Healthy Illinois 2021
SHIP Planning Council Meeting
Monday, October 5, 2015 1:00 PM – 4:30 PM

Planning Council Members Present: *Karen Ayala, Jay D. Bhatt, Posh Charles, Bill Dart, Jessica Gerdes, Judith Gethner, Eric Hargan, Rob Hilliard, Michael Holmes, Grace Hong Duffin, Thomas Hornshaw, Vincent D. Keenan, Larry Kissner, Keith Kudla, Kathy Lahr, Ray Marchi McCurdy, CJ Metcalf, Leticia Reyes-Nash, Todd S. Roberts, Richard Sewell, Charlie Weikel, Staci Wilson*

UIC SPH MidAmerica Center for Public Health Practice Staff Present: *Christina Welter, Jennifer McGowan, Geneva Porter, Linda Rosul*

Additional Participants*: Christina Koster, Mary Anne Wolfenson*

Topic	Discussion/Updates	Action Items/Decisions Made
Welcome	Meeting Purpose: • Review summary of focus group data • Review and discuss key criteria for recommending health priorities • Conduct voting on priorities • Discuss next steps Leticia Reyes-Nash reminded the Planning Council members that the OMA and Ethics Training are past due; the Ethics Training Form should be completed and signed and the demographics survey is due back to IDPH by October 14.	Approval of Minutes from September 2 to next meeting
Results Review	A recap of feedback results presented on September 28 webinar was provided by UIC SPH, Mid-America Center for Public Health Practice (MCPHP) Question: In the focus groups there was substantial interest in adding oral health as a health issue – what does that mean? • Structure of our process was to ask stakeholders if there were any additional health issues to add to consideration • Many topics were mentioned so our team divided those in to three areas: systems strategies, target populations and health issues • Oral health was an issue with substantial conversations of needing to be added • Discrete conversations occurred around infectious disease & respiratory issues – this was not significant, but given this was an issue raised, the team wanted to inform the Planning Council	

	The Planning Council does need to pick health issues for the SHIP, which is why we are focusing on the topics that fell under health issues for this conversation.	

Discussion of Plan Framework: Definitions	Feedback sessions indicated strong support for the 5 original health issues of Mental Health, Chronic Disease, Access to Quality Care, Social Determinants of Health, and Maternal Health.
	
	Substantial support was noted for Oral Health and additional mentions included Respiratory Issues (as a result of environmental factors) and Infectious Disease.
	
	MCPHP led a discussion regarding definitions of the 8 potential health issues identified to date. The group was asked to think about elemental definitions and then participated in individual reflection/break out groups. Outcomes of the group work included adding the following definitional elements:
	
	<u>Social Determinants of Health</u>
	• Step 1 – Solve poverty
	• Transcends all other priorities
	• Too big – root cause
	• Barriers to care
	• Circumstances beyond control
	• Personal/cultural/educational decisions
	  o Priority of health
	  o Deferral of care
	  o Social stigma
	
	<u>Access to Quality Care</u>
	• Primary and specialty distribution
	• Oral health
	• Navigation of use of system
	  o How to get quality provider
	  o Consumer education
	• Health literacy/cultural competence
	• Assurance of standard of care
	• What you need, when you need it, at a price you can afford
		Consensus reached for moving oral hea access to quality care.
		
		Consensus reached for respiratory issu chronic disease.

	• Workforce development – who do we need doing what in 2021-2026 regarding population health **<u>Oral Health</u>** • Preventative care • Adults and kids (All Kids/Medicaid) • Exams/x-rays • Cleanings/sealants • Adults with disabilities (Medicaid) • Seniors (Medicare) • Like ADA definition provided in handout • Physiological/psychosocial **<u>Infectious Disease</u>** • Vaccine preventable • STIs • Bioterrorism/naturally occurring/food-borne • Reactive/proactive • Navigation – how to use system, such as high quality medical home • Availability – who and when • Workforce development o School health interventions and education, due to increased STIs o Alcohol/drug abuse ratings **<u>Mental Health</u>** • Criminal justice needs • Lack of integration • Community behavioral health • Cultural stigma • Substance use disorder • Lacking workforce **<u>Chronic Disease</u>** • Rise of new chronic diseases o Aging population	

	o Advanced science • Proactive management/Cost of care o Hospitalization o Resource utilization • Control over long periods o Education o Access • Attack root causes o Smoking o Obesity • Respiratory issues *were added to Chronic Disease* o Environment/toxic/occupational o Air quality o Smoking (taxation/e-cigarettes) o Asthma o COPD **<u>Maternal and Child Health</u>** • Preventative o Prenatal, home visiting • Age of child/infant o Racial disparity o High infant mortality o Behind in developing countries • Factors to MCH o Age, weight, ethnicity, income, socioeconomic factors • Access to care – OB/GYNs Large group discussion: Discussion around the definition of each of the issues included the following: • Social determinants of health o Inclusion of gender and racial inequities o Geographic impact o Focus on actionable ideas o Social determinants comprises many elements o Personal/cultural/educational decisions of public ▪ Priority of health	

	▪ Deferral of care ▪ Social stigma • Many of these are beyond our control o Make sure planning reflects definition (multi-sectoral) o Health in all policies framework - how to redesign care ▪ Investment in job training o Missing housing o Need to focus on what is concrete and strategic: SDOH can be just one priority, the only priority, or a frame or the foundation for all of the other issues Questions: • A question was raised regarding how many priorities the SHIP will ideally have. • Christina Welter responded that smaller numbers of priorities were used in other state's SHIPs that we reviewed that seemed to be most effective. She also added the need to make a shift to more focused ideas and think of the capacity of the group. Decision Points: • Would you combine any of these? o Proposal to: ▪ Move respiratory issues under chronic disease ▪ Move oral health under access to quality care • Consensus for moving oral health to access to quality care (use of the fist to five approach) o Majority of 5s, one not super strong, middle ground comfortable • Consensus for respiratory issues to chronic disease o Majority 5s, one concern o Concern: Now has equal priority of all chronic diseases o Response: There will be multiple measures under chronic disease • There are big pillars and then other things that cross through all of them • A systemic way to present this is possible (refer to presentation)	
Discussion of Plan	Reviewed Measures of Success and strengths, barriers, opportunities, health	

Framework: Measures of Success	system weaknesses and strengths Small group discussion: • Break into 4 groups; each group will focus on two measures of success • Add specificity to measures-narrow down • Discuss the measures of success and whether opportunities and strengths align with measures • When you think of one of the statements, what would be a tangible measure? How would you know this was accomplished? • How do the shared strengths and opportunities align with the measure? Do the barriers overcome the measure as a focus? Large group discussion: Add specificity and clarify statements – consensus vote sought to drill the measures to a lower number of 8 to 4. • **Measure 1: Aligned clinical and primary prevention that results in effective, efficient partnerships to drive health improvement.** o Increase in age appropriate vaccinations o Decrease in number of kids with pre-diabetes/obesity o Increase in number of early childhood interventions o Decrease in recidivism rate o Decrease in infant mortality and pre-term births o Decrease in unintended teen pregnancies Discussion: -Shows clinical and PH integration -Re-define gold standard for care • **Measure 2: A holistic view of the patient that incorporates social determinants drivers of health serving as the foundation for models of clinical care and preventative strategies** o Increase in high school graduation rates o Decrease in unemployment rate o Increase in air quality o Increase in walkability index in each community o Elimination of food deserts	

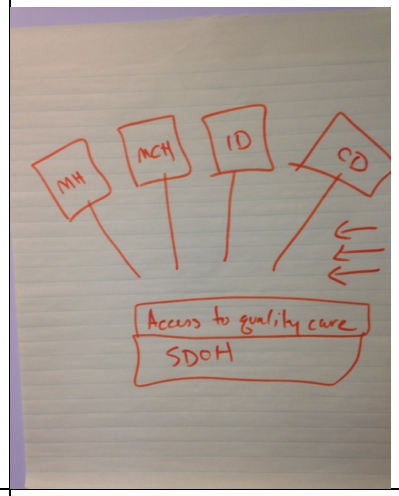
	o Lack of technology infrastructure Discussion: - We don't collect the data we need or we don't integrate it in a way that helps us achieve this. • **Measure 3: Effective data systems that allow for better patient care by reducing redundancies and communicating measures and outcomes to providers and partners.** o Adoption of a functioning HIE with a unified UHR for every state agency o Adoption was a barrier to getting there, there are a lot of private systems but not a unified one • **Measure 4: Aligned quality measures that are based on evidence and supported by payment incentives.** o HEDIS scores o Implementation of values-based pricing (nascent, competing incentives) Discussion: -There are competing incentives built within it right now -Develop a complete model -Value based purchasing – principals haven't radiated out through Medicaid -A larger adoption • **Measure 5: Innovation fostered through the continual growth of evidence based strategies and best practices that result in improved health outcomes, increased patient and provider satisfaction, and stabilized costs** o Increase data collection and type of data that is being collected o Strength-based on data analytics = decisions will be objective and based on the data o Increase enrollment to health care hopefully leads to happiness and stabilized funding o Research is there that answers the question of how do we	

	implement evidence-based strategies in a practical way o Overall patient satisfaction • **Measure 6: A comprehensive approach to consumer education that promotes health literacy, use of a medical home, and overall competency for navigating the health system.** o Collect the data and continually monitor what is working and evaluate o Important: Health literacy needs to work in in both directions: to/from community/patient, as well as provider o Help with costs and connecting to one another • **Measure 7: A workforce that maximizes the potential of current workers and cultivates new workers in order to address gaps and the needs of the health system.** o Ratio of licensed professionals (including geographic distribution/as well as a variety of types of licenses) o Evidence-based pipeline that matches supply to demand • **Measure 8: Decisions are made using a community oriented, asset-based approach to increasing prevention activities that address social determinants of health** o Increased number of Illinoisans who identify a patient-centered medical home o System to assess, monitor and fund asset-based approach **Discussion around Alignment/Combining** • Combine 1 & 8 o Synergy can be derived – number 1 is traditional healthcare, 8 rounds it out o Asset based framework makes it easier to integrate clinical and primary prevention. • Combine 1 & 2 o Preventative + illness=all of patient • Combine 2 & 8 o Are very similar • All of them include collecting data	

	Themes from this discussion - Thinking about it as if these are the ways in which we would define our work and our success, what is missing? • Spectrum of prevention from clinical to primary that's asset based - primary to tertiary prevention and patient to community prevention • Data/Use/Infrastructure – Technology, clinical & financial for data use • Use health communications very broadly (health literacy, awareness of health access) • Social determinants of health – does it stand alone or is it foundational? • 7 & 8 – how to communicate the data, CHW, expanding the communities • How can we drive towards improvement? • Measurement needs to be clear • Adopting principals of health access, with an eye towards social determinants of health in order to address the key principals of health – as opposed to a goal • Baseline of data of what is NOT accessible is not available now • Strategy pieces – we might not be solving the whole puzzle, but rather gathering pieces of the puzzle that we may be looking to achieve	

Discussion of Plan Framework: Public Health System Role	Reviewed feedback on the role of the public health system from the focus groups and Advisory Group of the Planning Council.
	
	Group Discussion:
	What can we collectively do?
	• Reduce the barrier of variation
	  o Create models
	• Collect and share data
	• Help come up with standard definitions, e.g. homelessness
	• Facilitate adoption of HIE from providers and payers
	• Demonstrate return on investment on community based interventions
	• Align and coordinate care of state agencies
	  o Comprehensive treatment
	  o Implementing UHR
		SDOH and Access to quality care as fc

	- Addressing access - Foster communication and coordination across state and public health systems - Insurance - Assess and evaluate the capacity of providers of the whole spectrum of workers - Advocacy - Share best practices What frame are all the things we just said? How would you frame this – local implementation, policy, etc. How are you doing your work? - Framing at the state level but with a deep connection for meaningful work on the ground (not dictating) - Call others to join once connection is developed - Need to create urgency around development - Guidance definitions - Create stronger alignment Should SDOH / Access to care be included or moved out to a value or frame? What can be consolidated? - Include quality as foundational - Foundations are basis/guidelines/guiding principle for the recommended priorities. - Tactical strategies that guide decision making Decision points: - General consensus from the group to consider SDOH and access to quality care as foundational tactics and strategies in addressing the identified health issues. - For this plan, we focus on SDOH and access to quality care in the context of the health priorities that are identified. - Diagram shows agreed upon framework:	

		
Voting On Priorities	Voting guidelines: • Consider the criteria set during the meeting when voting • Planning Council members have three sticky dots to use to vote • Can use all three dots however Planning Council members choose • Vote on flip charts Voting members: Jay Bhatt, Posh Charles, Bill Dart, Grace Hong Duffin, Jessica Gerdes, Judith Gethner, Eric Hargan, Tom Hornshaw, Vince Keenan, Larry Kissner, Keith Kuda, Kathy Lahr, Ray Marchiori, CJ Metcalf, Todd Roberts, Richard Sewell, Charlie Weikel, Staci Wilson Voting by proxy: Karen Ayala, Robert Hillard, Michael Holmes, Dave McCurdy Planning Council member comments: • Need to provide education to the general assembly about the role of governmental public health • Just because infectious disease won't be included, doesn't mean it is not a priority elsewhere o We will report to the GA on updates of where we are on delivery of SHIP	Voting Outcomes 1. Mental health (30 votes) 2. Chronic Disease (22 votes) 3. Maternal and Child Health (13 4. Infectious Disease (1 vote)

Next Steps	Call for action teams -Action Teams will be based on priorities -Will meet through February 2016 - November 9th Planning Council meeting will be an action planning meeting	
Public Comment	Mary Anne Wolfenson • Likes the respiratory issue as a priority because it impacts all ages; it's bigger than just healthcare	
Adjourn	4:30 PM	