3 FAMILY CASE MANAGEMENT PROGRAM

Revised October 2019

Family Case Management (FCM) is a statewide program that provides comprehensive service coordination to improve the health, social, educational, and developmental needs of pregnant women and infants (0 – 12 months) from low-income families in the communities of Illinois (410 ILCS 212/15). Family Case Management (FCM) aims to "assess current needs within the State and provide goals and objectives for improving the health of mothers, children, and for reducing infant mortality." (77 Ill. Adm Code 630.20 (a)(1)).

3.1 STAFFING QUALIFICATIONS

Revised October 2019

All case managers must be enrolled in the Family Case Management training provided by the Springfield Urban League within 3 months of working in Family Case Management and can be required to attend the training again at any time during their work with MCH Programs as required by the MCH Nurse Consultant or Agency MCH Coordinator.

3.1.1 Case Manager

Revised October 2019

The case manager must meet one of the following qualifications:

A. A registered professional nurse licensed pursuant to Section 12 of the Nurse Practice Act [225 ILCS 65] and
   a. two years' experience in community health or maternal and child health nursing, or
   b. a Bachelor of Science in Nursing (B.S.N.) degree from a recognized or accredited program and one year of experience in community health or maternal and child health nursing, or
   c. supervision by a registered professional nurse, licensed social worker, or licensed clinical social worker with the length of experience described herein, until the case manager obtains the length of experience required in subsection A(a) or A(b) of this Section.

B. A clinical social worker licensed pursuant to Section 9 or social worker licensed pursuant to Section 9A of the Clinical Social Work and Social Work Practice Act [225 ILCS 20] and 68 Ill. Adm. Code 1470 and:
   a. one year of experience in providing direct services to families with young children in a professional setting, or
   b. supervision by a registered professional nurse, licensed social worker or licensed clinical social worker with the length of experience described herein until the case manager obtains the length of experience required in subsection A(a) of this Section.

C. Possess a master's degree or baccalaureate degree in a behavioral science, social science, or health-related area; or a baccalaureate degree in any other area and one year of experience in providing direct professional child, family, or community services; or an associate degree and two years' experience in providing direct professional child, family, or community services. Case managers meeting only this qualification must be supervised by an appropriate case manager meeting the requirements of subsection A or B of this Section until they have a total of two years of supervised case management experience.

3.1.2 PROGRAM COORDINATOR

Revised October 2019

The MCH Coordinator is responsible for the overall administration of the program to assure compliance with all State policies and Federal regulations. Responsibilities may include:

A. Supervision, evaluation, and direction of MCH staff by ensuring that staff at all levels are competent to complete job specific duties when providing MCH program services.
B. Serve as the Local Agency liaison to State MCH Staff by:
    a. Providing communication regarding local agency questions, concerns, and any agency specific activities impacting the MCH Program
    b. Participating in State and Regional MCH conference calls and meetings
    c. Communicating to staff MCH Program updates and reinforcement of program requirements
C. Determine staff training needs and coordinate education opportunities.
D. Conduct Quality Assurance activities and monitor the following areas and identify improvement needs.
    a. Daily Clinic Operations
    b. MCH Reports
    c. Perinatal Education
    d. Agency Policy & Procedure
E. Attend professional conferences, seminars, workshops to update staff on current MCH practices and other information relevant to MCH.
F. Identify and collaborate with local Agencies and other community partners.
G. Manage assigned caseload per IDHS Grant Agreement.
H. Maintain oversight controls and records
I. Ensure employee compliance and program integrity.

3.1.3 CASE MANAGER ASSISTANTS & FRONTLINE/CLERICAL STAFF

Revised October 2019

Paraprofessionals and lay workers may be used to perform some case management functions under the supervision of the case manager. These functions may include:

A. Intake, follow-up with clients or Agencies to ensure that participants are accessing needed services
B. Provision of support and assistance that clients may require to access services
C. Conducting outreach activities
D. Maintaining client files and clinic schedule
E. Scheduling of appointments and follow-up on missed / upcoming appointments
F. Managing client correspondence

3.2 Eligibility

Revised October 2019

Eligibility for FCM services is outlined in the Illinois Family Case Management Act (410 ILCS 212/1) and is defined as follows: any pregnant woman or child through the age of one year enrolled in the Medicaid program on the effective date of this Act or whose income is up to 200% of the federal poverty level.

Pregnant women are eligible for services in Family Case Management throughout their pregnancy and up to 6 weeks post-partum.

Infants are eligible for services in Family Case Management throughout the first year of life.

3.3 CONTENT

3.3.1 FREQUENCY

Revised October 2019

The case management agency must have face-to-face contact with the client as specified below and have as much additional contact as necessary to facilitate the family's access to services. Each contact must include the activities described for the client type. Whenever possible, the face-to-face contact should be made by the assigned case manager.

- For infants, face-to-face contact at approximately two, four, six and twelve months of age.
- For pregnant women, face-to-face contact once each trimester of pregnancy active in the program.

Case management activities shall be conducted in the client's home as presented below.

- At least once prenatally.
- At least once during infancy in months 2 – 4 of the infant's life.

3.3.2 PROCESS - PREGNANT WOMEN & INFANTS

Revised October 2019

Outlined below are the guidelines for the full case management process. Agencies with a Family Case Management contract are expected to perform the following processes at a minimum to comply with the performance requirements of the grant.

The Agency is expected to provide case management services to at least 90% of the assigned caseload of pregnant women and infants.

Agencies are expected to do the following:

A. Conduct case finding from a weekly list of newly enrolled Medicaid clients by contacting and encouraging clients not currently active in case management to participate and enroll in the FCM program.
B. Clients will be assigned to a case manager continuously within 30 days of enrollment and must be reassigned if staffing changes occur. Measured through Cornerstone on PA02, through Chart Review.
C. Ensure that all clients have an assigned Primary Care Provider (PCP) as documented on PA03 in Cornerstone and measured through Chart Review.
D. All clients will be assisted in applying for benefits under the Medicaid program or referred to the Marketplace for insurance options if they do not currently have coverage.
E. All Infants must be grouped with the mother or guardian (if mother is not the guardian) as documented on PA06 in Cornerstone and measured through Chart Review.
F. The Agency will complete comprehensive needs assessments and develop individualized care plans in person with the client within forty-five (45) calendar days of initial successful client contact.
    a. The Agency will complete the following Cornerstone Assessments:
        i. 701 – Other Service Barriers,
        ii. 711 – Prenatal Risk or 712 – Infant Risk as appropriate
    b. Clients are to be referred to the available program most appropriate to their risk level (FCM, HRIF, or BBO).
        i. If an agency does not offer the program for which the client is most eligible, but another agency in the geographic vicinity does, it is expected that the client be referred to the most appropriate program for the client's needs.

3.3.3 Pregnant Women

Revised October 2019

It is expected that agencies will provide a minimum of the following services as measured through Cornerstone chart review and performance reports to all Pregnant Women enrolled in Family Case Management.

A. The following information is to be obtained and documented in Cornerstone as appropriate:
   a. Completion of the PA07 (Initial Prenatal Data) screen in Cornerstone with provision of the following:
      i. Estimated Date of Confinement (EDC) Date
      ii. Month when Prenatal Care Began
      iii. Number of Prenatal Medical visits prior to enrollment
   b. Completion of the PA10 (Postpartum Data) screen in Cornerstone with provision of the following at the Postpartum visit:
      i. Number of Prenatal Medical visits completed
      ii. Birthweight of the baby on PA11 (Birth Data) screen in Cornerstone (with written confirmation, e.g. birth certificate, crib sheet, etc.) If verbal only, enter "9999" in this section.
B. Ensure that the following assessments and education are provided, and appropriate educational materials are distributed to pregnant and postpartum women to supplement the education topics discussed.
   a. Nutrition
      i. Complete the Assessment AS01: 708 Q81 – 92 if the client is active in WIC.
      ii. Complete the Assessment AS01: 707D if the client is not active in WIC.
   b. Home Visit
      i. Complete the assessment AS01: 706 at the Home Visit.
   c. Assure that all enrolled pregnant women are educated on and screened for perinatal mood disorders and referred to services as appropriate.
      i. Screenings shall use a Medicaid-approved perinatal depression screening tool as indicated on the Department of Healthcare and Family Services website. The screening is to be completed during a face-to-face visit with the case manager and entered as a service entry (SV01: 825). This does not have to be repeated if there is documentation on the Service Entry Screen (SV01:825) that one was completed and confirmed by communication with the Primary Care or Obstetrical Care Provider along with a Case Note (CM04) detailing that verification has been obtained with the Provider.
      ii. Licensed health care workers providing Family Case Management, prenatal care, and postnatal care to women shall screen new mothers for perinatal mood disorder symptoms at a prenatal check-up visit on or after 20 weeks gestation and at the time of a postnatal check-up in the 42 days postpartum, or provide documentation that screening was completed and confirmed by communication with the Primary Care or Obstetrical Care Provider.

iii. FCM licensed health care workers providing prenatal and postnatal care to a woman shall include fathers and other family members, as appropriate, in both the education and treatment processes to help them better understand the nature and causes of postpartum mood disorders. This is to be documented through Cornerstone Case Notes and will be reviewed in chart audits.
iv. In accordance with the Perinatal Mental Health Disorders Prevention and Treatment Act (PMD), all women will receive information on postpartum mood disorders, including the Department's Postpartum Depression brochure and contact information for the Perinatal Depression Hotline.

C. Evidence of medical care coordination in accordance with the HFS vs. Memisovski Consent Decree from 1992 shall be expected to include the following:
   a. Adequacy of prenatal care as measured by the Kotelchuck Index
   b. Linkage with a Primary Care Provider
   c. All referrals (specialty care, mental health, housing, etc.) as documented on the Cornerstone system Service Provider Selection (RF01). Minimal documentation will include the reason for referral and documentation if follow-up has occurred.
      i. Clients are to be given a copy of the referral.

D. Pregnant women enrolled in the program are to receive at minimum the following services:
   a. Adequate prenatal care visits throughout pregnancy as measured by daily entry of client data into Cornerstone Data Entry Screens: PA07 (Initial Prenatal); PA10 (Postpartum); PA15 (Program Information); SV01 (Service Entry).
   b. Education about a Reproductive Life Plan as measured by timely entry of client data into Cornerstone Service Entry Screens: SV01:941 with a hard copy in the client record.
   c. Prenatal education/preconception & interconception health education as measured by timely entry of data into Cornerstone Service Entry Screens: SV01: PEWW through the Well Women education.
   d. At least one (1) Prenatal Depression Screening completed at ≥20 weeks of gestation as measured by timely entry of client data into Cornerstone Data Entry Screens: SV01-825 (Service Entry) with SV01-940 Postpartum Depression Brochure given in cases of a score over ten (10) as determined during the Depression Screening.
   e. A minimum of one (1) pre-natal face-to-face contact per trimester active in FCM including one (1) home visit as measured by timely entry of client data into Cornerstone Data Entry Screens: SV02 (Activity Entry) and AS01 706 Assessment.
   f. Education materials given for Prenatal Education as measured by timely entry of data into Cornerstone Service Entry Screens SV01:803.

E. Collaborate and link clients to other service Agencies in the community including primary care physicians and Medicaid managed care entities for service development and integration to maximize care coordination.

3.3.4 POSTPARTUM WOMEN

Revised October 2019

It is expected that agencies will provide a minimum of the following services as measured through Cornerstone chart review and performance reports to all Postpartum Women enrolled in Family Case Management.

A. Postpartum Women enrolled in the program are to receive at minimum the following services within 42 days of delivery to include:
    a. At least one (1) Postpartum Depression Screening completed as measured by timely entry of client data into Cornerstone Data Entry Screens: SV01-825 (Service Entry) with a hard copy in the client record and SV01 940 evidencing provision of Postpartum Depression Brochure to the mother, focusing on resources identified in the brochure.
    b. Reproductive Life Plan as measured by timely entry of client data into Cornerstone Data Entry Screens: SV01, code 942 with a hard copy in the client record;
    c. Prenatal education/preconception & interconception health education as measured by timely entry of data into Cornerstone Data Entry Screens: SV01, PEWW.
    d. Collaborate and link clients to other service Agencies in the community including primary care physicians and Medicaid managed care entities for service development and integration to maximize care coordination.

3.3.5 INFANTS

Revised October 2019

It is expected that agencies will provide a minimum of the following services as measured through Cornerstone chart review and performance reports to all Infants enrolled in Family Case Management.

A. Infants enrolled in the program are to receive at minimum the following services:
   a. Face-to-Face Visits with age-based assessments completed at newborn, 4 months, 6 months and 12 months from birth as measured by timely entry of client data into Cornerstone Data Entry Screens: SV02 (Activity Entry) screen and completed AS01: 708A-F assessments and / or screening.
   b. A minimum of one of each assessment completed as measured in the AS01: 712, 701 and Nutrition 708 Q81 if WIC active or Q81-90 if WIC not active within 45 days of activation in the program.
   c. At least one home visit at age 2 – 4 months as measured by AS01:706 Home Assessment, SV01:SSED (Safe Sleep Education) and SV02 (Activity Entry).
   d. Completion of Immunization Education based on current CDC Guidelines as documented in Cornerstone Data Entry Screen SV01:IMED at each Face-to-Face contact.
   e. Developmental Screenings per schedule as measured by timely entry of client data into Cornerstone Data Entry Screens: SV01:824 (Service Entry). Evidence of an objective Illinois Department of Healthcare and Family Services (HFS) Medicaid approved developmental screening can be through Agency administration of screening or documentation, including date of screening completion by another service provider completed in 6–12 month age range.
   f. A minimum of 3 required age based well child visits and appropriate sick visits as measured by timely entry of client data into Cornerstone Data Entry Screens: PA03 (Participant Enrollment) and SV01:806 and SV01:823.
   g. Educational materials given for Pediatric Health Education as measured by timely entry of data into Cornerstone Service Entry Screens SV01:807.
B. Collaborate and link clients to other service Agencies in the community including primary care physicians and Medicaid managed care entities for service development and integration to maximize care coordination.
C. Evidence of medical care coordination in accordance with the HFS vs. Memisovski Consent Decree from 1992 shall be expected to include the following:
   a. Education on the importance of childhood immunizations
   b. EPSDT participation at age one year
   c. Linkage with a Primary Care Provider
   d. All referrals (Early Intervention (EI), specialty care, mental health, housing, etc.) as documented on the Cornerstone system Service Provider Selection (RF01). Minimal documentation will include the reason for referral and documentation that follow-up has occurred.
      i. Clients are to be given a copy of the referral.

3.3.6 REFERRAL AND ADVOCACY

Revised October 2019

The case manager shall assure that any necessary referrals are made and advocate as necessary on the client's behalf for services identified in the individual care plan. The case manager will ensure that all infants in need of Early Intervention (EI) services based on the Developmental Screening will be referred to the necessary services, and documentation will be made in the Cornerstone System on the Referral Screen (RF01) with the reason for the referral and documentation that follow-up has occurred.

Minimal documentation requirements for all referrals on the RF01 screen in Cornerstone will include the reason for referral and documentation that follow-up has occurred.

Clients are to be given a hard copy of the referral.

3.3.7 FOLLOW-UP AND REASSESSMENT

Revised October 2019

Subsequent case management activities shall include, as necessary, a review of the implementation of the individualized care plan to date. The case manager should update the individual care plan using any additional information received from the physician or other service Agencies. These updates should occur at a quarterly minimum.

3.3.8 OUTREACH

Revised October 2019

"Outreach" means any activity to find and inform potential program clients of available services. The primary objective of outreach activities is to inform potential program clients of available services, eligibility criteria, and method of accessing services (for example, the name, address and phone number of the Agency). This is not to preclude the use of nontraditional methods of outreach that may be necessary to identify potential participants in hard-to-reach populations, such as persons who abuse substances or engage in prostitution. Acceptable Outreach methods are outlined in Section 3.3.9 of the Program Policy Manual.

The primary purposes of outreach are the following:

1. Build and maintain strong relationships, including execution of Linkage Agreements, with primary care medical providers, including but not limited to physicians, certified nurse midwives, nurse practitioners, physician assistants, and hospital labor and delivery and emergency room personnel.
2. Establishment of a working relationship between the FCM Agency and Medicaid Managed Care Organizations serving women within the Agency's service area, as directed by the Department of Human Services.

Costs for outreach may be documented on monthly PFRs for reimbursement if they have been documented in the approved budget under line item 15 known as the Grant Exclusives Line Item.

Costs for Outreach may not exceed 10% of the overall grant amount.

3.3.9 ALLOWABLE COST FOR OUTREACH AND CASE MANAGEMENT ACTIVITIES

Revised October 2019

A. Costs incurred for outreach activities as defined in section 3.3.8 of the Policy & Procedure Manual are allowed. However, health, general education, or other social service activities may not be included as outreach.
B. Salary and other expenses for staff conducting outreach and case management activities must be supported by documentation. Expenses incurred for the provision of any other direct service (including Client teaching) by staff conducting outreach and case management activities must be excluded. If program staff provide other direct services in addition to outreach and case management, the grantee's time and activity reporting system must distinguish between allowable and excluded costs.
C. Outreach can include community campaigns such as door-to-door canvassing, production and distribution of handbills, design and publication of newspaper announcements, and production and broadcast of public service announcements or paid advertising on radio or television.
D. Outreach efforts can be used to establish and maintain Linkage Agreements with social services agencies and other community-based organizations, including WIC agencies and local Public Health Departments (if the FCM Agency is an FQHC or other community-based organization), for purposes of early identification and referral of potentially eligible pregnant women and infants and for overall coordination of care for enrolled clients.
E. The Agency is expected to pursue partnerships with various community sectors that can provide additional support and services that enhance outreach efforts.
F. The Agency is responsible for identifying more global strategies emphasizing a community-wide approach for all reproductive-age women in the targeted services area with an emphasis on the importance of a healthy lifestyle and habits before, during and after pregnancy; the importance of early prenatal care; and preconception/inter-conception health education and safe sleep practices for the infant.
G. Agency will evaluate outreach activities annually for effectiveness
H. Appropriate approved billable Outreach includes, but is not limited to
    a. Printing and distribution costs associated with distribution of pamphlets, brochures, flyers, posters, tear-off info posters & similar printed materials about the case management program.
    b. Printed materials may be given to local entities such as schools, churches, social service agencies & local area service providers.
    c. attendance at health fairs promoting contact information and program services, speaking engagements with facilities and their staff as listed above
    d. Costs associated with the purchase & distribution of the paperback “What to Expect When You’re Expecting” to OB-GYN offices to make available to potential pregnant clients with non-removable attached program contact information
    e. Costs associated with dissemination of information about the program services through channels such as local community news articles, on the local radio station or TV channel
I. Outreach expenditures should be concentrated on activities which access and activate eligible clients to FCM program services.

J. Written approval must be obtained from the Department for awareness campaigns / promotions, and billboards prior to purchase and/or implementation.
K. Raffles are not allowable as a means of outreach.

3.3.10 CORNERSTONE WORKFLOW SHEETS

Revised October 2019

Pregnant Woman Cornerstone Workflow

Postpartum Woman Cornerstone Workflow

Infant Cornerstone Workflow

3.4 CASE CLOSURE

Revised October 2019

Case closure should occur when:

A. The client no longer meets age or income eligibility criteria for case management funding;
B. The client moves out of the grantee's service area;
C. The client dies; or
D. The case management agency is no longer able to reach the client.

At the time of closure, the case manager should ensure that the following activities have been completed, as appropriate for the client’s circumstances:

A. The client has located a medical care provider for continued care for himself or herself and his or her children;
B. The client is referred for family planning services;
C. The client is referred for postpartum WIC or Commodity Supplemental Food Program (CSFP) certification;
D. The client’s children are referred for WIC or CSFP certification;
E. The children have begun or been referred for immunizations (if these are not contraindicated or declined by the parent);
F. The client has completed application for Medicaid for his or her children; and
G. The client has been given information regarding child restraint seats.

If the client is moving to another area, the client’s case records may be transferred to the new case management agency if the client’s consent is obtained.

3.5 PEDIATRIC PRIMARY CARE

Revised October 2019

In specific circumstances where clients meet the income eligibility requirements for Medicaid, however, due to religious reasons, are unable to enroll in Medicaid services, FCM funds may be used to pay for Primary Care costs as outlined below.

Agencies may complete the Pediatric Primary Care Determination Worksheet (Addendum 03.05 Determination Worksheet) for pregnant women, and children to determine if they meet the following criteria:

1) Family income is at or below 318% of the Federal Poverty Level as determined by the Income Eligibility Guidelines Matrix (Addendum 03.05 Guidelines)
2) Are otherwise uninsured (i.e. do not have private insurance) and,
3) Are unable to enroll in state of Illinois Medicaid due to religious reasons.

Once eligibility has been determined, the health department may provide the following services:

1) prenatal healthcare office visits for FCM enrolled clients,
2) infants or children under 2 years of age with > 30% developmental delays per Early Intervention (EI) global assessment who need periodic developmental screening;
3) immunization administration;
4) vision screening and, or glasses;
5) hearing screening;
6) pregnancy testing;
7) head-to-toe physical assessment (EPSDT visit) on FCM enrolled clients who do not have a recorded EPSDT with their primary care physician;
8) routine and medically indicated dental services for FCM enrolled infants or pregnant women.

It is expected that Health Departments will keep a monthly record of claims using the Primary Care Monthly Claim Form (Addendum 03.05 Claim Form). The CPT / Procedure Service code and Reimbursement Rate should be commensurate with the current HFS Fee Schedule which is found at https://www.illinois.gov/hfs/SiteCollectionDocuments/6618SBLHCFeeSchedule.pdf

The claim form along with completed Determination Worksheets for any clients that claims are being processed for must be submitted to the MCH Nurse Consultant. Once the claims have been approved the agency will complete the Primary Care Quarterly Summary Report (Addendum 05.03 Summary Report) and submit it along with the Periodic Financial Report (PFR) for the last month of the quarter.

The PFR will include the claim amount documented on the Grant Exclusive line item of the PFR.