Current and Future State of the Public Health System in Illinois

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Presented by:
Illinois Department Of Public Health
University Of Illinois At Chicago School Of Public Health
The Illinois Public Health Institute

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Data to be Reviewed Today:

- IPLAN Strategies
- Local Health Department Survey on the IPLAN Process
- LHD Survey on the Public Health System Capacity and Capabilities
- Focus Group Data on Looking Back and Looking Ahead at the Public Health System

SCAN OF ILLINOIS PROJECT FOR LOCAL ASSESSMENT OF NEEDS (IPLAN) STRATEGIES

PURPOSE

- This collaborative effort characterizes health issues across the state and the strategies used to address them. Findings will inform health improvement plans and create capacity building initiatives (i.e. Leadership Institute).

Policy, Practice and Prevention Research Center

CODING PROCESS

Step 1: Initial review of IPLANs, strategies, and components

Step 2: Discussion of coding guidelines and goals

Step 3: Creation of coding guide

- Utilization of public health literature and glossaries throughout an iterative, collaborative process
- Identification of frameworks for classifying strategies
- Review by faculty at the School of Public Health

Step 4: Assessment of intercoder reliability

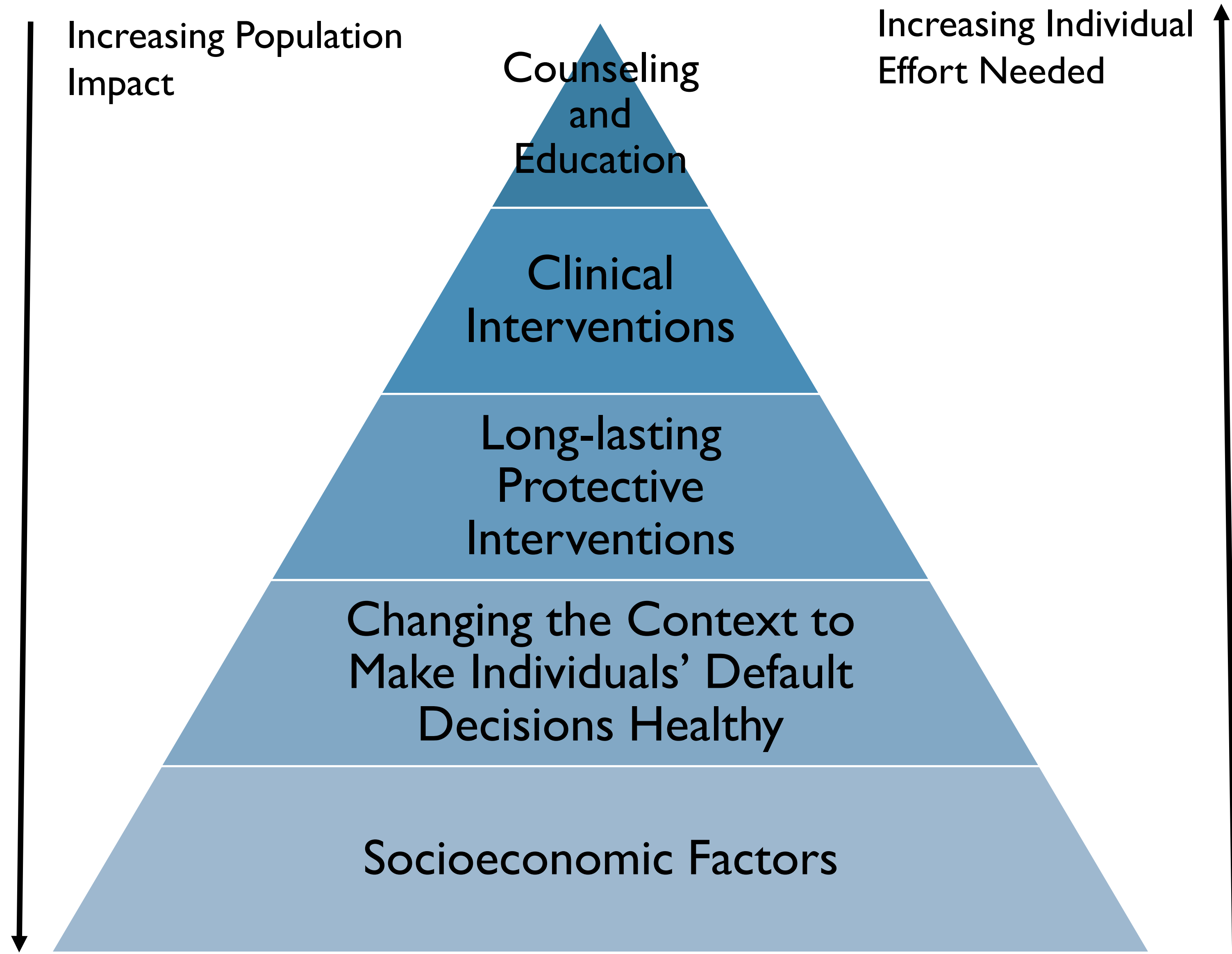
- Achieved 86.4% coder reliability (suggested target is 80%)

Step 5: Coding and review of 92 IPLANs

- **4 excluded due to unclear content or structure**

Step 6: Quality check to ensure coding was systematically applied across strategies

STRATEGY CATEGORIES BASED ON FRIEDEN'S HEALTH IMPACT PYRAMID



The Health Impact Pyramid. Frieden, 2010

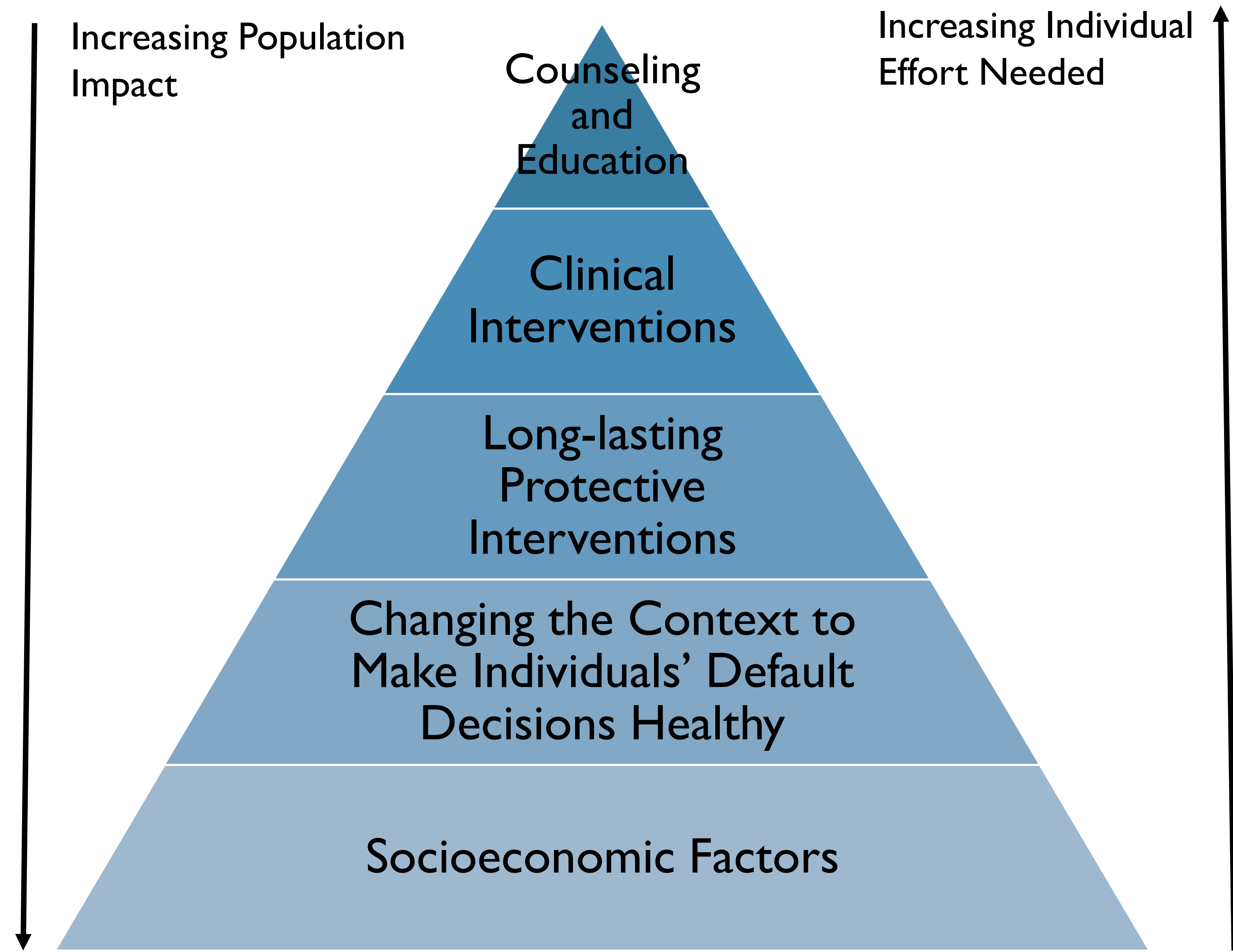
Strategy Categories	Codes and Definitions

Counseling and Education	• **Health Communication**
	  • Multi-media campaigns, flyers
	• **Health Education Activity**
	  • Health fairs, one-time classes
	• **Health Education/ Counseling**
	  • One-on-one, usually in clinic setting
	• **Programs**
	  • Multiple sessions, often evidence-based

Clinical Interventions	• Direct and/or ongoing medical treatments
Long-lasting Interventions	• Preventative services and screenings

Changing the Context to Make Individuals' Default Decisions Healthy	• **Policy Change**
	  • New policy or ordinance
	• **Systems Change**
	  • Emergence of new protocols or integrations
	• **Environmental Change**
	  • Physical changes

Socioeconomic Factors	• Addresses social determinants of health



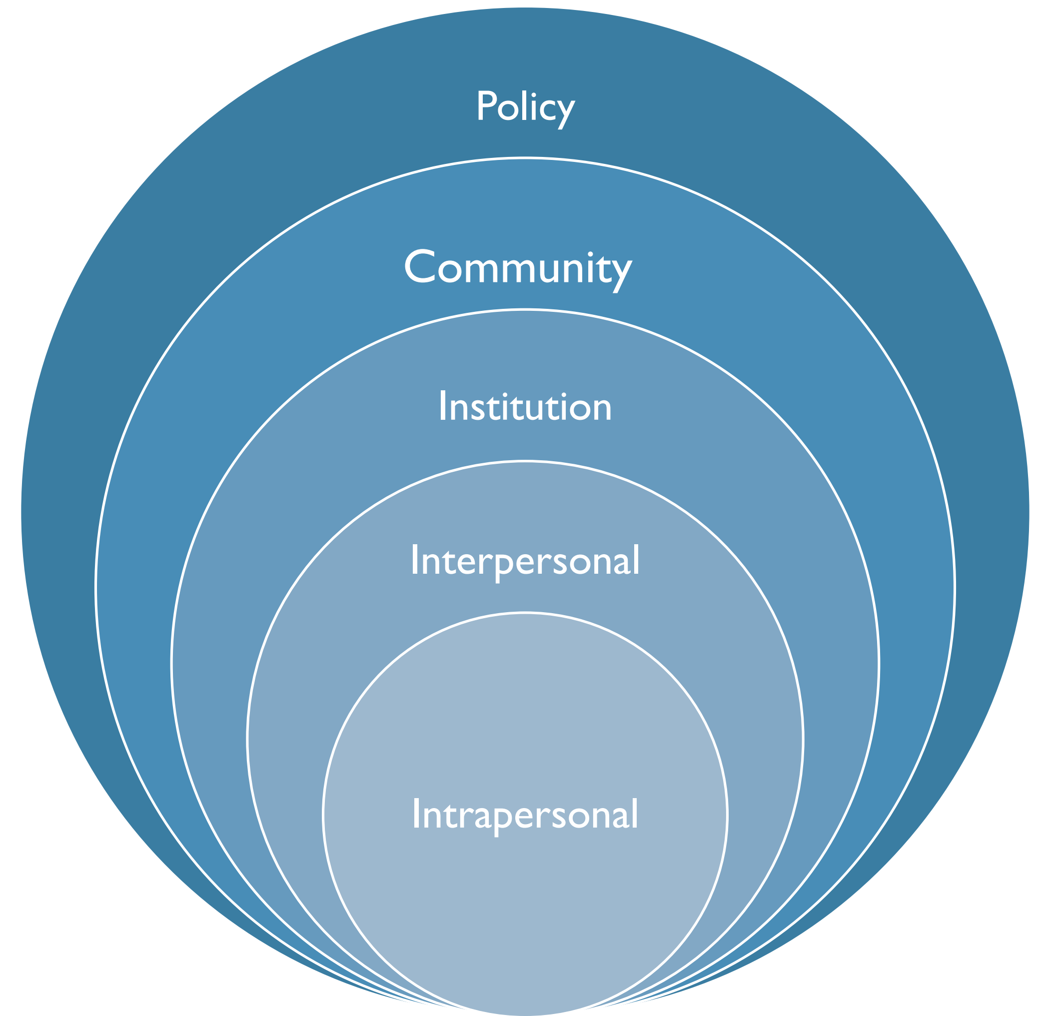
The Health Impact Pyramid. Frieden, 2010

ADDITIONAL STRATEGY ATTRIBUTES

In order to capture the full range of strategies in the IPLANs, we coded additional strategy types:

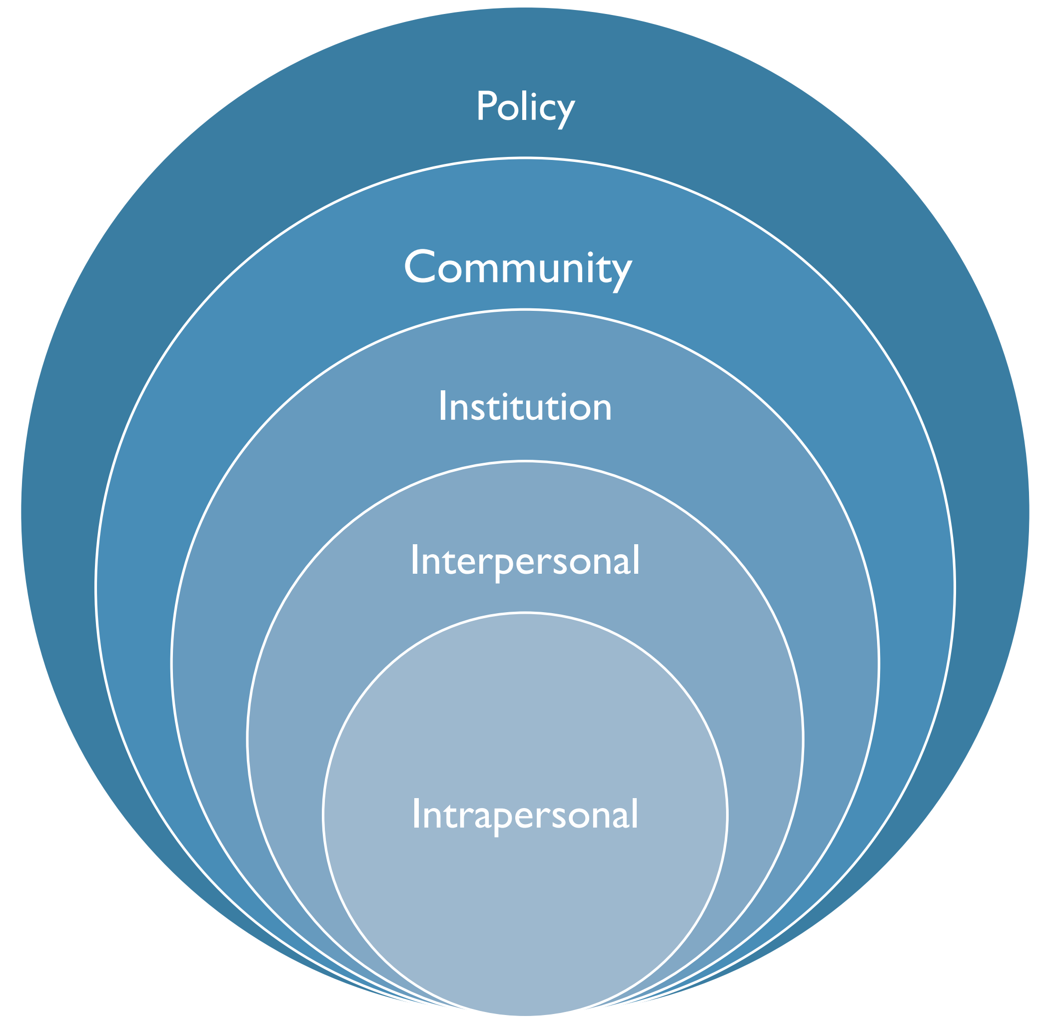
Health Education Initiative	Enabling and Increasing Access to Health Services	Direct Non-Clinical Services/ Resources	Collaboration/ Coalition/ Partnership	Professional Capacity Building/ Training	Advocacy
• Robust, multiple components tied to the initiative	• Ensuring availability and reducing barriers to health services	• Resource distribution such as food condoms, and radon testing kits	• Establishing work group to address health priority • Partner with an entity to provide trainings	• Education of health care providers, law enforcement, clergy, school staff regarding skills to serve the public and/or enhance their understanding of health issue	• Building support for specific health issue/ policy

STRATEGY LEVELS BASED ON THE SOCIOECOLOGICAL MODEL

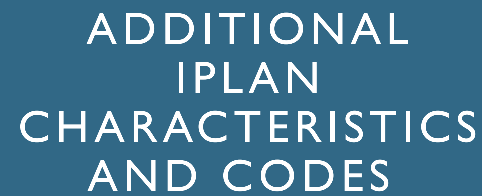


Socioecological Model

Strategy Categories	Definitions
Policy	• Policy creation or enforcement
Community	• Delivery of community services, enhancement of community physical environment
Institution	• Enhancements to organizational policies, targets skill enhancement of institutional leaders
Interpersonal	• Targets perception/attitudes of social networks, including provision of social support
Intrapersonal	• Targets knowledge of intervention individuals

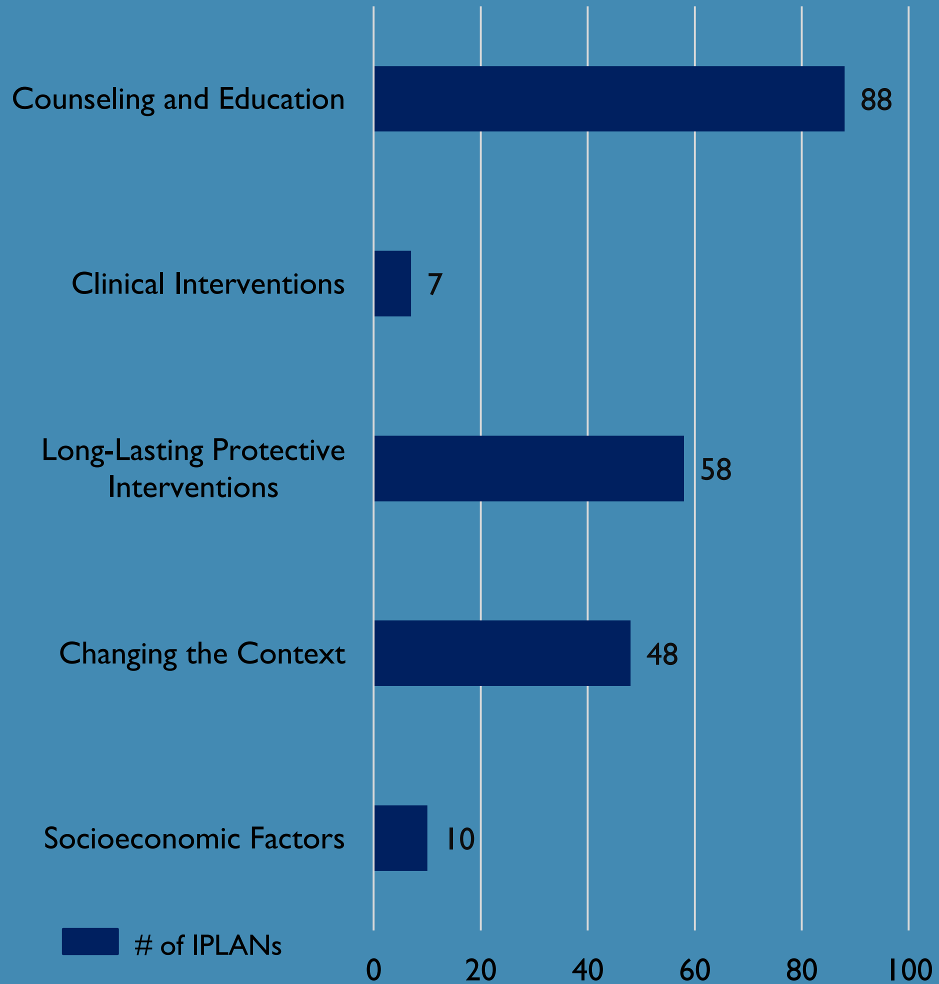


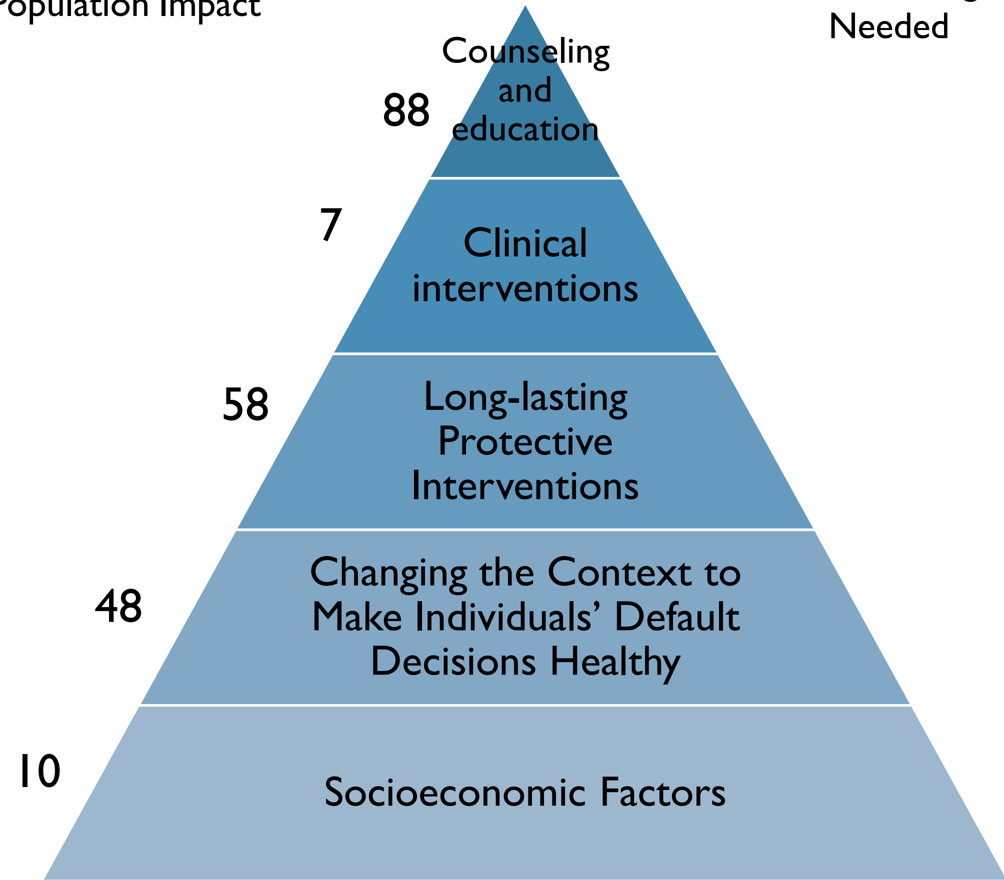
Socioecological Model



- Setting (school, clinical, worksite)
- Mobilizing For Action Through Planning and Partnerships (MAPP)
- Assessment Protocol for Excellence in Public Health (APEX PH)
- Smart Objectives
- Framework
- **Evidence-based strategies**
- **Unclear strategies**
- **Other strategies**

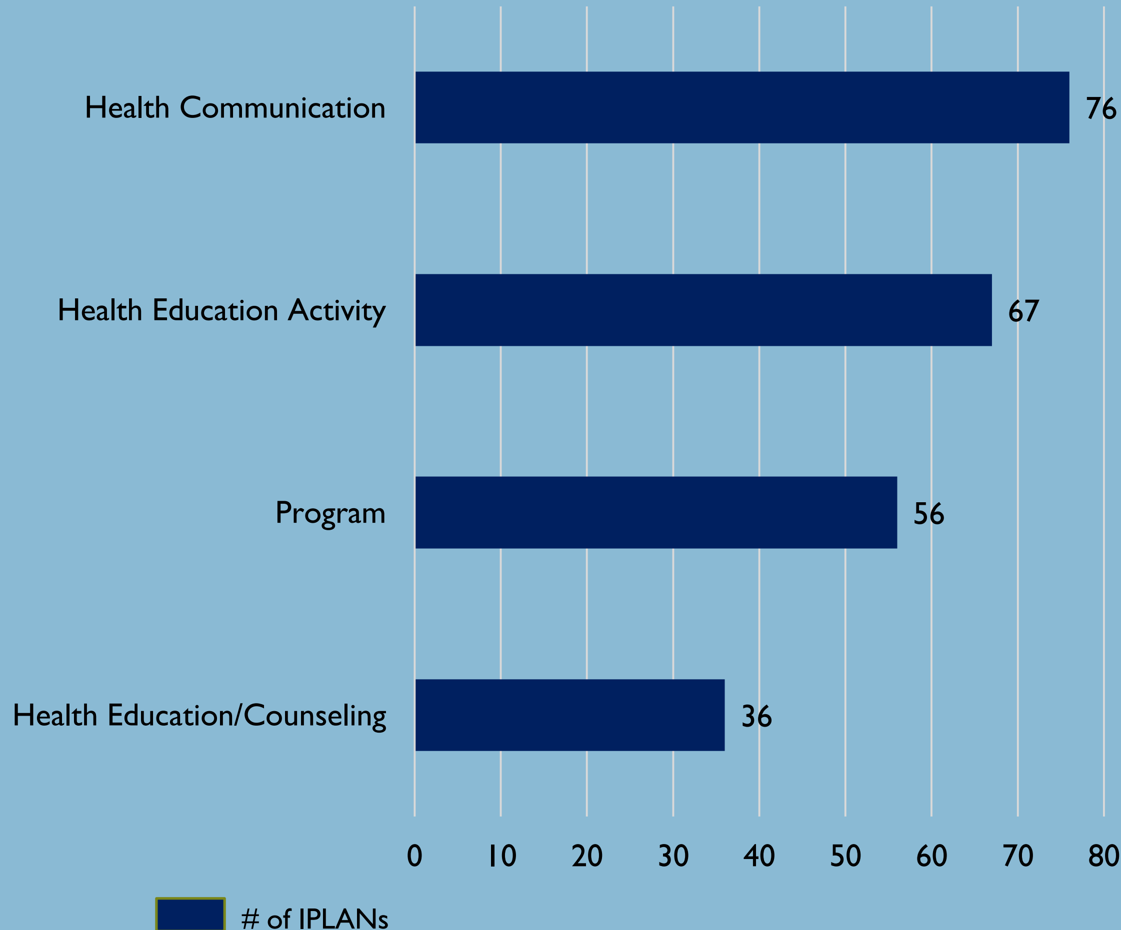
RESULTS



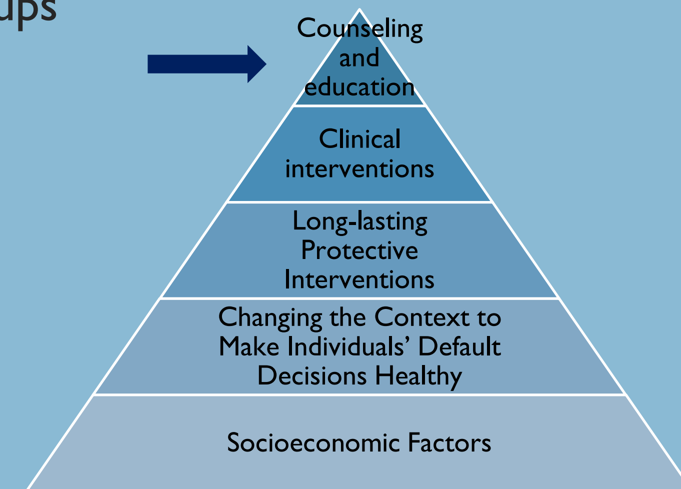


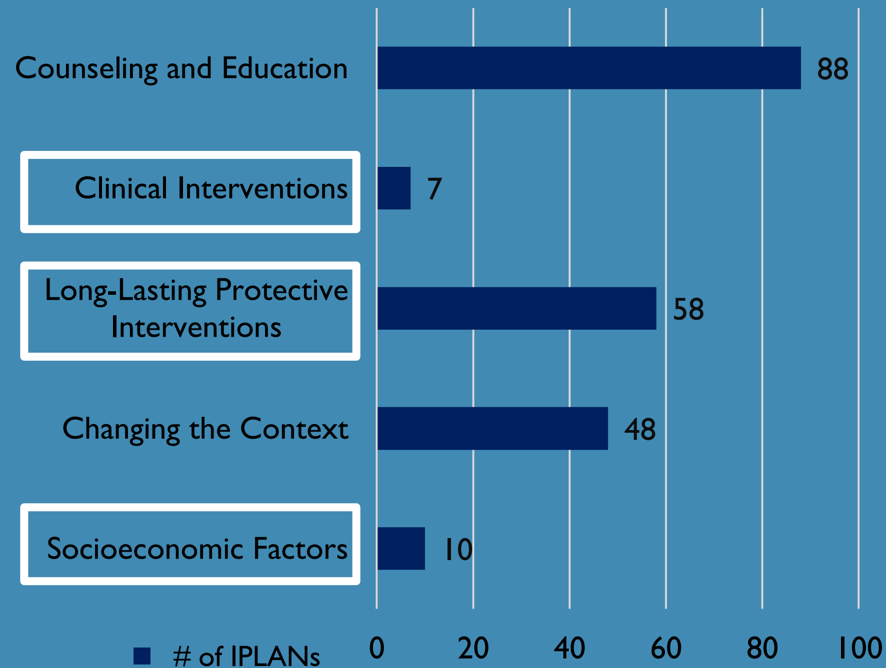
The Health Impact Pyramid. Frieden, 2010

BREAKDOWN OF HEALTH EDUCATION/COUNSELING STRATEGIES

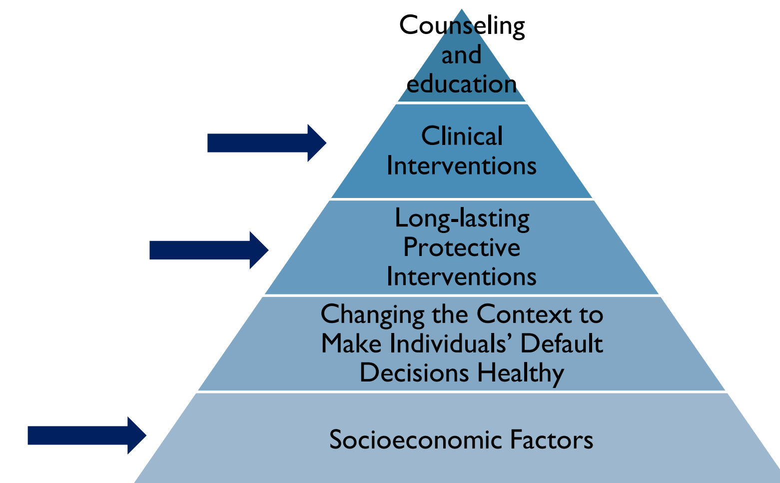


- **Health Communication** strategies ranged from creation of brochures, resource guides to community-wide, multi-media/ social marketing campaigns
- **Health Education Activities** ranged from health fairs to workshops targeting specific health topic
- **Programs included** Chronic Disease Management Programs, sexual health education curriculum, and C.A.T.C.H
- **Health Education/ Counseling** strategies ranged from in-clinic counseling to support groups

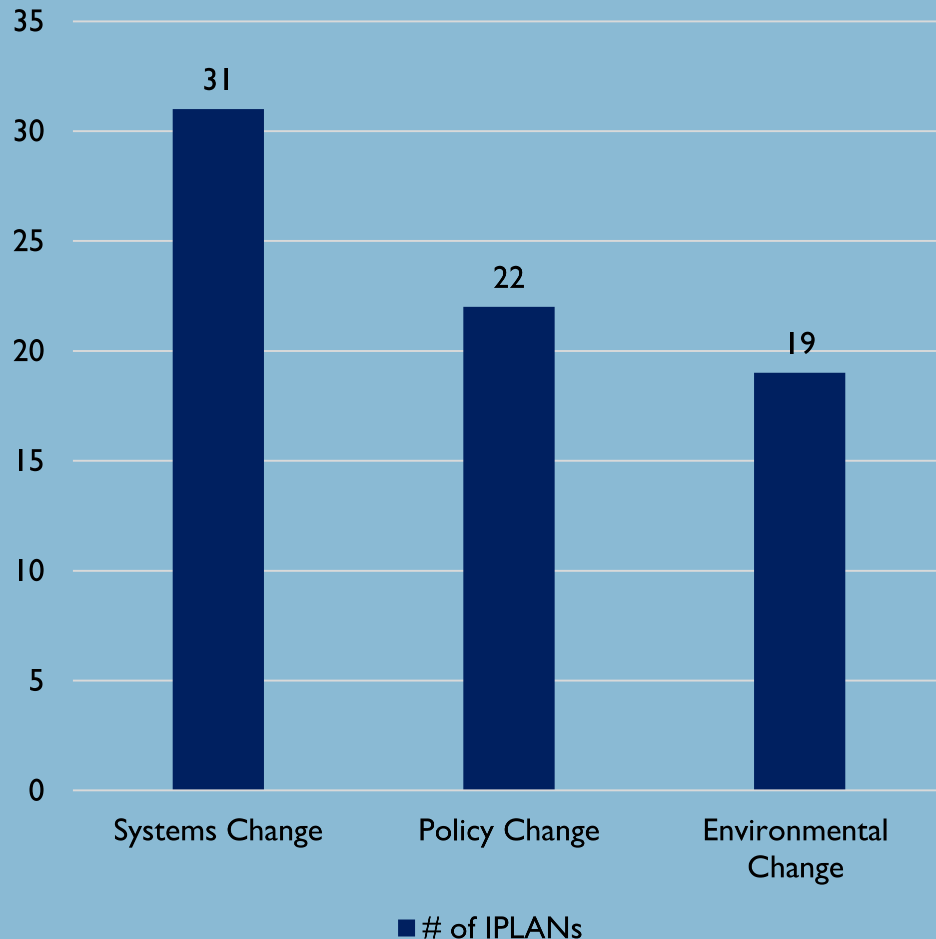




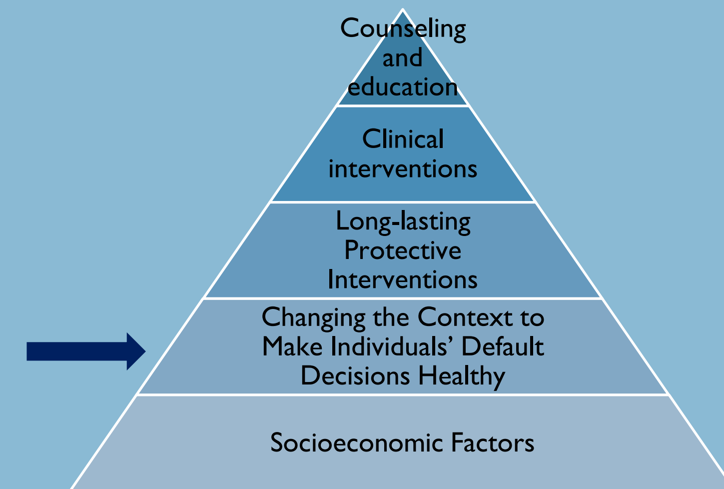
- **Clinical Interventions** included strategies to address chronic disease treatment
- **Long-Lasting Protective Interventions** primarily included screenings, few immunizations, and preventative services
- **Socioeconomic Factors** addressed housing quality and general strategies to improve SDOH



CHANGING THE CONTEXT TO MAKE INDIVIDUALS' DEFAULT DECISIONS HEALTHY



- **Systems Change** primarily included the implementation of care coordination, new screening protocols and tools
- **Policy Change** intervention strategies primarily included development of ordinances (primarily around smoking)
- **Environmental Changes** ranged from community gardens to infrastructure for biking/walking



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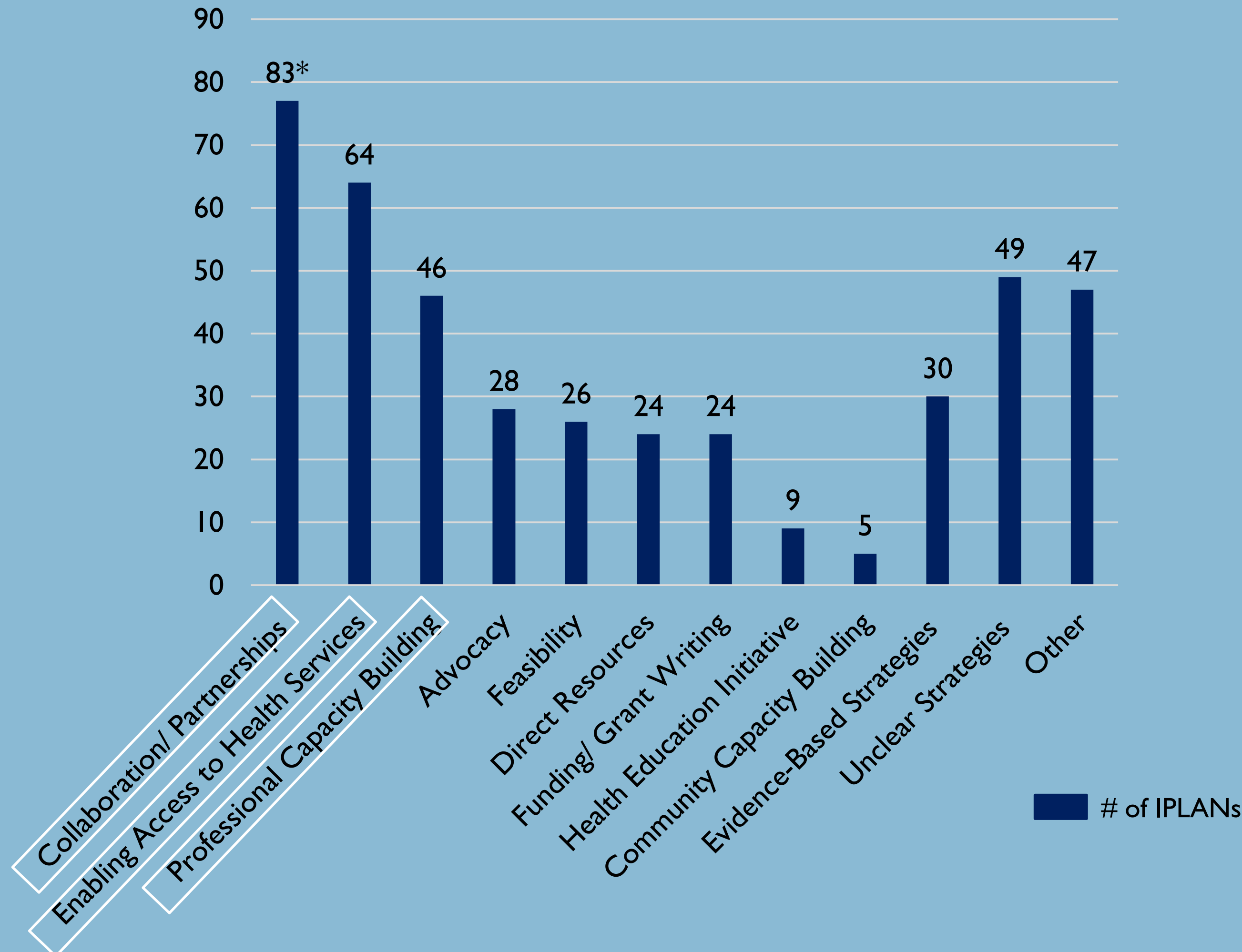

- **Collaboration/Partnership strategies** ranged from working with local organizations to discuss community issues to working with hospitals to increase screenings
- **Enabling Access to Health Services** ranged from helping residents sign up for health insurance to hiring practitioners to meet community needs
- **Professional Capacity Building** strategies primarily included provision of training for specific skills (cultural competency, trauma, communication) for health providers or school staff

* Due to the varied structure of IPLANs, some may have been omitted

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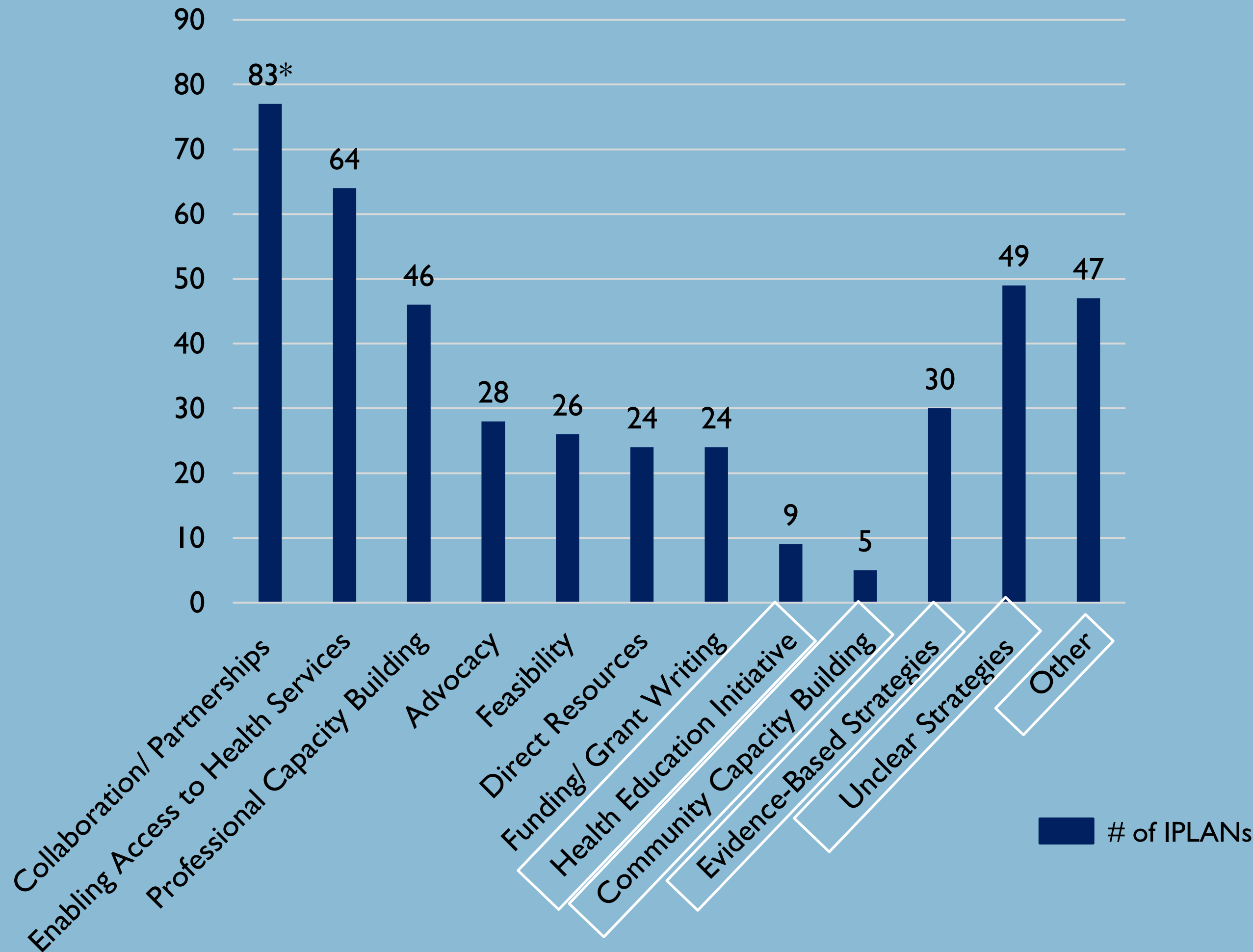

- **Health Education Initiatives** included implementation or support of multi-level health initiatives
- **Community Capacity Building strategies** included engaging community members in sustainable volunteer opportunities
- **Evidence Based-Strategies** were categorized when the IPLAN strategies were grounded in literature or references were linked
- **Unclear Strategies** were categorized when the IPLAN did not state how the intervention would be implemented/ who it was for
- **Other Strategies** include Mental Health First Aid, drug take-back programs, compliance checks

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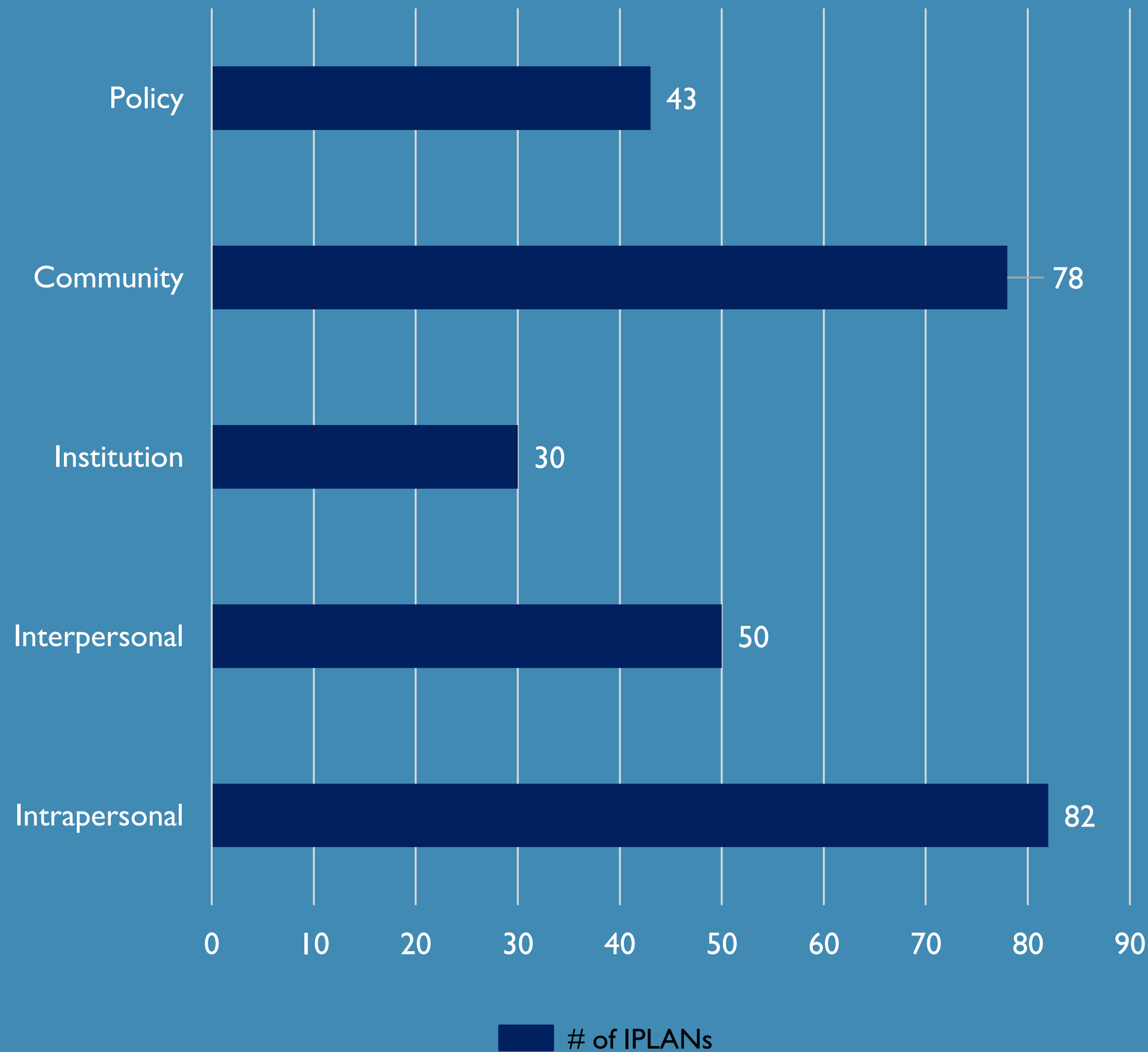
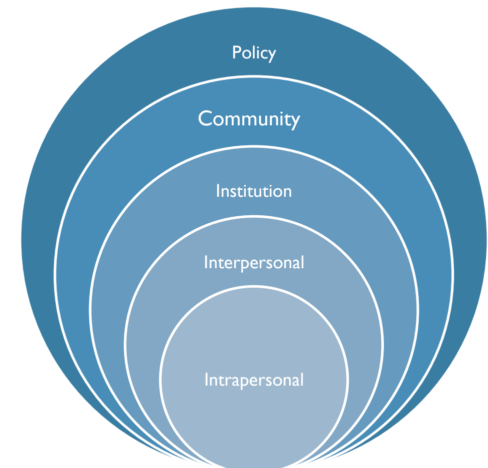


- A majority of interventions were found within the **intrapersonal level** and relate to health education activities
- **Community level interventions** range from community-wide communication campaigns to enhancing community services
- **Interpersonal level interventions** related to educating providers on resources for their patients and parental education
- Many of the **policy level** strategies were related to enforcement of a current Smoke-Free policies
- **Institution level** interventions ranged from enhancement of workplace environments to systematic training of employees and/or leadership surrounding health issue or protocol



CHALLENGES AND LIMITATIONS

- IPLANs varied in structure
  - 4 IPLANs were not coded
- We reviewed only the intervention strategies or Health Problem Worksheet for each IPLAN
  - Some health department activities may have been omitted
- Non-specific language within IPLANS made it difficult to categorize some strategies

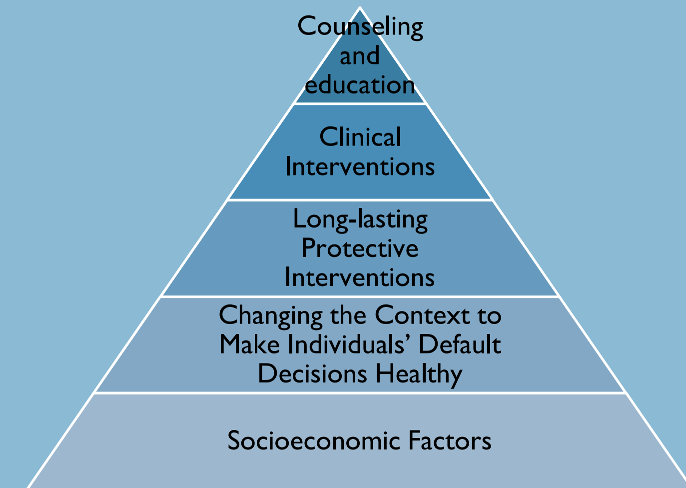
TAKE-AWAYS

- There is a need for more specificity when creating IPLANs
- About 1/3rd (n=30) of health departments mentioned the use of evidence-based strategies
- Many IPLANs (n=83) discussed partnerships with hospitals, schools, and other county organizations
  - Leveraging connections and recognizing need for collaboration
- Few IPLANs discussed Health Education Initiatives strategies (n=9) and Community Capacity Building (n=5)
  - Lack of large scope and multi-level interventions

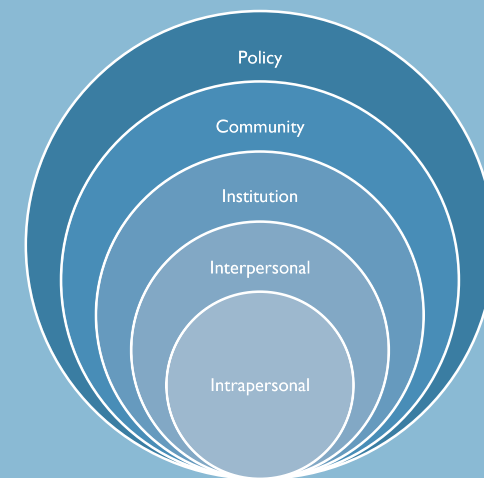
TAKE-AWAYS

- All IPLANs had health education intervention strategies (n=88) at the intrapersonal level
- Almost half of IPLANs included PSE changes (n=48)
  - Most were system changes related to enhanced care coordination and referral systems
- Few IPLANs addressed social determinants of health (n=10)
- Many community level interventions utilized health communication strategies

Increasing Population Impact



Increasing Individual Effort Needed



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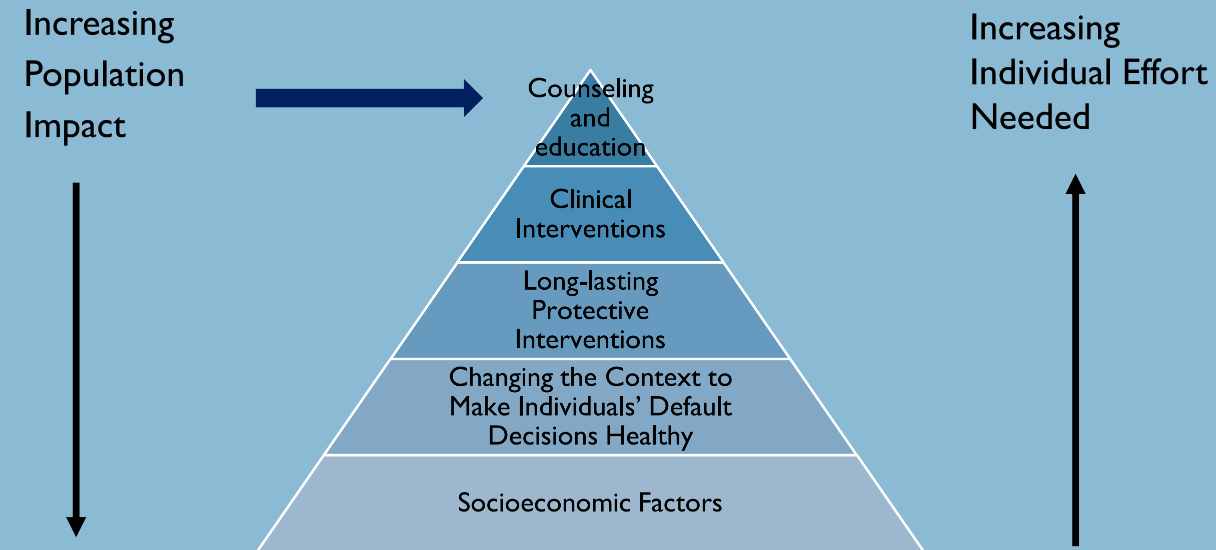

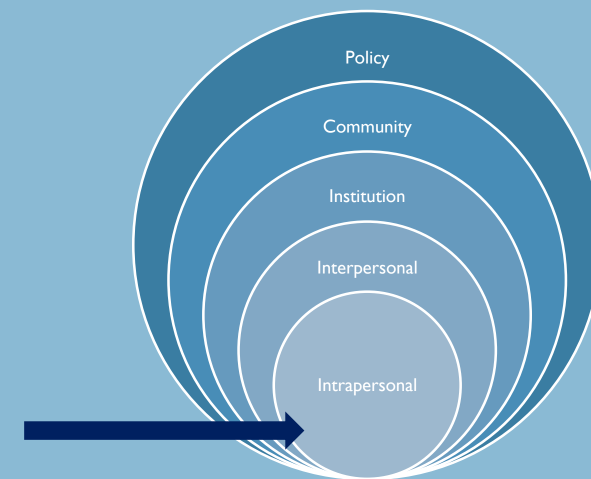

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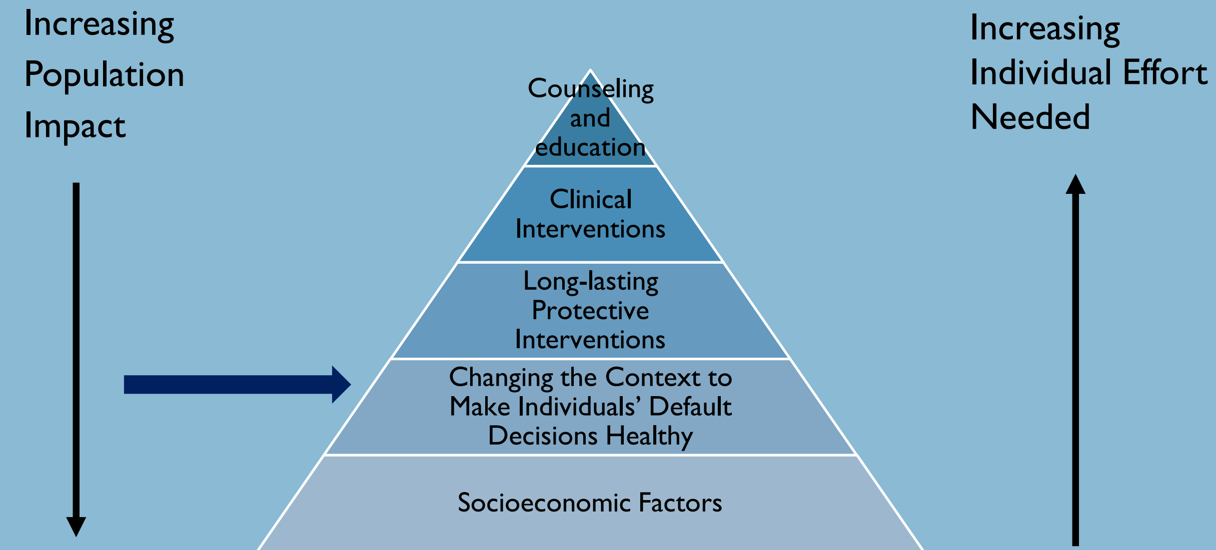

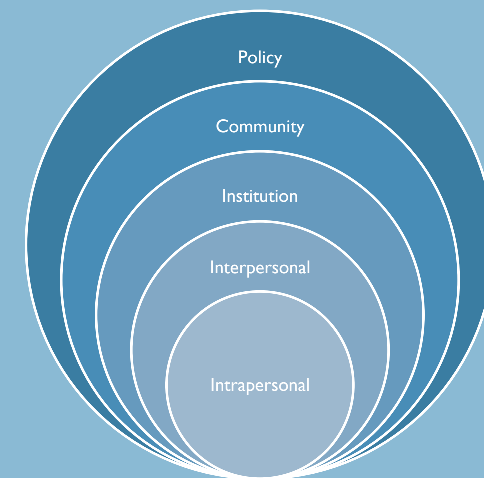

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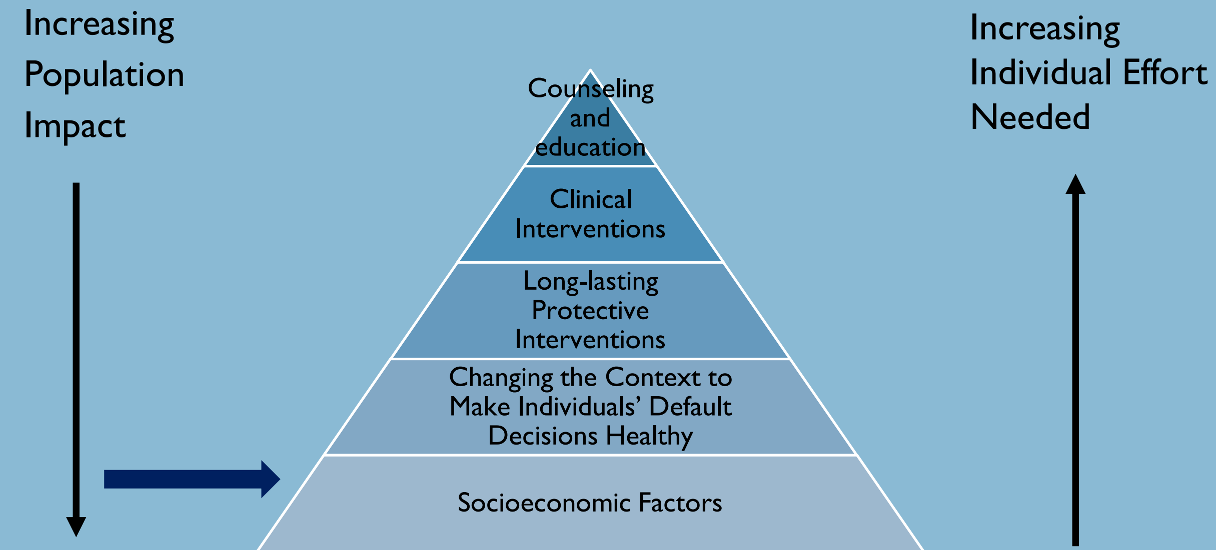

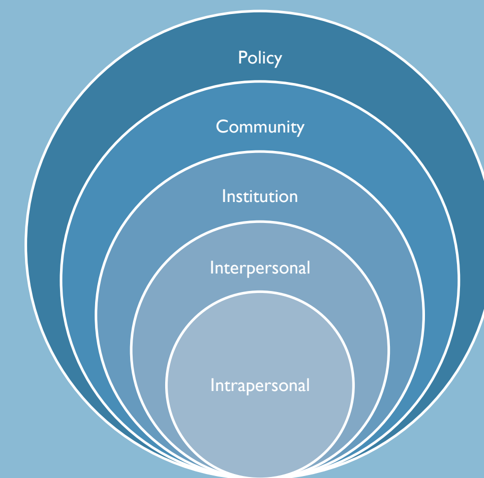

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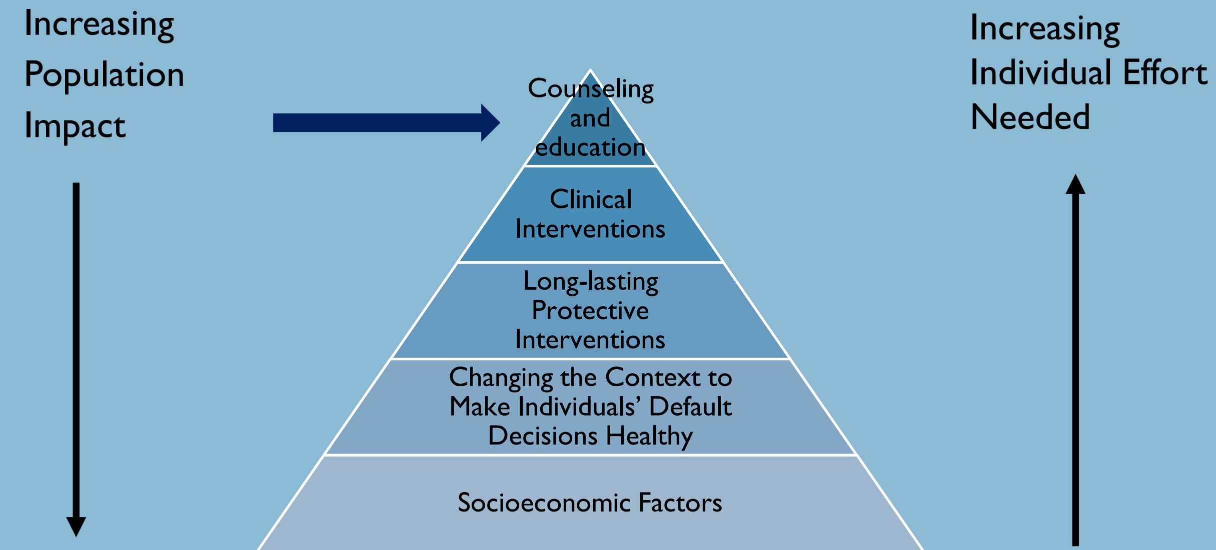

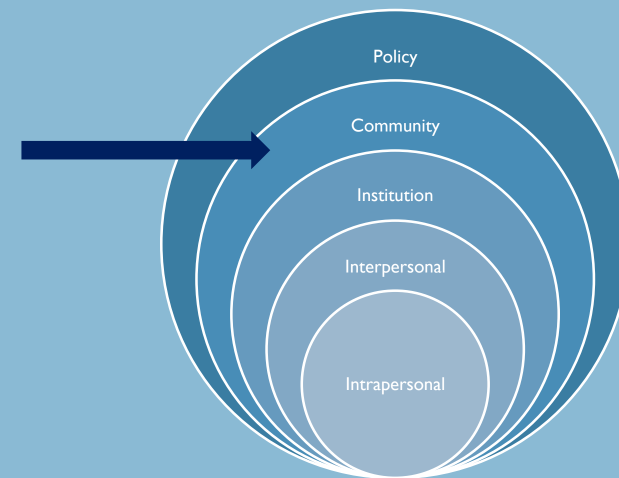

THANK YOU!

THANK YOU!

- Nelson Agbodo, Illinois Department of Public Health
- Christina Welter, Associate Director and
- Steve Seweryn, Co- Investigator

Policy Practice and Prevention Research Center UIC SPH

WE LOOK FORWARD TO YOUR QUESTIONS AND DISCUSSION!

- Yadira Herrera, MPH Candidate,

UIC School of Public Health

and

- Amber Uskali, MPH, Assistant Director

UIC Policy, Practice, and Prevention Research Center

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LHD Survey Responses on IPLAN

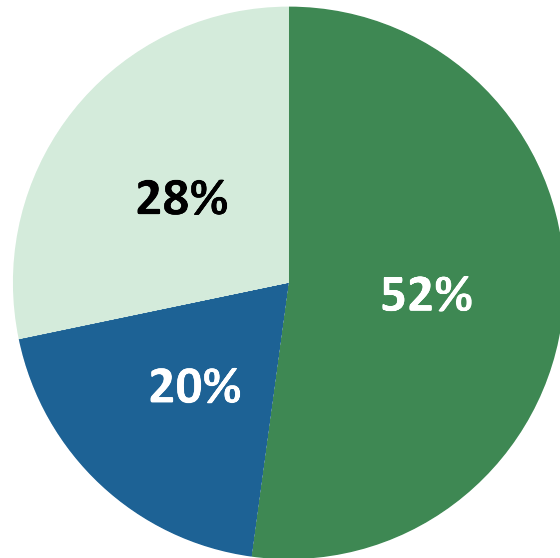
LAURIE CALL, IPHI

LHD Survey Responses Related to IPLAN

- Use of SHA and SHIP during IPLAN process
- How SHA/SHIP may help community with IPLAN
- SHA/SHIP and IPLAN integration
- Data and information needs
- Capacity-building needs (training and technical assistance)

When you complete the IPLAN process, do you use the Illinois State Health Assessment and State Health Improvement Plan (SHA/SHIP)?

n= 46



How do you use the SHA/SHIP in the IPLAN process?

Comparison
Compare priorities, resources, data, goals, and objectives between local and state departments.

Data
Use as a resource for data, research, and statistics at both state and local levels.

Alignment
Determine alignment of state and local plans.

Guidance
Use as a template and foundation for priorities and plans.

Why don’t you use the SHA/SHIP in the IPLAN process?

Local Issues
Limited usefulness and relevance when identifying local-level health needs.

Other Resource
Uses another resource (Healthy People) for the process

Awareness
Not aware of the SHA/SHIP

.

How might the IDPH SHA/SHIP process help your community with your IPLAN?

n= 20

Ideas for Process Improvement Respondents requested that their priorities be considered during the process, for the plan to kept up-to-date, for the process to be streamlined, to have a consistent survey process, and for different formats to be considered.

Comparison Ability to compare state and community plans.

Alignment Review priorities for alignment with state strategies.

Foundation It would increase awareness and provide foundation for developing plans.

Data More data may be available for analysis and objective setting.

Funding Support through non-grant-based funding as well as funding from the state for CHIP strategy implementation when aligned.

How might the IDPH SHA/SHIP and IPLAN processes be better integrated to improve the public health system and health outcomes?

n= 21

Strategy/Implementation
Respondents expressed the need to be able to **refresh strategies as needed**, **to create SHIP objectives and linked funding streams,** to **align priorities and strategies with programs**, and for **hospitals to partner with local health departments**.

Local
Reflect **local-level IPLAN strategies and outcomes** in thinking processes and assist local health departments with funding.

Data
Identify **trends and have local data reports** include robust BRFSS data.

Funding
Fund local-level processes and **identify funding streams for SHIP objectives** to aid in implementation.

Timing
Complete the SHA/SHIP before completing individual IPLANS, have both run concurrently, or **determine a more timely and fit process** to replace the IPLAN.

Communication
Share SHIP periodically to remind stakeholders of priorities and have members of the IPLAN committee interact with the SHA/SHIP members.

Hospital CHNAs
Connect processes more with hospitals' CHNAs.

What data and information might your community need from IDPH to inform your IPLAN process?

n= 18

Current
Update data to be current, relevant, and timely, especially on the IPLAN websites.

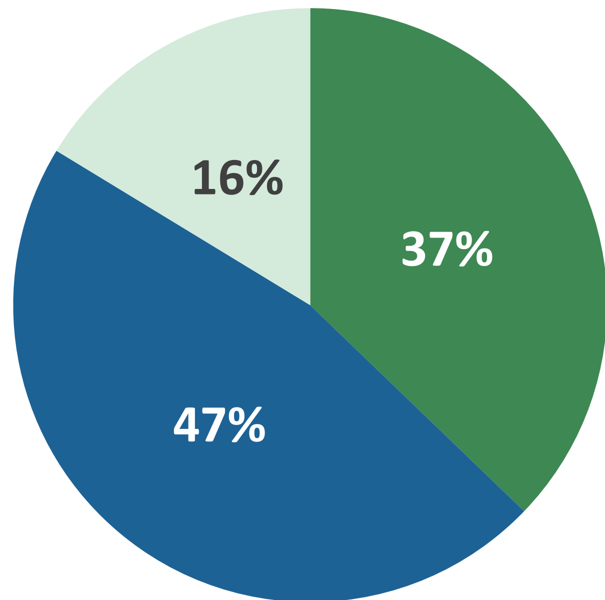
Health
Provide current health status data and statistics, related to BRFSS, social determinants of health, suicide rates (local), chronic disease indicators, vital records, and hospitalizations.

Zip Codes
Provide useful national and local data by zip code .

System
Provide a grant fillable system.

Does your health department have capacity building needs (i.e. training and technical assistance) related to any aspects of the IPLAN process?

n= 43



Training and Technical Assistance Needs for IPLAN

Training and Assessments
Provide training to staff, particularly on **how to develop a good IPLAN TEAM, how to start, and the basics of IPLAN, and shadow another department that is successful at IPLAN** activities. **Facilitate capacity and MAP assessments.**

Workforce
Local Health Departments have **lost many experienced staff members** and respondents requested **staff training and performance improvement workforce development**

Data
Provide s**upport for data analysis, data systems and the ability to sustain them, and resources to gather good data**.

Funding
Provide **funding to carry out goals and objectives**.

IPLAN Data Summary

- **Almost half of respondents** either **didn't know or doesn't use the Illinois SHA/SHIP** to complete their IPLAN process.
- Those who do use the SHA/SHIP **most frequently utilize it for comparison and data**.
  - Respondents noted limited relevance and usefulness for **identifying local-level health needs when creating their IPLANs.**
- Respondents noted most frequently the needs for improvements to the SHA/SHIP process to **better help with their IPLANs**.
  - Specifically, **their priorities** being considered during the process, the plan to the **kept up to date**, and the need for **consistent and streamlined processes**.
- Respondents identified the need to **integrate SHA/SHIP and IPLAN processes through improved strategies, local-level issues, data, funding, timing, communication, and integration** with other plans (Hospital CHNAs)
- Technical assistance and trainings needs were identified as **training and assessments, workforce, data, and funding.**

LHD Survey Responses on the Public Health System

LAURIE CALL, IPHI

To what extent does the public health system in Illinois (IDPH plus partners) demonstrate public health capability and capacity to: **Address social and structural determinants of health**

Capabilty (skills, knowledge, and expertise) to:

n= 48

Capacity (staff, time, and funding) to:

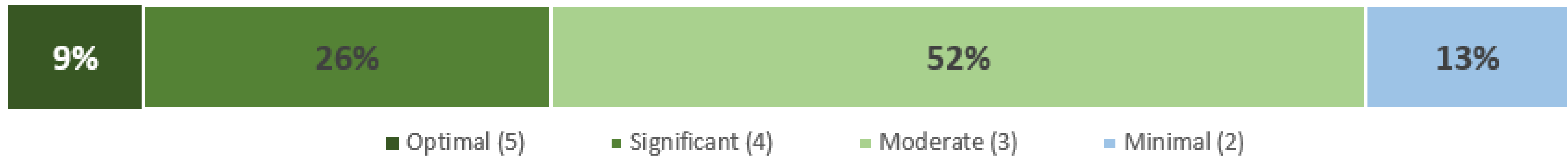
n= 46

To what extent does the public health system in Illinois (IDPH plus partners) demonstrate public health capability and capacity to:

Integrate and emphasize anti-racism and equity

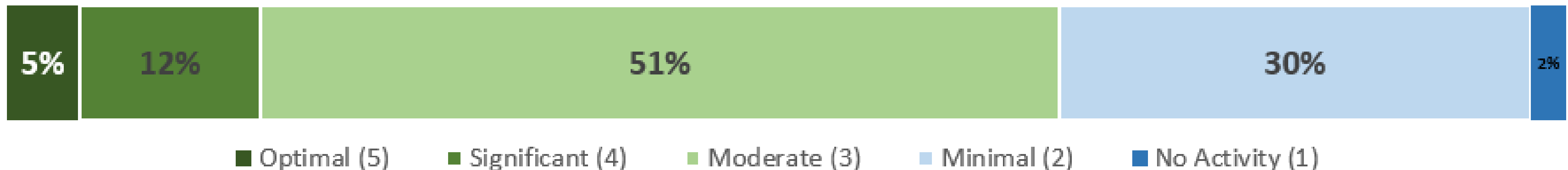
Capabilty (skills, knowledge, and expertise) to:

n= 46



Capacity (staff, time, and funding) to:

n= 43



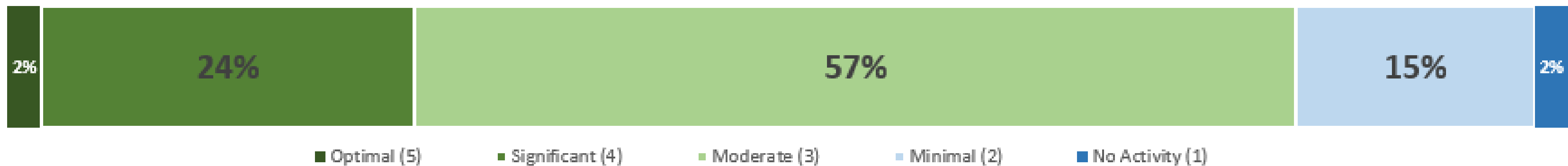
To what extent does the public health system in Illinois (IDPH plus partners) demonstrate public health capability and capacity to: **Monitor health status, collect and produce relevant data**

Capabilty (skills, knowledge, and expertise) to:

n= 49

Capacity (staff, time, and funding) to:

n= 46



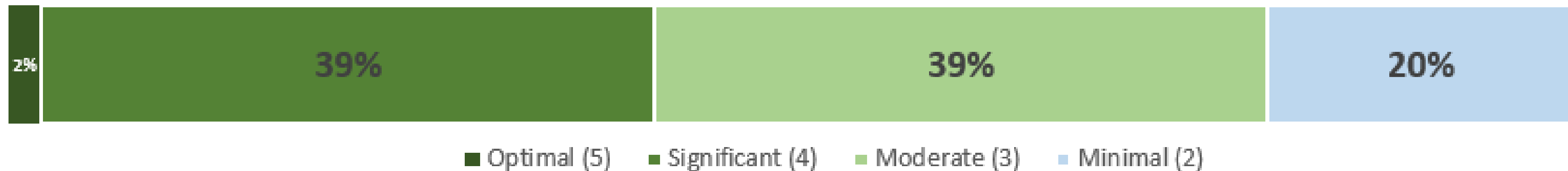
To what extent does the public health system in Illinois (IDPH plus partners) demonstrate public health capability and capacity to:
Diagnose and investigate health problems

Capabilty (skills, knowledge, and expertise) to:

n= 48

Capacity (staff, time, and funding) to:

n= 46



To what extent does the public health system in Illinois (IDPH plus partners) demonstrate public health capability and capacity to:
Prepare and respond to health threats in the community

Capabilty (skills, knowledge, and expertise) to:

n= 49

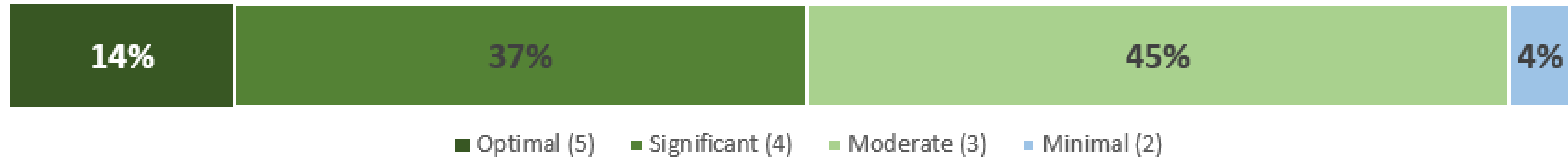
Capacity (staff, time, and funding) to:

n= 47

To what extent does the public health system in Illinois (IDPH plus partners) demonstrate public health capability and capacity to:
Inform, educate and empower communities about health

n= 49

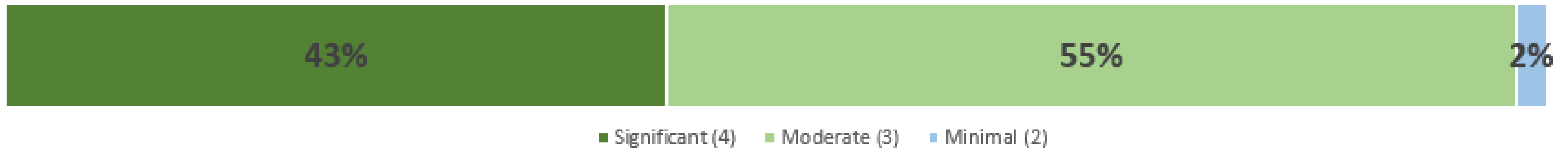
Capabilty (skills, knowledge, and expertise) to:

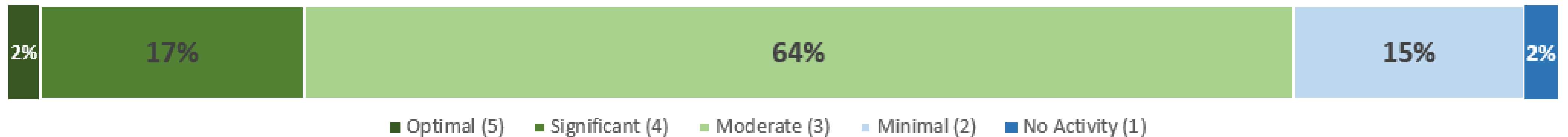


n= 47

Capacity (staff, time, and funding) to:

To what extent does the public health system in Illinois (IDPH plus partners) demonstrate public health capability and capacity to:
Develop policies and plans to support and guide action and efforts





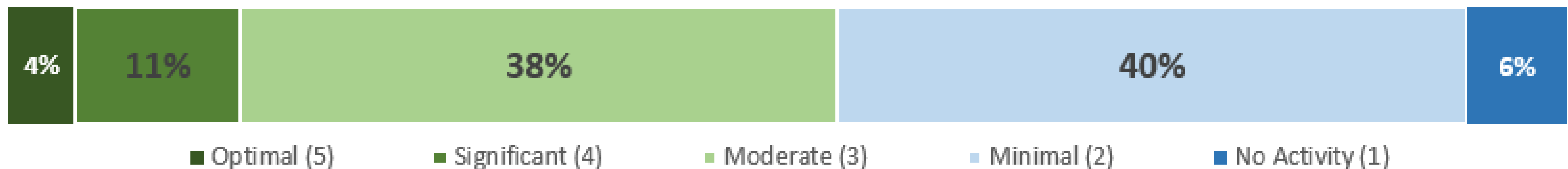
To what extent does the public health system in Illinois (IDPH plus partners) demonstrate public health capability and capacity to:
Enforce laws and regulations

Capabilty (skills, knowledge, and expertise) to:

n= 49

Capacity (staff, time, and funding) to:

n= 47

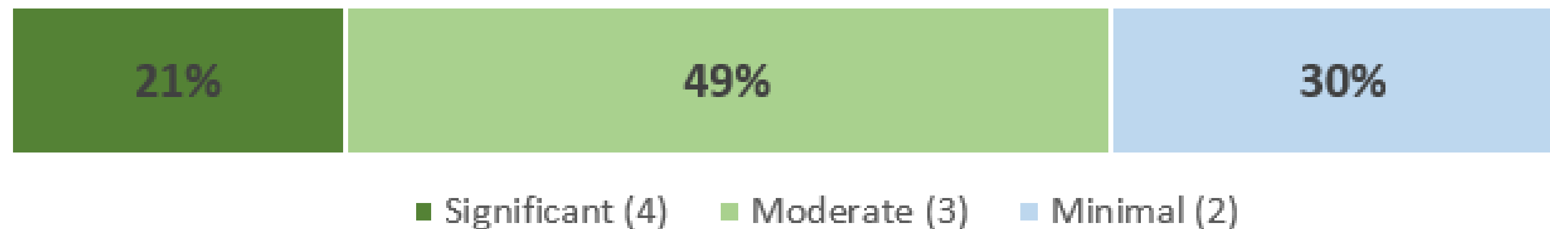


To what extent does the public health system in Illinois (IDPH plus partners) demonstrate public health capability and capacity to:

Link people to and assure access to personal health

n= 49

n= 47



To what extent does the public health system in Illinois (IDPH plus partners) demonstrate public health capability and capacity to:

Assure development and maintenance of a competent workforce

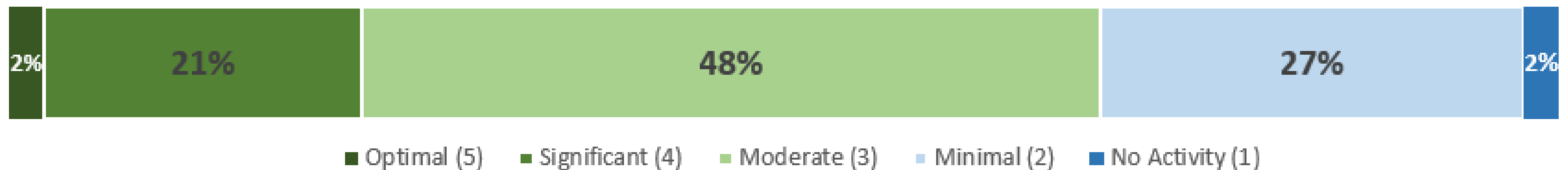
n= 47

n= 47

To what extent does the public health system in Illinois (IDPH plus partners) demonstrate public health capability and capacity to:
Evaluate effectiveness, accessibility and quality of services

n= 46

n= 44



To what extent does the public health system in Illinois (IDPH plus partners) demonstrate public health capability and capacity to:

Explore and research for innovation and insights to address public health problems

n= 45

Capabilty (skills, knowledge, and expertise) to:

n= 43

Capacity (staff, time, and funding) to:

Additional Comments (capability and capacity)

- IDPH would benefit from **additional staff** within the Department.
- It is challenging to score these areas on a statewide basis, particularly without the context of **NPHPS assessment meeting**.
- My reflection is not considering COVID CT grant as it is a one-time grant to assist PH System. **I am concerned what the public health system will look like after the grant.**
- There is a significant need for **staff and funding**. We have the knowledge to do but lack the funding and support.

Data Summary PH System **Capability**

- LHDs consistently reported the public health system in Illinois (IDPH plus partners) demonstrate public health **capability** (skills, knowledge, expertise) much greater than capacity (staff, time, funding). Typically Moderate to Significant
- 22% of respondents rated capability with **Enforcing Laws and Regulations** as minimal to no activity followed by 13% rating capability to **Integrate and Emphasize Anti-Racism and Equity** as 13% minimal.
- LHD respondents reported **highest PH system capability** with the following:
  - Diagnose and Investigate Health Problems – 67% optimal or significant
  - Prepare and Respond to Health Threats in the Community – 59% optimal or significant
  - Monitor Health Status, Collect and Produce Relevant Data – 57% optimal or significant
  - Inform, Educate and Empower Communities about Health 51% optimal or significant

Data Summary – PH System **Capacity**

- LHDs rated the **lowest capacity** (staff, time, funding) in the following areas ranked with the lowest capacity listed first:
  - Enforce Laws and Regulations – 46% minimal to no capacity
  - Addressing Social and Structural Determinants of Health – 39% minimal capacity
  - Assure Development and Maintenance of a Competent Workforce – 34% minimal to no capacity
  - Integrate and Emphasize Anti-racism and Equity – 32% minimal to no capacity
  - Link People to and Assure Access to Personal Health – 30% minimal capacity
  - Explore and Research for Innovation and Insights to Address Public Health Problems – 30% minimal to no capacity
  - Evaluate Effectiveness, Accessibility, and Quality of Services – 29% minimal to no capacity
- LHDs rated the **highest capacity** in the following areas:
  - Diagnose and Investigate Health Problems – 41% optimal to significant
  - Prepare and Respond to Health Threats – 34% optimal to significant
  - Inform, Education and Empower Communities about Health – 32% optimal to significant

Focus Group Data

SAMANTHA LASKY, IPHI

Focus Groups Conducted by IPHI:

- Local Health Department Leadership
- Equity Committee Members
- Emergency Managers/IEMA
- SHIP Priority Areas
- Hospital Representatives

- 90-minute focus groups
- Monday, September 28th – Friday, October 2nd
- Discussion focused around:
  - Current state of the public health system
  - Structural racism
  - COVID-19 response (looking back and looking ahead)
  - Future state of the public health system

Current State of the Public Health System

What is an example of how the public health system has done well and had a good outcome?

- Examples of **Collaboration** across the state public health system:
  - Development of a **diabetes state care plan**
  - **Regionalized perinatal system** in IL
  - **2002 top off drill**
  - **Regional healthcare coalitions**
- **Immunization** efforts:
  - Responses to **H1N1** and low infection rates in certain counties
  - Messaging and providing **seasonal Influenza vax** in timely manner
  - Vax and screening of **Hepatitis C**
- **Policy and Program Development**
  - SPHS making space for **different opinions** in policy
    - More resilient system
  - Working to get **legislation** together regarding **new programs**
    - Critical care training for paramedics (mobile integrated)
  - Using **research/evidence-based practices** and information

"The exchange of resources that might have gone unnoticed or unknown for any amount of time. The meeting of the [hc] coalition has helped bring a need and a resource together quicker and more effectively." – Hospital Reps

"In public health, we really stuck with research-based information that we have; sticking to science and using that to drive us in the right direction, especially here in Illinois." – LHD Leadership

What is an example of what has not been done well or has been ineffective?

"We have a challenge with continued long-term engagement with decision makers and elected officials.“
– EM/IEMA

A participant noted the issue of "finding the right people at IDPH to make a decision.“
– EM/IEMA

- **Access to Care**
  - Health care and services in **rural** communities
  - Access disparities for **Native population**
  - Accessibility for **people with disabilities** (not prioritizing home and community-based services over institutionalization)
- **Partnership Engagement**
  - Engagement with **decision makers and elected officials**
  - **EMS Advisory Board** – engagement has gone down
  - **Silos**
- **SPHS Communication**
  - From **IDPH to RHCCs** and within RHCC itself
  - Decision making – **SEOC to IDPH, issues with decentralized decision making, IDPH and IEMA**
  - Tight **deadlines from IDPH**
  - **Partner hospitals communication with RHCCs**
- **Data Limitations**
  - **Data systems and sharing**
    - **Can’t share** records, data (i.e. birth certificate data), and can't geocode
    - ICARE, APORS, Cornerstone are **challenging to pull data** out of in a timely manner
    - Difficulties **navigating CEMP and EM Resource**
    - **Funding**
  - **Data collection**
    - **Underserved populations aren’t represented in data collection** (i.e. housing, legal issues, healthcare, poverty)
      - People with disabilities, Native peoples, migrant farm workers
  - **Data access and availability**
    - **Dependent on IDPH for data in jurisdictions**
    - Need **better data and more timely access** to line level data
    - Better **communication regarding data at the County and region level**

What is an example of what has not been done well or has been ineffective? (cont.)

"Framework and vision is a start but need to invest and sustain across systems and invest funds to support these efforts."
– Priority Areas

"Majority of our services are undervalued in relation to what we're funded to do, but the expectations are always sky high."
– Equity Committee

- **Funding and Resource Limitations**
  - **Funding**
    - Lack of **funding for emergency management agencies**
    - Public health is **underfunded** and IL ranks near the bottom in the country
    - **Clinical settings stretched thin** with limited funding
    - Limited funding for **Native communities and migrant farm workers**
    - **Highly competitive funding streams for communities of color** and other **marginalized populations**
    - Funding is low, but **expectations are high**
  - **Resources**
    - Lack of resources for **Behavioral Health**
    - **Rural communities** need help and attention
    - **Chicago-oriented** resources
    - **No statewide coordinated trauma informed care**
    - Public health **not involved in housing or homelessness services downstate**

- **Workforce**
  - **Lack of staff;** Limited funding for adequate staffing
  - **CHWs aren't certified** in IL
  - Missing public health roles - **legal and policy, enough epidemiologists**
  - Shortages in **healthcare providers**
  - Lack of **Advanced Life Support paramedics**
  - Low **recruitment efforts**
  - Lack of SMEs on **behavioral changes**

"How that [data collection and communication] connects to other entities within the State [...] it's still very much separated." – Hospital Reps

Aspects of the Public Health System

STRONGEST

- **Collaboration**
  - Between community partners
  - Collegiality throughout the SPHS
  - Collaboration across counties
- **Responsiveness to Partners**
  - Good relationships with IDPH regional representatives (hospitals)
  - Communication with IDPH EMS Highway Safety
- **Leadership**
  - Leadership within Office of Women's Health
  - "Real leadership in our state around the mental health consultation in the early childhood space is a place where Illinois is seen as a leader" --LHD
- **Workforce Expertise**
  - Behavioral health expertise
  - Excellent grant writers
  - "The adaptability that most of us are able to accomplish and wear multiple hats across a broad range." – LHD

WEAKEST

- **Access to Care**
  - **Child mental health services** are inaccessible and limited
  - Health care inaccessible in Southern IL and other rural areas
- **Data Limitations**
  - Availability of data
  - Communication and collection of data is limited
- **Funding**
  - Lack of funding for behavioral health care and chronic disease
  - Lack of funding for staffing
  - Limitations and lack of flexibility due to categorical funding
- **Workforce Development**
  - Lack of staff
  - High turnover rates
  - Low wages/salaries

Future State of the Public Health System

Before COVID19, what were the most urgent priorities in the communities you serve?

- Access to Care
- Insurance - Medicaid
- Social Determinants of Health
- Food Insecurity
- Educational Attainment and Job Development
- Community Violence
- Chronic Disease
- Maternal and Child Health
- Emergency Preparedness and Response
- Mental Health
- Behavioral Health
- Substance Misuse
- Trauma

How do you think we should balance preparedness and response with addressing other community needs?

- **Balancing Normal Operations**
  - "Many members of the public health system have had to focus their limited resources and energy on COVID-19 preparedness and response. However, we know that those community needs and issues are not going away." – Hospital Reps
- **Communication and Collaboration**
  - More mindful communication and collaboration
  - **Trusted, consistent, united messaging**
  - Using **modern tech.** to improve communication
- **Decision Making**
  - Improved **transparency** on how decisions are made
- **Funding**
  - Using funding to **address inequities** and **messaging around myths related to COVID**
- **Workforce Development**
  - Integrating **community workers into clinical settings**
  - Including **people with lived experiences**
  - Adequate **compensation for staff and recruiting nurses**

What should be our goal in the next 18 months?

- **Access to Care and SDOH**
  - **HC and housing for people involved in corrections system**
  - **Accommodations for people with disabilities**
  - Focusing on **increased disparities**
  - **Food insecurity**
  - **Poverty**
- **Addressing and focusing on Community Care**
  - **Trauma informed care and equitable practices**
  - **Community trauma and building resilience**
- **Evaluation**
  - **After Action Reports** from COVID response, Improvement plans from AAR
- **Mental Health**
  - Extending services **into the community**
  - **Hospital occupancy and resource availability for behavioral health**
- **Planning**
  - Plans for **if something happens to the ACA**
  - Developing definite plan to develop **alternate care centers**

What are the best ways the public health system should work together towards this goal?

- **Data Improvements**
  - Inclusion of **sexual orientation, gender identity, ableism, and history of chronic disease in data collection**
  - **Data use agreements** and how the data is sent
  - Pushing down data **more frequently**
  - Updating **data programs** (i.e. APORS, ICARE)
- **Funding**
  - **Reimbursement for lay and community health workers** – recognizing team approach
  - Funding for **migrant farm workers**
- **Prevention**
  - "Society, as a whole, **doesn't value prevention** and the need to do more work in there." – LHD

What needs to change or improve?

- **Access to Care**
  - **No trauma centers in rural/Southern IL**
  - **Access to pediatric hospital supplies/resources** and **OB/GYNs**
  - **Mental health**
- **Medicaid Applications**
  - Filed faster, with more **mistakes.** People are **losing healthcare** because of these mistakes.
- **Workforce Development**
  - Hospitals and HC providers **stretched financially**
  - **Lack of licensed psychiatrists and psychologists**, dependent on social workers and LPCs
  - **Staff shortages (behavioral health)** and funding/low wages

What needs to happen to make sure the SHIP helps address this goal?

What does IDPH need to do?

What do you think is needed for the public health system to work together?

- **Assessment and Data**
  - Looking at **current and new data**
  - **IDPH assessment of its own employees and diversity**
  - Assessment of **policies** – outdated and misdirected policies
  - Massive **needs assessment with underserved populations**
  - **Assessment of services** – accessibility, culturally and linguistically competent
- **Setting Realistic Goals**
  - The **energy and the bandwidth to work on these priorities** is a concern
  - "I think we have to be very thoughtful that we **don't get committed or believe** that again, **we're going to be able to work on multiple [priorities]."** – LHD
  - Managing expectations of what we can **reasonably work on and accomplish**
- **Funding**
  - **Sustainability of programs**
    - "There has to be a **dedicated funding source** to sustain basic operations." – LHD
  - Funding to **ameliorate those needs** in the long-term
  - "When we have extraordinary situations that you have the **additional support.** " – LHD
  - "**Shifting of funds for different priorities** may end up hurting health departments pretty easily over the next couple of years, as everybody tries to recoup." – LHD

Focus Group Data Summary

Current State:

- Participants most frequently described examples of **collaboration, immunizations efforts, and program and policy development** as examples of what has been done well in the system.
- **Access to care, partnership engagement, SPHS communication, data limitations, funding and resources limitations, and workforce** were identified as ineffective aspects of the system.

Future State:

- There is a need for **communication and collaboration, improved decision making, funding, and workforce development to balance preparedness and address other community needs**.
- Participants identified **access to care and SDOH, addressing and focusing on community care, evaluation, mental health, and planning** as items that should be goals over the **next 18 months**.
  - To work together toward these goals, participants noted the need for **data improvements, funding, and a focus on prevention.**
- **Access to care, workforce development, and improved Medicaid application processes** were most frequently cited as needed changes and improvements in the system.
- Participants noted specific needs to work toward these improvements through **data and assessment, setting realistic goals, and funding for sustainability of programs**.

Thank you!

NEXT MEETING DATE:

FRIDAY, OCTOBER 30, 2020
10:30AM TO 12PM