MEETING MINUTES OF THE COOK COUNTY HEALTH CARE TASK FORCE

May 31, 2016

118 N. Clark St., 4th Floor Conference Room

I. Call to Order and Introductions

Attendees: Teresa Berumen, Mireya Vera, Michelle Garcia

II. Recommendations

Being that Community Health Workers primary focus is to improve health and social outcomes by building individual and community capacity for health knowledge and self-sufficiency through outreach, community education, informal counseling, social support, and advocacy.

Being that Cook County's limited English proficient population is significant in the County of Cook, according to the American Community Survey 8.4% of all households are linguistically isolated. Limited English proficiency (LEP) creates linguistic isolation. According to the American Community Survey, the following spoken languages demonstrate LEP populations in:

- Spanish 24.7 % LEP
- Indo-European (such as Polish, Russian, Italian, Greek,…) 26.6% LEP
- Asian/Pacific Islander (such as Mandarin, Cantonese, Hindi, Arabic, …) 28.9% LEP

Being that, uninsured and underinsured individuals continue to be 9% of persons that reside in the County of Cook; 12% Latinos/Hispanics and 12% African Americans according to enrollamerica.org 2015 data.

We therefore recommend for an improved direct access program to have the following:

1. The creation and utilization of a trained community health worker (CHW) model to offer culturally appropriate and linguistically appropriate communication to enrollees for enrollment and to facilitate navigation of the health care system. In addition, we recommend:
    a. One CHW position should be created for every 20 enrollees in program.
    b. The expansion of a CHW model in order to increase existing outreach and education efforts, as well as provide follow up services and ongoing preventative care services to enrollees.
    c. That CHW's represent languages spoken in Cook County by percentage of individuals who speak a particular language in the Cook County community being served.
    d. This program collaborate with established CBO's to learn about best practices in the CHW model and on outreach efforts.
2. The utilization of trained and qualified interpreters, foreign language and American Sign Language (ASL), for the limited English proficient (LEP) and deaf and hard of hearing individuals according to federal and state mandates.

    a. We recommend language proficiency testing be required for all individuals working in a bilingual capacity, including those working in the CHW position.
    b. For those CHW's who are not bilingual, an interpreter should be utilized when working with an LEP or ASL patient to ensure meaningful access to the healthcare system.
3. The provision of a medical ID card that serves as a Medical presumptive eligibility ID card / Municipal ID within the program that can potentially also be used for other county/city services similar to the New York municipal ID.
4. Patients never are charged more than 20 dollars per visit when seeking care within the program based on 600% Federal Poverty Guidelines. .
5. Charges made to individuals enrolled in the program for medical equipment not exceed allowable Medicaid program charges, including copays.
6. The exploration of a transportation program for those individuals that are unable to use public transportation to access health care facilities.
7. The expansion of the low cost pharmacy program currently existing within CCHHS for enrollees of the improved direct access program in order to provide consistently low cost medication to all enrollees.
8. On-going customer service training for all program staff to achieve customer service excellence.
9. The creation of one standard application for programs that currently exist and would be encompassed by an improved direct access program.

IV. Public Registered Speakers

None