



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

**State Narrative for
Illinois**

**Application for 2009
Annual Report for 2007**



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I. General Requirements

A. Letter of Transmittal

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

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

The Department's 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 Office of Family Health's headquarters in Springfield. Copies may be obtained by writing or calling the office:

Ralph M. Schubert, M.Sc., M.A.
Acting Associate Director for Family Health
Division of Community Health and Prevention
Illinois Department of Human Services
535 West Jefferson Street
Springfield, IL 62702-2736

/2008/ The Department's assurances and certifications of compliance with federal statutes and regulations that pertain to the Maternal and Child Health Block Grant are on file at the Division of Community Health and Prevention's headquarters in Springfield. Copies may be obtained by writing or calling the Project Director at:

Myrtis Sullivan, M.D., M.P.H.
Associate Director for Family Health
Illinois Department of Human and Prevention
1112 S. Wabash St.
Chicago, IL 60605
(312) 814-2434 //2008//

/2009/The Department's 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 Division of Community Health and Prevention's headquarters in Springfield. Copies may be obtained by writing or calling the office:

***Myrtis Sullivan, M.D., M.P.H.
Associate Director for Reproductive and Early Childhood Services
Illinois Department of Human Services
Division of Community Health and Prevention
1112 S. Wabash St.
Chicago, IL 60605
(312) 814-2434 //2009//***

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; expires May 31, 2009.

E. Public Input

The 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, 2006. 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; the Family Planning Advisory Council; the Perinatal Advisory Committee; the Genetic and Metabolic Diseases Advisory Committee; the Genetics Task Force of Illinois; Voices for Illinois Children; the Maternal and Child Health Training Program at the University of Illinois at Chicago School of Public Health; the Illinois Association of Public Health administrators; the Illinois Public Health Nursing Administrators Association; the Northern Illinois Public Health Consortium, Family Voices of Illinois; the Newborn Hearing Screening Advisory Committee; and DSCC's Family Advisory council. A legal notice inviting public comment was published in the Edwardsville Intelligencer. The Department received comments from only one organization during the public comment period: the Family-to-Family Health Information and Education Center at The ARC of Illinois. This organization 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. Department and DSCC staff have been meeting with the Family-to-Family Health Information and Education Center to develop plans to address these concerns.

/2009/ The 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 5 and June 27, 2008. A draft was distributed to the same committees as in 2007. A legal notice inviting public comment was published in the Edwardsville Intelligencer. In commenting on the draft, the ARC of Illinois Family-to-Family Health Information and Education Center, strongly encouraged the Title V program to examine the Prioritization of Need for Services (PUNS) database operated by DHS and direct MCH services to the entire population of children with disabilities.

As of July 2008, 14,954 individuals were interviewed by developmental disability service providers for urgency of need for services. The service needs of these individuals were categorized accordingly: emergency (need immediate services), 2670; critical (need services within a year), 7776; and planning (need services within five years), 4508. These statistics were reported through the DHS Division of Developmental Disabilities' Prioritization of Urgency of Need for Services (PUNS) database. The database provides information of type of services needed as well as the urgency with which they are needed. Information regarding referrals and source of referrals is not gathered by PUNS. Nonetheless, the Division of Developmental Disabilities (DD) works with other programs within DHS as well as other departments to promote referrals to PUNS.//2009//

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2008/ The State of Illinois evidenced significant improvement in several of its performance measures: the rate of birth for teenagers (NPM #8), the prevalence of childhood lead poisoning (SPM #5), and the proportion of children under 36 months of age in WIC or Family Case Management who received at least one developmental screening test (SPM #9). A new State Performance Measure on the percentage of females 15-24 years of age receiving services at Title X Family Planning clinics who received at least one test for Chlamydia (SPM #10) is included in this application. It replaces the original State Performance Measure #7 - the incidence of Chlamydia among adolescents and young adults. //2008//

/2008/ Illinois Department of Human Services (IDHS) will host a statewide Infant and Maternal Mortality Summit in Chicago on October 24-25, 2007. This summit will bring key stakeholders (including elected officials, community-based agencies, health care and service providers) together to develop and implement a statewide strategic plan to improve infant and maternal outcomes in Illinois. //2008//

/2008/ Statewide mortality data were released July 12, 2007 by the Illinois Department of Public Health (IDPH). Statistics available at this application's deadline are included in Form 12. A formal analysis of mortality statistics will be presented to HRSA at the MCH Services Block Grant application review meeting in August 2007 and submitted as an amendment to the application in September 2007. //2008//

/2009/ The Illinois Maternal and Child Health Coalition sponsored a two-part summit on Maternal and Infant Health in order to focus attention on the racial disparity in infant mortality and to develop new approaches to addressing this problem. The 10 broad strategies recommended by the summit include:

1) Increase access to comprehensive sex education including family planning; 2) Access to affordable health care for all across the lifespan; 3) Provide children's allowances i.e. universal income based supports similar to European countries; 4) Provide maternity/paternity paid leave; 5) Ensure the quality of prenatal and general healthcare in all communities; 6) Integration of case management systems and provide local resources for communities to develop systems of care; 7) End racially discriminative policies and practices in public institutions-such as education and housing, and criminal justice; 8) Maintain effective and efficient health data systems that provide timely health information that can be used to generate action; 9) Institute a public campaign to improve community mores in support of pregnant women; and 10) Advocate for community economic development in areas of employment, housing, and education in a manner that engages and empowers communities. //2009//

III. State Overview

A. Overview

/2007/ All of Section III was rewritten for the FFY 2007 application.

Population. Illinois ranks fifth in the nation in population, with 12.8 million people, including 3.4 million children under the age of 18, according to Census Bureau's population estimates as of July 1, 2005. In the year 2005, 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 181,200 live births annually. An average of 43,600 pregnancies are aborted each year.

According to the 2002 National Survey of Children with Special Health Care Needs (CSHCN), there are about 379,436 CSHCN in Illinois, or 11.6 percent of children under 18 years of age. In comparison, the survey identified 9.4 million CSHCN nationally, or 12.8 percent of children under 18 years of age. The survey identified 323,385 Illinois households with a CSHCN, or 19.2 percent of the state's households. Twenty percent of all households in the nation had a CSHCN. DSCC serves approximately 23,000 CSHCN with their current resources.

/2009/ According to the 2005-2006 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. //2009//

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, and two 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 2005 population estimates, there were 18 counties outside the collar counties whose populations exceeded 100,000. Other than these population centers, Illinois is characterized by rural areas. Using the USDA Rural-Urban Continuum classification scheme and 2004 population data, 66 of the 102 counties are considered rural. About two-thirds of Illinois' population (Chicago and the collar counties) is concentrated on less than ten percent of its land, while the majority of the state is characterized by small towns and farming areas.

In 2005, the U.S. Census Bureau estimated that 79.5 percent of the state's population was Caucasian, 15.2 percent was African-American, 4 percent was Asian, Native Hawaiian or Other Pacific Islander, 0.3 percent was Native American, and 1.0 percent was multiracial; 14 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's (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. All but ten counties (92 percent of Illinois) have some category of HPSA designation: 36 are geographic; 42 are low-income population; and 14 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 of CSHCN in some rural areas may have to travel three hours to access specialists' services.

/2008/ All but 22 counties (78 percent) of Illinois have some category of HPSA designation: 39 are geographic; 24 are low-income population; and 17 are sub county level. //2008//

Summary of Health Status. The most important health care needs of the state's population can be considered by population group:

/2008/ Recency of Vital Statistics data varies: 2004 for mortality statistics, and 2005 for natality statistics. //2008//

/2009/ Recency of Vital Statistics varies: 2005 for mortality statistics and 2006 for natality.//2009//

Maternal and Infant Health

Early and continuous access to prenatal care remains a challenge. Overall, 81 percent of the pregnant women in Illinois initiate prenatal care in the first trimester, while 79 percent receive adequate care (using the Kotelchuck Index of adequate prenatal care) throughout pregnancy.

Illinois' infant mortality rate has declined steadily for the past decade, and has declined 25 percent since 1993. The rate of 7.3 per 1,000 for 2004 is the second-lowest for the State of Illinois. The state's 2003 rate (7.6 per 1,000) still compares unfavorably with the provisional rate for the nation as a whole (6.9 per 1,000). Significant racial disparities in infant mortality persist by racial and ethnic groups: the rate for African-Americans is more than twice that of Caucasians (2.5:1 in 2004). The 2003 rate for African-American babies dropped to 14.8 per 1,000 live births in 2004 from 15.6 in 2003. The Caucasian rate dropped from 6.1 per 1,000 live births in 2003 to 5.9 in 2004. Chicago's infant mortality rate fell to 8.4 deaths per 1,000 live births in 2004, down from 9.6 in 2004 and surpassing the previous low of 8.6 per 1,000 live births in 2002. The downstate infant mortality rate (all geographic areas outside the city of Chicago) rose slightly from 6.8 per 1,000 live births in 2003, to 6.9 in 2004.

A total of 180,665 infants were born to Illinois residents in 2004 and 1,317 infants did not live to their first birthday that year.

/2008/ IDHS and Illinois Department of Healthcare and Family Services (IDHFS) have partnered with private funders and have developed a pilot program in the North Lawndale and Austin communities in Chicago to test a performance-based approach to reimbursement for intensive outreach to engage otherwise hard to reach women. The project Healthy Births for Healthy Communities was launched on July 1, 2006. //2008//

/2008/ Closing the Gap's Study of the Quality of Prenatal Care. This project allows IDHFS to perform an evaluation of the content and quality of medical care provided in Closing the Gap's target areas. Closing the Gap is funding the collection and preliminary analysis of medical record data. The Michael Reese Health Trust (MRHT) Partnership funds support a more in-depth analysis of the data by faculty from the University of Illinois at Chicago School of Public Health's Maternal and Child Health Training Program. //2008//

/2008/ Closing the Gap Medical Record Review. IDHFS and IDHS are working closely on this project. IDHFS, through its Peer Review Organization, is responsible for performing a prenatal care medical record review. Additionally, the MRHT provided grant funds to allow IDHFS to perform an evaluation of the content and quality of prenatal care in the Closing the Gap communities using the data from the medical record review. IDHFS is working with the University of Illinois at Chicago, School of Public Health to perform the evaluation. The medical record review, which began in November 2006, is currently in process. This project will result in development of a training curriculum to address issues identified in the evaluation. //2008//

/2008/ Behavioral Health Risk Assessment. IDHFS recently received a grant from the March of Dimes to implement a behavioral health risk assessment statewide, and is working with the Children's Research Triangle/National Training Institute Upstream to provide consultation and training services and to develop a comprehensive continuum of screening, assessment, brief intervention, and treatment of pregnant women at risk for substance abuse (alcohol, tobacco, and illicit drugs), depression, and domestic violence. //2008//

Childhood Health

According to CDC's National Immunization Survey data, the proportion of children in Illinois who are fully immunized reached 83.7 percent by December 2004 (the most recent data available at the time of submission).

/2008/ According to CDC's National Immunization Survey data, the proportion of children ages 19-35 months in Illinois who are immunized with the 4/3/3/1 series reached 84.8 percent by December 2005 (the most recent data available at the time of submission). //2008//

During FFY 2004 (the most recent data available), more Medicaid-eligible children received well child screenings than in previous years, based on the Center for Medicare and Medicaid Services (CMS) definitions. Approximately 1,221,600 children were eligible for Medicaid in FFY'04 and the overall participation ratio was 72.3 percent.

/2008/ The IDHFS is in the process of updating the Central Management System (CMS) 416 report at this time, and is unable to provide the number of Medicaid-eligible children and actual participation ratio based on the CMS definition. However, based on the Department's Medicaid claims data, there were 1,369,135 Medicaid-enrolled children for FFY05 and 1,461,933 Medicaid-enrolled children for FFY06. //2008//

Adolescent Health

The number of teen births has declined by 16 percent in the last five years, and the proportion of infants born to teenage mothers has declined by 16 percent at the same time. There were 17,819 births to teenagers in 2004; this represented 9.9 percent of all live births in the state. More than 88 percent of these young mothers were unmarried at the time they gave birth, posing a significant challenge for obtaining and maintaining economic self-sufficiency.

While the number of teen births decreased among Caucasian and African-American teens between 2000 and 2004, the number of births in that time period to Hispanic teen mothers peaked at 6,004 in 2001 and then dropped to 5,561 in 2004. While the number of Hispanic teen births in the city of Chicago decreased by 431 births between 2000 and 2004, the number downstate increased by 89 births. Most of these births occurred in the metropolitan counties surrounding the city of Chicago.

Reproductive Health

Illinois has about 706,500 women of reproductive age in need of subsidized family planning services. Illinois' Family Planning program had enough resources to serve only 21 percent of the women in need during CY'04.

Children with Special Health Care Needs

Through increasing awareness efforts, the Medical Home concept has now become a part of several grant activities in Illinois that involve quality improvement processes in physician practices, improving access to a Medical Home in the Head Start Association and Epilepsy Foundation, a Care Coordination Organizer funded through the American Legion, and a web-based information source for families and physicians about chronic health conditions managed in the primary care setting. Increased family and physician awareness of the Medical Home concept was accomplished through presentations at hospital grand rounds, in-office educational programs, new articles, various family programs, and word of mouth. For additional information on Medical Home grant activities, see Federal Performance Measure 3.

/2008/ DSCC has become involved in several activities that focus on spreading the Medical Home concept in multiple situations. In 2004, the Illinois Chapter of the American Academy of Pediatrics (ICAAP) obtained a \$1 million four-year grant to assist pediatric practices to implement a quality improvement process using the medical home model as the foundation of care. Nearly 20 practices participate in this grant activity. The DSCC Director is the principal investigator for this grant. DSCC participated in the second National Initiative for Children's Healthcare Quality

(NICHQ) Medical Home Learning Collaborative as well as the NICHQ Medical Home and Epilepsy Learning Collaborative. DSCC has also provided administrative and technical support to the national American Academy of Pediatricians (AAP) for development of a website for families to create a Medical Home Organizer. Families will be able to choose the separate contents from 20 state care organizers to customize their own child care notebook. The organizer will be available on the AAP Medical Home website under parent tools. DSCC continues to promote family and physician awareness of the Medical Home concept through presentation, the DSCC website, publications, brochures, and posters. //2008//

/2009/ In Illinois, the four-year Maternal Child Health Bureau grant will be ending in June 2008. This grant activity is demonstrating the value of a trained facilitator to structure quality improvement in a primary care practice setting. Other medical home activities include the development of an online "build your own care notebook" on the AAP www.medicalhomeinfo.org website. This is complete with a six-part tutorial to assist families and workshop facilitators to navigate through the website. The Arc of Illinois' website that houses the LifeSpan Database has now been expanded to include a wide variety of categories to list community resources for CSHCN.

Staff of the Genetics Program at IDPH have been involved with a seven state, regional HRSA funded project, the Region 4 Genetics Collaborative, focused on linking children with heritable disorders with a Medical Home. //2009//

The Illinois Interagency Coordinating Council on Transition has focused efforts on cross-agency training for member agencies on transition planning and services to improve access to transition services for youth with disabilities and their families. IDHS, IDPH, and DSCC have focused efforts on improving screening, evaluations, interventions, and reporting for newborns through the Newborn Hearing Screening Program. To improve access to care, DSCC is involved in the development of a Region 4 genetics website to increase physician and family awareness of newborn screening information and resources. Illinois screens newborns using tandem mass spectrometry for all conditions except cystic fibrosis.

/2009/ To improve access to care, DSCC is involved in the development of a Region 4 genetics website to increase physician and family awareness of newborn screening information and resources. Illinois screens newborns using tandem mass spectrometry for all conditions except cystic fibrosis.//2009//

/2008/ The Medical Home information website as part of the Region 4 Genetics Collaborative is for parents and physicians and is located at this site: www.genetics4collaborative.org. //2008//

/2008/ DSCC is collaborating with ARC of Illinois Life Span Database to expand the listing of community resources to all 102 counties in Illinois. DSCC staff, the Brain & Spinal Cord Injury Association, and the Autism Project are collaboratively contributing their respective lists of community resources to the database. Families and Medical Home providers can use this website to provide more comprehensive care for children and youth. //2008//

/2008/ Staff of the ARC of Illinois Family-to-Family Health Information and Education Center and the DCHP engaged in a series of meetings to develop strategies for reaching as many families as possible whose children have special health care needs but do not fall within the medical eligibility criteria for DSCC. //2008//

/2009/The staff of the Family to Family Health Information and Education Center will conduct workshops throughout the state to assist families and other professionals to navigate through the AAP www.medicalhomeinfo.org website on "Building Your Own Care Notebook". They will also participate in training Family Voices representatives throughout the states to facilitate workshops in their respective states. This training will take place in May 2008.

Staff of the Arc of Illinois Family to Family Health Information and Education Center received a small grant from Family Voices that helped to support a workshop for families on the various medical and waiver programs for children with special needs administered by the Department of Healthcare and Family Services.//2009//

Budget Highlights

/2009/ Highlights of the FY2008 budget are cost of living increases. FCM service providers received a 3% cost of living increase. The \$1.3 million increase was the first to be awarded in over a decade. Other providers that received cost of living increases were those delivering GP and TIPCM services, in total \$250,000 and \$150,000 respectively. 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 FCM services to pregnant women. A demonstration of the project will be conducted in Rockford, IL through the Winnebago CHD for the first two years of the contract. The program will then be implemented throughout the state during the remaining years of the contract. //2009//

Legislative Update

/2009/ Public Act 95-0422 amends the School Code by changing the physical examination requirement for students from "prior to entering 5th grade" to "prior to entering 6th grade." The Illinois Department of Public Health met with the Illinois State Board of Education to discuss the implementation of the Act and agreed that because the 2007-2008 school year had already commenced, the legislative change would be deferred until the 2008-2009. Public Act 95-0469, the Perinatal Mental Health Disorders Prevention and Treatment Act, became law January 1, 2008. The purpose of the law is to increase awareness and to promote early detection and treatment of perinatal disorders. Telepsychiatry: Public Act 095-0016 effective 7/18/07 authorizes IDHFS to reimburse psychiatrists provided by Telepsychiatry. Since many persons needing mental health care live long distances from a psychiatrist, this Act takes a step toward addressing the shortage of psychiatrists working in rural communities. Since signing, IDHFS has been developing the rule and procedures needed to implement this Act.//2009//

Health Care Financing. Enrollment in Health Maintenance Organizations (HMOs) 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 ten largest HMOs covered 1.5 million persons in 2005, a 38 percent decrease from the 1999 peak of 2.6 million. Four of the ten 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.

Three Managed Care Organizations (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. As of March 2006, these managed care programs served 149,497 people, a decrease of more than 25,000 people since March 2004.

/2008/ Two Managed Care Organizations (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. As of March 2007, these managed care programs served 129,077 people, a decrease of more than 20,000 people since March 2006. //2008//

/2009/As of June 2008, these managed care programs served 174,610 people, an increase of more than 28,000 people since June 2006. The increase is due to the implementation of the Primary Care Case Management program, where most IDHFS participants in Illinois have to choose a medical home.//2009//

Children in Illinois may receive publically-subsidized health insurance through Governor Blagojevich's "All Kids" initiative. All Kids has six components: All Kids Moms and Babies - coverage through Title XIX (Medicaid) for pregnant women and their infants up to age one year with income up to 200 percent of the FPL. All Kids Assist - coverage through Title XIX and Title XXI for children through age 18 with family income at or below 133 percent of the FPL. All Kids Share - coverage through a combination of Title XIX and Title XXI for uninsured children through age 18 with family income above 133 percent and at or below 150 percent of the FPL. Co-payments of \$2 per prescription and \$2 per medical visit are required, except for well-child visits and immunizations. All Kids Premium - offers coverage through a combination of Title XIX and Title XXI for uninsured children through age 18 with family income above 150 percent and at or below 200 percent of the FPL. Monthly premiums of \$15 for one family member, \$25 for two, \$30 for three, \$35 for four and \$40 for five or more family members are required. Co-payments of \$5 per medical visit, \$5 for brand name prescriptions and \$3 for generic prescriptions as well as an optional \$25 co-payment for non-emergency use of hospital emergency room services. There are no co-payments for well child visits or immunizations. Co-payments under both plans ("Share" and "Premium") are capped at \$100 per family per year. All Kids Rebate - uses Title XIX and Title XXI funds provided through a Health Insurance Flexibility Accounting demonstration program (HIFA) waiver to provide a payment to families with private health insurance coverage for their children. It allows a maximum reimbursement up to \$75 per eligible child per month for the premium costs paid by the family to purchase private health insurance that provides, at a minimum, physician's services and hospitalization. Children through age 18 with family income above 133 percent, and at or below 200 percent of the FPL are eligible. All Kids Expansion -- provides medical benefits for uninsured children under age 19 regardless of income or immigration status. The Illinois Department of Healthcare and Family Services is implementing both Disease Management and Primary Care Case Management to reduce Medicaid expenditures and provide the resources necessary for the implementation of the All Kids Expansion.

/2008/ All Kids Expansion - provides medical benefits for children under age 19 regardless of income or immigration status. It provides state funded health insurance to uninsured children through age 18 (parental income is not counted for children who are age 18) whose family income is greater than 200 percent of the FPL, and to children through age 18 who do not meet immigration requirements. Families with income greater than 200 percent of the FPL will pay co-pays and monthly premiums for All Kids Premium Levels 2 through 8 based on monthly income. The monthly premium per child under Premium Level 2 is \$40 with a maximum monthly premium of \$80 for two or more children, for Premium Level 3 is \$70 with a maximum monthly premium of \$140 for two or more children, for Premium Level 4 is \$100, with a maximum monthly premium of \$200 for two or more children, Premium Level 5 is \$150, Premium Level 6 is \$200, Premium Level 7 is \$250, and Premium Level 8 is \$300. Co-pays for services are based on Premium Level. Physician visits range from \$10 to \$25 per visit, generic prescription drugs range from \$3 to \$12 per prescription, brand name prescription drugs range from \$7 to \$28 per prescription, inpatient hospital admissions range from \$200 (25 percent of the All Kids payment rate) and outpatient services range from 5 - 25 percent of the All Kids payment rate Emergency room services range from \$30 to \$100 per visit. Families at Premium Levels 2-7 have an annual out-of-pocket maximum for hospital services ranging from \$500 to \$5,000 per child per year. All Kids expansion covers the same services as All Kids Share and All Kids Premium. //2008//

/2008/ Disease Management. "Your Healthcare Plus" is the new Disease Management program of the IDHFS beginning July 1, 2006. Your Healthcare Plus supports medical providers with the management of patients with complex chronic illnesses. IDHFS has commissioned McKesson

Health Solutions to administer the program. Provider and patient participation is voluntary; individuals eligible for the Your Healthcare Plus Program will have the right to "opt out." Currently, the program serves approximately 220,000 individuals which includes: 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 (utilizing the Health plan Employer Data and Information Set (HEDIS) definition); and 3) children and adults who are frequent emergency room users (defined as six or more visits a year.) //2008//

/2008/ New Program: Illinois Health Connect. In July 2006, the State of Illinois implemented a new program called Illinois Health Connect, which is a statewide Primary Care Case Management (PCCM) Program for most persons covered by an IDHFS Medical program. People who are enrolled in Illinois Health Connect will have a Medical Home through a Primary Care Provider (PCP). //2008//

/2008/ Through creating Medical Homes, the State expects to improve the quality of IDHFS Medical Program participant's health care, while at the same time creating cost savings. Potential enrollees will choose a PCP who will coordinate and manage their care by ensuring that they get primary and preventive health care services, including immunizations and health screenings, and that they avoid unnecessary emergency room visits and hospitalizations. Having a single PCP will also help people 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. PCPs will make referrals to specialists for additional care or tests as needed. //2008//

/2008/ Over 1.5 million patients including one million children enrolled in All Kids, 40,000 adults enrolled in FamilyCare and 100,000 elderly or disabled adults are eligible for Illinois Health Connect and will choose one PCP to act as their medical home. Physicians willing to provide a medical home for patients must enroll as an Illinois Health Connect PCP. //2008//

/2008/ The mandatory phase of Illinois Health Connect began in February 2007 in Cook and the collar counties. To date, there are over 2,200 providers participating as PCPs with a capacity to serve over three million patients. As Illinois Health Connect is expanded throughout the rest of Illinois, additional PCPs are being recruited. //2008//

/2009/ Illinois Health Connect is mandatory statewide. With the completion of the statewide mandatory enrollment, 96% of the eligible participants picked or were assigned to a PCP for their medical home. As new participants become eligible for Illinois Health Connect, they will have approximately 60 days to select a medical home or one will be assigned. To date, July 1, 2008, there are over 5,300 providers participating as PCPs in Illinois health Connect with a capacity to serve over five million patients. Illinois Health Connect will continue to expand the provider network through the on-going recruitment of providers not currently enrolled as Illinois Health Connect PCPs. //2009//

Illinois also provides presumptive eligibility for children under both Title XIX and Title XXI.

Illinois' FamilyCare program provides health insurance coverage to parents with income equal to or less than 185 percent of the FPL. Governor Blagojevich increased the eligibility threshold for FamilyCare to 133 percent of the FPL in September 2004 and from 133 to 185 of the FPL in January 2006. FamilyCare is financed with a combination of Title XIX and Title XXI funds and authorized by a Title XXI waiver.

FamilyCare has four components: FamilyCare Assist provides coverage for parents with incomes at or below 133 percent of the FPL. Co-payments of \$2 per medical visit and \$3 for brand-name

prescriptions are required. FamilyCare Share provides coverage for parents with income above 133 percent and less than or equal to 150 percent of the FPL. Co-payments of \$2 per prescription and \$2 per medical visit are required. Co-payments are capped at \$100 per year per family. FamilyCare Premium provides coverage for parents with incomes above 150 percent and less than or equal to 185 percent of the FPL. Monthly premiums of \$15 for one family member, \$25 for two family members, \$30 for three family members, \$35 for four family members and \$40 for five or more family members are required. Co-payments of \$5 per medical visit, \$5 per brand-name prescription, \$3 per generic prescription and \$25 for non-emergency use of hospital emergency services are required. Co-payments are capped at \$100 per family per year. FamilyCare Rebate provides a health insurance premium subsidy to families with private health insurance coverage. It allows a maximum reimbursement of up to \$75 per eligible family member per month for the premium costs paid by the family to purchase private health insurance that provides, at a minimum, physicians services and hospitalization. Eligible adults in families with incomes above 133 percent and less than or equal to 185 percent of the FPL are eligible.

In 2004, IDHFS submitted a report to the Governor and the General Assembly making recommendations on optional services for pregnant women that could be implemented under the Medicaid program to improve birth outcomes. Over the past two years, IDHFS has used that report as a guide to implement initiatives aimed at improving birth outcomes in Illinois. Since the original report was issued, many new initiatives have been implemented and Illinois has seen improvements in birth outcomes. Other initiatives will be implemented over the next two years. The status of the priority recommendations from the initial report are summarized below. The original report and the 2006 update are available at www.hfsillinois.com/mch/report.html.

//2008/ IDHFS continues to use the recommendations contained in the 2004 Report to the Governor and the General Assembly to implement initiatives aimed at improving birth outcomes. The original report and the 2006 update are available at www.hfsillinois.com/mch/report.html. Priority initiatives aimed at improving birth outcomes include the following: //2008//

//2009/ The 2008 update of the Report to the Governor and its earlier versions are available at www.hfsillinois.com/mch/report.html. //2009//

Planned Pregnancies

Two amendments to expand the Illinois Healthy Women (IWH) family planning waiver have been submitted to the federal government for approval. The first amendment requested federal financial participation in the cost of multivitamins and folic acid, and coverage of eligible women who are leaving the SCHIP program. The latter provision was approved; the former was denied. The second amendment requested expansion of coverage to include women at or below 200 percent of the FPL, regardless of their prior enrollment in Medicaid. Disposition of this amendment is pending. FamilyCare has been expanded incrementally to its current standard of 185 percent of the FPL, effective January 1, 2006. Work has begun on a new interconceptional care model targeting women who have experienced a fetal or neonatal loss, or had a premature or low birth weight infant. Reimbursement for preconceptional risk assessment will be implemented during 2006.

Mental Health During the Perinatal Period

A statewide perinatal mental health consultation services has been operating since 2004. Reimbursement for perinatal depression screening has been available since December 2004. Local health departments and other providers have been trained on how to use the Edinburgh Perinatal Depression Scale. A client brochure was developed and distributed to raise awareness of perinatal depression. The IDHFS web site includes treatment and referral resources for clients and providers. The state's toll-free hotlines have been provided with information on perinatal depression, including referral resources. A Perinatal Depression Coordination project has been implemented to coordinate perinatal depression services statewide.

//2008/ The University of Illinois at Chicago (UIC) is working with IDHFS to develop two alternative

treatment options for perinatal depression to address limited treatment resources in the state. The first option is a "step care" disease management protocol for treatment of perinatal depression in primary care settings and an accompanying quality monitoring process. The "step care" approach has been designed based on a disease management model. The "step care" approach gives providers the training and tools they need to successfully assess and treat perinatal depression and to refer women with greater symptom severity and/or insufficient treatment response. //2008//

/2008/ The second approach is a self-care tool for women experiencing perinatal depression. When medication is prescribed to treat perinatal depression, there are often other issues that are not being addressed, either due to lack of available resources, because the woman is not interested or is unable to access the services, or because services were not successful in the past. The self-care tool will provide women with suggestions for dealing with a variety of issues related to perinatal depression. //2008//

/2009/ As of September 2007, the UIC Peripartum Mental Health Consultation Service has trained more than 3,700 providers at workshops and presentations. The participants included: family medicine physicians (12.7 percent), obstetricians/gynecologists (10.6 percent), pediatricians (8.4 percent), nurses (40.8 percent), and other (27.5 percent). In addition, IDHFS has identified high-volume provider clinics statewide that are not yet billing for depression screening and UIC is targeting those sites for training. //2009//

Smoking Cessation

IDHFS has partnered with IDHS and IDPH to promote the Illinois Tobacco Quitline. Smoking cessation resources will be posted on IDHFS' web site. A client notice was mailed in November 2005 to inform beneficiaries of the availability of the Illinois Tobacco Quitline. This was followed by a provider notice in December 2005 to encourage providers to screen for tobacco use and provide treatment and referral to the Illinois Tobacco Quitline.

/2008/ MRHT awarded IDHFS a grant to fund a smoking cessation initiative to provide one-on-one peer counseling to pregnant women who smoke. IDHFS is in the process of engaging a smoking cessation expert to train three outreach workers who will provide peer counseling on smoking cessation in certain communities in Chicago. In addition, a smoking cessation patient survey is planned for 2007. //2008//

Certified Nurse Midwives are one of four advanced practice nursing (APN) specialties recognized under the Medical Assistance program (Title XIX, Title XXI and their related components) and eligible for reimbursement for services rendered. Effective January 1, 2006, all APNs (except psychiatric APNs) are reimbursed at the rate paid to physicians and are eligible to receive the enhanced rate available to "MCH providers." This may expand access to nurse midwifery across the state. This is particularly important in rural areas.

Lactation Counseling

A client notice was mailed in December 2005 to inform women of the benefits of breastfeeding and of the availability of breastfeeding education, counseling and support services available through the WIC program, the availability of breast pumps, and a toll-free hotline number for peer-to-peer breastfeeding support and counseling. This was followed by a provider notice in January 2006 containing similar information.

/2008/ To assist clients in procuring a breast pump through IDHFS, IDHS has developed a statewide list of medical providers carrying breast pumps. Procedures describing the process and requirements to receive a pump have been developed and shared with all providers. //2008//

/2009/All eligible clients can receive a double electric breast pump suitable for women periodically separated from their baby through the IDHFS durable medical equipment program. Education on the use of the pump, milk storage guidelines, etc. is provided by WIC while the pump is delivered directly to the client. Procedures describing the process

***and requirements to receive a pump have been developed and shared with all providers.
//2009//***

Case Management

IDHS and IDHFS are partnering with private funders to develop a pilot program in certain Chicago communities to test a performance-based approach to reimbursement for intensive outreach to engage otherwise hard-to-reach women.

Michael Reese Health Trust Partnership Projects. In December 2004, the Michael Reese Health Trust (MRHT) awarded IDHFS \$400,000 to support three projects for a two-year period, January 1, 2005 through December 31, 2006. Each of the projects is designed to be a pilot with an evaluation component to identify issues affecting quality of care or test the efficacy of a particular intervention in improving birth and health outcomes.

Closing the Gap's Study of the Quality of Prenatal Care. This project allows IDHFS to perform an evaluation of the content and quality of medical care provided in Closing the Gap's target areas. Closing the Gap is funding the collection and preliminary analysis of medical record data. The MRHT Partnership funds support a more in-depth analysis of the data by faculty from the University of Illinois at Chicago School of Public Health's Maternal and Child Health Training Program.

Fluoride Varnish for Young Children./Bright Smiles from Birth. IDPH, IDHFS and the IL Chapter American Academy of Pediatrics implemented a pilot project to train physicians in Chicago, the surrounding counties, and to Federally Qualified Health Centers in other parts of the State 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 and to evaluate this practice to determine its efficacy in improving oral health. The MRHT Partnership funds pay for the application of fluoride varnish and the program evaluation. Provider training is supported by a grant from the federal Health Resources and Services Administration. Additional information on this project is reported under State Performance Measure 4.

The Perinatal Depression Coordination Project involves the statewide expansion and coordination of perinatal depression services to develop a comprehensive approach to addressing perinatal depression for women enrolled in IDHFS' medical programs and builds upon the work of the Governor's Task Force on Perinatal Depression. With Michael Reese Health Trust Partnership funds, IDHFS has executed an interagency agreement with the UIC Peripartum Mental Health Consultation Service to continue perinatal depression consultation services for an additional year, coordinate the consultation services with other perinatal services throughout the state, including 24-hour client hotline and development of referral resources, coordinate perinatal depression efforts with the efforts of other initiatives designed to promote the health mental development of young children, evaluate the effectiveness of coordinated, comprehensive approach to perinatal depression and work toward a sustainable system of perinatal depression services.

Assuring Better Child Health and Development (ABCD) II. In the fall of 2003, IDHFS was selected to participate in a three-year initiative sponsored by the Commonwealth Fund and the National Academy for State Health Policy. This initiative, Assuring Better Child Health and Development II, known in Illinois as Healthy Beginnings, is designed to improve the social and emotional well-being of young children by strengthening the capacity of Illinois' Medicaid program to promote children's healthy mental development, including screening for perinatal depression. Four other states (California, Iowa, Minnesota and Utah) participate in ABCD-II. The MRHT funds the Illinois project.

Through a grant agreement with IDHFS, the Ounce of Prevention Fund (the Ounce) provides assistance in the administration of this initiative. Additionally, the Ounce subcontracts with other organizations, including the Illinois Chapter of the American Academy of Pediatrics, the Illinois Academy of Family Physicians, the Erikson Institute and the Illinois Association for Infant Mental

Health. Other state agencies, advocacy groups and providers also serve on advisory committees and subcommittees to direct and implement the project.

January 2004 marked the beginning of year one of this initiative and focused primarily on organizational and program design. Year two focused on the selection of four pilot sites, and provided training to those sites on the importance of developmental screening for children under three years of age and perinatal depression screening for mothers. The role of the pilot sites is to test best practices on how to integrate a social emotional component into primary health care and explore how Medicaid can promote children's healthy mental development. Each site was provide the Ages and Stages Questionnaire developmental screening tool, as well as the Ages and Stages Questionnaire / Social and Emotional scale at the time of their training. Each site was also trained on screening for maternal depression for mothers up to one year postpartum. During year three (2006), successful strategies learned from the pilot sites will be extended to other areas of the state. Further, a web-based training module for providers will be implemented, and an additional 40 minute training presentation is planned. In addition, IDHFS is planning to partner with the Enhancing Developmentally Oriented Primary Care (EDOPC) project. This project will also assist providers in assuring developmental screening and developmentally oriented care through the provision of technical assistance.

/2008/ On March 8, 2006, MRHT awarded \$300,000 to the IDHFS in support of the "Enhancing Developmentally Oriented Primary Care" project. In 2007, IDHFS received an additional \$139,787 from the Illinois Children's Healthcare Foundation (ICHF) allowing the extension of the program through 2008. Partners in the project include: the Advocate Health Care Healthy Steps Program, the Illinois Academy of Family Physicians (IAFP), the ICAAP and the Ounce of Prevention. //2008//

/2008/ The overall goal of EDOPC is to identify and overcome 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. 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. The EDOPC project coordinates with ABCD and the Perinatal Depression coordination project and provides technical assistance to providers. //2008//

/2009/DHS MCH Nurse Consultants and FCM Coordinator are working with EDOPC project to identify potential training sites throughout Illinois on Healthy Steps model of care, after receiving training themselves in November 2007 and January 2008. They are going out into communities across the state, working with AOK networks, FQHC's , local health departments and private provider practices. A training is planned for Region 1 and 2 providers in May and June 2008. //2009//

The Illinois Healthy Women (IHW) program is a five-year federal demonstration waiver to provide basic women's health care services, including family planning, to eligible women when they lose coverage under one of the IDHFS' Medical Assistance programs. Implementation began in April 2004. Women who are eligible for the program are systematically selected as they lose Medicaid coverage. Eligible women automatically receive a mailing about the program that includes a 3-month eligibility card, a program description and an enrollment form. A 12-month eligibility card is issued when the enrollment form is completed and returned. Under the application process, women who are at or below 200 percent of FPL can submit an application. Women who are not eligible for IHW are referred to the DHS Family Planning program for assistance.

This expansion of IHW will serve more women, allowing IDHS to use Title X funds to serve individuals who do not qualify for IHW (e.g., undocumented residents, men, women under 19 and over 44 years of age). It is estimated that approximately 44,400 additional women will be covered

under this expansion.

On February 19, 2004, the Illinois Department of Public Aid (as it was then known) submitted an amendment to the federal Centers for Medicare and Medicaid Services to request federal financial participation in the cost of multivitamins and folic acid and coverage of eligible women in the waiver who are leaving the SCHIP program. On March 28, 2006, IDHFS received approval to include women leaving the SCHIP program who are otherwise eligible for IHW in the waiver. However, the request for federal matching funds for the cost of multivitamins and folic acid was denied.

The Department of Public Aid submitted a second amendment on July 13, 2005, to request expansion of coverage to include women at or below 200 percent of the FPL, regardless of their prior enrollment in Medicaid. An expansion of IHW would serve more women, allowing IDHS to use Title X funds to serve individuals who do not qualify for IHW (e.g., undocumented residents, men, women under 19 and over 45 years of age). It is estimated that approximately 48,000 additional women will be covered under this expansion when it is approved by the Center for Medicare and Medicaid Services.

//2008/ The IHW family planning waiver expansion is being implemented in May 2007. The program will allow women to apply for coverage. They will be eligible if they: a) are at least 19, and no older than 44; b) are a U.S. citizen or legal permanent resident with a Social Security number; c) live in Illinois; d) meet the income guidelines; e) have no health insurance coverage for birth control; and f) are currently not pregnant. If the woman is pregnant, she is advised to apply for Moms & Babies by calling 1-866-ALLKIDS (1-866-255-5437). A preconceptional risk assessment tool is being piloted. //2008//

Settlement of Memisovski, et al., v. Maram, et al. The IDHFS and IDHS have signed a consent decree with the plaintiffs to settle the "Memisovski" lawsuit. The suit was a class action brought on March 23, 1992 on behalf of the Class of children in Cook County, Illinois, who, on or after July 1, 1990, have been, are, or will be eligible for the Medicaid program. The lawsuit alleged that IDHFS and IDHS violated the rights of the children in the Class by failing to provide these children with access to medical care and services to an extent at least equal to that available to the general population in the geographic area and by failing to provide them with adequate Early and Periodic Screening, Diagnosis and Treatment services. After trial, in which the Class members prevailed, the parties negotiated and signed a Consent Decree to resolve the lawsuit. The general provisions of the Decree include rate increases for "MCH providers" (physicians who agree to specific terms authorized by the OBRA'89 legislation for increased Medicaid reimbursement) and dentists, revision of Federally Qualified Health Centers rates, bonus payments for providers who meet EPSDT requirements and enhanced communication with providers and families. The rate increases were implemented on January 1, 2006.

Service Delivery System. With the exception of the Teen Parent Services program in part of Chicago, all of the primary and preventive care services in Illinois' Title V program are provided by IDHS or 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 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). As of July 1, 2004, there were 46 "resolution" health departments (those established by resolution of a county board) and 48 "referendum" health departments. These health departments serve 99.6 percent of Illinois' population.

/2008/ these health departments serve 99.7 percent of Illinois' population. //2008//

Community Health Centers. The Illinois Primary Health Care Association reports there are 155 Community Health Centers, Federally Qualified Health Centers or Healthy Schools Health 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. The Southern Illinois Healthcare Foundation is a lead agency for HealthWorks of Illinois. The Department is working with Access Community Health Network and with the Chicago Department of Public Health on the "Closing the Gap" initiative and with Lawndale Christian Health Center and PCC Wellness on the new Healthy Births for Healthy Communities project.

/2008/ The Illinois Primary Health Care Association reports there are now 281 Community Health Centers, Federally Qualified Health Centers, or Healthy Schools Healthy Communities grantees. //2008//

State-Level Initiatives. Three special initiatives at the state level will affect the service delivery system. 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: The Governor's commitment to voluntary access to high-quality early education services for all young children whose parents chose to participate; Past planning efforts; and The Council's commitment to ensuring that all Illinois children are safe, healthy, eager to learn and ready to succeed by the time they enter school.

The Governor has acted on the recommendations of the Early Learning Council to move toward preschool access for all three and four year olds whose parents want them to participate. The Governor's FY2007 budget proposal included an additional \$45 million for the Early Childhood Block Grant in each of the next three years as the first part of a five-year Preschool For All plan. The General Assembly appropriated the amount of money the Governor requested. The Preschool For All plan addresses several interrelated goals of the Council, including: Enhancing the quality of early learning programs for children birth to three and three to five that include quality assurance and evaluation; Expanding access to and the quality of early learning programs; Linking programs to others serving families with young children; and Developing the early childhood workforce to ensure an adequate, stable supply of highly-qualified and diverse individuals to staff early learning programs.

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 "Strategic Plan for Building a Comprehensive Children's Mental Health System in Illinois" was submitted to the Governor on June 30, 2005. The MCH program is represented on the Early Childhood Committee of the Partnership and its work groups. The work

of the Committee focuses on: An early childhood mental health consultation initiative, The adoption of diagnostic codes for very young children, Increasing the response to maternal perinatal depression, Establishing social emotional and developmental screening and assessment, Expanding and developing the early childhood mental health workforce, and Ensuring that parents are equal partners in the emerging children's mental health system.

/2008/ A large public awareness campaign was initiated with the release of a \$500,000 request for proposals to raise awareness that persons with mental illness can and do recover and that treatments are available and successful. Ten proposals were submitted and evaluated in early 2007. The partnership intends to begin the campaign during the SFY2008. //2008//

/2009/ To promote good mental health for everyone in Illinois, a public awareness campaign--Say It Out Loud-- was launched in May 2008. This campaign was initiated with the release of a \$500,000 request for proposals to raise awareness that persons with mental illness can and do recover and that treatments are available and successful. . The Say It Out Loud campaign uses radio spots, ads in newspapers statewide, billboards, t-shirts, brochures, palm cards, presentations and a website www.mentalhealthillinois.org. //2009//

The IDHS Bureau of Child Care and Development's Early Childhood Mental Health Consultant Pilot expanded from four to nine sites in FY2006. Each Mental Health Consultant works with childcare providers and the Child Care Resource and Referral Agency staff to provide program-level consultation and technical assistance, training, and community level support. The IDHS Bureau of Early Intervention utilizes mental health consultants and implemented a social emotional screening component at every Child and Family Connection Agency in Illinois. The Partnership received a grant from the Michael Reese Trust for a mental health consultation pilot to expand the capacity of community mental health agencies in Chicago to provide treatment services for children birth to seven years old. The partnership hosted an Early Childhood Mental Health Consultant Retreat and established a statewide early childhood mental health consultant network. A work group of the Early Childhood Committee is working toward the adoption of a Diagnostic Code: 0-3 R Crosswalk and will develop the training necessary for implementation. The Early Childhood Mental Health State Plan Work Group has written a charter to define the goals and outline the work of the group. This charter was adopted by the Directors of IDHS' Divisions of Mental Health and Community Health and Prevention. A work plan will be developed and activities initiated during FY2006.

/2008/ In FY'07 the Early Childhood Mental Health consultant pilot expanded to 13 sites. //2008//

/2009/ The IDHS Bureau of Child Care and Development's Early Childhood Mental Health Consultant Pilot is now a permanent part of the support services offered to families and providers in Illinois. Named "Caregiver Connections", the program will provide services throughout the state by the end of FY08. Each Mental Health Consultant works with childcare providers and the Child Care Resource and Referral Agency staff to provide program level consultation and technical assistance, training, and community level support.

Primary Care Psychiatric Consultation Line: The IDHFS and IDHS partnered with the Illinois Children's Mental Health Partnership to develop a model for a psychiatric phone consultation initiative for primary care providers. This psychiatric phone consultation model will provide: a statewide mental health and substance abuse consultation phone line, staffed by university based psychiatric experts, for primary care providers who treat children and adolescents; consultation on a variety of topics, including but not limited to assessment, treatment options, medication management and local community supports for publicly funded children experiencing mental health challenges; and the development of procedures and protocols for standard pediatric psychiatric conditions, including medication management. //2009//

There is a growing medical malpractice insurance crisis in Illinois. In response, the Illinois' General Assembly passed Senate Bill 0475, which limits awards for non-economic damages to \$500,000 against a physician and \$1 million against a hospital. The Illinois Department of Insurance will be required under certain circumstances to hold hearings regarding increases in medical malpractice insurance premiums. The bill was enacted in August 2005.

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.

B. Agency Capacity

Agency Capacity

The State of Illinois has the capacity to provide comprehensive quality care to pregnant women, mothers and infants, children (including those with special health care needs), adolescents, and women of reproductive age through a coordinated system of services. This system is supported primarily by the programs of the Division of Community Health and Prevention in IDHS, the Office of Health Promotion and the Office of Health Protection at IDPH, and the UIC Division of Specialized Care for Children (DSCC).

Statutory Base. The IDHS Division of Community Health and Prevention is responsible for administration of the Maternal and Child Health Block Grant, as well as the following state statutes: The Hearing Screening for Newborns Act requires hospitals to screen newborns for hearing loss. The Illinois Family Case Management Act gives IDHS statutory authority to operate the Family Case Management program and establishes the Maternal and Child Health Advisory Committee. This law replaced the Infant Mortality Reduction Act. The Problem Pregnancy Health Services and Care Act authorizes IDHS to establish projects which would assist women with problem pregnancies in obtaining services either directly or through referral. The Problem Pregnancy Health Services and Care Act authorizes IDHS to establish projects which would assist women with problem pregnancies in obtaining services either directly or through referral. The Prenatal and Newborn Care Act authorizes payment for prenatal care, delivery, postpartum care, and "two EPSDT-equivalent screenings" of the newborn.

The Illinois Department of Public Health is responsible for the administration of the following state statutes: The Developmental Disability Prevention Act authorizes regional perinatal health care in Illinois. The Phenylketonuria Testing Act authorizes newborn screening for phenylketonuria, hypothyroidism, galactosemia, "and other metabolic diseases as the Department may deem necessary." The Counties Code 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. The Illinois Lead Poisoning Prevention Act is comprehensive legislation regarding the use of lead in consumer products and dwellings. The law requires screening of children through age six; reporting results; the inspection and abatement of environmental lead hazards; and maintaining and providing educational materials. The Suicide Prevention, Education, and Treatment Act authorized IDPH to carry out the Illinois Suicide Prevention Strategic Plan. When funds are appropriated, IDPH is to develop five pilot programs that provide training and direct service programs to communities.

/2008/ The Suicide Prevention, Education, and Treatment Act authorized IDPH to carry out the Illinois Suicide Prevention Strategic Plan. It directs IDPH to appoint an advisory board to oversee the development and implementation of the Illinois Suicide Prevention Strategic Plan. In addition to the strategic plan, it also is charged with implementing: 1) a statewide suicide prevention

conference; 2) a media campaign; 3) a public awareness campaign; 4) education initiatives; and 5) when funds are appropriated, develop five pilot programs to provide training and direct service programs to communities. //2008//

The Reduction of Racial and Ethnic Disparities Act 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." This bill was enacted in August 2005.

In 1957, The Specialized Care for Children Act designated the University of Illinois as the agency to administer funds from "the United States Children's Bureau of the Department of Health, Education and Welfare" to support "a program of services for children who are crippled or suffering from conditions which may lead to crippling, including medical, surgical, corrective and other services and care, and facilities for diagnosis, hospitalization, and aftercare for such children."

Overview of Programs and Services. Illinois' Title V program focuses on three main areas: the reduction of infant mortality; the improvement of child health (including the health of children with special health care needs); and the prevention of teen pregnancy. Within these broad priorities are seven groups of programs: preconceptional; pregnancy; infancy and early childhood; middle childhood; adolescence; children with special health care needs; adults; and infrastructure development. Each group of programs is discussed below: Preconceptional. The Family Planning program and IDHFS' Illinois Healthy Women program are the state's primary strategies for improving preconceptional health. This program provides comprehensive family planning services related to the avoidance, achievement, timing, and spacing of pregnancy. Services include client education, counseling, screening, infertility services, pregnancy testing and options counseling, contraceptive methods, and identification and treatment of sexually transmitted diseases. Services are available statewide through a network of delegate agencies. A new protocol for preconceptional education was implemented this year. Further, Family Case Management program grantees can use a limited amount of their grant funds to provide family planning services for the medically indigent when there is no delegate agency nearby. All family planning services are provided in accordance with federal regulations for the Title X program. The Family Planning program is also supporting two male responsibility demonstration programs in Chicago.

/2008/ On June 20, 2007, IDHS sponsored a statewide satellite production that introduced a protocol for preconceptional education to Family Planning providers. Approximately 200 service providers attended this satellite training. Requests for copies of the production topped 300 and more requests continue to be satisfied. //2008//

/2009/ A statewide Pre/Interconceptional Care Committee was formed in FY'07, with the goal of developing and implementing a 3-5 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. //2009//

/2009/ A satellite training on Motivational Interviewing is planned for June 17th, 2008. The purpose of the training is to instruct providers in techniques to conduct interviews in a manner that promotes self-care and self-management around various health issues, including pre/interconceptional care. //2009//

/2009/An Interconceptional Care Pilot project, Healthy Births for Healthy Communities, continues on the westside of Chicago. The model is intended to improve birth outcomes in the pilot communities and targets women who have experienced a recent fetal or neonatal loss, or had a premature or low birth weight infant. To date, 83 women have enrolled. They

are followed by a nurse care manager and a community case manager who are in close regular and ongoing consultation with the participant's health care provider. Intervention lasts for 18 months and includes education related to reproductive health and linking with identified needed services., based on a variety of assessments. These women select a minimum of one self-care goal. In the past 18 months, only two women in the program have become pregnant.//2009//

//2009/ IDHFS, in partnership with IDHS launched a pilot to test a preconception care risk assessment tool in FY'08. This initiative allows IDHFS to develop, test, evaluate and validate a risk screening tool for preconception care. Once the tool has been tested, evaluated and validated, IDHFS intends to provide reimbursement for preconception risk screening, if found effective.//2009//

//2009/ Initial reports indicate that only 50 percent of postpartum women have a contraceptive method identified in their Cornerstone record, and a fraction have a documented referral to a family planning provider. In FY'09, FCM providers will be monitored for documentation of a family planning and the Integrated Plan for FCM and WIC services will include an objective related to referral of clients to a family planning provider. //2009//

Three other strategies are used to improve preconceptional health. The IDPH supports a statewide genetic counseling program through grants to medical centers for diagnostic, counseling and treatment services; through grants to local health departments for genetic case-finding and referral; and through grants to pediatric hematologists at medical centers that offer diagnosis, treatment, counseling and other follow-up services. The Title V program also works with the Illinois Chapter of the March of Dimes to conduct a statewide campaign promoting the consumption of folic acid. Finally, the Nutrition Services Section in the Division of Community Health and Prevention leads the state's Five A Day for Better Health initiative.

//2008/ The Five A Day program changed to the Fruits and Veggies - More Matters program in 2007. //2008//

Prenatal. The Title V program uses an array of services to improve pregnancy outcomes, including direct health care, enabling and population-based services. Direct health care services are provided through the "mini" block grant awarded to the Chicago Department of Public Health and, on a limited basis, through the Family Case Management program. (The "mini" block grant is described more fully below.) Two statewide enabling service programs are central to the Title V program's infant mortality reduction efforts: the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Family Case Management (FCM). The WIC program provides nutrition education and supplemental foods to pregnant or lactating women and children under the age of five from low-income families. FCM provides service coordination to low-income families with a pregnant woman or an infant.

The Title V program includes several targeted enabling service initiatives for pregnant women in particular areas or with particular health conditions. First, Targeted, Intensive Prenatal Case Management projects are placed in communities with high Medicaid expenditures during the first year of life and seek to prevent low birth weight. The number of agencies expanded in SFY'06 from 10 to 13. IDHS, IDHFS and several private foundations have worked together to develop and implement Healthy Births for Healthy Communities, which will provide performance incentives for outreach to high-risk pregnant women in two Chicago Community Areas. IDHS was awarded one of the original 15 Healthy Start projects to serve six community areas in Chicago's inner city. The Department also operates a federally-funded Closing the Gap project targeted to four Chicago Community Areas with high African-American infant mortality rates. The latter two projects are supported with grants from the Maternal and Child Health Bureau. IDHS continues to work with the AIDS Activity Section within IDPH to train prenatal care providers on strategies to prevent perinatal transmission of the HIV. Legislation has been passed to allow for the

implementation of rapid HIV/AIDS testing of pregnant women.

/2009/ Results of an evaluation of Closing the Gap suggested that ensuring access to prenatal care is not sufficient if that care is not responsive to a woman's unique needs and does not meet the recommended standards of care suggested by professional organizations and public health professionals. Not considering risk status, the study provided evidence that the quality/content of prenatal care provided to low-income women on Medicaid in four Chicago community areas did differ somewhat by care provider. When just examining the unadjusted relationship between provider type and content/quality of care it appeared that the majority of women receiving care from physicians were receiving content in the middle of the distribution (50-79%); compared to FQHCs, physicians were twice as likely to provide medium quality care as opposed to the highest quality care. //2009//

/2009/ In FY'08, FCM services were reinstated at the Cermak Women's Unit at the Cook County jail, for women who are pregnant at time they are arrested and incarcerated. Women are primarily African American and Hispanic, the majority of whom are less than 30 years of age. Two case managers are housed inside the jail and complete an assessment of client needs. Prior to discharge, the case managers assist the woman in access housing and intervention programs, as well as prenatal care services. An external Case Manager works with each woman upon discharge to assure she accesses community programs and stays connected with prenatal care. Approximately 50 new inmates a month are enrolled in the program. //2009//

Finally, at the population level, IDPH administers the state's regionalized perinatal care system. Four levels (capabilities) of perinatal care are well-defined in administrative rules: basic or Level I, intermediate or Level II, specialty or Level II+ with extended capabilities, and sub-specialty or Level III, with all facilities integrated into networks of care. Program 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. These services begin with two newborn screening programs. The state has supported a metabolic screening program for many years. The IDPH Newborn Screening Laboratory performs centralized testing on all samples and results are reported to IDPH Newborn Screening follow-up program staff. Infants with positive results for a genetic or metabolic disorder are followed through case closure or through diagnosis and initiation of treatment, and annually through 15 years of age. DSCC supports diagnostic evaluations necessary to establish a potentially DSCC eligible diagnosis. DSCC also provided care coordination for those children with eligible conditions, and financial assistance for specialty medical care if financial eligibility criteria are met. For young children who are deaf or hard of hearing, 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 the Illinois State Board of Education. On July 1, 2002, the newborn screening program added tandem mass spectrometry testing of all newborns for amino acids, organic, and fatty acid oxidation disorders. The Newborn Hearing Screening Program is jointly administered by IDHS, IDPH and DSCC. Hospitals report all hearing screening results to IDPH. The child's parents and physician are notified of the test results and provided with an informational brochure with guidance for follow-up testing. DSCC pays for diagnostic testing if the family does not have insurance coverage or financial assistance through the program for this service. Infants are referred as indicated to the CSHCN program and the Part C Early Intervention program.

/2008/ In July 2007, screening for cystic fibrosis will be added to the screening panel. In addition, screening for Lysosomal Storage Disorders is being considered in the next several years. //2008//

/2009/ The Governor signed Public Act 95-0695 in November 2007, which will require the

addition of screening tests for five lysosomal storage disorders, within the next three years. //2009//

The Title V program includes six statewide programs for infants and young children. The FCM program serves low-income families with infants and also serves a limited number of children who are under five years of age and are at risk for health or developmental problems. FCM grantees can use a limited amount of their grant funds to pay for primary pediatric care for medically indigent children. The WIC program also serves low-income children who are under five years of age and have a nutritional risk factor. The Early Intervention Program (authorized under Part C of the Individuals with Disabilities Education Act) provides coordinated, comprehensive, multidisciplinary services to enhance the growth and development of children from birth through 36 months of age who have developmental disabilities and delays. Services include case coordination, developmental therapy (special instruction), physical therapy, occupational therapy, speech therapy, assistive technology, nursing services, nutrition services, vision services, audiologic services and medical diagnostic services for purposes of eligibility determination. The EI program has added a social-emotional consultant in each of the 25 community-based agencies that provide intake and coordinate services for eligible families. The IDPH Childhood Lead Poisoning Prevention 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, investigates disease outbreaks, conducts educational programs, assesses vaccine coverage levels, conducts quality assurance reviews among 2,800 healthcare providers enrolled in the Vaccines for Children Program, and promulgates regulations related to vaccination. Finally, the Title V program and the Child Care program in IDHS jointly support a statewide network of Child Care Nurse Consultants who train and consult with child care providers.

The Title V program includes or works closely with several initiatives for infants and young children with particular needs or risk factors. The High-Risk Infant Follow-up Program, a component of FCM, serves infants who have a high-risk medical condition identified through the IDPH APORS program. These infants, as well as families who experience a perinatal death, are referred to local health departments for follow-up visits by registered nurses, and follow-up may continue until the child's second birthday. The Healthy Families Illinois Program seeks to prevent child abuse and neglect through intensive home visits that provide parenting skills education to high-risk families. The HealthWorks of Illinois (HWIL) Program, another component of FCM, is a collaborative effort of IDHS and the Illinois Department of Children and Family Services (DCFS) to ensure that wards of the state receive comprehensive, quality health care. The IDPH Early Childhood Caries (ECC) program integrates oral health into every WIC and Head Start program in Illinois. 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 hands-on instruction in the installation of the car seat. The program also works with state and local agencies to conduct car safety seat checks. The Sudden Infant Death Syndrome (SIDS) Program serves families who have experienced a sudden, unexpected infant death. Counseling and support services are offered to all families by a local public health nurse who has received training as a bereavement counselor.

//2009/ IDPH also provides funding to the not-for-profit organization, Sudden Infant Death Services of Illinois, to provide bereavement services for families and risk reduction education for health care providers and consumers. //2009//

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 Ounce of Prevention Fund on the Birth to Five Project to develop a comprehensive, coordinated, easily-accessible system of high-quality preventive services for children before birth and through five years of age. In 2002 Illinois

was selected as one of four states to receive funding from the Early Childhood Funders' Collaborative for the Build Initiative. Ten 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. Two additional sites initiated networks in FY2006 with Early Childhood Block Grant Funding from the Illinois State Board of Education. The Assuring Better Child Health and Development (ABCD II) Project, called Healthy Beginnings, is sponsored by the Commonwealth Fund and funded by the Michael Reese Health Trust. The purpose of Healthy Beginnings is to strengthen primary care services and systems that support young children's healthy mental development.

/2008/ The "Enhancing Developmentally Oriented Primary Care" project began in 2007 to identify and overcome 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. The EDOPC project helps Illinois' pediatric care providers through training, technical assistance and community support, implementing strategies to effectively provide developmentally oriented primary care. //2008//

Middle Childhood. The Title V program includes several programs for children in middle childhood. The Vision and Hearing Screening Program administered by IDPH 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. The Dental Sealant Grant Program (DSGP) works with interested communities to establish school-based programs for dental sealant applications, oral health education, outreach for All Kids enrollment, dental examinations and referral for dental treatment needs. Coordinated School Health Program grants are provided to 12 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 comprehensive consultation and technical assistance to schools throughout the state. Professional continuing education programs (School Health Days and Critical Issues Conferences) for qualified school and public health nurses, social workers, health educators, and school administrators are conducted annually. Forty School Health Centers provide health care services to students enrolled in elementary and middle schools. In collaboration with the IDPH Division of Oral Health, centers are serving as pilot sites to implement an oral health education curriculum into grades K-12. Two childhood asthma demonstration projects in Chicago use peer or community health educators to empower communities to deal with this complex health issue.

/2008/ Forty-one School Health Centers provide health care services to students enrolled in elementary and middle schools. //2008//

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; youth development and juvenile justice programs. The School Health Centers promote healthy lifestyles through health education and comprehensive direct physical, dental, and mental health services. Services are provided within or nearby the schools by licensed professional staff or through referral to other local health care providers. Health centers that meet established standards are enrolled as Medicaid providers. The School Health Centers engage in Continuous Quality Improvement (CQI) activities related to health risk assessment of students. The professional staff currently assesses each patient for overweight and other health problems. Health center staff then identify and implement health education, health promotion and interventions in these areas.

The Primary Teen Pregnancy Prevention Program provides support for community-based planning to reduce teen pregnancy, sexually transmitted infections and the transmission of HIV. This is done through a combination of education, service delivery and referrals appropriate to the age, culture and level of sexual experience of youth by providing services in either classroom or

community settings. The Primary Teen Pregnancy Prevention program providers focus their efforts on three of the five program components: sexuality education, family planning information and referrals, youth development, parental involvement, male involvement or public awareness.

Title V also includes four programs for teen parents. The Teen Parent Services (TPS) program is mandated for young parents (under age 21) who are receiving or applying for TANF and who do not have a high school diploma or its equivalent upon entry into the program. It is offered to young parents who receive Medicaid, WIC, FCM, or Food Stamps. TPS helps these young parents enroll and stay in school, and results in a young parent who is better prepared to make the transition from TANF or other public benefits to economic self-sufficiency. The program also assists any pregnant/parenting teen to access other IDHS programs and benefits. The Parents Too Soon (PTS) program helps new and expectant teen parents to develop nurturing relationships with their children, reduce the rate of subsequent pregnancy, improve their own health and emotional development, and promote the healthy growth and development of their children. Services include weekly home visits and monthly peer group meetings. The Responsible Parenting program assists adolescent mothers who are between 13 and 18 years of age to delay subsequent pregnancies, consistently and effectively practice birth control, continue their schooling to high school graduation, develop parenting skills and to cope with the social and emotional problems related to pregnancy and parenting. Finally, a Doula, or birthing assistant, is a woman who provides emotional support to a woman throughout the antepartum and postpartum periods. Five program sites provide Doula services beginning in the third trimester of pregnancy and continuing through the first three months following birth.

There are four youth development programs in the Division of Community Health and Prevention. The Youth Opportunity Program focuses on children who are TANF-eligible or other low-income families to help them break the generational cycle of welfare dependency and help prevent school dropout, unwanted pregnancies, and gang involvement. Students receive career development training and individual, group and family counseling. The Bureau of Youth Services and Delinquency Prevention offers community-based out-of-school time programming, as well as a comprehensive array of prevention, diversion, intervention, and treatment services targeting youth to stabilize families in crisis, prevent juvenile delinquency, and divert youth at risk of involvement in the child welfare, juvenile justice, or correctional systems. The Bureau of Community-Based and Primary Prevention funds community-based prevention initiatives and prevention training and education for youth in the areas of abstinence education, substance abuse prevention and volunteerism and community service. The Bureau's programming fosters the development of positive lifestyles and the reduction of substance abuse in Illinois through outcome/evidenced based planning and programming.

/2008/ There are now five youth development programs in the Division of community Health and Prevention. //2008//

/2008/ There also is the GEAR UP (Illinois Steps AHEAD) program, which is a discretionary grant program implemented to augment the number of low-income students who are academically prepared and ready to succeed in post secondary education. These services include college visits, tutoring, career exploration, and job shadowing. Students are accepted no earlier than seventh grade, and their progress is monitored throughout high school. //2008//

Children with Special Health Care Needs. The Title V program for children with special health care needs (CSHCN) is operated by the University of Illinois at Chicago's Division of Specialized Care for Children (DSCC). It serves approximately 23,000 children annually through the Core Program, the IDHFS Home Care Waiver Program, the SSI Disabled Children Program, and the Children's Habilitation Clinic.

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 services appropriate to the child's needs and financial support for those families who are financially eligible. The program serves children with impairments associated with the following categories: orthopedic, nervous system, cardiovascular, craniofacial deformities, hearing, organic speech, eye and urinary system and cystic fibrosis, hemophilia and inborn errors of metabolism.

Initial diagnostic evaluation services are provided in part by a network of more than 70 field clinics, consisting primarily of orthopedic clinics, administered and funded by DSCC, as well as through office visits with private physicians and other freestanding clinics. The clinic system allows medical specialists and professional staff to provide diagnostic evaluation and treatment of children with medical conditions eligible for DSCC services, assisting children to access specialists not available in their communities.

/2009/ DSCC administered and funded 56 field clinics. //2009//

DSCC has a network of 13 regional offices with care coordinators (nurses, social workers, and speech pathologists/audiologists) that develop an Individual Service Plan (ISP) for each child following the initial evaluation process to specify the care coordination services needed and the financial support required for treatment. The ISP reflects the child's and family's perceived needs, the medical needs as articulated by the managing physician, the appropriate service providers to meet those needs and all available sources of funding to address those needs.

/2008/ With the parents' permission, the ISP is shared with the child's Medical Home provider and all other specialists and therapists when appropriate. //2008//

Children with a potentially eligible condition receive diagnostic and care coordination services without regard to a financial eligibility. Families of those children requiring financial support for treatment services must demonstrate a total income below 285 percent of the federal poverty level adjusted for family size. All families must maximize existing health insurance benefits before financial assistance can be provided. Families of uninsured CSHCN who meet All Kids financial requirements are required to apply and enroll (if eligible) in All Kids in order to continue to receive financial assistance from DSCC. Children with All Kids coverage receive care coordination to assist them in accessing services and limited financial assistance for services not covered by All Kids.

DSCC employs eight bilingual staff members and has correspondence in Spanish available, including the Special Addition newsletter. Families whose primary language is not English or Spanish have use of the AT&T Language Line as a resource. In addition, the Family Advisory Council (FAC) promotes cultural diversity in its membership.

/2008/ DSCC currently employs 12 bilingual staff members to assist those families with limited English proficiency who speak Spanish. //2008//

/2009/ DSCC employed two additional bilingual staff members in the Chicago Administrative Office. These staff members provide limited English proficiency technical assistance to support care coordination staff throughout the state and promote quality in translated material.//2009//

DSCC operates the Title XIX Waiver for Home and Community-Based Services for Medically Fragile/Technology Dependent Children, which is administered through the IDHFS. The program provides cost-effective care coordination and 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. Beginning with FFY'05, the costs of skilled nursing services associated with this program have been excluded from the budget and expenditure reports in Forms 2, 3, 4 and 5.

DSCC is the agency designated to administer the Supplemental Security Income-Disabled Children's Program (SSI-DCP). Children are determined to be eligible for this program through the Illinois Disability Determination Services (IDDS), which, in turn, refers SSI medically eligible children to DSCC for further assistance. DSCC receives information on approximately 275 SSI-eligible children a month who are under 16 years of age.

/2008/ Currently, approximately 150 SSI-eligible children a month who are under 16 years of age are referred to DSCC. //2008//

/2009/ Approximately 170 SSI-eligible children a month who are under 16 years of age are referred to DSCC.//2009//

DSCC provides information and referral services to these SSI-eligible children by sending comprehensive profiles on state/local programs, including the DSCC Core Program, which may benefit the child or family. Families may request information in Spanish. Additionally, a toll-free 800 number is provided to all families to access further information and additional assistance. An application is sent to families with a child who may be eligible for DSCC services and the appropriate Regional Office provides referral follow-up. Through telephone contact or provision of program information, DSCC staff links those children under the age of five years to Part C Early Intervention, Part B Early Childhood, and Pre-Kindergarten for Children at Risk as appropriate. DSCC telephones families with children ages three to four to offer assistance in linking to appropriate resources.

/2009/ SSI-eligible children ages 14-16 years old also receive a telephone call to offer assistance in linking to appropriate resources, including transition planning resources.//2009//

The Children's Habilitation Clinic is located within the Children and Adolescent Center of the Outpatient Care Center, the University of Illinois at Chicago'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 for children with complex disabling conditions and developmental management to those children through age 21. For all second-year pediatric and medical residents at UIC's School of Medicine, and other health care students, the clinic also provides a required rotation in the care of children with disabilities. There are approximately 1,600 patient visits annually.

DSCC cosponsors the Institute for Parents of Preschool Children Who are Deaf or Hard of Hearing with IDPH, IDHS, the Illinois School for the Deaf, and the Illinois State Board of Education. This is a weeklong educational program for parents of children, ages birth to five, who have a significant hearing loss. The Institute provides an opportunity for parents to learn about deafness and their child's individual strengths and needs, as well as meet other parents who have children with hearing loss. The Institute for Parents of Preschool Children Who are Deaf or Hard of Hearing also provides multidisciplinary evaluations. At the conclusion of the Institute, parents meet with staff to discuss evaluation results and treatment recommendations and to plan for the future.

DSCC is collaborating with the Illinois Chapter of the American Academy of Pediatrics (ICAAP), the Illinois Academy of Family Physicians, and the Shriner's Hospitals for Children to identify and train Primary Care Physicians (PCP) to serve as the Medical Home Providers for CSHCN who participate in the Title V program. In order to be enrolled in DSCC, Medical Home Providers are required to complete a Continuing Medical Education (CME) Monograph on Medical Home (within six months of application), in addition to being board certified as a pediatrician or family physician and meeting the other DSCC general provider criteria. PCPs who complete training (and meet DSCC's general criteria) are able to bill for care coordination activities, follow-up on medically eligible conditions as agreed upon by the specialist, and telephone consultation, if needed with a pediatric specialist. DSCC care coordinators assist in facilitating communication and reports

among the providers involved with the individual child.

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 Early intervention (EI) program. 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. Other members of the Council represent state agencies in the following areas: education, corrections, employment/training, health, and human services.

DSCC, in collaboration with MCHB's Division of CSHCN, has developed and published a newsletter, *Special Addition*, containing articles of national and state interest. Illinois continues to coordinate the family newsletter template with more than 30 other states. *Special Addition* is available to families in both English and Spanish. ***//2009/ This collaboration ended this year. //2009//***

Adults. The Title V program supports or collaborates with several programs for adults. The Illinois Fatherhood Initiative conducts several activities to promote fathers' active participation in their children's lives. 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. Finally, the Title V program includes several infrastructure-building initiatives. The Chicago MCH Mini-Block Grant to the Chicago Department of Public Health supports direct and enabling services to pregnant women, children and women of reproductive age. The Department works with the UIC School of Public Health to conduct several leadership development program for state and local Title V program staff.

C. Organizational Structure

Organizational Structure

As described in previous MCH Services Block Grant Applications, the Governor has designated the IDHS as the state health agency responsible for the administration of the MCH Services Block Grant. 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, Childhood Lead Poisoning Prevention and Perinatal Care programs. In compliance with federal law, IDHS transfers 30 percent of Illinois' MCH Services Block Grant funds to DSCC for services to CSHCN. Copies of current interagency agreements are on file in the Division of Community Health and Prevention. Additional information about the structure of these three agencies is presented below.

The Illinois Department of Human Services. The IDHS is organized into six divisions. The Division of Community Health and Prevention (DCH&P) includes the family planning, infant mortality reduction, early childhood services (Early Intervention) and system development, 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 Supplemental Security Income Disability Determination Service, as well as programs for persons with developmental disabilities. The Division of Human Capital Development includes adult employment, income assistance, food and shelter, refugee services, child care, and special social service projects and is responsible for the Department's local offices. One or more local offices are located in almost every county of the state. Staffs in these

offices perform intake and eligibility determination for cash assistance, 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 Department has redefined the scope of its Maternal and Child Health program to include all of the programs within the Division of Community Health and Prevention that target women, infants, children and adolescents. The Division has implemented an interim organizational structure. The Director of Community Health and Prevention will now serve as Illinois' Title V Director. Responsibility for operational supervision of the eight program bureaus and the regional Community Support Services Consultants has been placed in an Associate Director for Community Support. The former Offices of Family Health and Prevention have been dissolved. The two Associate Directors advise the staff of all Division programs regarding policy and represent the Division to advocacy and provider groups, legislators, task forces, boards and other groups that affect the Division's services. The Division has established an Office of Program Planning and Development to support performance management, program evaluation, grant writing and new program implementation.

//2009/ A new organizational structure was adopted by the division in June 2008. There are five functional areas: Reproductive and Early Childhood Services, Youth and Adult Services, Community Support Services, Program Planning and Development, and Fiscal Services. //2009//

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. The Bureau of Maternal and Infant Health is responsible for the Family Planning, Family Case Management, Chicago Healthy Start, Targeted Intensive Prenatal Case Management, Closing the Gap, Early Childhood Comprehensive System Development (including the AOK Networks and the Healthy Child Care Illinois project), HealthWorks, Pediatric Primary Care, High-Risk Infant Follow-up, the Chicago Doula Project, Healthy Births for Healthy Communities, and Fetal and Infant Mortality Review programs, as well as the "Mini Block Grant" to the Chicago Department of Public Health. The Bureau of Child and Adolescent Health is responsible for the Teen Parent Services, Parents Too Soon, Healthy Families Illinois, School Health, Teen Pregnancy Prevention, and Responsible Parenting programs. The School Health program includes the Coordinated School Health program, School Health Centers and continuing education programs for school health personnel. The Bureau of Family Nutrition is responsible for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the Commodity Supplemental Foods Program, 5-A-Day for Better Health, Folic Acid, the Diabetes Prevention and Control Program (funded with a grant from CDC), and WIC and Senior Farmers' Market Nutrition Program.

The Office of Program Planning and Development oversees the leadership development programs supported by the State Systems Development Initiative.

The MCH program is supported by five other units: the Nutrition Services Section in the Bureau of Family Nutrition; the Bureau of Community Health Nursing; the Bureau of Performance Management Services in the Office of Program Planning and Development, the Bureau of Community Support Services, and the Bureau of Fiscal Support Services. The role of each of these units is described below.

The Nutrition Services Section in the Bureau of Family Nutrition is comprised of regional nutrition consultants, a state breastfeeding coordinator, and a state nutrition coordinator. All are masters-prepared Registered Dietitians with expertise in maternal and child health. The section provides

consultation and technical assistance on nutrition issues for the WIC and other maternal and child health programs.

The staff of the Bureau of Community Health Nursing (BCHN) work to ensure that the services provided by MCH program grantees are of high quality. The BCHN is composed of masters-prepared Maternal and Child Health Nurse Consultants who are geographically distributed throughout the state. The MCH Nurse Consultants develop and present in-service training, continuing education programs, and technical assistance for local agency staff. The BCHN is also responsible for the Asthma Education Program.

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 Bureau of Community Support Services performs contract monitoring and helps local program grantees integrate their services in order to respond effectively to community needs.

The Division of Community Health and Prevention's Bureau of Fiscal Support Services accounts for the Division's financial resources.

Information and Referral Helpline. MCH Helpline staff answer three 800 lines: 1) 800-323-GROW/4769; 2) 800-545-2200 (MCH); and 3) 800-843-6154, option #5 (DHS Customer Service Line). The staff of four field about 4,000 calls per month, including 300 Spanish-speaking calls. The MCH Helpline staff handle calls on a wide variety of health and human service needs. The Helpline also has a counselor on staff to take calls that require extended active listening prior to referring the caller on to appropriate local services. About 65 percent of callers are from the general public, and about 35 percent are local agency personnel.

//2008/ The MCH Helpline staff answer two 800 lines: 1) 80054502200 (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 callers 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. //2008//

The Illinois Department of Public Health. As a result of the reorganization of state human service agencies in 1997 (Public Act 89-0507), 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 Poisoning Prevention Act, which supports the Childhood Lead Poisoning Prevention Program; and the Prevention of Developmental Disability Act, which supports the perinatal care program. IDPH also operates the Vision and Hearing Screening Program 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.

The University of Illinois at Chicago Division of Specialized Care for Children. The University of Illinois at Chicago (UIC) Division of Specialized Care for Children (DSCC) administers the CSHCN program. 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 more than 60 satellite locations, DSCC maintains a strong focus on capacity building through family-centered, community-based care coordination activities and local systems development within all 102 counties in Illinois.

//2009/ DSCC currently has 40 satellite locations. //2009//

The Director of DSCC has available consultation and assistance from a major state university, including a School of Public Health, Colleges of Medicine, Nursing, Associated 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 Council (FAC) which 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 CSHCN. DSCC has leadership and/or membership involvement with the following CSHCN-related programs or activities: Illinois Chapter of the American Academy of Pediatrics Committee on Children with Disabilities, the Illinois Academy of Family Physicians, the Illinois Maternal and Child Health Coalition, Illinois Interagency Council on Early Intervention, Illinois Interagency Transition Consortium, Brain and Spinal Cord Injury Advisory Council, Illinois Universal Newborn Hearing Screening Advisory Committee, Illinois Genetics and Metabolic Diseases Advisory Committee, Illinois Campaign for Better Health (State Children's Health Insurance Program Work Group), Illinois Department of Public Health Hearing Screening Advisory Board, Illinois Department of Public Health Vision Screening Advisory Board, Department of Human Services School Health and School Nurse Advisory Boards, IFLOSSS (Coalition for Access to Dental Care), Healthy Child Care Illinois Steering Committee, and the UIC-SPH MCH Training Program. DSCC also has collaborative activities with Shriners' Hospitals for Children in Chicago.

//2008/ DSCC has four delegates, including a staff parent representative, to the Association for Maternal and Child Health Programs (AMCHP). The Director is the co-chair for the AMCHP Workforce Development Committee. DSCC staff attend the annual meetings to stay abreast of national issues. //2008//

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 which 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.

For additional information, please visit the DCHP web site (www.dhs.state.il.us/chp), the DSCC web site (www.uic.edu/hsc/dsc) or the IDPH web site (www.idph.state.il.us).

D. Other MCH Capacity

Other MCH Capacity

IDHS. There are a total of 221 FTE positions in the Department's MCH program. There are 94 FTE positions at the central office in Springfield. Regional staff are deployed as follows: Region 1 (Chicago), 87 FTEs; Region 2 ("collar counties" and northern Illinois) eight FTEs; Region 3 (north central Illinois) twelve FTEs; Region 4 (south central Illinois) twelve FTEs; and Region 5 (southern Illinois) eight 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. Central office staff includes 73 FTE professional and technical positions, and 21 FTE support staff positions. Statewide, the professional staff includes 21 registered nurses, 11 registered dietitians, and two social workers. At the time this application was submitted, 13 full-time positions were vacant.

Steven J. Guerra, Director of the Department's Division of Community Health and Prevention, is Illinois' Title V Director. He joined the IDHS in 2003 as the Associate Director for Prevention in the Division of Community Health and Prevention. He has had a distinguished 30-year career in human and community development. He has served and worked in the city and state government, social services, and the foundation communities. Mr. Guerra was appointed to serve as the Director of the Division of Community Health and Prevention in November of 2004. He holds a bachelor's degree in economics and a Master of Business Administration degree.

/2009/ Ivonne Sambolin is the Director of the Division of Community Health and Prevention (DCHP), Illinois Department of Human Services. Prior to assuming this position, Ms. Sambolin was Special Projects Coordinator for the Division's Bureau of Youth Services and Delinquency Prevention, and served as the Project Coordinator for the federal GEAR UP Program. In August 2007, Steven Guerra became the Governor's Deputy Chief of Staff for Social Services. //2009//

/2008/ In October 2006, Myrtis Sullivan, M.D., M.P.H., was appointed Associate Director for Family Health, Division of Community Health and Prevention and Illinois' Title V Director. 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. //2008//

DSCC. DSCC employs 196 FTEs to provide enabling services from local offices within the DSCC regional office system. Seventy-four FTEs in the Springfield Central Administrative Office provide necessary infrastructure support (system/policy development, core program technical assistance, administrative support, fiscal and information management, and personnel services) for the regional offices' care coordination system. An additional administrative office on the UIC campus accommodates six FTEs who provide Home Care Waiver Program technical assistance and administrative support activities. Over the last three years, administrative staffing in the Springfield Central Administrative office has been reduced by ten percent as a result of budget cuts. With those reductions, the available number of staff (administrative support, fiscal management, information systems support, and human resources) to support services to the field office care coordination staff have been impacted. Statewide temporary positions have been eliminated and overtime has been limited to support clinics and emergency situations with minimal impact in providing assistance to families. DSCC also provides direct services through the Children's Habilitation Clinic at UIC, which is staffed by five FTEs, including a developmental pediatrician, a clinical practice nurse specialist, clinical psychologist, medical social consultant, and support staff. Ancillary services such as physical therapy and speech pathology are obtained through contracts.

Charles N. Onufer, M.D., is the DSCC Director. In this capacity, he is responsible for planning and directing the State of Illinois' Program for Children with Special Health Care Needs. Dr. Onufer serves as Chairman of the Illinois Chapter of the American Academy of Pediatrics Committee on Children with Disabilities and also on other state Committees, including the Illinois Interagency Coordinating Committee on Transition, the Genetic and Metabolic Disease Advisory Committee, Vice President of the Brain and Spinal Cord Injury Advisory Council, Co-Chairman of the AMCHP Best Practices Committee, Chairman of the Medical Home Work Group for HRSA Region 4 Genetics Collaboration Committee, and is on the Planning Committee for the annual national MCH Leadership Conference Translating Research into Practice, implemented by the UIC-SPH Maternal and Child Health Program. Dr. Onufer is collaborating with over 30 other CSHCN programs to publish a biannual family newsletter, Special Addition, for families. Dr. Onufer is a Board certified Pediatrician, a Fellow of the American Academy of Pediatrics, and an Assistant Professor of Pediatrics at UIC. He received his Doctor of Medicine degree from Ohio

State University and completed his pediatric and fellowship training from Tripler Army Medical Center and Madigan Army Medical Center, respectively.

/2008/ The AMCHP Best Practices Committee has been renamed the AMCHP Workforce Development Committee. //2008//

/2009/ Currently DSCC employs 193 FTEs to provide enabling services from local offices in the DSCC regional office system and 59 FTEs in the Springfield central administrative office. The administrative office located at UIC in Chicago employs 6 FTEs and CHC employs 4.2 FTEs. DSCC re-aligned some support activities related to care coordination services so that the care coordinators' caseloads could be increased without having a negative impact on access to care coordination services. This was necessary in order to eliminate or move some positions within the agency. Through this realignment, professionals and paraprofessionals work in teams on each caseload and provide assistance to families more efficiently than our previous service model. Training was provided for all care coordination teams to improve their functioning. In addition, DSCC simultaneously streamlined the application forms and enrollment process. //2009//

/2009/ Dr. Onufer retired effective May 31, 2008. Gerri Clark, RN, MSN, has been appointed interim director. She has served as the Associate Director for Program Services at DSCC for the past nine years and held various positions in the Nebraska CSHCN program for seven years prior to coming to DSCC. //2009//

E. State Agency Coordination

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.

Interagency agreements among IDHS, IDPH and DSCC are on file at the Division of Community Health and Prevention's headquarters in Springfield.

IDHS, IDHFS, and IDPH are strengthening the state infrastructure for program planning and development through a three-way agreement for exchange of data for program planning, monitoring and evaluation. The agreement involves the exchange of vital records, Medicaid eligibility and service delivery, MCH and other program management data.

/2009/ The Family Case Management Act requires the Department to create a Maternal and Child Health Advisory Board. The board met for the first time on January 23, 2008 and met again on April 30th. This new board will strengthen state, regional, and local relationships for the coordination and integration of Title V with other state and federal programs. //2009//

/2009/ In FY '07 a Re-structuring Task Force recommended development and implementation of Risk Screening Tools that would stratify service delivery requirements within the Family Case Management program. The work of this task force continued in FY'08, with further revisions to Prenatal, Infant and Child Risk Screening Tools, with input from IDHS MCH Nurse Consultants and a subset of MCH Advisory Board members. Additionally, draft changes to the Illinois MCH Code are being discussed. Changes in Federal rules governing case management services will necessitate revisions to how case management services are provided in a number of Illinois programs, beginning as early as late FY'08 and continuing into FY'09. //2009//

The Family Case Management Act requires the Department to create a Maternal and Child Health Advisory Council. This new council will strengthen state, regional, and local relationships for the coordination and integration of Title V with other state and federal programs.

IDHS and DSCC collaborate to implement a variety of programs to serve the MCH and CSHCN populations. This collaboration includes both informal and formal linkages for service delivery.

Other Divisions Within The Illinois Department of Human Services. To enhance continuity of care for CSHCN, DSCC collaborates with IDHS' Division of Rehabilitation Services (DRS) in the following areas that benefit CSHCN: vocational rehabilitation services for clients at or near employable age; 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 CSHCN. Additionally, a three-agency agreement is in place between DSCC, DRS, and IDHFS to facilitate the transition of children from the waiver for medically fragile, technology dependent children operated by DSCC to the Home Service Program, which is another Home and Community-Based Services waiver operated by DRS for persons with disabilities through age 59.

DSCC maintains a Memorandum of Understanding with the Early Intervention Program to coordinate activities, including referral between the two programs 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.

The Division of Community Health and Prevention 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 move from welfare to work through intensive casework services that connect them to IDHS programs and benefits they need, and to local community resources where other services are provided. DCHP and the Division of Mental Health collaborate to promote the integration of service systems in order to provide a comprehensive array of mental health and support services to children and their families. DCHP and the Division of Alcoholism and Substance Abuse collaborate to coordinate and fund community-based services throughout the state for the prevention, intervention, treatment, and rehabilitation of alcohol and other drug abuse and dependency for at-risk or addicted individuals and their families.

//2009/ DCHP, the Division of Mental Health and the Division of Alcoholism and Substance Abuse and the Division of Mental Health sponsor an annual conference for service providers entitled, "Transforming Community Systems for Prevention, Treatment and Recovery" in order to disseminate best practices and facilitate service system integration at the community level. //2009//

Through an interagency agreement, the Illinois School for the Deaf, Early Intervention, Illinois Department of Public Health, Illinois State Board of Education, 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. In 2004, 2005 and 2006, DSCC provided family scholarships to families who attended the Institute to supplement the loss of income because of the week-long commitment.

IDHS and DSCC coordinate with other State agencies as noted 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 Family Case Management 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 Family Case Management program. For SFY'05, \$7.6 million in federal matching funds have been reimbursed to local health departments. Eightysix local health departments participate in the Family Case Management administrative claiming process.

/2008/ For SFY'06, \$8.6 million in federal matching funds have been reimbursed to local health departments. Eighty-six local health departments have signed intergovernmental agreements to participate in the Family Case Management administrative claiming process. //2008//

Local MCH programs, including local health departments, family planning clinics, and WIC agencies are serving as outstations for determining eligibility of pregnant women and initiating the All Kids (Title XIX and Title XXI) application process for children under 19 years of age. 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.

/2009/IDHFS maintains an interagency agreement with DSCC. It 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. /2009/ CMMS rules for targeted case management potentially will affect DSCC. DSCC is working with HFS to address necessary changes. //2009//

Illinois Department of Public Health. IDHS works with many divisions and programs within IDPH to develop preventive and primary care systems. IDPH and DSCC provide otologic/audiologic clinics in communities with high rates of children who receive no follow up after failure of school hearing screenings. A Memorandum of Understanding delineates collaborative activities for children identified through the Newborn Metabolic Screening, Genetic Counseling, Vision and Hearing Screening, and Hearing Instrument Consumer Protection programs.

/2008/ The Memorandum of Understanding with DSCC and Public Health is being updated to include Newborn Hearing Screening and APORS. //2008//

/2009/ The IDPH MOU was signed by IDPH in August 2007, and by the University of Illinois Chicago in October 2007. //2009//

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 Universal Newborn Hearing Screening and Intervention Grant.

/2008/ The HRSA Universal Newborn Hearing Screening grant will end in March 2008. //2008//

/2009/ DSCC was awarded the Universal Newborn Hearing Screening and Intervention: Reducing Loss to Follow-up after Failure to Pass Newborn Hearing Screening grant. //2009//

//2009/ A legislative initiative last year to support the program through the assessment of a fee for each newborn was unsuccessful. A bill has been introduced to appropriate funds to IDPH, DSCC and IDHS to sustain the program. //2009//

In 1999, the Illinois Department of Public Health received funding from the U.S. Centers for Disease Control and Prevention to build capacity and to develop a state plan to address asthma. As a result, the Illinois Asthma Program was formed and a statewide partnership was developed. The Partnership meets semi-annually, in addition to annual regional trainings and a yearly asthma conference. Five work groups and community asthma coalitions assist with the partnership's efforts. The Illinois Asthma Program (IAP) funds four coalitions to implement asthma state plan goals and funds a number of communities to develop asthma coalitions to begin to address asthma for World Asthma Day and funded 29 WIC clinics to provide asthma education to staff and clients.

IDHS works in collaboration with the IDPH's Illinois Asthma Initiative. The MCH program is represented at the advisory level and on the statewide subcommittees by MCH Nurse Consultants, Child Care Nurse Consultants, and School Health staff. Activities in 2005 included the distribution of asthma toolkits to child care providers. The Healthy Child Care Illinois nurse consultants ensure the distribution of the toolkits and will provide education about asthma. Other activities include offering an asthma calendar contest for Illinois fifth and sixth grade students and hosting an annual satellite program, which focused on a comprehensive approach to asthma management in schools. The program was held to educate school staff and parents on the management of asthma and the various components (roles of school staff, physical activity, medications and action plans and environmental and pest management issues) of an asthma management plan.

//2008/ IDHS works in collaboration with the IDPH's Illinois Asthma Initiative. The MCH program is represented at the advisory level and on statewide subcommittees by Public Health Nurse Consultants, Child Care Nurse Consultants, and School Health staff. Activities in 2006 included the distribution of asthma toolkits to child care providers, an asthma calendar contest for Illinois fifth and sixth grade students, and hosting an annual satellite program, which focused on asthma and physical activity in schools. The program was held to educate school staff and parents on the management of asthma and to differentiate asthma and exercise-induced asthma, triggers, prevention strategies, medications, peak flow meters, asthma action plans, and how schools can develop a school or school district emergency plan for asthma. //2008//

Illinois State Board of Education (ISBE). Although there is no formal agreement with the ISBE, program staff from the DSCC central office coordinate with State Board staff regarding issues for CSHCN in schools. DSCC distributes to families via its regional offices, "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 employs a school health consultant and refers questions on school health related issues 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 a 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 DHS 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 also conducts continuing education programs for school nurses and administrators and provides regular updates on school health issues through email and the publication of the School Health Dimensions newsletter. Finally, schools are also the main delivery sites for the Unmarried Parents and Youth Opportunity programs.

Illinois Department of Children and Family Services. DSCC collaborates with the Illinois Department of Children and Family Services (DCFS) on behalf of state wards of DCFS who have special health care needs and are eligible for DSCC services. Coordination activities include identifying referral mechanisms for sharing information. To enhance system collaboration, DSCC staff are available to provide in service training as needed on CSHCN to local and regional DCFS staff throughout the state. MCH program staff work with DCFS on the management of HealthWorks of Illinois, described earlier in this application.

/2009/ DSCC care coordination staff took advantage of available DCFS online training for mandated reporters. //2009//

Illinois is one of seven states selected to pilot Strengthening Families Through Early Care and Education. The Illinois Department of Children and Family Services (DCFS) initiated Strengthening Families Illinois through a collaboration of 30 partner organizations and state agencies from child welfare, child abuse prevention, and early childhood fields as well as parents and community leaders. Local learning networks have been established at five childcare centers across the state to work with families to build protective factors around children to prevent child abuse and neglect. The Child Care Nurse Consultants were trained to provide instruction about the protective factors to childcare providers throughout Illinois. The childcare providers will be prepared to recognize and develop parental resilience, foster social connections, increase knowledge of parenting and child development, provide concrete support in times of need for parents, and learn about the healthy social and emotional development of children. DCFS and IDHS collaborate on the operation of HealthWorks of Illinois, which establishes regional networks of primary and specialty care to ensure that children in foster care receive the health care services they require.

F. Health Systems Capacity Indicators

Introduction

/2008/ The IDPH Genetics/Newborn Screening program is developing an interface with the birth record. In 2007, a vendor, Pekin-Elmer, was selected to develop a web-based Newborn Metabolic Screening Data System that will interface with the birth record to ensure that all Illinois infants are screened. //2008//

/2008/ The data-sharing infrastructure in IL has been strengthened through a three-way agreement for exchange of data for program planning, monitoring, and evaluation between IDPH, IDHFS, and IDHS. It involves exchange of vital records, Medicaid eligibility and service delivery, MCH and other program management data. //2008

/2008/ In FFY07, Illinois' application for SSDI funding addressed the need to develop capacity to "mine" the MDW for pertinent data and approach the data from an epidemiological perspective. //2008//

/2008/ An epidemiologist and data analyst will be hired through the SSDI project to assist in

accomplishing these goals. //2008//

/2009/The SSDI Data Analyst position was filled. Christine Brophy, who has extensive background in IT and experience with numerous analytical software packages became a member of OPPD in December 2007. The Division of Community Health and Prevention applied for a CDC/CSTE MCH Epidemiological Fellow. Beginning July 2008, Amanda Bennett began her fellowship./2009//

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 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	70.4	64.1	66.1	66.3	59.7
Numerator	6243	5708	5886	6024	5325
Denominator	886515	890545	890545	909278	891315
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 - 2007

Hospital discharge data that were made final and available in 8/2008. Sources: IDPH Division of Health Policy, Facility Discharge Data. 2006 Illinois population estimates, US Census Bureau.

Notes - 2006

The number of non fatal injuries is hospital discharge data that were made final and available in 8/2007. Sources: IDPH Division of Health Policy, Facility Discharge Data. 2006 Illinois population estimates, US Census Bureau. (Revised 9/5/08)

Notes - 2005

The number of non fatal injuries is hospital discharge data that were made final and available in 8/2007. Sources: IDPH Division of Health Policy, Facility Discharge Data. 2005 Illinois population estimates, US Census Bureau.

Narrative:

In 2005 (the most recent data available), the rate of asthma hospitalization among children under five years of age was 66.1 per 10,000. The MCH program supports two demonstration projects to improve asthma management in young children; these activities were described earlier in the application.

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	93.9	95.0	87.2	87.3	86.2
Numerator	75351	68234	64135	66245	71434
Denominator	80287	71826	73578	75921	82892
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 - 2007

Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. Data from report used to prepare the CMS 416 report. Received from IDFHS 7/9/08. 2007 data are provisional.

Notes - 2006

Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. Data from report used to prepare the CMS 416 report. Received from IDFHS 7/9/08.

Notes - 2005

Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. Data from report used to prepare the CMS 416 report. Received from IDFHS 7/9/08.

Narrative:

The proportion of Medicaid-eligible infants that obtain routine well-child care has been steadily improving in Illinois. The proportion has exceeded 90 percent for the last five years and reached 95.4 percent in 2005 (the most recent data available). The high rate of utilization reflects the effort of several MCH programs to ensure that infants obtain appropriate well-child care. Until 2004, fewer than 300 infants a year were eligible for SCHIP for at least 30 days. Enrollment in SCHIP improved in 2005, and almost 97 percent of these infants received at least one well-child service. The small number of eligible children (842) limits the interpretation of the rate of well-child care utilization in this population.

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 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	69.3	98.1	97.5	97.2	89.3
Numerator	158	987	842	1009	1612
Denominator	228	1006	864	1038	1805
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 - 2007

Source: The source of the 2006 data report are the same with the exception of the word "HEDIS" included in the overall title - Executive Information System, HEDIS - Well Child Visits in the First 15 Months of Life (W15). Summary report "Title Specific Report - All HFS Enrolled" as of 11/16/2007, HCFS.

Notes - 2006

Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. Report titled "Well-Child Visits in the First 15 Months of Life" - data as of 3/30/2007. Only Title XXI reported here. Data are Provisional as of June 7, 2007.

Notes - 2005

Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. Report titled "Well-Child Visits in the First 15 Months of Life" - data as of 3/30/2007. Only Title XXI reported here.

Narrative:

Until 2004, fewer than 300 infants a year were eligible for SCHIP for at least 30 days. Enrollment in SCHIP improved in 2005, and almost 97 percent of these infants received at least one well-child service. The small number of eligible children (842) limits the interpretation of the rate of well-child care utilization in this population.

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 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	78.2	78.8	80.2	79.9	80
Numerator	135075	132359	133556	135403	
Denominator	172789	167931	166527	169479	
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 - 2007

At the time of this application, 2007 data is not available. An estimate is being provided at this time.

Notes - 2006

Source: Center for Health Statistics - IL Department of Public Health.

Notes - 2005

Source: Center for Health Statistics - IL Department of Public Health.

Narrative:

The proportion of women who received an adequate number of prenatal care visits has been steadily increasing, as measured by the Kotelchuck Index. In 2004, 78.8 percent of women who gave birth received an adequate amount of prenatal care as measured by the Kotelchuck Index; the percent increased to 80.2 percent in 2005.

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 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	73.1	72.3	71.1	70.0	66.2
Numerator	521974	638376	713621	754192	860024
Denominator	713888	883192	1003893	1078065	1298701
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 - 2007

Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. Report titled "Kidcare Performance Review Request #3.1 - Claims Paid Up To and Including 6/27/08. Title XIX and Title XXI included. The report is based upon the number of children eligible during CY2007.

Notes - 2006

Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. Report titled "Kidcare Performance Review Request #3.1 - Claims Paid Up To and Including 4/30/08. Title XIX and Title XXI included. The report is based upon the number of children eligible during CY2006.

Notes - 2005

Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. Report titled "Kidcare Performance Review Request #3.1 - Claims Paid Up To and Including 5/25/07. Title XIX and Title XXI included. The report is based upon the number of children eligible during CY2005.

Narrative:

The expansions of health care coverage in Illinois has increased the proportion of potentially Medicaid - eligible children by 57 percent since 2002. Despite the broadening eligibility criteria, the percent of children who received a service paid by Medicaid has remained constant since 2002. As the medical and human services fields adapt to the expanded coverage levels, it is expected that the proportion of children receiving a service paid by Medicaid will increase.

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 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	40.9	42.8	47.4	52.2	52.2
Numerator	94964	104284	131667	161447	161447
Denominator	231972	243792	277819	309570	309570
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 - 2007

No data released for 2007. Using 2006 data as provisional. Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. No report title given.

Notes - 2006

Source: Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. No report title given. These 2006 data are made final in year 2008.

Notes - 2005

Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. No report title given. Data as of 6/4/2007.

Narrative:

The proportion of Medicaid-eligible children between six and nine years-of-age who received any dental services reached 47.4 percent in 2005.

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	14.4	13.3	11.6	8.3	8.7
Numerator	5272	5101	4649	3155	3286
Denominator	36632	38439	40110	37981	37673
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 - 2006

The annual indicator is an estimate that includes two populations served by DSCC, including children who were newly eligible for SSI who receive information and referral services and SSI eligible children who also receive services through the Core and Home Care Program. Some number of children could be dually counted in these two groups.

Notes - 2005

The annual indicator is an estimate that includes two populations served by DSCC, including children who were newly eligible for SSI who receive information and referral services and SSI eligible children who also receive services through the Core and Home Care Program. Some number of children could be dually counted in these two groups.

Narrative:

Children with Special Health Care Needs. The proportion of state SSI beneficiaries under 16 years of age who received rehabilitative services through the CSHCN program decreased to 8.3 percent in 2005 (Health Systems capacity Indicator 8, Form 17). For a description of DSCC's efforts for SSI-eligible children, see Section III.B., "Agency Capacity", "Children with Special Healthcare Needs."

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2006	matching data files	9.2	7.7	8.6

Notes - 2009

Source: 2006 Birth file from IDPH matched to Medicaid data by DHS, Community Health & Prevention, Performance Support Services, August 2008.

Narrative:

In 2005, the percent of low birth weight births was higher among Medicaid-eligible infants (9.5 percent) than non-Medicaid eligible infants (7.2 percent). The percent distribution of low-birth weight among Medicaid and non-Medicaid infants is similar to previous years in that it is higher among Medicaid-eligible infants.

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2005	matching data files	8.2	6.2	7.2

Notes - 2009

2006 Birth and death data is not available at time of application. 2005 data is being used instead until it is available.

Narrative:

As in previous reports, the rate of infant mortality is higher among Medicaid-eligible infants (8.2 deaths per 1,000 live births) than non-Medicaid-eligible infants (6.2 deaths per 1,000 live births). These statistics are derived from the latest available data, calendar year 2004.

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	76.3	88.2	86.1

Notes - 2009

Source: 2006 Birth file from IDPH matched to Medicaid data by DHS, Community Health & Prevention, Performance Support Services, August 2008.

Narrative:

Improvement in the percent of infants born to women receiving prenatal care in the first trimester was reported across income groups in 2005 as compared to 2004. The percent of births receiving prenatal care in the first trimester among Medicaid-eligible was 74.3 percent in 2005 and 71.9 percent in 2004. The percent among non Medicaid-eligible was 87.4 in 2005 and 83.4 in 2004.

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 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	matching data files	73.8	85.4	79.9

Notes - 2009

Source: 2006 Birth file from IDPH matched to Medicaid data by DHS, Community Health & Prevention, Performance Support Services, August 2008.

Narrative:

As compared to 2004, greater percentages of women regardless of payment source were receiving adequate prenatal care according to 2005 vital statistics data. For Medicaid-eligible women, the percent receiving adequate prenatal care increased from 70.5 to 73 percent. Non-medicaid eligible women reported a modest increase in the percent receiving adequate prenatal

care from 2004 to 2005, 86.6 to 87.4 percent, respectively. These observed increases were reflected in the percent differences for the entire birth cohort; in 2004, 78.8 percent of pregnant women received adequate prenatal care and in 2005 the figure was 80 percent.

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)	2007	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
Infants (0 to 1)	2007	200

Notes - 2009

2006 levels. At the time of the application, did not receive the eligibility levels for 2007 from IDHFS.

Notes - 2009

2006 levels. At the time of the application, did not receive the eligibility levels for 2007 from IDHFS.

Narrative:

Pregnant women with family incomes at or below 200 percent of the federal poverty level are eligible for services under either Medicaid or SCHIP. Eligibility for children under SCHIP is 200 percent of the federal poverty level.

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 19) (Age range to) (Age range to)	2007	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 19) (Age range to) (Age range to)	2007	200

Narrative:

Children over one year-of-age from families with incomes below 133 percent of the federal poverty level are eligible for Medicaid; children from families with incomes between 133 and 200 percent of the federal poverty standard are eligible for SCHIP. All other uninsured children, regardless of income or citizenship, are eligible for All Kids.

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	2007	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	2007	200

Narrative:

Pregnant women with family incomes at or below 200 percent of the federal poverty level are eligible for services under either Medicaid or SCHIP. Eligibility for children under SCHIP is 200 percent of the federal poverty level.

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 program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	2	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	1	No
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State	3	No

discharges		
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	No

Notes - 2009

Narrative:

In FFY07, Illinois' application for SSDI funding addressed the need to develop capacity to "mine" the Maternal and Child Health data. The goals of Illinois' SSDI are to:

1. Improve and expand the availability of data used to gauge the health of mothers, infants, children, adolescents and children with special health care needs in Illinois;
2. Continue to develop MCH epidemiological infrastructure necessary for improving access to as well as use of data to support new and existing MCH program policies and practices; and
3. Support and improve collaborations within the Illinois Department of Human Services and among state and local stakeholders of maternal and child health services and issues.

The IDPH Genetics/Newborn Screening program is developing an interface with the birth record. In 2007, a vendor, Pekin-Elmer, was selected to develop a web-based Newborn Metabolic Screening Data System that will interface with the birth record to ensure that all Illinois infants are screened.

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)	2	No
Youth Tobacco Survey	3	No
Illinois Youth Survey	3	Yes

Notes - 2009

Narrative:

The 2006 version of the Illinois Youth Survey reports that the percent of students in 8th, 10th and 12th grades who had smoked cigarettes decreased to 16 percent from 2002 when the percent was 18.9 percent. The decrease in cigarette smoking was offset by an increase in the percentage of students reporting use of smokeless tobacco. In 2006, 6.6 percent of the students used smokeless tobacco compared to 3.9 percent in 2002.

IV. Priorities, Performance and Program Activities

A. Background and Overview

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:

Maternal and Infant Health

1. Reduce racial disparities in infant mortality - The reduction of infant mortality has been a priority for Illinois' Title V program for many years. While Illinois' infant mortality rate is steadily improving, it still lags behind the nation in the racial disparity between African-American and Caucasian infant mortality rates remains greater than 2:1. The expert panel on maternal and infant health convened for the needs assessment recommended as its top priority that the Title V program focus on reducing racial disparities in infant mortality.

The IDHS and the IDPH will address this objective through statewide initiatives (WIC, Family Case Management and the regionalized perinatal care program) as well as targeted initiatives for high-risk populations (Targeted Intensive Prenatal Case Management, the Chicago Healthy Start Initiative, the Illinois Healthy Start Programs Partnership, Closing the Gap, and Healthy Births for Healthy Communities). The MCH program will also work closely with the IDHFS to fully implement the recommendations of the Perinatal Task Force for expansion of optional Medicaid services for the reduction of infant mortality and the improvement of perinatal health.

/2008/ New Infant Mortality (IM) Initiatives: 1) Illinois' Title V Director has joined the National March of Dimes "Big Five Prematurity Summit" in San Jose, California from May 21 - 23, 2007. This summit addressed prematurity, low birth weight, and other factors that contribute to infant morbidity and mortality. The states represented (New York, Illinois, Texas, Florida, and California) account for over one-third of the premature births in the U.S.;

2) IDHS will join the Illinois Maternal and Child Health Coalition in co-sponsoring a statewide

Infant and Maternal Mortality Summit in Chicago on October 24 - 25, 2007. This summit will bring key stakeholders (including elected officials, community-based agencies, health care and service providers) together to develop and implement a statewide strategic plan to improve infant and maternal outcomes in Illinois. //2008//

//2009/ The Illinois Maternal and Child Health Coalition sponsored a two-part summit on Maternal and Infant Health in order to focus attention on the racial disparity in infant mortality and to develop new approaches to addressing this problem. The 10 broad strategies recommended by the summit include:

1) Increase access to comprehensive sex education including family planning; 2) Access to affordable health care for all across the lifespan; 3) Provide children's allowances i.e. universal income based supports similar to European countries; 4) Provide maternity/paternity paid leave; 5) Ensure the quality of prenatal and general healthcare in all communities; 6) Integration of case management systems and provide local resources for communities to develop systems of care; 7) End racially discriminative policies and practices in public institutions-such as education and housing, and criminal justice; 8) Maintain effective and efficient health data systems that provide timely health information that can be used to generate action; 9) Institute a public campaign to improve community mores in support of pregnant women; and 10) Advocate for community economic development in areas of employment, housing, and education in a manner that engages and empowers communities. //2009//

//2009/ Local WIC agencies receive monthly racial/ethnic reports which are designed to help them provide enhanced targeted outreach to potentially eligible WIC populations. //2009//

//2009/ The Department in conjunction with the University of Illinois at Chicago will convene a one-half day conference entitled, "Toxic Pregnancy: Conference on Effects of Environmental Toxicant Exposure on Embryonic and Fetal Development." The primary aim of the conference is to increase knowledge of environmental toxins and increase practice behaviors relating to reduce prenatal exposure, among clinicians who provide health care to pregnant women. It will be held in Chicago on October 24, 2008. The objectives of the conference include increasing knowledge, attitudes, and practice behaviors related to environmental exposures during pregnancy. //2009//

//2009/ The Illinois Birth to Five Project hosted a statewide Medicaid EPSDT Summit for state leaders. Dr. Myrtis Sullivan, Associate Director, Office of Family Health and Glendean Sisk, Program Administrator, Family Case Management attended. Modeled after the EPSDT State Leadership Summits, sponsored by the Maternal and Child Health Bureau-Health Resources and Services Administration of the U.S. Department of Health and Human Services, this Summit brought together 25-30 Illinois state leaders (public and private). Attendees included state representatives from Medicaid, Title V, Part C, child welfare, individual providers, parent advocates, directors of model programs, and foundations. The Summit was facilitated by Kay Johnson of Johnson Group Consulting. The Summit took place in June 25 - 26, 2008 in Chicago. Through extensive discussion and two rounds of prioritization, the group consensus supported six priority areas for short-term action: 1. Boost mental health services capacity in community health centers/Federally Qualified Health Centers (FQHC), 2. Increase clinic capacity and recruiting dentists for safety net clinics, 3. Consultation from specialist and sub-specialist medical providers, 4. Increase provider reimbursement for pediatric specialists and sub-specialists, 5. Grow and develop the early childhood mental health workforce and, 6. Use All Our Kids (AOK) sites for development of community pilot projects serving children at-risk.//2009//

//2009/ The DHS Office of Family Health is collaborating with the The Chicago Health Connection (an advocacy organization that promotes breastfeeding and the Doula

program) to plan breastfeeding promotion strategies for the entire state. These plans will include a breastfeeding summit to be held in Chicago in October 2008 and a WIC conference in April, 2009. //2009//

Progress will be monitored and reported in the Block Grant application and annual report through National Outcome Measure 2.

2. Reduce the rate of unintended pregnancy - This priority was identified through the needs assessment completed for the FFY'06 application, particularly among Medicaid-eligible women. In 2002, 43 percent of women who responded to Illinois' PRAMS survey indicated that their most recent pregnancy was mistimed or unwanted. The rate is as great as two-thirds among low-income women.

This objective will be addressed through the provision of family planning services through the Title X, Illinois Healthy Women and School Health Center programs, through the Abstinence Education and Teen Pregnancy Prevention Programs (both Primary and Subsequent) and through interconceptional care provided by the Family Case Management program, the Chicago Healthy Start Initiative, and Healthy Births for Healthy Communities. The IDHS will continue to work closely with IDHFS to coordinate the Family Planning program with Illinois Healthy Women (the Medicaid family planning demonstration waiver).

Annual performance will be measured through Illinois' PRAMS survey and reported in the Block Grant application and annual report through State Performance Measure 6.

//2008/ New Initiative: The Division of Community Health and Prevention at IDHS has developed a satellite videoconference on preconceptional and interconceptional care that will be distributed locally and nationally to promote well woman care and to educate and train care providers and other relevant professionals and stress the importance in incorporating strategies to improve well woman care at every service and medical visit. //2008//

3. Reduce the incidence of sexually transmitted infections, including HIV - This priority was selected because of the high rates and racial and ethnic disparities in sexually-transmitted infections in Illinois, including Gonorrhea, Chlamydia, and Human Immunodeficiency Virus, identified through the FFY'06 needs assessment.

The objective will be addressed primarily through the Family Planning and School Health Center programs. The IDHS Family Planning program has been an active participant in the Region V Infertility Project and the Illinois Infertility Project for many years. Both of these projects focus on the prevention of infertility through improved screening for Chlamydia through family planning and other sexually transmitted infection clinics. The IDHS and IDPH work together on both of these projects. The MCH program will also strengthen its collaboration with the IDPH AIDS Activity Section.

//2009/ IDHS and IDPH are collaborating on new ways to address the high rates of Chlamydia and other STI's in Illinois. A meeting was held with IDHS and IDPH representatives in early March to identify potential strategies. A joint action plan will be released in the fall of 2008. //2009//

Annual performance will be reported in the Block Grant application and annual report through State Performance Measure 10. Chlamydia was selected for the performance measure because its incidence is increasing among adolescents and young adults.

Child and Adolescent Health

1. Reduce adolescent risk-taking behavior and racial and ethnic disparities in teen births - This priority was selected because of the high rates of adolescent risk-taking behavior (use of alcohol,

marijuana and sexual activity) and the changing patterns of childbearing among racial and ethnic sub-groups of teens. The reduction of teen pregnancy has been a priority of the Title V program for many years, and the state's overall teen fertility rate and the proportion of all infants born to teen mothers continue to decline. However, the number of births to teens of Hispanic or Latino origin is increasing.

This priority will be addressed through the Teen Pregnancy Prevention programs (both Primary and Subsequent), the family support programs (Healthy Families Illinois, Parents Too Soon and Teen Parent Services), the Family Planning program, the Abstinence-Only Education program, the School Health Centers, and the community-based substance abuse prevention and youth service programs overseen by the Division of Community Health and Prevention.

Annual performance will be reported in the Block Grant application and annual report through National Performance Measure 8.

2. Promote healthy growth and development of children - This priority was selected because of the increasing prevalence of childhood overweight in Illinois, as described in the FFY'06 needs assessment.

This priority will be addressed by the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and by the School Health Centers. WIC's strategies to promote health growth and development are well known. The School Health Centers have implemented a Continuous Quality Improvement (CQI) process that includes health risk assessments of enrolled students and the development of interventions to reduce the incidence of overweight children. All of the health centers supported by IDHS will be addressing childhood overweight through this process.

Annual performance will be reported in the Block Grant application and annual report through National Performance Measure 14.

3. Improve access to preventive and primary health care services - This priority was selected on the recommendation of the expert panel on child and adolescent health convened for the FFY'06 needs assessment.

This priority will be addressed through the Family Case Management, WIC and Family Planning programs, the School Health Centers and the "Mini Block Grant" to the Chicago Department of Public Health. IDHS initiated two successful campaigns to improve the number of children in the WIC program who have health insurance and to improve the proportion of infants and children in Family Case Management and WIC who are fully immunized. Due in part to the success of the Family Case Management program, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) participation rate among infants exceeds 90 percent. School Health Centers will implement a CQI process to confirm the insurance status of enrolled children. The IDHS will also continue to work closely with the IDHFS to enroll uninsured children in All Kids and ensure timely and efficient implementation of the All Kids initiative.

//2009/ The State of Illinois' primary strategy for addressing this priority is IDHFS Primary Care Case Management (PCCM) program, "Illinois Health Connect." IDHFS implemented PCCM to promote the use of medical homes for both children and adults and to reduce Medicaid expenditures arising from inappropriate use of specialists and emergency departments. Illinois Health Connect was described earlier in this application. //2009//

Annual performance will be reported in the MCH Block Grant application and annual report through National Performance Measures 13.

4. Improve access to mental health services - This priority was selected on the recommendation of the expert panel on child and adolescent health convened for the FFY'06 needs assessment.

This priority will be addressed through the Family Case Management, WIC, Teen Parent Services, Healthy Families Illinois, Parents Too Soon programs, the AOK Networks, and the School Health Centers. Local providers of these services have been trained to conduct developmental screening through the State Early Childhood Comprehensive Systems initiative and the performance of developmental screening is monitored each quarter. Children who appear to have a developmental delay are referred to the Part C Early Intervention program for further assessment. The All Our Kids Early Childhood Networks work closely with community agencies to improve developmental screening and to improve the transition from Part C to Part B services under the Individuals with Disabilities Education Act. Mental health consultation is available through Part C Early Intervention Child and Family connections throughout the state. The Bureau of Child Care and Development expanded mental health consultation for local service and childcare providers from four to nine pilot sites in FY'06. The School Health Centers are an important source of mental health counseling for the student bodies they serve. The IDHS is an active participant in IDPH's Suicide Prevention Task Force. The MCH program is an active participant in the Illinois Children's Mental Health Partnership. The Division of Community Health and Prevention and the Division of Mental Health continue to lead the Early Childhood mental Health State Plan Work Group. The work group created a charter, approved by IDHS leaders, that outlines their mission to examine the contribution IDHS makes in early childhood mental health; identify system gaps, challenges, and opportunities; determine the essential elements of a comprehensive, coordinated early childhood mental health system; and develop strategies to improve access to and quality of mental health services for 0 - 5-year-old children and their families.

/2008/ In FY'07 the Early Childhood Mental Health Consultant pilot expanded to 13 sites. All pilot programs received continuation funding through fiscal year 2008. //2008//

/2009/ The ICMHP has identified the following Strategic Priorities for enhancing Illinois' system of mental health treatment services for children: 1) Promote ongoing family/consumer and youth involvement in administrative, policymaking and resource decisions regarding the Illinois children's mental health system at the state, regional and local level; 2) Advocate for increased children's mental health services and programs; 3) Develop culturally competent mental health consultation initiative(s) that educate, support and assist providers in key child-serving systems (e.g., early childhood, child care, primary care, public health, mental health and education); 4) Create a comprehensive, culturally inclusive, and multi-faceted public awareness campaign plan; 5) Build public and private sector awareness and response to maternal depression with attention to prevention and early intervention efforts, and necessary follow-up assessment and treatment services, where appropriate; 6) Build and enhance school-based activities focused on social and emotional educational and support services, and provide professional development and technical assistance to school administrators and staff; 7) Promote mental health screening and assessment and appropriate follow-up services of children and youth involved in the child welfare and juvenile justice systems; 8) Increase early intervention and mental health treatment services and supports for children: Ages 0-5 years; Transitioning out of public systems (e.g., child welfare, mental health, juvenile justice); Who have been exposed to or experienced childhood trauma (e.g., violence); Who need follow-up services in the SASS system beyond 90 days; and Who have mental health problems that are not severe enough to qualify them for public programs; 9) Convene a multi-agency and multidisciplinary work group to examine how children's residential mental health treatment services are funded and accessed in order to develop strategies for improving financing, cost-effectiveness, and access to residential services and alternative community services, where appropriate; and 10) Initiate development of a policy and research center(s) to support research-based workforce development, best practice models and technical assistance on children's mental health in such areas as cultural competence, family involvement and consumer-driven care. //2009//

Annual performance will be reported through the Block Grant application and annual report through National Performance Measure 16 and State Performance Measure 9.

Children with Special Health Care Needs

1. Improve access for CSHCN to quality healthcare through Medical Homes - This issue was identified by the CSHCN Advisory Panel and by families in both the national and the DSCC Family Surveys. This is also an area of special emphasis in the Healthy People 2010 goals for CSHCN.
2. Improve access for YSCHN to transition services - The complexity of transition issues for YSCHN was identified by the DSCC Family Surveys, (past and most recent), by respondents to the National Survey, and by the CSHCN Advisory Panel as particularly problematic for youth as they leave the services and supports provided to children.
3. The CSHCN Advisory Panel identified service linkage and coordination as an overarching concern. The DSCC Family Survey (past and most recent) demonstrated that families having children receiving SSI have significant problems in accessing needed services. DSCC is more effective in addressing these issues for families with children who are also enrolled in the DSCC program. DSCC continues to reach out to families whose children are not eligible to assist them in linking to appropriate programs and services in their local communities.

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	2003	2004	2005	2006	2007
Annual Performance Objective	98	99.5	99.9	99.6	99.7
Annual Indicator	99.5	99.9	99.9	99.8	99.2
Numerator	182979	181975	178700	176890	175837
Denominator	183899	182158	178872	177234	177234
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
	2008	2009	2010	2011	2012
Annual Performance Objective	99.8	99.9	99.9	99.9	99.9

Notes - 2007

Source: IDPH - Genetics. The 2007 vital records have not been released from IDPH. When these data become available, the final occurrent births will be reported.

Notes - 2006

Source: IDPH - Genetics. Denominator source: IDPH Center for Health Statistics - occurrent births.

Notes - 2005

The denominator is the final number of occurrent births in 2005. The numerator has been extrapolated to provide the same rate as the provisional as reported the year before. Each year

the prior year's denominator is revised when the final number of occurrent births is available from the Illinois Department of Public Health.

a. Last Year's Accomplishments

More than 99 percent of the children born in Illinois were screened for over 30 metabolic disorders. Actual performance (99.2 percent) was below the goal of 99.9 percent. Each year, IDPH screens more than 180,000 newborns for over 30 conditions (PKU, congenital hypothyroidism, galactosemia, congenital adrenal hyperplasia, biotinidase deficiency, hemoglobinopathies, amino acid, organic acid, and fatty acid oxidation disorders). Of these, more than 300 are diagnosed with one of these conditions, and another 4,100 are found to have an abnormal hemoglobin trait (refer to Form 6 in Appendix B). Staff assure that each infant receives appropriate referral, diagnosis, treatment, counseling, and long-term follow-up services.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

Newborns are routinely screened for more than 30 metabolic disorders. Infants with a positive screening result are followed through diagnostic evaluation, and children diagnosed for some conditions are followed up through 15 years of age.

Chicago. CDPH Maternal and Family Planning programs routinely screen for inherited disorders in community health clinics, and provide genetics education and referrals. Folic Acid is offered to all prenatal clients. The Public Health Nursing program receives referrals for children up to one year old for genetic disorders, and provides home visits and referrals to family counseling and genetics follow-up.

c. Plan for the Coming Year

The IDPH Genetics/Newborn Screening program will establish practices to ensure that every newborn in the state is screened. IDPH and DSCC will continue to partner in the care of children diagnosed with a metabolic or genetic disorder. A vendor, Pekin-Elmer, was selected to develop a web-based Newborn Metabolic Screening Data System that will have the capacity to interface with the birth record to ensure that all Illinois infants are screened. In March 2008, cystic fibrosis was added to the Newborn Screening panel.

Chicago. CDPH will continue routine genetics screening and referrals for genetics follow-up.

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	2003	2004	2005	2006	2007
Annual Performance Objective	60.6	60.6	60.6	60.6	60.8
Annual Indicator	60.6	60.6	60.6	60.6	60.3
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	60.3	60.3	60.5	60.5	60.7

Notes - 2007

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

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The 2005/2006 Children with Special Health Care Needs (CSHCN) Survey found that 60.3 percent of Illinois families with CSHCN ages 0 to 18 reported partnering in decision making at all levels and were satisfied with the services they receive. This was a .3 percent decline from the previous CSHCN Survey.

The DSCC Family Liaison continued to participate in training new care coordination staff and addressed family concerns about the program.

The DSCC Family Advisory Council (FAC) with membership made up of families from the 13 DSCC regions provided needed advice on the following:

Consumer feedback regarding the Medically Fragile/Technology Dependent Medicaid waiver was provided to a representative from the Department of Healthcare and Family Services.

Development of a 2008 DSCC Medical Home Calendar which included selected artwork from children across the state.

Strategies that DSCC could utilize for supporting families as partners in decision making.

The Family Page on the DSCC website and the Special Addition kept interested families informed of Maternal Child Health Bureau (MCHB) and DSCC initiatives and other resources. DSCC provided a stipend and travel reimbursement for FAC members. Members of the FAC were

supported in attending the AMCHP Conference in Washington DC.

The DSCC Family Liaison assisted AMCHP in the development of organizational changes which enhanced family leadership opportunities. The DSCC Family Liaison participated on AMCHP committees to promote family participation.

Over the past several years, DSCC and Early Intervention representatives have participated in the Bureau of Family Nutrition sponsored "Nutrition for Children with Special Health Care Needs Workshops." The most recent of these workshops was held in Bloomington, Illinois on November 2, 2007. The keynote address was very well received as presented by Timothy J. Drew, Ed.D, LCPC Coordinator of Child and Adolescent Behavioral Health Clinic OSF St Francis Medical Center in Peoria, Illinois. Dr. Drew's research interests and program development include ADHD, character education, parenting stress, mealtime interaction, and positive discipline. Increasing awareness of community resources for collaboration of services was also a focus with exhibits from DSCC, EI and the ARC of Illinois.

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				X
2. Promote family/physician partnership through the Medical Home initiative				X
3. Family education on state/federal activities through Special Addition/DSCC Family website				X
4. Collaboration with the Family-to-Family Health Information Center to improve access to information		X		
5. Collaboration with families in Individualized Service Plan development		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Family Liaison assisted in developing and conducting training for all DSCC regional office (RO) staff. The training emphasized teaming, family centered care, family professional partnerships and care plan development.

ROs are encouraged to recruit new family members for FAC. The FAC advised DSCC on: development of a more "family friendly" application; the DSCC Individual Service Plan to prepare for revision; and evaluation of the Care Notebook Tutorial.

DSCC collaborated with the Illinois Chapter of the American Academy of Pediatrics (ICAAP) in the National Medical Home Grant by promoting family participation in grant activities. The DSCC learning sessions on family involvement were provided for all families in the project, including how to tell their family stories about what it means to have a child with special health care needs. Technical assistance was provided for the new teams in family centered care and family professional partnerships.

DSCC collaborated with the Illinois' Family to Family Health Information and Education Center

(F2FHIEC) to address information and other resource needs identified. The DSCC Family Liaison serves on the F2F Advisory Board.

The DSCC Family Liaison assisted with the Newborn Hearing Grant activities by meeting with parent to parent support groups to determine resource availability, group mission and service gaps for families of infants with hearing loss.

c. Plan for the Coming Year

The DSCC Family Liaison will continue to explore ways to increase the cultural diversity of the DSCC Family Advisory Council.

The relationship with the Illinois Family to Family Health Information and Education Center will continue to expand this next year as the Center moves into their third grant year. Additional statewide family leadership trainings will be a major emphasis for the Center with the DSCC Family Liaison participating in the training development and implementation phases. The DSCC Family Liaison will continue to serve on this Advisory Board.

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	2003	2004	2005	2006	2007
Annual Performance Objective	50.7	50.7	50.7	50.7	50.9
Annual Indicator	50.7	50.7	50.7	50.7	45.1
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	45.1	45.3	45.3	45.5	45.5

Notes - 2007

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

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The 2005/2006 CSHCN Survey found that 45.1 percent of Illinois families with CSHCN reported that they received coordinated ongoing comprehensive care within a Medical Home. This data is not comparable to the previous CSHCN Survey.

DSCC continued involvement in Phase II of the Medical Home Grant that is testing the hypothesis that five practices with facilitators would make changes to improve the practices' quality more effectively and efficiently than the five practices that did not have a facilitator. Work also continued on: expanding the categories for the Life Span Database so it would contain a wide scope of community resources for children with special health care needs; integrating the 20 state Care Notebooks into the AAP's Medical Home website for families to create a customized care notebook for their child; promoting public awareness of the Medical Home concept through a statewide coloring contest for students in grades 1 through 6, and revising the Medical Home Primer for Pediatricians and Family Physicians that is available on the DSCC Medical Home website.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

The Life Span Database, website and training curriculum for building individualized care notebooks for CYSHCN was completed. Phase II of the ICAAP medical home grant continued through June 2008. Draft information was released from the American Board of Pediatrics outlining criteria related to quality improvement. Dr. Onufer collaborated with ICAAP to propose a pilot project for Illinois pediatricians that is similar to the Medical Home Project as a model for meeting recertification requirements.

c. Plan for the Coming Year

The expansion of categories addressing CYSHCN has been completed for the LifeSpan Database. During the coming year, the main goal is to populate the database with community resources. The following organizations have volunteered to contribute their listing of resources: Brain and Spinal Cord Injury Associations, the Hope School, IDHS, and the DSCC care coordinators from the 13 Regional Offices. Phase II of the ICAAP Medical Home grant will end in June 2008. Once data is compiled and analyzed, a report will describe the success or drawbacks of utilizing facilitators in practices to structure quality improvement. Preliminary data suggests that facilitators play a key role in successfully supporting practices to effectively and efficiently implement quality changes in their practices. Dr. Onufer is working with ICAAP staff to develop potential grant projects to continue supporting medical home activities in Illinois. The focus of the activities being considered involves quality improvement maintenance of certification (MOC)

activities and NCQA certification for pediatricians. Physicians engaging in quality improvement activities to meet MOC or NCQA certification may also be eligible for enhanced reimbursement through the contracts they have with health plans. The "building your own care notebook" project will be completed once representatives from Family Voices are trained to facilitate family workshops throughout the country. The medical home coloring contest will be repeated this year and DSCC will use the winning drawings to develop a 2009 calendar. The 7-C Medical Home Practice and Family Surveys will be tested and a validation process initiated so the surveys can be used in future medical home quality improvement projects.

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	2003	2004	2005	2006	2007
Annual Performance Objective	53.3	53.3	53.3	53.3	53.5
Annual Indicator	53.3	53.3	53.3	53.3	59.3
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	59.3	59.5	59.5	59.7	59.7

Notes - 2007

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

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The 2005/2006 CSHCN Survey found that 59.2 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 5.9 percent increase from the previous CSHCN Survey.

DSCC participated in Covering Kids and Families Illinois meetings, maintained liaison contacts with public/private organizations and shared program benefit information with key state agencies. DSCC assisted uninsured applicants and recipients to apply for the state All Kids Program. Approximately 5 percent of children enrolled in DSCC had no third party benefits during the last fiscal year.

DSCC collaborated with the state Illinois Department of Healthcare and Family Services to promote the state's Primary Care Case Management system by sharing information on DSCC's Medical Home Initiative activities and to identify the state CYSHCN population served by DSCC, which is an exempt group.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

DSCC maintains liaison contacts with key state agencies to promote awareness of DSCC as well as other public or private programs, including eligibility guidelines, services and enrollment procedures to assist CYSHCN and their families to access and pay for needed medical care. DSCC, an application agent, refers uninsured CYSHCN to apply to the All Kids Program and other private and public programs available to pay for needed care.

DSCC met with the Illinois Comprehensive Health Insurance Plan (ICHIP) to discuss the DSCC eligibility determination process as ICHIP and IDHFS work with health care expansion for those youth with chronic health conditions who are 19 years or older and would lose All Kids eligibility.

DSCC technical assistance staff provides training and technical support of benefit management activities for care coordination staff.

DSCC assisted the Family to Family Health Information and Education Center with development of a guide to Illinois and national internet resources for families with insurance issues. In addition, DSCC provided technical assistance to the Family to Family Health Information and Education Center in the development of "A Guide for Families of Children with Special Health Care Needs, All Kids Insurance vs. COBRA Coverage Which One Should I Pick."

c. Plan for the Coming Year

DSCC will continue as All Kids Application Agent throughout the state to enroll CYSHCN without insurance into the Medicaid, SCHIP and state health care expansion programs. DSCC will continue to investigate and evaluate additional benefit management family support materials for families of CYSHCN. DSCC will also work in collaboration with partners from Family Voices and the Family to Family Health Information Grant in the development of and access to insurance information and presentations for families throughout the state.

DSCC Benefit Management technical assistance staff will research and develop training materials and assess technical assistance strategies to enhance benefit management and transition activities and assist with access to private and public health care and funding of care. DSCC will

continue to support the participation of the CYSHCN and their families, their health care providers, public and private funding sources and care coordination staff in implementing a team approach and to maintain quality standards.

Contact information on the Family to Family Health Information Center will continue to be sent to all SSI eligible children, which includes assistance with health care and insurance questions. Health insurance options will continue to be discussed with transition age youth and their families prior to the 18th birthday.

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	2003	2004	2005	2006	2007
Annual Performance Objective	76.1	76.1	76.1	76.1	76.3
Annual Indicator	76.1	76.1	76.1	76.1	89.8
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	89.8	89.8	90	90	90.2

Notes - 2007

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

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The 2005/2006 CSHCN Survey found that 89.8 percent of Illinois families with CSHCN reported that the community-based services systems were organized so that they can use them easily. This was a 13.7 percent increase from the previous CSHCN Survey.

DSCC staff coordinated and collaborated with state and local agencies to identify and resolve service gaps and duplication. Two DSCC staff provided consultation to the Family to Family Health Information and Education Center in Illinois and served on the Advisory Committee for the Center. Community system development efforts continued in all areas of the CSHCN Healthy People 2010 goals with emphasis on Medical Home, Transition, Newborn Hearing and Early Intervention. DSCC continued to maintain an internet website to which information and links were

added or updated regularly, including information on Medical Home, Transition and Newborn Hearing and a variety of resources. A new website specifically about newborn hearing screening was developed and can be found at illinoisoundbeginnings.org.

Efforts to assist families of children eligible for SSI in accessing necessary services continued with telephone contact attempted for children ages 3 to 4 years and 14 to 16 years. DSCC mailed information (in English and Spanish) providing referral resource information to families of children age 16 years or less that are newly eligible for SSI.

DSCC also assisted the families of 500+ children who are technology dependent/medically fragile (TD/MF) to access needed services through a Home and Community Based Services (HCBS) Medicaid waiver so these children can live at home with their families in their communities. Efforts continued to facilitate the transition of these children as they approach 21 years of age and need to move to other programs for adults. DSCC worked closely with IDHFS, the state Medicaid agency, and IDHS-DRS and community agencies to address the needs of these children. The three-agency agreement addressing collaboration efforts for transition remained in effect.

Illinois' mechanism for families of individuals with developmental disabilities to make their needs known and help them access services, Prioritization of Urgency of Need for Services (PUNS) was used by DHS' Division of Developmental Disabilities to identify and provide services to children and adults most in need.

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 memorandum of understanding with agencies				X
3. Mutual referral process with Early Intervention Program				X
4. Collaborative efforts with state transition effort				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

IDHS DRS, DSCC and IDHFS continued working with a vendor on contract with IDHFS to develop an objective screening tool for HCBS waiver eligibility, a comprehensive assessment tool and a service plan that addresses service needs. IDHFS and DSCC are exploring strategies for making these tools available for use by care coordinators via laptop computers.

DSCC staff, as All Kids Application Agents, continued to assist families with no insurance to apply for the All Kids program. DSCC also continued working to assure that DSCC children, all of whom are exempt from the Medicaid Primary Care Case Management program, are appropriately identified in the Medicaid and PCCM databases, so that these children can be disenrolled from the PCCM program and its requirements. DSCC provided a supply of DSCC Medical Home calendars to the PCCM contractor for distribution to primary care physicians to increase awareness of DSCC and Medical Homes. DSCC care coordinators continue to assist families with children enrolled in All Kids and DSCC to access primary and specialty services.

Efforts to improve systems of services continue in the areas of Medical Homes, Transition, Newborn Hearing and Early Intervention. These are discussed in detail in other performance

measures.

DSCC continues to provide information to children newly eligible for SSI with phone calls attempted to families with children ages 3-4 years and 14-16 years to assist them in linking to appropriate services.

c. Plan for the Coming Year

DSCC will continue collaborative efforts with IDHFS and IDHS-DRS to improve the transition of children from the TD/MF Medicaid waiver as they reach 21 years of age to other appropriate programs and services. IDHFS and DSCC will continue developing quality management strategies that link to outcomes and provide data to assist with making system wide improvements in the overall quality of services for all children. Efforts to improve systems of services for CSHCN will continue, especially in the areas of Medical Homes, Transition, Newborn Hearing and Early Intervention. DSCC will produce and disseminate another calendar to promote care coordination and Medical Homes.

DSCC is exploring additional partnerships to prepare for the next Integrated Community Systems grant, especially looking at Federally Qualified Health Centers and other existing system development initiatives to promote statewide spread of system changes for children and youth with special health care needs.

DSCC will also continue to assist families having children age 16 years or less, newly eligible for SSI, to connect with needed services.

DSCC staff will continue to assist families needing support services for their children with developmental disabilities, including referral to the PUNS.

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	2003	2004	2005	2006	2007
Annual Performance Objective	5.8	5.8	5.8	5.8	5.9
Annual Indicator	5.8	5.8	5.8	5.8	44.2
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	44.2	44.2	44.4	44.5	44.6

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The 2005/2006 CSHCN Survey found that 44.2 percent of Illinois youth and their families received the services necessary to make transition to all aspects of adult life. This data is not comparable to the previous CSHCN Survey.

The Interagency Coordinating Council (ICC) on Transition continued to work toward system change by holding a strategic planning retreat in May 2007 to evaluate accomplishments, identify opportunities for improvement and create a vision for the future. The implementation process moved slowly and the ICC continued to struggle. Discussion was held and recommendations given that the ICC needed to identify a legislative liaison.

The Public Education and Outreach Committee received several additional survey responses from the Campus' Disability Support Services Offices that had not responded in the past. Institutions were asked "what documentation is required to access accommodations" for each of 16 "disability types" in three settings: academic/classroom, library/labs, and campus access. Twenty-six of the 46 respondents required similar documentation across settings but there was great variation. Campuses in the northern part of the state most frequently responded for learning disabilities: IEP, psychological, medical diagnosis, or IQ. Campuses in the southern region required IEP and a psychological diagnosis. The central Illinois campuses require psychological, IQ, and achievement tests. Other responses were vague such as "clinician statement," "psychological or comparable," "documentation on individual basis," and "written documentation". These findings were shared with transition planning committees and transition specialists in the secondary educational settings across the state to increase awareness of the variation in requirements as they assist students with transition to college. Nearly 60 percent of the Campus' Disability Support Services Offices indicated they would be interested in using a standard form for determining eligibility for services.

The Public Education and Outreach Committee planned a one-day event, Abilities, Aspirations, and Access, to expand the recruitment of students and school personnel into programs that provide the coursework for Learning Behavioral Specialist II(LBS-II)-Transition Specialist certification. All public universities were invited to send up to three representatives to work on creating a plan for seeking approval to develop a certification program. The event was cancelled due to lack of interest. The Council was informed by the Board of Higher Education that they will only look at certifications requiring over 18 hours and the LBS-II/Transition Specialist Certification only requires 12 hours.

DSCC staff again participated on the steering committee and subcommittees for the second annual statewide transition conference: "Real Options: Making the Move." For the first time in Illinois, a health care transition track was held on October 16th as part of this conference targeting health care providers, families, and youth. National experts in transition for youth with chronic health conditions/disabilities presented, including Peter Scal MD, Patience White MD and Patti Hackett. Fifty health care providers participated: 5 physicians, 15 nurses, 20 social workers and 1 physical therapist, along with child life specialists, public health providers and medical students. A plenary session by Patti Hackett which was attended by educators, school administrators, vocational specialists, community partners, advocates, transition specialists, care coordinators, health care providers, families and youth increased awareness that good health is essential to meeting education, employment and independent living goals and should not be

overlooked during transition planning.

Continued participation in Regional Transition Planning Consortiums allowed opportunities for networking, improved collaboration, and information resource sharing.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participation on the Illinois Interagency Coordinating Council for Transition				X
2. Transition training/technical assistance for care coordinators		X		
3. Expansion of state data collection mechanisms				X
4. Promoting awareness of transition issues/resources				X
5. Participation in Annual Statewide Transition Conference planning group				X
6. Expansion of partnerships and alliances				X
7.				
8.				
9.				
10.				

b. Current Activities

Over 730 participants attended the third annual conference: Beyond Expectations Time for Change in December, 2007. Patience White MD presented on health care transition at the Illinois' Medical Home Learning Collaborative in December 2007.

The University of Illinois at Chicago Department of Disability and Human Development Rehabilitation Research Training Center on Aging with Developmental Disabilities in collaboration with DSCC received a one-year grant from the Illinois Council on Developmental Disabilities. The project, Building Capacity among Pediatric Residents to Promote Health Advocacy among Persons with Developmental Disabilities, is aimed at medical students and residents. Students attend a two-hour presentation to increase their knowledge, improve attitudes and enhance self efficacy towards health advocacy for adolescents with intellectual/developmental disabilities and then observe through scheduled community based site visits good models of communication and health promotion, self advocacy, and health literacy skill building activities.

c. Plan for the Coming Year

DSCC's transition strategic plan goals include: provide information and training to adult healthcare providers and other stakeholders on healthcare transition; increase collaboration with transition partners to improve and sustain systems of care; and improve access to high quality, developmentally appropriate and uninterrupted healthcare. DSCC's Medical Advisory Board, administration, transition technical support staff and regional care coordinators will continue to identify adult health care providers in Illinois trained, willing and ready to care for youth/young adults with congenital/child onset chronic conditions to assist with transition to the adult health care system.

DSCC will increase community-based collaboration that is committed to developing a high-quality, well-coordinated, easily-accessible system of care within medical homes for young people with special health care needs around transition issues. Planning and collaboration has begun in an effort to prepare for the HRSA funding opportunity next fall for State Implementation Grants for Integrated Community Systems for Children and Youth with Special Health Care Needs.

Ongoing trainings for health care professionals, youth and families will be provided through the Annual Statewide Transition Conference and the Annual Illinois Youth with Disabilities Leadership Summit. DSCC will also continue to participate on state and local councils/committees to continue collaboration with external transition partners to improve and sustain systems of care.

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	2003	2004	2005	2006	2007
Annual Performance Objective	79	82	84.5	85	87
Annual Indicator	84.6	83.7	84.8	81.9	78.5
Numerator	216602				
Denominator	256031				
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
	2008	2009	2010	2011	2012
Annual Performance Objective	79	79	80	80	85

Notes - 2007

Estimated Vaccination Coverage with 4:3:1:3 Among Children 19-35 Months of Age - National Immunization Survey. Provisional data during preparation of this application is available for Q3-Q2. This report does not provide a numerator or denominator. The data are derived from a telephone interview of approximately 400 individuals.

The trend appears to be decreasing. However, the Confidence Interval for the percent coverage with 4:3:1:3 is +/- 6.8 suggesting that the decrease is not statistically significant. (2007 data caused a "Data Alert" or a departure from past performance with administering these immunization series.)

Notes - 2006

Estimated Vaccination Coverage with 4:3:1:3 Among Children 19-35 Months of Age - National Immunization Survey. Final data for a given year includes Q1-Q4, 2006. This report does not provide a numerator or denominator.

Notes - 2005

Estimated Vaccination Coverage with 4:3:1:3 Among Children 19-35 Months of Age - National Immunization Survey. Final data for a given year includes Q1-Q4, 2005. This report does not provide a numerator or denominator.

a. Last Year's Accomplishments

The most current release of the National Immunization Survey (NIS) results in 2007 indicates that series completion levels for Illinois are as follows: 4/3/1/3/3 series at 76.6 percent; 4/3/1/3/3/1 series reported at 72.5 percent. The NIS data for the Illinois federal project area that excludes the city of Chicago are as follows: 4/3/1/3/3 series at 76.9 percent and the 4/3/1/3 at 78.5 percent.

These series levels track additional vaccines that have been included on the ACIP recommended childhood immunization schedule.

IDHS, IDPH, and IDHFS have collaborated on a campaign to improve the immunization level of children participating in the WIC program. Local WIC agencies (most of which are local health departments) received regular reports from IDHS on the proportion of infants and toddlers in the WIC program who were fully immunized. In addition, IDPH provides funding to support immunization efforts in CEDA WIC agencies. During 2007, 85.9 percent of children ages 18-24 months served at one of 15 CEDA-operated sites met the 3/2/2 coverage and 84.9 percent of children ages 24-35 months met the 4/3/3/1 series coverage. Statewide, WIC children ages 12-18 months achieved 3/2/2 series coverage of 84.4percent. This is an increase from the previous reporting period.

IDHS is using the Cornerstone system to establish an immunization registry. Local health departments enter data on immunizations provided through their clinics. Data on immunizations provided to Medicaid eligible infants and toddlers by private sector physicians are added from IDHFS' Medicaid Management Information System on a monthly basis. Further, the Department has worked with the CDPH, the CCDPH and their software vendor to import immunization records from their data systems. Finally, Cornerstone is linked to IDPH's "Tracking Our Toddlers Shots," or "TOTS" software. IDPH provides TOTS software to interested physicians for use in their practices. TOTS transitioned to a web-based application in 2007 known as ICARE.

IDPH provides federal immunization grant funds to support Vaccines for Children Assessment, Feedback, Incentives and Exchanges (VFC-AFIX) and provider education initiatives through the Illinois Chapter of the American Academy of Pediatrics (ICAAP), Rockford Health Council, CCDPH, Will County Health Department, Macon County Health Department, Madison County Health Department, and Peoria City-County Health Department. In 2008, St. Clair County Health Department has also received supplemental funding to support these efforts. VFC operations require that a minimum of 25 percent of all enrolled providers receive a site visit annually. There are over 1,500 VFC sites (excluding Chicago) representing over 3,000 physicians. Historically, the Illinois project conducts over 500 site visits.

In addition, general revenue funds have been awarded annually since FY01 to four agencies providing direct services to children in areas identified as high risk to under immunization or access to health care services as well as areas with identified health care disparities.

Chicago. 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 2007, 1,062 children were born at the hospital and 100 percent received their "birth dose" Hepatitis B vaccine before they were discharged.

CDPH's Immunization Program operates nine walk-in immunization clinics that served over 6,911 children in 2007. For FY2007, 88.6 percent of two-year-olds were fully immunized in CDPH's Family Case Management, Public Health Nursing, and community health clinics, an increase over 87.1 percent for FY 2006.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The IDPH Immunization program distributes vaccines to local health departments and Vaccines for Children			X	
2. The IDPH Immunization program assesses immunization levels of children served in public clinics				X
3. The IDPH Immunization program directs additional resources to areas identified as "Pockets of Need."			X	
4. Additional outreach activities are conducted by the Chicago Department of Public Health & community organizations or coalitions			X	
5. IDHS monitors and distributes reports of immunization				X

coverage of children in the WIC program				
6. IDHS monitors immunization coverage of children in programs for infants, young children, and teen parents		X		
7. IDHFS sends reminder notices to families		X		
8. IDHFS collaborates with IDPH on Vaccines for Children				X
9. IDHFS provides patient-specific feedback on immunization status to Primary Care Case Managers				X
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 Vaccines for Children (VFC) program. The program operates the following:

- * distributes vaccines to public and private providers statewide through the Vaccines for Children Plus program;
- * conducts surveillance and investigates outbreaks of preventable childhood and adult diseases;
- * conducts mandatory assessments of vaccine coverage levels among various target populations, including VFC enrolled providers, and public clinics; and
- * works with the IDHFS to improve immunization levels among Medicaid-eligible children, as required for the Government Performance and Results Act.

Chicago. CDPH supports "Keeping Immunizations Current for Kids" (KICK), which is a provider-based reminder and recall program. The program is designed to educate providers regarding immunization recommendations and practices through the "Reaching Our Goals" curriculum and improve reminder/recall efforts to keep patients on schedule. Staff track children in need of immunizations and refer them to their providers, FastTrack clinics, or the CareVan. This activity is funded by state general revenue funds awarded by IDPH. The Immunization Program operates 9 immunization walk-in clinics that provide fast, free, and friendly immunization services to children 0-18 years of age. The 9 Fast Track clinics are located in 7 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 TOTS/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. The information will be followed up with consultation and technical assistance from regional staff.

IDPH will continue the following assessment activities:

- * Conduct and review the annual IDCFS/IDPH child care and Head Start survey. The survey will be distributed to approximately 2,200 child care and Head Start centers in Illinois (excluding Chicago). (A separate survey is conducted by the Chicago Department of Public Health. Results are provided to IDPH.) The 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. The survey has been revised to aid completion, improve compliance, and meet CDC reporting needs.

- * IDPH will conduct visits at a minimum of 25 percent of enrolled provider sites within VFC to determine VFC compliance and conduct assessment of practice coverage levels.

The annual quality assurance reviews to determine compliance with the Standards for Pediatric Immunization Practices will continue. The reviews have proven to be successful in identifying existing barriers and documenting recommendations for improvements in clinic practices.

Documentation required to comply with the National Childhood Vaccine Injury Act is reviewed thoroughly. 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 according to a curriculum developed entitled, "Reaching Our Goals." This peer education strategy

will also promote "birth dose" Hepatitis B vaccine efforts as well as adolescent immunization services and promotion. A grant agreement with Rockford Health Council will be maintained to address AFIX and provider education in Winnebago, Boone, and Ogle Counties. AFIX agreements were added in Peoria, Macon, and Madison Counties.

Chicago. The CDPH Immunization Program will continue to intensify strategies to improve immunization rates in Chicago, with the following current activities: outreach, FastTrack 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	2003	2004	2005	2006	2007
Annual Performance Objective	23.5	23	22	21	21
Annual Indicator	22.9	22.8	21.2	22.1	22.1
Numerator	5922	5983	5794	6120	6120
Denominator	258991	262266	273565	276507	276507
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
	2008	2009	2010	2011	2012
Annual Performance Objective	21	21	21	21	21

Notes - 2007

Vital Records data for births in 2007 are not available at this time. 2006 data is being used as provisional at this time. Refer to the general Form 11 Note.

Notes - 2006

Source: IDPH Birth for 2006, received August 2008.

Notes - 2005

Source: IDPH website containing vital statistics of births to teens under age 20 and the 2005 population estimates of females aged 15-17, US Census Bureau, available from: <http://www.census.gov/popest/states/asrh/files/>

a. Last Year's Accomplishments

The rate of births to 15 to 17 year old women in 2006 was 22.1 per 1,000; a slight increase from the rate reported in 2005 (21.2 per 1,000) and above Illinois' performance target (21 per 1,000). The birth rate among 15 to 17 year olds has declined by 28 percent between 2000 and 2006. The birth rate has declined among all racial and ethnic groups (whites, 24 percent; blacks, 26.7 percent; and Hispanics, 12 percent). The number of births to teen mothers as reported in 2006 increased by 326 births (less than one percentage point) from the record low set in 2005. These are the most recent Vital Statistics available.

Several programs in the Division of Community Health and Prevention contributed to preventing teen births:

* The Primary and Subsequent Teen Pregnancy Prevention programs provided services to

66,000 adolescents in SFY'07 and reported a repeat pregnancy rate of less than one percent.
 * Teen Parent Services helped more than 2,236 low income teen parents work on finishing school and move from welfare to work in SFY'07;
 * Parents Too Soon helped more than 1,914 teen parents develop parenting skills, delay a subsequent pregnancy, and finish school.
 * The Family Planning program, which provided comprehensive reproductive health services to 33,664 adolescents in CY' 07.
 * Parents Too Soon helped nearly 1,000 teen parents develop parenting skills, delay a subsequent pregnancy, and finish school.
 This comprehensive array of services includes widely recognized best practices for helping teens make healthy choices.

Chicago. The Greater Englewood Healthy Start program provided services to 18 pregnant adolescents age 17 and under, in CY2007. In addition, CDPH FCM, Public Health Nursing, and community health clinics provided services to 253 pregnant adolescents aged ten through 14, and 3,269 pregnant adolescents aged 15 through 19, during FY2007. In late 2006, CDPH received a five-year, \$2.5 million federal grant to promote responsible fatherhood to current and potential fathers of all ages. CDPH, in conjunction with Chicago Youth Programs, a community-based agency, has increased services within the existing Male Responsibility program in Englewood and initiated services in Uptown. The Promoting Responsible Fatherhood program addresses adolescent pregnancy primarily through a peer education and mentoring approach, encouraging adolescents and young men to assume some responsibility for preventing pregnancy, participating in family planning, delaying fatherhood until they achieve economic stability.

The Chicago Board of Education adopted a new Family Life and Comprehensive Sexual Health Education policy in April 2006. The policy requires that schools teach "comprehensive, age-appropriate sex education." Various youth leaders actively participated in the development of this policy, including CDPH's Male Responsibility Coordinator, and members of the Illinois Caucus on Adolescent Health.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDHS awards grants for Primary Teen Pregnancy Prevention programs		X		
2. IDHS awards grants for Subsequent Teen Pregnancy Prevention programs		X		
3. IDHS monitors repeat pregnancy rates among the clients of programs that serve teen parents				X
4. IDHS awards grants for Family Planning programs	X			
5. IDHS awards grants for Abstinence-only education programs		X		
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 Abstinence Only Education, PTS, TPS, TPP, SHCs, School Health, and Family Planning programs. (The federally funded Abstinence Only Education program recently ceased operation).

Chicago. Through its Family Case Management, Public Health Nursing, outreach, Family Planning, Healthy Start, Male Responsibility and Responsible Fatherhood programs CDPH

continues to assure that services are provided so that initial and repeat pregnancies are prevented. The Male Involvement and Family Planning programs provide education to teens on abstinence, the prevention of sexual coercion, HIV/STD, nutrition, exercise, and avoidance of smoking, alcohol, and drug use.

Chicago Public Schools use various curricula for their sex education program, including those from Planned Parenthood and Project Reality, an abstinence-only group.

c. Plan for the Coming Year

Prevention of teen pregnancy and sexual activity before marriage will be addressed by the routine activities of the PTS, TPS, TPP, SHCs, School Health, and Family Planning programs. Chicago. CDPH will continue to address adolescent pregnancy through Family Case Management, Public Health Nursing, outreach, Family Planning, Healthy Start, Male Responsibility, and Responsible Fatherhood programs The Chicago Public Schools will continue to work with youth leaders and the Illinois Caucus for Adolescent Health to continue to implement and improve their sex education curriculum.

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	2003	2004	2005	2006	2007
Annual Performance Objective	9.2	9.5	27	27	27
Annual Indicator	9.2	27.0	27.0	27.0	27.0
Numerator	14842	42219	42219	42000	42000
Denominator	161329	156370	156370	155356	155356
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
	2008	2009	2010	2011	2012
Annual Performance Objective	28	28	28	28	28

Notes - 2007

According to the IDPH, Oral Health program, the next oral health state level 3rd grade survey is planned for 2008-09. The 2004 through 2007 percentage is from its 2003-04 oral health survey results. Every year the MCH program has extrapolated this percentage to the statewide population of 3rd grade students located at the Illinois State Board of Education's website. Since the percentage has not changed, the MCH program is reporting last year's numerator and denominator.

The annual performance objectives for 2008-2012 have been adjusted one percent to correct a 'data alert' stating the state has already surpassed subsequent year's objectives. This has been true since 2005. It is possible in the future that Illinois will have a more positive method of reporting these data as a state instead of relying on the data collection of a very small underresourced public health program.

Notes - 2006

According to the IDPH, Oral Health program, the next oral health state level 3rd grade survey is planned for 2008-09. The 2004 through 2007 percentage is from its 2003-04 oral health survey results. Every year the MCH program has extrapolated this percentage to the statewide population of 3rd grade students located at the Illinois State Board of Education's website. Since the percentage has not changed, the MCH program is reporting last year's numerator and denominator.

The annual performance objectives for 2008-2012 have been adjusted one percent to correct a 'data alert' stating the state has already surpassed subsequent year's objectives. This has been true since 2005. It is possible in the future that Illinois will have a more positive method of reporting these data as a state instead of relying on the data collection of a very small underresourced public health program.

Source for this estimate: Fall Housing, 2006-2007 District Summary, State Total of Grade 3 Students. Illinois State Board of Education website. The numerator has been adjusted to reflect the last reported percent by IDPH in 2004.

Notes - 2005

In keeping with the detail sheet for this objective, the number of children in Grade 3 of Illinois public schools and facilities during school year 2004-05 is again being reported in FY2005. (Source: Illinois State Board of Education). IDPH estimates that 27 percent of those children are eligible to receive dental sealants through Medicaid and their Dental Sealant Program.

a. Last Year's Accomplishments

Illinois revised its goal of increasing the proportion of third grade children who have protective sealants on at least one permanent molar tooth. The state's actual performance was 27 percent. In school year 2003-2004, the IDPH Division of Oral Health (DOH) completed a basic screening survey of third grade children. The Healthy Smiles/Healthy Growth survey obtained important information about caries history (whether or not a child had evidence of any prior cavities), current untreated cavities, treatment urgency, presence of sealants, demographics, and socioeconomic variables. The survey found that 27 percent of all third graders had at least one dental sealant. The rate in the City of Chicago was 12 percent. In a 1993-1994 survey, 13 percent of third graders statewide and 3 percent in the City of Chicago had at least one sealant.

This performance measure is addressed by the IDPH Dental Sealant Grant program. Retention rates, monthly and quarterly reports, and on-site reviews are utilized to evaluate program performance. Communities are responsible for developing protocols for their programs in order to assure proper infection control, retention rates, equipment maintenance, patient referral and follow-up and adequate procedures for assuring eligibility.

The Chicago Department of Public Health Dental Sealant Program was initiated in 2001 and is growing steadily each year. During the school year 2006-2007 the School Based Dental Program performed oral health services on approximately 23,500 children and placed approximately 70,000 sealants. Services were provided in 540 Chicago Public Schools. Target grades were increased to include third and eighth grades. The program also began using a data system using scannable forms to aid their reporting process to the Chicago Public School (CPS) system and to the ISBE.

The Dental Sealant Grant Program completed an evaluation of the sealant program based on CDC's Program Evaluation Guide. The evaluation documented achievement of programmatic objectives, accomplishment of planned activities, and the quality of care provided through the program. Based on the evaluation of the program's data needs and collection process, the Division of Oral Health offered sealant program data software to community programs. DOH trained 12 grantee communities to collect data electronically that will provide program management and evaluation including an assessment of program cost effectiveness and averted disease rates.

The community programs provided school dental examinations as an adjunct to the program in order to assure their schools and the children they serve are compliant with the new school dental examination statute in Illinois. The mandate requires all children in Kindergarten, second, and

sixth grades to show proof of a dental examination. The first two years of data (2005-2007) demonstrated excellent compliance rates. In 2007, schools began to report oral health status information that may prove to be a valuable source of community specific data. The Chicago Public Schools did not submit the required data to ISBE either year. The Division's sealant program was highlighted in the Illinois Oral Health Plan II (IFLOSS 2007). Priorities and recommendations that appear in the new state Plan support efforts to promote, enhance, and expand the existing program. The Division of Oral Health served on the expert panel for the National MCH Oral Health Resource Center to review and revise the Seal America Manual -- the preeminent resource for sealant programs in the U.S.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDPH works with local health departments and schools to conduct dental sealant grant programs	X			
2. IDHFS contracts with Doral Dental to monitor sealant levels and conduct targeted outreach				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

IDPH has 60 dental sealant program grantees throughout the state that provide oral healthcare, oral health education, dental examinations, referrals for needed treatment, and outreach for All Kids enrollment.

The Division of Oral Health is providing technical assistance and training on a new dental sealant data system, SEALs for 12 community programs. The data system will not only monitor their program performance, it will provide monthly reports to the Division of Oral Health electronically, easing the amount of paperwork involved in the program. SEALs will be a source of oral health status data as it collects DMFTS information on every participating child.

The Division is working with the Illinois Department of Healthcare and Family Services to enhance the sealant program referral process using the Medicaid Administrator, Doral of Illinois, to contact families with children identified through the sealant program as needing dental treatment.

Chicago.

The Chicago Department of Public Health School-based Dental Sealant Program Quality Assurance Program continues to review oral health care providers finding a retention rate well over the 90 percent rate required by the State. The Chicago program has installed a data system using scannable forms that will aid their reporting process to IDPH, the Chicago Public School System and the Illinois State Board of Education. The Chicago program has expanded to all (over 500) Chicago Public Schools.

c. Plan for the Coming Year

The Division will continue to evaluate the use of the CDC's SEALs reporting software and to collect electronic data from additional grantees using other dental program data systems such as

Dentrix. The program will continue to work with HFS to monitor and assure case management/referral and the quality of oral health care provided in school-based programs. The Division of Oral Health will implement a Basic Screening Survey (BSS) of third grade children. The survey will be directed by the Division's Oral Health Epidemiologist and implemented in the 2008-2009 school year. All preparation and training of survey teams will be completed prior to September 2008. The Division's Surveillance Plan includes completing a BSS every five years. As with the 2003-2004 BSS, this survey will include collection of BMI data in collaboration with the IDPH obesity and nutrition programs.

Chicago. The CDPH School Based Dental Program plans to expand oral health services to include the CPS high schools. The program also is seeking to obtain a contract with the Chicago Archdiocese to provide oral health services to parochial schools.

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	2003	2004	2005	2006	2007
Annual Performance Objective	2.7	2.6	2.4	2.4	2.4
Annual Indicator	3.0	2.4	2.0	2.0	2.0
Numerator	76	64	55	55	55
Denominator	2534267	2699740	2752100	2752100	2752100
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
	2008	2009	2010	2011	2012
Annual Performance Objective	2	1.9	1.9	1.8	1.8

Notes - 2007

Vital Records data for births and deaths in 2006 or 2007 are not available at this time. Refer to the general Form 11 Note. Data from IDOT have been reported for this measure in the past but returned to IDPH for standard.

Notes - 2006

Vital Records data for deaths in 2006 are not available at this time. Refer to the general Form 11 Note.

Notes - 2005

Source: Center for Health Statistics - IDPH released on July 13, 2007 and U.S. Census Bureau

a. Last Year's Accomplishments

Illinois achieved its goal of reducing the rate of motor vehicle crash deaths among children between one and 14 years of age to 2.4 per 100,000 children. Actual performance was 2.04 per 100,000 in 2005, the most recent data available.

The Department continued its partnership with the city of Chicago Police Department, the Illinois State Police, the city of Chicago Hispanic Health Coalition, 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 1,200 car safety seats were distributed to low-income families, and

over 3,000 car seats were checked for proper seat installation. The Illinois State Police provided audiovisual equipment to play a videotape that portrayed the cause and effects of injuries and fatalities resulting from motor vehicle crashes. This included seat belt use, as well as proper car seat installation.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDHS conducts child safety seat checks. /2008/ Change to read: IDHS participates in child safety seat checks and seat distribution. //2008//		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Due to a lack of funds, the Department has significantly reduced the distribution of car safety seats. Although the Department continues to submit grant applications to the Illinois Department of Transportation to purchase car safety seats, it is not a priority grant recipient for IDOT and has not been awarded a grant in several years. The Department relies on community partners and recently distributed approximately 1,500 safety seats in 2008.

c. Plan for the Coming Year

The Department will expand the number of Child Safety Seat checks statewide, in conjunction with the Governor's Keep Kids Safe and Warm Campaign. The Department and the Illinois State Police, along with a network of health departments, community-based organizations, DHS local offices, and churches will conduct child safety seat checks and distribute child safety seats in the coming year. Use of child safety seats is a community issue. Many parents cannot afford to purchase a child safety seat or 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 "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	2003	2004	2005	2006	2007
Annual Performance Objective				31	28
Annual Indicator			30.0	28.0	25.7

Numerator			16187	15328	14483
Denominator			53960	54663	56315
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
	2008	2009	2010	2011	2012
Annual Performance Objective	26	27	27	28	28

Notes - 2007

The Numerator is infants Still Breastfed at 6 Months. The Denominator is infants Ever Breastfed. Source: Count and Percent of WIC Breastfed Infants, SFY 2007 Annual Report, CHP, IDHS. According to the Breastfeeding Report Card, United States 2007: Outcome Indicators (which reports WIC and Other data) the Illinois' percent at 'breastfed at 6 months' was 40.9.

The downward trend is due to stricter edits or quality assurances measures added to the client information system. Previously, WIC service providers reported breast feeding at the first assessment (newborn) and did not update that information upon subsequent visits. The information system now requires an update with every certification/assessment visit. The reported information more accurately reflects breast feeding behavior at six months than in previous years.

Notes - 2006

The downward trend is due to stricter edits or quality assurances measures added to the client information system. Previously, WIC service providers reported breast feeding at the first assessment (newborn) and did not update that information upon subsequent visits. The information system now requires an update with every certification/assessment visit. The reported information more accurately reflects breast feeding behavior at six months than in previous years

Source: Count and Percent of WIC Breastfed Infants, SFY 2006 Annual Report, CHP, IDHS.

Notes - 2005

This is a new performance measure for reporting year 2005. The Numerator is infants Still Breastfed at 6 Months. The Denominator is infants Ever Breastfed. Source: Count and Percent of WIC Breastfed Infants. The Ross survey data also tracks state performance for this measure. Illinois has tracked this information for some time and the proportion of WIC participants who continue breastfeeding for six months has increased from 11.4 percent in 1992 to 23.0 percent 10 years later. Source: 2005 Ross Survey Data.

a. Last Year's Accomplishments

In FY 07, 25.7 percent of WIC participants continued breastfeeding for six months. From the 2007 CDC Breastfeeding Report Card, United States -- 2007: Outcome Indicators, all Illinois women had a 40.9 percent breastfeeding rate at six months. The proportion of WIC participants who continued breastfeeding for six months more than doubled since 1992 when the six - month breastfeeding rate was 11.4 percent.

Illinois collects data on breastfeeding practices through the Cornerstone Information System for CDC Nutrition Surveillance Systems and internal and external use in identifying breastfeeding patterns and practices. These include: initiation and duration of breastfeeding, exclusivity, client contacts, and breast pump issuance.

To promote and support extended breastfeeding among the WIC population, DHS 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. Over 550 staff and community partners attended the two-day State Breastfeeding Conference last year. Additionally, over 125 staff participated in three Fundamentals of Breastfeeding trainings. Over 75 staff attended a week-long intensive breastfeeding training that resulted in a three year certification as a Certified Lactation Counselor. In a follow-up to the State Breastfeeding Conference, three Bridges to Breastfeeding workshops were held. Bridges to Breastfeeding is a new initiative focusing on community collaboration to help Illinois reach the Healthy People 2010 breastfeeding goals. Designed and developed by well-known breastfeeding experts Jan Barger, RN, MA, IBCLC and Carole Peterson, MS, IBCLC, the program brings together local hospital and health department staff around the issues of breastfeeding education and support. Nearly 300 staff were trained through these three workshops.

IDHS collaborates with the Illinois Department of Public Health, Division of Chronic Disease Prevention & Control, Office of Health, Nutrition, Physical Activity and Obesity Program to develop strategies to increase awareness of breastfeeding's role in preventing obesity. IDHS has worked together with IDPH to develop and implement the Grandmothers Tea project. Through this activity, grandmothers learn up-to-date breastfeeding information as well as ways to support breastfeeding women. .

Chicago/local agencies: CDPH held its 2nd annual "Breastfeeding Awareness Walk & Celebration" with over 860 in attendance, including men, women, grandparents, children and infants from all racial and ethnic groups. Dr. Terry Mason, Commissioner of the Chicago Department of Public Health led the walk and stated "With America's obesity epidemic currently threatening the future of an entire generation of boys and girls, it is vitally important that children get the best possible start in life and breastfeeding is unquestionably the best possible start." CDPH along with over 40 vendors and supporters provided the participants with live entertainment, lunch, healthy snacks, and take home items that included breastfeeding literature, tee shirts, book bags, school supplies and raffle gifts. Educational classes were offered this year as an additional feature in English & Spanish.

During FY 2007, the state count and percent of WIC breastfed infants report indicated that 23.9 percent of CDPH WIC infants were breastfeeding at six months.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

Illinois Breastfeeding Promotion Month will be celebrated in August, coinciding with International World Breastfeeding Week. In conjunction with the Olympics and using the WBW 2008 theme: Mother Support : Going for the Gold, DHS will promote breastfeeding. IDHS administers a state breast pump distribution program through local agencies. Breast pumps are available to eligible participants at WIC agencies throughout Illinois. DHS continues to support the activities of local agency Breastfeeding Coordinator statewide through technical assistance and educational materials. Breastfeeding program updates are provided on a regular basis through regional meetings and a bi-monthly newsletter. IDHS provides technical assistance and consultation to local agencies with Peer Counselor programs and other special breastfeeding projects. Thirty-five agencies provide Peer Counselor services to eligible participants. Over 76 Peer Counselors provide education and support to eligible participants. Last year, 83.5 percent of the women who received Peer Counselor services initiated breastfeeding. Chicago. CDPH is leading a citywide celebration in recognition of the importance of breastfeeding in the health of Chicago's children, the 3rd annual Breastfeeding Awareness Walk and Celebration, August, 2008. Over 30 CDPH WIC, FCM, and Public Health Nursing (PHN) staff are certified lactation counselors.

c. Plan for the Coming Year

The Loving Support Breastfeeding Peer Counselor Program continues to expand. Additional resources are allocated for improving existing programs and implementing new programs. Five new start-up Peer Counselor programs are planned.. IDHS continues to collaborate with the Illinois Department of Public Health, Division of Chronic Disease Prevention & Control, Office of Health, Nutrition, Physical Activity and Obesity Program to develop strategies to increase awareness of breastfeeding's role in preventing obesity and to develop additional strategies to promote and support breastfeeding. Upcoming projects include: implementing Baby Friendly policies at local WIC agencies and area hospitals, expanding the Bridges to Breastfeeding Program, and developing a database of businesses in Illinois that provide lactation services. Plans are underway to provide targeted regional workshops designed to standardize breastfeeding information and foster better working relationships between providers and hospitals. Three additional Bridges programs will be held in FFY08. Additionally a statewide breastfeeding conference will be held in the spring. Chicago. The CDPH Breastfeeding program will ensure there is at least one certified lactation counselor and a breastfeeding room at every WIC site. All CDPH programs will continue to educate clients and the public about the benefits of breastfeeding, and to promote support for all women who choose to breastfeed. Plans include holding a Friend/Family Day at five WIC sites, with the focus on breastfeeding education including a question and answer period. Another plan is to have all staff answering WIC phones state "Breastfeeding is baby's first nutrition." WIC staff will continue to be active on the Chicago Breastfeeding Task Force. CDPH plans to continue supporting and coordinating the annual Breastfeeding Awareness Walk and Celebration.

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	2003	2004	2005	2006	2007
Annual Performance Objective	95	100	96	97	99
Annual Indicator	86.9	95.3	96.2	98.6	99.2

Numerator	159805	173596	169068	170271	170706
Denominator	183899	182158	175659	172602	172145
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
	2008	2009	2010	2011	2012
Annual Performance Objective	99.2	99.2	99.2	99.2	99.2

Notes - 2006

The number of children reported to IDPH Newborn Hearing Program is the number reported by birthing hospitals as opposed to registered births.

Notes - 2005

Source: UIC-DSCC and IDPH. The denominator is the preliminary estimate of occurrent births for 2005 as reported in Form 6.

a. Last Year's Accomplishments

Preliminary data from 2006 indicates 177,234 live births according to vital records. The Illinois Department of Public Health (IDPH) indicated 173,048 infants were screened prior to discharge and reported. These statistics suggest a 97.5 percent screening rate for year four of the program.

Provisional data from 2007 indicated 171,594 infants to be screened. Of these infants 170,657 (99.0 percent) were screened prior to discharge. While data continues to arrive and follow-up is ongoing for the 5,947 (3 percent) of infants referred, and the 937 not screened, 174 infants born in 2007 have been identified with permanent hearing loss. The average age in months of identification of bilateral hearing loss was 2.8 months

DSCC is the recipient of Illinois' Universal Newborn Hearing Screening grant from the federal Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA). The funding supports the Illinois Newborn Hearing Program (INHP) coordinator at DSCC who oversees day-to-day program operations, including public awareness activities, training of audiologists, physicians, local health departments, and other participants in the follow-up system.

DSCC disseminated flow charts, fact sheets and screening brochures for parents to birthing hospitals and professionals providing education. Informational brochures for parents regarding newborn hearing screening and follow-up have been provided in English, Spanish and Polish.

During year two of the HRSA grant, the INHP coordinator worked with Early Intervention (EI) to identify children with a hearing loss. The project coordinator participated in the EI Credentialing Rules Review Committee proposing changes that would improve the enrollment process for audiologists as EI providers. The INHP addressed audiological services, payment and access to services for children covered by EI and Medicaid. The project coordinator has worked with EI and audiologists to encourage adherence to protocols.

The INHP and the National Center for Hearing Assessment and Management (NCHAM) provided a 51 continuing credit hour training opportunity for audiologists in assessment and amplification for infants and toddlers with hearing loss.

In addition, the following activities occurred: DSCC continued to send parent and professional information to stakeholders; the parent friendly, ADA compliant website:

www.illinoisoundbeginnings.org was completed; DHS, DPH and DSCC drafted legislation for ongoing funding of the INHP through a hospital based fee that was introduced in the Illinois' Spring 2007 session; and parent to parent groups were queried to determine resources, mission and gaps in parent to parent support and respondents were later brought together as a follow-up. Due to objections raised by the Illinois Hospital Association, the legislation was amended to become an appropriation to IDPH and was passed; however, the governor vetoed it.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Hospital screen each newborn for hearing loss			X	
2. Test results are reported to IDPH				X
3. Parent and physicians are notified of abnormal test results and informed of diagnostic testing procedures			X	
4. Diagnostic testing is performed by audiologists	X			
5. Confirmed diagnoses are reported to IDPH				X
6. Children with diagnosed hearing loss are referred to the Early Intervention and CSHCN programs		X		
7. 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

In year three of the HRSA grant, the INHP coordinator continues to work with EI to identify children with a hearing loss in their program. Through collaborative efforts, changes within Early Intervention rules were proposed. Changes included: redefining criteria for automatic eligibility due to a hearing loss that would include mild and unilateral hearing loss; and allowing audiologists with an Illinois license to participate in EI without additional credentialing.

The project coordinator participated in the Joint Task Force on Deaf and Hard of Hearing Education Options. The charge of the task force was to "undertake a comprehensive and thorough review of education and services available to the deaf or hard of hearing children in Illinois with the intent of making recommendations." In this first year of the task force EI issues were addressed and systematic, legislative and resource recommendations were made.

c. Plan for the Coming Year

DSCC applied for the next three year grant through HRSA to begin April 1, 2008. Grant funding has been awarded to address Illinois' challenges related to infants lost to follow up. Activities such as technical assistance, data monitoring, and inter agency collaboration will continue and will support the use of the Plan Do Study Act Quality Improvement activities which will be the primary focus of the grant.

The quality improvement activities will focus on strengthening the links between newborn hearing screening, definitive diagnosis, reporting to IDPH, referral to EI, and connection to a Medical Home for identified infants. The project will begin with 3 to 4 metropolitan birthing hospitals that also provide diagnostic pediatric audiology services within their network.

DSCC will continue to use UNHS grant funds to support the coordinator to oversee day to day program operations, including public and professional awareness activities, training of audiologists, physicians, speech language pathologists, local health departments and other participants in the follow-up system. Parent resources will continue to be provided at no charge to the hospitals, physicians, Early Intervention agencies and health departments. DSCC will also support IDPH in providing technical assistance to the hospitals regarding newborn hearing screening and referrals.

The INHP will continue to facilitate linkages to services provided by the Part C Early Intervention Program and/or the CSHCN Program operated by DSCC no later than six months of age, including linkages to family to family support and medical home services.

IDHS, IDPH and DSCC will continue to collaborate on system issues in the state. Specific efforts will focus on identifying providers and encouraging new Audiology providers to participate in the state Medicaid and Early Intervention Programs. Telephone and site visit support of hospital screening programs and diagnostic Audiology clinics will continue. Efforts will also focus on identifying why infant screenings are not reported to IDPH when births have been reported to vital statistics. A summary of reported screening and referral data as well as program activities will be shared with the advisory committee at least annually.

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	2003	2004	2005	2006	2007
Annual Performance Objective	6.9	6.8	6.7	6.6	5.9
Annual Indicator	7.1	6.7	6.0	5.9	5.9
Numerator	243000	230000	204000	198000	
Denominator	3416000	3409000	3424000	3339000	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	5.9	5.9	5.9	5.9	5.9

Notes - 2007

The final 2007 income data will be available when the Current Population Survey 2008 Annual Social and Economic Supplement will be released.

Notes - 2006

The annual Social and Economic Supplement , Table H10 (Number and Percent of Children Under 19 at or below 200% of Poverty by Health Insurance Coverage and State: 2006 (SCHIP allocation formula).

Notes - 2005

The annual Social and Economic Supplement , Table H10 (Number and Percent of Children Under 19 at or below 200% of Poverty by Health Insurance Coverage and State: 2005 (SCHIP

allocation formula), is the new source for this measure. These data come from the CPS 2006 Annual Social and Economic Supplement, formerly called the March Supplement (2005 Income).

a. Last Year's Accomplishments

IDHFS has partnered with over 1,300 community organizations, medical providers, and insurance agents who met as All Kids Application Agents to help enroll families throughout the state in All Kids and FamilyCare. All Kids, an affordable, comprehensive health insurance plan for all uninsured Illinois children age 18 or younger, was signed into law on November 15, 2005. When the plan went into effect on July 1, 2006 it pays for doctor visits, hospitalizations, dental care, vision care, prescription medications, medical equipment, and mental health services. The monthly premiums and co-pays are based on the family's income.

IDHFS mails information about All Kids to FCM and WIC recipients each year. Additionally, IDHFS mails a Member Handbook to all new members and makes it available on its web site: <http://www.allkids.com/customers/handbook.html> Notices are mailed to families with children annually, and when they are due for a screen, based on the periodicity schedule. Client information is made available by the IDHFS and IDHFS' Illinois Health Connect (PCCM program) on web sites (<http://www.hfs.illinois.gov> and Illinois Health Connect (<http://www.illinoishealthconnect.com/>) and through direct, targeted notices.

Chicago. The Office of Health Care Access (OHCA) provides information and advocacy to consumers on Medicaid and Medicare eligibility, public health entitlement programs, and on private insurance options. In CY2007, OHCA developed and distributed nearly 405,000 maternal and child health-related printed publications to consumers and partners. All publications are printed in English and Spanish; publications in other languages are printed as needed. OHCA provides application assistance to state and federal programs for families through the CAREline call center and in neighborhood health and mental health centers. The OHCAA CAREline answered over 1,200 calls from community residents having difficulty with their public health care plans. OHCA is the CDPH liaison for Illinois Health Connect, the state's primary care case management program, and for Your Healthcare Plus, the state's disease management program. In CY'07, the CDPH completed 3,110 All Kids applications and 3,777 individuals were approved and enrolled. All Kids administration now resides in OHCA.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

Of children enrolled in WIC, 94.1 percent had All Kids or other insurance coverage. FCM providers are required to document giving parent information regarding Illinois' All Kids program and information on how to enroll.

Chicago. Through its OHCA, clinics, home visiting programs, collaboration with other organizations and health fairs, CDPH staff continues to increase its emphasis on educating families and enrolling eligible individuals in All Kids and FamilyCare, and pregnant women in

Moms & Babies and Medicaid Presumptive Eligibility (MPE.)

c. Plan for the Coming Year

IDHS and IDHFS will continue to promote enrollment in All Kids to reduce the proportion of children without health insurance. IDHS will use the Cornerstone system to monitor the number of WIC/FCM eligible children who do not have insurance coverage. These children will be targeted by local WIC and Family Case Management grantees for additional outreach efforts to encourage their parents to enroll them in All Kids. IDHFS will continue to provide training and field staff support to All Kids Application Agents (AKAAs). SHCs will determine insurance status of all enrolled students and refer those without insurance to All Kids. Families can apply for All Kids or FamilyCare online at www.allkids.com, by mail through an AKA or at an IDHS Family and Community Resource Center.

In addition, the Healthy Child Care Illinois Program Child Care Nurse Consultants provide All Kids enrollment information to all of Illinois' child care providers and families who attend outreach education programs.

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

Chicago. CDPH staff will continue to increase its emphasis on enrolling eligible individuals in various state-sponsored health insurance programs including Medicaid, All Kids, FamilyCare, Moms & Babies, and Medicaid Presumptive Eligibility. Enrollments will be done by FCM, PHN, Immunization Program, and the clinics, as well as staff from the OHCA. The OHCA will continue to provide education for both providers and the community, and will continue to operate the CAREline. The OHCA's monthly call-in television show, CAREline Up Close brings information on state and federal health care programs to one million Chicago households each month.

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	2003	2004	2005	2006	2007
Annual Performance Objective				24	23
Annual Indicator			24.2	29.8	29.9
Numerator			19718		
Denominator			81616		
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
	2008	2009	2010	2011	2012
Annual Performance Objective	29.9	29.8	29.5	29	28.5

Notes - 2007

Source: Table 2C-Summary of Health Indicators, Children Aged <5 Years, Illinois 2007, CDC's Pediatric Nutrition Surveillance System (PedNSS).

Notes - 2006

Source: In March, 2007, the Illinois Cornerstone system was the source for 25.4 percent or 20,280 of state WIC children with high BMI. Cornerstone had been the source for 2005 and 2006. The 2006 data previously reported as 'final' will be revised this year.

The CDC's Pediatric Nutrition Surveillance System (PedNSS) will be the source for this measure hereafter and will be reported on Form 11 as a percentage only. The revised percentage for 2006 is 29.8.

Notes - 2005

Source: Illinois Cornerstone, IDHS, 3-31-06. There are 19,718 WIC children at or above the 85th percentile, indicating that 24 percent of WIC 2-5 year olds are at risk of overweight or already overweight.

PedNSS data from 2004 indicated that 30.1 percent of 88,898 children were at or above the 85th percentile, comparable to the national PedNSS data from 2003 that indicated 30.4% of 2,044,705 children between 2 and 5 years-of-age receiving WIC services were at or above the 85th percentile.

CDC generates PedNSS data from the height and weight entered rather than an assessment question in Illinois Cornerstone. Cornerstone reports are more timely and accessible and very comparable to PedNSS results.

a. Last Year's Accomplishments

In 2007, 29.9 percent of children between 2 and 5 years of age who received WIC services had a BMI score at or above the 85 percentile. Illinois is following the national trend in the epidemic of overweight/obesity. The prevalence of overweight in children (2-5 years of age) in Illinois has gradually increased from 9.3 percent in 1976 to 15.4 percent in 2006. An additional 14.5 percent of children in the same age group are considered "at-risk" for being overweight. The national average for overweight is 16.4 percent and at-risk is 14.8 percent (Pediatric Nutrition Surveillance System 2007).

The Division of Community Health and Prevention (CH&P) is in a unique position to impact childhood obesity. Within CH&P, the WIC Program is able to educate mothers during their pregnancy about weight gain, healthful eating and breastfeeding. Breastfeeding and early eating habits are important and nearly 50 percent of infants born in Illinois participate in the WIC Program, thus receiving prevention messages from the start. Routine contacts with WIC continue throughout the 4th year of life. In 2007, WIC served over 354,000 infants and children allowing multiple assessment and education contacts with families. CH&P provides after-school programming to children age 7-18 as well. Staff from the Bureau of Family Nutrition provides in-services to providers on participation in the Child and Adult Community Food Programs to ensure quality, healthy, foods are offered and reimbursed by the Illinois State Board of Education. Training of state nutrition staff is key in ensuring local providers and community partners receive the most current and effective strategies in nutrition and obesity prevention. IDHS Dietitians participated in the University of Alabama Pediatric Update satellite entitled "Prevention, Assessment and Treatment in Childhood Obesity: Recommendations from the AMA Expert Committee on Childhood Obesity" in June 2007. In July, an IDHS Dietitian attended "Implementation and Cost Benefits of Workplace Weight Strategies" in Chicago. This three day seminar provided current information on worksite wellness programming. Staff attended "Tipping the Scale... Managing Obesity in Southern Illinois" a one-day workshop presented by the Southern Illinois School of Medicine and the SIUC Center for Rural Health and Social Service Development. Key messages from the event that will be incorporated into IDHS programming include strategies to: communicate effectively with the overweight and obese population; sustain behavior change and promote physical activity in the fall. Ellyn Satter's "Raising a Healthy Eater" workshop was attended by four staff. Ms. Satter's eating competency tools and research were presented. Key messages will be presented in community programs and as part of staff training. In October 2007, WIC dietary risk factors changed to align more closely with the Dietary Guidelines for Americans. At the same time the assessment process itself was revamped to become more client-centered and behavior-change oriented. WIC staff across the state were trained on the new diet assessment process with an emphasis on motivational interviewing and client --centered techniques to assist families in making positive behavior changes in food choices, health and physical activity.

The IDHS Fruit and Vegetable Coordinator was involved in planning the "Move and Crunch Challenge" for elementary school principals which was launched in February 2008. This Challenge encourages principals to take the lead in modeling healthy behaviors such as being physical active and eating fruits and vegetables. They are invited to involve staff, students and parents in healthy activities during one week of March. Participating schools have been asked to submit their entries to the Illinois Nutrition Education and Training Program in April for a chance to win \$800 to spend on student nutrition education curriculum and materials. The Illinois Association of Health, Physical Education, Recreation & Dance was also involved in planning for this project.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Train IDHS BFN Nutrition Staff on obesity prevention and intervention strategies.				X
2. Train local WIC Providers on obesity prevention and intervention strategies.	X			
3. Collaborate with community partners such as CLOCC and the Illinois Interagency Nutrition Council to create common messages and maximize resources.		X		X
4. Provide nutritious foods through the WIC, CSFP and WIC Farmer's Market Nutrition Programs.	X	X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The WIC Program in partnership with the University of Illinois Extension provided "Cooking School" Programs on five occasions in 2007. The project will continue in 2008. Sessions are bi-lingual and held for four days. Students learn the basics of cooking using WIC foods IDHS staff is 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.

The Illinois State Nutrition Action Plan (I-SNAP) involves all USDA Food and Nutrition Section programs in Illinois and is carried out through the Illinois Interagency Nutrition Council (INC). Goals of I-SNAP are to: promote adoption of healthy dietary patterns and regular physical activity based on key messages in the Dietary Guidelines for Americans; and promote Healthy Community and School Nutrition Environments by increasing awareness about the importance of a healthy school nutrition environment.

IDHS Bureau of Family Nutrition staff meets regularly with staff from the Illinois Department of Public Health to discuss and coordinate obesity prevention efforts. IDPH is responsible for Illinois' Obesity Grant from CDC.

Beginning in the 2008 season the Illinois WIC Farmers Market Nutrition Program will be expanded to 10 counties.

c. Plan for the Coming Year

The Southern Illinois Healthy Child Task Force has been funded for SFY2009 to continue their efforts to prevent and address childhood obesity in southern Illinois. By August 2009, Illinois WIC Food Packages will reflect the U. S. Department Agriculture's proposed rule recommendations including: fruits and vegetable choices, whole grain foods, a reduction in juice provided, and a change to lowfat milk for children over two. Planning for these massive changes is already underway. Five fall workshops are being planned to continue to provide local WIC staff with skills needed to provide effective nutrition education and counseling. Training for State Nutrition staff is on-going as is that for local providers.

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	2003	2004	2005	2006	2007
Annual Performance Objective				12.4	12.2
Annual Indicator			12.6	12.1	10.4
Numerator			23000		
Denominator			182393		
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
	2008	2009	2010	2011	2012
Annual Performance Objective	10	10	10	10	10

Notes - 2007

Source: 2005 PRAMS, Illinois Department of Public Health (IDPH). 2006 and 2007 PRAMS data were not available for this application from IDPH.

The objectives for 2008-2012 have been adjusted to account for the decline of women who smoke in the last trimester as reported in the 2004 and 2005 PRAMS.

Notes - 2006

Source: 2004 PRAMS, Illinois Department of Public Health (IDPH). In 2004, among moms who reported receiving WIC services while pregnant, 17.8% reported smoking in the last trimester. Among moms not reporting WIC services, 8.0% reported smoking in the last trimester. 2005 and 2006 PRAMS data were not available for this application from IDPH.

Notes - 2005

Source: 2003 PRAMS, Illinois Department of Public Health (IDPH). Denominator is the total number of live births in 2003. Numerator is derived from the rate. In 2003, among moms who reported receiving WIC services while pregnant, 17.9% reported smoking in the last trimester. Among moms not reporting WIC services, 8.6% reported smoking in the last trimester. 2004 and 2005 PRAMS data was not available for this application from IDPH.

a. Last Year's Accomplishments

According to the 2005 PRAMS report (the most recent survey available), 18.8 percent of respondents said they smoked in the three months prior to pregnancy, 10.4 percent in the last three months of pregnancy, and 14.7 percent after delivery. Non-hispanic women, as well as

black and white women were more likely to smoke during all three time periods when compared to Hispanic women and women of all other races. Women with less than a high school education reported smoking more often during all time periods when compared to women with more than a high school education. Unmarried women and women whose deliveries were paid for by Medicaid reported much higher rates of smoking during all three time periods when compared to married women and women whose deliveries were not paid for by Medicaid.

In February 2005, the IDHS, IDPH, and IDHFS announced a new initiative to reduce smoking among women who are participating in WIC, FCM, and other MCH programs. This initiative builds on and extends the work that local health departments and other agencies have been doing to promote smoking cessation among women who are pregnant or who have infants or young children. 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 (CST), 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.

Chicago. CDPH's Women's Maternal Smoking Intervention program operates in WIC sites and CDPH Clinics. In 2007, the program provided services to 377 women, 22 percent more than in 2006. There were 193 women who were pregnant, of which 128 (66 percent) quit smoking, and 51 (26 percent) who cut down on their smoking. Also, 316 (84 percent) of all program women stopped smoking in front of their children. The Women's/Maternal Smoking Intervention program incorporated the NicAlert nicotine exposure screening to demonstrate exposure to secondhand smoke with WIC clients, motivating more women to report their smoking and smoking of others in their homes.

Table 4a, National Performance Measures Summary Sheet

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

6.				
7.				
8.				
9.				
10.				

b. Current Activities

A new on-line training module will be 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. Key messages are highlighted on the back of the Illinois WIC Food List which is given to every participant.

Chicago. The Women's/Maternal Smoking Intervention Program encourages providers to ask all women about their tobacco use. The provider will advise the smoker to quit and will offer materials that are supplied by the Illinois Tobacco-Free Communities (ITFC) grant, including a self-instruction booklet entitled "It's Time" (to quit), when it is assessed that the smokers want to quit. If the smoker wants additional assistance by phone, the ITFC representative will call them with further counseling and follow-up in three and six months. The ITFC representative will recommend the Illinois Tobacco QuitLine and the FREE "Courage to Quit" smoking cessation program, available at the Englewood Neighborhood Health Clinic, where FREE nicotine replacement therapy is offered.

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 QuitLine for ongoing assistance. Agencies will use a smoking cessation curriculum, i.e. 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.

In 2008 a new WIC Risk Factor will be added related to environmental tobacco smoke exposure. This will create a new opportunity for creating awareness of the risks of second-hand smoke to women, infants and children.

Chicago. The Women's/Maternal Smoking Intervention program will continue its NicAlert nicotine exposure screening in WIC clinics, and expand this screening in collaboration with at least two other CDPH programs, the Breast and Cervical Cancer Program and the Infant Mortality Reduction Initiative.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
---------------------------------------	------	------	------	------	------

Annual Performance Objective	5.4	5.4	5.4	4.7	6
Annual Indicator	4.7	6.7	5.5	5.5	5.5
Numerator	42	61	50	50	
Denominator	894002	905322	916148	916148	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	6	6	6	6	6

Notes - 2007

Vital Records data for deaths in 2006 or 2007 are not available at this time. Refer to the general Form 11 Note.

Notes - 2006

Vital Records data for deaths in 2006 or 2007 are not available at this time. Refer to the general Form 11 Note.

(Also these data are underreported for one reason because Illinois has not implemented a statewide Violent Death Reporting System. Development of such a system will improve reporting and the rates will likely increase. As such the annual indicators have been adjusted to 6 deaths per 100,000 youth.)

Notes - 2005

Source: Center for Health Statistics, IDPH, released July 13, 2007. Denominator from US Census Bureau.

a. Last Year's Accomplishments

- All 40 School Health Centers provide mental health counseling on-site and/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 Health Centers]." Training was provided via satellite to DCHP staff and contractors on signs, causes, and referral procedures on adolescent suicide. Below are highlights of some of the accomplishments from the IDPH Director Appointed Illinois Suicide Prevention Strategic Planning Committee and the Illinois Suicide Prevention Coalition:
- * The IDPH Director Appointed Illinois Suicide Prevention Strategic Planning Committee and the Illinois Suicide Prevention Coalition met bi-monthly and met quarterly.
 - * A team of four members from the Illinois Suicide Prevention Strategic Planning Committee participated in the first half of the 2007 National Preventing Violence through Education, Networking and Technical Assistance (PREVENT) Institute. PREVENT will help the multi-organizational team address suicide in Illinois. PREVENT is supported by a cooperative agreement from the Center for Disease Control and Prevention and is operated by the University of North Carolina Injury Prevention Research Center and the North Carolina Institute for Public Health.
 - * Resources were provided to the Illinois EMS/Trauma Advisory Boards regarding the Joint Commission on Accreditation of Healthcare Organizations' new national patient safety goals as they relate to suicide
 - * A map of the suicide data for Illinois over the five-year period of 2000 -- 2004 was developed

* Provided technical assistance to community-based teams to create local suicide prevention efforts.

* Provided technical assistance to Illinois Public Health Association in drafting a suicide prevention resolution.

Chicago. The Chicago Public Schools receive funding from CDC to monitor critical health behaviors in youth through implementation of the Youth Risk Behavior survey (YRBS.) Data are collected on a biannual basis. In 2003, 13.5 percent of CPS high school students seriously considered attempting suicide, and 11.2 percent had made a plan to attempt suicide. In 2005, 12.9 percent considered suicide and 10.6 percent had made a plan. In 2003, 12.1 percent of CPS high school students had attempted suicide and 4.7 percent had made a suicide attempt that required medical treatment. In 2005, 8.6 percent made a suicide attempt and 3.4 percent made an attempt that required medical treatment. 2007 data were collected, but the results are not yet available.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

IDHS is an ex-officio member of the IDPH's Illinois Suicide Prevention Alliance. IDPH program assisted in the development of the Illinois Suicide Prevention Strategic Plan. It presents 10 goals. Ask About Suicide - Educate everyone -- especially all mental health, social service, clergy, law enforcement and school personnel -- to ask about suicidal ideations and intentions.

Know Your Neighbor - Encourage networks of relatives, friends, neighbors and members of the faith community to decrease isolation.

Treatment Works - Advocate for a continuum of care for those at risk for suicide.

Ensure Safety to Live and Love - Promote utilization of suicide prevention services for victims of harassment and violence.

Knowledge is Power - Increase competency in suicide prevention and treatment for first responders.

Everyone Deserves Care - Increase access to mental health care.

Data Counts - Improve suicide-related data collection.

Suicide is Everyone's Business - Increase public awareness of the benefits of restricting access to means of suicide.

Help Break the Stigma - Reduce the stigma of suicide.

Bank on Saving Lives - Develop sustainable funding sources for implementing suicide prevention.,

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

c. Plan for the Coming Year

IDHS will continue to work with the Illinois Coalition of School Health Centers to provide mental health counseling services. A standard encounter form has been developed to document mental health services provided at each site. Preventive health education activities will be conducted. Coordinated School Health Projects utilize the eight components of a Coordinated School Health Program Model to provide prevention activities. These programs and activities focus on teen issues, including self esteem, violence prevention, student assistance programs, alcohol/substance abuse prevention, sexual abuse, and date rape prevention.

Through use of discretionary funds, IDPH will monitor the prevention strategies as outlined in the Suicide Prevention, Education, and Treatment Act. It is hoped that IDPH receives funding from SAMSHA to carry out these objectives.

Illinois has 12 certified local crisis centers that are part of the National Hopeline Network, and eight mutual local crisis centers that are part of the National Prevention Lifeline Network. There are more small local crisis centers currently not part of any network.

Below are planned activities for the coming year for the Illinois Suicide Prevention Alliance:

- * Conduct bi-monthly meeting of the Illinois Suicide Prevention Alliance.
- * Build capacity across Illinois to promote local suicide prevention efforts by building and/or expanding 15 -- 20 effective and efficient coalitions and partnerships through a training conference and support of local efforts.
- * Support research-based evaluation methods and technical assistance to replicate suicide prevention efforts in Illinois according to outcome measures.
- * Begin implementation of a public awareness campaign to reduce the stigma of suicide, increase awareness of risk factors, including mental illnesses, and promote linkage to human services for at-risk individuals.
- * Work with a qualified professional to analyze suicide data statewide (including attempt data) and train providers on how to collect better data.
- * Support and build school-based suicide prevention initiatives and professional development opportunities for staff, students, parents and other caregivers.
- * Develop and enhance the capacity of health service providers statewide to increase suicide prevention and early intervention.
- * Develop and enhance suicide prevention and early intervention activities of aging population service providers.
- * Support implementation of the Illinois Suicide Prevention Strategic Plan through work and efforts of the Illinois Suicide Prevention Alliance (ISPA).
- * Development and implementation of Suicide Prevention Month activities.

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	2003	2004	2005	2006	2007
Annual Performance Objective	82	82	83.5	83.5	81
Annual Indicator	82.5	81.1	81.0	83.1	83.1
Numerator	2430	2451	2375	2464	2464
Denominator	2946	3024	2932	2964	2964
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
	2008	2009	2010	2011	2012
Annual Performance Objective	82	82	82	82	82

Notes - 2007

IDPH natality data for 2007 were not available at the time this application was being prepared; 2006 data is being reported here as Provisional.

Notes - 2006

Source: IDPH, Center for Health Statistics, MCH Block Grant Natality Data, 2006 (received 8/2008).

Notes - 2005

Source: IDPH, Center for Health Statistics, MCH Block Grant Natality Data, 2005 (received 6/2007).

a. Last Year's Accomplishments

In 2006, there was an increase in the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. Despite the improvement, at 83.1 percent, Illinois' performance on this measure was slightly less than its expectations which was 83.5 percent. Provisional statistics suggest that the improvement will be short lived; at 81.7 percent, trend is downward similar to percentages reported in 2004 and 2005.

Primary responsibility for directing the Illinois Perinatal Program was shifted back to the Illinois Department of Public Health. 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, the Chicago Healthy Start Initiative, and the Closing the Gap project.

IDPH and the Statewide Quality Council have worked very closely with each of the ten perinatal networks on the monitoring and evaluation of the percentage of the very low birth weight infants born in a Level II+ or Level III facility. The methodology for incorporating perinatal outcome surveillance and plans for improving provider compliance with consultation, referral, and transfer protocols for high-risk maternal and neonatal patients are in place at all facilities, as well as the monitoring system for outcomes for the purpose of quality assessment and improvement. Chicago. In 2005, 733 very low birth weight infants were born to Chicago residents. Of these, 624 (85.1 percent) were born at Level III and Level II+ hospitals, locations capable of providing care for these infants. The 2004 percentage was 79.9. CDPH does not have data to determine the percentage of infants who were born at inappropriate facilities but were transferred to more appropriate facilities.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

Each of the 10 perinatal networks, as well as IDPH and the Statewide Quality Council, are monitoring and evaluating the percentage of very low birth weight infants born at appropriate facilities, and in-depth educational opportunities are given to those facilities who may have problems assessing those patients who should be transferred to a higher level of care. Members of the Statewide Quality Council as well as members of the Quality Improvement and Education Committee work together to establish and implement quality improvement plans that will lead to improved outcomes.

Chicago. The CDPH and members of the Chicago Maternal and Child Health Advisory Committee (CMCHAC) have participated in Perinatal Advisory Committee meetings and assisted in the development of perinatal rules and regulations. CMCHAC has reviewed perinatal rules and regulations, differentiating between those goals that are the legitimate responsibility of the IDPH and CDPH, for monitoring purposes.

c. Plan for the Coming Year

This performance measure will be addressed by IDPH through the routine operation of the perinatal care program.

Chicago. The CDPH and members of the CMCHAC will continue to participate in Perinatal Advisory Committee meetings and assist in the development of perinatal rules and regulations. CMCHAC is currently reviewing perinatal rules and regulations and comparing them with state and local city ordinances. The perinatal centers and the CDPH will continue to monitor the Level II hospitals to assess the care provided to neonates.

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	2003	2004	2005	2006	2007
Annual Performance Objective	83	84	84	82	82
Annual Indicator	82.0	80.7	81.8	86.1	86.1
Numerator	149587	145862	146265	148860	148860
Denominator	182393	180665	178872	172853	172853
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
	2008	2009	2010	2011	2012
Annual Performance Objective	87	87	87	87	87

Notes - 2007

IDPH data for 2007 were not available at the time this application was being prepared so we are using the 2006 figures as provisional.

Notes - 2006

Source: IDPH, Center for Health Statistics, MCH Block Grant, Natality Data, 2006 (received 8/2008).

Notes - 2005

Source: IDPH, Center for Health Statistics, MCH Block Grant, Natality Data, 2005 (received 6/2007). A departure from the MCH detail sheet, IDPH claims that this percentage is 86.7 percent based on the subtraction of the unknown trimester births (8.8 thousand) from total resident births. In keeping with the MCH detail sheet and past trends, Illinois MCH has slightly adjusted the performance objectives for 2007 through 2011.

a. Last Year's Accomplishments

Illinois more than met its objective to increase the proportion of women who began prenatal care in the first trimester of pregnancy to 82 percent. In 2006, actual performance was 86.1 percent; the most recent data available.

The Teen Parent Services program has addressed this goal through its integration and collaboration with the FCM program. Upon identification, eligible pregnant teens are immediately referred for FCM services in those agencies that do not provide both programs.

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. (That determinations made by MPE providers who assist the woman in the application process for ongoing assistance under Title XIX with the All Kids application completed at the same time.) Approximately 3,800 women are enrolled in MPE each month.

The IDHS, IDHFS, and the Steans Family Foundation implemented the Healthy Births for Healthy Communities initiative on July 1, 2006. The initiative is using a performance-based reimbursement strategy to pay for outreach activities in two Chicago Community Areas (Austin and North Lawndale). Two community-based organizations are conducting grassroots outreach efforts to engage multiparous women who are at increased risk of delivering a very low birth weight infant in WIC, FCM, Healthy Start or TIPCM. The IDHFS is matching the funds provided by the foundation and transferring these funds to IDHS. The Title V program, in turn, is managing the grants to the community-based organizations. Additional funds will be provided during the year to area hospitals to ensure that women are linked to the program by their emergency departments. The project partners are collaborating to develop an interconceptional care (case management) component for implementation later in the year. The project has been developed with the active participation of Closing the Gap and Westside Healthy Start.

Since its inception, Healthy Births for Healthy Communities initiative reported 380 women participants. The women enrolled are a high-risk group: 67 percent report having medically high-risk conditions such as chronic disease, previous pre-term birth, and less than 12-month interpregnancy intervals. The others have social risk factors such as homelessness and domestic violence. The project is measuring the effort it takes to find these high-risk women. On average, it is taking nearly five hours to find and enroll one high-risk woman.

At the Governor's request, the Illinois General Assembly provided an additional \$1.9 million for the TIPCM project in SFY'06. Three new communities were selected as target areas and

additional funds were provided to several other targeted communities. Enrollment in TIPCM programs increased by 2000 clients in FY'07. Expansion of TIPCM services is likely to be an outcome of current FCM Re-structuring activities.

There were 268 participants and 207 births in the five Doula project sites in Chicago in FY'07. Several FQHC and FCM sites outside the Ounce of Prevention Doula project have hired Doula's to work with prenatal clients in the FCM program. One is working with Asian immigrants at Henry Booth House; another with Mexican immigrants at Westside Futures, and another at TWO on the southside of Chicago.

Chicago. The number of women entering prenatal care during the first trimester has increased. Between 2004 and 2005, the percentage of Non-Hispanic Whites initiating prenatal care during the first trimester increased from 82.6 percent to 83.5 percent. For Hispanics the increase was from 75.8 percent to 77 percent. For Non-Hispanic Blacks the percentage was 69.3 percent in 2004 and 71.8 percent in 2005.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

Local IDHS office staff are being 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.

The Illinois Perinatal Mental Health Disorders Prevention and Treatment Act became effective 1/1/08. The Act requires that prenatal, postnatal and pediatric care providers educate women and their families about perinatal depression and offer screening. The Act identifies IDHS as having responsibility to provide education and training materials to providers. As a result, the Department provides access to trainings, brochures, treatment and referral services through linkage with the University of Illinois at Chicago, Evanston Hospital and Healthcare Alternative Systems.

DHS produced a satellite teleconference addressing screening, referral and treatment of perinatal depression and offered it to FCM providers statewide on February 5, 2008; 220 providers attended.

Chicago. CDPH continues to conduct outreach activities to identify and recruit high-risk pregnant women, promote postpartum and family planning visits to decrease unplanned pregnancies, enroll women in care following a positive pregnancy test result, and encourage newly-pregnant women to continue in care.

c. Plan for the Coming Year

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

The Doula project will focus attention on two observed sequelae to its services, breastfeeding initiation and post partum depression prevention. Program data indicates a 57 percent rate of initiation for Doula participants; a rate above the national norm for US teenagers. The Ounce and site staff will rededicate efforts to strengthening this outcome. The second area of research is the impact of Doula services on rates of suspected postpartum depression. Smaller studies done with two Doula programs (part of the Ounce's wider Doula network), demonstrated significant decreases in suspected rates of depression in comparison to a control group at the same site. Chicago. CDPH's strategies of providing outreach to identify and recruit high-risk pregnant women, promoting postpartum and family planning visits to decrease unplanned pregnancies; enrolling women in care following a positive pregnancy test result, and encouraging newly-pregnant women to continue in care will help reduce the number of women who delay early enrollment into prenatal care. CDPH has contracts with seven hospitals to provide midwifery-based prenatal and family planning services in five of its Neighborhood Health Centers.

D. State Performance Measures

State Performance Measure 1: *The incidence of maltreatment of children younger than age 18*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	7.9	7.8	7.7	7.9	7.8
Annual Indicator	7.9	7.8	7.9	7.9	7.6
Numerator	25503	25423	25571	25503	24772
Denominator	3220000	3240000	3220000	3230000	3240000
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	7.8	7.7	7.7	7.7	7.6

Notes - 2007

Source: Table 8 - County Distribution of Indicated Investigations. The numerator is the unique number of children indicated and an unduplicated count statewide. Illinois Department of Children and Family Services website.

Notes - 2006

Source: Table 8 - County Distribution of Indicated Investigations. The numerator is the unique number of children indicated and an unduplicated count statewide. Illinois Department of Children and Family Services website.

Notes - 2005

Data Source: Table 8 (County Distribution of Indicated Investigations) of the 2005 Annual Report of the Illinois Department of Children and Family Services (IDCFS). Number of children indicated is an unduplicated or unique count within the State. IDCFS reports the number of unique children

at a rate per 1,000. The denominator is not the official Census estimate but was revised to correspond with the IDCFS reported number and rate for 2005.

a. Last Year's Accomplishments

Illinois exceeded its goal to reduce the rate of child maltreatment to 7.8 per 1,000 children; the rate was 7.6 per 1,000 children in 2007.

Healthy Families Illinois (HFI) seeks to prevent child abuse and neglect through intensive home visits that improve family functioning, enhance the parent child relationship, encourage positive parenting, and promote healthy growth and development. Findings from a longitudinal evaluation of HFI conducted by Northern Illinois University indicated that the program is effective in engaging and retaining at-risk families, and in reducing the risk for child maltreatment in families determined to be at the greatest risk for child maltreatment at enrollment. The Department currently supports 49 HFI programs throughout the state. The Parents Too Soon, Parents Care and Share and the High-Risk Infant Follow-up programs also address the prevention of child abuse and neglect.

Chicago. According to the DCFS reports, the incidence of reported maltreatment of children consistently has declined: 6,558 children in 2003, 6,067 children in 2004, 5,275 children in 2005, and 5,129 children in 2006. Public health nurses and outreach workers assess clients and help mothers develop parenting skills. Through its Community Development Block Grant, the CDPH monitors seven community agencies whose specific role is to provide parenting education, assess parents for domestic violence, and refer them for follow-up as needed. These seven community agencies provided services to 919 clients in 2007. The Healthy Families program that CDPH operates in partnership with Metropolitan Family Services provides services in the South Chicago area. In 2007, Healthy Families provided services for 65 at-risk families. In 2007, the CDPH program, Greater West Side of Chicago Early Childhood Network (providing services in North/South Lawndale and East/West Garfield), sponsored two forums on child abuse and neglect, one for providers and the other for families. CDPH allows domestic violence agencies access to WIC and CDPH clinics to assess and provide counseling to clients.

In late 2006, CDPH received a five-year, \$2.5 million federal grant to promote responsible fatherhood to current and expectant fathers of all ages. CDPH, in conjunction with Chicago Youth Programs (CYP), a community-based agency, began services within the existing Male Responsibility program in Englewood, and initiated services in Uptown. The Promoting Responsible Fatherhood program provides fathers with group parenting skills classes and training, support groups, and individual counseling and follow-up.

The Chicago Safe Start (CSS) initially was funded as a part of a U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention's national demonstration project housed in CDPH's Office of Violence Prevention funded since 2000. The program's mission is to prevent and reduce the negative impact of exposure to violence on children ages six years and younger. This work is achieved through a balance of prevention and intervention efforts focusing on education, professional development, direct service innovation, and systems change oriented collaboration among city and state service providers, community organizations, and residents. The program has successfully influenced change in many systems that have contact with infants and children exposed to violence and the Safe Start evaluation indicates that their clients are improving as a result of the clinical services rendered. Since 2003, CSS has provided over 500 citywide training events reaching approximately 10,000 participants. Training evaluations conducted at least 18 months after participating in CSS training, show that 87 percent of participants were more aware of the problem of childhood exposure to violence, and 79 percent reported doing more personally to address childhood exposure to violence. From 2002 to 2007, 1,629 children have been referred to CSS contracted delegate agencies for exposure to violence services. In 2007, CSS held a citywide Summit on Childhood Exposure to Violence, which convened 150 professionals across disciplines and celebrated the first Chicago Safe Start week, which was authorized via the Mayor's proclamation.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Families Illinois provides voluntary home visits to at-risk families with young children		X		
2. Parents Too Soon programs provide home visits and peer groups to first time teen parents		X		
3. Other teen parenting programs help clients develop effective parenting skills		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

HFI works with families who are at risk of child maltreatment. A goal of the intervention is to help the primary care giver be aware of and attend to the "internal life" of the baby.

The Teen Parent Services program contributed to the achievement of this objective by assuring that all of the program participants benefit from parenting instruction.

The Strengthening Families Initiative educates a network of childcare providers to utilize protective factors around families to build resiliency. This initiative will operate in Kane County, North Lawndale Community Area in Chicago, southern Cook County, Peoria, and the "Southern 7" Counties (Alexander, Hardin, Johnson, Massac, Pope, Pulaski, and Union Counties).

Parents Care and Share is a network of parental support groups to prevent child abuse and neglect by helping parents to increase their protective factors. When parents become involved in a Parents Chare and Share support group, they come out of isolation, learn new positive parenting skills, grow in their self-esteem and confidence, and grow in their social functioning skills.

Chicago. CDPH continues to monitor community agencies whose specific role is to provide parenting education, assess parents for domestic violence, and refer them for follow-up as needed. The CDPH staff in all programs continues to assess women for domestic violence and refer them for counseling, and continues to allow domestic violence agencies access to WIC and CDPH clinics.

c. Plan for the Coming Year

This performance measure will be addressed by the HFI, PTS and Parents Care and Share programs. The MCH program will also work closely with the IDCFS to implement the Strengthening Families Initiative.

Chicago.

Through its Community Development Block Grant, the CDPH will continue to monitor community agencies whose specific role is to provide parenting education, assess parents for domestic violence, and refer them for follow-up as needed. The CDPH staff also will continue to assess women for domestic violence and refer them for counseling, and will continue to allow domestic violence agencies access to WIC and CDPH clinics to provide assessment and counseling to clients. Healthy Families will continue providing services in the South Chicago area. Greater West Side of Chicago Early Childhood Network will offer two forums (one for providers and one for parents) focusing on breaking the cycle of sexual abuse. The Responsible Fatherhood program will begin the Parent-Run Evening Preschool -- Fathers (PREP-F) program, in which fathers and their children attend evening and weekend program activities led by the fathers under the instruction of parenting/child development specialists. Fathers will learn positive, non-abusive parenting skills, and the activities will help them reconnect with their children. Chicago Youth

Programs' similar approach to program mothers (PREP) has dramatically reduced the risk/incidence of child abuse.

State Performance Measure 2: *The proportion of CSHCN ages 14 and above and their parents who receive comprehensive transition planning services to promote awareness of adult services*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	71	74	77	80.9	85
Annual Indicator	71.6	76.3	80.8	82.2	81.7
Numerator	1514	1602	1651	1612	1574
Denominator	2115	2100	2043	1960	1926
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	81.9	82	82	82.2	82.4

a. Last Year's Accomplishments

Illinois' performance objective to ensure that 85 percent of youth over 14 years of age and their parents receive comprehensive transition planning from DSCC staff was not achieved. Actual performance in FY '07 was 81.7 percent, which is slightly lower than the previous report. The agency began an extensive reorganization effort during this timeframe; and training activities, time and resources were focused to support the change process. A review of case records for youth ages 14-21 years shows that out of 81.7 percent, 71.0 percent received planning information on health care transition, 72.4 percent received information on vocations and 68.4 percent on community involvement/integration. This data reflects only DSCC care coordination efforts in transition planning.

Transition technical assistance site visits were continued through individual regional office meetings. The agenda included discussion on formalized health care transition programs/clinics to provide DSCC care coordinators with resources available to support and/or complement their care coordination efforts around health care transition. The Hemophilia and Cystic Fibrosis (CF) Centers in IL and surrounding states responded to a transition service phone survey administered by DSCC. The National Hemophilia Guidelines on Transition covering age specific components on self advocacy, independent health care behaviors, sexual health and lifestyle behaviors were presented to DSCC care coordinators. Transition services provided by CF Centers were highlighted, including promoting independence in health care management beginning by age 10 years. Some centers participate in staffing meetings/IEPs at schools and assist with college living arrangements. Information on transition clinics in Illinois and other health care transition projects/collaboratives was also provided to staff. A discussion on transition issues and resources for adult congenital heart patients was facilitated. Care coordinators from each regional office were asked to identify referral patterns for YSHCN as they transition to adult health care. A transition referral list of adult providers was developed and posted to the DSCC intranet for staff reference. This tool was developed to help identify adult practitioners interested in caring for adolescents and young adults with special health care needs. Staff was encouraged to identify more providers that care for adults with special health care needs.

DSCC continued work with health care providers, families, youth and other professionals to provide the health care transition breakout sessions for the statewide conference. Youths were identified through DSCC care coordinators and DSCC approved providers to participate on a consumer panel entitled: What Adolescents with Special Health Care Needs Have to Say About their Health Care Transition Experiences. DSCC also recruited health care providers and advocates for the additional 10 health care transition specific breakouts. The health care track

objectives included: describe the interplay between health care, vocational, educational and community life transitions; increase awareness of collaborative system efforts in the area of transition; discuss transition from a program provider perspective and how to promote development of skills in your interactions with youth.

Care coordinators continued to encourage youth leadership and participation in the Statewide Independent Living Council of Illinois' Youth with Disabilities Leadership Summit. DSCC again provided a presentation on health care transition for participating youth.

A presentation on transition was provided to DSCC's Medical Advisory Board (MAB) to increase awareness of DSCC's health care transition efforts. The MAB discussed recommendations on decreasing system barriers for enrolled youth transitioning from pediatric oriented health care systems to adult health care systems.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medical transition materials available on website				X
2. Care coordination staff development on transition				X
3. Evaluation of transition planning				X
4. Promoting awareness of transition issues and resources				X
5. Care coordination related to transition planning for DSCC children and youth		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A review of agency policies/procedures was performed and some modifications have been made to improve transition from pediatric healthcare to adult healthcare.

Training and technical assistance continue to be provided to health care professionals, secondary/post secondary educational partners, youth, families and other key stakeholders. DSCC's care coordination teams continue to inform families and assist with coordinating funding to support transition training opportunities.

A survey was sent to a sample of youth between 14 and 21 years to determine their perceptions of DSCC transition planning efforts and levels of success. Data is being analyzed.

c. Plan for the Coming Year

DSCC will continue to collaborate with the pediatric residency programs to establish transition training as part of a program rotation. A distance training module on YSHCN transition will be offered to all pediatricians and family physicians in Illinois.

A recent chart review found only 16.8 percent of youth, aged 14-21, have developed a written DSCC transition plan. Future regional office training/technical assistance site visits will focus on developing transition goals with youth and families and the importance of a written transition plan to ensure communication between team members, provide guidance, contact information, follow

up, and identify action steps and person(s) responsible. Real life samples of transition plans will be shared.

DSCC will strengthen transition efforts for recipients by working to improve access to high quality, developmentally appropriate, uninterrupted healthcare through facilitating transition to adult health care providers, referring to appropriate resources, providing anticipatory guidance and writing person centered plans. DSCC will continue to collaborate with community agency transition partners. Analysis of the youth survey will be completed and results disseminated.

A work group will be formed and charged with evaluating and improving DSCC's transition tools/materials. The work group will continue to gather feedback from youth, families, and colleagues in an effort to continuously evaluate transition service needs and advice on anticipatory guidance, transition tools, resources and training needs.

State Performance Measure 3: *The proportion of women and children up to 22 years of age who receive appropriate genetic testing, counseling, education and follow-up services*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	1.5	1.5	1.5	1.5	1
Annual Indicator	1.7	1.2	1.0	1.0	1.0
Numerator	101954	75981	61099	61056	60455
Denominator	6091399	6091399	6091399	6091399	6091399
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	1	1	1	1	1

Notes - 2007

Source: Total number served by clinical genetic, pediatric hematologist, and local health department grantees (data collection provided by quarterly reports for 2007), Genetics Program. The 2000 Census estimate provided by the Genetics Program was not reported until 2001 and will be continually used for this measure.

A change in data collection procedures resulted in a reduction in this performance measure. A data audit determined that in the past, service providers reported the number of individuals screened rather than the number referred for a genetic condition or concern. Guidelines were refined in an effort to capture the number of clients actually referred rather than merely screened. The performance target was lowered to 1.0 percent to reflect this change in practice. And, although, the performance target was met, the goal was not.

Notes - 2006

Source: Total number served by clinical genetic, pediatric hematologist, and local health department grantees (data collection provided by quarterly reports for 2006), Genetics Program. The 2000 Census estimate provided by the Genetics Program was not reported until 2001 and will be continually used for this measure.

Notes - 2005

Source: Total number served by clinical genetic, pediatric hematologist, and local health department grantees (data collection provided by quarterly reports for 2005), Genetics Program. The 2000 Census estimate provided by the Genetics Program was not reported until 2001 and will be continually used for this measure.

a. Last Year's Accomplishments

Rationale. This performance measure was chosen because Illinois has a substantial number of newborns, children, and adults whose genetic conditions necessitate extensive and coordinated health care services. Although local health agencies and genetic centers do receive minimal funding, there remain communities that seriously lack any resources to meet such needs. This performance measure is placed at the direct health care level of the pyramid, and is considered a risk factor type of service. This measure will be addressed by IDPH.

Illinois did not meet its goal of increasing the proportion of women and children who receive genetic testing, counseling, education, and follow up services. A change in data collection procedures resulted in a reduction in this performance measure. A data audit determined that in the past, service providers reported the number of individuals screened rather than the number referred for a genetic condition or concern. Guidelines were refined in an effort to capture the number of clients actually referred rather than merely screened. The performance target was lowered to 1.0 percent to reflect this change in practice. And, although, the performance target was met, the goal was not.

The Genetic Counseling and Education program staff provided technical assistance to local health departments, clinical geneticists, and other specialists who received funding. Local health departments received funding for nurses to serve as case managers, facilitators, educators, and referral sources for all clients in need of any service related to genetics. Clinical genetics centers received funding to provide diagnosis, counseling, treatment, and long range management to pediatric and adult patients. Satellite clinics have been staffed by medical geneticists in collaboration with specific local health departments.

Chicago. In 2007, 1,384 prenatal clients in the CDPH clinics were screened for genetic disorders. Of these, 165 (11.9 percent) of women were referred for follow-up. Of those, 23 (14 percent) kept their appointments. During FY2007, the Chicago Department of Public Health received 738 referrals for infants up to one year old for genetic disorders. Public Health nurses made 265 referrals for family counseling and 28 referrals for genetics follow-up.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDPH awards grants to medical centers for diagnostic, counseling and treatment services		X		
2. IDPH awards grants to local health departments for genetic case-finding and referral		X		
3. IDPH awards grants to pediatric hematologists at medical centers		X		
4. IDHFS reimburses for preconceptional risk assessment				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This performance measure is addressed through the routine operation of IDPH's Genetic Counseling program.

IDPH has finalized the development of a Statewide Genetics Plan. The plan was developed based on data collected during the Illinois Genetic Services Needs Assessment, conducted from 2003 through 2005; through review of other state genetic services plans and other available resources; and the knowledge and expertise of many diverse participants and stakeholders. The plan development process involved the guidance of a steering committee and input from seven

work groups, planning conference participants and statewide community forum attendees.

During FY08 the IDPH awarded 5 implementation grants to address the following priority areas identified in the State Plan.

Goal 1: Reduce barriers to access to genetic health care services.

Goal 2: Increase genomic awareness and literacy in the general public.

Goal 3: Promote integration of genomics into health care delivery systems through education of health professionals and the health care work force.

Goal 4: Address genetic services financing and reimbursement issues that impact individuals, families, and/or genetic service providers.

Goal 5: Identify and examine the ethical, legal and social issues (ELSI) relevant to clinical genetic services, genetic research and related applications.

Chicago. CDPH Maternal and Family Planning programs routinely screen for genetic disorders in community health clinics, and provide genetics education.

c. Plan for the Coming Year

Local health departments, clinical geneticists, and other specialists will continue to receive funding to provide assessment, counseling, education, and referrals for long term management of families with a member diagnosed with a genetic condition. IDPH's planned activities are as follows: Clinical genetics centers will provide genetic diagnosis, counseling, treatment, and management to pediatric and adult patients; satellite clinics staffed by medical geneticists and counselors will be on-site at local health agencies; local health departments will provide services related to genetics; use of the Genetic Screening Tool by local health departments will be expanded and this Tool has been integrated into Cornerstone to facilitate use by the local health department staff; specialized services (i.e., Illinois Teratogen Information Service, pediatric metabolic and endocrine clinics, and preconception/prenatal testing and counseling) will be expanded; workshops will be held for professionals, families, and the general public; and IDPH will collaborate with other programs, divisions, and departments in the state to provide comprehensive services to all families in need. With the implementation of newborn screening for cystic fibrosis, additional funding for Genetic Counseling Services has been provided to centers with cystic fibrosis specialists.

Chicago. The CDPH will continue to provide genetic information and referrals as needed, and will offer folic acid to all women receiving prenatal care and family planning services. Licensed genetic counselors will continue to provide genetic counseling to clients referred to them.

State Performance Measure 4: *The prevalence of Early Childhood Caries (ECC)*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	32	32	33	33	33
Annual Indicator	33.0	33.0	33.0	33.0	30.4
Numerator	175000	175000	175000	175000	
Denominator	530600	530600	530600	530600	
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	33	33	33	33	30

Notes - 2007

According to the Oral Health program at IDPH, "ECC prevalence - our Headstart BSS 2006-07 found that at the state level 30.4% of children in Head Start had caries experience." IDPH continues to report only the percentage to the MCH program. Form 16 has been revised for the 2009 application. Beginning with the 2007 annual report, only the percentage will be reported.

Notes - 2006

Per IDPH, Oral Health section, the figures for 2006 are the same as reported for 2004.

Notes - 2005

Per IDPH, Oral Health section, the figures for 2005 are the same as reported for 2004.

a. Last Year's Accomplishments

Rationale. This performance measure was chosen because 12 of the 19 Illinois communities completing an oral health needs assessment and comprehensive oral health plan in 1997 identified Early Childhood Caries, or "baby bottle tooth decay," as an oral health priority. This performance measure is placed at the population based services level of the pyramid, and is considered a risk factor type of service. This measure will be addressed by IDPH.

In 2001, the IDPH Division of Oral Health (DOH) completed a statewide prevalence study of Early Childhood Caries (ECC) in children participating in the WIC Program. The study found 33 percent of the children presented with ECC. The Division of Oral Health completed a comparable study in 2006.

The IDPH DOH, the IDHS WIC program, and the Head Start programs in Illinois are implementing a statewide oral health education program for women, infants and children participating in the WIC and Head Start programs. The program goal is to improve the oral health status of pregnant women and very young children through oral health education. The educational tools were developed based on a survey of the WIC Program Certified Health Professionals.

The Division and Illinois Chapter of the American Academy of Pediatrics (ICAAP) created a training program to teach pediatricians to apply fluoride varnishes, screen children, provide anticipatory guidance, and refer families to dentists for oral health care. IDPH and ICAAP joined with IDHFS and the UIC College of Dentistry to implement a research project to study the efficiency and efficacy of fluoride varnishes applied by pediatricians in MCH settings.

The Division's Epidemiologist completed the analysis of the 2006 ECC Basic Screening Survey (BSS) of two to four-year-olds in Head Start. The BSS has yielded oral health status of the children as well as a uniform method for ongoing data collection. Preliminary data shows a 30 percent ECC rate in the children screened.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDPH works with interested communities to establish community-based prevention programs				X
2. IDHFS supports a pilot test of the application of fluoride varnish	X			
3. IDHFS' contractor, Doral Dental, conducts outreach to All Kids-eligible children who have not received a dental service for 12 months		X		
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

IDPH continues to implement the ECC prevention project based on recommendations found in the Illinois Oral Health Plan II (IFLOSS 2007). The program is building oral health infrastructure within MCH programs.

IDPH expanded the training portion of the Program to additional Human Services programs such as Coordinated Child Care and Teen Reach in addition to every WIC, FCM, and Head Start in the state and is providing them incentives of toothbrushes, dental floss, and toothpaste as well as additional oral health educational tools.

The Division is developing an effort to assure that families of children with special health care needs receive the oral health education and referral to dental homes working with DSCC.

The Division's Epidemiologist has revised the data collection process to enable a statewide effort to complete annual ECC Basic Screening Survey (BSS) of two to four-year-olds in Head Start. The BSS will yield oral health status of the children as well as a uniform method for ongoing data collection.

The Division has expanded the ECC Prevention Program efforts by funding the creation of an Oral Health Network focusing on the Illinois safety net clinics through the Illinois Primary Health Care Association. The Division has implemented four community-based ECC Prevention Planning Projects to yield comprehensive community-based plans including outcomes, strategic interventions.

c. Plan for the Coming Year

IDPH will continue to work collaboratively with the MCH programs to assure long-term use of the educational tools. The DOH will continue to expand the ECC Prevention Program into additional MCH programs including those providing child care and support for teen mothers. The Division will review and revise all educational components of the program to assure that children with special health care needs are addressed and included in all aspects of the program.

The Division will expand a partnership with the Illinois Primary Health Care Association to continue to build an Oral Health Network within the IPHCA. The Oral Health Network will assist all oral health safety net clinics and their staff to implement measures aimed at reducing ECC.

The Division will work more closely with community agencies to improve their capacity to implement ECC prevention activities by engaging community partnerships and linking MCH, health and oral health entities. These community projects will use the Illinois Head Start Oral Health Plan and the Head Start program best practices published by the National Oral Health MCH Resource Center.

IDPH will continue to institutionalize a process to collect the oral health status information through the existing Head Start agencies and their dental providers, and distributing a form that will become a standardized tool for all Head Start exams at every Head Start agency to be used every year. The data collection form will be devised using optical scanning technology, precluding the need for data input. IDPH plans to use these data for program evaluation and for annual MCHB reporting.

State Performance Measure 5: *The prevalence of childhood lead poisoning*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	5.7	4.8	4.6	2.9	2.8
Annual Indicator	4.9	3.6	3.0	2.3	3.1
Numerator	13140	9843	8123	6480	10639
Denominator	267997	272757	275103	278078	340050
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	2.7	2.6	2.5	2.4	2.4

Notes - 2007

The 2007 calendar data are provisional.

The increase observed for 2007 is a direct result of intense screening activity in Chicago.

Notes - 2006

Source: IDPH, Division of Children's Health & Safety, Childhood Lead Poisoning Prevention Program. Based on available blood lead data for 2006 as of 06/07. These data have been revised during the 2007 annual report. As of 12/07, blood lead tests were reported on 278,078 Illinois children in 2006; 6,480 of those children had at least one blood lead test result greater than or equal to 10 µg/.

Notes - 2005

Source: IDPH, Division of Children's Health & Safety, Childhood Lead Poisoning Prevention Program. Based on available blood lead data for 2005 as of 06/06.

a. Last Year's Accomplishments

Rationale. The Healthy People 2010 objective is to eliminate the prevalence of blood lead levels exceeding 10 µg/dL in children aged 1 to 6. Illinois' rate lead poisoning, at 3.1 percent, is significantly higher than the national average of 1.6 percent and to other states of similar population. The increase observed for 2007 is a direct result of intense screening activity in Chicago. The program achievements in 2007 include: implementation of a home environmental investigation and a nurse home visit, when a child age thirty-six months and younger has a confirmed blood lead level greater than or equal to 10 µg/dL, as established by the June, 2006 amendment of the Lead Poisoning Prevention Act establishing new guidelines to further expand on lead poisoning prevention efforts in the state; update of the Childhood Lead Risk Assessment Questionnaire and translation of the document into Spanish and French; update of Guidelines for physicians in administering the Childhood Lead Risk Assessment Questionnaire; implemented a study aimed at determining the high risk populations and the increasing percentage of elevated blood lead levels among refugees in Illinois; update of Illinois Lead Program (ILP) web page for increased and easier access to include all lead program educational publications, license training forms and program forms; expansion of the Illinois Childhood Lead Poisoning Elimination Advisory Council to involve an increased number of non-traditional and faith-based organizations; and increased trainings offered to local health department staff and health care providers . Chicago. For fiscal year 2007 (most recent data available), 91,557 children aged 0 to 72 months were tested in Chicago. Of those tested, 2,373 children were identified with blood lead levels greater than or equal to 10 µg/dL. In calendar year 2007, 96,398 children were tested and 2,130 had a blood lead level greater or equal to 10 mg/dL. The screening rate among children has been consistently high over the last five years. Chicago Department of Public Health (CDPH), focuses testing on children three years of age and younger. Blood lead testing among children ages 0-2 years has increased from 29 percent in 1996 to 60 percent in 2007. The CDPH strives to assure that those children needing follow-up services receive them by providing follow up blood lead testing, education and for high risk young children, public health nurse home visits and home

investigations to determine the source of lead poisoning. CDPH continue to focus screening efforts to Chicago's high-risk neighborhoods on the south and west sides of the city. The percent of Medicaid-enrolled children screened increased from 52 percent in 2001 to 62 percent in 2006. Blood lead levels continue to decline at a rate exceeding that of other major cities. Chicago program achievements in 2007 include: Proposed regulations under Chapter 7-4 of the Municipal Code of Chicago: Lead Bearing Substances, decreases the sale, transfer and distribute to the public, products containing or coated with lead based on the percent of lead by total weight. This proposal gives clearer definition of products considered high in lead and under this regulation CDPH has the authority to embargo lead bearing products if rules and regulations of Chapter 7-4 are violated. The proposed rules and regulation also require any commercial establishment that offer paint or supplies intended for the removal of paint shall display information on safe lead work practices to reduce lead hazard exposure during renovations and remodeling in according to the Lead Poisoning Prevention Act of 2006. Other Chicago program highlights from the past year include: CDPH continues to implement the requirements of the new Illinois Lead Poisoning Prevention Act, passed on June 20, 2006. Working with Action for Children, all childcare providers received information packets about lead poisoning prevention, free lead poisoning prevention training, and information on how and when to provide lead poisoning information to parents enrolled in childcare programs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to increase the number of at-risk children screened for lead poisoning	X			
2. Maintain a statewide Lead Elimination Advisory Council				X
3. Maintain local advisory committees				X
4. Continue to coordinate activities with lead hazard reduction grant programs				X
5. Educate pregnant women and families with children under three years of age about lead poisoning through WIC clinics and Perinatal birthing hospitals		X		
6. Train medical residents and nursing students on appropriate clinical management of lead-poisoned children				X
7. Expand efforts with high-risk targeted areas to educate the public about lead poisoning prevention methods, intervention procedures, and safe home renovation practices				X
8.				
9.				
10.				

b. Current Activities

Illinois Lead Program entered into contracts with 80 delegate agencies to provide case management care for lead poisoned children in 89 of the 102 counties. The remaining counties are case managed by the ILP Regional Nurse Consultants. The Illinois Lead Program and the Illinois Childhood Lead Poisoning Elimination Advisory Council meet quarterly to discuss lead elimination activities under the following topics: elimination plan, case management, primary prevention, surveillance, strategic partnerships, work plan and evaluation. Quarterly data match reports will be generated following the Interagency Agreement by the Department of Public Health and the Department of Healthcare and Family Services (HFS) to identify, screen, and provide follow-up services to HFS enrolled children at risk of exposure to lead-bearing substances. Chicago: CDPH provides free blood lead testing at WIC sites throughout Chicago's high-risk

neighborhoods. CDPH and community stakeholders have established Lead Safe Chicago. This strategic plan focuses on leveraging dollars to make housing lead safe, motivating property owners to make their properties safe, increasing the identification of young children aged 0-3 years who are at risk for lead poisoning, and raising awareness about childhood lead poisoning among decision makers and those with the power to make housing lead safe.

c. Plan for the Coming Year

The ILP data management section is currently working with the Division of Information Technology to replace the current STELLAR (Systematic Tracking of Elevated Lead Levels and Remediation). This system will enhance data collection, monitoring lead levels at the delegate agency level, increase electronic reporting capabilities from laboratories as well as the transmission of reports to the local health departments and the Centers for Disease Control and Prevention (CDC). This program will have a front end mechanism in place to screen and reject reports from laboratories and providers failing to report all criteria requested with in the required data fields. This electronic reporting system should increase the accuracy in reporting to at least 95 percent and greatly reduce the lead reports error file.

The ILP will continue to collaborate with other environmental health programs to increase the education and awareness of health hazards and establish and implement intervention strategies. The Illinois Lead Program and the Illinois Childhood Lead Poisoning Elimination Advisory Council will continue to meet quarterly to discuss the progress of the strategic lead elimination activities in the state of Illinois.

The ILP will continue oversight of and assistance to the delegate agencies conducting case management and environmental investigation activities in support of their role of targeting and providing services to their high-risk populations.

Chicago. CDPH and community stakeholders will continue the plan to eliminate lead poisoning by 2010 focusing on the four areas: 1) leveraging funds for making housing lead-safe; 2) establishing compliance with lead-safe housing standards; 3) increasing identification of children with elevated lead levels; and 4) enhancing awareness of childhood lead poisoning among decision-makers. CDPH will also continue to provide leadership in implementing the Chicago Elimination Plan through the city's Lead Committee, which CDPH established and chairs. This group includes representation from the City's departments of Housing, Environment, Human Services, Planning, Budget and Law.

CDPH will continue to conduct data-matches for the state Medicaid agency, conducting direct outreach for Medicaid enrolled children who have not been tested, providing free blood lead testing at WIC sites in high-risk neighborhoods, with screening reviews in doctor's offices. CDPH will continue to target high-risk neighborhoods in Chicago, providing free blood lead testing at health fairs, centers and home-based daycare centers, community clinics and other locations. The staff will also provide information to parents regarding a medical home and information on All Kids and other programs. The program will continue to provide services to the highest risk young children aged 0-3 years, and to provide lead poisoning prevention.

State Performance Measure 6: *The rate of unintended pregnancy*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				43.5	43
Annual Indicator	43.8	41.3	42.2	42.2	42.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012

Annual Performance Objective	42.5	42	41.5	41	41
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Notes - 2007

The latest PRAMS data available from the Illinois Department of Public Health are 2005.

Notes - 2006

The latest PRAMS data available from the Illinois Department of Public Health are 2005.

Notes - 2005

Source: Illinois PRAMS Report, 2005, Unintended Pregnancy, 1998-2005. "The percentage peaked at 46.2 in 2001 and remained above 40 percent since 1999. Rates among women who were unmarried, young, black, lesser-educated or on Medicaid remained much higher than 40 percent over this time span."

a. Last Year's Accomplishments

Rationale. This performance measure was added to highlight the rate of unintended pregnancy in Illinois, particularly among Medicaid-eligible women. This health problem was identified through the needs assessment completed for the FFY'06 application. This objective will be addressed through the provision of family planning services through the Title X and School Health Center programs, through the Abstinence Education and Teen Pregnancy Prevention Programs (both Primary and Subsequent) and through interconceptional care provided by the Family Case Management program and Chicago Healthy Start Initiative. It addresses the "direct health care" level of the pyramid and is a "risk factor" service.

Annual performance is measured through Illinois' PRAMS survey. The most recent data available are from 2005. That year, 42 percent of pregnancies resulting in live births were unintended. This is a slight increase from the 2004 report of 41.3 percent. The Healthy People 2010 goal is to increase percent of intended pregnancies to 70 percent. Teens continue to represent the highest proportion of unintended pregnancies when compared to other age groups. Black women represent the highest percent of women with unintended pregnancies (69.6%), as do those who are not married (67.6%). Women whose deliveries are paid for by Medicaid (58.1%) have a rate of unintended pregnancy more than double that of women whose deliveries are paid for by other means (25.7%). There has been no decline in rate of unintended pregnancy in Illinois from 1998-2005.

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.

Chicago. During 2007, CDPH's Family Planning program distributed 282 doses of emergency contraception in community health clinics. Family Planning staff provided 48 outreach educational sessions to 1,680 participants in Chicago communities. Data for CY 2007 indicate 30 percent of contraception users received an extended exam to obtain highly effective hormonal contraceptives, and 50.1 percent of users are using hormonal methods. In 2007, the Interconceptional Care Pilot Project provided services to 30 women who have experienced a perinatal death, 70 percent of whom stated these pregnancies were unplanned. Ninety-five percent of these women stated they had plans to delay subsequent pregnancies for one and one-half to two years. In 2007, the CDPH Responsible Fatherhood program began to provide services to males in the Englewood and Uptown communities. That program's approach addresses unintended pregnancy primarily through a peer education and mentoring approach, encouraging men, particularly young men, to assume some responsibility for preventing pregnancy, participate in family planning, and delay fatherhood until they have reached economic stability.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide Family Planning services	X			

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

b. Current Activities

The Family Planning program's current activities to reduce the rate of unintended pregnancy include:

1. Offer a broad range of highly effective methods of contraception, including the provision of emergency contraceptives.
2. Ensure that at least 65 percent of users are receiving an extended exam in order to obtain hormonal contraceptives.
3. Participate in the ongoing promotion, evaluation, and data monitoring of the Illinois Healthy Women Medicaid Waiver.
4. Provide preconception education, including information about the importance of birth planning and spacing.
5. Promote the use of birth control through sexually transmitted disease clinics.
6. Continue efforts to improve awareness of and access to emergency contraception.
7. Monitor delegate agency outreach education activities to the target population to educate on the prevention of unintended pregnancies.

Chicago. The CDPH addresses unintended pregnancy through Family Planning, Male Responsibility, Healthy Start, and Responsible Fatherhood programs. The Interconceptional Care Pilot Project continues to visit these at-risk women and provide counseling and education on interconceptional care, well women care and health care maintenance so that subsequent pregnancies are planned, and the number of adverse pregnancy outcomes is reduced.

c. Plan for the Coming Year

The Department will address unintended pregnancy through the routine operation of the Family Planning and School Health Center programs, the Abstinence-Only Education, Teen Pregnancy Prevention Programs (both Primary and Subsequent) and by providing interconceptional care through the Family Case Management program and the Chicago Healthy Start Initiative.

Chicago. CDPH will continue to address unintended pregnancy through Family Planning, Male Responsibility, Healthy Start, Responsible Fatherhood, and the Interconceptional Care Pilot Project. The Interconceptional Care Pilot Project manager plans to develop a continuing education online course for CDPG staff, and provide at least two additional trainings to FCM sites on interconceptional care and services.

State Performance Measure 9: *The proportion of children under 36 months of age in WIC or FCM who have received at least one developmental screening test in the previous 12 months*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				63	66
Annual Indicator		56.9	60.6	64.4	66.1

Numerator		28040	28901	29775	33248
Denominator		49251	47671	46200	50302
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	66.5	67	68	69	71

Notes - 2007

Source: Illinois Department of Human Services, Community Health and Prevention, Cornerstone Q1, SFY2008.

Notes - 2006

Source: Illinois Department of Human Services, Community Health and Prevention, Cornerstone Q1, SFY2007.

Notes - 2005

Source: Illinois Department of Human Services, Community Health and Prevention, Cornerstone Q1, SFY2006.

a. Last Year's Accomplishments

Rationale. This performance measure was selected because the expert panel on child and adolescent health for the FFY'06 needs assessment recommended that the Department address the mental health needs of children through the MCH program. This performance measure highlights the unique role that the MCH program can play in identifying children who are experiencing developmental delays and ensuring that they have access to appropriate treatment. This performance measure is classified at the enabling level of the pyramid and as a "risk factor" service.

The Department monitors performance on this measure each quarter. Statewide performance of developmental screening in the WIC and FCM programs reached 66.1 percent by the end of 2007.

For the period January through December 2007, 66.8 percent (149 of 223) of 1 year olds were tested for developmental delay by their first birthday and 41.7 percent (25 of 60) of two year olds had six or more developmental screenings before their 2nd birthday. Next year's goal is 80 percent of one year olds will be tested for developmental delay by their first birthday and 80 percent of 2 year olds will have six or more developmental screenings before their 2nd birthday. Chicago. In FY 2007, 18,173 CDPH children, birth to 36 months, received developmental screening tests, resulting in 592 referrals for follow-up.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct developmental screening through the WIC and Family Case Management programs		X		
2. Conduct developmental screening through the Healthy Families Illinois, Parents Too Soon, and Teen Parent Services programs		X		
3. Provide additional training on early childhood development to Family Case Management, WIC, Healthy Families Illinois, Parents Too Soon, and Teen Parent Services providers through the State Early Childhood Comprehensive Systems initiative				X
4. Refer children who appear to have a developmental delay to the Part C Early Intervention program for further assessment		X		
5. The All Our Kids Early Childhood Networks will coordinate or promote developmental screening in the communities they serve		X		

6. The MCH program will participate in the Early Learning Council and the Early Childhood Committee of the Illinois Children's Mental Health Partnership				X
7. IDHFS leads the Assuring Better Child Development II and Enhancing Developmentally-Oriented Primary Care projects				X
8.				
9.				
10.				

b. Current Activities

The FCM program implemented a new policy for developmental screening. This new policy provided for:

- Developmental screenings on infants and children between 3 and 66 months
- An approved tool is to be used
- A licensed individual (R.N., Nutritionist, Social Worker or individuals with advanced degrees in child health) is to perform the screening
- Make appropriate referrals to Early Intervention
- Follow-up to ensure referral was successful

Local WIC agencies refer families to the Early Intervention Program as needed. Follow-up is documented in case notes. In February 2008, approximately 40 EI Managers were provided an update on the WIC Program to ensure consistent messages and referrals are made. Chicago. CDPH FCM staff administers the Denver Developmental Screening Test, and verifies receipt of other developmental screening. Other CDPH programs that monitor and facilitate receipt of developmental screenings include WIC, the Greater Westside of Chicago Early Childhood Network , and the greater Englewood Healthy Start Initiative.

c. Plan for the Coming Year

This performance measure will be addressed through the routine operation of the WIC and FCM programs. IDHS already measures the occurrence of developmental screening each quarter as a performance measure in the WIC and FCM programs. All of the local agencies that provide these services received training during FFY'05 in the use of the Ages and Stages Questionnaire Social and Emotional development scale, and many local program staffs have already been trained to use other developmental screening tests. Children who show evidence of developmental delay will be referred to the Part C Early Intervention program.

Chicago

CDPH programs will continue to perform developmental screenings, and monitor and facilitate receipt of screenings performed by other providers. Healthy Start case managers will perform developmental screening on at least 80 percent of enrolled children.

State Performance Measure 10: *Females 15 to 24 years of age receiving services at Title X family planning clinics tested at least once for chlamydia*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					57
Annual Indicator			55.9	55.1	55.9
Numerator			47645	43503	41040
Denominator			85178	78908	73478
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	58	59	60	61	61

Notes - 2007

This is a new state performance measure being introduced before the end of the needs assessment cycle. Therefore the Annual Performance Objective technically may not be measured until the 2007 annual report. The measure will indicate performance of the Family Planning program in collaboration with the STD Section at IDPH for identifying and treating chlamydia among young females. Source: 2007 FPAR

Notes - 2006

This is a new state performance measure being introduced before the end of the needs assessment cycle. Therefore the Annual Performance Objective technically may not be measured until the 2007 annual report. The measure will indicate performance of the Family Planning program in collaboration with the STD Section at IDPH for identifying and treating chlamydia among young females. Source: 2006 FPAR

Notes - 2005

This is a new state performance measure being introduced before the end of the needs assessment cycle. Therefore the Annual Performance Objective technically may not be measured until the 2007 annual report. The measure will indicate performance of the Family Planning program in collaboration with the STD Section at IDPH for identifying and treating chlamydia among young females. Source: 2005 FPAR

a. Last Year's Accomplishments

Rationale. Examining incidence of Chlamydia is not a precise measure of performance. It masks the efforts and successes of the various activities directed toward preventing the long-term effects of Chlamydia. From 1996 through 2005, the number of reported cases increased more than 90 percent, due in large measure to improved surveillance, increased testing, and the use of more sensitive diagnostic techniques.

Therefore, Illinois will replace the existing State Performance Measure 7 with the following: Increase the percentage of females 15 to 24 years of age receiving services at Title X Family Planning Clinics who receive at least one test for Chlamydia.

The Title X Family Planning Program partners with the IDPH STD program to reduce the prevalence of sexually transmitted diseases and prevent long-term genitourinary complications. In 2007, IDPH reported that 55.9 percent of females less than 25 years of age receiving services at Title X Family Planning Clinics received at least one test for Chlamydia. By 2008, IDHS/IDPH expects the percentage to increase to 58.8 percent.

Accomplishments in FY'07 directed to testing individuals most at risk of Chlamydia include:

- * IDPH reported that the number of Chlamydia tests submitted decreased and the positivity rate increased, indicating that clients are being appropriately targeted for testing. Efforts to reduce testing in females 25 years of age and older with no identified risk factors are ongoing, and have contributed to the decrease in testing.

- * Family Planning and SHCs increased testing among males, prompted by the availability of urine screening.

- * IDPH/IDHS Family Planning Program encouraged and monitored adherence to the screening criteria at family planning clinics, resulting in a decrease in the number of tests and an increase in the positivity rate.

- * Testing volume from SHCs increased significantly, because of the addition of new sites to the screening program, availability of testing at IDPH laboratories, and training provided to SHC staff on counseling and sex partner notification.

Chicago.

The CDPH Office of STD Surveillance reports on residents of Chicago between 15 -- 24 with Chlamydia: 15,536 persons for 2003; 14,135 persons for 2004; 15,239 persons for 2005, and 15,524 persons for 2006. Non-Hispanic Blacks are disproportionately impacted by Chlamydia. In 2006, 11,077 (71.4 percent) of cases among Non-Hispanic Blacks were reported, compared to 1,320 cases among Hispanics, and 407 cases among Non-Hispanic Whites.

A pilot project between CDPH's STDS/HIV/AIDS Division Adolescent Program and Chicago

Public Schools (CPS) provided STD/HIV information and testing to all juniors and seniors at two high schools. Sixteen percent of the students involved tested positive for Chlamydia.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide Family Planning services	X			
2. Provide STI testing and treatment through School Health Centers	X			
3. Collaborate with the IDPH Sexually Transmitted Disease Program and AIDS Activity Section				X
4. Participate in the Region V and Illinois Infertility Prevention Projects				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Family Planning (FP) Program and the IDPH STD program are continuing to encourage and monitor the age-based screening criteria for Chlamydia. A mailing was sent by IDPH-STD to each Title X FP Clinic to provide screening recommendations and site-specific data on screening coverage rates by age group for 2007. An analysis of 2007 CVR data from Title X Family Planning Delegate Agencies presenting the percent of clients tested for Chlamydia by age group will be conducted by IDPH-STD. During a required Family Planning Program training, the delegate agencies will receive a list of the percent of clients less than 25 years of age who received Chlamydia testing during 2007 and a review of the testing criteria.

Chicago

CDPH policy mandates all pregnant women should be screened at least once during their pregnancy. CDPH's STD/HIV/AIDS Division Adolescent Program and HIV Counseling and Testing unit are currently meeting with key CPS staff to revise CPS's confidentiality and Sexually Transmitted Infection (STI) policy/procedures/protocol. The revised policy/protocol will allow STI counseling and testing to occur in all high schools whether or not there is a school based health clinic. The adolescent program also re-established collaborations with the Illinois Youth Center-Chicago (providing a STD/HIV Health Education curriculum to approximately 130 youth housed in the facility) and with the YMCA.

c. Plan for the Coming Year

The Department will increase the screening coverage of young women receiving services at Title X Family Planning Clinics by continuing to adhere to the age-based screening criteria for Chlamydia. The Family Planning program and the IDPH STD program will undertake the following activities in FY'09 to reduce the rate of Chlamydia infection:

Retesting persons with positive tests: Continue to guide a project of retesting individuals with positive Chlamydia as presented in CDC's 2002 STD Screening and Treatment Guidelines. Chicago. The Healthy Start and Family Planning programs will continue to provide STD education, and all CDPH pregnant women will be screened at least once during their pregnancy. The CDPH STD/HIV/AIDS Division Adolescent Program and CPS are planning to extend STD/HIV information and testing to all juniors and seniors within all high schools. CDPH is currently looking to hire a Director of School Health (who would report jointly to CDPH

Commissioner Dr. Terry Mason and Mr. Arne Duncan, Chief Executive Officer of CPS.) The Adolescent program will continue to provide services to youth at the Cook County Juvenile Temporary Detention Center and the Illinois Youth Center-Chicago, and will continue to collaborate with community-based organizations and alternative and charter schools.

E. Health Status Indicators

Data for Health Systems Capacity Indicators 1 through 9 are presented on Forms 17, 18, and 19.

Prenatal Care. The proportion of women who initiate prenatal care in the first trimester of pregnancy increased in Illinois; the proportion was 82 percent in 2005 and 86 percent in 2006 (see National Performance Measure 18). Similarly, the proportion of women who receive an adequate number of prenatal care visits remained steady as measured by the Kotelchuck Index (see Health System Capacity Indicator 4 on Form 17). In 2005, 80.2 percent received an adequate amount of prenatal care as measured by the Kotelchuck Index. That percent was 79.9 in 2006.

Pregnant women with family incomes at or below 200 percent of the federal poverty level are eligible for services under either Medicaid or SCHIP (Healthy System Capacity Indicator 6 on Form 18). Eligibility for children under SCHIP is 200 percent of the federal poverty level.

Medicaid-eligible pregnant women are less likely than non-Medicaid-eligible women to initiate prenatal care in the first trimester of pregnancy (76.3 percent versus 88.2 percent in 2006, Health Systems Capacity Indicator 5c, Form 18) and less likely to have an adequate number of prenatal care visits (73.8 percent versus 85.4 percent in 2006, Health System Capacity Indicator 5d, Form 18).

Infants. The proportion of Medicaid-eligible infants who obtain routine well-child care has been above 80 percent in recent years (Health Systems Capacity Indicator 2, Form 17). The high rate of utilization reflects the effort of several MCH programs to ensure that infants obtain appropriate well-child care. Until 2004, fewer than 300 infants a year were eligible for SCHIP for at least 30 days. Enrollment in SCHIP improved in 2005, and 97.5 percent of these infants received at least one well-child service. This small number of eligible children limits the interpretation of the rate of well-child care utilization in this population (Health Status Indicator 3, Form 17). Most of the infants identified through the KidCare program were found to be eligible for Medicaid.

Infants from families with incomes below 200 percent of the federal poverty level are eligible for health insurance coverage through either Medicaid or SCHIP. Infants who were born to a Medicaid-eligible woman are covered through the first year of life on the Medicaid program. Otherwise, infants from families with incomes below 133 percent of the federal poverty standard are eligible for Medicaid (Health Systems Capacity Indicator 6a, Form 18). Infants from families with incomes between 133 and 200 percent of the federal poverty level are eligible for the SCHIP portion of All Kids. Further, uninsured infants who are not eligible for the Medicaid or SCHIP programs can be enrolled in All Kids, regardless of income or citizenship.

Children. Appropriate care of asthma in young children and access to oral health care are two persistent health care system problems in Illinois. In 2007 (the most recent data available), the rate of asthma hospitalization among children under five years of age decreased to 59.7 per 10,000, the lowest level in the last five years (Health Systems Capacity Indicator 1, Form 17). The MCH program supports two demonstration projects to improve asthma management in young children; these activities were described earlier in the application. In addition, the MCH program participates in several initiatives of Illinois Department of Public Health to reduce the burden of childhood asthma. The proportion of Medicaid-eligible children between six and nine years of age

who received any dental services reached 52.2 percent in 2006 (Health Systems Capacity Indicator 7, Form 17). Children over one year of age from families with incomes below 133 percent of the federal poverty level are eligible for Medicaid; children from families with incomes between 133 and 200 percent of the federal poverty standard are eligible for SCHIP (Health Status Indicator 6, Form 18). All other uninsured children, regardless of income or citizenship, are eligible for All Kids.

Children with Special Health Care Needs. The proportion of state SSI beneficiaries under 16 years of age who received rehabilitative services through the CSHCN program decreased to 8.7 percent in 2007 (Health Systems capacity Indicator 8, Form 17). For a description of DSCC's efforts for SSI-eligible children, see Section III.B., "Agency Capacity," "Children with Special Healthcare Needs."

Data Capacity. The Illinois MCH program has extensive capacity to analyze data from vital records, program records, Medicaid and special surveys. The Illinois Department of Public Health produces matched birth and death certificate files, although production is behind schedule due to staff shortages. The MCH program annually produces a file of matched vital records, Medicaid eligibility, paid claims and MCH program participation that allows comparison of natality characteristics among infants that were and were not covered by Medicaid or involved in any of several MCH programs. The MCH program's primary information system, Cornerstone, includes immunization records from Medicaid-eligible children and paid claims for EPSDT services. Cornerstone is used to operate the WIC program and data from it is provided to the U.S. Centers for Disease Control and Prevention (CDC) annually for the Pregnancy and Pediatric Nutrition Surveillance Systems. The Illinois Department of Public Health maintains a complete database on hospital discharges, maintains birth defects registry and conducts the Pregnancy Risk Assessment and Monitoring System (PRAMS), the Youth Tobacco Survey, and the Behavioral Risk Factor Surveillance (BRFSS) surveys for CDC.

There are two deficiencies in Illinois' MCH data capacity. First, the Illinois Department of Public Health is responsible for both the Newborn Metabolic Screening program and the Vital Records Systems but has not linked the two data systems. A contract has recently been issued to begin development during FY 2008 of an updated Newborn Metabolic Screening Data System. This system will assist the state in meeting its mandate to test all newborns and follow-up abnormal results with immediate and long-term referral to appropriate medical specialists, effective management and treatment. This system is needed to allow matching of screening records with all Illinois births, and to obtain accurate and complete demographic information on each Illinois birth. Without this system, no means currently exists to assure that all Illinois newborns are in fact screened, and often, accurate information is not available to IDPH staff to follow those infants with abnormal test results. Second, process and reporting vital events has been severely hampered by loss of staff resulting in lengthy delays in reporting current statistics. The Illinois Department of Public Health is in the process of building an Electronic Death and Birth-Related Data Registration system (EDRS/BRD) that will address the current manual and time-consuming means by which Vital Records collects and disburses data. IDPH will reengineer the Vital Records' data collection systems for births, deaths, and fetal deaths; the vital event registration systems; the mainframe-based editing and reporting systems for births, deaths, fetal deaths within a secure Internet-based environment.

F. Other Program Activities

Please refer to "Agency Capacity" for a complete description of Illinois' Title V program.

G. Technical Assistance

See Form 15 for this information.

V. Budget Narrative

A. Expenditures

Form 3. The Department and its partners expended a total of \$135.2 million in Maternal and Child Health Partnership funds and \$255.7 million in other federal funds, for a total expenditure of \$390.7 million during FFY'05 to operate the state's Maternal and Child Health program. The Maternal and Child Health Partnership includes the Maternal and Child Health Services Block Grant, State funds used for match and maintenance of effort, other state funds, local funds and program income.

The differences in the amount of state funds budgeted and expended resulted from minor changes in the budget items or amounts used to meet the match and maintenance of effort requirement. The amount of local funds (the amount used as match for Abstinence-Only Education) changed as the amount of the federal Abstinence-Only Education grant award changed. The amount of program income (from the Family Planning program) exceeded the estimated amount budgeted for FFY'05 by about 5.6 percent. Some of the apparent differences in the amounts budgeted and expended result from budgeting on the state fiscal year and reporting on the federal fiscal year. Overall expenditures of partnership funds were within two percent of the budgeted amount.

DSCC expended \$19.2 million for CSHCN from all sources in FFY'05, an aggregate increase in spending of \$0.4 million over FFY'04. Even though there was a \$0.2 million decrease in federal Block Grant funds for CSHCN in FFY'05, DSCC was able to increase the total funds expended on CSHCN by utilizing an additional \$0.4 million of State and local resources and \$0.2 million of other federal grants. Since FFY'02, DSCC has seen a steady decline in federal MCH Block Grant funds through a reduction in Illinois' allocation of MCH funds, in addition to the state's reduction in the funds for CSHCN from 32.1 percent to 30 percent of Illinois' allocation. In order to offset the decline in federal and State funds, DSCC worked with the Illinois Department of Healthcare and Family Services to identify the Medicaid-eligible children in the CSHCN program receiving care coordination services. DSCC was able to sustain the level of services for CSHCN in large part through this collaborative effort to generate additional revenue through Medicaid Administrative Claiming.

//2008/ The Department and its partners expended a total of \$144.4 million in Maternal and Child Health Partnership funds and \$254.8 million in other federal funds, for a total expenditure of \$399.2 million during FFY'06 to operate the state's Maternal and Child Health program. The Maternal and Child Health Partnership includes the Maternal and Child Health Services Block Grant, State funds used for match and maintenance of effort, other state funds, local funds and program income. //2008//

//2008/ The differences in the amount of state funds budgeted and expended resulted from minor changes in the budget items or amounts used to meet the match and maintenance of effort requirement. The amount of local funds (the amount used as match for Abstinence-Only Education) changed as the amount of the federal Abstinence-Only Education grant award changed. The amount of program income (from the Family Planning program) exceeded the estimated amount budgeted for FFY'06 by about 50 percent. Some of the apparent differences in the amounts budgeted and expended result from budgeting on the state fiscal year and reporting on the federal fiscal year. Overall expenditures of partnership funds were within two percent of the budgeted amount. //2008//

//2008/ DSCC expended \$19.9 million for CSHCN from all sources in FFY'06, an aggregate increase in spending of \$0.7 million over FFY'05. The increase was the result of a \$0.3 million decrease in federal MCH Services Block Grant funds in FFY'06, and an increase in the funds expended from state and local resources of \$1 million. Since FFY'02, DSCC has seen a steady decline in federal MCH Services Block Grant funds, due to reductions in Illinois' portion of MCH

funds and the state's decrease in funds allocated to CSHCN from 32.1 percent to 30 percent. In order to offset the decline in federal and state funds, DSCC worked with the Illinois Department of Healthcare and Family Services to identify the Medicaid-eligible children in the CSHCN program receiving care coordination services. DSCC was able to sustain the level of services for CSHCN in large part through this collaborative effort to generate additional resources of \$1.3 million through Medicaid Administrative Claiming. //2008//

//2009/ The Department and its partners expended a total of \$282.6 million in Maternal and Child Health Partnership funds and \$324.1 million in other federal funds, for a total expenditure of \$606.7 million during FFY'07 to operate the state's Maternal and Child Health program. The FFY'07 expenditures were substantially greater than those reported in FFY'06 (\$207.6 million) due to the decision to consider all of the division's activities as part of the Maternal and Child Health Partnership. In addition to the Maternal and Child Health Services Block Grant, State funds used for match and maintenance of effort, other state funds, local funds, and program income, the Maternal and Child Health Partnership includes funds expended for youth services, delinquency prevention, domestic violence, Early Intervention and substance abuse prevention. //2009//

//2009/ DSCC expended \$18.9 million for CSHCN from all sources in FFY'07, an aggregate decrease in spending of \$1.0 million over FFY'06. The decrease was the result of a \$1.0 million decrease in funds expended from state and local resources from FFY'06. DSCC generated \$1.4 million through Medicaid Administrative Claiming. //2009//

Form 4. The State of Illinois expended \$912,600 less for pregnant women than the amount budgeted. This was largely due to a shift in the population served through the Chicago Department of Public Health "Mini MCH Block Grant" toward children and adolescents. As a result, less of the total expenditure for the "mini-block" was allocated for services to pregnant women than the amount budgeted. Further, IDHS spent less on operations and the Cornerstone system than budgeted. Similarly, the amount expended for infants was nearly \$1.3 million less than the amount budgeted. In addition to the shift in the population served by the "mini block," IDHS expended less than the budgeted amount for Healthy Families Illinois and for the Cornerstone management information system during the reporting period. The State of Illinois expended \$441,500 more on children and adolescents than the amount budgeted. This was the result of a shift in the population served by the Chicago Department of Public Health's "mini-block" grant toward adolescents and by offsetting increases and decreases in spending in several program areas. These differences are largely due to budgeting on the state fiscal year, reporting on the federal fiscal year and the timing of payments during state fiscal years. The IDHS expended \$592,600 more for services to other adults than the amount budgeted. This was the result of expending more MCH Block Grant funds for Family Planning services than originally budgeted.

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 IDHS to have a Departmental Indirect Cost Allocation Plan for indirect costs to identify dollars that then become a part of the Public Assistance Cost Allocation Plan 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'05, DSCC spent in aggregate two percent more on services for CSHCN than in FFY'04. DSCC expended \$19.2 million from all sources in FFY'05, an increase of \$0.4 million over FFY'04. Even though there was a \$0.2 million decrease in the amount of federal MCH Block Grant funds in FFY'04, DSCC was able to increase the total funds expended on CSHCN by utilizing an additional \$0.4 million of State and local resources and \$0.2 million from other federal grants.

/2008/ The State of Illinois expended \$2.4 million less for pregnant women than the amount budgeted. This was largely due to budgeting on the state fiscal year and reporting on the federal fiscal year. Further, IDHS spent less on operations and the Cornerstone system than budgeted. The amount expended for infants was \$5.5 million more than the amount budgeted due largely to an expansion of the Targeted Intensive Prenatal Case management program. The State of Illinois expended \$186,485 more on children and adolescents than the amount budgeted. Again, this was primarily an artifact of state and federal fiscal year reporting. The IDHS expended \$3.4 million more for services to other adults than the amount budgeted. This was the result of program income generated through the Title X Family Planning program. //2008//

/2008/ 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 IDHS to 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. //2008//

/2009/ The State of Illinois expended approximately the amount budgeted for pregnant women. The amount expended for infants was approximately a million more than the amount budgeted due largely to continued expansion of targeted case management program activities. The State of Illinois expended substantially more on children and adolescents than the amount budgeted due principally to a cost of living increase awarded to youth service providers. The IDHS expended \$2.4 million more for services to other adults than the amount budgeted. This was the result of program income generated through the Title X Family Planning program. //2009//

/2008/ In FFY'06, DSCC spent in aggregate approximately four percent more on services for CSHCN than in FFY'05. DSCC expended \$19.9 million from all sources in FFY'06, an increase of \$0.7 million over FFY'05. Even though there was \$0.3 million decrease in the federal MCH Services Block Grant funds allocated to DSCC in FFY'06, the total funds expended on CSHCN were increased by approximately \$0.7 million, because an additional \$1.0 million was spent from state and local resources. //2008//

/2009/ In FFY'07 DSCC spent in aggregate approximately four percent less on services for CSHCN than in FFY'06. DSCC expended \$18.9 million from all sources in FFY'07, a decrease of \$1.0 million than in FFY'06. Even though the federal MCH Services Block Grant funds allocated to DSCC in FFY'07 remained the same, the total funds expended on CSHCN decreased by approximately \$1.0 million, because \$1.0 million less was spent from state and local resources. //2009//

Form 5. The decrease in the amount budgeted for infrastructure building resulted from the conversion of budgeted indirect costs to direct costs through the PACAP process described earlier, as well as minor changes in the items included in the budget and expenditure reports.

In FFY'05, DSCC expended \$0.3 million more on direct health care services and an additional \$0.2 million for enabling services in FFY'05. Conversely, DSCC spend \$0.2 million less for infrastructure building services in FFY'05. This shift of funds from infrastructure building to enabling services was largely due to a shift in spending for services such as transportation, community outreach and other family support services.

/2008/ The decrease in the amount budgeted for infrastructure building resulted from the conversion of budgeted indirect costs to direct costs through the PACAP process described earlier, as well as minor changes in the items included in the budget and expenditure reports. //2008//

/2008/ IDHS expended more than a budgeted during FFY'06 in direct health care and enabling services, due to increased costs associated with delivering services to teens and young families; the increases were \$3.7 million and \$2.7 million, respectively. //2008//

/2009/ In FFY'07, IDHS expended \$9 million more on infrastructure services than budgeted. The increase was an accounting issue in that all of the division's youth services programs were considered as MCH programming effort but were not accounted for in the original FFY'07 budget application. The expenditures for youth services programming is reflected in the FFY'09 application.//2009//

/2008/ In FFY'06, DSCC expended \$6.9 million on direct health care services and \$6 million on infrastructure building services, which was approximately the same amount expended in both types of services in FFY'05. In FFY'06, DSCC augmented the amount spent on enabling services by \$0.7 million from \$6.2 million in FFY'05 to \$6.9 million. The increase in funds spent for enabling services is largely due to a shift in the type of services needed such as transportation, community outreach, and other family support services. //2008//

/2009/ In FFY'07, DSCC expended \$6.1 million on direct health care services and \$6.3 million on infrastructure building services, which was \$0.8 million less in direct health care services but \$0.3 million more in infrastructure building services than in FFY'06. DSCC spent \$6.4 million on enabling services, which was \$0.5 million less than spent in FFY'06. //2009//

B. Budget

The Department has broadened the scope of programming and resources included in the Maternal and Child Health Services Block Grant to include all of the effort directed toward the health of children and women of child-bearing age in the entire Division of Community Health and Prevention. As a result, Forms 3, 4, and 5 indicate substantial increases in the budget. This represents the full range of activities under the control of the Director of Community Health and Prevention, who is now Illinois' Title V Director.

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, Closing the Gap 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 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.

/2008/ Form 3. The federal Abstinence Education Only grant was discontinued for FFY'08. Local MCH funds used in past years as match for this grant were not budgeted for FFY'08. //2008//

Form 4. IDHS has budgeted \$716,400 less for pregnant women in FFY'07 than FFY'06. This is largely due to reallocating the budget for the All Our Kids Assurance Networks from the budget for pregnant women to the budget for infants (a more appropriate classification). IDHS has also budgeted \$4.8 million less for infants in FFY'07. This is largely the result of changing the amount and allocation of state Early Intervention program funds for FFY'07. In FFY'06, \$13 million of state Early Intervention funds were allocated as enabling services for infants. In FFY'07, all \$61 million of state Early Intervention funds have been included in the Partnership; they were allocated across services for infants and older children on Form 4, based on the age distribution of the program's caseload. The reallocation reduced to \$8 million the amount of these funds allocated to services for infants.

/2008/ IDHS budgeted approximately \$13 million more for children from age one to 22 years in anticipation of a cost of living increase for providers of services to adolescents. //2008//

/2009/ IDHS budgeted approximately \$8 million more for children from age one to 22 years in anticipation of a cost of living increase for providers of services to adolescents.//2009//

/2008/ Form 5. Budgeted increases in FFY'08 for direct health care and enabling services are due to anticipated increases in the cost of providing services to adolescents among IDHS service providers. //2008//

/2009/ Budgeted increases in FFY'09 for enabling service are due to anticipated increases in the cost of providing services to adolescents among IDHS service providers. The increase in infrastructure reflects the department's plans to modernize its major maternal and child health information system, Cornerstone. //2009//

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'07 is \$16,575,000. The State of Illinois has exceeded these requirements by providing \$30,584,400 in State funds.

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 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 continue 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: Winnebago Family Planning, \$420,500; St Francis Perinatal Center, \$328,800; Chicago Department of Public Health (M&I, C&Y) \$5,017,400; Lake County Family Planning Demonstration, \$398,800 and the Dental Projects, \$398,000.

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, genetic diseases and the SIDS program, 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.

CSHCN. Through effective benefit management strategies, DSCC was able to offset project budget deficits, as they would potentially impact available funds for direct services for CSHCN. These strategies include increased staff training on benefit plans, taking advantage of contract discounts between medical care providers and insurance carriers, utilization of negotiated provider write-offs, and the use of dispute resolution techniques. In FFY 2005, DSCC was able to redirect funds to assist families through enabling services in accessing health care by providing financial assistance for transportation and establishing a family incentive program to maximize health benefits by reimbursing families for insurance co-payments on medical visits and medications.

/2008/ Through effective benefit management strategies, DSCC has been able to offset projected budget deficits, as the reductions have significantly impacted the available funds for direct services to CSHCN. These strategies include increased staff training on insurance benefit plans, taking advantage of contract discounts between medical providers and private insurance carriers, utilization of negotiated provider write-offs, and increased benefit coordination efforts with the Medicaid program. In FFY'06, DSCC was able to redirect an additional \$0.7 million of funds to assist families through enabling services in accessing health care by providing financial assistance to cover transportation costs to access medical care and establishing a family incentive program to maximize health benefits by reimbursing families their insurance co-payments on medical visits and medications. //2008//

/2009/ In FFY'07, DSCC spent \$6.4 million on enabling services which includes assisting families to access health care by providing financial assistance to cover transportation costs and continued the family incentive program to maximize health benefits by reimbursing families their insurance copayments on medical visits and medications. //2009//

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.