

Illinois

State Action Plan Table

2026 Application/2024 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
<b>Women/Maternal Health</b>					
Assure awareness, accessibility and quality of reproductive, primary, and specialty care for all women.	To increase the number of Illinois women ages 18-44 who had a preventative medical visit by 5% per year from FY26-30.	<p>Support innovative efforts to facilitate the receipt of high-quality care and address barriers to accessing care for women of reproductive age.</p> <p>Promote trauma informed prevention of sexual abuse, STI, unintended pregnancy, and intimate partner violence through education and evidence-based medically accurate sexual health education.</p> <p>Collect, analyze, disseminate, and utilize the findings from multiple data sources and Committees to generate actionable recommendations on system improvements.</p>	<p><i>Inactive - SPM ESM 2.1 - Well women ESM</i></p> <p>SPM ESM 2.2 - Percent of grantees that believe they were better equipped to address barriers to care after one year of participation in grant program</p>	SPM 2: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Promote the integration of community-based social and economic supports within a well-functioning, comprehensive, and respectful healthcare system for pregnant and postpartum women.	To increase the percentage of postpartum women completing a postpartum visit by 5% by 2030.	<p>Improve access and quality of care by ensuring that pregnant and postpartum patients are receiving health care and support services that meet their unique needs.</p> <p>Engage in bilateral channels of communication with clinical providers, family-run organizations, and individuals to inform state efforts, share resources, and gain input on optimization of State work.</p> <p>Collect, analyze, disseminate, and utilize the findings from multiple data sources and Committees to generate actionable recommendations on system improvements.</p>	<p>ESM PPV.1 - Percent of regular peer-learning meetings attended with active participation in presenting and/or responding to peer discussions</p> <p>ESM PPV.2 - Percent of emergency departments in Illinois with at least one staff person trained to recognize and provide care to pregnant or postpartum women</p>	NPM - Postpartum Visit	<p><b>Linked NOMs:</b></p> <p>Maternal Mortality</p> <p>Neonatal Abstinence Syndrome</p> <p>Women's Health Status</p> <p>Postpartum Depression</p> <p>Postpartum Anxiety</p>
Promote the integration of community-based social and	To identify one policy change or funding mechanism that IDPH Title V team can implement by FY30.	Assess and support housing for pregnant and postpartum women.	ESM HI-Pregnancy.1 - Number of new community and governmental	NPM - Housing Instability - Pregnancy	<p><b>Linked NOMs:</b></p> <p>Severe Maternal Morbidity</p> <p>Maternal Mortality</p> <p>Low Birth Weight</p>

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economic supports within a well-functioning, comprehensive, and respectful healthcare system for pregnant and postpartum women.			partnerships formed to support housing for pregnant women		Preterm Birth Stillbirth Perinatal Mortality Infant Mortality SUID Mortality Neonatal Abstinence Syndrome Postpartum Depression Postpartum Anxiety
<b>Perinatal/Infant Health</b>					
Support the comprehensive and coordinated integration of care systems during and after pregnancy to foster an environment that promotes optimal health for all infants throughout their first year.	To improve infant health by ensuring infants in Illinois receive high quality care in a risk-appropriate setting, the Title V program will work to increase the percent of infants delivered in a risk-appropriate setting increases by 5% per year through FY 30.	<p>Improve access and quality of care by ensuring that pregnant and postpartum patients are receiving health care and support services that meet their unique needs.</p> <p>Engage in bilateral channels of communication with clinical providers, family-run organizations, and individuals to inform state efforts, share resources, and gain input on optimization of State work.</p> <p>Collect, analyze, disseminate, and utilize the findings from multiple data sources and Committees to generate actionable recommendations on system improvements.</p> <p>Reduce SUID and sleep-related deaths through improved analytic capacity, community prevention activities and cross-agency collaboration.</p>	<i>Inactive - ESM RAC.1 - Ratio of maternal to infant hospital transports among very low birth weight infants</i> ESM RAC.2 - Percent of hospitals that documented and implemented a quality improvement initiative outside of current ILPQC initiatives	NPM - Risk-Appropriate Perinatal Care	<b><u>Linked NOMs:</u></b> Stillbirth Perinatal Mortality Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality
Support the comprehensive and coordinated integration of care systems during and after pregnancy to foster an environment that promotes optimal health for all infants	To increase the percentage of women who initiate breastfeeding and lengthen breastfeeding duration rates by 5% by FY 30.	Improve access and quality of care by ensuring that pregnant and postpartum patients are receiving health care and support services that meet their unique needs.	<i>Inactive - ESM BF.1 - Percent of live births occurring in Baby-Friendly hospitals</i> <i>Inactive - ESM BF.2 - Percent of birthing hospitals that are designated as Baby-Friendly</i> ESM BF.3 - Number of birth or early childhood health	NPM - Breastfeeding	<b><u>Linked NOMs:</u></b> Infant Mortality Postneonatal Mortality SUID Mortality

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throughout their first year.			experts trained as CLCs through state breastfeeding support		
<b>Child Health</b>					
Improve child health outcomes by ensuring access and availability to quality pediatric and dental care that centers family engagement and patient experience.	Increase the percent of children who receive a preventive dental visit by 5% by FY 30.	Partner with providers to increase oral health access and strengthen oral health data collection and disease surveillance to increase oral health outcomes in children ages 6 months to 5 years.	<i>Inactive - ESM PDV-Child.1 - Percent of children ages 1-18 enrolled in Medicaid with at least one preventative dental service</i> ESM PDV-Child.2 - Number of school-based health centers providing dental services onsite.	NPM - Preventive Dental Visit - Child	<b>Linked NOMs:</b> Tooth decay or cavities Children's Health Status CSHCN Systems of Care
Improve child health outcomes by ensuring access and availability to quality pediatric and dental care that centers family engagement and patient experience.	To increase the number of children who have access to quality pediatric care in a medical home model by 5% by FY 30.	Improve access to and quality of pediatric primary and mental health care, with a focus on innovation in healthcare delivery setting and data collection.  Collect, analyze, disseminate, and utilize the findings from multiple data sources and Committees to generate actionable recommendations on system improvements.	ESM MH.1 - Percent of regular peer-learning meetings attended with active participation in presenting and/or responding to peer discussions. ESM MH.2 - Percent of school health centers that participate in at least one IDPH-sponsored training initiative each year.	NPM - Medical Home	<b>Linked NOMs:</b> Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
<b>Adolescent Health</b>					
Support adolescents (including	To increase the percentage of adolescents (including CYSHCN) and their families who	Improve access to and quality of pediatric primary care, with a focus on innovation in healthcare delivery setting and data collection.	<i>Inactive - ESM TAHC.1 - Percent of provider practices</i>	NPM - Transition To Adult Health Care	<b>Linked NOMs:</b> CSHCN Systems of Care

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<p>CYSHCN) with knowledge, skills, and self-efficacy to access health care, school, and community-based services while preparing for transition to adult health care.</p>	<p>are engaged with the transition to adult healthcare by 5% through 2030.</p>	<p>Promote trauma informed prevention of sexual abuse, STI, unintended pregnancy, and intimate partner violence through education and evidence-based medically accurate sexual health education.</p> <p>Engage in collaborative efforts with UIC-DSCC's Youth Advisory Council (YAC) and stakeholders to create, review, and share educational resources on the transition to adult health care covering the youth experience, adult system navigation, guardianship options, independence, and other related transition needs.</p> <p>Promote awareness on transition to adulthood by conducting multiple channels of outreach efforts.</p>	<p><i>that were provided technical assistance on transition and have incorporated the six Core Elements of Transition into their practices</i></p> <p>ESM TAHC.2 - Percent of DSCC program participants ages 12-21 with a transition goal included in the person-centered care plan.</p> <p>ESM TAHC.3 - Percentage of DSCC developed transition-related resources developed with family and youth input.</p>		

**Children with Special Health Care Needs**

<p>Collaborate with families and community partners to support early screening and connection for children, especially those with special healthcare needs, to family-centered care within a medical home.</p>	<p>To ensure at least 70% of CYSHCN receive primary care in a medical home, ensuring care is coordinated, family-centered, and comprehensive for each child's needs by FY30.</p>	<p>Share results of analysis on impact of medical home on emergency room visits among CYSHCN with stakeholders and community members.</p> <p>Conduct ongoing needs assessment activities and research on the financing of services for CYSHCN to identify gaps and opportunities for improvement and provide education and support for families on navigating systems to achieve optimal health.</p> <p>Partner with the Illinois Chapter of the American Academy of Pediatrics and family-led organizations to create a training program that will focus on increasing the knowledge and skills of those interacting with CYSHCN and their families to improve health outcomes and promote family-centered care.</p> <p>UIC-DSCC will actively participate in the Big 6 Peer Learning Initiative</p>	<p>ESM MH.1 - Percent of regular peer-learning meetings attended with active participation in presenting and/or responding to peer discussions.</p> <p>ESM MH.2 - Percent of school health centers that participate in at least one IDPH-sponsored training initiative each year.</p>	<p>NPM - Medical Home</p>	<p><b>Linked NOMs:</b></p> <p>Children's Health Status            CSHCN Systems of Care            Flourishing - Young Child            Flourishing - Child Adolescent - CSHCN            Flourishing - Child Adolescent - All</p>
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		and its Medical Home/CYSHCN Subgroup.			
Collaborate with families and community partners to support early screening and connection for children, especially those with special healthcare needs, to family-centered care within a medical home.	To decrease the percent of CYSHCN that experience frustration and challenges when navigating the care system by 5% by 2030.	<p>Development of a community advisory board to support the UIC-DSCC Medical Advisory Board, Family Advisory Council, Youth Advisory Council, and CYSHCN community partners in the development of shared goals to promote high-quality medical home care tailored to the specific needs of Illinois CYSHCN and their families.</p> <p>Support collaborative efforts between IL Title V, family-led organizations, and child-facing programs to enhance peer support and educate Illinois CYSHCN and their families on navigating systems of care.</p> <p>Collaborate with child-facing programs (i.e. home visiting programs, schools, medical providers, EI, etc.) to expand knowledge on appropriate resource and referral networks for Illinois CYSHCN.</p> <p>Provide person and family-centered, strength-based, assessment-driven care coordination to medically eligible Illinois CYSHCN through UIC-DSCC care coordination programs.</p>	SPM ESM 1.1 - Percent of resources developed through the community advisory board oversight that address identified gaps and opportunities for improvement in care delivery and CYSHCN patient experience.	SPM 1: Percent of CSHCN who experienced difficulties or frustrations in accessing health care	

**Cross-Cutting/Systems Building**

Improve health outcomes in child and adolescent health by cultivating partnerships to enable children of all ages to grow, learn, and flourish in a safe environment.	To increase the percent of adolescents in Illinois with an adult mentor by 5% by 2030.	<p>Enhance community support to prevent injury and empower the whole child, including physical mental, and social-emotional wellbeing.</p> <p>Collect, analyze, disseminate, and utilize the findings from multiple data sources and Committees to generate actionable recommendations on system improvements.</p>	SPM ESM 4.1 - Self-rating of school's capacity as a trauma-informed community.	SPM 4: Adult mentor	
Promote optimal access to mental health and substance use screening, diagnosis, and treatment	To increase the percent of women who receive postpartum depression or anxiety screening by 5% by FY 30.	<p>Engage in cross-agency collaboration to improve coordination of and access to children's and maternal mental and behavioral healthcare.</p> <p>Collect, analyze, disseminate, and utilize the findings from multiple data sources and Committees to generate actionable recommendations on system improvements.</p>	SPM ESM 6.1 - Percent of providers reporting satisfaction with the state teleconsultation service.	SPM 6: Postpartum mental health screening	

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integrated with the health care system and in partnership with providers, schools, and community.					
Enhance statewide emergency preparedness for MCH populations affected by natural or man-made disasters, public health emergencies, and humanitarian emergencies.	To support emergency preparedness and trauma care by collaborating with a child-serving and perinatal-serving emergency preparedness effort each calendar year through 2030.	<p>Collaborate in and enhance efforts to ensure safety and continuity of care for pregnant women and children in disasters and emergencies.</p> <p>Support communities and outpatient healthcare providers in planning for and addressing the needs of MCH populations in disasters.</p>	SPM ESM 3.1 - Percent of hospitals participating in pediatric trauma facility recognition program	SPM 3: Percent of children, ages 0-18, who received care in a high-level pediatric trauma center following a traumatic injury	
Improve health outcomes in child and adolescent health by cultivating partnerships to enable children of all ages to grow, learn, and flourish in a safe environment.	To reduce the percent of adolescents with and without special health care needs who are bullied or who bully others by 5% by FY30.	<p>Support early literacy for Illinois children.</p> <p>Enhance community support to prevent injury and empower the whole child, including physical mental, and social-emotional wellbeing.</p>	SPM ESM 5.1 - Self-rating of school's capacity as a trauma-informed community.	SPM 5: Bullying	
Promote optimal access to mental health and substance use screening, diagnosis, and treatment integrated with	To increase the percent of adolescents who receive needed mental health treatment or counseling by 5% by FY 30.	<p>Engage in cross-agency collaboration to improve coordination of and access to children's and maternal mental and behavioral healthcare.</p> <p>Collect, analyze, disseminate, and utilize the findings from multiple data sources and Committees to generate actionable recommendations on system improvements.</p>	SPM ESM 7.1 - Percent of providers reporting satisfaction with the state teleconsultation service.	SPM 7: Adolescent mental health treatment	

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the health care system and in partnership with providers, schools, and community.					
Adopt a life course, intergenerational, and data-informed approach to improve health outcomes and survival of MCH populations, with a focus on the Black population.	Increase the percentage of Black women who receive postpartum depression for anxiety screening by 5% by FY30.	<p>Participate in efforts that address community barriers to receiving access to high quality, risk appropriate health care and support services that meet the unique needs of women and children in Illinois.</p> <p>Collect, analyze, disseminate, and utilize the findings from multiple data sources and Committees to generate actionable recommendations on system improvements.</p>	SPM ESM 6.1 - Percent of providers reporting satisfaction with the state teleconsultation service.	SPM 6: Postpartum mental health screening	