Illinois Maternal and Child Health Programs

Policy and Procedure Manual

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1 ADMINISTRATION

1.1 ILLINOIS MATERNAL & CHILD HEALTH PROGRAMS

Revised October 2019

The Family Case Management (FCM) Program is funded by Illinois General Revenue funds (GRF) allocated for Infant Mortality and administered through the Illinois Department of Human Services (DHS), Bureau of Maternal and Child Health (BMCH).

The High-Risk Infant Follow-Up (HRIF), HealthWorks (HWIL), and Better Birth Outcomes (BBO) Programs are funded by Illinois General Revenue Funds (GRF) allocated for Infant Mortality and Social Services Block Grant (SSBG) funds and administered by the BMCH.

Agencies receiving funding for these programs must follow administrative policies outlined in this Policy and Procedure Manual.

Contract agencies are required to follow obligations as outlined in the Department contract. Local agency procedures must meet the minimum requirements and may not be more stringent than the policies outlined in the Illinois Maternal and Child Health Policy and Procedure Manual.

1.2 LOCAL AGENCY AGREEMENT

1.2.1 LOCAL AGENCY ELIGIBILITY

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All public or private not-for-profit organizations, including: Local Public Health Departments, Community-Based Organizations, and Federally Qualified Health Centers recognized by the Illinois Department of Human Services as possessing a demonstrated capability of directing such projects are eligible to apply for DHS MCH Program Grants.

A Local Agency must directly or through written agreement with another party:

A. Provide ongoing health services for free, or at a reduced cost, to Illinois residents of areas, or members of populations, with substantial numbers of women, infants, and children.
B. Meet staffing standards (See Staffing)
C. Have the facilities and equipment necessary for the provision of case management services to women, infants, and children in a confidential setting.
D. Report known or suspected child abuse or neglect to the area office of the Illinois Department of Children and Family Services (DCFS) in accordance with state and federal statutes.
E. Be in compliance with Civil Rights non-discrimination laws and regulations.
F. Assure confidentiality is maintained with collection, handling, and disclosure of client information during all aspects of a client visit.
G. The agency must agree to help a program client apply for benefits under the Medicaid program.
H. Physical facilities to be used for serving clients must be comfortable, safe, and clean, and must meet local requirements for fire safety, building construction, sanitation, and health. The agency must be able to furnish proof upon request that all such local requirements have been met. In addition, a space for meetings with clients that is conducive to privacy should be available.
I. The agency must be capable of delivering services to the target population, demonstrate an understanding of the concept and delivery of case management services, and demonstrate (by written agreements or other means such as letters of support) linkages to relevant service and health care agencies serving the target area.
J. The agency must be able to conduct outreach activities to the target population and medical providers in the geographic area to be served.
K. Direct service staff for the program must meet the standards defined for each program in this manual.
L. The agency must be able to provide services in medical, home, and other settings such as schools and churches.
M. The agency must maintain an adequate and confidential client records system.
N. Documentation of all services provided is to be maintained in the Cornerstone System in accordance with the guidelines set forth in the Department's Cornerstone User Manual
O. The agency must maintain current standing orders and / or must have outlined steps to be followed for abnormal findings on EPSDT exams & developmental screenings documented and updated in the Agency Policy & Procedure Manual.

1.2.2 SUBCONTRACTING FOR SERVICES

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A. If an Agency must enter into a written agreement with another sub-recipient agency for the provision of services outlined in the Grant Agreement:
    a. Both agencies shall, in conjunction, meet all of the requirements for providing both health and administrative services and are subject to single audit requirements.
    b. The written agreement must define the program responsibilities of the sub-recipient agency and be approved by DHS prior to finalization of the agreement. The responsibilities include receiving training and monitoring by the Agency.
    c. A copy of such agreement must be on file at the Agency and with the sub-recipient Agency.
    d. Must follow Civil Rights non-discrimination laws and regulations.
B. If an Agency must enter into a written agreement with another party or a private physician for the provision of the broader range of health services:
    a. The written agreement must define the responsibilities of each party and must be approved by DHS during the application process.
    b. A copy of such agreement must be on file at the Agency and with the third party.
    c. Must follow Civil Rights non-discrimination laws and regulations.

1.2.3 LOCAL AGENCY GRANT AGREEMENT

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The Grant Agreement between the Local Agency and Department serves as the legal document obligating both parties to specify roles in the designated Maternal & Child Health (MCH) Program. The Grant Agreement contains conditions that bind the Local Agency to compliance with the following rules and regulations in addition to any rules and regulations identified in the grant agreement:

A. Federal Regulations (eCFR 200)
B. Illinois Title 77, Section 630 Maternal and Child Health Administrative Code
C. Illinois Family Case Management Act [410 ILCS 45]
D. Developmental Disability Prevention Act [410 ILCS 250]
E. Prenatal and Newborn Care Act [410 ILCS 225]
F. Grant Accountability and Transparency Act (44 Ill. Adm. Code 7000)
G. Grant Accountability and Transparency Act [30 ILCS 708]
H. Nurse Practice act (225 ILCS 65)
I. The BMCH Policy and Procedure Manual
J. The Cornerstone User Manual

Additional provisions of the Grant Agreement include:

A. Grant award totals
B. Reclamation procedures
C. Termination procedures

Any violation of compliance with the requirements of the Grant Agreement may be grounds for termination or suspension of the Grant Agreement.

1.2.4 ALLOCATION OF MCH FUNDS

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Once the amount of funds available to the Illinois Bureau of Maternal of Child Health is determined:

A. The Department allocates awards to Local Agencies through a Notice of Funding Opportunity process.
B. Administrative funds are allocated by use of a formula based on standardized costs per caseload.
C. The Department – Agency Grant Agreement serves as the legal basis for disseminating funds to local programs. Grant agreements must be signed and properly obligated through the Department and the Illinois Comptroller. Payments are scheduled on a monthly basis. All payments will be reconciled based on submitted documentation. Failure of the Agency to submit documentation may result in a reduction to the total award.

1.2.5 LOCAL AGENCY – RIGHT OF APPEAL

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Whenever the Department suspends or terminates a grant, the grantee may have such decision judicially reviewed. The provisions of the Administrative Review Law (Ill. Rev. Stat. 1989, Ch. 110, par. 3-101 et seq.) and the rules adopted pursuant thereto shall apply to and govern all proceedings for the judicial review of final administrative decisions of the Department hereunder.

1.3 Financial Reporting and Administrative Costs

1.3.1 Cost reporting

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Local Agency costs for each Maternal and Child Health Program Grant must be broken down and reported separately.

A description of each line item and examples of activities which may fall into these categories is provided for reference.

Addendum 1.3.1 – Allowable Costs by Line Item

1.3.2 FUNDING

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The method of payment to Maternal and Child Health grants is by reimbursement of expenditures. Repayment and reconciliation methodology will be documented in the annual agency agreement.

Once the amount of funds available to Illinois for the BMCH programs is determined:

- The Department allocates awards to Local Agencies through a grant review process.
- Administrative funds are allocated by use of a formula based on standardized costs per caseload.

The Department – Local Agency Grant Agreement serves as the legal basis for disseminating funds to local programs. Grant agreements must be signed and properly obligated through the Department and the Illinois Comptroller. Payments are scheduled on a monthly basis. All payments will be reconciled based on submitted documentation. Failure of the Provider to submit documentation may result in a reduction to the total award.

1.3.3 ALLOWABLE COSTS

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A. Costs associated with activities considered necessary to meet Program objectives by the Agency are allowable and may be charged to the grant.
B. Program management activities including accounting, auditing, budgeting, and outreach.
C. Allowable Costs for outreach activities as defined in the Outreach section are allowed. However, health, general education, or other social service activities may not be included as outreach.
D. Salary and other expenses for staff conducting activities required by the grant must be supported by documentation as described in Time and Activity subsection.
E. The agency must maintain an internal system of documenting time and activity; and separating activities performed under separate grants. Agencies may choose to use the SV02 documentation in Cornerstone as this system of documentation.
F. The agency must make its clinical and time reporting records available for inspection by authorized representatives of the Department.
G. When approved in the plan and budget, funds may be used for the direct costs of operating and maintaining the project. The following direct costs may be incurred:
    a. Salaries, including fringe benefits for full or part-time personnel employed for the program. The rates for personal services and fringe benefits shall be comparable to that paid to other employees of the agency.
    b. Fees for consultants and specialists.
    c. Travel of personnel, consultants, and specialists in carrying out the activities approved in the plan. Reimbursement shall be made in accordance with established delegate agency policies.
    d. Transportation of clients at the usual rates for the mode of travel that is consistent with the needs of the client, only once all options through Medicaid Managed Care Transportation Options have been exhausted, may be documented for the Better Birth Outcomes program if these costs are documented in the approved budget
    e. Supplies, as required in the operation of the project. The cost of supplies shall not exceed the lowest charge levels at which they are generally available in the area.
    f. Rental of privately-owned facilities where adequate space cannot be provided by the grantee agency. Rental charges shall not exceed the lowest rate for comparable space within the community as supported by bids.
    g. Equipment used in the operation of the project excluding the purchase of vehicles.
    h. Other expenditures directly related to the provision of project services, such as: telephone service, photocopying and scanning, utilities, etc. Purchases of items or services that do not vary significantly in quality from one supplier to another shall not exceed the lowest charge levels at which they are available in the area. A description for prorating costs must be provided.
H. Indirect costs may be included as a portion of the overall project costs as defined in the Grant Accountability and Transparency Act (GATA) [30 ILCS 708/15] if the indirect costs are budgeted along with the direct costs.

1.3.4 UNALLOWABLE COSTS

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A. Under no circumstances may the DHS MCH grants be charged in full or in part for the costs of services which are demonstrably outside of the scope of the MCH Program's authorizing statute.

   For example, the FCM grant may be charged to screen FCM clients for immunizations and refer and follow-up on FCM client immunizations, but FCM may not be charged for the cost to administer the shot, the vaccine, or vaccine-related equipment.

   Further, costs which are specifically disallowed by applicable Federal cost principles outlines in the 2CFR200 may not be charged to the DHS MCH grants.

B. Project funds shall not be used to pay the following:
   a. Inpatient care services
   b. Purchase, construction, or renovation of buildings
   c. Dues to societies, organizations, or federations
   d. Entertainment costs
   e. Cash payments to intended recipients of services
   f. Purchase or repair of vehicles
   g. Lobbying
   h. Any other costs not approved in the plan and budget.

C. Administrative costs shall not exceed 15% of the total grant award. Any deviation from this must be approved in writing by the Associate Director of the Office of Family Wellness after a review of the circumstances which would require such an exception. The Department will consider the following in determining whether to grant an exception:
   a. the nature of the project,
   b. ability to find resources in the community which will meet part of the needs of the project and thus invalidate the percentages,
   c. a targeting of the resources toward one particular component or identified unmet need by the grantee which clearly will inhibit the ability of the grantee to carry out the project.

1.3.5 TIME AND ACTIVITY

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Each agency must be able to document time, and activity spent by each employee on each grant. This documentation will be used to reconcile against reimbursement request of Personnel costs against each grant during audit and administrative review. The specific format of documenting this time may be determined by the agency, however each report must be signed by the employee, and the employee's supervisor. Cornerstone reports may be used to document time and activity; however, it is not required to be documented through Cornerstone.

The documentation must at minimum contain the following information:

1) Identification of the staff person.
2) The date on which the activity was conducted.
3) Activity type – At a minimum, categories must identify case management; outreach; administration of outreach and case management; accrued benefit time; and other direct services, as follows:
    a. Time Spent – The amount of time spent on each activity.
    b. Program – The employee is working in (FCM, BBO, HRIF/HWIL).

1.3.6 PRIOR APPROVAL FOR PURCHASES

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Prior Approval is not needed for:

1) Activation of clients
2) Clinical costs necessary to provide program services, including referrals
3) Outreach to prospective program clients
4) Rental or purchase of non-computer equipment (any nonexpendable item costing less than $5,000)

Costs allowable with prior approval from the Department:

1) Rental space costs – new sites / locations
2) Any computer software purchases, such as: word processing, spreadsheet, database, email, presentation, or anti-virus applications
3) Any computer equipment purchases, such as: personal computers, monitors, printers, and modems
4) Items costing more than $5,000
5) Purchase of capital assets, such as: buildings, land, and improvements to buildings or land that materially increase their value or useful life and cost more than $5,000

All requests must be in writing on Local Agency letterhead from the agency to the Department via the Administrative Contract Coordinator. The request must include:

1) Item Description
2) Model Number/Serial Number
3) Unit Cost
4) Justification for Purchase
5) Percentage of time the product will be used for each program
6) Number of Program Full Time Equivalents present in the Local Agency

1.3.7 INVENTORY MANAGEMENT

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Each local agency must maintain full and complete records concerning program operations. This includes maintaining property records as described below.

A) The Local agency must tag all equipment, valued at $100 or greater at the time of purchase, with a unique identification number
B) An inventory must be maintained of all tagged items purchased in full or partially with program funds. The inventory must include:
    1) Tag number/Inventory Number
    2) Item description
    3) Model Number/Serial Number
    4) Date of Purchase
    5) Unit Cost
    6) Location
C) Agencies using a blended inventory of all items must have a method to clearly indicate items purchased with program funds.

GUIDELINES FOR DISPOSAL OF PROGRAM EQUIPMENT

1) To dispose of equipment purchased with Program funds:
    i) If the item is on a depreciation schedule, and the timeframe of depreciation has not elapsed, the local agency must submit a request in writing, on agency letterhead, to the Department via the Administrative Contract Coordinator which includes:
        (1) Item description
        (2) Date of purchase
        (3) Unit cost (if available)
        (4) Justification for disposal
2) If the request is approved, a letter will be sent granting approval to dispose of the equipment. The letter must be kept on file with the inventory records.
3) Computer equipment approved for disposal must have all client information erased prior to disposal.

1.3.8 LOCAL AGENCY ACCOUNTING PROCEDURES

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A) Accounting System

Each Local Agency participating in a DHS MCH Program must have an established financial management system, which provides complete, separate, and accurate accountability of Program funds. The accounting system in the Local Agency must provide original evidences of:

1) Transactions
2) A chart of accounts
3) Ledgers for posting
4) Complete accountability of all obligations, payments, and reimbursements

B) Expenditure Documents

Source documents for expenditures must be available for audit, and records of payment of such expenses must allow for clear audit trails. To qualify for payment, an expenditure must be:

1) A documented program expense related to the grant
2) In compliance with federal and state regulations

1.3.9 FINANCIAL DOCUMENTATION

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A) Local agencies will receive MCH grants payments from the Department as follows:
   1) Payments are scheduled on a monthly basis.
      i) All payments are reconciled based on submitted documentation. Failure to submit documentation may result in a reduction to the total award.
   2) Periodic Financial Reports (PFR) must report expenditures by line item category in alignment with the current approved budget.

B) PFR Form Setup
   1) The PFR is a Microsoft Excel Spreadsheet file, and there is a tab for each month of expenditures.
   2) Expenditures are automatically calculated for the month as well as the Cumulative Amount Year to Date.
   3) Print Areas are pre-set - **Do not alter the print areas**.
   4) Any issues with the spreadsheet file, can be communicated by email at dhs.bmchedf@illinois.gov or by calling (217) 557-3105.

C) Step by Step Guide
   1) Save the spreadsheet file to your computer
   2) Complete the Information and Instructions Tab
      i) All fields are Mandatory
         (1) Agency Name
         (2) Agency FEIN
         (3) MCH Contract Number
         (4) MCH Program Name

         Information entered on this tab will automatically populate to each of the monthly tabs.
   3) Complete the applicable Month Expenses Tab
   4) All fields are mandatory

PFR Field	Purpose of the Field
Date Submitted	Submittal date of the EDF
Date Revised	Revision date of the PFR *This field is mandatory only if you are submitting a Revised PFR.*
Reporting Month Expenditures	MCH expenditures must be broken out by line item in alignment with the current approved budget. *If you do not have expenditures to report for a month, you must still submit a PFR with the Amount Claimed as $0.*
Certification and Authorized Local Provider Approval	A PFR is considered "Uncertified" unless it includes: • Typed or handwritten Name and Title of the Authorized Local Provider Official, **and** • Date Authorized • Authorization Signature
Report Prepared by	Enter the name, Email and Phone number of the person preparing the PFR.

   5) Submit your Periodic Financial Report

i) Periodic Financial Reports (PFR) must be submitted monthly.

ii) Deadline for submission of monthly PFRs is the 15th of the month following the month of service (i.e., PFR for July expenditures must be submitted to DHS by August 15th).

(1) Any month that an agency is not able to meet the deadline for submission of a monthly PFR may request an extension in writing prior to the 15th of the month.

iii) Choose one of the following options to submit your EDF each month:

(1) Print the completed monthly tab to Adobe PDF and email the file to dhs.bmchedf@illinois.gov. (Print Areas are pre-set. **Please do not alter the print areas**.)

OR

(2) Print hard copy of the correct monthly tab and fax to Program Coordinator at (217) 558-9548.

D) Helpful Information

1) Refer to the GATA training and 2 CFR 200 for detailed information on how to categorize expenses in conjunction with the agency approved budget.

1.3.10 PROGRAM AUDIT

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A) Local Agencies are required to be audited annually in accordance with: 2 CFR Part 200.501 Audit Requirements

B) 2 CFR 200.425 states "A reasonably proportionate share of the costs of audits required by, and performed in accordance with, the Single Audit Act Amendments of 1996 (31 U.S.C. 7501-7507), as implemented by requirements of this part, are allowable. Agencies should follow regulatory references in 2 CFR 200.425 for allowable and unallowable and unallowable audit costs. Any direct cost being charged to the program would be based on an organization's written costs allocation policy which meaningful allocation base and methodology would be included therein.

C) Allowable and unallowable Audit Costs are addressed in 2 CFR 200.425 (Subpart E – Cost Principles) . The Department retains the right to conduct audits of any and all Local Agency MCH Programs. There is no charge to the Local Agency for these audits.

D) No other audits are required in the MCH Program nor will outside audits be paid for from MCH funds. The requirements for Audit are set forth in 2 CFR 200 Subpart F and reflected in 44 IL Adm Code 7000.90; allowable and unallowable Audit Costs are addressed in 2 CFR 200.425 (Subpart E – Cost Principles.

1.3.11 LOCAL AGENCY SANCTIONS / RECOVERIES

Revised October 2019

The Local Agency shall have the right to appeal any sanction or recovery given by Programs or the financial review team to the Chief of the Bureau of Maternal & Child Health

A) The appeal shall indicate the reason why the sanction should not be imposed and/or why this recovery should not have been made.
B) The appeal shall be made within thirty (30) calendar days of this imposition of the sanction and/or the recovery of monies from the reimbursement voucher.

1.3.12 CLOSEOUT REPORTING PROCEDURES

Revised October 2019

The State Fiscal year runs from July 1 through June 30.

A) Costs must be separated so that expenditures are charged to the fiscal year in which the obligation was incurred.
B) The separation of costs must occur between the months of June and July to close out the state fiscal year.

1.4 RECORDS

1.4.1 RETENTION OF RECORDS

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A. Administrative

The following administrative records shall be maintained by the Local Agency for a period of three years:

a. All financial record of expenditures, third-party reimbursements, and other project income

b. An inventory record of all equipment purchased from project funds including (listing shall be cumulative and updated annually):

i. A description of the item.

ii. Inventory identification (I.D.) number. This can be a manufacturer's serial number or another I.D. number, but it must be permanently affixed to the item.

iii. Acquisition date and cost

iv. From whom purchased

v. Location and condition of the item. No property can be disposed of without prior written authorization of the Chief of the Bureau of Maternal and Child Health. Upon termination of a project, the equipment becomes the property of the Illinois Department of Human Services.

c. Personnel records for all project staff

d. Statistical information derived from project activities

B. Client Records

a. One record containing the appropriate information relative to that person's care shall be maintained on each client.

b. A record shall be maintained on each individual registered in the project. The record should be designed to accommodate entries by each discipline providing services for that project. Documentation showing preauthorization of services purchased by the project shall be maintained as a part of the individual's client record. All services provided to a particular client by each discipline must be easily reviewable by the other disciplines.

c. The record shall by useful as an administrative and health management tool.

d. Client records are to be maintained for a minimum of three (3) years from the date of case closure in Cornerstone.

1.4.2 DESTRUCTION OF RECORDS

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A. Program records that contain client data must be destroyed by incineration or shredding.
B. Disposal of records intact to a landfill or through a disposal service is not appropriate.
C. The Local Records Act regulates the destruction and preservation of public records within the State of Illinois. It mandates the Secretary of State, who is named the local records advisor, to assist local governments in implementation of the Act. This Act defines record material, explains the rights to public access of information, and sets standards for record keeping and microfilming. Additionally, the Act provides for the existence of a six-member Local Records Commission which regulates the disposal of local records and specifically forbids local officials from disposing of any public record without first obtaining their written approval.
D. Depending upon the local agency's status as a legal entity, the agency may be required to comply with both state and federal guidelines for destruction of records. Agencies which must comply with both state and federal requirements, are those that fall under the auspices of the Local Records Act. The Act defines an "agency" as "any court, and all parts, boards, departments, bureaus and commissions of any county, municipal corporation or political subdivision."

1.5 CONFIDENTIALITY

1.5.1 CONFIDENTIALITY

Revised October 2019

The following information relating to patients and persons requesting services shall be treated as confidential:

A. Names and addresses individually or by list.
B. Information contained in reports of medical examinations and treatments.
C. Information about financial resources.
D. Information contained in registers, in case records, correspondence, any forms or notations obtained from or about the individual and family concerning his/her condition or circumstances, including all such information whether or not it is recorded.
E. Records of state and local health department evaluations of such information.

1.5.2 CONSENT TO RELEASE INFORMATION

Revised October 2019

A. Agencies are expected to obtain signed consent or refusal of the following forms:
    a. Release of Information (ROI) form,
    b. HIPAA Privacy Rule form, and
    c. Cornerstone Informed Consent Form from all participants.
B. Information shall be kept confidential and shall not be divulged except as follows:
    a. Confidential information may be released only with the guardian or client's consent to agencies, institutions or individuals who are requested to provide maternal and child health services to the guardian, or client as a part of the program of the state agency.
    b. Confidential information may be released to other state or federal agencies having as their purpose the health and welfare of the mother or child for whom the client or guardian, on their behalf, has requested services. In these circumstances, the information may be released on if adequate assurances are given that:
        i. The confidential character of the information will be preserved;
        ii. The confidential information will be used only for the purpose for which it is made available;
        iii. Such proposals are reasonably related to the purposes of the program of the state or local agency and the functioning of the other agencies or programs; and
        iv. The standards of protection established by the other agencies or programs to which the confidential information is made available are at least equal to those established by the state or local health department.
    c. When a signed consent form is received from the client, confidential information must be released to the Department to evaluate the effectiveness of prenatal care, to conduct research to reduce infant and maternal morbidity and mortality, and to assist the Department in the allocation of resources. For clients who consent to collection of such data, the grantee will solely retain all identifying information of the clients (name, address, social security number, phone number) and provide code numbers to the Department in place of such information. The grantee will destroy the consent forms after the Department has completed its review of the data. That consent form will include:
        i. The name of the person signing the form
        ii. The name and address of the client
        iii. A statement of consent to release information for the purposes stated in this section
        iv. A protection against release beyond the Illinois Department of Human Services.
    d. Information may be disclosed in summary, statistical or other form, which does not make it possible to identify any particular individual.

1.5.3 REPORTING OF CHILD ABUSE AND NEGLECT

Revised October 2019

A. MCH Agencies are required to cooperate with investigations conducted pursuant to the Abused and Neglected Child Reporting Act 325 ILCS 5/1 and are conferred immunity by Section 9 of alleged child abuse.
    a. The cooperation required extends to DCFS
    b. State Police, and designated local law enforcement agencies.
B. There may also be instances in which State of local child protection services contact the local agency for information which might substantiate allegations of child abuse made by a third party, e.g. information on a child's appearance, abnormal interaction between a child and parent, information on missed appointments or a child's medical records. Such requests may be separate and distinct from any responsibility that the state or local agency might have under state law to report instance of child abuse. Therefore, the general disclosure policy shall apply to these requests.
C. Local agency staff should refer to state or local agency legal counsel to identify a legal imperative to respond e.g. a subpoena that cannot or should not, in the counsel's opinion, be contested or a perceived need to comply with the request in order to avoid any legal liability for possible consequences to the child or failure to provide the requested information.

1.6 Administrative and Clinical Performance Reviews

1.6.1 Annual Review

Revised October 2019

All DHS MCH grants will be evaluated at least annually by the state Maternal and Child Health staff and their designees to review the program's progress according to stated goals, measurable objectives, and administrative operations.

1.6.2 EVALUATION

Revised October 2019

The Department or it's designee will monitor the delivery of DHS MCH Program activities through:

A. Quarterly communication in which quarterly performance data and trends will be highlighted and technical assistance will be provided to recommend areas of improvement and discuss barriers to program service delivery as needed.
B. Annual programmatic clinical reviews shall address the following points:
    a. Comparison of the objectives enunciated in the project plan with the actual achievements of the project.
    b. Indicators of project productivity; e.g., clients served, encounters, referrals, tests performed, personnel trained, etc.
    c. Scope and success of program outreach efforts
    d. Unresolved problems; e.g., with fiscal resources, external relationships, etc. and issues which need to be addressed in the future.
    e. Annual on-site reviews which will include:
        i. Technical Assistance based on chart reviews performed by the MCH Nurse Consultant prior to the visit.
        ii. Clinical Review based on the Review Tool that applies to the quarterly performance reviewed.
        iii. An observation of service delivery when appropriate.
        iv. A review of data reports from the Departments Cornerstone system.
        v. Verification of documentation necessary per the Clinical Review Tool.

1.6.3 MCH Nurse Consultant Annual Review

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The Department will review the performance criteria of each program at least once annually following the steps outlined below.

A. The department will send a formal Annual review Introduction Letter to schedule the site visit to Agency Administrator and Program Coordinators at least 15 business days prior to the review date.
B. The MCH Nurse consultant will complete Chart Reviews for each program being reviewed from Cornerstone and evaluate the most recent quarterly performance report available for the agency using the Chart Review Tool for the corresponding quarter that is being reviewed (i.e. if FY19 Q4 data is being reviewed, the review tool used will be the FY19 review tool even if the date of the on-site review is scheduled after July 1, 2019).
    a. Chart Review Tools
C. The MCH Nurse Consultant will review randomly selected charts for each program using Department's current chart sample selection criteria for Case Management programs.
D. On the date(s) of the review, the MCH Nurse Consultant will complete the review and conduct any Technical Assistance (TA) that came up as being needed during the performance reviews.
E. The MCH Nurse Consultant will then complete the Clinical Review Tool and Review Findings (if any are found) and will return the outcomes of the review within 15 business days of completing the on-site review to the Agency Administrator and Program Coordinators.
    a. Clinical Review Tools
F. The Agency will receive a summary letter from the Department which will include the Clinical Review Tools for the programs reviewed and the Review Findings within 15 business days of receipt of the completed clinical review.
G. The Agency will respond to the MCH Nurse Consultant completing the review within 15 business days of the receipt of the summary letter with a Corrective Action Plan (CAP) for any of the findings revealed in the review.
H. The MCH Nurse Consultant will review and accept the CAP within 15 business days of receipt.
I. Follow-up will be provided by the MCH Nurse Consultant by phone or email to determine that the CAP has been completed in the timeframe outlined within three months of the CAP approval.

1.6.4 PROVISIONAL STATUS

Revised October 2019

A. If during an annual review, the MCH Nurse Consultant determines that the agency has substantially failed to comply with the terms of the grant agreement and program standards, they may recommend that an agency program be placed on provisional status.
B. Each MCH program that the agency offers is reviewed annually. Each Performance Review Tool will identify the total Review Findings for the program in question.
C. Any MCH program with five (5) or more Corrective Actions in a program reviewed may be recommended for provisional status for that program and the following actions will be taken.
    a. The Bureau Chief will meet with the MCH Nurse Consultant and any Department personnel deemed necessary to review Provisional Determination to discuss the recommendation and what steps the Department will require the Agency to take to remove the provisional status from their record.
    b. Once a final decision has been determined, the Agency will receive a letter of Provisional Status within 25 business days of the completion of the annual review which will outline why the Provisional Status was determined and what actions will need to be taken to remove the Provisional Status from the agency.
    c. The Agency will be asked to return a Corrective Action Plan (CAP) to the MCH Nurse Consultant within 15 business days of receipt of the Provisional Letter.
    d. Once the CAP is approved, the MCH Nurse Consultant will notify the agency in writing within 15 business days of receipt of the CAP from the Agency.
    e. The MCH Nurse Consultant will be available in subsequent months primarily by phone / email to provide ongoing Technical Assistance (TA) and assistance to try to meet the CAPs required in the program.
    f. A subsequent review of the program(s) put on provisional status will then be completed within 6 months of the formal notification of the program's provisional status and the Provision Letter being sent to the agency. If a satisfactory review is completed, then the agency will again be certified.
D. If an agency has substantially failed to comply with the grant award as documented at site reviews for two consecutive years and is placed on provisional status in 2 consecutive reviews, funding may be reduced or terminated. Substantial failure means failure to meet requirements other than a variance from the strict and literal performance which result in unimportant omissions or defects given the particular circumstances involved.

1.7 CIVIL RIGHTS

1.7.1 NONDISCRIMINATION

Revised October 2019

Projects are to be conducted in such a manner that no persons shall be excluded from participating in, be denied the benefits for, or be otherwise subjected to discrimination under such programs on the grounds of age, handicap, race, color, creed, religion, sex, or national origin pursuant to the provision of Title VI, Civil Rights Act of 1984, (42 U.S.C. 2000e et seq.); Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.).

Affirmative action shall be taken to ensure equality of opportunity in all aspects of employment in accordance but not limited to the following laws and regulations and all subsequent amendments:

A. The Illinois Human Rights Act (775 ILCS 5/1-101 et seq.), including, without limitation, 44 Ill. Admin. Code Part 750;
B. The Public Works Employment Discrimination Act (775 ILCS 10/1 et seq.);
C. The United States Civil Rights Act of 1964 (as amended) (42 USC 2000a- and 2000h-6). (See also guidelines to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons [Federal Register: February 18, 2002 (Volume 67, Number 13, Pages 2671-2685)]);
D. Section 504 of the Rehabilitation Act of 1973 (29 USC 794);
E. The Americans with Disabilities Act of 1990 (as amended) (42 USC 12101 et seq.); and
F. The Age Discrimination Act (42 USC 6101 et seq.).

Periodic reviews of operating procedures shall be made to assure that operating practice continues to be in conformity with the above requirements.

Any person has the right to file a complaint with the Department, the U.S. Department of Health and Human Services, or both, if they believe that discrimination on the grounds of age, handicap, race, color, creed, religion, sex or national origin is being practiced. If filed with the Department, the complaint shall be routed to the Director's office where it shall be reviewed and investigated by a special committee appointed by the Director. A report of final disposition shall be sent to the complainant and to the appropriate federal agency.

1.8 LOCAL AGENCY PROCEDURES

1.8.1 TERMINATION

Revised October 2019

A. All grants shall terminate on the dates specified in the contracts and shall not be extended.
B. Specific terms and conditions of termination or suspension of the grant is documented in the grant agreement and must be followed by the Agency and the Department.

1.8.2 STAFFING

Revised October 2019

A. The qualifications of each person employed by the Program shall meet, at a minimum the Illinois Merit System Standards.
B. Staffing for MCH programs would include at a minimum a Program Coordinator, Case Managers, and Frontline/Clerical staff.
C. Staffing for programs shall be reflective of the services to be provided, i.e., nursing, social work, psychology, and administration. The extent of staffing in the programs shall be dependent upon the program size and availability of personnel.
D. Agencies shall give assurance that the services will be provided by or supervised by qualified personnel. Qualifications shall be determined by reference to a merit system, established minimum qualifications, occupational standards, state and local licensing laws, and specialty board requirements. Such standards, laws, and requirements shall be incorporated by reference in the application for a grant.
E. Standards for each project shall meet state and local licensing laws and regulations and be in accord with national and state standards.
F. Arrangements for provision of services must be made in advance of implementing the project. Special consideration shall be given to the provision of space for:
    a. Counseling to assure privacy and dignity for the client; intake interviewing and physical examinations;
    b. The projected client load giving consideration to waiting room, babysitting services, records, bathroom, and for other necessary services.
    c. Space should assure privacy and efficient client flow.
G. Conducting MCH services involves a multi-disciplinary team approach to ensure the delivery of quality services. MCH agencies vary in size and therefore their staffing needs. Agencies must maintain adequate staffing to ensure operations are conducted effectively and efficiently.

1.8.3 IN-SERVICE TRAINING

Revised October 2019

The staff of the Department in cooperation with the local Agency staff will conduct in-service training programs for project personnel. Staff involved in the delivery of client services are required to attend.

Project staff are encouraged to attend and participate in appropriate educational programs and professional organizations.

Agencies are expected to schedule staff to attend the training offered by the Department within three (3) months of working in the MCH program. It is encouraged that supervisors send staff for training at any time regardless of duration of employment when the staff member's performance demonstrates a need to review program deliverables. The MCH Nurse Consultant may at any time require for Agency Personnel to attend training at any time during their work within the MCH programs.

It is expected that all Agency staff working in any of the MCH programs complete implicit bias training annually and/or within 3 months of employment and working within the MCH programs. The agency should document the type of implicit bias training received and date the training was completed. The log should be maintained by the Agency to account for compliance of staff working within the MCH programs and may be requested by the MCH Nurse Consultant during the annual review.

1.8.4 UTILIZATION OF COMMUNITY RESOURCES

Revised October 2019

It shall be the responsibility of each agency to coordinate the services provided through the agency with other sources or care in the community, such as but not limited to:

A. Illinois Medical Assistance Program
B. Local Health Departments
C. Neighborhood Health Centers
D. Local Child Development Clinics
E. Division of Specialized Care for Children
F. Local Hospitals
G. Local Children and Family Services Programs
H. Local Schools
I. Vocational Rehabilitation Services
J. Regional Perinatal Centers
K. Local Early Intervention Programs for Infants and Toddlers with Handicaps
L. Other related social service agencies

1.8.5 AGENCY POLICY & PROCEDURES AND QUALITY ASSURANCE

Revised October 2019

All agencies contracted with the DHS BMCH is expected to maintain an internal Agency Policy & Procedure Manual that aligns with DHS Policy & Procedures and Contract guidelines.

All programs that have a requirement of a Registered Nurse to provide case management services are required to maintain current standing orders.

Any agency that does not have a medical director or does not have a program staffing requirement of a Registered Nurse must include specific steps to be followed for abnormal findings on Developmental Assessments and Depression Screenings that are in alignment with current standard practices.

1.9 MANAGEMENT INFORMATION SYSTEMS

Revised October 2019

The Management Information System (MIS) for all Maternal and Child Health Programs is Cornerstone. All MCH staff must follow the Cornerstone User Manual expectations for entering and utilizing data to ensure proper service delivery.

Local agencies must adhere to the following system security requirements according to the Cornerstone System Security Plan in the Cornerstone User Manual.

1.9.1 MANAGEMENT CONTROLS

Revised October 2019

Each program should have a designated security coordinator. The security coordinator's duties are to:

A. Coordinate with the Department on system access for staff and appropriate access levels.
B. Ensure MCH employees receive security training via the Cornerstone system, both prior to being granted system access and as annual refresher training for all staff
C. Ensure that State owned equipment and resources are secure, and that equipment is accounted for by conducting an annual inventory
D. Conduct yearly audits of active IDs in Cornerstone and terminate any employees no longer working in the program.
E. Report security incidents to the Department immediately
F. Ensure continued operations during system disruption

1.9.2 OPERATIONAL CONTROLS

Revised October 2019

A. Personnel Security (see HB 901): All personnel responsible for the management, maintenance, operations, or use of system resources and access to sensitive information should have the appropriate management approval. Personnel security also includes establishing and maintaining procedures for enforcing personnel controls.
    a. The Department must:
        i. Issue and revoke user IDs and passwords
        ii. Determine appropriate staff access levels
        iii. Ensure separation of duties so as to not compromise system data or undermine technical controls.

1.9.3 PHYSICAL CONTROLS

Revised October 2019

Physical Controls are measures designed to prevent unauthorized physical access to equipment, facilities, material, information, and documents. Physical resources include, but are not limited to: desktop computers, portable computers, personal information devices, and printers. Rooms containing system hardware and software, such as local area network rooms or telephone closets, should be secured to ensure that they are accessible to authorized personnel only. The Local Agency Grant Agreement identifies specific guidance local agencies must follow to address physical security.

1.9.4 CONTINUITY OF OPERATIONS

Revised October 2019

A. Local agency information must be updated in Cornerstone including:
    a. Location information
    b. Holiday schedules
    c. Hours of operation
    d. Services provided
    e. Site contact information

1.9.5 SYSTEM DISRUPTIONS

Revised October 2019

A. In the case of a brief (<24 hours) system disruption such as interruption of communication and or connectivity the local agency must:
    a. Advise the Department
    b. Determine if clients will be rescheduled or if paper data collection and documentation processes will be initiated.
B. When services are disrupted for more than a day by disasters or security failures, essential operations will continue.

1.9.6 INCIDENT REPORTING

Revised October 2019

All actual or suspected instances of information asset misuse, theft, or abuse, as well as potential threats (e.g. hackers, computer viruses) or obvious weaknesses affecting security, must be reported to your immediate supervisor.

A. All serious infractions including, but not limited to, pornography or violence, must be immediately reported to the appropriate supervisor.
B. Any actual or suspected security breach, including any lost or broken Cornerstone equipment, must be immediately reported to the appropriate supervisor.
C. Local agency security coordinators are responsible for reporting such incidents. Within 24 hours of the report of the incident, the security coordinator is to submit a brief report of the incident that includes the type of breach, the individual responsible for the breach, and that individual's Cornerstone identification number. The report is to be addressed to the BMCH Bureau Chief at the Department of Human Services.

1.9.7 SECURITY AWARENESS, TRAINING, AND EDUCATION

Revised October 2019

MCH employees who manage, operate, program, maintain, or use Cornerstone should be aware of their security responsibilities.

A. Security training must be provided before system users are allowed access to the system.
B. Periodic refresher (e.g. annual) security training is required for continued access to the system.
C. Security training is designed to help system users become familiar with using Cornerstone's security features. Security training also ensures that users understand their responsibilities and security procedures for protecting any sensitive information they manage. Security training includes:
    a. The importance of protecting client privacy and data confidentiality.
    b. How to identify a security incident.
    c. Secure use of user IDs and passwords
D. Security training will be available through Cornerstone and authorized user access is dependent on successful completion of the course.

1.9.8 CORNERSTONE ANNUAL ACCESS REPORT RECONCILIATION

Revised October 2019

To comply with state policies local agencies are expected to monitor the IDHS HSPR1118 Cornerstone Active Employee report annually to ensure only those staff currently working for the agency have Cornerstone access and are assigned to only those programs in which they currently work.

Bureau of Maternal and Child Health Program staff will send each local agency the HSPR1118 report annually (N.B. Agencies providing multiple services will receive the report more than once and will need to respond to each program as requested).

Local agencies are responsible for:

1. Ensuring only active staff currently working for the agency are on the report. This includes those with no Citrix access.
2. Terminating any staff appearing on the report that are not current employees.
3. Correcting program access for staff who have changed positions (i.e. left WIC but now work in Case Management).

The following steps should be taken once agencies have received the HSPR1118 report from the Department.

1. Does the staff person work for the agency?	
Yes	*No*
Move on to step 2.	a) In the Cornerstone AD15 Employee Information Screen, terminate any staff appearing on the report that are not current employees. b) Document by writing on the HSPR1118 report any terminations that were made
2. Is the staff person assigned to the correct program(s)?	
Yes	*No*
Move on to step 3	a) In the Cornerstone AD15 Employee Information Screen, terminate staff from programs they no longer work in and/or add new programs they should be assigned to. b) Document by writing on the HSPR1118 report any changes that were made
3) Sign and Date the HSPR1118 Report & return by email to DHS.BMCHEDF@illinois.gov.	

2 CASE MANAGEMENT COORDINATION

2.1 CASE MANAGEMENT COORDINATION

2.1.1 CASE MANAGEMENT COORDINATION

Revised October 2019

Department grantees providing case management services should engage in activities (as described below) to coordinate with other agencies in the grantee's service area that provide case management services to the same types of persons as the grantee has agreed to serve. These activities are intended to avoid duplication of case management services at the local level and ensure that each client has only one lead case manager at any given time.

A. The case management agency should ensure that every family enrolled in case management continues to utilize primary medical care, regardless of the primary case management agency working with the family.
B. Case Management Coordination Agreements. Grantees of the Department's Division of Family Services should enter into written agreements with other agencies with the same geographic service area (in whole or in part) and with comparable scope of case management activities regarding coordination of case management services. These agreements must at least specify each grantee's target group for services, referral procedures, procedures to obtain informed consent for services and protection of client's privacy, and procedures to determine the agency most appropriate to provide case management services.
C. Determination of the Agency or Program most appropriate for the delivery of case management services. Following the assessments of a client's service needs, the case manager, other involved service Agencies, and the client (and the client's parent(s) or legal guardian(s), depending upon the client's ability to consent for services) should determine the one agency or program most appropriate to take a lead role in providing case management services if any of the criteria listed below are met. Only those Agencies for which the client has given written consent may participate in the determination of the most appropriate agency or program to provide case management. The criteria requiring such a determination are:
    a. the participant's most important problem requires expertise for case management that the grantee's staff does not possess;
    b. the participant's most important problem requires expertise for case management that another agency's staff does possess;
    c. the participant's problems are so complex as to require the close collaboration of several agencies for successful case management; and
    d. the participant prefers to obtain case management services from another agency.
D. Family Case Management Agencies in Chicago / Cook County (Region 1) must comply with the Chicago / Cook County FCM Client Transfer Policy and Procedures.

2.1.2 CLIENT TRANSFER POLICY

Revised October 2019

Clients may only be enrolled in services at one agency at a time. Based on this, it is essential that all agencies cooperate in adhering to the following client transfer policy to ensure that there is a strong continuity of care for clients, and each client is receiving the most appropriate service based on their individual needs. Every agency is expected to follow the policy as it is written, unless prior approval has been given and documented by the MCH Nurse Consultant.

A) Clients should be active in the most appropriate program based on their current needs.
B) If a client is a DCFS Youth in Care and is referred to a HWIL agency by the HWIL Lead Agency and is active in HRIF at another agency, the HWIL agency should notify the HRIF agency, however, may not activate the client until the HRIF agency transfers the case to them. The HWIL agency should notify the Lead Agency as to the status of that child. The HRIF agency will transfer a youth in care to the HWIL agency when one of the following occurs:
    a) The DCFS Youth in Care ages out of the HRIF program
    b) The DCFS Youth in Care no longer has medical issues that require the intensive case management provided by the HRIF program.
    c) The DCFS Youth in Care chooses to no longer participate in the HRIF program.
C) Prior to activating any client at an agency, it is imperative that a statewide lookup must be completed in Cornerstone. In areas where there may be multiple agencies providing similar services, a lookup must be completed for the mother as well as the infant in cases where an infant has been referred to an agency. If a mother is active at a different agency, the infant should be referred to the original agency where the mother has been receiving services to ensure continuity of care.
D) Anyone who appears on the HSPR0724 – case finding list should go through the statewide search process in Cornerstone and if that client, or the client's parent / guardian, or sibling is currently receiving services (and active) at another agency, the agency who received notification in the case finding list report, should not reach out to that family, since they will most likely continue to receive services at the agency they are already active with.
E) Requests for transfer of clients with an Active program status should only be made for one of the following reasons and the client must agree to the transfer prior to it being completed:
    a) the client's most important problem requires expertise for case management that the grantee's staff does not possess;
    b) the client's most important problem requires expertise for case management that another agency's staff does possess;
    c) the client has moved and is now located closer to a different agency; or
    d) the client prefers to obtain case management services from another agency.
        i. In these situations, the agency that the client is presenting to should have a conversation with the client emphasizing the importance of continuity of care. If the client still chooses to change agencies, it should be documented in the Case Notes (CM04) of Cornerstone what the reasoning is for the transfer.

If a transfer of an active client is deemed necessary, based on the reasons given above, the agency receiving the client must communicate directly with the agency who is going to be losing the client to

inform them of the transfer and request that the record be released in Cornerstone. This communication is to be documented in the Case Notes (CM04) of the client record for review at a later date.

Agencies initiating a transfer of a client who is currently active at another agency must complete a Transfer Request Form (Addendum 2.1.2 Client Transfer Request Form) which will be maintained in the client record at both the agency the client transferred from and the agency the client transferred to. These forms must be signed and shared with the program coordinators at both agencies effected by the transfer. These forms may not replace the documentation within the client record in Cornerstone and are not a requirement of the Department.

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.

4 HIGH RISK INFANT FOLLOW-UP PROGRAM

Revised October 2019

Infants and children (ages 0 – 2 years old) are referred to the high-risk infant follow up program either through the IDPH Adverse Pregnancy Outcomes Reporting System (APORS) or based on assessments done in the Family Case Management program which determine: that the infant has been diagnosed with a serious medical condition after newborn discharge; when maternal alcohol or drug addiction has been diagnosed; or when child abuse or neglect has been indicated based on investigation by the Illinois Department of Children and Family Services (See 410 ILCS 525/3 and 77 Ill. Adm. Code 840.210). The primary goals of HRIF are to:

- Minimize disability in high-risk infants by early identification of possible conditions requiring further evaluation, diagnosis, and treatment
- Promote optimal growth and development of infants
- Teach family care of the high-risk infant
- Decrease stress and potential for abuse

4.1 STAFFING QUALIFICATIONS

4.1.1 CASE MANAGER

Revised October 2019

The case manager must meet one of the following qualifications:

1) 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 1(a) or 1(b) of this Section.

4.1.2 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:

1. 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.
2. 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.
3. Determine staff training needs and coordinate education opportunities.
4. Conduct Quality Assurance activities and monitor the following areas and identify improvement needs:
    a. Daily Clinic Operations
    b. MCH Reports
    c. Infant & Child Education
    d. Agency Policy & Procedure
5. Attend professional conferences, seminars, and workshops to update staff on current MCH practices and other information relevant to MCH.
6. Identify and collaborate with local Agencies and other community partners.
7. Manage assigned caseload per IDHS Grant Agreement.
8. Maintain oversight controls and records
9. Ensure employee compliance and program integrity.

4.1.3 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:

1. Intake, follow-up with clients or Agencies to ensure that clients are accessing needed services
2. Provision of support and assistance that clients may require to access services
3. Conducting outreach activities
4. Maintaining client files and clinic schedule
5. Scheduling of appointments and follow-up on missed/upcoming appointments
6. Managing client correspondence

4.2 ELIGIBILITY

Revised October 2019

HRIF may be provided when the client is determined to be at high risk for medical complications by the primary care provider or by risk assessment. High-risk case management of infants and children may be provided by the case management agency when:

- The infant or child has been identified through the Adverse Pregnancy Outcome Reporting System (APORS) (See 410 ILCS 525/3) and 77 Ill. Adm. Code 840.210),
- When the infant has been diagnosed with a serious medical condition after newborn discharge,
- When maternal alcohol or drug addiction has been diagnosed or
- When child abuse or neglect has been indicated based on investigation by the Illinois Department of Children and Family Services.

HRIF infants or children will be followed until 24 months of age unless a complete assessment and the professional judgment of the nurse case manager at the first visit or any subsequent visits indicate that services are no longer needed. These clients and those whose conditions are minor and whose environments are stable may be transferred into Family Case Management.

HRIF services take precedence over HealthWorks of Illinois Medical Case Management.

4.2.1 APORS Designation Process

Revised October 2019

APORS staff at Illinois Department of Public Health (IDPH) collect case information from hospitals and other sources, such as the Newborn Metabolic Screening Program and the Newborn Hearing and Screening Program. IDPH APORS staff will proceed as follows once data has been collected:

a) Review the information provided by the hospitals and other sources, checking for inconsistencies and missing information. IDPH APORS refers any identified problems to the reporting hospital for resolution.
b) Review and code the list of diagnoses provided by hospitals and other sources. If the codes do not meet the APORS case criteria/definition (Examples: the baby did not die, was not less than 31 weeks gestation, the mother was not Hepatitis B positive or infant has a genetic disorder, etc.) per the IDPH APORS Case Definition Chart (Addendum 4.2.1 APORS Case Definition), then the case does not meet eligibility criteria for APORS.
c) Enter the case into the APORS database if the report was received by paper.
d) The IDPH APORS Review field in the software system is completed with a "Y" if there are no problems with the case, and the baby has not gone to an equal or higher-level reporting facility.
e) Once these steps are completed, the record is made available electronically to the local health department or community agency staff thru the IDPH APORS referral portal.

If further assistance is needed with APORS Referrals, please contact the APORS IDPH Manager: Jane Fornoff at 217-785-7133 or Jane.Fornoff@illinois.gov

4.2.2 PROCEDURE TO CHANGE HRIF DESIGNATION TO APORS

Revised October 2019

For an infant without a receipt of an APORS referral, contact the APORS Program by email at dph.apors@illinois.gov to request the APORS report. Before requesting such a report, the nurse should review the IDPH APORS Case Definition Chart (Addendum) to verify that the child meets the APORS case definition. Do not add "Y" (yes) APORS on Cornerstone PA11 (Birth Data) screen until an APORS report is received. If an infant has a high-risk condition that is not reportable to APORS, the infant may be provided HRIF services. Do NOT add "Y" (yes) to the APORS question on Cornerstone PA11 Birth Screen; it remains "N" (No).

4.3 CONTENT

4.3.1 FREQUENCY

Revised October 2019

All APORS referred clients must receive their first contact from the agency within seven (7) business days of referral.

A minimum of 6 face-to-face visits shall be made by the follow-up nurse at the following intervals for all clients:

1. within fourteen (14) business days of newborn hospital discharge,
2. a 4-month visit (between chronological months 2 – 5),
3. a 6-month visit (between chronological months 6 – 9),
4. a 12-month visit (between chronological months 10 – 15),
5. a 18-month visit (between chronological months 16 – 21),
6. a 24-month visit (between chronological months 22 – 25).

Infants and their families having actual or potential health problems identified by the nurse shall be visited more frequently for health monitoring, teaching, counseling, and/or referral for appropriate services. Occasionally, when an infant is receiving services at the Local Health Department, a follow-up visit may be conducted by the nurse at that time.

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

- At least once during infancy in months 2 – 4 of the infant's life
- For complex APORS conditions, three to four home visits may be needed. If the APORS condition is non-complex and the family is mobile, additional home visits will be based upon the professional judgement of the case manager. The nurse should document evidence of contact and location on the SV02 screen in Cornerstone for each contact.

4.3.2 PROCESS

Revised October 2019

Physical Assessment - to be completed by a registered nurse. The physical assessment will be documented in Cornerstone: AS01:708, questions 27-52. Each physical assessment should be documented by the nurse in the SV02 Cornerstone screen. A Maternal Child Health Nurse (MCH) will review documentation of physical assessments during program review.

The Case Manager is required to complete the following additional assessments:

- General Assessment (AS01:700),
- Other Barriers (AS01:701),
- Nutrition Assessment (AS01:708) Q81 if WIC active or Q 81-90 if not WIC active,
- Home Assessment (AS01:706).

The Infant Risk Assessment (AS01:712) should not be completed on known HRIF or APORS referred clients.

Developmental Assessments are to be completed by a registered nurse who has training in administering any of the Department of Healthcare and Family Services (HFS) approved developmental assessment tools. A developmental assessment will be completed at the 6-month visit and again at 12-, 18- and 24-month visits. The nurse shall document these developmental assessments in Cornerstone on the SV01:824 screen and a hard copy of the screening tool used will be placed in the client's file/record. Additional assessments may be completed and documented as necessary.

The purpose of the Primary Care Physician (PCP) Notification form (Addendum) is to inform the PCP of any abnormal/unusual or questionable findings resulting from the assessment of the infant by the public health nurse. It is not required that this form be sent to the primary physician after each assessment. The use of the PCP Notification Form is based on the professional judgment of the Case Manager. All pertinent information should be shared between the local public health nurse and primary care physician. However, the primary physician should be notified that the infant/child is active in HRIF program services.

Services to be provided include, but are not limited to:

- Ensure that all clients have an assigned Primary Care Provider and this provider is known to the client.
- Complete needs assessment and develop an individualized care plan.
- Update the Individualized Care Plan at least quarterly based on assessments and current client needs.
- Deliver all services to high-risk infants in accordance with the provisions of the current Department's Program Policy Manual.
- Collaborate with other service Agencies in the community including primary care physicians and Medicaid managed care entities for service development and integration and to maximize care coordination.
- Ensure enrolled infants receive developmental screening within the first 12 months of life utilizing a standardized screening tool.
- Ensure children in DCFS custody who are eligible for HRIF receive HRIF and are referred back to HWIL once they are no longer eligible for HRIF.

- Ensure that all children receive a Well Child /EPSDT Exams at minimum at the 4, 6, 12, 18- and 24-month visits and document these visits in Cornerstone Data Entry screens SV01:806.
- Initial Face-to-Face contact with infants (0-12 months) is to be made within fourteen (14) days of APORS referral as measured through chart review of the printed Infant Discharge Record (IDR) and the Cornerstone entry of SV02.
- Subsequent Face-to-Face Visits with age-based assessments are to be completed at 2-5 months, 6-9 months, 10-15 months, 16-21 months, and 22-25 months as measured by daily entry of client data into Cornerstone Data Entry Screen SV02.
- Infants are to receive a completed Home Visit and SIDS education at age 2 – 4 months as measured by AS01:706 Assessment, SV01:SSED and SV02. The content of home visits will be measured through annual electronic chart review during the scheduled review visit.
- Completion of Immunization Education based on current CDC Guidelines as documented in Cornerstone Data Entry Screen SV01:IMED at each Face-to-Face contact.
- Referrals are completed based on assessments and care plan as documented on the Cornerstone system referral screens (RF01).

4.3.3 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.

4.3.4 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.

4.3.5 CORNERSTONE WORKFLOW SHEETS

Revised October 2019

Infant/Child Cornerstone Workflow

4.4 CASE CLOSURE

Revised October 2019

Case closure should occur when:

1. The client no longer meets age or eligibility criteria for HRIF funding;
2. The client moves out of the grantee's service area;
3. The client dies; or
4. 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:

1. The client has located a medical care provider for continued care for himself or herself and his or her children;
2. The client is referred for family planning services;
3. The client is referred for postpartum WIC or Commodity Supplemental Food Program (CSFP) certification;
4. The client's children are referred for WIC or CSFP certification;
5. The children have begun or been referred for immunizations (if these are not contraindicated or declined by the parent);
6. The client has completed application for Medicaid for his or her children; and
7. 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.

5 HEALTHWORKS

Revised October 2019

Clients are referred to HWIL from DCFS Lead Agencies after the initial 45 days the child is in care. Grantees are expected to provide follow-up services and communicate regularly back to the Lead Agencies regarding issues pertaining to these cases and to maintain complete medical records for the child.

The primary goals of HWIL are to:

- Ensure that each child receives preventive health care services
- Ensure that each child is connected with a Primary Care Provider (PCP)
- Develop health care plans for incorporation into each child's overall DCFS service plan.

5.1 STAFFING QUALIFICATIONS

Revised October 2019

All case managers must be enrolled in the Case Management training provided by the Springfield Urban League within 3 months of working in any MCH program 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.

5.1.1 CASE MANAGER

Revised October 2019

The case manager must meet one of the following qualifications:

1) 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 1(a) or 1(b) of this Section.
2) 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 services to families with young children, 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 2(a) of this Section.
3) Possess a master's degree or baccalaureate degree in a behavioral science, social science, or a health-related area; or a baccalaureate degree in any other area and one year of experience in child, family, or community services; or an associate degree and two years' experience in child, family, or community services. Case managers meeting only this qualification must be supervised by a case manager meeting the requirements of subsection 1 or 2 of this Section until they have a total of two years of supervised case management experience.

5.1.2 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:

1. Supervision, evaluation, and direction of HWIL staff by ensuring that staff at all levels are competent to complete job specific duties when providing HWIL program services.
2. 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 HWIL Program.
    b. Participating in State and Regional HWIL conference calls and meetings
    c. Communicating to staff HWIL Program updates and reinforcement of program requirements.
3. Determine staff training needs and coordinate education opportunities.
4. Conduct Quality Assurance activities and monitor the following areas and identify improvement needs:
    a. Daily Clinic Operations
    b. HWIL Report
    c. Perinatal, Infant & Child Education
    d. Agency Policy & Procedure
5. Attend professional conferences, seminars, and workshops to update staff on current HWIL practices and other information relevant to HWIL.
6. Identify and collaborate with local Agencies and other community partners.
7. Manage assigned caseload per IDHS Grant Agreement.
8. Maintain oversight controls and records
9. Ensure employee compliance and program integrity.

5.1.3 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:

1. Intake, follow-up with clients or Agencies to ensure that clients are accessing needed services
2. Provision of support and assistance that clients may require to access services
3. Conducting outreach activities
4. Maintaining client files and clinic schedule
5. Scheduling of appointments and follow-up on missed / upcoming appointments
6. Managing client correspondence

5.2 ELIGIBILITY

Revised October 2019

HWIL clients are referred to HWIL from DCFS Lead Agencies after the initial 45 days the child is in care. These children are all youth-in care, which means that DCFS has custody of these children. HWIL children are not referred to the HWIL program through the DCFS 0 – 3 Intact services Programs.

5.3 CONTENT

5.3.1 FREQUENCY

Revised October 2019

All HWIL referred clients must receive their first contact from the agency within thirty (30) business days of referral from the HealthWorks Lead Agency.

Case Managers must, at minimum, have a Face-to-Face contact with the client every six (6) months enrolled in the program. Each Face-to-Face contact should be documented in Cornerstone with the appropriate SV02 activity code.

HWIL Clients who are dually enrolled in HRIF must be seen at the level of frequency prescribed by the HRIF program, including the home-visit.

Additional contacts with the client, the PCP of the client, or the DCFS HWIL Lead Agency may be made as necessary and as required by the HWIL Lead Agency's requirements.

5.3.2 PROCESS

Revised October 2019

Youth in Care are to receive a Comprehensive Health Evaluation (CHE) based on Early Periodic Screening Diagnostic and Treatment (EPSDT) standards.

Agencies are responsible for:

- Assisting the substitute caregiver with the selection of a PCP
- Obtaining health care information from previous physicians and other medical Agencies;
- Assuring that medical services – CHE's, yearly physicals, EPSDT visits, and other medical/immunization/dental/vision/hearing services are obtained
- Compiling health care information to send to the physician for the CHE's, assuring that medical needs are being met
- Developing an individualized Health Care Plan. The Youth in Care's caseworker will use the information to develop the client service plan

The HWIL Case Manager enters all data of the youth in care served in the Cornerstone system, maintains the record, forwards medical information to DCFS, and provides the ongoing medical case management of the youth in care from age 0 through 5. Ongoing Medical Case Management services are transferred to the HealthWorks Medical Case Management (IHWIL) designated agencies by the Health Works Lead Agency (HWLA). Downstate, the older Youth in Care population, ages 6-21, is medically case managed by HWLA.

If an infant is taken into custody after birth at the hospital, the birth records may suffice for initial health screening (HIS) and hospital discharge Physical Exam for comprehensive health evaluation (CHE). The case manager will need to collaborate with MCM agencies to complete health care information for Health Services Summary/Transfer Tool (for use by Medical Case Management Agency) to send to HWLA as needed.

Services to be provided include, but are not limited to:

- Complete the comprehensive needs assessment on successful contact with the development of an individualized care plan.
- Update the Individualized Care Plan at least quarterly based on assessments and current client needs.
- Provide medical case management services to all children in accordance with the HealthWorks program Policy Manual.
- Obtain previous health care histories on each assigned child in the care and custody of DCFS.
- Meet with the HealthWorks of Illinois Lead Agency at least quarterly to review cases.
- Input medical case management data and medical information using the Department's Cornerstone information system.
- All children are to be linked to a HealthWorks of Illinois Primary Care Physician and the selection is to be made known to the HealthWorks Lead Agency as measured through PA03 (Participant Enrollment) and chart review.
- All infants and children are to receive documented medical services according to EPSDT standards, including annual exams as measured through chart review of SV01:806 Well Child Visits, SV01:827

(Dental Visits), SV01:828 (Vision Screening), SV01:829 (Hearing Screening) and copy of medical record in the chart during onsite review.

- All children are to receive the following assessment through direct contact with the client or foster parent:
    - AS01:700 (Q43-51) General Assessment annually.
    - AS01:708 A-L Anticipatory Guidance assessment based on their age.
- All children must have documentation that they are current on needed immunizations as measured by IDPH ICARE; or medical record SV02:100 (if agency obtained records).
- All children must receive documented needed services including specialty care per the Individualized Health Care Plan.
- All children with special health care needs according to DCFS guidelines are to be referred to the DCFS Regional nurse as documented with a copy of written referral on file as well as in the Cornerstone system documented as an RF01.
- Evidence of medical care coordination is be expected to include the following:
    - Education on the importance of childhood immunizations
    - EPSDT participation at age one year
    - Linkage with a Primary Care Provider
    - 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.
        - Clients are to be given a copy of the referral.
- All children are to be successfully contacted by the case manager within thirty (30) business days of assignment.
- All pregnant Youth are to receive prenatal depression screenings as measured by timely entry of client data into Cornerstone Data Entry Screens: SV01:825.
- All Pregnant Youth in care are to receive preconception, inter-conception, and reproductive life plan education as measured by timely entry of client data into Cornerstone Data Entry Screens: SV01: 802, 941 and PEWW Well Woman's Education
- All parenting Youth are to receive postpartum depression screenings in the 42-day postpartum period as measured by timely entry of client data into Cornerstone Data Entry Screens: SV01:825 and 940.
- All parenting youth in care are to receive postpartum, inter-conception, and reproductive life plan education as measured by timely entry of client data into Cornerstone Date Entry screens: SV01 942 and PEWW.

An infant or child(ren) living with their mother, who is a DCFS ward, may be case managed under HRIF guidelines.

5.3.3 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.

5.3.4 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.

5.3.5 CORNERSTONE WORKFLOW SHEETS

Revised October 2019

Infant/Child Cornerstone Workflow

Pregnant Cornerstone Workflow

Postpartum Cornerstone Workflow

5.4 CASE CLOSURE

Revised October 2019

Case closure should occur when:

1. The client no longer meets age eligibility criteria for HWIL funding;
2. The child is no longer in DCFS custody;
3. The client moves out of the grantee's service area;
4. The client dies; or
5. 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:

If a child is active in HRIF, when the child is no longer eligible for or in need of HRIF services, the HRIF nurse should notify the HealthWorks Lead Agency (HWLA) when an HRIF case is closed.

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.

6 BETTER BIRTH OUTCOMES PROGRAM

Revised October 2019

High-risk pregnant women in areas of the state with higher than average Medicaid costs associated with poor birth outcomes and with higher than average numbers of Medicaid women delivering premature infants are enrolled in the Better Birth Outcomes (BBO) program.

BBO offers a standardized prenatal education curriculum that emphasizes the importance of regular prenatal medical care visits; home visits each trimester active in the program; and monthly engagement with the BBO case manager for continued prenatal education, care coordination and communication with the client's prenatal medical provider. The program's emphasis on reproductive life planning and health benefits associated with the delay of subsequent pregnancy impacts Illinois' infant mortality rate and rates of prematurity in Medicaid-eligible pregnant women. Women are enrolled in BBO through the duration of pregnancy up to six weeks postpartum. Because the pregnant women that are the target population for these services are not women who typically tend to seek out early prenatal medical care or other needed services, agencies participating in the BBO program are expected to develop an annual outreach plan.

6.1 STAFFING QUALIFICATIONS

Revised October 2019

All case managers must be enrolled in the Case Management training provided by the Springfield Urban League within 3 months of working in any MCH program 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.

6.1.1 CASE MANAGER

Revised October 2019

The case manager must meet one of the following qualifications:

1) Registered Nurse (RN)
2) Master's Degree Social Worker (MSW)
3) Master's Degree in Counseling Psychology
4) Licensed Professional Counselor (LPC)
5) Licensed Clinical Professional Counselor (LCPC)
6) Master's Degree in Human Services and Counseling with specialization in counseling
7) Master's Degree in Public Health (MPH) with specialization in public health nursing, women's health, or reproductive health

6.1.2 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:

1. Supervision, evaluation, and direction of BBO staff by ensuring that staff at all levels are competent to complete job specific duties when providing BBO program services.
2. 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 BBO Program.
    b. Participating in State and Regional BBO conference calls and meetings
    c. Communicating to staff BBO Program updates and reinforcement of program requirements.
3. Determine staff training needs and coordinate education opportunities.
4. Conduct Quality Assurance activities and monitor the following areas and identify improvement needs:
    a. Daily Clinic Operations
    b. Reports
    c. Perinatal Education
    d. Agency Policy & Procedure
5. Attend professional conferences, seminars, and workshops to update staff on current BBO practices and other information relevant to BBO.
6. Identify and collaborate with local Agencies and other community partners.
7. Manage assigned caseload per IDHS Grant Agreement.
8. Maintain oversight controls and records
9. Ensure employee compliance and program integrity.

6.1.3 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:

1. Intake, follow-up with clients or Agencies to ensure that clients are accessing needed services
2. Provision of support and assistance that clients may require to access services
3. Conducting outreach activities
4. Maintaining client files and clinic schedule
5. Scheduling of appointments and follow-up on missed/upcoming appointments
6. Managing client correspondence.

6.2 ELIGIBILITY

Revised October 2019

BBO services are to be offered to women eligible according to the guidelines below:

- High risk as determined by the Department of Healthcare and Family Services Medicaid claims data indicating Medicaid women with a prior poor birth outcome; or
- High risk as determined by the presence of two or more risk factors as identified by the 707G Cornerstone assessment or one risk factor when approved by the MCH Nurse Consultant;

If existing caseloads are at maximum capacity, women are to be enrolled in Family Case Management and followed as prenatal clients, until such time as there are available slots in the Better Birth Outcomes program.

6.3 CONTENT

6.3.1 FREQUENCY

Revised October 2019

Case Managers must, at minimum, have a Face-to-Face contact with the client every month they are enrolled in the program. Each Face-to-Face contact should be documented in Cornerstone with the appropriate SV02 activity code.

A minimum of one face-to-face contact must be completed as a home visit every trimester the client is active in the program.

A minimum of one face-to-face contact must be completed during the postpartum period as documented in Cornerstone with the appropriate SV02 activity code.

Best practices are to follow the schedule identified below in the ideal situation a client is enrolled for the full pregnancy:

- Month 1 Face-to-face in clinic
- Month 2 Home visit
- Month 3 Face-to-face in clinic
- Month 4 Face-to- face in clinic
- Month 5 Home visit
- Month 6 Face-to- face in clinic
- Month 7 Face-to- face in clinic
- Month 8 Home Visit
- Month 9 Face-to- face in clinic
- Postpartum Face-to- face in clinic

6.3.2 PROCESS

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 Better Birth Outcomes.

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
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, and the appropriate weight should be documented after receipt of proper documentation with birthweight.

Pregnant women enrolled in the program are to receive at minimum the following services:

c. 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); SV01:802 (Service Entry).
d. Ensure that all women receive the following assessments and education with appropriate education materials provided to clients.
    i. 707G Presence of ≥ 2 risk factors & identify (if 1 RF, must include MCH Nurse Consultant approval)
    ii. 700: 1-40 General
    iii. 701: Other Service Barrier
    iv. 703: Psychosocial Stress
    v. 704: Alcohol / Substance Abuse
    vi. 705: Violence
    vii. 706: Home Visiting
    viii. 707D: Women Nutrition
e. 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.
f. 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.
g. Provision of service or referral for childbirth education SV01:922 or RF01.
h. Provision of service or referral to parenting classes SV01:918 or RF01.

i. 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.
    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 or a Case Note (CM04) detailing that verification has been obtained with the Provider.
    ii. Licensed health care workers providing BBO 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. BBO 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.
j. 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.
k. Delivery of the Department's standardized BBO Health Education Curriculum in its provision of prenatal education to all enrolled women according to the BBO Prenatal Education Curriculum Guide with service codes entered in Cornerstone for all education modules provided.
l. Provide a comprehensive needs assessment and have a case management care plan developed within forty-five (45) calendar days of enrollment with appropriate referrals and updated as necessary throughout participation in the BBO program.
m. Provide the curriculum on Initiation of Breastfeeding or referral to a lactation specialist as documented in SV01:PEBF or RF01.
n. Refer all BBO women and infants born to BBO women who may be income-eligible to the WIC program.
o. Refer postpartum women in the Chicago area to the Best Practices in Inter-Conception Health (BPIH) program at the University of Chicago as indicated.

p. Communicate directly with the Medicaid Managed Care Organization (MMCO) on behalf of the client to assist in arranging transportation when necessary.

6.3.3 PRENATAL HEALTH EDUCATION CURRICULUM

Revised October 2019

GUIDELINES FOR USE

While the original curriculum is divided into a series of sessions structured by trimester, the workgroup recommends that case managers should discuss the individual topics based upon the client's knowledge and needs during any given point in time. Client needs should drive the education delivered with all, if not most of the content / topics listed over the course of the potential ten to eleven contacts made with the client. The curriculum should be administered with fidelity based upon client engagement & relationship building using a client centered approach and motivational interviewing techniques. Supporting Materials and Cornerstone Documentation listed below may be repeated for more than one trimester.

Addendum 6.3.3 Better Birth Outcomes Curriculum

6.3.4 CORNERSTONE WORKFLOW SHEETS

Revised October 2019

Pregnant Cornerstone Workflow

Postpartum Cornerstone Workflow

6.3.5 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.

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.

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

The Referral is documented as an initiation of the referral, the update on status of the referral, or the completion or refusal of the referral by the client.

6.3.6 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 quarterly.

6.3.7 TRANSPORTATION

Revised October 2019

1) Agencies are expected to assist clients in arranging for client transportation as necessary for prenatal care visits and appointments, visits for specialty medical care and/or other appointments specific to the woman's individual health needs and outlined in the plan of care.
2) Agencies must work closely with MMCOs to utilize transportation services provided.
3) Transportation costs that are incurred due to inability or lack of availability of MMCO transportation services or for clients not enrolled in Medicaid or a MMCO, may be documented for reimbursement on a monthly basis.
4) Agencies are expected to be able to provide proof of attempts to use other means of transportation for clients whenever possible.
5) The number of Gas Cards / Public Transportation Tokens purchased for clients should not exceed monthly assigned caseload without prior written approval from the Department.
6) Transportation costs may be documented on monthly Periodic Financial Reports (PFRs) for reimbursement if they have been documented in the budget under line item 15 known as the Grant Exclusives Line Item.
7) Costs for Transportation may not exceed 10% of the overall grant amount.

6.3.8 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 6.3.9 of the Program Policy Manual.

The primary purposes of outreach are the following:

3. 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.
4. Establishment of a working relationship between the BBO 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.

6.3.9 ALLOWABLE COST FOR OUTREACH AND CASE MANAGEMENT ACTIVITIES

Revised October 2019

1. Costs incurred for outreach activities as defined in section 6.3.8 of the Policy & Procedure Manual are allowed. However, health, general education, or other social service activities may not be included as outreach.
2. 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.
3. 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.
4. 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 BBO Agency is an FQHC or other community-based organization), for purposes of early identification and referral of potentially eligible pregnant women and for overall coordination of care for enrolled women.
5. The Agency is expected to pursue partnerships with various community sectors that can provide additional support and services that enhance outreach efforts.
6. 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.
7. Agency will evaluate outreach activities annually for effectiveness
8. 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
9. Outreach expenditures should be concentrated on activities which access and activate eligible clients to BBO program services.
10. Written approval must be obtained from the Department for awareness campaigns / promotions, and billboards prior to purchase and/or implementation.

11. Raffles are not allowable as a means of outreach.

6.4 CASE CLOSURE

Revised October 2019

Case closure should occur when:

1. the client no longer meets eligibility criteria for BBO funding;
2. the client moves out of the grantee's service area;
3. the client dies; or
4. the case management agency is no longer able to reach the client.

At the time of closure, the case manager should do their best to ensure that the following activities have been completed as appropriate for the client's circumstances:

1. the client has located a medical care provider for continued care for herself and her children;
2. the client is referred for family planning services;
3. the client is referred for postpartum WIC or Commodity Supplemental Food Program (CSFP) certification;
4. the client's children are referred for WIC or CSFP certification;
5. the children have begun or been referred for immunizations (if these are not contraindicated);
6. 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 according to the client transfer policy outlined in section 2.2 of the Policy & Procedure Manual.