State Title V Block Grant Narrative

The following PDF was created from the most up-to-date electronic files available from the State for its Title V Maternal and Child Health Services Block Grant 1999 annual report and 2001 application. Some changes in fonts, formatting, page numbers, and image quality may have occurred during the conversion of the document to a PDF.

Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

This PDF was produced by the National Center for Education in Maternal and Child Health under its cooperative agreement (MCU-119301) with the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.

1.3 Table of Contents

I. COMMON REQUIREMENTS FOR APPLICATION AND ANNUAL REPORT
1.1 Letter of Transmittal 0
1.2 Face Sheet 1
1.3 Table of Contents 2
1.4 Overview of the State 4
1.5 The State Title V Agency 9
1.5.1 State Agency Capacity 9
1.5.1.1 Organizational Structure 9
1.5.1.2 Program Capacity 15
1.5.1.3 Other Capacity 47
1.5.2 State Agency Coordination 49
1.5.3 Statutory Base 53
1.6 Performance Management Model 55

II. REQUIREMENTS FOR THE ANNUAL REPORT
2.1 Annual Expenditures 58
2.2 Annual Number of Individuals Served 58
2.3 State Summary Profile 58
2.4 Progress on Annual Performance Measures 58
2.4.1 Direct Health Care Services 59
2.4.2 Enabling Services 63
2.4.3 Population-Based Services 67
2.4.4 Infrastructure Services 77
2.5 Progress on Outcome Measures 87

III. REQUIREMENTS FOR APPLICATION
3.1 Needs Assessment of the Maternal and Child Health Population 93
3.1.1 Needs Assessment Process 93
3.1.2 Needs Assessment Content 96
3.1.2.1 Overview of the Maternal and Child Health Population Status 96
3.1.2.2 Direct Health Care Services 152
3.1.2.3 Enabling Services 152
3.1.2.4 Population-Based Services 160
3.1.2.5 Infrastructure Building Services 161
3.2 Health Status Indicators 168
3.2.1 Priority Needs 168
3.3 Annual Budget and Budget Justification 169
3.3.1 Completion of Budget Forms 169
3.3.2 Other Requirements 169
3.3.2.1 Maintenance of Effort 169
3.4 Performance Measures 172
3.4.1 National "Core" Five Year Performance Measures 172
3.4.1.1 Five Year Performance Targets 174

3.4.2 State "Negotiated" Five Year Performance Measures 174
3.4.2.1 Development of State Performance Measures 174
3.4.2.2 Discussion of State Performance Measures 175
3.4.2.3 Five Year Performance Targets 178
3.4.2.4 Review of State Performance Measures 178
3.4.3 Outcome Measures 178

IV. REQUIREMENTS FOR THE ANNUAL PLAN
4.1 Program Activities Related to Performance Measures 179
4.1.2 Enabling Services 181
4.1.3 Population-Based Services 185
4.1.4 Infrastructure Services 191
4.2 Other Program Activities 200
4.2.1 Direct Health Care Services 200
4.2.2 Enabling Services 203
4.2.3 Population-Based Services 203
4.2.4 Capacity/Infrastructure Building Services 205
4.3 Public Input 209
4.4 Technical Assistance 213

V. SUPPORTING DOCUMENTS
5.1 Glossary 214
5.2 Assurances and Certifications 222
5.3 Other Supporting Documents 228
5.4 Core Health Status Indicator Forms 241
5.5 Core Health Status Indicator Detail Sheets 248
5.6 Developmental Health Status Indicator Forms 260
5.7 Developmental Health Status Indicator Detail Sheets 273
5.8 All Other Forms 291
5.9 National "Core" Performance Measure Detail Sheets 340
5.10 State "Negotiated" Performance Measure Detail Sheets 359
5.11 Outcome Measure Detail Sheets 371
5.12 Notes 380

APPLICATION NARRATIVE
Illinois' Maternal and Child Health Services Block Grant
FFY 2001 Application and FFY 1999 Annual Report

I Common Requirements for the Application and the Annual Report

1.1 Letter of Transmittal

The letter of transmittal accompanies the original copy of the application.

1.2 Face Sheet

The application face sheet (SF 424) is the first page of the application.

1.3 Table of Contents

The table of contents begins on the second page of the application.

1.4 Overview of the State

Illinois ranks fifth in the nation in population, with 12.1 million people, according to 1999 census estimates. Approximately 2.8 million women in Illinois are of childbearing age (15 to 44 years). There are about 3.9 million children under the age of 22. In recent years, Illinois has averaged about 182,100 live births annually. About 51,000 pregnancies are aborted each year.

The total number of Children with Special Health Care Needs (CSHCN) in Illinois is difficult to estimate. The 1988 National Health Interview Survey (NHIS) Child Health Supplement estimated 31 percent of children under 18 years of age have one or more chronic conditions (or about 913,400 Illinois children). The NHIS reports that four percent of the children under 18 years, or about 117,900 Illinois children, have major activity limitations. The Illinois Department of Public Aid (IDPA) estimates that there are 14,000 CSHCN eligible for Medicaid, or 1.4 percent of all Medicaid-eligible children in Illinois.

Chicago and the "collar" counties are located in the northeast corner of the state. Sixty-four percent of the state's population resides in these six counties. Twenty-two cities of 25,000 or more in population account for about 1.1 million persons, or about nine percent of the state's

population. Other than these population centers, Illinois is characterized by rural areas. Using a standard of fewer than 50,000 residents to define "rural," 74 of the 102 counties are considered rural. About two-thirds of Illinois' population (Chicago and the collar counties) is concentrated on about six percent of its land, while the majority of the state is characterized by small towns and farming areas.

The 1998 Census Bureau estimates show that 81 percent of the population is European-American, 15 percent African-American and 10 percent Hispanic-American. Asians and Pacific Islanders represent three percent of the population, while Native Americans comprise two-tenths of a percent. Chicago is home to 59 percent of Illinois' African-Americans and 55 percent of the state's Hispanic-Americans.

The size of the rural area in Illinois is a significant geographic barrier to health care. All of 23 counties and parts of 54 more counties have been designated Medically Underserved Areas (MUAs). Residents of these counties often have to travel considerable distances to obtain medical care. This problem with provider distribution in rural areas creates barriers to care arising from problems with transportation, child care, hours of service, and related concerns.

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

- Early and continuous access to prenatal care remains a challenge. While 81 percent of the pregnant women in Illinois initiate prenatal care in the first trimester, only 74 percent receive adequate care throughout pregnancy[1].
- Illinois' infant mortality rate has declined steadily for the last 10 years, and has declined 23 percent since 1990. However, the state's 1998 rate (8.2 per 1,000) still compares unfavorably with the nation as a whole (7.2 per 1,000). Significant disparities in infant mortality persist by racial and ethnic groups: the rate for African-Americans is more than

[1]Using the Kessner Index of adequate prenatal care

twice that of Caucasians (2.7:1 in 1998).

- Illinois has made considerable progress in raising the proportion of children who are fully immunized by age 2 years; by the end of 1998, nearly 80 percent of the state's 2-year-olds were fully immunized.
- Compared to earlier years, more children eligible for Medicaid in Illinois are receiving health care. Overall, 74 percent of eligible children are participating in the program. The participation rate is quite good among infants (95 percent) but is low for preschool and primary-school aged children (58 and 80 percent, respectively). The Health Care Financing Administration's annual report on participation in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for federal fiscal year 1997 ranked Illinois eighth among the states in overall participation.
- The number of teen births has declined by eight percent in the last five years, and the proportion of infants born to teenaged mothers has declined by nearly five percent at the same time. There were 22,632 births to teenagers in1998; this represented 12.4 percent of all live births in the state. More than 85 percent of these young mothers were unmarried at the time they gave birth, posing a significant challenge for obtaining and maintaining economic self-sufficiency.
- Illinois has about 701,100 high-risk (low-income or adolescent) women of reproductive age in need of subsidized family planning services. Illinois' Family Planning program serves only 25 percent of the women in need.

About 22 percent of the state's population is served by a managed care plan. The ten largest Health Maintenance Organizations (HMOs) in Chicago covered 2.7 million persons in 1999, a 16 percent decrease from 1998[2]. Six of the 10 largest plans have enrollments in excess of 100,000 persons: Blue Cross Blue Shield of Illinois , Humana, Rush Prudential Health Plans, First Commonwealth, Cigna Healthcare of Illinois, and United Healthcare of Illinois. These six HMOs have enrolled about 2.4 million persons. Several HMOs participate in the voluntary managed care program for Medicaid recipients in Chicago. This managed care program serves

[2]Crane's Chicago Business, October 11, 1999, pp. 179-180.

more than one-quarter of a million women and children.

Children in low-income families may have health insurance either through the Medicaid program or through the State Child Health Insurance Program (S-CHIP). The programs are operated in Illinois under the name, "KidCare." Currently, approximately 1 million children (about one-fourth of all children in the state) are eligible for Medicaid at some time during the year. The Illinois Department of Human Services (IDHS) estimates that 190,700 uninsured children are potentially eligible for KidCare.

Both IDHS and the University of Illinois, Division of Specialized Care for Children are working closely with the Illinois Department of Public Aid, which administers the Title XIX and Title XXI programs, on the implementation of "KidCare," (the name under which both programs are marketed in Illinois) to expand the number of places that can assist families in completing an application.

Racial, ethnic, geographic and economic disparities in health status are often confounded in Illinois. While there is a two-fold disparity in infant mortality between African and European-Americans in Illinois, similar disparities are evident when contrasting Chicago, where most of the state's low-income, and racial and ethnic minority populations reside, with the remainder of the state.

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

The current priorities and corresponding initiatives of the Title V program include:

- Reduce infant mortality. The Family Case Management program has made a significant contribution to the reduction in the infant mortality rate during the last ten years. Since 1990 the infant mortality rate has decreased 23 percent statewide.

- Reduce very low birth weight. Medicaid-eligible women who participate in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) or Family Case Management (FCM) programs during pregnancy have a 25 percent lower rate of very low birth weight than Medicaid-eligible women who do not participate in either program.
- Increase the proportion of very low birth weight infants born in Level III perinatal centers. Illinois' regional perinatal care system has made equally important contributions to the reduction of infant mortality.
- Increase the proportion of children who are fully immunized by age 2 years. The Family Case Management, HealthWorks and Healthy Childcare Illinois programs, as well as the Illinois Department of Public Health's (IDPH) Immunization Program, are increasing the proportion of children who are fully immunized by age 2.
- Increase the number of low-income children, including Children with Special Health Care Needs (CSHCN), who receive medical care through the KidCare (SCHIP) program; IDHS's Family Case Management; School-Based/School-Linked Health Centers; Special Supplemental Nutrition Program for Women, Infants and Children (WIC); CSHCN offices and Early Intervention (Part C of the Individuals with Disabilities Education Act) programs promote KidCare enrollment.
- Reduce the rate of child abuse and neglect. Healthy Families Illinois is entering its fourth year, and received a 25 percent increase in its state appropriation from SFY'00. Five new program sites are planned for SFY2001.
- Improve adolescent health and reduce the incidence of teen pregnancy. Current adolescent health programs are being redesigned for SFY2001 to emphasize community-based approaches to the prevention of teen pregnancy.
- Increase community access to specialized medical services for CSHCN through care coordination activities.
- Enhance the comprehensive, community-based, culturally sensitive, care coordination system for CSHCN by implementing the medical home concept within the CSHCN Program.
- Increase assistance for CSHCN eligible for SSI in accessing needed services.
- Increase efforts to assist adolescents with special health care needs in accessing transition

services, with an emphasis on transition to adult health care.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

Illinois' Maternal and Child Health (MCH) Program is implemented by three agencies -- The Illinois Department of Human Services (IDHS), the Illinois Department of Public Health (IDPH) and the University of Illinois at Chicago Division of Specialized Care for Children (DSCC). The role of each of these agencies is described below.

The Illinois Department of Human Services is the Title V grantee. The IDHS is organized into five divisions:

- *Community Health and Prevention* (DCH&P) includes the MCH program, substance abuse prevention, domestic violence prevention and intervention, youth services and delinquency prevention, and early intervention services (Part C of the Individuals with Disabilities Education Act). The Office of Family Health is responsible for the MCH program (see below).
- *Disability and Behavioral Health Services* includes the Supplemental Security Income Disability Determination Service, as well as programs for developmental disabilities, rehabilitation services, mental health and treatment for alcohol and other drug addiction.
- *Transitional Services* includes adult employment, income assistance, food and shelter, refugee services, child care, and special social service projects.
- *Community Operations* is responsible for the Department's offices in every county of the state which perform intake and eligibility determination for cash assistance, Food Stamps, Medicaid, and Title XXI.
- *Support Functions* includes MIS (data processing), finance, legislative affairs, legal services, public information and auditing.

The Division of Community Health and Prevention is organized into two offices, the *Office of Family Health* and the *Office of Prevention*. The Office of Family Health has primary responsibility for the MCH program. The mission of the Office of Family Health is to promote

and improve the health status, economic self-sufficiency and integrity of families in Illinois by advocating for and assuring the availability and accessibility of comprehensive health and social services. This mission is accomplished through the activities of the Bureau of Maternal and Infant Health, the Bureau of Child and Adolescent Health and the Bureau of Family Nutrition. These bureaus have established a statewide network of comprehensive, community-based systems of health and social services for women of reproductive age, infants, children, and adolescents to assure family-centered, culturally-competent and coordinated services.

The MCH program is supported by four other units: the Nutrition Services Section in the Bureau of Family Nutrition; the Bureau of Community Health Nursing in the Office of Family Health; the Bureau of Performance Management Services and Support in the Division of Community Health and Prevention and the Bureau of Central and Field Operations in the Division of Community Health and Prevention. The role of each bureau is described below.

The Nutrition Services Section in the Bureau of Family Nutrition is comprised of eight staff, including 7 regional nutrition consultants and a state nutrition coordinator. All are masters-prepared Registered Dieticians. The section provides consultation and technical assistance on nutrition issues for the WIC and Commodity Supplemental Food programs as well as other maternal and child health programs such as Family Case Management, Prenatal, Pediatric Primary Care and Family Planning. The section's responsibilities in the WIC program include developing risk criteria, nutrition assessment standards and procedures, protocols and educational tools; monitoring nutrition services in the WIC program and providing continuing education and training for local agency WIC program staff. Responsibilities in the Commodity Supplemental Food program include monitoring the program and providing training for nutrition aids and local agency staff. The section also initiated and now coordinates the Inter-agency Nutrition Council. Council members represent the United States Department of Agriculture; the Illinois Hunger Coalition; the Illinois Community Action Association; the Illinois Aging, Commerce and Community Affairs, Public Aid and Public Health departments; the Illinois State Board of Education and the University of Illinois Extension Service. The Council explores methods to provide more effective and efficient use of available program

resources in an effort to extend services to a greater number of potentially eligible, needy Illinois residents. The Nutrition Services Section is also involved in special projects, including the 5 A Day for Better Health promotion, which encourages increased fruit and vegetable consumption. Breast-feeding promotion is a major component of the Nutrition Services program. Activities include increasing awareness of breast-feeding as the preferred method of infant feeding; coordinating opportunities for education and training on lactation management; and providing resources for breast-feeding promotion.

The staff of the Bureau of Community Health Nursing work to ensure that the services provided by MCH program grantees are of high quality. The bureau is staffed by masters-prepared nursing consultants who conduct medical record reviews and provide technical assistance to improve the knowledge and skills of service providers at the community level. The bureau also regularly conducts training programs for local service providers. These programs include a Pediatric Assessment course and Guidelines for Adolescent Preventive Services (GAPS), as well as other topics. The Bureau of Community Health Nursing is also responsible for two programs: Healthy Child Care Illinois and the Childhood Asthma project. Both programs are described below.

The Bureau of Performance Management Services and Support:

- provides support to DCH&P bureaus with respect to data analysis, evaluation design, database development and maintenance;
- develops health outcome reports using vital records and Cornerstone data;
- supplies spatial analyses of data using geographic information system (GIS) technology;
- coordinates the development of a Division-wide strategic plan that outlines the goals and objectives of the DCH&P programs;
- provides support to DCH&P bureaus with respect to professional development and training for department staff and DCH&P grantees;
- provides support to DCH&P bureaus with respect to conference planning and coordination; and

- serves as the liaison between DCH&P bureaus and the Office of Management Information Services in developing and maintaining program-specific information systems and data bases.

The Bureau of Central and Field Operations performs accounting, technical assistance and monitoring services for the DCH&P. The Central Operations section has overall responsibility for the Division's $500 million budget. The Field Operations section is responsible for monitoring and providing technical assistance to more than 700 local agencies that implement the Division's programs.

The Field Operations section uses management information system reports and other resources to monitor local agency activities and then plan and deliver appropriate technical assistance. The mission of the Field Operations section is to:

- Provide support and technical assistance to programs and local community agencies engaged in the delivery of health services and prevention;
- Assist local providers with the coordination and integration of MCH and prevention programs
- Support Cornerstone users at the local level; and
- Maintain the integrity of DCHP programs through site visits and contract compliance reviews.

The Field Operations section divides the state into regions for purposes of program monitoring. Each region is supervised by an administrator. Under their direction, each of 38 Regional Representatives is responsible for monitoring and technical assistance activities for a prescribed number of local agencies. These individuals work in close cooperation with local program staff and Department program staff to improve agency performance.

As described in previous MCH Services Block Grant Applications, the Governor has designated IDHS as the state health agency responsible for the administration of the MCH

Services Block Grant. Through an inter-agency agreement, MCH Block Grant funds are transferred to IDPH for the administration of the Vision and Hearing Screening, Oral Health, the Genetics and Childhood Lead Poisoning Prevention Programs. Further, DHS transfers funds from the SSDI grant to IDPH to conduct a survey to estimate the prevalence of childhood caries and transfers funds from the Universal Newborn Hearing Screening grant to IDPH to support the tracking of children with suspected hearing loss. A copy of the current interagency agreement is included in Section 5.3 (Other Supporting Documents).

The Illinois Department of Public Health. IDHS and IDPH share responsibility for the regionalized perinatal care program. As a result of the Human Services reorganization (Public Act 89-0507), IDPH retains responsibility for the following statutes and MCH programs:

- the Prevention of Developmental Disability Act, which supports the Perinatal Care Program;
- the Phenylketonuria Testing Act, which supports the newborn metabolic screening program;
- the Counties Code, which supports the Sudden Infant Death Syndrome program;
- the Illinois Lead Poisoning Prevention Act, which supports the Childhood Lead Poisoning Prevention program;
- the Vision and Hearing Screening Program; and
- the Division of Oral Health

The University of Illinois at Chicago Division of Specialized Care for Children The CSHCN program is administered by the University of Illinois at Chicago (UIC) Division of Specialized Care for Children (DSCC). DSCC is staffed to accomplish its traditional role as a provider and advocate of high quality specialty services for CSHCN through a network of regional offices and over 40 satellite locations to facilitate the community-based service system. DSCC maintains a strong focus of capacity building through family-centered, community-based care coordination activities and local systems development within all 102 counties in Illinois.

The Director of DSCC has available consultation and assistance from the resources of a major state university, including the School of Public Health, Colleges of Medicine, Nursing, Office of Business Affairs, Associated Health Professions, and Education, as well as numerous associated health facilities and programs. A statutory Medical Advisory Board composed of medical community leaders from across the state (medical school department chairpersons, hospital administrators, public health officials, senior practicing subspecialists, etc.) and a family member representative, meets three times per year to counsel the Director on program policy and activities. In addition, consultation and assistance is also available from the DSCC Family Advisory Council (FAC) which meets three times per year and has family member representation from all 13 regions of the state.

Frequent, close liaison is maintained with all major public and private agencies involved in services for CSHCN. DSCC has leadership and/or membership involvement with the following CSHCN-related programs or activities: Illinois Chapter of the American Academy of Pediatrics Committee on Children with Disabilities; Illinois Planning Council on Developmental Disabilities; Illinois Maternal and Child Health Coalition; Illinois Interagency Council on Early Intervention; Illinois Interagency Transition Consortium; Head and Spinal Cord Injury Advisory Council; Illinois Universal Newborn Hearing Screening Advisory Committee; Illinois Genetics and Metabolic Diseases Advisory Committee; Illinois Campaign for Better Health (State Children's Health Insurance Program Work Group); Illinois Department of Public Health Hearing Screening Advisory Board; Illinois Department of Public Health Vision Screening Advisory Board; Department of Human Services School Health Advisory Board; Hearing Impaired Behavior Disorder Advisory Board; Illinois Interagency Advisory Council for Deaf and Blind; Healthy Child Care Illinois Steering Committee, and Illinois Hemophilia Advisory Council.

In addition to senior DSCC staff participation on interagency boards, councils and task forces at the state level, regional office staff have developed and participate in numerous community working groups which involve local leaders and parent groups. These activities are exemplified by the regional staff involvement in: the State System Development Initiative,

Illinois Project for Local Assessment of Needs (IPLAN) meetings, Early Intervention Local Interagency Councils and Transition Planning Committees. This community involvement serves to identify local issues which have importance to statewide planning and system development.

1.5.1.2 Program Capacity

The State of Illinois has the capacity to provide comprehensive quality care to pregnant women, mothers and infants, children, and women of reproductive age through a coordinated system of services. This system is supported by the programs of the Office of Family Health in IDHS; the Office of Health Promotion at IDPH, and the UIC Division of Specialized Care for Children.

Infrastructure Development

Birth to Three Project. The Title V program and many other interested providers and advocates are working with the Ounce of Prevention Fund to re-examine the organization and delivery of services for pregnant women and children under three years of age. The overall purpose of this project is to create a comprehensive, coordinated, high-quality and easily accessible system of preventive services for children before birth and through three years of age.

The Ounce of Prevention Fund, established in 1982, is a public-private partnership which promotes the well-being of children and teens by working with families, communities and policy makers. Recognizing the family's critical importance in determining children's futures, the Ounce of Prevention Fund focuses on strengthening positive relationships within the family and enhancing the family's capacity to care for its members. Their programs, which target primarily communities with limited resources, are based on the conviction that it is more effective to promote healthy families than to treat problems later in life.

The project is supported by a grant from the Robert Wood Johnson Foundation to the Ounce of

Prevention Fund. More than 80 senior-level personnel from local, state and federal government agencies, community-based providers, policy organizations and research institutions are participating in the project. The participants have been organized into five standing committees. These include: System Coordination; Child Health and Development; Social and Emotional Health of Infants, Toddlers and Their Families; Training and Workforce Development; and Best Program Practices and Outcomes. Over the next three years, project staff and committee members will implement an extensive work plan developed during the planning phase in order to implement a comprehensive service system for young children.

The Birth to Three Project's first demonstration program is the establishment of ten "Birth to Three Assurance Networks". The purpose of a county-based Birth To Three Assurance Network is to assure that all children under age three and their families are known to their community so that they may receive the preventive, primary and tertiary services they and their families need. Each network will include a broad array of service providers who work with children under the age of three and their families. Membership may include individuals or agencies specializing in health, child development, education, social services, recreation or other services, as well as parents and representatives of the faith community. The goal of this collaboration is to develop and maintain an integrated system of service coordination that ensures that no child under the age of three misses the opportunity to receive services – from immunizations to Head Start to developmental therapy – that they need to grow and develop. The Department is supporting the local networks with Title V funds.

<u>The Chicago MCH Mini-Block Grant</u> to the Chicago Department of Public Health (CDPH) provides direct health services to pregnant women, children and women of reproductive age. These primary care services are provided to the medically indigent population in CDPH clinics and four Community Health Centers (Near North Health Services Corporation; University of Illinois, Mile Square Health Center; Circle Family Care Corporation; and the Friend Family Health Center of the University of Chicago). CDPH also uses these funds to support a prenatal weight-gain initiative, substance abuse prevention and treatment, a violence prevention initiative, a smoking cessation program for pregnant and childbearing-age women, a

school health program, a public health nurse home visitation program, a child abuse prevention project, a pediatric triage program, an infant mortality reduction program, a program for substance exposed infants, a program to move families off public assistance to self-sufficiency, and education for pregnant women and children about healthy behaviors. These programs are targeted to high risk areas within Chicago.

The Chicago MCH System Integration Project The Chicago Department of Public Health (CDPH) and the Illinois Department of Human Services (IDHS) are engaged in the Maternal and Child Health System Integration Project (MCH-SIP). Currently, services for pregnant women, infants and young children in Chicago are delivered not so much through an actual "service delivery system" but more through a compilation of discrete programs administered by myriad agencies. Services are delivered by no less than 100 provider agencies at well over 125 locations across the city and are supported by close to $130 million in funding. The Chicago MCH-SIP seeks to improve maternal and child heath status by creating a coordinated system of service delivery with strong local health department leadership. The Mayor's Advisory Council on Infant and Family Health (the MAC) will engage in a staff-facilitated vision development process. The vision statement will describe the ideal Chicago's MCH service delivery system. The MAC will conduct a two-part analysis of MCH service needs and resources across Chicago's 77 community areas and then develop strategies for system development and make recommendations for improvement to the CDPH and IDHS. The planning process will focus on all relevant programs; however, implementation will be staged, with initial efforts focused primarily on achieving better coordination and integration of the WIC and FCM programs. Efforts in years two and three will focus on other MCH services (Family Planning, Teen Parent Services, Parents Too Soon, MCH Block grant activities, Healthy Start, Healthy Families, and other services provided and supported by CDPH).

The Illinois Institute for Maternal and Child Health Leadership is intended for MCH program staff at local health departments and the regional offices of Illinois' CSHCN program. The institute first develops program knowledge through presentations on the core functions of public health — assessment, policy development and assurance. These presentations are given

by MCH program staff from Illinois and other states. The institute develops leadership skills by having the participants work in teams to address an MCH program issue proposed by one of the team members. The teams then work together for six months on the solution to the proposed issue. In the process, team members expand their program knowledge as they research and develop problem solving and teamwork skills. During the second six months of the institute, participants work independently to address an MCH problem in their own agency.

The Illinois MCH Data Use Academy The Department is working with the University of Illinois at Chicago School of Public Health's Center for Public Health Practice and City MatCH to replicate the urban Data Use Institute originally developed by City MatCH. Five teams have been selected for the first institute. The opening session is scheduled for September 2000. This will be followed by a series of skill-building conference calls focusing on analytic techniques. At the Academy's mid-point, the teams meet for a three day workshop that builds team work, analytic, and communication skills through a case study on teen pregnancy. The teams present their completed projects at the closing session, about one year after the opening session.

The Illinois MCH Leadership Society has been developed for graduates of the Illinois Institute for MCH Leadership. Fellows are encouraged to use the skills learned in the Illinois Institute of MCH Leadership, and apply them to issues relevant to maternal and child health program planning and implementation in Illinois. Excellence in public health practice as it relates to the core public health functions and essential services are the ultimate goal of the society. The objectives of the Society are to help graduate fellows:

- Apply leadership principles to practice at state, regional and local MCH initiatives
- Provide opportunities to network with other graduates of the Institute, and encourage collaboration
- Understand how national, state, and local MCH program goals are inter-related
- Foster the development of a network of public health leaders with expertise in MCH issues

- Assist state level public health professionals with program development and implementation
- Promote excellence in Maternal and Child Health practice statewide

The first annual meeting attracted 37 of 75 graduate fellows from three program years. Regional teams, facilitated by the MCH Nurse Consultants, select a group chair and meet periodically during the year to work on specific regional MCH issues. The Department is partnering with the UIC School of Public Health to administer the project, which is supported by MCH Block Grant funds.

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

Office of Family Health Programs

Chicago Healthy Start provides a comprehensive array of social and health services to men, women of child-bearing age and their young children at a single, accessible community location in a culturally and socially appropriate manner. Services are provided through five Chicago Healthy Start Family Centers (CHSFCs) which serve as "one-stop shopping centers" for intensive case management, prenatal care, pediatric primary care, family support, early intervention, substance abuse prevention, domestic violence prevention, counseling, and employment services. The centers also provide two essential enabling services, episodic child care and transportation, to remove common access barriers to care.

Healthy Start services are also available for pregnant and parenting women who have been detained in the Cook County Jail. Through the Healthy Start program, on-site case management and health education services are provided by Cermak Health Services. As a part of case management, the Helthy Start staff discuss arrangements for legal guardianship of their infants with these women prior to delivery. Once the women are released, they are linked with the corresponding Healthy Start Family Center for follow-up. Similarly, if a Helthy Start client becomes involved with the correctional systm, the staff of the Family Center works with the

Cermak Healthy Start project to ensure an optimal birth outcome. The case management component has served over 300 women. In 1997, the project received the "Program of the Year" awards from the National Commission on Correctional Health.

The Illinois Healthy Start Programs Partnership - The Illinois Healthy Start Programs Partnership is a unique collaboration at the state and local levels among Illinois' six Healthy Start projects and the Title V program. The Partnership was organized by the Department in March 1998 when the federal Maternal and Child Health Bureau announced that four Healthy Start Phase II Replication grants were being awarded to agencies in Illinois. All four of the new replication projects have participated in the Partnership since its inception. The Department also included the Chicago Department of Public Health as a Partnership member from the outset. The Chicago Department of Public Health is the local public health authority and an important provider of perinatal health services. The Chicago Department of Public Health subsequently received a Healthy Start replication grant as well. The Partnership identified four common projects: a joint marketing campaign; greater utilization of the Cermak Health Services project (which links the women's health service of the Cook County Jail to the Chicago-area Healthy Start projects); conducting a consumer workshop; and a Fetal and Infant Mortality Review project.

Family Case Management (FCM) is a statewide program that provides comprehensive service coordination to pregnant women and children. In FY2000, 114 Family Case Management agencies were funded by the department statewide including local health departments, community- based organizations and Federally Qualified Health Centers. Assessments are conducted and care plans developed on a wide range of needs including health care, mental health, social health, education, vocation, child care, transportation, psychosocial, nutrition, environment, development, and other services, as indicated. Contacts with clients include home and office visits at a frequency necessary to meet the clients' needs. FCM support services may include transportation and child care, as well as prenatal education and parenting classes. FCM providers are authorized to complete Medicaid Presumptive Eligibility (MPE) applications for the pregnant women and to assist families in completing the KidCare

application for their children.

The Family Planning Program provides comprehensive family planning services related to the avoidance, achievement, timing, and spacing of pregnancy. Services include client education, counseling, screening, infertility services, pregnancy testing and options counseling, contraceptive methods, and identification and treatment of sexually transmitted diseases. There are 57 agencies statewide, including hospitals, local health departments, single-service family planning centers, and multi-service organizations. Women of child-bearing age, including adolescents, with incomes less than 250 percent of the federal poverty level are eligible for family planning services on a sliding fee scale.

The Fetal and Infant Mortality Review (FIMR) Project brings together key members of the community to review information from individual cases of fetal and infant death in order to identify the factors associated with those deaths, determine if they represent system problems that require change, develop recommendations for change and assist in the implementation of change. FIMR programs have been established in Chicago and in Sangamon and Macon counties. A new FIMR program is being developed in Madison and St. Clair counties in association with a federal Healthy Start Program initiative. The individual case reviews are integrated with the statewide system of perinatal mortality and morbidity reviews conducted by the state's regional perinatal centers in these local areas.

The Healthy Families Illinois Program seeks to prevent child abuse and neglect through intensive home visits that provide parenting skills education to high-risk families. The purpose of the home visit is to create a relationship with the family that promotes healthy child development, strengthens the parent-child relationship, supports parents as children's first teachers and helps to reduce family isolation. Services are provided by 44 community-based public health, mental health, child welfare, or social service agencies to particular communities across the state. Fourteen of the programs are located in Cook County; five of these are operated as components of the Chicago Healthy Start Initiative. The Healthy Families Illinois Training Institute offers programs in basic and advanced home visiting, risk assessment,

program supervision and other continuing education topics of interest to program staff. Data for part of the outcome evaluation are being collected by the Center for the Study of Family Violence and Sexual Assault at Northern Illinois University.

The High-Risk Infant Follow-up program, a component of FCM, serves infants who have any of the following conditions: a serious congenital infection; an endocrine, metabolic or immune disorder; a blood disorder; birth weight of less than 1,501 grams; a urine toxicology positive for any drug, or signs of drug toxicity or withdrawal; discharge from a neonatal intensive care unit; or a congenital anomaly or other condition, such as intrauterine growth retardation or suspected hearing loss. These infants, or families who experience a fetal or infant death, are referred to local health departments for follow-up services. Services are provided statewide by registered nurses, and follow-up may continue until the child's second birthday. The goals of follow-up services are to promote optimal growth and development, teach the family how to care for the high-risk infant, prevent complications, decrease morbidity and mortality, decrease stress and potential for abuse, and ensure early identification and referral for further treatment and evaluation.

The Illinois Newborn Hearing Screening Program administered by DHS, IDPH and DSCC, has been developed to identify newborns with hearing loss prior to hospital discharge. Approximately 500 infants with significant hearing loss are born in Illinois each year. The goal is to lessen the impact of congenital hearing loss by identifying infants before 3 months of age and initiating early intervention services by 6 months of age. It is modeled after the Newborn Metabolic Screening program described below. Hospitals will refer infants with suspected hearing loss to IDPH. Parents and the child's physician are notified of the test result and provided with a list of audiologists who are willing to conduct diagnostic testing. DSCC will pay for diagnostic testing if the family is unable to afford it. Infants will be referred as indicated to the CSHCN program and Part C Early Intervention program.

Improving Screening for Alcohol Use During Pregnancy Among Providers. The Department works with the Children's Research Triangle to conduct *The 4P's Plus: Motivating Providers*

to Screen for Alcohol Use During Pregnancy with the WestSide Healthy Start project in Chicago. This project uses the *4P's* as a screening instrument for alcohol use by pregnant women. The *4P's* is a four-question screen specifically designed to quickly identify obstetrical patients in need of in-depth assessment or follow-up monitoring for alcohol and drug abuse. It can easily be integrated into the initial prenatal visit and used for follow up screening through the pregnancy. The four questions are broad-based and highly sensitive, requiring only yes or no answers from the patient regarding her alcohol and/or drug use problems during the current pregnancy, in her past, in her partner, and in her parents. One positive answer to any question is considered a positive screen and indicates that the patient requires more in-depth evaluation. The Children's Research Triangle trains the health care providers who are participating in the WestSide Healthy Start project to administer the screening questionnaire and collects data to track the use of the screening questionnaire and referral for subsequent assessment and treatment.

The Perinatal Care Program is a collaborative effort between IDHS and IDPH. It is a comprehensive statewide system of inpatient services created to provide optimal care throughout pregnancy and early infancy in order to improve the health of women and infants. Services are provided to pregnant women who require high-risk delivery and newborn infants who require neonatal intensive care. The length of the inpatient perinatal care varies based on the severity of illness and medical complications of the patients. Four levels (capabilities) of perinatal care are well defined in administrative rules to provide a basis for quality assurance and accountability of hospital-based providers: basic or Level I, intermediate or Level II, specialty or Level II with extended capabilities, and sub-specialty or Level III, with all facilities integrated into networks of care. Presently, 161 licensed maternity hospitals in Illinois and four tertiary hospitals in St. Louis, Missouri, participate in the regionalized perinatal care system.

Each region has a perinatal center that is required to establish and maintain a structure that ensures continuous quality improvement in perinatal care. This structure provides or coordinates an integrated program of quality improvement activities such as identification

The Problem Pregnancy Program supports innovative approaches for service delivery to women at risk for, or experiencing difficult pregnancies. Each program is tailored to meet the identified needs of its community. Many services are provided during the prenatal and postpartum period including prenatal education classes, life skills and parenting classes, residential services for high-risk pregnant adolescents, preconception counseling, abstinence education, postponement of a second pregnancy until after high school graduation, mentoring, and a fathers involvement class.

A Smoking Cessation Program will be implemented in WIC and FCM sites, focused on prenatal, postpartum, and lactating clients. The curriculum is based upon a stages-of-change model, and will include supportive written materials for client distribution and videos for viewing in the waiting areas. Training will be given to key clinic staff in a train-the-trainer format, with ongoing implementation support from the MCH nurses and regional TAM staff. Clients' smoking status will be evaluated at each contact, followed by a three to five minute counseling session as appropriate. Documentation of intervention will be indicated in the data system so that reports can be generated and distributed to sites to monitor their impact.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) seeks to improve the health status of women, infants and children; to reduce the incidence of infant mortality, premature births and low birth weight; to promote breastfeeding as the best choice for infant feeding; and to aid in the growth and development of children. The program serves income-eligible pregnant, breast- feeding and postpartum women, infants and children up to 5 years of age who have a medical or nutritional risk.

Participants receive food prescriptions based on their nutritional needs. WIC foods include milk, cheese, eggs, adult and infant cereal and juice, peanut butter, tuna, carrots, beans and infant formula. Food-specific vouchers are printed on-site at WIC clinics statewide. Participants obtain their WIC foods by redeeming the vouchers at program-approved grocery stores throughout the state and at WIC food centers in certain parts of Chicago.

There are grant agreements with 98 local agencies, including local health departments, not-for-profit health care agencies and social service agencies. Services are provided statewide through more than 220 clinics.

Targeted Intensive Prenatal Case Management The MCH program is working with Illinois' Birth To Five Political Action Committee to implement a targeted initiative to reduce Medicaid expenditures during the first year of life. Several communities in Chicago, suburban Cook County, and downstate have been identified by calculating average Medicaid expenditures during the first year of life by ZIP code. Further analysis by matching Medicaid vital records and program data demonstrated that Medicaid expenditures during the first year of life are reduced by 50 percent when women participate in either WIC or FCM during pregnancy. The new intervention will feature additional community-based outreach and retention strategies including financial incentives for women, as well as lower caseloads and explicit linkages to medical care, substance abuse treatment, smoking cessation, and access-promoting services such as transportation, translation, and child care.

Office of Prevention Programs

Domestic Violence Prevention and Intervention The Department of Human Services funds 67 domestic violence programs across the state. These programs provide services such as shelter, 24-hour crisis hotlines, individual and group counseling, legal advocacy, and children's services. Other supplemental services can include emergency medical care, employment assistance, educational assistance, and child care. These services help victims of domestic violence by giving them the tools they need for safety and self-sufficiency. In addition to these intervention services, domestic violence programs also provide prevention services such as anti-violence programs in schools and community education.

In Fiscal Year 1999, domestic violence programs in Illinois responded to over 158,000 hotline calls and provided 500,000 hours of services to 103,000 clients (80,000 adults and 23,000 children). Residential programs provided 177,000 nights of shelter. Programs also conducted

over 13,000 hours of prevention and outreach activities that reached over 173,000 community members.

The Department also funds 31 programs that provide services to male perpetrators of domestic violence against women. Fiscal year 2000 is the first year the Department has funded such services. Programs are located across the state and provide psycho-educational services to help men learn non-violent ways of relating to their intimate female partners.

Services for these programs are governed by the *Illinois Protocol for Partner Abuse Intervention Programs*, a set of guidelines that represent best practices in serving perpetrators. The Department monitors programs for compliance with these guidelines, with compliant programs published in a list the Department distributes statewide to the court system and social service agencies for referral purposes.

Pregnant Women and Domestic Violence The MCH Program and the Bureau of Domestic Violence Prevention and Intervention are conducting a demonstration program to link pregnant women to domestic violence intervention services. The intervention includes provider training on appropriate screening; assessment of risk and need for intervention services; documentation of risk; supportive referral for services; and quality assurance procedures to the ensure the implementation of the intervention's protocol. The program is being conducted with a local health department, an FQHC, and a domestic violence agency. The project is supported by a grant from the MCHB.

The Early Intervention (EI) Program provides coordinated, comprehensive, multi-disciplinary services to enhance the growth and development of children from birth through 36 months of age who have developmental disabilities and delays. Services also enhance the capacity of families to meet the developmental needs of their children. The infants and toddlers served are those who are experiencing delays in cognitive, physical, communication, social, emotional, and/or adaptive development, or are diagnosed with a physical or mental condition that has a high probability of resulting in a developmental delay, such as Down's syndrome or cerebral

palsy. Part C Early Intervention services may include, but are not limited to, service coordination, developmental therapy (special instruction), physical therapy, occupational therapy, speech therapy, assistive technology, nursing services, nutrition services, vision services, audiological services and medical diagnostic services for purposes of eligibility determination. Services are available at little or no cost to families and are provided in settings appropriate for the child and family.

IDPH Programs

Genetic Counseling Services are administered by IDPH to increase the awareness and availability of clinical genetic services to providers and consumers. The program has three components. First, grants to medical centers ensure that the full range of genetic diagnostic, counseling and treatment services are available statewide to all Illinois residents regardless of income. These services are provided to pediatric and adult clients for a variety of reasons: to families of infants and children with a birth defect, developmental disability, mental retardation or other genetic conditions; to pregnant women of advanced maternal age with an abnormal test result or who have concerns about exposure to a possible teratogen or who have a family history of a genetic disorder. Services are offered to any other individual with concerns about a birth defect, developmental disability, mental retardation, neurological or muscular impairment, cancer, vision or hearing loss, blood disorder or pregnancy loss. Second, grants are also provided to local public health departments for genetic case-finding and referral to ensure that education and other follow-up services are available to all families in need of genetic services. Third, grants to pediatric hematologists at medical centers offer diagnosis, treatment, counseling and other follow-up services to those infants and their families identified through newborn screening.

The Immunization Program promotes the use of vaccinations to prevent the occurrence and transmission of diseases; distributes vaccines to public and private providers; conducts

surveillance and investigation of vaccine preventable childhood and adult illnesses; provides educational and motivational resources to providers, day care centers, schools, colleges, hospitals and the general public; conducts assessment of vaccine coverage levels among target populations; conducts quality assurance reviews of clinics and providers using federally purchased vaccines; and develops and implements a statewide immunization information system.

The Vaccines for Children (VFC) program was created by the Omnibus Reconciliation Act of 1993 to support efforts to increase childhood immunization levels by providing federally purchased vaccines to children aged birth to 18 years who meet one of the following criteria: Medicaid enrolled, no health insurance, American Indian or Alaskan Native. In addition, children with health insurance that does not cover immunizations ("under insured") may receive VFC vaccines at Federally Qualified Health Centers (FQHC). In Illinois, VFC-Plus uses residual federal funds and general revenue funds to cover the "under insured" population in the same manner as VFC eligible individuals, thus eliminating the need to travel to FQHC facilities and ensuring that all children can be served in their primary medical home.

The Newborn Metabolic Screening Program includes the initial testing and follow-up of newborns for certain genetic and metabolic conditions. The goal of newborn screening is to facilitate early diagnosis to help prevent premature death, excessive morbidity, mental retardation, and other developmental disabilities; and at the same time increase the quality of life for those who are diagnosed with a condition identified through newborn screening. Illinois screens all newborns for six disorders: biotinidase deficiency, congenital adrenal hyperplasia, galactosemia, hemoglobinopathies, Phenylketonuria (PKU), and hypothyroidism. Infants with a positive metabolic screen receive diagnostic testing and follow up services. Families with a child who has a diagnosed disorder are eligible to receive counseling and treatment services.

Prevention of Perinatal HIV Transmission Illinois' four-year plan for prevention of perinatal HIV transmission applies several time-phased interventions. The first tier of the plan involves capacity-building interventions targeted toward health care professionals who provide prenatal

care and other public health services to pregnant women. This includes perinatal providers within birthing hospitals and providers of WIC, Family Planning, FCM and CHSI services. Capacity-building interventions are designed to improve providers' skills in providing HIV prevention counseling and offering HIV testing.

Within the perinatal care system, this intervention will replicate the demonstration project conducted between 1995 and 1998 by the Cook County MCH/HIV Integration Project in the six perinatal networks located in Cook County. Originally funded by Title V of the Comprehensive AIDS Resource Emergency (CARE) Act as a Special Project of National Significance (PNS), the project's objectives were: 1) identify barriers to integration of HIV counseling and testing into maternal and child services; 2) develop policies and protocols to address these barriers; and 3) improve perinatal providers' skills in counseling about HIV risk and offering HIV testing through on-site trainings. The project also developed *Prevention and Treatment of HIV Disease in Women and Children: Guidelines for Physicians and Other Medical Providers*. During 2000, IDPH, in collaboration with DHS, will replicate this project through the remaining four downstate perinatal networks.

IDPH, in close collaboration with DHS, will also conduct capacity-building interventions for local staff of the WIC, Family Planning, Family Case Management and Chicago Healthy Start Initiative projects. This will include assessing existing barriers to integration of HIV prevention services to pregnant women; identifying training opportunities, such as annual conferences or workshops; developing training curriculum and materials, and scheduling training events for 2001.

The second tier of the plan involves the formation of a Perinatal Task Force that will serve as an extension of the Illinois HIV Prevention Planning Group and include members from various social and medical programs that serve pregnant women at increased risk for HIV infection. Convened by the Department of Public Health, the Perinatal Task Force will be charged with 1) identifying and addressing barriers that impede a comprehensive approach to prenatal care, inclusive of routine HIV counseling and testing; and 2) identifying and prioritizing effective

interventions for preventing perinatal transmission.

Public information interventions comprise the third tier of the plan. This may include development or purchase of printed materials, such as brochures and newspaper ads. With direction from the Perinatal Task Force, innovative techniques, such as placement of information within pregnancy kits, will be explored. Dissemination of materials will be achieved through appropriate HIV prevention subcontractors, many of whom are community-based and targeting women at risk for HIV infection. Radio and/or television media campaigns also may be used, if additional funding is available.

Prioritized interventions derived from the Perinatal Task Force will constitute the fourth tier of the plan. More specifically, this tier will address implementation of more aggressive, client-based interventions through IDPH's nine established Regional Implementation Groups (RIGs). Community-based HIV prevention subcontractors will implement interventions specified as priorities in the Illinois Comprehensive HIV Prevention Plan, which may include street and community outreach, support groups, prevention case management, outreach HIV testing using OraSure kits, and risk reduction counseling.

The Sudden Infant Death Syndrome (SIDS) Program, administered by IDPH, serves families who have experienced a sudden, unexpected infant death. When an infant dies suddenly and unexpectedly, from any cause, the coroner or medical examiner is mandated to notify IDPH. Counseling and support services are offered to all families by a local public health nurse who has received training as a bereavement counselor. Services are offered to clients for as long as these services are requested; there is no pre-determined limit to the provision of these services. IDPH sponsors conferences and workshops for health care professionals, families and the general public to provide information about SIDS risk reduction strategies.

The Early Childhood Caries (ECC) Program (formerly Baby Bottle Tooth Decay), administered by IDPH's Division of Oral Health, works with interested communities to establish community-based prevention programs. Agencies involved in the ECC intervention

include IDPH, IDHS and IDPA; local health departments and other local health service agencies; and dental and dental hygiene societies and schools.

Preventive and Primary Care Services for Children and Adolescents

Services for Children

Office of Family Health Programs

Car Safety Seat Program, is designed to help mothers with young children use car seats. The car seat program makes car seats available at no charge to low-income clients through participating local health departments, hospitals, community organizations and IDHS offices. Clients are given hands-on instruction in installation and are required to view a video of tips on how to use the car seat correctly.

Childhood Asthma -- The Department is supporting two demonstration projects for children with asthma. First, the University of Illinois at Chicago School of Public Health's Childhood Asthma Initiative is supporting the UIC School of Public Health in training the parents of children with asthma to serve as peer educators and community health workers for other parents of children with this disease. Preference is given to TANF-eligible parents, thereby helping them toward financial self-sufficiency. This program is being implemented in six elementary schools. The UIC has also prepared a reference manual and provided training on the management of childhood asthma for Chicago Public School nurses. Second, the Children's Asthma Management Partnership is conducted by the Southside Health Consortium (a federal Healthy Start grantee) in Chicago. It has three components: (1) school-based screening and medical follow up for children, coupled with training for teachers and administrators on the symptoms and effects of asthma; (2) community-based services, including focus groups, parent support groups, children support groups and community outreach to build child asthma awareness; and (3) environmental assessment services to identify and reduce or eliminate risk factors in the child's home.

The HealthWorks of Illinois (HWIL) Program is a collaborative effort of IDHS and the Illinois Department of Children and Family Services (IDCFS). The purpose of HWIL is to ensure that children in IDCFS custody receive comprehensive, quality health care. Through HealthWorks, all children taken into custody by IDCFS receive an initial health screening within the first 24 hours, preferably before placement with a substitute care giver. Within 21 days after the initial health screening, new wards receive a comprehensive health evaluation based on Early Periodic Screening Diagnosis and Treatment (EPSDT) program standards.

IDHS has contracted with 19 agencies downstate to develop health care networks. These agencies are referred to as "lead agencies" and are responsible for recruiting primary care physicians and specialty care providers; training the medical case management agencies, IDCFS staff, substitute care givers, and providers about the HWIL system; managing the paper flow among agencies; and consulting with IDCFS regarding maintenance of this system. The MCH program assists the Cook County lead agency, which is funded directly by IDCFS, with program administration.

All local health departments downstate and 11 community-based agencies in Chicago serve as medical case management agencies for IDCFS wards under age 6. These medical case management agencies are responsible for: assisting the substitute care giver with the selection of a primary care physician; obtaining the child's health history and assuring that medical services (comprehensive health evaluations, yearly physicals, and other medical and dental services) are obtained. All lead agencies, either alone or with the assistance of their medical case management agencies, have recently begun to track and monitor EPSDT visits, immunizations and primary care physicians for IDCFS wards age 6 and over through the Cornerstone system, which will provide reliable, accurate data for the older ward population.

Through HealthWorks, the Department has recently begun to address the under-utilization of DSCC services by CSHCN who are in state custody. MCH and DSCC program staff conducted a special study of HealthWorks-enrolled children in Peoria and DuPage Counties to identify the children that were also enrolled with DSCC in the CSHCN program. Of about

650 active wards in those two counties, only two could be identified as DSCC clients. DHS, DCFS and DSCC therefore convened a meeting of the HealthWorks Lead Agencies and DSCC's Regional Administrators. The meeting was used to exchange information on program eligibility and operations and to have Lead Agencies and Regional Administrators begin formulating a plan to improve referrals to DSCC and to ensure that DSCC staff were promptly notified when wards were relocated. DHS and DSCC have devised a plan to place two staff in Chicago who can perform DSCC and HWIL care coordination activitities. The training curricula for the respectie roles have been compared. The content is substantially identical; with some modification, the curricula could be used to train one person to fill both roles. Funds to support these positions have not been identified.

The Illinois Coalition for Health System Development in Child Care seeks to link child care facilities and health and other service providers, improve access to health services by children and families, and improve the health status of children, families and child care providers. The MCH program and the Department's Child Care program are collaborating to support a child care nurse consultant for each of Illinois' 22 Child Care Resource and Referral Network Agencies. This project is supported by the Health System Development as child care grant, and by more than $1.6 million in federal Title V and Child Care Development funds.

By linking child care providers, families and health professionals together to promote the healthy development of children in child care settings, children will be assured access to needed preventive health services and a safe, healthy environment.

The School Health Program provides comprehensive consultation and technical assistance to schools throughout the state. These are provided through direct site visits, and statewide, regional and local meetings. Professional continuing education programs (School Health Days in the fall and Critical Issues Conferences in the spring) for qualified school and public health nurses are conducted annually, and continuing education credit is available for most training.

Comprehensive School Health Education grants are provided to16 local health departments and school districts to promote comprehensive health education for students in grades K-12. Programs focus annually on one or more of the eight components recommended by the federal Centers for Disease Control and Prevention: a healthy and safe school environment; health instruction through a planned, sequential K-12 curriculum; health services focused on prevention and control of disease; physical education provided through a planned, sequential curriculum; nutrition; health promotion information for faculty and staff; integration of parent, school and community efforts; and counseling, psychology and social services.

IDPH Programs

The Childhood Lead Poisoning Prevention Program (CLPP) is administered by IDPH and directs the screening of children, aged 6 months through 6 years, for lead poisoning, collects all blood lead test results, and provides medical case management pursuant to the Illinois Lead Poisoning Prevention Act (410 ILCS 45).

All ZIP codes in Illinois are classified by the CLPP as being low or high-risk areas based upon the age of housing stock in the community. In high-risk areas, a blood lead test is required before a child is admitted to day care or kindergarten. In low-risk areas, an assessment questionnaire is used to determine the need for blood testing. When a child is identified as poisoned (blood lead levels exceeding 10 mcg/dL) local health departments, acting as "delegate" programs for the CLPP, contact the family to provide educational material on the sources and consequences of lead poisoning, nutrition, cleaning techniques, and removal procedures. In severe cases (over 25 mcg/dL) inspections are made by delegate or IDPH staff to determine the source of poisoning. Delegate agencies also provide medical follow-up services to assure that severely poisoned children have received proper medical care. Follow-up includes re-testing to monitor lead levels following treatment and the success of abatement activities. In 2000, 81 local health departments acted as delegate agencies, covering 94

counties. The seven counties not covered by delegate agencies are served through IDPH regional offices.

The Childhood Safety Program, administered by IDPH, stresses efforts to reduce unintentional death and injury, the leading cause of death for children younger than 14 years of age. Through this program, direction, education and support are provided to children, parents, teachers, and health-related providers which will teach preventive measures and thereby diminish the deleterious consequences of accidents.

Community Water Fluoridation is the most effective public health measure available to prevent and control dental caries. The Division of Oral Health performs the critical tasks of monitoring the fluoride status of Illinois community water systems, as well as determining fluoride status of people using private wells and non-community systems in order to assure availability of optimal levels of fluoride for dental caries prevention. Every resident of Illinois is served by this program through either community water systems, non-community water supplies or private well ownership.

The Dental Sealant Grant Program (DSGP), administered by IDPH's Division of Oral Health, works with interested communities to establish school-based programs for dental sealant application. Through the DSGP, local health departments and other community-based agencies provide preventive oral health services to the target population, oral health education and referral for other oral health care needs. The program targets children ages 5-17 who are eligible for free and reduced-price lunch programs in schools. Sealants are applied by licensed dentists and dental hygienists who are volunteers, grantee agency employees, or dental and dental hygiene students.

The Oral Health Needs Assessment and Planning Program, administered by IDPH's Division of Oral Health, provides training, technical assistance, data, quality assurance and funding to interested communities in order to determine the community's oral health status and plan comprehensive oral health programs specific to meet community needs. The Association of

State and Territorial Dental Directors' "Seven-Step Model" and the Illinois Supplemental Guide are used. The step-by-step process outlined in these guides engages the community to provide integrated information about oral health status, the existing health system and resources. Community capacity is built and translated into development of appropriate community intervention strategies.

The Orofacial Injury Control and Prevention Program, Project Mouthguard, is an injury control initiative, administered by IDPH's Division of Oral Health, to reduce the incidence of orofacial sports injuries. Local communities work to increase knowledge and awareness of the importance of preventing these types of injuries and to implement community-based programs that extend the requirement for mouthguard use among children who participate in high-risk athletic activities. There are currently five project sites throughout Illinois.

The Vision and Hearing Screening Program, administered by IDPH, supports screening activities by local health departments, school districts or other contractors to identify children with possible anomalies. All screening services are performed by individuals trained and certified by IDPH. IDPH also coordinates ophthalmologic and optometric, as well as otologic and audiologic, examination clinics throughout the state.

Services for Adolescents

Office of Family Health Programs

The Abstinence Education Program supports 30 community-based abstinence-until-marriage programs serving 68 communities across the state. Agencies offer in-school and after-school-based programs. The school-based programs are curriculum driven, taught over periods ranging from eight to 10 weeks, in traditional middle and high school settings, to students aged 10 to 17. Curriculum content and intervention activities conform to the definition of abstinence education presented in Section 510 of Title V.

The after-school programs are community oriented, and include motivational activities, seminars, workshops, town hall assemblies, and youth or church group activities. Service providers are local health departments, schools, youth-serving community and faith-based organizations, as well as agencies that emphasize prevention and primary services, specifically designed to assist adolescents to attain self-sufficiency.

The Adolescent Pregnancy Prevention Program provides support for community-based planning to reduce teenage pregnancy and sexually transmitted diseases. The goals of this program are to enhance and focus collaborative relationships among community partners in order to strengthen teen pregnancy prevention, improve access to health services for adolescents and to increase the role of the schools in improving adolescent health. Local programs focus their planning efforts on at least one of the following components:

- sexuality education -- approaches may include abstinence-based programs (including contraceptive information) and human sexuality (reproductive health, marriage and family, dating, gender psychology);
- family planning services (testing for pregnancy and STDs or HIV, dispensing of contraceptives, and counseling);
- male involvement (addressing the role of the male in preventing teen pregnancy through job skills development and placement, and parenting and reproductive health education);
- youth development (focus on topics such as self-esteem building, conflict resolution and anger management, social skills, healthy choices, youth and adult mentoring, nutrition, and physical fitness);
- public awareness (to increase knowledge and influence the public's awareness of behavior related to teen pregnancy by recognizing the assets of youth in the community); or
- subsequent pregnancy prevention.

Male Responsibility. Illinois' Title X (Family Planning) program is supporting two male responsibility demonstration programs. The first, "Project Brotherhood: A Black Men's Clinic" is based at Woodlawn Health Center. The program consists of a special weekly clinic session that welcomes African-American men with or without appontments for health care.

Additional features include discussion groups which promote health awareness, healthy living, anger management and conflict resolution, parenting skills, and practical services for African-American men. The program is staffed by three African-American physicians, two male African-American social workers, a male outreach worker and a volutneer barber. Referrals are through peers, self, the Cook County Hosptial's trauma unit and the Safer Foundation, an organization with a 35 year history of serving ex-offenders.

Second, the Male Involvement in Subsequent Pregnancy Project will provide services for young men (ages 12 through 20). Services will include reproductive health and family planning information and education; direct access to health services designed to meet the needs of adolescent boys; social support through intensive, one-on-one relationships with a mentor; and training and employment as peer counselors . The program will work with the subsequent pregnancy prevention project for women at the Friend Family Health Center.

The Parents Too Soon Program has two components: primary prevention services and services for pregnant and parenting teens. There are 47 community social service providers. Approximately half of the sites are located in the Chicago area.

The primary prevention program is offered during or after school to children ages 6 through 17 who are not pregnant or parenting, in an effort to keep teenagers from becoming pregnant. The prevention programs help participants to complete their education, achieve economic self-sufficiency and become contributing members of their communities.

The second component, services for pregnant and parenting teens, is offered to teens (ages 13 through 19) who are pregnant and/or parenting. Services focus on the parent/child relationship and child development, completion and timeliness of required immunizations, completion of basic education, attainment of self-sufficiency, postponement of subsequent pregnancy, and education on other life skills. Services include weekly or bi-weekly home visits and/or weekly group meetings; developmental screening; referrals to other needed services; development of individual and family service plans.

Responsible Fatherhood programs, funded by the U.S. Office of Population Affairs, will be monitored by the Department of Human Services staff. These two new programs are located in the Chicago area; one will serve males under the age of 20; the other will serve males 20 years and older. One of the programs will focus on health awareness care, living and practical services; group and individual counseling for anger management/conflict resolution and parenting skills; résumé development, job search and transportation for job interviews. The other program will provide: 1) reproductive health and family planning information and education; 2) direct access to health services designed to meet the needs of adolescent males; 3) social support through intensive, one-on-one relationship with mentor/role model; 4) training and employment as peer counselors to advise adolescent providers and other young men attending family planning and primary health care clinics.

The School-Based/School-Linked Health Centers promote healthy lifestyles through health education and physical and mental health services. Services are provided to students who are otherwise unable to receive medical care when they need it, and to students who come from families who cannot afford health care. Services are provided within the schools by licensed professional staff and/or through referral to other health care providers. Each local community decides upon the services that will be provided by the center. There are currently 26 sites funded by IDHS throughout the state. Between three and five new centers are funded each year. Services are provided to children and adolescents in pre-kindergarten through 12th grade, and to adolescents and to children in Head Start programs. In January 1999, standards for School-Based/Linked Health Centers were approved by the Joint Committee on Administrative Rules (JCAR) (77 Ill. Admin. Code 2200). The standards provide the mechanism for certifying health centers and allowing them to be enrolled in a special Medicaid category.

The Illinois Coalition for School Based/Linked Health Centers was formed in 1998. Its mission is to improve the physical and mental health status of the children and adolescents in Illinois through the stabilization and expansion of school-based/linked health centers. The Coalition has established by-laws, hired a staff person, and created standing committees. Its goals are to network on behalf of the school health center model, provide public education, and

advocate for expansion and stabilization of the health center model.

The Teen Parent Services (TPS) Program is offered to young parents (under age 21), who are receiving TANF or KidCare Assist (Medicaid) and who are enrolled in below post-secondary education or short-term vocational training. TPS assists these young parents to stay in school to obtain a high school diploma or its equivalent, and thus become more self-sufficient and ease the transition from TANF to economic independence. TPS is part of the TANF employment and training program. This program was expanded statewide in 1995. Services are provided by 58 contractors (i.e., community based agencies, educational institutions, and health departments) and by Department staff in five IDHS field offices.

In FY 1999 TPS and the FCM Program collaborated to offer combined services to the TPS clients being served in local health departments with grants from both programs. Full integration of the programs occurs through a single case manager who works with the whole family to assess their educational needs as well as their health needs and, together with the young parent, establishes a plan for finishing school and gaining employment while developing good health practices and improving the health of the family. This service delivery model for teen parents has three main benefits:

- The case manager has more time to devote to each family in her case load because, through integrated service delivery, individual case load sizes are reduced.
- Two programs can be administered by an agency such as the local health department, without an increase in staff.
- Teen parents find the integrated service delivery model less confusing because they only need to contact one person to request help or report information.

As of FY2000, approximately 21 agencies integrate these two programs. Additionally, eight large providers, that are not health departments but offer both FCM and TPS programs in Cook County, have begun coordinating the two programs.

TPS is contracting with local health departments and other Family Case Management agencies

where possible, to be able to expand the integrated service delivery mode. In SFY2001, six health departments that are already FCM providers will be added as TPS contractors. In addition, TPS and FCM coordination is being pursued between TPS and FCM providers where the two programs are administered by different agencies.

The Unwed Parents Program assists unwed pregnant adolescents and their families in coping with the social and emotional problems related to pregnancy and in planning for the future well-being of the parent and child. Services include: assessment of the needs of clients and their children, counseling for clients and their families, home visits, and coordination of services with other agencies. Adolescents may receive services during pregnancy and for a semester after the delivery of their child. Services are provided by two agencies within three alternative schools in Chicago.

The Youth Opportunity Program is designed to break the generational cycle of welfare dependency and help prevent school drop-out, unwanted pregnancies and gang involvement. The program creates a unique partnership among six Chicago-area schools, school counselors or social services agencies and corporate sponsors. Students receive career development training and individual, group and family counseling. Monthly workshops on family and community responsibility (topics include sexuality, AIDS awareness, drugs, gangs, communication and problem solving skills) are given. Male and female programs focus on positive life choices including abstinence from sexual activity and family planning information, violence and domestic violence education and prevention. Skills for self-sufficiency are developed and job placement occurs after school, during the summer, and post graduation. Job shadowing, job placement, special program-related field trips, corporate partnerships and mentoring are key to the program. The program has received an award from the Council on State Governments.

Office of Prevention Programs

The Teen Responsibility, Education, Achievement, Caring and Hope Program (Teen REACH),

administered by the Department's Office of Prevention, seeks to reduce a myriad of risk-taking behaviors among children and adolescents. The program provides a variety of structured activities during non-school hours with the goals of promoting school success and preventing teen pregnancies, arrests, alcohol and drug use among children ages 6 through 17 living in high-poverty communities. Local programs must provide the core elements of Teen REACH, which are academic enrichment, recreational activities, life skills education, adult mentors, and parental involvement. Local programs can also provide additional services, including community service, employment skills training, and special programs tailored to boys and girls. Teen REACH has more than 150 program sites operated by 75 grantees throughout the state. The sites are operated by community-based agencies including schools, social service agencies and churches. Teen REACH also partners with the Illinois Alliance of Boys and Girls Clubs to fund local clubs, targeting at-risk youth for intensive outreach, encouraging the kids to participate in all of the Teen REACH core elements.

Juvenile Justice The Juvenile Justice program is a categorical grant program funded through the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention (OJJDP). It is made up of three sub-grant programs: the Formula Grant program, the Delinquency Prevention program and the Challenge Grant program.

The Illinois Juvenile Justice Commission is a 25-member body appointed by the Governor. Its role is to administer the implementation of the federal Juvenile Justice and Delinquency Prevention Act in Illinois, to advise the Governor and General Assembly on juvenile justice matters and to serve as the statewide advisory body to the Secretary of the Department of Human Services on juvenile justice issues.

Formula Grant program - To be eligible to receive formula grants, states must meet four core requirements, all of which have to do with the incarceration of juveniles.

Funds are currently being used to provide training for juvenile justice professionals, provide alternatives to secure detention, transport juveniles to and from detention in counties that do

not operate detention centers, assist jurisdictions in planning for detention centers and group homes. New programming will be targeted at counties that jail juveniles and counties with large minority populations. Program development will attempt to implement the federally-designed Comprehensive Strategy for Violent, Serious and Chronic Offenders.

Delinquency Prevention program - The model for this sub-grant program is Communities that Care, which is used for other programs in the Division of Community Health and Prevention. The model is based on assisting communities in identifying the factors that put their children at risk of delinquency, substance abuse and other problems and then developing strategies that will strengthen existing protective factors. Federal regulations require that these funds be competitively bid and that grants are limited to general-purpose units of local government. Also, in order to be eligible to apply for this funding, the jurisdiction must be in compliance with the core requirements of the formula grant program.

Challenge Grant program - The Challenge program is intended to shape and change policy through research and/or demonstration projects in juvenile justice. The OJJDP has identified the following seven activities for research: access to counsel, gender equity, detention screening, mental health needs of youth in the juvenile justice system, mental health aftercare needs of youth in the juvenile justice system, alternatives to suspension and expulsion from school and public attitudes regarding juvenile justice. Each year, a research and demonstration agenda is developed and projects are designed to address the agenda.

<u>Substance Abuse Prevention</u> The DHS Bureau of Substance Abuse Prevention provides leadership and resources to the Illinois community-based alcohol, tobacco and other drug abuse (ATOD) prevention system. As part of its duties, the Bureau sets direction, defines trends, promotes quality services, and provides funds, training, technical assistance and monitoring for quality assurance.

The Substance Abuse Prevention provider system in Illinois has a long history of quality services. Its focus over the last decade has been to transform the ATOD prevention system

from one based on activities to one based on outcomes. Initial planning for this began in 1991. Outcome driven planning has been required of contract agencies since 1994. Outcome/evidence based programming is now at the core of all provider work plan efforts. The foundation of this planning is centered around the principles of effective prevention set out in the *Communities That Care* model-community needs assessment, risk and protective factor analysis, community mobilization, and outcome measurement.

Illinois's ATOD prevention community network is one of the nation's most comprehensive. It includes a mix of local, regional, and statewide programs housed in both public and private agency settings. This network of 127 providers is comprised of educational institutions and local and statewide not-for-profit organizations. Each organization develops an outcome/evidence based plan within in its community or geographic area.

DHS funds Illinois substance abuse prevention efforts through three types of grants:

- *Comprehensive Community Based Providers (CBPs)* deliver direct prevention services in the communities they serve. These grants provide programming that targets the community at large and focus many of their strategies on community mobilization around ATOD issues. This focus on the community at large is in line with both state and federal emphasis on environmental strategies to address ATOD problems. As such, the efforts in each community center on use of model programs that 1) have been validated by research and/or are based on identified guidelines of effectiveness for prevention programming, and 2) address a multitude of domains (youth/peer, family, school, and community).
- *InTouch (Illinois Network to Organize the Understanding of Community Health)* is a management system composed of 19 regional agencies, each responsible for a specific geographic area called a Prevention Service Area (PSA). InTouch serves as a link between DHS funded community-based providers, state government, the research community, and local community efforts. Each community-based provider is affiliated with an InTouch office in its area. InTouch serves as one of the communication and training links for the Bureau.
- *Statewide Grants* are intended to support the overall prevention system and projects that

will impact and be accessible to all interested citizens to Illinois.

Services for Children with Special Health Care Needs

Core Program: In accordance with recommendations received from the Medical Advisory Board, DSCC has determined that its limited resources are best used to serve children who have impairments that are expected to be chronic; involve multiple physical defects, disabilities or handicaps; are amenable to treatment; have a need for long-term, highly specialized medical care; and have life expectancy sufficient to realize benefit from the treatment. The program's goal is to assure community-based family centered and culturally sensitive provision of comprehensive care coordination services for all CSHCN and their families. DSCC staff plan to achieve this goal through a progressive identification of Medical Home providers (pediatricians and family practice physicians) throughout the state.

The CSHCN program provides care coordination services for approximately 20,000 children annually who have impairments as a result of congenital or acquired conditions which may lead to chronic impairment. Additional services provided include comprehensive evaluation, medical care and related habilitative services appropriate to the child's needs and financial support of such care, subject to financial eligibility. The program serves children with orthopedic impairments, nervous system impairments, cardiovascular impairments, craniofacial deformities, hearing impairments, organic speech impairments, cystic fibrosis, hemophilia, inborn errors of metabolism, eye impairments and urinary system impairments.

Families and children receive diagnostic and care coordination services without regard to a financial means test. Families and children requiring treatment services and financial support must demonstrate a gross income below a determined level which currently is set at 285 percent of the federal poverty level adjusted for family size. All families must utilize existing health insurance benefits before financial benefits can be provided. Children with severe, long-term disabilities receive continued DSCC assistance in programming and coordinating care

regardless of family income.

Initial diagnostic evaluation services are provided in part by a network of over 40 field clinics administered and funded by DSCC, as well as private physicians and other free-standing clinics. The clinic system allows medical specialists and professional staff to provide for early evaluation of children with medical conditions eligible for DSCC services.

An Individual Service Plan (ISP) is developed for each child following the initial evaluation process to summarize the care coordination services needed and the financial support required for treatment. The ISP reflects the perceived needs and priorities of the child and family, the medical needs as articulated by the managing care physician and the plan by which the needs will be addressed. In order to coordinate efforts to meet the total needs of the children, DSCC professional staff (48 nurses, 25 social workers, and 18 speech pathologists/audiologists) located in 13 regional offices, work closely with other community public and private entities.

Home Care Program: DSCC administers the Title XIX Waiver for Home and Community-Based Services for Medically Fragile/Technology Dependent Children on behalf of the Department of Public Aid. Program objectives are: provide cost-effective care coordination and supportive home services to children with complex medical needs who would otherwise be at risk of prolonged institutionalization or re-institutionalization in a hospital or long-term care facility; implement and evaluate a care coordination system which optimizes the quality of life for the child and family while remaining responsive to diminished resource allocation and fiscal constraints; ensure the child and family receive care and services from qualified and responsive providers; and collaborate with other state agencies and programs to heighten an awareness of this population, eliminate duplication of services, and assist clients in the transition process to adult programs in a smooth and effective manner when appropriate.

Within each of the regional offices, the professional staff are specially trained in policies and procedures of the Home Care Program. Regional staff are responsible for ensuring access, accepting all referrals, and collaborating with the hospital discharge teams, families and other

funding sources to develop a comprehensive, cost effective, safe plan of care for inclusion of the child within the home and community. This entails locating providers who are in compliance with established standards that have been developed to ensure the safety and well-being of the child with complex care needs. Following approval of the plan and waiver, the home care consultant monitors and manages services in conjunction with the family.

Since its inception, the program has served over 950 children, with a current census of 270. Federal regulations allow a maximum of 400 waiver recipients at any time. Children/families receive one or more of the following services: private duty nursing; respite services; environmental modifications needed to accommodate the child and/or equipment; the training of nursing personnel; special equipment supplies; placement counseling, and medical day care.

SSI Program: As a component of the state's CSHCN Program, DSCC is the agency designated to administer the Supplemental Security Income-Disabled Children's Program (SSI-DCP). Children are evaluated as eligible for this program through the Social Security Administration and the Illinois Disability Adjudication Unit, who in turn refer SSI medically eligible children to DSCC for further assistance.

DSCC receives information on over 270 SSI-eligible children a month who are under 16. These children receive comprehensive profiles on state/local programs that could benefit the child or family, including information on DSCC services. For those children with potential medical eligibility for DSCC, a DSCC application is sent as a matter of course. In addition, DSCC has refocused its efforts to enhance linkage services for SSI medically-eligible children under 5 years of age to Part C Early Intervention, Part B Early Childhood, and Pre-Kindergarten for Children at Risk. The goal of this effort is to assure that SSI-eligible children receive prompt developmental and educational support through the available state service delivery system.

The Children's Habilitation Clinic: This clinic was formerly known as the Center for Handicapped Children. The name was changed in August 1999 to reflect focus on

rehabilitative management of children with disabilities. The Clinic is now located within the Children and Adolescent Center of the Outpatient Care Center, the University of Illinois-Chicago comprehensive outpatient facility. The move allowed staff to collaborate much more easily with other subspecialists and with primary care physicians and nurse practitioners. The staff continues to provide comprehensive diagnostic services for children with complex disabling conditions and to provide ongoing rehabilitation and developmental management to those children through age 21. The clinic provides a required rotation in the care of children with disabilities to all PL2 level pediatric and medical/pediatric residents, and to other health care students. There are approximately 1600 patient visits annually.

1.5.1.3. Other Capacity

Staffing

IDHS: There are 39 FTE MCH program staff at the central office in Springfield. Regional staff are deployed as follows: Region 1, Chicago, 58 FTEs; Region 2, "collar" counties and northern Illinois, five FTEs; Region 3, north central Illinois, two FTEs; Region 4, south central Illinois, one FTE; and Region 5, southern Illinois, six FTEs. Refer to Section 5.3, Other Supporting Documents, for a map of these regions. Regional staff are generally master's-prepared maternal and child health nursing consultants and regional representatives involved in quality assurance and technical assistance. Central office staff include 25 professional and technical FTEs, and 14 FTE support staff. The professional staff includes one physician, 25 registered nurses and two social workers.

Stephen E. Saunders, M.D., M.P.H., is the Department's Associate Director for the Office of Family Health at IDHS. In this capacity, he is responsible for planning and directing the State of Illinois' Maternal and Child Health Program. Dr. Saunders is the past President of the Association of Maternal and Child Health Programs. He also serves on numerous statewide committees in the area of maternal and child health, including the Executive Committee of the Illinois Chapter of the American Academy of Pediatrics, Early Childhood Intervention

Interagency Coordinating Council, the Perinatal Advisory Committee and the Medicaid Advisory Committee. Dr. Saunders is a Board-certified pediatrician and is a Fellow of the American Academy of Pediatrics. He received his Doctor of Medicine degree from the University of California and his M.P.H. from Harvard University.

DSCC: Within DSCC, 198.6 FTEs are assigned to the agency's regional office system. The central administrative office in Springfield supports the regional offices through system development, core program technical assistance, administrative support, fiscal and information management, and personnel services. Eighty-three FTEs are assigned to these centralized functions. An additional administrative office on the campus at UIC houses five FTEs providing Home Care program technical assistance and administrative support activities for DSCC. DSCC also administers the Children's Habilitation Clinic which is staffed by 4.6 FTEs, including a developmental pediatrician, a clinical practice nurse specialist, clinical psychologist, medical social consultant, and support staff. Ancillary services such as physical therapy and speech pathology are obtained through contracts. The Center is located in Chicago on the UIC campus.

Charles N. Onufer, M.D. is the agency Director. Dr. Onufer joined DSCC on June 1, 1996 after retiring from the United States Army with 27 years of experience. He is a Board-certified pediatrician with fellowship training in developmental pediatrics. He was the Medical Director for the Army's Program for Children with Disabilities in Europe and also the European Pediatric Consultant for the last nine years prior to his retirement from the armed forces. Dr. Onufer serves as co-chair of the Illinois Chapter of the American Academy of Pediatrics Committee on Children with Disabilities and also on other state committees including the Illinois Transition Consortium, the Genetic and Metabolic Disease Advisory Committee, the Brain and Spinal Cord Injury Prevention Committee, and is on the Planning Committee for the Annual Regions V & VII Leadership Conference. Dr. Onufer is a Fellow of the American Academy of Pediatrics and an assistant professor of pediatrics at UIC. He received his Doctor of Medicine degree from Ohio State University and his pediatric and fellowship training from Tripler Army Medical Center and Madigan Army Medical Center respectively.

1.5.2 State Agency Coordination

For a description of the organizational relationship among Illinois' human services departments please refer to section 1.5.1.1, "Organizational Structure".

IDHS and DSCC collaborate to implement a variety of programs to serve the MCH and CSHCN populations. This collaboration includes both informal and formal linkages for service delivery. Since January 1, 1998, IDHS has been the lead agency for the Part C Early Intervention Services program, and will be updating the Memorandum of Understanding regarding the programmatic relationship between IDHS and DSCC for the delivery of Early Intervention services. IDHS and DSCC coordinate with other State agencies as noted below.

Illinois Department of Public Aid IDHS and IDPA have a general agreement for the coordination of Title V and Title XIX program activities. This agreement allows each agency to refer eligible clients to the other for services. A separate agreement specifies that IDHS's programs will identify and refer children eligible for services through the EPSDT program. The two agencies have a separate agreement for the Family Case Management initiative that enables IDPA to claim federal matching funds through the Medicaid program for outreach and case management activities conducted by the Family Case Management program. This agreement was recently revised and updated.

Staff from the MCH program participated extensively in the development of Illinois' plan for Title XXI. Local MCH programs, including local health departments, family planning clinics, and WIC agencies are serving as outstations for determining eligibility of pregnant women and children under 19 years of age to initiate the application process for KidCare (Title XIX and Title XXI). Other agencies qualified to participate in the outstation application-taking process include Federally Qualified Health Centers, Rural Health Clinics, disproportionate share hospitals, and Medicaid Presumptive Eligibility (MPE) providers. In the near future, non-disproportionate-share hospitals may participate as outstation application-taking sites as well.

DSCC maintains a Memorandum of Understanding with IDPA, defining collaborative activities concerning the Medicaid Waiver program as authorized under provisions of Section 1915 (c) of the Social Security Act. The Home Care Program is described in detail under Program Capacity 1.5.1.2. IDPA determines program eligibility. DSCC provides care coordination, implements federal and state rules and monitors licensure for nursing agencies and providers of durable medical equipment. DSCC regional offices also provide outreach to low-income CSHCN in need of Medicaid and KidCare benefits.

Illinois Department of Public Health IDHS works with many divisions and programs within IDPH to develop preventive and primary care systems. Please refer to the Interagency Agreement in Section 5.3 for more information. DSCC and IDPH are updating a Memorandum of Understanding that delineates collaborative activities for children identified through the Newborn Metabolic Screening, Genetic Counseling, Vision and Hearing Screening, Hearing Instrument Consumer Protection or Newborn Hearing Screening programs.

DSCC, IDPH and DHS are collaborating to develop and implement a statewide universal newborn hearing screening program. IDPH is responsible for the screening and tracking processes. Local health departments follow up with the parents of an infant who has not had a timely diagnostic evaluation. DSCC has made a commitment to ensure that all infants with screening documentation of hearing loss will have adequate access to diagnostic evaluations and will continue to address the need for otologic and audiologic care for infants who meet financial eligibility requirements. DSCC also has a representative on the Newborn Hearing Screening Advisory Committee.

IDHS works in collaboration with IDPH's asthma surveillance project. The MCH program is represented on the statewide asthma partnership. Several interventions are being planned, including activities to: improve the knowledge of day care providers, local health departments, community based organizations and families regarding asthma management; develop a surveillance advisory group; develop local health department asthma initiatives; and disseminate "best practice" program ideas statewide.

Schools A variety of programs are operated through schools to meet the needs of children and adolescents. The school-based and school-linked health centers work with primary care providers to deliver comprehensive medical, mental health and health education services to school-age children and parenting students. These clinics work with HMOs to coordinate care that is provided to their clientele, refer for home specialty care, and get reimbursement for services provided. IDHS works with 16 local health departments to implement comprehensive school health programs. The MCH program also conducts continuing education programs for school nurses. Schools are also the main delivery sites for the Abstinence-Only Education, Unmarried Parents and Youth Opportunity programs.

Illinois State Board of Education (ISBE) Although there is no formal agreement with the ISBE, program staff from the DSCC central office coordinate with the state School Nurse Consultant regarding issues for CSHCN in schools. DSCC distributes to families via its regional office, "*A Parent's Guide: The Educational Rights of Students with Disabilities*," published by ISBE. DSCC regional office staff coordinate with the local schools regarding individual issues in the educational setting. DSCC co-sponsors the Institute for Parents of Children Who are Deaf or Hard of Hearing with IDPH, DHS, Illinois School for the Deaf and the State Board of Education. This is a week-long educational program for parents of children, ages birth to 5, who have a significant hearing loss. The Institute provides an opportunity for parents to learn about deafness and their child's individual strengths and needs as well as meet other parents who have children with hearing loss. At the conclusion of the Institute, parents meet with staff to discuss evaluation results and treatment recommendations and to plan for the future.

Illinois Department of Children and Family Services DSCC collaborates with the Illinois Department of Children and Family Services (DCFS) on behalf of wards of DCFS who have special health care needs and are eligible for DSCC services. Coordination activities include identifying referral mechanisms for sharing information. To address systems collaboration between the two agencies, DSCC has chosen a state performance measure to enhance DCFS staff understanding of the needs of CSHCN. DSCC staff provide in service training on CSHCN to local and regional DCFS staff throughout the state.

MCH program staff work with DCFS on the management of HealthWorks of Illinois, described earlier in this application.

Federally Qualified Health Centers (FQHC) Individual FQHCs receive grants for many MCH programs. The most significant collaboration is in the Chicago Healthy Start Initiative. The Winfield Moody Health Center, the Erie Family Health Center, The Mile Square Health Center, and Henry Booth House are the medical partners for four of the five Healthy Start Family Centers.

Illinois Office of Rehabilitation Services To enhance continuity of care for CSHCN, DSCC collaborates with DHS' Office of Rehabilitation Services (ORS) in the following areas that may benefit CSHCN: vocational rehabilitation services for clients at or near employable age; home services programs to avoid unnecessary institutionalization; education and habilitative services for children requiring education programming outside their communities; independent living programs; referral process for children determined medically eligible for SSI, and transition of DSCC Model Waiver children to the ORS home-based waiver program.

1.5.3 Statutory Base

IDPH was established on July 12, 1877, to regulate the practice of medicine and to promote sanitary and hygienic activities. In 1919, following a polio outbreak in 1916 and 1917, the Division of Child Hygiene and Public Health Nursing was created to address the health needs of mothers and children. This division's successor, the Division of Family Health, was transferred to the Illinois Department of Human Services at its inception on July 1,1997, and renamed the Office of Family Health. This office is responsible for administration of the Maternal and Child Health Block Grant, as well as the following state statutes:

MCH. The *Hearing Screening for Newborns Act*, P.A. 91-67, was enacted on July 9, 1999. According to the Act, all hospitals performing deliveries will be required to begin reporting by December 31, 2002.

The Infant Mortality Reduction Act authorizes grants "to develop or expand: (1) prenatal services; (2) perinatal services; (3) infant follow-up services in the first year of life; and (4) adolescent pregnancy services." Appropriations under this Act currently support the Family Case Management and Family Planning programs.

The Problem Pregnancy Health Services and Care Act authorizes IDHS to establish projects which would assist women with problem pregnancies in obtaining services either directly or through referral.

The Prenatal and Newborn Care Act authorizes payment for prenatal care, delivery, postpartum care and "two EPSDT-equivalent screenings" of the newborn.

The Developmental Disability Prevention Act authorizes regional perinatal health care in Illinois. IDPH establishes standards for hospital maternity services, designates perinatal centers, establishes programs to prevent high-risk pregnancies and develops criteria for the identification of high-risk pregnancies.

The Phenylketonuria Testing Act authorizes newborn screening for phenylketonuria, hypothyroidism, galactosemia, "and other metabolic diseases as the Department may deem necessary." IDPH also screens for congenital adrenal hyperplasia, hemoglobinopathies and biotinidase deficiency.

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

The Illinois Lead Poisoning Prevention Act is comprehensive legislation regarding the use of lead in consumer products and dwellings; screening of children under age six; and the reporting, inspection and abatement of environmental lead hazards.

The *Early Intervention Services System Act* provides state statutory authority to implement the

mandates provided in the Individuals with Disability Education Act, or "IDEA" (P.L. 102-119).

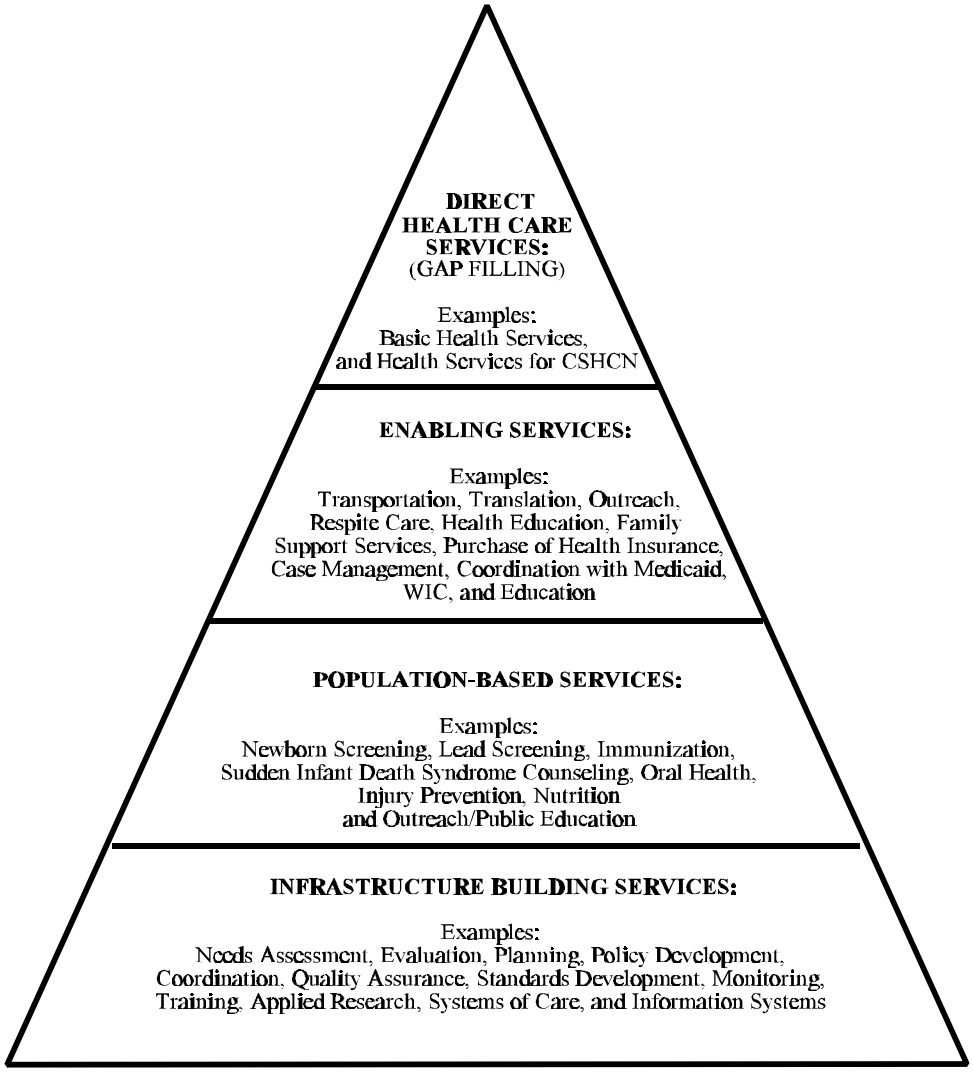
CSHCN. The *Specialized Care for Children Act* in 1957 designated the University of Illinois as the agency to administer funds from "the United States Children's Bureau of the Department of Health, Education and Welfare" to support "a program of services for children who are crippled or suffering from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

1.6 Performance Management Model

The Illinois Title V program uses a performance management model to guide its program efforts. After choosing a set of priority needs from the five year statewide needs assessment, resources are allocated and programs are designed and implemented to address these priorities. These program activities are described and categorized by the four levels of a pyramid: direct health care; enabling; population-based; and infrastructure building services [see Figure 2]. Imbedded within the levels of service [see Figure 3] are sets of national core performance measures and ten state- negotiated performance measures categorized into three types: capacity, process, or risk factor. Because of the flexibility inherent in the Block Grant, the program activities or the role that Title V plays in the implementation of each performance measure may vary. The program activities, as measured by these core and negotiated performance measures, are expected to have a collective contributory effect that will positively impact the national outcome measures for the Title V program.

Figure 2

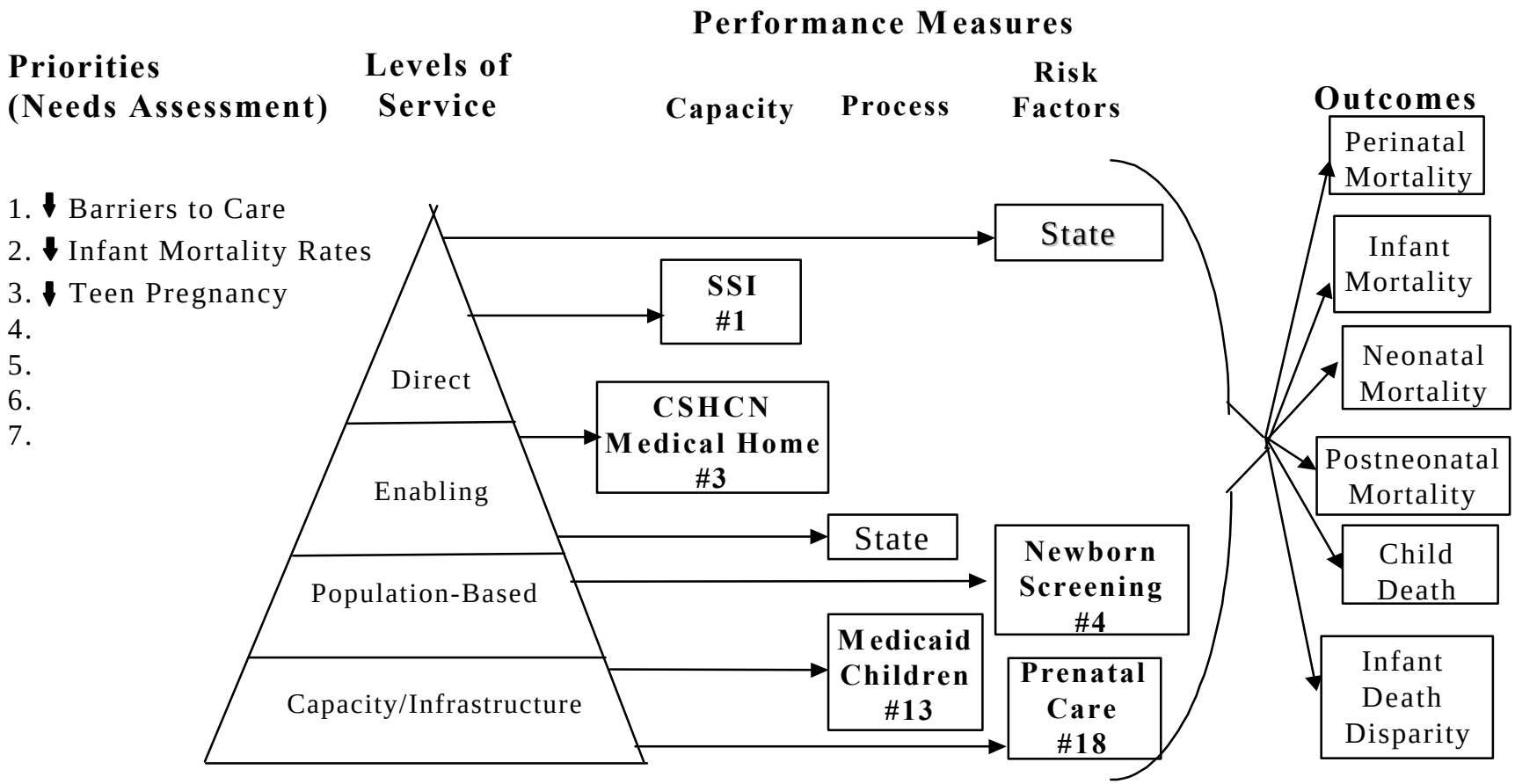
CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



MCHB/OSCH 10/20/97

Figure 3

Title V Block Grant
Performance Measurement System



*OSCH/MCHB 4/97 *PERFORMANCE MEASURE NUMBER(Examples Only)*

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

Please refer to Section 5.4 (Forms) for Form 3, "State MCH Funding Profile"; Form 4, "Budget Details by Types of Individuals Served"; and Form 5, "State Title V Program Budget and Expenditures by Types of Service".

2.2 Annual Number of Individuals Served

Please refer to Section 5.4 (Forms), for Form 6, "Number and Percentage of Newborns and Others Screened, Confirmed and Treated"; Form 7, "Number of Individuals Served Under Title V"; Form 8, "Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX"; and Form 9, "MCH Toll-free Telephone Line Reporting Form".

2.3 State Summary Profile

Please refer to Section 5.4 (Forms) for Form 10, "Title V Maternal and Child Health Block Grant Services Profile".

2.4 Progress on Annual Performance Measures

Please refer to Section 5.4 (Forms) for Form 11, "Tracking Performance Measures by Service Levels", for information on Illinois' progress toward achieving the national and State performance measures for the MCH Block Grant. Full descriptions of each program can be found in Section 1.5.1 of this application. A discussion of program activities related to each performance objective follows.

2.4.1 Direct Health Care Services

Direct Preventive and Primary Health Care Services for Pregnant Women, Mothers and Infants

State "Negotiated" Performance Measure #2: The proportion of women experiencing a live birth who have had a live birth in the prior eighteen months

Illinois achieved its goal of reducing the proportion of women with an interconceptional interval less than 18 months to 16.5 percent of all live births.

The Office of Family Health provided direct services to address this performance measure through the Family Planning Program. In addition, the Subsequent Pregnancy, Adolescent Health, School-Based/Linked Health Centers, Teen Parent Services, and the Parents Too Soon programs all provided services directly or by referral to address this performance measure; these programs focus exclusively on the teen population to ensure school completion and the attainment of self-sufficiency by delaying a subsequent pregnancy. Women served through the Family Case Management (FCM) and Healthy Start programs were assessed for family planning service needs, provided with information and referred for services.

The Department has made additional efforts to ensure that women who are leaving TANF (and are therefore losing Medicaid eligibility) are linked to local Family Planning delegate agencies. Each DHS local office is responsible for determining eligibility for TANF, Food Stamps, Medicaid and other benefits, and is therefore aware of women who are working their way off public assistance. Each local office and each Family Planning delegate agency is required to develop a written agreement regarding referral and outreach to women who are making the transition from welfare to work. The Department will monitor referrals to ensure that women who are losing Medicaid benefits can access comprehensive family planning services.

Chicago. Decreasing interconceptional periods has been identified as one of the Chicago

Department of Public Health's (CDPH) priorities in its strategy to reduce the infant mortality rate. In 1997, the University of Illinois at Chicago's Prevention Center collaborated with CDPH and the Mayor's Advisory Committee on Maternal and Child Health (MAC) to further understand the factors contributing to unintended pregnancies in Chicago. The University provided a graduate student who conducted several focus groups with Hispanic and African-American males and females of different ages. Those results are being used to plan programs to help reduce the rate of unintended pregnancies.

Excluding women who gave birth in the18th month, Chicago achieved an 18 month repeat pregnancy rate of 15.9 percent, and 15.4 percent in 1997. Among racial and ethnic groups in 1996 the non-Hispanic African-American rate was 18.8, the non-Hispanic Caucasian rate was 12.2 percent and the Hispanic rate was 14.3 percent. In 1997 the corresponding rates were 18.0 percent for African-Americans, 12.6 percent for non-Hispanic Caucasians, and 13.3 percent for Hispanics.

State "Negotiated" Performance Measure #8: The proportion of families who receive appropriate genetic testing, counseling and follow-up services

Illinois did not achieve its goal of increasing the proportion of women and children who receive genetic testing, counseling, education and follow-up services. The performance target was 3.5 percent and actual performance was 1.3 percent.

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

The number of women and children who received genetic services through IDPH-funded sources was 79,400. This number did not meet the State's *revised* annual performance objective of 3.5 percent, due to fewer clients reported as being screened by local health departments. This performance measure was redefined to make it more easily measured. Only those data regarding the actual number of women of childbearing age and children under the age of 22 years who received genetic services through IDPH-funded sources are included. The original target of 10 percent was set to reflect all genetic services being provided in the State to individuals of all ages. However, IDPH only captures data from those providers receiving grant funding. This change will more accurately reflect the genetic services being provided to the MCH population.

Chicago. Since 1995 the Chicago Department of Health has been providing alpha feto-protein testing to pregnant women and referring those with positive screens to the perinatal centers for counseling and follow-up. The Chicago Department of Health also has a team of public health nurses who are specially trained to provide education to the general population of women and counseling and education to those who have given birth to an infant with a congenital anomaly.

Direct Health Care Services for Children with Special Health Care Needs

Federal Performance Measure #1: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN program

Between July 1, 1998 and June 30, 1999, a total of 3,538 children under 16 years of age found medically eligible for SSI were referred to DSCC. Comprehensive community service profiles were provided to these children, including information on DSCC services. The estimated number of children receiving SSI that are age 16 and younger is 38,620.

DSCC designed a pilot project that specifically targeted SSI beneficiaries less than 16 years of age. The purpose of the pilot was to determine the best method to identify families eligible for DSCC and to inform them about DSCC and other community services. These results are

discussed in 3.1.2, Needs Assessment Content.

Federal Performance Measure #2: The degree to which the State CSHCN program provides or pays for specialty and sub-specialty services, including care coordination, not otherwise accessible or affordable to its clients

DSCC coordinated the delivery and payment for specialty or subspecialty services for children with eligible medical conditions. The medical services supported were those specialty, subspecialty services or acute medical services required to treat the child's medically eligible condition.

DSCC funds were used in excess of insurance or other third party payment reimbursement up to DSCC's payment schedule. All eligible children received care coordination services and benefits management to enable them to access medical services, supplies and durable medical equipment.

IDPH and DSCC provided otologic/audiologic clinics in communities with high rates of children who receive no follow-up after failure of school hearing screenings. Between October 1998 and June 1999, 395 children received these services at 29 clinics statewide. Thirty-three children were referred to DSCC for ongoing medical treatment and care coordination services.

To increase access to community-based care coordination services, DSCC staffed over 40 satellite offices at local health departments, schools, visiting nurses' associations and human service agencies. Home visits by DSCC consultants were encouraged as an integral component of care coordination.

2.4.2 Enabling Services

Preventive and Primary Care Enabling Services for Pregnant Women, Mothers and Infants

State "Negotiated" Performance Measure #1: The proportion of infants whose mothers receive adequate prenatal care, as measured by the Kessner Index

Illinois exceeded its performance target for this objective. The proportion of women who received an "adequate" amount of prenatal care in 1998 reached 74.2 percent, slightly greater than the target of 74.0 percent.

This measure was addressed primarily by the Family Case Management (FCM), WIC and Chicago Healthy Start Initiative programs. In addition, the Parents Too Soon (PTS), Teen Parent Services (TPS), the Unwed Parents Program, and School-Based/School Linked Health Centers promote early initiation of prenatal care and work with pregnant teens to ensure they continue to receive care throughout pregnancy.

The Family Case Management Program works closely with other DHS programs in conference planning. Workshops and satellite broadcasts of new information relating to program issues during the past year included Cornerstone updates, KidCare, Meet the Division, Common Sense to Fiscal Management, and Maternal and Child Health updates. In May 1999, the newly-developed FCM training was offered at the Community Health Training Center in Springfield and Chicago. Family Case Management agencies responded favorably to this training, and through the end of October 1999, 128 Family Case Managers from 40 agencies statewide had completed the training. This training has expanded the knowledge base of the case managers, allowing them better to serve the clients of their service area.

Women who participated in FCM or WIC during pregnancy in 1998 completed more prenatal care visits than women who did not participate. When compared to Medicaid-eligible women who did not participate in either program during pregnancy, the proportion of women who received more than an "adequate" amount of prenatal care was 22 percent higher (25.7 percent

vs 19.9 percent). The proportion who received an "adequate" amount of prenatal care was 18 percent greater (38.6 percent vs 31.5 percent). The proportion who received an "intermediate" number of visits was four percent lower (13.2 percent vs 13.7 percent) and the proportion who received an inadequate amount of prenatal care was 37 percent lower (19.4 percent vs 30.8 percent).

Chicago. The percentage of women who receive adequate prenatal care has been improving, but remains below the Year 2000 objective of 90 percent.

In 1996 and 1997, nearly two-thirds of all women in Chicago received "adequate" prenatal care, more than one-fourth received "intermediate" care and 10 percent received "inadequate" care (using the Kessner Index to determine adequacy of prenatal care). In both years, African-American women were the least likely to have received adequate care: More than 60 percent of Hispanic women and nearly 80 percent of Caucasian women received adequate prenatal care, while only 57 percent of African-American women did so. Further, 15 percent of African-American women received inadequate prenatal care in 1996 and 1997, compared to eight percent of Hispanic women and four to five percent of Caucasian women.

The percentage of women who did not receive prenatal care continued to decrease, but remains problematic particularly for African-Americans and Puerto Ricans. For example, in 1996 the respective rates were: non-Hispanic Caucasians 1.6 percent, non-Hispanic African-Americans 5.6 percent, Mexicans 1.6 percent, and Puerto Ricans 1.8 percent. In 1997 the percentages were: non-Hispanic Caucasians 1.0 percent, non-Hispanic African-Americans 5.5 percent, Mexicans 1.4 percent, and Puerto Ricans 2.5 percent. The overall rate for the population of those who received no prenatal care in 1996 and 1997 were 3.3 percent and 3.1 percent, respectively.

In 1995 the CDOH initiated an outreach project (The Robert Taylor Prenatal Outreach Project) in one census tract in the Grand Boulevard area to encourage women to enroll in

prenatal care. During the period 1996-1997, there was a 38.9 percent decrease in the number of births with no prenatal care (compared with an 11.1 percent in the city and a 0.5 percent decrease in the remainder of that community), and a 43.0 percent decrease in the number births with no prenatal care, or with the initiation of care in the third trimester.

Preventive and Primary Care Enabling Services for Children and Adolescents

State "Negotiated" Performance Measure #3: The incidence of maltreatment of children younger than age 18

Illinois exceeded its goal for the reduction of child maltreatment. The rate of child maltreatment in 1998 was 10.3 per 1,000 children, which is substantially less than the objective of 14.1 per 1,000.

The Illinois General Assembly appropriated an additional $2 million to IDHS for Healthy Families Illinois (HFI), bringing the total budget $10 million. HFI is an intensive home visiting program to reduce the occurrence of child abuse and neglect. The Department currently supports 44 HFI programs throughout the state and new programs will be added in SFY 2001. The Parents Too Soon (PTS) program's teen parenting projects also provide parenting education and social support.

The High-Risk Infant Follow-up program provided home visits by public health nurses. These visits were conducted with high-risk infants and parents were instructed regarding parenting skills and prevention and control of stress.

Chicago. The Prenatal Outreach Project in Robert Taylor, as currently being implemented, closely matches the objectives of the Healthy Families Illinois program.

Through its capital development grant, the Chicago Department of Health monitors three

delegate agencies whose specific role is to provide parenting education, assess those parents for domestic violence, and refer them for care, as needed.

Because of the connection between partner abuse and child abuse, the Chicago Department of Health assesses women in the Prenatal Outreach Project for domestic violence and refers them for counseling, as needed.

The Chicago Department of Health has grant funding to reduce dating violence among clients attending one of the clinics. WIC and Chicago Department of Health clinics provide assessment and counseling to clients referred by local domestic violence agencies.

Child maltreatment is also associated with substance abuse. The Healthy Family Intervention Program (Healthy FIT) is being implemented by the Chicago Department of Health in collaboration with the Department of Children and Family Services (DCFS), the DHS Office of Alcoholism and Substance Abuse, Mount Sinai Hospital, and the Chicago Healthy Start Initiative. The goal of this program is to treat substance abusing women both before and after delivery to reduce the proportion of children born with substance exposure, and to reduce harm to the child who is living in chaotic situations related to parental substance use.

State "Negotiated" Performance Measure #4: The proportion of TANF-enrolled young parents age 18 through 20 who will complete a high school education or its equivalent

Illinois exceeded its goal of 25 percent in 1999; actual performance was 26.6 percent.

The Teen Parent Services program helps TANF-enrolled young parents to complete high school or obtain an equivalency diploma. Participation in TPS is mandatory as a condition of eligibility for TANF. Teen parents who are eligible for KidCare Assist (Medicaid) may voluntarily enroll in TPS.

Enabling Services for Children With Special Health Care Needs

Federal Performance Measure #3: The proportion of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"

DSCC continued to measure performance in this area by reviewing Individual Service Plans (ISPs) for evidence of a Primary Care Provider. The Director of DSCC gave presentations to physicians at Federally Qualified Health Centers (FQHC) and two hospitals that serve significant numbers of CSHCN to explain the strategies DSCC is using to implement the Medical Home concept. The Director also presented the Medical Home concept and the vision for implementation for children served by the program to agency staff. Staff gave input regarding strategies and barriers. Articles explaining the Medical Home concept for CSHCN were published in statewide professional newsletters for pediatricians, family practice physicians, and the Primary Health Care Association, resulting in expressions of interest from a limited number of primary care physicians.

DSCC staff selected pilot sites based on primary care physicians who have experience with CSHCN and expressed interest in working with DSCC to pilot implementation of the Medical Home concept. These sites represent urban private practice, urban FQHC and rural group practice.

2.4.3 Population-Based Services

Population-Based Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

Federal Performance Measure #4: The proportion of newborns who receive at least one screening test for PKU, hypothyroidism, galactosemia, and hemoglobinopathies

More than 97 percent of the children born in Illinois were screened for six metabolic disorders.

Actual performance was slightly below the goal of 98 percent.

Each year, IDPH screens more than 178,000 newborns for six conditions (PKU, congenital hypothyroidism, galactosemia, congenital adrenal hyperplasia, biotinidase deficiency, and hemoglobinopathies). Of these, more than 200 are diagnosed and 5,045 are found to have an abnormal hemoglobin trait (refer to Form 6 in Section 5.2). Staff assure that each infant receives appropriate referral, diagnosis, treatment, counseling and long term follow-up services.

The proportion of infants in Illinois receiving at least one newborn metabolic screening test was 97.6 percent. This number came very close to meeting the State's annual performance objective of 98 percent, and did surpass the Healthy People 2000 Objective of 95 percent. Previously, the proportion of newborns screened for metabolic disorders was based on the Report of Maternal and Newborn Services. This report was discontinued. This year, reporting is based on the unduplicated number of intial screening specimens processed by the IDPH Division of Laboratories. Due to name changes and other reporting problems, the unduplicated number of infants screened may be higher than reported performance.

Federal Performance Measure #9: The percentage of mothers who breastfeed their infants at hospital discharge

Illinois exceeded its goal for increasing the proportion of mothers who were breastfeeding at hospital discharge. The state's actual performance in FY'98 was 38.2 percent, slightly greater than the objective of 38.0 percent.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides nutrition information, supplemental foods and referral to other health and social services for the target population. The WIC program in Illinois currently provides services each month to more than 240,000 pregnant, postpartum and breastfeeding women, infants and children up to age 5 years. Breastfeeding information and support is also provided to families.

The WIC program works closely with the Family Case Management Program to assure that families are receiving services for health care and other identified needs.

WIC program activities to promote and support breastfeeding include:

- providing technical assistance and consultation on breastfeeding promotion, support and management for health departments and local agencies administering WIC programs statewide.
- providing promotional items for local agency use in promoting breastfeeding within local communities.
- conducting annual training workshops for local agency breastfeeding coordinators.
- promoting and supporting the activities of the State and Regional Breastfeeding Task Forces throughout the state.
- supporting local agency activities through grants to provide training to agency staff, support peer counselor programs and other breastfeeding promotion activities.
- developing and distributing educational materials on breastfeeding for local agencies, health professionals and others involved with breastfeeding promotion, support and management.
- promoting and supporting the activities of the Physicians' Breastfeeding Network of Illinois as they promote breastfeeding education for physicians and in medical schools.
- supporting the activities of local agency breastfeeding coordinators statewide through technical assistance, training and educational materials
- providing breastfeeding training and educational opportunities to all health department staff including other agency programs, i.e., Family Case Management, Immunizations, etc.
- implementing state breast pump program including making breast pumps available to local agencies and training on managing breast pump programs.
- developing and implementing breastfeeding training based on documented educational needs for Family Case Management, WIC and other MCH providers.
- collecting data on breastfeeding practices through the Cornerstone Information System and CDC Nutrition Surveillance Systems.

Chicago. The WIC staff, case managers, public health nursing, and outreach workers monitor the breastfeeding activity of clients. However, in recognition of the fact that: a) mothers are discharged from hospital before the mother's milk is established, and before the infant "learns how to feed"; and b) attendance at WIC is insufficient to provide new mothers with the skills they need to feed the infant, and to withstand environmental barriers to breastfeeding, the Chicago Department of Health recently initiated a program to promote breastfeeding in one Chicago Community Area. The worker (a peer trained in lactation counseling) visits new mothers in their homes to provide the encouragement and support they need to initiate and continue breastfeeding.

Two goals of Healthy People 2010 are that at least 75 percent of mothers should breastfeed their babies in the early postpartum period, and that at least 50 percent of mothers should continue breastfeeding until their babies are 5 to 6 months of age. According to the CDOH Breastfeeding Tracking Report for February 2000, 34.9 percent or 5,650 infants were ever breast-fed. Of these, 3,125 (19.3 percent) were currently being breast-fed. Of the latter group, 410 or 13.1 percent were exclusively breast-fed, and the remaining 2,715 (86.9 percent) were partially breast-fed.

Federal Performance Measure #10: The percentage of newborns who have been screened for hearing impairment before hospital discharge

The MCH, CSHCN Part C Early Intervention, and IDPH Vision and Hearing programs have collaborated to implement a voluntary newborn hearing screening program. Approximately $1 million of federal Part C funds was used for one-time grants to hospitals for the purchase of newborn hearing screening equipment. P.A. 91-67, the Hearing Screening for Newborns Act, was enacted in July 1999, mandating universal screening and reporting by December 2002. DHS has formed the required Advisory Committee. Currently, 112 birthing hospitals are conducting either universal or targeted screening and 88 percent of the state's newborns are being screened. From June 1999 through May 2000, approximately 45 hospitals reported screening results from 29,900 births to IDPH. Of these, 28,852 were screened for hearing

loss, 5,349 were rescreened for hearing loss, and 1,069 nowborns were referred for further testing. Of those referred for further testing, 433 were determined to have no hearing loss; 18 were confirmed with hearing loss; five refused further testing; seven moved out of state; three died and 632 are pending follo-up. Based on the hospital survey, it may be inferred that 129,500 infants have been screened but not reported.

State "Negotiated" Performance Measure #9: The prevalence of early childhood caries

Illinois achieved its goal for reducing the prevalence of early childhood caries. The state's actual performance was 34.8 percent, somewhat below the objective of 39.0 percent.

The oral health program provided numerous community-based education and outreach activities to prevent early childhood caries. Interventions were conducted with parents in non-traditional settings so that parents begin thinking about oral health before they see the first tooth. The program also worked with interested communities to establish community-based programs designed to reduce the prevalence of early childhood caries. This included assisting communities to redesign their program and providing technical assistance.

Previously, the number of young children with dental caries was estimated through three surveys conducted between 1992 and 1994. Currently, the data to measure achievement of this objective is collected through 11 agencies participating in the IDPH Division of Oral Health's Community Oral Health Needs Assessment and Planning project. Five of the nine agencies have reported data and three have provided valid data. These communities are using the same protocol used by the Division of Oral Health in the 1992 and 1994 prevalence surveys.

Population-Based Preventive and Primary Care Services for Children and Adolescents

Federal Performance Measure #5: The percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B

The Illinois Immunization Program (IP), operated by IDPH, continues to conduct annual assessment of children in this age category served at all local health departments and Vaccines for Children (VFC) providers in Illinois. To determine 2 year old coverage levels, IDPH uses National Immunization Survey (NIS) results. Estimated coverage levels are "4:3:1"[3], 79.1 percent statewide (84.2 percent downstate and 66.7 percent in Chicago); and "4:3:1:3"[4], 77.5 percent statewide (82.8 percent downstate and 64.4 percent in Chicago).

The Immunization program has continued its linkage and partnership with the Community and Economic Development Association of Cook County (CEDA) to improve vaccine coverage levels among WIC clients and increase availability and accessibility of immunization clinic services. The linkage plan with CEDA has been approved by CDC since 1995. The Immunization Section holds a contractual agreement with CEDA that provides supplemental funding to the agency to provide routine assessment, referral and on-site vaccination services to WIC clients. CEDA utilizes Cornerstone to provide full management of health services to its clients including co-scheduling, referral and participant profiles that address the Standards of Pediatric Immunization practices. Outreach and further linkages have ben maintained through supplemental funds to several areas that have been identified as "pockets of need." A pocket of need is a county or community that has consistently demonstrated lower than state average vaccine coverage levels among its 2 year olds. Supplemental funds have assisted with resources to provide routine reminder/recall efforts (tracking) or administration of vaccines in "off" hours to accommodate working families.

During 1999, the program initiated efforts to educate mothers of newborns in selected hospitals in Illinois to ensure newborns begin immunizations on time. This project is known as "Baby Track" and has been promoted and expanded by Advocate Health Care. The Baby Advocate team consists of IDPH staff, local health department staff along with staff from Advocate

---

[3]Four doses of Diphtheria-Pertussis-Tetanus vaccine, 3 doses of Polio vaccine and 1 dose of Measles-Mumps-Rubella vaccine.

[4]Four doses of Diphtheria-Pertussis-Tetanus vaccine, 3 doses of Polio vaccine, 1 dose of Measles-Mumps-Rubella vaccine and 3 doses of haemophilus influenzae B vaccine.

hospitals, medical groups and health centers.

Tracking our Toddlers' Shots (TOTS) is an immunization record sharing system that has been in development since 1996 as a companion system for Cornerstone, to be used by private providers. TOTS is to help health care providers record, track and report their patients' immunization status. It provides multiple methods (voice, EDI and PC) of data access to ensure increased private provider participation. Several pilots are taking place now, with the Voice response and PC application components. The EDI component continues in development and testing.

School-based health centers have raised the immunization rate to 98 percent in participating schools. The centers also provide immunizations to children of adolescent parents. The centers have served as pilot sites for Hepatitis B immunizations administered at some high schools in Chicago.

Chicago. The Chicago Department of Health Immunization Program, case managers, outreach workers, VISTA volunteers, HOPE for Kids, WIC, several hospitals, physicians who participate in the Vaccine for Children's Program, Blue Cross and Blue Shield Illinois, and the Chicago Area Immunization Program are just a few of the agencies, organizations and individuals that have been involved in promoting timely immunization among children in the Chicago area. While the overall rate of immunization is 68 percent, levels of immunization remain uneven in the City.

The WIC-immunization intervention Project maintained an up-to-date immunization rate of 90 percent for the 0-2 year old enrollees in 19 Chicago Department of Health WIC sites for all 12 months of 1998.

Perinatal Hepatitis B Prevention, in an effort to ensure that at least 90% of birthing hospitals have written clinical and administrative procedures applying to HbsAg screening of all pregnant women, the program intensified its educational efforts in 1999 and implemented a

memorandum of understanding with the APORS program to improve reporting and follow up. A training video was developed and distributed to local health departments and perinatal network administrators for use in all hospitals. The section also maintained a contractual agreement with the Chicago Health Consortium-Immigrant/Refugee Area Health Education Center to maintain a Hepatitis B ("Catch Up" project targeting high risk populations, specifically among Asian/Pacific Islanders. As a result of the consortium's efforts, Hepatitis B immunization levels among the 10,000 infant and school aged children in Chicago and Cook County has risen from 43 percent to 80 percent.

The Care-Van (Blue Cross and Blue Shield) visited Chicago Housing Authority's public housing residences and several Head Start Programs and vaccinated children between the ages of 0-5 years.

Federal Performance Measure #6: The birth rate (per 1,000) among teenagers age 15 through 17

Illinois' exceeded its objective of 36.0 births per 1,000 15 to 17 year old women in 1998; actual performance was 32.7 per 1,000. The birth rate among 15 to 17 year olds has declined by nearly 20 percent between 1994 and 1998.

Abstinence-only education programs were initiated in FFY'98 with Section 510 funds. Thirty projects were selected through a competitive application process. Most of the programs are school-based and operated by community-based organizations. Fourteen of the projects are operating in Cook County (including Chicago); the remainder are distributed across the State. All of the projects conform to the definition of abstinence-only education presented in Section 510 of Title V.

PTS, Teen Pregnancy Prevention and School-Based/Linked Health Center programs conducted primary prevention activities including peer support groups, health promotion activities, health education, and development of health education curricula for use in schools. The Family

Planning program provided extensive counseling to teenagers in addressing pregnancy prevention and encouraging parent/child communication. Community education programs, conducted by staff at local Family Planning agencies, counseled teens about postponement of sexual activity and provided information about contraceptive methods. The main focus of Subsequent Pregnancy Projects is delay of subsequent pregnancy among teen mothers under age 18. The Comprehensive School Health grants use curricula that focus on decision-making, health education (including abstinence) healthy lifestyle choices, and communication.

Chicago. In 1996, the birth rate was 71.0 per 1,000 among teenagers aged 15 through 17 years of age. This had decreased to 68.4 in 1997. This rate is slightly less than double the State's rate of approximately 37.1 per 1,000 in 1996 and its goal of 36.5 per 1,000 in 1997. Until June 1998, through its CDBG programs, the CDOH funded several agencies to provide counseling to parenting and pregnant teens. During that time, repeat pregnancies were reduced by 8 percent, and the number of infant deaths were reduced from two in 1997 to zero in 1998.

Federal Performance Measure #7: The proportion of third grade children who have received protective sealants on at least one permanent molar tooth

Illinois exceeded its goal of increasing the proportion of third-grade children who have protective sealants on at least one permanent molar tooth. The state's actual performance was 26.6 percent, somewhat above the goal of 25.0 percent.

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

Prior to federal fiscal year 1999, the data used to measure current performance on this

objective were the results of a statewide, stratified random sample of ages 5, 6, 7, 8, 13 and 14 in Illinois public schools conducted in the 1993-1994 school year under the auspices of the Centers for Disease Control and Prevention. There are no plans to replicate this survey. For the federal fiscal years 1999 and 2000, the data used to measure this objective are collected from the IDPH's Dental Sealant Program grantees. The grantees are required to report the number of third graders in the schools targeted for the program and the number who received sealants through the program. To be eligible, children must be participating in the Free or Reduced-Price Lunch Programs. The results will be extrapolated to the number of third-graders in the State.

Chicago. In 1998, the Chicago Department of Health formed a Dental Task Force comprised of representatives from the federal and state agencies, the University of Illinois Schools of Dentistry and Public Health, and private dentists to develop a school-based sealant program for 2nd and 6th graders. The goal is to increase the quality and quantity of sealants provided to children. They have met with the Chicago Public School representatives and a pilot project in 15 schools began January 1, 2000. The other 180 schools will be phased in over a period of three to five years.

Federal Performance Measure #8: The rate of deaths per 100,000 children ages 1 - 14 caused by motor vehicle crashes

Illinois exceeded its goal of reducing motor-vehicle crash deaths among children between 1 and 15 years of age. The actual mortality rate was 3.3 per 100,000 children age 1 - 14 years in 1998, more than 20 percent below the goal of 4.2 per 100,000.

The Car Safety Seat Program is designed to promote the use of car seats to help low income families with young children. Car seats, when properly installed and used are effective in saving children's lives. The seats are made available at no cost to the family through participating local health departments, IDHS local offices, Teen Parent Services offices, and participating hospitals and community organizations. Parents are required to view a video

with a short presentation on tips on how to correctly install and use the car seat.

The Healthy Child Care Illinois project's Child Care Nurse Consultants provide educational training and resource referrals to day care providers and to families about the importance of child car safety restraint seats and the use of safety belts for older children.

Chicago. The Chicago Department of Health continues to distribute car seats for infants and toddlers. Parents must participate in an educational program before they qualify for a car seat. Case managers, public health nurses, and outreach workers counsel clients about the use of car seats for their children and also educate care givers about the safety needs for their clients.

2.4.4 Infrastructure Building

State "Negotiated" Performance Measure #7: The number of maternal and child health program staff from local health departments and DSCC regional offices who complete the MCH Leadership Institute

The MCH and CSHCN programs worked with the University of Illinois at Chicago School of Public Health to conduct a leadership institute for MCH program staff in local health departments and CSHCN staff in regional offices. With the third institute, which began in November 1998, the Department met its goal of enrolling 75 Fellows in the Institute. The Institute was supported by the SSDI grant in FFY'99.

Infrastructure-Building Services for Pregnant Women, Mothers and Infants

Federal Performance Measure #16: The percent of very low birth weight live births

The FCM and WIC programs have been working diligently during the last year to ensure that the delivery of these services is fully integrated at the local level. The Cornerstone

management information system, which supports both programs, has facilitated study of the impact of participation in these programs on birth outcomes. The very low birth weight rate among women who participated in both programs was 1.4 percent in 1998, one-third of the rate (3.7 percent) observed among Medicaid-eligible women who did not participate in either program during pregnancy. Similarly, the infant mortality rate among infants born to women who participated in both programs was 7.0 per 1,000 in 1997, less than half the rate (15.8 per 1,000) among infants born to Medicaid-eligible women who did not participate in either program.

Based on this analysis, Cornerstone data were then used to analyze WIC and FCM integration at the local level by examining the proportion of each provider's shared caseload. Full integration was defined as having 95 percent or more pregnant women and infants enrolled in both programs. Moderate integration was defined as having between 90 percent and 95 percent of the clients in both programs. Low integration was defined as having less than 90 percent of the clients in both programs. Integration rates were then color coded on a map and distributed to local agency administrators. Cornerstone was also used to prepare lists of families enrolled in only one of the programs, so that agencies could target these families for "inreach" activities. Further, the agencies were given focused consultation and technical assistance by DHS regional nursing and nutrition consultants. As a result, just over 94 percent of the women and infants in Illinois who qualify for WIC or FCM are also enrolled in the other program. This is expected to have a positive effect on the State's infant mortality rate.

When integration began, WIC integration was 87 percent in downstate Illinois; in August 1999, the percent of integrated clinics had risen to 92 percent. Family Case Management integration began at 92 downstate percent and by August 1999 the rate of integrated clinics was at 96 percent. For FY2001, the Family Case Management and WIC Programs will work together as a team to find innovative ways to assist the four counties statewide that have not achieved their integration goal to become totally integrated**.**

School-Based/Linked Health Centers referred pregnant students for prenatal care and monitored their use of services. Family Planning delegate agencies provided pregnancy testing, informed patients of the importance of early prenatal care and made referrals to prenatal care providers. Preconception health messages consistently included the importance of early prenatal care during pregnancy.

Chicago. The Chicago Department of Health supported the development and distribution of educational materials by the Illinois Maternal and Child Health Coalition to educate clients and practitioners about factors contributing to low birth weight and very low birth weight (VLBW). Case managers assist high risk pregnant women to access services in a timely manner to prevent the occurrence of VLBW infants.

Overall, the proportions of VLBW infants born in Chicago has remained relatively stable around 2.1 percent since 1989. The percentages have varied among the racial/ethnic groups with that for non-Hispanic African-Americans ranging from 3.2 to 3.4 percent, for non-Hispanic Caucasians from 1.4 to 0.9 percent, and for Hispanics 1.4 to 1.0 percent.

The Healthy Child Care Illinois project's Child Care Nurse Consultants have referred families to primary care providers and to health programs such as WIC, KidCare, FCM, HFI, and TPS.

Federal Performance Measure #17: The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates

Illinois fell somewhat short of its goal for this objective. Actual performance in 1998 was nearly 67 percent, just below the goal of 69 percent.

The Perinatal network provided on-going monitoring and evaluation of the percentage of very low birth weight infants born in a Level III facility or Perinatal Center, a required performance objective for each of the 10 regional perinatal centers. The statewide Quality Improvement

Council has guided the overall development and implementation of quality improvement within each regional perinatal network. These structures are now fully formed and functioning. The councils implemented their quality improvement work plans. Members of these councils participated in formal exchanges of information and ideas concerning quality improvement and their projects. Councils began to identify new projects and tasks that need to be accomplished to advance quality improvement in perinatal care within the regions and the State.

Despite these developments and a quarter century of regionalized perinatal care networks, one of every three VLBW infants in Illinois is delivered in a Level I or Level II hospital rather than a Level II+ or Level III facility for high-risk deliveries and neonates. Expanded use of prenatal risk assessment and increased compliance with perinatal network consultation, referral and transfer protocols may be necessary to increase the proportion of VLBW infants delivered at appropriate facilities for high-risk deliveries and neonates. Toward this end, the perinatal program has developed and implemented a methodology for incorporating perinatal outcomes surveillance and improving provider compliance with consultation, referral and transfer protocols for high-risk maternal and neonatal patients, as part of the perinatal facility designation process. In addition, the perinatal care program has developed and implemented a very low birth weight deliveries and neonatal outcomes monitoring system for the purpose of quality assessment and improvement concerning this special high risk population.

Chicago. The CDOH and Members of Chicago Maternal and Child Health Advisory Committee (CMCHAC) have participated in Perinatal Advisory Committee meetings, assisted in the development of perinatal rules and regulations.

Federal Performance Measure #18: The proportion of infants born to pregnant women receiving prenatal care beginning in the first trimester

Illinois did not achieve its objective to increase the proportion of women who begin prenatal care in the first trimester of pregnancy to 82 percent. Actual performance was 81.2 percent, slightly below the objective.

This performance measure is addressed by the FCM program. A 1998 program evaluation found that the rate of early initiation of prenatal care among program participants in general (62 percent) was slightly higher than the rate among Medicaid-eligible women who did not participate (58 percent).

The goal of IDPA's Medicaid Presumptive Eligibility (MPE) program is to promote early and continuous prenatal care to low-income pregnant women. Through presumptive eligibility, women were covered for prenatal care services from the date of the application. Also, a component of the Problem Pregnancy program is outreach to high-risk populations with immediate enrollment into prenatal care.

Chicago. In 1997, entry into prenatal care during the first trimester had improved for all women from the previous year, and indeed had reached the highest level since 1989 for all groups except Puerto Ricans. In 1996 and 1997, the overall percentages were, respectively, 74.1 percent and 75.2 percent. In 1996, the respective racial ethnic percentages were Non-Hispanic Caucasians, 85.6 percent; Non-Hispanic African-Americans, 68.4 percent; Hispanics, 73.7 percent; Mexicans, 73.1 percent; and Puerto Ricans, 76.2 percent. In 1997, the respective percentages were: Non-Hispanic Caucasians, 87.8 percent; Non-Hispanic African-Americans, 68.8 percent; Hispanics, 74.6 percent; Mexicans, 74.5 percent; and Puerto Ricans 74.5 percent. The non-Hispanic Caucasian percentage has surpassed the State's rate of 85 percent for the Year 2000 since 1996.

Infrastructure-Building Services for Children and Adolescents

Federal Performance Measure #12: The percent of children without health insurance

The number of uninsured children in Illinois has increased for the last three years. Based on U. S. Census Bureau estimates, the three-year annual average number of uninsured children from families with incomes below 200 percent of the federal poverty level in 1996, 1997 and 1998 was 277,000 or 7.7 percent of all children. The estimate for 1995, 1996 and 1997 was

221,000 children, or 6.4 percent of all children, and the estimate for 1994, 1995 and 1996 was 196,000 children, or 5.8 percent of all children.

KidCare, the name by which Medicaid and S-CHIP are marketed in Illinois, has five components:

- KidCare Moms and Babies -- coverage for pregnant women and infants up to age 1 year with income up to 200 percent of the FPL.
- KidCare Assist -- for children through age 18 with family income at or below 133 percent of the FPL.
- KidCare Share -- for uninsured children through age 18 with family income above 133 percent and at, or below, 150 percent of the FPL. Co-payments of $2 per medical visit are required, except for well-child visits and immunizations.
- KidCare Premium -- offers coverage for uninsured children through age 18 with family income above 150 percent and at or below 185 percent of the FPL. Monthly premiums of $15 for one child, $25 for two children or $30 for three children are required. Co-payments of $5 per medical visit, $5 for brand name prescriptions and $3 for generic prescriptions as well as $25 for non-emergency use of hospital emergency room services are also required. There are no co-payments for well child visits or immunizations. Co-payments under both plans ("Share" and "Premium") are capped at $100 per family per year.
- KidCare Rebate -- for families with private health insurance coverage for their children. It allows a maximum reimbursement up to $75 per eligible child per month for the premium costs paid by the family to purchase private health insurance that provides, at a minimum, physician's services and hospitalization. Children through age 18 with family income above 133 percent, and at or below 185 percent of the FPL are eligible. This part of KidCare is entirely funded by Illinois' General Revenue funds.

As of March 1, 2000, enrollment in KidCare had reached 90,800 women and children. (This is the cumulative number of women and children with approved applications since the initiation of KidCare in January 1998.) The IDPA is processing more than 325 applications per day,

with an 87 percent approval rate for applications submitted by KidCare Application Agents (KCAAs).

The majority (84 percent) of women and children covered by KidCare are eligible for the Medicaid portion of the plan. Approximately 5,900 children have enrolled in KidCare Share, 5,800 in KidCare Premium and 3,100 in KidCare Rebate.

A special survey was funded by IDPA and conducted by the University of Illinois at Chicago in 1998 to estimate the number of uninsured children in Illinois. Based on the survey results, there were 212,300 uninsured children in families with incomes below 250 percent of the federal poverty level at the time of the survey. Of these 212,300 children, 147,000 lived in families with incomes below 133 percent of the FPL (and therefore may be eligible for Medicaid), 43,800 lived in families with incomes between 133 percent and 185 percent of the FPL (and therefore may be eligible for S-CHIP) and 21,500 lived in families with incomes between 185 percent and 250 percent of the federal poverty level (and therefore are ineligible for Medicaid or S-CHIP in Illinois).

These 212,300 children represent approximately 17 percent of the children in families with incomes below 250 percent of the federal poverty level. Based on these estimates of the number of uninsured children, KidCare has reached approximately 45 percent of uninsured children who are potentially eligible for Medicaid and 27 percent of the children who are potentially eligible for S-CHIP.

During calendar year 1998, IDPA expanded off-site enrollment of eligible pregnant women and children. The efforts included simplifying the KidCare Application (previously called the MCH Medical Assistance Application) taken at outstation sites other than the local IDHS offices (such as local health departments) and increasing the number of outstation sites assisting with the application-taking process. Through these outreach efforts identification and enrollment of children potentially eligible for medical assistance will occur. Families of these children will be assisted in enrolling into the KidCare program thereby removing a significant

barrier to the receipt of medical care.

Beginning in February 2000, 12-month continuous eligibility was implemented for all children under age 19 who are eligible for KidCare.

Chicago. In order to increase the number of children who have health insurance coverage, Chicago Department of Health staff who have contact with clients are expected to enroll as many families as possible in the KidCare program. The Chicago Department of Health has also employed a coordinator and several outreach workers whose sole function is to ensure that clients are enrolled in the program by: a) completing and submitting applications; b) visiting IDHS offices to ensure receipt of the applications and c) providing enrollment information.

Federal Performance Measure #13: The percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program

Illinois did not achieve its goal to increase to 70 percent the proportion of children who are potentially eligible for the Medicaid program and who received a service paid by the Medicaid program. Actual performance was 67.9 percent.

FCM agencies conduct community outreach to identify families with potentially Medicaid-eligible or KidCare-eligible children who have not applied. Case managers work with individual families to decrease the barriers in obtaining Medicaid or KidCare (e.g., transportation, child care, lack of information about Medicaid and KidCare). In addition to identification, FCM enrolls the children into a system of care that ensures children receive appropriate medical care services and follow-up. Also, through the HealthWorks of Illinois program,100 percent of wards in downstate Illinois had received a comprehensive health evaluation.

Chicago. The Case management and outreach staff and Chicago Department of Health clinic staff all ensure that children who receive services are screened for Medicaid eligibility.

Medicaid applications are initiated and submitted for all eligible children. Case managers, public health nurses and outreach workers ensure that children are appropriately enrolled and linked with a service provider.

Federal Performance Measure #6: The rate (per 100,000) of suicide deaths among youths aged 15 - 19

Illinois did not achieve its objective to reduce the suicide rate among 15 to 19-year-olds to 6.9 per 100,000. The rate did decrease slightly from the prior year (from 7.7 per 100,000 to 7.6). There was one more adolescent suicide in 1998 than in 1997.

The number of School-Based and School-Linked Health Centers was increased to a total of 26 sites. All provide mental health counseling on-site and/or have written agreements with outside community providers. Health educators and ancillary staff provide additional support via small group meetings, adult mentors, peer mentors, peer support groups, parent and child activities, recognition of accomplishments, and building self-esteem. The programs assisted students in setting and achieving long and short term goals, thereby fostering hope and reducing the likelihood of contemplating suicide.

Satellite training is being provided to Division of Community Health & Prevention staff and contractors on signs, causes and referral procedures on adolescent suicide. Additionally, Bureau of Child and Adolescent Health staff and contractors will be trained on mental health issues, including adolescent suicide.

Infrastructure-Building Services for Children with Special Health Care Needs

State "Negotiated" Performance Measure #5: The proportion of CSHCN ages 14 and above who receive comprehensive transition planning services to promote awareness of adult services

To continue to address the family's need for comprehensive transition planning more reflective

of medical issues and to assist staff in coordinating transition services, DSCC reviewed its current provider credentialing process. More adult providers have been included (physician and medical centers, etc.) to serve CSHCN age 16 and over. This activity will include increased recruitment of adult providers for CSHCN.

State "Negotiated" Performance Measure #6: The proportion of DCFS caseworkers who have been trained on CSHCN and DSCC services

In 1997, DSCC identified the need to improve systems of care for CSHCN who also received services from IDCFS, Illinois' child welfare agency. Based upon this need, the Regional Office planned and developed an approach to enhance coordination of care statewide for children dually serviced by IDCFS and DSCC. A training module was developed and implemented to address issues with CSHCN for IDCFS caseworkers.

Federal Performance Measure #11: To increase the proportion of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care

In the summer of 1998, all DSCC intake staff attended a training on the State Child Health Insurance Program (KidCare) enrollment conducted by the Department of Public Aid (DPA). To further support enrollment in KidCare, additional enrollment training was provided by DPA throughout the state. DSCC's intake staff and professional medical consultants began to provide enrollment outreach to CSHCN who had no source of insurance and who sought application for DSCC assistance. All potentially KidCare-eligible families enrolled with DSCC were contacted and provided an information packet on the KidCare program and the assistance of DSCC staff in making application. All new and existing DSCC staff received continued training on benefits management to help maximize financial access to primary and specialty care through a variety of resources, including health insurance, managed care policies, SSI, Medicaid, KidCare and Early Intervention. DSCC is promulgating a rule to require families of CSHCN to apply for KidCare as a part of their eligiblity determination

process.

Federal Performance Measure #14: To increase the degree to which the State assures family participation in program and policy activities in the State CSHCN program.

Besides the development and implementation of the Family Advisory Council in 1999, DSCC employed a full-time family member as a Family Liaison Specialist (FLS). Located in the central administrative offices, the FLS advised DSCC administration on the development and promotion of family related activities to assure a family-centered, culturally-sensitive and community-based approach. In addition, the FLS trained, assisted and advised DSCC staff on family perspectives, family-centered care, care coordination, transition planning, Medical Home and educational/community resources. He also assisted and advised DSCC families on an as-needed basis on issues related to CSHCN. The FLS also coordinated the Family Advisory Council and participated in MCH conferences and leadership activities. To enhance staff awareness of family issues, family members participated in two DSCC staff conferences.

2.5 Progress on Outcome Measures

Outcome Measure #1: The infant mortality rate per 1,000 births

Illinois' infant mortality rate reached a plateau in 1998 when the rate was unchanged from 1997. The infant mortality rate in both years was 8.2 per 1,000, the lowest in state history.

The main causes of infant mortality include inadequate or no prenatal care, very low birth weight births and low gestational age. By reducing these causes, the rate of infant mortality can be reduced. Several programs addressed the underlying causes of infant mortality. The delivery and support of early and consistent prenatal care was provided through the Family Case Management program, the regionalized perinatal care program, and Illinois' network of six Healthy Start programs. These programs emphasized outreach and identification of pregnant women to ensure

they received the care necessary to ensure a healthy pregnancy and, subsequently, a healthy infant.

The analysis of perinatal outcomes among WIC and FCM program participants (refer to State Performance Measure 1) also examined the program's effect on lowering infant mortality. Women who participated in both programs had an infant mortality rate of 7.0 infant deaths per 1000 live births, 56 percent lower than the rate of 15.8 among Medicaid-eligible women who did not participate.

For African-Americans, Hispanics, single mothers, teen mothers and the entire population, the infant mortality rates were:

	African-American	Hispanic	Single	Teen	State
FCM or WIC	10.9	3.6	7.4	8.7	7.0
Medicaid, no intervention	19.7	9.2	17.7	16.6	15.8
Percent Decrease	44.7%	60.9%	58.2%	47.6%	55.7%

Thus, a major decrease in the infant mortality rates can be identified for each of these groups when the women participated in either program during pregnancy.

This outcome measure can be improved by increasing the rate of early entry into prenatal care, increasing health care coverage for low-income women, ensuring the provision of risk-appropriate prenatal care and reducing the teen pregnancy rate.

Chicago. The infant mortality rate in Chicago continues to decrease, but it remains higher than the national average. In 1997, the rate was at its lowest level since 1960, and with a rate of 10.7, continuing the decline from the 1995 rate of 12.6 per 1,000 live births. The rate in 1996 was 10.8 per 1,000 live births.

Outcome Measure #2: The disparity between the African-American and Caucasian infant mortality rate

The disparity in infant mortality rates has been stable for the last five years. The infant mortality rates European-Americans and African-Americans have been steadily declining for the last five years. The infant mortality rates among European-Americans during the five most recent years were 6.7 per 1,000 in 1994; 7.2 in 1995; 6.3 in 1996; 6.2 in 1997 and 6.3 in 1998. Among African-Americans, the infant mortality rates during the most recent five years were 17.9 per 1,000 in 1994; 18.2 in 1995; 17.4 in 1996; 16.5 in 1997 and 16.8 in 1998. The ratio of these two rates has been nearly uniform for the last five years: 27.:1 in 1994; 2.5:1 in 1995; 2.8:1 in 1996; 2.7:1 in 1997 and 2.7:1 in 1998. While the infant mortality rate has been steadily declining in both populations, the gap between them has not narrowed.

The programs that have influenced the reduction in the disparity rate and the means of further decreasing this rate are discussed in Outcome Measure #1.

Chicago. In 1996 and 1997, the infant mortality rate declined for African Americans, but it still continued to be higher than for all other ethnic groups in Chicago. The mortality rate in 1997 among African-American infants was 2.1 times greater than the rate among Caucasian infants.

Outcome Measure #3: The neonatal mortality rate per 1,000 live births

The neonatal mortality rate has decreased slightly since 1994, when the rate was 5.8 per 1,000 live births. In 1995 there was a slight increase to 6.2. Since 1996 the rate has remained at 5.4, the State's lowest neonatal mortality rate.

The major contributing factors of neonatal mortality are premature birth and low maternal age. These factors can be ameliorated by increasing the delivery of prenatal care, by decreasing the

number of teens becoming pregnant and by ensuring that pregnant women and infants with medical complications receive risk-appropriate care. The programs that address the issue of premature birth are the Family Case Management program, the Perinatal Care program, the Problem Pregnancy program, and the Chicago Healthy Start program. Each program has elements that provide or support the delivery of prenatal or postnatal health care services, or that reduce barriers to delivery of that care. Reducing the numbers of teenagers who become pregnant is a goal of the Family Planning program, the Parents Too Soon primary prevention component, the School-Based/Linked Health Centers, and the Subsequent Pregnancy programs.

Chicago. In 1997, as in previous years, the majority of infants who died in Chicago did so in the neonatal period. The neonatal mortality rate for all races maintained its downward trend from a high of 13.2 in 1980 to 6.8, but this was slightly higher than the lowest point achieved (6.3 in 1996). As with other indices, in 1996 and 1997, the non-Hispanic African-American babies fared worse than those of other groups in the city. In 1996, the neonatal mortality rate was 10.0 for non-Hispanic African-Americans, 3.7 for Caucasians and 3.5 for Hispanics. Within the Hispanic group, the rate was 3.5 for Mexicans, and 3.0 for Puerto Ricans.

Outcome Measure #4: The post-neonatal mortality rate per 1,000 live births

The rate of post-neonatal mortality rose slightly in 1998 to 2.8 per 1,000 live births. This follows five consecutive annual decreases, from 3.6 in 1992 to 2.7 in 1997.

There are three primary causes for post-neonatal mortality. These are Sudden Infant Death Syndrome (SIDS), child abuse and infections. The rate of child abuse and infections occurring within this population may be decreased through a variety of effective programs. The Healthy Families Illinois program provided family support and parenting skills education to decrease the likelihood that the parents would abuse their child(ren). Other programs provided case management to secure proper services for families who experienced or have the potential to experience abuse. These programs include Family Case Management, Healthy Start and Parents Too Soon.

The Family Case Management and Healthy Start programs provide case management services throughout the first year of life to ensure that children receive routine preventive care and primary care to prevent or treat infections before they become life-threatening.

Chicago. In 1996, the post-neonatal mortality rate was 7.3 for non-Hispanic African-Americans, 1.8 for Caucasians and 3.0 for Hispanics. Within the Hispanic group, the rate was 2.7 for Mexicans and 4.7 for Puerto Ricans. In 1997, the post neonatal mortality rate was 6.5 for non-Hispanic African-Americans, 1.9 for Caucasians and 2.2 for Hispanics. Within the Hispanic group the rate was 2.0 for Mexicans and 4.1 for Puerto Ricans. The 1997 rate was slightly worse for non-Hispanic Caucasians, but had improved for all other groups.

Outcome Measure #5: The perinatal mortality rate per 1,000 live births

Illinois' perinatal mortality rate rose in 1998 to 12.2 per 1,000 live births and fetal deaths, an increase from the 1997 rate of 11.5. Overall, the rate has declined since 1994, when the rate was 13.5 per 1,000.

The factors associated with perinatal mortality include very low birth weight and congenital anomalies. The incidence of very low birth weight births is addressed through the Perinatal Centers. These centers constituted a comprehensive statewide organization of inpatient services created to provide care throughout the reproductive process to improve the health of women and infants. The centers provided services to pregnant women who required high-risk delivery and to newborns who required neonatal intensive care. There are four levels of perinatal care capabilities to provide a basis for appropriate medical care for high-risk neonates. Very low birth weight was addressed through a variety of programs that increased the pregnant mother's entry into early prenatal care; that provided case management services to increase access to consistent and timely prenatal care; that decreased the use of alcohol, tobacco and other drugs during pregnancy; and that reduced the likelihood that a teenager would become pregnant.

The Department has convened the six federally-funded Healthy Start programs in Illinois to

establish the Healthy Start Programs Partnership. The group's main activity has been the development and implementation of a Fetal and Infant Mortality review (FIMR) process. The study procedures follow the protocols developed by the American College of Obstetricians and Gynecologists. The project is targeting the Chicago area since five of the six Healthy Start projects serve Chicago or suburban Cook County. The University of Chicago perinatal center is serving as the lead agency for the project. Recent activities have focused on securing institutional review board approval from more than 30 hospitals. Data collection is scheduled to begin in SFY'01.

Outcome Measure #6: The child death rate per 100,000 children ages 1-14

The child death rate in Illinois has been lower than the state's target level for two consecutive years. the 1998 rate of 22.1 deaths per 100,000 children was below the 1998 goal of 26.0 per 100,000. However, the 1998 rate was higher than the 1997 rate of 21.0 deaths per 100,000 children.

The death rate per 100,000 children between the ages of 1 and 14 decreased between 1991 to 1996. There was a slight increase in this rate during 1993 and 1994 which has since shown a down-turn and was at its lowest point in 1997. In 1991 the death rate per 100,000 children ages 1 - 14 was 32.7; 1992, 28.8; 1993, 29.1; 1994, 31.8; 1995, 29.8; 1996, 26.2; and 1997, 21.0.

The main contributors to child mortality are accidents and violence. IDHS has a child safety seat program intended to reduce death due to motor vehicle collisions. This program provides car seats to parents who are in financial need. More than 1,000 car seats were distributed in FFY'99. The program includes an educational component to increase awareness of the importance of providing car seat restraints for children, and how to properly install the seats. The Healthy Families Illinois program helps parents at risk for child abuse or neglect to develop appropriate parenting skills, thereby reducing the risk of violent injury.

The CCNCs work closely with day care providers (licensed and license-exempt) and with families on injury prevention issues such as safe transportation, playground, bicycle and fire safety, home

and facility safety.

Chicago. The death rate for children 1-14 in Chicago was 4.3 per 100,000 in 1996 and 3.0 in 1997. This latter figure was actually lower than the projected State level of 3.7 for year 2000.

III. REQUIREMENTS FOR APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

IPLAN. The Illinois Project for Local Assessment of Needs (IPLAN) is a strategic planning process, required under the Illinois Administrative Code, used to certify local public health departments. IPLAN was instituted in 1994 and involved IDPH and 86 local health departments in a comprehensive, community-based planning process, focusing on all aspects of public health, including MCH. The IPLAN process is based on the Assessment Protocol for Excellence in Public Health (APEX-*PH*), developed by the National Association of County and City Health Officials and others. Every five years, each local health department completes an organizational capacity assessment, following APEX-PH, Part I, and a community health needs assessment, modeled on APEX-PH Part II. The IPLAN process concludes with the development of a five-year community health plan.

The IPLAN community health needs assessment includes a review of public health indicators, the identification of at least three priority health problems, and the development of outcome objectives, impact objectives and at least one intervention strategy to address each impact objective. New developments include the creation of an Internet based data system, including numerous indicators in seven broad domains,[5] that is available to each local health department

[5]The MCH indicators in the IPLAN data set included: live births, infant mortality (and its components), low birth weight, maternal smoking and alcohol use during pregnancy, Kessner Index of prenatal care, proportion of women beginning prenatal care in the first trimester, newborns testing positive for cocaine, leading causes of mortality among children aged one to four years, children at low weight for height, teen birth rate, percent of births to teens, indicated cases of child abuse and neglect, rate of congenital anomalies, deliveries paid for by Medicaid, Medicaid-eligible children receiving EPSDT services, childhood cancers, basic series vaccinations, Haemophilius meningitis among infants and children through age four, vaccine preventable diseases (diphtheria, pertussis, tetanus,

and the general public. The Internet system provides data manipulation features including ranking, trends and percent change. The data system allows county, regional, state and national comparisons on most of the indicators. Most indicators contain information from 1990 through 1997. Additional morbidity and mortality data are available through other IDPH and governmental Internet web sites, and from the Illinois Center for Health Statistics. In addition, each local health department is provided with technical assistance in primary data collection methods (surveys, focus groups, etc.), group decision making and social marketing skills. For logistical purposes, the re-certification period is staggered. The local health departments completed their community needs assessments and community health plans throughout 1998 and 1999 with the submission of the plans to IDPH during 1999 and 2000. At the time of this report, 86 of the 94 local health departments have submitted their plan.

Among these health departments, more than 1,200 persons served on community planning groups. The community planning group identifies priority health problems, risk factors, direct and indirect contributing factors, and outcome and impact objectives. They then select a "proven intervention strategy" (based on the public health literature) for each priority public health problem. The plan is then submitted to the local board of health for adoption.

Children With Special Health Care Needs. DSCC utilized several methods to assess the needs of Illinois CSHCN:

- In 1997, a comprehensive needs assessment of families served by DSCC was conducted. Families and advocacy groups representing diverse cultures assisted in the development of the survey instrument which was mailed to a sample of DSCC clients and SSI recipients. The survey addressed six main areas: general information, family income, child's heath status, service availability, transition services, and health care financing.
- In 1998, in an effort to more clearly understand the linkages needed by children eligible for

measles, mumps, rubella, and polio), elevated blood lead levels, and sentinel events including infant hospitalization for dehydration, hospitalization for rheumatic fever among infants and children through age seventeen, and hospitalization for asthma among infants and children through age fourteen.

SSI, DSCC contacted a sample of these families by telephone to identify services that were needed and the best method to link families to these services.

- In 1998, focus groups were held in each of the thirteen regional offices with agency staff to identify local community needs. These groups used a modification of the Hanlon method to identify size of the problem, seriousness of the problem, and effectiveness of interventions to address the problem. Regional performance measures as well as the State Negotiated Performance Measures were developed through this process.
- In 1999, a financial analysis of families served by DSCC was conducted using information from DSCC's Child Health Information Management System (CHIMS). The goal of this effort was to assess DSCC's financial eligibility criteria in relation to eligibility for the State Child Health Insurance Program (Medicaid/KidCare).
- In June 1999, two regional Family Discussion Group meetings were held for participants who had a child with special health care needs under the age of 21 years enrolled in a managed health care plan. The discussions focused on family experiences with managed care organizations.
- In Fall 1999 Senior Administration, facilitated by John Reiss of the Institute for Child Health Policy, completed a Title V CSHCN Program Self-Assessment Survey, *Activities on Behalf of SSI Beneficiaries and Potential Beneficiaries.*
- In 2000, a telephone survey of providers was conducted to assess access to specialty care for CSHCN who are served by Medicaid.

From the above needs assessment activities, DSCC administration analyzed findings, developed State Performance measures to enhance infrastructure for CSHCN and made needed refinements to the Program, incorporating relevant findings into the Annual Plan. For DSCC, ongoing needs assessment is integral to the CSHCN program as issues constantly emerge and require resolution.

At the state level, the MCH program used information from a wide variety of resources to assess the needs of women, children, adolescents and children with special health care needs. This information included vital records; program-related data (Medicaid services and

expenditures; MCH program information, WIC program information); hospital discharge data; data from the Pregnancy Risk Assessment and Monitoring System (PRAMS) and Behavioral Risk Factor Surveillance System (BRFSS) surveys; data from the Adverse Pregnancy Outcome Reporting System (APORS, the state's birth defects registry), record reviews and other sources. Program managers used this information to revise program strategies and to set performance targets for the next five years.

3.1.2 Needs Assessment Content

3.1.2.1. Overview of the Maternal and Child Health Population Health Status

An analysis of statewide MCH data for the purposes of this application led to revision of the target levels for the MCH program's five-year and annual objectives, presented on Forms 11 and 12 in Section 5.8.

Pregnant Women

Women in Need of Subsidized Family Planning Services. There are an estimated 701,100 women in Illinois who need subsidized family planning services.[6] Approximately 40 percent of these women are teens; the remainder are women between ages 20 and 44 with family incomes below 250 percent of the federal poverty level.

Fertility. Illinois' fertility rate is declining. In 1994, the overall rate was 70.5 per 1,000 women, and has declined by three percent to 68.2 per 1,000 in 1998. The reduction was greater among non-whites (declining by 9.6 percent, from 86.9 per 1,000 in 1994, to 78.6 per 1,000 in 1998) than whites (declining 1.2 percent from 66.4 per 1,000 in 1994 to 65.6 per 1,000 in 1998).

[6]Alan Guttmacher Institute. 1997. *Contraceptive Needs and Services:1995, with selected articles from Family Planning Perspectives*. New York City, NY: Author. p. 14

In 1998, childbearing peaked among women in their late twenties (age-specific fertility rate, 120.4 per 1,000 women). The peak years for child bearing among whites is later than non-whites (white, 25-29 year olds, 119.7 per 1,000 women; 30-34 year olds, 101.5 per 1,000 women; non-whites, 20-24 year olds, 138.0 per 1,000 women; 25-29 year olds, 123.2 per 1,000 women; Hispanic: 20-24 year olds, 211.6 per 1,000; 25-29 year olds, 187.2 per 1,000). Hispanics had the highest fertility rate in 1998, at 118.5 per 1,000 women.

Teen fertility rates are higher among non-whites and Hispanics than among whites (white: 10-14 year olds, 0.4 per 1,000; 15-19 year olds, 41.0 per 1,000. Non-white: 10-14 year olds, 3.4 per 1,000; 15-19 year olds, 93.3 per 1,000 women; Hispanic: 10-14 year olds, 1.4 per 1,000 women; 15-19 year olds, 100.6 per 1,000 women).

Abortions. The abortion rate decreased by seven percent between 1995 and 1998, falling from 15.5 per 1,000 women aged 15 to 44 years to 14.4 per 1,000. The greatest improvement was seen among 18 to 19-year-olds, among whom the rate dropped from 38.2 per 1,000 in 1995 to 30.9 per 1,000 in 1998, a decrease of 19 percent. The decrease among 15 to 17-year-olds was nearly as great (17 percent), dropping from a rate of 18.1 per 1,000 in 1995 to 15.0 in 1998. Increases were observed for women between 25 and 34 years of age. Among 25 to 29-year-old women, the rate increased from 24.7 per 1,000 in 1995 to 25.5 per 1,000 in 1998, an increase of three percent. Among 30 to 34-year-olds, the rate increased from 12.8 per 1,000 women in 1995 to 13.0 per 1,000 in 1998, an increase of one percent. The highest abortion rate each year was among 20 to 24-year-olds; the 1998 rate was 37.9 per 1,000 women.

Intendedness of pregnancy. Approximately forty percent of births in Illinois are the result of unintended pregnancies. Data from the PRAMS survey shows that intendedness of pregnancy increases with maternal age and income. While only 21 percent of 10 to 17-year-olds intended to become pregnant with their most recent child, the proportion quickly increased to 53 percent among 18 to 29-year-olds, peaked among 30 to 34-year-olds (78 percent), and dropped slightly among women over 35 (74 percent).

A similar pattern was found when the data were analyzed by income: Of those in the lowest incomes group (less than $15,000 annually), 39 percent reported that their pregnancy was intended. This is continued with over 50 percent of women from families with incomes between $15,000 and $35,000 annually and more than three-fourths of women who were from families with incomes in excess of $35,000 per year.

Important racial and ethnic differences were found as well. While two-thirds of European-American women described their most recent pregnancy as intended, two-thirds of African-American women described their most recent pregnancy as unintended. Nearly as many Hispanic women (64 percent) as European-American women (67 percent) described their most recent pregnancy as intended.

Early initiation of prenatal care. The proportion of women initiating prenatal care in the first trimester has been increasing steadily in the last five years. In 1994, nearly 97 percent of all women began prenatal care in the first trimester of pregnancy. The proportion reached 80 percent in 1996 and remained slightly above 81 percent in 1997 and 1998. First trimester initiation of prenatal care has been increasing among women in each racial and ethnic group. Among African-Americans, the proportion has increased from 63 percent in 1994 to nearly 69 percent in 1998, an increase of 8.4 percent. Among Hispanic women, the proportion increased from nearly 68 percent in 1994 to nearly 72 percent in 1998, and increase of 5.6 percent. Among European-Americans, the proportion increased from 83 percent in 1994 to 84 percent in 1998, an increase of 1.2 percent. The greatest improvement has been observed among African-American women; therefore, the racial disparity has narrowed from 1.3:1 in 1994 to 1.2:1 in 1998.

The proportion of Medicaid-eligible women in 1998 who initiated prenatal care in 1998 was nearly 68 percent. Participation in MCH programs influenced initiation of prenatal care: the proportion was nearly 72 percent among Medicaid-eligible women who participated in either WIC or Family Case Management, but was only 58 percent among Medicaid-eligible women

who did not participate in either program.

Smoking. Based on PRAMS data, nearly one-fourth of women reported that they smoked during the three months prior to becoming pregnant. Smoking was slightly more common among younger women (28 percent of 18 to 29-year-olds); European-American women (26 percent); non-Hispanic women (28 percent); and poor women (less than $15,000 annual income, 33 percent). The demographic group with the lowest rate of smoking during the three months before conception was Hispanic women at 10 percent.

The prevalence of smoking during pregnancy decrease by 43 percent (from 24 percent in the three months before pregnancy to nearly 14 percent in the last three months of pregnancy). Smoking during the last trimester of pregnancy was more common among 18 to 29-year-olds (16 percent); European-American (15 percent); non-Hispanics (17 percent); and poor women (20 percent)–the same groups more likely to smoke in the three months before pregnancy.

Data from the 1998 Prenatal Nutrition Surveillance System show a slightly higher incidence of smoking during pregnancy (17 percent) among WIC participants. Fewer Illinois WIC participants, however, smoked during pregnancy that prenatal WIC participants nationally (22 percent).

Alcohol. Use of alcohol during the last trimester of pregnancy was reported through the PRAMS survey by nine percent of women overall. Consumption of alcohol was most common among older (15 percent among women over age 35); European-Americans (nine percent vs. six percent of non-European-Americans); women of Hispanic descent (11 percent) and women with family incomes in excess of $35,000 annually.

Data from the 1998 Prenatal Nutrition Surveillance System show a significantly lower incidence of alcohol consumption during pregnancy (0.5 percent) among WIC participants. Fewer Illinois WIC participants, however, consumed alcohol during pregnancy that prenatal WIC participants nationally (1.9 percent).

Adequacy of prenatal care. Nearly three-fourths of all women in Illinois obtained an "adequate" amount of prenatal care in 1998, when the Kessner Index is used to measure "adequacy." Among racial and ethnic groups, 78 percent of European-American women obtained an adequate amount of prenatal care in 1998, compared to 58 percent of African-American women and 62 percent of Hispanic women.

Participation in MCH programs (either WIC or Family Case Management) had a positive effect on the receipt of prenatal care. Overall, 58 percent of Medicaid-eligible women received an "adequate" amount of prenatal care in 1998. The proportion was substantially higher among Medicaid-eligible WIC and Family Case Management participants (63 percent) than among Medicaid-eligible women who did not participate in either program (47 percent). A similar pattern was observed when the Kotelchuck index was used: 67 percent of program participants obtained an "adequate" or "adequate plus" amount of prenatal care, compared to 51 percent of non-participants.

The proportion of women who receive an "adequate" amount of prenatal care has been steadily increasing. The proportion of women who received adequate care on the Kenner index increased from nearly 71 percent in 1994 to over 74 percent in 1998, an increase of 4.8 percent. The greatest improvement was observed among African-Americans, where the proportion of women receiving an "adequate" amount of prenatal care improved 14.3 percent, from 51 percent in 1994 to 58 percent in 1998. The proportion of Hispanic women receiving an "adequate" amount of prenatal care improved by 6.6 percent, from 58 percent in 1994 to 62 percent in 1998.

Marital Status. About one third of the infants born in Illinois each year are born to unmarried women. The five year (1994 through 1998) average proportion was 33.9 percent. While the proportion declined slightly between 1994 and 1997 (from 34.3 percent to 33.4 percent), it rose to 34.1 percent in 1998.

The proportion of infants born to unmarried women varies with race, Hispanic origin, and age.

The proportion is greater among African-Americans (77.9 percent), followed by persons of Hispanic origin (39.4 percent), and European-Americans (24.1 percent). The proportion decreases steadily with age, from virtually all births to women under 18 years of age (10-14 year olds, 99.6 percent, 15-17 year olds, 92.9 percent), to 80 percent of 18-19 year olds, about half of 20-24 year olds, less than one-fourth of 25-29 year olds, and about 13 percent of 30-34 year olds.

Unmarried mothers represent more than 80 percent of those who received no prenatal care, about 65 percent of those who receive inadequate prenatal care, and nearly half of those who had a low birth weight or very low birth weight infant. More than two-thirds of unmarried mothers are over age 19; nearly three-fourths are between 18 and 29 years of age.

Prenatal Nutrition. About one fourth (24 percent) of all pregnant women in 1998 reported (through the PRAMS survey) gaining 22 pounds or less during pregnancy, while more than 70 percent reported a weight gain of 23 pounds or more. Overall, ~~only one third~~ two-thirds of women responding to the PRAMS survey indicated that they had heard or read that consuming folic acid could prevent birth defects. Knowledge was lowest among 14 to 17-year-olds (45 percent; non-Caucasians (56 percent); Hispanics (56 percent) and poor women (52 percent).

Data from the 1998 Prenatal Nutrition Surveillance System indicates that 40 percent of prenatal WIC participants gained an ideal amount of weight (defined as 25 to 35 pounds) during pregnancy. Nationwide, 39 percent of WIC participants exhibit ideal weight gain. Illinois WIC participants appear to gain more weight during pregnancy that the average WIC participant nationally: only 28 percent of Illinois participants exhibited less than ideal weight gain, compared to 34 percent of participants nationally, and 32 percent of Illinois participants gained more than the ideal amount of weight, compared to 27 percent nationally. Anemia (low hematocrit or hemoglobin) was present in 18 percent of WIC participants during pregnancy and 39 percent of women post-partum.

Inter-pregnancy interval. In 1998, 61 percent of pregnant women delivering a second or

higher-order birth had an inter-pregnancy interval of 24 months or more. Thirty percent of the women having a second or higher order birth had an interval less than 24 months, 17 percent had an interval of less than 18 months and three percent had an interval of less than 12 months. Inter-pregnancy intervals were somewhat shorter among African-American women (20 percent were less than 18 months) when compared to European-American women (16 percent less than 18 months). Inter-pregnancy intervals among Hispanic women were nearly identical to those observed among European-American women. Overall, the proportion of women with an inter-pregnancy interval of less than 18 months has been steadily declining for the last seven years, and has declined 8.3 percent in the last five years (from 12 percent in 1994 to 11 percent in 1998).

Content of prenatal care. The PRAMS survey provides additional information on the content of prenatal care and other risk-reducing actions taken by pregnant women. On sixty percent of women reported that they knew that consumption of folic acid during pregnancy helped to prevent birth defects.

More than 80 percent of women reported that a health care provider had discussed the types of medication to take during pregnancy, steps to take if labor began early, fetal growth and development, nutrition, the effects of smoking, the effects of alcohol, and the benefits of breast feeding during a prenatal care visit. Nearly ninety percent of women reported that they had been asked during their prenatal care if they were smoking, and more than 85 percent reported being asked if they were drinking alcohol.

Other risk factors were discussed less frequently by health care providers during prenatal care visits. Slightly more than 70 percent of women reported that a health care provider had discussed HIV testing, and less than half reported that a health care provider had discussed HIV prevention. Slightly more than 70 percent reported that a health care provider discussed the affects of illegal drug use on their babies. Somewhat more than three-fourths of women reported that a health care provider had discussed postpartum birth control methods. About half of the women reported that a health care provider had discussed seat belt use during

pregnancy. Only 30 percent of women reported that they had been asked if they were being physically abused by their husband or partner.

Perinatal Transmission of HIV. Overall, through the PRAMS survey, nearly three-fourths of women reported that they were tested for HIV infection during their most recent pregnancy. Those least likely to be tested were women over 35-years-of-age (36 percent were not tested); European-Americans (29 percent were not tested); non-Hispanics (27 percent were not tested) and higher-income women (33 percent were not tested). A total of 756 reports of HIV+ infants have been made to the Illinois Department of Public Health in the last 11.5 years. An unduplicated total of 228 cases of AIDS resulting from perinatal transmission of the virus have been reported to the IDPH in the last 19 years.

Prematurity. Nearly ten percent of the live births in 1998 were premature (less than 37 weeks gestation). Most (77 percent) premature births occurred in the eighth month (32 - 36 weeks). The prematurity rate among women of Hispanic origin was 8.0 percent, lower than the rate among European-American women (8.4 percent) or African-American women (14.1 percent). The proportion of premature births occurring before 32 weeks gestation was higher in African-American women (25 percent) than it was among European-American women (16.5 percent0. The proportion of African-American infants who were small for their gestational age (16.9 percent) was more than twice the proportion observed among European-American women (7.9 percent).

Other indicators of perinatal health. Based on PRAMS survey results, nearly twenty percent of women who gave birth in 1998 were hospitalized during pregnancy. Premature labor was the most frequent reason for admission (37 percent) followed by nausea or dehydration (20 percent), vaginal bleeding (15 percent), kidney or bladder infection (12 percent), hypertension (11 percent) and diabetes (4 percent). Based on vital records data, nearly 20 percent of all births in 1998 were delivered by Cesarean section. Nearly two-thirds of these were primary C-sections. The fetal death rate in 1998 was 6.8 per 1,000 live births. The maternal mortality rate was 40 per 100,000 live births, based on 73 maternal deaths occurring within three

months of giving birth. Pregnancy (International Classification of Diseases, version 9, diagnosis codes 630 through 676) was identified as the underlying cause of death in 23 cases (a rate of 12.6 per 100,000 live births) and as the contributing cause of death in 36 cases (a rate of 19.7 per 100,000 live births).

Chicago.

Fertility. The fertility rate of the population is calculated by using the 1990 census data for population estimates in non census years in the 1990s. The rates are then calculated based on the number of births to mothers in a specific age group per 1,000 population. Between 1994 and 1998 there was an overall decrease in the fertility rate for the population, but the decrease was not evenly distributed. The greatest decline was among the three youngest age categories, teens 15-19, and among the age group 20-29 years. In contrast, there was an approximate 13 percent increase in the fertility rate for women aged forty years old and over, possibly reflecting the tendency of women to either delay pregnancy or to continue childbearing for longer periods.

Among racial/ethnic groups, the fertility rate decreased for all age groups except for those over age 40 years in the Non-Hispanic (NH) Black population. Although the fertility rate among NH White females is the lowest for all racial groups, it increased slightly in 1998. The fertility rate among NH White teens aged ten to fourteen years is the lowest for any group, and has continued to decline. In contrast the fertility rate for older NH White females (40 and older) has maintained a steady upward trend during the five-year period. The fertility rate for Hispanics is the highest for all age and ethnic groups (reflecting their younger age). Here as in other groups there was a decease in the rate among the age groups fourteen through twenty years.

*Unintended Pregnancies***.** It is estimated that 60% of all pregnancies in the United States are

unintended, i.e., mistimed or unwanted altogether[7]. These include 88 % to teenagers, 40% to married women, and 75% to women age 40 and over. Unintended pregnancies may have contributed to the increase in births to women aged forty years and over mentioned it the previous paragraph. Publicly-funded family planning services prevent 1.2 million unintended pregnancies in the United States each year. In many cases, they also serve as access points for other women's health care[8]. Patterns of unintended pregnancy among inner city residents show that half of all births to poor women in the United States are unplanned, and many of America's poorest live in large US cities[9]. In 1994, the CDPH interviewed clients in several high risk communities and discovered that among adults, as many as three fourths, and among adolescents aged 13-19 years of age, 94% of infants were unwanted at the time of conception. In more recent focus groups in Chicago, women said that they believed they had little control over their pregnancies, attributing the occurrence of pregnancy to the "will of God."

Risk factors for unintended pregnancies include lack of access to acceptable methods of contraception. Failure rates for some methods of reversible contraception, failure to plan until after the fact, a belief that it is "God's will", the unavailability of emergency contraceptives and abortion, the extended periods of time during a woman's life when pregnancy can occur, and failure to use contraceptives, or to use them correctly. Some women who experience unintended pregnancies readjust their plans and accept the reality of the pregnancy, while others continue to experience financial and emotional difficulties. Women who do not want a child may delay or never receive prenatal care. The unwanted child may be at risk for child abuse and neglect. CDPH programs to link mothers to family planning programs pre and post delivery must therefore be consistently implemented and evaluated.

---

[7]SS Brown, & L. Eisenberg, L. eds. (1995). *The Best Intentions: Unintended Pregnancy and the Well-being of Children and Families.* Washington, DC:National Academy of Sciences

[8]The Alan Guttmacher Institute, 1995. Family planning services in the United States. *Facts in Brief*. New York, NY; Brown & Eisenberg, 1995).

[9](The Alan Guttmacher Institute, 1993. Pregnancy and Birth in the United States. *Facts in Brief*. New York, N.Y.)

The CDPH has been using Federal, State and City funds to implement multiple strategies (provision of family planning services, educational outreach and funding of delegate agencies) independently or in collaboration with other agencies to attempt to reduce the number unintended pregnancies in the City.

Early Initiation of Prenatal Care. Early and consistent prenatal care helps to ensure a healthy pregnancy for the mother and the birth of a healthy infant, because it allows for education of the parents to take place. Furthermore, potential problems can be diagnosed and corrected in a timely manner. During the period 1994 through 1998, the time of entry into prenatal care improved steadily for all women. In 1998, the percentage who received prenatal care during the first trimester reached the highest level since 1989 for all groups except the Puerto Ricans. The respective percentages were non-NH Whites 88.6%, NH Blacks 69.1% (the highest ever for this group), Mexicans 75.2% and Puerto Ricans 74.3%. This was a decline for the Puerto Ricans, whose rate had moved from the high of 80.7% in 1989 to 74.3% in 1998. The percentage of women who did not receive prenatal care continued to decrease, but remains a problem particularly for Blacks and Puerto Ricans. In 1997 the respective percentages were, NH Whites 1.0%, NH Blacks 5.5%, Mexicans 1.3% and Puerto Ricans 2.5%. In 1998 the percentages were NH Whites 1.4%, NH Blacks 5.1%, Mexicans 1.3% and Puerto Ricans 2.0%. The overall rate in the population for those who received no prenatal care in 1997 and 1998 were 3.1 and 3.0 respectively (CDPH, June 1999).

Adequacy of Prenatal Care. Adequacy of prenatal care is linked to the timing of initiation of prenatal care since entry in the first trimester provides the opportunity for the woman to make the recommended number of visits to the health care professional. In Chicago, the number of women receiving adequate prenatal care has been increasing, and more women are receiving care in the first trimester of pregnancy. This analysis of the adequacy of prenatal care is based on the Kessner Index. In 1998, in Chicago, 65.3 percent of all women who gave birth received adequate prenatal, 25.0 percent received intermediate, 9.7 percent received inadequate care. Of the latter, 3.0 percent received no prenatal care. NH Black women were the least likely to have received adequate care (58.8%) as compared with Hispanics (63.2%), and NH

Whites (79.8%), and the most likely to have received inadequate prenatal care (14.2%) compared to Hispanics (7.8), and NH Whites (4.1%). This was an improvement in the rate for all groups except the Puerto Ricans, whose rate for adequate care decreased from a high of 67.8% in 1989 to the current 64.2%. This was an increase over the 61% from 1997 (CDPH, June 1999).

Since 1996, the CDPH has been implementing a number of outreach programs that are designed to increase early enrollment into, and thus the receipt of adequate prenatal care among high risk women in selected communities with high infant mortality rates. The earliest of these programs was implemented in one census tract (CT) and funded through the MCH block grant. The program was evaluated in 1998. Data from the baseline period of 1990-1991 were compared with an intervention period of 1996-1997. Data were abstracted from the Illinois Department of Human Services Data Files, and analyzed separately for the City of Chicago, the CT, and the Grand Boulevard (GB) community in which the CT is located. The results indicated that the proportion of births with no prenatal care decreased 39% in the CT, 0.5% in the GB, and 11% in Chicago. Similar changes were observed for women who received late or no prenatal care (43% in the CT, 14.2% in GB, and 18.4% in the City. The proportion of low birth-weight infants decreased 34% in the CT, 13% in GB, and 1% in Chicago. The CDPH is currently implementing other programs with Community Development Block Grant Funds.

Marital Status. Between 1994 and 1998, the percentage of births to unmarried women declined slightly from 56.0% to 53.4%, and the percentage to married women increased from 44% to 46.6%. Even though their percentages declined from 68.6% to 64.5%, NH Blacks who gave birth were significantly more likely than other ethnic groups to be unmarried. The black-white ratio of births to unmarried women remained approximately 4.1:1 over the period. Not surprisingly, there were more births to unmarried older women.

Maternal Weight Gain. A woman's pre-pregnancy weight, and her weight gain during pregnancy are related to the birth weight and thus the health of the infant. Consequently, based

on the mother's pre-pregnancy weight status, the Institute of Medicine (1991) defines adequate prenatal weight gain as follows: adult women who are:

a. underweight at conception should gain a total of 28-40 lbs. during pregnancy.
b. of normal weight at conception should gain a total of 25-35 lbs. during pregnancy.
c. overweight at conception should gain a total of 15-25 lbs. during pregnancy.
d. obese at conception should gain at least 15 lbs. during pregnancy.

Assuming an ideal weight gain of twenty-five pounds, NH Black and Mexicans were more likely than NH Whites and Puerto Ricans to have gained less than twenty-five pounds during their pregnancy.

The Greater Englewood Weight Gain in Pregnancy Initiative. Because of the persistence of low-birth weight infants in the Greater Englewood Community, the CDPH has been implementing a community-wide initiative to determine if ideal maternal weight would result in improved birth weight for their infants. Data were analyzed for 4,071 women who received prenatal care at the Englewood Neighborhood Health Center. (It should be noted that the only 128 women 133 infants were assessed at the baseline). Overall, there was improvement in the weight gain statuses for women during the intervention period. Compared with baselines of 25.8%, 36.7% and 37.5% respectively, during the intervention period from 1995 through 1999, 39.5% of women gained the recommended, 25.3% less than the recommended, and 35.2% more than the recommended weight during the prenatal period. Women whose pre-pregnancy weight placed them in the underweight, overweight and obese categories were more likely than those who were of normal weight to gain appropriately during their pregnancy, possibly because they were monitored more consistently. The base line-intervention period the percentages of women who gained the recommended weights were as follows: normal women decreased from 43% to 39.6%; underweight women improved from 38% to 45%; overweight women increased from 13% to 30.3% and obese women increased from 35% to 40%.

Data for 3,403 infants were matched with information from the birth certificates, and analyzed

for 3,390 infants. At baseline 7.9% of infants were classified as low birth weight. At the end of the intervention period, 13.7% of all infants were low birth weight possible related to the 17% of all births who were premature. There was no clear indication that the mother's weight gain affected the birth weight of the infant. Indeed, the low-birth weight percentage for women who were described as being of normal pre-pregnancy weight increased from a baseline of 7.9% to an average of 12.9% during the intervention period. Similarly, the low birth weight percentages increased among women whose pre-pregnancy weight placed them in the overweight (from 6.3% to 11.8%) and obese categories (11.1% to 13.5%). The only improvement was among women classified as underweight during the pre-conceptual period. Their infant low birth weight percentage changed from 22.2% to 17.8% (possibly linked to their more appropriate weight gain). Even though their percentages increased, the percentage of low birth weight infants born to overweight women was lower than among women in the normal weight category. Again the suggestion is that perhaps the additional attention paid to the obese and underweight women made a difference.

Inter-Pregnancy Interval. A short interval between births is a strong risk factor for poor birth outcomes since the mother's body must have adequate time to recover from the previous birth. There are fluctuations in these percentages, but the trend is generally downward. As with all other indices, although they experienced the greatest overall decline, higher percentages of NH Blacks have higher rates of short inter-pregnancy intervals than other racial/ethnic groups.

Perinatal Transmission of HIV. Perinatal transmission of HIV has decreased since 1995 following the successful introduction of zidovudine to treat HIV positive pregnant women[10]. Periodic sero-prevalence rates for HIV of child bearing women were conducted by the Illinois Department of Public Health between 1990 and 1997. During the period, the average rate of positive tests was 0.29%. The range was from 0.22% to 0.41%. There were substantial increases from 0.27% in 1994 to 0.33% in 1995, and to 0.41% in 1996. In 1997 the sero-

[10](CDC Update, CDC Statement for Release Wednesday, October 14, 1998).

prevalence rate declined to 0.28%. The estimate of HIV infections among racial/ethnic groups show that in 1997, the non-Hispanic White rate was 0.05%, the non-Black rate was 0.74%, and the Hispanic rate was 0.06%. The NH Blacks rate was 15 times higher than the non-Hispanic White rate. Over an eight-year period in Chicago, 80% of the estimated number of births to HIV infected mothers occurred among NH Blacks compared to 46% of the total births. .

An important component of the effort to address the needs of HIV-positive pregnant women over the past several years has been the Maternal/Child HIV Integration Project administered by the WCHP at the CORE Center. The project which was funded through Ryan White Title IV Special Projects of National Significance (SPNS) grant involved the provision of training to health care personnel in maternity hospitals and community health centers in an effort to promote effective HIV counseling and testing and encourage HIV pregnant women to participate in prophylactic HIV therapy. The project has been successful in increasing the percentage of pregnant women who agree to HIV testing, and earlier identification of those who are infected and their participation in anti-retro viral therapy. As a result, the rate of perinatal transmission of HIV was dramatically reduced. In 1997, the program identified thirty-six HIV-positive pregnant women and enrolled thirty-four of them in prenatal care and prophylactic HIV therapy. All infants born to women participating in prophylactic therapy were free of infection.

HIV Testing of Prenatal Clients was first implemented in the CDPH clinics in 1995. HIV positive pregnant women are referred for treatment at either Cook County, the University of Chicago or University of Illinois at Chicago perinatal centers. HIV positive infants are followed when possible at the referral hospital, while HIV negative infants are referred back to CDPH. HIV testing for family planning clients was initiated in 1998.

C-Section Rates. The C-section rates in Chicago followed an erratic pattern during the period 1994-1998, moving from 17.8 percent in 1994 to 18 percent in 1995, 16.7 percent in 1996, 16,8 percent in 1997 and 17.6 percent in 1998. The Chicago rates are low possibly because

even though NH Blacks Females have the most babies, their C-section rates are the lowest for all groups.

Fetal Deaths. The highest reported number of fetal deaths (654) occurred in 1992. Since then, the number has decreased. The numbers are as follows 1993 (620), 1994 (595), 1995 (510), 1996 (468), 1997 (410) and 1998 (438). It should be noted that these are not rates, and should be correlated with the decline in actual births during the same period.

Maternal Mortality. Maternal mortality rates for all races combined decreased between 1994 and 1998. The greatest decline was for NH Blacks females for whom the rate decreased from 2.1 in 1994 to 0.8 in 1998. This was a slight increase over the 1997 rate. The rate for Hispanics fluctuated over the period, reaching zero in 1996, increasing to 1.1 in 1997 and decreasing to 0.7 in 1998 (Table 12)

Infants

Number of births. There were 182,503 live births in Illinois in 1998. Most of these infants were of European descent (76 percent) 20 percent were of African descent, and 19 percent were of Hispanic descent.

Use of health care. Health care utilization by infants as measured by the rate of participation in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, has been sustained at a high level for several years. In 1996, 93.9 percent of infants eligible for Medicaid received a least one health screening. The proportion increased to 94.5 percent in 1997 and to 95.0 percent in 1998.

Nutrition. Data from the Pediatric Nutrition Surveillance System for 1999 show that 10.1 percent of the children in Illinois' WIC program were below the fifth percentile on height-for-age, 2.2 percent were below the fifth percentile on weight-for-height. The prevalence of these two conditions was the same in 1998, while low height-for-age had improved from 10.2

percent in 1997 and 10.5 percent in 1996. Compared to children participating in WIC across the nation in 1996, Illinois had a somewhat higher prevalence low height-for-age than the nation (10.5 percent in Illinois, 7.9 percent nationally) and a somewhat lower prevalence of low weight-for-height (2.3 percent in Illinois and 2.6 percent nationally).

The Pediatric Nutrition Surveillance System also examines the prevalence of anemia among children participating in WIC. In 1999, 17.7 percent of Illinois WIC participants were below the fifth percentile for hemoglobin and 20.6 percent were below the fifth percentile for hematocrit. Both indicators have improved from 1998, when the prevalence of low hemoglobin was 19 percent and the prevalence of low hematocrit was 22.3 percent. Compared to children participating in WIC nationally, Illinois participants had a higher prevalence of low hemoglobin (20.1 percent in Illinois compared to 18.5 percent nationally) and a higher prevalence of low hematocrit (20.3 percent in Illinois and 14.3 percent nationally).

The prevalence of childhood obesity among WIC participants is also measured through the Pediatric Nutrition Surveillance System. In 1999, 12.1 percent of Illinois' WIC participants were above the 95th percentile for weight-for-height. The prevalence of childhood obesity has increased steadily since 1995, when 10.8 percent of Illinois WIC participants were above the 95th percentile. The prevalence of childhood obesity among WIC participants in 1996 was higher in Illinois (11.8 percent) than in the nation as a whole (10.2 percent).

Finally, the Pediatric Nutrition Surveillance System also collects information on the prevalence of breast feeding among WIC participants. In 1999, by eight months of age, 42.3 percent of the infants in Illinois' WIC program had been breast fed for one or more days, and 16.5 percent had been breast fed for 6 or more months.

Early Intervention. The number of children who are active in the Early Intervention system has increased from 7,723 in February 1999 to 10,840 in January 2000, an increase of 40 percent. This improvement is the result of extensive outreach efforts conducted by the early intervention service system during the last year. Active children include those who are in the

process of eligibility determination. The number of eligible children (those children who have met eligibility requirements and whose parents have agreed to participate in the EI program) in January 2000 was 8,086, or 1.48 percent of the children born in Illinois between 1996 and 1998.

Hospitalization. The Illinois Health Care Cost Containment Council reported that 177,900 infants were discharged from a hospital in 1998. (This number does not include out-of-state births to Illinois residents, includes infants born in 1997, but discharged in 1998, and excludes infants born in 1998, but discharged in 1999). Of these, 21 percent were discharged as either neonates with significant problems (DRG 390) or full term infants with major problems (DRG 389).

The average length of stay for a "normal newborn" discharge was 1.9 days in 1998 and the average hospitalization cost was $1,216. As one would expect, the length of stay and average cost increased with the complexity of the infant's condition. The longest and most expensive stays were observed for premature infants with major problems (DRG 387), for whom the average length of stay was 13 days and the average expense was $26,800 and for infants who were extremely premature or who developed respiratory distress syndrome, for whom the length of stay averaged 31 days and the average expense was $88,4000. Two thirds of the very low birth weight infants born in Illinois during 1998 were born at a Level III Perinatal Center.

Metabolic disorders. The incidence of newborn metabolic disorder for which screening is mandated has been relatively stable for the last five years. The incidence of phenylketonuria was 8.7 per 100,000 live births in 1998, in the prior four years, the rate ranged from 4.9 per 100,000 live births to 11.4 per 100,000 live births; the absolute number of cases ranged from 9 to 21. The incidence of congenital hypothyroidism was 33.1 per 100,000 live births and ranged between 39.5 and 37.5 per 100,000 live births. The absolute number of cases ranged between 61 and 72 between 1995 and 1999. The incidence rate of galactosemia was 3.8 per 100,000 in 1998, and ranged between 2.2. and 8.1 per 100,000 in the last five years. The

absolute number of cases ranged between 4 and 15 between 1995 and 1999. The incidence rate of congenital adrenal hyperplasia was 7.1 per 100,000 live births in 1998 and fell as low as 3.2 per 100,000 live births in the last five years. During this timer period, the number of new cases ranged between 6 and 13 per year. There have been no confirmed cases of biotinidase deficiency in the last five years. Finally, the incidence rate of sickle cell anemia was 73.3 per 100,000 live births in 1998. The rate ranged between 63.3 and 80.8 per 100,000 live births between 1995 and 1999, with the actual number of new cases ranged between 117 and 154 new cases per year.

Hearing loss. The Department recently replicated a 1996 hospital survey to determine the number of hospitals that were performing newborn hearing screening and to estimate the number of newborns who were being screened. The results showed that 112 hospitals, or 74 percent of the hospitals providing obstetrical services, were screening for newborn hearing loss. A total of 93 hospitals were screening universally and 19 hospitals were conducting targeted screening. These hospitals account for more than 88 percent of the state's live births.

Hearing loss that is bilateral and permanent is estimated to be present in 1.2 to 5.7 per 1000 live births.[11] Based on these estimates, approximately 500 infants with significant hearing loss can be expected to be born in Illinois annually. A 1995 study found that the average age of suspicion of hearing loss in Illinois was 12.4 months, the average age of diagnosis of hearing loss was 20.2 months, and the average age of amplification was 31.7 months.[12]

Low Birth Weight. Illinois' low birth weight rate was 7.9 percent in 1998, and has remained virtually unchanged for the last five years. The rate was 8.0 percent in 1994, 7.9 percent in 1995, 7.8 percent in 1996 and 7.9 percent in 1997 and 1998.

---

[11]Northern JL, Hays, DH. 1994. Universal screening for infant hearing impairment: Necessary, beneficial and justifiable. Audiology Today. 6:10-13

[12]Kittrel, AP, and ARjmand, EM. 1996. The Age of Diagnosis of Sensorineural Hearing Impairment in Children. Presented at the 11th Annual Meeting of the American Society of Pediatric Otolaryngolgy, Orlando Florida, May 8, 1996.

The low birth weight rate among infants born during 1988 to women who were eligible for Medicaid was 10.2 percent. The effect of participation in the WIC and Family Case Management programs is illustrated by its effect on low birth weight. The low birth weight rate among program participants was 8.8 percent in 1998, 11 percent higher than the low birth weight rate for the entire population. The low birth weight rate in 1988 among the infants born to Medicaid-eligible women who did not participate in either program was 14 percent, 59 percent higher than the rate among program participants and 77 percent higher that the rate for the entire population.

Low Birth Weight and Multiple Births. Examination of singleton and multiple births for the whole population and by race shows that the state's low birth weight rate has remained level in recent years due to two offsetting trends. The number of multiple births has increased by 11 percent since 1994, at the same time that the number of births has declined by 3.5 percent. The increase in multiple births has occured only among Caucasians, among whom the number of multiple births has increased by 18 percent since 1994. Among African-American women, who are over-represented among the pregnant women served by major public health programs, the number of live births has decreased by 13 percent, and the number of multiple births has decreased by nine percent, since 1994.

These patterns are reflected in the state's low birth weight rate. The overall low birth weight rate varied between 7.9 percent adn 8.0 percent from 1994 through 1998. The low birth weight rate among African-American singleton infants decreased by 5.3 percent, while the rate among Caucasian singletons remained unchanged. Further, the low birth weight rate among African-American multiple births decreased by four percent, and the very low birth weight rate decreased by eight percent, between 1995 and 1998. At the same time, the low birth weight rate among white multiple births increased by 2.5 percent. These trends are reflected in the proportion of low birth weight infants that occur in each race and pregnancy group. In 1994, 43 percent of low birth weight infants were singleton deliveries to Caucasian mothers, 38 percent were singleton deliveries to non-Caucasian mothers, and 13 percent were multiple deliveries to Caucasian mothers. By 1998, the proportion of low birth weight due to non-

Caucasian singleton deliveries had decreased to 33 percent (1 13 percent drop), the proportion due to Caucasian multiple deliveries had increased to 18 percent (a 33 percent increase), and the proportion due to Caucasian singleton deliveries had increased to 44 percent (a three percent increase). The number of triplet and higher plural births has been steadily increasing in Illinois, rising from 107.9 per 100,000 live births in 1990 to 265.5 per 100,000 live births in 1998, a 143 percent increase in nine years. The IDPH Center for Health Statistics recently estimated that if the rate of plural birth had remained at its 1980 rate (two percent), Illinois' infant mortality rate in 1997 would have been 7.7 per 1,000 live births[13]. While the Department's efforts to reduce low birth weight and infant mortality have been effective, especially with African-American women, the increase in multiple births to Caucasian mothers, which may represent the use of fertility treatments, has offset this improvement and kept the overall low birth weight rate nearly unchanged.

Early Childhood Caries. The IDPH Division of Oral Health is currently using prevalence data of severe early childhood caries (formerly baby bottle tooth decay BBTD) collected in three studies conducted in 1992 and1994. The first and second determined 17 and 15 percent prevalence of BBTD respectively experienced by Head Start children statewide. The third found 11 percent in Chicago metropolitan area daycare sites.

Congenital Anomalies. The Illinois Department of Public Health's Adverse Pregnancy Outcome Reporting System collects information on a variety of congenital anomalies. There were ninety-one cases of neural tube defects (4.98 per 10,000 live births). The reported incidence of prenatal substance exposure was 8.8 per 1,000. The case definition includes newborns with a positive urine toxicology for any drug, as well as newborns that show signs of drug toxicity or withdrawal. There were 369 cases of selected anomalies that are associated with mental retardation, an incidence rate of 20.2 per 10,000 live births. The case definition includes Down Syndrome, Trisomy 13 (Patua syndrome), and Trismomy 18 (Edwards

[13]Illinois Center for Health Statistics. 2000. Characteristics of Plural Births in Illinois. *Vital Statistics Basic Research Series*. Vol. 3, No. 4, April 2000. Springfield, Illinois: Illinois Department of Public Health

syndrome) (ICD - 9 - CM codes 758.0, 758.1, and 758.2, respectively).

Mortality. There were 1,505 infant deaths in Illinois during 1998, resulting in an infant mortality rate of 8.2 per 1,000 live births. The steady decline in infant mortality has recently leveled off. The 1998 was unchanged from 1997. The 1997 rate was two percent lower than the 1996 rate of 8.4 per 1,000 live births. The 1996 rate, in turn, was nearly 10 percent lower than the 1995 rate of 9.3 per 1,000 live births.

The infant mortality rate among African-Americans is consistently more than two and a half times greater than the rate among European-American infants. The disparity in 1994 and 1998 was 2.7:1. The disparity decreased to 2.5:1 in 1995, rose to 2.8:1 in 1996, and decreased to 2.7:1 in 1997.

The infant mortality rate among Medicaid-eligible infants was 9.4 per 1,000 in 1998. This rate is significant influenced by the Family Case Management and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) programs. The infant mortality rate among infants whose mothers participated in both programs was 7.1 per 1,000 in 1998 (less than the rate for the entire population) and was 15.8 per 1,000 live births among women who participated in neither program. Most (81 percent) Medicaid-eligible pregnant women participated in either or both the Family Case Management and WIC programs in 1998.

The perinatal mortality rate decreased steadily between 1994 and 1997, declining from 13.5 per 1,000 live births and fetal deaths in 1994 to 11.9 per 1,000 events in 1997. The rate rose slightly in 1998 to 12.2 per 1,000 events.

Illinois' neonatal mortality rate has been level at 5.4 per 1,000 live births in 1996, 1997, and 1998. The rate was somewhat higher in 1995 (6.2 per 1,000 live births). The rate was slightly higher than the 1994 rate of 5.8 per 1,000 live births. The leading causes of neonatal death were disorders relating to short gestation and unspecified low birth weight (ICD-9-CM Code 765), 24 percent of neonatal deaths) congenital anomalies (ICD-9-CM codes 740-759, 21

percent of neonatal deaths) respiratory conditions of the newborn (ICD-9-CM codes 768-770), 15 percent of neonatal deaths) and maternal complications of pregnancy (ICD-9-CM code 761), 13 percent of neonatal deaths).

The neonatal mortality rate is strongly influenced by the sophistication of perinatal care available in the hospital (where the infant was born). The neonatal mortality rate among very low birth weight infants (500 through 1,499 grams) was 300.0 per 1,000 in Level One (least sophisticated) hospitals, 240.1 per 1,000 in Level II hospitals, 186.6 per 1,000 in Level II+ hospitals, and 128.4 per 1,000 in Level III hospitals.

Illinois postneonatal mortality rate has decreased steadily since 1994 when the rate was 3.3 per 1,000 live births. The rate decreased to 3.1 per 1,000 live births in 1995, decreased again to 3.0 per 1,000 live births in 1996, decreased again in 1997, reaching 2.8 per 1,000 live births and remained at that level in 1998. The leading causes of postneonatal mortality were Sudden Infant Death Syndrome (27 percent of post-neonatal deaths) and congenital anomalies (ICD-9-CM codes 740 through 759, 20 percent of post-neonatal deaths).

The mortality rate due to Sudden Infant Death Syndrome has been declining since 1994, when the rate was 1.3 per 1,000 live births. The rate increased to 2.09 per 1,000 live births in 1995, then decreased to 0.95 per 1,000 live births in 1996, 0.88 per 1,000 live births in 1997, and 0.82 per 1,000 live births in 1998. The number of infant deaths due to SIDS has decreased from 250 in 1994 to 151 in 1998. Data from the 1998 PRAMS survey found that 54 percent of mothers lay their infants down to sleep on their backs most of the time, 31 percent lay their infants down to sleep on their sides most of the time, and 15 percent lay their infants down to sleep on their stomachs most of the time.

IPLAN Results. Thirteen local health departments selected infant mortality as a community health priority. Their intervention strategies feel into six broad categories: smoking cessation; substance abuse; improving utilization of WIC, Family Case Management and prenatal care;

enhancing the quality of WIC and Family case Management services; injury prevention; and pregnancy prevention. Six local health departments selected one or more interventions to address smoking during pregnancy. specific intervention strategies included the development of smoking cessation programs for pregnant women or referrals to established programs in the community (6 agencies); providing prenatal health educationon the hazards of smoking (4 agencies); and community health education, school health education, and second-hand smoke exposure programs. Three local health departments targeted treatment of prenatal substance abuse as a strategy for reducing infant mortality. Their specific intervention strategies included screening WIC and Family Case Management participants for alcohol or substance abuse, with appropriate referral (all three agencies); providing more intensive (frequent) services through Family Case Management; conducting community health education on the effects of substance abuse in pregnancy; providing information to clients and health care providers about substance abuse treatment services in the community; and working to increase the number of pregnant, substance abusing women who are referred to the WIC and Family Case Management programs by other community agencies.

Several local health departments proposed strategies to improve utilization of WIC, Family Case Management, and prenatal care. These strategies included: providing community health education on the importance of early prenatal care, working with community providers to increase referrals to the WIC and Fmaily Case Management programs, decreasing transportation barriers, and promoting enrollment in KidCare.

The enhancements to WIC and Family Case Management proposed by several health departments included integrating the delivery of these two programs with other MCH services; enhancing the prenatal education and health promotion education provided to program participants; providing additional nutrition education (both pre-conceptionally and prenatally); and promoting the regular use of oral health care.

Several local health department proposed intervention to reduce infant deaths that were the result of injury. The strategies included community health education on injury prevention as

well as domestic violence; teaching non-violent conflict resolution in schools; and screening WIC and Family Case Management clients for domestic violence.

The reproductive health education intervention proposed by several local health departments to reduce infant mortality included community health education, abstinence education, and presenting pregnancy prevention curricula in public schools.

Chicago.

The number of births to women in Chicago has been declining over the years, with 5,942 or 10% fewer births in 1998 than in 1994. In 1998, there were approximately 51,382 live births in Chicago. This was an increase of 265 births from the previous year. Slightly more than 41.4% or 21,249 of these births were to NH Blacks, 34.0% or 17,480 were to Hispanics, 20.45 or 10,512 were to NH Whites. The remaining 4.2 or 2,137 infants were born to women with race/ethnicity defined as non-Hispanic other. Within the Hispanic group, Mexican births accounted for 77.7% or 13,720, Puerto Ricans for 12.9% or 2,215, and other Hispanic groups for the remaining 9.3 or 1,549 births. This was the lowest number of births to NH Blacks and Puerto Ricans since 1989. Births to NH Whites and Mexicans increased over their 1997 numbers.

The number and percentage of births decreased among the under 20 age group by 1,542 or 14.2 %, and among those aged 20-34 by 4,542 or 11.0%. Births fluctuated among those aged thirty-four years and older, but overall they increased during the period 1994-1998 by 2.5%. Among non-Hispanic Whites, births decreased for the age groups 10-34 years, but increased slightly for women more than thirty-four years of age. Births decreased in all age categories among NH Blacks, although, in absolute numbers, this group still had the highest total number of births in any group. In contrast, Hispanics had the highest birth rates. Among Mexican American women, births decreased in the age group under twenty years, but increased in the age group twenty years and older. Births also decreased among Puerto Rican women aged thirty-four years and under, but increased slightly in those over age thirty-four years. Among the non-Hispanic Other women births increased in those under age twenty and

among those over age thirty-four, but decreased in those aged twenty to age thirty-four years of age.

Low Birth-Weight. Low birth weight (less than 5.5 pounds at birth) is a major contributing factor to infant mortality in Chicago. Overall, the percentage of these babies born in Chicago has remained at or above 10.1% since 1980, reaching an all time high of 11.2% in 1993. The percentages have varied very little over time among the racial/ethnic groups. The rate for NH Blacks has ranged from 16.1 to 15.0 %, for NH Whites 6.6 to 7.5%, and for Hispanics 6.2 to 6.9%. In Chicago African American babies are thus more than twice as likely as those of other racial ethnic groups to be born weighing less than 5.5 pounds.

Low birth weight babies are, proportionately, more prevalent among multiple than among singleton births. Within the group with multiple births, more than 60% of infants were low birth weight, compared with an average of 9% for singleton births.

Birth Weight Distribution. Very low birth weight babies are the most fragile and therefore the most likely to die in the neonatal period. However, many of them are being kept alive with medical technology. It is usual for those who survive to have a variety of health problems. During the period 1994 to 1995, the percentage of very low birth weight singletons remained fairly constant between 1.71% and 1.79% (average 1.75%) of all singleton births. In contrast, among multiple births, the percentage of very low birth weight ranged from 13.3% to 16.3% with an average of 14.8%. Between 1994 and 1998, the percentage of infants with very low birth weights was highest among NH Blacks, and Puerto Ricans.

Low birth weight is associated with pre-term labor (less than 37 completed weeks of gestation), and with intra-uterine growth retardation. The majority of LBW babies in Chicago are associated with pre-term births. In 1998 in Chicago, the percentage of pre-term births (gestational age < 37 completed weeks) by race and ethnicity was 19.4% for NH Black, 10.5% for NH Whites and 12.3% for Hispanics. The percentage within the Hispanic group was 11.7 for Mexican Americans, and 15.2 for Puerto Rican Americans (CDPH August 12,

1999). The rates had decreased slightly for all groups except the Mexicans. The largest percentage decrease was among the Puerto Ricans, whose rate had moved from 17.1% in 1997.

Maternal smoking is associated with low birth weight, sudden infant death syndrome, placenta previa, premature rupture of the membranes, bleeding during pregnancy and spontaneous abortion. Regardless of race or ethnicity, the proportion of low birth weight infants born to mothers who smoked was consistently higher (approximately double) than for those who did not smoke.

.

Reports of cigarette smoking during the prenatal period are under reported. Nevertheless, the prevalence of cigarette smoking has continued to decrease for all races in Chicago from the high levels noted in 1989. In 1998, 8.8% of women reported that they smoked during pregnancy, in contrast to 15.6% who had admitted to this habit in 1989. Within the racial groups the 1998 percentages were 15.1 for NH Blacks, 8.3 for NH Whites, 1.2 for Mexicans, and 7.8 for Puerto Ricans. These reflected small decreases for all groups except the Mexicans. Further decreases should contribute to the reduction in low birth weight infants, with the resultant decrease in mortality and morbidity. Unfortunately this trend may be in danger of being reversed because of the noted increase in cigarette smoking among young women in Chicago.

Breast Feeding at Hospital Discharge. Breast-fed infants are generally healthier than those who are fed exclusively on formula. Regardless of socio-economic levels, the amount of breast feeding is important in protecting infants, especially those who are firstborn from illness. The incidence and duration of breast feeding have remained low at CDPH WIC sites. Two goals of Healthy People 2000, National Health Promotion and Disease Prevention Objectives are that at least 75% of mothers should breast-feed their babies in the early postpartum period, and that at least 50% of mothers should continue breast-feeding until their babies are five to six months of age. According to the CDPH Breast-feeding Tracking Report for the two year period 1998 and 1999, 3,835 (25.6%) of infants enrolled in WIC were being

breast-fed on hospital discharge.

Many women begin to breast-feed their infants but have difficulty continuing this practice at four to six months. The reasons women have given for discontinuing the practice included inadequate supply of milk, choice, concerns about contraception, return to work/school, infants weaned themselves from the breast, infant illness, and mothers' sore nipples. Some women know the advantages of breast feeding their infants, but choose not to do so. Some reasons for the reluctance include a feeling that their food habits were bad for their infants, belief that it would be painful, the possibility of failure, embarrassment, reluctance to be tied down, problems breast-feeding another child, and not knowing anyone who had ever breast-fed. The CDPH is actively promoting breast feeding by training outreach workers to provide support to mothers during home visits.

Congenital Anomalies. The CDPH is charged with the responsibility for monitoring the approximately 5,000 mothers and infants who are referred from local hospitals. During the period 1996-1999 the CDPH received 14,007 high risk infants and mothers from the five perinatal centers in Chicago. About 51% of them (7,186) were infants. In keeping with the trend for all births, the number of referrals has continued to decline since 1996. The highest number referrals are from the Cook County Hospital, although the number from the University of Illinois at Chicago Hospital had nearly doubled in 1999 (from 260 to 300) while those in from Cook County Hospital had decreased from 2,077 to 1,410. The perinatal centers referred 1,702 very low birth weight infants to CDPH between July 1997 and December 1999. One hundred and ninety-one deaths (11%) were reported among these infants.

The rates of neural tube defects per 10,000 among Chicago's infants have fluctuated during the period 1994-1998. The lowest rate was 2.3 in 1991. Among racial ethnic groups, NH Black infants had the lowest rates of neural tube defects. Neural tube defects are linked with a deficiency of folic acid in the diet. The CDPH has recently included the prescribing of folic acid to all women of child bearing age who use the clinics.

The Department of Children and Family Services (DCFS) and CDPH collaboration to monitor substance exposed infants' program started in October 1997. By December 1998, 704 infants had been referred to CDPH either by the DCFS gatekeeper nurse, or by the DCFS Child Protection Investigator. The City of Chicago bears the greatest burden with respect to women who abuse substances and the sequelae for the infant. Between the fourth quarter of FY 1996 and the third quarter of FY 1997, 1,848 infants in Illinois were born with positive toxicologies. Of these, 68.6% or 1,268 infants were born in Chicago. Thirty percent of these infants (554) were born low birth weight and 8.1% (150) were very low birth weight.

Of the 1,117 infants born addicted to cocaine, 754 or 67.5% were from Chicago. Eighty three percent (83.0%) or 927 infants were Black, 172 or 15.4 were White, and 18 or 1.6% were of unknown race/ethnicity. Sixty-one or 5.5% of infants were Hispanic. The low and very low birth weight percentages among the infants were 31.4% and 8.1% respectively.

Mortality. The infant mortality rate (IMR) in Chicago has continued to decrease during the five-year period. In Chicago, infant mortality rates vary considerably within community areas. Between 1995 and 1997, fifteen community areas had infant mortality rates significantly lower than the rest of the Chicago, seventeen had rates significantly higher than the rest of Chicago, and forty-five had rates not significantly different from the rest of Chicago. The seventeen community areas with the highest infant mortality rates (range 16.6-29.2) are located in the City's west and south sides, all predominantly low socioeconomic NH Blacks communities (CDPH, Infant Mortality in Chicago 1997, April 1999).

In 1997, the IMR was at its lowest level since 1960, and with a rate of 10.8, continued the decline from the 1995 rate of 12.6 per 1,000 live births. The 1997 rate was maintained in 1998. In 1998, the IMR decreased for NH Black, but it still continued to be higher than for all other racial/ethnic groups in Chicago. With an IMR of 16.4 (a slight increase over the 1997 rate of 16.2) compared to a non-Hispanic White rate of 6.7 (an increase from 6.2 in 1996) and a Hispanic rate of 6.9, NH Blacks babies were more likely than other infants to die. Between 1995 and 1998, the IMR increased for Puerto Ricans from 7.3 to 9.0.

Between 1995 and 1998, the African-American:Caucasian ratio for infant deaths remained steady, ranging from 3.3:1 in 1994 to a low of 2.5:1 in 1998. African American infants were therefore three to five times more likely than Caucasian infants to die before their first birthday.

About two-thirds of all infant deaths occur in the neonatal period. Together, congenital anomalies, short gestation and other unspecified low birth weight account for the majority of deaths. Since NH Blacks have the highest rates of low birth weight infants, and since many of these infants die, it is clear why their infant mortality rates remain higher than those for other racial/ethnic groups.

In 1998, as in previous years, the majority of infants who died in Chicago did so in the neonatal period. The NMR for all races maintained its downward trend from a high of 13.2 in 1980 to 6. 3 in 1998. This is the second time this rate was achieved, the first being in 1996. As with all other measures, during the period, the NH Blacks rate surpassed that of all other racial/ethnic groups, for example, the Black: White ratio ranged from 2.9 in 1994 to 1.7 in 1997. The ratio was 2.0 in 1998.

About one-third of all infant deaths occur in the postneonatal period. The leading causes of death are sudden infant death syndrome (SIDS), congenital anomalies, and other unspecified causes. Again, the larger number of SIDS deaths among NH Blacks contributed to their higher postneonatal mortality rates.

During the period 1994 through 1998, the postneonatal mortality rate for all races/ethnic groups declined from a high of 4.9 to 4.5. The lowest rate ever achieved was 3.9 in 1997. As with other indices, in 1998, the NH Blacks babies fared worse than those of other groups in the City. The PNMR was 7.6 (the lowest rate recorded since 1980 was 6.5 in 1997) for NH Black; 2.2 (an increase from 1.9 in 1997) for non-Hispanic Whites, and 2.4 for Hispanics (slightly up from 2.2 in 1997). Within the Hispanic group in 1998, the rate was 2.2 for Mexicans, and 4.1 for Puerto Ricans (15).

The total SIDS death rate in Chicago declined during the period 1994 through 1998. However, the NH Blacks rate remained higher than for all other racial/ethnic groups combined. The Black: White ratio for SIDS deaths between 1994 and 1998 varied from 2.4 in 1995 to 6.2 in 1996. The ratio was 4.3 in 1998. The CDPH has initiated an SIDS prevention educational program targeting NH Black. The goal is to eliminate SIDS as a cause of death among NH Blacks infants.

The number of deaths due to congenital anomalies decreased 33% from 158 in 1994 to 106 in 1998. Most of the change occurred in the neonatal period.

Children.

There were an estimated 715,000 children between ages one and four and an estimated 914,000 children between the ages of five and nine in Illinois 1n 1998.

Lead Poisoning. More than 238,000 children under age six were tested for lead poisoning in 1999. Nearly 26,400 were found to have blood lead levels between 10 and 14 ：g/dl; nearly 9,400 were found to have blood lead levels between 15 and 24 ：g/dl; nearly 2,200 were found to have blood lead levels between 25 and 44 ：g/dl; and 230 children had blood lead levels of 45 ：g/dl or more. Overall, 16 percent of the children tested were found to have elevated blood lead levels. There has been a significant reduction in the last four years in the number of children who have been found to have elevated blood lead levels. An average of 238,291 children were screened each year between 1996 and 1999. The proportion of children found to have an elevated blood lead level in 1996 was 31 percent. The proportion of children found with an elevated blood lead level has declined by 48 percent since 1996. IDPH will be undertaking an extensive analysis of childhood lead poisoning screening data in 2000 to ascertain if this change is the result of a change in screening practices or a real reduction in the prevalence of lead poisoning.

Health Care Utilization is much lower among Medicaid-eligible children between the ages of

one and five years. The EPSDT participation rate for children in this age group was 57 percent in FFY 1998, and has been steadily declining for the last three years (the participation rate was 58 percent in FFY 1997 and 60 percent in FFY 1996).

Hospitalization The five leading hospital discharge diagnoses in 1998 for children between age one and four years were: bronchitis and asthma (DRG 098, 620.1 per 100,000 children), pneumonia and pleurisy (DRG 091, 573.1 per 100,000 children), esophagitis, gastroenteritis and miscellaneous digestive disorders (DRG 184, 287.0 per 100,000 children), nutritional and miscellaneous metabolic disorders (DRG 298, 200.8 per 100,000 children) and seizure and headaches (DRG 026, 152.2 per 100,000 children). Bronchitis and asthma and pneumonia and pleurisy have been the first and second leading hospital discharge diagnoses, respectively, in this age group for the last five years (1994 through 1998), and neither rate has shown any consistent trend during this time period.

A similar pattern was observed among children between five and nine years of age. The five leading hospital discharge diagnoses were: bronchitis and asthma (220.9 per 100,000 children), pneumonia and pleurisy (174.4 per 100,000 children), esophagitis, gastroenteritis and miscellaneous digestive disorders (104.0 per 100,000 children), psychoses (DRG 430, 63.2 per 100,000 children) and childhood mental disorders (DRG 431, 63.0 per 100,000 children). The three leading hospital discharge diagnoses were the same for children in each age group, but the rates were much lower in the older age group: the rate for bronchitis and asthma was 64 percent lower, the rate for pneumonia and pleurisy was 69 percent lower and the rate for esophagitis, gastroenteritis and miscellaneous digestive disorders was 64 percent lower than the corresponding rates among 1 to 4-year-olds. Mental disorders emerged as the fourth and fifth leading causes in 5 to 9-year olds; these will be among the leading diagnoses among adolescents, as will be presented below. Nutritional and metabolic disorders were the next most frequent group of discharge diagnoses in each age group. The overall hospital discharge rate in this population was 1,687.3 per 100,000 children.

Seven local health departments identified asthma or respiratory problems as a community

health priority. Five agencies planned to offer asthma self-management programs. Two local health departments proposed community health education programs. Other health departments proposed activities with school nurses, ensuring that persons with asthma have access to primary care, working for the passage of a state statute to ban smoking in the work place and continuing education programs for school faculty, staff and health care providers.

Abuse and Neglect. The rate of child abuse and neglect declined to 10.4 per 1,000 children under 20 years of age in 1998, a 28 percent decline from the 1994 rate of 14.5 per 1,000 children. The rate has declined steadily from the 1995 rate of 15.4 per 1,000 children.

Twenty-three local health departments selected a community health priority related to violence. Sixteen agencies identified child abuse and neglect, nine selected intimate partner violence and six selected community or family violence, alone or in combination. A wide variety of interventions were proposed. To address child abuse and neglect, nine agencies proposed parenting education or support groups (including parents of CSHCN); six proposed to improve service coordination among community agencies; six proposed community health education programs, five proposed training service providers on screening, reporting or parent counseling; four agencies proposed the use of home visiting (all four were HFI program grantees), and three proposed school-based interventions. To address intimate partner violence, nine agencies proposed the development of direct service interventions (including victim support groups, abuser treatment services, peer educators, hiring a domestic violence advocate and the development of services for child victims); eight agencies proposed activities to increase screening and referral; four proposed community health education programs and one proposed the establishment of a domestic violence court. To address community violence, five agencies proposed school-based interventions (such as conflict resolution training), two proposed work site training programs, two proposed the adoption of local ordinances restricting sale or use of firearms; one proposed the adoption of an ordinance further restricting access to alcoholic beverages and one proposed a community health education program.

HIV Infection. There are about thirty cases of HIV infection reported each year among

children under age five, an incidence rate of 4.1 per 100,000 children. Fewer than ten new cases of HIV infection are reported among 5-12-year-olds each year.

Mortality. The mortality rate among children who were one through four years of age was 31.0 per 100,000 children in 1998. The mortality rate among African American children in this age group (57.8 per 100,000) was 2.5 times higher than the rate among European-American children (23.1 per 100,000) children. The mortality rate among children of Hispanic origin was less than one fifth of the rate among European-American children.

Unintentional injuries were the leading cause of death among children between one and four-years-of-age, with a rate of 8.95 per 100,000 children. This rate may be divided into motor vehicle accidents (2.94 per 100,000 children) and all other unintentional injuries (6.01 per 100,000 children). The overall rate of unintentional injury has fallen 47 percent in the last five years, decreasing consistently from 16.7 per 100,000 in 1994. The rate of motor vehicle-related deaths has not followed a consistent pattern over the last five years, although it is 26 percent lower than the 1994 rate of 3.95 per 100,000 children. The mortality rate due to all other unintentional injuries has steadily declined over the last five years, falling 56 percent from the 1994 rate of 12.8 per 100,000 children.

The mortality rate for the next leading cause of death among one to four year olds, congenital anomalies, has been relatively stable since 1994, averaging 31 deaths per year, a rate of 4.2 per 100,000 children in 1998 and 4.6 per 100,000 children in 1994. The third, fourth and fifth leading causes of death were heart disease, malignant neoplasms and homicide (5 year average of 16 to 22 deaths per year each).

Children 5-9 – The 1998 mortality rate among children five through nine years of age was 16.3 per 100,000; nearly fifty percent lower than the rate among one-to-four-year-olds. A racial disparity in the mortality rate was observed among this age group as well; however, the disparity in this age group (1.8:1) was not as large as the disparity observed among one-to-four-year olds (2.5:1). The mortality rate among African-American children in this age group

was 62 percent lower than the rate among one to four year old African American children . There were not enough deaths among children of Hispanic origin in 1998 to allow the calculation of precise or reliable rates.

Unintentional injuries were the only significant single cause of death among five to nine-year-olds between in 1998, with a mortality rate of 5.5 per 100,000 children. Deaths due to motor vehicle accidents, at 3.0 per 100,000 children, made up slightly more than half of this rate, with the remainder due to all other unintentional injuries at a rate of 2.5 per 100,000. The overall death rate due to unintentional injuries has steadily declined since 1994, falling 45 percent from the 1994 rate of 9.9 per 100,000 children. There were too few deaths due to any other single cause among five to nine-year-olds in 1998 to allow for the calculation of reliable or precise rates.

Chicago.

Immunization. The rate of immunization in Chicago for children by age 2 years has improved since the measles epidemics in 1989 and 1990, but overall, they are still below the national goal of 90 percent. The highest immunization levels for all vaccines were achieved in 1996. Since then, the levels have been fluctuating. The immunization levels are unevenly distributed within communities and among ethnic/racial groups, with NH Black children, especially those in public housing, least likely to be immunized. The CDPH strategies to improve immunization in these populations include fostering immunization/WIC linkages, providing outreach services to identify children in need of immunization, implementing fast track immunization services in clinics with low rates, instituting reminder recall systems and better monitoring of our own clinics to reduce the number of missed opportunities for immunization. The CDPH has also partnered with the University of Chicago's Pediatric Immunization Program to conduct additional outreach activities.

Obesity and other Nutrition Problems. During the period 1994-1998 the number of children aged 0-5 years enrolled in the CDPH WIC sites decreased. By 1997, the number had decreased by approximately 34% from 490,858 in 1995 to 323,945 in 1998. In 1999 the

numbers had again increased by 17% to 392,415. The WIC population of children consists predominantly of NH Blacks (49.43%) and Hispanic children (37.39%). Not quite explainable in the data is the dramatic increase in children classified as other in 1996 and 1997, with an equally sharp decline in 1998. This increase may have been linked to the simultaneous decrease in the number of children classified as Hispanic, an observation strengthened by the fact that both numbers moved in opposite directions in 1998. The explanation may have been linked to the Hispanic population's uncertainties about their eligibility for WIC as a result of their immigration status. The numbers for NH Blacks also decreased in 1998. During this period they were possibly influenced by the political and socio-economic environment emphasizing Welfare to Work programs.

With the exception of its WIC population, the CDPH has limited information on the infant nutrition practices among the population in Chicago. The CDC summarizes information on the WIC population and provides reports on the nutritional indicators of underweight, short stature, birth weight and hemoglobin/hematocrit values. The CDC Pediatric Nutrition Surveillance provides information on the nutritional status of infants and children who are enrolled in the WIC sites at the CDPH. The status of infants and children who were examined in 1994, 1998 and 1999 are as follows:

- Obesity: In 1994, 1998 and 1999 children enrolled in the WIC program at the CDPH sites were examined for the prevalence of obesity. For each year, approximately thirteen (13.17) percent of them were identified as being above the 95th percentile in weight for height. Excess weight for height (obesity) therefore continues to be a problem for many children in the WIC program.
- Underweight: Low weight for height (weight for height below the 5th percentile) was present in 3.67% of the children who were examined.
- Low Birth Weight: Seventy thousand, one hundred and eighteen (70,118) infants enrolled at CDPH WIC sites were examined for low birth weight. Of the group, 12.0% were found to meet the criteria. This percentage was higher than the 10.5% reported for the State.
- Short Stature: In 1994, 1998 and 1999, one hundred and fifty-eight thousand, three hundred and sixty-four (158,364) or 12.9 percent of pediatric clients were examined for

the prevalence of short stature (height for age below the 5th percentile). Of the infants and children examined, 12.9% were of short stature.

- Anemia: Hemoglobin and hematocrit values below the 5th percentile for age are prevalent among the pediatric WIC population. Ninety-three thousand, and ninety-nine (93, 099) were examined for the hemoglobin values, and 35,344 for hematocrit values. Of these children, 21.7% had low hemoglobin values, and 22.91 had low hematocrit values.

- Normal Growth: It is assumed that 83.16 % of children enrolled in the CDPH WIC sites had normal weight/height ratios.

Lead Poisoning. Chicago has one of the highest rates of lead poisoning in the country. Each year, over 20,000 children aged six years and younger are identified as being lead poisoned. In 1996 and 1997, 27% of the children screened had blood lead levels (BLL) of 10ug/dL and higher.

These numbers are of great concern since blood lead screening rates continue to be low. In 1998, only 31% (91,621) of the 296.742 children aged 6 and younger residing in Chicago (according to the 1990 census) were screened. There are no significant differences in screening rates or elevated rates by gender. Both boys and girls are screened at a rate consistent with the census. On average, nearly 5,000 children aged 24 months and younger have elevated blood lead levels, representing 21% of all EBL children. Given that the screening rates for young children are among the lowest (26% or 25444/96089), clearly this high-risk population of infants must be addressed. Clearly screening is insufficient among all children, but is particularly skewed in certain racial/ethnic groups as only 8% of all children screened are non-Hispanic white.

Race/ethnicity data does show increased rates of elevation among NH Blacks. Also, of significance is the lack of congruency between screening rates and representation in Chicago's population. In 1998, 45% of all children tested were NH Blacks (which is higher that the population proportion), 30% were Hispanic (again, this higher than the population proportion)

and only 5% were non-Hispanic white (which is significantly less than expected based on the population proportion). Considering that 59% of Chicago's housing stock was built prior to 1950 and that 28% of the total housing stock built prior to 1978 is in substandard condition, the extremely high rate of elevated BLLs Chicago is experiencing is not surprising.

Abuse and Neglect. The number of reports of child abuse and neglect is typically well below the actual occurrence. In 1993, the Department of Children and Family Services (DCFS) for Illinois received 75,000 notifications of suspected child abuse. Of these, 34,900 (46.5%) cases were in Cook County. Approximately thirty-six percent (35.7%) or 12,481 of the Cook County cases were subsequently confirmed as child abuse victims (McDonald, 1993). In Chicago, the incidence of child abuse varies by community area. Neglect is more prevalent in areas of high poverty.

Between 1995 and 1998, there were fewer hotline calls to DCFS of child abuse (42.4 vs. 35.9 per thousand). Similarly, the number of substantiated cases of abuse had declined (1995, 37%, 1998 31.8%). A number of reforms have been passed since 1995 that have allowed the DCFS to take more effective action to provide safety, security and permanency for the children. The reforms are coupled with performance standards that allow children to be cared for in the home of a relative; protocols to assess the level of care truly needed by a child; more careful assessment prior to placement in residential homes or outside of the state or community; subsidized guardianship, and a speedier process at terminating parental rights to allow for adoption of children. These reforms have resulted in the speedier movement of children into permanent settings, a 93% increase in adoptions in 1998 over 1997 and an 80% reduction in children placed outside Illinois since 1995.

Asthma. Asthma is the leading cause of chronic illness in childhood, and the incidence is increasing. In Chicago, in descending order of frequency, asthma is most prevalent in Puerto Ricans, NH Black, Cubans, NH Whites and Mexicans. Between January and April 1997, reported asthma cases at CDPH clinics were in order of frequency 198 in Uptown, 164 in Grand Boulevard, 122 in Roseland, and 108 in West Town. The average annual mortality

rates per 1,000,000 for children aged 0-4 years was 4.6 and for those age 5-14 years were 7.0. Factors contributing to the occurrence of asthma include heredity, viral respiratory infections in the first year of life, exposure to chemicals in the work place, dust mites, roaches pets and tobacco smoke. Children in low income housing are especially vulnerable because of the presence of dust mites, roaches and tobacco smoke. Asthma is particularly poorly controlled among children in low-income families, a responsibility shared by clients and health care professionals. Because the illness is not well understood, clients may fail to recognize early symptoms of an attack, or the factors that trigger an attack. In fact, because of asthma's variability, triggers may be hard to identify even in the same individual. The CDPH is an active member of the Chicago Asthma Consortium, a group that is specifically addressing the needs of persons with asthma.

HIV. Data on pediatric HIV infections are neither collected nor reported routinely. Information is therefore being presented on the number of reported pediatric AIDS cases. Between 1995 and 1997, cumulatively one hundred and seventy-six (176) pediatric (<13 years old) AIDS cases were reported. Fifty-four percent (54%) of these were female. Sixty-nine percent of the cases were NH Blacks, 9% were NH White, and 22% were Hispanic. Perinatal transmission accounted for 94% of the AIDS cases. Of the 163 cases for whom the mother's risk factor was known, 82% were due to contaminated needles (CDPH, September 1999).

Mortality The number of deaths among from all causes for children aged 1-14 years have been provided in lieu of divisions into the age groups 1-4 and 5-9. During the period 1995-1997 there were two hundred and one (201) deaths from all causes among children aged 1-14 years. Eighty-one (81) females and one hundred and twenty (120) males died. Male children were more likely than females and, and NH Blacks were more likely than other racial/ethnic groups to die.

The ten leading causes of death for children aged 1-14 years during the period 1995 to 1997 from highest to lowest were as follows:

- NH Black: Other unintentional injuries, homicide, motor vehicle accidents, congenital

anomalies, heart disease, cancer, pulmonary disease, pneumonia and influenza, HIV/AIDS, other infection and parasitic diseases.

- NH White: Cancer, motor vehicle accidents, other unintentional accidents, homicide, heart disease, nephritis, other infection and parasitic diseases, and stroke.

- Hispanics: Other unintentional injuries, homicide, cancer, motor vehicle accidents, congenital anomalies, heart disease, pneumonia and influenza, benign neoplasms, HIV/AIDS and perinatal conditions.
- Mexicans: other unintentional injuries, cancer, homicide, motor vehicle accidents, congenital anomalies, benign neoplasms, heart disease, pneumonia and influenza, and septicemia.
- Puerto Ricans: homicide, heart disease, other unintentional injuries, perinatal conditions, and pneumonia and influenza.

Of the 128 deaths among NH Blacks, seventeen (17) were from motor vehicle accidents, as were four (4) of the twenty-seven (27)among NH Whites, and four (4) of the thirty-four (34) among Mexicans. All deaths are potentially preventable. There were no recorded deaths from motor vehicle accidents among the Puerto Ricans. Of the 128 deaths among NH Blacks, twenty-six (26) were from other unintentional injuries, as were four (4) of the twenty-seven (27) among NH Whites, and eight (8) of the thirty-four (34) among Mexicans, and one (1) of the seven (7) among Puerto Ricans. Homicides accounted for twenty-two (22) deaths among NH Blacks, two (2) deaths among NH Whites, four (4) deaths among Mexicans and three (3) deaths among Puerto Ricans. All deaths are potentially preventable (Leading Causes of Death in Chicago 1995-1997, CDPH, May 1999).

Adolescents.

Risk Behavior. Preliminary results (unweighted observations) from Illinois 1999 Youth Risk Behavior Survey illustrate the following patterns in risk taking behavior among downstate high

school students in Illinois:

- Six percent had carried a weapon on school property in the prior 30 days.
- Twenty-six percent reported feeling so sad or hopeless almost every day for two weeks in a row that they stopped doing some usual activities.
- Eighteen percent reported that they had seriously considered suicide in the prior 12 months, and seven percent reported attempting suicide one or more times in the prior twelve months.
- Thirty-four percent reported that they had smoked cigarettes on one or more of the prior 30 days. Forty-seven percent of those who had ever smoked reported that they were between 13 and 14 years of age when they smoked their first cigarette.
- Fifty percent reported having at least one drink of alcohol during one or more of the prior 30 days.
- Twenty-one percent reported using marijuana one or more times in the prior 30 days.
- Less than three percent reported using cocaine one or more times in the prior 30 days.
- Less than two percent reported using heroin one or more times in their lives.
- Seven percent reported using methamphetamines one or more times in their lives.
- Fifty-two percent described themselves as being at about the right weight. This proportion was higher for boys (57 percent) than for girls (46 percent).
- Ninety percent reported that they had engaged in strenuous exercise on one or more of the past seven days.
- Ninety-three percent reported that they had been taught about AIDS or HIV infection in school.

Health Care Utilization. Receipt of periodic screening by Medicaid eligible children between six and 14-years-of-age has been increasing for the last three years. The EPSDT participation rate was 78 percent in FFY 1996, 79 percent in FFY 1997 and 80 percent in FFY 1998. The participation rate among older adolescents (15 to 20 years of age) has been in excess of 100 percent for the last three years.

Hospitalization. Mental illness was the leading cause of hospitalization among 10 to 14-year-

olds between 1994 and 1998. Psychoses (DRG 430) was the most frequent discharge diagnosis in 1998 (a rate of 376.9 per 100,000 children 10 to 14-years-of- age). The 1998 rate is 3.3 percent lower than the 1994 rate of 389.4 per 100,000 children. The lowest discharge rate for this condition was observed in 1996, when the rate fell to 347.4 per 100,000 children. When combined with the third and fourth leading causes (childhood mental disorders [DRG 431] and depressive neuroses [DRG 426], the overall discharge rate for mental disorders was 608.4 per 100,000 children 10 to 14 years of age). The combined discharge rate for these conditions in 1998 was 3.3 percent higher than the rate of 588.9 per 100,000 children in 1994. The rate had declined each year between 1994 and 1997, and then increased in 1998. The second leading cause of hospital discharge was bronchitis and asthma [DRG 098] with a discharge rate of 158.4 per 100,000 children 10 to14-years-of-age in 1998. The rate has not followed a consistent pattern since 1994, but the 1998 rate was 16 percent lower than the 1994 rate of 189.5 per 100,000 children. The fifth leading cause of hospital discharge was uncomplicated appendectomy (DRG 167) with a discharge rate of 85.7 per 100,000 children 10 to 14-years-of-age between in 1998. The 1998 rate was 24 percent lower than the 1994 rate of 112.1 per 100,000 children. The rate declined steadily during these five years.

The leading cause of hospital discharge among 15 to19-year-olds was pregnancy; this accounted for the first, third, and fifth leading diagnoses. When combined, the 1998 discharge rate for these three causes (childbirth, DRGs 370-375; other antepartum diagnoses with complications, DRG 383; and threatened abortion, DRG 379) is 2,718.4 per 100,000 children 15 to 19-years-of-age. (This is calculated as a rate per 100,000 children of both sexes for comparability.) The combined discharge rates for psychoses, the second leading cause, and depressive neuroses (DRG 426) was 782.8 per 100,000 children.

Eighteen local health departments selected mental health or suicide prevention as a community health priority. Thirteen agencies proposed community health education programs to increase the public's awareness of the signs and symptoms of mental illness or the availability of community mental health services. Ten agencies proposed interventions to improve the coordination among community mental health providers to improve access to care or to define

additional interventions. Seven local health department proposed training or continuing education programs to improve the ability of health and human service providers to screen, refer or treat patients or clients with mental illnesses. Five agencies proposed strategies to recruit additional mental health professionals to their communities or to extend the hours of available services among existing providers. Three local health departments plan to collect additional community baseline data on the prevalence of specific mental illnesses and two local health departments plan to assess coverage of mental health care among employer-sponsored health insurance programs.

High School Drop Out. The Illinois State Board of Education reports that the drop-out rate in public secondary schools was 7 percent in 1998. The rate has ranged between 6.3 percent and 7.3 percent in the prior nine years. The 1998 drop out rate was highest among African-American students in (14.8 percent, the highest rate in more than five years), followed by Hispanic students (12.2 percent in 1998, American Indian students (8.6 percent), Caucasian students (4.2 percent) and Asian-American students (2.7 percent). Since 1994, drop out rates have declined for all groups except African-Americans and American Indians.

Sexual Activity. Youth Risk Behavior Survey results from 1999 show that more than half (51.6 percent) of the respondents age 18 or older[14] indicated that they had had sexual intercourse at least once. The proportion was lowest among ninth graders (24 percent) but was similar among tenth, eleventh, and twelfth grades (45 through 49 percent). This is corroborated by the self-reported age at the first experience of intercourse (1.1 percent for age fourteen; 11 percent for age 15). The proportion of African-American students who reported having at least one experience of intercourse was 60 percent higher than the proportion of Caucasian students who reported at least one experience.

Of the students who reported having at least one experience of sexual intercourse, nearly half (43 percent) had only one partner; another fifth (19 percent) had two partners; eleven percent

[14] Youth Risk Behavior Survey data presented in this application are unweighted responses to survey items and cannot be generalized to the population. Analysis of the 1999 survey has not been completed.

had three partners; ten percent had four partners; 18 percent had five or more partners. Of the respondents who reported having intercourse in the last three months (28 percent of respondents), more than three-fourths (78 percent) reported having two partners and 11 percent reported having three or more partners.

Most (77 percent) of the sexually active respondents indicated that they had not used alcohol or drugs during their last experience of intercourse; most (65 percent) reported using a condom during their last experience of intercourse, and 14 percent reported using no method of contraception.

Sexually Transmitted Diseases. The 1998 incidence rate of sexually transmitted diseases among 10 to 14-year- olds was 77.0 per 100,000 children. The rate declined by 51 percent in the last five years, falling from 157.3 per 100,000 children in 1994. Chlamydia was the most common sexually transmitted disease in this age group, with an incidence rate of 50.2 per 100,000 children in 1998. Gonorrhea was second with an incidence rate of 50.2 per 100,000 children in 1998.

Among 15-19 year olds, the 1998 incidence for all sexually transmitted diseases was 1,985.1per 100,000 children. Chlamydia was the most common infection, with an incidence rate of 1,273.9 per 100,000 children in 1998. Gonorrhea was the next most frequent, with an incidence rate of 705.7 per 100,000 children. The 1998 incidence of Syphilis among 15-19 year olds was 13.6 per 100,000 children.

Pregnancy. Overall, fewer teens are having children. The 1998 birth rate for Illinois teenagers was 53.2 live births per 1,000 women aged 15 to 19 years, a decrease of 1.4 percent from 1997. The birth rate was 2.0 percent higher than the national rate of 51.1 per 1,000 women. The teen birth rate in Illinois has declined each year for the last five years, dropping from 62.3 births for every 1,000 women aged 15-19 years. This is a five year decrease of 14.6 percent.

Overall, fewer children are born to teens. The number of teen births in 1998, 22,632, was slightly lower than the previous year's total of 22, 646. This is in contrast with the national trend; there were slightly more teen births in the United States in 1998 (484,895) than there were in 1997 (483,220). During the last five years, the number of teen births has decreased from 24,668 to 22,632, a decrease of 8.3 percent.

The number and rate of teen births increases with the mother's age. A few infants are born to adolescents between 10 and 14 years of age each year; there were 462 such births in 1998. Births to adolescents between 15 and 17 years of age account for the next largest group (37 percent of the total in 1998). Most of the children born to teens are born to women between 18 and 19 years of age (61 percent of the total in 1998).

The birth rate and the number of births to each age group of mothers (10 to 14-year-olds, 15 to 17-year-olds and 18 to 19-year-olds) has been steadily decreasing. The greatest decrease in the birth rate has occurred among 15 to 17 year olds, declining by nearly 20 percent in the last five years. The birth rate among 10 to 14-year-olds has declined by less than one percent since 1994, but their infants account for only two percent of teen births. There has also been a decline of nearly four percent in the birth rate among 18 to 19-year-olds.

The number of births to the youngest teens -- 10 to 14-year-olds – has been steadily decreasing since 1994. There were 1.1 births for every 1,000 women aged 10-14 years in 1998; this was a slight decrease (0.9 percent) from the 1997 rate of 1.11. Since 1994, the rate has decreased from 1.56 births for every 1,000 women in this age group (a 29 percent decrease) and the number of births has declined from 645 to 462, a decrease of 28 percent.

The number of births to adolescents between 15 and 17-years-of-age has also declined since 1944. There were 32.7 live births for every 1,000 women aged 15 to 17 years in 1998. This was a decrease of four percent from the 1997 rate of 34.1 birth for every 1,000 women. Since 1994, the birth rate in this age group has decreased by 19.9 percent (from 40.8 per 1,000 women in 1994) and the number of births has decreased 13.5 percent (from 9,585 births in

1994 to 8,286 births in 1998).

There were 84.96 live births for every 1,000 women 18 to 19 years of age in 1998. This was a slight decrease (1.17 percent) from the 1997 rate of 85.97 births for every 1,000 18 to 19-year olds. Since 1994, the birth rate and the number of births among women in this age group has been steadily declining. The 1994 birth rate of 95.7 births per 1,000 18 to 19-year-olds was 12.6 percent higher than the rate in 1998. The number of births decreased by 3.8 percent, falling from 14,438 live birth in 1994 to 13,884 live births in 1998.

About one third of the women who give birth in Illinois each year are unmarried. This rate has fluctuated slightly during the last five years, dropping from 34.3 percent in 1994 to 34.1 percent in 1998. The proportion had decreased each year from 1994 through 1997 (reaching a low of 33.4 percent in 1997) before the increase in 1998.

As might be expected, unmarried child bearing is much more common among teens than it is among older women. In 1998, 85 percent of the teens who gave birth were unmarried. The proportion births to unmarried teen mothers has been steadily increasing during the last five years, rising from 83.7 percent in 1994 to 85.3 percent in 1998. While the proportion of births to unmarried teens has been increasing, the number of births decreased between 1994 (when there were 20,646 births to unmarried teens) and 1997 (when there were 19,132 births to unmarried teens). This was followed by a slight increase in 1998 to 19,310 births to unmarried teens. The proportion of births to married teens is decreasing faster (9.8 percent between 1994 and 1998) than the birth rate (4.2 percent between 1994 and 1998), resulting in fewer births to unmarried teens at the same time that the proportion of unmarried births is increasing.

While the proportion of unmarried teen births has been increasing, a greater number of infants are born to unmarried non-teens. In 1998, there were twice as many infants born to non-teenaged unmarried women (42,853) than teenagers (19,310). While the number of births to unmarried non-teens in 1998 was lower than the number in 1994, the number in 1998 reverses

four years of steady decline in the number of infants born to unmarried women.

Teen child bearing occurs at a greater rate among racial and ethnic minorities. There were 113.6 births for every1,000 African-American women between 15 and 19 years of age in 1998. This is a slight decrease (0.6 percent) from the 1997 rate of 114.3 per 1,000 15 to 19-year- olds. The number of births to 15 to 19-year-old African-American women in 1998 was only 11 fewer than in 1997. However, there has been a substantial decrease in the birth rate and the number of live births since 1994. The birth rate among 15 to 19-year-old African American women was 140.0 per 1,000 in 1994 and represented 10,634 births; by 1998, the rate had decreased by 18.9 percent and the number of births had decreased by 14 percent.

There is a significant disparity in birth rates when African American teens are compared with European-American teens, and this disparity is greatest among the youngest teens. The birth rate among African-American women between 15 and 19 years of age was 2.8 times higher in 1998 than the corresponding rate among European-American teens of the same age. The birth rate among African-American women between 10 and 14 years of age was 8.9 times higher than the rate among European-American women of the same age. Among 15 to 17-year-olds, the birth rate among African-Americans was 3.5 times higher than the rate among European-Americans. Finally, among 18 to 19-year-olds, the birth rate among African-Americans was 2.4 times higher than the birth rate among European Americans. African-American teens are more likely to begin childbearing earlier than their European-American counterparts.

The disparity in birth rates among African-American and European-American has been narrowing due to a more rapid decrease in birth rates among African-American teens than among European-American teens. The birth rate among European-American teens between 15 and 19-years-of-age decreased by 10.5 percent between 1994 and 1995. At the same time, the birth rate among African-American teens decreased by nearly 19 percent. As a result, the disparity in birth rates between these two groups has narrowed from a ratio of 3.1:1 in 1994 to 2.8:1 in 1998.

There were 102.1 live births for every 1,000 Hispanic women between 15 and 19-years-of-age in 1998. This is slightly lower than the 1997 birth rate of 102.4 per 1,000. There has been an eight percent decrease in the birth rate since 1994, when the rate was 110.95 per 1,000 15 to 19-year-olds. The number of births to Hispanic teens (of all ages) has increased by 7.1 percent since 1994, increasing from 5,085 in 1994 to 5,446 in 1998. There has not been a steady increase, however. In this five-year time period, there were slightly more than 5,440 live births in three years. The decrease in the birth rate among Hispanic 15 to 19-year-olds has closely mirrored the decrease among European-American teens. As a result, the birth rate among Hispanic teens has been roughly 2.5 times higher than the birth rate among European-American teens each year between 1994 and 1998.

IPLAN Results. Six local health departments selected teen pregnancy as a priority community health problem. All of them proposed one or more school-based interventions, including abstinence-only and abstinence based curricula. Others proposed out-of-school-time programs, including mentoring, male responsibility, and youth development (content that addresses decision-making, personal responsibility, postponing sexual involvement, and life planning). Several proposed strategies related to clinical family planning services, including revised clinic hours, promoting the use of Depo-Provera © and condom distribution. Two agencies proposed programs to help parents communicate with their children about sexuality and other risk behaviors.

Substance Abuse. The DHS conducts a period survey of substance abuse among 8th, 10th and 12th graders in public and private schools. The samples in 1995, 1997, and 1998 included approximately 4,500 students approximately equally divided between men and women, 8th, 9th, and 12th graders, and Cook, downstate urban, and downstate rural counties.

The proportion of adolescents reporting any substance use in the past month in 1998 (49.5 percent) was down slightly from 1997 (52.6 percent). Use in the past month increases with age, from 36.1 percent in 8th grade to 51.4 percent in 10th grade and 67.6 percent in 12th grade. Use in the past month was higher among European-American students (58.1 percent) than

African American students (35.6 percent) and students of Hispanic descent (48.3 percent. This pattern held for alcohol, tobacco, and marijuana, although the relative propositions changed (alcohol: European-Americans, 49 percent; African Americans, 24.4 percent; Hispanic-Americans, 40.0 percent. Tobacco: European-American 36.7 percent; African-Americans, 14.6 percent; Hispanic-Americans 24.5 percent. Marijuana: European-Americans 23.7 percent; African-Americans 22.2 percent. Use of cocain (including crack cocaine) in the last month was reported by 1.5 percent of adolescents. This was less than half the proportion reported in 19997 (3.3 percent). A similar decrease was reported for hallucinogens; 6.0 percent of adolescents reported use in the past month in 1997, while only 2.6 percent did so in 1998.

Overall, alcohol was the substance most frequently used by adolescents in the past month (40.7 percent) followed by tobacco (28.4 percent) marijuana (19.2 percent) smokeless tobacco (4.1 percent), inhalants (2.7 percent0, hallucinogens (2.6 percent) and cocaine (1.5 percent). The average age of first use among high school seniors was 13.1 years for tobacco, 13.8 years for alcohol, and 14.7 years for marijuana.

Twenty-five local health departments selected alcohol and substance abuse as an IPLAN priority health problem. The most frequently proposed intervention strategy was community health education or health promotion (22 agencies). The specific strategies included community health education campaigns (10); organizing community leaders (4); developing media strategies (4); sponsoring alcohol-free events (2); participating in national health promotion campaigns (1); and work-site education (1).

The second most frequently proposed intervention strategy was school-based programming (14 agencies). The next most frequent strategy was the development or continuation of youth programming (13 agencies), including: out-of-school-time activities (3); peer education or counseling (3); youth tobacco control programs (using CDC guidelines) (2); other community-based programs (2); the use of adult mentors (1); and the development of volunteerism opportunities for teens (1).

HIV. A total of 352 cases of HIV infection among children between 13 and 19-years-of-age were reported to the Illinois Department of Public Health between January 1988 and June 1999. These cases represent 1.5 percent of all HIV infections reported in that time period. A total of 100 cases of AIDS among children between 13 and 19-years of age, or 0.4 percent of all cases, were reported to the Illinois Department of Public Health between January 1988 and June 1999.

Mortality. The 1998 mortality rate among 10-14 year olds was 20.7 per 100,000 children. The rate among African-Americans was 32.0 per 100,000. This was 1.75 times higher than the rate among European-Americans (18.2 per 1,000). The mortality rate among 10-14 year olds of Hispanic origin (15.2 per 1,000) was somewhat lower than the rate among European-Americans.

There were 21 deaths due to homicide involving handguns among 10-14 year olds in 1998. The overall homicide rate among 10-14 year olds in 1998 was 2.9 per 100,000. Nearly all (21 of 24) of these deaths involved handguns. The racial and ethnic disparities in the homicide rate in this population was substantial. The relative risk for African-Americans was 4.6:1 (African American rate, 8.2 per 100,000; European-American rate 1.8 per 100,000). The homicide rate among 10-14 year olds of Hispanic origin was 4.5 per 100,000; the relative risk, when compared to European-Americans was 2.5:1. All of the homicides among children of Hispanic origin, 12 of the 13 homicides among 10-14 year old African Americans involved handguns.

There were too few suicides among 10-14 year olds to allow calculation of reliable rates.

The 1998 mortality rate due to motor vehicle collisions among 10-14 year olds was 4.0 per 100,000. Most of these deaths (29 of 34) occurred among European American children (rate 4.4 per 100,000); the occurrence of motor vehicle related deaths among racial and ethnic minorities was too rare to allow for calculation of reliable rates.

The other leading causes of death among 10-14 year olds were malignant neoplasms (19

deaths) and chronic obstructive pulmonary disease (9 deaths).

The 1998 mortality rate among 15 to 19 year olds was 98.9 per 100,000. A racial disparity in mortality rates was observed in this age group as well; the mortality rate among African-American adolescents was 154.4 per 100,000; the disparity when compared to European-Americans was 2.4.:1. The disparity between adolescents of Hispanic and European descent was less pronounced at 1.4:1.

The homicide rate among 15-19 year olds was 24.9 per 100,000. The racial and ethnic disparity in homicide rates was substantial; when compared to adolescents of European decent (10.2 per 100,000) homicide rate among African Americans (91.9 per 100,000) was nine times higher, and the rate among Hispanic Americans (42.6) was 4.2 times higher. Nearly all of these deaths (211 of 216 or 98 percent) involved handguns.

The 1998 suicide rate among 15-19 year olds was 7.6 per 100,000. Nearly all of these deaths (57 of 66, or 87 percent) occurred among adolescents of European descent.

The 1998 mortality rate due to motor vehicle collisions was 21.2 per 100,000. The rate was highest among European-Americans (23.0 per 100,000) followed by adolescents of Hispanic descent (18.6 per 100,000) and African descent (16.9 per 100,000). The mortality rate among men (27.3 per 100,000) was 1.9 times higher than the rate among women (14.6 per 100,000).

The other leading causes of death among 15-19 year olds was malignant neoplasms (36 deaths) and heart disease (27 deaths).

Five local health departments selected motor-vehicle related deaths as a community health priority. The most common intervention strategy, selected by all five agencies, was community health education (on topics such as driving under the influence of alcohol, seat belt use, use of child safety seats and use of bicycle helmets). Three local departments proposed school-based

interventions, including enhancement of drivers education programs. Two agencies proposed educational programs for parents and two agencies proposed programs to distribute child safety seats to low-income families. One agency proposed the establishment of a Safe Kids coalition and one agency proposed the establishment of a bicycle safety program.

Chicago

Sexual Activity. The rate of sexual activity among teenagers has decreased for the first time since the government began tracking the information in 1970. Approximately fifty (49.6%) percent of teenage girls had sex in 1995. This was a decrease from 55% in 1990. In 1997, the rate had fallen to 47.7%. The rate for teenage boys dropped from 60 percent in 1988 to 55 percent in 1995 (IDPH 23 Dec.1998), and to 49% in 1997. In short, fewer adolescents admit to having sex. However according to the National Youth Risk Behavior Survey (NYRBS) in 1997, adolescents in Chicago were still more likely than students nationally to have engaged in sexual intercourse beginning before age thirteen years, and to have continued this practice. Boys were more likely than girls to have engaged in intercourse, however once having started, boys were more likely than girls to become and remain abstinent. Among the racial/ethnic groups, Blacks were more likely than Hispanics or Whites to have engaged in sexual intercourse, and to have continued this practice. Hispanics were the most likely to be abstinent. Multiple partners were more common in Chicago and among black males than nationally. (CDPH, Jan. 1999). Nationally boys were less likely than girls to have had multiple partners.

Sixty-seven percent of those who admitted to being sexually active reported that they were using condoms. This was a 32% increase from 1991. However the potential for the transmission of SDTs had increased among Hispanic youth, since 7.4% of them admitted they had been or had gotten someone pregnant (an increase of 114.6% from the 3.4% previously reported). The rate had decreased minimally from 14.8% to 14.5% among NH Blacks.

Sexually Transmitted Diseases. In Chicago, for example, the age group 10-24 years comprise

23% of the population, but represented 64% of all STD cases reported in 1998. These cases were divided as follows: 1% among teens 10-14 years, 31% among 15-19 year olds and 32% among 20-24 year olds. Young women are the most likely to suffer frequent and severe complications from these infections. The high prevalence of STDs among young persons reflects their greater tendency to take risks, the lack of knowledge and awareness of STDs, the existence of barriers to STD treatment and prevention, lack of routine screening and health care designed specifically for adolescents, and lack of insurance coverage.

Chlamydia and gonorrhea are most prevalent in teens and young adults. Forty-three percent of all chlamydia and 34% gonorrhea cases are reported in teens aged 15-19 years old. Twenty-six percent of gonorrhea cases are reported in 20-24 year olds. In 1995 Chicago females aged 15-19 had a gonorrhea rate of 2,631 per 100,000. This rate was 3 times higher than the national rate of 847 per 100,000 females aged 15-19 (CDPH CDC, Division of STD Prevention Sexually Transmitted Disease Surveillance, 1996). In 1998, the two highest chlamydia rates were among the 15-19 and 20-24 age group (ratio ranged from 1,536/100,000 to 2,102/100,000). The rates per 100,000 were 396 for chlamydia and 501 for gonorrhea for all age groups. NH Blacks and Hispanics have significantly higher reported rates of gonorrhea and primary and secondary syphilis.

Adolescent girls have a higher STD infection rate than boys. This may be due in part to exposure by older men, but may also reflect a reporting bias, since girls are more likely to seek treatment at a public clinic, where reporting of STDs is more complete. In 1996 chlamydia was the most frequently reported STD in Chicago. Eighty-three percent (83%) of cases were found in women. Of these, 42% were found in females aged 15-19 years. In 1998, 56% of gonorrhea, 88% of chlamydia and 65% of primary and secondary syphilis cases were reported among females aged 11-24 years (CDPH September 1999).

Reported STD rates are higher among NH Blacks. The proportion of reported STDs ranges from 74%-85%. In 1998, NH Blacks made up 79% of all cases. More cases of STDs are reported among black and Hispanic women than among women in other ethnic groups.

Reported chlamydia cases decreased in below the levels of gonorrhea in both 1997 and 1998, however the percentage of cases had increased by 18% in 1998. Gonorrhea was the second most commonly reported condition in 1996, remained relatively stable in 1997, and increased by 21% in 1998. In 1996, 60% of cases were reported in women less than twenty-four years of age.

Pregnancy. In Chicago, in 1994 nearly one-third (27.8%) of all pregnant teens and half (49.6%) of pregnant teens under 15 received late or no prenatal care, as opposed to 10% of older women. Teenagers, particularly those younger than 15 years, have more complications and higher rates of maternal morbidity and mortality. They are more likely than older women to have still births and miscarriages.

Teen pregnancy can impose lasting hardships on both parent and child. The offspring of teen mothers tend to have the highest rates of illness and mortality. Teens are more likely to have premature or low-birth-weight babies. Babies born to teens represented 18.4 % of all births in Chicago in 1996, but their rate for low birth weight infants was 11.4 (CDPH, August 1998). Approximately 50% of the TANF welfare funds in Illinois are distributed to families created by teen pregnancy (Illinois Department of Public Aid).

Even though the rates of births to teens in the United States remain high, the national fertility rates have been declining. In 1997, births to teens nineteen years and under fell to their lowest level since 1988 when the current rate of 12.5 was first recorded. In 1993, there were 19,577 teenage mothers in Chicago who were parents of 24,000 children, all under age 5. Nearly 10,000 of these young parents were 17 years old and under. In 1996, teen births accounted for 9,696 infants, 4,262 or 43.9% were born to teens 17 years of age or younger, 5,434 infants were born to teens aged 18 to 19 years, and 970 or 10% were to mothers under 15 years of age. In 1997 in Chicago, there were 9,279 births to teenagers, or 18.8% of the total number of births. Of these, 4,077 or 43.9% were born to girls 17 years of age and younger. Births to 18- and 19- year-olds totaled 5,202 (IDPH, 23 Dec. 1998). In Chicago, the fertility rates among 15-19 year olds declined between 1989-1996 for all subgroups except the

Mexicans who experienced an increase (CDPH, August 1999). In 1998 the number of births to teens remained at 9,272 or 18.0% of all births. (IDPH January 12, 2000, Division of Communications)

Substance Abuse. In 1997, Chicago females (72.2%) were more likely than males (70.3%) to have had one drink in their lifetime, males were only slightly (37.3%) likelier than females (36.5%) to be current users had at least one drink during the preceding 30 days. However males were 24.1% more likely than females (16.6%) to be heavy drinkers (had episodes of heavy drinking $\geq$1 occasions during the 30 days preceding the survey). NH White and Hispanic students were more likely than NH Blacks to be current and heavy users of alcohol, however, their rates had declined from 1991-1997, whereas the rate for NH Blacks had increased.

Cigarette smoking has both short and long term consequences for the health of the individual. In children, cigarette smoking can result in a reduced rate of lung growth, shortness of breath, chronic coughs and aggravation of asthma and other allergies. Those who become addicted to smoking can develop lung cancer, chronic emphysema and cardiovascular disease. Despite the warnings, many young people join the ranks of smokers daily. Since 1991, smoking has been increasing among all youth, but especially among girls, for example, the percentage increase in Chicago between 1991 and 1997 moved from 15.35 to 26.2%, an increase of 65%. The rate for females doubled (from 13.0% 10 26.2%), whereas for males it increased by 39% from 19.7 to 27.4%. Among Chicago high school students in 1997, approximately 42.4 percent of NH Whites smoked, compared to just 24.9% of NH Blacks and 27.3% among Hispanics. Yet, the NH Black rate was up 138.8% from just 10.4 percent in 1991, and the NH White rate was up from 24% from 34.1% in 1991. Among Hispanic high school students, the rates rose by 12.7% from 24.2 % in 1991 to 27.3% in 1997.

The 1997 NYRBS data show that 26.8 percent of Chicago high school students were "current" smokers (those who smoked at least one day in the 30 days before they were surveyed), compared to 36.4 percent of high school students nationally. Additionally, 7.6 percent of

Chicago high school students are "frequent" smokers (those who smoked on at least 20 of the 30 days prior to being surveyed), compared to 16.7 percent nationally. Nationally, as in Chicago, NH Black youth smoked significantly less than (24.9%) NH Whites (42.4%) or Hispanics (27.3%). The transition to smoking among NH Blacks appears to occur between age 18 and 24 years and continues to increase after age 25 years.

The rise in youth smoking could potentially reverse the current downward trend in the City's infant mortality rate. Smoking during pregnancy contributes to low birth weight, the leading factor associated with infant death. And while the percentage of Chicago mothers who smoked during pregnancy has declined substantially since 1989 (from 15.6 percent to 10.0 percent), an increase in smoking among girls could slow or even reverse that trend.

Factors contributing to smoking among youth include family smoking and tolerance for smoking, availability, advertising, low self-esteem, and the perception that the behavior is acceptable. The prevalence of smoking appears to be correlated with income, with- low income individuals least likely to try to break the habit. Manfredi, et al (1992) interviewed women in a public housing complex and found that not only were they heavy smokers then, but they were less likely to try to stop smoking. To them the difficulty of trying to quit smoking was greater than the threat of lung cancer at some future date.

In 1997, Chicago students ranked below the national average on all indicators of illegal drug use: those who had used the substance at least once in their lifetime; those who were currently using the substance (i.e., to have used it on $1 of the 30 days prior to the survey)and, as in the case of alcohol, those who were involved in episodes of heavy use $1 occasions during the 30 days preceding the survey.

Chicago males (49.6%) were more likely than females (40.8%) to have used marijuana in their lifetime. They were also more likely (27.1%) than females (20.6%) to be current users. Nationally, while Black students were most likely to have tried marijuana at least once, Hispanics (28.6%), were more likely than NH Blacks (28.2%) or Whites (25.0%) to be current

users of marijuana.

Chicago males (7.2%) were more likely than females (3.4%) to have used cocaine in their lifetime. They were also more likely (4.6%) than females (2.1%) to be current users. Chicago males (3.5%) were also more likely than females (2.6%) to have used crack or freebase in their lifetime. Nationally and locally, Hispanics (14.4%) were significantly more likely than NH Blacks (1.9%) than NH Whites (8.08%) to have used all forms of cocaine and to be current users.

HIV Infection. Adolescents are not normally screened for HIV infections, therefore, it is not possible to say for certain the prevalence of infections among this population. The CDPH Epidemiology Division uses the case reports of AIDS to estimate infection in adolescents. By calculating a latency period of approximately 10 years between HIV infection and the manifestation of AIDS, the assumption is that people diagnosed with AIDS between the ages of 25-29 years were likely to have been infected in adolescence. AIDS diagnoses will likely be reduced because of the availability of anti-retro viral drugs that delay the onset of the disease. On the other hand, because HIV infection is now reportable, data on infections should be available in the future.

.

Mortality. Homicide is the leading cause of death among NH Blacks and Hispanics, and in persons aged 15-19 years (32% 10-14; 65% 15-19). Four percent of homicides in 10-19 year olds are related to firearms. Motor vehicle accidents are the leading cause of death among NH White adolescents. Homicides have been decreasing in Chicago and around the country. The most significant decline between 1994-1996 has been among adolescents aged 10-14 both in Chicago and in the USA.

Suicide, traditionally higher among whites, has increased among Blacks, so that this population now has the same degree of risk for suicide as Whites. The CDPH Epidemiology Department compared the suicide rates per 100,000 population of 15-19 year olds in Chicago, on the basis of the three variables: Contemplated suicide, attempted suicide, and completed

suicide. The first two measures were based on self- reports by high school students on the Youth Behavioral Risk Survey and thus exclude those who were not attending school. The second is from the Illinois Department of Public Health Vital Records data on completed suicides, and represent the total population of students. Based on these numbers, between 1991-1997 fewer students in each category contemplated suicide, but more attempted to kill themselves. The suicide rate declined to its lowest point in 1995, but began to climb in 1997. In 1997, female students were more likely than males to report that they had seriously considered suicide; however, the proportion who seriously attempted suicide was not significantly greater than for male students.

The risk factors for suicide among children include a family history of suicide and physical abuse, inability to form attachments, changes in environment during critical developmental phases, loss of friendships, cultural acceptance of suicide as a coping mechanism, lack of community supports, and easy access to the means of self-destruction. The risks for adolescents are similar, and also include break-up of relationships, suicidal behavior among peers and other significant others, substance abuse, and unwillingness to seek help for themselves or their peers when difficulties arise. Girls are more likely than boys to have seriously considered suicide, to have made a plan, to have attempted suicide, and to have received medical attention for the attempt.

Intentional Injuries Intentional injuries result from physical fights with and without the use of weapons. In 1997, Chicago students were more likely (130.5/100) than students nationally (115.1/100) to have engaged in physical fighting. They were also 97% more likely than students nationally to have been injured in a physical fight and to have been treated by a doctor or nurse. Chicago's male students were more likely (8.8%) than female students (5.4%) to have been treated by a doctor or nurse for a sustained injury.

3.1.2.2 Direct Health Care Services

This section has been combined with Section 3.1.2.3.

3.1.2.3 Enabling Services

Priority concerns regarding access to health care and health related services Illinois has made significant progress in reducing infant mortality and teen pregnancy during the last five years. While racial disparities persist in women's and children's health, improvements have been made in birth weight and teen pregnancy. Further improvements in adequacy of prenatal care, inter-pregnancy interval, infant mortality, child abuse and neglect, high teen pregnancy and school completion by low-income teen parents will depend upon maintaining and expanding the Family Case Management, WIC, Family Planning, Healthy Families Illinois, Parents Too Soon, Teen Parent Services, Teen Pregnancy Prevention and School Based Health Center programs, as well as initiating new efforts to reduce infant morbidity and mortality in certain areas of the state. Services for CSHCN will be improved through further implementation of the "medical home" concept.

Financial barriers to preventive and primary care. A recent study by the University of Illinois at Chicago found that there were 146,900 uninsured children in households with incomes below 133 percent of the federal poverty standard, and additional 43,800 uninsured children in households with incomes between 133 and 185 percent of the poverty level, and an additional 21,500 uninsured children in households with incomes greater than 185 percent of the federal poverty standard. The results of this study suggest that only six percent of the children in Illinois are uninsured, somewhat lower than the 7.7 percent estimated by the U.S. Census Bureau on the basis of the 1996, 1997 and 1998 Current Population Surveys.

The implementation of KidCare has extended health benefits coverage to children under the age of 19 from families with incomes below 185 percent of the federal poverty level and extended coverage through the Medicaid program to pregnant women (and their infants, when the mother was eligible for Medicaid during pregnancy) whose family income is below 200 percent of the federal poverty level. Uniquely in Illinois, a state-funded component of the program reimburses employers (at a fixed rate) for the cost of dependent coverage provided to families with incomes below 185 percent of the federal poverty level. Since the inception of KidCare on January 1, 1998, more than 109,000 women and children have obtained health benefits coverage through the combined Title XIX and Title XXI programs. Most (85 percent) of the

growth in enrollment has occurred in the Title XIX program (92,500 pregnant women and children). Enrollment in Title XXI reached 12,600 and enrollment in the state-funded employer rebate program reached 3,900 on July 1, 2000. An extensive outreach and public information campaign has been undertaken for the last sixteen months to increase KidCare enrollment.

Changes in Health Care Financing. Changes in Illinois' publicly-funded health care system over the last five years have had a modest impact on the enabling services provided at the state and local level to the Title V population. After an initial and unsuccessful pilot test between 1993 and 1995, no further action has been taken to introduce Medicaid managed care in Illinois. The voluntary managed care program for Medicaid recipients in Chicago, which was initiated prior to the statewide pilot test, is still operating and serves more than one-quarter of a million women and children. The implementation of Title XXI has provided health benefits coverage to about 12,600 children, a one percent increase to the number of children who were eligible for Title XIX at some time during FFY'98 (1,045,900). While the implementation of Title XXI has allowed both the MCH and CSHCN programs to redirect some of the funds earmarked to purchase health care services for uninsured children, most Title V program funds in Illinois have traditionally been used for the "other levels" of the "pyramid". Therefore, recent changes in public health care financing have had a relatively small effect on the services provided to the Title V population at the state and local level.

About 22 percent of the state's population is served by a managed care plan. The ten largest Health Maintenance Organizations (HMOs) in Chicago covered 2.7 million persons in 1999, a 16 percent decrease from 1998[15]. Six of the 10 largest plans have enrollments in excess of 100,000 persons: Blue Cross Blue Shield of Illinois , Humana, Rush Prudential Health Plans, First Commonwealth, Cigna Healthcare of Illinois, and United Healthcare of Illinois. These six HMOs have enrolled about 2.4 million persons.

[15]Crane's Chicago Business, October 11, 1999, pp. 179-180.

Most CSHCN using Medicaid continue to access services through fee-for-service. Commercial managed care is more prevalent for CSHCN who are covered by insurance through family employment. Managed care plans often change annually as employers try to decrease costs, families must change physicians, including their primary care physicians and specialists, physician membership in managed care plans changes and continuity of care for CSHCN is often compromised. Parents appreciated the low cost of co-pays, freedom from paperwork, and availability of case managers in Managed Care Organizations (MCOs). They also reported many difficulties. These included obtaining referrals to pediatric specialists, difficulty accessing mental health services, caps on therapy services; requirements to use mail order pharmacies, penalties for seeing an out-of-network physician, loss of referrals, lack of information about the complaint process, lack of coverage for diapers for children over 3, medical food for PKU diets, and autism as a medical condition.

Temporary Assistance for Needy Families. The Temporary Assistance for Needy Families (TANF) program, which is administered in Illinois by DHS, provides financial assistance to families with one or more dependent children. The TANF cash grant amount is determined by the number of eligible family members and the area of the state in which a family lives. The benefit is not increased due to the birth of a child more than 10 months after the family begins to receive TANF. Most families receiving TANF are also eligible for food stamp benefits and medical assistance. The majority of TANF families are headed by single mothers or pregnant women who turn to assistance because the child's father is absent and not providing support. Some two-parent households turn to assistance due to lack of income.

Most adults age 18 and older and their children are limited to 60 months of cash assistance over their lifetime. Assistance received in non-consecutive months and from other states all count toward the lifetime limit. In Illinois, the five-year time limit for cash benefits does not apply in any month in which the family has earned income and is working at 30 hours a week (35 hours for two parent families); or for any month in which a single parent is in an approved full-time post secondary degree program and is maintaining a 2.5 cumulative grade point. The five-year time limit does not apply to teen parents until they turn 18.

Families must cooperate with the following requirements in order to be eligible for TANF cash assistance:

- Activity Requirement - includes participation in work, training, and other self sufficiency activities;
- Child Support Enforcement - includes identifying and locating an absent parent, establishing paternity, and obtaining support payment; and
- School Attendance Initiative - includes ensuring that children (grades 1-8) attend school regularly.

Most of the families whose TANF case has been canceled due to earnings have not returned to the program, and the proportion who have not returned within 12 or 24 months has steadily increased. In June 1997, more than three-fourths of the families whose cases were canceled due to employment had not returned to TANF within 12 months, and nearly 70 percent had not returned within 24 months. By March 2000, the proportion who had not returned within 12 months was greater than 90 percent, and the proportion that had not returned within 24 months was 80 percent.

A study of former TANF recipients was recently completed by the University of Illinois at Urbana/Champaign. The survey was conducted six to eight months after the respondents had left welfare. Thirty-seven percent of the respondents indicated that they were employed continually over that period; 48 percent stated that the were employed consistently, and 15 percent stated that they had not been employed. The median wage for the employed respondents was $12,680 per year. The three most frequently mentioned barriers to employment were the need for child care (40 percent); coordinating child care and work schedules (33 percent) and child care costs (32 percent). Among the single parent households, 28 percent of respondents were on TANF again within one year of leaving. The most frequent reasons for returning to TANF were loosing or being unable to find a job (44 percent), the need for additional income (27 percent) and health-related concerns, including pregnancy or giving birth since leaving TANF (20 percent).

Illinois' TANF caseload has declined by 53 percent since the program began in July 1997. The initial caseload was 188,069 families; this has decreased to 88,702 families by April 2000. The implementation of TANF has had little effect on Medicaid or Food Stamp enrollment. Over this same time period, Medicaid enrollment increased by nine percent (from 392,376 in July 1997 to 426,284 in April 2000). Enrollment in Medicaid declined by two percent in SFY'98, increased by five percent in SFY'99 and has increased by 10 percent through April 2000. Enrollment in the Food Stamp program declined by 14 percent between July 1997 (416,353) and March 2000 (357,289). Enrollment in the Food Stamp program fell by eight percent in SFY'98 and by another five percent in SFY'99. However, enrollment in the Food Stamp program has risen by four percent through April 2000.

Results of the SSI pilot indicated that enhanced linkages to financial, medical and educational resources, specifically Part C Early Intervention services would benefit newly eligible SSI recipients.

Availability of Care. Data from the American Medical Association show that the ratio of primary care (non-federal family or general practice physicians in office-based practice) physicians to the entire population of the state was 1:4,592 in 1999. Fifty-five counties, representing 97.1 percent of the state's population, have primary care physician-to-population ratios less than the statewide rate. Five counties have fewer than 1,000 persons for every primary care physician; 16 counties have one primary care physician for every 2,000 to 2,999 persons; 27 counties have one primary care physician for every 3,000 to 3,999 persons; 10 counties have one primary care physician for every 4,000 to 4,999 persons; and 17 counties have one primary care physician for every 5,000 to 5,999 persons. The 47 counties that have a primary care physician-to-population ratio in excess of the state ratio represent less than three percent of the state's population.

There are about 8,100 dentists, 150 pedodontists and 300 oral surgeons in Illinois. (The number of dentists includes all licensed dentists including specialists. It includes those who continue to hold active licenses but do not practice because they live or practice in another

jurisdiction or are semi-retired or practice part-time.) According to the American Dental Association approximately 80 percent of all licensed dentists are general practitioners, approximately 6,500 currently in Illinois, one general dentist per 1,769 people. The entire State, with the exception of three rural counties (Brown, Scott and Henderson), qualifies as a dental health provider shortage area for low income people. In 1990, the four Illinois dental schools graduated 440 dentists annually. The Loyola University dental school closed in 1996 and the Northwestern University dental school is closing this year. In 2001, the two remaining Illinois dental schools will graduate about 100 dentists annually, a decrease of about 70 percent in one decade.

There are about 5,450 dental hygenists in Illinois. (This includes those who continue to hold active licenses but do not practice because they live or practice in another jurisdiction or are semi-retired or practice part-time.) According to the ADA, the appropriate ratio of dentist to dental hygienist is 2 to 1. This takes into account the number of dentists who do not employ dental hygienists. The ratio of dentist to dental hygienist in Illinois is 2 to 1.5. In 1990, the six dental hygiene schools graduated from 150 to 180 dental hygienists annually. In 2002, the ten dental hygiene schools will graduate approximately 285 dental hygienists. With two additional schools graduating their first students by 2003, Illinois will be graduating close to 350 dental hygienists annually, a 50 percent increase in a decade.

The number of persons in other health professions, based on active licenses, include 127,700 registered professional nurses; 26,450 licensed practical nurses; 3,150 occupational therapists; 5,450 physical therapists; 3,900 speech-language pathologists; 550 audiologists; 3,200 licensed social workers; 7,250 clinical social workers; and 3,250 clinical psychologists. Data were not available by county.

Illinois has seven accredited schools of medicine (six are located in Cook County, and one is located downstate) and 405 residency programs; 27 baccalaureate nursing programs, three dental schools; 10 schools of dental hygiene; 11 didactic programs in dietetics (leading to at least a baccalaureate degree); 10 doctoral programs in clinical psychology; six graduate

programs in social work, and 10 mental health counselor training programs.

CSHCN. The needs assessment identified that access to specialty medical care, respite care, genetic testing, counseling and dental care need to be improved for CSHCN. Not all medical services are supported by third party payers. Services most frequently not covered by a third party resource are hearing aids, hearing tests, diapers, ostomy supplies and some kinds of medical equipment. Therefore, gap-filling services remain a necessity for CSHCN. In addition, assessment found that 29.2% reported that the services are too far from their home and 14.6% have transportation problems in accessing medical services.

Illinois CSHCN have access to the following credentialed surgical centers: 18 cleft lip/cleft palate, 9 cranio-facial, 9 cochlear implant, 5 pediatric ambulatory surgical, 9 pediatric cardiac, and 6 epilepsy surgical centers.

Responses in the Family Survey indicate that many families may not have access to key components of a Medical Home as described by the American Academy of Pediatrics. In addition, regional offices reported that a range of 50% to 99% of DSCC families identified a primary care provider (PCP). Communication with the PCP ranged from "almost none" to "considerable." A lower range of 50-75% of families had an identified PCP in the Chicago urban area. Care coordinators in the Chicago area were less likely to communicate with PCPs. Staff identified barriers to working with a PCP including: physician time; DSCC caseloads; number of PCPs (particularly in the urban Chicago area); use of public clinics and ERs; physician attitudes toward government agencies; billing and insurance issues; complexity of the CSHCN's condition; highly mobile population; frequent changes in PCP due to insurance changes; and language/cultural barriers.

Under-served Areas. Using a population of less than 85,000 as a standard identifies 84 of Illinois' 102 counties as rural areas. These 84 counties represent 18 percent of the state's population. All of 19 and parts of 15 more counties have been designated primary care health professional shortage areas. Within the City of Chicago, all of 20 and part of 1 community

areas have been designated as primary care health professional shortage areas. Further, all of 19 counties and one or more townships in 51 more counties have been designated full or partial medically under-served areas or to have medically under-served populations. Within the City of Chicago, 12 community areas have been designated as fully medically under-served areas, 24 have been designated as partially medically under-served areas and one has been designated to have a medically under-served population. Maps depicting these designations may be found in Section 5.3, "Other Supporting Documents." Access to care due to a limited supply of health care providers remains a problem for both rural Illinois and inner-city Chicago.

The IDPH's Center for Rural Health (CRH) is responsible for Illinois' Primary Care Cooperative Agreement. Funds provided through the cooperative agreement are used to identify underserved populations and direct recruitment and retention activities to improve access to primary health care services. The CRH, with state and federal partners, conducts recruitment and retention workshops for rural and urban recruiters, conducts "Preparation for Practice" workshops for senior health professions students, provides technical assistance to small and rural hospitals, awards educational scholarships and administers a loan repayment program to increase the number of primary care providers in under-served areas of the state. During 1999, scholarships were provided for 127 medical students, 13 student nurse practitioners, 7 student physician assistants, 80 student nurses and one podiatric student. The CRH also receives a grant from the National Health Services Corps for a state and locally-matched loan repayment program. Eight health professionals received awards in 1999.

3.1.2.4 Population-Based Services

Illinois has extensive and successful programs providing population-based services for women and children. Illinois' success in meeting the need for these services is illustrated by several federal and state measures:

- More than 97 percent of the children born in Illinois were screened for six metabolic disorder. Actual performance was slightly below the goal of 98 percent.
- 70 percent of Illinois' birthing hospitals were screening newborns for hearing loss. These

hospitals account for approximately 88 percent of the state's births.

- According to the National Immunization Survey, 77.5 percent of the two-year-olds in Illinois have received 4 doses of Diphtheria, Tetanus and Pertussis vaccine, three doses of polio vaccine, one dose of Measles, Mumps and Rubella Vaccine and three doses of Haemophilus Influenzae B vaccine. Illinois' performance is still below the national objective of 80 percent by 2010.
- Each family who lost a child to Sudden Infant Death Syndrome received follow-up counseling.
- Illinois achieved its goal for reducing the prevalence of early childhood caries. The state's actual performance was 34.8 percent, somewhat below the objective of 39.0 percent.
- Illinois exceeded its goal of increasing the proportion of third-grade children who have protective sealants on at least one permanent molar tooth. The state's actual performance was 26.6 percent, somewhat above the goal of 25.0 percent.
- Illinois screened 238,365 children for lead poisoning in 1999, and sixteen percent of them were found to have elevated blood lead levels.
- Illinois exceeded its goal of reducing motor-vehicle crash deaths among children between 1 and 15 years of age. The actual mortality rate was 3.3 per 100,000 children age 1 - 14 years in 1998, more than 20 percent below the goal of 4.2 per 100,000.
- Illinois exceeded its goal for increasing the proportion of mothers who were breastfeeding at hospital discharge. The state's actual performance in FY'98 was 38.2 percent, slightly greater than the objective of 38.0 percent.

Most of these programs are operated by the IDPH. The IDHS and IDPH, along with DSCC are working to develop the state's program for newborn hearing screening. The IDHS has received a newborn hearing screening program grant from the federal Maternal and Child Health Bureau. Part of these grant funds are transferred to IDPH to support reporting and tracking of infants with suspected hearing loss. IDPH recently submitted a proposal to the federal Centers for Disease Control and Prevention for additional funds to support the newborn hearing screening program. The WIC program, which addresses breast feeding at hospital discharge, is operated by IDHS. Motor-vehicle related child mortality is addressed by each

agency, through Safe Kids coalitions supported by IDPH and through the Car Safety Seat program administered as a component of the Teen Parent Services program. Each of these programs is available statewide.

3.1.2.5 Infrastructure Building Services

Local Delivery System. The Office of Family Health provides no direct services. All of the primary and preventive care services are provided by grantees of the IDHS. Most often, these are local health departments. Community Health Centers also play an integral role in the delivery of primary and preventive care to pregnant women, mothers, infants, children and adolescents.

Local health departments. Local health departments were first established in Illinois by "AN ACT to authorize the organization of public health districts and for the establishment and maintenance of a health department for the same", (70 ILCS 905/1) effective July 1, 1917. Municipal health departments are governed by Section 17 of the Illinois Municipal Code of 1961 (65 ILCS 5/11-17-1). The statutory base for county and multiple county health departments (55 ILCS 5/5-25001) was revised July 1, 1990. Local health departments in Illinois are all tax supported to some degree. For county health departments, a local tax levy of as much as 0.1 percent of the assessed value of all taxable property in the county can be instituted through referendum; the actual rate is set, up to the legal maximum, through a vote of the county board (55 ILCS 5/5-25003 and 55 ILCS 5/5-25004). Counties that previously had established a tuberculosis sanitarium may abolish it and use its tax levy to establish a county health department (55 ILCS 5/5-25002).

While there are some differences in the statutes authorizing public health districts and county and multiple county health departments, both establish a board of health that is responsible for the operation of the health department. County and multi-county health departments can be established either by a resolution of the county board or by referendum of the voters. IDPH has statutory authority to "promulgate rules and regulations setting forth minimum standards

for programs and performance. The Department is further authorized to prescribe minimum qualifications for the professional, technical and administrative staff. . ." of a local health department (55 ILCS 5/5-25002). The minimum standards for four Health Protection programs (Infectious Diseases, Food Protection, Potable Water Supply, and Private Sewage Disposal) are contained in 77 Ill. Adm. Code 615; the Certified Local health Department Code (77 Ill. Adm. Code 600) contains minimum qualifications for personnel and public health practice standards.

There are eight "public health practice standards" that each local health department must perform to be certified by the IDPH:

- Assess the health needs of the community by establishing a systematic needs assessment process that periodically provides information on the health status and health needs of the community.
- Investigate the occurrence of adverse health effects and health hazards in the community by conducting timely investigations that identify the magnitude of health problems, duration, trends, location and populations at risk.
- Advocate for public health, build constituencies and identify resources in the community by generating supportive and collaborative relationships with public and private agencies and constituent groups for the effective planning, implementation and management of public health activities. The local health department shall develop and strengthen communication with units of government, health related organizations, health providers, citizens and news media.

- Develop plans and policies to address priority health needs by establishing goals and objectives to be achieved through a systematic course of action that focuses on local community needs and equitable distribution of resources, and involves the participation of constituents and other related governmental agencies. A community health plan that addresses at least three priority health needs will be developed during each certification period.
- Manage resources and develop organizational structure through the acquisition, allocation

and control of human, physical and fiscal resources; and maximizing the operation al functions of the local public health systems through coordination of community agencies' efforts and avoidance of duplication of services.

- Implement programs and other arrangements assuring or providing direct services for priority health needs identified in the community health plan by taking actions which translate plans and policies into services.
- Evaluate programs and provide quality assurance in accordance with applicable professional and regulatory standards to ensure that programs are consistent with plans and policies and provide feedback on inadequacies and changes needed to redirect programs and resources.
- Inform and educate the public on public health issues of concern in the community, promoting an awareness about public health services, availability, and health education initiatives which contribute to individual and collective changes in health knowledge, attitudes and practices towards a healthier community.

To complete the planning process described in the practice standards, local health departments are required to use the Illinois Project for Local Assessment of Needs (I-PLAN), or an equivalent process. I-PLAN is described in the Needs Assessment Process.

Local health departments, by state statute and administrative rule, constitute the cornerstone of the system for delivering preventive and primary care services to mothers, infants, children and adolescents. As of July 1, 2000, there were 47 "resolution" health departments (those established by resolution of a county board) and 47 "referendum" health departments. These health departments serve 99.5 percent of Illinois' population, and receive funding from IDHS and IDPH for some component of the preventive and primary care service system. All 94 local health departments are grantees of IDHS' MCH program.

Federally Funded Community Health Centers. Illinois has 34 community health centers funded under Section 330 of the Public Health Service Act; 20 are located in Chicago. Several of the centers are receiving program grants from IDHS and three Community Health Centers in

the Healthy Start Project Area are the "health care partner" in a Chicago Healthy Start Family Center. One of the Community Health Centers in St. Clair County is also a federal Healthy Start project grantee and is participating in IDHS' new MCHB-funded demonstration program to improve systems of care for pregnant women experiencing domestic violence.

Coordination with Other Federal Programs.

Medicaid. IDHS, IDPH and DSCC all work closely with Illinois' Medicaid and State Child Health Insurance Programs. The Title V Director and the CSHCN Director each serve on statewide advisory committees to the Illinois Department of Public Aid, the single state agency responsible for the administration of both Title XIX and Title XXI in Illinois. A revised interagency agreement with IDPA for claiming federal financial participation for the Family Case Management program is being prepared.

SSDI. The IDHS and DSCC are collaborating with the University of Illinois at Chicago School of Public Health's Center for Public Health Practice, Maternal and Child Health Training Program and the Department of Epidemiology and Biostatistics and the Department of Pediatrics at the University of Nebraska Medical Center to conduct the Illinois MCH Data Use Academy.

Early Intervention. The Office of Family Health and the Bureau of Part C Early Intervention are located within the same organizational unit at IDHS (the Division of Community Health and Prevention) The Title V Director is a member of the program's advisory committee. The Part C program has been an active participant in the new Universal Newborn Hearing Screening program.

Other Health Care Programs. The Office of Family Health is responsible for the School Health and WIC programs; information about these programs is provided in Section 1.5.

Ryan White and Title IV AIDS programs. The MCH program is working closely with the AIDS Activity Section at IDPH on the implementation of new efforts to reduce perinatal

transmission of HIV. Additional information may be found in Section 1.5.1.2.

Programs for CSHCN. The relationship between DSCC, IDHS and the Illinois State Board of Education for the SSI program, transition services, special education and vocational rehabilitation programs is discussed in Section 1.5 and other parts of this applicaiton.

Coordination with Provider and Consumer Associations.

Provider Associations. The Title V Director is a member of the Illinois Chapter of the American Academy of Pediatrics' Executive Council and has published articles on home visiting, Healthy Child Care Illinois, Newborn Hearing Screening and other MCH programs in the chapter's newsletter. The MCH program has worked with the state chapter on immunization projects, child health insurance and other concerns.

Parent and Consumer Groups. The Title V program's relationships with child, parent and family advocacy organizations is described in Section 4.3 of the application. Analysis of family participation in the State CSHCN Program, identified the need to increase access to family advice through a structured approach. A parent advisory committee has been established in the CSHCN program to address this need.

Four Constructs of A Service System

1) State program collaboration with State Agencies and Private organizations

DSCC maintains an ongoing collaborative relationship with state agencies through various program initiatives based on assessment of need and efforts to enhance comprehensive services for CSHCN. These agencies include, but are not limited to, the Illinois Department of Human Services, Illinois Planning Council for Developmentally Disabled, Illinois Department of Children and Family Services, the Illinois Department of Public Aid and the Illinois Department of Public Health. Individual program collaboration includes, the IPLAN process, the Birth To Three Assurance Network, the State Hemophilia Program, Newborn Genetic Screening, Universal Newborn Hearing Screening, Early Intervention, Statewide Transition

Consortium and Otology/Audiology Clinics.

2) State support for communities

DSCC staff participate in the Illinois Institute for MCH Leadership. This effort develops and brings leadership knowledge, skills and attitudes to DSCC staff working at the community level, providing increased awareness of the needs of CSHCN and their families in system planning activities. Through the statewide regional staff, DSCC supports community partnering to identify and meet the needs of CSHCN through participation with interagency coalitions, committees, and advisory groups, such as the Birth to Three Assurance Network, Early Intervention Local Interagency Councils, Transition Planning Committees, and Health Childcare Illinois.

3) Coordination of health components of community-based systems

Regional office professional staff maintain relationships with local health departments, WIC programs, Headstart programs, local physicians, and other community health providers to facilitate and enhance care coordination for CSHCN.

4) Coordination of health services with other services at a community level.

A pilot project is under way to implement the Medical Home concept for CSHCN to further enhance care coordination and service integration for this population. Through 13 Regional Offices, DSCC provides care coordination to eligible CSHCN throughout the state and links families to an array of community services including Part C Early Intervention, Special Education, Office Rehabilitation Services, and other family support services. As indicated, DSCC staff participate in IEP/IFSP development to enhance service integration for CSHCN. Statewide, DSCC staffs over 40 satellites to bring care coordination into local communities.

Monitoring and Quality Assurance.

The IDHS' Bureau of Community Health Nursing, the Nutrition Services Section in the Bureau of Family Nutrition, the Field Operations Section in the Bureau of Central and Field Operations and the Program Evaluation section in the Bureau of Performance Management

Systems and Support are all concerned with assuring the quality of nursing, nutrition and administration in MCH programs at the community level. The activities of these units are described in Section 1.5.1.1.

IDHS' minimum standards for Title V services and local service systems are presented in the *Maternal and Child Health Services Code*, the *Family Planning Services Code*, the *Regionalized Perinatal Care Code*, the *Problem Pregnancy Health Services and Care* Code, and the *Newborn Metabolic Screening and Treatment Code*. These rules describe the content of health services provided by MCH program grantees, the administrative requirements for MCH grant funds, and the standards to be followed in providing health services. The incorporated standards include:

- The *Accreditation Manual for Hospitals* of the Joint Commission on Accreditation of Health Care Organizations;
- *Hospital Care of Children and Youth*, American Academy of Pediatrics;
- *Guidelines for Perinatal Care*, American Academy of Pediatrics, American College of Obstetrics and Gynecology, and the March of Dimes;
- *Towards Improving the Outcomes of Pregnancy*, the National Foundation -March of Dimes;
- *Guidelines for Health Supervision II*, American Academy of Pediatrics;
- Standards for Obstetric - Gynecologic Services, American College of Obstetrics and Gynecology;
- *School Health: A Guide for Health Professionals*, American Academy of Pediatrics;
- *Standards of Maternal and Child Health Nursing Practice*, American Nursing Association;
- A Statement on the Scope of Maternal and Child Health Nursing Practice, American Nursing Association;
- Standard of Practice for the Perinatal Nurse Specialist, American Nursing Association;
- *Standard of Community Health Nursing Practice*, American Nursing Association;
- *Definition and Role of Public Health Nursing in the Delivery of Health Care*, American Public Health Association.

3.2 Health Status Indicators

Data for the "Core" and "Developmental" health status indicators are presented in the tables in section 5.4 and 5.6 of this application, respectively. The corresponding detail sheets are presented in sections 5.5 and 5.7, respectively.

3.2.1 Priority Needs

The priority needs are proposed for the general population of women and children:

- reduce the infant mortality rate;
- reduce the low birth weight rate;
- increase the proportion of very low birth weight infants born in a Level III facility or Perinatal Center;
- increase the proportion of children who receive primary care services as recommended in the Guidelines for Health Supervision of the American Academy of Pediatrics;
- reduce the fertility rate among girls ages 15 through 17; and
- reduce the rate of child abuse and neglect.

The following priorities are proposed for children with special health care needs:

- Improve community access for CSHCN to specialized medical services through care coordination activities.
- Enhance the comprehensive, community-based, culturally sensitive care coordination system for CSHCN by implmenting the Medical Home concept within the CSHCN program.

- Facilitate enrollment in the State Child Health Insurance Program (KidCare or Medicaid) for CSHCN who meet eligibility criteria and apply for financial assistance from DSCC.
- Increase assistance for CSHCN eligible for SSI in accessing needed services.
- Increase efforts to assist adolescents with special health care needs in accessing transition services, with an emphasis on transition to adult health care.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

Refer to the "FY 2001" columns in Form 3, Form 4, and Form 5 for an analysis of the Department's proposed budget for the coming year.

3.3.2 Other Requirements

3.3.2.1 Maintenance of Effort

IDHS and DSCC use State General Revenue funds, Title IV (IDCFS) funds, Title X (Family Planning program) funds, Title XX (Social Services Block Grant) funds, MCH set-aside funds and Healthy Start initiative funds in addition to Title V Block Grant funds to achieve the objectives described in this application.

The State has maintained its effort at the FFY'89 level. The amount of State support for the MCH program was $27,569,600. The State support demonstrated in this budget is $53.2 million in state General Revenue funds.

IDPH had five "programs of projects" in 1981. Maternal and infant, and children and youth projects were consolidated with the childhood lead project at the Chicago Department of Health, and continues as a consolidated MCH project. The Winnebago Family Planning Project and the Lake County Family Planning Demonstration Project continue as part of IDHS's comprehensive Family Planning program. The Intensive Infant Care Project at St. Francis Medical Center in Peoria continues to operate as a part of the Illinois regionalized perinatal care program. These projects are now administered by IDHS. The amount of funding awarded to each project is as follows:

Winnebago Family Planning	$406,500
St. Francis Perinatal Center	$361,200

Chicago Department of Health (M&I, C&Y)	$6,765,700
Lake County Demonstration	$361,600
Dental Projects	$333,000

IDHS has continued targeting funds to mandated Title V activities. Funds allocated to the State under this Title will only be used consistent with Section 508 to carry out the purpose of this Title or to continue activities previously conducted under the Consolidated Health Programs. IDPH continues to fund statewide projects addressing lead poisoning, genetic diseases and SIDS program while IDHS continues to fund programs related to adolescent pregnancy.

Sections 501(a)(1)(A) through (D) of the Social Security Act as amended by OBRA '89 describe the basic purposes of the MCH Block Grant. Illinois plans to use MCH Block Grant funds to achieve these purposes through its system development activities, as well as by providing grants for preventive and primary care services to agencies statewide. The purposes outlined in Sections 501(a)(1)(A) and (B) are achieved by the grants that IDHS awards for prenatal, perinatal, adolescent health promotion and pediatric primary care. The purpose outlined in Section 501 (a)(1)(C) is achieved by DSCC, in part with MCH Block Grant funds. The purpose outlined in Section 501 (a)(1)(D) is the principle responsibility of DSCC. The proportion of Title V funds used for Sections 501 (a)(1)(A) and (B) is 68 percent, and for Sections 501 (a)(1)(C) and (D) is 32.1 percent.

The required match is $17,625,204. The State of Illinois has exceeded that by providing a total of $53,165,956..

IDHS receives the MCH Block Grant and administers primary care programs. IDHS transfers 32.1 percent of its block grant funds to DSCC for the CSHCN program. IDHS gives highest priority to those areas in Illinois that have high concentrations of low-income families (an area where 20 percent of the families, or at least 1,000 individuals, have an income at or below the federal poverty level), that are medically under-served areas, or are areas of high infant

mortality and teenage pregnancy. Priority is also given to areas of high poverty rates which have a demonstrated need for services. Program grants are awarded to local political jurisdictions or private, non-profit agencies. Applications are reviewed by a committee and recommendations for funding are made to the Secretary of the Illinois Department of Human Services. Continuation applications receive priority in order to maintain continuity of services.

IDHS has not established a fee scale for use by its MCH program grantees, and has no plans to do so. Each project funded through the MCH program may elect to charge eligible recipients for certain services provided by the project. However, a flexible sliding-fee scale must be used when a project intends to charge for services and no fees are charged to low-income clients. The fee scale must be included for approval in the project application prior to any fees being charged. Further, all projects are required to have agreements with the Medicaid program for reimbursement of covered services for project patients who are Title XIX recipients. Steps must also be taken to obtain reimbursement from non-profit, semi-private and private medical insurance programs, when these programs cover services rendered by the projects. Finally, outpatient services must be provided at rates established by IDPA for the Medicaid program. These provisions are made to ensure that mothers and children from low-income families are not charged for services.

3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

The national "Core" performance measures for the Maternal and Child Health Services Block Grant are presented in Figure 4.

FIGURE 4

CORE PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined)			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care				X	X		
12) Percent of children without health insurance				X	X		

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program				X		X	
15) The rate (per 100,000) of suicide deaths among youths 15-19				X			X
16) Percent of very low birth weight live births				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

3.4.1.1. Five Year Performance Targets

The state's five year performance targets for the "Core" and "State Negotiated" performance measures are presented on Form 11, which may be found in Section 5.8.

3.4.2 State "Negotiated" Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

Illinois' proposed "State Negotiated" performance measures are presented in Figure 4A, below. Each measure is categorized by "level of the pyramid" (direct health care, enabling, population-based and infrastructure building) and by type (capacity building, process or risk factor).

FIGURE 4A

NEGOTIATED PERFORMANCE MEASURES SUMMARY SHEET

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The proportion of live births who receive adequate prenatal care, as measured by the modified Kessner Index		X					X
2) The proportion of women experiencing a live birth who have had a live birth in the prior eighteen months	X						X
3) The incidence of maltreatment of children younger than age 18		X					X
4) The proportion of TANF-enrolled young parents age 18 through 20 who will complete a high school education or its equivalent		X				X	
5) The proportion of CSHCN ages 14 and above and their parents who receive comprehensive transition planning services to promote awareness of adult services				X		X	
6) The proportion of DCFS caseworkers who have been trained on CSHCN and DSCC services				X		X	
7) The number of maternal and child health program staff DSCC and from local health departments who have completed the MCH Leadership Institute				X	X		
8) The proportion of families who receive appropriate genetic testing, counseling and follow-up services	X						X
9) The proportion of parents and care givers who use feeding practices that prevent Early Childhood Caries/Baby Bottle Tooth Decay			X				X
10) The number of maternal and child health program staff from local health departments and DSCC staff who have completed the Illinois MCH Data Use Academy				X	X		

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2.2. Discussion of State Performance Measures

State "Negotiated" Performance Measure #1 was chosen because of its relationship to infant mortality (a priority health problem) and to highlight the importance of prenatal care, including

prenatal genetic testing and counseling. It is at the "enabling service" level of the pyramid, addresses the population of pregnant women, and addresses a risk factor for infant mortality.

State "Negotiated" Performance Measure #2 was chosen because of its relationship to infant mortality (a priority health problem) and to highlight the importance of family planning services. It is at the "direct service" level of the pyramid, addresses the population of women of reproductive age, and is intended to prevent a risk factor for infant mortality.

State "Negotiated" Performance Measure #3 was chosen to address child abuse and neglect, a priority health problem. The objective is addressed by the Healthy Families Illinois initiative, as well as the Parents Too Soon home visiting projects, and programs directed at children with birth defects and genetic diseases who are at risk of abuse and neglect. It is at the "enabling" level of the pyramid (since program services consist of interventions to improve parenting skills), addresses the population of children and adolescents, and is intended to reduce a risk factor for child morbidity and mortality.

State "Negotiated" Performance Measure #4 was chosen to emphasize the importance of educational attainment in reducing welfare dependence and attaining economic self-sufficiency, which is at the core of the IDHS' mission. It is placed at the "enabling" level of the pyramid (since program services use a case management approach to support teen parents in completing their education), addresses the population of children and adolescents, and is a process type of service, since its attainment contributes to improved health status among adolescents.

State "Negotiated Performance Measure #5 Drafted protocol for staff is being reviewed for statewide implementation of transition plans for CSHCN as an expansion of enabling services for care coordination. Infrastructure building occurred when DSCC participated in the State Interagency Transition Council that developed a transition pamphlet for use by families and providers.

State "Negotiated" Performance Measure # 6 To enhance care coordination activities for CSHCN who are also wards of DCFS, an educational packet was developed to assist DCFS caseworkers in identifying CSHCN and facilitate collaboration with DSCC staff in the process of care coordination. This performance measure is related to infrastructure building and is considered a process type of service.

State "Negotiated" Performance Measure #7 was chosen to highlight the importance of leadership development in building a statewide infrastructure for MCH and CSHCN service delivery, which in turn contributes to the achievement of all of the state and federal performance measures. For these reasons, the objective is placed at the "infrastructure building" level of the pyramid, addresses all three populations and is considered a capacity type of service. The MCH Leadership Institute was initiated with State System Development Initiative funds, and the performance target established for the institute while it was supported by SSDI funds was achieved. The institute is now being sustained with MCH Block Grant Funds.

State "Negotiated" Performance Measure #8 was chosen because Illinois has a substantial number of newborns, children and adults whose genetic conditions necessitate extensive and coordinated health care services. These services should be an integral part of the health delivery system and provide, in addition to management of the indexed case, supportive counseling and an explanation of the inheritance risk factors for all family members. Although local health agencies and genetic centers do receive minimal funding, there remain communities which seriously lack any resources to meet such needs. Factors such as low income, access to transportation, lack of third party payers, and geographic isolation create problems and prevent many from receiving even the barest of genetic services. By utilizing established clinics and implementing specialty clinics within local public health agencies, IDPH will be able to reach specific sub-groups previously underserved.

Because preconception/prenatal genetic counseling, prenatal testing, newborn screening, and early diagnosis can each help prevent premature death, excessive morbidity, mental retardation

and other developmental disabilities, the link is readily apparent between this state performance measure and the Federal Outcome Measures #1, 3, 4, 5, and 6. In addition, there is a substantial integration of services within this performance measure offered by IDPH and both the Federal Core Performance Measures #1, 2, 3,4, 10, and 15 and the State Performance Measures #1, 3 and 5. This performance measure is placed at the "direct health care" level of the pyramid, and is considered a risk factor type of service. This measure will be addressed by IDPH.

State "Negotiated" Performance Measure #9 was chosen because 12 of the 19 Illinois communities completing an oral health needs assessment and comprehensive oral health plan in 1997 identified ECC/BBTD as an oral health priority, intervention strategy and/or source of primary community-specific data collection. This performance measure is placed at the "population-based services" level of the pyramid, and is considered a risk factor type of service. This measure will be addressed by IDPH.

State "Negotiated" Performance Measure #10 was chosen to highlight the Illinois MCH Data Use Academy as an effort to develop the data analysis, decision-making and advocacy skills of maternal and child health program staff at the local level, as well as central office staff from DSCC. The objective is directed to the "infrastructure building" level of the pyramid and is considered a "capacity building" service.

3.4.2.3 Five Year Performance Targets

Performance targets for Federal Fiscal Years 2001 through 2005, as well as actual performance data for Federal Fiscal Years 1996 through 1999, where available, are presented for each "State Negotiated" performance measure on Form 11 in Section 5.8.

3.4.2.4 Review of State Performance Measures

The state's proposed performance indicators will be reviewed and negotiated with MCHB personnel during the review of this application.

3.4.3 Outcome Measures

Please refer to Section 5.8, Form 12, for the annual targets for each outcome measure.

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

4.1.1 Direct Health Care Services

Direct Preventive and Primary Health Care Services for Pregnant Women, Mothers and Infants

State "Negotiated" Performance Measure #2: The proportion of women experiencing a live birth who have had a live birth in the prior 18 months

This performance measure will be addressed by the routine operation of the Family Planning, Family Case Management, Chicago Healthy Start, Teen Parent Services, Parents Too Soon and Subsequent Pregnancy Prevention programs.

The Teen Parent Services and Parents Too Soon programs, as well as the Subsequent Pregnancy Project, provide instruction on effective contraception use and monitor pregnancy prevention plans.

Based on Medicaid billing and TANF caseload information, it is apparent that TANF-eligible women of reproductive age are under-utilizing family planning services. Each Family Planning delegate agency is developing a written agreement with the IDHS local offices in its service area. The purpose of this agreement is to encourage more referrals for family planning services from the Department's local offices.

Chicago. Approximately 15 percent of the women in Chicago who gave birth in 1996 or 1997 had also given birth in the prior 18 months. The CDOH estimates that this proportion can be reduced to 13.9 percent by the year 2000 through three strategies. First, the CDOH has

changed its clinic policies so that a post-partum clinic visit is automatically scheduled at the time that responsibility for a woman's prenatal care is transferred to the staff of the hospital at which she plans to deliver. Second, the CDOH has asked its affiliated hospitals to refer women back to the clinic that provided their prenatal care. Third, the Chicago MCH Advisory Committee is working to implement a more effective follow-up system through the perinatal networks to ensure that women receive post-partum care.

State "Negotiated" Performance Measure #8: The proportion of families who receive appropriate genetic testing, counseling and follow-up services

Local health departments, clinical geneticists and other specialists will receive funding to provide assessment, counseling, education, and referrals for long-term management of families with a member diagnosed with a genetic condition. IDPH's planned activities are as follows:

- Clinical genetics centers will provide genetic diagnosis, counseling, treatment and management to pediatric and adult patients;
- Satellite clinics staffed by medical geneticists and counselors will be on site at local health agencies;
- Local health departments will provide services related to genetics;
- Use of the Genetic Screening Tool by local health departments will be expanded;
- Specialized services (i.e., Illinois Teratogen Information Service, pediatric metabolic and endocrine clinics and preconception/prenatal testing and counseling) will be expanded;
- Workshops will be held for professionals, families and the general public;
- IDPH will collaborate with other programs, divisions and departments in the state to provide comprehensive services to all families in need.

Direct Health Care Services for Children with Special Health Care Needs

Federal Performance Measure #1: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN program

DSCC will implement changes in the SSI-Disabled Children's Program to enhance service linkages based on recommendations from the FY99 SSI pilot project. Parents of SSI children age five and under that may be medically eligible for DSCC services will be sent an application. DSCC will contact the families that do not return the application. A method of evaluation will be established to monitor the results of this program implementation to identify needed revisions.

DSCC will continue to provide financial assistance for specialty hospital/medical care, therapy services, medications and durable medical equipment and supplies. For all Illinois children with suspected hearing loss, including newborns, DSCC will provide audiological/otologic diagnostic evaluations. DSCC plans to assist clients without health insurance or with inadequate health insurance to apply for KidCare. As KidCare provides financial assistance to a significant group of DSCC clients, the money saved from enrolling DSCC clients in KidCare will be used to expand care coordination activities by conducting more home or person-to-person visits, investing more effort in transition planning, and making more educational opportunities available to families regarding their child's medical condition.

4.1.2 Enabling Services

Preventive and Primary Care Enabling Services for Pregnant Women, Mothers and Infants

State "Negotiated" Performance Measure #1: The proportion of infants whose mothers receive adequate prenatal care, as measured by the Modified Kessner Index

This performance measure will be addressed through the FCM and WIC programs. The integration of these programs is facilitated by the Cornerstone management information system. Cornerstone has now been installed in all WIC and FCM agencies statewide. Management reports allow managers to track the utilization of both programs, and identify individuals who receive only one, but not both, services. Ideally, every pregnant woman and

infant participating in either program will receive services from both, since program eligibility criteria are identical. The Department will continue to monitor service integration and provide technical assistance on this topic to local service providers.

The Family Planning program, School-Based and School-Linked Health Centers, the Parents Too Soon pregnant and parenting program, the Unmarried Parents program, and the Teen Parent Services program will continue to provide information to pregnant women and teens regarding appropriate prenatal care.

The TPS and FCM programs have integrated and coordinated services in those downstate local health departments where both programs are available to the family. In FFY2001, such coordination will be expanded to other parts of the state. At the local program level for TPS, agencies are coordinated, referring for WIC and FCM and working with the MCH nurses to better provide health and prevention services. Special projects are taking place at the local level, including work with schools, churches and other organizations.

The new Targeted, Intensive Prenatal Case Management initiative will be implemented in at least four communities during FY '01. The use of incentives to promote regular participation in prenatal care will be tested.

Chicago. Case managers and public health nurses will continue to encourage women to enroll and remain in prenatal care until delivery. Family planning staff will ensure that women with positive pregnancy tests are enrolled in care as soon as the test has been confirmed, or ensure that those with negative tests who do not desire to be pregnant receive family planning services.

Preventive and Primary Care Enabling Services for Children and Adolescents

State "Negotiated" Performance Measure #3: The incidence of maltreatment of children younger than age 18

This performance measure is addressed by the Healthy Families Illinois and Parents Too Soon programs. The Illinois General Assembly appropriated an additional $2.0 million to further expand HFI for SFY2001. This increase will allow the Department to add as many as seven new program sites, bringing the total number in the state to 51. Two of these sites will be enhanced Parents Too Soon pregnant and parenting teen programs.

Chicago. The CDOH has identified the enhancement of parenting skills among families as a specific objective and has recently hired a child development specialist, whose job is to work more closely with parents and care givers to improve parenting skills. The CDOH plans to include males in the target group.

State "Negotiated" Performance Measure #4: The percent of TANF-enrolled young parents ages 18 through 20 who will complete a high school education or its equivalent (i.e., GED).

The Teen Parent Services (TPS) program has been working on several fronts to make services more readily accessible to TANF-eligible teen parents. Whenever possible, the services that help remove barriers to school completion, such as substance abuse or mental health treatment, domestic violence intervention and information about child support enforcement will be provided on-site. As an initial step, the MCH program worked with the Department's Office of Alcoholism and Substance Abuse (OASA) treatment to place a substance abuse counselor from a community-based substance abuse treatment agency at one of the Department's TPS program offices in Chicago. Various co-location approaches will be phased in to allow for unique geographic, logistic and systemic problems to be resolved.

The role of TPS program case managers at IDHS local offices has been expanded to include

determination of eligibility for TANF and food stamp benefits for the teen parent's entire family. This will facilitate service coordination, expand services and simplify service delivery to the family. Secondly, during FFY2000, the TPS program's target population was expanded to include teen parents who receive Medicaid but not TANF. By serving parents on KidCare Assist, case managers can target services to a broader population and increase the number of parents who attain and maintain self-sufficiency. Program case managers will monitor school attendance and school performance to ensure teen parents attain their high school diploma or GED.

In order to support TPS service providers statewide in achieving the goal of high school completion, a wide array of methods are being used and include:

- new program support staff have been located in Cook County;
- a comprehensive monitoring tool for contract compliance has been developed in collaboration with the Bureau of Central and Field Operations. The tool is designed to free up program staff so that they can focus on policy and individual client services;
- specialized training for supervisory staff, coordinated by Northern Illinois University (NIU);
- on-going supervisory/management meetings to address program concerns; and
- the establishment of an advisory work group to review policy and issues related to the program model.

Enabling Services for Children with Special Health Care Needs

Federal Performance Measure #3: The percent of Children with Special Health Care Needs (CSHCN) in the state who have a "medical/health home"

DSCC will finish the pilot efforts and use the findings from the pilots to determine the policy chamges needed, barriers and strategies for implementing the Medical Home for CSHCN in the DSCC program. As the number of primary care physicians working with DSCC increases, technical assistance from pediatric facilitators will be made available to Medical Home

Providers who have limited experience caring for CSHCN.

4.1.3 Population-Based Services

Population-Based Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

Federal Performance Measure #4: The percent of newborns in the state with at least one screening each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases)

The IDPH Newborn Metabolic Screening program will continue to ensure that every newborn in the state is screened. The Newborn Metabolic Screening program will implement the Computerized Accessible Network for Tracking Mothers/Infants Information System (CANTMIIS) statewide. This system will allow for complete tracking of all newborn screening specimens submitted to the State laboratory, as well as more timely access to results by hospital staff. IDPH and DSCC will continue to partner in the care of children diagnosed with a metabolic or genetic disorder.

Federal Performance Measure #9: To increase the percentage of mothers who breastfeed their infants at hospital discharge

WIC is the Special Supplemental Nutrition Program for (low-income) Women, Infants and Children that provides nutrition information, supplemental foods and referral to other health and social services for the target population. The WIC program in Illinois currently provides services each month to more than 240,000 pregnant, postpartum and breastfeeding women, infants and children up to age 5 years. Breastfeeding information and support is also provided to families. The WIC program works closely with the Family Case Management program to assure that families are receiving services for identified needs.

WIC program activities to promote and support breastfeeding include:

- providing technical assistance and consultation on breastfeeding promotion, support and management for health departments and local agencies administering WIC programs statewide.

- providing promotional items for local agency use in promoting breastfeeding within local communities.
- conducting annual training workshops for local agency breastfeeding coordinators.
- promoting and supporting the activities of the State and Regional Breastfeeding Task Forces throughout the state.
- supporting local agency activities through grants to provide training to agency staff, support peer counselor programs and other breastfeeding promotion activities.
- developing and distributing educational materials on breastfeeding for local agencies, health professionals and other involved with breastfeeding promotion, support and management.
- promoting and supporting the activities of the Physicians' Breastfeeding Network of Illinois as they promote breastfeeding education for physicians and in medical schools.
- supporting the activities of local agency breastfeeding coordinators statewide through technical assistance, training and materials provided.
- providing breastfeeding training and educational opportunities to all health department staff including other agency programs, i.e. Family Case Management, Immunizations, etc.
- implementing state breast pump program including making breast pumps available to local agencies and training on managing breast pump programs.
- developing and implementing breastfeeding training based on documented educational needs for Family Case Management, WIC and other MCH providers.
- collecting data on breastfeeding practices through the Cornerstone Information System and CDC Nutrition Surveillance Systems.

Chicago. The CDOH will continue to provide assistance in the home to support mothers in breastfeeding their infants. To assure that mothers leave the hospital knowing how to breastfeed their infants, WIC staff, CDOH case managers, clinic staff and hospital nurses will collaborate to provide prenatal and early postpartum counseling and support.

Federal Performance Measure #10: The percentage of newborns who have been screened for hearing impairment before hospital discharge

IDHS, IDPH, and DSCC are collaborating to implement universal newborn hearing screening. Grant funds received from the MCHB will be used for program coordination, staff and provider training, and tracking of newborns with suspected hearing loss.

DHS has convened a Newborn Hearing Screening Advisory Committee that includes audiologists, otolaryngologists, parents of hearing-impaired children, hospitals, third-party payors, local health departments, and others. The committee is addressing screening protocols, provider credentialing, reimbursement, and other policy issues.

The 1996 hospital survey was recently repeated. A total of 112 hospitals are now conducting newborn hearing screening, an increase of more than 50 hospitals in four years.

During FY '01, program activities will concentrate on training hospital staff on reporting procedures and on training local health department staff on follow-up and reporting.

State "Negotiated" Performance Measure #9: The prevalence of early childhood caries

The IDPH Early Childhood Caries (ECC) program will provide interested communities with standardized tools for data collection and educational materials for parents and care givers that address preventing early childhood caries. The communities will plan and implement prevention programs targeting areas demonstrating the most need for intervention. Activities will include working with community planning groups, data collection, education, evaluation; and developing a statewide ECC data surveillance system.

The Division of Oral Health targeted five interested counties for collection of data on the prevalence of early childhood caries. The sampling frame for the survey will include children ages 2 - 4 in the following: Head Start, Early Head Start, and WIC. The children will be examined for tooth decay and dental restorative treatment needs which will provide baseline information on the prevalence of ECC. Those identified with disease will be referred for treatment. In addition, consenting parents will be requested to complete a questionnaire prior

to the dental examination to provide additional information about their child, such as infant feeding practices, ethnicity, fluoride use, lifetime residence, county of birth, education of parents, use of dental services, third party payments, work absences due to the child's dental problems, and perceived need for dental treatment.

Children will be surveyed within a 12-month period. Both metropolitan and rural communities have been selected. It is expected that the survey sample will have more children from lower socio-economic families due to selected sampling sites. However, the sample will reflect the geographic distribution of low-income Illinois children.

The project will be using the newly developed ASTDD/CDC Screening Training Project to collect and analyze the data. Secondary data analysis will be done using Medicaid claim forms to identify how many Medicaid children are treated for smooth surface lesions on the anterior teeth. We will use this information to develop prevalence estimates for this population and cost of care.

The information collected will help with the planning of an integrated system to reduce the prevalence of ECC. The survey results will define the scale and scope of the intervention effort, guide the design of the intervention progress, specify the delivery methods and identify high-risk groups.

Population-Based Preventive and Primary Care Services for Children and Adolescents

Federal Performance Measure #5: The proportion of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B

Assessment activities will continue to be a key method of reviewing immunization compliance and protection levels among several age groups. Among the 2-year-old population, we will

continue the following assessment activities:

- Conduct and review the annual DCFS/IDPH day care and Head Start survey. The 1999 fall survey data is nearly completed. The Fall 2000 survey will be distributed to approximately 2,200 day care and Head Start centers in Illinois (excluding Chicago). The program will also work with the Child Care Resource and Referral Network to educate child care facility staff regarding implementation/enforcement of immunization requirements.
- Retrospective immunization record reviews will be conducted at 105 randomly selected facilities with selection based on stratification into three geographic locations/populations.
- Continuation of the verification of immunization histories of children in Illinois selected for participation in the National Household Interview Survey.
- Annual assessment of appropriate birth cohort served at local health departments. Cornerstone reports are used for this measurement.

Quality assurance -- the annual quality assurance clinic reviews to determine compliance with the Standards for Pediatric Immunization Practices will continue. The reviews have proven to be successful in identifying existing barriers and documenting recommendations for improvements in clinic practices. Documentation required to comply with the National Childhood Vaccine Injury Act is reviewed thoroughly. A process to include Community and Migrant Health Centers has been initiated, and in 2000, this will include 48 sites. Quality assurance reviews will use the AFIX strategy as developed by CDC. AFIX includes Assessment, Feedback, Incentives and eXchange. The AFIX process will also be performed at VFC private provider sites in 2000, as a CDC requirement to ensure that VFC participation criteria are met at the state and local levels.

WIC linkage -- the service agreement with CEDA will be maintained to improve vaccine coverage among WIC clients served in Cook county and selected sites within Chicago.

Registry development -- the TOTS team will continue to add pilot sites for all three

components of the system with the goal of beginning "roll out" later in 2000. Roll out will cover a period of approximately two years.

Federal Performance Measure #6: The birth rate (per 1,000) for teenagers aged 15 through 17 years

Prevention of sexual activity before marriage will be addressed by the routine activities of the Abstinence-Only Education, Parents Too Soon, Adolescent Health Promotion, School-Based/School-Linked Health Centers, School Health and Family Planning programs.

The new Adolescent Pregnancy Prevention program will begin offering services that have been selected through community planning to best address adolescent pregnancy in each participating area.

Chicago. Early in 1998, the CDOH determined that the best strategy for reducing teen pregnancy was to target children at an earlier age. Consequently the Community Development Block Grant agencies are being funded to redirect their programs to this younger population. Through case management, public health nursing, outreach, family planning and male responsibility programs, and collaboration with the Cradle-to-Classroom, the CDOH will continue to assure that services are provided so that repeat pregnancies among adolescents are avoided.

Federal Performance Measure #7: The percent of third grade children who have received protective sealants on at least one permanent molar tooth

The number of third grade children eligible for dental sealants and the number of third grade children receiving at least one dental sealant will be tracked by IDPH, Dental Sealant Grant Program staff.

Federal Performance Measure #8: The rate of deaths per 100,000 children ages 1 - 14 caused by motor vehicle crashes

The Childhood Safety Program administered by IDHS, Bureau of Child and Adolescent Health, provides car safety seats to low-income families. Through this program, parents are given car seats free of charge. They are given instruction through hands-on instruction and viewing of a video showing information on the importance of car safety seats.

The car safety seat program will work in communities to promote more Car Seat Check Up events, to train and educate on how to use and install car seats properly, and stress the importance of using the car seat correctly.

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

4.1.4 Infrastructure Building

State Negotiated Performance Measure #7: The number of Maternal and Child Health program staff from DSCC and from local health departments who complete the Illinois Institute for Maternal and Child Health Leadership.

The fifth session of the Illinois institute for Maternal and Child Health Leadership will be initiated during FY '01. The institute will use the same structure as earlier years. A three-day opening session will focus on the core functions of public MCH programs and team building. Teams will then undertake local projects. At the mid-year meeting teams will present their projects and participate in workshops on collaboration, MCH/CSHCN system integration, and leadership. Fellows will then complete individual projects at their home agency and present these at the closing session.

State "Negotiated" Performance Measure #10: The number of local health departments that

complete the MCH Data Use Academy

IDHS is working with CityMATCH, DSCC and the UIC School of Public Health's Center for Public Health Practice and MCH Training Program to replicate CityMATCH's Urban Data Use Institute in Illinois. This will extend the benefits of the Data Use Institute to smaller or rural health departments throughout the state. Five community teams will complete the academy's program during FFY '01.

Infrastructure-Building Services for Pregnant Women, Mothers and Infants

Federal Performance Measure #16: The proportion of very low birth weight live births

The IDHS Family Case Management, Chicago Healthy Start, Perinatal Care, Problem Pregnancy, School-Based/School-Linked Health Centers and Unwed Parents programs will continue their efforts to reduce the very low birth weight rate by ensuring that women initiate prenatal care early in pregnancy and by ensuring that women receive risk-appropriate prenatal care. The IDHS Family Planning program will continue to provide primary pregnancy prevention through reproductive health education and prompt referral for prenatal care. The IDHS WIC program will continue to address early entry into WIC for pregnant women and prompt referral for prenatal care.

Targeted, Intensive Prenatal Case Management -- The Department is launching a new initiative to reduce infant mortality and low birth weight in targeted areas of the state. Illinois' Medicaid program annually spends more than $320 million on health care services during the first year of life. The average cost for a Medicaid-eligible infant is more than $6,000. In approximately 15 areas of the state, the average cost is $10,400 and exceeds $175 million annually, while in the remainder of the state, the average Medicaid costs for the first year of life average less than $5,000. Even though these 15 areas account for only one-third of Medicaid births, they are responsible for more than half of the state's Medicaid costs in the first year of life.

Through the efforts of the new Illinois' Birth To Five Political Action Committee, the Department was appropriated $2 million in SFY'01 to implement Targeted, Intensive Prenatal Care Management, a new initiative to reduce Medicaid expenditures in the first year of life by reducing low birth weight. This reduction will be achieved by more extensive and culturally appropriate outreach; more intensive service coordination; and the provision of risk reduction interventions, such as smoking cessation, substance abuse treatment and treatment of infections associated with pre-term labor. The initiative is being designed with the assistance of an expert panel that includes private foundations, public health agencies and universities.

Chicago. Chicago Department of Health will continue vigorous case management of high-risk maternal clients to assure they are followed at the appropriate level hospital and receive the appropriate support services to reduce stress and some of the factors that contribute to the VLBW percentages. Chicago Department of Health will actively engage in the federal infant mortality reduction project with the Healthy Start agencies and the state to identify and correct preventable factors that contribute to this percentage.

Federal Performance Measure #17: The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates

The medical network, established as part of the Perinatal Care program, will continue providing on-going monitoring and evaluation of the percentage of very low birth weight infants born in a Level III facility or perinatal center. Members of the statewide Quality Improvement Council will continue implementation of their quality improvement plans.

Chicago. The Chicago MCH Advisory Council has assumed responsibility for the achievement of this standard as their special project. The perinatal centers will assume the responsibility, along with the Chicago Department of Health, for the monitoring of the Level II hospitals to ensure that this objective is accomplished.

Federal Performance Measure #18: The percent of infants born to pregnant women receiving

prenatal care beginning in the first trimester

Recent efforts to integrate FCM and WIC service delivery will assure that 95 percent of all pregnant WIC clients are also enrolled in FCM. Local IDHS office staff are being trained to routinely ask women of childbearing age if they are pregnant and, if so, to record this information in the department's data system. This information is then shared with FCM and CHSI agencies so staff can conduct outreach efforts and assist women with obtaining prenatal care.

The Department has retained the University of Illinois at Chicago's Survey Research Laboratory to conduct a survey of Medicaid-eligible women who did not participate in either WIC or FCM during pregnancy. There are approximately 6,000 such women in Chicago each year. The survey collects information on their familiarity with WIC, FCM, and the Chicago Healthy Start Initiative; their usual sources of prenatal and pediatric care; and perceived barriers to program participation. The survey will be conducted by telephone, with face-to-face follow-up; an additional set of questions has been included for informants when the respondent no longer uses the phone number or resides at the address provided to the Department. The survey results will be available in early FFY '01.

The Bureau of Child and Adolescent Health will continue to coordinate services with Family Case Management agencies to ensure entry into early prenatal care for pregnant adolescents which will include, but not be limited to, early identification of pregnancy, education regarding the importance of early and timely prenatal care, reduction of risky behaviors that could affect the outcome of the pregnancy, provision of health care services, and case management and referral to reduce the barriers to access to health care.

Chicago. CDOH's current strategies of promoting postpartum visits to reduce unplanned pregnancies, enrolling women in care following a positive pregnancy test result and keeping track of women who have tested positive to ensure that they continue in care and its focus on outreach in the highest risk communities will help to reduce the number of women appearing

late for prenatal care.

Infrastructure-Building Services for Children and Adolescents

Federal Performance Measure #12: The percent of children without health insurance

IDHS local office staff, who perform eligibility determinations for Title XXI, Title XIX and other means-tested public assistance programs, will receive more training in FFY2001. During March and April 1999, IDPA provided training to "enrolled outstation" sites (entities other than IDHS local offices authorized to accept applications) on the simplified KidCare application. (The application has been reduced to four pages from eight). "Outstation sites" have been renamed KidCare Application Agents and, by participating in the revised process for submitting applications, have the potential of receiving a $50 "technical assistance payment" for each approved application. Beginning April 12, 1999, applications completed by KidCare Application Agents are mailed to the Illinois Department of Public Aid's "KidCare Unit" in Springfield for centralized processing.

"KidCare Expert" training has been provided to local DHS offices on the revised application process and "KidCare experts" have been designated in each of the local offices statewide.

The Coalition for School-Based Linked Health Centers has worked with the Illinois Department of Public Aid to make the school-based linked health center outstation sites for KidCare applications. They will provide training as needed.

IDHS, DSCC and IDPA will be working closely with the Illinois Maternal and Child Health Coalition on a special project to improve KidCare enrollment. In February 1999, the Illinois Maternal and Child Health Coalition was awarded a three-year $1 million grant by the Robert Wood Johnson Foundation for the *Covering Kids Illinois* project. Funds will be used to cover the work of a statewide coalition and three local pilot sites (Cook, DuPage and Macon counties) to help uninsured children enroll in KidCare. A "Tool Kit" containing basic program

information, creative outreach strategies, listing of Application Agent contacts and local DHS office contacts by geographic area and order forms for materials, videos, radio spots, banners, etc., will be available to interested parties. Also, a *Covering Kids Illinois* Speakers Bureau has been developed which provides a KidCare presentation developed jointly by IDPA and the *Covering Kids* initiative with overheads and talking points to be used in presenting to interested groups.

IDPA is conducting a media campaign for KidCare enrollment. IDPA, through an independent contractor, has developed and run radio ads statewide. KidCare ads were posted on city transit buses in the Chicago area during May 1999. Also, public service announcements will run in the Chicago area for a limited number of weeks. The KidCare Hotline has increased the number of staff answering calls and expanded hours to include evenings and Saturdays.

A Request for Proposal was released at the end of May 1999 by IDPA to hire community based organizations to conduct community outreach to hard-to-reach populations likely to be eligible for KidCare. Examples of hard-to-reach populations are non-English speaking families, families residing in rural areas and families difficult to reach because of cultural barriers. IDHS will be working with IDPA on the implementation of this project.

Healthy Child Care Illinois Child Care Nurse Consultants (CCNCs) provide information to families and child care providers on how to access KidCare. The CCNCs coordinate training sessions for families and child care providers on how to access the "KidCare System".

Federal Performance Measure #13: The percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program

The Family Case Management program will continue to conduct outreach activities to market maternal and child health services at the local level. Identification of individuals who may qualify for Medicaid services is a high priority. Agencies may now complete a Medicaid/KidCare application at the time of identification of potentially eligible individuals.

Outreach activities are culturally relevant and may include, but not be limited to, advertising, door-to-door canvassing, providing information to local churches and community groups, and other special projects. Outreach focuses on the individual and her needs. It is provided in many cases by the agency that provides primary care services, thus assuring access to services.

Once enrolled in FCM, TPS, or PTS, parents are encouraged and assisted to obtain routine care for their children. Children who require specialized services are assisted with enrollment in the Early Intervention program, the CSHCN program or referred for other specialized care.

Healthy Child Care Illinois CCNCs assist families and day care providers to access programs such as Medicaid/KidCare, WIC, FCM, TPS and other federal and state programs.

Federal Performance Measure #15: The rate (per 100,000) of suicide deaths among youths aged 15 - 19

The School-Based/Linked Health Centers will continue activities related to identification of potentially troubled youth and provide direct care or referral to other services as necessary. In FFY2001 the number of School-Based/Linked Health Centers will increase to 30. In addition, IDHS will work with the Illinois Coalition of School-Based/Linked Health Centers to increase services. A standard database has been developed to maintain an accurate record of services at each site. Preventive health education activities will be increased; standards for health centers have been approved by the Joint Committee on Administrative of Rules (JCAR); and partnering activities with the medical health maintenance organizations will continue.

Infrastructure-Building Services for Children with Special Health Care Needs

State "Negotiated" Performance Measure #5: The proportion of CSHCN ages 14 and above and their parents who receive comprehensive transition planning to promote awareness of adult services

DSCC staff will revise technical support guidelines on transition that will include a checklist for family use. A statewide work group will obtain and share transition information, resources, and materials from other CSHCN programs that can be disseminated statewide, partularly focusing on adolescents with special health care needs making the transition to adult health care services.

State "Negotiated" Performance Measure #6: Increase IDCFS caseworker knowledge of CSHCN and DSCC

By 2001 DSCC's goal is to provide inservice for each DCFS region. Annual training will be provided throughout the State to promote orientation and proficiency for caseworkers in all DCFS offices. While the module will continue to target caseworkers, the audience may be expanded to include foster parents.

Federal Performance Measure #11: To increase the percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care

DSCC will implement an administrative rule amendment to make enrollment in the State Children's Health Insurance Program (Medicaid/KidCare) mandatory for DSCC applicants seeking financial assistance. In addition, families who do not have a source of health insurance and are at or below 185% (maximum percent for eligibility)of the Federal Poverty Level will be required to apply for Medicaid/KidCare. DSCC will continue to identify fiscal barriers in accessing needed specialty care for CSHCN at the state and local level.

DSCC will also undertake a pilot project that will team medical insurance resource staff from the DSCC central administration office with DSCC regional staff to provide a technical resource on benefits management. It is anticipated that these insurance specialists will provide specific techinical assistance on Managed Care Organizations (MCOs) plans covering DSCC eligible children and public third party payers, as well as develop knowledge of major employers in the assigned geographic area. For families served by DSCC, the project will enhance and update family education materials on third party payers. The teaming opportunity of the insurance specialist with field staff will also allow the insurance specialists to increase their knowledge of field staff operations and duties and develop specific understanding about third party payers and specialty providers common to regional office areas.

Federal Performance Measure #14: To increase the degree to which the State assures family participation in program and policy activities in the State CSHCN program

The Family Advisory Council (FAC) will address ways of increasing participation and communication with families served by DSCC through the development of a family newsletter, revisions to the Care Coordination Record and identification of methods to implement a statewide family support network. The FAC will also continue to advise DSCC administration on policy issues and the implementation of the Medical Home concept. All members of the FAC will continue to receive a stipend and travel expenses to participate. The Chairperson of the FAC will also be an *ex officio* member of the DSCC Medical Advisory Board.

4.2 Other Program Activities

4.2.1 Direct Health Care Services

Preventive and Primary Care Services to Pregnant Women, Mothers and Infants

Illinois Folic Acid Coalition **-** The Bureau of Family Nutrition and the Bureau of Community Health Nursing are working with the March of Dimes Defects Foundation, Greater Illinois Chapter, to organize the Illinois Folic Acid Coalition. The Coalition will work with the Department and other interested groups to reduce the occurrence of neural tube defects, spinal bifida and anencephaly by promoting the use of folic acid. An education and outreach campaign that will include the media will be developed, to carry the message on the importance of folic acid to all women of child-bearing age.

Doula Project -- A Doula, or birthing assistant, is a woman who provides emotional support to a woman giving birth throughout the antepartum and postpartum periods. The Parents Too Soon Doula Project is a joint venture with the Chicago Health Connection (CHC). In FY2000, the CHC will train "doulas" at three Parents Too Soon teen parenting projects to act as birth attendants. Doula services will be offered during the prenatal and perinatal period, and for up to 12 weeks postpartum for 50-60 participants at each site. Services include: prenatal classes; developing birthing support plans; frequent prenatal home visits; accompanying pregnant teens through labor and delivery; and extensive postpartum home visiting. The doulas will work in conjunction with Parents Too Soon program staff at each site, transitioning teen parents into on-going home visiting and a support group once the postpartum period has elapsed. The outcomes for this project include: increased rates of initiation of breastfeeding; decreased rate of cesarean section births; decreased rates of medically-complicated births; shortened labor times; and improved parent-child interaction at three months postpartum.

This promising intervention project is currently being evaluated by the Ounce of Prevention Fund's Research Division, with private funding from the Harris Foundation and the Robert Wood Johnson Foundation. Early results indicate that teen parents who receive doula support are much less likely to have cesarean section births and are much more likely to initiate breastfeeding. FY2000 began the first full year of DHS funding for this intervention, which was piloted with private foundation funding in the two previous years.

Prenatal and Pediatric Primary Care. This program will continue to serve women and children who are not eligible for the KidCare program

Problem Pregnancy Program. For the high-risk pregnant population, many activities will be part of this program during FFY2001, including:

- walk-in pregnancy testing;
- outreach education stressing the importance of early prenatal care;
- access to prenatal care in the first trimester with comprehensive and continued prenatal care;
- counseling, follow-up, support and educational services to low-income teens;
- identifying pregnant teens through multiple outreach efforts including through a liaison in the school system and word of mouth with other pregnant teens;
- linkage with prenatal medical care, social service agencies, family case management, family planning, abstinence education and subsequent pregnancy programs;
- monitoring participant compliance with prenatal care;
- transportation to prenatal classes and physician appointments; and
- Medicaid/KidCare referral and advocacy;
- preventive mental health assessment and, if indicated, referral for intervention
- redistribution of an educational brochure (in English and Spanish) addressing the potential correlation between periodontal disease and low birth weight infants;
- smoking cessation classes to pregnant women.

Coordination of services with appropriate referrals to family case management, family planning, Medicaid and KidCare, and many others is an integral component of these services to women who are at risk of, or experiencing a high risk pregnancy. The grantees are agencies experienced at appropriate service coordination and referral.

Preventive and Primary Care Services for Children and Adolescents

School Health. Six "School Health Days" are planned for this fall and three "Critical Issues" conferences are planned for the spring. The 16 comprehensive health education curriculum grantees will be encouraged to expand their target population and activities. The emergency first-aid booklet was distributed to all Illinois schools, licensed day care centers, licensed day care homes, juvenile justice facilities, local health departments and nonprofit agencies providing services to children and adolescents.

School-Based/Linked Health Centers provide dental services at three sites. Two hospital administered school-based health centers have purchased a mobile dental van which will provide services at both sites.

4.2.2 Enabling Services

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

High-risk Infant Follow-up. The MCH nurse consultants will continue their program activities which include monitoring infant development, teaching high-risk infant care to the family, providing support, and referring families to appropriate services. In the event of a perinatal death, the nurse offers the family counseling and access to adequate prenatal care for any subsequent pregnancies.

4.2.3 Population-Based Services

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

Sudden Infant Death Syndrome. The activities of this program, which is administered by

IDPH, will continue during the next fiscal year. Counseling and support services will be offered to all families in the state who experience the sudden, unexpected death of an infant. Files will be maintained on every case reported to IDPH and a database will be utilized from which aggregated data will be used for statistics.

Clinical Genetic Services. The activities of this program will continue during the next fiscal year. These services include provision of genetic services, and to increase the awareness of issues in clinical genetics for health care providers and consumers. Grants will continue to be provided to medical centers that offer the full range of genetic diagnostic, counseling and treatment services. This program is operated through IDPH.

Preventive and Primary Care Services for Children and Adolescents

Childhood Lead Poisoning Prevention Program The following objectives have been established for this IDPH program in FFY2001:

- re-evaluation of current targeted screening practices and implementation of revised strategy;
- ensure that all delegate programs are operating Y2K compliant equipment;
- ensure that all delegates install and are trained on the new tracking software - STELLAR 3;
- implement lead component of Tracking Our Toddlers Shots (TOTS) database for test input and review;
- establish STELLAR supervisor site for data collection and CDC reporting;
- increase the number of 1- to 2- year-old children screened by five percent;
- increase the number of 10 - to 26-month-old Medicaid-funded children screened by 10 percent;
- establish reporting and correction procedures for delegate case management activities;
- provide education to community providers on revised screening requirements;
- develop educational campaign for state workers on lead poisoning;
- develop comprehensive analysis of primary prevention approaches to determine potential

Policy;

- develop a pilot project to evaluate the scope of current primary prevention services and funding; and
- perform an evaluation of the effectiveness of current educational materials and techniques.

Oral Health Needs Assessment and Planning (OHNAP) Program. Results of a survey to assess the OHNAP program have been analyzed for Year-One, Year-Two and Year-Three grantees. These results indicate that over 50 percent of the communities that have completed the program have implemented some or all of their comprehensive oral health plans.

Orofacial Injury Prevention and Control Program, Project Mouthguard. Interested communities have formed advisory groups to direct orofacial injury prevention activities that will extend the requirement for preventive mouthguard use during athletic activities that pose risk of orofacial injuries. Communities will use oral health professionals to provide preventive mouthguards for children to assure use during high-risk sports activities. This program is administered through IDPH.

Vision and Hearing Screening Program. The audiologic, ophthalmologic and optometric screening services activities of this program within IDPH will continue to be delivered next fiscal year.

4.2.4 Capacity/Infrastructure Building

Information and Referral Helpline. The Helpline Help Me Grow, operated by IDHS, provides information on such topics as WIC, nutrition, immunizations, childhood lead screening, availability of pregnancy testing, family planning, KidCare, child safety seats, women's health issues, early intervention, medical care for pregnant and parenting teens and their children, advocacy, and support services. A trained counselor and an Hispanic interpreter are available. The Helpline received over 26,000 calls in SFY'98. The Helpline's information and referral capabilities will be expanded in support of the First Lady's child health promotion initiatives.

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants in Chicago

The Public Health Aide (PHA) Training Curriculum was completed. Nutrition staff developed the lesson plans for all age groups and provided training on these lesson plans. Staff from behavioral health reviewed and provided feedback as modules on violence prevention, substance abuse and mental health were developed. PHA's received training on the complete curriculum. The number included the new individuals who were recruited for the Holman Wellness and the East Garfield Prenatal Outreach Project. Many of the classes were presented with the assistance of staff from nursing, nutrition, communicable disease and immunization.

The Office of Violence Prevention provided training/retraining for staff at seven CDOH sites and 11 community organizations (schools, immigrant groups through the Office of Hispanic Affairs, and the Community Development Block Grant delegate agencies) on ways to screen and identify domestic violence, referral procedures, and available community resources.

Preventive and Primary Care Services for Children and Adolescents

The Illinois Coalition for Health System Development in Child Care IDHS is expanding the HSDCC project statewide through a collaboration between the Title V MCH program and the Child Care program. Through this collaboration, approximately $1.6 million is allocated each year to support "Child Care Nurse Consultants" (CCNC) who work with resource and referral agencies to train child care providers.

Illinois continues to expand the health system's development in child care by continued involvement with the Healthy Child Care Illinois Steering Committee and a close working relationship between the Office of Child and Family Services and the Division of Family Health.

The IDHS Office of Child Care and Family Services works with communities throughout Illinois to provide child care and other services to low-income families, refugees and homeless individuals. The Office is comprised of four Bureaus: Title XX Social Services; Refugee and Immigrant Services; Homeless Services and Supportive Housing; and Child Care and Development. The MCH program works with the latter bureau for the HSDCC project.

The Bureau of Child Care and Development provides child care services to working families whose annual incomes are no greater than 50 percent of the state median income. Child care is also provided to teen parents to allow them to complete high school and to families who receive Transitional Assistance to Needy Families (TANF)benefits and need child care to improve their ability to work. This bureau also oversees Illinois' network of Child Care Resource and Referral (CCR&R) Agencies.

For this collaboration, the Office of Family Health and the Office of Child Care and Family Services are providing funds to support a CCNC for each Child Care Resource and Referral Network. The CCNC is employed by the local health department that serves the community in which the CCR&R Network Agency is located, and is "out-stationed" at the CCR&R Network Agency on a full-time basis. The local health department receives a $60,000 to $90,000 contract to support the salary, travel expenses and professional development of the CCNC while the CCR&R Network agency receives an $8,000 contract to offset the costs of space, furniture and office/administrative supplies for the CCNC, as well as a one-time planning grant of $4,500 before the CCNC is hired..

The CCNC is the direct link between the health care and child care systems. The role of the CCNC includes the following:

- Establishing a consultative relationship with licensed child care centers and family child care homes;
- Assisting the CCR&R in health outreach to license-exempt providers;
- Facilitating health and safety training for infant and toddler care-givers;
- Facilitating training for Registered Nurses in each CCR&R's service area; and,

- Promoting KidCare (Illinois' combined Medicaid and State Child Health Insurance program)enrollment.

Healthy Child Care Illinois proposes the following objectives:

- Implement the child care nurse consultant network in the remaining eight service delivery areas
- Utilize the statewide quality assurance protocol to monitor, identify and address key indicators such as immunizations, communicable diseases, etc.

Activities that will be a part of the Healthy Child Care Illinois Project in FY 2001 include:

- Completion of the child care nurse consultant network by hiring eight nurses whose service delivery areas encompass 33 counties.
- Provide statewide training sessions for the remaining child care nurse consultants, scheduled for summer and fall of 2001
- Monitor progress through reports, regular telephone contact, and regularly scheduled meetings of the Child Care Nurse Consultant Network and the Healthy Child Care Illinois Steering Committee
- Utilize a statewide quality assurance protocol to track key indicators such as immunizations, communicable diseases, and strategies for improving access to child care for children with special health care needs.
- Twenty-two Child Care Nurse Consultants will facilitate and provide training programs for child care providers and nurses in their CCR&R service delivery area
- Plan, coordinate and conduct an annual Healthy Child Care Illinois annual conference in collaboration with Health systems Research and the Community Integrated Services Initiative.

The Bureau of Child and Adolescent Health partnered with the MCH nurse consultants to provide three Adolescent Health/GAPS training programs for health professionals who work

with the pre-adolescent/adolescent population.

Services for Children with Special Health Care Needs

Early Intervention, Part C DSCC will continue to have representation on the Illinois Interageny Coordinating Council on Early Intervention (IICEI) for system development and support. Financial assistance and care coordination for families and children eligible for both DSCC and Early intervention (EI) will continue to be provided for medical services not covered by EL, Part C (e.g., surgery, medications, durable medical equipment and supplies). DSCC will also continue to provide financial assistance and care coordination to help the child receive physical, occupational, speech therapy, and audiological services required to both treat the child's DSCC medically eligible condition and facilitate the achievement of milestones.

Managed Care Through a SPRANS grant, the Quality Community Managed Care: Phase II project, DSCC staff are developing collaborative relationships with two managed care organizations (MCOs), located in the Rockford and Champaign communities. DSCC regional office staff are piloting strategies to improve communication with the managed care entities and develop a care coordination model that includes the MCO, PCP, child/family, and DSCC staff to facilitate quality, comprehensive services for CSHCN. The most helpful strategies will be used with other MCO's in communities across the state.

4.3 Public Input

Parents, consumers and advocacy groups participate in the MCH and CSHCN programs in the following ways:

Parents and Consumers

- The School-based and school-linked health centers in Illinois have advisory boards to ensure input from parents and community leaders and to generate feedback from the local level to the state-level planning and policy development process. These local advisory boards include

parents, students, community leaders, health care providers, teachers and religious leaders.

- Each local Abstinence-Education program has an advisory committee that includes parents.
- The Newborn Hearing Screening Advisory Committee includes parents of hearing-impaired children as well as hearing-impaired adults.
- The Genetic and Metabolic Diseases Advisory Committee includes two parents as members.
- The Family Planning Advisory Council includes two consumers as members.
- Local Family Planning program grantees are required to have an Information and Education committee, which reviews patient education and promotional materials. Grantees are required to include consumers (including adolescents) as members of these committees.
- The Healthy Start program has an advisory board with strong consumer participation, as mandated by the federal initiative. Consumers are elected to the Healthy Start Consortium through participation in its committees. In addition, numerous other consumers attend monthly Consortium meetings and express their opinions on various aspects of program operation.
- The Early Intervention service system in Illinois involves parents and providers in all aspects of the system. The state council is one-third parents, as are the 45 local interagency councils throughout the state. An additional one-third of these groups are providers. Both DHS and DSCC are represented on the council.
- Local MCH program staff obtain consumer input through satisfaction surveys, including the WIC Participant Nutrition Survey. Survey results are considered in assessing local staff performance in meeting consumers' needs. These concerns are also presented to state-level staff through regional meetings and other venues.
- The CSHCN program has an active parent advisory committee of 13 members.

<u>Providers and Advocates</u>

- Each of the advisory boards identified above also include providers, and many include maternal and child health advocacy groups.
- The Advisory Boards for the Adolescent Health, Perinatal, School Health and Childhood Lead Poisoning Prevention programs include representation from providers and advocacy groups.
- Illinois Public Health Nursing Administrators Association (IPHNA) MCH Liaison Committee was organized in the Fall of 1994. The IPHNA is a statewide organization of the directors of

nursing at local health departments. In most instances, the director of nursing is the manager most directly concerned with implementing MCH services and developing MCH systems at the local level. A past president of the organization proposed the formation of the committee to ensure open communication between MCH program staff at the state and local levels. The group includes a representative from each of eight regions in the state, as well as the current IPHNA president. The liaison committee meets quarterly with the senior MCH staff from DHS to discuss policy, system development and operational problems.

- The Healthy Families Illinois Work Group is a statewide consortium of service providers and advocates who are interested in expanding the number of Healthy Families America sites in Illinois. The group includes more than 50 members, and is co-chaired by a Title V staff member and the vice president of a statewide child advocacy group.

The MCH Block Grant application was made available for public review and comment between the dates of June 10 and June 25. On June 10, 1999 it was posted on the Internet (www.state.il.us/agency/dhs/). It was distributed to Illinois MCH advocates and colleagues listed below.

Mary Driscoll, R.N., M.P.H.
Cook County Hospital

Susan Bekenstein, MSW, Chair
Family Planning Advisory Council
Lake County Health Department

John Hobart, M.D., Chair
Perinatal Advisory Committee
Evanston Women's Hospital

Eugene Pergament, M.D., Ph.D.
Department of OB/GYN
Northwestern Univ. Medical School

Jar-Fee Yung, Ph.D., Chair
Genetics Task Force of IL, Inc.
Mercy Hospital and Medical
Center, Chicago

Ms. Faye Eldar
Family Voices of Illinois

Rebecca E. Holbrook
Community Liaison
University of Chicago Hospital

Gaylord Gieseke, Vice President
Voices for Illinois Children

Arden Handler, Dr.P.H.
Evanston, Illinois

Kent Tarro, B.S., M.S. President
IL Association of Public Health
Administrators
Macoupin County Health Department

Bonnie Schaafsma, President
IL Public Health Nurse Assn.
Kankakee County Health Department

Robyn Gabel, Executive Director
IL Maternal and Child Health Coalition

These external reviewers represent the following advisory councils and constituency groups:

- Ms. Robyn Gabel and Ms. Mary Driscoll review on behalf of the Illinois Maternal and Child Health Coalition. The coalition has 95 member organizations, representing the diversity of communities, agencies and program staff providing maternal and child health services in Illinois.
- Ms. Beckenstein reviews on behalf of the Family Planning Advisory Council, which has 30 members representing Title X (family planning) delegate agencies across the state.
- Dr. Hobart reviews on behalf of the Perinatal Advisory Committee, which has 29 members representing the perinatal centers, physicians and other health professionals involved in providing perinatal care.
- Dr. Pergament is the current chairperson of the Genetic and Metabolic Diseases Advisory Committee which has 40 members. Dr. Yung is the chairperson of the Genetics Task Force of Illinois which has 60 members and represents medical geneticists, genetic counselors and laboratory personnel throughout Illinois. Dr. Ledbetter's term expires in September 1999 and will be replaced by Jar-Fee Young, Ph.D., Department of Pathology, Mercy Hospital, 2525 S. Michigan Ave., Chicago, IL 60612.
- Ms. Holbrook is the current chairperson of the Chicago Healthy Start Consortium. The

consortium has 35 active members, ten of whom are service consumers.

- Ms. Gieseke is a Vice President of Voices for Illinois Children, as statewide child advocacy organization. She also co-chairs the Healthy Families Illinois Working Group, which represents Healthy Families Illinois programs, advocacy groups and other interested organizations and individuals.
- Dr. Handler reviews on behalf of the Maternal and Child Health Training Program at the University of Illinois at Chicago School of Public Health.

- Mr. Tarro reviews on behalf of the Illinois Association of Public Health Administrators, which represents the executive directors of Illinois' local health departments.
- Ms. Schaafsma reviews on behalf of the Illinois Public Health Nursing Administrators association, which represents nursing directors of Illinois' local health departments.
- Ms. Eldar reviews on behalf of Family Voices of Illinois, an association of parents with CSHCN.

For the first time, the application was also reviewed by DSCC's Family Advisory Council.

4.4 Technical Assistance

The state currently has no need for technical assistance in its delivery of MCH Title V services.

Section 5.1

Glossary

GLOSSARY

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year's MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *[Title V Sec. 501(b)(4)]*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - ***(For budgetary purposes)*** Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. ***(For planning and systems development)*** Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under "Pregnant Women," "Infants," "Children with Special Health Care Needs," "Children," and "Others."

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

KidCare - Illinois' name for State Child Health Insurance Program (SCHIP)

Local Funding (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. *[Title V, Sec. 501 (b)(2)]*

MCH Pyramid of Health Services - (see "Types of Services")

Measures - (see "Performance Measures")

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

1) What is essential in terms of the provision of health services;
2) What is available, and
3) What is missing.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also "Performance Objectives")

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State administer this program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter

term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block Grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the State), *Other* Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services," and "Direct Medical Services."

Section 5.2

Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sects. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18 Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
(b) Establishing an ongoing drug-free awareness program to inform employees about-
    (1) The dangers of drug abuse in the workplace;
    (2) The grantee's policy of maintaining a drug-free workplace,
    (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
    (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
    (1) Abide by the terms of the statement; and
    (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2)

from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL,

"Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

Section 5.3

Other Supporting Documents

Section 5.4

Core Health Status Indicator Forms

Section 5.5

Core Health Status Indicator Detail Sheets

Section 5.6

Developmental Health Status Indicator Forms

Section 5.7

Developmental Health Status Indicator Detail Sheets

Section 5.8

All Other Forms

Section 5.9

National "Core" Performance Measure Detail Sheets

Section 5.10

State "Negotiated" Performance Measure Detail Sheets

Section 5.11

Outcome Measure Detail Sheets

Section 5.12

Notes