



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Illinois**

**Application for 2013
Annual Report for 2011**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The Illinois Department of Human Services' (IDHS) assurances and certifications of compliance with federal statutes and regulations that pertain to the Maternal and Child Health Services Block Grant are on file at the IDHS Division of Community Health and Prevention's (DCHP) headquarters in Springfield. Copies may be obtained by writing or calling the office:

Glendean Sisk, R.N., M.P.H.
Acting Associate Director, Office of Family Wellness
Division Family and Community Services
Illinois Department of Human Services
401 S. Clinton St.
Chicago, IL 60607
(312) 814-1354
Glendean.Sisk@Illinois.gov

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

Illinois' MCH Services Block Grant application was made available for public review/ comment via posting on the internet at www.dhs.state.il.us between June 7 and June 30, 2010 . A legal notice inviting public comment was published in the Arlington Heights Daily Herald, which has been designated as the official newspaper for publication of the State's legal notices.

The application was made available to the Expert Panel for the needs assessment, and to all of the participants in the professional and consumer forums conducted for the needs assessment, IDHS' Maternal and Child Health Advisory Board, the Division of Specialized Care for Children (DSCC) Family Advisory Council (FAC), Voices for Illinois Children, Family Voices, Family to Family (F2F) Health Information Center, the Illinois Maternal and Child Health Coalition (IMCHC), the Kids Public Education and Policy Project, and the Maternal and Child Health Training Program at the University of Illinois at Chicago (UIC) School of Public Health.

The public posting of the block grant application yielded comments from three important Illinois maternal and child health advocates: The Arc of Illinois, Illinois March of Dimes and Illinois Planned Parenthood. In general, the comments were positive and instructive. The Arc of Illinois called for the collection of data on children with special health care needs (CSHCN) who are eligible for services from the DSCC. In its comments, the Arc recommended several approaches to gathering this data especially that reported through Individual Family Services Plans (IFSP) for

Early Intervention. Several of the recommended approaches are in place. For instance, using its Cornerstone information system, the DCHP can identify maternal and child health clients who have an Individualized Family Service Plan (IFSP). The area that needs further exploration is the optimal use of the Prioritization of Urgency of Need for Services (PUNS) database that is operated and maintained by the DHS Division of Developmental Disabilities. In FFY2011, the Title V program will work to maximize the use of PUNS to identify unmet need in Illinois. Illinois Planned Parenthood offered important insights to the significance of family planning services to the overall health of women and children. In particular, Planned Parenthood is convinced that family planning services will have a strong role in the Title V program's ability to address many of its priorities, specifically: #2 - Integrate medical and community-based services for MCH populations and improve linkages of clients to the services; #4 - Expand availability, access to, quality, and utilization of medical homes for all children and adolescents, including CSHCN; #5 - Expand availability, access to, quality, and utilization of medical homes for all women; and #6 - Promote healthy pregnancies and reduce adverse pregnancy outcomes for mothers and infants. Finally, the Illinois March of Dimes agreed with the Title V agency's life course approach/ecological model to address the needs of mothers and children. It also strongly recommended that the Title V agency foster open communication and robust collaboration among all MCH providers. The March of Dimes also suggested that the Title V agency examine the factors associated with infant mortality in communities outside of the greater Chicago area, particularly those in southern Illinois.

/2012/Illinois' MCH Services Block Grant application was made available for public review/comment via posting on the internet at www.dhs.state.il.us between June 1 and June 30, 2011. A legal notice inviting public comment was published on June 1st and June 15th in the Taylorville Breeze Courier, which has been designated as the official newspaper for publication of the State's legal notices.

The public posting of the block grant application yielded comments from only one organization during the public comment period: the Family-to-Family Health Information and Education Center at The Arc of Illinois. The Arc raised questions regarding the Department's plans to address the needs of children with special health care needs and/or chronic illnesses or disabilities in several areas of programming. The Department has communicated with The Arc regarding its concerns and intends to set up a workgroup meeting with the Family-to-Family Health Information and Education Center to develop plans to address the questions and issues raised.//2012//

/2013/The MCH Block Grant application was made available for public review and comment between the dates of June 1 and June 30, 2012. Prior to that between the dates of January 30, 2012 and February 14, 2012, a draft was distributed to chairpersons of the following advisory committees or a senior member of the following organizations: the Illinois Maternal and Child Health Coalition; Illinois Centers for Fetal Alcohol Syndrome Disorders (ICFASD), Governor's Office Early Learning Council, Family Voices of Illinois, the WIC Advisory group, various areas of the Illinois Department of Public Health (including the Perinatal Program, Health Promotion Division and HIV and STD sections), the Illinois Department of Healthcare and Family Services, the University of Illinois Chicago, Division of Specialized Care for Children (UIC-DSCC) Family Advisory Council (FAC), and the Department of Children and Family Services. Between June 1, 2012 and June 30, 2012, it was posted on the Internet at <http://www.dhs.state.il.us/page.aspx>. A legal notice inviting public comment was published in the Taylorville Breeze-Courier, the newspaper currently designated for publication of the State's legal notices, on June 1 and 15, 2012. Only one comment was received as a result of the public posting. The comment was received from the Illinois Public Health Association. The comment had to do with the process of posting the application for public comment and of the way the grant was administered by DHS.//2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

In the FFY 2011 Maternal and Child Health Block Grant Application, DHS presented an extensive and innovative (at least for Illinois) needs assessment. Two main theories guided the needs assessment process: the life course theory and the ecological model. The life course theory acknowledges that an individual's health status is the sum of experiences over his/her lifespan, as well as the generations that preceded him/her. It emphasizes the development of health and health disparities across the continuum of pregnancy, infancy, childhood, adolescence, and adulthood. This life course framework is complemented by the ecological model, which acknowledges the complex biological and social environmental factors that influence health, including factors at the interpersonal, family, school, community levels and beyond. DHS also sought to frame priorities and performance measures from a health systems rather than a health status perspective. Because it is through health systems change that Illinois Title V can expect to improve the health of women, children, and families, this approach seemed more appropriate for monitoring Title V performance. Health outcomes also are part of ongoing monitoring, but these outcomes cannot be considered apart from the context of services, policy, and process.

Through an extensive and inclusive process, 10 state priorities and associated performance measures were identified and agreed upon. The following list presents the Illinois MCH priorities and performance measures.

2010 Illinois Priorities - 2010 State Performance Measures

Improve Title V's capacity to collect, acquire, integrate/link, analyze, and utilize administrative, programmatic, and surveillance data. - Extent to which Title V accesses, integrates, analyzes, and disseminates data from twelve state databases.

Integrate medical and community-based services for MCH populations and improve linkage of clients to these services, particularly CSHCN. - Extent to which Title V has completed specific activities related to promotion and enabling of MCH service integration.

Promote, build, and sustain healthy families and communities. - TBD

Expand availability, access to, quality, and utilization of medical homes for all children and adolescents, including CSHCN. - Percentage of Medicaid children (ages 1-17) receiving the appropriate number of well-child visits in the last year.

Expand availability, access to, quality, and utilization of medical homes for all women. - Percent of non-pregnant women ages 18-44 who have a primary medical care provider.

Promote healthy pregnancies and reduce adverse pregnancy outcomes for mothers and infants. - Percent of births that result from unintended pregnancies.

Address the oral health needs of the MCH population through **2013 data collection, 2013 prevention, screening, referral, and appropriate treatment.** - Percent of Medicaid children (ages 2-17) who received at least one preventive dental service in the last year.

Address the mental health needs of the MCH population through prevention, screening, referral, and appropriate treatment. - Percent of new moms reporting a healthcare provider discussed

postpartum depression with them during or after pregnancy.

Promote healthy weight, physical activity, and optimal nutrition for women and children. - Percentage of high school youth who meet recommended physical activity levels during 5 of last 7 days.

Promote successful transition of youth with special health care needs to adult life.- The proportion of CSHCN ages 14 and above and their parents who receive comprehensive transition planning services to promote awareness of adult services.

Nearly all of Illinois' State Performance Measures (SPM) changed as a result of the Needs Assessment Process. Several of the SPM, especially numbers 4, 5, 7 and 10, are measurable using existing data sources. The majority of the measures, however, are yet to be operationalized. As stated in the Needs Assessment, DHS intended to convene work groups for each priority to further review data for measurement and prepare action plans. Changes in staffing interrupted DHS intentions leaving many of the performance measures un-measurable.

Many changes in personnel in the past year have affected the Title V agency's capacity to conduct analysis of maternal and child health data. The epidemiologist working in PPD left to pursue other opportunities in November 2010. Shortly thereafter, the data analyst who was supported by SSDI funding also departed. Also, the epidemiologist working for the University of Illinois--Amanda Bennett--largely responsible for the development of Illinois' state performance measures in the MCH Block Grant left the project to focus her attention on obtaining a Ph.D. in public health. Finally, the MCH Director, Dr. Myrtis Sullivan, retired December 31, 2010.

The DHS addressed staff capacity in its proposal for FFY2012 State Systems Development Initiative (SSDI) competitive funding. As its first SSDI objective, DHS stated: By January 2012, the Office of Program Planning and Development (PPD) will hire an epidemiologist. The job description was submitted to Illinois' personnel system where it was classified as a Public Service Administrator. The position was published briefly and then removed from publication in February, 2012. Because of Illinois' significant budget challenges--funding shortfalls, facility closures, pension deficits--a hiring freeze was put into effect and remains. It is unlikely that DHS will be in a position to hire an epidemiologist in the foreseeable future. Therefore, DHS has turned to the University of Illinois, School of Public Health to provide needed epidemiological analysis. During the next year, the MCH Director and PPD will work with the university to further develop Illinois' state performance measures.

III. State Overview

A. Overview

POPULATION - Illinois ranks fifth in the nation in population, with 12.9 million people, including 3.2 million children under the age of 18, according to the U.S. Census Bureau's population estimates as of July 1, 2009. In the year 2009, there were approximately 2.7 million women in Illinois who were of childbearing age (15 to 44 years). In recent years, Illinois has averaged about 180,600 live births annually. An average of 45,300 pregnancies are aborted each year. //2012/ Illinois ranks fifth in the nation in population, with 12.8 million people, including 3.1 million children under the age of 18, according to the 2010 U.S. Census. In the year 2010, there were approximately 2.6 million women in Illinois who were of childbearing age (15 to 44 years). In recent years, Illinois has averaged about 177,500 live births annually. An average of 45,300 pregnancies are aborted each year. //2012//

According to the 2005-2006 (most current) National Survey of Children with Special Health Care Needs (CSHCN), there are about 451,776 CSHCN in Illinois, or 13.9 percent of children under 18 years of age. In comparison, the survey identified 10.2 million CSHCN nationally, or 13.9 percent of children under 18 years of age. The survey identified 323,673 Illinois households with a CSHCN, or 19.1 percent of the state's households. 20.9 percent of all households in the nation had a CSHCN. DSCC serves approximately 24,000 CSHCN with their current resources.

//2012/ A new methodology which greatly reduces the possibility of duplicated cases, identified almost 17,000 CSHCN served by DSCC. //2012//

//2013/ The 2009/2010 National Survey of Children with Special Health Care Needs (CSHCN) estimates 452,574 CSHCN in IL or 14.3% under the age of 18 years compared to 11.2 million or 15.1% nationally. This survey also estimates 350,670 households in IL with at least one CSHCN or 21.8% compared to 8.8 million or 23.0% nationally. //2013//

//2012/ Sixty-five percent of the state's population resides in Chicago and the six "collar" counties that surround it in the northeast corner of the state; two of those counties (Cook and DuPage) account for almost half of the state's population. Excluding Chicago, 28 cities of 50,000 or more in population account for over 2.3 million persons, or about 17 percent of the state's population. Using the 2010 Census, there were 20 counties outside the collar counties whose populations exceeded 100,000. //2012// Sixty-six percent of the state's population resides in Chicago and the six "collar" counties that surround it in the northeast corner of the state; two of those counties (Cook and DuPage) account for half of the state's population. Excluding Chicago, 26 cities of 50,000 or more in population account for over 2.1 million persons, or about 17 percent of the state's population. Using 2009 population estimates, there were 19 counties outside the collar counties whose populations exceeded 100,000. Other than these population centers, Illinois is characterized by rural areas. Using the U.S. Department of Agriculture (USDA) Rural-Urban Continuum classification scheme and 2007 population data, nine of the 102 counties are considered "completely rural," with less than 2,500 urban population regardless of proximity to a metropolitan area. Another 57 counties are considered "urban," with an urban population of 2,500 to 19,999 regardless of proximity to a metropolitan area. About two thirds of Illinois' population (Chicago and the collar counties) is concentrated on less than 10 percent of its land, while the majority of the state is characterized by small towns and farming areas.

//2012/ In 2010, according to the U.S. Census Bureau, 71.5 percent of the state's population was Caucasian, 14.5 percent was African American, 4.6 percent was Asian, Native Hawaiian or Other Pacific Islander, 0.3 percent was Native American, 2.3 percent was multiracial, and 6.7 percent was "some other race"; 15.8 percent of the state's population was of Hispanic origin. Chicago is home to almost half of the state's African Americans and 38 percent of the state's Hispanic Americans. //2012// In 2008, the U.S. Census Bureau estimated that 79.1 percent of the state's population was Caucasian, 14.9 percent was African American, 4.3 percent was Asian, Native

Hawaiian or Other Pacific Islander, 0.4 percent was Native American, and 1.2 percent was multiracial; 15.2 percent of the state's population was of Hispanic origin. Chicago is home to more than half of the state's African Americans and 49 percent of the state's Hispanic Americans.

The size of Illinois' rural area is a significant geographic barrier to health care. The Illinois Department of Public Health (IDPH) Center for Rural Health reports that there are 83 rural counties and 19 urban counties in Illinois. The Center further reports designation of Health Professional Shortage Areas (HPSA's) by county, township, and Census tract. Through calendar year 2008, all but four counties (96 percent) of Illinois have some category of HPSA designation: 45 are geographic; 43 are low-income population; and 10 are sub-county level. This problem of provider distribution in rural areas creates barriers to care arising from problems with transportation, child care, hours of service, and related concerns. Families in some rural areas may have to travel three hours to access specialists' services.

SUMMARY OF HEALTH STATUS - The most important health care needs of the state's population can be considered by population group. The most recently available data are presented.

Access to Prenatal Care - Early and continuous access to prenatal care remains a challenge. Overall, more than 80 percent of the pregnant women in Illinois initiate prenatal care in the first trimester and more than 80 percent receive adequate care (using the Kotelchuck Index of adequate prenatal care) throughout pregnancy. These rates are lower among women who participate in Medicaid. Approximately 10 percent of expectant women continue to smoke in the third trimester of pregnancy. (Refer to National Performance Measures 15 and 18 on Form 11, Health Systems Capacity Indicator 4 on Form 17 and Health Systems Capacity Indicator 5d on Form 18.)

Newborn Screening - Virtually every newborn in Illinois is screened for a panel of heritable conditions and for congenital hearing loss. The systems to ensure that these infants receive a diagnostic evaluation and on-going care are well established. (Refer to Form 6 and to National Performance Measures 1 and 10 on Form 11.)

Perinatal Health Care - More than 82 percent of very-low birth weight infants are born in hospitals equipped to care for high-risk deliveries and neonates. Illinois' regionalized perinatal care system is well established. (Refer to National Performance Measure 17 on Form 11.)

Infant Mortality - Illinois' infant mortality rate is steadily declining. However, significant racial disparities in infant mortality persist: the rate for African Americans is more than twice that of Caucasians. In 2007, ratio of Caucasian to African American infant deaths was 1:2.5 which differs slightly from that reported five years earlier (1:2.6, 2003). ***/2013/ In 2008, the ratio of Caucasian to African American infant deaths was 1:2.4. Although this rate shows a slight improvement, the disparity is still too high and must be addressed./2013//*** While Chicago's infant mortality figures suggest continued improvement, those for downstate (all geographic areas outside the city of Chicago) reported an increase, especially compared to past years. This is due in part to the gentrification of certain areas of Chicago and the resultant shift in demographics. The mortality rate among Medicaid-insured infants is also higher than the rate among other infants. An average of 180,600 live births and 1,200 infant deaths occur each year. (Refer to National Outcome Measures 1 and 2 on Form 12 and Health Systems Capacity Indicator 5b on Form 18.)

Childhood Health - Approximately 1.5 million children in Illinois are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP). Approximately ***/2013/ three-fourths //2013//*** two-thirds of eligible children receive at least one health service during the year. The proportion of infants who are eligible for Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and who receive at least one recommended health screening is approximately ***/2013/ 90 //2013//*** 85 percent; the proportion of SCHIP-eligible infants who receive at least one

health screening is higher, but the number of participating infants is much smaller. Less than six percent of children (including adolescents) in Illinois are uninsured. (Refer to National Performance Measure 13 on Form 11 and Health Systems Capacity Measures 2 and 3 **/2013/ and 7A //2013//** on Form 17.)

Breastfeeding - The proportion of breast-fed infants in Illinois' WIC program remains above 66 percent. The proportion who are still breast-fed at six months of age has increased significantly over the last two decades but has declined slightly in recent years. (Refer to National Performance Measure 11 on Form 11.)

/2013/The proportion of breast-fed infants in Illinois' WIC program is just over 69 percent. The proportion who are still breast-fed at six months of age has increased significantly over the last two decades but remains below the Healthy People 2020 breastfeeding goal for continued breastfeeding. (Refer to National Performance Measure 11 on Form 11).//2013//

Childhood Immunization - ***/2013/ According to CDC's National Immunization Survey data, the proportion of children ages 19 - 35 months in the U.S. who are fully immunized with the 4:3:1:3:3 series (see description below) reached nearly 78 percent for those children between the third quarter of 2010 through 2nd quarter 2011. For the Illinois project area, excluding the city of Chicago, the same series coverage measures 79.3 percent. The national Hib vaccine shortage between December 2007 and July 2009 continues to impact the statistics regarding series coverage due to differences in the brand type of the Hib vaccine as noted by the CDC in releasing the 2010 NIS results. (Refer to National Performance Measure 7 on Form 11.) //2013//*** /2012/ According to CDC's National Immunization Survey data, the proportion of children ages 19 - 35 months in the U.S. who are fully immunized against measles, mumps, rubella, diphtheria, pertussis, tetanus, polio, haemophilus influenzae B and Hepatitis B reached 76 percent for those children between the third quarter of 2009 through 2nd quarter 2010. For the Illinois project area, excluding the city of Chicago, the same series coverage measures 75.8 percent. It is believed that a national Hib vaccine shortage between December 2007 and July 2009 affected overall series coverage and may have disrupted follow-up at the local provider level necessary to keep children on schedule. (Refer to National Performance Measure 7 on Form 11.) //2012// According to CDC's National Immunization Survey data, the proportion of children ages 19 - 35 months in the U.S. who are fully immunized against measles, mumps, rubella, diphtheria, pertussis, tetanus, polio, haemophilus influenzae B and Hepatitis B reached 75 percent for those children between the third quarter of 2008 through 2nd quarter 2009. For the Illinois project area, excluding the city of Chicago, the same series coverage measures 74 percent. It is believed that a national Hib vaccine shortage between December 2007 and July 2009 affected overall series coverage and may have disrupted follow-up at the local provider level necessary to keep children on schedule. (Refer to National Performance Measure 7 on Form 11.)

Childhood Obesity - Approximately 30 percent of the children between two and five years of age who are enrolled in Illinois' Special Supplemental Nutrition Program for Women, Infants and Children (WIC) have a Body Mass Index at or above the 85th percentile. (Refer to National Performance Measure 14 on Form 11.)

Oral Health - /2012/ Slightly more than forty-one percent of children in third grade have a sealant on at least one permanent molar tooth. Access to oral health care for Medicaid-eligible or uninsured children in Illinois remains a significant challenge. The proportion of children between six and nine years of age who are eligible for Medicaid has been steadily increasing and now exceeds 50 percent. (Refer to National Performance Measure 9 on Form 11 and Health Systems Capacity Indicator 7B on Form 17.) //2012// Access to oral health care for Medicaid-eligible or uninsured children in Illinois remains a significant challenge. Slightly more than one-fourth of children in third grade have a sealant on at least one permanent molar tooth. The proportion of children between six and nine years of age who are eligible for Medicaid has been steadily

increasing and now exceeds 50 percent. (Refer to National Performance Measure 9 on Form 11 and Health Systems Capacity Indicator 7B on Form 17.)

Teenage Pregnancy - Overall, the number of teen births and the proportion of infants born to teenage mothers are steadily declining; the birth rate among girls who are between 15 and 17 years of age remains steady. (Please refer to National Performance Measure 8 on Form 11.)

Childhood Injury and Death - The mortality rate among children under 14 years of age due to unintentional injuries decreased, while deaths due to motor vehicle crashes increased slightly. The rate of non-fatal injuries requiring hospital admission has declined steadily; the rate of hospital admission for motor vehicle crashes comprises approximately five percent of this rate. (Refer to National Performance Measure 10 on Form 11 and to Health Status Indicators 3A, 3B, 4A and 4B on Form 20.)

The rate of suicide among Illinois' adolescents remains low; approximately 60 adolescents take their own lives each year. (Refer to National Performance Measure 16 on Form 11.)

Reproductive Health - According to the Alan Guttmacher Institute, Illinois has about 708,670 (2008) women of reproductive age in need of subsidized family planning services. Illinois' Family Planning program had enough resources to serve approximately 17% (2009) of these women. ***//2013/The CY11 Ahlers Annual Report indicated that 102,305 unduplicated individuals were served by Illinois' Family Planning program, which is 14.4% of the number of women in need (708,670).//2013//***

Children with Special Health Care Needs - The 2005/2006 National CSHCN survey found that 60.3 percent of families with CSHCN indicated that they are partners in decision making at all levels. For Children and Youth with Special Health Care Needs (CYSHCN) enrolled in DSCC, assessment and planning incorporates the family's priorities and needs. System efforts such as Medical Home, Transition, Newborn Hearing Screening, Early Intervention and the Integrated Systems Grant Advisory Committee integrate family participation. (Refer to National Performance Measure 2.)

//2013/ The 2009/2010 National CSHCN survey found that 71.1% of Illinois families with CSHCN indicated they are partners in decision making at all levels compared to 70.3% nationally. This data cannot be compared with the previous surveys because the questions were changed for this survey. //2013//

The 2005/2006 National CSHCN Survey found that 45 percent of CSHCN received care in a medical home. In the 2009 DSCC Family Survey, 93 percent of respondents felt they had a partnership with their primary care provider. Families were also asked how strongly they agree/disagree with six statements that indicate elements of a medical home. Families were least likely to agree with the statement that their personal doctor or nurse helps arrange for other health care services needed for their child and most likely to agree that their personal doctor or nurse treats their child with compassion and understanding.

//2013/ The 2009/2010 National CSHCN survey found that 44.5% of Illinois CSHCN received care in a medical home compared to 43.0% nationally. These results were very comparable to the 2005/2006 survey results for Illinois. Although the TAP grant has ended, UIC-DSCC is providing facilitation support to the Quality Improvement Teams that are continuing efforts begun under this grant. //2013//

For CYSHCN enrolled in DSCC, care coordination teams work with the family and primary care provider to promote a medical home. DSCC staff facilitate Quality Improvement Teams through the Building Community Based Medical Homes for Children and provide consultation to the Autism Program (TAP) HRSA grant. (Refer to National Performance Measure 3.)

The 2005/2006 National CSHCN survey found that 59.3 percent of Illinois families with CSHCN had adequate private and/or public insurance to pay for the services they need. Approximately five percent of children enrolled in DSCC have no third party benefits. In FY 2009, 45 percent of DSCC financially eligible families received DSCC financial assistance for eligible services. The National Survey also found that 23.4 percent of families with CSHCN pay more than \$1,000 out of pocket. The DSCC Family Survey found that 17 percent of families enrolled in DSCC paid \$1,000 or more out of pocket. In the 2009 DSCC Family Survey, less than one in five families reported that cost was a major factor in deciding whether their child received medical care. About one in 20 families reported that in the last 12 months, their child was denied care because the family could not pay. About 15 percent of families surveyed reported in the last 12 months, that the family went without necessities because of the cost of medical care. (Refer to National Performance Measure 4.)

/2013/ The 2009/2010 National CSHCN survey found that 62.1% of Illinois families with CSHCN had adequate private and/or public insurance to pay for the services their children needed. This compares to 60.6% nationally. These results demonstrate a continuing trend of improvement since 2001 when the results showed 53.3% had adequate insurance.

//2013//

The 2005/2006 CSHCN Survey found that 89.8 percent of Illinois families of CYSHCN reported that community-based services systems were organized so that they can easily use them. In the 2009 DSCC Family Survey 56 percent of families with CYSCHN reported one or more barriers to receiving services. The top five barriers reported were: needed service too far from home; All Kids/Medicaid not accepted; care not covered by insurance; delays in getting appointments; and waiting time in doctor's offices too long. CYSHCN enrolled in DSCC, including over 600 children enrolled in the Home and Community Based Services (HCBS) Medicaid waiver, receive care coordination, including comprehensive assessment and service plan development based on the family's priorities and needs. The DSCC 2009 Family Survey found the five most common reasons DSCC families requested care coordination assistance often or sometimes was: to meet with schools to help teachers plan; to help the child get special school services; to learn the child's rights for school; for help talking to medical providers; and help in understanding the medical treatment plan. Coordination with state programs such as the Adverse Pregnancy Outcome Reporting System (APORS), Supplemental Security Income (SSI), and Early Intervention (EI) promote referral and resource identification for CYSHCN. Through the U.S. Health Resources and Services Administration (HRSA) integrated systems grant and collaboration with the Illinois Chapter of the American Academy of Pediatrics (ICAAP) and other stakeholders, systems development is occurring for medical home, transition and other components. (Refer to National Performance Measure 5.)

/2013/ The 2009/2010 National CSHCN survey found that 64.6% of Illinois families of CSHCN reported they can easily access community based services compared to 65.1% nationally. The questions for this item were changed from the previous surveys and cannot be compared to those results. //2013//

The 2005/2006 National CSHCN Survey found that 44.2 percent of Illinois youth and their families received the services necessary to make the transition to all aspects of adult life. The 2009 DSCC Family Survey found that 87 percent of youth served by DSCC either have a transition plan or are developing a plan compared to 45 percent reporting having or developing a plan in 2005. The school system most commonly (68 percent) assists with developing the plan. Almost one-third reported that the DSCC Care Coordinator assisted in plan development. Forty-two percent of families reported that the transition plan met their youth's needs extremely or very well. DSCC also conducted a survey of DSCC enrolled youth/young adults in July 2007 to evaluate services being received and transition issues. More than half of the respondents had a written transition plan. There was a slight increase in the percentage of respondents attaining skills related to medication knowledge and knowing the name of their insurance coverage. Over half the respondents order their own medical supplies; less than half are completing medical history forms

at the doctor's office and signing medical consents forms. Fifty-six percent of respondents rated DSCC transition assistance as "most helpful" or "very helpful." DSCC participates on Interagency Coordinating Council for Transition with other state agencies. (Refer to National Performance Measure 6.)

/2013/ The 2009/2010 National CSHCN survey found that 45.3% of Illinois youth with special health care needs and their families received services necessary to make appropriate transitions to adult health care, work and independence compared to 40.0% nationally. These results are somewhat improved over the 2005/2006 finding of 44.2%. The questions were changed after the 2001 survey, therefore a trend cannot be considered. //2013//

HEALTH CARE FINANCING -- /2012/ Public Act 96-1501 Medicaid Reform, signed into law January 25, 2011, made some changes to Illinois' medical coverage programs for children. These changes are noted throughout this section. //2012// Illinois offers a variety of medical care coverage programs, as described below.

All Kids - Children in Illinois may receive publicly subsidized health insurance through the All Kids program. /2012/Coverage is available to all uninsured children in Illinois regardless of income or immigration status with family incomes up to 300 percent of the federal poverty level (FPL) effective July 1, 2011.//2012// Coverage is available to all uninsured children in Illinois regardless of income or immigration status. All Kids has several components, as follows:

(1) Moms and Babies - Coverage through Title XIX (Medicaid) for pregnant women and their infants up to one year of age, with family incomes up to 200 percent of the federal poverty level (FPL).

(2) All Kids Assist - Coverage through Title XIX, Title XXI (CHIP), and state subsidized health insurance for children through age 18, with family incomes at or below 133 percent of the FPL.

(3) All Kids Share - Coverage through Title XXI and state subsidized health insurance for children through age 18, with family income above 133 percent and at or below 150 percent of the FPL. Co-payments are assessed for prescriptions and medical visits, except for well-child visits and immunizations.

(4) All Kids Premium Level 1- Coverage through Title XXI and state subsidized health insurance for children through age 18, with family income above 150 percent and at or below 200 percent of the FPL. Monthly premiums are assessed based on family size and co-payments are required for prescriptions, physician office visits and non-emergency use of the Emergency Department. There are no co-payments for well child visits or immunizations, and there is an annual limit on the amount families are required to pay. There are seven additional tiers (levels) of premium and co-payment amounts and annual out-of-pocket payment limits that are based on family size and income.

(5) All Kids Rebate -- Offers state-subsidized rebate payments to families with private health insurance or employer sponsored group health insurance coverage for their children. The health insurance must cover at least physicians' services and hospitalization. Children through age 18 with family income above 133 percent and at or below 200 percent of the FPL are eligible.

(6) All Kids Expansion -- Offers state-subsidized rebate payments for insured children under age 19 regardless of family income or immigration status. /2012/Effective July 1, 2011, new enrollment for All Kids Premium Levels 3-8 ends. All Kids Premium Levels 3-8 covers children with income greater than 300 percent of the FPL. Families with children active in All Kids Premium Levels 3-8 on July 1, 2011 may continue to receive medical benefits at this level for up to one year if there is no break in coverage. //2012//

Information about All Kids is available at www.allkids.com. As a Health Services Initiative under Title XXI, Illinois provides presumptive eligibility for children requesting medical benefits under both Title XIX and Title XXI.

FamilyCare - This program provides coverage for parents and relatives who care for children under age 19. FamilyCare has four components, as follows:

(1) FamilyCare Assist - Coverage for parents with incomes at or below 133 percent of the FPL. Co-payments for medical visits and brand-name pharmaceuticals are required. There is no charge for generic prescriptions.

(2) FamilyCare Share - Coverage for some parents with income above 133 percent and less than or equal to 150 percent of the FPL. Co-payments are required for medical visits and brand name pharmaceuticals. There is an annual limit on family co-payments.

(3) FamilyCare Premium Level 1 - Coverage for some parents with incomes above 150 percent and less than or equal to 185 percent of the FPL. Monthly premiums are assessed and based on family size. Co-payments are required for medical visits and name-brand pharmaceuticals. There is an annual limit on family co-payments.

(4) FamilyCare Rebate - Health insurance premium subsidy to families with private or employer-sponsored group health insurance coverage. The private insurance plan must at least cover physicians' services and hospitalization. Adults in families with incomes above 133 percent and less than or equal to 200 percent of the FPL are eligible.

Information about Family Care is provided at www.familycareillinois.com

Illinois Healthy Women (IHW) - Provides coverage for family planning services. The program operates under a Section 1115 Medicaid waiver to demonstrate the program's impact on the rate of unintended pregnancy and associated savings to the Medicaid program. The program covers women who are ages 19 through 44, who are U.S. citizens and Illinois residents with family incomes at or below 200 percent of poverty. Information about the IHW program is provided at www.illinoishealthywomen.com.

Illinois Health Connect - Illinois Health Connect is the statewide Primary Care Case Management (PCCM) program for most persons covered by All Kids or FamilyCare. Participants are assigned to a medical home through a Primary Care Provider (PCP), which ensures that clients have access to quality care from a provider who understands their individual health care needs. A client's PCP serves as his/her medical home by providing, coordinating and managing the client's primary and preventive services, including well child visits, immunizations, screening, and follow-up care as needed. Having a PCP also helps those with chronic conditions like asthma, heart disease or diabetes to get the treatment and ongoing care they need to minimize the need for hospital care. The PCP will also make referrals to specialists for additional care or tests as needed. There are currently over 1.8 ~~/2013/1.9/2013/~~ million Illinois Health Connect clients with a PCP in a medical home. Information about the program is provided at www.illinoishealthconnect.com.

~~/2013/ DELETE THIS PARAGRAPH //2013/~~Disease Management - Your Healthcare Plus is a disease management program implemented in 2006. Your Healthcare Plus supports medical providers with the management of patients with complex chronic illnesses. The Illinois Department of Healthcare and Family Services (IDHFS) has contracted with McKesson Health Solutions to administer the program. Provider and patient participation is voluntary; individuals eligible for the Your Healthcare Plus Program may "opt out." Currently, the program serves approximately 253,000 individuals, including: 1) disabled adults who have been diagnosed with a chronic condition such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, end stage renal disease, hemophilia, Human

Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), malignancy, mental health, or other co-occurring conditions; 2) children and adults who have persistent asthma (as defined by the Health plan Employer Data and Information Set (HEDIS)); 3) children and adults who are frequent emergency room users (defined as six or more visits a year); and 4) individuals in the elderly (aged 65 and older) and the physically disabled Home and Community Based Waiver programs (waiver clients added to Your Healthcare Plus July 1, 2009.) Information about the disease management program is found at www.hfs.illinois.gov/dm.

Health Maintenance Organizations (HMOs) -- Enrollment in HMOs in Illinois continues to decline. In 2005 (the most recent data available), 12.5 percent of the state's population was covered by an HMO. There were 29 licensed HMOs in the state in 2004. The 10 largest HMOs covered 1.5 million persons in 2005, a 38 percent decrease from the 1999 peak of 2.6 million. Four of the 10 largest plans have enrollments in excess of 100,000 persons: Health Care Service Corporation, Health Alliance Medical Plans, Humana Health Plan, and Unicare Health Plans. These four HMOs have enrolled about 1.1 million persons, or 70 percent of the total. Changes in hospital ownership have not affected affiliation agreements for the regionalized perinatal care system. The number of hospitals providing obstetrical care has been declining; currently 133 hospitals are licensed to provide this service.

Managed Care Organizations (MCOs) - /2012/There are three MCOs currently participating in the voluntary managed care program serving certain Title XIX and Title XXI participants. Family Health Network serves these participants in Cook County. Harmony Health Plan serves Cook, Jackson, Kane, Madison, Perry, Randolph, St. Clair, Washington and Williamson counties. Meridian Health Plan serves the counties of Adams, Brown, /2013/ **Cook, DeKalb, Henderson, //2013//Henry, /2013/ Knox, //2013//Lee, /2013/ Livingston, //2013// McHenry, /2013/ McLean, //2013// Mercer, /2013/ Peoria, //2013// Pike, Rock Island, and Scott /2013/ Tazewell, Warren, Winnebago, and Woodford //2013// counties. In the counties that offer both MCOs and Illinois Health Connect, the Illinois Client Enrollment Broker (ICEB), contracted by the Illinois Department of Healthcare and Family Services, (HFS), conducts all client enrollment and education activities, including mailing choice education and enrollment materials and assisting with the selection of a health plan and PCP in an unbiased manner. Information about the voluntary managed care program can be found at <http://www.hfs.illinois.gov/managedcare/managedcare.html> or www.illinoisceb.com /2013/ **DELETE THE REST OF THIS PARAGRAPH** //2013// Two MCOs participate in the voluntary managed care program for certain Title XIX and Title XXI participants in Cook County. One of those MCOs also serves certain Title XIX and Title XXI participants in St. Clair, Madison, Perry, Randolph, and Washington Counties. A new MCO contracted to participate in the voluntary managed care program to serve Rock Island, Henry, Mercer, Adams, Brown, Scott and Pike counties in the western part of the state in December 2008.//2012// Two MCOs participate in the voluntary managed care program for certain Title XIX and Title XXI participants in Cook County. One of those MCOs also serves certain Title XIX and Title XXI participants in St. Clair, Madison, Perry, Randolph, and Washington Counties. A new MCO contracted to participate in the voluntary managed care program to serve Rock Island, Henry, Mercer, Adams, Brown, Scott and Pike counties in the western part of the state in December 2008.**

/2012/ Integrated Care Program -- The Integrated Care Program (ICP) is a new program HFS is launching in 2011. ICP will provide health care coverage to approximately 40,000 of Illinois' Aid to the Aged, Blind and Disabled (AABD) population. This mandatory program covers older adults and adults with disabilities already on Medicaid but not eligible for Medicare who reside in six selected Illinois counties. HFS has selected Aetna Better Health and IlliniCare Health Plan to manage the care of the members. Members will receive standard Medicaid services in the first year of the program, followed by long term care services in subsequent years.

This program is designed to bring together PCPs, specialists, hospitals, pharmacists and care coordinators who work as a team and, together with the member, make sure members are getting the best care. Members will have the choice of both a health plan and Primary Care Physician (PCP) who will get to know them and help them meet their healthcare goals. Information about

the Integrated Care Program can be found at www.illinoiscebicp.com //2012//

/2013/ Integrated Care Program -- In 2011, IDHFS implemented the Integrated Care Program (ICP) in six Illinois counties. The new program provides health care coverage to approximately 40,000 adults with disabilities and older adults residing in the counties of DuPage, Kane, Kankakee, Lake, Will and suburban Cook (non-606 ZIP codes). This mandatory program covers the full spectrum of Medicaid services through an integrated care delivery system. Two MCOs participate in the ICP program - Aetna and Centene-Illini Care. Members will receive standard Medicaid services in the first year of the program, followed by long-term care services in subsequent years.

The Integrated Care Program will bring together local primary care physicians, specialists, hospitals, nursing homes, and other providers where all care is organized around the needs of the patient in order to achieve improvements in health through care coordination. Members will have the choice of both a health plan and Primary Care Physician (PCP) who will get to know them and help them meet their health care goals. Information about the ICP can be found at www.illinoiscebicp.com. //2013//

SERVICE DELIVERY SYSTEM - With the exception of the Teen Parent Services (TPS) program in part of Chicago, all of the primary and preventive care services in Illinois' Title V program are provided by grantees of the IDHS or the Illinois Department of Public Health (IDPH) grantees. Most often, these are local health departments. Community Health Centers also play an integral role in the delivery of primary and preventive care to pregnant women, mothers, infants, children, and adolescents.

Local Health Departments -- Local health departments were first established in Illinois by "AN ACT to authorize the organization of public health districts and for the establishment and maintenance of a health department for the same" (70 ILCS 905/1, effective July 1, 1917). Municipal health departments are governed by Section 17 of the Illinois Municipal Code of 1961 (65 ILCS 5/11 17 1). The statutory base for county and multiple county health departments (55 ILCS 5/5 25001) was revised July 1, 1990. Local health departments in Illinois are all tax supported to some degree. For county health departments, a local tax levy of as much as 0.1 percent of the assessed value of all taxable property in the county can be instituted through referendum; the actual rate is set, up to the legal maximum, through a vote of the county board (55 ILCS 5/5 25003 and 55 ILCS 5/5 25004). Currently, there are 47 "resolution" health departments (those established by resolution of a county board) and 48 "referendum" health departments. These health departments serve 99.7 percent of Illinois' population.

Community Health Centers - The Illinois Primary Health Care Association (IPHCA) reports there are 330 Community Health Centers, Federally Qualified Health Centers (FQHCs), or Healthy Schools Healthy Communities grantees. Many of these centers are maternal and child health grantee agencies providing primary medical care, dental care services, mental health/substance abuse services, obstetrical and gynecological care, or other professional services. Individual FQHCs receive grants for many MCH programs. The most significant collaboration is in the Chicago Healthy Start Initiative. The Winfield Moody Health Center, the Erie Family Health Center, and Henry Booth House are the medical partners for three of the four Healthy Start Family Centers. Erie Family Health Center, Lawndale Christian Health Center, and the Chicago Department of Public Health implement the Targeted Intensive Prenatal Case Management project in the city of Chicago, and Aunt Martha's and Chicago Family Health Center provide services on the far south side. The Southern Illinois Healthcare Foundation is a lead agency for HealthWorks of Illinois (HWIL). The Department is working with Lawndale Christian Health Center and PCC Wellness on the Healthy Births for Healthy Communities project.

ALLOCATION OF RESOURCES - The IDHS allocates its resources by "giving highest priority to those areas in Illinois having high concentrations of low income families, medically underserved areas, and those areas with high infant mortality and teenage pregnancies . . ." (77 Ill. Adm. Code

630.20 (a)(2)). Allocation decisions are made on the basis of competitive proposals, per capita allocations, or by other means. By federal law, IDHS allocates 30 percent to DSCC for CSHCN.

The distribution of resources in the state roughly parallels the distribution of live births. Table 1 (attached) presents the proportion of live births and the proportion of program resources allocated to groups of counties, ranked by the number of live births. For example, Group 1 includes the ten counties with the greatest number of live births (Cook, DuPage, Kane, Lake, Madison, McHenry, Peoria, St. Clair, Will and Winnebago). The proportion of MCH program grant funds allocated to these counties is roughly equal to the proportion of the state's live births that occur in these 10 counties. This pattern continues throughout the remaining groups of counties.

Table 1

//2012/ Counties Grouped by Percent of Live Births and the Percent of MCH Program Grant Funds

Awarded to Agencies in Those Counties: Illinois, SFY'11

Group of Counties Ranked by Live Births; Percent of 2009 Live Births; Percent of MCH Funds

1; 77 %; 74 %

2; 11 %; 16 %

3; 4 %; 3 %

4; 3 %; 2 %

5; 2 %; 2 %

6; 1 %; 1 %

7; 1 %; 1 %

8; 1%; < 1%

9; < 1 %; 1 %

10; < 1 %; 1 % //2012//

Counties Grouped by Percent of Live Births and the Percent of MCH Program Grant Funds

Awarded to Agencies in Those Counties: Illinois, SFY'10

Group of Counties Ranked by Live Births; Percent of 2008 Live Births; Percent of MCH Funds

1; 76 %; 80 %

2; 10 %; 10 %

3; 4 %; 4 %

4; 3 %; 2 %

5; 2 %; 1 %

6; 1 %; 1 %

7; 1 %; 1 %

8; 1 %; 1 %

9; 1 %; <1 %

10; < 1 %; 1 %

B. Agency Capacity

The State of Illinois has the capacity to provide comprehensive quality care to pregnant women, mothers and infants, children, adolescents, and women of reproductive age through strong mutually agreed upon relationships between the Illinois Departments of Human Services, Public Health (IDPH), Healthcare and Family Services (IDHFS) and the University of Illinois. (Org chart attached.) The primary responsibility for Illinois' Title V program is that of the Division of Community Health and Prevention (DCHP)/**2013/Division of Family and Community Services (DFCS)//2013//** in IDHS. IDPH is responsible for the surveillance and policy infrastructure for health outcomes. The IDHFS underwrites access to health care for families in need. The needs of CSHCN are addressed by the Division of Specialized Care for Children, University of Illinois. The working relationships of these agencies are supported by interagency agreements that specify responsibilities in regard to service delivery, performance levels, data reporting, and data sharing. Although the working relationships are solid, data sharing. Presents challenges. State statutes, federal law (HIPAA) and interstate agreements are barriers to complete and smooth transfer of service delivery data. Illinois is addressing data sharing issues through various

measures, most significantly the development of the Medical Data Warehouse (MDW). In 2005, the Illinois General Assembly passed and the Governor enacted Public Act 094-0267, the Medical Data Warehouse Act. The act authorizes the IDHFS to "perform all necessary administrative functions to expand its linearly scalable data warehouse to encompass other health care data sources at both the Department of Human Services and the Department of Public Health." /2012/ In order to reflect this change the formerly named Medical Data Warehouse has been re-titled the Enterprise Data Warehouse (EDW). //2012//

/2012/ Multiple data sources will be consolidated into the MDW EDW in an effort to provide a complete picture of publicly-funded programming and to reduce duplication of data and/or conflicting information that currently exists in the various databases. The process (which deals with extraction, transformation, cleansing, loading, and then maintaining the data in the MDW EDW) will provide for high quality data. //2012//

/2012/ Interagency agreements identify the data to be shared and details how it may be used. Resulting from the agreements and the design of the MDW EDW, there is a more holistic view of the Medicaid beneficiary as well as the MCH service recipient. //2012// Multiple data sources will be consolidated into the MDW in an effort to provide a complete picture of publicly-funded programming and to reduce duplication of data and/or conflicting information that currently exists in the various databases. The process (which deals with extraction, transformation, cleansing, loading, and then maintaining the data in the MDW) will provide for high quality data.

Interagency agreements identify the data to be shared and details how it may be used. Resulting from the agreements and the design of the MDW, there is a more holistic view of the Medicaid beneficiary as well as the MCH service recipient. This enables the signatories of the agreement to see the other benefits that individuals may be receiving and design approaches that would improve service delivery, while providing assurances that they will not be receiving overlapping or duplicative services.

STATUTORY BASE

The Prenatal and Newborn Care Act (410 ILCS 225) and the Problem Pregnancy Health Services and Care Act (410 ILCS 230) establish programs to serve low-income and at-risk pregnant women.

The Developmental Disability Prevention Act (410 ILCS 250) authorizes regional perinatal health care and establishes the Perinatal Advisory Committee (PAC). HJR0111 (adopted in 2010) urges the PAC to investigate how Illinois can reduce the incidence of preterm births and report its findings and recommendations by November 1, 2012. The Perinatal HIV Prevention Act (410 ILCS 335) requires testing and counseling women on HIV infection.

The Newborn Metabolic Screening Act (410 ILCS 240), the Infant Eye Disease Act (410 ILCS 215), the Newborn Eye Pathology Act (410 ILCS 223) and the Hearing Screening for Newborns Act (410 ILCS 213) authorize health screening for newborns. The Genetic and Metabolic Diseases Advisory Committee Act (410 ILCS 265) created a committee to advise IDPH on screening newborns for metabolic diseases.

The Illinois Family Case Management Act (410 ILCS 212) authorizes the Family Case Management (FCM) program and creates the Maternal and Child Health Advisory Board. The WIC Vendor Management Act (410 ILCS 255) "establish[es] the statutory authority for the authorization, limitation, education and compliance review of WIC retail vendors..." The Counties Code (55 ILCS 5) provides for the autopsy of children under age two years and reporting of deaths suspected to be due to Sudden Infant Death Syndrome (SIDS) by the county coroner. /2012/ ..." A recent Senate Joint Resolution created a taskforce to review current activities, fiscal practices and evaluation outcomes of the EI program. //2012// The Early Intervention Services System Act (325 ILCS 20) "provide[s] a comprehensive, coordinated, interagency, interdisciplinary early intervention services system for eligible infants and toddlers ..." A recent

Senate Joint Resolution created a taskforce to review current activities, fiscal practices and evaluation outcomes of the EI program.

//2013//Within the Illinois School Code (105 ILCS 5/27-8.1), children enrolled public, private and parochial schools in kindergarten, 2nd grade and 6th grade are required to have an oral health examination.

Community Water Fluoridation Public Water Supply Regulation Act (415 ILCS 40/7a). In order to protect the dental health of all citizens, especially children, the IDPH shall promulgate rules to provide for the addition of fluoride to public water supplies by the owners or official custodians thereof. Such rules shall incorporate the recommendations on optimal fluoridation for community water levels as proposed and adopted by the U.S. Department of Health and Human Services.//2013//

The Child Hearing and Vision Test Act (410 ILCS 205) authorizes screening young children for vision and hearing problems. The Illinois Lead Poisoning Prevention Act (410 ILCS 45) requires screening, reporting, inspection and abatement of environmental lead hazards affecting children under six years of age.

The Alcoholism and Other Drug Abuse and Dependency Act (20 ILCS 301) authorizes substance abuse prevention programs. The Suicide Prevention, Education, and Treatment Act (410 ILCS 53) authorizes IDPH to carry out the Illinois Suicide Prevention Strategic Plan.

The Child and Family Services Act (20 ILCS 505/17 and 17a) authorizes the Comprehensive Community Based Youth Services program. The Probation and Probation Officers Act (730 ILCS 110/16.1) authorizes the Redeploy Illinois program and, along with the Illinois Juvenile Court Act (705 ILCS 405), the establishment of juvenile probation services. The Emancipation of Minors Act (750 ILCS 30) allows a homeless minor to consent to receive shelter, housing and other services."

The Specialized Care for Children Act designates the University of Illinois as the agency to administer federal funds to support CSHCN.

The Illinois Domestic Violence Act of 1986 (750 ILCS 60) defines abuse, domestic violence, harassment and neglect and other terms and authorizes the issuance of orders of protection. The Domestic Violence Shelters Act (20 ILCS 1310) requires the Department to administer domestic violence shelters and service programs.

The Reduction of Racial and Ethnic Disparities Act (410 ILCS 100) provides grants to individuals, local governments, faith-based organizations, health care providers, social service providers and others to "improve the health outcomes of racial and ethnic populations."

OVERVIEW OF PROGRAMS AND SERVICES - Illinois' Title V program focuses on the reduction of infant mortality; the improvement of child health (including CSHCN); and the prevention of teen pregnancy. Specifically:

Preconception - The IDHS' Family Planning and IDHFS' Illinois Healthy Women programs address preconception care through family planning services. Other initiatives include the Preconception/Interconception Care Committee (PICC) and the development of a preconception care risk assessment tool.

IDPH supports a statewide genetic counseling program through grants to medical centers for diagnostic, counseling and treatment services; grants to local health departments for genetic case finding, education and referral; and grants to pediatric hematologists. The Title V program also works with the March of Dimes on a statewide campaign promoting folic acid. The DCHP leads the state's "Fruits and Veggies -- More Matters" campaign.

Prenatal - Direct health care services are provided through funds to the Chicago Department of Public Health (CDPH) and the FCM program. Two statewide enabling service programs are central to the Title V program's infant mortality reduction efforts: the WIC and Family Case Management (FCM) programs.

Targeted, Intensive Prenatal Case Management (TIPCM) projects seek to reduce infant morbidity and mortality and prevent low birth weight. Healthy Start projects serve six community areas in Chicago's inner city. IDHS works with IDPH to train prenatal care providers on prevention of perinatal transmission of HIV. In addition, IDHFS is working with IDHS and local providers to develop a high-risk prenatal care model targeted to women who have had or are at risk for poor birth outcomes.

IDPH administers the state's regionalized perinatal care system. Four levels of care are defined in administrative rule, with all facilities integrated into networks of care. Activities focus on improving the quality of perinatal care and increasing the proportion of very low birth weight infants who are born in Level II+ or Level III centers.

Infants and Young Children - The Title V program includes direct service, enabling, population based and infrastructure building initiatives for infants and young children. Newborns are screened for metabolic diseases and congenital hearing loss. The state has supported a metabolic screening program for more than 45 years and now screens for 36 disorders. Infants with positive results are followed through 15 years of age. DSCC supports diagnostic evaluations to determine whether the infant is eligible for the CSHCN program. DSCC provides care coordination and/or specialty medical care for eligible children. The Newborn Hearing Screening Program is jointly administered by IDHS, IDPH, and DSCC.

The Title V program includes six ~~/2013/seven/2013/~~statewide programs for infants and young children. The FCM program serves low income families with infants and a limited number of children under five years of age who are at risk for health or developmental problems. FCM grantees can use some grant funds to pay for primary pediatric care for medically indigent children who are not eligible for KidCare or FamilyCare coverage. WIC also serves low-income children who are under five years of age and have a nutritional risk factor. The Part C EI program provides comprehensive services to enhance the development of children from birth through 36 months of age who have developmental disabilities and delays. ***/2013/The Maternal, Infant and Early Childhood Home Visiting Program (MIECHVP) provides evidence-based home visiting to improve service coordination for at-risk families in communities across Illinois.*** ~~//2013/~~The IDPH Illinois Lead Program directs the screening of children six months through six years of age for lead poisoning, collects all blood lead test results, and provides medical case management. The IDPH Immunization Program distributes vaccine, conducts surveillance for vaccine preventable diseases, investigates disease outbreaks, conducts educational programs, assesses vaccine coverage levels, conducts quality assurance reviews of providers enrolled in the Vaccines for Children (VFC) Program, maintains the statewide immunization information system (ICARE) and sets vaccination requirements for day care facilities, schools and colleges/universities. The Title V and the Bureau of Child Care at IDHS jointly support a statewide network of Child Care Nurse Consultants (CCNC) who train and consult with child care providers. ***/2013/WIC Community Outreach and Partnership Coordinators with the Bureau of Family Nutrition participated in the "Let's Move Childcare" training and are also available as resources for the child care providers.***~~//2013/~~

The High Risk Infant Follow up Program, a component of FCM, serves infants with a high risk medical condition identified through the IDPH Adverse Pregnancy Outcomes Reporting System (APORS). Infants and families who experience a perinatal death are referred to local health departments for follow up visits by registered nurses, which may continue until the child's second birthday. Healthy Families Illinois (HFI) reduces new and expectant parents' risk for child abuse/neglect through intensive home visits to improve parenting skills, enhance parent-child

bonds and promote healthy growth and development. HealthWorks of Illinois (HWIL), another component of FCM, is a collaborative effort of IDHS and the Illinois Department of Children and Family Services (IDCFS) to ensure that wards of the state receive comprehensive, quality health care. /2012/ The IDPH Early Childhood Oral Health Program integrates oral health into MCH programs and Head Start throughout the state. In addition, IDPH has a HRSA grant that focuses on the development of comprehensive oral health programs at the local level with a specific emphasis on preventing and reducing the burden of early childhood caries the most severe form of dental decay. //2012// The IDPH Early Childhood Caries (ECC) program integrates oral health into every WIC and Head Start program in Illinois. In addition, IDPH has a HRSA grant that focuses on the development of comprehensive dental services at the local level with a specific emphasis on early childhood caries. **/2013//The IDPH Early Childhood Oral Health integrates oral health into MCH programs and Head Start. One focus of IDPH is on the development of comprehensive oral health programs at the local level with a specific emphasis on preventing and reducing the burden of early childhood caries which is the most severe form of dental decay.** //2013//The goal of the Child Safety Seat program is a reduction in automobile related injuries and fatalities among children under the age of four. The program makes a limited number of car seats available at no charge to low income families. Families are given instruction in the installation of the car seat. The program also works with state and local agencies to conduct car safety seat checks. IDPH also provides funding to Sudden Infant Death Services of Illinois to provide bereavement services for families and risk reduction education for health care providers and consumers.

The Title V program includes four infrastructure development projects that affect young children. The Fetal and Infant Mortality Review (FIMR) project reviews fetal and neonatal deaths in Chicago to identify social risk factors and recommend preventive interventions. The Title V program and many providers and child advocates work with the Illinois Early Learning Council to develop a comprehensive, coordinated system of high-quality preventive services for children before birth and through five years of age. Twelve All Our Kids (AOK) Early Childhood Networks were established by the Birth to Five Project to improve local systems of care for families with young children. The Enhancing Developmentally Oriented Primary Care (EDOPC) project identifies and overcomes the barriers that pediatric primary care providers face in conducting developmental, social-emotional, postpartum depression, and domestic violence screenings, making appropriate referrals and attending to parents' developmental concerns.

Middle Childhood - The IDPH Vision and Hearing Screening Program supports screening activities by local health departments, school districts or other contractors to identify children with possible problems. IDPH also coordinates ophthalmologic, optometric, otologic, and audiologic examination clinics throughout the state. **/2013//The Dental Sealant Grant Program works with interested communities to establish school-based programs for prevention dental care highlighted by examinations and application of dental sealants and fluoride varnish. School-based dental sealant applications, oral health education, outreach to All Kids enrollment, dental examinations, and case management for dental treatment needs are methods that can identify at-risk populations and provide services. Access to an oral health education curriculum for grades K-12 that has been aligned to the states learning standards is available through the oral health program communities for use in their schools.** //2013//The Dental Sealant Grant Program works with interested communities to establish school based programs for /2012/preventive dental care including dental sealant and fluoride varnish//2012// dental sealant applications, oral health education, outreach for All Kids enrollment, dental examinations, and referral for dental treatment needs. **/2013/ The program no longer offers fluoride varnish.** //2013// An oral health education curriculum for grades K-12 was evaluated by Illinois School Health Centers and is now offered through the sealant program communities for use in their schools. Coordinated School Health Program grants are provided to several local health departments and school districts to promote implementation of a Coordinated School Health Program model to address the health needs of students in grades K 12. The School Health program provides consultation and technical assistance to schools throughout the state and health care services to students in elementary and middle schools. Professional

continuing education programs for qualified school and public health nurses, social workers, health educators, and school administrators are conducted annually. Childhood asthma demonstration projects in Chicago use peer or community health educators to empower communities to address this complex health issue.

Adolescents - The Title V programs for adolescents include direct health care services through School Health Centers; projects to prevent teen pregnancy; transition services for CYSHCN, family support programs for pregnant and parenting teens; positive youth development and juvenile justice programs. The School Health Centers promote healthy lifestyles through health education and comprehensive direct physical, dental, and mental health services. Services are provided by licensed professional staff or through referral to local health care providers. Health centers that meet established standards are enrolled as Medicaid providers.

The Teen Pregnancy Prevention--Primary (TPPP) program provides support for community-based planning to reduce teen pregnancy, sexually transmitted infections and the transmission of HIV. This is done through education, service delivery and referrals appropriate to the age, culture and level of sexual experience of youth in classroom or community settings. Providers focus on three of the six program components: sexuality education, family planning information and referrals, youth development, parental involvement, professional development (e.g. teachers) or public awareness.

Title V services for teen parents: The Teen Parent Services (TPS) program is mandated for parents under 21 who are applying for or receiving Temporary Assistance for Needy Families (TANF) and who do not have a high school diploma or its equivalent and/or who receive Medicaid, WIC, FCM, or Food Stamps/**2013/SNAP//2013//**. TPS helps participants enroll and stay in school, and to transition from TANF or other public benefits to economic self-sufficiency. The program also helps clients to access other IDHS services. The Parents Too Soon (PTS) program helps new and expectant /2012/ first-time //2012// teen parents develop nurturing relationships with their children, avoid or delay subsequent pregnancy, improve their own health and emotional development and promote the healthy growth and development of their child(ren). Four PTS program sites provide Doula services to provide emotional support to women throughout the antepartum and postpartum periods. The Responsible Parenting program helps adolescent mothers between 13 and 18 years of age to delay subsequent pregnancies, consistently and effectively practice birth control, obtain a high school degree, develop parenting skills, and cope with the social/emotional challenges of pregnancy and parenting.

DCHP/2013/The DFCS provides prevention, diversion and intervention services targeting youth to support families in crisis, prevent juvenile delinquency, encourage academic achievement and to divert youth at risk of involvement in the child welfare and juvenile justice systems. The Division also funds a demonstration project to provide re-entry services for youth exiting juvenile correctional facilities.//2013// DCHP

/2013/DFCS//2013//provides support to the Illinois Juvenile Justice Commission, the Redeploy Illinois Oversight Board and the Illinois Juvenile Detention Alternatives Initiative (JDAI) Partners Group. The Division also funds community-based prevention initiatives and prevention training and education for youth in the areas of substance abuse and delinquency prevention, and volunteerism.

/2013/The Illinois Juvenile Detention Alternatives Initiative (JDAI) Partners Group no longer exists. //2013//

Children with Special Health Care Needs - The Title V program for CSHCN is operated by the University of Illinois at Chicago's (UIC's) DSCC. It serves approximately 24,000 children annually through the Core Program, the IDHFS Home Care Waiver Program, the SSI Disabled Childrens Program, and the Children's Habilitation Clinic.

/2012/ A new methodology which greatly reduces the possibility of duplicated cases, identified

almost 17,000 CSHCN served by DSCC. //2012//

The goal of DSCC's Core Program is to assure community based, family centered, and culturally sensitive provision of comprehensive care coordination services for eligible CSHCN and their families. Core Program services include comprehensive evaluation, specialty medical care, care coordination, and related habilitative/rehabilitative services appropriate to the child's needs, and financial support for those families who are financially eligible. The program serves children with impairments in the following categories: orthopedic, nervous system, cardiovascular, craniofacial deformities, hearing, organic speech, eye and urinary system, cystic fibrosis, hemophilia, and inborn errors of metabolism. Children with a potentially eligible condition receive diagnostic and care coordination services without regard to financial eligibility.

Initial diagnostic evaluation services are provided in part by a network of field clinics, consisting primarily of orthopedic clinics, administered and funded by DSCC, and through office visits with private physicians and other freestanding clinics.

DSCC has 13 regional offices with additional satellite offices. Care coordinators (nurses, social workers, and speech pathologists/audiologists) develop an Individual Service Plan (ISP) for each child or youth to identify needed services and financial support. With the parents' permission, the ISP is shared with the child's or youth's medical home provider and other providers.

Families of children requiring financial support must have a total income below 285 percent of the federal poverty level. All families must maximize existing health insurance benefits before financial assistance can be provided. Families of uninsured CYSHCN who meet All Kids financial requirements are required to enroll in All Kids in order to receive financial assistance from DSCC. Children/youth with All Kids coverage receive care coordination to assist them in accessing services and limited financial assistance for services not covered by All Kids.

DSCC employs several Spanish-speaking staff and has written materials available in Spanish. Families whose primary language is not English or Spanish may use the AT&T Language Line. In addition, the FAC membership represents multiple cultures in providing input into DSCC initiatives and materials.

DSCC operates the Title XIX Waiver for Home and Community Based Services for Medically Fragile/Technology Dependent (MF/TD) Children, which is administered through the IDHFS. The program provides care coordination and cost effective supportive home services to children with complex medical needs who would otherwise be at risk of prolonged institutionalization or re-institutionalization in a hospital or long term care facility.

DSCC is the agency designated to administer the Supplemental Security Income-Disabled Children's Program (SSI-DCP). Children are determined to be medically eligible for this program through the Illinois Disability Determination Services (IDDS), which in turn refers SSI-eligible children to DSCC for further assistance. DSCC provides information and referral services to children who are SSI eligible by sending the family information in English and Spanish about the DSCC Core Program, and provides a toll free number for information and assistance. DSCC telephones families with children ages three to four to offer assistance in linking to appropriate resources, including Part B Early Childhood and Pre-Kindergarten for Children at Risk. Families with children ages 14-16 who are SSI-eligible also receive a telephone call to offer assistance in linking them to appropriate resources, including transition planning resources.

The Children's Habilitation Clinic /2012/ (CHC) //2012// is located within the Children and Adolescent Center of the Outpatient Care Center, UIC's comprehensive outpatient facility. This location allows clinic staff to collaborate with other sub specialists and with primary care physicians and nurse practitioners. Staff provides comprehensive diagnostic services and developmental management for children with complex disabling conditions through age 21.

DSCC co-sponsors the Institute for Parents of Preschool Children Who are Deaf or Hard of Hearing with IDPH, IDHS, the Illinois School for the Deaf, and ISBE. This is a week-long educational program for parents of children, ages birth to five, who have a significant hearing loss. The Institute also provides multidisciplinary evaluations.

To promote access to medical homes for CYSHCN, DSCC facilitates Quality Improvement Teams (QIT) by providing a trained facilitator to promote quality improvement in primary care practice settings, and learning sessions for new QITs. CYSHCN who are not enrolled in DSCC and who are enrolled in the All Kids program have a medical home with a Primary Care Provider (PCP) through the statewide Primary Care Case Management (PCCM) Program with Illinois Health Connect.

DSCC is represented on the Illinois Interagency Council on Early Intervention (IICEI). Care coordination is provided for families with children jointly enrolled in DSCC and EI program to coordinate between EI and DSCC to meet the child's medical and developmental needs. DSCC financial assistance is provided for specified medical services for families who are financially eligible (i.e., surgery, medications, durable medical equipment and supplies).

As a member of the Illinois Interagency Coordinating Council on Transition, DSCC is collaborating to develop a statewide plan to improve access to and availability of comprehensive transition services. Council members sponsor an annual statewide conference for all transition stakeholders. Other members of the Council represent state agencies in the following areas: education, corrections, employment/training, health, and human services.

DSCC publishes two editions of the "Special Addition" newsletter annually, which focuses on state and local topics of interest to families of children and youth with special health care needs. The newsletter is mailed to 8,000 families and is available to the public on the DSCC website.

Other Services for Adults - The Title V program supports or collaborates with several programs for adults. Parents Care and Share of Illinois conducts support groups across the state for parents. The Bureau of Domestic and Sexual Violence Prevention administers domestic violence and sexual abuse prevention programs throughout the state, offering comprehensive, community based services that meet the immediate and long term needs of victims and their children.

Infrastructure Building - Strong Foundations is designed to develop a statewide system of home visiting. ***/2013/By design at the federal level, Strong Foundations has been folded into the Maternal, Infant and Early Childhood Home Visiting Program (MIECHVP) to build enhanced support and infrastructure for home visiting services to families and young children in at-risk communities across the state. The Illinois Early Learning Council provides support and guidance to the MIECHVP./2013/***The Chicago MCH Mini Block Grant to the CDPH supports direct and enabling services to pregnant women, children, and women of reproductive age. Illinois' Title V program leads the work of the following advisory bodies and task forces: The Maternal and Child Health Advisory Board advises IDHS regarding the Family Case Management program and other activities related to maternal and child health and infant mortality reduction programs. The Family Planning Advisory Committee advises IDHS on family planning policy and program operations. The Universal Newborn Hearing Screening Advisory Committee, which advises IDHS, IDPH and DSCC on the newborn hearing screening program and develops training for hospitals, ensures referrals to the EI program and provides public information on congenital hearing loss. Illinois Interagency Council on Early Intervention, provides advice to DHS' Early Intervention program. ***/2012/*** The Early Intervention Task Force (established for a limited time and as a separate body from the Interagency Council) is conducting a comprehensive review of EI system. ***/2012/*** The Nutrition Services Advisory Committee advises IDHS on operation of the WIC program and coordination of nutrition programs. ***/2013/ The Interagency Nutrition Council, co-chaired by the Chief of the Bureau of Family Nutrition, is a statewide multidisciplinary organization with representatives from a variety of public, private, not-for-profit organizations working with the WIC program to promote health and wellness***

through nutrition education, coordination of services and access to nutrition programs, so that Illinois residents can achieve food security. The Bureau Chief facilitates the INC along with the Illinois Hunger Coalition, and members include food assistance programs in state agencies including DHS, Illinois State Board of Education, Department on Aging, Department of Public Health, Department of Agriculture, Department of Commerce and Economic Opportunity, the University of Illinois Extension (EFNEP and SNAP Ed) and our community partners including the Hunger Coalition, food banks, CLOCC, School Food Service Association, etc. In addition to INC, the Commission to End Hunger was established and began meeting in June 2011. They have published a report which was released in March 2012 and launched the No Kid Hungry Campaign. The priorities of the campaign are to increase participation in the school breakfast program and the summer feeding program. //2013// The Illinois Juvenile Justice Commission assures that youth who come into contact or may come into contact with the child welfare and the juvenile justice systems will have access to needed community, prevention, diversion, emergency and independent living services. The Redeploy Illinois Oversight Board encourages the deinstitutionalization of juvenile offenders by establishing projects in counties or groups of counties that reallocate State funds from juvenile correctional confinement to local jurisdictions. The Domestic Violence Advisory Council advises the Department on domestic violence prevention and treatment. The Council on Responsible Fatherhood was created to study social policies and practices regarding the value that each parent brings to the family unit.

Illinois' Title V program is represented on the following advisory committees and task forces: The Medicaid Advisory Committee advises the IDHFS regarding the services provided under the department's Medical Programs. The Illinois Early Learning Council coordinates existing programs and services for children from birth to five years of age. The State Board of Health advises the Director of Public Health regarding the core functions of needs assessment, goal setting, policy development and assurance of access to necessary services. The Perinatal Advisory Committee advises the director of Public Health on the operation of Illinois' regionalized perinatal care system. The Task Force on Chronic Disease Prevention and Health Promotion makes recommendations to the director of Public Health regarding the structure of chronic disease prevention and health promotion and the integration of efforts to ensure continuity of purpose and the elimination of disparity in the delivery of care. The Health Data Task Force works to create a system for public access to integrated health data. Illinois Health Policy Center Advisory Panel develops health policy to address critical issues facing the state. The Illinois Local Food, Farms and Jobs Council serves as a forum for discussing food issues, fosters coordination between local communities and sectors in the food system, builds local farm and food networks, supports and implements programs and services that address local needs. **//2013/ The Farmers Market Network serves as a bridge between the Bureau of Family Nutrition programs and Illinois Farmers as well as others interested in promoting Illinois farming. The Farmers Market Network statewide organization of local farmers, farmers market masters and community leaders, their work informs the Bureau on issues related to the successful training of farmers participating in the Farmers Market Nutrition Programs and use of the electronic benefit transfer system at local farmers markets. //2013//** The Parents and Community Accountability Study Committee studies racial and socioeconomic issues related to children. The Committee of Cooperative Services advises the State Superintendent of Education on the statewide development, implementation, and coordination of alternative learning opportunities programs to improve the educational outcomes of students at risk of academic failure through the coordinated provision of education, health, mental health, and human services. The School Success Task Force makes recommendations related to current State Board of Education policies regarding suspensions, expulsions, and truancies. The Commission on Children and Youth is charged with creating a five-year strategic plan to provide services to youth 0-24 years.

Despite the numerous resources committed to improving maternal and child health, there are significant challenges to Illinois' ability to maintain the level of service delivery experienced by mothers, infants, children and adolescents in the past. At the state administrative level,

individuals responsible for program policy and administration face staff shortages and salary cuts prompting several seasoned employees to leave public services. Efforts to fill vacancies continue in an environment of severe budget constraints. At the local level, many longtime MCH providers are divesting themselves of critical state-funded programs, (e.g. FCM and EI). Significant cuts in funding and delays in payment are the principle reasons cited.

CULTURAL COMPETENCE - The Title V program has several mechanisms to ensure that the assessment of need and allocation of resources at the state level and the delivery of services at the community level are culturally sensitive, relevant and competent. The Title V program analyzes and reports information by racial and ethnic subgroups in order to detect disparities in health status and allocate resources accordingly. The needs assessment presented with the FFY'11 application reflects more extensive participation by service providers and consumers than Illinois' Title V program has previously obtained. In addition, the State of Illinois has adopted guidelines on linguistic and cultural competence "as a mechanism for improving language and cultural accessibility and sensitivity in State-funded direct human services delivered by human service organizations that receive grants and contracts to serve the residents of the State of Illinois." Each new Request for Proposals issued by the State requires potential vendors to present a plan for improving access to culturally competent programs, services, activities for LEP customers, persons who are hard of hearing or deaf, and persons with low literacy. Service providers must adhere to specific guidelines and provide to consumers in their preferred language both verbal and written notices of their right to receive language assistance services that are culturally appropriate. Finally, the DCHP's training contractors routinely offer cultural competence training to community-based providers.

C. Organizational Structure

Please see the attached organizational chart. The Governor has designated the IDHS as the state health agency responsible for the administration of the MCH Services Block Grant in Illinois (in a letter from Governor Edgar to Secretary Shalala, June 10, 1997). Through an interagency agreement, MCH Services Block Grant funds are transferred to the IDPH for the administration of the Vision and Hearing Screening, Oral Health, Genetics, Illinois Lead Program and Perinatal Care programs. In compliance with federal law, IDHS transfers 30 percent of Illinois' MCH Services Block Grant funds to DSCC for services to CSHCN. Copies of current interagency agreements are on file in the Division of Community Health and Prevention. Additional information about the structure of these three agencies is presented below.

The Illinois Department of Human Services - The IDHS is organized into six divisions. The Division of Community Health and Prevention (DCHP) includes the family planning, infant mortality reduction, early childhood services (Early Intervention), WIC, school health, teen pregnancy prevention, teen family support, child abuse prevention, substance abuse prevention, domestic violence prevention and intervention, sexual assault prevention and response, youth services, and delinquency prevention programs. The Division of Developmental Disabilities includes the SSI Disability Determination Service and programs for persons with developmental disabilities. The Division of Human Capital Development includes adult employment, income assistance, food and shelter, refugee services and child care and is responsible for the Department's local offices. One or more local offices, called Family and Community Resource Centers, are located in almost every county of the state. Staff in these offices perform intake and eligibility determination for TANF, Food Stamps, Medicaid, SCHIP and other programs. The Division of Alcoholism and Substance Abuse is responsible for substance abuse treatment services. The Division of Mental Health is responsible for the state's system of community-based mental health care as well as psychiatric hospitals. The Division of Rehabilitation Services oversees the state's system of care for persons (mostly adults) who are physically challenged.

The Division of Community Health and Prevention is organized into five functional areas: Reproductive and Early Childhood Services, Youth and Adult Services, Community Support

Services, Fiscal Services, and Program Planning and Development. The responsibilities of each functional area are described below.

Illinois' Title V program is housed in the Reproductive and Early Childhood Services unit. The Bureau of Maternal and Infant Health is responsible for the Family Planning, Family Case Management, Chicago Healthy Start, Targeted Intensive Prenatal Case Management, Early Childhood Comprehensive System Development (including the AOK Networks and the Healthy Child Care Illinois project), Project LAUNCH, HealthWorks, Pediatric Primary Care, High-Risk Infant Follow-up, the Chicago Doula Project and Fetal and Infant Mortality Review programs, as well as the "Mini Block Grant" to the Chicago Department of Public Health. The Bureau of Part C Early Intervention is responsible for Illinois' services under Part C of the federal Individuals with Disabilities Education Act. The Bureau of Family Nutrition is responsible for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and related programs. The Nutrition Services Section in the Bureau of Family Nutrition is comprised of regional nutrition consultants, two state community outreach and partnership coordinators, two a state breastfeeding coordinator, and a state nutrition coordinator. All are Registered Dietitians and most are Master's trained, with expertise in maternal and child health. The section provides consultation and technical assistance on nutrition issues for the WIC and other MCH programs. The Bureau of Community Health Nursing has a staff of Master's prepared Maternal and Child Nurse Consultants who are distributed regionally throughout the state. The MCH Nurse Consultants conduct confidential medical chart audits including evaluation of client assessments, and overall coordination of medical care. Services are delivered in a variety of settings including health departments, hospitals, child care facilities, perinatal centers, schools, specialty clinics, federally qualified health centers, and community-based agencies. They also provide in-service training, continuing education programs and technical assistance for local agency staff, and integrate nursing expertise with DCHP programs.

Within Youth and Adult Services, the Bureau of Child and Adolescent Health is responsible for the Teen Parent Services, Parents Too Soon, Healthy Families Illinois, School Health, Subsequent Pregnancy Project, Parents Care and Share, Teen Pregnancy Prevention, Responsible Parenting programs, child safety seat distribution and checks. The School Health program includes the Coordinated School Health program, School Health Centers and continuing education programs for school health personnel. The Bureau of Youth Services and Delinquency Prevention offers prevention, diversion and intervention services targeting youth to support families in crisis, prevent juvenile delinquency, encourage academic achievement and to divert youth at risk of involvement in the child welfare, and juvenile justice. The Bureau of Community-Based and Primary Prevention is responsible for the Teen Pregnancy Prevention -- Primary Program, as well as the substance abuse prevention program, delinquency prevention, and volunteerism. These programs all target the general population or those at some risk; are provided in multiple domains (youth, families, schools and community settings); are aimed at multiple age groups; and utilize a variety of approaches (e.g., parent education, positive youth development, etc.).

Each DCHP-funded provider is assigned a Community Support Services Consultant (CSSC) as their primary liaison to the Division. Each of the five DHS Regions has a Regional Administrator who oversees the activities of the CSSCs and is responsible for coordinating the delivery of needed supports to providers. Regional Administrators and CSSCs assure that support is provided to Maternal and Child Health programs at the regional and community level in a way that is sensitive to the needs of clients and communities. At the community level, this is accomplished by partnering with community-based agencies. Accountability for Division programs is accomplished by performing required compliance monitoring and quality review of Division programs. CSSCs are liaisons between communities and CHP programs, assuring that provider needs are assessed and met on an on-going basis, so that quality service delivery is consistently achieved.

The Bureau of Fiscal Support Services is responsible for preparing contracts with more than 600

organizations each year to implement the Division's programs. The Bureau manages funds from more than 40 General Revenue Fund appropriations and 30 federal grants, giving the Division the most complex budget in the Department.

The Program Planning and Development unit is responsible for strategic planning, development and submission of applications for federal and foundation funds, and providing the information required for managing the performance of the Division's programs. Within Program Planning and Development, the Bureau of Performance Support Services (PSS) performs a variety of activities related to the collection, maintenance, and evaluation of community health and prevention data, and the development and presentation of training sessions to enhance the skills of prevention service providers.

The Division's bureaus and regional consultants have established a statewide network of comprehensive, community-based systems of health and social services for women of reproductive age, infants, children and adolescents to assure family-centered, culturally competent and coordinated services.

/2012/ The merger of the DCHP and DHCD has begun. As of now the various subdivisions will be pulled together with very few changes in administration. Day to day operations continue as before and leadership has not changed. Staff persons have been named to teams to help oversee key aspects of the merger. More will be known in the coming weeks and months as these teams move forward with their work. The intent is to complete the merger by January 1, 2012. //2012//

/2013/On 1/1/12 the Division of Community Health and Prevention and the Division of Human Capital Development were combined into a single, new division called the Division of Family and Community Services (DFCS). All programs and services housed in the two former Divisions continue to be provided but the reorganization has resulted in some realignment of programs. The new DFCS is organized into 6 Offices, each of which comprises multiple Bureaus. The Office of Family Wellness includes the Bureau of Family Nutrition and the Bureau of Maternal and Child Health (BMCH). The Office of Early Childhood includes the Bureau of Child Care and Development and the Bureau of Childhood Development (BCD). The Office of Community and Positive Youth Development includes the Bureau of Positive Youth Development (BPYD) and the Bureau of Youth Intervention Services. The Office of Family and Community Resource Centers (FCRC's) and Workforce Development Policy includes the Bureau of Training and Development; the Bureau of Policy Development; the Bureau of Family and Community Resource Centers; the Bureau of Local Office Transaction and Support Services; the Bureau of Workforce Development; and the Bureau of Supplemental Nutrition Assistance Program (SNAP) Integrity. Finally, the Office of Program Support and Program Evaluation includes the Bureau of Planning and Evaluation; the Bureau of Performance Management; the Bureau of Program Support and Fiscal Management; and the Bureau of Community Support Services.

The BMCH houses all programs from the former Bureau of Maternal and Infant Health, including the Title V program, with the exception of Project LAUNCH and Healthy Families Illinois, both now under the new BCD. The BMCH has also taken on the SNAP Education program. The Bureau of Family Nutrition retains its former name and is still responsible for the WIC and related programs. The School Health program is now also housed in this bureau. Part C Early Intervention is now under the BCD. All pregnancy prevention programming is now in the BPYD.//2013//

Information and Referral Helpline - The MCH Helpline staff answer two 800 lines: 1) 800/545-2200 (MCH); and 2) 800-843-6154, option #5 (IDHS Customer Service Line). The staff of two field about 1,000 calls per month, including Spanish-speaking calls. The MCH Helpline staff handle calls on a wide variety of health and human service needs. About 65 percent of the calls

are from the general public, and about 35 percent are local agency personnel. The automated WIC/EI Referral Line assists approximately 1,700 callers per month with locating their local WIC and/or EI office.

The University of Illinois at Chicago Division of Specialized Care for Children - DSCC administers the CSHCN program. The DSCC Director reports to the CEO of the UIC Healthcare Systems. DSCC is staffed to accomplish its traditional role of providing care coordination, accessing financial support for needed services, and advocating for high quality specialty services for CSHCN. Through a network of 13 regional offices and over 30 satellite locations, DSCC maintains a strong focus on family centered, community based care coordination activities and local systems development within all 102 counties in Illinois.

The Director of DSCC has access to consultation and assistance from the University of Illinois at Chicago, including a school of public health and colleges of medicine, nursing, allied health professions and education, as well as numerous associated health facilities and programs. A statutory Medical Advisory Board composed of medical community leaders from across the state and a family representative meet three times per year to counsel the Director on program policy and activities. In addition, consultation and assistance is also available from the DSCC Family Advisory Committee (FAC) that meets three times per year and has family member representation from all 13 regions of the state. The FAC Chairperson also serves as the family member representative on the DSCC Medical Advisory Board.

Frequent, close liaison is maintained with all major public and private agencies involved in services for CYSHCN. DSCC has leadership and/or membership involvement with the following CYSHCN related programs or activities: Illinois Chapter of the American Academy of Pediatrics Committee on Children with Disabilities, the Illinois Maternal and Child Health Coalition, Illinois Interagency Council on Early Intervention, Coordinating Council on Transition, Brain and Spinal Cord Injury Advisory Council, Illinois Universal Newborn Hearing Screening Advisory Committee, Illinois Genetics and Metabolic Diseases Advisory Committee, IFLOSS (Coalition for Access to Dental Care), and the Healthy Child Care Illinois Steering Committee. DSCC has /2012/ three //2012// four delegates, including a staff parent representative, to the Association for Maternal and Child Health Programs (AMCHP). DSCC staff attend the annual meetings to stay abreast of national issues.

In addition to senior DSCC staff participation on interagency boards, councils and task forces at the state level, regional office staffs have developed and participate in numerous community working groups that involve local leaders and parent groups. These activities are exemplified by the regional staff involvement in the AOK Early Childhood Networks, the Illinois Project for Local Assessment of Needs (IPLAN) process, Early Intervention Local Interagency Councils and Transition Planning Committees./2012/ These activities are exemplified by the regional staff involvement in the AOK Early Childhood Networks, Illinois Project for Local Assessment of Needs (IPLAN) process, Early Intervention Local Interagency Councils, and Transition Planning Committees.//2012//

The Illinois Department of Public Health - As a result of the reorganization of state human service agencies in 1997 (20 ILCS 1305), IDPH retains responsibility for the following statutes and MCH programs: the Phenylketonuria Testing Act, which supports the newborn metabolic screening program; the Counties Code, which supports the Sudden Infant Death Syndrome Program; the Illinois Lead, which supports the Childhood Lead Poisoning Prevention Program; and the Prevention of Developmental Disability Act, which supports the Perinatal Program. IDPH also operates the Vision and Hearing Screening Program, the Newborn Hearing Screening Registry and the Oral Health Program. IDHS and IDPH annually execute an interagency agreement regarding the coordination of MCH services provided or funded by each agency.

Illinois Department of Healthcare and Family Services (IDHFS) -- The IDHFS Bureau of Maternal and Child Health Promotion (BMCHP) has a focuses on preventive maternal and child health

services and partners with other state agencies, advocacy groups, private funders, provider organizations, academia, and interested parties to achieve maternal and child health goals.

For additional information on Illinois' Maternal and Child Health Program, please visit the DCHP web site (www.dhs.state.il.us/page.aspx?item=31754), the DSCC web site (www.uic.edu/hsc/dsc), the Illinois Early Hearing Detection and Intervention Program www.illinoisoundbeginnings.org the IDPH web site (www.idph.state.il.us) or the IDHFS Bureau of MCH Promotion web site (www.hfs.illinois.gov/mch).

An attachment is included in this section. IIC - Organizational Structure

D. Other MCH Capacity

Illinois Department of Human Services./2012/ Glendean Sisk RN, CRADC, MPH is the Acting Associate Director for Reproductive and Early Childhood Services, Division of Community Health and Prevention, and serves as Acting Illinois' Title V Director. As Acting Associate Director, Ms. Sisk supervises the Bureau Chiefs of the four bureaus within that functional unit --the bureaus of Family Nutrition; Maternal and Infant Health; Maternal and Child Health Nursing; and Early Intervention. ***/2013/Since the merging of the Division of Community Health and Prevention with the Division of Human Capital Development, Ms. Sisk is now the Acting Associate Director, Office of Family Wellness, Division of Family and Community Services./2013/*** In her position as Acting Title V Director, Ms. Sisk is responsible for developing Illinois' State Plan for maternal and child health, and the MCH Block Grant, Title X and Title XX funded family planning programs, and other federal grants; and for directing and coordinating the policy and activities required to carry out a statewide program in maternal health, family planning and child health including prenatal and pre-conceptional care, perinatal services, and MCH evaluation studies.

Ms. Sisk received her Bachelor's in Nursing from Northern Illinois University and a Master's in Public Health degree from Loma Linda University. She is a Registered Nurse and has an extensive background in Maternal and Child Health. She has served and worked in areas of obstetrical/gynecological nursing, substance abuse treatment, mental health, adolescent health, domestic violence and health education. Ms. Sisk has been a certified Alcohol and Drug Abuse Counselor since the mid-80's./2012// Myrtis Sullivan, M.D., M.P.H., was appointed Associate Director for Reproductive and Early Childhood Services, Division of Community Health and Prevention, and serves as Illinois' Title V Director. As Associate Director, Dr. Sullivan supervises the Bureau Chiefs of the four bureaus within that functional unit -- the bureaus of Family Nutrition; Maternal and Infant Health; Maternal and Child Health Nursing; and Early Intervention. In her position as Title V Director, Dr. Sullivan is responsible for developing Illinois' State Plan for maternal and child health, and the MCH Block Grant, Title X and Title XX funded family planning programs, and other federal grants; and for directing and coordinating the policy and activities required to carry out a statewide program in maternal health, family planning and child health including prenatal and pre-conceptional care, perinatal services, and MCH evaluation studies.

Dr. Sullivan received her M.D. and M.P.H. degrees from the University of Illinois at Chicago. She is a licensed pediatrician, and has an extensive background in Maternal and Child Health. She has served and worked in areas of pediatric emergency services, environmental health, asthma, breastfeeding promotion, and community-based collaborative research. Dr. Sullivan has authored and coauthored several books/chapters, journal articles, and various published reports and abstracts pertaining to health and medicine practices, pediatrics, and community-based collaboratives.

/2013/Dr. Sullivan has retired from State government. Glendean Sisk now serves as Acting Illinois' Title V Director, and as Acting Associate Director, Office of Family Wellness, which, since the 1/1/12 merging of the former divisions of Community Health and Prevention and Human Capital Development, now houses Illinois' Title V program./2013//

//2013/ Although the Division in which the Title V program has been merged with another, larger division, and the total number of full-time employees in the Division is now significantly larger (nearly 3,000) than it was previously, there is a contingent of approximately 170 FTE positions in the Division of Community Health and Prevention/2013/Division of Family and Community Services that continue to support the Maternal and Child Health program in Illinois. These 170 positions include//2013//There are approximately 75 FTE positions at the central office in Springfield. Regional staff are deployed as follows: Region 1 (Chicago) 60 FTEs; Region 2 ("collar counties" and northern Illinois) 10; Region 3 (north central Illinois) 10 FTEs; Region 4 (south central Illinois) 5 FTEs; and Region 5 (southern Illinois) 10 FTEs. Regional staff are generally Masters prepared maternal and child health nursing consultants, nutrition consultants and regional representatives involved in quality assurance and technical assistance and support for local providers and communities.

The MCH Nurse Consultants carry out public health core functions of assessment and policy development, and work with individuals, families and communities at the local and state levels, to assure quality in delivering MCH clinical programs. They participate in assessing community needs, and provide professional direction and leadership to nurses and allied health personnel delivering technical assistance services. The MCH nurses provide consultation to contracting agencies and local health departments in developing quality assurance programs. They work with school based health centers in developing medical records systems, and implementing family planning services. MCH Nurse Consultants provide nursing expertise and leadership in updating standards and enforcing regulations (codes and contractual specifications, with emphasis on programs such as Title V, WIC, Title X, Title XIX, Title XX , health plan requirements for pediatric, perinatal specialists services and criteria for out-of --plan referrals, regional networks coordination for special populations. MCH Nurse Consultants participate in program management activities, including assessing, certifying, and assuring quality services delivery to seven clinical programs operated by the Division of Community Health and Prevention.

//2013/Bureau of Family Nutrition Nutritionist Consultants provide expertise, guidance and interpretation of the Federal Regulations related to the WIC, WIC and Senior Farmers Market Nutrition Programs, SNAP Nutrition Education and the Commodity Supplemental Food Program. Nutritionist Consultants develop the state policies and procedures, review and provide guidance to grantees to ensure local policy, procedure and practice is in compliance with all state and federal requirements and program integrity is maintained.//2013//

Mr. Thomas F. Jerkovitz, M.P.A, C.P.A. was appointed Director of DSCC on November 16, 2009. Mr. Jerkovitz received his B.A. and M.P.A from the Pennsylvania State University. Mr. Jerkovitz gained extensive knowledge and administrative experience with large, complex children's health programs through a longstanding career in Illinois state government. He served in the Governor's Office as Senior Policy Advisor for Health and Human Services. In addition, Mr. Jerkovitz spent time in the Governor's Bureau of the Budget as the Division Chief for the Medical, Child Welfare and Health and Human Services Programs with responsibility for policy direction and fiscal management. He also served as the Executive Director of the Illinois Comprehensive Health Insurance Plan (ICHIP), a high-risk health insurance pool which had an annual expense of \$150.0 million and provided coverage for more than 16,000 individuals. Immediately before joining DSCC, Mr. Jerkovitz was the Director of Finance for Health Alliance Medical Plans, Inc.

Currently DSCC employs 180 FTEs to provide enabling services from local offices in the DSCC regional office system and 63 FTEs ***//2013/ 58 FTEs //2013//*** in the Springfield central administrative office. The administrative office located at UIC in Chicago employs 5 FTEs and CHC employs 4.2 FTEs. DSCC employs one full time Family Liaison who works with the FAC, trains care coordination teams and provides parent outreach. The University is currently operating under a hiring freeze due to the state's budget; DSCC is filling only those positions providing direct care coordination services.

E. State Agency Coordination

For a description of the organizational relationship among Illinois' human services agencies directly involved in the Title V program, please refer to "Organizational Structure," above. Interagency agreements among IDHS, IDHFS, IDPH and DSCC are on file at the Division of Community Health and Prevention's ***/2013/Division of Family and Community Services//2013/***headquarters in Springfield.

Other Divisions within the IDHS. The DCHP ***/2013/DFCS//2013/***collaborates with other Divisions within IDHS to improve the coordination and effectiveness of Title V programs, as follows:

DCHP and the Division of Human Capital Development collaborate to help TANF families through intensive casework services that connect them to IDHS programs and benefits and to local community resources where other services are provided. The two divisions also jointly finance Healthy Child Care Illinois, described later. ***/2013/Please see Organizational Capacity for a description of the merger of these two divisions as of 1/12/12.//2013/***

DCHP ***/2013/DFCS//2013/***and the Division of Mental Health work to integrate service systems to provide mental health and support services to children and their families. Both Divisions are active participants in the Illinois Children's Mental Health Partnership and the Illinois Children's Trauma Coalition, and are involved in Illinois' "Project LAUNCH" grant.

To enhance continuity of care for CSHCN, DSCC collaborates with IDHS' Division of Rehabilitation Services in vocational rehabilitation services for clients; home services programs to avoid unnecessary institutionalization; education and habilitative services for children requiring education programming outside their communities; independent living programs; referral process for children determined medically eligible for SSI, and transition of DSCC Home Care Waiver children to the DRS Home and Community-Based Services Waiver Program.

Through systems change efforts, DSCC and DRS have increased collaborative efforts targeted at transition planning for YSHCN. Additionally, a three-agency agreement is in place between DSCC, DRS, and IDHFS to facilitate the transition of youth from the Home and Community Based Services (HCBS) waiver operated by DSCC for children who are medically fragile/technology dependent to the Home Services Program, another Home and Community-Based Services waiver operated by the DRS.

Illinois' mechanism for families of individuals with developmental disabilities to make their needs known and help them access services. PUNS continues to be used by the IDHS Division of Developmental Disabilities to identify and provide services to children and adults most in need. DSCC care coordination staff informs families about the benefits of completing a PUNS assessment and refers families to the intake entities in their area.

DSCC maintains a Memorandum of Understanding with the Part C Early Intervention program to coordinate activities and is designated in state law as a member of the Illinois Interagency Council on Early Intervention. In addition, DSCC provides training and technical assistance for Early Intervention Service Coordinators.

Through an interagency agreement, the Illinois School for the Deaf, Part C Early Intervention program, IDPH, ISBE, and DSCC collaborate to provide the annual Institute for Parents of Preschool Children Who Are Deaf or Hard of Hearing, to enhance the knowledge of parents of infants and toddlers and provide multi-disciplinary evaluation. Since 2004, DSCC provides family scholarships to families who attended the Institute to supplement the loss of income because of the weeklong commitment.

IDHS and DSCC coordinate with other State agencies as described below:

Illinois Department of Healthcare and Family Services - IDHS and IDHFS have an Interagency Agreement for the coordination of Title V, Title XIX, and Title XXI program activities. This agreement allows each agency to refer eligible clients to the other for services. The two agencies have a separate agreement for the Family Case Management initiative that enables IDHFS to claim federal matching funds through the Medicaid program for outreach and case management activities conducted by the FCM program. IDHS and IDHFS have arranged for local health departments to claim federal matching funds through the Medicaid program for local expenditures that support the FCM program.

Local MCH programs, including local health departments, family planning clinics, and WIC agencies are serving as outstations for initiating the All Kids (Title XIX and Title XXI) application process for children under 19 years of age, their caretakers and for pregnant women. An annual notice is mailed to all families eligible for Title XIX or Title XXI (except individuals residing in long-term care facilities) to inform them of the WIC program and provide them with the Department's Health and Human Services hotline number.

Public/Private Partnerships - IDHFS works with several private foundations to use grant funds to operate pilot projects to improve birth and health outcomes. The projects involve partnerships with academia, advocacy organizations, provider organizations, providers, and other state agencies. Each project includes an evaluation component to identify issues affecting quality of care or test the efficacy of a particular intervention in improving birth and health outcomes, before being considered for statewide implementation.

Perinatal Health Status Report - Public Act 93-0536 (305 ILCS 5/5-5.23, enacted August 18, 2003) requires the IDHFS to submit a biannual report to the General Assembly concerning "the effectiveness of prenatal and perinatal health care services reimbursed under this section [the Illinois Medicaid program] in preventing low birth weight infants and reducing the need for neonatal intensive care..." The most recent report, published January 1, 2010, reviews the current status of Medicaid initiatives to promote perinatal health, including planned pregnancies, preconception risk assessment, the Healthy Births for Healthy Communities interconceptional care pilot, a comprehensive perinatal depression initiative, smoking cessation, and breastfeeding. The 2010 report also includes IDHFS' plans for implementing three new models of care to improve perinatal health. Each model will utilize care guidelines, actionable steps, provider training, care coordination, and appropriate referrals. The preconception care model for all women will focus on promotion of preconception care, provider training, technical assistance, and patient education. The high-risk prenatal care model will target women who have had previous poor birth outcomes or who have risk factors that contribute to poor birth outcomes. Important components of this model include a reimbursement strategy for care coordination and medical management of high-risk women, clinical indicators, provider feedback, patient education and engagement, case management that includes life and reproductive health goals, coordination with DHS' FCM program and integration with the Perinatal System. The high-risk preconceptional/interconceptional care model will target women who have had a recent poor birth outcome. The model will focus on health education, addressing chronic health conditions, assuring that women set reproductive and life planning goals, and increasing interpregnancy spacing through intensive pre- and interconceptional care interventions. The Perinatal Report can be viewed on the IDHFS Web site at: <http://www.hfs.illinois.gov/mch/report.html>

//2013/ The 2010 report identifies steps IDHFS has taken with its partners (other State agencies, advocate groups, MCH experts, local funding resources & others) to address perinatal health care needs & racial health disparities in Illinois; detail progress made in addressing priority recommendations as outlined in the 2004 Report to the General Assembly as a result of Public Act 93-0536; review trend data on IM, LBW & VLBW outcomes; identify progress made to address poor birth outcomes through analysis of trend data; identify next steps to improve birth outcomes. //2013//

The IDHFS and IDHS partner with the University of Illinois at Chicago and the NorthShore University HealthSystem to operate a comprehensive perinatal depression initiative, including reimbursement for risk assessment, a consultation service, provider training and technical assistance, a perinatal antidepressant medication chart, a 24-hour crisis hotline, and treatment and referral resources.

The IDHFS and IDHS partner with the Illinois Children's Mental Health Partnership and the University of Illinois at Chicago to offer Illinois DocAssist, a psychiatric phone consultation for primary care providers, nurses, nurse practitioners and other health professionals to screen, diagnose and treat the mental health and substance use problems of children and adolescents up to age 21. The service is available to providers who are enrolled in any medical program administered by IDHFS. Illinois DocAssist provides problem-based consultations and continuing medical education (CME) credit for training on behavioral health topics via in person workshops and web-based clinical resources. The program also provides identification of community resources for children and adolescents who require assistance outside the primary care setting. ***/2013/ This partnership now includes only the University of Illinois at Chicago and the IDHFS. //2013//***

Fluoride Varnish for Young Children/Bright Smiles From Birth - IDPH, IDHFS and the Illinois Chapter American Academy of Pediatrics implemented a project to train physicians to apply fluoride varnish to young children (under age three who have at least four erupted teeth) in the course of regular well-child visits. The goal of the Bright Smiles from Birth (BSFB) pilot project is to */2012/*reduce early childhood caries and to improve access to dental care *//2012//*for young children (under age three). BSFB is currently operating in Cook County, the "collar counties," Rockford and Peoria ***/2013/& the whole state//2013//***. Providers (physicians, nurse practitioners, ***/2013/ local health departments, //2013//*** FQHCs and hospital outpatient clinics) are trained by ICAAP to perform oral health screening, assessment, fluoride varnish application, anticipatory guidance, and make referrals to a "dental home" for follow-up dental care, and establishment of ongoing dental services. ICAAP works in partnership with the American Academy of Pediatric Dentistry to perform the trainings. During calendar year 2009, approximately 4,000 unduplicated children under age three received a fluoride varnish application in a pediatric practice. */2012/* The goal is to improve oral health and one of the impacts is to improve access to care. *//2012//*

The initiative has proven successful in improving access to dental care and studies confirm that fluoride varnish application is effective at reducing early childhood caries in young children (under age three). IDHFS is working to spread this initiative statewide as an evidence-based practice to address and improve the oral health of young children. */2012/IDPH/2013/, IDPH & ICAAP are //2013//* is working with local health department MCH programs to assure integration of oral health and Bright Smiles From Birth to provide preventive oral health care and oral health education to high risk children and their families. *//2012//* Additional information on this project is reported under SPM 13.

*/2012/*Assuring Better Child Health and Development (ABCD) III. ABCD is funded by The Commonwealth Fund and administered by the National Academy for State Health Policy (NASHP). Illinois was involved in ABCD II, the screening academy, and now in ABCD III. The project is focused on strengthening the capacity of Illinois' Medical Program to promote children's healthy development, specifically social emotional development, and care coordination among medical homes and Early Intervention including needed community-based resources. The first year planning activities have concluded. Currently, the project is in year two and focused on pilot testing including conducting learning collaboratives and identifying needed policy change strategies. Year three will focus on creating systems to spread identified successful activities are statewide. *//2012//* ***/2013/ The current focus of this project is on sustainability and spreading use of standardized referral forms and practices. The activities ensure that children screened at risk for developmental delay are referred to Early Intervention and the provider who refers is aware of the outcome. The IL Chapter, AAP, obtained approval for developmental screening Maintenance of Certification (MOC) for medical practices. This is***

a key outcome of ABCDIII and is an incentive to providers to participate. A tool kit will be finalized during year three to ensure that the quality improvement practices continue after conclusion of the ABCDIII project.//2013//

Enhancing Developmentally Oriented Primary Care (EDOPC). The ABCD quality improvement effort reinforced through the EDOPC project, which provides training and ongoing technical assistance to primary care providers. Based on the "Healthy Steps" model, the ICAAP, the Illinois Academy of Family Physicians (IAFP), and Advocate Health Foundation, partner with private foundations and IDHFS to operate the project. The overall goal of EDOPC is to identify and overcome the barriers that pediatric primary care providers face in conducting developmental, social-emotional, perinatal depression, and domestic violence screenings and assessments, making appropriate referrals, and attending to parents' developmental concerns. The IDHFS' PCCM Administrator, Automated Health Systems, the Erikson Institute, the Illinois Association for Infant Mental Health and the Ounce of Prevention, and other private foundations and advocate groups, are involved in promoting the project. The EDOPC project helps Illinois' pediatric care providers through training, technical assistance and community support, and by implementing strategies to effectively provide developmentally oriented primary care. IDHS' MCH Nurse Consultants and FCM Coordinator have been trained on the Healthy Steps model of care and are working with the EDOPC project to provide training in communities throughout Illinois. Trainings have been provided for AOK networks, FQHCs, local health departments, and private provider practices.

/2012/ Illinois (IDHFS) is working to implement the CHIPRA Child Health Quality Demonstration Project in partnership with Florida. The Project goals are to 1) test the collection of new CMS core measures and other selected supplemental measures of high priority; 2) collaborate with ongoing statewide Health Information Exchange (HIE) and Health Information Technology (HIT) development efforts to ensure that child health quality objectives are integrated, and child health performance measurement and quality improvement are fully supported; 3) support implementation of enhanced medical homes, through training and technical assistance for practice redesign addressing core medical home measures and creating strong referral and coordination networks, as well as through the integration of HIT; 4) evaluate the impact of the changes on the quality, coordination and efficiency of children's health care; and 5) build on measure development and HIT to support collaborative quality improvement projects to improve birth outcomes. Four workgroups, consisting of many stakeholders (including IDHS), support the work of the Project.//2012//

/2013/ During the second year (2/11-2/12), CHIPRA workgroups implemented tasks in the operational plan. Accomplishments include reporting on 17 of 24 core measures; submission of a use case (Prenatal Electronic Data Set) to the Illinois Health Information Exchange for consideration; recruitment of 63 practices to participate in the medical home initiative; significant work on Minimum Quality Standards for Prenatal Care. Work plans for project year 3 are pending. Plans include a data audit of CHIPRA measures, reporting on 21 of 24 core measures, public reporting of the measures via a Data Book on the IDHFS website, development of 2 new measures, implementation & testing of the Pediatric Electronic Data Set use case, implementation of medical home interventions including quality improvement initiatives & a peer learning group, completing work on the Minimum Quality Standards for Prenatal Care, developing recommendations for better collaboration between primary care & prenatal care providers & development of a quality improvement initiative focused on perinatal health.//2013//

/2012/The Project was funded for five years beginning in February 2010. The first year of the Project focused on planning and development of an operational plan. The second Project year, which began in February 2011, is focused on implementation. The workgroups have reconvened, created subgroups with specific charges, and are working on completing the 2011 tasks identified in the operational plan.//2012//

Illinois (IDHFS) was selected to implement a CHIPRA Quality Improvement Project in partnership with Florida. The Illinois/Florida CHIPRA Quality Improvement Project will 1) test the collection of new CMS core measures and other selected supplemental measures of high priority; 2) collaborate with ongoing statewide Health Information Exchange (HIE) and Health Information Technology (HIT) development efforts to ensure that child health quality objectives are integrated, and child health performance measurement and quality improvement are fully supported; 3) support implementation of enhanced medical homes, through training and technical assistance for practice redesign addressing core medical home measures and creating strong referral and coordination networks, as well as through the integration of HIT; 4) evaluate the impact of the changes on the quality, coordination and efficiency of children's health care and in particular, children with special health care needs; and 5) build on measure development and HIT to support collaborative quality improvement projects to improve birth outcomes. IDHS is represented on the advisory committee for the CHIPRA project.

MCH Nurse Consultants coordinate with State funded agencies and CSSCs to manage and provide oversight to all CHP clinical programs. They utilize standards of professional performance and best practices to assure quality in the delivery of clinical services. Program management includes review and certification of the following programs: Targeted Intensive Prenatal Case Management, reproductive health programs, School Based Health Clinics, High Risk Infant Follow-up/APORS, Healthy Start, FCM, HealthWorks and Childhood Asthma. Monitoring is provided at least annually, in accordance with all applicable federal and state statutes and regulations. MCH Nurse Consultants also coordinate continuing education, workshops and seminars at which MCH issues are presented.

CSHCN - The IDHFS maintains an interagency agreement with DSCC, which includes a description of each agency's responsibilities in implementing the Home and Community-Based Services (HCBS) Section 1915 (c) waiver for medically fragile, technology dependent children under the age of 21. The agreement also facilitates claiming federal matching funds for care coordination under the HCBS waiver and for Medicaid-eligible children in DSCC's Core Program. The agreement is reviewed annually and updated as necessary. DSCC's responsibilities are outlined in detail in the agreement. DSCC provides care coordination, utilization review, and conducts quality assurance activities including oversight of nursing agencies and providers of durable medical equipment that serve the children in the waiver. IDHFS funds the program and maintains final approval of waiver eligibility, plans of care, and hearing decisions. DSCC is also an All Kids application agent. The IDHFS and DSCC meet at least quarterly to discuss policies and issues directly associated with implementing the HCBS waiver program.

Illinois Department of Public Health - IDHS and DSCC work with many divisions and programs within IDPH to serve women, infants, children, and children with special health care needs. IDPH and DSCC provide otologic/audiologic clinics in communities with high numbers of children who receive no follow up after failure of school hearing screenings. A Memorandum of Understanding delineates collaborative services for children identified through the Newborn Metabolic Screening, Genetic Counseling, Vision and Hearing Screening, Hearing Instrument Consumer Protection, Universal Newborn Hearing Screening and Adverse Pregnancy Outcome Reporting Systems (APORS) programs.

IDPH, IDHS, and DSCC collaborate on the state's Universal Newborn Hearing Screening Program to enhance system development and implementation. DSCC has taken on responsibility for statewide system development activities related to this program. DSCC applied for and received the HRSA Universal Newborn Hearing Screening and Intervention Grant. The IDPH received a grant, the Early Hearing Detection and Intervention (EHDI) Tracking, Surveillance, and Integration Grant, from the Centers for Disease Control and Prevention (CDC).

In 1999, the IDPH received funding from the CDC to build capacity and to develop a state plan to address asthma. As a result, the Illinois Asthma Program (IAP) was formed and a statewide partnership was developed. The partnership meets twice a year, in addition to annual regional

trainings and an annual asthma conference. Five workgroups and community asthma coalitions assist with the partnership's efforts. The IAP funds four coalitions to implement asthma state plan goals, and funds an additional 14 communities to develop asthma coalitions in order to raise awareness and education about asthma as well as to strengthen community resources. The IAP also funded 47 WIC clinics to provide asthma education to staff and clients.

IDHS works in collaboration with the IDPH's Illinois Asthma Initiative. The MCH program is represented at the advisory level, and on statewide subcommittees by MCH Nurse Consultants, Child Care Nurse Consultants, and School Health staff. In order to improve the management of childhood asthma, the resulting burden of acute care on healthcare facilities, and the high costs of children's education due to asthma related absenteeism, the IDHS supports two demonstration projects. These projects are administered by the University of Illinois at Chicago School of Public Health. First, the Childhood Asthma Initiative trains TANF-eligible parents of children with asthma as "asthma peer educators". These parents then assist other parents of children with asthma to successfully manage their children's illness. The training also provides them with marketable skills, thereby helping them toward financial self-sufficiency. Additionally, it collaborates with the "breath-mobile" asthma van to provide screening and referral services to Chicago Public School children and their families.

The second program is the Altgeld Gardens/Murray Homes Asthma initiative created to identify families with asthma diagnosis or asthma symptoms, and create linkages to healthcare services. Health educators and community outreach workers at the TCA Clinic collect baseline data from parents or guardians to establish a diagnosis of asthma related symptoms. Parents are selected and trained by the University of Illinois at Chicago, and Asthma screenings and follow-up services are delivered from mobile vans. Community residents at Altgeld who currently utilize the TCA health services are given the opportunity to receive treatment, education, and follow-up care in a special asthma clinic.

Illinois State Board of Education (ISBE) - DSCC care coordinators help families to understand their educational rights using "A Parent's Guide: The Educational Rights of Students with Disabilities," published by ISBE. DSCC regional office care coordinators work with the local schools regarding individual issues in the educational setting.

ISBE no longer ~~/2013/now/2013/~~ employs a school health ~~/2013/nurse/2013/~~ consultant ~~/2013/who'll work with DHS & DPH staffs/2013/~~; questions on school health related issues are referred to the IDHS School Health program staff and to the appropriate programs within IDPH. The School Health program staff worked with the ISBE and a State Advisory Committee to publish numerous documents, including: "Recommended Guidelines for Medication Administration in Schools;" "Asthma Management: A Resource Guide for Schools;" "Diabetes in Children: A Resource Guide for School Health Personnel;" "First Aid Procedures for Injuries and Illnesses;" "Certificate of Child Health Examination;" and "Health Status of School Age Children and Adolescents in Illinois." Copies of these documents have been sent to all public and private schools in the state, as well as advocacy groups and individuals interested in these issues. The documents are also available electronically on the IDHS School Health Program web page. ISBE staff assist in the review of applicants for new School Health Centers and coordinated school health program grants.

Schools - A variety of programs are operated through schools to meet the needs of children and adolescents. First, the school health centers work through primary care providers to deliver comprehensive medical, mental health, dental and preventive health education services to school age children and parenting students. These clinics coordinate care provided to their clients with the clients' primary care provider. The clinics refer the client for specialty care as needed and seek third party reimbursement for services provided. Second, IDHS works with 12 local health departments to implement coordinated school health programs. Third, the MCH program ~~/2012/through its School Health Program, /2012/~~also conducts continuing education programs for school nurses and administrators and provides regular updates on school health issues

through email. Finally, schools are the main delivery sites for several programs, including Teen REACH, substance abuse prevention, Responsible Parenting and the Youth Opportunity programs.

Illinois Department of Children and Family Services -DCFS and IDHS collaborate on the operation of HealthWorks of Illinois, which establishes regional networks of primary and specialty care to ensure that children in foster care receive the health care services they require.

Illinois is one of seven states selected to pilot Strengthening Families through Early Care and Education. The DCFS initiated Strengthening Families Illinois through a collaboration of 30 partner organizations and state agencies in the fields of child welfare, child abuse prevention, and early childhood, along with parents and community leaders. Local learning networks have been established at five childcare centers across the state to work with families to build protective factors around children to prevent child abuse and neglect. The Child Care Nurse Consultants were trained to provide instruction about the protective factors to childcare providers throughout Illinois. Healthy Start and Targeted Intensive Prenatal Case Management staff received training on the Strengthening Families approach to client care in 2009.

DSCC collaborates with DCFS on behalf of state wards who have special health care needs and are eligible for DSCC services. Coordination activities include identifying referral mechanisms for sharing information. To enhance system collaboration, DSCC staff are available to provide in-service training as needed on CSHCN to local and regional DCFS staff throughout the state. DSCC care coordination staff participated in DCFS online training for mandated reporters

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

Narrative: In 2011 (the most recent data available), the rate of asthma hospitalization among children under five years of age was 57.7 per 10,000 residents. Both the rate and the absolute count of cases are the lowest since 2007. Part of this could be attributable to a change in counting cases due to new facilities in the state. In Illinois there is a small but growing number of freestanding Ambulatory Surgical Treatment Centers (ASTC's). As of 2012 IDPH licenses approximately 137 in Illinois. These centers may be seeing more persons with illnesses than traditional hospitals and thus are not reporting their illness cases in the same way. Overall, hospitalization rates for the period 2007-2010 continue to remain fairly stable. The increase in the rates in 2008 and 2009 can be in small part attributed to a change in the data collection and reporting mechanism used by IDPH. In both years an additional 16 diagnoses codes were added as the electronic Hospital Reporting system (known as e-Codes) was implemented. The MCH program supports a demonstration project to improve asthma management in young children; this activity was described earlier in the application.

Health Systems Capacity Indicator 02: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

Narrative: The proportion of Medicaid-eligible infants who obtain routine well-child care is large - 91.5 percent of HFS continuously enrolled children (Title XIX, Title XXI, and state-funded only) through 15 months of age received at least one well-child visit in 2010. 2011 provisional data looks encouraging also as the rate is 90.4%. Identification of a medical home is a key measure in assuring that infants receive well-child visits. It is required that all infants enrolled in Family Case Management, Healthy Start, and HealthWorks have an identified primary care provider. Case managers in these programs provide education to the mother on the importance of well-child care, and monitor mother's compliance in completion of these visits. Case managers request documentation of same from the mother and/or the provider or the state HFS Medi-system. Information is then entered into the Cornerstone data system. Quarterly performance reports on

the above mentioned programs are used to track an agency's performance.

Health Systems Capacity Indicator 03: The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

Narrative: Until 2004, fewer than 300 infants a year were eligible for SCHIP for at least 30 days. Enrollment in SCHIP in 2010 among recipients < 1 year of age was 1,830. Of these children continuously eligible for 90 days or more, 1,715 or 93.7 percent received at least one well-child service. 2011 data to date also appears good with 96.8% receiving at least one screen. 2011 data is provisional since providers have up to 18 months to submit claims for payment.

Health Systems Capacity Indicator 04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

The proportion of women who received an adequate number of prenatal care visits has been steadily increasing, as measured by the Kotelchuck Index. Despite the slight declines in 2006 and 2007, the long-term trend remains positive. Since 2003 the indicator has risen by an average of 0.5 percent in each of the succeeding years from 78.2 percent to 80.5 percent in 2008.

Health Systems Capacity Indicator 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

Narrative: Based on the EPSDT participation report (Title XIX, Form CMS-416, Line 10), between FFY2009 and FFY2010, there was a small percent increase in the number of children from < 1 through 20 years of age receiving at least one screening. Provisional data for 2011 shows a small percent decrease. Efforts to improve the EPSDT participation rate include the mailing of annual notices to families with children, and separate notices when a child is due for a screen, based on the periodicity schedule. IDHFS' medical home initiative, Illinois Health Connect (IHC), provides monthly panel rosters to primary care physicians (PCPs) that identify patients and whether the patients have received certain clinical services. PCPs receive bonus payments by meeting or exceeding benchmarks for particular services, including the percent of children in the practice who receive designated immunizations by age 24 months, the percent of children in the practice who receive at least one objective developmental screening by and between certain age ranges, and the percent of children in the practice who receive at least one capillary or venous blood test for lead poisoning by their 2nd birthday. IHC also conducts outbound calls to remind clients when they are due for services. IHC will assist clients in scheduling an appointment with the child's PCP and will send a reminder notice 7 days prior to the appointment. In addition, DentaQuest, the Dental Program Administrator, has an approved HFS Dental Program Outreach Program to target children without dental care within the last 12 months. The Outreach Program includes contacting beneficiaries' parent, guardian or caretaker relative by phone. Additionally, there is a Customer Satisfaction Survey conducted annually, which provides the Dental Program Administrator and HFS with information on whether or not beneficiaries knew about availability of dental services. A separate Customer Satisfaction Survey targeting parents, guardians or caretaker relatives of children who have not received services in the past 12 months is conducted to ascertain the reason for no dental care, and whether or not they knew about the availability of dental services.

Health Systems Capacity Indicator 07B: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Narrative: The proportion of Medicaid-eligible children between 6 and 9 years of age who received any dental services reached 67.5 percent in 2010, a significant increase when compared to earlier years. Provisional data for 2011 looks even better at 68.3%.

Health Systems Capacity Indicator 08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

Narrative: Children with Special Health Care Needs. The proportion of state SSI beneficiaries under 16 years of age who received rehabilitative services through the CSHCN program (HSCI 8, Form 17) was 10.3 in 2011. For a description of DSCC's efforts for SSI-eligible children, see Section III.B., "Agency Capacity," "Children with Special Healthcare Needs."

Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams).

Narrative: In 2009, the percent of low birth weight births was higher among Medicaid-eligible infants (9.5 percent) than non-Medicaid eligible infants (6.8 percent). The percent distribution of low-birth weight among Medicaid and non-Medicaid infants is similar to previous years in that it is higher among Medicaid-eligible infants. The rate for Medicaid was 9.8 in 2008 and 9.1 in 2007. For non-Medicaid, the rate was 6.9 in 2008 and 7.5 in 2007.

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

Narrative: As in previous reports, the rate of infant mortality is higher among Medicaid-eligible infants (6.9 deaths per 1,000 live births) than non-Medicaid-eligible infants (5.81 deaths per 1,000 live births). (CY 2007 data). The Chicago Healthy Start Project, Targeted Intensive Prenatal Case Management and Healthy Births for Healthy Communities are DHS case management programs that target women at high-risk for poor pregnancy outcomes. The goal of these programs is to enroll the women early in pregnancy, connect her with needed medical and social services, monitor care throughout pregnancy, and encourage adoption of healthy lifestyle behaviors. In the past two years, there has been a growing focus on adoption of a lifecourse model, with recognition that good prenatal care alone is not enough to reduce the overall incidence of infant mortality. There is a significant disparity between infant mortality rates of Caucasian and black infants in Illinois. Increasing focus on preconception/interconception health has occurred across many of the MCH programs this past year. Educational sessions have been provided for Healthy Start and School Health staff, as well as staff from FQHC's and Title X agencies. Illinois began participation in a national Healthy Start Learning Collaborative focused on Interconceptional Health in 2009.

Health Systems Capacity Indicator 05C: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

Narrative: Improvement in the percent of infants born to women receiving prenatal care in the first trimester was reported across income groups in 2005 as compared to 2004, and then again in 2006 as compared to 2005. However, the rate leveled off in 2007 before increasing dramatically in 2008 and then again in 2009, the most current data for the Medicaid-eligible population. Previous to 2009, the percent of births receiving prenatal care in the first trimester among Medicaid-eligible was 79.7 in 2008, 75.5 in 2007, 76.3 in 2006, 74.3 in 2005 and 71.9 in 2004. The percent among non Medicaid-eligible was 92.5 in 2008, 88.3 in 2007, 88.2 in 2006 and 87.4 in 2005.

Health Systems Capacity Indicator 05D: Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])

As compared to 2004, greater percentages of women regardless of payment source were receiving adequate prenatal care according to 2005 vital statistics data. That trend continued into 2006, however there was a modest decline in 2007 before a return to the levels in previous years for 2008 and 2009. In fact, 2009 marks the highest level of adequate prenatal care visits ever. For Medicaid-eligible women, the percent receiving adequate prenatal care in previous years was 73.7 in 2008, 70.5 in 2004, 73.0 in 2005, 73.8 in 2006 and 73.4 in 2007. Non-Medicaid eligible

women reported a modest increase in the percent receiving adequate prenatal care from 2004 to 2005, 86.6 to 87.4 percent, respectively, but then showed a reversal in 2006 with a rate of 88.2 percent, and then improved in 2007 with a rate of 86.8 but then reverted slightly in 2008 with a rate of 85.9. These observed increases were reflected somewhat in the percent differences for the entire birth cohort; in 2004, 78.8 percent of pregnant women received adequate prenatal care, in 2005 it was 80.0, in 2006 it was 79.9, in 2007 it was 80.0 percent and in 2008 it was 80.5 percent. Note that the 2009 cohort as shown is a provisional figure since IDPH has not yet supplied IDHS with the aggregate figure. The figure shown is for the less-than-100% birth file that is supplied to IDHS by IDPH under the current agreement. The 2009 "All" figure will be updated later when the totals are released by IDPH.

Health Systems Capacity Indicator 06A : The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)

Narrative: Infants from families with incomes at or below 133 percent of the federal poverty standard are eligible for Medicaid and are covered through All Kids Assist if their mothers were not eligible for Medicaid during pregnancy. If their mothers were not eligible for Medicaid during pregnancy, infants from families with incomes above 133 percent and less than or equal to 200 percent of the federal poverty standard are eligible for CHIP. These children are covered through All Kids Share if their families' incomes are more than 133 percent and up to and including 150 percent of the federal poverty standard and All Kids Premium Level 1 if their families' incomes are more than 150 and up to and including 200 percent of the federal poverty level. Infants from families with incomes above 200 percent of the federal poverty level are not eligible for CHIP but may be covered through All Kids Premium (at a higher premium level). Refer to "Health Care Financing" in Section III.A. of this application.

Health Systems Capacity Indicator 06B: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children

Narrative: Children from families with incomes at or below 133 percent of the federal poverty standard are eligible for Medicaid and are covered through All Kids Assist. Children from families with incomes above 133 percent and less than or equal to 200 percent of the federal poverty standard are eligible for CHIP. These children are covered through All Kids Share if their families' incomes are between 133 percent and 150 percent of the federal poverty standard and All Kids Premium Level 1 if their families' incomes are between 150 and 200 percent of the federal poverty level. These children may also qualify for premium assistance under All Kids Rebate. Children in families with income above 200% but at or below 300% are eligible for All Kids Premium Level 3 which is funded by cost sharing by the families and state funds. Children from families with incomes above 300 percent of the federal poverty level are not eligible for CHIP but may be covered through All Kids Premium (at a higher premium level) through June 30, 2011. Refer to "Health Care Financing" in Section III.A. of this application.

Health Systems Capacity Indicator 06C : The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women

Narrative: Pregnant women with family incomes at or below 200 percent of the federal poverty level are eligible for services under Medicaid. Women who are eligible for CHIP and become pregnant (all of whom are adolescents) are automatically deemed to be eligible for Medicaid. They are served through All Kids Moms and Babies. Refer to "Health Care Financing" in Section III.A. of this application.

Health Systems Capacity Indicator 09A: The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.

Narrative: Enhanced data integration is well underway in Illinois as evidenced by the data sharing interagency agreement, EDW and IDHS' role in both. Illinois is poised to conduct analysis and

research using an immense data warehouse. Resulting reports and studies undoubtedly will bolster the state's Title V MCH Services Block Grant Application and establish direction for MCH program and policy decisions. Prior to that end, Illinois must develop capacity to "mine" the warehouse for pertinent data and approach the data from an epidemiological perspective. Ultimately, this is the purpose of Illinois' State System's Development Initiative. The Department of Human Services (DHS) continues to export MCH service files from its Cornerstone system to the HFS Enterprise Data Warehouse (EDW). Staff members of Program Planning and Development (PPD), IDHS, have security access to the EDW. In 2010, PPD staff used the EDW to match Medicaid recipients with maternal and child health service data in the Cornerstone system. Because the EDW employs a sophisticated matching algorithm, results of the Medicaid/Cornerstone match demonstrated a marked improvement in the efficiency of the process as compared to results of the previous method of matching two distinct data files. A contract with the University of Illinois at Chicago (UIC), School of Public Health allows the MCH Director and PPD to explore and conduct several research priorities. Deborah Rosenberg, Ph.D., Research Associate Professor, Division of Epidemiology and Biostatistics is the principle investigator and reports to the MCH Associate Director. The UIC researchers are allowed to access the linked infant birth and death files that are kept on the MDW via a data-sharing agreement and file transfers from authorized IDHS staff. Dr. Rosenberg is instrumental in the preparation of the MCH statewide needs assessment. In particular, she assisted in shaping the needs assessment timeline and process and developing the analysis plan. Dr. Rosenberg participated in the expert panel and stakeholders' meetings, helped create the final data books, synthesized qualitative and quantitative data and facilitated the priority-setting process.

Health Systems Capacity Indicator 09B: The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.

Narrative: The Illinois MCH program has extensive capacity to analyze data from vital records, program records, Medicaid and special surveys. The IDPH produces matched birth and death certificate files, although production is behind schedule due to staff shortages. The MCH program annually produces a file of matched vital records, Medicaid eligibility, paid claims and MCH program participation that allows comparison of natality characteristics among infants that were and were not covered by Medicaid or involved in any of several MCH programs. The MCH program's primary information system, Cornerstone, includes immunization records from Medicaid-eligible children and paid claims for EPSDT services. Cornerstone is used to operate the WIC program and data from it is provided to the CDC annually for the Pregnancy and Pediatric Nutrition Surveillance Systems. The IDPH maintains a complete database on hospital discharges, maintains birth defects registry and conducts the Pregnancy Risk Assessment and Monitoring System (PRAMS), the Youth Tobacco Survey, and the Behavioral Risk Factor Surveillance System (BRFSS) surveys for CDC. IDHS, IDHFS, and IDPH are strengthening the state infrastructure for program planning and development through a three-way agreement for exchange of data for program planning, monitoring, and evaluation. The agreement involves the exchange of vital records, Medicaid eligibility and MCH service delivery, and other program management data. Records of vital events that occur in other states to Illinois citizens are governed by the Inter-Jurisdictional Exchange Agreement (IJA) administered by the National Association of Public Health Statistics and Information Systems. The IJA limits IDPH's ability to share vital records events that occur in other states unless specifically authorized by a state as set forth in the IJA addendum or unless written permission has been secured from the state. As a result, IDHS and IDHFS have direct electronic access to records of approximately 97 percent of the vital events that occur each year to the citizens of Illinois. The State of Illinois is embarking on a project to design an information system that encompasses its entire human services delivery system. With leadership from Governor Pat Quinn, seven state agencies have prepared a Planning Advance Planning Document (PAPD) to examine the feasibility of developing an enterprise solution to support the essential tasks of service provision -- intake, assessment, application, eligibility determination, casework, and provider management. The departments participating in this project are the Departments on Aging, Children and Family Services, Commerce and Economic Opportunity, Employment Security, Healthcare and Family Services,

Human Services and Public Health. Illinois uses its application for SSDI funding addressed the need to develop capacity to "mine" IDHFS' Medical Data Warehouse for pertinent data and approach the data from an epidemiological perspective.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Illinois Title V program uses a performance management model to guide its program efforts. After choosing a set of priority needs from the five year statewide needs assessment, resources are allocated and programs are designed and implemented to address these priorities. These program activities are described and categorized by the four levels of the MCH pyramid: direct health care; enabling; population based; and infrastructure building services. Imbedded within the levels of service are sets of national core performance measures and eight state negotiated performance measures categorized into three types: capacity, process, or risk factor. Because of the flexibility inherent in the Block Grant, the program activities or the role that Title V plays in the implementation of each performance measure varies. The program activities, as measured by these core and negotiated performance measures, are expected to have a collective contributory effect that will positively impact the national outcome measures for the Title V program.

B. State Priorities

The role of the Title V program in Illinois is to empower communities to develop an appropriate infrastructure and to enable women and children, including children with special health care needs, to access the preventive, primary, and specialty services they require. To fulfill this role, the Title V program considers health status, demographic, health care financing, and legislative factors when setting priorities and developing new initiatives. The current priorities and corresponding initiatives of the Title V program include:

Using a life course perspective, the Illinois maternal and child health priorities are intentionally written to cover the entire MCH population. This approach acknowledges that health status is the sum of experiences over the life course and affirms the importance of integrating services. Elimination of disparities is a major focus and disparities will be addressed in the measurement, monitoring, and action steps for each priority. Finally, priorities are framed from a health systems rather than a health status perspective because it is through health systems change that Illinois Title V can expect to improve the health of women, children, and families in the state.

- 1) Improve Title V's capacity to collect, acquire, integrate/link, analyze, and utilize administrative, programmatic, and surveillance data.
- 2) Integrate medical and community-based services for MCH populations and improve linkage of clients to these services, particularly CSHCN.
- 3) Promote, build, and sustain healthy families and communities.
- 4) Expand availability, access to, quality, and utilization of medical homes for all children and adolescents, including CSHCN.
- 5) Expand availability, access to, quality, and utilization of medical homes for all women.
- 6) Promote healthy pregnancies and reduce adverse pregnancy outcomes for mothers and infants.
- 7) Address the oral health needs of the MCH population through **/2013//data collection, //2013//prevention, screening, referral, and appropriate treatment.**
- 8) Address the mental health needs of the MCH population through prevention, screening, referral, and appropriate treatment.
- 9) Promote healthy weight, physical activity, and optimal nutrition for women and children.

10) Promote successful transition of youth with special health care needs to adult life.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	99.7	99.8	99.9	99	99
Annual Indicator	98.1	98.2	98.6	98.5	98.6
Numerator	862	961	1634	1499	1766
Denominator	879	979	1657	1522	1791
Data Source		IDPH, Genetics	IDPH, Genetics	IDPH, Genetics	IDPH, Genetics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	99	99	99	99	99

Notes - 2010

Source: IDPH - Genetics. Starting with CY 2007 data, the figures show the number of newborns with a positive screen that are followed until case closure. Previously the figures simply reported the number of infants screened versus infants born. The change was made upon the recommendation of a federal review team in August 2010.

Notes - 2009

Source: IDPH - Genetics. Starting with CY 2007 data, the figures show the number of newborns with a positive screen that are followed until case closure. Previously the figures simply reported the number of infants screened versus infants born. The change was made upon the recommendation of a federal review team in August 2010.

a. Last Year's Accomplishments

More than 98 percent of the children with abnormal screening results received follow-up. Actual performance (98.6 percent) was slightly below the goal of 99 percent.

Each year, IDPH screens approximately 160,000 newborns for 40 conditions (PKU, congenital hypothyroidism, galactosemia, congenital adrenal hyperplasia, biotinidase deficiency, sickle cell disease and other sickling hemoglobinopathies, cystic fibrosis, and multiple amino acid, organic acid, and fatty acid oxidation disorders). Of these, approximately 300 are diagnosed with one of these conditions, and another 4,200 are found to have an abnormal hemoglobin trait (refer to Form 6 in Appendix B). Staff assure that each infant receives appropriate referral, diagnosis, treatment, counseling, and long term follow-up services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct hospital-based screening			X	
2. Laboratory results are reported to IDPH			X	
3. Parents and physicians are notified			X	
4. Local health departments are contacted when children can't be located for diagnostic testing			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Newborns are routinely screened for 40 metabolic disorders. Infants with a positive screening result are followed through diagnostic evaluation, and all children diagnosed are followed up annually through 15 years of age. The new web-based Newborn Metabolic Screening Data System has been fully implemented. It has the capacity to interface with the birth record to ensure that all infants are screened, but that feature is not yet operational.

WIC and Public Health Nursing staff provide education to women concerning the recommended intake and benefits of folic acid for their and their infants' health. The Public Health Nurses are incorporating the Genetic Screening Tool on all home visits.

CDPH Maternal and Family Planning programs routinely screen for inherited disorders in community health clinics, and provide genetics education and referrals. In calendar year 2011, 4145 clients were screened for genetic disorders; 301 had positive indicators. The Public Health Nursing program receives referrals for children up to one year of age for genetic disorders, and provides home visits and referrals to family counseling and genetics follow-up. WIC and Public Health Nursing staff provides education to women concerning the recommended intake and benefits of folic acid. The Public Health Nurses are incorporating the Genetic Screening Tool on all home visits.

c. Plan for the Coming Year

The IDPH Genetics/Newborn Screening Program will continue to implement additional practices to ensure that every newborn in the state is screened. Currently a list of babies born out of the hospital setting is provided by the IDPH Division of Vital Records so the newborn screening staff can verify that screening has been performed on these newborns. If screening has not already been done, then the parents are notified to complete this as soon as possible. IDPH and DSCC will continue to partner in the care of children diagnosed with a metabolic or genetic disorder. A pilot testing period screening for seven lysosomal storage disorders (LSDs) has been delayed due to changes in testing methodology and delays in procuring equipment. It is projected that limited testing will begin early in 2013, with full-scale statewide testing in place by the end of 2013. Testing for severe combined immunodeficiency (SCID) has been mandated and will also likely be implemented in the same time frame as LSD testing.

Chicago. Through the end of June 2012, CDPH will continue routine genetic screening and referrals for genetics follow-up with clinic clients. CDPH will continue to provide March of Dimes information on benefits of folic acid at home visits, health fairs and WIC clinics. PHNs and WIC staff will give information on the following: Newborn screening and importance of follow-up,

children born with retardation, SIDS/safe sleep, folic acid/nutrition, well baby visits, infant care and breastfeeding.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	157739					
Reporting Year:	2011					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	157580	99.9	23	7	7	100.0
Congenital Hypothyroidism (Classical)	157580	99.9	241	83	83	100.0
Galactosemia (Classical)	157580	99.9	56	2	2	100.0
Sickle Cell Disease	157580	99.9	116	115	115	100.0
Biotinidase Deficiency	157580	99.9	7	1	1	100.0
Other Amino Acid Disorders	157580	99.9	44	1	1	100.0
Other Fatty/Organic Acid Disorders	157580	99.9	236	25	25	100.0
Other Congenital Adrenal Hyperplasia	157580	99.9	335	13	13	100.0
Other Pompe, Fabry, Gaucher diseases*	0	0.0	0	0	0	
Phenylketonuria-treatment provided	100		360	360	360	100.0
All Conditions Diagnosed-annual monitoring	4200		4200	4200	4000	95.2
Other/Fatty/organic/Amino Acid Disorders-treatment	145		145	145	145	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	60.8	60.3	60.3	60.5	60.5
Annual Indicator	60.3	60.3	60.3	60.3	71.1

Numerator					
Denominator					
Data Source		CHSCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	71.1	71.1	71.1	72	72

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

The 2009/2010 National CSHCN Survey found that 71.1% of families with CSHCN indicated they are partners in decision making at all levels and are satisfied with the services they receive. This result cannot be compared to the previous surveys due to substantial changes in measurement made to this survey. In order to be counted as meeting this outcome, families had to answer usually or always to 4 questions about how doctors or other health care providers work with them to make decisions about their child's healthcare services or treatment. CSHCN meeting this outcome had a higher probability of having their care coordination needs met, having no problems getting needed referrals, having a medical home, and/or having private insurance than those who did not meet the outcome.

UIC-DSCC provides care coordination services for CSHCN meeting medical eligibility criteria, regardless of their healthcare coverage, and payment for specialty medical care for CSHCN meeting financial criteria. Care coordination staff helps families obtain information about their child's medical condition, coordinate access to specialty care and develop questions to clarify treatment plans. Care coordinators have access to bilingual staff to assist in communicating with Spanish speaking families. Staff assists families to develop a partnership with a medical home

provider. Family partnerships are also promoted through Medical Home Quality Improvement Team (QIT) membership. UIC-DSCC QIT facilitators encourage family members to participate equally with practice staff.

UIC-DSCC promotes family partnership in decision making at the policy level through the Family Advisory Council (FAC). This group consists of family members with CSHCN served by UIC-DSCC's regional care coordinators. A FAC member presented at a UIC School of Public Health MCH graduate seminar on the topic of, "Families and Public Health: Lessons from Children with Special Health Care Needs" and developed a graphic depiction that detailed the "Many Hats of a Parent of a Child who is Medically-Fragile/Technology Dependent." The FAC assisted in development of a bereavement job aid to educate staff on the issues and resources for families whose child has died. FAC and the Family Liaison continued updating the UIC-DSCC Family Handbook and transition and Medical Home materials as needed. Families with CSHCN also serve on state level groups, such as the Illinois Interagency Council on Early Intervention, the Early Hearing Detection and Intervention advisory committee, and the Project Advisory Committee for the HRSA Integrated Systems grant.

Outreach activities with a focus on family partnership continued. The Family Liaison continued to serve on the Family-to-Family Health Information Center advisory board and participated on the Region 4 Genetics Transition work group. A major activity for the work group was enhancing the region website to include additional resources for families. The work group focused on identifying and promoting effective models addressing transition to adult services for youth with heritable disorders. For the youth with a genetic condition, transition issues include: medical care and disease management from knowledgeable adult health care providers, developing new relationships with adult health care providers, adapting to new service delivery approaches, changes in health care coverage/insurance, and learning to manage one's own health care.

UIC-DSCC continues to update the UIC-DSCC Family webpage to provide access to a wide array of topics and resources of interest to families of CSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote family/CSHCN Program partnerships through the Family Advisory Council (FAC).				X
2. Promote family/physician partnership through the Medical Home initiative.				X
3. Family education on state/federal activities through UIC-DSCC Family website.				X
4. Collaboration with the Family-to-Family Health Information Center to improve access to information.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Family Advisory Council, FAC, is reassessing their objectives, goals, and strategies to better assist UIC-DSCC. The FAC advises on communication strategies to reach families of CSHCN, including the Family Pages on the UIC-DSCC Internet site and the possible development of social media activities like Facebook. The UIC-DSCC Family Liaison (FL) explores new ways of helping

families tell their story about their experiences in accessing services for their CSHCN. The FL continues to facilitate activities of the FAC, as well as provide outreach to other initiatives using a family partnership approach, including serving on the IL Family-to-Family Health Information Center's advisory board. Information about The ARC of Illinois' Family-to-Family Health Information and Education Center is provided to SSI applicants up to age 16 years.

The Family Liaison continues training new care coordination staff on family-centered care and family partnership. The FL also presented to various groups on family centered care, transition and quality improvement. The Family Liaison also completed a five year commitment as a member of the AMCHP Governance committee which is responsible for ensuring the effectiveness of the full board.

c. Plan for the Coming Year

Continuing to work on the best way UIC-DSCC can utilize the members of the FAC will be a priority. The commitment and the dedication that the members provide to UIC-DSCC will be enhanced by a stronger connection between the families and UIC-DSCC. We will explore how the members can be better utilized on a regional level.

The UIC-DSCC Family Liaison will continue to facilitate activities of the FAC, as well as provide outreach to other initiatives, providing a family partnership approach such as serving on the IL Family-to-Family Health Information Center's advisory board. The UIC-DSCC Family Liaison will continue to participate in the Region 4 Genetics Transition group as it moves to the implementation phase of providing resources that will include newly developed videos on the region web page.

Training on family-centeredness and family partnership for UIC-DSCC care coordination teams will continue. Additionally, the Family Liaison will participate in efforts to develop online training modules for care coordination staff. Promoting family partnerships in Medical Home Quality Improvement Teams will continue to be a priority.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	50.9	45.1	45.3	45.3	45.5
Annual Indicator	45.1	45.1	45.1	45.1	44.5
Numerator					
Denominator					
Data Source		CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	44.5	44.5	44.5	45	45

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

The 2009/2010 CSHCN Survey found that 44.5 percent of Illinois families with CSHCN reported that they received coordinated ongoing comprehensive care within a Medical Home. This data shows a slight decrease from the previous CSHCN Survey; however, it was a smaller decrease than at the national level (47.1% down to 43.0%).

The Illinois Medicaid agency, Healthcare and Family Services (HFS), continued to assure medical homes for children, including some CSHCN, through the Primary Care Case Management program (PCCM). CSHCN enrolled in UIC-DSCC programs were excluded from the PCCM program.

Medical home is promoted in UIC-DSCC Regional Offices through care coordination with families by defining a medical home/primary care provider for each child, supporting that family-professional partnership and working with families to establish a comprehensive coordinated plan of care. 99% of UIC-DSCC enrolled children had a medical home. The Building Community-based Medical Homes for Children (BCMHC) project, a collaboration with the Illinois Academy of Pediatrics (ICAAP) funded by the Chicago Community Trust and Michael Reese Health Trust, supported five medical home quality improvement teams (QITs) and three additional "shadow" practices. One family medicine practice and 4 pediatric practices held monthly QIT meetings to work on practice transformation and participated in the second of 2 Learning Sessions.

Videotaped presentations were posted on the ICAAP website (<http://illinoisap.org/2010/12/medical-home-learning-session-2-videos/>). SIU Family and Community Medicine in Carbondale received Level 1 National Committee on Quality Assurance (NCQA) medical home recognition. The family medicine practice, a university-based residency program, included residents in training on the medical home approach to care and involved them in medical home team meetings and QI activities.

The Autism Program (TAP) Health Services Facilitators funded by a HRSA grant began working with 2 pediatric practices to establish medical home quality improvement teams. This grant, Improving Access to Community Care (IMPACC), provided resources for families and facilitated connections among service providers for children with Autism Spectrum Disorders (ASDs). UIC-DSCC staff continued to provide medical home consultation for the TAP grant. UIC-DSCC Medical Home QIT facilitation continued for five additional practices and technical assistance for one other practice. UIC-DSCC Regional Office care coordinators participate in QITs as program liaisons and to provide community resource information.

Five birthing hospitals participated in the EHD1 grant to reduce loss to follow-up for newborns that did not pass initial hearing screening. One strategy was identifying and reporting to IDPH the baby's medical home within the hospital system and noting the need for screening follow-up on the electronic medical record. The use of the crib card has been made available to all birthing hospitals. Parent partners shared an EHD1 informational packet with medical home providers.

ICAAP continued their partnership with Advocate Healthcare Systems Healthy Steps Program, the Illinois Academy of Family Physicians, and the Illinois Department of Healthcare and Family Services (HFS) on a project called Enhancing Developmentally Oriented Primary Care (EDOPC). This project is a statewide, comprehensive effort to increase primary care providers' use of validated tools for developmental, social-emotional, and maternal depression screening

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Integration of the Medical Home into care coordination that includes reimbursement.		X		
2. Medical Home physician training opportunities/Medical Home monograph.				X
3. Statewide physician outreach.				X
4. Quality improvement technical assistance to physician practices.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

99.5% of UIC-DSCC children have a medical home. Practices participating in the BCMHC project that ended in December, 2011, demonstrated improvement in scores on the Medical Home Index and implemented successful practice improvement activities. SIU Family and Community Medicine--West Frankfort, OSF Washington Pediatrics and La Rabida Children's Hospital received NCQA Medical Home recognition. UIC-DSCC provides facilitation to 11 additional pediatric practices. TAP's HRSA grant concluded, and UIC-DSCC is facilitating those 2 QI teams. Building on these efforts, OSF Medical Group is implementing a medical home approach in all the primary care practices in their regional health system. UIC-DSCC staff will provide training for the newly hired OSF staff facilitators for these sites.

ICAAP was awarded a 3 year HRSA Integrated Community Systems for CSHCN grant to improve access to services for children and families who receive healthcare through the Ambulatory and Community Health Networks (ACHN), a federally qualified health network, in Cook County. The first Learning Session is scheduled for the five practice sites in April. The State of Illinois and

ICAAP received funding through the Children's Health Insurance Program Authorization (CHIPRA) to improve care for children by assisting practices in "building medical homes". Practices in the ACHN grant are participating in the CHIPRA grant and are completing the NCQA practice survey.

c. Plan for the Coming Year

The second year of the ACHN grant project will emphasize identification of CYSHCN, care coordination and practice transformations that will improve the delivery of care for CSHCN. A second Learning Collaborative training session will be held to offer education and networking opportunities. Medical home promotion will continue within UIC-DSCC Regional Offices emphasizing the development of a comprehensive, coordinated plan of care that encompasses the child's and family's full medical home "team". UIC-DSCC will be implementing a new electronic case management system that will help to promote care coordination efforts. UIC-DSCC will provide medical home QI team facilitation to 8 additional primary care practices. HFS will continue to promote quality medical homes through the PCCM program. The CHIPRA Child Health Quality Demonstration Project requires HFS to implement a core set of 24 child health measures. These measures will be incorporated into the PCCM and MCO programs. CHIPRA grant efforts will continue in assisting primary care practices that have completed the NCQA assessment to make necessary improvements to achieve NCQA medical home recognition

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	53.5	59.3	59.5	59.5	59.7
Annual Indicator	59.3	59.3	59.3	59.3	62.1
Numerator					
Denominator					
Data Source		CHSCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	62.5	62.5	62.5	62.5	63

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

The 2009-2010 National CSHCN Survey found that 62.1 percent of Illinois families with CSHCN reported that they had adequate private and/or public insurance to pay for the services they need. This was a 2.9 percent increase from the previous CSHCN Survey.

Approximately 5 percent of children enrolled in DSCC had no third party benefits during the last fiscal year. UIC-DSCC care coordination teams assisted uninsured applicants and recipients to apply for the state All Kids Program. All Kids encompasses Medicaid, the State Children's Health Insurance Program and state funded coverage for children regardless of income level, citizenship or immigration requirements of Medicaid. UIC-DSCC care coordination teams referred potentially eligible families to the state's Health Insurance Premium Payment (HIPP) program which pays an individual's share of the private group or individual insurance premium to maintain access and funding for health care. For medically and financially eligible children, UIC-DSCC assisted with the payment of private insurance co-pays and deductibles for specialty care, for care not covered by private or public insurance and for exceptions needed to promote continuity of care. Families of CSHCN medically eligible for SSI-DCP received information and referral services, including information on The Arc of Illinois Family to Family (F2F) Health Information and Education Center.

To keep care coordination teams up-to-date regarding insurance industry and public health insurance programs, including the impact of Health Care reform for CSHCN, the benefit management technical assistance team continued the following efforts: monitored and analyzed state and federal resources regarding health care, produced a quarterly electronic newsletter for care coordination teams, continued developing a training on insurance appeals, and provided training on maximizing private health insurance and public health programs for care coordination teams. In addition, technical assistance was available to care coordination teams on child specific issues. In October 2010, the DSCC Director participated on a panel presentation regarding Health Care Reform sponsored by Family to Family and the Arc of Illinois.

"Questions and Answers about Health Insurance" is a UIC-DSCC developed guide based on a document from the Agency for Healthcare Research and Quality and America's Health Insurance Plans with permission. The guide provides information on private insurance, public programs, resources and tips for working with insurance, and continues to be available on UIC-DSCC's website and through UIC-DSCC Regional Offices.

In August 2010, the Illinois Pre-existing Condition Insurance Plan (IPXP) began taking applications, with coverage beginning in September 2010. Enrollment is being capped at 3000-6000.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Benefits management technical assistance team.		X		
2. Referral to All Kids.		X		
3. Family benefits management resources/resource development.		X		
4. Benefits management training for care coordination teams and families.				X
5. Promote enrollment of uninsured CSHCN in All Kids.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Effective July 1, 2011, income limits for All Kids were lowered to 300% of the Federal Poverty Level. Active All Kids Premium Level 3-8 cases remain in effect until June 30, 2012 if all other eligibility guidelines are met. Care coordination teams assist in helping families see with how this change affects their CYSHCN.

Care coordination teams assist families in maximizing all funding sources for needed services and assist uninsured CYSHCN to apply to All Kids and Medicaid. For medically and financially eligible children, UIC-DSCC assists with the payment of private insurance co-pays and deductibles for specialty care, for care not covered by private or public insurance and for exceptions needed to promote continuity of care. Efforts to refer families to the Health Insurance Premium Payment (HIPP) program continue.

UIC-DSCC's benefit management unit (BMU) supports care coordination teams through training and technical assistance, including monitoring and analyzing the impact of national health care reform. The insurance appeals training module was completed and is available for care coordination staff. BMU also provides current information on health insurance and public funding sources for care coordination teams through the UIC-DSCC monthly electronic newsletter for staff.

c. Plan for the Coming Year

New care coordination staff will receive training on maximizing public and private funding sources. Benefit management staff will provide technical assistance to care coordination teams for individual CYSHCN issues, monitor and analyze key legislation for impact on CYSHCN health care funding, provide outreach to key agencies and programs, collaborate with other key agencies, and promote awareness of health care funding issues and opportunities. The benefits management staff will continue to provide current information on health insurance and public funding sources for care coordination teams through the UIC-DSCC monthly electronic newsletter. In addition, the online training module for health insurance appeals will be revised for families and posted on the UIC-DSCC website. Benefit Management staff will continue technical assistance visits to provide care coordination teams with current information regarding health insurance and public funding as well as assist with individual CYSHCN issues.

UIC-DSCC will continue to assist financially eligible families with the payment of private insurance co-pays and deductibles for specialty care, for eligible care not covered by private or public insurance and for exceptions when eligible care is needed to promote continuity of care. This assistance will be dependent on availability of federal and state funding.

UIC-DSCC staff will also monitor implementation of national health care reform legislation and Illinois Medicaid Reform.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	76.3	89.8	89.8	90	90
Annual Indicator	89.8	89.8	89.8	89.8	64.6
Numerator					
Denominator					
Data Source		CHSCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	64.6	64.6	64.6	64.6	66

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The

a. Last Year's Accomplishments

The 2009/2010 National CSHCN Survey found that 64.6 percent of Illinois families with CSHCN reported that the community-based services systems were organized so that they can use them easily. This result cannot be compared to previous survey results because the questions and methodology were changed for this survey.

UIC-DSCC staff continued to coordinate and collaborate with state and local agencies to identify and resolve service gaps and duplication. UIC-DSCC staff collaborated with the Family to Family (F2F) Health Information and Education Center in Illinois, providing consultation and serving on the Center's Advisory Committee. Community system development efforts continued with emphasis on Medical Home, Transition, Newborn Hearing and Early Intervention. Refer to NPM #3, NPM #6, SPM #10 and NPM #12 for more detail. UIC-DSCC continued to maintain two internet websites to which information and links were added or updated regularly with a variety of resources. The UIC-DSCC website is <http://www.uic.edu/dsc/>, and the website specifically for newborn hearing screening is <http://www.illinoisoundbeginnings.org/>.

Efforts to assist families of children eligible for SSI in accessing necessary services continued with telephone contacts for children ages 3 to 4 years and 14 to 16 years. UIC-DSCC mailed UIC-DSCC information and information about the Family to Family Health Information Center (in English and Spanish) to families of children age 16 years or less that were newly eligible for SSI. Toll-free telephone numbers were also provided.

UIC-DSCC staff provided care coordination to the families of more than 600 children who are technology dependent/medically fragile (TD/MF) to facilitate access to needed services through a Home and Community Based Services (HCBS) Medicaid waiver so these children can live at home with their families in their communities. Efforts continued to facilitate the transition of these children to programs for adults by age 21.

UIC-DSCC staff assisted families without health insurance to apply for All Kids. UIC-DSCC care coordinators assist all families with children enrolled in UIC-DSCC, including those in All Kids, to access primary and specialty health care services.

UIC-DSCC continued to collaborate with the Illinois Chapter of the American Academy of Pediatrics (ICAAP) on the HRSA State Integrated System Implementation Grant for CYSHCN (D70). See NPM #2 and #6 for more details on this grant.

Illinois' mechanism for families of individuals with developmental disabilities to make their needs known and help them access services, Prioritization of Urgency of Need for Services (PUNS), continued to be used by the IDHS Division of Developmental Disabilities (DDD). UIC-DSCC care coordination staff informed families about the benefits of completing a PUNS assessment and referred families to the intake entities in their area.

UIC-DSCC joined efforts on several initiatives with the Department of Healthcare and Family Services (HFS), including the CHIPRA grant, the ABCD-III grant (Healthy Beginnings), and the Integrated Care pilot for individuals 19 years and older having Aged, Blind, and Disabled eligibility for Medicaid. The CHIPRA grant, in collaboration with Florida's Medicaid program, focuses on measuring and reporting child health quality, coordinating that reporting with health information system development, testing/enhancing provider-based models to improve primary care, and creating other means of improving child health quality, access, and delivery. The ABCD-III grant focuses on improving communication between primary care providers (PCPs) and Early Intervention (EI) service coordination units regarding referrals made for EI services.

UIC-DSCC participated in several stakeholder meetings and enrollment training for the Integrated Services pilot implemented in the counties of DuPage, Kane, Kankakee, Lake, Will and Suburban Cook. The UIC-DSCC Core program recipients are excluded as well as those with insurance or

Medicare.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Care coordination infrastructure for eligible families.		X		
2. Collaborative memoranda of understanding with agencies.				X
3. Mutual referral process with Early Intervention Program.				X
4. Collaborative efforts with state Transition efforts.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

UIC-DSCC continues collaborative efforts with ICAAP and other stakeholders on the HRSA Integrated Systems (D70) grant. See NPM #6 and SPM #10 for more details. Staff continues participating with HFS in CHIPRA and ABCD-III grant activities to improve quality of care for children and communication between PCPs and EI service coordinators. UIC-DSCC staff has also participated in HFS stakeholder meetings to determine changes needed in the All Kids/Medicaid program for serving children with complex medical needs.

UIC-DSCC staff continues to participate in system building activities related to newborn screening, newborn hearing screening, Early Intervention, transition and medical homes. In an effort to improve access to specialty care for children with hearing loss, UIC-DSCC collaborated with the UIC-College of Medicine in Rockford and the UIC-College of Medicine in Chicago to make otology services available via telemedicine for children in the region surrounding Rockford. The first telemedicine clinic was held on January 19, 2012.

UIC-DSCC staff continues to assist families needing support services for their children with developmental disabilities, including referral to PUNS. UIC-DSCC also continues to assist families having children age 16 years or less, newly eligible for SSI, to connect with needed services. The system of care coordination staff in 13 regional offices that serve CSHCN in their communities continues to be supported by UIC-DSCC.

c. Plan for the Coming Year

UIC-DSCC will continue collaborative efforts with ICAAP on the 2nd HRSA Integrated Systems grant. See NPM #6. Staff will continue participating with HFS in CHIPRA and ABCD-III grant activities to improve quality of care for children and communication between PCPs and EI service coordinators. UIC-DSCC staff will continue collaborations with HFS to address the needs of children with complex medical conditions.

UIC-DSCC staff at both the state and local levels will continue to participate in system building activities related to newborn screening, newborn hearing screening, Early Intervention, transition and medical homes. Otologic telemedicine services will continue to be supported in northwestern IL and may be expanded if feasible. Other telemedicine opportunities will be explored to improve access to care for CSHCN.

UIC-DSCC staff will continue to assist families needing support services for their children with developmental disabilities, including referral to PUNS. UIC-DSCC will also continue to assist families having children age 16 years or less, newly eligible for SSI, to connect with needed services. The system of care coordination staff in 13 regional offices that serve CSHCN in their communities will continue to be supported by UIC-DSCC.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	5.9	44.2	44.2	44.4	44.5
Annual Indicator	44.2	44.2	44.2	44.2	45.3
Numerator					
Denominator					
Data Source		CHSCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	45.3	45.3	45.3	46	46

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the

sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

The 2009/2010 National CSHCN Survey found that 45.3% of Illinois families of youth with special health care needs reported that they receive the services necessary to make appropriate transition to adult health care, work, and independence. This result is up from 44.2% (2005/2006) compared to 40.0% nationwide (decrease from 41.2% in 2005/06). Breaking down this measure further shows: discussion occurred for 52.2% of IL youth (nationwide 44.4%) on health care needs as they become adults; discussion on keeping health insurance coverage as an adult occurred for 30.0% of youth in IL (23.2% nationwide); 36.9% of CSHCN in IL got all needed anticipatory guidance (compared to 31.6% nationwide); 69.4 percent of youth were usually/always encouraged to develop age appropriate self management skills (70.1% nationwide); discussion on transition to providers that treat adults was not needed for 39.3% IL (35.2% nationwide) and discussion on transition to adult providers occurred for 14.2% (13.6% nationwide).

There has been significant progress in building the infrastructure and accomplishing program goals and objectives for the Integrated Systems Grant project through the HRSA grant (D70MC12840). UIC-DSCC assisted in developing transition training modules and materials for Continuing Medical Education and Maintenance of Certification credit for pediatricians that include: developing/maintaining a registry; providing a written transition policy; assessing health care skills; reviewing individualized transition goals; identifying an adult primary care provider; providing adult social service and insurance resources; providing a portable medical summary; and discussing the need for guardianship. UIC-DSCC also assisted in developing training modules and a day-long conference on transition for adult-oriented physicians to prepare them to facilitate successful healthcare transitions.

As part of the D70 grant, UIC-DSCC collaborated in the work of the Integrated Services Committee (ISC) made up of representatives from state government agencies, community organizations, family and youth partners, primary care providers, and others. In 2010, the ISC used the Champions Inc Needs Assessment Tool PM 6 Transition to Adult Life to identify needs and set priorities. The ISC focused on working towards integrating health goals into education and comprehensive school transition plans with increased awareness of health impacting educational/vocational goals. UIC-DSCC participates on the Project Advisory Committee (PAC) and helps identify transition promising practices.

UIC-DSCC is a member of the Illinois Interagency Coordinating Council on transition (IICC) that was established in 1990 (20 ILCS 3970), focuses on transitioning youth ages 14-21, and meets quarterly. During 2010/2011 the Data Collection and Analysis Committee convened to complete a comprehensive review of the data currently being collected by agencies represented on the Council. Data included: High School Graduation Rate, High School Graduation Rate for Students with Disabilities by County, High School Dropout Rate, Educational Environment, Students Aged 14-21 Receiving Special Education Services by Disability Category, Race/Ethnicity Distribution of Students Aged 14-21 Receiving Special Education Services, Anticipated Services Needed Upon Graduation from High School, State Performance Plan Indicator 13 (transition plans), State Performance Plan Indicator 14 (post-school outcomes). A synopsis of the data was provided to the Public Policy Committee to inform their work on policy around transition issues. The Public Policy Committee conducted a series of meetings pulling in a diverse group of stakeholders, including other ICC agencies, advocates, and service providers. Additionally, the committee collaborated with the University of Illinois at Chicago's Department of Disability and Human Development to analyze data from the Division of Rehabilitation Services and prepare a synopsis

of federal and state laws related to transition. As a result of their work, the Public Policy Committee made several recommendations to the IICC.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participation on the Illinois Interagency Coordinating Council for Transition.				X
2. Transition training/technical assistance for care coordinators.		X		
3. Expansion of state data collection mechanisms.				X
4. Promoting awareness of transition issues/resources.				X
5. Participation in Annual Statewide Transition Conference Planning Group.				X
6. Expansion of partnership and alliances.				X
7. Participation on the Illinois Integrated Services Committee to coordinate and integrate the efforts of state and community-based agencies in the areas of transition.				X
8. Participation on Medicaid Infrastructure Grant Greatest Expectation Committee to help with the development of transition planning outreach.				X
9. Transition training for physicians and allied health care providers.		X		
10.				

b. Current Activities

UIC-DSCC continues participating on the HRSA Integrated Systems grant project subcommittees. One outcome was the conference "Improving Quality of Care for Young Adults with Special Health Care Needs" for adult-oriented providers on September 15, 2011. Forty-seven attendees included 24 physicians, 12 nurses, and 11 others.

UIC-DSCC participated on the Medicaid Infrastructure Grant's Greatest Expectation committee to develop transition planning outreach through a series of booklets. Four new booklets called Great Expectations, to help parents understand special issues of Community Involvement, Independence, Health & Wellness, Finance, Employment Skills and Self-Advocacy for their children. UIC-DSCC's family webpage (<http://internet.dsccl.uic.edu/dscclroot/parents/parents.asp#a2>) has a link to these booklets which are divided by age; Book 1- 0-3, Book 2-Pre-school, Book 3- Grade School and Book 4-High School and Beyond. The goal is to help parents raise a strong, independent, well-adjusted child who happens to have a disability.

The ISC developed a presentation on Health Goals in the IEP/Transition Plan that was given at the IL State Board of Education Transition Institute and at the IL Statewide Transition conference, both in fall 2011. The ISC shared resource information with the Illinois Life Span project, <http://www.illinoislifespans.org/> in an effort to expand the electronic searchable database, designed to help users navigate the advocacy and service systems in Illinois.

c. Plan for the Coming Year

In year 3 of the Integrated Systems grant, pilot sites will receive technical assistance and will test the Transitioning Youth to Adult Health Care Course for physicians. The pilot sites will take Quality Improvement Basics Training; review Transition Course Tools and Resources; take the transition training course, choose three Key Clinical Activities to work on and participate in the Part 4 Maintenance of Certification track. The grant work has already increased outreach to

health providers around the state and increased interest in health care transition. The courses targeting adult health care providers will be developed further over the next year once the pediatric transition course is released.

The ISC presentation on Health Goals in the IEP/Transition Plan was submitted for the 2012 National Rehabilitation Association Conference in August 2012. The ISC will review results of the IL Youth in Transition School Survey and strategize to improve attitudes and increase health care transition planning.

UIC-DSCC will participate on the steering committee and subcommittees for the eighth annual IL Statewide Transition Conference on October 24-26th, 2012, in St. Charles, IL. The pediatric and adult physician courses, developed by the Integrated Systems Grant project, will be introduced and a virtual tour provided as part of the Health Plenary session at the statewide conference on October 25th.

UIC-DSCC will continue to collaborate with other state agencies, community and advocacy service agencies, physicians, youths and families to plan, develop, evaluate and disseminate information and resources to improve transition outcomes for youth and young adults with special health care needs.

UIC-DSCC will continue to strategize and recognize opportunities for improvement in PM 6 including opportunities to discuss health care needs as youth become an adult; discuss keeping health insurance coverage as an adult, provide anticipatory guidance, promote development of age appropriate self management skills, and discuss transition to adult providers. Many supporting tools have been created and will be disseminated to health care providers over the next year including: A Guide to Adult Benefits, Services, and Resources and Health Care Skills Sheets to support providers in their transition planning efforts with youth/young adults and families.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	87	79	81	81	82
Annual Indicator	78.5	78.7	73.4	78	77.9
Numerator					
Denominator					
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events					

over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	82	82	82	82	82

Notes - 2011

From CDC - NIS. Full CY 2011 data not available. Coverage Levels by Milestone Ages - 24 months by State and Local Area: "Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series - Before 24 Months of Age by State and Local Area - US, National Immunization Survey, Q3/2010-Q2/2011"

Notes - 2010

From CDC - NIS. Provided by CDC-NIS to MCH Bureau via e-mail sent 5/17/12. "Vaccination coverage for the 4:3:1:3:3 vaccine series among children 19 to 35 months - US, National Immunization Survey, 2010"

2010 data may be appreciably higher due to the new definition for Hib that takes into consideration the brand type (meaning some children only need 3 doses to be up to date, while others need 4 doses to be up to date),

Note last year the 4:3:1:3 rate was used. This measure replaces other data used previously.

Notes - 2009

From CDC - NIS. Estimated Vaccination Coverage with 4:3:1:3:3 Among Children 19-35 Months of Age by Race/Ethnicity and by State and Local Area -- US, National Immunization Survey, Q1/2009-Q4/2009.

Data reflects Hib shortage which began this year.

Note last year the 4:3:1:3 rate was used. This measure replaces other data used previously.

a. Last Year's Accomplishments

The most current release of the National Immunization Survey (NIS) results (7/2009-6/2010) indicate that series completion levels for Illinois are as follows: 4:3:1:3 series at 76 percent. The NIS data for the Illinois federal project area that excludes the city of Chicago are as follows: 4:3:1:3 series at 75.8 percent. These series levels track additional vaccines that have been included in the Advisory Committee on Immunization Practices (ACIP) recommended childhood immunization schedule.

IDHS, IDPH, and IDHFS have collaborated on a campaign to improve the immunization level of children participating in the WIC program. Local WIC agencies (most of which are local health departments) received regular reports from IDHS on the proportion of infants and toddlers in the WIC program who were fully immunized. In addition, IDPH provides funding to support immunization efforts in CEDA WIC agencies. During 2008, 85.7 percent of children ages 12-18 months served at one of 15 CEDA-operated sites met the 3/2/2 coverage and 83 percent of children ages 24-35 months met the 4/3/3/1 series coverage. Statewide in SFY 2010, WIC children ages 12-18 months achieved 3:2:2 series coverage of 85.3 percent. This is an increase from the previous reporting period. Levels for 4:3:3:1 at 24-35 months of age improved slightly from 77.6 percent in SFY 2009 to 78.8 percent. IDPH provides federal immunization grant funds to support Vaccines for Children Assessment, Feedback, Incentives and Exchanges (VFC-AFIX)

and provider education initiatives through ICAAP, Rockford Health Council, CCDPH, Will County Health Department, Macon County Health Department, Madison County Health Department, and Peoria City-County Health Department. VFC operations require that a minimum of 25 percent of all enrolled providers receive a site visit annually. There are over 1,748 VFC enrolled provider sites (excluding Chicago) representing over 3,000 physicians. In addition, general revenue funds have been awarded annually since FY01 to 4 agencies providing direct services to children in areas identified as high risk to under immunization or access to healthcare services as well as areas with identified health care disparities. However, due to reduction in overall GRF funds, these grants will not continue after FY10.

The VFC program was established to reduce or eliminate barriers to service and eliminate costs as a factor. However, it is not related to providing services to children only due to special needs. All children meeting VFC eligibility are covered. VFC allows children to receive immunizations in their medical home.

Chicago. The 2010 National Immunization Survey (NIS) results (1/2010-12/2010) indicate that series completion levels for the 4:3:1:3 childhood series was 79.9%. Chicago's level coverage was higher than the national level of 78.8% for the 4:3:1:3 childhood series. In March 2011, Chicago is received the award for highest series coverage (74.4%) among the six urban area immunization grantees during the opening session at 2011 National Immunization Conference (NIC). The award was based on the 4:3:1:-:3:1:4 series, which excludes Hib vaccine and is called the "modified" vaccine series in the MMWR article with 2009 NIS results. The NIC awards are based on the "mid-year" NIS data from last half of 2009 combined with first half of 2010.

The CDPH provides federal funds to St. Bernard Hospital to operate the Baby Immunization Tracking System (BITS), which is designed to track infants born at the hospital through their first years of life or until their shots are up-to-date. In 2011, 1,140 infants were born at the hospital and 98 percent received their "birth dose" of Hepatitis B vaccine before they were discharged. CDPH's immunization Program operates seven walk-in immunization clinics that served over 4,800 children in 2011.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The IDPH Immunization program distributes vaccines to local health departments and Vaccines for Children.			X	
2. The IDPH Immunization program assesses immunization levels of children served in public clinics.				X
3. The IDPH Immunization program directs additional resources to areas identified as "Pockets of Need."			X	
4. Additional outreach activities are conducted by the Chicago Department of Public Health & community organizations or coalitions.			X	
5. IDHS monitors and distributes reports of immunization coverage of children in the WIC program.		X		
6. IDHS monitors immunization coverage of children in programs for infants, young children, and teen parents.		X		
7. IDHFS sends reminder notices to families.			X	
8. IDHFS collaborates with IDPH on Vaccines for Children.				X
9. IDHFS included childhood immunizations (by age 2) as a bonus payment strategy within the managed care program (MCO and PCCM). The measure of childhood immunization by 24 months in addition to immunization by 36 months will also be added.				X

10. IDHFS provides patient-specific feedback on immunization status to Primary Care Case Managers.				X
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b. Current Activities

The IDPH Immunization program is federally funded and is authorized by Section 317 of the Public Health Service Act. Additional federal funds are awarded annually through the federal VFC program as established through OBRA93. The program operates the following: 1) distributes vaccines to public and private providers statewide; 2) conducts surveillance and investigates outbreaks of preventable childhood and adult diseases; 3) conducts mandatory assessments of vaccine coverage levels among various target populations; and 4) works with IDHFS to improve immunization levels among Medicaid-eligible children.

Chicago. The Immunization Program operates seven immunization walk-in clinics that provide fast, free and friendly immunization services to children 0-18 years of age. The seven Fast Track clinics are located in seven community areas.

c. Plan for the Coming Year

IDHS, IDPH, and IDHFS will continue the WIC immunization campaign. Immunization records will be added regularly to the Cornerstone and ICARE systems from the Medicaid Management Information System and the immunization tracking software used by the Chicago and Cook County Health Departments. Quarterly reports on the immunization coverage of one and two-year-olds will be provided to local WIC agencies, with follow-up consultation and technical assistance from regional staff.

IDPH will conduct and review the annual IDCFS/IDHS child care and Head Start survey through a random selection method developed by CDC. The Immunization Program will also work with the Child Care Resource and Referral Networks to educate child care facility staff regarding implementation and enforcement of immunization requirements. IDPH will visit at least 25 percent of enrolled provider sites with VFC to determine VFC compliance and conduct assessment of practice coverage levels. IDPH will continue the annual quality assurance reviews to determine compliance with the Standards for Pediatric Immunization Practices. Quality assurance reviews will use the AFIX strategy as developed by CDC. IDPH has a grant agreement with the ICAAP to extend AFIX services and conduct peer provider education. This strategy will also promote "birth dose" Hepatitis B vaccine efforts as well as adolescent immunization services and promotion.

The immunization program received supplemental funding in 2009 as part of the American Recovery and Reinvestment Act (ARRA) to increase vaccine coverage among children, adolescents and adults. ARRA direct assistance vaccine is utilized at the 95 certified health departments and will continue through December 31, 2011 to promote and deliver vaccinations to underinsured children and adolescents against varicella, meningococcal and pertussis disease.

In addition, IDPH-authorized health jurisdictions will also identify and promote pertussis (Tdap) vaccination to parents enrolled in WIC and Family Case Management programming operated by the health jurisdiction to reduce the risk of pertussis infections in newborns. Parents between the ages of 15 to 25 years will be the primary focus of this initiative, as the majority of reported infant pertussis in Illinois has occurred in households where parents fell in this age range.

The CDPH Immunization Program will continue to intensify strategies to improve immunization rates in Chicago with the following current activities: outreach, Fast-Track clinics, the CareVan, the WIC Immunization linkage program, and partnership with St. Bernard Hospital. CDPH's Public Health Nursing, Family Case Management, Healthy Start and the community health clinics will continue to track immunization status of two-year-olds and provide immunizations as necessary.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	21	21	21	21	19
Annual Indicator	22.1	21.2	19.2	19	19
Numerator	5988	5653	5057		
Denominator	270929	266679	263644		
Data Source		IDPH, Center for Health Statistics			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	19	19	19	19	19

Notes - 2011

Data are not available from IDPH for 2011 births. IDHS has no control over the processing or release of the State of Illinois Birth File. Therefore the rate for 2011 uses the rate from 2009 as an estimate. The approximate due date of the 2011 Birth File is May 2013.

Notes - 2010

Data are not available from IDPH for 2010 births. IDHS has no control over the processing or release of the State of Illinois Birth File. Therefore the rate for 2010 uses the rate from 2009 as an estimate. There is no due date for the 2010 Birth File. IDPH previously said it would be available "before 7/1/2012." As of 9/21/12 it is still not available.

Notes - 2009

Source: IDPH Birth for 2009, received May 2011. Denominator is Census population estimates for 2009.

Note that the rate is an all-time low for Illinois and is below the National rate of 20.1 per 1,000 per Preliminary 2009 birth data found at: http://www.cdc.gov/nchs/data/databriefs/db58_tables.pdf#2

a. Last Year's Accomplishments

The rate of births to 15 to 17 year-old women in 2009 was 19.2 per 1,000, the lowest rate in recent records. This was well below Illinois' performance target (21 per 1,000). The birth rate among 15 to 17-year-olds has declined by 18 percent between 2000 and 2005. A breakout by

race or ethnicity is not available at this time. This breakout will be available later this year when the IDPH releases its aggregate totals to IDHS.

Several programs in the Division of Community Health and Prevention work to reduce teen births. The Primary and Subsequent Teen Pregnancy Prevention programs provided services to 66,000 adolescents in SFY'09. The Teen Parent Services program helped more than 2,394 low-income teen parents work on finishing school and move from welfare to work in SFY' 09. In SFY 2010 the Parents Too Soon program helped nearly 2000 teen parents develop parenting skills, delay a subsequent pregnancy and finish school. The Family Planning Program provided comprehensive reproductive health services to 28,115 adolescents in 2010.

Chicago. In 2008, 2,026 teens aged 15 --17 years of age gave birth. This calculated - to a rate of 38.3 births per 1000 teens. . In 2009 there were fewer births to teens aged 15-17 years of age (1,764). The 2009 birth rate was 33.7 per 1000 teens.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDHS awards grants for Primary Teen Pregnancy Prevention programs.		X		
2. IDHS awards grants for Subsequent Teen Pregnancy Prevention programs.		X		
3. IDHS monitors repeat pregnancy rates among the clients of programs that serve teen parents.				X
4. IDHS awards grants for Family Planning programs.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Primary and secondary prevention of teen pregnancy and sexual activity before marriage is being addressed by the routine activities of the PTS, TPS, TPP, School Health Centers, School Health, and Family Planning programs. School Health Centers (SHCs) conduct risk assessment of all regular clinic users and provide anticipatory guidance, treatment or referral for sexual health and contraceptive services are included.

Chicago. Through its Family Case Management, Public Health Nursing, outreach, Family Planning, Healthy Start, and Male Responsibility programs, CDPH provides services so that unwanted pregnancies are prevented. The Male Involvement and Family Planning programs provide education to teens on abstinence; safe sex practices to avoid unintended pregnancy and sexually transmitted infections including HIV; contraception; the prevention of sexual coercion; domestic violence; and pre/inter-conception care including nutrition, exercise and avoidance of smoking, alcohol, and drug use. CDPH, along with Chicago Public Schools & Planned Parenthood of Illinois, has begun implementing the Wyman Center's Teen Outreach Program in 26 High Schools focusing on 9th grade classrooms. This evidence based intervention is proven to reduce teen births along with increase academic and attendance outcomes. This is a five year project that began September 2010 and will continue for a period of 5 years, with a goal of reducing the teen birth rate by 10% to 29 per 1000 births.

c. Plan for the Coming Year

Reduction of teen pregnancy will be addressed by the routine activities of the PTS, TPS, TPP, SHCs, School Health, and Family Planning programs.

Chicago

For the upcoming year, CDPH will partner with CPS to fully implement the Wyman Center's Teen Outreach Program in 26 High Schools. Additionally, CDPH will assist in the implementation of a social media/marketing campaign focusing on adolescent health and launch the implementation of Health Resource Rooms in the 26 high schools. These Health Resource Rooms will provide students in with information on a variety of health topics as well as make condoms available to the students.

CDPH established an Office of Adolescent and School Health which encompasses the Teen pregnancy Prevention Initiative, the School-based Oral Health Program and the STI/HIV Adolescent Health Program. The STI/HIV Adolescent Health Program continues to implement the STI Education and Screening Initiative in Chicago Public Schools. For the FY12 School Year, CDPH has educated 4, 240 students in 18 high schools (with a target of reaching 30 high schools by June 2012) and screened 2,751 students for Gonorrhea and Chlamydia. Nearly 64% of all students educated volunteered to be screened and of those tested, 7.42% were positive for Chlamydia, 80% were positive for Gonorrhea and .15% were dually infected. This project will continue for the following year and will attempt to provide services at 60 CPS high schools.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	27	28	28	42	43
Annual Indicator	27.0	27.0	41.5	41.5	41.5
Numerator	42000	42000	65000	64516	64516
Denominator	155356	155356	156512	155468	155468
Data Source		IDPH, Oral Health	IDPH, Oral Health	IDPH, Oral Health	IDPH, Oral Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	44	45	46	46.5	46.5

Notes - 2011

Data repeated from 2010 reporting year and marked as Provisional due to lack of response from IDPH. Several attempts requesting new data and narrative have been made with numerous IDPH staff. As of July 9, 2012 no updates from IDPH on Oral Health.

Notes - 2010

According to the IDPH, Division of Oral Health, the 2008-2009 survey of 3rd grade children showed 41.5 percent of 3rd grade children had sealants on at least one permanent molar tooth. Every year the MCH program has extrapolated this percentage to the statewide population of 3rd grade students located at the Illinois State Board of Education's website.

The very small underresourced public health program completes a statewide third grade Basic Screening Survey every five years based on the Association of State and Territorial Dental Directors and CDC guidance.

In FY2010, the Division of Oral Health served 166,607 children — 127,436 were on Medicaid, leaving 39,171 on Other or Private insurance.

/2013/IDPH completes a statewide 3rd grade Basic Screening Survey every five years based on the Association of State and Territorial Dental Directors and CDC guidance. The survey includes a height and weight measurement yielding BMI data.

In FY2011, IDPH assured preventive oral health care, oral health education and case management into dental homes for 157,212 children. Of these children, 122,272 were on Medicaid with the other 34,940 on private or other insurance.//2013//

Notes - 2009

According to the IDPH, Division of Oral Health, the 2008-2009 survey of 3rd grade children showed 41.5 percent of 3rd grade children had sealants on at least one permanent molar tooth. Every year the MCH program has extrapolated this percentage to the statewide population of 3rd grade students located at the Illinois State Board of Education's website.

The very small underresourced public health program completes a statewide third grade Basic Screening Survey every five years based on the Association of State and Territorial Dental Directors and CDC guidance.

In 2009, 18,367 3rd grade children received sealants covered by IDHFS medical programs (Title XIX, Title XXI, and State Funded) - IDHFS Dental Claims Data from the Medical Data Warehouse.

/2013/IDPH again participated the 2008-2009 Basic Screening survey entitled Healthy Smiles/Healthy Growth. The data for Chicago showed an increase in dental caries from 59 percent to 63.5 percent in the past five years (2003-2004 results), and an increase in students with sealant(s) from 12 percent to 34.3 percent in the same time period.//2013//

a. Last Year's Accomplishments

/2013/In FY 2011, the IDPH Dental Sealant Program is present in 68 of the 102 counties in Illinois. Including the coverage of schools in the city of Chicago, the number of children served each year has doubled since 2008. The growth in the number and size of safety net dental clinics has significantly increased the potential for linking children and their families to a dental home through the school-based program.

The IDPH Dental Sealant Grant Program continues to expand to reach the most vulnerable children by working with the community-based grantees to assure services for pre-school children and children with special health care needs.//2013//

Chicago:/2013/2010-2011 School Year. The Chicago Department of Public Health (CDPH) School-Based Oral Health Program is on target to perform oral health services for approximately 95,000 children and place approximately 168,000 dental sealants. Services will be provided in more than 500 schools during the 2010-2011 academic years. The program has converted from using their scannable dental record to using the Sealant Efficiency Assessment for Locals and States (SEALS) software program that allows

electronic data. The IDPH Division of Oral Health provides the software and training through the Centers for Disease Control and Prevention. Walk out letters and IDPH Oral Health School Dental Examination forms were provided to participating students. A system has been developed that not only sends parents follow up notices through the mail, but also provides a follow up by phone. This will improve the program's ability to assist parents in finding dental homes for their children.

Approximately 39,000 students presented with untreated dental decay and received a dental referral. Approximately 9,400 presented with urgent dental decay and received a dental referral.

IDPH has 50 dental sealant program grantees serving 67 percent of Illinois counties. Approximately 1,250 schools are visited providing oral health care, oral health education, dental examinations, referrals for needed treatment, and outreach for All Kids enrollment. More than half of the communities report serving Pre-Kindergarten, Early Head Start/Head Start, and education centers for children with disabilities. All of the communities operate a case management/referral program to assist families in finding dental homes for their children.//2013//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDPH works with local health departments and schools to conduct dental sealant grant programs.	X			
2. IDHFS contracts with /2013/Dataquest//2013// to monitor sealant levels and conduct targeted outreach.				X
3. IDPH works with IDHFS to monitor all school-based oral health program performance.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2013/The IDPH Division of Oral Health works with communities to implement the Sealant Efficiency Assessment for Locals and States (SEALS) data system. The system monitors their program performance and provides monthly reports electronically to IDPH, which eases the amount of paperwork. SEALS will be a source of oral health status data as it collects Decayed Missing Filled Teeth Surfaces information on every participating child. The city of Chicago program has adopted the SEALS program to eliminate the use of paper forms and scanning technology. IDPH is working with the IDHFS to expand the quality assurance component used for their grantees to include non-grantee school-based dental providers making performance evaluation consistent throughout the state.

Chicago: 2010-2011. The Chicago Department of Public Health School-based Dental Sealant Program Quality Assurance Program continues to review the work of oral health care providers. The more than 90 percent sealant retention rate exceeded IDPH requirements.

Chicago: 2010-2011. The Dental Sealant Program has implemented the SEALS electronic data

collection tool utilizing the oral health information from all of the dental providers in the program.

Since its inception, FY 2012 marked a milestone with more than 1 million children treated with more than 2 million sealants placed.

All School-based dental providers have been required to implement an expanded case management referral program.

c. Plan for the Coming Year

/2013//All school-based dental providers will implement a case management program using staff to contact families by phone to expand efforts to assist families in reaching dental home.

IDPH will provide dental sealant grantee communities and schools technical assistance and training to implement weekly school-based fluoride mouthrinse programs as a part of their oral health programs. Research demonstrates that school-based fluoride programs are an effective and efficient public health strategy to help prevent and to reduce dental decay. This prevention measure provides communities with the ability to extend oral health improvement activities from one to two dental events per year to weekly dental events throughout the school year. A 2010-2011 study by the Chicago Public Schools reported the need for more frequent oral health activities that the school-based mouthrinse program will help accomplish.

IDPH will begin planning the 2013-2014 Basic Screening Survey of the oral health status and BMI of Illinois 3rd graders. This survey will provide outcome data depicting caries experience. The survey will also provide impact data by measuring dental sealants and untreated dental decay. The data is critical to assess gaps and assist the state to plan future steps to improve oral health.//2013//

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	2.4	2	1.9	1.9	1.7
Annual Indicator	2.1	1.7	1.7	1.7	1.7
Numerator	54	45			
Denominator	2631525	2636251			
Data Source		IDPH - Vital Records			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

	2012	2013	2014	2015	2016
Annual Performance Objective	1.7	1.7	1.7	1.7	1.7

Notes - 2011

Vital Records data from IDPH for deaths in 2011 is not available at this time. See note for 2009 deaths for more information.

Notes - 2010

Vital Records data from IDPH for deaths in 2010 is not available at this time. See note for 2009 deaths for more information.

Notes - 2009

Data are not available from IDPH for 2009 deaths. IDHS has no control over the processing or release of the State of Illinois Death File. Therefore the rate for 2009 uses the rate from 2008 as an estimate. There is no due date for the 2009 Death File. IDPH previously said it would be available "before 7/1/2012." As of 9/21/12 it is still not available.

a. Last Year's Accomplishments

For calendar year 2008, the last year for which death data was available from IDPH for the state, Illinois achieved its goal of reducing the rate of motor vehicle crash deaths among children between one and 14 years of age to 2 per 100,000 children. Actual performance was 1.7 per 100,000 in 2008.

IDPH continued its partnership with the Chicago Police Department, the Illinois State Police, local hospitals and health centers, and the IDCFS to conduct community child safety seat checks. Through this partnership, 45 safety seat checks were held, and 1,400 car safety seats were distributed to low-income families, and more than 3,000 car seats were checked for proper seat installation. During a car seat check clients are shown how to properly use seat belts as well as proper car seat installation.

Children with special health care needs are referred to LaRabida Hospital for services.

Chicago. In Chicago in 2007, eleven children aged 14 years and younger died in motor vehicle accidents. This calculates at a rate of 2.5 per 100,000 children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDHS participates in child safety seat checks and seat distribution.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The IDPH Safe Kids Illinois program was transferred in 2009 to Children's Memorial Hospital in Chicago. The CDPH no longer distributes car seats; however, when they are available, staff encourage clients to attend the educational sessions and to receive a car seat.

c. Plan for the Coming Year

Child safety seat checks and distribution of child safety seats will be handled by the Illinois State Police, Illinois Department of Transportation, a network of health departments, community-based organizations, DHS local offices, churches and Children's Memorial Hospital. Use of child safety seats is a community issue.

Many parents cannot afford to purchase a child safety seat and/or do not know how to properly install the safety seat. The Child Passenger Protection Act was established to protect the health and safety of children through the proper use of an approved child safety restraint system.

Healthy Child Care Illinois provides families and child care providers with educational support and resource referrals on transportation safety to include the importance of child safety seats.

All students enrolled in school health centers are assessed for risk of unintentional injury and provided with health education focused on injury prevention, bicycle safety, and seat belt use.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	28	26	27	27	29
Annual Indicator	25.7	25.7	27.3	28.8	26.1
Numerator	14483	15193	16874	17926	15312
Denominator	56315	59219	61786	62305	58592
Data Source		IDHS, WIC Program	IDHS, WIC Program	IDHS, WIC Program	IDHS, WIC Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016

Annual Performance Objective	27	28	29	30	30
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Notes - 2011

The Numerator is infants Still Breastfed at 6 Months. The Denominator is infants Ever Breastfed. Source: Count and Percent of WIC Breastfed Infants, SFY 2011 Annual Report, FCS, IDHS.

Notes - 2010

The Numerator is infants Still Breastfed at 6 Months. The Denominator is infants Ever Breastfed. Source: Count and Percent of WIC Breastfed Infants, SFY 2010 Annual Report, CHP, IDHS.

Notes - 2009

The Numerator is infants Still Breastfed at 6 Months. The Denominator is infants Ever Breastfed. Source: Count and Percent of WIC Breastfed Infants, SFY 2009 Annual Report, CHP, IDHS.

a. Last Year's Accomplishments

In 2011, 26.1 percent of WIC participants continued breastfeeding for six months (from Count & Percent of WIC Breastfed Infants FY11). From the 2011 CDC Breastfeeding Report Card, United States --2011: Outcome Indicators, all Illinois women had a 44.5 percent breastfeeding rate at six months. Illinois collects data on breastfeeding practices through the Cornerstone Information System for CDC's Nutrition Surveillance Systems and internal and external use in identifying breastfeeding patterns and practices. These include: initiation and duration of breastfeeding, exclusivity, client contacts, and breast pump issuance.

To promote and support extended breastfeeding among the WIC population, IDHS has provided technical assistance and consultation on breastfeeding promotion, support and management for health departments and other local agencies administering WIC and other MCH programs statewide. Through regional and statewide training, staff are kept up to date with advances in breastfeeding research. Events included a two-day State Breastfeeding Peer Counselor Conference; week-long intensive breastfeeding trainings that resulted in certification as a Certified Lactation Counselor, Certified Lactation Specialist, or Breastfeeding Support Counselor; and three "Bridges to Breastfeeding" workshops.

Staff are trained to provide breastfeeding support and assistance to all mothers and babies, including CSHCN. Trainings and conferences provide opportunities to learn strategies and problem-solve special situations, e.g. babies with Down Syndrome, cleft palate, etc. Staff is encouraged to provide hands-on assistance to overcome special challenges in breastfeeding dyads.

IDHS provided technical assistance to local agencies with Peer Counselor programs and other breastfeeding projects. Peer counselors made over 58,150 participant contacts in FY11. Six Peer Counselor Enrichments provided updates and training to over 100 peer counselors and their supervisors. Three Loving Support peer counselor trainings trained 30 new peer counselors. Peer counselor supervisors were trained through conference calls and a statewide workshop.

Chicago and local agencies: CDPH continues to actively promote breast feeding activities in the City. In 2011, the agency held the 6th annual "Breastfeeding Promotion Walk and Celebration Day" at Rainbow Park and Beach. Participants, numbering over 800 people, including men, women, grandparents, children and infants from all racial and ethnic groups attended and rallied their support for breastfeeding. The event included numerous breastfeeding and child health advocacy organizations participating with CDPH making it very successful. The organizations included: Healthy Families of Illinois; March of Dimes; SIDs of Illinois; Chicago Breastfeeding Task Force; LaLeche League; Ameda and Medela. Live entertainment, lunch, healthy snacks, and take home items including breastfeeding literature, tee shirts, book bags, school supplies and raffle gifts were provided by vendors and supporters.

Hospital Collaboration: Through the "Bridges to Breastfeeding Program" and hospital networking

activities, local agency staff collaborate to provide seamless hospital-to-community-based breastfeeding counseling and services for breastfeeding moms and babies. . Through regional task forces throughout Illinois, WIC, hospital staff and community advocates work together to promote breastfeeding and support breastfeeding mothers and babies.

Community Collaboration: IDHS collaborated with Health ConnectOne, the University of Illinois at Chicago College of Public Health and other WIC and community organizations to produce the Illinois Breastfeeding Blueprint. The Blueprint reflects a needs assessment and a strategic plan for moving breastfeeding forward in Illinois.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDHS promotes breastfeeding through the WIC program.		X		
2. IDHS provides technical assistance and consultation on breastfeeding promotion for local WIC providers.				X
3. IDHS increases the grant awards of local WIC agencies that excel in breastfeeding initiation and duration.				X
4. IDHS distributes promotional items for World Breastfeeding Week and Illinois Breastfeeding Month.				X
5. IDHS conducts training programs for breastfeeding coordinators in local WIC programs.				X
6. IDHS supports the activities of state and regional breastfeeding task forces.				X
7. IDHS oversees a breast pump program.		X		
8. IDHS provides breastfeeding education to the local staff of other MCH programs.		X		
9. IDHS collects information for CDC's Prenatal and Pediatric Nutrition Surveillance Systems through Cornerstone.				X
10. IDHS is taking the lead in drafting a "Breastfeeding Blueprint for Illinois"		X		

b. Current Activities

Illinois Breastfeeding Promotion and Support Month will be celebrated in August, coinciding with International World Breastfeeding Week. IDHS continues to support the activities of local agency Breastfeeding Coordinators statewide through quarterly conference calls, technical assistance and educational materials. Breastfeeding program updates are provided on a regular basis through regional meetings and statewide conference calls.

IDHS provides technical assistance to local agencies with Peer Counselor programs and other breastfeeding projects. Seventy agencies and over 130 Peer Counselors provide services to eligible participants. Peer counselors make over 4800 participant contacts every month. Through planned peer counselor and supervisor conference calls, peer counselors continue to gain expert knowledge to provide improved breastfeeding peer counseling services to eligible participants. Peer counselor trainings and enrichments target current topics and provide opportunities for networking and continued education.//2012//

Training of staff and community partners continues to be a priority. Beside trainings focused on MCH program staff, regional task forces present breastfeeding conferences with nationally known speakers to help promote community awareness and education for members of their community.

c. Plan for the Coming Year

Illinois Breastfeeding Promotion and Support Month will be celebrated in August, coinciding with International World Breastfeeding Week. IDHS continues to support the activities of local agency Breastfeeding Coordinators statewide through quarterly conference calls, technical assistance and educational materials. Breastfeeding program updates are provided on a regular basis through regional meetings and statewide quarterly conference calls.

IDHS continues to provide guidance and oversight to local agencies with Peer Counselor programs and other breastfeeding projects.

Training of staff and community partners continues to be a priority. Beside trainings focused on MCH program staff, regional task forces present breastfeeding conferences with nationally known speakers to help promote community awareness and education for members of their community. The Illinois State Breastfeeding and Peer Counselor Conference will provide updated information on breastfeeding to local peer counselor training staff. Planned presentations include information on using social media to contact breastfeeding clients, as well as more clinical topics, e.g. breastfeeding the special needs baby.

Chicago. CDPH continues to lead a citywide celebration in recognition of the importance of breastfeeding for the health of Chicago's children. The 6th annual Breastfeeding Awareness Walk and Celebration was held in August 2011. All WIC sites have a designated breast-feeding room, furnished and decorated in a comfortable and welcoming manner. The CDPH is collaborating with the Chicago Consortium to Lower Obesity in Chicago's Children (CLOCC) to encourage Hospitals in Chicago to obtain the "Baby Friendly" designation. Seventeen of the nineteen delivery hospitals are actively pursuing this option and are in various stages of development. Eleven hospitals have signed up for mentoring, five are receiving funding; four of whom are in the discovery phase and one in the development phase. Eight hospitals are registered for Baby Friendly.

IDHS continues to work with IDPH on the "We Choose Health" Breastfeeding Workgroup. Through the IDPH's Community Transformation Grant "We Choose Health", several breastfeeding initiatives are underway to improve breastfeeding rates and the breastfeeding culture in Illinois.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	99	99.2	99.2	97	99
Annual Indicator	96.9	96.6	97.8	99.0	99.1
Numerator	174909	170629	167249	159550	155671
Denominator	180530	176634	171077	161108	157023
Data Source		IDPH, Vision & Hearing	IDPH, Vision and Hearing	IDPH, Vision and Hearing	IDPH, Vision and Hearing
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a					

3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	99	99	99	99	99

Notes - 2011

Source: IDPH Hi*track as of 3/21/2012 - as entered by U of I - DSCC.

Notes - 2010

Source: IDPH Vision and Hearing Screening Program, June 2011. Numbers indicated are based on infants reported to IDPH Vision and Hearing Program rather than vital statistics.

Notes - 2009

Source: IDPH Vision and Hearing Screening Program, April 2010.

a. Last Year's Accomplishments

The Early Hearing Detection and Intervention (EHDI) program is a shared initiative of 3 state agencies: Illinois Department of Public Health (IDPH), the University of Illinois at Chicago - Division of Specialized Care for Children (UIC-DSCC), the Title V CSHCN Program and the Illinois Department of Human Services, which administers Part C. Newborn hearing screening legislation was effective December 31, 2002. Legislation requires all birthing hospitals to screen infants prior to discharge, report to IDPH within 7 days, and make screening available for children born outside of the birthing hospital. When an infant does not pass the screening before discharge, IDPH works with the parents and Medical Home to obtain follow-up services. When a hearing loss is confirmed, IDPH refers the child/family to Part C, local health department and UIC-DSCC. Two-way sharing of child specific data is achieved through a release of information.

2010 data from the EHDI Program reveals 161,108 infants reported with 159,550 screened prior to discharge. The EHDI program is not linked to blood spot or electronic birth certificates. Of those infants reported, 99.0% were screened prior to discharge, 0.4% was reported as deceased prior to screening and 0.5% were not screened prior to discharge. The referral rate for those screened was 3.6%. Of the infants referred on inpatient hearing screening, 70.2% passed outpatient screening and were reported to EHDI. To date, 251 infants born in 2010 were reported with confirmed hearing loss of any type. This suggests an incidence rate of 1.57/1,000 for infants screened at birth.

Preliminary 2011 data indicates 157,023 infants reported and 155,671 infants screened prior to discharge. For 2011, 99.1% of the infants reported to the IDPH EHDI program were screened inpatient prior to discharge with a referral rate of 4.0%.

HRSA grant funds supported the coordinator to oversee operations and assist IDPH to provide training and technical assistance to hospitals, audiologists, physicians, home visiting staff and interventionists; facilitate linkages to the Part C, CSHCN, parent-to-parent support and medical home; encourage audiologists to participate in the state Medicaid and Part C Programs; and work with the newborn hearing advisory group.

During the 3 year cycle for the HRSA EHDI grant that ended March 2011, Illinois addressed lost to follow-up using the quality improvement model. UIC-DSCC coordinated a QI collaborative in the Chicago area with 5 large hospitals and community entities. Knowledge obtained through the NICHQ learning collaborative was applied. Over 40 change concepts that lead to change were shared. All change concepts strengthened links between screening, diagnosis, reporting, referral to Part C and connection to a Medical Home while using outcome measures to validate progress. Hospital staff, audiologists, interventionists, physicians and parents/consumers participated. Two

on-site learning sessions, conference calls, webinars, surveys and email supported the collaborative.

Over 120 families with a child who has a hearing loss were served through Guide By Your Side (GBYS). The program provided parent to parent support by trained parent guides. Support was available in English, Spanish and American Sign Language. In addition, GBYS provided state and community outreach to professional stakeholders.

With the support of national technical assistance, pilot training projects for hospitals were completed. Feedback from the quality improvement and pilot projects led to the development of parent materials. The new materials were created by parents for parents.

Supplemental funding assisted achieving: support for outreach to the Latino community (estimated as 15-20% of IL population); a resource manual for parents in English and Spanish; a call to action video for parents; and standardization of parent messages, materials, and outcome measures for birthing hospitals.

In April 2011 UIC-DSCC received a new 3 year HRSA EHDI grant. The grant focuses on reducing loss to follow-up and partnering with the Home Visiting Programs. During the first quarter UIC-DSCC partnered with IDPH to in-service birthing hospitals using a standardized training curriculum for hearing screening and train on the upgraded reporting system. Also, Home Visiting programs and their goals of hearing screening were identified. Initial collaboration with these stakeholders began.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Hospital screen each newborn for hearing loss.			X	
2. Test results reported to IDPH.				X
3. Parents and physicians are notified of abnormal test results and informed of diagnostic testing procedures.			X	
4. Diagnostic testing performed by audiologist.	X			
5. Confirmed diagnoses are reported to IDPH.				X
6. Children with diagnosed hearing loss are referred to Early Intervention and CSHCN programs.		X		
7. UIC-DSCC pays for diagnostic evaluation for families who cannot afford it or have insurance that does not cover it.	X			
8. IDHS convenes the Hearing Screening Advisory Committee and monitors program operation.				X
9.				
10.				

b. Current Activities

HRSA funding (2011-2014) was again awarded to reduce loss to follow-up in the IL EHDI system. Funds are used to provide oversight of operations; support IDPH in providing technical assistance to hospitals, audiologists, physicians, interventionists, and Home Visiting staff; facilitate linkages to the Part C, CSHCN, parent-to-parent support and Medical Home; encourage providers to participate in the state Medicaid and Part C Programs; and to work with the advisory group.

Grant goals include: increase parent and provider education of the 1-3-6 EHDI initiatives, reduce loss to follow-up, and improve timely outcomes for families and infants with hearing loss.

Activities include: collaborate with parents of children with a hearing loss to educate stakeholders at the community level; implement training at the birthing hospitals; implement quality

improvement strategies in hospitals such as scripted messages and scheduling follow-up; educate audiologists, interventionists, Medical Home and parents to enhance service delivery; and train Home Visiting staff in objective hearing screening, reporting and referrals.

Activities are evaluated by the program coordinator with assistance from national collaborators. The coordinator ensures cultural/linguistic sensitivity; measureable outcomes throughout screening, diagnosis and intervention; parent involvement; and flexibility to meet state needs.

CDPH continues to implement a tracking system for all EHDl referrals from IDPH.

c. Plan for the Coming Year

HRSa grant funding (April 2011-March 2014) will continue to be used to reduce loss to follow-up in the IL EHDl system. UIC-DSCC will continue to use EHDl grant funds to support the coordinator to oversee daily program operations, including supporting IDPH in providing technical assistance to hospitals, audiologists, physicians, interventionists and Home Visiting staff; facilitating linkages among the Part C, CSHCN, parent-to-parent support, and the Medical Home; encouraging new audiology providers to participate in the state Medicaid and Part C Programs; and working with the newborn hearing advisory group.

Specific grant goals include: increase parent and provider education of the 1-3-6 EHDl initiatives, reduce loss to follow-up through quality improvement initiatives, and improve timely outcomes for infants with hearing loss and their families. Activities such as technical assistance, data monitoring, and inter-agency collaboration will continue with IDPH and IDHS/Part C.

Additional activities will address outreach by working with specific hospitals, audiologists, Part C service coordinators, physicians and parents. Activities include: education of parents and professionals at the community and statewide level by parents of children with a hearing loss working through the GBYS and Illinois Hands and Voices program; standardization and implementation of training at the birthing hospitals for all screeners and administrators around proper screening, parent education and reporting; implementation of quality improvement activities by birthing hospitals using strategies for change such as scripted messages for parents and scheduling outpatient follow-up; provision of training for Home Visiting (Early Head Start and Parents as Teachers) programs on objective otoacoustic emission hearing screening for children birth through 3 years of age; education of audiologists, interventionists, Medical Homes and parents to enhance services; and review of statewide reporting criteria, forms, and submission process to make recommendations for improvement.

The activities will be continually evaluated by the program coordinator with technical assistance from national level contractors and collaborators. The coordinator will ensure cultural and linguistic sensitivity, measureable outcomes which support the reduction of loss to follow-up throughout screening, diagnosis and intervention, opportunities for parent involvement, and flexibility to meet the changing needs of the state.

CDPH will continue to implement a tracking system for all EHDl referrals from IDPH.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective	5.9	5.9	4.1	4	4
Annual Indicator	4.1	5.1	6.4	5.2	5.2
Numerator	138000	170000			
Denominator	3366000	3331000			
Data Source		Census Bureau, Current Population Survey			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	5	4.5	4	3.5	3

Notes - 2011

Source: U.S. Census Bureau, Current Population Survey, 2011 Annual Social and Economic Supplement. Data is for 2010.

2011 data is provisional and is estimate using 2010 data.

Notes - 2010

Source: U.S. Census Bureau, Current Population Survey, 2011 Annual Social and Economic Supplement. Data is for 2010.

Notes - 2009

Source:

Table HI10. Number and percent of children under 19 at or below 200% of poverty by health insurance coverage and state: 2009

U.S. Census Bureau, Current Population Survey, 2010 Annual Social and Economic Supplement.

a. Last Year's Accomplishments

In an effort to enroll uninsured children into the IDHFS' medical program for health care coverage, IDHFS has partnered with the Illinois Maternal and Child Health Coalition (IMCHC) since 2007 to conduct outreach and education to raise awareness of health insurance, health care services, improved health outcomes with health benefits coverage, health benefits coverage under IDHFS' medical programs, the importance of health insurance and identification of available health insurance and the need for appropriate health care utilization.

IDHFS partners with over approximately 900 community organizations, medical providers, and

insurance agents who are trained as All Kids Application Agents to help enroll families throughout the state in All Kids and FamilyCare.

Chicago. The Chicago Department of Public Health provides information on Medicaid and Medicare eligibility and public health entitlement programs through the distribution of maternal and child health-related printed publications to consumers and partners. Publications are printed in English and Spanish as well as in other languages as needed. Application assistance to state and federal programs for families is also provided in neighborhood health and mental health centers by the Division of Community Engagement. The CAREline answered over 1,200 calls from community residents between July 2010 and June 2011. Specific types of activities conducted by the Division of Community Engagement have changed because of the decreases in funding as of December, 2011.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDHS grantees assist families in applying for All Kids and FamilyCare.		X		
2. DSCC requires eligible families to apply for All Kids.		X		
3. IDHFS covers uninsured children through All Kids.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Of children enrolled in WIC in early 2010, 96 percent had All Kids or other insurance coverage. FCM providers are required to document giving parent information regarding Illinois' All Kids program and information on how to enroll. This information is recorded in Cornerstone and quarterly performance reports are issued to track compliance. /2012/ Most FCM providers are All Kids Application Agents, which allows them to assist clients in completing applications on-site. /2012/ Healthy Start and Targeted Intensive Prenatal Service providers also are required to disseminate information concerning All Kids coverage to new clients at time of program enrollment.

Chicago. Through its home visiting programs, collaboration with other organizations and health fairs, CDPH staff continues to increase its emphasis on educating families and enrolling eligible individuals in All Kids and FamilyCare, and pregnant women in Moms & Babies and Medicaid Presumptive Eligibility (MPE).

c. Plan for the Coming Year

IDHS and IDHFS will continue to promote enrollment in All Kids to reduce the proportion of children without health insurance. IDHS will use the Cornerstone system to monitor the number of WIC/FCM eligible children who do not have insurance coverage. These children will be targeted by local WIC and Family Case Management grantees for additional outreach efforts to encourage their parents to enroll them in All Kids. IDHFS will continue to provide training and field staff support to All Kids Application Agents (AKAAs). SHCs will determine insurance status of all

enrolled students and refer those without insurance to All Kids. In addition, the Healthy Child Care Illinois Program Child Care Nurse Consultants provide All Kids enrollment information to all of Illinois' child care providers and families who attend outreach education programs.

IDPH requires Dental Sealant programs to educate and enroll families in All Kids.

CDPH staff will continue to increase its emphasis on educating families and enrolling eligible individuals in various state-sponsored health insurance programs including All Kids, FamilyCare, Moms & Babies, and Medicaid Presumptive Eligibility. The education will be done through FCM, PHN home visiting programs, and Immunization Programs. CDPH will continue to provide education for both providers and the community through its Division of Community Engagement

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	23	29.9	29.8	29.5	29
Annual Indicator	29.9	30.3	30.2	29.9	30.4
Numerator	109549	121608	40172	40487	40575
Denominator	366250	401000	133023	135408	133471
Data Source		PedNSS	PedNSS	PedNSS	PedNSS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	29.5	29.5	29	29	28.5

Notes - 2011

Source: Table 2C-Summary of Health Indicators, Children Aged <5 Years, Illinois 2011, CDC's Pediatric Nutrition Surveillance System (PedNSS). 2011 numerator: estimated to create published rate; denominator: PEDNSS state data. Report date: 4/12/2012.

Notes - 2010

Source: Table 2C-Summary of Health Indicators, Children Aged <5 Years, Illinois 2010, CDC's Pediatric Nutrition Surveillance System (PedNSS). 2010 numerator: estimated to create published rate; denominator: PedNSS state data. Report date: 4/15/2011.

Notes - 2009

Source: Table 2C-Summary of Health Indicators, Children Aged <5 Years, Illinois 2009, CDC's Pediatric Nutrition Surveillance System (PedNSS). 2009 numerator: estimated to make published rate; denominator: PedNSS state data. Report date: 6/9/2010.

Note that the formula was revised showing how the percentage was obtained, however the rate remains the same. It was revised due to a misunderstanding of the PedNSS data. PedNSS provides the Denominator, not the Numerator, as was previously understood.

a. Last Year's Accomplishments

In 2008, 30.0 percent of children between 2 and 5 years of age who received WIC services had a BMI score at or above the 85 percentile. Illinois is following the national trend in the epidemic of overweight/obesity. The prevalence of overweight in children (2-5 years of age) in Illinois has gradually increased from 9.3 percent in 1976 to 15.3 percent in 2008. An additional 14.7 percent of children in the same age group are considered "at-risk" for being overweight. The national average for overweight is 16.4 percent and at-risk is 14.9 percent (Pediatric Nutrition Surveillance System 2008).

IDHS is in a unique position to impact childhood obesity. Within IDHS, the WIC Program is able to educate mothers during their pregnancy about weight gain, healthful eating and breastfeeding. Breastfeeding and early eating habits are important and nearly 50 percent of infants born in Illinois participate in the WIC Program, thus receiving prevention messages from the start. Routine contacts with WIC continue throughout the 4th year of life.

In 2010 two staff was assigned to focus on obesity efforts for the WIC program, both are master's prepared registered dietitians. These staff participates in various state and regional workgroups which are working on addressing obesity at all levels. The WIC packages released in 2009 continue to align with the Dietary Guidelines for Americans providing reduced fat milk for all participants over age 2, reducing cheese and juice quantities, adding whole grains and providing fresh, frozen or canned fruits and vegetables each month. Over 300 staff were trained on collecting accurate anthropometric measurements, new pregnancy weight gain recommendations from the IOM and diet assessment during a statewide workshop in the fall. Mini-grant opportunities were offered to active member organizations to develop or promote sustainable activities to impact childhood obesity within their individual service areas.

The Southern Illinois Healthy Child Task Force was funded SFY2011 to continue their efforts to prevent and address childhood obesity in southern Illinois. The group met regularly with good attendance and sharing of information and grant opportunities. A very successful conference was held in the Spring of 2010.

State Nutritionist Consultants have been trained and are training local agency WIC staff to provide nutrition education and counseling relevant to the needs of each individual using participant centered approaches. A pilot project was initiated in several locations across the state to work with staff to ensure services are participant centered and led to real behavioral changes. Children with special health care needs may receive foods items as well as specialized formulas based on physician recommendations with the goal of providing as normal diet possible to WIC's medically fragile population.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Train IDHS BFN Nutrition Staff on obesity prevention and intervention strategies.				X
2. Train local WIC Providers on obesity prevention and intervention strategies.	X			
3. Collaborate with community partners such as CLOCC and the Illinois Interagency Nutrition Council to create common messages and maximize resources.		X		
4. Provide nutritious foods through the WIC, CSFP and WIC Farmer's Market Nutrition Programs.	X	X	X	X
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

In addition to promoting/supporting breastfeeding, encouraging families to consume healthy foods and be active every day, the WIC Program partners with the University of Illinois Extension to provide "Cooking School" Programs. This project will continue in 2010. Students learn the basics of cooking using WIC foods. /2012/A downstate pilot was held in Springfield. Six on-site classes were held at a women's shelter. There were significant logistical barriers and it is unclear if the program will be offered in the future. IDHS staff remains involved with the Consortium to Lower Obesity in Chicago Children (CLOCC). Bureau of Family Nutrition staff participates in the following workgroups: Early Childhood, Health Communities, and Government Policy. The Bureau is listed in the CLOCC Program database which can be found on the website www.clocc.net. WIC staff provided public comments at the IDPH public hearings on childhood obesity in 2010.

In 2010 the Illinois WIC Farmers Market Nutrition Program was provided in 34 counties. Based on participant redemption data and farmer participation this program is being redistributed in 2011.

c. Plan for the Coming Year

The Southern Illinois Healthy Child Task Force has been funded for SFY2012 to continue their efforts to prevent and address childhood obesity in southern Illinois. The Task Force will evaluate the short-term benefits from the mini-grants to promote or initiate sustainable activities to address childhood obesity and determine how to best increase community involvement.

WIC staff is waiting for official guidance from USDA to begin implementation of new growth grids released by CDC in 2010. These grids were created by the World Health Organization (WHO) and reflect growth patterns of healthy, breastfed infants.

In partnership with the Illinois Nutrition Education Programs of the University of Illinois Extension and Illinois Head Start, WIC is developing a pilot project to reinforce the importance of programs serving the same population sharing the same message. The project will focus on increasing opportunities for families participating these programs to obtain reinforcing nutrition education reducing confusion and miscommunication.

In conjunction with the CHIPRA Child Health Quality Demonstration Project, IDHFS will implement and report on a core set of 24 child health measures. One of those measures is body mass index assessment for children/adolescents. IDHFS intends to work in partnership with the Illinois Chapter of the American Academy of Pediatrics (ICAAP) to develop and provide training for children's health care providers on BMI assessment.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	12.2	10	11	11	9.5
Annual Indicator	10.4	11.4	10.7	9.6	9.2
Numerator	17586	19380	18304	16628	15500
Denominator	169356	169854	171023	173212	167744
Data Source		IDPH,	IDPH,	IDPH,	IDPH,

		PRAMS	PRAMS	PRAMS	PRAMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	9	9	8.5	8.5	8

Notes - 2011

Source: 2009 PRAMS Report from Illinois Department of Public Health (IDPH).

Numerator and denominator were estimated to make the rate published by PRAMS. Denominator is the estimated number of pregnant women who gave birth to one or more infants in Illinois in 2009.

Notes - 2010

Source: 2008 PRAMS, Illinois Department of Public Health (IDPH).

Numerator and denominator were estimated to make the rate published by PRAMS. Denominator is the estimated number of pregnant women who gave birth to one or more infants in Illinois in 2008.

Notes - 2009

Source: 2007 PRAMS, Illinois Department of Public Health (IDPH).

The objectives for 2012-2016 have been adjusted to account for the decline of women who smoke in the last trimester as reported in the 2008 and 2009 PRAMS.

a. Last Year's Accomplishments

In the report for births that occurred in 2008, 9.6 percent of women reported smoking in the last trimester of their pregnancy. Non-Hispanic women, as well as black and white women were more likely to smoke three months before pregnancy, the last three months of pregnancy and after pregnancy when compared to Hispanic women and women of all other races. Women with less than a high school education reported smoking more often during all time periods when compared to women with more than a high school education. Unmarried women and women whose deliveries were paid for by Medicaid reported much higher rates of smoking during all three time periods when compared to married women and women whose deliveries were not paid for by Medicaid.

IDHS, IDPH, and IDHFS use a coordinated strategy to reduce smoking among women who are participating in WIC, FCM, and other MCH programs. It has three components: implementation of the "Five A's;" use of the Illinois Tobacco QuitLine; and reimbursement of smoking cessation medications through the Medicaid Program. MCH program staff were encouraged to enhance their current procedures by implementing the recommendations of the American College of Obstetricians and Gynecologists (ACOG). Their recommendations include the following steps, often referred to as "the five A's": Ask about tobacco use; Advise women to quit; Assess willingness to make a quit attempt; Assist in the quit attempt; and Arrange follow-up.

Pregnant or parenting women who are smoking may be referred to the American Lung Association QuitLine for ongoing assistance. The Illinois Tobacco QuitLine was developed by IDPH and the American Lung Association, and is supported by Tobacco Settlement Funds. The

QuitLine offers free, confidential counseling to smokers related to all stages of the quitting process, including nutrition and weight management, information about cessation medications, and management skills for dealing with withdrawal symptoms. QuitLine Staff will make appointments with callers for follow-up and provide on-going support through the process of quitting. All callers, regardless of income, are eligible to receive counseling services. QuitLine hours are 7:00 AM to 7:00 PM (CT), Monday through Friday. Bilingual services are available. The QuitLine is staffed by registered nurses and respiratory therapists who have been trained at the Mayo Clinic.

Enrolled pharmacies may bill the IDHFS Medicaid program on behalf of eligible women for certain medications and over-the-counter items to assist them in quitting the use of tobacco. IDHFS covers both prescription and over-the-counter smoking cessation products when obtained with a prescription.

CDPH's Women's Maternal Smoking Intervention program operates in WIC sites and CDPH Clinics. In 2011, the program provided services to 339 women who smoke, up 17% from 2010. Of those women, 193 (57%) were on Medicaid. One hundred and fifty-six (156) women were pregnant. Of these, 113 (72%) agreed to change their smoking behavior; 73 (47%) agreed to quit smoking, and 40 (26%) cut down on their smoking.

Cessation counseling by telephone was provided to 70 of the smokers who were referred to Courage to Quit, a smoking cessation workshop, and the Illinois Tobacco Quitline by CDPH's Illinois Tobacco-Free Communities' representative.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implementation of the "Five A's" in MCH programs.		X		
2. Promote the Illinois Tobacco QuitLine.			X	
3. The Medicaid program reimburses the cost of smoking cessation medications.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

An on-line training module is available to WIC and other IDHS health professionals via the Community Health Training Center. The module focuses on high-risk WIC participants. A portion of the module addresses the risks of smoking during pregnancy and the "Five A's" of smoking cessation.

Each Illinois WIC participant is required to receive education on the dangers of drugs, alcohol and tobacco. Key messages are displayed at local WIC offices via posters and brochures and are discussed during regular visits.

Chicago. WIC and MCH clinic clients, who are identified as smokers are advised to quit and are provided with self-help brochures for quitting, including referrals to the Illinois Tobacco-Free Communities (ITFC) representative for cessation counseling by telephone. The representative

also refers clients to Courage to Quit, a smoking cessation workshop, and the Illinois Tobacco Quitline. During 2011, FCM began implementing the NicAlert nicotine exposure screenings. They assessed 512 women and screened 202 (39.45 percent). Of those screened, 115 (57 percent) were found to be exposed to secondhand smoke by the cotinine levels discovered in their urine. Of the total assessed, 80 (16%) were smokers and were advised to quit and referred to cessation resources. All assessed were encouraged to pledge to make their homes smoke-free. As a result, 293 (57%) of the women took the pledge.

c. Plan for the Coming Year

The IDHS, IDPH, and IDHFS will continue the initiative to reduce smoking among women who are participating in WIC, FCM, and other Maternal and Child Health programs. Pregnant or parenting women who are smoking will be referred to the American Lung Association's QuitLine for ongoing assistance. Agencies will use a smoking cessation curriculum, "Make Yours A Fresh Start Family," to help clients quit or decrease their smoking. Materials will be available, at no charge, for use in promoting the QuitLine and the importance of smoking cessation to women who are participating in the WIC and FCM programs. Information on the smoking status of participants will be monitored through the Cornerstone System, and client progress available to providers on a quarterly basis. Additionally, IDHFS will be implementing several smoking cessation training initiatives in the next year to pilot evidence-based practices and evaluate results.

Chicago. The WIC clients will be monitored through the Cornerstone System on a quarterly basis, in an effort to reach unidentified clients who smoke. Staff will encourage them to quit smoking and pledge to make their homes smoke-free.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	6	6	5	5	6
Annual Indicator	6.5	7.3	7.3	7.3	7.3
Numerator	61	68			
Denominator	936963	925416			
Data Source		IDPH, Center for Health Statistics			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	7	6.5	6	6.5	6

Notes - 2011

Vital Records data from IDPH for deaths in 2011 is not available at this time. See note for 2009 deaths for more information.

Notes - 2010

Vital Records data from IDPH for deaths in 2010 is not available at this time. See note for 2009 deaths for more information.

Notes - 2009

Data are not available from IDPH for 2009 deaths. IDHS has no control over the processing or release of the State of Illinois Death File. Therefore the rate for 2009 uses the rate from 2008 as an estimate. There is no due date for the 2009 Death File. IDPH previously said it would be available "before 7/1/2012." As of 9/21/12 it is still not available.

a. Last Year's Accomplishments

All 40 School Health Centers provide mental health counseling on-site or have agreements with outside community providers for individual, group, or inpatient care as needed. The mental health committee within the Coalition for School Health Centers developed and distributed to the centers a document entitled "Suicide Assessment and Management: Guidelines for Illinois School Based Health Centers." Training was provided via satellite to DCHP staff and contractors on signs, causes, and referral procedures on adolescent suicide.

Below are highlights of the IDPH's suicide prevention activities. The Illinois Suicide Prevention Strategic Plan was officially released through the IDPH. A total of \$350,000 was appropriated by the Illinois General Assembly in FY08 to fund suicide prevention. IDPH contracted with the Mental Health America of Illinois (MHA) to implement activities during FY09. The contract included development of a public awareness campaign; building local coalitions; providing data analysis; and training providers in the field of aging, education and human services, in addition to including an evaluation component. In 2009, IDPH awarded a grant to Children's Memorial Hospital, Children's Data Lab to continue to implement the Illinois Violent Death Reporting System in three counties. More than half of the violent deaths in the system are suicides. IDPH provided funds to the Farm Resource Center to offer outreach crisis intervention in the 38 southernmost counties of the state. IDPH collaborated with the Pacific Institute for Research and Evaluation to update the Illinois data fact sheet sponsored by the Suicide Prevention Resource Center. IDPH provided technical assistance to state and local entities as well as conducted presentations and displays.

The Illinois Suicide Prevention Alliance serves as the advisory board to the IDPH. The members are appointed by the Director of Public Health.

Currently, there are no injury or suicide prevention activities focused on CSHCN.

Chicago. The Chicago Public Schools receive funding from CDC to monitor critical health behaviors in youth through implementation of the Youth Risk Behavior Survey (YRBS.) Data are collected on a biannual basis. /2012/In 2009, 13.3 percent of students had seriously considered attempting suicide during the 12 month period before the survey. This was similar to the 13.4 percent that was noted in 2007.//2012// In Chicago in 2007, 10 (5.3/100,000) youth committed suicide.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The School Health Centers provide mental health counseling.	X			
2. Mental health counseling services are available on-site from two Teen Parent Services program offices.	X			
3. IDHS provides training on the risk factors for adolescent suicide.				X
4. IDHS distributes information on teen suicide through the school health program.				X
5. IDHS participates in the Illinois Suicide Prevention Alliance.				X
6. IDPH will ensure that prevention programs serve as school gatekeepers and provide faculty training.				X
7. IDPH will ensure that prevention programs conduct community gatekeeper training.				X
8. IDPH will ensure that prevention programs provide community-based general suicide prevention education.			X	
9. IDPH will ensure that prevention programs include health providers and provide physician training and consultation about high-risk cases.				X
10. IDPH will ensure that prevention strategies include depression, anxiety, and suicide screening programs.			X	

b. Current Activities

Through state funds, IDPH contracted with Mental Health America of Illinois (MHAI) to implement suicide prevention activities. These activities included coordinating and implementing the Suicide Prevention Resource Center's (SPRC) two-day core competency training for communities interested in developing local suicide prevention coalition projects to assist in implementing the state plan. They also launched a public awareness campaign entitled "It Only Takes One." MHAI used IDPH funds to award seven mini-grants to appropriately qualified and trained organizations to train schools and school districts on suicide prevention. MHAI conducted training programs in the aging network during its annual conference. The University of Illinois Center for Prevention Research and Development evaluated these suicide prevention activities.

Chicago: CDPH does not specifically address adolescent suicide; however, most CDPH programs have policies and procedures related to crisis intervention, and provide clients with educational materials on depression and other conditions that can lead to suicide.

c. Plan for the Coming Year

IDHS will continue to work with the Illinois Coalition of School Health Centers to provide mental health counseling services. A standard encounter form has been developed to document mental health services provided at each site. Through use of discretionary funds, IDPH will monitor the prevention strategies as outlined in the Suicide Prevention, Education, and Treatment Act.

Through state funds, the IDPH will again contract with the Mental Health America of Illinois to implement additional suicide prevention activities. It is anticipated these activities will center on expanding the public awareness campaign, training professionals, supporting local initiatives and enhancing data. The activities will reflect the recommended next steps outlined in the Illinois Suicide Prevention Strategic Plan. IDPH will continue to facilitate the Illinois Suicide Prevention

Alliance and their activities which will include meeting on a regular basis, creating an annual report and serving as an advisor to the Department.

Chicago. CDPH programs will continue to address crisis situations according to existing policies and procedures and provide clients with educational materials on depression and other conditions that can lead to suicide. Chicago Public Schools will continue to conduct the YRBS and monitor adolescent high risk behavior.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	81	82	83	83	83
Annual Indicator	82.6	81.4	81.2	81.2	81.2
Numerator	2427	2276	2155		
Denominator	2938	2797	2655		
Data Source		IDPH, Perinatal	IDPH, Perinatal	IDPH, Perinatal	IDPH, Perinatal
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	83	83	83	83	83

Notes - 2011

Vital Records data from IDPH for births in 2011 is not available at this time. See note for 2010 for more information.

Notes - 2010

Data are not available from IDPH for 2010 births. IDHS has no control over the processing or release of the State of Illinois Birth File. Therefore the rate for 2010 uses the rate from 2009 as an estimate. There is no due date for the 2010 Birth File. IDPH previously said it would be available "before 7/1/2012." As of 9/21/12 it is still not available.

Notes - 2009

Source: IDPH, Center for Health Statistics, received May 2011.

a. Last Year's Accomplishments

In 2008, there was a slight decrease in the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. However, at 81.4, Illinois' performance on this measure exceeds the target set for 2008 (81 percent).

IDPH is working with the IDHS on the implementation and coordination of other MCH/perinatal programs and activities, such as the Fetal and Infant Mortality Review (FIMR) Project, Early Intervention (EI) Program and the Chicago Healthy Start Initiative.

IDPH and the Statewide Quality Council have worked closely with each of the 10 perinatal networks on the monitoring and evaluation of the percentage of the very low birth weight infants born in a Level II+ or Level III facility. The methodology for incorporating perinatal outcome surveillance and plans for improving provider compliance with consultation, referral, and transfer protocols for high-risk maternal and neonatal patients are in place at all facilities, as well as the monitoring system for outcomes for the purpose of quality assessment and improvement.

Chicago. In 2009, 873 very low birth weight infants were born to Chicago residents. Of these, 725 (83%) were born at Level III and Level II+ hospitals, locations capable of providing care for these infants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Each perinatal center uses continuous quality improvement to increase the proportion of infants born in Level II+ or Level III Centers.			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Each of the 10 perinatal networks, as well as IDPH and the Statewide Quality Council, are monitoring and evaluating the percentage of very low birth weight infants born at appropriate facilities. The Director of IDPH, based on a recommendation from the Perinatal Advisory Committee (PAC), sent a letter introducing the Maternal Hemorrhage Education Project to the Perinatal Network administrators and to the chief executive officers of all hospitals providing maternity services in Illinois. The project was a response to the Maternal Mortality Review Committee's (MMRC) past and continuing findings that the majority of deaths occurred while women were hospitalized, these deaths occurred at every level of care throughout the state, and women from all socioeconomic groups were affected. The goal of the project is to improve and reduce maternal morbidity and mortality due to obstetric hemorrhage. The Obstetric Hemorrhage Project concluded in October 2009. All hospitals that were provided grants submitted an education and simulation drill schedule and conducted same. All grantees were addressing the development of a hospital specific hemorrhage assessment and rapid response policy. The status of policy implementation is addressed at re-designation site visits during 2010 and will be reported on in the 2010 year narrative.

c. Plan for the Coming Year

This performance measure will be addressed by IDPH through the routine operation of the Perinatal Program.

Chicago. The CDPH will continue to participate in State's MCH Advisory Committee meetings, focusing on strategies to improve birth outcomes for infants in Illinois.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	82	87	86	87	87
Annual Indicator	86.0	86.3	86.6	86.6	86.6
Numerator	145898	142671	138701		
Denominator	169616	165348	160102		
Data Source		IDPH, Center for Health Statistics			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	87	87	87	87	87

Notes - 2011

Vital Records data from IDPH for births in 2011 is not available at this time. See note for 2010 for more information.

Notes - 2010

Data are not available from IDPH for 2010 births. IDHS has no control over the processing or release of the State of Illinois Birth File. Therefore the rate for 2010 uses the rate from 2009 as an estimate. There is no due date for the 2010 Birth File. IDPH previously said it would be available "before 7/1/2012." As of 9/21/12 it is still not available.

Notes - 2009

Source: IDPH, Center for Health Statistics, received May 2011.

a. Last Year's Accomplishments

Illinois did not meet its newly established target of 87 percent of women who began prenatal care in the first trimester of pregnancy. The most recent data available, 2008, show that Illinois fell short by less than a percentage point: 86.3 percent of women began prenatal care in the first trimester.

Providers are encouraged to integrate WIC and FCM services in Illinois. When a pregnant or parenting woman presents for WIC certification, she will also receive information about Family Case Management, and vice versa. Often, she and her infant are enrolled in both programs at the same agency on the same day. Throughout her pregnancy, she will be encouraged to think about future contraceptive plans and she will be referred to Family Planning upon delivery. In many areas of the state, all three services are provided in the same agency. FCM workers engage in varied outreach activities within communities to encourage those who are pregnant or suspect a pregnancy to enroll in FCM and WIC in the first trimester. Eligible women who become pregnant while receiving services from Family Planning are referred to FCM and WIC as soon as there is confirmation of pregnancy.

The goal of IDHFS's Medicaid Presumptive Eligibility (MPE) program is to promote early and continuous prenatal care to low income pregnant women. Through presumptive eligibility, women are covered for prenatal care services from the date of the MPE determination. Approximately 3,800 women are enrolled in MPE each month.

The Targeted Intensive Prenatal Case Management Program target population consists of "hard to reach high-risk pregnant women" who reside in 14 target areas throughout Illinois. The most common risk factor for inclusion in the program is presence of a chronic disease that impacts pregnancy (25.2%), followed by greater than 4th pregnancy or third child expected (12.8%), and previous preterm birth (12.6%).

Chicago. In FY08, 40,917 women (84.6%) in Chicago began prenatal care in the first trimester of pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. FCM and other case management programs conduct outreach and case finding activities.		X		
2. Local health departments and WIC programs help women complete Medicaid Presumptive Eligibility applications.		X		
3. FCM and other case management programs help women obtain medical care.		X		
4. Family Planning programs conduct options counseling and refer women to prenatal care providers.	X			
5. IDHS and IDHFS partner with private foundations to improve outreach in targeted communities.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Local IDHS office staff are trained to routinely ask women of childbearing age if they are pregnant and, if so, to record this information in the Department's data system. This information is then shared with FCM and Chicago Healthy Start Initiative (CHSI) agencies, so staff can conduct outreach efforts and assist women with obtaining prenatal care.

Chicago. CDPH continues to conduct outreach activities to identify and recruit high-risk pregnant women, to promote postpartum and family planning visits to decrease unplanned pregnancies, to

enroll women in care following a positive pregnancy test result, and to encourage newly-pregnant women to continue in care.

c. Plan for the Coming Year

The Title V program will address this performance measure by continuing current strategies to increase the proportion of women who begin prenatal care in the first trimester, including referrals from Family Planning programs, outreach and case finding activities through Family Case Management, integration of WIC and FCM services, integration of TPS and FCM programs, and the operation of School Health Centers.

Chicago. CDPH's strategies of providing outreach to identify and recruit high-risk pregnant women; of promoting postpartum and family planning visits to decrease unplanned pregnancies; of enrolling women in care following a positive pregnancy test result; and, of encouraging newly pregnant women to continue in care will help reduce the number of women who delay early enrollment into prenatal care. CDPH will continue to have contracts with seven hospitals that provide midwifery-based prenatal and family planning services in five of its Neighborhood Health Centers through June, 2012. After that date, prenatal and family planning services will be provided to the same population by various Federally Qualified Health Centers.

D. State Performance Measures

State Performance Measure 1: *Strengthen the State's Title V data capacity*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					34
Annual Indicator				23	20
Numerator				23	20
Denominator				48	48
Data Source				Survey	Survey
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	23	27	30	32	34

Notes - 2011

Due to the work by our Epidemiology staff at the University of Illinois at Chicago, School of Public Health, Division of Epidemiology/Biostatistics, the sources for this measure was clarified. The units of measurement were further defined and stringent rules were made to define success in each area. This was done in September 2012.

In addition, due to a lack of resources available to the state, our capacity has been hindered. As a result future performance objectives had to be revised. More recently developments have occurred which look more hopeful for state MCH staff capacity in this area.

Notes - 2010

Due to the work by our Epidemiology staff at the University of Illinois at Chicago, School of Public Health, Division of Epidemiology/Biostatistics, the sources for this measure was clarified. The units of measurement were further defined and stringent rules were made to define success in each area. This was done in September 2012.

In addition, due to a lack of resources available to the state, our capacity has been hindered. As

a result future performance objectives had to be revised. More recently developments have occurred which look more hopeful for state MCH staff capacity in this area.

a. Last Year's Accomplishments

On July 15, 2011, Illinois submitted an application for the State Systems Development Initiative Grant Program. One of the SSDI program's goals is to advance the development of performance measures for the state's priorities as presented in the FFY2011 Maternal and Child Health Block Grant. Loss of staff and expertise and with them the ability to pursue Illinois' priority measures as identified in the FFY2011 Needs Assessment prompted this goal of the FFY2012 State Systems Development Initiative.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. By August 2012, PPD will identify data sources and report on State Priorities: 1) Improve Title V's capacity to collect, acquire, integrate/link, analyze, and utilize administrative, programmatic, and surveillance data				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

As presented in the SSDI application, Illinois will pursue the following objective relative to State Performance Measure 1.

By August 2012, PPD will identify data sources and report on State Priorities: 1) Improve Title V's capacity to collect, acquire, integrate/link, analyze, and utilize administrative, programmatic, and surveillance data.

c. Plan for the Coming Year

SSDI project staff will attend the quarterly meetings of the MCH Advisory Board. Input and ideas gathered from these sessions will be reviewed and documented. This information will be supplemented by research literature where appropriate. SSDI project staff will then develop an action plan that details the inputs, activities, responsible parties and dates necessary to achieve progress toward SPM 1. Because SPM 1 concerns the enhancement of the state's capacity to collect and analyze data, SSDI project staff will develop strong working relationships with staff of the information technology (IT) offices of Public Health, Human Services, Children and Family Services and Healthcare and Family Services. SSDI staff will present the proposed action plan to the key IT staff in these departments to solicit input and identify potential technical and procedural barriers to collection and analysis of maternal and child health related data. The action plan will then be presented to the MCH Advisory Board for approval. The approved action plan will be incorporated in the FFY2013 MCH Block Grant application.

State Performance Measure 2: Integrate MCH services and improve linkage of clients to these services

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					9
Annual Indicator				8	8
Numerator				8	8
Denominator				15	15
Data Source				Survey	Survey
Is the Data Provisional or Final?					Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	10	11	12	13	14

Notes - 2011

This is an estimate based upon an informal internal review by MCH data staff. The Department plans to hire an MCH Epidemiologist. One of that person's duties will be to survey and assess the state's data capacity and work on strategies towards strengthening it.

Notes - 2010

This is an estimate based upon an informal internal review by MCH data staff. The Department plans to hire an MCH Epidemiologist. One of that person's duties will be to survey and assess the state's data capacity and work on strategies towards strengthening it.

a. Last Year's Accomplishments

On July 15, 2011, Illinois submitted an application for the State Systems Development Initiative Grant Program. One of the SSDI program's goals is to advance the development of performance measures for the state's priorities as presented in the FFY2011 Maternal and Child Health Block Grant. Loss of staff and expertise and with them the ability to pursue Illinois' priority measures as identified in the FFY2011 Needs Assessment prompted this goal of the FFY2012 State Systems Development Initiative.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. By Sept. 2012 the MCH Director, PPD & MCH Advisory Committee will present strategies for advancement of State Priority: The extent to which the Title V program has completed activities related to promotion & enabling of MCH service integration.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

As presented in the SSDI application, Illinois will pursue the following objective relative to State Performance Measure 2.

By September 2012, the MCH Director, PPD, and the MCH Advisory Committee will present strategies in the MCH Block Grant application for the advancement of the following State Priority : Integrate medical and community-based services for MCH populations and improve linkage of clients to these services, particularly CSHCN.

c. Plan for the Coming Year

A strategy for progress in State Priority 2 is the work of the entire MCH community, including the state agencies charged with bettering the lives of women and children as well as the local service providers that do the work. The Illinois Maternal and Child Health Advisory Board is representative of the MCH community. The Maternal and Child Health Advisory Board advises IDHS regarding the family health programming and other activities related to maternal and child health and infant mortality reduction programs. Key staff of the Illinois Departments of Public Health, Healthcare and Family Services, Children and Family Services and Human Services are members of the board. Local public health departments and community based organizations also are represented. The board meets quarterly. SSDI staff under the direction of PPD and the MCH Director will work with the advisory board to develop overarching strategies to advance this maternal and child health priority. SSDI staff will attend the quarterly meetings for the purpose of leading discussion and planning sessions relative to this priority. The strategies developed for priority 2 will be developed and incorporated in the FFY2013 Block Grant Application. Also, baseline data will be presented for each of this priority in the FFY2013 application.

State Performance Measure 3: *Identify a Title V comprehensive health promotion measure*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					0
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	0	0	0	0	0

Notes - 2011

The state has yet to identify the exact performance measure. The Department plans to hire an MCH Epidemiologist in coordination with the SSDI grant and one of that person's duties will be to identify a Title V comprehensive health promotion measure.

Notes - 2010

The state has yet to identify the exact performance measure. The Department plans to hire an MCH Epidemiologist in coordination with the SSDI grant and one of that person's duties will be to identify a Title V comprehensive health promotion measure.

Notes - 2009

The state has yet to identify the exact performance measure. The Department plans to hire an MCH Epidemiologist in coordination with the SSDI grant and one of that person's duties will be to identify a Title V comprehensive health promotion measure.

a. Last Year's Accomplishments

On July 15, 2011, Illinois submitted an application for the State Systems Development Initiative Grant Program. One of the SSDI program's goals is to advance the development of performance measures for the state's priorities as presented in the FFY2011 Maternal and Child Health Block Grant. Loss of staff and expertise and with them the ability to pursue Illinois' priority measures as identified in the FFY2011 Needs Assessment prompted this goal of the FFY2012 State Systems Development Initiative.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. By September 2012, the MCH Director , PPD, and the MCH Advisory Committee will develop a measurement strategy for State Performance Measure 3 -- Promote, build, and sustain healthy families and communities.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

As presented in the SSDI application, Illinois will pursue the following objective relative to State Performance Measure 3.

By September 2012, the MCH Director , PPD, and the MCH Advisory Committee will develop a measurement strategy for State Performance Measure 3 -- Promote, build, and sustain healthy families and communities.

c. Plan for the Coming Year

As discussed in the FFY'11 Needs Assessment, the concept of "healthy families and communities" relates to a wide spectrum of health issues, including: male involvement, child abuse, domestic violence, school health, neighborhood safety, built environment, etc. Because of this wide spectrum of work, identifying a measure as an indicator of Title V performance will ensure that programs are being held accountable for a united goal. The selection of this measure, however, needs to be well informed, and not selected hastily. In the Needs Assessment, a plan for developing a healthy family/community index was presented. The proposed plan will be adopted to meet this objective. The steps for achieving this are outlined below and will be completed by September 2012.

- 1) Conduct a literature review to identify potential measures of healthy families and communities, including review of existing indices on healthy families or communities.
- 2) Construct a state resource list that identifies programs and activities already in place in Illinois pertaining to healthy families and communities.

3) Crosswalk potential measures with the Illinois resource list to identify the potential measures for which Title V has a direct or primary influence.

4) Select a measure, or create a composite measure, for which Title V has a direct or primary influence, including identifying a data collection method.

State Performance Measure 4: Increase well-child visits

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					65
Annual Indicator		64.3	65.2	69.8	68.7
Numerator		204739	228243	264155	271353
Denominator		318479	350077	378244	395122
Data Source		IDHFS EIS Rpt.	IDHFS EIS Rpt.	IDHFS EIS Rpt.	IDHFS EIS Rpt.
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	69	70	70	71	71

Notes - 2011

Source: IDHFS, EIS Report "HEDIS - Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) - HFS Continuously Enrolled - IDPAEIS101-T1" - Data as of 6/5/2012

2011 data is not yet final. Providers have up to 18 months after the end of a year to submit claims.

Notes - 2010

Source: IDHFS, EIS Report "HEDIS - Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) - HFS Continuously Enrolled - IDPAEIS101-T1" - Data as of 6/5/2012

2010 data is final.

Notes - 2009

Source: IDHFS, EIS Report "HEDIS - Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) - HFS Continuously Enrolled - IDPAEIS101-T1" - Data as of 6/8/2011

a. Last Year's Accomplishments

The American Academy of Pediatrics recommends routine well child visits. Providers monitor a child's growth and development, provide preventive health care services (i.e., immunizations), screen for potentially serious health problems (i.e., lead poisoning or problems with vision or hearing) and inform parents through anticipatory guidance. The Academy recommends six such visits during the first year of life, to occur at one month, two months, four months, six months, nine months and twelve months of age.

Health insurance is essential for access to health care services. Virtually every child on WIC is,

by definition, eligible for the State of Illinois' All Kids program. The Department has been working with the IDHFS to increase the proportion of WIC-eligible children who also are enrolled in All Kids if they are not covered by their parents' health insurance. Local WIC/FCM agencies have been trained and certified by the IDHFS as "All Kids Application Agents." Local WIC program staff assists eligible families in applying for coverage through All Kids.

When this project began in September 2000, a total of 86 percent of WIC enrolled infants and children were documented in the Cornerstone system as having All Kids or private insurance coverage. Due to the continued efforts of local WIC agency staff, this proportion has steadily increased; by June 2011, 96.5 percent were documented as having health insurance. Due in part to this high rate, and also for other programmatic reasons, the Illinois WIC Program no longer monitors the insurance coverage for its clients.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Enrolling children in health insurance thru All Kids program		X		
2. High Risk Infant Follow-up (HRIF) program		X		
3. Healthworks program for DCFS children		X		
4. All Our Kids (AOK) Network program				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Department monitors FCM agencies to ensure that participating infants receive at least three well child visits during the first year of life. For SFY 2011, 87.3% of infants received 3 or more well child visits. That level of visits continues and actually has improved in the current SFY as evidence by the 89.2% rate of 3 or more visits through March 31, 2012.

High-risk infant follow-up occurs within the FCM program. Registered nurses conduct face to face and home visits to infants reported through the Adverse Pregnancy Reporting System at 2, 4, 6, 12, 18 and 24 months of age and during the visits are reviewing health status indicators with the parent, including completion of well-child visits.

DCFS wards are enrolled in the Healthworks program, provided through FCM services. Healthworks case managers are located across the state in health departments and community-based organizations, and are tracking completion of well-child visits, developmental screenings, dental and vision exams on children age newborn to 19 years of age.

All Our Kids Networks are located in 12 communities across Illinois. Their primary purpose is to improve and increase children's access to health services within a targeted community. These networks help to ensure that there are adequate resources to meet the varied health needs of children living in a community, including primary care.

c. Plan for the Coming Year

FCM and WIC providers will continue to act as "All Kids Agents" providing information regarding the state SCHIP program and assisting families in the enrollment process.

100% of enrolled clients are expected to have a primary care provider. Those that do not have a

primary care provider identified are given referrals and helped to locate one. Additionally, the state SCHIP program will automatically assign a provider if the participant does not voluntarily identify one within a specified time frame. Regional IDHS staff assigned to FCM providers monitor providers performance quarterly in both identification of participants primary care provider and at least 3 well-child visits during the first year of life. IDHS will continue to support FCM, WIC, APORS follow-up and Healthworks case management.

The federal ACA Home Visiting funding will allow Illinois to expand home visiting efforts in various parts of the state. Selected agencies will be expected to include monitoring and tracking of health status measures, regardless of the home visiting model they select. Completion of at least 3 well-child visits during the first year of life will be an expected performance measure, as will selection of a primary care provider and linkage with primary care.

State Performance Measure 5: *Increase the proportion of women who have a primary medical care provider*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					88
Annual Indicator		87.2	85.6	85.1	85.1
Numerator		1958748	1950535	1920658	
Denominator		2245832	2277535	2256149	
Data Source		IL- BRFSS	IL- BRFSS	IL- BRFSS	IL-BRFSS
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	89	90	91	92	92

Notes - 2011

2011 BRFSS data not available at his time. 2010 data used as provisional.

Notes - 2010

Source: 2010 IL BRFSS, IDPH, Center for Health Statistics.

Notes - 2009

Source: 2009 IL BRFSS, IDPH, Center for Health Statistics.

a. Last Year's Accomplishments

Women who are guardians of infants and children in the Family Case Management program, the WIC program and Healthy Start program are asked if they have a primary care medical provider. Those that do not are given referrals and assisted with completion of the application for the state Medicaid family Insurance plan. Women who are eligible are provided assistance in the application process for the Illinois Healthy Women's Medicaid-waiver program which covers family planning (birth control) and family planning related services.

Women accessing Title X Family Planning services are provided information on the IHW project, and are assisted in completing an application for same. In the past few years, the numbers of women referred into this program through Title X Family Planning clinics has rose from several thousand to approximately 30,000 annually.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Enrolling women in health insurance thru Medicaid and the Illinois Healthy Women (IHW) program		X		
2. Interconceptional Care Case Management program for at-risk women		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Efforts to enroll eligible women in the Illinois Healthy Women program are continuing. The state Title X Family Planning program continues to include this as a performance measure.

c. Plan for the Coming Year

FCM and Healthy Start programs will continue to provide information, referral, and linkage to primary care to non-pregnant women ages 18-44 years of age, and to assist them in enrolling in the state Medicaid family health insurance program when eligible.

State Performance Measure 6: *Reduce the percentage of unintended pregnancies*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					41
Annual Indicator		41.3	44.2	44.2	44.2
Numerator					
Denominator					
Data Source		PRAMS	PRAMS	PRAMS	PRAMS
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	41	41	41	41	41

Notes - 2011

2011 data is provisional and is based on the 2009 rate. 2011 PRAMS is not available. Based upon the last report, it is expected to be released in Spring 2014.

Notes - 2010

2010 data is provisional and is based on the 2009 rate. 2010 PRAMS is not available. Based upon the last report, it is expected to be released in Spring 2013.

Notes - 2009

2009 IL PRAMS report.

a. Last Year's Accomplishments

Annual performance is measured through Illinois' PRAMS survey. The most recent data available are from 2009. That year, 44.2 percent of pregnancies resulting in live births were unintended. The last time the rate was this high or higher was in 2001. The Healthy People 2010 goal was to increase percent of intended pregnancies to 70 percent. Teens continue to represent the highest proportion of unintended pregnancies when compared to other age groups. Black women represent the highest percent of women with unintended pregnancies (74.9%), as do those who are not married (68.8%). Women whose deliveries are paid for by Medicaid (59.6%) have a rate of unintended pregnancy more than double that of women whose deliveries are paid for by other means (26%). In the last decade and a half the rate of unintended pregnancy in Illinois has fluctuated from a low of 40% in 1998 to a high of 46.2% in 2001.

This performance measure was addressed through the routine operation of the Family Planning program, the School Health Centers, and the Primary and Subsequent Teen Pregnancy Prevention programs.

Two new Title X Family Planning Providers were added last year in underserved areas of the state. Macoupin County Health Department and Southern Illinois Healthcare Foundation began providing care to women and men in 2010. Additionally, Illinois Title X program received additional federal funding to support 2 new Male Involvement projects, and 2 new HIV Testing projects in Illinois. There are now a total of 3 Male Involvement projects and 3 HIV Testing projects across the state.

The PICC members provided training on Preconception/Interconception Health to Healthy Start staff and School-Based Health Center staff, and worked on a provider manual on the topic for IDHFS approved providers.

The Chicago Healthy Start providers continued their involvement in the national learning collaborative on Interconception Health.

Staff in Title x Family Planning Delegate agencies continued their efforts to increase the number of women enrolled in the Illinois Healthy Women program. Their efforts resulted in over 12,000 new enrollees.

IDHS continues to provide funding to 39 Delegate Agencies for provision of reproductive health services, including physical exams, pelvic exams, testing and treatment of STI's, contraceptives, and health education. Services are available to both females and males in communities across the state.

IDHS continues to partner with IDHFS on operation of School-Based Health Centers at various sites across the state, and to assure that those that are serving adolescents provide preconception health screening and counseling, do complete reproductive health exams and either refer for or provide contraceptives based on client request and choice.

Chicago. During 2010, the number of distributed doses of emergency contraception in community health clinics was 88. Fifty percent (50%) of contraceptive users received an extended exam, and 69% of users choose highly effective hormonal methods. During 2010, Family Planning staff provided 33 outreach educational sessions to 1,258 participants in Chicago communities.

In 2007, the Interconceptional Care Pilot Project provided services to 30 women who have experienced a perinatal death, 70 percent of whom stated these pregnancies were unplanned. Ninety-five percent of these women stated they had plans to delay subsequent pregnancies for one and one-half to two years. In 2007, the CDPH Responsible Fatherhood program began to provide services to males in the Englewood and Uptown communities. That program's approach addresses unintended pregnancy primarily through a peer education and mentoring approach, encouraging men, particularly young men, to assume some responsibility for preventing

pregnancy, participate in family planning, and delay fatherhood until they have reached economic stability. The Interconceptional Care Pilot Project was discontinued as staff was no longer available. The Responsible Fatherhood Program was also discontinued in the Uptown Community, but its concepts have been integrated as a part of the Healthy Start Program in the Greater Englewood Community.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide Family Planning services.	X			
2. Provide contraceptive services through School Health Centers.	X			
3. Provide education and other youth development interventions to prevent teen pregnancy.		X		
4. Provide interconceptional case management.		X		
5. Collaborate with IDHFS Illinois Healthy Women program.				X
6. IDHFS expands the eligible population upon approval of a federal waiver request.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Family Planning program's current activities to reduce the rate of unintended pregnancy include: 1) Offer a broad range of highly effective methods of contraception, including the provision of emergency contraception; 2) Participate in the ongoing promotion, evaluation, and data collection for the Illinois Healthy Women Medicaid Waiver; 3) Provide preconception education, including information about the importance of birth planning and spacing; 4) Promote the use of birth control through sexually transmitted disease clinics; 5) Continue efforts to improve awareness of and access to emergency contraception; and 6) Monitor delegate agency outreach education activities to the target population to educate on the prevention of unintended pregnancies.

Illinois Healthy Women Waiver allows eligible women to receive family planning (birth control) services free of charge at an IDHFS-enrolled provider of her choice. The Illinois Healthy Women Waiver was amended in 2007 to expand coverage to women who would otherwise be eligible for IDHFS Medicaid, and whose income was less than 200% of the federal poverty level.

Chicago. The CDPH addresses unintended pregnancy through all of its MCH programs, but in particular the Family Planning, Male Responsibility, and Healthy Start programs.

c. Plan for the Coming Year

IDHS will address unintended pregnancy through the routine operation of the Family Planning and School Health Center programs, the Teen Pregnancy Prevention Programs (both Primary and Subsequent) and by providing interconceptional care through the Family Case Management program and the Chicago Healthy Start Initiative. Additionally, IDHS will partner with IDHFS on several initiatives intended to improve pregnancy outcomes in high-risk women.

IDHFS approved providers may now seek reimbursement for annual adult preventive visits. This allows them to conduct annual preconception/interconception health visits that include a preconception risk assessment and provide education regarding a healthy lifestyle and healthy

behaviors, as well as referral and follow-up for treatment of identified chronic health conditions.

IDHS continues to facilitate the Preconception Interconception Committee, which is comprised of representatives from a number of state, local and private agencies. This committee is responsible for identifying and disseminating standards for preconception and interconception care, development of a training curriculum, and working with various provider groups to assure they receive appropriate training on the topic. The training curriculum developed by the PICC is being adapted for HFS providers, and will serve as the basis for development of a handbook that will be disseminated to HFS approved providers.

The Chicago Healthy Start sites supported by IDHS have been a part of a national learning collaborative focused on interconception health since 2009. All women who delivered while in the program since June 2009 have received education regarding interconception health and have developed an individualized Reproductive Life Plan addressing reproductive goals and interconceptional spacing.

IDHS and IDHFS are collaboratively developing a High-Risk Intensive Case Management program for women who have had a recent poor pregnancy outcome, or risk factors that contribute to poor outcomes. The case manager will provide health education, referrals for treatment of chronic diseases, assist the client with reproductive and life goal setting, and support measures which encourage adequate interconceptional spacing.

Chicago. CDPH will continue to address unintended pregnancy through Family Planning, Male Responsibility, Healthy Start and Interconceptional Care programs.

State Performance Measure 7: *Improve access and utilization of child dental services*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					95
Annual Indicator		92.4	93.3	92.5	93.3
Numerator		521076	615960	704545	760416
Denominator		564191	659906	761361	814601
Data Source		Illinois DHFS	Illinois DHFS	Illinois DHFS	Illinois DHFS
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	95	95	95	95	95

Notes - 2011

Source: "EPSDT Participation - Dental Services - 2007 through 2011" - IL Dept. of Healthcare and Family Services.

2011 data is not yet final. Providers have up to 18 months after the end of a year to submit claims.

Notes - 2010

Source: "EPSDT Participation - Dental Services - 2007 through 2010" - IL Dept. of Healthcare and Family Services.

Notes - 2009

Source: "EPSDT Participation - Dental Services - 2007 through 2010" - IL Dept. of Healthcare and Family Services.

a. Last Year's Accomplishments

The Department of Healthcare and Family Service (HFS) Dental Program is administered by DentaQuest of Illinois, LLC. DentaQuest is primarily responsible for processing and paying claims, performing outreach to providers and members, providing referrals to members, and maintaining the Dental Office Reference Manual. The following HFS programs have increased access to oral health care for children who are beneficiaries of the Illinois Medical Assistance Program (Medicaid): the Beneficiary Outreach Initiative, Bright Smiles from Birth, the Dental Grant Program, and the All Kids School-based Dental Program.

In FFY10, HFS, along with DentaQuest, supported and encouraged the concept of a "dental home" for HFS beneficiaries, particularly for infants, children, adolescents and persons with special needs. Through the Beneficiary Outreach Initiative, beneficiary education and outreach programs have been implemented in a variety of settings, including, but not limited to, dental offices, medical offices, schools and community venues. A brochure is mailed to beneficiaries annually to reinforce the value of seeking treatment at a "dental home". These efforts are succeeding, as evidenced by the growth in numbers of children accessing dental services.

In FFY11, HFS began working with IDPH through an interagency agreement which allowed IDPH Oral Health Consultants to serve as monitors of the All Kids School-based Dental Program. The consultants conducted site visits at schools throughout Illinois to review protocols and monitor the quality of services delivered. HFS and IDPH continue to support and encourage the concept of a "dental home" for HFS beneficiaries, particularly for infants, children, adolescents and persons with special needs. One way this was done was to strengthen the referral network in the School Program.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Beneficiary Outreach		X		
2. Bright Smiles from Birth			X	
3. Dental Grant Program				X
4. All Kids School-based Dental Program Quality Improvement			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FFY 11, the Beneficiary Outreach Initiative will be improved and expanded, as further research is done on effective methods for delivering educational messages to beneficiaries. The pilot Dental Home Initiative will encourage beneficiaries to go to the same dentist regularly for continuous, comprehensive care. The Broken Appointment initiative will likely improve access as beneficiaries will be encouraged through mailings and phone calls to keep their appointments, thus also ensuring that they receive continuous care at a dental home. Finally, the HFS Dental Program is promoting the age one dental visit, which is recommended by the American Academy of Pediatric Dentistry, the American Dental Association, the American Public Health Association, and the American Academy of Pediatrics. The earlier the first dental visit, the less likely a child is

to experience dental disease early in life, and the less costly dental care is in the following years.

In addition to the IDHFS program, Healthworks is a medical case management program for DCFS wards in Illinois administered by IDHS. Case managers are located in health departments and community-based organizations across the state, and track completion of required medical, dental and vision visits for wards age newborn to 19 years of age. All wards are expected to have a dental screening annually, beginning at age 2. Care givers are provided referral and linkage assistance to ensure the exams are completed

c. Plan for the Coming Year

Through Bright Smiles from Birth (BSFB), physicians and nurse practitioners are trained by the Illinois Chapter of the American Academy of Pediatrics (ICAAP) to perform oral health screening and assessment, fluoride varnish application, and anticipatory guidance for children ages birth to three. Additionally, they are trained to refer the children with treatment needs to dentists for necessary follow-up care and establishment of ongoing dental services. BSFB has been operating in Cook County, the Collar Counties, Rockford and Peoria. In FFY 11, ICAAP is expanding the trainings to other parts of the state. The initiative has proven successful in improving access to dental care, and studies confirm that fluoride varnish application is effective at reducing early childhood caries in young children. The numbers of children receiving fluoride varnish application and parents receiving anticipatory guidance will continue to grow.

Federally Qualified Health Centers (FQHCs), local health departments, and rural health clinics are all eligible to apply for grants through the HFS Dental Grant Program. In FFY11, this program was successful in helping to build the oral health infrastructure in Illinois, especially in geographic locations where there are shortages of dentists serving low-income families and limited access to oral health care for HFS beneficiaries. Grant funds are used, for example, for construction and new operatories and equipment, which allow for higher volumes of patients to be seen. In FFY10, the Dental Program was funding four dental clinics with grants of \$100,000 over a two-year period. In FFY11, the Dental Program will fund additional dental clinics with grant funds to be used over a three-year period, as a part of the State's 2010 capital budget from the Capital Development Board.

A subcommittee of DentaQuest's Peer Review Committee, including Dental Program staff, has been meeting over the past year to decide upon and implement changes to the All Kids School-based Dental Program, through which HFS-enrolled dentists visit schools and provide preventive services to children. In FFY10, HFS and the Illinois Department of Public Health (IDPH) signed an Interagency Agreement authorizing IDPH Oral Health Consultants to conduct site visits to schools on behalf of HFS. These visits have encouraged best practices according to industry standards and compliance with OSHA and HFS policy, thus assuring that children receive quality preventive services in the schools. In FFY11, a few more changes to the program will go into effect, including the requirement that providers have a referral plan for each community in which they provide services. This will ensure that students in need of restorative care receive the care that they need.

State Performance Measure 8: *Increase the distribution of mental health information to pregnant women*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					88.5
Annual Indicator		85.6	75	75	75
Numerator					

Denominator					
Data Source		PRAMS	PRAMS	PRAMS	PRAMS
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	77	79	81	83	85

Notes - 2011

2011 data is provisional and uses the 2009 data as an estimate.

Notes - 2010

2010 data is provisional and uses the 2009 data as an estimate.

Notes - 2009

Source: 2009 IL PRAMS Report.

Based upon the last report release date, it is expected to be issued in the Spring of 2014.

In the 2008 PRAMS report, the “percent of women (who) reported that a health care worker talked with them either during pregnancy or after delivery about ‘baby blues’ or postpartum depression” was reported.

In the 2009 PRAMS report, the “percent of women (who) reported that a health care worker talked with them during prenatal care about what to do if they felt depressed during their pregnancy or after the baby was born” was reported. This is slightly different in that the middle part of the statement “about what to do” implies treatment options as part of the woman’s perinatal care. Additionally, this new question asks only about talking to a prenatal care provider, thus limiting the time period of interest to pregnancy.

Future PRAMS will use this wording. Future Annual Performance Objectives will be revised to take into account this lowered level of response. It will be difficult to estimate or extrapolate since the question is new.

a. Last Year's Accomplishments

On July 15, 2011, Illinois submitted an application for the State Systems Development Initiative Grant Program. One of the SSDI program’s goals is to advance the development of performance measures for the state’s priorities as presented in the FFY2011 Maternal and Child Health Block Grant. Loss of staff and expertise and with them the ability to pursue Illinois’ priority measures as identified in the FFY2011 Needs Assessment prompted this goal of the FFY2012 State Systems Development Initiative.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. By Sept. 2012, the MCH Director, PPD & MCH Advisory Committee will present strategies in the MCH Block Grant application for: Address the mental health needs of the MCH population through prevention, screening, referral & appropriate treatment.				X
2.				
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

As presented in the SSDI application, Illinois will pursue the following objective relative to State Performance Measure 8.

By September 2012, the MCH Director, PPD, and the MCH Advisory Committee will present strategies in the MCH Block Grant application for the advancement of the following State Priority : Address the mental health needs of the MCH population through prevention, screening, referral, and appropriate treatment.

c. Plan for the Coming Year

A strategy for progress in State Priority 8 is the work of the entire MCH community, including the state agencies charged with bettering the lives of women and children as well as the local service providers that do the work. The Illinois Maternal and Child Health Advisory Board is representative of the MCH community. The Maternal and Child Health Advisory Board advises IDHS regarding the family health programming and other activities related to maternal and child health and infant mortality reduction programs. Key staff of the Illinois Departments of Public Health, Healthcare and Family Services, Children and Family Services and Human Services are members of the board. Local public health departments and community based organizations also are represented. The board meets quarterly. SSDI staff under the direction of PPD and the MCH Director will work with the advisory board as well as staff of the DHS Division of Mental Health Services to develop overarching strategies to advance this maternal and child health priority. SSDI staff will attend the quarterly meetings for the purpose of leading discussion and planning sessions relative to this priority. The strategies developed for priority 8 will be developed and incorporated in the FFY2013 Block Grant Application. Also, baseline data will be presented for this priority in the FFY2013 application.

State Performance Measure 9: Increase the percentage of youth participating in daily physical activity

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					67.5
Annual Indicator		0	44.7	0	48.5
Numerator					
Denominator					
Data Source		n/a	YRBS - CDC	n/a	YRBS - CDC
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	51	52.3	54	56.1	58

Notes - 2011

Source: Table 92, Percentage of high school students who did not participate in at least 60 minutes of physical activity on any day*, † and were physically active at least 60 minutes/day on 5 or more days, †, § by sex — selected U.S. sites, Youth Risk Behavior Survey, 2011. This was changed in 2012. The previous source was "Table 98. Percentage of high school students who

attended physical education (PE) classes, by sex "

Due to the work by our Epidemiology staff at the University of Illinois at Chicago, School of Public Health, Division of Epidemiology/Biostatistics, the sources for this measure was clarified.

This was because many people felt that physical education requirements were not something that Title V would be able to control directly (because PE is a Department of Education issue) and, therefore, physical education attendance would not really be measuring Title V's performance. We switched to the more general physical activity measure because people felt it would be a better short-term indicator of Title V work because there may be more opportunities for Title V to influence activity levels in communities.

Future Performance Objectives had to be revised accordingly.

Notes - 2010

This performance measure uses the YRBSS for its data source. There was no YRBS survey conducted in Illinois in 2010.

Notes - 2009

Source: Table 81: Percentage of high school students who were physically active, by sex — selected U.S. sites, Youth Risk Behavior Survey, 2009. This was changed in 2012. The old source was "TABLE 87. Percentage of high school students who attended physical education (PE) classes, by sex"

Due to the work by our Epidemiology staff at the University of Illinois at Chicago, School of Public Health, Division of Epidemiology/Biostatistics, the sources for this measure was clarified.

This was because many people felt that physical education requirements were not something that Title V would be able to control directly (because PE is a Department of Education issue) and, therefore, physical education attendance would not really be measuring Title V's performance. We switched to the more general physical activity measure because people felt it would be a better short-term indicator of Title V work because there may be more opportunities for Title V to influence activity levels in communities.

a. Last Year's Accomplishments

On July 15, 2011, Illinois submitted an application for the State Systems Development Initiative Grant Program. One of the SSDI program's goals is to advance the development of performance measures for the state's priorities as presented in the FFY2011 Maternal and Child Health Block Grant. Loss of staff and expertise and with them the ability to pursue Illinois' priority measures as identified in the FFY2011 Needs Assessment prompted this goal of the FFY2012 State Systems Development Initiative.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. By Sept. 2012, the MCH Director, PPD & the MCH Advisory Committee will present strategies in the MCH Block Grant application for advancement of State Priority : Promote healthy weight, physical activity & optimal nutrition for women & children.				X
2.				
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

The Illinois Physical Development and Health Task Force was created by Senate Bill 3374, just passed in May 2012. This law amends the existing School Code. The new Task Force is to make recommendations to the Governor and General Assembly on certain goals of the Illinois Learning Standards for Physical Development and Health. The Task Force will focus on updating the standards based on research in neuroscience that impacts the relationship between physical activity and learning. A report on their findings must be filed with the Governor and General Assembly by August 31, 2013.

c. Plan for the Coming Year

A strategy for progress in State Priority 9 is the work of the entire MCH community, including the state agencies charged with bettering the lives of women and children as well as the local service providers that do the work. The Illinois Maternal and Child Health Advisory Board is representative of the MCH community. The Maternal and Child Health Advisory Board advises IDHS regarding the family health programming and other activities related to maternal and child health and infant mortality reduction programs. Key staff of the Illinois Departments of Public Health, Healthcare and Family Services, Children and Family Services and Human Services are members of the board. Local public health departments and community based organizations also are represented. The board meets quarterly. SSDI staff under the direction of PPD and the MCH Director will work with the advisory board as well as the WIC and SNAP staff to develop overarching strategies to advance this maternal and child health priority. SSDI staff will attend the quarterly meetings for the purpose of leading discussion and planning sessions relative to this priority. The strategies developed for priority 9 will be developed and incorporated in the FFY2013 Block Grant Application. Also, baseline data will be presented for this priority in the FFY2013 application.

State Performance Measure 10: *Provide comprehensive transition planning for CSHCN ages 14 and above and their families*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					90.7
Annual Indicator				90.6	86.9
Numerator				879	870
Denominator				970	1001
Data Source				Record Review DSCC Youth 14-21 (50% Sample)	Record Review DSCC Youth 14-21 (50% Sample)
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	90.8	90.8	91	91	91.1

a. Last Year's Accomplishments

Illinois' performance objective to ensure that 90.7% of youth over 14 years of age enrolled with UIC-DSCC and their parents/guardians receive comprehensive transition planning from UIC-DSCC staff was not achieved. Actual performance in SFY '11 was 87.8%, which was a slight decrease from previous year (SFY'10, 90.6%; SFY'09, 83.6%). A review of 50% of case records for youth ages 14-21 years shows that for those that had some aspect of transition addressed, 79.7% (85.5% in SFY'10) received planning information on health care transition; 75.1% (82.0% in SFY'10) received information on vocations; and 68.3% (78.8% in SFY'10) on community involvement and integration. The data reflects only UIC-DSCC care coordination efforts in transition planning.

There was improvement in 7 of 13 UIC-DSCC regions, no change in one region, and lower performance in five regions. Five of the 7 regions showing improvement in transition planning had transition work group participants that act as transition champions in their respective regions. The greatest decrease statewide was a 10.5% drop in the area of community involvement and integration. All registered CYSHCN were required to have a new Assessment Worksheet and new revised Individual Service Plan completed between June 1, 2009 and September 2010. Staff was encouraged to address transition planning on the ISP for all transition age youth and young adults annually. The chart review found 45.3% of youth (50.5% in SFY'10) had a written transition plan statewide.

A Transition Planning Checklist was developed for tracking transition efforts with youth/families. It includes a list of tools/activities to promote transition-oriented care coordination services and follow-up and helps coordinate efforts and facilitate communication among all members of the Care Coordination Team. In October 2010 the newly developed Transition Milestones Skills Lists were released to assist youth/families and care coordination teams to assess Education, Employment, Financial, Health, Living and Social Skills. The Skills Lists and 82 Supporting Skills Tips & Tools sheets can be accessed at: <http://internet.dsccl.uic.edu/dscclroot/parents/milestones.asp>. The UIC-DSCC brochure, Plan for the Future, which is targeted to parents/caregivers was revised and released December 2010. It is also posted on the UIC-DSCC website. The UIC-DSCC transition work group has been involved in the development and review of transition materials including transition overview sheets, transition brochure and guide to benefits and resources as part of the collaborative partnership for the Integrated Systems Grant from Health Resources and Services Administration, D70MC12840.

UIC-DSCC supported 11 family members and 14 staff participating in the 6th Annual Transition Conference for youth and young adults with disabilities held in Effingham, IL, October 24-26, 2010. The conference, titled "Abilities, Aspirations & Access," invited participants to imagine the possibilities for youth and young adults with disabilities in the areas of independent living, education and training, employment, community integration, health care, and self advocacy. Conference sessions were organized into four tracks: education, community, employment, and health. A pre-conference session was held the afternoon of Sunday, October 24, to provide opportunities for those unable to attend during the week. UIC-DSCC presented "Strategies and Tools for Improving Health Care Transition". UIC-DSCC also exhibited and provided health care transition outreach materials and information. Staff recruited health care transition presentations, health care providers and coordinated the health track.

Regional resource contacts including transition services, charitable organizations, legal services, advocacy services, durable medical equipment and others have been shared with the Illinois Life Span project, <http://www.illinoislifespans.org/> in an effort to expand the electronic searchable database. The database is designed to help users navigate the advocacy and service systems in Illinois. UIC-DSCC promotes use of the statewide database to staff, providers and families to find needed services in their area.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medical transition material available on website.				X
2. Care coordination staff development on transition.				X
3. Evaluation of transition planning.				X
4. Promoting awareness of transition issues/resources.				X
5. Care coordination related to transition planning for UIC-DSCC children and youth.		X		
6. Collaborate in planning activities with local transition planning committees such as transition conferences, transition fairs, and newsletters.				X
7. Provide public education to CYSHCN and their families on Health Care Transition, including skill development, adult services and resource information.		X		
8. Participate and advocate for health goals in the IEP/Transition plan.		X		
9.				
10.				

b. Current Activities

A DVD, "Setting Sail" was developed by the UIC-DSCC transition workgroup for dissemination by care coordinators. It is also available on YouTube at <http://www.youtube.com/embed/1zcNxAdJDjs> and via a link posted on the UIC-DSCC website. This short video provides helpful tips and personal insights from several youth, young adults and families.

Staff is contacting IL Judicial Circuit Courts to gather guardianship information including available assistance/resources and guardianship court required forms and procedures. The information will be organized by county and made available for UIC-DSCC staff when working with families on guardianship. Mental Health resources including information on depression, hotlines and counseling will soon be posted to the UIC-DSCC's Transition Information and Resources webpage. Another addition will be college resources for students who are deaf or hard of hearing.

UIC-DSCC hosted a Webinar for staff on March 8, 2012 about the Department of Human Services/Division of Rehabilitation Services' Home Services Program to increase awareness of waiver services, eligibility, referral process and appeals.

Transition Tips of the Month have been developed as short PowerPoint presentations and recorded webinars. These tips have been sent to all UIC-DSCC staff every other month as a frequent reminder and as ongoing training to include topics requested through a staff survey.

c. Plan for the Coming Year

UIC-DSCC care coordination staff will strengthen transition efforts for recipients by continuing work to improve access to high quality, developmentally appropriate, uninterrupted healthcare through facilitating transition to adult health care providers, referring to appropriate resources, providing anticipatory guidance and writing person-centered plans. UIC-DSCC regional staff will continue to collaborate with community-based transition partners to strengthen and build community infrastructure that coordinates the efforts of the health, social, education and employment systems. The transition work group will continue to evaluate and improve UIC-DSCC's transition tools and materials. Feedback from youth, families, and staff will be gathered in an effort to continuously evaluate transition service needs and advise on anticipatory guidance, transition tools, resources and training needs. The implementation of the UIC-DSCC new

comprehensive assessment process is required and will continue to be reviewed to determine if staff assesses transition issues ongoing and develops plans with youth and families.

UIC-DSCC staff will continue to participate, promote and support youth and families through educational outreach opportunities including the 8th Annual Statewide Transition Conference, "Stepping Stones of Transition" October 24-26th; Integrated Service Committee presentations on Health in the IEP; Children's Memorial Hospital Transition Team's Transition webinars and in-person trainings for youths and their families; Got Transition Radio Episodes and others. The agency will be considering the use of Facebook and the possibility of adding transition topics/video clips for broader outreach to YSHCN and their families.

Ongoing staff development will be addressed through Webinar trainings (topics from staff survey: PUNS, Division of Rehabilitation Services/Vocation Services); Transition Tip of the Month; and a transition column in The Insider (internal monthly newsletter). Staff will also be informed of the new Employment First Initiative and interagency efforts to develop policies and practices to improve integrated employment outcomes and opportunities for all working-age adults with and without disabilities in Illinois.

UIC-DSCC staff will have an opportunity to participate during the pilot phase in the Transitioning Youth to Adult Health Care course developed through the Integrated Systems Grant from HRSA, D70MC12840. The course consists of the following 11 web-based modules: Introduction; Transition Registries; Assess Health Care Skills; Transition Goal Development; Insurance, Benefits, Services; Guardianship; Portable Medical Summary; Identifying Adult-Oriented Providers; Coding and Reimbursement; and Conclusion.

E. Health Status Indicators

Health Status Indicator 01A: The percent of live births weighing less than 2,500 grams.

Narrative: The percent of live births weighing less than 2,500 grams has remained stable, fluctuating by a 10th of a percentage point year after year since 2005. The DHS and its partners have instituted several initiatives to lower this rate. The Title V program uses an array of services to improve pregnancy outcomes, including direct health care, enabling and population-based services. Direct health care services are provided through the "mini" block grant awarded to the CDPH and, on a limited basis, through the FCM program. Two statewide enabling service programs are central to the Title V program's infant mortality reduction efforts: The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Family Case Management (FCM). The Department also operates two initiatives that are targeted to communities with high rates of low birth weight and infant mortality. IDHS was awarded one of the original 15 Healthy Start projects to serve six community areas in Chicago's inner city. IDHS subsequently implemented Targeted, Intensive Prenatal Case Management to serve high-risk pregnant women in several target communities across the state. The Family Planning and IDHFS' Illinois Healthy Women (IHW) programs are the state's primary strategies for improving preconceptional health. The Family Planning program provides comprehensive family planning services related to the avoidance, achievement, timing, and spacing of pregnancy. Services include client education, counseling, screening, infertility services, pregnancy testing and options counseling, contraceptive methods, and identification and treatment of sexually transmitted infections. Services are available statewide through a network of delegate agencies. IHW was implemented as a five-year waiver in April 2004; a complete description may be found in Section III of this application, under "Health Care Financing."

Health Status Indicator 01B: The percent of live singleton births weighing less than 2,500 grams.

Narrative: The absolute number of births and the percent remained relatively stable from 2005 to 2007 but in 2008 both the number of LBW births and the LBW percent declined. This decline is anticipated to continue into 2009. Please refer to the narrative for Health Status Indicator 1A for more discussion.

Health Status Indicator 02A: The percent of live births weighing less than 1,500 grams.

Narrative: The absolute number of births and the percent remained relatively stable from 2005 to 2007 but in 2008 the number of VLBW births declined. However, the total number of all infants born also dropped so the percentage remained the same. The rate is anticipated to be constant into 2009. Please refer to the narrative for Health Status Indicator 1A for further discussion.

Health Status Indicator 02B: The percent of live singleton births weighing less than 1,500 grams.

Narrative: The percent remained relatively stable from 2005 to 2007 but in 2008 the number of VLBW births declined for the first time below the 2,000 threshold. However, the total number of all infants born also dropped so the percentage remained the same. The rate is anticipated to be constant into 2009. Please refer to the narrative for Health Status Indicator 1A for more discussion.

Health Status Indicator 03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

Narrative: The number of deaths to children aged 14 years and younger decreased in 2008 as compared to 2007 and 2006; there were 39 fewer deaths for a rate of 4.1 per 100,000. In 2009 representatives from the Illinois Department of Children and Family Services' Child Death Review Program, the Illinois Department of Human Services' Maternal Child Health Program and the IDPH Injury and Violence Prevention Program formed a team to represent Illinois at the "Keeping Kids Alive" Symposium hosted by the National Center for Child Death Review and the Children's Safety Network. The Illinois team will continue to meet during 2010 to look for initiatives to collaborate on.

Health Status Indicator 03B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Narrative: Illinois experienced an increase in the rate of motor vehicle crash deaths among children between 1 and 14 years of age to 1.7 per 100,000 children.

IDPH continued its partnership with the Chicago Police Department, the Illinois State Police, local hospitals and health centers, and IDCFS to conduct community child safety seat checks. Through this partnership, 45 safety seat checks were held, and 1,400 car safety seats were distributed to low-income families, and more than 3,000 car seats were checked for proper seat installation. During a car seat check clients are taught how to properly use seat belts as well as proper car seat installation.

Health Status Indicator 03C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Narrative: The rate of death from unintentional injuries due to motor vehicle crashes among youth who were between 15- and 24-years-of-age decreased sharply from 2007 to 2008 (18.8 to 14.3 per 100,000, respectively). These deaths resulted in many years of potential life lost. One significant factor associated with motor vehicle crashes among this age cohort is alcohol consumption. DHS is administering a SAMHSA Statewide Incentive Grant, Partners for Success, which is addressing under-aged drinking as well as alcohol use among young adults in community areas throughout Illinois. The communities utilize an array of prevention techniques to reduce alcohol consumption. Underage drinking also is addressed by funding provided by the

Office of Juvenile Justice and Delinquency Prevention (OJJDP) grant programs called Enforcing Underage Drinking (EUDL). The purpose of the grant is to support the reduction of the availability of alcoholic beverages to and the consumption of alcoholic beverages by persons who are younger than 21 years old. The EUDL Block Grant supports enforcement strategies aimed at limiting retail and social access. The EUDL University Initiative targets two campuses and communities in the state. Each grantee is expected to work in partnership with a coalition and have developed a strategic plan and is implementing evidence-based enforcement and policy strategies in coordination with community education activities.

Health Status Indicator 04A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

Narrative: The rate of non-fatal injuries among children aged 14 years and younger decreased in 2011. While some of this change can be attributed to more effective intervention and education by our human service program, there could be another cause. In Illinois there is a small but growing number of freestanding Ambulatory Surgical Treatment Centers (ASTC's). As of 2012 IDPH licenses approximately 137 in Illinois. These centers may be seeing more injuries than traditional hospitals and thus are not reporting their injury cases in the same way. Other causes as mentioned are due to continuing program outreach and education. Home visiting is an effective invention in preventing unintentional and intentional injuries to young children. During the visit health professionals review safety practices with parents or care-takers of the child. Illinois administers several home visiting programs the newest of which is Strong Foundations. IDHS, DCFS and ISBE are worked together during FFY'09 and FFY'10 to develop the state's infrastructure to support evidence-based home visiting programs. These three agencies provide program grants to support three different approaches to home visiting for the purpose of supporting families and reducing the risk of child maltreatment. The approaches are: Healthy Families Illinois, Parents as Teachers and the Nurse-Family Partnership. The three agencies are working with the Home Visiting Task Force, a broad-based advisory group of service providers, advocates and parents established by the Early Learning Council. The project, called "Strong Foundations," is supported by a cooperative agreement from the federal Children's Bureau for "Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment." The project concluded in FFY'10 due to the premature loss of federal funding.

Health Status Indicator 04B: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

Narrative: The rate of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger that required hospitalization remained about the same between 2009 and 2011. Illinois continues to promote safety for young children via its Child Safety Seat program as well as other initiatives such as the "Click It or Ticket" campaign. Please refer to the narratives for Health Status Indicators 3A and 3B as well for additional discussion.

Health Status Indicator 04C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Narrative: The rate of motor vehicle crashes declined slightly in 2011 from 2010 but was higher than 2009. However, the absolute number of crash victims was below 1,500, the lowest since 2007. Per IDOT's "Crash Facts and Statistics" 2010 report, drivers aged 15-24 accounted for fewer drivers and total occupants killed than the highest age range of 25 to 34. Per the IDOT report "Illinois Crash Data 2006-2010", "young drivers account for about 8 percent of all licensed drivers; their involvement in crashes, however, is considerably higher. This over-representation" is approximately 44% higher than should be expected. Illinois has a number of programs that target young drivers such as "Operation Teen Safe Driving" and "PROM" (Please Return On Monday). These programs began in recent years and continue to promote safety awareness among young adults in motor vehicles. Of most recent note is a new state law that took affect January 1, 2012. As of 1/1/12, all persons must wear a seat belt in a vehicle. Before, only

passengers under the age of 19 are required to buckle up. Now all passengers, front and back seat, will be required to use a seat belt. If caught not wearing a seat belt, fines for violators will start at \$25. Please refer to the narrative for Health Status Indicator 3C for additional discussion.

Health Status Indicator 05A: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

Narrative: The rate of chlamydia among young women continues to climb. Since 2007 the rate has increased almost 1 percent or more each year through 2011 as has the absolute number of cases. In part this is a function of increased testing throughout the state. The Family Planning (FP) Program and the IDPH STD program are continuing to encourage and monitor the age-based screening criteria for Chlamydia. A mailing was sent by IDPH-STD to each Title X FP Clinic to provide screening recommendations and site-specific data on screening coverage rates by age group. The Family Planning delegate agencies continue to receive a list of the percent of clients less than 26 years of age who received Chlamydia and Gonorrhea testing and timeliness of treatment data. School Health Centers are actively involved with IDPH in increasing the number of youth screened and treated for Chlamydia. MCH nurses and School Health program staff conducted trainings for School Health Center staff to improve STI counseling and testing of youth served by the clinics.

Chicago. CDPH policy mandates all pregnant women should be screened at least once during their pregnancy. CDPH's STD/HIV/AIDS Division's Adolescent Program and HIV Counseling and Testing unit are meeting with key CPS staff to revise the Chicago Public School's (CPS) confidentiality and Sexually Transmitted Infection (STI) policies and procedures. The revised policy allows STI counseling and testing to occur in all high schools whether or not there is a school-based health clinic. The adolescent program also re-established collaborations with the Illinois Youth Center-Chicago (providing a STD/HIV Health Education curriculum to approximately 130 youth housed in the facility) and with the YMCA.

Health Status Indicator 05B: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

Narrative: The rate of women aged 20 through 44 years with a reported case chlamydia is steadily increasing over the last several years however it saw a slight downturn from 2009 to 2010 in both the absolute number of cases and the rate. However, both figures increased to new recent highs in 2011. As with the population of 15 to 19 year olds, a part this is a function of increased testing throughout the state. The Family Planning program and the IDPH STD program undertake the following activities to reduce the rate of Chlamydia infection: testing all clients seeking pregnancy testing; retesting persons with positive tests three months after treatment to detect reinfection; and provide testing of partners of family planning clients with positive test results.

Health Status Indicator 06A: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)

Narrative: Refer to Form 21 for the enumeration of infants and children aged 0 through 24 years of age. The distribution of infants and children by racial grouping suggests that Illinois is a diverse state comprised of several racial groupings and ethnicities. This is the first report to use the 2010 Census counts. Illinois will closely monitor the changes counts and percentages by race and compare future Census Estimates with the 2010 Census counts. Illinois will report trends and implications in future applications and reports.

Health Status Indicator 06B: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)

Narrative: The distribution of infants and children by ethnic grouping suggests that Illinois is a

diverse state. This is the first report to use the 2010 Census counts. Illinois will closely monitor the changes counts and percentages by ethnicity and compare future Census Estimates with the 2010 Census counts. Illinois will report trends and implications in future applications and reports.

Health Status Indicator 07A: Live births to women (of all ages) enumerated by maternal age and race. (Demographics)

Narrative: Overall births declined from 2008 to 2009 by a total of 5,557 or about 3.1%. The decline was seen in the two largest racial categories, with "White" births declining by 3.3% and "Black or African American" births declining by 3%. However, in the third largest racial category, "Asian", the decline was less, only 2.8%. For other discussion refer to Form 21 for the distribution of live births by maternal characteristics.

Health Status Indicator 07B: Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)

Narrative: Overall births declined from 2008 to 2009 by a total of 5,557 or about 3.1%. The decline was seen in the "Not Hispanic or Latino" births which declined by 2.4% and more prominently in the "Hispanic or Latino" births, which declined far more, by 5.6%. Please refer to the narrative for Health Status Indicator 7A for further discussion.

Health Status Indicator 08A: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)

Narrative: Most childhood deaths occur to infants (nearly 43 percent in 2008), followed by deaths among 20 -- 24 year olds (about 27 percent) and deaths among 15-19 year olds (about 17 percent). When compared with the data for calendar year 2003, there were 11.3 percent fewer deaths among children in 2008. When looking at the figures by race, White deaths declined 15.4% while Black deaths only declined 12.6%. However, when examining the rate by ethnicity, while the overall number of deaths declined 11.3%, for Hispanics the rate only decreased by 6%. The non-Hispanics' death rate declined by 14.8%. There were no dramatic shifts in the distribution of deaths by age ranges between 2003 and 2008 by either race or ethnicity.

Health Status Indicator 08B: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)

Narrative: Please refer to the narrative for Health Status Indicator 8A.

Health Status Indicator 09A: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)

Narrative: Infants and children aged 0 to 19 years of age in miscellaneous situations or enrolled in various state programs are presented.

Health Status Indicator 09B: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)

Narrative: Infants and children 0 to 19 years of age in miscellaneous situations or enrolled in various state programs are arrayed here by Hispanic ethnicity.

Health Status Indicator 10: Geographic living area for all children aged 0 through 19 years.

Narrative: Most of Illinois' children live in urban areas, which includes Rural-Urban Continuum codes 4 through 7 as defined by the USDA's Economic Research Service. According to its website, the Economic Research Service classifies "metropolitan ... counties by the population

size of their [metropolitan] area, and nonmetropolitan ... counties by degree of urbanization and adjacency to a [metropolitan] area or areas. The [metropolitan] and [nonmetropolitan] categories have been subdivided into three [metropolitan] and six [nonmetropolitan] groupings, resulting in a nine-part county codification. ... "[Metropolitan] counties are distinguished by population size of the Metropolitan Statistical Area of which they are part. [Nonmetropolitan] counties are classified according to the aggregate size of their urban population. Within the three urban size categories, [nonmetropolitan] counties are further identified by whether or not they have some functional adjacency to a [metropolitan] area or areas. A [nonmetropolitan] county is defined as adjacent if it physically adjoins one or more [metropolitan] areas, and has at least 2 percent of its employed labor force commuting to central [metropolitan] counties. [Nonmetropolitan] counties that do not meet these criteria are [classified] as nonadjacent." [http://www.ers.usda.gov/briefing/rurality/ruralurbcon/, March 26, 2010]. Compared with the data submitted with the FFY'06 application, the number of children living in rural areas (USDA ERS Rural-Urban Continuum Codes 8 and 9) decreased by 11.6 percent.

Health Status Indicator 11: Percent of the State population at various levels of the federal poverty level.

Narrative: Nearly 30 percent of Illinois' population is at or below 200 percent of poverty. The proportion of the population that is very poor (incomes below 50 percent of the federal poverty standard) remained the same from the most previous Census estimates at 5.6 percent. However the proportion of the population that is impoverished (incomes at or below the federal poverty standard) increased from 12.4 to 12.6 percent.

Health Status Indicator 12: Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.

Narrative: More than a third (37.7%) of Illinois' children 0 to 19 years of age are living at or below 200 percent of poverty. Compared with the data submitted with last year's application, the proportion of children who live in very poor families (with incomes below 50 percent of the federal poverty standard) increased from 7.7 to 7.9 percent of the population of children; the proportion of children who live in impoverished families (with incomes at or below the federal poverty standard) increased from 17.2 to 17.7 percent of the population.

F. Other Program Activities

Women of Child-Bearing Age - A statewide Pre/Interconceptional Care Committee was formed in FY'07, with the goal of developing and implementing a three- to five-year strategic plan. Membership consists of representatives from IDHS, IDHFS, IDPH, local Health Departments, Delegate Family Planning programs, March of Dimes, Illinois Maternal and Child Health Coalition and others. To date, a grid outlining recommended components of pre/interconceptional care has been developed, an Education and Outreach sub-committee has been formed, and a social marketing strategy is being defined.

With grant funds from the American College of Obstetricians and Gynecologists, CityMatCH and the NHSA, IDHS and IDPH are collaborating on a project to further reduce perinatal transmission of HIV. The objective of the FIMR/HIV Prevention Methodology is to review, identify, address, and reduce missed opportunities for prevention of mother-to-child HIV transmission. To this end, it is important to design protocols that will identify cases from a broad array of settings within a community and prioritize the review of cases that are more likely to elicit opportunities for improvement of systems.

Fetal Alcohol Syndrome - The Department was awarded a \$1 million contract from Northrop Grumman to implement a Fetal Alcohol Spectrum Disorder Prevention Program statewide over the next five years. The Brief Intervention for Alcohol Use will become part of the Department's

existing WIC and Family Case Management services to pregnant women. A demonstration of the project is being conducted in Rockford, Illinois, through the Winnebago County Health Department and the Macon County Health Department in Decatur, Illinois. Over 3,600 pregnant women have been asked about their alcohol use prior to pregnancy since the project began in 2008 and over 200 women have received a Brief Intervention. Plans are underway to expand to three additional sites in 2010 and 2011. Staff requires intensive training and follow-up. Statewide expansion will occur in 2012.

Early Childhood Development - The Early Learning Council, created in 2003 by Public Act 93-0380, coordinates existing programs and services for children from birth to five years of age in order to meet the early learning needs of children and their families. The Council is comprised of gubernatorial and legislative appointees representing a broad range of constituencies, and the MCH program is represented on four of five committees.

The Council chose to develop a comprehensive plan for Preschool for All based on voluntary access, past planning efforts, and ensuring that all Illinois children are safe, healthy, eager to learn, and ready to succeed by the time they enter school.

Children's Mental Health - The Illinois Children's Mental Health Partnership envisions a comprehensive, coordinated children's mental health system comprised of prevention, early intervention, and treatment services for children ages 0-18 years and for youth ages 19-21 who are transitioning out of key public programs. The MCH program is represented on the Early Childhood Committee of the Partnership and its work groups. The work of the Committee focuses on:

- (1) An early childhood mental health consultation initiative,
- (2) The adoption of diagnostic codes for very young children,
- (3) Increasing the response to maternal perinatal depression,
- (4) Establishing social emotional and developmental screening and assessment,
- (5) Expanding and developing the early childhood mental health workforce, and
- (6) Ensuring that parents are equal partners in the emerging children's mental health system.

//2012/ Obstetric hemorrhage remains a leading cause of maternal morbidity and mortality in Illinois. In response to this situation, the Illinois Department of Public Health mandated that the Obstetric Hemorrhage Education Project be implemented in all hospitals providing maternity services in the State of Illinois, by December 2009. The program included all providers of care on obstetric units including physicians, mid-level providers (midwives, CRNAs), nurses, and to a more limited extent, clerks, nursing assistants, and technicians. The Program was developed by the Illinois Maternal Mortality Review Committee with input from obstetric providers, anesthesia providers and perinatal nurses. The education project included:

- (1) Benchmark Assessment Validation (a pre-test, may be web-based)
- (2) Didactic lecture
- (3) Skills station with estimation of blood loss training
- (4) Multi-disciplinary simulation drill(s) with debriefing.

All birthing hospitals in Illinois have participated in the Obstetric Hemorrhage Education Project. IDPH is now in the process of assessing the competency of the care providers on obstetric units. To date, statistical data regarding the effectiveness of the program is not available. However, anecdotal accounts suggest that the program is an effective intervention. //2012//

G. Technical Assistance

See Form 15 for this information.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	21700000	21700000	21700000		21700000	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	28696702	27835800	27261867		27260000	
4. Local MCH Funds <i>(Line4, Form 2)</i>	0	0	0		0	
5. Other Funds <i>(Line5, Form 2)</i>	251784525	244230990	234159608		234159600	
6. Program Income <i>(Line6, Form 2)</i>	8000000	7760000	8000000		7760000	
7. Subtotal	310181227	301526790	291121475		290879600	
8. Other Federal Funds <i>(Line10, Form 2)</i>	414286114	414286114	416111558		416111558	
9. Total <i>(Line11, Form 2)</i>	724467341	715812904	707233033		706991158	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	22192394	21526622	20829781		20800000	
b. Infants < 1 year old	42360122	41089318	39759210		39759000	

c. Children 1 to 22 years old	195603720	189735608	183579028		183450600	
d. Children with Special Healthcare Needs	17107000	16300000	16056630		16060000	
e. Others	32065271	32048104	30096463		30010000	
f. Administration	852720	827138	800363		800000	
g. SUBTOTAL	310181227	301526790	291121475		290879600	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	0		100000		100000	
c. CISS	105000		105000		105000	
d. Abstinence Education	0		0		0	
e. Healthy Start	1484650		1484650		1484650	
f. EMSC	0		0		0	
g. WIC	352933300		352933300		352933300	
h. AIDS	0		0		0	
i. CDC	0		0		0	
j. Education	19579600		19579600		19579600	
k. Home Visiting	0		0		0	
k. Other						
Child Care	1066000		1066000		1066000	
Family Violence	2574500		2574500		2574500	
MIECHVP	0		3135997		3135997	
Other demonstrations	0		0		790150	
Substance Abuse	16466293		16466293		16466293	
Title X	6742978		6742978		6742978	
Title XX	10908090		10908090		10908090	
UNHS	225000		225000		225000	
Other Demonstrations	790150		790150		0	
Youth Services	1410553		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	121028058	118048217	113596935		113597000	
II. Enabling Services	142071786	137809632	133333954		133092100	
III. Population-Based Services	31913717	30956305	29954215		29954000	
IV. Infrastructure	15167666	14712636	14236371		14236500	

Building Services						
V. Federal-State Title V Block Grant Partnership Total	310181227	301526790	291121475		290879600	

A. Expenditures

INTRODUCTION. In general, expenditures for individual programs were somewhat below budgeted amounts. This is due in part to a gubernatorial instruction to reserve state funds in response to budgetary shortfalls and in part to the differences that result from budgeting on a state fiscal year and reporting expenditures on a federal fiscal year. Large differences between budgeted and expended amounts are due to inclusion of additional expenditures and reclassification of expenditures. The effect of reclassification is especially apparent on Form 5.

FORM 3. IDHS reported an additional \$79 million in expenditures for FFY'09. The final amount received for the MCH Block Grant, \$21.7 million, was somewhat less than the amount used in the FFY'09 budget projection (\$22.1 million). The State of Illinois has expended the entire FFY'09 award. IDHS, IDPH and DSCC provided a total of \$37.3 million in state funds to meet Title V's match and Maintenance of Effort requirements. This amount exceeds both required amounts. The State of Illinois reports the amount of local funds used to match expenditures of Title V Section 510 (Abstinence Education) funds as "local funds" for the MCH Block Grant. The additional expenditures of Other State Funds (\$39 million more than the amount budgeted) reflect the inclusion of all non-federal Part C Early Intervention program funds in the expenditure report. Prior reports have included only the case management funds. The State of Illinois reports the amount of funds collected by Title X (Family Planning) delegate agencies as program income. Collections were below expectations. The Department received and expended approximately \$40 million more for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) in FFY'09 than originally projected, while expenditures of other federal funds were below the budgeted amount, resulting in a net increase in expenditures of \$34 million.

DSCC expended \$18.0 million for CSHCN from all sources in FFY'09, an aggregate decrease of \$2.1 million from FFY'08. The decrease in overall spending for CSHCN was primarily from Other Fund sources which accounted for \$1.8 million of the decrease, while the State sources were reduced by \$0.3 million. While the primary reduction in spending was from Other Resources, the federal MCH Block Grant fund allocation remained the same in FFY'09 at \$6.6 million. The Other Federal Funds used for CSHCN purposes increased slightly to \$0.2 in FFY'09.

/2012/ IDHS reported a decrease in expenditures of \$8.8 million (2.7 percent) for FFY'10. //2012//

/2013/ IDHS reported a decrease in expenditures of \$8.65 million (2.8 percent) for FFY'11.//2013//

/2012/ DSCC expended \$17.0 million from all sources in FFY'10 for CSHCN, a decrease in spending of \$1.0 million from FFY'09. The reduction in spending was primarily from Other Fund resources which accounted for \$0.6 million of the decrease and \$0.4 million from the State. The expenditures from MCH Block Grant funds and Other Federal funds remained constant in FFY'10. //2012//

/2013/ UIC-DSCC expended \$16.3 million for CSHCN from all sources in FFY'11, an aggregate decrease of \$0.7 million from FFY'10. State resources accounted for the reduction in expenditures of \$1.1 million. The spending from Other Fund sources increased by \$0.4 million while the federal MCH Block Grant fund allocation remained constant in FFY'11 at \$6.5 million. The Other Federal Funds used for CSHCN purposes increased slightly to \$0.3 in FFY'11. //2013//

FORM 4: Expenditures Pregnant Women were \$2.4 million less than the amount budgeted largely as the result of using a different combination of state and federal funds to pay for the Cornerstone management information system than originally budgeted and changes in the way that federal-state partnership funds used to pay for the Cornerstone system are allocated on Form 4. The additional expenditures for children reflect the allocation of nearly all non-federal Early Intervention funds (approximately 90 percent of the total), the addition of state funds for substance abuse prevention and additional funds for operations. Expenditures for Others were approximately \$4.7 million less than the amount budgeted. While IDHS allocated more of its training and family planning expenditures to this category, the increases were offset by the reclassification of substance abuse program and operations expenditures and a \$3.3 million reduction in expenditures for domestic violence services.

The IDHS is required by Circular A-87 to have a Public Assistance Cost Allocation Plan (PACAP). The U.S. DHHS Division of Cost Allocation has requested that IDHS have a Departmental Indirect Cost Allocation Plan for indirect costs to identify dollars that then become a part of the PACAP each quarter in claiming federal reimbursement. IDHS does not use indirect rates for its programs. It is considered full costing on a quarterly basis. Amounts budgeted for indirect costs are converted to direct costs through the PACAP. The costs identified as administration reflect audit costs and PACAP costs in excess of actual personal services expenditures.

In FFY'09 DSCC spent 10.4 percent or \$2.1 million less on CSHCN services than in FFY'08. The federal MCH Block Grant funds spent to support the CSHCN remained at \$6.6 million, while the amount spent from State and Other Resources was reduced by \$2.1 million from FFY'08 to FFY'09.

/2012/ Expenditures for Pregnant Women were roughly the same as budgeted for FFY'10. The expenditures for children reflect the allocation of nearly all non-federal Early Intervention funds (approximately 90 percent of the total), the addition of state funds for substance abuse and additional funds for operations. Expenditures for Others were approximately the same as the amount budgeted.//2012//

/2013/ Expenditures by type of individuals decreased approximately 3 percent across all categories. //2013//

/2012/ In FFY'10 DSCC spent 5.6 percent or \$1.0 million less on CSHCN services than in FFY'09. The Federal MCH Block Grant funds spent to support CSHCN decreased by \$0.1 million while the Other Federal funds increased by the same amount. The amount spent from State and Other Resources decreased by \$0.4 million and \$0.6 million respectively in FFY'10. //2012//

/2013/ In FFY'11 UIC-DSCC spent 3.9 percent or \$0.7 million less on CSHCN services than in FFY'10. The federal MCH Block Grant funds spent to support the CSHCN remained at \$6.5 million, while the amount spent from State and Other Resources was reduced by \$0.7 million from FFY'10 to FFY'11. //2013//

FORM 5: The additional expenditures for Direct Health Care services reflect the inclusion of all non-federal expenditures for the Part C Early Intervention program and the inclusion of (Family Planning) program income. The amount expended for Enabling services was below the budgeted amount due to a number of changes in the classification of expenses. Expenditures for the Department's information systems (principally Cornerstone), training and program evaluations, Healthy Child Care Illinois and Coordinated School Health were reclassified as expenditures for Infrastructure Building. The Community Youth Services program was reclassified from Enabling to Population Based. Offsetting these reductions, the full amount of Part C expenditures for the Child and Family Connections agencies were reclassified as expenditures for Enabling services. The significant increase in expenditures for Population-Based services resulted from the reclassification of expenditures for the Teen REACH program, the Comprehensive Addiction

Prevention program, Community Youth Services and Communities For Youth programs as Population-Based. Finally, the difference between the amount budgeted and expended for Infrastructure Building reflects the inclusion of expenditures for the Cornerstone management information system and Healthy Child Care Illinois, a change in the allocation of expenditures for the Part C program and the allocation of IDHS' expenditures for operation among all four types of services.

In FFY'09 DSCC spent \$6.8 million on enabling services and \$6.0 million on infrastructure building services, a decrease of \$0.6 million and \$0.8 million respectively from FFY'08. The decrease in spending was largely due to more stringent hiring practices in replacement of care coordination staff and imposed reductions in the CSHCN operational budget allocations of State and Other Resources. The amount spent on direct services was reduced from \$5.8 million in FFY'08 to \$5.1 million in FFY'09. This reduction in spending was in large part due to policy changes requiring CSHCN families with no private health insurance to apply to the State Medicaid Program to be the primary payer for health care.

/2012/ In general, Illinois expended slightly less than that budget across all types of services.
//2012//

/2013/ Illinois expended approximately 3 percent less than that budgeted across all types of services.//2013//

/2012/ In FFY'10 DSCC spent \$5.7 million on enabling services and \$5.5 million on infrastructure building services, a significant decrease of \$1.1 million and \$0.4 million respectively from FFY'09. The decrease in spending continued from FFY'09 largely due to stringent replacement hiring of care coordination staff and State imposed reductions to operational and administrative funding. The amount spent on direct services for CSHCN increased from \$5.1 million in FFY'09 to \$5.5 million in FFY'10. The increase of \$0.4 million was due in part to DSCC's effort to provide more resources to assist CSHCN in need of health care services. //2012//

/2013/ In FFY'11 UIC-DSCC spent \$5.7 million on enabling services and \$5.1 million on infrastructure building services. Enabling service expenditures remained steady from FFY'10 while infrastructure service spending decreased \$0.4 million from FFY'10. This decrease in spending was related to continued stringent hiring practices in replacement of care coordination staff and State imposed reductions in operational funding. The amount spent on direct services was reduced from \$5.5 million in FFY'10 to \$5.2 million in FFY'11. The reduction was due in part to policy changes resulting in direct services cost savings. //2013//

B. Budget

STATE BUDGET HIGHLIGHTS - The State of Illinois is facing unprecedented fiscal problems. The shortfall in state General Revenue Funds (GRF) for the current year is expected to be \$13 billion. The Comptroller already estimates that \$6 billion in SFY'11 obligations will have to be deferred until SFY'12.

The IDHS' GRF budget has been reduced by \$312.6 million, or 7.7 percent, for SFY'11, with overall operations reduced by \$49.8 million and grants reduced by \$262.8 million. The grant reductions reduce or eliminate non-Medicaid programs in mental health and developmental disabilities, extend payment cycles for developmental disability programs and limit eligibility for mental health, developmental disability and rehabilitation services. Additional GRF amounts may be placed in reserve during the course of the fiscal year.

/2012/ The IDHS GRF budget has been reduced by 5 percent for SFY'12. Illinois' Infant Mortality Reduction Initiative has been reduced by 6.9 percent or \$2,622,000.//2012//

/2013/ The IDHS GRF budget for SFY'13 is roughly the same as that reported in the previous year.//2013//

The GRF allocated to the Division of Community Health and Prevention has been reduced by \$18.1 million or 8.2 percent for SFY'11. With three exceptions, this represents a ten percent reduction in all DCHP GRF accounts. The budget for FCM was reduced by 4.5 percent in order to preserve Medicaid matching funds. The budgets for HFI and PTS were not reduced from SFY'10 levels in order to meet the Maintenance of Effort requirement for the Patient Choice and Affordable Care Act's Maternal, Infant and Early Childhood Home Visiting Program. Overall, these reductions are expected to decrease the number of persons served through MCH programs by 42,100. The largest anticipated decrease is 15,300 women, infants and young children in FCM.

The IDPH's GRF budget has been reduced by \$17 million, or 11 percent, for SFY'11. These reductions will affect Women's Health Promotion, Rural Health, Community Health Center Expansion, Medical Student Scholarship, Prostate Cancer Awareness, Family Practice Residency and Immunization Outreach grants.

The IDHFS' GRF budget has been increased by \$162 million, or two percent, for SFY'11. This is the result of a \$169.2 million increase in Medicaid appropriations in order to maintain a 30 day payment cycle and a \$7.2 million decrease in agency operations.

/2013/The unfunded budget gap for HFS Medical Assistance Programs is currently expected to be \$1.5 billion in FY12. Due to the underfunding, the Department's bill processing timeframes will expand to about 120-160 days for many providers for a good portion of the year (state cash flow challenges may delay actual payment even longer). Ending FY12 bills on hand will be approximately \$1.9 billion. This continued pattern of deferring payment of bills means that the FY13 GRF appropriation for Medicaid will need to increase by almost \$2.7 billion just to maintain the same level of unpaid bills.//2013//

In recent years DSCC has experienced a significant reduction in State, Federal and Other Resources available for CSHCN. Through effective strategies, including staff training on public and private benefit plans and expanded resources to help families understand how to effectively use their health insurance, DSCC has been able to counteract funding deficiencies. The amount of funds available to pay for direct services to children and families continues to decline. In FFY'09, DSCC spent \$5.1 million on direct services for CSHCN, \$0.7 million less than was spent in FFY'08. By implementing these new strategies, DSCC has been able to redirect funds to assist families with more enabling services such as transportation assistance, health education and family support services. DSCC has implemented an incentive program for families to maximize their health benefits by reimbursing families their co-payments and out of pocket costs on medical visits and medications. In FFY'09 DSCC spent \$6.8 million on enabling services earmarked to help families obtain and maximize health benefits and to provide care coordination services. In addition, DSCC spent \$6.0 million on infrastructure building services to continuously assess the needs of CSHCN families and find ways to improve the systems of care through program assessments, policy evaluation and quality assurance reviews.

/2012/ DSCC continues to experience reductions in State, Federal and Other fund resources available to CSHCN. Effective strategies to utilize public and private benefit plans and payers have slowed the effect of ongoing funding deficiencies. In FFY'10 DSCC spent \$17.0 million for CSHCN which was \$1.0 million less than was spent in FFY'09. DSCC spent \$5.7 million to assist families with enabling services such as transportation assistance, health education and family support services. An additional \$5.5 million was spent on infrastructure building services to assist families in understanding and maximizing health benefits, program assessment, quality assurance and improving systems of care to CSHCN. In spite of an overall reduction in resources, DSCC spent \$0.4 million more on direct services in FFY'10. This increase was largely due to DSCC's effort to maintain a commitment to the direct health services of CSHCN at a time

when other resources from public and private benefit plans were being reduced. //2012//

/2013/ UIC-DSCC has experienced prolonged reductions in State and Other Resources available for CSHCN. In FFY'11, UIC-DSCC spent \$16.3 million for CSHCN, which was \$0.7 million less than was spent in FFY'10. UIC-DSCC maintained a consistent level of spending for enabling services at \$5.7 million in FFY'11, which provided transportation assistance, care coordination and health education services for families. In FFY'11 UIC-DSCC spending for infrastructure building services decreased by \$0.4 million to a level of \$5.1 to provide needs assessment and evaluation, planning, and policy development. UIC-DSCC spending for direct services also slightly decreased by \$0.2 million in FFY'11. The decrease in CSHCN spending is due to reductions in funding, particularly at the State level. Effective strategies to maximize use of public and private benefit plans and cost refinements have helped mitigate the effects of reduced funding. //2013//

FFY'11 BUDGET: IDHS, DSCC and IDPH use state General Revenue Funds, Tobacco Settlement funds, Title IV (DCFS) funds, Title X (Family Planning) funds, Title XX (Social Services Block Grant) funds, MCH Set-aside funds, Healthy Start Initiative funds, funds from the Substance Abuse and Mental Health Services Administration, USDA funds for Special Supplemental Nutrition Program for Women, Infants and Children (WIC), U.S. Department of Education funds for Part C of the Individuals with Disabilities Education Act and Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP), U.S. Department of Justice funds for juvenile justice and domestic violence and funds from private foundations in addition to Title V Block Grant funds to achieve the objectives described in this application.

FORM 3. The State MCH Budget is anticipated to be \$727 million FFY'11. This is an increase of \$122 million from the budget presented in the FFY'10 application but is an increase of \$27.6 million from the FFY'09 expenditures included in this year's Annual Report. This increase is the result of two factors: including the entire budget for non-federal funds used in the Part C Early Intervention program and a large anticipated increase in WIC funds for food expenditures. IDHS has traditionally reported the local funds used to match Abstinence-Only Education funds granted to Illinois through Section 510 of Title V as "Local MCH Funds." As the former federal appropriation for Abstinence-Only Education funds has expired and no additional guidance regarding the new federal appropriation has been issued by MCHB at the time of this application, no "Local MCH Funds" have been included in the State MCH Budget for FFY'11. The amount of State MCH Funds (Line 3) is sufficient to meet Illinois' match and Maintenance of Effort requirements (see below). The amount of State MCH Funds and Other Funds (Line 5) budgeted for FFY'11 are lower than FFY'09 expenditures, reflecting the financial challenges facing the State of Illinois.

//2012/ The State MCH Budget is anticipated to be \$704 million in FFY'12, a decrease of \$20 million from the budget presented in the FFY'11 application.//2012//

/2013/ The State MCH Budget is projected to be practically the same as that reported in the previous application.//2013//

FORM 4. The Federal-State Block Grant Partnership for FFY'11 includes \$21.7 million in services for pregnant women, \$42.4 million in services for infants, \$198.2 million in services for children and adolescents, \$17.1 million in services for children with special health care needs and \$32 million in services for others. The amounts budgeted for pregnant women and infants are less than the amounts budgeted for FFY'10 and less than the amount expended for FFY'09. This reflects a decrease in the budget for Family Case Management and Targeted Intensive Prenatal Case Management for SFY'11. The amount for children and adolescents is greater than the amount budgeted for FFY'10 but less than the amount expended for FFY'09. The change from FFY'10 reflects the inclusion of additional DCHP funds in budget report. The change from FFY'09 reflects reductions in GRF. The budget for CSHCN is approximately \$500,000 less than FFY'10 budget and \$700,000 less than FFY'09 expenditures. The trend in resources for CSHCN was

discussed above.

FORM 5. The Federal-State Block Grant Partnership for FFY'11 includes \$121 million in Direct Health Care services, \$142 million in Enabling services, \$31.9 million in Population-Based services and \$15.2 million in Infrastructure Building. These are significant changes from the FFY'10 budget and less than, but comparable to, FFY'09 expenditures. Most of the changes reflect reclassification of program budgets among the four types of services described on Form 5 and an increase in the amount of non-federal Part C Early Intervention funds included in the budget report.

/2012/ The Federal-State Block Grant Partnership for FFY'12 includes \$113.6 million in Direct Health Care services, \$133.3 million in Enabling services, \$29.9 million in Population-Based services and \$14.2 million in Infrastructure Building.//2012//

The additional expenditures for Direct Health Care services reflect the inclusion of all non-federal expenditures for provider payments in the Part C Early Intervention program. Expenditures for DCHP's information systems (principally Cornerstone), training and program evaluations, Healthy Child Care Illinois and Coordinated School Health programs were reclassified from Enabling to Infrastructure Building. The Community Youth Services program was reclassified from Enabling to Population-Based. Offsetting these reductions, the full amount of Part C expenditures for the Child and Family Connections agencies were reclassified as expenditures for Enabling services. The significant increase in expenditures for Population-Based services resulted from the reclassification of expenditures for the Teen REACH program, the Comprehensive Addiction Prevention program, Community Youth Services and Communities For Youth programs as Population-Based.

MATCH AND MAINTENANCE OF EFFORT. The amount of state support for the MCH program was \$27,569,600 in FFY'89. The required match for FFY'11 is \$16,275,000, based on an anticipated award of \$21.7 million. The State of Illinois has exceeded these requirements by providing \$28.7 million in state funds.

/2012/ The required match for FFY'12 is \$16,275,000, based on an anticipated award of \$21.7 million. The State of Illinois has exceeded these requirements by providing \$27.2 million in state funds.//2012//

PROGRAMS OF PROJECTS - IDPH had five "programs of projects" in 1981. Maternal and Infant (M&I) and Children and Youth (C&Y) projects were consolidated with the childhood lead project at the Chicago Department of Public Health and continue as a consolidated MCH project (the "MCH Mini Block Grant"). The Winnebago Family Planning Project and the Lake County Family Planning Demonstration Project have continued through SFY'10 as part of IDHS' comprehensive Family Planning program. The Intensive Infant Care Project at St. Francis Medical Center in Peoria continues to operate as a part of the Illinois regionalized perinatal care program. The amount of funding awarded to each project is as follows: St Francis Perinatal Center, \$325,649; Chicago Department of Public Health (M&I, C&Y) \$5,017,400 and the dental projects, **/2013/\$488,000//2013//**. The Family Planning program is currently in the final stages of competitive rebidding; an announcement of SFY'11 awards is expected during the Summer of 2010.

SECTION 501 PURPOSES - Sections 501(a)(1)(A) through (D) of the Social Security Act as amended by OBRA'89 describe the basic purposes of the MCH Block Grant. Illinois plans to use MCH Block Grant funds to achieve these purposes through its system development activities, as well as by providing grants for preventive and primary care services to agencies statewide. The purposes outlined in Sections 501(a)(1)(A) and (B) are achieved by the grants IDHS awards for family case management and adolescent health promotion and the grants that IDPH awards for perinatal care. The purpose outlined in Section 501(a)(1)(C) is achieved by DSCC, in part with MCH Block Grant funds. The purpose outlined in Section 501(a)(1)(D) is the principle

responsibility of DSCC. The proportion of funds used for Sections 501(a)(1)(A) and (B) is 70 percent, and for Sections 501(a)(1)(C) and (D) is 30 percent.

ALLOCATION OF RESOURCES - IDHS receives the MCH Block Grant and administers primary care programs. IDHS transfers 30 percent of its block grant funds to DSCC for the CSHCN program. IDHS gives highest priority to those areas in Illinois that have high concentrations of low-income families (an area where 20 percent of the families, or at least 1,000 individuals, have an income at or below the federal poverty level), that are medically under-served areas, or are areas of high infant mortality and teenage pregnancy. Priority is also given to areas with high rates of poverty that have a demonstrated need for services. Program grants are awarded to local political jurisdictions or private, non-profit agencies. Applications are reviewed by a committee and recommendations for funding are made to the Secretary of the Illinois Department of Human Services. Continuation applications receive priority in order to maintain continuity of services.

SECTION 508 PURPOSES - IDHS has continued to direct funds to mandated Title V activities. Funds allocated to the State under this Title will only be used in a manner that is consistent with Section 508 to carry out the purpose of Title V or to continue activities previously conducted under the Consolidated Health Programs. IDPH continues to fund statewide projects addressing lead poisoning, and genetic diseases, while IDHS continues to fund programs related to adolescent pregnancy.

FEE SCALE - IDHS has not established a fee scale for use by its MCH program grantees and has no plans to do so. Each project funded through the MCH program may elect to charge eligible recipients for certain services provided by the project. However, a flexible sliding fee scale must be used when a project intends to charge for services and no fees are charged to low-income clients. The fee scale must be included for approval in the project application prior to any fees being charged. Further, all projects are required to have agreements with the Medicaid program for reimbursement of covered services for project patients who are Title XIX, Title XXI or All Kids recipients. Steps must also be taken to obtain reimbursement from non-profit, semi-private and private medical insurance programs when those programs cover services rendered by the projects. Finally, outpatient services must be provided at rates established by the Illinois Department of Healthcare and Family Services for the Medicaid program. These provisions are made to ensure that mothers and children from low-income families are not charged for services.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.