Maternal and Child Health Services Title V Block Grant

Illinois

Created on 6/19/2015 6:44:02 AM

FY 2016 Application/ FY 2014 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

II. Components of the Application/Annual Report

II.A. Overview of the State

Population Size and Changes

Illinois is a large, well-populated state situated in the center of the United States. It is currently the fifth most populous state in the nation and was home to 12,880,580 residents in 2014. Chicago, the largest city in Illinois is home to 2.7 million people, making it the third largest city in the US. The total population of Illinois increased 3.3% between 2000 and 2010.

The age distribution in Illinois is similar to that of the nation. Nearly one in four (23.5%) Illinois residents are under age 18 — a total of over 3,000,000 children. Approximately 6% of the total population is under age 5 (nearly 800,000 children).

Because it is the fifth most populous state in the country, Illinois is frequently compared to the other "Big Five" states: California, Texas, New York, and Florida. Although these states differ greatly with respect to geography, demographics, and economics, the sheer number of people affected by these states' policies warrants comparison. Together, these five states are home to 37% of the US population.

The birth rate in Illinois during 2013 was 12.2 births per 1,000 persons in the population. The total fertility rate was 60.3 births per 1,000 women ages 15-44. The birth and fertility rates in Illinois are higher than those in Florida and New York, but lower than those in Texas and California.

Geographic Considerations

Two–thirds of the total Illinois population resides in Cook County and the "collar counties" — the five counties flanking Cook County. Between 2000 and 2010, the population of Cook County decreased by 3.4% and the population in the city of Chicago decreased by 6.9%. In contrast, most of the counties surrounding Cook County experienced a substantial population increase during 2000-2010. The five collar counties increased in population size by 15% during 2000-2010. In all Illinois, the county with the largest population increase during 2000-2010 was Kendall county (a county near Cook county, but not directly flanking it), which more than doubled in population size.

The remaining Illinois population is more sparsely spread throughout 96 other counties in Illinois. Several of these counties contain smaller metropolitan areas (like Peoria, Rockford, and Springfield) but many of them are rural counties. Many rural counties experienced declines in their population during 2000-2010. The Illinois maternal and child health system thus has the unique challenge of serving a broad array of communities and needs, from the highly urban and diverse Cook county, to the agricultural counties bordering Iowa, Kentucky and Missouri.

Education

Approximately 87% of Illinois adults are high school graduates and 31% are college graduates. Educational achievement is not evenly distributed in the state, however. Only 81% of adults in Cook County are high school graduates, indicating the need for increased educational focus in this county. The rates of high school and college graduation are slightly higher in Illinois than in the US as a whole. Additionally, Illinois has the highest percentage of high school graduates among the Big Five states.

Racial and Ethnic Diversity

The majority (62.7%) of the population in Illinois are non-Hispanic white persons. African Americans comprise 14.7% of the population, and Latinos of all ethnicities account for 16.5%. Overall in the state, Illinois racial demographics are comparable to US averages. In comparison to the Big Five states, however, Illinois has the largest non-Hispanic white population.

In Cook County, only 43% of the population is non-Hispanic white, while African Americans comprise 25% and

Latinos comprise 24%. Within the city of Chicago, this diversity is even more pronounced: 32% are non-Hispanic white, 33% are African-American, and 29% are Latino. So, while Illinois is more racially homogenous than other large states, the concentration pockets of racial minorities in the Chicago area presents unique challenges for culturally competent health care delivery.

Foreign Born Population

Illinois has a significant population born outside the United States. During 2009-2013, 13.8% of Illinois residents were foreign-born. The majority of these foreign-born residents (52.8%) are not US citizens. Foreign born Illinoisans come primarily from Latin America, with a sizeable Asian population as well. Reflecting this large immigrant population, more than 22% of Illinoisans speak a language other than English at home, with Spanish being the most common other language. Compared to the other Big Five states, Illinois has fewer foreign-born and non-English speaking residents.

Cook County has a higher percentage of foreign-born residents and non-English speakers than the rest of the state. Over 21% of Cook County residents were born outside the United States and 35% speak a language other than English at home.

Employment and Income

In 2009-2013, 66% of Illinois adults were in the civilian labor force — meaning that they were working or wanted to be working. Among those in the labor force In 2013, Illinois had an unemployment rate of 9.5%, a slight decline from 2009 when the unemployment rate was over 10%. Illinois' unemployment rate was lower than California and Florida but higher than New York and Texas.

The majority of Illinois residents were in occupations categorized as management / professional (37%) or sales / office (25%). The education, healthcare and social services industries are the largest employers in the state, employing about 23% of working Illinoisans. Other industries employing substantial percentage of Illinois residents include: manufacturing (13%), professional / scientific / management (11%), and retail (11%).

The per capita income in Illinois in 2009-2013 was $29,666, compared to a national average of $28,155. Illinois' per capita income was higher than that in California, Florida, and Texas, but lower than that of New York.

Poverty and Housing

In 2013, 14.7% of all Illinoisians lived in households with incomes below the federal poverty line (FPL). Children are more likely to live in poverty; 20.7% of children under 18 years old and 22.4% of children under 5 years old lived in poverty. Poverty in Illinois is more common in Cook County, and specifically in the city of Chicago. In Cook County, 17.7% of the total population and 25.9% of children lived in poverty; in Chicago, 23.0% of the total population and 34.0% of children lived in poverty. Of all Illinois households in 2013, 13.5% received food stamps and 2.6% received cash assistance.

Living in a female-headed household is strongly associated with poverty in Illinois. While 10.8% of all households were impoverished, 30.2% of female-headed households had incomes below the FPL. In female-headed households with children, the percentage in poverty was even higher; 40.5% of female-headed households with children under 18 years old and 47.6% of female-headed households with children under 5 years old were impoverished. Of the Big 5 states, Illinois has the highest poverty rate for female-headed households with children under 5 years old.

Poverty is also drastically different by race/ethnicity in Illinois. Among non-Hispanic white residents, the poverty rate was 9.5%, compared to 31.6% among African-Americans and 18.9% among Hispanics. Among children, this disparity in poverty is even further demonstrated: 11.3% of non-Hispanic white children under age 18 lived in poverty, compared to 44.0% of African-American children and 25.1% of Hispanic children.

In Illinois in 2013, 63.9% of housing units were owner-occupied — the highest of the Big 5 states. About one-third (32.8%) of families that owned their home paid more than 30% of their household income on their mortgage. For those families that rent a home, a major point of concern in Illinois is the high cost of rental housing. In 2013, 49.5% of families renting a home spent more than 30% of their income on rent. Low-income families are especially at risk for rental costs that consume large proportions of their household income.

II.B. Five Year Needs Assessment Summary

II.B.1. Process

The Illinois Department of Public Health's (IDPH), Office of Women's Health and Family Services (OWHFS), conducted Illinois' Maternal and Child Health (MCH) Needs Assessment for inclusion in the FFY2016 Maternal and Child Health Services Block Grant application. Through legislative action, the Block grant was transferred from the Illinois Department of Human Services (IDHS) to the OWHFS in July 2013. This is the first time, therefore, that the OWHFS has conducted the needs assessment and the team set out to conduct a robust process that would gather valuable information about the health of women, infants, and children in the state.

The main framework that guided the 2015 Needs Assessment process in Illinois was the life-course perspective, which links the impact of social, economic, environmental, and medical factors across time and generations. To make an impact in women's and children's health, the OWHFS believes that a life-course approach is necessary, as well as one that addresses the social determinants of health.

The main goal of the needs assessment was to gather a wide array of data that would inform priority-setting for the work of the Title V program over the next five years. To achieve this end, the OWHFS engaged a wide variety of stakeholders in data collection, data interpretation, and prioritization. The complexity and magnitude of current MCH challenges require innovative and collaborative approaches to solve these issues. Stakeholder engagement is critical to examining the strengths and capacity of the state's existing health service programs. There were four main mechanisms for gathering input from professional and consumer stakeholders: 1) a series of provider/organization surveys, 2) consumer focus groups, 3) key informant interviews, and 4) an invited expert panel that advised the office on recommended priorities.

When these four mechanisms were combined, hundreds of individuals and organizations were able to provide input into identifying MCH needs in Illinois and providing feedback about potential priority areas, strategies, and action steps. The surveys received a total of 227 responses, including forty-four local health departments, three faith-based organizations, and 180 MCH providers. Seventeen focus groups were held throughout the state, involving 176 consumers. Twenty-two key informant interviews were conducted with leaders in various fields of public health, healthcare, and other issues impacting women and children (e.g., domestic violence, mental health). Finally, seventeen state MCH experts and leaders external to the OWHFS provided input about the recommended priorities for Title V through an expert panel meeting.

Provider and Organization Surveys

Three separate targeted surveys were developed to gather input from local health departments, faith-based organizations, and MCH providers. The local health department survey asked questions about needs, barriers to services, and potential opportunities for leveraging health resources. The survey started out containing mostly open-ended questions, but an initial low response rate led to revisions that include rating scales and multiple choice questions. The focus of the survey was on severity of health needs across the life course. The faith-based survey asked organizations and churches to provide information about ministries programs that address the health needs of their congregation. The survey was emailed to 195 organizations, but only 3 organizations responded. The low response rate could have been due to survey recipients' preference for face-to-face and phone conversation. Finally, the MCH provider survey asked respondents to evaluate the state's progress in addressing the health needs identified in the 2010 needs assessment. Providers also had the opportunity to leave comments and elaborate on their responses through the use of text boxes. All of the surveys were available electronically through Qualtrics. OWHFS staff who had developed and administered the surveys analyzed the survey data.

Consumer Focus Groups

OWHFS partnered with organizations around Illinois to conduct consumer focus groups. The seventeen focus groups conducted represented all seven IDPH health regions throughout the state and gathered input from a diverse group of 176 consumer stakeholders. The goal was to collect information from health consumers about their experiences with the healthcare system and how it could be improved, including perceived barriers to accessing needed healthcare. Focus groups were one-hour long and were facilitated by a group leader who guided the conversation to address five questions developed by IDPH staff. Note-takers from the host agencies recorded focus group responses and submitted the notes to IDPH OWHFS staff. The focus group questions were:

1. What can be done to strengthen existing health services for you and your family?
2. What health services do you need that you are not currently getting?
3. What barriers do you experience in trying to get health services you need?
4. What challenges are specific to your age group?
5. What information about the Affordable Care Act would be most useful to you?

Halfway through the focus group process, OWHFS asked facilitators to begin collecting basic information on the demographics of group participants. So, while the demographic information is not available for all 176 participants, the data collected on 72 participants revealed that a diverse array of stakeholders were included. About 44% were white, 42% were African-American, and 9% were Latino. About 25% of participants were 24 years old or younger, 25% were 25-34 years old, 25% were 35-49 years old, and 25% were 50 years old or older (including 11% being 65 or older). Furthermore, about 15% of focus group participants were males. Furthermore, there were several "specialty" focus groups conducted, including one of Burmese refugees in the Rockford area, one for families of children with special healthcare needs, and one for adolescents/young adults conducted by the Illinois Caucus for Adolescent Health.

The staff involved in focus group administration conducted a thematic analysis of the notes received from the facilitators. Staff sorted through responses to identify major issues and themes within each group, and within each region. They then compiled the results across the state and identified common themes across all groups.

Key Informant Interviews

The OWHFS also conducted key informant interviews with professionals from various specialties within maternal and child health to gather more detailed information about the health needs of women, children and families, and the potential opportunities for Title V to make a difference. OWHFS staff developed a list of experts to invite to participate in an interview by considering the various population groups served by Title V (e.g., adolescents, women, fathers) and considering the various medical and social fields crucial for a well-rounded look at MCH in Illinois (e.g., mental health, early childhood education, domestic violence, etc.). A total of thirty-one experts and leaders were invited to participate in an interview and twenty-two completed an interview during March and April 2015.

Interviews were conducted by various OWHFS staff, including a designated note taker, and lasted between 20 and 60 minutes. A standard interview protocol was developed (see Appendices), including eight main questions and corresponding prompts. After the interview, the major themes and topics addressed by each informant were summarized by IDPH staff taking notes for the interview. The themes across informants were compiled into a spreadsheet that tracked the number of informants calling attention to each major theme.

Quantitative Databook

In addition to the qualitative data collection, a quantitative databook was generated to provide data from population-based sources on key MCH indicators. The databook was organized to include a demographics section, and fact sheets on select indicators for the six MCHB population domains. Illinois' CDC Assignee in MCH epidemiology conducted the analyses and created the databook. When planning the databook, the goal was to identify approximately six to eight health topics or key indicators that represented the health issues of each population domains. Within each topic, statewide trends, and relevant disparities (racial/ethnic, geographic, age-based, etc.) were reported, as data were available

available.

The data sources used in the databook included ten major statewide datasets representing Illinoisans: American Community Survey (ACS), Behavioral Risk Factor Surveillance System (BRFSS), Division of Specialized Care for Children (DSCC) Family Survey, Hospital Discharge, Maternity Practices in Infant Nutrition and Care (mPINC), National Immunization Survey (NIS), National Survey of Children's Health (NSCH), Pregnancy Risk Assessment Monitoring System (PRAMS), Vital Records, and the Youth Risk Behavior Surveillance System (YRBS).

Expert Panel

Finally, an expert panel was convened to help synthesize the qualitative and quantitative data and recommend Title V priority needs to OWHFS. State leaders in a variety of fields impacting women and children were invited to participate in the expert panel. Seventeen persons accepted the invitation and attended the expert panel meeting held on April 28, 2015. There were meeting locations in Springfield and Chicago connected by video conference and phone conference, and eleven OWHFS staff attended to observe the conversation and take notes. The expert panel meeting was facilitated by a contractor with expertise in strategic planning, meeting facilitation, and leadership development. After several meetings with OWHFS staff to learn of the desired outcomes for the expert panel, she developed the meeting agenda to guide the panel in developing a list of ten recommended MCH priorities. In advance of the meeting, the expert panel was provided with several documents they were asked to read and reflect on, including: brief summaries of the qualitative data findings, the MCH quantitative databook, a synthesis of important highlights from the databook, a list of Illinois' 2010 Title V priorities, and three priority list "scenarios" based on qualitative data, quantitative data, and the current work of the Title V program and OWHFS.

During the expert panel meeting, the facilitator asked participants to reflect on the information they had reviewed and to share their thoughts with the group. Small group exercises had the panel members work together to develop important criteria and premises for the Title V priorities. They evaluated the priorities that emerged from the data and discussed whether any 2010 priorities should be carried forward. Through a participatory process, expert panel members provided feedback on general topics and needs that they felt Title V should better address in the next five years.

In addition to the facilitator taking notes, the OWHFS also contracted with a graphic facilitator who illustrated the discussion on large pieces of paper on the wall as the conversation proceeded. These large illustrations can now be hung in the office to remind staff of the conversations during the panel and spark discussions with others who were not present at the meeting.

By the end of the meeting, the expert panel produced the following list of recommended priorities:

1. Increase equity/reduce disparities in adverse outcomes across MCH groups
2. Promote healthy pregnancies and reduce adverse pregnancy outcomes for mothers and infants
3. Greater emphasis on adolescent health, including risk-taking reduction and transition services
4. Promote quality well-women care
5. Address oral and medical needs through medical and dental homes
6. Support data capacity and infrastructure improvements
7. Address the mental health needs of the MCH population
8. Create linkages with early childhood care and parent support services/systems
9. Focus on dual generation strategies, family engagement and family-centered care
10. Workforce training and development to improve service quality and availability

II.B.2. Findings

The following sections outline the major findings of the needs assessment, which were obtained through the various qualitative and quantitative assessment methods previously discussed.

II.B.2.a. MCH Population Needs

Women's Health

Of women of reproductive age in Illinois, approximately 3% had chronic diabetes, 10% had chronic hypertension, and 9% had asthma. This translates to 70,000 Illinois women of reproductive age with diabetes, 220,000 women with hypertension, and 200,000 women with asthma. Smoking and obesity continue to be concerns for reproductive age women. Overall, nearly 16% of women ages 18-44 smoke, but smoking among reproductive aged women reaches nearly 26% in rural areas of Illinois. Additionally, 54% of women ages 18-44 are overweight or obese, but over 66% of African-American and Hispanic women are overweight or obese. Less than 50% of women met the recommendations for weekly physical activity and less than 25% of women met the recommendations for daily fruit and vegetable consumption.

Preventive care can be improved among Illinois women of reproductive age. In 2013, only about 62% of women ages 18-44 reported having at least one routine check-up in the last year, and only about 80% reported having a personal provider. While ACA has expanded health insurance coverage to nearly all women, insurance coverage does not necessarily lead to access and utilization of services. Focus group participants discussed many barriers to care, including transportation, difficulty finding providers (particularly those that take Medicaid), and long waiting lists for appointments.

Mental health is a great concern for women of reproductive age. Mental health problems and conditions are rampant among women. In 2013, over 15% of women ages 18-44 reported poor mental health in the last month. Mental health conditions are also the leading cause of hospitalization for women ages 15-44 after hospitalizations for delivery. There were over 24,000 mental health hospitalizations for reproductive-aged women annually during 2011-2013 – translating to nearly 1 hospitalization for every 100 women. Despite the great need for mental health services, there is a shortage of mental health providers, particularly for Medicaid women.

Sexually transmitted infections are a particular concern for young women in Illinois. The rate of Chlamydia infection among women ages 15-24 is over 340 cases per 10,000 women. The rate of Chlamydia among African-American women is six times higher than among white women. STIs are most common in the city of Chicago and in urban counties outside the Chicago metropolitan area.

Like many other outcomes, there are also wide racial disparities in maternal morbidity and mortality. The rate of severe maternal mortality (SMM) in Illinois was 160 per 100,000 deliveries in 2011-2013, higher than the national average reported by Callaghan as 129 per 100,000. The rate among African-American women, however, is over 270 cases per 100,000 deliveries, over two times that experienced by white women. A preliminary analysis of pregnancy-related mortality in Illinois found that African-American women were 250% more likely to die from pregnancy-related causes than white women.

Perinatal & Infant Health

Adequate prenatal care in Illinois has been slowly and steadily rising and meets the *Healthy People 2020* objective in the provisional 2013 and 2014 birth data. However, wide disparities by race/ethnicity, geography, and age persist in the adequacy and utilization of prenatal care. Geographically, adequate prenatal care is most common in rural areas (85%) and least common in Chicago (72%). Black and Hispanic women are less likely to receive adequate care than white women (W: 85%, B: 63%, H: 73%), and young mothers are less likely to receive at least adequate prenatal care than older mothers. The combination of these risk factors demonstrates the extent of staggering disparities in prenatal care in Illinois. Only 45.1% of young (<20), Black women in Chicago had adequate prenatal care, compared to 88.3% of

older (≥35), White women in rural counties. Barriers to care include transportation, childcare, lack of providers that take Medicaid, and long waiting lists for appointments.

Birth outcomes in Illinois are remaining level or slightly decreasing. Low birth weight and very low birth weight decreased from 8.0% and 1.4% in 2010 to 7.8% and 1.3% in 2014. Overall infant mortality decreased from 6.4 per 1,000 in 2010 to 6.2 per 1,000 in 2014; neonatal mortality remained level but a drop in post-neonatal mortality accounted for the decline. Despite these successes, wide disparities in birth outcomes are present by race/ethnicity in Illinois. Compared to infants of white mothers, infants born to African-American mothers are 2.1 times as likely to be LBW, 2.5 times as likely to be VLBW, and 2.8 times as likely to die in the first year of life. The disparities in post-neonatal mortality and particularly Sudden Unexplained Infant Death (SUID) mortality are even more striking; the black-white ratios for post-neonatal death and SUID death are 3.3 and 4.5, respectively.

A drastic drop in non-medically indicated early deliveries (NMIED) is an Illinois success story in perinatal health. For several years, there have been many national and state organizations that have worked to reduce this practice in birthing hospitals. As one example, the director of the Illinois Department of Public Health sent a letter to hospital CEOs in fall of 2013 encouraging adoption of hard stop policies. The NMIED rate decreased from 8.7% of term births in 2010 to 5.9% of term births in 2014 – a 32% decline in 5 years. Most states are striving to reach a level of 5.0% or lower, so Illinois is on track to achieve this in the near future. The NMIED work in Illinois also sparked a birth certificate quality improvement project that is currently underway to improve the accuracy of the birth files.

Breastfeeding is another area where Illinois has shown improvement. The Illinois rates of breastfeeding initiation, breastfeeding to twelve weeks, and exclusive breastfeeding to twelve weeks increased during 2004-2011 by 8%, 11%, and 17%, respectively. In 2011, the rate of breastfeeding initiation was 81.0%, close to meeting the *Healthy People 2020* objective of 81.9%. The improvements may be attributable to both national and state initiatives that have sought to support and promote breastfeeding, including a push to encourage hospitals to adopt Baby Friendly hospital practices. In a national survey on hospital practices, Illinois' state ranking on overall breastfeeding support improved from 35th in 2007 to 20th oin 2013. Despite some successes, challenges and opportunities remain. The rates of breastfeeding at later time points and for exclusive breastfeeding are still substantially below the *Healthy People 2020* objectives. Women in rural counties, black mothers, and young mothers are the less likely to breastfeed than their counterparts. Illinois hospitals also rank in the bottom half of state for breastfeeding practices like skin-to-skin contact, early breastfeeding, formula supplementation, and rooming-in.

Child Health

Only 4% of Illinois children under 18 were uninsured in March 2014. However, among children with insurance, nearly one-quarter have coverage that is not adequate to meet their healthcare needs (either in terms of consistency or benefits). So while ACA has improved the availability of insurance, some families still face significant financial barriers to healthcare for their children.

Primary and preventive care is important for all populations, but especially for children. Nearly 90% of Illinois children ages 0-17 had at least one well child visit in the last year, though this was slightly lower for Hispanic children (85%) and children in poor or near-poor families (85%). The medical home concept ensures that children receive comprehensive, coordinated, consistent, family-centered care. However, only about 56% of Illinois children received care that met all the requirements of a medical home in 2011-2012. There were also wide racial/ethnic and income-based disparities in having a medical home, with minority children and those from poor or near poor families being less likely to have a medical home. The medical home sub-component least likely to be present for Illinois children was family-centered care, which was experienced by only 68% of children, and only by 41% of Hispanic children and 58% of African-American children. There is an opportunity to improve the cultural sensitivity of child health providers, educating them to incorporate a family's values, customs, and language into care.

Children's primary care visits are important settings for preventive services, such as developmental screening, health education for families, and immunizations. The percent of toddlers (19-35 months) fully immunized with the 4:3:1:3:3:4 series (DTap, Polio, MMR, Hib, HepB, Varicella, Pneumococcal) increased from 53.7% in 2009 to 66.8% in 2013. Despite this success, Illinois is still far from meeting the *Healthy People 2020* objective of 80%. During the 2012-2013 school year, over 6% of kindergarteners in Illinois had exemptions to required school vaccinations, one of the top three highest exemption rates in the U.S. (surpassed only by Oregon and tied with Vermont). In the last year, there have been several outbreaks of vaccine-preventable diseases nationally and within Illinois that pose a threat to

children's health, particularly those who are very young, medically fragile, or immune compromised.

Several commonly expressed health concerns for children emerged from qualitative interviews and surveys: asthma, obesity, and injury. In the NSCH, 9% of Illinois children were reported to have current asthma, but was 19% among African-American children. Emergency department use for asthma is high in many Illinois counties, including both urban and rural areas. Childhood obesity also continues to be a persistent concern, though the rates of childhood overweight/obesity have leveled between the 2007 and 2011/12 NSCH. African-American and poor/near-poor children are 50-80% more likely than their counterparts to be overweight or obese. Finally, injury remains the leading cause of death for children ages 1 and older in Illinois. The highest injury-related mortality rates were in Chicago and rural counties. Black children had injury-related mortality rates twice as high as white children.

Oral health remains a challenge for Illinois children. The oral health status of 3rd grade children in Illinois has generally improved over the last decade, with reductions in untreated caries and increases in preventive sealants. But, only 39% of African-American 3rd graders had any dental sealants, compared to 49% or higher for all other racial/ethnic groups. In qualitative data collection, a lack of oral health providers was frequently expressed as a major barrier to obtaining needed child dental services, especially for the Medicaid population. Over 80% of children ages 1-17 had a preventive dental visit in the last year, but this was less common among African-American children (72%) and children in poor/near-poor families (74%). Of children on Medicaid, 51.5% had a preventive visit during 2014.

Children with Special Healthcare Needs

A survey of DSCC families found that the children served by the Illinois CSHCN represent a group of children with severe and complex health needs. Using the CSHCN screener in the NS-CSHCN, the most common type of special healthcare need was increased medical services (77%), followed by: specialized therapies (70%), functional limitations (67%), prescription medications (61%), and mental/behavioral health services (39%). Approximately 80% of the DSCC children surveyed had two or more of the types of special healthcare needs, and 49% had four or more of these types of special healthcare needs.

Adequacy of insurance is particularly salient for CSHCN. While 97.5% of DSCC children were covered by insurance at the time of the family survey, only 40% had insurance that was adequate, consistent, and had reasonable out-of-pocket expenses. Approximately 22% of DSCC families reported at least $1,000 in out-of-pocket expenses for their child's care in the last year. Such large expenses can place undue financial burdens on the family, demonstrated in the fact that 21% of DSCC families reported going without basic necessities in order to pay for their child's care. Of surveyed families, 58% received financial help from DSCC to cover their child's medical expenses.

DSCC Families reported whether their child had needed any of twenty-six specific healthcare services during the previous twelve months. The five most common service needs were: well child care (85%), dental care (77%), primary care (72%), prescription medications (72%), and specialty care (72%). Among those needing each service, the services with the highest unmet needs were: respite care (28.2%), mental health and/or counseling services for someone else in the family because of child's health condition (20.8%), home health aide (15.6%), mental health and/or counseling services for child (8.1%), and in-home nursing care (8.0%).

Only about 34% of DSCC children received care that was consistent with the medical home model. At least 85% of DSCC children had a usual source of well and sick care, a personal doctor or nurse, and no problems getting needed referrals, 79% experienced family-centered care, and 49% received effective care coordination. Medical home was lowest for young children ages 0-5, Hispanic children, children in poor families, and children with functional limitations. The low rates of medical home highlight the complexity of the care required for the CSHCN served by DSCC – managing their referrals and care coordination is all the more complex and difficult for providers to manage. In particular, families need more coordinated efforts between healthcare providers such as primary care and specialty physicians.

Family partnership remains a priority of the DSCC program. Approximately 63% of DSCC families reported being engaged in the decision-making process about their child's healthcare. This rate was slightly lower among families of Hispanic children (59%) and children in families under the poverty line (57%). The system of community-based services is also important for ensuring that CSHCN receive needed services. Overall, 45.9% of DSCC children experienced well-organized community-based services. When asked to describe the barriers that prevented their child from getting the care that was needed, DSCC families most commonly reported: needed service is too far from home

from getting the care that was needed, DSCC families most commonly reported: needed service is too far from home (31%), waiting time in the doctor's office is too long (22%), All Kids / Medicaid is not accepted (21%), care is not covered by my child's insurance (20%), and delays in getting appointments (20%).

Transition planning and services for youth and young adults is an important part of care for children with special healthcare needs. Of DSCC families with children ages 14 or older, 54% reported having a formal transition plan in place or currently under development. There is an opportunity to better educate parents about the need for a transition plan for all youth, as large a substantial proportion of families did not know if their child had a plan (7%) or did not believe their child needed one (10%). A review of DSCC records reported that 69% of DSCC youth ages 14-21 had received transition services, an improvement from previous years. Of the DSCC youth who had a transition plan or were in the process of developing one, 70% of families reported that the plan met their needs somewhat well or very well. Only 8% reported that the plan did not meet their needs very well or at all. Interestingly, 22% of families reported that they did not know how well the transition plan met their child's needs, perhaps indicating a need for educating families on transition issues and the importance of a transition plan for all YSHCN.

The DSCC family survey also gave families the change to provide open-ended comments about the joys and challenges of parenting a child with special healthcare needs. The major themes that emerged from the analysis of these comments were:

Theme 1: Joys of Parenting – feelings of pride, blessings, appreciation for progress, and positive sibling and family relationships, and how the joys outweigh the challenges

Theme 2: Financial Challenges – financial hardship, parent employment, financial strain relieved by DSCC, and frustration with income-dependent services

Theme 3: Insurance Challenges – frustration with Medicaid coverage, lack of available Medicaid providers, and private insurance cost-sharing burden

Theme 4: Geographic Challenges – lack of providers in certain regions, and lack of transportation options

Theme 5: Personal Challenges in Parenting – comparisons to other children, worry about the future, feeling stressed / overwhelmed, and school-related challenges

The data from this needs assessment identifies some areas that require continued efforts from the CYSHCN program in Illinois. There is a need for renewed efforts in educating families on the benefits of care coordination, medical home, and transition planning. This is particularly important for Spanish speaking families and those with lower health care literacy. DSCC will need to focus efforts to provide training for care coordinators on more effective care coordination that includes identifying gaps in knowledge on these topics and strategies for addressing these gaps. DSCC will also need to increase partnerships within communities where these families live and receive services. The Illinois Family-to-Family Health Information Center, FQHCs, Illinois Chapter of the AAP, Medicaid MCOs and other entities will also be important partners. Education about the National Standards for Systems of Care for CYSHCN targeted to providers, families, payers, and other stakeholders in these systems will also be important.

Adolescent Health

Unintentional injuries are the leading cause of death among adolescents, and of these deaths, the majority are due to motor vehicle accidents (MVA). MVA-injury deaths among teens 15-19 were highest in rural counties in Illinois, among whites, and among males. While only 7% of teens reported never or rarely using a seatbelt, other risk behaviors are of concern. In 2013, 45% of Illinois high school students who drove a car reported that they texted while driving during the last year. Additionally, 27% rode in a vehicle with a driver who had been drinking alcohol.

Violence is also a major concern for adolescents, with homicide being the second leading cause of death for Illinois adolescents. In 2011-2012, the youth homicide rate was 19 deaths per 100,000, well above the *Healthy People 2020* objective of 5.5 per 100,000. Over 60% of these homicides occurred in the city of Chicago, where the youth homicide rate was 51 per 100,000. Nearly three out of four youth homicide victims in Illinois were African-American. In 2013, 8% of Illinois high school students reported being in a physical fight on school property in the last month, and 9% reported not going to school because they felt unsafe. These experiences were even more common for Chicago

students, and Black or Hispanic students. Other types of bullying are also frequent, with 22% of high school students being bullied on school property and 17% being electronically bullied during the last month. Dating violence is also common among high school students, particularly for females. Among female students who dated, 14% experienced physical dating violence and 17% experienced sexual dating violence during the last year.

Mental health is also a concern for adolescents as suicide is the third most common cause of death. Suicide rates for Illinois youth ages 15-24 were highest in rural counties, among whites, and among males. The YRBS revealed alarming data about the mental health status of Illinois high school students. In 2013, 29% of students had felt safe or hopeless for a period of at least two weeks, nearly 20% had considered committing suicide, and 12% had attempted suicide in the last year. Since 2007, the proportions of students considering and attempting suicide have respectively risen by 47% and 86%.

Over 36% of Illinois high school students reported drinking alcohol and 21% of students reported recent binge drinking during the last 30 days. Tobacco use in the last 30 days was reported by 20% of students, and was highest among white students and males. Nearly one-quarter of Illinois high school students reported using marijuana during the last 30 days, which was most common among Hispanic and male students. Use of other drugs is also surprisingly common, with 18.4% of students reporting ever using prescription medications without a prescription, 12% ever using inhalants, and 9% ever using ecstasy.

One success in adolescent health in Illinois has been the recent decrease in teen births. In the last five years, births to women ages 15-17 dropped 40% and births to women ages 18-19 dropped 28%. The teen birth rate for women 15-19 in 2014 (22 per 1,000 women) is the lowest seen in recent history. Despite drops across all demographic groups, disparities and challenges remain. Birth rates for Black and Hispanic teens were 3.5 and 2.8 times as high as the rate for White teens. There are also geographic differences, with the county-level teen birth rates ranging from 5.7 births per 1,000 in Jo Daviess County to 51.4 births per in Vermilion County. There is room for improvement in reducing adolescent sexual risk taking. In 2013, only 58% of sexually active high school students reported using a condom during their last intercourse. Condom use was particularly low among Hispanic students (only 44%). Additionally, 17% of high school students had reported that they did not learn about HIV/AIDS in school. Both condom use and HIV/AIDS education are moving the wrong direction – the 2013 rates reported by teens were significantly worse than what was reported in 2007.

Cross-Cutting / Life Course

Illinois conducted a rigorous data collection and analysis process to gather qualitative information on the health needs of MCH populations from different sources: MCH providers, consumers, community members, and experts in various fields of MCH. For the most part, the findings resulting from these processes were cross-cutting and addressed common challenges for women, children, adolescents, and families. The basic qualitative data findings are summarized here, but more details about these findings are available in the Appendices.

A series of provider surveys were completed by over two hundred representatives from local health departments, faith-based organizations, and other health agencies/organizations. The following needs emerged as common themes from the provider surveys:

- Integrate MCH programs to reduce fragmentation and duplication of services
- Implement Electronic Medical Records (EMRs) so that consumer medical files can be readily accessed by MCH providers
- Increase communication with consumers about navigating the health care system
- Increase resources, programs, and education to promote physical activity and nutrition to reduce the risks of obesity, heart disease, high blood pressure, and tobacco-related diseases.
- Increase consumer access to affordable transportation to and from health services
- Increase consumer access to affordable mental health and behavioral health services
- Increase consumer access to affordable dental care
- Increase prenatal care in the first trimester

Consumer focus groups involved nearly two hundred persons throughout Illinois. The major themes that emerged across the state were:

across the state were:

- Lack of communication between consumers and providers
- Desire for comprehensive health education cutting across the life-course
- Need for enhanced care coordination
- Need for improving the reliability of transportation –especially in rural areas
- Lack of cultural competence and a lack of sensitivity in the delivery of health care
- Lack of affordable access to health service providers, specifically: dentists, mental health providers, and ophthalmologists.
- Difficulty in scheduling appointments
- Lack of timely access to health services.

Key informant interviews were conducted with nearly two dozen experts in various areas of MCH expertise. The major categories of needs that emerged from the interviews were:

- Barriers to access to health services
- Specific medical and health conditions of concern for women and children
- Health education and literacy
- Healthy eating and physical activity
- Infrastructure improvements
- Infant mortality
- Mental health
- Social determinants of health (SDOH), including racial/ethnic and geographic disparities
- Support services
- Trauma

II.B.2.b Title V Program Capacity

The State of Illinois has the capacity to provide comprehensive quality care to pregnant women, mothers, infants, children (including those with special healthcare needs), adolescents, and women of reproductive age through strong mutually agreed upon relationships between the Illinois Departments of Public Health (IDPH), Human Services (IDHS) and Healthcare and Family Services (IDHFS) and the University of Illinois. The primary responsibility for Illinois' Title V program lies within the IDPH Office of Womens Health and Family Services, Division of Maternal, Child and Family Health Services. IDPH is responsible for the population-health infrastructure for health outcomes. The IDHS provides case management and enabling services to specific MCH target populations. The IDHFS underwrites access to health care for families in need. The needs of CSHCN are addressed by the Division of Specialized Care for Children, University of Illinois. The working relationships of these agencies are supported by interagency agreements that specify responsibilities in regard to service delivery, performance levels, data reporting, and data sharing. Although the working relationships are solid, data sharing sometimes presents challenges. State statutes, federal law (HIPAA) and interstate agreements are barriers to complete and smooth transfer of service delivery data. Illinois is addressing data sharing issues through various measures, most significantly the development of the Medical Data Warehouse (MDW). In 2005, the Illinois General Assembly passed and the Governor enacted Public Act 094-0267, the Medical Data Warehouse Act. The act authorizes the IDHFS to "perform all necessary administrative functions to expand its linearly scalable data warehouse to encompass other health care data sources at both the Department of Human Services and the Department of Public Health." In order to reflect this change the formerly named Medical Data Warehouse was re-titled the Enterprise Data Warehouse (EDW). Multiple data sources have been consolidated into the MDW EDW in an effort to provide a complete picture of publicly-funded programming and to reduce duplication of data and/or conflicting information that currently exists in the various databases. The process (which deals with extraction, transformation, cleansing, loading, and then maintaining the data in the MDW EDW) improves the quality of data. Interagency agreements identify the data to be shared and details how it may be used. Resulting from the agreements and the design of the MDW EDW, there is a more holistic view of the Medicaid beneficiary as well as the MCH service recipient. This enables the signatories of the agreement to see the other benefits that individuals may be receiving and design approaches that would improve service delivery, while providing assurances that they will not be receiving overlapping or duplicative services.

STATUTORY BASE

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

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

ILCS 335) requires testing and counseling women on HIV infection.

The Newborn Metabolic Screening Act (410 ILCS 240), the Infant Eye Disease Act (410 ILCS

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

The Illinois Family Case Management Act (410 ILCS 212) authorizes the Family Case Management (FCM) program and creates the Maternal and Child Health Advisory Board.

The WIC Vendor Management Act (410 ILCS 255) "establish[es] the statutory authority for the authorization, limitation, education and compliance review of WIC retail vendors..." The Counties

Code (55 ILCS 5) provides for the autopsy of children under age two years and reporting of deaths suspected to be due to Sudden Infant Death Syndrome (SIDS) by the county coroner.

A Senate Joint Resolution created a taskforce to review current activities, fiscal practices and evaluation outcomes of the EI program. The Early Intervention Services System Act (325 ILCS 20) "provide[s] a comprehensive, coordinated, interagency, interdisciplinary early intervention services system for eligible infants and toddlers ..." A recent Senate Joint Resolution created a taskforce to review current activities, fiscal practices and evaluation outcomes of the EI program.

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

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

on optimal fluoridation for community water levels as proposed and adopted by the U.S. Department of Health and Human Services.

The Child Hearing and Vision Test Act (410 ILCS 205) authorizes screening young children for vision and hearing problems.

The Illinois Lead Poisoning Prevention Act (410 ILCS 45) requires screening, reporting, inspection and abatement of environmental lead hazards affecting children under six years of age.

The Alcoholism and Other Drug Abuse and Dependency Act (20 ILCS 301) authorizes substance abuse prevention programs. The Suicide Prevention, Education, and Treatment Act (410 ILCS

53) authorizes IDPH to carry out the Illinois Suicide Prevention Strategic Plan.

The Child and Family Services Act (20 ILCS 505/17 and 17a) authorizes the Comprehensive

Community Based Youth Services program.

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

services."

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

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

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

II.B.2.b.i. Organizational Structure

The Governor has designated the Illinois Department of Public Health as the state agency responsible for the administration of the Maternal and Child Health Services Block Grant in Illinois. Within the Illinois Department of Public Health, the MCH Services Block Grant is administered by the Office of Women's Health and Family Services (OWHFS). There are three divisions within OWHFS: the Division of Maternal, Child, and Family Health Services, the Division of Women's Health Services, and the Division of Population Health Management. The Division of Maternal, Child, and Family Services oversees the MCH programs administered by the Illinois Department of Human Services, the Regional Perinatal Health Program, Infant Mortality Reduction, School-Based Health Centers, Childhood Asthma Initiative, Teen Pregnancy Prevention (Primary and Subsequent), and the Chicago Mini-MCH grant. The Division of Women's Health Services administers the Illinois Breast and Cervical Cancer Program, Wise Woman, and Family Planning (Title X). The Division of Population Health Management maintains the Women's Health Hotline and provides grant management, outreach, and program support services.

Consistent with state statutes, the program for Children with Special Health Care Needs is administered through Inter-Agency Agreement (IGA) by the Division of Specialized Health Care Needs, University of Illinois Chicago.

Block grant funds are also transferred, by IGA, to the Illinois Department of Human Services for the administration of the case management and supportive services for the Perinatal/Infant population domain and to support Maternal and Child Health nurses to monitor and provide technical assistance to programs providing direct services to mothers, infants, and children.

Organizational Chart Attached

II.B.2.b.ii. Agency Capacity

The mission of IDPH is to promote health through the prevention and control of disease and injury. And the agency was first organized in 1877 with a staff of three and a two-year budget of $5,000. IDPH, which is one of the state's oldest agencies, and now has an annual budget of about $325 million in state and federal funds, headquarters in Springfield and Chicago, seven regional offices located around the state, three laboratories and 1,100 employees. The Director of IDPH is the State's Health Officer and one of the Governor's key cabinet members.

The Department is responsible for protecting the State's residents, as well as countless visitors, through the prevention and control of disease and injury. With more than 200 program components organized in its six offices, the Department provides and supports a broad range of services, including inspecting restaurants; vaccinating children to protect them against disease; testing to assure the safety of food, water, and drugs; licensing to ensure quality health care in hospitals and nursing homes; conducting investigations to control the outbreak of infectious diseases; collecting and evaluating health statistics to support prevention and regulatory programs; analyzing and shaping public policy; screening newborns for genetic diseases; and supporting local efforts to identify breast and cervical cancers in their early, more treatable stages. These programs touch virtually every age, aspect, and cycle of life.

The Office of Women's Health and Family Services (OWHFS), which administers the Maternal Child Health Services Title V Block Grant through its Division of Maternal, Child and Family Health Services, also contains the Division of Women's Health Services, which is responsible for the Illinois Breast and Cervical Cancer Program, (IBCCP), the Wise Woman program and the State's Family Planning Title X grant. The mission of the Office of Women's Health and Family Services is to improve health outcomes of all Illinoisans by providing preventative education and services, increasing health care access, using data to ensure evidence-based practice and policy, and empowering families. Under the leadership of the Title V Administrator the OWHFS is able to provide comprehensive population-based programming, education and support to women across the life-span. Through this comprehensive array of services, funded through federal and state dollars, the OWHFS has the capacity to positively impact the health and well-being of women, infants and children through pre and inter-conceptional care, education and support, school based health and adolescent pregnancy prevention programming. The OWHFS helps to coordinate internal and external efforts to use policy change to improve the health of women, increase public awareness of issues impacting the health of women and children, and to promote healthy behaviors and environments in community partnership with other programs and organizations.

The Specialized Care for Children Act designates the University of Illinois as the entity to administer federal funds to support CSHCN.The University of Illinois' Division of Specialized Care for Children (DSCC) provides care coordination for families with children and youth from birth to age 21 years having eligible medical conditions through the Core program and a network of 12 regional offices across the state.Families who meet financial eligibility criteria may also receive assistance with co-insurance, travel, and other costs related to their child's eligible condition.Families whose children have no health care coverage are required to apply for All Kids/Medicaid if their income appears to meet eligibility criteria.Other families who lack health insurance coverage are assisted to utilize the Marketplace website and resources to obtain coverage.Since Illinois expanded Medicaid coverage for individuals 19 years and older, DSCC assists youth with special healthcare needs to apply.This has improved access to care for those 19-20 year olds that were previously uninsured.

DSCC also operates a Home and Community-Based Services Medicaid waiver for children and youth who are medically fragile and technology dependent. This waiver is administered by the state's Medicaid agency, the Department of Healthcare and Family Services (HFS).

Since DSCC provides care coordination for children/youth in both programs, all children enrolled in either DSCC program are excluded from the state's Medicaid requirement for enrollment in managed care in the designated regions of the state. DSCC has worked with HFS, MCOs and providers to assure continuity of care for CYSHCN. DSCC has expanded provision of care coordination for other Medicaid children receiving in-home services.

In an effort to improve efficiency and effectiveness of DSCC care coordination, a web-based care coordination information system has been implemented over the past year. This system replaces the paper record previously used to document care coordination efforts. The software is called Efforts to Outcomes (ETO).

DSCC promotes use of its 800 number for easy access to information and referral resources as well as program assistance. DSCC has also created a very parent-friendly website that provides information about DSCC programs and regional office locations as well as numerous resources and events of interest for families with CYSHCN around the state. Additionally, DSCC has a FaceBook page on which events and resources are posted as well as connecting families. DSCC staff has participated in well over 100 community based events, health fairs, and meetings with families of CYSHCN.

DSCC is the agency designated to administer the Supplemental Security Income-Disabled Children's Program (SSI-DCP). Children are determined to be medically eligible for this program through the Illinois Disability Determination Services (IDDS), which in turn refers SSI-eligible children to DSCC for further assistance. DSCC provides information and referral services to children who are SSI eligible by sending the family information in English and Spanish about the DSCC Core Program, and provides a toll free number for information and assistance. DSCC staff telephones families with children ages birth to 5 and 14 to 16 years of age to offer assistance in linking to appropriate services and resources. Phone calls after traditional work hours have been very successful in reaching these families. If the child appears to have a condition that meets eligibility for any DSCC program, an application is offered.

II.B.2.b.iii. MCH Workforce Development and Capacity

The Title V Director, Dr. Brenda Jones, DHSc, RN, MSN, WHNP-BC, also the Deputy Director of the OWHFS, administers a comprehensive approach to women and children's health issues across their life span. In addition to Title V she oversees the Illinois Breast and Cervical Cancer Screening and WISEWOMAN and Family Planning Programs. Dr. Jones has a passion and vision for establishing health equity, reproductive justice and addressing access issues in rural health areas. Prior to joining IDPH she was the Administrative Service Line Director of Women

and Children at various hospitals across the country. She has also served as a consultant for a wide range of organizations, including the Department of Defense.

Andrea Palmer, BA, MPA, MBA, is Chief of the Division of Maternal, Child and Family Health Services. Andrea reports to the Title V Director and oversees the operations of the MCH programs and manages the Division Staff. Andrea has over 30 years of experience with the State of Illinois, Andrea joined the Title V staff in January 2014.

The MCH Senior Epidemiologist is Amanda Bennett, PhD, MPH. Dr. Bennett is a CDC field assignee in maternal and child health epidemiology with both her MPH and PhD in MCH epidemiology from the University of Illinois at Chicago. She joined the OWHFS as CDC assignee in December 2014. Prior to this time, Dr. Bennett worked with Illinois Title V in various positions since 2007, including as a student research assistant and summer intern, as a CSTE Applied Epidemiology Fellow during 2008-2010, and as a part-time contractor offering technical assistance and epidemiologic support. She joins the office with extensive experience in needs assessment program evaluation, and applied statistical methods.

The Title V program supports 21 FTE serving as statewide program coordinators, surveillance nurses, data analysts and administrative staff at IDPH and IDHS. All program coordinators and data analysts are either Bachelor or Masters prepared, all nurses are masters prepared.

The University of Illinois at Chicago Division of Specialized Care for Children - DSCC administers the CYSHCN program. Mr. Thomas F. Jerkovitz, M.P.A, C.P.A. Mr. Jerkovitz has had a longstanding career in Illinois state government. He served in the Governor's Office as Senior Policy Advisor for Health and Human Services. In addition, He worked in the Governor's Bureau of the Budget as the Division Chief for the Medical, Child Welfare and Health and Human Services Programs with responsibility for policy direction and fiscal management. He also served as the Executive Director of the Illinois Comprehensive Health Insurance Plan (ICHIP), a high-risk health insurance pool. Immediately before joining DSCC, Mr. Jerkovitz was the Director of Finance for Health Alliance Medical Plans, Inc.

Gerri Clark, RN, MSN, Associate Director for 15 years, previously worked in the Nebraska program for CYSHCN for 8 years; and Kevin Steelman, MBA, Associate Director for Finance, who has an extensive career in public health care finance as budget officer for the Illinois Department of Human Services and nine years as budget analyst for the Illinois General Assembly. Bob Cook has been the Family Liaison Specialist, a full-time paid position, for the past 15 years. His son was a DSCC recipient.

DSCC employs 215 FTEs to provide care coordination and other enabling services and 77 administrative staff that provide training, technical assistance, and other support and administrative services. Care coordinators have Bachelors or Masters Degrees.

The DSCC Family Advisory Committee (FAC) meets at least twice a year and has family member representation from the 12 regions of the state. Members of the FAC are paid a stipend and reimbursed for travel related to Committee meetings. The FAC Chairperson also serves as the family member representative on the DSCC Medical Advisory Board.

A survey of local MCH workforce, conducted as part of the needs assessment, revealed that a major strength is their empathy for the population served. Nearly 300 providers responded, recommending increased communication, better coordination of services and increased resources including educational resources.

The Title V program analyzes and reports information by racial and ethnic subgroups in order to detect disparities in

The Title V program analyzes and reports information by racial and ethnic subgroups in order to detect disparities in health status and allocate resources accordingly. Sub-award agreements include language requiring the provision of culturally and linguistically competent services.

DSCC includes training on cultural competence in its initial training for care coordination staff. Bilingual staff and translation services are also available as needed throughout the Title V program.

II.B.2.c. Partnerships, Collaboration, and Coordination

Frequent, close liaison is maintained with all major public and private agencies involved in services for CYSHCN. DSCC has leadership and/or membership involvement with the following CYSHCN related programs or activities: Illinois Chapter of the American Academy of Pediatrics (ICAAP) Committee on Children with Disabilities, The Arc of Illinois' Family-to-Family Health Information Center (F2F), the Illinois Maternal and Child Health Coalition, Illinois Interagency Council on Early Intervention, Coordinating Council on Transition, Illinois Universal Newborn Hearing Screening Advisory Committee, Illinois Genetics and Metabolic Diseases Advisory Committee, and IFLOSS (Coalition for Access to Dental Care). DSCC has four delegates, including a staff parent representative, to the Association for Maternal and Child Health Programs (AMCHP). DSCC staff attends the annual meetings to stay abreast of national issues and initiatives.

Specifically, DSCC has collaborated with ICAAP on previous HRSA grants for Medical Home, and two CSHCN State Implementation Grants that facilitated efforts to enhance Medical Home capacity and Transition through training, quality improvement and learning collaboratives. DSCC has developed a relationship with the Illinois LEND program to provide opportunities for trainees to meet families having CYSHCN in their home environments. Most recently, DSCC, LEND, ICAAP, F2F, and University of Chicago have partnered in the Action Learning Collaborative sponsored by AMCHP and MCHB for implementing the National Standards for Systems of Care for CYSHCN. DSCC's Director or representative participates in one of the School of Public Health courses on Maternal and Child Health every year. DSCC also participates on the state committee for emergency medical services for children.

DSCC has an interagency agreement with the Department of Healthcare and Family Services (HFS). DSCC participates in many HFS committees, including Medicaid Advisory Committee, Dental Policy Committee, Public Education Committee, and Care Coordination Committee, and consults HFS staff as needed on policy questions as well as specific children's situations.

DSCC staff provides consultation to The Arc of Illinois and the F2F staff, particularly in addressing case specific situations they encounter. DSCC is able to identify community specific resources or other information or support for most situations. DSCC and The Arc regularly link content on their websites to increase awareness of each other's resources.

II.C. State Selected Priorities

	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1 .	Assure accessibility, availability and quality of preventive and primary care for all women, particularly for women of reproductive age	Replaced	
2 .	Support healthy pregnancies and improve birth outcomes	Continued	
3 .	Support expanded access to and integration of early childhood services and systems	New	
4 .	Facilitate the integration of services within patient-centered medical homes for all children, particularly for children with special healthcare needs	Continued	
5 .	Empower adolescents to adopt healthy behaviors	New	
6 .	Assure appropriate transition planning and services for adolescents and young adults, including youth with special health care needs	Replaced	
7 .	Assure that equity is the foundation of all MCH decision-making; eliminate disparities in MCH outcomes	New	
8 .	Support expanded access to and integration of mental health services and systems for the MCH population.	Continued	
9 .	Partner with consumers, families and communities in decision-making across MCH programs, systems and policies	New	The need for consumer, family, and consumer engagement repeatedly emerged during the 2015 needs assessment. Illinois Title V wants to ensure that such groups are viewed as partners at all-levels of decision-making -- spanning from interactions occurring during healthcare services up to the state-level program/policy planning process.
10 .	Strengthen the MCH capacity for data collection, linkage, analysis, and dissemination; Improve MCH data systems and infrastructure	Continued	High-quality data and sound science should be the foundation for public health decision-making. Illinois Title V has historically had many challenges related to data capacity and infrastructure. While many large gains have occurred during the last several years, there is still much room for improvement. Continuing this priority will keep the development of data capacity and infrastructure as a major focus for Title V in the coming years.

Many sources of qualitative and quantitative data were reviewed by an external expert panel and by Title V staff (see Needs Assessment Process and Findings). Based on the recommendations set forth by the expert panel, a review of 2010 Priorities, an assessment of Title V capacity, and a discussion of feasibility and political will, Illinois Title V staff finalized the following list of ten priorities:

1. Assure accessibility, availability and quality of preventive and primary care for all women, particularly for

1. Assure accessibility, availability and quality of preventive and primary care for all women, particularly for women of reproductive age (Women's/Maternal Health). This priority was recommended by the expert panel and is similar to an Illinois priority from 2010 (#5). Focusing on "well-woman" care and prevention among women is a priority also emerging in many state and federal initiatives. For instance, promotion of long-acting reversible contraceptives (LARC) and an emphasis on pre-/inter-conception care are two components of well-woman care that are gaining traction within Illinois and, more broadly, the United States. It is likely that an emphasis on prevention and primary care for women will impact many future health outcomes, not only for the women themselves, but for their infants, children, and families.

2. Support healthy pregnancies and improve birth outcomes (Perinatal/Infant Health). This priority was recommended by the expert panel and continues an Illinois priority from 2010 (#6). Prevention of poor birth outcomes, such as prematurity and infant mortality, remains a core function and objective of the Title V program. This priority is framed to be more expansive than just considering those core infant outcomes, however. Illinois Title V seeks to promote healthy pregnancies and consider a wide range of influences on a mother-infant dyad's health during pregnancy and the postpartum period.

3. Support expanded access to and integration of early childhood services and systems (Child Health). This priority was recommended by the expert panel and is a new priority for Illinois Title V. The selection of this priority recognizes that Title V can do more to integrate with early childhood systems, including home visiting, early childhood education, childcare, and family support. Integration across service systems will be a key strategy for strengthening the impact of Title V programs and services. Early childhood services are also a state priority at the Governor's Office; Title V can link in with the work already underway through the leadership of the state Early Learning Council and the state Home Visiting Task Force.

4. Facilitate the integration of services within patient-centered medical homes for all children, particularly for children with special healthcare needs (Child Health & CSHCN). This priority was recommended by the expert panel and continues an Illinois priority from 2010 (#4). This priority reflects a consensus that Illinois needs to work on improving the quality of care for children and to support medical homes that provide continuous, comprehensive, family-centered, culturally-sensitive care that includes referrals and care coordination services. Medical homes also need to be integrated with other healthcare systems, such as oral health and mental health, connecting children to services as needed. All children are in need of a medical home and the high-quality care it provides, but this need is especially felt for children with special healthcare needs. Illinois will develop some strategies that address the unique medical home needs of CSHCN.

5. Empower adolescents to adopt healthy behaviors (Adolescent Health). The expert panel recommended one priority that encompassed adolescent health issues including risk-taking behaviors and transition planning. Because the Title V staff felt there that the strategies and issues involved in those two issues were quite distinct, it was decided to split the expert panel recommendation into two strategies. This priority is new for Illinois Title V, though a priority focusing on reducing risk taking behavior was developed in the 2005 needs assessment. This priority will address risk behaviors in adolescents by promoting healthy relationships, healthy lifestyles, and healthy choices.

6. Assure appropriate transition planning and services for adolescents and young adults, including youth with special health care needs (Adolescent Health & CSHCN). The expert panel recommended one priority that encompassed adolescent health issues including risk-taking behaviors and transition planning. Because the Title V staff felt there that the strategies and issues involved in those two issues were quite distinct, it was decided to split the expert panel recommendation into two strategies. This priority expands one of the Illinois priorities from 2010 (#10) by including all adolescents and young adults, not only those with special health care needs. While YSCHN are in particular needs of transition planning and services, it is acknowledged that all youth need help transitioning to adult systems of care and that there is much work to be done in improving the transition period for teens and young adults.

7. Assure that equity is the foundation of all MCH decision-making; eliminate disparities in MCH outcomes (Cross-Cutting). The expert panel recommended this priority, which is a new priority for Illinois Title V. This is the first time that Illinois has explicitly created a priority to focus on increasing equity. Illinois has wide disparities in many health outcomes by race/ethnicity and geography and these disparities are continuing to demonstrate inequities in systems of care and the social conditions in which people live. For instance, Illinois and other Region V states have some of the highest black-white disparities in infant mortality in the nation, and such disparities appear to be widening rather than narrowing. The IDPH Office of Women's Health and Family Services includes this equity-focus as one of the overarching goals of the office and it was important to ensure that Title V is also working towards this goal.

8. Support expanded access to and integration of mental health services and systems for the MCH population

(Cross-Cutting). The expert panel recommended this priority, which revises an Illinois priority from 2010 (#8). Mental health emerged in all data collection procedures as a major need of the MCH population in Illinois. There are wide disparities in care for mental health conditions and a great need for services across the state, but especially in rural areas. This priority affirms that, to truly impact many MCH outcomes, Title V will need to better coordinate with mental health systems for women, children, and adolescents. The framing of this priority reflects that Title V will likely have the greatest impact by collaborating with mental health programs/systems, rather than delivering mental health services directly.

9. Partner with consumers, families and communities in decision-making across MCH programs, systems and policies (Cross-Cutting). This priority was recommended by the expert panel and is a new priority for Illinois Title V. This priority reflects the MCHB emphasis on family/consumer engagement and makes it an even more explicit goal in Illinois. Having this as a state priority will ensure that Illinois intentionally engages consumers and families at all levels of decision-making – from care decisions during individual client encounters in public health programs all the way up to inclusion of such persons in the development of policies and new programs.

10. Strengthen the MCH capacity for data collection, linkage, analysis, and dissemination; Improve MCH data systems and infrastructure (Cross-Cutting). This priority was recommended by the expert panel and continues an Illinois priority from 2010 (#1). There was wide agreement among expert panel members and Title V staff that continuing to improve the MCH data capacity and infrastructure in Illinois is a vital piece of Title V practice. Program and policy decisions should be based on sound science; the availability, linkage, and analysis of state data are vital for generating the necessary evidence. Data are also key for program accountability and demonstration of program impact, both of which are increasing in focus at the national and state levels. Illinois has made major strides in data capacity and infrastructure during the last five years and keeping this priority will promote continued progress over the next five years.

Other Considerations

The expert panel recommended only one priority that was not retained by Title V staff: workforce development and addressing of provider shortages, particularly in rural areas. While staff deemed this an important need in our state, it was determined that workforce development and recruiting were better conceptualized as "strategies" falling under other priorities. For instance, mental health provider shortages continue to plague the state, and addressing such shortages through workforce development would be a strategy that would fit under priority #8. Likewise, provider shortages related to primary, specialty, and oral health care could fall under priorities #1 (well-woman) or #4 (medical home).

The expert panel and staff review also included explicit discussions of whether some priorities (particularly those on medical home and transition services) should be focused only on children with special healthcare needs, or encompass all children. In the end, it was decided that the priority should remain broad (though still specifically mention CSHCN as a target sub-group) because it is a broad, population-based, systemic approach that would be most likely to elicit change in the healthcare system and services available to children. The CSHCN program in the UIC Division of Specialized Care for Children was included in these discussions and was in favor of the broader priorities.

2010 Priorities That Were Discontinued

There were several priorities from 2010 that were replaced or discontinued:

2010-#2: Integrate medical and community-based services for MCH populations and improve linkage of clients to these services, particularly CSHCN. While this priority was not explicitly continued, the expert panel and staff felt that its essence was carried on in several of the new priorities, including #3 (early childhood), #4 (medical home), #6 (transition services), and #8 (mental health).

2010-#3: Promote, build, and sustain healthy families and communities. This priority was deemed too broad and posed difficulties over the last five years. It was difficult to develop specific strategies under this priority and associated performance measures were never developed. The expert panel and staff decided that it would be better to discontinue this priority in favor of more specific topics/areas to address.

discontinue this priority in favor of more specific topics/areas to address.

2010-#7: Address the oral health needs of the MCH population through prevention, screening, referral, and appropriate treatment. While oral health was discussed as a major need for women and children throughout the state, there was also concern about the feasibility of Title V to enact change, especially in light of the fact that the state public health department has been without a lead dentist over the oral health program for nearly one year. In discussions about medical homes, it was pointed out that providers should be linking services across sectors, including oral health. So, strategies to strengthen connections to oral health services will be developed under the new priority #4.

2010-#9: Promote healthy weight, physical activity, and optimal nutrition for women and children. This priority was discontinued in favor of some of the other cross-cutting issues that the expert panel and Title V staff deemed important. While obesity (and related chronic conditions) continues to be a concern for women and children, discussions on this topic concluded with the acknowledgement that healthy weight promotion, physical activity, and nutrition would fall under some of the other new established priorities, including: #1 (well-woman care), #2 (healthy pregnancies), #4 (medical home), #5 (healthy adolescents), and #7 (promote equity).

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

NPM 1-Percent of women with a past year preventive medical visit

	2016	2017	2018	2019	2020
Annual Objective	63	64	65.5	67	68.5

NPM 3-Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

	2016	2017	2018	2019	2020
Annual Objective	80.4	81.9	83.5	85.1	86.8

NPM 6-Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

	2016	2017	2018	2019	2020
Annual Objective	36.3	38.3	40.4	42.5	44.7

NPM 10-Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

	2016	2017	2018	2019	2020
Annual Objective	89.5	90.3	91.2	92.1	93.1

NPM 11-Percent of children with and without special health care needs having a medical home

	2016	2017	2018	2019	2020
Annual Objective	47.2	48.1	49	50	51

NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

	2016	2017	2018	2019	2020
Annual Objective	46.2	47.1	48	48.9	49.8

NPM 13-A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

	2016	2017	2018	2019	2020
Annual Objective	49.4	51.3	53.2	55.1	57
Annual Objective	81.6	82.4	83.2	84	84.8

NPM 14-A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

	2016	2017	2018	2019	2020
Annual Objective	6.8	6.5	6.2	5.9	5.6
Annual Objective	20.4	19.8	19.2	18.6	17.9

The chosen ten priorities were linked to the fifteen available national performance measures (NPM) to inform the selection of Illinois' eight NPM. After eliminating those NPM that did not link well with the

inform the selection of Illinois' eight NPM. After eliminating those NPM that did not link well with the state priorities, the remaining NPM were assessed for data availability, content area, and ability to impact change. Given that many of the Title V priorities are infrastructure- and systems-focused, priority was also generally given to those NPM that evaluated something about the health system or services (rather than specific health behaviors or outcomes). Through discussion with the epidemiology/data team of the OWHFS, one priority was ultimately selected for each population domain, with two "bonus" measures selected out of the remaining options. This resulted in the following list of chosen priority measures:

Women's / Maternal Health Domain:

NPM #1: Well-woman visits

This measure was directly connected with priority #1 on well-woman healthcare. Ensuring that women are better connected with primary care providers and are receiving preventive services will help in chronic disease management and long-term outcomes, including the reduction of poor birth outcomes (priority #2). Additionally, it represents a health service metric that could reasonably be impacted by Title V improvements to the infrastructure for preventive care for women.

Perinatal / Infant Health Domain:

NPM#3: Very Low Birth Weight Babies Born in Level III Hospitals

This measure was selected because it connects to priority #2 on improving birth outcomes. This indicator serves as a sentinel marker of the quality of perinatal hospital care for infants in Illinios, which is organized through a regionalized perinatal system. It would be expected that improvements to this perinatal healthcare infrastructure would result in many improved health outcomes for women and infants.

Child Health Domain:

NPM #6: Developmental screening for young children

This measure links to both priority #3 (improving linkages to early childhood services) and to priority #4 (medical home for children). It serves as both an indicator of a needed preventive service that should be a part of routine children's healthcare, but also a key process for identifying high-risk children who may need connections to other services. By improving developmental screening rates at young ages, children with delays or problems can be identified and appropriately referred to needed servies/programs.

Adolescent Health Domain:

NPM #10: Adolescent well visits

This measure links to priority #4 (medical home) by emphasizing the importance of preventive health

services among adolescents. If the pre-conception health framework is used as a lens for adolescent health, this measure also relates to priority #1 (well-woman care). It also indirectly relates to priority #5 (reduce adolescent risk taking), as patient education delivered in well visits may impact risk taking behaviors among teens. This measure was selected because of its connection to several priorities and to work already in place for the Illinois CoIIN team on pre-/inter-conception health.

Children with Special Health Care Needs Domain:

NPM #11: Medical home

This measures links directly to priority #4 (medical home for all children) and emphasizes the special needs of CSHCN. While priority #4 addresses medical home for all children, this measure will help to highlight the special situations facing children with special health care needs. This measure was selected because it is the main objective of priority #4.

NPM #12: Transition services for youth

This measure links directly to priority #6 (transition for youth) and emphasizes the special needs of YSHCN. While priority #6 addresses transition for all youth and young adults, youth with special healthcare needs are a particular population of interest that require extensive transition planning services. This measure was selected because it is the main objective of priority #6.

Cross-Cutting Domain

NPM #13: Dental services

While oral health services are not their own priority for Illinois Title V, the expert panel and staff conversations operated on the assumption that the medical home (priority #4) will appropriately link children to dental homes and that well-woman and pregnancy-related care (priorities #1 and 2) should include oral health assessments and treatment. This priority was selected because it is an important needs for Illinois women and children and will track the ancillary effects of preventive care and medical home usage.

NPM #14: Smoking

Smoking is a key predictor of poor birth outcomes (priority #2) and Illinois has large geographic disparities in smoking. While smoking itself is not a priority area for Illinois Title V, smoking cessation activities should be incorporated into well-woman care (priority #1) and prenatal / postpartum care (priority #2). Furthermore, child health providers should educate parents about the impact of second-hand or third-hand smoke on their children (priority #4 – medical home) and should seek to reduce the high smoking rates seen in rural areas (priority #7). Because smoking indirectly relates to so many priority areas, it was selected as a cross-cutting NPM.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

State performance and outcomes measures are not yet developed, but will be included in the FY2017 Application / FY2015 Annual Report. After linking the ten Illinois priorities with national outcome and performance measures, there are four priorities that have few or zero measures that are connected to them.

- Priority #7: Promote Equity; Reduce Disparities
- Priority #8: Mental Health
- Priority #9: Family Engagement
- Priority #10: Data capacity and Infrastructure

These four priorities are likely to be the subjects of the state performance and outcome measures that will be developed in the coming fiscal year. The goal is to ensure that each priority has at least one performance measure and one outcome measure with which it is associated, as is appropriate and feasible.

II.F.1 State Action Plan and Strategies by MCH Population Domain

State Action Plan Table
Women/Maternal Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Assure accessibility, availability and quality of preventive and primary care for all women, particularly for women of reproductive age	By 2020, improve the percent of women with a past-year preventive medical visit by 10% (2020 obj = 68.5%)	Identify and promote educational messages that improve the use of preventive health services among selected targeted populations. Increase availability of adjustable-height examination tables to ensure women with disabilities can obtain routine screening and preventive care. Integrate preconception/inter-conception care into routine primary care for women of reproductive age to include screening and follow-up for risk factors, such as smoking, management of chronic disease and contraception. Increase awareness of the impact on birth spacing through family planning education and improved access to highly-effective contraceptive methods, such as LARC.	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births	Percent of women with a past year preventive medical visit		

Women/Maternal Health - Plan for the Application Year

According to the findings from Illinois' 2015 Needs Assessment, key issues impacting the health of Illinois' women of childbearing age are chronic disease

According to the findings from Illinois' 2015 Needs Assessment, key issues impacting the health of Illinois' women of childbearing age are chronic disease, smoking, mental health issues, sexually- transmitted infections, access to preventative healthcare and health disparities. The overarching goal for Illinois' Title V program moving forward is to establish the infrastructure for comprehensive services and support for women across the life-span that will improve not only their health outcomes, but the outcomes of their babies. The following strategies will be implemented to accomplish the aforementioned goal.

- Identify and promote culturally sensitive, age appropriate educational messages that improve the use of preventive health services among targeted populations.

- Work with our sister Medicaid agency to integrate preconception/inter-conception care into routine primary care for women of reproductive age to include screening and follow-up for risk factors, management of chronic disease and contraception.

- Encourage healthcare providers to implement reminder systems for routine preventive health and follow-up visits.

- Develop a plan for implementation of screening, brief intervention and referral processes for smoking, alcohol/substance abuse and mental health issues.

- Increase women of childbearing age's awareness of the impact of birth spacing through family planning education and improved access to highly-effective contraceptive methods, such as LARC

- Increase health care provider's awareness of all aspects of cultural sensitivity, including racial, ethnic, geographic (rural versus urban) and patients with disabilities (e.g. increase availability of height adjustable examination tables).

Illinois will continue to implement case management services for pregnant and new mothers through the Family Case Management and Better Birth Outcome programs. The state will also continue to support the development of community systems, such as the All Our Kids (AOK) network to support the local networks of services and supports for women of childbearing age. The Title V program will work collaboratively with key partners such as our state's Medicaid agency, Department of Human Services and the Illinois Early Learning Council to coordinate and enhance the synergy of all primary and preventive healthcare services.

Medicaid Agency

IDHFS' activities to increase access to high quality, evidence-based family planning services for women and men in the Medicaid Program, and to provide comprehensive and continuous coverage to

IDHFS' activities to increase access to high quality, evidence-based family planning services for women and men in the Medicaid Program, and to provide comprehensive and continuous coverage to ensure that every pregnancy is a planned pregnancy include 1) June 2014, IDHFS provided guidance to enrolled providers regarding Medicaid covered family planning and reproductive health services to ensure that the full spectrum of family planning options and reproductive health services are provided to Medicaid recipients, and 2) August 2014, IDHFS released the Illinois Family Planning Action Plan to provide further information regarding patient centered family planning with important family planning policy changes and payment increases.

Women/Maternal Health - Annual Report

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	63	64	65.5	67	68.5

In the Cook and collar counties areas, women enrolled in the Family Case Management, Chicago Healthy Start, Better Birth Outcomes programs who screen positive for symptoms of perinatal depression are referred for further screening and assessment. In FY14, 624 women displaying symptoms of depression prenatally or in the child's first year of life, were referred to HAS. Those women who are determined to have depression are offered individual and group counseling at no cost to the client. Many of the women have co-occurring issues, such as being in a domestic violence situation, isolation from family and support, substance abuse in the home, and financial hardships. Many of the women are immigrants, and English is a second language. Culturally competent services are provided in one of 3 locations. Staff from HAS provide staff education for the DHS funded programs, upon request.

A small contract is provided to Northshore Hospital for operation and maintenance of the MOM's Hotline. This 24 hour hotline is specifically for individuals, families and providers who are seeking information related to perinatal mood disorders. Individuals and family members can call to obtain local provider information, referral information, and obtain answers to questions they might have regarding the condition. Providers can call for clinical support, and guidance related to care of a women experiencing perinatal mood disorders. This assists those providers who do not have experience in treating mood disorders, and feel unsure as to what medications and dosages to prescribe. Staff from Northshore are available to provide education for DHS funded programs, upon request.

The Perinatal Mood Disorders Act which became effective 1/2007 mandates that IDHS provide written materials to hospitals, physicians, and other providers on perinatal mood disorders, for client education. In 2014, DHS distributed 30,000" Is It The Baby Blue's or Something Else" brochures in

English, and 5,500 in Spanish across the state. These are shipped to birthing hospitals, physician practices, FCM providers and any other type of provider who requests same for distribution in their practice setting. The brochure contains general information regarding the signs and symptoms of perinatal mood disorders, as well as the MOM's Hotline number.

In 2014 and beginning of 2015, a small group of professionals continued work on development of the Rules to accompany the Perinatal Mood Disorders Act. These are now in the 2nd reading, and expected to be adopted in Spring Legislative Session. The Rules further define the mandated requirements for who is to offer screening, when, documentation and follow-up for positive screens.

The greatest barrier in meeting the needs of women across Illinois who display symptoms of perinatal mood disorders is money and availability of services. The Perinatal Mood Disorders Act was/is an unfunded mandate. Monies to support the MOM's Hotline and HAS are from Title V and from Illinois IMR funds, neither of which are unlimited or have the capacity to cover the estimated need.

Plan for FY16- In an effort to increase availability of services for those women who display signs and symptoms of perinatal mood disorders, IDPH and IDHS will work together with the perinatal program and ACOG to develop a safety net through- out the state. The goal will be to enhance the ability of the local OB/GYN/FP MD to initiate pharmacological services, and to improve the perinatal systems network for referral and treatment across the state.

Family Case Management: 233,694 Medicaid-eligible pregnant women , infants , or children were activated in FCM in FY 14. Of these, about 6500 were infants or children who met Adverse Pregnancy Outcome Reporting criteria and 5500 were pregnant wards, or infants/children under DCFS care. APORS follow-up and Healthworks, Il. are specialized case management services provided within the FCM program. IDHS had contracts with 110 providers across Illinois to deliver FCM services. Provider types include local health departments, FQHC's and Community Based Organizations. Services are governed by the Il. 77 MCH Administrative Code, and funded by Title V, Title XX, and state Infant Mortality Reduction monies. The goal is to reduce infant morbidity and mortality through assessment, referral, linkage and education regarding pregnancy and pediatric care to Medicaid-eligible families. Pregnant women are enrolled into the program as soon as they are found and agree to the services, then linked to prenatal care, WIC, community support services, and provided education regarding pregnancy, labor/delivery, and postpartum care. The infant and child is linked to pediatric care, including immunizations and well-baby checks, and the mother receives education regarding home safety, parenting, child development. Mothers and children are referred to specialty care, as indicated by various screenings and assessments that are completed throughout the program.

In July 2014, Il Dept of Healthcare & Family Services began mandatory and voluntary enrollment into Medicaid managed care plans across most of Illinois. This will happen through contracts with Accountable Care Entities, Managed Care Organizations, and other contracted groups. All are expected to provide case management services for at-risk pregnant women , infants and children. DHS and DHFS have been meeting twice a month for the past 18 months, developing a plan to avoid duplication of effort, while assuring that services are available across the state for the population in need. This

work continues, but was stalled slightly with the appointment of a new HFS Director in January. She has now indicated a desire to once again move forward with planning around this issue. The Better Birth Outcomes program was designed in collaboration and cooperation with HFS, and provides intensive prenatal case management services for high-risk pregnant women in areas of the state where there is a higher than average percent of premature births, and have higher than average Medicaid cost outlays associated with same. Currently, we are funding 22 providers for BBO services, and have enrolled about 5000 pregnant women. (Barb will provide you a separate narrative on BBO).

APORS services are mandated under state law, and must be provided by a public health RN. Healthworks wards are not included in the mandatory enrollment plan. Thus, these 2 sub-populations within FCM are not impacted by ACE's or MCO's. That means that whatever we do with HFS and FCM going forward, these 2 groups will still require some form of FCM services.

Additionally, ACE's and MCO's are not in place across the state, and may never be. The absence of same is most prevalent south of Springfield, which is also the area of the state which historically has the greatest paucity of physician services. In these areas, the local health department has often served as the point of entry for care, and has provided many basic direct services to support the health and well-being of pregnant women, infants and children. The FCM grant has assisted them in doing so, and loss of the grant would greatly diminish their ability to continue to do so.

The FY16 Governor's proposed budget calls for a $6.7 million cut to the Infant Mortality Reduction funds, which are used to support FCM, BBO and the AOK networks. This equates to a 10% cut to an already severely underfunded program. Talks are currently underway within the organization, and with varied stakeholders as to the best way to implement such a cut, if the proposed reduction is passed. Some suggestions are to move remaining funds and efforts into an expanded BBO model, use the funds to enhance/support home visiting programs, reduction of caseloads with enhancement of rates, and better integration of WIC and FCM services and dollars. It is anticipated that some changes will be implemented in FY16 and deeper changes will occur in FY17.

Regional MCH Nurse Consultants: IDHS currently has 9 Master's prepared MCH Nurse Consultants assigned to work with MCH contractors across the state. The nurses provide technical assistance, monitoring, evaluation, and staff development activities for recipients of DHS issued FCM, BBO, and Home Visiting grants, as well as provide support to DPH in monitoring Title X funded programs.

This past year, a lot of effort has been expended in preparing the nurses to work with the MIECHV and HFI funded projects across the state. They received education on the various models of service, program requirements that are in place, monitoring and evaluation, benchmarks, etc. and began working directly with the providers in April 2015. The intent is to assist providers in expanding the work they are doing related to health practices with pregnant women and children.

The cadre of MCH Nurses has shrunk from 15 several years ago, to the present 9. Most are covering more than 1 Region, and have approximately 40 projects each to work with. Ideally, they would remain within 1 region, and carry an assignment closer to 30 projects each. In order to accomplish this, we would need increased funding. Simultaneously, IDPH is requesting additional nursing support.

The plan for FY16 is to look at operational costs, and determine if there is a way to maintain support of the Regional MCH Nursing staff, and meet the

The plan for FY16 is to look at operational costs, and determine if there is a way to maintain support of the Regional MCH Nursing staff, and meet the needs of both DHS and DPH.

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

2015 ACA Adults - Effective January 1, 2014, Illinois expanded medical coverage to adults, age 19 through 64 years, under the new Affordable Care Act (ACA) Adult Program.

Illinois Healthy Women (IHW) - Provided coverage for family planning services. The program operated under a Section 1115 Medicaid waiver to demonstrate the program's impact on the rate of unintended pregnancy and associated savings to the Medicaid program. The program covered women who are ages 19 through 44, who are U.S. citizens and Illinois residents with family incomes at or below 200 percent of poverty. Effective December 31, 2014, the IHW program ended ,IHW was phased out beginning at the end of 2013. No new applications were accepted after 9/30/2013. Women who were enrolled as of1/1.2014 remained covered through 12/31/2014 when the program ended. They were encouraged to apply for full coverage under Medicaid or purchase insurance through the federal Marketplace.

State Action Plan Table			
Perinatal/Infant Health			
State Priority Needs	Objectives	Strategies	National Outcome Measures
Support healthy pregnancies and improve birth outcomes	By 2020, increase the percent of very low birth weight babies born in a Level III+ perinatal hospital by at least 10% (2020 obj. = 86.8%). By 2020, increase the percent of pregnant women who received dental services during pregnancy by at least 20% (2020 obj. = 57.0%). By 2020, decrease the percent of women who smoke during pregnancy by at least 15% (2020 obj. = 5.6%).	An error has occurred while processing HtmlTextBox 'htmlTextBox9': An error occurred while parsing EntityName. Line 1, position 493.	Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births

Perinatal/Infant Health - Plan for the Application Year

According to the 2015 MCH Needs Assessment racial disparity is the primary factor negatively impacting perinatal and infant health. Black and Hispanic women are less likely to receive adequate care than white women (W: 85%, B: 63%, H: 73%), and young mothers are less likely to receive at least adequate prenatal care than older mothers. The combination of these risk factors demonstrates the extent of staggering disparities in prenatal care in Illinois. Only 45.1% of young (<20), Black women in Chicago had adequate prenatal care, compared to 88.3% of older (≥35), White women in rural counties. Barriers to care include transportation, childcare, lack of providers that take Medicaid, and long waiting lists for appointments. Wide disparities in birth outcomes are present by race/ethnicity in Illinois. Compared to infants of white mothers, infants born to African-American mothers are 2.1 times as likely to be LBW, 2.5 times as likely to be VLBW, and 2.8 times as likely to die in the first year of life. Women in rural counties, black mothers, and young mothers are the less likely to breastfeed than their counterparts. Illinois hospitals also rank in the bottom half of state for breastfeeding practices like skin-to-skin contact, early breastfeeding, formula supplementation, and rooming-in. Illinois will implement the following strategies to improve the health and well-being of the perinatal and infant populations.

National Performance Measures	ESMs	SPMs
Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)		

- Increase awareness of the impact of health disparities on birth outcomes within high-risk communities.

- Identify local and regional risk factors through collection and analysis of local, regional, and statewide birth outcomes data

- Create and implement local and regional prevention strategies aimed at preventing premature births based on risk identification (interventions such as 17P and others)

- Collaborate with consumers through March of Dimes, Fetal IMR, Everthrive and Healthy Start, etc. to create consumer education and awareness plans.

- Review and update guidelines for maternal transfers to tertiary perinatal/neonatal centers for high risk antepartum, intrapartum & postpartum care.

- Develop care transition plan to ensure mother receives appropriate postpartum care in a timely manner and is transitioned to medical home.

- Work with Medicaid agency to review and improve content of comprehensive postpartum care visit.

- Develop and implement Continuing Medical Education (CME) training to educate obstetricians, dentists, and other well woman providers on the association ofpoor maternal oral health and preterm/low birth weight and early childhood caries.

- Identify successful programs in state and out-of-state that address the barriers facing providers

- Work with Perinatal Advisory Council (PAC) to review and revise state standards for Regional Perinatal Health, including the Neonatal Intensive Care Unit (NICU), Maternal and Surgical Levels of Care.

- Expand Maternal Mortality Review Committee to include a sub-committee reviewing non-clinical maternal mortalities occurring outside of the hospital. (e.g., deaths due to domestic violence, substance abuse, suicide)

- Collaborate with early childhood system, including home visitation, to expand knowledge and support to parents regarding follow-up to newborn screening, safe sleep, postpartum and inter-conception care.

- Continue to provide education and support to parents, providers and hospitals around safe sleep.

- Address Social Determinants of Health through the Infant Mortality Collaborative, Innovation and Improvement Network (CoIIN) sub-committees' work on improving service coordination and reducing poverty.

Illinois will continue to support the Regional Perinatal Health program, including its Regional Perinatal Centers. Through the hospital perinatal re-designation process the State will work with Regional Perinatal Administrators and hospitals to assure that policies and procedures are in place improve birth outcomes. The state will also continue to collaborate with the Illinois Perinatal Quality Collaborative to implement quality improvement processes in birthing hospitals around Golden Hour, Neonatal Outcomes, Birth Certificate Data Improvement and Early, Elective Deliveries.

To further improve perinatal and infant health outcomes, Illinois has implemented a Perinatal Strategic Plan to improve data collection and reporting, reduce disparities in access and quality, improve coordination of care and establish a state wide professional curriculum. The overarching goals of the strategic plan are to empower women throughout the lifespan, engage community, build quality improvement capacity and enhance strategic partnerships.

CHIPRA

The five-year CHIPRA Quality Demonstration Grant was scheduled to expire on February 21, 2015, but CMS has granted Illinois a 12-month no-cost extension through February 21, 2016. During 2015, IDHFS will focus attention on completing several activities and work on sustainability of others.

Since the child core measure set is integrated into IDHFS infrastructure, work in 2015 will focus on moving from measurement/reporting to quality improvement.

The Prenatal Care Quality Tool will be tested in two pilot sites in Rockford and Chicago, and the Prenatal Minimum Electronic Data Set will be pilot tested in two practices and one hospital in Chicago. Findings from the pilot testing will inform HFS decisions on spread of these quality improvement tools.

The medical home focus in 2015 will be promoting the concept of PCMH with public and private payers and aligning efforts. The final report for the PCMH-Asthma Learning Collaborative will be completed. A toolkit of resources to assist practices in transformation and applying for PCMH recognition will be developed and all documents will be shared widely to promote PCMH transformation/recognition.

The ILPQC will implement three new quality improvement initiatives – maternal hypertension, the Golden Hour, and birth certificate optimization. ILPQC will continue to engage hospitals and will host its third annual conference.

Best practices for perinatal transitions will be communicated to providers and stakeholders will be engaged to promote and educate providers on best practices.

The final report on the UIC postpartum visit and contraception study will be completed and will inform decisions on postpartum care.

The final report on the pilot testing of the Perinatal Education Toolkit will be completed and will inform decisions about patient education.

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	80.4	81.9	83.5	85.1	86.8

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

HRSA funding (2011-2014) was awarded to UIC-DSCC to reduce loss to follow-up. Grant goals included increase parent/ provider education of the 1-3-6 EHDI initiatives, reduce loss to follow-up, improve timely outcomes for infants, and surveillance for late-onset loss. Activities supported data reporting, collaboration with parents of children with a hearing loss to educate stakeholders, implementation of standardized online training on objective screening, and implementation of quality improvement strategies at birthing hospitals.

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

Highlights of annual statewide meetings: Bridges for developmental therapists-hearing/interventionists (63 participants), Academy of Audiology (229 participants), Head Start Association (190 participants), Teachers of Deaf and Hard of Hearing (249 participants), day long parent conferences, GBYS Parent Guide training (17 participants), and Parent Institute for Families; EHDI webinars/teleconferences for stakeholders; production /dissemination of quality improvement materials and Governor declared EHDI day recognizing stakeholders; direct parent-to-parent support (89 families); technical assistance on objective hearing screening (impacting > 25,000 children); CSHCN identification of 61 pediatric audiology sites; and CSHCN care coordination and support for diagnostic hearing evaluations and follow-up for children with hearing loss. UIC-DSCC applied for the competitive HRSA funding for 2014-2017 to reduce loss to follow-up after newborn hearing screening and was awarded the maximum amount of funding.

IDPH EHDI used CDC grant funding to improve the Hi*Track data system and implement quality assurance activities with reporters. For this period, 705 infants were reported to IDPH; 99.0% of the infants were screened prior to discharge with 0.4% deceased and 0.6% not screened to date. Of those screened 3.5% referred and 193 have a confirmed hearing loss. This data is within the nationally established targets.

Fetal Infant Mortality Review: The Chicago FIMR project began as a response to a requirement to the federal Chicago Healthy Start grant . DHS no longer has the federal funding for Healthy Start, but has continued to support the Chicago FIMR project through state IMR monies. We elected to do so beginning in calendar year 2014, because we also decided to continue funding what had been the federally supported Best Practices in Women's

Health project at University of Chicago. That was a 3 year demonstration project which ended in the summer of 2013, and the goal was to enroll women who had experienced a fetal or neonatal loss into a case management program that would support delay of a subsequent pregnancy for at least 17 months, focusing on interconception health needs. When the federal funding ended, we continued to support the project with state dollars. The FIMR project provided a dependable source of referrals into the case management program ,and continues to do so. APORS referrals come into U of C, interviews and chart reviews are conducted by FIMR staff, and women are offered an opportunity to participate in interconception case management services. The case managers from the 2 projects work collaboratively, and from the same office. Currently, there are 35 women enrolled in the ICC project.

FIMR case review meetings are held quarterly, and attended by an array of community professionals. Details of the loss are presented, and the group determines whether or not it appears the loss was preventable. The ICC case manager then gives a case presentation on the woman if she is active in the ICC project. So far, the majority of women are delaying subsequent pregnancy for an extended time, are returning to school and work, and are linked with needed medical/specialty services to help reduce risks in a subsequent pregnancy. Recently, we added another level to the ICC service- 3 area BBO programs will be referring women who have recently delivered, who have a history of poor birth outcomes, and are likely to become pregnant again soon, to the ICC project at U of C.

This is a unique pilot model that we are hoping proves successful, and that we can replicate in other parts of the state. Barriers to doing so are largely associated with the fact that this FIMR is an isolated group, and aside from FIMRs other Healthy Start programs have facilitated in Illinois, there are no other FIMR groups. In FY 16, IDPH will work with DHS to expand FIMR's statewide. This will allow DHS to then expand this pilot to other locations where we also have funded BBO programs.

Better Birth Outcomes (BBO) State fiscal year 2014 represented the "pilot" year of the Better Birth Outcomes program, designed to provide intensive prenatal case management services to high-risk pregnant women in designated target areas of the state with higher than average Medicaid costs associated with poor birth outcomes and higher than average numbers of women delivering premature infants. Twenty-one programs operated by local public health departments, Federally Qualified Health Centers and other Community-Based Organizations, provided BBO services to 5,057 women during calendar year 2014. Like Family Case Management services are governed by the Il. 77 MCH Administrative Code, and are funded by Title V, Title XX, and state Infant Mortality Reduction monies.

The goals are to reduce infant morbidity and mortality resulting from lack of adequate prenatal care and improve pregnancy outcomes for women with specific risk indicators through early identification and enrollment of high-risk women, assessment, referral, linkage and standardized prenatal education regarding pregnancy, labor and delivery, signs of pre-term labor, interconception care and education, education regarding contraceptive services and assistance in accessing prenatal care, contraceptive services and other services specific to identified needs. Each BBO woman develops a Reproductive Life Plan. Transportation support is available to assure that women can access their prenatal and other specialty medical and clinic appointments as outlined in their individualized plan of care. Women are enrolled in BBO through six-weeks postpartum, and receive a minimum of one face-to-face visit with their case manager and one other contact each month and one home visit each trimester of pregnancy. BBO case managers are only RN's or MSW's.

BBO's eligibility risk factors include: alcohol/substance abuse continuing during pregnancy, tobacco use continuing during pregnancy, previous pre-term birth, diseases/conditions that affect pregnancy, HIV or repeated STD infections, low or high pre-pregnancy weight, under age 15 or over age 40

term birth, diseases/conditions that affect pregnancy, HIV or repeated STD infections, low or high pre-pregnancy weight, under age 15 or over age 40 at time of conception, multi-fetus pregnancy, mental health issues as indicated by DSM_V classification, domestic violence, history of short pregnancy intervals, low educational attainment, current or prior involvement with child welfare or the justice system, and homeless or in temporary housing. BBO agencies are expected to conduct aggressive outreach to reach and engage women who normally do not seek care or services on their own accord.

During FY14 the foci of the program were: development and implementation of an outreach plan and securing linkage agreements with all medical and other social services providers within the service area in order to build a community-wide referral network and achievement of assigned caseloads. The Better Birth Outcomes program was designed in collaboration and cooperation with HFS, and DHS staff worked jointly with HFS throughout FY14 on Medicaid provider education and earlier identification and referral of pregnant women to BBO services through enhancements to the DHS Cornerstone system.

Regionalized Perinatal Health IDPH administers the state's Regionalized Perinatal Health Program. Four levels of care are defined in administrative rule, with all facilities integrated into ten regional networks of care. Activities focus on improving the quality of perinatal care and increasing the proportion of infants at risk for poor health outcomes, such as low birth weight/very low birth weight, who are born at facilities with the capacity and resources to meet their health needs. Regional Perinatal Administrators and educators work with the Department to implement quality improvement projects in their network hospitals, such as the Hemorrhage and Birth Certificate Data Improvement projects.

The Perinatal Advisory Council (PAC) serves as an advisory body to the State Health Officer. The council membership includes Neonatologists, Maternal Fetal Medicine Physicians, Nurses and other healthcare specialists. Sub-committees of PAC include the Statewide Quality Council, which guides the state's perinatal quality improvement projects; Maternal Mortality Review Committee, which reviews clinical deaths occurring during pregnancy, or within one year of birth, to determine if the cause was preventable, data from the findings are used to identify healthcare trends and inform the work of the Statewide Quality Council; the Healthcare Facilities committee is tasked with oversight of the hospital designation processes and making recommendations for hospital's requests for changes in level of designation and Perinatal Networks.

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

The High Risk Infant Follow up Program, a component of FCM, serves infants with a high risk medical condition identified through the IDPH Adverse Pregnancy Outcomes Reporting System (APORS). Infants and families who experience a perinatal death are referred to local health departments for follow up visits by registered nurses, which may continue until the child's second birthday. Healthy Families Illinois (HFI) reduces new and expectant parents' risk for child abuse/neglect through intensive home visits to improve parenting skills, enhance parent-child bonds and promote healthy growth and development. HealthWorks of Illinois (HWIL), another component of FCM, is a collaborative effort of IDHS and the Illinois Department of Children and Family Services (IDCFS) to ensure that wards of the state receive comprehensive, quality health

care. The IDPH Early Childhood Oral Health Program integrates oral health into MCH programs and Head Start throughout the state. The IDPH Early Childhood Oral Health integrates oral health into MCH programs and Head Start. One focus of IDPH is on the development of comprehensive oral health programs at the local level with a specific emphasis on preventing and reducing the burden of early childhood caries which is the most severe form of dental decay. 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 numberof car seats available at no charge to low income families. Families are given instruction in the installation of the car seat. The program also works with state and local agencies to conduct car safety seat checks. IDPH also provides funding to Sudden Infant Death Services of Illinois to provide bereavement services for families and risk reduction education for health care providers and consumers.

Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) .

Illinois has participated in the Region CoIIN since 2013, it re-launched as a national project in January 2015. Four strategy teams, consisting of a mix of state, local, clinical and academic stakeholders, will focus on:

Safe Sleep and Sudden Infant Death Syndrome (SIDS) Prevention: Goal is to improve safe sleep practices

Pre-conception/Inter-conception Care: Goal is to promote women's health before, during and after pregnancies, including a focus on post-partum visits

Social Determinants of Health: Goal is to integrate evidence-based poli-cies/programs and strategies to improve the social conditions and struc-tures that impact health and inequalities in birth outcomes

Risk-appropriate Perinatal Care (perinatal regionalization): Goal is to ensure the delivery of higher risk infants and mothers at hospitals that are properly equipped to handle their complex medical needs

The Office of Women's Health and Family Services (OWHFS) has committed to incorporating the efforts of this initiative into our work on a daily basis. Although the work has just launched to this new national platform, it is anticipated that a focused approach to each of these four areas over the coming years will not only reduce infant mortality, but also more generally improve the health of Illinois women, babies, and families.

WIC

The proportion of breast-fed infants in Illinois' WIC program is just over 70% at 70.2% of WIC participants initiate breastfeeding. The proportion who are still breast-fed at six months of age has increased significantly over the last two decades but has declined slightly in recent years .

The proportion who are still breast-fed at six months of age has increased significantly over the last two decades but remains below the Healthy People 2020 breastfeeding goal for 60.6% continued breastfeeding.

Medicaid

Perinatal Report to the General Assembly – Public Act 93-0536 (305 ILCS 5/5-5.23, enacted on August 18, 2003) requires IDHFS to submit a biennial report to the General Assembly detailing the effectiveness of improving birth outcomes through prenatal and perinatal health care services reimbursed by IDHFS for the purpose of preventing low birth weight infants, reducing the need for neonatal intensive care hospital services, and promoting Perinatal health. The report identifies steps the Illinois Department of Healthcare and Family Services has taken with its partners (sister and community agencies, advocacy groups, maternal and child health [MCH] experts, local funding resources and foundations) to address Perinatal health care needs and racial health disparities in Illinois; details the progress made in addressing the priority recommendations as outlined in the 2004 Report

address Perinatal health care needs and racial health disparities in Illinois; details the progress made in addressing the priority recommendations as outlined in the 2004 Report to the General Assembly as a result of Public Act (PA) 93-0536; provides trend data on infant mortality; low birth weight, and very low birth weight outcomes through analysis of trend data; and identifies next steps to improve birth outcomes.

The most recent report, published January 1,2014, reviews the current status of IDHFS and sister state agencies' initiatives promoting Perinatal health, including planned pregnancies, mental health during prenatal period, oral health, smoking cessation, case management and home visiting, Perinatal addiction, Perinatal HIV counseling, nurse midwifery, lactation counseling, labor support during the prenatal period, SMART Act Initiatives and other related initiatives. The 2014 report also includes plans for implementing a statewide multi-agency initiative to improve birth outcomes and reduce costs associated with babies born with low birth weight and very low birth weight or fetal deaths, as well as, developing two processes to enhance care coordination between IDHFS and IDHS for women identified with the potential for a high –risk birth outcome. First, using claims data, when a woman with a previous high-cost birth is identified, information will be shared with IDHS' Family Case Management (FCM) and Intensive Prenatal Case Management (IPCM) program. Second, a system is being developed whereby IDHFS enrolled providers can log into a secure web-based IDHS Cornerstone application to send an electronic referral to the FCM/IPCM program for women who are pregnant and at risk for a poor birth outcome. This web-based system will include a feedback loop to inform the referring provider about the outcome of the referral. These two systems assure that women at risk for a poor birth outcome are identified and provided access to FCM/IPCM programs early in the prenatal period in order to improve the birth outcome.

The Perinatal Report can be viewed on the IDHFS Web Stie at: http://www2.illinois.gov/HFS/Mediccal PRovider/Maternalandchildhealthpromotion/pages/report/aspx

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

CHIPRA

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

In December 2013, HFS reported to CMS on 25 of 26 CHIPRA core measures. The CHIPRA project continued to collaborate with the Agency for Healthcare Research and Quality and the Centers of Excellence on new measure development. HFS partnered with the DCFS Statewide Provider Database and the Illinois Health Information Exchange (ILHIE) to provide technology tools to CHIPRA practices working on patient centered medical home (PCMH) recognition. These tools will help practices meet recognition requirements related to community resources and electronic referrals. In late 2013 a Learning Group involving 14 practices engaged in adopting medical home principles concluded and planning for a PCMH Learning Collaborative using the clinical vehicle of asthma began. The Learning Collaborative is expected to begin in Spring 2014. The CHIPRA project convened workgroup to study and make recommendations on policies and incentives to encourage adoption of PCMH. The workgroup's report was released in March 2014. CHIPRA's work on improving birth outcomes continued during 2013, with the kick-off of the Illinois Perinatal Quality Collaborative (ILPQC) in November 2013, at which time the neonatal quality improvement initiative on infant nutrition started. The ILPQC partnered with the Illinois Hospital Association to host two OB Boot Camps on early elective delivery, with a third boot camp scheduled for April 2014, and the early elective delivery quality improvement initiative to start soon thereafter. Other activities focused on improving birth outcomes include working

with ILHIE to test sharing of prenatal data between prenatal providers and hospital, planning for the testing of a prenatal care quality tool/referral guidance, refining a provider tool kit and developing plans for testing the tool kit ,and convening a workgroup to study and make recommendations on care transitions from delivery to postpartum care and from postpartum care to primary care to improve the number of women who participate in a postpartum visit, use contraception, and are reconnected with their medical home for management of acute and chronic conditions.

In 2014, IDHFS published a second annual data book reporting on the child core set measures and reported 24 of 26 child core measures to CMS. IDHFS also incorporated a subset of the child core set into the Medicaid managed care contracts for reporting by the health plans. IDHFS completed its first statewide child satisfaction survey, the Consumer Assessment of Healthcare Providers and Systems (CAHPS), which includes a sample population of children with chronic conditions and questions specific to those children. Reporting of the child core set measures has been incorporated into IDHFS' infrastructure and will continue beyond the CHIPRA grant.

The CHIPRA Medical Home Incentives Workgroup issued recommendations to IDHFS on adoption and financing of patient-centered medical homes (PCMH) in the Medicaid/CHIP programs and medical home requirements were incorporated into managed care contracts.

A PCMH Learning Collaborative involving 15 primary care practices was launched in May 2014, with a clinical focus on asthma. Practices worked to adopt PCMH principles and asthma care management into their practices using plan-do-study-act cycles, best practices, and quality improvement science. The collaborative concluded in February 2015 and data shows significant improvement in adoption of PCMH principles and asthma care management. A final report is forthcoming. In addition, technical assistance was provided to two practices in applying for PCMH recognition.

During late 2013 and early 2014, the Illinois Perinatal Quality Collaborative (ILPQC) hosted three OB Boot Camps to educate hospital quality improvement teams on early elective delivery and quality improvement science. The ILPQC launched two new quality improvement initiatives in 2014 – infant nutrition and feeding and early elective delivery – with more than 80 hospitals participating on improvement teams. ILPQC and IDPH partnered to receive a three-year CDC grant for perinatal quality improvement work, awarded in September 2014. The second annual ILPQC conference was held in November 2014 and three new initiatives were identified for implementation in 2015 – maternal hypertension, the Golden Hour, and birth certificate optimization.

The CHIPRA Perinatal Care Transitions Workgroup worked on identifying best practices for perinatal care transitions. This information will be communicated to providers during 2015. Perinatal care transitions requirements were included in managed care contracts and a readiness review tool includes these requirements to assess contracted health plans' policies/systems to assure appropriate perinatal transitions.

A postpartum visit and contraception study was undertaken in partnership with the University of Illinois at Chicago, School of Public Health to explore and document perceptions of barriers to and preferences for the timing and location of the postpartum visit, access to postpartum contraception, and alternative approaches involving key informant interviews with women and providers. The study includes a literature review on postpartum contraception, interventions to increase postpartum visit rates, and evidence-based recommendations on the timing and frequency of postpartum visits. The study also pilot tested an adaptation of the CDC's *Reproductive Life Plan Tool* at the well-baby visit. Five literature reviews related to aspects of postpartum care were completed. These reviews addressed recommendations and guidelines for postpartum visits, utilization of the postpartum visit, interventions to increase attendance at the postpartum visit, recommendations and guidelines for counseling to increase use of postpartum contraception, and interventions to increase uptake of contraception in the postpartum period. A final report is forthcoming and will inform decisions about postpartum care.

A Perinatal Education Toolkit was developed by the CHIPRA Project to help clinical and community providers educate Medicaid women on the benefits and importance of preconception, prenatal, postpartum, and interconception care. The toolkit includes health communication and social marketing materials (images, messages, text) that are easily adaptable to a variety of media, an electronic guide of health education resources with direct links to free, publicly accessible materials, and checklists women can use when talking to their providers, which help them to take an active role in their perinatal health care. Pilots were initiated during 2014 to test the toolkit two communities – East St. Louis and Rockford. In East St. Louis, the pilot team includes a Federally Qualified Health Center (FQHC), a local health department and a hospital. In Rockford, an FQHC and a local health department are involved. Findings are forthcoming and will inform decisions about the toolkit.

State Action Plan Table						
Child Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Support expanded access to and integration of early childhood services and systems	By 2020, increase the percent of children under 5 years old who received a developmental screening using a parent-completed tool by at least 30% (2020 obj. = 44.7%)	Expand Healthy Families, maintain Family Literacy, increase parent education, improve knowledge of early brain and child development, support early literacy. Increase well-child screening completion and follow-up through training for health and early childhood professionals. Offer child care providers technical assistance to improve quality, phase in quality rating system, ensure sufficient monitoring of health and safety, and improve infant-toddler care.	Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) Percent of children in excellent or very good health	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool		

Facilitate the integration of services within patient-centered medical homes for all children, particularly for children with special healthcare needs	By 2020, increase the percent of children under 5 years old who received a developmental screening using a parent-completed tool by at least 30% (2020 obj. = 44.7%) By 2020, increase the percent of children without special healthcare needs receiving care in a medical home by at least 10% (2020 obj. = 63.9%) By 2020, increase the percent of children with special healthcare needs receiving care in a medical home by at least 10% (2020 obj. = 51.0%) By 2020, increase the percent of children ages 1-17 who received at least one preventive dental visit in the last year by at least 5% (2020 obj. = 84.8%). By 2020, decrease the percent of	Collaborate with ICAAP and HFS to continue to promote development of medical homes for all children, especially for CYSHCN, through website links with the AAP National Medical Home website for resources for practices. Improve asthma identification and support services, including education of families, referral of children with asthma to appropriate health care and social service agencies, and care coordination. Identify opportunities to link children's medical homes to dental homes and support integration of care. See other strategies for this priority under "CSHCN" domain.	Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) Percent of children in excellent or very good health	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool		

	children exposed to environmental tobacco smoke in the home by at least 15% (2020 obj. = 17.9%).					

Child Health - Plan for the Application Year

According to the 2015 MCH Needs Assessment, a primary concern for children's health is under insurance, or lack of insurance coverage sufficient to meet existing health needs. The medical home concept ensures that children receive comprehensive, coordinated, consistent, family-centered care. However, only about 56% of Illinois children received care that met all the requirements of a medical home in 2011-2012. There were also wide racial/ethnic and income-based disparities in having a medical home, with minority children and those from poor or near poor families being less likely to have a medical home. Asthma, obesity and injury were some of the commonly expressed health concerns for children emerged from qualitative interviews and surveys. Some of the strategies Illinois will implement, to improve children's health and well-being, include the following:

- Collaboration with the Illinois Chapter of the American Academy of Pediatrics and our states Medicaid agency to continue to promote development of medical homes for all children, especially for children and youth with special healthcare needs.
- Improve asthma identification and support services, including education of families, referral of children with asthma to appropriate health care and social service agencies, and care coordination.
- Identify opportunities to link children's medical homes to dental homes and support integration of care.
- Expand parent education regarding medical homes through social media

Illinois' Title V program will collaborate with early childhood systems to promote healthy families through increased parent education, expand MCH workforce knowledge of early child and brain development. The collaboration with the early childhood system will be enhanced to offer child care providers technical assistance to improve quality, phase in quality rating system, ensure sufficient monitoring of health and safety, and improve infant-toddler care.

Illinois will continue to fund the School Based Health program and encourage providers to partner with Managed Care Entities throughout the state to coordinate and improve children's access to comprehensive health services, including risk screening and referral and well child visits

coordinate and improve children's access to comprehensive health services, including risk screening and referral and well child visits.

Content of the fall 2016 educational programs will be determined through assessment of program evaluations and surfacing public health issues. Plan: Ongoing technical assistance and monitoring related to clinic operations, utilization of EHR, medical billing and clinical care will be provided to current sites and upon request to an additional 12 sites planning development of school health centers. Further development of a new school health data base will allow for improved program development and planning.

The Title V program will also continue to fund the Childhood Asthma initiative with a goal to standardize and expand services throughout the state.

Developmental Screening

During FFY2014, HFS and DHS continued collaborating to improve linkages between primary care providers and Early Intervention. HFS and DHS aligned the language included in consents obtained from parents/guardians to assure provides consistent wording regarding the release of information. This assures that consents obtained when a referral is made to Early Intervention using the *Standardized Early Intervention Referral Form* is consistent with the consent forms used by DHS' Early Intervention program. By aligning the language regardless of whether the family consents at the physician's office or upon contacting Early Intervention for services, information can be shared with the child's primary care provider so the provider receives information from Early Intervention about the child's eligibility for the program and what services they may receive, if eligible.

HFS and DHS intend to replicate the standardized referral process as an on-line tool. This would mean that referrals would occur electronically with information about the outcome of the referral sent back electronically. Currently, the referral process is based on faxing information. By developing an online system, HFS and DHS also have the opportunity to measure the consent process as information will be available at the recipient-level. The consent process was developed with an electronic exchange in mind and thus covers the release of information process necessary. Over several years, a great deal of progress was made on the online system. But, staffing issues and other priority projects stalled progress during FFY2014. Both DHS and HFS hope to continue development of the online system during FFY2015.

Child Health - Annual Report

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	36.3	38.3	40.4	42.5	44.7

The School-Based Health Program consists of two school health projects operated through OWHFS:

The School Based Health Program consists of five school health projects operated through OHAP.

School Health Center Project monitors the 63 school health centers operating in Illinois for compliance with TITLE 77 CH V: DEPART-MENT OF HUMAN SERVICES SUBCHAPTER J: SCHOOL-BASED/LINKED HEALTH CENTERS PART 2200, 43 of which receive grant funding from IDPH. The purpose of a school health center is to improve the overall physical and emotional health of school age children and youth by promoting healthy lifestyles and by providing accessible preventive health care. Through early detection and treatment of chronic and acute health problems, identification of risk-taking behaviors and appropriate anticipatory guidance, treatment and refer-ral, school health centers assure students are healthy and ready to learn. School Health Centers promote healthy life styles through risk assessment of clinic users and indicated health education and comprehensive physical, mental health and dental services. Students grades K-12 are evaluated individually and provided care focused on identified risks. Services are provided onsite by licensed profession staff or through referral to local health care providers. All students identified as sexually active receive comprehensive reproductive health education, STI testing and treatment and access to contraception. Students identified as overweight or obese participate in nutrition and physical activity projects. Those identified as at risk for behavior health problems are further evaluated and referred for appropriate services. Referrals for dental services are provided as needed. Care is coordinated with the students Primary Care Provider. IDPH School Health Program staff visit each of the 63 sites annually to determine compliance with Illinois statutory and current medical practice standards. Number of sites has increased from 57 to 63 in the past year. Forty three of the sites receiving funding for operations from IDPH.

Target population: School age children and adolescents to age 3-20.

Successes: Over 110,000 registered patients, 36,000 users, 105,000 visits-- medical 72,000, mental health 20,000 and dental 8,000. Performance measures focus on access to care, completion of risk assessment, STI testing and treatment, and immunization compliance.

School Health Technical Assistance and Training provides technical assistance and training to Illinois school health personnel serving 2.2 million school age children. Communication is designed to keep school health providers abreast with current health requirements, communicable and infectious disease issues, management of acute and chronic disease, education and grant opportunities, changes in public health rule and law, resources available through the Illinois Department of Public Health and other state agencies.

Daily phone calls and emails (Average 20 per day) School Administrators, School Nurses, Parents, Teachers, Other Agencies

Email list with 2700 members on which we post CDC, IDPH, ISBE, DHS announcements, grant opportunities, educational opportunities, etc.

Coordinated School Health Program grants were awarded to local health department to form partnerships with schools to identify local issues impacting the health of children and youth in grades K-12. An advisory board composed of health and education personnel, community agencies, parents and students is convened to determine priorities and develop and implement interventions designed to address those needs. Primary issues addressed included: nutrition and physical activity, pregnancy and STI prevention, bullying, drugs and alcohol.

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Childhood Asthma Initiative

Asthma is a complex disease that can be aggravated by various external factors. The Childhood Asthma Initiative acknowledges those factors and takes an inclusive community based approach to help children with asthma obtain their optimal health. We create partnerships with other social service agencies, health clinics, schools, faith based organizations and active community members to address all factors that can trigger a child's asthma.

The intervention at the school level involves screening children within the school for asthma diagnosis and symptoms, training of school staff and interested parents in

basic asthma control methods, and identifying parents to be further trained as parent peer educators. After school screenings are completed, asthma educators at Mobile CARE Foundation follow up with families to schedule appointments for children with asthma symptoms and to make sure children diagnosed with asthma are receiving regular treatment for their asthma on the primary care level. Staff at vschools and day care facilities also receive training on how to deal with asthma emergencies while the children are in their facilities. The last component to the school based intervention is to identify actively engaged parents at the local schools to serve as parent peer educators for that school and the community. These parents participate in an intensive asthma training that equips them to educate other parents within the schools and the community on how to manage their children's asthma. Once trained, these parent peer educators conduct presentations at their local schools and other community based locations. All of these services provided through the schools help to increase awareness about asthma within the community and serve to identify children in need of primary care and connects them to services for their asthma.

Currently: This past year we have conducted surveys at Carver Middle School, Curtis Elementary, Medgar Evers Elementary, Rudyard Kippling Elementary , Metcalf Elementary, and Wacker Elementary Schools. A total of 389 surveys were returned to Mobile C.A.R.E.; of these 34.90% had symptoms and/or diagnosis of asthma requiring services from Mobile C.A.R.E. and 18.90% had previous asthma diagnoses. After the completion of surveys Mobile C.A.R.E. has been providing comprehensive asthma care for children with asthma symptoms and diagnosis at these schools in our service area. Some schools have very active parent associations and we offer asthma presentations to the participants in these school based parent associations. This past year we have partnered with many of these parent organizations and conducted presentations at Kanoon Elementary, Tepochcalli, Dewey, Fulton, Seward, Corckery, Hammond, Pickard, Kippling, Evers, and Spry Elementary School. We have found that the parent associations are larger and more active in schools with a predominant Latino population. In the last two years we have trained parents to operate as peer educators in their child's school and local community from the following schools: Seward, Hedges, Suacedo, Fulton, Carver, Kanoon, and Tepochcalli. We will be conducting additional trainings in the next two months with parents at Kippling, Corckery, Spry and Little Village High School.

Challenges: One of the biggest challenges that we have faced is turnover of the schools' administrations. After building strong partnerships with the administrations in several schools we have had to virtually start over the following year due to a change in principal or vice principal at a school. Sometimes the new principal no longer wants Mobile C.A.R.E . at their school (which makes it harder for us to keep those patients) or sometimes a very active parent organization becomes inactive the following year because the new administration gives less attention and autonomy to the parent organization. Another continual challenge has been retention of the parent peer educators. After conducting trainings with the parents, assisting them in gaining the skills and confidence to present, and helping them facilitate their first presentation, they often do not continue in the program the following year. Many of the communities in which we work are transient neighborhoods - families move away, some parents begin working and no longer have the time, some lose interest, and others change phone numbers and become lost to follow up. To improve sustainability of our asthma initiatives we have established partnerships with community organizations that have systems in place to train and supervise peer educators . We have developed asthma specific modules for integration with Telpochcalli Community Education Project, Resurrection Project, Salud Sin Fronteras, Developing Communities Project, and Enlace Chicago and have scheduled 3 trainings in the month of April for educators in those programs.

A crucial component of the Childhood Asthma Initiative is the ability to provide inclusive care coordination for families with children with asthma. Our subcontractors at Mobile C.A.R.E. Foundation and Esperanza Health Centers have full time asthma educators on staff that follow up with their patients to ensure they receive the best quality of care according to the National Guidelines for asthma on a regular basis, thus keeping kids out of the emergency room. At these clinics patients receive Asthma Action plans, Asthma Control Tests, spirometry, asthma educations, home visits (if accepted), allergy testing, and many follow up calls to reschedule patients according to the severity of their asthma. Both facilities also follow up with patients after a hospital visits (through partnerships with St. Anthony and Roseland Hospital) and schedule them as soon as possible for a follow up appointment with their primary care physician.

Currently: Over the past two quarters 130 asthmatic patients have received direct services from our subcontractors at Esperanza Health Centers and Mobile C.A.R.E. regarding asthma trigger management education and spirometry. Last quarter Mobile C.A.R.E. began coordinating with the Emergency

Mobile C.A.R.E. regarding asthma trigger management education and spirometry. Last quarter Mobile C.A.R.E. began coordinating with the Emergency Room at Roseland Hospital to provide follow calls and visits on the vans for all pediatric patients who visited the emergency room with their chief complaint being shortness of breath. During the first two months alone Mobile C.A.R.E. received 108 Emergency Room Encounter Forms from Roseland Hospital emergency room.

Challenges: Numbers of patients educated on site by educators at Mobile C.A.R.E. and Esperanza in the targeted communities has taken awhile to grow as links with schools, hospital emergency rooms and the infrastructure for spirometry were developing. Numbers are increasing and coordinated care in both sites is functioning well.

We also work with local primary care providers in each of our service areas to ensure that they are aware of current National Asthma Guidelines and implement the procedures necessary to provide the best standard of care for their pediatric asthmatic patients. An Asthma and Allergy Specialist conducts trainings with the pediatric and family practice doctors, the Medical Assistants, Nurses, and Care Coordination teams at these local health clinics or hospitals. Asthma Educators funded through this grant provide asthma education for interested families in the waiting rooms at many of these local health clinics. Technical support is also offered for clinics that want to implement the Asthma Control Test or spirometry as part of their standard procedure of care. In addition we are providing asthma training for the Care Coordination team at Chicago Family Health Centers in Roseland.

Currently: Last year we brought in an asthma and allergy specialist to conduct clinical trainings with the staff at St. Bernard Hospital, Beloved Clinic, Damen Clinic, and Esperanza Health Centers. In the next two months we will host additional clinical trainings at Chicago Family Health Centers, Roseland Hospital and Esperanza Marquette School Based Health Center.

Challenges: One challenge has been building partnerships with physicians at health centers in the communities that we serve and convincing them to improve their protocols to provide a better standard of care for asthmatic patients. The new incentives for HMO's under Obama Care are changing what is being reimbursed for an asthma visit. Important issues have been variable insurance coverage and duplication of services by the HMOs serving our targeted population. Many clinics are not following the national guidelines for asthma care due to the fact that additional services, such as the Asthma Control Test, Spirometry, and Asthma Action Plans are not reimbursable. Esperanza Health Centers and other partnering agencies are developing systems to expand their asthma programs within the parameters of the various HMOs.

We have partnerships with many key community organizations to ensure that we are reaching as many people in the community as possible and to provide referrals for the variety of services that families may require. These partnerships include local Aldermanic offices, local Churches, the Mexican Consulate, Resurrection Project, Enlace Chicago, Developing Communities Projects, Environmental Equity Matters, Altgeld Riverdale Consortium, Chicago Public Libraries, Head Start programs and Chicago Public Schools, and other community based organizations. We also conduct ongoing presentations on Asthma Control and treatment for community members at these aforementioned and other local institutions with the purpose of connecting community members to available asthma resources.

Currently: This past year we have expanded partnerships with many community based organization to promote awareness to the problem of asthma in

Currently: This past year we have expanded partnerships with many community based organization to promote awareness to the problem of asthma in the community and how families can get their children's asthma under control. We attend many community events and health fairs and present at various organization to increase asthma knowledge in the areas that we serve. In the last two quarters we have educated a total of 617 people at health fairs and 678 people at the Mexican Consulate. In addition to the partnering organizations listed above we have also presented at the following community sites; Padres Angeles, Madero Health Fair, HopeFest, El Hogar del Niños, YMCA, Catholic Charities, Our Lady of Tepeyac, Daley Elementary's Fesitval del Niño, and Pilsen Wellness Center. A total of 375 people in the last two quarters have received asthma education through workshops at these partnering organizations and the local schools.

Challenges: The depth and reach of the outreach efforts are dependent on the variable numbers attending events and time available for individual education efforts. As a result we have developed programs that are flexible and can be adjusted to a variety of venues. In general our community outreach education programs have been well received and greatly increase the reach of the asthma program.

Oral Health

The IDPH Vision and Hearing Screening Program supports screening activities by local health departments, school districts or other contractors to identify children with possible problems. IDPH also coordinates ophthalmologic, optometric, otologic, and audiologic examination clinics throughout the state. The Dental Sealant Grant Program works with interested communities to establish school-based programs for prevention dental care highlighted by examinations and application of dental sealants and fluoride varnish. School-based dental sealant applications, oral health education, outreach to All Kids enrollment, dental examinations, and case management for dental treatment needs are methods that can identify at-risk populations and provide services. Access to an oral health education curriculum for grades K-12 that has been aligned to the states learning standards is available through the oral health

program communities for use in their schools. The Dental Sealant Grant Program works with interested communities to establish school based programs for preventive dental care including dental sealant and dental sealant applications, oral health education, outreach for All Kids enrollment, dental examinations, and referral for dental treatment needs. An oral health education curriculum for grades K-12 was evaluated by Illinois School Health Centers and is now offered through the sealant program communities for use in their schools.

Medicaid

Childhood Health - Approximately 1.7 million children and adolescents (ages 0 through 20 years) during FFY 2013 were eligible for Medicaid (Title XIX) or the State Children's Health Insurance Program (Title XXI) Of the children eligible for 90 continuous days or more, nearly three-fourths received at least one health service during FFY 2013. The proportion of infants who are eligible for Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and who receive at least one recommended health screening is approximately 86 percent; the proportion of SCHIP-eligible infants who receive at least one health screening is higher, but the number of participating infants is much smaller. Less than four percent of children (including adolescents) in Illinois are uninsured.

Illinois Medicaid Reform requires that 50% of Medicaid clients be enrolled in care coordination programs by 2015. In Illinois, care coordination will be provided to most Medicaid clients by a variety of "managed care entities," a general term that will include Coordinated Care Entities (CCEs), Managed Care Community Networks (MCCNs), Managed Care Organizations (MCOs) and Accountable Care Entities (ACEs)." The 50% enrollment projection was met by the 2015 timeline. This change means that over half of children enrolled in Title XIX and Title XXI will receive their health care through a managed care entity charged with providing preventive, treatment and care coordination to assure that each child receives services consistent with EPSDT requirements.

HFS' Bureau of Managed Care (BMC) conducts monthly conference calls and quarterly in-person meetings that include opportunities for educational exchange with managed care entities. The Bureau of

HFS' Bureau of Managed Care (BMC) conducts monthly conference calls and quarterly in-person meetings that include opportunities for educational exchange with managed care entities. The Bureau of Quality Management (BQM) is collaborating with BMC to provide educational content as part of quality improvement. These educational sessions focus on both population-based quality improvement, policy changes, evidence-based care (e.g, Illinois Family Planning Action Plan), care coordination advancements, and relevant cross-agency collaboration to improve care delivery (e.g., Early Hearing Dection and Intervention [EHDI], Early Intervention). Information shared at these educational meetings is not only to improve quality, but to assure managed care entities provide services per established guidelines and as contractually required.

Managed care contracts include provisions that care is to be provided consistent with the *Handbook for Providers of Healthy Kids Services*. The Healthy Kids Handbook revision of January 2015 follows guidelines set forth in the American Academy of Pediatrics (AAP) *Bright Futures* and other appropriate guidelines from CDC, ACIP, NHLBI. The contracts also include healthcare and quality of life (HQOL) to assess performance. These measures include frequency of well-child visits at 15 months of age; 3, 4, 5, 6 years of age and adolescent well-care visits. More information about quality measurement follows.

On an ongoing basis HFS conducts performance monitoring of the Medicaid healthcare delivery system through multiple mechanisms. Healthcare and Quality of Life (HQOL) performance measures are written into each managed care entity contract with performance reported by each plan. For enrollees in non-managed care areas, the Primary Care Case Management (PCCM) program provides health care. Quality measures are assessed by HFS for the PCCM program to track performance on a variety of MCH measures. PCCM providers also receive pay-for-performance bonus payments on selected measures if they provide a high level of care that meets or exceeds the established benchmarks for receiving the bonus payment. Finally, HFS tracks a number of quality measures including those used to report to the federal Centers for Medicare and Medicaid Services (CMS) on the Child Core Set and Adult Core Set measures. The report on the Child Core Set measures submitted to CMS for FFY2014 is available on HFS' web site at: http://www2.illinois.gov/hfs/SiteCollectionDocuments/2014CHIPAnnualReport.pdf. The *CHIPRA Core Set of Children's Health Care Quality Measures in Medicaid and CHIP: Illinois' Performance* provides trend data for the entire HFS covered population (Title XIX, Title XXI, state-only funded). The Data Book includes background information, comparison to benchmarks (when available) and key findings. The 2009-2012 data book is available on HFS' web site at: http://www2.illinois.gov/hfs/SiteCollectionDocuments/20092012CHIPRADatabook.pdf. The Adult Core Set measures reported to CMS for FFY2014 are available at:

http://www2.illinois.gov/hfs/SiteCollectionDocuments/FFY2014AdultCoreMeasuresReport.pdf. Per legislative mandate (PA93- 0536), since 2004 HFS biennially reports on the effectiveness of perinatal health care services delivered to Medicaid recipients. The 2014 report is available on HFS' web site at: http://www2.illinois.gov/hfs/MedicalProvider/MaternalandChildHealthPromotion/Pages/report.aspx. These measurement activities will continue into the foreseeable future.

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

HFS has encouraged providers to follow recommended guidelines for evaluation and management of overweight and obesity among children. In January 2014, HFS published an Informational Notice entitled "BMI Assessment and Obesity-related Weight Management Follow-up among Children and Adolescents: Documentation and Claims Coding Instructions". This notice describes HFS' policy around follow-up weight management visits. The policy provides that after documenting in claims that children are at or above the 85th percentile for weight, providers may bill for weight management visits for children that focus exclusively on problem-focused care for obesity. The full Informational Notice about this policy is available on HFS' web site at: http://www.hfs.illinois.gov/assets/012414n2.pdf. The information is also incorporated into HFS' Healthy Kids Handbook.

The Medicaid Agency is currently seeking Governor's Office approval to engage in a second public/private partnership to improve quality in obesity-related care among pediatricians. Through private foundation funding from Otho S.A Sprague Memorial Institute, HFS seeks to provide a multi-year grant to the Illinois Chapter, American Academy of Pediatrics (ICAAP) to improve provider practice around obesity care for children. The project builds upon initial activities engaged in by Sprague, ICAAP and HFS from 2011 through 2013 to improve the quality of obesity-related care for children. The first public/private partnership focused on provider education about Medicaid policies covering the prevention and treatment of obesity among children at risk for developing chronic conditions. If approved, the next partnership focuses on impacting provider practice change to improve the quality of care for patients at risk of obesity and obesity-related chronic conditions through ongoing medical education and training on recommended clinical guidelines for evaluation and management of overweight and obesity, as discussed in the department's Informational Notice released January 2014.

Oral Health - Slightly more than forty-one percent of children in third grade have a sealant on at least one permanent molar tooth. Access to oral health care for Medicaid-eligible or uninsured children in Illinois remains a significant challenge. The proportion of children between six and nine years of age who are eligible for Medicaid has been steadily increasing and now exceeds 50 percent. Access to oral health care for Medicaid-eligible or uninsured children in Illinois remains a significant challenge. Slightly more than one-fourth of children in third grade have a sealant on at least one permanent molar tooth. The proportion of children between six and nine years of age who are eligible for Medicaid has been steadily increasing and now exceeds 50 percent.

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

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

(1) Moms and Babies - Coverage through Title XIX (Medicaid) for pregnant women and their infants up to one year of age, with family incomes up to 209 percent of the federal poverty level (FPL).

(2) All Kids Assist - Coverage through Title XIX, Title XXI (CHIP), and state subsidized health insurance for children through age 18, with family incomes at or below 147 percent of the FPL.

(3) All Kids Share - Coverage through Title XXI and state subsidized health insurance for children through age 18, with family income above 147 percent and at or below 157 percent of the FPL. Co-payments are assessed for prescriptions and medical visits, except for well-child visits and immunizations.

(4) All Kids Premium Level 1- Coverage through Title XXI and state subsidized health insurance for children through age 18, with family income above 157 percent and at or below 209 percent of the FPL. Monthly premiums are assessed based on family size and co-payments are required for prescriptions, physician office visits and non-emergency use of the Emergency Department. There are no co-payments for well child visits or immunizations, and there is an annual limit on the amount families are required to pay.

(5) All Kids Premium Level 2- Coverage through Title XXI and state subsidized health insurance for children through age 18, with family income above 209 percent and at or below 318 percent of the FPL. Monthly premiums are assessed based on family size and co-payments are required for prescriptions, physician office visits and non-emergency use of the Emergency Department.

There are no co-payments for well child visits or immunizations, and there is an annual limit on the amount families are required to pay.

Information about All Kids is available at www.allkids.com. As a Health Services Initiative under

Title XXI, Illinois provides presumptive eligibility for children requesting medical benefits under both Title XIX and Title XXI.

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

(1) FamilyCare Assist - Coverage for parents with incomes at or below 138 percent of the FPL. Co-payments for medical visits and brand-name pharmaceuticals are required. There is no charge for generic prescriptions.

Fluoride Varnish for Young Children/Bright Smiles From Birth - IDPH, IDHFS and the Illinois Chapter American Academy of Pediatrics implemented a project to train physicians to apply fluoride varnish to young children (under age three who have at least four erupted teeth) in the course of regular well-child visits. The goal of the Bright Smiles from Birth (BSFB) pilot project is to reduce early childhood cavities and to improve access to dental care for young children (under age three). BSFB is currently operating statewide. Providers (physicians, nurse practitioners, local health departments, FQHCs and hospital outpatient clinics) are trained by ICAAP to perform oral health screening, assessment, fluoride varnish application, anticipatory guidance, and make referrals to a "dental home" for follow-up dental care, and establishment of ongoing dental services. ICAAP works in partnership with the American Academy of Pediatric Dentistry to perform the trainings. ICAAP provides on-line training. Approximately 27,000 unduplicated children under age three received a fluoride varnish application in a pediatric practice. The goal is to prevent early childhood cavities and one of the impacts is to improve access to care.

The initiative has proven successful in improving access to dental care and studies confirm that fluoride varnish application is effective at reducing early childhood cavities in young children (under age three). IDPH & ICAAP are working with local health department MCH programs to assure integration of oral health and Bright Smiles From Birth to provide preventive oral health care and oral health education to high risk children and their families.

Developmental Screening

During FFY2014, HFS and DHS continued collaborating to improve linkages between primary care providers and Early Intervention. HFS and DHS aligned the language included in consents obtained from parents/guardians to assure provides consistent wording regarding the release of information. This assures that consents obtained when a referral is made to Early Intervention using the *Standardized Early Intervention Referral Form* is consistent with the consent forms used by DHS' Early Intervention program. By aligning the language regardless of whether the family consents at the physician's office or upon contacting Early Intervention for services, information can be shared with the child's primary care provider so the provider receives information from Early Intervention about the child's eligibility for the program and what services they may receive, if eligible.

During July 2014, HFS published the *Standardized Illinois Early Intervention Referral Form* online via a provider Informational Notice. This form is used by medical providers and community-based organizations to initiate a referral to Early Intervention by submitting a standardized set of actionable information. The process includes a feedback form completed by Early Intervention to provide referral outcome information to the referring provider. This closing of the feedback loop assures the referring providers knows whether a family was able to be contacted by Early Intervention, whether an assessment was conducted, the outcome of the assessment and, if eligible for Early Intervention, what services the child will receive. More information about the referral process is in the Informational Notice available at: http://www.hfs.illinois.gov/assets/073014n1.pdf.

EPSDT

Efforts to improve the EPSDT participation rate include the mailing of annual notices to families with children, and separate notices when a child is due for a screen, based on the periodicity schedule. IDHFS' medical home initiative, Illinois Health Connect (IHC), provides monthly panel rosters to primary care physicians (PCPs) that identify patients and whether the patients have received certain clinical services based on IDHFS claims data. In addition, IHC PCPs have the opportunity to receive bonus payments by meeting or exceeding benchmarks for particular services, including the percent of children in the practice who receive designated immunizations by age 24 months, the percent of children in the practice who receive at least one objective developmental screening by and between certain age ranges, and the percent of children in the practice who receive at least one capillary or venous blood test for lead poisoning by their 2nd birthday. IHC also conducts outbound calls to remind clients when they are due for services and will assist clients in scheduling an appointment with the child's PCP. If IHC assists a client to secure an appointment with their PCP, IHC will mail the client a reminder notice 7 days prior to the appointment.

CHIPRA

CHIPRA quality grant activities with HFS and ICAAP continue with the mission of improving health outcomes for children. A new Illinois CHIPRA Patient-Centered Medical Home (PCMH)-Asthma Learning Collaborative is beginning with 20 practices that will strengthen the foundation for PCMH and make best practice changes to improve health outcomes for children with asthma that may be replicated with other chronic conditions. CHIPRA grant efforts with primary care practices will continue to promote coordination of existing child health improvement activities and planning for development of a comprehensive strategy to improve children's health in publicly financed programs in Illinois. The CHIPRA Medical Home Incentives Workgroup issued recommendations to IDHFS on adoption and financing of patient-centered medical homes (PCMH) in the Medicaid/CHIP programs and medical home requirements were incorporated into managed care contracts.

A PCMH Learning Collaborative involving 15 primary care practices was launched in May 2014, with a clinical focus on asthma. Practices worked to adopt PCMH principles and asthma care management into their practices using plan-do-study-act cycles, best practices, and quality improvement science. The collaborative concluded in February 2015 and data shows significant improvement in adoption of PCMH principles and asthma care management. A final report is forthcoming. In addition, technical assistance was provided to two practices in applying for PCMH recognition.

State Action Plan Table

Adolescent Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Empower adolescents to adopt healthy behaviors	By 2020, increase the percent of adolescents with a past-year preventive medical visit by at least 5% (2020 obj. = 93.1%)	Promote adoption of school-based programs that aim to prevent substance use, violence, and other risky behaviors. Expand support for and coordination of school-based health centers. Promote healthy sexual choices and behaviors for adolescents through primary prevention and health education programs. Support pregnant and parenting teens to prevent subsequent pregnancies and encourage achievement of educational goals. Work with school-based health centers to assure that adolescents are receiving appropriate risk screenings and education on healthy lifestyles.	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a mental/behavioral condition who receive treatment or counseling Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile) Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

Assure appropriate transition planning and services for adolescents and young adults, including youth with special health care needs						

Adolescent Health - Plan for the Application Year

According to the 2015 MCH Needs Assessment findings, the primary issues negatively impacting adolescent's health and well-being are injury, violence and mental health. The homicide rate in Chicago is 51 per 100,000, which is nearly 10 times the Healthy 2020 goal of 5.5 per 100,000. While the Title V program has recognized the impact of trauma on the provision of services to this population, injury and violence prevention are areas of opportunity for the Title V program, as our primary focus has been on teen pregnancy prevention. Below are the strategies we have identified to improve the health and well-being of Illinois' adolescents:

Promote the adoption of school-based programs that aim to prevent substance use, violence and other risky behaviors.

Expand support for and coordination of school-based health centers

Promote health sexual choices and behaviors for adolescents through primary prevention and health education programs

Support pregnant and parenting teens to prevent subsequent pregnancies and encourage achievement of educational goals

Assure school-based health centers provide adolescents appropriate risk screenings and education on healthy lifestyles.

The Title V program will enhance healthcare services provided to adolescents in School-Based Health Centers by offering incentives for the completion of well-child visits, including pre/inter-conception care to adolescents.

In the coming year the Title V program will enhance the effectiveness of the Primary Teen Pregnancy Prevention program by competitively bidding the program and requiring the use of evidence-based interventions.

While collaboration with the state's Home Visiting system will continue, the Healthy Families Illinois and Parents Too Soon programs have been moved to alternate funding streams.

Adolescent Health - Annual Report

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	89.5	90.3	91.2	92.1	93.1

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

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

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

The Illinois Subsequent Pregnancy Prevention (ISPP) program helps first time adolescent mothers delay a second pregnancy and remain in and complete high school and to ensure the teen and her child are healthy and prepared for school by providing an integrated model of service delivery with two primary interventions: intensive home visiting coupled with substantive training through membership in a peer support group. According to a MacArthur supported ten year evaluation (summary attached), ISPP has the lowest repeat pregnancy rates among other community-based programs around the country (3%) and gradua-tion rates among ISPP participants 19 years and older (70%) are TWICE THE NATIONAL AVERAGE for pregnant and parenting teens (Philliber, 2009). For the last five years, 90% of the young mothers in ISPP who are eligible to graduate receive their high school diploma; and a majority are now going on to college. Seven of ISPP participants have their Masters Degrees and 5 have returned to program to work as Subsequent Pregnancy Home Visitors.

IDHS provides prevention, diversion and intervention services targeting youth to support families in crisis, prevent juvenile delinquency, encourage academic achievement and to divert youth at risk of involvement in the child welfare and juvenile justice systems. The Department also funds a demonstration project to provide re-entry services for youth exiting juvenile correctional facilities. IDHS provides support to the Illinois Juvenile Justice Commission, the Redeploy Illinois Oversight Board. The Department also funds community-based prevention initiatives, training and education for youth in the areas of substance abuse and delinquency prevention, and volunteerism.

State Action Plan Table

Children with Special Health Care Needs

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Facilitate the integration of services within patient-centered medical homes for all children, particularly for children with special healthcare needs	By 2020, increase the percent of children with special healthcare needs receiving care in a medical home by at least 10% (2020 obj. = 51.0%)	Collaborate with ICAAP and HFS to continue to promote development of medical homes for all children, especially for CYSHCN, through website links with the AAP National Medical Home website for resources for practices. Assist Medical Home providers to connect families to community resources through DSCC regional office staffs. Work with F2F, Family Advisory Council and DSCC care coordinators to develop and/or review communication tools re: medical home for families. Utilize DSCC website to post information about the benefits of having a medical home. Post items on FaceBook page to promote medical homes and initiate conversations about what makes a good medical home.	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health Percent of children ages 19 through 35 months, who have received the 4:3:1:3 (4):3:1:4 series of routine vaccinations Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	Percent of children with and without special health care needs having a medical home		

Assure appropriate transition planning and services for adolescents and young adults, including youth with special health care needs	By 2020, increase the percent of youth with special healthcare needs who received comprehensive transition planning services by at least 10% (2020 obj. = 49.8%)	Continue to co-sponsor the annual Transition Conference, including participation on the planning committee and supporting DSCC youth and their families to attend. Maintain Transition Tips and Tools materials that support transition planning on DSCC website. Post transition opportunities on FaceBook. Provide training updates on Transition to DSCC care coordinators. Provide presentations on Transition to community groups. Continue coordination/collaboration efforts with Early Intervention, Home Visiting, local health departments, provider groups, HFS, Medicaid MCOs, F2F, and other community groups to address system barriers. Continue Action Learning Collaborative team efforts to implement the National Standards for Systems of Care for CYSHCN.	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care		

Children with Special Health Care Needs - Plan for the Application Year

DSCC currently has a team participating in the Action Learning Collaborative to promote the National Standards for Systems of Care for Children with Special Health Care Needs. The team has developed a training webinar for families and health care professionals on Family Professional Partnerships to improve the understanding of families and professionals about the importance of these partnerships as the basis of comprehensive systems of care for CYSHCN. A meeting is planned for September 21, 2015, to introduce these Standards to a wide range of stakeholders, including families, legislators, hospital systems, managed care organizations contracted with the Medicaid program, state agencies, early childhood advocates, federally qualified health centers, rural health centers, and other advocacy groups. One of the objectives of the meeting is to begin discussions around how to move forward in using these Standards to improve the systems of care in Illinois. Those discussions will help DSCC gain additional partners and develop further plans for using these Standards.

Medical Home:

DSCC will continue to collaborate with ICAAP and Healthcare and Family Services to promote development of Medical Homes for all children, especially for CYSHCN, including website links with the AAP National Medical Home website for resources for practices. DSCC participated with the HFS CHIPRA grant in the past on acceptable accreditations and incentives for promoting Medical Homes; however, changes in administration have been a barrier to implementation of those recommendations. DSCC will continue to work with HFS to include measures in their MCO contracts for Medical Homes.

One of the most successful strategies that DSCC has found was to connect DSCC care coordinators as resources to Medical Home providers to connect families to community resources. This strategy will continue. Additionally, DSCC has developed some materials to explain Medical Homes to providers and families. These materials and communication tools will be reviewed, revised and new ones developed if necessary. This review will include input from the DSCC Family Advisory Council, the Family-to-Family Health Information Center, and DSCC care coordinators. A specific item for review is the DSCC Family Handbook that tells families how DSCC can help them. Information about Medical Home will be reviewed and improved.

DSCC has a new, improved, more family-friendly website on which information about the benefits of having a medical home, including newsletter items, will be posted. DSCC also now has a presence on FaceBook and will promote Medical Homes there and initiate conversations about what makes a good medical home.

DSCC will continue to coordinate/collaborate with Early Intervention service coordinators, Home Visiting staff, local health departments, provider groups, HFS, Medicaid MCOs, F2F, and other community groups to address system barriers.

Transition:

DSCC will continue to promote transition planning for youth with special health care needs by continuing strategies that have been successful and implementing new ones. DSCC will continue to co-sponsor the annual statewide Transition Conference, including participation on the planning committee and supporting DSCC youth and their families to attend. DSCC's website has a number of Transition Tips and Tools materials that support transition planning. The e-newsletter will also be used to provide articles and tips for transition. DSCC will use its presence on FaceBook to promote transition opportunities and discussions. DSCC has provided numerous presentations to youth/parent groups and will continue to do so. For families whose children are enrolled in DSCC programs, care coordination staff will continue to address transition planning. Training updates on working with families and youth on transition will be provided to DSCC care coordinators.

Children with Special Health Care Needs - Annual Report

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	47.2	48.1	49	50	51

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	46.2	47.1	48	48.9	49.8

Families Partnering in Decision-Making at All Levels: The redesigned UIC-DSCC website was activated and includes links to social media (FaceBook) to promote communication with families and providers about UIC-DSCC programs and services and provide linkages to other resources. Helping families find what they want quickly and accurately in new ways was the goal during development of the new website.

The Family Advisory Council (FAC) piloted the revised family survey for the needs assessment and provided feedback. The survey was mailed with on-line options in English and Spanish. There was a section for families to comment on the services and supports they received and identify unmet needs.

Additional families were encouraged to share their stories to help update the UIC-DSCC website. FAC recruitment efforts were renewed to identify potential families who may have valuable contributions. The Family Liaison supports the FAC, provides outreach to other initiatives, and promotes a family partnership approach.

The Family Liaison continues to provide training to new care coordination staff on family-centeredness and family partnership. Efforts continued to redesign training for new staff with a greater emphasis on understanding the life span of individuals and families.

The Family Liaison continued leading a father's support session during the Institute for Preschool Children who have Hearing Impairment. Parent to Parent support for families of children with hearing loss statewide continued using the Guide By Your Side model.

Medical Homes: UIC-DSCC continued collaborative efforts with the Illinois Chapter of the American Academy of Pediatrics (ICAAP) on the HRSA Integrated Community Systems for CSHCN grant to improve access to quality services through medical homes for children and families who receive healthcare through the Cook County Health and Hospital System (CCHHS) Ambulatory and Community Health Networks (ACHN), a network of federally qualified health centers. Grant activities included improved processes for developmental screening, transition of care from the hospital and/or Emergency Department to the medical home, collaboration with Early Intervention (EI) service providers to ensure children were successfully integrated into and receive EI services, expanded use of registries and coordination with community partners to enhance coordination of care.

CCHHS initiated a system-wide Patient-Centered Medical Home (PCMH) with a focus on coordination of care within the Cook County Health System among all levels of care and across practice settings through the Chicago area Medical Home Network Connect Portal.

UIC-DSCC collaborated with ICAAP on improving coordination of care utilizing home visitors to facilitate the relationship between families and medical homes in 6 regions of the state. These efforts provide medical home providers a view into the families' home lives so they can more effectively provide health care services.

Adequate Private and/or Public Insurance: Training on maximizing public and private funding sources continued to be provided to new care coordination staff. Staff continued to monitor and analyze state and federal legislation for impact on CYSHCN health care funding. Staff continued to help CYSHCN explore benefits available through the ACA legislation and, if applicable, enroll in expanded Medicaid or the Marketplace. UIC-DSCC staff received training on the online All Kids/Medicaid application so they can assist families in applying. Technical assistance was provided to care coordination teams with current information regarding health insurance and public funding as well as assistance with individual CYSHCN issues, including contacting health insurance carriers and the state Medicaid program to clarify coverage issues. UIC-DSCC continued to assist financially eligible families with the payment of private insurance co-pays and deductibles for specialty care and for eligible care not covered by private or public insurance.

Community-Based Systems of Services: UIC-DSCC continued collaborative efforts with ICAAP on the HRSA Integrated Systems grant focusing efforts in the Ambulatory and Community Health Network in Cook County. Staff continued participating with HFS on CHIPRA grant activities to improve quality of care for children and access to medical homes. A work group investigated and developed recommendations to HFS to incentivize physician practices to become Medical Homes for children. Staff also

continued attending HFS meetings regarding care coordination and children with complex medical needs.

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

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

The new website http://dscc.uic.edu/ was activated and new features, including social media, added.

UIC-DSCC staff continued to participate in system building activities related to newborn screening, newborn hearing screening, Early Intervention, transition and medical home and referral to the Prioritization for Urgency of Unmet Need for Services (PUNS) program for persons with intellectual/developmental disabilities. Staff also continued to contact families having children up to age 16 years, newly eligible for SSI, to help them to connect with needed services.

NPM 6 Transition: UIC-DSCC continued identifying opportunities to increase the number of families of CYSHCN receiving services necessary to make appropriate transition to adult health care, work and independence. Training on transition assessment, strategies to promote discussion, available anticipatory guidance, community supports, resources and required follow-up was provided to care coordination teams.

Physicians were encouraged to take an active role in transition through various strategies, including the Transitioning Youth to Adult Health Care courses for physicians available at: http://icaap.knowldgedirectweb.com and through contacts with providers, conference presentations, medical home teams and website links. DSCC has also given presentations to provider groups, such as transition planning and services given to health care providers at the Erie Family Health Center, a Federally Qualified Health Center.

UIC-DSCC coordinated the health care track for the annual Statewide Transition Conference and participated on the conference steering committee. The 9th annual statewide conference held October 2013 provided another educational opportunity for physicians, other health care professionals, families, transition age youth, care coordinators and community providers. UIC-DSCC supported 6 youth and their families to attend the Transition conference.

The UIC-DSCC Resource Directory continued to provide important transition resources including Transition Milestones and Transition Skills, Tips and Tools, http://dscc.uic.edu/browse-resources/transition-resources/

Care coordination teams continued information sharing with youth, families, community providers, physicians, IEP teams, and vocational rehabilitation

Care coordination teams continued information sharing with youth, families, community providers, physicians, IEP teams, and vocational rehabilitation specialists in a variety of forums.

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

HRSA funding (2011-2014) was awarded to UIC-DSCC to reduce loss to follow-up. Grant goals included increase parent/ provider education of the 1-3-6 EHDI initiatives, reduce loss to follow-up, improve timely outcomes for infants, and surveillance for late-onset loss. Activities supported data reporting, collaboration with parents of children with a hearing loss to educate stakeholders, implementation of standardized online training on objective screening, and implementation of quality improvement strategies at birthing hospitals.

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

Highlights of annual statewide meetings: Bridges for developmental therapists-hearing/interventionists (63 participants), Academy of Audiology (229 participants), Head Start Association (190 participants), Teachers of Deaf and Hard of Hearing (249 participants), day long parent conferences, GBYS Parent Guide training (17 participants), and Parent Institute for Families; EHDI webinars/teleconferences for stakeholders; production /dissemination of quality improvement materials and Governor declared EHDI day recognizing stakeholders; direct parent-to-parent support (89 families); technical assistance on objective hearing screening (impacting > 25,000 children); CSHCN identification of 61 pediatric audiology sites; and CSHCN care coordination and support for diagnostic hearing evaluations and follow-up for children with hearing loss. UIC-DSCC applied for the competitive HRSA funding for 2014-2017 to reduce loss to follow-up after newborn hearing screening and was awarded the maximum amount of funding.

IDPH EHDI used CDC grant funding to improve the Hi*Track data system and implement quality assurance activities with reporters. For this period, 705 infants were reported to IDPH; 99.0% of the infants were screened prior to discharge with 0.4% deceased and 0.6% not screened to date. Of those screened 3.5% referred and 193 have a confirmed hearing loss. This data is within the nationally established targets.

Comprehensive Transition Planning for CSHCN Ages 14 and Above and Their Families: Transition resources were included on the redesigned UIC-DSCC website. The DSCC transition workgroup assisted in development of the introduction and descriptions for the Transition Milestones Skills Lists and supporting Skills, Tips & Tools to enhance the message and outreach to youth and families.

A new Transition tool on decision making and problem solving was developed. The tool on chores was revised. Staff training on transition was also developed. This training complements the new web-based care coordination information system and demonstrates transition assessment, planning, documentation and follow-up with youth and families using the new record format, reminders and letters.

Staff worked to improve access to high quality, developmentally appropriate, uninterrupted health care through facilitating transition to adult health care providers, referring

to appropriate resources, providing anticipatory guidance and developing person-centered plans. Staff has continued participation and outreach on local transition planning committees, transition fairs and transition related in-services. A survey of staff was done to identify physicians who are willing to accept these youth with special healthcare needs into their adult-oriented medical practice. This continued to be an ongoing need.

A review of 472 records showed continued effort to ensure 73.9% of youth over 14 years of age enrolled with UIC-DSCC and their parents/guardians received comprehensive transition planning from UIC-DSCC staff. The review showed that for those youth ages 14-21 years that had some aspect of transition addressed, 51.3% (SFY'13, 43.7%) received planning information on health care transition; 48.3% (SFY'13, 48.0%) received information on transition to work; and 46.6% (SFY'13 39.3%) on Independence. Data reflects only UIC-DSCC care coordination efforts in transition planning.

State Action Plan Table
Cross-Cutting/Life Course

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Assure that equity is the foundation of all MCH decision-making; eliminate disparities in MCH outcomes	By 2020, reduce the black-white disparity in infant mortality to no more than 2.0 (2010-2014 average was 2.8). By 2020, increase the percent of families who reported their child's healthcare provider "always" was sensitive to their family customs and values by at least 10% (2020 obj. = 81.2%).	Promote the use of SDOH framework in health disparities interventions, including the development of health policies and prevention strategies. Establish methods to educate and empower women and their families to manage diseases that disproportionately affect minority groups. Promote the expansion of safety-net providers and their capacity to offer primary health care to minority groups and uninsured and underinsured populations. Create reproductive social capital in vulnerable communities.				

Partner with consumers, families and communities in decision-making across MCH programs, systems and policies	By 2020, increase the percent of children receiving family-centered care by at least 10% (2020 obj. = 74.4%) By 2016, develop a state performance measure and 5-year performance objectives related to this priority.	Enhance coordination and integration of family support services. Educate providers to encourage family partnership in decision making and family-centered care within pediatric medical homes. Invest in community building and urban renewal. Strengthen father involvement, especially in African -American families. Support the implementation and maintenance of Family Councils containing a cross-representation of consumers from each of the State's geographic regions and the MCH domains.				

Strengthen the MCH capacity for data collection, linkage, analysis, and dissemination; Improve MCH data systems and infrastructure	By 2016, implement a request process/system to organize data and analysis requests. By 2017, complete the linkage of birth and infant death certificates to allow for detailed analysis of infant mortality. By 2016, develop a state performance measure and 5-year performance objectives related to this priority.	Support and facilitate data linkages across administrative, programmatic, and surveillance databases. Increase staff capacity for data management, analysis and translation through training and workforce development. Implement a standardized data request system to manage and organize internal and external data requests. Forge partnerships with other divisions, offices, departments, and organizations that will increase the availability of relevant and timely MCH data for Title V staff.				

Support expanded access to and integration of mental health services and systems for the MCH population.	By 2016, develop a state performance measure and 5-year performance objectives related to this priority.	Encourage and support routine psychosocial assessment in healthcare and in MCH services. Support the creation and distribution of screening tools to identify individuals in need of services and the capacity to receive such services. Improve screening for perinatal depression during well-woman, prenatal, and well-child care. Required contracted providers to receive training on trauma-informed care and Motivational Interviewing.				

	By 2020, increase the percent of pregnancy women who receive dental services during pregnancy by at least 20% (2020 obj. = 57.0%). By 2020, increase the percent of children ages 1-17 who received at least one preventive dental visit in the past year by at least 5% (2020 obj. = 84.8%).	See also priority action plans for adverse birth outcome priority ("perinatal health") and medical home for children ("child health"). Develop and implement CME training to educate obstetricians, dentists, and other well-woman providers on the association of poor maternal oral health and preterm/low birth weight and early childhood caries. Identify opportunities to link children's medical homes to dental homes and support integration of care.	Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months Percent of children in excellent or very good health	A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year		

	By 2020, decrease the percent of women who smoke during pregnancy by at least 15% (2020 obj. = 5.6%). By 2020, decrease the percent of children exposed to environmental tobacco smoke in the home by at least 15% (2020 obj. = 17.9%).	Identify local and regional risk factors for prenatal tobacco through analysis of birth outcomes data. Create and implement local and regional prevention strategies aimed at preventing adverse birth outcomes based on risk identification. Link back to priorities on reducing adverse birth outcomes (Perinatal/Infant health domain) and medical home for children (Child Health/CSHCN domains).	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births Percent of children in excellent or very good health	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes		

Cross-Cutting/Life Course - Plan for the Application Year

OWHFS Data and Epidemiology Team

The continuation of a state priority focusing on data capacity and infrastructure demonstrates the commitment of OWHFS to ensuring that programs are well-supported with sound science and evidence. The office envisions a continuous process of improving the state MCH data systems, gaining access to relevant data sets housed in other state agencies, and developing greater staff capacity for analysis and support. There are four overarching strategies that will guide the work on the data priority:

Strategy #1: Support and facilitate data linkages across administrative, programmatic, and surveillance databases. Improving OWHFS' capacity for high-quality epidemiologic analysis is dependent upon improving the interoperability of MCH data systems to enhance information available on women's and children's health. Data linkage is a priority strategy for the upcoming fiscal year, with two key linkages being focus areas for OWHFS. The first linkage of interest is to create a linked birth-infant death file to enhance infant mortality surveillance and research. Illinois has not has a matched infant birth-death file since 2008, when a shift to a new electronic data system for vital records and lack of staff resources required the discontinuation of this link. OWHFS plans to take the lead on initiating conversations with key IDPH partners about the importance and feasibility of linking the birth and infant death files. The second data linkage of interest is that of birth files and maternal and infant hospital discharge records. OWHFS will work with the Division of Patient Safety and Quality (manager of hospital discharge data) and the Division of Vital Records (manager of birth files) to support the linking of these systems and will contribute to the development of a work plan and timeline.

Strategy #2: Increase staff capacity for data management, analysis and translation through training and workforce development. The CDC assignee has recently initiated bimonthly data team meetings for the OWHFS staff members whose positions include data roles and functions. These team meetings will serve as a forum for staff to learn about what others are working on with respect to their programs data, and will facilitate the sharing of information across staff members. This will also be a forum for developing a cohesive data agenda that can coordinate the data-related efforts across OWHFS. This may include developing guidelines for how OWHFS reports indicators (e.g., using standard definitions of race/ethnicity). The CDC assignee will also use this group as a way to assess the office capacity for data collection, management, analysis, and dissemination and to identifying training needs for staff. The coordination of this group is in its infancy, but is planned to continue through the coming fiscal year.

Strategy #3: Implement a standardized data request system to manage and organize internal and external data requests. During the coming fiscal year, the OWHFS data manager and CDC assignee will work to develop a protocol and policies on the sharing of data in individual and aggregate forms. This will include review of IDPH statutes / regulations, discussion with the IDPH legal team, and development of standards around the way that data is reported in aggregate form. They will also develop a standardized process by which internal programs and external organizations can request data access or analytic assistance from the OWHFS data team.

Strategy #4: Forge partnerships with other divisions, offices, departments, and organizations that will increase the availability of relevant and timely MCH data for Title V staff. Because few of the population-based datasets are housed or managed directly by OWHFS, staff access to many important MCH datasets is dependent on collaboration with other IDPH divisions and with other state agencies. Continued partnership is needed to maintain OWHFS direct access to data systems such as: vital records (IDPH Division of Vital Records), PRAMS (IDPH Center for Health Statistics), BRFSS (IDPH Center for Health Statistics), Hospital Discharge data (IDPH Division of Patient Safety and Quality). The data team will continue to invest in these partnerships and to work collaboratively to demonstrate the importance of the data sharing agreements that are in place. In addition, the data team will work to develop new data sharing partnerships, such as those with Medicaid, the Department of Human Services. When possible and relevant, Title V may financially contribute to the improvement of population-based data systems to ensure the availability of timely data. This may include financial support to improve data collection procedures (one potential opportunities includes: funding PRAMS outreach and incentives), as well as the OWHFS offering staff time and resources for data linkage and analysis. This strategy will also involve continued partnership with the UIC-SPH for technical assistance and advising on epidemiological issues, including potential partnerships with faculty, students, and interns who can support the OWHFS data agenda.

During FY2016, the action plan for each of these strategies will be further developed and the data team will create a state performance measure that can capture changes in capacity and infrastructure over time.

Cross-Cutting/Life Course - Annual Report

NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	49.4	51.3	53.2	55.1	57
Annual Objective	81.6	82.4	83.2	84	84.8

NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	6.8	6.5	6.2	5.9	5.6
Annual Objective	20.4	19.8	19.2	18.6	17.9

Medicaid Agency - Illinois Department of Healthcare and Family Services (HFS)

Illinois Health Connect

Illinois Health Connect continued to operate as a statewide Primary Care Case Management (PCCM) program for most persons covered by All Kids or FamilyCare. Participants are assigned to a medical home through a Primary Care Provider (PCP), which ensures that clients have access to quality care from a provider who understands their individual health care needs. A client's PCP serves as his/her medical home by providing, coordinating and managing the client's primary and preventive services, including well child visits, immunizations, screening, and follow- up care as needed. Having a PCP also helps those with chronic conditions like asthma, heart disease or diabetes to get the treatment and ongoing care they need to minimize the need for hospital care. The PCP will also make referrals to specialists for additional care or tests as needed. At the end of SFY14, there were over 1.7 million clients enrolled in PCCM. Information about the program is provided at www.illinoishealthconnect.com.

For SFY2015, the Primary Care Case Management program was the Department's first step toward implementing managed care throughout the state. Currently, Illinois is in the midst of increasing its healthcare delivery systems to ensure it is more patient-centered, with focus on improved health outcomes, enhanced patient access, and patient safety. These efforts include expanding the current healthcare delivery system to assist the state in meeting the Medicaid reform law under P.A. 96-1501 and the Affordable Care Act (ACA) initiatives.

To meet these goals, upwards of 1.5 million people on Medicaid and All Kids in five mandatory managed care regions, including those individuals currently enrolled in Illinois Health Connect in those regions, will be moved into some form of Care Coordination with a Managed Care Health Plan. This means that during the reporting period for SFY 2015, a large number of clients currently enrolled in Illinois Health Connect will join Managed Care Health Plans for their care coordination services. Illinois Health Connect will continue to be a choice for clients in the non-mandatory managed care regions; however, it will no longer be a statewide Health Plan Choice for clients. Illinois Health Connect will also provide some program support for the CCEs and ACEs.

Voluntary Managed Care (VMC) -- Three Managed Care Organizations (MCOs) participated in the Voluntary Managed Care program serving certain Title XIX and Title XXI participants. Family Health Network served participants in Cook County. Harmony Health Plan served participants in Cook, Jackson, Kane, Madison, Perry, Randolph, St. Clair, Washington and Williamson counties. Meridian Health Plan served the counties of Adams, Brown, Cook, DeKalb, Henderson, Henry, Knox, Lee, Livingston, McHenry, McLean, Mercer, Peoria, Pike, Rock Island, Scott, Tazewell, Warren, Winnebago and Woodford. The VMC contracts ended in June 2014, and those 3 health plans (FHN, Harmony, and Meridian) transitioned to FHP-ACA plans, described in the 2015 section.

In July 2014, HFS implemented the Family Health Plan – Affordable Care Act Program. This program serves women, children and the ACA adult population. The goal was to expand the VMC

In July 2014, HFS implemented the Family Health Plan – Affordable Care Act Program. This program serves women, children and the ACA adult population. The goal was to expand the MMC program into a fully integrated care coordination program to serve all of the clients' needs. Nine MCOs now participate in the program, including Aetna Better Health, Blue Cross Blue Shield, CountyCare, Family Health Network, Harmony, Health Alliance, IlliniCare, Meridian and Molina. As of February 2015, there were 1,117,212 million clients enrolled in this program. Enrollment by region and health plan can be found at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/FHPEnrollment.aspx

Integrated Care Program -- In 2011, HFS implemented the Integrated Care Program (ICP) in six Illinois counties. The program provided health care coverage to approximately 40,000 seniors and persons with disabilities s residing in the counties of DuPage, Kane, Kankakee, Lake, Will and suburban Cook (non-606 ZIP codes). This mandatory program covers the full spectrum of Medicaid services through an integrated care delivery system. Two MCOs participated in the pilot ICP program -- Aetna Better Health and Centene-IlliniCare. Members received standard Medicaid services in the first year of the program (known as Service Package 1), followed by long-term care services (known as Service Package 2) in subsequent years. This included Home and Community-Based Service (HCBS) waivers, allowing participants to receive non-traditional services in the community or in their own homes, rather than being placed in an institutional setting.

In 2013, HFS expanded the ICP to include the Rockford region (July 2013), the Central Illinois region (September 2013), the Metro East region (September 2013) and the Quad Cities region (November 2013). ICP expansion continued in 2014, with the addition of MCOs including Molina Healthcare, Meridian, Health Alliance, Community Care Alliance of Illinois, and CountyCare, and later Blue Cross Blue Shield, Cigna-HealthSpring, and Humana. As of February 2015, there were 120,000 clients enrolled in an ICP health plan. These plans are expected to continue to participate in ICP for the duration of 2015.

Data Integration

Enhanced data integration is well underway in Illinois as evidenced by the data sharing interagency agreement, EDW and IDHS' role in both. Illinois is poised to conduct analysis and research using an immense data warehouse. Prior to that end, Illinois must develop capacity to "mine" the warehouse for pertinent data and approach the data from an epidemiological perspective. Ultimately, this is the purpose of Illinois' State System's Development Initiative. The Department of Human Services (DHS) continues to export MCH service files from its Cornerstone system to the HFS Enterprise Data Warehouse (EDW). Staff members of Program Planning and Development (PPD), IDHS, have security access to the EDW. In 2012, PPD staff used the EDW to match Medicaid recipients with maternal and child health service data in the Cornerstone system. Because the EDW employs a sophisticated matching algorithm, results of the Medicaid/Cornerstone match demonstrated a marked improvement in the efficiency of the process as compared to results of the previous method of matching two distinct data files. The algorithm for identifying women with a potentially high-risk pregnancy was piloted in FFY 14.

Illinois is using integrated interagency data to conduct analyses relavant to MCH program and policy development. Furthermore, data is being used to identify women with a potentially high-risk pregnancy and to enroll them into case management services. This information is also being shared with respective managed care organizations. Work is under way to share Newborn Screening data between IDPH and IDHFS.

Medical Homes

HFS promotes quality medical homes in the PCCM and Integrated Care programs. The CHIPRA project requires implementation of child health measures that are being incorporated into the PCCM and MCO contracts. CHIPRA efforts continue in assisting primary care practices that have completed the NCQA assessment to make necessary improvements to achieve NCQA medical home recognition, if they desire. As part of the CHIPRA grant effort, ICAAP has 12 pediatric and family physician practices actively engaged in a medical home learning group. UIC-DSCC provides facilitation to 4 additional pediatric practices. The Primary Care Case Management program assures that enrollees receiving care through the fee-for-service delivery system are assigned to medical homes. IDHFS recently completed the transition of more than 50% of its covered population to a care coordinated delivery system. Each of the health plans is required to assure that all enrollees have medical homes.

OWHFS Data and Epidemiology Team

In July 2013, the Illinois Title V (Maternal and Child Health Services) Block Grant was transferred from the Illinois Department of Human Services (IDHS) to the Illinois Department of Public Health (IDPH), Office of Women's Health and Family Services (OWHFS). Improving the data capacity of the Title V program was one of the major reasons for the agency change because many population-based datasets for women's and children's health were housed in IDPH. Subsequently, the OWHFS has placed a strong emphasis on developing the data capacity and infrastructure of the Title V program. To

that end, an Intergovernmental Agreement (IGA) between IDPH-OWHFS and the University of Illinois at Chicago School of Public Health (UIC-SPH) was enacted in January 2014 to allow UIC-SPH faculty and students in the maternal and child health epidemiology program to serve as epidemiologic consultants and data analysts for Title V. Dr. Deb Rosenberg, Research Associate Professor in Epidemiology and Biostatistics, served as the lead epidemiologist for the IGA grant and its projects. Under the IGA, Dr. Rosenberg employed one doctoral student and one master's in public health student to carry out data analyses and projects related to Title V work. This IGA has provided IDPH-OWHFS with epidemiologic technical assistance, support, and consultation in ways leading to more systematic use of the array of data housed within IDPH and other state agencies. The IGA also eased the burden of data access by allowing UIC-SPH staff to act as IDPH employees in matters related to data sharing, extraction, and analysis.

Major projects and accomplishments of the UIC IGA team during FY2014 included:

- Collaborated with the IDPH Division of Patient Safety and Quality to analyze birth data on early elective delivery, create hospital-specific data sheets, and send a letter encouraging hospitals to adopt hard stop policies against this practice
- Served as core writers for relevant grant and special project applications, including: SSDI full application and supplement, Every Mother Initiative, Perinatal Quality Collaborative, application for a CDC MCH epidemiology assignee, and AMCHP Life Course Indicator Technical Assistance Project
- Conducted epidemiological analysis on key topics of interest for Title V, including: obesity and risk factors among women of reproductive age, teen birth in Southern Illinois, safe sleep behaviors and risk factors, and an exploration of geographic disparities in MCH that highlight rural health needs.
- Compiled and analyzed data needed to report on the required performance measures in the Title V 2013 Annual Report, including the development of standardized protocols to improve the measurement of several key indicators that were without documentation from previous years
- Provided data support and technical assistance to the Illinois teams participating in the Collaborative Innovation and Improvement Network to Reduce Infant Mortality (CoIIN), including presenting relevant data analyses to the workgroups
- Served as data lead on the Illinois Perinatal Quality Collaborative (IL-PQC) and member of Leadership Team; provide technical assistance on data collection, analysis, and reporting
- Examined data quality issues on birth certificates to inform the state's Birth Certificate Data Quality Improvement Project that was kicked off in November 2014 in a collaboration between OWHFS, IDPH Division of Vital Records, ILPQC, and the Illinois Hospital Association.

FY 2014 was also a year for re-organizing and expanding internal OWHFS epidemiology support and expertise. After working to fill vacant positions and to create new positions, the OWHFS was able to employ one data manager and four program data staff who support the day-to-day data collection and reporting activities of OWHFS programs. Additionally, in December 2014, OWHFS was able to bring on a full-time CDC Senior Epidemiology assignee who now serves as the Team Lead for all MCH-related epidemiological work. Under the leadership of the CDC assignee, the MCH Epidemiology Team will focus on expanding Title V's data capacity and infrastructure by standardizing measurement, expanding access to additional data systems, facilitating data linkages, coordinating/streamlining data use, and promoting high-level epidemiological analysis.

Other Programmatic Activities

ASTHO Breastfeeding Project: OWHFS, in conjunction with funding from ASTHO, is working to increase maternity practices which support breastfeeding. In a very short time this project has yielded some amaz-ing results. Some of the goals included: increase in the current breast-feeding rate at Touchette Regional Medical Center of 30% for new moth-ers and successfully implement Skin to Skin contact within the First hour of life (current rate is 50%). April numbers show the breastfeeding rate rose to 56% from the March rate of 23%. The Skin to Skin rate went up in April to 69% from the March rate of 46%. Additionally, the project be-gan working with Decatur Women's Prison to provide support to their existing Mom's/Babies Program. The Decatur Women's Prison has re-ceived much needed support from this funding. They received hospital grade breast pumps, breast pumping supplies, breast pads and storage equipment. Further educational training will also be provided.

The Illinois Breast and Cervical Cancer Program (IBCCP) offers free breast and cervical cancer screening to women ages 35 to 64. OWHFS' IBCCP staff work closely with its 34 Lead Agencies to ensure that all clients receive timely diagnostic follow-up and that clients who need cancer treatment are referred to the appropriate source. Routine performance monitoring and high quality use of data to achieve positive program outcomes are great strengths of IBCCP. According to CDC's National Core Indicators Performance Report, IBCCP exceeded or met all eleven core indicators and scored higher than the national average in six categories. Based on Illinois' Octo-ber 2014 Core Indicators Performance Report, 97.9% of IBCCP women with an abnormal breast screening result received diagnostic follow-up and 96.6% started treatment. Of the IBCCP women who had an abnormal Pap, 97.3% completed follow-up and 94.1% started treatment, as treatment is not always necessary for abnormal Pap results based on the ASCCP cervical algorithms.

The Illinois WISEWOMAN (Well-Integrated Screening and Evaluation for Women Across the Nation) Program (IWP) extends pre-ventive health services to women who are participants of the Illinois Breast and Cervical Cancer Program (IBCCP) by focusing on reduc-ing cardiovascular disease risk factors such as high blood pressure, elevated cholesterol, obesity, sedentary lifestyle, diabetes, and smoking. IWP works closely with its seven local partners to ensure that eligible uninsured/under-insured women in Cook, Stephenson, JoDaviess, Carroll, Lee, Ogle, Tazewell, Fulton, Menard, Sangamon, and St. Clair Counties receive cardiovascular screenings to deter-mine their risk factors. Between July 1, 2014 and June 30, 2015, over 400 women received cardiovascular screenings and benefitted from personalized risk reduction counseling to reduce their individual risk factors. Over 300 women participated in at least one health coaching and/or lifestyle program session, such as the Expanded Food and Nutrition *Education Program, so they could increase their physical activity levels and improve their nutrition for healthier hearts.*

Home Visiting

The Illinois home visiting system embraces the State's early childhood vision of every child entering kindergarten safe, healthy, ready to succeed, and eager to learn. The Illinois home visiting system recognizes the home as the most influential learning environment in which to strengthen the parent-child relationship and help reach the child's full potential. The overall goals of Illinois home visiting are to promote positive parenting and healthy child growth and development, and to prepare young children for school success.

The Illinois home visiting system consists of **high-quality, intensive** services that:

1. Promote **parent-child attachment**;

2. Provide **developmental screening**, monitoring, and referrals; and

3. Provide **linkages to community resources and services**.

3. Provide **linkages to community** resources and services.

In Illinois, home visiting is supported by the following funding streams:

- FederalMaternal, Infant, and Early Childhood Home Visiting (MIECHV) Program – through the Health Resources and Services Administration (HRSA), as part of the Affordable Care Act of 2010

- Illinois Department of Human Services – General Revenue Funds

- Illinois State Board of Education – Early Childhood Block Grant

- Local private funders, such as the United Way

II.F.2 MCH Workforce Development and Capacity

II.F.3. Family Consumer Partnership

Through the creation of the MCH Family Council, the Illinois Department of Health (IDPH), Office of Women's Health (OWH) insures the intentional practice of working with families across the life course towards positive health outcomes. The establishment of this council provides a space for family leadership at individual, community, and policy levels.

The Council will provide feedback and offer recommendations on the implementation and evaluation of Illinois maternal and child health programming. Additionally, Council members share their perspectives on critical consumer issues and needs across the lifespan. The Council offers input on consumer engagement and involvement efforts to the Director of the Office of Women's Health and Program Directors by communicating issues of central importance to supporting family members.

IDPH will support Family/Consumer Partnerships in the following areas:

- Advisory Committees
- Strategic and Program Planning
- Quality Improvement
- Workforce Development
- Block Grant Development and Review
- Materials Development
- Advocacy

Below is an update on EverThrive IL's progress to date on the below deliverables:

1. *Compile and review with Department leadership several national evidence-based curricula and refine to fit Illinois' needs for enhanced community, family, and consumer engagement strategies to improve MCH outcomes.*

2. *Develop the infrastructure for and convene a MCH Family Council comprised of consumers of Title V programs to provide feedback and offer recommendations on the implementation and evaluation of IL MCH programming.*

During the second half of FY15, EverThrive IL and IDPH refined the program structure and framework of the MCH Family Council. EverThrive IL will use many of the tools developed by Family Voices, an organization that works on behalf of children and youth with special health care needs (CYSHCN) in the development of this Council. The mission of *Family Voices* is to advocate for health care services that are *family centered*, community-based, comprehensive, coordinated, and culturally competent for all children, *promote the inclusion of families* as decision makers at all levels of health care, and support essential partnerships between families and professionals.

While family engagement in the Title V CYSHCN programs is well established, this is the first such council that will address family involvement for the *entire MCH program population* in Illinois, and one of the only that will exist in the United States. In addition to the tools and resources provided by Family Voices, EverThrive IL is using components of the following evidence-based community engagement curricula to develop the council.

- Head Start Parent, Family and Community Engagement Framework
- FRIENDS: National Resource Center for Community-Based Child Abuse Prevention
- Allina Health Citizen Health Action Teams

As the Council is created they will approve their own mission, develop committee goals, set a meeting schedule, meet at an annual Illinois MCH conference, and generate a list identifying current best practices, challenges, and recommendations for improving programs.

The following goals were established for the first year of the Council:

- Create and maintain a MCH Family Council that represents Illinois consumers of Title V programs.

- Engage Illinois Council members for at least one year to improve systems and activities through program evaluation and implementation.

- Provide professional development opportunities and trainings for both Council members and program staff.

The Council intends to impact the following areas:

- Promotion of consumer and family centered program environment

- Consumer/family and provider partnerships

- A focus on health literacy

- Community partnerships

Additionally, EverThrive IL and partners will provide professional development opportunities and trainings for Council members.

In order to serve on the Council participants must be consumer or client of an IDPH OWH program and commit to serve at least one year. Eligible programs include:

- Illinois Healthy Women

- Illinois Healthy Women
- Family Case Manager
- Maternal, Infant and Early Childhood Home VisitingProgram (MIECHVP)
- Better Birth Outcomes (BBO)
- Illinois Breast and Cervical Cancer Program (IBBCP)
- Illinois WISEWOMAN Program
- Healthy Start

The Council will include representation from the 7 IDPH regions of the state: Champaign, Chicago, West Chicago, Edwardsville, Marion, Peoria, and Rockford. The participants will include men and women and represent the racial and ethnic breakdown of the region. The Council will consist of between three to four participants from each region, for a maximum of 28 council members

In FY16, EverThrive IL will develop the Council beginning with the following three regions: Edwardsville (East St. Louis), Chicago, and Rockford. EverThrive IL has very strong partners in these regions whereas the remaining four (Champaign, West Chicago, Marion, and Peoria) will require more relationship building. Health Department contacts in Edwardsville (East St. Louis), Chicago, and Rockford are very supportive of this project, and are helping recruit participants.

- Winnebago County Health Department – Rockford
- Chicago Department of Public Health – Chicago
- St. Clair County Health Department – Edwardsville

These participants from these three regions will take the lead on generating the framework and structure for the council and define goals and objectives. In year two, we will expand to the other four regions with a solid structure in place and understanding of the council's role, the lead participant role, etc.

The first meeting will be held in Cahokia, IL in the Edwardsville Region on Saturday, May 30, 2015 with three program participants that agreed to participate. This initial meeting will be an introduction to the Council, discussion of level of commitment, and a needs assessment of the participant's experience with Title V programs. The following questions were adapted from the IDPH Title V Needs Assessment recently completed.

1. What Title V programs have you participated in

2. What are strengths of the services you received?

3. What can be done to strengthen existing health services for you and your family?

4. What health services do you need that you are not currently getting?

5. What barriers have you experienced in trying to get health services you need?

6. What challenges are specific to your age group?

This same meeting will happen in Rockford and Chicago in June and July of 2015.

The introductory meeting will be followed by quarterly meetings either in person or by conference call. At least one meeting will be held in person for the whole council. Below is the proposed schedule of meeting.

- Meeting #1, Q1 – Getting started (2 hours)
  - Goals and objectives of the Council
  - Training or capacity building needs of the Council Members
- Meeting #2, Q2 – Laying the groundwork (2 hours)

- Training – Introduction to program evaluation and SWOT

- Facilitated SWOT or Needs Assessment of Title V programs

- Meeting #3, Q3 – Planning – MCH Conference

- IDPH Presentation on results from Title V Needs Assessment

- Council develops set of recommendations for the state

- Meeting #4, Q4 – Bringing it all together (half day)

- In-person meeting for all Council Members (requires travel)

- First half: Training - TBD

- Second Half - Presentation to IDPH Office of Women's Health

II.F.4. Health Reform

II.F.5. Emerging Issues

The IDPH Office Women's Health and Family Services (OWHFS) continues to identify and address the public health priorities affecting women, infants and children of Illinois. One issue that emerged strongly in this assessment was the unique needs of Illinois adolescents, particularly for special adolescent populations such as Lesbian, Gay, Bisexual, and Transgender/Transsexual (LGBT) youth. The unique public health needs of adolescents are diverse and vastly important. When appropriate, OWHFS is exploring how address these emerging needs, and enhance service provision within the expansion of Medicaid and the advancement of the Affordable Care Act.

To address adolescent health, OWHFS developed two state priorities in the adolescent domain that focus on improving health behaviors and providing transition services to the adult medical system. In both of these priorities, OWHFS is working with internal and external stakeholders to address the unique and growing needs of Illinois adolescents, especially in the areas of reproductive health, (proactive) mental health services, workforce development and engagement of risk reduction opportunities across the life-course perspective. In particular, the Office is committed to working with our network of educational, clinical and community engagement partners to ensure the unique needs of adolescents are prioritized within their services.

In addition, OWHFS is invested in supporting the needs of adolescents who identify as LGBT. Issues of particular concern are: the lack of LGBT-friendly medical centered homes, undiagnosed mental illness, disproportionate rates of alcohol and drug use/abuse, self-reported bullying, and suicide attempts among LGBT adolescents. OWHFS is keenly aware of the longstanding adverse health effects from bullying and other Adverse Childhood Events (ACEs), and is planning to invest in research and community partnerships to address this emerging and critical issue. Whenever possible, OWHFS engages adolescents in the planning process to help address their priority public health issues.

II.F.6. Public Input

II.F.7. Technical Assistance

III. Budget Narrative

	2012		2013		2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$21,700,000	$21,700,000	$21,700,000	$20,161,097	$21,700,000	
Unobligated Balance	$0	$0	$0	$0	$0	
State Funds	$27,261,867	$27,261,867	$27,260,000	$27,260,000	$27,260,000	
Local Funds	$0	$0	$0	$0	$0	
Other Funds	$234,159,608	$234,159,608	$234,159,600	$234,159,600	$234,159,600	
Program Funds	$8,000,000	$8,000,000	$7,760,000	$7,760,000	$7,760,000	
SubTotal	$291,121,475	$416,111,558	$290,879,600	$416,111,558	$290,879,600	$0
Other Federal Funds	$416,111,558	$291,121,475	$416,111,558	$289,340,697	$423,189,908	
Total	$707,233,033	$707,233,033	$706,991,158	$705,452,255	$714,069,508	

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$20,911,675		$18,734,500	
Unobligated Balance	$0		$0	
State Funds	$27,260,000		$0	
Local Funds	$0		$0	
Other Funds	$234,159,600		$0	
Program Funds	$6,392,507		$0	
SubTotal	$288,723,782		$18,734,500	
Other Federal Funds	$409,665,976		$0	
Total	$698,389,758		$18,734,500	

III.A. Expenditures

III.B. Budget

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Title V IGA with attachment (final) - signed by HFS and DPH.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - IL Title V 2015 Databook FINAL.pdf

Form 2

MCH Budget/Expenditure Details
State: Illinois

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$18,734,500	
Of the Federal Allocation, the amount earmarked for:		
A. Preventive and Primary Care for Children	(%)	(%)
B. Children with Special Health Care Needs	(%)	(%)
C. Title V Administrative Costs	(%)	(%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$0	
5. OTHER FUNDS (Item 18e of SF-424)	$0	
6. PROGRAM INCOME (Item 18f of SF-424)	$0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$0	$0
A. Your State's FY 1989 Maintenance of Effort Amount	$27,569,600	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$18,734,500	$0
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$0	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$18,734,500	$0

9. OTHER FEDERAL FUNDS

No Other Federal Programs were provided by the State on Form 2 Line 9.

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$21,700,000
A. Preventive and Primary Care for Children	$8,000,000
B. Children with Special Health Care Needs	$6,510,000
C. Title V Administrative Costs	$800,000
2. UNOBLIGATED BALANCE	$0
3. STATE MCH FUNDS	$27,260,000
4. LOCAL MCH FUNDS	$0
5. OTHER FUNDS	$234,159,600
6. PROGRAM INCOME	$7,760,000
7. TOTAL STATE MATCH	$269,179,600

Form Notes For Form 2:

None

Data Alerts for Form 2:

1 . The value in Line 1, Federal Allocation, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.

2 . The value in Line 1A, Preventive And Primary Care Expended, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.

3 . The value in Line 1B, Children with Special Health Care Needs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.

4 . The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

5 . The value in Line 3, State MCH Funds, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

6 . The value in Line 5, Other Funds, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

7 . The value in Line 6, Program Income, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

8 . The value in Line 7, Total State Match, Annual Report Expended is less than State’s 1989 Maintenance of Effort Amount. Please add a field level note indicating the reason for the discrepancy.

Form 3a

Budget and Expenditure Details by Types of Individuals Served
State: Illinois

I. TYPES OF INDIVIDUALS SERVED	FY16 Application Budgeted	FY14 Annual Report Expended
IA. Federal MCH Block Grant		
1. Pregnant Women		
2. Infants < 1 year		
3. Children 1-22 years		
4. CSHCN		
5. All Others		
Federal Total of Individuals Served	$0	$0
IB. Non Federal MCH Block Grant		
1. Pregnant Women		
2. Infants < 1 year		
3. Children 1-22 years		
4. CSHCN		
5. All Others		
Non Federal Total of Individuals Served	$0	$0
Federal State MCH Block Grant Partnership Total	$0	$0

Form Notes for Form 3a:

None

Data Alert for Form 3a:

None

Form 3b

Budget and Expenditure Details by Types of Services
State: Illinois

	FY16 Application Budgeted	FY14 Annual Report Expended

I. TYPES OF SERVICES

IIA. Federal MCH Block Grant

1. Direct Services

A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One

B. Preventive and Primary Care Services for Children

C. Services for CSHCN

2. Enabling Services

3. Public Health Services and Systems

4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service

Pharmacy

Physician/Office Services

Hospital Charges (Includes Inpatient and Outpatient Services)

Dental Care (Does Not Include Orthodontic Services)

Durable Medical Equipment and Supplies

Laboratory Services

Direct Services Total	$0

Federal Total

	FY16 Application Budgeted	FY14 Annual Report Expended

IIB. Non-Federal MCH Block Grant

1. Direct Services

   A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One

   B. Preventive and Primary Care Services for Children

   C. Services for CSHCN

2. Enabling Services

3. Public Health Services and Systems

4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service

   Pharmacy

   Physician/Office Services

   Hospital Charges (Includes Inpatient and Outpatient Services)

   Dental Care (Does Not Include Orthodontic Services)

   Durable Medical Equipment and Supplies

   Laboratory Services

   Direct Services Total

Non-Federal Total

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

Form 4

Number and Percentage of Newborns and Others Screened, Cases Confirmed and Treated
State: Illinois

Total Births by Occurrence **154,803**

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Propionic acidemia	153,233	55	0	0
Methylmalonic acidemia (methylmalonyl-CoA mutase)	153,233	54	1	1
Methylmalonic acidemia (cobalamin disorders)	153,233	54	1	1
3-Methylcrotonyl-CoA carboxylase deficiency	153,233	100	4	4
3-Hydroxy-3-methyglutaric aciduria	153,233	100	0	0
Holocarboxylase synthase deficiency	153,233	0	0	0
ß-Ketothiolase deficiency	153,233	3	2	2
Glutaric acidemia type I	153,233	69	0	0
Carnitine uptake defect/carnitine transport defect	153,233	338	2	2
Medium-chain acyl-CoA dehydrogenase deficiency	153,233	83	5	5
Very long-chain acyl-CoA dehydrogenase deficiency	153,233	53	4	4
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	153,233	11	0	0
Trifunctional protein deficiency	153,233	10	0	0
Argininosuccinic aciduria	153,233	62	3	3

Citrullinemia, type I	153,233	62	0	0
Maple syrup urine disease	153,233	33	1	1
Homocystinuria	153,233	138	0	0
Classic phenylketonuria	153,233	72	11	11
Tyrosinemia, type I	153,233	211	0	0
Primary congenital hypothyroidism	153,233	225	105	105
Congenital adrenal hyperplasia	153,233	405	9	9
S,S disease (Sickle cell anemia)	153,233	67	47	47
S, βeta-thalassemia	153,233	7	3	3
S,C disease	153,233	34	24	24
Biotinidase deficiency	153,233	9	1	1
Cystic fibrosis	153,233	679	41	41
Severe combined immunodeficiences	153,233	889	3	3
Classic galactosemia	153,233	277	18	18
Isovaleric acidemia	153,233	65	0	0

1b. Secondary RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Methylmalonic acidemia with homocystinuria	153,233	54	0	0
Malonic acidemia	153,233	20	0	0

Isobutyrylglycinuria	153,233	0	0	0
2-Methylbutyrylglycinuria	153,233	0	0	0
3-Methylglutaconic aciduria	153,233	0	0	0
2-Methyl-3-hydroxybutyric aciduria	153,233	0	0	0
Short-chain acyl-CoA dehydrogenase deficiency	153,233	190	11	11
Medium/short-chain L-3-hydroxyacl-CoA dehydrogenase deficiency	153,233	17	0	0
Glutaric acidemia type II	153,233	5	1	1
Medium-chain ketoacyl-CoA thiolase deficiency	153,233	5	0	0
2,4 Dienoyl-CoA reductase deficiency	153,233	14	0	0
Carnitine palmitoyltransferase type I deficiency	153,233	24	0	0
Carnitine acylcarnitine translocase deficiency	153,233	91	0	0
Carnitine palmitoyltransferase type II deficiency	153,233	90	0	0
Argininemia	153,233	12	0	0
Citrullinemia, type II	153,233	0	0	0
Hypermethioninemia	153,233	0	0	0
Benign hyperphenylalaninemia	153,233	0	0	0
Biopterin defect in cofactor biosynthesis	153,233	0	0	0
Biopterin defect in cofactor regeneration	153,233	0	0	0
Tyrosinemia, type II	153,233	0	0	0
Tyrosinemia, type III	153,233	0	0	0

Various other hemoglobinopathies	153,233	43	16	16
Galactoepimerase deficiency	153,233	0	2	2
Galactokinase deficiency	153,233	0	0	0
T-cell related lymphocyte deficiencies	153,233	0	7	7

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	149,912	5,086	152	152

3. Screening Programs for Older Children & Women

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment

4. Long-Term Follow-Up

For those newborns diagnosed through blood spot screening, they are followed annually through fifteen years of age with staff of the Newborn Screening Program contacting the pediatric sub-specialist to verify compliance with treatment and to monitor growth and developmental milestones. If needed, cases are referred to a local public health nurse to provide family assistance. Currently no screening data or reports of diagnosed cases of newborns with a critical congenital heart defect are reported to the Newborn Screening Program, however families of all newborns with such a diagnosis are reported to the birth defects registry, which provides periodic follow-up by a public health nurse, through two years of age. All newborns identified with a hearing loss are referred to early intervention services and to the state Children with Special Health Care Needs Program which provide ongoing follow-up services.

Form Notes for Form 4:
None

Field Level Notes for Form 4:

1. **Field Name :** Total Births by Occurrence

   Fiscal Year : 2016

   Column Name :

   Field Note :

   Provisional Birth Data, HFS-EDW

2. **Field Name :** Severe combined immunodeficiences - Positive Screen

   Fiscal Year : 2016

   Column Name : Core RUSP Conditions - Newborn

   Field Note :

   7 of these presumptive positives were confirmed as cases for T-cell related lymphocyte deficiencies and are not listed as confirmed cases on this line.

3. **Field Name :** Classic galactosemia - Positive Screen

   Fiscal Year : 2016

   Column Name : Core RUSP Conditions - Newborn

   Field Note :

   2 of these presumptive positive screens were confirmed cases of galactoepimerase deficiency and are not listed as confirmed cases on this line.

4. **Field Name :** Galactoepimerase deficiency - Confirmed Cases

   Fiscal Year : 2016

   Column Name : Secondary RUSP Conditions - Newborn

   Field Note :

   Confirmed cases were identified out of presumptive positive screens for Galactosemia

5. **Field Name :** T-cell related lymphocyte deficiencies - Confirmed Cases

   Fiscal Year : 2016

   Column Name : Secondary RUSP Conditions - Newborn

   Field Note :

   Confirmed cases were identified out of presumptive positives for Severe Combined Immune Deficiency

6. **Field Name :** Newborn Hearing - Confirmed Cases

   Fiscal Year : 2016

   Column Name : Other Newborn

   Field Note :

   Preliminary Data; confirmation of cases still in process of being reported to IDPH

7. **Field Name :** Newborn Hearing - Referred For Treatment

   Fiscal Year : 2016

   Column Name : Other Newborn

   Field Note :

   All confirmed cases referred to Early Intervention services

Form 5a

Unduplicated Count of Individuals Served under Title V

State: Illinois

Reporting Year 2014

		Primary Source of Coverage				
Types of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private/Other %	(E) None %	(F) Unknown %
1. Pregnant Women						
2. Infants <1 year of Age						
3. Children 1 to 22 Years of Age						
4. Children with Special Health Care Needs						
5. Others						
Total						

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

An error has occurred while processing Report 'Form5b':
An error occurred while invoking data retrieval method.
---------- InnerException ----------
Exception has been thrown by the target of an invocation.
---------- InnerException ----------
Object reference not set to an instance of an object.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX
State: Illinois

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	154,203	111,401	26,391	144	9,532	80	2,296	4,359
Title V Served	0	0	0	0	0	0	0	0
Eligible for Title XIX	77,094	37,093	25,615	26	1,713	129	996	11,522
2. Total Infants in State	153,280	110,836	26,111	141	9,514	80	2,277	4,321
Title V Served	0	0	0	0	0	0	0	0
Eligible for Title XIX	71,142	34,815	22,203	12	1,825	135	997	11,155

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	119,312	33,682	1,209	154,203
Title V Served	0	0	0	0
Eligible for Title XIX	54,833	15,142	7,119	77,094
2. Total Infants in State	118,601	33,488	1,191	153,280
Title V Served	0	0	0	0
Eligible for Title XIX	49,907	14,898	6,337	71,142

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1. **Field Name :** 1. Total Deliveries in State

Fiscal Year : 2016

Column Name : Total All Races

Field Note :

Deliveries = 2014 birth data (provisional) + 2013 fetal death data (final)
2014 fetal death data not yet available, so 2013 used as estimate
Includes only IL occurrences to IL residents

2. **Field Name :** 2. Total Infants in State

Fiscal Year : 2016

Column Name : Total All Races

Field Note :

Deliveries = 2014 birth data (provisional)
Includes only IL occurrences to IL residents

Form 7

State MCH Toll-Free Telephone Line and Other Appropriate Methods Data
State: Illinois

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(888) 522-1282	(888) 522-1282
2. State MCH Toll-Free "Hotline" Name	Women's Health Line	Women's Health Line
3. Name of Contact Person for State MCH "Hotline"	Donna Lindemulder	Donna Lindemulder
4. Contact Person's Telephone Number	(217) 524-0851	(217) 524-0851
5. Number of Calls Received on the State MCH "Hotline"		4,572
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names	CSHCN- DSCC Hotline	CSCHN - DSCC Hotline
2. Number of Calls on Other Toll-Free "Hotlines"		14,481
3. State Title V Program Website Address	http://www.dscc.uic.edu	www.dscc.uic.edu
4. Number of Hits to the State Title V Program Website		37,624
5. State Title V Social Media Websites	http//www.facebook.com/dscc.uic.edu	CSHCN Facebook
6. Number of Hits to the State Title V Program Social Media Websites		2,367

Form Notes for Form 7:
None

Form 8

State MCH and CSHCN Directors Contact Information
State: Illinois

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name

Title

Address 1

Address 2

City / State / Zip Code

Telephone

Email

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name

Title

Address 1

Address 2

City / State / Zip Code

Telephone

Email

3. State Family or Youth Leader (Optional)

Name

Title

Address 1

Address 2

City / State / Zip Code

Telephone

Email

Form Notes for Form 8:
None

Form 9
List of MCH Priority Needs
State: Illinois

Application Year 2016

	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1 .	Assure accessibility, availability and quality of preventive and primary care for all women, particularly for women of reproductive age	Replaced	
2 .	Support healthy pregnancies and improve birth outcomes	Continued	
3 .	Support expanded access to and integration of early childhood services and systems	New	
4 .	Facilitate the integration of services within patient-centered medical homes for all children, particularly for children with special healthcare needs	Continued	
5 .	Empower adolescents to adopt healthy behaviors	New	
6 .	Assure appropriate transition planning and services for adolescents and young adults, including youth with special health care needs	Replaced	
7 .	Assure that equity is the foundation of all MCH decision-making; eliminate disparities in MCH outcomes	New	
8 .	Support expanded access to and integration of mental health services and systems for the MCH population.	Continued	
9 .	Partner with consumers, families and communities in decision-making across MCH programs, systems and policies	New	The need for consumer, family, and consumer engagement repeatedly emerged during the 2015 needs assessment. Illinois Title V wants to ensure that such groups are viewed as partners at all-levels of decision-making -- spanning from interactions occurring during healthcare services up to the state-level program/policy planning process.
10 .	Strengthen the MCH capacity for data collection, linkage, analysis, and dissemination; Improve MCH data systems and infrastructure	Continued	High-quality data and sound science should be the foundation for public health decision-making. Illinois Title V has historically had many challenges related to data capacity and infrastructure. While many large gains have occurred during the last several years, there is still much room for improvement. Continuing this priority will keep the development of data capacity and infrastructure as a major focus for Title V in the coming years.

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name: Priority Need 1
Field Note:
Replaces 2010 priority #5 (medical home for women)

Field Name: Priority Need 2
Field Note:
Continues 2010 priority #6

Field Name: Priority Need 4
Field Note:
Continues the essence of 2010 priority #4, with slight changes to wording and framing.

Field Name: Priority Need 6
Field Note:
Replaces 2010 priority #10. This new framing of the priority expands the focus for transition planning/services to all youth, not only those with special healthcare needs.

Field Name: Priority Need 8
Field Note:
Continues the essence of 2010 priority #8, with slight changes to wording and framing.

Field Name: Priority Need 10
Field Note:
Continues 2010 priority #1

Form 10a
National Outcome Measures
State: Illinois

Form Notes for Form 10a:

NPM 1: 2013 = 62.0%, stable 2009-2013
5-Year Target Setting Method (5yr-TSM): 10% improvement

NPM 3: 2014 = 78.9%, stable 2010-2014
5yr-TSM: 10% improvement

NPM 6: 2011/12 = 34.4%, 63% improvement 2007-2011/12
5yr-TSM: 30% improvement

NPM 10: 2011/12 = 88.7%, 4% improvement 2007-2011/12
5yr-TSM: 5% improvement

NPM 11 for CSHCN: 2011/12 = 46.4%, stable 2007-2011/12
5yr-TSM: 10% improvement

NPM 12 for CSHCN: 2009/2010 = 45.3%, stable 2005/6 - 2009/10
5yr-TSM: 10% improvement

NPM 13A: 2011 = 47.5%, 23% improvement 2007-2011
5yr-TSM: 20% improvement

NPM 13B: 2011/12 = 80.8%, stable 2007-2011/12
5yr-TSM: 5% improvement

NPM 14A: 2013 = 7.0%, 11% improvement 2010-2013
5yr-TSM: 15% improvement

NPM 14B: 2011/12 = 21.0%, 10% improvement 2007-2011/12
5yr-TSM: 15% improvement

NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester

NOM-1 Notes:

None

Data Alerts :

None

NOM-2 Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM-2 Notes:
None

Data Alerts :

None

NOM-3 Maternal mortality rate per 100,000 live births

NOM-3 Notes:
None

Data Alerts :

None

NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)

NOM-4.1 Notes:
None

Data Alerts :

None

NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

NOM-4.2 Notes:
None

Data Alerts :

None

NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM-4.3 Notes:
None

Data Alerts :

None

NOM-5.1 Percent of preterm births (<37 weeks)

NOM-5.1 Notes:
None

Data Alerts :

None

NOM-5.2 Percent of early preterm births (<34 weeks)

NOM-5.2 Notes:
None

Data Alerts :

None

NOM-5.3 Percent of late preterm births (34-36 weeks)

NOM-5.3 Notes:
None

Data Alerts :

None

NOM-6 Percent of early term births (37, 38 weeks)

NOM-6 Notes:
None

Data Alerts :

None

NOM-7 Percent of non-medically indicated early elective deliveries

NOM-7 Notes:
None

Data Alerts :

None

NOM-8 Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM-8 Notes:
None

Data Alerts :

None

NOM-9.1 Infant mortality rate per 1,000 live births

NOM-9.1 Notes:
None

Data Alerts :

None

NOM-9.2 Neonatal mortality rate per 1,000 live births

NOM-9.2 Notes:
None

Data Alerts :

None

NOM-9.3 Post neonatal mortality rate per 1,000 live births

NOM-9.3 Notes:
None

Data Alerts :

None

NOM-9.4 Preterm-related mortality rate per 100,000 live births

NOM-9.4 Notes:
None

Data Alerts :

None

NOM-9.5 Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM-9.5 Notes:
None

Data Alerts :

None

NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM-10 Notes:
None

Data Alerts :

None

NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

NOM-11 Notes:
None

Data Alerts :

None

NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Data Alerts :

None

NOM-13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Data Alerts :

None

NOM-14 Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

NOM-14 Notes:
None

Data Alerts :

None

NOM-15 Child Mortality rate, ages 1 through 9 per 100,000

NOM-15 Notes:
None

Data Alerts :

None

NOM-16.1 Adolescent mortality rate ages 10 through 19 per 100,000

NOM-16.1 Notes:
None

Data Alerts :

None

NOM-16.2 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

NOM-16.2 Notes:
None

Data Alerts :

None

NOM-16.3 Adolescent suicide rate, ages 15 through 19 per 100,000

NOM-16.3 Notes:
None

Data Alerts :

None

NOM-17.1 Percent of children with special health care needs

NOM-17.1 Notes:
None

Data Alerts :

None

NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM-17.2 Notes:
None

Data Alerts :

None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

NOM-17.3 Notes:
None

Data Alerts :

None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

NOM-17.4 Notes:
None

Data Alerts :

None

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

NOM-18 Notes:
None

Data Alerts :

None

NOM-19 Percent of children in excellent or very good health

NOM-19 Notes:
None

Data Alerts :

None

NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

NOM-20 Notes:
None

Data Alerts :

None

NOM-21 Percent of children without health insurance

NOM-21 Notes:
None

Data Alerts :

None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

NOM-22.1 Notes:

None

Data Alerts :

None

NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM-22.2 Notes:

None

Data Alerts :

None

NOM-22.3 Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM-22.3 Notes:

None

Data Alerts :

None

NOM-22.4 Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM-22.4 Notes:

None

Data Alerts :

None

NOM-22.5 Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM-22.5 Notes:

None

Data Alerts :

None

Form 10a
National Performance Measures
State: Illinois

NPM 1-Percent of women with a past year preventive medical visit

	2016	2017	2018	2019	2020
Annual Objective	63	64	65.5	67	68.5

NPM 3-Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

	2016	2017	2018	2019	2020
Annual Objective	80.4	81.9	83.5	85.1	86.8

NPM 6-Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

	2016	2017	2018	2019	2020
Annual Objective	36.3	38.3	40.4	42.5	44.7

NPM 10-Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

	2016	2017	2018	2019	2020
Annual Objective	89.5	90.3	91.2	92.1	93.1

NPM 11-Percent of children with and without special health care needs having a medical home

	2016	2017	2018	2019	2020
Annual Objective	47.2	48.1	49	50	51

NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

	2016	2017	2018	2019	2020
Annual Objective	46.2	47.1	48	48.9	49.8

NPM 13-A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

	2016	2017	2018	2019	2020
Annual Objective	49.4	51.3	53.2	55.1	57
Annual Objective	81.6	82.4	83.2	84	84.8

NPM 14-A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

	2016	2017	2018	2019	2020
Annual Objective	6.8	6.5	6.2	5.9	5.6
Annual Objective	20.4	19.8	19.2	18.6	17.9

Form 10b
State Performance/Outcome Measure Detail Sheet
State: Illinois

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c
Evidence-Based or Informed Strategy Measure Detail Sheet
State: Illinois

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d

National Performance Measures (Reporting Year 2014 & 2015)

State: Illinois

Form Notes for Form 10d:

None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	99.0	99.0	99.0	99.0	99.0
Annual Indicator	98.6	98.7	98.8	98.1	
Numerator	1,766	1,604	2,071	9,724	
Denominator	1,791	1,625	2,096	9,916	
Data Source	IDPH, Genetics	IDPH, Genetics	IDPH, Genetics	IDPH, Genetics	
Provisional Or Final ?				Final	

Data Alerts:

None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	60.5	71.1	71.1	71.1	72.0
Annual Indicator	71.1	71.1	71.1	71.1	
Numerator					
Denominator					
Data Source	CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey	
Provisional Or Final ?				Final	

Data Alerts:

None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	45.5	44.5	44.5	44.5	45.0
Annual Indicator	44.5	44.5	44.5	44.5	
Numerator					
Denominator					
Data Source	CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey	
Provisional Or Final ?				Final	

Data Alerts:

None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	59.7	62.5	62.5	62.5	62.5
Annual Indicator	62.1	62.1	62.1	62.1	
Numerator					
Denominator					
Data Source	CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey	
Provisional Or Final ?				Final	

Data Alerts:

None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	90.0	64.6	64.6	64.6	64.6
Annual Indicator	64.6	64.6	64.6	64.6	
Numerator					
Denominator					
Data Source	CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey	
Provisional Or Final ?				Final	

Data Alerts:

None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	44.5	45.3	45.3	45.3	45.3
Annual Indicator	44.2	45.3	45.3	45.3	
Numerator					
Denominator					
Data Source	CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey	CSHCN SLAITS Survey	
Provisional Or Final ?				Final	

Data Alerts:

None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	82.0	82.0	82.0	78.0	78.0
Annual Indicator	77.9	78.7	74.0	75.8	
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	
Provisional Or Final ?				Final	

Data Alerts:

None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	19.0	19.0	15.0	11.0	11.0
Annual Indicator	15.2	13.5	11.4	10.1	
Numerator	4,037	3,520	2,927	2,577	
Denominator	265,206	260,596	256,134	256,134	
Data Source	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW	
Provisional Or Final ?				Provisional	

Data Alerts:

None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	43.0	44.0	45.0	46.0	46.0
Annual Indicator	41.5	41.5	41.5	49.8	
Numerator	64,516	64,516	64,516		
Denominator	155,468	155,468	155,468		
Data Source	IDPH, Oral Health	IDPH, Oral Health	IDPH, Oral Health	IDPH, Oral Health	
Provisional Or Final ?				Final	

Data Alerts:

None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	1.7	1.7	1.4	1.3	1.2
Annual Indicator	1.3	1.3	1.0	1.0	
Numerator	34	34	26	26	
Denominator	2,574,430	2,574,430	2,499,834	2,499,834	
Data Source	IDPH - Vital Records	IDPH - Vital Records	provisional death files - DHFS-EDW	provisional death files - DHFS-EDW	
Provisional Or Final ?				Provisional	

Data Alerts:

None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	29.0	27.0	28.0	50.0	50.0
Annual Indicator	44.5	49.8	48.8	47.0	
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	
Provisional Or Final ?				Final	

Data Alerts:

None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	99.0	99.0	99.0	99.0	99.0
Annual Indicator	99.2	99.1	98.8	98.9	
Numerator	156,049	154,005	149,187	149,912	
Denominator	157,343	155,345	150,996	151,655	
Data Source	IDPH, Vision and Hearing	IDPH, Vision and Hearing	IDPH, Vision and Hearing	IDPH, Vision and Hearing	
Provisional Or Final ?				Final	

Data Alerts:

None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	4.0	5.0	3.5	5.0	5.0
Annual Indicator	5.2	6.2	6.9	4.0	
Numerator		191,000	206,000		
Denominator		3,105,000	3,001,000		
Data Source	Census Bureau, Current Population Survey	Census Bureau, Current Population Survey	Current Population Survey (Census)	Current Population Survey (Census)	
Provisional Or Final ?				Final	

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	29.0	29.5	29.5	29.0	29.0
Annual Indicator	30.4	30.4	30.4	30.4	
Numerator	40,575	40,575	40,575	40,575	
Denominator	133,471	133,471	133,471	133,471	
Data Source	PedNSS	PedNSS	PedNSS	PedNSS	
Provisional Or Final ?				Provisional	

Data Alerts:

None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	9.5	9.0	9.0	8.5	8.5
Annual Indicator	9.2	9.2	8.9	10.1	
Numerator	14,830	14,830	13,663	15,245	
Denominator	161,764	161,764	153,759	151,665	
Data Source	IDPH, PRAMS	IDPH, PRAMS	IDPH, PRAMS	IDPH, PRAMS	
Provisional Or Final ?				Final	

Data Alerts:

None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	6.0	7.0	5.8	5.8	5.8
Annual Indicator	6.2	7.9	3.9	6.3	
Numerator	57	73	34	55	
Denominator	922,092	922,092	877,192	877,192	
Data Source	IDPH, Vital Records	IDPH, Vital Records	provisional death records, DHFS-EDW	provisional death records, DHFS-EDW	
Provisional Or Final ?				Provisional	

Data Alerts:

None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	83.0	83.0	83.0	83.0	83.0
Annual Indicator	88.9	87.3	79.1	78.9	
Numerator	2,142	2,055	1,631	1,634	
Denominator	2,410	2,355	2,062	2,071	
Data Source	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW	
Provisional Or Final ?				Provisional	

Data Alerts:

None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	87.0	87.0	87.0	83.0	84.0
Annual Indicator	82.8	82.9	82.9	82.3	
Numerator	124,676	121,499	115,491	121,460	
Denominator	150,534	146,511	139,279	147,525	
Data Source	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW	provisional birth data, DHFS-EDW	
Provisional Or Final ?				Provisional	

Data Alerts:

None

Form 10d

State Performance Measures (Reporting Year 2014 & 2015)

State: Illinois

SPM 1 - Title V data capacity and usage

	2011	2012	2013	2014	2015
Annual Objective	34.0	23.0	27.0	24.0	0.2
Annual Indicator					
Numerator	20	15	18	20	
Denominator	1	1	1	1	
Data Source	Staff Report	Staff Report	Staff Report	Staff Report	
Provisional Or Final ?				Final	

Data Alerts:

None

SPM 2 - Integrate MCH services and improve linkage of clients to these services

	2011	2012	2013	2014	2015
Annual Objective	9.0	10.0	11.0	12.0	13.0
Annual Indicator					
Numerator	8	8	0	7	
Denominator	15	15	15	15	
Data Source	Survey	Survey	Staff Report	Staff Report	
Provisional Or Final ?				Final	

Data Alerts:

1 . A value of zero has been entered for the numerator for year 2013 SPM# 2. Please review your data to ensure this is correct

SPM 3 - Identify a Title V comprehensive health promotion measure

	2011	2012	2013	2014	2015
Annual Objective	0.0	0.0	0.0	0.0	0.0
Annual Indicator			0.0	0.0	
Numerator					
Denominator					
Data Source			Staff Report	Staff Report	
Provisional Or Final ?				Provisional	

Data Alerts:

None

SPM 4 - Percent of Medicaid children ages 3-6 receiving at least one well-child visit in the last year

	2011	2012	2013	2014	2015
Annual Objective	65.0	69.0	70.0	70.0	71.0
Annual Indicator	71.2	68.2	69.1	68.6	
Numerator	272,659	257,258	239,812	217,222	
Denominator	383,171	377,062	347,234	316,460	
Data Source	IDHFS EIS Rpt.	IDHFS EIS Rpt.	IDHFS EIS Rpt.	IDHFS EIS Rpt.	
Provisional Or Final ?				Provisional	

Data Alerts:

None

SPM 5 - Percent of women of reproductive age who have a primary medical care provider

	2011	2012	2013	2014	2015
Annual Objective	88.0	89.0	90.0	90.0	90.0
Annual Indicator	78.8	83.9	79.6	80.4	
Numerator	1,790,684	1,868,478			
Denominator	2,271,540	2,226,974			
Data Source	IL-BRFSS	IL-BRFSS	IL-BRFSS	IL-BRFSS	
Provisional Or Final ?				Provisional	

Data Alerts:

None

SPM 6 - Percent of live births resulting from unintended pregnancies

	2011	2012	2013	2014	2015
Annual Objective	41.0	41.0	41.0	41.0	41.0
Annual Indicator	44.2	44.2	42.5	42.0	
Numerator	71,100	71,100	65,962	62,915	
Denominator	160,698	160,698	155,246	149,951	
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	
Provisional Or Final ?				Provisional	

Data Alerts:

None

SPM 7 - Percent of Medicaid children receiving preventive dental services during last year

	2011	2012	2013	2014	2015
Annual Objective	95.0	95.0	95.0	52.0	52.0
Annual Indicator	46.3	48.8	50.5	51.5	
Numerator	697,930	759,190	798,269	796,490	
Denominator	1,507,472	1,554,421	1,581,522	1,547,301	
Data Source	IDHFS CMS 416 Report	IDHFS CMS 416 Report	IDHFS CMS 416 Report	IDHFS CMS 416 Report	
Provisional Or Final ?				Provisional	

Data Alerts:

None

SPM 8 - Percent of women whose prenatal care provider discussed perinatal depression

	2011	2012	2013	2014	2015
Annual Objective	88.5	77.0	79.0	79.0	79.0
Annual Indicator	74.0	74.0	76.3	76.9	
Numerator	118,038	118,038	116,456	116,594	
Denominator	159,502	159,502	152,717	151,707	
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	
Provisional Or Final ?				Provisional	

Data Alerts:

None

SPM 9 - Percent of youth participating in regular physical activity during the week

	2011	2012	2013	2014	2015
Annual Objective	67.5	51.0	52.3	52.0	54.0
Annual Indicator	48.5	48.5	49.9	49.9	
Numerator					
Denominator					
Data Source	YRBS - CDC	YRBS - CDC	YRBS - CDC	YRBS - CDC	
Provisional Or Final ?				Provisional	

Data Alerts:

None

SPM 10 - Percent of youth with special healthcare needs receiving comprehensive transition planning services

	2011	2012	2013	2014	2015
Annual Objective	90.7	90.8	85.0	86.0	87.0
Annual Indicator	87.8	83.4	65.4	69.1	
Numerator	879	746	608	327	
Denominator	1,001	894	929	473	
Data Source	Record Review DSCC Youth 14-21 (50% Sample)	Record Review DSCC Youth 14-21 (50% Sample)	Record Review DSCC Youth 14-21 (50% Sample)	Record Review DSCC Youth 14-21	
Provisional Or Final ?				Final	

Data Alerts:

None

Form 11
Other State Data
State: Illinois

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Illinois

Please click the link below to download a PDF of the State Action Plan Table.

State Action Plan Table