**Section 630.40 Health Services For Children In The First Year Of Life**

The Division of Community Health and Prevention, State of Illinois Department of Public Health, through its Maternal and Child Health Program may allocate funds for programs providing health services for infants in the first year of life in accord with the standards of the American Academy of Pediatrics set forth in Section 630.80(a)(5), and Regionalized Perinatal Health Care Code (77 Ill. Adm. Code 640). One or more of the following MCH services may be included in application proposals for Title V and State MCH Project grant funds.

a) Services in the Neonatal Period

1) Evaluation of the newborn infant immediately after delivery and institution of appropriate support procedures.

2) Complete physical examination, including length, weight, and head circumference, skin, head, eyes, ears, nose, mouth, thorax, lungs, cardiovascular system, abdomen, genitalia, musculoskeletal system, neuromuscular system and reflexes.

3) Laboratory tests to screen for lead poisoning and genetically-determined diseases as defined in the Newborn Metabolic Screening and Treatment Code (77 Ill. Adm. Code 661).

4) Diagnosis and treatment or referral and follow-up of general health problems.

5) Preventive procedures to include:

A) Gonoccal eye infection prophylaxis.

B) Administration of vitamin K.

6) Assessment for high risk conditions and appropriate consultation and/or referral within the Perinatal System including genetic evaluation and counseling services where appropriate.

7) Nutritional assessment and services and supplementation as needed.

8) Bonding and attachment support activities including provision for extended contact between parents and their infant immediately after delivery and, where desired by the parents, rooming-in arrangements or the equivalent.

9) Arrangements for continuous, comprehensive pediatric care for the newborn following discharge from the hospital.

10) Home health services.

11) Referral for Public Health nursing follow-up including those identified through the Adverse Pregnancy Outcome Reporting System.

b) Services During Balance of First Year of Life

1) Periodic health assessment to include:

A) History and systems review (general medical and social, family and genetic background, with items of inquiry determined by age, developmental stage, and likelihood of potential problems).

B) Complete physical examination to include:

i) Height and weight.

ii) Head circumference.

iii) Vision and hearing evaluation.

C) Assessment of Development and Behavior using age appropriate tools.

D) Screening and laboratory tests as indicated, including hemoglobin/hematocrit and tuberculin skin test; and, for infants at risk, such procedures as lead poisoning, parasite, and sickle cell screening for those children not screened in the newborn period.

E) Nutritional assessment, services and supplementation as needed (including provision of such supplements as iron and vitamin D, and adequacy of fluoride intake). For those clients on nonpublic supplies, water should be tested for nitrates by the Illinois Department of Public Health Laboratories.

2) Immunizations according to state and nationally recognized standards.

3) Diagnosis and treatment or referral and follow-up of general health problems, both acute and chronic.

4) Home health services.

5) Counseling and anticipatory guidance with referrals and follow-up as needed regarding:

A) Infant development and behavior.

B) Maternal nutritional needs, especially if breast feeding, and infant nutritional needs and feeding practices.

C) Automobile restraints for infants, and general injury prevention concepts (especially home injuries and unintentional poisoning).

D) Infant stimulation and parenting skills, with appraisal to identify parents at risk of child abuse or neglect.

E) Need for and importance of immunizations.

F) Effect on children of parental smoking, use of alcohol and other drugs, and other health-damaging behaviors.

G) The importance of a source of continuous and comprehensive care for mother and child, including identification of available resources to help with such problems, as sudden illness or breast-feeding difficulties.

H) Recognition and management of illness.

I) Infant care skills.

J) Child care arrangements.

K) Using community health resources such as WIC, food stamps, welfare and social services that significantly affect health status.

L) Other relevant topics in response to parental concern.

6) Counseling and provision of appropriate treatment and/or referral to appropriate services (including Early Intervention Programs for Infants and Toddlers with Handicaps, programs for children with special health care needs, home health and homemaker services) as needed for parents:

A) who have health problems that seriously affect their capacity to care for the infant.

B) whose infant is seriously ill.

C) whose infant has a chronic illness or handicapping condition.

D) whose infant is or is about to be hospitalized.

c) SIDS

Education, information and counseling services for all families whose infants die as a result of Sudden Infant Death Syndrome (SIDS), as well as training for those professionals who would be involved in a SIDS incident.

1) Coroners report suspected SIDS cases to Statewide SIDS Program within 72 hours.

2) Condolence letter and SIDS information sent to family.

3) Referral to local agency for family follow-up.

A) Family is contacted to schedule a home visit and the completed initial home visit report is returned to SIDS Program within two weeks.

B) Follow-up visit report form returned after subsequent visits or telephone contacts.

4) Counseling and/or referral to appropriate services or support groups as needed. (Parent support groups, mental health).

5) Workshops and/or in-services related to SIDS for professionals. Directed at, but not limited to, coroners, Emergency Medical Technicians, first responders, emergency room personnel, funeral home directors, clergy, social workers, and public health nurses.

d) Local Health Nursing Follow-up for the High-Risk Mother

1) Purpose

Home visits to families of high-risk/pregnant and postpartum women have a two-fold purpose: assessment of the woman and the family/environment and facilitation of early intervention for identified problems.

2) Agencies to Provide Services

A) All Local Health Departments shall provide follow-up services to residents of their counties.

B) The Department may contract with a local health agency or county nurse to provide follow-up services to residents of areas without a Local Health Department.

3) Eligibility for Services

Any pregnant or postpartum patient identified as high-risk by a Level III hospital and referred to a Local Health Department or other designated local health agency shall be offered follow-up services. The patient may decline those services.

4) Services To Be Provided

A) Home visits to high-risk pregnant women shall be scheduled as often as the client's condition warrants or as requested by the attending physician. A post-discharge visit shall be made as soon as possible after discharge. Additional visits may be made during the postpartum period (i.e., 6 weeks following the date of delivery) for pregnancy-related conditions as indicated or as requested by the attending physician. If additional visits are for chronic health conditions (e.g., chronic hypertension, CVA, advanced cardiac disease), the patient should be referred to the licensed home health agency in the area for long-term follow-up.

B) Local health agencies that provide services must adhere to the provisions of this Part.

e) Local Health Nursing Follow-up for High-Risk Infants

1) Purpose

The purpose of the infant follow-up program is to minimize disability in high-risk infants by identifying as early as possible conditions requiring further evaluation, diagnosis, and treatment and by assuring an environment that will promote optimal growth and development.

2) Agencies to Provide Services

A) All Local Health Departments shall provide follow-up services to residents of their counties.

B) The Department may contract with a local health agency to provide follow-up services to residents of areas without a Local Health Department.

3) Eligibility for Services

Any infant eligible for the Adverse Pregnancy Outcomes Reporting System (APORS) and referred to a Local Health Department or other designated local health agency shall be offered follow-up services. The family may decline those services.

4) Services To Be Provided

A) A minimum of 6 visits shall be made by the follow-up nurse as soon as possible after newborn hospital discharge and at infant chronological ages 2, 6, 12, 18 and 24 months. Infants and their families having actual or potential health problems identified by the nurse shall be visited more frequently for health monitoring, teaching, counseling and/or referral for appropriate services. Occasionally, when an infant is receiving services at the Local Health Department, a follow-up visit may be conducted by the nurse at that time.

B) Follow-up services shall include:

i) Health history, including: prenatal and natal history; parental concerns; family history of genetic disease or unexplained mental retardation; compliance with medical regimen, if any, including medications, treatments and visits to the physician; infant care, including nutrition, elimination and sleep activity; and family/infant interaction, family coping and parental knowledge of injury prevention.

ii) Physical assessment, developmental assessment, and age specific anticipatory guidance based on the American Congress of Obstetricians and Gynecologists guidelines or current recommendations of the State that are found in subsection (e)(5).

iii) Based on the results of the health history and physical assessment, the nurse shall identify problems, make nursing diagnoses and arrange for intervention. Intervention may include: counseling the family as to the importance of regular primary health care by the family physician, pediatrician or clinic; encouraging scheduled return visits to the Perinatal Center; family teaching/counseling by the follow-up nurse; referral to the physician or other screening, diagnostic or support services depending on the nature of the problem; and follow-up on referrals.

5) Local health agencies must adhere to the provisions of this Part and the Department's High Risk Infant Tracking Supplement for Local Health Departments, which may be obtained from the Department's Division of Community Health and Prevention.

f) Access-Related Services

1) Outreach services.

2) Translator and 24-hour emergency telephone services.

3) Child care services to facilitate obtaining needed health services.

4) Availability of services directly or through referral for handicapping conditions.

5) Transportation.

(Source: Amended at 35 Ill. Reg. 452, effective December 22, 2010)