



# ILLINOIS PRENATAL TO THREE POLICY AGENDA

**FEBRUARY 2020**



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# OVERVIEW

## ***Our Vision for the Children of Illinois***

*We envision Illinois as a place where every young child—regardless of race, ethnicity, income, language, geography, ability, immigration status or other circumstance—receives the strongest possible start to life so that they grow up safe, healthy, happy, ready to succeed and eager to learn.*

### **The Opportunity**

The first three years of life are the most rapid and critical period of development in the entire human lifespan and provide the greatest opportunity to set the foundation for healthy development and learning. The experiences that children have during their earliest years shape their brains in a profound and significant way that sets them up for lifelong success or lifelong challenges. In order to ensure that all children reach their full potential, families must be supported in their communities by programs and policies that prioritize this critical and special window of opportunity. Fortunately, Illinois' families have a bold champion in Governor Pritzker. Now is the time to build on the great progress Illinois has made in providing a comprehensive approach to supporting children under three and be truly audacious in setting a vision and course of action to realize Governor Pritzker's goal of making Illinois the best state in the nation for families to raise young children.

With generous support from the Irving Harris, McCormick and Stone Foundations, the Ounce of Prevention Fund, together with the Governor's Office of Early Childhood Development, facilitated the launch of the Prenatal to Three (PN3) Initiative. The PN3 Initiative brought together a diverse group of more than one hundred Illinois expert stakeholders to develop an ambitious, comprehensive, multi-year strategic policy agenda to ensure that Illinois' youngest children and their families, especially those furthest from opportunity, are on a trajectory for success. The overall goal of the PN3 Initiative is to improve access to high-quality services for 50,000 Illinois infants and toddlers and their families earning under 200 percent of the Federal Poverty Level (FPL) by 2023 and 100,000 Illinois infants and toddlers in families earning under 200 percent FPL by 2025.

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*"Illinois will become the best state in the nation for families raising young children."*

*J.B. Pritzker, Illinois Governor*

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### **Developing the PN3 Agenda**

The PN3 Policy Agenda was developed collaboratively by over one hundred stakeholders. In its role as convener, the Ounce of Prevention Fund built a large coalition with broad public and private representation from not only the early childhood system, but other child and family serving systems that play a critical role in serving families during the prenatal to three period, such as healthcare and family economic security programs and services. The full coalition met four times between September and December 2019. A core leadership team was also convened to guide the work of the coalition.

The PN3 Coalition committed to applying a racial equity framework to developing the agenda, in alignment with the Illinois Early Learning Council’s racial equity priorities. The Coalition also committed to a focus on the Early Learning Council’s priority populations (see *Appendix A*). In addition, the Coalition adopted a set of planning principles to guide the work. They included:

- Big picture thinking that focuses on large systems shifts with a clear path to implementation, including strategies tied to outcomes that can be attained within five years;
- An aligned approach that complements existing state efforts and considers better access to existing programs and services in addition to adding new capacity;
- A commitment to addressing quality alongside access;
- A representative process; and
- Pursuing cross-sector, integrated solutions that address children’s needs and assets holistically.

The bulk of the PN3 Policy Agenda was developed by six working groups with expert leadership:

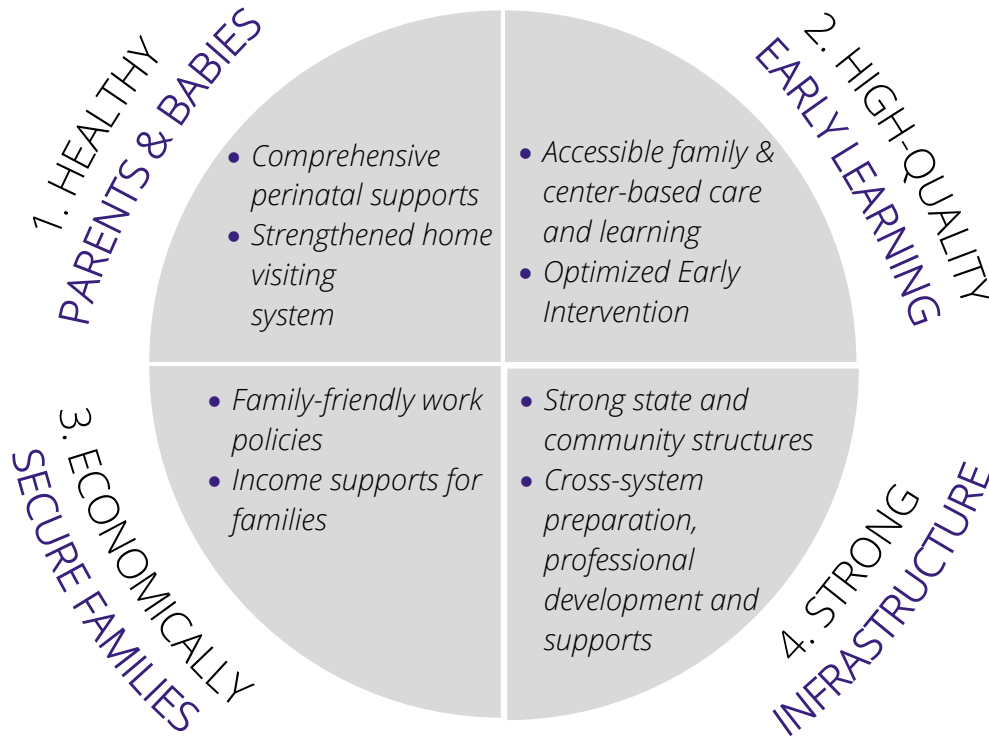
- Perinatal Support
- Early Intervention
- Home Visiting
- Child Care and Development
- Family Economic Security
- Cross-System Issues

The working groups identified where Illinois needs to increase access to services that exist through enrollment or expansion efforts, how to improve quality of existing programs and services, and new services or innovations that are needed. In developing recommended policy priorities, the working groups were asked to examine data, apply a racial equity lens and focus on Illinois’ priority populations. Additionally, working groups reviewed existing strategic plans, reports, and other efforts to ensure alignment, and engaged various councils and coalitions in order to gather their input and feedback. All working groups had access to technical assistance to support their efforts (see *Appendix B* for list of coalition, core team and workgroup members).

Working groups used a template to identify topic-specific strategies and objectives toward achieving the overall PN3 Initiative goals, along with rationales for the selected strategies and estimated impacts. Those topic-specific templates were vetted by the PN3 Coalition and other experts, analyzed for themes across working groups, and then synthesized and organized into broad goals (see *Appendix C* for working group templates).

## Goals & Strategies

The PN3 Policy Agenda goals fall into four categories: Healthy Parents and Babies, High-Quality Early Learning, Economically Secure Families and Strong Infrastructure. For each goal, this document outlines key strategies we will use to execute our vision for the children of Illinois.




## Objectives

For each goal, we articulate concrete objectives. Our objectives fall into seven categories:


 Expansion of Services

 Policy Change

 Investment

 Workforce

 Data Use

 Awareness

 Cohesion

## **Projected Impacts**

As stated above, the goal of the initiative was to impact at least 100,000 infants and toddlers and their families by 2025. It is anticipated that the Illinois PN3 Policy Agenda will far exceed that goal, with an estimated impact of at least 200,000 additional children and families by 2025 being touched by the policy proposals presented in the agenda (more detail on the projected impacts can be found in *Appendix D*). Highlighted impacts include:

- More than doubling capacity in high-quality center- and family-based care and targeting quality improvement strategies to impact 7,000 infants and toddlers;
- Increasing access to evidence-based home visiting to 15,000 more children and their families by expanding services and removing barriers to currently available services to meet the current demand;
- Doubling the number of children served in Early Intervention by reaching an additional 22,000 families eligible for services;
- Offering nearly 30,000 new parents a newborn nurse home visit through expansion of universal newborn supports in 10 new Illinois communities and implementation in four Chicago hospitals, reaching 20% of all newborns and their parents;
- Extending postpartum healthcare coverage continuously for 12 months to reach 63,500 birthing parents;
- Growing access to doula services from 1,100 to 15,100 birthing parents; and
- Increasing enrollment rates for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) by 10% to reach nearly 19,000 more people.



# HEALTHY PARENTS & BABIES



## HEALTHY PARENTS & BABIES

**PROBLEM TO SOLVE:** The United States has the highest rate of maternal mortality among comparable developed countries.<sup>i</sup> Among women who survive pregnancy and childbirth, 50,000 women each year experience life-threatening pregnancy-related complications.<sup>ii</sup> Additionally, data show that nationally, 60% of cases of maternal mortality are preventable.<sup>iii</sup> These poor outcomes are experienced considerably more often by women of color, and across all racial and ethnic groups, black women experience these poor outcomes most often.<sup>iv</sup> According to a Center for Disease Control analysis of national data, non-Hispanic black women experienced rates of pregnancy-related mortality at 3.2 times the rate of non-Hispanic white women.<sup>v</sup> Rates of infant mortality are also relatively high in the US, with a rate of 5.8 deaths per 1,000 live births in 2017, and infants born to non-Hispanic black mothers have the highest mortality rates among all racial and ethnic groups.<sup>vi</sup>

Unfortunately, maternal and infant mortality and morbidity outcomes in Illinois lag behind the national data. In its most recent Maternal Mortality and Morbidity Report, the Illinois Department of Public Health reports that in Illinois, non-Hispanic black women are six times as likely to die of a pregnancy-related condition as non-Hispanic white women.<sup>vii</sup> Furthermore, 72% of the pregnancy-related deaths and 93% of violent pregnant-associated deaths in Illinois were deemed preventable. According to the IDPH Illinois Infant Mortality Data Report published in 2018, Illinois ranks 36th out of 50 states and the District of Columbia in infant mortality as of 2014.<sup>viii</sup> Although the infant mortality rate in Illinois has decreased over time, major racial/ethnic disparities persist, with the infant mortality rate for infants born to Non-Hispanic black women consistently sitting at two to three times the rate as non-Hispanic white women.<sup>ix</sup>

Structural racism in health care and social service delivery is the cause of these disparities in outcomes.<sup>x</sup> Experts agree that how people are treated during childbirth can affect the health and well-being of parents and children.<sup>xi</sup> Other factors that contribute to poor outcomes are related to limitations in the current constellation of services and supports available for pregnant people and families with infants. Prenatal care visits are important, but as currently structured and funded, they do not address the full scope of supports and needs of pregnant people and families, especially families at higher risk for poor birth outcomes. Data show that maternal mortality risk increases after 42 days postpartum, yet health care coverage and other post-partum support services generally end sooner than that. This lessens continuity of care, decreases access to services and increases risk for maternal mortality and morbidity.

The policy recommendations below were developed specifically to address structural racism in service systems that care for pregnant people and new families, promote a strong continuum of support during the first year postpartum, and ensure a prenatal touch to better connect people to more resources that can holistically address the needs of families. Additionally, these recommendations echo those in the 2018 IDPH Maternal Mortality and Morbidity Report.

## STRATEGY: COMPREHENSIVE PERINATAL SUPPORTS



### **Expansion of Services**

- *Voluntary Universal Newborn Supports:* Expand universal newborn nurse home visits for all newborns that includes a comprehensive assessment, referral and connection to all services needed, including health and community services that address social determinants of health.
- *Voluntary Universal Prenatal Supports:* Establish voluntary universal prenatal connection/visit that provides anyone who is pregnant with a comprehensive assessment, referral and connection to all services needed, including health and community services that address social determinants of health.
- *Intrapartum Care:* Address intrapartum care by incentivizing community expansion of Baby Friendly Hospitals and alternative and free-standing birthing centers.
- *Developmental Screenings:* Increase rates of developmental screening and establish data mechanisms to collect individual child data across sectors to ensure early identification and connection to needed services for all infants and toddlers.



### **Policy Change**

- *Extended Postpartum Health Care Coverage and Supports:* Extend the postpartum period of health coverage and supports for all Illinois birthing parents for the full 12 months after birth.
- *Statewide Taskforce:* Establish a statewide taskforce to gather data from pregnant and birthing individuals on their experiences in the health care delivery system. Develop recommendations for actions to improve the quality of care given during the perinatal period.
- *Illinois Perinatal Rating:* Establish an Illinois perinatal rating component to the Illinois Hospital report card and consumer guide to health care report.






### **Investment**

- *Funding for Community-Based Perinatal Support:* Increase funding for community-based perinatal support, including perinatal health workers, educators, advocates, and home visitors, with intentional focus on grants to Black-led community-based organizations that can be most responsive to the needs of Black families, who are disproportionately impacted by maternal and infant mortality and morbidity.
- *Funding for Universal Newborn Supports:* Identify sources of sustainable funding for statewide universal newborn supports expansion.
- *Funding for Doulas:* Expand funding and access to community-based doulas. Ensure coverage of community-based perinatal services through Medicaid, Managed Care Organizations and private insurance.






### **Workforce**

- *Recruit and Retain Workforce:* In anticipation of greater demand for perinatal services, recruit and retain perinatal health care providers that are representative of the communities they serve.

- 
**Workforce, continued**
  - *Professional Development:* Establish policies and protocols for embedded professional development and reflective practice for all perinatal health care providers that address institutional and systemic racism and implicit bias.
- 
**Awareness**
  - *Public Awareness Campaign:* Co-create a public awareness campaign with communities of color focused on infant and maternal health that empowers people with the knowledge and tools to advocate for themselves.
- 
**Cohesion**
  - *Cohesive Approach:* Establish a multi-disciplinary, collaborative team approach in the healthcare system inclusive of doulas, midwives, lactation consultants, perinatal healthcare workers, and other paraprofessionals to ensure stronger connection as to the experiences expecting families are having with the healthcare delivery they are receiving.

## STRATEGY: STRENGTHENED HOME VISITING SYSTEM

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**Expansion of Services**
  - *Equitable Expansion:* Add capacity to serve all eligible families with home visiting services that meet their needs throughout the state.
  - *Local Capacity:* Build local capacity of home visiting providers to access additional funding to build new or augment existing home visiting services.
  - *Expand Successful Innovations:* Scale and institutionalize successful home visiting innovations to serve families with more complex needs.
- 
**Investment**
  - *Increase State and Federal Funding:* Increase state and federal funding for home visiting services to support salary increases for home visitors and added capacity to serve 13,000 more families.
  - *New Financing Mechanisms:* Use Medicaid reimbursement, Managed Care Organization administrative dollars, and Family First Prevention Services Act implementation to support home visiting services.
- 
**Workforce**
  - *Increase Compensation:* Increase the compensation of home visiting and doula staff to improve retention and equity.
  - *Recruit and Retain Workforce:* Support the recruitment and retention of a representative workforce that reflects the demographics of families in the community.
  - *Professional Development:* Remove barriers to preparatory education, professional development, and embedded job supports to improve the quality of doula and home visiting services and staff retention.



### **Data Use**

- *Align and Improve Data Systems:* Increase cohesive and timely collection and reporting of enrollment data across the major funders of home visiting to better inform resource allocation and provide disaggregated data on participant demographics and workforce composition.



### **Awareness**

- *Public Awareness:* Increase awareness of benefits and availability of intensive home visiting services to increase enrollment of home visiting services by eligible families.



### **Cohesion**

- *Streamline Processes:* Streamline funding and monitoring processes across home visiting funders at the state level to improve the ability of local home visiting agencies to access funding and create greater coherence in program quality.
- *Coordinated Intake:* Establish a Coordinated Intake process in all communities in which home visiting is available to ensure families can access home visiting services seamlessly and at the earliest point possible.



# HIGH-QUALITY EARLY LEARNING

## HIGH-QUALITY EARLY LEARNING

**PROBLEM TO SOLVE:** The science is clear that the first three years of life are the most critical developmental period in the entire human lifespan. It is during these years that the foundation of the brain architecture is built, setting a child up for lifelong success, or lifelong challenges. Despite the research the effectiveness of early learning and development interventions, the United States invests relatively little in its youngest learners. On a per-capita basis, the United States spends roughly six times less on education for infants and toddlers than on K-12.<sup>xii</sup> This shortchanges our children exactly when the potential benefit is greatest.

The current dearth of infant-toddler care is frequently described as a crisis across the country.<sup>xiii</sup> In Illinois, the impacts of this crisis are acute. There are significantly fewer early childhood slots for infants and toddlers compared to their 3- to 5-year-old peers.<sup>xiv</sup> Current capacity of licensed child care provides access to only 25% of infants and toddlers across Illinois, with many communities experiencing access rates of less than 10%. Access rates fall even further when it comes to high-quality care, with capacity for only 5% of infants and toddlers to access ExceleRate Gold Circle of Quality rated programs.<sup>xv</sup> (See *Appendix E* for maps detailing access rates around the state.)

Inadequate and flawed funding structures are the primary drivers of lack of access to high-quality infant-toddler care. Reimbursement for providers through the Child Care Assistance Program (CCAP) is structured to support market rates and does not take into account the true cost of providing quality care. Quality care for children under three is labor intensive and expensive to provide.<sup>xvi</sup> The amount of money parents pay for care is not enough for businesses to provide high-quality care and pay child care providers a living wage.<sup>xvii</sup> Inadequate funding also leads to abysmally low wages for caregivers in early learning settings, which further exacerbates access challenges.<sup>xviii</sup> Nearly half (46 %) of child care workers in Illinois are paid so little that they receive some form of public benefits (EITC, Medicaid, Food Stamps, TANF), at a cost of \$71.4 million.<sup>xix</sup> Teachers in infant-toddler classrooms are compensated less, and poor compensation coupled with difficult and demanding working conditions create high turnover and have led to a workforce shortage despite the low qualification requirements in Illinois child care licensing standards.<sup>xx,xxi</sup>

Services provided under Part C of the Individuals with Disabilities Education Act (IDEA) also known as Early Intervention (EI), are critical for children who have or are at risk for significant developmental delays. The expected prevalence rate for eligibility for EI is 13% yet Illinois only serves approximately 4% of children under age 3.<sup>xxii</sup> EI services are underutilized and too many children found eligible and entitled to receive services are not able to get services in a timely manner. A lack of awareness of EI and the full range of eligibility criteria, even among early childhood and health providers, also leads to many children not ever accessing the services that can make a difference in their lifelong trajectory.

The objectives below present opportunities to revamp and strengthen current programs and services and make the most of new investments over time specifically focused on the needs of infants and toddlers and the professionals who work with them and their families. The agenda also calls for further study of the complex issues of access to high quality care in a quickly changing economy and the advancement of universal access to preschool.

## STRATEGY: ACCESSIBLE FAMILY & CENTER-BASED CARE AND LEARNING



### **Expansion of Services**

- *Equitable Expansion:* Dramatically increase capacity to serve more families with high-quality infant/toddler family- and center-based care that meets the needs of families throughout the state employing the use of contracts and increased provider reimbursement rates to make high quality care economically viable for providers.
- *Local Capacity:* Build local capacity of community-based organizations and other early childhood providers to access additional funding specifically for infant/toddler care.
- *Family Child Care Networks:* Redesign and expand commitment to family child care networks that are responsive to community needs and preferences to support homes in achieving higher circles of quality in ExceleRate.
- *Early Head Start:* Expand center-based Early Head Start and Early Head Start-Child Care Partnerships in order to serve more infants and toddlers in high-quality care.



### **Policy Change**

- *Tiered Funding for QRIS:* Establish a tiered funding ladder for ExceleRate Illinois that reflects the cost of delivering services at each circle of quality.
- *CCAP Contracts:* Expand use of contracts in the Child Care Assistance Program to ensure dedicated slots and adequate funding for high-quality infant-toddler care.
- *Licensing Alignment:* Embed Gateways to Opportunity Early Childhood Credentials into DCFS licensing standards to promote increased program quality and continuity of care infants and toddlers in Child Care Assistance Programs.



### **Investment**

- *Increase State and Federal Funding:* Increase state and federal funding for infant-toddler family and center-based care and allocate a higher percentage of current Child Care Assistance Program and Early Childhood Block Grant funds to infant-toddler care. Ensure that funding is adequate to support the tiered funding ladder for ExceleRate Illinois.
- *Support for Quality Improvement:* Establish quality improvement grants that provide funding and technical assistance for infant-toddler family and center-based providers to support programs to participate in and achieve higher circles of quality in ExceleRate Illinois.
- *Expand Facilities:* Establish annual funding to build new or modify existing facilities to serve infants and toddlers.
- *Workforce Supports:* Increase opportunities for staff to enter and advance their careers by reserving and prioritizing scholarship and wage supplements for infant/toddler candidates, and expanding opportunities to provide funds directly to higher education institutions to support infant/toddler cohorts.



### **Workforce**

- *Representative Workforce:* Develop a well-qualified workforce representative of the children served, including a focus on the bilingual/bicultural workforce, where the greatest disparities exist.
- *Compensation:* Increase salaries of all infant-toddler providers, applying the state's cost-model for quality framework.



## **Awareness**

- *Develop a Roadmap:* Produce a comprehensive report on the current state of access to and need for infant-toddler early learning and care, its impact on the economy, child and family outcomes, etc., and propose a roadmap for moving forward to meet demand for high-quality child care that supports positive economic development in Illinois.

## **STRATEGY: OPTIMIZED EARLY INTERVENTION**



## **Expansion of Services**

- *Increase Children Served under Existing Eligibility Criteria:* Ensure primary referral sources (families, early childhood providers, health professionals, etc.) and EI evaluation teams understand and use the current EI eligibility criteria to make appropriate referrals and eligibility determinations.
- *Decrease Service Delays:* Implement identified strategies for decreasing service delays for families and children found eligible for EI including provider rate increases, telehealth and specialized teams.
- *Remove Barriers:* Modify service delivery approaches and scale innovative models to successfully engage and serve children and families with complex needs who are underrepresented in EI, including children experiencing homelessness, those involved in the child welfare system and who are lead-exposed.



## **Policy Change**

- *Revise Eligibility Criteria:* Establish a multi-disciplinary taskforce to develop recommendations for modifying eligibility criteria for EI by expanding the medically diagnosed conditions that result in automatic eligibility, revising the at-risk eligibility criteria, and considering decreasing the percentage of delay required for eligibility.
- *Revise Billing to Facilitate Collaboration:* Establish billing mechanisms to promote teaming across EI provider disciplines and with other early childhood providers to best support families.



## **Investment**

- *Increase State and Federal Funding:* Increase state and federal funding to respond to projected growth in demand for EI services.
- *Rate Increases:* Continue annual rate increases to improve recruitment and retention of EI professionals.



## **Workforce**

- *Recruitment and Retention of Workforce:* Increase the number of EI professionals, including service coordinators, interpreters and providers, credentialed and enrolled in the system with an intentional focus on providers who are ethnically/culturally and linguistically representative of the families/children served.
- *Professional Development:* Implement ongoing and embedded professional development to strengthen professionals' knowledge and skills related to recommended practices and ensure reflective supervision and practice-based coaching are provided to EI professionals.





### ***Workforce, continued***

- *Decrease Service Coordinator Caseloads:* Decrease Service Coordinator caseloads to increase the quality of care families receive and promote staff retention.



### ***Data Use***

- *Online Data Management System:* Ensure the new EI data system is an online data management system accessible to all relevant stakeholders that supports real-time data collection, reporting, billing and monitoring and promotes teaming across EI professionals.



### ***Awareness***

- *Launch Public Awareness Campaign:* Develop and launch a public awareness campaign (inclusive of public service announcements, billboards, social media, parent testimonials, etc.) to promote community awareness about EI, its purpose and benefits, what high quality services look like, and how to access services.
- *Parent Engagement:* Expand Early Intervention Training Program to provide education and support to families receiving EI services in order to ensure they understand what to expect from EI services and can meaningfully participate.



# ECONOMICALLY SECURE FAMILIES

## ECONOMICALLY SECURE FAMILIES


**PROBLEM TO SOLVE:** Research is clear that poverty is the single greatest threat to children’s well-being. Unfortunately, poverty disproportionately impacts families with young children. Children under age 3 are more likely than children in any other age group, or adults, to experience poverty, and in fact, children under three are more than twice as likely to experience poverty than adults age 65 and over.<sup>xxiii</sup> At the same time, parents of infants and toddlers face many barriers to accessing income supports and employment opportunities that can lift them out of poverty. Safety net programs are not being used to their full potential, both because families are not aware of the programs and because of the onerous participation requirements. For example, in Illinois, only 43% of eligible families accessed WIC in 2018. Addressing barriers to enrollment could help improve child outcomes.<sup>xxiv</sup>


The barriers to living-wage employment opportunities that are compatible with parenting are even greater. Among developed nations, the United States is one of only a few that do not provide mandated paid leave for new parents.<sup>xxv</sup> In Illinois 60% of working people do not even have access to unpaid family and medical leave.<sup>xxvi</sup> In the critical few months after birth, it is best that infants are primarily cared for by a parent, as infants are still developing their brain and central nervous system and forming a secure attachment or bond with one or a few primary caregivers. It is through these first attachment relationships that babies start to learn about the world around them and how to regulate themselves in that world, which sets the stage for all learning to follow. Birthing parents also need time and rest to heal from the process of giving birth, which may involve recovering from a major surgery for those who gave birth via cesarean delivery. In addition, caring for a newborn is both physically and emotionally demanding, and very much a full-time job in and of itself.


As described in the previous section, as parents return to work, there isn’t enough child care available to meet the demand, and the child care that is available is very expensive. There has also been significant growth in low-wage jobs with non-traditional and/or irregular scheduling, which creates major challenges for parents of very young children who rely on those jobs for income. For those many parents who must return to work within one to two weeks after birth, the challenge of finding child care becomes even greater, as child care is not licensed to care for children under the age of 6 weeks in Illinois.

The objectives below provide tangible and achievable steps that Illinois can take to improving the economic health of families that will have a direct and profound impact on the well-being and success of Illinois’ infants and toddlers and their families.


## STRATEGY: FAMILY-FRIENDLY WORK POLICIES


-  **Policy Change**
- *Paid Family and Sick Leave:* Support legislation providing paid family and sick leave for residents.
  - *Job Search:* Establish job search as an eligible activity for the Child Care Assistance Program for parents of children under age 3.
  - *Stable Work Hours:* Enact policies to increase predictability of work hours, especially in low-wage jobs.


-  **Workforce**
- *Access to Jobs:* Increase access to jobs for parents paying a living wage by leveraging workforce development programs and ensuring they are tailored needs of families with young children.


-  **Cohesion**
- *Cross-System Linkages:* Establish intentional collaborations across child care and workforce development programs and the business community to support parents with young children in accessing jobs and job supports and addressing challenges related to variable work hours.

## STRATEGY: INCOME SUPPORTS FOR FAMILIES

-  **Expansion of Services**
- *Increase Benefits Usage:* Expand efforts to streamline eligibility determination across multiple benefit programs, remove barriers to redetermination, and employ strategies to support families accessing public benefits, such as co-location, smartphone applications and benefits navigators.
  - *Mitigate Impact of Public Charge:* Enact strategies to prevent Public Charge from dissuading eligible families from enrolling in public benefits, such as specialized training for staff and public awareness messaging.
  - *Increase Access to WIC:* Enact strategies to increase usage of the Special Supplemental Nutrition Program for WIC, including expanding food options, particularly those that are allergy-friendly, and providing same- or next-day appointments.

-  **Policy Change**
- *Earned Income Tax Credit (EITC):* Increase impact of EITC by increasing the amount of the payment, making the payment monthly rather than in one lump sum, and expanding eligibility to include unpaid caregivers.

-  **Investment**
- *Accurate Counts:* Ensure that everyone is counted in the 2020 Census, especially children under age 5 to ensure Illinois receives its fair share of federal funds.
  - *Universal Basic Income:* Explore efficacy and feasibility of a Universal Basic Income program.

-  **Cohesion**
- *Cross-Program Collaboration:* Increase collaboration across the early childhood system and WIC.



# STRONG INFRASTRUCTURE

## STRONG INFRASTRUCTURE

**PROBLEM TO SOLVE:** The success of the program- or topic-specific objectives described in this agenda will largely be determined by the strength of the infrastructure that supports the system as a whole. Currently, the early childhood system is very complex and highly fragmented, making it difficult for families and professionals alike to navigate programs and services.<sup>xxvii</sup> Robust, statewide systems for referral, information sharing, community planning, and ongoing collaboration among child and family serving systems are not in place at the community level, nor are communities adequately supported in building such systems.

At the state level, data systems are also fragmented and not aligned to appropriately inform both service provision and community planning efforts. Administrative capacity at state agencies is also extremely limited, which impacts the ability of the state to build stronger cross-agency early childhood infrastructure and respond to projected increases in children and families being served. Finally, as Illinois and other states work to address critical workforce shortages, it is essential to make improvements to cross-system professional development and supports.<sup>xxviii</sup>

Just as early childhood programs, services, and data systems are fragmented, so too are early childhood professional competencies, pipelines and pathways, and professional development and supports. Lack of integration and alignment prevents the state from both ensuring uniform standards of quality for families across programs and services and capturing efficiencies in building and supporting the workforce and a strong system overall.

The recommendations put forth in this section are undoubtedly ambitious but are also achievable and would go a long way toward supporting the aims of this agenda.

## STRATEGY: STRONG STATE AND COMMUNITY STRUCTURES



### **Expansion of Services**

- *Administrative Capacity:* Strengthen administrative capacity across state agencies that administer early care and learning programs and services to respond to projected increases in children and families served.



### **Data Use**

- *Align and Improve Data Systems:* Increase comprehensive, aligned, and timely collection and reporting of data across early care and learning programs and services to better inform resource allocation and community planning, provide disaggregated data on participant demographics and workforce composition, and to measure progress and outcomes.



### **Cohesion**

- *Referral and Service Integration:* Increase collaboration across family-serving systems, including early care and education, child welfare, health, and mental health systems, to establish systematic referral pathways, procedures to share information, and to collaboratively serve families.
- *Establish Statewide System of Community Collaboration:* Establish a state-wide system for collaboration that includes a lead entity and collaborations that serve all areas of the state to implement 1) community driven planning for 0-5 services and accessing funding opportunities; 2) supporting full enrollment and staffing in all programs; 3) engagement of the families who most need services; and 4) a “no wrong door” approach for all families seeking services and supports.
- *Develop an Integrated, Cross-System Approach to Developmental Screening:* Data on whether individual children receive developmental and social emotional screenings is currently not available, and although children can and do receive developmental screenings from multiple entities, it is likely that many children are not screened using validated tools at the recommended periodicity, thus resulting in under-identification of children who need developmental supports. The Administration should immediately move to implement Early Learning Council recommendations to develop mechanisms across early learning and health systems to know whether all children are receiving the developmental and social emotional screenings and use this data to inform targeted efforts to increase developmental screenings in areas of greatest need.
- *Priority Populations:* To the extent possible, integrate and align policies and practices across systems serving the Early Learning Council’s official priority populations and build the capacity necessary to ensure priority populations can access and participate in early childhood programs and services.

## STRATEGY: CROSS-SYSTEM PREPARATION, PROFESSIONAL DEVELOPMENT & SUPPORTS



### ***Expansion of Services***

- *Infant/Early Childhood Mental Health Consultation:* Establish statewide system for mental health consultation that functions across all early childhood settings at the recommended dosage led by a centralized entity that manages the training and professional development, provider database, and deployment of the workforce.



### ***Workforce***

- *Professional Development Integration:* Align and integrate early childhood professional development across infant/toddler programs and services utilizing a shared quality framework.
- *Pipeline and Pathways:* To the extent possible, align professional competencies across infant/toddler preparation programs to expand the workforce prepared for multiple infant/toddler workforce roles.



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# APPENDICES

## ILLINOIS EARLY LEARNING COUNCIL RACIAL EQUITY PRIORITIES & PRIORITY POPULATIONS

**Definition of Racial Equity in Illinois:** *A racially equitable society values and embraces all racial/ethnic identities. In such a society, one's racial/ethnic identity (particularly Black, Latino, Indigenous and Asian) is not a factor in an individual's ability to prosper.*

An early learning system that is racially equitable is driven by data and ensures that:

- Every young child and family regardless of race, ethnicity, and social circumstance has everything s/he/they need to develop optimally;
- Resources, opportunities, rewards, and burdens are fairly distributed across groups and communities so that those with the greatest challenges are adequately supported and not further disadvantaged; and
- Systems and policies are designed, reframed or eliminated to promote greater justice for children and families.

### Illinois Early Learning Council Racial Equity Priorities:

- Align and standardize race/ethnicity data collection and reporting.
- Evaluate and identify whether processes for distributing resources exacerbate racial disparities, including agency contracting.
- Address race/ethnicity disparities in terms of workforce compensation and advancement. For example, lead teachers are predominantly White (<80%) versus people of color in lower positions.
- Eliminate racial/ethnic disparities for children participating in all programs that contribute to school readiness and life success.
- Address racial disparities in enrollment in preschool for 3- and 4-year olds
- Address racial disparities in enrollment in prenatal to age 3 services

### Illinois Early Learning Council Priority Populations

- Children of teen parents
- Children experiencing homelessness
- Children in families in poverty/deep poverty
- Children/families with Department of Children and Family Services involvement
- Children with disabilities
- Children of migrant or seasonal workers
- Primary caregiver did not complete high school/no GED
- Families that face barriers based on culture, language and religion
- Children of a parent with a disability
- Children/family with refugee or asylee status

## APPENDIX B

\* Denotes core team member

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# PN3 Master Agenda Template

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### Illinois Prenatal to Three Initiative

**Illinois vision:** We envision Illinois as a place where every young child—regardless of race, ethnicity, income, language, geography, ability, immigration status, or other circumstance—receives the strongest possible start to life so that they grow up safe, healthy, happy, ready to succeed and eager to learn.

**The Illinois Prenatal to Three Initiative goals:** (1) Increase the number of families and children prenatal to age three who are connected to essential and high-quality healthy, development, and social-emotional support services and (2) increase the availability of affordable, high-quality child care for infants and toddlers across diverse settings.

**Initiative targets:** The initiative will result in improved access to high-quality services for 50,000 Illinois infants and toddlers in families earning under 200% FPL by 2023 and 100,000 Illinois infants and toddlers in families earning under 200% FPL by 2025.

# Perinatal Support: Prenatal, Intrapartum and Postpartum

<p><b>1. Expand and improve the continuum of perinatal supports for all pregnant persons, newborns, and their family and community support systems regardless of their immigration status.</b></p> <p><b>Rationale:</b> Prenatal care visits are important, but they aren't designed to address the full scope of supports and needs of pregnant people and families. A prenatal touch is an engagement to connect people to more resources, which will improve health and birth outcomes for pregnant people and babies. Several communities across the country are beginning a universal prenatal touchpoint by perinatal navigators in their work with families</p>		
Objective	Projected Impact	Tactics
<p>1.1 Expand universal newborn nurse home visits for all newborns that includes a comprehensive assessment, referral and connection to all services needed, including health and community services.</p> <p>(See this objective as written in the HV template)</p>	<p>1.1 Universal newborn/family support home visit will be available in no less than 50% of all Illinois counties over a ten-year period. Look at HV template for timing and impact of expansion of universal newborn home visits to new communities.</p> <p>1.1 New strategies and approaches designed to reach all families with a new birth will be added for non-traditional locations of family support including community centers, libraries, parks, etc.</p>	<p>1.1 Identify additional communities to offer universal newborn home visit and develop readiness. Ensure expansion is in communities that experience the greatest disparities in access to health care and other services. (see HV template)</p> <p>1.1 Identify and advocate for additional funding streams to support expansion (year 1 and each year)</p> <p>1.1 Adopt a community saturation approach identifying leaders and community locations to host perinatal support i.e. 4<sup>th</sup> trimester support groups, fussy baby support groups, dad's groups, early parenting support groups, etc.</p> <p>1.1 Fund and establish a voluntary perinatal registry for anyone that is pregnant or has just delivered a baby for the purposes of connecting families (fathers, grandparents, partners) to an on-going support system</p>
<p>1.2 Establish voluntary universal prenatal connection/visit that provides anyone that is pregnant with a comprehensive assessment, referral and connection to services.</p>	<p>1.2 At least 80% or more of pregnant individuals (there were 149,309 live births in IL in 2017, so this would be 119,512) in the state of Illinois will experience improved perinatal</p>	<p>1.2. In Year 1, models and approach for IL to consider to provider universal prenatal visits will be identified. Work includes research on models currently being piloted and used in other states for a universal prenatal visit, and identifying how this will align with IL's effort to provide universal post-partum nurse visits.</p>

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	care and be better connected to health and social supports by 2025 (need to identify year to year impact and estimate uptake)	<p>1.2 In Year 2, implement two to three demonstration communities from different areas of the state, and focused in areas of greatest need to gather lessons learned, evaluate implementation to inform scaling.</p> <p>1.2 By year 5, provide system for universal prenatal visits across the state to all people who choose to them.</p>
1.3 Establish a public awareness campaign focused on infant and maternal health that empowers people with the knowledge and tools to advocate for themselves.	1.3 Current systems of perinatal care and support will grow to serve identified target numbers above.	<p>1.3 Expand Illinois Department of Public Health maternal mortality risk training for home visitors to support healthy births and post-partum care. Consider extending to additional early childhood providers.</p> <p>1.3. Move focus to community-based outreach by co-creating with individual communities a public education campaign strategy based on individual community context.</p>
1.4 Address intrapartum care, by incentivizing community expansion of Baby Friendly Hospitals and Alternative and Free-Standing birthing centers. (need to identify impact and tactics)		
1.5 Expand funding and access to community based doulas that may be embedded in programs such as home visiting or function as stand-alone community based services. Require MCOs and private insurance coverage of community-based perinatal services.	1.5 Community based doulas will be available to all pregnant people who need/want them by 2025 (or maybe we have them in the communities with the greatest needs by then. Need to identify markers for 2023/2025).	<p>1.5 Pass legislation to provide for Medicaid financing for doulas (year 1)</p> <p>1.5 Identify mechanisms and models to implement expansion of doulas that bill Medicaid and ensure expansion of workforce.</p>
1.6 Increase funding for community-based perinatal support including perinatal health workers, educators, and advocates, home visitors.(need to attach more tangibly to the impacts and tactics)		<p>1.6 Expand Centering Pregnancy groups and connect to the prenatal touch, and doula strategies above.</p> <p>Perinatal navigators</p>

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<p><b>2. Extend the postpartum period of services and supports for the full 12 months after birth regardless of immigration status with a dyadic focus.</b></p> <p><u>Rationale:</u> Data shows that maternal mortality risk increases after 42 days postpartum, yet medical care in programs generally are looking at a shorter periods of time which lessens continuity of care and services and increases risk for maternal mortality and morbidity A strong continuum of support during the first year postpartum can reduce the occurrence of maternal mortality and morbidity as well as infant mortality.</p>		
Objective	Projected Impact	Tactics
2.1 In year 1 establish through 1115 waiver post-partum coverage for one year for all births that are eligible for federal funding.	2.1 & 2.2 An additional “x” number of women will have full year coverage postpartum by 2021 and by 2022.	2.1 Implement 1115 waiver for one year of post-partum coverage.
2.2 In year 2, an extension of coverage for a full -year post-partum for all births who the state is not eligible for federal funding (like All Kids).		2.2 Identify costs and numbers associated with implementing extension of coverage for women not eligible for federal coverage Year 1, and implement extension Year 2.
<p><b>3. Improve the quality of care during the perinatal period by establishing procedures and protocols that address the institutional and systemic racism and implicit bias that can result in persistent disparities in maternal care and increase maternal mortality and morbidity.</b></p> <p><b>Rationale:</b> The data shows that 60% of cases of maternal mortality are preventable. The Giving Voice to Mothers Study showed that mistreatment is experienced more frequently by women of color, when birth occurs in hospitals, and among those with social, economic or health challenges. Mistreatment is exacerbated by unexpected obstetric interventions, and by patient-provider disagreements. Experts agree how people are treated during childbirth can affect the health and well-being of mother, child, and family, One study done over a four year period in California revealed that the relationships between pregnant black individuals and their health-care providers are often a source of stress, anger and distress during a vulnerable time. Improving the quality of care for all pregnant people of color will improve the care that all receive during the perinatal period and possibly beyond.</p>		
3.1 Establish policies and procedures for embedded professional development and reflective practice for all perinatal health care providers.		
3.2 Establish a statewide taskforce project under ILPQC supports to gather data from pregnant and birthing individuals regarding their experiences in the health care delivery system during the perinatal period and then develop recommendations for actions to improve the quality of care given during the perinatal period.		

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3.3 Team approach in the healthcare system to have more of a voice and connection as to the experiences women are having with the health care delivery they are receiving.		
3.4 Establish an Illinois perinatal rating component to the Illinois Hospital report card and consumer guide to health care report.		

# Early Intervention

1. Build on and expand awareness and outreach efforts to increase participation in EI.		
<b>Rationale:</b> The more community members, including families and early childhood and health providers, understand about EI, the more likely families will be referred, and participate in EI.		
Objective	Projected Impact	Tactics
<p>1.1 Develop and launch the Early Intervention: Let's Take a Look! campaign, which could entail: public service announcements, billboards, video testimonials, texting efforts for new parents, and/or social media outreach, to promote community awareness about EI, its purpose and benefits, what high quality services look like, and how to access services by year 1 (2021).</p>	<p>1.1 As of September 2019, there were a total of 23,219 active Individualized Family Service Plans (IFSP). With the proposed extensive outreach efforts, it is anticipated that we will serve twice as many families and children (46,000) by year 5 (2025).</p>	<p>1.1 Secure EI funding and personnel, including the EI Clearinghouse, the Parent Training and Information Centers, Early CHOICES, and the Early Intervention Training Program (EITP), to create and disseminate public service announcements, texting efforts, video testimonials and/or social media platform related to what EI is, the benefits, referral procedures, families' experiences, etc.</p> <p>1.1 Advocate for funding and enlist the services of a professional design company to evaluate EI's overall branding.</p> <p>1.1 Recruit and engage representative families from across the state who have previously participated in EI services to participate in community awareness and outreach efforts.</p> <p>1.1 Engage Community Organizing and Family Issues (COFI) to expand their outreach efforts to engage families in understanding EI and benefits of participation.</p> <p>1.1 Conduct focused outreach in communities to understand why families decline participation in EI, particularly in communities that have the lowest participation rates (families who are eligible but decline services).</p> <p>1.1 Fund and establish a voluntary registry of families who have participated in EI for the purpose of connecting families to an on-going support system.</p>

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		1.1 EI, with input from EI partners, will develop survey/measure that asks families to explicitly report on the quality of their EI services/experiences.
1.2 More referrals will be made to EI by all primary referral sources including families, early childhood providers and health professionals by year 2 (2022).	1.2 With intentional outreach efforts, it is expected that the EI program will receive more referrals.	1.2 Promote and disseminate the Standardized Referral and Fax back Form to all primary referral sources and track usage.  1.2 Promote and disseminate the <i>Tools to Support Inclusion</i> webinar to early childhood systems, with potential revisions targeted to the health sector.  1.2 Grow the EI program's infrastructure (providers, service coordinators, EI Partners, such as the Bureau) to support additional EI referrals/evaluations.  1.2 All of the above tactics in 1a. are applicable here.
1.3 <b>Expand the EI infrastructure</b> , including the Bureau of EI and administrative partners, to support the increase in children and families eligible and participating in EI services by year 5 (2025).	1.3 Growth in infrastructure will allow better support for larger number of children and families served.	1.3 Advocate for funding increase to grow infrastructure and increase staff allocations.
<p><b>2. Expand a new EI workforce so that families can receive services from professionals who have similar ethnic/cultural/linguistic backgrounds and support the existing workforce to provide high-quality, family-centered services.</b></p> <p><u>Rationale:</u> Recruiting enough professionals and a workforce that is representative of the families served in Illinois has the potential to improve families' experiences in EI. Further, ongoing professional developed efforts aimed specifically at enhancing the capacities of the EI workforce (new and current professionals) to support and partner with families living under 200% FPL may improve families' experiences in EI, enhancing their capacities to meet the needs of their children, while also positively impacting provider/professional retention.</p>		
<b>Objective</b>	<b>Projected Impact</b>	<b>Tactics</b>
2.1 <b>Increase the number of EI professionals</b> , including service coordinators, interpreters and providers credentialed and enrolled in the system by year 5 (2025).	2.1 As of September 2019 (per Provider Connections), there are a total of 4,798 credentialed providers in the EI system. With focused recruitment efforts, it is projected that approximately 4,800 more EI professionals	2.1 Partner with higher education institutions across the state to disseminate information about EI, particularly in human/child development, family studies, speech, psychology, social work, OT and PT programs, with the intention of recruiting professionals in college.  2.1 Explore options for scholarships and loan forgiveness for service in the field to attract more EI professionals.

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	<p>across disciplines will be recruited across disciplines to serve children and families by year 5 (2025).</p>	<p>2.1 Partner with Provider Connections to:</p> <ul style="list-style-type: none"> <li>• explore and establish career pathways for families who have been served by early intervention and want to pursue a career in EI.</li> <li>• survey professionals about the reasons why they have let their EI credential lapse.</li> <li>• work with Illinois State Board of Education (ISBE) to develop strategies to begin recruitment efforts as early as high school.</li> <li>• develop a pathway to re-enroll providers whose credential has expired.</li> </ul> <p>2.1 Enlist professional organizations’ (i.e., Illinois Developmental Therapy Association) assistance with recruitment and retention of EI professionals.</p>
<p>2.2 Recruit more EI professionals across disciplines who are <b>ethnically/culturally and linguistically representative</b> of the families/children served by year 5 (2025).</p>	<p>2.2 At this time, the projected impact cannot be determined because the EI system does not require professionals to indicate their race/ethnicity.</p>	<p>2.2 All tactics above in 2a. apply here.</p> <p>2.2 Engage community organizations, such as the Chicago Association of Black Social Workers and the Latino Association of Social Workers, to help prepare, recruit, retain, and promote EI professionals who culturally/ethnically and linguistically represent the families/children who participate in Part C services.</p> <p>2.2 Collaborate with The Bureau of Early Intervention and Provider Connections to determine the feasibility and legality of asking EI professionals to indicate their race/ethnicity when enrolling in the system.</p>
<p>2.3 Expand professional development efforts that focus on strengthening professionals’ knowledge and skills related to</p>	<p>2.3 With expanded professional development</p>	<p>2.3 Partner with EITP to explore the possibility of developing and implementing a <b>“reflective supervision credential”</b> that would</p>



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<p>implementing recommended practices by year 5 (2025).</p>	<p>efforts, it is projected that at least 4,800 professionals will have access to learning opportunities focused on implementing recommended practices. With the implementation of recommended practice, it is more likely that families and children will experience high-quality services.</p>	<p>build the capacity of local leadership to provide <b>ongoing reflective supervision and coaching</b> to its professionals.</p> <p>2.3 Advocate for funding so that the <i>Diversity-Informed Tenets for Work with Infants, Children, and Families</i> training can be offered to EI professionals. Additionally, EITP can highlight some of the program's free resources on their FaceBook page, website and within their offerings.</p> <p>2.3 Advocate for the requirement of newly enrolled EI professionals (during their first 3-year credentialing cycle) to take 20 of the required 30 hours of professional development by choosing from a selection of EITP's offerings related to the content listed in objective 2c.</p> <p>2.3 Advocate for increased funding to support a <b>transdisciplinary service delivery approach</b> to better support the complex needs of families and children living in poverty. See Service Delivery Approaches Workgroup recommendations (#9).</p> <p>2.3 Engage and partner with the EI Monitoring program to collect data that reflects the quality of services that providers are demonstrating (and thus what parents are receiving). This information can help focus professional development efforts.</p>
<p>2.4 Decrease Service Coordinators' caseloads (per the recommendation in the Service Delivery Workgroup's report) to increase the quality of care families and children receive and potentially impact professional retention by year 5 (2025).</p>	<p>2.4 Across the state, the average number of children and families each Service Coordinator is supporting at one time is <b>55</b> (some CFCs have higher counts, especially during times of turnover). The service delivery workgroup's</p>	<p>2.4 Partner with the Bureau of EI to address the current number of Service Coordinator vacancies across the state.</p> <p>2.4 Survey Service Coordinators who have recently left the field about reasons why they decided to leave.</p> <p>2.4 Explore the CFC contract agencies to determine barriers (such as lack of flex time; working evening/weekend hours) that may be limiting the working conditions of Service Coordinators and</p>

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	<p>recommendations is as follows:</p> <p>2.4 Revise funding formula to include children in intake and ensure that each service coordinator has no more than <b>45 active cases</b> (without reducing per service coordinator allocation from level in place at time of recommendation).</p>	<p>impacting recruitment and retention.</p> <p>2.1, 2.2, &amp; 2.3 Given there is limited to no upward mobility for EI professionals, <b>advocate for annual pay increases for all EI professionals to promote provider recruitment and retention.</b></p>
<p><b>3. Improve communication &amp; collaboration within and across early childhood systems to better support families and children living under 200% FPL.</b></p> <p><u>Rationale:</u> Improved communication and collaboration within and across early childhood systems has the potential to increase family referrals to, and participation in, appropriate programs and promote comprehensive, high-quality services.</p>		
<b>Objective</b>	<b>Projected Impact</b>	<b>Tactics</b>
<p>3.1 To promote improved communication and collaboration across early childhood systems, compensate EI professionals for time collaborating with professionals outside of EI (within early childhood) by year 1 (2021).</p>	<p>3.1 It is projected that by compensating EI professionals for their time collaborating and communicating with professionals in partnering programs will incentive some professionals to engage in this activity/recommended practice. As a result of teaming, families and children should receive more comprehensive, high-quality services.</p>	<p>3.1 <b>Advocate for increased EI funding and procedural changes</b> to support EI professionals' ability to bill for time communicating and collaborating with professionals outside of EI who are also partnering with the family/child, particularly in relation to families involved in child welfare and/or experiencing homelessness.</p>
<p>3.2 <b>Develop an online data management system</b> (for information collection, dissemination, sharing and track) that can be</p>	<p>3.2 A shared online data management system that both professionals and parents can</p>	<p>3.2 Advocate for additional funding, engage stakeholders and complete the Request for Proposal (RFP) process to support the development of the online data management system.</p>

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<p>accessed by EI families and professionals by year 1 (2021) to facilitate improved communication and collaboration within the EI system.</p>	<p>access has the potential to create opportunities for improved collaboration and communication across team members.</p>	
<p>3.3 Develop and facilitate cross-systems professional development opportunities and activities that promote communication and collaboration across partnering systems each year (2021, 2022, 2023, 2024, &amp; 2025).</p>	<p>3.3 It is projected that ongoing cross systems professional development efforts will create opportunities for professionals to learn more about early childhood programs and promote ongoing collaboration across programs to better serve families and children.</p>	<p>3.4 Partner with EITP to develop and facilitate learning opportunities to <b>promote cross-systems collaboration</b> (see EI and home visiting policy recommendations report).</p> <p>3.4 With the Inclusion Subcommittee, review and expand the <i>Natural Partners</i> training and the <i>Welcoming Each and Every Child</i> training and ongoing supports to both EI and childcare providers who support infants and toddlers in EI.</p> <p>3.4 Implement the Inclusion Subcommittee’s recommendations to the Department of Human Services (DHS) on Inclusion in Child Care.</p>
<p><b>4. Revise and expand the EI eligibility criteria to include more children and families who are eligible for services.</b></p> <p><u>Rationale:</u> Expanding the eligibility criteria to specifically include more children and families who have experienced significant risk factors, can potentially strengthen families’ protective factors.</p>		
<p><b>Objective</b></p>	<p><b>Projected Impact</b></p>	<p><b>Tactics</b></p>
<p>4.1 Modify the low birth weight diagnosis eligibility from 1,000 to 1,200 grams by year 5 (2025).</p>	<p>4.1, 4.2, 4.3 &amp; 4.4 By revising the eligibility criteria, it is expected that more children and families will be eligible for EI services.</p>	<p>4.1 Explore other states criteria for preterm and low birthweight eligibility to expand EI access to preterm and low birthweight infants</p> <p>4.1 Advocate for any necessary procedural or legislative changes necessary to achieve objective.</p>
<p>4.2 Make the following changes to the at-risk eligibility category by year 5 (2025):</p> <ul style="list-style-type: none"> <li>Align the current at-risk eligibility criteria with the Service Delivery Workgroup’s recommendation</li> </ul>		<p>4.2 Implement Service Delivery Workgroup recommendations related to at-risk criteria (see report for details).</p> <p>4.2 Explore impact of adding exposure to Zika Virus and extended hospital stay to eligibility criteria.</p>

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<ul style="list-style-type: none"> <li>• Include babies who have been exposed to the Zika Virus</li> <li>• Include babies who have experienced extensive hospital stays at birth (45 days or more)</li> </ul>		<p>4.2 Advocate for necessary procedural or legislative change to achieve objective.</p>
<p>4.3 Add “neonatal abstinence syndrome” to the category of medical conditions likely to result in a developmental delay (automatically eligible) for babies who have been exposed to opioids by year 5 (2025).</p>		<p>4.3 Explore impact of adding opioid exposure to eligibility criteria.</p> <p>4.3 Advocate for necessary procedural or legislative change to achieve objective.</p>
<p>4.4 Change the percentage delay eligibility criteria to serve children who have a 20% delay in any one area of development and their families by year 5 (2025).</p> <p>OR</p> <p>4.5 Determine the feasibility of lowering the delay percentage to 20% (from 30%) in any one area of development by year five (2025).</p>		<p>4.4 or 4.5. Begin documenting the percentage delay for children found ineligible for early intervention to collect information on how many more children and families may be found eligible according to this category to support systemic changes.</p>
<p>4.6 Support (new and current) EI professionals’ understanding of the eligibility criteria (see 4.1., 4.2., 4.3 &amp; 4.5 above), by offering high-quality online and face-to-face professional development inclusive of an “eligibility refresher” learning opportunity by year 5 (2025; depending on when eligibility changes).</p>	<p>4.6. As EITP updates their learning opportunities to include the newest eligibility criteria, it is projected that new professionals entering the system will have access to learning opportunities that reflect these changes. Further, with the development of an online “refresher eligibility” learning opportunity, it is projected that professionals (who have been in the system), will have an opportunity to review the EI eligibility criteria.</p>	<p>4.6 Partner with EITP to develop practice guidance and continue to utilize existing materials and trainings to support professionals’ understanding of the eligibility criteria as their knowledge and interpretation of the criteria may impact the number of families and children deemed eligible for services.</p>

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<p>4.7 Expand the EI infrastructure, including the Bureau of EI and administrative partners, to support the increase in children and families eligible and participating in EI services by year 5 (2025).</p>	<p>4.7 Growth in infrastructure will allow better support for larger number of children and families served and larger provider pool.</p>	<p>4.7 Advocate for funding increase to grow infrastructure and increase staff allocations.</p>
<p><b>5. Families and children experiencing the most barriers will receive EI services without experiencing service delays.</b></p> <p><u>Rationale:</u> It has been well documented that during the birth to three years, infants and toddlers can experience a rapid period of brain development and growth. Prolonged service delays, especially for children with delays and/or disabilities who are living in poverty, can negatively impact children and families. Decreasing service delays creates equitable experiences for all families/children in Illinois during this critical developmental period.</p>		
<p><b>Objective</b></p>	<p><b>Projected Impact</b></p>	<p><b>Tactics</b></p>
<p>5.1 <b>Decrease service delays</b> for families and children eligible for EI by year 5 (2025).</p>	<p>5.1 On August 31, 2019, 1,159 children and families were experiencing unresolved delays in service delivery. Among these families and children, the average delay was 130 days, with a median of 100 days. With focused efforts to reduce the amount of time families and children are waiting for services (as a result of systemic barriers), it is projected that families will not wait longer than 30 days to receive recommended IFSP services.</p>	<p>5.1 Pilot billable tele-health EI services, especially for those families experiencing delays in receiving any of the recommended IFSP services.</p> <p>5.1 Explore a <b>“tiered rate” system</b>, providing professionals with a higher reimbursement rate who provide services to families and children in underserved communities/hard to reach areas/high concentration of service delays.</p> <p>5.1 Explore and resolve barriers to successfully providing services in families’ natural environments, particularly in the areas experiencing service delays.</p> <p>5.1 Explore and resolve transportation-related barriers that would potentially allow families to access EI services (with improved transportation options) in their natural environments.</p>
<p>5.2 Establish <b>specialized teams</b> who are uniquely equipped to provide services to families and children experiencing homelessness, living in rural areas and who are in the child welfare system by focusing efforts and supports on CFCs (to be determined) by year 5 (2025).</p>	<p>5.2 Increase the number of children and families receiving EI services who are experiencing homelessness, living in rural communities and children in the child welfare system.</p>	<p>5.2 Partner with local agencies, CFCs and independent providers to identify and develop specialized IFSP teams who have specialized skills to partner with families and children living in poverty and who have the capacity to provide flexible services as families experience changing life circumstances. See Service Delivery Approaches Workgroup recommendations and homelessness &amp; EI memo for details.</p>

# Home Visiting

**1. Stabilize the home visiting provider community, secure needed increases in compensation, and ensure sufficient funds to enroll an additional 13,000 families in home visiting by 2025. Increase existing funding and identify new funding streams to maintain existing programs and expand the availability of high-quality home visiting.**

Year 1: Target funding increases from 2020-2021 toward restoring capacity among home visiting programs hit by the budget impasse.

Year 2: Target funding increases toward compensation increases designed to increase retention of home visiting staff.

Year 3 – 5: Target funding increases toward new “slots,” including new home visiting programs in communities with gaps in service capacity, as well as quality add-ons to support IECMH consultation, cross-system training, and racial equity and implicit bias training, etc.

Objective	Projected Impact	Tactics
<p>1.1 Increase state and federal funding to support salary increases across funding streams and added capacity to serve 13,000 more families in home visiting.</p>	<p><i>1.1., 1.2, &amp; 1.3 Dependent on funding wins, set a goal for a per year number of new families to bring into home visiting services.</i></p> <p><i>1.1., 1.2, &amp; 1.3 13,000 additional low-income families are enrolled in home visiting services by 2025. (1-3)</i></p> <p><i>1.1., 1.2, &amp; 1.3 \$150m increase to the ECBG, with the request that at least 25% go toward PI (1)</i></p> <p><i>1.1., 1.2, &amp; 1.3 State funding for HFI/PTS increases by \$15mm by 2023, targeted toward quality components.</i></p>	<p>1.1 Pass bill to raise infant/toddler set-aside floor to 25%-30%, and lobby ISBE, the governor’s office, and the ILGA to appropriate more funds to accommodate statutory change. Advocate for \$150m increase to the ECBG, with the request that at least 25% go toward PI, as required by law, and prioritize improving salaries</p> <p>1.1 Lobby DHS, the governor’s office, and the ILGA to appropriate more funds through state budget process. Ensure programs can write in for quality components and other funds not tied to enrollment. Standardize and raise the cap on funds that can be spent on administrative functions.</p> <p>1.1 Complete cost modeling and service saturation analysis for the spectrum of home visiting services to help ILGA understand the full cost of high-quality home visiting and cost of reaching saturation. Ensure full cost of home visiting is communicated to the Governor’s finance commission.</p>

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	<p>\$4 mm for FY21 to raise salaries for home visitors among IDHS funded programs (1)</p> <p>1.1., 1.2, &amp; 1.3 MIECHV funding increases by ~\$8.4 mm by 2023 (1)</p>	<p>1.1 Organize a coordinated ask around the MIECHV reauthorization across providers and the public-private home visiting landscape.</p> <p>1.1 Organize a coordinated ask around Head Start and Early Head Start funding across providers and the public-private home visiting landscape.</p>
<p>1.2. Build local capacity of home visiting providers to access additional funding to build new or augment home visiting services</p>		<p>1.2 Using PDG B-5 funds, identify communities with little to no home visiting capacity and a need for services, and award mini grants for communities to strategize and plan for increasing the capacity of home visiting programs</p> <p>1.2 Map out existing sources and quantities of private funding for home visiting across the state. Based on that study, make a projection for feasible increases statewide in private funding for the home visiting system.</p> <p>1.2 Create and disseminate a toolkit, trainings and coordinated TA to communities seeking support on how to tap into private funding for their home visiting programs [Could be in cross-systems piece as an activity for local collaboratives/capacity building]</p>
<p>1.3. Pursue new funding through Medicaid reimbursement of home visiting services and/or MCO administrative dollars</p>		<p>1.3 Building upon existing related credentials, develop and build support for cross-model, cross-funder credentials that would permit home visitors to be reimbursed by Medicaid.</p>

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		<p>1.3 Conduct outreach with HFS to discuss the potential of adding doula and home visiting services to the Medicaid billing codes</p> <p>1.3 Pursue legislation to mandate coverage for doula and home visiting services by Medicaid; convene a body (like the Home Visiting Task Force) to plan for the implementation of reimbursement for home visiting and doula services, including planning for provider credentials and potential registry.</p> <p>1.3 Conduct outreach to and strengthen relationships with MCOs around ways to leverage Medicaid dollars or MCO administrative funds to support home visiting.</p> <p>1.3 Collaborate with the national offices of NFP, PAT, HFA, to gather lessons learned and strategies from other states utilizing Medicaid dollars to support home visiting.</p> <p>1.3 Document lessons learned and outcomes from the GOECD led MCO-home visiting collaborations; present a roadshow on the merits and mechanics of MCO-home visiting to IAMHP conference, individual MCOs.</p>
<p><b>2. Advance a comprehensive workforce strategy, inclusive of compensation, career pathways and the recruitment of a racially and linguistically diverse workforce, professional development, racial equity training, IECMH consultation, in-service supports, and training to improve retention of home visiting staff and improve program quality.</b></p>		
<p><b>Objective</b></p>	<p><b>Projected Impact</b></p>	<p><b>Tactics</b></p>
<p>2.1 Increase the compensation of home visiting and doula staff to improve retention and equity</p>	<p>2.1, 2.2, &amp; 2.3 By 2025, 70% of home visiting work force is paid at levels outlined in ELC Quality Committee Compensation/HVTF guidelines. (1-2)</p> <p>2.1, 2.2, &amp; 2.3 Average home visitor/doula/direct service staff turnover is reduced by 10% by 2025. (Baseline turnover is 30% per current estimates) (1-2)</p>	<p>2.1. Building on work done for PDG B-5, develop a set of compensation guidelines for home visiting professionals; vet these recommendations with the home visiting workforce, the Home Visiting Task Force, and the Quality Committee of the ELC.</p> <p>2.1 Create cross-funder agreement on compensation floor for home visiting workforce with regular COLA.</p> <p>2.1 Align requests for funding increases on ISBE PI and IDHS HFI/PTS funding streams to create an advocacy ask around salary increases, and greater salary parity across funding streams. Target increases in funding to compensation increases for home visitors and doulas.</p>



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	<p>2.1, 2.2, &amp; 2.3 By 2025, 65% of home visiting programs receive at least 10-12 hours of Infant and Early Childhood Mental Health Consultation per month. (3)</p> <p>2.1, 2.2, &amp; 2.3 355 programs x an average of 5 HVs per program x 65% = 975 home visitors. 975 HVS x average caseload of 18 families per year = 20,768 young children/families receiving higher quality HV services due to increased access to IECMH consultation.</p> <p>2.1, 2.2, &amp; 2.3 By 2025, 65% of programs provide/and or connect their home visitors to cultural sensitivity/implicit bias training. (3)</p> <p>2.1, 2.2, &amp; 2.3 355 programs x an average of 5 HVs per program x 65% = 975 home visitors. 975 HVS x average caseload of 18 families per year = 20,768 young children/families receiving higher quality HV services due to increased cultural sensitivity/implicit bias training.</p>	<p>2.1 Explore mechanisms to tie increases in state funding from ISBE and IDHS to salary increases for home visiting direct service staff. Model compensation parity in PFA/PFAE into other Home Visiting programs.</p>
<p>2.2 Support the recruitment and retention of a diverse workforce that matches the demographic profile of families in the community</p>		<p>2.2 Explore pathways for parent participants for careers in home visiting, including gathering information from HIPYPY and ParentChild+ national models, to create a strategy for supporting dual-language</p>

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		<p>learner families who receive home visiting to become linguistically diverse home visitors. Pilot a pathway program, targeting recruitment toward English Language Learner families</p> <p>2.2 Create cross-funder guidance to strengthen the recruitment and hiring of diverse staff, representative of communities served by home visiting.</p> <p>2.2. Building on the 2019 CPRD Continuous Quality Improvement survey of the MIECHV workforce, craft a set of recommendations to the core home visiting funders on how to reduce staff turnover while promoting program quality. Support core funders in creating a timeline/strategic plan for implementation of workforce recommendations.</p> <p>2.2 Engage the Advance IL Educator Workforce Pipeline work group to craft strategies and ensure cohesion with strategies to support the K-12 educator workforce</p> <p>2.2 Ensure all home visitors in state/federally funded programs can receive the Gateways Scholarship.</p> <p>2.2 Ensure that all home visitors, across funding streams are registered in Gateways; construct parameters/guidelines to clarify who is a part of the home visiting workforce.</p> <p>2.2 Collaborate with the Tenets Initiative to explore avenues to make the Diversity-Informed Tenets for Work with Infants, Children, and Families available as training to home visiting programs across funding streams.</p> <p>2.2 Convene a meeting with home visiting leadership and the Illinois Children's Mental Health Partnership to strategize around ways to increase access to Infant and Early Childhood Mental Health Consultation.</p>
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<p>2.3 Remove barriers to preparatory education, professional development, on-going training, and embedded job supports to improve the quality of doula and home visiting services as well as staff retention</p>		
<p><b>3. Increase alignment across home visiting programs and systems, including cross-system data collection, shared outcome metrics, quality standards, monitoring and professional development, to improve the equitable allocation of resources to align with community-need, increase opportunities for shared professional development, and set benchmarks by which to measure progress.</b></p>		
Objective	Projected Impact	Tactics
<p>3.1 Align and increase the cohesive collection and reporting of enrollment, data across the major funders of home visiting to better inform resource allocation</p>	<p>What do meaningful systems impacts look like?</p>	<p>3.1 Convene a meeting with the Data, Research and Evaluation Subcommittee of the Integration and Alignment Committee (of the ELC) and IECAM to facilitate a conversation with the major funders about the priority data measures to standardize and the cadence of reporting; elevate the level of detail included in the MIECHV Needs Assessment as the goal for major periodic reporting on the statewide home visiting system, and identify more short-term goals for data reporting (enrollment, participant retention, staff turnover and qualifications).</p> <p>3.1 Conduct scan of capacity (slots), home visiting eligibility, and actual enrollment to determine areas of over-saturation or under-reach; ensure information is shared across funders before NOFOs are released. Encourage cross-funding stream coordination of NOFO releases.</p> <p>3.1 Convene IAC/DRE and home visiting funders to review areas for improvement in data collection on capacity/enrollment; create recommendations and conduct a standard cross-funder analysis of capacity/enrollment on an annual basis.</p> <p>3.1 Using funder data on enrollment versus funded capacity, at the mid-year point between NOFOs, identify areas with excess capacity and create a strategy for the redeployment of funds to areas with enrollment waiting lists.</p> <p>3.1 Update GOECD/Ounce initial data crosswalk.</p>

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<p>3.1 Align and increase the collection and reporting of disaggregated data on participant demographics and workforce composition across the major funders of home visiting to improve equity in service delivery as well as workforce recruitment and retention</p>		<p>3.2 Ensure inclusion of disaggregated data in the MIECHV 2020 Needs Assessment; Create a strategy for prioritizing disaggregated data in the MIECHV data contract recompetes.</p> <p>3.2 Convene a meeting with the Data, Research and Evaluation Subcommittee of the Integration and Alignment Committee (of the ELC) and IECAM to facilitate a conversation with the major funders about the ability to collect racially disaggregated participant and workforce data; elevate the level of detail included in the MIECHV Needs Assessment as the goal for major periodic reporting on the statewide home visiting system.</p> <p>3.2 Create and disseminate to the major funders a map of the top five languages spoken by county/community, and additional data on each priority population per county, tracked to the home visiting programs in the area. Task each major home visiting funder with reporting out numbers of priority populations served.</p>
<p>3.2 Streamline funding and monitoring processes to improve the ability of community programs to access funding and create greater coherence in program quality</p>		<p>3.3 With HV funders, HVTF, GOECD Inter Agency Team, and ILGA, explore options for increased alignment including shared contracting language, accountability legislation, data sharing/systems agreements, coordination of NOFOs, across HV funders; Crosswalk data collection requirements across funding streams and model type; examine HIPPA and other data sharing restrictions</p> <p>3.3 Update GOECD/Ounce initial data crosswalk.</p> <p>3.3 Develop recommendations for shared outcome measures and gather feedback from stakeholders across funding streams.</p> <p>3.3 Create and disseminate (in NOFOS, to funded programs) guidance from all major funders of home visiting on what is and what is not duplication of services across the range of existing home visiting models and early childhood programs.</p> <p>3.3 Gather and synthesize pain points from providers on the NOFO processes across funders and work to implement recommendations</p>

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		on how to better support applicants and streamline communication across funding streams.
<p><b>4. Remove barriers to enrollment and participation in home visiting services faced by eligible families, including raising awareness of home visiting in supporting healthy development in the prenatal to three period, and expanding the array of responsive services available and reaching priority population families.</b></p>		
<b>Objective</b>	<b>Projected Impact</b>	<b>Tactics</b>
<p>4.1 Increase awareness of benefits and availability of intensive home visiting services to increase uptake of home visiting services by eligible families.</p>	<p>4.1, 4.2, &amp; 4.3 Statewide share of families eligible for HV who chose to participate is 40% by 2025. (1)</p> <p>4.1, 4.2, &amp; 4.3 Statewide, home visiting programs are enrolled at 85% of capacity, on average by 2025. (1)</p> <p>4.1, 4.2, &amp; 4.3 3-4 state and/or local home visiting champions are identified; champions engage in at least 1 public home visiting action, including writing op-eds, speaking at conferences and hearings, writing testimony, and attending site visits with legislators to home visiting programs. (1)</p> <p>4.1, 4.2, &amp; 4.3 Secure placement of at least 3 stories about HV/doula in the media annually. (1)</p> <p>4.1, 4.2, &amp; 4.3 4-6 regional home-visiting parent councils are established by 2025,</p>	<p>4.1 Plan and initiate a public awareness campaign on the various home visiting programs (EHS, PI, PTS, HF, etc.) eligibility criteria, priority populations, access and availability of and outcomes of evidence-based home visiting to increase referral and enrollment.</p> <p>4.1 Develop a home visiting messaging document for ratification by the major funders to unify communication about the benefits and array of home visiting services</p> <p>4.1 Identify state champions with interest in early childhood, child and maternal health, and family well-being to serve as home visiting spokespeople. Award home visiting champions at public event to garner media coverage of statewide PN3 HV related activities.</p> <p>4.1 Establish parent governing councils/cross-model parent advisory bodies to elevate participant voice, offer recommendations to the national models and major state funders of home visiting, and inform workforce strategies. Seek guidance from the ELC Family Advisory Council on the formation &amp; capacity building of parent advisory bodies; ensure representation from regional parent councils on the Family Advisory Council.</p> <p>4.1 Create and disseminate to the major funders a map of the top five languages spoken by county/community, tracked to the linguistic capacity of the home visiting programs in the area.</p> <p>4.1 Collect and analyze data on the share of the home visiting workforce by linguistic capacity, establish goals for growing the home visiting workforce to serve specific linguistic needs per estimates of future population growth.</p>

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	<p>meeting at least bi-annually (1-2)</p> <p>4.1, 4.2, &amp; 4.3 Annually, 400 families of infants and toddlers with intact family DCFS cases receive outreach from DCFS home visiting specialist annually by 2023. (2)</p> <p>80 enroll in evidence-based home visiting services (reimbursable through FFPSA) annually by 2023.</p> <p>4.1, 4.2, &amp; 4.3 Annually, 100 families experiencing homelessness will be served by The Home Visiting Homeless Families Demonstration Project.</p> <p>4.1, 4.2, &amp; 4.3 Increased availability of evidence-based home visiting models that are designed to provide ongoing supports to priority population families. (2)</p> <p>4.1, 4.2, &amp; 4.3 15% increase in referrals to home visiting as collected in Child Find data, by 2023. (3)</p>	<p>4.1 Conduct outreach to and collaborate with major home visiting models to identify existing adaptations to support families that are unable to access necessary resources due to limited English proficiency, linguistic isolation, and/or religious or cultural beliefs, practices or norms that differ from those of the service providers.</p> <p>4.1 Educate programs about available model adaptations; create/obtain clarity from funders on ability of programs to implement flexible home visiting services.</p> <p>4.1 Create guidance to clarify that dual language learners, even if not experiencing limited English proficiency, are encompassed by the 2019 Priority Populations Recommendations.</p>
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<p>4.2 Institutionalize successful home visiting innovations to increase access to targeted services among priority population families</p>		<p>4.2 Increase MCOs’ and IAMHP’s knowledge of the value of high-quality home visiting in meeting HEDIS measures and performance metrics. Work with GOECD, IAC Health Subcommittee to develop resources for MCO Care Coordinators that will facilitate referral process to home visiting for families. Partner with pilot with Meridian in East St. Louis and DeKalb; support project leads in sharing lessons learned and updates with other MCOs.</p> <p>4.2 Gather qualitative and quantitative data about families currently accessing dual language home visiting services.</p> <p>4.2 Develop a standard MOU between DCFS/Purchase of Service agencies and home visiting programs to establish referral processes, roles and responsibilities, information sharing agreements, shared meeting obligations and shared training goals/opportunities. Base recommendations on lessons learned in I-PPYC white paper in MOUs.</p> <p>4.2 Conduct DCFS-home visiting cross-trainings to increase awareness of how home visiting can serve foster families with young children.</p> <p>4.2 Disseminate information to programs and major funders of home visiting on which models can qualify for reimbursement under FFPSA.</p> <p>4.2 Implement the procedural changes recommended by the HV-EI work group of the Home Visiting Task Force.</p> <p>4.2 Conduct HV-EI cross trainings for providers across the state.</p> <p>4.2 Survey home visiting families on how they received their referrals and back-map the sources of home visiting</p> <p>4.2 Crosswalk data collection requirements across CI for HV, FC IL, child welfare, EI, Medicaid, and IDPH programs to identify potential shared data systems or requirements for communication across data systems.</p>
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		<p>4.2 Distribute early childhood desk reference (for MCO Care Coordinators) from the ELC’s Integration and Alignment Subcommittee MCO Ad Hoc Work Group.</p> <p>4.2 Develop clear guidance on enrollment in Family Case Management, WIC and BBO case management and home visiting; distribute to providers and funders with FAQ for providers.</p> <p>4.2 Conduct a scan of mental health/behavioral health services locally to identify gaps in available referrals from home visitors.</p> <p>4.2 Conduct a scan of treatment/resources for substance use disorder. Disseminate information on Catholic Charities doula and home visiting services available for parents recovering from substance use disorder.</p> <p>4.2 Analyze Child Find data by screening source and referral type; conduct targeted outreach based on those findings to increase the availability of data on developmental screenings and referrals and to strengthen referral pathways from screening entities to home visiting programs.</p>
<p>4.3 Increase collaboration with other family-facing and early childhood systems to improve the referral pathway to home visiting (DCFS, EI, child care, health and mental health systems, MCOs, etc.)</p>		
<p><b>5. Expand universal newborn supports (which may include Family Connects or BabyTALK newborn encounters) to connect every family with a new birth to a comprehensive health screening and nurse home visit, and referrals to health services and local community resources, including home visiting, based on individual needs and family wishes.</b></p> <p><u>Rationale:</u> Universal newborn support services (UNSS) can reduce the stigma around traditional home visiting targeted to at-risk families, and increase awareness among eligible families about the benefits and availability of evidence-based home visiting programs. Expanding UNSS is a method of increasing enrollment and engagement, in line with our longer-term goal of meeting a higher saturation rate of home visiting services among the eligible population. Similarly, Coordinated Intake for home visiting is a tool to streamline enrollment and improve family navigation of the home visiting system. Given the complexity of differing program models, eligibility requirements, and service catchment areas, there is a</p>		



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pressing need for regional points of entry to the home visiting system given the complexity of differing program models, eligibility requirements, and service catchment areas.		
<b>Objective</b>	<b>Projected Impact</b>	<b>Tactics</b>
5.1 Identify communities ready for the next phase of the statewide expansion of universal newborn supports	<p>5.1, 5.2, &amp; 5.3 20,000 families of newborns are offered a screening and visit from a trained nurse-home visitor within 4 weeks postpartum by 2025 outside of Chicago. (1-2)                      4 large communities                      6 small communities</p> <p>5.1, 5.2, &amp; 5.3 Annually, 35,000 families of newborns are offered a screening and visit from a trained nurse-home visitor within 4 weeks postpartum by 2025 in Chicago. (1-2)                      Average acceptance of nurse home visit will be 85% by 2023.</p> <p>5.1, 5.2, &amp; 5.3 30 communities complete Community Readiness Assessment by 2023, statewide. (1)</p>	<p>5.1 Working in partnership with the Illinois Perinatal Quality Collaborative (ILPQC), conduct outreach to birthing hospitals throughout Illinois to explain the program model, explore strategies for connecting the community health goals of hospitals and medical providers with universal newborn supports goals, and to gain their insider perspectives concerning effective strategies to engage and enter into working collaborations with hospital systems.</p> <p>5.1 Conduct outreach to prenatal and social service providers in the community about universal newborn supports services prior to implementation to ensure a robust agreement by families with newborns to participate in the program after delivery.</p>
5.2 Identify source of sustainable funding for statewide universal newborn supports expansion (not to supplant funding for existing EBHV).		5.2 Conduct FC IL or BabyTALK site visits with state agency leadership, members of ILGA to build support among policy makers for sustainable funding for universal newborn supports. Ensure strategy emphasizes that universal newborn supports is not home visiting, and is not duplicative of or a replacement for core intensive evidence based home visiting services.

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<p>5.3 Plan for the alignment and coordination of CI for HV and universal newborn supports to strengthen referral processes to home visiting, and to ensure prenatal outreach to families before universal newborn supports through CI for HV.</p>		<p>5.3 Conduct community visioning and planning meetings in communities where CI for HV and universal newborn supports programs will be situated to discuss alignment of referral processes, roles and responsibilities, information sharing agreements, shared meeting obligations and shared training goals/opportunities.</p>
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# Child Care and Development

<p><b>1. Improve the quality of infant/ toddler center-based programs so more children receive a high-quality service.</b></p> <p><u>Rationale:</u> Only a small percentage of slots are rated Silver or Gold in ExceleRate. CCAP funding is structured to support market rates, not quality. Prevention Initiative funding has seemed inaccessible for most centers.</p>		
Objective	Projected Impact	Tactics
<p>1.1 Establish a tiered funding/ tiered QRIS ladder for child care <u>centers</u> to improve quality in steps up to PI standards and add layered PI funding. Determine funding levels based on the cost modeling now underway. Support through expansion of IDHS child care contracts rather than simple per diem reimbursements.</p>	<p>1.1 45 additional centers in the PDG B5 pilot achieve a Silver or Gold Circle of Quality by 2023 serving 1,575 infants/ toddlers, and 135 more centers between now and 2025 serving 4,725 infants/toddlers.</p> <p>1.1 [45 eligible Pilot centers in cost area two x 35 I/T per center = 1,575 children. An additional 90 centers by 2025 = 3,150 I/T children.] [INCCRRA – current: Bronze: 108 centers, 2,509 I/T cap. Silver: 260 centers, 9,087 I/T cap. Gold: 410 centers, 14,502 I/T cap. -Average I/T cap = 35 per center.</p>	<p>1.1 Complete the ExceleRate standards revisions to reflect tiered staffing costs for teacher/child ratios, credentialed staff, and compensation.</p> <p>1.1 Pilot the new system.</p> <p>1.1 Work with the Funding Commission to incorporate into new formulas</p>
<p><b>2. Improve the quality of home-based infant/toddler child care so more children receive a high-quality service.</b></p> <p><u>Rationale:</u> The highest percentage of infants and toddlers in child care is still in home-based care (licensed and license-exempt), even though demand for center-based care has increased. Very few of the slots are in Silver or Gold rated programs.</p>		
Objective	Projected Impact	Tactics
<p>2.1 Establish a tiered funding/ tiered QRIS ladder for <u>family child care homes</u> to improve quality in steps to ExceleRate Silver and Gold. Determine funding levels based on analysis of costs and program components.</p>	<p>2.1 XX family child care homes achieve Silver or Gold status by 2025, serving XX children birth through 2.</p> <p>At this point, planning is not sufficient to project numbers.</p>	<p>2.1 Engage ExceleRate Subcommittee during 2020 in a planning process to develop a tiered funding/ tiered QRIS ladder parallel to that for centers.</p> <p>Implement pilot in 2021 in conjunction with PDG B5 and IDHS funding.</p>
<p>2.2 Redesign and expand commitment to funding family child care networks across ECE funding streams, establishing 16 new</p>	<p>2.2 400 licensed and license-exempt family childcare providers participate in networks/hubs</p>	<p>2.2 Establish a workgroup made up of experienced network operators, providers and</p>

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<p>networks/hubs. Networks will focus on supporting homes in achieving Silver and Gold Circles of Quality. Allow variability in network design to reflect community needs and preferences. Build models that ensure that networks actively support continuous quality improvement in homes.</p>	<p>(25/network), increasing quality for 2,000 children birth to three (5 per provider).  [IDHS – Currently funding 4 networks outside of Chicago with 94 providers and a total capacity of 729 children, all ages.]</p>	<p>local collaborations and Erikson Institute to re-imagine network design.  2.2 Determine cost ranges for network contracts. Expand contracting in the FY21 DHS budget and consider higher reimbursement rates.  2.2 Support expansion of existing networks, and, where networks do not exist, work with early childhood organizations, school districts or other entities to seed networks that can use ECBG and other sources of funding to boost quality, and compensation.</p>
<p><b>3. Expand the number of well-designed and equipped infant/toddler classrooms and home-based settings.</b></p> <p><u>Rationale:</u> Demand for center-based infant/toddler services has grown rapidly, while demand for preschool classrooms in centers has declined as more public schools offer Preschool for All. The need for flexible home-based birth to three child care remains high, in part because of the growth of unusual hour jobs.</p>		
Objective	Projected Impact	Tactics
<p>3.1 Open 200 more birth to three classrooms, either in new spaces or by conversion of preschool classroom space.</p>	<p>3.1 Add classroom capacity for 2,000 infants/toddlers between now and 2025. (Not sure if capital projects could be completed in 2 years.)  <a href="#">[Assumptions shown on separate spreadsheet.]</a></p>	<p>3.2 Fund renovations for existing center-based providers to convert classrooms to serve infants/toddlers, as well as new facilities through capital grant.</p> <ul style="list-style-type: none"> <li>• Determine areas of need (IFF report)</li> <li>• Participate in planning for capital grant, both for \$100 million earmarked for ece and for some of \$500,000 not earmarked.</li> <li>• Find funding to help CBOs develop capital grant plans &amp; proposals.</li> </ul>
<p>3.2 Fund furnishings and materials of family child care homes to achieve higher ExceleRate Circles, and, for exempt homes to achieve licensing. Use mandates and incentives to ensure that these spaces remain available for families receiving CCAP.</p>	<p>3.2 Improve the physical environments for XX children birth through 2 in home-based settings.</p>	<p>3.2 Participate in planning with IDHS and with PDG B-5</p>

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<b>4. Expand the infant/toddler workforce and increase the qualifications of the current workforce.</b>		
<b>Objective</b>	<b>Projected Impact</b>	<b>Tactics</b>
4.1 Develop a well-qualified workforce that is representative of the children served, including a focus on the bilingual/bicultural workforce, which is greatly underrepresented.	<p>4.1 XX new teachers and family child care providers enter workforce each year by 2025 above current levels, impacting XX children [4 children for each teacher. Disaggregate]</p> <p><b>4.1</b> XX teachers and family child care providers increase their education qualifications by one degree or credential level by 2025</p> <p>[Spreadsheet under construction including relevant figures from the Gateways ECE Workforce report 2017]</p>	<p>4.1 Partner with high schools and institutions of higher education to market ece teaching opportunities as a career.</p> <p>4.1 Develop a comprehensive approach to support education expenses for prospective and current educators, with a focus on underrepresented groups. Implement tuition reimbursement approach piloted during RTT-ELC and identify opportunities to support cohort models and loan forgiveness.</p>
<b>5. Improve access to CCAP-supported child care for families working non-traditional hours.</b>		
<p><u>Rationale:</u> Non-traditional and variable work schedules are increasingly common. Children in affected families need stable, consistent care even when work schedules change.</p>		
<b>Objective</b>	<b>Projected Impact</b>	<b>Tactics</b>
5.1 Revise CCAP eligibility criteria and develop program models that layer funding to meet the developmental needs of children in families working variable hours.	<p>5.1 XX additional children whose parents work non-traditional hours served by 2023, and XX between now and 2025.</p> <p>[IAFC or IDHS – number of CCAP infants &amp; toddlers now served during non-traditional hours, in centers, FCC, and FFN care.]</p>	<p>5.1 Support current IDHS initiatives to expand CCAP eligibility.</p> <p>5.1 Develop and implement additional options to serve this population.</p>
5.2 Engage advocates, government and business in a think tank to resolve the child care crisis created by the growth of low-wage jobs requiring non-traditional hours.	N/A	5.2 Identify a lead organization and invitee list. Find funding for this planning.

# Family Economic Security

1. Increase family income and economic security		
Rationale: Putting more money in families' pockets is considered the best way to provide families more economic stability. By providing families with more unrestricted dollars families can provide for family needs like diapers, clothes, etc.		
Objective	Projected Impact	Tactics
1.1 Enact paid family and medical leave for all Illinois residents.	1.1 <u>149,390</u> children were born in Illinois in 2017. <u>60 percent of working people in Illinois</u> do not have access to even unpaid Family and Medical Leave. In 2016, <u>only 13 percent of workers</u> had access to paid family leave nationally. Paid leave would truly make a difference in the lives of parents and babies. If 21.5% of families with young children are living in poverty and 7.4% of children have no parent in the household, 14.1% of new parents living at 200% of the poverty level could benefit from this new policy. This means that a paid family and medical leave policy could impact up to 21,064 families.	1.1 Expand the coalition supporting a paid leave program. 1.1.2 Advocate to elected officials to pass comprehensive paid family and medical leave legislation that is as inclusive as possible and takes into consideration those adults not working a 40-hour workweek.
1.2 Implement an Earned Income Tax Credit (EITC) that serves families with small children.	1.2 Our current EITC is 18% of the federal one. If we raised it to 40%, like Washington DC, we would potentially give families an extra \$1500 dollars a year for those with three or more children and \$1200 for those with two or more kids. The EITC is for those families that are below 200% of the Federal Poverty Level.	1.2 Expand the coalition working on an increased EITC to include early childhood voices.  1.2.1 Advocate to elected officials for legislation that increases the EITC (in 2021). Consider different EITC models that give families money monthly instead of once a year.  1.2.2 Consider including unpaid caregiving as work that qualifies for EITC.
1.3 Create an End Child Poverty campaign in Illinois.	1.3 As of 2018, there were 370,238 children zero to three living at or under 200% of the poverty level.	1.3 Build a coalition to End Child Poverty in Illinois.

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		<p>1.3.1 Follow up with the Illinois basic income pilot at the end of 2020 to see how families with small children fared.</p> <p>1.3.2 Advocate and build support for a universal basic income pilot for families with children zero to three.</p>
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**2. Increase the usage of existing public benefits program.**  
Rationale: Safety net programs are not being used to their full potential. That is partially because families are not aware of the programs and also because of the possible onerous requirements put on low-income families to participate in the programs. Alleviating some of those requirements or making the programs easier to access could help improve child outcomes.

<b>Objective</b>	<b>Project Impact</b>	<b>Tactics</b>
<p>2.1 Make public benefits programs easier to access.</p>	<p>Illinois has 63,500 babies 0-3 that are at 50% of FPL and 139,690 babies 0-3 that are 100% of FPL. Public benefits programs support families whose income is between 50% and 200% of FPL.</p> <p>In 2018, there were 268,084 moms, babies, and toddlers being served by the WIC program. The program is only serving 43.5% of eligible participants. If we could increase the usage by 10-15 percentage points, we could impact 40,000 more families.</p>	<p>2.1 Advocate for the creation of a cross-system application so that a parent does not have to know what programs exist to be able to apply for them (at minimum CCAP, SNAP, TANF, WIC, &amp; Medicaid). Allow for adjunctive eligibility and for automatic enrollment where family is qualified instead of requiring a family to check off or affirmatively apply for every program.</p> <p>2.1.1 Consider a smart phone application for ease of use and accessibility.</p> <p>2.1.2 Leverage MCO's role in care coordination as an existing service to connect families and increase uptake of other programs. Increase the use of one-pagers/desk references to the early childhood and public benefits services available to families.</p> <p>2.1.3 Increase the use of co-location offices or ensure that every office is the "right door" for families.</p>

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		<p>2.1.4 Put benefits “navigators” in pediatrician waiting rooms (starting with MCOs).</p>
<p>2.2 Decrease onerous requirements of public benefits programs that make it more difficult for families to participate.</p>		<p>2.2 Increase collaboration between WIC and the Early Learning system. See <a href="#">Making WIC Work in Illinois</a>.</p> <p>2.2.1 Increase food options for WIC especially taking into consideration allergies. Do not make parents provide doctor’s note on allergies every single time they go to WIC office.</p> <p>2.2.2 Provide same-day or next day appointments for WIC.</p> <p>2.2.3 Allow for phone call WIC appointments so that families do not have to attend all of their appointments in person which is difficult for many families.</p>
<p>2.3 Increase the collaboration of public benefits programs.</p>		<p>2.3 Train all client-facing DHS staff about public charge and the impact of the rule.</p> <p>2.3.1 Create informational fact sheets that explain public charge and how it impacts public benefits programs and make sure they are available at ALL offices that handle public benefits even if those programs are not impacted by public charge.</p> <p>2.3.2 Create public media campaign and go on different news outlets to disseminate public charge information.</p>
<p>2.4 Increase the usage of CCAP, TANF, SNAP, Medicaid, and WIC.</p>		<p>2.4 Ensure that the 2020 Census counts every single child by making sure all client-facing staff in any state program is aware of the importance</p>



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		<p>of the census and reminds clients about it when relevant.</p> <p>We applaud the State of Illinois for <u>appropriating \$29 million</u> for Census outreach efforts and creating an office tasked with ensuring an accurate count of all Illinoisans.</p> <p>2.4.1 Ensure that the state is investing in resources to do census outreach so that all babies and toddlers are counted.</p> <p>2.4.2 As the census gets closer, ensure that all DHS frontline staff is trained on the census and is providing everyone with a handout on the importance of filling out the census.</p> <p>2.4.3 Invest in outreach focused on the hard to count communities which includes small children.</p>
<p>2.5 Ensure that the Public Charge rule does not dissuade eligible families from enrolling in public benefits.</p>		<p>2.5 Reduce churn in Medicaid by making redetermination less onerous. Instead of dis-enrolling if contact is not made, send letter that says “if everything remains the same you don’t have to do anything. If anything has changed, call us.”</p> <p>2.5.1 Invest in navigator program to help families enroll in public benefits programs. Many agencies were forced to lay-off staff when federal government chose to stop funding the program.</p>
<p>2.6 Ensure that everyone is counted in the 2020 Census, especially children under five.</p>		<p>2.6 Create a cross-issue coalition interested in providing undocumented pregnant women with SNAP.</p>

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		2.6.1 Advocate for legislation that would provide undocumented pregnant women with SNAP through their pregnancy and some months post-delivery.
<p><b>3. Increase access to jobs for parents that pay a livable wage.</b>  <u>Rationale:</u> Parents would like to be able to work and provide for their little ones, but many times there are several obstacles that stand in the way. Providing assistance with some of those obstacles will provide more financial stability to families and ultimately provide better outcomes.</p>		
<b>Objective</b>	<b>Projected Impact</b>	<b>Tactics</b>
3.1 Lower the percentage of parents with kids zero to three that are unemployed and want to enter the workforce by X%.	3.1 As of 2018, there were 370,238 children zero to three living at or under 200% of the poverty level. The Child Care Assistance Program is currently serving about 132,000 children. There are parents that would like to access the program but are unable to do so because they do not have child care.	3.1 Build support for and advocate for parents to be able to access CCAP while they are job searching so that they can job search, interview, and start a job while having child care. Not having child care is an obstacle for many families that would like to be a part of the workforce.
3.2 Make it easier for parents of kids zero to three that want to enter the workforce to do so.	3.1 Illinois has about 139,000 children zero to three at 100% of the poverty level. Providing access to job training and child care to those parents could lower that number.	3.2 Provide priority slots to parents of kids 0-3 for workforce development programs.  3.2.1 Co-locate workforce development programs with child care.
		3.3 Provide a career counselor/workforce support person at all public benefits offices waiting rooms.

# Cross-Systems

1. Develop Statewide Infrastructure to support Community Systems Development		
Rationale: A structured system of supports will enable community systems to create and implement collaborative strategies and activities that address the unique need, cultures and strengths of local communities.		
Objective	Projected Impact	Tactics
<p>1.1 Fund and implement statewide community systems infrastructure that includes a state lead entity, 4 regional support entities, and 75-100 local community collaborations across the state. Functions of local collaborations include: 1) coordinated planning for services, 2) support family navigation to services they need, 3) support full enrollment in existing services; 4) support coordinated enrollment in early childhood services 0-5.</p>	<p>1.1 &amp; 1.2 Local collaborations' strategies will align to support the State's goals and objectives for Prenatal-3. Improve coordination of efforts between Statewide agencies and local efforts.</p> <p>1.1 &amp; 1.2 Systemic changes at the State and local level to ensure improved outcomes for families and their children.</p> <p>1.1 &amp; 1.2 Diversified representation on the collaboration allows for input and feedback regarding programs and policies that result in equitable outcomes for families and their children.</p> <p>1.1 &amp; 1.2 85% of local early childhood collaborations will align their strategies to support the State's goals and objective for Prenatal-3.</p>	<p>1.1 &amp; 1.2 Year 1: Define the objectives, performance indicators, functions, roles and structure of community collaborations.</p> <p>1.1 &amp; 1.2 Define what supports the Statewide infrastructure will provide. While the system is Statewide it should also support local mechanisms in every community; priorities/communities are locally informed.</p> <p>1.1 &amp; 1.2 Year 2: Establish dedicated and sufficient State funding to support the state, regional and local community collaboration infrastructure.</p> <p>1.1 &amp; 1.2 Amend contracts/grants to require collaboration that includes the broader social services system in order to avoid duplication of services. Contracts should require communities to use data in writing their applications.</p> <p>1.1 &amp; 1.2 Align quality standards/outcomes across funded programs so that programs have common set of metrics to track and report on.</p> <p>1.1 &amp; 1.2 Develop family advisory boards that provide family voice in all aspects of community collaboration.</p>

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		1.1 & 1.2 Align data among models and funders to improve the state's policy/ decision-making.
1.2 Community collaborations will have access to consistent and detailed data to support collaborative and informed decision making. The data will be used to help communities and the State measure progress and areas for improvement.		
<p><b>2. Increase access to Infant/Early Childhood Mental Health Consultation to programs and professionals working with children and families.</b></p> <p><u>Rational:</u> I/ECMHC is a multi-level, proactive approach that focuses on supporting and enhancing children's social emotional development and overall health and well-being. I/ECMHC teams multi-disciplinary I/ECMH professionals with those who work with young children and their families in a wide variety of settings. I/ECMHC has been shown to reduce preschool expulsions, improve parent-child relationships, increase the development of positive social skills, and increase retention rates of early childhood professionals.</p>		
<b>Objective</b>	<b>Projected Impact</b>	<b>Tactics</b>
2.1 Enhance cross system collaboration and increase system capacity to implement a quality I/ECMHC approach, with the vision that every early childhood serving organization will have access to I/ECMHC. Staff who work in early childhood programs will have regular access to reflective consultation and professional development regarding mental health issues, social and emotional development and child well-being.	<p>2.1 All systems currently implementing I/ECMHC will serve all programs in their system (453 programs in ISBE, 176 in HS/EHS, 9,694 in child care, 22 in MIECHV, 31 in HFI, 20 in PTS, 25 in EI).</p> <p>2.1 I/ECMHC will be expanded into other systems (IDPH, DCFS, DMH).</p> <p>2.1 By 2023, there will be 300 I/ECMHCs on the database.</p> <p>2.1 By 2025, there will be 600 I/ECMHCs on the database.</p>	<p>2.1 Complete cost modeling and service saturation analysis for the spectrum of consultation services to help ILGA understand the full cost of high-quality I/ECMHC and cost of reaching saturation.</p> <p>2.1 In year 1, secure funding that is consistent with the cost-modeling for a Lead Entity, expanded common orientations for consultants, reflective practice groups, and database/evaluation.</p> <p>2.1 Work with Higher Education and professional organizations to recruit, grow, and diversify the I/ECMHC workforce.</p> <p>2.1 Utilize the MHC Initiative pilot project data and evaluation to scale up the MHC Initiative pilot projects.</p> <p>2.1 Increase the amount of the quality set-aside of CCDBG dedicated to MHC to expand the</p>

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		<p>amount of consultants available to child care programs.</p> <p>2.1 Increase funding within IDPH to expand MHC within public health departments.</p> <p>2.1 Increase funding within DCFS to expand MHC within child welfare.</p>
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# Workforce

<p><b>1. Expand workforce preparation pathways to increase the number of qualified birth-to-three professionals able to meet the needs of diverse children and families.</b></p> <p><u>Rationale:</u> Professionals with expertise working with children from birth-to- three and their families will meet qualifications for positions across the Infant/Toddler sector and provide staff with greater mobility, encouraging them to remain in the field.</p> <p><b>High Priority: Short-Midterm Implementation – 2020-2023</b></p>		
Objective	Projected Impact	Tactics
<p>1.1 75% of home visitor preparation programs will crosswalk their preparation process with the Gateways to Opportunity competencies. This will allow home visitors to expand to articulate coursework to other Gateways credentials such as the ECE and Infant/Toddler credentials.</p>	<p>1.1 Higher education institutions and other partners will crosswalk the preparation content for EI and Home Visitor programs with the competencies in the Gateways to Opportunity ECE and Infant/Toddler Credentials so that more staff are qualified and eligible for a range of positions in the birth to three field.</p>	<p>1.1 Align Gateways competencies across birth to three preparation programs to create an expanded workforce that is prepared for multiple birth to three workforce roles.</p> <p>1.1 Work with Western IL University's Early Intervention Training Program (EITP) to review and align IL's EC competencies, which all EC credentials and degrees are based on, and new EI competencies to eliminate duplicative content and encourage course transfer between EC, ECSE, and EI prep programs.</p> <p>1.1 To address teacher shortages in EC and special education, design cohort opportunities for school districts, community-based programs, and IHEs to partner to provide preparation programs for licensed teachers to earn specialized endorsements such as the LBS1 or the Special Ed Approval.</p>
<p>1.2 Research new and non-traditional opportunities for recruiting and supporting early childhood teacher candidates into the field.</p>	<p>1.2 Create resources to support 200 new teachers join the workforce. This could provide services for an additional 1,000 children.</p>	<p>1.2 Learn about statewide workforce initiatives provided through entities not traditionally focused on early childhood such as the Workforce Innovation and Opportunity Board (WIOA), the state's Perkins V plan, and the Illinois Department of Commerce &amp; Economic</p>

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		Opportunity (DCEO). Develop an understanding of how these entities intersect to both support higher ed institutions and candidates.
1.3 Create new pipelines for interested candidates to pursue early childhood degrees and credentials.	1.3 Approximately 75 new candidates will annually pursue early childhood careers impacting 300 children each year.	1.3 Work with INCCRRA Dual-Credit programs to transition high school students into 2-yr institutions to earn early childhood credentials and Associate degrees
1.4 Develop marketing materials to highlight variety of career pathways available in early childhood and school districts across the state at a variety of levels.		1.4 Distribute materials to higher school and higher education advisors and counselors, CCR & Rs and other entities to let candidates know about impactful career opportunities.
<p><b>2. Address issues of cultural, linguistic, and ability equity and implicit bias among birth to three teachers to ensure that children’s development and learning is optimally supported to foster learning, school readiness, and success in school and later</b></p> <p><u>Rationale:</u> Children have stronger educational and developmental outcomes when they have safe, stable environments that allow them to develop the relationships and trust necessary to comfortably explore and learn from their surroundings.</p> <p>Teachers who represent the linguistic and cultural backgrounds of children and families often develop stronger relationships with those families and children.</p> <p><b>High Priority: Short-term Implementation – 2020-21</b></p>		
<b>Objective</b>	<b>Projected Impact</b>	<b>Tactics</b>
2.1 50% of early childhood teachers and assistant teachers in licensed childcare center programs (N= approximately 480 based on IL’s Early Childhood Workforce 2017 report from INCCRRA) will have access to professional development opportunities to learn more about early childhood social-emotional development and mental health supports.	2.1 Approximately 1,920 children in licensed (1 teacher/assistant teacher to 4 children ratio) licensed childcare settings will have teachers who have been trained to support their social emotional and challenging behaviors in a socially constructive manner.	2.1 In partnership with the Early Learning Council’s Inclusion Subcommittee and GOECD promote access to mental health and Pyramid Model trainings for lead and assistant teachers in licensed childcare centers to support staff in productively working with children with challenging behaviors.
2.2 The Gateways to Opportunity Multilingual Credential will be offered at Levels 2, 3, and 4 at 50% of the state’s 2-year colleges with preparation programs for early childhood staff.	2.2 Approximately 300 children from birth-three will have a teacher who holds a Gateways Multilingual Credential.	2.2 Promote the new Multilingual Credential at the 2020 Higher Education Forum.  2.2 Revise the Credential following the pilot phase and make it broadly available to all of the state’s 2-year colleges with an early childhood preparation program.

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		2.2 Work with ISBE to align the Credential to the 4-year Bilingual/ESL Endorsement
<p><b>3. Increase wages for early childhood teachers working in programs supported by federal and state funding streams as well as private pay tuition that is commensurate with the complex and responsive knowledge and skills required. Wages for Infant/Toddler teachers are particularly impacted.</b></p> <p><u>Rationale:</u> Early childhood educators in IL working outside of schools earn wages in the 2<sup>nd</sup> percentile of annual earnings. These wages have remained stagnant since 2015 and have not kept up with inflation or cost of living changes in the state. Infant/Toddler classrooms licensed by DCFS have an annual teacher turnover rate of 37%. (Voices from the Front Lines of Early Learning 2017, IL Early Childhood Workforce Survey Report)</p> <p><b>High Priority: Short to Mid-Range Implementation – 2020-2023</b></p>		
<b>Objective</b>	<b>Projected Impact</b>	<b>Tactics</b>
3.1 Educator compensation, wellbeing, and retention directly impacts the quality and stability of ECE programs. Continuing to develop cost models and advocate administratively for increasing teacher and assistant teacher salaries in IL’s CCAP and Head Start programs will allow them to recruit and retain qualified classroom staff and provide greater continuity of care for children and their families.	3.1 Reduce Infant/Toddler teacher turnover to an annual rate of 25% which will provide more stability for approximately 600 Infants/Toddlers whose teachers have an Infant/Toddler Credential in IL.	3.1 Give more staff support in earning Infant/Toddler Credentials.  3.1 Incrementally increase wages for Infant/Toddler teachers to align with cost models
<p><b>4. Advocate for early childhood programs remaining open, particularly in rural or other under-served areas.</b></p> <p><u>Rationale:</u> As in other areas of education, there is a significant and growing shortage of early childhood teachers across geographic areas, program types and funding streams. There is also a leaky pipeline supply of EC teacher candidates given under-resourced higher education preparation programs and the costs associated with earning Credentials and degrees relative to future wages.</p>		
<b>Objective</b>	<b>Projected Impact</b>	<b>Tactics</b>
4.1 Support existing early childhood programs so that they can continue operation in their communities during times of staff shortages.		4.1 Develop short-term authorization language with IDHS to allow programs to remain open while current teachers pursue additional education.



**APPENDIX D**

**PROJECTED IMPACTS OF PN3 AGENDA**

<b>Service</b>	<b>Baseline (based on best available data as of February 2020)</b>	<b>Projected Increase (inclusive of expanded capacity and improved quality)</b>	<b>Projected Reach by 2025</b>
Infant Toddler Care and Development (family and center-based services) *	5,000 family and center-based infant-toddler Silver or Gold rated slots (FY18)	<ul style="list-style-type: none"> <li>• 2,000 licensed/licensed exempt infant-toddler slots will achieve Silver or Gold rating</li> <li>• 5,000 new Silver or Gold rated infant-toddler slots in family and center-based care will be created</li> </ul>	12,000 Silver or Gold rated infant-toddler slots in family and center-based programs
Home Visiting	<ul style="list-style-type: none"> <li>• 19,000 funded slots</li> <li>• 17,000 children receive services (FY18)</li> </ul>	<ul style="list-style-type: none"> <li>• 2,000 more children will be reached through fully enrolling slots</li> <li>• 13,000 new home visiting slots will be added</li> </ul>	32,000 children and their families
Early Intervention	Approximately 22,000 children with IFSPs (single point in time, FY18)	22,000 more children will have IFSPs (single point in time)	44,000 children (single point in time)
Universal Newborn Supports**	1,570 families received the offer of a nurse home visit (FY19)	<ul style="list-style-type: none"> <li>• Expansion to 10 new communities will offer a nurse home visit to 25,600 families</li> <li>• Chicago sites will offer a nurse home visit to 4300 families**</li> </ul>	31,470 families will receive the offer of a nurse home visit
Continuous health coverage post-partum for 12 months***	75,000 eligible persons (FY18)	<ul style="list-style-type: none"> <li>• 11,000 currently ineligible persons due to immigration status will be made eligible</li> <li>• 52,500 persons who typically lose benefits during redetermination process will maintain eligibility</li> </ul>	86,000 persons

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Doula services ****	1,100 persons receive doula services attached to state-funded home visiting programs (FY19)	14,000 persons	15,100 persons
Access to benefits (WIC)*****	185,360 persons (FY18)	18,536 persons	203,896 persons

All projected impacts represented in the chart above are best estimates based on the data that is currently available and are limited to those associated to policy proposals with direct impacts on children and families. Where baseline data is not available, it is noted. Due to limitations in data availability and challenges translating some policy proposals that indirectly impact families to a direct projected impact estimate, this chart is not inclusive of every policy proposed in the Illinois PN3 agenda, such as those related to workforce and paid family leave.

*\*Current and projected numbers based on data sourced from IECAM and IFF's report, [Access and Quality for Illinois Children: Statewide Early Childhood Education Needs Assessment](#). Capacity includes licensed and license exempt capacity in family and center based child care, Early Head Start and Prevention Initiative funded programs.*

*\*\* Baseline data for Universal Newborn Supports only includes nurse visits conducted via the Illinois Family Connects model in Peoria and Stephenson counties.*

*\*\*\*Approximately 50% of Illinois births are covered by Medicaid, equivalent to 75,000 births. On average, 70% of people lose coverage during redetermination. Therefore, a change in policy to 12 months continuous coverage is projected to impact approximately 52,500 persons who would maintain coverage and an additional 11,000 persons who are currently not covered due to immigration status.*

*\*\*\*\* Data on doula services available outside of those funded through home visiting not currently available. Projected impact based on estimate of 20% of all Medicaid funded pregnancies utilizing services.*

*\*\*\*\*\*Projected impact based on goal of increasing enrollment in WIC by 10%. Baseline data on WIC enrollment is from [Making WIC Work in Illinois: Opportunities & Recommendations for Program Improvement](#).*

