Macon County Health Department
MIECHV/Igrow Program

Effective Date: 11/18/13

Subject: Igrow Intake Coordinator(CI) and Igrow Community Coordinator (CSD) outreach process.

Purpose: To find, inform, and engage eligible families in the MIECHV/igrow program and to link them with home visiting agencies and available community resources.

Procedure:

1. Outreach activities may be performed by the CI, CSD, and home visiting agencies (HV).

    A. Intake Coordinator (CI)
        i. Outreach may occur at the CI office, partnering agencies, public events, or client home.
        ii. Outreach is conducted over the phone, though the Macon County igrow website, by fax, email, mail correspondence, as well as participation in community event, or by face to face contact with eligible clients.
        iii. Partnering agencies include, but are not limited to the Macon County Health Department, DOVE, Safe from the Start, DCFS, Baby Talk, Bright Start, Planned Parent Hood, New Life Pregnancy Center, HFI, and Early Beginnings.
        iv. Partnering agencies provide the CI with contact information (phone or address) for potential eligible clients per MOU and agency specific policy.

    B. Community Coordinator (CSD)
        i. Outreach is conducted through attendance at community events, coalitions, and public speaking engagements. CSD will promote igrow program awareness
        ii. CSD will attempt MOUS with partnering agencies during outreach activities and complete CI referrals as indicated.
        iii. Partnering agencies include, but are not limited to the Macon County Health Department, DOVE, Safe from the Start, DCFS, Baby Talk, Bright Start, Planned Parent Hood, New Life Pregnancy Center, HFI, and Early Beginnings.
        iv. Partnering agencies provide the CI with contact information (phone or address) for potential eligible clients per MOU and agency specific policy.

    C. Home Visiting Agency (HV)
        i. Outreach may occur at the HV office, partnering agencies, public events, or client home.
        ii. Partnering agencies include, but are not limited to the Macon County Health Department, DOVE, Safe from the Start, DCFS, Baby Talk, Bright Start, Planned Parent Hood, New Life Pregnancy Center, HFI, and Early Beginnings.
        iii. HV agencies agree to forward referrals to CI.

2. Other types of outreach could include but are not limited to:
    A. door to door canvassing
    B. production and distribution of handbills to schools, churches, federal, state, county and local offices, community organizations, hospitals, cultural organizations, public and senior housing, shelters, food banks, grocery stores and Laundromats
    C. production and broadcast of public service announcements
    D. paid advertising on radio and television

E. billboard advertisements
F. health fairs

3. CI, CSD, and igrow Supervisor will collaborate with community providers to enhance client enrollment.

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Intake Coordinator

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Community Coordinator

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Supervisor Signature and Title

Review Dates:	Signature and Title:
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Effective: 11/18/13

Subject: igrow Intake Coordinator (CI) Referral Process

Purpose: Client(s) and families enrolled in the MIECHV/igrow program are connected to and receive comprehensive home visiting services and receive referrals to appropriate community services.

Procedure: The CI will contact potential clients, explain the available home visiting and community services, and enroll interested clients with the proper program.

1. The CI receives referrals from WIC, Baby Talk, Dove, Safe from the Start, DCFS and other social service agencies in Macon County.
2. The CI will contact referred clients via phone, letter, or in person to explain the available home visiting programs.
3. If client is interested in home visiting the CI will collect client data using the Central Intake Assessment Tool (CIAT).
   Components of CIAT:
   - Identifying Information/Demographics: Documentation of demographic information will be performed by the CI. Identifying information includes name, address, living arrangements, telephone number, sex, race, Hispanic origin, date of birth, status of father involvement, number of children, birth date of children, Medicaid status, other current support services, education, military involvement, date of initial contact and initiation of services.
   - Behavioral Assessment- Documentation of mental and behavioral health, substance abuse, Department of Children and Family Services (DCFS) involvement, physical abuse, family past, use of cigarettes, use of alcohol, implementation of past or current Individual Education Plan (IEP), and prenatal care.
   - Priority Population Category – Families must meet one or more of the MIECHV priority categories to receive MIECHV home visiting services. Categories are as follows:
     - First time mother/teen mother (age 21 & under)
     - Low education level- Did not complete high school
     - Mental/behavioral health- includes history of substance use
     - Low income families
     - Military families
     - History of abuse, neglect, or DCFS involvement
     - Tobacco/smoker in home
     - History of developmental delays
4. 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.
   Program criteria:
   - Bright Start: Expertise in working with mentally delayed parents. Accepts families who are ineligible for HFI. Accepts expectant mothers, children up to age five, first time parents, single parents, teen parents, homeless, multiple children residing in same family, families with poor support system. Eligible clients may also receive WIC/TANF/Food stamps/SNAP/ Social Security/disability or have chronic medical condition, excessive lack of prenatal care, attempted abortion, parental alcohol/substance use/exposure, mental health concerns, abuse, parent incarcerated, DCFS involvement, custodial grandparents, and infant in foster care.
   - Early Beginnings: Expertise in working with mentally delayed parents. Accepts families who are ineligible for HFI. Accepts expectant mothers, children up to age five, first time parents, single parents, teen parents, homeless, multiple children residing in same family,

families with poor support system. Eligible clients may also receive WIC/TANF/Food stamps/SNAP/ Social Security/disability or have chronic medical condition, excessive lack of prenatal care, attempted abortion, parental alcohol/substance use/exposure, mental health concerns, abuse, parent incarcerated, DCFS involvement, custodial grandparents, and infant in foster care.

- HFI: Expertise in early intervention/parent education. Client needs to be pregnant and in the 2nd or 3rd trimester, within 2 weeks postnatal, must meet IDHS income eligibility criteria, and be a first or second time parent. Clients can also be single parents, teen parent, homeless, have poor support system, on WIC/TANF/Food stamps/SNAP/ Social Security/disability, have chronic medical condition, excessive lack of prenatal care, attempted abortion, parental alcohol/substance use/exposure, mental health concerns, abuse, parent incarcerated, and DCFS involvement as long as family is still intact.

5. MIHOPE: After the CIAT and program determination are completed the CI introduces the MIHOPE research project to the client.
   - A brief description of the project is given.
   - CI informs the client that researchers will be calling from a (609) area code.
   - CI informs the client that incentives will be given for participating in the MIHOPE research project. Clients are instructed that MIHOPE will define scope of incentive.
   - If the client agrees to MIHOPE participation CI will make this notation on the CIAT.
6. CI will refer 100% of positive screens to the appropriate program model within 48 business hours.
   a. The CIAT is scanned to computer and electronic copy is emailed to the appropriate home visiting agencies.
   b. The supervisor of each home visiting service, (Bright Start, Early Beginnings, and HFI) are responsible for entering the client's name into the MIHOPE web intake for randomization.

7. CI will request HV agency respond within 48 business hours confirming receipt and outcome of referral.

8. 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.

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Intake Coordinator

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Community Coordinator

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Supervisor Signature and Title

Review Dates:	Signature and Title:
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Effective: November 18, 2013

Subject: Monitoring and Problem-Solving

Purpose: To ensure that the igrow Intake Coordinator (CI), Community Coordinator (CSD), and the MIECHV/igrow partnering agencies maintain a line of open communication and work to resolve potential problems.

Procedures:

1. The CI, CSD, and the MIECHV partnerships will communicate through face to face meetings, email, and phone.
2. Shared information includes, but is not limited to outreach/referral updates, completed CIATS, collaboration referrals, case load/program openings, MIHOPE research statistics, client updates, event participation, funder updates, and agency concerns.
3. The Executive Board will meet no less than quarterly and review MIECHV/igrow statistics and collaborations including:
    - Program openings for PI and MIECHV
    - Total number of CIATS completed
    - Number of CIATS sent to each partnership
    - MIHOPE research numbers/statistics
    - General Concerns
4. The CI and CSD will discuss any issues/problems with direct supervisor.
5. Any and all issues/problems affecting MIECHV partnerships will be addressed at the next Executive Board meeting and referred to State as appropriate. Emergency Executive Board meetings will be called if issues/problems require immediate attention.
6. The CI, CSD, and CI/CSD direct supervisor will participate as members of the CQI team. MCHD partnering agency will participate as per protocol.
    - Bi-weekly CQI meetings are held to allocate duties, and discuss concerns and adjustments for CQI plan.
    - CQI team participates in quarterly phone conference meetings with CQI specialist.

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Intake Coordinator

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Community Coordinator

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Supervisor Signature and Title

Review Dates:	Signature and Title:
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Effective: November 18th, 2013

Subject: Supervision and Training

Purpose: To ensure the igrow Intake Coordinator (CI) and igrow Community Coordinator (CSD) receive reflective supervision and thorough MIECHV related trainings.

Procedures:

1. Formation of organizational chart for CI agency. Refer to appendix A.
2. Formation of organizational chart for CSA agency. Refer to appendix A.
3. CI and CSD receive weekly reflective supervision for one hour or more as needed. Supervision topics and outcome are documented in template. See PPM for hard copy template.
4. The CI and CSD worker participate in quarterly role-specific training. Additional training pertinent to CI and or CSD role will be attended when available.

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Intake Coordinator

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Community Coordinator

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Supervisor Signature and Title

Review Dates:	Signature and Title:
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Effective: January 1, 2003

Subject: Mandated Reporting of Child Abuse

Policy: In compliance with the "Abused and Neglected Child Reporting Act" (IL Rev. Stat., Ch. 23, par 2051, sec 1), all mandated reporters as defined in Ch. 23, par 2054, sec 4, are required to "immediately report or cause a report to be made" to the Department of Children and Family Services (DCFS) when there is "reasonable cause to believe a child known to them in their personal or official capacity may be an abused child or a neglected child" (CH 23, par. 2054, sec 4).

Purpose: To ensure the igrow Intake Coordinator and Community Coordinator are aware of their responsibility in protecting the children they serve.

Procedures:

7. Prior to initiating a telephone report, mandated reporters must notify their immediate supervisor of their concerns and/or intent to report suspected abuse and/or neglect.
8. When appropriate, discuss the case with the family and encourage the family to report the incident themselves. Inform the family that MCHD staff is under lawful obligation to report the incident.
9. Call the DCFS Hotline to make a verbal report.
10. Complete a Written Confirmation or Suspected Child Abuse/Neglect Report. Copies of the form will be distributed as follows:
    a. The original will be sent to the DCFS Office within 24 hours of verbal report
    b. A copy will be provided to the Asst FCM/WIC Coordinator
    c. A copy will be given to the case manager so that it may be maintained in the client's hard copy chart
11. Complete documentation of the incident in the client's Cornerstone record (Case Notes).
12. Proper training will be implemented and reviewed annually to maintain staff at the trained level to appropriately identify the potential of abuse/neglected children.

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Intake Coordinator

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Community Coordinator

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Supervisor Signature and Title

Review Dates:	Signature and Title:
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