Illinois State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Assure accessibility, availability and quality of preventive and primary care for all women, particularly for women of reproductive age.	By 2025, increase the percentage of women ages 18-44 with a past year preventive medical visit by at least 10%.	1-A. Support the implementation, dissemination, evaluation and improvement of the Illinois Healthy Choices, Healthy Future Perinatal Education Toolkit, which includes information and resources for consumers of women during preconception, prenatal, postpartum, and interconception care. 1-B. Partner with the Illinois Department of Corrections (DOC) and two state women's correctional centers to support ongoing health promotion activities for incarcerated women and staff training, and to ensure women and infants receive the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) services while residing in DOC facilities. 1-C. Implement well-woman care mini grants to assist local entities in assessing their community needs and barriers; and, develop and implement a plan to increase well-woman visits among women ages 18-44 years based on the completed assessment. 1-E. Support the Chicago Department of Public Health (CDPH) efforts to foster, partner, and collaborate with organizations and agencies providing male and partner involvement programs.	ESM WWV.1 - Number of women ages 18-44 receiving a preventative health visit through services provided by grantees of the well woman program	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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					NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

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					Formerly NOM 24) - PPD
Promote a comprehensive, cohesive, and informed system of care for all women to have a healthy pregnancy, labor and delivery, and first year postpartum.	By 2025, decrease the percent of cesarean deliveries among low-risk first births by 5%.	2-A. Convene and facilitate state Maternal Mortality Review Committees (MMRC and MMRC-V) to review pregnancy-associated deaths and develop recommendations to improve quality of maternal care as well as reduce disparities and address social determinants of health. 2-B. Partner with the statewide Severe Maternal Morbidity (SMM) Review sub-committee to develop recommendations for standardizing and improving hospital-level SMM case reviews across Illinois' Regionalized Perinatal System. (Completed in FY22) 2-C. Participate in and collaborate with the Illinois Maternal Health Task Force established through the I- PROMOTE-IL program (HRSA Maternal Health Innovation Grant) to develop a statewide IL Maternal Health Strategic Plan to translate and build on findings and implement recommendations from the Illinois MMRC, MMRC-V and SMM. 2-D. Support and collaborate with the state-mandated Illinois Task Force on Infant and Maternal Mortality Among African Americans to assess the impact of overt and covert racism on pregnancy related outcomes, identify best practices and effective interventions, address social determinants of health, and develop an annual report with recommendations to improve outcomes for African American women and infants. 2-E. Facilitate the collaborative effort between the Illinois Maternal Health Task Force and the Illinois Task Force on Infant and Maternal Mortality Among African Americans to align their strategies and activities towards improving maternal health in Illinois. 2-F. Participate in state inter-agency committee efforts to improve Medicaid coverage and care coordination for pregnant and postpartum women with the extension of coverage from 60 days to 12 months postpartum, allowing managed care reinstatement within 90 days, and waiving hospital presumptive eligibility. 2-H. Assess, quantify and describe the impact of childcare on prenatal, intrapartum and postpartum care in Illinois, and develop optional strategies and approaches that can be implemented in clinic and hospital	ESM LRC.1 - Percent of birthing hospitals participating in an Illinois Perinatal Quality Collaborative (ILPQC) obstetric quality improvement initiative ESM LRC.2 - Percent of births occurring in hospitals that participated in at least one Illinois Perinatal Quality Collaborative (ILPQC) obstetric quality improvement initiative	NPM - Percent of cesarean deliveries among low-risk first births (Low-Risk Cesarean Delivery, Formerly NPM 2) - LRC	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM

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		settings. 2-I. Support the Illinois Perinatal Quality Collaborative (ILPQC) in its implementation of obstetric and neonatal quality improvement projects initiatives in birthing hospitals. 2-K. Partner with Illinois Department of Healthcare and Family Services (HFS) (Medicaid agency) in the National Academy for State Health Policy (NASHP) Maternal and Child Health Policy Innovation Program (MCH PIP). (Started in FY21) 2-G. Convene and partner with key stakeholders to identify gaps in mental health and substance use disorder services for women that include difficulties encountered in balancing multiple roles, self-care and parenting after childbirth; and leverage expertise to develop recommendations for system level improvements for Title V consideration and implementation. 2-J. Support the Perinatal Mental Health Program that includes a 24-hour telephone consultation for crisis intervention for women suffering from perinatal depression 2-L. (New) Partner with the University of Illinois at Chicago, School of Public Health, Division of Health Policy and Administration (UIC-HPA) to explore the influence of healthcare provider access and the casual effects of events or policies on this access. 2-M. (New) Partner with the University of Illinois at Chicago (UIC) through the Center for Research on Women and Gender (UIC-CRWG) enhance all emergency departments (EDs) understanding and ability to recognize and provide care for pregnant and postpartum birthing person			
Support an intergenerational and life course approach to oral health promotion and prevention.	By 2025, increase the percent of women who have a preventative dental visit during pregnancy by 5%.	9-A. Partner with IDPH Oral Health Section (OHS) to expand oral health outreach to the most at-risk maternal populations by engaging local programs and organizations. 9-C. Collaborate with OHS to design and implement the first Basic Screening Survey (BSS) for Pregnant Women that will assess the burden of oral diseases and barriers to access care.	ESM PDV-Pregnancy.1 - Percent pregnant women enrolled in Medicaid with at least one preventative dental service during	NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with

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		9-E. Participate in the Partnership for Integrating Oral Health Care into Primary Care project with OHS and a local health department to integrate the interprofessional oral health core clinical competencies into primary care practice, particularly for pregnant women and adolescents.	prenatal period ESM PDV-Pregnancy.2 - Number of WIC staff trained on oral health issues		special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Assure accessibility, availability and quality of preventive and primary care for all women, particularly for women of reproductive age.	By 2025, decrease the rate of chlamydia infections in women ages 15-24 by 5%.	1-C. Implement well-woman care mini grants to assist local entities in assessing their community needs and barriers; and, develop and implement a plan to increase well-woman visits among women ages 18-44 years based on the completed assessment.			SOM 1: Rate of chlamydia infections in women ages 15-24
Strengthen workforce capacity and infrastructure to screen for, assess and treat mental health conditions and substance use disorders.	By 2025, increase the percent of pregnant women whose health care provider talked to them about depression during pregnancy by 10%.	1-D. 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 to screen, to assess, to refer, and to treat pregnant and postpartum women for depression and related behavioral health disorders. (Completed FY22) 2-J. Support the Perinatal Mental Health Program that includes a 24-hour telephone consultation for crisis intervention for women suffering from perinatal depression.		SPM 4: Percent of pregnant women whose health care provider talked to them about depression during pregnancy	
Strengthen workforce capacity and infrastructure to screen for, assess and treat	By 2025, reduce the percentage of women ages 15-44 hospitalized for MHSU-related issues by 5%.	2-A. Convene and facilitate state Maternal Mortality Review Committees (MMRC and MMRC-V) to review pregnancy-associated deaths and develop recommendations to improve quality of maternal care as well as reduce disparities and address social determinants of health. 2-I. Support the Illinois Perinatal Quality Collaborative (ILPQC) in its			SOM 2: Mental health and substance use (MHSU)-related inpatient hospitalizations for women ages 15-44

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mental health conditions and substance use disorders.		implementation of obstetric and neonatal quality improvement initiatives in birthing hospitals, including continued sustainability of the Mothers and Newborns Affected by Opioids (MNO) initiative. 2-G. Convene and partner with key stakeholders to identify gaps in mental health and substance abuse services for women that include difficulties encountered in balancing multiple roles, self-care and parenting after childbirth; and leverage expertise to develop recommendations for system level improvements for Title V consideration and implementation. 8-B. Partner with the Illinois Department of Corrections and Logan Correction Center on health promotion activities for incarcerated women focused on substance use recovery and trauma health education. 8-G. Collaborate with other state and national initiatives to address opioids and substance use to ensure a focus on women of reproductive age, including participation in the ASTHO Opioid Use Disorder, Maternal Outcomes, Neonatal Abstinence Syndrome Initiative (OMNI) Learning Collaborative. (Completed FY21)			
Promote a comprehensive, cohesive, and informed system of care for all women to have a healthy pregnancy, labor and delivery, and first year postpartum.	Annually increase the percent of women who have a postpartum visit within 12 weeks after giving birth and received recommended care components by 5%.	Strategies for this newly required NPM will be developed during FY25	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Support healthy pregnancies to improve birth and infant outcomes.	By 2025, increase the percent of VLBW infants born in a Level III+ Neonatal Intensive Care Unity (NICU) by at least 5%.	3-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. 3-B. Implement surveillance systems to assess the impact of COVID-19 on pregnant women and neonates, including use of CDC's Surveillance of	ESM RAC.1 - Ratio of maternal to infant hospital transports among very low birth weight infants	NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) (Risk-Appropriate	NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per

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		Emerging Threats to Mothers and Newborns (SET-NET) system and development of system to track universal testing of pregnant women admitted for labor and delivery. (Completed FY23) 3-C. Support the Fetal and Infant Mortality Review (FIMR) program to identify factors that contribute to fetal and neonatal loss and subsequent adverse pregnancy outcomes and develop recommendations to improve quality of care as well as address social determinants of health. 3-D. Support the Illinois Perinatal Quality Collaborative (ILPQC) in its implementation of obstetric and neonatal quality improvement projects initiatives in birthing hospitals. (Same as strategy 2-I) 3-G. Support and collaborate with the Illinois Task Force on Infant and Maternal Mortality Among African Americans to assess the impact of overt and covert racism on pregnancy related outcomes, identify best practices and effective interventions, address social determinants of health, and develop an annual report with recommendations to improve outcomes for African American women and infants. (Same as strategy 2-D) 3-K. (New FY 24) Partner with the University of Illinois at Chicago, School of Public Health, Division of Health Policy and Administration (UIC-HPA) to explore the influence of healthcare provider access and the casual effects of events or policies on this access. (Same as strategy 2-L) 3-L. (New FY 24) Partner with the University of Illinois at Chicago (UIC) through the Center for Research on Women and Gender (UIC-CRWG) enhance all emergency departments (EDs) understanding and ability to recognize and provide care for pregnant and postpartum birthing person. (Same as strategy 2-M)		Perinatal Care, Formerly NPM 3) - RAC	1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related
Support healthy pregnancies to improve birth and infant outcomes.	By 2025, increase the percent of infants who are ever breastfed by at least 5%. By 2025, increase the percent of infants who are exclusively breastfed for a least six (6)	3-E. Collaborate with partners to support statewide efforts to improve breastfeeding outcomes and reduce disparities. 3-F. Partner with the Illinois Department of Corrections (DOC) and two state women's correctional centers to support ongoing health promotion activities for incarcerated women and staff training, and to ensure women and infants receive Special Supplemental Nutrition Program for Women,	ESM BF.1 - Percent of live births occurring in Baby-Friendly hospitals ESM BF.2 - Percent of birthing hospitals	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) -

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	months by 5%.	Infants, and Children (WIC) services while residing in DOC facilities. (Same as strategy 1-B) 3-H. Provide support to pregnant women at risk for poor birth outcomes through an array of case management and home visiting programs by the Illinois Department of Human Services (DHS) Maternal, Infant and Early Childhood Home Visiting (MIECHV) program, and ensure these DHS programs align with Title V priorities. 3-I. Support the Chicago Department of Public Health (CDPH) in implementation of Family Connects Chicago to ensure nurse home visits for all babies and parents immediately following birth and linkage to a network of community supports to assist with longer term, family identified needs.	that are designated as Baby-Friendly	(Breastfeeding, Formerly NPM 4B) - BF	IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
Support healthy pregnancies to improve birth and infant outcomes.	Increase the proportion of infants who are put to sleep in a safe sleep environment by 10%	3-J. Promote infant safe sleep education through community-based educational activities and campaigns.	ESM SS.1 - Number of caregivers reached through community-based infant safe sleep promotion and education programs	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
Child Health					
Strengthen families and communities to assure safe and healthy	By 2025, increase the percent of children under the age of 3 years who receive a developmental screening using a parent-completed screening tool by 10%.	4-A. Participate on the Illinois Early Learning Council to facilitate coordination between early childhood systems to assure that health is recognized as an integral component of Improving children's educational outcomes as well as overall health and well-being.	ESM DS.1 - Percent of Medicaid recipients ages 1-5 receiving at least one screening	NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) -

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environments for children of all ages and abilities to live, play, learn, and grow.		4-B. Collaborate with home visiting programs, including the MIECHV program and early childhood providers, to support the alignment of activities. 4-E. Certify and 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. 4-G. (New)Facilitate the Enhancing Reach Out and Read Illinois (ROR-IL) Program to provide every Illinois child aged six months to five years access to new, high-quality books through their pediatric care.		screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Support an intergenerational and life course approach to oral health promotion and prevention.	By 2025, increase the percent of children ages 1 though 17, who have a preventive dental visit in the past year by 5%.	9-B. Partner with IDPH Oral Health Section to support and to assist MCH populations and key stakeholders, which include women of reproductive age, school personnel and families, to access oral health education, dental sealants, fluoride varnish, Illinois All Kids (Medicaid) enrollment, dental home referrals, and to comply with Illinois' mandatory school dental examinations for children in kindergarten, second, sixth, and ninth grades. 9-D. Participate in "Implementation of Quality Indicators to Improve the Oral Health of the Maternal and Child Health Population" Pilot Project with Oral Health Section to pilot a series of measures to inform the creation of a national set of indicators.	ESM PDV-Child.1 - Percent of children ages 1-18 enrolled in Medicaid with at least one preventative dental service ESM PDV-Child.2 - Number of school-based health centers providing dental services onsite.	NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Strengthen workforce capacity and infrastructure to screen for, assess and treat mental health conditions and substance use	By 2025, decrease the percent of children with unmet health care needs during the last year by 10%.	4-C. Convene partners to develop administrative rules and to coordinate implementation of a new state law requiring social/emotional screening during school physicals. 4-D. Identify gaps in mental health programs and resources for Illinois children, develop partnerships with and within organizations focused on improving mental health among children and adolescents, and support the implementation of mental wellness programs that facilitate system level improvements as well as address social determinants of health.		SPM 3: Percent of children with unmet mental health care needs	

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disorders.		4-F. Collaborate with organizations and programs to address the impact of adverse childhood experiences (ACE) and toxic stress on mental and physical health in children and adolescents. 8-A. Partner with the Illinois Children's Mental Health Partnership to develop and to implement a model for children's mental health consultation for local health departments and other public and private providers in the public health and healthcare delivery system.			
Strengthen families and communities to assure safe and healthy environments for children of all ages and abilities to live, play, learn, and grow.	Annually increase the percent of children with and without special health care needs who have a medical home by 5 %	Strategies for this newly required NPM will be developed during FY25	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Adolescent Health					
Assure access to a system of care that is youth-friendly and youth-responsive to assist adolescents in learning and adopting healthy behaviors.	By 2025, increase the percent of adolescents ages 12-17 who receive a preventive medical visit during the last year by 5%.	5-A. Facilitate the Illinois Adolescent Health Program (AHP) to increase adolescents' access to preventive and primary through adolescent-friendly clinics that provide comprehensive well- care visits, address behavioral, social, and environmental determinants of health. 5-B. Collaborate with the Illinois Chapter of the American Academy of Pediatrics to encourage providers to adopt lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA), and adolescent-friendly services and spaces. 5-E. Certify and support school-based and school-linked health centers to expand access to primary health care, mental health, and oral health services for children and adolescents. (Same as strategy 4-E) 5-G. Support the implementation of the Chicago Healthy Adolescents and Teens (CHAT) program to improve sexual health education, sexually	ESM AWV.1 - Number of adolescents (ages 10-21) served by school-based health centers ESM AWV.2 - Number of adolescents (ages 10-21) receiving a well visit through services provided by grantees of the adolescent health program	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

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		transmitted infections (STIs) screening, and linkage to health care services.			NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination,

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					Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Strengthen transition planning and services for children and youth with special health care needs.	By 2025, increase the percent of youth that are transitioning through phases of adolescence and into adulthood receive appropriate education and information from school health centers and other health professionals regarding health care needs.	6-B. Promote public education on transition services through use of social media and outreach presentations at community organizations. 6-D. Partner with health care providers to educate and support practice initiatives focused on preparation for transition to adulthood, including providing technical assistance to practices on using the 6 Core Elements of Transition 3.0 Toolkit for Providers, and developing youth- focused educational resources for provider practices.	ESM TR.1 - Percent of provider practices that were provided technical assistance on transition and have incorporated the six Core Elements of Transition into their practices ESM TR.2 - Percent of DSCC program participants ages 12-21 with a transition goal included in the person-centered care plan	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC
Assure access to a system of	By 2025, decrease the rate of chlamydia infections in women	5-E. Certify and support school-based and school-linked health centers to expand access to primary health care, mental health, and oral health			SOM 1: Rate of chlamydia infections in women ages 15-24

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care that is youth-friendly and youth-responsive to assist adolescents in learning and adopting healthy behaviors.	ages 15-24 by 5%.	services for children and adolescents. (Same as strategy 4-E) 5-G. Support the implementation of the Chicago Healthy Adolescents and Teens (CHAT) program to improve sexual health education, sexually transmitted infections (STIs) screening, and linkage to health care services.			
Strengthen workforce capacity and infrastructure to screen for, assess and treat mental health conditions and substance use disorders.	By 2025, reduce the percent of high school students who attempted suicide by 5%.	5-C. Participate on and collaborate with the statewide Adolescent Suicide Prevention Ad Hoc Committee to develop a strategic plan to reduce suicide ideation and behavior among youth. 5-D. Identify gaps in mental health programs and resources for Illinois children, develop partnerships with and within organizations focused on improving mental health among children and adolescents, and support the implementation of mental wellness programs that facilitate system level improvements as well as address social determinants of health. 5-F. Collaborate with organizations and programs to address the impact of adverse childhood experiences (ACE) and toxic stress on mental and physical health in children and adolescents. (Same as strategy 4-F)			SOM 3: Percent of high school students who attempted suicide in the last 12 months
Children with Special Health Care Needs					
Strengthen transition planning and services for children and youth with special health care needs.	By 2025, provide care coordination on transition issues such as healthcare, education, work and community independence as evidenced by assessment and appropriate goal development and increase by 5% the percentage of youth served by UIC-DSCC with documented transition assessments with appropriate goals developed.	6-A. Develop and implement Youth Transition Council. 6-B. Promote public education on transition services through use of social media and outreach presentations at community organizations. 6-C. Implement a transition curriculum for youth and caregivers and improve linkage to online guardian resources. 6-D. Partner with health care providers to educate and support practice initiatives focused on preparation for transition to adulthood, including providing technical assistance to practices on using the 6 Core Elements of Transition 3.0 Toolkit for Providers, and developing youth- focused educational resources for provider practices.	ESM TR.1 - Percent of provider practices that were provided technical assistance on transition and have incorporated the six Core Elements of Transition into their practices ESM TR.2 - Percent of DSCC program participants ages 12-21 with a transition	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		6-E. Partner with the Illinois Medicaid agency, Medicaid Managed Care Organizations, Medicaid waiver operation programs, and/or private insurance providers to provide education and recommendations on practices pertaining to preparation for transition to adulthood. 6-F. Co-sponsor the annual Illinois Transition Conference and ensure the participation of UIC-DSCC youth and families in the conference and in conference planning. 6-G. Assist medically eligible CYSHCN, their families, and their providers with the transition to adult health care. Ensure person-centered transition goals are included in plans of care for participants between the ages of 12 and 21. 6-H. Continue participation in the Big 5 CYSHCN State Collaborative that seeks to identify and adopt common population health approaches for CYSHCN for all state participants.	goal included in the person-centered care plan		
Convene and collaborate with community-based organizations to improve and expand services and supports serving children and youth with special health care needs.	By 2025, decrease the percentage of parents and caregivers that report difficulties in accessing resources and obtaining care for their children by 10%.	7-A. Partner with sister agencies, community organizations, and provider practices to address systemic issues and challenges impacting CYSHCN, and to develop a report with recommendations. 7-C. Collaborate with the state's Medicaid agency to develop strategies to improve home nursing coverage and address financial challenges for medically fragile children and youth in Illinois. 7-E. Promote educational resources available through DSCC's online library to parents and caregivers of CYSHCN. 7-G. Develop and disseminate informational sheets on the impact of social determinants on the health of CYSHCN; disseminate to key stakeholders and consumers; and ensure online availability.		SPM 1: Percent of CSHCN who experienced difficulties or frustrations in accessing health care	
Convene and collaborate with community-based organizations to improve and expand services	By 2025, increase the percentage of parents and caregivers reporting that they partner in the decision-making for child's care by at least 10%.	7-B. Expand UIC-DSCC Family Advisory Council to include participation from families of CYSHCN who may not be enrolled in one of DSCC's care coordination programs. 7-D. Continue to support the Advanced Practice Nurse (APN) fellowship for developmental pediatrics by serving as a clinical partner to Almost Home Kids.		SPM 2: Percent of CSHCN whose family was a partner in decision-making for child's care	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
and supports serving children and youth with special health care needs.		7-F. Collaborate with the Illinois Chapter of American Academy of Pediatrics (ICAAP) and other provider groups to improve education, awareness, and usage of medical home best practices in Illinois.			
Convene and collaborate with community-based organizations to improve and expand services and supports serving children and youth with special health care needs.	Annually increase the percent of children with and without special health care needs who have a medical home by 5 %	Strategies for this newly required NPM will be developed during FY25	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Cross-Cutting/Systems Building					
Strengthen the MCH epidemiology capacity and data systems.	By 2025, increase the MCH data capacity score to at least 26 out of 30.	10-A. Enhance staff capacity for data management, analysis and translation through training and workforce development. 10-B. Improve data infrastructure and systems, including initiatives to improve accuracy, timeliness, and quality of data. 10-C. Analyze data, translate findings, and disseminate epidemiologic evidence to support MCH decision-making. 10-D. Forge partnerships that will increase the availability, analysis, and dissemination of relevant and timely MCH data.		SPM 5: Title V MCH data capacity score	
Strengthen workforce capacity and infrastructure to screen for, assess and treat mental health conditions and	Annually, decrease the percent of children with unmet health care needs during the last year by 10%	8-A. Partner with the Illinois Children's Mental Health Partnership to develop and to implement a model for children's mental health consultations for local health departments and other public and private providers in the public health and health care delivery system.		SPM 5: Title V MCH data capacity score	

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substance use disorders.					