix E



Provided by the Center for Public Partnerships and Research at the University of Kansas

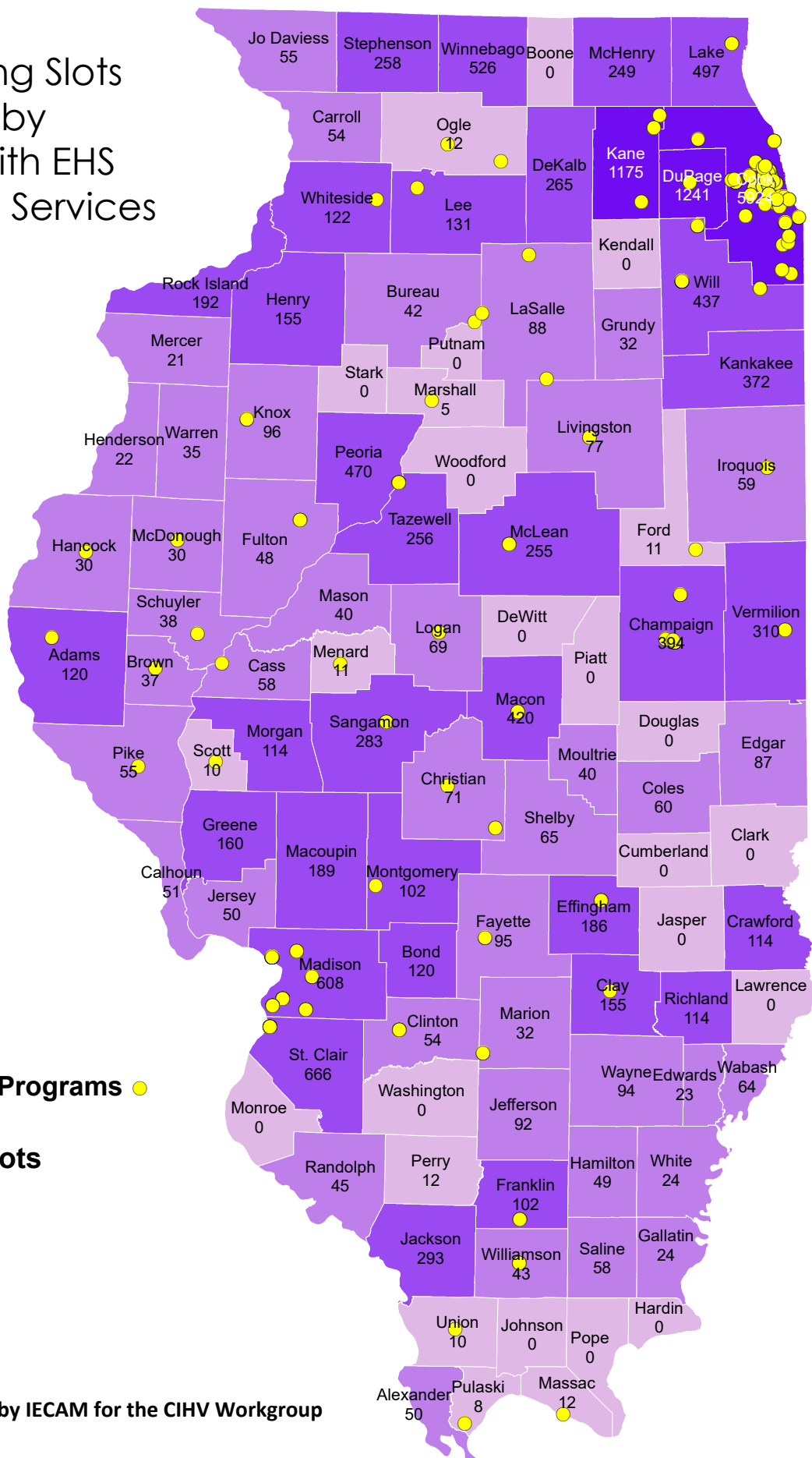
Appendix F

Home Visiting Slots FY2019 by CCR&R Boundaries



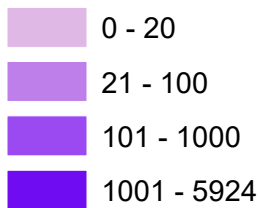
Appendix G

Home Visiting Slots FY2019 by Counties with EHS Home Visiting Services



Location of E/HS Programs ●

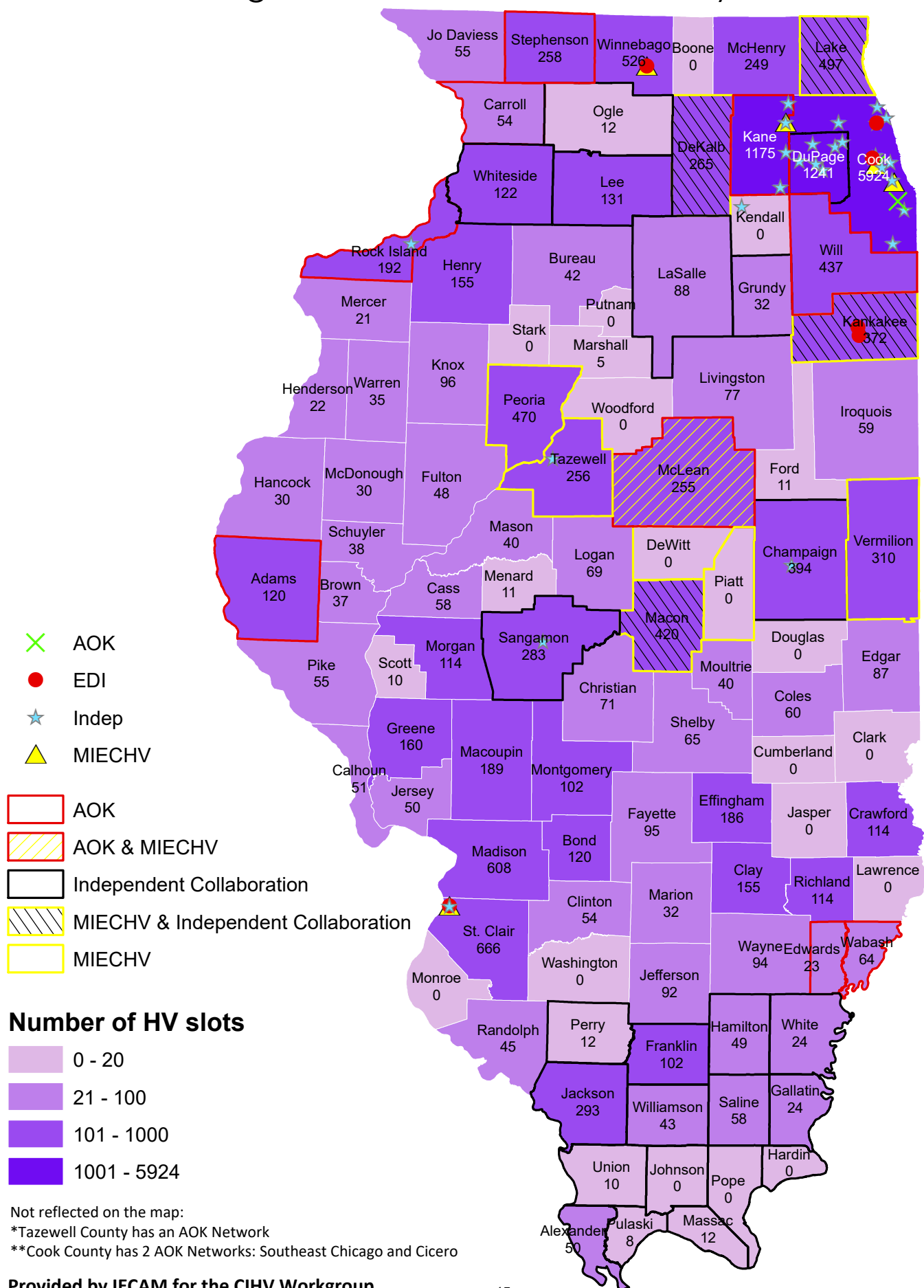
Number of HV slots



Provided by IECAM for the CIHV Workgroup

Appendix H

Home Visiting Slots FY2019 with Community Collaborations



Appendix I



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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This Issue Brief would not have been possible without the lived experiences of the individuals and organizations that make up the coordinated intake agencies and communities working in Illinois to improve outcomes for Illinois children. We thank them for their dedication and for their ongoing contributions to building our state's home visiting system.

The authors gratefully acknowledge the following individuals and organizations for contributing their considerable time and expertise throughout the development of this Issue Brief:

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- Stacey McKeever, Illinois Governor's Office of Early Childhood Development
- Peter Mulhall, Center for Prevention Research and Development, School of Social Work, University of Illinois
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respectively, for the Maternal, Infant, and Early Childhood Home Visiting Program, and 0% financed with nongovernmental sources. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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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

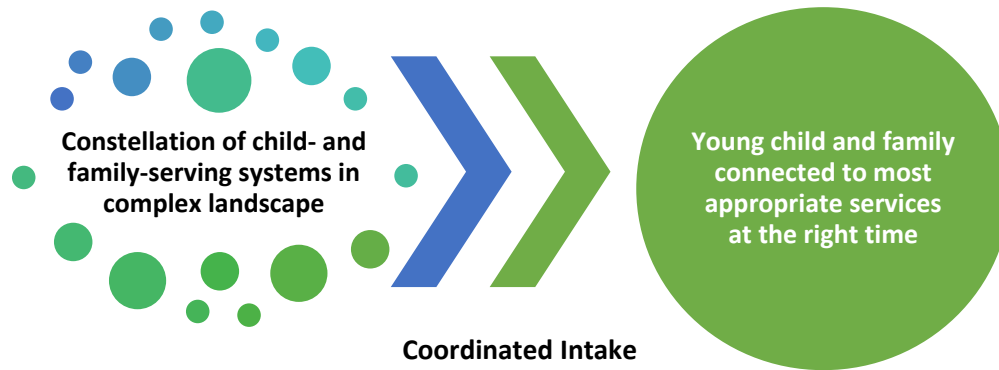


Figure 1. Coordinated intake can be a conduit to help streamline a complex array of local services for a young child.

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.

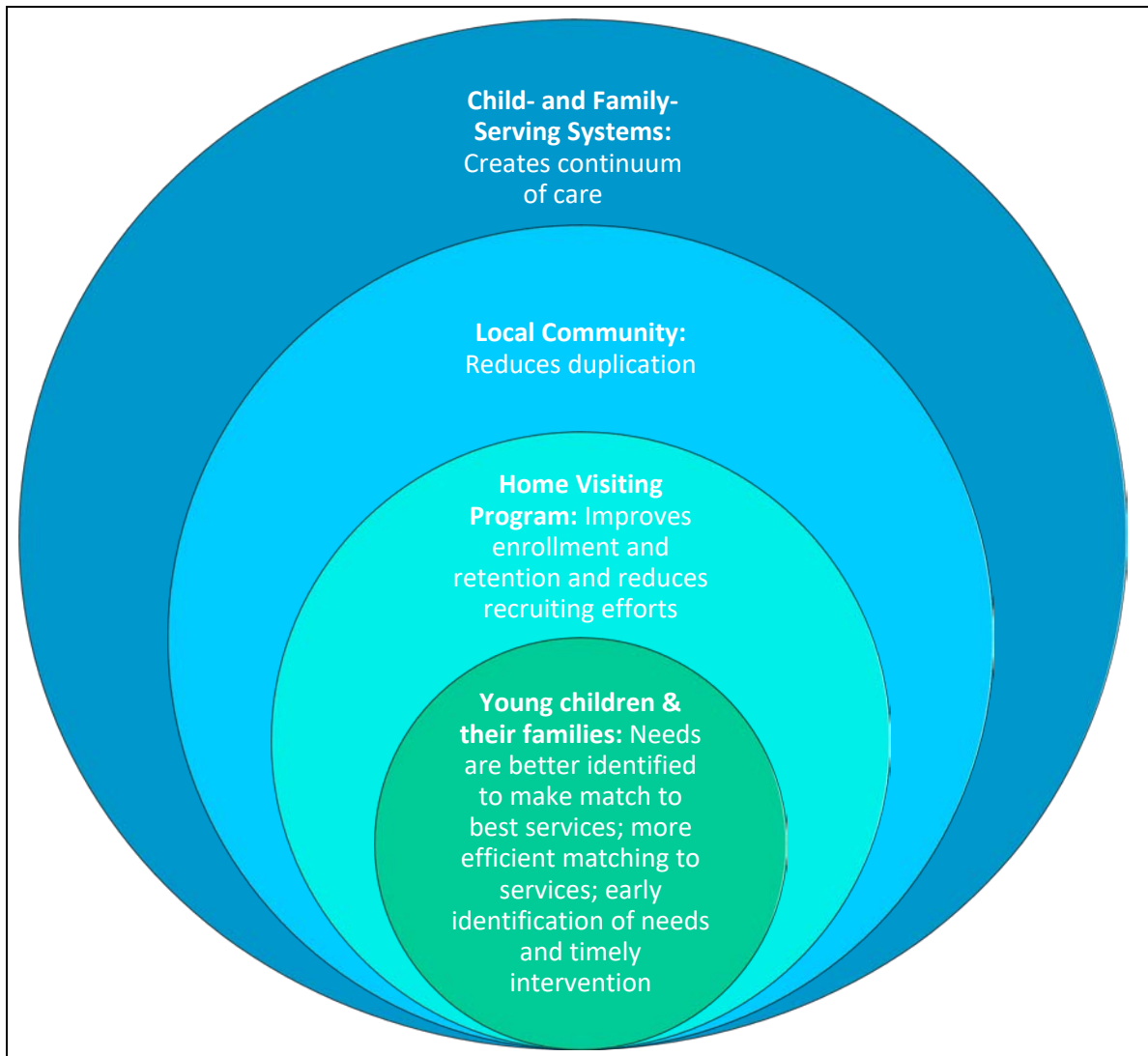


Figure 2. Coordinated intake can provide benefits at multiple levels.

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.dcactionforchildren.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.

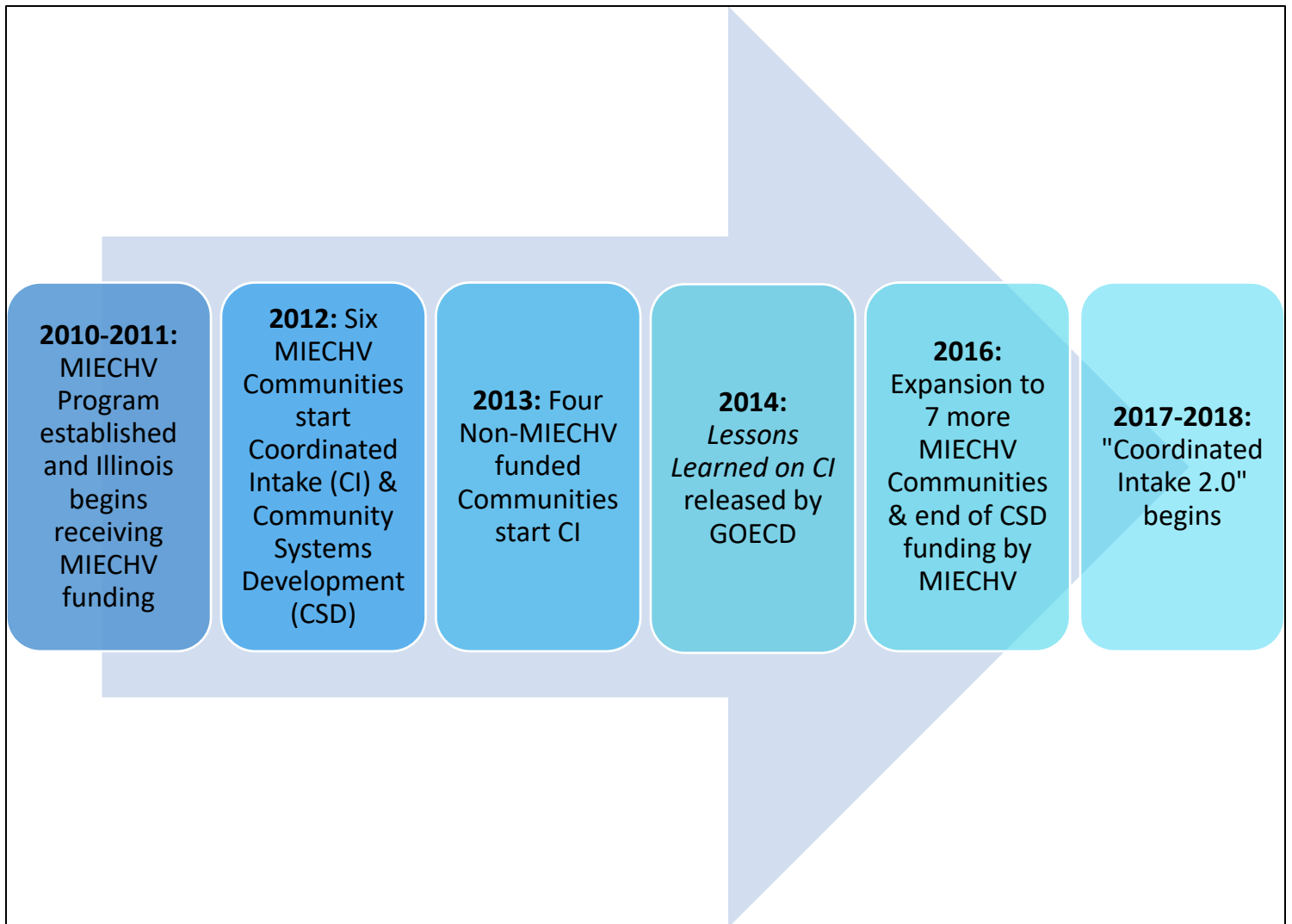


Figure 4: A brief history, to date, of launching coordinated intake for home visiting in Illinois.

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%2023April2018.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

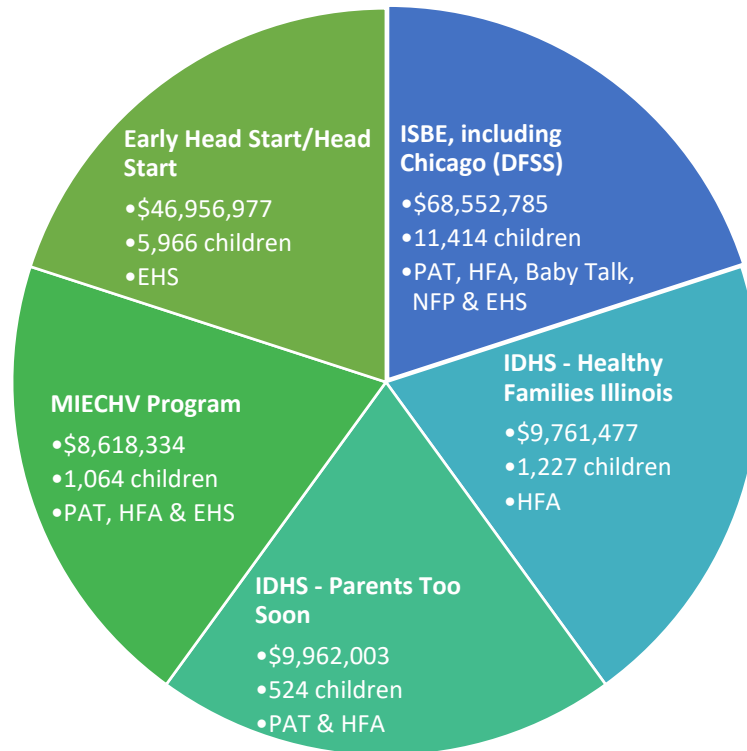
Illinois has invested robustly in the home visiting system for the last 30 years and looks to expand such investments into the future. For example, the home visiting system is exploring a variety of options and opportunities, including a potential state plan amendment which would enable home visiting 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.

Rev. 11/15/17

Appendix J

Coordinated Intake in Illinois: Policy Recommendations for the Current System

Background

This report and its recommendations are grounded in the experiences of the Family Recruitment Specialist (FRS) of the State's Maternal Infant Early Childhood Home Visiting (MIECHV) team, who has been providing technical assistance to Coordinated Intake (CI) communities across Illinois since May of 2018. Working at the community level has enabled FRS to gain foundational knowledge of the CI system, understand the common challenges faced by communities, elevate best practices across communities and identify policy level barriers impeding a strong system. The FRS position is housed at the Ounce of Prevention's Illinois policy team.

The report will begin by reviewing the purpose of CI and the major elements of a strong CI system. The next section will present a high level overview of CI in Illinois, focusing on the common problems faced in most areas. The final section will introduce and explore the recommendations for bolstering CI, with each of the recommendations addressing a major challenge.

The purpose of CI

CI is a collaborative process that facilitates enrollment into home visiting programs within a community. Trained CI workers monitor home visiting program capacity, facilitate enrollment and support family recruitment.

When CI is working well, the CI worker and home visiting partners in the community engage with families, especially those who would most benefit, to facilitate enrollment in a program best meeting their needs. While communities create unique models tailored to their locality, the structures supporting a robust system are the same. In order to achieve a strong CI framework the CIs must:

- 1) Be connected and embedded in early childhood/social service system of their community;
- 2) Have knowledge of home visiting and social service landscape for their community and ways of accessing them;
- 3) Maintain strong connections with the community and use various outreach strategies to inform families about home visiting;
- 4) Lead a strong home visiting collaborative that has an agreed-upon vision with policies and procedures that contribute to that vision;
- 5) Use data to support functioning of CI and home visiting system and to inform outreach strategies; and
- 6) Receive continued support through reflective supervision and access to ongoing professional development opportunities.¹

¹ This is based off of the CI Elements of Quality Framework which can be referenced in Appendix A.



The current state

As of July 2019, CI exists in 12 communities through MIECHV funding² and in 5 areas through other sources. As you can see from the map to the left, CI is situated in a diverse range of locations that vary in population density and demographics.

CI workers are housed out of community based organizations or health departments. In some situations, the CI works out of an agency that also runs its own home visiting programming and participates in the CI collaborative. The work of a CI is largely completed by one full-time employee, although there are situations where the job is shared among two full-time staff.

CIs fulfill many roles: they are the conveners of their local home visiting collaborative; monitor home visiting program capacity for their community area; oversee outreach efforts to recruit families; initiate and maintain partnerships for referral sources; complete screens for families referred to home visiting; track and analyze recruitment and enrollment data to inform outreach; and maintain awareness of community resources for referrals to services in addition to home visiting.

Home visiting programs are the other major player in the CI system and are responsible for participating in monthly collaborative meetings; supporting family recruitment; and sharing information on families—both those that the program individually recruited and enrolled and those referred from CI.

The data system used by CIs and their home visiting program partners varies by community, with some locations using a combination of communication platforms to share and track home visiting referrals and enrollment. MIECHV-funded CIs and home visiting programs are required to use Visit Tracker, which tracks enrollment and also records MIECHV-benchmark data. Non-MIECHV funded

²The major findings of this report are based off of experiences in the 12 MIECHV communities only. Localities operating CI using other funding are relatively new players.

home visiting programs do not have access to Visit Tracker and in areas where CI works with these programs, something that occurs across all CI MIECHV communities, there is no automated, streamlined method of sharing referral information. In these situations, CIs and home visiting programs relay enrollment status through fax, e-mail or phone.

Families enter the CI system through three major channels: from the CI through individual recruitment efforts; from partner home visiting programs; and from community referral sources. The origin of a referral determines the CIs workflow, with each community using their own established method. At a high level, referrals recruited by the CI are screened by the CI and passed to the most appropriate programs. The same approach is used for referrals from partner organizations, like Early Intervention (EI), child care providers and medical providers. Referrals from home visiting partner programs are more complex and can be sent to CI as “keepers,” families that the program would like to enroll, or “non-keepers,” families that the program cannot enroll. In a keeper scenario, the CI verifies the family is not already receiving services from another agency and then adds the family to their records for tracking purposes. For non-keepers, the CI completes the same agreed-upon process for referrals from CI and from partner organizations.³

CI communities have also established varied feedback loop processes once the family has been referred to home visiting. In addition to using an array of platforms (Visit Tracker, e-mail) the agreed-upon time frame for programs to respond and relay family enrollment status varies.

Common challenges

Although CIs operate in distinct communities with their own unique systems, programs experience a common set of challenges, which may include: weak partner buy-in; difficulties with engaging and enrolling families; overburdened CI staff; and a disconnected data system.

Weak partner buy-in

Home visiting programs in CI communities have largely not committed to full-fledged participation in the system. Partner buy-in is vital for CI to work in a community and without commitment from all local programs, the system falls apart. One major symptom of a weak collaboration is inconsistent attendance at monthly collaborative meetings. When partner programs do not regularly participate, bringing the most appropriate decision makers to the table on a consistent basis, the collaborative can't discuss strategies for improving recruitment and enrollment practices and move those decision points together as a group. Without active participation from all members, the group becomes stagnant.

Weak partner buy-in negatively impacts communication between CI and home visiting programs in day-to-day work as well. Partner programs may neglect to share information on caseload capacity and families they recruit and enroll into their programs—both families that are referred by CI and

³ Visual representations of these referral workflows can be seen in Appendix B.

families that programs individually recruit on their own. As a result, the CI lacks knowledge of home visiting program capacity for their community area—a foundational responsibility for their work. One very real consequence for this is evident when families are dually, sometimes triply, enrolled in multiple programs participating in the same collaborative.

Difficulty engaging and enrolling families

Successfully engaging with families, many of whom have to overcome a host of barriers to simply enroll and continue to access services, is challenging and often takes an inordinate amount of a CI's and home visitor's time. Connecting with families referred to CI can take multiple outreach attempts that span over weeks or months, while recruiting families referred from CI can take just as long.

Not only is the system time-consuming but very often families are lost in the process altogether. Families drop off after each stage of the referral workflow. It is very common for families to get lost in the hand-off from CI to the home visiting program. The challenges of engaging families are evident in the uptake rate for home visiting, just 10-25% of families referred from CI are ultimately enrolled in a program.

Overburdened CI staff

The CIs current set of responsibilities was previously divided between two jobs— a CI worker who managed referral pathways and a Community Systems Development (CSD) worker, who cultivated community partnerships resulting in referrals to home visiting. When MIECHV started in 2010, funding supported both the CI and CSD positions, but beginning in 2016 the Federal Health Resources and Services Administration, which administers the MIECHV Program, instituted new infrastructure spending requirements that discontinued funding of the CSD position. Even though financial support for the position ended, the need to maintain a strong community presence persisted and those responsibilities were folded into the work of CI. It's very challenging to excel, let alone manage, a job that was meant to be shared between two people.

Additionally, each of these positions requires unique skill sets that may not be easily found in one person. While overseeing referrals, the traditional role of CIs, necessitates skills in attention to detail and being organized, the CSD's job of establishing community connections requires a completely different set of competencies, including community organizing, meeting facilitation and effective interpersonal communication.

Disconnected data system

Right now, home visiting programs are using different data systems based on the requirements of their model and/or funder, while some programs have no system at all. When CIs collaborate with programs operating with a different data system, sharing and receiving updates on referrals is more manual and time consuming. CIs must e-mail, call or fax their partners to pass along families and get updates on their enrollment.

Often times, despite multiple outreaches to the partner program, the CI is never able to get information on a family's enrollment. According to a recent analysis of 6 months of referral data across all MIECHV CI communities, of the 1,248 referrals sent to home visiting programs from CI, only 184 were confirmed enrolled. This 14% enrollment rate is largely the result of the CI never receiving communication from their partners on whether a family was enrolled.⁴

Without these data, CIs cannot have an accurate picture of caseload capacity for their home visiting partner programs and at the community level. On an individual family level, CIs cannot know whether families screened for home visiting, many of whom present with a variety of risk factors, are ultimately connected with a service that could greatly benefit them.

Recommendations

Just as CI communities experience a common set of challenges, the policy approaches for alleviating those concerns are the same. Each of the proposed recommendations addresses a corresponding barrier to successful a CI system.

- 1) The organization housing CI should be a neutral entity, not also participating in the collaborative as a home visiting service provider;
- 2) The referral pathway for families from recruitment to enrollment should be as streamlined as possible;
- 3) The current CI workload should be shared across two people with different, discrete responsibilities; and
- 4) CI and home visiting partner programs should all use one data system to communicate back and forth on the status of referrals.

With expertise on the CI system and knowledge of their community, CIs have developed innovative strategies for identifying families and supporting enrollment. They are passionate about serving their communities and connecting families to home visiting. Although they are committed to their work, there are policy-level barriers complicating these efforts. Enacting these policy changes will enable CIs to more effectively harness their passion for working in their communities.

Recommendation 1: Address weak partner buy-in by requiring the CI position be housed in a neutral organization.

The organization housing CI should not also participate in the collaborative as a home visiting program. When an organization houses both CI and a home visiting program, outside agencies participating in the collaborative view the CI's role as a conflict of interest— that the CI is working to fill caseloads for their internal home visiting program and not for the entire community. When the CI worker is perceived as prioritizing their own organization's caseloads, partner programs are more hesitant to fully participate in CI as a system.

⁴ Bryce Marable, Referral Analysis Spreadsheet Calls (2019). See Appendix C.

While the State, through its technical assistance and compliance arms, has encouraged and required CIs to take transparency measures by offering collaborative wide communication on the status of referrals both as a best practice and including it as a metric for site reviews, communities haven't uniformly adopted these practices. Requiring CI be implemented by a neutral party would completely eliminate the need to institute such transparency processes. The CI would not have to overcome perceptions of favoritism. Trust is the cornerstone of a strong collaborative—a building block that leaders are continually supporting. Operating CI out of a neutral organization would position the worker to be more successful at going about the process of building and maintaining trust.

Recommendation 2: Support successful enrollment and engagement through a streamlined referral system.

CI as a system needs to account for the low uptake rate and create referral policies and practices that make it easier to enroll in a home visiting program. The referral pathway for a family through CI should be as simple as possible.

One option is to minimize the number of touches or times a CI or home visitor engages with a family, before they are enrolled. CIs and their program partners can achieve this by combining what were two separate touches into one or completely eliminating a touch altogether. For example, a CI and a home visitor could team up for the first contact so that the CI completes the screen and the home visitor schedules the initial appointment all at once, eliminating what would be a gap between these two stages in the referral process.

Another alternative is to remove the CIs outreach to complete the screening form altogether. In this option, for scenarios when referrals are received from community partners or through the CIs own recruitment efforts, the referral form would have all the necessary information for the CI to determine eligibility and send the family to the most appropriate home visiting program. The CI now no longer has to reach out to the family to complete the screen and one step in the referral process has been removed.

Certainly, families may still drop off even with a simplified referral process, because of other real barriers they face like lacking access to a regular source of communication, transportation challenges or unstable housing. However, a more coordinated approach to processing referrals would ensure families are not lost because of inefficiencies in the enrollment system itself.

Recommendation 3: Support overburdened staff by funding two positions for the CI system.

CIs current workload should be shared across two people with different, discrete responsibilities. CIs are struggling under all the tasks their job requires. This is understandable— their job used to be completed by two individual full-time employees. Returning to the days of a two-person system would enable CIs to devote their attention to managing the referral pathway, through completing screens, referring families to home visiting programs and following up on these referrals—their original, full-time job.

Additionally, community outreach is just as time intensive and should be another person's full-time job. A second employee would hold the equally important responsibility of cultivating referral sources by developing community partnerships.

One supervisor would manage the CI and community outreach worker individually and as a team. In this way, the work independently carried out by each staff person would complement one another in support of the overarching vision of facilitating enrollment for all families into home visiting programs best meeting their needs.

Increased investment in two staff would bring about multiple positive returns: stronger community connections between home visiting and the broader early childhood and social service systems, improved relationships between collaborative partners and less overburdened, overworked CI staff who are now empowered to take a more thoughtful and strategic approach to their work.

Recommendation 4: Respond to disconnected or nonexistent data systems by linking all home visiting programs in CI communities with one platform.

CI and home visiting partner programs need to use one data system to communicate back and forth on the status of referrals. This would facilitate regular communication between partners on referrals for home visiting services, enabling the CI to achieve one of their major responsibilities of tracking caseload capacity for their community. Beyond supporting the CIs day-to-day work, one data system would also strengthen coordination and collaboration at the systems level. With data tracked in one place, CI and partner programs would have improved understanding of community needs and capacity and apply this information to recruitment efforts and to the application process for new funding opportunities.

A closed loop referral data system will not resolve all communication problems for a collaborative. Partner programs may still have reservations about participating in the collaborative or there can be challenges with using the technology. However, a single data system would remove a barrier to communication between partner programs because everyone would at least be using the same platform.

Moving forward

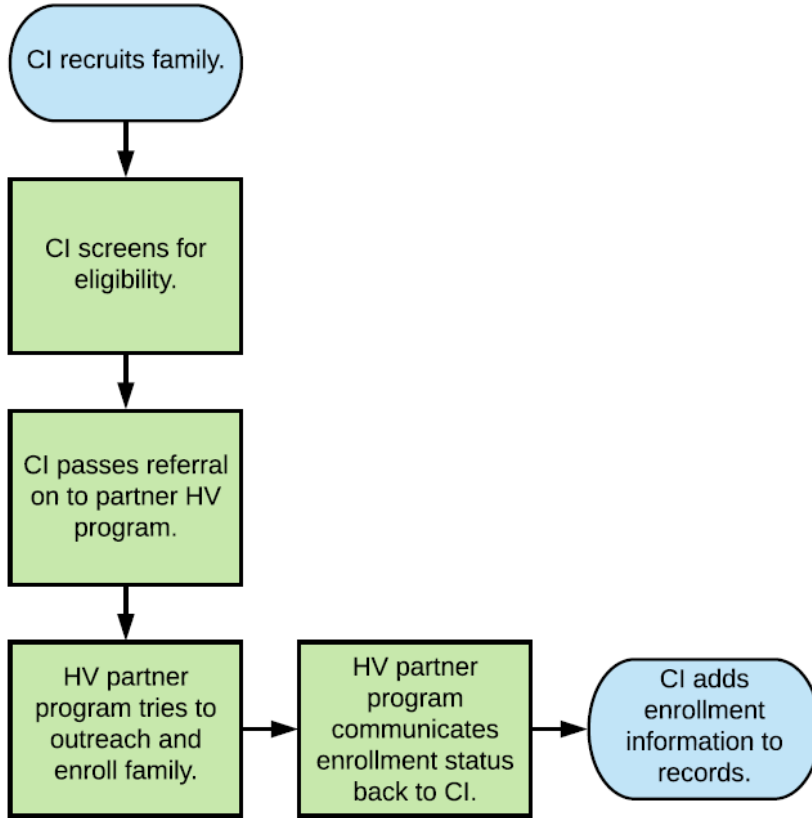
CIs are passionate and committed to supporting children and families. Despite this dedication, the system is not engaging with families who would most benefit from these services—only 10% of eligible families receive home visiting in the State of Illinois. The CI framework was designed to improve family experience with the home visiting system, but if there are internal elements working against this ultimate goal, CI almost becomes a barrier to enrollment. Making changes to the CI system can be used as a lever to support improved enrollment in home visiting by positioning programs to be more successful at family engagement and recruitment. The recommendations outlined above represent the path forward for strengthening CI as a tool for enrolling more families into home visiting.

Coordinated Intake (CI) Elements of Quality						
Through outreach and relationship building CI identifies and recruits families who would most benefit from home visiting services and, with knowledge of program capacity at the community level, facilitates enrollment in home visiting program best meeting the needs of the family.						
	Partnerships	Community Knowledge	Outreach	Collaborative	Data	Support
Quality pillars	1. CI is connected and embedded in early childhood/social service system of their community.	2. CI has knowledge of home visiting and social service landscape for their community and ways of accessing these services.	3. CI maintains strong connections with community and uses various outreach strategies to inform families about home visiting.	4. CI leads a strong home visiting collaborative that has an agreed-upon vision with policies and procedures that contribute to that vision.	5. CI uses data to support functioning of CI and home visiting system and to inform outreach strategies.	6. CI receives continued support through reflective supervision and access to ongoing assistance and professional development opportunities.
Quality elements	CI has relationships with community partners that facilitate the identification and enrollment of families into home visiting programs.	CI knows home visiting program and eligibility criteria for their community.	CI oversees outreach initiatives to spread the word about home visiting. The outreach should incorporate a variety of methods and strategies.	The collaborative meets on a monthly basis, with core partners regularly in attendance.	CI maintains accurate count of home visiting program capacity in community area.	CI receives adequate supervision.
	CI regularly meets with community partners to maintain relationships.	CI knows resources available in their community, along with their eligibility criteria and intake procedures.	CI is able to engage with families and community members about home visiting in a compelling manner. This may involve refining talking points, along with developing targeted messages for certain populations.	The collaborative has an agreed-upon mission statement and has agreed-upon policies, procedures and activities to support this mission statement.	CI is a source of data for community building and applications for program funding.	CI completes onboarding training within a timely manner and continues to participate in trainings, professional development, technical assistance and continuous quality improvement activities.
	CI participates and/or facilitates meetings of community partners.	CI makes referrals to community resources.		CI uses an agreed-upon framework for receiving referrals, directing them to collaborative partners and for learning status of referrals from partners.	CI enters referral data into agreed-upon data management system.	
	CI identifies and engages with new community partners that could serve as referral sources. CI tailors engagement to the unique needs and preferences of community partner.			CI has an established process for communicating status of referrals to home visiting collaborative.	CI uses standardized screening tool for assessing eligibility for home visiting programs.	
				CI manages conflict and issues as they arise within the collaborative.		

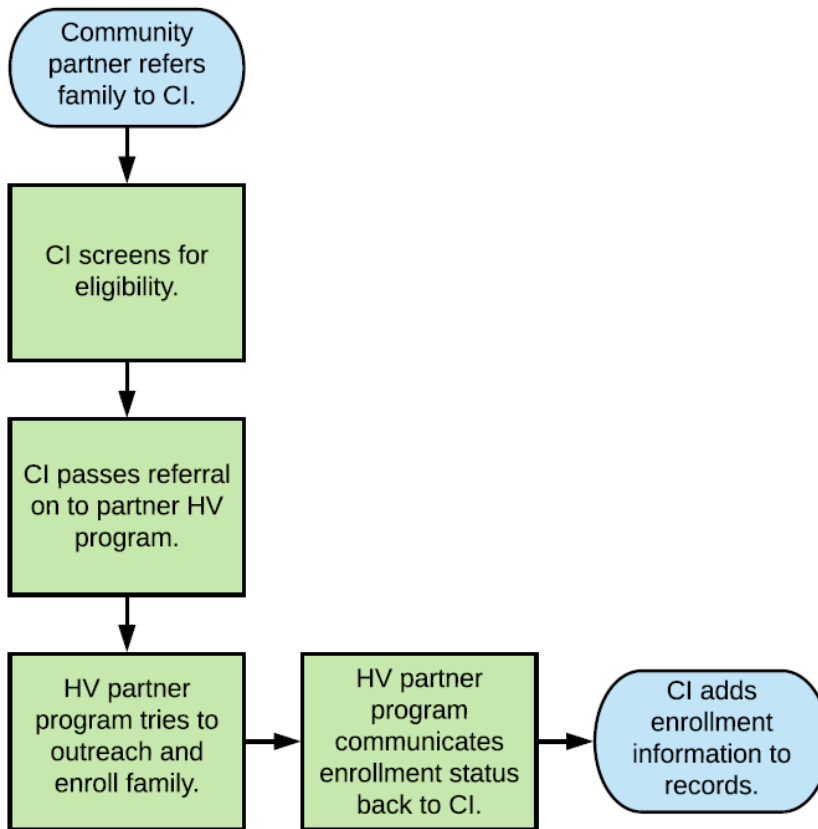
Appendix A: CI Quality Framework

Appendix B: CI referral workflows

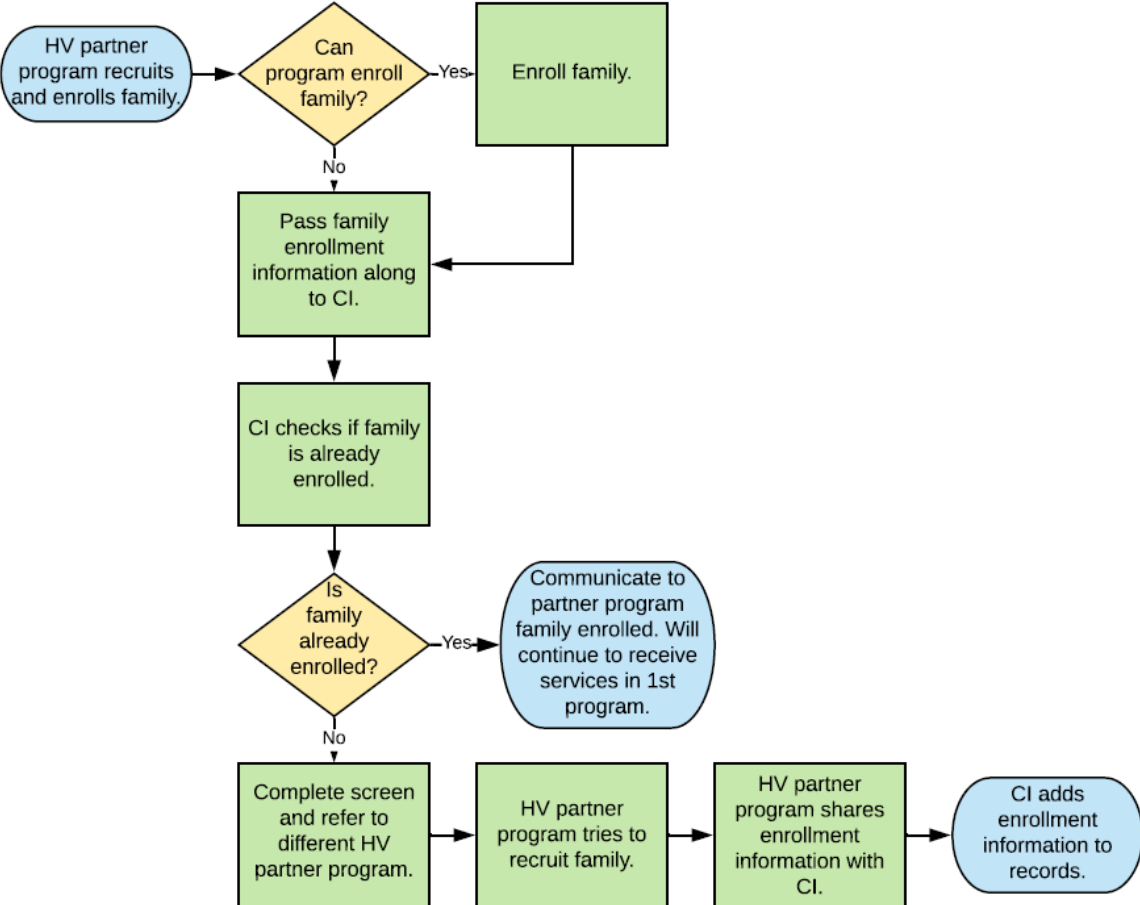
Coordinated intake workflow in practice: CI recruit



Coordinated intake workflow in practice: community partner



Coordinated intake workflow in practice: partner home visiting program



Referral Analysis Spreadsheet Calls

High-level trends and takeaways

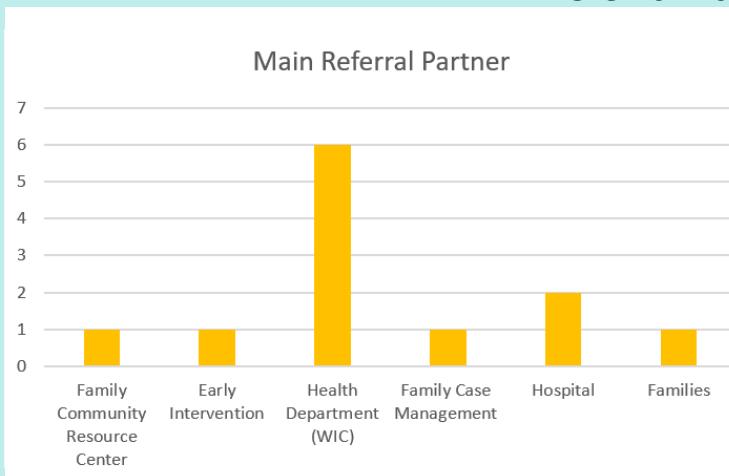
MIECHV CI staff recently analyzed six months of referral data to identify trends in where referrals are/are not originating and the success rate for those referrals—whether they were ultimately connected to home visiting services. Major themes from the analysis are detailed below.

First, some totals. For the previous six-month period there were:



** This is incomplete data. Identifying the status of referrals sent over to home visiting was not always able to be identified by CI.

Referral Patterns



CI's have one major referral source, most often their local health department.

Home visiting programs would like to engage medical providers, Family Case Management, the Women Infants and Children (WIC) program, Family Community Resource Centers and high schools.

Other takeaways:

Once CI's connect with a family to complete the CIAT, the family is often willing to do the screening for home visiting eligibility and best fit.

Home visiting programs vary in how successful they are in outreaching families. Some programs process referrals right away while others wait a little bit before outreaching.

Back and forth communication between home visiting programs and CIs is not always consistent. Programs not using Visit Tracker or experiencing challenges using Visit Tracker is a common barrier.

Overall, CI staff are conscientious, creative, outgoing and passionate. They are open to analysis as a positive step in finding ideas for improvement.

Citations

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Inclusive Services in Illinois Early Care and Education Settings

Ann Kremer and Bernie Laumann, Early CHOICES

Inclusion of Young Children with Disabilities in Early Care and Education Settings – Strategic Plan Outline

Recommendations to Promote Inclusive Services in Illinois Early Care and Education Settings

Early Inclusion Graphic

PDG B-5 Strategic Plan Outline

Inclusion of Young Children with Disabilities in Early Care and Education Settings

1. Description of Strategic Planning Process

The strategic planning process took place over multiple meetings and a review of recent reports and recommendations from federal agencies and national organizations that focus on the inclusion of young children with disabilities in community-based early care and education settings. Also, there are many Illinois needs assessments, projects, recommendations and reports used to compile these recommendations. Please note the reference list at the end of this document.

2. State Vision

Illinois commits to the inclusion of each and every child with special needs with typically developing peers in all early childhood environments.

This vision statement is an outcome of the 2017 Early Childhood Inclusion Policy Summit attended by key policy makers and program leaders from across the state. The Summit brought together private and public policy leaders across Illinois, with the express aim of applying the US Department of Health and Human Services and the US Department of Education's Joint Policy Statement on Inclusion of Children with Disabilities in Early Childhood Programs, to advance policies and practices across the state that support inclusion as part of all high quality early learning environments.

The result of this summit was to create the vision statement and use it to assure that future policy decisions would promote the inclusion of young children with disabilities in high quality early care and education settings with appropriate supports and services for each individual child.

Key policy makers and program leaders from across Illinois, a) The Illinois Department of Children and Family Service (DCFS), b) Early CHOICES, c) the Illinois State Board of Education (ISBE), d) the Governor's Office of Early Childhood Development (GOECD), and e) the Illinois Head Start Association (IHSA) developed and promote the [Illinois Early Childhood Inclusion Vision Statement](#).

3. State Mission

Our state's mission is to promote these Guiding Principles:

Increase Equitable Opportunity: Inclusion of children with special needs is a priority in decision making about program design and resource allocation in order to ensure equitable access and full participation in all early childhood environments.

Partner with Families: We ensure the meaningful and supported engagement of families in policy/ guidance decisions, planning, and evaluation of programs, as well as in Individualized Family Service Plan, Individualized Education Program, transition and other family/professional meetings.

Share Benefits of Inclusion: We recognize and intentionally raise public awareness of the well-researched benefits for all children of high-quality inclusion in all early childhood settings.

Build and Support a Competent Workforce: All professionals who work with children should have the knowledge, competencies and supports to implement evidence-based practices. We deliberately shift policy to support elements critical to this effort: appropriate professional standards, embedded professional development, culturally and linguistically responsive practices, positive attitudes and beliefs about inclusion, and knowledge of disabilities.

Unified Purpose: We intentionally and strategically engage in formal collaboration across agencies to make significant progress toward high quality inclusion across early childhood settings.

Set Goals and Track Data: Across agencies we set concrete goals for expanding access to inclusive and high quality early learning opportunities, including a base line number of children with and without disabilities in all early childhood settings, and benchmarks that track progress toward the goal.

4. Stakeholder Members

Stakeholders include families of young children with disabilities, early care and education providers, leaders within Illinois early childhood organizations, agencies, advocacy groups, and early intervention. Several face-to-face and online meetings took place to advise Early CHOICES staff regarding the development of this strategic plan. The names, affiliations, and committee memberships may be found on pages 9-10.

5. Goals/Objectives/Action Steps

Goal 1: Increase clear, targeted outreach to families of young children with disabilities and those who serve them about what inclusion is, why it is important, and their child's right to receive special education services in the least restrictive environment (IDEA, 2004).

Objective: 1a.) Use existing resources (web page, electronic newsletter, and social media) to create a consistent message about inclusion of young children with disabilities across

various early care and education systems (e.g., Early Intervention, home visiting, community based organizations (CBOs), Head Start programs, Preschool for All Programs, etc.). Information must reach all sectors and be in small accessible learning objects.

Objective: 1b.) Disseminate information to families of young children with disabilities about existing educational and social settings available to them in their community where inclusive opportunities are provided for their children. This should occur at the very first opportunity to understand inclusion.

Objective: 1c.) Disseminate information about inclusion to early care and education providers with access to families of young children (e. g., home visitors, Early Head Start providers, health care providers, therapists, child care directors, etc.).

Action Steps:

- Provide information about inclusion in multiple languages that is understood by multiple audiences (e.g., families, child care providers, translators).
- Participate in outreach events/activities (i.e., exhibits at local interagency fairs, Child Care Resource Service meetings, Head Start Professional Development Conference, regional AEYC meetings, etc.) for professionals working across various early care and education systems regarding the importance of inclusive opportunities for young children with disabilities.
- Create and share examples of outstanding practices in inclusion. Include a variety of settings (e.g., family child care, center-based care, etc.). These examples could be shared at family events, conferences, workshops, and agency fairs.
- Update and share out new *Understanding LRE* online module. This is underway and will have a new title and focus towards families and EI providers.

Goal 2: Increase tangible supports to CBOs to increase the number of high-quality early care and education settings that all families may access for their child with a disability.

Objective: 2a.) Expand access to enhanced public funding to more programs serving young children with disabilities to improve services and access to high quality inclusive child care.

Objective: 2b.) Increase child care capacity to provide high-quality inclusive child care through technical assistance (TA) and professional development (PD).

Objective: 2c.) Revise quality standards related to inclusion within ExceleRate.

Objective: 2d.) Increase funding to ensure high quality structures are in place that support inclusion.

Action Steps:

- Increase the number of Early CHOICES staff to provide professional development and technical assistance across the mixed delivery service model including childcare and public and private preschools.
- Make available inclusion training and technical assistance through expanding the number of Early CHOICES staff. Early CHOICES staff would promote best practices across systems with an interdisciplinary team of support supervised under one professional development provider.
- Provide information and coaching to support early care and education providers concerning the recently enacted IL policies around the suspension and expulsion of young children enrolled in child care settings.
- Early CHOICES staff provides expanded ongoing job embedded coaching to child care providers throughout the state in order to increase collaboration and efficiency for service delivery (e.g. speech/language therapy, occupational therapy, etc.).
- Early CHOICES staff will collaborate with other state early care and education leaders to revise the quality standards related to inclusion within ExceleRate.
- Early CHOICES staff will work with state early care and education leaders to promote enhanced funding to ensure high quality structures are in place in programs that enroll young children with disabilities.

Goal 3: Provide guidance, incentives, and accountability to support Local Education Agencies (LEAs) to ensure that special services are provided to young children with disabilities within the mixed delivery service model.

Objective: 3a.) Create and implement guidance with administrators of LEAs and CBOs, Head Start directors, EI professionals and families to provide inclusive opportunities for serving young children with disabilities across the state.

Objective 3b.) Elevate models of successful collaboration between LEAs, Early Intervention providers and CBOs to serve children with disabilities with supports and services within CBOs

Objective: 3c.) State leaders (ISBE, DHS) will assure that state rules and regulations are in place to allow LEAs flexibility to provide services and supports and CBOs flexibility to collaborate with LEAs.

Action Steps:

- Identify regions in the state where opportunities for creating models of cross agency service delivery would be accepted. These may be identified through ISBE staff, Child Care Resource Services staff, Head Start, etc.
- Create a task force that includes all stakeholders to advise guidance and problem solve issues of boundaries, transportation and support services availability.
- Provide incentives to regions to build community-based networks for supporting inclusive services for young children. Invite members of networks in other regions (AoK Network, Partner, Plan, Act) to serve as mentors for new networks.

Goal 4: Provide guidance, incentives, and accountability to support Early Early Intervention to ensure that special services are provided to infants and toddlers with disabilities within the mixed delivery service model.

Objective: 4a.) Build infrastructure to support EI providers and early care and education providers (Prevention Initiative, Early Head Start, child care) to provide services with the intent of maximizing inclusive opportunities for infants and toddlers with disabilities and their families.

Objective: 4b.) State leaders (ISBE, DHS) will continue to expand the Natural Partners work to build communication and models across EI and community based organizations (CBOs).

Action Steps:

- Identify regions in the state where opportunities for creating models of cross agency service delivery would be accepted. These may be identified through Child and Family Connections staff, Child Care Resource Services staff, Early Head Start, Prevention Initiative programs, etc.
- Provide incentives to regions to build community-based networks for supporting inclusive services for infants and toddlers. Invite members of Natural Partners in other regions to serve as mentors for new networks.

Progress Indicators

Increase in number of Early CHOICES staff providing consultation and coaching to support high quality early care and education for young children with disabilities.

Increase in online information and print materials about high quality inclusion that are available in multiple languages.

Increased number of contacts and dissemination of materials explaining high quality inclusion to families of infants/toddlers and preschoolers with disabilities.

Increased contacts and dissemination of materials to providers and leaders of early care and education settings regarding high quality inclusion for young children with disabilities.

Increase in the number of infants and toddlers with disabilities served in natural environments (e.g., Prevention Initiative, Early Head Start, family child care homes, infant/toddler child care centers, community playgroups, etc.).

Increase in the number of preschool age children (3 to 6 yrs. old) receiving special education supports and services in the least restrictive environments (LRE) (e.g., Preschool for All, Head Start programs, community-based early care and education settings, family child care homes, etc.).

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Inclusion Stakeholders/Committee Members

The following individuals provided expertise and substantive guidance in the development of the goals, objectives, and action steps to address the inclusion of young children with disabilities and their families outlined in the PDG B-5.

Name/ Organization	PDG B-5 Core Group	Inclusion Committee (IL Early Learning Council)	EC Least Restrictive Environment (EC LRE) Stakeholders
Karen Berman, Ounce of Prevention	X	X	
Vanessa Castro, IL Dept. of Children & Family Services	X		
Kristy Doan, Illinois State Board of Ed (ISBE)	X	X	X
Donna Emmons, Head Start	X	X	
Ann Freiburg, Illinois Dept. of Human Services (IDHS), Early Intervention	X		
Nakisha Hobbs, IDHS Division of Family and Community Services, Child Care	X		
Ann Kremer, Early CHOICES	X	X	X
Lori Orr, Illinois Governor's Office of Early Childhood Development (IGOECD)	X		X
Emily Ropars, Early CHOICES	X		X
Bernadette Laumann, Consultant	X	X	X
Chelsea Guillen, Illinois Early Intervention Training Program (EITP)		X	
Pam Reising-Rechner Early CHOICES	X		X
Michael Garner-Jones, IDHS, Child Care	X		
Julie Schackman, Early CHOICES			X
Lauri Morrison Frichtl, Head Start		X	X
Joni Strichlow, Illinois Network of Child Care Resource & Referral Agencies (INCCRRA)			X
Beth Knight, INCCRRA			X
Anni Reinking, Southern IL University at Edwardsville (SIUE)			X
Rose Slaght, StarNet			X
Emily Reilly, StarNet			X
Melissa McCollough, East Moline School District			X

Name/ Organization	PDG B-5 Core Group	Inclusion Committee (IL Early Learning Council)	EC Least Restrictive Environment (EC LRE) Stakeholders
Mina Wright, Parent			X
Christopher Wright, Individual with a disability			X
Kathy Slattery, STAR NET			X
Donna Nylander, IGOECD			X
Cori Mohr, Parent			X
Silvia Rodriguez, Parent			X
Evelyn Green, STAR NET			X
Monique Hovinga, STAR NET			X
Penny Smith, ISBE			X
Denise Henry, STAR NET			X
Shannon Cibaro, Mannheim School District 83			X
Lynn Owens, Lake Zurich School District			X
Susan Connor, EITP			X
Sandy Ginther, Community Member			X
Christine Coleman, Collinsville School District			X
Amanda Quesenberry, Illinois State University (ISU)			X
Ernie Cherullo, Cook Co. District 130			X
Antionette Taylor, Early Childhood Professional Learning			X
Colleen Cunningham, DHS			X
Elizabeth Frisbie, Infant EC Mental Health			X
Clare Killey, Aspire			X
Robin Latman, Frankfort School District, 161			X
Kim Nelson, Four Rivers Special Ed Cooperative			X
Connie Schugart, STAR NET			X
Kristy Smiley, Riverbend Head Start			X
Carol Weisheit, IL Association for the Education of Young Children (ILAEYC)			X

**Recommendations to Promote Inclusive Services in
Illinois Early Care and Education Settings**
December, 2019

This report provides a general summary of the work undertaken by private and public stakeholders to promote inclusive services for young children with disabilities and their families in Illinois. Across Illinois the early care and education community strives to meet national policies and recommended practices in inclusion ([IDEA, 2004](#); [DEC/NAEYC 2009](#); [U.S. Department of Health and Human Services & U.S. Department of Education, 2015](#)) to provide specialized supports and services to young children with disabilities and their families.

A recent document, [State Indicators of high-quality Inclusion](#) (National Early Childhood Technical Assistance Center (ECTA) & National Center for Pyramid Model Innovations (NCPMI), 2019), was created as a guideline for state policy makers and practitioners working to ensure high-quality inclusive services for all young children with disabilities and their families. This document is used to organize current work happening in Illinois as well as suggest recommendations for the future.

INDICATOR 1: Cross-Sector Leadership

A state level cross-sector leadership team exists with the ability to implement a shared mission, vision, strategic plan and recommendations to support high-quality inclusion across the early childhood system.

Illinois has several state level cross-sector leadership teams that focus on young children with disabilities and their families:

- 1). The [Illinois Early Intervention Interagency Council \(IEIIC\)](#) convened by the Illinois Department of Human Services (IDHS) Division of Early Intervention is mandated under IDEA, 2004. Although the focus of the IEIIC is not specifically on inclusion, the council does influence state policy and practices that impact services for young children with disabilities and their families.
- 2). The [Illinois Early Learning Council \(ELC\)](#) is facilitated by the [Illinois Governor's Office of Early Childhood Development \(GOECD\)](#). Within the ELC the [Integration and Alignment Committee](#), made up of public and private providers undertakes overall cross-sector planning for the early care and education community. One of the subcommittees of the Integration and Alignment Committee is the [Inclusion Subcommittee](#). This subcommittee is made up of key leaders/providers from public and private agencies (e.g., Illinois State Board of Education, the Illinois Early Intervention Training Program, the Ounce of Prevention, Head Start, Illinois Department of Human Services, Early Choices, and direct service practitioners) that serve young children with disabilities and their families.
- 3). The [Early Childhood Least Restrictive Environment Stakeholders Consortium](#). The EC LRE Stakeholder Consortium promotes inclusion of children with special needs with typically developing peers in all environments where they learn, grow and have appropriate supports to

succeed. The LRE Stakeholders Consortium has representatives from the child care community, the IL Department of Human Services, the Illinois State Board of Education, families, advocacy organizations, and other entities focused on inclusion. The EC LRE Stakeholder Consortium mission statement was adopted in January, 2015:

The EC LRE Stakeholder Consortium promotes inclusion of children with special needs with typically developing peers in all environments where they learn, grow, and have appropriate supports to succeed.

Several members serve on more than one of these three groups so there is cross communication between the entities. Since the first Illinois Early Childhood Policy Summit in 2017 there has been increased efforts to build communication among these bodies.

Recommendations:

- Continue meetings of state-level cross-sector leadership teams that focus on inclusive services for young children with disabilities and their families. Assure the group's recommendations move from advisory bodies to implementation bodies such as the Inter Agency Team (IAT)
- Strengthen support for cross-sector leadership teams at the local level and add a focus on inclusion. This effort may be located regionally (e.g., Child Care Resource and Referral Area [CCR & R]). Local cross-sector leadership teams would include local educational area (LEA) administrative staff, Early Intervention (EI) professionals, mental health professionals, Head Start leadership, and private early care and education providers. Presently there are cross-sector collaborative groups (e.g., AOK Network, Regional Child Care Directors meetings, Local Interagency Council (LIC), etc.) however local cross sector leadership teams may not consistently design and implement high-quality inclusive services for young children with disabilities and their families in various areas of the state.

INDICATOR 2: Policy/Guidance

State early care and education agencies have aligned policies and procedures that promote high-quality inclusion.

For many years Illinois agencies and early care and education providers have collaborated to promote high-quality inclusion.

- 1) In 2001 a cross agency group of key early care and education leaders from various state agencies in Illinois convened as the *Illinois Partners for Access and Equity Project*. The group met to examine state early care and education policies and procedures to better promote serving young children with disabilities in settings with typically developing peers. One important outcome of this group's work is the guidebook, [One of Us: Access and Equity for All Young Children](#) (2005) with examples of inclusion in early care and education settings in Illinois. The purpose of the guidebook was to encourage and

promote increased access for preschool-aged children with disabilities to be educated with their typically developing peers.

- 2) The Department of Children and Family Services (DCFS), Early CHOICES, the Illinois State Board of Education (ISBE), the Governor's Office of Early Childhood Development (GOECD), and the Illinois Head Start Association (IHSA) developed and promotes the [Illinois Early Childhood Inclusion Vision Statement](#). This vision statement is an outcome of the 2017 Early Childhood Inclusion Policy Summit. The intent for this summit was to create the vision statement and use it to assure that future policy decisions would promote the inclusion of young children with disabilities in high-quality early care and education settings with appropriate supports and services for each individual child.
- 3) ExceleRate Illinois and Early CHOICES promote [The Illinois Inclusion Guidelines](#) to provide guidance about high-quality inclusive practices in early care and education settings. These guidelines were developed to promote the highest level of quality relating to inclusion within the state's quality rating and improvement system (ExceleRate Illinois).
- 4) ISBE has included guidance about serving young children with disabilities in publicly funded preschool (Preschool for All) in the [Preschool for All Implementation Manual](#).
- 5) ISBE has provided clarification on what inclusion means for Early Childhood Block Grant programs with this recent guidance. This [guidance](#) describes high-quality inclusive practices and expectations.
- 6) ISBE staff designs guidance for LEAs to provide support for young children with disabilities who are served in community based organizations (CBOs) (e.g., child care and Head Start).
- 7) The Illinois Department of Human Services (IDHS) ensures that all eligible children with disabilities can receive funding through the Child Care Assistance Program (CCAP). Illinois does not maintain a waitlist for CCAP funding (i.e., all children who apply and are found eligible receive it). However, the quality/supply side of the equation is challenging in that the child's family is responsible for finding a child care provider who can enroll their child. There is a very limited number of child care options. Some child care providers don't feel they have the skills, some do not have appropriate facilities, and others have long waiting lists. Therefore, this issue also links to the requirements under professional development and the allocation of resources (Weglarz-Ward, Santos, & Hayslip, 2019).

Recommendations:

- Both the Illinois Inclusion Guidelines and the Illinois Early Childhood Inclusion Vision Statement must be promoted during cross sector policy decision meetings, implementation plans, trainings, conferences, parent groups, and other settings where plans for providing special services for young children with disabilities and their families are discussed.

- Provide guidance, incentives, and accountability to support Local Education Agencies (LEAs) to ensure that special services are provided to young children with disabilities within the mixed delivery service model.
- Provide guidance, incentives, and accountability to support Early Intervention to ensure that special services are provided to infants and toddlers with disabilities within the mixed delivery service model.
- Ensure that all public and private early care and education providers (through webinars, training, licensing contacts) have access to clearly written procedures and online training materials that promote high-quality inclusion.
- Prioritize young children with disabilities when assigning access to regular early childhood environments. Illinois DHS should be more intentional about prioritizing children with disabilities for child care. Simply obtaining a CCAP voucher for child care is insufficient when there is no provider who will enroll a child with disabilities or successfully support them.

INDICATOR 3: Family Engagement

State early care and education agencies engage families as essential partners when developing, implementing, and evaluating policies and initiatives that facilitate inclusion.

Families of children with disabilities are members of state committees and subcommittees that develop, implement, and evaluate policies and initiatives that facilitate inclusion. Families are members of the state Illinois Interagency Council on Early Intervention (ICEI), the EC LRE Consortium, local interagency councils, and Head Start Program Policy Councils.

Recommendations:

Use public outreach methods to maximize parental choice and knowledge about inclusion of young children with disabilities.

- Provide families with strategies for maximizing school services. Parent education opportunities will be provided on transition services, special education rights, and parent leadership training to support peers. Support will be provided by Early CHOICES staff to develop and disseminate inclusion-focused public awareness resources and training materials for families.
- Extend opportunities for families of young children with disabilities to participate in cross agency policy discussions through technology, home visits, and other non-traditional formats for obtaining family members' ideas, experiences, and challenges for inclusion in early care and education settings.

- Connect families of young children with disabilities to training opportunities (e.g. [Partners in Policy Making](#)) to increase their awareness of special education policies and practices and how to effectively participate on boards, interagency councils, local planning groups, and other activities.

INDICATOR 4: Accountability, Data Use and Continuous Quality Assurance Systems

State early care and education agencies require and support local programs in collecting and using data to evaluate and improve how well children with disabilities are accessing and participating in inclusive early childhood programs.

Multiple agencies in Illinois (IDHS, ISBE, Head Start, etc.) collect data about the number of young children with disabilities who are served in early intervention, early childhood special education, and in Head Start. Child care data regarding children with disabilities served in child care settings is also collected but may be under-reported due to some child care centers not being aware whether a child has an Individual Family Service Plan (IFSP) or Individual Education Plan (IEP) in place. IDHS and ISBE fund the [Illinois Early Childhood Asset Map \(IECAM\)](#) to provide Illinois early care and education data in a centralized online location. IECAM includes demographic data as well as locations of early care and education providers by county. The website is open access and providers, families, and policy makers may contact IECAM staff by email and/or phone to ask specific data related questions regarding early care and education data in Illinois.

The Child Care and Development Block Grant (CCDBG) clarifies the definition of children with disabilities in accordance with federal laws. Currently on the CCAP application, there is a question that asks applicants to report if a child has special needs. This is a non-mandatory field, and applicants do not receive context for IDHS' definition of special needs. Within the CCR&R's determination of eligibility, the application asks if a child has an Individual Education Plan (IEP) or an Individual Family Service Plan (IFSP) if the applicant is between 162% and 185% of poverty level. This current data collection only represents a snapshot in time. The data does not accurately convey what occurs at the center-based or program level.

Illinois stakeholders must develop an agreed upon definition of young children with disabilities and carefully collect accurate baseline data indicating where children are enrolled. Using this data, stakeholders can develop a continuous quality improvement plan. There are current ideas for the integration and merging of data that could be built upon (e.g. matching Head Start data to ISBE Student Information System (SIS) data and/or reviewing data of children who have been found to have a disability and eligible for Social Security Income (SSI) benefits). Any data integration alignment efforts should prioritize collecting data on the enrollment of children with disabilities in child care. Illinois is only collecting information on a diagnosed special need when families apply or re-determine. This number will never be an accurate representation of how many children with disabilities are in child care, which makes it hard to truly understand the scope of the problem.

Furthermore, the required data collection does not provide much information about children who are excluded from child care programs. Although this is a common national problem, Illinois is

poised to realize the potential of CCDBG funding around data collection. Illinois stakeholders need to think about all the information that is still needed in order to make better public policy decisions that will help children with special needs get in the door.

Recommendations:

- Collect specific, timely information from IDHS, ISBE, Head Start, home visiting programs, and child care providers regarding numbers of young children with disabilities participating in inclusive early childhood settings. Make this data available through the IECAM website in order for communities to evaluate whether young children with disabilities are accessing and participating in inclusive early childhood programs in their region/county/neighborhood.
- Together with IDHS and ISBE design a data collection method to access information about where infants, toddlers, and young children (birth to 8 yrs.) with disabilities are being served in natural settings (e.g., family child care) and in inclusive early education settings (e.g., CBOs, after school care, etc.). The data would provide an accurate account of where young children with disabilities are receiving special education services and supports.
- Monitor Child Find data and consider recommendations for the collection and dissemination of this data. Include referrals and follow-up data to determine if families are accessing needed services and/or if specific children are being excluded from child care.
- Improve accuracy of data collection for Part C and Part B. Use data to inform stakeholders about underserved areas of the state in terms of providing trainings, outreach, and coaching to support the inclusion of young children with disabilities in community-based settings (CBOs).

INDICATOR 5: Funding

State early care and education agencies actively implement cross-sector strategies to allow coordination and leveraging of funds and resources at the local level to provide high-quality inclusion.

The implementation of cross-sector strategies for the coordination and leveraging of funds and resources at the local level to provide high-quality inclusion is dependent on relationships among local providers. A recent report, [“Ensuring Equitable Access to Funding for All Birth-to-Five Classroom-Based Early Childhood Programs”](#) by the Mixed Delivery System Ad Hoc Committee of the Illinois Early Learning Council Integration and Alignment Committee includes

a number of recommendations for coordination and leveraging of funds and resources to provide high-quality inclusion.

The [Preschool Inclusion Finance Toolkit](#) (ECTA Center, 2018) provides guidance and tools to better plan for blending and braiding funds to support children in community placements.

Early Intervention services may occur in the natural environments (e.g., home, family child care) so that services follow the child however, when a child turns three if they are eligible for early childhood special education services the assurance of the supports following the child is unlikely. Families are often forced to choose between services at the LEA location or keeping their child enrolled in a center-based child care setting. This is also true for some children with disabilities enrolled in Head Start programs who are then bussed to the LEA for itinerant speech/language services rather than receiving those services at the Head Start program.

Recommendations:

- Members of the Inclusion Subcommittee of the Illinois Early Learning Council Integration and Alignment Committee will create written guidance about how to layer funding streams to provide examples for LEAs, community based organizations, and Head Start programs about how to use funds to support young children with disabilities and their families in natural environments. The [Early Childhood Technical Assistance Center \(ECTA\) Preschool Inclusion Finance Toolkit \(2017\)](#) provides examples of how to determine costs to support inclusion in early care and education settings.
- State leaders (e.g., IDHS, ISBE,) will assure that state rules and regulations are in place to allow LEAs and EI providers flexibility to provide services and supports in the natural environment/LRE. Using documents in this report, create sample templates for braiding and blending funding that communities may use to assign funding responsibilities in a local mixed delivery system (e.g., transportation, itinerant teacher/coaches, etc.).
- Build infrastructure to support EI providers to provide services in CBOs with the intent of maximizing inclusive opportunities.
- The recommendations from the Mixed Delivery Systems Report coupled with the Illinois Early Childhood Inclusion Vision Statement and the ECTA Preschool Finance Kit will be implemented to assure families and children have access to high-quality inclusive placements across their community where specialized services support young children with disabilities in natural environments/LRE.
- Increase tangible supports to CBOs to increase the number of high-quality early care and education settings that all families may access for their child with a disability.
- Local community planning groups focused on mixed delivery systems of care should include advocates and families of young children with disabilities who can bring their

unique situations and issues to the planning and implementation phases of a local mixed delivery system.

INDICATOR 6: State Early Learning Standards/Guidelines

State early learning standards or guidelines for developmental expectations of children include specific strategies and adaptations to support the needs of children with disabilities.

Illinois early care and education providers developed the [Illinois Early Learning Guidelines for Children Ages Birth to Three Years Old](#) (IELGs) and the [Illinois Early Learning and Development Standards \(for preschool ages 3-5 years old\)](#) (IELDS). Resources (online documents, webinars, face-to-face training, and conference sessions) have been created and are available to program staff. Resources aligned to the IELGs and the IELDS address specific adaptations to support the needs of young children with disabilities are available to any providers online through the [Illinois Early Learning Project](#) (funded by ISBE). Opportunities to practice specific strategies and adaptations to support the needs of children with disabilities should be made easily accessible to child care providers, home visitors, and other early care and education professionals.

Recommendations:

- Professional development that addresses specific strategies and adaptations to support the needs of children with disabilities should be made available to child care providers through online resources (i.e., webinars, video examples, and/or during convenient times). These may include Saturday workshops, one-to-one coaching sessions, reflective supervision meetings, etc.
- Create systemic structures to provide job embedded coaching, mentoring, and reflective supervision opportunities. On the job training and support are critical to child care providers' development of professional confidence and competence to serve young children with disabilities. These structures must be offered in the context of a cross system model and support early care and education for young children.

INDICATOR 7: Program Standards

State early care and education agencies have standards for measuring program quality that contain procedures and practices for including children with disabilities within local early care and education programs.

The National Association for the Education of Young Children (NAEYC), the national professional organization for early childhood educators, has adopted a new position statement, *Advancing Equity in Early Childhood Education* (NAEYC, 2019) that addresses the rights of all

children to equitable learning opportunities that help them achieve their full potential. The purpose of this position statement is to:

- 1) “provide high-quality early learning programs that build on each child’s unique individual and family strengths, cultural background, language(s), abilities and experiences and
- 2) eliminate differences in educational outcomes as a result of who children are, where they live, and what resources their families have.” (NAEYC, 2019, p. 4).

Both the Illinois Preschool for All/Preschool Expansion Programs and the Head Start Program Performance Standards include standards for measuring program quality that include procedures and practices for including young children with disabilities. [ExceleRate Quality ratings \(Bronze, Silver, and Gold\)](#) include one standard for measuring program quality that contains procedures and practices for inclusion. The Gold level of quality requires the highest level of commitment from program administration and staff to providing quality inclusive services.

Recommendations:

- Continue to encourage programs and family child care providers to work toward the highest level of quality (Gold) and to provide additional training for teaching staff to address specific procedures for working with young children with disabilities. As programs attain a higher quality rating, all children enrolled benefit.
- Expand the opportunities for programs to attain the Outstanding Practice in Inclusion (OPI). Provide opportunities for programs to visit those who have attained the OPI and engage in discussions/problem solving with staff. OPI directors can serve as mentors to other programs.
- Revise quality standards related to inclusion. Embed the Illinois Inclusion Guidelines in any newly revised ExceleRate standards into all levels of the quality rating scale.

INDICATOR 8: Allocation of Resources to Support Personnel

State and early care and education agencies provide sufficient specialized technical assistance and consultative services to support local programs in implementing high-quality inclusive practices.

The [Early CHOICES](#) staff and the [Early Intervention Training Program \(EITP\)](#) staff provide state-wide technical assistance and consultative services to early care and education programs and families of young children with disabilities. The [Early Intervention Clearinghouse](#) also provides free videos, training materials, books, and reports to providers and families of young children with disabilities ages birth to five. All of these resources are free to any providers and

families however child care staff may need more direct consultation services and/or a local inclusion specialist who can come on site to collaborate and problem solve issues pertaining to including a particular child.

The Project Collaborative Care (PCC) was a study conducted throughout Illinois in 2015-2017 with the purpose of better understanding the inclusion of very young children with disabilities in child care from the perspectives of professionals (Weglarz-Ward, Santos, & Hayslip, 2019). The study included an online survey of 620 child care providers and 371 IDEA Part C EI providers from across the state. Providers represented both center-based and family child care, directors, owners, teachers, and other early childhood professionals as well as a range of EI providers across disciplines. The top five barriers to inclusion identified were:

- Not enough training to prepare child care providers to effectively work with young children with disabilities who are enrolled in child care programs;
- High teacher to student ratios (too many children per each adult);
- Child care facilities are not designed for children with disabilities (e.g., rooms are too small for wheelchairs, adequate supplies, lack of special equipment, or lack of assistive technology);
- Not enough high-quality child care programs; and
- Lack of time for planning and coordinating services for children with disabilities between child care providers and EI providers.

One barrier to providing inclusive services is that it is difficult for a provider to wait for a child with special needs to come to them, then apply for a rate add-on through CCAP, and then make changes to their program based on one child, which can be further complicated that the child may then leave. While this structure empowers families on an individual level, there still needs to be a base level of quality infrastructure that makes a family want to come to a provider in the first place.

Currently in IL, providers may receive increased payments for serving children with disabilities. However, it is only available to site-administered programs, which represent a very small percentage of the full child care workforce in Illinois. We also know from field surveys that it is underutilized even within site-administered programs, because the paperwork is cumbersome. The amount of the payment should also be sufficient to provide the necessary supports.

Recommendations:

- Hire staff with training in EI/ECSE and inclusion experience to work as Inclusion Specialists to build relationships and provide technical assistance to providers in local early care and education settings. Similar to the Infant Mental Health Providers, the local Inclusion Specialist may work directly and indirectly with a number of programs to support practices and coach early care and education providers as they include children with disabilities in home-based and center-based care. The Inclusion Specialist could be housed regionally in an existing structure (e.g., the Child Care Resource and Referral Network (CCR & R), STAR NET, or through the Regional Office of Education (ROE). A central facilitation piece would include Early Choices as the preschool inclusion initiative. The Early Intervention Training Program (EITP) could serve as the facilitator

for inclusion in natural environments for infants/toddlers with disabilities and their families. The key for this structure is to assure continuity of support and consistent messaging on inclusion. The inclusion specialists should be connected to one another across the state so that they can be a support to one another and their ongoing professional development is consistent. It is critical to coordinate and partner with other entities to offer/publicize joint professional development opportunities.

Provide grants and contracts directly to child care providers to:

- Support staff needs, in the form of training and technical assistance.
- Modify a child care setting to accommodate children with diverse abilities and needs (building ramps, widening doors, etc.)
- Buy items such as sensory equipment or computer equipment and software for children with special needs
- Incentivize providers to open in an area they may not otherwise consider or to serve children for whom care is more costly or more involved due to a child's disability.
- Allow for staff time to be spent on planning, collaboration, and teamwork (both internally and with external partners): provide funding for staff release time to attend meetings; provide funding for substitutes to attend meetings; provide training stipends for those seeking professional development (including college course work); pay EI/SPED providers for collaboration time with child care providers regardless of where child receives services (as child care providers are not official providers)

INDICATOR 9: Coordination of Professional Development Resources

State early care and education agencies use a cross-sector approach to coordinate evidence-based professional development efforts to build personnel capacity to provide high-quality inclusive programs.

Federal, state, and private agencies provide professional development opportunities throughout Illinois. Early care and education programs have been able to access professional development activities to support young children with disabilities and their families sponsored by Illinois STAR NET, Illinois Division for Early Childhood of the Council for Exceptional Children (IDEC), Illinois Association for the Education of Young Children (ILAEYC), the Early Intervention Training Program (EITP), Early CHOICES, and the Early Childhood Professional Learning Program. Some professional development has been offered online and/or free of charge while others (state and local conferences) have charged a registration fee. For child care providers day time conferences and face-to-face workshops may not be offered when they are

free to attend. Financial assistance for scholarships may also be limited for family child care providers and center care staff.

Trainings currently available include the following topics:

- What is inclusion and why is it important for young children and their families
- Developmental screenings (how to conduct developmental screenings, discuss results, and how and where to refer children and families to obtain screenings if unable to do them within program)
- How to support families through the process of referral and receipt of any services, including IDEA Parts C & B
- Children with special needs
- Challenging behaviors
- The Inclusive Classroom Profile (ICP)
- The Illinois Inclusion Guidelines
- The Pyramid Model

Currently, the CCR&R's have Infant-Toddler Specialists and Mental Health Consultants. While these are beneficial resources that may overlap with issues concerning children with special needs and inclusion, these professionals may not have specific expertise in inclusion. The Head Start model employs Disability Coordinators whose primary role is to support classroom staff to serve children with special needs. Other states, (e.g., North Dakota) offers technical support from an experienced Inclusion Specialist at no cost to early childhood service providers.

Recommendations:

- Day time workshops and training to build capacity for serving young children with disabilities could be made available via online videos for child care providers to access at a convenient time. Free brief online courses (see the [Virtual Lab School](#) as an example) focused on young children with disabilities and their families (assistive tech, curriculum adaptations, goal setting, etc.) may be offered through joint planning and implementation among the state's professional development leaders.
- Workshops and webinars are only the first steps for high-quality professional development. It is essential to have ongoing support through system supported coaching and mentoring experiences. Job embedded support and coaching is critical to successful inclusion. Child care providers, therapists, and teachers also need funds and personnel to cover release time for team meetings, consultations, and on-site coaching.
- The Child Care and Development Fund (CCDF) recommends Inclusion Specialists as members of CCR&R's. This strategy builds upon the Head Start model, which assigns a Disability Coordinator to work with staff in Head Start programs. The Inclusion Specialist serves an invaluable role in providing: educational resources, connections for families to community resources, on-site observations, and strategies for enriching environments. North Dakota uses the Quality Set-Aside to pay for Inclusion Specialists.

INDICATOR 10: EC Personnel Standards, Credentialing, Certification, & Licensure Requirements

State early care and education agencies' personnel standards, certifications, credentialing and licensure requirements include competencies for supporting children with disabilities and their families.

The Illinois State Board of Education approves teacher credentialing, certification, and licensure requirements for teachers working in public school settings. This includes Preschool for All/Preschool Expansion classrooms. In order to offer a professional educator license, the teacher education programs in institutions of higher education in Illinois must align pre-service teacher education course work to the Illinois Professional Teaching Standards (IPTS) as well as to the particular area of licensure being offered to the candidates (e.g., a professional educator license in early childhood education [ECE]). The IPTS, the ECE professional licensure standards, and the Early Childhood Special Educator (ECSE) Letter of Approval standards all include competencies for supporting children with disabilities and their families.

The Gateways to Opportunity Illinois Professional Development System ECE Credential (Levels 2-5) also include competencies that align to the [Division for Early Childhood of the Council for Exceptional Children \(DEC\) Initial Personnel Standards and Specialty Set](#).

The [Early Intervention Developmental Therapist credential](#) is administered to individuals with a Bachelor's degree who have completed a series of college level courses focused on early intervention/early childhood special education.

The Inclusion Summit (2017) addressed licensing and personnel preparation topics. The Illinois Council on Developmental Disabilities (ICDD) provided funding for a landscape study, a review of competencies that align with high-quality inclusion and a series of meetings to bring stakeholders together to address issues of licensing, training and teacher preparation in Illinois.

Recommendation:

- Currently there is a shortage of licensed professionals working in EI and early childhood special education (ECSE). Opportunities should be provided for loan forgiveness and monetary incentives to attract more individuals to work in this field.
- In order to provide coaching and itinerant early childhood special services throughout the state there needs to be an increase in the number of highly qualified EI and ECSE especially in rural areas of the state. Higher education providers can look to apply for special federal personnel training grants that focus on preparing practitioners to work in EI/ECSE in order to increase the number of highly qualified professionals working in the field. Federal personnel training grants provide tuition waivers and may provide resources to cover other education and training expenses.

INDICATOR 11: Preservice Education and Personnel Preparation

Institutes of Higher Education require specific courses and practicum experiences that prepare early care and education personnel to implement effective inclusive practices to engage children with disabilities and their families.

Institutes of higher education in Illinois offer specific courses and practicum experiences that prepare early care and education personnel to work with young children with disabilities and their families. A challenge for faculty in higher education is finding high-quality inclusive early childhood programs where pre-service teachers and therapists can complete their practicum and student teaching experiences.

A recent landscape analysis of early childhood teacher preparation in two and four year colleges in Illinois highlights the confusing and difficult pathways that pre-service teachers must navigate in order to become licensed to work in EI and ECSE settings around the state.

Recommendation:

- Provide early care and education programs with the necessary funding for supports and services to ensure high-quality inclusion. The more inclusive programs demonstrating high-quality environments for children with disabilities, the easier it will be for institutes of higher education to form partnerships where pre-service teachers can complete their practicum experiences in appropriate settings.
- Faculty in higher education pre-service early childhood teacher education programs should promote high quality inclusion in the early care and education settings where they place students for practicum experiences.
- Faculty in pre-service educator preparation programs should continue working together to ensure that early childhood teacher preparation plans (i.e., course work and practica) in Illinois two and four year institutions embed the attitudes, knowledge and skills that new teachers need to successfully meet the individual development and learning needs of each child in their care.

INDICATOR 12: Public Awareness

State early care and education agencies implement ongoing public awareness strategies regarding the legal foundations and benefits of inclusion that target a variety of audiences, including families.

Illinois stakeholders have provided public awareness through exhibits at conferences, meetings, online trainings through the two state Parent Information and Training Centers, Equip for Equality, The Autism Program, STAR NET, the Early Intervention Training Program, Early

CHOICES, the Early Intervention Clearinghouse, the Illinois Early Learning Project, and the Illinois State Board of Education Division for Early Childhood.

We have no or limited outreach to families, home visitors and early intervention providers to specifically help them understand inclusion. *Natural Partners* is an Early Intervention training that works to build the bridge between EI providers and community child care providers. IDHS and ISBE offer some outreach through transition from EI to EC [When I am 3 Where Will I Be](#) and an online module [Understanding LRE](#). A survey by Maternal, Infant and Early Childhood Home Visiting (MIECHV) showed that families, and home visitors don't always understand what exactly is meant by inclusion and are not sure how to implement recommended practices in inclusion.

Recommendation:

- Increase efforts to support families and providers at the very first opportunity to understand inclusion. Targeted ongoing public awareness to families and providers starting at birth across the system that supports families of young children.
- Reach out to all sectors and create small, accessible learning objects that highlight the benefits of inclusion.
- Engage in outreach/public awareness about the legal foundations and benefits of inclusion through non-traditional networks (e.g., public library play groups; informal parenting groups; home visiting programs). The other PDG B-5 Activity includes creating a public awareness campaign about the benefits of inclusion. This campaign will target audiences (e.g., families, agency staff school district personnel, parent support groups) through social media, on-line family groups, written materials in public libraries, playgroups, camps, recreation programs and other entities who serve families of young children. (See indicator #3 above.)
- Reach out and provide resources about inclusion to all lead agencies that serve young children in Illinois (e.g., DCFS, IDHFS, OECED, IBHE, Illinois Guardianship and Advocacy, DSCC, etc.).

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PDG B-5 Strategic Plan Outline

Inclusion of Young Children with Disabilities in Early Care and Education Settings

1. Description of Strategic Planning Process

The strategic planning process took place over multiple meetings and a review of recent reports and recommendations from federal agencies and national organizations that focus on the inclusion of young children with disabilities in community-based early care and education settings. Also, there are many Illinois needs assessments, projects, recommendations and reports used to compile these recommendations. Please note the reference list at the end of this document.

2. State Vision

Illinois commits to the inclusion of each and every child with special needs with typically developing peers in all early childhood environments.

This vision statement is an outcome of the 2017 Early Childhood Inclusion Policy Summit attended by key policy makers and program leaders from across the state. The Summit brought together private and public policy leaders across Illinois, with the express aim of applying the US Department of Health and Human Services and the US Department of Education's Joint Policy Statement on Inclusion of Children with Disabilities in Early Childhood Programs, to advance policies and practices across the state that support inclusion as part of all high quality early learning environments.

The result of this summit was to create the vision statement and use it to assure that future policy decisions would promote the inclusion of young children with disabilities in high quality early care and education settings with appropriate supports and services for each individual child.

Key policy makers and program leaders from across Illinois, a) The Illinois Department of Children and Family Service (DCFS), b) Early CHOICES, c) the Illinois State Board of Education (ISBE), d) the Governor's Office of Early Childhood Development

(GOECD), and e) the Illinois Head Start Association (IHSA) developed and promote the [Illinois Early Childhood Inclusion Vision Statement](#).

3. State Mission

Our state's mission is to promote these Guiding Principles:

Increase Equitable Opportunity: Inclusion of children with special needs is a priority in decision making about program design and resource allocation in order to ensure equitable access and full participation in all early childhood environments.

Partner with Families: We ensure the meaningful and supported engagement of families in policy/ guidance decisions, planning, and evaluation of programs, as well as in Individualized Family Service Plan, Individualized Education Program, transition and other family/professional meetings.

Share Benefits of Inclusion: We recognize and intentionally raise public awareness of the well-researched benefits for all children of high-quality inclusion in all early childhood settings.

Build and Support a Competent Workforce: All professionals who work with children should have the knowledge, competencies and supports to implement evidence-based practices. We deliberately shift policy to support elements critical to this effort: appropriate professional standards, embedded professional development, culturally and linguistically responsive practices, positive attitudes and beliefs about inclusion, and knowledge of disabilities.

Unified Purpose: We intentionally and strategically engage in formal collaboration across agencies to make significant progress toward high quality inclusion across early childhood settings.

Set Goals and Track Data: Across agencies we set concrete goals for expanding access to inclusive and high quality early learning opportunities, including a base line number of children with and without disabilities in all early childhood settings, and benchmarks that track progress toward the goal.

4. Stakeholder Members

Stakeholders include families of young children with disabilities, early care and education providers, leaders within Illinois early childhood organizations, agencies, advocacy groups, and early intervention. Several face-to-face and online meetings took place to advise Early CHOICES staff regarding the development of this strategic plan. The names, affiliations, and committee memberships may be found on pages 9-10.

5. Goals/Objectives/Action Steps

Goal 1: Increase clear, targeted outreach to families of young children with disabilities and those who serve them about what inclusion is, why it is important, and their child's right to receive special education services in the least restrictive environment (IDEA, 2004).

Objective: 1a.) Use existing resources (web page, electronic newsletter, and social media) to create a consistent message about inclusion of young children with disabilities across various early care and education systems (e.g., Early Intervention, home visiting, community based organizations (CBOs), Head Start programs, Preschool for All Programs, etc.). Information must reach all sectors and be in small accessible learning objects.

Objective: 1b.) Disseminate information to families of young children with disabilities about existing educational and social settings available to them in their community where inclusive opportunities are provided for their children. This should occur at the very first opportunity to understand inclusion.

Objective: 1c.) Disseminate information about inclusion to early care and education providers with access to families of young children (e. g., home visitors, Early Head Start providers, health care providers, therapists, child care directors, etc.).

Action Steps:

- Provide information about inclusion in multiple languages that is understood by multiple audiences (e.g., families, child care providers, translators).
- Participate in outreach events/activities (i.e., exhibits at local interagency fairs, Child Care Resource Service meetings, Head Start Professional Development Conference, regional AEYC meetings, etc.) for professionals working across various early care and education systems regarding the importance of inclusive opportunities for young children with disabilities.
- Create and share examples of outstanding practices in inclusion. Include a variety of settings (e.g., family child care, center-based care, etc.). These examples could be shared at family events, conferences, workshops, and agency fairs.
- Update and share out new *Understanding LRE* online module. This is underway and will have a new title and focus towards families and EI providers.

Goal 2: Increase tangible supports to CBOs to increase the number of high-quality early care and education settings that all families may access for their child with a disability.

Objective: 2a.) Expand access to enhanced public funding to more programs serving young children with disabilities to improve services and access to high quality inclusive child care.

Objective: 2b.) Increase child care capacity to provide high-quality inclusive child care through technical assistance (TA) and professional development (PD).

Objective: 2c.) Revise quality standards related to inclusion within ExceleRate.

Objective: 2d.) Increase funding to ensure high quality structures are in place that support inclusion.

Action Steps:

- Increase the number of Early CHOICES staff to provide professional development and technical assistance across the mixed delivery service model including childcare and public and private preschools.
- Make available inclusion training and technical assistance through expanding the number of Early CHOICES staff. Early CHOICES staff would promote best practices across systems with an interdisciplinary team of support supervised under one professional development provider.
- Provide information and coaching to support early care and education providers concerning the recently enacted IL policies around the suspension and expulsion of young children enrolled in child care settings.
- Early CHOICES staff provides expanded ongoing job embedded coaching to child care providers throughout the state in order to increase collaboration and efficiency for service delivery (e.g. speech/language therapy, occupational therapy, etc.).
- Early CHOICES staff will collaborate with other state early care and education leaders to revise the quality standards related to inclusion within ExceleRate.

- Early CHOICES staff will work with state early care and education leaders to promote enhanced funding to ensure high quality structures are in place in programs that enroll young children with disabilities.

Goal 3: Provide guidance, incentives, and accountability to support Local Education Agencies (LEAs) to ensure that special services are provided to young children with disabilities within the mixed delivery service model.

Objective: 3a.) Create and implement guidance with administrators of LEAs and CBOs, Head Start directors, EI professionals and families to provide inclusive opportunities for serving young children with disabilities across the state.

Objective 3b.) Elevate models of successful collaboration between LEAs, Early Intervention providers and CBOs to serve children with disabilities with supports and services within CBOs

Objective: 3c.) State leaders (ISBE, DHS) will assure that state rules and regulations are in place to allow LEAs flexibility to provide services and supports and CBOs flexibility to collaborate with LEAs.

Action Steps:

- Identify regions in the state where opportunities for creating models of cross agency service delivery would be accepted. These may be identified through ISBE staff, Child Care Resource Services staff, Head Start, etc.
- Create a task force that includes all stakeholders to advise guidance and problem solve issues of boundaries, transportation and support services availability.
- Provide incentives to regions to build community-based networks for supporting inclusive services for young children. Invite members of networks in other regions (AoK Network, Partner, Plan, Act) to serve as mentors for new networks.

Goal 4: Provide guidance, incentives, and accountability to support Early Early Intervention to ensure that special services are provided to infants and toddlers with disabilities within the mixed delivery service model.

Objective: 4a.) Build infrastructure to support EI providers and early care and education providers (Prevention Initiative, Early Head Start, child care) to provide services with the intent of maximizing inclusive opportunities for infants and toddlers with disabilities and their families.

Objective: 4b.) State leaders (ISBE, DHS) will continue to expand the Natural Partners work to build communication and models across EI and community based organizations (CBOs).

Action Steps:

- Identify regions in the state where opportunities for creating models of cross agency service delivery would be accepted. These may be identified through Child and Family Connections staff, Child Care Resource Services staff, Early Head Start, Prevention Initiative programs, etc.
- Provide incentives to regions to build community-based networks for supporting inclusive services for infants and toddlers. Invite members of Natural Partners in other regions to serve as mentors for new networks.

Progress Indicators

Increase in number of Early CHOICES staff providing consultation and coaching to support high quality early care and education for young children with disabilities.

Increase in online information and print materials about high quality inclusion that are available in multiple languages.

Increased number of contacts and dissemination of materials explaining high quality inclusion to families of infants/toddlers and preschoolers with disabilities.

Increased contacts and dissemination of materials to providers and leaders of early care and education settings regarding high quality inclusion for young children with disabilities.

Increase in the number of infants and toddlers with disabilities served in natural environments (e.g., Prevention Initiative, Early Head Start, family child care homes, infant/toddler child care centers, community playgroups, etc.).

Increase in the number of preschool age children (3 to 6 yrs. old) receiving special education supports and services in the least restrictive environments (LRE) (e.g., Preschool for All, Head Start programs, community-based early care and education settings, family child care homes, etc.).

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Inclusion Stakeholders/Committee Members

The following individuals provided expertise and substantive guidance in the development of the goals, objectives, and action steps to address the inclusion of young children with disabilities and their families outlined in the PDG B-5.

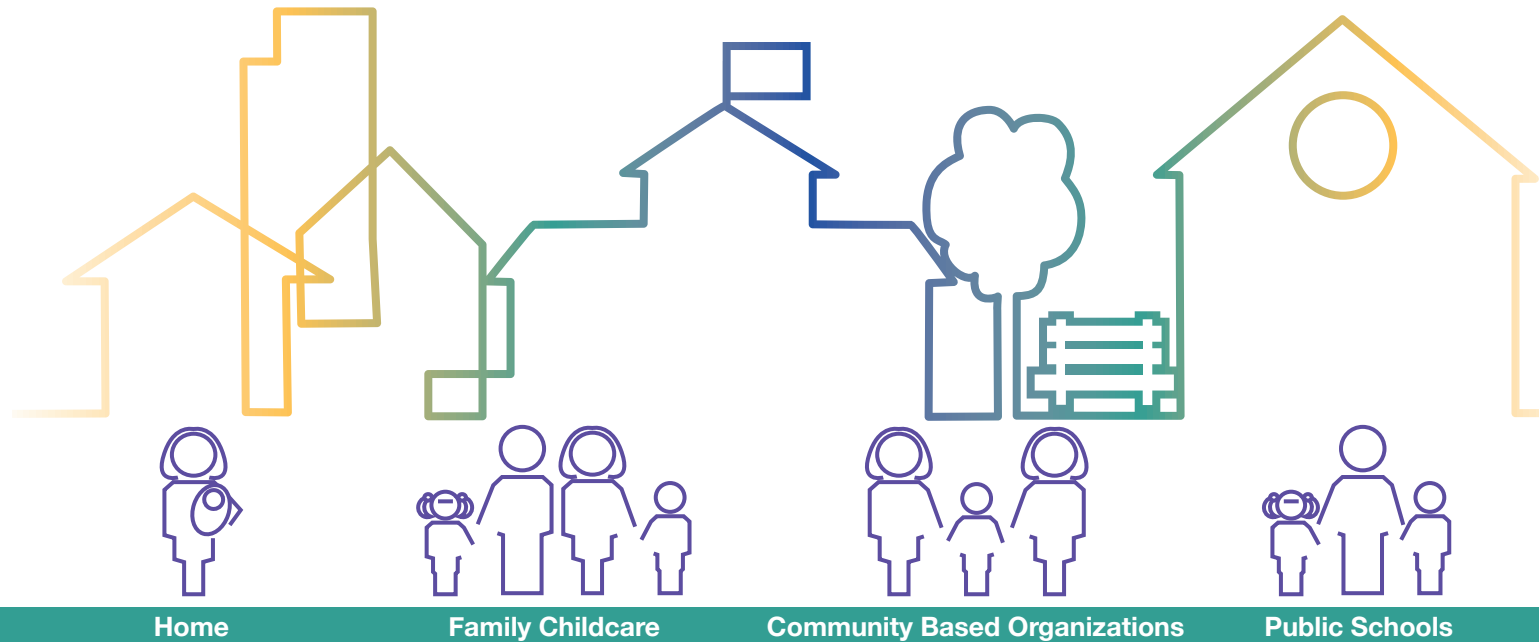
Name/ Organization	PDG B-5 Core Group	Inclusion Committee (IL Early Learning Council)	EC Least Restrictive Environment (EC LRE) Stakeholders
Karen Berman, Ounce of Prevention	X	X	
Vanessa Castro, IL Dept. of Children & Family Services	X		
Kristy Doan, Illinois State Board of Ed (ISBE)	X	X	X
Donna Emmons, Head Start	X	X	
Ann Freiburg, Illinois Dept. of Human Services (IDHS), Early Intervention	X		
Nakisha Hobbs, IDHS Division of Family and Community Services, Child Care	X		
Ann Kremer, Early CHOICES	X	X	X
Lori Orr, Illinois Governor’s Office of Early Childhood Development (IGOECD)	X		X
Emily Ropars, Early CHOICES	X		X
Bernadette Laumann, Consultant	X	X	X
Chelsea Guillen, Illinois Early Intervention Training Program (EITP)		X	
Pam Reising-Rechner Early CHOICES	X		X
Michael Garner-Jones, IDHS, Child Care	X		
Julie Schackman, Early CHOICES			X
Lauri Morrison Frichtl, Head Start		X	X
Joni Strichlow, Illinois Network of Child Care Resource & Referral Agencies (INCCRRA)			X
Beth Knight, INCCRRA			X
Anni Reinking, Southern IL University at Edwardsville (SIUE)			X
Rose Slaght, StarNet			X
Emily Reilly, StarNet			X

Name/ Organization	PDG B-5 Core Group	Inclusion Committee (IL Early Learning Council)	EC Least Restrictive Environment (EC LRE) Stakeholders
Melissa McCollough, East Moline School District			X
Mina Wright, Parent			X
Christopher Wright, Individual with a disability			X
Kathy Slattery, STAR NET			X
Donna Nylander, IGOECD			X
Cori Mohr, Parent			X
Silvia Rodriguez, Parent			X
Evelyn Green, STAR NET			X
Monique Hovinga, STAR NET			X
Penny Smith, ISBE			X
Denise Henry, STAR NET			X
Shannon Cibaro, Mannheim School District 83			X
Lynn Owens, Lake Zurich School District			X
Susan Connor, EITP			X
Sandy Ginther, Community Member			X
Christine Coleman, Collinsville School District			X
Amanda Quesenberry, Illinois State University (ISU)			X
Ernie Cherullo, Cook Co. District 130			X
Antionette Taylor, Early Childhood Professional Learning			X
Colleen Cunningham, DHS			X
Elizabeth Frisbie, Infant EC Mental Health			X
Clare Killey, Aspire			X
Robin Latman, Frankfort School District, 161			X
Kim Nelson, Four Rivers Special Ed Cooperative			X
Connie Schugart, STAR NET			X
Kristy Smiley, Riverbend Head Start			X
Carol Weisheit, IL Association for the Education of Young Children (ILAEYC)			X

INCLUSION IN ILLINOIS Birth to 5 Across Systems

Built on [Illinois Early Childhood Inclusion Vision Statement](#)

Supported by [The U.S. Department of Education and the U.S. Department of Health and Human Services Joint Policy Statement on Inclusion](#), the [NAEYC and DEC Joint Inclusion Statement](#) and the [National Early Childhood Inclusion Indicators Initiative](#).



Early Intervention (EI) Services and Early Childhood Special Education Services through the Local Education Agencies (LEAs) follow the child and family in their community: provided in homes, public schools, community-based organizations (CBOs) and family childcare.

Public Outreach

- Effort to support families and providers at the very first opportunity to understand inclusion
- Must reach all sectors and be in small accessible learning objects
- Use of social media and other strategies to reach across the state

Guidance, incentives and accountability to support LEAs

- Create and implement guidance and models for LEAs to provide specialized services in the LRE which includes child care, Head Start or private preschool
- Assure state rules and regulations are in place to allow LEAs flexibility to provide services and supports

Supports to CBO's to increase access

- Expand access to enhanced public funding to more programs
- Increase child care capacity to provide high-quality inclusive childcare through TA & PD
- Revise quality standards related to inclusion within ExceleRate
- Increase funding to ensure high quality structures are in place

Guidance, incentives and accountability to support EI

- Build infrastructure to support providers to provide services in CBO's with the intent of maximizing inclusive opportunities
- Continue to expand Natural Partners work to build communication and model across EI and CBOs

ExceleRate Illinois Quality Framework with indicators of high-quality inclusion built in throughout each circle of quality.

Illinois Professional Development System Alignment: Recommendations for Next Steps

Sara J. Beach, Consultant

Illinois PD System Alignment: Recommendations for Next Steps

**Submitted by: Sara J. Beach, M.Ed.
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Governor's Office of Early Childhood Development
12/31/19**

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Introduction:

National early childhood experts and organizations (NAEYC, ECPC-CSPD and the Early Childhood Technical Assistance Center) recommend that each state should have a statewide system for in-service professional development and technical assistance in place for early childhood personnel *across disciplines*. It is furthermore recommended that professional development offerings be coordinated across the diverse parts of the early childhood system and delivered collaboratively, as appropriate. In Illinois, we are just beginning on the path to achieving such coordination. Currently the state has several separate, “siloed” systems in place to serve early childhood professionals who work in the different sectors of Early Childhood Care and Education (ECCE), which includes birth to five programs such as preschool, child care, early intervention, mental health, and home visiting. While many of the issues and problems our early childhood care and education system is experiencing come down to inadequate funding levels, efforts can be undertaken to unify the disparate systems, identify strengths from which to build, and better support the most “at risk” parts of the system.

Process and Resources Utilized for this Report:

To develop the recommendations for this report, multiple stakeholders were queried through in-person meetings, phone interviews, emails, and web-based focus groups. A strong sampling of input was elicited to gather recommendations representing multiple different perspectives. A review of previous systems work, informal collaborations that already exist, academic research, and recommendations of National organizations was also undertaken. The voices heard during this process largely have echoed recommendations previously provided by the Mixed Delivery System Ad Hoc Committee, which stated in their 2019 report: (There were three lessons learned from the [other] states that were studied):

- 1) a strong infrastructure and integrated governance structure is needed to effectively implement a Mixed Delivery System;
- 2) intensive support and community-level planning are essential for a successful Mixed Delivery System;
- 3) funding needs to be stable and robust enough to attract and retain a high-quality early childhood workforce.

Individual stakeholder Interviews were undertaken in August, September, and October of 2019. Early in the process of eliciting input and feedback from state professional development (PD) stakeholders and leaders, various Early Learning Council (ELC) committee members as well and other stakeholders from within the ECCE, Head Start, higher education, and early intervention sectors suggested that for organizing the expansive process of identifying key recommendations for alignment of the state’s early childhood PD system, national early childhood professional and research bodies such as NAEYC, UNC Frank Porter Graham Institute’s National Implementation Research Network (NIRN), the Early Childhood Personnel Center (ECPC), and the Early Childhood

Technical Assistance Center (ECTAC) should be resourced for their guiding principles and benchmarks.

The concerns articulated by PD stakeholders for this report were aligned with different quality indicators outlined in the NAEYC resource entitled “Build it Better: Indicators of Progress to Support Integrated Early Childhood Professional Development Systems,” which includes a survey instrument. It is notable that the (Indicators of Progress) “PD System Indicators Survey Instrument” was developed specifically to help state leaders work together to build a better PD system, and was piloted by state teams that included a wide range of potential users and primary stakeholders – including Head Start, state departments of education and special education, state early childhood advisory councils, state higher education system offices, early intervention and early childhood special education agencies, kindergarten through third grade school-age child care, infant/toddler child care and family child care, and affiliates of NAEYC, CEC/DEC, NAFCC, ACCESS, and NAECTE as well as relevant others.

NAEYC has outlined four core principles that should guide policies for creating integrated statewide early childhood professional development systems:

1. Policy must increase professional development *system integration* across early childhood education sectors and settings from birth through age 8.
2. Policy must include *quality assurances* for professional development.
3. Policy must support *workforce diversity* and *equitable access* to professional development.
4. Policy must *increase compensation parity* across early childhood education sectors and settings from birth through age 8.

NAEYC has also identified six essential policy areas where the four above principles should be applied:

1. Professional Standards,
2. Career Pathways
3. Articulation
4. Advisory Structures
5. Data, and
6. Financing

The NAEYC survey instrument allows state teams to measure six indicators of progress (one for each policy area) for each of the four principles identified by NAEYC: for a total of 24 indicators.

An assessment tool created by the Early Childhood Personnel Center was also resourced for its progress indicators. The ECPC works to integrate preservice and in-service learning systems in Early Intervention / other early childhood programs, aligning programs of study to state and national professional organization personnel standards and cross-disciplinary competency areas, and to integrate DEC recommended practices into programs of study. ECPC has outlined a “Comprehensive System of Personnel

Development” for states and has provided an ECPC-CSPD Assessment for statewide strategic planning teams. This assessment tool shares many of the same quality indicators as that provided by NAEYC and was also referenced during the research undertaken for this report.

Focus Group Webinars:

During the month of October, four (1-1/2 hr.) webinar-based focus groups were held in order to collect input, brainstorm solutions, and generate recommendations for our state-wide PD system. Issues that were raised by individuals through interviews were able to be developed more deeply, with more voices to share. Initially, three webinars were scheduled (10/15, 10/17, and 10/21) but because some participants reported difficulties with logging into the call during the second webinar, an additional webinar was added on 10/24/19.

Below is a depiction of the webinar which includes the list of the topics discussed as well as the questions asked during the webinars. The webinars were recorded, and extensive notes were taken to document attendees’ responses. Specific questions about the “why” and the “how” of recreating our system were asked and answered, and there was much agreement as to what the issues are. However, the potential solutions generated were relatively general in nature. All information collected through these webinars was added to the insights collected from the individual interviews.

Issues discussed via webinars:

- Multiple, “siloes” systems for providing and receiving PD in the state.
- Multiple Funding Streams; Confusion over regs; Blending and Braiding funds.
- Lack of Coordination / Collaboration between Systems
- Underutilization of Resources
- Overlap / Duplication of Content (Confusion for Registrants)
- Multiplicity of Training Calendars
- Shortage of Inclusion Training and Supports
- Shortage of Leadership Training and Leadership Support
- Provider Capacity Issues
- Multiple “Coaches” throughout the Illinois PD System (creates confusion and overwhelms programs)
- Lack of Access to Practice-Based Coaching

Questions asked during webinars included:

What can be done to reduce the degrees of “separateness” and “disjointedness” that currently exist?

What recommendations do you have to address the confusion program leaders have in accessing multiple funding streams?

In what ways could Ste PreK, Child Care Center, Family Child Care, Home Visiting, ECMHC, and Head Start / EHS better collaborate?

Are there ways these systems can be better integrated, aligned, or coordinated?

How can collaborations and partnerships be incentivized?

What should be done to better coordinate and share resources that are available within the various sectors of our Early Childhood System?

What should be done to avoid unnecessary, confusing, and costly duplications?

Where and what processes can be combined, integrated, or better connected in order to reduce process duplications?

Is there a need to combine, connect, or better integrate PD calendars and registration systems?

If so, how would it look? Ideas for how this could be done?

How to make sure all ECE programs receive adequate training and ongoing supports around inclusion?

Are there any ways that the number, types, and scopes of the multiple different program coaches in IL could be reduced, combined, integrated, coordinated, connected?

In what ways can we increase the availability of coaching for all early childhood programs, but most especially childcare?

How can we increase availability and access to leadership development?

What is needed in our system in order to ensure that every program is working on parent, family, and community engagement?

Inclusion, Challenging Behaviors, and Leadership are 3 topics that have been identified as needing increased supports. Are there others?

How should the system address shortages and inequities in these areas?

What other issues need to be addressed?

Description of the Issues Most Frequently Articulated by IL Stakeholders:

An unintegrated governance structure for ensuring collaborative, cross-sectored, and equitable professional development: The perception of professional development providers and other stakeholders within the state's early childhood system is that the early childhood professional development systems are currently not part of an integrated system or governmental infrastructure. This was perhaps the most urgent and widespread agreement amongst interviewees. In order to prevent a fractured system from being perpetuated, a commitment to cross-sector collaboration and equity,

policies, decision-making, communications, are coming first from the leaders and policy-drivers at the governance level.

Multiple systems operating in siloes cause confusion for PD recipients: Within the Early Care and Education category of providers, Illinois' child care, public school preschool and 0-3 programming (Prevention Initiative), Early Head Start / Head Start, family friends and neighbors child care (FFN), infant / early childhood mental health, early intervention, and home visiting providers all receive professional development in different places and in different ways based on different sets of funder requirements. This was communicated by multiple stakeholders, who feel this is a situation which tends to confuse providers. Currently there are not definitive communications or linkages between the different sectors to know what the other is needing or doing, which allows for duplications in training topics being provided by multiple entities (with no standardization), as well as missed opportunities for shared training events and cost-sharing. The disparate PD systems each create learning events to meet different sets of objectives, per funders. Still, these major veins are more alike than different; there are many more shared practices and PD needs than there are differences. For example, all of the different ECCE sectors queried have a need to provide training and supports around family engagement, trauma-informed practices, and social-emotional learning. Among the professional development leaders working specifically with preschool, special education, child care, early intervention and Head Start professionals, stakeholders agreed that there is much these sectors could and should be sharing when it comes to professional development. For example, all types of programs reported the need for more leadership training and job-embedded PD supports, especially at the beginning levels (for new site directors, new owners, instructional leaders and teachers).

Unaligned visions and undefined learning outcomes: Because the visions and objectives of the professional development offerings for the multiple sectors are all different and have not been aligned, documentation of participation is different across the venues, and the relative values of different PD events are difficult to compare. Varying, unaligned outcomes send unclear messages to participants and program administrators not only about what participants need, but what they will be gaining from professional development. Furthermore, a disjointed early childhood PD system makes communication and collaborations with practitioners and professionals from other state systems (e.g. child welfare; child and family health) complicated and impractical.

Unclear Career Pathways: There is not one clear career pathway or ladder (across the different sectors) for all early childhood professionals to enter; however, some state leaders / PD stakeholders feel that there should be lattice that is all-inclusive. A career ladder or lattice that includes clearly defined professional roles and titles, clearly designated degree and credentialing requirements for each position, designation of the different settings within which each role may work, and clearly illuminated cross-system steps for advancement does not currently exist.

Multiple tracking systems for credentialing and licensing different early childhood practitioners causes confusion and duplicative recordkeeping. There is confusion amongst teachers and other early childhood practitioners, as well as professional development providers, around earning CEU's, CPDU's, EI credit hours and Gateways credit hours. Family childcare providers and community-based organization birth-5 teachers, as well as Head Start providers and home visiting providers, utilize Gateways for tracking credits. Public school preschool teachers earning or maintaining a Professional Educator's License are required to use the "ELIS" tracking system. EI providers have their system through Provider Connections to work within for compiling their credit hours. The multiplicity of tracking systems creates an unclear, incomplete picture of the totality of training obtained across systems. The new legislation enabling Gateways Level 5 credentialed teachers to qualify as lead teachers in the public school pre-K system, and the previous Race To Top emphasis on bringing public school teachers into the Gateways system have each helped to unify the two systems, but have also increased confusion over where early childhood professionals must record and track their professional development hours. According to some stakeholders, having multiple credentialing bodies necessitates that professional development providers must provide multiple different evaluations and must address more than one set of objectives and guidelines within the professional development activities they provide, creating increased paperwork and complicating the evaluation process for participants.

Disparate Professional Development Offerings Across Multiple Sectors: According to national experts, all sectors within a state's early childhood system should have equal access to evidenced-based professional development practices that incorporate a variety of adult learning strategies, including job-embedded applications such as coaching, reflective supervision, professional learning communities and supportive mentoring. Currently, this is not the case within Illinois. Numerous stakeholders pointed to inequities within our system, which put workers in some parts of the system at a disadvantage: funding levels do not allow for childcare and early intervention professionals to access the training and development support that is needed in order to ensure high levels of quality in their work. For example, Early intervention providers are individual contractors paid for direct service hours; therefore they have little incentive to devote many hours to professional learning. Stakeholders have shared that many independently owned and operated childcare centers, as well as non-profit community-based childcare organizations, lack the systems and infrastructures that would allow them to engage in increased levels of job-embedded professional development. They are understaffed and unable to recruit qualified teachers. The 2017 Illinois Early Childhood Workforce hiring Survey Report reported turnover rates of 42% in preschool childcare classrooms, and 37% in infant-toddler classrooms, as compared to a 21% rate in school-based preschool classrooms. Rather than focusing on expanding the knowledge and skills of their workforce, most independently operated centers have had to adopt a "crisis management" approach in which the main goal is keeping classrooms staffed. Because of the resulting differences in structural quality, independently owned childcare centers have much more difficulty in obtaining or maintaining a Silver or Gold

Circle of Quality (which are necessary to compete for other funding streams such as PFA or PFAE).

Lack of access to job-embedded PD: The field of Implementation Science has generated a large body of research on the use of training and other professional learning strategies for improving teacher performance and student learning. It has been well-documented that training alone is not sufficient for changing teacher and child outcomes (Metz Allison, Bartley Leah, 2012; Darling-Hammond, L., Wei, R. C., Andree, A., Richardson, N., & Orphanos, S.2009; Blasé, K. A., Fixsen, D. L., Naoom, S. F., & Wallace, F., 2005); therefore to be effective at improving quality, professional development *necessarily* must include job-embedded activities such as professional learning communities, coaching, and team lesson planning. However, while stakeholders agree that job-embedded professional development is desirable, they complain that it is not accessible to a majority of programs, regardless of sector. System-wide there is a lack of consistency in funding availability, with stark differences noted by childcare stakeholders regarding the levels of funding (and therefor options) that preschool vs. childcare programs can access. Some stakeholders pointed to disparate and inequitable funding streams as the cause; others stated that childcare programs do have the option to write for PFA/PFAE/PI funding but lack the structural quality that would enable them to do so. Regardless, childcare resource and referral (CCR&R) directors, preschool professional development providers and research experts alike have all indicated that job-embedded options are not affordable to many programs. CCR&R funding is currently inadequate to meet the levels of need in the childcare sector when it comes to providing coaching for teachers or instructional leaders (or in providing supports to leaders to do so within their own programs), whereas school-based preschools do have access to principal consultants, program support specialists, and teacher coaches, for building and sustaining quality. Various stakeholders reported that childcare center, home, and group home providers feel as though they have been set up to fail, or in the very least, they struggle to meet the Silver or Gold levels of quality. Providers across both preschool and childcare sectors want the state to financially support the provision of job-embedded professional development methods, and also to “figure out” how to measure and give credit for these methods. Finally, to keep pace with technology and the workforce, PD providers emphasize that we must invest more time, efforts, attention and funding to the provision of online and web-based options for learning.

Outdated methods and measures: Some highly qualified voices in our state PD system have questioned/criticized our focus on CEU’s, CPDU’s, and credits, suggesting that we (and the field as a whole) need to instead be focusing on developing new, innovative, and alternate pathways to teacher preparation and teacher improvement, in accordance with the latest research around adult learning and teacher transformation (reference: D. Pacchiano, J. Scritchlow interviews). Professional development providers in the state, including both ISBE-funded and childcare related PD providers, with agreement from HV and E-I providers, have stated that more can and should be done to develop new ways for earning teacher and practitioner credentials. More focus should be placed on bridging pre-service and in-service programming, including increasing

partnerships and collaborations between PD and higher-ed providers statewide, as well as supporting the competencies-based frameworks currently in development with the help of the Illinois Network of Child Care Resource and Referral Agencies (INCCRRA) and Illinois' Professional Development Advisory Committee (PDAC).

State PD stakeholders noted an insufficient or lack of system-level coordination of funding; lack of planning, transparency, consistency and cohesion from funding bodies. The Illinois State Board of Education has increased its emphasis on the provision of PFA, PFAE, and PI slots within community-based organizations. However, the majority of CBO's lack the organizational infrastructures necessary for managing the high-level expectations of these grants. Placing these slots within community-based programs that lack the necessary organizational capacities to support them places a significant burden on an already tenuous system. Ironically, the problem of poor structural quality among many independently owned centers and non-profit community-based organizations cannot be addressed unless they are able to take in additional funding beyond parent fees and CCAP dollars. This leaves them stuck on a never-ending cycle of staff turnover, new hiring, basic training, lack of adequate supports, and more turnover. Several providers pointed to the state-issued RFP processes for competing for PFA, PFAE, and PI funds as problematic and prohibitive, an issue that affects not only school-based programs but child care centers, regional offices of education, and Head Start programs as well, since they are all eligible for this funding. What does that have to do with professional development? There is a direct link between the ways funding in which is provided, and the state of the professional development system in Illinois. There are multiple issues, including:

- a) Key players (those with funding decision-making powers) are currently not making cross-sector funding decisions collaboratively. Agreement that cross-sector PD should be prioritized has not previously been a part of the overall system's leadership. Furthermore, there has not previously been any joint commitment to including job-embedded PD costs in child care, early education, home visiting, or early intervention cost-per-child determinations (see discussion below).
- b) (It is a given that different types of PD providers and programs have different requirements to meet, depending on the funder).
- c) Because of staffing levels, only the larger public-school programs and a few heavily funded CBO's have managed to make job-embedded PD workable.
- d) Funding for adequate staffing levels across sectors is key, as is a mechanism for earning credit for non-traditional forms of PD.
- e) Program Support Specialists and Principal Consultants have reported that a majority of community-based programs outside of Chicago do not compete for PFA/PFAE/PI funds primarily because of lack of knowledge how to navigate the system, and secondly timing factors: lack of enough notice, short grant windows and delayed timing of state pay-outs at start-up.
- f) The ability of community-based organizations (CBOs) to secure additional funding would help to increase their organizational quality and set the stage for more expansion through blending and braiding funds. In turn, this would

increase their ability to engage in job-embedded professional development, which is needed to build and sustain and quality. Multiple components of the PD system must therefore be addressed simultaneously: governance; funding; leadership; and quality. Leaving one or more out of the equation will perpetuate a broken and misaligned system.

Illinois' lack of equitable investments in quality across multiple parts of the early childhood system has direct consequences for professional development. Illinois has worked over the past few years to expand the capacity of early childhood slots available in the state: in addition to preschool and childcare, early intervention and home visiting services have been targeted for increases. However, it is shortsighted to provide more care, preschool education, or supports for birth to age 3 without adequately investing in the infrastructures needed to support and sustain them. Systemically, expanding ECCE slots requires also funding the professional development activities that will ensure these services are implemented to quality standards. There is an urgent need (as discussed above) to increase the job-embedded supports provided for new and underqualified teachers fulfilling the lead teacher and 0-3 caregiver positions; however, there are also indirect costs involved with doing so:

- a) The cost of providing *training and supports for leadership* (especially instructional leadership, but also administrative). PFAE-funded programs are required to have an Instructional Leader. However, program support specialists report that many school-based and community-based programs alike do not have a clear understanding of the role of the instructional leader, and/or have not been able to access training specific to instructional leadership, let alone administration of full-day programming. Principals in Pre-k – 5 buildings need training on developmentally-appropriate practices; directors in school-based and community-based programs all need training in administration and inclusive and collaborative leadership, as well as the facilitation of job-embedded professional learning. In addition to training, coaching must be provided to ensure leaders' knowledge transfer into practice.
- b) The cost of covering classrooms with *qualified substitutes* while teachers attend training and participate in coaching and PLCs. High quality, effective PD is dependent first on ensuring adequate staffing levels and the provision of classroom substitutes for teacher release time. Likewise, training and support personnel such as program consultants, coaches and mental health consultants are needed for classroom-based transfer of knowledge to practice.

There is significant supportive research on the benefits of early intervention and home visiting services; however, their effectiveness is dependent upon practitioner quality, which can only be sustained through ongoing professional development. PD providers from multiple branches of our system have emphasized that since we know training alone does not lead to quality improvements, then no one part of our system, nor the system as a whole, should be providing training without funding the additional supports that are needed to make PD a worthwhile investment. When cost-per-child funding allotments do not include the PD supports needed to bolster these services, their quality suffers and the system remains disjointed.

Only a very small percentage of FFN providers actually access the training and quality improvement supports directed to them and of which they are required to participate while receiving CCAP. According to the 2019 Action for Children research brief on investments in FFN providers, wide variations in FFN situations, non-standard working hours, high rates of provider turnover, and declining CCAP participation since the institution of training and monitoring requirements make targeting and recruiting willing FFN participants for training very difficult. Furthermore, most FFN providers are in the age ranges of 18-29 and 50-59, presenting specific age-related challenges and requiring different training options. Finally, FFN providers are a highly diverse group, requiring much flexibility, innovation, and individualization for PD with this specific sector of the system. Sadly, although thousands of children are being cared for by friends and family providers, there have been significant declines over the past several years, and most families who have left the FFN care category have left CCAP altogether. It is clear that FFN providers, who do need support and training, cannot be painted with the same PD brush as the rest of our system. Outreach efforts, training and support must be relationship-based and community level.

Recommendations:

Table 3 corresponds to Table 3 in the AIR Strategic Plan Strawman Outline, and includes the basic recommendations put forth in this report, which are discussed in more detail after the chart.

Table 3

Strategic goal (described in Part 4)	Section A. Identification of activities to leverage policy alignments, program quality, and service delivery	Section B. Identification of activities to improve transitions from ECE to elementary school	Section C. Strategies for improved coordination and collaboration among ECE PD providers	Indicator data
<p><i>Coordinate supports for community collaborations and providers:</i></p> <p><i>Develop a cohesive, collaborative approach to providing systematic statewide T&TA to</i></p>	<p>Develop policies that support job-embedded professional development activities, such as including JEPD costs in funding formula for child care, early education, and 0-3 slots.</p> <p>The IAT should include Professional Development as a key component of the work addressed by the Inter Agency Team</p> <p>IAT should create (or</p>	<p>Support high-quality, job-embedded professional development for all early childhood practitioners, regardless of program type.</p>	<p>Create an inclusive, comprehensive, cross-sector state-level forum (statewide PD website) (*specifications listed in body of the report)</p> <p>Create and distribute infographic and other print materials that outline, crosswalk, and explain the various parts of the early</p>	<p>NAEYC “Build it Better” PD System Indicator Survey Instrument (24 indicators) measuring:</p> <ol style="list-style-type: none"> 1. Professional Standards, 2. Career Pathways 3. Articulation 4. Advisory Structures 5. Data, and 6. Financing

<p><i>communities and community providers</i></p> <p><i>Shift the access to ECCE professional development (PD)</i></p>	<p>designate) a CSECPD (Cross-Sector Early Childhood Professional Development) Leadership Team (possibly PDAC)</p> <p>The CSECPD Leadership Team (or PDAC) should further develop a multi-year (with timetable and benchmarks) implementation plan to address all cross-sector PD activities</p> <p>CSECPD Team should:</p> <ul style="list-style-type: none"> • Create CSECPD<->Stakeholder feedback loops • Conduct formative and summative evaluations to monitor implementation and effectiveness of the activities of the CSECPD plan; • Use the NAEYC “Build it Better” PD System Indicators Survey Instrument to assess the state’s current levels of PD systems integration, across 24 quality indicators in the following six policy areas: <ol style="list-style-type: none"> 1. Professional Standards, 2. Career Pathways 3. Articulation 4. Advisory Structures 5. Data, and 6. Financing • Also utilize CECPC-CSPD Assessment (an E-I instrument) as appropriate <p>IAT should plan for and ensure that funding and resources are available to sustain the implementation of</p>		<p>childhood professional development system and how they relate to one another</p> <p>Include infographic and information on from print materials on the statewide PD forum (website)</p>	<p>ECPC-CSPD Assessment (Early Childhood Personnel Center) instrument measuring:</p> <ol style="list-style-type: none"> 1. Leadership, Coordination and Sustainability 2. State Personnel Standards 3. Pre-Service Personnel Development 4. In-Service Personnel Development 5. Recruitment and Retention 6. Evaluation
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	the cross-sector early childhood professional development plan.			
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Recommendations: Following are key recommendations developed throughout the process of collecting stakeholder input. These recommendations have been aligned to the progress indicators defined above, and have been included in the Implementation Plan, which is found in Appendix B. This Implementation Plan is not prescriptive; rather it contains recommended steps based on this report. Furthermore, specific timelines have not been firmly established within the Implementation Plan; an IAT-designated, cross-sector early childhood professional development team should make these determinations in conjunction with the IAT.

Recommendation #1a): Ensure that cross-sector collaboration and equitable planning takes place at the governance level first, by including Professional Development as a key component of the work addressed by the Early Childhood Interagency Team (IAT) Inter Agency Team. The IAT has the authority and responsibility to influence not only policies and procedures, but also funding decisions within their respective departments. The goal of including professional development as a high priority within the IAT is that this high-level governing body with unified vision, mission, and objectives will ensure that the highest levels of leadership are responsible for governance and for leading their departments in the implementation of unifying, cross-sector PD initiatives across ECCE. The Governor’s Office of Early Childhood Development, The Illinois State Board of Education, the Illinois Department of Human Services, Illinois Department of Health, Department of Children and Family Services, and the Illinois Head Start Association must all agree upon the goals, objectives, expectations, and funding commitments for creating a unified, cross-sector professional development system. This will require the IAT to set the vision and then be actively communicating within IAT members’ respective offices, so that funding decisions and administrative accountability follow and support the vision.

1b): The IAT should ensure that:

- The IAT establishes a vision, mission, and purpose specifically for cross-sector professional development (aligned with the overall early childhood system), makes decisions and implements processes that reflect these.
- Input is solicited from key partners from cross-sector early childhood systems, technical assistance programs, institutions of higher education, parent organizations and any other relevant stakeholders across disciplines.
- Additional stakeholder input, including from families, is actively solicited and considered by the IAT in setting priorities and determining governing decisions.
- The IAT advocates for and identifies resources for cross-sector priorities and activities; and
- The IAT disseminates information on the early childhood professional development plan to relevant public and private audiences.

- Plans for and ensures that funding and resources are available to sustain the implementation of the CSECPD plan (discussed in Recommendations 2a and 2b, below).

(Above bullet pts. were based on input from stakeholders and the progress indicators from the NAEYC PD System Survey Instrument)

Recommendation #2a): The IAT should create or designate a CSECPD (Cross-Sector Early Childhood Professional Development) Leadership Team -- such as the Professional Development Advisory Council (PDAC) to work on cross-sector alignment activities. The task force should include representation from:

- a. the state childcare agency, Head Start Collaboration Office, and state early education specialists in the Department of Education;
- b. the state Early Childhood Advisory Council and other committees focused on early childhood professional development as relevant in the state: members of the ELC;
- c. the state higher education system office, early childhood teacher certification office, and early childhood faculty consortia as relevant in the state;
- d. early intervention/early childhood special education agencies;
- e. school-age childcare through third grade, infant/toddler child care, and family child care, and those tasked with outreach and training for FFN providers.
- f. state affiliates of national early childhood professional associations including NAEYC, the Council for Exceptional Children Division of Early Childhood (CEC/ DEC), the National Association for Family Child Care (NAFCC), ACCESS (the national association of early childhood faculty in associate degree granting institutions), the National Association of Early Childhood Teacher Educators (NAECTE), and
- g. others as relevant in the state.

2b): The IAT Leadership Team should work closely with this task force or designated body to ensure that this team:

- Utilizes NAEYC’s “Build it Better: Indicators of Progress” (March 2016) Survey Instrument to assesses the state’s status on each of the 24 progress indicators;
- Uses the indicators of progress to develop a detailed, multi-year implementation plan (with timeline and benchmarks) for cross-sector professional development system building;
- Ensures that the cross-sector early childhood professional development implementation plan is aligned with and informed by stakeholder input, national and professional organization PD standards, state requirements, and the vision, mission, and purpose of the cross-sector early childhood development systems involved in the cross-sector early childhood professional development plan.
- Ensures policy-practice feedback loops: Articulating a process for two-way communication between stakeholders and the Leadership Team (Task Force) for

- soliciting input and sharing information on the implementation of activities (following the Plan-Do-Study-Act cycle);
- Includes strategies for engaging in ongoing formative and summative evaluation of the activities (as part of the Plan-Do-Study-Act cycle);
- Monitors both the implementation and effectiveness of the activities of the cross-section early childhood professional development plan, and ensures practice experiences are being fed back to the policy level to inform decision-making and continuous improvement (Bartley, 2012)

Recommendation #3): The IAT Professional Development Task Force or designated body should work to create and distribute print materials that outline and explain the various parts of the early childhood professional development system and how they relate to one another. Professional Development providers and leaders who participated in the information gathering sessions felt that an easy “first step” would be the creation of crosswalk or an "infographic" that promotes a shared vocabulary across sectors. Print materials would show the different sectors of early childhood programming and types of professional development providers in the state, where different types of early childhood professionals can go for professional development, the different credentials or credits offered by each, and who is eligible to attend, so that ECCE professionals can not only understand but know how to access the appropriate PD opportunities. This infographic or other print materials would also help professionals from other disciplines such as child welfare or early intervention to understand and work more cohesively with the early childhood education system.

Recommendation #4): Create an inclusive, comprehensive, cross-sector state-level forum (statewide PD website) Multiple focus group participants suggested that beyond print materials, what is also needed is an inclusive and comprehensive statewide-level forum (which could perhaps be a website), a “one-stop shop” for PD information that includes:

- A clear and explicit definition of Professional Development, its key components, and the state of Illinois’ vision for how it fits within the overall early childhood system, including:
 - a statement of statewide adoption of the “Learning Forward” definition of Professional Development, and identification of the key components all professional development offerings (regardless of sector) must aspire to;
 - an explanation of how Illinois’ system of professional development is supportive of the state’s PDG B-5 vision;
 - a strong emphasis on reflective practices, with examples, protocols, tools, and links to reflective practice resources
 - explicit and aligned (coordinated between ISBE, ILHSA, DHS, DCFS, ECMHC body, HV, and meant for ALL ECCE professionals) objectives and outcomes statements, supporting:
 - continuous quality improvements;

- inclusive and culturally responsive practices throughout our system;
 - reduction and elimination of implicit bias, suspension and expulsion;
 - job-embedded, collaborative learning
- Terms and definitions of ECCE professional positions: descriptions of the ECCE positions and settings individuals may qualify for;
- Explanations of the various types of credentials, certificates, licenses, and degrees; links to credentialing and licensing bodies; listings of IL higher education programs with related degrees;
- Descriptions and links to the career ladders and different pathways: including a transparent depiction of the “stages” of teacher, practitioner, and leader development;
- For those providers who do not see ECCE as a profession but rather a temporary FFN support to families, links to FFN-friendly pages with simple and accessible information, so that they can easily find the information that applies to them, as well as options for career pathways when desired. Information about benefits and incentives for participating in training / monitoring.
- Descriptions and links to Professional Development providers serving different parts of the system;
- Links to training calendars for multiple providers; ability to search entire calendar across sectors;
- Information about individual professional development planning, along with sample individual professional development plans.
- Information (for program leaders of all types) about program self-assessment, CQIP creation in conjunction with IPDPs, along with simple and explicit explanations of data-based decision-making and the Plan-Do-Study CQI process.

Recommendation #5: The IAT’s future state policies and funding initiatives should emphasize and support high-quality, job-embedded professional development for all early childhood practitioners, regardless of program type. As a state and across sectors, Illinois should develop and implement initiatives that provide equitable access and resources for ECCE providers to engage in collaborative, job-embedded professional development. This should include Practice-Based Coaching whenever possible. Future funding must support this focus. “Job-embedded” may look differently for different types of providers (most especially, FFN providers, who need more flexible and more individualized, family-oriented, and different incentives to participate) in order to take advantage. Stakeholders emphasized the need for coaching to be accessible to all ECCE practitioners. These efforts will require emphasizing the role of job-embedded professional development facilitator and/or instructional coaches; and as such it means that leaders across sectors will need training and supports in whole leadership and specifically their role as pedagogical leaders, as they oversee instructional coaches and in many cases are the providers of job-embedded professional development.

Recommendation #6: Support efforts to develop new, alternative, and innovative ways for teachers to become qualified and for friend, family, and neighbor providers to be reached. Include higher-ed and Department of Public Health leaders/decision-makers in IAT and/or the task force designated by IAT for developing cross-sector PD solutions. More focus should be placed on bridging pre-service and in-service programming (increasing partnerships and collaborations between PD and higher-ed providers statewide), including but not limited to support for the competencies-based frameworks currently in development with PDAC’s leadership. Additionally, because research is clear that training alone is not effective, professional development *must* include job-embedded activities such as PLCs, coaching, COPs; therefore the state should support efforts around determining how to measure and credit these methods. To keep pace with technology and the workforce, invest more time, efforts, attention and funding in the provision of online and web-based options for learning.

Recommendation #7: Further Development of a multi-year Implementation Plan for Cross-Sector Professional Development. The Implementation Plan in Appendix B for this report is a starting point. It includes the recommendations from this report, and several of the beginning level progress indicators outlined in NAEYC’s Build it Better: PD System Survey Instrument. The Cross-Sector Early Childhood Professional Development Leadership Team should develop a multi-year implementation plan with timelines and benchmarks, including:

- Plans for addressing all 24 indicators of progress outlined in the NAEYC “Build it Better: PD System Alignment Survey Instrument.”
- Ensuring that the cross-section early childhood professional development plan is aligned with and informed by stakeholder input, NAEYC PD indicators/standards, state requirements, and the vision, mission, and purpose of the cross-sector early childhood development systems involved in the CSECPD;
- Articulating a process for two-way communication between stakeholders and the leadership team for soliciting input and sharing information on the implementation of activities;
- Including strategies for engaging in ongoing formative and summative evaluation of the activities;
- Monitoring both implementation and effectiveness of the activities of the CSECPD plan
- Regular feedback to, and guidance from, the IAT.

Conclusion:

Illinois has entered an exciting and hopeful time of great opportunities for the development of a unified early childhood system. Many of the issues and problems our ECCE system has experienced over recent years have been due to inadequate funding levels and the lack of structures in place for coordinating diverse parts of the system so that professional development could be a collaborative effort across sectors. But now is a time of great promise, with increased commitments to not only funding but to equity, collaboration, and finding the best cross-sector solutions. Aligning its vision and

governance with the national early childhood leaders and organizations, continuing to elicit and respond to the voices of providers and families in the communities, and utilizing the latest research to guide its innovations and implementation will help the state to be successful. Illinois can be proud of not only its vision but the new levels of commitment toward unifying and transforming this unique system, for the benefit of all its children and families.

Appendix A: References

Appendix B: Implementation Plan

The project described was supported by the Preschool Development Grant Birth through Five Initiative (PDG B-5), Grant Number 90TP0001-01-00, from the Office of Child Care, Administration for Children and Families, U.S. Department of Health and Human Services. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Office of Child Care, the Administration for Children and Families, or the U.S. Department of Health and Human Services.

Appendix A: References

Individual Stakeholder Interviews:

Interview Date	Names	Organizations
8.14.19	Beth Knight	INCCRRA
9.15.19	Joni Scritchlow	INCCRRA
9.26.19	Carries Bires	OPF
9.05.19	Cindy Berrey	The Center - ECPL
10.31.19	J Weiner, M Hawley, D Pacchiano	OPF
9.05.19	Karen McCarthy	ISBE
8.22.19	Kathy Villano	The Center - ECPL
10.1.19	Linda Langosh	Head Start
10.9.19	Lynne Burgett	The Center = ECPL
10.23.19	Susan Connors	IL State University
8.16.19	Tom Layman	OECD
10..5.19	Teri Talan	McCormick Center
	Lauri Morrison -Frichtl	ILHSA
	Carol Weisheit	IL AEYC
	Jill Bella	McCormick Center
	Barbara Volpe	McCormick Center

Focus Group Webinars:

10/15/19 Webinar Participants

Facilitator: Sara Beach, Independent Cons. – OECD / Synapse Early Learning Systems

Marsha Hawley- OPF

Cindy Berrey – The Center

Joni Scritchlow – INCCRRA

Matt Sulzen – OPF (H.V.)

Lori Rhoades (higher-ed)

Emily Ropars - CHOICES

Jackie Hansen- Synapse Early Learning

10/17/19 Webinar Participants

Facilitator: Sara Beach, Independent Cons. – OECD / Synapse ELS

Pandora Taylor – Indep Cons.

Ann Kremer - CHOICES

Kayla (CCRR Springfield)

Missy Brown (CCRR So. IL)

Kathy Villano – The Center - ECPL

Lynne Burgett – The Center ECPL
Stephanie Whitt
Jackie Hansen- Synapse Early Learning
Karen McCarthy - ISBE
Kathy Slattery - Starnet
Lauren Riley - OPF
Marcy Mendenhall - CBO

10/21/19 Webinar Participants

Facilitator: Sara Beach, Independent Cons. – OECD / Synapse ELS
Cindy Berrey (The Center – ECPL)
Danette Connors (YW Metro Chicago)
Susan Connor – IL State (E-I)
Sandy Young – Indep. Cons.
Tranae – CCRR&R Mt. Vernon
Heidi =CHASI Granite City
Elaine Rodgers -
Brenda Eastham – CCRR
Denise Henry - Starnet
Jackie Hansen- Synapse Early Learning

10/24/19 Webinar Participants

Facilitator: Sara Beach, Independent Cons. – OECD / Synapse ELS
Marlene Christ - Starnet
Rebecca Livengood - INCCRRA
Toni Porter - INCCRRA
Cindy Wall - INCCRRA
Teri Talan -McCormick Center for EC Leadership
Emily Ropars - CHOICES
Jackie Hansen- Synapse Early Learning

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BUILD Initiative

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Systems Building:

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System Guides: Child Care TA

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Kindergarten Transition

FaKelia Guyton and Jaclyn Vasquez, DuPage Early Childhood Collaboration

Implementation Plan

Feasibility Rubric

Feasibility Rating Sheet

Bensenville Kindergarten Transitions Planning Team Implementation Plan

Bensenville Kindergarten Transitions Planning Team Implementation Plan: Identified recommendations that will be piloted in Bensenville SD2 and Bensenville Early Learning Services Collaboration Prepared by: DuPage KTAC Planning Team					
KTAC Recommendation	Starting Date	Ending Date	Cost	Person Responsible	Remarks
2) Receive information about the kindergarten transition from ECE providers, early childhood collaboratives, local school districts, and kindergarten transition collaboration groups.	Planning: Build Job Description in Jan/February Hiring Process: Spring 2020 Hire: latest Fall 2020	One Time	Part- Time to Full Time Position funding	Project Manager of Bensenville Early Learning Services (BELS) Collaboration	In order to enhance parent education and communication to parents, the group discussed the possibility of coordinated efforts. <u>A Parent/Family Coordinator</u> could serve as a liaison between entities and help to align efforts The role of the coordinator would include leading the child find, parent education and communication efforts, lead identified transition workgroups for all PreK and K teacher.
3.) Are actively engaged by ECE teachers and administrators to establish relationships prior to and throughout the transition. AND 24.) Have the opportunity to participate in local transition workgroups involving parents,	Plan for 2020/2021: Kick-off for January 2021.	Ongoing	Costs would include protected TIME to collaborate and Additional Sub/Stipends to engage in transition conversations for both K and PreK.	Parent/Family Coordinator	<u>These three recommendations ultimately have the same request.</u> Teachers explained that they do engage PreK educators in their buildings throughout the year, but are not engaged with programs from feeder schools (private childcare etc.) Teachers also identified that they do not participate in outside transitions work groups involving parents, educators and the community collaboration.

Bensenville Kindergarten Transitions Planning Team Implementation Plan

<p>educators, and community collaborations to develop a local plan for a successful kindergarten transition. AND 28.) Participate, during protected release time and with adequate substitute teachers available, in aligned professional development for ECE and kindergarten educators and administrators.</p>					<p>They also identified the desire to align PD, possibly in a Professional Learning Community (PLC) around the same foundational practices (SEL, Trauma, etc.)</p> <p>The Bensenville Team has identified that they would like to begin to connect and invite Private schools to engage in conversations.</p> <p>In forming a transitions workgroup, they could involve PreK and K educators and the Collaboration.</p>
<p>7) Participate in bridge programs (especially for those children with limited ECE experience) hosted by educators and supported by community organizations. AND 35) Offer summer boost programming to reduce summer learning loss and allow children and families to become familiar with schools and staff.</p>	<p>Planning: January 2020</p> <p>Implementation: Summer 2020</p>	<p>Yearly</p>	<p>The cost would need to include added days, children, food, supplies, and staff.</p>	<p>As indicated previously, it was suggested to increase the number of Kindergarten Round Up days and to extend our catchment to children that did not participate in an EC program.</p>	<p>It was discussed that the community currently engages in Kindergarten Roundup. Currently Kindergarten Roundup is three, 2-hour days, for currently registered preschool children in the middle of the summer.</p> <p>The recommendations were to add more days in order to intentionally reach out to all providers and identify children that have not had PreK experience.</p> <p>The PreK-K team recommended to increase the day from its current two hour window to a full day. Additionally, it was suggested to change Kindergarten Roundup to last 2-3 weeks prior to the start of the school year.</p>

Bensenville Kindergarten Transitions Planning Team Implementation Plan

					<p>There was perspective that this would have high impact if we had intensive outreach to our parents regarding the times, dates and purpose of round up. It is important to underscore that parents would be able to meet teachers.</p> <p>As indicated previously, it was suggested to increase the number of Kindergarten Round Up days and to extend our catchment to children that did not participate in an EC program.</p>
<p>8.) Participate in teacher-led workshops and small group therapy that focuses on social emotional development and mental health consultation.</p>	<p>Plan for 2020/2021</p> <p>Transition Work Group to identify partners in spring 2020</p>	Ongoing	Workshop costs	<p>BELS Collaboration: Partner with Social Workers and/or Community partner to lead workshops on Social Emotional and mental health</p> <p>(These workshops could take place during the above mentioned transition team meetings)</p>	<p>Teachers thought this would be very impactful. They wonder if a community partner or social worker could support to lead the conversations.</p> <p>Some ideas presented by the teachers were as follows:</p> <ol style="list-style-type: none"> 1) Embed the work of the newly hired a bi-lingual ECE mental health consultant. 2) Mr. Garber in the classroom/"Fred Rogers"

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				Could take place during PLC time	
15) Have the opportunity to engage with coordinated service providers across sectors, or comprehensive community partnerships, that support local collaborations for the kindergarten transition and provide services for families.	January 2020	On-going	Planning time Possible funds to support outreach and communication	Project Manager of Bensenville Early Learning Services (BELS) Collaboration	The recommendation is to continue to build-out existing and new cross-sector partners to support the holistic wrap-around and coordinated supports for children and families.
19) Connect with coordinated health, education, and social service referral and service delivery systems.	January 2020	On-going	This requires time (typically added time to a member of the Collaboration) and possibly communication support	TBD with members of the BELS community Collaboration	It was discussed that this is currently happening but the communication needs to be improved.
27.) Kindergarten educators are supported to visit ECE classrooms before the end of the program year and share information about kindergarten programs	Planning: Jan 2020 Implementation: Spring 2020	Yearly	Planning time Additional Support Staff and Stipends for Teachers	Admin, K Team and PreK team	Add additional registration times for Kindergarten parents to make it more accessible for more parents. Redirect funds to provide opportunity for teachers to be compensated to meet with parents during non-traditional hours.

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<p>with early childhood educators and families.</p>			<p>Need: Additional registration night with all support members and teachers</p>		<p>Kindergarten teachers identified that they currently attend registration in the Pre-K wing, but the challenge is with so many children being bussed, many parents do not come on site which limits the opportunity to connect. Currently, the district does not offer other times for parents to come in register in the day. If the current money utilized for substitute teachers was re-appropriated to stipends to offer registration time during non-traditional school hours, it is felt that the number of parents attending would increase.</p> <p>Teachers stated: “We may have to do this because we have more busses- it would be nice to do this because right now we have to take a sub release day to test PreK in the K classrooms to test- it’s hard to find subs too- We could redirect resources from Subs to the evening extra registration night. Johnson doesn’t go to district PreK. Schools should have two separate nights: 1) PreK Registration night 2) K Registration night...to be named “<i>Kindergarten Connect</i>” instead of registration night. “</p>
<p>34) Create kindergarten transition plans in fulfillment of Title I requirements (where applicable) through coordination</p>	<p>Begin Planning Spring 2021</p>	<p>Living Document- On-going</p>	<p>Planning time</p>	<p>Parent/Family Coordinator to lead the design of the plan with work group input</p>	<p>PreK/K teachers, with the Family Coordinator, as part of the Transitions workgroup would design a Transition plan.</p> <p>It was the perspective of the PreK and K teacher planning team that a transition plan could support the districts intentional efforts</p>

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<p>with early childhood collaborations.</p>					<p>to engage families and community alignment to provide holistic supports for children ultimately to promote school readiness.</p> <p>One role of the Transition work group would be to plan a transition plan in fulfillment of Title 1 requirements.</p>
<p>42) Gather feedback from teachers, administrators, and families to determine how best to share information and data with an emphasis on whole child development.</p> <p>A. Analyze disaggregated school and district KIDS assessment and other data, data available through the Illinois Early Childhood Asset Map (IECAM), and other local and national sources to identify areas of community need that will affect school readiness</p>	<p>Planning for Data Collection: January 2020</p>	<p>During 2020/ 2021 School Year</p>	<p>The Collaboration is currently engaged in a partnership with external researchers.</p>	<p>Project Manager of Bensenville Early Learning Services (BELS) Collaboration</p>	<p>The Collaboration will engage their external researchers to support the gathering of additional information and feedback to support intentional planning around program development.</p>

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<p>45) Consider how to best integrate families of all backgrounds, including those with mixed immigration status, families without permanent housing, families who are justice involved, caregivers who work non-traditional hours, and others.</p>	<p>Beginning January 2020</p>	<p>On-going</p>	<p>This will require planning time and possibly implementation funding- depending upon the chosen strategies.</p>	<p>BELS Collaboration and District Administration</p>	<p>The BELS Collaboration is currently engaged in B-3 programming- with the full-service community schools in the area. The recommendation is to continue to intentionally integrate all families and consider different ways of engaging and empowering as well as connecting to private and parochial schools that service children outside of the school district in the community.</p>
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TITLE: Feasibility Rubric

DATE: 11/2019. Developed by DuPage KTAC Planning Team for LEA: Bensenville SD2

FOCUS: KTAC report review of KT recommendations

Criteria	1- No thank you	2	3- It may take some work but we could make this happen	4	5- Highly recommended
<p>Resources: Recommendation requires additional Resources. Resources include funding for materials, and staff hours to implement the recommendation.</p>	<p>Recommendation requires a lot of funding sources: Materials, funding, and staff hours that require more than \$500 to implement</p>	<p>\$400 range</p>	<p>Recommendation requires few funding resources: Materials, funding, and staff hours that require \$300 range implement</p>	<p>\$200 range</p>	<p>Recommendation requires minimal to no funding or resources: Materials, funding, and staff hours that require \$0- \$199 to implement.</p>
<p>Personnel: Recommendation requires additional personnel to support the implementation. Ex: Extra staff to support a family literacy night.</p>	<p>Recommendation needs 10 or more additional staff to support recommendation.</p>	<p>8-9 staff</p>	<p>Recommendation needs 5-7 additional staff to support recommendation.</p>	<p>3-4</p>	<p>Recommendation needs 0-2 additional staff to support recommendation.</p>
<p>Sustainable: To what degree can this recommendation be embedded into the ongoing curriculum without threat of cutting the recommendation due to unforeseen circumstances?</p>	<p>Recommendation is too complicated and relies heavily on resources, staffing, and planning time- if funding is cut this will not survive.</p>		<p>Recommendation needs some resources, staffing, and planning time- if funding is cut, we will be able to re-use templates and resources from the first implementation of the recommendation; it will not be as labor or cost intensive for additional iterations but will still require more than \$200 to implement.</p>		<p>Recommendation is “low maintenance” and does not require many resources, planning time or staffing and can easily be integrated into the yearly curriculum. This recommendation will not need more than \$100 to implement.</p>
<p>Time: What is the time frame needed for the planning and implementation of the recommendation?</p>	<p>Recommendation has requires more than 20 hours to implement (this includes both planning and implementation time.</p>	<p>15-19 hours</p>	<p>Recommendation has requires 10-14 hours to implement (this includes both planning and implementation time.</p>	<p>5-9 hours</p>	<p>Recommendation has requires 1-4 hours to implement (this includes both planning and implementation time.</p>

TITLE: D KTAC Feasibility Rating
DATE: 11/2019. Developed by DuPage KTAC Planning Team for LEA: Bensenville SD2
FOCUS: KTAC Recommendation Rating

KTAC Recommendation	Resources	Personnel	Sustainable	Time	Total
1) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
2) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
3) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
4) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
5) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
6) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
7) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
8) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
9) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
10) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
11) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
12) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
13) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
14) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
15) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
16) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
17) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
18) Recommended Practice	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	

Lessons Learned/Best Practices From the Erikson DCFS Early Childhood Project: Early Intervention and Child Welfare

Andria Goss, Program Director, Erikson Institute - Department of Children and Family Services (DCFS) Early Childhood Project

Lessons learned/ best practices from the Erikson DCFS Early Childhood Project

Submitted by

Andria Goss, Program Director,

Erikson Institute - Department of Children and Family Services (DCFS) Early Childhood Project

Updated February 19, 2020

Background

The Erikson DCFS Early Childhood Project is a collaboration between the Erikson Institute and the Illinois Department of Children and Family Services (DCFS). The project serves children who have become involved with the child welfare system because of abuse or neglect, mostly under the age of 5. The project's Developmental/Infant Mental Health (D/IMH) Specialists, who focus on interrupting patterns of abuse, are experts in understanding the needs of young children who have experienced significant trauma, and they also support DCFS in making crucial decisions that affect the lives of young children and their families. The project's core activities are:

- Conducting clinical assessments for young children in the care of or being closely monitored by DCFS;
- Assuring referrals for Early Intervention (EI) and mental health services for DCFS-involved children up to age 5;
- Providing consultations, referrals, trainings, and other resources for families with young children in the child-welfare system; and
- Training child-welfare professionals across the state.

Early Intervention supports families with children between the ages of birth to three with disabilities or developmental delays in promoting their child's optimal development and to facilitate the child's participation in family and community activities. Infants and toddlers are evaluated and/or assessed to see if there is a delay in one or more of these areas: physical, cognitive, communication, social or emotional, adaptive. If the child is eligible for services, an Individualized Family Service Plan (IFSP) will be written to set functional outcomes. Families then receive support from EI direct service providers to help their infants and toddlers reach their outcomes. Child and Family Connections (CFC) sites house Service Coordinators and provide regional access points to EI across the state. Each CFC facilitates at least one Local Interagency Council (LIC) to increase public awareness of EI, coordinate developmental screenings, and recruit EI providers.

For 100% of assessed cases in which there is an identified need, each D/IMH specialist is responsible for: referring directly to the EI system and outlining reasons for EI referral in both verbal and written form for parents, caregivers and case managers, to facilitate understanding of the child's needs and to support parents' interest in follow-through with EI evaluation and services.

For 100% of cases in which the case manager has identified specific concerns, but the child has not had an assessment, each D/IMH Specialist is responsible for facilitating case manager referrals to EI. For children in care, referrals can be made directly by the D/IMH Specialist. In Intact families, D/IMH Specialists will refer the family directly to EI for services and support case managers engaging the parents.

In all cases where referrals have been made, the D/IMH Specialist remains available to families and case managers to facilitate and troubleshoot connections with the EI system. First, the D/IMH Specialist contacts the CFC the week after a referral is made, to assess if initial contact has been made with the family. If the evaluation has not happened, the D/IMH Specialist supports engagement of the family (for example, by re-referring to EI or referring to a new CFC based on placement changes). These efforts could include contacting the family, EI and case manager to assure engagement (these activities are tracked). If the parent appears reluctant to engage in recommended services, the D/IMH Specialists offer ways of addressing these issues, including contacting the parent/caregiver to encourage participation.

The program's success hinges on supported follow up with EI at all levels. First, D/IMH Specialists follow up on individual cases in which they made the referral. Second, D/IMH Specialists, Project Assistants, Supervisors and the Project Associate Director attend meetings with CFCs, LICs, other EI collaborations, and EI workgroups with the Ounce of Prevention. Third, the Project Director has a weekly standing meeting with the DHS EI Bureau Chief.

Identifying Barriers to Service for Families

In 2013, the Erikson DCFS Early Childhood Project played a central role in Project Link, a two-year federal demonstration project led by Children's Home and Aid. Project Link helped Illinois gain a deeper understanding of the barriers preventing children involved in the child welfare system from accessing early intervention enrichment services. For this demonstration, Children's Home and Aid examined over 350 child welfare cases in the three neighboring Chicago communities of Englewood, West Englewood, and Greater Grand Crossing.

The analysis of the data showed that rates of developmental screening and enrollment in early intervention and early education programs varied depending on the type of child welfare case and the age of the child. Children receiving intact family services and children of youth in care had lower rates of screening for developmental delays than children in foster care. Additionally, Project Link data showed that infants and toddlers in all types of DCFS settings were less likely to be enrolled in an early care and education program than children ages three to five. Interviews with stakeholders from early childhood and child welfare systems indicated a barrier that impeded collaboration was that child welfare and early childhood systems each lacked thorough knowledge of the other.

In response, the Erikson DCFS Early Childhood Project, along with the Ounce of Prevention Fund, the Governor's Office of Early Childhood Development (GOECD), the DHS Bureau of Early Intervention, and DCFS partnered to develop the Serving Families Together Initiative, beginning in 2017. The overall goal of the initiative was to increase access to EI and home visiting for children and families involved in the child welfare system, through building cross-systems knowledge and relationships. For two years, this initiative planned and executed cross trainings which brought together home visitors, EI providers, and child welfare workers in communities across Central and Southern Illinois. The trainings were planned and executed by local representatives from these three systems, with support provided by a statewide steering committee.

- In April 2017, four cross-systems trainings were successfully held in Southern Illinois, reaching over 300 home visitors, child welfare workers and Early Intervention (EI) providers. The focus was to build cross-systems knowledge and relationships, and to support EI providers, home visitors, and child welfare workers in working together as a team. Feedback was extremely

positive: over 97% of participants reported that the trainings were relevant to their needs. The primary issue identified was that there were few child welfare staff in attendance.

- In the Central region trainings, completed in April 2018, approximately 360 people attended across the four sites, with Peoria being the best attended at over 110 attendees. There was a fairly good mix of attendees from the three primary service systems (EI, home visiting, and child welfare), in part due to additional outreach to the child welfare system during the planning of these trainings. Evaluations from both sets of trainings revealed attendees nearly universally agreed that cross-training should happen on a regular basis at the community level.

Based on the findings from focus groups and various evaluation efforts throughout the Serving Families Together project, efforts of Serving Families Together Statewide Advisory Committee turned to developing tools that smaller communities can use to duplicate the cross-training efforts on a more local, smaller scale.

To further identify barriers to service, the Erikson DCFS Early Childhood Project began providing close follow up for all EI referrals made by the Project, starting last year. In the short time since, follow up has revealed that barriers, rather than belonging to any one system, are frequently an interaction between system functioning and family functioning as summarized below.

1. Inefficient cross-system communications:

- a. Because the DCFS and DHS email servers are not on the same secure network, emailing sensitive family-level data, such as for referrals, is not possible. To make referrals to Early Intervention, Erikson DCFS Early Childhood staff have to fill out referral forms which must be faxed.
- b. The same server barrier applies to EI and DCFS/POS child welfare staff. The Erikson DCFS Early Childhood staff must follow up on individual referrals with phone calls, and in order to obtain six-month follow ups on whether families referred by the Project successfully engage, one Erikson DCFS Early Childhood staff has to set up phone and in person meetings to communicate information about clients. This level of follow up therefore seems out of reach for case managers, given the heavy load of crisis-driven work they carry.

2. Role confusion:

- a. Early Intervention providers are often grateful to have the Erikson DCFS Early Childhood staff to ask about how to follow up with the case managers. Without someone embedded in DCFS, if a family cannot share case manager contact information it is very difficult to find out who might be managing a DCFS case.
- b. Both systems find roles confusing. Case managers may have difficulty differentiating between EI and the Erikson DCFS Early Childhood Project staff. EI uses different providers for service coordination and each therapy, which leads to further confusion. The same thing happens to EI providers: they have difficulty knowing the difference between case managers, investigators and Erikson DCFS Early Childhood staff.

3. EI system limitations

- a. Geographic boundaries: Families and children in care are often moved suddenly for many reasons. Services fall through easily when a family moves from one CFC catchment area to another. EI in Cook County has made efforts to be flexible when this happens. However, EI is not designed to allow for quick transitions between CFC's.

- b. **Need for additional EI providers:** In some communities, the demand for EI services is higher than the current number of providers can fulfill. As a result, some child welfare involved families have received delayed, incomplete, or no EI services.
- 4. **Tight timelines for family engagement:** Families who are difficult for child welfare case managers to engage are also difficult for EI service coordinators to engage. When referrals are at risk of falling through, it is often due to parents failing to respond on the tight timelines that EI is mandated to uphold. The Erikson DCFS Early Childhood Project has had some success in linking the case manager to this information, who then follows up with the family. While this feedback loop helps in some cases, the families that are hard to engage remain so, and EI cannot hold cases open indefinitely.
- 5. **Mandatory vs. voluntary services:** There is tension between child welfare and EI around the nature of the mandate for services. EI providers, whether they work directly for a CFC or are independently contracted for service, identify themselves as firmly directed by parent/caregiver wishes and see themselves offering a voluntary service. Child welfare intact services are voluntary as well, although failure to comply with intact services may lead in some cases to further action by child welfare. Eligible children in care are mandated by DCFS policy to receive EI. However, the caregivers of these children sometimes do not follow through. In these cases, there is confusion about who, if anyone, has the capacity to mandate those caregivers to access EI services.
- 6. **State agency structure:** All of the barriers for both the child welfare and early intervention systems need to be understood in the context of the way in which the State of Illinois has organized its systems to deliver services. While in some states, Children and Family Services and Health and Human Services are under the same umbrella, in Illinois child welfare services are under the Department of Children and Family Services, and EI falls under the Department of Human Services. Each organization is a large entity, with its own policies, procedures, forms and processes. These processes are usually complex, owing to years of adding policies and procedures to address issues as they come up, while rarely taking policies away. Furthermore, both systems employ hundreds of people who must learn the elaborate policies and procedures of their employer, as well as the complex delivery of service to families. These two organizations developed separately from one another. The functioning of each system is already complex for those who work for that system. As these two organizations are separate, the processes of one are often opaque to the other.
- 7. **Variation across contracted providers:** Further complicating this picture is that both EI and child welfare case management services are frequently contracted to different private agencies. This adds to the number of organizational structures that can have potential differences. For example, one DCFS case manager may make referrals to three different CFCs who deliver EI. While governed by the same policies, each CFC is also a product of its parent agency. This can lead to small differences in the way EI is delivered locally that confuse the child welfare case manager. Furthermore, individual therapists who provide EI service are independent contractors, who may or may not understand the child welfare system. Case management styles can differ between private agencies, and EI workers could encounter multiple agencies who deliver child welfare services.

If one takes a purely systemic view, the potential for confusion, the difficulty in disseminating updated information (as things are constantly changing) and the overwhelming amount someone would have to know to negotiate all these different systems is very clear. In addition to the large potential for staff members of these systems to feel lost, or not understand how to access the service of the other, the families serviced by the child welfare system often have multiple, long-standing difficulties. As many of these families are less resourced, they are dependent on systems like these to deliver the services they need. They are in a great deal of distress, and yet have to negotiate so many different providers and systems. These conditions result in many, many systemic holes where services could potentially fall through for people who are already struggling to meet the considerable demands of parenting and day-to-day living.

One answer to effectively supporting families seems to lie in cross-system professionals going the extra mile to connect with one another and understand one another's systems. However, each system has their own documentation process and data system, and those systems do not allow easy communication with one another. Communicating results across systems largely relies on pen and paper, which takes a great deal of time and energy.

Recommendations:

Based on the information above, the following actions are recommended:

- 1) **Overhaul data technology systems:** To eliminate the time-consuming nature of communications between child welfare and early intervention staff, technological infrastructure needs to be overhauled to accommodate easy communication of confidential information between case managers and EI providers of all kinds. Communication for case planning should be able to occur easily so that professionals can support families across. Of course, for many cases, consent will need to be received. However, that transfer of the information at present is labor and time intensive.

The Erikson DCFS Early Childhood Project has firsthand experience with how time consuming it is to gather and aggregate data across systems. Closer reporting requirements from all systems indicate a need for data systems that store and can have data manipulated and extracted much more easily across these systems.

- 2) **Continue to consider cross-training opportunities:** Past cross-collaboration large-scale training efforts have led to a recommendation to leverage federal initiatives, such as PDG B-5, and other similar opportunities to explicitly support improved collaboration across child and family serving systems at both the state and local levels. The current PDG B-5 grant being used to fund planning for a child welfare/ home visiting collaboration is a realization of this recommendation.

As the system expands the utilization of home visiting with child welfare participants, this training effort should continue to be explored. The cross- collaboration trainings are most effective at the local level when the systems see a need for them. Any future roll outs of cross training should be well coordinated efforts across multiple systems, and support should be offered to communities who are invested in this work, rather than imposed on a larger scale from outside parties. This approach is currently being used by a joint initiative of the Ounce of Prevention and the CS3 (Community Systems Statewide Supports), which is offering technical assistance to communities that want to build capacity for cross-systems trainings.

Erikson DCFS Early Childhood Project: Home Visiting and Child Welfare: Home Visiting Proposal

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Proposal for Home Visiting Expansion in Illinois Child Welfare

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Executive Summary: Home Visiting Expansion in Illinois Child Welfare

This Home Visiting proposal seeks to expand the delivery of home visiting services to young pregnant and parenting women in care, aged 13-21, and pregnant and new parents of children aged 0-3 years who are receiving prevention child welfare services through the Illinois Department of Children and Family Services (DCFS) Intact Family Services, with a priority focus on parents of children less than 6 months old. DCFS will implement evidence-based in-home parenting interventions through existing early childhood home visiting capacity within Illinois. This Home Visiting proposal has been developed as a component of Family First Prevention Services Act (FFPSA).

Home visiting has the strongest impact when initiated during pregnancy. Begun prenatally, home visiting services have strong evidentiary support for improving engagement and maternal and health outcomes, and parenting practices. This proposal targets 400 families to engage with home visiting services in Year 1. Typical child welfare engagement outcomes would suggest about 20% of this population would *actually* engage in the intervention in year-one.

To maximize federal claiming of funds from the Title IV-E requirements of the FFPSA legislation, home visiting interventions are considered eligible for reimbursement under the FFPSA prevention services Title IV-E program. At least 50% of funding expended on the state's funded prevention services must be classified as "*Well Supported*" by evidence. The Title IV-E Clearinghouse rated these three home visiting programs as "*Well-Supported.*" Through partnerships with sister agencies, Illinois currently offers home visiting programs including Healthy Families America, Parents as Teachers, and Nurse-Family Partnership.

Given the complexity of the home visiting referral system, DCFS will need to create the internal infrastructure to support home visiting referrals for pregnant women and mothers over the age of 21 who are being served primarily through DCFS Intact Family Services. Given the time sensitive nature of the prenatal period, prevention casework staff in intact family services (including intact family recovery programs), will be offered the support of the Home Visiting Specialists [*to be established*] as a part of the DCFS/ Erikson Institute Early Childhood Project. The DCFS/Erikson Early Childhood team currently provides screening, assessment and consultation to this population and links families to Early Intervention, and therefore has some established networks with the Illinois Department of Human Services and the Illinois State Board of Education, as sister agencies to DCFS that provide home visiting.

As the single state agency for the federal Title IV-E program, DCFS processes all eligible IV-E claiming for reimbursement. DCFS currently maintains a state appropriation for the purpose of allowing the pass through of funds from the Title IV-E program to public entities for eligible services. An Interagency Agreement will need to be developed with each public agency interested in participating in the Title IV-E Prevention claiming. This agreement will outline each entity's responsibility and liability. Since IV-E operates as an open-ended entitlement grant, claiming requires that qualifying services as outlined in the State's IV-E plan and provided to a qualified individual within the defined prevention candidacy population may be partially reimbursed at approximately 50% (less administrative processing fees).

Home Visiting Expansion in Illinois Child Welfare (DRAFT)

I. Overview

This Home Visiting proposal has been developed as a component of Family First Prevention Services Act (FFPSA) planning, due to its focus on preventing child welfare involvement for families with very young children. It provides a plan for expanding existing early childhood programming provided by DCFS through the DCFS/Ericksen Early Childhood program to include home visiting services. Home visiting services target pregnant women and new parents for support at the most critical developmental period. When initiated prenatally in particular, home visiting services have strong evidentiary support for improving engagement and maternal and health outcomes, and parenting practices. The proposal targets 400 families in year one for this prevention service. In keeping with FFPSA, the program connects families with the home visiting intervention currently provided through Sister Agencies partnerships. Three of the models identified by the IV-E Clearinghouse as well-supported programs are currently in use in Illinois.

Background. Beginning in 2015, the Illinois Department of Children and Family Services (DCFS) participated in planning a pilot initiative with the Home Visiting Task Force, a sub-committee of the Early Learning Council, to provide home visiting services to pregnant and parenting youth in care known as the “*Illinois Pregnant and Parenting Youth in Care - Home Visiting Pilot (IPPYC - HVP)*.” Pregnant and parenting youth participated in the pilot from November 2016 to March 2019. The pilot evaluation by Chapin Hall Center for Children showed that pilot clients benefitted from the services they received from their home visitors and doulas. They learned about childbirth, child development, and parenting; and strengthened coping skills. Some of the clients developed positive relationships with the fathers of their babies. The outcomes of the pilot provided guidance about implementation, highlighted in this proposal.

During 2018, DCFS also participated in the Project HOPE Initiative, which focused on developing innovative practices to serve mothers and their young children, grounded in lived experiences of the mothers themselves. The Harnessing Opportunity for Positive, Equitable Early Childhood Development Project (Project HOPE), was designed to generate substantive progress toward improving equitable outcomes for young children (prenatal to age five) and their families by building the capacity of local communities, state leaders, cross-sector state teams, and local coalitions to prevent social adversities in early childhood and promote child well-being.¹ During this program, there were opportunities to meet with the beneficiaries of home visiting, doulas, and parents’ that experienced fetal death. These meetings informed program design and the focus on racial equity for work with mothers in distressed communities, at higher risk for poor maternal and child outcomes.

¹ The HOPE Consortium. (2018). *Harnessing opportunity for positive, equitable early childhood development*. Retrieved from: <https://www.projecthopelaunch.com>

DCFS is now preparing to build on the foundation laid by the pilot by partnering with the Illinois Early Learning Council and the Governor's Office of Early Childhood Development, in a strategic planning process under the Preschool Development Grant, and the Maternal Infant Early Childhood Home Visiting (MIECHV) program. Together, they will implement a coordinated intake system to connect pregnant and parenting youth and new parents and parents-to-be over the age of 21 to one of the well-supported home visiting interventions. (e.g., Healthy Families America, Parents as Teachers, Nurse-Family Partnership) identified by the Title IV-E Prevention Services (Family First) Clearinghouse.

Home visiting, particularly when combined with doula supports and provided prenatally, can improve birth and maternal health outcomes. Since Illinois DCFS seeks to expand home visiting services beyond the population served by the pilot to include pregnant and parenting women over the age of 21, policy changes approved through the DCFS Office of Children and Family Policy will be required, that mirror Teen Parenting Services Network (TPSN) policy. DCFS already has policy updates for pregnant and parenting youth through the age of 21 under review, i.e., Draft Procedures 302 Appendix J to guide operations of the Illinois Teen Parenting Services Network (TPSN). Policies and procedures to operate home visiting services for pregnant and parenting women over the age of 21 would be adopted, building from TPSN policies. **[See Attachment 1 for DCFS Home Visiting Policy draft.]**

Given the complexity of the home visiting referral system, DCFS will need to create the internal infrastructure to support home visiting referrals for pregnant women and mothers over the age of 21 who are being served primarily through DCFS Intact Family Services. Given the time sensitive nature of home visiting services, prevention casework staff in intact family services and intact family recovery programs, will be offered the support of the Home Visiting Specialists [to be established] as a part of the Erikson Institute DCFS Early Childhood Project. Referrals from DCFS to home visiting staff will require regular communication between DCFS and home visiting staff, consultation, follow-up processes, and active monitoring of referrals.

Our budget request is for about \$521,100 of new funds from Illinois DCFS. **[See Attachment 2 for the Budget Proposal for this program.]**

II. Why Home Visiting?

Broadly speaking, home visiting programs work with families with young children who are experiencing one or more risk factors, including poverty, history of substance use disorder or violence, risk for child maltreatment, first-time or adolescent parents, or children with disabilities. Programs may serve families from pregnancy to kindergarten, depending on the program. The content of programs varies, but most strengthen the parent-child relationship, model positive parenting skills, encourage economic self-sufficiency, support child development, promote learning and school readiness, and/or provide early detection for developmental delays and health issues. Based upon the Erikson Institute's 2019 *Risk and Reach* report, 35 of Illinois' 102 counties demonstrate high-risk on at least one of the four key health risk indicators (severe maternal morbidity, preterm births, lead exposure, and exposure to

violent crime), and eight counties show high-risk on two or more of the four key health risk indicators.²

Features of Evidenced-Based Home Visiting (EBHV). EBHV refers to a set of research-based services, delivered to families in their homes, designed to improve developmental trajectories for young children by supporting strong parent-child relationships. While there are a number of EBHV models, they generally share the following characteristics (Source: Ounce of Prevention Illinois Birth to Three Institute):

- Their underlying premise is that the quality of the parent-child relationship is the primary determinant of a child’s development. Services therefore are directed at the parent and the parent-child relationship.
- Services begin early on in infancy, often prenatally, in order to support the attachment process and to promote positive interaction during a crucial time for brain development.
- Services are offered intensively, often weekly at the beginning, and over a long period (generally three to five years) to maximize their potential for impact.
- Because it is crucial to the well-being of their children, the development of the parents (their education, living situation, mental health, etc.) is attended to also.
- Services are guided by a standardized curriculum that attends to the child’s development in a holistic manner.

[See Attachment 3 for the Summary Logic Model of Home Visiting programs.] This summary logic model presents home visiting activities mapped to prenatal, birth, and perinatal outcomes; short-term outcomes; and longer-term outcomes from various EBHV programs (Early Head Start Parent, Family, and Community Engagement (PFCE) Framework, Healthy Families America Logic Model, Nurse-Family Partnership logic model, and Parents as Teachers logic model).

Optimal Timing of EBHV Services in Early Pregnancy. While home visiting services can demonstrate positive impacts when initiated post-pregnancy, the beneficial effects of home visiting services are amplified most when services begin early in pregnancy. Home visiting begun prenatally may increase use of prenatal care, improve infant health, increase vaccination, and reduce infant visits to the emergency room.³

² Erikson Institute (2019). *Illinois Risk and Reach Report*. Chicago, IL: Author. Retrieved from:

<https://riskandreach.erikson.edu/illinois-map/>

³ Sama-Miller, E., Akers, L. Mraz-Esposito, A., Zukiewicz, M., Avellar, S., Paulsell, D., and Del Grosso, P. (2018). *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.

Issel, L. M., Forrestal, S. G., Slaughter, J., Wiencrot, A., & Handler, A. (2011). A review of prenatal home visiting effectiveness for improving birth outcomes. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 40(2), 157-165.

El Fadl, R. A., Blair, M., & Hassounah, S. (2016). Integrating maternal and children’s oral health promotion into nursing and midwifery practice: A systematic review. *Plos One*, doi: 10.1371/journal.pone.0166760; AND

Peacock, S., Konrad, S., Watson, E., Nickel, D., & Nuhajarine, N. (2013). Effectiveness of home visiting programs on child outcomes: a systematic review. *BMC Public Health*, 13, doi: 10.1186/1471-2458-13-17

Overall benefits of home visiting programs. Evaluation findings from 88 home visiting programs in the Mother and Infant Home Visiting Program Evaluation (MIHOPE) from 12 states, and 66 home visiting program in the Mother and Infant Home Visiting Program Evaluation (MIHOPE-Strong Start) in 17 states show positive impact of these programs on family outcomes.⁴ MIHOPE programs target pregnant women or families with children less than 6 months of age, and MIHOPE-Strong Start targets pregnant women in the first 32 weeks of pregnancy, primarily Medicaid eligible individuals. Compared to control group outcomes, this cross-state evaluation showed positive and statistically significant outcomes for home visiting program participants on improved quality of the home environment, fewer emergency department visits for the child, reduced frequency of psychological aggression toward the child, and fewer child behavior problems. Positive effects were sustained through 15 months, on average, based upon follow-up study measurements. MIHOPE included 4,229 families and the MIHOPE-Strong Start analysis included 2,900 families (1,845 of whom were recruited for MIHOPE but who also met the criteria for being enrolled in MIHOPE-Strong Start).

The MIHOPE and MIHOPE-Strong Start evaluation findings also show some potential for reducing household aggression, such as mothers' experience with intimate partner violence and mother's use of domestic violence services. Reduced household violence is associated with positive and statistically significant reductions in parental depression and parental stress, as well as increased use of parental discipline using gentle guidance. The reduced household aggression and increased use of gentle parent discipline practices may then be moderating the reductions shown in child behavior problems. Based on this national evaluation of home visiting programs, the results do not show statistically significant differences in prenatal health behaviors, breastfeeding practices, or maternal and infant health outcomes, though. Since few women in the study smoked and nearly all received prenatal care, these factors may contribute to indeterminate findings for impact on prenatal child and maternal health outcomes.

The cross-state evaluation team found that home visiting participants vary in the duration of services received; 28 percent of families did not participate in home visiting beyond six months and 55 percent of families still received about 2 visits per month on average after a year. Short-stayers tended to be younger, have poorer self-rated health and less education, than longer-stayers. Families that move more than once in the past year and women with difficulty trusting others are more difficult to engage in home visiting. Evaluation findings recommend training home visitors in different approaches to trust-building and strategies for staying connected to mothers as they move.

Benefits of Engaging Doulas in Home Visiting. Doulas are community health workers who have expertise in pregnancy health, childbirth preparation, labor support, lactation counseling,

Kilburn, M. R. & Cannon, J. S. (2017). Home visiting and use of infant health care: A randomized clinical trial. *Pediatrics*, 139(1): e20161274

See also: County health rankings & roadmaps (2019). Early childhood home visiting programs. Retrieved from <https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/early-childhood-home-visiting-programs>

⁴ Charles Michalopoulos, Sarah Shea Crowne, Ximena A. Portilla, Helen Lee, Jill H. Filene, Anne Duggan, and Virginia Knox. (2019). *A Summary of Results from the MIHOPE and MIHOPE-Strong Start Studies of Evidence-Based Home Visiting*. OPRE Report 2019-09. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

and newborn care. As specialized home visitors, doulas provide home-based education and support services during the last half of pregnancy through 6-weeks postpartum. Doulas accompany laboring women to the hospital to provide emotional support, tangible comfort measures, and guidance on breastfeeding and bonding with the newborn. A meta-analysis of effects of including doulas in home-based visiting showed that doula services are associated with improved maternal and child health outcomes including fewer Caesarean deliveries, decreased use of analgesia/anesthesia, shorter labors, and higher Apgar scores.⁵ One randomized controlled trial of using community doulas with home visiting found increased breastfeeding initiation among young, low-income mothers, compared to the control group.⁶

[Ounce of Prevention Illinois Birth to Three Institute](#) data indicate that participants who come in through the front door of doula, tend to engage better and stay longer. This is perhaps because a) doula services establish a paradigm for later services - i.e. it is clear at the start that the services are focused on the parents' relationship with, and attachment to, their baby, and b) the nature of the services (24/7 availability, asking for the participant's "wish list", being with her through many hours of labor and delivery, giving back rubs, etc.) may be a very different experience of social services than they have had before, and this may make them more receptive to other types of service.

Based upon a randomized controlled trial by Hans et al. (2018)⁷ of Illinois' doula home visiting in an Illinois sample of about 300 women, program participation was associated with positive infant-care behaviors. Compared to the case management control group, mothers receiving doula home visiting services were more likely to attend childbirth preparation classes, less likely to use epidural pain medication during labor, and more likely to initiate breastfeeding, although the breastfeeding impact was not sustained at the 3-month follow-up. Program participants were more likely than the control group to put infants on their back to sleep and utilize car seats at three weeks. However, the program did not show intervention effects for Caesarean delivery, baby birthweight, birth prematurity, or postpartum depression.

Impacts of Home Visiting for Reducing Infant Mortality. One of the leading indicators of population health is the rate of infant mortality, i.e., death before reaching age one. As of 2018, Illinois ranked 30th in the nation with a 6.3% infant mortality rate (per 1,000 live births).⁸ In Illinois and nationally, African-American mothers are disproportionately more likely to experience a death of their infant than White, Asian, or Latina mothers. In Illinois, the rate of infant mortality for African-American mothers is 12.2%, compared to 4.3% for Asian mothers,

⁵ Hodnett, E. D., Gates, S., Hofmeyr, G. J., and Sakala, C. (2013). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*, 7, doi: 10.1002/14651858.CD003766.pub5.

⁶ Edwards, R. C., Thullen, M. J., Korfmacher, J., Lantos, J. D., Henson, L. G., & Hans, S. L. (2013). Breastfeeding and complementary food: Randomized trial of community doula home visiting. *Pediatrics*, 132, S160-S166. Doi: 10.1542/peds.2013-1021P

⁷ Hans, S. L., Edwards, R. C., & Zhang, Y. (2018). Randomized controlled trial of doula home visiting services: Impact on maternal and infant health. *Maternal and Child Health Journal*, 22 (Supplement 1): S105-S113.

⁸ United Health Foundation (2018). *America's health rankings: Health of women and children*. Retrieved from https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/IMR_MCH/state/IL

5.1% for White mothers, and 5.4% for Latina mothers.⁹ A 20-year longitudinal follow-up in a randomized controlled trial on the effects of home visiting showed significant decreases in both maternal and infant mortality, in a sample of primarily African-American women.¹⁰

According to DCFS, sleep suffocation is the leading cause of reported child deaths in Illinois. Nationally, Sudden Unexpected Infant Death (SUID) accounted for approximately 3,600 infant deaths in the United States in 2017.¹¹ In Illinois, the SUID rate is higher for non-Hispanic Black infants (3% per 1,000 live births in 2015) than for non-Hispanic Whites or Hispanic infants (less than 1% per 1,000 live births in 2015).¹² SUID risk factors include prone sleeping, bed-sharing, soft bedding use, and maternal smoking.

The Illinois MIECHV Program analyzed infant safe sleep data to determine how often caregivers enrolled in HV programs provided safe sleep environments for their infants in relation to breastfeeding status and tobacco use. The preliminary analysis¹³ found that breastfeeding caregivers in this study bed-shared less often than their non-breastfeeding counterparts. The reasons for breastfeeding without bed-sharing are multifactorial, but this calls into question the commonly held assumption that bed-sharing is necessary for successful breastfeeding. The analysis also found that an infant living with a tobacco user is less likely to be sleeping safely. This finding suggests that a multifaceted approach to safe sleep counseling may be needed for such families. Another important finding is that caregivers participating in Illinois MIECHV-supported home visiting programs demonstrated greater adherence to safe sleep guidelines than expected. This highlights the importance, success, and ongoing opportunity of the health promotion role that home visitors play in the lives of the women and children receiving their critical and comprehensive services.

Benefits of home visiting for substance-abusing pregnant and parenting mothers.

According to the Substance Abuse and Mental Health Administration, substance use disorders (SUDs) are recognized as a chronic disease with expected lapses. Substance use disorders adversely affect child and maternal health outcomes. However, pregnancy offers an opportunity for substance abuse treatment as most new parents want the best care and environment for raising their children. In Illinois, as in many states, the opioid epidemic has had devastating consequences. Since 2008, opioid overdoses have resulted in the deaths of

⁹ United Health Foundation (2018). *America's health rankings: Health of women and children*. Retrieved from https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/IMR_MCH/state/IL

¹⁰ Olds, D. A., Kitzman, H., Knudtson, M. D., Anson, E., & Smith, J. A. (2014). Effect of home visiting by nurses on maternal and child mortality. Results of a 2-decade follow-up on a randomized controlled trial. *JAMA Pediatrics*, 168(9), 800-806. Doi: 10.1001/jamapediatrics.2014.472

¹¹ Centers for Disease Control and Prevention. (2017). *Sudden Unexpected Infant Death and Sudden Infant Death Syndrome*. Washington, DC: Author. Retrieved from <https://www.cdc.gov/sids/data.htm>

¹² Illinois Department of Public Health Office of Women's Health and Family Services (2018). *Illinois infant mortality data report*. Springfield, IL: Author. Retrieved from <http://www.dph.illinois.gov/sites/default/files/publications/owhfs-infant-mortality-data-report-update-030618.pdf>

¹³ Hussain, S., Lowell, G. S., Roehler, D. R., Quinlan, K. P., Tandon, S. D., & Schwartz, L. (2018). You can have your breastmilk and safe sleep too: a preliminary analysis of infant safe sleep data in a Midwestern home visiting program. *Injury Epidemiology*, doi: 10.1186/s40621-018-0138-y

nearly 11,000 Illinois residents, and in 2017, there were 2,200 opioid-related deaths of Illinois residents alone.¹⁴

Many pregnant women with opioid use disorder receive no, or very little, prenatal care. As a result, they may end up going to the hospital emergency department late in pregnancy or even during labor. Opioid-dependent women are more likely to neglect prenatal care because they may fear being incarcerated for illicit drug use or for exposing their fetus to illicit drugs; they may not recognize they are pregnant; they may lack funds to pay for services, transportation, or daycare; and/or they may fear losing custody of their other children (Howard, 2016).¹⁵ SAMHSA (2018) offers evidence-based guidelines for effectively engaging with, and treating pregnant and parenting women with opioid use disorders.¹⁶

Illinois will continue to work with providers specializing in serving pregnant and parenting women with opioid use disorders to expand service delivery directed at improving maternal and child health outcomes for this population. For example, Cook County agencies such as Haymarket, Maryville Moms, and the Women’s Treatment Center each have evidence-based, trauma-informed programming for pregnant and parenting mothers with substance use disorders. Illinois has partner agencies covering Northern, Central, and Southern regions, as well as Cook County to serve families affected by substance use disorders. While there are substance use treatment centers across the state, the home visiting programs will prioritize providers that serve pregnant women and new mothers that utilize doula supports, such as Haymarket. Additionally, Illinois is working to expand its demonstration program serving intact families with substance use disorders, called Intact Family Recovery (IFR). **[See Section V, Target Population and Planned Service Delivery.]**

III. Illinois’ Vision, Background, and Experience in Delivering Home Visiting Services

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. 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. In 2017, the Illinois Home Visiting system served 11,491 children and 10,958 Illinois families across 189 local agencies.

¹⁴ Illinois Department of Public Health (2019). *Illinois Opioid Action Plan*. Retrieved from: <http://www.dph.illinois.gov/opioids/ilplan>; AND National Institute on Drug Abuse (2019). *Illinois Opioid Summary*. Retrieved from: <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/illinois-opioid-summary>

¹⁵ Howard, H. (2016). Experiences of opioid-dependent women in their prenatal and postpartum care: Implications for social workers in health care. *Social Work in Health Care*, 55(1), 61–85. doi:10.1080/00981389.2015.1078427

¹⁶ Substance Abuse and Mental Health Services Administration. (2018). *Clinical guidance for treating pregnant and parenting women with opioid use disorder and their infants*. HHS Publication No. (SMA) 18-5054. Rockville, MD: Author.

Illinois home visiting is supported by the following funding sources:

- [Maternal Infant and Early Childhood Home Visiting \(MIECHV\) Program](#) administered by [Illinois Governor's Office of Early Childhood Education](#)
- [Illinois Department of Human Services- Healthy Families Illinois](#)
- [Illinois State Board of Education \(through the Early Childhood Block Grant\)- Prevention Initiative](#)
- [Illinois Office of Head Start](#)

These funding streams support a network of over 300 programs across the state serving approximately 19,000 families per year. According to [Erikson Risk and Reach Report](#), home visiting services are available in 85 of Illinois 102 counties. The most commonly used Evidence based home visiting model in Illinois are:

- [Parents as Teachers](#) (FFA Clearing House approved- well supported)
- [Healthy Families America](#) (FFA Clearing House approved- well supported)
- [Early Head Start- Home Based](#)
- [Baby Talk](#)

DCFS has been a participant in several leadership activities related to home visiting including:

- The Executive Committee of the Early Learning Council
- The Executive Committee of the Home Visiting Task Force a subcommittee of the Early Learning Council
- The Executive Committee of the I/ECH Mental Health Consultation a sub-committee of the Illinois Children's Mental Health Partnership

Illinois Policies and Training to Increase Safe Sleep Practices. To address the risk factors and complement the MIECHV benchmark on safe sleep, the Illinois MIECHV Program partnered with SIDS of Illinois, The Ounce of Prevention Fund OPF, and Illinois Association for Infant Mental Health to develop safe sleep policies and provide statewide infant safe sleep training to MIECHV funded home visitors and trainers of home visitors. The safe sleep policy requires all MIECHV funded programs to educate parents about the American Academy of Pediatrics (AAP) safe sleep guidelines.

The Illinois MIECHV Program has also made progress in developing and implementing training on safe sleep. ISBE is supporting this new training through the alignment efforts, as well. ISBE has provided funding for the development of the training and has offered the training to its home visiting staff. The half-day safe sleep training, which started in April 2017 and will continue to be offered on a regular schedule several times per year for new home visiting staff, educates home visitors about current safe sleep guidelines and ways to overcome caregiver barriers in practicing these guidelines. The policy and trainings will encourage meaningful safe sleep discussions between home visitors and caregivers leading to an increased understanding and practice of infant safe sleep guidelines among caregivers.

After receiving feedback through Continuous Quality Improvement (CQI) projects from Illinois home visitors indicating a significant barrier to safe sleep was access to a safe crib, the Illinois MIECHV Program proposes to continue our partnership with SIDS of Illinois to provide AAP-approved portable cribs and safe sleep new baby packages. The new baby packages include an

AAP-approved sleep sack, a baby book reinforcing safe sleep practices written by leading safe sleep researcher, Rachel Moon, MD, and other materials/resources that address safe sleep. MIECHV funded HV programs will coordinate with SIDS of Illinois to obtain portable cribs for families who need them and safe sleep new baby packages to give to new babies born while enrolled in the Illinois MIECHV Program.

Illinois' Implementation and Evaluation Findings from the Illinois Pregnant and Parenting Youth in Care - Home Visiting Pilot. From November 2016 to March 2019, 43 pregnant and parenting youth in care participated in Healthy Families Illinois (HFI) home visiting services.¹⁷ Chapin Hall Center at the University of Chicago conducted an implementation evaluation of this pilot program using program data collected from home visitors and doulas; interviews with home visitors, doulas, supervisors, and young parents; and analysis of child welfare administrative data. **[See Attachment 4 for Summary of Findings].**¹⁸ The purpose of the evaluation was not to measure the effects of providing home visiting services on parent and child outcomes, but to assess the pilot's implementation and to identify changes needed to scale-up of the delivery of home visiting service to not only to pregnant and parenting youth in care but also to other child welfare system-involved families.

The lessons learned from the home visiting pilot have implications for expanding the delivery of home visiting services not only to pregnant and parenting youth in care throughout Illinois but also to other child welfare system-involved families, including those receiving intact services. Specifically, the results of the evaluation suggest that the following will be needed to scale up the delivery of home visiting services as is currently being planned:

- Developing policies around information sharing between child welfare caseworkers and home visiting staff so that home visitors are aware of placement changes and other events (e.g., hospitalizations, running away, detention) that can impact service delivery.
- Educating caseworkers and congregate care staff about the voluntary nature of home visiting services and the confidential nature of the home visitor-client relationship.
- Providing home visitors with training about the child welfare system including policies and procedures relevant to their child welfare clients.
- Preparing home visitors for Child and Family team meetings to optimize their engagement and maximize their ability to support their child welfare client.
- Identifying ways in which the HFI practice model can be adapted to better meet the needs of child welfare clients.
- Supporting home visitors and doulas by providing them with infant mental health consultation.

Illinois plans to address these concerns and lessons learned in the expansion of home visiting services. **[See Attachment 1 for DCFS Home Visiting Policy draft.]**

IV. Principles and Practices of Home Visiting Service Delivery

¹⁷ Although fathers and fathers-to-be were eligible for the pilot, all the pilot participants were female.

¹⁸ Dworsky, A., Gitlow, E., & Ethier, K. (2019). *Home visiting for pregnant and parenting youth in care: Final report*. Chicago, IL: Chapin Hall at the University of Chicago.

Overall Approach. Understanding disparities in child and parent well-being across race and ethnicity, the Illinois home visiting system in Illinois approaches service delivery and systems design through a strengths-based racial equity lens. Since learning begins at birth, and relational health and care begins before birth, home visiting services in Illinois foster seamless, uninterrupted, and equitable access to high quality early childhood experience and services from the prenatal through early childhood periods. The statewide home visiting system encourages multi-disciplinary collaboration across state and local providers serving families and young children. State agencies and community-based providers in health, mental health, early intervention, child welfare, economic security, and human services work together to deliver home visiting services. Illinois offers targeted, needs-based services based on the needs of high-risk populations, while also operating from a universal vision that all new parents and families can benefit from additional supports and resources. In this way, Illinois' home visiting services reach more young children with services that are responsive to family needs, circumstances and preferences. Illinois' works to adopt innovative strategies for home visiting service delivery while advancing equity-driven, structural changes to the systems that serve families and young children. The Illinois home visiting system builds a coordinated continuum of high-quality services that are accessible to all who can benefit from them, focused upon:

- Strengthening positive attachment and social-emotional development to improve parent-child relationships;
- Promoting maternal, infant, and early childhood health, mental health, and safety, with an eye toward documented disparities in health outcomes;
- Providing developmental screening, monitoring, and referrals to bolster school-readiness;
- Linking families to community resources and services and promote cross-system collaboration; and
- Integrating Infant Mental Health Consultants and doulas as a necessary component of prenatal to early childhood service delivery models.

According to the Illinois Home Visiting Vision and Priorities [2019]:

“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 Illinois home visiting system is committed to ensuring equity in how family members access and receive services. The Illinois home visiting system recognizes the home as the most influential learning environment in which to strengthen the parent-child relationship and help reach the child’s full potential. The overall goals of Illinois home visiting are to promote positive parenting, healthy child growth and development, and to prepare young children for school success. In order to achieve these goals, the Illinois home visiting system is committing to initiating innovative practices and promoting cross-system collaboration for entities working with young children and families.”

Across these priorities, and agnostic of approaches and funding streams, the Illinois home visiting system strives to operate and grow within a set of core principles:¹⁹

- **Continuum of Services** – Home visiting is an integral part of a well-coordinated continuum of services for families, beginning prenatally and continuing through early childhood.
- **Evidence-based** – Home visiting programs use models and curricula whose effectiveness is supported by research.
- **Entrepreneurial and participant-informed** – The home visiting system recognizes the value of family experience and voice and strives to grow promising practices and innovations emerging from community and participant input.
- **Culturally and linguistically responsive** – Home visiting actively honors parent and community perspectives and ensures that services are culturally and linguistically responsive.
- **Voluntary and accessible** – Families are free to choose whether or not to participate, and statewide, those who want to can access services in their community.
- **Outcome driven** – The State is able to demonstrate outcomes related to maternal and child health, school readiness, and reduction of child abuse and neglect.
- **Skilled Workforce** – Home visiting services are delivered by early childhood professionals, who must receive appropriate professional development and compensation.
- **Aligned** – Home visiting services are aligned with the Illinois Early Learning Guidelines (IELGs) and Illinois Early Learning and Development Standards (IELDS).

Summary of Interviews by the Home Visiting Specialist.

During the months of August and September 2019, the DCFS Home Visiting Specialist (hired through funds from the state’s Preschool Development Grant Birth through Five, or PDG B-5) had opportunities to meet with HV providers. While these efforts are preliminary, a number of the providers are eager to establish better communication with the DCFS surrounding the families served through HV. Providers explained that DCFS families often experience very complex situations and require additional resources from DCFS. During this planning stage, the program proposed a flow chart to describe the process of program operations for the DCFS Home Visiting Program (**See Figure 4 in Program Operations Section**). A proposed policy that addresses the time-sensitive nature of the prenatal period and the need for more coordination and communication needing to occur between the child welfare case worker and home visiting providers (**See Attachment 1**).

V. Proposed Program and Scope of Work

How will DCFS utilize Home Visiting Services?

DCFS will administer a home visiting program [HVP] through existing early childhood programming. The DCFS Erikson Early Childhood Project was created in 1998 to support the

¹⁹ The Illinois Home Visiting Task Force (2019). The Illinois Home Visiting Task Force Vision and Priorities for 2019. See: <https://www2.illinois.gov/sites/OECD/EarlyLearningCouncil/Pages/HomeVisitingTaskForce.aspx>

needs of young child welfare involved children and their families. The Erikson team, which covers the entire state, is highly trained in the areas of development, infant mental health, and child welfare. This unique perspective provides the frame for better understanding the impact of a young child's experiences and support for child well-being. In addition, the program has worked extensively with intact family services. Engagement within intact agencies will support the implementation of home visiting programming which is not commonly used by child welfare programs. The Early Childhood team currently links families to Early Intervention and therefore has some established networks with the Illinois Department of Human Services as a Sister Agency.

Target Population and Proposed Services.

To maximize maternal and child health and well-being outcomes, as well as to align with HV program requirements, families with children pre-natal to 6 months are the priority population. There are two primary target populations for home visiting services: 1) Pregnant women and parents of children who meet the criteria for Illinois' Intact Family Services and Intact Family Recovery programs (priority given to family members with children aged 6 months or younger; however, families with children aged 3 and younger may be served by home visiting); and 2) pregnant and parenting youth in care, both those aged 13-17, and aged out youth 18-21 with newborns.

(a) Intact Family Services - Pregnant women and parents of children with children younger than 6 months, and younger than 3 years.

DCFS has statewide data on children 0-3 and 0-6 months served by intact family services. Data has been clustered in this way because home visiting can serve families of children 0-3. To maximize maternal and child health and well-being outcomes, as well as to align with HV program requirements, families with children pre-natal- 6 months are the priority population. **Table 1 provides estimates on the target population within Intact Family Services.**

Table 1. Estimates of Children <6 months and <3 years old in Intact Family Services (by DCFS and POS) for FY18, FY19, and FY20 (July 1-5, 2019)

Intact Family Services Cases for past Fiscal Years Served by DCFS/POS			
	FY18	FY19	FY20
DCFS Cases	577	1,057	604
POS Cases	6,888	7,235	3,624
Total Cases	7,465	8,292	4,228
Total Children in these Total Cases	18,991	21,123	10,849
Total Children aged 6 months and under	1,794	1,881	921
% Children aged 6 months and under	9.4%	8.9%	8.5%
Total Children aged 3 years and under	6,664	7,589	3,922
% Children aged 3 years and under	35%	36%	36%

There is no data currently available on pregnancies for population in Intact Family Services. In Year 1, we anticipate engaging 400 families, including pregnant and parenting youth in care and families in intact family services and intact family recovery (see below). While we do not expect that all families that we intend to engage in home visiting outreach will accept home visiting services, this a 10-fold increase from the current home visiting service pilot. The Healthy Families America pilot served 43 pregnant and parenting youth from November 2016-March 2019. In order to identify and engage these 400 youth and families, 4 new Home Visiting specialists would be added to serve the state.

(b) Intact families served by the Intact Family Recovery (IFR) Program

The majority of cases are involved with DCFS following the birth of a substance exposed infant (SEI). Other substance-affected family cases are also eligible for referral to Intact Family Recovery services. Illinois statute requires that all infants born substance or alcohol exposed must be reported to DCFS and to the IDPH Adverse Pregnancy Outcomes Reporting System (APORS). Following an investigation, the Division of Child Protection determines whether an indicated case of abuse or neglect exists and that the children can safely remain at home while the family receives services. Due to the chronic and progressive nature of substance use disorders, children in substance affected families are at imminent risk of entering foster care if the family members’ substance use disorders are not successfully addressed. Families are initially assessed as part of the child protection investigation and continually throughout the life of a case. Child Protection investigators perform substance abuse screens on all adult family members living in the household. The Investigation team can refer families to the IFR program when families meet the requirements of substance use disorders and an intact family case.

Since 2000, DCFS has attained positive outcomes for women who have been served through intact family recovery services. The program seeks to improve child welfare outcomes by providing an Alcohol and Other Drug Assessment (AODA) assessment and referral service and by utilizing Recovery Coaches to assist birth parents with obtaining AODA treatment services and in negotiating departmental and judicial requirements associated with drug recovery and concurrent permanency planning. Over an 18-24-month period, recovery coaches and caseworkers work with women in three phases. The first phase concentrates upon preparing parents for substance abuse treatment, including arranging for child care, medical care, and school assessments for children. The second phase emphasizes provision of parenting supports during treatment, including personal goal-setting and aftercare planning. The third phase is

focused on maintaining recovery, implementing behaviors targeted toward personal goals, and continued parenting supports. A sample of the outcomes that the program has identified²⁰ are as follows:

- Children of parents in the demonstration group receiving Recovery Coach services were more likely (10.0%) to be reunified with their parents in 12-24 months than children in the control group (7.9%).
- Children in the demonstration group took, on average of 827 days to achieve reunification, compared to 946 days for children in the control group.
- As of September 30, 2018 (latest cost estimate available), the waiver demonstration has generated approximately \$8,825,816 in savings for the State of Illinois.

In the Title IVE demonstration program, Intact Family Recovery services were provided to families in Cook County since 2000. With a grant from the Administration of Children and Families, surrounding counties (Winnebago, Kane, Will, and Boone) have implemented intact family recovery services that are being evaluated through a randomized controlled trial from 2018-2023. DCFS proposes an expansion of Intact Family Recovery from 2020-2025 in Central and Southern Illinois. **[See Attachment 6 for an Overview of proposed Intact Family Recovery expansion.]**

(c) Pregnant and parenting youth in care

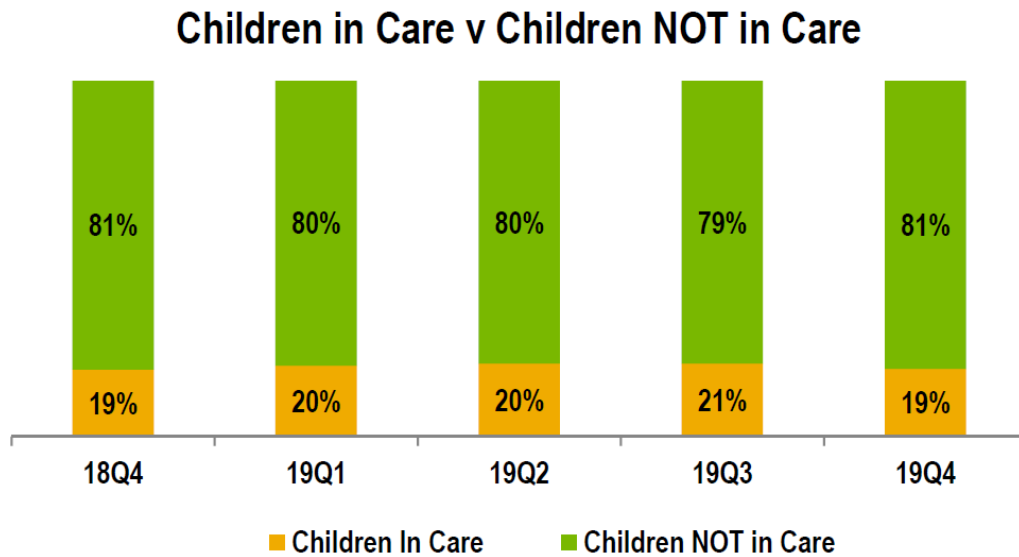
As of FY19, there are about 465 youth in DCFS care who are pregnant and/or parenting. Children of youth in the child welfare system are disproportionately more likely to have their own children involved in the child welfare system, reinforcing inter-generational effects. A review of 10 international studies of risk factors for child welfare involvement showed that child welfare involvement is associated with: a maternal history of low socioeconomic status, receipt of public benefits, single parenthood, being younger at first pregnancy, having a disability or learning difficulties, smoking during pregnancy, having a mental illness, and misuse of alcohol or drugs.²¹ Among the Illinois population of pregnant/parenting youth in care for FY19, approximately 20% have children in DCFS care, and about 80% do not have children in DCFS care.²² **See Figure 1 below.**

²⁰ Illinois Department of Children and Family Services (2018, November). *Final Evaluation Submission to the U.S. Children's Bureau, Department of Health and Human Services.*

²¹ Simkiss, D. E., Stallard, N., and Thorogood, M. (2012). A systematic literature review of the risk factors associated with children entering public care. *Child: Care, Health, and Development*, 39 S, 628-642. Doi: 10.1111/cch.12010

²² UCAN (2019). *TPSN Year-End Report FY19*. Chicago, IL: Author.

Figure 1. FY19 Proportion of Children in DCFS Care among Illinois Pregnant and Parenting Youth in Care



By contrast, among youth with no risk factors in their background at early adolescence, only 3% of those youth later become child-welfare involved during adulthood (based on a U.S. sample of 1,000 seventh and eighth graders).²³ According to Thornberry et al. (2014), risk factors associated with maltreatment of their own children in adulthood include family background/structure, education level, antisocial behaviors, and precocious transitions.

We anticipate between 32 -58 new youth entering this category annually² (either youth currently in care who will become parents or new youth who will enter care and become pregnant/parent). The descriptive analysis revealed that a large amount of youth had pronounced needs that would require intense and specialized services. As determined by a recently completed (within the last year) Child and Adolescent Needs and Strengths (CANS) instrument (83% completion rate), 42% of youth had behavioral or emotional functioning needs that reached the clinical level.³ Almost 22% of youth struggled with parenting, while 17% had substance abuse disorders.

However, the data from Medicaid claims examining lifetime reported disorders revealed that the majority of youth had much more pronounced needs. For example, mood (affective) and anxiety disorders were present in 78% of youth. Other disorders included the following: mental and behavioral disorders due to psychoactive substance use (61%), adult personality and behavior disorders (46%), pervasive and specific developmental disorders (38%), schizophrenia & other non-mood psychotic disorders (36%), other unspecified mental disorders (21%), behavioral syndromes associated with physiological disturbances and physical factors (8%), and intellectual disabilities (6%). Service considerations will need to take into account demographic and case related characteristics.

²³ Thornberry, T. P., Matsuda, M., Greenman, S. J., Augustyn, M., Bears, H.,...Ireland, T.O. (2014). Adolescent risk factors for child maltreatment. *Child Abuse and Neglect*, 38(4), 706-722.

In particular, the current pregnant and parenting youth in care varied by gender (74% females and 26% males), minority status (71%), Spanish as preferred language (4%), age (mean 18.6), geography (67% from Cook county), length of stay (57% have been 4 or more years in care), living arrangements (almost 40% reside in transitional or independent living), and permanency goal (92% have independence). Additionally, 36% of youth have been in an unknown location or detention in the last 12 months.

(d) Aged out pregnant and parenting youth 18-21

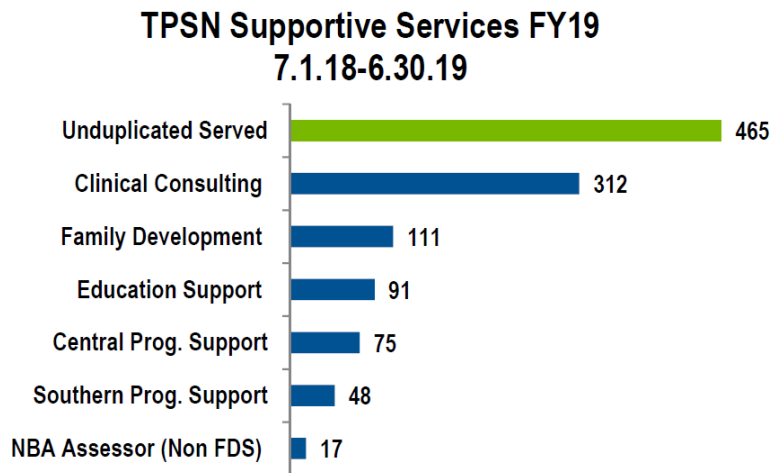
As of FY19, there are about 100 former youth in care, aged 18-21, who have a child on their own and may be in need of support services to prevent re-entry to care for themselves or their child. The descriptive analysis using the latest available (prior to exit) CANS youth-version instrument revealed that 43% of former youth had behavioral or emotional health needs, characterized at the clinical level.³ Approximately, 27% struggled with parenting while 22% reported moderate or severe substance abuse disorder. Additionally, 26% of former youth had past exposure to family violence.

This population benefits from a range of services from the Teen Parenting Services Network, and DCFS proposes to expand evidence-based programming to this population (e.g., Healthy Families America home visiting services, Nurturing Parenting Program, and other home visiting services as available).

TPSN services. TPSN provides a variety of supportive services for pregnant and parenting youth including clinical support and intervention, parenting education, and education support. TPSN's innovative programs also focus on building self-esteem, leadership development and preparing youth for independence. Throughout FY19 (7/1/18-6/30/19), a total of 633 pregnant and parenting youth were in the Network. Among them, 465 unduplicated youth received one or more service directly provided by TPSN, which represents 73% (465/633) of the broader TPSN pregnant and parenting population in the Network during this time period. The graph below illustrates the services that TPSN offered to youth, based on their individual needs, along with the number of youth served during this time period.²⁴

²⁴ UCAN (2019). TPSN Year-End Report FY19. Chicago, IL: Author.

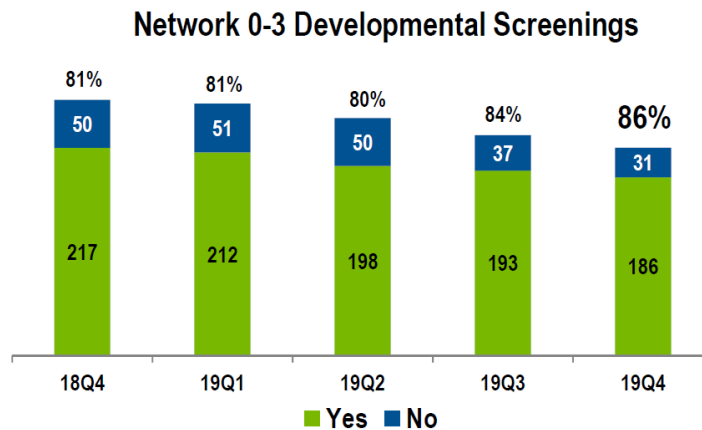
Figure 2. Service Types Received among Illinois Pregnant/Parenting Youth in the Teen Parenting Services Network (TPSN) in FY19



TPSN conducts new birth assessments (NBA) for all newborns among youth in the network. TPSN also continues to emphasize the importance of early developmental screening, in order to identify any developmental concerns that can be addressed through Early Intervention Services. TPSN service providers, including the DCFS Early Childhood Unit, Child Find, TPSN Family Developmental Specialists and PPT providers administer the Ages and Stages Questionnaire (ASQ) with parents and their children at different intervals, depending on the child’s age, and whether a concern is identified. Additionally, DCFS requires all New Birth Assessors to administer the ASQ developmental screening as part of the NBA process, ensuring that the vast majority of babies receive at least one developmental screening. The graph below illustrates the status of the Network’s efforts to ensure that the children (ages 0-3) receive a development screening over the last year.²⁵ The large majority of young children of TPSN participants receive their new birth assessments and developmental screenings. Among those who do not receive these services, every effort is made to follow-through. According to the FY19 TPSN report, of the 31 children who were noted as not having a developmental screening among the FY19 TPSN participants, 3 had an NBA in progress, and therefore the data for their developmental screening was not yet be entered. For the remaining 29 children, none of them had an NBA completed (Excluded, Unable to Assess, Entered Network after Child’s birth).

²⁵ UCAN (2019). TPSN Year-End Report FY19. Chicago, IL: Author.

Figure 3. FY19 Developmental Screenings of Children Born to Young Parents in DCFS Care



TPSN Programming Beyond Home Visiting: In addition to family development, clinical consulting, education support program, and other services, the Countdown to 21 (C21) staffing process (formerly known as DCIPP) provides adequate, strengths-based planning for pregnant and parenting youth leaving state care. The Department plans to expand its use of the Nurturing Parenting Program to 5 of 8 TPSN providers. Expansion of the program will support youth statewide, and that have been identified by DCFS for indicated child abuse and neglect; or who are at high risk for child abuse and neglect.

Nurturing Parenting Program for pregnant and parenting youth in care. The Nurturing Parenting Program (NPP) is a curriculum-based psycho-educational and cognitive-behavioral group intervention with home coaching that seeks to modify maladaptive beliefs that contribute to abusive parenting behaviors and to enhance parents' skills in supporting attachments, nurturing, and general parenting.

The program supports families in achieving the following goals:

- Increase parents' sense of self-worth, personal empowerment, empathy, bonding, and attachment;
- Increase the use of alternative strategies to harsh and abusive disciplinary practices;
- Increase parents' knowledge of age-appropriate developmental expectations;
- Reduce abuse and neglect rates.

Illinois DCFS currently has 7 statewide providers to pregnant and parenting youth through the Teen Parenting Services Network (TPSN). TPSN utilizes the AAPI [The Adult Adolescent Parenting Inventory] as a tool to help guide services in order to ensure that the youth's service team can identify and address any potential areas of risk or concern around parenting before a problem arises. While this tool has been in use by TPSN for some time, the program did not utilize the evidence based curriculum that targets the constructs measured by the AAPI. Beginning in FY20, the program will adopt the Nurturing Parenting Program (NPP). Out of the 7 providers, 5 will offer the Nurturing Parenting Program (NPP) beginning in FY20. Of these 5 agencies, based on their current caseload, they will target 80 youth. The providers are:

1. Catholic Charities PASS Program*
2. Crittenton Centers*
3. Cunningham Children's Home Project Parenthood Program*
4. Chestnut
5. Hoyleton's Parenting Program
6. Metropolitan Mom's Plus Program*
7. Springfield Urban League*

Asterisk (*) denotes NPP provider. If NPP was the recommended curriculum for all 8 providers; based on agencies capacity, 130-150 youth could be served.

Dosage: Intact families and Placement cases, into the tertiary level [treatment] of need. Dosage includes group sessions and home coaching sessions. IB3 utilized up to 23 sessions: 16-group and up to 7 home coaching sessions.

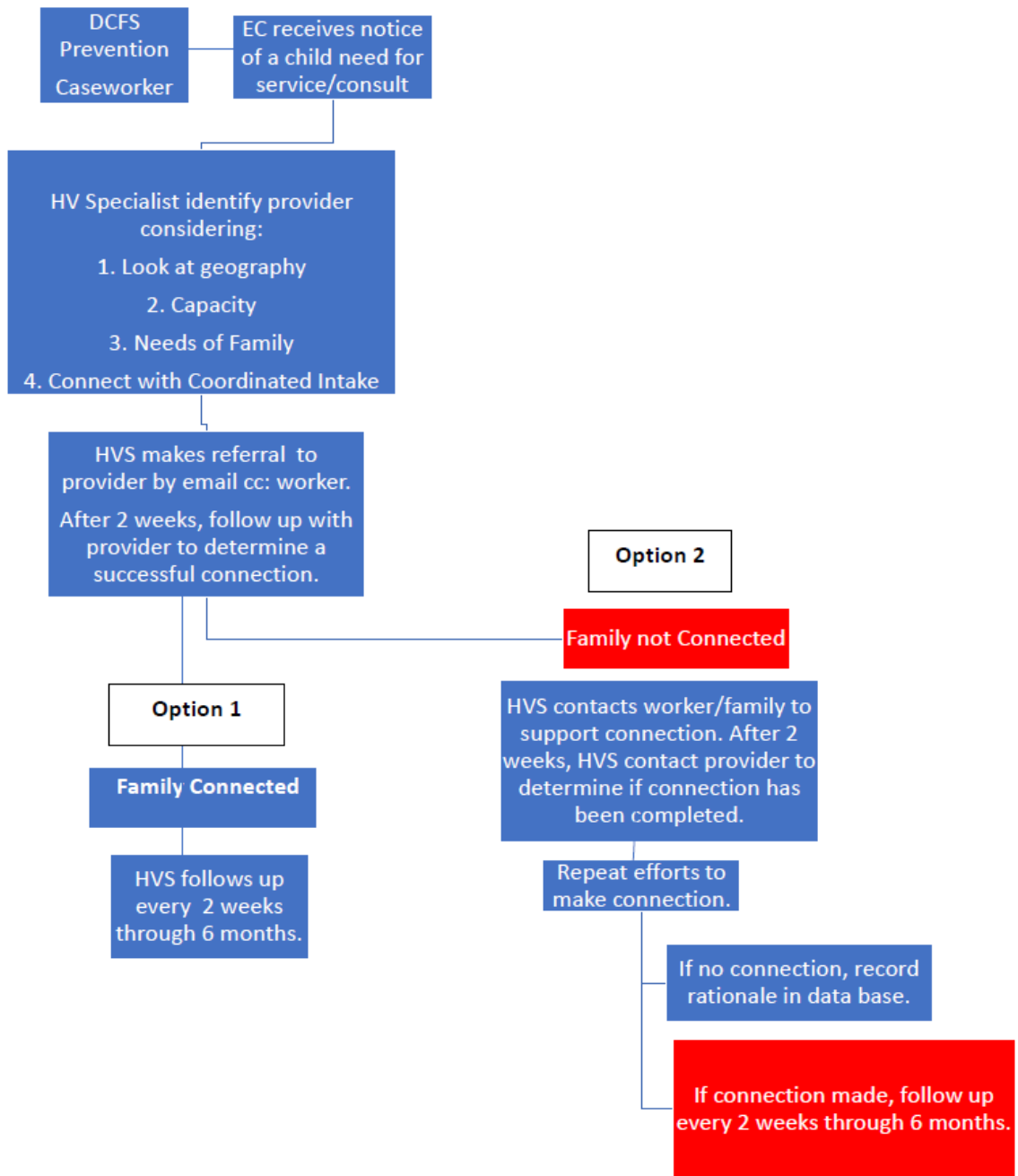
Program Operations

Families in need of HV services will be identified by their caseworker or as the result an EC screening or consult. When the family is identified, the recommendation will be forwarded to the HVP who will then refer the family to a provider. Many HV programs use coordinated intake to centralize the referral process. In those cases, the HVS will work with coordinated intake to assure linkage. Once we have notification that the connection has occurred, we will follow up every 2 weeks through six months to determine status/progress. If the family does not connect after the initial referral, the HVS, will make attempts to support the worker and family to engage the family.

Once a family is connected to a home visiting program, it is critical that the home visiting staff and the prevention caseworker communicate with each other to update the prevention plan. Sister Agencies cannot seek funds for interventions that they may provide that are not clearly identified in the prevention plan.

We anticipate the home visiting specialist will convene regular calls with home visiting providers within their regions. The home visiting specialists will also support communication and collaboration between child welfare prevention providers and home visiting providers.

Figure 4. Workflow Chart of Home Visiting Service Delivery (DRAFT)



Use of I/ECH Consultation to support clinical needs, collaboration and retention. The Illinois Children's Mental Health Partnership works closely with numerous public and private stakeholders to implement a multi-year Infant/Early Childhood Mental Health Consultation Initiative (Initiative) with the goal of developing and testing a universal, effective and sustainable Illinois Infant/Early Childhood Mental Health Consultation (I/ECMHC) Model, supported by an expanded and well qualified workforce. The DCFS Home Visiting Pilot will utilize the I/ECMHC model with our Home Visiting Specialists in order to support effective consultation with intact casework staff. In addition, the Home Visiting agencies also utilize I/ECMHC consultation to effectively serve the target client population. This was an essential resource in the teen parent pilot.

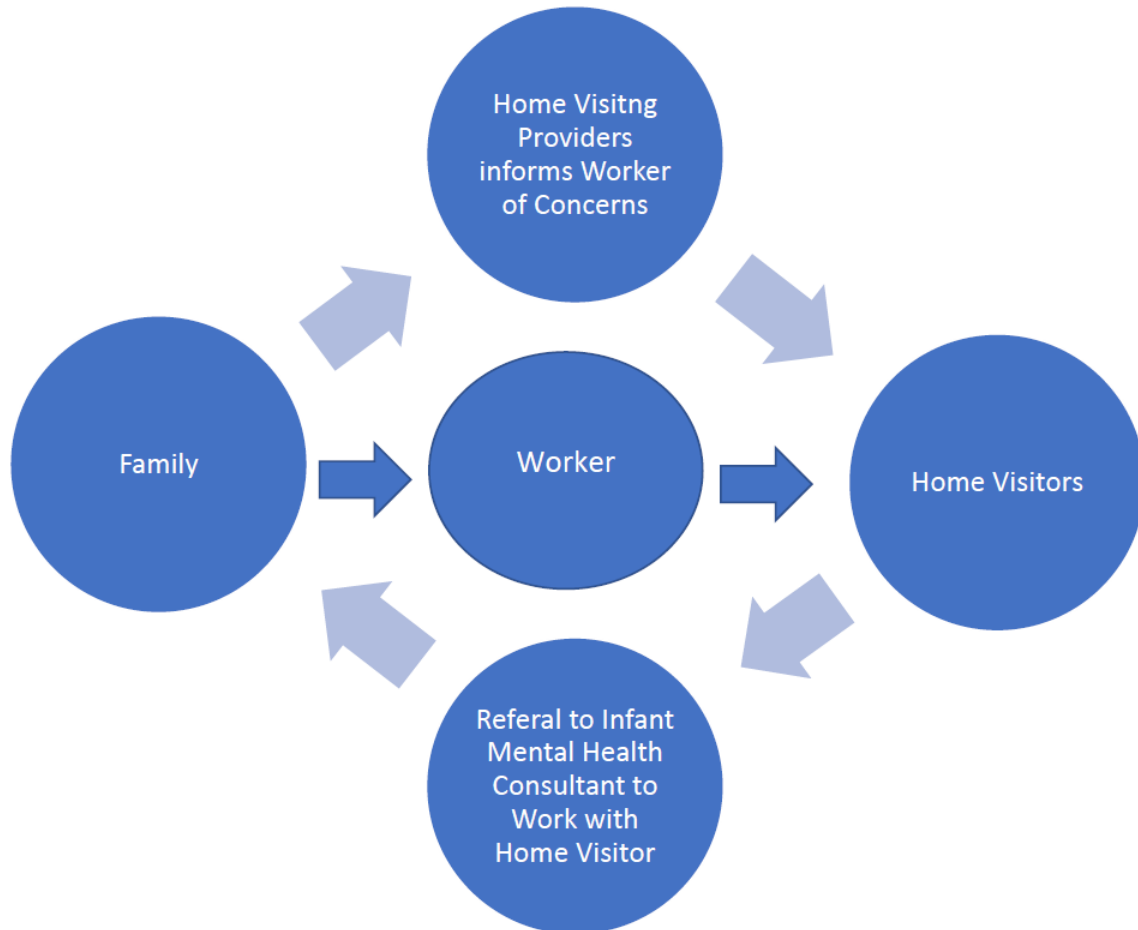
Infant and Early Childhood Mental Health Consultation (IECMHC) is a multi-level, proactive approach that teams multi-disciplinary infant early childhood mental health professionals with people who work with young children and their families to support and enhance children's social emotional development, health and well-being. **See Figure 5 below.**

IECMHC recognizes that social and emotional development is the foundation for success in learning and in life, and can be supported by strong partnerships between families, providers, programs, systems and IECMHC professionals. These partnerships promote and support infant/young children's healthy social emotional development; are a catalyst for building the capacity of providers and families to recognize the powerful influence of their relationships on young children's development (prenatally through early elementary), recognize young children's developmental needs, and support responsive caregiving.

Strategies used include: a relational, strengths-based and individualized approach to working with a wide variety of children, families, providers, and systems in diverse communities and settings; skilled observation, screening, assessment; and the development of individualized, targeted plans designed to help children reach their full potential.

Figure 5. Home Visiting Referral Process to Mental Health Consultation

Home-Visiting Referral Process to Infant Mental Health



Review of Maps of Capacity and CW census to identify target communities

The geographic distributions of our target population within intact family services and among pregnant and parenting youth in care illustrate the population needs to be served by home visiting programs.

The Illinois Early Childhood Asset Map produced maps which show home visiting program distribution by high-risk counties with number of children meeting <185% free or reduced-price lunch income criteria. An illustrative statewide map includes home visiting services by county including the: Prevention Initiative (PI) Home Visiting, Early Head Start (EHS) home-based program, Maternal Infant and Early Childhood Home Visiting (MIECHV) Program (MIECHV), Healthy Families Illinois (HFI), and Parents Too Soon (PTS) programs. **[See Attachment 7 for Illinois Early Childhood Asset Map.]** This map shows that Cook County has the highest population of children meeting <185% free or reduced-price lunch income criteria. However, surrounding Cook counties, Kankakee, Rock Island, Peoria, McLean, Champaign/Vermillion,

Sangamon/Macon, and Madison/St. Clair, have substantial numbers of children meeting <185% free or reduced-price lunch income criteria.

DCFS has worked to generate analyses of counts of intact family cases served by Intact Family Services in each county in FY19 for children aged 6 months and under and children aged 3 years and younger, in order to plan for home visiting service delivery by state geographic regions. This analysis will support DCFS in understanding population trends in Illinois, relative to potential needs for home visiting services. Program capacity to deliver different evidence-based home visiting programs in these geographic regions varies. **[See Attachment 8 for county-level mapping charts for Intact Family program cases with children 6-months and under, and children aged 3 and under].**

VI. Use of Evidence-Based Home Visiting Models

Illinois currently offers home visiting programs including Healthy Families America, Parents as Teachers, and Nurse-Family Partnership. In order to maximize federal claiming of funds from the Title IV-E requirements of the Family First Prevention Services Act (FFPSA) legislation, Illinois Department of Children and Family Services (DCFS) must implement evidence-based interventions. Home visiting interventions are considered eligible for reimbursement under the FFPSA prevention services Title IV-E program. At least 50% of funding expended on the state's funded prevention services must be classified as "Well Supported" by evidence.

DCFS has begun coordinating planning with other Illinois agencies to offer evidence-based prevention services to families including mental health services, substance use treatment, and in-home parenting skill training, including home visiting. States choose evidence-based interventions tailored to the needs of its population and based on evidence ratings by the Title IV-E Clearinghouse (<https://preventionservices.abtsites.com/>). The Title IV-E Clearinghouse classifies programs and practices as "Well Supported", "Supported", or "Promising" based on the evidence. The federal reimbursement of prevention services will be 50% through 2025, and then at the Federal Medical Assistance Percentage (FMAP) rate. Administration and training costs are reimbursable at 50%.

Healthy Families America, Parents as Teachers, and Nurse-Family Partnership programs each have Well-Supported evidence ratings according to the Title IV-E Clearinghouse. **[See Attachment 5 for detailed overview of these home visiting services from the California Evidence-Based Clearinghouse.]** Few programs rated by the Title IV-E Clearinghouse have been shown to be effective with children, youth, and families in the child welfare system in improving child welfare outcomes. It is therefore important to evaluate the effects of Illinois' implementation of home visiting program with rigorous evaluation designs, with DCFS-involved youth and families.

Healthy Families America. Among the home visiting programs with Well-Supported evidence ratings, Healthy Families America has tailored its intervention model to adapt to the needs and strengths of the child welfare population. Healthy Families America (HFA) is a home visiting program model tailored to families who may have histories of trauma, intimate partner violence, mental health issues, and/or substance abuse issues. HFA's services begin in pregnancy and are intended to support new parents through the first 3-5 years. Program

participation is optional and relatively intensive. During pregnancy and for a minimum of six months after the baby is born, weekly home visits are recommended. Home visits are 50-60 minutes in length, on average. Home visitors may meet with families more than 1x per week, depending on nature of the risks, crises, etc. The frequency of home visits decreases over time, depending on the age of the child and needs of the mother and family.

Parent as Teachers (PAT). The PAT program provides parents with child development knowledge and parenting support and conducts early detection of developmental delays and health issues. Features of the program include: one-on-one home visits, monthly group meetings, developmental screenings, and linkages and connections for families to needed resources. With the aim of preventing child abuse and neglect and increasing children's school readiness, parent educators conduct the home visits using structured visit plans and guided planning tools. Local sites offer at least 12, hour-long home visits annually with more offered to higher-need families. PAT serves families for at least two years between pregnancy and kindergarten.

Nurse-Family Partnership. The Nurse-Family Partnership (NFP) is a home visiting program designed for first-time, low-income mothers and their children. The program features one-on-one home visits by a trained registered professional nurse, early in the woman's pregnancy. Monthly home visits begin no later than the 28th week of gestation, and conclude when the woman's child turns 2 years old. NFP's services target improvements in (1) prenatal and maternal health and birth outcomes, (2) child health and development, and (3) families' economic self-sufficiency and/or maternal life course development. Home visiting nurses teach positive health related behaviors, competent care of children, and maternal personal development (family planning, educational achievement, and participation in the workforce).

Continuous Quality Improvement

The Illinois HV system includes multiple evidence-based models funded through multiple funding streams and requires a cross-model monitoring approach to assure fidelity and quality system-wide. Two major funders of Illinois Home Visiting, MIECHV and ISBE, have been using the Home Visiting Program Quality Rating Tool (HVPQRT) to monitor for quality and drive the CQI process. The HVPQRT was designed to be easily understandable, feasible to conduct in a timely manner, and capable of providing a process for programs to reflect on their strengths as well as areas of challenge. It provides a uniform standard of quality across Illinois HV programs and a mechanism by which HV programs may monitor their own quality improvement.

An evaluation of the HVPQRT was carried out under the FY15 and FY16 MIECHV Innovations/Competitive grants. Overall results of the evaluations indicated that the HVPQRT is a useful tool for assessing program quality across models. It was able to differentiate programs across multiple dimensions of quality and provide relatively stable estimates of quality across time and raters.

- Utilization - tracking utilization of the models;
- Quality - measurement of implementation fidelity;
- Identification of Barriers - feedback from home visiting staff and clients; outcomes (for ex. Difficult to engage families; when additional resources are needed (IMH services); difficult to engage caseworker)

VII. Cross System Collaborations and Funding

DCFS has an existing MOU with Healthy Families America/International serving teen parents (through aged 21). Additional MOU's may need to be created in order to support effective cross collaboration between systems. Multi-year funding agreements are essential to support program sustainability (Wasserman, 2006).²⁶ As the Erikson DCFS Early Childhood Project Home Visiting Specialist pilot progresses, the challenges they find in cross-system collaboration will inform seeking additional MOU's.

In February 2018, the Family First Prevention Services Act (FFPSA) was signed into law to transform federal financing for child welfare programming in two major ways. First, FFPSA allows Title IV-E funding to be used to fund up to one-year of evidence-based prevention services for children and families who are "candidates for foster care," i.e., at "imminent risk" of child welfare involvement. Second, FFPSA regulates financial support for youth in congregate care settings to limit long stays in congregate care, provide residential treatment options for youth with clinical need, and establishes criteria for Qualified Residential Treatment Programs (QRTPs). The deadline for states to begin implementation of Title IV-E provisions is October 1, 2021. At least 50% of the state's funded prevention services must be classified as "Well Supported" by evidence, according to the Title IV-E Clearinghouse (<https://preventionservices.abtsites.com/>). The federal reimbursement of prevention services will be 50% through 2025, and then at the Federal Medical Assistance Percentage (FMAP) rate. Administration and training costs are reimbursable at 50%.

There are three areas of funding that will need to be considered in this program. These are: 1) The Home Visiting Intervention, provided by Sister Agencies, 2) The DCFS Home Visiting Program, and 3) support for Infant/ Early Childhood Mental Health Consultation, which provides support directly to home visitors providing services to child welfare families.

1. Funding for the HV intervention provided by Sister Agencies: Illinois Department of Human Services (IDHS) and Illinois State Board of Education (ISBE)

As the Single State Agency for the federal Title IV-E program, DCFS processes all eligible IV-E claiming for reimbursement. DCFS currently maintains a state appropriation for the purpose of allowing the pass through of funds from the Title IV-E program to public entities for eligible services. The stated legislative intent of this appropriation is, "To fund the claiming and capture of increased Title IV-E federal reimbursements." This is a non-general revenue fund appropriation, from the Department's Children's Services Fund which is an Other State Fund (OSF) line and allows for the immediate pass-through of processed claims. The Department intends to request a legislative increase in this appropriation in SFY21, to expand the claiming opportunity from the existing Title IV-E traditional claims that have been processed for many years to include the new Title IV-E Prevention services once the Department elects to participate in the program.

An Interagency Agreement will need to be developed with each public agency interested in participating in the Title IV-E Prevention claiming. This agreement will outline each entity's responsibility and liability. Since IV-E operates as an open-ended entitlement grant, claiming

²⁶ Wasserman, M. (2006). *Implementation of home visitation programs: Stories from several states*. Chicago, IL: Chapin Hall Center for Children.

requires that qualifying services as outlined in the State's IV-E plan and provided to a qualified individual within the defined prevention candidacy population may be partially reimbursed at approximately 50% (less administrative processing fees). Outlined in-depth within the Interagency Agreement is the detailed File Transfer Protocol (FTP) or required billing elements necessary to submit a claim. These files which contain the family and billing information must be submitted no less than quarterly, but are broken out by month of service. Following each quarter of service, it takes approximately 90 days for the claims to be processed and returned to the state and transferred to the agency in accordance with the Agreement.

2. Funding for the Home Visiting Program

Given expansion of Home Visiting to the child welfare system was a priority of the Preschool Development grant, funding for the first Home Visiting Specialist position was implemented for FY20. Erikson projects the cost for 4 FTE Home visiting specialists and their supervisor at \$521,110. **The budget can be found in Attachment 2.**

3. The Pre-School Development Grant

The Preschool Development Grant Birth-5 is a federally funded (DHHS) grant to support statewide early childhood systems building. Illinois' PDGB-5 for year 1 included funds to support a position (Home Visiting Specialist) to be housed at DCFS and which will facilitate identification of barriers and challenges to engagement of children in child welfare into our home visiting system. If awarded, year 2 would include implementation of plans developed in year 1. This planning is, and can continue to, support and coordinate with the FFPSA planning.

VIII. Evaluation

During the TPSN pilot, weekly consultation calls were required to monitor service delivery and troubleshoot when services are not consistently delivered. We anticipate the home visiting specialist will convene regular calls with home visiting providers within their regions.

In a meta-analysis of home visiting programs' effects on child maltreatment outcomes, Catherine Casillas and her colleagues at the University of Colorado²⁷ found that training, supervision, and fidelity monitoring have significant effects on program outcomes, especially child maltreatment outcomes. Role playing during training was actually found to be more effective than trainees completing a practice case, which can be anxiety-provoking. Home visiting programs with supervisors who listened and provided emotional support to their home visitors had more positive impact than those with less reflective and supportive supervisors. Programs with consistent, ongoing, and embedded fidelity monitoring had better results than programs with infrequent fidelity monitoring.

The program evaluation team will design and implement a program evaluation that will measure program effectiveness for program participants compared to non-program participants, matched on key demographic characteristics. The purpose of this evaluation will be to understand the effectiveness of home visiting services among child-welfare involved families that are more difficult to engage populations.

²⁷ Casillas, K. L., Fauchier, A., Derkash, B. T., & Garrido, E. F. (2016). Implementation of evidence-based home visiting programs aimed at reducing child maltreatment: A meta-analytic review. *Child Abuse & Neglect*, 53, 64-80.

The program evaluation will measure outcomes according to the logic model (**See Attachment 4**), which maps program implementation to short and longer-term outcomes. The program evaluation will also measure fidelity of implementation to the model, as well as track the receipt of home visiting services by program type, and by important sub-groups (e.g., pregnant and parenting youth in care, mothers with substance use disorders, parents with mental health disorders, etc.). Wherever possible, evaluation of home visiting model fidelity will be conducted in alignment with each model's fidelity monitoring, to avoid duplication of effort and to minimize burden on the home visiting programs. Wasserman (2006) reports on the importance of understanding program implementation factors and service delivery to understanding outcomes achieved by the expansion of home visiting services to our child-welfare involved target population.²⁸

The program evaluation will include assessment of:

- Training operations and delivery
- Program implementation by model type (HFI, PAT, etc.)
- Program implementation for various sub-populations
 - Intact family services
 - Intact family recovery
 - Pregnant and parenting youth in care by age
- Program outcomes attained for home visiting participants vs. non-participants, including:
 - Parent engagement during pregnancy
 - Parent engagement after pregnancy
 - Parenting behaviors and practices
 - Maternal health behaviors and outcomes
 - Child health outcomes
 - Indicated reports of child maltreatment
 - Child entry into DCFS care

²⁸ Wasserman, M. (2006). *Implementation of home visitation programs: Stories from several states*. Chicago, IL: Chapin Hall Center for Children.

Attachments

Attachment 1. DCFS/ Home Visiting Policy (DRAFT Proposed)

The Illinois Department of Children and Family Services recognizes that child welfare involved young children are at increased risk for adverse experiences that can impact their early relationships and development. IDCFS also recognizes that there are evidenced based approaches i.e. home visiting services which can support and strengthen the parent child relationship. The parent child relationship is one of the most important factors in a young child's development.

In keeping with this knowledge, the Illinois Department of Children and Family Services commits to facilitating effective linkage to home visiting programs for families with children prenatal to three years old identified as in need of these home visiting services. As home visiting availability varies by community, this linkage will occur whenever there is a program the family qualifies for within the service area. IDCFS will also track when families are not able to be referred for this service due to lack of an available resource or a lack of program in the family's area. In keeping with Family First Prevention Services Act, priority will be given to linkage to home visiting programs that are well-supported.

Right of and Best Practice for Serving Prevention Population (i.e. Intact Family Services) Child Welfare Involved Families with Children Birth to Three: To be connected to ongoing parenting supports and community resources.

Identification of Families in need of Home Visiting Services:

Families may be identified as in need of home visiting services through the following means:

1. Prenatal Events- While home visiting services can demonstrate positive impacts when initiated post-pregnancy, the beneficial effects of home visiting services are amplified most when services begin early in pregnancy. Home visiting begun prenatally may increase use of prenatal care; improve infant health, increase vaccination; and reduce infant visits to the emergency room.

For these reasons, the prenatal population will be a priority population for initiating Home Visiting Services. This policy will **REQUIRE** the IDCFS/POS case manager to contact Erikson DCFS Early Childhood Project at **____(intake email needed)_____** within 72 hours following any of the following pregnancy or parenting events:

- Disclosure of pregnancy by a client served in prevention [i.e. intact] services;
- Partner pregnancy (a parent being served in prevention services believes their partner is pregnant or is the parent of a child already born);
- Delivery;
- Miscarriage; or Stillbirth.

The IDCFS/POS case manager must also record any of these events in a Significant Event Report. (See Procedures 331, Significant Event Reports.)

2. A case manager may identify the need for home visiting given they identify a parent is parenting a child younger than 6-months of age.
3. The need for home visiting may be recognized through consultation or assessment of a family with the Erikson Institute DCFS Early Childhood Project. The Erikson DCFS Early Childhood Project receives notification of all newly opened intact family cases with children Birth to three and offers assessment or consultation through individual outreach to case managers.
4. Parents may request home visiting services or in-home parenting support if they have children within the target age group.

When a family is identified as in need of Home Visiting services in any of the above circumstances, IDCFS policy dictates efforts be made to link a family to a Home Visiting provider in the family's community (of note, there are 17 counties statewide where this service is not available).

In keeping with a family's right to Home Visiting services, IDCFS notes the following responsibilities with regard to Home Visiting referrals below.

Home Visiting Referrals and Operations

The Erikson Institute DCFS Early Childhood Project will:

- Locate available Home Visiting resources and their qualifying criteria. The Project will build relationships with staff at these Home Visiting programs, and keep updated lists of available Home Visiting programs and their intake criteria and census;
- With appropriate consent, facilitate direct referrals or utilize coordinated intake to Home Visiting programs that the family qualifies for;
- Will offer follow up and support to assure the referrals result in the family's successful engagement in the Home Visiting services.
- Will provide consultation to prevention casework staff to support engagement in Home Visiting services- if needed, they will provide consultation to Home Visiting providers around system issues preventing engagement.
- Will track efforts to support referrals and the outcomes, including barriers to the service implementation.
- Will notify the case manager and supervisor of the outcomes of referrals, and enlist their support if there are barriers to the family's engagement
- Will connect families and home visitors with mental health consultation when need has been identified by the Home Visiting provider.
- Will track areas where child welfare involved families do not have access to Home Visiting services.

The IDCFS/ POS Intact Case Manager will:

- Consider Home Visiting as a critical, voluntary service for any family with young children, in utero to age 6 months-old;
- Notify the Erikson DCFS Early Childhood Project whenever there is a prenatal event (see above);
- Assure that parental consent to make the Home Visiting referrals is obtained as needed;
- Will support efforts to link families through consulting with the Erikson DCFS Early Childhood Project and family to address barriers to service;
- Will maintain contact with the Erikson DCFS Early Childhood Project and Home Visiting staff as needed.
- Notify home visiting staff of placement changes and other significant events (e.g., hospitalizations, running away, detention) that can impact service delivery.
- Provide support for family members as they determine membership in their child and family team, to consider inclusion of home visiting providers.

IDCFS values its community partners. In keeping with the community partnerships behind home visiting, for child welfare involved families.

The Home Visiting Programs will:

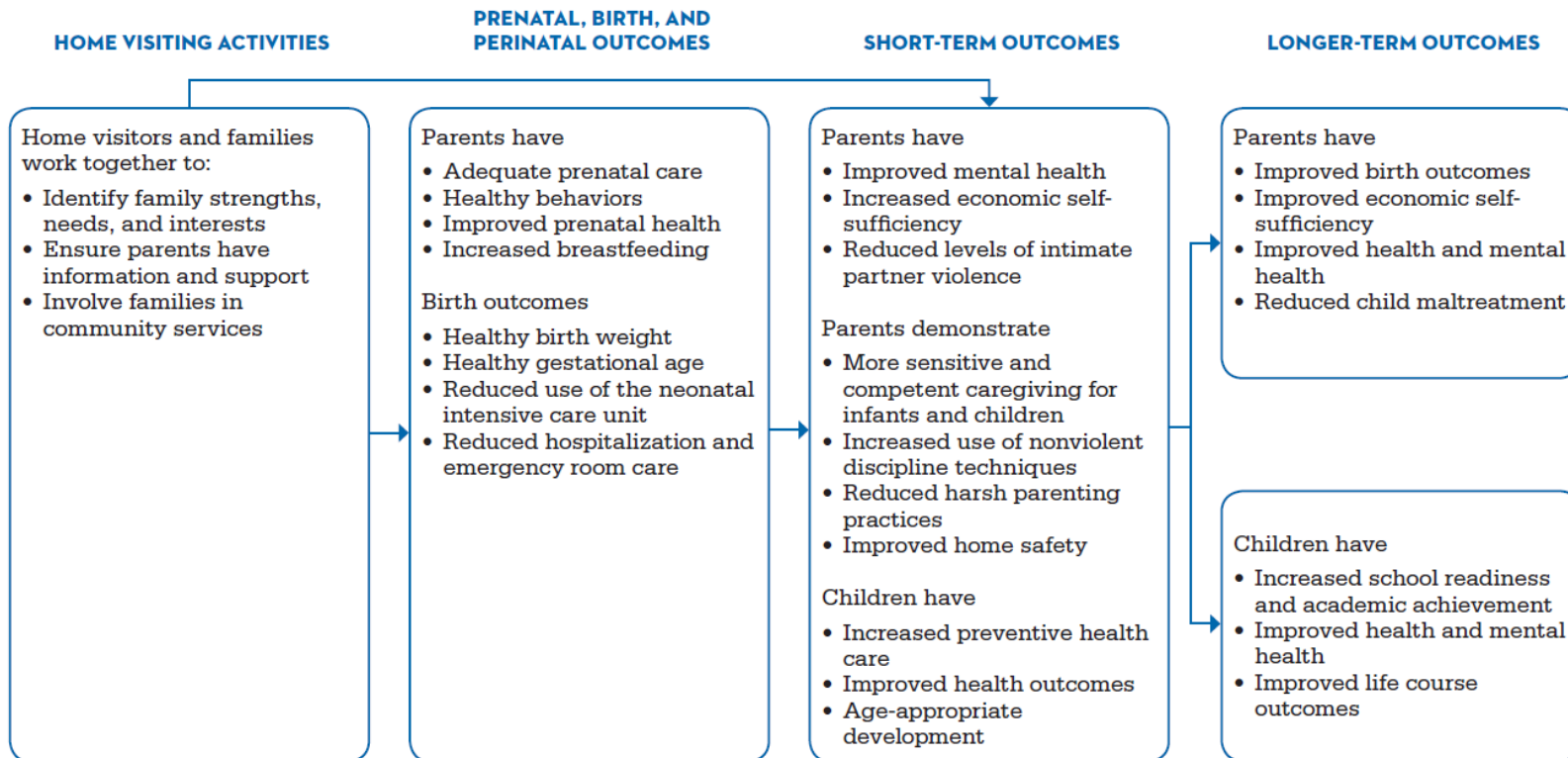
- Assure communication of engagement, treatment plans and outcomes with the child welfare IDCFS/POS case manager to be added to the child welfare prevention(service) plan. This is essential to assure reimbursement for the services through the Family First Prevention Service Act.
- Will communicate with IDCFS/POS partners before closing referrals or open service cases for child welfare involved families.

Attachment 2: DCFS Early Childhood Budget Proposal for the Home Visiting Program

Table of Budget Categories and Proposed Expenditures

Not Available	

Attachment 3. Logic Model of Home Visiting Services²⁹



SOURCES: Early Head Start Parent, Family, and Community Engagement (PFCE) Framework, Healthy Families America logic model, Nurse-Family Partnership logic model, and Parents as Teachers logic model

²⁹ Charles Michalopoulos, Sarah Shea Crowne, Ximena A. Portilla, Helen Lee, Jill H. Filene, Anne Duggan, and Virginia Knox. (2019). *A Summary of Results from the MIHOPE and MIHOPE-Strong Start Studies of Evidence-Based Home Visiting*. OPRE Report 2019-09. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Attachment 4. Summary of Chapin Hall Center for Children Evaluation of the Home Visiting Pilot for Pregnant and Parenting Youth in Foster Care

The home visiting pilot connected pregnant and parenting youth in foster care with home visiting services. Nine Healthy Families Illinois (HFI) programs participated in the pilot. Those programs provided home visiting services to 43 youth in care who were pregnant or who had a child under age one at the time they enrolled. Several major themes emerged from Chapin Hall's evaluation.

Factors influencing engagement. Several factors influenced young people's decision to engage in home visiting services. These included the voluntary nature of home visiting services, the promise of confidentiality, the dependability of their doulas and home visitors, their need for parenting education, and their desire for baby items.

Building trusting relationships is challenging but key. The home visitor-client relationship is central to the HFI model and pilot clients grew to trust their home visitors and doulas although they were sometimes slow to open up.

Need for a Natural Support System. Many pilot clients lacked a natural support system. Home visitors and doulas filled roles that these natural supports otherwise would.

Benefits of home visiting services. Pilot clients benefitted from the services they received from their home visitors and doulas in a number of different ways. They learned about childbirth, child development and parenting. They also developed coping skills and some of the clients developed positive relationships with the fathers of their babies.

Factors complicating youth engagement and service delivery. Two factors--placement instability and personal crises-- had an adverse impact on engagement and service delivery. Although some pilot clients had relatively stable placements while they were enrolled, others changed placements multiple times. Many pilot clients also experienced one or more non-placement events, such as detention, hospitalization or running away, that disrupted their placements. Personal crises related to mental health problems and intimate partner violence also hindered the delivery of home visiting services.

Navigating the child welfare system is challenging for home visitors. Despite attending a cross-training designed, in part, to familiarize HFI program staff with the child welfare system, home visitors and doulas still had many questions about how DCFS works and about the services and resources available to their pilot clients. Working with pilot clients in congregate care posed an additional set of challenges and prevented some HFI programs from delivering services as usual.

Sharing information with the child welfare system is a complicated issue for HFI program programs. Staff disagreed about the importance of knowing about a pilot client's background but agreed that other information was essential to their jobs. HFI program staff also raised concerns about sharing information about their pilot clients with child welfare workers and about their role in child welfare team meetings.

Variation in the ability of programs to work with this population. Factors such as the state budget impasse and staff turnover affected the ability of HFI programs to work with this population. The willingness of HFI programs to accommodate this population's unique needs also affected the extent to which they were able to keep their pilot clients engaged.

Maintaining fidelity to the HFI model can be a challenge. Home visitors and doulas often deviated from what they typically do to engage and deliver services to their pilot clients. These deviations stemmed from several factors including difficulties enrolling youth in the pilot, the need of pilot clients for extra support, the HFI level system, which dictates how often clients are seen, and working with pilot clients whose children were in DCFS care.

Home visitors and doulas routinely exceeded expectations. Home visitors and doulas frequently went “above and beyond” what they were expected to do to meet the needs of their clients. Pilot clients interpreted this as evidence that their home visitors and doulas “genuinely care.”

Supports for home visitors and doulas. All of the HFI programs that participated in the pilot had access to infant mental health consultants and FAN training. Both were helpful to home visitors and doulas in their work with pilot clients.

Attachment 5. Descriptions of Evidence-Based Home Visiting Interventions (from California Evidence-Based Clearinghouse, CEBC): Healthy Families America, Parents as Teachers, and Nurse-Family Partnership

Healthy Families America [Home Visiting for Child Well-Being] (HFA)

Source: <http://www.cebc4cw.org/program/healthy-families-america-home-visiting-for-child-well-being/>

Target Population: Overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences; families are determined eligible for services once they are screened and/or assessed for the presence of factors that could contribute to increased risk for child maltreatment or other poor childhood outcomes, (e.g., social isolation, substance abuse, mental illness, parental history of abuse in childhood, etc.); home visiting services must be initiated either prenatally or within three months after the birth of the baby. **HFA** services are offered voluntarily, intensively, and over the long-term (3 to 5 years after the birth of the baby).

The goals of **Healthy Families America (HFA)** are:

- Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth
- Cultivate and strengthen nurturing parent-child relationships
- Promote healthy childhood growth and development
- Enhance family functioning by reducing risk and building protective factors

HFA is a home visiting program model designed to work with families who may have histories of trauma, intimate partner violence, mental health issues, and/or substance abuse issues. **HFA** services are offered voluntarily, intensively, and over the long-term (3 to 5 years after the birth of the baby).

HFA is theoretically rooted in the belief that early, nurturing relationships are the foundation for life-long, healthy development. Building upon attachment, bio-ecological systems theories, and the tenets of trauma-informed care, interactions between direct service providers and families are relationship-based; designed to promote positive parent-child relationships and healthy attachment; services are strengths-based; family-centered; culturally sensitive; and reflective.

The **HFA** model is based upon 12 Critical Elements. These Critical Elements are operationalized through a series of standards that provide a solid structure for quality, yet offer programs the flexibility to design services specifically to meet the unique needs of families and communities.

HFA's Vision: All children receive nurturing care from their family essential to leading a healthy and productive life.

HFA's Mission: To promote child well-being and prevent the abuse and neglect of our nation's children through home visiting services.

The essential components of **Healthy Families America (HFA)** include:

- o The 12 Critical Elements: Initiate services prenatally or at birth

- o Use standardized screening and assessment tools to systematically identify and assess families most in need:
 - The Parent Survey (formerly the Kempe Family Stress Checklist) or other **HFA**-approved tool is used to assess the presence of various factors associated with increased risk for child maltreatment or other adverse childhood experiences.
- o Offer services voluntarily and use positive, persistent outreach efforts to build family trust
- o Offer services intensely and over the long-term, with well-defined criteria and a process for increasing or decreasing frequency of service
- o Take into account the culture of families in the services offered such that staff understands, acknowledges, and respects cultural differences of families:
 - Staff and materials used by the site reflect to the greatest extent possible the cultural, language, geographic, racial, and ethnic diversity of the population served.
- o Focus on supporting the parent(s) as well as the child through services that cultivate the growth of nurturing, responsive parent-child relationships and promote healthy childhood growth and development
- o Link all families to a medical provider to ensure optimal health and development
 - Depending on the family's needs, they may also be linked to additional services related to: finances, food, housing assistance, school readiness, child care, job training, family support, substance abuse treatment, mental health treatment, and domestic violence resources.
- o Ensure Family Support Specialists have an adequate amount of time to spend with each family to meet their unique and varying needs and to plan for future activities by providing services in accordance with principles of ethical practice and with limited caseloads
- o Select service providers based on:
 - Their personal characteristics
 - Their willingness to work in, or their experience working with, culturally diverse communities
 - Their knowledge and skills to do the job
- o Provide intensive training to service providers specific to their role to understand the essential components of family assessment, home visiting, and supervision.
- o Ensure service providers have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families
 - All service providers receive basic training in areas such as culture, reporting child abuse, determining the safety of the home, managing crisis situations, and responding to mental health, substance abuse, or intimate partner violence issues, drug-exposed infants, and services in their community.
- o Give service providers ongoing, effective supervision so they are able to develop realistic and effective plans to empower families

Healthy Families America (HFA) directly provides services to parents/caregivers and addresses the following:

Expectant or new parents screened and/or assessed as moderate to high risk for child maltreatment and/or poor early childhood outcomes (e.g., mental health issues, domestic violence, substance abuse, poverty, housing, lack of education, lack of social support, etc.).

Services Involve Family/Support Structures:

This program involves the family or other support systems in the individual's treatment: While the focus is on the primary caregiver and index child, HFA welcomes all interested family members in home visits, and works to engage fathers in particular. In addition, parents are linked to other services in the community as needed, as detailed under the service content section.

Recommended Intensity:

Families are offered weekly home visits for a minimum of six months after the birth of the baby. Home visits typically run 50-60 minutes. Upon meeting the defined criteria for family functioning, visit frequency is reduced to biweekly visits, monthly visits, and quarterly visits and services are tapered off over time. Typically, during pregnancy, families receive 2-4 visits per month. During times of crisis families may be seen 2 or more times in a week.

Recommended Duration:

Services are offered prenatally or at birth until the child is at least three years of age and can be offered until they are five years of age.

Delivery Setting

This program is typically conducted in a(n): Birth Family Home.

Homework

This program does not include a homework component.

Languages

Healthy Families America (HFA) has materials available in a language other than English: Spanish

For information on which materials are available in this language, please check on the program's website or contact the program representative ([contact information](#) is listed at the bottom of this page).

Resources Needed to Run Program

The typical resources for implementing the program are:

- A local implementing agency or a collaboration of host agencies that provide office space with confidentiality related to participant files/records
- Computer and email
- Data or tracking system
- Cell phones
- Program Manager
- 1 FTE Supervisor per 5-6 FTE direct services staff (home visitors and/or assessment staff)
- Travel expense reimbursement (mileage) for home visitors

- A community advisory board
- Diversified, and sustainable funding

Prerequisite/Minimum Provider Qualifications

Program staff is selected because of a combination of personal characteristics, experiential, and educational qualifications.

Direct Service Staff should have qualifications including, but not limited to:

- Experience in working with or providing services to children and families
- An ability to establish trusting relationships
- Acceptance of individual differences
- Experience and willingness to work with the culturally diverse populations that are present among the program's target population
- Knowledge of infant and child development
- Open to reflective practice (i.e. has capacity for introspection, communicates awareness of self in relation to others, recognizes value of supervision)
- Minimum of a high school diploma or equivalent
- Infant Mental Health endorsement preferred

Supervisors should have qualifications including, but not limited to:

- A solid understanding of and experience in supervising and motivating staff, as well as providing support to staff in stressful work environments
- Knowledge of infant and child development and parent-child attachment
- Experience with family services that embrace the concepts of family-centered and strength-based service provision
- Knowledge of maternal-infant health and dynamics of child abuse and neglect
- Experience in providing services to culturally diverse communities/families
- Experience in home visiting with a strong background in prevention services to the 0-3 age population
- Master's degree in human services or fields related to working with children and families, or Bachelor's degree with 3 years of relevant experience
- Experience with reflective practice preferred
- Infant Mental Health endorsement preferred

Program managers should have qualifications including, but not limited to:

- A solid understanding of and experience in managing staff
- Administrative experience in human service or related program(s), including experience in quality assurance/improvement and program development
- Master's degree in public health or human services administration or fields related to working with children and families, or a Bachelor's degree with 3 years of relevant experience

Education and Training Resources

There is a manual that describes how to implement this program , and there is training available for this program.

Training Contact:

Kate Whitaker
www.healthyfamiliesamerica.org
kwhitaker@preventchildabuse.org
phone: (520) 297-9158

Training is obtained:
Training is provided in person either in state or regionally

Number of days/hours:
4 full days for direct service staff, 5 days for supervisors

Two tracks: Parent Survey (assessment) and Integrated Strategies (home visiting)
Three day advanced clinical and reflective practice training for Supervisors

Pre-Implementation Materials

There are pre-implementation materials to measure organizational or provider readiness for **Healthy Families America (HFA)** as listed below:

The **HFA** model is supported by 12 research-based critical elements and a series of corresponding best practice standards. At the time a provider seeks to affiliate with **HFA**, they are required to submit an implementation plan that discusses how they intend to carry out model requirements. It is not unusual at this stage for sites to be uncertain of some areas, and a structured consultation phone call occurs to help the organization determine its level of readiness to begin implementation. Prior to implementation, **HFA** sites are also provided a copy of the HFA Site Development Guide.

Formal Support for Implementation

There is formal support available for implementation of **Healthy Families America (HFA)** as listed below:

The HFA National Office provides ongoing implementation support, including a 3-day in-person Implementation Training that focuses intensely on what is expected to deliver **HFA** services in accordance with the *HFA Best Practice Standards*. Technical assistance (provided both in-person and remotely), staff training, and periodic accreditation site visits to measure each site's ability to implement the model with fidelity are also components of the formal implementation support offered to sites. The National Office also provides CQI guidance as needed on how to address best practice standards not in adherence. Some materials are available at the HFA website: www.healthyfamiliesamerica.org

Fidelity Measures

There are fidelity measures for **Healthy Families America (HFA)** as listed below: **HFA** requires implementing sites to utilize the **HFA** Best Practice Standards and to demonstrate fidelity to the standards through periodic accreditation site visits. The *HFA Best Practice Standards* serve as both the guide to model implementation, as described above, and as the tool used to measure adherence to model requirements. There are 153 standards and each is coupled with a set of rating indicators to assess the site's current degree of fidelity to the model.

All **HFA** affiliated sites are required to complete a self-study that illustrates current site policy and practice, and an outside, objective peer review team uses this in conjunction with a multi-day site visit to determine the site's rating (of exceeding, meeting or not yet meeting) for each standard.

Implementation Guides or Manuals

There are implementation guides or manuals for **Healthy Families America (HFA)** as listed below:

HFA has a *Site Development Guide* and *State Systems Development Guide* that are accessible via the **HFA** website. The *HFA Best Practice Standards* is an extensive model-specific implementation document provided to all HFA affiliated sites. *HFA Site Development Guide* is a comprehensive planning guide to support prospective sites and new sites. It provides expert guidance and practical tips related to community planning, organizational infrastructure, budgeting, staffing, local advocacy, etc. The *HFA State Systems Development Guide* provides similar guidance as the *Site Development Guide* but is geared toward state leaders who want to strengthen state-level infrastructure to support HFA home visiting in their state. The *HFA Best Practice Standards* is the go-to document for purposes of understanding the required elements of model implementation and expectations related to all aspects of policy and practice.

Parents as Teachers

Source: <http://www.cebc4cw.org/program/parents-as-teachers/>

Target Population: Families with an expectant mother or parents of children up to kindergarten entry (usually 5 years).

Parents as Teachers is an early childhood parent education, family support and well-being, and school readiness home visiting model based on the premise that "all children will learn, grow, and develop to realize their full potential." Based on theories of human ecology, empowerment, self-efficacy, attribution, and developmental parenting, **Parents as Teachers** involves the training and certification of parent educators who work with families using a comprehensive curriculum. Parent educators work with parents to strengthen protective factors and ensure that young children are healthy, safe, and ready to learn. An agency may choose to use the Parents as Teachers model to focus services primarily on pregnant women and families with children from birth to age 3 or through kindergarten.

The four goals of **Parents as Teachers** are:

1. Increase parent knowledge of early childhood development and improve parenting practices
2. Provide early detection of developmental delays and health issues
3. Prevent child abuse and neglect
4. Increase children's school readiness and school success

The essential components of **Parents as Teachers** include:

Personal Visits: Home visitation is a key component of the **Parents as Teachers** model, with personal visits of approximately 60 minutes delivered at a minimum once a month, depending on family needs. Parent educators share research-based information and use evidence-based practices by partnering, facilitating, and reflecting with families. Parent educators use the Parent as Teachers curriculum in culturally sensitive ways to deliver services that emphasize parent-child interaction, development-centered parenting, goal setting and family well-being.

- Parent-child interaction focuses on promoting positive parenting behaviors and child development through parent-child activities.
- Development-centered parenting focuses on the link between child development and parenting on the key developmental topics (e.g., attachment, discipline, health, nutrition, safety, sleep, transitions/routines, healthy births).
- Developing goals and a vision for the future is vital for family. Parent educators work collaboratively with families to identify, set, and achieve goals that lead to positive outcomes.
- Family well-being includes a focus on family strengths, capabilities, skills, and the building of protective factors.
-

Screenings:

Annual child health, hearing, vision, and developmental screenings, beginning within 90 days of enrollment, are a component of the model. Child screenings:

- Assess developmental progress regarding cognitive, language, social-emotional, and motor skills
- Screen for delays or problems in vision/hearing/health

- Provide information about child’s health and developmental progress through on-going tracking of developmental milestones

Many programs also carry out adult screenings to identify parental depression, substance abuse, and intimate partner violence.

Group Connections: Another component of the **Parents as Teachers** model is monthly or more frequent group connections, which parents can attend with their child to obtain information and social support and share experiences with their peers. Group connections formats include family activities, presentations, community events, parent cafes, and ongoing groups. There are no set recommendations of the group size.

Resource Network: Additionally, **Parents as Teachers** maintains ongoing relationships with institutions and community organizations that serve families. Parent educators help families identify needs, set goals, connect with appropriate resources, and overcome barriers to accessing services.

Parents as Teachers directly provides services to parents/caregivers and addresses the following:

- Pregnant or parent of a child prenatal through Kindergarten in possible high-risk environments:
- Teen parents
- Low income
- Parental low educational attainment
- History of drug abuse in the family
- Chronic health conditions effecting the child or parents

Services Involve Family/Support Structures:

This program involves the family or other support systems in the individual's treatment: This program involves the family or other support systems in the individual's treatment: Children in the family are included in the home visits that focus on parent-child interaction. Other family members in the home such as grandparents are also invited to take part in home visits. Parents are connected to other agencies in the community as the need arises.

Recommended Intensity:

At least 12 home visits annually to families with one or no high-needs characteristics. At least 24 home visits annually to families with two or more high-needs characteristics. In some cases, visit frequency may be gradually decreased as the family transitions out and into other services. Home visits last approximately 60 minutes. At least 12 group connections (or meetings) annually, Annual screening of children for developmental, health, hearing, and vision problems each year

Recommended Duration:

At least two years

Delivery Settings

This program is typically conducted in a(n):

- Adoptive Home

- Birth Family Home
- Child Care Center
- Community Agency
- Foster/Kinship Care
- Outpatient Clinic
- School

Parents as Teachers includes a homework component:

There are parent-child follow-up activities in the curriculum for the parent educators to choose from based on parenting behaviors or child development they want to encourage. Parent educators introduce a follow-up activity at the end of their visits, and encourage parents to engage in it before the next personal visit. Families are also encouraged to read together between visits.

Resources Needed to Run Program

The typical resources for implementing the program are:

Staffing Requirements - **PAT** programs have two primary staff positions: (1) parent educators who provide home visiting services and (2) their supervisors. It also is recommended that the affiliate identify staff to serve as the data entry specialist and to provide administrative support to the parent educators and supervisors.

Staff Ratio Requirements - The **PAT** program requires that a supervisor be assigned not more than 12 parent educators to supervise, regardless of whether the parent educators are full-time or part-time employees. The **PAT** program also requires that full-time parent educators complete no more than 60 visits per month, with new parent educators (those working for PAT less than one year) conducting no more than 48 visits per month. Fifty visits per month is the optimal number to be completed by full-time parent educators in their second year or beyond, and 40 visits per month is the optimal number to be completed by full-time parent educators in their first year.

Average Cost per Family and Purchase of Program Model or Operating License - On its website (see link at bottom of page), the PAT National Center provides a Budget Toolkit for programs to estimate basic program implementation costs (including affiliate fees), from which a per-family cost can be estimated. Curriculum materials are included in the cost of training and renewal. Some affiliates offer incentives to help retain families. The costs for family incentives vary by affiliate.

Data Systems/Technology Requirements - The PAT National Center has developed and offers a data management system, Penelope, and offers free access to it for **PAT** affiliates. Affiliates are not required to use Penelope, but affiliates should use a data-tracking or management information system.

Prerequisite/Minimum Provider Qualifications

The **PAT** program requires that, at a minimum, parent educators have a high school diploma or general equivalency degree (GED) and at least two years' previous supervised work experience with young children and/or parents. The **PAT** program prefers for parent educators to have at least a four-year degree in early childhood education or a related field, or at least a two-year degree, or 60 college hours in early childhood or a related field. It is recommended that parent educators have prior experience working with young children and/or parents.

Education and Training Resources

There is a manual that describes how to implement this program, and there is training available for this program.

Training Contact:

Donna Hunt O'Brien, Director, Training and Curriculum Development
Parents as Teachers National Office
www.parentsasteachers.org
phone: (866) 728-4968 x276

Training is obtained:

Requirements for Program Certification: To become an approved **PAT** model affiliate, all applicants must (1) contact the PAT National Center or state **PAT** office to review expectations for fidelity and quality and to assess their fit with the **PAT** model; (2) submit an affiliate plan that covers program design and services, funding sources, service population, leadership, recruitment and retention, public awareness efforts, and evaluation; (3) receive approval of a final affiliate plan; (4) send parent educators to pre-service training; and (5) have parent educators undergo professional development to renew certification annually.

Pre-Service Staff Training: The PAT National Center requires all parent educators implementing the **PAT** model to attend and successfully complete a three-day foundational training and a two-day model implementation training. Affiliates that offer services to families with children age 3 years through kindergarten must attend a second foundational training. The PAT National Center also requires that supervisors complete the two-day model implementation training and recommends that they attend the foundational training. Additional training might be needed to administer assessments or outcomes measures required by a funder or sponsoring agency. In addition to the trainings, the PAT National Center offers professional development opportunities for professionals who work with special populations. The trainings are one- or two-day sessions taught by instructors experienced with working with the special populations.

In-Service Staff Training: To renew certification, the PAT National Center requires that parent educators complete a minimum of 20 hours of professional development during the first year, 15 hours the second year, and 10 hours per year thereafter.

Training Materials: Training materials, including the foundational training guides, *PAT Toolkit Cards*, and *Model Implementation Guide*, are available to parent educators and supervisors through the PAT National Center.

Qualified Trainers: All training sessions are taught by experienced, certified **PAT** national trainers with backgrounds in education, human development, or social services; most trainers have delivered **PAT** or are actively involved in doing so.

Technical Assistance: Technical assistance and implementation support are available to **PAT** affiliates through the National Center's Affiliations and Program Support department, which includes **PAT** state offices and approved regional technical assistance specialists.

Number of days/hours:

At least 5 days of initial training and more for supervisors and those working with special populations (see above for more information)

Pre-Implementation Materials

There are pre-implementation materials to measure organizational or provider readiness for **Parents as Teachers** as listed below:

Prior to sending home visitors to attend a training, new organizations must complete an Affiliate Plan that details their implementation plan. Information on how to start and implement a program is available in the Quality Assurance Guidelines posted at www.parentsasteachers.org.

Formal Support for Implementation

There is formal support available for implementation of **Parents as Teachers** as listed below: The PAT National Center provides ongoing technical assistance to any organization who is implementing the **Parents as Teachers** model and requests assistance. Each state is assigned a National Center technical assistance provider who provides statewide information as well as one-on-one work with the programs. Technical assistance is provided on a variety of topics with a focus on meeting the 17 **Parents as Teachers** essential requirements. These essential requirements focus on staffing and staff oversight, visit frequency, delivering home visits, using the require forms, screenings and participating in model fidelity reviews. The National Center also provides technical assistance to those programs using the Penelope database.

Fidelity Measures

There are fidelity measures for **Parents as Teachers** as listed below:

To help achieve fidelity to the **PAT** model, the PAT National Center requires that affiliates provide annual data on their fidelity to the program model through an Affiliate Performance Report. In addition, affiliates are expected to participate in the affiliate quality endorsement and improvement process in their fourth year of implementation and every fifth year thereafter.

The **Parents as Teachers** Quality Standards are comprised of 17 essential requirements and 100 additional standards for high quality implementation. **Parents as Teachers** also provides the Quality Assurance (QA) Guidelines to assist organizations in understanding the expectations for model implementation. The QA Guidelines incorporate information that supports the implementation the **Parents as Teachers** quality standards. Finally, staff members attending Model Implementation training are also provided with the Model Implementation Guide which provides additional resources for model implementation. The Data in Motion manual helps affiliates to understand how, when and why to collect data and encourages them to use data to improve their programs and services.

Nurse-Family Partnership (NFP)

Source: <http://www.cebc4cw.org/program/nurse-family-partnership/>

Target Population: First-time, low-income mothers (no previous live births)

For children/adolescents ages: 0 – 5

For parents/caregivers of children ages: 0 – 5

Program Overview

The **Nurse-Family Partnership (NFP)** program provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday.

Program Goals

The primary goals of **Nurse-Family Partnership (NFP)** are:

- To improve pregnancy outcomes by promoting health-related behaviors
- To improve child health, development and safety by promoting competent care-giving
- To enhance parent life-course development by promoting pregnancy planning, educational achievement, and employment

The program also has two secondary goals:

- To enhance families' material support by providing links with needed health and social services
- To promote supportive relationships among family and friends

The essential components of **Nurse-Family Partnership (NFP)** include:

Clients:

- Voluntary
- First time mothers
- Low income
- Enrolled early in pregnancy
- Intervention context:
- Within a 1:1 therapeutic relationship
- Visits are in the clients home
- Visit schedule per guidelines and client's needs

Nurses and Supervisors:

- Complete all **NFP** core education

Application of the intervention:

- Nurses use their judgment to apply the **NFP** visit guidelines across 6 domains:
 1. Personal Health
 2. Environmental Health
 3. Life Course Development
 4. Maternal Role
 5. Family and Friends
 6. Health and Human Services

Nurses apply the three theories through current strategies:

1. Self-Efficacy
2. Human Ecology

3. Attachment

Nurses carry manageable caseloads, no more than 25 families

Reflection and Clinical Supervision:

- 1:1 weekly clinical supervision for each nurse with the nurse supervisor
- Case conferences are structure, at least 2 times a month
- Nurse supervisors conduct joint home visits with each nurse three times a year

Program Monitoring and Use of Data:

Nurses collect data as specified by the **Nurse-Family Partnership** National Service Office (NFP NSO), and all data is sent to the **NFP** NSO's national database called Efforts to Outcomes (ETO)

NFP NSO reports data to agencies to assess and guide program implementation.

Agencies use these reports to monitor, identify and improve variances, and assure fidelity to the **NFP** model.

Agency:

- Is networked with other services in the community
- Has community support for sustainability
- Child/Adolescent Services

Nurse-Family Partnership (NFP) directly provides services to children/adolescents and addresses the following:

- First child of a mother with a low socio-economic status
- Parent/Caregiver Services

Nurse-Family Partnership (NFP) directly provides services to parents/caregivers and addresses the following:

- Pregnant with first child, low socio-economic level

Recommended Intensity:

Ideally, nurses begin 60-90 minute visits with pregnant mothers early in their pregnancy (about 16 weeks gestation). Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Visits are weekly for the first six weeks after the baby is born, and then every other week through the child's first birthday. Visits continue on an every-other-week basis until the baby is 20 months. The last four visits are monthly until the child is two years old. Nurses use their professional nursing judgment and increase or decrease the frequency and length of visits based on the client's needs.

Recommended Duration:

Clients are able to participate in the program for two-and-a-half years and the program is voluntary.

Delivery Settings

This program is typically conducted in a(n):

- Birth Family Home
- Community Agency

Homework

This program does not include a homework component.

Languages

Nurse-Family Partnership (NFP) has materials available in a language other than English: Spanish

For information on which materials are available in this language, please check on the program's website or contact the program representative ([contact information](#) is listed at the bottom of this page).

Resources Needed to Run Program

The typical resources for implementing the program are:

- Office space that facilitates confidentiality related to clients and health care records
- Computer and telecommunication capabilities
- Cell phones
- 1 FTE Nurse Supervisor per 4 FTE nurse home visitors
- 0.50 FTE clerical/data entry support for each 4-nurse team serving 100 families
- Adequate travel expense reimbursement (mileage) for home visitors

In addition, a community advisory board and strong, stable, and sustainable funding for agency operations is recommended.

Prerequisite/Minimum Provider Qualifications

- Nurse home visitors:
Registered Nurse with a Bachelor's Degree in nursing, as a minimum qualification
- Nurse Supervisor:
Registered Nurse with a Bachelor's Degree in nursing, as a minimum qualification, and a Master's Degree in Nursing preferred

Education and Training Resources

There is a manual that describes how to implement this program , and there is training available for this program.

Training Contact:

Joan Barrett, Education Manager
Nurse-Family Partnership - National Service Office
joan.barrett@nursefamilypartnership.org
phone: (866) 864-5226

Training is obtained:

Orientation self-study plus training provided in Denver, which also includes distance-learning strategies

Number of days/hours:

For Nurse Home Visitors AND Supervisors:

Unit One: 40 hours of orientation self-study

Unit Two: 25 hours over 3 ¾ days in Denver of face-to-face education and experiential practice

Unit Three: approximately 10 hours of additional distance education and a series of team-based, supervisor-led topical professional development modules

For Supervisors (in addition to the above):

Supervisor Unit One: 10 hours of additional self-study

Supervisor Unit Two: 1 additional day of Supervisor

Orientation during Unit Two education week in Denver

Supervisor Unit Three: 20 additional hours over 3 days, face-to-face in Denver

Ongoing consultation with a Nurse-Family Partnership Nurse Consultant

Annual Supervisor Education and Refresher: 20 hours over 3 days, face-to-face in Denver annually

Pre-Implementation Materials

There are pre-implementation materials to measure organizational or provider readiness for **Nurse-Family Partnership (NFP)** as listed below:

The pre-implementation materials are used as part of **NFP's** planning and development process. Key steps in the local planning and development process include the following:
Data-driven assessment of need: Interested parties can request program materials to help them determine whether implementing the program makes sense in their own communities. These materials pose pertinent questions and suggest statistical analyses (e.g., identifying child abuse rates, crime, unemployment, and health problems) to inform decision-making.

Review of existing services: Interested parties perform a thorough assessment of currently available services for low-income women and children to determine how the program could fit into that continuum.

Creation of task force to select program host: Based on the assessment of existing services, interested parties set up a planning task force with representatives of the various organizations (e.g., hospitals, public health departments, women's clinics, community organizations) that might host or support the program. This task force then decides which agency would be the best host for the program.

Feasibility assessment: The selected agency performs a feasibility assessment during which it considers its ability to staff and finance the program, including whether it can serve enough women to be viable.

Determination of referral sources and outreach methods: Using program materials, the agency designs a referral and outreach process to ensure that qualified women hear about the program.
Development of implementation plan: The agency develops an implementation plan that incorporates processes for identifying sustainable sources of funds, hiring and training staff, ensuring client identification and outreach, and managing the program with fidelity to the model.

Hiring: The agency hires nurses and a nursing supervisor. The Nurse-Family Partnership National Program Office offers sample job descriptions and interviewing guidance.

The materials are available at www.nursefamilypartnership.org.

Formal Support for Implementation

There is formal support available for implementation of **Nurse-Family Partnership (NFP)** as listed below:

Ongoing training is provided for nurses and their supervisors. Nurses and their supervisors participate in a 9-month comprehensive training program to learn how to conduct the in-home visits. The training incorporates a combination of a self-study workbook, web-based training activities, and two onsite training sessions at the Nurse-Family Partnership National Service Office in Denver. Ongoing education and training occurs for both new nurse home visitors and supervisors hired to implement the program. Supervisors receive ongoing consultation to help them develop strong skills with respect to reflective supervision, along with coaching from experienced program consultants.

Fidelity Measures

There are fidelity measures for ***Nurse-Family Partnership (NFP)*** as listed below: Before becoming a NFP Implementing Agency, there must be assurance by the applying agency of its intention to deliver the program with fidelity to the model tested. Such fidelity requires adherence to all of the Nurse-Family Partnership Model Elements. The elements can be found at www.nursefamilypartnership.org/communities/model-elements.

Nurses collect client and home visit data as specified by the Nurse-Family Partnership National Program Office, and all data is sent to the Nurse-Family Partnership National Program Office's national database. The Nurse-Family Partnership National Program Office reports out data to agencies to assess and guide program implementation, and agencies use these reports to monitor, identify and improve variances, and assure fidelity to the ***NFP*** model.

Implementation Guides or Manuals

There are implementation guides or manuals for ***Nurse-Family Partnership (NFP)*** as listed below:

The Nursing team at the Nurse-Family Partnership National Service Office provides both face-to-face and distance learning environments for the core education required of all Nurse-Family Partnership Nurse Home Visitors and Nurse Supervisors prior to client enrollment. This specialized nurse training helps establish therapeutic relationships between the client and nurse home visitor, which in turn preserves the clinical integrity of the ***Nurse-Family Partnership*** model.

New nurses also learn the visit-to-visit guidelines, which provide a consistent content and structure for each of the 64 planned home visits. With assistance from supervisors and consultation from the National Service Office, nurses develop strong communication, personal relationship building, and problem-solving skills. Teams of nurses at local Nurse-Family Partnership Implementing Agencies meet regularly for case conferences, where they receive guidance from supervisors and colleagues to help them deliver the best possible care to their clients. Team meetings also help individual nurses cope with the stress inherent in working with clients who may have numerous personal and health-related crises, and who may be at high-risk for violence in their homes and neighborhoods. In addition to Nurse-Family Partnership core education and the visit-to-visit guidelines, nurse home visitors meet regularly with their supervisors to develop a reflective practice and continuously assess their clinical nursing skills. - See more at: <http://www.nursefamilypartnership.org/nurses/initial-education#sthash.mjNCITrK.dpuf>.

For more information, contact Erika Messenger-Bantz at erika.bantz@nursefamilypartnership.org or (866) 864-5226.

Research on How to Implement the Program

Research has been conducted on how to implement **Nurse-Family Partnership (NFP)** as listed below:

The Denver trial compared the **NFP** model delivered by RNs vs paraprofessionals, and is on target comparing the **NFP** model delivered by two different home visiting providers.

1. Olds, D., Robinson, J., O'Brien, R., Luckey, D. W., Pettitt, L. M., Henderson Jr., C. R., ... Talm, A. (2002). Home visiting by paraprofessionals and by nurses: A randomized controlled trial. *Pediatrics*, *110*(3), 486-496.
2. Olds, D., Robinson, J., Pettitt, L. M., Luckey, D. W., Holmberg, J., Ng, R. K., ... Henderson Jr., C. R. (2004). Effects of home visits by paraprofessionals and by nurses: Age four follow-up results of a randomized trial. *Pediatrics*, *114*(6), 1560-1568.
3. Olds, D., Holmberg, J., Donelan-McCall, N., Luckey, D. W., Knudtson, M. D., & Robinson, J. (2014). Effects of home visits by paraprofessionals and by nurses on children: Follow-up of a randomized trial at ages 6 and 9 years. *JAMA Pediatrics*, *168*(2), 114-121.

Studies to develop strategies to increase client participation and retention and analyses are being conducted in partnership with the Children's Hospital of Philadelphia to examine differences in implementation and outcomes across communities implementing the model in Pennsylvania.

Attachment 6. Proposed Expansion of Intact Family Recovery program

Intact Family Recovery (IFR) Program – Five Year Timeline

Year 1

- Implement IFR programs in the 16 counties of the DCFS Champaign Area office; either through a federal demonstration funding, if awarded, or Family First/DCFS funding.
- Develop a process and outcome evaluation plan for the IFR program and select an evaluator.
- Develop a planning process with DHS-SUPR to develop and implement family based substance use disorder treatment services designed to collaborate with the IFR programs in each DCFS region and sub region. (ongoing throughout the five year period)

Year 2

- Implement IFR programs in the four DCFS Immersion Sites (Lake County, Quad Cities, St. Clair County, Mt. Vernon)
- Develop an IFR model adapted for use in rural areas of Illinois; develop a plan to implement the IFR model in rural counties

Year 3

- Implement IFR programs in the remaining counties of the Rockford sub region.
- Implement IFR programs in the remaining counties of the East St. Louis sub region.
- Transition collar county IFR programs from federal demonstration funding to Family First/DCFS funding. (federal demonstration grant funds services in Will, Kankakee, Grundy, Boone and Winnebago Counties)
- Implement the IFR model in the 10 Illinois counties with the highest rates of substance exposed infant cases where children are placed in foster care.

Year 4

- Implement IFR programs in the remaining counties of the Aurora sub region.
- Implement IFR programs in the remaining counties of the Peoria sub region

Year 5

- Implement IFR programs in the Springfield sub region
- Implement IFR programs in the remaining counties of the Marion sub region

Annually

Review the evaluation findings and revise and update the IFR program model as indicated. (ongoing throughout the five-year period)

Attachment 7. Home Visiting Programs by county in FY19

Source: Illinois Early Childhood Asset Map

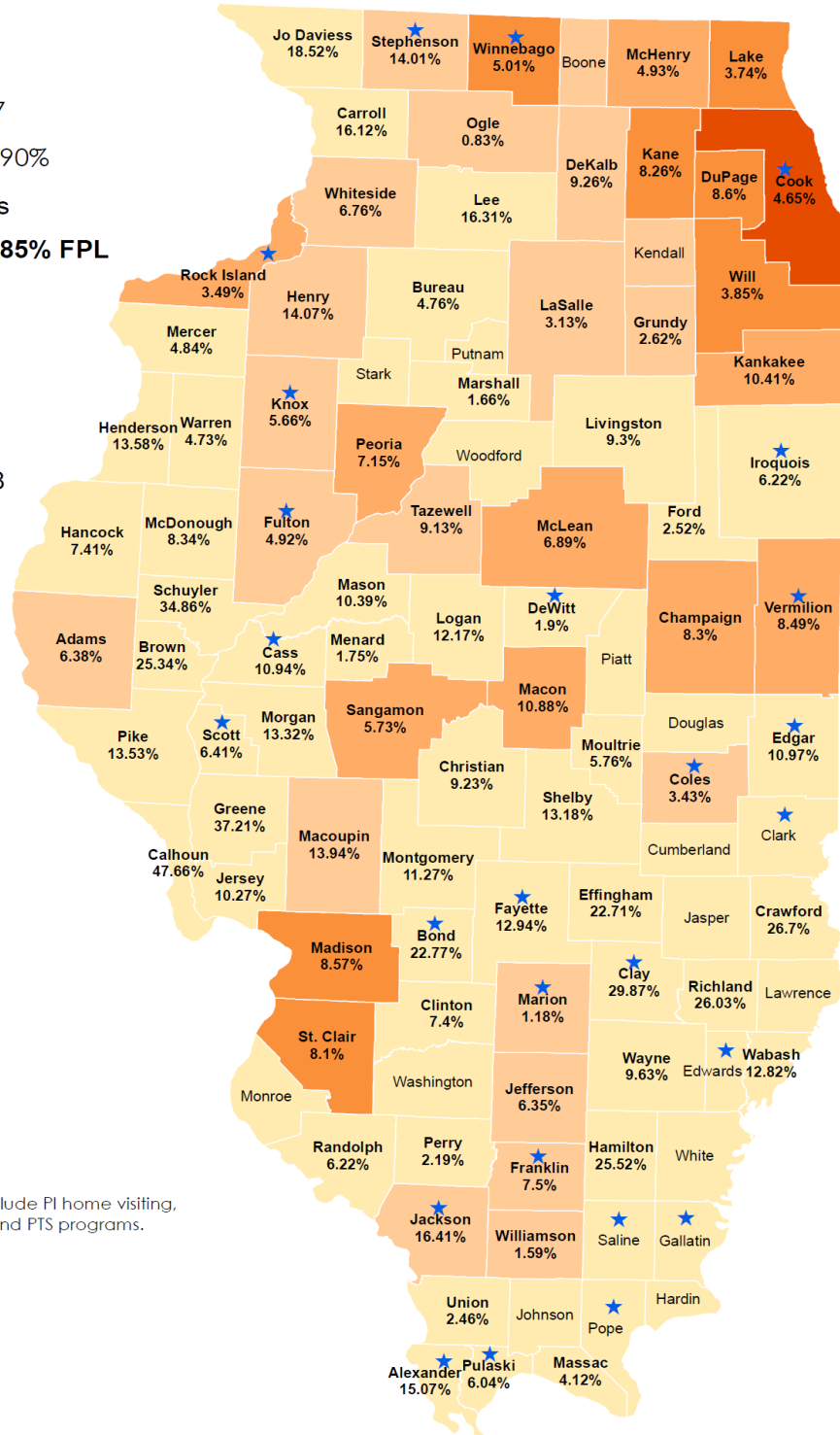
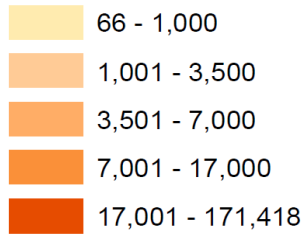
Home visiting programs by county - FY2019

Slots state total: 21,947

Slots state average: 5.90%

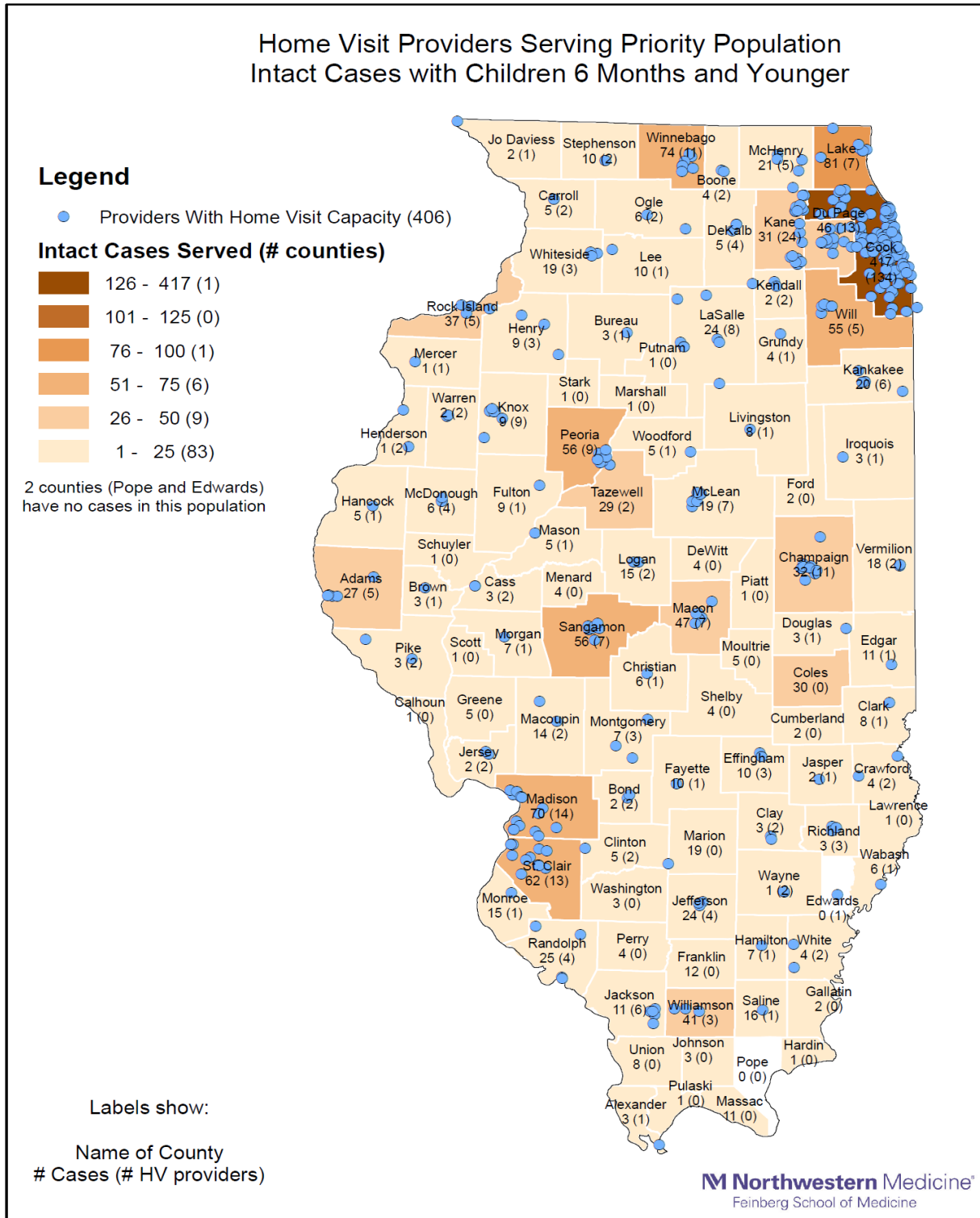
★ high risk counties

Number of children <185% FPL



Note: Home visiting programs include PI home visiting, EHS home-based, MIECHV, HFI, and PTS programs.

Attachment 8. Illinois DCFS Maps of Cases served by Intact Family Services (less than 6 months and less than 3 years old) – DRAFT as of 09/13/19





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