Maternal and Child Health Services
Title V Block Grant

State Narrative for Illinois

Application for 2015
Annual Report for 2013

Document Generation Date: Monday, June 09, 2014

Table of Contents

I. General Requirements

A. Letter of Transmittal

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

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 Public Health's (IDPH) 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 IDPH headquarters in Springfield. Copies may be obtained by writing or emailing the office:

Dr. Brenda Jones, DHSc, MSN, RN, WHNP-BC
Deputy Director, MCH Title V Director
Office of Women's Health & Family Services
Illinois Department of Public Health
122 S Michigan Ave. 7th FLoor
Chicago, IL 60603
Brenda.L.Jones@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//

/2014/The MCH Block Grant application was made available for public review and comment between the dates of June 1 and June 30, 2013. Prior to that during the first week of March, 2013, a draft was distributed to members of the following advisory committees or organizations: the Illinois Maternal and Child Health Coalition; Illinois Office for National Organization on Fetal

Alcohol Syndrome (NOFAS); Governor's Office Early Learning Council; Family Voices of Illinois; Illinois Association of Public Health Administrators (IAPHA); The Family Planning Advisory Council; The Illinois Public Health Association; Voices for Illinois Children; The Genetics Task Force of Illinois; MCH Training Program at U of I - Chicago, School of Public Health; The Genetics Task Force of Illinois; various areas of the Illinois Department of Public Health (including the Perinatal Program, Health Promotion Division and HIV and STD sections), various offices and bureaus within the Department of Human Services; 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), The Chicago Department of Public Health; and the Department of Children and Family Services. Between June 1, 2012 and June 30, 2013, it was posted on the Internet at http://www.dhs.state.il.us/page.aspx?item=66263. 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 3, 10, 17 and 26, 2013. Only two comments were received as a result of the public posting. One comment was received from the Illinois Public Health Association. The comment asked about the upcoming transfer of the Block Grant to the Department of Public Health. The other comment was received from Family Voices for Illinois. The comment asked about information for those Children with Special Health Care Needs (CSHCN) who are not being served by the DSCC, including identification, tracking and referral using the Prioritization of the Need for Services (PUNS) database.//2014//

II. Needs Assessment

In application year 2015, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

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// /2014/In 2009, the ratio of Caucasian to African American infant deaths was 1:2.6, indicating that the rate has remained steady over the last several years.//2014// 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/2014/1.6 million//2014// 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 /2014/ four //2014// 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.)

/2015/ 1.7 million children and adolescents (ages 0 through 20 years) during FFY 2013 were eligible for Medicaid (Title XIX) or the State Children's Health Insurance Program (Title XXI) (Source: CMS-416 report run for Titles XIX and XXI).

Of the children eligible for 90 continuous days or more, nearly three-fourths received at least one health service during FFY 2013.

Proportion of infants… who received at least one recommended health screening is approximately 86 percent. (FFY 2013 -- CMS -- 416 report run for Titles XIX and XXI) //2015//

Breastfeeding - The proportion of breast-fed infants in Illinois' WIC program remains above 66 percent ***/2015/ is just over 70% at 70.2% of WIC participants initiate breastfeeding. //2015//*** 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 /2014/ 70 //2014// 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 ***/2015/ still below the Healthy People 2020 breastfeeding goal of 60.6% . //2015//***(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 /2014/ 79 //2014// percent for those children /2014/ in CY 2011 //2014// 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 /2014/ 78.1 //2014// 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 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.

/2014/ Illinois Health Connect -- Illinois Health Connect (IHC) is the statewide Primary Care Case Management (PCCM) program for most persons covered by an IDHFS Medical Program. 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 1.7 million clients with a PCP in an IHC medical home. Information about the program is provided at www.illinoishealthconnect.com. //2014//

/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//

/2014/ Voluntary Managed Care (VMC) -- Three Managed Care Organizations (MCOs) currently participate in the Voluntary Managed Care program serving certain Title XIX and Title XXI participants. Family Health Network serves participants in Cook County. Harmony Health Plan serves participants in Cook, Jackson, Kane, Madison, Perry, Randolph, St. Clair, Washington and Williamson counties. Meridian Health Plan serves the counties of Adams, Brown, Cook, DeKalb, Henderson, Henry, Knox, Lee, Livingston, McHenry, McLean, Mercer, Peoria, Pike, Rock Island, Scott, Tazewell, Warren, Winnebago and Woodford. There are currently over 239,000 clients enrolled with a VMC for a medical home. Information about the voluntary managed care program can be found at http://www.hfs.illinois.gov/managedcare/managedcare.html or www.illinoisceb.com.

Integrated Care Program -- In 2011, HFS implemented the Integrated Care Program (ICP) in six Illinois counties. The program provides health care coverage to approximately 40,000 seniors and persons with disabilities s 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 Better Health and Centene-IlliniCare. Members received standard Medicaid services (known as Service Package I) in the first year of the program and began receiving long-term care services (known as Service Package II) effective February 2013.

The Integrated Care Program brings 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. //2014//

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. ***/2015/ The primary responsibility for Illinois' Title V program is that of the Illinois Department of Public Health Office of Women's Health & Family Services. //2015//*** 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 childrren, 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.

/2015/ Preconception- The IDHS Family Planning and tIDHFS Meidcal Programs address preconception care through family planning services. IDHFS' covered benefits include the reimbursement for the preconception care risk assessment. //2015//

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.
/2015/ A new case management program that targets only the highest risk pregnant women was launched in January 2013. Funding is only available for those communities that have the highest rates of prematurity and the greatest Medicaid costs associated with same. Thus far, 22 providers have been awarded funds and there are approximately 2000 women enrolled statewide. The model of care is an adaptation of the Michigan model, with limited assigned caseloads, expectations of contact at least twice monthly, use of a standardized prenatal curriculum, coordination of care with other providers, outreach and community collaboration. The program is a cooperative effort between IDHS and IDHFS, and replaces the former TIPCM program. //2015//

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 ***/2015/ and other inherited //2015//***diseases and
congenital hearing loss. The state has supported a metabolic screening program for more than 45 years and now
screens for 36 ***/2015/ 40 //2015//*** disorders ***/2015/ including critical congenital heart disease (CCHD), which was added to the screening panel in 2013. Testing for six lysosomal storage disorders and severe combined immune deficiency (SCID) will be added in July 2014. //2015//*** 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. ***/2015/ The Better Birth Outcomes program provides case management services to high-risk pregnant women up through 6 weeks post-partum, with the goal of linking these women to specialty care, reducing poor birth outcomes, and improving overall health status.***

*//**2015**//* 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 ***/2015/ and high //2015//*** 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 ***/2015/ through risk assessments and indicated //2015//*** 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//.
/2015/ The program is available in two DHS staffed offices in Chicago to pregnant and parenting teens in Chicago and the surrounding suburbs. //2015// 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. ***/2015/ A web-based care coordination information system has been implemented to improve efficiency and effectiveness of care coordinators in the regional offices. The ISP has been transformed to be more reflective of the care coordination activities that address the child's and family's needs. //2015//***

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. ***/2015/Care coordination staff is now also referring families and youth to "Get Covered Illinois" for insurance and the online Medicaid application, especially those over 19 years of age, for expanded Medicaid.//2015//***

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. ***/2015/UIC-DSCC in conjunction with the Department of Healthcare and Family Services (HFS) operates the Home Care Program for technology dependent, medically fragile children of families who desire assistance to care for their child in their home. The Home Care Program is based on a physician-prescribed, HFS-approved plan for care of the child in the family's home that is implemented in cooperation with the child, family, private health insurers and community resources. UIC-DSCC provides care coordination for children that meet established***

medical criteria for inclusion in
the Home Care Program.//2015//

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. /2014/Efforts to contact families have been expanded to include SSI-eligible children ages birth to 5
years and 14 to 16 years of age.//2014//

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./***2015/The CHC concluded operations on August 30, 2013.//2015//***

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. ***/2015/UIC-DSCC collaborates with the Illinois Chapter of the American Academy of Pediatrics to***
promote expansion of medical homes throughout the state.//2015//

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. /2014/DSCC no longer publishes this newsletter.//2014//
***/2015/UIC-DSCC has redesigned its website (http://dscc.uic.edu/) and begun to use social media to connect with
families having children with special health care needs and provide helpful information on events and resources.
Visitors to the website are given the opportunity to sign up for the electronic newsletter.//2015//***

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. ***/2015/ The Home Visiting Task Force, a standing committee of the Early Learning Council, serves as the strategic advisory body for the statewide system of home***

visiting programs, including the State's federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) grant. //2015//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 was 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.

/2015/ The Affordable Care Act and Illinois blueprint to reduce Medicaid expenditures will bring about many changes and challenges in the coming years in the delivery of maternal and child health services. Benefits will be greater access to primary and specialty care for most, while potential loss of sustaining support funds in the public health sector may erode overall health of communities. Additionally, rural areas will remain at risk for limited access to care associated with limited numbers of providers, lack of specialty care, and transportation issues. //2015//

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.

/2014/ In fiscal year 2014, the Illinois Department of Public Health (IDPH) will be responsible for the administration
of funds available to the state under Title V of the Social Security Act. Consistent with state statutes, the program
for Children with Special Health Care Needs will continue to be administered by the Division of Specialized Health
Care Needs, University of Illinois Chicago. Administrative oversight for the Title V mini-MCH Block Grant awarded to
Chicago Department of Public Health and the funds awarded to DSCC will become the responsibility of Illinois
Department of Public Health.//2014//

/2015/ The Illnois Department of Public Health (IDPH) Office of Women's Health& Family Services (OWHFS) assumed administrative responsibility for the Maternal and Child Health Services grant in July 2013.
The mission of IDPH is to promote the health of the people of Illinois through the prevention and control of disease and injury. The Department, in partnership with local health departments and other agencies, employs population-based approaches in its prevention programs.
The Department is responsible for protecting the State's residents, as well as countless visitors, through the prevention and control of disease and injury. With more than 200 program components organized in its offices, the Department provides and supports a broad range of services, including inspecting restaurants; vaccinating children to protect them against disease; testing to assure the safety of food, water, and drugs; licensing to ensure quality health care in hospitals and nursing homes; conducting investigations to control the outbreak of infectious diseases; collecting and evaluating health statistics to support prevention and regulatory programs; analyzing and shaping public policy; screening newborns for genetic diseases; and supporting local efforts to identify breast and cervical cancers in their early, more treatable stages. These programs touch virtually every age, aspect, and cycle of life.
The OWHFS works to eliminate health disparities for the women and children of Illinois by promoting a coordinated, comprehensive and prevention focused approach to women's and children's healthcare across the lifespan. The OWHFS helps to coordinate internal and external efforts to use policy change to improve the health of women, increase public awareness of issues impacting the health of women and children, and to promote healthy behaviors and environments in community partnership with other programs and organizations. //2015//

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.

/2015/ The IDHS Bureau of Community Health Nursing merged with the Bureau of Maternal and Infant Health (BMIH) in 2011. There are currently 8 FTE Master's prepared RN's who work with the MCH programs in BMIH. //2015//

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. /2014/The DSCC Director reports to the Chief
Executive Director of Medicaid Support Services, Office of the Provost, University of Illinois at Chicago.//2014// 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.

//2014//. To better align its internal operations and be prepared to meet the challenges and opportunities of the
Patient Protection and Affordable Care Act (ACA), The Illinois Department of Healthcare and Family Services, and

specifically its Division of Medical Programs, is in the process of reorganization. An important element of that reorg is
the establishment a new Bureau of Quality Management (BQM), to consolidate and expand the quality monitoring,
improvement and assurance activities of a number of bureaus, including the former Bureaus of Maternal & Child
Health Promotion and Interagency Coordination.
//2014//

For additional information on Illinois' Maternal and Child Health Program, please visit the DCHP web site
(www.dhs.state.il.us/p

D. Other MCH Capacity

/2015/ Dr. Brenda Jones is the Deputy and Title V Director for the Illinois Department of Public Health, Office of Women's Health & Family Services(OWHFS) in Illinois. Dr. Jones administers the Title V Maternal & Child Health Block Grant, Title X Family Planning, Illinois Breast & Cervical Screening Program (IBCCP), and the Illinois WISEWOMAN Program (IWP). Dr.Jones is a registered professional nurse who has focused 25 years of her health care career in the areas of women and children's health. Beginning her career as a labor and delivery nurse in 1991, she went on to become a women's health nurse practitioner in 1999 and obtained her doctorate in health science from Nova Southeastern University in 2008, focusing her research on quality maternal child safety. She also has worked within the Department of Defense as a nurse consultant for Army Child, Youth and Family Services where she worked with children with special needs. Dr. Jones has held positions as director of women's health care and consultant at health care facilities across the country.
In 2012, Dr. Jones received the March of Dimes Nursing Excellence Award. This distinguished award recognized Jones's professional accomplishments, personal commitment to the care of mothers and babies, and her "can do" spirit to go the extra mile. In addition, she was the recipient of the National Healthy Teen Network "Outstanding Prevention Award" for starting an innovative pregnancy teen clinic in the Chicago Roseland area.
In 2010, she was selected as a Women's Health care provider and educational consultant for the Navy/Project Hope "Continuing Promise" Mission in South America's George Town, Guyana and Paramaribo Surinam. She was selected again in 2011 to provide services to women and education to providers in Costa Rica and El Salvador. //2015//
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. ***/2015/ The MCH Nurse Consultants are assigned to work with FCM, Healthy Start, Better Birth Outcomes, Title X Family Planning, School Health, High-risk Infant Follow-up, Healthworks case management for DCFS wards, and provide consultation, education and technical assistance to other MCH programs such as Home Visiting on an as needed basis. //2015//***

/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. /2014/The hiring freeze has been lifted. All positions are scruntinized to assure necessary infrastructure to continue to serve families.//2014//

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.

/2015/ Inter-Governmental Agreements among IDHS, IDHFS, IDPH and DSCC are on file at the IDPH headquarters in Springfield.

The OWHFS works collaboratively with the following Offices within IDPH to facilitate the synergistic provision of services and supports to Illinois' MCH population. The Office of Health Promotion provides preventive health services with respect to chronic diseases, as well as to metabolic and genetic disorders in newborns, vision and hearing disorders in children, oral health, and unintentional injuries and violence. Preventive health services include health education, screening, counseling, and follow-up. The Office of Health Protection engages in the prevention and control of infectious diseases, including vaccine preventable diseases and AIDS; and in protection from environmental health hazards and dangers related to contaminated food, drugs and dairy products. Program activities include childhood immunizations, AIDS prevention and drug treatment, childhood lead poisoning prevention, regulation of private water supplies, and laboratory testing. //2015//

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. ***/2015/ At the end of CY 2013, two of these partnships concluded their activities. The efforts of one project will be sustained through efforts of the Illinois Chapter, American Academy of Pediatrics (ICAAP) and Advocate Charitable Foundation. These efforts are also maintained through updates to the HFS Handbook for Providers of Healthy Kids Services. These efforts are to inform providers about best practices related to objective developmental screening and referral. The second grant related to promoting best practice continue through updates to the Handbook and through ICAAP. Grant funding opportunities may be pursued as funding becomes available that this consistent with HFS efforts to improve prevention and treatment services delivered to children and adolescents. //2015//***

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//

//2014// The 2012 report describes the steps HFS has taken with its partners (other State agencies, advocacy
groups, maternal and child health experts, local funding resources and others) to address the perinatal health care
needs and racial health disparities in Illinois; detail the progress made in addressing the priority recommendations
as outlined in the 2004 Report to the General Assembly as a result of Public Act 93-0536; review the available trend
data on infant mortality, low birth weight and very low birth weight outcomes; identify the progress made to
address poor birth outcomes through analysis of trend data; and identify next steps in improving birth
outcomes.//2014//

/2015/ The most recent report, published January 1,2014, reviews the current status of IDHFS and sister state agencies' initiatives promoting Perinatal health, including planned pregnancies, mental heatlh during prenatal period, oral health, smoking cessation, case management and home visiting, Perinatal addiction, Perinatal HIV counseling, nurse midwifery, lactation counseling, labor support during the prenatal period, case management and home visiting, SMART Act Initiatives and other related initiatives. The 2014 report also includes plans for implementing a statewide multi-agency initiative to improve birth outcomes and reduce costs associated with babies born with low birth weight and very low birth weight or fetal deaths, as well as, developing two processes to enhance care coordination between IDHFS and IDHS for women identifieid with the

potential for a high --risk birth outcome. First, using claims data, when a woman with a previous high-cost birth is identified, information will be shared with IDHS' Family Case Management (FCM) and Intensive Prenatal Case Management (IPCM) program. Second, a system is being developed whereby IDHFS enrolled providers can log into a secure web-based IDHS Cornerstone application to send an electronic referral to the FCM/IPCM program for women who are pregnant and at risk for a poor birth outcvome. This web-based system will include a feedback loop to inform the referring provider about the outcome of the referral. These two systems assure that women at risk for a poor birth outcome are identified and provided access to FCM/IPCM programs early in the prenatal period in order to improve the birth outcome. //2015//

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.

/2015/ IDHS provides funding to NorthShore Health Systems to support the operation of a 24 hour Crisis Hotline for persons experiencing or living with symptoms of perinatal mood disorder. Professional staff are available to answer calls from clients, family members, or providers and to provide information regarding services available within the persons community. Funding is also provided to Healthcare Alternative Systems in Chicago, for assessment and treatment of women identified at risk for perinatal mood disorder in any of the BMIH case management programs. //2015//

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 ***/2015/ on-line //2015//***trainings. During calendar year 2009, approximately 4,000 ***/2015/ over 35,000 //2015//*** unduplicated
children under age three received a fluoride varnish application in a pediatric practice./2012/ The goal is to improve
oral health, ***/2015/ prevent early childhood cavities //2015//*** 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//

/2014/ The ABCD III grant funding ended in October 2012. However, cross-agency collaboration continues with
IDHS to continue improving the referral and feedback communication loop between primary care providers and Early
Intervention.//2014//

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.
/2014/ The EDOPC project received an additional year of funding for CY2013 to continue on-going activities.//2014//
/2015/ The EDOPC project concluded at the end of CY 2013. Activities initiated will be maintained through the efforts of the Illinois Chapter of the American Academy of Pediatrics and Advocate Charitable Foundation. These efforts are also maintained through updates to the HFS Handbook for Providers of Healthy Kids Services. //2015//

/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//

/2015/ In December 2013, HFS reported to CMS on 25 of 26 CHIPRA core measures. The CHIPRA project continued to collaborate with the Agency for Healthcare Research and Quality and the Centers of Excellence on new measure development. //2015//

/2015/ CHIPRA provided to funding to the Illinois Perinatal Quality Collaborative (ILPQC) in November 2013, to start the neonatal quality improvement initiative on infant nutrition. //2015//
/2014/The number of measures in the core measure set reported to CMS increased from 17 (in grant year 2) to 20 (
in grant year 3). The CHIPRA project convened an expert panel to provide input on development of new measures,
and based on that panel's recommendations, the CHIPRA project has decided to focus new measure development
efforts on collaboration with the Agency for Healthcare Research and Quality's Centers of Excellence rather than
independently developing new measures. Illinois completed it's first annual data audit by its External Quality
Review Organization to validate the integrity of the data used for performance measurement. A Qualify of Care
Measures Committee was created and meets regularly to address issues related to the initial programming and
ongoing maintenance of quality measures. //2014//

/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. ***/2015/ A new interagency agreement***
between HFS and UIC-DSCC expands the population to include other children that require in-home services to receive UIC-DSCC care coordination. Care coordination staff also assists families to apply for All Kids or Medicaid using the online application. //2015//

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. ***/2015/ Administrative oversight of the Asthma Initiative moved to IDPH in 2013. //2015//*** 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

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.*

Health Systems Capacity Indicators Forms for HSCI 01 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	61.6	60.2	57.7	54.5	51.5
Numerator	5505	5027	4821	4554	4303
Denominator	893952	835577	835577	835577	835577
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

Notes - 2013
Numerator: Illinois hospital discharge data for Q1-Q4 CY2013-- inpatient data only, includes fatal cases; ICD 9 codes 493.0-493.9 in any diagnosis code field
Denominator: 2010 Census population estimates for children <5 yrs

Notes - 2012
Sources: IDPH Division of Health Policy, Facility Discharge Data. 2010 US Census, Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data

Notes - 2011
Hospital discharge data that were made final and available in May 2011. The addition of additional diagnoses codes starting in 2008 only added a small percentage more than using the previous method of reporting.

Sources: IDPH Division of Health Policy, Facility Discharge Data. 2010 US Census, Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data

Narrative:
In 2013, the rate of asthma hospitalization among children under five years of age was 51.5 per 10,000 residents. Both the rate and the absolute count of cases are the lowest since 2008. 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.

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.*

Health Systems Capacity Indicators Forms for HSCI 02 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	86.3	91.5	90.4	88.0	85.7
Numerator	71236	59530	53016	49991	47967
Denominator	82577	65042	58621	56818	55950
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

Notes - 2013
Source: CMS-416 report (CMS-416_HCFA_Format), HFS Continuously Enrolled Recipients. The CMS-416 report is used for this measure since it is reported to Federal CMS for Title XIX. Rounding may be off due to pre-set functions in Federal CMS report. Report ran: 3/10/2014
2013 data is not yet final. Providers have up to 18 months after the end of a year to submit claims.

Notes - 2012
Source: CMS-416 report (CMS-416_HCFA_Format), HFS Continuously Enrolled Recipients. The CMS-416 report is used for this measure since it is reported to Federal CMS for Title XIX. Rounding may be off due to pre-set functions in Federal CMS report. Report ran: 3/11/2013

Notes - 2011
Source: CMS-416 report (CMS-416_HCFA_Format), HFS Continuously Enrolled Recipients. The CMS-416 report is used for this measure since it is reported to Federal CMS for Title XIX. Rounding may be off due to pre-set functions in Federal CMS report. Report ran: 4/27/2012

Narrative:
While the proportion of Medicaid-eligible infants who received at least one periodic screening in 2013 (85.7%) is lower than seen in previous years, the 2013 data is not yet finalized as providers have up to 18 months to file claims. It is likely that this percentage will rise once the data are finalized.

The proportion of continuously-enrolled HFS children (Title XIX, Title XXI, and state-funded only) who received at least one well-child care visit was 97.4% in CY2011 and 97.1% in CY2012. 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.

2015 - The proportion of Medicaid-eligible infants who received at least one well-child care visit in CY 2012 is 97.1% of HFS continuously enrolled children (Title XIX, Title XXI) through 15 months.

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.*

Health Systems Capacity Indicators Forms for HSCI 03 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	96.0	93.7	98.1	78.5	76.3
Numerator	1857	1715	5810	8365	8024
Denominator	1935	1830	5923	10659	10517
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

Notes - 2013
Source: Illinois Department of Healthcare and Family Services. Report - IHFS IDPAEIS100 - Well Child Visits in the First 15 Months of Life (W15) -
HFS Continuously Enrolled Recipients. This HEDIS measure is used since it is reported to Federal CMS for Title XXI. 2013 data are provisional. Report run on 4/17/2014.

Notes - 2012
Source: Illinois Department of Healthcare and Family Services. Report - IHFS IDPAEIS100 - Well Child Visits in the First 15 Months of Life (W15) -
HFS Continuously Enrolled Recipients. This HEDIS measure is used since it is reported to Federal CMS for Title XXI. Report run: 4/17/2014

Notes - 2011
Source: Illinois Department of Healthcare and Family Services. Report - IHFS IDPAEIS100 - Well Child Visits in the First 15 Months of Life (W15) -
HFS Continuously Enrolled Recipients. This HEDIS measure is used since it is reported to Federal CMS for Title XXI. Report run: 4/20/2013

Narrative:

Until 2004, fewer than 300 infants a year were eligible for SCHIP for at least 30 days. Enrollment in SCHIP in 2011 among recipients < 1 year of age was 5,923, but nearly doubled in 2012 and 2013 to over 10,000 children. Of these children continuously eligible for 90 days or more, 78.5% of children in 2012 and 76.3% of children in 2013 received at least one well-child visit. The 2013 rate is likely to increase when the data are finalized since providers have up to 18 months to file claims.

2015- CY 2013 data show that 97.9 % of SCHIP eligible infants through 15 months of age and continuously enrolled for 90 days or more, received at least one well-child healthcare visit.

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.*

Health Systems Capacity Indicators Forms for HSCI 04 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	80.3	78.3	77.9	78.3	78.0
Numerator	125605	115688	117301	114869	109255
Denominator	156490	147795	150587	146763	140073
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

Notes - 2013
Data Source: 2013 provisional birth data

13,264 births were missing information on the Kotelchuck Adequacy of Prenatal Care Index due to missing information on # of prenatal care visits, timing of prenatal care entry, or invalid estimates for gestational age, birthweight, etc.

Notes - 2012
Source: provisional birth data from DHFS-EDW

Notes - 2011
Source: provisional birth data from DHFS-EDW.

Narrative:
In 2013, 78.0% of women received at least adequate care. The percent of women with at least adequate prenatal care according to the Kotelchuck index has remained around 78% over the last four years.

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

Health Systems Capacity Indicators Forms for HSCI 07A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	77.9	78.2	80.1	82.1	79.1
Numerator	962105	1032569	1052722	1047498	975771
Denominator	1235568	1321027	1313481	1276075	1233052
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

Notes - 2013
Source: IHFS IDPAEIS110 - Child Access to Primary Care, HFS Continuously Enrolled Recipients. CAP is a HEDIS quality measure of MCO programs that is also applied to the PCCM. The CAP measure is provided for #07A beginning in 2009 for trend period 2007-2009. The data include Title XIX only.
2013 data are provisional. Report run: 4/17/2014

Notes - 2012
Source: IHFS IDPAEIS110 - Child Access to Primary Care, HFS Continuously Enrolled Recipients. CAP is a HEDIS quality measure of MCO programs that is also applied to the PCCM. The CAP measure is provided for #07A beginning in 2009 for trend period 2007-2009. The data include Title XIX only.
Data finalized for 2012: 4/17/2014

Notes - 2011
Source: IHFS IDPAEIS110 - Child Access to Primary Care, HFS Continuously Enrolled Recipients. CAP is a HEDIS quality measure of MCO programs that is also applied to the PCCM. The CAP measure is provided for #07A beginning in 2009 for trend period 2007-2009. The data include Title XIX only. 2011 data is final. Report ran: 4/9/2013

Narrative:
Based on the EPSDT participation report (Title XIX, Form CMS-416, Line 10), between FFY2012 and FFY2013, there was a small percent change decrease in the number of children from < 1 through 20 years of age receiving at least one screening.

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 based on IDHFS claims data. In addition, IHC PCPs have the opportunity to 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 and will assist clients in scheduling an appointment with the child's PCP. If IHC assists a client to secure an appointment with their PCP, IHC will mail the client a reminder notice 7 days prior to the appointment.

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.*

Health Systems Capacity Indicators Forms for HSCI 07B - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	61.3	67.5	68.3	68.5	69.4
Numerator	197599	225008	238064	249402	256074
Denominator	322568	333230	348319	363838	368856
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

Notes - 2013
Source: IHFS MERA report "CMS416_HCFA_Format" for EPSDT participation. Annual Indicator from calculated participation ratio
Numerator from age-specific Line 12a
Denominator from age-specific Line 1b, representing children enrolled for at least 90 continuous days
2013 data is provisional on CMS guidance. CMS-416 FFY2013 report ran: 3/10/2014

Notes - 2012
Source: IHFS MERA report "CMS416_HCFA_Format" for EPSDT participation. Annual Indicator from calculated participation ratio
Numerator from age-specific Line 12a
Denominator from age-specific Line 1b, representing children enrolled for at least 90 continuous days
CMS-416 FFY2012 report ran: 3/11/2013

Notes - 2011
Source: IHFS MERA report "CMS416_HCFA_Format" for EPSDT participation. Annual Indicator from calculated participation ratio
Numerator from age-specific Line 12a
Denominator from age-specific Line 1b, representing children enrolled for at least 90 continuous days
CMS-416 FFY2011 report ran: 4/27/2012.

Narrative:
The proportion of Medicaid-eligible children between 6 and 9 years of age who received any dental services reached 69.4% in 2013, the highest percentage ever seen. Since 2009, this rate has gone up 8 percentage points (or a 13% improvement). It is likely that the 2013 rate may be even higher than reported here because the data are not yet finalized, as providers have up to 18 months to file claims.

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

INDICATOR #05 *Comparison of health system capacity*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

indicators for Medicaid, non-Medicaid, and all MCH populations in the State					
Percent of low birth weight (< 2,500 grams)	2013	payment source from birth certificate	9.2	6.9	8

Notes - 2015
Data Source: provisional 2013 birth data obtained from IDHFS Electronic Data Warehouse (EDW).

185 births were missing payment source on birth certificate.

Narrative:
The 2013 provisional birth certificate data reveal low birth weight rates that vary by Medicaid status. Deliveries paid for by Medicaid had higher rates of low birth weight than deliveries paid for by other sources: 9.2% vs. 6.9%. Medicaid deliveries represent higher risk populations as they include low income families and immigrants (as Illinois' SCHIP program covers the deliveries of pregnant undocumented immigrants). The overall percent of low birth weight deliveries in Illinois was 8.0% for 2013.

These differences by Medicaid status are similar to what has been seen in previous years. In 2009, the most recent available FINAL birth certificate data, the percent of low birth weight births was 9.5% among Medicaid births and 6.8% among non-Medicaid births. The LBW rates for Medicaid births were 9.8% in 2008 and 9.1% in 2007. For non-Medicaid births, the LBW rates were 6.9% in 2008 and 7.5% in 2007.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2009	matching data files	8.1	4.9	7.2

Notes - 2015
Illinois has not generated a matched birth-infant death file since 2008 deaths for infants born in 2007-2008 births. Because of this, payer-specific infant mortality rates are not available for more recent years.

Narrative:
The data reported here are from 2008 deaths to infants born in 2007-2008, the last matched birth-death certificate data available in Illinois. The ability to calculate infant mortality by payer status requires the matching of infant birth and death certificates. Due to updates to the vital records system in Illinois and the resources invested in upgrading the system, IDPH has not performed the birth-death match since 2008 and there are not immediate plans to do so in the future.

In 2008, Medicaid births had a higher rate of infant mortality (8.1 per 1,000 births) than non-Medicaid births (4.9 per 1,000 births). The overall state infant mortality rate in 2008 was 7.2 per 1,000 births. Medicaid deliveries represent higher risk populations as they include low income

families and immigrants (as Illinois' SCHIP program covers the deliveries of pregnant undocumented immigrants).

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2013	payment source from birth certificate	74.9	90	82.9

Notes - 2015
Data Source: provisional 2013 birth data obtained from IDHFS Electronic Data Warehouse (EDW).

14,058 births were missing valid dates for entry of prenatal care to calculate trimester of entry. Using clinical estimate gestational age to back-calculate estimated start of pregnancy, any births with prenatal care dates starting before the pregnancy start date were set to missing values.

Narrative:
The 2013 provisional birth certificate data reveal that entry into prenatal care varies by Medicaid status. Deliveries paid for by Medicaid had lower rates of first-trimester entry into prenatal care than deliveries paid for by other sources: 74.9% vs. 90.0%. Medicaid deliveries represent higher risk populations as they include low income families and immigrants (as Illinois' SCHIP program covers the deliveries of pregnant undocumented immigrants). The overall percent of births where the woman entered prenatal care in the first trimester was 82.9%

PRAMS data from 2009 indicate that 78.7% of Medicaid women and 90.7% of non-Medicaid women got prenatal care as early as they wanted it. Among women who did not get prenatal care as early as they wanted, the top reasons for the delay varied by payer status. For Medicaid women, the top 3 reasons were: 36.2% didn't have Medicaid card yet, 35.9% couldn't get an appointment, and 33.2% didn't have enough money or insurance for visit. For non-Medicaid women, the top 3 reasons were: 50.3% couldn't get an appointment, 32.9% had a doctor or health plan that would not start care as early as desired, and 15.6% had too many other things going on.

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])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

MCH populations in the State					
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2013	payment source from birth certificate	70.7	84.5	78

Notes - 2015
Data Source: provisional 2013 birth data obtained from IDHFS Electronic Data Warehouse (EDW).

13,264 births were missing Kotelchuck index -- most due to invalid dates for timing of entry into prenatal care

Narrative:
The 2013 provisional birth certificate data reveal that adequacy of prenatal care (measured by the Kotelchuck index) varies by Medicaid status. Deliveries paid for by Medicaid had lower rates of adequate prenatal care than deliveries paid for by other sources: 70.7% vs. 84.5%. Medicaid deliveries represent higher risk populations as they include low income families and immigrants (as Illinois' SCHIP program covers the deliveries of pregnant undocumented immigrants). The overall percent of births where the woman entered prenatal care in the first trimester was 78.0%

Both timing of entry to prenatal care and number of prenatal care visits go into the calculation of the Kotelchuck adequacy of prenatal care utilization index. PRAMS data from 2009 indicate that 78.7% of Medicaid women and 90.7% of non-Medicaid women got prenatal care as early as they wanted it. Among women who did not get prenatal care as early as they wanted, the top reasons for the delay varied by payer status. For Medicaid women, the top 3 reasons were: 36.2% didn't have Medicaid card yet, 35.9% couldn't get an appointment, and 33.2% didn't have enough money or insurance for visit. For non-Medicaid women, the top 3 reasons were: 50.3% couldn't get an appointment, 32.9% had a doctor or health plan that would not start care as early as desired, and 15.6% had too many other things going on. Information about the specific reasons why women may not have received as many prenatal care visits as desired is not available.

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2013	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2013	200

Narrative:
Infants from families with incomes at or below 200 percent of the federal poverty standard are eligible for Medicaid. 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.

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2013	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2013	200

Narrative:
Children from families with incomes at or below 133 percent of the federal poverty standard are eligible for Medicaid. 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.

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2013	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2015
Illinois not cover pregnant women under CHIP. We cover the unborn children of pregnant women who are not Medicaid eligible (due to immigration or
institutional status) up to 200% in CHIP, but they would be included as infants.

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.

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

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for**	**Does your MCH program have Direct access to the**

	program planning or policy purposes in a timely manner? (Select 1 - 3)	electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	1	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	3	No
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	Yes

Notes - 2015

Narrative:
In October 2013, the IDPH Office of Women's Health and Family Services (OWHFS) and the University of Illinois at Chicago School of Public Health (UIC-SPH) signed an Inter-Governmental Agency (IGA) Agreement that makes much progress in the data capacity of the Title V program. Deborah Rosenberg, Ph.D., Research Associate Professor, Division of Epidemiology and Biostatistics is the principle investigator and reports to the Deputy Director for Women's Health and Family Services, Dr. Brenda Jones. Under this IGA, UIC-SPH is able to obtain access to individual-level data from IDPH to analyze for the purposes of program development, needs assessment, and surveillance. Access to the state electronic data warehouse was granted in April 2014 and includes access to birth, death, and fetal death files at the individual level.

Enhanced data integration is underway in Illinois as evidenced by the development of an electronic data warehouse housed at the Illinois Department of Healthcare and Family Services. Illinois is poised to conduct analysis and research using an immense data warehouse. Prior to that end, Illinois must develop capacity to "mine" the warehouse for pertinent data and approach the data from an epidemiological perspective. Files that are currently contained in the EDW include: vital records (birth, death, and fetal death files), Department of Human Services MCH service files from Cornerstone, Medicaid claims data. DHS has implemented a matching algorithm of the Cornerstone and Medicaid data, but OWHFS staff do not yet have individual-level access to such files. The capacity to match vital records data to Medicaid claims data is also there, but OWHFS staff do not have access to Medicaid claims files to perform a match.

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

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Illinois Youth Tobacco Survey	3	No
Illinois Youth Survey	3	No

Notes - 2015

Narrative:
There are several data sources from which the MCH program accesses statistics regarding adolescent health and risk behaviors. The Youth Tobacco Survey, administered and managed by IDPH, provides data on the prevalence of tobacco use - smoking and otherwise. The Illinois Youth Survey, managed by IDHS, provides data on ATOD use as well as risk factors associated with drug use. Finally, the YRBS, managed by the Illinois State Board of Education and Chicago Public Schools, provides information regarding adolescent health and behavior, including topics beyond ATOD use like physical activity, depression, bullying and more.

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.
/2014/Illinois' Family Case Management (FCM) program was begun in 1990 and continues to be the state's signature intervention to promote healthy pregnancies. FCM provides individual case management and wrap-around services to 300,000 women, infants and children annually. By design, FCM is coupled with WIC as each program offers unique services to the MCH clientele. Of the births occurring in 2009 (the latest vital statistics available), 45 percent (75,236) received FCM and/or WIC services.

In a recent analysis of low and high cost births, the Departments of Human Services and

Healthcare and Family Services found that the largest number of low cost births was enrolled in FCM/WIC while the largest number of high cost births was not. The implication being that FCM/WIC is serving low risk births while not serving those at greater need for the services. A logical explanation for the finding is self-selection. Expectant women seeking WIC and by program design enrolled in FCM may possess different characteristics than those who do not seek WIC. It is reasonable to assume that women who seek services are attuned to the needs of their pregnancy and by that factor alone are at less risk of an adverse birth than those women who do not seek services. In any event, the data suggest that a number of high cost births are not involved in DHS' maternal health intervention.
In January 2013, DHS initiated a prototype program -- Better Birth Outcomes -- to address high risk/high cost births. Twenty-one agencies across the state were selected to conduct BBO. The prototype shifts the programming focus to pregnant women and uses a standardized evidence-informed prenatal care education curricula (Becoming a Mom -- March of Dimes). The prototype also incorporates the Life-Course perspective into care coordination, utilizing a reproductive life plan to increase women's inter-conception periods. Results of the BBO prototype will be observed and evaluated over the course of SFY2014. It is anticipated that the program will result in fewer high risk/high cost births.
Program redesign is taking place in a determinative manner for the remaining Family Case Management providers. Like Better Birth Outcomes, the programming focus will shift from infants and children (which at present constitute 60 percent of the FCM caseload) to pregnant women. During SFY2014, FCM providers are required to increase by 10 percentage points the number of pregnant women enrolled at their agency from that reported at the close of SFY2013. FCM providers also will deliver an abbreviated version of the standardized prenatal care education curricula used by Better Birth Outcomes. //2014//

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99.9	99	99	99	99
Annual Indicator	98.6	98.5	98.6	98.7	98.8
Numerator	1634	1499	1766	1604	2071
Denominator	1657	1522	1791	1625	2096
Data Source	IDPH, Genetics	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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	99	99	99	99	99

Notes - 2013
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 - 2012
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
Illinois continues to provide timely follow-up and clinical management to nearly 99% of infants who screen positive for any of the genetic and metabolic conditions covered by the state screening program. 2,096 infants screened positive for any condition in 2013 and 2,071 received timely follow-up services.

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, sicle 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.				
2.				
3.				
4.				
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 web-based Newborn Metabolic Screening Data System 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 2012, approximately 4,000 clients were screened for genetic disorders; 300 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 by 2014, with full-scale statewide testing in place by July 2014. Testing for severe combined immunodeficiency (SCID) has been mandated and will also likely be implemented in the same time frame as LSD testing.

Chicago. 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:	**156000**			
Reporting Year:	**2013**			
Type of Screening Tests:	**(A) Receiving at**	**(B) No. of**	**(C) No. Confirmed**	**(D) Needing**

	least one Screen (1)		Presumptive Positive Screens	Cases (2)	Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	155687	99.8	30	13	13	100.0
Congenital Hypothyroidism (Classical)	155687	99.8	182	98	98	100.0
Galactosemia (Classical)	155687	99.8	18	1	1	100.0
Sickle Cell Disease	155687	99.8	100	79	79	100.0
Biotinidase Deficiency	155687	99.8	1	0	0	
Cystic Fibrosis	155687	99.8	724	40	40	100.0
Fatty/organic Acid Disorders	155687	99.8	434	31	31	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	155687	99.8	442	6	6	100.0
Other Amino Acid Disorders (not including PKU)	155687	99.8	164	9	9	100.0
Phenylketonuria treatment provided	383		383	383	383	100.0
Other/Fatty/Organic/Amino Acid Disorders - treatment provided	221		221	221	221	100.0
All Conditions Diagnosed - annual monitoring	4482		4482	4482	4482	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	2009	2010	2011	2012	2013
Annual Performance Objective	60.3	60.5	60.5	71.1	71.1
Annual Indicator	60.3	60.3	71.1	71.1	71.1
Numerator					
Denominator					
Data Source	CSHCN SLAITS Survey	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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	71.1	72	72	72	72

Notes - 2013
For 2011-2015, 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 - 2012
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 - 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.

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 and 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 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 coordination staff.
All children found medically eligible for UIC-DSCC programs are assigned a care coordination team that assists
families in identifying informational and service needs and developing a plan to meet those needs. Care
coordinators encourage families to partner with their child's various service providers to achieve their child's
goals. When appropriate, care coordinators also support families in advocating for their child's needs to be met.
Bilingual staff and other interpreter services are utilized as needed for families that are not comfortable
communicating in English.

Care coordination staff continued to help families obtain information about their child's medical condition,
coordinate access to specialty care and develop questions to clarify treatment plans. Staff assisted families to
develop a partnership with a medical home provider. Family partnerships are also promoted through Medical
Home Quality Improvement Team (QIT) participation. QIT facilitators encourage family members to participate
equally with practice staff.

Although the Family Advisory Council met fewer times in the year, the Family Liaison maintained regular
communication with the members throughout the year to share information and obtain comments individually. The members of the FAC contributed to the redesign of the UIC-DSCC website and discussion of a possible Facebook page. As consumers of our services, our FAC members provided unique feedback which was used to describe how UIC-DSCC assists families. The Family Liaison and the FAC were involved in the planning stages for the next family survey.

UIC-DSCC supported 32 parents and 23 children with hearing loss to participate in the week-long Institute for
Parents of Preschool Children who are Deaf or Hard of Hearing. The Family Liaison led a "Dads" support group.
Discussion focused on important issues from the father's perspective on raising a child with hearing loss.
Feedback was positive from the participants. UIC-DSCC provided support for parents of children with hearing loss
statewide, with a parent-to-parent program that provides unbiased emotional support and resources through
trained, experienced parent guides. The Guide By Your Side model is used for this support.

UIC-DSCC also supported 8 families and youth to attend the annual Transition Conference and other families to
attend conferences pertaining to their child's diagnosis.

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 and Facebook page.				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 redesigned UIC-DSCC website was activated and includes links to social media to promote communication with families and providers about UIC-DSCC programs and services and provide linkages to other resources. Helping families find what they want quickly and accurately in new ways was the goal during development of the new website.

The FAC piloted the revised family survey and provided feedback. The survey is being mailed with on-line options in English and Spanish. There is a section for families to comment on the services and supports they received and identify unmet needs. The survey in 2009 provided valuable family comments which have been used to improve services.

Additional families will be encouraged to share their stories for future use in projects including updating the UIC-DSCC website. FAC recruitment efforts will be renewed to identify potential families who may have valuable contributions. The Family Liaison supports the FAC, provides outreach to other initiatives, and promotes a family partnership approach.

The Family Liaison continues to provide training on family-centeredness and family partnership for new staff.
Training for new staff is being redesigned with a greater emphasis on following the life span of individual families.

The Family Liaison is again leading a father's support session during Institute. Support for parents of children with hearing loss statewide continues using the Guide By Your Side model.

c. Plan for the Coming Year

The Family Advisory Council, (FAC) as a diverse group with children served by UIC-DSCC, continues to provide feedback on services. Ways to enhance participation and increase membership on the FAC will continue to be

explored. "Go To Meeting" software will enable the FAC to easily review and discuss materials and issues during the meetings as an alternative to attending in person. Additional family stories from FAC members will be documented for posting on our website.

The Family Liaison will assist the Hope Institute in Springfield in developing a family support network which will
benefit families with CYSHCN across the state. The Family Liaison will explore new ways to assist with the Institute for Parents of Preschool Children who are Deaf or Hard of Hearing (Institute). He will also represent UIC-DSCC and families on the state's Advisory Council on head and Spinal Cord Injuries.

Outreach to families and providers will continue through the UIC-DSCC website and social media. The family survey results will be used to inform the needs assessment and priority setting process in 2015.

Family Centered Care and Family Partnership concepts will continue to be presented in training new staff and in
collaborations with programs and initiatives, such as Early Intervention, Early Hearing Detection and Intervention, Medical Home activities, and Transition.

UIC-DSCC will continue to explore opportunities to promote family involvement and to provide information to families about changes in systems and services they use, including health care, education, and other support programs.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	45.3	45.3	45.5	44.5	44.5
Annual Indicator	45.1	45.1	44.5	44.5	44.5
Numerator					
Denominator					
Data Source	CSHCN SLAITS Survey	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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	44.5	45	45	45	45

Notes - 2013
For 2011-2015, 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 - 2012
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 - 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.

a. Last Year's Accomplishments
The Illinois Chapter of the American Academy of Pediatrics (ICAAP) was awarded a 3 year HRSA Integrated
Community Systems for CSHCN grant in 2011 to improve access to quality services for children and families who
receive healthcare through the Cook County Health and Hospital System (CCHHS) Ambulatory and Community
Health Networks (ACHN), a network of federally qualified health centers. ICAAP and UIC-DSCC staff provided training and resources on implementing the medical home model with quality improvement (QI) team facilitation for 5 centers in this network that serves more than 16,000 children. The second and third Learning Sessions were held for the 5 participating medical home teams. A standardized developmental screening process was established in the practice sites emphasizing partnership with Early Intervention Child and Family Connections (CFC). Part 4 Maintenance of Certification was offered for physicians participating in the online developmental screening QI activity. Transition of care, ensuring patients receive coordination of health care services during the movement between health care providers and settings, was initiated as a new focus for practice improvement. The Medical Home Network in Chicago is helping to facilitate

innovative partnerships between public and private organizations such as Illinois Medicaid, south side hospitals, federally qualified health centers and high volume Medicaid private practices to reduce the fragmentation of care and improve health status of vulnerable populations. Along with transition of care, coordinating care within the ACHN Medical Home Neighborhood was also initiated.

CCHHS is expanding and implementing medical home efforts through a system-wide Patient-Centered Medical Home (PCMH). The State of Illinois and ICAAP received funding through the Children's Health Insurance Program
Authorization (CHIPRA) grant to improve care for children by "building medical homes". ICAAP is guiding medical
home improvement initiatives throughout the grant period focusing both on systems issues identified through the self-assessments, such as care coordination, and specific CHIPRA core child health measures. ACHN grant practices are also participating in the CHIPRA grant and are utilizing the NCQA practice survey to guide practice
improvements. ICAAP has 12 pediatric and family physician practices participating in a medical home learning group. Two Learning Sessions were held.

UIC-DSCC provides medical home team facilitation to 2 additional pediatric practices. UIC-DSCC Regional Offices are committed to the key component of quality health care in the medical home-care coordination. Regional Office staff promote medical home through active care coordination in partnership with the family. A comprehensive coordinated plan of care is developed which defines the medical home/primary care provider for each child and supports the family partnership with their healthcare provider. Healthcare and Family Services (HFS), the Illinois Medicaid agency, promotes quality medical homes for children through the Primary Care Case Management program (PCCM), and Integrated Care program. CSHCN enrolled in UIC-DSCC programs are excluded from the PCCM program.

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.				X
3. Statewide physician outreach.				X
4. Quality improvement technical assistance to physician practices.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

UIC-DSCC promotes medical home by coordination of care with primary care and specialty providers. Emphasis is
placed on the development of a comprehensive, coordinated plan of care that includes the child's full medical home "team" ensuring that families maintain a central role. The care plan development is being enhanced by the
implementation of the new care coordination information system, Efforts to Outcomes (ETO), which is beginning April 2014. A strong assessment of the family's needs in conjunction with linkages to appropriate community providers and resources will be better documented with follow-

up to ensure true family-centered care.

The Integrated Systems grant work with ICAAP continues through the 5 quality improvement teams with strong
emphasis on developmental screening, partnerships with the Medical Home Neighborhood, and transition of care
through the Medical Home Network.

The CHIPRA Medical Home Learning Group held the final learning session focusing on care coordination and
engaging the Medical Home Neighborhood in care coordination.

In addition to the grant facilitated medical home quality improvement teams, UIC-DSCC facilitates 2 additional
medical home teams. NCQA has recognized 1293 physicians and their practices in Illinois as medical homes as of
2014.

c. Plan for the Coming Year

The UIC-DSCC care coordination information system, Efforts to Outcomes, will be fully operational within all Regional Offices. Collaborative care coordination, including a comprehensive assessment, linkages to primary care providers and community resources will effectively address the needs of the child and family. Care coordination efforts will be documented and tracking of effectiveness can occur. UIC-DSCC Medical Home QI team facilitation continues for one additional practice team.

The ACHN grant activities will be concluding with evaluation of the project through comparison of baseline Medical
Home Index and Family Index scores with those at the end of the project. Additionally, baseline and final data on
developmental screening and transitions of care from hospitalization and Emergency Department to the primary care provider will be evaluated. Medical Home QI Team facilitation will continue for 5 practice sites through September 2014 and the conclusion of the evaluation components.

CHIPRA quality grant activities with HFS and ICAAP continue with the mission of improving health outcomes for
children. A new Illinois CHIPRA Patient-Centered Medical Home (PCMH)-Asthma Learning Collaborative is beginning with 20 practices that will strengthen the foundation for PCMH and make best practice changes to improve health outcomes for children with asthma that may be replicated with other chronic conditions.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	59.5	59.5	59.7	62.5	62.5
Annual Indicator	59.3	59.3	62.1	62.1	62.1
Numerator					

Denominator					
Data Source	CSHCN SLAITS Survey	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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	62.5	62.5	63	63	63

Notes - 2013
For 2011-2015, 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 - 2012
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 - 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.

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 UIC-DSCC had no third party benefits. UIC-DSCC assisted those
meeting financial eligibility criteria with payment for eligible specialty services.
New staff received training on strategies to maximize insurance and All Kids/Medicaid coverage. Case specific
technical assistance related to coverage issues was provided to staff providing care coordination. Updates on health insurance trends, All Kids/Medicaid changes, and Affordable Care Act (ACA) implementation were provided to staff through the bimonthly newsletter.

Care coordination teams continued to assist families in maximizing all funding sources for needed services and
assisted uninsured CYSHCN to apply to All Kids and Medicaid. For medically and financially eligible children, UIC-DSCC continued to assist families with the payment of private insurance co-pays and deductibles for eligible specialty care and eligible care not covered by private or public insurance.

Staff monitored the implementation of the ACA legislation and provided information about changes/issues resulting from the Illinois Save Medicaid Access and Resources Together Act (SMART Act) of May 2012. Staff also updated training on benefits management to coincide with future implementation of the new care coordination software. A Frequently Asked Questions document was developed to aid staff in documenting children's coverage details.

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/Medicaid.		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 and/or Medicaid.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
New care coordination staff continues to receive training on maximizing public and private funding sources. Staff
monitors and analyzes state and federal legislation for impact on CYSHCN health care funding, provides outreach to key agencies and programs, collaborates with other key agencies, and promotes awareness of health care funding issues and opportunities. Current information on health insurance and public funding sources continues to be provided to care coordination teams through the UIC-DSCC electronic newsletter. Staff continues to help CYSHCNs explore benefits available through the ACA legislation and, if applicable, enroll in expanded Medicaid. UIC-DSCC staff has received training on the new online All Kids/Medicaid application so they can assist families in applying. The online training module for health insurance appeals is being revised for families and will be posted on the UIC-DSCC website. Technical assistance visits are conducted to provide care coordination teams with current information regarding health insurance and public

funding as well as assist with individual CYSHCN issues. UIC-DSCC continues to assist financially eligible families with the payment of private insurance co-pays and deductibles for specialty care and for eligible care not covered by private or public insurance.

c. Plan for the Coming Year

New care coordination staff will be trained on maximizing public and private funding sources. Staff will monitor and analyze state and federal 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. Current information on health insurance and public funding sources will continue to be provided to care coordination teams through the UIC-DSCC electronic newsletter. Technical assistance visits will be conducted to provide care coordination teams with current information regarding health insurance and public funding as well as assist with individual CYSHCN issues. Staff will continue to encourage CYSHCNs to explore benefits available through the ACA legislation and, if applicable, assist CYSHCNs to enroll in expanded Medicaid. UIC-DSCC will continue to assist financially eligible families with payment for private insurance co-pays and deductibles for specialty care and eligible care not covered by private or public insurance. This assistance will be dependent on availability of federal and state funding.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	89.8	90	90	64.6	64.6
Annual Indicator	89.8	89.8	64.6	64.6	64.6
Numerator					
Denominator					
Data Source	CSHCN SLAITS Survey	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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	64.6	64.6	66	66	66

Notes - 2013

For 2011-2015, 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 - 2012
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 - 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.

a. Last Year's Accomplishments
The 2009/2010 National CSHCN Survey found that 64.6 percent of Illinois families with CSHCN reported that
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.
CSHCN that reported having a medical home were less likely to report having difficulties or delays receiving
services.

UIC-DSCC staff continued to coordinate and collaborate with state and local agencies to identify and resolve
service gaps and duplication. Efforts included collaboration with the Family to Family (F2F) Health Information and
Education Center in Illinois, specifically consultation on issues for individual CYSHCN and families. Community
system development efforts and coordination 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.

Efforts were initiated to redesign the UIC-DSCC website to improve communication with families and other

stakeholders. The agency also initiated a contract for a new, web-based care coordination information system to
improve the efficiency and effectiveness of care coordination staff in assisting families. A website specifically
related to newborn hearing screening is http://www.illinoissoundbeginnings.org/.

Efforts to assist families of children eligible for SSI in accessing necessary services continued. UIC-DSCC
information and information about the Family to Family Health Information Center (in English and Spanish) was
sent to families of children age 16 years or less that were newly eligible for SSI. Toll-free telephone numbers
were also provided. Telephone contacts have been expanded to include all children birth to 5 years and 14 to 16
years of age. Contacting families in the early evening hours was tested and has proven to be a successful
strategy. The system of care coordination staff in 13 regional offices that serve CSHCN in their communities
continues to be supported by UIC-DSCC.

UIC-DSCC staff provided care coordination to the families of more than 600 children who are medically
fragile/technology dependent (MF/TD) 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.
Care coordinators were identified to work solely in this program.

Families without health insurance were assisted to apply for All Kids. UIC-DSCC care coordinators assisted all
families with children enrolled in UIC-DSCC, including those in All Kids, to access primary and specialty health care
services. Staff also participated in HFS stakeholder meetings as changes were made in the All Kids/Medicaid
program, especially those related to children with complex medical needs.

Collaboration with the Illinois Chapter of the American Academy of Pediatrics (ICAAP) continued on the HRSA State Integrated System Implementation Grant for CYSHCN in practices in Cook County. See NPM #3 and #6 for more details on this grant.

Illinois' mechanism for families of individuals with developmental/intellectual 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 areas.

UIC-DSCC joined efforts on several initiatives with the Department of Healthcare and Family Services (HFS),
including the CHIPRA grant. 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. Efforts of the Category C workgroup were directed toward
assisting physician practices to apply for and achieve NCQA medical home recognition. A subgroup also worked on developing recommendations for HFS to incentivize practices to adopt strategies to improve their capacity to
provide medical homes for children.

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 interagency agreements with state agencies				X
3. Mutual referral process with Early Intervention Program.				X
4. Collaborative efforts with state Transition efforts.				X
5. Collaboration on CHIPRA grant activities.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

UIC-DSCC continues collaborative efforts with ICAAP on the HRSA Integrated Systems grant focusing efforts in the Ambulatory and Community Health Network in Cook County. See NPM #3 for more details. Staff continues
participating with HFS on CHIPRA grant activities to improve quality of care for children and access to medical homes. A work group investigated and developed recommendations to HFS to incentivize physician practices to become Medical Homes for children. Staff also continued attending HFS meetings regarding care coordination and children with complex medical needs.

Through a new intergovernmental agreement with HFS, UIC-DSCC became the single point of entry for children
receiving in-home services through the MF/TD HCBS Medicaid waiver and EPSDT. Staff in the Home Care program will provide care coordination for these children.

The new web-based care coordination information system development was completed and staff training has
begun. The first office went "live" on March 14, 2014.

The new website http://dscc.uic.edu/ has been activated, and new features, including social media, are in place.

UIC-DSCC staff continues to participate in system building activities related to newborn screening, newborn hearing screening, Early Intervention, transition and medical home and referral to PUNS. See NPM #6, 12 and State PM #10.

Staff continues to contact families having children up to age 16 years, newly eligible for SSI, and help them to
connect with needed services.

c. Plan for the Coming Year

UIC-DSCC will continue collaborative efforts with ICAAP on their 2nd HRSA Integrated Systems grant. See NPM #3 for more details. Staff will continue participating with HFS in CHIPRA grant activities to improve quality of care for children and access to medical homes. Staff will also continue collaboration with HFS and other stakeholders to address the needs of children with complex medical conditions. Home Care staff will continue as the single point of entry for children receiving in-home nursing through the All Kids/Medicaid program and the MF/TD HCBS waiver.

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. Telemedicine opportunities will continue to 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/intellectual disabilities, including referral to PUNS. Staff will also continue to contact families having children age 16 years or less, newly eligible for SSI, and help them to connect with needed services, including calling families in the evening. The system of care coordination staff in 13 regional offices that serve CSHCN in their communities will continue to be supported by UIC-DSCC. The web-based care coordination information system will be fully operational and will enable care coordinators to more easily assist families from their offices, in the children's homes, and at other locations in the community. Strategies for funding community level efforts to improve access to care to meet the unique needs of CSHCN will be explored, particularly in underserved areas.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	44.2	44.4	44.5	45.3	45.3
Annual Indicator	44.2	44.2	44.2	45.3	45.3
Numerator					
Denominator					
Data Source	CSHCN SLAITS Survey	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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	45.3	45.3	46	46	46

Notes - 2013
For 2011-2015, 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 - 2012
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 - 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.

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.

The Illinois Chapter of the American Academy of Pediatrics (ICAAP) and UIC-Division of Specialized Care for
Children utilized the HRSA grant (D70MC12840), Illinois Integrated Services for Children and Youth with Special
Healthcare Needs Project, 2009-2013 (hereafter referred to as the Illinois Integrated Services Project) to develop training and resources for physicians to improve health care transition. UIC-DSCC and ICAAP were provided the opportunity to present twice at the national conference, 13th

Chronic Illness and Disability Conference: Transition from Pediatric to Adult-based Care October 2012 sponsored by Baylor College of Medicine. A presentation was also provided at the 8th Annual IL Statewide Transition Conference October 24, 2012. Got Transition National Health Care Transition Center has included Illinois Integrated Services Project information under the Provider Resources web page. A poster describing the project and outcomes was presented at the Association of Maternal and Child Health Program 2013 Annual Conference. The grant work has increased outreach and interest in health care transition throughout IL.

The Integrated Services Project pilot sites completed testing the curricula in December 2012. Web-based
Transition trainings opened to a national audience June 18, 2013. Maintenance of Certification Part IV approval
was received from all three primary care boards as an incentive. Course enrollment is available at http://icaap.knowledgedirectweb.com. Two separate curricula were developed, one for pediatricians and another
for adult providers.

Curriculum on Integrating Health Goals in IEPs was presented at the 8th Annual IL Statewide Transition
conference and at the 2013 Illinois Maternal and Child Health Coalition Conference. The curriculum was developed by the Integrated Services Committee which was part of the Illinois Integrated Services Project. The evaluations indicated this presentation was well received and participants found handouts and examples of health issues to be addressed in the IEP helpful. A webinar on Health Goals in IEPs was held for parents with several host sites coordinated across the state to support in-person attendance for those without internet. This presentation has been archived at: https://www.youtube.com/watch?v=EVbG56T1IJM&feature=youtu.be. UIC-DSCC continued participation on the Integrated Services Committee (ISC) to coordinate and integrate the efforts of state and community-based agencies on transition. Staff also continued participation on the Project Advisory Committee (PAC) to promote promising transition practices as the project was developed and implemented.

The Illinois Interagency Coordinating Council on transition (IICC) that was established in 1990 (20 ILCS 3970),
focuses on transitioning youth ages 14-21, has not been active and met only once during this timeframe.

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. Promoting awareness of transition issues/resources.				X
4. Participation in Annual Statewide Transition Conference Planning Group.				X
5. Expansion of partnership and alliances.				X
6. 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
7. Transition training for physicians and allied health care providers.		X		
8.				
9.				

10.				

b. Current Activities
UIC-DSCC sent post cards to UIC-DSCC-enrolled physicians throughout IL to promote the Integrated Systems Grant Transitioning Youth to Adult Health Care courses in September.

The training committees met for an annual review of the transition courses on November 12, 2013. Modules and
resources were updated to include the Affordable Care Act information. Course evaluations indicated the pre/post-tests needed to be revised and a subcommittee completed revisions.

Strategies to promote successful health care transition for CYSHCN, including examples of the Transition Milestones and supporting Skills, Tips & Tools, and the Integrated Services Project were presented at the Statewide Transition Conference October 24-25, 2013. UIC-DSCC Transition materials were exhibited at the Muscular Dystrophy Association Transitions Seminar on March 8, 2014.

UIC-DSCC provided technical assistance through discussion on IL efforts in interagency transition planning with staff from the National Alliance to Advance Adolescent Health and the Center for Health Care Transition Improvement on
August 14, 2013.

c. Plan for the Coming Year
UIC-DSCC will continue to participate on the planning committees for the annual Statewide Transition Conference. Staff will present on health care transition and provide Transition Milestones and supporting Skills, Tips & Tools. Collaboration with state agencies, advocacy and community service agencies, physicians, youths and families will continue for planning, developing, evaluating and disseminating information and resources to improve transition outcomes for youth and young adults.

UIC-DSCC will continue to strategize and identify opportunities to increase the number of families of CYSHCN
receiving services necessary to make appropriate transition to adult health care, work and independence. According to 2009/2010 National Survey, discussion occurred for 52.2% of IL youth (nationwide 44.4%) on health care needs as they become adults. Care coordination teams will receive additional training on transition assessment, discussion, available anticipatory guidance and appropriate follow-up. Physicians will be encouraged to take an active role in transition through opportunities, such as grand rounds and Transition Conferences. UIC-DSCC will continue to promote the Transitioning Youth to Adult Health Care courses for physicians through contacts with providers, conference presentations, medical home teams and website links. UIC-DSCC Transition Skills, Tips & Tools on Health Insurance for Teens and the Guide to Adult Benefits, Services, and Resources will be updated to include information on the Affordable Care Act and links to the Application for Benefits Eligibility (ABE), navigators, in-person counselors, certified application agents and website http://getcoveredillinois.gov/. UIC-DSCC will continue to disseminate resources to youth and families to promote discussions on keeping health insurance coverage as an adult. The new UIC-DSCC website will continue to provide important transition resources, and care coordination teams will continue to share information to address and improve on the 2009/10 CSHCN survey result of 36.9% of CSHCN in IL who get all needed anticipatory guidance (compared to 31.6% nationwide). Educational outreach and supporting skill sheets will be provided to IL physicians, school providers, youths and families to promote, encourage and increase the percentage of youth developing age appropriate self-management skills (2009/10 results showed 69.4% of IL youth; 70.1% nationwide). As more health care providers participate in the Transitioning Youth to Adult Health Care course, discussions on transition by adult providers should improve from the 14.2% (13.6 % nationwide)

results shown in the 2009/10 CSHCN survey.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	81	81	82	82	82
Annual Indicator	73.4	78	77.9	78.7	74
Numerator					
Denominator					
Data Source	National Immunization Survey	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	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	82	82	82	82	82

Notes - 2013
Source: Vaccination coverage for the 4:3:1:3:3 vaccine series among children 19 to 35 months - US, National Immunization Survey, 2012. (available http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/data/tables-2012.html)

Margin of error for Illinois is +/- 4.6%

2012 NIS includes infants born January 2009 - May 2011

Notes - 2012
From CDC - NIS. Full CY 2012 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,CY 2011", received in e-mail from Region V office 5/10/13.

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"

a. Last Year's Accomplishments
The most current release of the National Immunization Survey (NIS) results (CY 2012) indicate that the 4:3:1:3:3 series completion level for 19-35 month old children in Illinois is 74.0% (+/- 4.6%). In the city of Chicago, this series completion rate is 67.4% (+/- 8.5%) and in the rest of Illinois, it is 77.1% (+/- 5.4%). This represents a decrease from the prior years' data, but because of the margin of error, it is not a statistically significant decline.

IDHS, IDPH, and IDHFS have collaborated on a campaign to improve the immunization level of children participating in the WIC program. 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.

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.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

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.

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 50 percent of VFC-enrolled provider sites to determine compliance with VFC requirements; the I-CARE registry system will be utilized to determine practice coverage levels. IDPH will continue to combine VFC compliance visits with annual quality assurance reviews at VFC-enrolled provider practices 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.

IDPH has provided guidance to public and private health care providers through its Health Alert Network (HAN) to promote pertussis (Tdap) vaccination of parents with young infants; parents enrolled in WIC and Family Case Management programming operated by a local health department should seek availability of Tdap vaccination 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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	21	21	19	19	15
Annual Indicator	19.2	16.9	15.0	13.0	10.8
Numerator	5057	4572	4037	3520	2927
Denominator	263644	269999	269999	269999	269999
Data Source	IDPH, Center for Health Statistics	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	11	11	10	10	10

Notes - 2013
Sources: births - 2013 provisional birth data from DHFS-EDW; women age 15-17 - 2010 Census. 2010 Census counts used for 2013 since Census estimates do not break out ages by single year.

Notes - 2012
Sources: births - provisional birth data from DHFS-EDW; women age 15-17 - 2010 Census. 2010 Census counts used for 2012 since Census estimates do not break out ages by single year.

Notes - 2011
Sources: births - provisional birth data from DHFS-EDW; women age 15-17 - 2010 Census. 2010 Census counts used for 2011 since Census estimates do not break out ages by single year.

a. Last Year's Accomplishments
The rate of births to 15 to 17 year-old women in 2013 was 10.8 per 1,000, the lowest rate in recent records. Though the 2013 birth data are provisional, the declining trend in teen births over the last five years is promising. The birth rate among 15 to 17-year-olds has declined by 43% between 2009 and 2013.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
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.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	28	42	43	44	45
Annual Indicator	41.5	41.5	41.5	41.5	41.5
Numerator	65000	64516	64516	64516	64516
Denominator	156512	155468	155468	155468	155468
Data Source	IDPH, Oral Health	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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	46	46.5	46.5	46.5	46.5

Notes - 2013
Source: 2008-2009 Basic Screening Survey conducted by IDPH Oral Health Program. A new survey is underway for the 2013-2014 school year, but data will not be available until summer 2014.

Notes - 2012
Data repeated from 2011 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 June 28, 2013 no updates from IDPH on Oral Health.

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.

a. Last Year's Accomplishments
IDPH Division of Oral Health is currently conducting an updated basic screening survey of 3rd grade students during the 2013-2014 school year. Updated data on this performance measure will be added as the data become available (hopefully during summer 2014).

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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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 providers to include non-grantee school-based dental providers making performance evaluation consistent throughout the state.

c. Plan for the Coming Year

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 mouthrise 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 throughtout 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 conduct 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.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1.9	1.9	1.7	1.7	1.4
Annual Indicator	1.7	1.4	1.3	1.3	1.3
Numerator			34	34	34
Denominator			2574430	2574430	2574430
Data Source	IDPH - Vital Records	IDPH - Vital Records	IDPH - Vital Records	IDPH - Vital Records	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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	1.3	1.2	1.2	1.2	1.1

Notes - 2013
Numerator: Vital Records data for 2013 deaths are not available at this time. 2010 death data are reported here as provisional. Deaths identified in IDHFS Electronic Data Warehouse by abstracting all deaths with any "V" code in "underlying cause of death" field.

Denominator: 2010 Census population estimates

Notes - 2012
Numerator: Vital Records data for 2012 deaths are not available at this time. 2010 death data are reported here as provisional. Deaths identified in IDHFS Electronic Data Warehouse by abstracting all deaths with any "V" code in "underlying cause of death" field.

Denominator: 2010 Census population estimates

Notes - 2011
Numerator: Vital Records data for 2011 deaths are not available at this time. 2010 death data are reported here as provisional. Deaths identified in IDHFS Electronic Data Warehouse by abstracting all deaths with any "V" code in "underlying cause of death" field.

Denominator: 2010 Census population estimates

a. Last Year's Accomplishments
Calendar year 2010 is the last year for which final death data was available from vital records. According to the available data, Illinois reduced the rate of its motor vehicle crash deaths among children between one and fourteen years of age from 1.7 per 100,000 in 2008 to 1.4 per 100,000 in 2009 to 1.3 per 100,000 in 2010. Thirty-four children ages one to fourteen died as a results of motor vehicle accidents in 2010.

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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
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.

Through a grant from the Illinois Department of Transportation the Illinois Department of Human Services purchased 100 infant car seats and through a collaboration with the Illinois Sate Police installed the car seats in cars of 100 low-income new parents, who were also provided with safety education.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	27	27	29	27	28
Annual Indicator	27.3	28.8	44.5	49.8	48.8
Numerator	16874	17926			
Denominator	61786	62305			
Data Source	IDHS, WIC Program	IDHS, WIC Program	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	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	50	50	50	52	52

Notes - 2013
Data Source: National Immunization Survey, 2013. As shown in 2013 CDC Breastfeeding Report Card, including data on 2010 births.

Measurement of Indicator Changed starting in year 2011. Data will now come from National Immunization Survey and estimate the percent of all Illinois infants who are breastfed at six months age.

Previous indicator used WIC data (from IDHS) to estimate the percent of breastfed infants who were still breastfed at 6 months of age. This indicator is no longer available from the WIC program because they only record food package status at six months, not actual breastfeeding behavior.

Because of the change in population (new population is all infants, old population was WIC infants who were ever breastfed), the data prior to 2011 are not comparable with the new indicator.

Notes - 2012
Data Source: National Immunization Survey, 2012. As shown in 2012 CDC Breastfeeding Report Card, including data on 2009 births.

Measurement of Indicator Changed starting in year 2011. Data will now come from National Immunization Survey and estimate the percent of all Illinois infants who are breastfed at six months age.

Previous indicator used WIC data (from IDHS) to estimate the percent of breastfed infants who were still breastfed at 6 months of age. This indicator is no longer available from the WIC program because they only record food package status at six months, not actual breastfeeding behavior.

Because of the change in population (new population is all infants, old population was WIC infants who were ever breastfed), the data prior to 2011 are not comparable with the new indicator.

Notes - 2011
Data Source: National Immunization Survey, 2011. As shown in 2011 CDC Breastfeeding Report Card, including data on 2008 births.

Measurement of Indicator Changed starting in year 2011. Data will now come from National Immunization Survey and estimate the percent of all Illinois infants who are breastfed at six months age.

Previous indicator used WIC data (from IDHS) to estimate the percent of breastfed infants who were still breastfed at 6 months of age. This indicator is no longer available from the WIC program because they only record food package status at six months, not actual breastfeeding behavior.

Because of the change in population (new population is all infants, old population was WIC infants who were ever breastfed), the data prior to 2011 are not comparable with the new indicator.

a. Last Year's Accomplishments
2013 marks the beginning of a shift in how this performance measure was measured for Illinois (see data notes) to be more population-based. 2012 and 2011 data have been back-updated to adjust to this new measurement method. According to 2013 National Immunization Survey data, 48.8% of Illinois infants were breastfed at six months of age, a slight, but not statistically significant, reduction from the 49.8% estimate from 2012. According to 2009 IL-PRAMS data, non-Hispanic black women are less likely than women of other races/ethnicities to initiate breastfeeding. Only 64.4% of black women initiated breastfeeding in 2009, compared to 79.6% of white women and 86.6% of Hispanic women.
In 2013 26.5% of WIC participants continued breastfeeding for six months (from Count and Percent of WIc Breastfed Inants FY 13). From the 2012 CDC Breastfeeding Report Card, United States 2013.

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: week-long intensive breastfeeding trainings that resulted in certification as a Certified Lactation Counselor, Certified Lactation Specialist, or Breastfeeding Support Counselor; Breastfeeding Fall Breastfeeding Workshops and four"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 93,000 participant contacts in FY12 Two Loving Support peer counselor trainings trained 22 new peer counselors. Peer counselor supervisors were trained through quarterly conference calls.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

WIC agencies continue to promote the WIC Philosophy of Breastfeeding, which is Breastfeeding is the normal and expected method of infant feeding, all women can breastfeed, and every mom wants what's best for her baby and every baby wants to breastfeed. IDHS provides technical assistance to local agencies with Peer Counselor programs and other breastfeeding projects. Seventy agencies and over 150 Peer Counselors provide services to eligible participants. Peer counselors make over 8,800 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.

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.

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. Hospitals throughout Illinois are working to become Baby Friendly Hospitals by implementing best practices around breastfeeding.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99.2	97	99	99	99
Annual Indicator	97.8	99.0	99.2	99.1	98.8
Numerator	167249	159263	156049	154005	149187
Denominator	171077	160822	157343	155345	150996
Data Source	IDPH, Vision and Hearing	IDPH, Vision and 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?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	99	99	99	99	99

Notes - 2013
Source: IDPH Vision and Hearing Screening Program, March 5, 2014, 2011-2013 data are based on infants reported to IDPH Vision and Hearing Program rather than vital statistics. Final birth data beyond 2009 are not available.

Notes - 2012
Notes - 2012
Source: IDPH Vision and Hearing Screening Program's Hi*track, September 11, 2013. Numbers indicated are based on infants reported to IDPH Vision and Hearing Program rather than vital statistics. Final birth data beyond 2009 are not available.

Notes - 2011
Source: IDPH Hi*track as of 3/21/2012 - as entered by U of I - DSCC.

a. Last Year's Accomplishments

The Early Hearing Detection and Intervention (EHDI) program is a shared initiative of 3 state agencies: IDPH, UIC-DSCC and IDHS which includes Part C (Early Intervention). Legislation was effective Dec 31, 2002 and requires all birthing hospitals to screen infants prior to discharge, report to IDPH within 7 days, and make screening available for infants born outside of the hospital. When an infant does not pass the screening, IDPH works with the parents and Medical Home to obtain documentation of follow-up. UIC-DSCC assists with connecting families to diagnostic and intervention providers. IDPH refers the child/family to IDHS Part C, MCH Family Case Management, and UIC-DSCC. Two-way sharing of child specific data is achieved only through an authorization to release information.

HRSA funding (2011-2014) was awarded to UIC-DSCC to reduce loss to follow-up. UIC-DSCC uses funds to support grant goals that include increase parent/ provider education of the 1-3-6 EHDI initiatives, reduce loss to follow-up, and improve timely outcomes for infants. Activities support data reporting, collaboration with parents of children with a hearing loss to educate stakeholders; implementation of training on objective screening; and implementation of quality improvement at screening sites.

Funds also support oversight of operations by the EHDI coordinators; technical assistance and education to hospitals, audiologists, physicians, interventionists, and HV staff; linkages to the Part C, CSHCN, parent-to-parent support and Medical Home; participation in the state Medicaid and Part C Programs; and work with state/national stakeholders. Activities are evaluated ensuring cultural/linguistic sensitivity; measureable outcomes of screening, diagnosis and intervention; parent involvement; sustainability and flexibility.

Highlights of UIC-DSCC activity include support and participation at the annual statewide educational meetings for developmental therapists-hearing (60), Academy of Audiology (298), Head Start Association (223), Teachers of Deaf and Hard of Hearing (325) , Guide By Your Side (GBYS) Parent Guide training (17), and 4 parent conferences; monthly webinars/teleconferences for stakeholders; production/dissemination of materials to support quality improvement in screening and Governor declared EHDI day; CSHCN program support for diagnostic evaluations and care coordination for families of children with hearing loss; compilation of 59 self-identified pediatric audiology sites; and Parent-to-Parent support by trained guides for 87 families through GBYS. Support was available in English, Spanish and American Sign Language (ASL).

A quality assurance survey of parents of children with a hearing loss diagnosed since the mandate took effect is in process. Survey questions address access to services and service delivery. Categories

include: hospital
screening technique and follow-up; diagnostic testing access and communication from medical personnel; Part C
Early Intervention enrollment and service satisfaction; attitudes towards universal hearing screening; and need
for parent support. Collaborative efforts included training for 223 Home Visiting staff using the Early Childhood
Hearing Outreach otoacoustic emission hearing screening curriculum to complete objective hearing screening
using otoacoutic emissions that impacts over 20,000 children; CDC funding (2011-2016) was awarded to IDPH for
data tracking and surveillance and supports maintenance and administration of a State-wide data tracking
system utilized by all IL birthing facilities; provision of technical assistance and education to stakeholders;
communication of the importance of screening and follow up to physicians and parents; and initiating referrals for
follow up.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Hospital screens 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 (2011-14) was again awarded to UIC-DSCC to reduce loss to follow-up. Goals and activities continued
as in the previous year with the addition of surveillance for late-onset loss. Highlights include supported the annual
statewide meetings for developmental therapists-hearing (planned 70), Academy of Audiology (258), Head Start
Association, Teachers of Deaf and Hard of Hearing (249), day long parent conferences, GBYS Parent Guide training
(16), and Parent Institute for Families; EHDI webinars/teleconferences for stakeholders; production/dissemination
of quality improvement materials and Governor declared EHDI day recognizing stakeholders; direct parent-to-parent
support (93 families); technical assistance on objective hearing screening (impacting > 20,000 children); CSHCN
identification of 63 pediatric audiology sites; and CSHCN care coordination and support for

diagnostic hearing
evaluations. UIC-DSCC applied for the competitive HRSA funding for 2014-2017 to reduce loss to follow-up after
newborn hearing screening.

IDPH EHDI used CDC grant funding to address instructional needs of Hi*Track reporters, develop HI*Track training
modules for 24/7 access, improve reporting of all births at 98% consistency, and develop/implement report cards for
birthing facilities.

c. Plan for the Coming Year
Pending HRSA grant funding award for April 2014-March 2017 UIC-DSCC will work to reduce loss to follow-up
(diagnosis and intervention) through providing oversight of operations by the EHDI coordinator; providing education
to hospitals, audiologists, physicians, interventionists, and home visiting staff; facilitate linkages to the Part C and
CSHCN programs, parent-to-parent support and Medical Home; encouraging participation in the state Medicaid and
Part C Programs; and work with state/national stakeholders.

Goals: child specific data sharing between program partners; quality improvement teams at the community level
addressing follow-up; sustain inpatient hearing screening rate of greater than 97%; complete outpatient hearing
screening or diagnosis and documentation no later than 3 months of age and enrollment and documentation for
Part C no later than 6 months of age; direct parent-to-parent support for parents of children with a hearing loss;
and annual objective otoacoustic emission hearing screening in Home Visiting Programs.

Activities will include: identify data system capacity and needs; finalize the UIC-DSCC and IDPH interagency
agreement; cross-match diagnostic data between entities; identify stakeholders at the community level to
participate in quality improvement for underserved areas; educate stakeholders on the quality improvement model;
spread the use of educational materials that were created by parents; host opportunities for stakeholder input;
obtain documentation of diagnostics and intervention services through parent guides; and train on otoacoustic
emission screening, protocols and reporting.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance	4.1	4	4	5	3.5

Objective					
Annual Indicator	6.4	5.2	5.2	6.2	6.9
Numerator				191000	206000
Denominator				3105000	3001000
Data Source	Census Bureau, Current Population Survey	Census Bureau, Current Population Survey	Census Bureau, Current Population Survey	Census Bureau, Current Population Survey	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	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	6	6	6	5	5

Notes - 2013
Source: U.S. Census Bureau, Current Population Survey, 2013 Annual Social and Economic Supplement. Data is for 2012.

Standard error of estimate is 0.9

Notes - 2012
Source: U.S. Census Bureau, Current Population Survey, 2012 Annual Social and Economic Supplement. Data is for 2011.

Standard error for estimate is 0.8

(value corrected during 2013 reporting year because previous number could not be validated with Census data)

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.

a. Last Year's Accomplishments
The Current Population Survey (CPS) of the Census Bureau estimates that 6.9% of Illinois children under 19 years old were uninsured in 2013. This represents a slight (but not statistically significant) increase over the 2012 estimate of 6.2%

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Of children enrolled in WIC, 96 percent had insurance coverage. FCM providers are required to document giving parent information regarding Illinois' Medicaid program and information on how to enroll. This information is recorded in Cornerstone and quarterly performance reports are issued to track compliance.

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 insurance enrollment 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 Medicaid. 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. 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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	29.8	29.5	29	29.5	29.5
Annual Indicator	30.2	29.9	30.4	30.4	30.4
Numerator	40172	40487	40575	40575	40575
Denominator	133023	135408	133471	133471	133471
Data Source	PedNSS	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?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	29	29	28.5	28.5	28.5

Notes - 2013
No new data. PedNSS survey was discontinued by CDC. No new data available at this time. Use 2011 data as provisional for 2013.

Development of a new data system to mirror PedNSS for Midwest states is currently underway, but not yet implemented.

Notes - 2012
No new data. PedNSS survey was discontinued by CDC. No new data available at this time. Use 2011 data as provisional for 2012.

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.

a. Last Year's Accomplishments
Data for this performance measure is no longer available for Illinois because the CDC PedNSS data system has been discontinued. The National Survey of Children's Health does not provide BMI estimates for children under ten years old because of issues with validity of parent-reported height and weight data. In the 2011/2012 National Survey of Children's Health, 33.6% of 10-17 year olds in Illinois were overweight or obese, compared to 31.3% in the United States. This survey also showed wide disparities in childhood weight status by race/ethnicity: 31.2% of non-Hispanic white children, 45.5% of non-Hispanic black children, and 33.5% of Hispanic children in Illinois were overweight or obese.

An autoplotting system has been successfully incorporated into the Cornerstone MIS as part of the WIC anthropometric data collection. This increases the accuracy of the data collected, decreases data collection time for the clinic staff and increases the accuracy of the information provided to the family on the child's growth.

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. In SFY2012 the taskforce again received funding. The group changed the focus of the special funding to small mini grants to be used as seed money to promote sustainable community interventions. Taskforce members were eligible to apply for funding to start small community gardens, enhance nutrition education and physical activity opportunities at community events and train additional staff to provide support to breastfeeding clients. Agencies receiving funds provided updates to the full taskforce continuing the networking and learning opportunities.

State Nutritionist Consultants have been trained. WIC staff have completed training 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. All staff continue to receive additional training, guidance and support on a regular basis to promote lifestyle changes that will result in healthier lifestyles through improved nutritional intake and increased physical activity. 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.				
2.				
3.				
4.				
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" or Shopping Programs. Students learn the basics of cooking using WIC foods. A downstate Cooking School 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 without significant input from community partners. IDHS staff remain 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.

c. Plan for the Coming Year

The Southern Illinois Healthy Child Task Force has been funded for SFY2013 to continue their efforts to prevent and address childhood obesity in southern Illinois. The Task Force will again

provide the opportunity for members to apply for mini-grants to promote or initiate sustainable activities to address childhood obesity. and determine how to best increase community involvement.

In partnership with the Illinois Nutrition Education Programs of the University of Illinois Extension and Illinois Head Start, WIC continues 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.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	11	11	9.5	9	9
Annual Indicator	10.7	9.6	9.2	9.2	9.2
Numerator	18304	16628	14830	14830	14830
Denominator	171023	173212	161764	161764	161764
Data Source	IDPH, PRAMS	IDPH, PRAMS	IDPH, PRAMS	IDPH, PRAMS	IDPH, 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?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	8.5	8.5	8	8	8

Notes - 2013
Source: 2009 PRAMS, obtained from IDPH, Illinois Center for Health Statistics. Numerator and denominator are weighted estimates of PRAMS data.
There are currently delays in obtaining more recent PRAMS; 2010 PRAMS data is estimated to be released in summer 2014.

Notes - 2012
Source: 2009 PRAMS, obtained from IDPH, Illinois Center for Health Statistics. Numerator and denominator are weighted estimates of PRAMS data.
There are currently delays in obtaining more recent PRAMS; 2010 PRAMS data is estimated to be released in summer 2014.

Notes - 2011
Source: 2009 PRAMS, obtained from IDPH, Illinois Center for Health Statistics. Numerator and denominator are weighted estimates of PRAMS data.
There are currently delays in obtaining more recent PRAMS; 2010 PRAMS data is estimated to be released in summer 2014.

a. Last Year's Accomplishments
In 2009 (the most recent year of PRAMS data available), 9.2% of Illinois women smoked during the last three months of pregnancy. Given that 20.9% of new mothers reported that they had smoked prior to pregnancy, the fact that only 9.2% reported smoking during pregnancy suggests that over half of smoking women are quitting while they are pregnant. Among women who smoked prior to pregnancy, approximately 31.8% quit altogether during pregnancy and the postpartum period, 26.1% quit during pregnancy but resumed after delivery, and 42.1% continued smoking during and after pregnancy.

Smoking rates before, during, and after pregnancy varied widely among Illinois women by several characteristics. Non-Hispanic women were more likely to smoke three months before pregnancy (28.7%), during the last three months of pregnancy (13.5%) and after pregnancy (20.3%) when compared to non-Hispanic black (19.3% before pregnancy, 8.2% during pregnancy, and 15.0% after pregnancy) or Hispanic women (9.0% before pregnancy, 2.0% during pregnancy, and 4.4% after pregnancy). Smoking at all three time periods was higher for women with lower education attainment, women on Medicaid, and unmarried women.

Smoking among women also widely varied by region. During the three months before becoming pregnant, smoking rates were: 15.3% in Cook County, 16.8% in the Collar Counties, 26.3% in other urban counties, and 40.3% in rural Illinois counties. During the last three months of pregnancy, smoking rates were: 5.2% in Cook County, 6.8% in the Collar Counties, 13.0% in other urban counties, and 21.7% in rural Illinois counties. After pregnancy, smoking rates for new mothers in Illinois were: 10.5% in Cook County, 9.2% in the Collar Counties, 20.0% in other urban counties, and 21.1% in rural Illinois counties. Rural counties not only had the highest smoking rates at all three time points, but also had the lowest quit rates during pregnancy among women who smoked prior to pregnancy (only about 40% smoking women quit during pregnancy compared to 60% in Cook County, 60% in the Collar Counties, and 50% in other urban counties).

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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
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.

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	2009	2010	2011	2012	2013

Annual Performance Objective	5	5	6	7	5.8
Annual Indicator	7.3	5.8	6.2	7.9	7.9
Numerator			57	73	73
Denominator			922092	922092	922092
Data Source	IDPH, Center for Health Statistics	IDPH, Center for Health Statistics	IDPH, Vital Records	IDPH, Vital Records	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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	5.8	5.8	5.8	5.8	5.8

Notes - 2013
Data Sources: Numerator - 2010 death certificate data obtained via IDHFS Electronic Data Warehouse. Denominator - 2010 Census population estimates.

Vital Records data for deaths beyond 2010 are not available at this time.

Notes - 2012
Data Sources: Numerator - 2010 death certificate data obtained via IDHFS Electronic Data Warehouse. Denominator - 2010 Census population estimates.

Vital Records data for deaths beyond 2010 are not available at this time.

Notes - 2011
Data Sources: Numerator - 2009 death certificate data obtained via IDHFS Electronic Data Warehouse. Denominator - 2010 Census population estimates.

Vital Records data for 2011 deaths are not available at this time. Data for 2009 was received too late to update 2009-2010 measures, so 2009 data used as provisional for 2011.

a. Last Year's Accomplishments
In 2010 (the most recent year of final death data available), there were 73 suicide deaths among youth ages 15 to 19, a rate of 7.9 deaths per 100,000 youth. This is an increase from the 57 teen suicide deaths in 2009 that led to a rate of 6.2 deaths per 100,000 youth. Further analysis needs to be done to examine the characteristics of such deaths and identify reasons for the increase from 2009 to 2010.

In May 2013 School Health Center staff and school nurses participated in a suicide prevention program at the annual conference of the Illinois Coalition for School Health Centers and the School Health Program.

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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

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.

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.

IDPH School Health Centers will continue to provide mental health counseling services on-site or through referral. Data is collected from the health centers to monitor diagnosis codes and services provided.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	83	83	83	83	83
Annual Indicator	81.2	88.2	88.9	87.3	79.1
Numerator	2155	2180	2142	2055	1631
Denominator	2655	2471	2410	2355	2062
Data Source	IDPH, Perinatal	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	83	83	83	85	85

Notes - 2013
Source: 2013 provisional birth data from DHFS-EDW. Includes only births in Illinois hospitals (IL resident births occurring out of state are not included). In 2013, there were 24 level III birthing hospitals located within Illinois.

Infants with recorded birthweight less than 350 grams were not included in analysis (due to likelihood of incorrect recording of birthweight). Excluded births: 185 births had missing birthweight (146 <350g, 39 recorded as "9999") and 20 VLBW births had missing hospital name.

Notes - 2012
Source: provisional birth data from DHFS-EDW

Notes - 2011
Source: provisional birth data from DHFS-EDW

a. Last Year's Accomplishments
In 2013, 79.1% of very low birth weight births were delivered in Level III perinatal hospitals. This is a decrease from the percentages in 2010-2012, which were consistently 87-88%. Further analysis needs to be done to understand whether the decrease is due to changes in the methods for measurement in 2013 (see data notes) or whether it represents a true decrease. Healthy People 2020 has set the objective that 83.7% of VLBW infants would be born in Level III hospitals by 2020.

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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
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.

c. Plan for the Coming Year
This performance measure will be addressed by IDPH through the routine operation of the Perinatal Program.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86	87	87	87	87
Annual Indicator	86.6	89.6	89.7	89.6	82.9
Numerator	138701	135160	136446	132607	115491
Denominator	160102	150767	152188	148000	139279
Data Source	IDPH, Center for Health Statistics	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	87	87	87	87	87

Notes - 2013
Data Source: 2013 provisional birth data obtained via the IDHFS Electronic Data Warehouse.

Analysis Notes: Only date of prenatal care entry is included in provisional birth data files. By comparing this date to date of birth and gestational age at delivery, the gestational age (in weeks) at prenatal care entry was estimated. Prenatal care <= 13 weeks gestation was defined as first trimester entry. Any women whose records showed starting prenatal care prior to pregnancy (gestational age at PNC entry <0) were given missing values. 14,058 (9.2%) women had invalid/missing values for timing of entry to prenatal care.

Notes - 2012
Source: provisional birth data from DHFS-EDW

Notes - 2011
Source: provisional birth data from DHFS-EDW

a. Last Year's Accomplishments

In 2013, 82.9% of live births were delivered to women who started prenatal care during the first trimester of pregnancy. This is a decrease from the percentages in 2010-2012, which were consistently close to 90%. The methods for calculating this indicator changed in 2013 (see data notes), which may have affected measurement. Further analysis needs to be done to understand whether the decrease is due to changes in the methods or whether it represents a true decrease.

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 new program -- Better Birth Outcomes -- targets "hard to reach high-risk pregnant women" who reside in areas with a high incidence of adverse pregnancy outcomes. 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%).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
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.

In January 2013, DHS initiated a prototype program -- Better Birth Outcomes -- to address high risk/high cost births. Twenty-one agencies across the state were selected to conduct BBO. The prototype shifts the programming focus to pregnant women and uses a standardized evidence-informed prenatal care education curricula (Becoming a Mom -- March of Dimes). A major

objective of the program is to find and enroll women in the first trimester of their pregnancy. The prototype also incorporates the Life-Course perspective into care coordination, utilizing a reproductive life plan to increase women's inter-conception periods. Results of the BBO prototype will be observed and evaluated over the course of SFY2014. It is anticipated that the program will result in fewer high risk/high cost births.

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

Program redesign is taking place in a determinative manner for the Family Case Management providers. Like Better Birth Outcomes, the programming focus will shift from infants and children (which at present constitute 60 percent of the FCM caseload) to pregnant women. During SFY2014, FCM providers are required to increase by 10 percentage points the number of pregnant women enrolled at their agency from that reported at the close of SFY2013. FCM providers also will deliver an abbreviated version of the standardized prenatal care education curricula used by Better Birth Outcomes.

D. State Performance Measures

State Performance Measure 1: *Title V data capacity and usage*

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

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			34	23	27
Annual Indicator		23	20	15	18
Numerator		23	20	15	18
Denominator		48	48	48	1
Data Source		Survey	Staff Report	Staff Report	Staff Report
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	24	26	28	30	30

Notes - 2013

Determined by staff report using standardized matrix developed specifically for this measure (see detail sheet).

2013 Score Breakdown is as follows:
Availability: 11 / 12 points
Integration: 4 / 12 points
Analysis: 2 / 12 points
Dissemination: 1 / 12 points
TOTAL SCORE = 18 / 48 points

Notes - 2012
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 - 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.

a. Last Year's Accomplishments
The Title V program moved from the Illinois Department of Human Services (IDHS) to the Illinois Department of Public Health (IDPH), Office of Women's Health and Family Services in July 2013. Much of the data work during the last year has focused on understanding the extent of the MCH data available in the data, and on obtaining needed permissions for Title V staff to access individual-level data. An Intergovernmental Agreement (IGA) between IDPH-OWHFS and the University of Illinois at Chicago School of Public Health (UIC-SPH) was enacted to allow UIC-SPH faculty and students in the maternal and child health department to serve as epidemiologic consultants and data analysts for the Title V program. The IGA also eased the burden of data access by allowing UIC-SPH staff to act as IDPH employees in matters related to data sharing, access, and analysis. UIC-SPH partners, Deborah Rosenberg, PhD and Amanda Bennett, MPH of the Division of Epidemiology & Biostatistics, are now able to access individual-level vital records (including birth, death, and fetal death certificates) through the state electronic data warehouse. Additionally, they have already received PRAMS data from 2004-2009 and will continue to receive more recent years as they are finalized and become available for analysis. Now that data access has begun to be established and the IGA is being implemented, the program hopes to improve its ability to integrate data systems, perform specialized analyses, and disseminate research findings to internal and external partners.
An attachment is included in this section. IVD_SPM1_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Create and Implement Inter-Governmental Agency Agreement between IDPH Office of Women's Health and Family Services and University of Illinois at Chicago School of Public Health for technical assistance in MCH epidemiology.				X
2. Enable UIC-SPH epidemiology consultants to access statewide electronic data warehouse for obtaining birth, death, and fetal death certificates.				X
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

The UIC-SPH epidemiology consultants have been conducting specialized data analyses on data that is readily available, such as birth certificates and PRAMS. Such data is informing Title V program activities and informing partnerships with other organizations and agencies. Efforts are also currently underway to expand the level of data access available to UIC-SPH epidemiology consultants, including access to provisional death records (current death record access is only for finalized death data), statewide and county-level BRFSS datasets, YRBS (both Chicago and IL - outside Chicago datasets), and other population-based datasets so that the scope of the analyses available to Title V is widened. Expanding routine data access for consultants under the IGA and creating systems for requesting special sub-sets of population based data (such as hospital discharge data or Medicaid claims data) are high priorities for the next few months. Expanding the scope of the data available to the Title V program is the first step towards moving into data systems integration/linkage, performing specialized epidemiologic analyses, and disseminating research findings to partners and the public.

c. Plan for the Coming Year

As part of the lead-up to the 2015 needs assessment, many specialized, detailed data analyses will be conducted on many MCH topics of interest. A databook containing information on a wide variety of MCH indictors will be compiled by the epidemiology staff of the Title V program. The hope is to include, at minimum, statewide estimates, trend analyses, racial/ethnic disparity estimates, and geographic disparity estimates for the indicators included in the databook. This databook would then be used during the needs assessment process to inform priority-setting and goals for the next five years of Title V in Illinois.

There is also interest at the state-level in linking hospital discharge data and birth certificates over the next year. Such a dataset would enable detailed analyses related to infant and maternal health on topics such as early elective delivery, maternal morbidity, and infant mortality. Discussions are underway to consider what action steps would need to be taken to start the process of linking these data systems to create matched records.

As noted earlier, responsibility for the MCH Block Grant shifts from DHS to IDPH on July 1, 2013. Responsibility for SSDI also shifts to the MCH Block Grant agency. Throughout the next year, IDPH will establish the priorities for strengthening Illinois' Title V data capacity.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			9	10	11
Annual Indicator		8	8	8	
Numerator		8	8	8	
Denominator		15	15	15	15
Data Source		Survey	Survey	Survey	
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	12	13	14	14	14

Notes - 2013
This performance measure was developed when the Title V program was housed in the Illinois Department of Human Services, which administers many of the individual programs funded by IDHS.

Now that Title V has moved to IDPH Office of Women's Health and Family Services, the specific action items that made up the score components for this SPM are not relevant. During the 2015 needs assessment, if this continues to be a priority, a new performance measure will be developed to measure progress in improving service delivery to MCH clients.

Notes - 2012
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 - 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.

a. Last Year's Accomplishments
This performance measure was developed when the Title V program was housed in the Illinois Department of Human Services, which administers many of the individual programs funded by IDHS. With the move of Title V from IDHS to the IDPH Office of Women's Health and Family Services, the specific action items that made up the score components for this SPM are not relevant.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
This state performance measure will be considered inactive for the remainder of this cycle. While priority #2 (Integrate MCH services and improve linkage of clients to these services) remains important for Title V, this specific indicator will be retired. Rather than create a new indicator that may be changed next year with the completion of the 2015 needs assessment, IDPH will hold off on defining a new specific measure that measures progress in service integration and linkage.

c. Plan for the Coming Year
During the 2015 needs assessment, if this continues to be a priority, a new performance measure will be developed to measure progress in improving service delivery to MCH clients.

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	2009	2010	2011	2012	2013
Annual Performance Objective			0	0	0
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?				Provisional	
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	0	0	0	0	

Notes - 2013
Priority #3: "Promote healthy families and communities" was identified when when the Title V program was housed in the Illinois Department of Human Services. They were unable to identify a specific performance measure to track progress in this priority due to staff turnover and shortages.

Currently, Illinois has a COIIN (Collaborative Improvement & Innovation Network to Reduce Infant Mortality) sub-committee focusing on social determinants of health. Once that sub-committee develops specific aims and tracking measures (by summer/fall 2014), such measures will be considered as potential options for SPM #3.

Notes - 2012
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 - 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.

a. Last Year's Accomplishments
Priority #3: "Promote healthy families and communities" was identified when the Title V program was housed in the Illinois Department of Human Services. At the completion of the 2010 needs assessment, a plan was in place to identify a specific indicator to measure progress in this priority within one year. However, due to staff turnover and staff shortages, IDHS was unable to identify a specific performance measure for this priority and the field has remained blank over several years.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
Currently, Illinois has a CoIIN (Collaborative Improvement & Innovation Network to Reduce Infant Mortality) sub-committee focusing on social determinants of health (SDOH). This sub-committee will be developing specific aim statements and process measures for tracking progress in addressing the SDOH in Illinois communities. Once that sub-committee develops specific aims and tracking measures (by summer/fall 2014), such measures will be considered as potential options for SPM #3. Some topics that may be areas of focus for this group include: food security / food "deserts", children's saving allowances, living wage and other economic development programs, or barriers to prenatal care entry and healthcare services. This group will also consider a wide array of SDOH indicators that may be added to statewide surveys and data systems.

c. Plan for the Coming Year
As the SDOH-focused CoIIN team moves forward with establishing their priorities and measurement standards, this will set the stage for other SDOH-focused research activities in state MCH programs. If priority #3 is selected as a continuing priority after the 2015 needs assessment, a specific state performance measure will be selected from the standard measures identifying by the CoIIN.

State Performance Measure 4: *Percent of Medicaid children ages 3-6 receiving at least one well-child visit in the last year*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			65	69	70
Annual Indicator	65.2	69.8	71.2	68.2	69.1
Numerator	228243	264155	272659	257258	239642
Denominator	350077	378244	383171	377062	346874
Data Source	IDHFS EIS Rpt.	IDHFS EIS Rpt.	IDHFS EIS Rpt.	IDHFS EIS Rpt.	IDHFS EIS Rpt.
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	70	71	71	72	72

Notes - 2013
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 4/08/2014

2013 data are not yet final. Providers have up to 18 months after the end of a year to submit claims.

Notes - 2012
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 4/09/2013

2012 data are not yet final. Providers have up to 18 months after the end of a year to submit claims.

Notes - 2011
Source: IDHFS, EIS Report "HEDIS - Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) - HFS Continously Enrolled - IDPAEIS101-TI" - Data as of 4/09/2013.

a. Last Year's Accomplishments
In 2013, 69.1% of Illinois children ages 3-6 on Medicaid had at least one well-child visit, nearly a one percentage point increase from the rate of 68.2% in 2012. Well-child visits were selected as one key indicator of primary care that is delivered through high-quality medical homes. Healthy People 2020 has set the objective that 63.3% of children would have access to a medical home by 2020. According to the 2011/2012 National Survey of Children's Health, 55.4% of Illinois children ages 0 to 17 received care meeting the criteria of a comprehensive medical home. Medical home access varied widely by race/ethnicity, where 72.9% of non-Hispanic white children, 45.3% of non-Hispanic black children, and only 27.1% of Hispanic children received care in the context of a medical home. Children who were from families with lower income, lower parental educational attainment, and mother-only households were less likely to receive care consistent with the medical home model. Additionally, only 46.4% of CSHCN in Illinois received care in a medical home, compared with 58.1% of non-CSHCN.

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.

As a result of that change, the monitoring of the insurance status of enrolled children is now with the FCM program. As of June 2012, 90% of the FCM enrolled infants and children have insurance. Since at any given time throughout the fiscal year about 95% or more of children receiving WIC are also enrolled in FCM, this is a good proxy measure for the effectiveness of

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
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 2012, 88.6% of infants received 3 or more well child visits. This is an increase from SFY 2011 when the rate was 87.3%.

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 communitybased 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 wellchild 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: *Percent of women of reproductive age 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	**2009**	**2010**	**2011**	**2012**	**2013**

Annual Performance Objective			88	89	90
Annual Indicator	85.6	85.1	78.8	83.9	83.9
Numerator	1950535	1920658	1790684	1868478	1868478
Denominator	2277535	2256149	2271540	2226974	2226974
Data Source	IL-BRFSS	IL-BRFSS	IL-BRFSS	IL-BRFSS	IL-BRFSS
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	90	90	90	92	92

Notes - 2013
Source: 2012 BRFSS Data. 2013 BRFSS data not yet available, but are expected to be released during summer 2014.
Only non-pregnant women ages 18-44 are included in the numerator and denominator.
95% Confidence Interval = (80.5% - 87.0%)

Notes - 2012
Source: 2012 BRFSS Data
Only non-pregnant women ages 18-44 are included in the numerator and denominator.
95% Confidence Interval = (80.5% - 87.0%)

Notes - 2011
Source: 2011 BRFSS Data
Only non-pregnant women ages 18-44 are included in the numerator and denominator.
95% Confidence Interval = (75.0% - 82.6%)

a. Last Year's Accomplishments
In 2012, 83.9% of non-pregnant Illinois women of reproductive age had a regular doctor/nurse for primary care. This is an increase from the 2011 rate of 78.8%, though the increase was not statistically significant. Having a regular healthcare provider is one important component of comprehensive care in a medical home. Access to healthcare through a regular doctor/nurse was not equal for all women in Illinois. In 2012, 88.8% of non-Hispanic white, 83.4% of non-Hispanic black, and only 74.2% of Hispanic women of reproductive age reported having a regular care provider.

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.				
2.				
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
The BBO, 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: *Percent of live births resulting from unintended pregnancies*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			41	41	41
Annual Indicator	44.2	44.2	44.2	44.2	44.2
Numerator			71100	71100	71100
Denominator			160698	160698	160698
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	41	41	41	41	41

Notes - 2013
Source: 2009 Pregnancy Risk Assessment Monitoring System (PRAMS).

2013 data is provisional and is based on the 2009 rate. 2013 PRAMS is not available. 2010 PRAMS data are expected to be released during summer 2010.

Notes - 2012
Source: 2009 Pregnancy Risk Assessment Monitoring System (PRAMS).

2012 data is provisional and is based on the 2009 rate. 2012 PRAMS is not available. 2010 PRAMS data are expected to be released during summer 2010.

Notes - 2011
Source: 2009 Pregnancy Risk Assessment Monitoring System (PRAMS).

2011 data is provisional and is based on the 2009 rate. 2011 PRAMS is not available. 2010 PRAMS data are expected to be released during summer 2010.

a. Last Year's Accomplishments

In 2009 (the most recent data available from PRAMS), 44.2% of Illinois live births were the result of unintended pregnancies. Unintended pregnancies reflect pregnancies that are mistimed (wanting a pregnancy later) and unwanted (not wanting to be pregnant). The unintended birth rate showed wide disparities by race/ethnicity; 35.3% of births non-Hispanic white women, compared to 74.8% of births to non-Hispanic black women and 47.3% of births to Hispanic women, resulted from unintended pregnancies. Additionally, births to women who were young, were low-income, had low educational attainment, and were unmarried had higher rates of births from unintended pregnancies than their older, higher income, better educated, and married counterparts. Additionally, women whose delivery was paid for by Medicaid had nearly twice the rate of births from unintended pregnancies than non-Medicaid women (59.6% vs. 26.0%). Rates of births from unintended pregnancy were similar across regions, except for significantly lower rates in the Collar Counties (46.1% in Chicago, 36.5% in Collar Counties, 49.0% in other urban counties, and 48.9% in rural counties).

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.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1.				
2.				
3.				
4.				
5.				
6.				
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 not be eligible for IDHFS Medicaid, and whose income was at or below 200% of the federal poverty level.

c. Plan for the Coming Year

Unintended pregnancy through the routine operation of the Family Planning, School Health Center programs, and the Teen Pregnancy Prevention Programs will be the responsibility of the

Illinois Department of Public Health. Effective July 1, 2013, these programs were transferred from IDHS to IDPH

State Performance Measure 7: *Percent of Medicaid children receiving preventive dental services during last year*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			95	95	95
Annual Indicator	93.3	92.5	46.3	48.8	50.5
Numerator	615960	704545	697930	759190	798269
Denominator	659906	761361	1507472	1554421	1581522
Data Source	Illinois DHFS	Illinois DHFS	IDHFS CMS 416 Report	IDHFS CMS 416 Report	IDHFS CMS 416 Report
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	52	52	52	54	54

Notes - 2013
Source: 2013 report from Illinois Department of Healthcare and Family Services: "Early and Periodic Screening, Diagnosis, and Treatment Services for Children, Illinois' CMS-416 Reporting"
Numerator = Line 12b summed for ages 1-20 (number of children receiving preventative dental services in last year)
Denominator = Line 1b summed for ages 1-20 (number of continuously eligible EPSDT children)

This represents a change from how this measure was reported in previous years. Previously, the values included infants <1 year of age, though these infants would not be expected to have had preventative dental care. Additionally, the previous denominator was children who received any dental services, rather than all children. To create a measure more in line with recommendations for dental services and to monitor preventive care in the entire population, the numerator and denominator were changed starting with 2011 data. 2009-2010 data are not comparable to data in 2011 and beyond. Annual performance objectives were changed in 2013 to align with the new measurement method.

2013 data are not yet final. Providers have up to 18 months after the end of a year to submit claims.

Notes - 2012
Source: 2012 report from Illinois Department of Healthcare and Family Services: "Early and Periodic Screening, Diagnosis, and Treatment Services for Children, Illinois' CMS-416 Reporting"
Numerator = Line 12b summed for ages 1-20 (number of children receiving preventative dental services in last year)
Denominator = Line 1b summed for ages 1-20 (number of continuously eligible EPSDT children)

This represents a change from how this measure was reported in previous years. Previously, the values included infants <1 year of age, though these infants would not be expected to have had preventative dental care. Additionally, the previous denominator was children who received any dental services, rather than all children. To create a measure more in line with recommendations for dental services and to monitor preventive care in the entire population, the numerator and

denominator were changed starting with 2011 data. 2009-2010 data are not comparable to data in 2011 and beyond.

2012 data are not yet final. Providers have up to 18 months after the end of a year to submit claims.

Notes - 2011
Source: 2011 report from Illinois Department of Healthcare and Family Services: "Early and Periodic Screening, Diagnosis, and Treatment Services for Children, Illinois' CMS-416 Reporting"
Numerator = Line 12b summed for ages 1-20 (number of children receiving preventative dental services in last year)
Denominator = Line 1b summed for ages 1-20 (number of continuously eligible EPSDT children)

This represents a change from how this measure was reported in previous years. Previously, the values included infants <1 year of age, though these infants would not be expected to have had preventative dental care. Additionally, the previous denominator was children who received any dental services, rather than all children. To create a measure more in line with recommendations for dental services and to monitor preventive care in the entire population, the numerator and denominator were changed starting with 2011 data. 2009-2010 data are not comparable to data in 2011 and beyond.

a. Last Year's Accomplishments
In 2013, 50.5% of Medicaid children ages 1-20 received at least one preventative dental service, a 9.6% increase in only two years. Because of differences in the methodology for measuring this performance measure, data prior to 2011 is not comparable to 2011-2013 data. This is also well above the Healthy People 2020 objective of 33.2%, indicating that Illinois is performing well in this area. Statewide, the 2011-2012 National Survey of Children's Health estimates that 80.8% of Illinois children received at least one preventative dental visit in the last year, above the national average of 77.2%.

Strengthened the referral portion of the All Kids School-based Dental Program to assure students receive necessary treatment and establish Dental Home.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
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. The Illinois Dental Periodicity Schedule has been updated to reflect the recommendation.

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 statewide. 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 continue to grow.

State Performance Measure 8: *Percent of women whose prenatal care provider discussed perinatal depression*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			88.5	77	79
Annual Indicator	75	75	74.0	74.0	74.0
Numerator			118038	118038	118038
Denominator			159502	159502	159502
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	79	79	81	81	81

Notes - 2013
Source: 2009 Pregnancy Risk Assessment Monitoring System (PRAMS) from Illinois Center for Health Statistics (IDPH). 2013 PRAMS data is not yet available; 2010 PRAMS data is expected to be released Summer 2014.

Question #22k (Phase 6): "During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about... what to do if I feel depressed during pregnancy or after my baby is born? Please count only discussions, not reading materials or video". Women who did not receive any prenatal care skipped this question in the original survey, but were recoded as "no" responses for the purpose of this indicator.

Notes - 2012
Source: 2009 Pregnancy Risk Assessment Monitoring System (PRAMS) from Illinois Center for Health Statistics (IDPH). 2012 PRAMS data is not yet available; 2010 PRAMS data is expected to be released Summer 2014.

Question #22k (Phase 6): "During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about... what to do if I feel depressed during pregnancy or after

my baby is born? Please count only discussions, not reading materials or video". Women who did not receive any prenatal care skipped this question in the original survey, but were recoded as "no" responses for the purpose of this indicator.

Notes - 2011
Source: 2009 Pregnancy Risk Assessment Monitoring System (PRAMS) from Illinois Center for Health Statistics (IDPH). 2011 PRAMS data is not yet available; 2010 PRAMS data is expected to be released Summer 2014.

Question #22k (Phase 6): "During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about... what to do if I feel depressed during pregnancy or after my baby is born? Please count only discussions, not reading materials or video". Women who did not receive any prenatal care skipped this question in the original survey, but were recoded as "no" responses for the purpose of this indicator.

a. Last Year's Accomplishments
In 2009 (the most recent data available from IL-PRAMS), 74.0% of women reported that their healthcare provider discussed postpartum depression with them during prenatal care. In the same survey year, 30.5% of new mothers reported possible symptoms of postpartum depression, as measured by the self-report of "sometimes", "often" or "always" experiencing at least two specific PPD symptoms since their infant was born. Postpartum depression symptoms did not vary by maternal demographic characteristics such as race/ethnicity, age, education, or income status. Additionally, 9.1% of new mothers reported that they had been diagnosed with postpartum depression by a healthcare provider. Of women with postpartum depression diagnoses, 71.8% were receiving treatment, either in the form of medications and/or counseling. Previous detailed study of 2004-2008 PRAMS data showed that minority women diagnosed with postpartum depression were less likely to be receiving any treatment for their depression than white women, even after adjusting for maternal characteristics and insurance.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Administration of the MCH Block grant transferred to the Illinois Department of Public Health on 7/1/13. IDPH will work with key partners at the Illinois Department of Human Services and Chicago Department of Public Health to document activites conducted to increasing the percentage of pregnant women who receive mental health information during pregnancy.

c. Plan for the Coming Year
Administration of the MCH Block grant transferred to the Illinois Department of Public Health on 7/1/13. IDPH will work with key partners at the Illinois Department of Human Services and

Chicago Department of Public Health to document activites conducted to increasing the percentage of pregnant women who receive mental health information during pregnancy.

State Performance Measure 9: *Percent of youth participating in regular physical activity during the week*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			67.5	51	52.3
Annual Indicator	44.7	0	48.5	48.5	48.5
Numerator					
Denominator					
Data Source	YRBS - CDC	n/a	YRBS - CDC	YRBS - CDC	YRBS - CDC
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	54	56.1	58	58	58

Notes - 2013
Source: 2011 YRBS data from CDC website. 2013 YRBS data will be available June 12, 2014 per CDC website.

Inverse of Values displayed in Table: Physically Active At Least 60 Minutes Per Day On Less Than 5 Days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)

Notes - 2012
Source: 2011 YRBS data from CDC website. YRBS is conducted bi-annually during odd years.

Inverse of Values displayed in Table: Physically Active At Least 60 Minutes Per Day On Less Than 5 Days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)

Notes - 2011
Source: 2011 Youth Risk Behavior Survey Data from CDC website. Inverse of Values displayed in Table: Physically Active At Least 60 Minutes Per Day On Less Than 5 Days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)

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.

a. Last Year's Accomplishments

In 2011, 48.5% of high school students were physically active for at least 60 minutes during at least five of the last seven days and 23.2% were physically active during seven of the last seven days. For both measurements, boys were more likely to be physically active than girls. Blacks and Hispanics were less likely than white youth to be physically active. Healthy People 2020 set the objective that 20.2% of high school youth would be physically active every day during the last seven days by 2020. Physical activity is merely one risk factor that is related to childhood overweight/obesity. In the 2011/2012 National Survey of Children's Health, 33.6% of 10-17 year olds in Illinois were overweight or obese, higher than the national average of 31.3%. The NSCH also showed wide disparities in childhood weight status by race/ethnicity: 31.2% of non-Hispanic white children, 45.5% of non-Hispanic black children, and 33.5% of Hispanic children in Illinois were overweight or obese.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
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 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

The MCH Block grant was transferred to the Illinois Department of Public Health on 7/1/13. IDPH will work with the appropriate partner to identify and document the activities to increase the percentage of youth participating in regular physical activity each week.

State Performance Measure 10: *Percent of youth with special healthcare needs receiving comprehensive transition planning services*

Tracking Performance Measures

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

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			90.7	90.8	85

Annual Indicator		90.6	87.8	83.4	65.4
Numerator		879	879	746	608
Denominator		970	1001	894	929
Data Source		Record Review DSCC Youth 14-21 (50% Sample)	Record Review DSCC Youth 14-21 (50% Sample)	Record Review DSCC Youth 14-21 (50% Sample)	Record Review DSCC Youth 14-21 (50% Sample)
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	86	87	88	89	89.1

Notes - 2013
50% record review of youth 14-21 in DSCC program.

Decrease in recent years is likely the result of reductions in staff training and technical assistance, which may have led to perceptions of transition services as being of lower priority for DSCC staff

a. Last Year's Accomplishments
Illinois' performance objective to ensure that 85% 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 '13 was 65.4%. A review of 50% of case records for youth ages 14-21 years shows that for
those that had some aspect of transition addressed, 43.7% received planning information on health care
transition; 48.0% received information on vocations; and 39.3% received information on community involvement
and integration. Data reflects only UIC-DSCC care coordination efforts in transition planning.

Performance improved by 3.6% in only one regional office. The chart review process was performed by training
staff instead of the regional staff. It is not clear if this decrease in performance is indicative of a more objective
review process by the outside party or due to other factors such as program priorities or program changes. Staff
was encouraged to address transition planning for all transition age youth/young adults annually. Only 34.4% of
youth had a written transition plan in their records.

UIC-DSCC Transition Milestones Skills Lists and supporting Skills Tips & Tools sheets continue to be used to assist
youth/families and care coordination teams to assess skills and promote transition readiness in the areas of
Education, Employment, Financial, Health, Living and Social. These are available in Spanish and English at:
http://dscc.uic.edu/browse-resources/transition-resources/.

UIC-DSCC collaborated to promote family participation in the Health and Transition to Adulthood: Building the
Foundation for Success webinar held in September 2012 as part of the partnership for the HRSA

Integrated
Systems Grant (D70MC12840). UIC-DSCC supported 8 family members' participation in the 8th Annual Transition
Conference. The conference promoted family involvement, self-determination, interagency collaboration, effective
program structure and youth development. Conference sessions were organized into four tracks: education,
community, employment, and health. UIC-DSCC staff gave four presentations: "Stepping Through Transition with
Care Coordination" repeated this session and "Creating a Care Notebook to Manage Your Own Health Care" and
co-presented "Illinois Statewide Health Care Transition Project: New Model", the HRSA Integrated Systems Grant
(D70MC12840) project. UIC-DSCC also exhibited, providing health care transition outreach materials and
information. Staff coordinated the health track.

Transition Tips of the Month were sent to staff as short trainings and intermittent reminders using PowerPoint/Webinars to address training needs. The December 2012 Transition Tip of the Month was on IEPs and
Conflict Resolution Options with examples incorporated on related transition issues. The transition article,
Addressing Health in the IEP/Transition Plan, was published in staff newsletter in August 2012, and the January-
February 2013 issue showcased resources from the 8th Annual Transition Conference. The online courses
developed through the Integrated Services grant were made available to UIC-DSCC staff at no cost with up to 15
nurse contact hours provided. Numerous resources for health care professionals and families remain available at:
http://illinoisaap.org/projects/medical-home/transition/. On May 23, 2013 a Transition Webinar was provided to
staff. Case Scenarios were presented to demonstrate health care transition assessment, planning and follow up.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Health care 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, webinars and newsletters.				X
7. Provide education to CYSHCN and their families on Health Care Transition, including skill development, adult services and resource information including referral and assistance with application for social services, transportation.		X		
8. Participate and advocate for health goals in the IEP/Transition plan.		X		

9.				
10.				

b. Current Activities
Transition resources are included on the redesigned UIC-DSCC website. The transition workgroup provided
feedback on the introduction and descriptions of the Transition Milestones Skills Lists and supporting Skills, Tips &
Tools to enhance the message and outreach to youth and families.

A new Transition tool on decision making and problem solving is under development. The tool on chores is being
revised. Staff training on transition is being developed for Summer of 2014. Timing of this training is important with
the implementation of the new web-based care coordination information system. The training will demonstrate
transition assessment, planning, documentation and follow-up with youth and families using the new record format,
reminders and letters.

UIC-DSCC continued participation on the planning committees for Annual Statewide Transition conference. Staff
works to improve access to high quality, developmentally appropriate, uninterrupted health care through facilitating
transition to adult health care providers, referring to appropriate resources, providing anticipatory guidance and
developing person-centered plans. Staff has continued participation and outreach on local transition planning
committees, transition fairs and transition related in-services.

c. Plan for the Coming Year
Training staff will follow-up with UIC-DSCC offices showing the highest efforts on transition and evaluate how
transition efforts are monitored, the manager's expectations and the care coordinators' priorities. Those that met
performance objectives will be recognized by administration. Transition will be a standing agenda item for the
regional managers' meetings. The importance of transition planning as a component of care coordination will be
emphasized to all staff. Additional training on transition will be provided after full implementation of the new
information system. Training will emphasize/reinforce transition assessment, discussion, documentation, planning
and follow through, including using helpful features of the new software. The website and social media will be used
to post stories and transition events.

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. UIC-
DSCC staff will continue to participate, promote and support youth and families through educational outreach
opportunities. Care coordinators will continue to assess transition needs of CYSHCN and their

families and develop
strategies to address these needs.

UIC-DSCC in partnership with ICAAP will continue to reach out to pediatric and adult-oriented physicians to promote
participation in the Transitioning Youth to Adult Health Care courses. Staff will identify opportunities to provide
transition outreach to health care providers, informing them about UIC-DSCC care coordination teams, medical home
facilitators and transition expertise is available to provide support as they work on transition with CYSHCN and their
families. UIC-DSCC will continue interagency collaboration working with stakeholders and transition partners
throughout Illinois to improve transition outcomes for CYSHCN in Illinois.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	8.4	8.2	8.0	7.9	8.0
Numerator	14372	13258	12649	12348	12243
Denominator	171077	161828	157592	155581	153152
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

Notes - 2013
2013 provisional birth certificate data from IDHFS-EDW
153,337 total live births occurring in IL in 2013

Analysis Notes:
Infants with birthweight <350g were recoded to missing values
185 infants have missing birthweight and were excluded from analysis; 39 had '9999' listed on birth certificate, 146 were <350g and thus recoded as missing values

Notes - 2012
2012 provisional birth certificate data from IDHFS-EDW:
155,779 total live births occurring in IL in 2012

Analysis Notes:
Infants with birthweight <350g were recoded to missing values
198 infants have missing birthweight and were excluded from analysis; 43 had '9999' listed on birth certificate, 155 were <350g and thus recoded as missing values

Notes - 2011
2011 provisional birth certificate data from IDHFS-EDW:
157,785 total live births occurring in IL in 2011

Analysis Notes:
Infants with birthweight <350g were recoded to missing values
193 infants have missing birthweight and were excluded from analysis; 38 had '9999' listed on birth certificate, 155 were <350g and thus recoded as missing values

Narrative:
In 2013, 8.0% of all births in Illinois were low birth weight. This is similar to the rates reported in 2011 and 2012, all of which use provisional birth records data. 2009 is the most recent year of final birth data, so data from 2010-2013 may be subject to change upon finalization by IDPH.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	6.5	6.1	6.1	6.1	6.2
Numerator	10676	9798	9255	9080	9088
Denominator	164513	161828	151592	149636	147251
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

Notes - 2013
Source: 2013 provisional birth data from DHFS-EDW

Notes about Analysis:
153,337 total live births occurring in Illinois during 2013
Numerator and Denominator include only singleton live births -- 5,887 plural births excluded from analysis
Infants with birthweight <350g were recoded to missing values -- 199 infants were excluded from analysis due to missing birthweight or plurality

Notes - 2012
Source: 2012 provisional birth data from DHFS-EDW

Notes about Analysis:
155,779 total live births occurring in Illinois during 2012
Numerator and Denominator include only singleton live births -- 5,940 plural births excluded from analysis
Infants with birthweight <350g were recoded to missing values -- 203 infants were excluded from analysis due to missing birthweight or plurality

Starting with 2011 data, the methods for reporting this measure have been changed to be more precise. Data prior to 2011 may not be comparable to 2011 and beyond:
Old Method:
Numerator: singleton live births <2500g (not excluding those with birth weight <350g)
Denominator: all live births

Notes - 2011
Source: 2011 provisional birth data from DHFS-EDW

Notes about Analysis:
157,785 total live births occurring in Illinois during 2011
Numerator and Denominator include only singleton live births -- 5,999 plural births excluded from analysis
Infants with birthweight <350g were recoded to missing values -- 194 infants were excluded from analysis due to missing birthweight or plurality

Starting with 2011 data, the methods for reporting this measure have been changed to be more precise. Data prior to 2011 may not be comparable to 2011 and beyond:
Old Method:
Numerator: singleton live births <2500g (not excluding those with birth weight <350g)
Denominator: all live births

Narrative:
In 2013, 6.2% of singleton births in Illinois were low birth weight. This is similar to the rates reported in 2010-2012, all of which use provisional birth records data. 2009 is the most recent year of final birth data, so data from 2010-2013 may be subject to change upon finalization by IDPH.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	1.6	1.5	1.4	1.4	1.4
Numerator	2655	2471	2243	2177	2082
Denominator	171077	161828	157592	155581	153152
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

Notes - 2013
2013 provisional birth certificate data from IDHFS-EDW
153,337 total live births occurring in IL in 2013

Analysis Notes:
Infants with birthweight <350g were recoded to missing values
185 infants have missing birthweight and were excluded from analysis; 39 had '9999' listed on birth certificate, 146 were <350g and thus recoded as missing values

Notes - 2012
2012 provisional birth certificate data from IDHFS-EDW:
155,779 total live births occurring in IL in 2012

Analysis Notes:
Infants with birthweight <350g were recoded to missing values
198 infants have missing birthweight and were excluded from analysis; 43 had '9999' listed on birth certificate, 155 were <350g and thus recoded as missing values

Notes - 2011
2011 provisional birth certificate data from IDHFS-EDW:
157,785 total live births occurring in IL in 2011

Analysis Notes:
Infants with birthweight <350g were recoded to missing values
193 infants have missing birthweight and were excluded from analysis; 38 had '9999' listed on birth certificate, 155 were <350g and thus recoded as missing values

Narrative:
In 2013, 1.36% of all births in Illinois were low birth weight. This suggests a slight, but steady, decrease over time as the VLBW rates were 1.42% in 2011 and 1.40% in 2012. The measurement of this indicator changed starting with 2011 data by excluding births with <350 grams recorded on the birth certificate. The higher rates in 2009 and 2010, therefore, may be partially attributable to these 'improbable' birth weights being counted in the numerator. 2009 is the most recent year of final birth data, so data from 2010-2013 may be subject to change upon finalization by IDPH.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	1.2	1.1	1.1	1.0	1.0
Numerator	1971	1810	1630	1553	1514
Denominator	164513	161828	151592	149636	147251
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

Notes - 2013
Source: 2013 provisional birth data from DHFS-EDW

Notes about Analysis:
153,337 total live births occurring in Illinois during 2013
Numerator and Denominator include only singleton live births -- 5,887 plural births excluded from analysis

Infants with birthweight <350g were recoded to missing values -- 199 infants were excluded from analysis due to missing birthweight or plurality

Notes - 2012
Source: 2012 provisional birth data from DHFS-EDW

Notes about Analysis:
155,779 total live births occurring in Illinois during 2012
Numerator and Denominator include only singleton live births -- 5,940 plural births excluded from analysis
Infants with birthweight <350g were recoded to missing values -- 203 infants were excluded from analysis due to missing birthweight or plurality

Starting with 2011 data, the methods for reporting this measure have been changed to be more precise. Data prior to 2011 may not be comparable to 2011 and beyond:
Old Method:
Numerator: singleton live births <2500g (not excluding those with birth weight <350g)
Denominator: all live births

Notes - 2011
Source: 2011 provisional birth data from DHFS-EDW

Notes about Analysis:
157,785 total live births occurring in Illinois during 2011
Numerator and Denominator include only singleton live births -- 5,999 plural births excluded from analysis
Infants with birthweight <350g were recoded to missing values -- 194 infants were excluded from analysis due to missing birthweight or plurality

Starting with 2011 data, the methods for reporting this measure have been changed to be more precise. Data prior to 2011 may not be comparable to 2011 and beyond:
Old Method:
Numerator: singleton live births <2500g (not excluding those with birth weight <350g)
Denominator: all live births

Narrative:
In 2013, 1.02% of all births in Illinois were low birth weight. This suggests a slight, but steady, decrease over time as the VLBW rates were 1.08% in 2011 and 1.04% in 2012. The measurement of this indicator changed starting with 2011 data by excluding births with <350 grams recorded on the birth certificate. The higher rates in 2009 and 2010, therefore, may be partially attributable to these 'improbable' birth weights being counted in the numerator. 2009 is the most recent year of final birth data, so data from 2010-2013 may be subject to change upon finalization by IDPH.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 03A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	4.1	4.7	2.0	2.0	2.0
Numerator		124	52	51	51
Denominator		2644750	2574430	2574430	2574430

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

Notes - 2013
Data Source: all vital records data obtained from IDHFS-EDW. 2013 death data are not available at this time
Numerator: 2010 final death records, deaths determined by underlying COD V00-X59, Y85-86 (to make similar to Healthy People 2020 and CDC methods for determining unintentional injury)
Denominator: 2010 Census population estimates for children 0-14 yrs old

In 2011, the methods for reporting this indicator were changed, making previous years of data non-comparable with data for 2011 and beyond. The change included more restrictive identification of unintentional injury by including only deaths with underlying cases of death codes V00-X59, Y85-86. This makes measurement of this indicator equivalent to that reported for Healthy People 2020 Injury & Violence Prevention Objective #11: Reduce fatalities due to unintentional injury.

Notes - 2012
Data Source: all vital records data obtained from IDHFS-EDW. 2012 death data are not available at this time
Numerator: 2010 final death records, deaths determined by underlying COD V00-X59, Y85-86 (to make similar to Healthy People 2020 and CDC methods for determining unintentional injury)
Denominator: 2010 Census population estimates for children 0-14 yrs old

In 2011, the methods for reporting this indicator were changed, making previous years of data non-comparable with data for 2011 and beyond. The change included more restrictive identification of unintentional injury by including only deaths with underlying cases of death codes V00-X59, Y85-86. This makes measurement of this indicator equivalent to that reported for Healthy People 2020 Injury & Violence Prevention Objective #11: Reduce fatalities due to unintentional injury.

Notes - 2011
Data Source: all vital records data obtained from IDHFS-EDW. 2011 death data are not available at this time
Numerator: 2009 final death records, deaths determined by underlying COD V00-X59, Y85-86 (to make similar to Healthy People 2020 and CDC methods for determining unintentional injury)
Denominator: 2010 Census population estimates for children 0-14 yrs old

In 2011, the methods for reporting this indicator were changed, making previous years of data non-comparable with data for 2011 and beyond. The change included more restrictive identification of unintentional injury by including only deaths with underlying cases of death codes V00-X59, Y85-86. This makes measurement of this indicator equivalent to that reported for Healthy People 2020 Injury & Violence Prevention Objective #11: Reduce fatalities due to unintentional injury.

Narrative:
In 2010 (the most recent year of final death data available), there were 51 child deaths due to unintentional injury. This represents virtually no change from 2009, when there were 52 child unintentional injury deaths. Comparison to previous years of data is not appropriate because the

methods for identifying unintentional injury deaths changed with analysis of the 2009 data (reported in 2011).

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 03B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	1.7	1.4	1.3	1.3	1.3
Numerator		38	34	34	34
Denominator		2644750	2574430	2574430	2574430
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

Notes - 2013
Data Source: all vital records data obtained from IDHFS-EDW. 2013 death data are not available at this time
Numerator: 2010 final death records, deaths determined by underlying COD "V" codes
Denominator: 2010 Census population estimates for children 0-14 yrs old

Notes - 2012
Data Source: all vital records data obtained from IDHFS-EDW. 2012 death data are not available at this time
Numerator: 2010 final death records, deaths determined by underlying COD "V" codes
Denominator: 2010 Census population estimates for children 0-14 yrs old

Notes - 2011
Data Source: all vital records data obtained from IDHFS-EDW. 2011 death data are not available at this time
Numerator: 2010 final death records, deaths determined by underlying COD "V" codes
Denominator: 2010 Census population estimates for children 0-14 yrs old

Narrative:
In 2010 (the most recent year of final death data available), there were 34 deaths to among youth ages o to 14 due to motor vehicle crashes -- a death rate of 1.3 per 100,000 children. This represents a slight decrease from the number (38 deaths) and rate (1.4 per 100,000 children) of child MVA deaths seen in 2009 (reported in 2010 field).

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 03C - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	14.3	12.3	12.9	12.9	12.9

Numerator		225	232	232	232
Denominator		1830971	1801056	1801056	1801056
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

Notes - 2013
Data Source: all vital records data obtained from IDHFS-EDW. 2013 death data are not available at this time
Numerator: 2010 final death records, deaths determined by underlying COD "V" codes
Denominator: 2010 Census population estimates for youths 15-24 yrs old

Notes - 2012
Data Source: all vital records data obtained from IDHFS-EDW. 2012 death data are not available at this time
Numerator: 2010 final death records, deaths determined by underlying COD "V" codes
Denominator: 2010 Census population estimates for youths 15-24 yrs old

Notes - 2011
Data Source: all vital records data obtained from IDHFS-EDW. 2011 death data are not available at this time
Numerator: 2010 final death records, deaths determined by underlying COD "V" codes
Denominator: 2010 Census population estimates for youths 15-24 yrs old

Narrative:
In 2010 (the most recent year of final death data available), there were 232 deaths to among youth ages 15 to 24 due to motor vehicle crashes -- a death rate of 12.9 per 100,000 youth. This represents a slight increase from the number (225 deaths) and rate (12.3 per 100,000 youth) of youth MVA deaths seen in 2009 (reported in 2010 field).

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	325.5	336.5	312.1	313.5	293.8
Numerator	8583	8664	8036	8072	7563
Denominator	2636730	2574430	2574430	2574430	2574430
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

Notes - 2013
Data Source: Illinois hospital discharge data -- inpatient only; Q1-Q4 CY2013
Numerator: Number of children 0-14 who were hospitalized in an inpatient facility with nonfatal injuries in 2013 (ICD 9 codes 800-999 listed for any diagnosis code)
Denominator: 2010 Census population estimates for children 0-14 yrs old

Notes - 2012
Data Source: Illinois hospital discharge data -- inpatient only; Q1-Q4 CY2012
Numerator: Number of children 0-14 who were hospitalized in an inpatient facility with nonfatal injuries in 2012 (ICD 9 codes 800-999 listed for any diagnosis code)
Denominator: 2010 Census population estimates for children 0-14 yrs old

Notes - 2011
Sources: IDPH, Office of Policy, Planning and Statistics, Division of Health Policy, Facility Discharge Data. 2010 Census.

Narrative:
In 2013, there were 7,563 inpatient hospitalizations for non-fatal injuries among children 14 years old and younger. This translates to a rate of 293.8 hospitalizations per 100,000 children and is a substantial decrease from the previous year's rate of 313.5 per 100,000.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	17.5	17.3	17.4	16.4	12.2
Numerator	461	446	447	423	315
Denominator	2636730	2574430	2574430	2574430	2574430
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

Notes - 2013
Data Source: Illinois hospital discharge data -- inpatient only; Q1-Q4 CY2013
Numerator: Number of children 0-14 who were hospitalized in an inpatient facility with nonfatal injuries from a motor vehicle accident in 2013 (ICD 9 codes E810-E825 listed for any diagnosis code)
Denominator: 2010 Census population estimates for children 0-14 yrs old

Notes - 2012
Data Source: Illinois hospital discharge data -- inpatient only; Q1-Q4 CY2012
Numerator: Number of children 0-14 who were hospitalized in an inpatient facility with nonfatal injuries from a motor vehicle accident in 2012 (ICD 9 codes E810-E825 listed for any diagnosis code)
Denominator: 2010 Census population estimates for children 0-14 yrs old

Notes - 2011
Sources: IDPH, Office of Policy, Planning and Statistics, Division of Health Policy, Facility Discharge Data. 2010 Census.

Narrative:
The rate and absolute number of non-fatal motor vehicle accident (MVA) to children ages 0 to 14 decreased significantly from 2012 to 2013. The injury rate was 16.4 per 100,000 children in 2012 (423 total hospitalizations) and down to 12.2 per 100,000 in 2013 (315 per 100,000). Inpatient hospitalizations overall for Illinois were down about 5% in 2013 compared to 2012, but this does not fully explain the 25% decrease in child MVA injury hospitalizations.

We also examined outpatient emergency department (ED) visits to determine whether the decrease in hospitalizations might be offset by an increase in outpatient visits. In 2012, children 0-14 years old had 11,735 outpatient ED visits related to MVA and they had 10,179 outpatient visits in 2013 (a decrease of about 13%). So, it appears that there may truly have been a decrease in MVA injury during these two years, as there were fewer outpatient and inpatient visits in 2013 than in 2012.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 04C - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	82.6	86.1	83.2	86.1	71.1
Numerator	1519	1550	1498	1551	1281
Denominator	1839391	1801056	1801056	1801056	1801056
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

Notes - 2013
Data Source: Illinois hospital discharge data -- inpatient only; Q1-Q4 CY2013
Numerator: Number of youths 15-24 who were hospitalized in an inpatient facility with nonfatal injuries from a motor vehicle accident in 2013 (ICD 9 codes E810-E825 listed for any diagnosis code)
Denominator: 2010 Census population estimates for youths 15-24 yrs old

Notes - 2012
Data Source: Illinois hospital discharge data -- inpatient only; Q1-Q4 CY2012
Numerator: Number of youths 15-24 who were hospitalized in an inpatient facility with nonfatal injuries from a motor vehicle accident in 2012 (ICD 9 codes E810-E825 listed for any diagnosis code)
Denominator: 2010 Census population estimates for youths 15-24 yrs old

Notes - 2011
Sources: IDPH, Office of Policy, Planning and Statistics, Division of Health Policy, Facility Discharge Data. 2010 Census.

Narrative:
The rate and absolute number of non-fatal motor vehicle accident (MVA) to young adults ages 15 to 24 decreased significantly from 2012 to 2013. The MVA injury rate for youth was 86.1 per 100,000 in 2012 (1,551 total hospitalizations) and down to 71.1 per 100,000 in 2013 (1,281 per 100,000). Inpatient hospitalizations overall for Illinois were down about 5% in 2013 compared to 2012, but this does not fully explain the 17% decrease in young adult MVA injury hospitalizations.

We also examined outpatient emergency department (ED) visits to determine whether the decrease in hospitalizations might be offset by an increase in outpatient visits. Young adults 15-24 years old had 28,485 outpatient ED visits related to MVA in 2012 and 25,725 outpatient ED visits related to MVA in 2013 (a decrease of about 10%). So, it appears that there may truly have been a decrease in MVA injury during these two years, as there were fewer outpatient and inpatient visits in 2013 than in 2012.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	37.6	39.4	40.4	40.7	36.1
Numerator	16854	17669	18117	18260	16199
Denominator	448663	448356	448663	448356	448356
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

Notes - 2013
Source: IDPH, STD Section - final 2013 case counts.
Denominator: 2010 Census population estimate.

Notes - 2012
Source: IDPH, STD Section, and 2010 Census. The increase in the rate can be partially attributed to increased testing throughout the state.

Notes - 2011
Source: IDPH, STD Section, and 2010 Census. The increase in the rate can be partially attributed to increased testing throughout the state.

Narrative:
The rate of chlamydia among young women in 2013 was 36.1 per 1,000, the lowest rate seen during the last five years. Still, over 16,000 young women were reported to have a case of chlamydia. The increase in chlamydia rate during 2009-2012 may have been partially attributable to increased STI screening and testing in Illinois.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05B - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	12.2	11.8	12.6	13.3	13.1
Numerator	26743	25756	27509	29120	28520
Denominator	2197857	2183397	2183397	2183397	2183397
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

Notes - 2013
Source: IDPH, STD Section - final 2013 case counts.
Denominator: 2010 Census population estimate.

Notes - 2012
Source: IDPH, STD Section, and 2010 Census.

Notes - 2011
Source: IDPH, STD Section, and 2010 Census.

Narrative:
The 2013 rate of chlamydia among women ages 20-44 was 13.1 per 1,000, similar to the rate of 13.3 per 1,000 seen in 2012. Nearly 29,000 women were reported to have a case of chlamydia in 2013. The general increase in chlamydia rate during 2009-2013 may be partially attributable to increased STI screening and testing in Illinois.

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.

/2015/ The statewide Preconception/Interconception Care Committee has disbanded. However, IDHS MCH Nurse Consultants are available to provide training on the topic and demonstrate how to integrate this into client education to any health provider that serves pregnant and parenting women. In the past year they have provided training to MIECHV and other Home Visiting providers, Family Case Management providers, and the Better Birth Outcomes providers. Additionally, they have developed an addendum to the March of Dimes, Becoming A Mom curriculum related to interconceptional health for use in all Better Birth Outcomes projects in Illinois. //2015//

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//

/2015/ The Childhood Asthma Initiative includes education of families with asthma, school and daycare staff, community groups and residents in low resource urban communities; identification and training of school parents using a comprehensive asthma education training curriculum; and supervision of community educators working with families of children with asthma on mitigation of asthma triggers and decreasing morbidity from the disease. Asthma education in this project continues throughout the city. The low resource communities specifically targeted for more intense intervention include Altgeld Gardens, Englewood, Pilsen, Little Village, and Back of the Yards.

The Asthma Initiative addresses asthma in the Altgeld Gardens/Murray Homes community through a partnership with Mobile CARE asthma vans, which provide asthma treatment, education and follow up care for students at more than 50 Chicago Public Schools. Mobile CARE schedules visits to a different school each day so that children with asthma can receive asthma care without having to miss more than an hour of school. Mobile CARE patients receive spirometry measurements in addition to their quick reliever, controller, and/or allergy medications. Within the Altgeld Gardens/Murray Homes community, families of children with asthma in the community receive additional education from the asthma educator, parents at the schools are trained to give presentations about the disease and families whose children continue to have uncontrolled asthma receive follow up home visits. Mobile CARE, in partnership with the UICSPH Childhood Asthma Initiative, is currently exploring options of expanding into the Roseland Community in collaboration with the Roseland Hospital. //2015//

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 2013		FY 2014		FY 2015	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	21700000		21700000			
2. Unobligated Balance *(Line2, Form 2)*	0		0			
3. State Funds *(Line3, Form 2)*	27260000		27260000			
4. Local MCH Funds *(Line4, Form 2)*	0		0			
5. Other Funds *(Line5, Form 2)*	234159600		234159600			
6. Program Income *(Line6, Form 2)*	7760000		7760000			
7. Subtotal	290879600		290879600			
8. Other Federal Funds *(Line10, Form 2)*	416111558		423189908			
9. Total *(Line11, Form 2)*	706991158		714069508			

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2013		FY 2014		FY 2015	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	20800000		20800000			
b. Infants < 1 year old	39759000		39759000			
c. Children 1 to 22 years old	183450600		183450600			

d. Children with Special Healthcare Needs	16060000		16060000			
e. Others	30010000		30010000			
f. Administration	800000		800000			
g. SUBTOTAL	290879600		290879600			
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0			
b. SSDI	100000		91000			
c. CISS	105000		105000			
d. Abstinence Education	0		0			
e. Healthy Start	1484650		1484650			
f. EMSC	0		0			
g. WIC	352933300		352933300			
h. AIDS	0		0			
i. CDC	0		0			
j. Education	19579600		19579600			
k. Home Visiting	0		0			
k. Other						
Child Care	1066000		1066000			
Family Violence	2574500		2574500			
MIECHVP	3135997		3136997			
Other Demonstrations			7901500			
Substance Abuse	16466293		16466293			
Title X	6742978		6742978			
Title XX	10908090		10908090			
UNHS	225000		200000			
Other demonstrations	790150					

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2013		**FY 2014**		**FY 2015**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	113597000		113597000			
II. Enabling Services	133092100		133092100			
III. Population-Based Services	29954000		29954000			
IV. Infrastructure Building Services	14236500		14236500			
V. Federal-State Title V Block	290879600		290879600			

Grant Partnership Total						

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//

/2014/ IDHS reported a steady state in expenditures for FFY'12.//2014//

/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//

/2014/ In FFY'12 UIC-DSCC expended $14.8 million for CSHCN from all sources, which is an aggregate decrease of
$1.5 million from FFY'11. Other funding resources accounted for $1.1 million of the decrease while State resources
only decreased by $0.095 million. The federal Block Grant fund spending also decreased by $0.325 million in FFY'12.
//2014//

***/2015/ In FFY'13 UIC-DSCC expended $14.1 million for CSHCN from all sources, which is an aggregate decrease of
$0.7 million from FFY'12. Spending from other funding resources increased slightly by $0.09 million while State
resources spending declined by $0.6 million. The Federal Block Grant fund spending also decreased by $0.1 million in
FFY'13. //2015//***

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//

/2014/ Expenditures by type of individuals held steady across all categories. //2014//

/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//

/2014/ UIC-DSCC spent 9.2 percent or $1.5 million less on CSHCN services than in FFY'11. The federal MCH Block
Grant funds spent to support the CSHCN decreased by 4.8%, while the amount spent from State and Other
Resources was reduced by $1.2 million from FFY'11 to FFY'12. //2014//

***/2015/ UIC-DSCC spent 4.7 percent or $0.7 million less on CSHCN services than in FFY'12. The Federal MCH Block
Grant funds spent to support the CSHCN decreased by 1.5%, while the amount spent from State and Other
Resources was reduced by $0.5 million from FFY'12 to FFY'13. //2015//***

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//

/2014/ Illinois expended approximately the same amount that was budgeted across all types of services.//2014//

/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 heath 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//

/2014/ In FFY'12 UIC-DSCC spent $5.3 million on enabling services and $4.2 million on infrastructure building
services. Enabling service expenditures decreased slightly from FFY'11 while infrastructure service spending
decreased $0.857 million from FFY'11. The amount spent on direct services was reduced from $5.2 million in FFY'11
to $5.1 million in FFY'12. //2014//

***/2015/ In FFY'13 UIC-DSCC spent $5.0 million on enabling services and $5.3 million on infrastructure building
services. Enabling service expenditures decreased slightly from FFY'12 while Infrastructure service spending
increased $1.1 million from FFY'12. The amount spent on Direct services in FFY'13 was reduced from $1.3 million in
comparison to FFY'12. //2015//***

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//

/2014/ UIC-DSCC continues to face reductions in all sources of funds available for CSHCN. In FFY'12 UIC-DSCC spent
$14.8 million for CSHCN, which is a reduction of $1.5 million from FFY'11. Spending for enabling and direct services
decreased marginally to $5.3 million and $5.1 million respectively. Services such as transportation assistance, care

coordination and medical services remained fairly constant. Funding spent on infrastructure building decreased more
significantly by $0.857 million in FFY'12. This decrease is a result of State driven budget cuts and overall reduced
funding. Therefore UIC-DSCC has continued to be restrained in staff hiring and replacement while not reducing the
quality of CSHCN service delivery. //2014//

***/2015/ UIC-DSCC continues to address reductions in all sources of funds available for CSHCN. In FFY'13 UIC-DSCC
spent $14.1 million for CSHCN, which is a reduction of $0.7 million from FFY'12. Spending for enabling and direct
services decreased to $5.0 million and $3.6 million respectively. Funding spent on infrastructure building increased
by $1.1 million in FFY'13. UIC-DSCC is continuing to be restrained in staff hiring and replacement while not reducing
the quality of CSHCN service delivery. //2015//***

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.