Illinois Department of Human Services
Bureau of Maternal and Child Health
High Risk Family Case Management Program

Policy and Procedure Manual

Effective July 1, 2024

1 ADMINISTRATION

1.1 ILLINOIS HIGH RISK FAMILY CASE MANAGEMENT PROGRAM

The Illinois Department of Human Services (IDHS) Bureau of Maternal and Child Health (BMCH) High Risk Family Case Management (HRFCM) Program is a statewide program that provides nursing assessment and interventions, screenings and referrals, diagnoses-specific education, and service coordination to Illinois residents who meet the eligibility criteria to improve the health, social, educational, and developmental needs of high-risk pregnant & postpartum individuals and/or their high-risk infants throughout pregnancy and the first one year after birth. Families requiring services beyond the first year may be authorized with Departmental approval.

The Illinois Department of Human Services (IDHS) Bureau of Maternal and Child Health (BMCH) facilitates nurse case management services to high-risk birthing families statewide with the goal of reducing maternal and infant mortality and morbidity rates at both the state and local level with an emphasis on addressing racial/ethnic disparities in outcomes. To eliminate barriers to client transportation and decrease risk of communicable diseases in the high-risk population, nurse visits are expected to occur exclusively in the home setting for the duration of pregnancy and the first three months after birth, and as needed thereafter.

In alignment with the Improving Health Care for Pregnant and Postpartum Individuals Act (20 ILCS 1305/10-23 new), the bureau has expanded and revised the previously offered High Risk Infant Follow-Up (HRIF) and Better Birth Outcomes (BBO) programs by now offering a single, comprehensive High-Risk Family Case Management (HRFCM) Program to vulnerable high-risk family units to improve both maternal and infant outcomes overall and to reduce racial disparities in outcomes and services provided.

The HRFCM program covers increased expenses to support higher program quality and required nurse to family (dyads) staffing ratios. Caseloads will be limited to medically high-risk family dyads (birthing individual and infant). The HRFCM program will not provide services to low-risk dyads. The Department will provide a HRFCM Vulnerability Index (Appendix A) for the list of risk factors used to determine “medically high-risk” eligibility criteria for the program described herein. Families not meeting the eligibility criteria may be approved with Departmental approval.

The HRFCM Program is funded by Illinois General Revenue funds (GRF) and Social Services Block Grant (SSBG) allocated for Infant Mortality and administered through the Illinois Department of Human Services (DHS), Bureau of Maternal and Child Health (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 Uniform Grant Agreement. Local agency procedures must meet the minimum requirements outlined in the Illinois Maternal and Child Health Policy and Procedure Manual.

1.2 LOCAL AGENCY AGREEMENT

1.2.1 LOCAL AGENCY ELIGIBILITY

Through a competitive, merit-based review and selection process, the Bureau will grant funds to agencies that will be responsible for overall administration of the program in the entire geographic area awarded, have demonstrated experience and/or capacity to meet staffing and caseload requirements either through employment or sub-contractual relationship, and have demonstrated experience and capacity internally or through partnerships to provide maternal health nursing assessment and/or nurse case management services to high-risk maternal child health populations with fidelity.

The types of applicants that may apply for the grant award are public or private organizations that have or will have a physical presence in the eligible geographic area and the required staffing model in place within 90 days of the contract start date for which they intend to provide HRFCM services for the geographical area applied for. Grantees failing to have required staffing model and nurse to client ratios in place within 90 days of the grant agreement start date or at any time during the grant period may be subject to grant suspension or termination.

Eligible applicants are inclusive of units of local government, hospitals, community-based organizations, federally qualified health centers, and nonprofit organizations that serve the eligible community in the geographical area applied for.

A local agency must directly or through written agreement with another party:

A. Provide program services to Illinois residents at no cost to the family.
B. Meet staffing standards. (See Staffing)
C. Prioritize preventing the leading causes of maternal and infant morbidity and mortality.
D. Promote diversity and inclusion with demonstrated efforts to adapt services to fit the cultural contexts of the individuals, families, or communities.
E. Have the facilities and equipment necessary for the provision of case management services to pregnant and postpartum individuals and infants in a confidential setting.
F. Have the ability and willingness to provide services in the family's home.
G. 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.
H. Be in compliance with Civil Rights non-discrimination laws and regulations.
I. Assure confidentiality is maintained with collection, handling, and disclosure of client information during all aspects of a client visit.
J. The agency must agree to help a program client apply for benefits under the Medicaid program and Supplemental Nutrition for Women, Infants and Children (WIC).
K. 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.

L. The agency must be capable of delivering services to the target population, demonstrate an understanding of the concept and delivery of high-quality Maternal Child Health (MCH) nursing assessment, intervention and nurse case management services and demonstrate (by written agreements or other means such as letters of support) linkages to relevant social service and health care agencies serving the target area.

M. The agency must be able to conduct outreach activities to the target population and medical providers in the geographic area to be served. (See Outreach)

N. Direct service staff for the program must meet the standards defined for each program in this manual.

O. The agency must maintain an adequate and confidential client records system.

P. Documentation of all services provided is to be maintained in the Department's data Management Information System (MIS) in accordance with the guidelines set forth in the Department's Data MIS User Manual

Q. The agency must have the ability to access physician consultation for development of standing orders and/or written agency policy and procedure in place to address staff's role and responsibilities in required interventions in the event of abnormal values, assessments findings, and health concerns.

1.2.2 SUBCONTRACTING FOR SERVICES

Subcontractor Agreement(s) and budgets for direct service must be pre-approved by the Department and on file with the Department. Subcontractors are subject to all provisions indicated in this manual. The successful applicant Agency shall retain sole responsibility for the performance and monitoring of the subcontractor.

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 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

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:

1. The HRFCM Policy and Procedure Manual
2. Management Information System Manual
3. Illinois Family Case Management Act [410 ILCS 212]
4. 325 ILCS 5: Abused and Neglected Child Reporting Act
5. 405 ILCS 95: Perinatal Mental Health Disorders Prevention and Treatment Act
6. 740 ILCS 110 Mental Health and Developmental Disabilities Confidentiality Act
7. 45 CFR 160
8. 45 CFR 164
9. Federal Regulations (eCFR 200)
10. Grant Accountability and Transparency Act (44 Ill. Adm. Code 7000)
11. Nurse Practice act (225 ILCS 65)
12. Title II of the Health Insurance Portability and Accountability Act of 1996

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

The HRFCM program covers increased expenses to support higher program quality and required nurse to family (dyads) staffing ratios. Caseloads will be limited to medically high-risk family dyads (birthing individual and infant). The HRFCM program will not provide services to low-risk dyads.

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. The Department sends a Notice of State Award (NOSA) which shall include the grant award amount, terms and conditions of the award, and specific conditions, if any.
C. Grants are then paid on a reimbursement basis each month based on actual expenditures

claimed unless another method is requested and approved by the Department.

D. 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.
E. The local agency under the NOFO may be eligible to receive two subsequent one-year grant renewals for this program. Renewals are at the discretion of the Department and are based on sufficient appropriation and performance criteria including, but not limited to:
    i. Grantee has performed satisfactorily during the previous reporting period;
    ii. All required reports have been submitted on time, unless a written exception has been provided by the Division/Department;
    iii. No outstanding issues are present (e.g., in good standing with all pre-qualification requirements and no outstanding corrective action, etc.).

1.3 FINANCIAL REPORTING AND ADMINISTRATIVE COSTS

1.3.1 COST REPORTING

Local Agency costs for each grant must be broken down and reported separately. Staff that are working on multiple awards or projects (federal, state, or other) should be allocated based on the amount of time spent on the award if it is able to be tracked via time records or other reliable method. Otherwise, the time, benefits, etc. should be charged as indirect costs based on the agency's approved indirect cost rate.

Technical assistance and a description of each line item and examples of activities which may fall into these categories may be requested by emailing DHS.BMCHEDF@ilinois.gov.

1.3.2 ALLOWABLE COSTS

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, and budgeting.
C. Allowable Costs for outreach activities as defined in the Outreach section are allowed. However, health education, 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 Department's MIS 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 upon request.
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 direct service personnel required to meet the program deliverables in alignment with projected caseload and staffing requirements. The rates for personnel services and fringe benefits shall be comparable to that paid to other employees of the agency and at fair market salary for those performing similar duties.
b. Fees for consultants and specialists required to meet the program deliverables.
c. Travel of personnel, consultants, and specialists in carrying out the activities approved to maintain the program. Mileage, per diem, and lodging may not exceed the current U.S. General Services Administration rate.
d. Supplies needed to meet program deliverables (which include computers and medical tools costing less than $5,000.00 per item if the agency does not have a lower threshold outlined in their local capitalization policy).
e. 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.
f. Other expenditures directly related to the provision of project services, such as: telephone service, photocopying and scanning, office supplies, 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. other budget categories will not be allowed to capture costs incurred for common or joint objectives and that cannot be readily identified with a particular final cost objective including but not limited to:
    a. Costs of operating and maintaining facilities,
    b. General Administrative Expenses,
    c. Property Insurance,
    d. Administrative Support,
    e. Clerical Support.

1.3.3 UNALLOWABLE COSTS

Under no circumstances may the HRFCM grant be charged in full or in part for the costs of services which are demonstrably outside of the scope of the Program's authorizing statute. *For example, the HRFCM grant may be charged to screen HRFCM clients for immunizations and refer and follow-up on HRFCM client immunizations, but HRFCM may not be charged for the cost to administer the injection, the vaccine, or injection/vaccine-related equipment.*

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

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. Client transportation assistance
i. Gifts or other tangible items distributed to clients or prospective clients as an incentive for program completion or program enrollment, with the exception of printed educational material or pens/folders with program name and program contact phone number printed on them
j. Research & Development, Equipment, and Construction costs
k. Any other costs not approved in the plan and budget.

Direct Administrative costs shall not exceed 15% of the total grant award. Any deviation from this must be approved in writing by the Bureau Chief of the Bureau of Maternal and Child Health 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 program and thus invalidate the percentage
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 program

1.3.4 TIME AND ACTIVITY

Each agency must be able to document time, and activity spent by each employee on the grant. This documentation will be used to reconcile against reimbursement request of Personnel costs against each grant during audit and fiscal 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. The Department's MIS may be used to document time and activity; however, it is not required to be documented through the Department's MIS.

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 program employee is working in (HRFCM)

1.3.5 PRIOR APPROVAL FOR COSTS

Prior Approval is not needed for:

1) Activation of high-risk clients/families meeting the eligibility criteria
2) Clinical costs necessary to provide program services, including referrals
3) Outreach to prospective program clients as included in outreach plan and approved budget
4) Rental or purchase of non-computer supply items already approved in the budget (any nonexpendable item costing the lesser of $5000 or amount determined in the provider agency's capitalization policy)

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 hardware purchases, such as: personal computers, monitors, printers, and modems, regardless of cost
4) Any items costing more than $5,000 each
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
6) Media campaign content including social media, billboards, and TV or radio ads (see Outreach)

All requests for prior approval 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
7) At least two quotes/bids and reason why the chosen bid was selected

1.3.6 OUTREACH

"Outreach" means any activity to find and inform potential high-risk families of available services. Program services provided to families already enrolled are not considered outreach activities. The primary objective of outreach activities is to inform potential high-risk families and medical, social, or

other types of inpatient or outpatient service providers 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 with substance use disorder.

Acceptable Outreach methods are outlined in Section 1.3.7 of the Program Policy Manual.

The primary purposes of outreach are the following:

1. Build and maintain strong relationships in the local community with medical providers, including but not limited to physicians, certified nurse midwives, nurse practitioners, physician assistants, mental health providers, and hospital labor and delivery and emergency room personnel

2. Build and maintain strong relationships in the local community with social and human services providers, including but not limited to WIC, Early Childhood Home Visiting, Substance Use Prevention and Recovery, Housing Assistance, Welcoming Centers, and Community Based Organizations providing emergency items and supplies

3. Establishment of a working relationship between the Local Agency and Medicaid Managed Care Organizations serving individuals within the Local Agency's service area, as directed by the Department of Human Services

4. Raising awareness to eligible populations on the benefit of the program and promote program enrollment to interested clients

Costs for outreach may be documented on IDHS-provided Expenditure Documentation Forms (EDFs) monthly for reimbursement if they have been documented in the approved budget under category #15 known as the Grant Exclusives Line Item (GELI).

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

1.3.7 ALLOWABLE COST FOR OUTREACH AND CASE MANAGEMENT ACTIVITIES

Costs incurred for outreach activities as defined in section 1.3.6 of the Policy & Procedure Manual are allowed. However, health education, general education, or other social service or clinical activities may not be included as outreach.

A. 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.
B. Outreach can include community campaigns such as production and distribution of brochures/flyers, design and publication of newspaper announcements, billboards, and

production and broadcast of public service announcements or paid advertising on radio, television, or social media.

C. 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 Local Agency is an FQHC, hospital, or other community-based organization), for purposes of early identification and referral of potentially eligible pregnant individuals and infants and for overall coordination of care for enrolled clients.
D. The agency is expected to pursue partnerships with various community sectors that can provide additional support and services that enhance outreach efforts.
E. The agency is responsible for identifying more global strategies emphasizing a community-wide approach for all reproductive-age individuals in the targeted service 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.
F. The Local Agency will evaluate outreach activities quarterly for effectiveness. The Department may request a copy of the outreach plan at any time.
G. 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 HRFCM program.
    b. Printed materials may be given to local entities such as schools, churches, & local area healthcare, social, or human 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, TV channel, or social media.
H. Outreach expenditures should be concentrated on activities which access and activate eligible clients to HRFCM services.
I. Written approval of content must be obtained from the Department for awareness campaigns / promotions, billboards, bus wraps, or social media prior to purchase and/or implementation.
J. Raffles are not allowable as a means of outreach. These items may require specific verbiage.

1.3.8 TRANSPORTATION

1. Local agencies are expected to assist clients in arranging for client transportation utilizing benefits though the client's Medicaid Managed Care Organization (MMCO) as necessary for prenatal care visits and appointments, visits for specialty medical care and/or appointments specific to the individual's health needs.
2. Local agencies must work closely with the MMCOs to utilize transportation services provided.

3. Difficulties accessing MMCO transportation or other value-added services (VAS) programs and benefits should be reported to the Bureau Chief.

1.3.9 PEDIATRIC PRIMARY CARE

In specific circumstances where enrolled high-risk clients meet the income eligibility requirements for Medicaid, however, due to religious reasons, are unable to enroll in Medicaid services, HRFCM funds may be used to pay for Primary Care costs as outlined below, if noted in the Grant Agreement Special Conditions Exhibit and approved budget.

Agencies must complete the Pediatric Primary Care Determination Worksheet (available from the Department upon request) for pregnant individuals 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 current Federal Poverty 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 Local Agency may provide the following services:

1) prenatal healthcare office visits for enrolled clients
2) infants 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 enrolled clients who do not have a recorded EPSDT with their primary care physician
8) routine and medically indicated dental services for enrolled infants or pregnant individuals

It is expected that the provider will keep a monthly record of claims using the Primary Care Monthly Claim Form (available from the Department upon request). The Current Procedural Terminology (CPT) code and Reimbursement Rate should be commensurate with the current HFS Fee Schedule.

The claim form along with completed Determination Worksheets for any clients that claims are being processed for must be submitted to the DHS MCH Nurse Consultant. Once the claims have been approved the agency will complete the Primary Care Quarterly Summary Report (available from the Department upon request) 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.

1.3.10 INVENTORY MANAGEMENT

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 time frame of depreciation has not elapsed, the local agency must submit a request in writing, on agency letterhead, to the Department at DHS.BMCHEDF@illinois.gov which includes:
      (1) Item description
      (2) Date of purchase
      (3) Unit cost (if available)
      (4) Justification for disposal
      (5) Specification of which program(s) item is allocated to
      (6) Copied to Regional Nurse Consultant
      (7) Email Subject should read as follows: Agency Name – Disposal of Program Equipment
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.

1.3.11 LOCAL AGENCY ACCOUNTING PROCEDURES

A) Accounting System
   Each Local Agency participating in the HRFCM 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 evidence 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 including the Illinois Grant Accountability and Transparency Act (GATA) and Federal Uniform Guidance (2 CFR 200)

1.3.12 FINANCIAL DOCUMENTATION AND GRANT PAYMENTS

The method of payment to the HRFCM grant is by reimbursement of expenditures unless another method is requested and approved prior to reporting expenditures.

1) Local agencies will receive grant payments from the Department, reconciled based on submitted monthly documentation. Failure of the Provider to submit documentation may result in a reduction to the total award. All payments will be reconciled based on submitted documentation. Supporting documentation must be available to the Department upon request including, but not limited to:
    - Receipts from a vendor.
    - Invoices.
    - Electronic order confirmation from a vendor.
    - QuickBooks invoices.
    - Back-up documentation.
    - Monthly narratives.
2) Detailed instructions along with the Expenditure Documentation Form (EDF) are provided by the Department at the beginning of the contract period and are sent to the designated Program Administrator and Fiscal Contact.
3) Local agencies must adhere to the specified payment terms in their contract agreement.

1.3.13 PROGRAM AUDIT

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.

1.3.14 LOCAL AGENCY SANCTIONS / RECOVERIES

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.

1.3.15 CLOSEOUT REPORTING PROCEDURES

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

A. Administrative Records
   The following administrative records shall be maintained by the Local Agency for a period of three years, unless required for a longer period by local agency policy or state or federal legislation or rules:
   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 the DHS MIS, unless required for a longer period by local agency policy or state or federal legislation or rules.

1.4.2 DESTRUCTION OF RECORDS

A. Program records that contain client data must be destroyed by incineration or shredding.
B. Disposal of intact records 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

The agency shall adhere to all the guidelines set forth in Title II of the Health Insurance Portability and Accountability Act to ensure adequate level of security and privacy for confidentiality and safety of client's information.

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

A. Names and addresses individually or by list on any type of document or report
B. Information contained in reports of medical examinations and treatments
C. Information about financial resources
D. Information contained in registers, case records, correspondence, or any forms or notations obtained from or about the individual and family concerning their 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

The facility shall have space to assure privacy and dignity for the client during counseling, education, intake interviewing, and physical examinations.

All staff working in the HRFCM program must complete the Employee Confidentiality & Compliance Agreement for Programs, to assure that all information is treated with confidentiality. A copy of the form can be requested from the DHS MCH Nurse Consultant at any time.

1.5.2 CONSENT TO RELEASE INFORMATION

A. Agencies are expected to obtain signed consent or refusal of the following forms for all participants:
    a. Release of Information (ROI) form
    b. Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule form
    c. Management Information System Informed Consent Form
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 gestational parent or child for whom the client or guardian, on their behalf, has requested services. In these circumstances, the information may be released only 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
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

A. Local Agencies providing HRFCM services 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 DHS ADMINISTRATIVE AND PROGRAMMATIC REVIEW – EVALUATION AND MONITORING

All DHS grantees will be evaluated per the Department protocol to review the program's progress according to stated goals, measurable objectives, and administrative operations. The Department or it's designee will monitor the delivery of program activities through, but not limited to:

A. Communication with local agency which may include performance data, trending community concerns, staffing vacancies, caseload management, and/or facilitation of technical assistance (TA).
B. Scheduled and as-needed technical assistance at the discretion of the Department to recommend areas of improvement and discuss barriers to program service delivery
C. Scheduled programmatic clinical reviews, following the Department's protocol, including but not limited to documentation and observation of service delivery.
    i. The Department will notify provider of any findings of noncompliance in the programmatic clinical review.
    ii. When a review contains a finding of noncompliance, the Department must require local provider to submit a Corrective Action Plan (CAP), with timelines as indicated in writing to the provider.
    iii. The Department will monitor provider implementation of Corrective Action Plans and will notify the provider in writing once the CAP is resolved.
D. Failure to comply with Programmatic Reviews, technical assistance recommendations, or Corrective Action Plans may result in grant program suspension, termination, or submission of the grantee's record to the Illinois Stop Payment List Tracking System for review.

Review Tools will be provided to contracted agencies by the Department. These will be sent to the Local Agency Administrator and the Program Coordinator of each agency and can be requested from the MCH Nurse Consultant at any time.

1.7 CIVIL RIGHTS

1.7.1 NONDISCRIMINATION

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

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 Local Agency and the Department.
C. Specific conditions for grantee requesting grant termination or suspension may be considered by the Department.

1.8.2 STAFFING

A. Minimum staffing for the HRFCM program includes an RN Program Coordinator and at least one RN Case Manager FTE for every 50 families (dyads) to carry out the duties and responsibilities as outlined in 3.1.1 (see RN Case Manager) and 3.1.2 (see RN Program Coordinator)
B. Assistants, Frontline/Clerical/and multidisciplinary staff may be used for client contacts outside of the required RN components of the program as outlined in 3.1.3 (see Multidisciplinary and Support Staff)
C. Staffing for programs shall be reflective of the community/population being served, mirroring the cultural, ethnic, and linguistic characteristics of families served.
D. The agency shall ensure the duties assigned to staff are appropriate for job title and within the scope of their credentials.
E. Local agencies must report staff changes to the Bureau within 14 calendar days of vacancy,

leave of absence, or new hire.

F. Local agencies shall fill any staff vacancies without delay and notify the Bureau of recruitment and hiring plan including anticipated timeline.
G. Standards for each project shall meet state and local licensing laws and regulations and be in accord with national and state standards.
H. Arrangements for staffing and provision of services must be made in advance of implementing the program.
I. To ensure security of the Department's MIS, all new users must be approved by the Department before a user ID will be issued. Requests will be processed after:
    a. The new staff member is entered into the MIS
    b. The Regional Nurse Consultant has confirmed the new staff with the Program Designee which can be done by emailing the name, job title, and start date.

1.8.3 PROFFESIONAL DEVELOPMENT AND TRAINING

Program staff are encouraged to attend and participate in appropriate educational programs, trainings, and professional organizations to enhance professional development and promote best practices for culturally sensitive, clinically competent, and respectful services.

RN Case Managers and RN Coordinators are expected to attend required in-person BMCH Combined Training offered by the Department within six months of working in the HRFCM program. The BMCH Combined Training requires on-site attendance in either Springfield or Chicago. Costs associated with travel, per diem, and lodging are approved grant expenditures when included on the approved budget.

RN Coordinators are expected to attend required virtual RN Coordinator Training offered by the Department within six months of working in the HRFCM program.

Implicit Bias training is required within six months of working in the program with refresher courses required during each new fiscal year. The agency may select any option listed in the I PROMOTE-IL Implicit Bias Training Inventory and should document name of training received and the date the training was completed. A log for implicit bias training should be maintained by the local agency for all staff working in the HRFCM program. The training logs must be made available to the DHS MCH Regional Nurse Consultant upon request.

Repeat trainings may be required at the discretion of the Department as part of technical assistance recommendations or Corrective Action Plans when performance indicates a need to review programmatic requirements.

The Department may offer additional required training topics not listed above when indicated (for example: clinical training on best practices or protocols regarding emerging public health concerns).

The Department will offer optional trainings throughout the fiscal year and registration information will be provided. Trainings offered by the Department have no registration fee and Continuing Education Units (CEUs) are often provided.

1.8.4 UTILIZATION OF COMMUNITY RESOURCES

It shall be the responsibility of each agency to coordinate and document 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. Health Departments
C. Neighborhood Health Centers
D. Child Development Clinics
E. Division of Specialized Care for Children
F. Hospitals
G. Children and Family Services Programs
H. Schools
I. Vocational Rehabilitation Services
J. Regional Perinatal Centers
K. Early Intervention Programs for Infants and Toddlers with Disabilities
L. Mental health therapy and/or perinatal bereavement support groups
M. Other related social service agencies

1.8.5 AGENCY POLICY & PROCEDURES AND QUALITY ASSURANCE

All local agencies providing HRFCM services are expected to maintain an internal agency policy & procedure manual that aligns with DHS Policy & Procedures and Grant Agreement guidelines.

The local agency shall develop, implement, annually review, and maintain written local agency policy and procedures such as:

- Providing appropriate referral information for connecting families to other available services not provided at the local agency
- Remaining in compliance with HIPAA, Release of Information, and MIS data entry
- Responsibilities and interventions required of each staff role in the event of abnormal values, assessment findings, and health concerns including but not limited to expediting emergency pre-hospital or hospital care, assisting family to contact primary care provider, contacting primary care provider on client's behalf, or increasing frequency of follow-up visits with client and/or repeat assessments. Agencies with a Medical Director must maintain physician standing orders for abnormal findings including but not limited to maternal physical assessment, maternal hypertension, maternal pregnancy warning signs, postpartum warning signs, perinatal depression screen, infant developmental screen, infant physical assessment, anthropometrics/growth
- Outreach to ensure high-risk families in community are reached to obtain minimum monthly caseload expectations

- Addressing when caseload exceeds maximum service capacity
- Maintaining continuity of services to families in the event of vacancies, extended leave of absences, or caseload capacity. This may include transferring to another agency if client agrees.

Local Agencies are encouraged to utilize data collected internally to drive and support continuous quality improvement.

1.9 MANAGEMENT INFORMATION SYSTEM (MIS)

The Bureau's HRFCM program requires service providers to use the Bureau's designated Data Management Information System (MIS). Required training and technical assistance will be provided to funded programs to support best practices in program delivery, data collection, and reporting.

All HRFCM staff must follow the MIS User Manual expectations for entering and utilizing data to ensure proper service delivery. The Department will provide a MIS Guide List specific to the MIS system codes, screen, and description used.

All new users must be approved by IDHS before a user ID will be issued.

All staff must follow documentation requirements of each contact with the family as outlined in the required training program offered by the Department as noted in 1.8.3 (see Professional Development and Training). The MIS User Manual may be referenced for step-by-step instruction and examples of specific documentation screens and reports. However, the Department recommends requesting 1:1 technical assistance from the DHS MCH Regional Nurse Consultant to ensure documentation requirements specific to the HRFCM program are being met in the MIS.

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

1.9.1 MANAGEMENT CONTROLS

Each local agency 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 HRFCM program staff complete MIS security training prior to being granted system access and on an annual basis
C. Ensure that State owned equipment and resources are secure, and that equipment is accounted for by conducting an annual review of inventory
D. Conduct, at minimum, annual audits of active IDs in the MIS 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

A. Personal Information Protection (see 815 ILCS 530): 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

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 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

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

1.9.5 SYSTEM DISRUPTIONS

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 by contacting the DHS MCH Nurse Consultant
    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.
C. In the event of a major disruption such as a natural disaster or public health emergency, the

Department will issue alternative guidance for program operations.

1.9.6 INCIDENT REPORTING

All actual or suspected instances of information asset misuse, theft, or abuse, as well as potential threats (e.g., hackers, computer viruses, etc.) 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 equipment used for grant activities, 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 written report of the incident that includes the type of breach, the individual responsible for the breach, and that individual's MIS 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

HRFCM staff who manage, operate, program, maintain, or use the Department's MIS should be aware of their security responsibilities.

A. Security training must be completed by system users prior to users initially accessing the system.
B. Completion of annual security training is required for continued access to the system.
C. Security training is designed to help system users become familiar with using the Department's MIS 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 the Department and authorized user access is dependent on successful completion of the course.

1.9.8 MIS ANNUAL ACCESS REPORT RECONCILIATION

To comply with state policies local agencies are expected to monitor the Department's MIS Active Employee report annually, at minimum, to ensure only those staff currently working for the agency have MIS access and are assigned to only those programs in which they currently work.

The Bureau will send each Local Agency the Active Employee Report twice per year.

Local agencies are responsible for:

1. Ensuring only active staff currently working for the agency are on the report
2. Terminating any staff appearing on the report that are not current employees
3. Correcting program access for staff who have changed positions

The following steps should be taken once agencies have received the Active Employee Report from the Bureau.

1. Does the staff person work for the agency?

Answer:	Action Step:
Yes	Move on to step 2.
No	a) In the Employee Information Screen, terminate any staff appearing on the report that are not current employees. b) Document by writing on the Active Employee report any terminations that were made.

2. Is the staff person assigned to the correct program(s)?

Answer:	Action Step:
Yes	Move on to step 3
No	a) In the 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 Active Employee Report any changes that were made.

3) Sign and Date the Active Employee Report & return by email to your DHS Registered Nurse Consultant. If you need your Consultant's contact details, please email DHS.BMCHEDF@illinois.gov.

2 SERVICE COORDINATION

2.1 MULTIPLE PROGRAM SERVICE COORDINATION

Department grantees providing HRFCM services should engage in activities (as described below) to coordinate with other agencies in the grantee's service area that provide similar services to the same population as the grantee has agreed to serve (WIC, Early Childhood Home Visiting, Hospital-Provided Case Management, Nurse Home Visiting, etc.). This coordination is intended to avoid duplication of

services at the local level and ensure that each client has only one lead RN case manager at any given time.

A. The HRFCM agency should ensure that every family enrolled in the HRFCM program continues to utilize primary medical care, regardless of the primary case management agency working with the family.
B. Agencies providing DHS HRFCM services should enter into written agreements with other agencies with the same geographic service area (in whole or in part) who offer similar social or health services to the same population. These agreements must specify, at minimum, 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(ies) most appropriate to provide services to meet the needs of the family.
C. Following the assessment of a client enrolled in multiple programs, the RN Case Manager, RN Program Coordinator, other involved social service or health Agency staff, 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 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. The factors used to determine if services from multiple programs are indicated should include:
    a. the participant's most important problem requires expertise that the agency's staff does not possess; and
    b. the participant's most important problem requires expertise that another agency's staff does possess; and
    c. the participant's problems are so complex as to require the close collaboration of several agencies for the family to successfully meet their health goals and the family requests to be enrolled in multiple programs and understands the services offered at each.

2.2 CLIENT TRANSFER POLICY

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 families, and each family 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.

Before activating any client, it is imperative that the client meets the eligibility criteria and a lookup in the MIS has been completed of the birthing parent, siblings, and infant name to determine if the family is already enrolled at another agency.

If a referral has been received and an MIS lookup has identified that the birthing parent, any sibling, or the infant is already active at an agency, the HRFCM agency performing the lookup should not reach

out to that family and the family should continue to receive services at the agency in which they are already active.

A) 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 family's most important problem requires expertise that the grantee's staff does not possess, and the receiving agency has capacity to provide services outside of their usual service area
    b) the family's most important problem requires expertise that another agency's staff does possess, and the receiving agency has capacity to provide the service outside of their usual service area
    c) the family has moved into the receiving agency's service area; or
    d) the family prefers to obtain HRFCM services from another agency and the receiving agency has capacity to provide the service outside of their usual service area
        i. If a parent requests to transfer their family to another agency, the agency should have a conversation with the client emphasizing the importance of continuity of care. If the client still requests to change agencies, the sending agency should verify with the receiving agency that they have the capacity to provide service to the client outside of their usual service area. A detailed Case Note should be documented in the MIS.

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 the MIS. A detailed Case Note should be documented in the MIS.

To ensure continuity of care, the birthing parent and infant should be enrolled at the same agency and have the same assigned RN Case Manager as each other, unless:

a. The birthing parent and infant are not part of the same family (gestational surrogate, adoption, etc.)

b. The birthing parent does not have a relationship with the infant and the infant has a primary caregiver/guardian who is not the birthing parent

c. The birthing parent and infant live in 2 separate service areas

d. The birthing parent requests that the infant be assigned a separate case manager from the birthing parent

3 HIGH RISK FAMILY CASE MANAGEMENT PROGRAM

3.1 STAFFING QUALIFICATIONS

Staffing recruitment, hiring, and retention shall mirror the cultural, ethnic, and linguistic

characteristics of families served. Agencies shall ensure the duties assigned to staff are appropriate for the job title and within the scope of their credentials.

Minimum direct service staffing to complete the required program deliverables includes:

1. RN Case Manager (one Full Time Equivalent per 50 families)
2. RN Program Coordinator

In many agencies, staffing may be combined, whereas the RN Program Coordinator also provides direct service in alignment with caseload and agency needs.

Optional additional support staffing includes:

1. Frontline/Clerical staff
2. Interpreter staff
3. Multi-disciplinary staff

3.1.1 RN CASE MANAGER

The RN Case Manager must meet one of the following qualifications:

A. A Registered Nurse (RN) with an unencumbered license pursuant to the Nurse Practice Act [225 ILCS 65]

B. An Advanced Practice Registered Nurse (APRN) with an unencumbered license pursuant to the Nurse Practice Act [225 ILCS 65]

RN/APRN to family ratio should not exceed 50 families per one RN/APRN Full Time Equivalent (FTE). The RN Case Manager is responsible for completing the required nurse visits as outlined in the Uniform Grant Agreement.

Nursing assessment and intervention shall be in accordance with national and state standards and best practices.

3.1.2 RN PROGRAM COORDINATOR

The HRFCM Program Coordinator must meet one of the following qualifications:

A. A Registered Nurse (RN) with an unencumbered license pursuant to the Nurse Practice Act [225 ILCS 65]

B. An Advanced Practice Registered Nurse (APRN) with an unencumbered license pursuant to the Nurse Practice Act [225 ILCS 65]

The HRFCM 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 HRFCM staff by ensuring that staff at all levels are competent to complete job specific duties when providing HRFCM services.
    a. Determine staff training needs and coordinate education opportunities.
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 HRFCM Program
    b. Participating in State and Regional MCH conference calls and meetings
    c. Communicating to staff HRFCM Program updates and reinforcement of program requirements
C. Conduct Quality Assurance activities and monitor the following areas and identify improvement needs.
    a. Daily Clinical Operations
    b. Reports
    c. HRFCM Program Curriculum
    d. Local Agency Policy & Procedure
D. Attend professional conferences, seminars, workshops to update staff on current MCH practices and other information relevant to MCH.
E. Identify and collaborate with Local Agencies and other community partners.
F. Manage assigned caseload per IDHS Grant Agreement.
G. Maintain oversight controls and records.
H. Ensure employee compliance and program integrity.
I. Coordinate with the agency Security Coordinator to ensure continuity of operations. (See 1.9 Management Information Systems)

3.1.3 MULTI-DISCIPLINARY SUPPORT STAFF

Agencies are encouraged to use a multi-disciplinary approach for client contacts above and beyond the required nurse contacts, including but not limited to Licensed Clinical Professional Counselor, Licensed Professional Counselor, Licensed Practical Nurses, Licensed Clinical Social Workers, Clinical Social Worker, Licensed Dieticians, Certified Nursing Assistants, Nursing Assistant, Medical Assistant, Case Management Assistant, Paraprofessional, or Community Health Worker.

Agencies must ensure duties assigned to staff are appropriate for job title and within the scope of their credentials. Appropriate multi-disciplinary activities outside of the required nurse visits, when in the scope of credentials, may include but are not limited to:

A. Assisting the nurse with intake/anthropometrics or vital signs
B. Follow-up with clients to ensure that participants are accessing needed services after initial referral
C. Provide interpreter services
D. Provision of support and assistance that clients may require outside of the required nurse visits (counseling, education, etc.)
E. Conducting outreach activities
F. Maintaining client files and clinic schedule

G. Scheduling of appointments and follow-up on missed and/or appointments
H. Managing client correspondence

3.2 ELIGIBILITY

Eligibility for HRFCM services is defined as a family/dyad or individual meeting all of the following:

1. Pregnant or postpartum individual up to 12 months after birth and/or infant up to 12 months after birth; and
2. Household income less than 200% Federal Poverty Level (FPL); and
3. The presence of at least one risk factor as noted on the Vulnerability Index (see Appendix 5.1 Vulnerability Index).

3.3 PROGRAM CONTENT

3.3.1 EQUITY

The Department is working to counteract systemic racism and inequity, and to prioritize and maximize diversity throughout its service provision process. This work involves addressing existing institutionalized inequities, aiming to create transformation, and operationalizing equity and racial justice. It also focuses on the creation of a culture of inclusivity for all regardless of race, gender, religion, sexual orientation, or ability.

To eliminate barriers to client transportation and decrease risk of communicable diseases in the high-risk-r population, nurse visits are expected to occur exclusively in the home setting for the duration of pregnancy and the first three months after birth as described below (see Frequency)

3.3.2 FREQUENCY AND LOCATION

The assigned HRFCM RN Case Manager must provide face to face contact with the family as specified below.

1. Throughout the duration of pregnancy and throughout the first three months after birth: families must receive a monthly nurse home visit
2. Throughout the fourth through twelfth month after birth, or for the duration of time in the program: families must receive a monthly nurse face to face contact (in the clinic or home setting)

As much additional contact as necessary may be provided by the RN or by the multidisciplinary team

per the nurse's discretion, to assist the family in meeting their health goals.

3.3.3 NURSE ASSESSMENT OF THE HIGH-RISK FAMILY

It is expected that agencies will provide the following services as measured through MIS documentation review, reports, and/or and through DHS MCH Nurse Consultant observation of services. Initial phone contact should occur within 7 days of receiving referral. The initial home visit should be completed within 14 days of program enrollment and may be completed sooner when clinically indicated.

Initial Nurse visit for the high-risk family should include, but not be limited to:

1. Review known risk factors from the vulnerability index, referral/intake information and gather resources in anticipation of the visit with the family.
2. Obtain the family's desired goals for health and wellness
3. Assess current and relevant past concerns
    a. Obtain reproductive/pregnancy health history
    b. Obtain medical/surgical history
    c. Obtain psychosocial history
    d. Current prescription and over-the-counter medications or supplements
4. Assess current and relevant past psychosocial concerns & barriers to health goals. Provide referrals and assist with linkage if indicated
    a. Intimate partner violence
    b. Mental health concerns
    c. Substance use, alcohol, tobacco, marijuana
    d. Social determinants of health & barriers (transportation, financial, nutrition, etc.)
5. Assess current and relevant past health promotion or protective factors. Provide referrals and assist with linkage if indicated
    a. Immunizations
    b. Prenatal care
    c. Primary medical home
    d. Specialists
    e. Dental care
    f. Psychosocial support system
6. Complete head to toe physical assessment including vital signs, height, weight, and head circumference (infants). Provide referrals and assist with linkage if indicated.
    a. If pregnant: include pregnancy warning signs and fetal movement
    b. If postpartum: include postpartum warning signs and surgical wounds or tears and reproductive well being
    c. If infant: include developmental/growth and nutritional status
7. Utilize motivational interviewing style of communication to discuss diagnoses or risk-specific education in alignment with family's desired goals
8. For any abnormal findings or complications, provide interventions as needed
9. Collaborate with family to identify and mitigate barriers to accessing desired supports and services.

10. Provide health and diagnoses-specific education as recommended in the High-Risk Family Case Management Curriculum

Follow-up monthly nurse visits for the high-risk family should include, but not be limited to:

1. Assess for any new or ongoing risk factors
2. Review the family's desired goals for health and wellness including any new goals & follow-up on progress of prior goals
    a. Assess for any new health concerns & follow-up on progress of resolving prior concerns
    b. Obtain any new diagnoses, complications or conditions, updated pregnancy or delivery information
    c. Obtain any medication changes or updates
3. Assess for any new psychosocial concerns & new barriers to health goals & follow-up on progress of referrals and/or ongoing treatment
    a. Intimate partner violence
    b. Mental health concerns
    c. Substance use, alcohol, tobacco, marijuana
    d. Social determinants of health & barriers (transportation, financial, nutrition, etc.)
4. Assess for new health promotion or protective factors & follow-up on progress of referrals and/or ongoing treatment
    a. Immunization updates
    b. Prenatal care
    c. Primary medical home
    d. Specialists
    e. Dental care
    f. Psychosocial support system
5. Head to toe physical assessment with vital signs, height, weight, and head circumference (infants). Follow-up on progress of referrals and/or ongoing treatment
    a. If pregnant: include pregnancy warning signs and fetal movement
    b. If postpartum, include postpartum warning signs
    c. If infant, include developmental, nutritional status, and sleep environment
6. For any abnormal findings or complications, provide interventions as needed
7. Collaborate with family to identify and mitigate barriers to accessing desired supports and services
8. Provide health and diagnoses-specific education as recommended in the High-Risk Family Case Management Curriculum

3.3.6 REFERRAL AND ADVOCACY

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 plan of care. Documentation should include reason for referral, client acceptance/decline, and follow-up to ensure closed-loop referrals. Coordination of care by both agencies is expected to occur when indicated.

3.4 CASE CLOSURE

Case closure should occur when:

A. The family no longer meets eligibility criteria

B. The family demonstrates adequate support through other programs or means and/or reports self-sufficiency to meet their desired health goals for their family

C. The family requests to no longer receive HRFCM services as outlined in this manual

D. The client moves out of the grantee's service area (if the client leaves the service area for more than 30 days regardless of reason)

E. Both members of the dyad are deceased

F. The local agency is no longer able to reach the client (with documented contact attempts within 30 days)

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/family has located a medical care provider for continued care for themself and their children

B. The client/family is referred for family planning services

C. The client/family is referred for WIC

D. The children have begun or been referred for immunizations (if these are not contraindicated or declined by the parent)

E. The client/family has completed an application for Medicaid, SNAP, and TANF

F. The client has been given information regarding child safety seats and infant safe sleep

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.

4 ADVERSE PREGNANCY OUTCOMES REPORTING SYSTEM (APORS)

4.1 APORS DESIGNATION PROCESS

Adverse Pregnancy Outcome Reporting System (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 for referral to the HRFCM Program per the IDPH APORS Case Definition Chart (available from IDPH or IDHS MCH Nurse Consultant) then the case does not meet eligibility criteria for referral to HRFCM.
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 through the IDPH APORS referral portal.

If further assistance is needed with APORS Referrals, please contact the APORS IDPH Manager at DPH.APORS@illinois.gov.

4.2 PROCEDURE TO CHANGE HRIF DESIGNATION TO APORS

For an infant without a receipt of an APORS referral with a known diagnoses meeting referral criteria, 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 (available from IDPH or IDHS MCH Nurse Consultant) to verify that the child meets the APORS case definition for referral to the DHS HRFCM program. Do not add “Y” (yes) APORS on the MIS Birth Data screen until an APORS report is received. If an infant has a high-risk condition that is not reportable to APORS but is listed on the HRFCM Vulnerability Index, the infant may be provided HRFCM services. Do NOT add “Y” (yes) to the APORS question on the MIS Birth Screen; it remains “N” (No).

4.3 CONTACT

All APORS referred families who accept services should be enrolled in HRFCM Program. (See 3 – High Risk Family Case Management Program)

5 APPENDIX

5.1 HRFCM VULNERABILITY INDEX

IDHS High Risk Family Case Management Program - Vulnerability Index

Eligibility for HRFCM services is defined as a family/dyad or individual meeting all of the following:

1. Pregnant or postpartum individual up to 12 months after birth and/or infant up to 12 months after birth
2. Household income less than 200% Federal Poverty Level (FPL)
3. The presence of at least one risk factor as noted on the Vulnerability Index below

Elevated Risk due to Previous or Current Poor Birth Outcome(s):

- Fetal or Infant Loss (20 weeks +0 days or greater)
- Premature Birth (36 weeks + 6 days or less)
- Low birth weight (less than 5 lbs. 8 oz. or 2500 grams)

Elevated Risk due to High-Risk Medical Diagnosis(es) or Social Condition(s) of Birthing Person:

- Self-reported use of tobacco, marijuana, opioids, benzodiazepines, barbiturates, cocaine, alcohol, (current or within past six months)
- Positive toxicology screen (current or within past six months)
- Currently on Medication Assisted Treatment (MAT) for Opioid Use Disorder
- Pre-pregnancy BMI < 18.5 or $\geq$ 40
- Age <15 or >45 years
- Sickle Cell Disease (excluding SC trait/carrier)
- Placenta Previa/Accreta/Percreta
- Ante/Peri/Postpartum Hemorrhage Requiring Blood Transfusion
- Cardiomyopathy
- Pulmonary Embolism
- Deep Vein Thrombosis
- Hypertension (any type diagnosed by medical provider)
- Preeclampsia/Eclampsia most recent pregnancy
- Current abusive relationship/intimate partner violence
- Frequent unscheduled visits to L&D/triage/ER/Urgent Care (greater than two in past six months)
- Frequent unscheduled hospital admissions (greater than 2 in past twelve months)
- Diabetes (any type diagnosed by medical provider)
- Mental Health diagnosis by medical provider requiring medication
- Less than 12 months since last delivery/birth
- Currently Homeless or at risk of homelessness within next 3 months
- DCFS involvement (current or within 1 year)
- Involved parent incarcerated, on parole or probation
- Active, untreated Sexually Transmitted Illnesses

Elevated Risk due to High-Risk Medical Diagnosis(es) or Social Condition(s) of Infant:

- Cardiac defects
- Kidney/renal/urinary abnormality
- Neonatal abstinence syndrome (symptoms of withdrawal present)
- Gastrointestinal abnormality
- Orthopedic abnormality
- Brain/Central Nervous System abnormality
- Feeding abnormality (tracheoesophageal fistula or atresia, cleft palate, cleft lip, tube feedings required after hospital discharge)
- Growth abnormality (SGA, IUGR, Failure to Thrive)
- Hepatitis B or C exposure
- Multiple gestation (triplets or greater)
- Caregiver with diagnosis of developmental delays
- Cytomegalovirus infection
- Metabolic disorders
- Ventilator dependence after hospital discharge
- Seizure disorder
- Blood disorders/coagulopathy/anemia