Healthy ILLINOIS 2021

Maternal and Child Health Action Team Meeting

Friday February 5, 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	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 #1
2. Come to consensus on objectives and activities for goal #1

Where We Were – MCH Action Team

- Goals #1 SHIP Action Team:
  - Assure accessibility, availability and quality of preventive and primary care for all women, adolescents, and children, particularly children with special healthcare needs with a focus on integration of services through patient-centered medical homes.
- Key Points:
  - Access to contraception and expansion of accessibility LARC
    - Comprehensive services
    - Promote the use of medical homes
  - Eligibility for EI services

Policy, Systems and Environmental Strategies

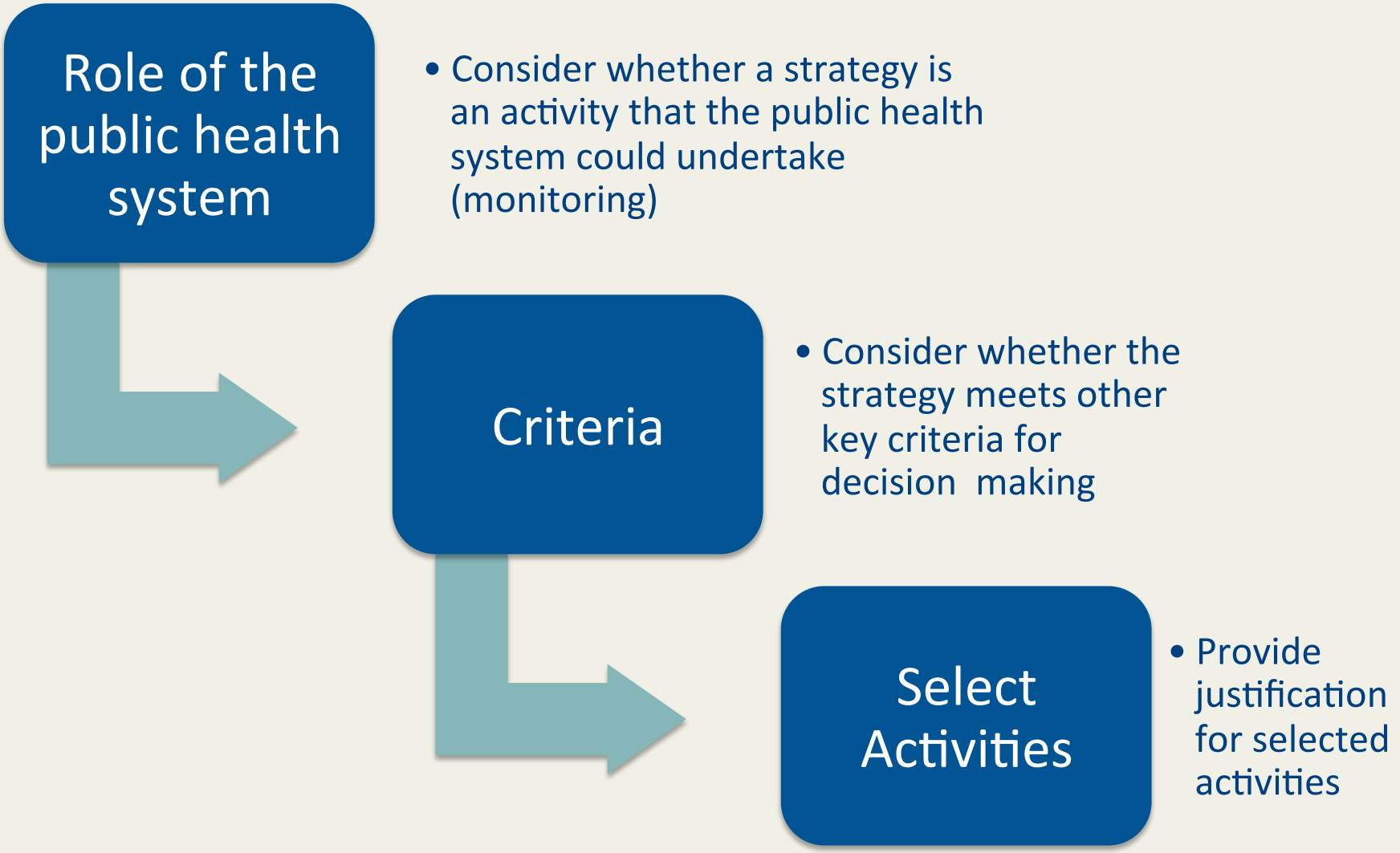
- Policy Change
  - Policy change includes the passing of laws, ordinances, resolutions, mandates, regulations, or rules
  - Examples: schools establishing a policy that prohibits junk food in school fundraising drives.
- Systems Change
  - System change involves change made to the rules within an organization. Systems change and policy change often work hand-in-hand.
  - Examples: Creating a community plan to account for health impacts of new projects
- Environmental Change
  - 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 (may require work in between)
Friday 2/11	Goal #2 - focus on action planning (may require work in between)
Friday 2/19	Goal #3 - focus on action planning (may require work in between)
Friday 2/26	Goal #4 - focus on action planning (may require work in between)
2/26-3/9	Writing first draft of the State Health Improvement Plan
Monday 3/14	Planning Council and Action Teams In-Person Meetings: Presentation and discussion
Thursday 3/17	State Board of Health Presentation
Late March	Public Hearings
Late April	Final Submission
April and beyond	How do we regroup to continue discussion and efforts?

GOAL #1 - OBJECTIVES

Goal: Assure accessibility, availability and quality of preventive and primary care for all women, adolescents, and children, including children with special healthcare needs with a focus on integration of services through patient-centered medical homes.

Objective	Justification SMART
Access and Availability of Patient Centered Medical Homes	
1. Availability of patient centered medical homes	
2. Expand the patient-centered medical home model in Illinois, particularly for mothers and children.	Per the MCH databook, disparities exist in terms of children seen in a medical home--statewide, about half (56%) of Illinois children received care in a medical home during 2011-2012 (the goal set by MCHB is 63%). This global number masks a fair amount of disparities, with populations of color and lower-income populations having lower rates of services within a medical home.
3. Increase frequency and quality of child well visits to medical home.	
4. Decrease the White-Hispanic disparity in proportion of children who have access to a medical home by at least 10% from 46% to 36% over next 5 years.	There were significant differences by race/ethnicity for children who received care in a medical home. In 2011-2012, approximately 73% of White children had a medical home, compared to 45% of Black children, and only 27% of Hispanic children.
Prevention	
5. Impact overweight and obesity in school age children and youth.	

Goal: Assure accessibility, availability and quality of preventive and primary care for all women, adolescents, and children, including children with special healthcare needs with a focus on integration of services through patient-centered medical homes.

Objective	Justification SMART
Prevention and Quality	
6. Reduce White-Black disparity in % of Illinois Births to Women Receiving No Prenatal Care from 3.2% to 2.2% within 5 years.	Black women were the most likely among the racial/ethnic groups to not receive prenatal care.
7. Increase access to Long Acting Reversible Contraceptives (LARC) at delivery and in the postpartum period.	In the United States, about half of all pregnancies are unintended. Postpartum women, particularly those who are low-income, are at risk for unintended and short-interval pregnancy as well as pre-term delivery and adverse birth outcomes. Immediate postpartum LARC may reduce unintended and short-interval pregnancy, and is the most effective and highly continued form of reversible contraception. Timing of LARC immediately postpartum has many benefits, including convenience and safety.

Goal: Assure accessibility, availability and quality of preventive and primary care for all women, adolescents, and children, including children with special healthcare needs with a focus on integration of services through patient-centered medical homes.

Objective	Justification SMART
8. 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. More info can be found at: https://www.communitycarenc.org/population-management/pregnancy-home/pmh-pathways/pmh-care-pathways-postpartum-care-and-transition-w/ . devleop patient centered data base to increase patient follow up and use of postpartum care through innovative patient centered strategies
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.	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.

Goal: Assure accessibility, availability and quality of preventive and primary care for all women, adolescents, and children, including children with special healthcare needs with a focus on integration of services through patient-centered medical homes.

Objective	Justification SMART
Quality	
10. Increase the number of primary care practices recognized by the National Committee for Quality Assurance (NCQA) as Patient-Centered Medical Homes	Improve quality of care
11. Develop and replicate models for integrating primary care practices with community public health and human service programs.	Improve quality of care
Availability of Care	
12. Test where there are areas of decrease access where there are lack of providers	Local health systems, hospital partners
13. Reduce the number of primary care, behavioral health and oral health HPSAs in Illinois	Improve availability of care

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. Work with physicians to identify whether patient center medical homes are		American Academy of Pediatrics		
1. Increase knowledge about patient centered medical home				
1. Educating physicians on patient centered medical home				
2. Establish a state definition of medical home		Champion: HFS Coordinator: IDPH	Taking MCHB guidance, determine what is a medical home in IL. 1/1/2017	All providers and provider organizations can verbalize the components of a medical home for children in IL
2. Determine quality metrics for each of the 5 subcomponents of a medical home		Champion: HFS Coordinator: IDPH	Convene an advisory group to complete this charge 1/1/2018	There are clear metrics for each component.
2. Consider an incentive program for practices to encourage practices to be "certified" as a medical home		Champion: HFS Coordinator: IDPH	Once advisory group determines metrics, they can work to determine incentives and funding mechanisms 12/31/2019	Practices are eager to get certified and percentage of care conducted inside a medical home increases year-over-year.

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?
3/5. Change in School Code to require additional physicals at grades 3 and 11.		IDPH, IL AAP, IASN	- Involve partners- Illinois Chapter AAP, ISBE, IDPH, school nurses - Amend School Code and rule change to Child Health Examination Code - Change IWAS system to collect additional data - Provider information campaign to assure support Fall 2017	Increase frequency and quality of medical home well child visits with focus on reducing overweight and obesity through increased nutrition and physical activity education and treatment or referral when indicated.
3/5. Change in School Code to include aggregate number of students reported as above the 85th BMI percentile for age and sex on the required K, 3, 6, 9, and 11 physicals in the data that must be reported to ISBE related to physical examination and immunization compliance.				
3/5. Change in Child Health Examination Code to specify nutrition and physical activity education be provided as part of Diabetes Risk Assessment				
4. Completed targeted outreach efforts to increase enrollment into quality early childhood programs serving children ages 0-5, which assist in establishment of medical home.		Champion: DHS, ISBE, DFSS, CPS Coordinator: Ounce of Prevention Fund (?)	Identify target geographic areas and which early childhood programs are provided there; Identify localized processes that can support expanded access to early childhood.	Enrollment of children in quality early childhood programs will be tracked and disaggregated by race/ ethnicity to monitor improvements by group.

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?
4. Promote health providers' increased understanding of early childhood programs and the role they play in helping children and families to achieve good health outcomes and encourage them to discuss and support enrollment in high quality early childhood programs.		Champion: Lurie Children's Hospital; EverThrive; Ounce of Prevention Fund; ICAAP Coordinator: Early Learning Council, Health Subcommittee; Ounce of Prevention Fund	Launch work through the Early Learning Council in partnership with health providers and stakeholders, representing a variety of medical settings.	Effective processes to promote health providers' increased understanding of early childhood programs and the role they play in helping children and families to achieve good health outcomes will be identified; Recommendations on how to encourage providers to discuss and support enrollment in high quality early childhood programs will be completed and piloted.
6. 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 (?)	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.

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?
7. Create policies that improve ability for hospitals to provide LARC at delivery for patients		Champion: IDPH/ HFS/Medicaid	Work with hospitals to understand current barriers to implementation of LARC at delivery	
7. Create educational campaign for obstetric providers statewide on providing LARC at delivery			Develop provider education materials on providing LARC at delivery, in partnership with stakeholders and in consultation with other states who have conducted similar initiatives	
7. Create patient education campaign to provide patient awareness of the availability of LARC at delivery			Develop public education campaign to create patient awareness of the option of LARC at delivery, in partnership with stakeholders and in consultation with other states who have conducted similar initiatives	
7. Increase access to LARC availability and utilization at health clinics for all low-income women			Partner with key stakeholders to determine current barriers to widespread access and utilization of LARC	

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?
10. Identify the number, size, and specialty of NCQA-recognized PCMHs in each Chicago Community Area, suburban Cook County Township, county, and HPSA; identify each HPSA without an NCQA-recognized PCMH that provides primary care for children (including CSHCN) or women of child-bearing age			Assign staff resources for assembling, analyzing, and presenting the data 12/31/2016	We have provider:patient ratios for each provider type in each HPSA for calendar year 2015 and know the additional number of providers required to eliminate all of Illinois' HPSA designations.
10. Identify a tax incentive that can be used to increase the number of HPSAs with an NCQA-recognized PCMH for children (including CSHCN) or women of child-bearing age.				
11. Ensure that Medicaid managed care plans offer contracts to all of the local health departments that serve a plan's target area		Champion: Illinois Public Health Association Coordinator: HFS		Every certified local health department that wished to contract with a Medicaid managed care plan has the opportunity to do so at payment rates equal to the amount that would have been earned through fee-for-service reimbursement
11. Increase the number of managed care plans that include at least one local health department from its service area on a committee that formulates policy for benefits covered by the health plan.		Champion: Illinois Public Health Association Coordinator: HFS and DOI		Every managed care organization in Illinois has a local health department representative on a committee that formulates policy for benefits provided through the plan.
11. Develop and evaluate models for integrating primary care practices with community public health and human service programs.				

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?
12. Draft geo-access map to identify density of provider to population / Call providers to identify gaps – launch steps, surveys		DPH		Rates of immunizations, early pregnancy care, contraceptive use
12. Implement Navigator program for areas that lack providers		DPH		
13. Update information on the FTE and distribution of FP, Ped, OB/GYN, psychiatric physicians, APNs, CNMs, psychologists, LCPCs, LPCs, dentists, and RDHs, as well as the number, size, staffing, and patient volume of FQHCs in each HPSA and determine the number of FTEs of each provider type that will be necessary to remove the HPSA designation.		Champion and Coordinator: IDPH Center for Rural Health	Assign staff resources for assembling, analyzing, and presenting the data 12/31/2016	We have provider:patient ratios for each provider type in each HPSA for calendar year 2015 and know the additional number of providers required to eliminate all of Illinois' HPSA designations.
13. Increase the appropriation for state-funded loan repayment programs operated by IDPH			June 30, 2018	The appropriation of state funds for loan repayment programs increases $3,775,600 to
13. Increase the amount of student loan debt that can be repaid from $25,000 per year to $50,000 per year.				The annual amount of student loan debt is increased from $25,000 to $50,000 per year.

WRAPPING UP

Next Steps

- Complete Action Planning Template for Goal #2: https://app.box.com/s/sjxf4sknrdyvzd7zwcccczhk2f3dk9j0
- Email by **12 PM on 2/10**
- MCH Data Book available as a resource: https://app.box.com/s/2p6arcemv1van1lsvu8b2c76rbevonc1

Action Planning Template

Action Team:					
	Goal:				
	Objective 1:				
	Justification:				
	Activity	**Launch Steps**	**Target Date**	**Champion Organization**	**Health Outcome**
1					
2					
3					

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