STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

FOLLOW-UP REPORT

DEPARTMENT OF HUMAN SERVICES' EARLY INTERVENTION PROGRAM

APRIL 2002

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WILLIAM G. HOLLAND

To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

This is our Follow-up Report of the Department of Human Services' Early Intervention Program.

The audit was conducted pursuant to Public Act 92-307, which became effective on August 9, 2001. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
April 2002

REPORT DIGEST

FOLLOW-UP REPORT

DEPARTMENT OF HUMAN SERVICES' EARLY INTERVENTION PROGRAM

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State of Illinois
Office of the Auditor General

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SYNOPSIS

Public Act 92-307 directed the Office of the Auditor General to conduct a follow-up to its 1993 evaluation of the Early Intervention (EI) Program. A separate audit of the Department of Human Services' (DHS) EI Program, directed by Legislative Audit Commission Resolution Number 122, will be released in the summer of 2002.

Significant changes have been made to the operation of the EI Program since our 1993 audit, including establishing a statewide system of Child and Family Connections offices (CFCs) for intake and service coordination responsibilities, establishing a Central Billing Office, and implementing a fee-for-service payment system. These changes have resulted in Program improvements since our 1993 audit. There remain, however, areas where further improvements are warranted.

- **Child Find and Public Awareness:** The percentage of children participating in the EI Program has increased in recent years; however, rates of participation varied across the State. Additional outreach and public awareness efforts are necessary.
- **Availability of Providers:** In response to our survey, CFCs reported shortages of some types of EI providers; however, monthly reports filed by CFCs with DHS listed few children not receiving services due to the lack of providers. Also, the number of EI providers has increased.
- **Children Delayed in Receiving Services:** As of October 31, 2001, CFCs reported 1,196 children who were delayed in receiving services. Many of these children did not have an Individualized Family Service Plan (IFSP) prepared within the required 45 days. Family delays, such as parents not responding to inquiries, were reported as the primary reason for the delay in 52 percent of the cases.
- **Service Coordinator Caseloads:** Service coordinators' caseloads varied widely among CFCs, from a low of 34 to a high of 82 cases per service coordinator.

In June 2001, DHS implemented the Quality Enhancement (QE) process to help ensure that children receive appropriate, consistent, and quality interventions. The federal government raised concerns about the QE process. DHS has begun making revisions to the QE process.

While DHS has taken steps to improve Program planning, an overall long-term strategic plan for the Program has not yet been developed.

REPORT CONCLUSIONS

The Early Intervention (EI) Program provides services to children, birth to 36 months of age, who have disabilities due to developmental delay, have a medically diagnosed mental or physical condition that typically results in developmental delay, or have been determined to be at risk of a substantial developmental delay. The EI Program is administered by the Department of Human Services (DHS). DHS contracts with various entities to provide most Program components, including case coordination, public awareness, billing, provider credentialing, and training functions. In Fiscal Year 2001, DHS reported EI Program expenditures totaling $96 million, $74.8 million of which was paid to providers of early intervention services. As of December 31, 2001, 9,910 children had Individualized Family Service Plans (IFSPs) authorizing them to receive EI services, such as speech language therapy, developmental therapy, and physical therapy.

In 1993, the Office of the Auditor General completed an audit of the Early Intervention Program. The 1993 audit found that although the framework being established for the EI Program should be capable of providing services under State and federal laws, several areas needed to be addressed.

Public Act 92-307, effective August 9, 2001, directed the Auditor General to conduct a follow-up evaluation of the Early Intervention Program. In addition, the Legislative Audit Commission adopted Resolution Number 122 in June 2001 directing the Auditor General to conduct an audit of the EI Program examining the adequacy of its management information systems and contractor monitoring. We are issuing two reports on our audit of the Early Intervention Program: this first report follows up on issues raised in the 1993 audit; a second report, to be issued during the summer of 2002, will examine issues specifically identified in Legislative Audit Commission Resolution Number 122.

The operation of the Early Intervention Program has changed significantly since our 1993 audit. In 1997, Child and Family Connections offices (CFCs) were established statewide to carry out intake and service coordination responsibilities. Responsibility for the Program was transferred to the Department of Human Services in January 1998. Also in 1998, the method for funding early intervention services changed from a grant program to a fee-for-service system. In 1999, DHS contracted with a vendor to operate the Central Billing Office (CBO) to process all payments related to the Early Intervention Program. In 2001, DHS implemented many new program changes.

These changes have resulted in Program improvements since our 1993 audit. There remain, however, areas where further improvements are warranted. DHS is in the process of working toward addressing many of these areas:

- **Child Find and Public Awareness**: The percentage of children participating in the EI Program increased in recent years, but began to decline during the summer of 2001. DHS officials attributed some of the decline to Program changes associated with insurance and family fees. Rates of participation in the Program varied across the State. Additional outreach and public awareness efforts are necessary, especially in counties with low participation rates.

- **Availability of Providers:** In response to a survey we sent asking whether there were a sufficient number of providers so that services were not delayed, 20 of the 25 CFCs noted a severe shortage in one or more early intervention provider types. However, monthly reports filed by CFCs listed relatively few children who were not receiving services due to a lack of early intervention service providers. Also, the number of providers enrolled in the Program increased from 2,200 in September 1998 to approximately 4,200 by January 2002, according to DHS officials.

- **Children Delayed in Receiving Services:** As of October 31, 2001, CFCs reported 1,196 children who were delayed in receiving services. Most of these children were not receiving services because an IFSP had not been prepared within the required 45 days. Family delays, such as parents not responding to inquiries, were reported as the primary reasons for the delay in 52 percent of the cases. System delays, such as high CFC caseloads or providers not completing assessments in a timely manner, accounted for the remaining 48 percent of the cases. In cases where there were system delays, 85 percent of the children were reported delayed two months or less for services.

- **Service Coordinator Caseloads:** Service coordinators' average caseloads varied widely among CFCs, from a low of 34 to a high of 82. DHS officials noted that some of the variations were caused by funded vacancies that the CFCs did not fill or by projected caseloads which did not materialize. High caseloads were cited by several CFCs as a primary reason why IFSPs were not completed within the required 45 days. Some CFCs with high caseloads, however, implemented IFSPs on a more timely basis than did CFCs with lower caseloads.

- **Cost and Client Information:** In August 1995, the Early Intervention Services System Act was amended to require the Illinois Interagency Council on Early Intervention's annual report to include information on the estimated number of eligible children and the estimated cost of providing services to all eligible infants and toddlers in the State. The annual report issued jointly by DHS and the Council for the year ending September 1999 did not include the statutorily required information. The annual report for the year ending September 2000 had not been issued as of January 2002.

In June 2001, the Department implemented the Quality Enhancement (QE) process, which was established to ensure that all eligible children and their families receive appropriate, consistent, and quality interventions. According to DHS officials, the U. S. Department of Education's Office of Special Education Programs (OSEP) raised concerns regarding the QE process because the IFSP team was not developing the IFSP which details the type and amount of care a child and family will receive. OSEP has not yet made its Part C grant award of approximately $16.6 million to Illinois for federal fiscal year 2001 pending revision of the QE process. DHS has begun to undertake revisions to the QE process.

Public Act 92-307, effective August 9, 2001, made significant changes to the Early Intervention Program. These changes included: establishing new eligibility requirements; mandating changes in the credentialing and training of EI providers; setting new insurance and family fee requirements; and requiring the bidding of certain EI contracts. The Department has implemented many of the new requirements; implementation of others is still underway.

The EI Program has taken steps to improve planning. In late 2001, the EI Bureau began to develop performance measures for some aspects of the EI system, as well as an Operations Plan that contains goals and objectives to improve the Program's operations and management. DHS has also developed an Improvement Plan to address issues raised as part of the Continuous Improvement Monitoring Process. In 2001, the Illinois Interagency Early Intervention Council developed a Vision and Mission Statement and established Principles of Early Intervention. While key planning efforts have been initiated, DHS has not developed an overall long-term strategic plan for the EI Program. (pages 1-3)

BACKGROUND

On August 9, 2001, Public Act 92-307 was signed into law. In addition to making significant changes in the Department of Human Services' operation of the Early Intervention Program, it also contained a requirement that the Office of the Auditor General conduct a follow-up evaluation of the Early Intervention Program. In 1993, the Office of the Auditor General released an evaluation of the EI Program. The Public Act required the follow-up evaluation be completed by April 30, 2002.

In 1993, the Office of the Auditor General released an evaluation of the EI Program. Public Act 92-307 required a follow-up evaluation be completed.

In addition, the Legislative Audit Commission adopted Resolution Number 122 in June 2001 directing the Auditor General to conduct an audit of the EI Program examining the adequacy of its management information systems and contractor monitoring. We are issuing two reports on our audit of the Early Intervention Program: this first report follows up on issues raised in the 1993 audit; a second report, to be issued during the summer of 2002, will examine issues specifically identified in Legislative Audit Commission Resolution Number 122.

The Early Intervention (EI) Program provides services to children, birth to 36 months of age, who have disabilities due to developmental delay, have a medically diagnosed mental or physical condition that typically results in developmental delay, or have been determined to be at risk of a substantial developmental delay. The EI Program is administered by the Department of Human Services (DHS).

DHS contracts with various entities to provide most Program components, including case coordination, public awareness, billing, provider credentialing, and training functions. In Fiscal Year 2001, DHS reported EI Program expenditures totaling $96 million, $74.8 million of which was paid to providers of early intervention services.

Over the past two and one-half years, the number of children with active Individualized Family Service Plans (IFSPs) authorizing them to receive EI services, such as speech language therapy, developmental therapy, and physical therapy, has increased.

Over the past two and one-half years, the number of children with active Individualized Family Service Plans (IFSPs) authorizing them to receive EI services, such as speech language therapy, developmental therapy, and physical therapy, has increased. As shown in Digest Exhibit 1, in September 1999, DHS reported there were 7,769 children with active IFSPs. As of December 2001, the number of children with active IFSPs was 9,910. The number of children with active IFSPs has decreased since the spring of 2001. DHS attributed some of the decline to Program changes associated with insurance and family fees.

The Office of the Auditor General 's 1993 audit of the Early Intervention Program found that although the framework being established for the EI Program should be capable of providing services under State and federal laws, several areas needed to be addressed. These included: services were not available in all parts of the State; some eligible children were not being served and were on waiting lists; IFSPs were not being completed within the required 45 days; and State agencies were not collecting information on the number of children eligible for services, the number served by all programs, or the cost of services per child.

Digest Exhibit 1
EI CASELOAD -- ACTIVE IFSPs
Sept. 1999 - Dec. 2001

Month	Children with Active IFSPs
September 1999	7,769
December 1999	8,671
March 2000	9,956
June 2000	11,355
September 2000	11,902
December 2000	11,575
March 2001	11,749
June 2001	11,698
September 2001	10,629
December 2001	9,910

Source: OAG from DHS reports (Central Billing Office data prior to Oct. 2000, Cornerstone data after Oct. 2000).

The operation of the Early Intervention Program has changed significantly since our 1993 audit. In 1996, the U. S. District Court in the Northern District of Illinois found that the State was violating the federal Individuals with Disabilities Education Act (IDEA). The Court's Order required the State to undertake numerous actions to address system deficiencies (Marie O. v. Edgar case). In March 2000, the Court terminated its supervision of the State's actions noting it had "observed substantial improvement" in the State's compliance with the IDEA.

In 1997, Child and Family Connections offices (CFCs) were established statewide to carry out intake and service coordination responsibilities. Responsibility for the Program was transferred from the State Board of Education to the Department of Human Services in January 1998. Also in 1998, the method for funding early intervention services changed from a grant program to a fee-for-service system. In 1999, DHS contracted with a vendor to operate the Central Billing Office to process all payments related to the Early Intervention Program.

These changes have resulted in Program improvements since our 1993 audit. There remain, however, areas where further improvements are warranted. DHS is in the process of working toward addressing many of these areas. (pages 3-15)

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CHILD FIND AND PUBLIC AWARENESS

For the EI Program to be effective, eligible children and their families need to be identified and provided information about the Program. State and federal laws require the EI Program to establish Child Find and public awareness efforts. Child Find includes activities to ensure that all infants and toddlers in the State who are eligible for EI services are identified, located, and evaluated. Public awareness activities are intended to disseminate information about the Program to primary referral sources, such as hospitals, physicians, and child care programs.

There are indications that Child Find and public awareness efforts have improved in recent years, but there remain additional areas for improvement. One measure to ascertain the effectiveness of the EI Program's Child Find and public awareness efforts is the participation rate. The participation rate is the percentage of children in the age group from 0 to 3 years who are receiving services through the EI Program in a given geographic area. The higher the participation percentage, the greater the indication that the public is aware of the Program and is accessing it. Areas with low participation rates may indicate that additional outreach is needed to educate the public about the EI Program.

Illinois' participation rate has increased significantly since 1998. In December 1998, Illinois' statewide participation rate was .9 percent; in December 2001, it was 1.8 percent.

Illinois' participation rate has increased significantly since 1998. In December 1998, Illinois' statewide participation rate was .9 percent; in December 2001, it was 1.8 percent.

While the Illinois rate has improved, there are still areas of concern. The first is that there are significant differences in participation rates among the 102 counties in Illinois. As shown in Digest Exhibit 2, in July 2001, Calhoun County and Carroll County had the lowest participation rates at .7 percent. Wabash County had the highest rate at 7.6

Digest Exhibit 2
VARIATIONS IN COUNTY PARTICIPATION RATES
For selected counties in July 2001

Counties with Lowest Rates	
Calhoun County	.7%
Carroll County	.7%
Scott County	1.0%
Counties with Highest Rates	
Wabash County	7.6%
Gallatin County	7.1%
White County	5.1%
Largest Counties	
Cook County (Chicago only)	1.6%
Cook County (excluding Chicago)	1.9%
DuPage County	1.5%
Statewide Average	2.0%

Source: OAG from DHS documents.

percent. DHS followed-up with CFCs in counties with low participation rates. Appendix C in the report lists all Illinois counties and their participation rates.

A second area of concern regarding Illinois' participation rate is that the number of cases with IFSPs has been decreasing since May 2001. The number of active IFSPs is used to calculate the participation rate. In May 2001, the number of cases with an active IFSP was 12,034. By December 2001, the number of cases with active IFSPs declined to 9,910, or an 18 percent decrease since May 2001. Illinois' statewide participation rate declined from 2.2 percent in December 2000 to 1.8 percent in December 2001. DHS officials attributed some of the decline to Program changes associated with insurance and family fees.

By December 2001, the number of cases with active IFSPs declined to 9,910, or an 18 percent decrease since May 2001. DHS officials attributed some of the decline to Program changes associated with insurance and family fees.

We surveyed the 25 CFCs and asked if there were areas where improvements could be made in the outreach activities of the EI Program. Twenty-one of the 25 CFCs responded that improvements could be made. Some of the suggestions included: improving connections with physicians and nurses; providing additional funding for promotional ads and more outreach activities; and more effectively dealing with language issues (such as in Hispanic areas where English is a second language).

In late 2001, the EI Bureau began the development of the Early Intervention Operations Plan. The Plan contains goals, objectives, and action steps covering a wide range of Early Intervention Program areas. The Operations Plan contains an objective to develop action plans to increase participation in areas with low participation rates. We recommended that the Department should continue efforts to increase public awareness of the Early Intervention Program, specifically focusing such efforts in areas of the State with low EI Program participation rates. (pages 19-23)

AVAILABILITY OF PROVIDERS

An effective early intervention system requires an adequate number of providers to deliver services. The Auditor General's 1993 audit found that there was a shortage of early intervention service providers. The audit reported that there were 99 providers of early intervention services, many of which were community or local government agencies that provided a variety of services.

The EI annual report for the year ending September 30, 1998, reported that approximately 2,200 providers had enrolled in the Program; as of January 2002, the EI Bureau reported that approximately 4,200 providers were credentialed to provide early intervention services.

Since the 1993 audit, the early intervention delivery system changed. In 1993, funding for EI services was paid to local service providers in the form of grants. In 1998, the service delivery system changed to a fee-for-service

system. The Illinois Interagency Council on Early Intervention's annual report for the year ending September 30, 1998, reported that approximately 2,200 early intervention providers had enrolled in the Program. As of January 2002, the EI Bureau reported that approximately 4,200 providers were credentialed to provide early intervention services.

Monthly reports submitted by CFCs reported that relatively few children were not receiving services because a provider was unavailable. In the June 2001 monthly reports, CFCs reported 54 cases that were delayed due to providers being unavailable, which accounted for only 4 percent of all children reported delayed for services that month.

Twenty of the 25 CFCs we surveyed responded that there was a severe shortage in at least 1 of the 16 types of service providers for which we inquired.

While the CFCs' monthly reports contained relatively few instances where services were delayed due to a lack of providers, CFCs' responses to our November 2001 survey identified a more prevalent problem. Twenty of the 25 CFCs responded that there was a severe shortage in at least 1 of the 16 types of service providers for which we inquired. Generally, the CFCs in the Cook County area reported fewer severe shortages of providers than CFCs located elsewhere in the State.

Transportation was the service most frequently cited as having a severe shortage -- 12 of the 25 CFCs. Ten CFCs reported shortages in vision services, while nine cited shortages in speech and language therapy. We recommended that the Department of Human Services should follow-up with the CFCs that reported shortages of providers and develop strategies to recruit additional providers where needed. (pages 24-26)

CHILDREN DELAYED IN RECEIVING SERVICES

Our 1993 audit reported that there were 1,048 children waiting for services to be provided, as of November 1, 1992. Providers surveyed as part of the 1993 audit reported that children waited anywhere from 2 weeks to 12 months for services. In 1993, providers received a set amount of grant funds to pay for services. According to DHS officials, when providers' grant funds were expended, children had to wait for services. The 1994 Marie O. class action complaint noted that the State's decision to provide mandated services only as appropriated funds became available "has resulted in serious and systematic unavailability and inadequacy of services in the State of Illinois."

While there continued to be children delayed in receiving services, there are important differences between the numbers reported for 1993 and 2001.

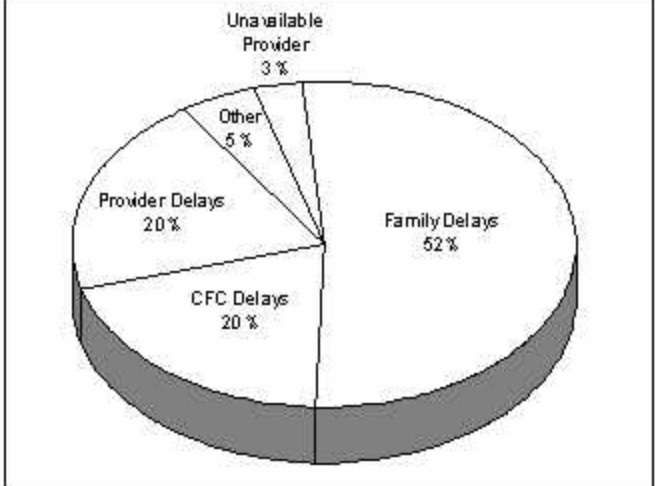
Whereas in 1993 services were not available due to a lack of State funding, in 2001, funding was available for needed services. A major reason why children were not receiving services in 2001 (52 percent of the cases in October 2001) was delays reported to be due to family reasons, such as the parent was unable to be contacted or did not respond to inquiries. The CFCs' ability to process cases and arrange for services is limited if there are delays associated with the parents.

As of October 31, 2001, CFC monthly reports identified 1,196 children as delayed in receiving services.

As of October 31, 2001, CFC monthly reports identified 1,196 children as delayed in receiving services. We identified instances where CFCs did not include in their monthly reports all the cases where children did not have an IFSP within the required 45 days. Our review of the EI Program's management information will be examined in greater detail in our report covering matters included in Legislative Audit Commission Resolution Number 122, to be issued in the summer of 2002.

As shown in Digest Exhibit 3, delays due to family reasons were cited as the primary reason for a child not receiving services in 52 percent (618 of 1,196) of the cases. Provider delays comprised the second largest reason (239 cases) why children were not receiving services. Provider delays included instances where the provider was untimely in completing evaluations and assessments. The third largest reason for service delays was CFC delays. CFC delays also accounted for 20 percent (234 cases) of the cases where children were not receiving services.

Digest Exhibit 3
REASONS SERVICES TO CHILDREN WERE DELAYED as of October 31, 2001



Source: OAG analysis of Statewide Monthly Managers' Report for October 2001.

In reporting children delayed in receiving services, DHS distinguishes between children delayed in receiving services due to family reasons (such as parent delays) versus system delays (such as CFC delays, lack of provider, etc.). As of October 31, 2001, of the 578 children not receiving services due to system delays, 493 (85 percent) were reported to be delayed in receiving services for two months or less; 71 were delayed for three to four months, and 14 were delayed for five or more months.

During the first six months of Fiscal Year 2002, approximately 50 percent of the IFSPs were not completed within the required 45 days, according to EI staff; IFSPs were completed an average of 75 days after the initial referral, or 30 days longer than required by law.

Our 1993 audit reported that IFSPs were not being completed within the required 45 days. The preparation of IFSPs within the 45 day time period continues to be a problem. Of the 1,196 children CFCs reported as delayed in receiving services as of October 31, 2001, 891 (74 percent) were over 45 days without an initial IFSP. During the first six months of Fiscal Year 2002, approximately 50 percent of the IFSPs were not completed within the required 45 days, according to EI staff. A DHS report run at our request showed that IFSPs were completed an average of
75 days after the initial referral, or 30 days longer than required by law. The average number of days CFCs took to complete the IFSPs ranged from a low of 50 days to a high of 106 days, according to DHS.

The potential effectiveness of the EI Program is diminished if services are not received in a timely manner. An important step in receiving needed services in a timely manner is the preparation of the Individualized Family Service Plan within the required 45 days. We recommended that the Department of Human Services should continue to monitor and follow-up on cases where children are not receiving services in a timely manner. When EI system delays are the cause for the delays, action should be taken to address such causes. (pages 26-29)

SERVICE COORDINATOR CASELOADS

There were wide variations in the average caseloads of service coordinators across the 25 CFCs. As of October 31, 2001, the average caseloads ranged from 34 cases to 82 cases.

There were wide variations in the average caseloads of service coordinators across the 25 CFCs. As of October 31, 2001, the average caseloads ranged from 34 cases to 82 cases. Six CFCs had average caseloads under 40, while 3 had average caseloads that exceeded 70 cases per service coordinator.

High caseloads were cited by several CFCs as a primary reason why IFSPs were not completed within the required 45 days. Some CFCs with high caseloads, however, implemented IFSPs on a more timely basis than CFCs with lower caseloads.

As part of the funding formula for CFCs, DHS based CFC funding on a caseload of approximately 50 IFSP cases per service coordinator. In some instances, projected caseloads did not materialize, according to EI officials; in other instances, CFCs had funded vacancies that they chose not to fill. The Bureau does not have any service coordinator caseload standards.

Service coordinators play a key role in the early intervention system. Excessive caseloads can have a detrimental effect on children and families receiving timely, comprehensive services. We recommended that the Department of Human Services should review the appropriateness of CFC caseloads. (pages 29-31)

PROGRAM INFORMATION AND ANNUAL REPORTS

Our 1993 audit found that the State did not have complete information on the number of eligible children, the number of children served, or the cost of services. The audit recommended that State agencies collect this information and noted that the General Assembly may wish to consider establishing a requirement that such information be reported by the Illinois Interagency Council on Early Intervention (IICEI) on an annual basis. Effective August 11, 1995, the Illinois Early Intervention Services System Act was amended to require that the annual report prepared by the IICEI include this information.

The annual report issued by DHS and the Council for the year ending September 1999 did not contain the statutorily required information on program participants and cost.

The annual report issued by DHS and the Council for the year ending September 1999 did not contain the statutorily required information on program participants and cost. DHS officials stated that the information required by Section 4 of the Early Intervention Services System Act will be included in the 2001 annual report. Also, the most recent EI annual reports have not been issued in a timely manner. The annual report for the year ending September 1998 was issued in November 1999; the report for the year ending September 1999 was issued in November 2001; and the annual report for the year ended September 2000 had not been issued as of January 2002.

We recommended that the Department of Human Services and the Illinois Interagency Council on Early Intervention should issue the annual report required by the Illinois Early Intervention Services System Act in a timely manner. Furthermore, the annual report should contain the information required by Section 4 of the Act. (pages 33-34)

QUALITY ENHANCEMENT PROCESS

In June 2001, the Department implemented the Quality Enhancement (QE) process, which was established to ensure that all eligible children and their families receive appropriate, consistent, and quality interventions. The QE team (comprised of a developmental pediatrician, an Illinois Medical Diagnostic Network coordinator, the child's CFC service coordinator, the CFC parent liaison, and two local providers) reviews the child's evaluation and assessment.

The U. S. Department of Education's Office of Special Education Programs (OSEP) raised concerns regarding the QE process because the IFSP team was not developing the IFSP which details the type and amount of care a child and family will receive.

According to DHS officials, the U. S. Department of Education's Office of Special Education Programs (OSEP) raised concerns regarding the QE process because the IFSP team was not developing the IFSP which details the type and amount of care a child and family will receive. OSEP noted that, "A State may neither confer the final determination of the early intervention services on a body that does not meet those requirements, nor require a parent to initiate mediation or an administrative proceeding . . . in order to secure the early intervention services determined necessary by the IFSP team."

OSEP directed DHS to revise the State's IFSP procedures to make them consistent with the requirements of Part C of the federal IDEA. OSEP has not yet made its Part C grant award of approximately $16.6 million to Illinois for federal fiscal year 2001 pending revision of the QE process. In February 2002, DHS proposed a revised QE process to OSEP for review. DHS plans to implement a revised procedure in some parts of Illinois in spring 2002, with full implementation by July 1, 2002. (pages 35-36)

IMPLEMENTATION OF PUBLIC ACT 92-307

DHS has taken steps to implement many of the requirements of Public Act 92-307, which became effective on August 9, 2001.

DHS has taken steps to implement many of the requirements of Public Act 92-307, which became effective on August 9, 2001. The Public Act makes significant changes to the Early Intervention Program, including: establishing new eligibility requirements; mandating changes in the credentialing and training of EI providers; setting new insurance and family fee requirements; and requiring the bidding of certain EI contracts. Appendix D in the report contains a summary of the status of DHS' implementation of the requirements of Public Act 92-307. Given that the changes required by Public Act 92-307 have only been recently implemented, the scope of this audit did not include assessing the impact
of these changes or whether changes made to rules, policies, and procedures have actually been implemented in practice. We recommended that the

Department of Human Services should continue its efforts to implement all the requirements of Public Act 92-307. (pages 36-37)

STRATEGIC PLANNING

The EI Program has undergone significant changes in recent years. In such a changing Program environment, formal planning is critical to ensure that the changes are consistent with, and supportive of, the main Program goals and objectives.

The Early Intervention Program has taken steps to improve Program planning. In late 2001, the EI Bureau began to develop performance measures for some aspects of the EI system, as well as an Operations Plan that contains goals and objectives to improve the Program's operations and management. DHS developed an Improvement Plan as part of the federal Continuous Improvement Monitoring Process.
In 2001, the Illinois Interagency Early Intervention Council developed a Vision and Mission Statement and established Principles of Early Intervention. While key planning efforts have been initiated, DHS has not developed an overall long-term strategic plan for the EI Program. Such a plan would allow Program managers to assess the degree to which the Program is having its intended effect.

While key planning efforts have been initiated, DHS has not developed an overall long-term strategic plan for the EI Program. Such a plan would allow Program managers to assess the degree to which the Program is having its intended effect.

We recommended that the Department of Human Services should establish a formal plan for the Early Intervention Program which establishes goals and objectives, as well as performance measures to determine whether desired outcomes are being achieved. (pages 37-38)

AGENCY RESPONSE

The Department of Human Services agreed with the eight recommendations made in the audit report. The Department's written response can be found in Appendix E of the report.

WILLIAM G. HOLLAND
Auditor General

WGH\JS
April 2002

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LIST OF ACRONYMS

CBO -- Central Billing Office

CFC -- Child and Family Connections

DHS -- Department of Human Services

DSCC -- University of Illinois' Division of Specialized Care for Children

EI -- Early Intervention

IDEA -- federal Individuals with Disabilities Education Act

IFSP -- Individualized Family Service Plan

IICEI -- Illinois Interagency Council on Early Intervention

IMDN -- Illinois Medical Diagnostic Network

ISBE -- Illinois State Board of Education

LIC -- Local Interagency Council

OAG -- Office of the Auditor General

OSEP -- U. S. Department of Education's Office of Special Education Programs

QE -- Quality Enhancement

ROE -- Regional Office of Education

Chapter One

BACKGROUND

REPORT CONCLUSIONS

The Early Intervention (EI) Program provides services to children, birth to 36 months of age, who have disabilities due to developmental delay, have a medically diagnosed mental or physical condition that typically results in developmental delay, or have been determined to be at risk of a substantial developmental delay. The EI Program is administered by the Department of Human Services (DHS). DHS contracts with various entities to provide most Program components, including case coordination, public awareness, billing, provider credentialing, and training functions. In fiscal year 2001, DHS reported EI Program expenditures totaling $96 million, $74.8 million of which was paid to providers of early intervention services. As of December 31, 2001, 9,910 children had Individualized Family Service Plans (IFSPs) authorizing them to receive EI services, such as speech language therapy, developmental therapy, and physical therapy.

In 1993, the Office of the Auditor General completed an audit of the Early Intervention Program. The 1993 audit found that although the framework being established for the EI Program should be capable of providing services under State and federal laws, several areas needed to be addressed.

Public Act 92-307, effective August 9, 2001, directed the Auditor General to conduct a follow-up evaluation of the Early Intervention Program. In addition, the Legislative Audit Commission adopted Resolution Number 122 in June 2001 directing the Auditor General to conduct an audit of the EI Program examining the adequacy of its management information systems and contractor monitoring. We are issuing two reports on our audit of the Early Intervention Program: this first report follows up on issues raised in the 1993 audit; a second report, to be issued during the summer of 2002, will examine issues specifically identified in Legislative Audit Commission Resolution Number 122.

The operation of the Early Intervention Program has changed significantly since our 1993 audit. In 1997, Child and Family Connections offices (CFCs) were established statewide to carry out intake and service coordination responsibilities. Responsibility for the Program was transferred to the Department of Human Services in January 1998. Also in 1998, the method for funding early intervention services changed from a grant program to a fee-for-service system. In 1999, DHS contracted with a vendor to operate the Central Billing Office (CBO) to process all payments related to the Early Intervention Program. In 2001, DHS implemented many new program changes.

These changes have resulted in Program improvements since our 1993 audit. There remain, however, areas where further improvements are warranted. DHS is in the process of working toward addressing many of these areas:

- **Child Find and Public Awareness:** The percentage of children participating in the EI Program increased in recent years, but began to decline during the summer of 2001. DHS officials attributed some of the decline to Program changes associated with insurance and family fees. Rates of participation in the Program varied across the State. Additional outreach and public awareness efforts are necessary, especially in counties with low participation rates.

- **Availability of Providers:** In response to a survey we sent asking whether there were a sufficient number of providers so that services were not delayed, 20 of the 25 CFCs noted a severe shortage in one or more early intervention provider types. However, monthly reports filed by CFCs with DHS listed relatively few children who were not receiving services due to a lack of early intervention service providers. Also, the number of providers enrolled in the Program increased from 2,200 in September 1998 to approximately 4,200 by January 2002, according to DHS officials.

- **Children Delayed in Receiving Services:** As of October 31, 2001, CFCs reported 1,196 children who were delayed in receiving services. Most of these children were not receiving services because an IFSP had not been prepared within the required 45 days. Family delays, such as parents not responding to inquiries, were reported as the primary reasons for the delay in 52 percent of the cases. System delays, such as high CFC caseloads or providers not completing assessments in a timely manner, accounted for the remaining 48 percent of the cases. In cases where there were system delays, 85 percent of the children were reported delayed two months or less for services.

- **Service Coordinator Caseloads:** Service coordinators' average caseloads varied widely among CFCs, from a low of 34 to a high of 82. DHS officials noted that some of the variations were caused by funded vacancies that the CFCs did not fill or by projected caseloads which did not materialize. High caseloads were cited by several CFCs as a primary reason why IFSPs were not completed within the required 45 days. Some CFCs with high caseloads, however, implemented IFSPs on a more timely basis than did CFCs with lower caseloads.

- **Cost and Client Information:** In August 1995, the Early Intervention Services System Act was amended to require the Illinois Interagency Council on Early Intervention's annual report to include information on the estimated number of eligible children and the estimated cost of providing services to all eligible infants and toddlers in the State. The annual report issued jointly by DHS and the Council for the year ending September 1999 did not include the statutorily required information. The annual report for the year ending September 2000 had not been issued as of January 2002.

In June 2001, the Department implemented the Quality Enhancement (QE) process, which was established to ensure that all eligible children and their families receive appropriate, consistent, and quality interventions. According to DHS officials, the U. S. Department of Education's Office of Special Education Programs (OSEP) raised concerns regarding the QE process because the IFSP team was not developing the IFSP which details the type and amount of care a child and family will receive. OSEP has not yet made its Part C grant award of

approximately $16.6 million to Illinois for federal fiscal year 2001 pending revision of the QE process. DHS has begun to undertake revisions to the QE process.

Public Act 92-307, effective August 9, 2001, made significant changes to the Early Intervention Program. These changes included: establishing new eligibility requirements; mandating changes in the credentialing and training of EI providers; setting new insurance and family fee requirements; and requiring the bidding of certain EI contracts. The Department has implemented many of the new requirements; implementation of others is still underway.

The Early Intervention Program has taken steps to improve Program planning. In late 2001, the EI Bureau began the development of an Operations Plan that contains goals and objectives to improve the operations and management of the EI Program. DHS has also participated in, and developed an Improvement Plan to address issues raised as part of, the Continuous Improvement Monitoring Process. The Program is developing measures that could be used to assess various aspects of system performance. In 2001, the Illinois Interagency Early Intervention Council developed a Vision and Mission Statement and established Principles of Early Intervention. While key planning efforts have been initiated, DHS has not developed an overall long-term strategic plan for the EI Program. Such a plan would allow Program managers to assess the degree to which the Program is having its intended effect.

INTRODUCTION

On August 9, 2001, Public Act 92-307 was signed into law. In addition to making significant changes to the Department's operation of the Early Intervention Program, it also contained a requirement that the Office of the Auditor General conduct a follow-up evaluation of the Early Intervention Program. In 1993, the Office of the Auditor General released an evaluation of the EI Program. The Public Act required the follow-up evaluation be completed by April 30, 2002.

In addition, on June 26, 2001, the Legislative Audit Commission (LAC) adopted Resolution Number 122 directing the Office of the Auditor General to conduct a performance audit of the Department of Human Services' Early Intervention Program. LAC Resolution Number 122 directed the Auditor General to determine:

- Whether the Program's management information system provides the information needed to monitor services provided and contractor performance;

- Whether contracts with entities coordinating and providing services contain reporting mechanisms (such as performance measures or deliverables) to allow the Program to monitor and evaluate their performance;

- Whether the Program has established a system to monitor and assess contractor activities, including: CFC referral practices; provider compliance with established billing, service, and supervision requirements; and geographic variances in service utilization, services accessed, and provider billing patterns; and

- Whether the Department has procedures in place to ensure that services provided to clients are consistent with the Individualized Family Service Plan (IFSP).

The audit work pursuant to both Public Act 92-307 and Legislative Audit Commission Resolution Number 122 was conducted as one audit. However, two separate reports will be issued: this one specifically following up on issues raised in the 1993 audit; and another during the summer of 2002 addressing the determinations in Legislative Audit Commission Resolution Number 122. Many of the issues that will be covered in our second audit report, such as the monitoring of contractors and providers and the adequacy of management information systems, also impact the effectiveness of the EI Program.

1993 OAG AUDIT

In 1993, the OAG completed an audit of the Early Intervention Program. The report concluded that the framework being established for the EI Program should be capable of providing services under federal and State laws, but there were several areas that needed to be addressed. These included: services were not available in all parts of the State; some eligible children were on waiting lists and were not being served; some required Program components had not been fully implemented; and the progress of children was not being tracked. The audit also noted that agencies did not collect information on the number of children eligible for the Program, the number served, or the cost of services.

LEGAL REQUIREMENTS

In 1986, Congress passed Public Law 99-457, which provided funds for a system of early intervention for infants and toddlers with disabilities. Early intervention services are designed to:

- Enhance the development of infants and toddlers with disabilities and to minimize their potential for developmental delay;

- Reduce the educational costs to society by minimizing the need for special education and related services after infants and toddlers with disabilities reach school age;

- Minimize the likelihood of institutionalization of individuals with disabilities and maximize the potential for their independent living in society;

- Enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities; and

- Enhance the capacity of state and local agencies and service providers to identify, evaluate, and meet the needs of historically under-represented populations, particularly minority, low-income, inner-city, and rural populations.

The law, which amended the Individuals with Disabilities Education Act (IDEA) (20 USC 1400 *et. seq*.) encourages states to develop a statewide, comprehensive, coordinated system of early intervention services.

In response to the federal law, Illinois created the State Interagency Council on Early Intervention. The State's Early Intervention Services System Act (325 ILCS 20/1 *et. seq*.), became effective in September 1991. The requirements found in State law are similar to those in federal law.

Marie O. v. Edgar

In March 1994, a class action complaint was filed in the U.S. District Court in the Northern District of Illinois alleging the failure of Illinois to provide critical early intervention services to developmentally-delayed children. The complaint alleged that only 26 percent of the eligible children were being served, that children were placed on long waiting lists for services, and that Individualized Family Service Plans were not being completed in a timely manner. The Auditor General's 1993 *Evaluation of the Early Intervention Services System* was Exhibit A to the complaint.

On February 1, 1996 the Court entered a Summary Judgment in favor of the plaintiffs. The Order found that the State was violating the federal Individuals with Disabilities Education Act (IDEA). On September 19, 1996 a final Order and Judgment was issued. The Order required the State to undertake numerous actions to address system deficiencies. Such actions included: increasing public awareness and informing families of their rights; implementing a comprehensive Child Find System; completing IFSPs on all eligible children within prescribed time periods; eliminating waiting lists; and implementing new financial procedures (such as billing Medicaid for certain services). The Court also established a system to monitor the State's progress in accomplishing these requirements.

On March 15, 2000, the U.S. District Court, Northern District of Illinois terminated the Court's supervision of the State's actions required by the September 1996 Order. In the March 2000 Opinion, the Court wrote:

> Since the issuance of the Court's Order and the initiation of the Court's oversight, the Court has observed substantial improvement in the State's compliance with Part C. There exists now one responsible state agency, clear lines of communications, and systems adopted to effectuate the Order. The State has provided those in need of assistance with an ability to so request it and has publicized methods of public access to Part C. Indeed, the systems that have been put in place afford a reasonable basis to gather and use reliable statistics.

Public Act 92-307

On August 9, 2001, Public Act 92-307 was signed into law. The Act makes significant changes to the Early Intervention Program. These changes include revisions to eligibility requirements, interagency agreements, provider qualifications, IFSP requirements, and personnel

development. It also requires the maintenance of an EI web-site, the establishment of a system of family fees, a screening device to determine eligibility for other programs, and a quarterly reporting process. In Chapter Three we will review the Department's progress in implementing the requirements imposed by Public Act 92-307.

OVERVIEW OF THE EARLY INTERVENTION PROGRAM

In its 22nd Annual Report to Congress, the U. S. Department of Education's Office of Special Education Programs, which is the federal agency responsible for monitoring states' early intervention programs, noted the importance of timely early intervention services. Development occurs at a more rapid rate during the first three years of life than at any other age. Therefore, the facilitation of early learning and the provision of timely early intervention services to infants and toddlers with disabilities is critical.

The Illinois Department of Human Services (DHS) became the lead agency for the EI Program on January 1, 1998. Before 1998, the Illinois State Board of Education (ISBE) was the lead agency. DHS' Bureau of Early Intervention is located under the DHS Office of Associate Secretary. The Bureau has 11 employees. Most EI activities and functions (such as service coordination, billing, public awareness, provider enrollment, etc.) are contracted.

The EI Program has many different components and processes. Exhibit 1-1 summarizes the various processes involved in the EI Program. Many of these specific components are required by federal and State law. DHS must provide ongoing public awareness and Child Find efforts, which focus upon early identification of eligible children throughout the State. Child Find includes activities to ensure that all infants and toddlers in the State who are eligible for EI services are identified, located, and evaluated. Public awareness activities are intended to disseminate information about the Program to primary referral sources, such as hospitals, physicians, and child care programs.

The 25 Child and Family Connections offices (CFCs) located throughout the State (which serve as regional intake entities) and Local Interagency Councils (LICs) are required to coordinate public awareness and Child Find activities with DHS. DHS has also entered into an interagency agreement with ISBE regarding public awareness and Child Find responsibilities required by Parts B and C of the federal Individuals with Disabilities Education Act (IDEA).

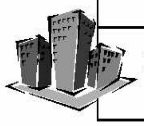
Children under 36 months of age are eligible for EI services if they are experiencing:

- Developmental delay (30 percent and above) in at least one of the following areas:
  - cognitive development,
  - physical development, including vision and hearing,
  - speech, language and communication development,
  - social-emotional development, or
  - adaptive self-help skills;

Exhibit 1-1
EARLY INTERVENTION SERVICES PROCESS OVERVIEW

Public Awareness and Child Find

DHS, CFCs, and Local Interagency Councils conduct public awareness efforts to educate the public about early intervention services and to identify children eligible for the Program.

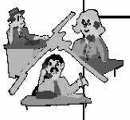


Child & Family Connections (CFC) Offices

25 regional offices statewide receive referrals to the Program and explain and coordinate EI services.

Referral and Intake Process

Referrals to the Program can be made by the child's parents, medical providers, social service agencies, or other members of the community. CFC staff enter the child's information into DHS' Cornerstone System and assign a service coordinator.



CFC Service Coordination

Service coordinator notifies and provides the family with Program orientation; informs the child's parents of their rights; arranges for the child to receive an evaluation plan to determine eligibility for the Program; and prepares the case for QE review.

Quality Enhancement (QE) Review

QE team (comprised of a developmental pediatrician, an Illinois Medical Diagnostic Network coordinator, the child's CFC service coordinator, a CFC parent liaison, and two local providers) reviews the evaluation report and service recommendations to ensure service levels are appropriate.

Individualized Family Service Plan (IFSP)

Following QE Review, the service coordinator contacts the family and service providers to schedule the IFSP meeting. The IFSP is developed based on QE recommendations, individual needs of the child, and resources and concerns of the family. Service providers are selected and the service plan is implemented. During the first 6 months of Fiscal Year 2002, an average of 75 days elapsed from the time a case was referred to a CFC and an IFSP was prepared; State and federal law requires IFSPs to be developed within 45 days.

Source: OAG analysis of DHS documents and interviews.

- A medically diagnosed physical or mental condition typically resulting in developmental delay; or

- Other circumstances that put them at risk of substantial developmental delay. This risk must be determined by a qualified multidisciplinary team.

Families access the EI Program through the CFC that serves their local area. According to DHS, CFCs have been operational since the fall of 1997. CFCs include county health departments, regional offices of education, hospitals, and not-for-profit community agencies. Exhibit 1-2 shows the CFC regions throughout the State. CFC service coordinators are responsible for coordinating the evaluation/assessment, eligibility determination, and developing, monitoring, and updating the Individualized Family Service Plan (IFSP).

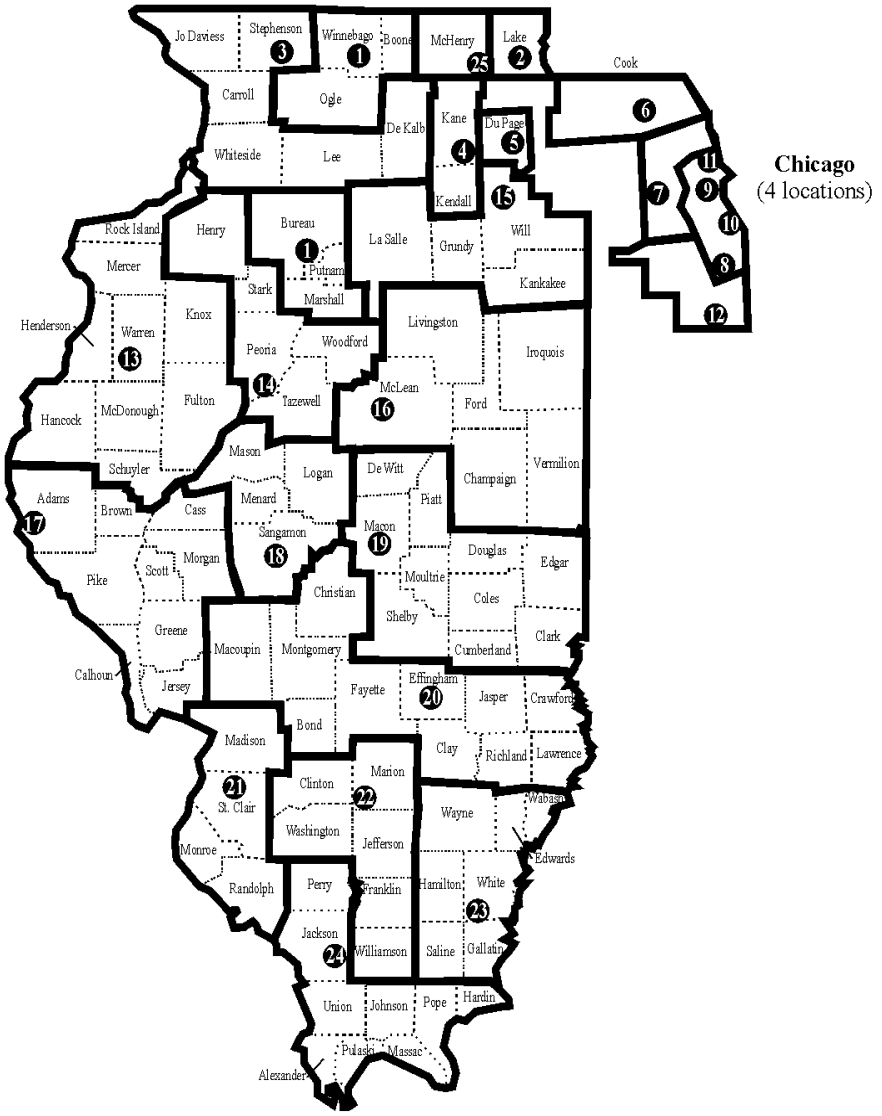
After a child has been referred to a CFC and determined to be eligible through an evaluation, the CFC refers the case to a Quality Enhancement (QE) team. The QE team (comprised of a developmental pediatrician, an Illinois Medical Diagnostic Network coordinator, the child's CFC service coordinator, the CFC parent liaison, and two local providers) reviews the recommended services for the child to ensure appropriate service levels.

After the QE review, the CFC service coordinator facilitates the development of an IFSP for the child. The IFSP must be developed jointly by the family and appropriate qualified personnel. The IFSP must include, among others, the following: services necessary to enhance the development of the child, services necessary to enhance the capacity of the family to meet the developmental needs of the child, a statement of the child's present developmental levels in the five developmental domains, a statement of the family's resources, a statement of the major outcome expected to be achieved, and a statement of the specific EI services necessary to meet the unique needs of the child and family. The initial IFSP is required to be completed within 45 days of referral to the CFC.

The service coordinator arranges for implementation of the IFSP. The parent can choose to accept or decline any or all of the services without jeopardizing other services. Exhibit 1-3 shows the services that are available under the EI program. At least every six months the IFSP is required to be reviewed to determine progress in achieving the outcomes and whether any modification of the outcomes or services is warranted. An annual IFSP review is also required to evaluate and revise the IFSP for the child.

EI services are available through a network of enrolled providers. EI officials reported that, as of January 2002, there were approximately 4,200 providers enrolled in the EI Program. These providers can either be employed by a larger institution, be an independent practitioner, or serve in both capacities. DHS has contracted with Provider Connections (affiliated with Western Illinois University) to credential providers and provide statewide training on early intervention-related topics to CFCs and providers.

Exhibit 1-2
CHILD & FAMILY CONNECTIONS LOCATIONS



CFC Office Locations

1. Rockford - Access Services of Illinois
2. Waukegan - Lake County Health Department
3. Freeport - Regional Office of Education #8
4. Batavia - Kane Kendall Case Coordination Serv.
5. Lombard - PACT, Inc.
6. DesPlaines - Clearbrook
7. Westchester - Suburban Access, Inc.
8. Chicago - Easter Seals Society of Metro Chicago
9. Chicago - Hektoen Institute for Medical Research, Cook County Children's Hospital
10. Chicago - LaRabida Children's Hospital
11. Chicago - Rush-Presbyterian St. Luke's Medical Center - Illinois Masonic Medical Center
12. Homewood - Suburban Access, Inc.
13. Roseville - Education Service Region #26
14. Peoria - Peoria County Board for the Care and Treatment of Persons with a Developmental Disability c/o Allied Agencies
15. Joliet - Easter Seal Rehabilitation Center of Will/Grundy Counties
16. Bloomington - Child Care Resource & Referral Network
17. Quincy - Regional Office of Education #1
18. Springfield - Sangamon County Health Department
19. Decatur - Macon County Community Mental Health Board
20. Effingham - ARC Community Support Systems
21. Swansea - Special Children, Inc.
22. Centralia - Regional Office of Education #13
23. Norris City - Wabash & Ohio Valley Special Education District
24. Carbondale - Archway
25. Crystal Lake - Options & Advocacy for McHenry Co.

Source: OAG analysis of DHS CFC listing.

Claims for reimbursement for EI services provided are processed through the Central Billing Office (CBO). In fiscal year 1999, the University of Illinois at Chicago, Division of Specialized Care for Children (DSCC) was under contract to function as the Central Billing Office for the EI program. In fiscal year 2000, the operation of the CBO function was transferred to the Illinois Primary Health Care Association.

Exhibit 1-3
EARLY INTERVENTION SERVICES

1. Assistive Technology Devices and Services
2. Audiology, Aural Rehabilitation and Related Services
3. Developmental Therapy
4. Family Training and Support
5. Health Consultation
6. Medical Services for Diagnostic and Evaluation Purposes
7. Nursing
8. Nutrition
9. Occupational Therapy
10. Physical Therapy
11. Psychological and Other Counseling Services
12. Service Coordination
13. Social Work and Other Counseling Services
14. Speech Language Therapy
15. Transportation
16. Vision Services

Source: DHS Administrative Code.

Once an Individualized Family Service Plan is developed, the service authorizations are entered into DHS' Cornerstone system, which is the case management information system used by the EI Program. The authorization includes the child's name as well as the amount of time for each session. When a provider submits a bill to the CBO for payment, the system matches the information obtained from the authorization to the bill. If the information matches, the payment is placed onto a tape. The Comptroller receives the tape of billings and processes payments.

The Illinois Interagency Council on Early Intervention was established by statute (325 ILCS 20/4) to advise and assist the lead agency (DHS). It is comprised of directors and associate directors of eight State agencies, parents familiar with programs for infants and toddlers, a member of the General Assembly, and a person involved in the preparation of professional personnel to serve infants and toddlers. It is also required to prepare an annual report to the Governor and General Assembly on the status of the Early Intervention Program in Illinois.

Local Interagency Councils on Early Intervention (LICs) have been established across the State to emphasize planning to identify and coordinate all resources and services in their area. A primary responsibility of the 44 LICs is to plan at the local level to identify and coordinate all resources and services within each CFC area. Participants in the LICs include providers, parents, local education agencies, and representatives of State agencies.

EARLY INTERVENTION OPERATING INFORMATION

Our 1993 audit reported that the total number of children served by the State's Early Intervention Program could not be determined because all agencies did not collect the information. The audit reported that three agencies (the Department of Mental Health and Developmental Disabilities, State Board of Education, and the Department of Rehabilitation Services) served a total of 8,646 infants and toddlers in fiscal year 1992, but that the total may be overstated due to

duplicate counting of children among the three agencies. DHS reported that for the year ending December 1, 2001, 22,130 children were served by the EI Program.

Over the past two and one-half years, the number of children with active Individualized Family Service Plans (IFSPs) has increased. As shown on Exhibit 1-4, in September 1999, DHS reported there were 7,769 children with active IFSPs. As of December 2001, the number of children with active IFSPs was 9,910.

As Exhibit 1-4 shows, the number of children with active IFSPs has significantly decreased since the spring of 2001. DHS analyzed the decrease in IFSPs and found that the caseload has fallen even though the number of children referred to the Program and the number of children leaving active services have not changed significantly. DHS concluded that fewer children were being found eligible for the Program and noted that this may be due to better training and technical assistance. DHS also stated that fewer families were deciding to enter the Program, because of changes such as the new requirements for insurance and family fees.

Exhibit 1-4
EI CASELOAD -- ACTIVE IFSPs
Sept. 1999 - Dec. 2001

Month	Children with Active IFSPs
September 1999	7,769
December 1999	8,671
March 2000	9,956
June 2000	11,355
September 2000	11,902
December 2000	11,575
March 2001	11,749
June 2001	11,698
September 2001	10,629
December 2001	9,910

Source: OAG from DHS reports (Central Billing Office data prior to Oct. 2000, Cornerstone data after Oct. 2000).

Exhibit 1-5 contains expenditures of the Early Intervention Program over the past three fiscal years. The largest component of Program expenditures was payments to service providers. Of the Program's $96 million in expenditures in fiscal year 2001, $74.8 million went to service providers. In our 1993 audit, we concluded that the State could not identify all expenditures for the Early Intervention Program. Three agencies could identify some EI expenditures (State Board of Education, Department of Mental Health and Developmental Disabilities, and the Department of Rehabilitation Services) which totaled $14.4 million in fiscal year 1992.

Exhibit 1-5
EARLY INTERVENTION EXPENDITURES
(in thousands)

	Fiscal Year 1999	Fiscal Year 2000	Fiscal Year 2001
Service Providers	$ 19,349.9	$ 47,395.4	$ 74,761.8
Child and Family Connections (CFCs)	$ 12,500.4	$ 10,183.3	$ 15,488.0
Central Billing Office	$ 850.8	$ 1,512.4	$ 1,500.0
Provider Connections	$ 517.5	$ 690.0	$ 600.0
Personal Services and Related	$ 359.4	$ 1,106.2	$ 1,162.7
Miscellaneous	$ 11,364.4	$ 6,090.5	$ 2,454.9
TOTAL	**$ 44,942.4**	**$ 66,977.8**	**$ 95,967.4**

Source: OAG from DHS EI Bureau.

As Exhibit 1-5 shows, payments to service providers increased significantly over the three year period. In December 1998, the EI Program served 4,849 children, as reported by the federal

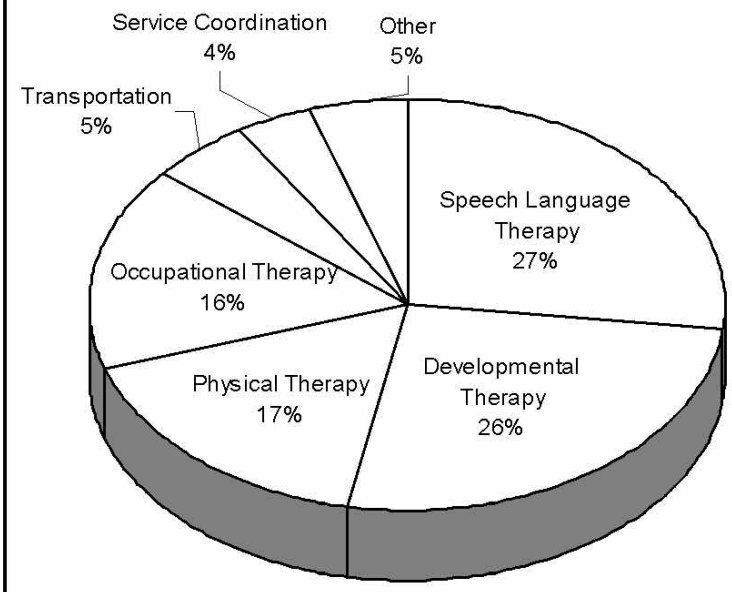
Office of Special Education Programs in its annual report for Congress. By December 2000, the number of children with active IFSPs served through the EI Program had increased to 11,575.

Payments to the 25 Child and Family Connections offices for service coordination and other activities comprised the second largest component of EI spending, $15.5 million in fiscal year 2001. The Central Billing Office, operated by the Illinois Primary Health Care Association accounted for $1.5 million of the fiscal year 2001 expenditures, while Provider Connections (affiliated with Western Illinois University) received $600,000 to perform provider credentialing and training functions.

Prior to 1998, 72 local provider agencies received grants to provide services to children eligible for early intervention services. In October 1998, however, the method of funding changed to a fee-for-service method, by which any provider credentialed by DHS can provide early intervention services. As of January 2002, DHS reported there were approximately 4,200 providers of early intervention services enrolled in the State.

Four of the 16 early intervention services accounted for the vast majority of services paid through the Central Billing Office. As shown in Exhibit 1-6, 27 percent of all services provided in fiscal year 2001 were for speech language therapy. Developmental therapy accounted for 26 percent of all services provided. Physical therapy and occupational therapy accounted for 17 percent and 16 percent of services provided, respectively. Service coordination is another major type of early intervention service; however, most service coordination is provided by the CFCs, which are paid directly by DHS and do not bill through the Central Billing Office.

Exhibit 1-6
FY 01 SERVICES PROVIDED



Source: OAG analysis of CBO Billing Data.

FEDERAL REVIEWS OF ILLINOIS' EARLY INTERVENTION PROGRAM

The federal Department of Education's Office of Special Education Programs (OSEP) has been involved in three reviews of Illinois' Early Intervention Program since 1998. OSEP is responsible for assessing the impact and effectiveness of State and local efforts to provide early intervention services. In 1998 and 1999, OSEP conducted two reviews of the EI Program. The

purpose of these reviews was to determine whether DHS was meeting its responsibility to ensure that early intervention services for infants and toddlers with disabilities and their families were administered in a manner consistent with federal requirements contained in Part C of the Individuals with Disabilities Education Act.

The 1998 OSEP monitoring report contained the following findings:

- DHS was not ensuring that service coordination, meeting the requirements of Part C, was available to all eligible children and their families;

- DHS had not ensured that early intervention services were individually determined and that needed services were included on the IFSP and provided. Specific areas identified were the lack of individualized decisions by the IFSP team, lack of personnel, and lack of sufficient funds or other resources; and

- DHS had not fulfilled its obligation for the general administration, supervision and monitoring of programs and activities used by the State to implement the Statewide system in the areas of: confidentiality; providing program information in clients' native languages; policies related to payment for services and fees; and supervision and monitoring of programs.

A follow-up review was conducted in 1999. The purpose of the 1999 visit was to determine the progress DHS had made in addressing the areas of noncompliance identified in the 1998 visit, as well as to review other areas of Program implementation. OSEP's 1999 review focused on four specific areas: Child Find and public awareness; provision of early intervention services; transition from Part C to preschool or other appropriate services at age three; and the lead agency's administrative responsibilities for implementation of the Statewide system of early intervention services.

Based on the 1999 review, OSEP concluded that the State had addressed the following findings from the 1998 review: 1) lack of personnel; 2) lack of sufficient funds or other resources; 3) confidentiality; 4) prior notice and native language; and 5) policies related to payment for services and fees.

There were two areas of noncompliance that OSEP determined that the State had not corrected: 1) provision of service coordination; and 2) lack of individualized decisions by the IFSP team to determine needed early intervention services. In a third area, supervision and monitoring, OSEP found that DHS made progress since the 1998 visit; however, a 1999 finding was made related to the comprehensiveness of DHS' methods of monitoring. In addition, OSEP made two additional findings, not addressed in the 1998 report, in the following areas: 1) lack of comprehensive evaluation and assessments, including family-directed assessments; and 2) lack of appropriate transition planning.

DHS is also participating in OSEP's Continuous Improvement Monitoring Process. OSEP began Illinois' Continuous Improvement Monitoring review in April 2000. The review includes DHS, the State Board of Education (which has responsibility for Part B of the Individuals with

Disabilities Education Act which covers children age 3 through 21), and stakeholders representing children and families, schools, service providers, and professional organizations.

The first step in the Continuous Improvement Monitoring Process was a self-assessment prepared by the stakeholders. Illinois completed its self-assessment in December 2000. After the completion of the self-assessment, the next step was the development of an Improvement Plan. As part of the Continuous Improvement Monitoring Process, a series of 11 public forums were held in October 2001. At these forums, approximately 150 participants provided input on questions such as: whether there were barriers to the EI referral process; whether children with disabilities were receiving all the services they need; and how the State was involved in assuring that appropriate services were provided to eligible children.

Illinois' proposed Improvement Plan was submitted to OSEP in January 2002. Many of the items we identified as areas where improvements are needed were also identified as areas needing attention in the Improvement Plan, and will be discussed in subsequent chapters of this report.

AUDIT SCOPE AND METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The objectives for this evaluation were to follow-up on issues raised in our 1993 audit of the Early Intervention Program, review the Department's planning efforts for the EI Program, and assess the Department's efforts to implement requirements of Public Act 92-307. Other matters which we examined as part of our management audit of the Early Intervention Program pursuant to LAC Resolution Number 122 also impact the effectiveness of the Program. These include the adequacy of the Program's management information systems, as well as the adequacy of the Program's monitoring of contractor performance. These matters will be reported in our subsequent report related to LAC Resolution Number 122.

We conducted interviews of Department of Human Services staff, including those from the Bureau of Early Intervention, Office of Community Health and Prevention, Office of Contract Administration, and Office of Internal Audits. We also interviewed the Chair of the Illinois Interagency Early Intervention Council and officials from the U. S. Department of Education's Office of Special Education Programs and the Central Billing Office.

In November 2001, we sent a survey to the 25 CFCs asking for their input regarding various aspects of the Early Intervention Program. All 25 CFCs responded to our survey. A copy of the survey, as well as a summary of the CFCs responses, can be found in Appendix B.

We reviewed the federal and State legal requirements that pertain to the Early Intervention Program, as well as the management controls established over the Program. Results of these reviews are contained in both this report and the report that will be issued pursuant to Legislative

Audit Commission Resolution Number 122. We placed reliance on prior audits of the Cornerstone and Central Billing Office systems and conducted an application review of the Cornerstone system testing its control objectives. We examined monitoring reviews done of Illinois' Early Intervention Program conducted by the U. S. Department of Education's Office of Special Education Programs (OSEP), as well as the Continuous Improvement Monitoring Process conducted in conjunction with OSEP, and OSEP's review of Illinois' Part C Application.

We reviewed monthly managers' reports submitted by CFCs to DHS for the year ending June 30, 2001, as well as for the month of October 2001. We reviewed other Program information, including annual reports, training documentation, planning documents, Illinois Interagency Council on Early Intervention meeting minutes, and other Program materials.

REPORT ORGANIZATION

The remainder of this report is organized into the following chapters:

- **Chapter Two** follows up on issues raised in our 1993 audit and other reviews done of the Early Intervention Program; and

- **Chapter Three** examines other issues, including the Quality Enhancement process, implementation of Public Act 92-307, and the EI Program's planning process.

Chapter Two

FOLLOW-UP TO 1993 AUDIT

CHAPTER CONCLUSIONS

In 1993, the Office of the Auditor General completed an audit of the Early Intervention Program. The 1993 audit found that although the framework being established for the EI Program should be capable of providing services under State and federal laws, several areas needed to be addressed. Public Act 92-307, effective August 9, 2001, directed the Auditor General to conduct a follow-up evaluation of the Early Intervention Program.

The operation of the Early Intervention Program has significantly changed since our 1993 audit. In 1997, Child and Family Connections offices (CFCs) were established statewide to carry out intake and service coordination responsibilities. Responsibility for the Program was transferred to the Department of Human Services in January 1998. Also in 1998, the method for funding early intervention services changed from a grant program to a fee-for-service system. In 1999, DHS contracted with a vendor to operate the Central Billing Office to process all payments related to the Early Intervention Program. In 2001, DHS implemented many new program changes, including requiring insurance companies be billed for eligible services and increasing a sliding fee scale.

These changes have resulted in Program improvements since our 1993 audit. There remain, however, areas where further improvements are warranted. DHS is in the process of working toward addressing many of these areas:

- **Child Find and Public Awareness**: The percentage of children participating in the EI Program increased in recent years, but began to decline during the summer of 2001. DHS officials attributed some of the decline to Program changes associated with insurance and family fees. Rates of participation in the Program varied across the State. Additional outreach and public awareness efforts are necessary, especially in counties with low participation rates.

- **Availability of Providers:** In response to a survey we sent asking whether there were a sufficient number of providers so that services were not delayed, 20 of the 25 CFCs noted a severe shortage in one or more early intervention provider types. However, monthly reports filed by CFCs listed relatively few children who were not receiving services due to a lack of early intervention service providers. Also, the number of providers enrolled in the Program increased from 2,200 in September 1998 to approximately 4,200 by January 2002, according to DHS officials.

- **Children Delayed in Receiving Services:** As of October 31, 2001, CFCs reported 1,196 children who were delayed in receiving services. Most of these children were not receiving services because an IFSP had not been prepared within the required 45 days. Family delays, such as parents not responding to inquiries, were reported as the primary reasons

for the delay in 52 percent of the cases. System delays, such as high CFC caseloads or providers not completing assessments in a timely manner, accounted for the remaining 48 percent of the cases. In cases where there were system delays, 85 percent of the children were reported to be delayed two months or less for services.

- **Service Coordinator Caseloads:** Service coordinators' average caseloads varied widely among CFCs, from a low of 34 to a high of 82. DHS officials noted that some of the variations were caused by funded vacancies that the CFCs did not fill or by projected caseloads which did not materialize. High caseloads were cited by several CFCs as a primary reason why IFSPs were not completed within the required 45 days. Some CFCs with high caseloads, however, implemented IFSPs on a more timely basis than did CFCs with lower caseloads.

- **Cost and Client Information:** In August 1995, the Early Intervention Services System Act was amended to require the Illinois Interagency Council on Early Intervention's annual report to include information on the estimated number of eligible children and the estimated cost of providing services to all eligible infants and toddlers in the State. The annual report issued jointly by DHS and the Council for the year ending September 1999 did not include the statutorily required information. The annual report for the year ending September 2000 had not been issued as of January 2002.

BACKGROUND

In 1993, the Office of the Auditor General completed an audit of the early intervention system. Although the State law establishing the Program was passed in 1991, Illinois had been receiving early intervention funding from the federal government since 1987. The audit concluded that although the framework being established should be capable of providing services under State and federal law, there were still several areas that needed to be addressed. These areas included:

- Services were not available in all parts of the State;

- Some eligible children were not being served and were on waiting lists;

- Individualized Family Service Plans were not being completed within the required 45 days;

- Most State agencies did not collect information on the number of children eligible for services, the number served by all programs, or the costs of services per child; and

- Some required federal and State program components had not been fully implemented.

The operation of the Early Intervention (EI) Program has significantly changed since 1993. In 1997, a system of Child and Family Connections offices (CFCs) which carry out intake and service coordination responsibilities was established statewide. Responsibility for the Program was transferred to the Department of Human Services in January 1998. Also in 1998, the method for funding early intervention services changed from a grant program to a fee-for-service system.

The number of providers has increased to approximately 4,200 as of January 2002, according to DHS. In 1999, DHS contracted with a vendor to operate a Central Billing Office to process all payments related to the Early Intervention Program. The number of children served by the Program reached a high of 12,034 in May 2001. In 2001, DHS implemented many new program changes, including requiring insurance companies be billed for eligible services and increasing a sliding fee scale.

Prior to 1998, Early Intervention was a grant program. Under the grant system, funded agencies were unable to provide services to all eligible children in the State. A class action lawsuit (Marie O.) required that early intervention services be made available to all eligible children. In 1998, the method of funding early intervention services changed from a grant program to a fee-for-service system. With the fee-for-service system, the provider base was opened up. The result, according to DHS officials, was an increase in providers and the number of children being served, along with an increase in the amount of funds needed to provide the services.

In our follow-up evaluation of the Early Intervention Program, as directed by Public Act 92-307, effective August 9, 2001, we reviewed issues raised in our 1993 audit of the EI Program, as well as other assessments and reviews of the Program. In this Chapter we examine: Child Find and public awareness efforts; availability of providers; children delayed in receiving services; timeliness of IFSP development; service coordinators' caseloads; training of CFC staff and providers; and program information and annual reports. Other matters which we examined as part of our audit of the Early Intervention Program, and which will be reported in our subsequent report related to the audit determinations of LAC Resolution Number 122, include the adequacy of the EI Program's management information systems, as well as the adequacy of the Program's monitoring of contractor performance.

CHILD FIND AND PUBLIC AWARENESS

For the EI Program to be effective, eligible children and their families need to be identified and provided information about the Program. State and federal laws require the EI Program to establish Child Find and public awareness efforts. Child Find includes activities to ensure that all infants and toddlers in the State who are eligible for EI services are identified, located, and evaluated. Public awareness activities are intended to disseminate information about the Program to primary referral sources, such as hospitals, physicians, and child care programs.

There are several entities involved in the State's Child Find activities. An interagency agreement between DHS and the Illinois State Board of Education (ISBE) requires ISBE to educate local education agencies of their Child Find responsibilities and that they are primary referral sources to the EI Program. The local education agencies are required to conduct public awareness activities targeting families and other primary referral sources. They are also required to conduct or arrange for screenings to be conducted to actively seek out infants and toddlers with disabilities or delays.

Local Interagency Councils (LICs) are responsible for the coordination, design, and implementation of Child Find and public awareness activities for their geographic region. The

LICs, of which there are 44 statewide, are volunteer organizations. The CFCs are also required to participate in public awareness and Child Find activities by disseminating information to the primary referral sources and working with the LICs in their geographic region. According to EI officials, CFCs receive $3,000 a year for each LIC in their geographic area to assist the LIC in coordinating these activities. In addition, DHS provides funding to CFCs for a LIC Coordinator position.

DHS has contracts with two other entities to provide assistance in its Child Find and public awareness efforts: Regional Office of Education #20 and the Illinois Public Health Association. DHS contracts with Regional Office of Education #20 to provide public awareness materials. These materials include pencils, early intervention brochures, growth charts, EI fact sheets, and babysitter packets. The materials are sent to entities that request them, including CFCs, schools, providers, hospitals, and local agencies. The ROE also collects the monthly screening reports submitted by the CFCs and prepares a summary report for the Bureau.

DHS also contracts with the Illinois Public Health Association to operate the Early Intervention Clearinghouse. The mission of the Clearinghouse is to make available a library and information resources related to early childhood intervention. The Clearinghouse is also required to establish a toll-free number, and publish a quarterly informational newsletter.

There are indications that some improvement has been made by DHS in the areas of Child Find and public awareness in recent years, but there remain additional areas for improvement. There are at least two measures to ascertain the effectiveness of the EI Program's Child Find and public awareness efforts -- participation rates and the number of children referred to the Program.

The participation rate is the percentage of children in the age group from 0 to 3 years who are receiving services through the EI Program in a given geographic area. The higher the participation percentage, the greater the indication that the public is aware of the Program and is accessing it. Areas with low participation rates may indicate that additional outreach is needed to educate the public about the EI Program.

Exhibit 2-1
ILLINOIS V. NATIONAL PARTICIPATION RATES

Year	Illinois Average	National Average
December 2001	1.8%	1.8%
December 2000	2.2%	2.0%
December 1999	1.5%	1.8%
December 1998	.9%	1.6%

Source: U. S. Dept. of Education, Office of Special Education Programs and DHS.

As shown by Exhibit 2-1, Illinois' participation rate has increased significantly since 1998. In December 1998, Illinois' statewide participation rate was .9 percent; in December 2001, it was 1.8 percent. Based on information from federal reports, as of December 1, 1994, Illinois' participation rate was 1.45 percent. The national average over the 1998 - 2001 period ranged from 1.6 percent to 2.0 percent. While the national average provides some perspective with which to compare Illinois' participation rate, there are differences among the states (such as reporting methodologies and eligibility requirements) that may impact rates reported by other states, and thus, limit comparisons.

While the Illinois rate has improved, there are still areas of concern. The first area of concern is that there are significant differences in participation rates among the 102 counties in

Illinois. As shown in Exhibit 2-2, in July 2001, the counties with the lowest participation rates were Calhoun County and Carroll County, with participation rates of .7 percent. The county with the highest rate was Wabash County, which had a rate of 7.6 percent. A complete listing of participation rates by county is located in Appendix C.

The participation rates of counties with small populations of children age 0 to 3 can be positively or negatively affected by a small number of children who either participate or do not participate in the EI Program. For example, Calhoun County had a .7 percent participation rate in July 2001, as shown on Exhibit 2-2. However, there were only 141 births in Calhoun County in the three year period from 1997 through 1999 according to DHS data, and there was only one child with an active IFSP in July 2001. If there had been, for example, two more children in the EI Program, the .7 percent participation rate would have increased to over 2 percent.

Exhibit 2-2
VARIATIONS IN COUNTY PARTICIPATION RATES
For selected counties in July 2001

Counties with Lowest Rates	
Calhoun County	.7%
Carroll County	.7%
Scott County	1.0%
Counties with Highest Rates	
Wabash County	7.6%
Gallatin County	7.1%
White County	5.1%
Largest Counties	
Cook County (Chicago only)	1.6%
Cook County (excluding Chicago)	1.9%
DuPage County	1.5%
Statewide Average	2.0%

Source: OAG from DHS documents.

In its 1999 monitoring report on the Illinois EI Program, the federal Office of Special Education Programs (OSEP) noted:

> *After analysis of June 1999 data, OSEP was concerned about the great variability in service rates across the State. For example, 1.28% were served in Chicago, 1.51% in Cook, 1.04% in DuPage, 1.11% in Mercer, 2.33% in Pope, 2.24% in Union, and 5.65% in Wayne. This variability may, or may not, be evidence of deficiencies in DHS' public awareness and child find efforts. However, given the high poverty of Chicago and the fact that only 1.28% of infants and toddlers in that city receive Part C services compared to the national average of 1.7%, OSEP is extremely concerned about the strong possibility that not all eligible children are being identified, evaluated, and served.*

We asked DHS what they were doing to follow-up in areas where participation rates were low in comparison with those in other counties. In November 2001, the EI Bureau Chief sent an e-mail to the four EI staff responsible for working with the 25 CFCs. We were provided with responses to the e-mail from 5 CFCs. Examples of the responses are shown in Exhibit 2-3. These responses provide some feedback to DHS as to what actions are being taken by the CFCs to improve participation rates.

In late 2001, the Bureau began the development of the Early Intervention Operations Plan. The Plan contains goals, objectives, and action steps covering a wide range of Early Intervention Program areas. The Operations Plan contains an objective to develop action plans to increase participation in areas with low participation rates.

The second area of concern regarding Illinois' participation rate is that the number of cases with IFSPs in Illinois has been steadily decreasing since May 2001. The number of active IFSPs is used to calculate the participation rate. In May 2001, the number of cases with an active IFSP was 12,034. By December 2001, the number of cases with active IFSPs declined to 9,910, or an 18 percent decrease since May 2001. As shown in Exhibit 2-1, Illinois' statewide participation rate declined from 2.2 percent in December 2000 to 1.8 percent in December 2001.

Exhibit 2-3
CFC RESPONSES TO EI BUREAU FOLLOW-UP ON LOW PARTICIPATION RATES

Carroll County: "We mail letters and brochures to all agencies we can think of which might be referral sources for Carroll County children (and eventually the other counties as well). Carroll County also has a radio station, and we will send a public service announcement to them. If you have other suggestions, we would certainly be open to hearing them."
Calhoun and Scott Counties: "We have been historically low [in Scott County]. Scott does not even have its own health department. Our next provider meeting is in Scott County, maybe that will spark some interest. Myself and the LIC coordinator will hit the PR hard for these two counties."
Kane and Kendall Counties: "The CFC is actively involved in community activities to ensure awareness of EI. Some of the activities in the community include school and transition meetings and local health fairs. The number of active cases is down due to families opting to use their private insurance services outside the EI system."

Source: OAG from DHS.

A second measure of the effectiveness of the EI Program's Child Find and public awareness activities is the number of referrals to the Program. The higher the number of referrals to the Program, the greater the likelihood that the public is aware of the EI Program.

The number of referrals to CFCs increased when compared from 1998 to 2001. The EI Program's 1998 annual report stated there were 15,225 referrals to CFCs from October 1997 through September 1998. From the time period October 2000 through September 2001, DHS reported 16,291 children were referred to CFCs.

It is not clear, however, whether the number of referrals has remained consistent, or whether they have declined over the past year. Based on information provided by the EI Bureau from Cornerstone reports, the number of cases being referred to CFCs has remained fairly consistent over the past 16 months. Referrals averaged 1,374 per month during the last 9 months of fiscal year 2001 and 1,370 per month during the first 7 months of fiscal year 2002.

The CFC monthly managers' reports, however, reported a significantly higher number of referrals for the period January through June than did the Cornerstone reports. For example, in March 2001, the managers reported a total of 1,837 cases referred to them; the Cornerstone report listed 1,642 referrals, or a difference of 195 cases. If the monthly managers' reports are more accurate, then the number of referrals decreased in the second half of 2001.

We surveyed the 25 CFCs and asked if there were areas where improvements could be made in the outreach activities of the EI Program. Twenty-one of the 25 CFCs responded that improvements could be made. Some of the suggestions included:

- Improving connections with physicians and nurses (4 CFCs);

- Providing additional funding for promotional ads and more outreach activities (4 CFCs); and

- More effectively dealing with language issues (such as in Hispanic areas where English is a second language) (4 CFCs).

Three CFCs noted that the Local Interagency Councils, which share responsibility with the CFCs to conduct Child Find activities, lack time or funding to carry out such activities. When we asked CFCs whether there were areas where the Local Interagency Councils could be more effective, 8 of the 25 CFCs cited increased Child Find and public awareness efforts.

An important component of Child Find is the screening process. Screenings are conducted to determine whether a child is potentially eligible for EI services. We reviewed the Summary of Child Find Screening Reports prepared by ROE #20 for the first 5 months of fiscal year 2002. CFCs reported a total of 6,273 screenings of children age 0 through 35 months during July - November 2001. During the same 5 month period in 2000, CFCs reported conducting slightly more screenings -- 6,890. DHS does not set any specific standards for CFCs or LICs related to Child Find or public awareness activities (such as a minimum number of screenings or basic activities that must be carried out).

Illinois' Continuous Improvement Plan, submitted to the U. S. Department of Education's Office of Special Education Programs (OSEP) in January 2002, identified areas where the State's public awareness and Child Find system needed to be improved. The Plan noted that screenings at public health departments and childcare settings were not being consistently reported. The Plan also noted that there were counties in Illinois with participation rates less than 1.6 percent. Finally, the Plan noted that additional analysis needs to be done to ensure that children from diverse racial or ethnic backgrounds are adequately being referred to the EI Program.

CHILD FIND AND PUBLIC AWARENESS	
RECOMMENDATION NUMBER **1**	***The Department of Human Services should continue efforts to increase public awareness of the Early Intervention Program, specifically focusing such efforts in areas of the State with low EI Program participation rates.***
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Department will continue its efforts to increase public awareness of the program. One of the ways this will be accomplished is through a performance contract measure with all Child and Family Connections (CFC) offices. There will be a specific performance measure related to penetration rates in CFC contracts for FY03. The Department will also continue to work with specific counties with low participation rates to assist the CFCs in determining methods to raise the rates.

AVAILABILITY OF PROVIDERS

An effective early intervention system requires an adequate number of providers to deliver services. The Auditor General's 1993 audit found that there was a shortage of early intervention service providers. The audit reported that there were 99 providers of early intervention services. Many of these providers were community or local government agencies that provided a variety of services.

Since the 1993 audit, the early intervention delivery system changed in Illinois. In 1993, funding for EI services was paid to local service providers in the form of grants. In 1998, the service delivery system changed to a fee-for-service system. The Illinois Interagency Council on Early Intervention's Annual Report for the year ending September 30, 1998, reported that approximately 2,200 early intervention providers had enrolled in the Program. As of January 2002, the EI Bureau reported that approximately 4,200 providers were credentialed to provide early intervention services.

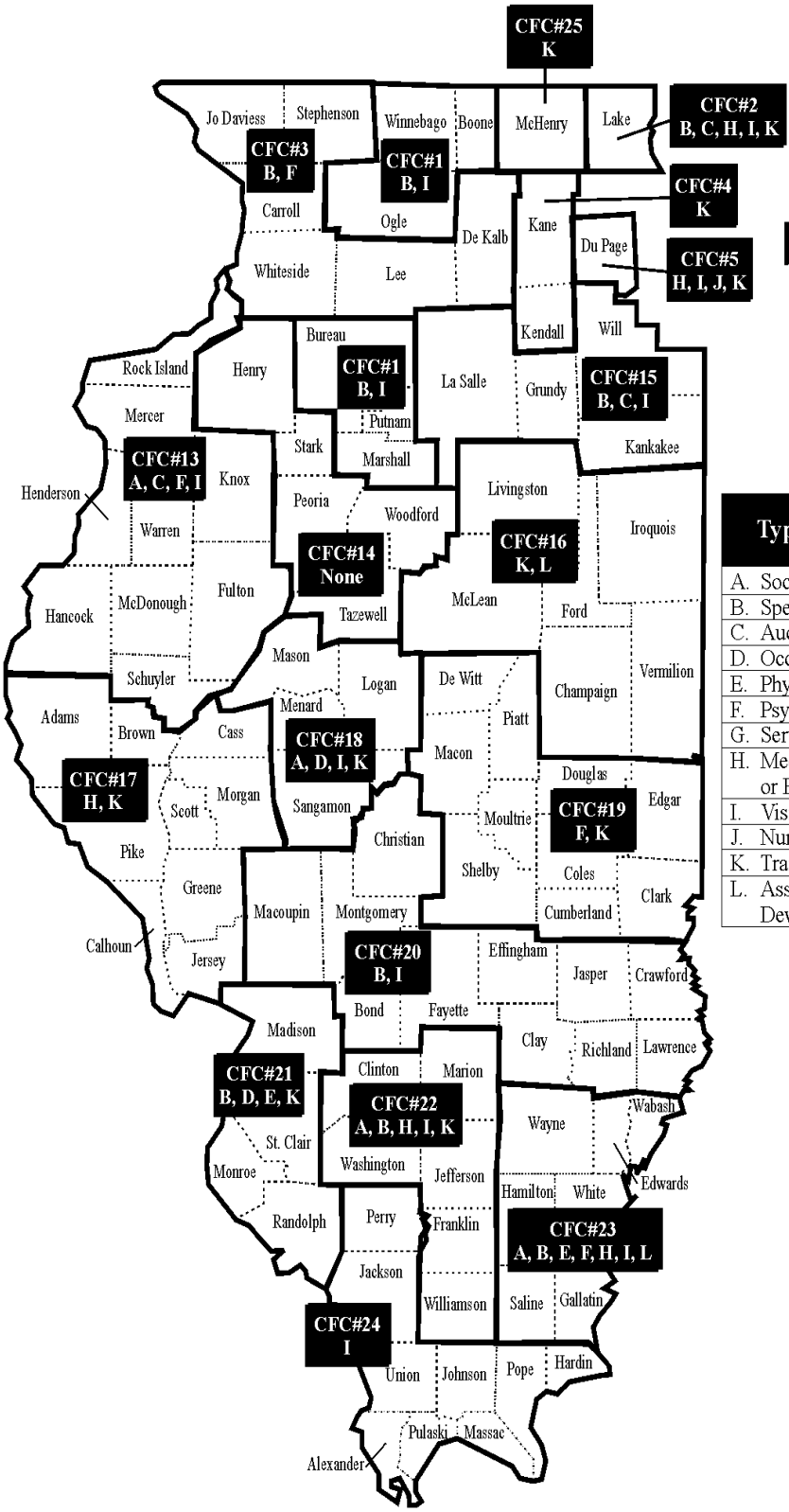
The monthly managers' reports submitted by CFCs reported that relatively few children were delayed for services because a provider was unavailable. In the June 30, 2001 monthly managers' reports, the CFCs reported 54 cases that were delayed due to providers being unavailable, which accounted for only 4 percent of all children reported delayed for services that month. During the month, the unavailability of providers in 11 of the 54 cases was resolved. Of the remaining 43 unresolved cases, 37 were due to the unavailability of speech therapy providers. Two CFCs accounted for the majority of unavailable speech therapy providers -- CFC #1 had 20 cases and CFC #2 had 12 cases. Providers were also reported to be unavailable for developmental therapy, physical therapy, and audiological services.

While the CFCs' monthly managers' reports contained relatively few instances where services were delayed due to a lack of service providers, CFCs' responses to our November 2001 survey identified a more prevalent problem. In our survey, we asked the CFCs to identify whether there was an adequate number of providers in their CFC area for the various types of services. The survey defined adequacy as whether there was "a sufficient number of providers so that client services are not delayed." If there was not an adequate number of providers, we asked the CFCs whether there was a slight or severe shortage.

Twenty of the 25 CFCs responded that there was a severe shortage in at least 1 of the 16 types of service providers for which we inquired. Generally, the CFCs in the Cook County area reported fewer severe shortages of providers than CFCs located elsewhere in the State. Exhibit 2-4 shows the provider types for which CFCs reported a severe shortage.

Transportation was the service most frequently cited as having a severe shortage -- 12 of the 25 CFCs. Ten CFCs reported a severe shortage in vision services, while nine cited a severe shortage in speech and language therapy.

Exhibit 2-4
PROVIDER SHORTAGES REPORTED BY CFCS



Type of Service Provider	# of CFCs Citing Shortages
A. Social Work Services	5
B. Speech, Language Therapy	9
C. Audiology	3
D. Occupational Therapy	2
E. Physical Therapy	2
F. Psychological Services	4
G. Service Coordination Services	1
H. Medical Services for Diagnostic or Evaluation Purposes	6
I. Vision Services	10
J. Nursing	1
K. Transportation	12
L. Assistive Technology Devices and Services	2

Source: OAG analysis of CFC responses to November 2001 survey.

The majority of the CFCs (18) noted that shortages were caused by a lack of providers. Other reasons cited were that providers did not want to participate in the Program due to the low reimbursement rates, insurance issues, and constant changes being made to the system.

Provider recruitment is one of the responsibilities of the Local Interagency Councils (LICs). Our survey asked CFCs whether there were specific areas where the LICs could be more active. Fourteen of the 25 CFCs (56 percent) responded that the LICs could be more active in the recruitment of providers to the EI Program.

Increasing the number of bilingual providers in the EI Program is also an area where improvement is needed. Four of the CFCs surveyed noted that a shortage of bilingual providers existed. The four CFCs were located in the City of Chicago. Also, the monthly managers' reports contain a category called "Unavailable Bilingual Provider or Interpreter." On average, there were six cases per month in fiscal year 2001 where CFCs reported services being delayed due to the unavailability of a bilingual provider or interpreter.

The Self-Assessment report prepared as part of the federal Continuous Improvement Monitoring Process noted that while the number of translators increased from 1999 to 2000, there remained anecdotal evidence that there were pockets in the State where translators or providers for specific languages may not be available. The Self-Assessment report recommended that the State continue to work with LICs and CFCs in recruiting bilingual providers and translators to work with families who do not speak English. The public forums held in October 2001 also discussed the need to use bilingual interpreters and recruit bilingual providers. Finally, the Improvement Plan submitted to the federal OSEP in January 2002 contained strategies to improve the availability of bilingual providers or interpreters.

PROVIDER AVAILABILITY	
RECOMMENDATION NUMBER **2**	***The Department of Human Services should follow-up with the CFCs that reported shortages of providers and develop strategies to recruit additional providers where needed. Also, DHS should continue its efforts to recruit bilingual providers and interpreters for participation in the EI Program.***
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Department will continue to follow-up with CFCs that report provider shortages. There is currently a process in place for CFCs to contact the Bureau of E.I. when there are shortages of providers. Bureau staff works with the CFC to recruit providers. We will increase our efforts to recruit bilingual providers and interpreters for the program.

CHILDREN DELAYED IN RECEIVING SERVICES

Our 1993 audit reported that there were 1,048 children waiting for services to be provided as of November 1, 1992. Providers surveyed as part of the 1993 audit reported that children waited anywhere from 2 weeks to 12 months for services. As discussed earlier, in 1993, providers

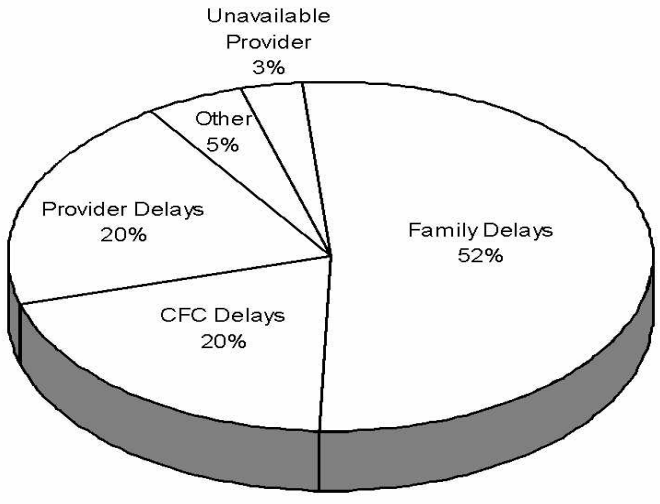
received a set amount of grant funds to pay for services. According to DHS officials, when providers' grant funds were expended, children had to wait for services. The Marie O. class action complaint noted that the State's decision to provide mandated services only as appropriated funds became available "has resulted in serious and systematic unavailability and inadequacy of services in the State of Illinois."

As of October 31, 2001, CFC monthly managers' reports identified 1,196 children as delayed in receiving services. We identified instances where CFCs did not include in their monthly managers' reports all the cases where children did not have an IFSP within the required 45 days. Consequently, it is likely that the number of children delayed in receiving services is greater than the 1,196 reported in the October 2001 monthly managers' reports. Our review of the EI Program's management information systems will be examined in greater detail in our report covering matters included in Legislative Audit Commission Resolution Number 122, to be issued in the summer of 2002.

In 2001, while there continued to be children delayed in receiving services, there are important differences between the numbers reported for 1993 and 2001. Whereas in 1993 services were not available due to a lack of State funding, in 2001, funding was available for needed services. A major reason why children were not receiving services in 2001 (52 percent of the cases in October 2001) were delays due to family reasons, such as the parent was unable to be contacted, did not respond to inquiries, did not show up for meetings, refused services, or was waiting for a specific provider to become available to serve their child. The CFCs' ability to process cases and arrange for services is significantly limited if there are delays associated with the parents.

Also, in 2001, DHS reported a case as being delayed if an IFSP was not in place within the required 45 days, or if an annual IFSP review had not been done in a timely manner. DHS noted that had this criteria been used in 1993 to report waiting lists, that the number of children reported as waiting would have been significantly higher.

Exhibit 2-5
REASONS SERVICES TO CHILDREN WERE DELAYED
as of October 31, 2001



Source: OAG analysis of Statewide Monthly Managers' Report for October 2001.

As shown in Exhibit 2-5, delays due to family reasons were cited as the primary reason for the child not receiving services in 52 percent (618 of 1,196) of the cases in October 2001. Provider delays comprised the second largest reason (239 cases) why children were not receiving services. Provider delays included instances where the provider was untimely in completing evaluations and assessments or was sick. The third largest reason for

service delays was CFC delays. CFC delays accounted for 20 percent (234 cases) of the cases where children were not receiving services. Some of the CFCs we surveyed reported high caseloads as a primary reason for delays in completing the IFSPs. Service coordinator caseloads are discussed later in this Chapter.

In reporting children delayed in receiving services, DHS distinguishes between children delayed in receiving services due to family reasons (such as parent delays) versus system delays (such as CFC delays, lack of provider, etc.). The statewide monthly managers' report analysis prepared by DHS ages the cases where the child is not receiving services due to system delays. As of October 31, 2001, of the 578 children not receiving services due to system delays, 493 (85 percent) were delayed in receiving services for two months or less; 71 were delayed for three to four months, and 14 were delayed for five or more months.

The percent of the CFC's caseload where services were delayed varied across the State. Eighteen percent of the children in CFC #1 were reported as delayed in receiving services as of October 31, 2001, whereas only three percent of children were so reported in CFCs #13 and #25. The Operations Plan being developed by the EI Bureau contains an objective to "develop strategies to eliminate waiting lists."

The 1,196 children that CFCs reported as delayed in receiving services as of October 31, 2001 fell into one of three categories:

- 891 (74 percent) were over 45 days without an initial IFSP;
- 81 (7 percent) had an IFSP but were not getting all the services on the IFSP; and
- 224 (19 percent) were overdue for their 6 month or annual IFSP review.

Our 1993 audit also reported that IFSPs were not being completed within the required 45 days. State law (325 ILCS 20/11) and EI administrative rule (89 Ill. Adm. Code 500.70) require that an IFSP be completed within 45 days of a child's referral to the EI Program. As part of our 1993 audit, we reviewed 80 cases and found that 46 cases contained IFSPs that were not completed within 45 days and 8 cases had no IFSPs. We recommended that IFSPs be developed within the required 45 days.

The preparation of IFSPs within the 45 day time period continues to be a problem. During the first six months of fiscal year 2002, approximately 50 percent of the IFSPs were not completed within the required 45 days, according to EI staff. We requested that DHS run a report that showed the average number of days from the time a client was referred to the Program to the date the IFSP was prepared. IFSPs were completed an average of 75 days after the initial referral, or 30 days longer than required by law. The average number of days CFCs took to complete the IFSPs ranged from a low of 50 days to 106 days, according to DHS.

In our survey of CFCs, we inquired as to the primary reasons why IFSPs were not completed within the required 45 day timeframe. Parent delays were cited by 23 of the 25 CFCs as a primary reason. Other reasons reported by the CFCs were: provider delays, such as late

evaluation reports (10 CFCs); high service coordinator caseloads (7 CFCs); the Quality Enhancement process (4 CFCs); and insurance issues (2 CFCs).

The potential effectiveness of the EI Program is diminished if services are not received in a timely manner. An important step in receiving needed services in a timely manner is the preparation of the Individualized Family Service Plan within the required 45 days.

CHILDREN DELAYED IN RECEIVING SERVICES	
RECOMMENDATION NUMBER **3**	***The Department of Human Services should continue to monitor and follow-up on cases where children are not receiving services in a timely manner. When EI system delays are the cause for the delays, action should be taken to address such causes.***
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Department will continue to monitor and follow-up on cases where children are not receiving services in a timely manner. Currently this is accomplished with the four staff within the Bureau of E.I. that are assigned to work with the CFCs. In FY03 there will be special emphasis on performance measures that address this issue along with follow-up by Bureau of E.I. staff.

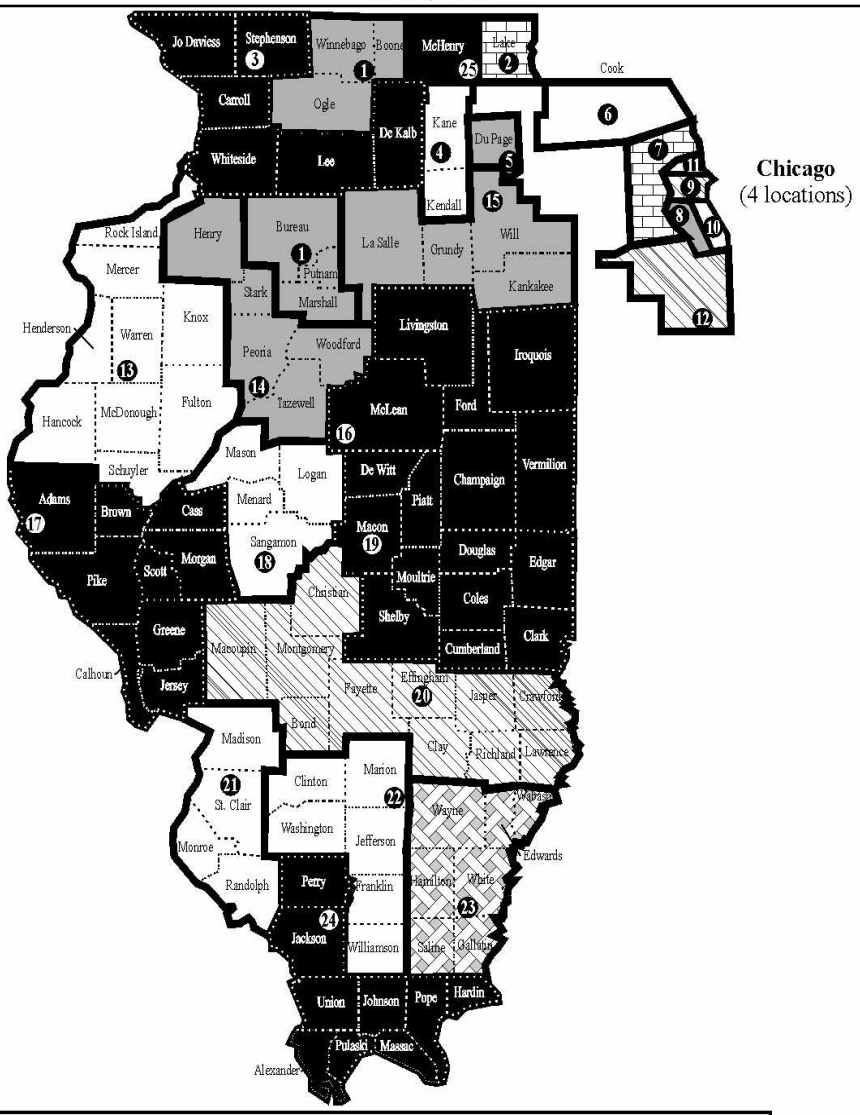
SERVICE COORDINATOR CASELOADS

There were wide variations in the average caseloads of service coordinators across the 25 CFCs. We analyzed the caseload information from the Cornerstone system for the month ending October 31, 2001. The average caseloads ranged from 34 cases at CFC #16 to 82 cases at CFC #23. Six CFCs had average caseloads under 40, while 3 had average caseloads that exceeded 70 cases per service coordinator. Exhibit 2-6 shows the average caseloads for each of the 25 CFCs as of October 31, 2001.

As part of the funding formula for CFCs, DHS based CFC funding on a caseload of approximately 50 IFSP cases per service coordinator. In some instances, projected caseloads did not materialize, according to EI officials; in other instances, CFCs had funded service coordinator vacancies that they chose not to fill. The EI Bureau does not have any service coordinator caseload standards.

Service coordinators play a key role in the early intervention system. Excessive caseloads can have a detrimental effect on children and families receiving timely, comprehensive services. Service coordinators' responsibilities include coordinating the child's assessments, participating in the QE reviews and IFSP development, helping families find available providers, and monitoring the delivery of services.

Exhibit 2-6
AVERAGE SERVICE COORDINATOR CASELOADS
as of October 31, 2001



Average Service Coordinator Caseloads

30 - 39	40 - 49	50 - 59	60 - 69	70 - 79	80 - 89
CFC 25	CFC 15	CFC 22	CFC 20	CFC 7	CFC 23
CFC 24	CFC 14	CFC 21	CFC 12	CFC 2	
CFC 19	CFC 8	CFC 18	CFC 9		
CFC 17	CFC 5	CFC 13			
CFC 16	CFC 1	CFC 11			
CFC 3		CFC 10			
		CFC 6			
		CFC 4			

Source: OAG analysis of DHS monthly enrollment reports.

In responding to the survey we sent to CFCs in November 2001, high caseloads were cited by 7 CFCs as a primary reason for IFSPs not being completed within 45 days, including two of the three CFCs with the highest caseloads. It should be noted, however, that caseload is but one factor that impacts the effectiveness of CFC activities. For example, some CFCs with high caseloads implement IFSPs on a more timely basis, on average, than CFCs with lower caseloads.

High caseloads and their impact on effective service coordination were reported at the public forum meetings held in October 2001, as well as in the Continuous Improvement Plan. Reducing service coordinator caseloads was cited as a primary way to improve system performance in most of the areas examined as part of the public forum meetings.

The Continuous Improvement Plan stated that "Service coordinators report that the number of children and families on their caseloads makes it difficult to provide comprehensive service coordination." The Plan sets a deadline of September 2002 for obtaining accurate service coordination caseload data and reviewing its appropriateness compared to State established and nationally accepted criteria.

SERVICE COORDINATOR CASELOADS	
RECOMMENDATION NUMBER **4**	***The Department of Human Services should review the appropriateness of CFC caseloads compared to State established and nationally accepted criteria, as called for in the Improvement Plan submitted to the federal Office of Special Education Programs. When CFC caseloads deviate significantly from such criteria and when such deviations are determined to be limiting effective service coordination, appropriate follow-up action should be taken.***
DEPARTMENT OF HUMAN SERVICES RESPONSE	This issue will be addressed in the FY03 performance contracting measures. The Department will also provide more technical assistance to the CFCs to ensure they have appropriate resources to ensure effective service coordination.

SERVICE COORDINATOR AND PROVIDER TRAINING

Training of service coordinators and providers is an important element in an effective early intervention system given the importance of the coordination of services and delivery of services. DHS has provided or facilitated training of service coordinators and providers; however, additional training is needed.

All 25 CFCs responded to our survey that additional training was needed. The following three areas were mentioned most frequently:

- New insurance requirements: 20 CFCs
- Outcome writing and IFSP development: 9 CFCs

- Cornerstone: 6 CFCs

DHS officials stated that training either has been provided or is being planned in the areas identified by CFCs. Exhibit 2-7 identifies some of the training provided to CFCs and providers in calendar year 2001.

Exhibit 2-7
EXAMPLES OF TRAINING PROVIDED TO CFCs AND PROVIDERS
Calendar Year 2001

PROVIDER CONNECTIONS COORDINATED TRAINING:

- **Parent Liaison Training:** Covered the roles and responsibilities of the Parent Liaison, family issues, cultural diversity, and accessing resources.
- **EI Systems Overview:** Reviewed the basics of Illinois' Early Intervention System (such as history, legislation process, and impact on children and their families).
- **EI Specialist Documentation:** Provided an overview of the process for gathering information and managing case note documentation.
- **Battelle Development Inventory:** Reviewed the administration of the Battelle Assessment Instrument, which is used in the assessment of young children.
- **IFSP & Team Building for EI Specialists:** Addressed issues related to the development of the IFSP.
- **Hawaii Early Learning Profile:** Reviewed the objectives and administration of the Hawaii Early Learning Profile, which is a curriculum-based assessment tool.
- **EI Home Visiting:** Highlighted the home visiting philosophy and methodology.

DHS COORDINATED TRAINING:

- **CFC Comprehensive Training Institute:** Provided an overview of the Early Intervention Program in Illinois.
- **Cornerstone and Other Enrollment Issues:** Focused on changes in Cornerstone related to the EI Program.
- **Clarification of Key Policies and Procedures Teleconference:** Covered topics such as family insurance and fees.
- **Regional Update Meetings:** Included topics such as Quality Enhancement, insurance, family fees, and Cornerstone.
- **Regional Insurance Billing Provider Meetings:** Taught providers how to bill and establish themselves with insurance companies, HMOs and PPOs.

Source: OAG from DHS documents.

In addition, testimony at the public forum meetings held across the State in October 2001 identified the need for additional training of CFC personnel and providers. Additional training for service coordinators was cited as a way to improve the referral and evaluation processes. Forum participants noted the need for additional service coordinator and provider training related to including families in the IFSP development process, as well as assuring that appropriate services are provided to infants and toddlers with disabilities. Training for service coordinators was also recommended for planning the transition to other services upon the child's attainment of age three.

The Continuous Improvement Monitoring Process also identified outcome training as something that needed to be accomplished to help ensure comprehensive, coordinated services. Service coordinators reported that they were not sufficiently prepared to develop functional outcomes. The Improvement Plan reported that Quality Enhancement teams noted that EI service providers are also not sufficiently prepared to develop functional outcomes. Also, 19 of the CFC site evaluations conducted by DHS in 2001 noted that IFSPs did not have clear goals and/or outcomes with timelines, indicating the need for outcome training.

The Improvement Plan, submitted to the federal OSEP in January 2002, established a goal of implementing statewide training for service coordinators and EI providers on the development of functional outcomes by December 2002. EI officials stated that a "Train the Trainer" session was held in February 2002 for the statewide training on outcomes.

DHS has recognized the need for additional CFC and provider training. The first quarterly report prepared by the Secretary of DHS, as required by Public Act 92-307, identified the need to provide more training to CFCs and providers. The quarterly report noted that, "CFC's are being asked to perform an increasingly complex role. Families in all parts of the state should receive consistent services from CFCs and providers." Also, the Operations Plan being developed by the EI Bureau contains objectives to provide more and better training to CFCs as well as pediatric training to providers.

SERVICE COORDINATOR AND PROVIDER TRAINING	
RECOMMENDATION NUMBER **5**	***The Department of Human Services should continue its efforts to ensure that CFC staff and providers receive the training necessary to effectively provide services to EI children and their families.***
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Department is currently in the process of enhancing training for CFC staff and providers for FY03. The Department has a training workgroup consisting of all of the entities that are currently contracted for training services (IMDN, Provider Connections and the Community Health Training Center). This workgroup is developing training consistent with Public Act 92-307 and the amendments to 89 Ill. Adm. Code 500.

PROGRAM INFORMATION AND ANNUAL REPORTS

Our 1993 audit found that the State did not have complete information on the number of eligible children, the number of children served, or the cost of services. The audit recommended that State agencies collect this information. The audit also noted that the General Assembly may wish to consider establishing a requirement that such information be reported by the Illinois Interagency Council on Early Intervention (IICEI) on an annual basis.

Effective August 11, 1995, the Illinois Early Intervention Services System Act was amended to require that the annual report prepared by the IICEI include the following:

> *The annual report shall include (i) the estimated number of eligible infants and toddlers in this State, (ii) the number of eligible infants and toddlers who have received services under this Act and the cost of providing those services, and (iii) the estimated cost of providing those services under this Act to all eligible infants and toddlers in this State. (325 ILCS 20/4)*

The Annual Report for the year ending September 30, 1997 contained some of the information required by the law. The 1997 Report estimated the number of eligible infants and toddlers to be 12,420. The 1997 Report did not include the cost of services received in the reporting year, noting that "there is no single mechanism in place at this time to provide an accurate child count or the total amount of dollars actually spent to provide early intervention services by all agencies involved in this initiative." It went on to say that such data should be available when the Central Billing Office became operational.

Finally, the report estimated the total cost of providing services to all eligible infants and toddlers to be $51.6 million. The report noted that "not all children receive services from the day of birth -- many begin at 18 months and will not be found no matter how extensive and efficient Child Find becomes."

The Council's 1998 annual report also contained some of the statutorily required information. It estimated that 8,640 children would be eligible for the program and that it would cost $43.2 million to serve them.

The annual report issued by DHS and the Council for the year ending September 1999 did not contain the statutorily required information on program participants and cost. DHS officials stated that the information required by Section 4 of the Early Intervention Services System Act will be included in the 2001 annual report.

DHS and the Council issue a joint report. DHS prepares the report, the Council reviews the report, and the Council Chairperson signs the report's cover letter. While the Early Intervention Services System Act does not contain any deadline as to when the annual reports are to be submitted, the most recent EI annual reports have not been issued in a timely manner. The annual report for the year ending September 1998 was issued in November 1999; the report for the year ending September 1999 was issued in November 2001; and the annual report for the year ended September 2000 had not been issued as of January 2002.

PROGRAM INFORMATION AND ANNUAL REPORTS	
RECOMMENDATION NUMBER **6**	***The Department of Human Services and the Illinois Interagency Council on Early Intervention should issue the annual report required by the Illinois Early Intervention Services System Act in a timely manner. Furthermore, the annual report should contain the information required by Section 4 of the Act.***
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Department agrees with this recommendation and future annual reports will be issued as required and contain what is outlined in Section 4 of the Act.

Chapter Three

OTHER ISSUES

CHAPTER CONCLUSIONS

In June 2001, the Department implemented the Quality Enhancement (QE) process, which was established to ensure that all eligible children and their families receive appropriate, consistent, and quality interventions. According to DHS officials, the U. S. Department of Education's Office of Special Education Programs (OSEP) raised concerns regarding the QE process because the IFSP team was not developing the IFSP which details the type and amount of care a child and family will receive. OSEP has not yet made its Part C grant award of approximately $16.6 million to Illinois for federal fiscal year 2001 pending revision of the QE process. DHS has begun to undertake revisions to the QE process.

Public Act 92-307, effective August 9, 2001, made significant changes to the Early Intervention Program. These changes included: establishing new eligibility requirements; mandating changes in the credentialing and training of EI providers; setting new insurance and family fee requirements; and requiring the bidding of certain EI contracts. The Department has implemented many of the new requirements; implementation of others is still underway.

The Early Intervention Program has taken steps to improve Program planning. In late 2001, the Bureau began the development of an Operations Plan that contains goals and objectives to improve the operations and management of the EI Program. DHS has also participated in, and developed an Improvement Plan to address issues raised as part of, the Continuous Improvement Monitoring Process. The Program is developing measures that could be used to assess various aspects of system performance. In 2001, the Illinois Interagency Early Intervention Council also developed a Vision and Mission Statement and established Principles of Early Intervention. While key planning efforts have been initiated, DHS has not developed an overall long-term strategic plan for the EI Program. Such a plan would allow Program managers to assess the degree to which the Program is having its intended effect.

QUALITY ENHANCEMENT PROCESS

In June 2001, the Department implemented the Quality Enhancement (QE) process, which was established to ensure that all eligible children and their families receive appropriate, consistent, and quality interventions. The QE team (comprised of a developmental pediatrician, an Illinois Medical Diagnostic Network coordinator, the child's CFC service coordinator, the CFC parent liaison, and two local providers) reviews the child's evaluation and assessment. The CFC also prepares a QE Presentation Form that contains a brief overview of the family's concerns and goals for the child.

During the 1st quarter of fiscal year 2002, the QE teams completed a total of 4,865 reviews, according to DHS. Some key statistics from the quarterly report include the following:

- 49 percent of the QE reviews resulted in no changes to the recommended services.

- The QE review reduced the total number of service hours 20 percent statewide from what was originally proposed (47,816 hours originally proposed; 38,444 hours QE recommended).

- There was wide variation in the percentage decrease in the service hours among the 11 QE areas: for example, hours were reduced by 43 percent by the SIU QE team, whereas the Peoria QE team averaged a 9 percent reduction in service hours.

- There was also wide variation in the average number of service hours recommended per child among the CFCs. Prior to the QE review, the SIU QE area had the highest average number of hours per child per month-- 12.6, while the Peoria QE area had the lowest at 6.7. As a result of the QE review, the average number of hours per child after the QE review was fairly close in these two regions: 7.1 in SIU and 6.1 in Peoria. The Rockford QE area had the highest average number of service hours per child per month after the QE review: 10.6.

The U. S. Department of Education's Office of Special Education Programs (OSEP) concluded that the QE process is inconsistent with Part C of the federal IDEA, which requires that the group developing the IFSP include the parent and otherwise meet the IFSP team participant requirements. According to DHS officials, OSEP raised concerns regarding the QE process because the IFSP team was not developing the IFSP which details the type and amount of care a child and family will receive. OSEP noted that, "A State may neither confer the final determination of the early intervention services on a body that does not meet those requirements, nor require a parent to initiate mediation or an administrative proceeding . . . in order to secure the early intervention services determined necessary by the IFSP team."

OSEP directed DHS to revise the State's IFSP procedures to make them consistent with the requirements of Part C. According to DHS officials, OSEP has not yet made its Part C grant award of approximately $16.6 million to Illinois for federal fiscal year 2001 pending revision of the QE process. In February 2002, DHS proposed a revised QE process to OSEP for review. DHS plans to implement a revised procedure in some parts of Illinois in spring 2002, with full implementation by July 1, 2002.

IMPLEMENTATION OF PUBLIC ACT 92-307

DHS has taken steps to implement many of the requirements of Public Act 92-307, which became effective on August 9, 2001. The Public Act makes significant changes to the Early Intervention Program, including: establishing new eligibility requirements; mandating changes in the credentialing and training of EI providers; setting new insurance and family fee requirements; and requiring the bidding of certain EI contracts. Appendix D contains a summary of the status of DHS' implementation of the requirements of Public Act 92-307. Given that the changes required by Public Act 92-307 have only been recently implemented, the scope of this audit did not include

assessing the impact of these changes or whether changes made to rules, policies, and procedures have actually been implemented in practice.

Some of the required changes to DHS' administrative rules were accomplished in July 2001, prior to the enactment of the Public Act. A DHS official stated that the proposed EI rules being developed in the spring of 2001 were adjusted to conform to Senate Bill 461 (which became Public Act 92-307). These changes included revisions to the eligibility definition, required contents of the Individualized Family Service Plan (IFSP), establishment of a sliding fee schedule in law, and new insurance requirements. Other items required by Public Act 92-307 that have been implemented by DHS include: the development of a screening device to determine eligibility for Medicaid, KidCare, and the University of Illinois' Division of Specialized Care for Children; enrollment of CFCs as KidCare agents; maintenance of an Early Intervention web-site; and an interagency agreement with the Department of Public Aid.

There are some requirements of Public Act 92-307 that DHS has not yet fully implemented. For example, Section 5 of the Act requires DHS to enter into interagency agreements with the Illinois Department of Public Aid and the University of Illinois' Division of Specialized Care for Children (DSCC) within 60 days of the Act's effective date. An interagency agreement with the Department of Public Aid was signed on December 19, 2001, more than 4 months after the effective date of the Act. DHS had not entered into the required interagency agreement with DSCC as of February 2002. DHS officials stated that one was being reviewed by both agencies.

IMPLEMENTATION OF PUBLIC ACT 92-307	
RECOMMENDATION NUMBER **7**	***The Department of Human Services should continue its efforts to implement all the requirements of Public Act 92-307.***
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Department agrees with this recommendation and will continue to implement the requirements.

STRATEGIC PLANNING

The EI Program has undergone significant changes in recent years. The State agency responsible for managing the program has changed, the payment method for services switched from a grant program to fee-for-service system; new insurance and family fee requirements have been implemented; and a Quality Enhancement process was put in place. In such a changing Program environment, planning is difficult and strong management controls become even more important. However, in such a changing environment, formal planning is even more critical to ensure that the changes are consistent with, and supportive of, the main Program goals and objectives.

The Early Intervention Program has taken steps to improve Program planning. DHS is developing measures to assess the performance of CFCs as well as other aspects of the EI system. DHS is participating in the federal Continuous Improvement Monitoring Process, in which various aspects of the Program are reviewed, not only by DHS staff, but other stakeholders in the process, including families, providers, and CFCs. Areas for improvement have been identified and an Improvement Plan has been developed. In late 2001, the Bureau began the development of an Operations Plan that contains goals and objectives to improve the operations and management of the EI Program.

In 2001, the Illinois Interagency Early Intervention Council developed a Vision and Mission Statement and established Principles of Early Intervention. While key planning efforts have been initiated, DHS has not developed an overall long-term strategic plan for the EI Program. Such a plan would allow Program managers to assess the degree to which the Program is having its intended effect.

STRATEGIC PLANNING	
RECOMMENDATION NUMBER **8**	***The Department of Human Services should establish a formal plan for the Early Intervention Program which establishes goals and objectives for the Program, as well as performance measures to determine whether desired outcomes are being achieved.***
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Department will finalize the Operations Plan that is currently in development. It will be reviewed to ensure it establishes goals and objectives for the program.

APPENDICES

APPENDIX A

PUBLIC ACT 92-307

PUBLIC ACT 92-307
Office of the Auditor General Audit Requirement

(325 ILCS 20/15) (from Ch. 23, par. 4165)

Sec. 15. The Auditor General of the State shall conduct a follow-up evaluation of the system established under this Act, in order to evaluate the effectiveness of the system in providing services that enhance the capacities of families throughout Illinois to meet the special needs of their eligible infants and toddlers, and provide a report of the evaluation to the Governor and the General Assembly no later than April 30, 2002. Upon receipt by the lead agency, this report shall be posted on the early intervention website.
(Source: P.A. 87-680.)

Passed in the General Assembly May 31, 2001.

Approved August 9, 2001.

APPENDIX B

CHILD AND FAMILY CONNECTIONS (CFC) SURVEY RESPONSES AND SURVEY QUESTIONNAIRE

Appendix B
SUMMARY OF RESPONSES TO CFC SURVEY

This Appendix summarizes the responses received to the survey we mailed to CFCs in November 2001. All 25 CFCs responded to the survey. A copy of the survey sent to the CFCs is found immediately after this summary of CFC responses. Many CFCs provided more than one comment to the questions.

Question: Are there areas where improvements could be made in the outreach activities of the EI program (such as the Child Find System and public awareness programs)?

YES: 21 NO: 4

Comments:	**# of CFCs**
– Improve connections with physicians and nurses	4
– Language issues: More outreach in Hispanic areas, in areas where English is second language, more materials in native languages	4
– More funding: for promotional ads, more outreach activities	4
– LIC time and funding constraints	3
– State develop materials and strategies that could be adapted for local use, state driven child find activities	2
– Lack of providers to volunteer to do screenings	2
– Conduct screenings at local Public Aid and WIC offices, local school districts, DCFS offices	2
– Referral network needs to be re-informed and strengthened	1
– Statistics from Schools to see what children screenings are missing	1
– Better coordination/reporting of screenings between Head Start and LICs	1
– Statewide toll free # to connect to individual CFCs	1
– Reach out to statewide associations	1
– Assistance in finding providers in rural areas	1
– Change LIC to marketing employee of the CFC	1
– System put in place to conduct screening on a regular basis	1
– No minimum requirements for LICs re: child find activities	1

Question: For those IFSPs that are not completed within the 45 days time frame, please describe the primary reasons for delays:

Comments:	**# of CFCs**
– Parent/Family delays (schedules, no shows, no response, making decisions)	23
– Providers (mainly late provider reports)	10
– High caseloads	7
– QE	4
– Insurance	2

Question: For each of the following services, please indicate whether or not there is an adequate number of providers in your CFC area. Adequacy is defined as a sufficient number of providers in CFC area so client services are not delayed.			
Type of Service Provided	**Adequate**	**Slight Shortage**	**Severe Shortage**
Family Training	21	4	0
Social Work Services, including Counseling, and Home Visits	10	10	5
Special Instruction	18	4	0
Speech, Language Pathology	9	8	9
Audiology	15	7	3
Occupational Therapy	15	8	2
Physical Therapy	15	8	2
Psychological Services	9	12	4
Service Coordination Services	19	5	1
Medical Services for Diagnostic or Evaluation Purposes	12	7	6
Early Identification, Screening, And Assessment Services	14	11	0
Vision Services	6	8	10
Nursing	17	7	1
Nutrition	16	9	0
Transportation	6	7	12
Assistive Technology Devices And Services	19	4	2

Question: If you noted any services for which an adequate number of providers was not available, please list the reasons.	
Comments:	**# of CFCs**
– Lack of providers	18
– Provider unwilling due to pay reasons (slowness of pay, low pay)	10
– Insurance (e.g., too expensive, billing)	3
– Instability of system	2
– No statewide monitoring of providers	1
– Questionable quality of providers	1
– QE process	1
– Too many hoops to jump through	1
– Providers unwilling due to constant changes	1

Question: On average, how many complaints, if any, does your CFC receive monthly regarding providers billing for services not provided?	
Comments:	**# of CFCs**
– 0 complaints	2
– 0 - 1 complaints	9
– 2-5 complaints	8
– response not quantified	6

Question: On average, how many complaints, if any, does your CFC receive monthly regarding providers providing poor quality services?	
Comments:	**# of CFCs**
– 0 complaints	1
– 0 - 1 complaints	4
– 1 - 5 complaints	8
– 6 - 10 complaints	2
– 11 - 20 complaints	3
– response not quantified	7

Question: What have been the positive effects, if any, of the QE process?	
Comments:	**# of CFCs**
– Service Coordinator training, education, and understanding	16
– Better teaming/ team approach	7
– Ensures appropriate level of services for the child	7
– More accountability for providers	3
– Medical expertise available for consultation	3
– Better provider reports	2
– Looks at whole child, multidisciplinary approach	1
– Helps providers understand their role	1
– Identifies training needs	1
– Caseloads have decreased	1
– Outcomes more appropriate	1

Question: What have been the negative effects, if any, of the QE process?	
Comments:	**# of CFCs**
– Staff time, workload, and travel costs	10
– Service Coordinator placed in position of "go between"	9
– Inadequate SC/provider training on QE from DHS or IMDN	4
– Parents feel left out of process/ parents not involved	3
– Time delays (linking to services)	3
– Parents/providers feel services are being inappropriately cut back	3
– Lack of administrative and technical support to CFCs for QE	2
– Providers feel professional judgment is not respected, not willing to work with team	2
– Inconsistencies between QE teams	2
– Not addressing children being over-served	1
– Providers fight change	1
– Increase in mediation/hearings	1
– Guidelines do not reflect current treatment beliefs	1
– Delays in medical exams	1
– Service coordinators quitting	1
– People making decisions about children they haven't met	1
– Conflicts of interest	1
– Loss of services	1

Question: What improvements, if any, could be made to the QE process?	
Comments:	**# of CFCs**
– Train, educate QE participants	8
– Include only children above review parameters or those medically complex cases	6
– Allow IFSP team members to participate	6
– Review only a sample of cases	3
– Allow more time for review	2
– Hold providers accountable for inadequate evaluations	2
– Make decisions advisory only	2
– Services are decided by professionals who never see children	1
– Should have 3 provider disciplines at each meeting	1
– Therapist should not review own charts	1
– Use projector to save paper	1
– Should have authority to recommend all 16 services	1
– Enhanced consistency	1
– Guidelines for CFCs regarding poor provider reports and QE forms	1
– Further parent/provider education	1
– Reduce travel	1

Question: Are there areas where improvements could be made in the eligibility determination aspects of the EI Program (such as the screening and assessment of infants and toddlers)? ***YES: 21 NO: 4***	
Comments:	**# of CFCs**
– Clarification, training to providers about tools, including their usage and limitations	4
– Establishing evaluation teams funded by DHS	4
– Providers do not always use assessment tools appropriately, differences in quality of reports	3
– Provider assessments are delayed	2
– Children should be screened by their school districts	2
– A review of screening process is needed (# of screenings has decreased)	1
– An interdisciplinary team approach needs to be used	1
– Increase funding for screenings	1
– Revise definition of "at risk"	1
– Create assessments at the CFCs independent of direct service provision	1
– Screen every child yearly	1
– Difficulty in finding providers to do screenings	1

Question: Are there changes or improvements to DHS' Cornerstone MIS that would be of benefit to your CFC operation? ***YES: 22 NO: 3***	
Comments:	**# of CFCs**
– Customized/better reports for local use	5
– Expand managers' ability to resolve issues locally	4
– Outdated technology/ antiquated/DOS system	4
– Merge SV02 and CM04	3
– Resolve "Heat" tickets more quickly	3
– Training on Cornerstone/Foxfire	2
– Allow more space for comments	2
– Include QE presentation forms on Cornerstone	2
– Often not functioning	1
– Does not allow for good data collection	1
– Bureau staff need access to system	1
– Streamline entry of multiple authorizations	1
– Link case notes with service activity screen to eliminate duplication	1
– Add spell check function	1
– Change payee or provider on the SV07 screen w/o new authorization	1
– Ability to upload/download to a secure site	1
– Offer Foxfire to everyone	1
– Have the EI number on each screen	1
– Faster method to print off authorizations for providers	1
– Foxfire difficult to work with	1
– Expand reasons for why families are closing the case to include insurance and fee issues	1
– Easier to read authorizations	1
– Address labels do not print out correctly	1
– Add joint screening tool as a screen	1
– More management tools	1

Question: Are there any areas where your CFC staff would benefit from additional training? ***YES: 25 NO: 0***	
Comments:	**# of CFCs**
– Insurance requirements	20
– Outcome writing/IFSP	9
– Cornerstone	6
– SC training	3
– Other	7

Question: Please define the role of the Local Interagency Council (LIC) in your area.	
Comments:	**# of CFCs**
– Public awareness and community involvement	17
– Child Find	13
– Provider recruitment	8
– Transition	7
– Screenings	6
– Training	6
– Resource directories	5
– Forum for coordination	4
– Liaison between CFC and school district	3
– Advises CFC	3
– Liaison between CFC and providers	2
– Organizes monthly meetings	1
– Find gaps in service	1
– Insufficient help in provider recruitment	1

Question: Are there specific areas where your Local Interagency Council could be more active? ***YES: 22 NO: 3***	
Comments:	**# of CFCs**
– Provider recruitment	14
– LIC is not effective, volunteers	7
– Child find and public awareness	6
– Better direction, training, policies and procedures from DHS	4
– Child find screenings	2
– Increased parent participation	1
– Evaluation of the needs of the CFC	1

Question: Does your CFC provide direct services to children/families? ***YES: 11 NO: 14***	
Comments:	**# of CFCs**
– Service Coordination	11
– Early identification and screening	3
– Family training	1
– Family support	1

Question: Do any CFC employees provide direct services to children outside of CFC working hours?

YES: 4 NO: 20 DON'T KNOW: 1

Question: Does your CFC have Internet access on-site?

YES: 24 NO: 1

Question*: *Are there aspects of the EI Program upon which DHS could improve?

YES: 23 NO: 2

Comments:	**# of CFCs**
– Improved communication: • Inform CFCs on the status of changes • Consistent instruction regarding CFC processes and service coordination • Present changes to a focus group of parents, providers, CFCs • Notify CFC managers before changes are made • Consistent answers to questions • Unclear communication of new procedures • Late development of new procedures	15
– Additional training	6
– Tighten credentialing process and other provider issues	4
– Better way of implementing changes in the system	3
– Increased # of DHS staff to provide support	1
– Written documentation of procedural changes	1
– Reevaluate the caseloads of service coordinators	1
– Clearer guidelines for transferring cases between CFCs	1
– TAM staff completing site visits are unfamiliar with EI, no follow-up	1

Question: In what ways could the EI program be more efficient or effective?	
Comments:	**# of CFCs**
– Improve communications	7
– Reduce SC caseloads	5
– Sufficiently fund CFCs	5
– More training for CFCs/ providers	5
– Program needs a clear vision and a plan to achieve it	3
– Reduce paperwork	2
– DHS funding for evaluation teams for greater uniformity in standards	1
– Hold providers accountable for submitting inadequate evaluations	1
– Improved "Heat" ticket process	1
– Regular provider monitoring and auditing	1
– More frequent, sensitive QE meetings	1
– Treat all EI providers equally	1
– Enhance serving of at risk families	1
– Criminal background checks on providers	1
– Involve parents in QE process	1
– Better documentation of policy changes	1
– Pay provider bills only when there is clear evidence services have been provided	1
– Reexamine how $ is distributed to LICs with dense populations	1
– Improve effectiveness in working with insurance companies	1
– Reduce CFC workload	1
– Appreciate CFC work	1
– Answer questions consistently	1
– Stop changes	1

Source: OAG summary of CFC responses to November 2001 survey.

CHILD AND FAMILY CONNECTIONS OFFICES
SURVEY QUESTIONNAIRE

INSTRUCTIONS: The purpose of this survey is to gain a better understanding of the services Child and Family Connections Offices provide for the Early Intervention Program, as well as to identify ways the Program could be improved. Enclosed is a self addressed stamped envelope. Please contact Jim Dahlquist at 217/524-8748 or OAG27@mail.state.il.us, if you have any questions.

Please return the completed survey by November 26, 2001 to:
Jim Dahlquist, Audit Supervisor
Illinois Office of the Auditor General
740 East Ash Street
Springfield, IL 62703-3154

1. Person completing this survey:

   Name: _____ Title: _____

   Agency: _____ Phone: _____

   E-Mail Address: _____ Fax: _____

2. Are there areas where improvements could be made in the outreach activities of the Early Intervention Program (such as the Child Find System and public awareness programs)?

   Yes_____ No_____

   If yes, please describe what changes or improvements would be desirable:

   _____

   _____

   _____

   _____

3. Are there areas where improvements could be made in the eligibility determination aspects of the Early Intervention Program (such as the screening and assessment of infants and toddlers)?

   Yes_____ No_____

   If yes, please describe what changes or improvements would be desirable:

   _____

   _____

   _____

   _____

4. For those IFSPs that are not completed within the required 45 day timeframe, please describe the primary reasons for the delays:

_____

_____

_____

5. A. For each of the following services, please indicate using an "x" whether or not there is an adequate number of providers in your CFC area. Adequacy is defined as a sufficient number of providers in CFC area so client services are not delayed.

Type of Service Provided	Adequate	Slight Shortage	Severe Shortage
Family Training			
Social Work Services, including Counseling, and Home Visits			
Special Instruction			
Speech, Language Pathology			
Audiology			
Occupational Therapy			
Physical Therapy			
Psychological Services			
Service Coordination Services			
Medical Services for Diagnostic or Evaluation Purposes			
Early Identification, Screening, and Assessment Services			
Vision Services			
Nursing			
Nutrition			
Transportation			
Assistive Technology Devices and Services			

B. If you noted any services for which an adequate number of providers was not available, please list the reasons why (for example, no providers available in CFC area, lack of providers willing to participate in program, etc.).

_____

_____

_____

6. On average, how many complaints, if any, does your CFC receive monthly regarding providers:

A. Billing for services not provided? _____

B. Providing poor quality of services? _____

C. Other? _____ Please explain. _____

_____

_____

7. A. Does your CFC provide direct services (such as those listed in Question 5) to children/families? Yes _____ No _____

If yes, please identify the services provided. _____

_____

_____

B. Do any CFC employees provide direct services (such as those listed in Question 5) to children outside of CFC working hours?

Yes _____ No _____ Don't know _____

If yes, please identify the services provided. _____

_____

_____

8. Regarding the Quality Enhancement (QE) process :

A. What have been the positive effects, if any, of the QE process?

_____

_____

B. What have been the negative effects, if any, of the QE process?

_____

_____

C. What improvements, if any, could be made to the QE process?

_____

_____

9. Are there any areas where your CFC staff would benefit from additional training (such as use of the Cornerstone system; insurance requirements; client referral process; IFSP requirements; other)?

Yes _____ No _____

If yes, please explain.

_____

_____

_____

_____

10. Are there changes or improvements to DHS' Cornerstone Management Information System that would be of benefit to your CFC operations?

    Yes _____ No _____

    If yes, please explain.

    _____

    _____

    _____

    _____

    _____

11. Does your CFC have Internet access on-site? Yes _____ No _____

12. Please define the role of the Local Interagency Council (LIC) in your area.

    _____

    _____

    _____

    _____

    _____

13. Are there specific areas where your Local Interagency Council (LIC) could be more active (for example: planning and evaluation, provider recruitment, report development)?

    Yes _____ No _____

    If yes, please explain.

    _____

    _____

    _____

    _____

    _____

14. Are there aspects of the Early Intervention Program upon which DHS could improve (such as improved communication, technical support, etc.)

Yes _____ No _____

If yes, please explain.

_____

_____

_____

_____

15. In what ways, if any, could the Early Intervention Program be more efficient or effective?

_____

_____

_____

_____

16. If you like to receive a copy of the final report, please check this box. ☐

THANK YOU FOR YOUR TIME AND ASSISTANCE WITH THIS SURVEY.

PLEASE FEEL FREE TO INCLUDE ANY ADDITIONAL DOCUMENTS, COMMENTS, OR SUGGESTIONS.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

APPENDIX C

EARLY INTERVENTION PARTICIPATION RATES BY COUNTY

Appendix C
COUNTY EI PARTICIPATION RATES FOR JULY 2001
(Percent of Children with Active IFSPs Compared to 1997-1999 Live Births)

COUNTY	PARTICIPATION RATE
Adams	2.3
Alexander	2.3
Bond	3.4
Boone	1.9
Brown	1.9
Bureau	1.6
Calhoun	0.7
Carroll	0.7
Cass	3.5
Champaign	1.9
Christian	1.5
Clark	1.9
Clay	3.8
Clinton	2.8
Coles	2.5
Cook (excluding Chicago)	1.9
Cook (Chicago only)	1.6
Crawford	5.1
Cumberland	2.5
DeKalb	3.3
DeWitt	2.5
Douglas	2.3
DuPage	1.5
Edgar	2.6
Edwards	3.7
Effingham	2.8
Fayette	3.1
Ford	2.3
Franklin	3.2
Fulton	2.4
Gallatin	7.1
Greene	2.8
Grundy	1.5
Hamilton	3.3
Hancock	1.5
Hardin	3.3
Henderson	2.9
Henry	1.3
Iroquois	2.4
Jackson	2.0
Jasper	2.4
Jefferson	3.2
Jersey	1.6
JoDaviess	2.2
Johnson	3.0
Kane	1.9
Kankakee	2.4
Kendall	1.2
Knox	2.0
Lake	2.5
LaSalle	2.0
Lawrence	5.1
Lee	3.8
Livingston	2.2
Logan	2.0
Macon	2.4
Macoupin	2.9
Madison	2.0
Marion	4.6
Marshall	1.4
Mason	1.3
Massac	2.4
McDonough	3.1
McHenry	2.1
McLean	2.2
Menard	2.2
Mercer	1.4
Monroe	1.6
Montgomery	1.7
Morgan	2.1
Moultrie	3.7
Ogle	2.7
Peoria	2.0
Perry	1.5
Piatt	2.5
Pike	3.9
Pope	3.5
Pulaski	2.3
Putnam	3.1
Randolph	1.6
Richland	4.3
Rock Island	1.7
Saline	4.7
Sangamon	3.2
Schuyler	4.7
Scott	1.0
Shelby	3.4
Stark	2.1
St. Clair	1.9
Stephenson	3.4
Tazewell	2.6
Union	3.1
Vermilion	2.3
Wabash	7.6
Warren	1.7
Washington	4.4
Wayne	3.8
White	5.1
Whiteside	2.1
Will	2.8
Williamson	3.6
Winnebago	2.4
Woodford	1.9

Source: OAG from DHS data

APPENDIX D

STATUS OF DHS' IMPLEMENTATION OF PUBLIC ACT 92-307

Appendix D
STATUS OF DHS' IMPLEMENTATION OF
PUBLIC ACT 92-307

PA 92-307 Requirements	Required Completion Date	Date Completed	Status (as of Feb. 27, 2002)
1.) ELIGIBILITY: Expands the definition of "eligible infants and toddlers" by adding continuing eligibility for children who require services to make developmental gains. **(Section 3)**	**None Specified**	**7/1/01***	DHS' administrative rules include PA 92-307's eligibility requirements. **(89 Ill. Adm. Code 500.10, 500.50)**
2.) CREDENTIALING RULE: Requires DHS to establish by rule credentialing qualifications for providers. **(Section 3)**	**2/5/02**	**2/6/02**	Credentialing rules were published in Volume 26, Issue 8 of the Illinois Register.
3.) EI WEBSITE: Requires the EI website to contain the following: current annual report, annual reports for previous 3 years, the most recent funding application under IDEA, the proposed modifications of the application, notice of Council meetings, notice of Council agendas, Council minutes for the previous year, proposed and final EI rules, requests for proposals, and all reports created for dissemination to the public. **(Section 5)**	**9/8/01 for documents specified in the Act; new documents shall be posted within 3 working days of their completion.**	**Partially Completed**	DHS' website contains only annual reports for 1998 and 1999. While DHS' website contains the revised modifications of IDEA's most recent funding application, it does not contain the application.
4.) INTERAGENCY AGREEMENTS: Requires DHS to develop a revised interagency agreement with DPA and DSCC establishing that EI funds are to be used as the payor of last resort as well as a hierarchical order of payment, and billing and payment procedures. **(Section 5)**	**10/8/01**	**Partially Completed**	DHS entered into an interagency agreement with DPA on 12/19/01, which designates DHS as the payer of last resort for EI services. The DHS-DSCC interagency agreement has not been finalized.

* An asterisk indicates the effective date of DHS' administrative rules or Child and Family Connections (CFC) Procedure Manual.

PA 92-307 Requirements	Required Completion Date	Date Completed	Status (as of Feb. 27, 2002)
5.) IFSPs: Specifies that the IFSP must include the identification of services appropriate to meet the child's needs, including the frequency, intensity, and method of delivering services. Requires multidisciplinary team developing the IFSP to consult DHS therapy guidelines and its designated experts. **(Section 11)**	**None Specified**	**7/1/01***	DHS' administrative rules require the IFSP to identify this information. In addition, services beyond those recommended by DHS therapy guidelines must be sufficiently justified by the IFSP team. **(89 Ill. Adm. Code 500.80, 500.90)**
6.) IFSP INSURANCE REQUIREMENTS: Requires CFCs to explain insurance and fee requirements to families. Requires the IFSP to state whether the family has insurance as well as specific information about it. **(Section 11)**	**None Specified**	**8/01***	DHS' CFC Procedure Manual includes an explanation of insurance and fee requirements to families.
		2/13/02	DHS developed an insurance procedure manual, which includes policies and procedures for service coordinators.
7.) FEES: Requires a sliding fee scale based on family income. **(Section 13)**	**None Specified**	**7/1/01***	DHS' administrative rules establish a sliding fee schedule. **(89 Ill. Adm. Code 500.130)**
8.) CATASTROPHIC CIRCUMSTANCES: States that the inability of parents to pay family fees due to catastrophic circumstances or extraordinary expense shall not result in denial of services. A family must show (i) out-of-pocket medical expenses in excess of 15% of gross income, (ii) a fire, flood, or disaster causing a direct out-of-pocket loss in excess of 15% gross income, or (iii) other catastrophic circumstances causing out-of-pocket losses in excess of 15% gross income. **(Section 13)**	**None Specified**	**Partially Completed**	DHS' administrative rules state that families shall not be denied services based on inability to pay. The rules include subsections (i) and (ii), but does not define "other" catastrophic circumstances in subsection (iii). **(89 Ill. Adm. Code 500.130)** DHS officials stated that the Department viewed the third subsection as an option and decided not to include this reason for exemption in the administrative rules.
9.) PAYOR OF LAST RESORT: Requires DHS to ensure EI funds are used as the payor of last resort for EI services. **(Section 13)**	**None Specified**	**7/1/01***	DHS' administrative rules establish EI funds as the payor of last resort. **(89 Ill. Adm. Code 500.80, 500.125)**

PA 92-307 Requirements	Required Completion Date	Date Completed	Status (as of Feb. 27, 2002)
10.) SCREENING DEVICE: Requires DHS to develop a screening device for determining eligibility for Medicaid, KidCare, and DSCC. **(Section 13.5)**	**10/8/01**	**11/28/01**	DHS developed *The Screening Device for Determining Family Fees and Eligibility for KidCare/ Medicaid and DSCC*.
11.) KID CARE AGENTS: Requires each CFC to enroll as a "KidCare Agent" in order to complete KidCare applications. **(Section 13.5)**	**None specified**	**2/8/02**	DHS officials reported all CFCs have been enrolled as KidCare agents.
12.) DSCC TRAINING GUIDELINES: Requires DHS to develop training guidelines for CFCs and providers that explain eligibility and billing procedures for services through DSCC. **(Section 13.5)**	**10/8/01**	**Partially Completed**	Training documentation (Illinois Early Intervention Services Systems Training) addresses DSCC eligibility procedures but does not address DSCC billing procedures.
13.) DSCC PROVIDER: States that DHS must require an individual applying for or renewing enrollment as a provider to state whether or not he or she is also a DSCC provider. This information shall be noted next to the provider's name on the roster of Illinois EI providers, and CFCs shall make every effort to refer families eligible for DSCC services to them. **(Section 13.5)**	**None specified**	**Pending**	EI officials stated that there is a new enrollment process being created, which will include an enrollment packet. The enrollment packet will require each provider to identify whether or not he or she is a DSCC provider. The packet is also being incorporated into the new credentialing process.
14.) PRIVATE INSURANCE: Requires DHS to determine at the point of new applications for EI services and for all children enrolled in the EI program, at CFCs, whether a child is insured under a private health insurance plan or policy. **(Section 13.10)**	**None Specified**	**7/1/01***	DHS' administrative rules require service coordinators to collect information on the child's insurance as part of IFSP Development. **(89 Ill. Adm. Code 500.80)**

PA 92-307 Requirements	Required Completion Date	Date Completed	Status (as of Feb. 27, 2002)
15.) TRANSFERS: States that if a child has been receiving services from a non-network provider, and the CFC determines that the family is enrolled in a managed care plan, the CFC shall require the family to transfer to a network provider. **(Section 13.20)**	**10/8/01**	**12/1/01**	CFC Managers sent a third and final notice to families. A copy of the notice was also posted on the EI website. The notice stated, "If the use of your insurance will require you to change provider(s), your current provider(s) can continue to bill for services up to December 1, 2001 so that you may transfer to a new provider(s) without interrupting services to your child."
16.) MATRIX AND ACTION PLAN: Requires DHS and others to develop a matrix and action plan identifying: EI providers, fully credentialed EI providers, and EI services covered; credentialed specialists who are members of managed care plans in the region; and all managed care plans available to providers in the region. **(Section 13.20)**	**3/10/02**	**Ongoing**	A matrix of providers enrolled with insurance companies was prepared and posted on the EI website.
17.) CLOSED NETWORKS: Requires DHS to work with networks that closed enrollment to additional providers to encourage their admission of EI providers, and to report the initial result of these efforts to the EI Legislative Advisory Committee. **(Section 13.20)**	**2/1/02**	**Pending**	DHS met with insurance representatives in the fall of 2001 and plans to meet with them again.
18.) INSURANCE EXEMPTION: Requires DHS to establish procedures for families to apply for an exemption restricting the use of its private insurance plan or policy based on material risk of loss of coverage. **(Section 13.25)**	**None**	**7/1/01***	DHS' administrative rules establish insurance exemption procedures. **(89 Ill. Adm. Code 500.130)**

PA 92-307 Requirements	Required Completion Date	Date Completed	Status (as of Feb. 27, 2002)
19.) PROVIDER TRAINING: Requires DHS to provide the following provider training: • Practice and Procedures of Private Insurance Billing. • The role of CFCs; service coordination; program eligibility determinations; family fees; Medicaid, KidCare, and DSCC applications, referrals, and coordination with EI; and procedural safeguards. • Intro. to the EI Program. • Evaluation and assessment of birth-to 3 children, IFSP development, monitoring, and review; best practices; service guidelines; and quality assurance. **(Section 13.30)**	**None Specified**	**Partially Completed**	Private insurance billing training was provided in 6/01 and 1/02. According to EI Officials, Systems Overview training assists in meeting this requirement. In addition, a training workgroup was established to create training curriculum meeting these requirements. DHS hopes the curriculum will be effective in the summer of 2002.
20.) COMPETITIVE PUBLIC CONTRACTING: If DHS enters into a contract for some of its responsibilities, it shall be subject to a public request for proposals and posted on the EI website. Any current contracts that have not met these requirements shall be subject to public bid no later than July 1, 2002 or the date of termination of any contract in place. **(Section 13.32)**	**7/1/02**	**Partially Completed**	Three requests for proposals, including EI Clearinghouse, EI Public Awareness, and EI Personnel Development, have been put out for bid and posted on the EI website. According to EI officials, CBO, Cornerstone, and Springfield Urban League (SUL) contracts will not be re-bid at this time because they were bid in FY 01 and have options for renewal.
21.) QUARTERLY REPORTS: Requires DHS to provide to the EI Legislative Advisory Committee and simultaneously to the public through the EI website, quarterly reports containing monthly data and other program information. **(Section 13.50)**	**9/21/01 and then quarterly thereafter.**	**Ongoing**	The first Quarterly Report was completed on 9/21/01. The second Quarterly Report was completed on 1/31/02.

Note: While this review examined the actions taken by DHS to implement the requirements of Public Act 92-307, given the recent enactment of the Act, we did not assess the effect of the actions or whether DHS was adhering to the rules, policies, and procedures established pursuant to Public Act 92-307.
Source: OAG review of DHS documentation and interviews.

APPENDIX E

AGENCY RESPONSES

George H. Ryan, *Governor*

Illinois Department of Human Services

Linda Reneé Baker, *Secretary*

509 West Capitol • Springfield, Illinois 62704

April 11, 2002

Mr. Jim Schlouch
Performance Audit Director
State of Illinois
Office of the Auditor General
Iles Park Plaza
740 East Ash
Springfield, IL 62703-3154

Dear Mr. Schlouch:

Thank you for the opportunity to respond to your report of the Early Intervention Program: Follow-up Report of the OAG 1993 Audit.

We are pleased you found changes made to the program have resulted in program improvements. As you know, DHS is also participating in the federal Office of Special Education's Continuous Improvement Monitoring Process. This review includes DHS, the State Board of Education, and stakeholders representing children and families, schools, service providers and professional organizations. Many of the items you identified as areas needing improvement were identified as areas needing attention in our Improvement Plan.

Attached are responses to the specific recommendations in your report.

If you have any questions, please contact me.

Sincerely,

James R. Donkin, CIA
Chief Internal Auditor

JRD:lb
Attachment

ILLINOIS DEPARTMENT OF HUMAN SERVICES
RESPONSES
EARLY INTERVENTION PROGRAM:
FOLLOW UP REPORT OF THE OAG 1993 AUDIT

RECOMMENDATION NUMBER 1

The Department of Human Services should continue efforts to increase public awareness of the Early Intervention Program, specifically focusing such efforts in areas of the State with low E.I. program participation rates.

RESPONSE:

The Department will continue its efforts to increase public awareness of the program. One of the ways this will be accomplished is through a performance contract measure with all Child and Family Connections (CFC) offices. There will be a specific performance measure related to penetration rates in CFC contracts for FY03. The Department will also continue to work with specific counties with low participation rates to assist the CFCs in determining methods to raise the rates.

RECOMMENDATION NUMBER 2

The Department of Human Services should follow-up with the CFCs that reported shortages of providers and develop strategies to recruit additional providers where needed. Also, DHS should continue its efforts to recruit bilingual providers and interpreters for participation in the E.I. program.

RESPONSE:

The Department will continue to follow-up with CFCs that report provider shortages. There is currently a process in place for CFCs to contact the Bureau of E.I. when there are shortages of providers. Bureau staff works with the CFC to recruit providers. We will increase our efforts to recruit bilingual providers and interpreters for the program.

RECOMMENDATION NUMBER 3

The Department of Human Services should continue to monitor and follow-up on cases where children are not receiving services in a timely manner. When E.I. system delays are the cause for the delays, action should be taken to address such causes.

RESPONSE:

The Department will continue to monitor and follow-up on cases where children are not receiving services in a timely manner. Currently this is accomplished with the four staff within the Bureau of E.I. that are assigned to work with the CFCs. In FY03 there will be special emphasis on performance measures that address this issue along with follow-up by Bureau of E.I. staff.

RECOMMENDATION NUMBER 4

The Department of Human Services should review the appropriateness of CFC caseloads compared to State established and nationally accepted criteria, as called for in the Improvement Plan submitted to the federal Office of Special Education Programs. When CFC caseloads deviate significantly from such criteria and when such deviations are determined to be limiting effective service coordination, appropriate follow-up actions should be taken.

RESPONSE:

This issue will be addressed in the FY03 performance contracting measures. The Department will also provide more technical assistance to the CFCs to ensure they have appropriate resources to ensure effective service coordination.

RECOMMENDATION NUMBER 5

The Department of Human Services should continue its efforts to ensure that CFC staff and providers receive the training necessary to effectively provide services to E.I. children and their families.

RESPONSE:

The Department is currently in the process of enhancing training for CFC staff and providers for FY03. The Department has a training workgroup consisting of all of the entities that are currently contracted for training services (IMDN, Provider Connections and the Community Health Training Center). This workgroup is developing training consistent with Public Act 92-307 and the amendments to 89 Ill. Adm. Code 500.

RECOMMENDATION NUMBER 6

The Department of Human Services and the Illinois Interagency Council on Early Intervention should issue the annual report required by the Illinois Early Intervention Services System Act in

a timely manner. Furthermore, the annual report should contain the information required by Section 4 of the Act.

RESPONSE:

The Department agrees with this recommendation and future annual reports will be issued as required and contain what is outlined in Section 4 of the Act.

RECOMMENDATION NUMBER 7

The Department of Human Services should continue its efforts to implement all of the requirements of Public Act 92-307.

RESPONSE:

The Department agrees with this recommendation and will continue to implement the requirements.

RECOMMENDATION NUMBER 8

The Department of Human Services should establish a formal plan for the Early Intervention Program which establishes goals and objectives for the Program, as well as performance measures to determine whether desired outcomes are being achieved.

RESPONSE:

The Department will finalize the Operations Plan that is currently in development. It will be reviewed to ensure it establishes goals and objectives for the program.