Local Health Department Webinar

Tuesday, March 22, 2016
Agenda

<table>
<thead>
<tr>
<th>Agenda Topic</th>
<th>Time Allotted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Welcome</td>
<td>9:30 – 9:45</td>
</tr>
<tr>
<td>2. State Innovation Model Update</td>
<td>9:45 – 10:15</td>
</tr>
<tr>
<td>2. Process Overview and State Health Assessment Findings</td>
<td>10:15 – 10:45</td>
</tr>
<tr>
<td>- Cross-cutting</td>
<td></td>
</tr>
<tr>
<td>- Behavioral Health Action Team</td>
<td></td>
</tr>
<tr>
<td>- Chronic Disease Action Team</td>
<td></td>
</tr>
<tr>
<td>- Maternal and Child Health Action Team</td>
<td></td>
</tr>
<tr>
<td>5. Next Steps</td>
<td>11:25 – 11:30</td>
</tr>
</tbody>
</table>

3/22/16
WELCOME
Healthy Illinois 2021

State Health Assessment

State Health Improvement Plan

State Innovation Model
Key Milestones

1. Developed State Health Improvement Plan
2. Completed State Health Assessment with Health Indicators
3. Established SHIP Action Teams and SIM Workgroups
Healthy Illinois 2021 Products

State Health Assessment

State Health Improvement Plan / Plan For Population Health
State of Illinois is committed to prevention and population health improvement
STATE INNOVATION MODEL UPDATE
Agenda

• State Innovation Model (SIM) Design Process
• Overview of SIM Workgroups
• Recommendations from SIM Workgroups*
  - Consumer Needs
  - Data and Technology
  - Physical and Behavioral Health Integration
  - Quality Measure Alignment
• Healthy Illinois 2021 Plan Next Steps

* Under State review
SIM Design Process

Oversight and Direction from the Governor’s Office

Behavioral Health (Mental Health and Substance Use) Identified as the SIM Priority

Reviewed Illinois Alliance for Health Innovation Plan and Stakeholder Recommendations

System Gap Analysis

Interviewed State leadership to identify needs and priorities in the health system

State Health Assessment

Reviewed and incorporated SHA findings

Further refined recommendations based on current needs

Identified behavioral health as a common issue

Identified recommendations that are still relevant
Overview of SIM Workgroups

• The Workgroups are comprised of stakeholders from across the State with expertise in physical and/or behavioral health.

• The responsibilities of the Workgroups include:
  - Provide design and implementation recommendations for the Healthy Illinois 2021 Plan
  - Ensure design and implementation components are practical and can be operationalized
  - Identify opportunities for cross-Workgroup collaboration to remove barriers and silos

– The Workgroups met monthly from October 2015 through February 2016 to develop recommendations; all recommendations are currently under State review.
CONSUMER NEEDS WORKGROUP
Medicaid Permanent Supportive Housing

Strategy Recommendations
To offer individuals, families and children permanent supportive housing using the Housing First approach in order to achieve the Triple Aim of better care for individuals, better health for populations and lower per capita costs.

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>High-Level Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medicaid eligible individuals, families and children</td>
<td>• Individual Housing Transition Services</td>
</tr>
<tr>
<td>• Behavioral health (mental health and substance use) diagnoses,</td>
<td>• Individual Housing and Tenancy Sustaining Services</td>
</tr>
<tr>
<td>including individuals with complex health issues and at risk for</td>
<td>• State-Level Housing Related Collaborative Activities</td>
</tr>
<tr>
<td>institutional care</td>
<td></td>
</tr>
</tbody>
</table>

Housing First is a methodology for ending homelessness in which housing is obtained as quickly as possible without limitations or expectations (e.g., substance use treatment, counseling, etc.) for individuals experiencing homelessness.

Additional Recommendations
• Educate managed care organizations (MCOs) on current supportive housing programs
• Provide technical assistance to current supportive housing providers
• Enhance the relationship between behavioral health providers and supportive housing providers
• Develop partnerships with MCOs to further enhance and incorporate supportive housing services into current case management and service coordination programs
Behavioral Health Self-Management Program

- Increase the number of Wellness Recovery Action Plan (WRAP) and Whole Health Action Management (WHAM) facilitators by collaborating with MCOs and community-based organizations to fund and deliver trainings
- Educate MCOs, providers and other stakeholders on program value
- Explore key partnerships with community-based organizations to provide additional supports to clients (e.g., transportation, childcare)
- Evaluate how behavioral health self-management programs impact outcomes for clients
Non-Emergency Transportation

• Increase availability and access to non-emergency transportation (NET) services by improving awareness on the following:
  - Becoming a NET vendor
  - Enrolling as a Medicaid provider

– Educate clients, particularly Medicaid fee-for-service clients, about the NET benefits and availability of mileage reimbursement for transportation to and from medical appointments

• Create a consumer-facing webpage to provide guidance, particularly to Medicaid fee-for-service clients, on how to access NET services and make it available in multiple languages
DATA AND TECHNOLOGY WORKGROUP
Standard Consent Form

• A standard consent form can provide a consistent approach to gathering consent and to sharing substance use information regulated by 42 CFR Part 2, as well as other sensitive health information.

• Recommendation consists of two steps:
  - Develop legislation to require a standard consent form
  - Develop a standard consent form

**Benefits**

- Supports health information exchange for treatment and care coordination
- Reduces complexity for providers and provider office staff
- Increases consumer understanding of the consent process
- Improves ability to track, for treatment purposes, consumers who have provided consent
Standard Behavioral Health Domains for Continuity of Care Documents

• Existing Continuity of Care Documents (CCDs) do not include adequate information to understand the history and needs of behavioral health consumers, which causes barriers:
  - Coordinating physical and behavioral healthcare
  - Addressing consumer needs for other social services

• The State should promote the adoption of a standard CCD that captures additional behavioral health data elements, as endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA)

Additional Behavioral Health-Related Data Elements Include:

- Homeless Details
- Peer Group Involvement
- Criminal Justice System Involvement
- Substance Use Disorder
Data Sharing

State agencies should use policy and funding levers to encourage regional health information exchanges (HIEs) to:

• Develop HIE and data sharing service offerings that are tailored to the specific needs and resources of various provider types, which will require:
  - A feasibility assessment
  - Identification of target provider types
  - Determination of the operational and clinical needs
  - Development of technical solutions that align with provider technological capabilities and resources

• Integrate Medicaid MCOs and other payers into the HIE data sharing system to maximize potential investment in the statewide HIE system and ensure important data points (e.g., behavioral health data) are included in the flow of information, which will require:
  - Collaboration and outreach with payers
  - Creation of a value proposition
  - Development of a financial model that will promote participation by multiple regional HIEs and payers
PHYSICAL AND BEHAVIORAL HEALTH INTEGRATION WORKGROUP
CMS provides the option for states to amend their Medicaid state plans to create Medicaid Health Homes, authorized by Section 2703 of the Affordable Care Act. Illinois is exploring a Behavioral Health Homes (BHHs) pilot to:

- Improve overall health outcomes (including social determinants of health)
- Reduce avoidable utilization of intensive medical services and settings
Behavioral Health Homes (Cont’d)

Eligibility Criteria
- Adults with serious mental illnesses and children with serious emotional disorders
- Clients with a mental health condition and a substance use disorder
- Clients with a mental health condition or a substance use disorder, and one of the designated chronic conditions or risk factors (designated chronic conditions and risk factors are still to be determined)

BHH Provider Types
- Providers should be Rule 132 certified to apply to serve as a BHH; Rule 132 certification confirms providers have baseline ability to serve clients with behavioral health conditions
- Providers with Rule 132 certification should partner with a primary care provider

BHH Staffing Structure*
- BHH Director
- Care Coordinator
- Nurse Care Manager
- Primary Care Physician Consultant
- Behavioral Health Clinician

*The State should use Illinois-specific credentials when determining qualifications for these roles
QUALITY MEASURE ALIGNMENT

WORKGROUP
### Healthy Illinois 2021 Measure Synopsis

The Healthy Illinois 2021 Measures:
- Represent measures currently adopted in Illinois and in the United States
- Address adults and children
- Address multiple physical and behavioral health conditions
- Report on key stakeholders across the continuum of care

<table>
<thead>
<tr>
<th>Measure Count</th>
<th>Adoption</th>
<th>Population</th>
<th>Conditions</th>
<th>Target for Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MCO P4P</td>
<td>MCO Non-P4P</td>
<td>DMH</td>
<td>NOMs</td>
</tr>
<tr>
<td></td>
<td>SIM Round 1</td>
<td>CCBHC Grant</td>
<td>CMS Core</td>
<td>National</td>
</tr>
<tr>
<td></td>
<td>Adults</td>
<td>Children</td>
<td>Diabetes</td>
<td>Serious Mental Illness</td>
</tr>
<tr>
<td></td>
<td>Substance Use</td>
<td>PCP</td>
<td>BH Provider</td>
<td>Hospital</td>
</tr>
<tr>
<td></td>
<td>MCOs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure Count</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>8</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>12</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>5</td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>
# Healthy Illinois 2021 Measure Set

<table>
<thead>
<tr>
<th>Medical Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Developmental Screening in the First Three Years of Life (SDEV)</td>
</tr>
<tr>
<td>2. Initiation and Engagement of Alcohol and Drug Dependence Treatment (IET)</td>
</tr>
<tr>
<td>3. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</td>
</tr>
<tr>
<td>4. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)</td>
</tr>
<tr>
<td>5. Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%)</td>
</tr>
<tr>
<td>6. Medication Reconciliation</td>
</tr>
<tr>
<td>7. Use of Evidence-Based Practices (EBPs): Behavioral Health</td>
</tr>
<tr>
<td>8. Mental Health Utilization (MPT)</td>
</tr>
<tr>
<td>9. Follow-Up After Hospitalization (within 30 days) (behavioral health-related primary diagnosis)</td>
</tr>
<tr>
<td>10. Inpatient Hospital 30-Day Readmission Rates for a Behavioral Health Diagnosis (IIHR)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recovery-Oriented Services and Supports/Social Determinants of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Increased Retained Employment or Return to/Stay in School</td>
</tr>
<tr>
<td>12. Increased Stability in Housing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client Experience/Evaluation of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Mental Health Statistics Improvement Program (MHSIP) Consumer Survey</td>
</tr>
<tr>
<td>14. MHSIP Family Survey</td>
</tr>
</tbody>
</table>
SIM – NEXT STEPS
Next Steps

*Healthy Illinois 2021 Plan* review process:

- **Executive Committee** will review and provide feedback by April 1st.
- **Workgroups** will review relevant sections of the *Healthy Illinois 2021 Plan* and provide feedback by April 29th.
- **State** will submit *Healthy Illinois 2021 Plan* to Center for Medicare and Medicaid Innovation in July.
- Updates will be incorporated from the Executive Committee.
- State will conduct public webinars on the *Healthy Illinois 2021 Plan* in late April and early May.
Questions?
The basic planning process

**Current state:**
Where are we now?

- Where are we now? What is the situation?
- What are our strengths? What are our resources? What are our limitations?
- What are opportunities?
- What are threats?

**Future State:**
Where do we want to be?

- Where do we want to be?
- How will we know we’re successful?
- What are our measures of success?
- How will we measure progress?

**Strategies and actions:**
How do we get there?

- Select strategies based on best options
- Selection helps to focus the work based on resources and leverage points
**Illinois’ State Health Assessment and Plan for Population Health Improvement Timeline**

<table>
<thead>
<tr>
<th>Phases</th>
<th>Basic activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1: April – May 2015</td>
<td>• Conduct primary and secondary data analysis for SHA</td>
</tr>
<tr>
<td>Phase 2: May-June 2015</td>
<td>• Engage Planning Council members</td>
</tr>
<tr>
<td></td>
<td>• Assess data, indicators and measure availability</td>
</tr>
<tr>
<td>Phase 3: June –July 2015</td>
<td>• Facilitate Planning Council review of data toward draft priorities, develop strategic approach, and align organizational strengths</td>
</tr>
<tr>
<td>Phase 4: August – September 2015</td>
<td>• Conduct focus groups and continued organizational feedback sessions</td>
</tr>
<tr>
<td></td>
<td>• Analyze results of vetting process statewide</td>
</tr>
<tr>
<td>Phase 5: October – December 2015</td>
<td>• Planning Council reviews SHA</td>
</tr>
<tr>
<td></td>
<td>• Submit final draft of the SHA</td>
</tr>
<tr>
<td>Phase 6: December 2015 - February 2016</td>
<td>• Undertake action planning</td>
</tr>
<tr>
<td></td>
<td>• Review and revise actions plans with Planning Council</td>
</tr>
<tr>
<td>Phase 7: March – April 2016</td>
<td>• Public commentary on SHIP</td>
</tr>
<tr>
<td>Phase 8: April 2016</td>
<td>• SHIP Plans submitted for final approval</td>
</tr>
</tbody>
</table>
Who is participating?

Leadership Team

UIC SPH & IDPH Team

Planning Council

Behavioral Health Action Team

Chronic Disease Action Team

MCH Action Team
Key Steps

• Applied a sound framework for conducting the assessment
• Built on existing work
• Identified a preliminary, flexible set of priorities
• Engaged stakeholders in the assessment and final prioritization process
## Data Used

<table>
<thead>
<tr>
<th>Health Priorities and Status Assessment</th>
<th>Forces of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Status Indicators</td>
<td>State Agency Review</td>
</tr>
<tr>
<td>IPLANs</td>
<td>Focus Groups</td>
</tr>
<tr>
<td>CHNAs</td>
<td>Organizational Presentation</td>
</tr>
<tr>
<td>State Agency Review</td>
<td></td>
</tr>
<tr>
<td>Focus Groups</td>
<td></td>
</tr>
<tr>
<td>Organizational Presentations</td>
<td></td>
</tr>
</tbody>
</table>

### Community Themes & Strengths

<table>
<thead>
<tr>
<th>Public Health System Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Agency Review</td>
</tr>
<tr>
<td>Focus Groups</td>
</tr>
<tr>
<td>Organizational Presentation</td>
</tr>
</tbody>
</table>
Qualitative data

What did we do?
• Inquired about assets and what was working
• Asked/reviewed what was already done (e.g. I-PLANS)
• SHA and Appendix (and SHIP) summarize key themes and areas of alignment (e.g. selection of SHIP interventions was based on alignment)

Why did we do this?
• To show areas of where we can coordinate better, align our work, and leverage resources, e.g. shared needs and ways to address the needs

Quantitative data

What did we do?
• Co-selected national indicators and where possible, benchmarks
• Created a template and process for collecting and producing data across IDPH departments (e.g. demographic, vital statistics, and health outcome data)
• Produced comprehensive results that show trend, disparity, geography comparisons to available benchmarks in one place (e.g. Data Book and SHA)

Why did we do this?
• Producing integrated data allows for even more meaningful comparisons to show gaps and needs
• Modeling a system to provide data for comparison to be used by IDPH and its stakeholders
Examples

- IPLANs
- CHNAs
- Critical Care Hospitals
- State Agency Reports
- IDPH Secondary Data
Stakeholder Feedback

- Talked with 94 organizational representatives through Focus Groups
- Reached over 300 people through presentations
- Presented to over 10 organizations, such as the Illinois Alliance to Prevent Obesity & Catholic Charities

3/22/16
What’s Different?

About the process:
• Used existing data (IPLAN, CHNA priorities, state agency needs assessments)
• Asset based approach for decision-making
• Measurement system was piloted
• Launch steps were recommended
• Champions were recommended

Relevant for LHDs:
• IPLAN data was reviewed and significantly integrated for health prioritization
• Some county-level data will be available
• Possibility of statewide standard measurement system is in play
• Alignment of agenda is already occurring (IPHA annual meeting)
HEALTHY ILLINOIS 2021: STATE HEALTH ASSESSMENT RESULTS
Frame for SHA

- Social Determinants of Heath
- Access to Care
- Behavioral Health
- Chronic Disease
- Maternal and Child Health
Social Determinants of Health

• “If you look at the social determinants of health as well, addressing those would affect all the other things on the list.”
# Access to Care

## Rate of Emergency Department Discharges for Type II Diabetes, per 10,000 Adults

**Illinois Overall and by Race/Ethnicity, 2014***

*Source: IDPH, Division of Patient Safety and Quality*

<table>
<thead>
<tr>
<th>Category</th>
<th>Rate</th>
<th>CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Illinois Overall</strong></td>
<td>288.0</td>
<td>(286.9-289.0)**</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>601.5</td>
<td>(597.4-605.5)</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>224.0</td>
<td>(222.8-225.1)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>283.6</td>
<td>(280.8-286.3)</td>
</tr>
<tr>
<td>Non-Hispanic Other</td>
<td>296.0</td>
<td>(291.8-300.3)</td>
</tr>
</tbody>
</table>

*Denominator is the mean 2012-2014 data, from Claritas
**(95% confidence intervals)
Chronic Disease

• Chronic disease:
  – Long-lasting condition that can be controlled but not cured
  – Leading cause of death and disability in the United States

• “You don’t realize until you’re in another state that has smoke, how much you’re thinking I’m glad that passed and we live in a state with [a smoke-free ban].”
## Smoking

### Percent of All Adults Reporting Smoking*
Illinois Overall and by Race/Ethnicity, 2014

*Current Smoker

**Healthy People 2020 TU-1.1 Reduce cigarette smoking by adults.

***95% confidence intervals

<table>
<thead>
<tr>
<th>Benchmark**</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois Overall</td>
<td>16.7 (15.2-18.2)***</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>25.2 (20.3-30.9)</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>16.5 (14.8-18.2)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>12.9 (9.6-17.1)</td>
</tr>
</tbody>
</table>

Source: IDPH, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)
## Percent of Obesity Among Children Ages 10-17*
Illinois Overall and by Race/Ethnicity, 2011

*Based on 95\textsuperscript{th} Percentile of Body Mass Index (BMI) for age.

**Healthy People 2020 NWS-10.4 Reduce the proportion of children and adolescents aged 2 to 19 years who are considered obese. Target: 14.5, based on BMI 95\textsuperscript{th} percentile.

***(95% confidence intervals)

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percent</th>
<th>Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois Overall</td>
<td>19.3</td>
<td>(15.4 - 23.1)</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>28.5</td>
<td>(18.1 - 39.0)</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>16.3</td>
<td>(11.5 - 21.1)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>21.4</td>
<td>(11.5 - 31.3)</td>
</tr>
<tr>
<td>Non-Hispanic Other</td>
<td>8.8</td>
<td>(2.1 - 15.5)</td>
</tr>
</tbody>
</table>

Source: Child and Adolescent Health Measurement Initiative, Data Resource Center
National Survey of Children's Health (NSCH)
Behavioral Health

• Behavioral health includes the emotions, behaviors and biology relating to mental health, including one’s ability to function in everyday life and one’s concept of self.

• “Mental health drives your chronic diseases because if you can’t take care of yourself you’re not going to get out of bed, you’re not going to go to work, you’re not going to care for your babies. It just rolls and if they’re sad and depressed, and you try and get them on medication, it’s taboo…”
Poor Mental Health Days

Percent of Adults Reporting Poor Mental Health More than 7 Days in a Month*
Illinois Overall and by Gender and Age, 2014

Source: IDPH, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)

*"...how many days during the past 30 days was your mental health not good?"
## Poor Mental Health Days and ACEs

### Average Number of Days per Month Illinois Adults Report Mental Health Not Good According to Number of ACEs

<table>
<thead>
<tr>
<th>ACEs</th>
<th>Average Days</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 or more</td>
<td>7.0</td>
<td>5.9, 8.0</td>
</tr>
<tr>
<td>1-3</td>
<td>3.6</td>
<td>3.2, 4.1</td>
</tr>
<tr>
<td>none</td>
<td>2.9</td>
<td>2.5, 3.3</td>
</tr>
</tbody>
</table>

Data Source: 2013 IL BRFSS, IL Department of Public Health
Maternal and Child Health

• MCH Domains:
  1. Women/Maternal Health
  2. Perinatal/Infant Health
  3. Child Health
  4. Children with Special Health Care Needs
  5. Adolescent Health
  6. Cross-cutting or Life Course

• There is a need “to coordinate with [agencies] and make sure sound public health policies are in sync with Medicaid, WIC, and SNAP.”
Infant/Child Mortality

Infant Mortality* Rate per 1,000 Live Births, 2010-2013
By Year and Race and Ethnicity

Source: IDPH, Center for Health Statistics and Division of Vital Records

Benchmark**: 6.0 per 1,000

* Death in the first year of life.
** Healthy People 2020 MICH-1.3 Reduce the rate of all infant deaths (within 1 year)
Maternal Mortality

Maternal Mortality Rate A.
Deaths to Women Directly Related to Pregnancy
per 100,000 Live Births, 2010-2014*
Overall By Year
and 2-Years Combined for Race/Ethnicity

Source: IDPH, Center for Health Statistics and Division of Vital Records

* 2014 data are provisional

**Healthy People 2020 MICH-5 Reduce the rate of maternal mortality—number of female deaths due to obstetric causes within 42 days of pregnancy.

Benchmark**: 11.4 per 100,000 live births
Feedback

• What questions do you have about the data presented?
• How can the information shared in the State Health Assessment be useful for your work?
• What other data would be useful for your work?
HEALTHY ILLINOIS 2021: STATE HEALTH IMPROVEMENT PLAN
SHIP Timeline

• Submit State Health Assessment: January 15
• Action Team Meetings: December 2015 – February 2016
• Planning Council Meeting: March 2016
• Public Hearings: March 2016
• Submit State Health Improvement Plan: April 2016
# Action Planning Template

**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, linkage and continuity of services through patient-centered medical homes.

**Focus Area:** Implement quality standards, performance measures, and reimbursement rates and procedures for patient-centered medical homes in managed care and fee-for-service environments, as well as technical assistance, consultation, and training resources

**Measure:** By January 1, 2022, implement reimbursement of medical homes and necessary supportive infrastructure

<table>
<thead>
<tr>
<th>Activity/Strategy</th>
<th>Launch Steps : Data Sharing and Use, Partnerships, Health Communication, Community/Clinical Linkages, Social Determinants of Health, Other Training</th>
<th>Target Date</th>
<th>Recommended Champion/Coordination Organization</th>
<th>What are possible measures of success?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect evidence regarding PCMH</td>
<td>Collect practice-based evidence and evidence-based practices regarding the definition, measurement, and reimbursement of PCMH</td>
<td>12/31/2016</td>
<td>Coalition of payers, managed care plans and other care coordinators (including DNSH); health advocates; state health agencies (IDPH, IDHFS, DCFS; IDHS); primary care provider associations</td>
<td>Publish recommendations for PCMH terms, performance measures and reimbursement models.</td>
</tr>
</tbody>
</table>
| Convene state and federal, public and private, managed care and fee-for-service payer organizations | - Identify payer advocacy organizations  
- Convene provider organizations  
- Review policy recommendations  
- Develop a consensus statement supporting PCMH | 12/31/2017 | Coalition of health advocates | Publish a consensus statement of PCMH concepts, performance measures, reimbursement procedures, and experience in other states and demonstration projects. |
| Conduct a Medicaid Demonstration projects | - Develop 1115b waiver application  
- Launch, conduct, evaluate | 1/1/2019 | Coalition of health advocates | Illinois’ Medicaid program conducts a successful PCMH demonstration project (demonstrating that PCMH is cost-saving). |
| Implement PCMH reimbursement through private insurance plans | Draft, advocate for, and pass legislation authorizing private health insurance plans to reimburse for services provided through recognized PCMHs | 1/1/2022 | Coalition of health advocates | Reimbursement is available for PCMH services provided in all public and private managed care and fee-for-service health insurance plans available in Illinois. |
Decision Criteria

Role of the Public Health System

**SDOH**
- How does a proposed strategy address social / ecological factors?

**Access**
- How does a proposed strategy address access to care?

**MCH**
- How does a proposed strategy promote maternal and child health?

**Urgency**
- Is there a crisis?
- Are there efforts to build on?

**Impact**
- How many individuals does this reach?
- How is disparity addressed?

**Evidence-Based**
- Has this strategy been used before with measured success?

**Resources**
- What resources could be leveraged?
- Are new resources required?
IMPLEMENTATION
RECOMMENDATIONS – CROSS CUTTING
Conceptual Framework for Public Health System
Public Health System Leadership

• Prioritization of the plan, including considering winnable battles and a policy framework for implementation.

• Coordination of cross cutting issues such as data infrastructure, training, communication, funding, promising practices, and evaluation approach.

• Social determinants of health and other structural issues such as housing, employment and education.

• Promotion of the plan and communication with stakeholders around priorities.

• Strengthening the statewide data system.
Social Determinants of Health and Access to Quality Care

• Recommendations:
  – Investments in access and quality of services
    • Strategies discussed in the Behavioral Health Action Team
  – PSE approach to population health improvement
    • Decision criteria for the Chronic Disease Action Team
  – Consider equity in decision-making
    • Goal of the Maternal and Child Health Action Team
  – Social determinants of health should be a stand-alone priority with corresponding strategies and an action plan
    • Need to develop specific system and infrastructure strategies to address SDOH and access
IMPLEMENTATION

RECOMMENDATIONS – ACTION TEAMS
Action Team Co-Chairs

- Maternal and Child Health: Anita Stewart, BCBS IL, and Andrea Palmer, IDPH
- Behavioral Health: Maureen McDonnell, TASC, and Diana Knaebe, IDHS
- Chronic Disease: Vince Bufalino, Advocate Health Care, and Tiffany Pressley, IDPH

- Action teams also include participants from local health departments, community based organizations, universities and state agencies
Maternal and Child Health

1. 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.

2. Support healthy pregnancies and improve birth and infant outcomes.

3. Assure that equity is the foundation of all MCH decision-making; eliminate disparities in MCH outcomes.

4. Strengthen the MCH data systems, infrastructure and capacity
Maternal and Child Health Strategy Examples

• 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.
  – Promote understanding of benefits of medical homes among consumers and families by engaging consumers in formulation of patient center medical home policy

• Assure that equity is the foundation of all MCH decision-making; eliminate disparities in MCH outcomes.
  – Provide training to local MCH programs/entities on the health equity approach/use of equity lens by engaging IDPH health equity team.
Behavioral Health

1. Improve the collection, utilization and sharing of behavioral health-related data in Illinois
2. Build upon and improve local system integration
3. Reduce deaths due to behavioral health crises
4. Improve the opportunity for people to be treated in the community rather than in institutions
5. Increase behavioral health literacy and decrease stigma
6. Improve response to community violence
Behavioral Health Strategy Examples

• Improve the collection, utilization and sharing of behavioral health-related data in Illinois
  – Determine what data currently exists on critical behavioral health problems, resources and assets; draw on the resources of state agencies and private associations.

• Build upon and improve local system integration
  – Expand evidence-based community education/capacity building efforts such as Mental Health First Aid, SafeTALK, Question, Persuade and Refer, Zero Suicide, Illinois Youth Suicide Prevention Project and other efforts to provide resources and tools to community members to be able to effectively respond to others who may be experiencing emotional distress with the goal of increasing community social and emotional intelligence and response.
Chronic Disease

1. Increase Opportunities for Healthy Eating
2. Increase Opportunities for Active Living
3. Increase Opportunities for Tobacco-Free Living
4. Increase Opportunities for Community-Clinical Linkages
Chronic Disease Strategy Examples

• Increase Opportunities for Tobacco-Free Living
  – Pursue passage of state and local legislation that would raise Illinois’ legal age to purchase tobacco products from 18 to 21.

• Increase Opportunities for Healthy Eating
  – Pursue passage of state and local legislation which would create a $0.01-cent-per-ounce excise tax on sugar sweetened beverages. Ensure that revenue generated by this tax is dedicated to health, obesity prevention, and Medicaid funding.
Feedback

• What questions do you have about the action plans?
• How can the information shared in the State Health Improvement Plan be useful for your work?
• In what ways can you leverage the recommendations to align your work with the plan?
NEXT STEPS
“Vision without action is merely a dream. Action without vision just passes the time. Vision with action can change the world.”

~ J.A. Barker
Public Hearings

Monday, March 28, 1:30 – 4:30
Bilandic Building
160 N. LaSalle Street, Room C500
Chicago, IL

Wednesday, March 30, 1:30 – 4:30
Public Safety Facility
285 N. Seven Hills Road
O’Fallon, IL

Thursday, March 31, 1:30 – 4:30
Normal Public Library 206 W. College Ave.,
Community Room A & B Normal, IL
Next Steps

• Go to www.healthycommunities.illinois.gov to learn more

• Share this information with partners

• Consider alignment with SHIP strategies
Thank you!

• Meeting documents available at www.healthycommunities.illinois.gov
• Questions can be sent to HealthyCommunitiesIL@uic.edu