



# Community Counseling Centers of Chicago

**Community Counseling Centers of Chicago (C4)  
Application for HFS Healthcare Transformation Collaboratives**

**“Building Community Bridges for Better Crisis Intervention”  
April 12, 2021**



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# Application for Transformation Funding Cover Sheet

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## Executive Summary

### *Summary of Opportunity for Improvement:*

C4 Chicago (The Community Counseling Centers of Chicago), in partnership with our Collaborators proposes to build strength in community by constructing Collaborative Bridges across the gaps, now often fatal, among the scattered islands of service in the disadvantaged communities targeted by Illinois' Department of Healthcare and Family Services (HFS). Collaborative Bridges Teams (CBTs) would improve behavioral health and other health outcomes and reduce health care costs by creating an unprecedented continuity of care between hospital and community. This concept is designed to be scalable across the City of Chicago and beyond. Under the program proposed here, C4, with three collaborating hospitals and one other community behavioral health organization, would provide proof of concept through a pilot program on the acutely underserved West Side of Chicago.

### *Alignment with Objectives of HFS' Healthcare Transformation Collaboratives initiative:*

- **Improving Care For Targeted Communities:** Crisis Intervention and the associated healthcare and community policing infrastructure that support (or don't support) are outdated, fragmented and mis-funded. Our model proposes to improve care for our most vulnerable populations.
- **Address Economic Factors:** Our CBT puts resources closer to the patient in a more time appropriate client-centered, intimate manner; when it is most important for support and intervention. Our model will self-sustain (and hopefully become city-wide) by the final year of funding (Year 3).
- **Data- and Community-Driven:** C4 and our Collaborators feel very passionate about the high value of what our model represents for the populations affected, the communities involved, and the community bridges needing to be built. As this Application reflects and details, we were exhaustive in our data review and inclusive in our outreach to validate our theories and generate the massively broad base of support for our proposal.

The CBT creates the connective tissue for a disconnected and overwhelmed healthcare system ensuring continuity of care from community to Emergency Room or Psychiatric Ward, back to community, to follow-up to recovery. Below is a snapshot of the value proposition of a CBT:

- Consist of mental health professionals with a variety of credentials, who are embedded in the community and integrated with the hospital and other critical points of care
- In the community, the CBT team will identify people with behavioral and other health needs and support them in connecting with hospital or community care.
- Prior to a patient's discharge from the hospital, the community-based, multi-disciplinary CBT would be aware of their pending release, understand the patient's inpatient treatment, know their clinical and social determinants of need and be prepared to receive them.
- The team would ensure that the patient was stable on their medication and acclimating back into the community following discharge.

- Most importantly, the CBT would ensure that the patient attends their follow-up appointments and continues all prescribed treatments, including group and/or individual therapy and case work linkages to other services.
- In addition to care coordination services, these patients will be connected to Master-level mental health and substance abuse therapists to receive immediate short-term therapy until they can be connected with caregivers in their community.

This relationship among the relevant agencies corresponds directly to the objectives of the grant, improving outcomes and reducing the overall cost of healthcare. It will drastically reduce the cycle of failed care due to lack of continuity resulting in chronic emergency room visits, 911 calls resulting in police and fire department responses and compounding illnesses resulting in acute care needs. CBT will enhance that personal, community-to hospital-to community support by integrating and sharing information through linkages among Electronic Medical Records. The CBT Collaborators see this as an opportunity to create bridges between the various islands of care, filling often fatal gaps in services.

The CBT Collaborators, again, will seize the opportunity created by (name of program) to construct bridges among the various islands of care, spanning often fatal gaps in the service continuum. This pilot proposal represents our template. We will need considerable latitude to implement, test, learn and adapt. In the end, however, we will create a model for service that can be adapted and scaled across all of the communities targeted by HFS, and beyond. Sadly, the gaps we seek to bridge are nearly universal in the Illinois and in the American healthcare system.

#### ***Overview of C4 and our Collaborators:***

- **C4 Chicago** has, for 50 years, built strength in community by partnering Chicago's most underserved and at-risk populations, enabling them to live, work and thrive in their communities. A pioneer in the notion of community-based care, C4 has established the highest level of respect and credibility among community stakeholders. It is this leadership position that has allowed C4, to approach and partner with other long-standing leaders and the institutions that they represent in developing the CBT initiative. Our involvement in this program will enhance our rapidly expanding presence on the West Side. Our current growth is fueled by a Trauma-Informed Community Care (TICC) grant from the City of Chicago and is based upon our city-wide leadership in SASS programming and a strong and well-established child-serving program in Humboldt Park. C4 also provides training for the Crisis Intervention Trained unit of the Chicago Police Department, one over 20 community endorsers of this proposal.
- **Humboldt Park Health** is an integral part of Chicago's safety net and a leader in advocacy for its Humboldt Park and surrounding-area constituents. This 200-bed general acute-care hospital is mission-driven to "...provide high-quality and compassionate health care services by partnering with patients and their families, our employees, physicians and the communities we serve." HPH shares the commitment of its partners in the Community Bridges Team Collaborative (CBT) to the people of the West Side, who need and deserve high-quality medical care and supportive services.

- **Hartgrove Behavioral Health System** plays an essential role in the West Side community by delivering “all-encompassing psychiatric healthcare services.” The 119-bed safety-net facility plays an especially vital role in the care of the community’s children and adolescents in crisis. Like its partners in the CBT, Hartgrove is committed to improving the total health of the people of the West Side.
- **Habilitative Systems, Inc. (HSI)** is a nationally-recognized human services agency that uses a continuum of care approach to provide much-needed programs to underserved populations and people living with an array of health and human service needs. Headquartered on the west-side of Chicago, HSI has offered supportive programs to Chicago’s most disadvantaged and vulnerable residents for 40 years and provides services to over 7,000 people annually in the North Lawndale, West Garfield, Austin and Englewood communities in Chicago.
- **The Loretto Hospital (TLH)** is an acute-care safety-net hospital located in the Austin neighborhood on Chicago’s West Side. TLH has 122 licensed beds and serves over 33,000 patients each year from Chicago's Austin and surrounding communities. TLH is more than a hospital or healthcare provider; it is an anchor of health for the West Side community and has a long tradition of advocating for the underserved and disadvantaged. Loretto partners with numerous agencies and providers to ensure its patients and the community in which they live receive holistic healthcare and social services to maximize their health and well-being.
- **Chicago Police Department/Crisis Intervention Training (CIT) Program:** C4 has partnered with CPD via the CIT program for years, and we have several levels of support within the City of Chicago, CPD, and CIT. Because of the proposal timeline CBT has not yet fully coordinated with CPD but CPD has expressed its support and commitment to this, further, collaboration in the accompanying letter.

***The Goals of our Collaboration:***

We have come together to address a few immediate key following problems in our Chicago communities:

1. Lack of integrated and coordinated Crisis Response for the Underserved
2. Poor follow-up behavioral care and support for the Underserved post-crisis event
3. Lack of defined Life Improvement Measures and means to track progress of people or populations of people

Our Community Bridges model aspires to make meaningful impact in the following areas:

1. Improving access to care for the Underserved and At Risk, including:
  - a. Better care during Crisis Event
  - b. Ensuring follow-up treatment and connections to care post-Crisis Event
  - c. Managing transitions of care across locations and modalities and into a permanent Integrated Medical Home
2. Filling gaps in care for the Underserved and At Risk, and Chronic Mentally Ill and SUD

3. Reducing the number of interactions with police officers and thereby reducing the number of negative policing interactions in our communities
4. Enhancing care and reducing costs for the highest cost patient population in healthcare
5. Reducing hospitalizations and nursing home stays

### ***Our Partners, Supporters and the Communities We Serve***

C4 has served Chicago's underserved and at-risk communities for decades and have established the highest level of respect and credibility among community stakeholders. It is this leadership position that has allowed C4 to approach and partner with other long-standing leaders and the institutions that they represent. Our initial work will expand on our existing footprint on the West Side of Chicago, and in years 2-3 expand our North Side footprint, partnering with community hospitals and support agencies to address the stated challenges and achieve the desired outcomes. Our community partners include hospitals, social services agencies and the Chicago Police Department.

Below is a quick summary of our partners and Collaborators. Each of these organizations are long-standing pillars in the Chicago/Cook County healthcare safety net that cares for our most vulnerable people in their most vulnerable moments:

#### **Year 1:**

- Humboldt Park Health
- The Loretto Hospital
- Hartgrove Hospital
- Habilitative Systems, Inc.
- Chicago Police Department via Crisis Intervention Team (CIT) Training Program and Chicago Alternative Policing Strategy (CAPS)

#### **Years 2-3:**

- Three additional hospitals. Conversations have already begun with:
  - Lurie's Childrens Hospital
  - Thorek Hospital
  - St. Mary's & St. Elizabeth's Hospital
- Treatment Alternatives for Safe Communities (TASC)
- Heartland Health Centers

#### **Beyond:**

- Extend C4 and Bridges program to South Side of Chicago
- Partner with other Medicaid Transformation initiatives focused on South Side
- Expand West Side outpatient network
- Expand North Side outpatient network

## *How CBT Will Work*

Our CBTs, during the pilot and beyond, will be built off an existing set of resources, better staffed and coordinated with patient and patient care at the center of our model:

- The design of the CBT program builds on our established clinical approach, developed through our partnership with the Illinois Health Practice Alliance (IHPA) and our approach to hospital monitoring, post-crisis treatment, and discharge coordination through the Screening, Assessment, and Support Services (SASS)/MCR system, for which C4 is the largest provider in the city and on the West Side. C4 follows and teaches adherence to the principles of trauma-informed approach as recommended by SAMHSA, including safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and recognizing cultural, historical, and gender issues.
- Through this grant, CBT would bring on peer professionals to do initial comprehensive needs assessments and linkage when referral was triggered by a hospital referral. C4 would also include on this team LPHAs to complete HEDIS measures and provide expertise, and SUD and behavioral health QMHP clinicians for short-term therapy until long-term linkage is established.
- The overarching purpose of the CBTs program is to ensure our clients receive everything they need to live independent, stabilized lives within their communities. This model has worked in most intensive level of outpatient services offered now in sites of service in the Edgewater/Uptown area, and it is CBT's intention to expand this proven model to serve those on the West Side.

**These services will work together synergistically in a more contemporary Care Coordination Model to assist those members of the communities significantly impacted by a diagnosis of one or more mental illnesses. It will be informed by, and coordinate with, a variety of other, established and proven services currently provided by C4 and HSI, including:**

- **Crisis Triage:** With the recent change in law, via Emergency Medical Services Act, the West Side Bridges location will be able to receive clients in crisis and divert from expensive emergency rooms, thus reducing the cost of healthcare and the burden over overcrowding emergency rooms.
- **Peer driven Drop-In Center:** Provides opportunities for socialization and participation in psychoeducational groups. Additionally, those served have access to and taught how to utilize computers as a daily living skill. Additionally, this environment provides opportunities to interact with certified staff who themselves are successfully navigating their own mental health challenges.
- **Assertive Community Treatment:** The most intensive level of outpatient care. Clients may be seen daily if necessary and assisted with medication management, shopping, cleaning, laundry, budgeting, etc.
- **Community Support Treatment:** Many of the same services provided by ACT but less frequently, allowing clients to assume more and more responsibility for their own care as they learn and grow.

- **Psychiatric services:** Clients meet with a psychiatrist or APN who attends to their psychiatric medications needs and concerns. The intended eventuality is that this service be performed by the safety net hospital's psychiatrist on site; either face to face or via tele-psychiatry.
- **Vocational Rehab Services via Supported Employment:** Those interested and able to one day, return to the workforce, may begin working with a vocational rehab specialist right away. They do not have to wait until they feel they are ready. We provide these services help them get ready.
- **Co-located Primary Medicine Services:** Clients who do not have a primary care physician may see a medical professional within offices to ensure they are stable in the mental health as well as their physical health. Additionally, the Drop-In Center provides seminars regarding nutrition and living healthy lifestyles.
- **Co-located Pharmacy:** Pharmacists work closely with staff to prepare bubble packs which ensure clients are taking their medications as prescribed. This service will be supported by the Bridges team with the community as an additional support and stabilization.
- **Onsite Phlebotomy Services:** Clients may have their blood drawn and tested by laboratory professionals on site.
- **Representative Payee Services:** Clients receive assistance with paying bills and budgeting. Participants receive spending money that can be obtained twice a week in a bank like setting.

**By utilizing a combination of these services, our clients are psychiatrically hospitalized less often, avoid placement in nursing homes, spend less time in emergency rooms and have fewer interactions with the police.**

### ***Implementation Overview:***

In our initial year of funding, this team will focus explicitly and exclusively on the West Side of Chicago. We propose, to ensure our services are robust and cohesive, that we rent space for this team and for others to operate in the Austin community. This facility would be designed to be a community center for all community stakeholders to access and host community events and would include drop-in service, as well as, clinical substance SUD and mental health services.

CBT would be comprised, initially, of two Licensed Professional Healing Arts (LPHAs), four paraprofessional staff from the West Side, and four Qualified Mental Health Professionals (QMHPs) with both mental health and substance SUD training and expertise. In years two and three, the collaborative would continue to solidify and expand work with our West Side CBT while also focusing expansion of our work more formally with additional North Side Chicago hospital partners in Uptown, Edgewater, Rogers Park, and Lakeview, to expand these services there.

It is the business plan of CBT to be self-sustaining going into Year 4, as detailed herein and in our attached CBT Budget Proforma. Finally, and just as importantly, the presence of the wraparound services providing revenue (both Medicaid Billing and leasing income) and ensure the building itself is self-sustaining within three years of grant approval. As indicated previously, this center would be open for community use, with C4 as the primary caretaker.

## ***How Our Model Will Innovate and Re-Design Care***

The CBT model leverages years of experience and knowledge of our community Collaborators and partners, and curates a new model based on what we know works, centered around these factors:

- Importance of connecting with patients at time of crisis
- Knowing Social Determinants
- Timely Responses to Hospitals for Intervention
- Making Existing Bridges Stronger via CBT
- Building on the success of the SASS system
- Melding Evidence-Based Best Practices with Communities and Cultures of Focus
- Develop a framework of adult Mobile Crisis Response
- Leveraging Telehealth and Virtual Medicine
- Cultivating an innovative, collaborative culture driven by adaptable leadership
- Addressing Health Equity and Racial Equity

Below is a summary of each of these components that combine to fuel our innovation and improvements to care and communities:

**Importance of connecting with patients at time of crisis:** Without adequate preventive mental health support systems, and awareness among the communities of the availability of services that effectively acknowledge racial inequalities and mental health stigma, often individuals don't present until they have had a crisis episode. We operate with the foundation that reaching someone as they experience adverse stress is critical to avoiding their developing deeper trauma and chronic mental illness. This collaborative believes that treatment is a partnership between the client, staff, and network of family and friends all within the community where strength is found. We believe that enabling healing in a safe, trusted environment is critical for the well-being of those we serve. And we believe that one's efforts in seeking help reflect a foundational strength for recovery and growth, despite the ongoing stigmatism around mental health issues.

**Knowing Social Determinants:** Additionally, through our screenings and assessments, this team would focus on all social determinants of health and would leverage NowPow! to connect to services that best support your patient's needs as indicated. The team would ensure that the patient is stable on their medication, complete Safety Planning and Crisis Stabilization when indicated, and ensure that hospital patients are acclimating well following discharge.

**Timely Responses to Hospitals for Intervention:** The team of hospital community liaisons would respond to all hospital referrals within 24-hours to schedule a needs assessment and would meet the individual in the setting of their choosing to complete an initial assessment. This team then would begin the work of connecting this group by leveraging relationships with community housing, health, economic, substance SUD recovery, and mental health agencies to connect them with services. In the interim, this team would use their own substance SUD, case management,

and mental health resources to support the client to ensure their immediate needs are met, that they are stable, and that they are connected to long-term supports.

**Making Existing Bridges Stronger via CBT:** This team would look to be the connective tissue for the community, and through our affiliations with the Behavioral Health Consortium of Cook County, the Lurie All Hands Health Network, the Primary Care-Behavioral Health Learning Collaborative (which comprises of thirty-two FQHCs, CMHCs, and County Care and which C4 is the lead fiscal agent), IHPA, West Side United, and NowPow!, as well as our long clinical history of focusing on complete client hospital needs in the community would be able to effectively link patients to services indicated by their need's assessment.

Our work plan would entail building partnerships, bridges, and rapport with organizations in the community that residents already trust. This will include schools, FQHCs, and community organizations. Through community engagement, we will encourage referrals and integrated care. Based on data provided by the city, the communities we serve have been disproportionately affected by unsafe work conditions, both before the pandemic and during, financial strain, exposure to violence, and systemic racism. The CBT would respond to those needs by implementing anti-racist practices, advocating for families' basic needs, and using mental health therapy as a way to help clients understand what happened to them while facing systems that insisted there was something wrong with them.

**Building of the success of the SASS system:** CBT's model would draw upon similar philosophies of care that the SASS system created for post-crisis follow-up, but would expand its focus beyond the narrow lens of crisis support, expanding to adults and to youth that have needs outside of the SASS model of after-care and hospital monitoring support (i.e., substance misuse, housing, et al.). While the SASS model is held in esteem across the country, its downside, as much of Illinois Medicaid fee-for-service model, is that it inherently discourages extensive outreach and engagement. As post-crisis work is built around fee for service model, unless a family shows willingness to engage in post-crisis treatment there is limited ability for providers to expand significant resources on engaging families. This model would allow this team to focus fully on being able to provide unbillable outreach and engagement while building a sustainable revenue model. This team also would spend time participating in hospital departmental staff meetings with outpatient, inpatient and emergency room teams to be able to anticipate needs of both the hospital and their patients being referred.

**Melding Evidence-Based Best Practices with Communities and Cultures of Focus:** Our short term therapy would draw from Cognitive Processing Treatment modalities of treatment and trauma-informed approaches. Trauma-informed behavioral health services place a premium on conceptualizing clients' presenting problems and symptoms as the results of trauma that occurred to them through no fault of their own. It is the deep recognition that individual trauma results from a stress reaction from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. It is through this approach that our clinicians are able to organize their interventions, going beyond preconceptions of pathology to focus on the individual.

**Develop a framework of adult Mobile Crisis Response:** Focused on both prevention and stabilization, these community teams will leverage C4's Crisis Response services and HSI's focus on adult crisis response and affiliation with West Side Triage Center. These CBTs will provide the framework for future system enhancements for adult Crisis Response, including partnering with CPD, CAPS and other community stakeholders.

**Leveraging Telehealth and Virtual Health:** Central to our strategies to expand and improve Access will be leveraging and expanding Telehealth and emerging Virtual Health solutions. CBT services will focus on access to connecting to timely psychiatry services and medication support in our engagement with patients. We will look primarily to connect patients to with providers close to home and in their communities, and will leverage partnership with Hartgrove Hospital through their telepsychiatry services when there is psychiatry needs that cannot be met by current providers of care.

**Cultivating an innovative, collaborative culture driven by adaptable leadership:** The program design, as a pilot, is shaped to allow extensive testing, learning and adapting. In years one to three we will need to exercise great creativity and flexibility to adjust to our experiences in the community and among our partners. The governance, management and clinical implementation of CBT will be carefully focused on capturing new insights and translating them into practice. We will report annually on what we are learning and how we are adapting.

***Addressing Health Equity and Racial Equity:***

We applaud and fully support HFS' focused interest on addressing both Health Equity and Racial Equity in the Illinois Medicaid Transformation initiative. Among the many racial health disparities that have been highlighted by the COVID-19 pandemic is the lack of access to preventative care that many African American and Latinx people have. Similarly, based on the current fee-for-service structure, a higher monetary value is placed on crisis intervention versus preventative care. Without needing to rely on fee-for-service, we will be able to focus more on preventative care that will also include help with linking clients to primary care physicians with whom they feel comfortable.

In addition to data cited by HFS in its own reports and studies, there is an overwhelming amount of evidence that the African Americans and Latinx populations experience significant disadvantages when it comes to healthcare in general and behavioral health in particular. Below are just a few examples:

- According to a 2021 study by the Health Care Consortium of Chicago, "The Challenging Future of the Chicago Safety Net," life expectancy on the West Side is up to 14 years lower than in the predominantly white Streeterville neighborhood.
- The CDC reports that the COVID-19 pandemic has seen a disproportionate rise in suicidal ideation in the Black and Hispanic populations.

Advancing Health Equity and Racial Equity are central to C4's mission and central to the missions of all our Collaborators and partners. Included in the CBT model are specific pursuit tactics:

- Ensuring that we measure, track and report our progress on Key Health Population Statistics and develop specific tactics to reduce the gap.
- Hiring within our own communities and promoting within our own organizations and communities
- Deploying care delivery into the communities
- Partnering with CPD, CAPS and CITs to change the dialogue in the community, both in the context of Crisis Intervention and long-term healing and improved relations

### ***Summary & Next Steps: Our Readiness & Feasibility***

We appreciate HFS' leadership in making these funds available to help our communities. We hold near to us the responsibility we bear daily in what we do, and take serious the stewardship HFS' entrusts to us via this and other funding and support resources. We believe our proposal is a good one, and aligns well with the objectives identified by HFS:

- ***Improve Care for Targeted Communities:***
  - We have been inclusive in our collaboration amongst multiple stakeholders in the community to address both healthcare and social determinants of health
  - Our CBT model ensures healthcare and SDOH services are linked to improve outcomes, and seeks to improve relations with Crisis Intervention, Community Policing, and Improved Access and Care Coordination for our most vulnerable populations
- ***Address Economic Factors:***
  - There will be no reduction in access to services; access to services will be greatly expanded over the 3-year term
  - The innovative CBT model projects to add approximately 50 new jobs
  - CBT will be sustainable after the 3-year term via a combination of economic levers including via utilization-based payments
- ***Data and Community-Driven:***
  - Base on community needs and input
  - Equitable / reduce disparities
  - Use data to design and promote integration of care
  - Have identified goals, measurable metrics and verifiable project milestones

We stand ready to immediately begin our work and our learning should we be awarded and entrusted with funding. Our attached "Milestones" details our workplan, geared to quick launch:

- Convene with Collaborators to construct detailed Implementation Plan
- Begin recruitment and hiring process for targeted resources in safety net hospital Emergency Departments, C4 and partner agencies
- Begin sourcing space options for community center
- Engagement with MCOs to define Value-Based and Utilization-Based incentives
- Launch community education and engagement tactical plan

As indicated above we will, in each process and at each phase, incorporate the learnings of the pilot and adjust course, but always toward the goals identified above.

## Community Input

Like all of organizations filing Applications, we are very much already engrained in our communities. But providers of services like ours hold a unique position and importance in community relations on many levels. We are often in the middle of people’s most troubling moments, there is often police involvement, and emotions are high and hopes are low during these intense experiences. This kind of connection and relationships in our communities make all of us involved in CBT very passionate about addressing some of these issues and putting in sustainable solutions.

Our primary service area encompasses the Chicago zip codes of 60647, 60639, 60651, 60644, 60624, 60612, 60623.

The following community partners have issued letters of support (copies attached):

<b>Letters of Support</b>	
<b>From Community Leaders</b>	
David O. Brown	Chicago Police Department
Aaron Galeener	Cook County Health Department
Allison Arwady	Department of Health
Laura McAlpine	McAlpine Consulting
Stephanie Jackson	Advanced Bottom Line Management (ABLM)
<b>From Illinois Elected Officials</b>	
Chris Taliaferro	Alderman, 29 <sup>th</sup> Ward
Daniel La Spata	Alderman, 1 <sup>st</sup> Ward
Greg Harris	U.S. Representative, 13 <sup>th</sup> District
James Cappleman	Alderman, 46 <sup>th</sup> Ward
Jason Ervin	Alderman, 28 <sup>th</sup> Ward
Kelly Cassidy	U.S. Representative, 14 <sup>th</sup> District
Kimberly Lightford	Senator, 4 <sup>th</sup> District
Michael Rodriguez	Alderman, 22 <sup>nd</sup> Ward
Michael Scott, Jr.	Alderman, 24 <sup>th</sup> Ward
Michael Simmons	Senator, 7 <sup>th</sup> District

C4 took a very extensive and inclusive approach in engaging our community before deciding to proceed with this Application. We've spoken with a broad and diverse group of our stakeholders:

- Aldermen
- State Senators
- Hospital CEOs
- City of Chicago and Chicago Police Department
- Community Civic Leaders and Business Leaders
- Patients and Community Members
- MCOs

The Collaborators have made contacts with all the state legislators and Alderman representing the service area of CBT and continue to engage in dialogue with them. In order to deepen their buy-in, CBT will also take the lead in a series of briefings of key legislators and Aldermen. One of these, with Senator Michael Simmons, has already been held. Others are currently in the planning stages. CBT will follow these with annual updates and briefings to all elected officials seeking their continuing support and offering opportunities to suggest improvements to the program.

On an ongoing basis, our CBT programs will continue to be very engaged with our communities. The program director and supervisor will participate in community organizations and will work with community stakeholders to identify needs that are being unmet and will adapt our approach to better address these needs. CBT will host community meetings quarterly, and our expanded screenings will identify unmet needs. We will continue to interview clients, community members, and front-line staff to better understand the specific challenges related to mental health that their communities are facing. CBT will further develop systems of integrated collaboration and communication through referral to community providers.

We will also continue to solicit input on our websites and expand Community Outreach to West side communities:

- Targeted digital outreach, in multiple languages, to parents
- Targeted digital outreach, in multiple languages, to teens
- Outreach to acknowledge and address issues related to mental health stigma

C4 has existing established partnerships with Bickerdike Redevelopment Corporation through its involvement with the Humboldt Park New Communities Program (NCP), with Casa Central through its Connecting the Dots Coalition, and with the Chicago Children's Advocacy Center through its involvement on the Providing Access to Hope and Healing (PATHH) Steering Committee. C4's Diversity, Equity, and Inclusion (DEI) Task Force are also in the process of identifying training sessions that can make its members better allies to the communities we serve as well as assure that our staff and board reflect the diversity of our consumers.

## Data

The members of CBT are all supporters of evidence-based care and data-driven decision making. We drew upon an enormous amount of data available for many aspects of our formation; but like others, found that many of the data points we are looking for in future state do not exist and as such will need to be curated over the course of transformation. Below is a summary of our approach, including the data used in our design, the methodology for collection, and the results of our analysis.

**Data used in design:** In designing this program the Collaborators relied on current data at a national level and local level. Our data was sourced from a core set of reliable sources with relevant data to our work:

### **CBT hospital partners' Community Health Needs Assessments (CHNAs)**

- 79% of our patient populations are Black and Latinx
- Humboldt Park Health (HPH), formerly known as Norwegian American Hospital (NAH), in their 2019 CHNA, identified Mental Health and Substance Use Disorders as their #1 initiative
- That same CHNA gave birth to NAH's renaming to renaming and re-branding to HPH with the tagline "Advancing Health Equity"
- Behavioral Health issues were top issues in nearly every Focus Group:
  - Chronic Stress among youth and adults in communities
  - Lack of education among public servants and patients about mental illness and Substance Use Disorders
  - Difficulty in accessing care due to shortage of clinicians, poor health insurance/cost issues, and overwhelmingly, a variety of social determinants
- Social and Structural Determinants of Health (SDOH) were consistently identified across Collaborators:
  - Employment
  - Education
  - Community Safety
  - Food Systems
  - Housing

### **Illinois Hospital Association (IHA) COMPDATA Healthy Communities Institute:**

- Emergency Room Visits due to Mental Health among adults between 2015-2017 for associated zip codes indicated a range of 195 per 10,000 in 60624 to 52.8 per 10,000 in 60642
- Emergency Room Visits due to Substance Use among adults between 2015-2017 for associated zip codes indicated a range of 178 per 10,000 in 60624 to 19.5 per 10,000 in 60642
- These data indicate skyrocketing visits/encounters compared to the 2016 CHNA cycle, where the lowest rate was 9.0/10,000 in 60642 and the highest rate was 89.6/10,000 in 60624

### **Chicago Department of Public Health (CDPH):**

- Current ongoing data sharing
- Development of enhanced data sharing and technical assistance and thought leadership
- Quarterly meetings

## **Healthcare Council of Chicago’s 2021 report “The Challenging Future of the Chicago Safety Net”:**

- Chicago’s safety net communities are in a precarious position, with combined losses across hospitals totaling \$1.76B in coming years, with the primary 7 hospitals projected to lose \$1.3B by 2024. Coupled with the uncertainty of the impact of COVID-19, now is the time for transformative thinking on how to improve care for our communities for the long term.
- Health Equity is an issue:
  - 79% of our patient populations are Black and Latinx and compared to the broader City of Chicago, the south and west sides have the most scarce access to medical, mental health, and social resources
  - Individuals experiencing poverty are more likely to have adverse health outcomes; our communities Poverty Rates 28-61% compared to the city overall at 19.5%
- Health Outcomes ultimately speak to the urgency of the problems:
  - There are many data points to speak to the composite health outcomes that result from the institutional and social inequities we see on the West Side and South Side of Chicago, and specifically with regard to the impact of Mental Illness and Substance Use.
  - Life Expectancy is a key indicator of overall Health Equity impact on Health Outcomes. Since 2001, life expectancy has increased 2.5 years for the top 5% of earners but remained stagnant for the bottom 5%.
  - In Chicago, life expectancy for individuals who live in the West Side and South Side varies greatly from individuals who live in the Loop or the North Side. Notably in our own neighborhoods, comparatively Englewood (68.1) to Hyde Park (80.6) or West Garfield Park (69.9) to the Loop (81.7)

## **HFS Transformation Narrative November 2020:**

- The top 3 Admitting Diagnosis for hospitalizations in our primary service areas:
  - Mood Affective Disorders (Bipolar, Depression)
  - Schizophrenia, Schizotypal Disorders
  - Psychoactive Substance Use Disorders (Alcohol, Opioids)
- Community-Delivered Intervention and Transition of Care Innovation Models Focus Transformation on these objectives:
  - Improve Care for Targeted Communities
  - Address Economic Factors
  - Data and Community-Driven

## **West Side United March 2021 Report: “Where Do We Go From Here?”**

- We need new community-based collaboratives to confront systemic racism and injustice and to improve relations between our people and the police who are sworn to protect us
- Racial Equity Rapid Response Team (RERRT) initiative

## **MCO Data:**

- County Care utilization and HEDIS data
- Other MCO data across Collaborators
- Ongoing Data Sharing between MCOs and providers enabling acceleration

**Methodology of collection:** All CBT Collaborators contributed to and participated in contributing data and engaging in dialogue around improvement ideas.

- Data was collected and analyzed specifically to better understand:
  - Areas of poor care and gaps in care in behavioral health and crisis intervention
  - How crisis intervention and behavioral health overall were unique in the world of transformation and value-based care, especially with regard to the patchwork of community agencies involved, and of course, the impact and influence of community policing
  - What was and was not being done by stakeholders and why:
    - Resource restrictions
    - Access to talent
    - Access to care
    - Access to data
    - Non-compliance with best practices in care protocols
- “Reasonableness tests” were applied to our findings to ensure that we were focused both on relevant issues, and within the framework our the HFS Transformation Collaborative objectives

**Results of analysis:** The analysis confirmed what we know intuitively and to some degree have been working incrementally to improve individually and independently; confirming both the validity of our collaborative and the focus for our launch. The initial analysis led to the joint Transformation Collaborative Grant proposal to ensure resources sufficient to launch and build this hospital/community integration:

- We compared that to data indicating that follow-up appointments kept strongly correlates with recovery from behavioral health difficulties
- Waitlists data for community providers are of extreme concern
- MCOs are not linking to community providers or doing care coordination adequately or affectively in the community
- Rates of engagement currently are low
- There is woefully inadequate discharge planning in Emergency Room

### ***Transforming Data Development:***

Under the CBT program, future data development will be done both via CBT and via CBT stakeholders, but always will be leveraged to get best practices and new learnings into practice quickly. Each CBT Collaborator will have the responsibility to assign a lead care coordinator assigned to each collaborating hospital. That person’s responsibility will include working with the hospital to track key behavioral data, e.g., frequency of follow-up visits and key outcomes data. Each hospital and collaborator will report monthly on each of the key data points. CBT stakeholders will meet quarterly to adjust to review data, assess performance by hospital and make major adjustment in the program based upon the learnings. The care coordinators will be at liberty to make other adjustments in real time to serve the needs of clients/patient, ensure the integrity of the data, create efficiencies, and other transformative work.

## Health Equity and Outcomes

While racial and ethnic minorities experience mental health and substance use disorders at the same rate as whites, the illness may go untreated for longer periods of time. This disparity is caused by multiple factors, including access to behavioral health services, cultural stigma associated with mental health, and systemic racism and discrimination.

- The West Side of Chicago is chronically and alarmingly under-resourced, and all resources are overwhelmed. CBT will provide the bridge, and access to resources to make sure that while waiting for connection needs are met
- There is significant lack of treatment options on the West Side compared to other areas of Chicago
- There has been an increase in African American suicides driven by many of the societal and systematic forces at play today
- Most of America has seen the slide showing Life Expectancy going from 82 years of age to 69 years of age across a 6 block stretch of Chicago. This is real. This is wrong. And our mission is to drive that change.
- More immediate connections with patients, and providing screening and timely Needs Assessments coupled with timely and affective follow-up represent immediate improvement opportunities

By nature of our work, CBT and our partners have seen first hand the tragic consequences of decades of systematic racism and social inequities. We know that these inequities drive the poor outcomes; in ways we can measure and in ways we need to better measure other than Life Expectancy. We have a few core goals in our commitment to advancing Health Equity:

1. Continuing to raise awareness of it and fighting it in our daily work and communication
2. Innovating ways to credibly track, measure, report and improve on Health Equity and Health Outcome measures for our populations
3. Deepen our work with Chicago Police Department and its programs to better address root causes for social unrest, and together create and implement healing solution

### Quality Metrics

The CBT model aligns well with the pillars in the Department’s Quality Strategy. CBT’s work will focus on two (2) of the HFS Quality Pillars but will touch all five (5) Quality Pillars.

<b>Adult Behavioral Health</b>	<b>Child Behavioral Health</b>	<b>Maternal and Child Health</b>	<b>Equity</b>	<b>Improving Community Placement</b>
<p>Follow-up After Hospitalization for Mental Illness (FUH) 7 Day, 30 Day</p> <p>Follow-Up After Emergency Department Visit for Alcohol and Other Drug SUD or Dependence (FUA) (7 Day, 30 Day)</p>	<p>Follow-up After Hospitalization for Mental Illness (FUH) (7 Day, 30 Day)</p> <p>Follow-Up After Emergency Department Visit for Mental Illness (FUM) (7 Day, 30 Day)</p>	<p>Prenatal and Postpartum Care (PPC)</p> <ul style="list-style-type: none"> <li>• Timeliness of Prenatal Care</li> <li>• Postpartum Care</li> </ul> <p>2. Childhood Immunization Status (CIS)— (Combo 3)</p>	<p>Adults’ Access to Preventive and Ambulatory Health Services (AAP)</p>	<p>LTSS Comprehensive Care Plan and Update</p>
<p>CBT Engagement and Care Plan after ER Visit</p> <p>CBT Follow-up and Care Plan after Hospitalization</p>	<p>CBT Engagement and Care Plan after ER Visit</p> <p>CBT Follow-up and Care Plan after Hospitalization</p>	<p>CBT Needs Assessments will address child/maternity questions</p> <p>CBT Care Plan as Needed with Care Team</p>	<p>CBT improves access to Care and assurance that there is continuity of care from hospital to treatment.</p>	<p>CBT improves access to Care and assurance that there is continuity of care from hospital to treatment.</p>

Additionally, CBT and Collaborators and stakeholders will work collaboratively with HFS to establish a baseline for the service community and a tracking process as well as negotiated improvement targets. For metrics currently not tracked, we will work in a leadership capacity with HFS to propose a method for tracking:

<b>Existing Quality Metrics to Adapt to CBT</b>	<b>New Quality Metrics to Adapt Vis CBT</b>
<ul style="list-style-type: none"> <li>▪ Reduction in Emergency Department visits</li> <li>▪ Increase percentage of Patient Assessment and Care Plans</li> <li>▪ Increase percentage of Meeting Needs Within 6 Months</li> <li>▪ Completion of Follow-Up Hospitalization (FUH/HEDIS) screenings</li> <li>• Reduction of Emergent Hospital Admissions</li> <li>• Reduction of Re-Hospitalizations</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reduced time between referral and services</li> <li>▪ Increase Volume of Patient Drop Offs-Police</li> <li>▪ Increase Volume of Patient Drop Offs-Ambulance (leveraging new law)</li> <li>▪ Reduction of Police Encounters in Total</li> <li>▪ Increase in Police/Community Collaboration (Messaging, Events)</li> </ul>

## Care Integration and Coordination

All stakeholders in healthcare acknowledge fragmentation and lack of care coordination as a cause of poor care, high healthcare costs, and health inequities. Addressing and implementing innovative solutions to improve care integration and care coordination is central to our narrative above under “How Our Model Will Innovate Care”.

Many of our core tactics on care innovation revolve around making sure we have the right resources and support in place at the right time for the right patient. C4 and our Collaborators and partners know this, and know it especially important in a world changed by the pandemic and social unrest. It’s never been more important to do this the right way, which is why we are excited about CBT: Its concept and its value proposition was not born out of a need to come up with an idea for a Transformation Application; the concept and value proposition have increasingly become apparent. The timing of the HFS Transformation Collaboratives is a blessing and an opportunity to make it a reality.

To summarize and reinforce how we will work to reduce fragmentation and improve care coordination:

- **Leveraging the SASS model, and Updating Existing Bridges and Support Services:** We refer to CBT as “the connective tissue for the community”, which we each serve already in some capacity in the work we do. We also strong community networks through our affiliations with hospitals, community behavioral organizations, CPD and other social support resources, and many FQHCs, CMHCs, and Cook County Health System, and well positioned to for expanding to adults and to youth that have needs outside of the SASS model of after-care and hospital monitoring support (i.e., substance misuse, housing, other services).
- **Integrating Healthcare Services with Social Services:** The communities targeted for care improvement by the CBT model represent some of the most complex, and are those who need help from healthcare resources and social services. The CBT model helps integrate resources and provide bridges to and from each side. It is through this approach that our clinicians are able to organize their interventions, going beyond preconceptions of pathology to focus on the individual.
- **Getting with patients during time of crisis and knowing their SDOHs:** It is critical to reach someone as they experience adverse stress; it is critical to avoiding their developing deeper trauma and chronic mental illness. It is equally important to know their social determinants, so that a wholistic care plan can be created, managed, and updated to help our patients move forward with life. Through the variety of data and resources available, we will continue to take a leadership role in incorporating this into our work.
- **Working closely with Hospital EDs and Behavioral Health Departments:** Now more than ever with enabling legislation, we have an opportunity to re-create how we coordinate care for our patients. This team then would begin the work of connecting this group by leveraging relationships with community housing, health, economic, substance SUD recovery, and mental health agencies to connect them with services, and importantly, building in better follow-up tools and resources to stay connected.

### Access to care

Access to care, and access to resources, are a challenge for all underserved communities. This problem can be especially troublesome for populations suffering from Mental Illness or SUD, as there is often a Crisis Event that is both a healthcare and oftentimes a social issue. For us to best care for these populations wholistically, we need to look a combination of factors:

1. Access to healthcare services
2. Access to social services, and
3. How those service agencies and resources work together to best serve the population

### **CBT's work to improve Access centers around these focus areas:**

- Front end: Crisis Intervention and Support
- Back end: Follow-up care from Hospitalizations or ED Visits
- Preventive:
  - To avoid Crisis, and when in Crisis how to best handle and seek support
  - Education about triggers of Crisis Events and avoidance strategies

### Social Determinants of Health

The range of personal, social, economic, and environmental factors that influence health status, known as determinants of health, fall under several broad categories. CBT and our partners are well-versed in how Social and Structural Determinants of Health (SDOH) influence how people and populations are able to achieve and maintain wellness. We consider these core SDOHs:

- Employment
- Education
- Community Safety
- Food Systems
- Housing

The first contribution CBT makes is in strengthening health outcomes through greater care coordination. Failures of health, often unnecessary and often by-products of a fragmented system, compound all of the social determinants of health—making it difficult for people in our communities to hold a job or stay in school, live and work in safe places, afford nutritious food, and pay the rent. Also, CBT is envisioned to combine and coordinate healthcare and social support resources to minimize impact of SDOH on our patients and populations.

Individuals are unlikely to be able to control many of the determinants of health directly. These determinants, social and behavioral are targeted in our service provision, and particularly with the inclusion of our Crisis Intervention and Follow-up To Hospitalization and Follow-up To Emergency Department Visits services. While CBT cannot eliminate the determinants, we address health disparities first by enhancing health, then by actively understanding and managing SDOHs, while working at removing the stigma of addiction and mental health conditions and the barriers to treatment in underserved communities.

## Budget

Please see attached CBT Budget Proforma with Narrative Summary. Below is a summary and key highlights of our economic package and proposal:

### *Executive Summary of Economic Levers:*

- We are seeking \$11.7M over the 3-year term of our proposal: \$3.1M/Year 1, \$3.9M/Year 2, and \$4.6M/Year 3.
- We include Revenue Projections based on strategies to generate other sources including Philanthropy and MCO Value-Based Contracting.
- CBT projects to be self-sustaining going into Year 4
- Included with the Application is a spreadsheet with itemized costs and corresponding assumptions in the format provided by HFS. Assumptions are based on partner experience (salaries, benefits, stated or current vendor cost, etc.) and market research.

### *Key Points of the Model:*

- The CBT Collaborative (CBT) proposes a new hub for care coordination and post-crisis therapies in the Austin neighborhood, which houses the lowest number and breadth of outpatient behavioral-health and community services on the West Side of Chicago. CBT leadership has compiled data around service availability and volumes that indicates that all providers serving this population for crisis treatment and prevention are at maximum capacity, with long waiting periods for new patients to be engaged.
- CBT has identified several vacant spaces that would be ideal for this essential initiative in Austin, two of which once housed a CVS or Walgreen's. The budgeted costs for space were obtained via public real estate listings.
- The needs for the space have been determined based on current crisis volumes measured by diagnosis codes related to crisis for emergency department encounters and inpatient hospital stays for both detox and psychiatric services.
- A new center is needed that would include an unprecedented scope of available staff and services at a single location, as detailed in the Application this budget accompanies. Because the most common time for a repeat crisis, including suicide, is between discharge or release from the hospital and the first appointment for follow-up care, CBT has budgeted one new FTE per hospital partner in addition to the staff who would work in the new center. The new hospital employee would be dedicated to this initiative and would take the lead within each hospital on Collaborative activities: linkage with services and development of the Needs Assessment and plan of care.
- For each hospital partner, there would be a multidisciplinary team dedicated to ensuring crisis survivors leaving CBT partner hospitals receive coordinated care plans that include every resource needed to access care and achieve long-term stability.

## **Milestones**

Please see attached CBT GANTT Stand Up Plan With Milestones. Key highlights of our implementation planning include:

- Hire all staff for team and begin training on care coordination and cognitive processing treatment through summer.
- Rent space on West Side for team to operate out of, ensure that there is capability for drop-in services.
- Hire EHR consultant to begin to develop EHR technology platform to better coordinate with hospitals.
- Train staff in trauma informed approach, cognitive processing therapy, and linkage.
- Begin to attend staffing with behavioral health teams at hospitals partnered with.
- Have first community meeting to develop linkage and coordination efforts.
- Develop resource system for linkage and integrating teams work with NowPow! system
- Have space on West Side operational for team.

We can begin our Implementation Plan immediately, with a quick launch to accelerate progress:

- Begin recruitment and hiring process for targeted resources in safety net hospital Emergency Departments, C4 and partner agencies
- Begin sourcing space options for community center
- Engagement with MCOs to define future Value-Based Care contracts to address Utilization-Based incentives
- Launch community education and engagement tactical plans

## **Racial Equity**

Most of the clients of CBT Collaborators and partners are young people of color. In 2020, 80% of all clients served were people of color. C4's mental health experts that provide therapy services to our clients mirror the demographics of our clients. This team prioritizes hiring staff that reflect the West Side. We prioritize hiring staff that speak Spanish to assure that our Latinx adolescents with Spanish-speaking parents have access to family therapy the same way their English-speaking peers do. A cornerstone of C4's service delivery model is embedding our clinicians in the communities in which we provide therapy by partnering with our clients' natural supports, with a large focus with school systems and services in the home:

- We fundamentally believe that focusing on the strength of community ensures our ability to effectively work with clients from their perspectives and worldviews.
- We support people of color by affirming their worth and reality that they are often disadvantaged, through no fault of their own.
- We will consider their values, cultures and experiences that are unique to people of color.
- We will acknowledge and welcome their truths, including the ways the mental health systems have also failed them and hope that we can do better.
- We are cautious to not pathologize our people of color.

In working with West Side communities, we have found that weak social support systems, particularly within the immediate family, often is the biggest indicator of an individual's outcomes and success in their lives. In prioritizing the importance of engagement and prevention, we have invested resourcing in ensuring our staff have the ability to approach all youth with trauma-informed lens and are able to work with them from where they are situated. The CBT team will work within African American and Latinx communities, and we will work with community churches, houses of worship, and other faith-based community organizations, in both cases to better partner in learning how cultural traditions influence social determinants, but also to better understand how these influence these communities in managing their mental health needs but conversely impacts their ability to seek help.

***How CBT collaboration will incorporate racial equity:***

C4's vision as an agency is to be recognized as being essential to the well-being of the communities we serve and are very much invested in the continuous assessment of how we can use resources we have to best serve the needs of the communities we serve -- within the communities we serve.

Nationally, police departments are being called upon to increasingly respond to crisis situations, it has been found that 80% of the calls that police respond to have been in response to social problems. The current system of leaning upon police to respond to situations better suited for social workers increases the likelihood that people experiencing a mental health or substance use crisis may end up in confrontations with law enforcement personnel, be transported to emergency rooms and admitted to inpatient psychiatric facilities, or transported to a jail and subject to ongoing involvement in criminal justice systems. When individuals have traumatic experiences with police, they are less inclined to seek help when they need it, often leading to more acute mental health outcomes.

Central to equity on the Westside is working to de-criminalize behavior that is offensive and remediable, and to seek care in communities for the individuals involved either as perpetrators or victims. This starts with not pathologizing behavior and in continued work with the Chicago police to further develop crisis response in the community, moving from a threat-based response to de-escalation and remediation and as an alternative to, or concomitant to, criminal justice involvement.

All the CBT Collaborators are committed to continuing to develop equitable and effective crisis response solutions to ensure that vulnerable adults experiencing mental health or substance use needs are responded to in a manner that is least damaging and most apt to result in a peaceful and therapeutic outcomes. The Chicago Police Department also supports this project on many levels, including via our CIT Program Training, but was not able to formally sign on as a "Collaborator" during the time period required. But interest and energy are high around the CBT ideas we've discussed with them.

CBT will also look at how stigma is central to this in all our communities, and how this negative affect has been deepened by the COVID-19 pandemic. Stigma is central to this, and C4 invests in

continuously measuring our ability to successfully engage the community in services. The CBT collaborative is dedicated in raising mental health awareness and recognizing the impact stigma has had in entrenching individual and one’s community mental health needs. C4’s hospital liaison team is driven to work towards the goal of partnering with all of our diverse communities to help improve care for our communities.

Without adequate preventive mental health supports and marketed availability of services that effectively acknowledge racial inequalities and mental health stigma, often individuals don’t present to C4 until they have had a crisis episode. We operate with the foundation that reaching someone as they experience adverse stress is critical to avoiding their developing deeper trauma and chronic mental illness. This coalition is acutely aware how stressors related to race adds additional stress.

**Minority Participation**

Below is a partial list of current entities that are certified by the Illinois Business Enterprise Program (BEP) and not-for-profit entities that our partnering in the CBT collaborative with a brief summary of their role in the mission; we continue to work with our Collaborators to expand this list as we know there are more BEP partners with us.

GMA Construction Group	MBE		General Construction (did C4 buildout at Belle Plaine; can do buildout of leased space)
Martin Branding	MBE		Currently doing signage at C4/Belle Plaine; samefor leased space
Onyx Architects	MBE		Architect
Daysprings Inc.	MBE		Janitorial Services for C4/Belle Plaine & North; same for leased space

CBT, C4 and our Collaborators and Partners will continue to make our DEI strategies pillars of our collective and individual mission, vision and purpose statements. We will work together, and with HFS and others to develop ways to expand our approach to these issues.

**Jobs**

We have attached the data for our Collaborators detailing the number of existing employees delineated by job category and including the zip codes of the employees’ residence.

Over the course of our 3-year launch proposed herein, we plan on hiring over sixty (60) people. By policy, it is always our preference to hire from our communities and immediate neighborhoods. By definition, 12 of these 40 jobs must come from our communities and

neighborhoods. More specifically, the para-professionals as a requirement of their job duties will need intimate familiarity with the communities, their cultures, and its resources.

Organizations participating in CBT each have Diversity, Equity and Inclusion (DEI) strategies in place in their organizations and are committed to continuing to focus on improving these levels, and developing benchmarks. Another important part of our workforce development will be continued efforts at improving community relations between the healthcare community, the policing community, and our diverse communities.

### **Sustainability**

CBT's plan projects that we will self-sustaining in Year 4. This will be achieved via the following strategies:

- Engagement with MCOs to create Value-Based Care models that provide incentives, funding, data sharing and support. Specifically, to provide funding for up front ongoing Care Coordination Fees (as the MCOs currently do for many providers), and to provide Shared Savings incentives (as the MCOs currently do for many providers) to share some of the savings generated from our programs with us to fund the ongoing operations and reduce reliance on additional funding from HFS.
- Engaging HFS and MCOs in development of other alternative funding models to further our collective efforts beyond Year 3.

Over the course of the past 30 years, many of our Collaborators and partners have been party to initiatives that get launched and are not sustainable. We bring these learnings to this initiative and understand from the beginning that it must self-sustain over time.

### **Governance structure**

CBT is a collaborative, and creates no new entity, hence there is not a Board of Directors, but we will be governed by an inclusive and diverse Oversight Committee. Below is a summary of how we envision governance of CBT to be led through the Oversight Committee:

- Composition:
  - There will be two representatives from each Collaborator (suggest one clinical and one business leader), plus two at-large community members
- Meeting Cadence:
  - Weekly for the first 3 months, then monthly if organizationally ready
  - Eventually, the committee could decide to meet less regularly
- Functions:
  - Manage implementation and ensure to scheduled milestones, review and monitor Financial, Operational, and Quality Stewardship
  - Manage Quality Metrics to Performance Thresholds
  - Expanding CBT
  - Strategic Planning
  - Community Engagement and Relations
  - Government Relations and communication with HFS

### Summary & Next Steps:

We believe our proposal is a good one, and aligns well with the objectives identified by HFS:

- ***Improve Care for Targeted Communities:*** We have been inclusive amongst stakeholders in the community to address both healthcare and social determinants of health
- ***Address Economic Factors:*** There will be no reduction in access to services, we are estimating to add approximately 50 new jobs, and CBT will be sustainable after the 3-year term via a combination of economic levers including via utilization-based payments
- ***Data and Community-Driven:*** Our proposal and Application was created based on community needs as we all know it from the data we have access to and the people we work with every day; we combine that data and information into goal-driven targeted interventions for specific highly vulnerable, highly costly populations

We stand ready to immediately begin our work should we be awarded and entrusted with funding. The attached “Milestones” document details our workplan:

- Convene with Collaborators to construct detailed Implementation Plan for immediate realization of program benefits to communities, with full 3-Year Workplan constructed within 30 days and updated monthly
- Begin recruitment and hiring process for targeted resources in safety net hospital Emergency Departments, C4 and partner agencies
- Begin sourcing space options for community center
- Engagement with MCOs to define future Value-Based Care contracts to address Utilization-Based incentives
- Launch community education and engagement tactical plan

As indicated above we will, in each process and at each phase, incorporate the learnings of the pilot and adjust course, but always toward the goals identified above.

On behalf of C4 and all of our Collaborators and partners, we applaud HFS’ leadership in launching the Healthcare Transformation Collaboratives to help us help our communities better together. We appreciate the opportunity to submit this proposal, and humbly await your review and response.