|  |
| --- |
| Bureau of Maternal & Child Health, Illinois Department of Human Services**FY17 MIECHV and HFI Home Visiting: Chart Review Tool** |
| Agency: |  | Present = XAbsent = ONot applicable = N/A |
| Site: |  |
| Program Model:  |  HFI  PAT  EHS |
| Reviewer: |  |

| Patient Case/Cornerstone Number |  |  |  |  |  | **Totals** |
| --- | --- | --- | --- | --- | --- | --- |
| X | 0 |
| Family enrolled prior to 37 weeks gestation? |  |  |  |  |  |  |  |
| DOB or Due Date of Target Child |  |  |  |  |  |  |  |
| Birth occurred preterm? Y/N |  |  |  |  |  |  |  |
| **Prenatal** | Prenatal Care start date 1st trimester |  |  |  |  |  |  |  |
| Adequate # prenatal visits from program start date |  |  |  |  |  |  |  |
| Postnatal visit within 8 wks if enrolled prenatally or within 30 days postpartum if enrolled postnatally |  |  |  |  |  |  |  |
| Mother seeing a practitioner with appropriate skill level to meet needs |  |  |  |  |  |  |  |
| **Use of alcohol, tobacco or illicit drugs** | Screening documented within 30 days of program enrollment |  |  |  |  |  |  |  |
| Referral if indicated |  |  |  |  |  |  |  |
| Follow-up if referral made |  |  |  |  |  |  |  |
| **Domestic Violence screening** | Domestic Violence Screening occurred within 6 months of program enrollment using FWV Relationship Assessment Tool or other standardized tool, and as needed |  |  |  |  |  |  |  |
| Referral if indicated |  |  |  |  |  |  |  |
| Follow-up if referral made |  |  |  |  |  |  |  |
| **Inter-conception education** | Education provided on inter-conception care including timeliness and appropriateness of education |  |  |  |  |  |  |  |
| **Contraception use postpartum** | Selection of contraception method by 6 wks postpartum |  |  |  |  |  |  |  |
| Method in use by return of sexual activity |  |  |  |  |  |  |  |
| Contraception type |  |  |  |  |  |  |  |
| **Maternal Depression** | Depression screening : if enrolled postnatally, screening is completed by 3 months postpartum. |  |  |  |  |  |  |  |
| If enrolled prenatally, 1 screening is completed prenatally, 1 screening completed postpartum, and as indicated by mother’s history and presentation,  |  |  |  |  |  |  |  |
| Referral if indicated |  |  |  |  |  |  |  |
| Follow-up if referral made |  |  |  |  |  |  |  |
| **Family needs identified and referred for services** | Referrals for food, shelter, clothing, education, job, car seats and other services made if indicated |  |  |  |  |  |  |  |
| Follow-up if referral made |  |  |  |  |  |  |  |
| **Family health care coverage** | Target child has health insurance |  |  |  |  |  |  |  |
| Primary caregiver has continuous coverage of health insurance for at least 6 consecutive months |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Information and linkages provided on access to health insurance, Medicaid, marketplace if indicated |  |  |  |  |  |  |  |
| **Breastfeeding** | Support and education provided |  |  |  |  |  |  |  |
| Supportive family members included |  |  |  |  |  |  |  |
| Initiation |  |  |  |  |  |  |  |
| Baby still breastfed at 6 months  |  |  |  |  |  |  |  |
| **Nutrition** | Connected to WIC office |  |  |  |  |  |  |  |
| Age appropriate nutrition education |  |  |  |  |  |  |  |
| **Well child visits** | Well child visits completed at following intervals:* By 1 month
* 1-2mo
* 3-4 mo
* 5-7 mo
* 8-10 mo
* 11-13 mo
* 14-16 mo
* 17-19 mo
* 20-29 mo
 |  |  |  |  |  |  |  |
| One well child visits occurred annually ages 3-5 years |  |  |  |  |  |  |  |
| **Immunizations** | 3-2-2 Immunization by 12 mos |  |  |  |  |  |  |  |
| 4-3-3-1 Immunization by 24 mos |  |  |  |  |  |  |  |
| **Developmental Screening** | 1 ASQ screenings at 9 months |  |  |  |  |  |  |  |
| 1 ASQ screenings at 18 months |  |  |  |  |  |  |  |
| 1 ASQ screening at 30 months |  |  |  |  |  |  |  |
| ASQ SE screening at 10-14 mos |  |  |  |  |  |  |  |
| Evidence that Developmental Surveillance is completed at all other recommended Well-Child Health visits  |  |  |  |  |  |  |  |
| Referral if indicated |  |  |  |  |  |  |  |
| Follow-up if referral made |  |  |  |  |  |  |  |
| Results shared with medical provider |  |  |  |  |  |  |  |
| Caregiver reports reading, storytelling, singing with child daily at every visit |  |  |  |  |  |  |  |
| **Dental** | Regular dental care initiated at 12 months |  |  |  |  |  |  |  |
| Child has regular dentist |  |  |  |  |  |  |  |
| Mom has regular dentist |  |  |  |  |  |  |  |
| Periodic Oral Care education provided |  |  |  |  |  |  |  |
| **Vision & Hearing** | Periodic Vision surveillance using age appropriate tools (ie Bright Futures, EI Vision Development Checklist) |  |  |  |  |  |  |  |
| Periodic Hearing surveillance using age appropriate tools (ie Bright Futures) |  |  |  |  |  |  |  |
| Referral if indicated |  |  |  |  |  |  |  |
| Follow-up if referral made |  |  |  |  |  |  |  |
| **Childhood injury prevention** | Education provided on prevention of injury including timeliness and appropriateness of education |  |  |  |  |  |  |  |
| Did childhood injury requiring medical treatment occur ? (Y/N) |  |  |  |  |  |  |  |
| If so, did further injury prevention education occur |  |  |  |  |  |  |  |
| Safe Sleep education provided |  |  |  |  |  |  |  |
| Caregiver reports safe sleep recommendations are followed at every visit for the first 12 months. |  |  |  |  |  |  |  |
| **Emergency Room visits for non-emergency care** | Appropriate emergency room use for mother and child |  |  |  |  |  |  |  |
| Referrals and education if indicated |  |  |  |  |  |  |  |
| **Medical Care Coordination** | Overall evidence of medical care coordination |  |  |  |  |  |  |  |
| **Comments:**  |
|  |
|  |
|  |
|  |

FY17 MIECHV and HFI Home Visiting Chart Review Tool 11-13-2016