Healthy ILLINOIS 2021

Maternal and Child Health Action Team Meeting

Thursday February 11, 2016

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
IDPH
PROTECTING HEALTH, IMPROVING LIVES

UIC MidAmerica Center for Public Health Practice

Agenda

Agenda Topic	Time Allotted
1. Welcome / Logistics - Roll Call - Minutes	9:30 – 9:40 AM
2. Action Planning Process - Objectives - Activities	9:40 – 10:50AM
6. Next Steps	10:50 – 10:55 AM
7. Public Comment	10:55 – 11:00 AM
8. Adjourn	11:00 AM

Meeting Purpose

1. Discuss goal #2: Support healthy pregnancies and improve birth and infant outcomes.
2. Come to consensus on objectives and activities for goal #2

Where We Were – MCH Action Team

- Goal #2 for SHIP Action Team:
  - Support healthy pregnancies and improve birth and infant outcomes
- Key Points:
  - Reducing racial disparities in infant mortality, which includes improving the quality of pre-conception, prenatal, and inter-conceptional care
  - Includes developmental outcomes and infant mental health outcomes

Where We Were – MCH Action Team

- Last week:
  - Developed "Sub-Goals" for Goal #1 last week
  - Drafted SMART objectives for sub-goals
  - Team member should complete feedback survey on goal #1 if you haven't already

Policy, Systems and Environmental Strategies

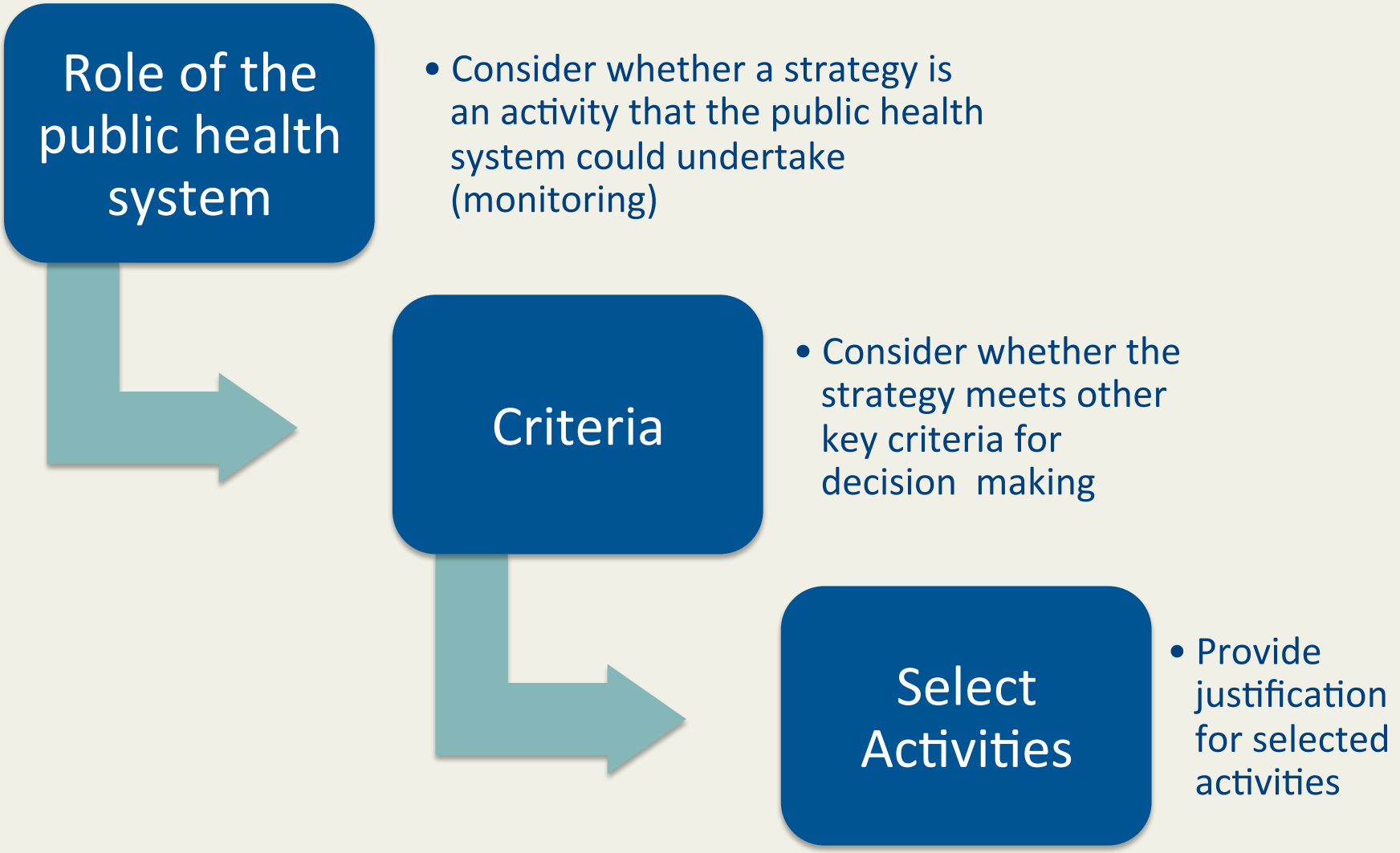
- Policy
  - Policy change includes the passing of laws, ordinances, resolutions, mandates, regulations, or rules
  - Examples: schools establishing a policy that prohibits junk food in school fundraising drives.
- Systems
  - System change involves change made to the rules within an organization. Systems change and policy change often work hand-in-hand.
  - Examples: Creating a community plan to account for health impacts of new projects
- Environmental
  - Environmental change is a change made to the physical environment.
  - Examples: Municipality undertakes a planning process to ensure better pedestrian and bicycle access to main roads and parks

Proposed Criteria

Role of the Public Health System

SDOH	Access	MCH	Urgency	Impact	Evidence -Based	Resources
• How does a proposed strategy address social / ecological factors?	• How does a proposed strategy address access to care?	• How does a proposed strategy promote maternal and child health?	• Is there a crisis? • Are there efforts to build on?	• How many individuals does this reach? • How is disparity addressed?	• Has this strategy been used before with measured success?	• What resources could be leveraged? • Are new resources required?

Using this information to select strategies



Where we're going

Meeting date	Proposed discussion focus
Friday 1/29	Review and discuss decision criteria with strategy examples
Friday 2/5	Goal #1 - focus on action planning
Friday 2/11	Goal #2 - focus on action planning (complete follow up survey – submit template for Goal #3)
Friday 2/19	Goal #3 - focus on action planning (complete follow up survey – submit template for Goal #4)
Friday 2/26	Goal #4 - focus on action planning (complete follow up survey)
Friday 3/4	Proposed 2 hour in-person (9:30 – 11:30) meeting to finalize action plans
Monday 3/14	Planning Council and Action Teams In-Person Meetings: Presentation and discussion
Late March	Public Hearings
Late April	Final Submission

GOAL #1 - OBJECTIVES

Proposed Objectives – Should be SMART!
Support healthy pregnancies and improve birth and infant outcomes
1. Increase the proportion of pregnant women who receive early and adequate prenatal care by 5% within 5 years.
2. Increase the proportion of pregnant women who receive early and adequate quality prenatal care, as defined by ACOG guidelines, from 78.1% in 2014 to 85% by 2021
3. Increase rates of prenatal care by 20%, particularly for low-income women and populations of color.
4. Reduce disparities in maternal morbidity by XX 2021.
5. Improve postpartum transitions of care from delivery to postpartum visit to follow-up primary care particularly for high risk women.
6. Reduce the rate of unintended pregnancy.
7. Increase the percent of women of reproductive age (18-44 years old) with a preventative medical visit in the last year by at least 10% (measurable via BRFSS; baseline in 2013 was 61.9%).
8. Develop wrap-around supports for pregnant mothers of CSHCN.
9. Reduce disparities in pre-term birth outcomes by XX percent by 2021.
10. Decrease the proportion of non-medically indicated deliveries from 5.9% in 2014 to 5% by 2021.
11. Increase the proportion of infants who are ever breastfed from 81% in 2011 to 85% by 2021.
12. Promote women returning for their postpartum visit between 21-56 days.

Justifications

- Increase the proportion of pregnant women who receive early and adequate prenatal care by 5% within 5 years.
  - In Illinois at least adequate prenatal care slightly increased from 76.9% in 2010 to 78.1% in 2014.The objective is also used for Healthy People 2020- MICH 10.2. Details on national objective are as follows: Measure: percent; Baseline (Year): 70.5 (2007); Target: 77.6; Target-Setting Method: 10 percent improvement; Data source: National Vital Statistics System-Natality (NVSS-N); Centers for Disease Control and Prevention, National Center for Health Statistics (CDC/NCHS) http://www.healthypeople.gov/node/4834/data_details
- Increase rates of prenatal care by 20%, particularly for low-income women and populations of color.
  - Statewide, 78% of pregnant women are receiving at least adequate prenatal care.
- Improve postpartum transitions of care from delivery to postpartum visit to follow-up primary care particularly for high risk women.
  - Postpartum care is an opportunity to promote the health and well-being of women through preventive care and assist in the transition to regular well-woman visits with a PCP. Priorities include the following: (1) identifying the most high risk patients prior to discharge from the hospital post-delivery, and providing contact information for the postpartum care provider and education about reasons to contact the provider; (2) scheduling a comprehensive postpartum visit for ALL women at within the first 6 weeks after delivery; (3) Scheduling early post-delivery follow-up for at risk women; (4) Scheduling follow-up diabetes screening for postpartum patients with gestational diabetes; (5) Coordinating the transition to primary care from postpartum care, particularly for women with medical complications who ideally should be seen within 3 mo post delivery by a PCP.

Justifications

- Identification of women at high risk of adverse birth outcomes at two time points; post delivery so can be navigated to appropriate interconception care, and at initiation of prenatal care to navigate risk reduction strategies during prenatal care.
  - There are many medical, socio-economic, and behavioral risk factors that significantly affect birth outcomes for low-income women. There are a limited number of resources to provide comprehensive and continuing wrap-around care for low-income pregnant women, and our goal is to maximize those limited resources for health management and home health resources for the most high-risk patient population. This includes increasing access to Long Acting Reversible Contraceptives and counseling for postpartum birth control; navigation of women postpartum to primary care to treat medical co-morbidities; and ensuring that at risk women are identified during early pregnancy and linked to appropriate interventions to reduce the risk of preterm birth.
- Promote women returning for their postpartum visit between 21-56 days
  - About half of women return for postpartum visit. This is an important checkpoint for birth outcomes and post-pregnancy counseling for the mother.

GOAL #1 - ACTIVITIES

Activities	Policy, system, environmental? Existing or new resources? SDOH? Other criteria?	Champion / Coordinator	Launch Activities / Target Date	How will we know if we're successful?
1. Completed targeted outreach efforts to increase enrollment into Doula/ home visiting programs, which assist women access primary and preventive care.		Champion: DHS Coordinator: Ounce of Prevention Fund; Early Learning Council, Homevisiting Taskforce	Share data on pregnancies with doula/home visiting network; Identify target geographic areas and which doula/ home visiting programs are provided there; Identify community ambassadors and health workers that can assist in referral process.	Enrollment of women in home visiting/ doula programs will be tracked and disaggregated by race/ ethnicity. Additionally, # of women by race/ethnicity who received prenatal care will be collected.
1. Expand access to peer support and doula programs for low income women through the creation of community-based training and support programs (Title V recommended strategy)				
1. Promote positive pre-pregnancy, prenatal, and inter-conception health behaviors through targeted and culturally relevant messaging and education for women, especially young women and women of color (Title V recommended strategy)				

Activities	Policy, system, environmental? Existing or new resources? SDOH? Other criteria?	Champion / Coordinator	Launch Activities / Target Date	How will we know if we're successful?
2. Develop and implement system with incentives for providers and women to enter care in the first trimester.			Insurance policy changes, provider training, consumer education.	
2. Reinstitute concept of MCH providers who are certified as delivering high quality prenatal care.				
3. Determine barriers to prenatal care among sub-populations		IDPH/EverThrive IL	By 1/2018	Review of Healthy People 2020 data
8. Identify expectant mothers of CSHCN		All- including DHS/ DRS,DHS/DD		Mothers of CSHCN keep more appointments, are supported to follow doctor's self-care orders, stress and anxiety related to care of their child w/ special needs is reduced
8. Identify supports needed to attend appointment (e.g.- inclusive child care, respite, Medicaid NCPAS services &c)				

Activities	Policy, system, environmental? Existing or new resources? SDOH? Other criteria?	Champion / Coordinator	Launch Activities / Target Date	How will we know if we're successful?
9. Identification of women at high risk of adverse birth outcomes at two time points; post delivery so can be navigated to appropriate interconception care, and at initiation of prenatal care to navigate risk reduction strategies during prenatal care.				
10. Support reimbursement for Doula care by Medicaid.				
11. Support reimbursement for Doula care by Medicaid.				
11. Support expansion of Baby Friendly hospitals.				
12. Develop a social marketing campaign about the importance of postpartum visits		IDPH/EverThrive IL	By 1/2018	Increase in percentage of postpartum visits via HFS data

WRAPPING UP

Next Steps

- Complete Action Planning Template for Goal #3: https://app.box.com/s/zhdolonnbq2jklaqgl3vob179esu8ft9
- Email by **12 PM on 2/18**
- MCH Data Book available as a resource: https://app.box.com/s/2p6arcemv1van1lsvu8b2c76rbevonc1

Public Comment

- State your name and organization
- 1-2 minutes for comment

Adjourn

- Slides available at www.healthycommunities.illinois.gov
- Questions can be sent to HealthyCommunitiesIL@uic.edu