

Appendix A

**Discussion Results from the Regional Health Care
Safety Net Summit**

Health and Medicine Policy Research Group

Summit held June 23rd, 2009

**Preliminary Recommendations for the Health Care Safety Net in the 7-county
Region of Northeastern Illinois**

Introduction to Preliminary Recommendations

Health and Medicine Policy Research Group, in collaboration with 8 other organizations, began the Regional Health Care Safety Net Initiative in 2006 to build on the successes of the previous Chicago/Cook County Summit and to address the new and intensified problems of today. This collaborative effort, which uses the World Health Organization's framework for strengthening a health system, is designed to create a **regional blueprint** to more efficiently and effectively provide quality health services for uninsured, Medicaid, and other vulnerable populations across the seven county region (Cook, DuPage, Kane, Kendall, Lake, McHenry, and Will counties). The economic downturn, political leadership changes, and shifting populations provide an opportunity to create sustainable change.

Since 2006, workgroups around six topic areas (Data and Demographics, Health Equity, Finance, Planning/Governance, Access to Personal Health Services, and Workforce) have convened to research the current state of the safety net in the region. The steady progress to date has resulted in:

- ❖ a detailed description about each of the seven county's needs and resources (through key informant meetings in each county and assembling of existing demographic, health services, and status data);
- ❖ background information about models and "leading practices" in other metropolitan areas; and
- ❖ prioritization and support for working on the region's needs at a Pre-Summit meeting in fall 2008.

Since February 2009, a Summit Planning Committee and other safety net experts, have used the work of the past 2 years to draft these preliminary recommendations for strengthening the health safety net, recognizing that the preliminary recommendations are not complete and perhaps may not include the BEST recommendations for the region. **These preliminary recommendations are a basis for discussion, debate, and collaboration to move the region toward a more coordinated and seamless safety net system.**

The June 23, 2009 Summit was a process designed to allow a large group of safety net stakeholders to come together to affirm the need for more regional efforts to secure the health care safety net and to respond to the preliminary set of recommendations and begin to develop ways of moving the recommendations to action. The discussion results of the Preliminary Recommendations breakout session at the Summit are outlined below. **Bolded** statements are edits and/or additions made during the Summit by participants. The worksheets were originally structured as follows:

- ❖ A problem statement developed by the workgroups for each topic area
- ❖ An overarching vision for that topic area
- ❖ A set of preliminary recommendations, usually in sub-categories that address the vision and problem statement
- ❖ When known, a brief description of local or other regional examples that are already implementing the recommendation
- ❖ Feedback was then requested regarding
 - Your organization's Level of Support for the preliminary recommendation on a scale ranging from 1 (not at all supportive) to 5 (very supportive).
 - Your organization's potential role in implementing this preliminary recommendation, from taking a Leadership role (**L**), to being a Participant (**P**) or Resource (**R**) in the effort, to simply desiring to Stay Informed (**SI**), or not taking any role (**NR**).

Preliminary Recommendations for the Northeastern Illinois 7-County Region: Discussion Results

Health and Medicine Policy Research Group

Regional Health Care Safety Net Initiative

Updated 7/16/09

Data/IT Problem Statement

Healthcare safety net providers in the northeastern IL region are faced with many data and information technology (IT) challenges, although many opportunities exist for improvement. The most significant challenges identified included:

1. IT systems do not currently link safety net services across the region.
2. Different municipalities and agencies collect their data differently, making it difficult to interpret geographical and population trends.
3. It is difficult to access regional aggregate data.

Data/IT Vision: There will be improved data sharing, data consistency, and data access throughout the region.

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support ¹	Your Role in Implementing this Recommendation ²
Data Sharing:			
A.) Encourage providers in the region to adopt electronic health records, especially as money from the American Recovery and Reinvestment Act becomes available to do so. Safety net providers and public health departments need to be equally involved in use of electronic health records.	Many areas across the U.S. have adopted the use of Electronic Medical Records.	4.8	Leader: David Carvalho (IDPH)
B.) Develop a Health Information Exchange that is both regional and statewide.			
C.) Link, to the extent possible , Electronic Health Records data to social services, mental health, and other systems not connected to the record in a manner to be specified with appropriate privacy	The Palmetto Project in South Carolina has created an enhanced HIPAA-compliant records management system called the AccessNET Information Management	4.6	Resource: David Carvalho

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² Participants were asked to describe their or their organization's role in implementing the recommendation. Roles included Leadership (**L**), Active Participant (**P**), Resource (**R**), Staying Informed (**SI**), or taking No Role (**NR**).

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support ¹	Your Role in Implementing this Recommendation ²
protections (e.g., secured access for only authorized users for authorized purposes) in order to track clients across service systems and as appropriate to track specific services provided.	System (AIMS) that includes a database accessible to all providers and navigators to ensure the patients receive the services they need.		
D.) Develop a referral system to refer residents across safety net institutions for needed care. This requires that computer and IT systems are interoperable in the region. This can eventually build into a state-wide referral system.	The Cook County Health and Hospital System uses the I.R.I.S. referral system to refer patients throughout the County. This could be broadened to include the entire region.	4.8	Resource: David Carvalho
E.) Improve provider understanding of limits and allowances of HIPAA and FERPA regulations among safety net providers so as to decrease barriers to sharing aggregate data, when necessary (Clarify with whom)	Information forums could be conducted to teach providers about the type of health information that can and cannot be shared according to HIPAA and FERPA regulations.	4.25	
F.) Create partnerships with non-health groups (i.e.: education, housing, transportation, urban planners, etc.) to create information exchanges that improve the linkages between health data and the social determinants of health.	Obesity is a health issue that is impacted not only by physiology and health behaviors (i.e.: diet and exercise), but also by food availability, land-use, public safety, and education. To be truly effective in reducing rates of obesity, all organizations that can impact the condition should work together.	4	Resource: Marie Connolly (St. Francis Univ.) Participants: Russell Pietrowiak (CMAP), Marie Connolly
G.) Encourage the public and the health community to use the upcoming Illinois 2-1-1 calling system to increase public awareness and access of health and safety net resources. Encourage safety net providers to ensure their information is	An Illinois resident from Kane County should be able to call the 2-1-1 system and find out where to locate a doctor who accepts Medicaid.	4.5	Participants: Russell Pietrowiak

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support ¹	Your Role in Implementing this Recommendation ²
inputted into the 2-1-1 system.			
Data <i>Comprehensiveness and Consistency</i>			
A) Develop service indicators for the regional and county-specific health safety net. Potential indicators could be the number of providers willing to take Medicaid, how many Medicaid patients they can take, length of wait time to see a provider, etc.	There may be a statewide public health informatics center for comprehensive health planning (if Governor signs bill)	4.33	Resource: David Carvalho Participant: Marie Connolly
B) Determine the health care resource capacity (agencies/organizations, hospital beds, staff, etc.) across the region, rather than per facility.		4.75	Leader: David Carvalho Participant: Marie Connolly
C) Collect data about patients, the health care workforce, and location of services in a consistent manner, at minimum, on a regional level. Include pharmacy data. Link healthcare workforce with facility planning	There should be standards about what data, at a minimum, should be collected by each data collecting entity in the region, so as to add consistency to data collecting methods.	4.8	Resource: David Carvalho Participant: Marie Connolly
D) Collect data in a manner that enables analyses to be conducted using a variety of geographic levels, one of which must be the county or regional level. Develop standards for collecting and reporting public health data. This refers to categorization of race, ethnicity, age-groups, geographies, etc.		4.75	Leader: David Carvalho
E) Create and measure progress in health across the region against a standardized set of performance indicators (currently under construction in the CMAP-Health Committee) and track the results over a sustained period of time (20+ years).	The CMAP Health committee has developed a set of 15 health indicators, including infant mortality rate, smoking prevalence, and sexually transmitted disease incidence, that will be used to track health outcomes in the	4.67	Participant: David Carvalho

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support ¹	Your Role in Implementing this Recommendation ²
	region over time.		
Data Access			
A) Identify and eliminate legal barriers to allow for confidential data access (from hospitals, schools, etc.). Determine ways the region can work within HIPAA and FERPA regulations to increase access to this data. Consider whether modifications to HIPAA and FERPA are needed for effective HIE.		4.25	
B) Address the lack of workforce capacity for data collection, reporting, and dissemination at the State level so data can more effectively be disseminated to organizations in the region.		4.75	Participant: David Carvalho
C) Include a “secure access” area in the Illinois Health Data Dissemination Initiative web-based data system for health professionals, public health agencies and planners to access raw and detailed health data in the state.		3.33	Participant: David Carvalho
Other Actions: -Mary Ann Kelly (MCHC) volunteers to work on planning grants for Data/IT initiatives -David Carvalho agreed to set up the Comprehensive Health Planning Board if the Governor signs the bill into law - Elissa Bassler (IPHI) agreed to work on the health data taskforce to accelerate the capacity via advocacy.			

Access to Care Problem Statement

Access to health care safety net services can be a serious challenge in the Northeastern IL region. The most significant challenges identified included:

1. There is a lack of access to primary care providers in the region
2. Every resident of the region does not have access to comprehensive health services (medical, specialty, dental, mental, vision health, etc.)
3. There is a lack of access to medications for the safety net population.

Access to Care Vision: Every resident of the region will have access to comprehensive health services.

Recommendation <small>(Bold statements are those added during the June 23rd Regional Health Care Safety Net Summit)</small>	Local and Regional Examples	Level of Support ³	Your Role in Implementing this Recommendation ⁴
Primary and Specialty Care Services:			
A) Increase access points for primary care and coordinate primary care with other services, with specific attention to geographic areas of greatest need. Need to define access points.	School based health centers, clinics in homeless shelters, urgent care centers, ERs, STD clinics, mobile vans, etc. can all be used as entry points to get people into a primary care setting/medical home. These services should then be coordinated with other services, including mental and dental health services.	4.75	Leader (within her own organization): Venonicia Bate (Alexian Brothers) Resources: Rashmi Chugh, Victoria Bigelow (Access to Care), Sarah Allen (Lake County HD) Participants: Valerie Webb (CCDPH), Marsha Conroy (Aunt Martha's Youth Services), Jamie Martinez (Stroger Hospital), Joan Sheforgen (PrimeCare Community Health)
B) Create a regional web-based, two way referral network so safety net providers can identify safety net primary care providers and/or specialists and make referrals throughout the region. IRIS administrators are from Cook Country, the main IRIS could	Cook County Health and Hospital System currently uses the I.R.I.S. system to refer patients to services. I.R.I.S. could be expanded for the region. The Palmetto Project in South Carolina also uses a state-wide referral network.	4.33	Resource: Sarah Allen Participants: Rashmi Chugh, Marsha Conroy, Jaime Martinez, Joan Sheforgen

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Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support ³	Your Role in Implementing this Recommendation ⁴
collaborate with other “satellite” IRIS administrators from collar counties – with the system being legislatively supported/maintained.			
C) Develop financial incentives to encourage health professionals to work in primary care settings.	Loan repayment options to encourage graduates to choose a primary care career and incentives for training programs to graduate students entering the primary care residences should be considered.	4	Resources: Victoria Bigelow, Sarah Allen Participants: Victoria Bigelow, Marsha Conroy
D) Offer financial incentives to medical care (primary and specialty care) professionals who accept uninsured and Medicaid populations on a regular basis.	Tax breaks for non-profit hospitals could be expanded to any provider that provides care to safety net populations beyond a predetermined threshold; Medicaid and Medicare rates for primary care should be increased (Medicaid to Medicare rates).	4.1	Resource: Victoria Bigelow Participants: Marsha Conroy
E) Work with State and Federal Legislators to improve reimbursement rates and timeliness of payment (prompt payment in line with State and Federal standards) for medical care providers to expand safety net provider networks across all specialties.	The Illinois State Medical Society, Illinois Chapter of Academy of Pediatrics, and the Illinois Academy of Family Physicians have all been working on this issue.	4.3	Resources: Rashmi Chugh, Victoria Bigelow, Sarah Allen, Marsha Koelliker (Equip for Equality) Participants: Marsha Conroy, Jaime Martinez
F) Strive to ensure every resident has a medical home.	Access to Care and Access DuPage, among many others, work to ensure every resident has a medical home.	4.8	Leader (within her own organization): Venonicia Bate (Alexian Brothers) Resources: Rashmi Chugh, Victoria Bigelow, Talana Hughes (Sickle Cell Assoc. of IL), Sarah Allen, Mary Ellen Saunders (ElderCare @ ChristChurch) Participants: Victoria Bigelow,

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support ³	Your Role in Implementing this Recommendation ⁴
			Marsha Conroy, Jaime Martinez, Joan Sheforgen, Lynne Bergero
<p>Other Recommendations:</p> <p>R. 6% charity care should be mandated as a condition for MD licensure</p> <p>R. Physicians who take on Medicaid caseloads should get a tax break for giving charity care</p> <p>R: Need to address inpatient access; inpatient care</p> <p>R: Need to address the lack of specialists in collar counties</p> <p>R: Need to explore expanding tax breaks, nonprofit access to private physicians (need to define this for hospitals)</p> <p>R: Add the following wording (from Mental Health) adapted to primary care: Develop a regional plan specifically addressing whether the region has adequate capacity of primary care, addressing linkage to other systems including mental health, dental and vision.</p>			
Mental Health Services			
<p>A) Create an inventory of the mental health services available to the safety net population in the region as this is critical to increasing access to these services.</p> <p>Also a need for massive screening of mental health services for youth and special populations.</p>		4.6	<p>Resources: Rashmi Chugh, Sarah Allen</p> <p>Participants: Valerie Webb, Marsha Conroy, Jamie Martinez, Karen Baker (Northwest Community Hospital)</p>
<p>B) Add the services in the newly created inventory to the web-based referral</p>		4.4	<p>Resource: Sarah Allen</p> <p>Participants: Rashmi Chugh,</p>

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support ³	Your Role in Implementing this Recommendation ⁴
network.			Marsha Conroy
C) Develop a regional plan specifically addressing whether the region has adequate capacity of mental health, addressing linkage to other systems including primary care.		4.4	Resources: Shana Alford (CMAP), Sarah Allen Participants: Rashmi Chugh, Victoria Bigelow, Marsha Conroy
Dental/Oral Health Services			
A) Create an inventory of the dental/oral health services available to the safety net population in the region as this is critical to increasing access to these services.		4.5	Resource: Rashmi Chugh, Sarah Allen Participant: Marsha Conroy, Joanna Brown (Chicago Dental Society), Karen Baker
B) Add the services in the newly created inventory to the web-based referral network.		4.3	Resource: Sarah Allen Participant: Marsha Conroy
C) Offer incentives (financial or otherwise) to encourage more people to work in the field of dentistry.		3.8	Leader (within her own organization): Venoncia Bate (Alexian Brothers) Leader (within her own organization): Venoncia Bate (Alexian Brothers) Participant: Marsha Conroy
D) Explore options for expanding access to dental services by increasing the number of dentists who are willing to serve the safety net population.	There may be ways to encourage private dental providers to work together to provide more services to the uninsured/vulnerable populations. An example might be that each dentist in the region would volunteer for 4 hours a month at a safety net dental clinic to provide services.	4.4	Leader: Marsha Conroy (Aunt Martha's Youth Services Center) Resource: Sarah Allen Participants: Victoria Bigelow, Joanna Brown
E) Develop a regional plan specifically addressing whether the region has adequate capacity of dental health providers and services, addressing		4.4	Resource: Shana Alford, Victoria Bigelow, Sarah Allen Participants: Victoria Bigelow, Marsha Conroy

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support³	Your Role in Implementing this Recommendation⁴
linkage to other systems.			
F) legislate to get all doctors and dentists to take Medicaid. (This legislated solution applies to all specialties.			
G) improve reimbursements for expanded services, not just extractions			
Vision Health Services			
A) Review the current Illinois State mandate that every child receives a vision screening before entering school and ensure every child is able to receive appropriate and affordable vision screening.	The mandate requires that children enrolling in school for the first time receive an eye exam by an optometrist or ophthalmologist, when there may be additional appropriate ways to receive this screening.	3.8	Resource: Rashmi Chugh Participants: Marsha Conroy, Jaime Martinez
B) There should be incentives (financial or otherwise) to encourage optometrists/ ophthalmologists to see the safety net population	Stroger Hospital has a free glasses program but there are no free vision services known in Cook County.	4.2	Participant: Marsha Conroy
C) Develop an inventory of regional vision care services and identify gaps.		4.4	Participant: Marsha Conroy
D) Develop a regional plan specifically addressing whether the region has adequate capacity of vision care providers, addressing linkage to other systems including primary care.		4.3	Participant: Marsha Conroy
Pharmaceutical Services			
A) Most pharmaceutical companies have benefit programs for people who cannot afford their medications. There is currently no coordination between these companies. The region should promote the coordination and management of medication access from these pharmaceutical benefits programs (this could be done through a web-based	MedNet is a program used in 4 counties of Florida that is a web-based IT system that helps secure free prescription medications for those who are eligible. The database auto-fills patient information into all applications for pharmaceutical assistance programs at the site of patient contact.	4.2	Resource: Sarah Allen Participant: Marsha Conroy

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software system).			
Other Points of Access:			
A) Pursue the provision of school-based health services to increase access to a greater community population.	Schools are often center points in communities and school based health centers and school nurses can be used as promoters of getting children, adolescents, and parents into primary care settings. The Illinois Coalition for School Health Centers is working on this.	4.1	Participants: Rashmi Chugh, Valerie Webb, Marsha Conroy, Jaime Martinez, Joan Sheforgen
B) Explore the use of school-based data to plan for health services across the region (and examine the FERPA regulations for data sharing to be sure about what can and cannot be shared).		3.6	Participants: Rashmi Chugh, Marsha Conroy, Jaime Martinez
C) Safety net clinics in the region should coordinate their hours to ensure after hour services are available every day in most areas of the region.	A coalition of providers in the Kansas City area have coordinated their clinic schedules to ensure there is always access to after-hour services in underserved areas.	4.5	Resource: Rashmi Chugh Participant: Marsha Conroy
D) The region should identify its capacity needs and then increase the enrollment of eligible residents into various safety net support and entitlement programs (Medicaid, All Kids, etc.).	It is important to increase enrollment of eligible residents into support and entitlement programs, but this will only work if we know what the current capacity is of the health system and then ensure capacity to meet the need of the newly enrolled clients. DuPage county has been working on this.	4.6	Leader: Rashmi Chugh (DuPage County Health Department) Participants: Marsha Conroy, Joan Sheforgen
E) ADD SENIORS throughout all recommendations			

Systems Finance Problem Statement

Financing the healthcare safety net is a serious challenge in the Northeastern IL region. The most significant challenges identified included:

1. Key safety net providers lack necessary resources
2. There is a lack of adequate financing mechanisms, accountability for a regional safety net, and little overall accountability and coordination

Systems Finance Vision: The region will have sufficient financial resources to provide comprehensive health services to all residents of the region.

Recommendation <small>(Bold statements are those added during the June 23rd Regional Health Care Safety Net Summit)</small>	Local and Regional Examples	Level of Support ¹	Your Role in Implementing this Recommendation ²
A) Create a “brain trust” to develop financing models and schemes that would work in the best interest of the regional safety net. This “brain trust” would be made of a diverse group of health leaders and consumers throughout the region and would be trained by financial experts on various financing models/schemes. The “brain trust” would then take this knowledge and determine the best model/scheme for the region.	The Obama Administration has been using teams of stakeholders to discuss options for change. This would be a similar team to determine options for financing the safety net in the region. Include CMS in brain trust.	Only 2 people completed these ratings	Leaders: Andrea Bempong, Randall Mark (CCHHS) Participants: Bob Remer (Consultant), Veronica Jackson (Latinos for a Healthy Illinois)
B) Explore the option of a regional taxing authority or designate part of an existing tax (i.e. sales, cigarette) to add new money to the safety net system.	Parkland Health & Hospital System in Dallas, TX receives 29% of its funding from area property taxes.		Leaders: Veronica Jackson (Latinos for a Healthy Illinois), Randall Mark Participant: Bob Remer
C) Work in coalition with provider organizations, city, county, State and Federal officials to expand Medicaid/CHIP and raise Illinois	Work with Illinois physician groups, State and Federal officials and legislators.		Leaders: Veronica Jackson (Latinos for a Healthy Illinois), Randall Mark

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Medicaid rates to expand the safety net provider network and sustain safety net programs and systems.			
D) Engage more regularly with elected officials and political leaders throughout the region to get them to work together for more regional health funding. A Health Caucus could be created for these officials to advocate for increased health money.			Participants: Bob Remer, Randall Mark
E) Revise fund distribution formulas used by the Illinois Department of Public Health (IDPH) to promote a more regional approach to public health.			
F) Monitor and analyze the safety net impact of recent capital funding legislation intended to support hospital capital construction and recent Federal and State allocations to FQHCs to assess the expected impact at a neighborhood or regional level. Review the Safety Net impact statements for selected CON projects and contribute to the Comprehensive Health Plan to be developed by IDPH.			
G) Explore financing for advanced practice nurse-run clinics as a way of using money more efficiently, promoting the use of technology to reduce costs, and improving access in underserved pockets of the region.	Demonstration project for billing for advance practice RNs and other RNs.		Leaders: Veronica Jackson, Andrea Bempong
H) Expand covered services under Medicaid to be more comprehensive (include dental, vision, etc.).	Medical Nutrition Therapy (Dietetics), Podiatry, Chiropractic		Resource: Veronica Jackson

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support¹	Your Role in Implementing this Recommendation²
I) Expand “Access to Care” model across the region to ensure efficient use of resources. This model currently exists in Cook and DuPage counties. The model could be implemented in the other counties.			Participants: Randall Mark
<p>Additional Recommendations:</p> <ul style="list-style-type: none"> -Create a regional taxing body to pay for safety net healthcare. -Ensure provisioning of DSH funds in region. Could also be block grant funding. -Tax non-profit hospitals or tax-exempt hospitals. -Reexamine the amount of charity care provided by non-profit hospitals. Mandate a certain level of charity care. May want to tie in charity care with working with CHCs, population programs. -Encourage retired physicians to start “free” clinics. Federalize Medicaid. Expand coverage under Medicaid. Fold Medicaid into Medicare. Single payer. Reduce bureaucratic delays in credentialing providers (which translates into increased costs). Do more health prevention programs to reduce healthcare costs, and provide funds/reimbursement for health promotion programs. Cover dental services. 			

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support ¹	Your Role in Implementing this Recommendation ²
Community-based services integration. Do no harm to County Hospital if there are reductions/enlargement of state DSH funds.			

Health Equity Problem Statement

There are vulnerable groups throughout the region who use safety net services, including immigrants and refugees, people experiencing homelessness, older adults, the LGBT community, and prisoners. It is important that these groups have access to culturally appropriate, comprehensive health services. The most significant challenges identified facing vulnerable groups in the region included:

1. The healthcare needs of undocumented/immigrant residents are not properly addressed.
2. There is limited awareness of services available to the vulnerable populations who could use the safety net.
3. Gaps with regard to language and culture affect quality of care. There aren't standards or minimum requirements.

Health Equity Vision: Health Equity will be a priority in all safety net planning and services.

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support ¹	Your Role in Implementing this Recommendation ²
A) Develop a standard depository of assessment “tools” to detect an organization’s cultural and linguistic competence. The assessment should include linguistic assessments of staff.	The Palmetto Project in South Carolina uses a state-wide referral network which lists the language proficiencies of all providers in the state.	4	Leaders: Leticia Reyes (IDPH) Resources: Susan Bauer (Community Health Partnership of Illinois), Bechara Choucair (Heartland Int’l Health) Participants: Leticia Reyes, Sandra Ankebrant (CCHHS)
B) Develop an inventory/study of culturally appropriate care available in the region. (It is difficult to define “culturally appropriate”)	The Chicago Bilingual Nurse Consortium has been working on such an inventory for nursing care.	2.89	Leader, Resource, Participant: Faye Manaster (Arc of Illinois)
C) Strengthen partnerships with social service organizations for immigrant and refugee populations to help better understand their participant access to healthcare services. These organizations should be incorporated more into regional health planning efforts.	Potential social service organizations to partner with include the Chinese Mutual Aid Association and the Cambodian Mutual Aid Association.	4	Leader: Faye Manaster Participants: Bechara Choucair, Faye Manaster
D) Recruit and retain a more diverse			Resource: Sandra Ankebrant

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workforce to meet the needs of diverse populations. Bilingual and/or bicultural hiring practices should be encouraged. Financing for interpretation services must be considered as there is currently an inadequate bilingual/bicultural workforce.		4.6	Participants: Marie McCarthy (PrimeCare Community Health), Bechara Choucair
E) Advance the concept of “trauma-informed care” and develop training for dissemination to safety net organizations throughout the region.	An organizational expert on trauma-informed care could conduct trainings to organizations working with immigrants/refugees, the homeless, women and girls, etc. to help them better care for patients who may have been affected by trauma.	3.38	Resource: Bechara Choucair
F) Explore and further utilize existing models of community health workers and patient navigators to ensure they are in the areas of greatest need throughout the region.	The Chicago Community Health Workers Local Network could expand to the entire region and include patient navigation services. Individual health organizations (like Alivio Medical Center) also recruit and train community health workers and these models should be explored further. The Kennedy version of the Health Reform bill contains language of support for community health workers. The Palmetto Project (South Carolina) has created a Patient Navigator Network in a 5-county region to help better distribute patient navigators.	4.62	Resource: Sandra Ankebrant Participants: Susan Bauer, Kathye Gorosh (New Age Services Corp.), Amy Pooruta (CCDPH)
G) Increase resources to resettlement organizations to help immigrants and refugees navigate the healthcare system		3	Resource: Susan Bauer

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support ¹	Your Role in Implementing this Recommendation ²
H) Increased collaboration between groups providing services to people experiencing homelessness is needed. Vulnerable populations, including the homeless.	Heartland Alliance had developed a Metropolitan Chicago Healthcare for the Homeless Network though funding from HRSA.	3.57	Resource: Kathye Gorosh Participants: Kathye Gorosh, Bechara Choucair
I) Develop creative ways of maintaining health records for transient populations (the homeless, migrant workers, etc). Invest in Data/IT	The Migrant Clinicians Network has created a mobile health record device that patients can take with them. Follow-up visits can be conducted with a different provider and that provider “plugs-in” the device to view the patient’s medical record.	4.38	Resource: Susan Bauer, Sandra Ankebrant
J) Behavioral health services should be integrated into primary care services. The region should research models of integration and determine which models work best and which models may be most appropriate for the NE IL region. Be sure “addiction services” are included in behavioral health	The EMERGE program in Travis County, TX has reduced both ER visits and reported depression through the integration of behavioral health and primary care services.	4.7	Leaders: Marie McCarthy, Kathye Gorosh Resource: Kathye Gorosh
K) Safety net providers should increase their awareness of and sensitivity to the health issues facing the Lesbian, Gay, Bisexual, and Transgender (LGBT) community so they can provide appropriate services to that community.	Many providers may not be aware of the issues facing the LGBT community and trainings should occur throughout the region to address the care for this group.	3.38	
L) Include specialty care in a referral network.		4.57	Resource: Sandra Ankebrant Participant: Shaunta McGee (YWCA of Lake County)
M) Partner with social service organizations to reduce barriers to health, to with housing example.		3.75	Leader: Leticia Reyes Resource: Kathye Gorosh Participants: Leticia Reyes, Kathye Gorosh, Shaunta McGee
N) Educate and enlighten the public at large about health equity.		4.33	Leader: Leticia Reyes Resource: Susan Bauer

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support ¹	Your Role in Implementing this Recommendation ²
			Participants: Amy Boruta, Shaunta McGee
O) Address health disparities throughout the region		4.56	Leader: Shaunta McGee Resource: Marie McCarthy Participant: Amy Boruta
P) Increase awareness of organizations already doing these things. expand program (CEED) at UIC, Latino Res., Pol., Training		3.5	Participant: Shaunta McGee
Q) Equity includes prevention, equity means they don't get the diseases.		4.38	Leader: Leticia Reyes Participants: Kathye Gorosh, Shaunta McGee

Workforce Problem Statement

The northeastern IL region faces challenges related to the health care safety net workforce. Issues identified as priorities for the region include the following:

1. The need for increased coordination of area-wide health professional education and planning
2. Health care workforce attrition and erosion as the demand for health care increases in the region and shortages of key health professions and occupations worsen.

Many of the major workforce challenges require macro-level, national attention. There are, however, strategies through which the health care safety net workforce in the 7-county region can be strengthened. The regional health care safety net workforce will be significantly strengthened if there is a regional health authority or entity that plans, coordinates, and funds education and training for the health workforce in the region. Some of these functions could be performed, although not nearly as effectively, by an area-wide health professional education and training consortium.

Workforce Vision: There will be a well-prepared health workforce that is diverse, of adequate number, interdisciplinary, and distributed in a more efficient, effective, and coordinated way.

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support ¹	Your Role in Implementing this Recommendation ²
A) The multiple health workforce plans/initiatives throughout the region need to be coordinated and aligned in order to foster more efficient workforce planning, and to ensure that planning for the safety net workforce fits seamlessly with other workforce development efforts.	Several groups have workforce planning initiatives, including the Metropolitan Chicago Healthcare Council (MCHC) and the Governor’s Commission on Nursing; ensure these efforts are aligned.	4.57	Resource: Melanie Dreher (Rush Nursing) Participants: Irene Pierce (Lake County HD), Leslie Roundtree (Chicago State Univ.), Patricia Lewis (UIC Nursing)
B) Increased emphasis on interdisciplinary collaboration and use of health profession teams promoting continuity of care through “medical home” models.	Interdisciplinary collaboration streamlines services and uses health professionals in the most effective manner. If nurses, physician assistants, and others can help manage	4.71	Participants: Stephen Stobile, Leslie Roundtree, Patricia Lewis

¹ Support for each recommendation was rated on a scale of 1(not at all supportive) to 5 (very supportive) during the June 23rd Summit, and the number shown is the AVERAGE of all participant ratings.

² Participants were asked to describe their or their organization’s role in implementing the recommendation. Roles included Leadership (**L**), Active Participant (**P**), Resource (**R**), Staying Informed (**SI**), or taking No Role (**NR**).

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support ¹	Your Role in Implementing this Recommendation ²
	a patient's disease, physicians can be more efficient and effective for the actual disease treatment. Interdisciplinary teams will use the most appropriate skill sets at the most appropriate times.		
C) Develop financial incentives for training institutions and/or individuals to shift health professionals away from specialty and high-technology settings to primary care access points.	Financial resources could be awarded to training institutions which meet specific targets for placing their students in safety net practice settings.	3.67	Participants: Stephen Stobile, Leslie Roundtree, Patricia Lewis
D) Develop special stipends or financial incentives for medical students based on no. of students matching into primary care residencies.		3.83	Leader: Stephen Stobile (CCHHS) Participant: Leslie Roundtree
E) Expand career ladders and other skill development initiatives for low wage healthcare workers who play critical roles in the healthcare safety net.	Long term care and home health aides could advance into medical technology and LPN careers.	3.86	Leader: Joe Zaroni (UIC)
F) Promote (through professional standard setting or financial incentives) education and training programs that incorporate skills development and training in new communication and information technologies.	Health professionals should learn how to perform distance management of chronic diseases (and perhaps should partner with technology companies that provide distance management software) so that fewer office visits need to be made by each patient and resources can be used more efficiently.	4	Participant: Stephen Stobile
G) Increase collaboration with health providers to expand clinical practice placements in interdisciplinary safety net practice settings.	Area training programs should partner with clinical settings that serve the safety net population so that students can gain experience in these settings during their clinical training. MCHC is doing this work with nursing	4.83	Resource: Melanie Dreher Participants: Stephen Stobile, Patricia Lewis, Joe Zaroni

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support¹	Your Role in Implementing this Recommendation²
	students. The Schweitzer Fellows Program also does this.		
H) Link “low barrier “access points in the health system such as community-based retail clinics and alternative health providers to medical homes for long term follow up and continuity of primary care through the development of a regional referral system.	Walgreens Take Care Clinics provide low barrier access points into the health care system, among other examples. Regional referral networks should be updated so that the low-barrier access points can link patients to other safety net providers in a “medical home” model. Emphasizing the use of the low barrier access points may ultimately use the workforce more effectively and efficiently.	3.14	Participant: Leslie Roundtree
I) Revisit and revise as necessary policies that restrict the workforce from being as efficient as possible.	There is a policy that only nurses who live within the Chicago city limits can be tenured as faculty at several Chicago health professional schools, limiting the ability of these institutions to increase enrollments. This residency policy should be reconsidered in light of the current and future shortage of nurses in the region.	3.5	Participant: Leslie Roundtree
J) Provide physicians with incentives to work in safety net settings; provide extra incentives to work on teams; and provide additional incentives to work in hard to recruit geographic areas.			
K) Start a summer jobs program in safety net providers as a connection for potential future recruitment.			
L) Integrate language and culturally appropriate services in all recommendations.			

Recommendation (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support¹	Your Role in Implementing this Recommendation²
M) Establish a career support system for community health workers including health benefits as well as retirement pensions.			
N) Bring pipeline programs such as Chicago Community Colleges and the Chicago Public Schools to the table to discuss the needs for the health care workforce.			
O) Augment medical training with leadership and management skill training.			
P) Consider recruiting and training nurses from Spanish-speaking countries.			

Planning/Coordinating Problem Statement

Healthcare safety net providers in the northeastern IL region are faced with challenges in planning and coordinating safety net services across the region. The most significant challenges identified were the following:

- 1.) Planning is neither integrated (i.e.: it occurs in silos and is disconnected from implementation and outcomes) nor occurs on a regional level. Intentional health safety net planning at the regional level is limited.
- 2.) There is an over-emphasis on a medical approach, which limits health promotion and disease prevention services

Planning/Coordinating Vision: There will be improved regional coordination and planning of safety net services.

OPTIONS for Regional Planning/Coordination (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support ¹	Pros of this Option	Cons of this Option
A.) Establish a regional voluntary council/consortium for coordination and planning of the health safety net service providers.	The Northern Illinois Public Health Consortium (NIPHC) is a 501c4 membership organization of the public health departments in the region. NIPHC’s role could be expanded to include coordinating for all aspects of the safety net.	4 fives 2 fours 2 threes 1 two 2 ones Ave: 3.45	i. Good starting point ii. Feasible iii. Would like to see this option work on a concrete initiative iv. All 7 counties are already working together v. Provide a forum for planning vi. NIPHC is an existing organization with buy-in from County Health Departments and is the logical link between all for the development of a regional planning agenda	i. Limited authority in general ii. Limited authority over private providers iii. Low formal structure iv. Might divert NIPHC from its original goals v. Difficult to evaluate if it cannot monitor anything vi. More talk- no action vii. People might not bother with this option due to low authority
B.) Establish a not-for-profit regional body that coordinates the 7 county region’s health care safety net planning and systems monitoring.	The Chicago Metropolitan Agency for Planning (CMAP) is a not-for-profit, legislatively mandated, local government agency which comprehensively plans and	3 Fives 4 Fours 2 Threes 1 Two 0 Ones	i. Mandated by government ii. Higher level of planning vs Option A iii. Data	i. No \$\$ control ii. If CMAP were to include health planning, it could get lost/Health is small pieces of larger

¹ Support for each recommendation was rated on a scale of 1(not at all supportive) to 5 (very supportive) during the June 23rd Summit, and the number shown is the AVERAGE of all participant ratings.

<p>OPTIONS for Regional Planning/Coordination (Bold statements are those added during the June 23rd Regional Health Care Safety Net Summit)</p>	<p>Local and Regional Examples</p>	<p>Level of Support¹</p>	<p>Pros of this Option</p>	<p>Cons of this Option</p>
<p>The consensus of the group was that this was the best option to move forward with.</p>	<p>coordinates land use and transportation in the 7-county region. CMAP’s role could be expanded to include health planning beyond the Go To 2040 plan.</p>	<p>Ave: 3.9</p>	<p>iv. Voluntary v. Connection to broader determinants of health vi. Connection to political leadership vii. Systems monitoring viii. Evaluation ix. Regional focus x. Integrates with other sector issues like transportation, education (CMAP) xi. Involves the broader civic leadership/community in healthcare issues and delivery xii. Legitimacy</p>	<p>plan iii. CMAP may not employ enough people to deal with health planning iv. CMAP has no history in health planning – this would be new for them v. No implementation authority vi. (IF not CMAP) have to establish the body through legislative action vii. No clout</p>
<p>C.) Establish a not-for-profit regional body that coordinates the 7 county region’s health care safety net planning and systems monitoring while also allocating resources to implement the region’s plans.</p>	<p>The Primary Care Coalition in Montgomery County, Maryland, is a 501c3 organization that allocates resources for and coordinates the safety net, providing access to high-quality, accessible, equitable, evidence-based, cost-effective comprehensive health services to low income, uninsured County residents.</p>	<p>1 Five 3 Fours 3 Threes 3 Twos 0 Ones Ave: 3.2</p>	<p>i. Planning coordination ii. \$\$\$ iii. Voluntary iv. Potentially combined with Option A, would help bring in funding v. envision the group seeking grants vi. Allocating funding will be the factor that attracts interests of providers in 7 county area vii. Higher level of investment</p>	<p>i. No existing regional examples ii. Data collection for monitoring could be difficult – start with several “simple” data elements first iii. Might not be able to allocate resources w/o a mandate iv. Similar to old HSA experience v. Another political entity requiring counties to cede power</p>

<p>OPTIONS for Regional Planning/Coordination (Bold statements are those added during the June 23rd Regional Health Care Safety Net Summit)</p>	<p>Local and Regional Examples</p>	<p>Level of Support¹</p>	<p>Pros of this Option</p>	<p>Cons of this Option</p>
			<p>viii. Can provide coordination and planning mechanism</p>	<p>and money?</p>
<p>D.) Establish a public, governmental regional health authority that plans, coordinates, monitors, and allocates resources (using State funding or tax money) for the region's health care safety net.</p>	<p>The Regional Transit Authority is an example of a governmentally mandated authority that plans, coordinates, monitors, and allocates resources for the region's transportation.</p>	<p>0 fives 6 fours 2 Threes 0 twos 2 Ones Ave: 3.2</p>	<p>i. Everyone to come to the table ii. Almost complete in terms of versions provided iii. Highly formal structure iv. High connectedness v. \$\$ provided vi. Mandatory vii. Has authority to act viii. Can have a capacity to implement plans ix. Coordination of resources</p>	<p>i. Never tried on a regional basis for health ii. Lacks authority iii. Asking for \$\$ iv. Narrow focus</p>
<p>E.) Establish a public, governmental regional health authority that plans, coordinates, monitors, allocates resources (using State funding or tax money) AND provides safety net services (public sector) throughout the 7 county region.</p>	<p>The New York City (NYC) Health and Hospitals Corporation is the largest municipal health care system in the country and coordinates and provides services across all of the boroughs of NYC.</p>	<p>3 Fives 0 Fours 1 Three 3 Twos 3 Ones Ave: 2.7</p>	<p>i. Controls monetary resources ii. Most powerful iii. Authority to act iv. Highly formal structure v. Mandatory</p>	<p>i. Political approval across counties is not feasible ii. No authority over private providers iii. Too bureaucratic iv. Too broad for this area v. Duplication? vi. Where would the power come from? vii. Voluntary might fetch more genuine interest</p>

OPTIONS for Regional Planning/Coordination (Bold statements are those added during the June 23 rd Regional Health Care Safety Net Summit)	Local and Regional Examples	Level of Support ¹	Pros of this Option	Cons of this Option
F.) Hybrid of Options A and B – Create both a not-for-profit regional voluntary council/consortium (that coordinates the 7-county regional health care safety net planning and systems) and have the NIPHC work with the 7 county health departments to conduct specific planning within each county.	Northern Illinois Public Health Consortium and Chicago Metropolitan Agency for Planning		i. Expertise of CMAP and Local Health Departments ii. Use of existing groups that currently work together on a smaller level iii. CMAP and NIPHC serve as starting points who’s roles can be expanded iv. Will operate at regional and local levels that are already in place v. Has authority and resources to be implemented vi. Regional focus	i. Division of labor ii. Political will iii. Need to incentivize participation iv. Overall, need to be part of broader healthcare reform
G.) Hybrid of Options B and C		1 two	None discussed	None discussed

The Planning/Coordinating Group also discussed these options in regard to their functions and their levels of formality and authority. Two charts were created to depict the options in those regards.

MODEL		Planning	Coordination	Monitoring	Resource Allocation	Providing Services
A	NFP	X	X			
B	NFP	X	X	X		
C	NFP	X	X		X	
D	Public	X	X	X	X	
E	Public	X	X	X	X	X
F (combo of A and B)	NFP	X	X	X		
G (combo of A and C)	NFP	X	X	X	X	

		Low ---- Authority ---- High
Low---Formality---High		Option D Option E
		Option C
	Option B	
	Option A	