February's Care Management Webinar

Wednesday, February 19, 2025

CountyCare
A MEDICAID HEALTH PLAN

Oncology Navigation program – Evolent Health

CountyCare CME Training

February 19, 2025

Agenda

- Introductions
- Oncology Navigation Program overview
- Impact Case Examples
- High-level overview of CME/EVH collaboration (Referral/Escalation, Resources, and Care Rounds)
- Contact Information

Member Participation

Cancer Care Navigation Program

Who is eligible to participate?

- Active CountyCare member
- 18 years or older
- Confirmed cancer diagnosis

How do members join the program?

- Referrals from CountyCare Care Managers
- Interest form on CountyCare website
- Data model
- Referrals from Providers

Our end-to-end oncology care navigation model is guided by four principles for scaled member impact

Targeted, early member identification

- **Real-time data visibility** on population and member needs
- **Advanced analytics** for robust population stratification
- **Unique data assets** through Oncology clinical oversight: e.g., Treatment auths for Med Onc, Rad Onc to understand risk for symptom/side effect severity
- **AI-driven analytics and proprietary risk algorithms** built on claims and auth data

Member engagement at scale

- **Population-wide** reach
- **Multi-modal** options
- **High-tech / high-touch** for 24/7 individualized support
- **Comprehensive integrated model** combining concierge clinical and navigation services with “patient first” technology
- **Multiple ways to engage** – human telephonic, digital/app
- **Tailored intensity** of intervention based on need

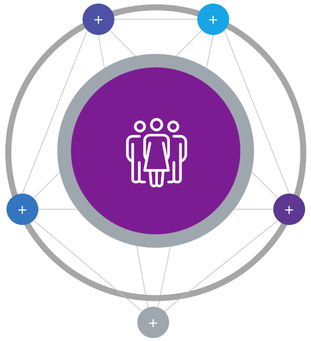
Value creation through robust clinical and social support

- **High-impact interventions** targeting unwarranted cost
- **Ability to address all patient needs** (clinical, SDoH)
- **Symptom management** through services and intuitive, clinically rigorous member tech
- **High-value specialist** selection analytics and support
- **Advanced illness navigation** delivered by specialists in goal-concordant care

Seamless integration into the member’s care ecosystem

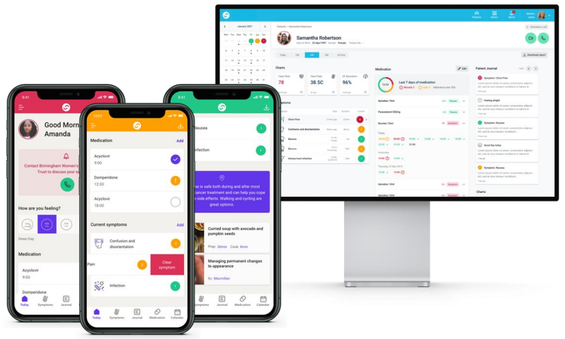
- **Provider clinical alignment** on patient management
- **Information continuity** across all patient touches
- **Provider practice engagement** and collaboration on configuring escalation plans
- **Structured status updates**
- **Close partnership with health plan Care Management** with referrals into program based on clear criteria

We are integrating concierge care services with “patient-first” technology to support a more connected, empowered care journey



Data-Driven Oncology Care Navigation Services

- **High-touch concierge program** delivering structured and on-demand personalized support
- **Multidisciplinary care team** led by nurses and behavioral specialists trained in patient activation
- **Targeted member identification** using predictive risk algorithms powered by auth and claims data
- **High-impact interventions** including needs assessment, education, connection to social resources, advanced illness care



Powered by Member-Centric Digital Technology

- **Partnership with Careology** digital cancer care platform fully integrated with care navigation services
- **Empowers members** and caregivers with intuitive, clinically rigorous personalized tools and content
- **Member-facing app** for symptom management, med adherence, vitals monitoring, direct connection to care
- **Patient-reported outcomes data** for real-time visibility on member status
- **Integrates with UM** for end-to-end management of cancer care journey

Program impact areas

Enhanced member experience | Health equity | Improved care outcomes & quality of life | Reduced avoidable inpatient / ED utilization | Goal-concordant care

Comprehensive Oncology Member Engagement Stages

Member Identification and Outreach

Eligible ONCOLOGY members are identified for the program and contact is initiated.

Three methods of identification:

1. Externally initiated –e.g., provider referrals and CountyCare initiated referrals
2. Evolent initiated – e.g., members identified through data analytics and established algorithms for cancer-related needs
3. Member initiated – e.g., member independently learn about the program and reach out to CountyCare or Evolent for enrollment

Careology Member Onboarding

Members have the option to use the Careology app to track cancer-related activities. If they choose to opt out of the Careology app, they will still have access to our full Oncology Navigation interdisciplinary team.

- For members interested in Careology, the Care Navigator assists with app setup and functionality walkthroughs, empowering members to log symptoms, manage appointments, and track health data
- For members not interested in the app, navigation services are provided without it, ensuring access to personalized support for all enrolled members

Member Engagement

Care Navigator engages with member throughout the predefined duration of the program based on the member's needs.

- Care Navigators will address immediate clinical needs as well as care coordination requests
- Care Navigator engage members in goals of care discussions, supporting decision making around treatment plans and quality of life
- For members facing significant sx burden, navigators facilitate referrals to palliative, ensuring comprehensive sx management and support
- Members using the Careology app benefit from sx tracking, goal setting, and monitoring health data, enhancing engagement with the program

Member Graduation

Care Navigator identifies a member who is ready for graduation from the program.

Graduation Criteria:

1. Transitioned into survivorship or onto hospice services
2. Met all program goals
3. Had all outstanding needs and symptoms fully resolved

- Care Navigator provide final care summaries to members' providers and health plans, ensuring a smooth transition
- Graduates access to the Careology app continues for personal health management beyond the program

Member Transition to Hospice

Care Navigator provide comprehensive education to members and families on hospice services.

- Care Navigator addresses misconceptions, divergent expectations, and confirms eligibility
- Care Navigators guide the hospice referral process, confirm coverage, local agencies, and assist with care compact
- Care Navigators ensure that members and their families have a clear understanding of what to expect and feel supported during this transition
- Care Navigators advocate for appropriate cadence, services, and DME upon hospice enrollment

Envisioning the transformed journey: Enabling a connected, empowered cancer care experience for members, their caregivers, and care team

	Pre-Treatment	Treatment	Post-Treatment	*Benefits*
Member & Caregivers	I am **guided** on diagnostic process, **know status** of my care and **high-quality providers** for the best care	**My needs and goals** are reflected in my care plan, and I have the tools and support to **manage treatment**	I am **connected to support and empowered** in my care choices, in survivorship or high-quality palliative care	**For members & caregivers:** ✓ *Improved **experience*** ✓ *Improved **outcomes*** ✓ *Health **equity*** ✓ ***Goal-concordant** care*
Provider Care Team	**My patient is fully supported** on questions, coordinating care, and **accessing specialists**	I have a **complete picture** of my patient's symptoms and concerns, and an **extra layer of support** between visits	I have integrated **expert support for difficult conversations** on end-of-life to empower my patient	**For providers:** ✓ ***Support for patients** outside of visits* ✓ ***More time** for patient care* ✓ *Improved **outcomes*** ✓ ***Reduced back office and administrative burden***
Health Plan Care Team	I have **powerful data insights** to reach members early in their cancer journey with the right support	I have a **specialized partner** for supporting the complex needs of members with cancer during active treatment	I am equipped to **navigate members to palliative and hospice care** through sensitive interventions	**For health plans:** ✓ *Improved **outcomes** and reduced **avoidable cost*** ✓ *Better able to **manage oncology-specific needs***

High-touch, tailored interventions educate, activate & support patients during their cancer journey

MEET DIANA

STATS

- Age 74
- Stage IV Fallopian tube cancer
- Diagnosed through biopsy ordered by PCP
- Husband is her caregiver
- Surgery, Chemo, Targeted Therapy

CHALLENGE

Family coping with the recent loss of close family members while navigating Diana's diagnosis and treatment

OPPORTUNITY

Help Diana identify a cancer care team and feel more in control of her care. Diana is outreached through cold call efforts and quickly recognizes the benefits of the program

OUR APPROACH:

Personalized plan • Provider feedback loops • Longitudinal patient engagement

Intake Assessment

A care navigator skilled in motivational interviewing initiates outreach to Diana and completes an initial holistic assessment.

Diagnostic and Treatment Complexity

- Initial Presentation: Lumps on neck which persisted and increased in size
- Underwent ultrasound and MRI, both suspicious for malignancy
- Biopsy confirmed cancer with metastatic spread to lymph nodes and abdomen

Treatment: Targeted therapy added to chemo.

Prior Hospitalizations noted before enrollment

(January 2024)
Multiple admissions for cough, mucus buildup, pain, and pneumonia

Navigation and Medical Collaboration

During a scheduled session, patient reported dyspnea, constipation, fatigue, weakness, and chest pain.

- Escalation process deployed, leading to collaboration with primary care team
- X-ray ordered to assess possible pleural effusion, confirming fluid buildup
- Outpatient thoracentesis scheduled, successfully resolving symptoms
- Post-procedure follow-up

Her care navigator notifies PCP with identified symptom burden, proactively addressing anticipated needs

Communicating Clinical Updates and Escalations to CCH and CME

Patient flagged in weekly roster
Case will be provided to CCH and explored for potential case review for monthly rounds.

Additional Navigation Support

Patient received a $32,000 bill related to her treatment

- Navigator facilitated 3-way call the academic ceneter billing and additional 3-way call to Member Services
- Appeal submitted and approved, reducing patient responsibility to $580
- Patient and caregiver express significant financial relief

Goals of Care Discussions

- Patient expressed concern about treatment burden and impact on quality of life
- Palliative care and hospice education provided to explore options based on treatment efficacy and patient values
- Patient awaiting CT scan before deciding on further treatment

TARGET RESULTS FOR DIANA

Experience

With Stressors managed

Enhanced Symptom Management
Supportive Decision-Making
Psychosocial Support
Financial Relief
Care Coordinatrion

Cost savings

Diana avoids unnecessary hospital and ED visits by proactively monitoring her symptoms. Including significant OOP cost savings.

Estimated Cost: $25,200

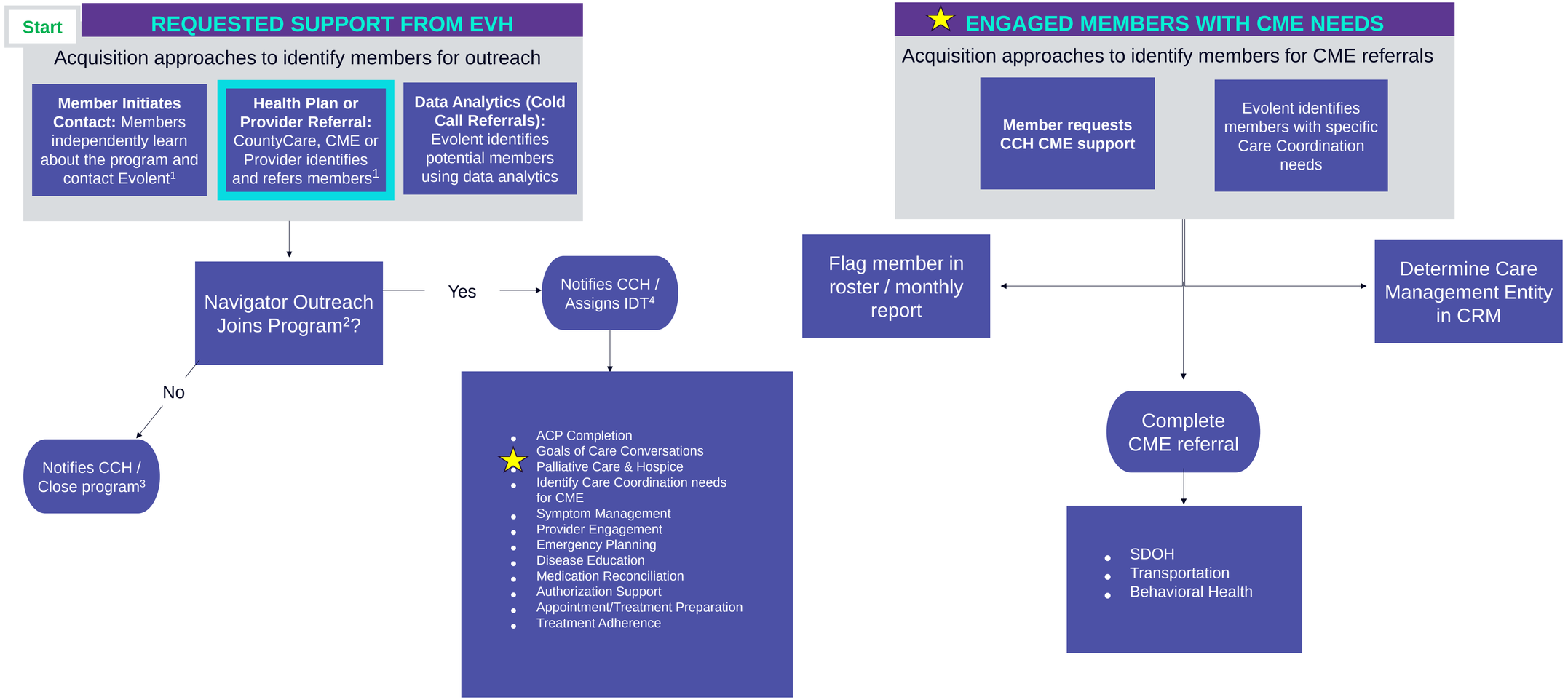
Where Can CCH + EVH + CME Work Together to Support Members?

Situation	EVH	CCH	CME
Referrals: If CCH identifies a member that meets criteria for the oncology navigation program, they will send a referral to the EVH navigation team.	Evolent will process the referral, assign a Care Navigator and being outreach to the member.	CCH will review the program benefits with the member before referring them to ensure a warm hand off. Resources: Provider FAQs APPROVED CountyCare Script for Navigation Introduction APPROVED.docx	CMEs can also complete referrals to the oncology navigation program. They will review the program benefits with the member before referring them to ensure a warm hand off utilizing the same resources as CCH.
Lost Contact: If Evolent loses contact with an engaged member	Evolent would follow their standard protocol prior to closing. If the member has a trusted contact on file, Evolent could reach out to them to verify the member's well-being and obtain any updated contact information. Evolent may also contact provider for updated contact information. Upon the fourth consecutive failed outreach attempt, Evolent will flag the patient in care rounds to leverage support of CCH team.	CountyCare will support Evolent by attempting to contact the member using one of their modalities in attempt to reengage. "Both the Care Coordinator and Community Resource Navigators will attempt to reach the members up to 5 times to complete the HRS. These outreaches include, outgoing phone calls, outgoing text messages, sending an Unable to Reach letter, contacting the Medical Home or PCP's office (these numbers can usually be found in Point-Click-Care), and calling an Emergency contact if one can be located." Outreach for Non-LTSS Care Coordinators Workflow.docx	N/A
Transportation Needs: When a patient needs transportation to a medical appointment	Evolent assists with determining transportation benefits available through their own health plan, a CC would refer the member to local community organizations or transportation services.	CountyCare provides transportation to and from scheduled medical, behavioral, dentist, and eye appointments, pharmacies, medical equipment providers, certain events sponsored by CountyCare, or Women, Infants, and Children (WIC) food assistance locations. Resources: Covered Services – CountyCare Health Plan to schedule a ride through CountyCare's transportation partner, Modivcare at least 72 hours (3 days) before your appointment, public transportation, mileage reimbursement.	CMEs can also complete scheduling for transportation and reimbursement. If EVH navigation team requires support in scheduling transportation for members, they will submit referrals to the CME team via determined process by Evolent's Clinical Care Management Liaison. CMEs will then follow standard protocol to manage transportation arrangements for member.
Palliative Care & Hospice Referrals	Evolent would lead the coordination of care transitions into palliative care or hospice.	CountyCare has the opportunity to identify patients who may benefit from palliative care and/or hospice services or education. These patients can be referred to the navigation program, flagged in roster if already engaged and can also be discussed during monthly care rounds.	CMEs can also identify patients with palliative care and/or hospice needs and leverage navigation team for support.
SDOH Needs: When a patient is facing SDOH barriers such as housing, food insecurity, financial stressors	Evolent addresses need through a combination of internal resources, community partnerships/referrals, completion of financial assistance applications, and leveraging existing benefits from the member's health plan.	CountyCare provides • Care Management Program, Care Coordination • Emergency Food Program, FoodSmart • Housing, community resources, in-home support • LTC, Vision, Dental, Pharmacy	EVH navigation team will submit referrals to the CME team via determined process by Evolent's Clinical Care Management Liaison. CMEs will then follow standard protocol to manage SDOH needs based on available benefits and resources.
Behavioral Health Needs	Evolent would follow their standard protocol to initiate community referrals to address BH needs and provide mobile crisis response services.	CCH offers behavioral health services to treat mental health and substance use disorders. Behavioral health services are available for both children and adult members. Covered Services – CountyCare Health Plan	EVH navigation team will submit referrals to the CME for in-network outpatient, inpatient, and residential BH referrals.

Workflow: Member Referrals & Support

Key

Represents the steps that involve CCH or market CMEs

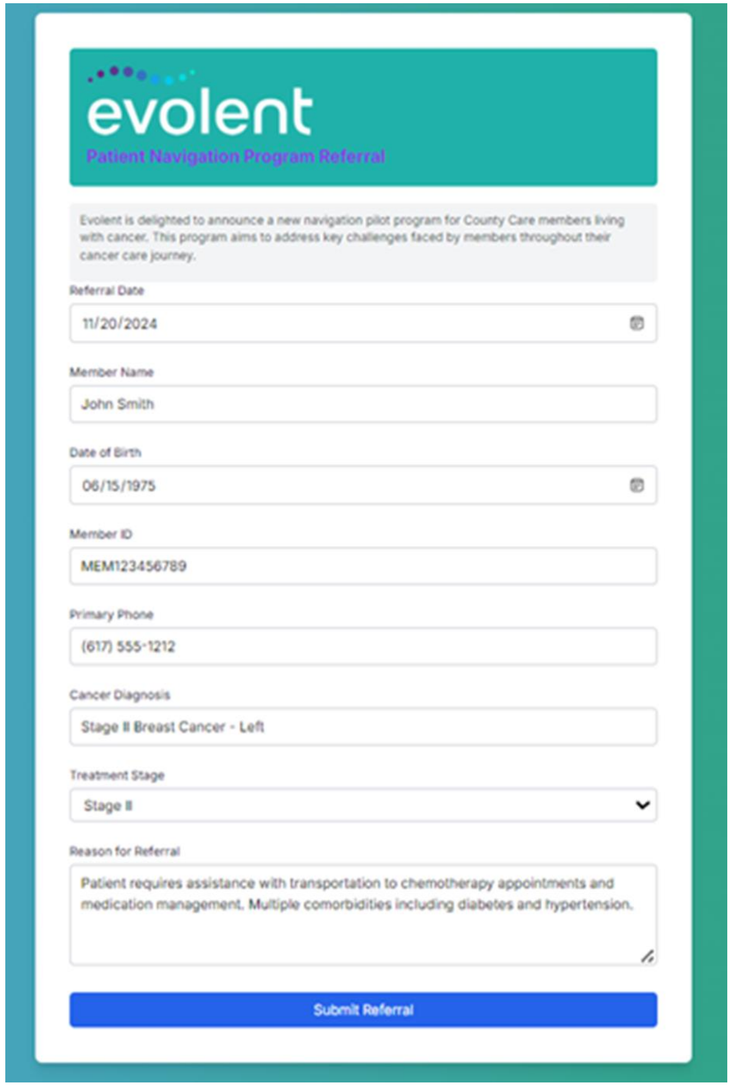


1. Educational content for Health Plan and Provider informing them of the program and content for them to share with members to learn more (brochures, email, etc.). Link to be included in email to a landing page where the member can learn more and complete a form to speak to a care navigator about the program.
2. Comprehensive overview of program is provided ensuring the patient understands supportive services.
3. Decline and reasoning are tracked, and re-engagement strategies are applied based on Health Plan/Provider preferences.
4. Member will receive confirmation of their enrollment in the program and will be assigned a Clinical Navigator (Oncology Nurse), Advance Illness Navigator (LMSW, LCSW, LC), and Care Navigator (Care Coordinator)

Streamlining Referrals & Escalations

- Referral & Escalation Form Link
  - Designed for ease of use and seamless communication
  - Accessible referral and escalation forms in a single link
  - Streamlines workflows for faster navigation team outreach
  - Real-Time Support: Immediate connection to full navigation team
- Features
  - One-Page Design: Essential questions only, eliminating need to gather date from multiple sources
  - Instant Error Notification: Alerts for misspelled names or incorrect ID numbers, with prompts for verification
  - Document Upload Capability: Add necessary files directly within the form
  - Confirmation Email: Includes successful transaction receipt and turnaround time for referral completion.

http://providers.evolent.com



CME Resources

Script
Talking Points
FAQs

Provider FAQs:

- Which CountyCare members are eligible for the program and how are they referred?

o CountyCare patients diagnosed with cancer are eligible for our navigation program. Patients are typically referred through CountyCare's Community Health Workers, CMEs, or their healthcare provider or identified through Evolent's data to ensure the right patients are connected to our services.

- When does the program begin?

o The program begins as soon as the patient is referred, is connected with a dedicated navigator, and consents to program enrollment. Patients will be contacted by the navigation team to provide thorough education around the program and begin assessing for needs. Following patient consent, members will have immediate access to the Careology app, a 24/7 digital platform that helps them track symptoms, manage medications, and connect with their care team. Members can opt in or opt out of using this app feature at any time throughout their journey.

- An overview of the program

o Evolent's comprehensive Care Navigation Program combines personalized support and a high-tech platform to deliver a more connected, empowered patient experience for health plan members living with cancer. The program is designed to help patients navigate the challenges of cancer treatment and ensure that they receive care aligned with their goals. We aim to improve quality of care, increase patient satisfaction, facilitate better adherence to treatment, and reduce avoidable hospital visits and unwanted care at the end of life.

- How will members participate in the program?

o Patients participate in the program by engaging with their assigned navigation team, encompassing nursing, behavioral health, social work, and care coordination disciplines, who will guide them through their journey. Patients will have a set cadence of outreach based on need/risk but can also reach out to their navigation team as needs arise. Needs could include assistance with managing symptoms, advance care planning, scheduling appointments, treatment questions or concerns, emergency planning, and connecting to resources. Participation is flexible based on each unique experience and patient preference.

- How do our providers engage/enroll the members in the program?

o Providers can engage or enroll members by completing a simple referral process, either through CountyCare or through Evolent's navigation team. This ensures that referrals can be processed, in a timely manner and eligible members are quickly connected to our support team. Once the referral is completed, the navigation team ensures that the provider is kept in the loop with confirmation and any relevant updates. This "closed-loop" communication gives providers peace of mind, knowing that their patients are connected to resources without additional follow-up on their end.

CountyCare Script for Navigation Introduction

Evolent's comprehensive Oncology Care Navigation Program combines personalized support and a high-tech platform to deliver a more connected, empowered patient experience for health plan members living with cancer. The program is designed to help patients navigate the challenges of cancer treatment and ensure that they receive care aligned with their goals, improving quality of care, increasing patient satisfaction, facilitating better adherence to treatment, and reducing avoidable hospital visits and unwanted care at the end of life.

Script for Navigation & Careology:

"We are offering a new service for some of our CountyCare patients living with cancer and I believe it could be helpful for you. It is a personalized Care Navigation Program, offered as one of CountyCare's health plan benefits and provided at no cost as part of NCQA standards. The program gives you access to a team of navigators, who can help you in many ways. They can coordinate your appointments. They can help you manage symptoms. They can help make sure your care team understands your goals and preferences for your care. They can connect you to resources like support groups, and help you manage challenges around family, work, and social life. You can think of this team as an extension of your doctor's office, ready to assist with everyday questions, so you can focus on what matters most to you.

You will also have access to Careology, a comprehensive digital platform designed by cancer specialists to support your physical and mental well-being. With Careology, you can monitor your symptoms, track medications, and receive helpful guidance. The app integrates with Bluetooth devices, such as smartwatches and blood pressure monitors, giving a real-time snapshot of your health. It's also connected with our navigation team, allowing navigators to respond quickly to any immediate needs or severe symptoms.

Patients have the flexibility and autonomy to opt in and out of any program features as well as the entire navigation program whenever they choose. This ensures that patients can access support on their own terms and adjust their level of engagement as their needs evolve.

This program is available to you at no added cost. I can let them know you're interested, and the navigation team will reach out to you to get you started."

Talking Points:

- **No-Cost Service for County Care Patients:** This service is available at no cost to our CountyCare patients with cancer diagnoses, supporting them in their care journey while reducing the workload for healthcare providers.
- **County Care Integration:** The navigation program is integrated with your CountyCare team, meaning we work together to support you. This partnership allows us to provide you with seamless, coordinated care, so you can access the full range of support and services offered by both CountyCare and your navigation team. Together, we're here to make sure you have everything you need.

Primary Points of Contact

Evolent

- Medical Director: Dr. Kamal Golla vgolla@evolent.com
- Director of Member Services: Julie Moloney jmoloney@evolent.com
- Rachel Zerbian rzerbian@evolent.com

CountyCare & CME

- Jessica Chatman jessica.chatman@cookcountyhhs.org
- Marco Shelby marco.shelby@cookcountyhealth.org

Responding to Potential Immigrant Enforcement Activities

Cindy San Miguel

Director of Health Equity

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Response to Increased threat of deportations

- President Trump reversed guidance that restricted ICE and CBP from carrying out immigration enforcement at "sensitive" locations: churches, schools and healthcare settings.
- We have seen an increase in calls from HBIA/S members expressing concerns
- Response: Ensure team that does any member-facing (customer service reps, CMs, outbound call center staff) work is trained on what to do if ICE shows up looking for a specific individual. The ICE agent must have a judicial warrant signed by a judge if they want access to see a person.
- As part of Cook County Health, we are following CCH guidance and protocol and calling CCH Police, our facility manager and our legal team if there is any interaction with ICE.
- **For Cook County Health staff, training is now required in LMS. Please make sure you complete that training ASAP.**

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Potential National Anti-Immigrant Policies

- Trump promised on the campaign trail, the largest deportation effort in American history. The logistical, staffing, and resource challenges to making this happen are significant; however, the rhetoric is damaging.
- Trump could reinstate changes he made during his 1st term to public charge which created fear and misinformation about accessing programs and services (like healthcare coverage).
- DACA: The Trump administration opposes the Deferred Action for Childhood Arrivals (DACA). We could see the administration try to eliminate this program. The Supreme Court upheld the challenge in 2020, but the legal effort may succeed in the new term.
- The Trump administration has expressed hostility towards people seeking asylum. He could also reduce the refugee admission ceiling as he did during his 1st term.
- The Trump administration could reinstate the “Remain in Mexico” border policy, which would create more asylum seekers facing unsafe conditions at the border.

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https://www.brookings.edu/articles/what-to-expect-on-immigration-policy-from-a-trump-white-house/
https://www.kff.org/racial-equity-and-health-policy/issue-brief/expected-immigration-policies-under-a-second-trump-administration-and-their-health-and-economic-implications/

Protections in Illinois for People who are Immigrants/Immigrating

- **The IL Way Forward Act** became law in August 2021. The law prohibits law enforcement and state/local government from contracting with US Immigration and Customs Enforcement (ICE) to detain those in immigration custody (local jails cannot detain people facing deportation). Local police cannot coordinate with ICE, share information with ICE, or let ICE access people in police custody.
- **The Trust Act** became law in 2017. It prohibits local law enforcement from participating in immigration enforcement.
- **The VOICES Act (Voices of Immigrant Communities Empowering Survivors)** VOICES provides procedural protections for immigrants victimized by violent crime or human trafficking who have assisted law enforcement in investigating/prosecuting certain crimes. Survivors of crime may qualify for a U-visa, and survivors of human trafficking may qualify for a T-visa.
- **Sanctuary City Ordinances.** This passed in 2006. There is no legal definition of sanctuary cities but is an unofficial term for any jurisdiction that discourages local law enforcement from cooperating with ICE. It prevents local officers from asking about someone's immigration status, detaining someone due to immigration status, or working with ICE agents. BUT the federal government can enforce immigration laws anywhere in the country, even if local police do not assist. Trump plans to declare a national emergency and use the US military for mass deportation. That action would violate federal law, but it is speculated that Trump will use the Insurrection Act of 1807, which gives the president emergency powers to use Fed troops on domestic soil to curb local unrest/rebellion.
- Even in a very protective city/state, those who are immigrants will be facing threats this upcoming year.

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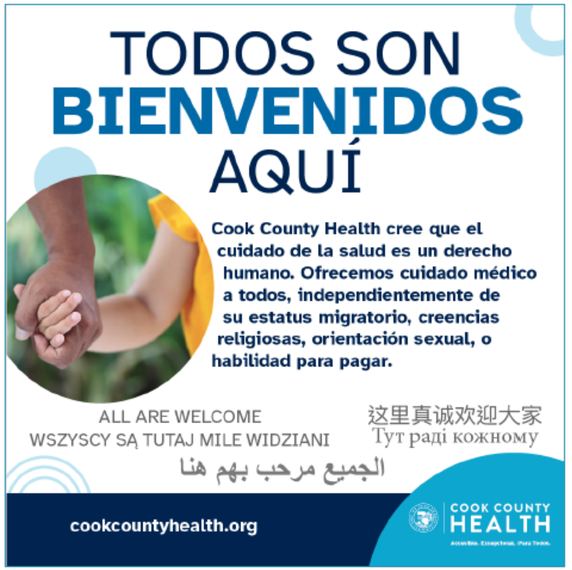
Pritzker signs law banning local jails from detaining people facing deportation - Chicago Sun-Times
Illinois Way Forward (SB 667) passes General Assembly | ICIRR
Immigration Rights
Chicago and Illinois have sanctuary laws. What does that actually mean? - WBEZ Chicago

Cook County Health Response

Cook County Health's Mission to Care for All

- Cook County Health proudly cares for all residents, regardless of immigration status
- All people should be able to access health care safely, without fear of legal repercussions
- Goal of this training is to empower staff to protect patients' rights



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Cook County Health Response

US Immigration and Customs Enforcement (ICE)

- US Immigration Customs and Enforcement (ICE) agents are treated like any other law enforcement agency that may present at a CCH facility.
- The US Department of Homeland Security guidance directs ICE agents to refrain from taking any enforcement action in or near “protected areas”, except in extreme cases. Protected areas include:
  - Hospitals
  - Doctor’s offices
  - Health clinics and urgent cares
  - Vaccination and testing sites
  - Social service agency locations

CCH is not required to comply with any immigration enforcement activities unless the activity is directed by a judicial warrant.

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Cook County Health Response

Responding to ICE

If an agent presents to a CCH facility:

- Ask agent to wait in the lobby
- Do not consent to any activity
- Contact ALL of the following departments (in order):
  - **Cook County Hospital Police:**
    - 312-864-8097
  - **On Duty Administrator (ODA) or facility manager:**
    - Stroger- 312-864-8952 / Tiger Connect
    - Provident- 312-572-2039 / Tiger Connect
  - **Risk Management (Legal):**
    - 773-502-0995
    - 847-927-7770

Call CCH Risk Management (Legal) for guidance any time an ICE agent presents to a CCH facility.

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Know Your Rights

- If you believe you are witnessing ICE activity, please call ICIRR's 24-Hour Family Support Hotline at 1-855-HELP-MY-FAMILY (1-855-435-7693) to report it.
- If you find yourself interacting with an ICE officer in any location including your workplace, or out in the community, remember that you:
  - Have the right to remain silent when questioned or arrested by immigration officers
  - Should remain calm and keep your hands where the officer can see them
  - DO NOT:
    - discuss your immigration or citizenship status with the police, immigration agents, or other officials
    - sign anything you do not understand. You should state that you wish to speak with an attorney
- If an officer knocks on your door at home: Do NOT open the door. Teach your children not to open the door.
  - ICE officers must have a warrant signed by a judge to enter your home. ICE "warrants" are not signed by judges; they are ICE forms signed by ICE officers and they do not grant authority to enter your home without your consent

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Know Your Rights

- If you are outdoors and think you see immigration officers nearby:
  - Move to a safe indoor space
  - If you are a U.S. citizen and feel safe to do so, record the activity with your phone or write down any relevant information about what you witness—ALWAYS being careful to not interfere or otherwise obstruct the operation
- DO NOT
  - Post unverified information on social media
  - Interfere with the investigation or otherwise put yourself in harm's way

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Resources

- Immigration | Cook County
- Illinois Coalition for Immigrant & Refugee Rights: www.icirr.org
- State of Illinois Resources: https://illinoisattorneygeneral.gov/rights-of-the-people/civilrights/immigration/
- Resources from Know Your Rights Training: KYR Training 12-2024
  - Chicago Immigration Legal Providers
  - Advice on how to create safety plan
  - Handout in Spanish that members can use with picture of a warrant

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Resources

Handouts in English, Spanish, Chinese and French can be found here:

[KYR Handouts]

ILLINOIS COALITION FOR IMMIGRANT & REFUGEE RIGHTS

KNOW YOUR RIGHTS

WHEN INTERACTING WITH IMMIGRATION OFFICERS (ICE)

- **If you believe you are witnessing ICE activity**, please call ICIRR's 24-Hour Family Support Hotline at 1-855-HELP-MY-FAMILY (1-855-435-7693) to report it.
- **If you find yourself interacting with an ICE officer in any location including your workplace, or out in the community, remember that you:**
  - Have the right to remain silent when questioned or arrested by immigration officers
  - Should remain calm and keep your hands where the officer can see them
  - DO NOT:
    - discuss your immigration or citizenship status with the police, immigration agents, or other officials
    - sign anything you do not understand. You should state that you wish to speak with an attorney
- **If an officer knocks on your door at home:** Do NOT open the door. Teach your children not to open the door.
  - ICE officers must have a **warrant signed by a judge** to enter your home. ICE "warrants" are not signed by judges; they are ICE forms signed by ICE officers and they do not grant authority to enter your home without your consent
- **If you are outdoors and think you see immigration officers nearby:**
  - Move to a safe indoor space
  - If you are a U.S. citizen and feel safe to do so, record the activity with your phone or write down any relevant information about what you witness—ALWAYS being careful to not interfere or otherwise obstruct the operation
- **DO NOT**
  - Post unverified information on social media
  - Interfere with the investigation or otherwise put yourself in harm's way

NEED SUPPORT? CALL ICIRR'S FAMILY SUPPORT NETWORK HOTLINE: 1-855-435-7693

ILLINOIS COALITION FOR IMMIGRANT & REFUGEE RIGHTS

CONOZCA SUS DERECHOS

CUANDO INTERACTÚE CON AGENTES DE INMIGRACIÓN (ICE)

- **Si cree que es testigo de una actividad de ICE,** llame a la línea directa de apoyo familiar de 24 horas de ICIRR al 1-855-HELP-MY-FAMILY (1-855-435-7693) para reportarlo.
- **Si usted se encuentra interactuando con un oficial de ICE en cualquier lugar,** incluyendo su lugar de trabajo, o en la comunidad, recuerde que usted:
  - Tiene derecho a permanecer en silencio cuando sea interrogado o arrestado por oficiales de inmigración
  - Debe permanecer tranquilo y mantener sus manos donde el oficial pueda verlas
  - **NO**:
    - comparta su estatus de inmigración o ciudadanía con la policía, agentes de inmigración u otros funcionarios
    - firme nada que no entienda. Debe declarar que desea hablar con un abogado
- **Si un agente toca la puerta de su casa:** NO abra la puerta. Enseñele a sus hijos a no abrir la puerta.
  - Los agentes de ICE deben tener una **orden firmada por un juez** para entrar a su casa. Las "órdenes" de ICE no están firmadas por jueces; son formularios de ICE firmados por oficiales de ICE y no dan autoridad para entrar a su casa sin su permiso.
- **Si está al aire libre y cree ver agentes de inmigración cerca:**
  - Vaya a un espacio interior seguro
  - Si usted es ciudadano estadounidense y se siente seguro de hacerlo, grabe la actividad con su teléfono o escriba cualquier información relevante sobre lo que vea, teniendo siempre cuidado de no interferir u obstruir de otro modo la operación.
  - **NO**:
    - Publique información no verificada en las redes sociales
    - Interferir en la investigación o se ponga en peligro de otro modo

¿NECESITA AYUDA? LLAME A LA LÍNEA DIRECTA DE APOYO FAMILIAR DE ICIRR: 1-855-435-7693

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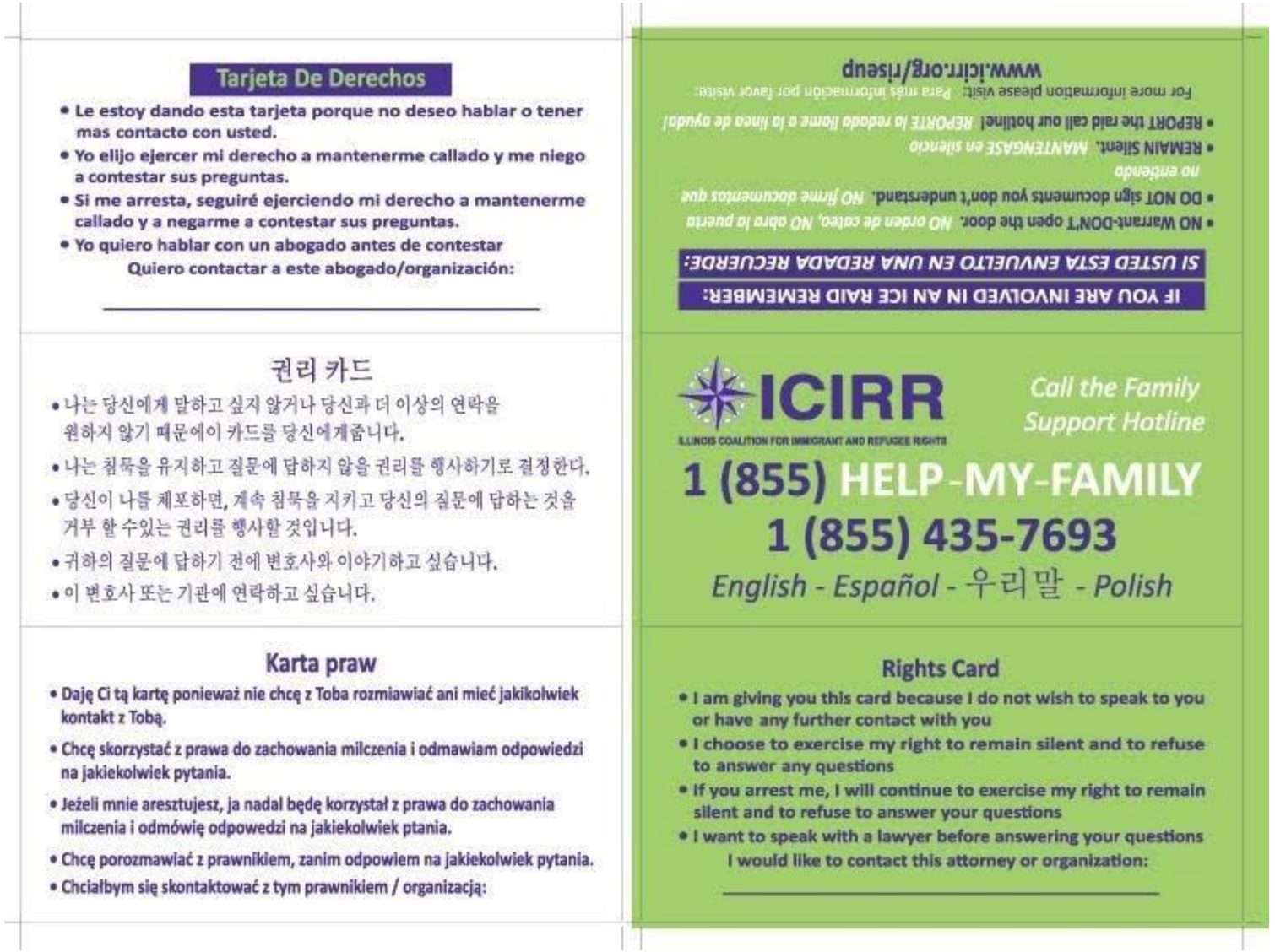
Resources



Tarjeta De Derechos

- Le estoy dando esta tarjeta porque no deseo hablar o tener mas contacto con usted.
- Yo elijo ejercer mi derecho a mantenerme callado y me niego a contestar sus preguntas.
- Si me arresta, seguiré ejerciendo mi derecho a mantenerme callado y a negarme a contestar sus preguntas.
- Yo quiero hablar con un abogado antes de contestar

Quiero contactar a este abogado/organización:

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권리 카드

- 나는 당신에게 말하고 싶지 않거나 당신과 더 이상의 연락을 원하지 않기 때문에이 카드를 당신에게줍니다.
- 나는 침묵을 유지하고 질문에 답하지 않을 권리를 행사하기로 결정한다.
- 당신이 나를 체포하면, 계속 침묵을 지키고 당신의 질문에 답하는 것을 거부 할 수있는 권리를 행사할 것입니다.
- 귀하의 질문에 답하기 전에 변호사와 이야기하고 싶습니다.
- 이 변호사 또는 기관에 연락하고 싶습니다.

Karta praw

- Daję Ci tą kartę ponieważ nie chcę z Toba rozmiawiać ani mieć jakikolwiek kontakt z Tobą.
- Chcę skorzystać z prawa do zachowania milczenia i odmawiam odpowiedzi na jakiekolwiek pytania.
- Jeżeli mnie aresztujesz, ja nadal będę korzystał z prawa do zachowania milczenia i odmówię odpowedzi na jakiekolwiek ptania.
- Chcę porozmawiać z prawnikiem, zanim odpowiem na jakiekolwiek pytania.
- Chciałbym się skontaktować z tym prawnikiem / organizacją:

IF YOU ARE INVOLVED IN AN ICE RAID REMEMBER:

SI USTED ESTÁ ENVUELTO EN UNA REDADA RECUERDE:

- NO Warrant-DON'T open the door. *NO orden de cateo, NO abra la puerta*
- DO NOT sign documents you don't understand. *NO firme documentos que no entiendo*
- REMAIN Silent. *MANTENGASE en silencio*
- REPORT the raid call our hotline! *REPORTE la redada llame a la línea de ayuda!*

For more information please visit: *Para más información por favor visite:*

www.icirr.org/riseup

ICIRR

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Call the Family Support Hotline

1 (855) HELP-MY-FAMILY

1 (855) 435-7693

English - Español - 우리말 - Polish

Rights Card

- I am giving you this card because I do not wish to speak to you or have any further contact with you
- I choose to exercise my right to remain silent and to refuse to answer any questions
- If you arrest me, I will continue to exercise my right to remain silent and to refuse to answer your questions
- I want to speak with a lawyer before answering your questions

I would like to contact this attorney or organization:

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Announcements

- Next webinar is March 19th, 2025!
- Slides posted on CountyCare Care Coordination Webpage:
  - http://www.countycare.com/carecoordination
- Have feedback? Ideas for future topics? Please share!
  - https://redcap.link/23k1fzzb

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- Please email questions/concerns: stephanie.nickles@cookcountyhealth.org