Priority Area	Strategies (*Ongoing for the entire grant period unless otherwise noted)*	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	Women's / Maternal Health			
#1: Assure accessibility, availability and quality of preventive and primary care for all women, particularly for women of reproductive age	A. Support dissemination of the Illinois *Healthy Choices, Healthy Future* Perinatal Education Toolkit, which includes resources about pre-/inter-conception health and the transition to postpartum care. B. Partner with the Illinois Department of Corrections and two state women's correctional centers to support ongoing health promotion activities for incarcerated women (including health education programs and lactation support) and prison staff training. C. Identify pregnancy-associated deaths and facilitate state Maternal Mortality Review Committees (one focused on pregnancy-related deaths and one focused on violent deaths) D. Conduct reviews of severe maternal morbidities (SMM) through the regional administrative perinatal centers and convene statewide SMM review sub-committee to develop recommendations for improving local reviews of SMM. E. Participate in ASTHO Long-Acting Reversible Contraceptives (LARC) State Learning Collaborative and advise state family planning program and contraceptive initiatives *(completed; FY16-FY18).* F. Collaborate with the IDPH Division of Oral Health to convene stakeholders and develop a statewide report and resource manual for oral health during pregnancy and early childhood. G. Lead CoIIN- Social Determinants of Health workgroup to assess, quantify and describe the impact that child care has on prenatal, intrapartum and postpartum care in Illinois and develop optional strategies and approaches that could be implemented in clinic and hospital settings to address child care *(started in FY18).* H. Participate in *Partnership for Integrating Oral Health Care into Primary Care* project with IDPH Division of Oral Health and a local health department to integrate the interprofessional oral health core clinical competencies into primary care practice, particularly for pregnant women and adolescents *(started in FY19).* I. Establish well-woman care mini grant program to assist local entities in assessing their community for need and barriers and developing a plan to increase well woman visits among women ages 18-44 *(started in FY19).*	ESM-1.1: Number of individuals receiving information on the Illinois *Healthy Choices, Healthy Future* Perinatal Education Toolkit ESM-13.1.1: Development of statewide strategic plan on oral health during pregnancy and early childhood	NPM-1: % women with a past year preventive medical visit NPM-13A: % Pregnant women who had their teeth cleaned SPM-1: % Medicaid-enrolled women ages 21-44 using a most or moderately effective contraception method	NOM-2: Severe maternal morbidity NOM-3: Maternal mortality rate NOM-23: Teen Birth rate NOM-24: Postpartum depression symptoms SOM-1: Chlamydia infection rate among women ages 15-24 SOM-5: Mental health and substance use hospitalizations to women ages 15-44

Priority Area	Strategies (*Ongoing for the entire grant period unless otherwise noted)*	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	Women's / Maternal Health (continued)			
#1: …preventive and primary care for all women… *(continued)*	J. Partner with UIC Center for Research on Women and Gender to implement a program at two clinic sites to expand the capacity of health care providers in the state of Illinois to screen, assess, refer and treat pregnant and postpartum women for depression and related behavioral health disorders *(started in FY19).*	*See previous page*	*See previous page*	*See previous page*
	Perinatal / Infant Health			
#2: Support healthy pregnancies and improve birth and infant outcomes	A. Maintain a strong system of regionalized perinatal care by supporting perinatal network administrators and outreach/education coordinators and identifying opportunities for improving the state system: I. Utilize the Levels of Care Assessment Tool (LOCATe) to describe neonatal and maternal levels of care and inform improvements to the regionalized perinatal system. *(completed FY16-FY18)* II. Conduct a study of very preterm infants (<32 weeks) delivered outside Level III facilities to identify reasons for no maternal or neonatal transport and barriers to risk-appropriate care. III. Convene risk-appropriate care CoIIN workgroup to develop a quality improvement initiative to increase the percentage of very preterm infants (<32 weeks) delivered in Level III facilities. IV. Update state Obstetric Hemorrhage Toolkit based on information in the ACOG patient safety bundle and distribute updated materials to all Illinois hospitals. *(completed in FY18)* V. Designate and maintain perinatal levels of care and support and maintain administrative perinatal centers. B. Collaborate with the Illinois Perinatal Quality Collaborative to implement quality improvement projects in birthing hospitals that will improve health outcomes. I. Birth Certificate Accuracy Initiative *(FY14-FY15)* II. Maternal Hypertension Project *(FY15-FY17)* III. Mothers and Newborns Affected by Opioids *(FY17-FY19)* C. Convene partners to support statewide efforts to improve breastfeeding outcomes and reduce disparities.	ESM-3.2: Percent of very preterm births delivered in non-Level III hospitals that have a very preterm review form submitted to IDPH ESM-4.1: Percent of live births occurring in Baby-Friendly hospitals ESM-5.1: Percent of new mothers who reported they were told by a healthcare provider to put their baby to sleep on his/her back	NPM-3: % Very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) NPM 4A - % infants ever breastfeeding NPM-4B: % infants exclusively breastfeeding for at least 6 months NPM-5A: % infants placed to sleep on back NPM-5B: % infants placed to sleep on separate, safe sleep surface NPM-5C: % infants placed to sleep without soft bedding or blankets	NOM-1: % Births with prenatal care in the first trimester NOM-4: LBW deliveries NOM-5: Preterm births NOM-6: Early term births NOM-7: Non-medically indicated elective deliveries NOM-8: Perinatal mortality NOM-9.1: Infant mortality NOM-9.2: Neonatal mortality NOM-9.3: Post neonatal mortality NOM-9.4: Preterm-related mortality NOM-9.5: Sleep-related SUID death rate NOM-10: % Infants with fetal alcohol exposure in the last 3 months of pregnancy

Priority Area	Strategies (*Ongoing for the entire grant period unless otherwise noted)*	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	Perinatal / Infant Health (continued)			
#2: Support healthy pregnancies and improve birth and infant outcomes *(continued)*	D. Support hospital Baby-Friendly designation by assessing barriers to progress and provide resources to assist hospitals in overcoming these barriers. *(completed in FY17)* E. Partner with the Illinois Department of Corrections and two state women's correctional centers to support health promotion activities for incarcerated women (including health education programs and lactation support) and prison staff training. *(Same as strategy 1-B)* F. Provide support to pregnant women at risk for poor birth outcomes through an array of case management and home visiting programs through the Illinois Department of Human Services (DHS); Ensure DHS programs align with Title V priorities. G. Distribute information on topics related to health in pregnancy to women through service providers and social media. Utilize materials from IL CHIPRA and leverage existing public awareness campaigns, such as Text4Baby and Connect4Tots. H. Provide home visiting services to families with newborns identified in the Adverse Pregnancy Outcome Reporting System (APORS) through the IDHS High-Risk Infant follow-up program. I. Support the Illinois Home Visiting Task Force in the design and implementation of the Illinois Family Connects pilot to offer universal home visiting to determine family support needs and refer them to appropriate services. J. Through the CoIIN Safe Sleep workgroup, create a safe sleep toolkit that provides educational information to hospitals, home visiting agencies, childcares and other organizations on developing evidence-based safe sleep policies and promoting safe sleep. K. Participate in IDPH Zika Action Team to develop state readiness plan emphasizing needs of MCH populations. Ensure public messaging includes information related to pregnancy prevention, distribute educational materials to partners, and support APORS in enhancing microcephaly surveillance. (*completed in FY17*) L. Collaborate with IDPH Lead Prevention Program and other partners on the CoIIN- Maternal and Child Environmental Health workgroup to update screening questionnaire, guidelines, and resources on lead exposure for pregnant women *(started in FY18).* M. Ensure population-based metabolic and hearing screening for Illinois newborns.	*See previous page*	*See previous page*	*Continued from previous page* NOM-11: Neonatal abstinence syndrome rate NOM-12: Newborns screened for heritable disorders SOM-3: Black-white ratio of infant mortality rates (NOM-9.1)

Priority Area	Strategies (*Ongoing for the entire grant period unless otherwise noted)*	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	Child Health			
#3: Support expanded access to and integration of early childhood services and systems	A. Work with the Governor's Office of Early Childhood Development and the Illinois Early Learning Council to develop an environmental scan of developmental screening, including social and emotional screens, including options for data collection, places of screening, and validated screening tools. *(completed in FY18)* B. Collaborate with the UIC Leadership and Education on Neurodevelopment and other Disabilities (LEND) program to train early childhood providers to conduct autism screening while conducting developmental and social-emotional screens. *(completed in FY17)* C. Participate on the Governor's Children's Cabinet and Illinois Early Learning Council to facilitate coordination between early childhood systems and assure that health is recognized as an integral component of improving children's educational outcomes. D. Collaborate with home visiting programs, including the Maternal, Infant, and Early Childhood Home Visiting program and early childhood providers to encourage alignment of activities. E. Convene partners to develop administrative rules and coordinate implementation of a new state law requiring social/emotional screening during school physicals.	ESM-6.1: Conduct environmental scan of developmental screening in Illinois *(completed in 2016)* ESM 6.2: Develop administrative rules to implement state requirements for social-emotional screening during school physicals	NPM-6: % Children (10-71 months) receiving a developmental screening using a parent-completed tool	NOM-13: % Children meeting the criteria developed for school readiness *(developmental)* NOM-17.3: % Children diagnosed with autism spectrum disorder NOM-17.4: % Children diagnosed with attention deficit disorder / attention deficit hyperactivity disorder NOM-19: % Children in excellent or very good health NOM-22.1: 7-vaccine series for children 19-35 months
Other Child Health Activities: ASTHMA	A. Improve asthma identification and support services, including education of families, referral of children with asthma to appropriate health care and social services, and care coordination through community-based partnerships *(completed in FY18).* B. Provide training, support, and technical assistance to school nurses in Illinois.	None (no NPM)	No NPM	NOM-15: Child mortality rate SOM-4: Asthma hospitalization rate for children 0-4
Other Child Health Activities: ORAL HEALTH	A. Financially support the IDPH Division of Oral Health to provide dental sealants to children, particularly those with Medicaid or without dental insurance. B. Collaborate with the IDPH Division of Oral Health to convene stakeholders and develop a statewide report and resource manual on oral health during pregnancy and early childhood. *(same as strategy #1-F)* C. Participate in *Implementation of Quality Indicators to Improve the Oral Health of the Maternal and Child Health Population Pilot Project* with IDPH Division of Oral Health to pilot a series of measures to inform the creation of a national set of indicators *(started in FY19).*	ESM-13.2.1: Number of children provided with dental sealants by state oral health program	NPM-13B: % Children who had a preventive dental visit in the last 12 months	NOM-14: % Children ages 1 to 17 who have decayed teeth or cavities in the last 12 months NOM-19: % Children in excellent or very good health

Priority Area	Strategies (*Ongoing for the entire grant period unless otherwise noted)*	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	Adolescent Health			
#5: Empower adolescents to adopt healthy behaviors	A. Certify and financially support school-based and school-linked health centers to expand access to primary health care, mental health, and oral health services for Illinois children and adolescents. B. Provide training, support, and technical assistance to school nurses in Illinois. C. Facilitate collaboration of School-based Health Centers (SBHCs) and the state Family Planning (Title X) program to directly provide family planning services in SBHCs. D. Work with the Illinois Chapter of the American Academy of Pediatrics to encourage providers to adopt "adolescent-friendly" principles in their practice E. Implement an Adolescent Health Initiative to support communities' efforts to increase adolescents' access to preventive and primary healthcare, and to become adolescent-friendly clinics *(started in FY18).* F. Serve on statewide Adolescent Suicide Ad hoc Committee to develop strategic plan to reduce suicide ideation and behavior among youth in Illinois *(started in FY19*).	ESM-10.1: Number of adolescent well visits provided by school-based health centers	NPM-10: % Adolescents (ages 12-17) with a preventive medical visit in the past year SPM-4: % High school students reporting they attempted suicide in the last year	NOM-16.1-3: various adolescent mortality rates NOM-19: % in excellent or very good health NOM-20: % Adolescents overweight or obese NOM-22.2-22.5: various vaccination measures NOM-23: Teen Birth Rate NOM-25: % children not able to get needed health care in last year SOM-1: Chlamydia infection rate among women ages 15-24
#6: Assure appropriate transition planning and services for adolescents and young adults, including youth with special health care needs	*Other activities related to transition services specifically for youth with special healthcare needs are listed under the CSHCN domain* J. Partner with School-Based Health Centers and other interested providers to educate and encourage pediatric providers to incorporate transition into routine adolescent well visits, and to use a standardized transition tool (e.g. Physician Resource Tools housed on ICAAP's website, including the transition checklist [readiness assessment], the Portable Medical Summary, and the informational skill sheets, along with the Six Core Elements of Health Care Transition).	ESM-12.1: % school-based health centers (SBHCs) incorporating transition readiness assessments into adolescent well visits ESM-12.2: Develop mechanism for tracking transition assessment in SBHCs	NPM-12: % Adolescents (with and without special health care needs) who received services necessary to make transitions to adult health care	NOM-17.2: % Children with special health care needs (CSHCN) receiving care in a well-functioning system NOM-19: % Children in excellent or very good health

Priority Area	Strategies (*Ongoing for the entire grant period unless otherwise noted)*	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	Children with Special Healthcare Needs			
#4 (*revised for FY2019*): Enhance the capacity of families to connect CYSHCN to the health and human services they require for optimal behavioral, developmental, health, and wellness outcomes.	A. Provide care coordination for families with medically-eligible CYSHCN. B. Train DSCC Care Coordination teams to use a person-centered approach to care plan development. C. Collaborate with health and human service providers to develop comprehensive, person-centered, shared plans of care for CYSHCN. D. Use information about family satisfaction to improve the quality of care coordination for CYSHCN. E. Facilitate the development of community-based networks of services for CYSHCN. F. Participate in advisory committees for Medicaid, IDEA, early childhood, Workforce Innovation and Opportunity Act, and other initiatives that develop policy regarding CYSHCN. G. Collaborate with ICAAP and IDHFS to encourage implementation of medical homes for all children, especially for CYSHCN. H. Partner with health care providers and systems to identify and address barriers to high-quality, comprehensive care. I. Conduct outreach and marketing activities to inform providers and families of CYSHCN of UIC-DSCC's services. J. Provide financial assistance to low-income, medically-eligible CYSHCN with services not covered by their health plans. K. Provide information about services for CYSHCN and refer families not eligible for UIC-DSCC services to appropriate community resources.	None (no NPM)	No NPM SPM-6: Number of CYSHCN who receive information, referral, and/or care coordination each year from UIC-DSCC.	NOM-17.2: % Children with special health care needs (CSHCN) receiving care in a well-functioning system
#6: Assure transition planning and services for adolescents and young adults, including youth with special health care needs	A. Assist medically-eligible CYSHCN, their families, and their providers with the transition to adult health care. B. Provide staff training on person-centered transition assessment, planning, and support. C. Improve transition planning by using transition assessment tools appropriate for age (12-13, 14-17, 18-19, 20 or more) and developing appropriate person-centered goals.	ESM-12.3: % of adolescents and young adults participating in DSCC Core and Home Care Programs who received comprehensive transition services	NPM-12: % Adolescents (with and without special health care needs) who received services necessary to make transitions to adult health care	NOM-17.2: % Children with special health care needs (CSHCN) receiving care in a well-functioning system

Priority Area	Strategies (*Ongoing for the entire grant period unless otherwise noted)*	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	Children with Special Healthcare Needs (continued)			
#6: Assure transition planning and services for adolescents and young adults, including youth with special health care needs *(continued)*	D. Implement a survey of participants and families on transition needs at age groups 16 years and 20 years to see if UIC-DSCC care coordination is helping meet transition-related needs. E. Co-sponsor the annual Transition Conference, including participation in conference planning, and supporting attendance by UIC-DSCC youth and families. F. Maintain Transition Tips and Tools materials on UIC-DSCC website, including links to national health care transition resources at Got Transition's website. G. Promote UIC-DSCC staff participation in outreach and collaboration with community-based transition stakeholders. H. Provide information to the public on transition by posting planning/training opportunities on social media and giving presentations to community groups. I. Work with Illinois' LEND program and other key stakeholders to develop appropriate messaging for parents focused on the transition of adolescents from pediatric to adult care. J. Partner with School-Based Health Centers and other interested providers to educate and encourage pediatric providers to incorporate transition into routine adolescent well visits, and to use a standardized transition tool (e.g. Physician Resource Tools housed on ICAAP's website, including the transition checklist [readiness assessment], the Portable Medical Summary, and the informational skill sheets, along with the Six Core Elements of Health Care Transition). K. Continue coordination/collaboration efforts with local health departments, provider groups, IDHFS, Medicaid MCOs, F2F, and other community groups to address system barriers that prevent comprehensive transition planning for adolescents (especially YSHCN).	*See previous page*	*See previous page*	*See previous page*
	Cross-Cutting / Life Course			
#7: Assure equity is the foundation of all decision-making; eliminate disparities in MCH outcomes	A. Support the development and implementation of the online Infant Mortality Health Equity Toolkit through CoIIN Social Determinants of Health workgroup. *(completed in FY17)* B. Launch training on the use of the Infant Mortality Health Equity Toolkit to provide information and resources to local health departments and other organizations to incorporate an equity framework into planning. *(completed in FY17)*	None (no NPM)	*Consider disparities (by race/ethnicity, age, CSHCN status, geography) in all NPM*	*Consider disparities (by race/ethnicity, age, CSHCN status, geography) in all NOM* NOM-17.1: Percent children with special healthcare need

Priority Area	Strategies (*Ongoing for the entire grant period unless otherwise noted)*	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	Cross-Cutting / Life Course (continued)			
#7: Assure equity is the foundation of all decision-making; eliminate disparities in MCH outcomes *(continued)*	C. Promote existing training resources on life course, health equity, and social determinants of health to members of boards/groups working on MCH issues. D. Expand OWHFS (IDPH) requirements for describing disparities in grants/proposals and require demonstration of how health equity guides decision-making and program planning. E. Participate on IDPH Health Equity Council. F. Ensure that data reports produced by Title V describe relevant disparities and discuss potential root causes, implications, and recommendations for moving towards equity. G. Collaborate with Committee on Institutional Cooperation (CIC) and Big 10 universities on Health Equity-focused funding proposals supporting policy analysis and data collaboration. *(completed in FY18)*		SPM-7: % of MCH staff who completed at least one training or professional development activity related to health equity during the last year	NOM-21: Children without health insurance SOM-3: Black-white ratio of infant mortality rates (NOM-9.1)
#8: Support expanded access to and integration of mental health and substance use services and systems for the MCH population	A. Support training on trauma-informed care, motivational interviewing, and mental health first aid for public health and medical professionals. *(completed in FY16)* B. Partner with the State Health Improvement Plan (SHIP) Behavioral Health Action Team to carry out statewide strategies. *(completed in FY17)* C. Partner with the Illinois Children's Mental Health Partnership to develop and implement a model for children's mental health consultations for local health departments and other public and private providers in the public health and healthcare delivery system. D. Develop state outcome measure on mental health and substance use among women of reproductive age; analyze data to demonstrate burden and importance of issue; develop data reports to disseminate findings. E. Coordinate and support the state Neonatal Abstinence Syndrome (NAS) Advisory Committee, including organizing the annual report due to the legislature and implementing new data collection, reporting, and surveillance activities. *(completed FY19)* F. Partner with the Illinois Department of Corrections and Logan Women's Prison on health promotion activities for incarcerated women focused on substance use recovery and trauma health education. (*same as strategy 1-B*)	None (no NPM) *See previous page*	No NPM SPM-4: % High school students reporting they attempted suicide in the last year *See previous page*	NOM-10: Infants born with fetal alcohol exposure in the last 3 months of pregnancy NOM-11: Neonatal abstinence syndrome rate NOM-16.3: Adolescent suicide rate, ages 15-19 per 100,000 NOM-18: % Children with a mental or behavioral condition who received needed treatment or counseling NOM-24: Postpartum depression symptoms

Priority Area	Strategies (*Ongoing for the entire grant period unless otherwise noted)*	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	Cross-Cutting / Life Course (continued)			
	G. Identify pregnancy-associated deaths and facilitate two state Maternal Mortality Review Committees (including one focused on violent deaths). (*same as strategy 1-C)* H. Conduct environmental scan of Illinois' opioid treatment locations that will treat pregnant women on Medicaid; Develop a directory to help health care providers appropriately refer women to the nearest community-based resources. *(completed in FY18)* I. Collaborate with state initiatives to address opioids and substance use to ensure a focus on women of reproductive age. J. Convene cross-agency partners in the ASTHO Opioid Use Disorder, Maternal Outcomes, Neonatal Abstinence Syndrome Initiative (OMNI) Learning Collaborative. *(started in FY19)* K. Partner with UIC Center for Research on Women and Gender to implement a program at two clinic sites to expand the capacity of health care providers in the state of Illinois to screen, assess, refer and treat pregnant and postpartum women for depression and related behavioral health disorders *(same as strategy 1-J; started in FY19).* L. Serve on statewide Adolescent Suicide Ad hoc Committee to develop strategic plan to reduce suicide ideation and behavior among youth in Illinois *(same as strategy 5-F; started in FY19*).	*See previous page*	*See previous page*	*Continued from previous page* SOM-5: Mental health and substance use hospitalizations to women ages 15-44
#9: Partner with consumers, families and communities in decision-making across MCH programs, systems and policies	A. Implement a Title V MCH Family Council in each of the seven Illinois Public Health regions. B. Maintain the UIC-DSCC Family Advisory Council. C. Leverage existing community and family coalitions to obtain ongoing feedback on the health needs of women, children, families, and communities, and the strengths and weaknesses of current systems serving these populations.	None (no NPM)	No NPM SPM-8: Number of MCH Family Council members who attended at least half of the regional council meetings over the last year	No NOM

Priority Area	Strategies (*Ongoing for the entire grant period unless otherwise noted)*	Evidence-Based Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	Cross-Cutting / Life Course (continued)			
#10: Strengthen capacity for data collection, linkage, analysis, and dissemination; Improve MCH data systems and infrastructure	A. Develop data products and reports for a variety of audiences. B. Present findings of epidemiologic and other studies conducted by Title V and its partners at state and national meetings and conferences; publish in peer-reviewed journals or state morbidity and mortality review. C. Develop and implement data linkage plans for data sources relevant to MCH D. Support efforts to sustain improvements in birth certificate accuracy through partnership with the ILPQC and the IDPH Division of Vital Records. E. Partner with and support Illinois PRAMS to use innovative strategies for improving response rates, including public outreach, implementation of web-based survey, and introduction of incentives for survey respondents. F. Support the development and use of questions focused on the social determinants of health in state health surveys. G. Maintain and enhance e-PeriNet data system for perinatal hospital reporting of quality and outcome data. H. Maintain the CDC MCH epidemiology field assignee position to strengthen scientific leadership and enhance data capacity and infrastructure. I. Mentor graduate student interns and fellows in epidemiology J. Enhance training and workforce development opportunities for staff. K. Obtain technical assistance and epidemiologic support from the UIC Center of Excellence in Maternal and Child Health through an intergovernmental agreement. L. Provide epidemiologic technical assistance to, and collaborate with, other IDPH divisions, other state agencies, and external partners on data projects M. UIC-DSCC will collaborate with the UIC Center of Excellence in MCH to analyze data collected for the next statewide needs assessment. N. Implement the CDC Maternal Mortality Review Information Application (MMRIA) to collect standardized information on pregnancy-associated mortality *(started in FY19).*	None (no NPM)	No NPM SPM-5: Score for access, utilization, and reporting of ten MCH data sources	No NOM