Cook County Behavioral Health Continuum of Care

RECOMMENDATIONS FOR STRATEGIC DIRECTION TO COOK COUNTY HEALTH & HOSPITALS SYSTEM

Preliminary Draft: Options for Formulating Future Actions
Scope of Project and Recommendations

In February 2015, Cook County Health & Hospitals System (CCHHS) engaged Health Management Associates (HMA) to provide a strategic review and assessment of its behavioral health continuum of care including:

• Review of outpatient and inpatient mental health services and sites, including the Cermak facility
• Environmental scan of national and state health care policy changes and trends
• Interviews with internal and external stakeholders
• Review of CCHHS documents, data sets and other publicly available information on the current behavioral health delivery system
• Identification of strategic recommendations for behavioral health care within CCHHS
# CCHHS Behavioral Health Services Steering Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virgilio Arenas MD</td>
<td>Addiction Psychiatrist</td>
</tr>
<tr>
<td>Christine Brown MSW, LCSW, ACM</td>
<td>Director – Social Service/ACHN</td>
</tr>
<tr>
<td>Debra Carey</td>
<td>Chief Operating Officer for Ambulatory Services</td>
</tr>
<tr>
<td>Michael Colombatto PsyD</td>
<td>Director of Behavioral Health, ACHN</td>
</tr>
<tr>
<td>Krishna Das MD</td>
<td>Chief Quality Officer</td>
</tr>
<tr>
<td>Doug Elwell</td>
<td>Deputy Chief Executive Officer of Finance and Strategy &amp; Interim Deputy CEO of Operations</td>
</tr>
<tr>
<td>Claudia Fegan MD</td>
<td>Executive Medical Director</td>
</tr>
<tr>
<td>Steven Glass</td>
<td>Executive Director of Managed Care</td>
</tr>
<tr>
<td>Andrew Segovia Kulik MD</td>
<td>Interim Chair, Psychiatry</td>
</tr>
<tr>
<td>Mark Loafman MD</td>
<td>Chair, Family and Community Medicine</td>
</tr>
<tr>
<td>Juleigh Nowinski Konchak MD</td>
<td>Preventive Medicine Residency</td>
</tr>
<tr>
<td>Mary Sajdak</td>
<td>Senior Director, Integrated Care</td>
</tr>
<tr>
<td>Agnes Therady</td>
<td>Executive Director of Nursing</td>
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</tbody>
</table>

**PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS**
National Trends in Behavioral Health

**Importance of Mental Health.** Untreated depression and other serious mental illness have both a negative financial and health impact; early identification and access to treatment for these disorders can lead to improved outcomes.

**Integration.** Health systems and communities are realizing an integrated behavioral health strategy is essential to achieving the Triple Aim (improving patient experience of care, improving the health of populations and reducing cost). Behavioral health care is becoming more accessible and connected to the broader health care system.

**Health Disparities.** Other factors such as race/ethnicity, income level, geographic location, and insurance status are key determinants of disparities in both physical and behavioral health across populations and specifically within the populations served by CCHHS. Amid the focus on the health disparities of adults and youth with behavioral health disorders, state and federal policy makers have paid particular attention to quality and coordination of care.

**Managed Care.** Reimbursement to and by managed care organizations is incentivizing, using bonus payments or sharing savings across providers, attention to the holistic health care needs of individuals through improved care coordination across primary care, behavioral health, and other specialty providers.

**Diversion.** As community-based mental health services have been challenged to meet the service needs, many believe law enforcement departments and jails have become de facto service providers to persons with behavioral health disorders. Jail diversion programs have emerged as a viable alternative to the criminalization and inappropriate criminal detention of individuals with mental health and substance use disorders. In addition, several models for addressing re-entry into the community following incarceration have been found helpful in reducing recidivism for these individuals.
State and County Behavioral Health Context

- Budget cuts result in reduced capacity and limit eligibility for services
- Delayed state payments further incapacitate community behavioral health organizations

- City of Chicago closes 50 percent of behavioral health clinics mostly on the south and west sides of Chicago
- Capacity for services to uninsured in Chicago reduced significantly

- Consent decrees further limit eligibility for services and restrict capacity to non-class members in publicly funded system of care

- ACA provides Medicaid to an estimated 86,000 newly eligible people living with a mental illness in Illinois

- 100 percent of Cook County Medicaid recipients enrolled in Medicaid managed care
- More BH Providers close doors due to multiple challenges within changing environment

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS
Impact of the State System for CCHHS

Since 2009, the impact of these changes include:

• Emergency room visits for people experiencing psychiatric crises increased by 19 percent between 2009 and 2012. If the year following the closure of the city clinics is included (through 2013), 37 percent more people were discharged from emergency rooms for psychiatric treatment.

• Studies show that between 20-60 percent of incarcerated individuals have a mental illness.

• The National Alliance to End Homelessness estimates that approximately 32 percent of the 14,144 individuals who currently experience homelessness on any given night in Illinois have a serious mental illness.

The FY2016 proposed Illinois budget, which includes significant cuts to Medicaid and other publically funded mental health services will continue to impact behavioral health services and the individuals living with serious mental illness.
As a result of these system changes, more newly insured and others with behavioral health conditions are seeking care within the CCHHS system.

Many of these individuals have been unable to access services in the community and as a result are seeking care in crisis through the ED.
CountyCare

In late 2012, Illinois obtained a Section 1115 demonstration waiver that allowed the state to get an early start on the Affordable Care Act (ACA) Medicaid expansion for adults in Cook County.

The demonstration was designed to help the state and CCHHS build capacity and experience to support implementation of the expansion in 2014 and get a jump-start on enrollment.

CCHHS incorporated the new health plan as CountyCare.

Over 618,000 uninsured adults are estimated to be eligible for the ACA’s Medicaid expansion in Illinois, with over 341,000 of them residing in Cook County. CCHHS serves as a large public hospital system and a key safety-net provider for the low-income uninsured population in Cook County.
## Top 1 Percent of CountyCare Members by Average Total Cost and IP/ED Utilization

<table>
<thead>
<tr>
<th>Volume Ranking</th>
<th>Diagnosis/Condition</th>
<th>Count of Members</th>
<th>Average of Total</th>
<th>Maximum of Total</th>
<th>Minimum of Total</th>
<th>Average of IP</th>
<th>Average of ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Psychiatry - Psychotic and Schizophrenic Disorder</td>
<td>77</td>
<td>$26,670</td>
<td>$103,924</td>
<td>$7,466</td>
<td>3.8</td>
<td>7.8</td>
</tr>
<tr>
<td>2</td>
<td>Cardiology - Ischemic Heart Disease</td>
<td>75</td>
<td>$34,030</td>
<td>$205,728</td>
<td>$9,912</td>
<td>1.8</td>
<td>2.5</td>
</tr>
<tr>
<td>3</td>
<td>Psychiatry - Mood Disorder, Depressed</td>
<td>68</td>
<td>$25,318</td>
<td>$85,442</td>
<td>$7,432</td>
<td>4.1</td>
<td>7.3</td>
</tr>
<tr>
<td>4</td>
<td>Psychiatry – Mood Disorder, Bi-Polar</td>
<td>63</td>
<td>$25,936</td>
<td>$71,332</td>
<td>$8,382</td>
<td>4.8</td>
<td>9.4</td>
</tr>
<tr>
<td>5</td>
<td>Cardiology- Cardiovascular Diseases, Signs and Symptoms</td>
<td>62</td>
<td>$23,972</td>
<td>$112,591</td>
<td>$7,500</td>
<td>1.8</td>
<td>7.5</td>
</tr>
<tr>
<td>10</td>
<td>Chemical Dependency – Alcohol Dependence</td>
<td>45</td>
<td>$25,508</td>
<td>$146,324</td>
<td>$8,165</td>
<td>4.9</td>
<td>10.7</td>
</tr>
<tr>
<td>14</td>
<td>Psychiatry- Organic Drug or Metabolic Disorders</td>
<td>35</td>
<td>$20,703</td>
<td>$56,402</td>
<td>$7,575</td>
<td>6.7</td>
<td>6.5</td>
</tr>
<tr>
<td>38</td>
<td>Chemical Dependency – Acute Alcohol Intoxication</td>
<td>12</td>
<td>$28,677</td>
<td>$77,182</td>
<td>$11,539</td>
<td>2.3</td>
<td>27.8</td>
</tr>
</tbody>
</table>

**SOURCE:** CountyCare Health Plan, Executive Committee, May 26, 2015 (July 2014 – March 2015 Claims)
High Emergency Room and Inpatient Utilization at CCHHS for Behavioral Health

Total Number of Patients receiving Behavioral Health Services: 79,508
January 1, 2013 – April 1, 2015 (27 months)

- Number of Individuals with Admissions: 10,206
- Number of Individuals who visited the ED: 21,079
- Number of Individuals with High IP Utilization (>=10 visits): 17
- Number of Individuals with High ED Utilization (>=20 visits): 36
- Mean: 1.35
- Mean: 1.67
- Range: 1-20
- Range: 1-67

Data Represents Individuals with a Behavioral Health Diagnosis at Any Diagnostic Level (Primary, Secondary, Tertiary, etc.)

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS
IP Visits by Behavioral Health Diagnosis, January 1, 2013 – April 1, 2015

CCHHS BH Encounters

- Alcohol: 31%
- Cocaine: 10%
- Opioid: 16%
- Depression: 14%
- Bipolar: 5%
- Anxiety: 9%
- Other MI: 5%
- Paranoid/Psychotic: 1%
- Schizophrenia: 4%
- Other Substance Abuse: 5%

N = 10,206

CCHHS BH High Utilizers (≥ 10 Admissions)

- Alcohol: 23%
- Cocaine: 9%
- Opioid: 18%
- Bipolar: 12%
- Anxiety: 8%
- Depression: 9%
- Other Substance Abuse: 9%
- Paranoid/Psychotic: 2%
- Schizophrenia: 1%

N = 17

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS
CCHHS Behavioral Health Service Resources

Emergency Department (ED)

• CCHHS currently provides crisis mental health and substance abuse services within the Stroger Emergency Department utilizing multiple providers from both within and outside its network.

• The Department of Psychiatry provides limited screening, brief intervention, and referrals to treatment for substance use related concerns through its SBIRT Team.

• The Department also provides psychiatric consultation to ED staff, primarily telephonically, to support assessment and medication interventions by ED physicians.

• CCHHS currently utilizes a local community mental health provider contracted to offer crisis mental health services within the Stroger ED. Within this no-cost arrangement, the provider bills Medicaid and retains reimbursement for services delivered.
ED Visits by Behavioral Health Diagnosis, January 1, 2013 – April 1, 2015

CCHHS BH Encounters

- Alcohol: 22%
- Opioid: 14%
- Cocaine: 8%
- Anxiety: 9%
- Bipolar: 10%
- Depression: 20%
- Schizophrenia: 8%
- Paranoid/Psychotic: 3%
- Other MI: 4%
- Other Substance Abuse: 2%

N= 21,079

CCHHS BH High Utilizers (≥ 20 Visits)

- Alcohol: 27%
- Opioid: 7%
- Cocaine: 8%
- Anxiety: 6%
- Bipolar: 7%
- Depression: 19%
- Schizophrenia: 19%
- Paranoid/Psychotic: 4%
- Other MI: 2%
- Other Substance Abuse: 1%

N= 36

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS
There are large numbers of individuals coming into the emergency room and being admitted to the hospital for behavioral health disorders.

Despite its role and size, CCHHS has limited capacity to provide specialty behavioral health services to its patients. Therefore CountyCare members are seeking behavioral health services outside of CCHHS and experiencing delays in obtaining access to services.
CCHHS Behavioral Health Resources

Department of Psychiatry

Budgeted for 37.0 FTE staff members
- 4.0 FTE staff members (Oak Forest Health Center)
- Psychiatrist (0.2 FTE- Sengstacke Health Center)
- Majority of staff (33 FTE) at John H. Stroger, Jr. Hospital medical campus

- Psychologists (2) retiring within 90 days
- Vacant positions (3: psychologist, substance abuse counselor and consult liaison psychiatrist)

- Administration: 3.2 FTE [includes Chair-.5 FTE & Staff Psychiatrist (.7 FTE) and Administrator/Assistant Administrator (2 FTE)

The Department of Psychiatry provides between 26,000 to 30,000 patient visits yearly

There is no designated inpatient psychiatric unit within CCHHS
CCHHS Behavioral Health Resources

Department of Psychiatry Consultation services provided to general medical units at Stroger and Provident Hospitals to address behavioral health needs of patients

### Consult Liaison/ JSH Inpatient: (3.2 FTE)

<table>
<thead>
<tr>
<th>FTE</th>
<th>Position</th>
<th>Core Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>Psychiatrist</td>
<td>Assessment/ Medical Consultation</td>
</tr>
<tr>
<td>1.0</td>
<td>Registered Nurse</td>
<td>MH Screening/ HP Assessment/ Medical Chart Review/ Training</td>
</tr>
<tr>
<td>1.0</td>
<td>Licensed Clinical Social Worker</td>
<td>MH Screening/ Assessment/ Medical Chart Review</td>
</tr>
</tbody>
</table>

### SBIRT (Consult Liaison/ JSH Inpatient): (5.6 FTE)

<table>
<thead>
<tr>
<th>FTE</th>
<th>Position</th>
<th>Core Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.1</td>
<td>Psychiatrist</td>
<td>Medication Management/ Assessments/ Case Supervision</td>
</tr>
<tr>
<td>1.0</td>
<td>Director/ Counselor III</td>
<td>Manage Operations/ Women Peer Program</td>
</tr>
<tr>
<td>3.0</td>
<td>Counselor II</td>
<td>Identify/ Screen Assessment/ Refer/ Individual/Group Counsel/ Brief Intervention/ Assessment</td>
</tr>
<tr>
<td>1.5</td>
<td>Psychologist</td>
<td>Pain Clinic-Biofeedback / Assessment/Individual &amp; Group Therapy/ Neuro-Psych testing</td>
</tr>
</tbody>
</table>

### Fantus Health Center Staffing (14.6 FTE)

<table>
<thead>
<tr>
<th>FTE</th>
<th>Position</th>
<th>Core Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>Psychiatrist</td>
<td>Medication Management/ Assessments/ Case Supervision</td>
</tr>
<tr>
<td>1.6</td>
<td>Nurse Practitioner</td>
<td>Medication Management/ Assessments/ Injections</td>
</tr>
<tr>
<td>3.7</td>
<td>Psychologist</td>
<td>Psychotherapy, Neuro-Psych testing, Individual/ Group Counseling/ Assessment</td>
</tr>
<tr>
<td>2.0</td>
<td>Clinic Administrators</td>
<td>Oversee Clinic Flow and Manage Support Staff</td>
</tr>
</tbody>
</table>

### Core Center Staffing (2.6 FTE)

<table>
<thead>
<tr>
<th>FTE</th>
<th>Position</th>
<th>Core Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.6</td>
<td>Psychiatrist</td>
<td>Medication Management/ Assessments/ Case Supervision</td>
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<tr>
<td>0.4</td>
<td>Nurse Practitioner</td>
<td>Medication Management/ Assessments/ Injections</td>
</tr>
<tr>
<td>0.2</td>
<td>Psychologist</td>
<td>Psychotherapy, Individual/ Group Counseling/ Assessment</td>
</tr>
<tr>
<td>1.0</td>
<td>Psychologist</td>
<td>Research</td>
</tr>
</tbody>
</table>

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS
CCHHS Behavioral Health Resources

Correctional Health/Cermak Health Services

Department of Mental Health Services at Cermak Health Services

• Onsite mental health screening, 24-hour crisis intervention and stabilization, psychiatric services, therapeutic services
• 200-300 new detainees screened daily
• Male infirmary units = 62 beds (3 units)
• Female acute and chronic mental health infirmary unit = 20 beds (1 unit)

Cermak Staffing

• 93 employees, 9-10 psychiatrists, psychologists, social workers and other staff

CCDOC houses typically 8500 individuals (capacity: 10,000)
• Twenty (20) percent estimated to have behavioral health conditions
### Current ACHN Behavioral Health Staffing Plan (15 Centers including GMC)

<table>
<thead>
<tr>
<th>Social Work (FTE)</th>
<th>Psychologist</th>
<th>Psychiatrist</th>
<th>APN</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 Budgeted</td>
<td>5.64 Budgeted</td>
<td></td>
<td>3 Budgeted</td>
</tr>
<tr>
<td></td>
<td>2 FTE report to Department of Psychiatry .32 FTE employed by Loyola</td>
<td>1 FTE (.2 FTE and .8 FTE) report to Department of Psychiatry</td>
<td>3 FTE report to Department of Psychiatry</td>
</tr>
<tr>
<td>5 Vacancies</td>
<td>Vacancies: 2 - .5 FTE positions</td>
<td></td>
<td>Vacancies: 3</td>
</tr>
<tr>
<td>Total includes 6 LCSWs</td>
<td></td>
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</table>

**Total includes 6 LCSWs**

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**PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS**
Summary of Current State

Limited Behavioral Health Outpatient Leads to High Utilization of Other Services.

Individuals with Behavioral Health Conditions Cannot Access Specific Behavioral Health Services Needed (failed referral, long waits, and under identified need).

Symptoms Exacerbate and Reach Crisis Level and then Require Intensive and Expensive Services.

Preliminary Draft: Options for Formulating Future Actions
Recommendations to the Board for Behavioral Health Strategic Direction

Integration of Primary Care and Behavioral Health

• Expanded and improved implementation of integration of behavioral health into primary care.

• Engage individuals with behavioral health conditions earlier in the treatment process in order to reduce the need for more intensive services.

• Develop and implement a well defined model and commit additional investments in additional staff, formalized training, and other supports for improved implementation of the model.
Limitations of Current Integration Model

Efforts to integrate behavioral health into primary care have been substantially focused on the co-location of behavioral health services with primary care and the emergency department. Based on the SAMHSA-HRSA levels of integrated care, CCHHS services mainly fall in level 2-4 services.

<table>
<thead>
<tr>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEVEL 1</td>
<td>LEVEL 2</td>
<td>LEVEL 3</td>
</tr>
<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
</tr>
<tr>
<td>LEVEL 4</td>
<td>LEVEL 5</td>
<td>LEVEL 6</td>
</tr>
<tr>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
</tr>
</tbody>
</table>

- Limited capacity to provide care due to the utilization of traditional models of therapy and psychiatric care.
- CCHHS social work staff are providing case management services rather than supports a social worker could provide if they were working “at the top of their license” and as necessary in an efficient integrated care model.
Integration Model Expansion-Challenges

• CCHHS’ larger system planning for integrated care has been under resourced
• Space limitations for additional services
• Provider readiness for change
• Culture shift to team based care
Integration- Opportunities

• Many of the limitations of the current models of integration at CCHHS and the problematic trends such as high use of intensive services and poor outcomes could be reversed or at least improved with a more refined implementation of the model and realignment of resources across the system.
  
  o CCHHS must utilize its resources in the most efficient and effective manner currently the provider resource is not maximized across disciplines (e.g., social work, psychology, psychiatry, primary care).
  
  o Analysis of provider functions and movement towards a stepped model of care would significantly improve the system approach. Clinical care in integrated settings follows a system of “stepped care” to allow effective treatment to be provided with the minimum amount of intervention and cost necessary at that level.
Specific Recommendations for Developing and Expanding Integrated Care

1. **Conduct a Provider Function Assessment**—Examine the functions that are currently being provided on care teams across providers. In addition identify the additional functions that CCHHS desires in an integrated care model (e.g., screening, registry tracking, health promotion, brief intervention, psychiatry consult).

2. **Re-align Provider Time**—Establish re-alignment of provider time to maximize providers practicing at the top of their license.

3. **Brief Intervention**—Reorient social work staff and psychologists to provide brief intervention rather than traditional 40-60 minute therapy, to spread resources across a far larger population and implement issue/problem specific behavioral change.

4. **Re-vamp SBIRT**—Provide SBIRT with fidelity to the model and train a broader group of staff in the model, facilitating expanded services to a broader population, enabling SBIRT team members to be the referral source for individuals needing specialty services.

5. **Workforce and Training**—Evaluate workforce readiness, provider preferences, and training as provider functions are re-aligned. Commit resources to address needs will be critical to success.

6. **Reimbursement**—Actively pursue improved billing process for many of the services outlined for the PCMH care manager can be reimbursed as well as other services that behavioral health providers will perform in the stepped care model,

7. **Emergency Department Services-Crisis Intervention**—Address concerns regarding the current arrangements for behavioral health services in the ED (use of multiple different resources and processes to meet patient mental health and SUD needs and lack of psychiatry oversight and access to the full record for consults performed by Thresholds) and integrate behavioral health services within the emergency department.
Recommendations to the Board for Behavioral Health Strategic Direction

Expanding Specialty Behavioral Health Services

Recommendations for expansion of behavioral health services include the addition of specialty behavioral health services within CCHHS to complete the Stepped Care Model.

• Data reviewed and information gathered in interviews indicated waits and other potential access problems for specialty behavioral health services within the Cook County service area.

• Lack of access likely contributes to the significant use of emergency department and inpatient services, and is often linked to the significant number of individuals served through the criminal justice settings including Cermak.
Recommendations to the Board for Behavioral Health Strategic Direction

Expanding Specialty Behavioral Health Services

Recommendations for expansion of behavioral health services include the addition of specialty behavioral health services within CCHHS to complete the Stepped Care Model.

• Engage in more detailed review of utilization data as well as assessment of the impact of additional services in primary care to assist in determining the right balance of primary care and community based specialty services necessary to support CCHHS patients

• Expand CCHHS Medicaid provider profile and obtain certification as a community mental health provider to receive Medicaid reimbursement.
Opportunities to Expand Specialty Behavioral Health Services

<table>
<thead>
<tr>
<th>Medicaid Specialty Mental Health Services</th>
<th>Non-Medicaid Services funded by DHS Addressing Social Determinants of Health</th>
<th>Specialty Substance Use Disorder (SUD) Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Assessment</td>
<td>Assertive Community Treatment – Vocational Services</td>
<td>Outpatient (group or individual)</td>
</tr>
<tr>
<td>Psychological Evaluation</td>
<td>Job Finding Supports</td>
<td>Intensive Outpatient (group or individual)</td>
</tr>
<tr>
<td>Treatment Plan Development, Review and Modification</td>
<td>Crisis Intervention – Pre-Hospitalization Screening</td>
<td>Day Detoxification</td>
</tr>
<tr>
<td>Assertive Community Treatment</td>
<td>Psychosocial Rehabilitation</td>
<td>Day Treatment</td>
</tr>
<tr>
<td>Case Management—Mental Health</td>
<td>Psychotropic Medication Administration</td>
<td></td>
</tr>
<tr>
<td>Case Management—Transition Linkage and Aftercare</td>
<td>Psychotropic Medication Monitoring</td>
<td></td>
</tr>
<tr>
<td>Community Support (Individual, Group)</td>
<td>Psychotropic Medication Training</td>
<td></td>
</tr>
<tr>
<td>Community Support—Team</td>
<td>Therapy/Counseling</td>
<td></td>
</tr>
</tbody>
</table>

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS
CCHHS
Behavioral Health Continuum of Services

ACT/FACT

Primary Care Provider

Behavioral Health
In Community

BH Provider

PRELIMINARY DRAFT: OPTIONS FOR FORMULATING FUTURE ACTIONS
Summary and Next Steps

National, state, and local environmental factors have led to a gap in needed mental health and substance use disorder services for residents in Cook County, leading to high utilization of emergency and inpatient services, contributing to increased costs and less than desired health outcomes.

Recognizing the need for more access to behavioral health services combined with CCHHS’s role as a safety net provider for Cook County, it is essential for the system to expand its integration of behavioral health services and develop access to needed specialty services for individuals with chronic and persistent mental illness and emerging or existing substance use disorders.

Successful achievement of this goal will result in improved outcomes for patients and reduced costs to both CCHHS and the Cook County Jail. This initiative will not be without its challenges. However CCHHS also brings strengths through existing resources and partnerships to support success.

This strategic initiative will require a multi-year commitment, including dedicated staff and facility resources.