# Maternal and Child Health Services Title V Block Grant

# Illinois

# FY 2017 Application/ FY 2015 Annual Report

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

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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.

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### II.A. Overview of the State

**Illinois Demographic Information**

***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 Illinoisans 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.

**Illinois Department of Public Health Overview**

The Illinois Department of Public Health (IDPH) is one of the longest standing state agencies, established in 1877 as the State Board of Health. It now has headquarters in Springfield and Chicago, seven regional offices, two laboratories, and over 1,100 employees. IDPH houses over 200 public health programs covering the spectrum of diseases/conditions and the life course. The vision of IDPH is: "Communities of Illinois will achieve and maintain optimal health and safety" and the mission of IDPH is to: "Protect the health and wellness of the people in Illinois through the prevention, health promotion, regulation, and the control of disease and injury".

The Office of Women's Health and Family Services (OWHFS) is one of six programmatic offices with IDPH, with a Deputy Director that reports directly to the IDPH Director. OWHFS houses three divisions: the Division of Maternal, Child, and Family Services (the seat of Title V), the Division of Women's Health, and the Division of Population Health Management. These divisions work together closely and are united by a common vision and mission. The vision of OWHFS is "a future free of health disparities, where all Illinoisans have access to continuous high quality health care" and the mission of OWHFS is to: “improve health outcomes of all Illinoisans by providing preventive education and services, increasing health care access, using data to ensure evidence-based practice and policy, and empowering families”.

In 2015 Illinois embarked on a three-pronged approach to improving the health of Illinois’ residents, Healthy Illinois 2021, which includes the State Health Improvement Plan (SHIP), State Health Assessment (SHA), and State Innovation Model (SIM), the three statewide initiatives focus on improving the health of Illinois residents through strategic approaches and engaging all aspects of the public health system. Through the State Health Assessment process Illinois identified the three health priorities that will be used to formulate the goals and strategies contained within the State Health Improvement Plan, Behavioral Health, Chronic Disease and Maternal and Child Health. The State’ Title V Director served as a co-chair for the MCH Action team, this enabled the State to assure that the goals and objectives of the SHIP, outlined below, are aligned with the goals and objectives of the Illinois Title V Action Plan.

1. Assure accessibility, availability and quality of preventive and primary care for all women, adolescents, children, including those living with special healthcare needs, with a focus on interration of services through patient-centered medical homes.
2. Support healthy pregnancies and improve birth and infant outcomes.
3. Assure that equity I the foundation for all MCH decision-making; eliminated disparities in MCH outcomes.
4. Strengthen the MCH data-system, infrastructure and capacity.

**History of Title V in Illinois**

For many years, Title V in Illinois sat in the Illinois Department of Public Health. In 1997, there were major reorganization for state agencies and Title V was shifted to the newly created Illinois Department of Human Services (IDHS). The rationale for this move was to more closely align Title V with direct service programs like public aid, WIC, and food stamps. Even though administratively Title V was moved, some Title V funded programs, such as newborn genetic screening, remained at IDPH. While the connection to IDHS fostered direct service provision for Title V programs, the shift to IDHS resulted in many difficulties related to data access and analysis capacity.

After years of consideration, Illinois Title V was moved back to IDPH in July 2013. Title V was placed within the newly created OWHFS at IDPH, which was formerly the Office of Women’s Health. There were three major benefits guiding this decision. First, IDPH has more of a population health focus, with a goal of improving the health and well-being of the entire population, as opposed to targeting services directly to specific populations. Secondly, IDPH would enable Title V to shift away from direct and enabling services towards the more foundational levels of the MCH pyramid: population-based and infrastructure-building activities. Finally, and perhaps most importantly, IDPH had the support and infrastructure to improve the data capacity of Title V by providing epidemiologic expertise and enabling access to public health and vital records data systems.

Illinois’ goal of reorganizing the MCH system was to create an integrated set of services to promote the health of women, infants, children, adolescents, as well as children with special health care needs. Such a system is in a better position to reduce duplication, promote collaboration, and improve efficiency. The realignment of the Title V MCH Block Grant led to a significant paradigm shift for Illinois. It has afforded the state the opportunity, responsibility and capacity to measure and improve performance, evaluate program effectiveness, and translate data into programs and policies. Illinois’ MCH programs can now benefit from comprehensive data analyses to better identify needs, set priorities, target resources and measure impact – in short, to be evidence-based and data-driven. This reorganization has also attracted more qualified MCH leaders, epidemiologists and program managers, which can further strengthen the state’s capacity.

## Health Reform in Illinois

The State of Illinois has been engaged in a significant health care reform effort for the last several years. Illinois received a State Innovation Grant from the federal Centers for Medicare and Medicaid Innovation. This grant enabled the state to implement a large scale, comprehensive, and participatory planning process to develop a plan for achieving the "Triple Aim" of improving the patient's experience of care (including quality and satisfaction), improving the health of populations, and reducing the *per-capita* cost of health care. The resulting plan made recommendations in five areas: (1) Create comprehensive, integrated delivery systems, along with payment reforms to support them; (2) ensure that additional supports and services are available for people with specific needs; (3) enhance public health efforts focusing on environmental and social factors that negatively affect large segments of the population; (4) ensure that the workforce has the appropriate education, training and compensation to implement the new integrated delivery systems and enhance public health; and (5) expand the state's leadership role in promoting continuous improvement in the public health and health care systems. The Governor's Office submitted an 1115(b) demonstration waiver proposal to the federal Center for Medicare and Medicaid services to implement sweeping reforms in Illinois' Medicaid program. To date, the federal government has not responded to the waiver request.

At the same time, the Illinois General Assembly passed (and the Governor enacted) the Saving Medicaid Access and Resources Together, or SMART, Act, which became effective in January 2013. Among many Medicaid reforms, the law established the goal of enrolling at least half of all Medicaid beneficiaries in a "care coordination," or managed care, plan by January 1, 2015. This has led to a rapid expansion of Medicaid managed care within the state. Initial expansion efforts focused on high-risk, high-cost populations, such as senior citizens who are dually enrolled in Medicare and Medicaid, as well as some programs for children with complex medical conditions (excluding CSHCN served by DSCC). However, since more than half of the state's Medicaid beneficiaries are children, successful implementation of the SMART Act would require the enrollment healthy children in a managed care arrangement, thus affecting the organization, funding, and delivery of Maternal and Child Health services in Illinois.

The Illinois General Assembly passed an additional Medicaid reform bill in 2013 that established the "Accountable Care Entities" or ACEs, as a hospital-based managed care network specifically targeting the "Family Health" population, which included children, pregnant women, and "ACA Adults" or childless adults who qualified for Medicaid under the Affordable Care Act. Following a competitive selection process, the statute gave the ACEs 18 months to operate as care coordination entities while providers would continue to be paid on a fee-for-service basis. After 18 months of operation, the ACEs would switch to partial capitation, meaning that they would receive a monthly payment for services to each enrolled beneficiary but would also have "stop loss" coverage from the IDHFS for extraordinarily large expenditures. Following this 36-month implementation period, the ACEs were to be fully at-risk managed care organizations. The ACE authorizing statute also specified that networks include hospitals, primary and specialty physicians, behavioral health providers and substance abuse treatment agencies. The law was silent on the inclusion of Local Health Departments, which are important providers of Maternal and Child Health services in Illinois.

IDHFS, the State Medicaid agency, released a request for proposals in August 2013 to identify Accountable Care Entities. The Department also identified 30 counties in Illinois as "mandatory enrollment areas," meaning that all Medicaid beneficiaries in those counties were required to enroll in a "care coordination" or managed care plan. Once fully implemented, IDHFS would no longer directly reimburse providers on a fee-for-service basis for services provided to Medicaid beneficiaries enrolled in a managed care plan. Like the authorizing statute, the request for proposals was similarly silent on the inclusion of Local Health Departments. Concerned that this might leave Illinois Local Health Departments as "out-of-network providers" for Medicaid beneficiaries in the MCH population, Illinois' public health advocacy agencies began working with both IDHFS and with local health departments to ensure that local health departments would be included in and ready for full implementation of Medicaid managed care.

IDHFS provided assurances that local health departments and school-based health centers would at least be offered contracts by managed care organizations. Local health departments report problems in engaging the ACE organizations in contract negotiations and IDHFS staff work with the managed care organizations to address these problems. Further, Title-X funded family planning providers and school-based health centers have been designated "direct access providers," meaning that they will continue to receive fee-for-service reimbursement for the services they provide, regardless of the patient's enrollment in a managed care plan. Recently, Illinois public health advocacy agencies have requested that this status be extended to local health departments as well.

**Statutory Base Related to Maternal and Child Health**

- 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) urged 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 children, the IDPH shall promulgate rules to provide for the addition of fluoride to public water supplies by the owners or official custodians thereof. Such rules shall incorporate the recommendations on optimal fluoridation for community water levels as proposed and adopted by the U.S. Department of Health and Human Services.
- 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 (110ILCS345) 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. Five Year Needs Assessment Summary

### 2016 Five-Year Needs Assessment Summary

### II-B-1: Process

One of the priorities that emerged from the 2015 needs assessment was to ensure ongoing engagement of families and consumer stakeholders in decision-making. To address this need, Title V contracted with EverThrive Illinois to convene and implement MCH Family Councils in each of the state's 7 public health regions. So far, councils have been established in three regions: Chicago, Edwardsville (SW Illinois), and Rockford (NW Illinois), and are in progress of being established in the other four regions. Council membership includes women identified through partnerships with Healthy Start and local health departments.

### II-B-2: Findings

### II-B-2-a: MCH Population Needs

*Women's / Maternal Health*
Maternal morbidity and mortality were identified as areas of concern for maternal health and this continues in the updated data. In 2014, severe maternal morbidity increased by about 5% over the average from the previous three years. Additionally, the number of pregnancy-associated deaths increased from 69 deaths in 2014 to 97 deaths in 2015. These deaths are still in the process of being tracked and reviewed, so it is not yet known how many were pregnancy-related but the increase of about 40% within one year is concerning.

*Perinatal / Infant Health*
Risk-appropriate care and having an effective regionalized perinatal system have been topics of high priority in Illinois in the last year. Through the work of CoIIN, Illinois established that the percent of very preterm infants being delivered in a Level III+ facility has not substantially changed over the last several years. Illinois is now undertaking a study of very preterm infants delivered outside level III facilities to gain insight into the reasons why maternal and/or neonatal transfer to a higher level facility did not occur.

Neonatal abstinence syndrome has also emerged as a priority in Illinois due to the passage of legislation creating a statewide NAS Advisory committee. Illinois will be undertaking an in-depth study of state data related to NAS and opioid use to inform the work of the Advisory committee as they develop strategies to address this growing public health concern.

*Child Health*
Since the 2015 needs assessment, no new needs have emerged for child health. Early childhood development and medical home remain priorities of the Illinois Title V program.

*Adolescent Health*
While the needs assessment identified adolescent mental health and suicide as issues of concern, provisional 2015 death certificate data suggested an alarming increase in the rate of adolescent suicides. In 2014, the final adolescent suicide mortality rate was 6.5 per 100,000 teens 15-19, but this increased to 8.5 per 100,000 in 2015. This represents a relative increase of over 30% within one year; an additional 17 adolescents died by suicide in 2015 compared to 2014. The 2015 death certificates have yet to be finalized, but this topic will be monitored to establish whether this increase reflects a true increase in incidence or a surveillance/measurement issue.

*Children with Special Healthcare Needs*
Since the 2015 needs assessment, no new needs have emerged for CSHCN. Medical home, transition, and family partnership remain priorities of the Illinois Title V program.

*Cross-Cutting / Life Course*
The purpose of the MCH Family Councils is to provide feedback and recommendations related to Illinois' MCH programming and perspective on critical consumer issues covering health across the lifespan. The initial meetings of three regional councils have generated a feedback and recommendations to the Title V program covering topics such as: social service staff, service access, coordination and communication, reducing barriers to services, and community outreach. Many of the identified themes also emerged during the MCH needs assessment in 2015, including: health literacy, mental health services, care coordination, and addressing barriers to care (e.g., transportation and childcare). The councils' recommendations and recurrent themes will be considered in the development and implementation of the strategies outlined in the state action plan.

## II-B-2-b: Title V Program Capacity

*i. Organizational Structure*

The Illinois Department of Public Health (IDPH) is designated as the state agency responsible for the administration of the MCH Services Block Grant in Illinois. Within IDPH, the Title V Block Grant is administered by the Office of Women's Health and Family Services (OWHFS) through the Division of Maternal, Child, and Family Health Services (DMCFHS). DMCFHS oversees the Title V-funded MCH programs listed below, as well as fostering collaborations and partnerships with other state programs and systems impacting MCH.

Illinois Programs Funded by Title V

- Teen Pregnancy Prevention – Primary (*IDPH*)
- Regionalized Perinatal System (*IDPH*)
- School Based Health Centers/School Nurse TA (*IDPH*)
- Fetal Infant Mortality Review (*IDPH*)
- Family Planning (*IDPH*)
- Child Dental Sealant Program (*IDPH*)
- Childhood Asthma Initiative (*University of Illinois at Chicago, School of Public Health*)
- Family Case Management (*IDHS*)
- Better Birth Outcomes (*IDHS*)
- Chicago Mini MCH Block Grant (*Chicago Department of Public Health*)
- Illinois Perinatal Quality Collaborative (*Northwestern University*)
- Children with Special Healthcare Needs (CSHCN) (*University of Illinois, Division of Specialized Care for Children*)

Consistent with state statute, the state program for Children with Special Health Care Needs is administered through

Inter-Governmental Agreement (IGA) by the Division of Specialized Care for Children, University of Illinois Chicago.

*(Organizational Chart attached)*

*ii. Agency Capacity*

The mission of IDPH is to promote health through the prevention and control of disease and injury. The Director of IDPH is the State's Health Officer and one of the Governor's key cabinet members.

Under the leadership of the OWHFS Deputy Director and DMCFHS Chief / Title V Administrator, IDPH is able to provide comprehensive population-based programming, education and support to women and families across the life-span. In addition to the programs directly funded by Title V, OWHFS also oversees the Illinois Breast and Cervical Cancer Program, (IBCCP), the WiseWoman program and the Family Planning Title X grant. Through this comprehensive array of services and external partnerships, 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 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 who have 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.

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 telephone families with children ages birth to 5 and 14 to 16 years of age to offer assistance in linking to appropriate services and resources.

*iii. MCH Workforce Development and Capacity*

Dr. Brenda Jones, previous Deputy Director of the IDPH OWHFS and Title V Director, resigned her position in August 2015. In November 2015, Ms. Shannon Lightner, MSW, assumed the role of Deputy Director of the OWHFS and oversees the three divisions of the office.

Ms. Andrea Palmer, MPA, MBA, is Chief of the Division of Maternal, Child and Family Health Services and the Title V Director as of February 2016. Ms. Palmer oversees the operations of the Title V block grant, state MCH programs, and manages the Division Staff. She has over 30 years of experience with the State of Illinois, and joined the Title V staff in January 2014.

Illinois' CDC Assignee in MCH epidemiology is Amanda Bennett, PhD, MPH. Dr. Bennett received her training in MCH epidemiology from the University of Illinois at Chicago, School of Public Health. She joined IDPH as MCH Epi assignee in December 2014.

Thomas F. Jerkovitz, MPA, CPA is the Director of the UIC Division of Specialized Care for Children (DSCC). Mr. Jerkovitz has had a longstanding career in Illinois state government, previously serving in the Governor's Office as Senior Policy Advisor for Health and Human Services, as the Division Chief for the Medical, Child Welfare and Health and Human Services in the Governor's Bureau of the Budget , as the Executive Director of the Illinois Comprehensive Health Insurance Plan (ICHIP), and as Director of Finance for Health Alliance Medical Plans, Inc.

DSCC is supported by several other key staff members. Gerri Clark, RN, MSN, has been the Associate Director of DSCC for 16 years. Ms. Clark previously worked in the Nebraska program for CYSHCN for 8 years. Kevin Steelman, MBA, is Associate Director for Finance. Mr. Steelman has an extensive career in public health care finance as budget officer for IDHS and budget analyst for the Illinois General Assembly. The DSCC Family Liaison Specialist is Bob Cook, who has been in this full-time paid position for the past 16 years. His son was a DSCC recipient and he has extensive knowledge of the program and the needs of families.

The DSCC Family Advisory Committee (FAC) meets at least twice a year and has family member representation from the 12 DSCC 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.

## II-B-2-c: Partnerships, Collaboration, and Coordination

Illinois' Title V grant is implemented through a collaborative partnership between the IDPH (IDPH), Illinois Department of Human Services (IDHS), Illinois Department of Healthcare and Family Services (IDHFS), and the University of Illinois at Chicago (UIC). IDPH is the administrator of the grant and provides population-based services to enhance the State's public health infrastructure, with a particular focus on coordination and collaboration across state initiatives and programs. IDHS provides direct and enabling services to targeted populations at risk for poor health outcomes, including WIC, case management and home visiting services. IDHFS administers the state Medicaid program, and works to improve access to, utilizations of, and quality of care for women and children in Illinois. UIC is the home of the Division of Specialized Care for Children (DSCC), the state program for children with special healthcare needs. The working relationships of these agencies are supported by inter-governmental agency agreements that specify responsibilities in service delivery, performance levels, reporting, and data sharing.

Additionally, IDPH has a formal intergovernmental agreement (IGA) with the UIC Center of Excellence in MCH (within the UIC School of Public Health) to obtain epidemiologic support and assistance. Through this IGA, MCH faculty have assisted with strategic planning, performance measure development, and representation on statewide tasks forces involving MCH data or programs. Additionally, several graduate students have partnered with IDPH to analyze data on specific topics of interest to Illinois Title V and to produce data products that support state decision-making.

Title V also collaborates with other program areas within IDPH, including Title X Family, Division of Vital Records, Division of Patient Safety and Quality, Division of Chronic Disease, Division of Epidemiologic Studies (including Adverse Pregnancy Risk Assessment Monitoring System – the state birth defects registry), Pregnancy Risk Assessment Monitoring System (PRAMS), and the HIV Fetal and Infant Mortality Review (HIV-FIMR), to name a few.

Title V collaborates with a wide variety of other external stakeholders on issues related to MCH. In the state action plan, it is apparent that the majority of the work being done by Title V is only possible through partnerships to improve state systems and infrastructure. Title V participates in statewide committees already underway, but also acts as convener for other initiatives. Some notable ongoing partnerships include: the Governor's Office of Early Childhood Development, Illinois Early Learning Council, Illinois Home Visiting Task Force, Illinois Hospital Association, Illinois

Perinatal Quality Collaborative, EverThrive Illinois (MCH policy organization), and March of Dimes. Illinois Title V has also been included in state public health strategic planning efforts, such as the State Health Improvement Plan, the state Zika Action Plan, and Governor Rauner's newly convened Children's Cabinet.

DSCC maintains close relationships with all major public and private agencies involved in services for CYSHCN, including the 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), EverThrive Illinois, 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).

**Five-Year Needs Assessment Summary (Submitted on July 15, 2015)**

**II.B.1. Process**

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 Illinois Department of Public Health's (IDPH), Office of Women's Health and Family Services (OWHFS) has conducted the Title V needs assessment. The OWHFS 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 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.

***Provider and Organization Surveys***

Three separate targeted surveys were developed to gather input from local health departments, faith-based organizations, and MCH providers. These surveys were available electronically and distributed by email to relevant partners. 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 on the severity of health needs across the life course. Forty-four local health departments responded to the survey.

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 three 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. A total of 180 MCH providers responded to this survey.

***Consumer Focus Groups***

OWHFS partnered with organizations around Illinois to conduct consumer focus groups. Seventeen focus groups were conducted and represented all seven IDPH health regions throughout the state. These groups 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. Themes were identified within each focus group, within each region, and then compiled across the state.

***Key Informant Interviews***

OWHFS also conducted key informant interviews with professionals from various specialties within maternal and child health to gather more detailed information about potential opportunities for Title V. 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.). 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 MCH Epi Assignee conducted the analyses and created the databook to focus on a few key topics and indicators that represented the health issues of each population domain. Within each topic, statewide trends and relevant disparities (racial/ethnic, geographic, age-based, etc.) were reported, as data were available.

The data sources used in the databook included ten major datasets: American Community Survey (ACS), Behavioral Risk Factor Surveillance System (BRFSS), Division of Specialized Care for Children (DSCC) Family Survey, Hospital Discharge Data, 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 synthesize the qualitative and quantitative data and recommend 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, the contractor 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

***Selection of Final Priorities***

OWHFS Staff met after the expert panel meeting to discuss the recommendations and develop the final list of state priority areas. While referencing the Title V 2010 Priorities and the 2015 needs assessment data, staff discussed the expert panel recommendations in light of the state's capacity, feasibility, and political will. Through an iterative discussion, staff developed the ten priority topic areas. Nearly all of the expert panel recommendations were adopted, with only one recommendation omitted (workforce development and provider shortages). 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. Upon coming to consensus on the list of ten priorities, two staff members took the lead on developing the exact language and framing of these topic areas. Draft versions of the priorities were circulated to OWHFS staff for comment and revisions. The final priority list is discussed in Section II.C.

### 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 described.

### 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.

Smoking is a particular concern for Illinois women, particularly those living in rural areas. About 16% of Illinois women ages 18-44 currently smoke, but this rises to 26% in rural Illinois. Given the connection to a myriad of chronic health conditions, as well as the link to preterm birth and poor health outcomes for infants and children, this issue warrants continued focus and priority.

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. Intimate partner violence may also contribute to mental health problems and needs to be addressed for Illinois women. About 3% of Illinois women delivering a baby reported they were physically abused by their husband/partner in the year prior to pregnancy -- a number that is almost certainly underestimated. Young and African-American women are most likely to experience physical partner violence.

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.

The data suggest that Illinois must place a strong effort on meeting the needs of complex health issues among

women. To make an impact, Title V must continue to build relationships between community and primary care providers. This collaboration needs to ensure that all women have timely, appropriate clinical services, maintenance and follow-up. Illinois will focus on care coordination, increase patient education, awareness, and self management of disease. The lack of mental health services is a growing concern for this population. Enhancing quality prenatal care is also a priority for the state.

***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.

Poor 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. he 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. he 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 35$^{th}$ in 2007 to 20$^{th}$ 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.

Infant Mortality remains a concern for the state. The Title V Program will lead in an initiative to bring together leaders from community, social service agencies, faith-based organization, local health departments, and perinatal

providers through the work of COIIN. Illinois has hired an Infant Mortality Coordinator to build collective impact among these groups. Illinois Perinatal Regionalization Program has created a multi-disciplined taskforce using data to ensure infants are born at the right place at the right time. This group has produced great work and the state looks to the future direction of this task force. Rural health breastfeeding rates continue to be a concern. Through a grant with ASTHO and contribution of Title V funds, Illinois has several hospital-community collaborations in place and will continue to work to increase the strength and number of these projects.

***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 leveled between the 2007 and 2011/12 NSCH. However, disparities in obesity remain concerning; 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 3$^{rd}$ 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 3$^{rd}$ 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.

It is important for Illinois to better understanding and address the barriers that prevent children from receiving adequate care. One of the barriers discovered through focus groups was the lack of cultural awareness and sensitivity. The OWHFS has completed Trauma-Informed Training and plans to implement this educational awareness into all programs/grants for FY 2016. Addressing disparities in the burden of asthma and obesity is critical. Title V currently supports educating providers and navigators in high risk communities on the importance of inclusion of spirometry in routine asthma care. The OWHFS plans to continue this work as some very promising outcomes have been documented.

***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 (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 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 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.  ince 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.  irth rates for Black and Hispanic teens were 3.5 and 2.8 times as high as the rate for White teens.  here 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.

OWHFS has hired an adolescent health coordinator to increase building collective impact among community and faith-based organizations, school based health centers to focus on enhancing adolescence social skills, problem-solving skills and self-confidence.  Although Illinois is proud of the reduction in teen births, nevertheless this will remain an active priority.  National data have shown LGBTQ youth to be at increased risk for suicidal thoughts and behaviors, suicide attempts, and suicide.  Understanding how to support this population is an emerging priority in Illinois.  The 2015 Youth Risk Behavior Survey (YRBS) includes a question about how a student identifies their sexuality ; these data could be used in the future in Illinois to examine disparities and emerging health concerns for the LGBT youth population.

***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:

- 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

An important priority for OWHFS is the promotion of health literacy. Research has shown that individuals with low levels of health literacy are least equipped to benefit from the Affordable Care Act, with potentially costly consequences for both those who pay for and deliver their care, as well as for themselves. Rates of low health literacy are disproportionately high among lower-income population. OWHFS is examining how to better promote health literacy within Title V programs and through the various services providers with which women and families

have contact.

**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 Women's Health and Family Services, Division of Maternal, Child and Family Health Services. IDPH is responsible for the population-health infrastructure for health outcomes. IDHS provides case management and enabling services to specific MCH target populations. 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.

**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 Care for Children, 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 the Illinois Department of Public Health (IDPH) is to promote health through the prevention and control of disease and injury. 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. With more than 200 program components organized in its six offices, IDPH 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.

The IDPH Office of Women's Health and Family Services (OWHFS), administers the Maternal Child Health Services Title V Block Grant through its Division of Maternal, Child and Family Health Services. 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. OWHFS 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. 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. Ms. Palmer reports to the Title V Director and oversees the operations of the MCH programs and manages the Division Staff. She has over 30 years of experience with the State of Illinois, and joined the Title V staff in January 2014.

Illinois' Senior MCH 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 has 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.

Thomas F. Jerkovitz, MPA, CPA is the Director of the UIC Division of Specialized Care for Children (DSCC). 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.

DSCC is supported by several other key staff members. Gerri Clark, RN, MSN, has been the Associate Director of DSCC for 15 years. Ms. Clark previously worked in the Nebraska program for CYSHCN for 8 years. Kevin Steelman, MBA, is Associate Director for Finance,. Mr. Steelman 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. The DSCC Family Liaison Specialist is Bob Cook, who has been in this full-time paid position for the past 15 years. His son was a DSCC recipient and he has extensive knowledge of the program and the needs of families.

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. 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.

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.

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

Illinois' Title V grant is implemented through a collaborative partnership between the Illinois Department of Public Health, administrator of the grant and providing population-based services to enhance the State's public health infrastructure; the Illinois Department of Human Services, which provides enabling services to targeted populations at risk for poor health outcomes; Illinois Department of Healthcare and Family Services, which administers the State's Medicaid program. The Maternal and Child Health program collaborates closely with the University of Illinois Chicago, School of Public Health, which provides epidemiological support and guidance to enhance the state's data analysis, use and dissemination.

Recognizing the importance of coordination and collaboration across systems to improve the overall health and well-being of Illinois' mothers, infants, children and adolescents, the Title V program has begun to cultivate a relationship with the Illinois Early Learning Council and Home Visiting Task Force.

Title V partners with the key stakeholders, such as the March of Dimes, Illinois Perinatal Quality Collaborative (ILPQC) and the Illinois Hospital Association (IHA) to enhance the quality of services provided to mothers and infants in the hospital at birth.

The MCH School Health program partners with EverThrive Illinois Child and Adolescent Health Initiative to provide technical assistance and training to support the development and operation of Illinois School-Based Health Centers. In partnership with IDPH School Health Program staff, the Initiative convenes a school health center Steering Committee to identify common issues and needs.

Close liaison is maintained with all major public and private agencies involved in services for CYSHCN, including the 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). .

**II.C. State Selected Priorities**

| No. | Priority Need |
|---|---|
| 1 | Assure accessibility, availability and quality of preventive and primary care for all women, particularly for women of reproductive age |
| 2 | Support healthy pregnancies and improve birth/infant outcomes |
| 3 | Support expanded access to and integration of early childhood services and systems |
| 4 | Facilitate the integration of services within patient-centered medical homes for all children, particularly for children with special healthcare needs |
| 5 | Empower adolescents to adopt healthy behaviors |
| 6 | Assure appropriate transition planning and services for adolescents and young adults, including youth with special health care needs |
| 7 | Assure that equity is the foundation of all MCH decision-making; eliminate disparities in MCH outcomes |
| 8 | Support expanded access to and integration of mental health services and systems for the MCH population. |
| 9 | Partner with consumers, families and communities in decision-making across MCH programs, systems and policies |
| 10 | Strengthen the MCH capacity for data collection, linkage, analysis, and dissemination; Improve MCH data systems and infrastructure |

The state priorities selected during the 2015 needs assessment process remain the same:

Many sources of qualitative and quantitative data were reviewed by an external expert panel and by Title V staff during the 2015 needs assessment process to inform a list of potential state priorities. Based on the recommendations set forth by an 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 women of reproductive age (Women's/Maternal Health)
2. Support healthy pregnancies and improve birth and infant outcomes (Perinatal/Infant Health)
3. Support expanded access to and integration of early childhood services and systems (Child Health)
4. Integrate services within patient-centered medical homes for all children, particularly for children with special healthcare needs (Child Health & CSHCN)
5. Empower adolescents to adopt healthy behaviors (Adolescent Health)

6. Assure appropriate transition planning and services for adolescents and young adults, including youth with special health care needs (Adolescent Health & CSHCN)
7. Assure that equity is the foundation of all MCH decision-making; eliminate disparities in MCH outcomes (Cross-Cutting)
8. Support expanded access to and integration of mental health services and systems for the MCH population (Cross-Cutting)
9. Partner with consumers, families and communities in decision-making across MCH programs, systems and policies (Cross-Cutting)
10. Strengthen the MCH capacity for data collection, linkage, analysis, and dissemination; Improve MCH data systems and infrastructure (Cross-Cutting)

These priorities remained unchanged for this year, with the exception of one minor wording change that was suggested by stakeholders; for priority #2, it was reworded to focus on improving "birth **and infant** outcomes." This acknowledges that many of the infant outcomes of interest (including infant mortality, development/mental health, and breastfeeding) go beyond the perinatal period.

These ten priorities serve as the foundation for the MCH Action Plan, with strategies developed to address each of these areas and improve the outcome and performance measures related to each priority.

## 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
- NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- NPM 11 - Percent of children with and without special health care needs having a medical home
- NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
- 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
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

**SELECTION OF NATIONAL PERFORMANCE MEASURES**

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

**Perinatal / Infant Health Domain:**
*NPM#3: Very Low Birth Weight Babies Born in Level III Hospitals*

**Child Health Domain:**
*NPM #6: Developmental screening for young children*

**Adolescent Health Domain:**
*NPM #10: Adolescent well visits*

**Children with Special Health Care Needs Domain:**
*NPM #11: Medical home*
*NPM #12: Transition services for youth*

**Cross-Cutting Domain**
*NPM #13: Dental services*
*NPM #14: Smoking*

## DEVELOPMENT OF NATIONAL PERFORMANCE MEASURE OBJECTIVES

We sought to use a standardized methodology to set the performance objectives for the next five years of NPM data. This involved looking at baseline data values, considering trends in the indicator over the last 5-10 years, and assessing what level of change would be reasonable and achievable based on improvements to public health infrastructure and services. The endpoint objective for 2020 was established and then the interim years were filled in to show the progress needed to get to that point. The notes pertaining to each NPM are copied below:

NPM 1: Well-Woman Care
Baseline: 2013-14 average = 65.9% (BRFSS) (2011-2014 showed #'s jumping between 62-69%)
Recent Trends: Level between 2009-2014
Target Setting Method: 10% improvement (over 2013-2014 average) by 2020

NPM 3: VLBW in Level III Hospitals
Baseline: 2013 = 79.4% (final birth data)
Recent Trends: Level between 2010-2014
Target Setting Method: 10% improvement by 2020

NPM 6: Developmental Screening for Children <5 years
Baseline: 2011/12 = 34.4% (NSCH)
Recent Trends: 60% Improvement between 2007 and 2011/12
Target Setting Method: 30% improvement by 2020

NPM 10: Adolescent Well Visits
Baseline: 2011/12 = 88.7% (NSCH)
Recent Trends: 4% improvement between 2007 and 2011/12
Target Setting Method: 5% improvement by 2020

NPM 11: Medical Home for CSHCN
Baseline: 2011/12 = 46.4% (NSCH)
Recent Trends: Level between 2007 and 2011/12
Target Setting Method: 10% improvement by 2020

NPM 12: Transition Services for CSHCN
Baseline: 2009/2010 = 45.3% (NS-CSHCN)
Recent Trends: Level between 2005/6 and 2009/10
Target Setting Method: 10% improvement by 2020

NPM 13A: Dental Services for Pregnant Women
Baseline: 2013 = 42.4% (PRAMS)
Recent Trends: unknown, only 2 years of data
Target Setting Method: 10% improvement by 2020

NPM 13B: Preventive Dental Services for Children
Baseline: 2011/12 = 80.8% (NSCH)
Recent Trends: Level between 2007 and 2011/12

Target Setting Method: 5% improvement by 2020

NPM 14A: Prenatal Smoking
Baseline: 2013 = 7.0% (birth files)
Recent Trends: 11% Improvement during 2010-2013
Target Setting Method: 15% improvement by 2020

NPM 14B: Smoke Exposure for Children
Baseline: 2011/12 = 21.0% (NSCH)
Recent Trends: 10% improvement between 2007 and 2011/12
Target Setting Method: 15% improvement by 2020

**SUMMARY: LINKAGE OF STATE PRIORITIES TO NATIONAL PERFORMANCE AND OUTCOME MEASURES**

After the national performance measures (NPMs) were selected for Illinois, they and the national outcome measures (NOMs) were cross-walked back to the ten state priorities. This cross-walk was created for several purposes: 1) to examine the alignment of the state priorities with national priorities, 2) to highlight gaps in national measures that may need to be filled by state outcome and performance measures, and 3) to inform the selection of strategies in the action plan for each priority by focusing the outcome and performance measures of interest.

The first six state priorities were each related to at least one NPM and at least one NOM. These priorities are more traditional priorities that focused on a specific MCH population domain and a particular health issue to improve for that population. Some NPM and NOM fit with more than one state priority, while others were more specific to only one state priority. All of the NOM were related to at least one of the first six Illinois priorities.

The remaining four state priorities (#7: equity, #8: mental health, #9: family/consumer partnership, and #10: data capacity/infrastructure), were all classified by Illinois as "cross-cutting" or "life course" priorities; these priorities were less consistently related to the NPM and NOM. For priority #7, which focused on equity, there were no NPM or NOM that captured a measure of equity, though Illinois could examine the disparities in any of the NPM/NOM and use that as measure of equity. Additionally, there were two NOM that help describe the demographics of Illinois and potential vulnerable populations (CSHCN and uninsured children), but no true "outcome" measures focusing on equity. For priority #8 (mental health), there was no related NPM, but there were a few related NOM. However, these mental-health-related NOM focus exclusively on child and adolescent health, not on women's mental health or substance use.
For priorities 9 and 10, there were no related NPM or NOM, highlighting a need for establishing of state performance and outcome measures.

| **Priority** | **NPM:**<br>**National Performance Measure(s)** | **NOM:**<br>**National Outcome Measure(s)** |
|---|---|---|
| #1: Assure accessibility, availability and quality of preventive | 1: % women with a past year preventive medical visit | 1: Births with prenatal care in the first trimester<br><br>2: Severe maternal morbidity |

| | | |
|---|---|---|
| and primary care for all women, particularly for women of reproductive age | | 3: Maternal mortality rate<br><br>4.1: LBW deliveries<br>4.2: VLBW deliveries<br>4.3: Moderately LBW deliveries<br><br>5.1: Preterm births<br>5.2: Early preterm births<br>5.3: Late preterm births<br><br>6: Early term births |
| #2: Support healthy pregnancies and improve birth outcomes | 1: % women with a past year preventive medical visit<br><br>3: % Very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)<br><br>13A: % Pregnant women who had their teeth cleaned<br><br>14A: % Women smoking during pregnancy | 1: Births with prenatal care in the first trimester<br><br>2: Severe maternal morbidity<br><br>3: Maternal mortality rate<br><br>4.1: LBW deliveries<br>4.2: VLBW deliveries<br>4.3: Moderately LBW deliveries<br><br>5.1: Preterm births<br>5.2: Early preterm births<br>5.3: Late preterm births<br><br>6: Early term births<br><br>7: Non-medically indicated elective deliveries<br><br>8: Perinatal mortality<br><br>9.1: Infant mortality<br>9.2: Neonatal mortality<br>9.3: Post neonatal mortality<br>9.4: Preterm-related mortality<br>9.5: Sleep-related SUID death rate<br><br>10: Infants with fetal alcohol exposure in the last 3 months of pregnancy<br><br>11: Neonatal abstinence syndrome rate<br><br>12: Newborns screened for heritable disorders |
| #3: Support expanded access to and integration of early childhood | 6: % Children (10-71 months) receiving a developmental screening using a parent-completed tool | 13: Children meeting the criteria developed for school readiness *(developmental)*<br><br>17.3: Children diagnosed with autism spectrum |

| | | |
|---|---|---|
| services and systems | | disorder<br><br>17.4: Children diagnosed with attention deficit disorder / attention deficit hyperactivity disorder (ADD/ADHD)<br><br>19: Children in excellent or very good health |
| 4: Facilitate Integration of services within patient-centered medical homes for all children, particularly for CSHCN | 6: % Children (10-71 months) receiving a developmental screening using a parent-completed tool<br><br>11: % Children (with and without special healthcare needs) who have a medical home<br><br>13B: % Children who had a preventive dental visit in the last 12 mos<br><br>14B: % Children who live in a household with someone who smokes | 14: Children ages 1 to 17 who have decayed teeth or cavities in the last 12 months<br><br>15: Child mortality rate<br><br>18: Children with a mental or behavioral health condition who received treatment or counseling<br><br>19: Children in excellent or very good health<br><br>20: Children and adolescents who are overweight or obese<br><br>22.1-5: various vaccination measures |
| #5: Empower adolescents to adopt healthy behaviors | 10: Adolescents (ages 12-17) with a preventive medical visit in the past year | 16.1-3: Adolescent mortality rate, motor vehicle mortality rate, suicide rate<br><br>19: Children in excellent or very good health<br><br>20: Adolescents who are overweight / obese<br><br>22.2-22.5: various vaccination measures |
| #6: Assure appropriate transition planning and services for adolescents and young adults, including youth with special health care needs | 12: Adolescents (with and without special health care needs) who received services necessary to make transitions to adult health care | 17.2: Children with special health care needs (CSHCN) receiving care in a well-functioning system |
| #7: Assure that equity is the foundation of all decision-making; eliminate disparities in MCH outcomes | No NPM<br>*(but can consider disparities in the selected NPM)* | 17.1: Percent of children with special healthcare needs<br><br>21: Children without health insurance<br><br>*(can also consider disparities in any of established NOM)* |

| | | |
|---|---|---|
| #8: Support expanded access to and integration of mental health services and systems for the MCH population | No NPM | 10: Infants with fetal alcohol exposure in the last 3 months of pregnancy<br><br>11: Neonatal abstinence syndrome rate<br><br>16.3: Adolescent suicide rate, ages 15-19 per 100,000<br><br>17.3: Children diagnosed with autism spectrum disorder<br><br>17.4: Children diagnosed with attention deficit disorder / attention deficit hyperactivity disorder (ADD/ADHD)<br><br>18: Children with a mental or behavioral condition who received needed treatment or counseling |
| #9: Partner with consumers, families and communities in decision-making across MCH programs, systems and policies | No NPM | No NOM |
| #10: Strengthen the MCH capacity for data collection, linkage, analysis, and dissemination; Improve MCH data systems and infrastructure | No NPM | No NOM |

**SELECTION OF EVIDENCE-BASED STRATEGY MEASURES**

*Evidence-based strategy measures are still in the process of being developed. This section will be updated by July 15, 2016*

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

*State performance and outcome measures are still in the process of being developed. This section will be updated by July 15, 2016*

### II.F. Five Year State Action Plan

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

Illinois' Maternal and Child Health Services, Title V, activities are implemented primarily through a collaborative relationship between the Illinois Department of Public Health (IDPH), which administers the grant, the Illinois Department of Human Services (DHS), the City of Chicago's Department of Public Health, Division of Maternal, Infant, Child and Adolescent Health (MICAH), and Illinois' Medicaid agency, the Illinois Department of Healthcare and Family Services (HFS).

State Action Plan Table

Please go to the Appendix to view a full version of the State Action Plan Table.

**Women/Maternal Health**

**Measures**

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 67.2 | 68.5 | 69.8 | 71.1 | 72.5 | 73.8 |

**Data Source: Behavioral Risk Factor Surveillance System (BRFSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 69.8 % | 2.1 % | 1,617,749 | 2,319,244 |
| 2013 | 62.0 % | 2.1 % | 1,441,461 | 2,326,099 |
| 2012 | 69.2 % | 2.0 % | 1,610,387 | 2,328,544 |
| 2011 | 63.2 % | 2.1 % | 1,468,310 | 2,324,146 |
| 2010 | 63.5 % | 2.1 % | 1,514,123 | 2,383,986 |
| 2009 | 63.9 % | 1.9 % | 1,527,522 | 2,390,757 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**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, 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.

Convene public and private partners, including our sister state agencies, managed care and fee for service payers to expand the availability of patient-centered medical homes for women.

Collaborate with the University of Illinois School of Public Health, Illinois' Family Planning program and the Illinois Department of Healthcare and Family Services (HFS) to develop a pilot for pediatricians and family practice physicians to offer women an opportunity to complete a reproductive health planning tool during their infants well-baby visits.

Partner with key stakeholders, including healthcare provider organizations, state case management programs, the Women, Infant and Children (WIC) nutrition program and infant and early childhood providers to improve patient navigation from prenatal to postpartum care, particularly for women with chronic diseases.

Provide training and support to home visiting providers, Healthy Start, WIC, Better Birth Outcomes, Family Case Management and other providers working directly with expectant and new mothers to increase patient awareness of the impact of birth spacing and highly effective contraception, particularly Long Acting Reversible Contraception (LARC) inserted immediately following birth.

Collaborate with HFS to develop training and support for health care providers around the effective use of LARC.

Work with HFS 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.

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

Collaborate with key stakeholders, including the Illinois Breast and Cervical Cancer and Wise Woman programs and the Division of Chronic Disease to identify strategies that can be implemented to raise women's awareness of strategies and activities that may be implemented during childbearing years to prevent the on-set, or increase early identification and treatment of chronic disease.

Make Mental Health First Aid training available to non-healthcare providers working with women to increase awareness of the signs and symptoms of mental illness and to enhance their capacity to assist women to access appropriate care.

Work with IDPH's Office of Minority Health to increase the Department's effectiveness in addressing health disparities and to 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.

**Women/Maternal Health - Annual Report**

In the Cook and collar counties areas, women enrolled in the Family Case Management (FCM) and Better Birth Outcomes (BBO) programs who screen positive for symptoms of perinatal depression are referred for further screening and assessment. In FY 15, 450 women displaying symptoms of depression prenatally or during the infant's first year of life, were referred to Healthcare Alternative Systems (HAS). 408 clients received behavioral

health services in SFY 16 year to date with 2 months left in the FY and appear to meet or exceed FY 15 numbers. Those women who are determined to have depression are offered individual and group counseling at no cost to the client. Many of these women have co-occurring issues, such as being in a domestic violence situation, isolation from family and support systems, homelessness, substance abuse in the home, and financial hardships. Many of the women are immigrants, and English is their 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 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 woman 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. Northshore served 225 women in SFY 15, exceeding the goal by 300% and surpassing FY 14 service delivery to this population by 11%. 70 DHS providers utilized the services of the hotline during this timeframe, surpassing FY 14 DHS provider call volume by 17%. Northshore is also available to provide education for DHS case management funded providers upon request.

The Perinatal Mental Health Disorders Prevention and Treatment Act, also known as the Perinatal Mood Disorders Act, which became effective January 1, 2007 mandates that IDHS provide written materials to hospitals, physicians and other providers on perinatal mood disorders for client education. In the first two quarters of SFY 15, DHS distributed 350,000 "Is it The Baby Blues or Something Else" brochures in English across the state. These were shipped to birthing hospitals, physician practices, FCM providers and other types of providers 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.

A small group of professionals continued to work on development of the Rules to accompany the Perinatal Mood Disorders Act in 2015. The Rules further define the mandated requirements for who is to offer screening, when, documentation and follow-up for positive screens. The Joint Commission on Administrative Rules adopted the new rules per 39 Illinois Register 9919, effective July 1, 2015.

The greatest barrier in meeting the needs of women across Illinois who display symptoms of perinatal mood disorders continues to be funding and availability of, and access to services. The Perinatal Mood Disorder statute is an unfunded mandate. Monies to support the MOM's Hotline and HAS are from the General Revenue Fund and Infant Mortality Reduction (IMR) Initiative funds, neither of which are unlimited nor have the capacity to cover the estimated need.

In July 2014 the Illinois Department of Healthcare and Family Services (IDHFS) began mandatory and voluntary enrollment into Medicaid managed care plans across most of Ilinois. This happened through contracts with Accountable Care Entities (ACE), Managed Care Organizations (MCO), and other contracted groups. ACEs were subsequently removed from the models of care.
The functions of an ACE, e.g., care coordination, have been incorporated into the MCO plans. All models of care are expected to provide case management services for pregnant women, infants and children at risk for poor health outcomes.

Because care coordination is also a component of the IDHS Better Birth Outcome program, the IDHS and IDHFS have been meeting regularly to avoid duplication of effort, while assuring that services are available across the states.

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

The Chicago Department of Public Health's WIC program collaborated with the UIC College of Dentistry to improve awareness of oral health for WIC clients. Collaboration began in August 2015 and is ongoing. UIC provided group and one-on-one training sessions on Motivational Interviewing for WIC nutritionists with an emphasis on oral health. Dental workshops were also held in the WIC waiting room. Overall, the goal was to increase oral health education among women and children served by CDPH WIC.

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**Perinatal/Infant Health**

**Measures**

**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 | 2021 |
| Annual Objective | 81.9 | 82.7 | 83.6 | 84.4 | 85.2 | 86 |

**FAD not available for this measure.**

**Perinatal/Infant Health - Plan for the Application Year**

According to Illinois' 2015 MCH Needs Assessment, racial disparities are a major concern in Illinois and are negatively impacting the state's overall outcomes in 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 the nation 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. Supporting healthy pregnancies and improving birth outcomes are the priorities for the Perinatal/Infant health domain. To achieve these priorities Illinois continues to implement the 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. Strategies include:

- Utilize existing programs and partnerships, such as the Family Case Management, Better Birth Outcomes, Women Infant and Children (WIC), Healthy Start and Maternal, Infant and Early Childhood Home Visiting Program (MIECHVP) to increase women's awareness of accessing preventive and primary healthcare through patient-centered comprehensive medical homes. Provide education and support to these partners to assure that women have access to information on family planning and effective contraception, including Long Acting Reversible Contraceptives (LARC) inserted at birth, dental visits and smoking during pregnancy.

- Promote the awareness and use by healthcare professionals, of the Perinatal Education Toolkit established by the Child Health Insurance Program Re-Authorization Act (CHIPRA) Quality Demonstration Grant workgroup, which contains patient information on preconception, prenatal, postpartum and interconceptional health topics and provider information including postpartum care transition strategies, prenatal care quality tool and high-risk referral crosswalks developed from the American Congress of Obstetricians and Gynecologists (ACOG) and Illinois Academy of Family Physicians (IAFP) guidelines.

- Continue to support the Regional Perinatal Health program, including its Administrative Perinatal Centers. To assure that hospitals are delivering care in accordance with the State's Administrative Rule and to facilitate the transport of mothers and infants at risk of poor health outcomes to facilities designated to have the capacity to

provide an appropriate level of care.

- Contribute to the Illinois Perinatal Quality Collaborative in order to continue to improve the quality of healthcare services provided in birthing hospitals, particularly the Hypertension Safety Bundles and Golden Hour Quality Improvement project for newborns.

- Work to improve the outcomes of premature infants by continuing the Medical Study that will allow the Department to survey birthing hospitals designated at levels less than III, who deliver pre-term infants to identify and ameliorate barriers to transports to appropriate levels of care.

- Collaborate with state and community partners such as the Illinois Quit Line, and Illinois Lung Association to develop and disseminate educational materials on smoking during pregnancy.

- 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.

- Work with experts in the field to develop and implement Continuing Medical Education (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.

- 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.

- Continue to support the Maternal Mortality Review Committee (MMRC) for violent deaths, which will include a reviews of non-clinical maternal mortalities occurring outside of the hospital. (e.g., deaths due to domestic violence, substance abuse, suicide)

- Work with the Centers fo Disease Control and Prevention to enhance the identification, selection and abstract of maternal deaths for review by the MMRC and MMRC –V.

- 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.

**Perinatal/Infant Health - Annual Report**

Family Case Management: The Family Case Management Program (FCM) is a statewide program that helps families below 200% of the federal poverty level, with a pregnant woman, infant, or young child to obtain the health care services and other assistance they may need to have a healthy pregnancy and to promote the child's healthy development. The Better Birth Outcomes (BBO), Adverse Pregnancy Outcome Reporting System (APORS), High Risk Infant Follow (HRIF) and Health-works of Illinois are specialized case management services provided within the Family Case Management (FCM) program. The Illinois Department of Human Services (IDHS) contracts with 107 providers across Illinois to deliver FCM services. The goal is to reduce infant morbidity and mortality through assessment, referral, linkage and education regarding pregnancy and pediatric care to Medicaid-eligible families. FCM providers are provided with "case-finding" lists of potentially eligible pregnant women, identified through Medicaid billing. Providers conduct outreach to locate and enroll identified women. Families are enrolled in FCM anytime during the pregnancy and are followed until the child is one year old. In addition to referrals and support for prenatal care during pregnancy, the mother receives education regarding home safety, injury prevention, parenting and child development ; infants are linked to pediatric care, including immunizations, well-baby checks and developmental screening.

Better Birth Outcomes (BBO), available in 22 of Illinois' most vulnerable Counties, focuses exclusively on pregnant women at high risk for poor birth outcomes. Pregnant women who have a history of high cost births are highlighted on the "case-finding" list. Providers conduct outreach using a standard assessment process engage and enroll pregnant women. The prenatal education curriculum, as developed by the March of Dimes, is provided to each participant either by a registered nurse or a master's trained social worker. The coordination among medical and social service providers is the hallmark of the program. Communication mechanisms between prenatal care providers and BBO care coordinators are in place. Interfaces between the state's large information systems (e.g., Medicaid Claims, Vital Statistics and Cornerstone) alert care coordinators of at-risk women, inform the care providers and coordinators of the services being delivered, and report performance in terms of services delivered and pregnancy outcome.
In the Cook and collar counties areas, women enrolled in the Family Case Management (FCM) and Better Birth Outcomes (BBO) programs who screen positive for symptoms of perinatal depression are referred for further screening and assessment.

In FY 15, 450 women displaying symptoms of depression prenatally or during the infant's first year of life, were referred to Healthcare Alternative Systems (HAS). 408 clients received behavioral health services in SFY 16 year to date with 2 months left in the FY and appear to meet or exceed FY 15 numbers. Those women who are determined to have depression are offered individual and group counseling at no cost to the client. Many of these women have co-occurring issues, such as being in a domestic violence situation, isolation from family and support systems, homelessness, substance abuse in the home, and financial hardships. Many of the women are immigrants, and English is their 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.

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The Joint Commission on Administrative Rules adopted the new rules for the Perinatal Mood Disorders Act, effective July 1, 2015.

The greatest barrier in meeting the needs of women across Illinois who display symptoms of perinatal mood disorders continues to be funding and availability of, and access to services. The MOM's Hotline and HAS are from the General Revenue Fund and Infant Mortality Reduction (IMR) Initiative funds, neither of which have the capacity to cover the estimated need.

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Because care coordination is also a component of the IDHS Better Birth Outcome program, the IDHS and IDHFS have been meeting regularly to avoid duplication of effort, while assuring that services are available across the states.

Regionalized Perinatal Health Program Illinois has a robust Regionalized Perinatal Health program. Birthing hospitals are categorized according to their capacity to serve mothers and newborns at risk for poor health outcomes. The levels of care are as follows:

| Level of Care | Current IDPH |
|---|---|
| **Level I** | · Care to healthy newborns ≥37 wks gestation |
| **Level II** | · Care to newborns >32 weeks gestational age and 1500 g BW<br>· Mechanical |

| | |
|---|---|
| | ventilation/CPAP <6 hours |
| **Level IIE** | · Care to newborns >30 weeks or 1250 grams |
| **Level III** | · Care for all preterm infants<br>· Provide or facilitate transport<br>· 24 hour service for medical/surgical specialists |

Each birthing hospital must align itself with one of the ten Administrative Perinatal Centers and its' corresponding Regional Network. Each Administrative Perinatal Center (APC) is affiliated with a teaching institution, required to have extensive resources, including Neonatologists, Maternal-Fetal Medicine Physicians and Pediatric Surgeons; and designated to provide the highest level of care. APCs are responsible for implementation of the State's regionalized perinatal health program and provide the following services:

1. Continuing education for health care professionals
2. Leadership and implementation of Continuous Quality Improvement Projects, including Regional Quality Council meetings for network hospitals.
3. Maternal and neonatal transport services, when patients must be transferred to a higher level of care.
4. Consultation services for high risk perinatal patient

During the Report year the Administrative Perinatal Centers assisted hospitals in preparing for designation and re-designation site visits by providing training, technical assistance and support to assure that their perinatal resources and services were consistent with the standards of care required for the hospital's designated level. Perinatal Centers also assisted network hospitals in establishing Mortality and Morbidity Review committees to review perinatal deaths and selected morbidities to identify factors which may be preventable and signal an opportunity for quality improvement.

Perinatal Advisory Committee The Perinatal Advisory Committee (PAC) advises the Director of the Department of Public Health on issues related to Perinatal Health. The PAC consists of four sub-committees, which include:

1. Maternal Mortality Review Committee (MMRC)- which reviews selected maternal deaths to identify opportunities for quality improvement, such as the Obstetrical Hemorrhage Education program.
2. State Quality Council – Through Administrative Perinatal Centers monitors the quality of perinatal health care and identifies and supports quality improvement projects which improve services and perinatal outcomes.
3. Facility Designation – Provides guidance on the regional perinatal infrastructure, including recommending the approval of hospital designations.

During the report year the Perinatal Advisory Committee had an Ad Hoc committee considered the American

Academy of Pediatrics recommended changes in Levels of Neonatal Care. The committee recommended that Illinois modify current data collection to gather the information necessary for an informed decision to be made about the levels of care needed within the State.

Birth Certificate Quality Improvement Project: At the recommendation of the PAC State Quality Council, IDPH Division of Maternal and Child Health Services brought together a representative of the Regional Perinatal Health Program, representatives from the Divisions of Vital Records; Hospital Safety, which houses hospital discharge data; epidemiological support from the University of Illinois School of Public Health; the Illinois Hospital Association and the Illinois Perinatal Quality Collaborative. With the assistance of UIC, the team reviewed a random sampling of birth certificate data related to the health history and demographics of mothers delivering in Illinois and found that there were obvious inconsistencies and inaccuracy in the data being reported in seventeen key variables from the birth certificate. A driver diagram was developed to establish to identify an aim and strategies to improve the quality of Illinois' birth certificate data. With funding from the Centers for Disease Control and Prevention, IDPH contracted with the Illinois Perinatal Quality Collaborative to develop and successfully implement a quality improvement plan for birthing hospitals to achieve 95% accuracy on the seventeen key variables of the birth certificate.

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.

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. For infants born in 2015, there were approximately 877 infants considered lost to follow-up at 60 days of age. Referrals for these infants were sent to local health departments (LHDs) across the state for assistance in locating the child and facilitating follow-up. Approximately 41% of infants referred to LHDs have been resolved to date. Additionally, DSCC loaned oto-acoustic emissions hearing screening equipment and training to 17 rural LHDs to use in WIC clinics or home visits to improve the lost to follow up numbers.

IDPH and DSCC met with HFS and their contracted Managed Care Organizations to explain EHDI efforts and goals. The Department of Human Services Bureau of Early Intervention implemented an Intergovernmental Agreement to facilitate a data exchange that will improve EHDI program tracking of infants with hearing loss.

IDPH EHDI used CDC grant funding to improve the Hi*Track data system transitioning to a web-based platform for easier reporting to IDPH

. For this period, 152,201 infants were reported to IDPH; 98.9.0% of the infants were screened prior to discharge with 0.5% deceased and 0.7% not screened to date. Of those screened 3.2% referred and 282 have a confirmed hearing loss. This data is within the nationally established targets.

The Chicago Department of Public Health  Maternal, Infant, Child and Adolescent Health Bureau, along with its volunteer advisory committee, oversaw the *Right Place, Right Time* Initiative. The committee reviewed and provided revisions to the Chicago Fire Department's (CFD) standing medical orders related to obstetric transport to ensure that women deliver at the "right place and right time." An in-service was offered for all CFD EMS staff on caring for obstetric patients and determining which facility to transport patients.

**Child Health**

**Measures**

**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 | 2021 |
| Annual Objective | 36.3 | 38.3 | 40.4 | 42.5 | 44.7 | 46.8 |

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 34.4 % | 3.1 % | 288,409 | 838,437 |
| 2007 | 21.1 % | 2.5 % | 183,009 | 867,645 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**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:

Support the Illinois Children's Cabinet, Governor's Office of Early Childhood Development and Early Childhood Inter-Agency Team's efforts to create synergy and coordination between the State's multiple child-serving systems.

Coordinate and support the Illinois' Children's Cabinet and State Health Improvement Plan's efforts to promote development of medical homes for all children, including for children and youth with special healthcare needs.

Collaborate with the Governor's Office of Early Childhood Development and the Illinois Early Learning Council to create a comprehensive coordinated system to monitor developmental and social emotional screening completed within the State's various child-serving systems.

Through collaboration with the Illinois Leadership and Education in Neurodevelopmental and other Disabilities (LEND), increase awareness, training and support for the early identification and treatment of Autism.

Illinois' Title V program will collaborate with early childhood systems to promote healthy families through increased parent education, expansion of the MCH workforce's 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. The School Health program annual workshops will include a discussion about the role of school nurses in providing health education and life skill development.

The Title V program will also continue to fund the Childhood Asthma initiative and collaborate with other Asthma initiatives within the State, 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.

Childhood Obesity

The Medicaid Agency is currently seeking Governor's Office approval to engage in a 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.

Update - A continuation grant to HFS from Otho S.A. Sprague Memorial Institute 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. The project is funded into 2017.

An Early Intervention Care Coordination Provider Toolkit was released in November 2015 (SFY2016) to help providers initiate a referral to Early Intervention services for children with suspected developmental delay, and to receive information back from Early Intervention about the outcome of the referral. This provider toolkit was developed by Illinois Healthy Beginnings II (IHB2). IHB2 was a three-year project with funding from The Commonwealth Fund to the Illinois Department of Healthcare and Family Services (HFS). The project was administered by the National Academy for State Health Policy (NASHP). Collaborators on the project were the Illinois Department of Human Services (DHS); Illinois Chapter, American Academy of Pediatrics (ICAAP) and HFS.

The goal of the IHB2 Project is two-fold:

- To ensure that Illinois children with suspected developmental delay or risk factors receive coordinated comprehensive care in which providers interacting with the family are aware of each other, appropriately access a variety of services, and collaborate to ensure the best possible outcomes are achieved for the child; and

- To create support for children and their families who may be at risk for developmental delay or disability but who do not meet Early Intervention or special education eligibility guidelines.

To encourage success in meeting these goals, the purpose of the toolkit is to provide a referral resource for enhancing care coordination among primary care medical homes, early intervention service providers, and community service providers that work with Illinois children and their families. The content of the toolkit recognizes that **linking medical homes to home visitors, childcare providers, and providers serving homeless children and families,** enables the PCP to:

- Provide more comprehensive care, and

- Increase knowledge of access to resources not typically available in a medical home.

Likewise, by **collaborating with the medical home, the home visitor, childcare provider, and providers serving homeless children and families** may be able to:

- Communicate the family's health needs and risk factors back to the PCP,

- Increase opportunities for referral to additional services or consultation,

- Reinforce the need to use referrals for additional services, and

- Reinforce the need to use the medical home (not the emergency room) for primary health care.

The tookit is available at: http://www.illinois.gov/hfs/MedicalProviders/MaternalandChildHealth/Pages/Early-Intervention-Care-Coordination-Provider-Toolkit-.aspx

EPSDT

Efforts to improve the EPSDT participation rate include the mailing of annual notices to families with children. 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. MCOs also have quality measures included in their contracts that are the basis for ongoing evaluation by HFS. These measures are compared to national HEDIS® percentiles used as benchmarks to gauge performance. The plans engage in collaborative performance improvement projects (PIP) currently focused on behavioral health care coordination. HFS conducts quarterly quality meetings with plans to disseminate information about performance, provide quality improvement information, and to educate plans about existing state agency services to encourage cross-agency/plan collaboration and coordination.

Title V will actively contribute as a member of the SIAC Health Subcommittee. The SIAC works to recommend appropriate changes to early childhood systems and improve coordination and integration across early childhood programs in order to address the comprehensive nature of children's healthy development and readiness for school. As of Spring 2016, SIAC's Health Subcommittee will be working to develop recommendations and implementation steps that strengthen the relationship between health and early childhood provider sectors to promote increased

awareness of and enrollment in high quality early childhood programs and services that play a critical role in supporting children and families to achieve the best health outcomes.

Chicago Department of Public Health (MICAH) will implement the Child Opportunity Index (COI) by using local data to map child opportunity in the domains of social and economic, health and environment, and education in Chicago's 77 community areas. We will use this index to assess various health outcomes and inform interventions.

**Child Health - Annual Report**

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

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.

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 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 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 5 million children and adolescents (ages 0 through 20 years) during FFY 2015 were eligible for Medicaid (Title XIX). Of the children eligible for 90 continuous days or more, over one half received at least one health service during FFY 2015. This rate is lower than in previous years due to an increase in the periodicity schedule for recommended visits used in the CMS-416 report to the federal government. The analysis producing the CMS-416 results underwent review to assess programming logic, accuracy and conformance to CMS-

416 guidance. Compared to previous reports, this results in decreased counts of eligible individuals (Lines 1a-1b) as recipients were regrouped from Title XIX to Title XXI, decreased counts of screens received (Line 6), increased counts of referrals to corrective treatment (Line 11), and increased counts of eligibles enrolled in managed care (Line 13). 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 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 2016 report is available on HFS' web site at.

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 "'Bio-U 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 85st 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.illinois.gov/hfs/MedicalProviders/notices/Pages/prn140124c.aspx. The information is also incorporated into HFS' Healthy Kids Handbook.

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 318 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 FFY2015, 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.

During November 2015, HFS, DHS and the Illinois Chapter of the American Academy of Pediatrics (ICAAP) released a toolkit to improve adoption and use of the Early Intervention referral forms. The toolkit, entitled, "Coordinating Medical Homes and Community Services: A Resource for Enhancing Referrals and Care Coordination among Primary Care Medical Homes, Early Intervention Service Providers and Community Service Providers," is available on the HFS web site. This provider toolkit was developed by Illinois Healthy Beginnings II (IHB2). IHB2 was a three-year project with funding from The Commonwealth Fund to the Illinois Department of Healthcare and Family Services (HFS). The project was administered by the National Academy for State Health Policy (NASHP). Collaborators on the project were the Illinois Department of Human Services (DHS); Illinois Chapter, American Academy of Pediatrics (ICAAP) and HFS.

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.

The City of Chicago began the development of *Connect4Tots,* a free texting services offered to City residents, that provides information and resources to caregiver of children 1-3 years of age.
MICAH staff co-chaired this advisory committee of early childhood health content experts and developed the framework of the program. *Connect4Tots* will launch in the Summer of 2016.

**Adolescent Health**

**Measures**

**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 | 2021 |
| Annual Objective | 89.5 | 90.3 | 91.2 | 92.1 | 93.1 | 94 |

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 88.7 % | 1.7 % | 933,080 | 1,051,653 |
| 2007 | 85.1 % | 1.9 % | 914,102 | 1,074,244 |
| 2003 | 75.0 % | 2.0 % | 807,333 | 1,076,808 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**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

Utilize the School Health program's annual workshops to provide technical assistance to school nurses on transition planning for children with an Individual Education Plan (IEP)

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 continue to 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.

Using an evaluation plan developed in collaboration with the Harvard School of Public Health, the Teen Pregnancy Prevention-Primary program will evaluate the effectiveness of the implementation of the current programming, identify a select number of evidence-based Teen Pregnancy Prevention curricula to be utilized by all programming and develop a competitive application for on-going programming.

Work with key stakeholders, including Illinois' Family Planning and School Health programs, HFS and the American Academy of Pediatrics to increase the availability of adolescent-friendly clinics that provide family planning services.

Work with the Leadership and Education for Neurodevelopmental and other Disabilities (LEND) program and other key stakeholders to develop appropriate messaging for parents and adolescents transitioning from pediatric to adult health care.

Partner with the state Early and Periodic Screening, Diagnosis and Testing (EPSDT) program to educate and encourage pediatric providers to incorporate transition planning into their routine adolescent well-child visits, including the use of the standardized transition tools such as the transition readiness assessment.

Continue to co-sponsor the annual Transition Conference, including the participation on the planning committee and supporting DSCC youth and families to attend.

Continue to promote transition planning via social media, including maintaining Transition Tips and Tools materials on the DS website, linking with national health care transition resources at Got Transition's website and posting transition planning and training opportunities.

Continue coordination and collaboration with the Early Intervention and evidence-based home visiting programs, local health departments, health-care provider groups, HFS, Medicaid Managed Care Organizations, Family2Family and other community groups to address system barriers.

Renew Action Learning Collaborative team efforts to implement the National Standards for Systems of Care for children and youth with special healthcare needs.

Utilize data from the National Survey of Children's Health to establish a baseline on the state's performance in transitioning youth from pediatric to adult care; conduct in-depth analysis of the new survey questions regarding transition.

IDPH funded School Health Centers will continue to participate in a project to increase adolescent well visits for students who were not required to have required school physicals in FY 16. Illinois requires physicals for entry into grade K, 6$^{th}$ and 9$^{th}$. The intent is to increase well child visits for grades 7, 8, 10, 11, and 12. Many of these adolescents, especially those living in poverty, see a doctor only for sick visits. Well visits are defined as those that include a physical exam, review and update of immunizations, Bright Futures risk assessment and related anticipatory guidance, treatment or referral, HPV vaccine, Influenza vaccine and STI testing and treatment if sexually active.

**Adolescent Health - Annual Report**

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 purpose of the Illinois Teen Pregnancy Prevention-Primary (TPP-P) Program, which is funded completely with Title V dollars, is to reduce teenage pregnancy, sexually transmitted infections, and HIV/AIDS among 11 to 18 year olds in Illinois through education and shared knowledge that involves family and partners. TPP-P promotes respect for patient needs and preferences and sensitivity to nonmedical and spiritual dimensions of care. Through collaboration and team management, a free flow and accessibility of information is provided to program participants.

The Illinois Teen Pregnancy Prevention Program is designed to support the implementation of direct services (evidence-based curriculum, work with a coalition and two supplemental activities) that target youth in grades 5th through 12th in a geographic area with a high demonstrated need. The TPP-P Program is based on collaborative relationships among community partners. The purpose of the local coalition is to promote capacity building by involving community stakeholders in planning for and the delivery of services aimed at reducing teen pregnancy. Capacity building also supports the local level coordination of services and collaboration amongst various stakeholders, including parents and youth.

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. 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.

CDPH collaborated on the youth authored "Chicago Wears Condoms" campaign, a city-wide social marketing campaign and companion website on the importance of condoms and where to locate free condoms throughout the City. The campaign launched in December 2015.

CDPH launched the Condom Availability Program (CAP), which included the placement of condom dispensers with free condoms in CPS high schools, school based health centers, and City Colleges. Over 50 partners were recruited for the CAP by September 2015.

## Children with Special Health Care Needs

### Measures

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 47.2 | 48.1 | 49 | 50 | 51 | 51.9 |

**Data Source: National Survey of Children's Health (NSCH) - CSHCN**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 46.4 % | 3.5 % | 271,960 | 585,615 |
| 2007 | 45.9 % | 3.5 % | 264,785 | 577,349 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: National Survey of Children's Health (NSCH) - NONCSHCN**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 58.1 % | 1.8 % | 1,402,407 | 2,412,095 |
| 2007 | 58.2 % | 1.7 % | 1,465,878 | 2,518,125 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

### 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 | 2021 |
| Annual Objective | 46.2 | 47.1 | 48 | 48.9 | 49.8 | 50.7 |

**Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2009_2010 | 45.3 % | 3.7 % | 76,540 | 169,119 |
| 2005_2006 | 44.2 % | 3.4 % | 71,822 | 162,576 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

DSCC will strengthen collaborative efforts with IDPH and other partners in using the National Standards for Systems of Care for Children with Special Health Care Needs to improve the systems of care for Children with Special Health Care Needs in Illinois. Partners necessary to this work will be Healthcare and Family Services (HFS), the state Medicaid agency, and its contracted MCOs; the Early Intervention/Part C program; the LEND program; the Illinois Chapter of the American Academy of Pediatricians (ICAAP); the Family-to-Family Health Information Center; Illinois children's hospitals; and other interested stakeholders.

**Medical Home:**

DSCC will collaborate with IDPH, 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. DSCC will also 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 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**

Families Partnering in Decision-Making at All Levels: The UIC-DSCC website 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 is the goal of the new website.

Additional families were encouraged to share their stories to help update the UIC-DSCC website. Family Advisory Council (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 to provide facilitation for a Quality Improvement team in Peoria working to improve their capacity to provide a medical home to children in their practice. This group practice is also working to achieve NCQA Patient Centered Medical Home (PCMH) recognition. Efforts have focused on immunization rates for 12-14 month old children, AAP Practice Guidelines for Care of Down Syndrome Children, and Asthma management. They also surveyed families on recognition of care coordination efforts and access to the office by phone. As of March, 2016, over 2,000 sites have been granted NCAQ PCMH recognition, and nearly 1,400 more sites (163 organizations) have been accredited by the Joint Commission under Primary Care Medical Home. UIC-DSCC published a newsletter on Medical Home, describing the components of a medical home, providing resources for families to use, and linking to a webinar on Family Professional Partnerships that UIC-DSCC hosted.

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. 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. Since the implementation of mandatory Medicaid Managed Care in certain areas of the state, there have been more questions from families and providers as they learned how this model of service delivery and payment works. 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: Through an 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. There are now over 1,000 children receiving DSCC care coordination and in-home nursing services.

New resources have been added to the UIC-DSCC website, and events and time-limited information has been shared via social media.

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 CYSHCN, and their families, receiving services necessary to make appropriate transition to adult health care, work and independence. Training to enhance knowledge and comfort level to address transition issues was provided to care coordination teams including: Six Core Elements of Health Care Transition, transition assessment, strategies, review and availability of anticipatory guidance, community supports, resources and required follow-up.

Outreach to health care practices and professionals through various strategies to improve implementation of the Six Core Elements, awareness of the Transitioning Youth to Adult Health Care courses for physicians available at: http://illinoisaap.org/projects/medical-home/transition/, contacts with providers, conference presentations, medical home teams and website links and through empowering YSHCN and their families to ask their provider about transition policy and assistance with health care transition.

UIC-DSCC coordinated the health care track for the annual Statewide Transition Conference and participated on the conference steering committee, and presented a breakout session. The 10th annual statewide conference held October 2014 provided another opportunity for physicians, other health care professionals, families, transition age youth, care coordinators, school staff, vocational specialists 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 specialists in a variety of forums.

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.

**Cross-Cutting/Life Course**

**Measures**

**NPM-13 A) Percent of women who had a dental visit during pregnancy**

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 43.2 | 44.1 | 44.9 | 45.8 | 46.6 | 47.5 |

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012 | 45.7 % | 1.7 % | 68,338 | 149,680 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

**NPM-13 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 | 2021 |
| Annual Objective | 81.6 | 82.4 | 83.2 | 84.0 | 84.8 | 85.6 |

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 80.8 % | 1.3 % | 2,366,216 | 2,927,243 |
| 2007 | 80.5 % | 1.3 % | 2,415,937 | 3,001,356 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

### NPM-14 A) Percent of women who smoke during pregnancy

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 6.8 | 6.5 | 6.2 | 5.9 | 5.6 | 5.4 |

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 6.8 % | 0.1 % | 10,676 | 157,969 |
| 2013 | 7.0 % | 0.1 % | 10,962 | 156,104 |
| 2012 | 7.1 % | 0.1 % | 11,282 | 158,098 |
| 2011 | 7.5 % | 0.1 % | 12,099 | 160,484 |
| 2010 | 7.9 % | 0.1 % | 12,984 | 163,555 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

### NPM-14 B) Percent of children who live in households where someone smokes

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 20.4 | 19.8 | 19.2 | 18.6 | 17.9 | 17.3 |

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 23.6 % | 1.4 % | 719,969 | 3,055,778 |
| 2007 | 26.0 % | 1.4 % | 818,392 | 3,151,742 |
| 2003 | 30.9 % | 1.3 % | 868,471 | 2,814,599 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

**Goal #1: Staff capacity**

During FY2017, OWHFS hopes to hire a person into the vacant data manager position. This position has been vacant since November 2015, when the data manager, Mr. Eduardo Alvarado, was promoted to IDPH HIV/AIDS Section Chief. The data manager would be responsible for planning analytic studies, compiling statistical data, and producing data reports related to maternal and child health, as well as coordinating reporting requirements for Title V and SSDI.

Illinois continues to be dedicated to developing and mentoring young professionals through internships and fellowships. During FY2017, OWHFS will apply for a CSTE Fellow in MCH Epidemiology, to be jointly mentored by CDC assignee Dr. Bennett and Dr. Jane Fornoff, epidemiologist and manager for the Adverse Pregnancy Outcomes Reporting System (state birth defects registry). Additionally, OWHFS will apply to host a summer MCH epidemiology intern through the Graduate Student Epidemiology Program (GSEP). Other student internships may be arranged, as needed, and in conjunction with faculty projects at the UIC Center of Excellence in MCH.

**Goal #2: Infrastructure and systems**

During FY2017, OWHFS will continue to monitor the quality of the birth certificate data to assess the impact of the birth certificate accuracy quality improvement project carried out during FY2015. The CDC assignee will assess the birth certificate data once 2014-2015 data are finalized to examine changes over time in missing data, invalid responses, and implausible values. The final evaluation findings will be summarized in a data brief and distributed to partners and hospitals involved in the QI project.

OWHFS is currently exploring opportunities for enhancing existing IDPH datasets through data linkage. Datasets of particular interest include vital records, hospital discharge, and APORS (state birth defects registry). Partnerships with the stewards of each of these datasets must be convened to discuss the feasibility of such linkages and to develop linkage plans. We hope to pursue linkage of hospital discharge and birth certificates during FY2017.

During FY2017, it is hoped that the e-Perinet system will be enhanced by creating the ability for hospitals upload

their electronic medical record data in an automated process. E-Perinet is the state database for reporting of hospital data for the regionalized perinatal system, as well as reporting of sentinel perinatal hospital events, like neonatal or maternal discharge, or perinatal mortality. The development of the automated upload capability has been underway during FY2016, and the launch would allow for reduced burden of reporting, while also increasing completeness and accuracy of reports.

**Goal #3: Epidemiologic Evidence to Support Decision-Making**

Generating, disseminating, and using epidemiologic evidence remains at the heart of the state priority on data. As the need arises, projects will be prioritized for analysis. Some analytic projects already planned for the FY2017 include:

- Evaluation of the Teen Pregnancy Prevention – Primary (TPPP) program
- Analysis of data from the Very Preterm (VPT) Review form mandated for all VPT deliveries occurring outside Level III hospitals
- Analysis of neonatal morbidity (hospital discharge)
- Analysis of severe maternal morbidity after the transition to ICD-10 coding in the Illinois hospital discharge data

**Goal #4: Partnerships**

Key partnerships with UIC School of Public Health, other internal IDPH programs, and the state Medicaid agency (IDHFS) will continue to be fostered to improve the ability to access, utilize, translate, and disseminate epidemiologic evidence. In addition, new partnerships will be fostered as the need or opportunity arises.

**Cross-Cutting/Life Course - Annual Report**

As a result of the 2015 needs assessment, Illinois chose to continue to make data capacity and infrastructure one of the ten state MCH priorities: "#10: Strengthen the MCH capacity for data collection, linkage, analysis, and dissemination; Improve MCH data systems and infrastructure. This demonstrates commitment to ensuring evidence-based practice and data-driven decision-making. The state strategies in the action plan for this priority cover four main goals, which are listed below. During FY2015, Illinois made substantial progress in all four of these goals and began to create a foundation for further improvements in data capacity and infrastructure.

1. Enhance **staff capacity** for data management, analysis and translation through training and workforce development
2. Improve data **infrastructure and systems**, including improving accuracy, timeliness, and quality of data
3. Increase the analysis, translation and dissemination of **epidemiologic evidence** that supports MCH decision-making
4. Forge **partnerships** that will increase the availability, analysis, and dissemination of relevant and timely MCH data

**Goal #1: Staff capacity**

In December 2014, Illinois obtained a CDC field assignee in maternal and child health epidemiology, Dr. Amanda Bennett. The four key points of the CDC assignment are: (1) evaluation/development of surveillance systems; (2) capacity-building; (3) MCH epidemiological studies; and (4) collaboration and consultation on MCH epidemiologic issues. More specifically, the assignee is expected to: (a) conduct research and surveillance in the area of maternal, infant, child, and adolescent morbidity and mortality; (b) build epidemiology capacity within the MCH program; (c)

provide information needed by managers and program leaders for MCH program development, management, evaluation, and resource allocation; and (d) provide consultation to the State on MCH issues, as needed. Prior to the start of Dr. Bennett's assignment, there was no MCH epidemiologist working within the IDPH OWHFS or with the Title V program on a full-time basis. Epidemiology support had largely been contracted out to academic partners and was provided on a project-by-project basis, rather than including an internal person who could provide scientific leadership to the Title V program.

During FY 2015, Dr. Bennett convened three meetings for 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. Periodic meetings for this group will continue over time.

**Goal #2: Infrastructure and systems**

During FY2015, OWHFS was able to obtain access to hospital discharge data through a data sharing agreement with the IDPH Division of Patient Safety and Quality. This agreement granted OWHFS access to datasets on inpatient hospitalizations for all children ages 0-19 and for women of reproductive age (15-45 years) to be used in surveillance, monitoring, evaluation, and other special studies of interest to the state MCH programs. The access to this data system allowed OWHFS to conduct studies on severe maternal morbidity and mental health hospitalizations (described further in goal #3).

During FY2015, OWHFS partnered with the Illinois Perinatal Quality Collaborative to roll-out a birth certificate accuracy quality improvement project in Illinois birthing hospitals. This project sought to train hospitals on standard definitions for 17 key variables of interest and to conduct chart audits to examine how the accuracy of these fields changed over time. Accuracy was defined as having a birth certificate correctly match the recorded information in the hospital medical record (including potential correct recording of unknown or missing values). All of Illinois' 116 birthing hospitals were encouraged to participate, and 107 hospitals submitted rosters for participation in the initiative. A face-to-face kick-off meeting was held in May 2015, where training materials were distributed. At baseline, the total accuracy rate for the 17 variables combined was 87%, but the variable specific accuracy ranged from 76% (WIC participation) to 95% (NICU admission). The goal was to reach 95% accuracy overall and for each of the 17 key variables. By November 2015, the overall accuracy had risen to 96% and 12 of the 17 variables were at 95% or higher, with another two variables at 94% accuracy. The three variables that still have opportunity for improvement are infant feeding at discharge, prenatal care, and date of last menstrual period. This project completed in December 2015 and is now moving towards a sustainability phase. ILPQC, OWHFS, and IDPH Division of Vital Records are collaborating to develop plans for continued training for birth certificate clerks, evaluation of the initiative, and ongoing monitoring of birth certificate data quality.

**Goal #3: Epidemiologic Evidence**

Illinois has four active CoIIN workgroups: Safe Sleep, Risk-Appropriate Care, Social Determinants of Health (SDOH), and Pre/Inter-conceptional Health. The CDC assignee has served as a data co-lead and provided analytic and technical assistance to the various workgroups of the Illinois CoIIN team though: 1) using provisional birth and infant death certificate data to calculate quarterly infant mortality and prematurity rates for the six CoIIN outcome measures; 2) providing input into the design and interpretation of stakeholder surveys; 3) supporting evidence-based decision making by analyzing relevant data from various data sources; 4) helping the Risk-Appropriate Care

workgroup plan a special study to review the reasons why very preterm infants are delivered outside Level III hospitals.

During FY2015, Illinois completed the required Title V needs assessment. Illinois's needs assessment included a variety of data collection methods to identify the major health needs of women, infants, children, adolescents, and families in Illinois. The culmination of the Illinois Title V needs assessment was an expert panel that reviewed the data and developed recommendations for the ten priorities on which to focus during 2016-2020. The CDC assignee led or supported the various qualitative and quantitative data collection, analysis, and interpretation activities of the Title V needs assessment. For qualitative data, she provided input about survey questions, developed a semi-structured guide for key informant interviews, and synthesized qualitative data from focus groups, surveys, and interviews into a "key theme" document. For quantitative data, she analyzed a wide variety of data to produce charts on key MCH indicators in the five population domains set by MCHB (i.e., women's heatlh, infant health, child health, adolescent health, children with special healthcare needs) and produced an 80-page databook that summarized the needs assessment data (http://www.dph.illinois.gov/sites/default/files/publications/publicationsowhil-title-v-2015-databook.pdf). Through these efforts, Illinois was able to establish state priorities that were data-driven and supported by mutliple types of data.

Illinois was one of eight teams accepted in to the first cohort of the AMCHP Life Course Indicators Intensive Technical Assistance Project, running from December 2014 to February 2015. During this project, state received analytic assistance to calculate a sub-set of life course indicators and consultation from a communications expert about creating a product from the state analysis of selected indicators. The CDC assignee led the Illinois team in the TA project, comprised of IDPH staff and partners from other MCH organizations in Illinois. The assignee analyzed a sub-set of 15 life course indicators, and organized meetings to discuss the relevance and implications of the data for Illinois programs. Ultimately, this resulted in a study of how concentrated disadvantage is associated with adverse MCH programs, which has been used to inform geographic targeting of state programs. Dr. Bennett created several resources for IDPH staff and other professional partners on the methodology and results of the study. She developed an 8-page report and a standard PowerPoint presentation that outlined the study details, findings, and maps of CD levels. These documents were circulated to IDPH staff, including OWHFS program personnel, and other epidemiologists throughout the Department. For epidemiology staff, she also developed an Excel file containing the raw CD values to facilitate use of the indicator.

The CDC assignee conducted several small analytic projects on various MCH topics to inform work in the state:

- An analysis of severe maternal morbidity based on hospital discharge data. This was the first time this indicator was applied to the Illinois discharge data and it will continue to be monitored since it is a Title V national outcome measures.
- A brief analysis and data fact sheet on mental health hospitalizations among women of reproductive age. (http://www.dph.illinois.gov/sites/default/files/publications/publicationsowhmental-health-fact-sheet-hospitalizations.pdf

**Goal #4: Partnerships**

Illinois Title V continued to build a partnership with the University of Illinois School of Public Health, Maternal and Child Health Epidemiology Program, to obtain epidemiologic technical assistance and support. Through the IGA enacted in 2013, UIC faculty provided assistance on analytic projects and in representing MCH epidemiology at state workgroups and committees.

Additionally, the CDC assignee sought to better develop relationships with other data users and stewards at IDPH. Partnerships with the Division of Vital Records, Division of Patient Safety and Quality (discharge data), and PRAMS

program continue. These partnerships allow not only for data access, but for mutual benefit in analysis, data translation, and interpretation of findings.

**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%.

***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.

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

Under the direction of the Deputy Director of the Office of Women's Health and Family Services, Shannon Lightner, MPA, MSW, Title V Director, Andrea Palmer, MPA, MBA, is the Chief of the IDPH Division of Maternal, Child and Family Health Services. Andrea is a career employee with over 30 years of service to the State of Illinois. Mrs. Palmer has worked in a number of capacities, with increasing responsibilities, from case worker to Bureau Chief, serving low-income families at risk for poor health, economic, educational and social outcomes within the Illinois Departments of Public Aid and Human Services. The Division of Maternal, Child and Family Health Services is supported by several key personnel, including Dr. Trishna Harris, DNP, APN, WHNP-BC, CNM and Miranda Scott, MBA, MALS, BSN, RN, LNC, Perinatal Health Nurses responsible for working directly with Illinois Regional Perinatal Networks and Birthing Hospitals to assure that healthcare services meet the standards of care identified in the State's Administrative Code; Kelly Vrablic, MPH, Infant Mortality Reduction Coordinator, responsible for bringing the multiple programs, with a myriad of funders, aimed at reducing infant mortality into alignment to create synergy and collective impact; Victoria Jackson, RN,MSN, IL\PEL-CSN who is responsible for the School Based Health programs, including supervising three Registered Nurses who monitor and provide technical support to all of Illinois' School Based Health Centers to assure that they are providing quality, culturally relevant healthcare services in accordance with the State's Administrative Code and without regard for the center's funding source; Marcella Abrams, MPA, MHS, CADC, responsible for the Adolescent Health programs and strategies, including Teen Pregnancy Prevention –Primary programming and Alexander Smith, BA, who provides administrative support to the Division including scheduling, computer issues and maintenance of advisory groups such as the Neonatal Abstinence Advisory Council and the Perinatal Advisory Council.

Thomas F. Jerkovitz, MPA, CPA is the Executive Director of the UIC Division of Specialized Care for Children (DSCC). 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.

DSCC is supported by several other key staff members. Gerri Clark, RN, MSN, has been the Associate Director since 1999. Ms. Clark previously worked in the Nebraska program for CYSHCN for 8 years. Kevin Steelman, MBA, is

Associate Director for Finance, Mr. Steelman 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. The DSCC Family Liaison Specialist, Bob Cook, has retired, and DSCC is recruiting among families having CSCHN to fill the vacancy.

DSCC employs 200 FTEs to provide care coordination and other enabling services and 75 administrative staff that provide training, technical assistance, and other support and administrative services. Care coordinators have Bachelors or Masters Degrees. 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 CSHCN program.

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

DSCC provides care coordination training to new staff during the first six weeks in their position. Training is provided via online topical modules, in-person case study sessions, and peer mentoring. Topics include care coordination, family-centered care, program eligibility, policies and Administrative Rules, resources, medical home, transition, mandated reporting, HIPAA, working with providers, etc. Case studies include challenging or less common situations to assist care coordinators in developing/improving problem-solving skills. Additional training is provided periodically to update staff. Recent topics included transition planning, assessment and developing a care coordination plan.

**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 and Family Services (OWHFS) 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 delivered a report to the Department that provides feedback and offers 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.

DSCC continues to partner with families and youth through family-centered care and person-centered planning principles. Families and youth are integrally involved in the entire care coordination process (assessment, planning, implementation, and evaluation). DSCC also continues to seek family input through the Family Advisory Council,

which is coordinated by the Family Liaison Specialist.

### II.F.4. Health Reform

The State of Illinois has been engaged in a significant health care reform effort for the last several years. Illinois received a State Innovation Grant from the federal Centers for Medicare and Medicaid Innovation. This grant enabled the state to implement a large scale, comprehensive, and participatory planning process to develop a plan for achieving the "Triple Aim" of improving the patient's experience of care (including quality and satisfaction), improving the health of populations, and reducing the *per-capita* cost of health care. The resulting plan made recommendations in five areas: (1) Create comprehensive, integrated delivery systems, along with payment reforms to support them; (2) ensure that additional supports and services are available for people with specific needs; (3) enhance public health efforts focusing on environmental and social factors that negatively affect large segments of the population; (4) ensure that the workforce has the appropriate education, training and compensation to implement the new integrated delivery systems and enhance public health; and (5) expand the state's leadership role in promoting continuous improvement in the public health and health care systems. The Governor's Office submitted an 1115(b) demonstration waiver proposal to the federal Center for Medicare and Medicaid services to implement sweeping reforms in Illinois' Medicaid program. To date, the federal government has not responded to the waiver request.

At the same time, the Illinois General Assembly passed (and the Governor enacted) the Saving Medicaid Access and Resources Together, or SMART, Act, which became effective in January 2013. Among many Medicaid reforms, the law established the goal of enrolling at least half of all Medicaid beneficiaries in a "care coordination," or managed care, plan by January 1, 2015. This has led to a rapid expansion of Medicaid managed care within the state.

Initial expansion efforts focused on high-risk, high-cost populations, such as senior citizens who are dually enrolled in Medicare and Medicaid, as well as some programs for children with complex medical conditions (excluding CSHCN served by DSCC.) However, since more than half of the state's Medicaid beneficiaries are children, successful implementation of the SMART Act would require the enrollment healthy children in a managed care arrangement, thus affecting the organization, funding, and delivery of Maternal and Child Health services in Illinois.

The Illinois General Assembly passed an additional Medicaid reform bill in 2013 that established the "Accountable Care Entities" or ACEs, as a hospital-based managed care network specifically targeting the "Family Health" population, which included children, pregnant women, and "ACA Adults" or childless adults who qualified for Medicaid under the Affordable Care Act. This model was subsequently removed from Illinois' healthcare delivery system.

The Department identified 30 counties in Illinois as "mandatory enrollment areas," meaning that all Medicaid beneficiaries in those counties were required to enroll in a "care coordination" or managed care plan. Now fully implemented, IDHFS no longer directly reimburses providers on a fee-for-service basis for services provided to Medicaid beneficiaries enrolled in a managed care plan. Like the authorizing statute, the request for proposals was similarly silent on the inclusion of Local Health Departments as "out-of-network providers" for Medicaid beneficiaries in the MCH population. Current IDHFS guidance to LHDs is to contract with MCOs for delivery of services in mandatory managed care areas.

IDHFS provided assurances that local health departments and school-based health centers would at least be offered contracts by managed care organizations. Local health departments report problems in engaging the ACE organizations in contract negotiations and IDHFS staff work with the managed care organizations to address these problems. Further, Title-X funded family planning providers and school-based health centers have been designated "direct access providers," meaning that they will continue to receive fee-for-service reimbursement for the services they provide, regardless of the patient's enrollment in a managed care plan. Recently, Illinois public health advocacy agencies have requested that this status be extended to local health departments as well.

IDPH and the public health advocacy organizations continue to work with both IDHFS and local health departments to ensure that the delivery of Medicaid-funded direct, enabling, and population-based MCH services through local health departments will continue.

The IDPH Office of Women's Health and Family Services is committed to assisting Illinois' women and their children to increase their access to healthcare through appropriate coverage.

The Illinois Breast and Cervical Cancer Program (IBCCP), which is available in each of Illinois' 102 counties, encourages local lead agency staff to navigate eligible women to Expanded Medicaid or the Marketplace. Lead Agencies educate the women about the Affordable Care Act (ACA), help them overcome barriers that prevent them from signing-up for health insurance and based on eligibility, help navigate the women to Expanded Medicaid or the Marketplace. IBCCP is tracking the number of women who migrate to ACA and to date 32 percent of the IBCCP women have migrated. IBCCP has assisted **15,742** women in transitioning to ACA Expanded Medicaid or the Market place insurances. The program also surveys those women who have not yet migrated to determine the reason they did not migrate. Through December 31, 2014, approximately, 8,534 women were surveyed and of these women, 24.3 percent said they did not migrate because they couldn't afford the premium, 24.9 percent cited due to a lack of understanding, 12.2 percent said they had limited ability to enroll, 8.8 percent would rather pay the penalty and lack resources, and 29.8 percent was for other reasons.

All IBCCP lead agencies have an ACA navigator, a clinic navigator, a patient navigator or they facilitate education and connection to navigators. In November 2014, IBCCP conducted a survey of the lead agencies to determine how many were connected with an ACA navigator. Of the 34 lead agencies, all of them except two are connected with an ACA patient navigator. The patient navigators communicate with all members of the healthcare team on behalf of the client. They utilize clinical protocols and help refer clients to the nurse case manager when diagnostic follow-up or treatment is needed. Patient navigators assist the clients one-on-one to reduce healthcare barriers and give emotional support, education and counseling related to their specific needs.

The Illinois Department of Human Services, which administers the Family Case Management program, also requires contractual providers to assist expectant and new mothers to access appropriate healthcare coverage.

### II.F.5. Emerging Issues

Space holder for emerging issues with Neonatal Abstinence Syndrome and Lead Poisoning

### II.F.6. Public Input

### II.F.7. Technical Assistance

**III. Budget Narrative**

| | 2013 | | 2014 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| **Federal Allocation** | $21,700,000 | $20,161,097 | $21,700,000 | $21,086,346 |
| **Unobligated Balance** | $0 | $0 | $0 | $0 |
| **State Funds** | $27,260,000 | $27,260,000 | $27,260,000 | $28,702,696 |
| **Local Funds** | $0 | $0 | $0 | $2,834,100 |
| **Other Funds** | $234,159,600 | $234,159,600 | $234,159,600 | $0 |
| **Program Funds** | $7,760,000 | $7,760,000 | $7,760,000 | $0 |
| **SubTotal** | $290,879,600 | $289,340,697 | $290,879,600 | $52,623,142 |
| **Other Federal Funds** | $416,111,558 | $416,111,558 | $423,189,908 | |
| **Total** | $706,991,158 | $705,452,255 | $714,069,508 | $52,623,142 |

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

| | 2015 | | 2016 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| **Federal Allocation** | $20,911,675 | | $21,086,346 | |
| **Unobligated Balance** | $0 | | $0 | |
| **State Funds** | $27,260,000 | | $28,814,276 | |
| **Local Funds** | $0 | | $2,891,000 | |
| **Other Funds** | $234,159,600 | | $0 | |
| **Program Funds** | $6,392,507 | | $0 | |
| **SubTotal** | $288,723,782 | | $52,791,622 | |
| **Other Federal Funds** | $409,665,976 | | $17,032,691 | |
| **Total** | $698,389,758 | | $69,824,313 | |

| | 2017 | |
|---|---|---|
| | Budgeted | Expended |
| Federal Allocation | | |
| Unobligated Balance | | |
| State Funds | | |
| Local Funds | | |
| Other Funds | | |
| Program Funds | | |
| SubTotal | | |
| Other Federal Funds | | |
| Total | | |

III.A. Expenditures

III.B. Budget

## IV. Title V-Medicaid IAA/MOU

## V. Supporting Documents

No Supporting documents were provided by the state.

## VI. Appendix

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**Form 2**
**MCH Budget/Expenditure Details**

**State: Illinois**

| | FY17 Application Budgeted |
|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | |
| A. Preventive and Primary Care for Children | |
| B. Children with Special Health Care Needs | |
| C. Title V Administrative Costs | |
| 2. UNOBLIGATED BALANCE | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 27,569,600 | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Same as item 18g of SF-424) | |
| 9. OTHER FEDERAL FUNDS<br>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) | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | |

| OTHER FEDERAL FUNDS | FY17 Application Budgeted |
| --- | --- |
| No Other Federal Programs were provided by the State on Form 2 Line 9. | |

| | FY15 Application Budgeted | | FY15 Annual Report Expended |
|---|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 20,911,675 | | |
| A. Preventive and Primary Care for Children | $ 8,000,000 | (38.3%) | |
| B. Children with Special Health Care Needs | $ 6,273,503 | (30%) | |
| C. Title V Administrative Costs | $ 800,000 | (3.8%) | |
| 2. UNOBLIGATED BALANCE | $ 0 | | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 27,260,000 | | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 0 | | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 234,159,600 | | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 6,392,507 | | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 267,812,107 | | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 27,569,600 | | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Same as item 18g of SF-424) | $ 288,723,782 | | |
| 9. OTHER FEDERAL FUNDS<br>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) | $ 409,665,976 | | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 698,389,758 | | |

| OTHER FEDERAL FUNDS | FY15 Annual Report Expended |
| --- | --- |
| No Other Federal Programs were provided by the State on Form 2 Line 9. | |

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

None

**Data Alerts:**

None

**Form 3a**
**Budget and Expenditure Details by Types of Individuals Served**

**State: Illinois**

## I. TYPES OF INDIVIDUALS SERVED

| IA. Federal MCH Block Grant | FY17 Application Budgeted | FY15 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | | |
| 2. Infants < 1 year | | |
| 3. Children 1-22 years | | |
| 4. CSHCN | | |
| 5. All Others | | |
| Federal Total of Individuals Served | | |

| IB. Non Federal MCH Block Grant | FY17 Application Budgeted | FY15 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | | |
| 2. Infants < 1 year | | |
| 3. Children 1-22 years | | |
| 4. CSHCN | | |
| 5. All Others | | |
| Non Federal Total of Individuals Served | | |
| Federal State MCH Block Grant Partnership Total | | |

**Form Notes for Form 3a:**

**Field Level Notes for Form 3a:**

None

**Data Alerts:**

None

**Form 3b**
**Budget and Expenditure Details by Types of Services**

**State: Illinois**

**II. TYPES OF SERVICES**

| IIA. Federal MCH Block Grant | FY17 Application Budgeted | FY15 Annual Report Expended |
|---|---|---|
| 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 Line 4 Expended Total | | |
| **Federal Total** | | |

| IIB. Non-Federal MCH Block Grant | FY17 Application Budgeted | FY15 Annual Report Expended |
|---|---|---|
| 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 Line 4 Expended Total | | |
| **Non-Federal Total** | | |

**Form Notes for Form 3b:**

**Field Level Notes for Form 3b:**

None

**Form 4**

**Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated**

**State: Illinois**

**Total Births by Occurrence: 154,178**

**1. 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 |
|---|---|---|---|---|
| Core RUSP Conditions | 153,377 (99.5%) | 9,940 | 430 | 430 (100.0%) |

| Program Name(s) | | | | |
|---|---|---|---|---|
| Methylmalonic acidemia (methylmalonyl-CoA mutase) | Isovaleric acidemia | 3-Methylcrotonyl-CoA carboxylase deficiency | ß-Ketothiolase deficiency | Glutaric acidemia type I |
| Carnitine uptake defect/carnitine transport defect | Medium-chain acyl-CoA dehydrogenase deficiency | Very long-chain acyl-CoA dehydrogenase deficiency | Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency | Argininosuccinic aciduria |
| Citrullinemia, type I | Maple syrup urine disease | Homocystinuria | Classic phenylketonuria | Primary congenital hypothyroidism |
| Tyrosinemia, type I | Congenital adrenal hyperplasia | S,S disease (Sickle cell anemia) | S, βeta-thalassemia | S,C disease |
| Biotinidase deficiency | Cystic fibrosis | Hearing loss | Severe combined immunodeficiences | Classic galactosemia |
| Propionic acidemia | Methylmalonic acidemia (cobalamin disorders) | 3-Hydroxy-3-methyglutaric aciduria | Holocarboxylase synthase deficiency | Trifunctional protein deficiency |
| Critical congenital heart disease | Adrenoleukodystrophy | Mucopolysaccharidosis, type I | | |

**2. Other Newborn Screening Tests**

None

### 3. Screening Programs for Older Children & Women

None

### 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 Adverse Pregnancy Outcomes Reporting System (state 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:** | **2015** |
| | **Column Name:** | **Total Births by Occurrence Notes** |
| | **Field Note:** provisional 2015 birth data, as of 5/3/2016 | |
| 2. | **Field Name:** | **Core RUSP Conditions - Positive Screen** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Core RUSP Conditions** |
| | **Field Note:** without hearing screening, number of presumptive positive screens for genetic/metabolic conditions is 234 | |
| 3. | **Field Name:** | **Core RUSP Conditions - Confirmed Cases** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Core RUSP Conditions** |
| | **Field Note:** without hearing screening, number of confirmed cases for genetic/metabolic conditions is 234 | |
| 4. | **Field Name:** | **Core RUSP Conditions - Referred For Treatment** |
| | **Fiscal Year:** | **2015** |
| | **Column Name:** | **Core RUSP Conditions** |
| | **Field Note:** without hearing screening, number referred for treatment of genetic/metabolic conditions is 234 | |

**Data Alerts:**

None

**Form 5a**
**Unduplicated Count of Individuals Served under Title V**

**State: Illinois**

**Reporting Year 2015**

| | | 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 | 0 | | | | | |

**Form Notes for Form 5a:**

None

**Field Level Notes for Form 5a:**

None

**Form 5b**
**Total Recipient Count of Individuals Served by Title V**

**State: Illinois**

**Reporting Year 2015**

| Types Of Individuals Served | Total Served |
|---|---|
| 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** | 0 |

**Form Notes for Form 5b:**

None

**Field Level Notes for Form 5b:**

None

**Form 6**
**Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX**

**State: Illinois**

**Reporting Year 2015**

### 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 | 153,066 | 110,562 | 26,254 | 127 | 9,714 | 44 | 1,971 | 4,394 |
| Title V Served | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Eligible for Title XIX | 69,712 | 34,990 | 23,140 | 7 | 1,551 | 117 | 1,075 | 8,832 |
| 2. Total Infants in State | 152,143 | 109,997 | 25,974 | 124 | 9,696 | 44 | 1,952 | 4,356 |
| Title V Served | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Eligible for Title XIX | 70,797 | 36,348 | 22,233 | 18 | 1,832 | 113 | 1,133 | 9,120 |

### 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 | 117,956 | 33,645 | 1,465 | 153,066 |
| Title V Served | 0 | 0 | 0 | 0 |
| Eligible for Title XIX | 49,427 | 13,577 | 6,708 | 69,712 |
| 2. Total Infants in State | 117,245 | 33,451 | 1,447 | 152,143 |
| Title V Served | 0 | 0 | 0 | 0 |
| Eligible for Title XIX | 49,772 | 14,320 | 6,705 | 70,797 |

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **1. Total Deliveries in State** |
| | **Fiscal Year:** | **2014** |
| | **Column Name:** | **Total All Races** |
| | **Field Note:**<br>Deliveries = 2015 birth data (provisional) + 2013 fetal death data (final)<br>2014-15 fetal death data not yet available, so 2013 used as estimate<br>Includes only IL occurrences to IL residents | |
| 2. | **Field Name:** | **1. Eligible for Title XIX** |
| | **Fiscal Year:** | **2014** |
| | **Column Name:** | **Total All Races** |
| | **Field Note:**<br>2015 eligibility data from Illinois Department of Healthcare and Family Services | |
| 3. | **Field Name:** | **2. Total Infants in State** |
| | **Fiscal Year:** | **2014** |
| | **Column Name:** | **Total All Races** |
| | **Field Note:**<br>Deliveries = 2015 birth data (provisional)<br>Includes only IL occurrences to IL residents | |
| 4. | **Field Name:** | **2. Eligible for Title XIX** |
| | **Fiscal Year:** | **2014** |
| | **Column Name:** | **Total All Races** |
| | **Field Note:**<br>2015 eligibility data from Illinois Department of Healthcare and Family Services | |

**Form 7**

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

**State: Illinois**

| A. State MCH Toll-Free Telephone Lines | 2017 Application Year | 2015 Reporting Year |
|---|---|---|
| 1. State MCH Toll-Free "Hotline" Telephone Number | | |
| 2. State MCH Toll-Free "Hotline" Name | | |
| 3. Name of Contact Person for State MCH "Hotline" | | |
| 4. Contact Person's Telephone Number | | |
| 5. Number of Calls Received on the State MCH "Hotline" | | |

| B. Other Appropriate Methods | 2017 Application Year | 2015 Reporting Year |
|---|---|---|
| 1. Other Toll-Free "Hotline" Names | | |
| 2. Number of Calls on Other Toll-Free "Hotlines" | | |
| 3. State Title V Program Website Address | | |
| 4. Number of Hits to the State Title V Program Website | | |
| 5. State Title V Social Media Websites | | |
| 6. Number of Hits to the State Title V Program Social Media Websites | | |

**Form Notes for Form 7:**

None

**Form 8**
**State MCH and CSHCN Directors Contact Information**

**State: Illinois**

| 1. Title V Maternal and Child Health (MCH) Director | |
|---|---|
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| Title | Division Chief/Title V Director |
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| 2. Title V Children with Special Health Care Needs (CSHCN) Director | |
|---|---|
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| 3. State Family or Youth Leader (Optional) | |
|---|---|
| Name | |
| Title | |
| Address 1 | |
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| City/State/Zip | |
| Telephone | |
| Extension | |
| Email | |

**Form Notes for Form 8:**

None

**Form 9**
**List of MCH Priority Needs**

**State: Illinois**

**Application Year 2017**

| No. | Priority Need |
|---|---|
| 1. | Assure accessibility, availability and quality of preventive and primary care for all women, particularly for women of reproductive age |
| 2. | Support healthy pregnancies and improve birth/infant outcomes |
| 3. | Support expanded access to and integration of early childhood services and systems |
| 4. | Facilitate the integration of services within patient-centered medical homes for all children, particularly for children with special healthcare needs |
| 5. | Empower adolescents to adopt healthy behaviors |
| 6. | Assure appropriate transition planning and services for adolescents and young adults, including youth with special health care needs |
| 7. | Assure that equity is the foundation of all MCH decision-making; eliminate disparities in MCH outcomes |
| 8. | Support expanded access to and integration of mental health services and systems for the MCH population. |
| 9. | Partner with consumers, families and communities in decision-making across MCH programs, systems and policies |
| 10. | Strengthen the MCH capacity for data collection, linkage, analysis, and dissemination; Improve MCH data systems and infrastructure |

**Form 9 State Priorities-Needs Assessment Year - Application Year 2016**

| No. | 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. |

| No. | 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 |
|---|---|---|---|
| 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 (NOMs)**

**State: Illinois**

**Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 79.9 % | 0.1 % | 123,288 | 154,241 |
| 2013 | 77.4 % | 0.1 % | 117,495 | 151,818 |
| 2012 | 76.9 % | 0.1 % | 118,852 | 154,532 |
| 2011 | 76.8 % | 0.1 % | 120,944 | 157,580 |
| 2010 | 76.1 % | 0.1 % | 119,027 | 156,399 |

**Legends:**
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 1 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2013 | 167.5 | 3.4 % | 2,472 | 147,574 |
| 2012 | 168.6 | 3.4 % | 2,535 | 150,336 |
| 2011 | 167.8 | 3.3 % | 2,559 | 152,545 |
| 2010 | 166.7 | 3.3 % | 2,620 | 157,217 |
| 2009 | 161.8 | 3.2 % | 2,639 | 163,090 |
| 2008 | 138.6 | 2.9 % | 2,310 | 166,681 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 2 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2010_2014 | 16.0 | 1.4 % | 128 | 801,159 |
| 2009_2013 | 16.7 | 1.4 % | 136 | 813,766 |
| 2008_2012 | 17.6 | 1.5 % | 147 | 833,630 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 3 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 8.2 % | 0.1 % | 12,929 | 158,491 |
| 2013 | 8.2 % | 0.1 % | 12,898 | 156,820 |
| 2012 | 8.1 % | 0.1 % | 12,935 | 159,049 |
| 2011 | 8.2 % | 0.1 % | 13,232 | 161,185 |
| 2010 | 8.3 % | 0.1 % | 13,666 | 165,043 |
| 2009 | 8.4 % | 0.1 % | 14,316 | 171,063 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.1 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 1.5 % | 0.0 % | 2,409 | 158,491 |
| 2013 | 1.5 % | 0.0 % | 2,319 | 156,820 |
| 2012 | 1.5 % | 0.0 % | 2,410 | 159,049 |
| 2011 | 1.6 % | 0.0 % | 2,498 | 161,185 |
| 2010 | 1.6 % | 0.0 % | 2,553 | 165,043 |
| 2009 | 1.5 % | 0.0 % | 2,588 | 171,063 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.2 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 6.6 % | 0.1 % | 10,520 | 158,491 |
| 2013 | 6.8 % | 0.1 % | 10,579 | 156,820 |
| 2012 | 6.6 % | 0.1 % | 10,525 | 159,049 |
| 2011 | 6.7 % | 0.1 % | 10,734 | 161,185 |
| 2010 | 6.7 % | 0.1 % | 11,113 | 165,043 |
| 2009 | 6.9 % | 0.1 % | 11,728 | 171,063 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.3 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 10.1 % | 0.1 % | 16,016 | 158,485 |
| 2013 | 10.0 % | 0.1 % | 15,615 | 156,750 |
| 2012 | 10.0 % | 0.1 % | 15,891 | 158,321 |
| 2011 | 10.1 % | 0.1 % | 16,326 | 161,097 |
| 2010 | 10.4 % | 0.1 % | 16,959 | 163,887 |
| 2009 | 10.0 % | 0.1 % | 17,071 | 170,435 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5.1 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 3.0 % | 0.0 % | 4,777 | 158,485 |
| 2013 | 2.9 % | 0.0 % | 4,599 | 156,750 |
| 2012 | 3.0 % | 0.0 % | 4,675 | 158,321 |
| 2011 | 3.0 % | 0.0 % | 4,883 | 161,097 |
| 2010 | 3.0 % | 0.0 % | 4,985 | 163,887 |
| 2009 | 2.9 % | 0.0 % | 4,998 | 170,435 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5.2 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 7.1 % | 0.1 % | 11,239 | 158,485 |
| 2013 | 7.0 % | 0.1 % | 11,016 | 156,750 |
| 2012 | 7.1 % | 0.1 % | 11,216 | 158,321 |
| 2011 | 7.1 % | 0.1 % | 11,443 | 161,097 |
| 2010 | 7.3 % | 0.1 % | 11,974 | 163,887 |
| 2009 | 7.1 % | 0.1 % | 12,073 | 170,435 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5.3 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 24.6 % | 0.1 % | 38,916 | 158,485 |
| 2013 | 24.7 % | 0.1 % | 38,770 | 156,750 |
| 2012 | 25.0 % | 0.1 % | 39,527 | 158,321 |
| 2011 | 25.3 % | 0.1 % | 40,688 | 161,097 |
| 2010 | 27.1 % | 0.1 % | 44,440 | 163,887 |
| 2009 | 26.1 % | 0.1 % | 44,541 | 170,435 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 6 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: CMS Hospital Compare**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014/Q2-2015/Q1 | 2.0 % | | | |
| 2014/Q1-2014/Q4 | 2.0 % | | | |
| 2013/Q4-2014/Q3 | 2.0 % | | | |
| 2013/Q3-2014/Q2 | 2.0 % | | | |
| 2013/Q2-2014/Q1 | 2.0 % | | | |

**Legends:**

Indicator results were based on a shorter time period than required for reporting

**NOM 7 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2013 | 6.3 | 0.2 % | 994 | 157,395 |
| 2012 | 6.6 | 0.2 % | 1,049 | 159,625 |
| 2011 | 6.3 | 0.2 % | 1,015 | 161,707 |
| 2010 | 6.3 | 0.2 % | 1,035 | 165,612 |
| 2009 | 6.4 | 0.2 % | 1,100 | 171,602 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 8 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2013 | 6.0 | 0.2 % | 937 | 156,931 |
| 2012 | 6.5 | 0.2 % | 1,036 | 159,160 |
| 2011 | 6.6 | 0.2 % | 1,058 | 161,312 |
| 2010 | 6.8 | 0.2 % | 1,130 | 165,200 |
| 2009 | 6.9 | 0.2 % | 1,185 | 171,163 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.1 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2013 | 4.1 | 0.2 % | 638 | 156,931 |
| 2012 | 4.4 | 0.2 % | 707 | 159,160 |
| 2011 | 4.7 | 0.2 % | 754 | 161,312 |
| 2010 | 4.7 | 0.2 % | 772 | 165,200 |
| 2009 | 4.7 | 0.2 % | 796 | 171,163 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.2 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2013 | 1.9 | 0.1 % | 298 | 156,931 |
| 2012 | 2.1 | 0.1 % | 329 | 159,160 |
| 2011 | 1.9 | 0.1 % | 304 | 161,312 |
| 2010 | 2.2 | 0.1 % | 358 | 165,200 |
| 2009 | 2.3 | 0.1 % | 389 | 171,163 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.3 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2013 | 243.4 | 12.5 % | 382 | 156,931 |
| 2012 | 280.9 | 13.3 % | 447 | 159,160 |
| 2011 | 267.8 | 12.9 % | 432 | 161,312 |
| 2010 | 287.5 | 13.2 % | 475 | 165,200 |
| 2009 | 285.7 | 12.9 % | 489 | 171,163 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.4 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2013 | 87.3 | 7.5 % | 137 | 156,931 |
| 2012 | 99.3 | 7.9 % | 158 | 159,160 |
| 2011 | 76.3 | 6.9 % | 123 | 161,312 |
| 2010 | 86.6 | 7.2 % | 143 | 165,200 |
| 2009 | 84.7 | 7.0 % | 145 | 171,163 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**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**

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012 | 7.2 % | 0.8 % | 10,751 | 150,288 |
| 2010 | 6.6 % | 0.7 % | 10,253 | 154,675 |
| 2009 | 6.8 % | 0.7 % | 10,941 | 161,340 |
| 2008 | 6.4 % | 0.6 % | 10,596 | 164,694 |
| 2007 | 6.3 % | 0.6 % | 10,634 | 168,540 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 10 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2013 | 3.7 | 0.2 % | 545 | 147,575 |
| 2012 | 3.1 | 0.1 % | 461 | 150,337 |
| 2011 | 3.3 | 0.2 % | 505 | 152,545 |
| 2010 | 3.0 | 0.1 % | 465 | 157,217 |
| 2009 | 2.7 | 0.1 % | 442 | 163,090 |
| 2008 | 2.3 | 0.1 % | 376 | 166,681 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**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)**

**FAD Not Available for this measure.**

**NOM 12 - Notes:**

None

**Data Alerts:**

None

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

**FAD Not Available for this measure.**

**NOM 13 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 15.4 % | 1.2 % | 452,230 | 2,932,085 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 14 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 14.3 | 1.0 % | 209 | 1,462,877 |
| 2013 | 15.9 | 1.0 % | 236 | 1,483,881 |
| 2012 | 16.4 | 1.0 % | 246 | 1,504,495 |
| 2011 | 16.9 | 1.1 % | 256 | 1,515,669 |
| 2010 | 18.2 | 1.1 % | 279 | 1,532,476 |
| 2009 | 18.7 | 1.1 % | 286 | 1,532,989 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 15 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 31.0 | 1.4 % | 532 | 1,713,763 |
| 2013 | 30.5 | 1.3 % | 529 | 1,735,582 |
| 2012 | 32.5 | 1.4 % | 571 | 1,757,282 |
| 2011 | 34.8 | 1.4 % | 620 | 1,781,918 |
| 2010 | 33.8 | 1.4 % | 608 | 1,801,540 |
| 2009 | 33.7 | 1.4 % | 610 | 1,812,129 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.1 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012_2014 | 8.9 | 0.6 % | 235 | 2,631,277 |
| 2011_2013 | 9.3 | 0.6 % | 250 | 2,678,849 |
| 2010_2012 | 9.6 | 0.6 % | 261 | 2,723,749 |
| 2009_2011 | 9.9 | 0.6 % | 274 | 2,759,577 |
| 2008_2010 | 10.1 | 0.6 % | 281 | 2,781,358 |
| 2007_2009 | 12.8 | 0.7 % | 357 | 2,787,643 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.2 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012_2014 | 6.3 | 0.5 % | 166 | 2,631,277 |
| 2011_2013 | 6.5 | 0.5 % | 175 | 2,678,849 |
| 2010_2012 | 7.1 | 0.5 % | 194 | 2,723,749 |
| 2009_2011 | 7.0 | 0.5 % | 194 | 2,759,577 |
| 2008_2010 | 6.6 | 0.5 % | 184 | 2,781,358 |
| 2007_2009 | 6.3 | 0.5 % | 176 | 2,787,643 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.3 - Notes:**

None

**Data Alerts:**

None

**NOM 17.1 - Percent of children with special health care needs**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 19.5 % | 1.2 % | 600,765 | 3,088,140 |
| 2007 | 18.5 % | 1.2 % | 592,266 | 3,198,016 |
| 2003 | 17.0 % | 1.0 % | 547,447 | 3,220,883 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**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**

**Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2009_2010 | 18.9 % | 1.9 % | 78,794 | 417,651 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 17.2 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 2.1 % | 0.5 % | 54,876 | 2,612,786 |
| 2007 | 1.5 % | 0.5 % | 39,016 | 2,676,571 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**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)**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 6.8 % | 0.9 % | 176,204 | 2,607,871 |
| 2007 | 4.4 % | 0.6 % | 117,911 | 2,660,027 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 17.4 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 56.4 % | 5.5 % | 147,867 | 261,968 |
| 2007 | 54.8 % | 5.9 % | 113,710 | 207,476 |
| 2003 | 65.8 % | 5.9 % | 104,557 | 158,825 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 18 - Notes:**

None

**Data Alerts:**

None

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

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 84.0 % | 1.2 % | 2,594,254 | 3,088,140 |
| 2007 | 84.9 % | 1.1 % | 2,715,176 | 3,198,016 |
| 2003 | 83.3 % | 1.1 % | 2,682,018 | 3,219,265 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**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)**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 33.6 % | 2.2 % | 470,177 | 1,400,473 |
| 2007 | 34.9 % | 2.1 % | 476,031 | 1,363,168 |
| 2003 | 31.2 % | 1.9 % | 417,643 | 1,338,661 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: WIC**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012 | 31.6 % | 0.1 % | 33,385 | 105,663 |

**Legends:**

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: Youth Risk Behavior Surveillance System (YRBSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2013 | 25.9 % | 1.2 % | 139,805 | 540,710 |
| 2011 | 26.0 % | 1.3 % | 149,736 | 575,658 |
| 2009 | 27.2 % | 1.7 % | 157,973 | 580,094 |
| 2007 | 28.3 % | 1.3 % | 158,242 | 558,411 |

**Legends:**

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 20 - Notes:**

None

**Data Alerts:**

None

**NOM 21 - Percent of children without health insurance**

**Data Source: American Community Survey (ACS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 3.8 % | 0.2 % | 112,754 | 2,980,762 |
| 2013 | 4.3 % | 0.3 % | 131,019 | 3,020,939 |
| 2012 | 3.3 % | 0.2 % | 99,447 | 3,059,501 |
| 2011 | 3.4 % | 0.2 % | 104,359 | 3,092,794 |
| 2010 | 4.8 % | 0.3 % | 149,169 | 3,123,757 |
| 2009 | 4.4 % | 0.2 % | 139,860 | 3,169,817 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 21 - Notes:**

None

**Data Alerts:**

None

**NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)**

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 68.3 % | 2.9 % | 154,004 | 225,517 |
| 2013 | 66.8 % | 2.7 % | 153,459 | 229,659 |
| 2012 | 68.5 % | 2.5 % | 160,526 | 234,237 |
| 2011 | 66.3 % | 2.9 % | 161,910 | 244,227 |
| 2010 | 59.5 % | 2.8 % | 149,583 | 251,471 |
| 2009 | 53.7 % | 3.0 % | 142,175 | 264,547 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**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**

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014_2015 | 53.0 % | 1.3 % | 1,517,078 | 2,865,115 |
| 2013_2014 | 53.6 % | 1.3 % | 1,585,822 | 2,959,695 |
| 2012_2013 | 52.5 % | 1.8 % | 1,535,454 | 2,923,884 |
| 2011_2012 | 45.1 % | 2.0 % | 1,341,208 | 2,973,530 |
| 2010_2011 | 50.6 % | 2.8 % | 1,497,616 | 2,959,716 |
| 2009_2010 | 37.8 % | 2.1 % | 1,188,988 | 3,145,472 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**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**

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 64.4 % | 3.3 % | 272,346 | 422,945 |
| 2013 | 53.2 % | 3.9 % | 224,219 | 421,333 |
| 2012 | 41.2 % | 4.3 % | 175,644 | 426,244 |
| 2011 | 51.6 % | 3.8 % | 222,077 | 430,523 |
| 2010 | 39.7 % | 3.4 % | 169,036 | 426,127 |
| 2009 | 34.3 % | 3.4 % | 150,430 | 438,226 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 44.7 % | 3.4 % | 196,660 | 440,441 |
| 2013 | 34.8 % | 3.8 % | 153,208 | 439,862 |
| 2012 | 24.3 % | 4.0 % | 108,182 | 445,858 |
| 2011 | 6.2 % | 1.5 % | 27,870 | 450,900 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**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**

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 91.9 % | 1.2 % | 793,354 | 863,386 |
| 2013 | 86.2 % | 2.1 % | 742,369 | 861,195 |
| 2012 | 77.3 % | 2.8 % | 674,186 | 872,102 |
| 2011 | 71.8 % | 2.4 % | 632,868 | 881,423 |
| 2010 | 66.2 % | 2.4 % | 578,664 | 873,786 |
| 2009 | 59.5 % | 2.5 % | 534,405 | 898,696 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**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**

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 77.1 % | 2.2 % | 665,503 | 863,386 |
| 2013 | 79.0 % | 2.3 % | 680,655 | 861,195 |
| 2012 | 67.7 % | 3.0 % | 590,581 | 872,102 |
| 2011 | 66.5 % | 2.6 % | 586,332 | 881,423 |
| 2010 | 56.6 % | 2.5 % | 494,379 | 873,786 |
| 2009 | 53.5 % | 2.5 % | 480,562 | 898,696 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.5 - Notes:**

None

**Data Alerts:**

None

**Form 10a**
**National Performance Measures (NPMs)**

**State: Illinois**

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 67.2 | 68.5 | 69.8 | 71.1 | 72.5 | 73.8 |

**Data Source: Behavioral Risk Factor Surveillance System (BRFSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 69.8 % | 2.1 % | 1,617,749 | 2,319,244 |
| 2013 | 62.0 % | 2.1 % | 1,441,461 | 2,326,099 |
| 2012 | 69.2 % | 2.0 % | 1,610,387 | 2,328,544 |
| 2011 | 63.2 % | 2.1 % | 1,468,310 | 2,324,146 |
| 2010 | 63.5 % | 2.1 % | 1,514,123 | 2,383,986 |
| 2009 | 63.9 % | 1.9 % | 1,527,522 | 2,390,757 |

**Legends:**
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** **2020**

**Field Note:**
Baseline: 2013-14 average = 65.9% (BRFSS) (2011-2014 showed #'s jumping between 62-69%)
Recent Trends: Level between 2009-2014
Target Setting Method: 10% improvement (over 2013-2014 average) by 2020

**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 | 2021 |
| Annual Objective | 81.9 | 82.7 | 83.6 | 84.4 | 85.2 | 86.0 |

**FAD not available for this measure.**

**Field Level Notes for Form 10a NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2020** |

**Field Note:**
Baseline: 2013 = 79.4% (final birth data)
Recent Trends: Level between 2010-2014
Target Setting Method: 10% improvement by 2020

**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 | 2021 |
| Annual Objective | 36.3 | 38.3 | 40.4 | 42.5 | 44.7 | 46.8 |

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 34.4 % | 3.1 % | 288,409 | 838,437 |
| 2007 | 21.1 % | 2.5 % | 183,009 | 867,645 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** **2020**

**Field Note:**
Baseline: 2011/12 = 34.4% (NSCH)
Recent Trends: 60% Improvement between 2007 and 2011/12
Target Setting Method: 30% improvement by 2020

**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 | 2021 |
| Annual Objective | 89.5 | 90.3 | 91.2 | 92.1 | 93.1 | 94.0 |

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 88.7 % | 1.7 % | 933,080 | 1,051,653 |
| 2007 | 85.1 % | 1.9 % | 914,102 | 1,074,244 |
| 2003 | 75.0 % | 2.0 % | 807,333 | 1,076,808 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** **2020**

**Field Note:**
Baseline: 2011/12 = 88.7% (NSCH)
Recent Trends: 4% improvement between 2007 and 2011/12
Target Setting Method: 5% improvement by 2020

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 47.2 | 48.1 | 49.0 | 50.0 | 51.0 | 51.9 |

**Data Source: National Survey of Children's Health (NSCH) - CSHCN**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 46.4 % | 3.5 % | 271,960 | 585,615 |
| 2007 | 45.9 % | 3.5 % | 264,785 | 577,349 |

**Legends:**
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: National Survey of Children's Health (NSCH) - NONCSHCN**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 58.1 % | 1.8 % | 1,402,407 | 2,412,095 |
| 2007 | 58.2 % | 1.7 % | 1,465,878 | 2,518,125 |

**Legends:**
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** **2020**

**Field Note:**
Baseline: 2011/12 = 46.4% (NSCH)
Recent Trends: Level between 2007 and 2011/12
Target Setting Method: 10% improvement by 2020

**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 | 2021 |
| Annual Objective | 46.2 | 47.1 | 48.0 | 48.9 | 49.8 | 50.7 |

**Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2009_2010 | 45.3 % | 3.7 % | 76,540 | 169,119 |
| 2005_2006 | 44.2 % | 3.4 % | 71,822 | 162,576 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Field Note:** **may need to re-establish performance objectives once 2016 NSCH data is available and new baseline for transition is established. | |
| 2. | **Field Name:** | **2020** |
| | **Field Note:** Baseline: 2009/2010 = 45.3% (NS-CSHCN) Recent Trends: Level between 2005/6 and 2009/10 Target Setting Method: 10% improvement by 2020 | |

**NPM 13 - A) Percent of women who had a dental visit during pregnancy**

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 43.2 | 44.1 | 44.9 | 45.8 | 46.6 | 47.5 |

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2012 | 45.7 % | 1.7 % | 68,338 | 149,680 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** **2020**

**Field Note:**
Baseline: 2013 = 42.4% (PRAMS)
Recent Trends: unknown, only 2 years of data
Target Setting Method: 10% improvement by 2020

**NPM 13 - 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 | 2021 |
| Annual Objective | 81.6 | 82.4 | 83.2 | 84.0 | 84.8 | 85.6 |

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 80.8 % | 1.3 % | 2,366,216 | 2,927,243 |
| 2007 | 80.5 % | 1.3 % | 2,415,937 | 3,001,356 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** **2020**

**Field Note:**
Baseline: 2011/12 = 80.8% (NSCH)
Recent Trends: Level between 2007 and 2011/12
Target Setting Method: 5% improvement by 2020

**NPM 14 - A) Percent of women who smoke during pregnancy**

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 6.8 | 6.5 | 6.2 | 5.9 | 5.6 | 5.4 |

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014 | 6.8 % | 0.1 % | 10,676 | 157,969 |
| 2013 | 7.0 % | 0.1 % | 10,962 | 156,104 |
| 2012 | 7.1 % | 0.1 % | 11,282 | 158,098 |
| 2011 | 7.5 % | 0.1 % | 12,099 | 160,484 |
| 2010 | 7.9 % | 0.1 % | 12,984 | 163,555 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** **2020**

**Field Note:**
Baseline: 2013 = 7.0% (birth files)
Recent Trends: 11% Improvement during 2010-2013
Target Setting Method: 15% improvement by 2020

**NPM 14 - B) Percent of children who live in households where someone smokes**

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| Annual Objective | 20.4 | 19.8 | 19.2 | 18.6 | 17.9 | 17.3 |

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2011_2012 | 23.6 % | 1.4 % | 719,969 | 3,055,778 |
| 2007 | 26.0 % | 1.4 % | 818,392 | 3,151,742 |
| 2003 | 30.9 % | 1.3 % | 868,471 | 2,814,599 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** **2020**

**Field Note:**
Baseline: 2011/12 = 21.0% (NSCH)
Recent Trends: 10% improvement between 2007 and 2011/12
Target Setting Method: 15% improvement by 2020

**Form 10a**
**State Performance Measures (SPMs)**

**State: Illinois**

None

**Form 10a**

**Evidence-Based or-Informed Strategy Measures (ESMs)**

**State: Illinois**

None

**Form 10b**
**State Performance Measure (SPM) Detail Sheets**

**State: Illinois**

None

**Form 10b**
**State Outcome Measure (SOM) Detail Sheets**

**State: Illinois**

No State Outcome Measures were created by the State.

**Form 10c**
**Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets**

**State: Illinois**

None

**Form 10d**
**National Performance Measures (NPMs) (Reporting Year 2014 & 2015)**

**State: Illinois**

**Form Notes for Form 10d NPMs and SPMs**

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 | 95.4 |
| Numerator | 1,766 | 1,604 | 2,071 | 9,724 | 11,519 |
| Denominator | 1,791 | 1,625 | 2,096 | 9,916 | 12,074 |
| Data Source | IDPH, Genetics | IDPH, Genetics | IDPH, Genetics | IDPH, Genetics | IDPH, Genetics |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:** The number of resolved (normal or diagnosed) cases is divided by the number of presumptive positive screens. Hearing screening is included in 2015. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:** In 2014, there were two major changes that resulted in a large increase in the denominator for this performance measure. First, the change most affecting the values was the addition of hearing screening as one of the conditions included in the calculation of this indicator. There were 5,086 presumptive positive screens that required follow-up, making up nearly half of the cases included in the denominator, and accounting for 2/3 of the increase in the denominator between 2013-2014. Secondly, 2014 was the first year of screening for severe combined immune deficiency during the entire calendar year. There were 889 presumptive positive screens that required follow-up for definitive diagnosis and treatment. | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:** Source: IDPH - Genetics. Starting with CY 2007 data, the figures show the number of newborns with a positive screen that are followed until case closure. Previously the figures simply reported the number of infants screened versus infants born. The change was made upon the recommendation of a federal review team in August 2010. | |

| | | |
|---|---|---|
| 4. | **Field Name:** | **2012** |

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

**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 | 71.1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | CSHCN SLAITS Survey | CSHCN SLAITS Survey | CSHCN SLAITS Survey | CSHCN SLAITS Survey | CSHCN SLAITS Survey |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. | |
| 3. | **Field Name:** | **2013** |

**Field Note:**
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

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

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

5. **Field Name:** **2011**

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

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

**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 | 44.5 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | CSHCN SLAITS Survey | CSHCN SLAITS Survey | CSHCN SLAITS Survey | CSHCN SLAITS Survey | CSHCN SLAITS Survey |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**Field Note:**
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

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

2. **Field Name:** **2014**

**Field Note:**
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

**Field Note:**
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

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

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

5. **Field Name:** **2011**

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

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

**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 | 62.1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | CSHCN SLAITS Survey | CSHCN SLAITS Survey | CSHCN SLAITS Survey | CSHCN SLAITS Survey | CSHCN SLAITS Survey |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:** For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:** For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:** For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. | |
| 4. | **Field Name:** | **2012** |

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

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

| | | |
|---|---|---|
| 5. | **Field Name:** | **2011** |

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

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

**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 | 64.6 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | CSHCN SLAITS Survey | CSHCN SLAITS Survey | CSHCN SLAITS Survey | CSHCN SLAITS Survey | CSHCN SLAITS Survey |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.<br>All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.<br>All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. | |
| 3. | **Field Name:** | **2013** |

**Field Note:**
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

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

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

5. **Field Name:** **2011**

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

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

**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 | 45.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | CSHCN SLAITS Survey | CSHCN SLAITS Survey | CSHCN SLAITS Survey | CSHCN SLAITS Survey | CSHCN SLAITS Survey |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**Field Note:**
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

**Field Note:**
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

**Field Note:**
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

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

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

5. **Field Name:** **2011**

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

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

**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 | 74.6 | 77.2 | 76.9 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | National Immunization Survey | National Immunization Survey | National Immunization Survey | National Immunization Survey | National Immunization Survey |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**Field Note:**
Source: Vaccination coverage for the 4:3:1:3:3 vaccine series among children 19 to 35 months - US, National Immunization Survey, 2014. (available http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/data/tables-2013.html)

2014 data is for infants born January 2011-May 2013. Margin of Error is +/- 5.1%

2. **Field Name:** **2014**

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

2013 data is for infants born January 2010-May 2012. Margin of Error is +/- 4.9%

3. **Field Name:** **2013**

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

Margin of error for Illinois is +/- 4.6%

2012 NIS includes infants born January 2009 - May 2011

4. **Field Name:** **2012**

| | | |
|---|---|---|
| | **Field Note:**<br>From CDC - NIS. Full CY 2012 data not available. Coverage Levels by Milestone Ages - 24 months by State and Local Area: "Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series - Before 24 Months of Age by State and Local Area - US, National Immunization Survey,CY 2011", received in e-mail from Region V office 5/10/13. | |
| 5. | **Field Name:** | **2011** |
| | **Field Note:**<br>From CDC - NIS. Full CY 2011 data not available. Coverage Levels by Milestone Ages - 24 months by State and Local Area: "Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series - Before 24 Months of Age by State and Local Area - US, National Immunization Survey,Q3/2010-Q2/2011" | |

**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 | 10.2 | 9.5 |
| Numerator | 4,037 | 3,520 | 2,926 | 2,577 | 2,396 |
| Denominator | 265,206 | 260,596 | 256,134 | 253,172 | 253,172 |
| Data Source | provisional birth data, DHFS-EDW | provisional birth data, DHFS-EDW | final birth data, DHFS-EDW | provisional birth data, DHFS-EDW | provisional birth data, DHFS-EDW |
| Provisional Or Final ? | | | | Provisional | Provisional |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Data Sources:<br>Numerator = births to women ages 15 to 17 from provisional 2015 birth data from DHFS-EDW<br>Denominator is July 2014 post-censal estimate (released June 2015) for all females ages 15 to 17 in Illinois. (2015 post-censal estimates not yet available) | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>Data Sources:<br>Numerator = births to women ages 15 to 17 from provisional 2014 birth data from DHFS-EDW<br>Denominator is July 2013 post-censal estimate (released June 2014) for all females ages 15 to 17 in Illinois. (2014 post-censal estimates not yet available) | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>Data Sources:<br>Numerator = births to women ages 15 to 17 from FINAL 2013 birth data from DHFS-EDW<br>Denominator is July 2013 post-censal estimate (released June 2014) for all females ages 15 to 17 in Illinois. | |
| 4. | **Field Name:** | **2012** |
| | **Field Note:**<br>Data Sources:<br>Numerator = births to women ages 15 to 17 from provisional 2012 birth data from DHFS-EDW<br>Denominator is July 2012 post-censal estimate (released June 2014) for all females ages 15 to 17 in Illinois. | |
| 5. | **Field Name:** | **2011** |

**Field Note:**
Data Sources:
Numerator = births to women ages 15 to 17 from provisional 2011 birth data from DHFS-EDW
Denominator is July 2011 post-censal estimate (released June 2014) for all females ages 15 to 17 in Illinois.

**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 | 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 | IDPH, Oral Health |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Source: 2013-2014 Basic Screening Survey of 3rd grade students conducted by IDPH Oral Health Program (Healthy Smiles, Healthy Growth)<br><br>No new data available for 2015. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>Source: 2013-2014 Basic Screening Survey of 3rd grade students conducted by IDPH Oral Health Program (Healthy Smiles, Healthy Growth) | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>Source: 2008-2009 Basic Screening Survey conducted by IDPH Oral Health Program. A new survey is underway for the 2013-2014 school year, but data will not be available until summer 2014. | |
| 4. | **Field Name:** | **2012** |
| | **Field Note:**<br>Data repeated from 2011 reporting year and marked as Provisional due to lack of response from IDPH. Several attempts requesting new data and narrative have been made with numerous IDPH staff. As of June 28, 2013 no updates from IDPH on Oral Health. | |
| 5. | **Field Name:** | **2011** |
| | **Field Note:**<br>Data repeated from 2010 reporting year and marked as Provisional due to lack of response from IDPH. Several attempts requesting new data and narrative have been made with numerous IDPH staff. As of July 9, 2012 no updates from IDPH on Oral Health. | |

**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 | 1.6 | 1.1 | 1.2 |
| Numerator | 34 | 34 | 40 | 26 | 30 |
| Denominator | 2,574,430 | 2,574,430 | 2,499,834 | 2,471,062 | 2,471,062 |
| Data Source | IDPH - Vital Records | IDPH - Vital Records | death files - DHFS-EDW | death files - DHFS-EDW | death files - DHFS-EDW |
| Provisional Or Final ? | | | | Final | Provisional |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Numerator: provisional 2015 death certificates for children ages 0-14. Deaths identified by abstracting all deaths with any "V" code in "underlying cause of death" field. Source: Electronic Data Warehouse (EDW), Illinois Department of Healthcare and Family Services (DHFS).<br><br>Denominator: 2014 post-censal population estimate for children 0-14 (released June 2015). 2015 post-censal estimates not yet available. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>Numerator: FINAL 2014 death certificates for children ages 0-14. Deaths identified by abstracting all deaths with any "V" code in "underlying cause of death" field. Source: Electronic Data Warehouse (EDW), Illinois Department of Healthcare and Family Services (DHFS).<br><br>Denominator: 2014 post-censal population estimate for children 0-14 (released June 2015). | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>Numerator: final 2013 death certificates for children ages 0-14. Deaths identified by abstracting all deaths with any "V" code in "underlying cause of death" field. Source: Electronic Data Warehouse (EDW), Illinois Department of Healthcare and Family Services (DHFS).<br><br>Denominator: 2013 post-censal population estimate for children 0-14 (released June 2014) | |
| 4. | **Field Name:** | **2012** |

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

Denominator: 2010 Census population estimates

5. **Field Name:** **2011**

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

Denominator: 2010 Census population estimates

**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 | 47.1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | National Immunization Survey | National Immunization Survey | National Immunization Survey | National Immunization Survey | National Immunization Survey |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Data Source: National Immunization Survey, 2013-2014 combined for births occurring during 2012. Margin of error is +/- 5.8%http://www.cdc.gov/breastfeeding/data/NIS_data/ | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>Data Source: National Immunization Survey, 2013. As shown in 2014 CDC Breastfeeding Report Card, including data on 2011 births. | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>Data Source: National Immunization Survey, 2012. As shown in 2013 CDC Breastfeeding Report Card, including data on 2010 births. | |
| 4. | **Field Name:** | **2012** |
| | **Field Note:**<br>Data Source: National Immunization Survey, 2011. As shown in 2012 CDC Breastfeeding Report Card, including data on 2009 births.<br><br>Measurement of Indicator Changed starting in year 2011. Data will now come from National Immunization Survey and estimate the percent of all Illinois infants who are breastfed at six months age.<br><br>Previous indicator used WIC data (from IDHS) to estimate the percent of breastfed infants who were still breastfed at 6 months of age. This indicator is no longer available from the WIC program because they only record food package status at six months, not actual breastfeeding behavior.<br><br>Because of the change in population (new population is all infants, old population was WIC infants who were ever breastfed), the data prior to 2011 are not comparable with the new indicator. | |

| | | |
|---|---|---|
| 5. | **Field Name:** | **2011** |

**Field Note:**
Data Source: National Immunization Survey, 2010. As shown in 2011 CDC Breastfeeding Report Card, including data on 2008 births.

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

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

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

**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 | 98.9 |
| Numerator | 156,049 | 154,005 | 149,187 | 149,912 | 150,769 |
| Denominator | 157,343 | 155,345 | 150,996 | 151,655 | 152,446 |
| Data Source | IDPH, Vision and Hearing | IDPH, Vision and Hearing | IDPH, Vision and Hearing | IDPH, Vision and Hearing | IDPH, Vision and Hearing |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Source: HI*Track hearing screening database, provided by IDPH Hearing and Vision program May 2015. Denominator number is based on infants reported to IDPH Vision and Hearing Program rather than vital statistics. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>Source: IDPH Vision and Hearing Screening Program, May 2015. 2011-2014 denominator data are based on infants reported to IDPH Vision and Hearing Program rather than vital statistics. | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>Source: IDPH Vision and Hearing Screening Program, March 5, 2014, 2011-2013 data are based on infants reported to IDPH Vision and Hearing Program rather than vital statistics. | |
| 4. | **Field Name:** | **2012** |
| | **Field Note:**<br>Notes - 2012<br>Source: IDPH Vision and Hearing Screening Program's Hi*track, September 11, 2013. Numbers indicated are based on infants reported to IDPH Vision and Hearing Program rather than vital statistics. Final birth data beyond 2009 are not available. | |
| 5. | **Field Name:** | **2011** |
| | **Field Note:**<br>Source: IDPH Hi*track as of 3/21/2012 - as entered by U of I - DSCC. | |

**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 | 7.3 | 6.0 |
| Numerator | | 191,000 | 206,000 | 5,387 | 4,472 |
| Denominator | | 3,105,000 | 3,001,000 | 73,956 | 73,920 |
| Data Source | Census Bureau, Current Population Survey | Census Bureau, Current Population Survey | Current Population Survey (Census) | Current Population Survey (Census) | Current Population Survey (Census) |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Source: U.S. Census Bureau, 2015 Current Population Survey. Data obtained from http://www.census.gov/cps/data/cpstablecreator.html. Table of Age x Health Insurance Coverage | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>Source: U.S. Census Bureau, Current Population Survey, March 2014 Annual Social and Economic Supplement. Data is for 2013. Data obtained from Kaiser http://kff.org/other/state-indicator/children-0-18/ | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>Source: U.S. Census Bureau, Current Population Survey, 2013 Annual Social and Economic Supplement. Data is for 2012.<br><br>Standard error of estimate is 0.9 | |
| 4. | **Field Name:** | **2012** |
| | **Field Note:**<br>Source: U.S. Census Bureau, Current Population Survey, 2012 Annual Social and Economic Supplement. Data is for 2011.<br><br>Standard error for estimate is 0.8<br><br>(value corrected during 2013 reporting year because previous number could not be validated with Census data) | |
| 5. | **Field Name:** | **2011** |

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

2011 data is provisional and is estimated using 2010 data.

**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 | 30.4 |
| Numerator | 40,575 | 40,575 | 40,575 | 40,575 | 40,575 |
| Denominator | 133,471 | 133,471 | 133,471 | 133,471 | 133,471 |
| Data Source | PedNSS | PedNSS | PedNSS, 2011 | PedNSS, 2011 | PedNSS, 2011 |
| Provisional Or Final ? | | | | Provisional | Provisional |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>No new data. PedNSS survey was discontinued by CDC. No new data available at this time. Use 2011 data as provisional for 2014. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>No new data. PedNSS survey was discontinued by CDC. No new data available at this time. Use 2011 data as provisional for 2014.<br><br>Development of a new data system to mirror PedNSS for Midwest states is currently underway, but not yet implemented. | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>No new data. PedNSS survey was discontinued by CDC. No new data available at this time. Use 2011 data as provisional for 2013.<br><br>Development of a new data system to mirror PedNSS for Midwest states is currently underway, but not yet implemented. | |
| 4. | **Field Name:** | **2012** |
| | **Field Note:**<br>No new data. PedNSS survey was discontinued by CDC. No new data available at this time. Use 2011 data as provisional for 2012. | |
| 5. | **Field Name:** | **2011** |

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

**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 | 10.1 | 8.8 | 6.5 |
| Numerator | 14,830 | 14,830 | 15,245 | 13,202 | 9,562 |
| Denominator | 161,764 | 161,764 | 151,665 | 149,551 | 146,154 |
| Data Source | IDPH, PRAMS | IDPH, PRAMS | PRAMS | PRAMS | PRAMS |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Source: 2013 PRAMS, obtained from IDPH, Illinois Center for Health Statistics. Numerator and denominator are weighted estimates of PRAMS data.<br><br>95% Confidence Interval = 5.1% - 8.0% | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>Source: 2012 PRAMS, obtained from IDPH, Illinois Center for Health Statistics. Numerator and denominator are weighted estimates of PRAMS data.<br><br>95% Confidence Interval = 6.9% - 10.8% | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>Source: 2011 PRAMS, obtained from IDPH, Illinois Center for Health Statistics. Numerator and denominator are weighted estimates of PRAMS data.<br><br>95% Confidence Interval = 8.3% - 11.8% | |
| 4. | **Field Name:** | **2012** |
| | **Field Note:**<br>Source: 2009 PRAMS, obtained from IDPH, Illinois Center for Health Statistics. Numerator and denominator are weighted estimates of PRAMS data.<br>There are currently delays in obtaining more recent PRAMS; 2010 PRAMS data is estimated to be released in summer 2014. | |
| 5. | **Field Name:** | **2011** |

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

**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 | 5.1 | 6.5 | 8.5 |
| Numerator | 57 | 73 | 45 | 56 | 73 |
| Denominator | 922,092 | 922,092 | 877,192 | 861,712 | 861,712 |
| Data Source | IDPH, Vital Records | IDPH, Vital Records | death records, DHFS-EDW | death records, DHFS-EDW | death records, DHFS-EDW |
| Provisional Or Final ? | | | | Final | Provisional |

**Field Level Notes for Form 10d NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Data Sources:<br>Numerator - 2015 provisional death certificate data obtained via IDHFS Electronic Data Warehouse.<br>Denominator - 2014 post-censal population estimates (released June 2015). 2015 post-censal estimates are not yet available. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>Data Sources:<br>Numerator - 2014 final death certificate data obtained via IDHFS Electronic Data Warehouse.<br>Denominator - 2014 post-censal population estimates (released June 2015). | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>Data Sources:<br>Numerator - 2013 final death certificate data obtained via IDHFS Electronic Data Warehouse.<br>Denominator - 2013 post-censal population estimates (released June 2014) | |
| 4. | **Field Name:** | **2012** |
| | **Field Note:**<br>Data Sources: Numerator - 2010 death certificate data obtained via IDHFS Electronic Data Warehouse.<br>Denominator - 2010 Census population estimates.<br><br>Vital Records data for deaths beyond 2010 are not available at this time. | |
| 5. | **Field Name:** | **2011** |

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

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

**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 | 81.1 | 79.4 | 81.5 |
| Numerator | 2,142 | 2,055 | 1,666 | 1,634 | 1,643 |
| Denominator | 2,410 | 2,355 | 2,053 | 2,058 | 2,017 |
| Data Source | provisional birth data, DHFS-EDW | provisional birth data, DHFS-EDW | birth data, DHFS-EDW | birth data, DHFS-EDW | birth data, DHFS-EDW |
| Provisional Or Final ? | | | | Provisional | Provisional |

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**Field Note:**
Source: 2015 provisional birth data from DHFS-EDW. Includes only births in Illinois hospitals (IL resident births occurring out of state are not included). In 2015, there were 24 level III birthing hospitals located within Illinois.

Infants with recorded birthweight less than 350 grams were not included in analysis (due to high likelihood of incorrect recording of birthweight). Excluded births: 191 births had missing birthweight (160 <350g, 31 recorded as "9999") and 16 VLBW births had missing hospital name.

2. **Field Name:** **2014**

**Field Note:**
Source: 2014 provisional birth data from DHFS-EDW. Includes only births in Illinois hospitals (IL resident births occurring out of state are not included). In 2014, there were 24 level III birthing hospitals located within Illinois.

Infants with recorded birthweight less than 350 grams were not included in analysis (due to high likelihood of incorrect recording of birthweight). Excluded births: 182 births had missing birthweight (154 <350g, 28 recorded as "9999") and 14 VLBW births had missing hospital name.

3. **Field Name:** **2013**

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

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

4. **Field Name:** **2012**

**Field Note:**
Source: provisional birth data from DHFS-EDW

| | | |
|---|---|---|
| 5. | **Field Name:** | **2011** |

**Field Note:**
Source: provisional birth data from DHFS-EDW

**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 | 86.7 | 85.4 | 85.0 |
| Numerator | 124,676 | 121,499 | 119,804 | 120,398 | 116,249 |
| Denominator | 150,534 | 146,511 | 138,190 | 141,063 | 136,749 |
| Data Source | provisional birth data, DHFS-EDW | provisional birth data, DHFS-EDW | birth data, DHFS-EDW | birth data, DHFS-EDW | birth data, DHFS-EDW |
| Provisional Or Final ? | | | | Provisional | Provisional |

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**Field Note:**
Data Source: 2015 provisional birth data obtained via the IDHFS Electronic Data Warehouse.

Analysis Notes: Only date of prenatal care entry is included in EDW birth data files. By comparing this date to date of birth and gestational age at delivery, the gestational age (in weeks) at prenatal care entry was estimated. Prenatal care <= 13 weeks gestation was defined as first trimester entry. Any women whose records showed starting prenatal care prior to pregnancy (gestational age at PNC entry <0) were given missing values. 8,662 (6.0%) women had invalid/missing values for timing of entry to prenatal care.

2. **Field Name:** **2014**

**Field Note:**
Data Source: 2014 provisional birth data obtained via the IDHFS Electronic Data Warehouse.

Analysis Notes: Only date of prenatal care entry is included in EDW birth data files. By comparing this date to date of birth and gestational age at delivery, the gestational age (in weeks) at prenatal care entry was estimated. Prenatal care <= 13 weeks gestation was defined as first trimester entry. Any women whose records showed starting prenatal care prior to pregnancy (gestational age at PNC entry <0) were given missing values. 6,870 (4.6%) women had invalid/missing values for timing of entry to prenatal care.

3. **Field Name:** **2013**

**Field Note:**
Data Source: 2013 final birth data obtained via the IDHFS Electronic Data Warehouse.

Analysis Notes: Only date of prenatal care entry is included in EDW birth data files. By comparing this date to date of birth and gestational age at delivery, the gestational age (in weeks) at prenatal care entry was estimated. Prenatal care <= 13 weeks gestation was defined as first trimester entry. Any women whose records showed starting prenatal care prior to pregnancy (gestational age at PNC entry <0) were given missing values. 7,567 (5.2%) women had invalid/missing values for timing of entry to prenatal care.

| | | |
|---|---|---|
| 4. | **Field Name:** | **2012** |

**Field Note:**
Data Source: 2012 provisional birth data obtained via the IDHFS Electronic Data Warehouse. (analysis updated July 2014)

FINAL DATA UPDATE (as of 5/26/16): 86.6% (121,682 / 140,554) [7,628 (5.2%) excluded due to missing date of PNC entry]. TVIS system did not allow update of older data.

Analysis Notes: Only date of prenatal care entry is included in provisional birth data files. By comparing this date to date of birth and gestational age at delivery, the gestational age (in weeks) at prenatal care entry was estimated. Prenatal care <= 13 weeks gestation was defined as first trimester entry. Any women whose records showed starting prenatal care prior to pregnancy (gestational age at PNC entry <0) were given missing values. 9,268 (5.9%) women had invalid/missing values for timing of entry to prenatal care.

| | | |
|---|---|---|
| 5. | **Field Name:** | **2011** |

**Field Note:**
Data Source: 2011 provisional birth data obtained via the IDHFS Electronic Data Warehouse. (analysis updated July 2014)

FINAL DATA UPDATE (as of 5/26/16): 85.9% (123,605 / 143,910) [6,912 (4.6%) excluded due to missing date of PNC entry]. TVIS system did not allow update of older data.

Analysis Notes: Only date of prenatal care entry is included in provisional birth data files. By comparing this date to date of birth and gestational age at delivery, the gestational age (in weeks) at prenatal care entry was estimated. Prenatal care <= 13 weeks gestation was defined as first trimester entry. Any women whose records showed starting prenatal care prior to pregnancy (gestational age at PNC entry <0) were given missing values. 7,251 (4.6%) women had invalid/missing values for timing of entry to prenatal care.

**Data Alerts:**

None

**Form 10d**
**State Performance Measures (SPMs) (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 | 25 |
| Denominator | 1 | 1 | 1 | 1 | 1 |
| Data Source | Staff Report | Staff Report | Staff Report | Staff Report | Staff Report |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** **2015**

**Field Note:**
Performance Objective for 2015 is 24. TVIS system would only allow an annual objective between 0 and 1.

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

2015 Score Breakdown is as follows:
Availability: 11 / 12 points
Integration: 4 / 12 points
Analysis: 5 / 12 points
Dissemination: 5 / 12 points
TOTAL SCORE = 25 / 48 points

2. **Field Name:** **2014**

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

2014 Score Breakdown is as follows:
Availability: 11 / 12 points
Integration: 4 / 12 points
Analysis: 3 / 12 points
Dissemination: 2 / 12 points
TOTAL SCORE = 20 / 48 points

3. **Field Name:** **2013**

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

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

4. **Field Name:** **2012**

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

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

5. **Field Name:** **2011**

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

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

**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 | 7 |
| Denominator | 15 | 15 | 15 | 15 | 15 |
| Data Source | Survey | Survey | Staff Report | Staff Report | Staff Report |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>No changes from previous year. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>This performance measure was developed when the Title V program was housed in the Illinois Department of Human Services, which administers many of the individual programs funded by IDHS.<br><br>During 2014, the IDPH Office of Women's Health and Family Services began the process of creating a new resource database / directory to house information on MCH programs and services throughout the state. As of April 2015, 388 agencies/organizations and 893 programs are represented in the database.<br><br>Breakdown of 2014 Score for SPM #2:<br>A. Explore Availability & Completeness of Existing Systems, Identify Gaps: 3 / 3 (completely accomplished)<br>B. Improve Existing Resource Databases: 2 / 3 (mostly accomplished)<br>C. Promote Use of Resource Databases: 1 / 3 (partially accomplished)<br>D. Hold Statewide Summit to Lin Programs/Services: 0 / 3 (not yet started)<br>E. Design and Implement a Web-Based Queriable System: 1 / 3 (partially accomplished)<br>TOTAL: 7 / 15 | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>This performance measure was developed when the Title V program was housed in the Illinois Department of Human Services, which administers many of the individual programs funded by IDHS.<br><br>Now that Title V has moved to IDPH Office of Women's Health and Family Services, the specific action items that made up the score components for this SPM are not relevant. During the 2015 needs assessment, if this continues to be a priority, a new performance measure will be developed to measure progress in improving service delivery to MCH clients. | |

| | | |
|---|---|---|
| 4. | **Field Name:** | **2012** |
| | **Field Note:**<br>This is an estimate based upon an informal internal review by MCH data staff. The Department plans to hire an MCH Epidemiologist. One of that person's duties will be to survey and assess the state's data capacity and work on strategies towards strengthening it. | |
| 5. | **Field Name:** | **2011** |
| | **Field Note:**<br>This is an estimate based upon an informal internal review by MCH data staff. The Department plans to hire an MCH Epidemiologist. One of that person's duties will be to survey and assess the state's data capacity and work on strategies towards strengthening it. | |

**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 | 0.0 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | | Staff Report | Staff Report | Staff Report |
| Provisional Or Final ? | | | | Provisional | Provisional |

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** **2015**

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

2. **Field Name:** **2014**

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

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

3. **Field Name:** **2013**

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

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

4. **Field Name:** **2012**

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

| | | |
|---|---|---|
| 5. | **Field Name:** | **2011** |

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

**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 | 67.7 |
| Numerator | 272,659 | 257,258 | 239,812 | 217,222 | 202,337 |
| Denominator | 383,171 | 377,062 | 347,234 | 316,460 | 298,934 |
| Data Source | IDHFS EIS Rpt. | IDHFS EIS Rpt. | IDHFS EIS Rpt. | IDHFS EIS Rpt. | IDHFS EIS Rpt. |
| Provisional Or Final ? | | | | Provisional | Provisional |

**Field Level Notes for Form 10d SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Source: IDHFS, EIS Report "HEDIS - Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) - HFS Continuously Enrolled - IDPAEIS101-T1" - Data as of 5/24/2016<br><br>2015 data are not yet final. Providers have up to 18 months to file claims. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>Source: IDHFS, EIS Report "HEDIS - Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) - HFS Continuously Enrolled - IDPAEIS101-T1" - Data as of 5/15/2015<br><br>2014 data are not yet final. Providers have up to 18 months to file claims. | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>Source: IDHFS, EIS Report "HEDIS - Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) - HFS Continuously Enrolled - IDPAEIS101-T1" - Data as of 4/08/2014<br><br>2013 data are now final (updated 5/15/15). | |
| 4. | **Field Name:** | **2012** |
| | **Field Note:**<br>Source: IDHFS, EIS Report "HEDIS - Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) - HFS Continuously Enrolled - IDPAEIS101-T1" - Data as of 4/09/2013<br><br>2012 data are not yet final. Providers have up to 18 months after the end of a year to submit claims. | |
| 5. | **Field Name:** | **2011** |

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

**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 | 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 | IL-BRFSS |
| Provisional Or Final ? | | | | Final | Provisional |

**Field Level Notes for Form 10d SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Source: 2014 BRFSS Data. Only women ages 18-44 are included in analysis.<br>95% Confidence Interval = (61.1% - 78.2%)<br><br>2015 BRFSS data not yet available. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>Source: 2014 BRFSS Data. Only women ages 18-44 are included in analysis.<br>95% Confidence Interval = (61.1% - 78.2%) | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>Source: 2013 BRFSS Data (updated May 2015). Only women ages 18-44 are included in analysis.<br>95% Confidence Interval = (76.2% - 83.0%) | |
| 4. | **Field Name:** | **2012** |
| | **Field Note:**<br>Source: 2012 BRFSS Data<br>Only non-pregnant women ages 18-44 are included in the numerator and denominator.<br>95% Confidence Interval = (80.5% - 87.0%) | |
| 5. | **Field Name:** | **2011** |
| | **Field Note:**<br>Source: 2011 BRFSS Data<br>Only non-pregnant women ages 18-44 are included in the numerator and denominator.<br>95% Confidence Interval = (75.0% - 82.6%) | |

**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 | 42.0 | 41.3 | 47.1 |
| Numerator | 71,100 | 71,100 | 62,915 | 61,975 | 69,082 |
| Denominator | 160,698 | 160,698 | 149,951 | 150,211 | 146,615 |
| Data Source | PRAMS | PRAMS | PRAMS | PRAMS | PRAMS |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** **2015**

**Field Note:**
Source: 2013 Pregnancy Risk Assessment Monitoring System (PRAMS).
95% Confidence Interval: 44.2% - 50.0%

Starting in Phase 7 (2012), the question on pregnancy intention included the option "I wasn't sure how I felt". The women selecting this response were grouped in the "unintended" category. In 2013, the number of women selecting "not sure" rose, while the number of women selecting "I wanted to be pregnant then" decreased. These changes combined led to a fairly large increase in unintended pregnancies between 2012-2013.

2. **Field Name:** **2014**

**Field Note:**
Source: 2012 Pregnancy Risk Assessment Monitoring System (PRAMS).
95% Confidence Interval: 38.0% - 44.6%

Starting in Phase 7 (2012), the question on pregnancy intention included the option "I wasn't sure how I felt". The women selecting this response were grouped in the "unintended" category.

3. **Field Name:** **2013**

**Field Note:**
Source: 2011 Pregnancy Risk Assessment Monitoring System (PRAMS).
95% Confidence Interval: 39.1% - 44.8%

4. **Field Name:** **2012**

**Field Note:**
Source: 2009 Pregnancy Risk Assessment Monitoring System (PRAMS).

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

5. **Field Name:** **2011**

**Field Note:**
Source: 2009 Pregnancy Risk Assessment Monitoring System (PRAMS).

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

**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 | 35.1 |
| Numerator | 697,930 | 759,190 | 798,269 | 796,490 | 513,228 |
| Denominator | 1,507,472 | 1,554,421 | 1,581,522 | 1,547,301 | 1,460,906 |
| Data Source | IDHFS CMS 416 Report | IDHFS CMS 416 Report | IDHFS CMS 416 Report | IDHFS CMS 416 Report | IDHFS CMS 416 Report |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** **2015**

**Field Note:**
Source: 2015 report from Illinois Department of Healthcare and Family Services: "Early and Periodic Screening, Diagnosis, and Treatment Services for Children, Illinois' CMS-416 Reporting"
Numerator = Line 12b summed for ages 1-20 (number of children receiving preventative dental services in last year)
Denominator = Line 1b summed for ages 1-20 (number of continuously eligible EPSDT children)

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

2. **Field Name:** **2014**

**Field Note:**
Source: 2014 report from Illinois Department of Healthcare and Family Services: "Early and Periodic Screening, Diagnosis, and Treatment Services for Children, Illinois' CMS-416 Reporting"
Numerator = Line 12b summed for ages 1-20 (number of children receiving preventative dental services in last year)
Denominator = Line 1b summed for ages 1-20 (number of continuously eligible EPSDT children)

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

3. **Field Name:** **2013**

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

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

4. **Field Name:** **2012**

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

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

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

5. **Field Name:** **2011**

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

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

**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 | 76.9 | 76.9 | 76.0 |
| Numerator | 118,038 | 118,038 | 116,594 | 115,642 | 112,796 |
| Denominator | 159,502 | 159,502 | 151,707 | 150,318 | 148,378 |
| Data Source | PRAMS | PRAMS | PRAMS | PRAMS | PRAMS |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** **2015**

**Field Note:**
Source: 2013 Pregnancy Risk Assessment Monitoring System (PRAMS).
95% Confidence Interval: 73.6% - 78.5%

Question #22k (Phase 7): "During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about... what to do if I feel depressed during pregnancy or after my baby is born? Please count only discussions, not reading materials or video". Women who did not receive any prenatal care skipped this question in the original survey, but were recoded as "no" responses for the purpose of this indicator.

2. **Field Name:** **2014**

**Field Note:**
Source: 2012 Pregnancy Risk Assessment Monitoring System (PRAMS).
95% Confidence Interval: 74.1% - 79.7%

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

3. **Field Name:** **2013**

**Field Note:**
Source: 2011 Pregnancy Risk Assessment Monitoring System (PRAMS).
95% Confidence Interval: 74.0% - 78.5%

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

4. **Field Name:** **2012**

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

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

| | | |
|---|---|---|
| 5. | **Field Name:** | **2011** |

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

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

**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 | 49.9 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | YRBS - CDC | YRBS - CDC | YRBS - CDC | YRBS - CDC | YRBS - CDC |
| Provisional Or Final ? | | | | Provisional | Provisional |

**Field Level Notes for Form 10d SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:**<br>Source: 2013 YRBS data from CDC website. 2015 YRBS data not yet publicly available (expected release date summer 2016)<br><br>Inverse of Values displayed in CDC Table: "Physically Active At Least 60 Minutes Per Day On Less Than 5 Days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)" | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:**<br>Source: 2013 YRBS data from CDC website. Survey is administered every 2 years, so 2014 data not available.<br><br>Inverse of Values displayed in CDC Table: "Physically Active At Least 60 Minutes Per Day On Less Than 5 Days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)" | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:**<br>Source: 2013 YRBS data from CDC website.<br><br>Inverse of Values displayed in CDC Table: "Physically Active At Least 60 Minutes Per Day On Less Than 5 Days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)" | |
| 4. | **Field Name:** | **2012** |

**Field Note:**
Source: 2011 YRBS data from CDC website. YRBS is conducted bi-annually during odd years.

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

5. **Field Name:** **2011**

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

This was changed in 2012. The previous source was "Table 98. Percentage of high school students who attended physical education (PE) classes, by sex ". Due to the work by our Epidemiology staff at the University of Illinois at Chicago, School of Public Health, Division of Epidemiology/Biostatistics, the sources for this measure was clarified.

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

Future Performance Objectives had to be revised accordingly.

**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 | 64.9 |
| Numerator | 879 | 746 | 608 | 327 | 300 |
| Denominator | 1,001 | 894 | 929 | 473 | 462 |
| 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 | Record Review DSCC Youth 14-21 |
| Provisional Or Final ? | | | | Final | Final |

**Field Level Notes for Form 10d SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2015** |
| | **Field Note:** The record review was completed by a group of staff not involved with the youth whose records were chosen for review. | |
| 2. | **Field Name:** | **2014** |
| | **Field Note:** The record review was completed by a group of staff not involved with the youth whose records were chosen for review. | |
| 3. | **Field Name:** | **2013** |
| | **Field Note:** The decrease in the annual indicator from 2012 is mainly due to a more objective process for the record review. This year the record review was completed by a group of staff not involved with the youth whose records were chosen for review. | |

**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 current application/annual report.

## State Action Plan Table

### State: Illinois

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

**State Action Plan Table**

**State: Illinois**

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
|---|---|---|---|---|---|
| | **Women's / Maternal Health** | | | | |
| **#1: Assure accessibility, availability and quality of preventive and primary care for all women, particularly for women of reproductive age** | a. Convene state and federal, public and private, managed care and fee for service payers to understand the landscape of patient centered medical homes for women with the potential for developing a strategy for expansion or enhancement.<br>b. Collaborate with University of Illinois School of Public Health, Title X and Illinois Department of Healthcare and Family Services to develop a pilot for Pediatricians/Family Practice doctors to offer women an opportunity to complete a reproductive health planning tool during the infant's well-baby visits.<br>c. Improve navigation from prenatal care to postpartum care by supporting the roll | *(Development in progress)* | NPM-1: % women with a past year preventive medical visit | NOM-1: % Births with prenatal care in the first trimester<br>NOM-2: Severe maternal morbidity<br>NOM-3: Maternal mortality rate<br>NOM-4.1: LBW deliveries<br>NOM-4.2: VLBW deliveries<br>NOM-4.3: Moderately LBW deliveries | *NPM #1*: By 2020, improve the percent of women with a past-year preventive medical visit by at least 10%<br>*NOM #2*: By 2020, decrease the rate of severe maternal morbidity by at least 10% |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
|---|---|---|---|---|---|
| | out of the Illinois Department of Healthcare and Family Services' prenatal to postpartum care efforts and working with the OB-GYN, Family Medicine and Midwife professional organizations to expand to providers serving privately insured women.<br><br>d. Support use of the IDHFS women-centered postpartum checklist brochure developed through IL CHIPRA by sharing the checklist with medical professional organizations, and program sites for WIC, Family Case Management, and Healthy Start.<br><br>e. Provide training and support to home visiting providers, Healthy Start, WIC, Better Birth Outcomes, Family Case Management and other providers working with expectant and new mothers, to increase patient awareness of highly effective contraception, particularly post-partum Long-Acting Reversible Contraception (LARC).<br><br>f. Collaborate with the Illinois Department of Healthcare and Family Services to | | | NOM-5.1: Preterm births<br><br>NOM-5.2: Early preterm births<br><br>NOM-5.3: Late preterm births<br><br>NOM-6: Early term births | |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
|---|---|---|---|---|---|
| | develop training and support for healthcare providers to facilitate their ability to educate women and provide access to LARC. | | | | |
| | **Perinatal / Infant Health** | | | | |
| **#2: Support healthy** | a. Provide case management and support to pregnant women at risk for | *(Development in progress)* | NPM-3: % Very low birth weight | NOM-1: % Births with prenatal care | *NPM #3*: By 2020, increase |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
|---|---|---|---|---|---|

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
|---|---|---|---|---|---|
| **pregnancies and improve birth outcomes** | poor birth outcomes through Illinois Department of Human Services programs, such as: Family Case Management, Better Birth Outcomes, Healthy Start, and evidence-based home visiting programs. Ensure that MCH programs align with Title V goals and priorities.<br><br>b. Support perinatal network administrators and outreach/education coordinators to maintain strong system of regionalized perinatal care by:<br>i. Implementing an epidemiologic study to understand the reasons why very preterm infants (<32 weeks) are delivered outside Level II facilities<br>ii. Implementing a quality improvement initiative to increase the percentage of very preterm infants born in Level III hospitals<br>iii. Utilizing the Levels of Care Assessment Tool (LOCATe) to describe neonatal and maternal levels of care in Illinois and to inform improvements to Illinois' | | (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)<br><br>NPM-13A: % Pregnant women who had their teeth cleaned<br><br>NPM-14A: % Women smoking during pregnancy | in the first trimester<br><br>NOM-2: Severe maternal morbidity<br><br>NOM-3: Maternal mortality rate<br><br>NOM-4.1: LBW deliveries<br><br>NOM-4.2: VLBW deliveries<br><br>NOM-4.3: Moderately LBW deliveries<br><br>NOM-5.1: Preterm births<br><br>NOM-5.2: Early preterm births<br><br>NOM-5.3: Late preterm births<br><br>NOM-6: Early term births<br><br>NOM-7: Non- | the percent of VLBW babies born in a Level III+ perinatal hospital by at least 10%.<br><br>*NPM #13A*: By 2020, increase the percent of pregnant women who has their teeth cleaned during pregnancy by at least 10%.<br><br>*NPM #14A*: By 2020, decrease the percent of women who smoke during pregnancy by at least 15%.<br><br>*NOM #1*: By 2020, increase the percent of women receiving |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
|---|---|---|---|---|---|
| | regionalized perinatal system<br>c. Explore creation of a portal for information and referrals to pre-/inter-conception health services and support for women who have had a prior adverse pregnancy/birth outcome<br>d. Review the state Maternal Mortality Review process and identify opportunities for improving efficiency in abstraction, data collection, and the ability to analyze trends<br>e. Conduct hospital-level reviews of severe maternal morbidities to determine the causes and develop a corrective action plan | | | medically indicated elective deliveries<br>NOM-8: Perinatal mortality<br>NOM-9.1: Infant mortality<br>NOM-9.2: Neonatal mortality<br>NOM-9.3: Post neonatal mortality<br>NOM-9.4: Preterm-related mortality | prenatal care in the first trimester by at least 5%. |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
|---|---|---|---|---|---|
| | f. Collaborate with the Illinois Perinatal Quality Collaborative to implement quality improvement projects in birthing hospitals that will improve health outcomes, such as the statewide maternal hypertension project<br><br>g. Update state Obstetric Hemorrhage Toolkit based on information in the ACOG Obstetric Hemorrhage Bundle and distribute updated educational and training materials to all Illinois hospitals through the Regionalized Perinatal System<br><br>h. Partner with the March of Dimes to implement the Healthy Babies are Worth the Wait public awareness campaign through distribution at all publicly funded perinatal sites (such as WIC, FCM, Healthy Start, etc.)<br><br>i. Distribute information to women through service providers and social media (e.g., Facebook and Twitter) on topics related to health in pregnancy, including: oral health, smoking, and chronic disease management. Utilize | | | NOM-9.5: Sleep-related SUID death rate<br><br>NOM-10: % Infants with fetal alcohol exposure in the last 3 months of pregnancy<br><br>NOM-11: Neonatal abstinence syndrome rate | |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
|---|---|---|---|---|---|
| | prenatal care materials from IL CHIPRA and leverage existing public awareness campaigns, such as Text4Baby.<br><br>j. Partner with the Illinois Quit Line and the Illinois Lung Association to implement a public awareness campaign to reduce smoking through the dissemination of pamphlets, handouts and other printed material.<br><br>k. Through CoIIN Safe Sleep workgroup, create a safe sleep toolkit that provides educational information for public health professionals on ways to promote safe sleep and gives information to hospitals, home visiting agencies, childcares and other organizations on developing evidence-based safe sleep policies<br><br>l. Provide home visiting services to families with newborns identified in the Adverse Pregnancy Outcome Reporting System (APORS) through the IDHS High-Risk Infant follow-up program<br><br>m. Participate in IDPH Zika Action Team to develop readiness plan emphasizing needs of MCH populations. Ensure that | | | | |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| | public messaging includes information related to both prevention of pregnancy and prevention of Zika transmission, and distribute educational materials to partner organizations. Support state birth defects registry (APORS) in enhancing surveillance of microcephaly, and in providing information to CDC Registry for Zika in Pregnancy.<br><br>n. Support state breastfeeding initiatives, including promoting Baby-Friendly hospital designation and breast milk banks through the Regional Perinatal Centers, evaluating the impact of the 2011 Illinois Breastfeeding Blueprint, and strategizing with HealthConnect One about updating the Blueprint to drive breastfeeding program and policy development. | | | | |
| | **Child Health** | | | | |
| **#3: Support** | a. Work with the Governor's Office of | *(Development* | NPM-6: % | NOM-13: % | *NPM #6*: By |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| **expanded access to and integration of early childhood services and systems** | Early Childhood Development and the Illinois Early Learning Council to create a comprehensive coordinated system for developmental screening, including social and emotional screens. Contribute to the development of driver diagrams for a quality improvement initiative and to the conduction of an environmental scan related to developmental and social-emotional screening.<br><br>b. Promote use of parent-completed developmental screening tools in non-medical sites, such as Healthy Start, WIC, and Head Start.<br><br>c. Collaborate with the Leadership and Education on Neurodevelopment and other Disabilities (LEND) program at UIC to train early childhood and home-visiting providers to conduct screening for autism while conducting developmental and social emotional screens.<br><br>d. Participate on the Governor's Children's Cabinet and the Inter-Agency Team to facilitate coordination and | *in progress)* | Children (10-71 months) receiving a developmental screening using a parent-completed tool | Children meeting the criteria developed for school readiness *(developmental)*<br><br>NOM-19: % Children in excellent or very good health | 2020, increase the percent of children under 5 years old who received a developmental screening using a parent-completed tool by at least 30%. |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| | synergy between the various early childhood systems.<br>e. Provide training and support to home visiting and early childhood providers to encourage family literacy and healthy families through improved knowledge of early brain and child development and support of early literacy.<br>f. Partner with the Illinois Early Learning Council to assist childcare providers with improving quality, phasing in quality rating systems, ensuring sufficient monitoring of health and safety, and improving infant-toddler care. | | | | |
| **4: Integrate** | a. Work with F2F, DSCC Family | *(Development* | NPM-6: % | NOM-14: % | *NPM #6*: see |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| **services within patient-centered medical homes for all children, particularly for CSHCN** | Advisory Council and care coordinators, and MCH program staff to develop and disseminate information to educate parents about the components of a Medical Home.<br><br>b. Utilize DSCC and IDPH websites and social media platforms to post information for families about the components of a medical home and high-quality care.<br><br>c. Work with key stakeholders, including IDHFS (Medicaid), to develop training and support for healthcare providers about the components of a Medical Home.<br><br>d. Collaborate with ICAAP and IDHFS to continue to encourage implementation of medical homes for all children, especially for CYSHCN, through promotion of the AAP National Medical Home website, which includes resources for medical practices<br><br>e. Engage DSCC staff to serve as a resource for educating medical home providers to improve their understanding | *in progress)* | Children (10-71 mos) receiving a developmental screening using a parent-completed tool<br><br>NPM-11: % Children (with and without special healthcare needs) who have a medical home<br><br>NPM-13B: % Children who had a preventive dental visit in the last 12 mos<br><br>NPM-14B: % Children who live in a household with someone who smokes | Children ages 1 to 17 who have decayed teeth or cavities in the last 12 months<br><br>NOM-15: Child mortality rate<br><br>NOM-18: % Children with a mental or behavioral health condition who received treatment or counseling<br><br>NOM-19: % Children in excellent or very good health<br><br>NOM-20: % Children and adolescents who are overweight or obese | priority 4<br><br>*NPM #11*: By 2020, increase the percent of children who have a medical home by at least 10%.<br><br>*NPM #13B*: 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%.<br><br>*NPM #14B*: By 2020, decrease the percent of children exposed to environmental |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| | of community resources and ability to connect families to needed services<br><br>f. 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 through community-based partnerships and programs.<br><br>g. Engage school-based health centers in a quality improvement project related to asthma management and education of students and school staff. (Through partnership with IDPH Division of Chronic Diseases and Illinois chapter of the American Lung Association)<br><br>h. Collaborate with Illinois Department of Healthcare and Family Services to identify opportunities to link children's medical homes to dental homes and support integration of care. | | who smokes | NOM-22.1-5: various vaccination measures | tobacco smoke in the home by at least 15%.<br><br>*NOM #22.1*: By 2020, increase the percent of fully vaccinated children 19-35 months by at least 10%. |
| | **Adolescent Health** | | | | |
| **#5: Empower adolescents to** | a. Provide evidence-based teen pregnancy prevention education in | *(Development in progress)* | NPM-2: % Adolescents | NOM-16.1-3: Adolescent | *NPM #12*: By 2020, increase |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| **adopt healthy behaviors** | school and after-school settings through contracted sites for the Teen Pregnancy Prevention – Primary (TPPP) program; Conduct evaluation of TPPP program and incorporate program changes to improve efficiency and adolescent health outcomes<br><br>b. Use bonus payments to incentivize School Based Health Centers (SBHC) to provide well visits, risk assessments, and appropriate referrals for follow-up care to adolescent patients.<br><br>c. Partner with Title X to use bonus payments to incentivize School Based Health Centers to become adolescent friendly clinics that directly provide family planning services within the SBHC.<br><br>d. Work with the Illinois Chapter of the American Academy of Pediatrics to encourage providers to adopt "adolescent-friendly" principles in their practice<br><br>e. Partner with IDHFS (EPSDT) and AAP to educate and encourage pediatric | | (ages 12-17) with a preventive medical visit in the past year | mortality rate, motor vehicle mortality rate, suicide rate<br><br>NOM-19: % Children in excellent or very good health<br><br>NOM-20: % Adolescents who are overweight or obese<br><br>NOM-22.2-22.5: various vaccination measures | the percent of adolescents with a past-year preventive medical visit by at least 5%.<br><br>*NOM #22.3*: By 2020, increase the percent of adolescents who received the HPV vaccine by 20% for females and 30% for males. |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| | providers to incorporate transition into routine adolescent well visits, and to use a standardized transition tool (e.g., transition readiness assessment in Six Core Elements of Health Care Transition) *(cross-listed in priority #6)* | | | | |
| **#6: Assure appropriate transition planning and services for adolescents and young adults, including youth with special health care needs** | a. Work with LEND and other key stakeholders to develop appropriate messaging for parents and adolescents transitioning from pediatric to adult care.<br>b. Co-sponsor the annual Transition Conference, including participating on the planning committee and supporting attendance by DSCC youth and families.<br>c. Maintain Transition Tips and Tools materials on DSCC website, including linking with national health care transition resources at Got Transition's website.<br>d. Provide information to the public on transition by posting planning/training opportunities on social media and giving presentations to community groups.<br>e. Provide training updates on Transition | *(Development in progress)* | NPM-12: % Adolescents (with and without special health care needs) who received services necessary to make transitions to adult health care | NOM-17.2: % Children with special health care needs (CSHCN) receiving care in a well-functioning system | *NPM #12*: By 2020, increase the percent of youth with special healthcare needs who received comprehensive transition planning services by at least 10%.<br><br>*NOM #17.2*: By 2020, increase the percent of CSHCN receiving care in a well-functioning system by at least 20%. |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| | to DSCC care coordinators.<br>f. Continue coordination/collaboration efforts with local health departments, provider groups, HFS, Medicaid MCOs, F2F, and other community groups to address system barriers that prevent comprehensive transition planning for adolescents (particularly those with special healthcare needs).<br>g. Renew Action Learning Collaborative team efforts to implement the National Standards for Systems of Care for CYSHCN.<br>h. Establish a baseline on state transition performance based on upcoming estimates from the 2015/16 National Survey of Children's Health; conduct in-depth analysis of new transition questions and comparison to other states.<br>i. Partner with IDHFS (EPSDT) and AAP to educate and encourage pediatric providers to incorporate transition into routine adolescent well visits, and to use a standardized transition tool (e.g., | | | | |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| | transition readiness assessment in Six Core Elements of Health Care Transition). | | | | |
| | **Children with Special Healthcare Needs** | | | | |
| **See priority #4 : Medical Home** (child health) | Illinois made a deliberate decision to develop strategies for medical home that address the unique needs of CSHCN, but also more broadly address medical home for all children in Illinois. The full list of strategies is available under priority #4 in the child health domain. | *See priority #4* | | | |
| **See priority #6 : Transition** (adolescent health) | Illinois made a deliberate decision to develop strategies for transition to adult healthcare that address the unique needs of YSHCN, but also more broadly address transition planning and services for all adolescents in Illinois. The full list of strategies is available under priority #6 in the adolescent health domain. | *See priority #6* | | | |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| | **Cross-Cutting / Life Course** | | | | |
| **#7: Assure that equity is the foundation of all decision-making; eliminate disparities in MCH outcomes** | a. Support the development and implementation of the online Infant Mortality Health Equity Toolkit through CoIIN Social Determinants of Health workgroup<br><br>b. Launch training on the use of the Infant Mortality Health Equity Toolkit to provide information and resources to local health departments and other organizations to incorporate an equity framework into planning<br><br>c. Promote and train health services agencies, including internal program units within IDPH, to use the health equity assessment tool developed (by the Minnesota Department of Health)<br><br>d. Expand OWHFS (IDPH) requirements for describing disparities in grants/proposals and require demonstration of how health equity is guiding decision-making and program | *(Development in progress)* | No NPM | NOM-17.1: Percent children with special healthcare needs<br><br>NOM-21: Children without health insurance | *Disparity in NOM #9.1:* By 2020, reduce the black-white disparity in infant mortality to no more than 2.0.<br><br>*Subcomponent of NPM #11:* 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%. |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| | planning<br>e. Promote existing training resources on life course, health equity, and social determinants of health to members of boards/groups working on MCH issues<br>f. Engage IDPH Health Equity Team to provide training to local MCH programs/entities on the health equity approach and use of equity lens<br>g. Ensure that data reports produced by Title V describe relevant disparities (by geography, race/ethnicity, age, disability status, etc), but also discuss potential root causes, implications, and recommendations for moving towards equity.<br>h. Collaborate with Committee on Institutional Cooperation (CIC) and Big 10 universities on Health Equity-focused funding proposals supporting policy analysis and data collaboration. | | | | |
| **#8: Support expanded** | a. Support training on trauma-informed care, motivational interviewing, and | *(Development in progress)* | No NPM | NOM-10: The % infants born with | By 2016, develop a state |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| **access to and integration of mental health services and systems for the MCH population.** | mental health first aid for public health and medical professionals through webinars, and other educational opportunities, for providers working with mothers, fathers, infants, children, including those with special healthcare needs and adolescents.<br><br>b. Support positive youth development activities in adolescent health programs, such as Teen Pregnancy Prevention – Primary (TPPP) program<br><br>c. Conduct analysis of data related to mental health and substance use among women of reproductive age to demonstrate burden and importance of issue; develop data reports to disseminate findings.<br><br>d. Conduct death reviews for violence and substance-related maternal deaths through the Maternal Mortality Review Committee-Violent Deaths (MMRC-V); generate annual report that summarizes public health recommendations for preventing such deaths | | | fetal alcohol exposure in the last 3 months of pregnancy<br><br>NOM-11: Neonatal abstinence syndrome rate<br><br>NOM-16.3: Adolescent suicide rate, ages 15-19 per 100,000<br><br>NOM-18: % Children with a mental or behavioral condition who received needed treatment or counseling | performance measure related to this priority.<br><br>By December 2016, conduct an analysis of neonatal abstinence syndrome in Illinois.<br><br>*NOM #18*: By 2020, increase the percent of children with a mental health or behavioral health condition who received treatment or counseling by at least 10%. |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| | e. Partner with the State Health Improvement Plan (SHIP) Behavioral Health Action Team to encourage the creation of local behavioral health planning councils and the development of collaborative action plans.<br>f. Partner with the State Health Improvement Plan (SHIP) Behavioral Health Action Team to support routine psychosocial assessment in healthcare and MCH services.<br>g. Support the Illinois Home Visiting Task Force in the design and implementation Universal Newborn Support System pilot, which will offer home visiting to every newborn and their family in Illinois for the purposes of determining their needs for support and referring them to appropriate services<br>h. Partner with the Illinois Children's Mental Health Partnership to develop and implement a model for children's mental health consultations for local health departments and other public and private providers in the public health and | | | | |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| | healthcare delivery system<br>i. Coordinate and support the state Neonatal Abstinence Syndrome (NAS) Advisory Committee by: *(cross-listed in priority #2)*<br>i. Recommending committee membership and connecting partners to enhance multi-disciplinary committee<br>ii. Presenting information about best practices for NAS prevention, treatment, and surveillance gleaned from other states and national partners<br>iii. Reviewing, compiling, and analyzing data<br>iv. Organizing the annual report due to the state legislature<br>v. Implementing new data collection, reporting, and surveillance activities as required by HB1 (PA 99-0480) | | | | |
| **#9: Partner with** | a. Implement a Title V Family Advisory Council in each of the seven Illinois | *(Development in progress)* | No NPM | No NOM | By July 2016, develop a state |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| **consumers, families and communities in decision-making across MCH programs, systems and policies** | Public Health regions<br>b. Maintain DSCC Family Advisory Council<br>c. Empower families of CSHCN through trainings to advocate for their children's care and the importance of medical home and transition services<br>d. Leverage existing community and family coalitions, such as Healthy Start family council and the Arc of Illinois, to obtain ongoing feedback on the health needs of women, children, families, and communities, and the strengths and weaknesses of current systems serving these populations. | | | | performance measure related to this priority.<br><br>*Subcomponent of NPM #11:* By 2020, increase the percent of children receiving family-centered care by at least 10%. |
| **#10: Strengthen the** | a. Within IDPH OWHFS, implement a standardized data/statistics request | *(Development in progress)* | No NPM | No NOM | By July 2016, develop a state |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| **MCH capacity for data collection, linkage, analysis, and dissemination; Improve MCH data systems and infrastructure** | system to allow staff to manage and organize internal and external data requests<br><br>b. Develop data products (fact sheets, data briefs, surveillance reports) for variety of audiences<br><br>c. Present findings of epidemiologic and other studies conducted by Title V and its partners at state and national meetings and conferences; publish in peer-reviewed journals or state morbidity and mortality review<br><br>d. Develop and implement data linkage plans for data sources relevant to MCH, including: vital records, hospital discharge, Medicaid claims, program data, etc.<br><br>e. Support efforts to sustain improvements in birth certificate accuracy through partnership with ILPQC and Division of Vital Records<br><br>f. Partner with and support Illinois PRAMS to use innovative strategies for improving response rates, including | | | | performance measure related to this priority.<br><br>By December 2016, implement a request process/system to organize data and analysis requests. |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| | public outreach, implementation of web-based survey, and introduction of incentives for survey respondents<br><br>g. Support the development and use of questions focused on the social determinants of health in state health surveys, such as PRAMS and BRFSS<br><br>h. Enhance e-Perinet data system (for perinatal hospital reporting of outcome data) to create ability to electronically upload patient data from medical records, thus reducing manual data entry burden<br><br>i. Obtain Title V staff access to vital records for out-of-state occurrences to Illinois residents, thus improving completeness of Illinois data on births and deaths<br><br>j. Maintain the CDC MCH epidemiology assignee position to strengthen scientific leadership and strategic plan for enhancing data capacity and infrastructure<br><br>k. Conduct quarterly “data team” meetings for internal OWHFS staff | | | | |

| Priority Area | Strategies | Evidence-Based Strategy Measures | National Performance Measures | National Outcome Measures | Objectives |
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| | l. Mentor graduate student interns and fellows in epidemiology, including GSEP and CSTE Fellows<br>m. Enhance training and workforce development opportunities for analytic staff<br>n. Maintain relationship between OWHFS and the MCH epidemiology program at the University of Illinois at Chicago School of Public Health through an intergovernmental agreement (IGA)<br>o. Support Illinois Perinatal Quality Collaborative efforts with epidemiologic technical assistance<br>p. Collaborate with other IDPH divisions, other state agencies, and external partners on data projects<br>q. Foster collaboration between DSCC and the University of Illinois MCH Epidemiology Program to improve data systems and analyze data related to CSHCN programs and services. | | | | |