

## CI PRACTICES AND PROCEDURE MANUAL CROSSWALK

CICERO	ELGIN	MACON COUNTY	ROCKFORD	SOUTHSIDE CLUSTER	VERMILION COUNTY
<b>Effective Date(s)</b>					
11/28/12 12/5/12 12/15/12 1/22/13 3/11/13 9/4/13	12/13/13	11/18/13	None specified	None specified	None specified
<b>Function Governed?</b>					
CI, CSD, and Home Visitor	CI, CSD, and Supervisors	CI, CSD, and Supervisor	CI, CSD, and Supervisors	CI and CSD	CI, CSD, Supervisors
<b>Mission Statement</b>					
No reference	No reference	No reference	“[The mission of the Early Learning Council of Rockford Area (ELCRA) is] to support quality early learning opportunities for all young children and their parents through the collaboration of educators, service providers and community members.”	“[SELN] is a collaborative that supports and improves outcomes for expectant moms and children birth to five in the Englewood, West Englewood and Greater Grand Crossing communities.”	No reference
<b>Identification of Home Visiting Providers in the Network</b>					
No reference	No reference	No reference	<ul style="list-style-type: none"> <li>• Easter Seals- Doula</li> <li>• La Voz Latina</li> <li>• Rockford School District</li> <li>• City of Rockford Early Head Start Program</li> </ul>	No reference	<ul style="list-style-type: none"> <li>• Aunt Martha’s/Center for Children’s Services</li> <li>• Danville School District 118</li> <li>• East Central Illinois Community Action Agency</li> </ul>

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<b>COORDINATED INTAKE FUNCTIONS</b>					
<b>CI Worker Title(s)</b>					
Coordinated Intake Worker	Coordinated Intake Worker	Igrow Intake Coordinator	Coordinated Intake Worker	<ul style="list-style-type: none"> <li>• SELN Coordinated Intake</li> <li>• Family Engagement Coordinator</li> </ul>	Coordinated Intake Worker (CIW)
<b>Role of CI in Recruitment Efforts</b>					
No reference	CI leads response for calls that emerge from community outreach and supplements the CSD's work through the dissemination of marketing materials.	CI engages in outreach over the phone, through the Macon County website, written correspondence, community events and face to face.	<ul style="list-style-type: none"> <li>• CI does not do outside recruitment, but may make referrals when seeing a need in families coming in for services such as WIC</li> <li>• CI receives potential clients through the County Health Department and partner agencies, then reaches out to schedule CIAT, etc.</li> <li>• Outreach materials have been created if a need for outside recruitment ever arises</li> </ul>	SELN uses a three-tiered recruitment strategy <ul style="list-style-type: none"> <li>• Tier 1: door to door</li> <li>• Tier 2: community partners</li> <li>• Tier 3: media and local government</li> </ul>	CIW attends and recruits at local community events, support groups, parenting groups, and by using different referral sources in the community. This complements the CSD's work.

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<b>Role of Collaborative in Recruitment Efforts</b>					
No reference	“MIECHV home visit programs and other participating agencies in the Elgin Home Visitation Referral System submit referrals to CI, using a referral form that collects (a) basic referral information needed to assign the family to a program and (b) additional, risk factor information as contained in the CIAT.”	<ul style="list-style-type: none"> <li>• HV agency may conduct outreach efforts, including door to door canvassing, distribution of marketing materials, broadcast media and health fairs</li> <li>• Partner agencies agree to forward referrals to CI</li> </ul>	<ul style="list-style-type: none"> <li>• Lavos Latina recruits families through center programs, such as GED, job skills, English and citizen classes, and education programs. The agency serves more than 5,000 clients and families, and is well known in the Hispanic community</li> <li>• Rockford Head Start is very successful in raising awareness for home visiting and recruiting families through grassroots efforts. This includes door to door outreach, targeted recruitment, church bulletins, word of mouth, speaking engagements, and posting flyers at social service agencies, medical homes, stores, day care centers, and Laundromats</li> <li>• Home visiting agencies and the County Health Department forward referrals to CI</li> </ul>	<ul style="list-style-type: none"> <li>• “Our MIECHV-funded partners... are a critical part of the outreach effort at all levels”</li> <li>• “Each agency brings their own community history and recruitment sources to the network and plays a key role in the outreach efforts”</li> </ul>	<ul style="list-style-type: none"> <li>• When partner organizations are contacted by potential clients, they refer them to CIW</li> <li>• Once the partner receives the referral form from CI, they contact clients to inform them about programs and services being offered</li> <li>• If client is not reached, the information is sent back to the CIW, who attempts to make contact</li> <li>• If client is reached, the partner completes a client assessment as well as any other paperwork and then enrolls them</li> </ul>
<b>Elapsed Time before First Contact by CI</b>					
No more than 24 hours	No more than 48 hours	No reference	No reference	No more than 24 hours	No reference

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<b>Obtaining Consents and other Confidentiality Concerns</b>					
<ul style="list-style-type: none"> <li>• “Coordinated intake obtains a photo release, consent to participate in program, and a MIECHV ETO informed consent form at the time of intake”</li> <li>• “All participant information is treated as confidential”</li> <li>• CI will only release information to partner MIECHV team</li> <li>• Participants have the right to revoke their release on written notice</li> </ul>	<ul style="list-style-type: none"> <li>• All participant information is to be treated as confidential</li> <li>• Referral forms to include bilingual releases in plain language</li> <li>• Consents must be obtained before CI can process the referral</li> <li>• CI will only release referrals to partner HV agencies with signed MOUs</li> <li>• Participants have the right to revoke their release on written notice</li> </ul>	No reference	No reference	<ul style="list-style-type: none"> <li>• CI and community partner given joint responsibility for obtaining parental consent</li> <li>• Consent must be obtained before referral sent to CI</li> </ul>	<ul style="list-style-type: none"> <li>• “Coordinated intake obtains a consent [form from client] to participate in the program and MIECHV informed consent form at the time of the intake”</li> <li>• “All of the information must be signed by the client at the time of the intake”</li> <li>• All client information is treated as confidential, information is only to be released to the MIECHV partners (who must all adhere to terms of established MOUs)</li> <li>• Clients may revoke the release and exchange of information in writing, and the MIECHV team will document it</li> </ul>
<b>CIAT Completion</b>					
Completed by CI staff at first home visit.	Ordinarily completed by the HV agency – CI may assist.	CI staff to complete CIAT.	CI worker has contact with client to complete CIAT and then enters it into ETO.	CI staff to complete prior to first contact by HV agency.	The CIW completes and evaluates CIAT.

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<b>Screening and Assignment Criteria</b>					
<p>Following the CIAT completion, the participant is referred to one of the two HV agencies.</p>	<ul style="list-style-type: none"> <li>• “CI maintains a current data set of specific Home Visit Program criteria such as service area, age restrictions, types of mothers served, language restrictions and the like”</li> <li>• “To determine assignment, CI uses current flow chart/decision which provides consideration of several factors: priority population, address in Elgin, IL, type of mother, age of mom/baby/child. If a family is eligible for more than one program, factors related to the programs are considered, including number of referrals already pending, number of slots still open, and restrictions for eligibility due to program model”</li> </ul>	<ul style="list-style-type: none"> <li>• “The CI determines home visiting program based on program criteria. If client is eligible for more than one program the client is given options to enroll in the program of their choice”</li> <li>• Procedure specifies the specific expertise of each funded HV agency and lists program criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Clients at the WIC office, who are interested in home visiting, as well as those sent to CI from the Health Department or partner agencies, complete the CIAT. Two of the home visiting programs also require a “weighted priority form” to be completed, which aids in determining family risk factors and how immediate the need for service is</li> <li>• “Basic demographics are used to determine which program is best for a family (including income). We have two programs that serve young, first time moms. Depending on their ethnicity or other factors, they will be referred to one agency or the other”</li> <li>• Families with a high risk score will be referred to a specific agency outside of Rockford, as will clients who live in other towns</li> <li>• Two programs will take children from birth to 3, while others have different age restrictions (baby under 30</li> </ul>	<p>“CI staff refer client to agency which best fits the needs of the client based on the initial screening.”</p> <ul style="list-style-type: none"> <li>• Referral date and maternal age</li> <li>• Weeks pregnant and/or age of baby</li> <li>• Primary and secondary contact information</li> </ul>	<ul style="list-style-type: none"> <li>• CIW schedules client intake, during which CIAT is completed</li> <li>• After evaluating the CIAT and using the MIECHV referral criteria cheat sheet, the CIW assigns eligible clients to the program that best fits their needs. The referral is then sent to the chosen partner’s contact person</li> <li>• Mothers must be pregnant and/or have children under three, as well as meet one or more of the following criteria: single, teenager, fall below the poverty line, have mental health issues, and/or have multiple children under the age of three</li> </ul>

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			days or 3 months)		
<b>Discussion of MIHOPE Randomization</b>					
N/A	Performed by HV agency	<p>“After the CIAT and program determination are completed, the CI introduces the MIHOPE research project to the client.</p> <ul style="list-style-type: none"> <li>• A brief description of the project is given</li> <li>• CI informs the client that researchers will be calling from a (609) area code</li> <li>• CI informs the client that incentives will be given for participating in the MIHOPE research project. Clients are instructed that MIHOPE will define the scope of incentive</li> <li>• If the client agrees to MIHOPE participation, CI will make this notation on the CIAT”</li> </ul> <p>“The supervisor of each home visiting service.. are [sic] responsible for entering the client’s name into the MIHOPE web intake for randomization.”</p>	N/A	To be performed by HV agency within 48 hours.	During the intake process, after the CIAT is completed, the CIW enrolls eligible clients in MIHOPE.

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<b>Elapsed Time Between Referral From CI and First Contact by HV Agency</b>					
No more than one week with first home visit scheduled within two weeks.	No reference	“CI will refer 100% of positive screens to the appropriate program model within 48 business hours.”	“Not applicable at this time.”	No more than two business days.	Every Tuesday, CI sends an update to the MIECHV partners, who must respond with “appropriate information” by the end of the day. CI then sends an email to all partners regarding clients, each Friday.
<b>Procedure if HV Agency does not Promptly Accept Referral</b>					
No reference	No reference	No reference	No reference	<ul style="list-style-type: none"> <li>• If CI doesn’t receive confirmation of contact within two business days from referral, the CI will contact family and receiving agency to ensure continued interest in service</li> <li>• Families can be reassigned if agency is unresponsive or cannot take the case</li> </ul>	No reference

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<b>Waiting List</b>					
<ul style="list-style-type: none"> <li>• “When the home visiting program obtains a waiting list, central intake will administer ASQ. We will keep a copy for our records and refer and link to Child Family Connections # 7 (708) 449-0625 as needed”</li> <li>• Families will be moved to the waiting list after three unsuccessful efforts to reach them by the HV agency. CI then assumes responsibility for contacting the family. After six months, the case may be terminated by unanimous consent of the MIECHV committee</li> <li>• “If the family decides to continue services, Coordinated Intake will implement a risk assessment. Based on the outcome, the family will either receive priority for services or, continue to be on waiting list until a space becomes available”</li> </ul>	<ul style="list-style-type: none"> <li>• “CI maintains a waiting list whenever necessary, and notifies families that they are on the waiting list</li> <li>• CI to mail a community resources list to waiting list families</li> <li>• Families on the waiting list are prioritized in accordance with risk factors</li> <li>• CI to track families that age out of PAT program at age 2 and 9 mos. (HFI and NFP cases age out at age 2.)</li> </ul>	No reference	<ul style="list-style-type: none"> <li>• If there are no openings, CI contacts the medical home with status of referral and then places the client on a waitlist. Once a spot opens, the home visiting agency notifies CI, who then sends information of clients on the waitlist to the home visiting agency, whose responsibility it is to then contact clients</li> <li>• A waitlist has been maintained for months</li> </ul>	No reference	No reference other than capacity and waitlists for the programs are monitored monthly

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<b>Referrals Outside of Designated Communities</b>					
No reference	“CI makes every attempt to refer clients who are out of our programs’ service areas- such as another county. CI maintains a file of families for whom no home visit program is available after notifying them of this situation.”	No reference	One home visiting program serves outside of Rockford. If a client lives in another town, they are referred there.	No reference	No reference
<b>Aging Out</b>					
<ul style="list-style-type: none"> <li>• The HV agency is expected to begin discussing transitions whenever children reach 30 months and begin reducing the frequency of home visits</li> <li>• CI is responsible for issuing a termination letter one month before the child ages out</li> </ul>	No reference	No reference	No reference	No reference	<ul style="list-style-type: none"> <li>• Services may continue until child turns three</li> <li>• Clients are recommended to complete a home visiting transition plan, which may vary by partner program</li> <li>• Termination procedures vary by agency</li> <li>• Preschool</li> </ul>
<b>Exit Interview</b>					
CI conducts exit interviews for all families departing HV programs and notes results in the family’s file.	No reference	No reference	No reference	No reference	No reference

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<b>Database Maintenance</b>					
No reference outside of ETO.	“CI continuously collects and maintains data for all Kane County home visit programs in the Kane County Access Home Visit database and in the MIECHV Excel Transparency Database.”	“All pertinent client information received will be entered by the CI into the Client contact Excel spreadsheet/Visit Tracker (when enabled). CIATs will be filed according to assigned home visiting agency.”	“Data from CIAT is entered immediately into data system (ETO) and placed on the waitlist for services. It is then entered into an excel spreadsheet for backup purposes.”	“CI staff maintains a database of all referrals both made and received. Records will indicate if services were received or not. CI will notify Referring Agency of the client placement outcome within seven business days.”	No reference outside of ETO.
<b>Dissemination of Reports</b>					
No reference	<p>In addition to ad hoc special referral reports, CI produces and disseminates standard monthly referral reports, including:</p> <ul style="list-style-type: none"> <li>• Referrals “In” (10<sup>th</sup> of month)</li> <li>• Referrals “Out” (1<sup>st</sup> of month)</li> <li>• Disposition (2<sup>nd</sup> Friday)</li> <li>• Feedback (3<sup>rd</sup> Friday)</li> <li>• Type of Mother (1<sup>st</sup> and 10<sup>th</sup> of month)</li> <li>• MIECHV Active Caseload Trend</li> <li>• Transparency</li> <li>• Benchmark</li> </ul>	<p>CI and CSD to disseminate reports, including outreach/referral updates, completed CIATs, collaboration referrals, caseload/program openings, MIHOPE research statistics, client updates, event participation, funder updates and agency updates.</p>	<ul style="list-style-type: none"> <li>• “WCHD and partnering agencies hold monthly meetings. The purpose of the meeting is to communicate agency issues/potential issues, and update on agency activities. Data and/or outreach reports are made available to all agencies at this time”</li> <li>• “Any issues are communicated and discussed at monthly partner meetings. If necessary, follow-up meetings are held individually for resolution, and followed up by Program Director”</li> <li>• “The CI worker will share information on waitlist, and current status of home visiting</li> </ul>	<ul style="list-style-type: none"> <li>• Caseload and referral data distributed monthly</li> <li>• Recruitment effort data distributed quarterly</li> </ul>	<ul style="list-style-type: none"> <li>• Community Needs Assessment distributed as it is completed by Vermilion County</li> <li>• Program capacity and waitlists monitored and shared with partners monthly</li> <li>• Referrals monitored and shared with partners weekly</li> <li>• Community outreach monitored/shared monthly</li> <li>• Partners consistently assess clients to track progress and submit “data to the appropriate entities”</li> <li>• Problems are identified and the collaboration works to resolve them at monthly collaborative meetings</li> </ul>

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			referrals”		
<b>COMMUNITY SYSTEMS DEVELOPMENT FUNCTIONS</b>					
<b>CSD Title(s)</b>					
Community Systems Developer	Community Systems Developer	igrow Community Coordinator	Community Systems Developer	Community Systems Developer	Community Systems Developer
<b>Recruiting Community Partners</b>					
No reference	<ul style="list-style-type: none"> <li>• CSD collaborates with the Kane County AOK Early Childhood Network Coordinator to facilitate Elgin’s contribution to the AOK strategic plan</li> <li>• CSD collaborates with the Kane County AOK Early Childhood Network Coordinator to lead the implementation of the HV component of the AOK strategic plan</li> <li>• CSD identifies one new partner per month and works towards an MOU</li> </ul>	<ul style="list-style-type: none"> <li>• CSD conducts outreach through attendance at community events and public awareness campaign</li> <li>• CSD will “attempt” MOUs with partnering agencies</li> </ul>	<ul style="list-style-type: none"> <li>• The CSD does agency visits to explain home visiting (what the MIECHV program is and its benefits) and develops MOUs to partner with other agencies</li> <li>• Early Learning Council of the Rockford Area (ELCRA), a comprehensive community collaboration represented by retired teachers, early learning, day care, and preschool directors, as well as Head Start personnel, health care providers, and United Way, serves in an advisory capacity, supports the efforts of MIECHV, and has contributed to raising awareness of the program and its benefits</li> <li>• The CSD participates in quarterly meetings and assigned subcommittees.</li> </ul>	Formal relationships aren’t mandated, but execution of MOUs with partners are “preferred and a program goal”	<ul style="list-style-type: none"> <li>• CSD is responsible for marketing materials and outreach at community events</li> <li>• Materials include giveaways (outlet plugs, measuring spoons, hand sanitizer), flyers, brochures, and a resource guide poster</li> <li>• The Early Childhood Network (ECN) meeting occurs quarterly and is open to anyone in the community involved in early childhood (all partners are invited). Each meeting focuses on finding solutions to different key issues</li> <li>• To maintain relationships, other community agencies are invited to the ECN meeting</li> <li>• The CSD also participates in events held by other agencies</li> </ul>

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			<ul style="list-style-type: none"> <li>• Rockford Health Council also serves in an advisory capacity and heads an Early Care and Education subcommittee that supports MIECHV</li> </ul>		in the community
<b>Concerns and Complaints</b>					
<p>“Concerns and complaints will be tracked through a Concern and Complaint Log. The Log will be distributed to everyone on the team and kept and updated by CSD. Anyone who has a complaint will add to the log and email CSD. CSD will try to resolve the complaint. Next team meeting we will address concerns or celebrate comments.”</p>	No reference	No reference	No reference	No reference	<p>“Contact the supervisor of the coordinated intake.” (Natalie Williams)</p>

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<b>JOINT CSD AND CI FUNCTIONS</b>					
<b>Parent/Community Engagement</b>					
<ul style="list-style-type: none"> <li>• CSD is responsible for designing bilingual marketing materials</li> </ul>	<ul style="list-style-type: none"> <li>• CSD facilitates the Elgin Parent Empowerment Group</li> <li>• CSD conducts and documents outreach activities in accordance with the current Elgin MIECHV Plan priorities</li> </ul>	See above	<ul style="list-style-type: none"> <li>• Neither the CI nor CSD does direct recruiting to families. Most are recruited from the Winnebago County Health Department (WCHD) WIC program, others come from partnering agencies</li> <li>• “The role of the CI and CSD is to reach out to community agencies that serve at-risk and target populations. This is actively being done through meeting with various agencies to help identify target populations; those that may be in need of immediate service”</li> <li>• “The agency MOU/agreement allows for agencies to meet annually to review programs, and update on service activities. Copies of the MOUs are issued to agency partners”</li> </ul>	<ul style="list-style-type: none"> <li>• “COFI works closely with us in these (Tier 1) outreach efforts through street teams, and parent-driven consumer outreach”</li> <li>• “SELN brings parents and community partners together to build an integrated community of care on the south side of Chicago”</li> <li>• Stated goals for families include improved outlook, access to quality health care and ECE services, and “lifelong learners”</li> </ul>	<ul style="list-style-type: none"> <li>• Participation in community events, such as the Health and Safety Fair, Georgetown Fair Week, and Week of the Young Child</li> <li>• Advertisements: bus sign; two billboards in the community; signs at the Georgetown football games and community arena; website</li> <li>• Both the CIW and CSD may attend the quarterly ELN meetings</li> </ul>

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<b>Recruitment Incentives</b>					
No reference	CI, CSD and HV agency staff and supervisors implement incentive programs as needed.	No reference	No reference	No reference	No reference
<b>Resource Guide</b>					
“CSD will have an annually updated resource guide that will be given to participants on a case by case basis.”	CI and CSD staff to complete training on use of the Kane County Community Guide, as updated by the CSD.	No reference	No reference	CSD will maintain an annually updated resource guide and make it available if needed.	<ul style="list-style-type: none"> <li>• “CSD will have an annually updated resource guide and will keep an updated copy of the resource list”</li> <li>• The resource guide may include providers of day care, Head Start, kindergarten, education/training, individual and family counseling, doulas, substance abuse counseling, parent/interaction/support groups, shelters, school screenings, and other social services</li> </ul>

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<b>Referral to Other Services</b>					
<ul style="list-style-type: none"> <li>• “If we do not provide the services the participants need, Coordinated Intake and Home Visitors will refer participants to other agencies, by referring to resource guide”</li> <li>• “When a family is in need of service, the referral must be documented in ETO”</li> </ul>	<p>CI and CSD staff to make non-home visiting referrals in accordance with the Kane County Community Guide and the “MIECHV-developed Elgin Resource sheet.”</p>	No reference	No reference	<p>“If we do not provide the services the participants need, CI and home visitors will refer participants to other agencies and non-MIECHV programs by utilizing the resource guide.”</p>	<ul style="list-style-type: none"> <li>• “If we do not provide the services the participants need, Coordinated Intake and Home Visitors will refer participants to other agencies, by referring to resource guide”</li> <li>• “When a family is in need of service, the referral must be documented in ETO”</li> </ul>
<b>Emergency Procedures</b>					
<ul style="list-style-type: none"> <li>• “If participant is in need of food, clothes, shelter, we will refer participant to community resources, i.e. 911 and etc.”</li> <li>• “As emergencies rise within our families we will refer and link our families to resources, to assess their needs”</li> <li>• “If suicidal, assess them, immediately refer to Cicero Family Service, call 911, Cares Hotline and SASS”</li> </ul>	<p>“CI and CSD will make Emergency Referrals for food, shelter, utilizing 911 or other resources to assess their needs as needed for mental health, suicide threats, [and] domestic violence.”</p>	No reference	No reference	<p>“As emergencies rise within our families, we will refer and link our families to resources to assess their needs.”</p>	<ul style="list-style-type: none"> <li>• “If participant is in need of food, clothes, shelter, we will refer participant to community resources, i.e. 911 and etc.”</li> <li>• “As emergencies rise within our families we will refer and link our families to resources, to assess their needs”</li> <li>• “If suicidal, assess them, immediately call 911”</li> </ul>

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<b>Mandated Reporting of Child Abuse</b>					
No reference	No reference	<ul style="list-style-type: none"> <li>• Prior to initiating a telephone report, mandated reporters must notify their immediate supervisor</li> <li>• Where appropriate, the case is to be discussed with the family and encourage the family to report the incident themselves</li> <li>• Call the DCFS Hotline</li> <li>• Make a written report</li> <li>• Document the incident in Cornerstone</li> <li>• Engage in mandated training</li> </ul>	No reference	No reference	No reference
<b>Training and Supervision</b>					
No reference	<ul style="list-style-type: none"> <li>• CI and CSD staff attend MIECHV-required core trainings within 90 days of hire</li> <li>• CI and CSD attend KCHD required training per Department policy</li> <li>• CI and CSD receive additional training as needed and determined with their supervisors</li> <li>• Supervisors provide one hour</li> </ul>	<ul style="list-style-type: none"> <li>• “CI and CSD will discuss any issues/problems with direct supervisor”</li> <li>• Weekly one hour reflective supervision sessions for CI and CSD</li> <li>• CI and CSD staff to attend quarterly role-specific training and additional trainings when available</li> </ul>	<ul style="list-style-type: none"> <li>• “CI and CSD receive reflective supervision on a monthly basis or as needed, under the guidance of the Program Director”</li> <li>• “CI and the CSD worker participate in all trainings as offered by MIECHV in accordance to role/position, and as trainings become available”</li> </ul>	<ul style="list-style-type: none"> <li>• CI and CSD staff meet at least monthly with supervisor</li> <li>• CI and CSD staff attend Learning Communities and other trainings</li> </ul>	Trainings vary based on what CI and CSD consider to be helpful considering their current community roles

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	of reflective supervision to per week <ul style="list-style-type: none"> <li>• Performance management is achieved collaboratively between staff and supervisors in accordance with KCHD policy</li> <li>• Trainings and reflective supervision sessions are documented per attached forms</li> </ul>				
<b>CQI Discussion</b>					
No reference	<ul style="list-style-type: none"> <li>• Reports generated by CI used to facilitate CQI</li> <li>• Explicit reference to CQI in discussion of referral and outreach processes</li> </ul>	The CI, CSD and their supervisor will participate as members of the CQI team.	<ul style="list-style-type: none"> <li>• “Both the CI and CSD are members of the CQI team. Members of the team are expected to strategically plan with the CQI Coordinator to identify potential issues, develop an action plan, formulate SMART goals, and identify inputs and resources”</li> <li>• “CQI has been useful to assure quality programming and that new goals are being met”</li> </ul>	No reference	The CSD and CIW participate in CQI.