Informing the CCHHS Strategic Plan:
Community Health Planning Initiatives

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Community Health Assessment and Community Health Improvement Planning: Presentation Overview/Goals

- Provide a brief history of community health assessment and planning activities
- Review of current planning efforts Cook County and Illinois with a focus on common priorities
- Identify opportunities for alignment with existing health planning efforts
Brief History of Local Community Health Planning
Long history of planning in public health...

- Illinois was one of the first states to require community health assessment and planning of all certified Local Public Health Departments (LHDS)
  - 1994 – Illinois Project for Local Assessment of Needs IPLAN – codified into LHD certification requirements
  - Community Health Needs Assessment (CHA) and Community Health Improvement Plan (CHIP)
  - Cycle is every 5 years
  - 2016 – most LHDs including the 6 LHDs in Cook County are in 5th round of IPLAN
- 2012: Public Health Accreditation Board – voluntary national accreditation
  - CHA and CHIP required as pre-requisite for PHAB Accreditation
  - Both CCDPH and CDPH are PHAB Accredited Health Departments

- CCDPH’s IPLAN process (WePLAN); to be completed by mid-2016.
- CDPH’s process is Healthy Chicago 2.0; plan released earlier this month
Other Community Health Planning Initiatives

• **State Health Improvement Plan (SHIP)**
  - Required by Public Act
  - Current year: Healthy Illinois 2021 – plan released earlier this month

• **Hospital Community Health Needs Assessment (CHNA)**
  - Mandated of not-for-profit (NFP) hospitals by IRS
  - ACA implementation

• Cycle is every 3 years
  - 1st cycle 2012/13 – most hospitals conducted independently
  - Few involved public health in process
  - 2016 - most local NFP hospitals entering second cycle
Prior Plans: Common Problems, Common Priorities

- 2012 review of local health department IPLAN Priorities among Northern Illinois Public Health Consortium (NIPHC) member departments
- 64% of priorities selected were in 5 health problem areas

NIPHC
Chicago
Cook
Du Page
Evanston
Grundy
Kane
Kendall
Lake
Skokie
McHenry
Will
Winnebago

Prior Plans: Common Problems, Common Priorities

• Review of Chicago and Suburban Cook hospital CHNAs from Round 1: 2012-2013 (n=31)
• Top priorities – similar results:

- Obesity / Heart Health: 81%
- Access to Care: 71%
- Diabetes / Chronic Kidney Disease: 52%
- Violence and Injury: 42%
- Mental and Behavioral Health: 29%
Prior Plans: Common Problems, Common Priorities

2015 State health assessment process:
Conducted a review of priorities in existing plans statewide

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

Source: IDPH, 2016
Expertise and Opportunities for Alignment

• Throughout Cook County and Illinois there have been and continue to be tremendous efforts in community assessment and health planning

• Good news – Lots of planning efforts provide a strong framework for what needs to be done to improve health

• Recurring theme of ‘Common Problems; Common Priorities’

• Result: Increased emphasis and effort on the need for collaboration and partnerships to improve implementation and achieve broader impact
Current Community Health Planning Activities
## Healthy Illinois 2021 Healthy Priority Action Team Goals

<table>
<thead>
<tr>
<th>Behavioral Health</th>
<th>Chronic Disease</th>
<th>Maternal and Child Health</th>
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<tbody>
<tr>
<td>1.</td>
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<tr>
<td>Improve the collection, utilization and sharing of behavioral health-related data in Illinois</td>
<td>Increase Opportunities for Healthy Eating</td>
<td>Assure accessibility, availability and quality of preventive and primary care for all women, adolescents, and children, including children with special healthcare needs with a focus on integration of services through patient-centered medical homes.</td>
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<td>2.</td>
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<td>Build upon and improve local system integration</td>
<td>Increase Opportunities for Active Living</td>
<td>Support healthy pregnancies and improve birth and infant outcomes.</td>
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<td>Reduce deaths due to behavioral health crises</td>
<td>Increase Opportunities for Tobacco-Free Living</td>
<td>Assure that equity is the foundation of all MCH decision-making; eliminate disparities in MCH outcomes.</td>
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<td>Improve the opportunity for people to be treated in the community rather than in institutions</td>
<td>Increase Opportunities for Community-Clinical Linkages</td>
<td>Strengthen the MCH data systems, infrastructure and capacity</td>
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<td>5.</td>
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<td>Increase behavioral health literacy and decrease stigma</td>
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<td>6.</td>
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<td>Improve response to community violence</td>
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Source: IDPH, 2016
### Cook County Certified Local Health Departments

#### 2015/2016 Plans: Common Priorities

<table>
<thead>
<tr>
<th><strong>Chicago DPH (Healthy Chicago 2.0)</strong></th>
<th><strong>Cook County DPH (WePlan2020)</strong></th>
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<tbody>
<tr>
<td>• Access to health care and human services</td>
<td>• Chronic Disease</td>
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<tr>
<td>• Child and adolescent health</td>
<td>• Mental Health</td>
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<tr>
<td>• Chronic disease prevention and control</td>
<td>• Social/Structural Determinants including</td>
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<tr>
<td>• Community development</td>
<td>▪ Economic Development / Living Wage;</td>
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<tr>
<td>• Data &amp; Research</td>
<td>▪ Addressing Institutionalized Racism</td>
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<tr>
<td>• Education equity</td>
<td><strong>Stickney DPH</strong></td>
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<tr>
<td>• Infectious Disease</td>
<td>• Overweight and Obesity</td>
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<td>• Mental health and substance abuse</td>
<td>• Physical Activity</td>
</tr>
<tr>
<td>• Partnerships and community engagement</td>
<td>• Untreated hypertension</td>
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<tr>
<td>• Violence and injury prevention</td>
<td><strong>Oak Park DPH</strong></td>
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<td></td>
<td>• Access to Adequate Health &amp; Dental Care</td>
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<tr>
<td></td>
<td>• Chronic Disease</td>
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<td></td>
<td>• Mental Health for All Ages</td>
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<td></td>
<td>• Obesity</td>
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<td>• Teen Alcohol and Drug Use</td>
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<tr>
<th><strong>Evanston DPH (E-Plan)</strong></th>
<th><strong>Skokie DPH</strong></th>
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<tr>
<td>• Mental Health</td>
<td>• Creating a healthy environment</td>
</tr>
<tr>
<td>• Violence</td>
<td>• Improving access to healthcare</td>
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<tr>
<td>• Obesity</td>
<td>• Preventing obesity</td>
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<tr>
<td></td>
<td>• Preventing tobacco use</td>
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Health Impact Collaborative of Cook County (HICCC)

2015/2016 County-wide CHNA Process
- Collaborative CHNA for Round 2
- Region-wide process
- Three subregions
  - North - Central - South

Lead Partners
- Illinois Public Health Institute
- 6 local health departments
  - Cook County Dept of Public Hlth
  - Chicago Dept of Public Hlth
  - Stickney Public Health District
  - Evanston Health Dept
  - Oak Park Health Dept
  - Skokie Health Department
- Presence Health
- Advocate HealthCare
- Rush University Medical Center
- Loyola University Medical Center
- Illinois Hospital Association

Participants
- 26 non-profit hospitals
- > 90 stakeholder agencies

2016 Priorities
- Access to Care and Community Services
- Chronic Disease (CVD, Diabetes, Obesity)
- Behavioral and Mental Health
- Social Determinants of Health: economic development and institutional racism
Common Problems, Common Priorities

• Across new plans common themes emerge
  • Access to care and community services
  • Behavioral/mental health/substance abuse
  • Chronic disease: cardiovascular/diabetes/obesity
  • Structural and social determinants of health
    • Economic development/Systemic racism

• Focus on achieving health equity
Opportunities for Alignment with Current/New Local and State Community Health Planning Efforts
Examples of existing alignment with CHIP priorities and CCHHS activities

• **Access to Care** – improve patient access to needed clinical care
  - CCHHS is working to improve the Patient Experience and better facilitate access to needed care for patients

• **Chronic Disease** – increasing opportunities for prevention
  - Working to enroll those exiting Jail into health care
  - Food is Medicine Partnership with Food Depository – Food insecurity screening

• **Focus on Social Determinants of Health** – to improve Health Equity
  - Implementing an integrated care system that screens for needs outside of the clinical delivery setting – working to connecting patients to community resources

• **Behavioral/Mental Health**
  - CCHHS integration of behavioral health at ACHN Clinics
  - Addition of Community Triage Center on the South Side of Chicago
Layer interventions on the Health Impact Pyramid to increase impact with an emphasis toward:

- Prevention
- Changing community context through policy/advocacy
- Focus on health equity addressing community structural determinants that impact health
CCHHS Strategic Objectives: Opportunities

- **Improve Health Equity**
  - Most CHIP plans include a focus on social determinants; need to focus beyond clinical setting/medical model

- **Provide high quality, safe and reliable care**
  - Access to care assumes care is high quality and comprehensive - addressing needs of whole person including preventive factors and community context factors

- **Demonstrate value, adopt performance benchmarking**
  - Plans have population and impact benchmarks; tying process and performance benchmarks to outcomes demonstrates value to those in the community; connect internal benchmarks to larger population measures

- **Develop human capital**
  - Building staff capacity to address complex health conditions of patients and to work more effectively in collaboration with partners and communities.

- **Lead in Medical Education and Clinical Investigation relevant to vulnerable populations**
  - Community plans seek to create an expanded understanding of what contributes to health and wellness including social stratification and community conditions -- essential concepts for clinical staff.
Recommendations for Alignment and Partnership

• Utilize the existing assessments and community health data analysis for strategic planning efforts

• Identify areas for strategic alignment and complementary interventions with existing CHIP priorities and plans

• Build on existing partnerships and efforts - limited new funds/state budget impasse make collaboration imperative

• Work collaboratively with CCDPH, CDPH and HICCC and community partners to identify opportunities for CCHHS to take on specific areas for implementation
Questions?