Illinois Benchmarks and Constructs and Where to Find in Visit Tracker

Benchmarks	Constructs	Timeline for Collection and Goal	Where within Visit Tracker to Enter the Data
A. Improved Maternal and Newborn Health	Construct 1: Prenatal Care	All dates of Prenatal Doctor visits from case opening until child is born must be recorded. *Goal: to meet minimum number of required visits per the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (see chart called Frequency of on-going Prenatal Care).*	At each personal contact while prenatal, ask, "Approximately when was your last prenatal care medical visit?" and indicate the visit date either on the PVR (down in the child section for the prenatal child or on the Health Info page for the CHILD. [i] Prenatal children are added into Visit Tracker as soon as the pregnant mother is enrolled. Use "Baby" as their name, "P" (for Prenatal) as their gender, and enter their due date instead of Birth date.
	Construct 2- Parental use of alcohol, tobacco or illicit drugs	Record from case opening - Update at least quarterly or whenever you know of a change. *Goal: reduction of use between 36 weeks and birth.*	On the first personal contact with the guardian, you will need to ask the below questions and record the answers on the PVR or on the Health Info page for the Guardian. At any time you learn of a change, go to Guardian -Health Info screen to add an additional entry. Has parent smoked any cigarettes in the past two weeks? Has parent drank alcohol in last 30 days? Has parent used illicit drugs in last 30 days?
	Construct 3- Post Partum use of Contraception	Information must be entered by 6 weeks postpartum *Goal: An increase in the number of mothers who use contraception by 6 weeks postpartum.*	This data should be entered on the Guardian Health Info when mother begins using contraception up to when the child is six weeks old.
	Construct 4- Inter-birth intervals	Information must be entered by 6 weeks postpartum. *Goal: An increase in the number of mothers who receive Information on family planning and the benefits of Child*	At any personal contact, discuss & counsel on inter-birth intervals and note that in the appropriate section on the PVR. [ii] Click "I" for information was shared next to "inter-birth interval"

		Spacing of at least 18 months shared.	
	Construct 5- Screening for maternal depressive symptoms.	Screened at least once during the third trimester of pregnancy or the first two months postpartum *Goal: An increase in the number of pre/postnatal mothers who are screened using EPDS during the above timeframe.*	At any personal contact, note if you conducted a screening for the maternal depressive symptoms. [iii] (If a referral is made as a result of this depression screening, please enter it also on this PVR) - AND go to Guardian-Assessments and enter the score for the EPDS
	Construct 6- Breastfeeding	Updated at every home visit until 6 months postpartum. *Goal: an increase in the number of infants who are breastfed until they are 6 months old*	At every personal contact until the answer is "weaned" or "never", note if the child is being breastfed and the # of weeks so far or if the child was Never breastfed or has been weaned. [iv] This can also be entered on the Child-Health info screen.
	Construct 7- Well-child visits	All dates of well child medical visits from case opening until child reaches 15 months of age must be recorded *Goal: children obtain at least 5 well-child visits by the time they are 15 months old.*	At each personal contact, ask the mother if the child has visited a health care provider since your last visit. Note the approx. date and reason on the PVR. This can also be noted on the Child-Health info screen. Enter "well-child" for type
	Construct 8. Maternal & child health insurance status.	At case opening and update at least quarterly or as soon as you become aware of changes. *Goal: An increase in the number of Mothers and children who have health insurance*	Upon enrollment and quarterly, ask if primary guardian and children are insured. Note this on the Health Info page for the guardian and child. Update this on the Health Info, anytime you learn of a change.
B. Reduced Child Abuse and Neglect and ER Visits	Construct 9- Visits for children to the emergency department from all causes	All dates of visits to the emergency room starting from case opening must be recorded. Update at least quarterly or whenever you know of a visit to the ER. *Goal: A decrease in the number of children who visit the emergency room.*	At each personal contact, ask the mother if the child has visited a health care provider since your last visit. Note the approx. date and reason on the PVR. OR this can be noted on Child-Health screen under Child Medical Visits- choose "ER/urgent" for type.
	Construct 10- Visits of	All dates of visits to the emergency	At each personal contact, ask the mother if they

	mothers to the emergency department from all causes.	room starting from case opening must be recorded. Update at least quarterly or whenever you know of a visit to the ER. *Goal: A decrease in the number of mothers who visit the emergency room.*	have visited a health care provider since your last visit. Note the approx. date and reason on the PVR. OR this can be noted on Guardian-Health screen under Guardian Medical Visits- choose "ER/urgent" for type.
	Construct 11- Information provided or training of participants on prevention of child injuries topics	This information must be provided by 3 months post enrollment. *An increase in the number of guardians who receive Information on child injury topics by 3 months post enrollment.*	At any personal contact, note if you discussed prevention of child injuries and note that in the appropriate section on the PVR[v] by clicking "I" for information shared next to "Injury Prevention".
	Construct 12- Incidence of child injuries requiring medical treatment.	All dates of incidents requiring medical attention starting from case opening must be recorded. Update at least quarterly or whenever you know of an incident. *Goal: A decrease in the number of children who require medical attention for injuries*	At each personal contact, ask the mother if the child has visited a health care provider since your last visit. Note the approx. date and reason on the PVR. All medical visits with "injury" notes as the reason will count here.
	Construct 13- Reported suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated).	N/A- Administrative Data	N/A
	Construct 14- Reported substantiated/indicated maltreatment (substantiated/indicated/ alternative response victim) for children in the program.	N/A- Administrative Data	. N/A
	Construct 15- First-time victims of maltreatment for children in the	N/A- Administrative Data	NA

	program.		
C. Improvement in School Readiness and Achi[vi]evement	Construct 16- Parent support for children's learning & development (e.g., appropriate toys available; read & talk with child).	N/A- Field Data collectors will be collecting (PICCOLO and HOME)	N/A- Field Data collectors will enter scores on scantron or directly in Visit Tracker.
	Construct 17- Parent knowledge of child development & of their child's developmental progress.	N/A- Field Data collectors will be collecting (KIDI)	N/A- Field Data collectors will enter scores on scantron or directly in Visit Tracker.
	Construct 18- Parenting behaviors & parent-child relationships (e.g. discipline strategies, play interactions).	N/A- Field Data collectors will be collecting (PICCOLO)	N/A- Field Data collectors will enter scores on scantron or directly in Visit Tracker.
	Construct 19- Parenting behaviors & parent-child relationships (e.g. discipline strategies, play interactions).	N/A- Field Data collectors will be collecting (KIDI)	N/A- Field Data collectors will enter scores on scantron or directly in Visit Tracker.
	Construct 20- Parent emotional well-being or parenting stress.	N/A- Field Data collectors will be collecting (PSI)	N/A- Field Data collectors will enter scores on scantron or directly in Visit Tracker.
	Construct 21- Child's general development	ASQ-3 completed at 6 months, 12 months and annually thereafter. *Goal: An increase in number of children screened at 12 months of age.*	Enter ASQ-3 screening by pulling up the child in Visit Tracker, click "screenings" on the left, then Click "New Screening", and when the screening record pops up, scroll down to the Development area and choose the ASQ-3 tool. Note scores and if there was a concern in any area, check that area.[vii] If you made a referral to another agency as a result of a concern found, note that at the bottom of the screen.

	Construct 22- Child's general cognitive skills.	ASQ-3 completed at 6, months, 12 months and annually thereafter. *Goal: An increase in number of children screened at 12 months of age.*	Scores entered as explained in construct 21 above
	Construct 23- Child's positive approaches to learning including attention.	ASQ-3 completed at 6, months, 12 months and annually thereafter. *Goal: An increase in number of children screened at 12 months of age.*	Scores entered as explained in construct 21 above
	Construct 24- Child's social behavior, emotion regulation & emotional well-being.	ASQ-SE completed at 6, months, 12 months and annually thereafter. *Goal: An increase in number of children screened at 12 months of age.*	Scores entered as explained in construct 21 above except the screening tool chosen will be ASQ-SE and the score will be entered in the social-emotional area. Note a concern/delay and document if a referral was made if applicable. The ASQ-SE score may also be entered in the social emotional area of the ASQ-3 screen.
	Construct 25- Child's physical health & development (well-child visits).	All dates of well child medical visits from case opening until child reaches 15 months of age must be recorded. *Goal: children obtain at least 5 well-child visits by the time they are 15 months old.*	No extra data is needed here because home visitors have entered well-child visits on construct 7.
D. Domestic Violence	Construct 26- Screening for domestic violence	Screen must occur within 45 days of case opening and quarterly thereafter. *Goal: An increase in the number of mothers screened for domestic violence within 45 days of enrollment.*	To enter that a domestic violence screening was conducted, on the PVR, check the appropriate box "DOVE/Futures Without Violence/4 P's". [viii] AND go to Guardian-Assessments and enter the score for the FUTURES assessment.
	Construct 27- Referrals for domestic violence services for families with identified need.	Referral is made whenever score on relationship assessment tool is positive. *Goal: An increase in the number of mothers who are referred for DV services when they score positive.*	On the PVR where the depression screening is indicated (construct 25), if the mother screened positive for a domestic violence risk, note also if a referral was made by clicking the "R" next to Domestic Violence Services (construct 27) [ix] or note the Referral on the Guardian-Resource Referral screen

	Construct 28- Safety plan completed for families with identified DV need.	Safety Plans are developed whenever a referral is made for domestic violence. *Goal: An increase in the number of mothers who develop a safety plan when they are referred to domestic violence services.*	Create a Domestic Violence Safety plan if screened positive on construct 26. To do so, from either the PVR Goals section or under the Guardian Goals link on the left, create a "Domestic Violence Safety Plan" Goal. Go ahead and click "Met" to indicate completion. [x]
E. Family Economic Self Sufficiency	Construct 29- Household* income & benefits.	At case opening and update at least quarterly or as soon as you become aware of changes. *Goal: An increase in household income and benefits*	Indicate Household income & # in home on the Guardian Demographics screen – scroll to bottom. This should be done at enrollment and checked quarterly . [xi] A MIECHV household consists of Primary guardian, other parent if they live in the household and all children in the household.
	Construct 30- Graduation from high school or obtained a General Equivalency Diploma for enrolled guardian.	Documented whenever a parent identifies education as a goal. Update progress at least quarterly or as soon as you become aware of changes. *Goal: An increase in goals met for guardians who identify education as a goal.*	For every Guardian who identifies education as a goal, in the Guardian PVR, in the Goals section, create a goal with goal area of "Education". Click on "met" when the goal is reached.
	Construct 31- number of hours per month spent by primary parent in employment & educational programs	At case opening and update at least quarterly or as soon as you become aware of changes. *Goal: An increase in the number of hours spent in employment or education.*	The # of hours spent in employment and education is indicated in data entry from construct 30. (# of hrs in care of infant will be inferred by state sys.)
	Construct 32- Household Health insurance status.	At case opening and update at least quarterly or as soon as you become aware of changes. *Goal: An increase in the number of households who are insured.*	Indicate Health insurance status of Guardian and each child on their respective Health Info screens. There is also a question "Are all family members covered at this time?" that should be answered when entering the Guardian insurance status. A MIECHV family consists of Primary guardian, other parent if they live in the household and all children in the household.
F. Coordination and Referrals	Construct 33- Number of families identified for necessary services.	Document scores for assessments/screens. *Goal: ASQ completed at 12 months of age,*	When a family member is assessed using the ASQ, EPDS or Futures Relationship Assessment Tool. Document the scores in appropriate areas (See

		EPDS within 3rd trimester or within 2 months postpartum, Futures within 45 days of enrollment.	above constructs 5, 21 and 26).
	Construct 34- Number of families with an identified service need who are referred to an available community service within one month of positive screening	Whenever there is a positive score on ASQ, EPDS or Futures, document a referral. ASQ positive=Concern/Delay EPDS positive=14 or above Futures positive=21 or above *Goal: An increase in the number of referrals made when there is a positive score*	When a score for any of the ASQ, EPDS, or Futures are positive, document a referral on the guardian resource referral page for the Futures and EPDS or directly on the ASQ in the child's screening page.
	Construct 35- The number of families who complete referrals to available community resources	Whenever a referral is made document the outcome of the referral. *Goal: An increase in number of Guardians who complete a referral*	When a referral is made the home visitor needs to do "follow-up" and note if the Guardian "received services" (ie. Did the parent get in touch with the agency and at least pursue services?). Go to the Guardian – Resource Referral screen and click the Edit button on the referral and then note the date you conducted follow-up and then note if the Guardian did "receive services". Only Guardians who "received services" will be counted as "completed referrals". [xii] OR, if the referral was made on the screening data entry page as a result of a delay, go back to that screening entry and note the follow-up information at the bottom. Answer Yes to the question "Was service/intervention received as a result of this referral?"
	Construct 36- The number of agencies in the community which serve families with young children with which the home visiting provider has an identified contact person.	N/A- collected by Coordinated Intake/Community System Developer in each community	N/A

	Construct 37- MOUs or other formal agreements with other social service agencies in the community.	NA- Collected from Coordinated intake and/or Community System Developers.	N/A

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[i] The PVR can be found by going to the Guardian record (not child), then click "Contact History" on the left and then click the word "Private" associated with the visit date previously scheduled.

[ii]

Family well-being factors discussed:
(choose "I" if information was shared, "R" is referral was made, "N" for nothing)

N I R
( ) ( ) (•) Adult Education, job training, college

N I R
(•) ( ) ( ) Inter-birth Intervals

[iii]

Were any of the following completed?
[ ] Family-centered assessment [ ] Parenting assessment [x] Depression Screening

[iv] **Breastfeeding Survey:** (•) Ongoing ( ) Never ( ) Weaned [ ] Total wks breastfed

[v] (•) ( ) ( ) Injury Prevention

Development

Developmental Screening Completed? (•) Yes ( ) No

Screening Type: ASQ-3 (National)

Screening Result: Concern

	Score	Delay / Concern
Communications	25	☑
Gross Motor	45	☐
Fine Motor	40	☐
Intellect/Prob Solve	50	☐
Personal-Social	52	☐

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Were any of the following completed?

☐ Family-centered assessment ☐ Parenting assessment ☐ Depress

☑ DOVE/Futures Without Violence ☐ Other outcomes measurement

4 P's will be added soon.

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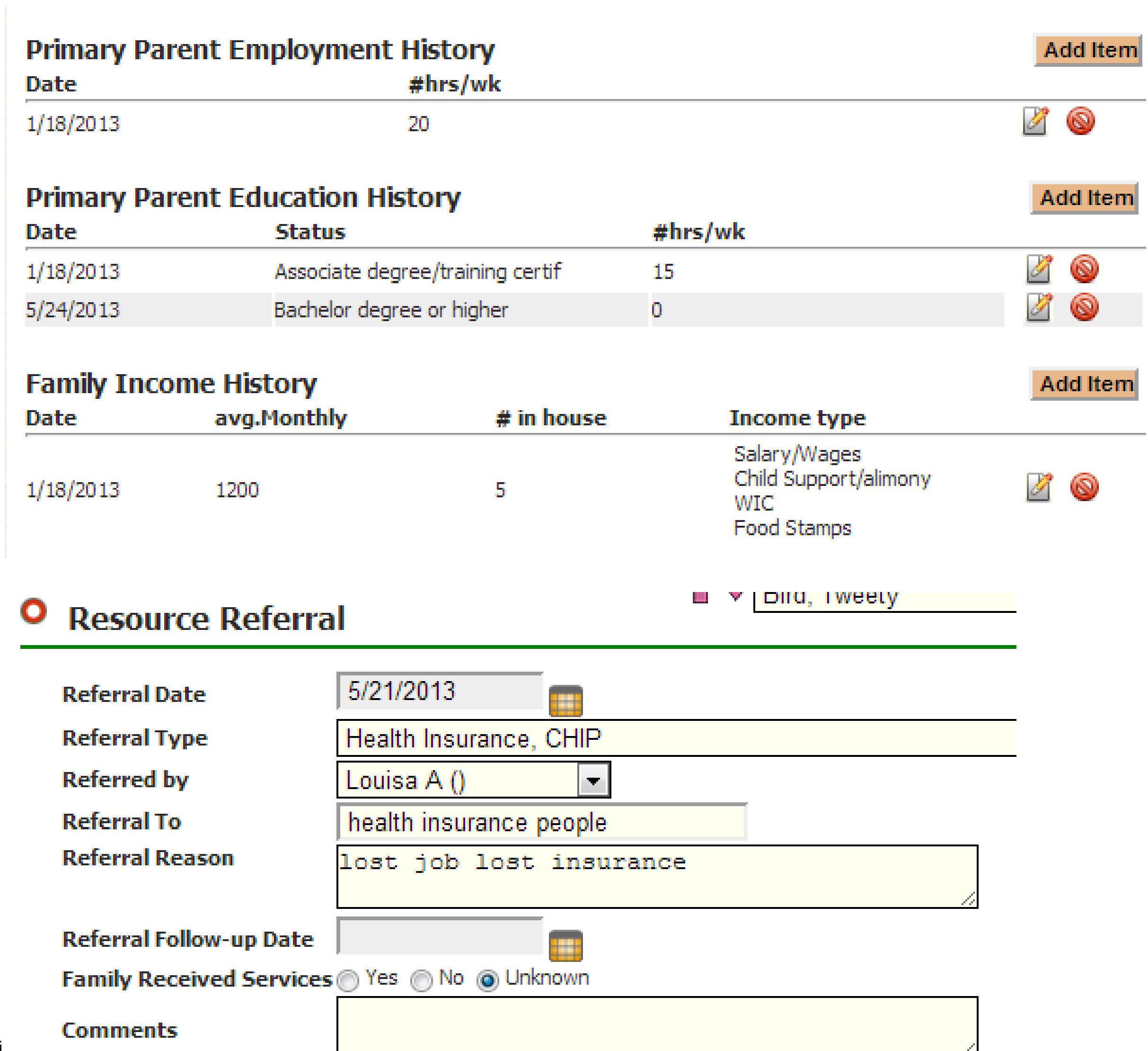
ix (•) ( ) ( ) Domestic Violence Services

Goal Area: Domestic Violence Safety Plan

Goal

Status ( ) Abandoned ( ) Met (•) Unmet **Date Met**

x



Primary Parent Employment History Add Item

Date	#hrs/wk
1/18/2013	20

Primary Parent Education History Add Item

Date	Status	#hrs/wk
1/18/2013	Associate degree/training certif	15
5/24/2013	Bachelor degree or higher	0

Family Income History Add Item

Date	avg.Monthly	# in house	Income type
1/18/2013	1200	5	Salary/Wages Child Support/alimony WIC Food Stamps

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Resource Referral

Bird, Tweety

Referral Date	5/21/2013
Referral Type	Health Insurance, CHIP
Referred by	Louisa A ()
Referral To	health insurance people
Referral Reason	lost job lost insurance
Referral Follow-up Date	
Family Received Services	Yes / No / Unknown (selected)
Comments	

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