ILLINOIS DEPARTMENT OF PUBLIC HEALTH

IDPH

PROTECTING HEALTH, IMPROVING LIVES

Illinois Title V Overview, CYSHCN & Priorities (2021-2025)

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National Title V Overview

- Created in 1935; Title V of Social Security Act
- Focuses on improving the health and well-being of the nation's mothers, infants, children (including those with special needs), and their families
- Administered by the Health Resources and Services Administration (HRSA)
- 59 states and jurisdictions receive funding

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Taking a Look at Illinois

Who we serve

- 12.8 million people *(6th largest state population)*
- 2.6 million reproductive-aged women (15 to 44 years)
- 3 million children
- 155,000 hospital births in 2014

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Illinois Title V Funding & Structure

- $21 million annually
- Administered by → IDPH Office of Women's Health and Family Services, Division of Maternal, Child, and Family Health Services
- CYSHCN Sub-award → UIC-Division of Specialized Care for Children (specified in the state legislature)
- Chicago Department of Public Health (CDPH) MCH Mini-grant → localized version of the Title V Block Grant in Chicago.

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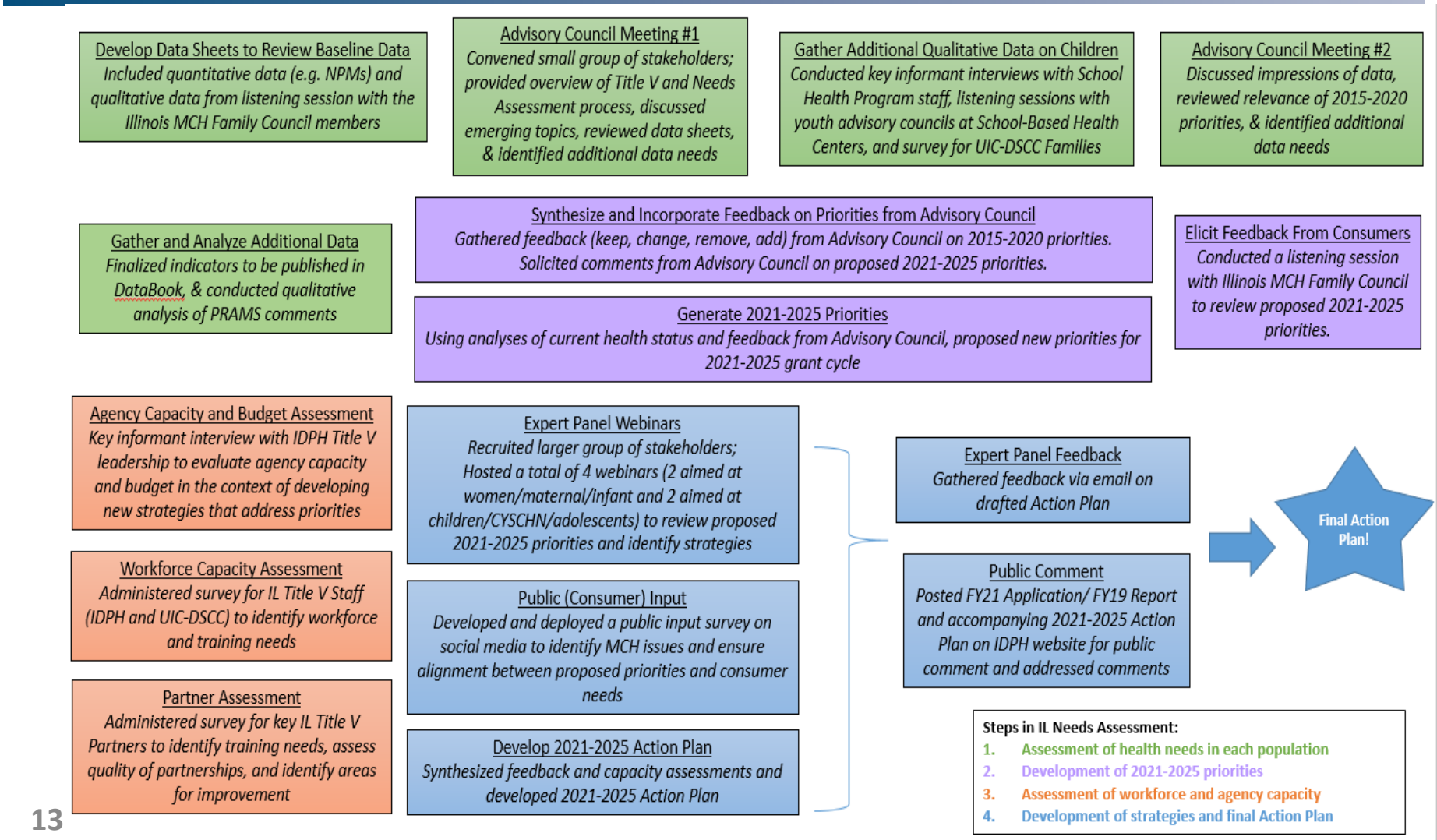
Overview - IL Title V Needs Assessment



Illinois Priorities - FY 2021-2025

#1: Assure accessibility, availability, and quality of preventive and primary care for all women, particularly for women of reproductive age. *Repeat*	#2: Promote a comprehensive, cohesive, and informed system of care for all women to have a healthy pregnancy, labor and delivery, and first year postpartum. *New*	#3: Support healthy pregnancies to improve birth and infant outcomes. *Repeat*	#4: Strengthen families and communities to assure safe and healthy environments for children of all ages and enhance their abilities to live, play, learn, and grow. *New*	#5: Assure access to a system of care that is youth-friendly and youth-responsive to assist adolescents in learning and adopting healthy behaviors. *Revised*
#6: Strengthen transition planning and services for children and youth with special health care needs. *Revised*	#7: Convene and collaborate with community-based organizations to improve and expand services and supports serving children and youth with special health care needs. *New*	#8: Strengthen workforce capacity and infrastructure to screen for, assess, and treat mental health conditions and substance use disorders. *Repeat*	#9: Support an intergenerational and life course approach to oral health promotion and prevention. *New*	#10: Strengthen the MCH epidemiology capacity data systems. *Revised*

Domain: Women/Maternal, Perinatal/Infant, Child Health, Adolescent, CYSHCN, Cross-Cutting

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Types of Strategies

- Convene a Taskforce
- Develop and Disseminate Best Practices
- Partner with other Organizations to Develop Plans/Processes
- Produce Data Reports
- Provide Education/Information
- Monitor health status/monitor interventions to address health status concern
- Support other Organizations through Technical Assistance

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Title V Priorities (2021-2025)

#6: Strengthen transition planning and services for children and youth with special health care needs.

Revised

#7: Convene and collaborate with community-based organizations to improve and expand services and supports serving children and youth with special health care needs.

New

CYSHCN

Each priority must have at least one:

- Evidence-based program or strategy
- Mechanism for routine feedback from consumers, families and communities to guide decision-making and program planning
- Publication annually on TBD topic or Title V program
- Program or strategy that is applying a health equity framework

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Domain: CYSHCN

Proposed Action Plan

#6: Strengthen transition planning and services for children and youth with special health care needs.

Revised

A. Develop and implement a youth transition council.

B. Promote public education on transition services through use of social media and outreach presentations at community organizations.

C. Implement a transition curriculum for youth and caregivers; and improve linkage to online guardian resources.

D. Partner with health care providers to educate and support practice initiatives focused on preparation for transition to adulthood, including providing technical assistance to practices on using the 6 Core Elements of Transition 3.0 Toolkit for Providers, and developing youth-focused educational resources for provider practices.

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Domain: CYSHCN

Proposed Action Plan

#6: Strengthen transition planning and services for children and youth with special health care needs.

Revised

E. Partner with state Medicaid agency, Medicaid Managed Care Organizations, Medicaid waiver operation programs, and/or private insurance providers to provide education and recommendations on practices pertaining to preparation for transition to adulthood.

F. Co-sponsor the annual state Transition Conference and ensure the participation of UIC-DSCC youth and families in the conference and in conference planning.

G. Assist medically eligible CYSHCN, their families, and their providers with the transition to adult health care. Ensure person-centered transition goals are included in plans of care for participants between the ages of 12 and 21.

H. Continue participation in the Big 5 CYCHSC State Collaborative that seeks to identify and adopt common population health approaches for CYSHCN for all state participants.

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Domain: CYSHCN

Proposed Action Plan

#7: Convene and collaborate with community-based organizations to improve and expand services and supports serving children and youth with special health care needs.

New

A. Partner with sister agencies, community organizations, and provider practices to address systemic issues and challenges impacting CYSHCN, and to develop a report with recommendations.

B. Expand UIC-DSCC Family Advisory Council to include participation from families of CYSHCN who may not be enrolled in one of DSCC's care coordination programs.

C. Collaborate with the state's Medicaid agency to develop strategies to improve home nursing coverage and address financial challenges for medically fragile children and youth in Illinois.

D. Continue to support the Advanced Practice Nurse (APN) fellowship for developmental pediatrics.

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Domain: CYSHCN

Proposed Action Plan

#7: Convene and collaborate with community-based organizations to improve and expand services and supports serving children and youth with special health care needs.

New

E. Promote educational resources available through DSCC's online library to parents and caregivers of CYSHCN.

F. Collaborate with Illinois Chapter of American Academy of Pediatrics (ICAAP) and other provider groups to improve education, awareness, and usage of medical home best practices in Illinois.

G. Develop informational sheets with facts on impact of social determinants on the health of CYSHCN to be shared with others (e.g., policymakers) and available online.

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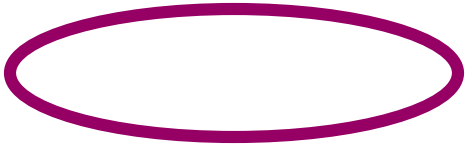
THOUGHTS…

REACTIONS…

QUESTIONS?

IL Title V posted its Title V FY21 Application/FY19 Annual Report and Action Plan are available for Public Comment until Friday, September 4th.

Please visit:
http://dph.illinois.gov/topics-services/life-stages-populations/maternal-child-family-health-services



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Division of Specialized Care for Children

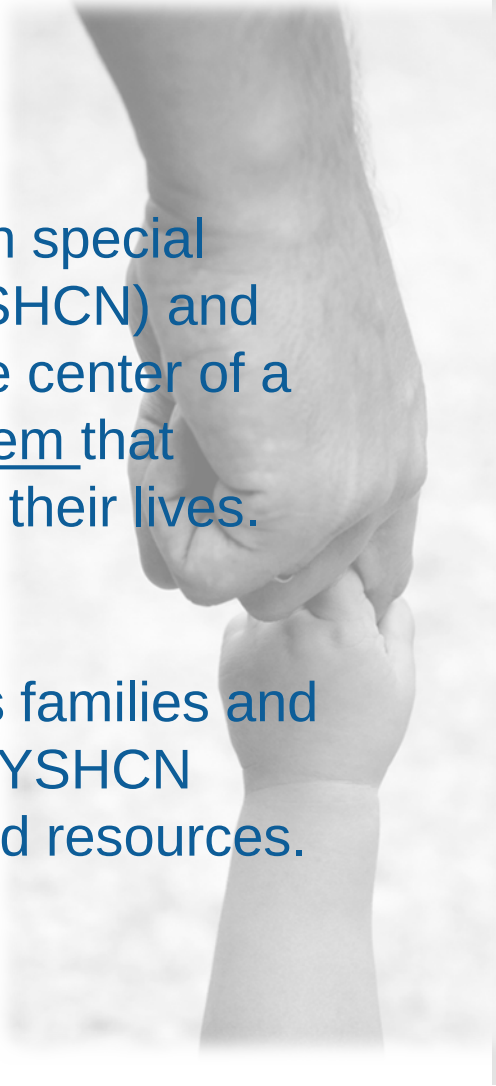
Our Vision and Mission

Vision

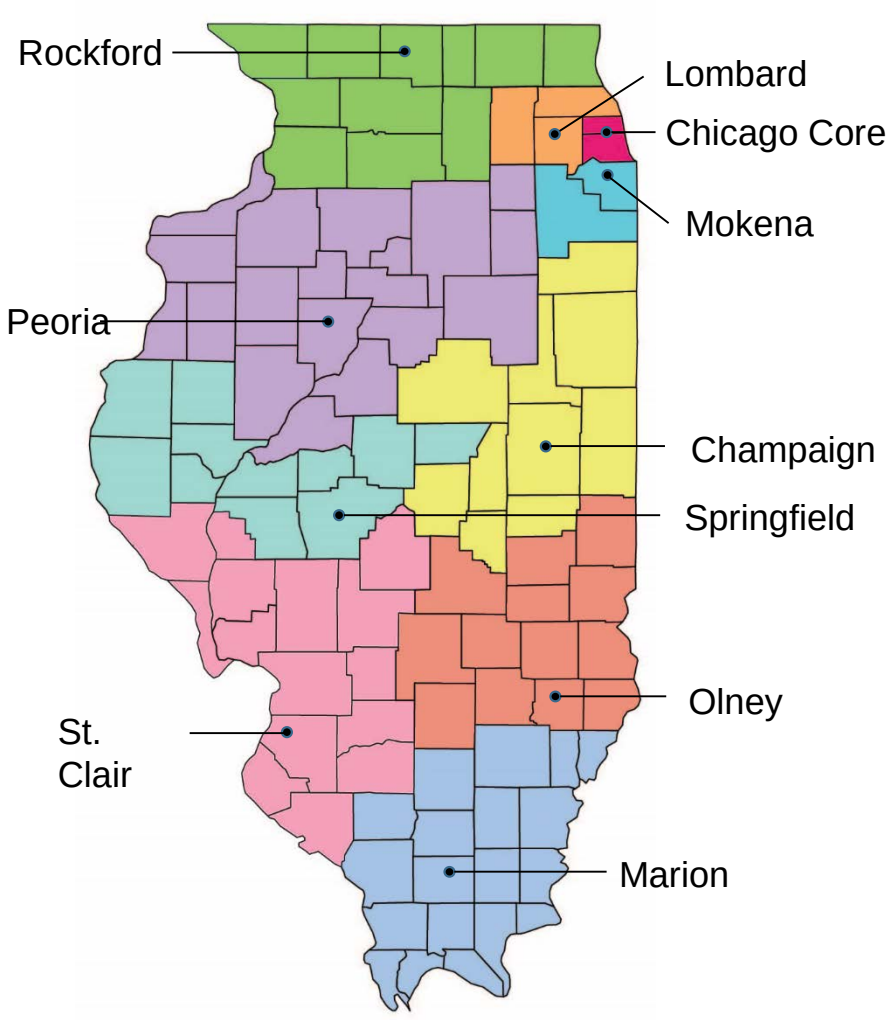
- Children and youth with special healthcare needs (CYSHCN) and their families will be the center of a seamless support system that improves the quality of their lives.

Mission

- We partner with Illinois families and communities to help CYSHCN connect to services and resources.



Core Regional Office Map



Care Coordination

We define care coordination as a **person- and family-centered**, **strength-based**, **assessment-driven** approach of empowering families to achieve their goals, ultimately leading to positive health outcomes, improved quality of life and overall family satisfaction.

DSCC Care Coordination efforts focus on partnering with families and communities to help children with special healthcare needs connect to services and resources they need.

Care Coordination

- Our care coordination is tailored to each child and family.
- Care coordination teams can include:
  - Registered nurses
  - Social workers
  - Speech-language pathologists
  - Audiologists
  - Respiratory therapists
  - Health insurance specialists

How Care Coordination Helps

- Access diagnostic tests
- Find specialized medical care
- Help families maximize insurance & understand coverage/benefits
- Coordinate services among providers
- Develop a care plan focused on a family's strengths & goals
- Attend school meetings
- Prepare for the transition to adulthood

How Care Coordination Helps

- Communicate with doctors & specialists
- Explain medical treatment plans
- Assist with transportation for medical appointments
- Connect families for parent-to-parent support
- Locate community resources
- Pay for eligible medical expenses when income guidelines are met

Who We Serve

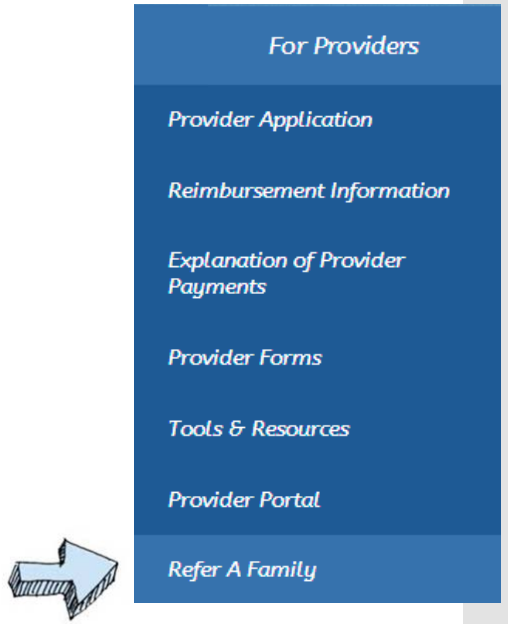
- DSCC provides care coordination services through three programs:
  - **Core Program** – Ages birth to 21 with medically eligible conditions.
  - **Connect Care Program** – Ages birth to 21 with special healthcare needs who are enrolled in a Medicaid Health*Choice* Illinois plan that has contracted with DSCC for care coordination.
  - **Home Care Program** – Child or youth in need of in-home shift nursing.

We're Here to Help

- Care coordination is free for all DSCC participants, regardless of a family's income.
- If a child's condition isn't listed in our eligible categories, we still can help.
  - Many children have associated conditions with their diagnosis that may be eligible.
  - Our staff is always ready to assist with referrals and resources.

Applications & Referrals

- Call us at (800) 322-3722
  - Caregiver's name
  - Phone number
  - Child's address
  - County or zip code
- Visit our website
  - Download PDF application
  - Fill out "Refer a Family" form
- Find a local regional office
  - https://dscc.uic.edu/find-an-office



Connect with Us

-  (800) 322-3722
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dscc.uic.edu
-  UIC Specialized Care for Children