Priority Area	Strategies	Evidence-Based Strategy Measures	National Performance Measures	National Outcome Measures	Objectives
Women's / Maternal Health					
#1: Assure accessibility, availability and quality of preventive and primary care for all women, particularly for women of reproductive age	a. Convene state and federal, public and private, managed care and fee for service payers to understand the landscape of patient centered medical homes for women with the potential for developing a strategy for expansion or enhancement. b. Collaborate with University of Illinois School of Public Health, Title X and Illinois Department of Healthcare and Family Services to develop a pilot for Pediatricians/Family Practice doctors to offer women an opportunity to complete a reproductive health planning tool during the infant's well-baby visits. c. Improve navigation from prenatal care to postpartum care by supporting the roll out of the Illinois Department of Healthcare and Family Services' prenatal to postpartum care efforts and working with the OB-GYN, Family Medicine and Midwife professional organizations to expand to providers serving privately insured women. d. Support use of the IDHFS women-centered postpartum checklist brochure developed through IL CHIPRA by sharing the checklist with medical professional organizations, and program sites for WIC, Family Case Management, and Healthy Start. e. Provide training and support to home visiting providers, Healthy Start, WIC, Better Birth Outcomes, Family Case Management and other providers working with expectant and new mothers, to increase patient awareness of highly effective contraception, particularly post-partum Long-Acting Reversible Contraception (LARC). f. Collaborate with the Illinois Department of Healthcare and Family Services to develop training and support for healthcare providers to facilitate their ability to educate women and provide access to LARC.	*(Development in progress)*	NPM-1: % women with a past year preventive medical visit	NOM-1: % Births with prenatal care in the first trimester NOM-2: Severe maternal morbidity NOM-3: Maternal mortality rate NOM-4.1: LBW deliveries NOM-4.2: VLBW deliveries NOM-4.3: Moderately LBW deliveries NOM-5.1: Preterm births NOM-5.2: Early preterm births NOM-5.3: Late preterm births NOM-6: Early term births	*NPM #1*: By 2020, improve the percent of women with a past-year preventive medical visit by at least 10% *NOM #2*: By 2020, decrease the rate of severe maternal morbidity by at least 10%

Priority Area	Strategies	Evidence-Based Strategy Measures	National Performance Measures	National Outcome Measures	Objectives
Perinatal / Infant Health					
#2: Support healthy pregnancies and improve birth outcomes	a. Provide case management and support to pregnant women at risk for poor birth outcomes through Illinois Department of Human Services programs, such as: Family Case Management, Better Birth Outcomes, Healthy Start, and evidence-based home visiting programs. Ensure that MCH programs align with Title V goals and priorities. b. Support perinatal network administrators and outreach/education coordinators to maintain strong system of regionalized perinatal care by: i. Implementing an epidemiologic study to understand the reasons why very preterm infants (<32 weeks) are delivered outside Level II facilities ii. Implementing a quality improvement initiative to increase the percentage of very preterm infants born in Level III hospitals iii. Utilizing the Levels of Care Assessment Tool (LOCATe) to describe neonatal and maternal levels of care in Illinois and to inform improvements to Illinois' regionalized perinatal system c. Explore creation of a portal for information and referrals to pre-/inter-conception health services and support for women who have had a prior adverse pregnancy/birth outcome d. Review the state Maternal Mortality Review process and identify opportunities for improving efficiency in abstraction, data collection, and the ability to analyze trends e. Conduct hospital-level reviews of severe maternal morbidities to determine the causes and develop a corrective action plan f. Collaborate with the Illinois Perinatal Quality Collaborative to implement quality improvement projects in birthing hospitals that will improve health outcomes, such as the statewide maternal hypertension project g. Update state Obstetric Hemorrhage Toolkit based on information in the ACOG Obstetric Hemorrhage Bundle and distribute updated educational and training materials to all Illinois hospitals through the Regionalized Perinatal System	*(Development in progress)*	NPM-3: % Very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) NPM-13A: % Pregnant women who had their teeth cleaned NPM-14A: % Women smoking during pregnancy	NOM-1: % Births with prenatal care in the first trimester NOM-2: Severe maternal morbidity NOM-3: Maternal mortality rate NOM-4.1: LBW deliveries NOM-4.2: VLBW deliveries NOM-4.3: Moderately LBW deliveries NOM-5.1: Preterm births NOM-5.2: Early preterm births NOM-5.3: Late preterm births NOM-6: Early term births NOM-7: Non-medically indicated elective deliveries NOM-8: Perinatal mortality	*NPM #3*: By 2020, increase the percent of VLBW babies born in a Level III+ perinatal hospital by at least 10%. *NPM #13A*: By 2020, increase the percent of pregnant women who has their teeth cleaned during pregnancy by at least 10%. *NPM #14A*: By 2020, decrease the percent of women who smoke during pregnancy by at least 15%. *NOM #1*: By 2020, increase the percent of women receiving prenatal care in the first trimester by at least 5%.

Priority Area	Strategies	Evidence-Based Strategy Measures	National Performance Measures	National Outcome Measures	Objectives
#2: Support healthy pregnancies and improve birth outcomes *(continued)*	h. Partner with the March of Dimes to implement the Healthy Babies are Worth the Wait public awareness campaign through distribution at all publicly funded perinatal sites (such as WIC, FCM, Healthy Start, etc.) i. Distribute information to women through service providers and social media (e.g., Facebook and Twitter) on topics related to health in pregnancy, including: oral health, smoking, and chronic disease management. Utilize prenatal care materials from IL CHIPRA and leverage existing public awareness campaigns, such as Text4Baby. j. Partner with the Illinois Quit Line and the Illinois Lung Association to implement a public awareness campaign to reduce smoking through the dissemination of pamphlets, handouts and other printed material. k. Through CoIIN Safe Sleep workgroup, create a safe sleep toolkit that provides educational information for public health professionals on ways to promote safe sleep and gives information to hospitals, home visiting agencies, childcares and other organizations on developing evidence-based safe sleep policies l. Provide home visiting services to families with newborns identified in the Adverse Pregnancy Outcome Reporting System (APORS) through the IDHS High-Risk Infant follow-up program m. Participate in IDPH Zika Action Team to develop readiness plan emphasizing needs of MCH populations. Ensure that public messaging includes information related to both prevention of pregnancy and prevention of Zika transmission, and distribute educational materials to partner organizations. Support state birth defects registry (APORS) in enhancing surveillance of microcephaly, and in providing information to CDC Registry for Zika in Pregnancy. n. Support state breastfeeding initiatives, including promoting Baby-Friendly hospital designation and breast milk banks through the Regional Perinatal Centers, evaluating the impact of the 2011 Illinois Breastfeeding Blueprint, and strategizing with HealthConnect One about updating the Blueprint to drive breastfeeding program and policy development.	*See previous page*	*See previous page*	*(continued from previous page)* 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 NOM-11: Neonatal abstinence syndrome rate	*See previous page*

Priority Area	Strategies	Evidence-Based Strategy Measures	National Performance Measures	National Outcome Measures	Objectives
	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 create a comprehensive coordinated system for developmental screening, including social and emotional screens. Contribute to the development of driver diagrams for a quality improvement initiative and to the conduction of an environmental scan related to developmental and social-emotional screening. b. Promote use of parent-completed developmental screening tools in non-medical sites, such as Healthy Start, WIC, and Head Start. c. Collaborate with the Leadership and Education on Neurodevelopment and other Disabilities (LEND) program at UIC to train early childhood and home- visiting providers to conduct screening for autism while conducting developmental and social emotional screens. d. Participate on the Governor's Children's Cabinet and the Inter-Agency Team to facilitate coordination and synergy between the various early childhood systems. e. Provide training and support to home visiting and early childhood providers to encourage family literacy and healthy families through improved knowledge of early brain and child development and support of early literacy. f. Partner with the Illinois Early Learning Council to assist childcare providers with improving quality, phasing in quality rating systems, ensuring sufficient monitoring of health and safety, and improving infant-toddler care.	*(Development in progress)*	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-19: % Children in excellent or very good health	*NPM #6*: By 2020, increase the percent of children under 5 years old who received a developmental screening using a parent-completed tool by at least 30%.
4: Integrate services within patient-centered medical homes for all children, particularly for CSHCN	a. Work with F2F, DSCC Family Advisory Council and care coordinators, and MCH program staff to develop and disseminate information to educate parents about the components of a Medical Home. b. Utilize DSCC and IDPH websites and social media platforms to post information for families about the components of a medical home and high-quality care. c. Work with key stakeholders, including IDHFS (Medicaid), to develop training and support for healthcare providers about the components of a Medical Home.	*(Development in progress)*	NPM-6: % Children (10-71 mos) receiving a developmental screening using a parent-completed tool	NOM-14: % Children ages 1 to 17 who have decayed teeth or cavities in the last 12 months NOM-15: Child mortality rate	*NPM #6*: see priority 4 *NPM #11*: By 2020, increase the percent of children who have a medical home by at least 10%.

Priority Area	Strategies	Evidence-Based Strategy Measures	National Performance Measures	National Outcome Measures	Objectives
4: Integrate services within patient-centered medical homes for all children, particularly for CSHCN *(continued)*	d. Collaborate with ICAAP and IDHFS to continue to encourage implementation of medical homes for all children, especially for CYSHCN, through promotion of the AAP National Medical Home website, which includes resources for medical practices e. Engage DSCC staff to serve as a resource for educating medical home providers to improve their understanding of community resources and ability to connect families to needed services f. Improve asthma identification and support services, including education of families, referral of children with asthma to appropriate health care and social service agencies, and care coordination through community-based partnerships and programs. g. Engage school-based health centers in a quality improvement project related to asthma management and education of students and school staff. (Through partnership with IDPH Division of Chronic Diseases and Illinois chapter of the American Lung Association) h. Collaborate with Illinois Department of Healthcare and Family Services to identify opportunities to link children's medical homes to dental homes and support integration of care.	*See previous page*	*(continued from previous page)* NPM-11: % Children (with and without special healthcare needs) who have a medical home NPM-13B: % Children who had a preventive dental visit in the last 12 mos NPM-14B: % Children who live in a household with someone who smokes	*(continued from previous page)* NOM-18: % Children with a mental or behavioral health condition who received treatment or counseling NOM-19: % Children in excellent or very good health NOM-20: % Children and adolescents who are overweight or obese NOM-22.1-5: various vaccination measures	*(continued from previous page)* *NPM #13B*: By 2020, increase the percent of children ages 1-17 who received at least one preventive dental visit in the last year by at least 5%. *NPM #14B*: By 2020, decrease the percent of children exposed to environmental tobacco smoke in the home by at least 15%. *NOM #22.1*: By 2020, increase the percent of fully vaccinated children 19-35 months by at least 10%.

Priority Area	Strategies	Evidence-Based Strategy Measures	National Performance Measures	National Outcome Measures	Objectives
	Adolescent Health				
#5: Empower adolescents to adopt healthy behaviors	a. Provide evidence-based teen pregnancy prevention education in school and after-school settings through contracted sites for the Teen Pregnancy Prevention – Primary (TPPP) program; Conduct evaluation of TPPP program and incorporate program changes to improve efficiency and adolescent health outcomes b. Use bonus payments to incentivize School Based Health Centers (SBHC) to provide well visits, risk assessments, and appropriate referrals for follow-up care to adolescent patients. c. Partner with Title X to use bonus payments to incentivize School Based Health Centers to become adolescent friendly clinics that directly provide family planning services within the SBHC. d. Work with the Illinois Chapter of the American Academy of Pediatrics to encourage providers to adopt "adolescent-friendly" principles in their practice e. Partner with IDHFS (EPSDT) and AAP to educate and encourage pediatric providers to incorporate transition into routine adolescent well visits, and to use a standardized transition tool (e.g., transition readiness assessment in Six Core Elements of Health Care Transition) *(cross-listed in priority #6)*	*(Development in progress)*	NPM-2: % Adolescents (ages 12-17) with a preventive medical visit in the past year	NOM-16.1-3: Adolescent mortality rate, motor vehicle mortality rate, suicide rate NOM-19: % Children in excellent or very good health NOM-20: % Adolescents who are overweight or obese NOM-22.2-22.5: various vaccination measures	*NPM #12*: By 2020, increase the percent of adolescents with a past-year preventive medical visit by at least 5%. *NOM #22.3*: By 2020, increase the percent of adolescents who received the HPV vaccine by 20% for females and 30% for males.
#6: Assure appropriate transition planning and services for adolescents and young adults, including youth with special health care needs	a. Work with LEND and other key stakeholders to develop appropriate messaging for parents and adolescents transitioning from pediatric to adult care. b. Co-sponsor the annual Transition Conference, including participating on the planning committee and supporting attendance by DSCC youth and families. c. Maintain Transition Tips and Tools materials on DSCC website, including linking with national health care transition resources at Got Transition's website. d. Provide information to the public on transition by posting planning/training opportunities on social media and giving presentations to community groups.	*(Development in progress)*	NPM-12: % Adolescents (with and without special health care needs) who received services necessary to make transitions to adult health care	NOM-17.2: % Children with special health care needs (CSHCN) receiving care in a well-functioning system	*NPM #12*: By 2020, increase the percent of youth with special healthcare needs who received comprehensive transition planning services by at least 10%.

Priority Area	Strategies	Evidence-Based Strategy Measures	National Performance Measures	National Outcome Measures	Objectives
#6: Assure appropriate transition planning and services for adolescents and young adults, including youth with special health care needs *(continued)*	e. Provide training updates on Transition to DSCC care coordinators. f. Continue coordination/collaboration efforts with local health departments, provider groups, HFS, Medicaid MCOs, F2F, and other community groups to address system barriers that prevent comprehensive transition planning for adolescents (particularly those with special healthcare needs). g. Renew Action Learning Collaborative team efforts to implement the National Standards for Systems of Care for CYSHCN. h. Establish a baseline on state transition performance based on upcoming estimates from the 2015/16 National Survey of Children's Health; conduct in-depth analysis of new transition questions and comparison to other states. i. Partner with IDHFS (EPSDT) and AAP to educate and encourage pediatric providers to incorporate transition into routine adolescent well visits, and to use a standardized transition tool (e.g., transition readiness assessment in Six Core Elements of Health Care Transition).	*See previous page*	*See previous page*	*See previous page*	*(continued from previous page)* *NOM #17.2*: By 2020, increase the percent of CSHCN receiving care in a well-functioning system by at least 20%.
Children with Special Healthcare Needs					
See priority #4 : Medical Home (child health)	Illinois made a deliberate decision to develop strategies for medical home that address the unique needs of CSHCN, but also more broadly address medical home for all children in Illinois. The full list of strategies is available under priority #4 in the child health domain.	*See priority #4*			
See priority #6 : Transition (adolescent health)	Illinois made a deliberate decision to develop strategies for transition to adult healthcare that address the unique needs of YSHCN, but also more broadly address transition planning and services for all adolescents in Illinois. The full list of strategies is available under priority #6 in the adolescent health domain.	*See priority #6*			

Priority Area	Strategies	Evidence-Based Strategy Measures	National Performance Measures	National Outcome Measures	Objectives
	Cross-Cutting / Life Course				
#7: Assure that equity is the foundation of all decision-making; eliminate disparities in MCH outcomes	a. Support the development and implementation of the online Infant Mortality Health Equity Toolkit through CoIIN Social Determinants of Health workgroup 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 c. Promote and train health services agencies, including internal program units within IDPH, to use the health equity assessment tool developed (by the Minnesota Department of Health) d. Expand OWHFS (IDPH) requirements for describing disparities in grants/proposals and require demonstration of how health equity is guiding decision-making and program planning e. Promote existing training resources on life course, health equity, and social determinants of health to members of boards/groups working on MCH issues f. Engage IDPH Health Equity Team to provide training to local MCH programs/entities on the health equity approach and use of equity lens g. Ensure that data reports produced by Title V describe relevant disparities (by geography, race/ethnicity, age, disability status, etc), but also discuss potential root causes, implications, and recommendations for moving towards equity. h. Collaborate with Committee on Institutional Cooperation (CIC) and Big 10 universities on Health Equity-focused funding proposals supporting policy analysis and data collaboration.	*(Development in progress)*	No NPM	NOM-17.1: Percent children with special healthcare needs NOM-21: Children without health insurance	*Disparity in NOM #9.1:* By 2020, reduce the black-white disparity in infant mortality to no more than 2.0. *Subcomponent of NPM #11:* By 2020, increase the percent of families who reported their child's healthcare provider "always" was sensitive to their family customs and values by at least 10%.
#8: Support expanded access to and integration of mental health 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 through webinars, and other educational opportunities, for providers working with mothers, fathers, infants, children, including those with special healthcare needs and adolescents. b. Support positive youth development activities in adolescent health programs, such as Teen Pregnancy Prevention –Primary (TPPP) program	*(Development in progress)*	No NPM	NOM-10: The % infants born with fetal alcohol exposure in the last 3 months of pregnancy	By 2016, develop a state performance measure related to this priority.

Priority Area	Strategies	Evidence-Based Strategy Measures	National Performance Measures	National Outcome Measures	Objectives
#8: Support expanded access to and integration of mental health services and systems for the MCH population. *(continued)*	c. Conduct analysis of data related to mental health and substance use among women of reproductive age to demonstrate burden and importance of issue; develop data reports to disseminate findings. d. Conduct death reviews for violence and substance-related maternal deaths through the Maternal Mortality Review Committee-Violent Deaths (MMRC-V); generate annual report that summarizes public health recommendations for preventing such deaths e. Partner with the State Health Improvement Plan (SHIP) Behavioral Health Action Team to encourage the creation of local behavioral health planning councils and the development of collaborative action plans. f. Partner with the State Health Improvement Plan (SHIP) Behavioral Health Action Team to support routine psychosocial assessment in healthcare and MCH services. g. Support the Illinois Home Visiting Task Force in the design and implementation Universal Newborn Support System pilot, which will offer home visiting to every newborn and their family in Illinois for the purposes of determining their needs for support and referring them to appropriate services h. Partner with the Illinois Children's Mental Health Partnership to develop and implement a model for children's mental health consultations for local health departments and other public and private providers in the public health and healthcare delivery system i. Coordinate and support the state Neonatal Abstinence Syndrome (NAS) Advisory Committee by: *(cross-listed in priority #2)* i. Recommending committee membership and connecting partners to enhance multi-disciplinary committee ii. Presenting information about best practices for NAS prevention, treatment, and surveillance gleaned from other states and national partners iii. Reviewing, compiling, and analyzing data iv. Organizing the annual report due to the state legislature v. Implementing new data collection, reporting, and surveillance activities as required by HB1 (PA 99-0480)	*See previous page*	*See previous page*	*(continued from previous page)* 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	*(continued from previous page)* By December 2016, conduct an analysis of neonatal abstinence syndrome in Illinois. *NOM #18*: By 2020, increase the percent of children with a mental health or behavioral health condition who received treatment or counseling by at least 10%.

Priority Area	Strategies	Evidence-Based Strategy Measures	National Performance Measures	National Outcome Measures	Objectives
#9: Partner with consumers, families and communities in decision-making across MCH programs, systems and policies	a. Implement a Title V Family Advisory Council in each of the seven Illinois Public Health regions b. Maintain DSCC Family Advisory Council c. Empower families of CSHCN through trainings to advocate for their children's care and the importance of medical home and transition services d. Leverage existing community and family coalitions, such as Healthy Start family council and the Arc of Illinois, to obtain ongoing feedback on the health needs of women, children, families, and communities, and the strengths and weaknesses of current systems serving these populations.	*(Development in progress)*	No NPM	No NOM	By July 2016, develop a state performance measure related to this priority. *Subcomponent of NPM #11:* By 2020, increase the percent of children receiving family-centered care by at least 10%.
#10: Strengthen the MCH capacity for data collection, linkage, analysis, and dissemination; Improve MCH data systems and infrastructure	a. Within IDPH OWHFS, implement a standardized data/statistics request system to allow staff to manage and organize internal and external data requests b. Develop data products (e.g., fact sheets, data briefs, surveillance reports) for variety of audiences c. Present findings of epidemiologic and other studies conducted by Title V and its partners at state and national meetings and conferences; publish in peer-reviewed journals or state morbidity and mortality review d. Develop and implement data linkage plans for data sources relevant to MCH, including: vital records, hospital discharge, Medicaid claims, program data, etc. e. Support efforts to sustain improvements in birth certificate accuracy through partnership with ILPQC and Division of Vital Records f. 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 g. Support the development and use of questions focused on the social determinants of health in state health surveys, such as PRAMS and BRFSS h. Obtain Title V staff access to vital records for out-of-state occurrences to Illinois residents, thus improving completeness of Illinois data on births and deaths	*(Development in progress)*	No NPM	No NOM	By July 2016, develop a state performance measure related to this priority. By December 2016, implement a request process/system to organize data and analysis requests.

Priority Area	Strategies	Evidence-Based Strategy Measures	National Performance Measures	National Outcome Measures	Objectives
#10: Strengthen the MCH capacity for data collection, linkage, analysis, and dissemination; Improve MCH data systems and infrastructure *(continued)*	i. Enhance e-Perinet data system (for perinatal hospital reporting of outcome data) to create ability to electronically upload patient data from medical records, thus reducing manual data entry burden j. Maintain the CDC MCH epidemiology assignee position to strengthen scientific leadership and strategic plan for enhancing data capacity and infrastructure k. Conduct quarterly "data team" meetings for internal OWHFS staff l. Mentor graduate student interns and fellows in epidemiology, including GSEP and CSTE Fellows m. Enhance training and workforce development opportunities for analytic staff n. Maintain relationship between OWHFS and the MCH epidemiology program at the University of Illinois at Chicago School of Public Health through an intergovernmental agreement (IGA) o. Support Illinois Perinatal Quality Collaborative efforts with epidemiologic technical assistance p. Collaborate with other IDPH divisions, other state agencies, and external partners on data projects q. Foster collaboration between DSCC and the University of Illinois MCH Epidemiology Program to improve data systems and analyze data related to CSHCN programs and services.	*See previous page*	*See previous page*	*See previous page*	*See previous page*