Cook County Health Behavioral Health Programs & Services

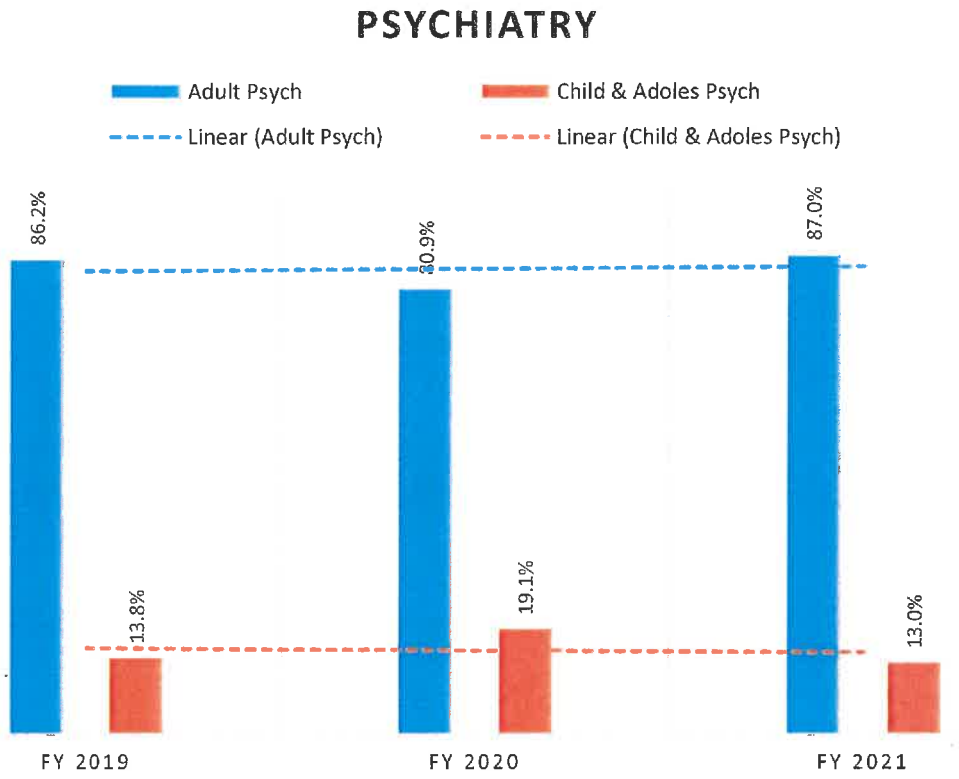
July 21, 2021

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS

None Grant Based Services

1.Project overview

a. **Project activities:** The department of Psychiatry is comprised of (4) interlinked divisions. The divisions provided an array BH/ Psychiatric services to 8,695 patients in the CCH system in the 2nd quarter of FY 2021. Out of the 8,695 patients serviced 1,295 of them were for children, adolescents, and young adults (continued care after 18 years of age with same provider service). BH/ Psychiatric services are funded through the CCH. The following table lists the divisions and programs/ clinics:



	2019	2020	2021
Adults	7404	7208	7400
Child & Adolescent	1188	1701	1295
N=	8592	8909	8695

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Division	Program/ Clinic	Worksite
Adult Psych	Bariatric Clinic	JSH
	Endocrinology	JSH
	HIV-BH	Core Ctr.
	Injection	Austin BH/ Provident BH
	MAT	Austin BH
	Medication Management	Austin BH/ Provident BH/Blue Island
	Neuropsychiatry	Provident BH
	Oncology	JSH
	Pain Clinic	Blue Island/JSH
	Psychotherapy (Indv/Group)	Blue Island/JSH/Prieto/Provident
	Telepsychiatry	Provident BH/ JSH
Child & Adolescent Psych	AYAC	JSH
	Endocrinology (Peds)	JSH
	Inpatient Consultation	JSH
	Medication Management	JSH
	Psychotherapy (Indv/ Group)	JSH
	Positive Parenting Program (Triple P)	JSH
Consult Liaison	Inpatient Consultation	JSH
	Inter-discipline BH Training	JSH
	Medical Student Teaching/ Training	JSH
ER Psych	ER Consultation	JSH/ Provident BH
	Inter-discipline BH Training	JSH/ Provident BH
	Medical Student Teaching/ Training	JSH/ Provident BH

b. The department of BH/ Psychiatry currently collaborate with Threshold Inc. in the JSH ER. Threshold assist in complex referral placement of patients requiring psychiatric hospitalization to private and public facilities. We also have a collaborative relationship with CDPH providing access to BH/ Psychiatric services to patients from underserved communities in the Chicagoland area.

c. Financial summary-quarterly investments: The department of Psychiatry expended $1.4 million quarterly (FY 2021 Annual budget $5.6 million) for Adult, Child & Adolescent, Emergency Room and Consult Liaison Psychiatric services within the CCH system. Current upward trends projects 9.2% volume increase of patient services for the past 3 years. With continued increases it will require a significant staff investment to keep (safe) pace with the current MH patient service needs.

2. As a result of introducing the telepsychiatry platform to our service menu the BH/ Psychiatry patient show rate has improved dramatically from pre-Covid period 2019. In 2019 the BH/ Psychiatry show rate was 69.4% during 2nd quarter compared with 86% for the 2nd quarter of 2021.

3. During the Covid pandemic we learned several lessons: A) Develop a staff succession plan to maintain adequate skilled staff B) Diversify service delivery methods (telepsychiatry and develop pop up BH clinics) C) Increase and enhance future collaborative community partnerships.

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4. Future Plans & Sustainability:

a) Increase the number of Prescribers

b) Integrate best practice clinic model through department "Case Conference Series"

c) Develop "Pop Up" BH Clinics

d) Develop Telepsychiatry services within ACHN sites

JRM/rr

3. **Lessons Learned**: During the COVID pandemic we learned several lessons: A) Develop a staff succession plan to maintain adequate skilled staff- Mental Health issues effected everyone during COVID, including our staff and "burn-out" and high stress were addressed during these times. B) Diversify service delivery methods were essential (Telepsychiatry and develop pop up BH clinics) and C) Increase and enhance future collaborative community partnerships- the importance of building these networks provided the linkages otherwise gaps and the lack of delivery of care would have prevailed.

4. **Future Plans & Sustainability:**

a) Increase the number of Psychotropic Medication Prescribers

b) Integrate best practice clinic model through department "Case Conference Series"

c) Develop "Pop Up" BH Clinics-provides staffing to clinics where service gaps are present

d) Develop Telepsychiatry services within ACHN sites

JRM/rr

The Behavioral Health Consortium of Illinois
Organizational Overview

The Behavioral Health Consortium of Illinois

The Behavioral Health Consortium of Illinois, LLC (BHC) includes providers of mental health and substance use disorder services for both adult and youth populations. Through its member organizations, individuals have access to a robust continuum of outpatient, community-based, and residential settings across a wide geographic area located in high need communities including the City of Chicago, as well as Western, Southern and Northern Cook County.

The Behavioral Health Consortium members currently include:

- Bobby E Wright Comprehensive Behavioral Health Center
- Community Counseling Centers of Chicago
- Family Guidance Centers, Inc.
- Habilitative Systems, Inc.
- Haymarket Center
- Heartland Alliance Health
- Human Resources Development Institute, Inc.
- Lutheran Social Services of Illinois
- Metropolitan Family Services
- Pillars
- Sinai Health System
- The South Suburban Council on Alcoholism and Substance Abuse

Purpose

The purposes of the BHC is: (a) to operate a network of clinically-integrated behavioral health service providers in Cook County and its surrounding communities who serve as preferred providers to CountyCare and other third-party payors; (b) to share best practices and promote evidence based practice for the provision of high quality behavioral health services; (c) to achieve efficiencies among the member organizations; and (d) to provide behavioral health services over a broader continuum of care inclusive of the social determinants of health.

The BHC believes that all people have the right to accessible and affordable high quality behavioral health care that prevents illness and promotes wellness. Member organizations:

- Provide quality health care that improves the well-being of the communities it serves
- Embrace the unique needs of specific communities and cultures through effective and equitable quality care and services that are responsive to diverse cultural beliefs and practices, preferred languages, and health literacy
- Seek to eliminate racial, linguistic, and ethnic health disparities and empower individuals and families to participate in their own health care
- Build consensus and coalitions around important health issues leading to innovative solutions

- Serve low-income and underserved people in the city of Chicago, as well as Western, Southern and Northern Cook County

The BHC recognizes the importance of providing and connecting the people we care for to services that impact the social determinants of health.

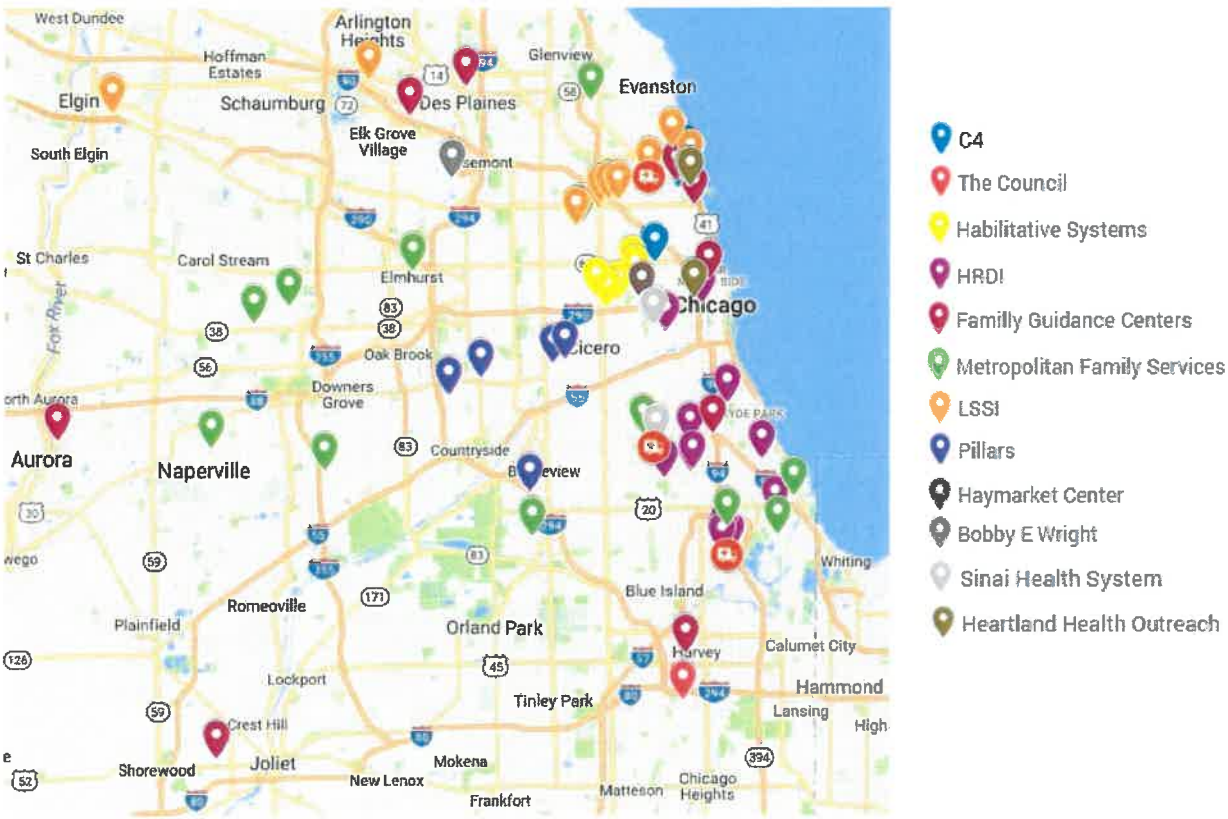
Services Currently Provided by the BHC

Member organizations are licensed Illinois Department of Mental Health (DMH) and the Department of Drug and Alcohol Services (DASA). Services provided include the following: Assertive Community Treatment; Community Support Treatment; Psychosocial Rehabilitative Services; Medication Assisted Treatment; ASAM Level I, II, III.5 Addiction Treatment Services (outpatient services; intensive outpatient/partial hospitalization services and clinically managed high-intensity residential services); Child and Adolescent Treatment Services; and Adult Mental Health Counseling.

The BHC is contracted by CountyCare to provide additional services including a Behavioral Health Access Line, psychiatric inpatient transition support services, medical detox transition support services, and learning collaboratives.

BHC Member Locations

BHC member locations span across Cook County and include over 75 office-based locations.



Behavioral Health Access Line (BHAL) - 1.844.433.8793

- **Program Overview**-CCH Behavioral Health Access Line (BHAL) established in 2017 provides information and linkage to BH services for patents who are residents of Cook County, including direct scheduling with provider members of the Behavioral Health Consortium
- **Program Description:** The BHAL line serves as an internal resource for CountyCare, ACHN, care managers, Stroger ED, and Stroger inpatient units for linking patients to BH specialty services. The BHAL operates Monday–Friday from 8:30 AM-4:30 PM- no weekends or holidays. The line is staffed by behavioral health professionals (LCSW). The line will does not serve as a crisis line, however, may provide crisis intervention for providers and patients when necessary.

  BHAL is staffed by LCSWs who are able to make an appointment for a caller within a week

  • You can call with the member or you can have them call us themselves. No referrals without the patient or the responsible party also being on the phone.

  • Voicemails are answered usually the same day or next business day.

  • Initial screening takes about 15-20 minutes and involves taking demographic information, a brief mental health and substance use history, a risk assessment and information about the presenting problem.

  • After screening, staff identify geographic preference and patient preference to determine appointment location.

  • Provider agencies have sites throughout the City and suburban cook county and services provided include:

  • Assertive Community Treatment, Community Support - Treatment, Psycho-social rehab services, Medication Assisted Treatment, an array of substance use services, mental health counseling and psychiatry.
- **Financial Investments**-supported by 2 FTE CCH LCSW staff
- **Results and Impact** -Receives about >100 calls/week and roughly 400-500 call /month.
- **Fast appointment with BHC providers within less than 1 week time-period**
- Preferred provider: The Behavioral Health Consortium of Illinois (**BHC**) is a group of providers of mental health and substance use disorders services for both adult and youth populations. • Through the BHC individuals have access to a continuum of outpatient community based and residential settings across a wide geographic area including the city of Chicago, and suburban Cook County. The BHAL staff is intricately knowledgeable about the services that this is 12 member agency can manage and therefore are able customize patients' request to the appropriate provider
- **Lessons Learned:** Initial lengthy Behavioral Health assessment was performed; however, it was considered redundant and time consuming (45min/assessment) as each BHC member upon receipt of the referral had to undergo a similar assessment often repeating the same questions. Subsequently a 10- 15min BH triage assessment was adopted in collaboration of the BHC to

streamline the process and triage the callers so that direct linkages to the referral providers more efficiently. This allowed patients to be managed faster and in receipt of BH appointments with the BHC immediately (within 24-48 hrs.).

- **Future Plans & Sustainability- Funded thru CCH**

Screening Brief Intervention Referral &Treatment (SBIRT)

Program Overview: services are based on cooperative agreement with Cook County and the State (DASA) to expand the continuum of care of screening, brief intervention referral to treatment.

2 LCSWs - universal screening, brief intervention, assessment, and referral to treatment to Hospital and health center patients.

Staff: Admin, Coordinator, Community Care coordinator, Referral Coordinators, Community Treatment Centers (provided brief treatment)

Location: County, Stroger

Program description SBIRT

The SBIRT program is a substance abuse intervention that integrates Screening Brief Intervention and Referral to Treatment (SBIRT) for at- risk alcohol and drug use patients seen in Cook County Health and Hospitals System (CCHHS). SBIRT substance abuse counselors and health care workers at CCHHS hospitals and health care centers provide nearly 900 patients per month for tobacco, alcohol, and other drugs.

SBIRT services are coordinated under the leadership of the Department of Psychiatry. The goal of the program is to intervene early and prevent problems for patients with harmful levels of alcohol and/or other substance use and increase access to specialized substance abuse treatment for patients with addiction.

Collaborators

Department of Psychiatry-Consultation/Liaison service

Cook County Health and Hospitals System

SUD Team-Stroger

Results and Impact

Provide valuable inpatient coverage for SUD issues as well as coverage for the Stroger ED

Lessons Learned

- Value of Collaboration-team work is necessary for success

- Value of Funding Sources- staffing has always been problematic due to lack of staff if one member is out than the other is overwhelmed as the sole manager of the BHAL.
- Value of Space-
- Patient Privacy-HIPAA training to staff and clients
- Value Child Care Services -often receive calls from managed care or family members regarding care for child and adolescent services, requires utilization of other community providers to support the volume of calls and expansive list of services for children.

Financial Investment-Funded through CCH

Future Plans & Sustainability:

- Develop strategies and implement monthly meetings with BHC to solidify best practices and improve processes and workflows
- Increase staffing is necessary due to growth and utilization of this resource
- Support current Staff with Development Track and Career Growth
- Collaboration between Bureau Substance Abuse Service Programs

Community Triage Centers (CTCs)

Program Overview: crisis center that serves as early intervention for those patients who are experiencing emotional stressors or Mental Health/SUD disorders pre-arrest and are recommended for treatment by collaboratively working with CPD to provide an alternative to arrest.

Program Description: Two triage centers were created to serve Southside and Westside of Chicago

- 1. **Roseland (HRD) CTC** was established in 2017 as:
    - Walk-in crisis center
    - Provide access to crisis resolution in a less intensive setting.
        - Including short term follow-up to those recently released from inpatient care; or
        - Individuals requiring additional support following a crisis to maintain stabilization and avoid inpatient admission.
    - Can also serve as an early intervention to prevent arrest through collaboration with CPD for patients with emotional stress from Mental Health or Substance Use Disorders.
    - No mobile crisis component
    - Offers a 24 hour/day, 7day/week alternative to emergency rooms.
- 2. **Westside (BEW/HSI) CTC**
    - Leverages the Roseland CTC's framework, with added elements that address opioid use disorder, including substance use disorder screening and training, distribution of naloxone kits, linkage case management, and recovery support services.
    - Includes a mobile crisis component.
        - Have administered naloxone to multiple individuals in the community following overdose.

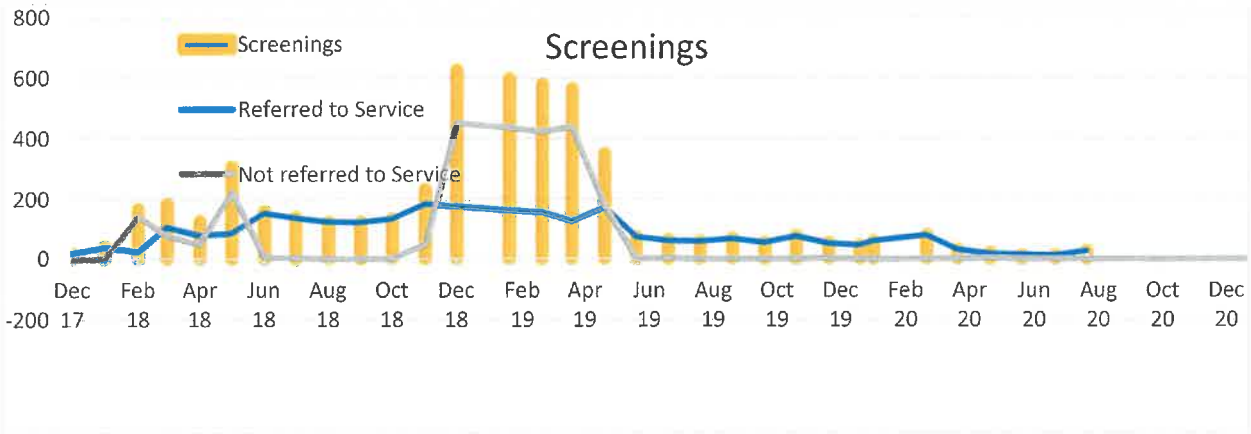
Financial Investment: Supported annually by CCH Funding.

Results and Impact

Fig 1. Number of Crisis Assessment perform- data is relative of the reduction with client encounters due to COVID:

24

Fig 2. Westside CTC data-shows a dramatic decreased volumes due to COVID and without mobile crisis resembled volumes consistent with the opening of the Westside CTC (2017)



Lessons Learned

Changes in the leadership with the new Chief of Police at Chicago Police Department underwent major re-organization at the top leadership level as well as interfered with key collaborative stakeholders to continue building the model for CIT (crisis intervention team) trained officers and the management of MH/SUD clients.

Value of Community Engagement- was used to draw attention to the CTC for behavioral health needs with targeted messages to de-stigmatize how MH/SUD are managed.

Importance of collaborating with CPD by attending beat meetings and community town halls.

Importance of educating clients, police and family members regarding the CTC and the services that are provided

Transportation for Clients who require services outside the CTC -inpatient, housing, medical care, etc.

Future Plans & Sustainability-Crisis mobile units funding is necessary but not provided based on funding. A corporate or private funding sponsor will be sought provide more support. Currently, there is no funding to sustainable the mobile crisis unit.

Cook County Health Behavioral Health Programs & Services

July 21, 2021

Grant Based Services

Grant: SOR (State-wide Opioid Response, formerly STR) "Warm-Handoff" Programming
Funder: SAMHSA
Time period: initially 7/1/2017-6/30/2018, renewed annually. Current contract through 6/30/2022
Funded amount: $1,400,000 annually ($5.6 million to date)
Co-PIs: Diane Washington, MD, Sarah Elder, LCSW CADC

1 .Project overview
This service protocol aims to increase access and coordination to substance use treatment services, including Medications for Opioid Use Disorder (MOUD) to patients located in health care settings of CCH.

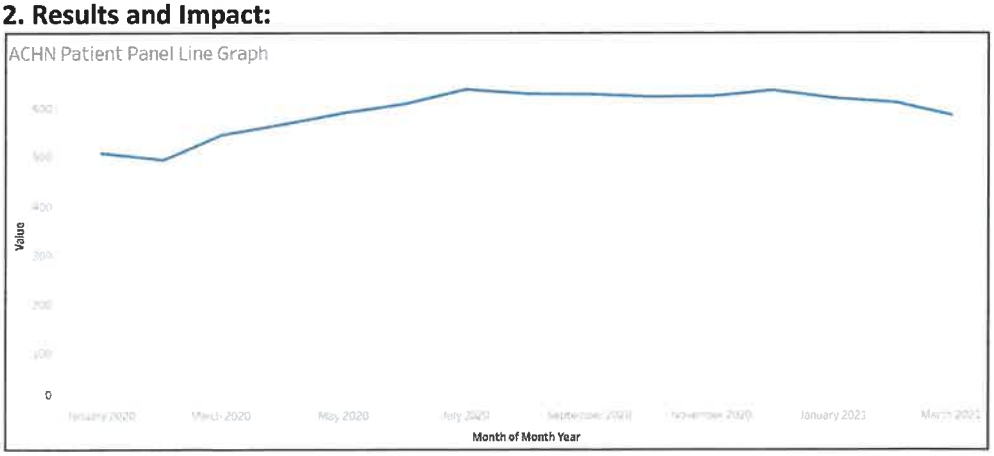
a. Project activities-

- Identify patients in settings of and ACHN, JSH ED and Inpatient settings that meet criteria for Opioid Use Disorder, Cocaine Use Disorder, and/or other stimulant use disorders.
- Provide education and brief intervention to enhance motivation for engaging in MAT and recovery services.
- Identify patients who are willing to accept referral to substance use treatment services.
- Provide assessments for patients to determine appropriate level of care.
- When appropriate, facilitate patient placement in MOUD services, including an appointment at MOUD site.
- Link patients to Care Coordination.
- Provide overdose prevention education and facilitate access to Naloxone.

b. Collaborators:
Across the settings of JSH ED, Inpatient, and ACHN, the success of this grant lies in cross- departmental collaboration. Family Medicine, Internal Medicine, Psychiatry, Nursing, Pharmacy, Social Work, Center for Health Equity and Innovation/Health Research and Solutions, Housing, etc, have all partnered to support system transformation around supporting patients with substance use and opioid use disorder.

c. Financial summary-quarterly investments
This budget funds 10 Recovery Coaches across 12 ACHN sites, 1 Social Worker on the inpatient unit at JSH, 1 Recovery Coach in the ED, 2 Recovery Coach Coordinators, and 1 Grants Data Coordinator.

2. Results and Impact:



- ACHN MAT patient volume grew by 25% during COVID, now 600 individuals/month
- 74% of patients who complete an SUD intake indicate wanting to stay with CCH for primary care. This service line, when done well and appropriately staffed, can build the CCH patient population that comes here for all healthcare needs. (source: Business Intelligence, MAT and SUD intake forms 5/1/20-4/30/21)
- 58% of patients at intake identify as African American/Black. We serve a diverse population and the population hit hardest by the overdose crisis. (source: Business Intelligence, MAT and SUD intake forms 5/1/20-4/30/21)
- 1 in 5 of our patients who complete an intake within ACHN report being on probation, parole, or EM. The justice involved population is at particularly high risk of overdose and often experience fragmented care. As the health care provider at Cermak and the ability to warmly transition coordinated care out to the community, including ACHN, we are uniquely positioned to serve this vulnerable position. (source: Business Intelligence, MAT and SUD intake forms completed in ACHN, 6/1/20-5/31/21)

3. Lesson learned

This grant touches virtually every CCH patient with opioid use disorder. The recovery coaches funded through SOR provide critical recovery support to patients during an opioid crisis and critical support to CCH providers, many of whom endorse the recovery coach intervention to be essential to their willingness to provide SUD/MAT care.

4 .Future Plans & Sustainability

To maintain current patient engagement and volume within ACHN SUD/MAT, all of these recovery coach positions will need to be maintained with extramural funding or shifted to permanent CCH positions.

Comprehensive MAT
IDHS SUPR Grant
Annual Funding, currently on 4th renewal. Period: July 1, 2021-June 30, 2022.

1.Project overview
The aim of this program is to:

- Provide education to all detainees at CCDOC with OUD on all 3 forms of FDA approved medication for Opioid Use Disorder and recovery supports
- When appropriate, initiate and maintain MOUD while detained at CCDOC
- Provide post-release care coordination and prevent overdose for individuals leaving CCDOC .

a. Project activities-
When conceptualized, the Comprehensive MAT program at Cermak was intended to deploy Recovery Coaches to various tiers of CCDOC to engage detainees, facilitate small group discussions for detainees in the pre-contemplation or contemplation stages of change, introduce recovery support services, and review myths and benefits of engaging in MOUD. From these groups, patients could self-identify to initiate MOUD while at Cermak (if not already on MOUD from the community) and sign up to engage in care coordination post-release. Detainees would complete a screening tool to help identify needs once released back to the community. Post-release, Community Health Workers (CHWs) would meet with individuals in the community to ensure that they were successfully connected to treatment or recovery support services. COVID forced our team to pivot activities as group facilitation no longer was supported given safety and social distancing measures. Our team instead focused on post-release planning and outreach efforts after someone left the jail. Additionally, our team supported reinforcing COVID-related education and supporting risk reduction.

b.Collaborator's or other organizations involved and if you were able to leverage volunteer resources to magnify grant-funded efforts.
No partner organizations are grant funded to participate in this project.
Informally, we lean heavily on partner agencies inside the jail, including: Westcare, THRIVE, Sherriff's office programming, and TASC. Once released, our care coordination team collaborates with CCH ACHN centers for buprenorphine and Naltrexone, community Methadone Clinics including Family Guidance Centers, Drexel Counseling, A Safe Haven, Haymarket, South Suburban Council, Henry's House for Sober Living, etc.

c. Financial summary-quarterly investments
The annual budget for this grant is $658,083.
Staff funded:

- 1 Recovery Coach Coordinator
- 2 Recovery Coaches
- 2 Community Health Workers (CHW)s.

Grant: Partnerships to Support Data-driven Approaches to Emerging Drug Threats
Funder: U.S. Department of Justice, Bureau of Justice Assistance
Time period: 9/2019-12/2022 **Funded amount:** $600,000
Co-PIs: Keiki Hinami, MD MS, Juleigh Nowinski Konchak, MD MPH

1 .Project overview: This grant supports partnership between health, public health, social service and criminal justice to foster data-driven collaboration around substance use disorder (SUD) care and overdose prevention. This work aligns closely with the CCH SUD program goal of optimizing access to evidence-based care and reducing overdose risk for our patients.

a. Project activities-

1) Data linkages between the Cook County Adult Probation and Cook County Medical Examiner (CCME) to estimate opioid-related mortality among individuals on adult probation.
2) Efforts to enhance CCME forensic toxicology data for surveillance of emerging drug threats and disseminate information to community partners to inform overdose prevention efforts.
3) A qualitative study of housing options for individuals on probation with SUD.
4) Data linkages between the Cook County Sheriff's Office and Cook County Medical Examiner (CCME) to estimate opioid-related mortality among individuals on electronic monitoring.

b. Collaborators:

Cook County Adult Probation Cook County Medical Examiner Cook County Sheriff's Office
Chicago Department of Public Health Chicago Police Department
Chicago Recovery Alliance High Intensity Drug Trafficking Area Program
IL Criminal Justice Information Authority
IL Division of Substance Use Prevention and Recovery Justice Advisory Council

CCH partners: Behavioral Health, Center for Health Equity and Innovation/Health Research and Solutions, Cermak Health Services, CCDPH, Emergency Medicine/Toxicology, JTDC

c. Financial summary-quarterly investments

Funding supports a project coordinator, part of the project team and data analysts' time, data linkage costs, and partners' time (Adult Probation, IL Criminal Justice Information Authority, and community outreach partner- TBD)

2. Results and Impact

Aim 1 is complete, finding individuals on probation to be fifteen times more likely to die from opioid-related mortality (ORM) than the general county population. These data have been used in probation staff trainings and quality improvement efforts around SUD treatment. Aims 2, 3, and 4 are in process.

3. Lesson learned

The effectiveness of data plus narrative at fostering opportunities for collaboration.

4. Future Plans & Sustainability

Aim 1, 2, and 4 are one-time activities not meant for sustainment. Aim 1 successfully served as a use case for data linkage between partners to improve the health of vulnerable populations, and has already created additional collaborative opportunities. Expansion of this data-linkage collaboration would require additional extramural investment. Aim 3 will require additional funding if it is to be sustained beyond 2022, TBD.

Grant: CMS Demonstration Project: Sec. 1003 of Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act
Funder: IL Department of Healthcare and Family Services
Time period: 10/2019-9/2022 **Funded amount:** $1,845,859 **PI:** Juleigh Nowinski Konchak, MD MPH

1 .Project overview: CMS' goal is to increase the treatment capacity of Medicaid providers to deliver substance use disorder (SUD) treatment and recovery services. 15 states received this planning grant, and 5 of the 15 will receive a 35-month demonstration project. IL HFS received $4.15 million for the planning grant, of which $1.84 million was subcontracted to CCH to 1) perform a needs assessment of SUD treatment for Medicaid beneficiaries and 2) to provide training and technical assistance to increase prescribing of medications for addiction treatment (MAT).

a. Project activities:
1) Needs assessment of SUD treatment for Medicaid beneficiaries- completed Nov. 2020
2) External partnerships to expand MAT, create trainings, and implement state-wide resources.
3) Internal partnerships to expand MAT access throughout CCH clinical sites and departments.

b. Collaborators:
CCH: Adolescent Medicine, Behavioral Health, Center for Health Equity and Innovation/Health Research and Solutions, CCDPH, Emergency Medicine, Family and Community Medicine, Internal Medicine, OB/GYN, Policy, Preventive Medicine, Psychiatry, Toxicology
External:
AMITA Health, Carle Foundation, Gibson Area Hospital, Health Resources in Action, Heartland Alliance, IL Society of Addiction Medicine, PrimeCare Community Health, Rush University, subject matter experts, UI Health

c. **Financial summary-quarterly investments:**
Part of project team's time plus a newly hired behavioral health training coordinator

2. Results and Impact (Jan-May 2021)
Statewide:
- 14 newly active buprenorphine prescribers
- 57 healthcare providers receiving MAT technical assistance & 84 clinicians receiving experiential MAT training
- 1,138 attendees at MAT trainings
- Development of clinician resources on the IL Helpline for Opioids and other substances.

Highlighted CCH activities:
- Optimization of MAR assessment, initiation, and referral for emergency department, ambulatory, and hospitalized patients, including special populations (i.e. pregnant patients).
- Developed workflow for new MAT prenatal clinic, implemented multidisciplinary MAT/SUD case rounds on inpatient service, and expanded QI efforts for buprenorphine Bridge clinic serving patients referred from crisis settings to transition to ACHN, including toxicology fellow engagement.
- Cross-department collaboration re: resident and attending MAR training, with implementation of a required addiction medicine rotation for junior family medicine residents and planning for curricula for internal medicine residents and senior family medicine residents.
- Piloted MAR chart review tool for QI in Family and Community Medicine

3. Lesson learned, Future Plans, & Sustainability:
The state will take over maintenance and sustainment of the statewide resources.

Grant: The Comprehensive Opioid, Stimulant, and Substance Abuse Site-based Program
Funder: U.S. Department of Justice
Time period: 10/2020-09/2023 **Funded amount:** $1,200,000 **PI:** Juleigh Nowinski Konchak, MD MPH

1 .Project overview
This project brings together stakeholders from the housing continuum, substance use disorder (SUD) treatment, criminal justice, and public health sectors to address recovery housing capacity; develop a regional recovery housing information system; and implement and evaluate an intervention to promote referral to medications for addiction treatment, recovery housing, and recovery and psychosocial support for individuals with SUD. This work aligns with the CCH SUD program goal of optimizing access to evidence-based care for our patients and CCH's housing program goals of addressing gaps in the housing continuum for our patients.

a. Project activities-

1) Establish a learning and action network (LAN) to bring together key stakeholders in SUD care for justice-involved individuals to identify challenges with navigating recovery housing and transitional housing and inform the development of the interventions proposed in the grant.

2) Pilot a web-based regional recovery housing information system with two recovery home partners and the State's Division of Substance Use Prevention and Recovery to enable real-time identification of vacancies in recovery homes for individuals seeking housing.

3) With partners, conduct a feasibility study for a low barrier, harm reduction and recovery-oriented, transitional housing model for justice-involved individuals with SUD to address gaps in the current recovery housing landscape. This model may be piloted in years 2 and 3.

4) Fund recovery home beds for CCH justice-involved patients.

b. Collaborators:

All Chicago	Cook County Adult Probation	Cook County Public Defender's Office
Cook County Sheriff's Office	Cook County State's Attorney's Office	
Family Guidance	Heartland Alliance	Henry's House
IL Criminal Justice Information Authority	IL Division of Substance Use Prevention and Recovery	
IL Helpline for Opioids/other substances	Lighthouse Institute of Chestnut Health Systems	
Lutheran Social Services of Illinois	Salvation Army	WestCare Foundation

CCH: Behavioral Health, Center for Health Equity and Innovation/Health Research and Solutions, CCDPH, &Psychiatry
Grant funds are augmented by the State's investment in the Illinois Helpline and the State's ongoing funding of recovery homes. Additional funding is being explored by partners to support the harm reduction housing pilot.

c. Financial summary-quarterly investments
Grant funding supports part of the salaries of the project management team (C. Haley, K. Hinami, & J. Nowinski Konchak). A project coordinator and a recovery coach are in the hiring process. Partners are funded to participate in the LAN, accept patients at recovery homes when other funding sources are N/A, conduct the feasibility study, evaluate the project, and potentially pilot the low-barrier transitional housing.

2. Results and Impact
We have mobilized partnerships to meet deliverables, with contracts in process. The first LAN meeting is 8/5/21.

3. Lesson learned, Future Plans & Sustainability
We are in the early implementation phase. The recovery home information system work does not require financial support from the grant for sustainment. The recovery coach and project coordinator positions will need to be maintained with extramural funding or shifted to permanent CCH positions.

Lost To Care Alert System (LCAS)/OD2A

CDC's Overdose to Action Cooperative Agreement which is a 3 year funding commitment through September 20221 .

Project overview

Medication for Addiction Treatment (MAT) including agonists like methadone and buprenorphine, and the antagonist naltrexone is the primary evidence-based treatment for Opioid Use Disorder (OUD) (1). A recent authoritative meta-analysis showed that mortality risk is mitigated while taking MAT, but is expectedly elevated during periods of treatment non-adherence or relapsed illicit use; the pooled risk of opioid overdose mortality was 0.24 (0.20-0.28) among patients receiving MAT, 0.68 (0.55-0.80) after cessation of MAT, and 2.43 (1.72-3.15) for untreated periods; moreover, retention in treatment for >1 year compared to ≤1 year was associated with a lower mortality rate (1.62 (1.31-1.93) vs. 5.31 (-0.09-10.71)), underscoring the importance of efforts to sustain patient engagement in care (2). Unfortunately, periods of non-adherence to MAT treatment is common, where about half of patients on buprenorphine, for example, fall out of care within 4-6 months (3). Interventions to re-engage patients who are lost to MAT have not been widely published. However, among patients living with HIV/AIDS, who similarly experience the lost-to-care phenomenon, the use of patient navigators (4, 5) and eHealth interventions (6, 7) appear promising. A local innovation that adds to these strategies is a real-time alert system that was associated with a 58-86% re-engagement rate in the Cook County Health system (8). The goal of the present research proposal is to adapt the local real-time alert system to re-engage patients lost-to-MAT-care, implement the system in Cook County Health, and to conduct an outcome evaluation. The Cook County Department of Public Health funds this initiative through Overdose Data to Action grant funding, which is multi-year grant funding from the Centers for Disease Control and Prevention (CDC).

a. **Project activities**

- On May 24th, the pilot of this program launched. ACHN Recovery Coaches began receiving text and email alerts for patients out of care greater than 10 days. Once an alert is a received, the coach begins outreach to invite a patient back in to care.
- The next arm of the LCAS will be turning on real-time alerts to our ACHN Recovery Coaches when a patient lost to care is registered at JSH Emergency Room. At time of the alert, a Recovery Coach in the ED will be able to initiate a bedside engagement to invite that patient back into MAT care.
- The third arm will be to utilize the above model to alert a coach at Cermak when a patient is registered to the jail.

These touchpoints (ED and Cermak) allow a Recovery Coaches to leverage these points in a patient's care as a "teachable moment" to leverage engagement. Currently, we are unable to turn on this mechanism in the LCAS due to inadequate staffing levels in these areas.

b. Collaborator's or other organizations involved and if you were able to leverage volunteer resources to magnify grant-funded efforts.

While not supported formally by grant funding, currently, CCH is having exploratory conversations to expand the LCAS delivery with community partners. Family Guidance Center and Haymarket have both offered to deploy Recovery Coaches in the settings of our emergency rooms at Stroger Hospital and Provident. With the appropriate privacy agreements in place, the LCAS would identify individuals in care with both of these entities and if an individual was lost to care from the respective entity and registered in the associated ED, an alert to the FGC or Haymarket Coach would fire, directing the coach to initiate a bedside intervention to navigate the individual back to care.

c. Financial summary-quarterly investments

Implementation and evaluation of the LCAS is funded by the CDC's Overdose to Action Cooperative Agreement which is a 3 year funding commitment through September 2022. Beyond the fixed implementation cost, LCAS operates with minimal maintenance and, thus, negligible operating cost. Furthermore, LCAS is designed to support the routine activities of CCH recovery coaches through automation of several of their tasks. For these reasons, LCAS is expected to remain operational well beyond the funding period.

2. Results and Impact

In the first month of implementation LCAS identified over 200 out-of-care patients and created a registry that is being used by CCH Recovery Coaches in their outreach efforts. In addition, we generated alerts for 3 distinct out-of-care patients who were registered in the Stroger emergency department in the month of June. Future evaluation will assess the ability of Recovery Coaches to successfully engage these patients back into care.

There have already been several success stories following the launch of the LCAS system with our ACHN recovery coaches. One patient who was lost to care, identified through the LCAS and received an outreach call from our ACHN Coach. When our coach reached out to the patient, the patient reported she had lost the clinic's phone number and our coach was able to schedule her for an appointment with the provider the next day. She was so thankful the coach had outreached to her.

In addition to the alerts coaches receive to initiate outreach to patients lost to care, the partnership between data staff and program staff has allowed the build of the system to serve to support quality assurance around programmatic activities coaches are tasked with completing. The system supports reminders for coaches to complete specific documentation at a patient level as required by the Joint Commission.

3. Lesson learned

As with any new program, the build and implementation of the LCAS system came with some challenges and required team members to quickly identify challenges, propose solutions, and work with the data and software team to make improvements to the system. The collaboration and partnership between program staff and the data team was instrumental and effective. We

have learned how important this collaboration is as well as how innovative and effective technology solutions can be to support a vulnerable population.

4. Future Plans & Sustainability

LCAS is associated with minimal operating cost by design, allowing the current system to function indefinitely. However, our plan is to use LCAS as a platform on which future grant funding may allow the implementation of new features. These new features include the capability to send embedded links directly to patient's mobile devices that could simplify scheduling of future clinic appointments.

Grant: K12 Chicago Center of Excellence in Learning Health Systems Research Training (ACCELERAT) Program award
Funder: Agency for Healthcare Research and Quality, through Northwestern University
Time period: 1/2021-12/2022 **Funded amount:** $338,662
PI: Juleigh Nowinski Konchak, MD MPH **Primary Mentor:** Bill Trick, MD

1 .Project overview:
This program provides scholars with protected time for learning health systems-related research and training, with an expectation of a successful independent research award upon completion of the program. This project develops a regional learning health system approach to substance use disorder (SUD) care among community corrections-involved individuals in Cook County. This work aligns with the CCH SUD program goal of optimizing access to evidence-based care for our patients. 19.7% of the more than 450 SUD intakes performed at ACHN (6/1/2020-5/31/2021) were with patients on probation, parole, or electronic monitoring (source: Business Intelligence).

a. Project activities:
Aim 1: **Implementation of strategies to increase referrals by adult probation to SUD treatment partners who offer medications for addiction treatment (MAT).** Launch and evaluate a pilot program for probation officers involving training and utilization of a new workflow for referrals to SUD care, using the IL Division of Substance Use Prevention and Recovery's treatment locator resources.

Aim 2: **Refine and pilot a patient reported outcomes (PRO) tool to address stigma within CCH clinical care for justice involved patients with SUD.** Utilize the 4+ years of patient-reported outcomes within the CCH SUD program, with input from patients, recovery coaches, and providers regarding best use of these data to inform care.

Aim 3: **Create a data-sharing infrastructure for a CJ-SUD regional learning health system.** A CCH, CCME, and Cook County Sheriff's Office partnership to estimate opioid-related mortality (ORM) among individuals on electronic monitoring. This activity may serve as a catalyst for a broader data-linkage infrastructure.

b. Collaborators:
Illinois' Helpine for Opioids and other substances
Cook County Sheriff's electronic monitoring program
Cook County Adult Probation
Northwestern University
Grant funds are augmented by the State's investment in the Illinois Helpline and other CCH SUD-related grants.

c. **Financial summary-quarterly investments:**
Part of PI's time, part of Ms. Huiyuan Zhang's time (research analyst), research software, and training.

2. Results and Impact
We are 6 month into this 24 month research/training program. Aim 1 is IRB approved and will launch in August. Aim 2 and 3 will undergo IRB review in coming months. One manuscript is under review, another is being revised for resubmission, and this work will be presented at the 2021 American Public Health Association conference. These efforts have fostered trust, partnership, and collaboration between arms of the Cook County government around the shared goal of improved outcomes for justice-involved individuals with SUD. PI has received formal training in implementation science research will benefits this and future work at CCH.

3. Lesson learned
Research embedded within a complex delivery system is dynamic, and change can be positively embraced.

4. Future Plans & Sustainability:
The PI will apply for additional research funding for CCH to continue this work prior to the completion of the training program. This is an expectation of the training program.

SAMHSA Women's Re-Entry
Funding Period: 1/15/20-1/14/2025

1.Project overview

The Cook County Offender Reentry Program's (CCORP) focus over the next five years is to expand and sustain community treatment and services for 475 women offenders/ex-offenders with a substance use disorder (SUD) or SUD with co-occurring mental health disorder who are returning to Cook County, Illinois (IL) from the Logan Correctional Center ("Logan"), an Illinois Department of Corrections' (IDOC) female prison, and who face barriers accessing and remaining engaged in care. More than two-thirds of the women (68%) at this facility have a severe SUD.

a.Project activities

- Women with SUD currently at Logan, Decatur, or Fox Valley Correctional facilities, returning to Cook County and open to treatment (i.e recovery homes, IOP or OP) services at Haymarket are navigated to treatment services.
- Women who enroll in the program are paired with a care coordinator who provides a gender-responsive, trauma informed care coordination model.
- Women enrolled in the program are eligible for Medicaid application support via one of CCH's financial counselors.

b.Collaborator's or other organizations involved and if you were able to leverage volunteer resources to magnify grant-funded efforts.

Haymarket and the Women's Justice Institute are supportively funded for this initiative.

c. Financial summary-quarterly investments

The 5 Year budget for this grant is $2,125,000. This funds CHW from CCH personnel, a care coordinator from the Women's Justice Institute, a project Director from Haymarket and recovery home beds at Haymarket.

In addition to CCH resources, The Women's Justice Institute (WJI) also received a Pritzker foundation grant to expand care coordination resources, personnel, training, and re-entry supplies for women (i.e. toiletries, bus cards, etc).

2. Results and Impact

The funder-established target for the SAMHSA Re-entry program is to navigate 108 women per year from Logan, Decatur or Fox Valley Correctional Centers to Haymarket services for recovery home beds, IOP or OP for substance use disorder. Due to COVID, our ability to recruit for this program has been significantly impacted as the correctional centers have been closed to external visitors for most of this year. To date, we have successfully navigated 30 women to SUD services at Haymarket and provided them with care coordination services.

While COVID has stunted our ability to provide direct services to women being released from these correctional settings, much progress has been made to strengthen collaborations across institutions including IDOC, Illinois Parole board, the Women's Justice Institute, Haymarket, and Cook County Health. These large systems have teamed together to provide a gender-

responsive, trauma Informed care coordination model that is comprehensive and incorporates the woman's voice, goals, and strengths to the care plan. Women's Justice Institute provided gender-responsive training to 6 ACHN social workers, a Care Coordinator at Cermak, and one CCH Community Health Worker.

3. Lesson learned

The primary challenges for this grant have also been the strengths. While this grant has formal and funded support to partner with Haymarket and WJI, the success of this grant has also required partnering with IDOC, parole, and other partners. Developing one model which all parties have stake, support, and responsibility for requires ongoing efforts by all.

4 .Future Plans & Sustainability

This work will only be sustainable (and potentially expandable) if these positions within the SUD program (recovery coaches and CHWs) are maintained or expanded. We will need to maintain extramural funding or shift these to permanent CCH positions. Additionally, funding to support the medications and the administration of these medications by pharmacy or nursing staff is necessary for sustainability.

Program Overview: Justice Mental Health Challenge (JMHC)

Program Description: to expand efforts to reduce the cycle of incarceration for individuals with mental illness or substance use disorder in Cook County for the Justice and Mental Health Collaborative. CCH is partnering with multiple stakeholders for this effort: Cook County Office of the Chief Judge, State's Attorney's Office, Public Defender's Office and community partners: Bobby E. Wright Behavioral Health and HRDI. CCH and partners propose an evaluation and strategic expansion of the misdemeanor diversion court program to other branch courts, thereby safely diverting more people with mental health and co-occurring mental illness (MI) and substance abuse (CMISA) from unnecessary incarceration and enhancing linkage to services at these critical intercepts.

Collaborators:

CCH

Cook County for the Justice and Mental Health Collaborative

Cook County Office of the Chief Judge,

State's Attorney's Office,

Public Defender's Office

Community partners: Bobby E. Wright Behavioral Health and HRDI

Financial Investments: Federal US Dept of Justice 750K over 2-year period

Results and Impact

This initiative has been hampered by COVID related issue and the management of the court offices that were not open during this period. Currently the courts are not operating in full capacity. SO some innovative strategies were the utilization of providing "virtual MH Courts" to better manage the pandemic. Collaborating with Chief Judges' office, States attorneys, Public Defenders and 2 Community agency BEW and HRDI we are currently working to build the model and staff it appropriately. A small pilot has some its feasibility, however, we will need to secure approval from MacArthur Foundation and US Justice Office for this shift from in-person participation with client to the virtual platform. The model requires intricate flexibility and short-term scheduling request from the Judges for cases to be reviewed by the virtual capacity.

This strategy is receiving lot of accolades and has been used in other large counties (LA County) during the COVIC period. We have a group of Judges that want to move this capability forward currently and for the future.

The often unpredictability of when the cases are called can be cumbersome as staff is waiting to be called by the judges to provide supporting information about the clients history and current treatment plans. Some virtual courts are busier than others dependent on the high traffic areas in the city and suburbs.

Future Plans & Sustainability: Funded and by US. Department of Justice, Office of Justice Programs and Mac Arthur Foundation. Currently in currently in year 2 of the grant. Currently looking for sustainable options via the MacArthur Foundation or other federal resources. Also looking at remuneration models where this work can be sustained for via generation of billable services.

Project Overview: MEND

MEND is unique in its intensity and efficacy in serving families whose lives have been upended by a child's serious chronic condition. The program works best when interlaced with the pediatric specialty clinic so that families can be connected to the program before they leave the doctor's office. (Referrals without that direct, immediate connection have not proven to be successful.) Since the family systems training typical of Marriage and Family Therapists is essential to the program's success, the innovation of bringing those Community Mental Health Clinic services on campus (not typically available in hospital or medical outpatient settings) has also proven to be essential to the program's success. The partnership with Lutheran Social Services Inc. (LSSI) also enables support from Medicaid for ongoing sustainability.

Project Activities:

CCH serves families at the edge of our social safety net, and our parents often hold jobs that do not provide the flexibility required to adequately care for a chronically ill child. The pandemic significantly increased stress in situations where stressors was already at a maximum. To the extent that we can enable children to better care for themselves and empower parents to learn more effective ways to support their children, helps all concerned to develop the confidence to better manage these conditions. Ultimately, our families will gain more resilience in the face of all external stressors, including the pandemic. MEND is at the end of its second year and is utilizing a virtual platform with hopes to bring the individual and group and family sessions back onto the Stroger campus.

Results and Impact:

Fig. 1 MEND Dashboard

2021	JAN	FEB	MAR	APR	MAY
Referrals received	13	4	24	21	14
Contacted	6	4	12	18	8
Scheduled Intake	2	2	4	12	7
Pre-Teens (8-12)	9	20	11	15	5
Teens (13-18)	3	7	2	3	4
Families therapy	36	40	44	48	12
Family/Individual	20	28	22	10	8

Lessoned Learned:

Teen group (ages 13-18) is the hardest to group to engage in activities. Many strategies such as working directly with the Pediatric Specialty Physician who initiated the referral and providing a "warm hand off"

during the clinic visit have shown slight improvement in volume, however, numbers are still staggered despite full engagement from the teens' parents during the Family sessions. Currently exploring incentivizing strategies. This was problematic and reflective in the general number during COVID

Low-income families often to do not receive this level of individualized care and parent support.

Education models that have been implemented for the parent groups allows sharing of experiences and promoted shared accountability amongst them

After hours provided the ability for parent to attend therapeutic session as this did not impose or interrupt their work schedules.

Face to face encounters provide a more tangible shared experience for the children towards Ambassadorship a targeted designation through this process.

Financial Investments: Project funding of 249K has completely utilized

Funding was provided by Illinois Children Healthcare Foundation (ICHF)

Corporate funding from Meridian Health Plans

Lessons Learned:

COVID made innovative approach to continue treatment for these children, so a virtual ZOOM platform allowed the program to deliver services.

Despite the shut down of in person participation the parent and children were invested in utilizing this platform.

The difficulties occurred when competition for ZOOM participation from schools became exhaustive to commit to attendance, however, we were able to use evening hours and specific days to break up the monotony of virtual overload.

Committed staff and providers to collaborate to assure participation in the MEND program was essential treatment intervention to receiving their medical care.

Future Plans & Sustainability-New funding source is required to continue the good work of this program. Nine months of program funding to support immediate expansion is required to enabling transition to sustainable funding via Medicaid: $140,140

Project Overview: Chicago Westside Early Diversion Program (CWEDP)

Project activities:

The Chicago Westside Early Diversion Program (CWEDP) aims to divert and prevent, over one year, 500 people with serious mental illness (SMI), substance use disorder (SUD) or co-occurring disorder (COD) who have experienced or are at high risk of experiencing mental health crises from contact with detention, connecting them to community-based behavioral health treatment and services.

The CWEDP will target Chicago Police Department (CPD) Districts 11 and 15, areas within the Westside of Chicago that are near the Westside Triage and Wellness Center (a partnership between Habilitative Services Inc., Bobby E. Wright Comprehensive Behavioral Health Center and Cook County Health & Hospital System) and disproportionately experience SMI, SUD and COD. CCH and the CPD, under the support of the Cook County Safety and Justice Challenge, will lead the CWEDP project. CCH is the safety-net healthcare provider for the 5.2 million residents of Chicago and suburban Cook County, IL.

The CPD is comprised of 25 police districts and serves approximately 2.9 million residents. In 2017, there were 5,270 mental health-related dispatches within the target area, comprising 26% of all mental health-related dispatches in Chicago[1]. In 2014, the rate of hospitalizations due to substance use or mental health disorders in the target area was 195.4 per 100,000 persons (versus 176.3 per 100,000 in Chicago). The total population of the target area is about 500,000 people and they tend to be minorities and of low socioeconomic status—16.5% of the population do not have insurance (versus 3.2% in Chicago) and 27.6% of individuals live below the poverty line (versus 20.9% in Chicago). Forty-five percent are male, and 10.4% are Non-Hispanic White, 78.6% Non-Hispanic Black, 0.5% Non-Hispanic Asian/Pacific Islander, and 9.3% Hispanic. About 5% of people within the target population are foreign-born and 3.6% have limited English proficiency[2]. In Chicago, 4% of adults identify as gay or lesbian, the number identifying as transgender or bi-sexual is small[3]

Collaborators:

Bobby Wright/Habilitative Services Inc.,

Chicago Police Department

Cook County Health

Results and Impact:

Fig 1. Describes the types/ services that were provided

ogram	Cohort	Grant ID	FFY	FFQ	Indicator	Number	Result Name	Result Description
EDP-rly version	EarlyDiv02	SM80512	2021	1	WD2	22	CPD Training	From 10/1-12/31 2020, we trained CPD officers and 4 non-CPD officers Basic CIT training. Please note, thes members were trained in our COVII alternative training schedule. This means they completed 3 days of classroom training; in 2021, officers complete the remaining 2 days befc the end of June 2021.
EDP rly version	EarlyDiv02	SM80512	2021	1	S1	111	Assessment Screenings	Clients brought to the Triage Cente Chicago Police were administered t NOMS assessment designed for Sou Side Diversion.
EDP rly version	EarlyDiv02	SM80512	2021	2	S1	111	Individual screenings	Number of individuals brought in fo Crisis assessments by CPD.
EDP rly version	EarlyDiv02	SM80512	2021	1	R1	131	Post Assessment Referrals	Every client assessed received a ref for services beyond their initial crisi contact with Chicago Police Department.
EDP rly version	EarlyDiv02	SM80512	2021	2	R1	131	Referral for mental health treatment	Number of clients referred to ment health services after crisis assessme completed

Financial Investments –SAMSHA/MacArthur Funding

Lessons Learned:

Working with CPD in the midst of changes in Commander in Chief and the changes that occur when new leadership takes over.

Community engagement is essential piece in the vison of the community and how the partnership are established and open to assist are patients who are in emotional stress or having mental health issues

Partnership with the Safety Justice Challenge should have been more defined in order to be effective with similar strategies.

Future Plans & Sustainability-Carry-over request for funding to support the development of Wellness Model to be incorporated.