DeKalb County Board of Health Meeting

TUESDAY, JUNE 25, 2024

I. Approval of Agenda

APPROVAL OF THE BOARD OF HEALTH MEETING AGENDA OF 06-25-2024

II. Approval of Minutes

APPROVAL OF THE BOARD OF HEALTH MEETING MINUTES OF 05-28-2024

APPROVAL OF THE PERSONNEL COMMITTEE MEETING MINUTES OF 06-13-2024

III. Committee Reports

IV. Persons To Be Heard From The Floor*

* Any member of the public may address the Board of Health or Committee for up to 3 minutes on any topic of their choosing, limited to thirty minutes in total.

V. Presentation

FAMILY CASE MANAGEMENT (FCM) PROGRAM

PRESENTED BY LISA GONZALEZ, PUBLIC HEALTH ADMINISTRATOR

FCM – **Who do we serve?**

- Any pregnant individual or child through the age of one year enrolled in the Medicaid program or whose income is up to 200% of the federal poverty level.
- Pregnant and postpartum individuals are eligible for services in Family Case Management throughout their pregnancy and up to 9 months after delivery date.

FCM – **Who do we serve?**

- Infants are eligible for services in Family Case Management throughout the first year of life.
- Family Case Management supports the whole family, with a focus on the infant and postpartum mom.

FCM – **Program Goals**

- The Family Case Management Program is a statewide program that provides comprehensive service coordination to improve the health, social, educational, and developmental needs of pregnant individuals and from low-income families.
- Family Case Management aims assess needs and increase positive health outcomes for infants and children and reducing infant mortality.

FCM – The First Appointment

- Clients meet with a RN during intake to develop their individualized care plan empowering parents to collaborate in making goals for their pregnancy and infant care.
- Clients are also enrolled in WIC and receive referrals to other community programs.

FCM – Safe Sleep Home Visit

- All infants receive one home visit focused on safe sleep.
- Information on best practices for safe sleep is shared.
- Families can receive a sleep sack and pack and play at the home visit, funded through a grant from Northwestern Medicine.

FCM – **Assessments**

- Nurses can provide head to toe physical assessments for infants.
- All moms receive prenatal and postnatal depression screening.
- Nurses follow up with client's OB or primary care doctors when there is a concern.

FCM – **Ongoing Care**

- Clients are able to meet with any Nurse or Nutritionist or follow up in person visits.
- Clients are monitored by their primary case manager, and are seen in the office every three months.

FCM – **High Risk Infant Follow Up**

- The FCM High Risk Infant Follow-up program is for infants born with high risk factors such as prematurity, small size for gestational age and birth defects. Infants who meet the eligibility guidelines are referred to DCHD by the hospital when the infant is discharged home.
- Public Health Nurses can work with the families for the first two years of life. There is no income eligibility for participation and the program is free.

FCM – High Risk Infant Follow Up

Services Provided –

- Assistance in obtaining pediatric primary care, including well-child visits, immunizations and specialty medical care.
- Developmental screenings of the infant by the Public Health Nurse at specified ages.
- Home visits by Public Health Nurse until your child is 2 years of age, or until you no longer need the service.
- Referral to appropriate community resources and services based on the assessment of the infant/family needs.

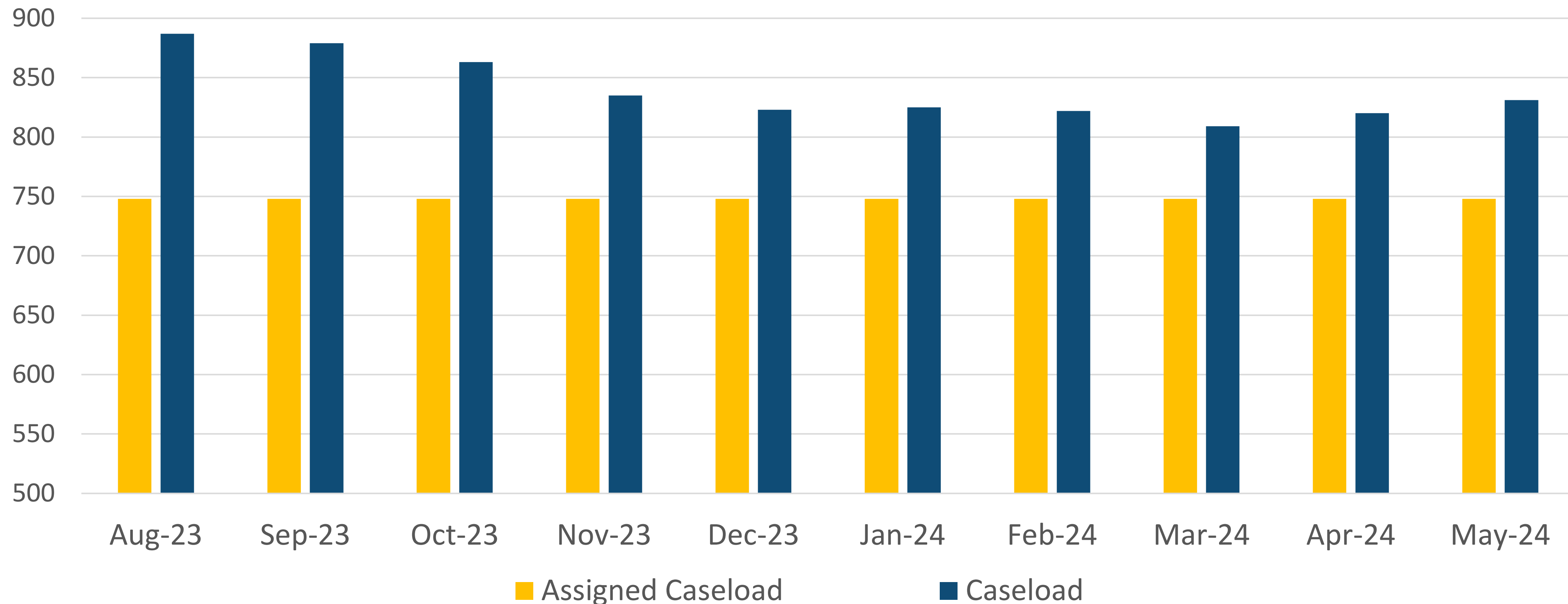
FCM – High Risk Infant Follow Up

Conditions that are considered high risk -

- A birth defect or congenital anomaly
- A blood disorder
- Infant death (before discharge from the newborn stay)
- A metabolic, endocrine, or immune disorder
- Multiple births (3 or more)
- Prematurity (less than 30 weeks)
- A prenatal drug exposure
- A serious congenital infection
- Other conditions

Family Case Management Caseload

Consistently above assigned caseload; currently enrolling 16 new families per week.



DeKalb County Health Department
Prevent • Protect • Promote

FCM – **Funding**

- Bureau of Maternal & Child Health Grant
  - Caseload Assignment for SFY25: **748**
  - SFY25 Funding Based on Caseload: **$396,440**

FCM Billable Screenings

Payer Source	2019	2020	2021	2022	2023	2024 Jan-June
Medicaid	$60,440	$35,955	$18,560	$33,698	$38,044	$41,118
Private Pay	$5,368	$5,061	$1,635	$6,907	$2,929	$2,272
Total	**$65,808**	**$41,016**	**$20,195**	**$40,605**	**$40,973**	**$43,390**

Ages and Stages Developmental Screening	
Per Screening	$16.08

Edinburgh Depression Screening	
Per Screening	$24.23/ $14.60

FCM – Nurse Case Managers

Alex Diehl
Public Health Nurse

Gaby Ortiz
Public Health Nurse

Susan Scheffler
Public Health Nurse

Michele Aldridge
Public Health Nurse

Lasting Impacts of FCM

“Its rewarding when clients take information that we talk with them about to the doctor to advocate for their baby’s needs.”
- Nurse Case Manager

“I love it when we remove barriers and we can meet their needs, but it is frustrating when the systems outside the health department are overwhelmed.” *- Nurse Case Manager*

“We work together to ask, “what else can we do for you?”
- Nurse Case Manager

Lasting Impacts of FCM Continued

“Because we are removing barriers we are retaining clients and able to help them make change.” - *Nurse Case Manager*

“What I do is meaningful. I have autonomy to impact long term outcomes. For many families I am it! I am their only source of education, guidance and support.”
- Nurse Case Manager

Questions?

VI. Combined Report

NONE

VII. Financial Data

REVIEW AND APPROVAL OF FINANCIAL STATEMENT FOR MAY 2024

VIII. Old Business

2022-2027 IPLAN – FINAL REVIEW AND APPROVAL

Illinois Project for Local Assessment of Needs (IPLAN)

- The IPLAN is a community health assessment and planning process that is required of, and conducted every five years by, local health jurisdictions in Illinois.
- IPLAN is grounded in the core functions of public health and addresses public health practice standards.

Review of IPLAN Components

Community Health Needs Assessment

Community Health Improvement Plan

Organizational Capacity Assessment

In lieu of an Organizational Capacity Assessment, the DeKalb County Health Department (DCHD) completed a Strategic Plan, an allowed acceptable alternative, according to the Illinois Administrative Code, Section 600.410.

Community Health Needs Assessment (CHNA)

The CHNA aims to identify prevalent health needs among residents in DeKalb County, illuminating health disparities that particularly affect medically underserved, low-income, and uninsured populations.

CHNA insights inform the development of new strategies with the goal of advancing public health and well-being within our communities.

Prioritization

- The Community Engagement Council's (CEC) goals are to review, discuss and analyze the primary and secondary data collected in the CHNA process, identify prevalent health needs among residents in DeKalb County, and prioritize the identified community health needs.

Rank	Health Priority
1	Behavioral Health
2	Access to Health Care
3	Cardiovascular Disease
4	Substance Use Disorders
5	Cancer
6	Diabetes
7	Obesity
8	Food Access
9	Homelessness and Housing
10	Transportation

2022-2027 IPLAN Priorities

Behavioral health

Access to Care

Substance Abuse

Community Health Improvement Plan (CHIP)

- The CHIP was developed using the priorities selected by the CEC during the prioritization portion of the CHNA process.
- Research was conducted to determine the evidence-based intervention strategies under each health priority.
- The outcome objectives, impact objectives and intervention strategies were selected based on the available community health data and in alignment with existing community and health department priorities and funding opportunities.

CHIP Priority #1

- **Behavioral health** encompasses eating, sleep, attention and hyperactivity, impulse control, personality, developmental, trauma and stressor-related, psychosomatic, mood, substance abuse and mental health disorders.
- Each of these issues can significantly impact an individual's overall health and quality of life, requiring comprehensive and integrated approaches to treatment and support.

Behavioral Health Objectives

Outcome Objective:

Establish a coordinated system for people diagnosed and/or living with behavioral health conditions in DeKalb County no matter their age, race/ethnicity, gender, or socioeconomic status, by 2027.

Behavioral Health Objectives

Impact Objectives:

1. Decrease stigma and increase behavioral health literacy by partnering to provide two annual Mental Health First Aid trainings for community members.
2. Increase community awareness of adverse childhood experiences (ACES) and trauma by partnering to provide at least one trauma-specific training every two years.
3. Improve the system of care for children 0-8 years old with an emphasis on early screening, detection and referral into behavioral health services.

CHIP Priority #2

- **Access to Care** refers to the ability of individuals and communities to obtain timely and appropriate medical services, including preventive, diagnostic, treatment, and rehabilitative care, as needed to maintain and improve health outcomes.
- Access to care is a fundamental component of healthcare equity and plays a crucial role in promoting overall well-being and reducing disparities in health outcomes.

Access to Care Objectives

Outcome Objective:

To promote and advocate for a system of care that assures accessibility, availability and quality prenatal, preventive, primary care and health education for individuals and families in DeKalb County by 2027.

Access to Care Objectives

Impact Objectives:

1. Decrease the number of people who are uninsured.
2. Increase utilization of healthcare enrollment assistance.
3. Increase pregnant women receiving early and adequate prenatal care.
4. Increase the number of women who receive assistance with the completion of the Medicaid Presumptive Eligibility (MPE) application.
5. Increase the number of families who receive assistance All Kids Insurance applications.

CHIP Priority #3

- **Substance Abuse** is the harmful/hazardous use of psychoactive substances, including alcohol and illicit drugs, characterized by a pattern of behavior that leads to significant impairment or distress, such as failure to fulfill responsibilities, risky use, social or interpersonal problems, and physical dependence.

- Substance abuse can lead to physical and mental health issues, financial and legal problems, and strained family relationships. It burdens communities with increased crime, economic costs and healthcare demands.

Substance Abuse Objectives

Outcome Objectives:

1. Reduce the drug overdose incidence rate by expanding the use of proven harm reduction strategies.
2. Reduce the incidence of tobacco use and vaping among youth.
3. Reduce the incidence of substance use among pregnant women.

Substance Abuse Objectives

Impact Objectives:

1. Develop a strategy to include fentanyl test strips for distribution through the DeKalb County Opioid Overdose Prevention Program.
2. Decrease the number of opioid overdoses in DeKalb County.
3. Increase the number of community partners who offer Naloxone distribution.
4. Reduce the rate of women who smoke during pregnancy.
5. Collaborate with Northwestern Medicine to expand and enhance current tobacco and vaping prevention and cessation programing for school aged children

2022-2027 IPLAN Next Steps

June

CEC and BOH to review and provide feedback on the CHIP.

BOH to review & approve the IPLAN.

July-Sept

DeKalb County 2022-2027 IPLAN is submitted to the IDPH.

IDPH reviews IPLAN and requests edits/clarification if needed.

IPLAN is approved and DCHD is re-certified by mid September.

Questions?

IX. New Business

X. Executive Session

EMPLOYMENT MATTERS

ANNUAL PERFORMANCE REVIEW OF THE PUBLIC HEALTH ADMINISTRATOR

XI. Correspondence and News

XII. Adjournment