Minutes of the Meeting of the Board of Directors of the Cook County Health and Hospitals System (CCHHS) held Friday, February 24, 2017 at the hour of 9:00 A.M. at 1900 West Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Hammock called the meeting to order.

Present: Chairman M. Hill Hammock and Directors Virginia Bishop, MD, MPH; Mary Driscoll, RN, MPH; Ric Estrada; Ada Mary Gugenheim; Emilie N. Junge; Mary B. Richardson-Lowry; Layla P. Suleiman Gonzalez, PhD, JD; and Sidney A. Thomas, MSW (9)

Absent: Vice Chairman Hon. Jerry Butler (1)

Additional attendees and/or presenters were:

Ekerete Akpan – Chief Financial Officer
Debra Carey - Chief Operating Officer, Ambulatory Services and Interim Chief Operating Officer, Hospital-Based Services
Krishna Das, MD – Chief Quality Officer
Steven Glass – Executive Director of Managed Care
Charles Jones – Director of Strategic Sourcing and Supply Chain Management
Jeff McCutchan – Interim General Counsel
Deborah Santana – Secretary to the Board
John Jay Shannon, MD – Chief Executive Officer
Agnes Therady – Executive Director of Nursing
Ozuru Ukoha, MD – John H. Stroger, Jr. Hospital of Cook County

II. Employee Recognition

Dr. John Jay Shannon, Chief Executive Officer, recognized employees for outstanding achievements. Details and further information is included in Attachment #8 - Report from the Chief Executive Officer.

III. Public Speakers

Chairman Hammock asked the Secretary to call upon the registered public speakers.

The Secretary called upon the following registered public speakers:

1. Linda Coronado — Representative, Health Task Force for Commissioner Jesús García (7th District)
2. Dr. Linda Rae Murray — Board Member, Health and Medicine Policy Research Group
3. George Blakemore — Concerned Citizen

Following the public testimony by Ms. Coronado and Dr. Murray (written testimony included – Attachment #1) regarding response to changes in immigration policies from Health & Medicine Policy Research Group, the Directors discussed follow-up to this important issue. Chairman Hammock stated that he will read the report that was provided, and he and Dr. Shannon will come back with a proposal about how to address it and discuss as a group.

IV. Board and Committee Reports

A. Minutes of the Board of Directors Meeting, January 27, 2017

Director Gugenheim, seconded by Director Estrada, moved the approval of the Minutes of the Board of Directors Meeting of January 27, 2017. THE MOTION CARRIED UNANIMOUSLY.

B. Human Resources Committee Meeting, February 16, 2017

i. Meeting Minutes
ii. Metrics (Attachment #2)

Director Richardson-Lowry presented the Meeting Minutes and reviewed the metrics with Gladys Lopez, Chief of Human Resources. The Board reviewed and discussed the information.

During the review of the information, Director Junge inquired regarding the net total number of nursing vacancies, including those who left in this quarter. Ms. Lopez responded that she will provide that information.

Action was taken on this item following the adjournment of the closed meeting.

Director Estrada, seconded by Director Thomas, moved the approval of the Minutes of the Human Resources Committee Meeting of February 16, 2017. THE MOTION CARRIED UNANIMOUSLY.

C. Managed Care Committee Meeting, February 16, 2017

i. Meeting Minutes
ii. Metrics (Attachment #3)

Director Junge presented the Meeting Minutes and reviewed the metrics with Steven Glass, Executive Director of Managed Care. The Board reviewed and discussed the information.

The Board discussed membership and marketing efforts. Mr. Glass stated that he and Caryn Stancik, Executive Director of Communications, will be providing a marketing update on the health plan and System in April; included in that update will be a recap on market research that has been done. Director Suleiman Gonzalez requested that they include in the update a clear analysis of the organization's competitive advantage, and information on how this is being messaged.

Mr. Glass referenced a previous request for information on the number of Spanish-speaking employees in the call center. There are currently 4 employees out of a total staff of 37 that are bilingual in Spanish; additionally, there are 3 more bilingual employees who are currently in training and are expected to begin taking calls in the next couple of weeks.

Director Junge requested that information be provided on the attendance at the various redetermination events that have been held. Mr. Glass responded that this information can be provided.

Director Thomas, seconded by Director Driscoll, moved the approval of the Minutes of the Managed Care Committee Meeting of February 16, 2017. THE MOTION CARRIED UNANIMOUSLY.

IV. Board and Committee Reports (continued)

D. Finance Committee Meeting, February 17, 2017

i. Meeting Minutes, which included the following action items and report:
- Approval of Contracts and Procurement Items (detail was provided as an attachment to this Agenda)

ii. Metrics (Attachment #4)

Director Estrada provided an overview of the Meeting Minutes. Charles Jones, Director of Strategic Sourcing and Supply Chain Management, provided a brief overview of the contractual requests that were considered at the Finance Committee Meeting. It was noted that request number 12 remains pending review by Contract Compliance.

During the discussion of the financial reports included in the metrics, Chairman Hammock requested that a robust review and discussion of the pension liability take place at a future meeting. The review should include information on its history through to its current state and future expectations, and the role the County plays in it. This information will be helpful in light of the upcoming collective bargaining negotiations.

Director Estrada noted that, at the Finance Committee Meeting, there was a discussion on the subject of overtime. Because this subject touches on many areas, including Finance and Human Resources, the administration is looking into a deep dive on the subject in the near future, perhaps at the full Board level. Director Thomas requested that the subject of the health fund and impact of litigation cases be included in the deep dive. He is interested in receiving information on how those impact the budget, what the impact has been, and where that impact is reflected in the reports.

> Director Richardson-Lowry, seconded by Director Driscoll, moved the approval of the Minutes of the Meeting of the Finance Committee of February 17, 2017. THE MOTION CARRIED UNANIMOUSLY.

E. Quality and Patient Safety Committee Meeting, February 17, 2017

i. Meeting Minutes, which include the following action items and report:
- Approval of Stroger Hospital Department/Division Chair reappointments
- Approval of Medical Staff Appointments/Reappointments/Changes

ii. Metrics (Attachment #5)

Director Gugenheim presented the Meeting Minutes and reviewed the metrics with Dr. Krishna Das, Chief Quality Officer. The Board reviewed and discussed the information.

> Director Junge, seconded by Director Driscoll, moved the approval of the Minutes of the Quality and Patient Safety Committee Meeting of February 17, 2017. THE MOTION CARRIED UNANIMOUSLY.

F. Audit and Compliance Committee Meeting, February 17, 2017

i. Meeting Minutes

Chairman Hammock presented the Meeting Minutes for the Board's consideration.

> Director Estrada, seconded by Director Suleiman Gonzalez, moved the approval of the Minutes of the Audit and Compliance Committee Meeting of February 17, 2017. THE MOTION CARRIED UNANIMOUSLY.

V. Action Items

A. Approve proposed appointment of Stroger Hospital Department Chair(s) and Division Chair(s)

There were no proposed appointments presented for this item.

B. Approve proposed appointment of Provident Hospital Department Chair(s) and Division Chair(s) (Attachment #6)

Debra Carey, Chief Operating Officer, Ambulatory Services and Interim Chief Operating Officer, Hospital-Based Services, presented the one (1) proposed appointment of a Provident Hospital Department Chair for the Board's consideration.

> Director Gugenheim, seconded by Director Richardson-Lowry, moved the approval of the proposed Provident Hospital Department Chair. THE MOTION CARRIED UNANIMOUSLY.

C. Approve proposed Amendments to the Bylaws of the John H. Stroger, Jr. Hospital of Cook County Medical Staff (Attachment #7)

Dr. Ozuru Ukoha, President of the Executive Medical Staff (EMS) of Stroger Hospital, provided an overview of the proposed Amendments to the Bylaws of the John H. Stroger, Jr. Hospital of Cook County Medical Staff. These changes are being made in order to meet regulatory requirements. They received provisional approval from the Board and the Medical Staff. They are now returning to the Board for final approval.

> Director Gugenheim, seconded by Director Richardson-Lowry, moved the approval of the proposed Amendments to the Bylaws of the John H. Stroger, Jr. Hospital of Cook County Medical Staff. THE MOTION CARRIED UNANIMOUSLY.

D. Contracts and Procurement Items

There were no contracts and procurement items presented directly for the Board's consideration.

E. Any items listed under Sections IV, V and VIII

VI. Report from Chairman of the Board

Chairman Hammock commented on recent reports about potential effects of changes to the Affordable Care Act. Right now, there is little known about what the changes or potential cost might be. It is such a hot topic and is widely discussed, but until details are known, this organization will continue to operate as effectively as possible, and yet stay in touch. He assured the Directors that they will be kept in the information loop, and when details are known, they will be shared.

VII. Report from Chief Executive Officer (Attachment #8)

Dr. Shannon provided an update on several subjects; detail is included in Attachment #8.

VIII. Closed Meeting Items

A. Provident Hospital Medical Staff Credentialing Matter
B. Minutes of Human Resources Committee Meeting, February 16, 2017
C. Evaluation and consideration of annual incentive for CCHHS Chief Executive Officer
D. Minutes of Quality and Patient Safety Committee Meeting, February 17, 2017
E. Minutes of Audit and Compliance Committee Meeting, February 17, 2017
F. Claims and Litigation
G. Discussion of personnel matters

Director Estrada, seconded by Director Gugenheim, moved to recess the open meeting and convene into a closed meeting, pursuant to the following exception to the Illinois Open Meetings Act: 5 ILCS 120/2(c)(**1**), regarding "the appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity."

On the motion to recess the open meeting and convene into a closed meeting, a roll call was taken, the votes of yeas and nays being as follows:

Yeas: Chairman Hammock and Directors Bishop, Driscoll, Estrada, Gugenheim, Junge, Richardson-Lowry and Thomas (8)

Nays: None (0)

Absent: Vice Chairman Butler and Director Suleiman Gonzalez (2)

THE MOTION CARRIED UNANIMOUSLY and the Board convened into a closed meeting.

Chairman Hammock declared that the closed meeting was adjourned. The Board reconvened into the open meeting.

Director Richardson-Lowry, seconded by Director Estrada, moved to approve a bonus award payment to be made to Dr. John Jay Shannon, Chief Executive Officer, in the amount of $37,500.00. THE MOTION CARRIED UNANIMOUSLY.

IX. Adjourn

As the agenda was exhausted, Chairman Hammock declared that the meeting was ADJOURNED.

Respectfully submitted,
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXX
M. Hill Hammock, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

ATTACHMENT #1

Statement of the Health Task Force for Commissioner Jesús García (7th District) before the Board of the Cook County Health and Hospitals System.

February 24, 2017

Good morning,

I am Linda Coronado speaking on behalf of the 7th District Health Task Force of Commissioner Jesús García. We come before you this morning to raise urgent questions about the response of the Cook County Health & Hospital System to the attack of President Trump on marginalized communities. Those under attack from President Trump include the communities your health system serves; the African-American, Asian, Middle East, Latino communities as well as other marginalized groups like the LGBTQ and religious minorities particularly Muslims.

One of Trump's earliest actions was to attempt to implement his "Muslim ban" by banning all travel from seven nations, three of them on the continent of Africa. As Nkosazana Dlamini-Zuma, head of the African Union, stated; "The very country to which many of our people were taken as slaves during the transatlantic slave trade has now decided to ban refugees from some of our countries."

This action was followed by a widening of the kinds of immigrants sought after and arrested by ICE. These actions have included raids in communities, arrests of people seeking justice in our courts and the arrest of a youth protected by DACA.

The 7th District is a district of immigrants. The election of Donald Trump has already caused damage in immigrant communities. Lurie Children's Hospital as publicly called attention to the negative impact on our children with increased anxiety among many children from naturally born citizen, to children of immigrants with legal status and of course children without documents. Lurie staff have confirmed at least four suicides among DACA students since November.

The change in our communities is palpable. Retail commerce is down on 26th street and in other communities with large number of immigrants. Visits to physicians, including your hospitals and health centers, school attendance and other normal activities are curtailed out of fear of ICE arrests and deportations. The negative impact of this administration's policies can be seen in the Polish, Irish, Asian, African and the Latino communities.

In addition to the negative impact in our immigrant communities, all communities in Cook County are damaged by these policies. Any policies that create fear and terror among some of our people places public safety and public health in jeopardy for all communities.

This reality is why the Cook County Board of Commissioners and the Health and Hospital System has clear ordinances and policies designed to ensure that all are treated with dignity and respect. However, the long standing policies and procedures of this board are now inadequate. What is needed is a rapid, public clarification of actions being taken by the health system to address this threat.

We recommend the document; " Public Health Actions for Immigrant Rights: A Short Guide to Protecting Undocumented Residents and Their Families for the Benefit of Public Health and All Society" as one way to organize your actions The policies of the system need to be carefully reviewed and clarified where necessary. Health system staff need training on the policies and procedures. Staff also should be trained about basic rights of immigrants. Signage needs to be widely displayed indicating that our facilities are

welcoming and safe. Public health and other community workers should have buttons indicating the provision of safe services. The policies should be made public. We need to make sure that patients can be referred to organizations and services to assist them with protecting their legal rights. We need to work to strength our ties to communities already preparing emergency rapid response activities where health information is an essential part of that preparation. We need action from this Board now.

HEALTH AND MEDICINE POLICY RESEARCH GROUP

Statement to the Cook County Health & Hospitals Board Concerning response to changes in immigration policies from Health & Medicine Policy Research Group

February 24, 2017

Linda Rae Murray M.D. MPH

Good morning. My name is Linda Rae Murray and I rise on behalf of the Board of Health and Medicine to ask that you take prompt actions to address the rapidly changing situation with immigrants, both those with and without documents; and other marginalized groups such as Muslims, LGBTQ people and communities of color.

Our County government, and its health system are to be congratulated for progressive policies designed to protect of the rights of all people and treat everyone with dignity and respect. These longstanding policies and procedures were designed for an atmosphere that no longer exists. In a short few weeks the new President and his administration have taken actions designed to create division, fear, and terror in the communities you serve.

Cook County has an estimated 307,000 undocumented residents. The majority of immigrants in our County originate from Mexico and other nations in Latin American; however, all parts of the world are represented. In addition to Latino neighborhoods, people from our Polish, Asian, and African communities are staying home. They are afraid to get groceries, send children to school, and keep doctor's appointments. You can see this if you look at retail sales on 26th street or clinic visits in the Cook County system.

Since slavery, Black Americans have been stigmatized, incarcerated, shot like dogs in the streets by a system of structural racism and a criminal justice system that views us as sub-human. It should come as no surprise that data from Homeland Security show undocumented immigrants of African descent have been disproportionately turned over to ICE (Immigration and Customs Enforcement) for deportation. Some estimate that the deportation rate for those of African descent is five times higher than others. Black immigrants make up only 7% of the total immigrant population; however, 20% of all immigrants in deportation proceedings due to criminal convictions are of African descent.

President Trump has greatly expanded the definition of who will be prioritized for ICE raids. Furthermore, any non-prioritized folk caught up in such raids may be subject to detention and deportation. These actions have included young people with DACA status. A woman seeking justice in our courts on matters of domestic violence has been arrested. Earlier this week ICE returned to detention a young woman with a diagnosis of a brain tumor in need of surgery.

We urge this board to respond to these rapidly changing and unpredictable new policies of the Federal government. Such action would be completely in line with the County's long standing policies and our traditional of caring for all regardless of status or ability to pay.

The Cook County Department of Public Health has been a national leader on health equity for well over a decade. They play a leadership role in the National Association of City and County Health Officers (NACCHO), the National Collaborative for Health Equity (through the Collaborative for Health Equity – Cook County) and other national leadership bodies around health equity. Most recently Human Impact's national leadership group around health equity issued an important document we have included in your packet. ("Public Health Actions for Immigrant Rights: A Short guide to protecting undocumented residents and their families for the benefit of

public health and safety.") This document has been extremely well received around the nation. The guide benefited from the contributions of Mr. James Bloyd MPH, a member of the Cook County Department of Public Health, and a national leader on Health Equity. We encourage the Health and Hospitals System to make use of this excellent guide.

We know that both the City and County governments are actively exploring ways to respond to the new administration and protect our residents. However, only this Board, the leadership, and staff of the health system are capable of responding with the specialized level of detail to protect patients and the public. We do NOT wish to increase the level of panic in our communities. We believe a thoughtful, prompt, and transparent process will help reassure patients and the communities you serve. We urge this board to form a special Task Force to protect marginalized communities. The most important goal is to assure that the spirit of the health systems present policies to protect our patients, and public health and safety of all residents of Cook County can be realized. This task force should include members of this board, leadership of the health system, rank and file workers, and community organizations familiar with immigration issues. The task force should be empowered to consult with appropriate sister agencies (e.g. States Attorney, Sheriff) as well as outside experts. The Task force should begin by address the following points:

1. To review and clarify (and recommend modification if necessary) present system policies designed to protect our patients. For example, is the present collection of social security numbers necessary ? When none is offered and recorded as such in the EMR is this an inadvertent way to identify vulnerable populations ? What should staff do if police or ICE appear without a legal warrant seeking access to patients ? What steps should be taken to protect patients who are referred outside of our system for services? Health system staff working on visas need to be afforded legal counseling. The details of such scenarios need to be carefully examined and appropriate revisions and clarifications made.
2. Train all staff about the truth and myths around immigration and the details of the clarified system policies and procedures. Staff need to understand the history of immigration in the United States, the rights people enjoy, and the health and safety impact of immigration policy. Clinical staff, in particular, may need refresher training on how to provide services to vulnerable populations without causing additional trauma around immigration status.
3. There needs to be abundant and clear signage in multiple languages reassuring staff, patients, and visitors that we are a welcoming institution. We have enclosed one example in our packet.
4. The health system needs to be prepared to refer patients for legal and other services they might need.
5. The health system needs to monitor show rates, utilization of its services and other indicators of neighborhood distress in immigrant and marginalized communities.
6. The Cook County Department of Public Health should prepare a policy brief detailing the threat of Trump's immigration policies to the public health and safety of all who live in the county.
7. The Health & Hospitals System board and management should continue to play a visible leadership role by designing and implementing best practices for medical and public health providers in our state.

We are confident that this Board and our health system will rise to the occasion. The staff and board of HMPRG stands ready to assist in any way we can.

SANCTUARY
FOR OUR PEOPLE

Your Black Lives Matter

Immigrants, we have no walls

Women, your bodies are your own

Queer/Non-conforming/Trans people, you are seen and loved

Individuals with disabilities, you make us stronger

Muslims, you are honored here

Young people, your voice is powerful

YOU ARE SAFE HERE
YOU BELONG

Chicago ACT Collective

Public Health Actions for Immigrant Rights: A Short Guide to Protecting Undocumented Residents and Their Families for the Benefit of Public Health and All Society

Who is This Guide For? People working at local health agencies who are looking to protect and support undocumented residents and their families.

Who Created this Guide? A workgroup of Public Health Awakened, a group of public health professionals organizing a health equity-based response to the Trump administration.

How Can You Use This? We hope the ideas and actions in here resonate and that you move forward with at least some of them at your health department. Please share the ideas with others. And feel free to use all of the document or any excerpts to help make your case!

Who to Contact? If you have questions or edits, please email: immigrationguide@humanimpact.org.

Actions You Can Take - The Summary

Action #1: Continue to promote health agency policies to provide services to all people, and to ensure all people understand that they are welcome at the agency

Action #2: Support cities, counties, and states that pledge to provide sanctuary in different forms to undocumented residents

Action #3: Advocate that local and state government create a legal defense fund for undocumented residents

Action #4: Connect undocumented clients and their families with legal rights and community organizing groups

Action #5: Join/build alliances that cross issue areas and include immigration

Action #6: Encourage and support the efforts of sister agencies, including in criminal justice, to protect undocumented people and their families

Action #7: Encourage labor enforcement to adopt and implement policies that protect worker rights, regardless of immigration status

Action #8: Review other health agency policies and services, considering how undocumented populations may be impacted

Action #9: Work to change a narrative that portrays undocumented people negatively

Note: A set of slides (google slides and powerpoint) covering the content of this document is also available for use.

A Promise to Deport Millions

President Trump's 100 day plan includes deporting 2 million undocumented residents from the US. The plan calls for a massive increase in scale and speed of deportations, which already reached historic highs under President Obama, whose administration deported 2.5 million people in his first 7 years in office.

Trump says he will focus on deporting undocumented people with criminal records. With fewer undocumented people with criminal records in the US now as a result of Obama's policies, Trump has already expanded the definition of who is a 'criminal' to include people who are merely charged or suspected of committing crimes. Being in the US without documents may become a 'criminal' act. Sensitive locations, like schools and clinics, may be raided. People without criminal records will also get entangled in the Trump administration's efforts.

Going backwards in time. The last time the US focused on deporting such massive numbers of people was in 1954, under Eisenhower. "Operation Wetback" led to the deportation of 3.8 million Mexican Americans. Going back further, during the Great Depression, **county social workers supported and participated in the deportation of 2 million Mexican American people**, including 1 million US citizens (see Decades of Betrayal: Mexican Repatriation in the 1930's). For an excellent paper on the history, exclusion, and exploitation of Mexican-American people in the US, see Doug Massey's Racial Formation in Theory and Practice: The Case of Mexicans in the United States.

A contradiction of public health principles. Core principles of public health include equity, valuing every life, and preventing harm. The President's plan contradicts our values and ethics. People come to the US to improve their lives, often in response to physical and sexual violence, and poverty. Amidst worldwide economic turmoil and war, while capital and goods—but not people—flow freely across borders, we remember that it is part of the US origin story to welcome people to this country, with or without documentation.

Deportation and threat of deportation affect not only undocumented people, but also their children and family members who are often legal residents, anyone perceived to be an immigrant based on skin color or other factors, other people with whom they share communities or schools, and our broader society.

By the numbers

- Approximately 11 million undocumented immigrants live in the US currently, according to the Pew Research Center.
- An estimated 4.5 million US-citizen children live in families in which at least one person is undocumented, according to Human Impact Partners.
- At 2012 deportation levels—much lower than what Trump proposes—more than 150,000 US-citizen kids a year had a parent deported, according to Human Impact Partners.

This is a Public Health and Community Safety Issue

- **Deportation and threat of deportation create a climate of fear** that affects undocumented as well as documented immigrants, their families, and their communities.
- **Immigrants change health-seeking behaviors for themselves and their family members if they fear being stopped by police and potential deportation.**

  As described in a Massachusetts study, Arizona study, a survey of primary care providers, a survey of patients, a Los Angeles study and HIPs Family Unity, Family Health report:

  - **Immigrants miss medical appointments or less often use public services like health clinics**—regular doctor visits, diabetes education, vaccines, prenatal care, HIV education, getting medications, care for communicable diseases like tuberculosis, etc.
  - **They eat less healthy food if afraid to drive.** Access to grocery stores with produce and healthy food options often requires travel, which may be a deterrent and adversely impact health.
  - **People are afraid to use parks, exercise outdoors, and participate in their communities.**

- Documented and undocumented immigrants experience **exacerbated health conditions like stress, anxiety, and hopelessness** due to fears of deportation for themselves or members of their community (see Hacker, et al 2011).
- **Children experience direct impacts, including poorer child health, poorer behavioral outcomes, and poorer educational outcomes**.
  - Nearly 30% of undocumented parents in the report said their **US-citizen children are afraid either all or most of the time.** Nearly half said that their child had been anxious, and three-quarters said that a **child has shown symptoms of post-traumatic stress disorder** (see HIP's Family Unity, Family Health report).
  - **A recent study found a 24% increase in risk of low birth weight** among infants born to Latina mothers after a major immigration raid, when compared to birth weights before the raid (see Novak et al, 2017).
- **Threat of deportation makes victims of domestic violence and gender-based violence less safe.** Domestic violence victims often remain with their abuser rather than risk being detained and/or deported when seeking protection from abuse (see Applied Research Center's 2011 report and American Public Health Association's 2012 policy statement).
- **It also makes law enforcement more difficult** (see Major Cities Chiefs Police Association's 2013 position statement and a Police Foundation 2009 report). People who witness or are victims of a crime are less likely to report the crime or cooperate as witnesses if they fear deportation or questions about immigration status for themselves or someone they know when going to police.
  - One survey found this lower likelihood to contact police among both undocumented (70%) and US-born Latinos (28%) (see Theodore et al's 2013 report).
- **Decriminalization and harm reduction are part of public health prevention.** It is in the interest of public health to support policies that unify families rather than separating them—particularly for

what in some cases can be merely accusations of crime. NACCHO has a strong policy statement with useful language on the health of documented and undocumented immigrants—including families —as a public health and equity issue. The Minnesota Department of Health also published Immigrant Health: A Call to Action with helpful recommendations.

- In addition to the public health implications of supporting people facing deportation, economists find that **immigrants typically contribute more through income, payroll, and other taxes to support public programs like Medicare and Social Security than they receive in government benefits**. For example, immigrants contributed $115 billion ***more*** than they received from Medicare between 2002 and 2009, according to a 2013 study published in the journal Health Affairs. That's to say nothing of many nonfinancial contributions to their cities and states. *(While we believe that the public health evidence above should stand on its own, the economic evidence here or similar evidence may be helpful in some places.)*

Addressing immigration and deportation issues adds work for many public health programs and staff that are already stretched. We encourage you to think creatively about how to do this work: the undocumented population is one of the most marginalized in our country and Trump's policies will make their health needs—and the health needs of their families and communities—even greater. They need our support.

Action #1: Continue to promote health agency policies that provide services to all people, and ensure all people understand that they are welcome at the agency

Background: Health Agencies Serve All People

- Health agencies can be a primary resource in supporting the health of immigrants regardless of their status and, in turn, public health in general.
- Health agencies often directly provide undocumented immigrants, and their children who may have legal status, with key health services or can direct clients to other providers for these services. Examples include immunizations, maternity services, prenatal care, adult health, family planning services, communicable disease screenings, child health services, adult health services, case management, tuberculosis testing and care, and nutrition programs.
- Common barriers to accessing care can include language, transportation, fear or mistrust that immigration status will be collected or reported, misinformation or a complexity of rules regarding eligibility, lack of insurance, and discrimination. These barriers may be exacerbated during times of political uncertainty.

What Health Departments Can Do

- Research the resolutions and protections that your agency has in place already around keeping all people safe. If you're going to promise that all are safe, make sure that's legally accurate.
- Publicly state agency commitment, such as on San Francisco's Post-Election Information webpage, which "affirms that their medical and social service agencies are sanctuaries for all regardless of immigration status," or similar to what school districts and universities are doing to reaffirm commitments to safe spaces for all.
- Post signs in multiple languages that are welcoming to everyone, build linguistic sensitivity, and avoid alienating vocabulary (e.g., avoid the word "illegals"; see Action #9 for more about language). Examples of language in San Francisco include:

  - "You're safe here!"
  - "You can continue to receive care here"
  - "Your health care coverage has not changed here"
  - "San Francisco is and will always be a sanctuary city"

- Distribute "know your rights" pamphlets in waiting rooms. See examples from the National Immigration Law Center and the American Civil Liberties Union.

- Health departments can try to avoid collecting patient data that would identify or be used to deport undocumented people. To do so, you must understand the legal actions necessary, as this KCET article, this Mother Jones article and this Los Angeles Daily News article describe is being done by various agencies in California, University of California, and in New York City. Work with your epidemiologists, statisticians, and clinical staff to understand what types of personal data might be vulnerable to subpoena and to limit the amount of information available that could be used to identify undocumented people.

- Track or study to the extent possible the number of un-enrollments in health department services and programs, and develop ways to encourage undocumented people to continue to use those services and programs.

- Train staff. Look to partner with other health agencies to host regional trainings, and most efficiently use resources. Topics may include:
  - Identifying the particular needs of undocumented clients or people in families with mixed immigration status
  - Working together with clients on these issues
  - Knowing the rights of undocumented immigrants and helping them know their own rights
  - Setting up clinics in ways that protect the privacy of clients and their data
  - Handling interactions with federal Immigration and Customs Enforcement (ICE) or with patients, if ICE agents come into a clinic or hospital or other provider setting. ICE must treat private spaces differently than public spaces. American Civil Liberties Union has more information—your local chapter may be able to provide information.
  - Understanding what information is mandatory versus optional for patients to share during patient consent, or for staff to share with ICE

- For examples of materials available, see:
  - Example approach to talking about DACA authored by the Boston Medical Legal Partnership (note the July 2016 date—this information may change)
  - Promising practices for increasing access to health services for undocumented clients or mixed-status families in this Urban Institute research brief (again note the 2012 date and that this information may change)

- Ensure the availability of trained interpreters when providing services to community members, including undocumented residents, whose primary language is not English.

- Ensure health care services are affordable for low-income and undocumented people.

- Advocate for continued funding to provide resources for undocumented people.

- Communicate with and share these strategies with fellow county/local agencies and decision makers, including public social services, children and family services, housing agencies, mayors, and city council members.

Action #2: Support cities, counties, and states that pledge to provide sanctuary in different forms to undocumented residents

Background: Primer on "Sanctuary" Cities, Counties, or States

- There is no legal obligation—for a city, county, or state—to assist with federal civil immigration enforcement. It is voluntary and at the discretion of the corresponding decision-makers. See the Immigrant Legal Resource Center's (ILRC) recent report.
- Hundreds of places identify as "sanctuaries"—one recent count found 4 states, 364 counties, and 39 cities. There is no single definition of a sanctuary city, county, or state. Another option is to call for "welcoming" cities, counties, or states.
- Some advocates are focusing on county and state laws more than city ordinances. Many law enforcement decisions are at county levels—in the hands of the sheriff—and city ordinances typically don't apply to counties.
- Certain policies typify "sanctuary" places. They vary in strength of their wording. Also, be aware that places may identify as "sanctuaries" while still promoting policies that harm undocumented people. Even if you are in a sanctuary place, look at the specific policies and their impacts.
- With nuances in the law, it is important that instead of wording these policies as a general call not to comply with ICE, they instead use more specific language stating that county resources or time will not be used to target residents on the basis of immigration status.
- An important issue is whether people with criminal records are included in sanctuary policies. To that end, see the model language below from Oak Park, IL.

What Health Agencies Can Do: Advocate for Model Language and Policies

If sanctuary policies already exist in your city, county, or state. Help implement and continue to support policies and actions described below, particularly if there is a police or sheriff's department in the health agency's service area. You can also argue for more inclusive policies, such as not allowing any collaboration with ICE even when people with criminal records are involved.

If they do not yet exist in your city, county, or state. Advocate for the adoption of these policies or actions, explaining how they support health and equity. Again, do this particularly if there is a police or sheriff's department in the health agency's service area.

If looking to replicate model language, see the language proposed in Oak Park, IL that is very similar to language changes being proposed in Chicago, IL. In Oak Park, the Welcoming Village Ordinance is supported by Village residents led by Proyecto de Accion de los Suburbios del Oeste/ West Suburban Action Project. Importantly, the ordinance language strives to criminalize no one, by eliminating loopholes or 'carve outs' that lead to a destructive "good immigrant - bad immigrant" narrative (see more on this narrative below).

If the language above is not feasible in your area (i.e., if protection of those with criminal records is completely not viable), here is another example to read: County of Santa Clara's 2011 ordinance.

Where possible, incorporate the health rationale/citations stated at the beginning of this document into the policy or in advocating for the policy, to highlight the connections between health and deportations.

When you look at policies in your area—if you're trying to figure out whether they would help or harm—below are main ideas to look for, as summarized in the ILRC report above:

- Local law enforcement should not hold or detain undocumented people for ICE, nor alert ICE if a person recently held is undocumented.
- In places that do hold or detain people for ICE, local law enforcement should require ICE to have a warrant to access the secured area of the jail, or should enact protections for the undocumented person so they can refuse an ICE interrogation.
- Local law enforcement should prohibit officers or employees from asking a person's birthplace or immigration status.
- Local jurisdictions should prohibit the use of local resources in complying with ICE requests.

Additional actions for which to advocate:

- Issuing local ID cards to allow undocumented people to access government or other services, such as in New York City, Phoenix, Detroit, Washington DC, and others.
- The City of Seattle's 7 points of protection.
- Laws that avoid criminalizing daily activities. For example, at least 10 states including California, passed laws to allow undocumented immigrants to get driver's licenses and driving privileges, an action that helps them avoid driving illegally to meet basic needs for themselves or their families.
- Creating an office similar to the Office of Immigrant Affairs recently formed in Los Angeles County to protect all immigrant residents of the county. See this Los Angeles Times article. (Note: the process in Los Angeles included impact reports by the Superintendent of Schools and Sheriff.)

Last, work with other agencies and elected officials to develop a plan if Trump delivers on his threat to cut federal funds for places that have sanctuary policies.To prepare for that time, work now on quantifying specific benefits and harms from cuts or withholding funds related to sanctuary cities (e.g., number and types of programs that could be cut, number of people not served.)

In some jurisdictions, the political terrain can be challenging to navigate. Some health departments are using the resources they have for community capacity building or resident leadership programs to support leaders outside of public health, such as youth, who can help lead advocacy efforts. Public health agencies can use tools such as power analysis to think through with whom to partner and develop an inside/outside strategy.

Action #3: Advocate that local and state government create a legal defense fund for undocumented residents

Background

Undocumented immigrants, including young children, are not guaranteed representation in court for immigration-related cases. People with representation have far better (7-fold) success in court.

Cities and counties are pledging money for legal services to people facing deportation. Examples include:

- Los Angeles (both City and County) are creating a $10 million fund to provide legal services to people facing deportation (see NPR story). The County will commit $3 million over the next 2 years and private foundations are supporting the effort (see ABC story).
- Chicago approved a $1.3 million fund for similar purposes (see Chicago Tribune story).

- San Francisco, Alameda County, and New York are reportedly considering something similar.
- Two proposed bills in California, AB 3 and SB 6, would create a state program to fund legal representation for people facing deportation, and state-funded regional centers to train defense attorneys and public defender's offices on immigration law and the consequences of criminal convictions.

What Health Agencies Can Do

- Encourage local and state elected officials to fund legal services for undocumented residents, describing the health and equity outcomes associated with deportation.
- Identify agencies, including public defenders offices and nonprofit legal clinics, that may be working on legal defense funds. Learn what their plans are and if they have ideas about how your health agency can help. They may also be able to increase your understanding of the political landscape.

Action #4: Connect undocumented clients and their families with legal rights and community organizing groups

Background

Many places around the country have community organizing groups and legal service groups that support undocumented residents and their families. These organizations can help undocumented residents and their families by, for example, providing legal services (e.g., helping to file paperwork, providing representation in court), building their leadership skills, connect undocumented people to others in similar situations to reduce isolation and fear and to build their voice and power, and avoiding unnecessary interactions with police that an undocumented person may not welcome. Actions also include helping to resist deportations, providing an underground railroad of sanctuary churches, declaring restaurants as sanctuary places, and organizing to provide community-based healthcare in the face of cuts.

What Health Agencies Can Do

- Get a pulse on what's happening, then figure out how your health agency can support it. Partnering closely with these community organizations can help with multiple actions listed in this document.
    - Starting small, with one-on-one meetings with potential partners, can be a way to move into this area if it's new to your public health agency.
    - Over time, your goal should be to build strategic, long-term, and trusting relationships with these organizations. See the New York City Immigration Coalition's Health Collaborative as one example.

Examples of actions that public health departments can take include:

- Provide data and research to these partners, including research using community-based participatory research methods.
- Help disseminate "know your rights" information and flyers in public health clinics, newsletters, and other health department dissemination activities. See National Immigration Law Center for examples of know your rights resources.
- Find specific ways that your agency can support their capacity building and power building work.
- Advocate in support of these partners and their work, using the health department's standing as experts and lifting up the voices of undocumented people and their families in all stages of policy and program development and at all levels of decision making. For

example, co-sponsor community events and forums, such as "Know Your Rights" clinics on immigration, health, and social services.

- To find these groups in your jurisdiction:
  - Reach out to the national networks or organizations that coordinate and support local groups, such as:
    - The Fair Immigration Reform Movement (FIRM; http://fairimmigration.org/)
    - United We Dream (http://unitedwedream.org/)
    - We Belong Together (https://www.domesticworkers.org/we-belong-together)
    - National Council of La Raza (NCLR; http://www.nclr.org/)
    - Check for potential partners on local college campuses, which may have groups already formed around immigration.
  - Email Human Impact Partners (immigrationguide@humanimpact.org). They have worked with many of these groups and are happy to connect you.
- Refer undocumented clients and their families to these community organizations and legal services organizations when helpful.

Action #5: Join/build alliances that cross issue areas and include immigration

Background

Undocumented immigrants are not the only population under attack or feeling threatened. Social justice advocates will fight many other battles, supporting many other groups during the coming years. We will all be stronger and more successful if we join existing alliances or create new alliances that work together. To build power, we need integrated, coordinated, and strategic infrastructure and networks.

Potential allies include people or organizations who you as a public health professional already know and work with. They also may include less well-known (to public health), yet crucial partners like criminal justice reform advocates, union organizers, and others who work with the most marginalized communities. These groups may already incorporate an immigration frame into their work. For example, the Movement for Black Lives platform includes undocumented people in a call to elevate the experiences of marginalized Black people and describes specific actions to take around immigration. Work with these groups can expand the meaning of sanctuary places (as discussed in Action 2) to become 21st century sanctuary places that include, but are not only about, undocumented immigrants. It is important to work with local community organizing groups and advocates who are connected to national movements, such as: Black Lives Matter; LGBTQ issues; labor (e.g., unions, worker centers, Fight for 15); faith-based tolerance and unity; housing; transportation; health care; climate change; voting rights; etc.

What Health Agencies Can Do

- Identify conversations and meetings you are not involved in but it makes sense to join, show up, and listen. In spaces where you are a new face or where public health is not traditionally represented, it may mean only showing up at first to listen, while building relationships.
- Join local alliances between these groups, if they already exist, to bring the power of public health to this work. In these spaces, raise the concerns of the undocumented populations with whom you work.
- If local alliances do not yet exist, health agencies can help convene them: invite potential allies to the table, provide facilitation and space, and support the work partners decide to pursue together.

Action #6: Encourage and support the efforts of sister agencies, including in criminal justice, to protect undocumented people and their families

Background

Many decisions that affect undocumented residents and their families are outside of public health's direct control, yet health agencies often have relationships with decision makers in other sectors. Health agencies have an opportunity and an obligation to use those relationships to improve health and advance health equity. This is the underlying idea of Health in All Policies.

Examples of sanctuary policies being enacted by other sectors include:

- Sheriffs who manage and operate county jails where people are brought when they are arrested. Most people are turned over to ICE from these jails. Therefore, policies related to the jail have the greatest impact on deportation.
- Police departments, many of which have stated their non-cooperation with ICE, as described in the section about sanctuary cities, counties, and states.
- Public defenders, some of whom in Oakland are creating a rapid response network to represent undocumented residents.
- School districts in many cities (e.g., San Francisco, Oakland, Berkeley, Sacramento, and Seattle) have passed resolutions stating that public schools are sanctuaries to immigrant and Muslim families and declaring that they will do everything legally possible to protect families and students from immigration enforcement actions on their campuses.
- Some other social services agencies have taken stands as well.

What Health Agencies Can Do

- Understand what your sister agencies (sheriff, police, education, etc.) are already doing with regard to undocumented residents. Increasingly, government agencies are partnering to advance equity (see the Government Alliance on Race & Equity for example).
- For sister agencies already putting in place policies and procedures to support undocumented residents and their families: reach out to show support and to share evidence that these policies will improve health and equity.
- Meet with leadership at agencies that have not yet begun to put in place such policies and procedures to discuss the health and equity impacts of not doing so and to encourage them to put in place such policies. While it may take time and effort to build relationships and to move sister agencies, health agencies should use whatever power and relationships they have to encourage them along. One strategic decision to make is when and how to bring others (e.g., city council members that agree with the need to protect undocumented residents, community organizations that support undocumented residents, public defenders) into the discussion.
- See above #2 re: encouraging cities, counties, and states to pledge to provide sanctuary in different forms to undocumented residents.

Action #7: Encourage labor enforcement to adopt and implement policies that protect worker rights, regardless of immigration status

Background

The US employs 8 million undocumented workers according to a 2016 Pew Research Center analysis. There is a history in this country of exploiting workers who are perceived as more vulnerable because of their immigration status, denying them workplace rights, or deterring them from asserting those rights. The law is clear that it is illegal to exploit, deny, or deter in this way, with protections in place to pay the minimum wage and overtime to all workers, regardless of status or other attributes. It is also illegal for an employer to retaliate against a worker who files a discrimination claim by reporting the individual to immigration officials. Given that living wage and secure employment in safe conditions are foundational determinants of health, public health has grounds to advocate for a pro-worker stance, and encourage the protection of ***all*** workers' rights.

In recent years, unions have taken a more pro-immigrant stance and have fought for comprehensive immigration reform and immigrant rights. They can be strong allies in passing the policies and taking the actions suggested in this guide.

What Health Agencies Can Do

Public health can take a number of actions, including those in a National Employment Law Project report:

- Help your clients who are undocumented workers to know their basic employment rights.
- Encourage stronger statutory protections to protect workers from employer retaliation.
- Leverage the agency's own regulatory authority to support compliance with labor laws. For example, the San Francisco Department of Public Health has revoked or suspended health permits for employers who do not comply with local labor laws, such as those found guilty of wage theft (see Bhatia et al, 2013).
- Educate policymakers about the public health impacts of wage theft and the disproportionate vulnerability to it for undocumented immigrants. See this Minkler et al, 2014 article in the American Journal of Public Health and a report about the health impacts wage theft in Los Angeles.
- Support a strengthened firewall between immigration enforcement, local law enforcement agencies, and state labor law enforcement.
- Collaborate with partners like immigrant work centers, unions, and other labor groups to research and document the health impacts of poor working conditions on immigrant low-wage workers. For example, as described in this US Centers for Disease Control and Prevention blog.

Action #8: Review other health agency policies and services, considering how undocumented populations may be impacted

Background

There are a variety of other policies and practices that affect undocumented populations differently or through which they can be deported. For example, this story from Texas reveals how disaster response might provide an opportunity for ICE to screen for immigration status.

What Health Agencies Can Do

- Review all department policies and practices, considering how they could impact undocumented populations. Revise policies and practices to mitigate any potential negative impacts on undocumented populations and to reduce opportunities for deportation.

Action #9: Work to change a narrative that portrays undocumented people negatively

Background

Views about all immigrants, or those assumed to be immigrants, including undocumented immigrants are greatly influenced by the dominant narrative articulated by elected officials and the media. Many elements of the current dominant narrative are incredibly harmful. For example it:

- Calls undocumented people "illegal." As Holocaust survivor Elie Wiesel stated, "No human being is illegal. That is a contradiction in terms." See Colorlines' "Drop The I Word" campaign.
- Incorrectly claims that undocumented immigrants take jobs from US citizens and are a drain on the economy. As discussed above, immigrants benefit the economy.
- Distinguishes between "good" and "bad" immigrants. For example, immigrants from places like Mexico or majority Muslim countries have been referred to as terrorists and rapists, while those from other places are described as hard-working and productive. Or news media may be sympathetic towards children, but criminalize other immigrants.
- Labels undocumented people as "criminals" and claims that deporting immigrants makes communities safer. In fact, non-citizens are arrested less often than their citizen counterparts.

Narratives and framing are critical to policy change. Divisive narratives make it harder to build support for and pass policies that are important for public health, such as ensuring access to healthcare, regardless of immigration status. Public health must partner with immigration rights groups and other groups that can help improve framing and narratives to communicate about health, work to shift the narrative around immigration in public health and more broadly, and tie communication strategies to our ongoing work.

To protect the health of our country, including undocumented populations and their families, and to win policy reforms, this narrative must change.

What Health Agencies Can Do

- Train staff and partners to use language and a narrative that supports undocumented populations and their families. See examples from linguist Anat Shenker-Osorio and from Opportunity Agenda as a potential guides that include specific messages and wording suggestions. Migration is Beautiful is an effort by artists to change the way people think of immigration.
- Reach out to immigrant-rights groups, especially those led by immigrants and/or that are community organizing groups that work with immigrants, to develop communication strategies and messages. They will have local and contextual experience and ideas that can add to resources from other communications research. Communication strategies from public health agencies should support and align with the goals, framing, and messages from these community groups. This may not mean using the same language—public health agencies may choose to lead with a health argument and use data and research to support their statements while community groups may have access to residents' stories and be more comfortable using passionate language—but these two approaches can supplement and amplify each other. Makani Themba wrote this blog about the need to connect

communication strategy to organizing strategy and the danger of developing communication materials in absence of community partnerships.

Act Now!

Please continue to give us feedback about this document. But more importantly, **please begin to use it now. Choose a few things you can advance at your public health agency and start to work on them. The time is now. If we don't step up, who will?**

Public Health Woke
Agenda

Welcome

Lorraine M. Conroy, ScD, CIH, Acting Dean UIC School of Public Health

Immigrants Rights a Fight for Social Justice

Jesús "Chuy" García Cook County Commissioner, 7th District

Review of "Public Health Actions for Immigrant Rights"

James Bloyd, MPH Cook County Health Department

Special Thanks To The Following Organizations

Collaborative for Health Equity, Cook County; 7th District Cook County Health Task Force; Health & Medicine Policy Research Group; Radical Public Health; UIC School of Public Health, Coordinating Center for Public Health Practice

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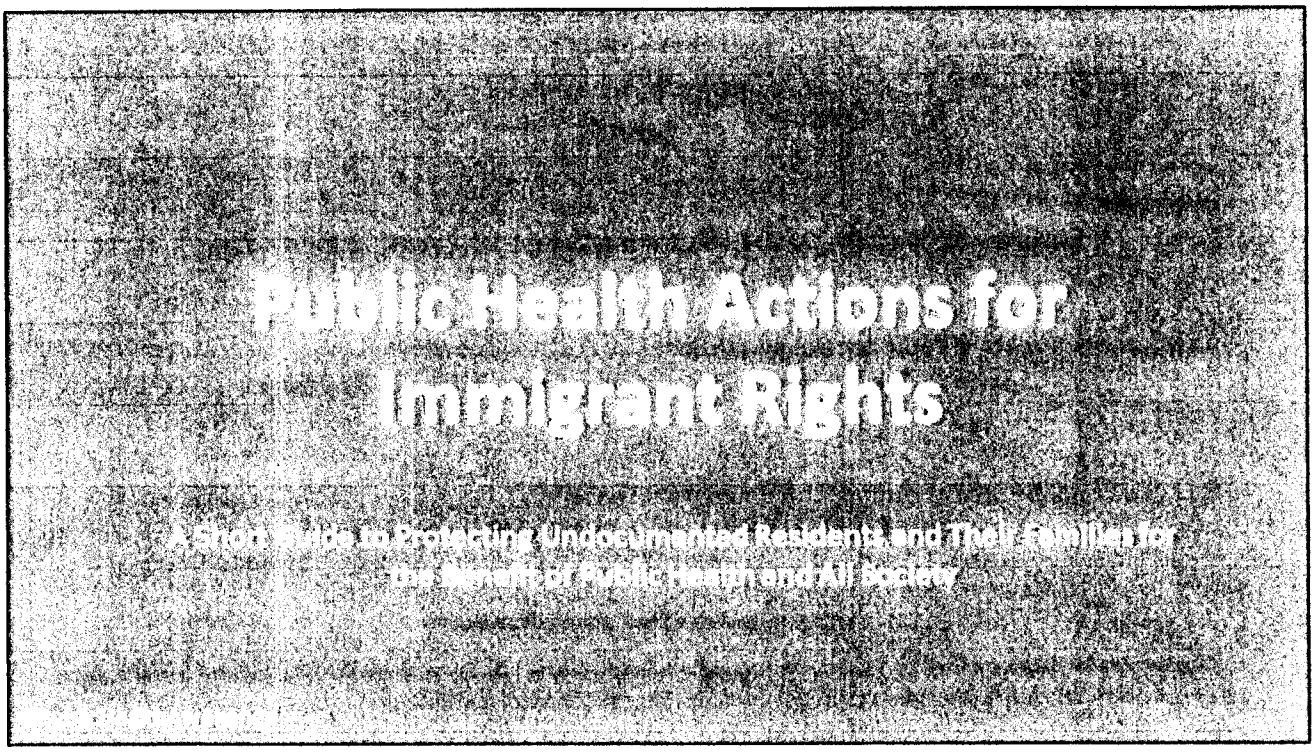
Documents are available at the CHE Cook County webpage: www.checookcounty.org
https://www.checookcounty.org/contact-c1sxh


Public Health Actions for
Immigrant Rights

Concern: Accelerating Deportations

Number and pace of deportations expected to increase

Obama	2008-2016	2.5 million
Trump	?	2 million

A widening net

- Many undocumented persons with criminal records already deported under Obama administration
- The Trump administration will need to cast a wider net
  - Expanded definition of 'criminal'
  - Those without criminal records entangled in efforts

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3

Current Administration has promised to deport 2 million undocumented residents.

- Obama Administration: 2.5 million undocumented residents over **7 YEARS**
- Trump wants to deport 2 million in an unknown time period
- Massive increase in scale and speed of deportations will tax our enforcement resources, and ensnare innocent people

A Widening Net:

Trump says he will focus on deporting undocumented people with criminal records. With fewer undocumented people with criminal records in the US now as a result of Obama's policies, Trump has already [illegible] to include people who are merely charged or suspected of committing crimes. Being in the US without documents may become a 'criminal' act.

A Contradiction to Public Health Principles

Accelerated deportations contradict our values and ethics.

People come to the US to improve their lives, often in response to physical and sexual violence, oppression, and poverty.
We remember that it is part of the US origin story to welcome people to this country, with or without documentation.

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Captial and goods can move freely across borders, but not people. That is the core of the problem - we can change these laws.

Local Government Has Been Complicit In Past Mass Deportations

Great Depression
County social workers supported and participated in deportation of 2 million Mexican-American people, *including 1 million US citizens*

1954 "Operation Wetback"
Eisenhower deported 3.8 million Mexican Americans

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5

Source: Decades of Betrayal: Mexican Repatriation in the 1930's (https://www.amazon.com/Decades-Betrayal-Mexican-Repatriation-1930s/dp/0292730735)
Source: Racial Formation in Theory and Practice: The Case of Mexicans in the United States (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2831337/pdf/nihms-227052.pdf)
Image Source: "Mexicans Keep Going" (https://)
Image Source: "Eisenhower" (https://)

11,000,000

undocumented immigrants live in the US currently

4,500,000

US-citizen children live in families in which at least one person is undocumented

150,000+

US-citizen kids a year had a parent deported

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6

Source: Human Impact Partners (http://www.humanimpact.org/projects/hia-case-stories/family-unity-family-health-an-inquiry-on-federal-immigration-policy/)
Image Source: Other Words (https://otherwords.org/[illegible])

Deportation and threat of deportation affect not only undocumented people, but also their children and family members who are often legal residents, anyone perceived to be an immigrant based on skin color or other factors, other people with whom they share communities or schools, and our broader society.

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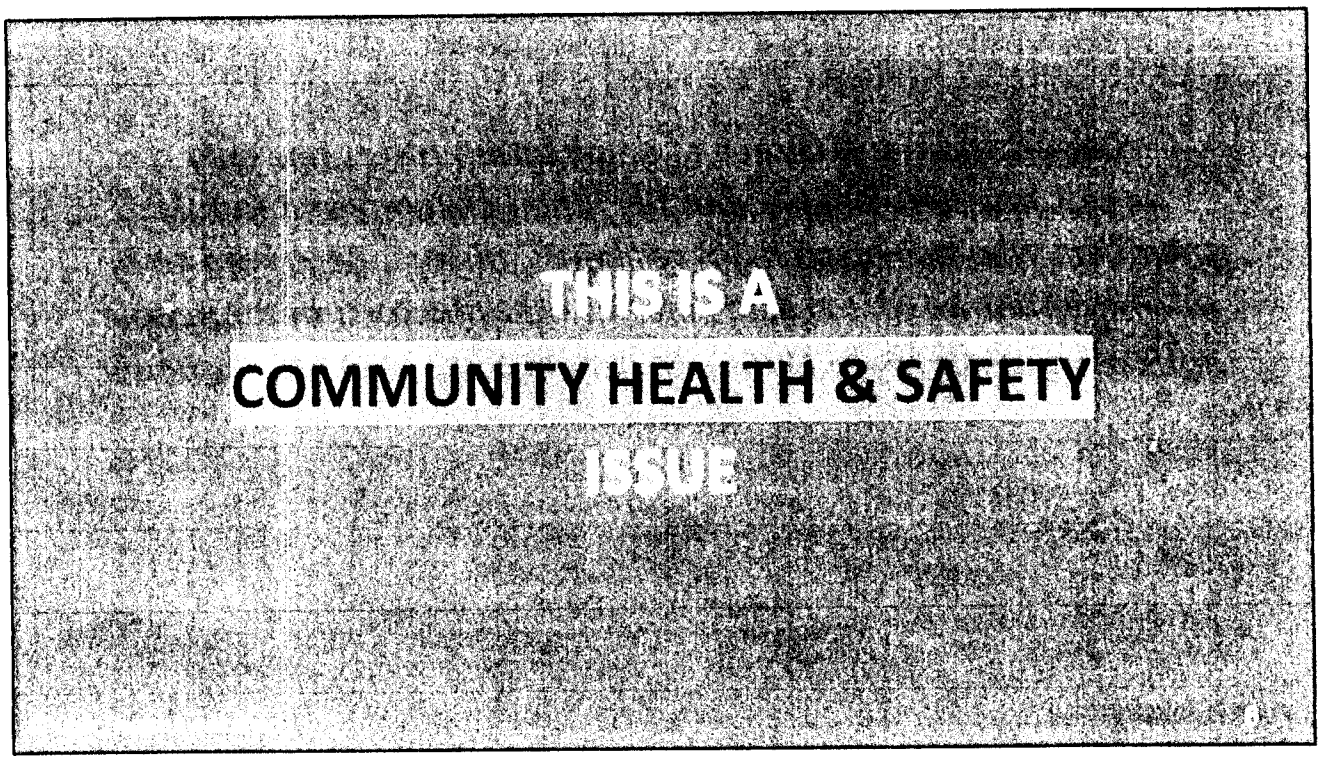
A recent study found a 24% increase in risk of low birth weight among infants born to Latina mothers REGARDLESS OF DOCUMENTATION STATUS after a major immigration raid, when compared to birth weights before the raid (see Novak et al. 2017).

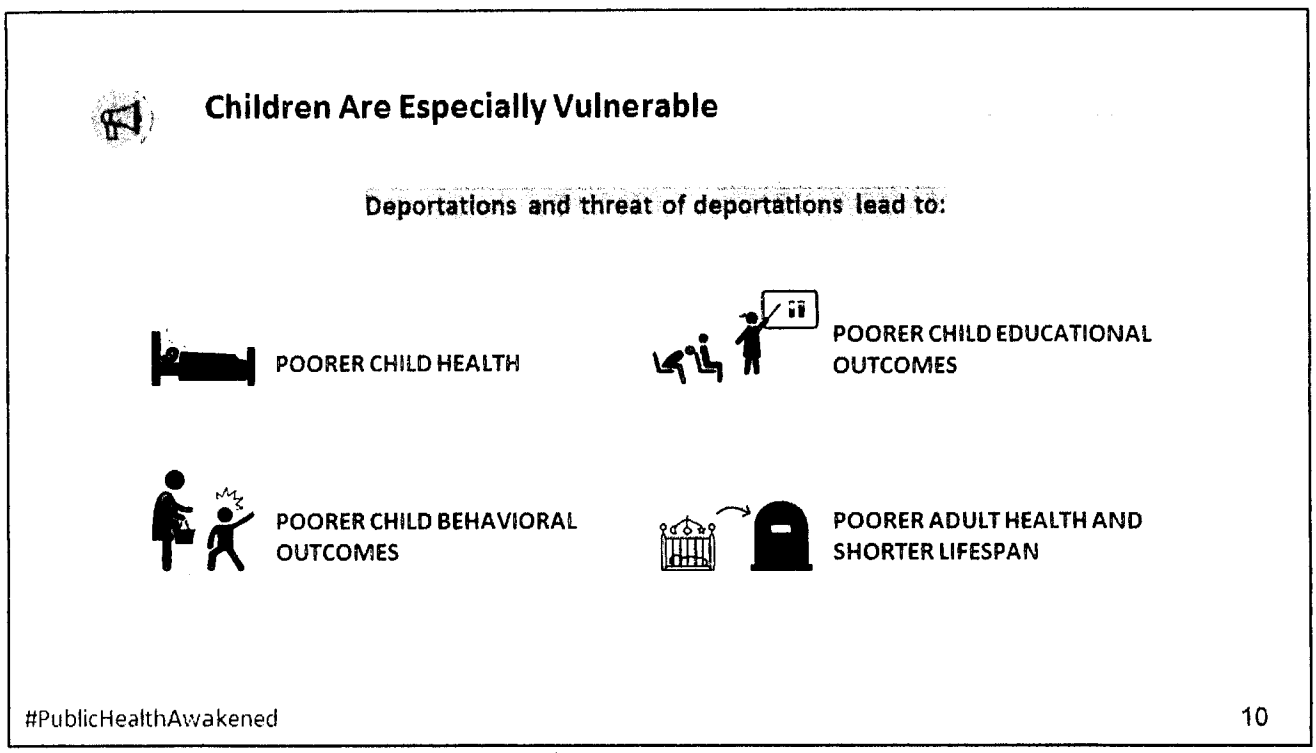

THIS IS A
COMMUNITY HEALTH & SAFETY
ISSUE

Immigrants change health-seeking behaviors for themselves and their family members if they fear being stopped by police and potential deportation.

As described in a Massachusetts study, Arizona study, a survey of prenatal care providers, a survey of patients, a Los Angeles study and HIPs Family Unity Family Health report:

- **Immigrants miss medical appointments or less often use public services like health clinics**—regular doctor visits, diabetes education, vaccines, prenatal care, HIV education, getting medications, care for communicable diseases like tuberculosis, etc.
- **They eat less healthy food if afraid to drive.** Access to grocery stores with produce and healthy food options often requires travel, which may be a deterrent and adversely impact health.
- **People are afraid to use parks, exercise outdoors, and participate in their communities.**

Image Source: Designs by mohit arora, Marie Ringeard, Delwar Hossain, Luis Prado, corpus delicti, ProSymbols, Anton Gajdosik, H Alberto Gongora for The Noun Project (http://thenounproject.com)



POORER CHILD HEALTH

Children of undocumented immigrants will continue to suffer from mental health issues, symptoms of post-traumatic stress disorder, lower use of health care than children of documented immigrants and reduced household income. An estimated 43,000 U.S. citizen children will experience a decline in their health status after the change in household income associated with the absence of a primary earner.

POORER CHILD EDUCATIONAL OUTCOMES

U.S. citizen children who live in families under threat of detention or deportation will finish fewer years of school and face challenges focusing on their studies.

POORER CHILD BEHAVIORAL OUTCOMES

Children of undocumented immigrants will suffer behavioral problems, such as aggression, anxiety and withdrawal, which can lead to poor school performance and poor development. Approximately 100,000 U.S. citizen children will show signs of withdrawal after a parent's arrest.

POORER ADULT HEALTH AND SHORTER LIFESPAN

Almost 17,000 more undocumented parents of U.S. citizen children will consider themselves in poor health.

Children experience direct impacts, including poorer child health, poorer behavioral outcomes, and poorer educational outcomes.

- Nearly 30% of undocumented parents in the report said their **US-citizen children are afraid**

either all or most of the time. Nearly half said that their child had been anxious, and three-quarters said that a **child has shown symptoms of post-traumatic stress disorder** (see HIP's Family Unity, Family Health report).

- **A recent study found a 24% increase in risk of low birth weight** among infants born to Latina mothers after a major immigration raid, when compared to birth weights before the raid (see Novak et al, 2017).

Image Source: Designs by Star and Anchor Design, Oliviu Stoian, Melonnie Manohar, Stephanei Wauters, TukTuk Design, Gan Khoon Lay, James Keuning for The Noun Project (http://thenounproject.com)

Fear of Deportation Leads to Stress and Trauma

Deportation and the Threat of Deportation:

LEAD TO MENTAL HEALTH ISSUES AMONG KIDS - Nearly 30% of undocumented parents in the report said their **US-citizen children are afraid either all or most of the time**. Nearly half said that their child had been anxious, and three-quarters said that a child has shown **symptoms of post-traumatic stress disorder**.

LEAD TO POOR BIRTH OUTCOMES - A recent study found a **24% increase in risk of low birth weight among infants born to Latina mothers after a major immigration raid**, when compared to birth weights before the raid (see [illegible]).

#PublicHealthAwakened 11

- **Children experience direct impacts, including poorer child health, poorer behavioral outcomes, and poorer educational outcomes**.
    - Nearly 30% of undocumented parents in the report said their **US-citizen children are afraid either all or most of the time.** Nearly half said that their child had been anxious, and three-quarters said that a **child has shown symptoms of post-traumatic stress disorder** (see HIP's [illegible] report).
    - **A recent study found a 24% increase in risk of low birth weight** among infants born to Latina mothers after a major immigration raid, when compared to birth weights before the raid (see [illegible]).

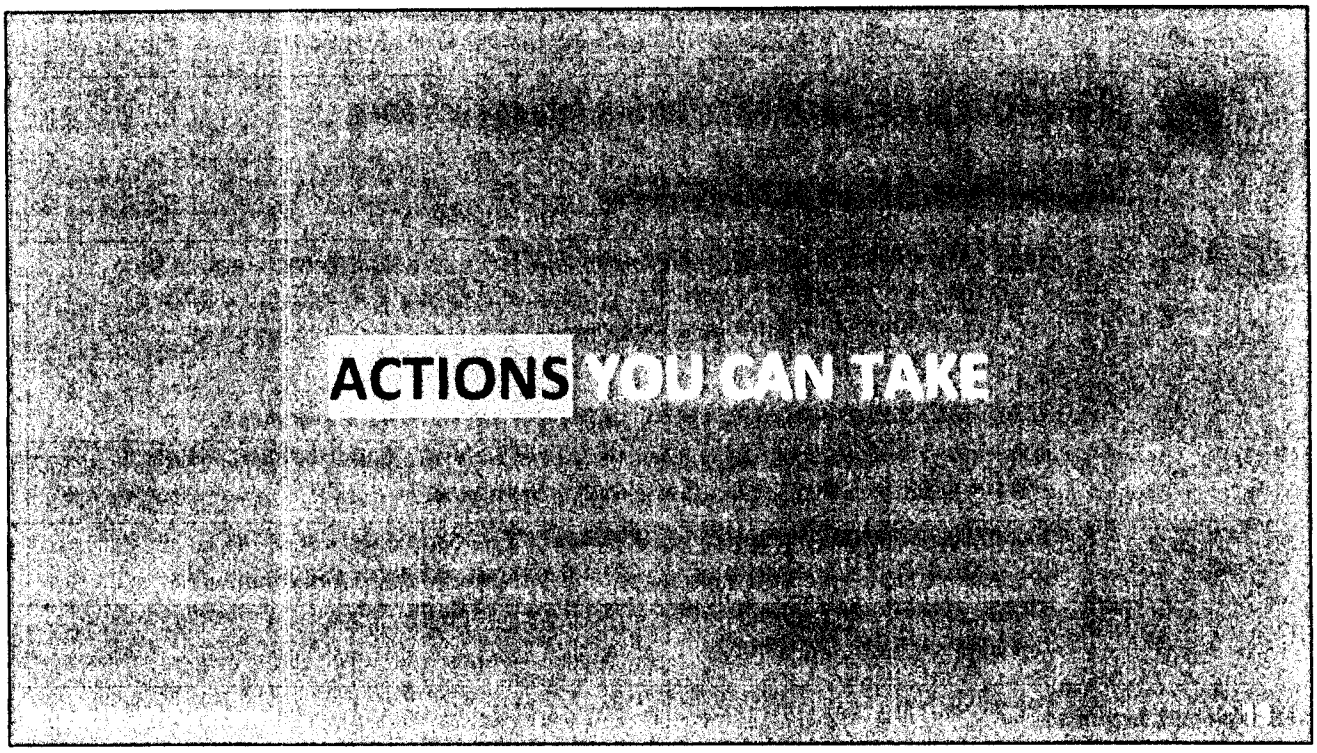
Fear of Deportation Makes Communities Less Safe

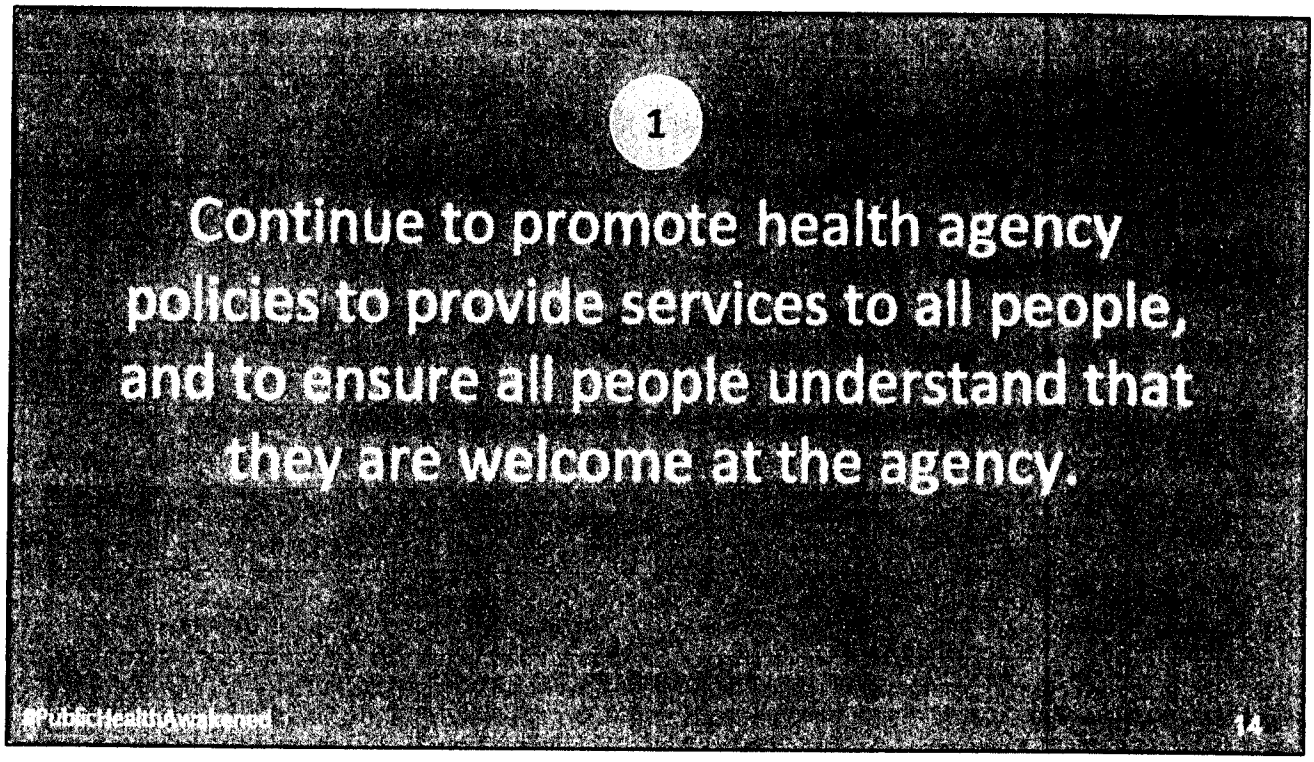
Deportation and the Threat of Deportation:

- **MAKE LAW ENFORCEMENT MORE DIFFICULT** - People who witness/are victims of a crime are less likely to report the crime or cooperate as witnesses if they fear deportation or questions about immigration status for themselves or someone they know.
- **MAKE VICTIMS OF VIOLENCE LESS LIKELY TO GO TO POLICE** - Domestic violence victims often remain with their abuser rather than risk being detained and/or deported when seeking protection from abuse
- **EXACERBATE MENTAL ILLNESS & INSTABILITY** - Documented and undocumented immigrants experience **exacerbated health conditions like stress, anxiety, and hopelessness** due to fears of deportation for themselves or members of their community.

#PublicHealthAwakened 12

- **It also makes law enforcement more difficult** (see Major Cities Chiefs Police Association's 2013 position statement and a Police Foundation 2009 report). People who witness or are victims of a crime are less likely to report the crime or cooperate as witnesses if they fear deportation or questions about immigration status for themselves or someone they know when going to police.
  - One survey found this lower likelihood to contact police among both undocumented (70%) and US-born Latinos (28%) (see [illegible] 2013 report).
- **Threat of deportation makes victims of domestic violence and gender-based violence less safe.** Domestic violence victims often remain with their abuser rather than risk being detained and/or deported when seeking protection from abuse (see [illegible] and [illegible]).
- Documented and undocumented immigrants experience **exacerbated health conditions like stress, anxiety, and hopelessness** due to fears of deportation for themselves or members of their community (see [illegible]).


ACTIONS YOU CAN TAKE


1
Continue to promote health agency policies to provide services to all people, and to ensure all people understand that they are welcome at the agency.
#PublicHealthAdvanced
14

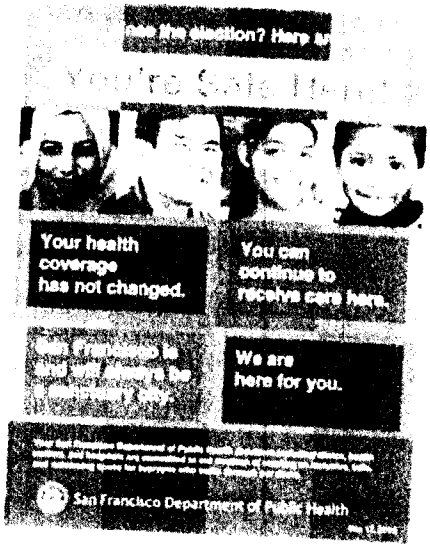
BACKGROUND:

Health Agencies Serve All People

- Primary resource to support health of immigrants regardless of status
- Directly provide key health services / direct clients to relevant providers
- Political uncertainty may exacerbate barriers to access

What Health Agencies Can Do

- Research your agency's resolutions and protections for legal accuracy
- Publicly state agency commitment
- Post signs in multiple languages, that are linguistically sensitive, and avoid alienating vocabulary
- Distribute "know your rights" pamphlets
- Avoid collecting patient data that can be used to identify or deport undocumented people



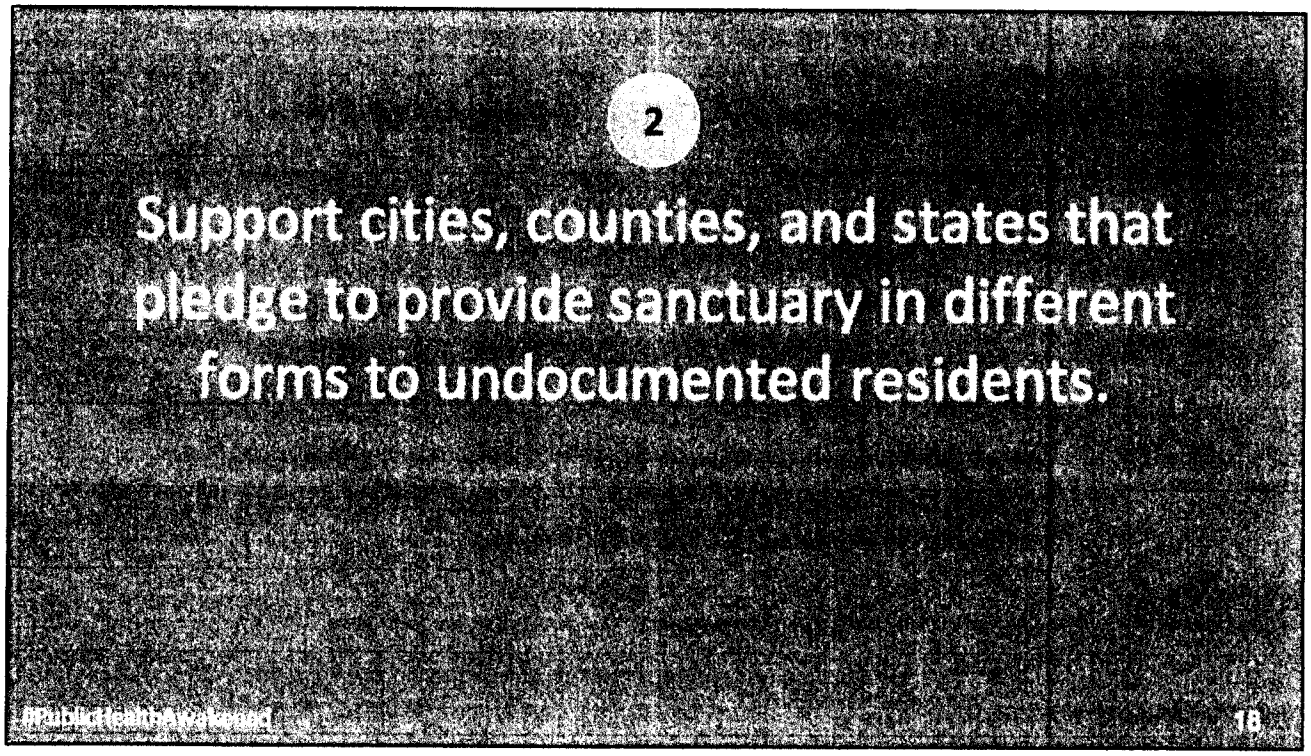
#PublicHealthAwakened

16

Image Source: We_are_here_for_you.pdf
(https://www.sfdph.org/dph/files/electronic/We_are_here_for_you.pdf)

What Health Agencies Can Do

- Track/study # of un-enrollments to encourage undocumented people to continue seeking health agency support
- Train staff in proper response to U.S. Immigration and Customs Enforcement (ICE) action
- Work with other health agencies to promote regional efforts and efficiently utilize resources
- Ensure availability of trained interpreters
- Ensure affordability of healthcare services & advocate for continued funding
- Communicate with & share these strategies broadly with other service agencies and decision makers


2
Support cities, counties, and states that pledge to provide sanctuary in different forms to undocumented residents.
#PublicHealthAwakening
18

BACKGROUND:

Primer on "Sanctuary" Cities, Counties, or States

There is no legal obligation—for a city, county, or state—to assist with federal civil immigration enforcement

There is no single definition of a sanctuary city, county, or state

It is important to understand the details of the policies your jurisdiction has in place before communicating these details publicly

When drafting a "sanctuary" policy, the most defensible approach is to state that jurisdictional "time/resources will not be used to target residents on the basis of immigration status"

WHAT HEALTH AGENCIES CAN DO:

Advocate for Model Language and Policies

WHERE SANCTUARY POLICIES ALREADY EXIST

- Help implement & continue to support policies.
- Argue for inclusive policies

WHERE SANCTUARY POLICIES DO NOT EXIST

- Advocate for adoption of policies/actions that support health and equity

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20

WHAT HEALTH AGENCIES CAN DO:

Advocate for Model Language and Policies

Model language tips and examples:

Incorporate health rationale/citation at beginning of policy document to highlight connections between health & deportations

Ensure that language does not have loopholes or carve-outs for specific categories of immigrants (i.e., based on criminal record, immigration status, etc.)

Oak Park, IL "Welcoming Village Ordinance"

County of Santa Clara, CA "2011 Ordinance"

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21

NOTE: When in presentation mode, click on boxes to take you to sample language.

WHAT HEALTH AGENCIES CAN DO:

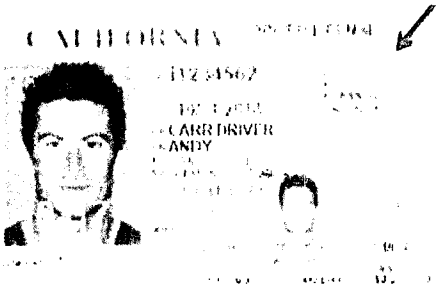
Advocate for Model Language and Policies

When determining if policies HELP or HARM, look for:

- Local law enforcement should:
  - NOT HOLD, DETAIN OR INFORM ON undocumented people for ICE
  - REQUIRE ICE to have warrant / ENACT PROTECTIONS for undocumented persons to refuse ICE interrogation
  - Be PROHIBITED FROM ASKING a person's birthplace or immigration status
- Local jurisdictions should PROHIBIT USE of local resources in complying with ICE requests

WHAT HEALTH AGENCIES CAN DO:

Advocate for Model Language and Policies



Additionally advocate for:

- Local ID cards to allow undocumented people to access government or other services
- The City of Seattle's 7 points of protection
- Laws that prohibit criminalizing daily activities (e.g. driver's license)
- Create offices that work to protect ALL immigrant residents of a county (e.g. Los Angeles County's Office of Immigrant Affairs)

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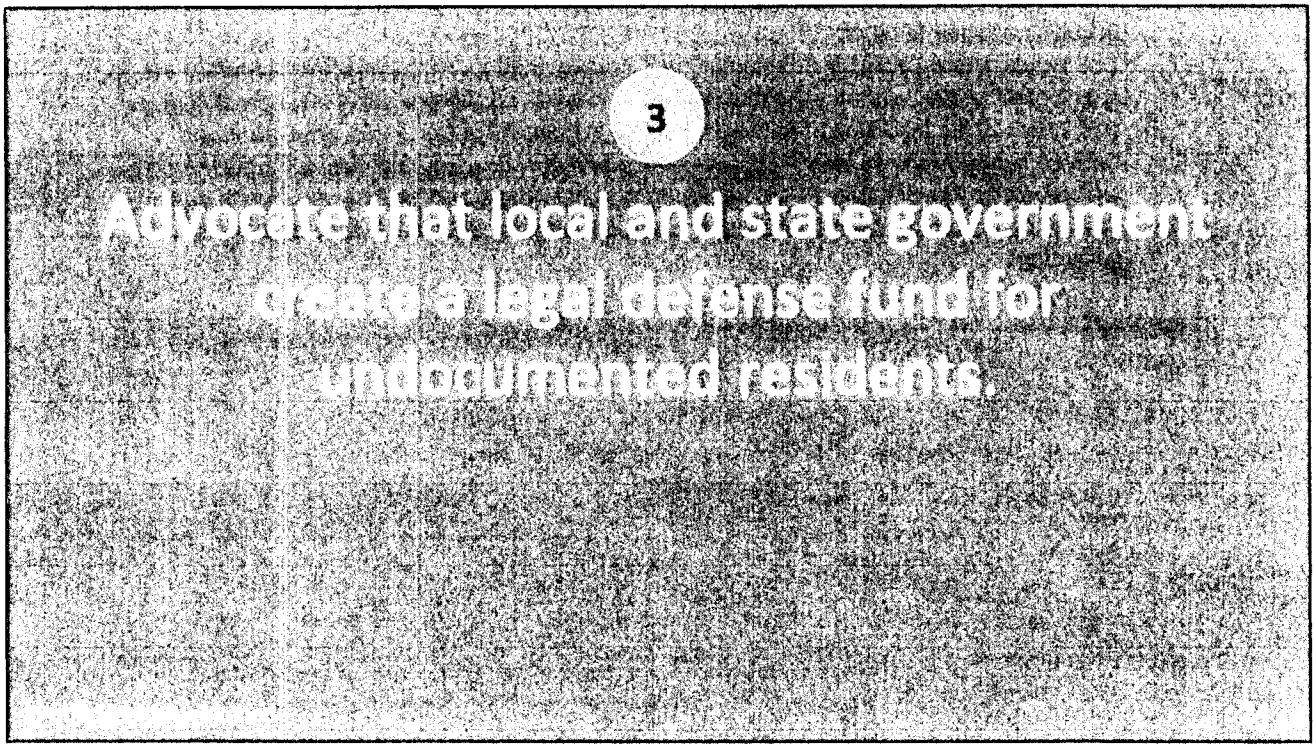
The City of Seattle's 7 points of protection

1. City employees will not ask residents seeking City services about immigration status, unless police officers have a reasonable suspicion that a person is committing or has committed a felony criminal-law violation.
2. City employees will serve all residents and services will remain accessible to all residents, regardless of immigration status, ancestry, race, ethnicity, national origin, color, age, sex, sexual orientation, gender variance, marital status, physical or mental disability, or religion.
3. Seattle Police officers will continue to defer detainer requests from the U.S. Department of Homeland Security's Immigration and Customs Enforcement to King County, as jails are in King County's jurisdiction.
4. City departments will issue a letter to all contractors receiving General Fund dollars to clarify and inform about these policies.
5. An Inclusive and Equitable City Cabinet will be created, made up of representatives from:
    a. Seattle Police Department,
    b. Office of Civil Rights,
    c. Office of Immigrant and Refugee Affairs,
    d. Office of Labor Standards,
    e. Department of Neighborhoods,
    f. Office of Economic Development,
    g. Office of Policy and Innovation,
    h. City Budget Office,
    i. Office of Intergovernmental Relations,
    j. Department of Education and Early Learning, and
    k. Seattle Human Services Department
6. The Inclusive and Equitable City Cabinet develop a programmatic investment strategy for $250,000 to directly address the needs of unauthorized immigrant children in Seattle Public

Schools and their families.

7. The Inclusive and Equitable City Cabinet will develop public awareness efforts around hate speech and crimes; review potential implications on City departments of any new initiatives and intent of the incoming Presidential administration; collaborate with immigrant and refugee communities to identify areas of need and new or expanded efforts for partnership; and develop a specific agenda and action plan to help the Mayor build a coalition of cities during the upcoming West Coast Mayor's Summit and the U.S. Conference of Mayors gatherings.

Image Source: Know Your Rights: California AB 60 Driver's Licenses (https://www.aclunc.org/our-work/know-your-rights/california-ab-60-drivers-licenses)


3
Advocate that local and state government create a legal defense fund for undocumented residents.

Background

Undocumented immigrants, including young children, are not guaranteed court representation for immigrant-related cases

7-fold better success rate in court with representation

Cities and counties pledging money for legal services (funds) to people facing deportation.

Los Angeles: $10M (city/county) + $3M (county) + private foundation

Chicago: $1.3M

California AB3 & SB6: Create state program to fund representation + state-funded regional centers to train defenders

What Health Agencies Can Do

Encourage local & state elected officials to fund legal services for undocumented residents, emphasizing health & equity

Identify agencies (public defenders, nonprofit legal clinics) already working on legal defense funds

Seek knowledge and partnership opportunities

Capacity building of political landscape


4
Connect undocumented clients and their families with legal rights and community organizing groups.
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27

Background

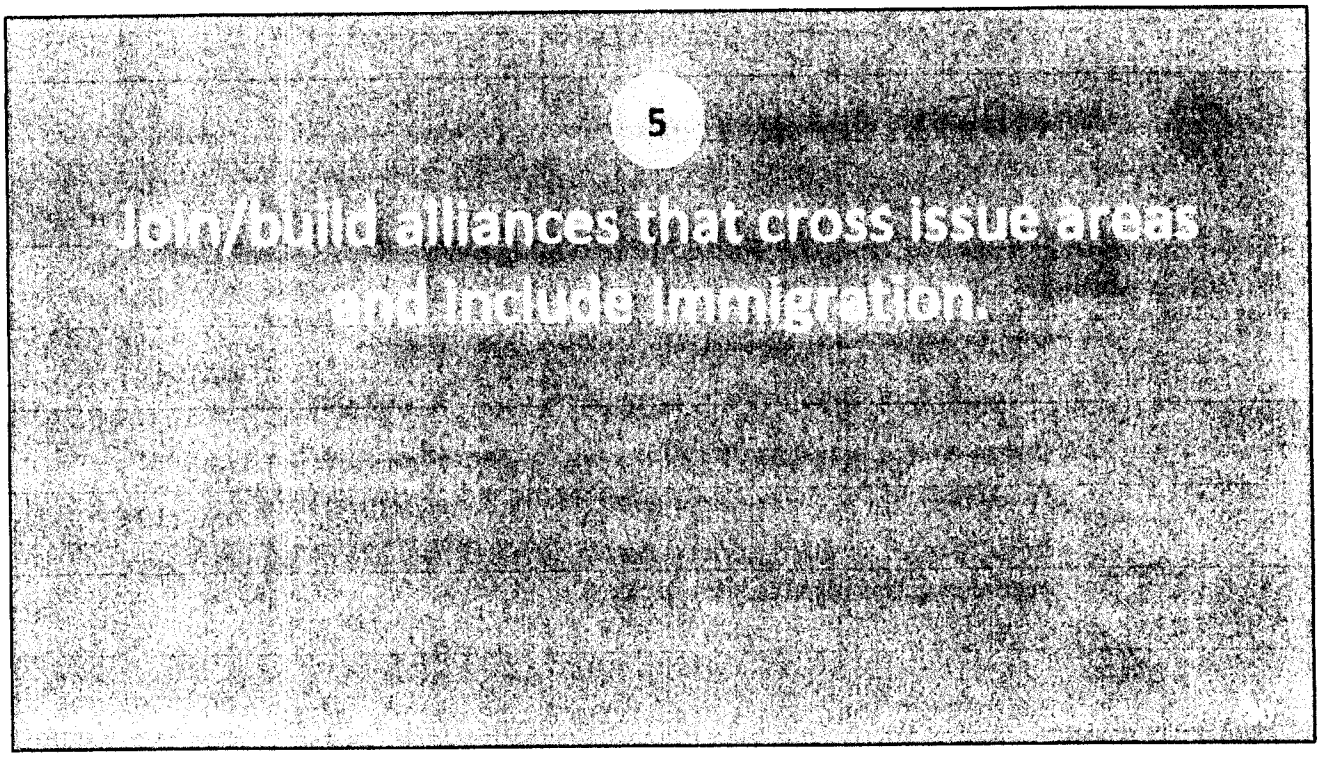
Many community organizing and legal services groups already support undocumented residents/families by:

- **BUILDING THEIR CAPACITY:** Develop leadership skills, reduce isolation/fear, avoid unnecessary contact with police
- **HELPING THEM TAKE ACTION:** By resisting deportations, "underground railroad" sanctuary churches, sanctuary restaurants, organizing for community-based healthcare

What Health Agencies Can Do

HAs can support & partner with community organizing and legal service groups:

- One-on-one meetings to establish new relationships
- Focus on building strategic, long-term, trusting relationships
- Utilize HA expertise as voice for undocumented people/families in ALL stages of policy/program development & decision-making
- Activity refer undocumented clients/families to these community organizing and legal service groups


5
Join/build alliances that cross issue areas and include immigration.

Background

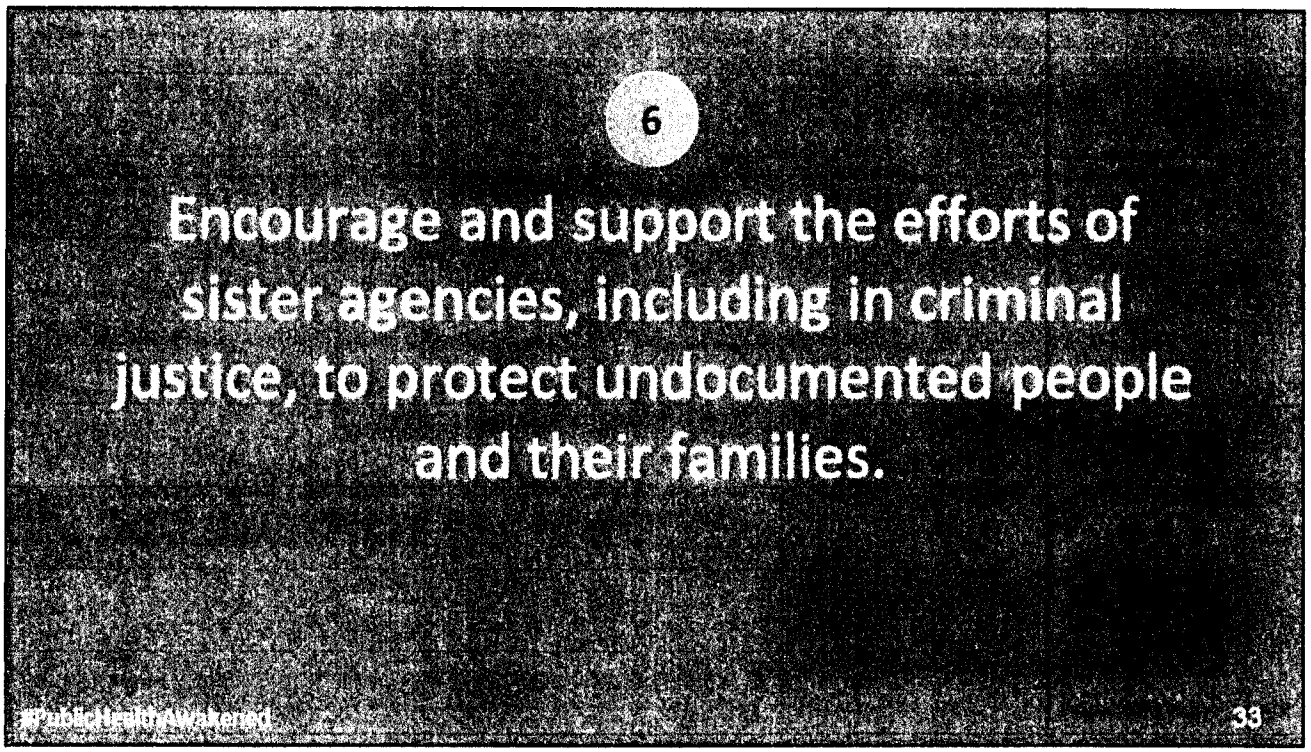
- Other groups beyond undocumented persons are also under attack or feeling threatened
- Focus on building power: integrate, coordinate, and setup strategic infrastructure and networks
- Identify trusted allies and reach out to less well-known groups
- Work with to local community organizing groups/advocates connected to national movements & in a breadth of fields

What Health Agencies Can Do

Identify relevant meetings & conversations where public health is not actively involved, but could contribute

Join alliances to bring the voice of public health to these groups and advocate for undocumented populations

If alliances non-existent, have your HA act as a convener for these groups


6
Encourage and support the efforts of sister agencies, including in criminal justice, to protect undocumented people and their families.
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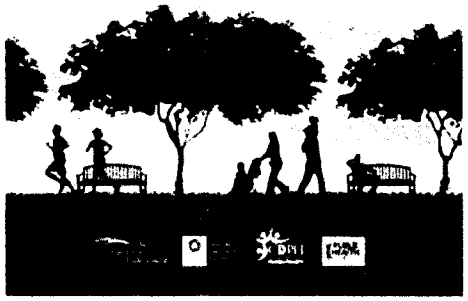
33

Background



Health in All Policies:

- Decisions affecting undocumented persons/families made outside public health
- HAs have or can build relationships with these decision-makers
- Use these relationships as opportunity to improve health & advance health equity

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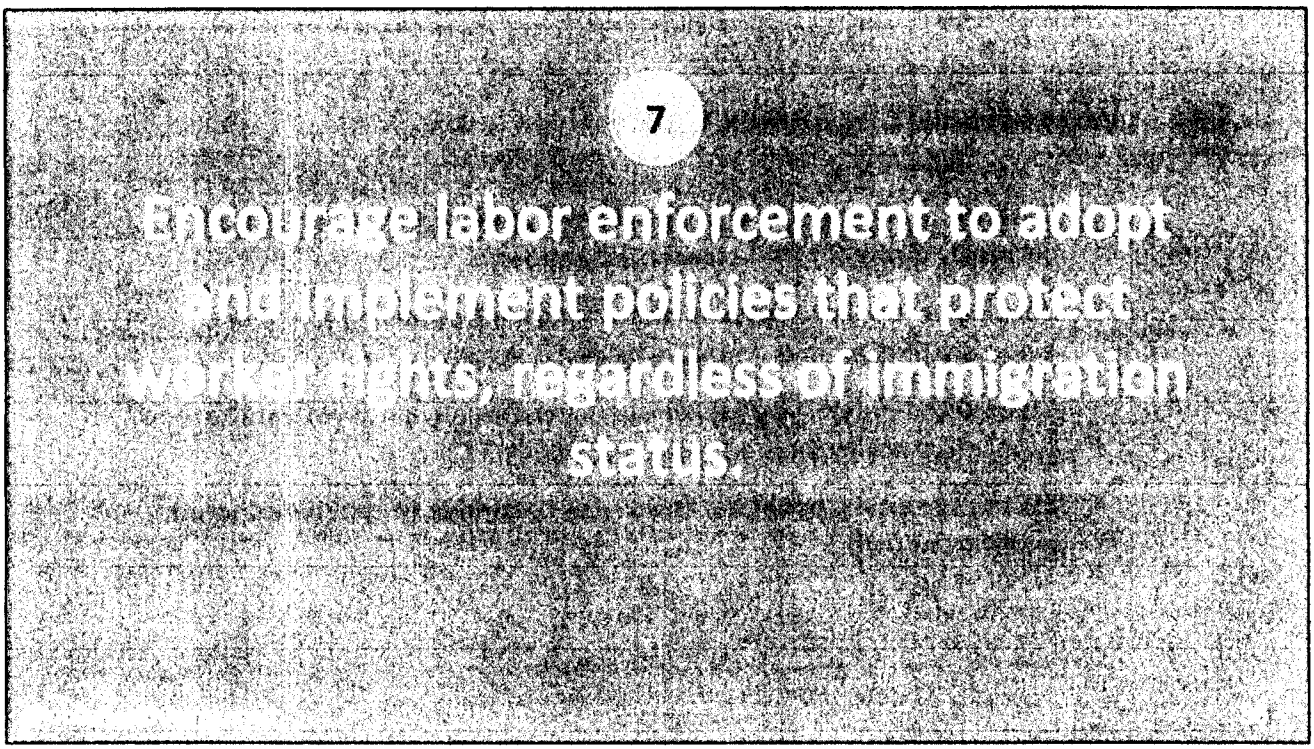
34

Image Source: Health in All Policies: A Guide for State and Local Governments
(http://www.[illegible])

What Health Agencies Can Do

- Determine what sister agencies (sheriff, police, education, etc.) are currently doing for undocumented residents
- Reach out to sister agencies already offering supporting to share evidence that policies improve health & equity
- Meet with leadership at sister agencies that have not yet established supportive policy/procedures - BE STRATEGIC!
- Encourage cities, counties, and states to pledge to provide sanctuary in different forms


7
Encourage labor enforcement to adopt and implement policies that protect workers' rights, regardless of immigration status.

Background

- US has a long history of exploiting workers perceived vulnerable due to immigration status
- Living wage & secure employment in safe conditions foundational determinants of health
- Public health is obligated to advocate pro-worker stance & protect ***all*** workers' rights.

8,000,000
Million undocumented workers

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37

Source: 2016 Pew Research Center (http://www.pewhispanic.org/2016/11/03/size-of-u-s-unauthorized-immigrant-workforce-stable-after-the-great-recession/)
Image Source: Design by anbieru adaleru for The Noun Project (https://thenounproject.com)

What Health Agencies Can Do

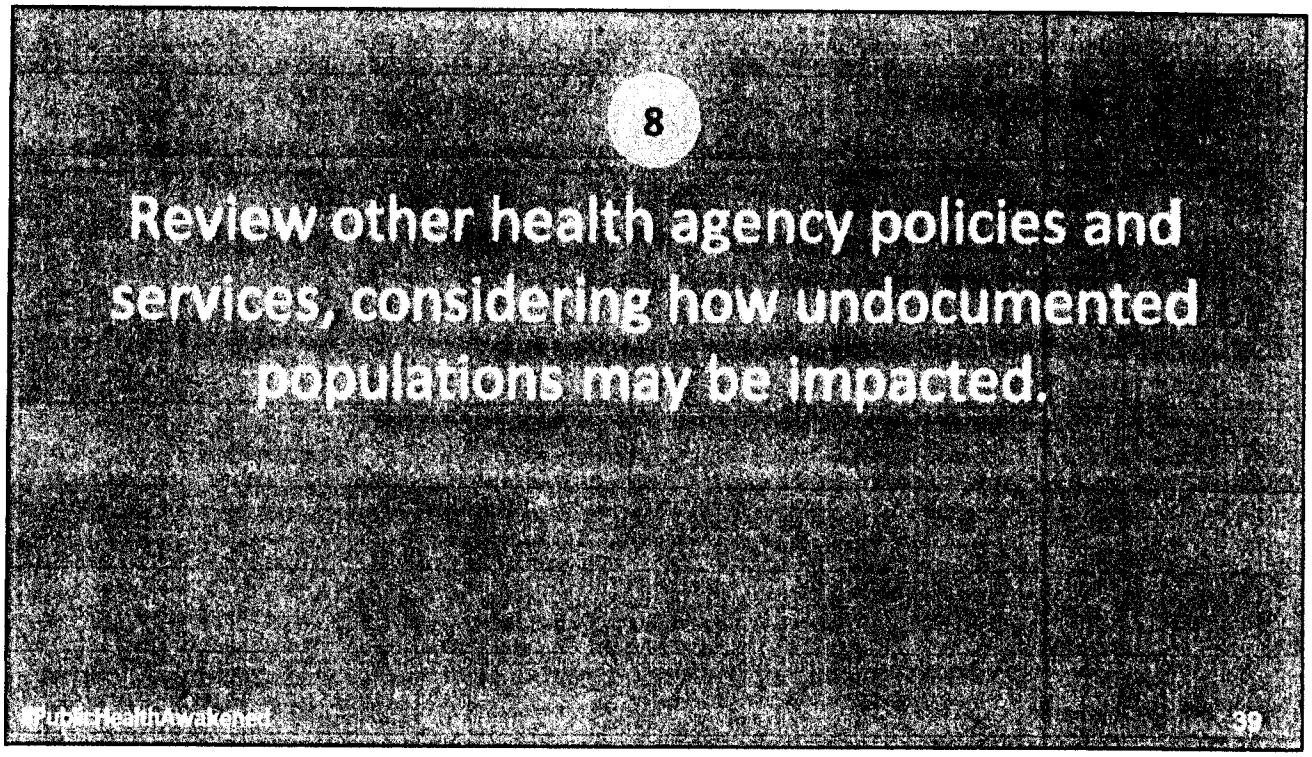
Help undocumented workers understand their employment rights

Educate policymakers on public health impacts of wage theft and the disproportionate vulnerability to it for undocumented immigrants

Support a strengthened firewall against law enforcement agencies

Leverage HA's regulatory authority to support compliance with labor laws

Visit the National Employment Law Project Report for more ideas on public health action.


8
Review other health agency policies and services, considering how undocumented populations may be impacted.
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Background

There are a variety of other policies and practices that affect undocumented populations differently or through which they can be deported. For example, policies related to:

Evacuation in the case of natural disaster

Cooperation with emergency response/ responders

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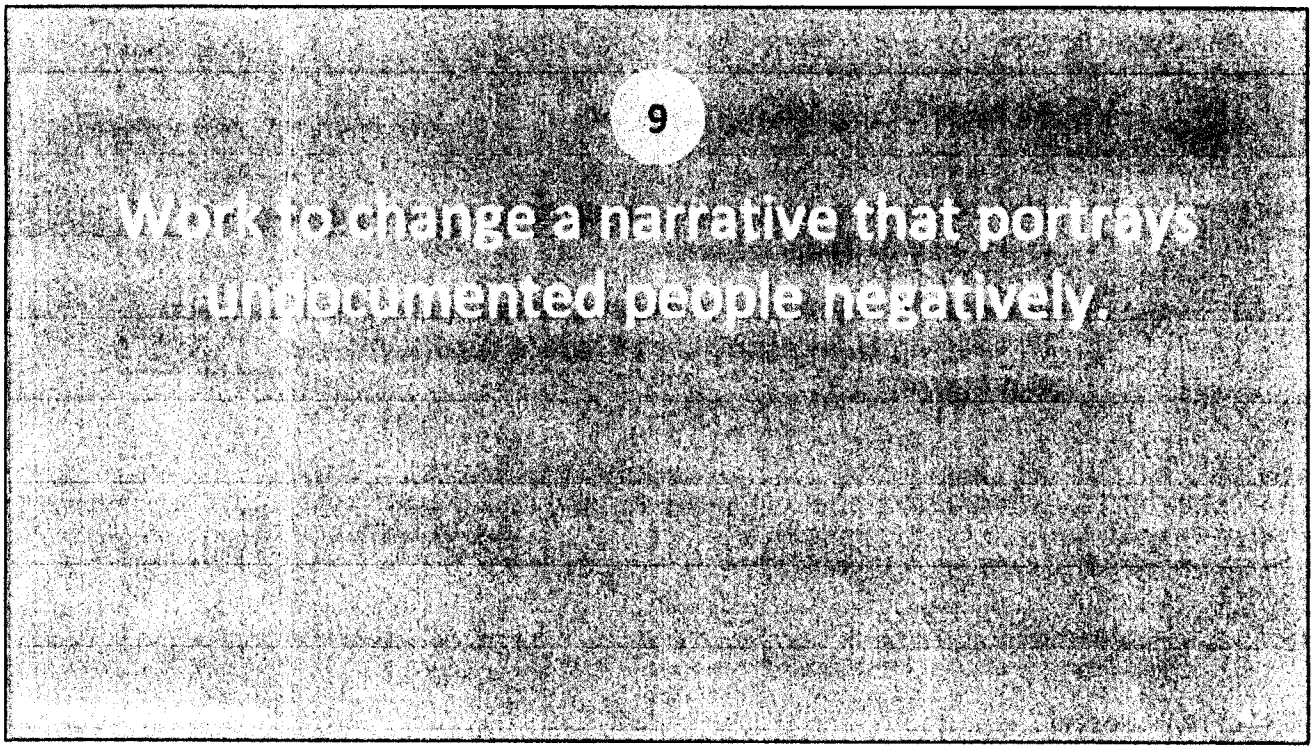
Source: 2016 Pew Research Center (http://www.pewhispanic.org/2015/11/03/size-of-u-s-unauthorized-immigrant-workforce-stable-after-the-great-recession/)

What Health Agencies Can Do

- Review HA policies/practices, considering how they could impact undocumented populations
- Revise policies/practices to mitigate any potential negative impacts on undocumented populations & reduce opportunities for deportation


9
Work to change a narrative that portrays undocumented people negatively.

Background

- Elected officials/media influence public view on all immigrants
- Dominant narrative incredibly harmful
  - Calling undocumented people "illegal"
  - Incorrect claims that undocumented immigrants take jobs from US citizens & are a drain on the economy
  - "Good vs bad" immigrants; deporting "criminals" creates safer communities

Narratives and framing are critical to policy change.

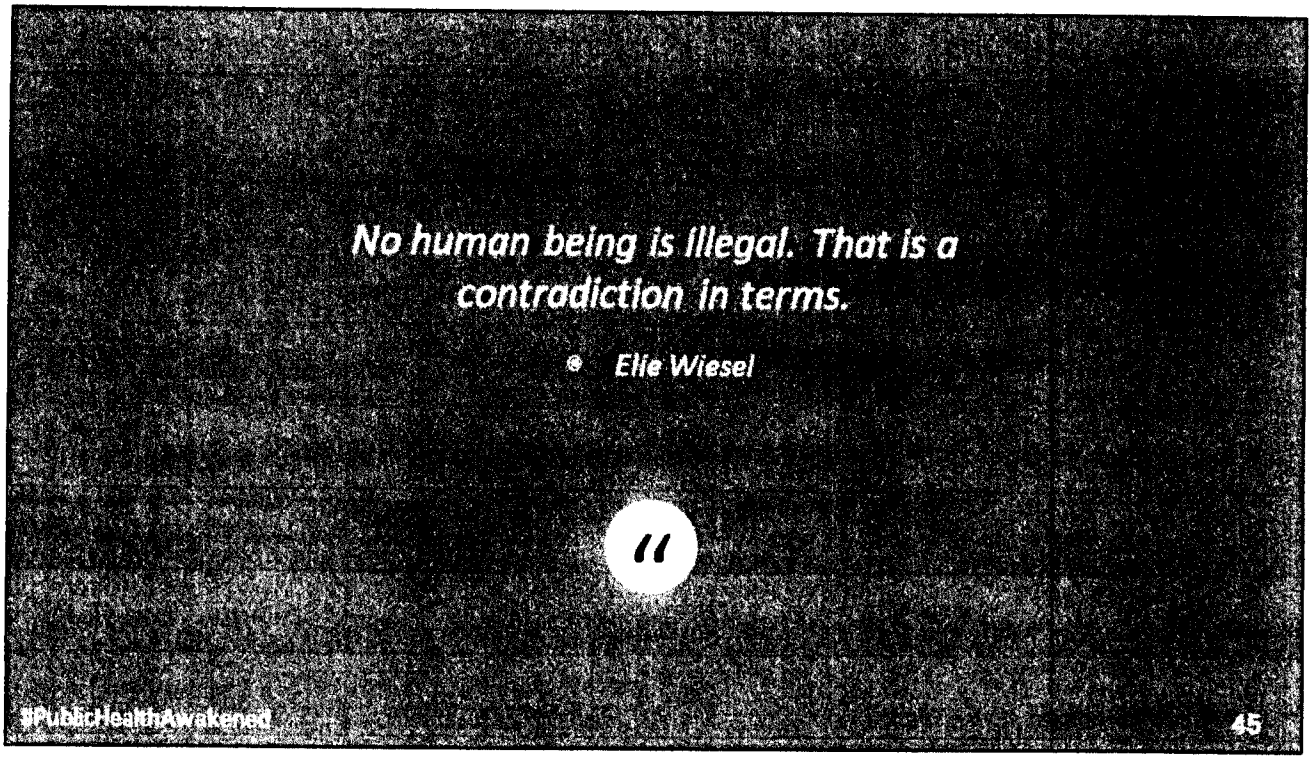
What Health Agencies Can Do

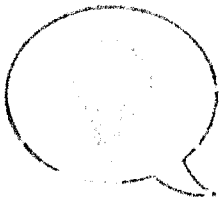
Train HA staff/partners to use language/narrative that supports undocumented populations and their families

Reach out to immigrant-rights groups (especially led by immigrants and/or COGs that work with immigrants) to develop communication strategies & messaging

- Local & contextual experience, ideas that can add to resources from other communications research

Align communications messaging and framing


No human being is illegal. That is a contradiction in terms.
Elie Wiesel
#PublicHealthAwakened
45



Act now!

Any questions ?

You can contact us at ImmigrationGuide@HumanImpact.org

To access the full guide, go to bit.ly/PHAIRguide

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46

NOTE: Links are clickable.

ATTACHMENT #2

COOK COUNTY HEALTH & HOSPITALS SYSTEM

Human Resources Metrics for CCHHS Board Of Directors February 24, 2017

Gladys Lopez, Chief of Human Resources

Human Resources Metrics Summary

DATA THROUGH: 01/31/17

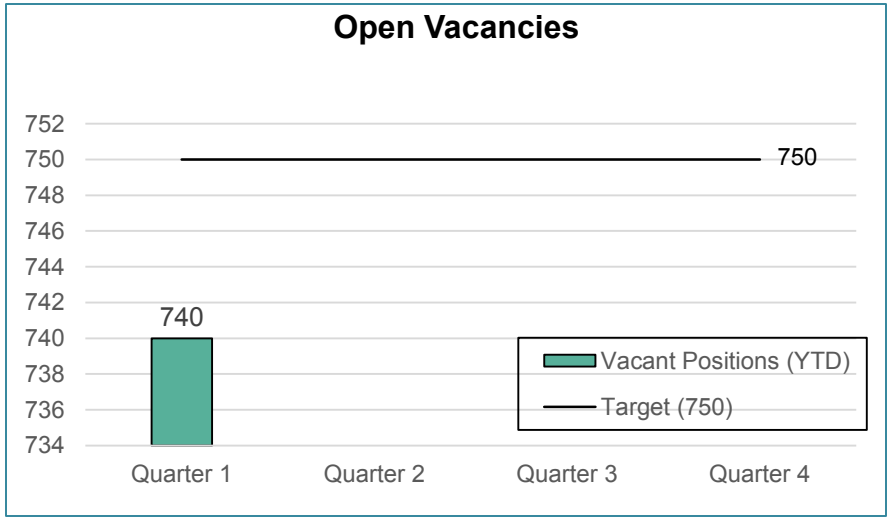
Gladys Lopez, Chief of Human Resources

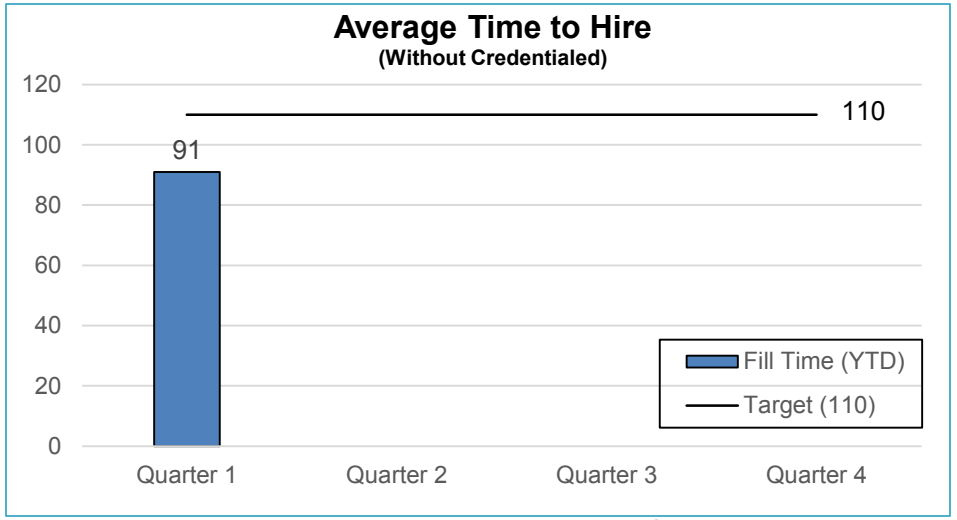
Goal: Continue to maintain open vacancies at 750 or ≤

Fiscal Year 2017
December 1, 2016 - November 30, 2017

OPEN VACANCIES	FY16 TOTAL	FY16 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY16 TOTAL YTD		
Total CCHHS Vacant Positions:	724	750	740				**740**	-10	-1%
Total RTHs in HR (In Process):	**513**		**625**				**625**		

AVERAGE TIME TO HIRE	FY16 TOTAL	FY16 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4			
Average Days to Hire (Month): (With Credentialed)	120	NA	109						
Average Days to Hire (Month): (Without Credentialed)	**108**	**110**	**91**				**91**	-19	-17%





Both FY16 and FY17 data is for the first two months of the first Quarter.

Human Resources Metrics Summary

DATA THROUGH: 01/31/17

Gladys Lopez, Chief of Human Resources

Goal: Continue to maintain open vacancies at 750 or ≤

Fiscal Year 2017

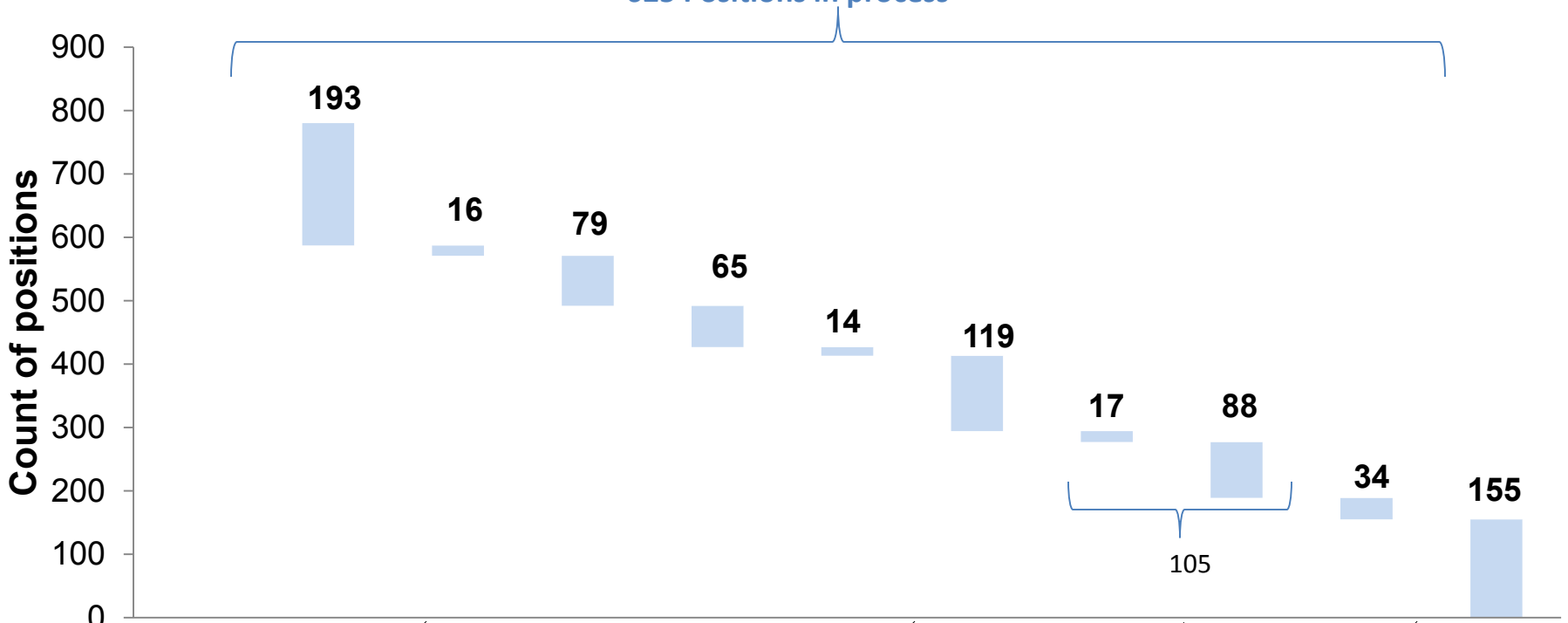
December 1, 2016 - November 30, 2017

VACANCIES FILLED	FY16 TOTAL YTD	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY17 TOTAL YTD
CCHHS External	33	75				75
CCHHS Filled Displacement	0	41				41
Total CCHHS External:	33	116				116
CCHHS Internal	8	39				39
GRAND TOTAL CCHHS:	41	155				155
Nursing External	2	22				22
Nursing Filled Displacement	0	0				0
Total Nursing External	2	22				22
Nursing Internal	1	22				22
GRAND TOTAL NURSING:	3	44				44

Both FY16 and FY17 data is for the first two months of the first Quarter.

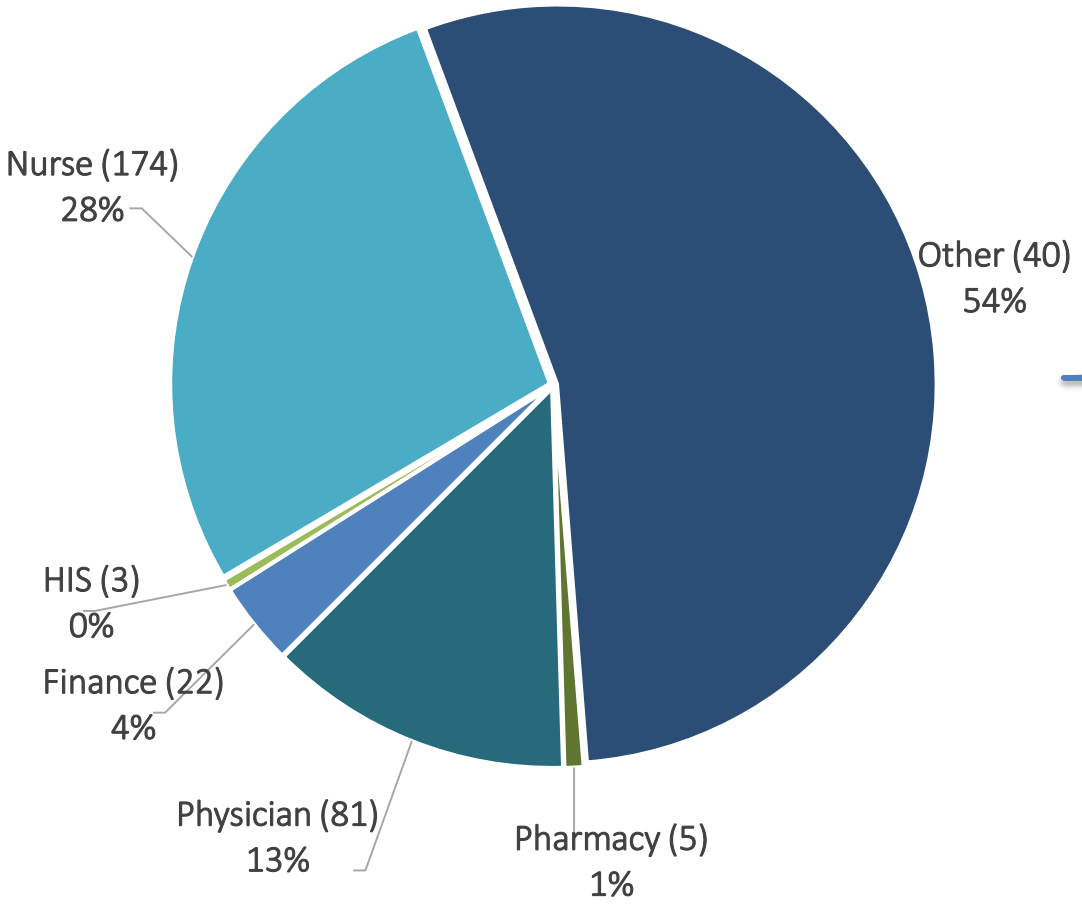
CCHHS Hiring Waterfall & Snapshot (01/30/17)

625 Positions in process



Shared Responsibility	Human Resources	Management	Human Resources	Management Human Resources

Request to Hires in Process - *625
Additional Information of the Positions in "Other"



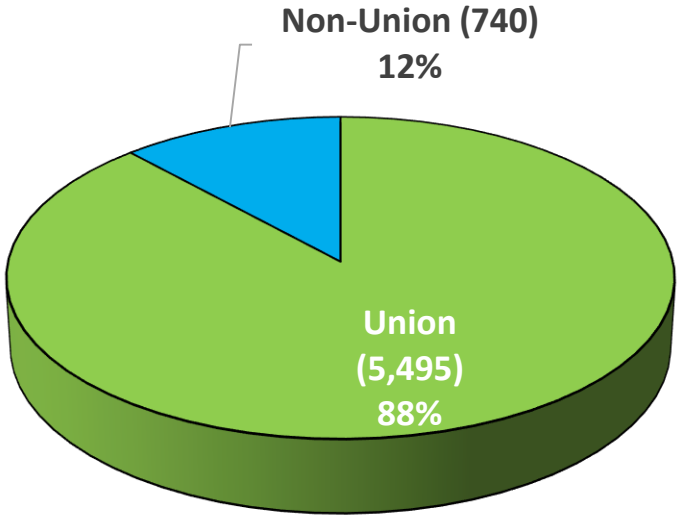
Other Job Classification In Process	RTHs to HR as of 01/27/17	In Process
Community Based Social Work Care Coordinator	13	13
Community Health Worker	13	13
Food Service Worker	13	13
Medical Assistant	39	25
Medical Social Worker III	19	18
Mental Health Specialist III	24	20
Psychiatric Social Worker	14	7
Special Procedures Technician	14	14
Ward Clerk	19	15

*Does not include Consultants, Registry and House Staff

CCHHS Employee Demographics: 6,235*

5,495 Union compared to 740 Non-Union Employees

- CCHHS has
  - 12 Unions
    - 3 largest: SEIU, NNOC & AFSCME
  - 26 Collective Bargaining Agreements
  - 88% unionized workforce



- ***Public-sector workers throughout the US have a union membership rate (34.4%) almost five times higher than that of private-sector workers (6.4%).***
- ***Public-sector workers includes: local, state and federal workers***
- ***Industries typically represented by unions: education, hospitality, protective services, public safety, transportation, etc.***

*Data is as of 01/31/17

ATTACHMENT #3

CountyCare Program Update & Metrics

Prepared for: CCHHS Board of Directors, February 2017 Meeting

February 24, 2017

Steven Glass, Executive Director, Managed Care

CountyCare HEALTH PLAN

Quality, Risk Management & Utilization

Key Measures	Oct'16	Nov'16	Dec'16	Jan'17	% Change to Month Prior	Trend	FYTD'17 Budget or Goal	% of Budget/ Goal
1) QUALITY - HY'17 P4P Measures								
1.1) Ambulatory Access Outcome Measure								
Adult Access to Prevention: Total CC (AAP)	70.8%	72.1%	74.5%		3.3%	▲	90%	82.8%
2) RISK MANAGEMENT								
2.1) Completed HRS/HRA (all populations, cum)								
Overall	57.1%	57.5%	57.0%	67.3%	18.1%	▲	100%	67.3%
MHN ACO	78.8%	78.9%	80.4%	87.7%	9.1%	▲	100%	87.7%
La Rabida Care Coordination (CSNs only)	90.1%	90.4%	90.3%	90.4%	0.1%	--	100%	90.4%
CCHHS CCC	36.2%	39.9%	35.9%	47.4%	32.0%	▲	100%	47.4%
2.3) Completed Care Plans on High Risk Members								
ACA/FHP	65.0%	65.0%	62.3%	62.5%	0.2%	▲	50.0%	125.0%
ICP	75.7%	72.1%	74.4%	75.2%	0.7%	▲	75.0%	100.2%
3) UTILIZATION								
3.1) CountyCare Contribution to CCHHS (Cum FYTD)	$174,066,897	Data Not Yet Available	Data Not Yet Available	Data Not Yet Available			$280,628,489	62.0%
3.2) ER Utilization/1,000 member months (per month)	**Jul'16**	**Aug'16**	**Sept'16**	**Oct'17**	**Change from Prior Month**	**Trend**	**Rolling 12-Mo Average**	**Current to Baseline**
ACA	76.6	81.6	77.6	72.1	-7.1%	▲	66.1	109.1%
FHP	50.2	55.5	57.1	52.9	-7.3%	▲	47.1	112.3%
ICP	99.7	105.4	102.9	99.6	-3.2%	▲	91.4	109.0%
3.4) Total Readmission Rates (same diagnosis within 30 days)								
ACA	15.8	17.6	17.0	10.7	-37.1%	▲	16.0	66.9%
FHP	5.0	5.6	3.8	3.7	-2.6%	▲	5.0	74.0%
ICP	24.5	28.1	25.8	14.2	-45.0%	▲	24.0	59.2%
3.5) BH Readmission Rates (same diagnosis within 30 days)								
ACA	7.6	9.5	8.2	6.1	-25.6%	▲	8.2	74.4%
FHP	0.6	1.3	0.6	0.7	16.7%	▼	0.8	87.5%
ICP	9.2	11.4	12.5	6.7	-46.4%	▲	10.5	63.8%

Membership & Operations

Key Measures	Oct'16	Nov'16	Dec'16	Jan'17	% Change to Month Prior	Trend	FYTD'17 Budget or Goal	% of Budget/ Goal
4) MEMBERSHIP								
4.1) Monthly Membership	147,281	145,946	144,071	142,843	-0.9%	--	142,500	101.1%
ACA	60,587	59,643	58,056	56,686	-2.4%	▼	55,000	105.6%
FHP	81,746	81,330	80,989	81,044	0.1%	--	82,500	98.2%
SPD	4,948	4,973	5,026	5,113	1.7%	▲	5,000	100.5%
Home/Community Waiver (incl DD)	*764*	*701*	*699*	*701*	0.3%			
LTC	*319*	*313*	*303*	*346*	14.2%			
4.2) FYTD Member Months	1,721,152	1,867,098	144,071	286,914			285,000	100.7%
ACA	*739,857*	*799,500*	*58,056*	114,742			110,000	104.3%
FHP	*933,875*	*1,015,205*	*80,989*	162,033			165,000	98.2%
SPD	*47,420*	*52,393*	*5,026*	10,139			10,000	101.4%
4.5) Cook County Enrollment by Health Plan (rank order)							**Rank**	
Aetna Better Health Inc.	110,569	110,858	111,230		0.3%	--	5th	
Blue Cross Blue Shield	210,973	212,141	214,579		1.1%	▲	1st	
CountyCare	**147,042**	**145,463**	**144,032**		**-1.0%**	▼	**3rd**	
Family Health Network (incl CCAI)	190,315	187,561	183,904	Data Not Yet Available	-1.9%	▼	2nd	
Harmony Health Plan	99,581	98,892	98,083		-0.8%	--	7th	
IlliniCare Health Plan	103,570	103,207	102,462		-0.7%	--	6th	
Meridian Health Plan	136,405	135,469	135,475		0.0%	--	4th	
Molina Health Care (FHP/ACA only)	84,594	86,989	81,406		-6.4%	▼	8th	
NextLevel Health	48,537	48,622	56,606		16.4%	▲	9th	
5) OPERATIONS								
5.2) Member & Provider Services Call Center							**Goal**	**Goal Met**
Abandonment Rate	4.79%	3.28%	2.30%	1.31%	-1.0%	▲	< 5%	Y
Hold Time	0:01:01	0:00:33	0:00:26	0:00:13	-0:00:07	▲	< 0:01:00	Y
Average Speed to Answer (member services as of 4/1)								
% Calls Answered < 30 seconds	67.25%	81.83%	87.93%	94.09%	6.1%	▲	> 80%	Y
5.3) Claims/Encounters Acceptance Rate					1.8%	▲	85%	Y

Data Charts

Provided for Informational Purposes Only

Quality Metrics

Provided for Informational Purposes Only

Key Measures	Oct'16	Nov'16	Dec'16	Jan'17	% Change to Month Prior	Trend	FYTD'17 Budget or Goal	% of Budget/ Goal
1) QUALITY - HY'17 P4P Measures								
1.1) Ambulatory Access Outcome Measure								
Adult Access to Prevention: Total CC (AAP)	70.8%	72.1%	74.5%		3.3%	▲	90%	82.8%
1.2) All Other HEDIS Pay-For-Performance Measures								
Breast Cancer Screening (BCS)	61.4%	62.1%	61.0%		-1.8%	▼	70%	87.1%
Cervical Cancer Screening (CCS)	38.2%	39.0%	39.1%		0.3%	--	70%	55.9%
Comprehensive Diabetes Care: HbA1c Testing (CDC)	78.6%	79.5%	79.4%		-0.1%	--	90%	88.2%
Comprehensive Diabetes Care: Nephropathy Testing (CDC)	85.3%	86.2%	86.9%		0.8%	--	85%	102.2%
Comprehensive Diabetes Care: Eye Exam (CDC)	30.7%	34.9%	32.8%		-6.0%	▼	65%	50.5%
Follow-up After Hospitalization for Mental Illness: 30d (FUH)	27.9%	27.0%	26.6%		-1.5%	▼	75%	35.5%
Alcohol & Other Drug Dependence Treatment: Ages 13+ Engagement (IET)	4.5%	4.4%	8.5%		93.2%	▲	45%	18.9%
Alcohol & Other Drug Dependence Treatment: Ages 13+ Initiation (IET)	33.1%	33.2%	35.4%		6.6%	▲	20%	177.0%
Postpartum Care (PPC)	51.7%	49.7%	49.5%		-0.4%	--	70%	70.7%
Timeliness of Prenatal Care (PPC)	66.7%	66.8%	51.7%		-22.6%	▼	90%	57.4%
Weight Assessment & Counseling: Nutrition, Total (WCC)	7.4%	7.4%	7.8%		5.4%	▲	75%	10.4%
Weight Assessment & Counseling: Phys Activity, Total (WCC)	1.2%	1.2%	1.4%		16.7%	▲		
Well-Child Visits in the First 15 Months of Life: 6 Visits (W15)	23.1%	23.3%	16.0%		-31.3%	▼	70%	22.9%
Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)	48.1%	49.3%	48.7%		-1.2%	▼	70%	69.6%

Key:	@ or Better Than Goal	Within 5% of Goal	> 5% From Goal

CountyCare HEALTH PLAN

Risk Management & Utilization Metrics

Provided for Informational Purposes Only

Key Measures	Oct'16	Nov'16	Dec'16	Jan'17	% Change to Month Prior	Trend	FYTD'17 Budget or Goal	% of Budget/ Goal
2) RISK MANAGEMENT								
2.1) Completed HRS/HRA (all populations, cum)								
Overall	57.1%	57.5%	57.0%	67.3%	18.1%	▲	100%	67.3%
MHN ACO	78.8%	78.9%	80.4%	87.7%	9.1%	▲	100%	87.7%
La Rabida Care Coordination (CSNs only)	90.1%	90.4%	90.3%	90.4%	0.1%	--	100%	90.4%
CCHHS CCC	36.2%	39.9%	35.9%	47.4%	32.0%	▲	100%	47.4%
2.2) High-Risk Stratification (all populations, cum)								
Overall	4.0%	6.1%	3.9%	3.7%	-5.8%	▼	3.0%	123.7%
MHN ACO	2.5%	4.6%	4.1%	3.8%	-5.7%	▼	3.0%	127.3%
La Rabida Care Coordination (CSNs only)	15.5%	15.5%	15.9%	15.7%	-1.4%	▼	3.0%	522.0%
CCHHS CCC	4.8%	12.0%	4.1%	3.2%	-21.2%	▼	3.0%	106.3%
2.3) Completed Care Plans on High Risk Members								
ACA/FHP	65.0%	65.0%	62.3%	62.5%	0.2%	▲	50.0%	125.0%
ICP	75.7%	72.1%	74.4%	75.2%	0.7%	▲	75.0%	100.2%
3) UTILIZATION								
3.1) CountyCare Contribution to CCHHS (Cum FYTD)	$174,066,897	Data Not Yet Available	Data Not Yet Available	Data Not Yet Available			$280,628,489	62.0%
3.2) ER Utilization/1,000 member months (per month)	**Jul'16**	**Aug'16**	**Sept'16**	**Oct'17**	**Change from Prior Month**	**Trend**	**Rolling 12-Mo Average**	**Current to Baseline**
ACA	76.6	81.6	77.6	72.1	-7.1%	▲	66.1	109.1%
FHP	50.2	55.5	57.1	52.9	-7.3%	▲	47.1	112.3%
ICP	99.7	105.4	102.9	99.6	-3.2%	▲	91.4	109.0%
3.3) Inpt Utilization/1,000 member months (per month)								
ACA	16.7	15.5	14.9	13.2	-11.4%	▲	14.5	91.0%
FHP	9.1	9.2	8.8	8.0	-9.8%	▲	8.3	96.5%
ICP	39.5	38.5	41.4	42.4	2.6%	▼	35.8	118.5%
3.4) Total Readmission Rates (same diagnosis within 30 days)								
ACA	15.8	17.6	17.0	10.7	-37.1%	▲	16.0	66.9%
FHP	5.0	5.6	3.8	3.7	-2.6%	▲	5.0	74.0%
ICP	24.5	28.1	25.8	14.2	-45.0%	▲	24.0	59.2%
3.5) BH Readmission Rates (same diagnosis within 30 days)								
ACA	7.6	9.5	8.2	6.1	-25.6%	▲	8.2	74.4%
FHP	0.6	1.3	0.6	0.7	16.7%	▼	0.8	87.5%
ICP	9.2	11.4	12.5	6.7	-46.4%	▲	10.5	63.8%

Key:	@ or Better Than Goal	Within 5% of Goal	> 5% From Goal

Membership Metrics

Provided for Informational Purposes Only

Key Measures	Oct'16	Nov'16	Dec'16	Jan'17	% Change to Month Prior	Trend	FYTD'17 Budget or Goal	% of Budget/ Goal
4) MEMBERSHIP								
4.1) Monthly Membership	147,281	145,946	144,071	142,843	-0.9%	--	142,500	101.1%
ACA	60,587	59,643	58,056	56,686	-2.4%	▼	55,000	105.6%
FHP	81,746	81,330	80,989	81,044	0.1%	--	82,500	98.2%
SPD	4,948	4,973	5,026	5,113	1.7%	▲	5,000	100.5%
Home/Community Waiver (incl DD)	*764*	*701*	*699*	*701*	0.3%			
LTC	*319*	*313*	*303*	*346*	14.2%			
4.2) FYTD Member Months	1,721,152	1,867,098	144,071	286,914			285,000	100.7%
ACA	*739,857*	*799,500*	*58,056*	114,742			110,000	104.3%
FHP	*933,875*	*1,015,205*	*80,989*	162,033			165,000	98.2%
SPD	*47,420*	*52,393*	*5,026*	10,139			10,000	101.4%
4.3) Mbrs by Delegated Care Management Group								
CCHHS (ACHN, LTSS, non-MHN ACO)	75,354	80,351	77,277	76,361	-1.2%	▼		
MHN ACO	70,205	63,559	67,766	67,446	-0.5%	▼		
La Rabida Care Coordination (CSNs only)	1,423	1,379	1,378	1,328	-3.6%	▼		
4.4) Members Lost to Medicaid Cancellation								
# Mbrs Due for Redetermination	3,781	2,967	1,915	1,915	-35.5%	▲		
# Rede Cancellations	2,443	1,855	3,105	1,504	67.4%	▼		
# Coverage Restored	746	924	1,269	916	37.3%	▲		
% Cancelled Due to Lack of Rede	44.9%	31.4%	95.9%	30.7%	205.5%	▼	< 22%	-4.8%
4.5) Cook County Enrollment by Health Plan (rank order)							**Rank**	
Aetna Better Health Inc.	110,569	110,858	111,230		0.3%	--	5th	
Blue Cross Blue Shield	210,973	212,141	214,579		1.1%	▲	1st	
CountyCare	**147,042**	**145,463**	**144,032**		**-1.0%**	▼	**3rd**	
Family Health Network (incl CCAI)	190,315	187,561	183,904	Data Not Yet Available	-1.9%	▼	2nd	
Harmony Health Plan	99,581	98,892	98,083		-0.8%	--	7th	
IlliniCare Health Plan	103,570	103,207	102,462		-0.7%	--	6th	
Meridian Health Plan	136,405	135,469	135,475		0.0%	--	4th	
Molina Health Care (FHP/ACA only)	84,594	86,989	81,406		-6.4%	▼	8th	
NextLevel Health	48,537	48,622	56,606		16.4%	▲	9th	

Key:	@ or Better Than Goal	Within 5% of Goal	> 5% From Goal

Operations Metrics

Provided for Informational Purposes Only

Key Measures	Oct'16	Nov'16	Dec'16	Jan'17	% Change to Month Prior	Trend	FYTD'17 Budget or Goal	% of Budget/ Goal
5) OPERATIONS								
5.1) Claims Payment Turnaround Time: % Paid < 30 days (FHP/ACA only)		87.7%	0%		-23.4%	▼	90%	97.4%
5.2) Member & Provider Services Call Center							Goal	Goal Met
Abandonment Rate	4.79%	3.28%	2.30%	1.31%	-1.0%	▲	< 5%	Y
Hold Time	0:01:01	0:00:33	0:00:26	0:00:13	-0:00:07	▲	< 0:01:00	Y
Average Speed to Answer (member services as of 4/1)								
% Calls Answered < 30 seconds	67.25%	81.83%	87.93%	94.09%	6.1%	▲	> 80%	Y
5.3) Claims/Encounters Acceptance Rate					1.8%	▲	85%	Y

Key:	@ or Better Than Goal	Within 5% of Goal	> 5% From Goal

ATTACHMENT #4

Cook County Health & Hospitals System

Board of Directors : November 2016 Financials

Financial Statements

FY 2016 Unaudited Statement of Revs, Exps and Changes in Net Position (in thousands)

Operating Revenue	1,621,111
Operating Expenses	
Salaries & Benefits	643,632
Supplies	117,296
Purchased Services, Rental / Other	196,487
Claims Expense	720,710
Insurance Expense	23,287
Depreciation	26,870
Utilities	11,968
Services provided by other County Offices	31,265
Total Operating Expenses	1,771,515
Operating Margin	(150,404)
Operating Margin %	-9%
Non Operating Revenue	156,559
Net Income/(Loss) Before Pension Exps & Capital Contribution	**6,155**
Transfer - Pension	48,012
Pension Expense *	(235,305)
Capital Contributions	7,399
Change in Net Assets	(173,739)
Net Position at beginning of year	(3,799,217)
Net Position at end of year	**(3,972,956)**

*12 months of Pension Liability per GASB

Balance Sheet as at Nov-16 (in thousands)

	Oct-2016.	Change	Nov-2016.
ASSETS			
CURRENT ASSETS:			
Cash and cash equivalents:			
Total cash & cash equivalent	289,667	80,816	370,483
Total property taxes rec	124,588	7,712	132,300
Total receivables	291,313	-74,059	217,254
Inventories	3,998	0	3,998
TOTAL CURRENT ASSETS	709,566	14,469	724,035
Refundable Deposit	25,000	0	25,000
CAPITAL ASSETS:			
Depreciable assets - net	389,627	-7,011	382,616
TOTAL ASSETS	1,124,193	7,458	1,131,651
Deferred outflows of resources	93,364	0	93,364

Balance Sheet as at Nov-16 (in thousands)

	Oct-2016.	Change	Nov-2016.
LIABILITIES & NET POSITION			
Current Liabilities:			
Total Current Liabilities	**564,812**	**9,935**	**574,747**
Long-term Liabilities			
Compensated absences	36,204	-998	35,206
Self Insurance claims	139,663	1,231	140,894
Reserve-tax objection suits	13,216	0	13,216
Net pension liability	4,390,759	14,376	4,405,135
Total Long-Term Liabilities	**5,144,653**	**-550,202**	**4,594,451**
TOTAL LIABILITIES	**5,709,465**	**-540,267**	**5,169,198**
Deferred inflows of resources	28,774	0	28,774
NET POSITION:			
Investment in capital assets	389,627	-7,011	382,616
Unrestricted -	-4,344,683	(10,891)	(4,355,574)
TOTAL NET POSITION (DEFICIT)	**-3,955,056**	**(17,902)**	**(3,972,958)**

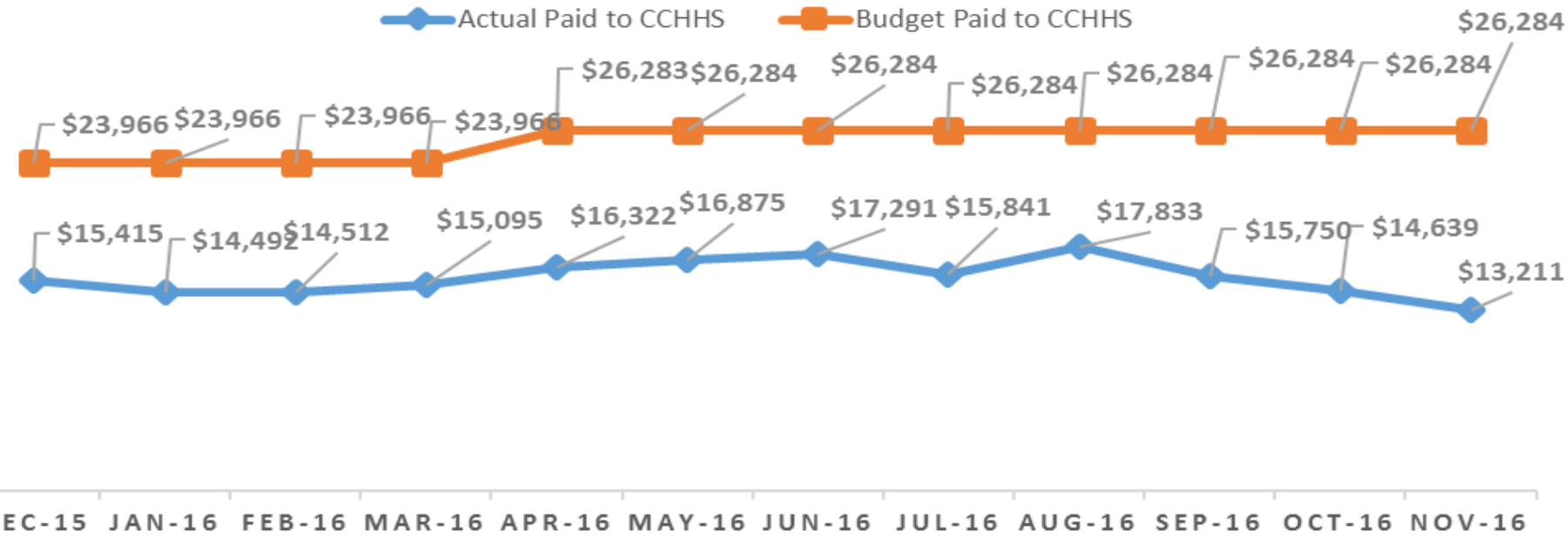
Financials - CountyCare Income Statement November 2016 (in Millions)

	Year to Date Actual	*Year to Date* Budget	*Year to Date* Variance
Member Months	1,726,149	1,963,028	(236,879)
Total Revenue	**909.68**	**933.54**	**(23.86)**
Expense			
Total Admin Expenses	56.63	57.47	0.84
CCHHS Clinical Expenses	187.28	279.86	92.58
External Clinical Expenses	667.71	536.20	(131.51)
Total Clinical Expenses	854.99	816.06	(38.93)
Total Expenses	**911.62**	**873.53**	**(38.09)**
Medical Loss Ratio (MLR)	91%	87%	-4%
Net Income Before IGT	(1.94)	60.01	(61.95)
	0	(60.49)	60.49
Net Income After IGT	(1.94)	(0.48)	(1.46)
IGT			
Total CCHHS Impact	**185.34**	**279.38**	**(94.04)**

Board Finance Dashboard

Key Measures	2014	2015	Oct-16	Nov-16	Change From Prior Month	FYTD'16 Budget or Goal	% to Budget or Goal
Days in Patient Accounts Receivable (Net)*	37	33	52	49.0	-5.8%	49.8	-1.6%
Days Cash on Hand	96	108	62	78	25.8%	60	30.0%
Overtime as %tage of Gross Salary	8.3%	7.3%	7.9%	8.0%	-1.3%	5.0%	60.0%
CCHHS Capture of CountyCare (Cash vs Budget			55.7% ($14.6M)	50.2% ($13.2M)	-5.4% (-$1.4M)	100% ($279.38M)	67% ($187.3M)

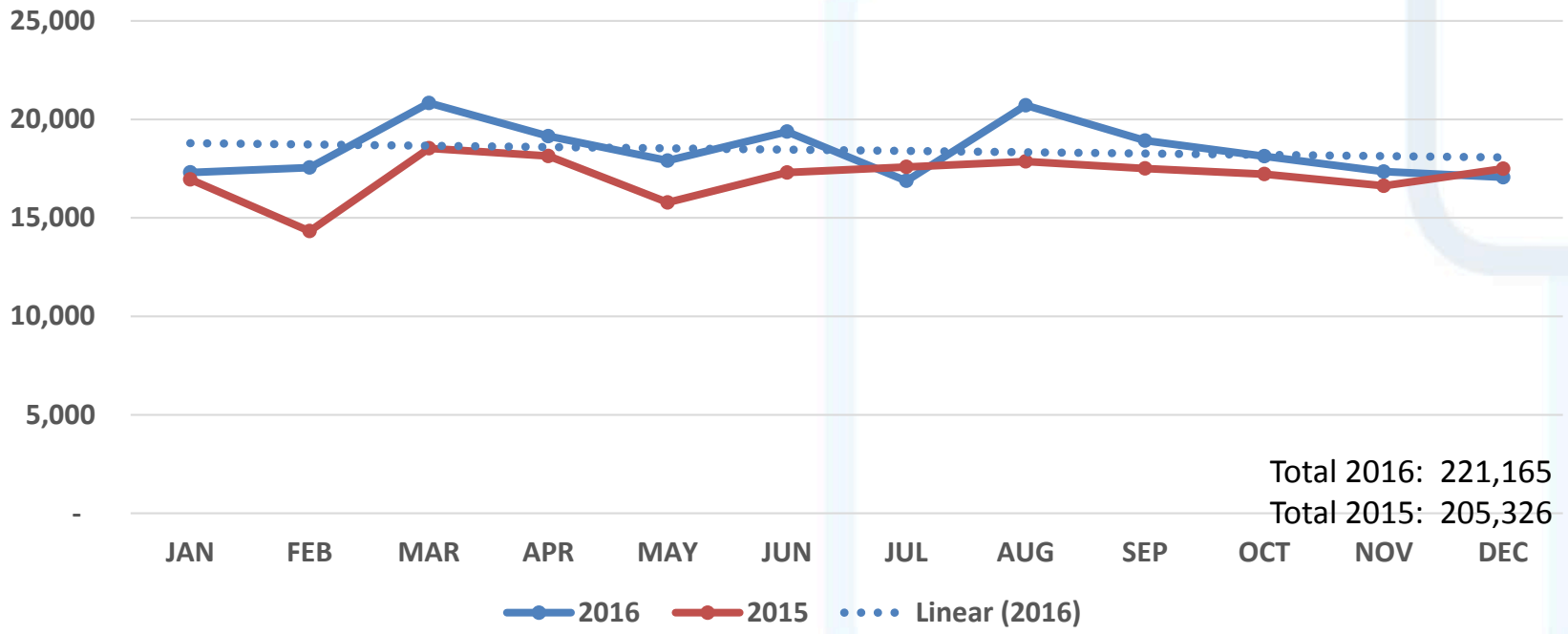
COUNTYCARE NET IMPACT ON CCHHS (IN THOUSANDS)



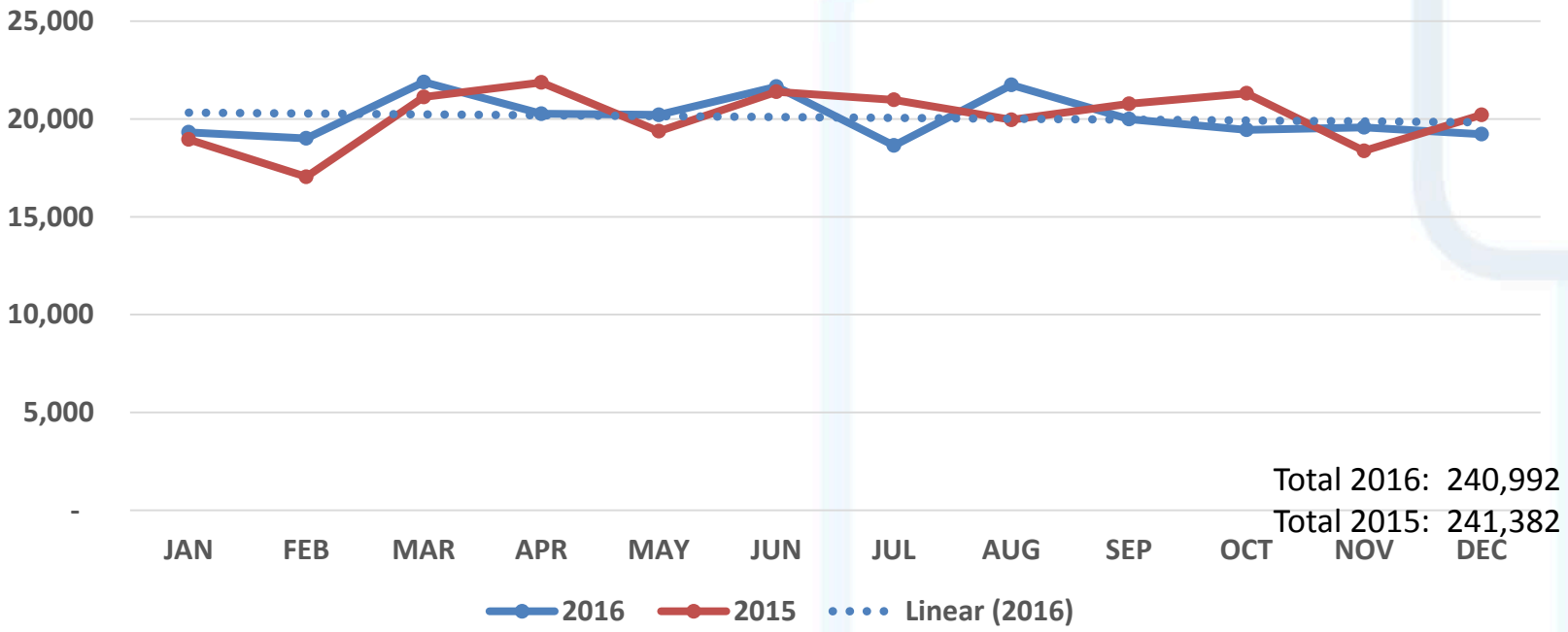
Volumes / Stats

Board of Directors Meeting: February 2017

Primary Care Provider Visits month over month trend

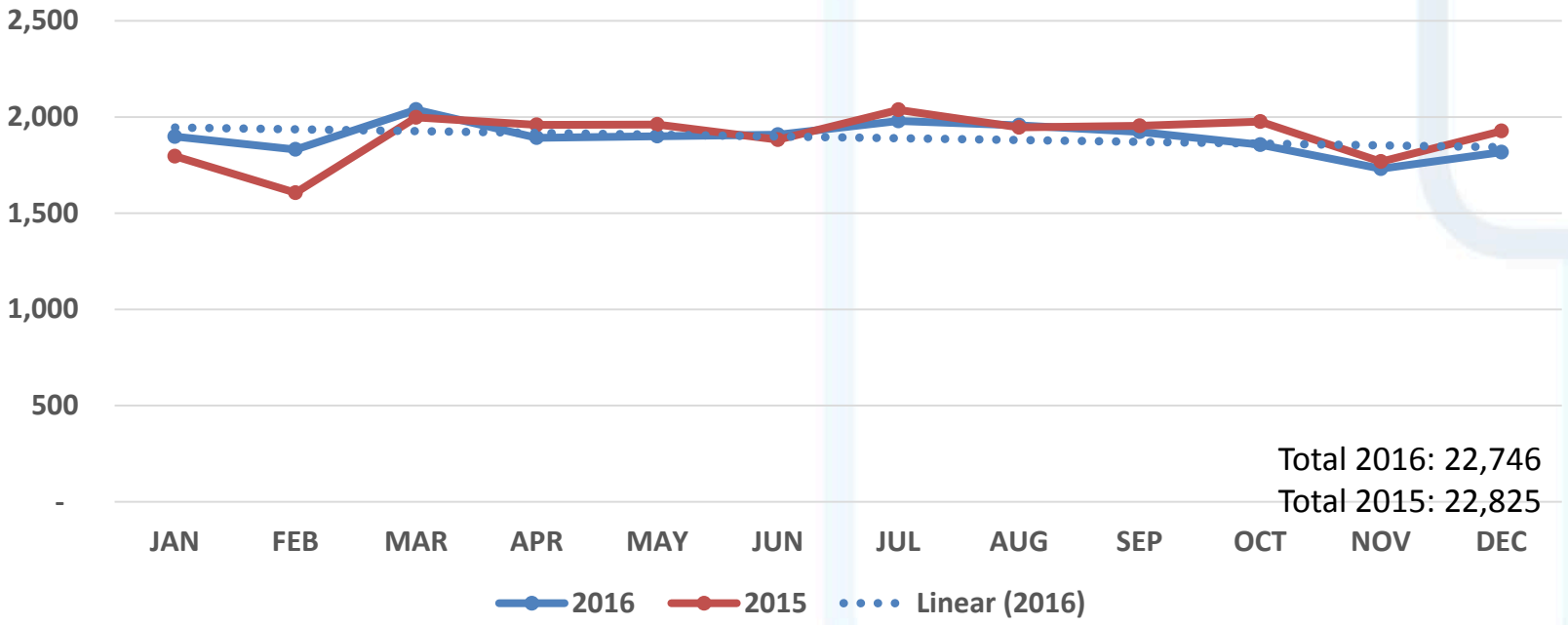


Specialty Care Provider Visits month over month Trend



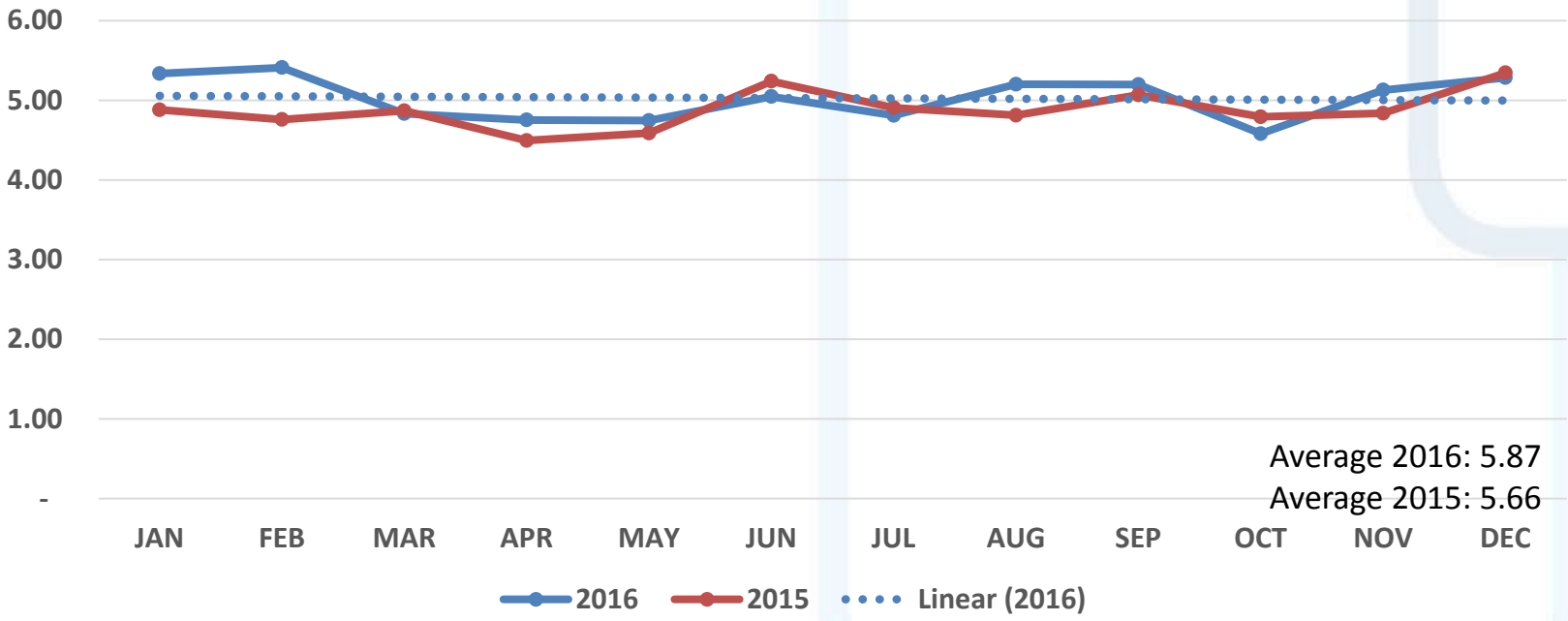
Total 2016: 240,992
Total 2015: 241,382

Total Inpatient Discharges- month over month trend



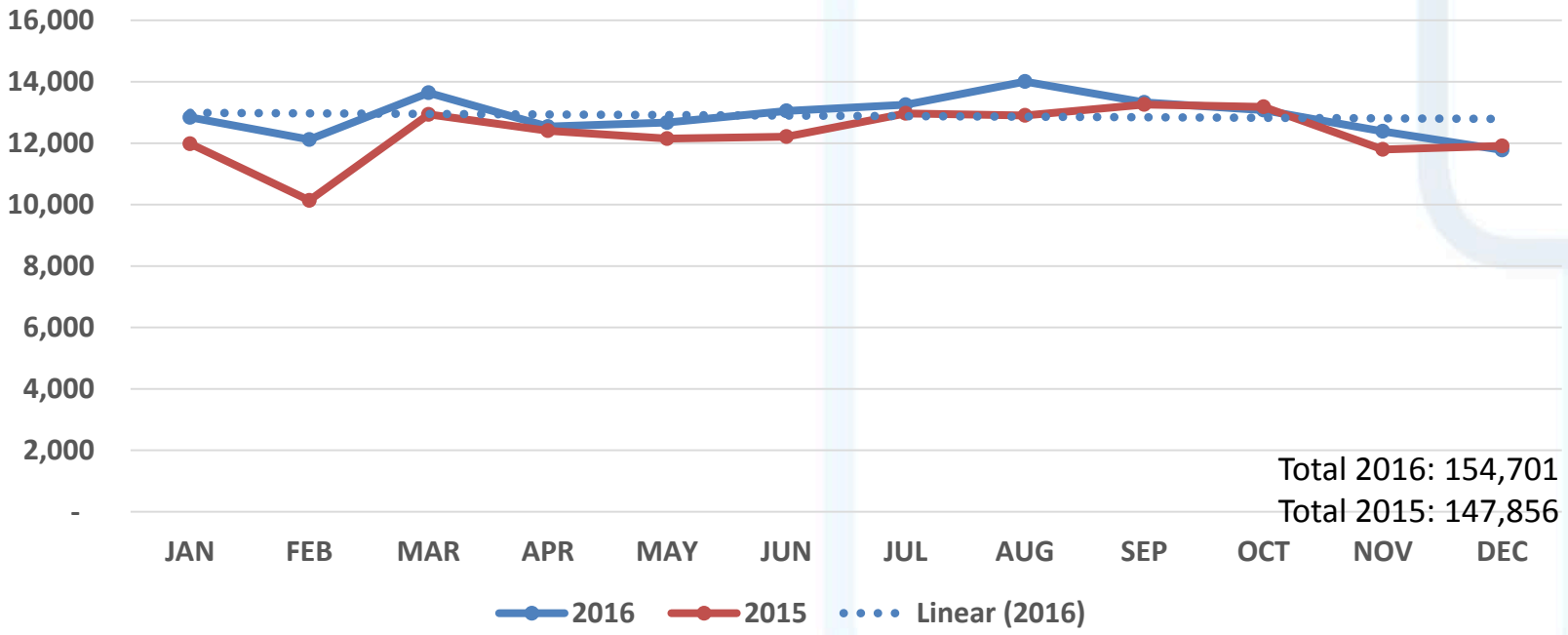
*includes PICU & Nursery

Average LOS-
month over month trend



*includes PICU & Nursery, hourly census

Total Emergency Room Visits - month over month trend



*includes Adult, Peds and Trauma

ATTACHMENT #5

COOK COUNTY HEALTH & HOSPITALS SYSTEM

CCHHS Board of Directors Meeting
Quality and Patient Safety Committee
Dashboard Overview

24 February 2017

Krishna Das, MD, Chief Quality Officer

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

Board Quality Dashboard

CCHHS QPS Committee Dashboard	CCHHS Board Metrics - Quality						
Data as of 2/3/2017							
PERFORMANCE MEASURES	CY 2015	CY 2016				TARGET	VARIANCE*
	4Q15	1Q16	2Q16	3Q16	4Q16		
Stroger							
Core Measures	Monthly Composite						
Venous Thromboembolism (VTE) Prevention Only (%)	88			78 **	83**	99%	-16%
Efficiency - Operating Room	Monthly %						
Surgery Begins at the Scheduled Time (%)	48*	46*	60*	53*	60***	80%	-20%
Safety	Total # of Events						
Events: Ulcers, Falls, CLABSI and CAUTI	30	28	32	24	22		
Patient Experience							
Willing to Recommend Hosp (% top box)	71	70	72	71	74	85%	-11%
Provident							
Core Measures							
Venous Thromboembolism (VTE) Prevention Only (%)	98			94 **	92**	99%	-7%
Efficiency - Operating Room	Monthly %						
Surgery Begins at the Scheduled Time (%)	83	74	78	85	87	80%	7%
Patient Experience							
Willing to Recommend Hosp (% top box)	89	78	N/S*	N/S*	N/S*	85%	-7%
ACHN							
Diabetes Control % with Hgb A1C < 9%	77	74	75	75	78	78%	0%
Patient Experience: Moving Through Visit	63	64	64	63	63	75%	-12%
Patient Experience: Telephone Access	63	62	60	60	59	75%	-16%

LEGEND
* Data represents automated collection
** VTE reported from Qtrly eCQM
***OR Times revised data collection
* Variance is target to recent month
* N/S: Not Sufficient data collected
**N/S: Pneumococcal no longer being measured

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS

ATTACHMENT #6

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

COOK COUNTY HEALTH & HOSPITALS SYSTEM
1900 West Polk Street, Chicago, Illinois 60612
www.cookcountyhhs.org (312) 864-6000

February 14, 2017

John Jay Shannon, MD
Chief Executive Officer
Cook County Health & Hospitals Systems
jjshannon@cookcountyhhs.org
Sent Via Email

Dr. Shannon,

I am bringing forth to you at this, time my recommendation of appoint Dr. Richard Keen, the System Chair of the Department of Surgery, as the Chair of the Department of Surgery at Provident Hospital of Cook County ("Provident").

As outlined in Section 13.06 (A) of the Provident Bylaws, Appointment of Department Chairs, prior to making this recommendation I consulted with the following individuals: Ms. Tanya Seaton, Provident Site Administrator; Dr. Arnold Turner, Provident Medical Director; and Dr. Valerie Hansbrough, President of the Provident Medical Staff. Additional, I consulted with the Provident Medical Executive Committee on February 10, 2017.

Thank you for your consideration of this matter.

APPROVED
FEB 24 2017
BY BOARD OF DIRECTORS OF THE COOK COUNTY HEALTH AND HOSPITALS SYSTEM

Sincerely,

Debra Carey,

Debra D. Carey, SM
Interim Chief Operating Officer, Hospital Based Services
Cook County Health and Hospitals System
Phone Number: 312-864-0719
Email: dcarey2@cookcountyhhs.org

cc: Claudia M. Fegan, CCHHS Executive Medical Director
Valerie Hansbrough, President of the Provident Medical Staff
Gladys Lopez, CCHHS Chief of Human Resources
Jeff McCutchan, CCHHS Interim General Counsel
Charlene Luchsinger, CCHHS Director of Medical Staff Services

ATTACHMENT #7

PROPOSED REVISIONS
TO BYLAWS OF THE JOHN H. STROGER, JR. HOSPITAL OF COOK COUNTY
MEDICAL STAFF (EFFECTIVE JANUARY 14, 2014)
TO COMPLY WITH CMS AND JC STANDARDS

Article XI: Other Medical Staff Committees

SECTION 12. HOSPITAL QUALITY IMPROVEMENT AND PATIENT SAFETY COMMITTEE

a. Composition

The Hospital Quality Improvement and Patient Safety Committee shall consist of the Department Chairs and the President. The members from the administration shall include the Executive Medical Director; the Chief Quality Officer; the Chief Operating Officer of Hospital Based Services; the Chief Operating Officer of Ambulatory Services; the Chief Nursing Officer for the Hospital; the Chief Financial Officer for the Hospital; the Director of Supply Chain Management; the Chief of Clinical Informatics; the System Director of Health Information Management; the System Director of Infection Control; the Director of Patient Experience; and the System Director of Pharmacy.

Ex officio members include the Chief of Clinical Integration, the Chief Business Officer, the Executive Director of Nursing, the Director of Multicultural Affairs, the Chief Financial Officer for the System, the Chief Medical Information Officer, and the Chair of the Quality and Patient Safety Committee of the Board.

There shall be an Ambulatory and Community Health Network Quality Council Subcommittee of the Hospital Quality Improvement and Patient Safety Committee.

b. Officers

The Chair and Vice-Chair of the Hospital Quality Improvement and Patient Safety Committee shall be named by the President.

c. Duties

The Hospital Quality Improvement and Patient Safety Committee shall have the following duties to be performed in the course of internal quality control for the purpose of reducing

morbidity or mortality and improving patient care and patient safety:

(i) oversee and coordinate quality improvement activities throughout the Hospital;

(ii) review fulfillment of the overall responsibility of the Medical Staff for the quality of medical care provided to patients;

(iii) coordinate Hospital and Departmental processes for evaluation of patient care;

(iv) ensure that clinically valid criteria generally acceptable to the clinical staffs are used to assess patient care problems and to measure compliance with achievable goals;

(v) ensure that all contracted medical services achieve the standards of care set by the departments;

(vi) recommend to the Hospital and Medical Staff actions to reduce morbidity and mortality and improve patient care and monitor the implementation of those actions;

(vii) ensure that outside consultants and outside review bodies are used appropriately in the quality evaluation activities;

(viii) receive regular reports from the Hospital Oversight Committee and direct referrals to the Peer Review committee when indicated;

(ix) receive regular reports of departmental quality improvement activities at the Hospital including morbidity and mortality reviews and the reports of the following committees: Blood Bank and Transfusion, Cancer, Critical Care, Operating Room, Surgical Function Review, Medical Information, and the Drug Usage Evaluation Subcommittee of the Drug and Formulary Committee

(x) approve an annual Hospital Quality Assessment and Performance Improvement Plan and forward it to the Executive Medical Staff Committee and then to the Board for approvals;

(xi) report the findings of quality improvement activities throughout the Hospital to the Executive Medical Staff Committee; and

(viii) support the reporting of quality improvement and patient safety activities to the

Quality and Patient Safety Committee of the Board through the President and the Chief Quality Officer.

d. Meetings

The Hospital Quality Improvement and Patient Safety Committee shall meet at least nine (9) times per year, keep a written record of its proceedings, and submit at least quarterly reports to the Executive Medical Staff Committee for the purposes of informing them of the activities of the various committees, reducing morbidity or mortality and improving patient care and patient safety.

e. Ambulatory and Community Health Network ("ACHN") Quality Council Subcommittee of the Hospital Quality Improvement and Patient Safety Committee

(i) Composition

The Chair of the Ambulatory and Community Health Network Quality Council Subcommittee shall be appointed by the Chair of the Hospital Quality Improvement and Patient Safety Committee, with the concurrence of the President and the Chief Operating Officer of Ambulatory Services. The Chair of the Ambulatory and Community Health Network Quality Council Subcommittee shall be a Member of the Medical Staff and the Executive Medical Staff Committee.

The Vice-Chair of the Ambulatory and Community Health Network Quality Council Subcommittee shall be the System Director of Ambulatory Quality.

The Ambulatory and Community Health Network Quality Council Subcommittee shall consist of at least four (4) additional members as follows from any of the following areas: two (2) Members of the Medical Staff; one (1) from Nursing; and one (1) Advanced Practice Provider.

Ex officio members of the Ambulatory and Community Health Network Quality Council Subcommittee include: the Executive Medical Director; the Executive Director of Nursing; the Medical Director; the Chief Operating Officer of Ambulatory Services; the Chief Medical Information Officer; and the Chair of the Hospital Quality Improvement and Patient Safety Committee.

(ii) Duties

The Ambulatory and Community Health Network Quality Council Subcommittee shall have the following duties to be performed in the course of internal quality control for the purpose of reducing morbidity or mortality and improving patient care and patient safety in the Hospital's outpatient clinics:

- oversee and coordinate quality improvement activities throughout the Hospital's outpatient clinics;
- recommend to the Hospital Quality Improvement and Patient Safety Committee actions to reduce morbidity and mortality and improve patient care and monitor the implementation of those actions;
- report the findings of quality improvement activities throughout the Hospital's outpatient clinics to the Hospital Quality Improvement and Patient Safety Committee;
- support the reporting of quality improvement and patient safety activities to the Hospital Quality Improvement and Patient Safety Committee; and
- complete other quality related duties as assigned by the Hospital Quality Improvement and Patient Safety Committee.

(iii) Meetings

The Ambulatory and Community Health Network Quality Council Subcommittee shall meet at least nine (9) times per year, keep a written record of its proceedings and actions, and submit copies of such written records to the Hospital Quality Improvement and Patient Safety Committee. Additionally, the Ambulatory and Community Health Network Quality Council Subcommittee will submit reports to the Hospital Quality Improvement and Patient Safety Committee as requested by the Committee.

PROPOSED REVISIONS
TO BYLAWS OF THE JOHN H. STROGER, JR. HOSPITAL OF COOK COUNTY
MEDICAL STAFF (EFFECTIVE JANUARY 14, 2014)
TO COMPLY WITH CMS AND JC STANDARDS

ARTICLE III: MEDICAL STAFF MEMBERSHIP

SECTION 1. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of the Hospital is a privilege which shall be extended only to professionally competent physicians, dentists and podiatrists who continuously meet the qualifications, standards and requirements set forth in these Bylaws and in the Rules and Regulations promulgated pursuant to these Bylaws.

SECTION 2. QUALIFICATIONS FOR MEMBERSHIP

a. To qualify for membership, physicians, dentists and podiatrists shall be only those physicians, dentists and podiatrists;
   (i) who have a license to practice in the State of Illinois and, when appropriate, authority from the Federal and Illinois governments to prescribe controlled substances;
   (ii) who document their education, training and demonstrated current competence;
   (iii) who participate in continuing medical education activities sufficient to maintain medical, dental or podiatric licensure in the State of Illinois;
   (iv) who adhere to the ethics of their profession;
   (v) who are of good reputation;
   (vi) who are able to work with others in a cooperative and professional manner; and
   (vii) who possess a physical and mental health status sufficient to assure the Medical Staff and the Board that any patient treated by them in the Hospital shall be given medical care of a standard generally accepted by the medical profession.

b. No physician, dentist or podiatrist shall be entitled to membership on the Medical Staff or to exercise any clinical privileges merely by virtue of the fact:
   (i) that he or she is licensed to practice medicine, dentistry or podiatry in this or any other state;

(ii) that he or she is certified in any professional specialty;

(iii) of any previous appointment to this or any other Hospital or clinic;

(iv) of any present appointment to this or any other Hospital or clinic;

(v) of membership in any professional society; or

(vi) of any administrative or contractual agreement.

c. No physician, dentist or podiatrist shall be denied membership on the Medical Staff because of his or her actual or perceived status, practice, or expression of that person's race, color, sex, age, religion, disability, national origin, ancestry, sexual orientation, marital status, parental status, military discharge status, source of income, gender identity or housing status.

No person shall discriminate against any County employee or applicant for County employment because of race, color, sex, age, religion, disability, national origin, ancestry, sexual orientation, marital status, parental status, military discharge status, source of income, housing, or any other protected category established by law, statute or ordinance.

ATTACHMENT #8

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

JOHN JAY SHANNON, MD
CHIEF EXECUTIVE OFFICER
COOK COUNTY HEALTH & HOSPITALS SYSTEM
REPORT TO THE BOARD OF DIRECTORS
February 24, 2017

Employee Recognition

- Seven new graduates have completed Cook County Health & Hospitals System's Leadership Development Program (LDP). This selective program identifies up-and-coming staff members and provides them with training and resources to hone their leadership skills, with an eye toward ensuring excellence in patient care and satisfaction. The new LDP graduates are:

  - **Mamtha Bajjappa**, Nursing Coordinator II, Emergency Department, Stroger Hospital
  - **Priscilla Bennett-Guthrie**, Administrative Analyst III, Emergency Department, Stroger Hospital
  - **Lezah Brown-Ellington, PhD, MSPH, CHMM**, Director of Life Safety, Safety Department, CCHHS
  - **Dawn Dixon**, Call Center Supervisor, System Finance, Oak Forest Health Center
  - **Alex Normington**, Director of Media, CCHHS Administration
  - **Vilas Potdukhe**, Physical Therapy Supervisor, Provident Hospital
  - **Shivon Tannan**, Manager of Referral Services, Managed Care, CCHHS Administration

- For the past year, South Cluster Community Outreach Worker **Xandria Hair** has worked closely with Year Up Chicago on providing healthcare and insurance resources for students who attend this leadership, development educational program. Thanks to the hard work Xandria, the Cook County Health & Hospitals System was named Year Up Chicago's Community Partner Award at its recent graduation. Year Up Chicago guides low income students through a 1-year training program to prepare them for the workforce and school. Because of her and the impact she's had on the students, many of the young people who are a part of Year Up Chicago now have health coverage after she assisted them with applying for Medicaid.

- Congratulations to **Dr. Terry Mason** for being featured as one of The HistoryMakers, which is the nation's largest African-American oral/video history collection. Dr. Mason, Chief Operating Officer at Cook County Department of Public Health, was interviewed by the HistoryMakers about the many contributions he has made in the medical field throughout his 30-plus year career. Dr. Mason's interview can be viewed at Chicago Public Library locations.

- **Dr. Emad Hakemi**, a cardiologist completing his last year of fellowship with CCHHS, was featured by CBS News in two stories about the effect the President's Executive Order banning travel/immigration from seven Muslim-majority countries will have on the American health care system. Dr. Hakemi, a native of Syria, is representative of the tremendous skill and expertise health systems see in international medical graduates. His perspective demonstrated at a national level why it is important to recruit the top physicians, regardless of country of origin, to learn and work in the U.S. Here at CCHHS, our patients and staff represent a myriad of cultures, ethnicities, religions and nations of origin and we are proud to welcome medical professionals of the highest caliber to our system.

- John H. Stroger, Jr. Hospital has been recertified by the Illinois Department of Public Health as a Primary Stroke Center. To receive this designation, a hospital must demonstrate that they meet nationally-recognized standards to support better outcomes for stroke care, including a dedicated stroke-focused program. Congratulations to **Dr. Michael Kelly, Dr. Adaku Uzomba, Dr. Lakshmi Warrior and the rest of the stroke team** for being recognized for the outstanding care provided to stroke patients.

Patient Experience

- CCHHS leadership received a letter from a patient thanking the trauma team at Stroger Hospital for the expert care they provided. This patient especially wanted to show gratitude to **Ernie Purnell**, RN, calling him a "very dedicated and caring asset to John H. Stroger Jr. Hospital's Trauma Unit. Mr. Purnell was very attentive to my needs as well as my pain, doing all he could to ensure I was as comfortable in spite of my injuries. Mr. Purnell is a blessing to your staff as he was a blessing to me."

Activities and Announcements

- On February 24, a **CountyCare Redetermination** event will take place at Stroger Hospital. This is the first "Rede" event in 2017 which seeks to help CountyCare members maintain their Medicaid coverage by helping them submit their re-enrollment materials in a timely manner. About 5,000 CountyCare members with Redetermination expiration dates at the end of February and March received invites to attend this event. In addition, each of these members have received reminder telephone calls from the Financial Assistance Call Center to submit their paperwork to the State of Illinois.

  IMPACT 2020 Objective 2.4

- On March 28, a **CountyCare Enrollee Advisory Committee (EAC)** meeting will take place at the Cottage Grove Health Center in Ford Heights. The EAC meeting provides CountyCare Health Plan members with an opportunity to have an open dialogue with staff on the plan and its benefits. Approximately 1,500 invitations, each containing a survey, were mailed to CountyCare members who live within a 3 mile radius of the meeting location.

  IMPACT 2020 Objective 2.4

- To date, CCHHS' Fresh Truck partnership with the **Greater Chicago Food Depository** has resulted in 32 visits to 9 CCHHS community health centers – Logan Square, Cottage Grove, Robbins, Oak Forest, Englewood, Prieto, the CORE Center, Austin and Cicero. Collectively, the Fresh Truck distributions have resulted in fresh fruits and vegetables provided to 3,604 households which includes 12,629 individuals. Most of the individuals receiving produce screened positive for food insecurity at a CCHHS health center visit.

  Vista Health Center is the next site to be trained and have Fresh Truck visits scheduled. All remaining CCHHS sites will have Fresh Truck visits before the end of 2017.

  IMPACT 2020 Objective 6.3

- The Chicago Police Department recently expanded its internal order allowing police officers to utilize the **Community Triage Center** (CTC) to Districts 4,6, 7, and 22. This increases the Districts to five and substantially increases the reach of the CTC.

  IMPACT 2020 Objective 1.6, 7.1

ACA Protection Efforts

IMPACT 2020 Objective 7.1

- CCHHS continues to engage with our Congressional delegation, state and local elected officials, peer public health systems, healthcare associations and advocacy groups with regard to this changing and dynamic environment.

- February 15, 2017: Dr. Shannon testified at a joint Public Hearing of the Cook County Committee on Workforce, Housing & Community Development and the Chicago City Council Committee on Workforce Development & Audit. The public hearing was convened by Cook County Commissioner Bridget Gainer and city of Chicago Alderman Patrick O'Connor and Alderman Amaya Pawar.

  This purpose of the hearing was to take testimony on proposed changes to the Patient Protection and Affordable Care Act (ACA) and any impact those potential changes will have on the city, county and local hospitals and any other federal legislation that may impact access to quality healthcare in Chicago and Gook County.

  In addition to Dr. Shannon, others who testified at the hearing included Chicago Department of Public Health Commissioner Dr. Julie Morita, Illinois Hospital Association Senior Vice President Patrick Gallagher, Marva Hall representing City Colleges of Chicago as well as a number of healthcare service providers and advocates.

- February 18, 2017: Dr. Shannon spoke at a press conference & rally hosted by Congressman Danny Davis (D-7th CD). The focus of the press conference followed by a brief rally was to talk about the importance of the Patient Protection and Affordable Care Act (ACA) and the benefits to Cook County/CCHHS, Chicago and the residents of the 7th Congressional District.

- February 21, 2017: Dr. Shannon and Cook County Board President Toni Preckwinkle spoke at a press conference & rally hosted by SEIU on the CCHHS Central Campus. The focus of the event was to strongly urge all members of Congress not to repeal the ACA. Media clips from the press conference: CLTV Politics Tonight; CLTV; WTTW; WGN; NBC Chicago; Fox Chicago

- February 23, 2017: Dr. Shannon participated in Round Table hosted by Congressman Krishnamoorthi (D-8th CD). The discussion centered on the Affordable Care Act and the possible impact of repeal. Other participants included representatives of AMITA Health, St. Alexius Medical Center, the DuPage County Health Department, the DuPage Health Coalition VNA Health Care, Ecker Center for Mental Health, Alexian Brothers Medical Center, University of Illinois Hospital Health and Science Center and Health & Disability Advocates.

- February 23, 2017: Dr. Shannon met with Congressman Brad Schneider (D-10th CD). In addition to discussing CCHHS strategic plan, Dr. Shannon discussed the Affordable Care Act and the possible impact of repeal.

- ACA-related media interviews:

  1/25/2017: Affordable Care Act repeal on an urban health system, *PBS NewsHour*, Dr. Jay Shannon, CEO

  2/2/2017: Medicaid expansion and managed care, *NPR Illinois Issues*, Mary Sajdak, Senior Director of Integrated Care

  2/6/2017: Effect of ACA on HIV-positive patients, *Vox News*, Dr. Greg Huhn, CORE Center Attending Physician

2/6/2017: Medicaid expansion impact for victims of gun violence, *Obama Foundation/ StoryCorps,* Andrew Wheeler, Patient and Family Support Services Coordinator, and patient

2/14/2017: ACA repeal and block granting of Medicaid, *Chicago Tribune,* Dr. Jay Shannon, CEO

2/16/2017: Hospital supply chain budgeting amidst ACA/ trade uncertainty, *New York Times*, Dr. Jay Shannon, CEO, and Doug Elwell, Deputy CEO

2/21/2017: ACA repeal and block granting Medicaid, *Fox Chicago*, Dr. Jay Shannon

Upcoming 3/1/2017: The future of the ACA, *Modern Healthcare,* Dr. Jay Shannon, CEO

- Selected media clips, newsletters attached.

Legislative Update

Local

- On February 13, 2017, the Nominating Committee for the Cook County Health & Hospitals System convened to begin the process to provide recommendations for the terms of three CCHHS System Board Directors that expire June 30, 2017. The Nominating Committee is required to provide the Cook County Board President with the names of three potential candidates for each vacancy. The County Board President will then select three candidates from the names submitted to the Cook County Board for their advice and consent.

  Pursuant to Cook County ordinance, the Nominating Committee is comprised of fourteen member organizations, namely the Civic Federation of Chicago, Civic Committee of the Commercial Club of Chicago, Chicago Urban League, Healthcare Financial Management Association, Suburban Primary Healthcare Council, Illinois Public Health Association, Metropolitan Chicago Healthcare Council, Health and Medicine Policy Research Group, Chicago Department of Public Health, Cook County Physicians Association, Chicago Federation of Labor, Chicago Medical Society, Association of Community Safety Net Hospitals and Midwest Latino Health Research Center.

  The Nominating Committee is scheduled to meet next on February 23, 2017.

State

- Illinois is in its 20th month without a comprehensive state budget in place. The state "stopgap" budget that provided 18 months of human service and higher education funding ended December 31, 2016.

- Senate President Cullerton and Senate Minority Leader Radogno have been working on a package of bills that seek to resolve the state budget impasse. The bills are tied to each other, so that in order for any of the bills to become law, they must all pass and become law. The bills include new revenue sources, gaming expansion, as well as items from the Governor's "turnaround agenda" such as freezing local property taxes and local government consolidation. Negotiations continue on these bills in the Senate.

- On February 15, 2016 Governor Rauner delivered his 3rd state budget address. The address had no mention of Medicaid. The Governor's proposed FY18 state budget includes expenses of $37.3B with state revenues projected at $32.7B. The FY18 budget proposal accounts for the $4.6B gap between expenses and revenues with a line item referred to as "Working together on a 'grand bargain'".

The Illinois Department of Healthcare and Family Services' (HFS) held an agency budget briefing following the Governor's budget address. HFS Director Felicia Norwood indicated the proposed FY18 budget does not include any cuts to provider rates, services, or eligibility. The FY18 HFS budget does project a slight increase in the number of ACA Medicaid expansion adults and assumes that at least 66% of Medicaid beneficiaries will be enrolled in managed care statewide. Director Norwood acknowledged Cook County as being a strong partner with the state, and the Medicaid costs offset by Cook County were highlighted in her presentation.

The Illinois Department of Public Health's (IDPH) FY18 budget includes funding to address childhood lead poisoning through increased investments in screening and capital improvements, and an effort to lower the current childhood lead intervention level from ≥10μg/dL to the CDC's recommended level of ≥5μg/dL.

- SB741, CCHHS' legislation to strengthen annual flu shot requirements for healthcare workers, was introduced by Senator Emil Jones III. SB741 has been assigned to the Senate Public Health Committee. A hearing is scheduled for February 28, 2017.

  SB741 would prohibit "moral or philosophical exemptions" as a reason that healthcare workers could decline a flu vaccine and adds health departments as entities subject to this requirement. This legislation works toward CCHHS' strategic plan Objective 7.5 "Advocate for influenza vaccine requirement for all health care workers in Illinois."

Federal

- The Senate confirmed Tom Price's nomination as Secretary of Health and Human Services on February 10, 2017. His leadership is likely to bring more focus on the Administration's effort to repeal and replace the Patient Protection and Affordable Care Act (ACA). As a former member of the House, and Chairman of the House Budget Committee, Secretary Price was a vocal opponent of the ACA and introduced ACA repeal legislation while a member of Congress.

- President Trump's nominee to be CMS Administrator, Seema Verma, appeared before the Senate Finance Committee on February 16, 2016 for her nomination hearing. It is expected Ms. Verma will soon be confirmed as CMS Administrator. Verma has an extensive Medicaid consulting background and advised then Governor Pence on a number of Medicaid matters, including Indiana's Medicaid expansion and proposals to expand health savings accounts.

- In January, the House and Senate Budget Committees passed budget resolutions calling for the repeal of the Patient Protection and Affordable Care Act (ACA). The budget resolution, which does not have the force of law, called for the health care committees to present legislation to repeal the ACA by January 27, 2017. That deadline was not met and committees are in the process of drafting legislation. The House of Representatives is moving forward first and is likely to mark-up legislation at the end of February/beginning of March. Discussion documents indicate that House legislation will repeal the Medicaid expansion and replace the current Medicaid program with per-capita caps at current state matching rates.

- A number of Republican Governors and Senators have raised concerns regarding the repeal strategy as well as concern for the future of the Medicaid expansion that have been put in place in several of their states. Key members of the Senate have indicated that the process should be slowed down and that there should be clarity around a replacement program and its impact on patients.

Protection of Medicaid remains a key priority for CCHHS at both the State and Federal level.

Community Outreach

March 1	CCHHS and CountyCare promotion at the **Year Up Chicago Open House** which will take place at their headquarters located at 223 W. Jackson Avenue in Chicago. Year Up Chicago is a one-year, intensive training program that provides low-income young adults, ages 18-24, with a combination of hands-on skills development, coursework eligible for college credit, corporate internships, and wraparound support. As many of the participants are in need of healthcare and health insurance resources, this has become a great partnership for the organizations.
March 2	CCHHS and CountyCare promotion at the **Willow Creek Community Church Annual Job and resource Fair** at the church located at 67 E. Algonquin Road in South Barrington. The Willow Creek Community Church anticipates 70-80 employers from the community and hundreds of job seekers. The event will bring federal, local and state resources together with the private sector and non-profits to work collectively to provide employment, health and community resources for the residents of South Barrington, Illinois.
March 2	CCHHS and CountyCare promotion at **Greater Chicago Food Depository Fresh Food Truck Distribution** at the Dr. Jorge Prieto Health Center located at 2424 S. Pulaski Road in Chicago.
March 7	CCHHS and CountyCare promotion at the **Ventanilla de Salud ("Health Window Program")** sponsored by the **Consulate General of Mexico** at the Consulate located at 204 S. Ashland Avenue in Chicago. Ventanilla de Salud is a program that bridges the gap between institutions and non-profit agencies and individuals regardless of their immigration status, providing access to public services such as preventive health, health education and guidance on the health system in the United States.
March 9	CCHHS and CountyCare promotion at the **World Kidney Day** which is hosted by the **National Kidney Foundation of Illinois** at the Oak Lawn Community Center located at 4625 W 110th Street in Oak Lawn. The event will provide free kidney, diabetes and blood pressure screenings to the community. All services will be free of charge. Participants will also have access to various screenings, nutrition education, insurance information and tour the KidneyMobile.
March 11	CCHHS and CountyCare promotion at the **Women's Health Fair** which is hosted by **NEIU Carruthers Center for Inner City** Studies at the university campus located at 700 East Oakwood Boulevard in Chicago.
March 11	CCHHS and CountyCare promotion at the **Chicago Resident Service Fairs** hosted by the **City of Chicago** at Olive Harvey College located at 10001 S. Woodlawn Avenue in Chicago. The event will feature one-stop workshops where residents can speak with experts from different city agencies to learn more about the many services that are already available, as well as new initiatives that we are launching. These include everything from basic neighborhood services like recycling and garbage collection to programs offering tax guidance, financial advice, job and skills training, and much more. Information will also be available on new City initiatives like our new Homebuyer Assistance program, which helps homebuyers' access financial assistance for their down payment and closing costs on a new home. At these events, personal wellness services will be available for you and your family, including blood pressure screenings and vaccines.

March 16	CCHHS and CountyCare promotion at the **Re- Entry Education Summit** hosted by the **City Colleges of Chicago and the City of Chicago** at Olive Harvey College located at 10001 S. Woodlawn Avenue in Chicago. The City Colleges of Chicago is hosting a Reentry Education Summit and Resource event with the purpose to bring experts in the criminal justice industry to inform students, staff, and community members who have criminal records about their rights and educational opportunities. The summit will display a wide range of services, supports, and resources that will help individuals with reentry into the community.
March 17	CCHHS and CountyCare promotion at the **South Suburban College Women's Conference** which will take place at the collage located at 15800 S. State Street in South Holland. The **SSC Business & Career Institute** is sponsoring this annual event to promote the health and well-being of women in the Southland. The event will offer a variety of dynamic workshops and vendors focusing on all aspects of health and business.
March 18	CCHHS and CountyCare promotion at the **Park Forest League of Women Voters Panel Discussion on Health Care Delivery in the South Suburbs** which will take place at the Park Forest Village Hall located at 350 Victory Drive in Park Forest. This timely program seeks to address local concern about loss of resources related to any changes in Congress with respect to the Affordable Care Act. Panelists include several representatives from South Suburban Health and Hospital systems and Behavioral Health organizations. Presenters will share information and engage in discussion regarding access to health care, behavioral health resources as well as Medicaid and healthcare financial assistance resources.
March 21	CCHHS and CountyCare promotion at the **Ministers Conference of South Cook County Meeting** which will take place at the First Pentecost Assemblies International Church located at 14559 S. Green Street in Harvey. The Ministers Conference of South Cook County brings together local ministers and social service providers and facilitates a mechanism to communicate about resources and community concerns.
March 21	CCHHS and CountyCare promotion at the **Ventanilla de Salud ("Health Window Program")** sponsored by the **Consulate General of Mexico** at the Consulate located at 204 S. Ashland Avenue in Chicago. Ventanilla de Salud is a program that bridges the gap between institutions and non-profit agencies and individuals regardless of their immigration status, providing access to public services such as preventive health, health education and guidance on the health system in the United States.
March 23	CCHHS and CountyCare promotion at **Greater Chicago Food Depository Fresh Food Truck Distribution** at the Oak Forest Health Center located at 15900 S. Cicero Avenue in Oak Forest.
March 24	CCHHS and CountyCare promotion at the **Summit of Hope** which is hosted by the **Illinois Department of Corrections** at Willey B. White Park located at 1610 W. Howard in Chicago. The Summit of Hope a community expo, bringing together local service providers to create a "one-stop" environment for parolees and probationers to obtain necessary assistance to move past barriers. Many of the over 5000 attendees are in need of health insurance.
March 24	CCHHS and CountyCare promotion at the **St. Xavier University Health Fair** which will take place at the SXU Shannon Center located at 3700 W. 103rd Street in Chicago. The 14th Annual Health Fair sponsored by the Saint Xavier University is targeted to students, faculty and community residents. A variety of screenings, seminars and social, health and governmental resources will be available free of charge.

March 25	CCHHS and CountyCare promotion at the **Community Health and Family Resource Fair** which is hosted by **Strategic Human Services and the North Lawndale Community News** at the North Lawndale Community News building located at 325 S. California Avenue in Chicago. As part of their initiative to improve health, Strategic Human Services and the North Lawndale Community News are partnering with the American Heart Association to help raise awareness on the harmful effects of added sugar in our diets. The primary focus of this event is to improve health, raise awareness in our communities and analyze how much participants learned from the North Lawndale Community News' efforts, and whether they will make any health and beverage changes.
March 28	CCHHS and CountyCare promotion at **Greater Chicago Food Depository Fresh Food Truck Distribution** at the Logan Square Health Center located 2840 W. Fullerton Avenue in Chicago.
March 31	CCHHS and CountyCare promotion at the **Job Fair and Health Awareness Black LGBTQ EXPO** which is hosted by the **Doty Foundation, the Coalition for Justice and Respect, the Empowerment Center and SHARP Studies** at King Center located at 4314 South Cottage Grove Avenue in Chicago.

Estimated Fiscal Impact of ACA Repeal on CCHHS

Elimination of Medicaid Reimbursement for Care of ACA Adults

Increased Uncompensated Care Costs

Approximately **$100M annually** in CountyCare reimbursements but could be as high as $200M

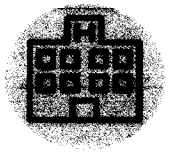
At least **$100M annually** in reimbursements from other Medicaid MCOs but could be as high as $250M

At least **$100M annually** in bad debt & charity care but could be as high as $500M in additional expenses

Conservative Estimate of the Annual Impact of ACA Repeal on CCHHS is at least $300M

Unknowns:

- Reimbursement structures
- Waiver opportunities
- DSH/BIPA funding
- Waiver opportunities



- Sustainability of local health care safety nets
- Number of MCOs serving Cook County

- Utilization of CCHHS services by Medicaid enrollees
- Migration of patients from other systems to CCHHS due to lack of insurance

January 30, 2017 Volume 4, Issue 2

SYSTEM BRIEFS

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS

- The **rear corridor of Stroger Hospital will be under construction starting this evening at 7:00 p.m.** Access to the hallway between the rear door of Clinic F and the Emergency Department will be blocked during this time so crews can reconfigure a fire door and install a new temporary fire door in that area. This construction will prepare the hallway to connect to the new Central Campus Health Center.

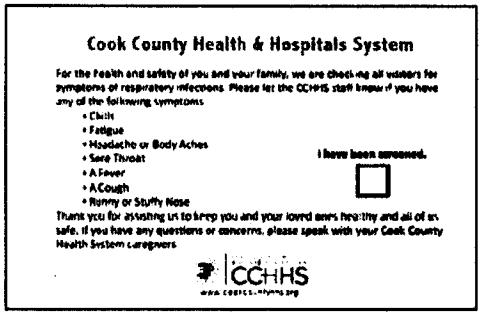
- **Apply to participate in the next cohort of CCHHS' Leadership Development Program (LDP) by Tuesday, January 31.** LDP identifies up-and-coming system leaders and provides them with training and resources to hone their skills. Over a three-month period, LDP participants study strategies and skills that can be utilized to improve the patient experience. The application can be found on the Intranet.

- **Attention Central Campus Parkers:** Please be advised that vehicles parked on the campus illegally (in front of hospital, on the plaza, outside of the Administration Building, in wrong spaces or on patient floors in the parking garage, etc.) will be ticketed and towed at owner's expense starting immediately.

- The installation of the new equipment for the **pneumatic tube system** in the Stroger pharmacy on the first floor will begin on Wednesday, February 1. The installation process includes an upgrade to the system's computer software which will require a full system shutdown. The system is scheduled to be **shut down between 3:00 pm and 9:00 pm.** Pharmacy staff will deliver medications every 30 minutes while stat medications will be delivered immediately. Any questions should be directed to 312-864-2180.

- The **Stroger Police Department** will be moving today to their new location adjacent the Emergency Department. The Police Department phone number has not changed. The room number is 1320.

- **Flu Season has arrived**. Flu season has arrived and as such CCHHS is enacting several strategies system-wide to reduce the spread of influenza among our patients, visitors and staff. Until further notice, employees who did not receive a flu shot are required to **wear a mask** at all times unless they are working in a private, enclosed office. Managers are expected to enforce this rule. Masks are available in clinical areas or through materials management. Patients and visitors should be properly screened for flu symptoms. Screening cards *(see picture at right)* should be at all information desks. If they are not, managers should email cboosedavis@cookcountyhhs.org. We are not restricting hospital visitors at this time but should the incidence of flu increase, we will reevaluate.


Cook County Health & Hospitals System

For the health and safety of you and your family, we are checking all visitors for symptoms of respiratory infections. Please let the CCHHS staff know if you have any of the following symptoms

- Chills
- Fatigue
- Headache or Body Aches
- Sore Throat
- A Fever
- A Cough
- Runny or Stuffy Nose

I have been screened. ☐

Thank you for assisting us to keep you and your loved ones healthy and all of us safe. If you have any questions or concerns, please speak with your Cook County Health System caregivers

CCHHS

- The **Damen entrance to the** Illinois Medical District (IMD) **Blue Line station will be temporarily closed** beginning at 9 a.m. **Monday, February 6 until mid-May** to facilitate a modernization project. The renovation project will make improvements to all three entrances of the IMD station, including the complete reconstruction of the main stationhouse on Ogden Avenue to make it ADA accessible. The station will remain open throughout the entire construction project. Customers can access the station via the main entrance on Ogden Avenue or the additional entrance on Paulina Avenue, which is now ADA accessible. For more information on the project visit: http://www.transitchicago.com/imd/.

About System Briefs

System Briefs is a publication intended to update all CCHHS staff on important initiatives, programs and services. Managers are encouraged to share this information with their teams as well as to post it in employee areas to ensure that all employees receive the information.

February 9, 2017 Volume 4, Issue 3

SYSTEM BRIEFS

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS

- The **Office of Research & Regulatory Affairs is going electronic** and will no longer be accepting initial Institutional Review Board (IRB) submissions on paper as of March 1. Investigators submitting new research applications can now use **IRBManager, a new electronic submission system**. The office will still accept paper submissions for existing studies (progress reports, amendments, etc.) through the month of March. Please email CCHHSIRB@cookcountyhhs.org for log-in information.

  The Office of Research & Regulatory Affairs is hosting monthly open workshops to assist researchers with the IRB process. The workshops will be held on the 3rd Wednesday of every month from 12:00-2:00 pm in 335 Hektoen. The first workshop will be held on February 15 and will review the new IRB Manager.

- As we continue to promote the positive impact of the **Affordable Care Act (ACA)**, we are recruiting patients to provide **testimonials for newspaper, radio and television interviews**. The ideal candidate is a patient who is newly covered under Medicaid (aka ACA/Medicaid expansion adult) and who we are caring for in a new manner such as through one of our primary care medical homes rather than the emergency room. The best stories include the patient and their care team. If you know a patient who may be willing to 'tell their story', please call Monifa Thomas at 312-864-5268. Please do not email any PHI.

- On Friday, February 24th, CCHHS will commemorate the **American Heart Association's Go Red Day** to promote awareness of women's heart disease. Staff across the system are invited to wear red. Take photos of your team in red and submit them to Cheryl Boose-Davis for inclusion in system publications and on social media channels.

- CCHHS staff members who have not received the annual influenza vaccine for the 2016-17 season need to **wear a surgical face mask** per CCHHS Policy, "Mandatory Influenza Vaccination for Personnel", #08.01.03.

  Masks need to be worn by unvaccinated staff at all times while in CCHHS buildings, regardless of the employee's reason for not receiving the vaccine. Masks do not need to be worn if the staff member is working alone in a closed office space.

  Surgical face masks can be obtained in all clinical areas or by contacting Materials Management. Worn masks that become damaged or dirty should be swapped out for new masks. The Infectious Disease and Infection Control teams will determine when masking for non-vaccinated employees is no longer necessary based on influenza trends.

- **Attention Central Campus Parkers**: Please be advised that vehicles parked on the campus illegally (in front of hospital, on the plaza, outside of the Administration Building, in wrong spaces or on patient floors in the parking garage, etc) will be ticketed and towed at owner's expense starting immediately.

- A reminder that the **Damen entrance to the** Illinois Medical District (IMD) **Blue Line station is closed until mid-May** to facilitate a modernization project. The renovation project will make improvements to all three entrances of the IMD station, including the complete reconstruction of the main stationhouse on Ogden Avenue to make it ADA accessible. The station will remain open throughout the entire construction project. Customers can access the station via the main entrance on Ogden Avenue or the additional entrance on Paulina Avenue, which is now ADA accessible. For more information on the project visit: http://www.transitchicago.com/imd/.

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February 17, 2017 Volume 4, Issue 4

SYSTEM BRIEFS

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS

- On Friday, February 24th, CCHHS will commemorate the **American Heart Association's Go Red Day** to promote awareness of women's heart disease. Staff across the system are invited to wear red. Take photos of your team in red and submit them to Cheryl Boose-Davis for inclusion in system publications and on social media channels.

- March 30th is recognized in healthcare organizations as **Doctor's Day** to recognize their hard work and dedication. We invite all employees to nominate a CCHHS **MD, DD, DDS, DMD, PsyD and DPM** for **Doctor of the Year** by simply sending an email with the name and department of the deserving doctor to doctoroftheyear@cookcountyhhs.org. Nominations must be sent by February 28th, 2017. Doctor of the Year will be announced on Doctor's Day, March 30, 2017.

- The following **Finance departments** currently housed on the Central Campus **will move to 1340 Damen Avenue, Chicago** this month. Phone numbers and email addresses for these individuals will remain the same. **Please be advised that to prepare for the move, phone numbers and computers will shut down at 3pm today, Friday, February 17th.** We expect that they will be back up by noon on Tuesday.

Health Information Management effective February 21
General email: HIM@cookcountyhhs.org
Daily clinical document pick up from Stroger inpatient and outpatient clinics will continue. The Release of Information office will remain in the Fantus basement until their new space in the former transportation office on the first floor of Stroger is ready.

Budget effective February 21
General email: CCHHSbudget@cookcountyhhs.org

Finance & Accounting effective February 21
Staff phone numbers/email addresses will not change.

Accounts payable effective February 21
Email for invoices only: AccountsPayable@cookcountyhhs.org
Staff phone numbers/emails addresses will not change.

Costs & Reimbursements effective February 21
Staff phone numbers/email addresses will not change.

Payroll effective February 28
General email: payroll@cookcountyhhs.org
General phone: 1-312-864-4750
Fax: 312-864-9386 or 312-864-9736
Instructions for in person activities such as signing up for direct deposit and on submitting w4s will be forthcoming.

About System Briefs

System Briefs is a publication intended to update all CCHHS staff on important initiatives, programs and services. Managers are encouraged to share this information with their teams as well as to post it in employee areas to ensure that all employees receive the information.