Healthy ILLINOIS 2021

STATE HEALTH IMPROVEMENT PLAN

UIC

Illinois Department of Public Health
IDPH
Protecting Health. Improving Lives

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For more information, please visit:
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LETTER FROM THE DIRECTOR

DEAR ILLINOIS STAKEHOLDERS:

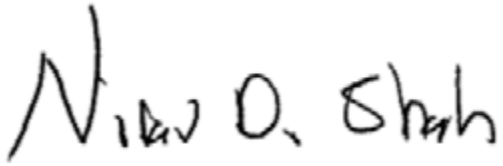
Thank you for your interest in the Healthy Illinois 2021 initiative. In January 2016, I shared the State Health Assessment that focused on the current state of health in Illinois. Here you will find part two of this initiative, the State Health Improvement Plan. This document represents the culmination of a yearlong process, in which stakeholders have committed to bringing their ideas and expertise to the table in order to improve the health of all Illinois residents. I appreciate the work that went into the creation of the State Health Assessment and State Health Improvement Plan; it was a truly collaborative process.

Healthy Illinois 2021 represents three statewide initiatives working to improve the health of Illinois residents. The Illinois Department of Public Health (IDPH) recognizes the need to assess the health status of Illinois residents and to establish health improvement strategies that address the identified health issues and disparities. The State Health Improvement Plan details the approaches and strategies that can lead to health improvement in our priority areas: behavioral health, chronic disease, and maternal and child health. Healthy Illinois 2021 also includes the plans for state health system innovation that started under the State Innovation Model initiative.

Healthy Illinois 2021 was made possible through the work and effort of many individuals and organizations across the State of Illinois. Participants were convened by IDPH, the Illinois Governor's Office, and the University of Illinois at Chicago School of Public Health MidAmerica Center for Public Health Practice.

Members of the Healthy Illinois 2021 Planning Council guided this process using their experience and statewide perspective. I'm grateful for their work and commitment. Action Team members worked specifically on the Healthy Illinois 2021 health improvement strategies, and the co-chairs for the Action Teams provided leadership and direction.

In order to move forward with this plan, we will continue to count on your partnership and commitment to this process. I look forward to continuing this important health improvement work with you.



Nirav D. Shah, MD, JD
Director, Illinois Department of Public Health

EXECUTIVE SUMMARY

BACKGROUND

Leading health improvement and tackling health equity is the mission of the public health system. In the state of Illinois, one initiative to fulfill this mission is a coordinated project titled Healthy Illinois 2021. This initiative is composed of three statewide efforts: the State Health Assessment (SHA), the State Health Improvement Plan (SHIP), and the plans for state health system innovation that started under the State Innovation Model (SIM). Collectively, these components work together to align and coordinate plans, processes, and resources to drive health improvement and work toward health equity.

Executive Summary continued »

The Healthy Illinois 2021 SHIP was made possible through the collaborative and coordinated effort of many individuals and organizations across the state of Illinois. Participants were convened by the Illinois Department of Public Health (IDPH), the Illinois Governor's Office, and the University of Illinois at Chicago School of Public Health MidAmerica Center for Public Health Practice. The Healthy Illinois 2021 Planning Council, appointed by Governor Bruce Rauner in 2015, guided the initiative and included representation from numerous sectors including transportation, education, health care, environment, and social service.

The first product of Healthy Illinois 2021, the SHA — along with a statewide databook, Health Data: Core Indicators — was completed in January 2016. This companion document, the SHIP, represents the work of numerous stakeholders sharing their knowledge and expertise. This process began with a review of existing state agency plans and reports, continued with numerous qualitative and quantitative information-gathering sessions with public health stakeholders across the state, and culminated with the development of action plans, led by key stakeholders with expertise in the health priority areas.

The fruits of this labor are described in this SHIP document which outlines the goals, measurable objectives, and strategies to improve the health of Illinois residents specifically in the areas of behavioral health, chronic disease, and maternal and child health. The SHIP builds on the work of the SHA by providing a blueprint to address the social determinants of health, access to quality care, and the state's health priorities. The SHIP should guide overarching statewide goals and objectives that organizations can adopt to align their work. This plan is a dynamic document; it is expected to be updated and refined as Illinois begins implementation.

Method (Action Planning Process)

The framework used for the development of the SHIP was based on an iterative assessment process with several layers of input from key stakeholders. Data that informed the process were obtained from several sources, including local needs assessments such as IPLANs (Illinois Project for Local Assessment of Needs) and community health needs assessments; a health system assessment; state agency reports used to identify statewide strengths, opportunities, and barriers; focus groups and presentations conducted across the state; and health status data. From this process, Planning Council members established a preliminary list of health priorities, which are described in the SHA.

The State Health Improvement Plan process focused on the development of action plans to address the health priorities identified specifically in the State Health Assessment: behavioral health, chronic disease, and maternal and child health. Action Teams were established as an opportunity to engage stakeholders, and to build commitment and accountability around the health priorities. The action planning process relied heavily upon the expertise of key stakeholders working within the behavioral health, chronic disease, and maternal and child health arenas.

Action Teams were charged with developing action plans and were provided tools to assist with goal development activities, including the establishment of guiding principles and criteria for strategy selection. Action Teams considered strategies that focused on social determinants of health, access to quality care, integration of clinical and public health interventions, and other decision-making criteria.

In addition to describing the overall process of goal and strategy selection, the SHIP includes specific examples depicting how strategies can be implemented.

Results (Implementation Recommendations)

Implementation recommendations were developed in six areas with a heavy focus on goals, objectives, and strategies related to behavioral health, chronic disease, and maternal and child health. In addition to recommendations specific to the aforementioned health priorities, guidance also clarified the role of the public health system and integrated social determinants of health and access to quality care through the recommended action steps.

• Public Health System Role

Conversations across all Action Teams helped frame key implementation recommendations stressing the need for overall infrastructure to ensure plan implementation. The group stressed that the useful and standardized collection, distribution, and utilization of data is a crucial role of the public health system.

• Social Determinants of Health and Access to Quality Care

The Planning Council recommended that social determinants of health and access to quality care be priorities for action planning at the start of the implementation stage; these priorities were repeatedly mentioned during the strategy selection process of each of the Action Teams and were overwhelmingly agreed upon as implementation requirements for the plan. The culminating discussions about the SHIP emphasized the need for continued and even more focused recommendations to address the social determinants of health.

• Health Priority Areas and Action Plans

More than 80 individuals and organizations participated in one of the three Health Priority Action Teams. After exploring both health data and national, state, and local resources, the teams developed goals, objectives, and strategies to achieve health improvement and tackle health equity.

HEALTHY ILLINOIS 2021 HEALTH PRIORITY ACTION TEAM GOALS

BEHAVIORAL HEALTH	CHRONIC DISEASE	MATERNAL AND CHILD 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	1. Increase opportunities for tobacco-free living 2. Increase opportunities for healthy eating 3. Increase opportunities for active living 4. Increase community-clinical linkages to reduce chronic disease	1. Assure accessibility, availability, and quality of preventive and primary care for all women, adolescents, and children, including children with special health care needs, with a focus on integration, linkage, and continuity 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 maternal and child health (MCH) decision making; eliminate disparities in MCH outcomes 4. Strengthen public health data systems, infrastructure, and capacity through unified statewide planning and leadership

Conclusion

Many lessons were learned throughout the SHIP development process, and it is expected that many more will evolve throughout implementation. One lesson learned is that in order to make progress in improving health outcomes, particularly in the areas of behavioral health, chronic disease, and maternal and child health, full participation of a broad array of stakeholders within Illinois' public health system is required to build infrastructure and accountability. Additionally, throughout the action planning process, many stakeholders identified themselves as ready and willing to assist in this endeavor as the implementation phase begins and further refinement of the action steps occurs throughout the next five years.

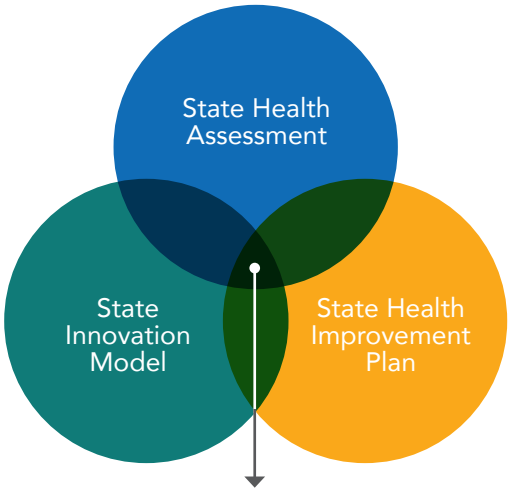
For more information, please visit:
www.healthycommunities.illinois.gov

INTRODUCTION

The mission of the Illinois Department of Public Health (IDPH) is to protect the health and wellness of the people of Illinois through the prevention, regulation, and control of disease and injury and the promotion of health. In accordance with Illinois state statute 20 ILCS 5/5-565,[1] IDPH is designated to lead an effort to create a unified strategy for improving the state's public health system.

Introduction continued »

IDPH engaged subject matter experts and community stakeholders in an action planning process to address statewide health priorities. These priorities include behavioral health, chronic disease, and maternal and child health. Partners and stakeholders have worked with IDPH to develop goals, objectives, and strategies to drive health improvement in these areas. Action plans for each priority area build upon statewide and local health improvement efforts in order to leverage best practices and align assets and resources. This process is an important strategic component of the Healthy Illinois 2021 initiative, where the following three major statewide projects are united.



Healthy Illinois 2021

Healthy Illinois 2021 Components

Healthy Illinois 2021 is composed of three statewide initiatives that work together to coordinate and align plans, processes, and resources to lead health improvement and health equity.

• Illinois State Health Assessment

The State Health Assessment (SHA) is a systematic approach to accessing, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health.

• Illinois State Health Improvement Plan

The State Health Improvement Plan (SHIP) is a five-year systematic plan to address issues identified in the SHA. Based on the SHA, the SHIP describes how the state health department and the communities it serves can work together to improve the health of the population. The SHIP also represents the Plan for Population Health.

• Illinois State Innovation Model

The State Innovation Model (SIM) considers multi-payer health care payment and service delivery models that aim to improve health system performance, increase quality of care, and reduce costs.

State Health Improvement Plan Purpose and Use

This report presents the strategies recommended to address health improvement in three priority areas identified through the SHA: behavioral health, chronic disease, and maternal and child health. The SHIP builds on the work of the SHA by providing a blueprint to address priority health issues as well as high-level recommendations for how to improve the public health system infrastructure and address social determinants of health and access to quality care. The document is a framework for implementation that promotes evidence-based best practices and recommends ways to address core health issues and factors that impact health. It also identifies gaps and offers strategies for addressing these gaps in a coordinated fashion. This is not a plan for what the state government, by itself, should do. Rather, the intent is for organizations and agencies working across the state to adopt these initiatives and join the many agencies working in a common direction. Along with the SHA, the SHIP document represents the first phase of a five-year plan that should be updated and refined on a regular basis. It reflects the work of committed organizations, associations, research institutions, agencies, and many others across the state to create actionable and measurable recommendations to improve health.

> The three priority areas identified through the SHA are **behavioral health, chronic disease,** and **maternal and child health.**

Healthy Illinois 2021 Measures of Success

Healthy Illinois 2021 represents a coordinated approach to lead health improvement and tackle barriers to health equity. With a five-year timeline, the Healthy Illinois 2021 Planning Council agreed that success of the overall initiative would be realized by making improvements to the public health system infrastructure, along with improving specific priority health issues that benefit all Illinois residents. The Planning Council established broad infrastructure goals as an operational vision of success. Healthy Illinois 2021 will result in:

- Aligned and coordinated clinical and primary prevention strategies
- Patients and community residents that are viewed holistically
- Effective data systems and infrastructure
- Aligned quality measures
- Innovation that occurs through use of evidence-based strategies and best practices
- Consumer education improvements
- Maximized current workers and cultivated new workers within the public health system
- Community-oriented, asset-based decision making

Participants

The Healthy Illinois 2021 initiative is guided by a Planning Council appointed by Governor Bruce Rauner in 2015. Planning Council members represent organizations from numerous sectors including transportation, education, health care, environment, and social service. Organizations include state agencies, community-based organizations, associations, public health departments, health and hospital systems, insurance companies, and other entities, which collectively constitute the public health system in Illinois. As a statewide

body, the Planning Council is convened by the Governor's Office and IDPH. The MidAmerica Center for Public Health Practice at the University of Illinois at Chicago School of Public Health also led this effort.

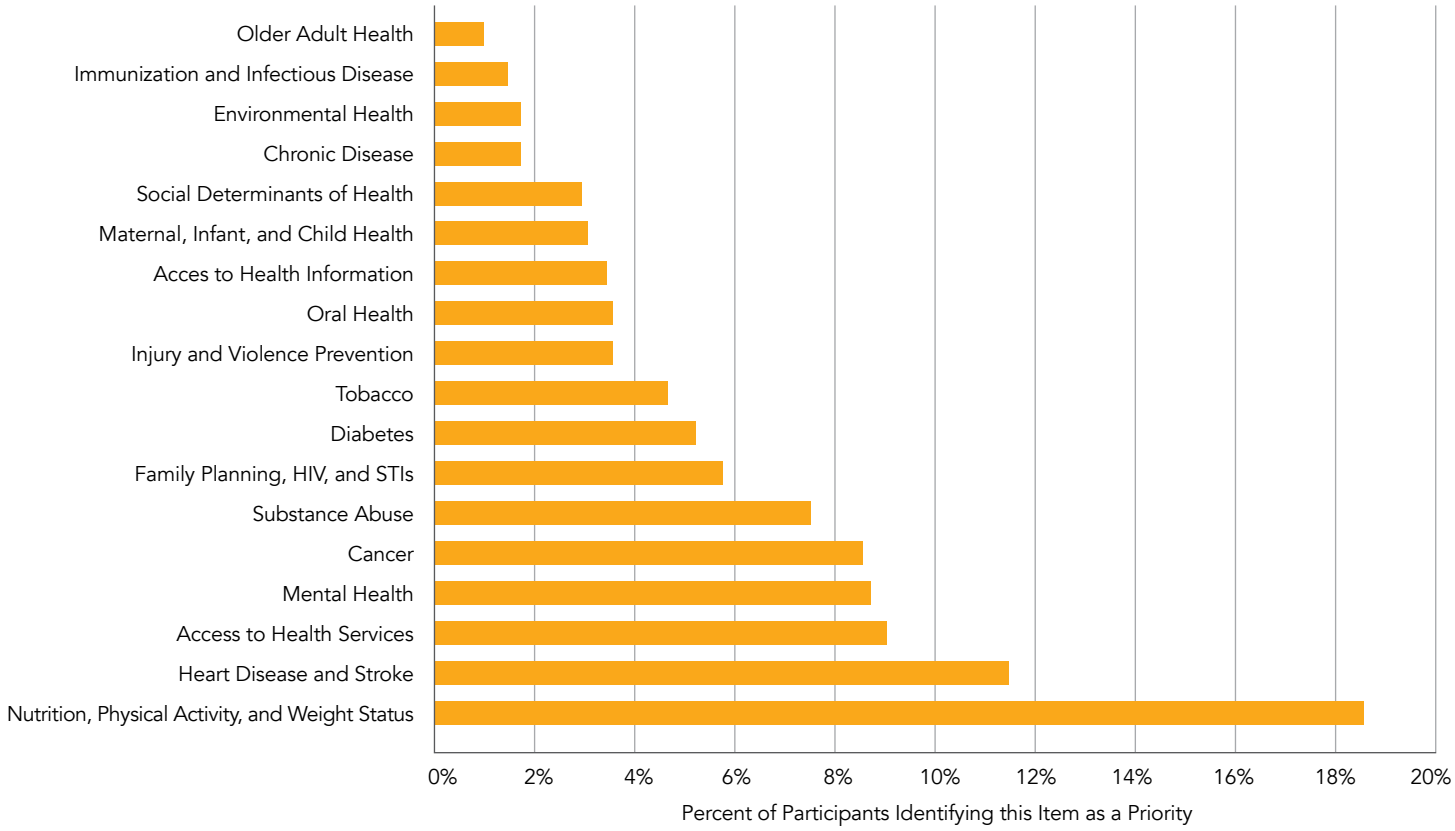
Healthy Illinois 2021 Action Teams were established for each priority area. Two co-chairs representing a state agency and an external stakeholder group provided leadership for these teams. Action Teams also included participants from local health departments, community-based organizations, universities, and state agencies.

Action Teams held open meetings between December 2015 and March 2016 to establish goals, objectives, and strategies to achieve health improvement in the priority areas. Working meetings were held weekly or bi-weekly, and Action Team members provided specific input throughout the process. The agendas, minutes, and other materials are available at http://www.healthycommunities.illinois.gov/action_teams.htm.

State Health Improvement Plan Framework

The State Health Improvement Plan Framework is based on an iterative assessment process with several layers of input from key stakeholders. Data that informed the process were obtained from several sources, including local needs assessments such as IPLANs (Illinois Project for Local Assessment of Needs) and community health needs assessments;[2] a health system assessment; state agency reports used to identify statewide strengths, opportunities, and barriers; and health status data. Planning Council members established a preliminary list of health priorities that was then narrowed down to include just five. The list of five priorities shows strong alignment with the priorities identified through the local IPLANs and community health needs assessments.

EXAMPLE OF DATA REVIEWED: PRIORITIES IDENTIFIED THROUGH IPLANs



The assessment findings and preliminary priorities were then vetted locally and regionally through focus groups and organizational presentations. Eleven focus groups were conducted in five counties representing different regions of the state: Cook County, Lee County, Champaign County, St. Clair County, and Sangamon County. Almost 100 participants represented their organizations at these sessions. Additionally, eleven sessions for stakeholder organizations were held with over three hundred people participating. In total, over 400 organizational leaders had input in the State Health Assessment through the stakeholder engagement process. There was overwhelming support for the preliminary health priorities selected by the Planning Council.

PRELIMINARY PLANNING COUNCIL PRIORITIES

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

A review of transcripts from the focus group sessions provided rich detail about how health issues are being experienced throughout Illinois and the efforts organizations are making to address them. Over 100 pages of transcripts and notes were reviewed, and the themes were categorized and tallied in order to identify overarching themes. The biggest issue with early priority setting was the determination of how health priorities are defined. Participants requested that more detail on each priority area be available to allow them to better understand the issues. Just over one-third of the additional priorities suggested could easily be categorized under the broader themes of behavioral health, access to quality care, chronic disease, social determinants of health, or maternal and child health. Most of the remaining suggested priorities focused more on specific strategies or target populations, as opposed to health issues.

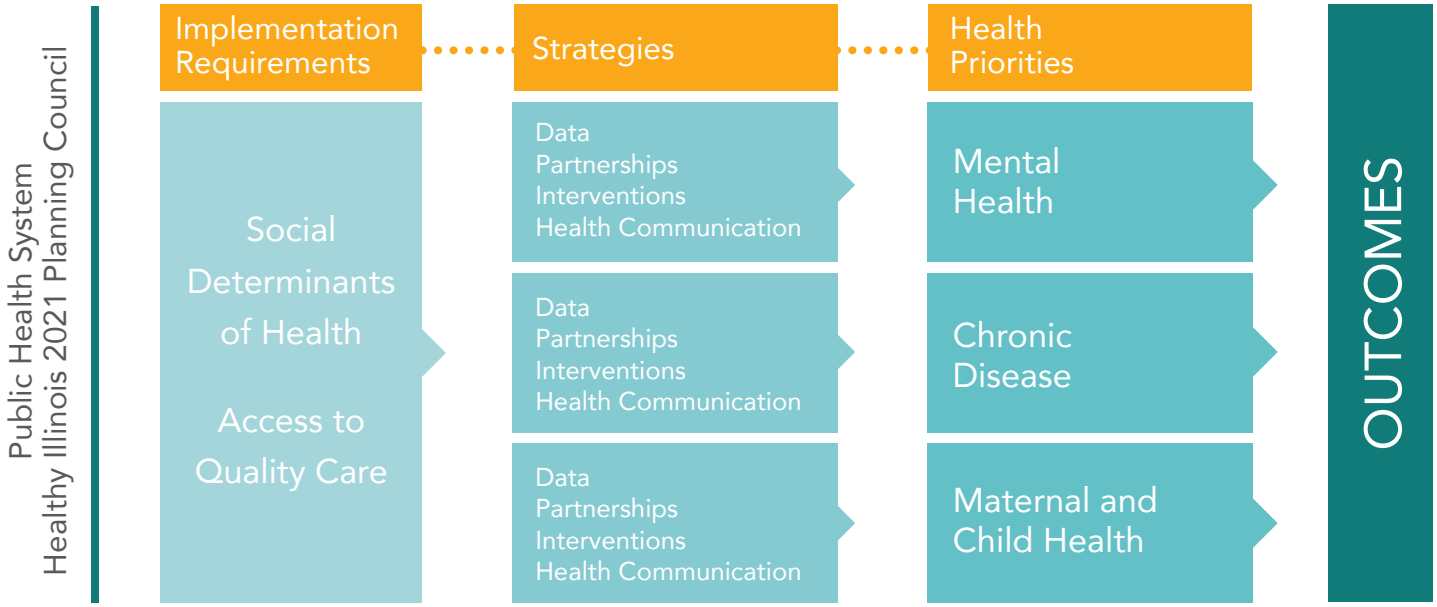
The feedback obtained during stakeholder engagement sessions was reported back to the Planning Council for final prioritization. After a facilitated discussion using standardized prioritization tools (e.g., prioritization matrix and dotmocracy, also known as idea rating sheets or sticker dot voting), the Planning Council selected behavioral health, chronic disease, and maternal and child health as the statewide health priorities with social determinants of health and access to quality care as key decision drivers for strategy selection.

State Health Improvement Plan Framework

The following narrative is a description of the State Health Improvement Plan Framework, which follows the diagram below. During meetings of the Planning Council, the group agreed that access to quality care and social determinants of health were fundamental overarching issues that should serve as implementation requirements for addressing each of the three health priorities. These implementation requirements are seen as areas that must be addressed throughout the action planning process in order for the health improvement plan to be successful. Thus, Action Teams, in developing their action plans, considered social determinants of health and access to quality care when selecting strategies. Action Teams and the Planning Council also considered how these principles relate to the public health system more broadly.

In order to improve health outcomes in these priority areas, the Planning Council and other stakeholders were asked to consider what types of strategies could be implemented at a statewide level. The group considered strategies that have been successful in the past, using examples and evidence from state agency needs assessments and operational reports, and their own experience. Data, partnerships, interventions, and health communication were the areas that emerged as most important or impactful. Throughout the action planning process, these areas provided a lens for examination and were considered when recommending implementable strategies. In discussing the role of the system, the Planning Council recommended itself to be the entity to provide infrastructure and oversight for plan implementation.

STATE HEALTH IMPROVEMENT PLAN FRAMEWORK



ACTION PLANNING PROCESS

STATE HEALTH IMPROVEMENT PLAN PROCESS

The State Health Improvement Plan process focused primarily on developing action plans to address the health priorities identified in the State Health Assessment: behavioral health, chronic disease, and maternal and child health. Action Teams were established in December 2015 to drive implementation, as an opportunity to broadly engage stakeholders and to build commitment and accountability around health priorities.

Action Planning Process continued »

The Action Team meetings began with training that covered the State Health Assessment process, to help newly engaged stakeholders understand the current state of the initiative and the guiding principles for Healthy Illinois 2021.

Each Action Team met several times to develop goals, measurable objectives, and strategies to improve health in the priority areas. The Appendix provides a summary of the goals and measurable objectives. Because some of the measurable objectives, such as "building partnerships," were qualitative in nature, whereas others, such as "reducing mortality rates," were quantitative, the process of setting targets required the use of different approaches for different objectives.

Spreadsheets for the work of each of the Action Teams exist as working documents containing additional notes and detail, including suggestions for launch steps, champions to solicit, and recommended coordinating organizations for the recommended goals. These spreadsheets also include justification and rationale for the goals and strategies chosen by the Action Teams as they developed the recommendations. These working documents will be available to reference and build upon during implementation of the SHIP.

The Healthy Illinois 2021 Planning Council provided input on the action plans by participating as members of the Action Teams and through meetings held in March and April 2016. Members of the public had an opportunity to comment on the health improvement goals and strategies through the open meetings of the Action Teams, as well as through three public hearings that were held across the state about the SHIP. The transcripts and testimonies from the public hearings may be found at http://www.healthycommunities.illinois.gov/.

HEALTHY ILLINOIS 2021 GUIDING PRINCIPLES

- Develop a statewide approach
- Consider assets upon which to build
- Leverage resources, e.g., infrastructure
- Promote alignment of strategies and resources across the state
- Tactically address social determinants of health and access to quality care
- Promote prevention from a policy, systems, environmental, and program perspective

Strategy Selection Process

Criteria for selecting strategies were developed to guide and support the Action Teams. In line with the national movement to promote primary care and governmental public health integration for population health improvement, the Action Teams considered strategies that focused on traditional clinical prevention interventions, innovative clinical prevention, and total population or community-wide prevention.[3] These criteria are specific to the needs of the Healthy Illinois 2021 process and include consideration of the following areas:

SOCIAL DETERMINANTS OF HEALTH	ACCESS	MATERNAL AND CHILD HEALTH	URGENCY	IMPACT	EVIDENCE-BASED OR PROMISING PRACTICES	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?

- **Social Determinants of Health:** These are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Each group considered how a proposed strategy addressed social and ecological factors.

- **Access:** This is the timely and appropriate use of personal health services to achieve the best health outcomes. Attaining good access to care requires 1) gaining entry into the health care system; 2) gaining access to sites of care where patients can receive needed services, including transportation services; and 3) finding providers who meet the needs of individual patients and with whom patients can develop relationships based on culturally competent communication and mutual trust.

- **Maternal and Child Health:** This criterion focuses on six population health domains: 1) women/maternal health; 2) perinatal/infant health; 3) child health; 4) children with special health care needs; 5) adolescent health; and 6) cross-cutting or life course. Viewing strategies from a maternal and child health life course perspective can reveal disparities that need to be considered in the strategy selection process.

- **Urgency:** This addresses a particularly concerning aspect of the health priority or strengthens areas where timeliness is vital. Groups considered how a strategy addressed the presence of a crisis or opportunity to build on existing momentum.

- **Impact:** This references the ability to reach a broad section of the population. Groups considered how many individuals a proposed strategy might reach as well as whether the strategy addressed disparities.

- **Evidence-Based or Promising Practices:** An evidence-based practice is one that has been evaluated and shown to make a positive difference in important outcomes. Groups considered whether success of a particular strategy has previously been measured. Sources of evidence-based or promising practices include the National Prevention Strategy, Healthy People 2020, the Guide to Community Preventive Services, and national health policy.

  NOTE: Programs or policies that are evidence-based or promising practices are noted in the action plan sections in italics.

  Additional evidence-based and promising practices were discussed in the context of activities necessary to implement specific strategies, and this information will be considered as a next step for implementation of the SHIP.

- **Resources:** In their review of proposed strategies, the groups considered the availability of resources and infrastructure to be leveraged as well as the need for new resources.

While recognizing that each strategy might not meet all of the criteria, the Action Teams agreed that strong consideration of these factors during the strategy selection process would allow them to remain true to the guidelines, principles, and spirit of the Healthy Illinois 2021 initiative. These criteria also allowed for a framework to reference in justifying strategy selection and reaching consensus.

Transcripts and testimonies from the public hearings may be found at **www.healthycommunities.illinois.gov**

IMPLEMENTATION RECOMMENDATIONS

CROSS-CUTTING ISSUES

Public Health System Role

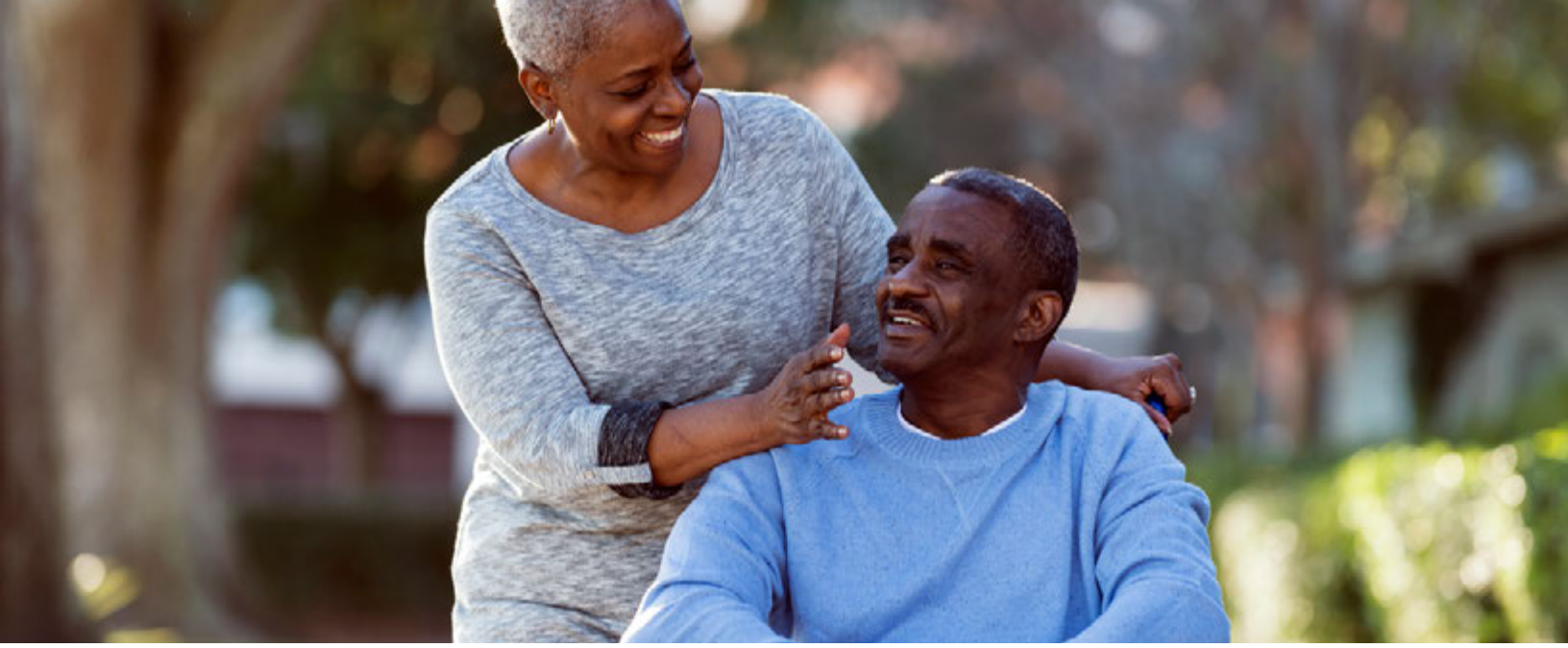
Social Determinants of Health and Access to Quality Care

HEALTH PRIORITY AREAS AND ACTION PLANS

Behavioral Health

Chronic Disease

Maternal and Child Health



CROSS-CUTTING ISSUES

PUBLIC HEALTH SYSTEM ROLE: BACKGROUND

The public health system is a multi-sector stakeholder system that includes all public, private, and voluntary entities that contribute to the delivery of essential public health services. Entities recognized for providing public health services include the governmental public health infrastructure, businesses, the clinical care delivery system, communities, schools, and a broad array of nongovernmental organizations and community-based entities, including faith-based organizations, that have the capacity to influence health. The Institute of Medicine (IOM) recently recommended the formal change of "public health system" to "health system"; however, for the purpose of consistency this document will continue to use the term "public health system."[4]

As noted, the Healthy Illinois 2021 Planning Council is a diverse group of representatives from multiple sectors who were appointed by Governor Bruce Rauner to guide assessment and improve efforts around population health and tackle barriers to health equity. Planning Council members serve as representatives of the public health system with a charge to develop a state health improvement plan that will provide direction for identified health priorities.

A critical point of discussion for SHIP implementation is the ability of public health system members to act on recommendations at the health priority level while providing the infrastructure for the system to carry out its work. Accordingly, the Healthy Illinois 2021 Planning Council will transition to become the Healthy Illinois 2021 Implementation Coordination Council, or ICC. The ICC may have several roles during the implementation process, including but not limited to providing ongoing oversight and leadership of SHIP implementation by addressing gaps found in the initial planning phase (e.g., launch a social determinants of health action team), designing a structural and organizational approach to implementation (e.g., launch health priority action teams and a statewide public health data committee), regularly monitoring and reporting progress of the plan, and addressing needed improvements.

Given this pending transition and the need for overall infrastructure to ensure plan implementation, the Healthy Illinois 2021 Planning Council considered ways in which the ICC could implement health improvement strategies related to the health priority areas. Information and discussions around the role of the ICC focused on three areas:

1. Establishing measures of success for the overall public health system;
2. Assessing and reviewing data to vet the identified measures of success for gaps, strengths, opportunities, and challenges in order to produce system strategies and identify a specific role; and
3. Reviewing Action Team recommendations for system needs within and across the health priorities to make recommendations for overall public health system improvements.

Measures of Success

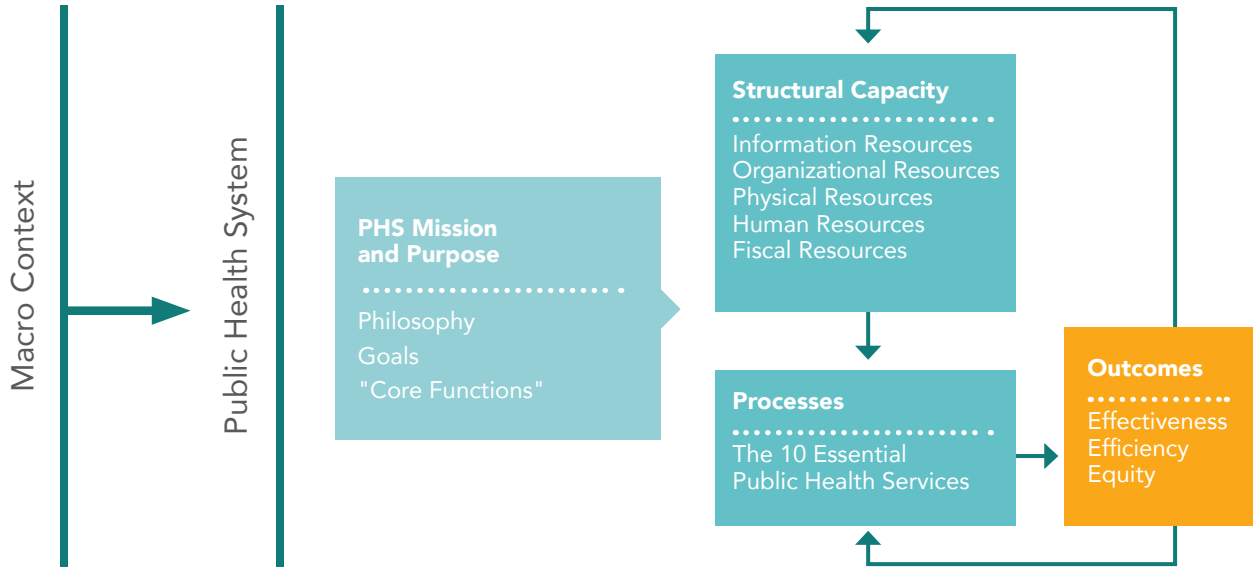
As previously noted, the Healthy Illinois 2021 Planning Council identified broad infrastructure goals, including the following operational measures of success for the Healthy Illinois 2021 process. In addition to the following statements that describe how this plan would be successful, use of the plan by Illinois stakeholders is critical to success. The plan is a resource to assist stakeholders in Illinois in aligning their work around priority areas to support a collective, unified movement to address the priorities. This document should guide overarching statewide goals and objectives for health improvement in priority areas that organizations can adopt to align their work.

1. Aligned and coordinated clinical and primary prevention strategies
2. Patients and community residents are viewed holistically
3. Effective data systems and infrastructure
4. Aligned quality measures
5. Innovation that occurs through use of evidence-based strategies and best practices
6. Consumer education improvements
7. Maximized current workers and cultivated new workers within the public health system
8. Community-oriented, asset-based decision making

State Health Assessment: Health System Feedback

Handler, Issel, and Turnock proposed a conceptual framework for the public health system.[5] The framework has become the basis for understanding the necessary components to undertake and demonstrate health improvement, and includes several key elements and interactions including (but not limited to) iterative relationships among the mission and purpose of the public health system, processes, structural capacity, and ultimately outcomes.

CONCEPTUAL FRAMEWORK OF THE PUBLIC HEALTH SYSTEM (PHS) AS A BASIS FOR MEASURING SYSTEM PERFORMANCE



Feedback from State Health Assessment data presented to the Healthy Illinois 2021 Planning Council aligns with this conceptual framework and calls for a comprehensive approach to address health priority improvement within a larger systems framework (as shown on page 19). The SHIP Framework includes a Planning Council and an Implementation Coordination Council that supports implementation of health improvements. Data presented and discussed by the Planning Council addressed the following framework elements:

- **Public health mission and purpose:** The system would promote community-level health improvement across the state while improving statewide infrastructure. As noted earlier, the system would focus implementation and intervention on the social determinants of health and access to quality care. In addition, many comments addressed the need to promote coordinated, best-practice agendas across the plan — for both infrastructure and interventions — to align and leverage resources, prevent duplication, and increase clarity and focus on measured improvement.

- **Process:** Four core areas emerged as the key process and strategy steps to plan implementation: data analysis and translation for decision making, partnerships for collective alignment and impact, use of community-clinical linkages, and health communications.

- **Structural capacity:** Feedback from public health system partners across the state specifically called for improvement of the health system infrastructure overall and the data infrastructure in particular. This included assessing and evaluating provider and workforce capacity; collecting, managing, sharing, and utilizing data; considering fiscal strategies to help support the work; and assuring a coordinated approach to align and implement the work.

- **Outcomes:** There was overwhelming interest in strengthening the public health system's ability to demonstrate returns on investments for proposed interventions, as well as to monitor, measure, report, and evaluate progress.

PUBLIC HEALTH SYSTEM ROLE: RECOMMENDATIONS

Public Health System Leadership

Both the Planning Council and the Action Teams called for public health system leadership to facilitate both plan implementation and ongoing discussion and action beyond the plan to improve the public's health. Specifically, the following recommendations addressed ways in which immediate leadership is needed to improve public health system infrastructure. These recommendations are a result of multiple discussions throughout this process, including previous Planning Council meetings, focus groups, and action planning meetings, culminating with a final SHIP Planning Council meeting where the role of the public health system was revisited.

- **Prioritization of the plan, including the consideration of winnable battles and a policy framework for implementation.** Taking a phase-in approach to the strategies suggested in this plan is recommended, including considering what can be implemented by aligning and leveraging existing infrastructure. A policy, systems, and environmental change framework is recommended for a statewide approach.

- **Coordination of cross-cutting issues such as data infrastructure, training, communication, funding, promising practices, and evaluation approach.** Leveraging resources and reviewing existing plans and strategies is recommended to improve coordination. Consideration of how cross-cutting factors will be integrated across priorities was identified as an initial step.

- **Develop action items to address social determinants of health and other structural issues such as housing, employment, and education.** Further consideration around structural issues, including specific action planning to address them, is recommended. Each of the health priority areas cannot be seen in isolation. Without a clear path out of poverty, including access to stable quality housing, a steady income, and opportunities for education, attending to health issues is a distant priority for the many

Illinois individuals, families, and communities that are currently living in poverty (14.4% of the population overall in Illinois, see State Health Assessment).

- **Promotion of the plan and communication with stakeholders around priorities.** Recommendations include emphasis on dissemination of the plan, deliberate communication around the health priorities, and an effort to further engage stakeholders.

- **Strengthen the statewide data system.** Three recommendations were provided to improve the statewide data system. First, a vision should be articulated for a statewide data system that rationalizes and streamlines the measurement approach for assessing and monitoring the full spectrum of indicators relevant to improving the public's health, including structural factors (such as social determinants of health), medical and behavioral risk factors, characteristics of the health care delivery system and of other public health programs, and health outcomes. Second, a statewide public health data committee should be established and charged with developing the technical, organizational, and analytic specifications for making the vision a reality. Third, the capacity to implement the data committee's specifications should be ensured, including having adequate numbers of information technology and analytic personnel at both the leadership and staff levels, and ensuring that data, program, and policy personnel work collaboratively toward health improvement.

- **Stakeholder roles for implementation.** In order to continue momentum toward implementation, Healthy Illinois 2021 Planning Council members and Action Team members were asked to consider their role in ongoing SHIP activities. These responses serve as a commitment from the public health community to continue driving toward health improvement. They considered roles for the Implementation Coordination Council, state agencies, and themselves as the public health community. Additional detail on recommended roles is provided below.

These leadership recommendations are a result of multiple discussions including **SHIP Planning Council meetings, focus groups,** and **action planning meetings.**

Recommended Roles of the Public Health Community in SHIP Implementation

Success will require the continued engagement of stakeholders across disciplines and at every level in every part of the state. As previously noted, the SHIP is a statewide plan. It is not a plan to be implemented solely by government or by any single sector.

Recommended Role of the SHIP Implementation Coordination Council

Both the Healthy Illinois 2021 Planning Council and the Action Teams took some time to explore the role of the SHIP Implementation Coordination Council. A variety of roles were recommended, falling into three categories: strategic activities, proactive activities, and responsive activities.

Strategic

- Consider and execute innovative models to promote prevention (e.g., public health prevention fund)
- Advocate for the use of best practices
- Address system gaps/needs (e.g., launch a social determinants of health action team)

Proactive

- Prioritize SHIP recommendations to develop and oversee a focused statewide agenda
- Launch implementation structures such as health priority action teams and a statewide public health data committee
- Create an overarching communication plan
- Monitor health status and impact indicators, evaluate results, and report on progress
- Facilitate cross-agency data production (data briefs)
- Promote common strategic approaches, e.g., data, partnerships, health communications, community-clinical linkage interventions (common measurement approaches, share best-practice/evidence-based interventions across the state, etc.)
- Explore approaches to funding mechanisms to support multi-year, scope-based funding
- Align resources, prevent duplication, and promote coordination (e.g., align state agencies' approaches to prevention)
- Support local-level SHIP plan adoption and alignment, including facilitating stronger integration between clinical care and public health

Responsive

- Respond to funding opportunities collectively

Recommended Role of the Action Teams

As the action planning process drew to a close, each of the Action Teams articulated a desire to continue to work together with the SHIP Implementation Coordination Council. While each group had a unique approach, Action Teams identified similar visions of their role. These visions included the following desires:

Partnerships and Collaboration

- Participate in a learning collaborative
- Serve as a convener to bring a broad array of public health, health care, and other stakeholders working on SHIP priorities to the table
- Establish formal implementation workgroups
- Foster collaboration and partnership building
- Continue to be partners with each other on population-specific issues
- Collaborate with hospitals on the community health needs assessment process and with local government on public health issues
- Support efforts to connect priorities to organizations at the state and city levels to champion work
- Share information about existing partnerships working on priority areas

Communication and Technical Support

- Disseminate the action plans
- Help frame and promote messaging regarding the SHIP priorities
- Provide expertise, resources, and technical assistance to families in Illinois
- Provide training and collaborate to develop a training institute for integrative behavioral health care in primary care and schools

Monitoring and Participating in Implementation

- Monitor progress toward SHIP objectives, including setting benchmarks for different phases of implementation
- Monitor and report on best practices
- Participate in pilot or demonstration projects
- Work toward data collection in new areas
- Implement recommendations as part of their respective organizations, including policy support

Resource Development

- Increase philanthropic and federal dollars that enter the State of Illinois to fund public health initiatives
- Collaborate with other entities on federal grant applications

Recommended Role of the State Government

Partnerships and Collaboration

- Continue to provide a space for stakeholders to meet and support implementation
- Partner with local communities in implementation

Communication and Technical Support

- Issue periodic written reports on progress toward SHIP implementation, including successes and identified barriers
- Intentionally link, where possible, state agency reports, plans, and other communications to the SHIP
- Provide technical expertise and support to organizations, coalitions, and others working to implement SHIP recommendations across the state

Monitoring and Participating in Implementation

- Monitor implementation of all recommendations in the SHIP
- Lead implementation efforts where appropriate, e.g., data infrastructure improvements
- Set up an interagency implementation team to support these efforts

Resource Development

- Link state grant opportunities, where appropriate, to the SHIP priorities and recommendations
- Lead and support efforts to obtain new resources to implement SHIP recommendations

Implementation of Infrastructure Recommendations

In order to take action on proposed strategies, examples are needed to highlight how the SHIP can be integrated across infrastructure and health priorities. The following is one example of how this work might be achieved.

IMPLEMENTATION SUCCESS STORY: ALIGNING AGENDAS TO INCREASE CAPACITY AND SUPPORT POPULATION HEALTH IMPROVEMENT

The Rationale

The Illinois public health system members, including statewide, regional, and local governmental agencies and nonprofit, faith-based, private-sector, and many other organizations, are working together to facilitate population health improvement and tackle barriers to health equity. Achieving this vision requires collaboration and alignment of key clinical, community, and clinical-community strategies. This is an area of opportunity for the public health system. The Illinois Department of Public Health's 2015 Public Health Stakeholder Satisfaction Survey Report (described in the State Health Assessment) revealed that improvement is needed in research to find new insights and innovative solutions to health problems. Further, a 2013 report titled "Assessing the State of Workforce Development in Illinois: Practice Perspectives from the Field" acknowledged that greater work is needed to develop and execute a systematic approach to public health workforce development.[6]

The Evidence

A key approach to the implementation and adoption of effective interventions to facilitate population health improvement is the use of workforce development strategies, including education and training.[7] Given that approximately 50% or less of the public health workforce has formal public health training, providing opportunities for education and information sharing is vital.[8] Moreover, conferences remain an important approach to help increase knowledge, skills, and abilities within the public health system to undertake a process and drive decision making toward best practices to improve population health.[9]

The Strategy

The Illinois Department of Public Health, the Illinois Public Health Association, the University of Illinois at Chicago School of Public Health (UIC SPH) MidAmerica Center for Public Health Practice, and the UIC SPH Prevention Research Center are aligning their practice and research agendas as well as training resources to collaboratively present a statewide leadership conference in September 2016 focused on disseminating evidence-based strategies to address population health improvement. The new conference will be offered for the first time in the state's history and was initiated through purposeful and strategic alignment with the State Health Improvement Plan. The conference, *Public Health on the Cutting Edge: Assuring Equity and Brokering Investment in Population Health*, focuses on the role of public health in addressing current challenges and opportunities for population-level health improvements in Illinois, while addressing health disparities and health equity. The conference will provide an opportunity to discuss the strategies identified in the State Health Improvement Plan: data, partnerships, interventions, and health communication.

SOCIAL DETERMINANTS OF HEALTH AND ACCESS TO QUALITY CARE: BACKGROUND

As previously noted, for the purposes of the State Health Improvement Plan, social determinants of health and access to quality care were considered implementation requirements for achieving health improvement across the state.

State Health Assessment Background

Information collected through the SHA's stakeholder engagement process showed that addressing social determinants of health is an underlying tenet of health improvement work regionally and locally. For example, one focus group participant indicated that organizations are "looking at addressing all of these [issues], but through the social determinants of health [lens]. So our mission is really to eliminate barriers towards accessing health care through working with social service organizations."

The changing health care environment also informed the discussion around access to quality care during the State Health Assessment process. Although health care reform has increased access to care, there are still concerns about the quality and affordability of services provided. Issues raised in the State Health Assessment included the distribution of primary and specialty care providers across the state, the standard of care across the state, navigating the health care system to find quality providers, and ensuring consumers can receive the services they need at a price they can afford.

> "Our mission is really to eliminate barriers towards accessing health care through working with social service organizations."
>
> **» Focus group participant**

A CALL FOR INCREASED PRIORITIZATION OF SOCIAL DETERMINANTS OF HEALTH AND ACCESS TO QUALITY CARE

During the action planning process, broad factors that affect health in all the priority areas were raised as key issues that need to be addressed in order to improve health in any one area. These factors include social determinants of health and access to quality care. While the Action Teams addressed various social and ecological factors in the plans, a systematic approach to addressing these areas was recognized as a greater need. Both the Action Teams and the Planning Council acknowledge that social determinants of health and access to quality care should be stand-alone priorities with corresponding strategies and an action plan. The Planning Council recommended that this effort should be an early focus at the start of the implementation stage. The areas of consideration that are reflected in the SHIP action plans — as well as those that need to be prioritized in the next phase of the planning and implementation — are described on the next page.

Priority Areas Recommended for Action Planning by the SHIP Implementation Coordination Council	Examples of Current Social Determinants of Health and Access Factors Described in Action Plans
Access **Built Environment** **Community Safety** **Education** **Equity** **Housing** **Job Availability**	**Access to Services:** • Assure integration, linkage, and continuity of services through patient-centered medical homes • Increase access to and quality of behavioral health services **Built Environment:** • Increase policy, systems, and environmental (PSE) strategies around healthy living and healthy eating **Equity:** • Increase use of tools and resources to consider equity in decision making for maternal and child health issues

HEALTH PRIORITY AREAS AND ACTION PLANS

BEHAVIORAL HEALTH

CHRONIC DISEASE

MATERNAL AND CHILD HEALTH

BEHAVIORAL HEALTH: BACKGROUND

Definitions

As the State of Illinois works to advance prevention, early intervention, treatment, and care related to behavioral health, it is imperative that the terminology used in the SHIP reflect consumer, provider, and community input. The term "behavioral health" is intended to be inclusive of both mental health conditions and substance use problems. We understand that the term "behavioral health" is not universally accepted; however, our commitment is to use respectful language that supports ongoing and future work in the field.

Mental health is described by the World Health Organization (WHO) as a state of well-being in which an individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. The positive dimension of mental health is stressed in the definition of health as contained in the WHO constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[10] The *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-5), refers to substance use disorders as being defined as "mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home."[11]

Given the extent to which mental health and substance abuse problems can co-occur, it was decided that substance abuse and mental health should be addressed under a broader umbrella term of behavioral health.

Priority Background

In Illinois, approximately 15% to 17% of all Illinois adults reported experiencing poor mental health for more than one week in a month, and in 2014, one of five young adults in Illinois — ages 18 to 24 — reported experiencing poor mental health for more than one week in a month. In 2013, 39,501 children and adolescents were served in the Illinois public mental health system in various capacities.[12] According to the Substance Abuse and Mental Health Services Administration, 8.5% of all adolescents in Illinois aged 12 to 17 had at least one major depressive episode within the year prior to being surveyed (in 2009 to 2013).

Suicide is related to poor mental health, and disparities exist among those who have committed suicide (1,365 people in 2014). The suicide rate among non-Hispanic whites is higher than the Healthy People 2020 objective and more than twice as high as that of groups whose rates fall below the national objective. Additionally, in 2014, men had a suicide rate four times greater than that of women in Illinois. The suicide rates among adults were similar across age groups, although the highest rates were among those age 45 to 64.

Behavioral health problems are further reflected in data from Illinois emergency rooms. Between January 1, 2012, and December 31, 2014, there were 110.89 emergency department visits per 10,000 people for behavioral health issues, including mental health, alcohol, and substance abuse problems.[13]

> "It's not only having the providers who are able to properly diagnose those conditions and prescribe the right medications for that person, but it's also having an individual who can walk the journey with them."
>
> **» Focus group participant**

The State Health Assessment (SHA) identified limited access to behavioral health services in specific areas of the state as a barrier, but it also highlighted opportunities to increase access to services. The SHA also found the public health system could improve its performance by assuring care and linking people to care, which would include behavioral health services. An emerging concern was the identification of new resources and alternative strategies for addressing behavioral health.

Illinois' behavioral health infrastructure is in a time of major transition with budget reductions that have been ongoing for at least eight years, shifts in incentives such as managed care expansion, new opportunities in Medicaid, increasing capacity of health departments and community health centers (including federally qualified health centers), and the population shift from uninsured to insured via the Affordable Care Act. However, the State Health Assessment indicated that there are still barriers for vulnerable populations accessing treatment for substance abuse and mental health conditions. Unfortunately, it is unclear exactly how much behavioral health capacity is needed and whether the market will address these gaps.

It is well known that social determinants affect health status and that they must be addressed in order to be holistic in approach. Specifically, research and experience in behavioral health has long recognized the impact of employment and housing on health status. For example:

- Loss of employment can trigger depression, despair, and negative coping behaviors such as substance use. Conversely, attaining employment is well understood as a key to stable recovery for people with mental illness and substance use disorders.
- Lack of decent, affordable housing is a major impediment to healing. Safe, stable, and sober housing is a critical factor in recovery.
- Exposure to violence, either as a victim, witness, or offender, also impacts health status. Domestic violence, gun violence, and other violent experiences generate stress, anxiety, depression, and despair, and often trigger negative coping behaviors.
- Community-wide conditions of poverty, unemployment, and poor housing are increasingly well understood as primary factors in creating poor health status. Behavioral health is heavily impacted by the stress and despair that accompany these situations.

Alleviating the underlying social and economic conditions is beyond the scope of the Behavioral Health Action Team on its own. However, it is recommended that the State Health Improvement Plan Implementation Coordination Council undertake a focused effort to engage the business community, state and local economic and housing development agencies, and advocacy groups to join forces to collectively improve these fundamental social determinants of health.

Action Team Background

The Healthy Illinois 2021 Behavioral Health Action Team, formed to address this priority, was composed of over 25 members representing a diverse array of organizations involved in behavioral health in Illinois, including practicing behavioral health providers, health systems, local public health departments, state associations, community-based organizations, higher education, and consumer advocacy entities. Many had not previously worked together, which resulted in relationship building amid robust conversations on behavioral health issues in Illinois.

The Action Team met five times from December 2015 to early March 2016. The co-chairs, Diana Knaebe, chief, Division of Mental Health at the Illinois Department of Human Services, and Maureen McDonnell, director for Business and Health Care Strategy Development at TASC, Inc. (Treatment Alternatives for Safe Communities), led the group and held weekly calls with each other over an eight-week period to report on and monitor the group's work.

The Action Team further divided into three subgroups to determine goals for the SHIP from a prevention, early intervention, and treatment perspective. The subgroups met individually and together at full team meetings and, in addition to discussing behavioral health issues in Illinois, also reviewed national efforts, such as Healthy People 2020 goals, for reference. This process resulted in a set of six goals, for which corresponding recommended measurable objectives and strategies were developed. Many of the measurable objectives are process related. As monitoring and implementation occurs, reference to and retrieval of data from other sources is recommended because the measures used from the State Health Assessment Core Indicator Summary include those with a focus on suicide and reports of experiencing poor mental health for more than one week per month.

Strategies to address the proposed goals were selected on the basis of the decision criteria for the Healthy Illinois 2021 process, as well as the group's behavioral health knowledge and experience. Action Team recommendations include policy, systems, environmental, and programmatic strategies to address behavioral health improvement. Additionally, there was much discussion on ways to begin working on particular strategies as launch steps that are more specific than those outlined in this document, e.g., identify means to increase awareness among providers and community regarding first-episode intervention programming within the state. This discussion is documented in a separate working document that can be referenced and built upon during implementation, as noted earlier.

BEHAVIORAL HEALTH GOALS

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

IMPLEMENTATION SUCCESS STORY: COMMUNITY ASSETS

The Rationale

Community assets for addressing behavioral health needs exist in health systems, local health departments, health plans, law enforcement, schools, and community behavioral health providers. Building upon the existing system is essential so that problems can be identified early and those in need can have easy access to high-quality services.

To maximize effectiveness, the assets of these potential partners must be garnered for focused, determined, and collaborative action. Such local action can produce important results including, but not limited to, reduction in the initiation of underage drinking and illicit drug use, and reduction in crises such as overdoses, suicide attempts, and emergency department visits.

The Evidence

Several evidence-based community education and capacity building efforts exist, including *Mental Health First Aid; SafeTALK; Question, Persuade, and Refer; Zero Suicide; the Illinois Youth Suicide Prevention Project;* and others. These efforts provide resources and tools that can increase the capacity of community members to effectively respond to others who may be experiencing emotional distress.

The successful use of such efforts requires that all parts of the system be aware they exist, and that they be supported by expert technical assistance and consultation.

The Strategy: Building on Strengths for SHIP Implementation

The Action Team identified several strategies to build upon local action with state-level action:

1. Create local behavioral health planning councils with diverse membership;
2. Ensure universal access to naloxone (NarCan) among first responders and health care providers (as required by HB1/PA 99-0480);
3. *Expand evidence-based community substance abuse prevention coalition efforts such as those that are federally funded;*
4. Survey medical group associations' memberships to identify conditions most relevant for children, adolescents, and adults, as well as integration practices;
5. Submit a request for information (RFI) for a regional training center for primary care provider integrated care;
6. Identify existing funding mechanisms in Illinois for screening and brief intervention; and
7. Develop training curriculum such as the one used in Cherokee Health Systems.[14]

BEHAVIORAL HEALTH: ACTION PLAN RECOMMENDATIONS

Note: Evidence-based or promising practices appear in italics in the Strategies sections.

GOAL 1: Improve the collection, utilization, and sharing of behavioral health-related data in Illinois.

MEASURABLE OBJECTIVE (by 2017):

- A framework for surveillance and planning that is data driven and specific, including proposed approaches for monitoring disparities (race/ethnic, gender, geography, etc.) where possible, is produced and presented to the SHIP ICC.*

  Baseline: TBD | Target: By Jan. 1, 2017

Focus Area: Data

Strategies:

1. Determine which data currently exist on critical behavioral health problems, resources, and assets.
2. Draw on the resources of other state agencies and private associations.
3. Select critical benchmark measures for annual review of existing data.
4. Establish a process for annual review of surveillance/asset data and adjustment of plans and programs to reduce problem prevalence.
5. Determine how to improve data collected over the five-year term of this SHIP.
6. Implement new public health data collection, reporting, and surveillance activities regarding the opiate overdose epidemic as required by HB1 (PA 99-0480).

> "Numbers have an important story to tell. They rely on you to give them a voice."
>
> **» Stephen Few**
> *Author and Data Visualization Expert*

* Asterisk indicates a measure without a baseline. The SHIP Implementation Coordination Council can address measurement as an initial action step for measurable objectives where no baseline is indicated.

GOAL 2: Build upon and improve local system integration.

MEASURABLE OBJECTIVE (by 2017):

- Evidence of new or strengthened partnerships with a wide variety of stakeholders to enhance and support the development of medical and health homes that integrate mental and physical health and wellness across the continuum of services (from prevention through treatment).*

  Baseline: TBD | Target: By Jan. 1, 2017

Focus Area: Local System Integration

Strategies:

1. Encourage the creation of local behavioral health planning councils that include, at a minimum, local health departments, local law enforcement, community health systems including hospitals and physician practices, and local behavioral health providers to develop collaborative action plans.
2. *Expand evidence-based community education/ capacity-building efforts* such as those previously identified so that community members have increased capacity to respond to others who may be experiencing emotional distress with the goal of increasing our community social and emotional intelligence and response.
3. *Expand evidence-based community substance abuse prevention coalition efforts* such as those led/funded through the Office of National Drug Control Policy and the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP), with the Illinois Alcoholism and Drug Dependence Association (IADDA) as a partner.
4. Community-based coalitions should review and select SHIP strategies that they feel most able to jointly implement.
5. Develop Illinois Centers of Behavioral Health Excellence to maximize effectiveness of local efforts through expert technical assistance and consultation.
6. Identify primary care/family practice providers who provide early identification and intervention care. Engage these providers in training efforts focused on other health care providers.
7. Support and expand efforts such as *Community Child Care Connection*, *Nurse-Family Partnership*, *Parents as Teachers*, *infant mental health consultation*, and other initiatives for younger children (aged 0-3).

* Asterisk indicates a measure without a baseline. The SHIP Implementation Coordination Council can address measurement as an initial action step for measurable objectives where no baseline is indicated.

GOAL 3: Reduce deaths due to behavioral health crises.

MEASURABLE OBJECTIVES (by 2021):

- Reduce opioid overdose mortality rate.*

  Baseline: To be obtained from Vital Records | Target: To be obtained from the baseline (20% reduction)

- Reduce age-adjusted suicide rate.

  Baseline: 10.2 per 100,000; State Health Assessment | Target: 8.16 per 100,000 (20% reduction)

- Reduce the number of young adults (aged 18-24) who report experiencing poor mental health for more than one week per month.

  Baseline: To be obtained from Behavioral Risk Factor Surveillance System (BRFSS)
  Target: To be obtained from the baseline (20% reduction)

- Reduce age-adjusted suicide rate among the veteran population.*

  Baseline: TBD | Target: To be obtained from the baseline (20% reduction)

Focus Area: Death Reduction

Strategies:

1. Identify providers who can provide early intervention for people at risk.
2. Provide universal access to naloxone (NarCan) so that first responders, health care providers, law enforcement, and families can mitigate the effects of overdoses.
3. Conduct outreach to those who have attempted suicide and provide education regarding *"warm lines" (peer-run listening lines staffed by people in recovery themselves)* that are available.
4. Expand access to necessary mental health and substance abuse treatment.
5. *Increase the effectiveness of discharge plans for people visiting emergency departments* to prevent future suicide attempts.
6. *Increase the effectiveness of discharge plans for people leaving structured institutional care* (jails, prisons, residential substance abuse treatment sites, and other similar settings), which is a known high-risk period for drug overdoses.
7. Prevent unnecessary exposure to narcotic pain medications.
8. Build the capacity of health plans to manage opiate dependence effectively.

GOAL 4: Improve the opportunity for people to be treated in the community rather than in institutional settings.

MEASURABLE OBJECTIVES (by 2021):

- Reduce emergency department visits, hospitalizations, and incarceration due to behavioral health issues by narrowing the treatment gap and building and sustaining community-based behavioral health treatment capacity.*

  Baseline: TBD | Target: To be obtained from the baseline (25% reduction)

- Leverage partners for united action and opportunity for funding (see Goal 1).*

Focus Area: Treat people in the community rather than in institutions.

Strategies:

1. Build partnerships to focus on narrowing the treatment gap by increasing knowledge of alternative programming in lieu of institutional settings.
2. Invest in a robust community-based system that provides evidence-based behavioral health treatment and supportive services.
3. Establish a high-level working group to develop a detailed plan of action within FY 2016.
4. Review models for effective community care/ readmission prevention currently in use in Illinois hospitals/health systems.
5. Review alternatives to incarceration programs currently in use across Illinois.

* Asterisk indicates a measure without a baseline. The SHIP Implementation Coordination Council can address measurement as an initial action step for measurable objectives where no baseline is indicated.

GOAL 5: Increase behavioral health literacy and decrease stigma.

MEASURABLE OBJECTIVE (by 2021):

- Increase behavioral health literacy and conduct more *Mental Health First Aid trainings* to build community capacity in this area.*

  Baseline: Based on analysis of reports on pre- and post-test results to ascertain current percentage change in knowledge from aggregate | Target: To be obtained from the baseline pre- and post-test results

Focus Area: Increase behavioral health literacy and decrease stigma.

Strategies:

1. Launch a public education campaign aimed at promoting mental health awareness, social and emotional skill building, and resiliency. Build on proven effective campaigns.
2. Develop cross-leadership team for public education campaign development and monitoring.
3. Enlist providers and schools via health or physical education classes.
4. Research mandatory mental health education/ curriculum in schools.
5. Promote and increase awareness of Illinois State Board of Education social and emotional learning standards.

GOAL 6: Improve response to community violence.

MEASURABLE OBJECTIVE (by 2021):

- Increase mental health outreach to communities with the highest rates of violence.*

  Baseline: TBD | Target: TBD

Focus Area: Respond to community violence.

Strategies:

1. Identify communities across Illinois with the heaviest burden of violence.
2. Train community leaders, community-based organizations, spiritual leaders, etc., on *Critical Incident Stress Debriefing (CISD).*
3. Develop crisis response teams, like the Federal Emergency Management Agency's (FEMA) Community Emergency Response Teams (CERTs), which include clergy, community agencies, and health care providers.

CHRONIC DISEASE: BACKGROUND

Definition

Chronic diseases are long-lasting conditions that can be controlled but not cured and affect the worldwide population. Chronic diseases are described by the Centers for Disease Control and Prevention (CDC) as the leading cause of death and disability in the United States. At a national level, chronic diseases are responsible for seven of ten deaths each year, equaling 1.7 million deaths. Additionally, chronic disease treatment accounts for 86% of our nation's health care costs. The CDC includes heart disease, stroke, cancer, diabetes, obesity, and arthritis as some of the most common and costly chronic conditions.

Background

Chronic disease was identified as a health priority by the SHIP Planning Council for several reasons. It was a frequent priority for both local health departments and hospitals identified during the State Health Assessment process. Of 511 priorities raised by 120 not-for-profit hospitals, 152 (or nearly one-third) related to chronic disease or related risk factors. Additionally, the State Health Assessment found that half of the top ten local priorities identified by local health departments related to chronic disease. There is also alignment across many state agencies that chronic disease is a major health priority.

Health indicator data show continued poor health outcomes related to chronic diseases. The two leading causes of death in Illinois are chronic diseases: heart disease and cancer, each accounting for approximately 24,000 deaths in Illinois each year. The subset of deaths due to ischemic heart disease accounts for approximately 13,000 deaths in Illinois annually. The age-adjusted mortality rates for ischemic heart disease and for cancer were each close to the corresponding Healthy People 2020 objectives. However, for each cause of death, the death rates for non-Hispanic blacks in Illinois are higher than the benchmark. Hispanics had lower mortality rates for both heart disease and cancer compared to non-Hispanic blacks and non-Hispanic whites.

In 2014, the percentage of Illinois adults who reported having diabetes was similar to the percentage of adults who reported diabetes nationally, at 10.2% and 9.7% respectively. A higher percentage of both non-Hispanic

blacks (14.0%) and Hispanics (12.7%) reported having diabetes, compared with non-Hispanic whites (9.1%).

Risk factors associated with chronic diseases include but are not limited to obesity, smoking, and lack of physical activity. In 2014, almost one in three Illinoisans were obese. Approximately two of five non-Hispanic black adults were also in this category. Approximately one in five children in Illinois were obese, with closer to one in three non-Hispanic black children in Illinois being in this category.

Smoking is perhaps the most well established risk factor for a wide array of negative health outcomes. Overall, one in six adults in Illinois reported being current smokers in 2014, and one in four non-Hispanic black adults reported smoking. Among pregnant women, smoking rates are lower, but still problematic as approximately 10% of women reported smoking during pregnancy.

Physical activity is recognized as an approach for preventing chronic disease and disability. In 2014, around a quarter of adults in Illinois reported engaging in no physical activity during the past month. Among children, the percentages are lower, but every child should be engaging in at least some vigorous physical exercise.

Action Team Background

The Chronic Disease Action Team included nearly 40 organizational representatives from state, regional, and local agencies from multiple sectors including health care, governmental public health, transportation, nonprofit agencies, and academia to discuss a coordinated Chronic Disease Health Improvement Action Plan. The formation of the SHIP Chronic Disease Action Team represents the first time a statewide collaborative approach was undertaken to address risk factors for multiple chronic diseases with the support and input of multiple agencies.

CHRONIC DISEASE GOALS

1. Increase opportunities for active living
2. Increase opportunities for healthy eating
3. Increase opportunities for tobacco-free living
4. Increase opportunities for community-clinical linkages

The Action Team first convened in December 2015 and held eight meetings. The group also completed two surveys to help gather additional statewide information on existing resources for chronic diseases, prioritize the final risk factors that were then turned into the final action plan goals, and discuss the vision of the group's future. An in-person meeting was held in early February to consider partner organizations' agendas and plans, along with national evidence-based and best practices. Individuals representing statewide or regional organizations presented their prevention agendas. The four goals that were ultimately selected address the primary risk factors associated with chronic disease.

Measurable objectives were selected for each of the goals to ensure the ability to monitor progress over time and were drawn from the State Health Assessment Core Indicator Summary. All outcome measures were selected from the State Health Assessment Core Indicator list. Throughout the process, the group considered initiatives that were already underway throughout the state and looked for existing alignment across organizations. In general, a policy, systems, and environmental (PSE) framework was adopted to recommend comprehensive statewide approaches to address structural issues that impact health as well as promote sustainable change toward health improvement.

Nearly all of the goals also have elements of infrastructure building, and the Action Team agreed to recommend broader public health system infrastructure improvements in the areas of assessment, data sharing and use, training and communication, plan alignment, and evaluation across all areas of the plan.

IMPLEMENTATION SUCCESS STORY: COMPLETE STREETS

The Rationale

Getting regular exercise can reduce the risk of heart disease, diabetes, cancer, injury, and depression.[15] In 2014, around a quarter of adults in Illinois reported engaging in no physical activity in the past month, and over 8 percent of children 6 to 17 reported engaging in no physical activity in the past week that resulted in sweating and breathing hard for at least 20 minutes.[16] Walking or bicycling is an effective way to get regular exercise, but many residents of rural areas lack safe ways to travel to school, work, or errands without a car.[17-19]

The Evidence

To increase physical activity, the CDC's Community Preventive Services Task Force recommends making walking easier through changes to street design and zoning. Complete Streets is a planning and policy approach that provides for the needs of all users in the design of community streets.

Complete Streets projects make community improvements such as adding sidewalks and bicycle lanes that can increase frequency of exercise by 48.4% and promote weight loss when combined with health education.[20, 21] Narrowing traffic lanes and adding bike lanes and trees increase safety for pedestrians by making safe crossing easier and calming traffic.[22, 23]

The Strategy: Building on Strengths for SHIP Implementation

Complete Streets is a well-established strategy in Illinois to increase physical activity and reduce chronic disease risk factors. For example, nearly a quarter million residents were reached with Complete Streets policies or resolutions as a part of the IDPH's WeChooseHealth Initiatives from 2011 to 2014. In addition, the Illinois Department of Transportation (IDOT) and Active Transportation Alliance (ATA), among other partners, continue collaborative work toward implementing Complete Streets policies across the state.

Opportunities for increasing adoption of Complete Streets policies remain, including building on the existing successful work of ATA, IDOT, and other partners. One of the goals established by the Chronic Disease Action Team was to increase opportunities to promote active living by adopting policy, systems, and environmental approaches to increasing physical activity opportunities in the built environment. The Action Team recommends a focus on transportation, to increase opportunities for physically active transportation by promoting robust policies, plans, roadway design, construction, and maintenance practices that accommodate pedestrians, bicyclists, and transit users. A key strategy includes enhancing *new and existing Complete Streets policy adoption and implementation at all levels of government.*

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The Action Team recommended that together ATA, IDOT, and their partners launch action steps including to:

1. Conduct a statewide gap analysis of the proposed intervention;
2. Consider key priority communities based on interest and need (but acknowledge resource issues and time);
3. Explore partnerships with metropolitan planning agencies, state government, nonprofits, schools, academic centers, and others to undertake the work;
4. Promote awareness building through existing communications (e.g., IDPH, IAPO, IPHA, CMAP);
5. Explore ways to integrate and align training and education opportunities into existing activities and/or offer low-cost training options;
6. Research ways to integrate plans to align shared goals and initiatives (such as the State Bicycle Transportation Plan); and
7. Develop shared funding agendas for collaborative work.

Complete Streets is a well-established strategy in Illinois to increase physical activity and reduce chronic disease risk factors.

CHRONIC DISEASE: ACTION PLAN RECOMMENDATIONS

Note: Evidence-based or promising practices appear in italics in the Strategies sections.

GOAL 1: Increase opportunities for tobacco-free living.

MEASURABLE OBJECTIVES (by 2021):

- Reduce the percentage of Illinois adults reporting smoking.

  Baseline: 16.7% Illinois overall; BRFSS | Target: 15.4% (5% reduction)

- Reduce the rate of age-adjusted ischemic heart disease mortality.

  Baseline: 91.5 per 100,000; Vital Records | Target: 87 per 100,000 (5% reduction)

Focus Area 1: Adopt comprehensive tobacco control programs.

Strategies:

1. Acquire funding for statewide evidence-based and best practices for tobacco prevention and cessation efforts.
2. Maintain funding for the *Illinois Tobacco Quitline.*
3. Enhance enforcement of the *Smoke-Free Illinois Act.*
4. Implement a grassroots campaign to encourage adults to stop smoking in cars with minors.
5. Implement health communication tools to de-normalize smoking.
6. Increase the number of smoke-free schools, hospitals, and housing units.
7. Enhance participation in the *Youth Tobacco Survey* at the local level.

Focus Area 2: Pursue passage of state and local legislation that would raise Illinois' legal age to purchase tobacco products from 18 to 21.

Strategies:

1. Advocate passage of a Tobacco 21 law in Illinois.
2. Conduct media advocacy by leveraging media and messaging in support of passing the Tobacco 21 law.
3. Highlight *Tobacco 21* initiatives at the local level.

Focus Area 3: Promote fiscal strategies that decrease the consumption of tobacco products.

Strategies:

1. Raise cigarette taxes statewide (excluding the City of Chicago) by $1.
2. Introduce legislation to increase and create equal taxation on all types of tobacco, e-cigarettes, and tobacco-derived products.
3. Eliminate discounts for tobacco products.
4. Address issues of tax evasion, smuggling, and counterfeit products.
5. Reduce the sale of single cigarettes (loosies).

> "Tobacco tax increases are one of the most effective ways to reduce smoking and other tobacco use, especially among kids. Every 10 percent increase in cigarette prices reduces youth smoking by about seven percent and total cigarette consumption by about four percent."
> **» Tobacco-Free Kids**

GOAL 2: Increase opportunities for healthy eating.

MEASURABLE OBJECTIVES (by 2021):

- Reduce the percentage of obesity among children ages 10-17.

  Baseline: 19.3% for Illinois overall; National Survey of Children's Health | Target: 18.3% (5% reduction)

- Reduce the percentage of obesity among adults.

  Baseline: 29.5% for Illinois overall; BRFSS | Target: 28.0% (5% reduction)

- Reduce the percentage of adults reporting diabetes.

  Baseline: 10.2% for Illinois overall; BRFSS | Target: 9.7% (5% reduction)

- Reduce the rate of emergency department discharges for type 2 diabetes.

  Baseline: 288 per 10,000; Hospital Discharge Data | Target: 273.6 per 10,000 (5% reduction)

- Reduce the rate of age-adjusted ischemic heart disease mortality (same as for Chronic Disease, Goal 1).

  Baseline: 91.5 per 100,000; Vital Records | Target: 87 per 100,000 (5% reduction)

Focus Area 1: Pursue passage of state and local legislation which would create a penny-per-ounce excise tax on sugar sweetened beverages. Ensure that revenue generated by this tax is dedicated to health, obesity prevention, and Medicaid funding.

Strategies:

1. Create a penny-per-ounce excise tax on sugar-sweetened beverages, to be paid by beverage distributors, including manufacturers and bottlers.
2. Create a dedicated Wellness Fund into which sugar-sweetened beverage tax revenues would be deposited. Allocate the Wellness Fund to healthy eating and active living efforts and to Medicaid. Allocate a portion of the revenue for Medicaid to community-clinical linkages and the remainder to supporting current Medicaid services, thus helping to address the state budget shortfall.
3. Create a public oversight body composed of chronic disease, healthy eating, and active living experts and stakeholders to prioritize, plan, and oversee the spending of the healthy eating and active living Wellness Fund resources.
4. Promote educational campaigns to inform the public about the health problems associated with sugar-sweetened beverage consumption, such as a statewide Rethink Your Drink campaign in schools.
5. Engage in the existing campaign to pass the Healthy Eating Active Living (HEAL) Act, which has a strong coalition and several years of campaign efforts behind it. Expand community engagement efforts including key stakeholders, community groups, and champions.
6. Continue to include sugar-sweetened beverage and water consumption questions in BRFSS.

Focus Area 2: Increase access to affordable healthy food.

Strategies:

1. Conduct environmental scans of produce pricing in different communities with an emphasis on low-income neighborhoods. Analyze and report on the results.
2. Convene stakeholders and partners to advance healthier food retail efforts.
3. Promote farmers markets across the state, particularly in underserved areas.
4. Promote incentives and zoning to attract supermarkets that carry fresh produce to areas where availability is low.
5. Promote Healthy Corner Store initiatives.
6. Support and promote community, school, and neighborhood gardens.
7. Improve quality of public school lunch standards.
8. Promote usage of food stamps for purchasing healthy foods.

   8a. Create a double-bucks incentive program matching funds for Supplemental Nutrition Assistance Program (SNAP) purchases at farmers markets.

   8b. Grow the use of SNAP benefits and incentive programs at farmers markets to increase retail options open to food-insecure customers.
9. Establish other areas of funding for healthier food retail.

Focus Area 3: Decrease access to unhealthy food.

Strategies:

1. Create procurement policies that encourage reductions in the availability of unhealthy food in vending machines in publicly owned buildings, schools, and health care facilities.
2. Implement environmental scans in hospitals, large worksites, and university cafeterias and vending areas.
3. Increase the number of private and public businesses and other places that adopt standards for healthy food and beverages.
4. Implement a statewide marketing policy for unhealthy foods and beverages.
5. Modify the built environment to decrease access to unhealthy foods.
6. Promote healthy worksites (see Goal 1, Focus Area 3).
7. Modify the built environment in grocery stores.

Focus Area 4: Enhance communication approaches to providing accurate and identifiable information about healthy eating to diverse populations.

Strategies:

1. Enhance the Food Labeling Program.
2. Provide nutrition labeling around school, hospital, and worksite cafeterias and in vending areas.
3. Incorporate nutrition education at each health care visit.
4. Require and provide funding for nutrition education in public schools for children and families.
5. Promote adoption of an evidence-based cooking class program.
6. Promote healthy eating programs and advertisements aimed at specific target populations.
7. Convene a collective of diverse chronic disease-related interest groups to circulate common messages and call for unified action.
8. Implement national/state campaigns on healthy choices through public service announcements.
9. Promote local healthy eating behavior programs.
10. Use proven marketing techniques to promote healthier foods.

GOAL 3: Increase opportunities for active living.

MEASURABLE OBJECTIVES (by 2021):

- Reduce the percentage of Illinois adults reporting no physical activity in the last 30 days.

  Baseline: 24% for Illinois overall; BRFSS | Target: 22.8 (5% reduction)

- Reduce the percentage of Illinois children who report not engaging in vigorous physical activity.

  Baseline: 8% for Illinois overall; National Survey of Children's Health | Target: 7.6% (5% reduction)

- Reduce the percentage of adults reporting diabetes (same as for Chronic Disease, Goal 2).

  Baseline: 10.2% for Illinois overall; BRFSS | Target: 9.7% (5% reduction)

- Reduce the rate of emergency department discharges for type 2 diabetes (same as for Chronic Disease, Goal 2).

  Baseline: 288 per 10,000; Hospital Discharge Data | Target: 273.6 per 10,000 (5% reduction)

- Reduce the rate of age-adjusted ischemic heart disease mortality (same as for Chronic Disease, Goals 1 and 2).

  Baseline: 91.5 per 100,000; Vital Records | Target: 87 per 100,000 (5% reduction)

Focus Area 1: Adopt policy, systems, and environmental (PSE) approaches to increasing physical activity opportunities in the built environment.

Strategies:

1. Build and maintain bikeway and walkway systems that are integrated with other transportation systems to improve continuity and connectivity.
2. Enhance new and existing *Complete Streets* policy adoption and implementation at all levels of government.
3. Encourage the adoption and implementation of pedestrian and bicycle master plans.
4. Promote the integration of health impact assessments into transportation and development decisions.
5. Pursue joint-use agreements for opening playgrounds, gymnasiums, and recreational facilities and promote their use.
6. Improve recreation areas and other aspects of the physical environment to improve aesthetics and safety.
7. Promote "smart growth" land use principles and practices through local and regional development policies and plans, zoning codes, and other mechanisms.
8. Assess the proximity of residential areas to stores, jobs, schools, and recreation areas.
9. Increase and reform transportation funding programs that support walking, bicycling, and public transit projects.
10. Develop a communications agenda to promote active living strategies.
11. Develop a training agenda for active living strategies to align resources and integrate training opportunities.
12. Align similar plans for active living strategies to integrate and implement, where possible, shared strategies.
13. Engage local health directors and boards of health to participate in local and regional transportation planning.
14. Engage network of possible nonprofit partners in Illinois, many of which support healthy living initiatives.

Focus Area 2: Increase physical activity opportunities for children ages 0-18.

Strategies:

1. Promote physical activity in children ages 0-5.
2. Promote the *CDC's Whole School, Whole Community, Whole Child model.*
3. Create a regional message environment to promote clarity and consistency of health promotion and public education for nutrition, physical activity, and screen time for children.
4. Expand statewide physical activity strategies in partnership with organizations that serve or influence children.
5. Increase *Safe Routes to School initiatives* across the state.
6. Decrease the number of physical education waivers that are granted to schools.
7. Protect Illinois elementary and secondary school physical education requirements.
8. Promote minimum requirements for physical activity for children to include 150 minutes of instructional physical education for elementary school children and 225 minutes for middle and high school students per week for the entire school year.
9. Promote the utilization of the *Comprehensive School Physical Activity* Program *(CSPAP)* within Illinois schools.
10. Encourage the Illinois State Board of Education to provide designated funding to schools to meet the state mandate for daily physical education.
11. Support the Stakeholder and Expert Task Force on Physical Education recommendations on professional development.
12. Support the Stakeholder and Expert Task Force on Physical Education recommendations to develop methodologies and tools for a statewide data system to correlate with other available data (attendance, academic performance, behavior, etc.) and use fitness scores to determine a plan of action for improving physical education programs in order to create the most benefits for academics, behavior, and health.

Focus Area 3: Increase the number of organizations in business, health care, and government that will improve their wellness approaches through policy, systems, and environmental change by increasing opportunities to access at least one of the following: 1) water, 2) healthy food vending, 3) physical activity, 4) health promotion programs including healthy eating and tobacco-free living, and 5) benefit/deductible savings.

Strategies:

1. Increase adoption of worksite wellness policies including but not limited to general worksite wellness, smoke-free/tobacco-free, physical activity, healthy food and vending, breastfeeding, and benefit/deductible saving policies.
2. Implement an incentive program to promote adoption of wellness policies and programs in schools, hospitals, and businesses.

GOAL 4: Increase community-clinical linkages to reduce chronic diseases.

MEASURABLE OBJECTIVES (by 2021):

- Reduce the percentage of adults reporting diabetes (same as for Chronic Disease, Goals 2 and 3).

  Baseline: 10.2% for Illinois overall; BRFSS | Target: 9.7% (5% reduction)

- Reduce the rate of emergency department discharges for type 2 diabetes (same as for Chronic Disease, Goals 2 and 3).

  Baseline: 288 per 10,000; Hospital Discharge Data | Target: 273.6 per 10,000 (5% reduction)

- Reduce the rate of age-adjusted ischemic heart disease mortality (same as for Chronic Disease, Goals 1-3).

  Baseline: 91.5 per 100,000; Vital Records | Target: 87 per 100,000 (5% reduction)

Focus Area 1: Increase community-clinical linkages to prevent and manage chronic disease.

Strategies:

1. Reduce sodium intake through sodium reduction policy initiatives, e.g., restaurant menu labeling.
2. Implement home-based, multi-trigger, multi-component environmental interventions for children and adolescents.
3. Increase the availability of evidence-based smoking cessation programs such as the *Illinois Tobacco Quitline, Freedom From Smoking, and Courage to Quit.*
4. Strengthen community health worker training and education in chronic disease management.
5. Expand self-management programs like the *Chronic Disease Self-Management Program, the Asthma Self-Management Education Program, and the National Diabetes Prevention Program*, and ensure that those types of programs are implemented in communities with a high burden of chronic disease.
6. Reduce out-of-pocket costs to increase preventive screenings for chronic diseases.
7. Promote reimbursement for care coordination services.
8. Promote Medicaid and other insurance reimbursement for community-based lifestyle change programs such as *the Diabetes Prevention Program, the Chronic Disease Self-Management Program, MEND, and the Chronic Diabetes Self-Management Program.*
9. Assess lessons learned and the feasibility of expansion of best practices for the Illinois Community Health and Aging Collaborative, specifically Pathways to Health, as a model partnership for community-clinical linkage activities.

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10. Explore governmental public health, clinical providers, and other stakeholder facilitators and barriers for community-clinical linkages for preventative activities at the statewide level.

11. Increase data sharing and use between and among clinical and nonclinical partners as a means to identify and monitor health outcomes, identify appropriate clinical and community interventions, and assess and evaluate impact.

12. Integrate food insecurity screening and referral systems in clinical settings.

MATERNAL AND CHILD HEALTH: BACKGROUND

Definition

Maternal and child health (MCH) focuses on six population health domains: 1) women/maternal health; 2) perinatal/infant health; 3) child health; 4) children with special health care needs; 5) adolescent health; and 6) cross-cutting or life course. Work in this area seeks to improve access to health care and delivery of quality public health services to women and children.

Background

MCH was identified as a preliminary priority by the Planning Council and subsequently reinforced through the stakeholder engagement process across the state. During the State Health Assessment stakeholder engagement process, it became evident that organizations are already addressing MCH issues through the services they provide and the populations they serve. Focus group participants noted that there is a need "to coordinate with [agencies] and make sure sound public health policies are in sync with Medicaid, WIC, and SNAP." It was also suggested that community-based approaches should be assessed and used to address maternal mortality.

Several health status indicators reinforce the selection of MCH as a priority. In 2014, for example, although infant mortality rates in Illinois were better than the national objective for non-Hispanic whites, Hispanics, and non-Hispanics, the mortality rate for non-Hispanic black infants was approximately three times higher. Although the child mortality rates in Illinois were better than the Healthy People 2020 objective, the pattern over time looks similar to that for infant mortality, with persistent disparities between non-Hispanic blacks and all other racial/ethnic groups.

Maternal mortality is very rare but, like infant mortality, is monitored worldwide as a reflection of the overall health of a society. Historically, maternal deaths resulting directly from medical complications of pregnancy have been monitored, but it is becoming more typical to also document all deaths of women occurring within one year following pregnancy. In 2013, 19 Illinois women died from causes related to pregnancy itself, and a total of 54 Illinois women died within one year of giving birth from all causes combined.

Large disparities exist between non-Hispanic blacks and non-Hispanic whites, and also between Hispanics and non-Hispanic whites, with respect to maternal death due to medical causes related to pregnancy itself. Only the rate for non-Hispanic whites meets the Healthy People 2020 benchmark. The disparities also exist, though to a lesser extent, when any cause of death within one year of pregnancy is considered.

Pregnant women with severe maternal morbidity are women with potentially life-threatening conditions related to their pregnancy. Non-Hispanic black women have higher rates of severe maternal morbidity than other racial/ethnic groups, but only the rate for non-Hispanic white women in Illinois meets the Healthy People 2020 benchmark. No improvement occurred between 2010 and 2014 in the rate of severe maternal mortality or in the racial/ethnic disparities. Variation in rates of severe maternal morbidity across Illinois may be related to access to care or quality of care.

Approximately one in twelve infants born in Illinois are low birthweight, a risk factor for infant death as well as other health problems in surviving infants. Although the rates for non-Hispanic white and Hispanic women met the Healthy People 2020 objective in 2013, the rates for non-Hispanic black and other non-Hispanic women did not. Almost one in seven non-Hispanic black pregnant women delivered a low-birthweight infant in 2013.

Action Team Background

The Maternal and Child Health Action Team included 20 active members representing academia, local health departments, community-based organizations, insurance companies, and state agencies. The Action Team held ten meetings, the majority of which were conference calls, culminating with an in-person meeting in March. Weekly calls were also held with the co-chairs of this group to discuss meeting and process design.

The Maternal and Child Health Action Team grounded their work by reviewing a recent federally mandated, comprehensive needs assessment conducted for the MCH Title V program. In 2015, this statewide needs assessment identified ten priority areas for the Title V program that addressed the range of MCH population health domains. Building on existing efforts, consistent with the Healthy Illinois 2021 process, the Team selected priorities by reviewing the priorities that emerged from the Title V needs assessment

The four goals that were ultimately selected represent areas where work for the Title V program could be leveraged or where implementation gaps existed. The team used the Healthy Illinois 2021 planning process as an opportunity to dive deeper into the Title V priorities, particularly in identifying activities needed to begin implementing strategies. The groups discussed focusing on the areas of greatest impact for this process as a way to narrow down the ten Title V priorities and select the Healthy Illinois 2021 focus areas. The group also noted that all the original priorities would continue to be focus areas of IDPH's Title V program and this set of goals was a chance to elevate particular issues.

For each of the goals, health or process measurable objectives were selected to ensure the ability to monitor progress over time. The outcome measures were selected from the State Health Assessment Core Indicator Summary or the Illinois Maternal and Child Health Databook (a central piece of the comprehensive needs assessment) whenever possible. The group discussed including baseline racial and ethnic data with the measure to ensure a focus on disparities as progress is monitored in these areas. Where possible, this information is included.

Strategies to address these goals were selected on the basis of the expertise of the group, taking into consideration the decision criteria for the Healthy Illinois 2021 process. Action Team recommendations include policy, systems, environmental, and programmatic strategies to address health improvement in MCH as well as strategies to increase MCH capacity. A variety of activities that are more specific than the strategies referenced in this document were discussed as ways to begin working on particular strategies. For example:

- **Goal 1:** Design continuing education around MCH concepts, increase enrollment into programs to ensure that children access ongoing healthcare, and conduct a *Well-Woman Campaign.*
- **Goal 2:** Promote increasing the duration of breastfeeding to the 6-month mark, expand on the policy work of school-based health centers related to pregnancy and birth outcomes, promote preventive medical visits for women of reproductive age, and ensure that providers discuss with mothers key concepts such as birth spacing, family planning, and contraception education.
- **Goal 3:** Utilize the online health equity toolkit developed through the work of the Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality, and identify grant programs in which expansion of requirements for demonstrating the use of an equity assessment would be appropriate.
- **Goal 4:** Establish interagency partnerships to discuss data-sharing needs and barriers and leverage public health and epidemiology training programs to improve analytic capacity and develop the epidemiology workforce (e.g., CSTE fellowship, EIS officers, graduate students at the UIC School of Public Health).

MATERNAL AND CHILD HEALTH GOALS

1. Assure accessibility, availability, and quality of preventive and primary care for all women, adolescents, and children, including children with special health care needs, with a focus on integration of services through patient-centered medical homes
2. Support healthy pregnancies and improve birth and infant outcomes
3. Ensure that equity is the foundation of all MCH decision making; eliminate disparities in MCH outcomes
4. Strengthen data systems, infrastructure, and capacity relevant to MCH

IMPLEMENTATION SUCCESS STORY: IMPROVING QUALITY AND ACCESS TO CARE ACROSS THE REPRODUCTIVE AND PERINATAL CONTINUUM

The Rationale

Several issues related to reproductive and perinatal health, such as the rising rates of maternal mortality, stagnant rates of infant mortality, high proportions of preterm and low-birthweight births, and continuing disparities in pregnancy outcomes in the United States, have led states to focus on health risks faced by women of childbearing age.[24] Addressing these issues is a focus for improving quality and access to care across the continuum.

The Evidence

In order to increase quality and access to care, several steps have been identified as critical to implementation that take into account national guidelines and best practices from other states. For example, a recommendation by the Maternal and Child Health Action Team is to increase access to early and adequate quality prenatal care as defined by American Congress of Obstetricians and Gynecologists guidelines. Additionally, other states are launching statewide programs to identify women with prior preterm birth and improve access to, education about, and utilization of 17-hydroxyprogesterone (17-OHP) for women with prior preterm birth.

The Strategy

There are several opportunities to strengthen work around improving quality and access to MCH services. The Maternal and Child Health Action Team recommends building on the work of the Children's Health Insurance Program Reauthorization Act (CHIPRA) program that developed an online perinatal toolkit for dissemination in Illinois. The Healthy Choices, Healthy Futures Perinatal Education Toolkit for providers was created through partnership with numerous MCH stakeholders. It provides information and resources for providers of women during preconception, prenatal, postpartum, and interconceptive care and can be promoted broadly across Illinois as a mechanism to increase quality of and access to care. Another recommended activity is to identify community ambassadors, home visiting/doula programs, and community health workers that can assist in referring patients to services and promote follow-up for mothers and children at risk of poor health outcomes. Strong community health worker programs and networks exist and could be leveraged to promote these activities.

MATERNAL AND CHILD HEALTH: ACTION PLAN RECOMMENDATIONS

Note: Evidence-based or promising practices appear in italics in the Strategies sections.

GOAL 1: Assure accessibility, availability, and quality of preventive and primary care for all women, adolescents, and children, including children with special health care needs, with a focus on integration, linkage, and continuity of services through patient-centered medical homes.

MEASURABLE OBJECTIVES (by 2021):

- Implement reimbursement of medical homes and necessary supportive infrastructure.*
- Increase the number of primary care practice sites certified by the National Committee for Quality Assurance, URAC, or the Joint Commission.

  Baseline: 3,495 | Target: 4,550 (30% increase)
- Increase the proportion of children who have a medical home.

  Baseline: 56%; 2011-12 National Survey of Children's Health | Target: 61.6% (10% increase)
- Increase the proportion of women of reproductive age (18-44 years old) who completed a medical visit for preventive care in the last year.

  Baseline: 61.9%; BRFSS | Target: 68.1 (10% increase)

Focus Area 1: Implement quality standards, performance measures, 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.

Strategies:

1. Collect evidence-based practices regarding the definition, measurement, and reimbursement of *patient-centered medical homes (PCMH).*
2. Convene state and federal, public and private, managed care and fee-for-service payer organizations to develop support for increasing the use of PCMH.
3. Conduct a Medicaid demonstration project to test cost savings related to PCMH.
4. Implement PCMH reimbursement through private insurance plans.

* Asterisk indicates a measure without a baseline. The SHIP Implementation Coordination Council can address measurement as an initial action step for measurable objectives where no baseline is indicated.

Focus Area 2: Engage providers in understanding how to provide a medical home.

Strategies:

1. Organize providers by leveraging provider organizations.
2. Increase provider education.
3. Adopt a policy framework.
4. Establish mechanisms for providers to receive financial and other supports for progress toward full PCMH certification.
5. Promote certification of practices by accreditation organizations.
6. Implement PCMH model practices in primary care residency programs.

Focus Area 3: Promote understanding of the benefits of medical homes among consumers and families.

Strategies:

1. Engage consumers in the formulation of PCMH policy.
2. Promote utilization of PCMH, especially by women, infants, children, and adolescents, including children with special health care needs (CSHCN).

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

MEASURABLE OBJECTIVES (by 2021):

- Reduce preterm birth, including a focus on disparities.

  Baseline: 11.7% for Illinois overall | Target: 10.5% (10% reduction)

- Reduce the rate of maternal mortality, prioritizing populations impacted by health disparities, to meet the Healthy People 2020 objective.

  Baseline: 12.1 per 100,000 for Illinois overall, 18.6 per 100,000 for non-Hispanic blacks, 10.4 per 100,000 for non-Hispanic whites, and 15.0 per 100,000 for Hispanics; Vital Records Target: 11.4 deaths per 100,000 live births

- Reduce the rate of all infant deaths (within 1 year of birth) to meet the Healthy People 2020 objective.

  Baseline: 6.2 per 1,000 for Illinois overall, 4.4 per 1,000 for non-Hispanic whites, 12.2 per 1,000 for non-Hispanic blacks, 5.8 per 1,000 for Hispanics, 4.1 per 1,000 for Asians/Pacific Islanders; Vital Records | Target: 6.0 per 1,000 births

Strategies:

1. Increase quality of and access to care across the reproductive and perinatal continuum.
2. Improve navigation from prenatal care to postpartum care to primary care.
3. Identify high-risk mothers at initiation of prenatal care and at delivery for additional services, support, and navigation.
4. Reduce infant mortality by leveraging *existing programs* and clinical opportunities.
5. Expand access to *highly effective contraception*.

GOAL 3: Assure that equity is the foundation of all maternal and child health (MCH) decision making; eliminate disparities in MCH outcomes.

MEASURABLE OBJECTIVES (by 2021):

- Complete an equity self-assessment.

  Baseline: NA | Target: IDPH and at least 10 local health departments

- Launch training on the use of the health equity toolkit to increase the number of local health departments that utilize a health equity approach in their planning.*

- Launch training on the use of the health equity toolkit to increase the number of state agencies that report the use of a health equity approach in their needs assessments or annual reports.*

Focus Area 1: Complete an assessment of state and local health departments' use of equity as a foundation or frame in decision making.

Strategies:

1. Establish partnerships for implementation of equity assessment.
2. Expand requirements for describing disparities in grants/proposals to demonstrate use of assessment; when appropriate, link funding awards to demonstration of completion and use of the tool.

Focus Area 2: Ensure that state agencies and organizational partners are promoting health equity in all policies and are aligned in their approach.

Strategies:

1. Promote training resources on life course, health equity, and social determinants of health to members of boards/groups working on MCH issues.
2. Provide training to local MCH programs on the health equity approach and use of an equity lens by engaging the IDPH health equity team.
3. Promote state agencies' incorporation of a health equity focus as part of funding opportunities.
4. Identify and leverage efforts in which grant programs already exist to promote use of this model.

* Asterisk indicates a measure without a baseline. The SHIP Implementation Coordination Council can address measurement as an initial action step for measurable objectives where no baseline is indicated.

GOAL 4: Strengthen public health data systems, infrastructure, and capacity through unified statewide planning and leadership.

MEASURABLE OBJECTIVES (by 2021):

- IDPH will convene a statewide public health data strategy committee, composed of internal and external stakeholders, to assess the data landscape and develop priorities for system-wide improvement.

  Baseline: NA | Target: By Jan. 1, 2017, at least two meetings held

- Data linkages will be implemented and routinely accomplished on an annual basis.

  Baseline: NA | Target: 5 new data linkages

- IDPH will increase the number of interns, fellows, EIS officers, and other public health trainees in epidemiology supported by the department.*

  Baseline: TBD | Target: 10% increase

- IDPH will increase the number of public health indicators available on public data query systems.*

  Baseline: TBD | Target: 20% increase

- IDPH will add a data resource list to the public website.*

Focus Area 1: Improve the overall approach to data systems, infrastructure, and capacity.

Strategies:

1. Establish a statewide data strategy committee.

Focus Area 2: Improve data infrastructure and systems, including improving accuracy, timeliness, and quality of data.

Strategies:

1. Establish routine data linkages to examine health across the lifespan.
2. Expand data collection on MCH populations.
3. Produce a complete set of finalized vital records data files before the end of the following calendar year.
4. Support efforts to sustain improvements in birth certificate accuracy.
5. Ensure that data on children with special health care needs (CSHCN) are routinely included and updated in state data sets.

Focus Area 3: Strengthen capacity for data analysis and reporting.

Strategies:

1. Prioritize and develop an agenda for internal data analysis activities.
2. Promote partnerships to enhance capacity for analysis.
3. Create a streamlined process for allowing stakeholders to request and use public data sets.
4. Facilitate data sharing and collaboration across agencies.
5. Enhance training and workforce development opportunities for analytic staff.

Focus Area 4: Improve reporting and dissemination of public health data.

Strategies:

1. Develop reporting approaches to promote consistency across internal and external reports, such as approaches for reporting racial/ethnic disparities, geographic variation, and trend data.
2. Enhance IDPH web-based portals (e.g., IQuery, community health map/hospital report card) for timely dissemination of public health data.
3. Increase awareness of existing web-based data reports, query systems, and portals.

CONCLUSION AND NEXT STEPS:

FROM PLANNING TO ACTION

LESSONS LEARNED

During the course of the SHIP planning process, several lessons were learned about the function of this plan. For instance, the systems of preventive and clinical care often still operate separately, making the work to integrate these systems difficult. Another challenge is a tendency to focus on health issues as opposed to system issues or structural issues that often require a longer view. Addressing structural factors such as the social determinants of health requires time, resources, and dedication. It also takes time to build collaborative groups, both for the guidance of a planning process and for action or implementation planning, alongside overall coordination of the entire process. Further, taking full advantage of the rich data sources available in the state in order to understand and monitor progress requires a more integrated approach to data use than is currently in place.

Nonetheless, the asset-based approach taken in this planning process resonated with many planning participants, and created an opportunity for connectivity, alignment, and action. The planning process also allowed groups to focus more on implementation. For example, where strategies were already proposed or even underway in at least one part of the state, this approach allowed stakeholders to focus on what would be needed to put them into action statewide. Finally, the process was an opportunity to build awareness around the health priorities and strategies to address the priorities.

The State Health Improvement Plan is a living document and is intended to be monitored and built on during the duration of the plan. The goals, objectives, and strategies are an important starting point for work toward addressing the health priorities. The recommendations should be used for implementation, but reflection and improvement is encouraged. The SHIP should be used by public health system partners as overarching statewide goals and objectives for health improvement in priority areas with which organizations can align their work, or that partners can use to identify strategies and practices for their own health improvement efforts.

Next Steps

Recommendations for next steps have been described throughout the document. The most pressing areas for consideration by the State Health Improvement Plan Implementation Coordination Council include:

1. Developing a framework for plan implementation, including development of roles and responsibilities for implementation leadership, coordination, action, and monitoring and evaluation
2. Developing an action plan specifically to address the social determinants of health
3. Prioritizing recommendations made by the Action Teams
4. Implementing a framework for improving data infrastructure, analysis, dissemination, and use

In the next phase of the collective movement toward health improvement, a commitment to changing the health of Illinois residents is needed from all partners in the public health system. William Pollard, renowned physicist and Episcopal priest, said, "Without change there is no innovation, creativity, or incentive for improvement." Now is the time to direct our energy toward innovation that results in healthier, more equitable communities across Illinois.

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APPENDIX:
MEASURABLE OBJECTIVES LIST

HEALTHY ILLINOIS 2021 MEASURABLE OBJECTIVES

BEHAVIORAL HEALTH ACTION TEAM MEASURES

Goal	Measurable Objectives	Baseline	Target *(by 2021 unless otherwise noted)*
GOAL 1: Improve the collection, utilization, and sharing of behavioral health-related data in Illinois.	A framework for surveillance and planning that is data-driven and specific, including proposed approaches for monitoring disparities (race/ethnic, gender, geography, etc.) where possible, is produced and presented to the SHIP ICC.	TBD	By Jan. 1, 2017
GOAL 2: Build upon and improve local system integration.	Evidence of new or strengthened partnerships with a wide variety of stakeholders to enhance and support the development of medical and health homes that integrate mental and physical health and wellness across the continuum of services (from prevention through treatment).	TBD	By Jan. 1, 2017
GOAL 3: Reduce deaths due to behavioral health crises.	Reduce opioid overdose mortality rate.	To be obtained from Vital Records	To be obtained from the baseline (20% reduction)
	Reduce age-adjusted suicide rate.	10.2 per 100,000; State Health Assessment	8.16 per 100,000 (20% reduction)
	Reduce the number of young adults (aged 18-24) who report experiencing poor mental health for more than one week per month.	To be obtained from Behavioral Risk Factor Surveillance System (BRFSS)	To be obtained from the baseline (20% reduction)
	Reduce suicide rate among the veteran population.	TBD	To be obtained from the baseline (20% reduction)
GOAL 4: Improve the opportunity for people to be treated in the community rather than in institutional settings.	Reduce emergency department visits, hospitalizations, and incarceration due to behavioral health issues by narrowing the treatment gap and building and sustaining community-based behavioral health treatment capacity.	TBD	To be obtained from the baseline (25% reduction)
	Leverage partners for united action and opportunity for funding.		
GOAL 5: Increase behavioral health literacy and decrease stigma.	Increase behavioral health literacy and conduct more Mental Health First Aid trainings to build community capacity in this area.	Based on analysis of reports on pre- and post-test results to ascertain current percentage change in knowledge from aggregate	To be obtained from the baseline pre- and post-test results
GOAL 6: Improve response to community violence.	Increase mental health outreach to communities with the highest rates of violence.	TBD	TBD

CHRONIC DISEASE ACTION TEAM MEASURES

Goal	Measurable Objectives	Baseline	Target *(by 2021 unless otherwise noted)*
GOAL 1: Increase opportunities for tobacco-free living.	Reduce the percentage of Illinois adults reporting smoking.	16.7% Illinois overall; BRFSS	15.4% (5% reduction)
	Reduce the rate of age-adjusted ischemic heart disease mortality.	91.5 per 100,000; Vital Records	87 per 100,000 (5% reduction)
GOAL 2: Increase opportunities for healthy eating.	Reduce the percentage of obesity among children ages 10-17.	19.3% for Illinois overall; National Survey of Children's Health	18.3% (5% reduction)
	Reduce the percentage of obesity among adults.	29.5% for Illinois overall; BRFSS	28.0% (5% reduction)
	Reduce the percentage of adults reporting diabetes.	10.2% for Illinois overall; BRFSS	9.7% (5% reduction)
	Reduce the rate of emergency department discharges for type 2 diabetes.	288 per 10,000; Hospital Discharge Data	273.6 per 10,000 (5% reduction)
	Reduce the rate of age-adjusted ischemic heart disease mortality.	91.5 per 100,000; Vital Records	87 per 100,000 (5% reduction)
GOAL 3: Increase opportunities for active living.	Reduce the percentage of Illinois adults reporting no physical activity in the last 30 days.	24% for Illinois overall; BRFSS	22.8 (5% reduction)
	Reduce the percentage of Illinois children who report not engaging in vigorous physical activity.	8% for Illinois overall; National Survey of Children's Health	7.6% (5% reduction)
	Reduce the percentage of adults reporting diabetes.	10.2% for Illinois overall; BRFSS	9.7% (5% reduction)
	Reduce the rate of emergency department discharges for type 2 diabetes.	288 per 10,000; Hospital Discharge Data	273.6 per 10,000 (5% reduction)
	Reduce the rate of age-adjusted ischemic heart disease mortality.	91.5 per 100,000; Vital Records	87 per 100,000 (5% reduction)
GOAL 4: Increase community-clinical linkages to reduce chronic diseases.	Reduce the percentage of adults reporting diabetes.	10.2% for Illinois overall; BRFSS	9.7% (5% reduction)
	Reduce the rate of emergency department discharges for type 2 diabetes.	288 per 10,000; Hospital Discharge Data	273.6 per 10,000 (5% reduction)
	Reduce the rate of age-adjusted ischemic heart disease mortality.	91.5 per 100,000; Vital Records	87 per 100,000 (5% reduction)

MATERNAL AND CHILD HEALTH ACTION TEAM MEASURES

Goal	Measurable Objectives	Baseline	Target *(by 2021 unless otherwise noted)*
GOAL 1: Assure accessibility, availability, and quality of preventive and primary care for all women, adolescents, and children, including children with special health care needs, with a focus on integration, linkage, and continuity of services through patient-centered medical homes.	Implement reimbursement of medical homes and necessary supportive infrastructure.		
	Increase the number of primary care practice sites certified by the National Committee for Quality Assurance, URAC, or the Joint Commission.	3,495	4,550 (30% increase)
	Increase the proportion of children who have a medical home.	56%; 2011-12 National Survey of Children's Health	61.6% (10% increase)
	Increase the proportion of women of reproductive age (18-44 years old) who completed a medical visit for preventive care in the last year.	61.9%; BRFSS	68.1 (10% increase)
GOAL 2: Support healthy pregnancies and improve birth and infant outcomes.	Reduce preterm birth, including a focus on disparities.	11.7% for Illinois overall	10.5% (10% reduction)
	Reduce the rate of maternal mortality, prioritizing populations impacted by health disparities, to meet the Healthy People 2020 objective.	12.1 per 100,000 for Illinois overall, 18.6 per 100,000 for non-Hispanic blacks, 10.4 per 100,000 for non-Hispanic whites, and 15.0 per 100,000 for Hispanics; Vital Records	11.4 deaths per 100,000 live births
	Reduce the rate of all infant deaths (within 1 year of birth) to meet the Healthy People 2020 objective.	6.2 per 1,000 for Illinois overall, 4.4 per 1,000 for non-Hispanic whites, 12.2 per 1,000 for non-Hispanic blacks, 5.8 per 1,000 for Hispanics, 4.1 per 1,000 for Asians/Pacific Islanders; Vital Records	6.0 per 1,000 births
GOAL 3: Assure that equity is the foundation of all MCH decision making; eliminate disparities in MCH outcomes.	Complete an equity self-assessment.	NA	IDPH and at least 10 local health departments
	Launch training on the use of the health equity toolkit to increase number of local health departments that utilize a health equity approach in their planning.		
	Launch training on the use of the health equity toolkit to increase the number of state agencies that report the use of a health equity approach in their needs assessments or annual reports.		

continued »

MATERNAL AND CHILD HEALTH ACTION TEAM MEASURES *continued*

Goal	Measurable Objectives	Baseline	Target *(by 2021 unless otherwise noted)*
GOAL 4: Strengthen public health data systems, infrastructure, and capacity through unified statewide planning and leadership.	IDPH will convene a statewide public health data strategy committee, composed of internal and external stakeholders, to assess the data landscape and develop priorities for system-wide improvement.	NA	By Jan. 1, 2017, at least two meetings held
	Data linkages will be implemented and routinely accomplished on an annual basis.	NA	5 new data linkages
	IDPH will increase the number of interns, fellows, EIS officers, and other public health trainees in epidemiology supported by the department.	TBD	10% increase
	IDPH will increase the number of public health indicators available on public data query systems.	TBD	20% increase
	IDPH will add data resource list to the public website.		

For more information, please visit:
www.healthycommunities.illinois.gov

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