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: Commissioner Bridget Gainer, Commissioner Chuy Garcia, Venoncia Bate, Linda Coronado, Michelle Garcia, Steven Glass, Kathleen Gregory, John Keller, Sandy Kraiss, Diane Limas, Andrea Munoz, Dr. Linda Rae Murray, Luvia Quinones, Dan Rabbitt, Sendy Soto, John Squeo, Mireya Vera

II. Subcommittees Breakout

Subcommittee met from 8:15 – 9:00 a.m. See subcommittee minutes

III. Public Registered Speakers

None

IV. Recommendations

Partnerships Subcommittee

*(*Guest Speakers: Sherri Cohen, Healthy Chicago 2.0 and Judy Haasis, Community Health)

1. Explore using existing backbone organizations, i.e., County Care, to create the most complete network to provide care for the uninsured.
2. Restore and increase funding to serve the uninsured and safety net;
3. Explore opportunities to remove economic barriers to health access, for example, sliding scale fees;
4. Support and/or work in collaboration with other health access efforts including but not limited to Healthy Chicago 2.0, Healthy Impact Collaborative of Cook County, Cook County Department of Public Health's WE Plan, the Chicago Hospitals Community Needs Health Assessment, and the State Health Improvement Plan (SHIP), and plans of other suburban public health departments.

Finance Subcommittee

1. ONE STANDARD OF CARE. High quality comprehensive personal health services built on primary & community health principles - which must include behavioral and oral health - and coordinated with appropriate specialty services. And equally important high, quality public health services dedicated to fighting for the conditions necessary for healthy individuals and communities.
2. The Cook County Health and Hospitals System is committed to achieving HEALTH EQUITY and the ELIMINATION OF STRUCTURAL RACISM. A commitment to provide CULTURALLY APPROPRIATE AND LINGUISTICALLY SPECIFIC CARE. A commitment to have a well trained staff at all levels including COMMUNITY HEALTH WORKERS that reflect the communities CCHHS serves. A commitment to actively participate in PIPELINE AND HEALTH WORKER TRAINING PROGRAMS TO CHANGE THE FACE OF HEALTH CARE.

3. A commitment to ADEQUATELY FUND CARE for the uninsured and under-insured. The present situation of $369 million of uncompensated care (which excludes the costs of care at Cermak Health Facilities and the public health services provided by the Cook County Department of Public Health) and only $121 million is not sustainable. More importantly, this does not allow for appropriate investment in the CCHHS operational infrastructure. A promise to send NO patient to a collection agency.

Data/IT Subcommittee

1. Use the Medical Home model which will link patients with care anchored in the safety nets;
2. Explore ways to leverage systems to gather information in order to understand total access to care.
3. Do an evaluation (pilot) project (with 10 Hospitals/FQHCs)

Barriers Subcommittee

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 collaborates 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.

V. Public Registered Speakers

None