

With membership comprised of community leaders in health and human services, we are working together to ensure that low income DuPage County residents have timely access to critical services coordinated in an efficient and effective manner.

Our planning prioritizes interventions that reduce health disparities by addressing both the social and physical determinants of health, often in concert.

DuPage Safety Net Plan for Health and Human Services

2016-2018



A Joint Strategic Plan of the DuPage Health
Coalition and DuPage Federation on Human
Services Reform

OUR MISSION



The Mission of the DuPage Health Coalition is to develop and sustain in DuPage County a system for effectively and efficiently managing the health of low income populations across the continuum of care.



The Federation's mission is to improve the lives of vulnerable people in DuPage County by leveraging relationships and knowledge to build an effective and efficient health and human service system.

The DuPage Safety Net Plan for Health and Human Services celebrates and coordinates the efforts of a host of inter-connected organizations, programs, and facilities in DuPage County working together to

- 1. Ensure that at-risk residents have timely access to necessary essential health and human services,*
- 2. Coordinate services in both systems in ways that increase the effectiveness and efficiency of the overall Safety Net, and*
- 3. Identify opportunities to strengthen partnerships between health care and human service providers to reduce health and well-being disparities disproportionately impacting the poor.*

While some of the projects outlined within this Plan are directed by the DuPage Health Coalition and the DuPage Federation, many are community initiatives under the leadership of collaborating partners. Accordingly, both major goals and initiatives intended to address plan goals are grouped by the organization tasked with leading them.

OUR VISION AND GUIDING PRINCIPLES

Planning efforts at the DuPage Health Coalition and the DuPage Federation on Human Services Reform are guided by the following principles:

- 1. Collaboration** – We believe that working in partnership results in greater community impact. Indeed, we believe that a true collaboration enhances the capacity of each partnering organization to fulfill its own specific organizational mission more effectively. A corollary is the belief that **public/private partnerships** often address both health and social issues more effectively than each sector could independently.

2. **Shared Responsibility** – Safety net planning incorporates the expectation that every individual, organization, and sector of the community that has a stake in the issue of improving the health of low-income persons will contribute proportionately to safety net development and maintenance.
3. **Mosaic Approach** – The DuPage Safety Net Plan for Health and Human Services presupposes continuation of multiple programs, models, and organizations addressing the issue of health care and human services to at risk populations. It expressly does not embody a “one size fits all” philosophy, nor does it seek to develop a centralized management structure.
4. **System Focus** – Planning efforts recognize the fragmentation of the mainstream health and human service system and resultant harm on efforts to optimize services access for all persons. Specifically it recognizes historic lack of coordination between the public health system, the medical system, human services and other community organizations. Accordingly, DuPage Safety Net Planning places heavy emphasis on coordination of effort, non-duplication of services, inter-organization cooperation, and, where appropriate, functional integration. It encourages each partner organization to do what it does best, while emphasizing synergy in the design of how the various components interact with each other.
5. **Strategic Asset Focus** – The DuPage Safety Net Plan for Health and Human Services places particular emphasis upon serving those segments of the Target Population for whom greatest gaps between need and available services can be demonstrated. Additionally, our plan places proportionally greater emphasis on community assets vs. deficits. Asset focus taps into full community potential instead of fixating on its limitations
6. **Demonstrable Accountability** –Each strategy within this Safety Net Plan identifies accountable organizations overseeing strategic effort and specific measurable key indicators demonstrating progress against goals and targets.
7. **Person-Centered Approach** – The DuPage Safety Net Plan for Health and Human Services recognizes that commitment to high quality patient care must undergird all planning, and that plans must anticipate and mitigate barriers commonly experienced by low income and at-risk persons.
8. **Coordinated, Efficient Use of Technology,** – The DuPage Safety Net Plan for Health and Human Services endorses the idea that the availability of secure patient information across institutional and business boundaries (with appropriate safeguards) enhances the coordination, efficiency and quality of person centered care. Further, it seeks to marshal technological innovation where doing so improves safety net services. Priority will be afforded to plans that increase the efficiency and effectiveness of care delivery, support integration of providers across health sectors, and demonstrably support improved health outcomes and/or reduced cost of care.
9. **Orientation toward Evolution** – Our plan seeks to anticipate changes in both target population needs and the health care and human services sector, and proactively plans for future as well as current needs. This principle applies to planning for both the system and the individual. Plans are intended to support improved self-sufficiency.
10. **Community Focus, Regional Awareness** – As the name implies, this plan and both organizations are primarily focused on safety net services provided within DuPage County. However, given increasing regionalization of both health and human services, our plan also endorses participation in collaborations engaging partners and supporting consumers throughout the greater metropolitan area, and occasionally beyond it.

THE TARGET POPULATION

The community of focus for Safety Net services includes: all persons who lack access to necessary health or human services for economic reasons. From a lens of health access, this populations includes those covered by or eligible for Medicaid, as well as persons with household incomes under 200% of the Federal Poverty Level who are either without medical insurance coverage, underinsured, or at risk of un/underinsurance.

It should be noted that minorities, immigrants, refugees, and non-English speakers are disproportionately represented within the target population.

MAJOR GOALS OF THE DUPAGE SAFETY NET PLAN FOR HEALTH AND HUMAN SERVICES

GOAL 1: Comprehensive Assessment and Enrollment in Appropriate Services - All members of the target population eligible for health insurance coverage, coordinated health access or other health and human services are properly and promptly enrolled in the appropriate program. Barriers to enrollment are thoroughly evaluated and mitigation plans supporting connecting households to the best services for which they qualify are developed.

This goal is a strategic priority for both the DuPage Health Coalition and the DuPage Federation, with projects initiated, led, and funded by both organizations (as well as other community partners).

GOAL 2: Timely Access to Essential Health Services - Every individual within the target population has timely access to each of the following healthcare services, as needed:

- A. Primary Care First Every individual within the target population has a “medical home” from which to receive care which is affordable, accessible, and coordinated.
- B. Medical specialists (including rehabilitative and vision care)
- C. Hospital services
- D. Behavioral health treatment
- E. Prescription drugs
- F. Maternal/Child and Women’s Health Services
- G. Oral health services
- H. Preventive and wellness services and chronic disease management
- I. Effective Care Coordination

While both organizations commit time and energy to support this goal, the DuPage Health Coalition is more commonly the lead agency in planning, development and operations, alongside collaborative health partners. Funding for initiatives related to this goal is more typically originated at the DuPage Health Coalition, with support and consultation from the DuPage Federation.

GOAL 3: Timely Access to Essential Human Services Every individual within the target population has timely access to each of the following human services, as required: (list still in development). Human Services generally include (but are not limited to):

- A. Supports for persons with physical and mental disabilities, such as supported employment, permanent supportive housing, vocation rehabilitation;
- B. Protective Services, such as child welfare services, sexual assault and domestic violence services, adult protective services;
- C. Safety Net Services, subsidized housing, public benefits, food pantries, homeless shelters, crisis intervention services, etc.
- D. Prevention and early intervention programs that keep problems from occurring or deal with them early before they become expensive and difficult to treat, such as pregnancy prevention and substance abuse prevention programs for teens, etc.



While both organizations commit time and energy to support this goal, the DuPage Federation is more commonly the lead agency in planning, development and operations, alongside key human service partners. Funding for initiatives related to this goal is more typically originated at the DuPage Federation, with support and consultation from the DuPage Health Coalition.

Goal 4: Effective Management of the Social Determinants of Health – The World Health Organization defines the social determinants of health (SDH) as “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.” We recognize that health, broadly defined, is inseparable from these conditions, and, as such, we understand that no plan for health care can ignore these important factors affecting health. Accordingly, this plan seeks first to understand and ultimately to reduce those disparities in health and well-being which are either caused by or directly correlated to poverty. Notably, efforts should focus on both harm reduction, where social determinants of health disproportionately and negatively impact low income community residents, and also health promotion, where there is evidence that social and environmental forces can buffer or bolster the health of the community.

This is a new goal to both organizations, with both leadership and funding still to be determined. It is anticipated that successful efforts to examine, understand, and strategically address social determinants of health will require equal health and human service collaboration, and will thus succeed through shared goal setting, leadership, and funding.

TERMS AND PLAN DETAILS

The bulk of this strategic plan focuses on a description of programs, services, and planning efforts intended to support achieving each of plan goal. The plan employs the following terms and icons throughout.

1. Accountable Partner - Each project identified has one or more accountable organizations tasked with leading the efforts described and monitoring progress against goals.
2. Key Metrics – Each Project has (or will have) one or more metrics intended to support year over year evaluation of project success. Metrics will be tracked and reported annually.
3.  Projects not previously reported in prior safety net plans are commemorated by a “new” icon as commemorated here.
4.  This symbol commemorates projected goals for project enhancement, often with projects that are not new but are evolving their efforts in novel ways or setting more ambitious future goals.

GOAL 1: COMPREHENSIVE ENROLLMENT IN AVAILABLE BENEFITS AND SERVICES

All members of the target population eligible for health insurance coverage, coordinated health access and other resources are properly and promptly enrolled in the appropriate program. Barriers to enrollment are thoroughly evaluated, and DuPage County partners develop effective strategies connecting individuals and families to programs for which they qualify.

Responsibility for achieving this goal is most typically shared amongst partners, including the DuPage Federation, the DuPage Health Coalition, and other community agencies.

DuPage Federation on Human Services Reform

OPEN DOOR – a program focused on persons in crisis who require advocacy in order to expedite their applications for benefits through the Illinois Department of Human Services.

Key Metrics: # Clients Served, Rate of Successful Enrollment

MAKING THE CONNECTION BENEFITS TRAINING – a program that trains Health and Human Services professionals about the types and requirements of public benefits available to eligible persons, and how to enroll those eligible persons in the relevant benefits programs.

Key Metrics: # Training Participants; # of Unique Trainings


 **SOAR (SSI/SSDI OUTREACH, ACCESS AND RECOVERY)** – a program designed to increase the timeliness and efficiency with which people who are homeless or at risk of homelessness due to mental illness or other disabling conditions are enrolled in Social Security disability benefits.

Key Metrics: # of Applications Initiated/Approved, Average time from Application to Disposition

DuPage Health Coalition

ACCESS DUPAGE ENROLLMENT NETWORK – A network of public and private community agencies at which staff or volunteers are trained to initiate the process of enrolling or re-enrolling eligible applicants in the Access DuPage program. This enrollment process is then completed by Access DuPage staff.

Key Metrics: Average Weekly Enrollment, Total Annual Enrollment

 In FY 16 Access DuPage will introduce an online application to reduce cost/processing time, as well as adding at least two enrollment sites vs. FY15 baseline, as well as developing referral relationships with 2 or more new partners. By FY 17 Access DuPage will expand services to seniors (65+) and double its over 65 year old enrollment.



SILVER ACCESS, ACA PREMIUM SUBSIDY ASSISTANCE- DuPage Health Coalition proposes a new program to assist low income ACA subsidy eligible patients to purchase health insurance through the Federal Marketplace. Patients will be referred by community partners, screened by navigators, and qualified for ACA Premium Subsidy by DHC Staff. Members will also be provided assistance addressing other barriers to care.

Key Metrics: Total Enrollment; Monetary Value of Assistance, Communities Served



In FY 16 Silver Access will serve at least 250 ACA eligible members. In FY 17 and FY 18 Silver Access will serve 500 or more members annually.



POST ACA HEALTH ACCESS ASSESSMENT-The DuPage Health Coalition proposes a new research study in FY16 and FY17 to assess former enrollees' current enrollment in and access to health care services. DHC will screen at least 500 clients by phone and 500 clients by web survey. In addition to data collection, clients with identified barriers to health and human services will be provided resources and support resolving access issues.

Key Metrics: # Surveys Completed, # Focus Groups Conducted, Report of Findings Available to Public



Former AD Members will be surveyed using a nationally validated instrument in coordination with UIC with DHC staff. In FY 16 DHC will conduct 1,000 surveys from a 6,000 member pool. Data will be incorporated into future planning efforts and subjects reporting barriers to care will be offered support resolving issues reported.



GET KIDS COVERED DUPAGE-If funded, DuPage Health Coalition will partner with IPHA to increase pediatric health insurance enrollment through outreach to uninsured parents, engagement with DCHD screened school age children, and collaborative partnership with early intervention and human service partners. The project aims to reduce by 33% the estimated 6,500 uninsured children living in DuPage, and equally seeks to connect their parents to care through federal, state, and local programs

Key Metrics: # of uninsured children enrolled in coverage; # of insured children retained in coverage; # of parents enrolled in health programs



In FY 17 and FY18 DHC will enroll at least 2,000 currently uninsured children in health coverage, and will support successful redetermination of an additional 2,000 or more children. In addition, 100% of the parents of the children engaged in coverage will be offered assistance enrolling in available services.

Other Community Partners

DUPAGE COUNTY INTAKE AND REFERRAL – DuPage County provides both information and referral services and home and site based assessment and referral services. A call center is available to anyone in DuPage County who needs assistance. Clients are screened for services including energy assistance, enrollment in public benefit programs, family self-sufficiency programs and senior services (including SHIP counseling).

Key Metrics: # clients screened by phone, # clients appointed or benefitted, # choices for care screenings, # comprehensive senior services evaluations.

HEALTH DEPARTMENT CLIENT BENEFIT SERVICES – Trained specialists, available at all Health Department public health centers, help persons enroll in the programs for which they are eligible, particularly Medicaid/AllKids, ACA/Marketplace, Access DuPage, and Food Stamps programs. The health department also screens for and connects patients to a number of human services. Applicants are seen by appointment or on a walk-in basis at certain times.

Key Metrics: # of intake clients served (adult, child), # and type of applications completed, % of successful applications by type



ENGAGE DUPAGE – Trained specialists (health department employees) are embedded at local area emergency rooms and other sites of care. Benefit specialists engage low income patients presenting for care to support their enrollment in all services for which they qualify and reduce identified barriers to care.

Key Metrics: # of intake clients served (adult, child), # and type of applications completed, % of successful applications by type; # of participating hospitals



Engage DuPage will retain staff at 2 or more DuPage Hospitals in FY 16 and add an additional hospital in FY17. In addition to new site growth, Engage DuPage will add same site lines of service at one or more hospital by end of FY18.



HUNGER VITAL SIGNS- As a companion to the 1000 Days project, Hunger Vital Signs is a best practice approach to screening for food insecurity in primary care settings. Success implementation of project will significantly increase screening and will also incorporate practical strategies to connect families to nutrition resources.

Key Metrics: # of participating providers, # of patients/families screened, # of food prescriptions provided

GOAL 2A: ESSENTIAL HEALTH SERVICES – PRIMARY CARE FIRST

Every individual within the target population has a “primary care medical home” from which to receive care which is affordable, accessible, and coordinated.

Definition: For purposes of this DuPage Safety Net Plan a “medical home” is defined as a medical clinic or medical practice which when optimally designed (1)Serves as the nexus of primary medical care, (2)Provides care in a site that is easily accessible to the patient, (3)Links each patient to a team of health care professionals who have knowledge of that patient’s history and family and social circumstances, thereby ensuring the continuity of the patient-provider relationship, (4) Provides organized, evidence-based care, including the use of decision support systems, (5) Encourages patient-centered interactions to increase patients’ involvement in their own care, (6) Ensures that patients have access to care and their clinical information after office hours, (7) Provides care coordination to facilitate delivery of the right health care services, in the right order, at the right time, and in the right setting, and (8) Provides care that is linguistically appropriate for the patient.

Responsibility for achieving this goal as described within this plan is most typically led by the DuPage Health Coalition.

DuPage Health Coalition

ACCESS DUPAGE PRIMARY CARE NETWORK -Assign members enrolled in Access DuPage to a medical home. This allows some control over the allocation of low-income uninsured persons to various Health Safety Net medical home sites, mitigating concern that providers will have more uninsured patients than they can handle.

Key Metrics: Average Weekly Enrollment by Provider Type, Total # of Participating PCP Providers, Available PCP Assignments.



Access DuPage will add at least one FQHC provider in FY 16 and an additional FQHC provider by FY 18.

FQHC NETWORKS — Maintain a strong network of Federally-qualified health centers (FQHCs) managed by partner organizations; goal includes 100% participation in Access DuPage by FQHC partners with DuPage County sites.

Key Metrics: Payor Mix, Total PCP visits/patients by Payor Source



MEDICAL HOME SUPPLY AND DEMAND ANALYSIS — Maintain annual data and maps that display both supply (Health Safety Net Resources) and demand (numbers and types of anticipated populations) by geographic region within DuPage.

Key Metrics: Mapping of Medicaid patient supply/demand, health safety net sites of care, Access DuPage enrollment, and analysis of Medicaid provider participation



By no later than FY17 the DuPage Health Coalition will add tracking of Medicare Patient Volumes and enrollment to data capture. DHC will also review special populations and add additional mapping to support community planning for Medicaid managed care, ACA enrollment, or other identified needs. Data will be shared with Impact DuPage in FY 16 and made available on the DHC website by no later than FY 17.

GOAL 2B: ESSENTIAL HEALTH SERVICES – SPECIALTY CARE

Every individual within the target population has timely access to **medical specialists** (including rehabilitative and vision care)

Responsibility for achieving this goal as described within this plan is most typically led by the DuPage Health Coalition.

DuPage Health Coalition

ACCESS DUPAGE SPECIALTY CARE COORDINATION — Access DuPage collaborates with hundreds of local specialists and specialty groups, developing mutually agreed upon parameters for pro bono care delivery at a frequency and volume comfortable to the provider. When the need for specialty care is identified for a particular patient, AD specialty coordinators contact providers and request low/no cost consultation

Key Metrics: # Specialty Referrals, # Unique Patients Served, # Participating Specialists



Each year Access DuPage will grow specialty network to include new providers/groups, with the goal of the addition of one large group (5+ providers) or two or more smaller groups (1+ provider) annually.

HOSPITAL BASED SPECIALISTS — Maintain a strong network of hospital affiliated ancillary specialists who accept Access DuPage.

Key Metrics: # of Hospital Based Groups Participating in Access DuPage



MEDICAID SPECIALTY CARE SERVICES

— Medicaid Specialty Access is insufficient to meet demand, and participating providers report that volumes of requested care are unsustainable. The DuPage Health Coalition intends to begin a planning process and develop strategies in increase access, support provider equity, and ensure efficient use of available resources.

Key Metrics: TBD



Develop and implement strategic approaches to increasing specialty care access for Medicaid enrollees. Goals include exploring role of Access DuPage in supporting specialty care referral coordination, use of “fair share” methodology to expand provider participation, viability of Private Provider Specialty Clinics, and other strategies TBD

Other Community Partners



FQHC SPECIALTY CARE SERVICES

— FQHC’s have limited capacity to offer specialty care services at their clinics, but maximizing the quantity of specialty care services provided to patients at their primary care site is beneficial, and also reduces the demand for specialty care services in the Community. Goal includes growth of specialty care access through adoption of one or more strategies including partnerships with other provider groups, increased use of midlevel providers with specialty capacity, residency partnerships, or other strategies TBD.

Key Metrics: # and Type of Onsite Specialists and # of Specialty Visits



In FY17 and FY18 goal is to grow specialty care access at FQHC’s through adoption of one or more strategies including partnership with other provider groups, increased use of midlevel providers with specialty capacity, residency partnerships, and other strategies TBD.

GOAL 2C: ESSENTIAL HEALTH SERVICES - HOSPITAL SERVICES

Every individual within the target population has timely access to hospital services, including diagnostic services, emergency room services, urgent care services, series visits, and extensive services such as inpatient admissions, observation stays and day surgeries.

Responsibility for achieving this goal as described within this plan is most typically led by the DuPage Health Coalition.

DuPage Health Coalition

HOSPITAL CHARITY CARE POLICIES – Each DuPage County hospital has charity care guidelines that direct how all or part of a hospital bill may be written off for patients depending on their incomes. Such policies are consonant with the Charity Care Requirements recently promulgated by the Illinois Legislature (SB 3261). The

DuPage Health Coalition will track and report annually at calendar and fiscal year total charity care expended in service of Access DuPage members.

Key Metrics: Total Charity Care

HOSPITAL ACCESS FOR ACCESS DUPAGE MEMBERS - Consonant with charity policies, DuPage County hospitals provide various hospital services at little or no charge to Access DuPage members. This goal incorporates tracking of the following metrics on a calendar and fiscal year basis (inpatient care, observation stays, day surgeries, ED visits, outpatient services, series visits, and total retail charges).

Key Metrics: Volume and donated value of following: Inpatient Care, Observation Stays, Day Surgeries, ED Visits, Outpatient Services, Series Visits, Total Retail Charges

HOSPITAL EQUITY — Efforts will be made to insure that the services provided to Access DuPage patients by DuPage County hospitals are distributed among these hospitals in an equitable fashion. Equity is defined as the percentage of services that each hospital might be expected to provide based on the residence of Access DuPage members by community and the relative market share of each hospital (for DuPage County inpatients) by community. This goal tracks variance between anticipated and actual hospital charges for Access DuPage, and actively works to address unanticipated variance. Variance will be evaluated at both calendar and fiscal year.

Key Metrics: Variance between anticipated and actual hospital charges; # of participating hospitals



DHC will seek to achieve and maintain 100% hospital participation across all hospitals within DuPage County borders, as well as those with significant DuPage County market share but physical locations outside of DuPage County.



MEDICAID MANAGED CARE ACCESS IN HOSPITALS – Each DuPage area hospital determines which Medicaid Managed Care Products they accept, but patients enrolling in plans are often ill informed of provider plan participation. This goal supports development of metrics reviewing hospital participation in Medicaid plans and seeks to create strategies maximizing patient access and hospital equity. The DuPage Health Coalition will be an active partner in efforts to improve access and equity, and will seek opportunities to strengthen and promote efforts to achieve Medicaid managed care equity.

Key Metrics: TBD; metric to demonstrate hospital participation in Medicaid plans



DHC through its collaborative partnerships will seek opportunities to reduce access to care gaps, partnering with hospitals, QHPs, and patients/navigators to inform plan selection and plan participation.

GOAL 2D: ESSENTIAL HEALTH SERVICES - BEHAVIORAL HEALTH

Every individual within the target population has timely access to mental health and substance abuse disorder services.

Responsibility for achieving goals described within this plan is most typically led by other community partners.

Community Led Projects with Active DuPage Health Coalition and DuPage Federation Engagement



BEHAVIORAL HEALTH PREVENTION AND TREATMENT LEADERSHIP TEAMS – *A group of community health leaders and content experts working to coordinate behavioral health services throughout the County. Planning sets concrete goals for prevention based outcomes and treatment based access, coordination, service delivery and quality objectives. Both the Federation and Health Coalition leaderships, as well as board members participate in this collaborative effort. This plan endorses the treatment goals included below:*

Improve Access to Behavioral Health Services

Outcome Objective 1

By December 31, 2018, establish a system of navigation that improves the ability of the provider network to ensure consumers understand, access, and receive treatment services.

- 1.1 By December 31, 2016, develop an integrated model for navigator and resource and referral system.
- 1.2 By December 31, 2016, identify at least one strategy to address social and economic barriers to behavioral health treatment services.
- 1.3 By December 31, 2017, develop a coordinated system of managing real-time supply and demand of behavioral health care.
- 1.4 By December 31, 2018, implement pilot phase of navigator/resource and referral system
- 1.5 By December 31, 2018, educate 10% of primary care partners, 10% of school educators, 10% of justice system providers about behavioral health resources in the community.

Increase Quality Providers

Outcome Objective 2

By December 31, 2018, create a system of measurement of quality where at least 5 safety net behavioral health provider partners adopt and share common quality indicators.

- 2.1 By December 31, 2017, identify common subjective and objective quality indicators for DuPage County behavioral health treatment providers.

Outcome Objective 3

By December 31, 2018, explore and implement one or more innovations to increase pipeline capacity of quality providers.

- 3.1 By December 31, 2017, establish at least two partnerships with psychiatric and mid-level provider training institutions to increase pipeline capacity of quality providers working within DuPage County.



INTEGRATED HEALTH SERVICES AT VNA HEALTH CARE (PARTNERSHIP WITH METROPOLITAN FAMILY SERVICES) – *A joint program that collocates counseling and psychiatric services in an FQHC setting. DuPage Health Coalition provides modest funding to support this project.*

Key Metrics: # Clients Served, # Psychiatric Visits, # Counseling visits, payor mix



Project goals include successful implementation in FY 16 and year over year same site and new site growth.


Other Community Partners

DCHD CRISIS SERVICES – *The DuPage County Health Department Crisis Unit offers 24 hour services for consumers in high acuity need, offering a range of resources including crisis beds, counseling, and comprehensive assessment and stabilization services.*

Key Metrics: # crisis clients served and # of assessments performed

DCHD BEHAVIORAL HEALTH INTAKE – *A moderate acuity central telephone based resource supporting preliminary assessment and linkage to DCHD and community behavioral health appointments.*


Key Metrics: # of appointments offered/kept; # of clients served (outpatient, crisis, psychiatric, adult, child)

 **MYCARE** – *A joint DCHD and VNA Health Care program that provides integrated primary and behavioral health services to adults with serious mental illnesses who have, or are at risk for, co-occurring primary care conditions and chronic diseases.*


Key Metrics: # of clients served, # primary care visits per patient

 **HAMDARD HEALTHCARE BEHAVIORAL HEALTH SERVICES** *Hamdard Healthcare, DuPage Counties newest FQHC, offers both behavioral health services and full time psychiatric services.*

Key Metrics: # of counseling and psychiatric visits; payor mix.

 **MENTAL ILLNESS COURT ALTERNATIVE PROGRAM AND DRUG COURT** – *The purpose of DuPage County Mental Illness Court Alternative Program (MICAP) and Drug Court Program is redirection of offenders who have a mental health diagnosis or substance abuse problem that was a contributing factor in the commission of a non-violent crime. MICAP/Drug Court provides sentencing alternatives with the focus on integrated treatment services diverting the offender from traditional prosecution.*

Key Metrics: # of clients adjudicated and recidivism rate

 **THE LIVING ROOM** – *The living room providing peer directed support to patients living with chronic mental illness. The living room offers a safe and comfortable alternative to inappropriate ED utilization, supporting patients and families with episodic care coupled with ongoing resources.*

Key Metrics: Program goals/metrics and key partners are still being established, but are anticipated to include both quality and cost of care indicators, and reduction in avoidable ED use.

GOAL 2E - ESSENTIAL HEALTH SERVICES - MEDICATION ACCESS

Every individual within the target population has timely access to prescription medications.

Responsibility for achieving this goal as described within this plan is shared between the DuPage Health Coalition and other community partners.

DuPage Health Coalition

DRUG ASSISTANCE PROGRAMS (DAP) – DAP programs are those programs sponsored by various pharmaceutical companies which provide without charge prescription medications to eligible categories of indigent patients.

Key Metrics: # DAP applications and total annual DAP savings

ACCESS DUPAGE DRUG BENEFIT PROGRAM – Access DuPage purchases covered prescription medications for members that are not available by other means. CVS Caremark serves as the Pharmacy Benefit Manager (PBM) for this program, responsible for maintaining a network of pharmacies from which such medications can be obtained, and developing with Access DuPage a formulary of covered medications. Access DuPage members are responsible for a modest copayment per medication.

Key Metrics: # RX's filled annually, total average drug spend per enrollee, generic utilization/substitution.



By FY 17 DHC will employ competitive bid process to determine competitiveness of current pricing

Other Community Partners

340B DRUG PROGRAMS – Certain Health Safety Net providers offer a 340B Drug Pricing Program. Under such a program, as authorized by Section 340B of Public Law 102-585 (the Veterans Health Care Act of 1992), the cost of covered drugs available to certain categories of patients is limited to specified amounts, typically resulting in savings of 20% to 50%.

Key Metrics: 340B Participation and # or 340B served patients/medications



Efforts will be made to extend the benefits of 340B pricing to groups of patients who are eligible to participate in the program but are not currently participating. One community goal is the better alignment of 340B pricing to support Access DuPage enrollees and/or reduce ADHC Pharmacy Cost.

GOAL 2F -ESSENTIAL HEALTH SERVICES - MATERNAL, CHILD AND WOMEN'S HEALTH SERVICES

Appropriate persons within the target population have timely access to services that improve maternal, child and women's health.

Responsibility for achieving this goal as described within this plan is commonly led by community partners.

Community Led Projects with Active DuPage Health Coalition Engagement

ILLINOIS BREAST AND CERVICAL CANCER SCREENING PROGRAM (WHY WAIT) - Offers 40-64 year old un/underinsured women breast cancer screening and 35-64 year old women cervical cancer screening. Younger women with symptoms also may qualify. Basic services offered include clinical breast exam, mammogram, pelvic exam and Pap test, all free of charge. DuPage Health Coalition also partners with this program to offer navigation services to clients needing assistance.

Key Metrics: # screenings, # of patients navigated, and total positive cancer diagnoses are tracked.

Other Community Partners

WOMEN INFANT & CHILDREN SUPPLEMENTAL NUTRITION SERVICES— Federally-funded program with state administration, WIC serves income eligible families with children thru age 5. WIC offers information, assessment, education, and vouchers to assist in nutritious food purchase.

Key Metrics: # of families and children served and value of benefit

FAMILY CASE MANAGEMENT (FCM) —provides services to residency and income eligible families of very young children prior to and following pregnancy. Families are linked to appropriate public benefits, obstetric care, and primary care. Families receive health education in the areas of health care, immunizations, child growth and development, and child safety. All families are connected to public health nurse, case manager, or other trained professional who works closely on programmatic and family derived goals.

Key Metrics: Average monthly enrollment

EVIDENCE BASED INTENSIVE HOME VISITING PROGRAMS — (1) Intended to reduce stress and promote healthy outcomes, Healthy Families Illinois provides home visits by Family Support Workers from pregnancy through school age of the child. (2) Nurse-Family Partnership offers first-time, expectant mothers (over the age of 18) the support of a Registered Nurse early in her pregnancy, as well as ongoing nurse home visits that continue until her child's second birthday. Both programs work with the Family Case Management program. Both programs offer information and referrals for healthcare, childcare, job training and other support services in the community. Positive parenting skills, infant nutrition and basic care, home safety issues, child development and child guidance are topics of focus.

Key Metrics: # Healthy Families Home Visits, # Nurse Family Partnership Home Visits; # clients served

IMMUNIZATION SERVICES —Fee based adult immunizations, and pediatric immunizations offered with low/no cost access for un/underinsured patients.

Key Metrics: # children served; # immunizations provided

VISION AND HEARING SCREENINGS — Vision and hearing screening for any child attending DuPage schools; families of children needing follow up care are contacted and services needs are case managed after screening, including linkage of uninsured and under-insured families with community resources and low/no cost services.

Key Metrics: # of school based vision and hearing exams

GOAL 2G - ESSENTIAL HEALTH SERVICES - ORAL HEALTH

Every individual within the target population has timely access to oral health services.

Responsibility for achieving this goal as described within this plan is commonly led by community partners.

Other Community Partners

DCHD DENTAL CLINIC – A five chair dental clinic targeting low-income individuals with urgent oral health needs, as well as offering case management services and other dental treatment for the chronically ill. Utilizing a workforce of dental hygiene students, services are also offered to prenatal clients.

Key Metrics: # of clients served (children and adult) and type of care provided



By FY 17 DCHD Dental Services will add an additional site and dental chairs in Lombard location.

DCHD DENTAL SEALANT PROGRAM – Preventive dental care is provided to children in a school-based setting. Children of all income levels are offered dental examinations including the state mandated school exam for grades K, 2 and 6. Additional preventive services are offered to children that qualify for Medicaid, or for free and reduced meals at school.

Key Metrics: # of children served and type of care provided

DCHD SMILE SQUAD MOBILE DENTAL CLINIC – A 40-foot semi-truck containing two state-of-the-art treatment rooms takes general dental services to children at schools, neighborhood resource centers, DuPage County Public Health Centers, and Head Start sites.

Key Metrics: # of children served and type of care provided

DENTAL HEALTH INTAKE AND REFERRAL – A central telephone intake combines a financial and needs assessment of each caller. Depending on the callers needs an appointment or referral is made with the appropriate provider.

Key Metrics: # of children served and type of care provided

DENTAL CARE CONNECTIONS – Eligible clients that require dental services (those with incomes under 200% of the Federal Poverty Level) are linked with participating private dentists in the community who agree to provide services at a negotiated, highly-discounted fee.

Key Metrics: # of clients served; # of participating providers

DUPAGE DENTAL DISCOUNT PROGRAM – A program, open to everyone and designed to complement dental health insurance, provides discounts from usual and customary fees to enrollees who pay a modest monthly fee.

Key Metrics: # of persons enrolled and # of participating providers



COLLEGE OF DUPAGE DENTAL HYGIENE SCHOOL – *The COD Dental Hygiene program operates a 30-chair dental hygiene clinic open to everyone that provides a comprehensive range of dental hygiene services at discounted rates. Second year dental hygiene students provide approximately 800 clinical hours rotating in Health Department Dental Programs.*

Key Metrics: # of clients served



MIDWESTERN UNIVERSITY COLLEGE OF DENTISTRY –*The dental clinic offers a full range of general dental services provided by third and fourth year dental students. The clinic is a resource for DuPage County residents of all income levels.*

Key Metrics: # of dental chairs, # of patients served, # of dental students educated



CDS DENTAL CLINIC –*The dental clinic offers a full range of general dental services provided at no charge by volunteer dentists. The clinic is a resource for low income DuPage County residents.*

Key Metrics: # of patients served; # of volunteer providers

GOAL 2H - ESSENTIAL HEALTH SERVICES – PREVENTION AND HEALTHY LIVING

Every Individual within the target population has timely access to preventive and wellness services and chronic disease management

Responsibility for achieving this goal as described within this plan is commonly led by community partners.

Other Community Partners

FORWARD (FIGHTING OBESITY REACHING HEALTHY WEIGHT AMONG RESIDENTS OF DUPAGE) – *a broad-based coalition that promotes effective and sustainable policy, system and environmental strategies for children and families to achieve a healthy weight. FORWARD encompasses multiple strategies too numerous to enumerate here, but of special relevance are those programs which can be incorporated into medical homes to identify overweight and obese patients and then provide provider training, patient counseling, and referral to community programs as required. This plan intends to support goals advanced in FORWARD’s strategic plan once ratified.*

Key Metrics: Strategic Plan to be Included once ratified



SMOKING CESSATION – *DuPage County Health Department offers free smoking cessation classes and peer support throughout the year. Classes are offered without regard to income and attendees also receive free smoking cessation aids.*

Key Metrics: # of classes, # of participants, and quit rate.

GOAL 2L - ESSENTIAL HEALTH SERVICES – COORDINATED CARE

Every individual within the target population benefits from care coordination models developed to increase efficiency and effectiveness of care delivery. Increasingly, it is presumed that models will reduce barriers to creation of high performing interdisciplinary teams and multi-sector partnerships incorporating all relevant health and human service partners.

Note: Care coordination and case management are integrated into many of the strategies outlined within this plan. This section therefore focuses on new innovations or efforts not otherwise identified in other sections.

Responsibility for achieving this goal as described within this plan is shared between the DuPage Health Coalition and other community partners.

DuPage Health Coalition

ACCESS DUPAGE UTILIZATION MANAGEMENT – **Appropriate** use of a hospital emergency department occurs when a reasonable person might conclude that a medical emergency exists. A medical emergency is defined as “severe symptoms which occur suddenly and unexpectedly, and if treatment is not rendered within the first 48 hours on onset, could cause serious harm to bodily functions or even death.” Emergency department services are not appropriate for (1) conditions that have been present for a number of days and have not suddenly worsened, or (2) conditions that are neither life-threatening nor permanently damaging.¹ Appropriate use of a convenient care center occurs when a patient has been directed there by a Medical Home provider for after-hours care or for a situation requiring immediate attention that the Medical Home provider is unable to provide. Because emergency department/ convenient care services have a high potential for inappropriate utilization by Access DuPage members, particular attention will be paid to monitoring the use of such services.

Key metrics: Access DuPage ED Use Rate and total annual cost of care per AD Enrollee.



MCO PARTNERSHIPS – Medicaid Managed Care has brought new entrants, managed care organizations (MCOs), into our healthcare landscape. These MCO’s enter into contracts with the State of Illinois to provide health care to specific populations of enrolled Medicaid beneficiaries. DuPage Health Safety Net partners will seek opportunities to partner with such MCOs to develop collaborative care coordination models that improve healthcare access and delivery.

Key Metrics: # of Formal Partnerships initiated; other metrics TBD



DATA INTEGRATION FOR HEALTH IMPACT (DASH DUPAGE) – In partnership with other health care partners, the DuPage Health Coalition will explore opportunities to integrate data collection and communication efforts between providers of traditionally defined health care and human service partners serving the same patient populations. Examples of early efforts include data sharing between the health department and hospital partners and EPIC Access for the Access DuPage program.

Key Metrics: Development of mutual consent documents; # of new data sharing relationships initiated.



HIGH INTENSITY PATIENT NAVIGATION SERVICES *Building on the success of ongoing patient navigation services, Access DuPage will identify a small number of patients whose utilization and disease burden suggests would benefit from higher level support services.*

Key Metrics: # of clients served; other metrics TBD



CARE COORDINATION FOR SILVER ACCESS ENROLLEES *— In addition to providing subsidy assistance to purchase health insurance, the DuPage Health Coalition will work with partners to identify strategies improving the health literacy of new entrants in the health care marketplace. Plans may include education about program use but may also offer additional navigation support.*

Key Metrics: # of clients served and percentage of clients connected to primary care

DuPage Health Coalition, DuPage Federation on Human Services, & Other Partners TBD



COMMUNITY STRATEGIES SUPPORTING AGING WELL *- In partnership with other health care partners, the DuPage Health Coalition and the DuPage Federation will explore opportunities to enhance partnerships between providers of health and human services for seniors and caregivers. To support this project, the DuPage Federation will develop a new profile on aging, the DuPage Health Coalition will analyze Medicare connected assets and barriers to care (current and projected) and a planning project will be initiated, guided by the data and community leader insight.*

Key Metrics: Profile Completion, Planning Project Initiation



To support this project, the DuPage Federation will develop a new profile on aging, the DuPage Health Coalition will analyze Medicare connected assets and barriers to care (current and projected) and a planning project will be initiated, guided by the data and community leader insight.

GOAL 3A – ESSENTIAL HUMAN SERVICES – SUPPORTS FOR PERSONS WITH PHYSICAL AND MENTAL DISABILITIES

Every individual within the target population has access to supports for persons with physical and mental disabilities, such as supported employment, permanent supportive housing and vocational rehabilitation.

Responsibility for achieving this goal as described within this plan is shared between the DuPage Federation and other community partners.

DuPage Federation on Human Services Reform



COMMUNITY PROFILE AND SYSTEM CAPACITY ANALYSIS EVALUATING DELIVERY OF SERVICES TO PERSONS WITH DISABILITIES *— In collaboration with PACT and other providers of services,*

the DuPage Federation will undertake the completion of a profile on persons with physical and developmental disabilities, and subsequently develop indicators of system capacity compared to identified needs.


Key Metrics: Completion of Profile on Persons with Physical and Developmental Disabilities; development of indicators of system capacity compared to estimated need.

GOAL 3B – ESSENTIAL HUMAN SERVICES – PROTECTIVE SERVICES


Every individual has access to protective services such as child welfare services, sexual assault and domestic violence services, and adult protective services.

Responsibility for achieving this goal as described within this plan is shared between the DuPage Federation and other community partners.

DuPage Federation on Human Services Reform

 **PROTECTIVE SERVICES ALIGNMENT INITIATIVE** – *Given tight regulations and parallel but sometimes redundant efforts, it is hoped that improved coordination of effort might achieve greater efficiency without compromising support to consumers. Often there are multiple organizations and systems of protection engaged with the same or similar clients. The Federation will convene a discussion among those responsible for protective services to adults, to identify ways to align and simplify currently overlapping systems and make them more efficient*

Key Metrics: TBD


 *Although a number of community partners provide 24 hour coverage for acute protective service needs (sexual assault, dv, elder abuse, etc.) DuPage County providers have not conducted a formal review to determine whether there is an opportunity for increased efficiency through closer alignment of efforts.*

GOAL 3C – ESSENTIAL HUMAN SERVICES - SAFETY NET HUMAN SERVICES

Every individual within the target population has access to safety net human services, including affordable housing or shelter, public benefits, food, utilities, crisis intervention services, etc.


Responsibility for achieving this goal as described within this plan is shared between the DuPage Federation and other community partners.

DuPage Federation on Human Services Reform

 **CLIENT SUBSIDY** – *The Open Door project , under the umbrella of the DuPage Federation, will review best practices and develop or adopt existing protocols for efficient use of 'flexible funds' that can be used to address homeless prevention and other emergency needs, as well as metrics assessing the impact and benefit of these funds for families in crisis.*

Key Metrics: TBD

Other Community Partners

 **FAMILIES BUILDING FUTURES 2.0** – *In cooperation with DuPage County Health Department, Peoples' Resource Center, DuPage County Community Services and other partners, this project will work with Open Door clients with serious barriers toward achieving self-sufficiency through peer support and intensive case management.*


Key Metrics: TBD

GOAL 3D –ESSENTIAL HUMAN SERVICES – PREVENTION AND EARLY INTERVENTION

Every individual within the target population has access to prevention and early intervention geared programs that keep problems from occurring or manage this in a proactive, cost and impact effective manner, such as pregnancy prevention and substance abuse prevention for adolescents, etc..


Responsibility for achieving this goal as described within this plan is shared between the DuPage Federation and other community partners.

DuPage Federation on Human Services Reform

 **EARLY CHILDHOOD REGIONAL COLLABORATIVE** – *The Early Childhood Research Collaborative is a broad coalition of providers and funders working to ensure that all DuPage children enter kindergarten safe, healthy, ready to succeed and eager to learn. Includes early childhood needs assessment. The intention is to start early in order to make sure that these children mature into successful students and eventually into successful adults.*

Key Metrics: TBD

Other Community Partners

 **1,000 DAYS** – Under the leadership of the DuPage County Health Department, the 1,000 days project is focused on increasing rates of breastfeeding and reducing child food insecurity.

Key Metrics: TBD

GOAL 4 - SOCIAL DETERMINANTS OF HEALTH

DuPage County will grow our capacity to effectively track and manage the Social Determinants of Health


The World Health Organization defines the social determinants of health (SDH) as “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.” We recognize that health, broadly defined, is inseparable from these conditions, and, as such, we understand that no plan for health care can ignore these important factors affecting health. Accordingly, this plan seeks first to understand and ultimately to reduce those disparities in health and well-being which are either caused by or directly correlated to poverty. Notably, efforts should focus on both harm reduction, where social determinants of health disproportionately and negatively impact low income community residents, and also health promotion, where there is evidence that social and environmental forces can buffer or bolster the health of the community.

Relationship between social determinants and health – From a disparities lens, social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries and population groups. Low socioeconomic status is associated with an increased risk for many diseases, including cardiovascular disease, arthritis, diabetes, chronic respiratory diseases, and cervical cancer as well as for frequent mental distress.

Responsibility for achieving this goal is shared between all partners, but the DuPage Federation and the DuPage Health Coalition will take a leadership role in advancing this effort.

This is a new goal to both organizations, with both leadership and funding still to be determined. It is anticipated that successful efforts to examine, understand, and strategically address social determinants of health will require equal health and human service collaboration, and will thus succeed through shared goal setting, leadership, and funding.

Other Community Partners


 **SOCIAL DETERMINANT DATA DASHBOARD** – DuPage County does not currently have a shared means of tracking our success promoting positive social determinants and reducing health disparities tied to social determinants (often but not exclusively economic). In FY16 and FY17, priority will be placed on improved data collection and reporting and assessing key social determinant data. Where possible, Healthy People 2020 recommendations will be incorporated into the Impact DuPage tracking and website.


Key Metrics: Inclusion of Social Determinant Data in Dashboard. Likely key measures in to include % of persons living in poverty, % of renter households spending more than 30% income on housing, % of children 0-17 living in poverty, % of households with children reporting very low food security.

DuPage Federation on Human Services Reform

LANGUAGE ACCESS RESOURCE CENTER (LARC) – *The Language Access Resource Center offers intensive training programs to professionals interested in supporting limited English proficient consumers with high quality interpreting and translating services. In addition to training interpreters, LARC coordinates provision of services, offering competitively priced high quality interpretation in dozens of languages. The Federation plans to continue operating its LARC program, growing service delivery and training capacity to meet demand in sectors of health, education, legal system, law enforcement, and human services.*

Key Metrics: # of trainings, # of languages; # of hours if interpretation provided, # of interpreters trained


 Areas of particular focus include finding and training interpreters fluent in the languages of new refugee resettlement.

 **COMMUNITY INTERPRETING TRAINING** – *Among new immigrant and refugee communities, often there is no one who speaks English well enough to be admitted to our traditional Interpreter training, but interpretation needs persist*


Key Metrics: # of trainings, # of languages

 **ADDITIONAL PROFILE REPORTING AND UPDATING** – *The DuPage Federation will review and update current Federation Profiles of At-risk Populations, with the goal of developing detailed descriptions of conditions facing at-risk populations and formulating recommendations for impactful strategies.*

Key Metrics: Number of Profiles updated. Goal is update of 1 profile per year.

 **CHILDHOOD TRAUMA (ACES)** – *There is compelling data to suggest that exposure to childhood trauma has long lasting negative health results, increasing rate and disabling consequence of physical and behavioral illness. This project will first identify the impact of adverse childhood experiences on children's ability to succeed in school and in life, then recommend practical steps that can be taken in health, human services, education and law enforcement settings to address and mitigate these impacts.*

Key Metric: Profile to be completed in 2016

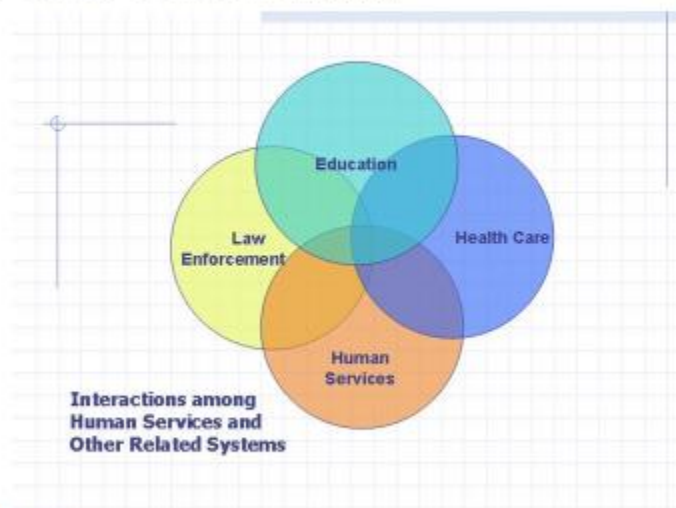
 The Federation will compile a profile on Adverse Childhood Experiences, which will include an inventory of service providers likely to encounter traumatized children as well as services addressing the effects of trauma. The profile will make recommendations for identification and treatment.

APPENDIX 1: STATISTICS RELATED TO THE TARGET POPULATION

What Do the Data Tell us?



“It’s all a lot more interconnected than I ever realized....”

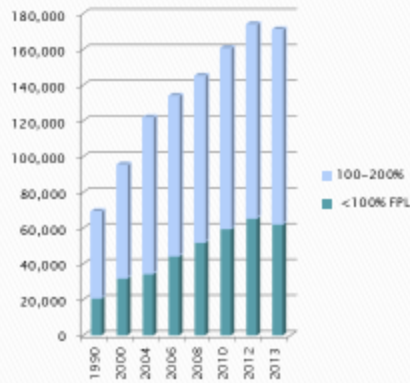


Selected Collaborations DuPage

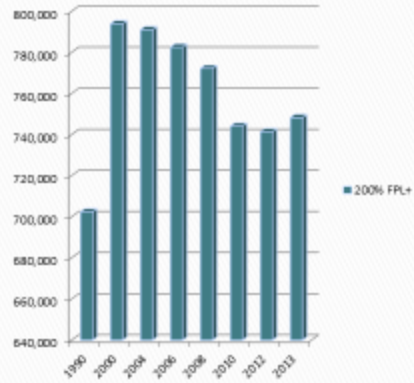
When	What	Topic	Result
1995	DuPage Federation	Welfare Reform	Research, Planning, Change Management
1997	Continuum of Care	Homeless	Reduced need, increased resources
2001	Access DuPage	Access to Care	Organized \$328 million of donated care to 49,693 patients over 12 years
2003	First DuPage Medical Access Plan	Access to Care	Expanded access to health, mental health, oral health care
2003	First FQHC in DuPage	Access to Care	Navigated process to establish first FQHC in county; now there are 5.
2004	Positive Parenting DuPage	Parenting	Coordinated services for new parents
2005	DuPage Mental Health Access Plan	Access to Mental Health Care	Increased access to MH care, including multi-lingual services
2005	Language Access Resource Center	Linguistic Access	1,000 Interpreters trained; >20,000 interpreter sessions; 50 organizations trained
2005	We Go Together for Kids	Access to Care	Mental Health, Nutrition, After school
2007	DuPage Health Safety Net Plan I	Health Planning	FQHCs, DuPage Health Coalition
2007	DuPage Health Coalition	Health Planning	Increased access to health care
2007	DuPage Oral Health Plan	Access to Care	Increased access to oral health care
2007	DuPage Funder Collaboration	Planning	Community Assessment, precursor to Impact DuPage
2008	FORWARD	Obesity	All schools tracking BMI
2008	DuPage Patient Navigation Project	Access to Care	Increased access to cancer treatment
2009	Community Healthcare Network of the Western Suburbs	Access to Care	Increased access to health care in West Cook suburbs
2011	Coordinated Access To Community Health	Access to Care	Increased access to health care Sangamon County
2012	DuPage Health Safety Net Plan II	Health	ACA Implementation, Transition
2013	Enroll DuPage	Access to Care	Enrollment in ACA coverage
2013	Engage DuPage	Access to Care	Increased coverage for uninsured ED patients
2014	Impact DuPage	Planning	Analyze data, set priorities, Collective Impact
2013	Northeast Illinois Home Centered Care	Complex Seniors	Develop model for home centered care for multi-problem seniors and persons with disabilities.

Trend One:
DuPage County has become more diverse, less affluent and older.

Low Income Populations are Growing while Higher Income Populations decline



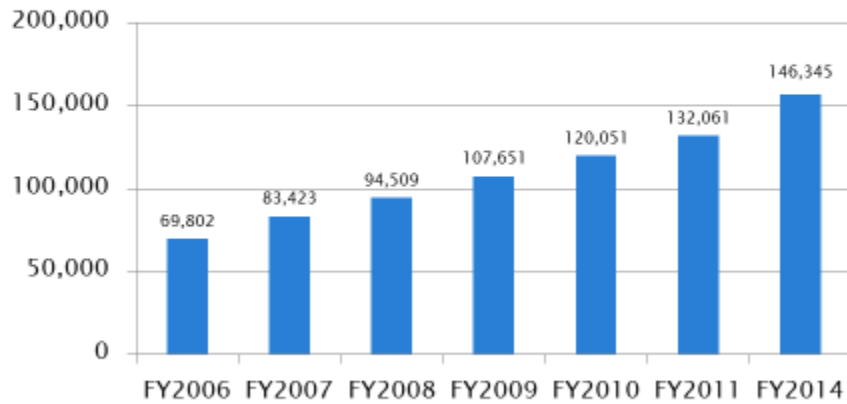
Low Income



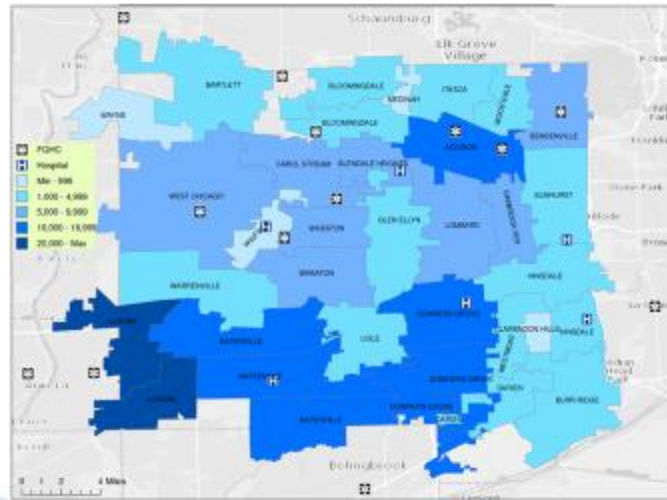
More Affluent

Medicaid Enrollment in DuPage has grown dramatically over the past few years.

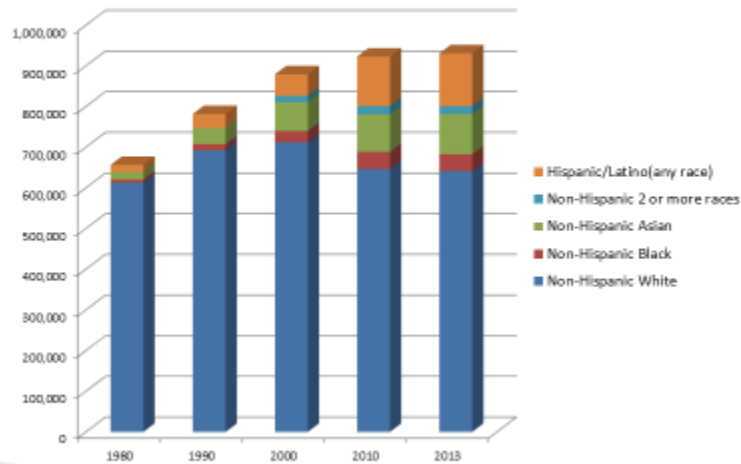
DuPage Medicaid Enrollment



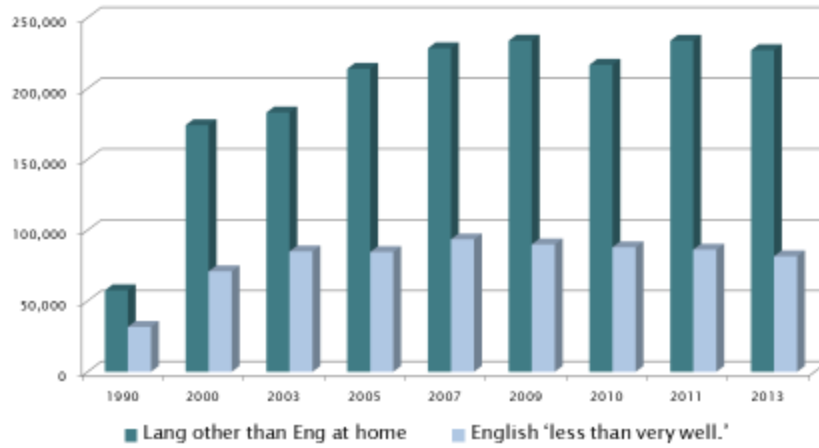
Medicaid Enrollment in 2014



Change in Racial/Ethnic Population DuPage County 1980-2013



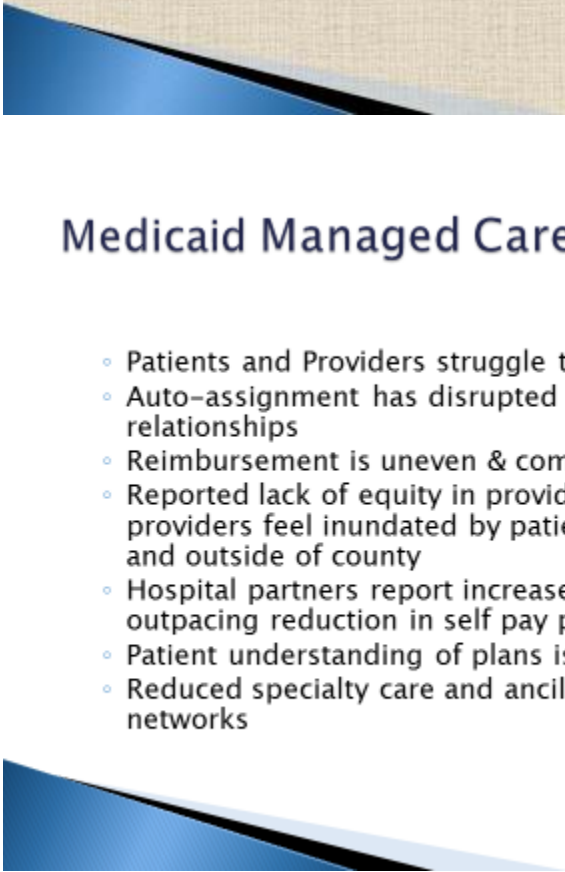
The number of people in DuPage County with limited English proficiency is significantly increasing.



The Silver Tsunami

DuPage	2000	2015	2020	2025	2030	Change
Total >65	88,948	133,018	163,604	196,131	223,164	457%
Asian > 65	6,003	18,863	24,576	30,778	37,677	528%
Hispanic >65	1,988	5,502	7,889	11,326	15,690	689%
White >65	83,575	114,282	137,361	161,428	178,636	114%
Black >65	726	2,269	3,325	4,668	6,221	757%



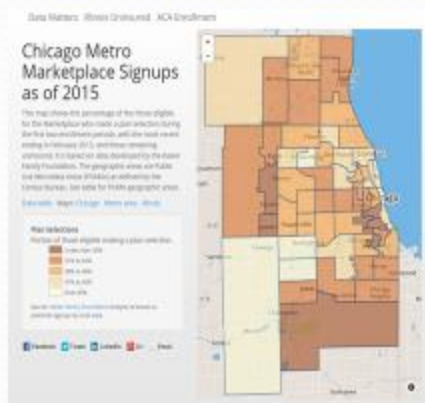


Trend Two: Changes are presenting new challenges and opportunities

Medicaid Managed Care

- Patients and Providers struggle to navigate new systems
- Auto-assignment has disrupted historic patient relationships
- Reimbursement is uneven & communication challenging
- Reported lack of equity in provider participation; providers feel inundated by patients coming from within and outside of county
- Hospital partners report increases in Medicaid patients outpacing reduction in self pay patients and bad debt
- Patient understanding of plans is very poor
- Reduced specialty care and ancillary care due to narrow networks

ACA Marketplace Enrollment



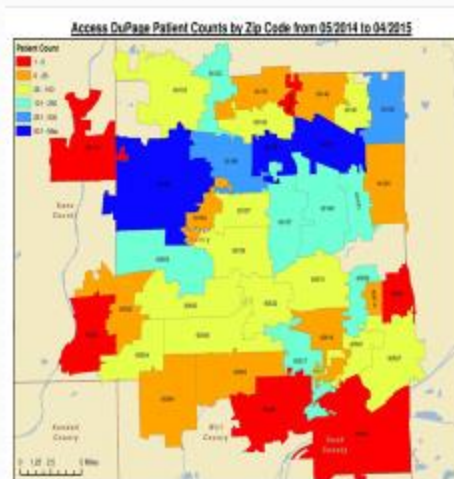
- ▶ Bronze plans avoid tax penalty but offer \$K+ deductible and no carve outs for medication or primary/specialty care
- ▶ Legal US residents in US fewer than 5 years disproportionately hit; zero income families have premiums & out of pocket costs
- ▶ National data and navigator report confirm high rate of bronze plan and/or no plan selection amongst lowest income families
- ▶ Rate of uninsurance below 10% nationally, but still leaves thousands uninsured.

1 in 3 Eligible Patients Enrolled in ACA in DuPage

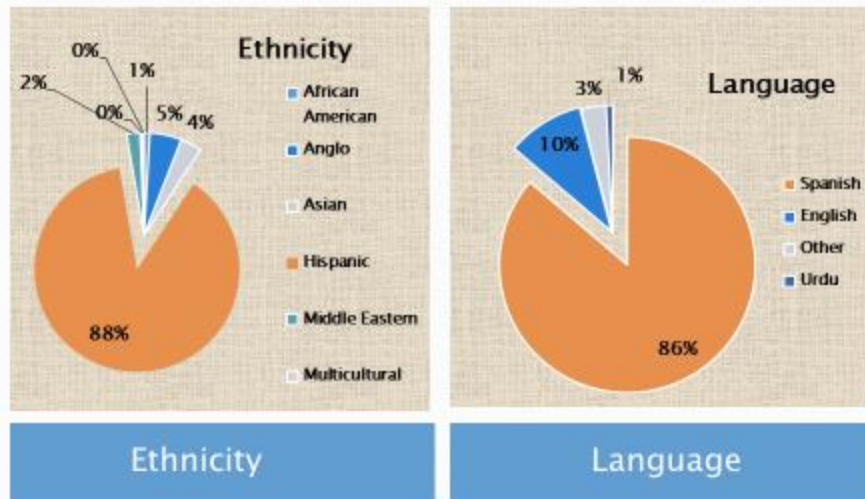
Many Low Income patients remain un/underinsured

Access DuPage

- ▶ Prior to ACA more than 12,000 enrollees annually
- ▶ In FY 16 Access DuPage anticipates average enrollment of 4,000 and annual enrollment of ~6,000
- ▶ Typically employed at low wage service jobs
- ▶ Although all communities are represented, highest enrollment from West Chicago, Carol Stream, Glendale Heights, Addison, Bensenville, Lombard, Westmont, Downers Grove
- ▶ Patients are slightly younger, healthier; high generic pharmacy utilization
- ▶ Most patients treated at FQHCs for primary care
- ▶ Strong specialty care participation; more than 950 patients received more than 1500 referrals to specialists in FY 14
- ▶ DuPage County Hospitals and DuPage County Board of Health are largest sources of financial support, along with CMF and United Way
- ▶ Direct Program cost of **\$471 per member per year**



Access DuPage Patient Demographics FY 15



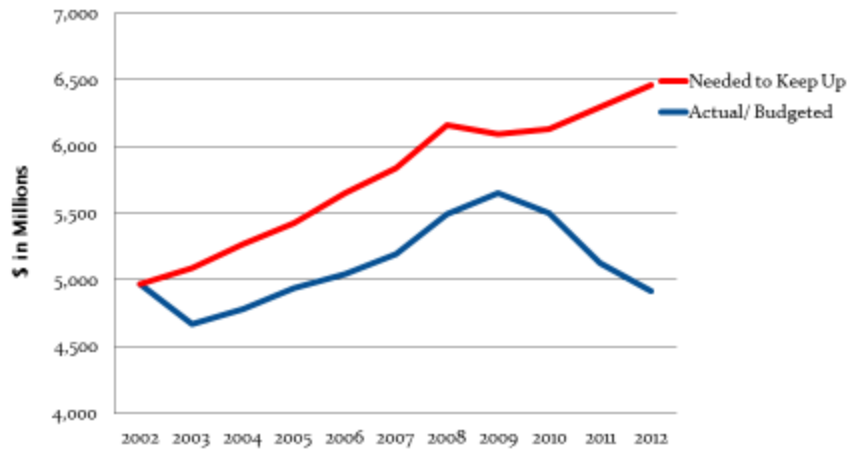
State and Federal Budget Challenges

- ▶ No budget hitting human services very hard
- ▶ 29% cut since 2012
- ▶ Late payments affecting both sectors
- ▶ Misallocation of funding hits DuPage hard
- ▶ Government shutdown likely
- ▶ Budget pressures at Federal level

State

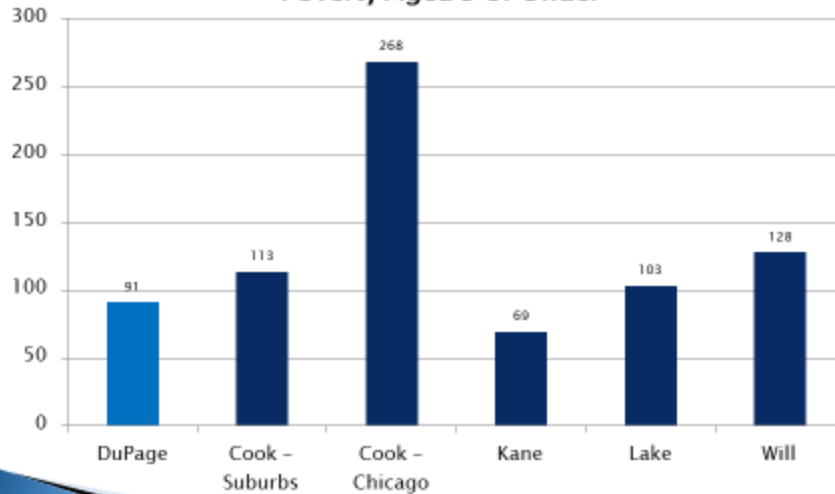
Federal

Comparison of Illinois Statewide Human Service Budget to Inflation and Population: 2002–2012



Source: Center for Tax and Budget Accountability

Head Start Enrollment per 1,000 Children in Poverty Aged 5 or Under



Source: Illinois Early Childhood Asset Map and U.S. Census

Trend Three: Adverse Childhood Experiences Impact Long-term Health

Two important lines of research

- ▶ ACES Study – Researchers identified impact of childhood trauma on health outcomes in adulthood. Those with 4+ types of trauma had significantly worse health and social outcomes.
- ▶ To Fix Health, Help the Poor – Researchers examined health *and* social services expenditures in several countries and found that health outcomes were better in countries with higher social services spending.

Adverse Childhood Experiences (ACES)

- Abuse
 - Emotional
 - Physical
 - Sexual
- Neglect
 - Emotional
 - Physical
- Household Dysfunction
 - Mother treated violently
 - Household substance abuse
 - Household mental illness
 - Parental separation or divorce
 - Incarcerated household member

Examples: Health Effects of ACEs

- Heart Disease 2.2x
- Depressed 4.6x
- Suicide attempt 12.2x
- Alcoholic 7.4x
- Illegal drug use 4.7x
- Injected drugs 10.3x
- STD 2.5x
- Cancer 1.9x
- Stroke 2.4x
- Pulmonary Disease 3.9x
- Diabetes 1.6x
- Broken bones 1.6x
- Hepatitis/jaundice 2.4x
- Fair/poor health 2.2x
- Juvenile Delinquency
- Teen Pregnancy
- Educational Failure
- Violence

