2024 Substance Use and Mental Disorders Plan Update Appendices

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Appendix A

Palm Beach County Resilience and Recovery Ecosystem of Behavioral Health and Substance Use Disorder Care

PALM BEACH COUNTY RESILIENCE & RECOVERY ECOSYSTEM OF BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER CARE

ASAM* MULTIDIMENSIONAL ASSESSMENT (MESO)

ACUTE INTOXICATION AND/OR WITHDRAWL POTENTIAL
Exploring an individual's past and current experiences of substance use and withdrawl.

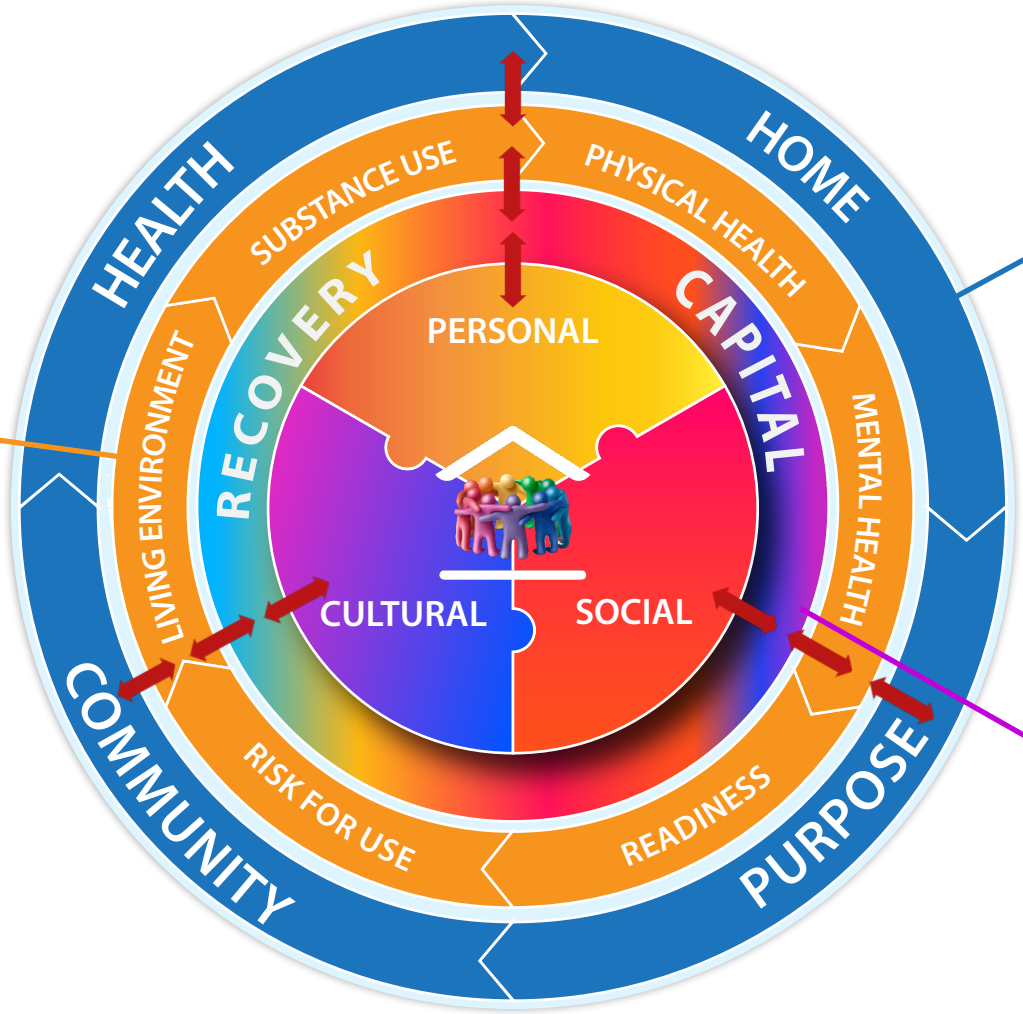
BIOMEDICAL CONDITIONS AND COMPLICATIONS
Exploring an individual's health history and curretn physical condition

EMOTIONAL, BEHAVIORAL,OR COGNITIVE CONDITIONS AND COMPLICATIONS
Exploring an individual's thoughts, emotions, and mental health issues

READINESS TO CHANGE
Exploring an individual's readiness and interest in changing

RELAPSE, CONTINUED USE,OR CONTINUED PROBLEM POTENTIAL
Exploring an individual's unique relationship with relapse or continued use or problems

RECOVERY/LIVING ENVIRONMENT
Exploring an individual's recovery or living situationand the surrounding people places



SAMHSA** DIMENSIONS OF RECOVERY (MACRO)

HEALTH
Overcoming or managing one's disease(s) or symptoms, and making informed, healthy choices that support physical and emotional well-being

HOME
Having a stable and safe place to live

PURPOSE
Conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society

COMMUNITY
Having relationships and social networks that provide support, friendship, love, and hope

RECOVERY CAPITAL (MICRO)

PERSONAL
- Generational Health
- Mental Wellbeing
- Nutrition
- Employment
- Education
- Housing Situation
- Transportation
- Clothing

SOCIAL
- Family Support
- Significant Other
- Social Support
- Social Mobility
- Healthy Lifestyle
- Access To Healthcare
- Safety

CULTURAL
- Beliefs
- Spirituality
- Sense of Purpose
- Cultural Relevance
- Sense of Community
- Values

MACRO
Concern with interaction and interdependence of individuals with their surrounding physical, social, and cultural systems in order to holistically assess how individuals affect and are affected by such systems. Make accessible a network of services and supports that is personcentered and builds on the strengths and resilience of individuals, families, and communities to achieve improved health, wellness, and quality of life.

MESO
Non-conflicted entity serving as a single point of contact providing assessment, level of care determination, referral, prior authorization and payment of certain care, and, care monitoring across clinical and non-clinical recovery support and social services aimed at achieving seamless movement in order to increase recovery capital and improve long-term recovery outcomes.

MICRO
Increasing recovery capital through network of "recovery hubs" and other support services providing nonclinical resources, including peer support, employment and job training linkages, social and recreational activities intended for people in or seeking recovery. Recovery capital and its indexing is the depth and breadth of internal and external resources that can be used by someone to begin and sustain their health and wellness.

*American Society of Addiction Medicine **US Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration

Appendix B

Palm Beach County Community Services Department
Neutral Care Coordination Executive Summary and Proposal

PROPOSAL

Establishing a Palm Beach County Neutral Care Coordination Entity and executing a person-centered, recovery-oriented system of care

Executive Summary
June 2023

Overview

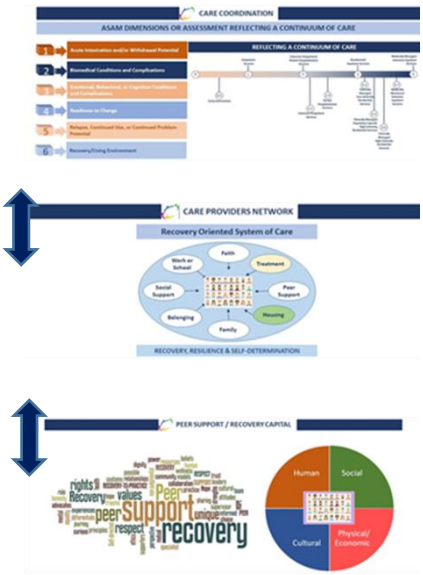
In July 2021, the Community Services Department (CSD) with the assistance of a team with expertise in neutrally coordinating and managing substance use disorder and mental health care completed a detailed proposal, "*Establishing a Palm Beach County Neutral Care Coordination Entity and executing a person-centered, recovery-oriented system of care.*" The proposal's objective was to plan and budget for achieving the Board of County Commissioners (BCC) major goal of establishing a readily accessible, integrated and coordinated recovery-oriented system of care that meets the needs of Palm Beach County residents and improves long-term recovery outcomes as well as quality of care.

The BCC first established this goal in November 2019. The Board as part of it identifying substance use has subsequently renewed the goal and behavior disorders as a strategic priority, most recently in November 2022. The BCC continues to do so in consideration of historic and continued challenges faced by the County's substance use disorder and behavioral system of care. Challenges exacerbated by both the opioid and COVID epidemics, which has created great systemic stress. Moreover, challenges that remain and include, but are not limited to:

- Fragmented and disjointed care from multiple treatment, social and recovery support providers.
- Treating the client based upon the services available at a particular provider rather than based upon their individualized needs.
- Ineffective transitioning of clients from one level of care or one service provider to another.
- Lack of timely sharing of needed treatment information among providers.
- Lack of monitoring and follow-up to ensure client engagement.
- Lack of accountability and agreed upon responsibilities among multiple treatment, social and recovery support providers serving one client.

CSD developed and executed a system of care model that is instrumental to achieving the BCC's goal. The model is consistent with achieving the process metrics related to the BCC goal above as follows:

- Implement care coordination.
- Establish recovery community organizations and recovery community centers; broaden the reach of peer support services across the continuum.
- Launch a Recovery Capital Instrument and train providers in its use.
- Support the Healthcare District's Addiction Stabilization Unit serve and integrate primary care and behavioral health services in partnership with the PBC Medical Society.



Outcomes

To date, the model's execution has identified the substance use disorder and behavioral needs of the client population; and, improved client care with linkage efforts across all health domains. It has also informed policy, planning, and programmatic decisions as well as served as the lens through which funding opportunities are identified and applied for. Fully executed, the model will inform public payers of appropriate level of care purchases resulting in cost-savings that will be reinvested to needed social determinant of health, recovery support and prevention services.

Additionally, significant progress has been made toward achieving the BCC's strategic priority of "Addressing substance use and behavior disorders by providing evidence-based prevention, medication-assisted treatment, and recovery support services." Moreover, toward its major goal of establishing a readily accessible, integrated and coordinated recovery-oriented system of care that meets the needs of Palm Beach County residents and improves long-term recovery outcomes as well as quality of care.

On November 15, 2022, the BCC approved an updated report containing findings and recommendations related to substance use and mental disorders entitled *Substance Use and Mental Disorders Plan Update, March 2022*, prepared by the Palm Beach County Behavioral Health, Substance Use and Co-Occurring Disorder Steering Committee. Said findings and recommendations included an Overarching Priority Recommendation to, "Implement person-centered, recovery-oriented system of care that is readily accessible and integrated inclusive of Neutral Care Coordination; Care Provider Network and Recovery Supports to ease transitions and continuity of care, remove barriers and improve long-term recovery outcomes."

Recovery Community Centers

In a major system of care advance, the BCC also approved completing the network of local recovery community organizations (RCO) and allied recovery community centers (RCC) on May 2, 2023. The aim is to foster a recovery-ready community, provide recovery support services, and engage and empower an authentic recovery voice.

Two sites are established in Delray Beach and Lake Worth Beach with expansion to take place in Riviera Beach and Belle Glade. Additionally, a countywide RCO coordinates the activities of, provides technical assistance to, the local RCOs, and provides public awareness, training, and advocacy services throughout Palm Beach County.

The network and its centers provide the model's critical underpinnings of peer supports and recovery support services. RCCs are intended to be recovery hubs facilitating "one-stop shopping" in the accrual of recovery capital and provide strong, recovery-specific, social support.

Research has shown that peer support facilitates recovery and reduces health care costs. Peer support is often coupled with recovery support services that include access to evidence-based practices such as supported employment, education, and housing; assertive community treatment; illness management; and peer-operated services.

These services have been shown to: reduce expensive inpatient service use; reduce recurrent psychiatric hospitalizations; improve individuals' relationships with health care providers; better engage individuals in care; and, significantly increase individuals' abilities to manage their symptoms and reduce their reliance on formal services while achieving positive recovery outcomes.

Recovery Capital Indexing

Recovery Capital		
Social Capital	**Personal Capital**	**Cultural Capital**
Family Support Significant Other Social Support Social Mobility Healthy Lifestyle Access to Healthcare Safety	General Health Mental Wellbeing Nutrition Employment Education Housing Situation Transportation Clothing	Beliefs Spirituality Sense of Purpose Cultural Relevance Sense of Community Values
60.85	52.36	70.76

Success at the individual level with respect to the CSD's behavioral health initiatives is being measured through deployment of the Recovery Capital Index®, (RCI).

RCI measures substance use disorder wellness using three domains (social, personal and cultural) and twenty-two components providing a comprehensive baseline and assessment of intervention effectiveness to allow for the tracking of client progress and tailored support. It is a peer-reviewed and validated assessment tool.

In 2020, the RCI was incorporated as a requirement into all of the Department's behavioral contracts as was the development of an individualized recovery plan developed parallel to historic treatment plans.

Additionally, providers are being required to and measured on completing a warm hand-off to the RCC's non-clinical environment. This is important because the length of an individual's engagement in clinical and non-clinical care (not length of stay in a singular treatment facility) is an important predictor to achieving long-term recovery outcomes.

To date, more than 2,500 RCI surveys have been completed with a 94 percent completion rate. In other words, of individuals who have initiated the 68-question survey, 94 percent have completed it.

5 Highest Indicators	
Sense of Purpose	77.8
Beliefs	72.7
Safety	69
Values	68.7
Sense of Community	68.2

5 Lowest Indicators	
Financial Wellbeing	37.1
Employment	46.4
Housing/Living Situation	48.4
Nutrition	49.7
Access to Healthcare	51.5

The overall average scores as well as the highest and lowest indicators are found in the charts. The results are not static. They are regularly interpreted and used to inform the individualized recovery plans; services offered at the RCC's; and, CSD's budgeting and planning.

Comprehensive Opioid Stimulant Substance Use Program

Palm Beach County was awarded a federal Department of Justice Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) that the OBHSUD leveraged to engage with Florida Atlantic University School of Social Work and Criminal Justice (FAU) as a research partner to investigate the efficacy of the Office's system of care work; its recovery-oriented initiatives and RCI deployment. The County's COSSUP aim is to reduce overdose deaths, promote public safety, and support access to treatment and recovery services in the criminal justice system.

> "I did a year in jail, which sucked. But the people here (RCC) are great. It doesn't matter what... If you don't call, you can just show up, and a friendly face with a smile and the personalities that walk around here and help everybody out is good. You need more like that in the world these days. There's not enough of it."
>
> *Michael, COSSUP Participant*

The County's COSSUP was operationalized in July 2021 through a contract with Rebel Recovery. Given housing stability's key predictive value in achieving long-term recovery outcomes, a primary focus of the program is on achieving housing stability for criminal justice involvement individuals at high risk of overdose. COSSUP also expedites recovery support services, provides housing vouchers, care coordination, and flex fund support.

OBHSUD worked closely with FAU and Rebel Recovery to define and measure housing stability standards and other recovery support interventions in the recovery residence environment in order to determine their impact on long-term recovery outcomes. Both qualitative and quantitative analytics is being used to measure the following:

1. Identifying barriers to long-term recovery & recidivism.
2. Determining the impact of recovery capital, housing stability and a recovery-oriented system of care on individuals with criminal justice involvement and substance use histories through the utilization of Recovery Capital Indexing.
3. Understanding whether, the services provided by Peer Support Specialist (PSS) effective in long-term recovery and recidivism reduction.
4. Understanding if housing stability is effective in long-term recovery and recidivism reduction.

FAU, using Recovery Capital Indexing, defined outcome as 90-day overall personal capital which includes factors such as general health, mental and emotional wellbeing, nutrition, employment, education, financial wellbeing, housing and living situation, transportation, and clothing. Two other major outcomes examined were re-arrest and housing stability at 90 days.

"(NAATP is) encouraged by your efforts in Palm Beach County, in particular your work related to measuring and monitoring recovery capital… We strongly believe this is the key to real and lasting reform. We have been following the progress of Palm Beach County's systems work with great interest, as we believe you may be the first county in the nation to adopt this approach on a broad scale. This work serves as a model that we hope will be implemented throughout the country with support and encouragement from NAATP."

Marvin Ventrell, NAATP CEO

In research findings published in fall 2022, FAU found the County's COSSUP is demonstrating efficacy and outcomes that are not only informing Palm Beach County's system of care work but also the nation. National organizations such as the National Association of Addiction Treatment Providers are taking note and affirming the County's work. As has Georgetown Law's O'Neill Institute for National & Global Health Law in its recently published report, "*Transcending MET (Money, Ego, Turf) A Whole Person, Whole Government Approach to Addressing Substance Use Disorder through Aligned Funding Streams and Coordinated Outcomes."*

FAU's study demonstrated the importance of having a RCC as a safe space in an individual's early recovery and reentry period to begin self-reflection, and build self-worth and self-efficacy. The study found of the 36 participants in the project's first year, 86 % (n= 31) did not have a re-arrest. Of the 14 % (n = 5) that had a re-arrest, only one participant had a new charge whereas the others were based on technicalities.

The study is making important contributions to understanding the relationship between an individual's recovery capital and achieving long-term recovery through known predictors of such. The study, through analyses between re-arrest and continuous variables, demonstrated two significant results. One, the recovery capital score on Access to Healthcare at baseline was significantly associated with re-arrest. Moreover, the recovery capital Values score at baseline were predictive of re-arrest at end of program.

The overall Cultural Capital and Family Support recovery capital scores at baseline were statistically significantly and directly associated with stable housing at 90 days. Additionally, the overall Social Capital recovery capital score at baseline was significant as a predictive variable with stable housing in addition to other sub scores under Social Capital.

Findings from the qualitative and quantitative results demonstrated the importance of targeting interventions focused on building social and cultural capital. First year statistical results are holding true through the completion of the project's second year.

This program demonstrates the importance of peer support specialists, care coordination and building community connections to increase personal capital that aids in long-term recovery and reducing recidivism rates. An area FAU highlighted is the notable barrier that court fees present in the individual's recovery and recidivism reduction. Another area highlighted was the significant racial disparities with personal capital and its impact on recovery and recidivism.

There were also several housing barriers noted in the program such as not accepting participants that were being treated with medication for opioid use disorder. Additionally,

recruiting recovery residences to participate in the program's Recovery Housing Provider Network proved difficult. This was true despite a 26-week resident housing voucher that met market rate and participant requirements that did not exceed Florida Association of Recovery Residences certification standards or applicable federal law.

The OBHSUD is currently finalizing proposals to establish transitional and affordable housing opportunities for the target populations in order to address these housing barriers.

Neutral Care Coordination Entity

In 2022, 211 Palm Beach and Treasure Coast reported 20,534 calls seeking assistance for mental health or substance use disorders (including 801 suicide related calls) representing 27.01% of all its calls. This kind of call volume begs for more than the historic information and referral response to such calls. It also calls for a systemic approach that addresses the historic and continued challenges faced by the County's substance use disorder and behavioral system of care identified earlier; not the least of which is the fragmented and disjointed care that currently exists from multiple treatment, social and recovery support providers.

Ariana Ciancio, LMHC, MCAP, Service Population Advocate Manager for the Delray Beach Police Department who serves Delray Beach's homeless population served on the team that developed the July 2021 proposal, "*Establishing a Palm Beach County Neutral Care Coordination Entity and executing a person-centered, recovery-oriented system of care."* She also served seventeen years as Lead Care Coordinator for National Council on Alcoholism and Drug Dependence-New Jersey (NCADD-NJ) neutral care coordination program which is now in place for twenty five years and has conducted more than 150,000 neutral assessments

"Neutral Care Coordination was key in getting people properly assessed and referred to appropriate care based on their individual needs. This would be critical in the implementation of the ROSC initiative as it will provide neutrality and an individual plan of care in Palm Beach County."

Ariana Ciancio, LMHC, MCAP
Service Population Advocate Mgr.

Ariana states, "Neutral Care Coordination was key in getting people properly assessed and referred to appropriate care based on their individual needs. This would be critical in the implementation of the ROSC initiative as it will provide neutrality and an individual plan of care in Palm Beach County." She and the team's work in developing the proposal provide great depth as to the proposed Neutral Care Coordination Entity's (NCCE), function, form, processes as well as budget requirements and justifications.

To summarize, the NCCE, an initial point of contact for those in need, is central to the County's system of care efforts. The primary goals of the NCCE are to:

- Ensure uniform assessment of substance use and/or mental health severity throughout the client population in order to decrease fragmentation of treatment services among providers offering various levels of care.
- Maintain and utilize a comprehensive continuum of addiction and/or mental health treatment services integrated with other social, non-clinical and recovery

support services.

- Provide the structure, process, and outcome measures necessary to meet care coordination goals and to streamline continuity, communication, and tracking of clients across providers and service settings.
- Accomplish the necessary underlying structure and processes needed to meet care coordination goals.

The NCCE will provide assessment, referral and care coordination services oriented toward individualized service plans unique to the individuals' needs and in consideration of their choices. It will also serve as prior authorizer and payer of certain care.

These services will be coordinated and provided within a Care Provider Network of treatment, social and recovery services. They will be also complemented by, as well as, with the underpinnings of peer supports, which are tied to recovery capital outcomes measuring and monitoring through the established RCO and RCCs.

In a study published in the American Journal of Public Health, researchers tested the effectiveness of a long-term coordinated care strategy - intensive case management (ICM) - compared with usual care (UC) which was piloted by the NCADD-NJ and since has become the standard of care coordination for the state's welfare-to-work population.

UC is often referred to as the "screen and refer" model and was the standard of care in New Jersey at the time of the study. ICM is consistent with a chronic disease management strategy that augments current disconnected episodes of acute care with longer-term care strategies and cross-systems coordination that addresses other health and social needs and provides relapse monitoring and support during extended periods.

Researchers found ICM clients had significantly higher levels of substance abuse treatment initiation, engagement, and retention compared with UC clients. In some cases, ICM treatment attendance rates were double those of UC rates. Additionally, almost twice as many ICM clients were abstinent at the 15-month follow-up compared with UC clients.

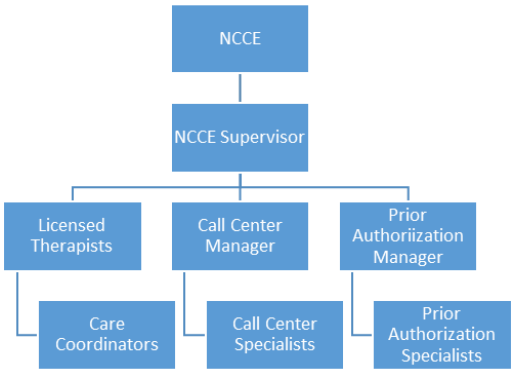
NCADD-NJ through its Work First New Jersey Substance Abuse and Behavioral Health Initiative has coordinated the substance use and behavioral health care of approximately 5,800 (unduplicated) individuals annually for the state's welfare to work population since 1998. It reports that in 2022, through validated appropriate level of care assessments, 89% of treatment placements were for outpatient care while 11% of placements were for inpatient care.

NCADD-NJ also reports its average cost per client per episode of care is $3400 compared to the national average of between $14,000 and $23,000. This is one example of how a neutral entity responsible for assessing need and coordinating care can result in fewer high-intensity treatment and cost savings.

NCCE Project Personnel and Budget

Detailed Personnel, Budget and Justifications are found within the detailed proposal, "*Establishing a Palm Beach County Neutral Care Coordination Entity and executing a person-centered, recovery-oriented system of care."* To summarize, NCCE staff costs were calculated assuming 20,000 admissions (not unduplicated) to substance use disorder or mental health services annually. Staffing requirements are based on a five (5) day workweek consisting of 7.5 hours per day, excluding a 30-minute lunch break. Proposed salaries include fringe benefits at a rate of 30% of stated salaries.

The NCCE Supervisor will have administrative responsibility for the entity. The Supervisor will also be responsible for the supervision of a team of licensed therapists and the Call Center Manager.



NCCE Licensed Therapists will have responsibility for conducting a mental health and substance use disorder clinical assessment. Licensed Therapists will also be responsible for supervising care coordinators and serving as initial authorizers of certain care.

Care Coordinators, as key personnel to the system of care, will be responsible for conducting a comprehensive case management assessment that addresses multiple life domains and developing an Integrated Recovery Plan that is person-centered and respects client choice. Care Coordinators will also be responsible for monitoring progress of the treatment plan authorized by the Licensed Therapist and the Integrated Recovery Plan. They will also be linking clients to appropriate care and resources in the community as well as serving as ongoing authorizer's of payment care.

The NCCE Prior Authorization Manager will have administrative responsibility for the Prior Authorization Unit and be responsible for planning, assigning and supervising the work of the Prior Authorization Specialists.

Prior Authorization Specialists will be responsible for processing of prior authorizations as well as interact directly with providers to assist them in billing and claims. Specialists will also be responsible for gathering, compiling and preparing information to be entered into related reporting systems.

The NCCE Call Center Manager will have administrative responsibility for the Call Center and be responsible for planning, assigning and supervising the work of the Call Center Specialists.

Call Center Specialists will be responsible for specialized contact with individuals seeking mental health and substance use disorder services through the Call Center. They are also responsible for answering inquiries and furnishing information to individuals by telephone or other means; scheduling assessments with Licensed Therapists; reviewing and processing related paperwork and preparing and reconciling reports.

Initial Phase @ 5,000 admissions annually

Title	Quantity	Salary*	Total
Supervisor	1	$59,269	$59,269
Licensed Therapist	5	$56,305	$281,525
Care Coordinator	9	$45,853	$412,677
PA Manager	1	$38,311	$38,311
PA Specialist	3	$33,698	$101,094
Call Center Manager	1	$52,131	$52,131
Call Center Specialist	1	$36,393	$36,393
		Sub-total	$981,400
		Fringe (@ 30%/salary)	$294,420
		Total	$1,275,820

Second Phase @ 15,000 admissions annually

Title	Quantity	Salary*	Total
Supervisor	1	$59,269	$59,269
Licensed Therapist	15	$56,305	$844,575
Care Coordinator	27	$45,853	$1,208,031
PA Manager	1	$38,311	$38,311
PA Specialist	8	$33,698	$269,584
Call Center Manager	1	$52,131	$52,131
Call Center Specialist	2	$36,393	$72,786
		Sub-total	$2,544,687
		Fringe (@ 30%/salary)	$763,406
		Total	$3,308,093

Final Phase @ 20,000 admissions annually

Title	Quantity	Salary*	Total
Supervisor	1	$59,269	$59,269
Licensed Therapist	18	$56,305	$1,013,490
Care Coordinator	35	$45,853	$1,604,855
PA Manager	1	$38,311	$38,311
PA Specialist	9	$33,698	$303,282
Call Center Manager	1	$52,131	$52,131
Call Center Specialist	2	$36,393	$72,786
		Sub-total	$3,144,124
		Fringe (@ 30%/salary)	$943,237
		Total	$4,087,361

PROPOSAL

Establishing a Palm Beach County Neutral Care Coordination Entity and executing a person-centered, recovery-oriented system of care

July 2021

Rationale

Historic and recent challenges faced by the County's behavioral health and substance use disorder system of care, particularly those related to addressing its opioid and COVID epidemics, has created great systemic stress. These challenges include a reported 26% increase in first quarter opioid overdose deaths from 112 in 2019 to 144 in 2020. Moreover, a staggering 79% increase in the second quarter from 91 in '19 to 163 in '20. Overall, there was a 27% increase in deaths from 446 in '19 to 566 in '20. The first two quarters of 2021, show a downward trend with 71 confirmed opioid deaths and 167 overdose deaths overall.

> The pandemic caused me to lose my job and to have depression and anxiety. Being alone is one of the things I do not like about the pandemic.
>
> *Storyteller: Female 18-30 years old*

On a good note, suicides were reported down year over year by 32%. This alone though does not tell the complete tale of COVID's impact. One need only review Palm Health Foundation's COVID-19 Story Collection Project, wherein more than 900 community members told their very personal, and sometime heart-wrenching, stories of how coronavirus has affected their lives to get a true picture.

The systemic challenges remain and include, but are not limited to:

- Fragmented and disjointed care from multiple treatment, social and recovery support providers.
- Treating the client based upon the services available at a particular provider rather than based upon their individualized needs.
- Ineffective transitioning of clients from one level of care or one service provider to another.
- Lack of timely sharing of needed treatment information among providers.
- Lack of monitoring and follow-up to ensure client engagement.
- Lack of accountability and agreed upon responsibilities among multiple treatment, social and recovery support providers serving one client.

These challenges continue to force key stakeholders and others to analyze the system of care and to explore ways to improve long-term recovery outcomes and quality of care. In its wisdom, the Board of County Commissioners (BCC) identified the opioid epidemic, behavioral and substance use disorder as a high strategic priority in 2019.

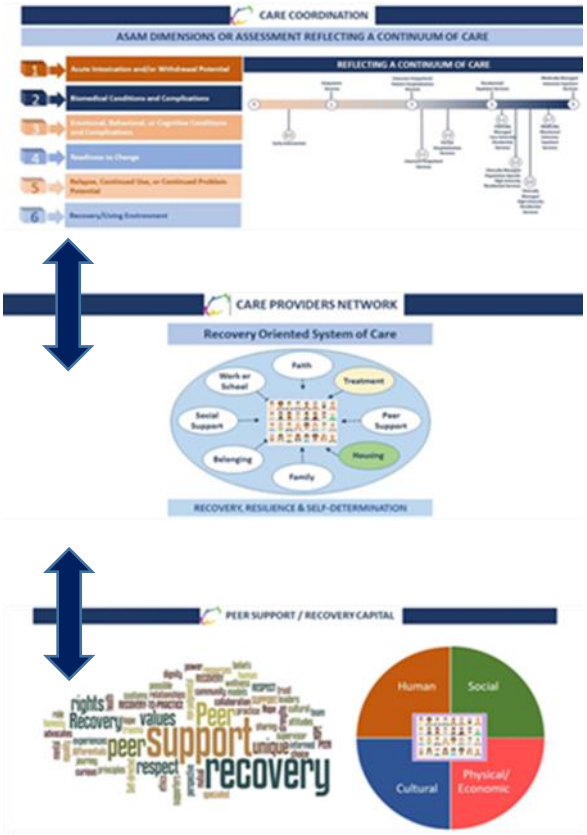
The BCC identified as an important goal the establishment of a readily accessible, integrated, person-centered and coordinated recovery-oriented system of care that commits to quality, evidence-based addiction and mental health services and integration of the Addiction Stabilization Facility.[1] Since, a cross-departmental team of key County staff, Department leads

[1] Hulick, J. Young, L. "Substance Use and Behavior Disorders Cross Departmental Team." Palm Beach County Board of County Commissioners Presentation. West Palm Beach, FL, November 16, 2019.

and resources has been utilized to plan and budget strategically as it aims to re-tool behavioral health care services for the residents of Palm Beach County.

B. Project Description

The Community Services Department developed a system of care model which is expected to truly deliver on and implement the person-centered, recovery-oriented system of care envisioned by the BCC which, to date, has been elusive. It is also expected to identify the behavioral health and substance use disorder needs of the client population; improve client care with linkage efforts across all health domains; and, inform public payers of appropriate level of care purchases resulting in anticipated cost-savings which will be reinvested to needed social, recovery support and prevention services.



The proposed system of care is consistent with achieving the process metrics related to the BCC goal above as follows:

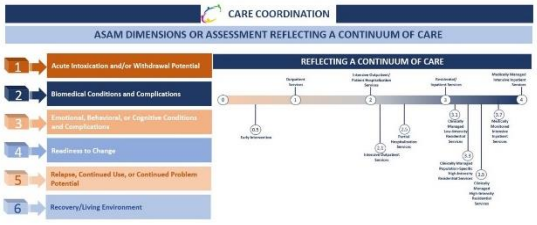
- Implement care coordination.
- Establish recovery community organizations and recovery community centers; broaden the reach of peer support services across the continuum.
- Launch a Recovery Capital Instrument and train providers in its use.
- Support the PBC Healthcare District's (HCD) efforts to have the Addiction Stabilization Facility (ASF) serve as the central point of intake/triage center for all overdose cases; and, integrate primary care and behavioral health services in partnership with the PBC Medical Society.

The system of care will also inform policy, planning, and programmatic decisions as well as be the lens through which funding opportunities are identified and applied for. A Neutral Care Coordination Entity (NCCE) will be central to the system. It will provide assessment, referral and care coordination services oriented toward individualized service plans unique to the individuals' needs and in consideration of their choices. It will also serve as prior authorizer and payer of certain care.

These services will be coordinated and provided within a Care Provider Network of treatment, social and recovery services. They will be also complemented by, as well as, with the underpinnings of peer supports, which are tied to recovery capital outcomes measuring and monitoring through recovery community organizations and allied recovery community centers.

The model affords the unique ability to rapidly provide the exact recovery services called for and allow appropriate services to be maintained which will improve long-term recovery outcomes. A coordinated continuum of substance use disorder treatment and recovery services is also an effective and a very good predictor to an individual achieving long-term recovery.

B. (1) Project Description / Neutral Care Coordination Entity



In a study published in the American Journal of Public Health, researchers tested the effectiveness of a long-term coordinated care strategy - intensive case management (ICM) - compared with usual care (UC) which was piloted by the National Council on Alcoholism and Drug Dependence-New Jersey (NCADD-NJ) and since has become the standard of care coordination for the state's welfare-to-work population.

UC is often referred to as the "screen and refer" model and was the standard of care in New Jersey at the time of the study. ICM is consistent with a chronic disease management strategy that augments current disconnected episodes of acute care with longer-term care strategies and cross-systems coordination that addresses other health and social needs and provides relapse monitoring and support during extended periods.

Researchers found ICM clients had significantly higher levels of substance abuse treatment initiation, engagement, and retention compared with UC clients. In some cases, ICM treatment attendance rates were double those of UC rates. Additionally, almost twice as many ICM clients were abstinent at the 15-month follow-up compared with UC clients.[2]

NCADD-NJ through its Work First New Jersey Substance Abuse and Behavioral Health Initiative has coordinated the substance use and behavioral health care of approximately 5,800 (unduplicated) individuals annually for the state's welfare to work population since 1998. It reports that in 2020, through validated appropriate level of care assessments, 89% of treatment placements were for outpatient care while 11% of placements were for inpatient care. It also reports its average cost per client per episode of care is $3400 compared to the national average of between $14,000 and $23,000.[3] This is one example of how a neutral entity responsible for assessing need and coordinating care can result in fewer high-intensity treatment and cost savings.

[2] Improving 24-Month Abstinence and Employment Outcomes for Substance-Dependent Women Receiving Temporary Assistance for Needy Families With Intensive Case Management Research and Practice | Peer Reviewed | Morgenstern et al. American Journal of Public Health | February 2009, Vol 99, No. 2 pp, 328 to 333.
[3] Wolff, S. Hightower. R. "Work First New Jersey Substance Abuse and Behavioral Health Initiative." Sober Homes Task Force presentation. West Palm Beach, FL, September 27, 2018.

The primary goals of the NCCE are to:

- Ensure uniform assessment of substance use and/or mental health severity throughout the client population in order to decrease fragmentation of treatment services among providers offering various levels of care.
- Maintain and utilize a comprehensive continuum of addiction and/or mental health treatment services integrated with other social, non-clinical and recovery support services.
- Provide the structure, process, and outcome measures necessary to meet care coordination goals and to streamline continuity, communication, and tracking of clients across providers and service settings.
- Accomplish the necessary underlying structure and processes needed to meet care coordination goals.

A NCCE module will be designed and developed to support on-going client engagement and enable services to be coordinated across the continuum of substance use disorder and mental health care. This care will be integrated with other social, non-clinical and recovery support services.

The NCCE will be a non-conflicted, neutral body, which serves as a single point of entry (SPOE) for referrals to providers as well as prior authorizer of and payer of certain care. Its core values are:

- Client choice and identified needs shall be the primary driver of service engagement and referral in a timely fashion. Clinical decisions shall be based on client need and obtaining best available care.
- Care coordination shall assist the client with a successful transition between assessments, initial placement, through a seamless movement along the continuum of care.
- Coordination services to include facilitation of communication among all professionals involved with the client and the community identified provider which most closely meets client's needs.
- Primary role is to eliminate barriers to achieve acceptance and admission to the appropriate level of care and facility in a timely manner.

Key elements to ensure NCCE services are client-centered and recovery-oriented include but are not limited to:

- Facilitate face-to-face or phone interview with the client and treatment provider when needed for admission review and acceptance. Utilization of an 800-phone line available 24/7 to link targeted individuals and the community-at-large to most appropriate resource to meet their needs.

- Facilitate completion of paperwork and other admission requirements in a timely manner (including release of information).
- Assist with provision of any evaluation reports needed (medical, psychiatric, dental, medication records, legal information, etc.).
- Identify any client barriers, facilitate scheduling of any necessary appointments (i.e., medical clearances, evaluations, etc.), and obtain reports as needed.
- Ensure medical needs are met in a timely manner to not delay engagement in treatment.
- Linkages to services (i.e., public assistance, social security, disability, legal services, pre-natal care, homeless services, medical care, self-help meetings/resources, HIV testing, counseling for domestic violence, trauma, recovery community centers, recovery community organizations and other community supports).
- Communicate with required collateral contacts involved with the client regarding assessment results, admissions, denials or delays for admissions, and case status as needed and with appropriate consents.
- Assist with potential barriers such as transportation to treatment and appointments.
- Monitor waiting lists for admission to treatment facilities and keep client and professionals informed via phone or email.
- Review consents for accuracy and forward as appropriate safeguarding client's privacy and confidentiality, as required by law.
- Maintain up-to-date records and ensure compliance with HIPAA and other legal requirements.
- Ensure on-going clinical case reviews occur with treatment providers to ensure targeted goals are being met and that placement and services continue to remain appropriate.
- Apply a cross-systems approach to case management by communicating with other agencies and advocating for the client to ensure client needs and goals are being met. Agencies may include public assistance, parole or probation officers, child protection services, etc.
- Track and report on outcomes measures.
- Participate and when needed, facilitate discharge and step-down planning conferences.

B. (1)(a) Intake and Assessment

Key Intake and Assessment components of the NCCE will include:

- An Immediate Need Profile (INP), in the form of a short questionnaire is to be completed as part of the intake process. The INP is to assess: acute intoxication and/or withdrawal potential; severe physical health problems; imminent danger or risk of future harm; inability to function in activities of daily living (ADL); dangerous living environment; any requirements by a 3rd party agency for the client to engage in a

treatment program within a specified time frame (i.e., court mandate – drug or family court).[4]

- Have access to Mobile Crisis Unit and/or emergency personnel if an involuntary treatment placement is required to ensure client does not engage in self-harm or harm to others or has an emergent medical need that requires transport to a hospital emergency room and/or receiving facility.
- A comprehensive assessment shall be completed independently by the client and provided to a separate staff member.

B. (1)(b) Referral to and Coordination of Treatment and Other Care Services

Referrals shall be based on Assessment results and appropriate level of care as determined by assessment to ensure client is recommended for the most clinically appropriate and least restrictive level of care. Referral is individualized and involves clients in decision-making. Other client-focused considerations include informed decision-making, strength-based recommendations and access to formal and informal supports and resources that will support treatment and recovery.

Neutral Care Coordinators' priority goals are to:

- Eliminate barriers.
- Develop Client individualized recovery plan (treatment, discharge, recovery supports and services, and an on-going recovery plan with provisions for peer supports and interventions as needed to help support and sustain recovery). Service planning across the continuum of care is to be discussed from the beginning, with pro-active steps taken from the outset to ensure client's future success.
- Prioritize client choice through transparent explanation of treatment options and recommendations based on screening and assessment so that Client makes informed choice and is involved in planning process (which optimizes successful treatment experiences and outcomes).
- Utilize Motivational Interviewing techniques.
- Present pros-cons of recommended treatment options and risks of treatment versus no treatment.
- Memorialize client decisions in writing through utilization of a Treatment and Recovery Plan Agreement.

[4] Here are some examples of INPs from other states (NJ, MO and CA).
NJ:https://www.state.nj.us/humanservices/dmhas/initiatives/managed/Immediate_Need_Profile.pdf
MO: http://18vtj92co9zb1qy8011oc0fw-wpengine.netdna-ssl.com/wp-content/uploads/The-ASAM-Criteria-Immediate-Need-Profile.pdf
CA (San Bernardino County): https://wp.sbcounty.gov/dbh/wp-content/uploads/2019/03/SUDRS027-Immediate-Need-Profile_FILLABLE-02.2019.pdf

- Obtain reciprocal releases signed by client to share information with the referring agency and collateral contacts.
- Treatment referral to appropriate level of care and intensity of services, based on ASAM criteria or LOCUS and results of DSM-5 diagnosis (if co-occurring)- with an immediate warm hand-off if possible. Contacts with providers are to be completed in client's presence and with resources as needed to get client to (transported to) treatment (i.e., if in-patient and client does not have transportation, then transportation should be set up as part of the care coordination along with finding an in-patient bed; if outpatient treatment is recommended and client lacks housing, transportation, these ancillary needs shall be met to remove barriers to treatment).
- Maintain client contact – outreach and manage (coordinate) integrated care through client engagement throughout the process.

B. (1)(c) Prior authorization and payer of certain care

Prior authorization shall be based on identified client need and most appropriate recommended level of service for a specified timeframe. The following are the goals of Prior Authorization:

- Care Coordination and Treatment Provider collaboration.
- Ensuring clinically appropriate treatment placement and movement along the continuum of care.
- Systematic and accurate payment structure designed to generate payment at the beginning of every month (optimally with a payment module integrated into the health information system).
- Accountability and compliance by the treatment provider community.
- Eliminate gaps in services.
- Ensure client eligibility and troubleshooting.

Continued service reviews ensure that appropriate services are delivered and that either anticipated progress is being made toward the established clinical goals or the treatment plan is adjusted accordingly. This review allows the Care Coordinator to obtain necessary clinical information to document the need for ongoing care.

Payment Authorization Process:

- Prior-Authorization for services are transmitted via secure web portal to the provider prior to delivery of services authorized for a designated length of stay and for a specific number of designated service units.
- Providers are responsible for submitting a written request via this portal for continuing services beyond the pre-authorized time and/or for more than the pre-authorized number of designated service units. All requests must be submitted with a clinical justification for continued services prior to the expiration of the pre-authorized time

and/or designated service units, for outpatient services, not less than five (5) business days before the initial time expires and for residential placement, not less than two (2) business days before the expiration of the preauthorization period. Once the clinical reasons for continued service are reviewed and as appropriate, have been approved, a new prior-authorization will be generated to the provider that will authorize a new service period and/or new number of service units, which will be eligible for reimbursement.

- All treatment services must be pre-authorized prior to clients receiving them.

Payment Authorization (PA)

An electronic system for prior-authorizations and payment authorizations will be developed in conjunction with the health information utilization system, which will verify delivery of services that are eligible for payment.

Treatment Providers would be responsible for entering clients' weekly attendance into a Payment Authorization module that would be developed and integrated into the Prior Authorization module in a secured web portal.

At the beginning of each month, the Payment Authorization Unit would be responsible for processing the invoices for the treatment providers for the prior month's pre-authorized treatment services. The Payment Authorization Unit reviews the attendance, along with the services that were pre-authorized for clients and authorizes payment (or reimbursement) accordingly.

The Payment Authorization Unit enters the approvals into the (Fiscal Agent's Management Information system) which then notifies the providers that their Payment Authorizations are ready). Following notice of approval, Providers may login to the secure web based portal and download their Payment Authorizations to submit with invoices for payment. Once providers have received their Payment Authorizations, they must submit their claims through the fiscal agent for payment.

B. (1)(d) Call Center

A NCCE Call Center will facilitate access to care for Palm Beach County residents with substance use disorder and mental illness challenges through a 24/7/365 telephonic single point of access. Call Center Specialists will be trained to field calls, provide resources, and conduct a brief screening.

The Specialist will schedule a complete substance use/mental health assessment with an NCCE Licensed Therapist for those residents identified as in need based on the initial screen. The assessment will be scheduled as soon as possible but no later than three business days from

initial contact. In emergencies, the specialist will triage callers to the most appropriate provider.

The Call Center will be staffed from 8:00AM – 5:00PM daily, Monday through Friday. The Center's second and third shifts along with weekend shifts will be staffed via a memorandum of understanding with Palm Beach County 211.

The Call Center Manager will oversee the monitoring of calls recorded through the Call Center operations and the completion of documentation audits for utilization management. The Manager will monitor compliance with quality standards, accreditation requirements, audit requirements, internal protocols and Palm Beach County 211's compliance with the memorandum of understanding.

Performance indicators pertaining to Call Center calls shall include but are not limited to professionalism, respect and courtesy, providing correct information, making sure the caller is aware of next steps or what next to expect, determining the correct call resolution status, and documenting the call properly, and following specific protocols for handling registration, providing community information and referrals.

Additionally, the Call Center Manager shall establish policy and procedures to seek feedback about residents' experience and satisfaction in their interactions with the Call Center. The Manager shall support and facilitate suggestions, feedback, and input into Quality Improvement activities, which may include, but not be limited to, using the following:

- Telephone surveys made to residents' services to inquire about their experience in speaking with Call Center Specialists.
- Mailed satisfaction surveys sent to residents inquiring about satisfaction and degree to which services helped residents.
- Targeted surveys to community organizations or system partners assessing their experience with the Call Center.
- Following up with residents regarding whether they are satisfied in the resolution of complaints.

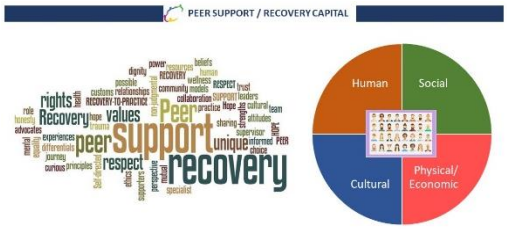
C. Project Description / Care Provider Network

The Care Provider Network (CPN) is a coordinated network of community based services and supports that will be person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve long-term recovery and improved health, wellness, and quality of life for those with or at risk of substance use disorders.

The CPN will require NCCE Care Coordinators to engage people and families in community support networks to ease their integration back into the community. The services and supports will be delivered in more traditional behavioral health and substance use disorder settings as well as less traditional non-clinical settings like Recovery Community Centers (RCC). RCCs provide services, adding a third tier to the 2 existing tiers of formal treatment and mutual help organizations.

The services and supports may include resources such as: recovery centers and activities; peer supports; mutual help groups; housing; transportation; education and vocational services; mental health and substance use disorder services; medical care, including HIV services; financial and budget counseling; legal and advocacy services; prevention for children and adolescents; and parenting and family services.

D. Project Description / Recovery Community Centers - Peer Support – Recovery Capital



Peer support services will be delivered by individuals through a network of Recovery Community Organizations (RCO) and allied Recovery Community Centers (RCC). Peers have common life experiences with the people they are serving and a unique capacity to help each other based on a shared affiliation and a deep understanding of this experience. Research has shown that peer support facilitates recovery and reduces health care costs. Peer support is often coupled with recovery support services which include access to evidence-based practices such as supported employment, education, and housing; assertive community treatment; illness management; and peer-operated services.

These services have been shown to: reduce expensive inpatient service use, reduce recurrent psychiatric hospitalizations, improve individuals' relationships with health care providers, better engage individuals in care, and significantly increase individuals' abilities to manage their symptoms and reduce their reliance on formal services while achieving positive recovery outcomes.

RCCs are intended to be recovery hubs facilitating "one-stop shopping" in the accrual of recovery capital and provide strong, recovery-specific, social support. They may include, but not be limited to, housing; transportation; education and vocational services; mental health/substance use disorder services and medical care linkages, including HIV services; financial and budget counseling; legal and advocacy services; prevention for children and adolescents; and parenting and family services.

RCCs have been found to be of particular help to those more vulnerable individuals beginning recovery from substance use disorder who have few resources and low recovery capital. That said, they offer value to many others in the early years of recovery stabilization and beyond. They have also been found to provide a unique function in helping participants build recovery

capital and thereby increase quality of life and self-esteem, and decrease psychological distress.[5]

The measures of success for the project will occur at the patient level using the Recovery Capital Index®, (RCI) secured through license and user agreement by Palm Beach County Community Services Department (CSD) and Southeast Florida Behavioral Health Network (SEFBHN) with the Index's developer, Face It TOGETHER (FIT). Additional outcome measures will also be explored, developed and integrated into the system of care.

RCI measures substance use disorder wellness using three domains (social, personal and cultural) and twenty-two components providing a comprehensive baseline and assessment of intervention effectiveness to allow for the tracking of client progress and tailored support. It is a peer-reviewed and validated assessment tool. The validation process verified the design of the RCI domains – personal, social, and cultural capital. Variables significantly related to substance use disorder wellness, based on the RCI, are primary substance use disorder, substance use disorder identification, employment, and income. The RCI accurately described the individual's current state of recovery and it was validated as a tool to measure substance use disorder wellness.[6]

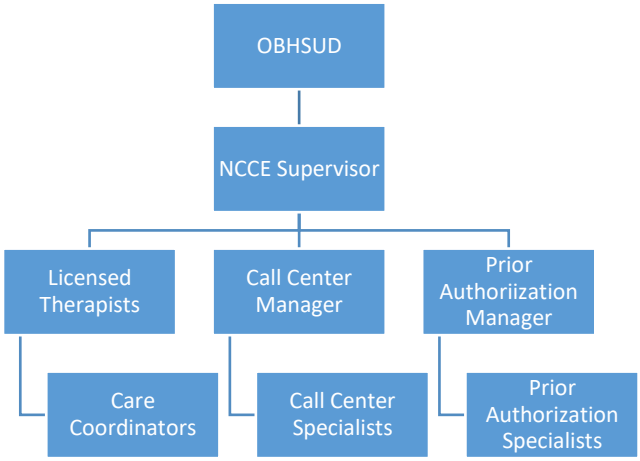
CSD's system of care model affords the unique ability to rapidly provide the exact recovery services called for and allow appropriate services to be maintained which will improve long-term recovery outcomes. A coordinated continuum of substance use disorder treatment and recovery services is also an effective and a very good predictor to an individual achieving long-term recovery.

[5]Occup. Ther. Int. 15(4): 205–220 (2008) Published online 9 October 2008 Effectiveness of a peer-support community in addiction recovery: participation as intervention, Boisvert, et. al.

[6] Validating a Survey for Addiction Wellness: The Recovery Capital Index | Peer Reviewed | Whitesock et al. S D Med. | 2018 May;71(5):202-212.

D. NCCE Project Personnel and Budget

A NCCE Supervisor will have administrative responsibility for the entity. The Supervisor must possess a Florida license as a licensed Clinical Social Worker, Licensed Mental Health Counselor, Marriage and Family Therapist or Psychologist.



The Supervisor will also be responsible for the supervision of a team of licensed therapists and the Call Center Manager. Therapists and the Call Center Manager will have to demonstrate evidence of working with substance use disorder and co-occurring disorders population and have prior supervisory experience. (See PBCHR Job Description #03969, PG 34 - Licensed Therapist Coordinator)

NCCE Licensed Therapists will have responsibility for conducting a mental health and substance use disorder clinical assessment. The Licensed Therapist must possess a Florida license as a licensed Clinical Social Worker, Licensed Mental Health Counselor, Marriage and Family Therapist or Psychologist.

Licensed Therapists will also be responsible for supervising care coordinators and serving as initial authorizers of certain care. They will have to demonstrate advanced training, knowledge and experience working with clients with substance use disorders and co-occurring disorders as well as be qualified to diagnose using the DSM-5, and identify appropriate levels of care using ASAM criteria, LOCUS and other evaluative instruments. (See PBCHR Job Description #03120, PG 32 – Licensed Therapist)

Care Coordinators will be responsible for conducting a comprehensive case management assessment that addresses multiple life domains and developing an Integrated Recovery Plan that is person-centered and respects client choice. Care Coordinators must possess a Bachelor's Degree from an accredited college or university with major course work in Social Work, Sociology or Psychology or related field.

Care Coordinators will also be responsible for monitoring progress of the treatment plan authorized by the Licensed Therapist and the Integrated Recovery Plan. They will also be linking clients to appropriate care and resources in the community as well as serving as ongoing authorizer's of payment for certain care. They will have to demonstrate evidence of working with substance use populations and knowledge in formal/informal community systems and resources. (See PBCHR Job Description #03057, PG 24 – Case Manager I)

A NCCE Prior Authorization Manager will have administrative responsibility for the Prior Authorization Unit and be responsible for planning, assigning and supervising the work of the

Prior Authorization Specialists. The Manager must possess a four (4) year college or university degree with major course work in Business or Public Administration or a related field.

The Manager will have to demonstrate experience in billing and payment processes preferably in a health care environment as well as staff supervision. They will also have to demonstrate evidence of a working knowledge of mental health and substance use disorder. (See PBCHR Job Description #00903, PG 17 – Data Processor II)

Prior Authorization Specialists will be responsible for processing of prior authorizations as well as interact directly with providers to assist them in billing and claims. They must have graduated from high school or any equivalent recognized certification and have one (1) year of data processing experience.

Specialists will also be responsible for gathering, compiling and preparing information to be entered into related reporting systems. Additionally, they will be responsible for inputting, reviewing and verifying data from a variety of source documents. (See PBCHR Job Description #00902, PG 12 – Data Processor I)

A NCCE Call Center Manager will have administrative responsibility for the Call Center and be responsible for planning, assigning and supervising the work of the Call Center Specialists. The Manager must possess an Associate Degree with major course work in Business or Public Administration or a related field.

The Manager will have to demonstrate experience in Call Center, Helpline operations or customer service related activities. They will also have to demonstrate evidence of a working knowledge of mental health and substance use disorder as well as formal/informal community systems and resources. (See PBCHR Job Description #09304, PG 29 – Customer Service Supervisor)

Call Center Specialists will be responsible for specialized contact with individuals seeking mental health and substance use disorder services through the Call Center. They are also responsible for answering inquiries and furnishing information to individuals by telephone or other means; scheduling assessments with Licensed Therapists; reviewing and processing related paperwork and preparing and reconciling reports.

Specialists will have to demonstrate evidence of a working knowledge of mental health and substance use disorders as well as formal/informal community systems and resources. They must possess an Associate Degree with coursework in Human Services or a related field and experience in Call Center, Helpline operations or customer service related activities. (See PBCHR Job Description #00447, PG 15 – Customer Service Specialist I or #03506, PG 19 – Case Manager Trainee).

Personnel Budget

Fully Staffed

A fully staffed NCCE would require the following personnel for the reasons stated below in the Budget Justification.

Title	Quantity	Salary	Total
Supervisor	1	$59,269	$59,269
Licensed Therapist	18	$56,305	$1,013,490
Care Coordinator	35	$45,853	$1,604,855
PA Manager	1	$38,311	$38,311
PA Specialist	9	$33,698	$303,282
Call Center Manager	1	$52,131	$52,131
Call Center Specialist	2	$36,393	$72,786
		Sub-total	$3,144,124
		Fringe (@ 30%/salary)	$943,237
		Total	$4,087,361

Budget Justification

The NCCE staff costs were calculated assuming 20,000 admissions (not unduplicated) to substance use disorder or mental health services annually. Staffing requirements are based on a five (5) day work week consisting of 7.5 hours per day, excluding a 30-minute lunch break. Proposed salaries include fringe benefits at a rate of 30% of stated salaries. Therapists, as explained above, will not only conduct assessments, but will also meet with case coordinators to assist and approve the individualized plans for clients.

Care Coordinators, as central figures to this model, carry significant responsibilities that include reviewing clinical services, obtaining consents, securing and appropriately sharing records with providers as needed, locating placements for identified services, identifying barriers and resolving them and following up with clients to ascertain client engagement and satisfaction with services.

Initial Prior Authorization and Client ASAM / Psychosocial Assessment (Licensed Therapist)

Each Therapist assesses five clients/day @ 1.5 hours per assessment and reserves 7.5 hours per week to meet with care coordinators to review, assist and approve individualized service plans developed by care coordinators and time for emergency evaluations.
7.5 hours X 4 days/week = 30 hours + 7.5 hours = 37.50 hours/week

37.5 hours X 47 weeks = 1762.50 total hours for Therapist to be available to conduct assessments and oversee development and approval of individualized care plans annually
Estimated required therapeutic hours for 20,000 clients X 1.5 hours per client = 30,000 therapeutic hours annually.

30,000 hours / 1762.50 hours per Therapist = 17.02 Licensed therapists rounded up to 18 so as not to create a backlog, lead to incomplete or rushed assessments, and to allow time for emergency assessments and to work with care coordinators to develop and oversee individualized care plans and conduct prior initial approval of certain care.

Clinical Service Review (CSR) and Ongoing Authorizations (Care Coordinator)

Each Coordinator would have three CSR's X 1 hour per CSR per episode for a total of 60,000 hours (20,000 clients x 3 CSRs) of CSR review.
Additionally, Care Coordinators will require on average, 4 to 5 hours per week for gathering and having documents executed and transferred to referral sources, supporting linkages with warm transfers and conducting follow-up with clients, updating individualized service plan updates and approving certain care.
60,000 hours / 1762.50 hours per year for Care Coordination = 34.04 Care Coordinators required to provide Care Coordination Services for 20,000 clients.

Authorization Payments (Prior Authorization Specialist)

Each Prior Authorization Specialist would process billing claims @ 15 minutes (.25) per claim. The number of claims equals 20,000 admissions x 3 CSRs for a total of 60,000 claims. 60,000 claims x .25 hours per claim equals 15,000 hours to process claims annually.

15,000 hours / 1762.50 per Prior Authorization Specialist = 8.5 Prior Authorization Specialist required.

Call Center (Call Center Specialist)

The NCCE Call Center staff costs were calculated based on data from PBC 211 calls in FY 2020 which amounted to 20,413 substance use disorder and mental health calls. The NCCE Call Center would field day shift calls or one-third of all calls equaling 6,804. Calls on average are 10 minutes long, which adds up to approximately six calls per hour. 6,804 calls / 6 calls per hour equals 1,134 hours to process calls annually, (approximately 45 calls per day) for the Call Center Specialist 329 days in 47 weeks (M-F)

1,134 hours / 1762.50 per Call Center Specialist = .64 FTE, which although rounded up would equal one (1) Call Center Specialist, however, to avoid a back-up of calls, account for illness, emergencies, etc., and allow for lunch, periodic breaks and reasonable need to obtain answers to questions that are not immediately available at the work station, two (2) specialists are needed.

Phased-in

A phased-in approach would reduce initial staffing levels and increase the number of therapists, care coordinators and PA Specialists over a three (3) to five (5) year period until the NCCE is fully staffed. Accordingly, the first year budget would be:

Title	Quantity	Salary	Total
Supervisor	1	$59,269	$59,269
Licensed Therapist	8	$56,305	$450,440
Care Coordinator	15	$45,853	$687,785
PA Manager	1	$38,311	$38,311
PA Specialist	5	$33,698	$168,490
Call Center Manager	1	$52,131	$52,131
Call Center Specialist	2	$36,393	$72,786
		Sub-total	$1,529,212
		Fringe (@ 30%/salary)	$458,764
		Total	$1,987,976

In year 2, two Licensed Therapists, five care coordinators and one PA Specialist would be hired; followed in year 3 by adding another two Licensed Therapists, five care coordinators and one PA specialist, bringing the annual totals for these positions and the overall budget expense to the following:

Year 2 (additional staff and associated fringe only):

Title	Quantity	Salary	Total
Licensed Therapist	2	$56,305	$112,610
Care Coordinator	5	$45,853	$229,265
PA Specialist	1	$33,698	$33,698
		Subtotal	$375,573
		Fringe @ 30%/salary	$112,672
		Total additional funding	$488,245
		Cumulative total:	2,101,596

Year 3: (additional staff and associated fringe only):

Title	Quantity	Salary	Total
Licensed Therapist	2	$56,305	$112,610
Care Coordinator	5	$45,853	$229,265
PA Specialist	1	$33,698	$33,698
		Subtotal	$375,573
		Fringe @ 30%/salary	$112,672
		Total additional funding	$488,245
		Cumulative total:	$2,964,466

Year 4: (additional staff and associated fringe only):

Title	Quantity	Salary	Total
Licensed Therapist	3	$56,305	$168,915
Care Coordinator	5	$45,853	$229,265
PA Specialist	1	$33,698	$33,698
		Subtotal	$431,878
		Fringe @ 30%/salary	$129,563
		Total additional funding	$561,441
		Cumulative total:	$3,525,907

Year 5: (additional staff and associated fringe only):

Title	Quantity	Salary	Total
Licensed Therapist	3	$56,305	$168,915
Care Coordinator	5	$45,853	$229,265
PA Specialist	1	$33,698	$33,698
		Subtotal	$431,878
		Fringe @ 30%/salary	$129,563
		Total additional funding	$561,441
		Cumulative total	$4,087,348

E. Recovery Community Center Objectives, Personnel and Budget

Palm Beach County currently has two RCCs operating in Delray Beach and West Palm Beach. As stated above, RCCs are intended to be recovery hubs facilitating "one-stop shopping" in the accrual of recovery capital and provide strong, recovery-specific, social support.

RCCs have been found to be of particular help to those more vulnerable individuals beginning recovery from substance use disorder who have few resources and low recovery capital. As such, it is the aim of CSD to establish a countywide network of RCCs and proposes to establish three additional (RCC) as well as allied recovery community organizations (RCO); and, to provide recovery peer support and other recovery capital services.

Objectives

The RCO/RCCs shall:

- Provide peer-to-peer recovery support services to promote sustained recovery and prevent recurrence of substance use disorder in a supportive substance-free environment but shall not provide any services that require a facility license. Substance-free environment shall be defined as one in which all RCO/RCC staff, volunteers and program participants agree to keep the Center free from substances at all times. Substances are defined to include alcohol, as well as illicit and illegal drugs and related paraphernalia.

- RCO/RCC's shall create a Recovery Center Board comprised, in majority part, of representatives from the local recovery community who shall also acknowledge and agree that the services and activities are member-inspired and premised on peer support. RCO/RCC services shall comport with SAMHSA's Recovery Oriented System of Care Principles; as well as Encompassing the Core Values of Keeping Recovery First; Participatory Process; Authenticity of Peers Helping Peers; Leadership Development; and Cultural Diversity and Inclusion and shall aim to:

    - Strengthen the linkage between treatment and recovery;
    - Increase support for sustained recovery within the community;
    - Support individuals in their recovery and provide them with a sense of hope;
    - Help prevent recurrence of substance use;
    - Provide recovery resources;
    - Provide a trauma informed community where individuals can achieve a full and satisfying life free of trauma and its consequences;
    - Improve life skills;
    - Provide a center for community-based leadership to grow and

develop; and,

- Lead to improved outcomes such as:
  - Improved recovery capital measurements;
  - Engagement and treatment;
  - Increased employment;
  - Increased enrollment education/vocational training;
  - Increased social connectedness; and
  - Reduced involvement in the criminal justice system.

Additionally, all services and activities shall be led and driven by the recovery community via the RCOs (i.e. individuals who have experienced addiction and recovery, either directly or indirectly as a family member or friend) and a Board comprised, in majority part, of representatives from the local recovery community as described above, which shall be created and responsive to community needs. RCC's shall allow individuals access to training, social, educational and recreational opportunities as well as information about substance use disorder treatment, recovery support services, and information about other community resources.

RCC programming may include, but not be limited to: services focused on wellness, nutrition and illness management, self-care, smoking cessation, stress management, financial management, literacy education, job and parenting skills, social events and recreational activities. Housing assistance such as finding sober living homes, apartments and roommates may also be provided as well as telephone support.

Furthermore, peer support services shall be provided by appropriately trained, certified and supervised individuals skilled in the constructs of recovery, peer support interventions and recovery capital. Peer support services shall be measured and monitored by use of Recovery Capital Index (RCI) and certified by The Council on Accreditation of Peer Recovery Support Services (CAPRSS).

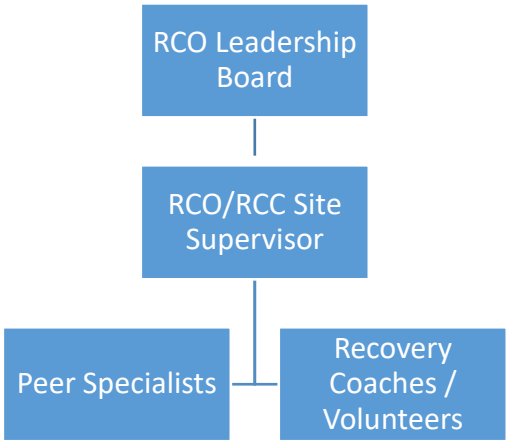
In addition, lastly, no individual shall be denied full access to, participation in and enjoyment of RCCs or RCOs services or activities, available or offered to others, due to the use of legitimately prescribed medications.

Personnel

Basic assumptions for personnel to staff the RCCs and RCO include having a talent pool with direct or indirect lived experience. Additionally, obtaining community and client input in terms of services and supports on community- specific levels that are made available through the RCCs/RCO is a critical component that will increase effectiveness and utilization. A recent research study shows how effective RCCs are for building social capital, engaging individuals throughout their recovery journey and provides a non-judgmental safe haven and most

critically, a sense of community (social capital).[7] Moreover, it is anticipated that connections and relationships will be built by the RCCs/RCOs with their local Addiction Stabilization Unit (ASU) so that peer outreach can begin as early as possible.

An RCO/RCC Site Supervisor will have administrative responsibility for the RCO/RCC. The person must possess a Bachelor's Degree in Social Work, Sociology, or a related field. It is preferred that the Supervisor be an individual with lived experience.



The Supervisor will also be responsible for the supervision of a team of peer specialists, recovery coaches and volunteers. They will have to demonstrate evidence of working with substance use disorder populations, knowledge in formal/informal community systems and resources as well as have supervisory experience. (See PBCHR Job Description #3010, PG 34 – Human Services Operations Supervisor)

Peer Specialists will be responsible for providing peer support services. They will also be responsible for linking individuals to appropriate care and resources in the community

Peer Specialists will have to demonstrate evidence of working with substance use populations. They must be a person with lived experience and possess a high school diploma or an equivalent recognized certification. Additionally, they must possess Florida Certified Recovery Support Specialist or obtain National Certified Peer Specialist certification. (See PBCHR Job Description #03250, PG 15 – Peer Specialist)

[7] Kelly, J. F., Stout, R. L., Jason, L. A., Fallah-Sohy, N., Hoffman, L. A., & Hoeppner, B. B. (2020). One-stop shopping for recovery: An investigation of participant characteristics and benefits derived From U.S. recovery community centers. Alcoholism: Clinical and Experimental Research, 44(3), 711-721. doi: doi.org/10.1111/acer.14281. (For summary of study, see, Recovery community centers: Is participation in these newer recovery support services associated with better functioning and quality of life? - Recovery Research Institute (recoveryanswers.org).)

Budget

Title	Quantity (Per Site)	Salary	Total (x 3 Sites)
Site Supervisor	1	$59,269	$177,807
Peer Specialists	3	$109,079	$327,237
	Sub-total	$168,348	$505,044
	Fringe (@ 30%/salary)	$50,504	$151,512
	Total Staff	$218,852	$656,556
Other Costs		**Cost**	**Total (x3 sites)**
Rent (Min. 2500 sf x 18 sq. ft.)		$45,000	$135,000
Utilities @ $500 mo.		$6,000	$18,000
Insurance		$4,000	$12,000
Supplies		$1,148	$3,444
	Total Other	$56,148	$168,444
	Total Project	$275,000	$825,000

Project Logic Model

Identified current situation in the community What needs to change?	***Outcome What will change? Who will the change impact?***	***Outcome/Indicator Projected # and % achieving each outcome What will the change look like?***	***Strategies to be implemented Identify the timeframe and scope of activities.***	***Resources List those available to conduct the identified strategies (Include partnerships)***	***Resources List those needed to conduct the identified strategies (Include partnerships)***	***Measurement Tools, processes, etc. How do you know what happened?***
Need/Planning	***Impact***	***Impact***	***Activities/Outputs***	***Inputs***	***Inputs***	***Accountability***
Services need to be coordinated and multiple providers serving the same clients need to communicate with each other with appropriate privacy and confidentiality consents.	Neutral care coordinators will assess clients and work with an approved individualized plan to coordinate services and members of individuals' care team members to implement individualized recovery-centric plans. Neutral care coordinators will consistently use screening tools to assess client needs and facilitate scheduling of evaluations by trained clinicians who will determine the most appropriate level of care, treatment goals, and develop a recovery plan to be implemented and coordinated by the neutral care coordinators. Individuals will be assessed holistically, including determining if clients have access to stable, secure housing; food;	Residents in Palm Beach County seeking treatment for behavioral health, substance use and/or co-occurring disorders will be able to access individualized need-based services and/or treatment (including clinical and non-clinical needs) with the assistance of a care-coordinator who will conduct an immediate needs screening, clinicians who will conduct holistic assessments. Care-coordinators will provide warm hand-offs to individually identified needed levels of care and help with navigation across systems beyond treatment and through recovery. PBC Residents in need of treatment, supports and services for behavioral health, substance use and/or co-occurring disorders will be able to access individually identified services that are based on person-centered informed choice recovery plans.	A neutral care coordination entity will be created which will serve as a single point of entry and also as authorizer and payer of certain care. Neutral care-coordinating entity will be created with sufficient personnel who will be responsible for initial screening, clinical assessments and case management. Train and employ a sufficient number of credentialed/ certified neutral care coordinators to work with clients with substance use and/or co-occurring substance use and mental health disorders. Develop a policy for neutral care coordination. Develop a policy for credentialing neutral care coordinators that involves required training and obtaining a certificate or credential.	Executed MOUs/MOAs demonstrating agreements to share information and data regarding shared clients, as well as agreements to collaborate on client care, development of individualized service plans as needed, and coordinate care and transitions across providers of services. SEFBHN, Managing Entity, Healthcare District, Non-profits involved in providing care and services, including, housing, mental health counseling, and other social service providing entities	TBD	Call center will track the number of calls and referrals, and where referrals are made. Client satisfaction surveys will be completed within 45 days of ending services for referred individuals. Care Coordinators will conduct outreach to clients monthly to facilitate engagement and keep documentation of client contacts in electronic record through CSD identified data system.

	water; employment and/or education/training that leads to self-sufficiency; and physical and mental well-being. LOCUS and/or ASAM criteria will be used to assess appropriate levels of care in the least restrictive appropriate setting, followed by as expeditious as possible referral or placement.		Develop or adopt an existing training for neutral care coordination that will ensure essential skills are taught and which will lead to a certificate or credential when completed.			

Identified current situation in the community What needs to change?	***Outcome What will change? Who will the change impact?***	***Outcome/Indicator Projected # and % achieving each outcome What will the change look like?***	***Strategies to be implemented Identify the timeframe and scope of activities.***	***Resources List those available to conduct the identified strategies (Include partnerships)***	***List those needed to conduct the identified strategies (Include partnerships)***	***Measurement Tools, processes, etc. How do you know what happened?***
Need/Planning	***Impact***	***Impact***	***Activities/Outputs***	***Inputs***	***Inputs***	***Accountability***
Various systems (providers, organizations serving individuals with substance use disorders, mental health disorders and co-occurring disorders) are operating in silos ("acting solely within their own spheres of influence") and not sharing critical client information with appropriate consents as needed, which leads to a smaller number of appropriate and individualized referrals. Impact is also on clients who are forced to navigate across systems on their own, which creates a barrier to obtaining treatment/services (i.e. an excuse not to get treatment and/or services).	Care coordination will facilitate communication across providers which will make it easier for clients to obtain appropriate levels of care for treatment and support through recovery.	Number of clients seeking treatment and recovery supports will increase by implementing care coordination.	Contractually mandate collaboration and coordination across entities serving individuals with substance use disorders and/or co-occurring mental health and substance use disorders. Develop communication protocols and Memoranda of Understanding (MOU) or Memoranda of Agreement (MOA) across provider and funding entities that will facilitate information sharing that allows for seamless transition of clients from one service or provider to another, based on individualized treatment and recovery plans, with appropriate warm hand-offs.	Neutral Care Coordination entity Increase usage of ASU through educating Emergency Department (ED) doctors & hospital staff (PB Med Society); SF Healthcare Finance Council	TBD	Number of ED and hospital staff reached through medical detailing each quarter. Number of clients that are referred to NCCE per quarter. Cost per client and per referral or linkage to service

Appendix C

Recovery Management and Recovery-oriented Systems of Care: Scientific Rationale and Promising Practices Summary of Findings

Recovery Management and Recovery-oriented Systems of care:
Scientific Rationale and Promising Practices
Chapter Fifteen
A Closing Reflection: Recovery, Science, and Systems Transformation

Summary of findings

Scientific research findings reviewed in this monograph support calls for a transformation in the structure and service processes in the United States from a model of acute intervention to a broader model of sustained recovery management. More specifically, the findings call for:

- Strengthening the infrastructure of addiction treatment to ensure sustained continuity of support and accountability to the individuals, families, and communities served by addiction treatment institutions;
- more proactive systems of identifying, engaging, and ensuring service access for individuals and families at the earliest possible stage of AOD-related problem development;
- individual, family, and community needs-assessment protocols that are comprehensive, strengths-based, and ongoing;
- the utilization of multidisciplinary and multi-agency service models for supporting long-term recovery for those individuals, families, and neighborhoods experiencing severe, complex, and enduring AOD problems;
- the reconstruction of the service relationship from an expert model to a partnership model involving a long-term recovery support alliance;
- expanding the service menu, with an emphasis on evidence-based and recovery-linked service practices;
- ensuring each client and family an adequate dose and duration of pre-treatment, in-treatment, and post-treatment clinical and recovery support services;
- exerting a greater influence on the post-treatment recovery environment by shortening the physical and cultural distance between the treatment institution and the natural environments of those served, and by intervening directly to increase family and community recovery capital;
- assertive linkage of clients and families to recovery mutual aid groups and other indigenous recovery support institutions;
- models of post-treatment monitoring (recovery check-ups for up to five years following discharge from primary treatment), ongoing stage-appropriate recovery education, sustained recovery coaching, and, when needed, early re-intervention; and
- the systematic and system-wide collection and reporting of long-term post-treatment recovery outcomes for all individuals and families admitted to addiction treatment.

White, M. (2008). Recovery management and recovery-oriented systems of care: scientific rationale and promising practices, pp. 131-132.

Appendix D

The Opioid Epidemic: How Wellbeing Can Help Bend the Curve; important warning signs for individuals who are at the highest risk of overdose

The Opioid Epidemic: How Wellbeing Can Help Bend the Curve

Individual aspects of wellbeing are also critically important to understanding what increases or decreases drug overdose rates in states. The following are the most important warning signs for individuals who are at the highest risk:

Career Wellbeing:

- Does not have a leader in their life who creates enthusiasm about the future
- Does not like what they do every day
- Does not routinely learn or do interesting things

Social Wellbeing:

- Does not have someone in their life who encourages good health
- Does not receive positive energy from friends and family

Financial Wellbeing:

- Is not satisfied with standard of living compared with the people around them

Physical Wellbeing (Physical Health/Pain):
Currently has or is being treated for asthma

- Currently has or is being treated for high cholesterol
- Disagrees that physical health is "near perfect"
- Has significant daily physical pain
- Has ever had a heart attack

Physical Wellbeing (Physical Energy/Activity):

- Healthcare provider has limited their exercise
- Has not felt active and productive in prior seven days
- Poor health has prevented normal activity two or more days in the past month

Physical Wellbeing (Mental Health):

- Does not feel good about physical appearance
- Has been clinically diagnosed with or is being treated for depression

Community Wellbeing:

- Is not proud of the community where they live

Witters, D., June 20, 2023. *The Opioid Epidemic: How Wellbeing Can Help Bend the Curve*, GALLUP, https://news.gallup.com/poll/507368/opioid-epidemic-wellbeing-help-bend-curve.aspx.

Appendix E

Palm Beach County City/County, Regional/Abatement funds Settlement Agreement funding projections.

City/County Funding Projections

City/County Fund Total Adjusted*	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Distributors	$ 7,325,179.15	$ 6,304,622.95	$ 8,513,747.86	$ 8,513,747.86	$ 8,513,747.86	$ 10,957,977.13	$ 12,893,184.96	$ 12,893,184.96	$ 12,893,184.96	$ 10,833,241.18
Janssen	$ 7,634,552.64	$ 4,961,182.23	$ 7,934,591.73	$ 8,858,798.32	$ 1,094,895.78	$ 1,656,698.63	$ 1,656,698.63	$ 2,117,462.37	$ 2,117,462.37	$ 2,117,462.37
Teva	$ 4,840,662.48	$ 3,180,209.33	$ 523,484.33	$ 523,484.33	$ 523,484.33	$ 855,574.95	$ 855,574.95	$ 855,574.95	$ 855,574.95	$ 855,574.95
CVS	$ 336,666.67	$ 2,811,666.67	$ 2,811,666.67	$ 2,811,666.67	$ 2,811,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67
Allergan	$ 718,636.36	$ 1,404,886.35	$ 1,404,886.35	$ 1,404,886.35	$ 1,404,886.35	$ 1,633,636.35	$ 1,633,636.35	$ 1,633,636.35	$ 1,633,636.35	$ 1,633,636.35
Walgreens	$ 486,666.67	$ 3,974,166.67	$ 3,974,166.67	$ 3,974,166.67	$ 3,974,166.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67
Walmart		$ 25,341,503.38								

Select your subdivision from drop list below.
If accessing via DropBox, use the"open in" at the top and select Excel, otherwise use the "download" option at the top. Open the file and select "Enable Editing".

**Subdivision	Percentage	Distributed December 2022	Distribute 2023	Distribute 2024	Distribute 2025	Distribute 2026	Distribute 2027	Distribute 2028	Distribute 2029	Distribute 2030	Distribute 2031
Palm Beach County	5.866649283905280%	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Distributors		$ 429,742.57	$ 369,870.12	$ 499,471.73	$ 499,471.73	$ 499,471.73	$ 642,866.09	$ 756,397.94	$ 756,397.94	$ 756,397.94	$ 635,548.27
Janssen		$ 447,892.43	$ 291,055.16	$ 465,494.67	$ 519,714.63	$ 64,233.70	$ 97,192.70	$ 97,192.70	$ 124,224.09	$ 124,224.09	$ 124,224.09
Teva		$ 283,984.69	$ 186,571.73	$ 30,710.99	$ 30,710.99	$ 30,710.99	$ 50,193.58	$ 50,193.58	$ 50,193.58	$ 50,193.58	$ 50,193.58
CVS		$ 19,751.05	$ 164,950.62	$ 164,950.62	$ 164,950.62	$ 164,950.62	$ 213,350.48	$ 213,350.48	$ 213,350.48	$ 213,350.48	$ 213,350.48
Allergan		$ 42,159.87	$ 82,419.76	$ 82,419.76	$ 82,419.76	$ 82,419.76	$ 95,839.72	$ 95,839.72	$ 95,839.72	$ 95,839.72	$ 95,839.72
Walgreens		$ 28,551.03	$ 233,150.42	$ 233,150.42	$ 233,150.42	$ 233,150.42	$ 301,350.22	$ 301,350.22	$ 301,350.22	$ 301,350.22	$ 301,350.22
Walmart		$ -	$ 1,486,697.13	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Yearly Distribution		$ 1,252,081.64	$ 2,814,714.93	$ 1,476,198.18	$ 1,530,418.14	$ 1,074,937.21	$ 1,400,792.78	$ 1,514,324.64	$ 1,541,356.03	$ 1,541,356.03	$ 1,420,506.35

***Amounts listed are projections until funding is received**

****Amounts listed include funds allocated from other subdivisions**

Year 11	Year 12	Year 13	Year 14	Year 15	Year 16	Year 17	Year 18
$ 10,833,241.18	$ 10,833,241.18	$ 10,833,241.18	$ 10,833,241.18	$ 10,833,241.18	$ 10,833,241.18	$ 10,833,241.18	
$ 855,574.95	$ 855,574.95	$ 2,626,725.00	$ 2,626,725.00	$ 2,626,725.00			
$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67
$ 1,633,636.35							
$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67

Distribute 2032	Distribute 2033	Distribute 2034	Distribute 2035	Distribute 2036	Distribute 2037	Distribute 2038	Distribute 2039	
Year 11	Year 12	Year 13	Year 14	Year 15	Year 16	Year 17	Year 18	
$ 635,548.27	$ 635,548.27	$ 635,548.27	$ 635,548.27	$ 635,548.27	$ 635,548.27	$ 635,548.27	$ -	
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
$ 50,193.58	$ 50,193.58	$ 154,100.74	$ 154,100.74	$ 154,100.74	$ -	$ -	$ -	
$ 213,350.48	$ 213,350.48	$ 213,350.48	$ 213,350.48	$ 213,350.48	$ 213,350.48	$ 213,350.48	$ 213,350.48	
$ 95,839.72	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
$ 301,350.22	$ 301,350.22	$ 301,350.22	$ 301,350.22	$ 301,350.22	$ 301,350.22	$ 301,350.22	$ 301,350.22	
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
$ 1,296,282.26	$ 1,200,442.55	$ 1,304,349.71	$ 1,304,349.71	$ 1,304,349.71	$ 1,150,248.96	$ 1,150,248.96	$ 514,700.70	$ 24,791,658.48

Regional/Abatement Funding Projections

Regional/Abatement Fund Total Adjusted *	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Distributors	$ 35,888,672.84	$ 25,642,141.47	$ 31,533,141.23	$ 31,533,141.23	$ 31,533,141.23	$ 29,281,272.34	$ 30,134,098.23	$ 30,134,098.23	$ 30,134,098.23	$ 24,603,346.68
Janssen	$ 24,164,159.36	$ 14,461,285.45	$ 21,914,631.93	$ 24,231,309.77	$ 4,769,794.08	$ 4,207,991.23	$ 3,679,492.32	$ 4,690,100.81	$ 4,990,745.56	$ 4,555,526.50
Teva	$ 15,182,370.73	$ 9,758,223.82	$ 2,673,623.82	$ 2,673,623.82	$ 2,673,623.82	$ 2,341,533.20	$ 2,046,341.55	$ 2,046,341.55	$ 2,046,341.55	$ 1,987,303.22
CVS	$ 6,457,777.78	$ 10,582,777.78	$ 10,582,777.78	$ 10,582,777.78	$ 10,582,777.78	$ 9,757,777.78	$ 8,535,555.56	$ 8,535,555.56	$ 8,535,555.56	$ 8,291,111.11
Allergan	$ 3,501,363.61	$ 4,645,113.60	$ 4,645,113.60	$ 4,645,113.60	$ 4,645,113.60	$ 4,416,363.60	$ 3,861,818.15	$ 3,861,818.15	$ 3,861,818.15	$ 3,750,909.06
Walgreens	$ 9,107,777.78	$ 14,920,277.78	$ 14,920,277.78	$ 14,920,277.78	$ 14,920,277.78	$ 13,757,777.78	$ 12,035,555.56	$ 12,035,555.56	$ 12,035,555.56	$ 11,691,111.11
Walmart	$ 75,154,824.84									

Select your subdivision from drop list below.
If accessing via DropBox, use the"open in" at the top and select Excel, otherwise use the "download" option at the top. Open the file and select "Enable Editing".

Subdivision	Percentage	Distributed April 2023**	Distribute 2023	Distribute 2024	Distribute 2025	Distribute 2026	Distribute 2027	Distribute 2028	Distribute 2029	Distribute 2030	Distribute 2031
Palm Beach County	8.601594372052590%	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Distributors		$ 3,086,998.06	$ 2,205,633.00	$ 2,712,352.90	$ 2,712,352.90	$ 2,712,352.90	$ 2,518,656.27	$ 2,592,012.90	$ 2,592,012.90	$ 2,592,012.90	$ 2,116,280.08
Janssen		$ 2,078,502.97	$ 1,243,901.12	$ 1,885,007.75	$ 2,084,278.98	$ 410,278.34	$ 361,954.34	$ 316,495.00	$ 403,423.45	$ 429,283.69	$ 391,847.91
Teva		$ 1,305,925.95	$ 839,362.83	$ 229,974.28	$ 229,974.28	$ 229,974.28	$ 201,409.19	$ 176,018.00	$ 176,018.00	$ 176,018.00	$ 170,939.76
CVS		$ 555,471.85	$ 910,287.62	$ 910,287.62	$ 910,287.62	$ 910,287.62	$ 839,324.46	$ 734,193.87	$ 734,193.87	$ 734,193.87	$ 713,167.75
Allergan		$ 301,173.10	$ 399,553.83	$ 399,553.83	$ 399,553.83	$ 399,553.83	$ 379,877.68	$ 332,177.93	$ 332,177.93	$ 332,177.93	$ 322,637.98
Walgreens		$ 783,414.10	$ 1,283,381.77	$ 1,283,381.77	$ 1,283,381.77	$ 1,283,381.77	$ 1,183,388.24	$ 1,035,249.67	$ 1,035,249.67	$ 1,035,249.67	$ 1,005,621.96
Walmart		$ 6,464,513.18		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Yearly Distribution		$ 14,575,999.21	$ 6,882,120.16	$ 7,420,558.15	$ 7,619,829.38	$ 5,945,828.74	$ 5,484,610.18	$ 5,186,147.37	$ 5,273,075.81	$ 5,298,936.05	$ 4,720,495.44

*Amounts listed are projections until funding is received

Year 11	Year 12	Year 13	Year 14	Year 15	Year 16	Year 17	Year 18
$ 24,603,346.68	$ 24,603,346.68	$ 23,879,130.60	$ 23,879,130.60	$ 23,879,130.60	$ 21,706,482.36	$ 21,706,482.36	
$ 1,987,303.22	$ 1,987,303.22	$ 5,824,795.00	$ 5,824,795.00	$ 5,824,795.00			
$ 8,291,111.11	$ 8,291,111.11	$ 8,046,666.67	$ 8,046,666.67	$ 8,046,666.67	$ 7,313,333.33	$ 7,313,333.33	$ 7,313,333.33
$ 3,750,909.06							
$ 11,691,111.11	$ 11,691,111.11	$ 11,346,666.67	$ 11,346,666.67	$ 11,346,666.67	$ 10,313,333.33	$ 10,313,333.33	$ 10,313,333.33

Distribute 2032	Distribute 2033	Distribute 2034	Distribute 2035	Distribute 2036	Distribute 2037	Distribute 2038	Distribute 2039	
Year 11	**Year 12**	**Year 13**	**Year 14**	**Year 15**	**Year 16**	**Year 17**	**Year 18**	
$ 2,116,280.08	$ 2,116,280.08	$ 2,053,985.95	$ 2,053,985.95	$ 2,053,985.95	$ 1,867,103.57	$ 1,867,103.57	$ -	
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
$ 170,939.76	$ 170,939.76	$ 501,025.24	$ 501,025.24	$ 501,025.24	$ -	$ -	$ -	
$ 713,167.75	$ 713,167.75	$ 692,141.63	$ 692,141.63	$ 692,141.63	$ 629,063.27	$ 629,063.27	$ 629,063.27	
$ 322,637.98	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
$ 1,005,621.96	$ 1,005,621.96	$ 975,994.24	$ 975,994.24	$ 975,994.24	$ 887,111.10	$ 887,111.10	$ 887,111.10	
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
$ 4,328,647.53	$ 4,006,009.55	$ 4,223,147.06	$ 4,223,147.06	$ 4,223,147.06	$ 3,383,277.93	$ 3,383,277.93	$ 1,516,174.37	$ 97,694,428.99

Appendix F

Settlement Agreement Core Strategies and Allowable Uses

Schedule A

Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("**Core Strategies**")[, such that a minimum of __% of the [aggregate] state-level abatement distributions shall be spent on [one or more of] them annually].[1]

A. Naloxone or other FDA-approved drug to reverse opioid overdoses

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. Medication-Assisted Treatment ("MAT") Distribution and other opioid-related treatment

1. Increase distribution of MAT to non-Medicaid eligible or uninsured individuals;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

4. Treatment and Recovery Support Services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication with other support services.

C. Pregnant & Postpartum Women

1. Expand Screening, Brief Intervention, and Referral to Treatment ("SBIRT") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("OUD") and other Substance Use Disorder ("SUD")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

3. Provide comprehensive wrap-around services to individuals with Opioid Use Disorder (OUD) including housing, transportation, job placement/training, and childcare.

D. Expanding Treatment for Neonatal Abstinence Syndrome

1. Expand comprehensive evidence-based and recovery support for NAS babies;

2. Expand services for better continuum of care with infant-need dyad; and

3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

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[1] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the Term Sheet.

E. Expansion of Warm Hand-off Programs and Recovery Services

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;

2. Expand warm hand-off services to transition to recovery services;

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions. ;

4. Provide comprehensive wrap-around services to individuals in recovery including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. Treatment for Incarcerated Population

1. Provide evidence-based treatment and recovery support including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and

2. Increase funding for jails to provide treatment to inmates with OUD.

G. Prevention Programs

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools.;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. Expanding Syringe Service Programs

1. Provide comprehensive syringe services programs with more wrap-around services including linkage to OUD treatment, access to sterile syringes, and linkage to care and treatment of infectious diseases.

I. Evidence-based data collection and research analyzing the effectiveness of the abatement strategies within the State.

Schedule B

Approved Uses

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:[2]

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (MAT) approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Treatment of trauma for individuals with OUD (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

8. Training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD or mental health conditions, including but not limited to training,

[2] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the Term Sheet.

scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. [Intentionally Blank – to be cleaned up later for numbering]

13. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

14. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.

15. Development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in treatment for or recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved medication with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have – or at risk of developing – OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically-appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL-JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

    a. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);

    b. Active outreach strategies such as the Drug Abuse Response Team (DART) model;

    c. “Naloxone Plus” strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    d. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model;

    e. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

f. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions (CTI), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome (NAS), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.

6. Child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Enhanced family supports and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including but not limited to parent skills training.

10. Support for Children's Services – Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Fund medical provider education and outreach regarding best prescribing practices for opioids consistent with Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:

    a. Increase the number of prescribers using PDMPs;

    b. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

c. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increase electronic prescribing to prevent diversion or forgery.

8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Fund media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Fund community anti-drug coalitions that engage in drug prevention efforts.

6. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

7. Engage non-profits and faith-based communities as systems to support prevention.

8. Fund evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create of support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address

mental health needs in young people that (when not properly addressed) increase the risk of opioid or other drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, individuals at high risk of overdose, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities provide free naloxone to anyone in the community

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Provide training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Support screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in sections C, D, and H relating to first responders, support the following:

1. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitation, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local, or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services; to support training and technical assistance; or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to share reports, recommendations, or plans to spend opioid settlement funds; to show how opioid settlement funds have been spent; to report program or strategy outcomes; or to track, share, or visualize key opioid-related or health-related indicators and supports as identified through collaborative statewide, regional, local, or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection, and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g. Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

Appendix G

Language Dictionary

Language Dictionary: A Key to Common Terms and Their Definitions

The Language Dictionary is the beginning of an iterative process that will help shift language to being person-first, minimize and eventually eliminate stigma and serve as a resource for common terminology.

Addiction Stabilization Unit (ASU) – An addiction stabilization unit (or, addiction stabilization facility (ASF")) is a facility, such as the one located at JFK Hospital, where individuals who have been brought into the emergency department (ED) can be brought for observation following an overdose and where they can be assessed for further treatment, such as in-patient hospitalization, psychiatric evaluation that may lead to a voluntary or involuntary (Baker Act) psychiatric hospitalization, referral or placement in an in-patient detoxification program or referral for outpatient treatment.

Assessment – "An ongoing process used to determine the medical, psychological, and social needs of individuals with substance-related conditions and problems. It can take the form of biological assays (e.g., blood or urine samples), as well as clinical diagnostic interviewing and the completion of self-report measures to determine the presence of a substance use disorder or other psychiatric condition, and other symptoms and challenges with the ultimate goal of developing a fully informed and helpful treatment and recovery plan."[1]

Behavioral Health is "an umbrella term that refers to your overall wellbeing and how it is impacted by your behaviors"[2] While behavioral health and mental health tend to overlap, and many organizations substitute one term for the other, distinct differences do exist between the two. The U.S. Department of Health and Human Services defines mental health as a person's psychological, emotional, and social wellbeing. And while some mental health issues may be impacted by behavior, many mental health disorders have neurological or biological causes, meaning that simply changing a person's behavior may not cure them of that illness.[3]

Some examples of mental health disorders include:[4]

- Bipolar disorder.
- Schizophrenia.
- Depression.

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[1] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[2] https://www.projectknow.com/drug-addiction/behavioral-health/ (Extracted 12/22/2020).

[3] Grant, J.E., Potenza, M.N., Weinstein, A. & Gorelick, D.A. (2010). Introduction to Behavioral Addictions. *American Journal of Drug and Alcohol Abuse. 36(5), 233–241.* U.S. Department of Health and Human Services. (n.d.). *What Is Mental Health?* Bienvenu, O.J., Davydow, D.S. & Kendler, K.S. (2011). Psychiatric 'diseases' versus behavioral disorders and degree of genetic influence. *Psychological Medicine, 41(1), 33–40.*

[4] U.S. Department of Health and Human Services. (n.d.). *What Is Mental Health?* Bienvenu, O.J., Davydow, D.S. & Kendler, K.S. (2011). Psychiatric 'diseases' versus behavioral disorders and degree of genetic influence. *Psychological Medicine, 41(1), 33–40.*

- Generalized anxiety.
- Social anxiety.
- Attention-deficit/hyperactivity disorder (ADHD).

Examples of behavioral health disorders include:[5]

- Substance abuse disorders.
- Eating disorders.
- Behavioral addictions.

Care Coordination "involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient."[6]

Coaching is a way of interacting that builds confidence and competence in the person being coached. It is a style of communication that allows for empowerment and self-realization.

Cognitive Behavioral Therapy (CBT) "is a **psycho-social intervention that aims to improve mental health.** CBT focuses on challenging and changing unhelpful cognitive distortions (e.g. thoughts, beliefs, and attitudes) and behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems."[7] It is also defined as: "A prevalent type of talk therapy (psychotherapy) that involves working with a professional to increase awareness of inaccurate or negative thinking and behavior and to learn to implement new coping strategies."[8]

Co-occurring Disorders means having both a mental health and substance use disorder or, phrased differently, the "occurrence of two disorders or illnesses in the same person, also referred to as co-occurring conditions or sometimes dual diagnosis." [9]

Community-based Treatment and Services are those services and supports that occur in the person's community.

Damp Housing: Housing where tenants do not need to be "clean" when entering the program but are expected to be actively working on recovery from substance use problems.[10]

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[5] Id.

[6] https://www.ahrq.gov/ncepcr/care/coordination.html. (Extracted 12/22/2020).

[7] en.m.wikipedia.org/wiki/Cognitive_behavioral_therapy (Extracted 12/22/2020).

[8] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[9] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[10] https://www.heretohelp.bc.ca/visions/housing-and-homelessness-vol4/housing-glossary (Extracted 12/30/2020).

Deep End Treatment is residential, in-patient long term care.

Detoxification or detox "is the medical process focused on treating the physical effects of withdrawal from substance use and comfortably achieving metabolic stabilization; a prelude to longer-term treatment and recovery."[11]

Employment is an indicator for recovery wellness and research shows that it can be part time, full time or volunteer as long as it is fulfilling for the person engaged in the work activities.

Evidence-based Practices refers to "patient care informed through the integration of clinical expertise and best available clinical evidence from systematic research."[12]

Harm reduction "is a set of policies and practices intended to reduce the negative effects of drug and alcohol use. Harm reduction programs exist for several types of drugs, including opioids, alcohol, stimulants, Ecstasy, and marijuana. They range from needle exchange sites to managed alcohol programs to drug-testing kits at music festivals."[13]

Intensive Out-Patient Treatment is "time limited, intensive, non-residential clinical treatment that often involves participation in several hours of clinical services several days per week. It is a step below partial hospitalization in intensity."[14]

Intervention is "the act of interfering with the outcome or course especially of a condition or process (as to prevent harm or improve functioning)."[15]

Maintenance means the intentional use of MAT without a taper as a means of resolving a substance use disorder (e.g. methadone at scale for the past 60 years or so in the U.S.).

Mental Health "includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices."[16]

Moderation includes the non-problematic recreational use of drugs and/or alcohol (e.g. over 80% of Americans age 18 or older who have reported trying alcohol at some point in their life but do not meet the criteria for an Alcohol use disorder).

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[11] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[12] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[13] https://americanaddictioncenters.org/harm-reduction# (Extracted 12/29/2020).

[14] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[15] https://www.merriam-webster.com/dictionary/intervention (Extracted 12/23/2020).

[16] https://www.mentalhealth.gov/basics/what-is-mental-health (Extracted 12/23/2020).

Motivational Interviewing is a "clinical approach that helps people with mental health and substance use disorders and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health by helping them to explore and resolve ambivalence about changes. The approach upholds four principles: expressing empathy and avoiding arguing; developing discrepancy; rolling with resistance; and supporting self-efficacy (client's belief s/he can successfully make a change). This is non-directive approach to counseling that attempts to help patients resolve ambivalence about changing substance use and mobilize motivation and action toward healthier change."[17]

Neutral Care Coordination is services provided by a non-conflicted, neutral body functioning as a single point of entry for referrals to providers. Services include assessment, initial level of care determination, referral, care coordination across a continuum of clinical and non-clinical care, as well as prior authorization and payment of certain care. NCC values individualized care and individual choice in development of care plans. Individualized care plans are the primary drivers of care engagement and are aimed at achieving successful, seamless movement along a continuum of clinical care through non-clinical recovery support and social services to improve long-term recovery outcomes.

Peer Support can be volunteer or paid and "offer[s] valuable guidance and connection to individuals in recovery through the process of sharing their own experiences in recovery from substance use disorder."[18]

Prevention "is the act of stopping something or ensuring something does not happen."[19]

Recovery Capital Index™ (RCI) "is a holistic, person-centered metric that tracks wellness of the whole person."[20]

Recovery Capital encompasses "the resources (social, physical, human and cultural), which are necessary to begin and maintain recovery from substance use disorder."[21]

Recovery means the intentional non-use of mind-altering substances (i.e. drugs and alcohol) as a means of resolving a substance use disorder. It is worth noting that this includes prescribed use of MAT on a taper even if the particular MAT drug involved is abuse-able.

Recovery Community Center (RCC) "A center or hub that organizes recovery networks regionally and nationally to facilitate supportive relationships between individuals in recovery as well as family and friends of people in recovery. Centers may provide advocacy training, peer

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[17] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[18] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[19] https://www.yourdictionary.com/prevention (Extracted 12/23/2020).

[20] WeFaceItTogether.org

[21] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

support organization meetings, social activities, job linkage, and other community based services."[22]

Recovery Community Organization (RCO) "An independent, non-profit organization led and governed by representatives of local communities of individuals in recovery from a substance use disorder."[23]

Recovery-oriented System of Care (ROSC) is "a coordinated network of community based services that involve a strengths-based and personalized approach to recovery and increases in quality of life."[24]

Recovery Homes are "alcohol- and drug-free living facility for individuals recovering from alcohol or other drug use disorders that often serves as an interim living environment between detoxification experiences or residential treatment and mainstream society. Also known as Sober Houses, Sober Living Houses (SLHs), Sober Living Homes, or Sober Living Environments." [25]

Social Capital "is the effective functioning of social groups through interpersonal relationships, a shared sense of identity, a shared understanding, shared norms, shared values, trust, cooperation, and reciprocity. Social capital is a measure of the value of resources, both tangible (e.g., public spaces, private property) and intangible (e.g., actors, human capital, people), and the impact that these relationships have on the resources involved in each relationship, and on larger groups. It is generally seen as a form of capital that produces public goods for a common purpose."[26]

Substance Use Disorder is a "clinical term describing a syndrome consisting of a coherent set of signs and symptoms that cause significant distress and or impairment during the same 12-month period."[27]

Supported Employment "is founded on the belief that anyone can work if they are provided the right supports. Individuals who have not traditionally participated in competitive employment based upon their disability are the primary focus of Supported Employment. The expected outcome of Supported Employment is that individuals will maintain the appropriate level of employment (either full/part time) based upon their skills, interest and abilities."[28]

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[22] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[23] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[24] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[25] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[26] https://en.wikipedia.org/wiki/Social_capital (Extracted 12/23/2020).

[27] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[28] https://resourcecenter.org/services/manufacturing-services/employment-services/community-based-employment/supported-employment/ (Extracted 12/23/2020).

Treatment is the "management and care of a patient to combat a disease or disorder. Can take the form of medicines, procedures, or counseling and psychotherapy."[29]

Wet Housing is "housing where tenants are not expected to abstain from using alcohol and other drugs, and where entering a rehabilitation program is not a requirement. Tenants have access to recovery services and get to decide if and when they use these services. Wet housing programs follow a harm reduction philosophy."[30]

Wrap-around Services "is an intensive care coordination and management process focused on building a team comprised of formal (professionals) and informal (natural) supports."[31]

[29] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[30] https://www.heretohelp.bc.ca/visions/housing-and-homelessness-vol4/housing-glossary (Extracted 12/30/2020).

[31] http://www.socflorida.com/documents/professionals/Wraparound%20in%20Florida%20White%20Paper.pdf.

2024 Substance Use and Mental Disorders Plan Update Appendices

Appendix A	Palm Beach County Resilience and Recovery Ecosystem of Behavioral Health and Substance Use Disorder Care
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Appendix A

Palm Beach County Resilience and Recovery Ecosystem of Behavioral Health and Substance Use Disorder Care

PALM BEACH COUNTY RESILIENCE & RECOVERY ECOSYSTEM OF BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER CARE

ASAM* MULTIDIMENSIONAL ASSESSMENT (MESO)

ACUTE INTOXICATION AND/OR WITHDRAWL POTENTIAL
Exploring an individual's past and current experiences of substance use and withdrawl.

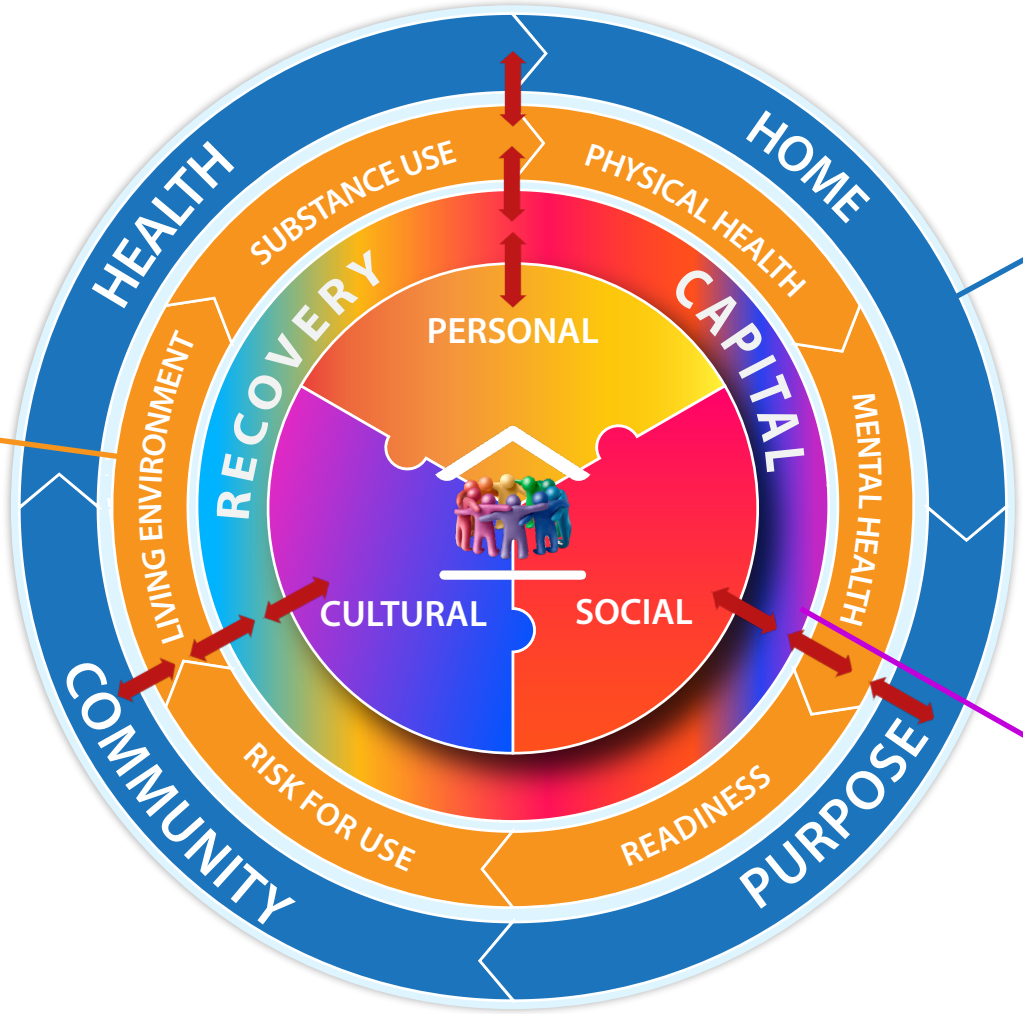
BIOMEDICAL CONDITIONS AND COMPLICATIONS
Exploring an individual's health history and curretn physical condition

EMOTIONAL, BEHAVIORAL,OR COGNITIVE CONDITIONS AND COMPLICATIONS
Exploring an individual's thoughts, emotions, and mental health issues

READINESS TO CHANGE
Exploring an individual's readiness and interest in changing

RELAPSE, CONTINUED USE,OR CONTINUED PROBLEM POTENTIAL
Exploring an individual's unique relationship with relapse or continued use or problems

RECOVERY/LIVING ENVIRONMENT
Exploring an individual's recovery or living situationand the surrounding people places



SAMHSA** DIMENSIONS OF RECOVERY (MACRO)

HEALTH
Overcoming or managing one's disease(s) or symptoms, and making informed, healthy choices that support physical and emotional well-being

HOME
Having a stable and safe place to live

PURPOSE
Conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society

COMMUNITY
Having relationships and social networks that provide support, friendship, love, and hope

RECOVERY CAPITAL (MICRO)

PERSONAL
- Generational Health
- Mental Wellbeing
- Nutrition
- Employment
- Education
- Housing Situation
- Transportation
- Clothing

SOCIAL
- Family Support
- Significant Other
- Social Support
- Social Mobility
- Healthy Lifestyle
- Access To Healthcare
- Safety

CULTURAL
- Beliefs
- Spirituality
- Sense of Purpose
- Cultural Relevance
- Sense of Community
- Values

MACRO
Concern with interaction and interdependence of individuals with their surrounding physical, social, and cultural systems in order to holistically assess how individuals affect and are affected by such systems. Make accessible a network of services and supports that is personcentered and builds on the strengths and resilience of individuals, families, and communities to achieve improved health, wellness, and quality of life.

MESO
Non-conflicted entity serving as a single point of contact providing assessment, level of care determination, referral, prior authorization and payment of certain care, and, care monitoring across clinical and non-clinical recovery support and social services aimed at achieving seamless movement in order to increase recovery capital and improve long-term recovery outcomes.

MICRO
Increasing recovery capital through network of "recovery hubs" and other support services providing nonclinical resources, including peer support, employment and job training linkages, social and recreational activities intended for people in or seeking recovery. Recovery capital and its indexing is the depth and breadth of internal and external resources that can be used by someone to begin and sustain their health and wellness.

*American Society of Addiction Medicine **US Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration

Appendix B

Palm Beach County Community Services Department
Neutral Care Coordination Executive Summary and Proposal

PROPOSAL

Establishing a Palm Beach County Neutral Care Coordination Entity and executing a person-centered, recovery-oriented system of care

Executive Summary
June 2023

Overview

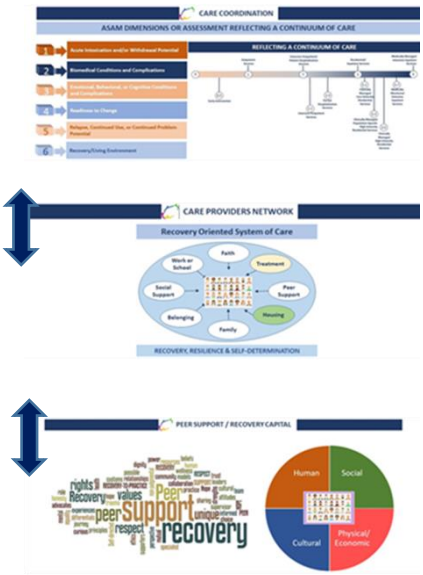
In July 2021, the Community Services Department (CSD) with the assistance of a team with expertise in neutrally coordinating and managing substance use disorder and mental health care completed a detailed proposal, "*Establishing a Palm Beach County Neutral Care Coordination Entity and executing a person-centered, recovery-oriented system of care.*" The proposal's objective was to plan and budget for achieving the Board of County Commissioners (BCC) major goal of establishing a readily accessible, integrated and coordinated recovery-oriented system of care that meets the needs of Palm Beach County residents and improves long-term recovery outcomes as well as quality of care.

The BCC first established this goal in November 2019. The Board as part of it identifying substance use has subsequently renewed the goal and behavior disorders as a strategic priority, most recently in November 2022. The BCC continues to do so in consideration of historic and continued challenges faced by the County's substance use disorder and behavioral system of care. Challenges exacerbated by both the opioid and COVID epidemics, which has created great systemic stress. Moreover, challenges that remain and include, but are not limited to:

- Fragmented and disjointed care from multiple treatment, social and recovery support providers.
- Treating the client based upon the services available at a particular provider rather than based upon their individualized needs.
- Ineffective transitioning of clients from one level of care or one service provider to another.
- Lack of timely sharing of needed treatment information among providers.
- Lack of monitoring and follow-up to ensure client engagement.
- Lack of accountability and agreed upon responsibilities among multiple treatment, social and recovery support providers serving one client.

CSD developed and executed a system of care model that is instrumental to achieving the BCC's goal. The model is consistent with achieving the process metrics related to the BCC goal above as follows:

- Implement care coordination.
- Establish recovery community organizations and recovery community centers; broaden the reach of peer support services across the continuum.
- Launch a Recovery Capital Instrument and train providers in its use.
- Support the Healthcare District's Addiction Stabilization Unit serve and integrate primary care and behavioral health services in partnership with the PBC Medical Society.



Outcomes

To date, the model's execution has identified the substance use disorder and behavioral needs of the client population; and, improved client care with linkage efforts across all health domains. It has also informed policy, planning, and programmatic decisions as well as served as the lens through which funding opportunities are identified and applied for. Fully executed, the model will inform public payers of appropriate level of care purchases resulting in cost-savings that will be reinvested to needed social determinant of health, recovery support and prevention services.

Additionally, significant progress has been made toward achieving the BCC's strategic priority of "Addressing substance use and behavior disorders by providing evidence-based prevention, medication-assisted treatment, and recovery support services." Moreover, toward its major goal of establishing a readily accessible, integrated and coordinated recovery-oriented system of care that meets the needs of Palm Beach County residents and improves long-term recovery outcomes as well as quality of care.

On November 15, 2022, the BCC approved an updated report containing findings and recommendations related to substance use and mental disorders entitled *Substance Use and Mental Disorders Plan Update, March 2022*, prepared by the Palm Beach County Behavioral Health, Substance Use and Co-Occurring Disorder Steering Committee. Said findings and recommendations included an Overarching Priority Recommendation to, "Implement person-centered, recovery-oriented system of care that is readily accessible and integrated inclusive of Neutral Care Coordination; Care Provider Network and Recovery Supports to ease transitions and continuity of care, remove barriers and improve long-term recovery outcomes."

Recovery Community Centers

In a major system of care advance, the BCC also approved completing the network of local recovery community organizations (RCO) and allied recovery community centers (RCC) on May 2, 2023. The aim is to foster a recovery-ready community, provide recovery support services, and engage and empower an authentic recovery voice.

Two sites are established in Delray Beach and Lake Worth Beach with expansion to take place in Riviera Beach and Belle Glade. Additionally, a countywide RCO coordinates the activities of, provides technical assistance to, the local RCOs, and provides public awareness, training, and advocacy services throughout Palm Beach County.

The network and its centers provide the model's critical underpinnings of peer supports and recovery support services. RCCs are intended to be recovery hubs facilitating "one-stop shopping" in the accrual of recovery capital and provide strong, recovery-specific, social support.

Research has shown that peer support facilitates recovery and reduces health care costs. Peer support is often coupled with recovery support services that include access to evidence-based practices such as supported employment, education, and housing; assertive community treatment; illness management; and peer-operated services.

These services have been shown to: reduce expensive inpatient service use; reduce recurrent psychiatric hospitalizations; improve individuals' relationships with health care providers; better engage individuals in care; and, significantly increase individuals' abilities to manage their symptoms and reduce their reliance on formal services while achieving positive recovery outcomes.

Recovery Capital Indexing

Recovery Capital		
Social Capital	**Personal Capital**	**Cultural Capital**
Family Support Significant Other Social Support Social Mobility Healthy Lifestyle Access to Healthcare Safety	General Health Mental Wellbeing Nutrition Employment Education Housing Situation Transportation Clothing	Beliefs Spirituality Sense of Purpose Cultural Relevance Sense of Community Values
60.85	52.36	70.76

Success at the individual level with respect to the CSD's behavioral health initiatives is being measured through deployment of the Recovery Capital Index®, (RCI).

RCI measures substance use disorder wellness using three domains (social, personal and cultural) and twenty-two components providing a comprehensive baseline and assessment of intervention effectiveness to allow for the tracking of client progress and tailored support. It is a peer-reviewed and validated assessment tool.

In 2020, the RCI was incorporated as a requirement into all of the Department's behavioral contracts as was the development of an individualized recovery plan developed parallel to historic treatment plans.

Additionally, providers are being required to and measured on completing a warm hand-off to the RCC's non-clinical environment. This is important because the length of an individual's engagement in clinical and non-clinical care (not length of stay in a singular treatment facility) is an important predictor to achieving long-term recovery outcomes.

To date, more than 2,500 RCI surveys have been completed with a 94 percent completion rate. In other words, of individuals who have initiated the 68-question survey, 94 percent have completed it.

5 Highest Indicators	
Sense of Purpose	77.8
Beliefs	72.7
Safety	69
Values	68.7
Sense of Community	68.2

5 Lowest Indicators	
Financial Wellbeing	37.1
Employment	46.4
Housing/Living Situation	48.4
Nutrition	49.7
Access to Healthcare	51.5

The overall average scores as well as the highest and lowest indicators are found in the charts. The results are not static. They are regularly interpreted and used to inform the individualized recovery plans; services offered at the RCC's; and, CSD's budgeting and planning.

Comprehensive Opioid Stimulant Substance Use Program

Palm Beach County was awarded a federal Department of Justice Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) that the OBHSUD leveraged to engage with Florida Atlantic University School of Social Work and Criminal Justice (FAU) as a research partner to investigate the efficacy of the Office's system of care work; its recovery-oriented initiatives and RCI deployment. The County's COSSUP aim is to reduce overdose deaths, promote public safety, and support access to treatment and recovery services in the criminal justice system.

> "I did a year in jail, which sucked. But the people here (RCC) are great. It doesn't matter what... If you don't call, you can just show up, and a friendly face with a smile and the personalities that walk around here and help everybody out is good. You need more like that in the world these days. There's not enough of it."
>
> *Michael, COSSUP Participant*

The County's COSSUP was operationalized in July 2021 through a contract with Rebel Recovery. Given housing stability's key predictive value in achieving long-term recovery outcomes, a primary focus of the program is on achieving housing stability for criminal justice involvement individuals at high risk of overdose. COSSUP also expedites recovery support services, provides housing vouchers, care coordination, and flex fund support.

OBHSUD worked closely with FAU and Rebel Recovery to define and measure housing stability standards and other recovery support interventions in the recovery residence environment in order to determine their impact on long-term recovery outcomes. Both qualitative and quantitative analytics is being used to measure the following:

1. Identifying barriers to long-term recovery & recidivism.
2. Determining the impact of recovery capital, housing stability and a recovery-oriented system of care on individuals with criminal justice involvement and substance use histories through the utilization of Recovery Capital Indexing.
3. Understanding whether, the services provided by Peer Support Specialist (PSS) effective in long-term recovery and recidivism reduction.
4. Understanding if housing stability is effective in long-term recovery and recidivism reduction.

FAU, using Recovery Capital Indexing, defined outcome as 90-day overall personal capital which includes factors such as general health, mental and emotional wellbeing, nutrition, employment, education, financial wellbeing, housing and living situation, transportation, and clothing. Two other major outcomes examined were re-arrest and housing stability at 90 days.

"(NAATP is) encouraged by your efforts in Palm Beach County, in particular your work related to measuring and monitoring recovery capital… We strongly believe this is the key to real and lasting reform. We have been following the progress of Palm Beach County's systems work with great interest, as we believe you may be the first county in the nation to adopt this approach on a broad scale. This work serves as a model that we hope will be implemented throughout the country with support and encouragement from NAATP."

Marvin Ventrell, NAATP CEO

In research findings published in fall 2022, FAU found the County's COSSUP is demonstrating efficacy and outcomes that are not only informing Palm Beach County's system of care work but also the nation. National organizations such as the National Association of Addiction Treatment Providers are taking note and affirming the County's work. As has Georgetown Law's O'Neill Institute for National & Global Health Law in its recently published report, "*Transcending MET (Money, Ego, Turf) A Whole Person, Whole Government Approach to Addressing Substance Use Disorder through Aligned Funding Streams and Coordinated Outcomes."*

FAU's study demonstrated the importance of having a RCC as a safe space in an individual's early recovery and reentry period to begin self-reflection, and build self-worth and self-efficacy. The study found of the 36 participants in the project's first year, 86 % (n= 31) did not have a re-arrest. Of the 14 % (n = 5) that had a re-arrest, only one participant had a new charge whereas the others were based on technicalities.

The study is making important contributions to understanding the relationship between an individual's recovery capital and achieving long-term recovery through known predictors of such. The study, through analyses between re-arrest and continuous variables, demonstrated two significant results. One, the recovery capital score on Access to Healthcare at baseline was significantly associated with re-arrest. Moreover, the recovery capital Values score at baseline were predictive of re-arrest at end of program.

The overall Cultural Capital and Family Support recovery capital scores at baseline were statistically significantly and directly associated with stable housing at 90 days. Additionally, the overall Social Capital recovery capital score at baseline was significant as a predictive variable with stable housing in addition to other sub scores under Social Capital.

Findings from the qualitative and quantitative results demonstrated the importance of targeting interventions focused on building social and cultural capital. First year statistical results are holding true through the completion of the project's second year.

This program demonstrates the importance of peer support specialists, care coordination and building community connections to increase personal capital that aids in long-term recovery and reducing recidivism rates. An area FAU highlighted is the notable barrier that court fees present in the individual's recovery and recidivism reduction. Another area highlighted was the significant racial disparities with personal capital and its impact on recovery and recidivism.

There were also several housing barriers noted in the program such as not accepting participants that were being treated with medication for opioid use disorder. Additionally,

recruiting recovery residences to participate in the program's Recovery Housing Provider Network proved difficult. This was true despite a 26-week resident housing voucher that met market rate and participant requirements that did not exceed Florida Association of Recovery Residences certification standards or applicable federal law.

The OBHSUD is currently finalizing proposals to establish transitional and affordable housing opportunities for the target populations in order to address these housing barriers.

Neutral Care Coordination Entity

In 2022, 211 Palm Beach and Treasure Coast reported 20,534 calls seeking assistance for mental health or substance use disorders (including 801 suicide related calls) representing 27.01% of all its calls. This kind of call volume begs for more than the historic information and referral response to such calls. It also calls for a systemic approach that addresses the historic and continued challenges faced by the County's substance use disorder and behavioral system of care identified earlier; not the least of which is the fragmented and disjointed care that currently exists from multiple treatment, social and recovery support providers.

Ariana Ciancio, LMHC, MCAP, Service Population Advocate Manager for the Delray Beach Police Department who serves Delray Beach's homeless population served on the team that developed the July 2021 proposal, "*Establishing a Palm Beach County Neutral Care Coordination Entity and executing a person-centered, recovery-oriented system of care."* She also served seventeen years as Lead Care Coordinator for National Council on Alcoholism and Drug Dependence-New Jersey (NCADD-NJ) neutral care coordination program which is now in place for twenty five years and has conducted more than 150,000 neutral assessments

"Neutral Care Coordination was key in getting people properly assessed and referred to appropriate care based on their individual needs. This would be critical in the implementation of the ROSC initiative as it will provide neutrality and an individual plan of care in Palm Beach County."

Ariana Ciancio, LMHC, MCAP
Service Population Advocate Mgr.

Ariana states, "Neutral Care Coordination was key in getting people properly assessed and referred to appropriate care based on their individual needs. This would be critical in the implementation of the ROSC initiative as it will provide neutrality and an individual plan of care in Palm Beach County." She and the team's work in developing the proposal provide great depth as to the proposed Neutral Care Coordination Entity's (NCCE), function, form, processes as well as budget requirements and justifications.

To summarize, the NCCE, an initial point of contact for those in need, is central to the County's system of care efforts. The primary goals of the NCCE are to:

- Ensure uniform assessment of substance use and/or mental health severity throughout the client population in order to decrease fragmentation of treatment services among providers offering various levels of care.
- Maintain and utilize a comprehensive continuum of addiction and/or mental health treatment services integrated with other social, non-clinical and recovery

support services.

- Provide the structure, process, and outcome measures necessary to meet care coordination goals and to streamline continuity, communication, and tracking of clients across providers and service settings.
- Accomplish the necessary underlying structure and processes needed to meet care coordination goals.

The NCCE will provide assessment, referral and care coordination services oriented toward individualized service plans unique to the individuals' needs and in consideration of their choices. It will also serve as prior authorizer and payer of certain care.

These services will be coordinated and provided within a Care Provider Network of treatment, social and recovery services. They will be also complemented by, as well as, with the underpinnings of peer supports, which are tied to recovery capital outcomes measuring and monitoring through the established RCO and RCCs.

In a study published in the American Journal of Public Health, researchers tested the effectiveness of a long-term coordinated care strategy - intensive case management (ICM) - compared with usual care (UC) which was piloted by the NCADD-NJ and since has become the standard of care coordination for the state's welfare-to-work population.

UC is often referred to as the "screen and refer" model and was the standard of care in New Jersey at the time of the study. ICM is consistent with a chronic disease management strategy that augments current disconnected episodes of acute care with longer-term care strategies and cross-systems coordination that addresses other health and social needs and provides relapse monitoring and support during extended periods.

Researchers found ICM clients had significantly higher levels of substance abuse treatment initiation, engagement, and retention compared with UC clients. In some cases, ICM treatment attendance rates were double those of UC rates. Additionally, almost twice as many ICM clients were abstinent at the 15-month follow-up compared with UC clients.

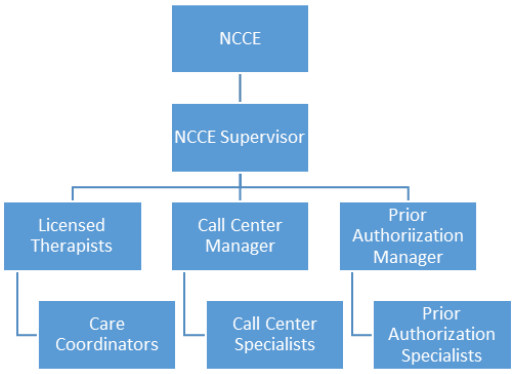
NCADD-NJ through its Work First New Jersey Substance Abuse and Behavioral Health Initiative has coordinated the substance use and behavioral health care of approximately 5,800 (unduplicated) individuals annually for the state's welfare to work population since 1998. It reports that in 2022, through validated appropriate level of care assessments, 89% of treatment placements were for outpatient care while 11% of placements were for inpatient care.

NCADD-NJ also reports its average cost per client per episode of care is $3400 compared to the national average of between $14,000 and $23,000. This is one example of how a neutral entity responsible for assessing need and coordinating care can result in fewer high-intensity treatment and cost savings.

NCCE Project Personnel and Budget

Detailed Personnel, Budget and Justifications are found within the detailed proposal, "*Establishing a Palm Beach County Neutral Care Coordination Entity and executing a person-centered, recovery-oriented system of care."* To summarize, NCCE staff costs were calculated assuming 20,000 admissions (not unduplicated) to substance use disorder or mental health services annually. Staffing requirements are based on a five (5) day workweek consisting of 7.5 hours per day, excluding a 30-minute lunch break. Proposed salaries include fringe benefits at a rate of 30% of stated salaries.

The NCCE Supervisor will have administrative responsibility for the entity. The Supervisor will also be responsible for the supervision of a team of licensed therapists and the Call Center Manager.



NCCE Licensed Therapists will have responsibility for conducting a mental health and substance use disorder clinical assessment. Licensed Therapists will also be responsible for supervising care coordinators and serving as initial authorizers of certain care.

Care Coordinators, as key personnel to the system of care, will be responsible for conducting a comprehensive case management assessment that addresses multiple life domains and developing an Integrated Recovery Plan that is person-centered and respects client choice. Care Coordinators will also be responsible for monitoring progress of the treatment plan authorized by the Licensed Therapist and the Integrated Recovery Plan. They will also be linking clients to appropriate care and resources in the community as well as serving as ongoing authorizer's of payment care.

The NCCE Prior Authorization Manager will have administrative responsibility for the Prior Authorization Unit and be responsible for planning, assigning and supervising the work of the Prior Authorization Specialists.

Prior Authorization Specialists will be responsible for processing of prior authorizations as well as interact directly with providers to assist them in billing and claims. Specialists will also be responsible for gathering, compiling and preparing information to be entered into related reporting systems.

The NCCE Call Center Manager will have administrative responsibility for the Call Center and be responsible for planning, assigning and supervising the work of the Call Center Specialists.

Call Center Specialists will be responsible for specialized contact with individuals seeking mental health and substance use disorder services through the Call Center. They are also responsible for answering inquiries and furnishing information to individuals by telephone or other means; scheduling assessments with Licensed Therapists; reviewing and processing related paperwork and preparing and reconciling reports.

Initial Phase @ 5,000 admissions annually

Title	Quantity	Salary*	Total
Supervisor	1	$59,269	$59,269
Licensed Therapist	5	$56,305	$281,525
Care Coordinator	9	$45,853	$412,677
PA Manager	1	$38,311	$38,311
PA Specialist	3	$33,698	$101,094
Call Center Manager	1	$52,131	$52,131
Call Center Specialist	1	$36,393	$36,393
		Sub-total	$981,400
		Fringe (@ 30%/salary)	$294,420
		Total	$1,275,820

Second Phase @ 15,000 admissions annually

Title	Quantity	Salary*	Total
Supervisor	1	$59,269	$59,269
Licensed Therapist	15	$56,305	$844,575
Care Coordinator	27	$45,853	$1,208,031
PA Manager	1	$38,311	$38,311
PA Specialist	8	$33,698	$269,584
Call Center Manager	1	$52,131	$52,131
Call Center Specialist	2	$36,393	$72,786
		Sub-total	$2,544,687
		Fringe (@ 30%/salary)	$763,406
		Total	$3,308,093

Final Phase @ 20,000 admissions annually

Title	Quantity	Salary*	Total
Supervisor	1	$59,269	$59,269
Licensed Therapist	18	$56,305	$1,013,490
Care Coordinator	35	$45,853	$1,604,855
PA Manager	1	$38,311	$38,311
PA Specialist	9	$33,698	$303,282
Call Center Manager	1	$52,131	$52,131
Call Center Specialist	2	$36,393	$72,786
		Sub-total	$3,144,124
		Fringe (@ 30%/salary)	$943,237
		Total	$4,087,361

PROPOSAL

Establishing a Palm Beach County Neutral Care Coordination Entity and executing a person-centered, recovery-oriented system of care

July 2021

Rationale

Historic and recent challenges faced by the County's behavioral health and substance use disorder system of care, particularly those related to addressing its opioid and COVID epidemics, has created great systemic stress. These challenges include a reported 26% increase in first quarter opioid overdose deaths from 112 in 2019 to 144 in 2020. Moreover, a staggering 79% increase in the second quarter from 91 in '19 to 163 in '20. Overall, there was a 27% increase in deaths from 446 in '19 to 566 in '20. The first two quarters of 2021, show a downward trend with 71 confirmed opioid deaths and 167 overdose deaths overall.

> The pandemic caused me to lose my job and to have depression and anxiety. Being alone is one of the things I do not like about the pandemic.
>
> *Storyteller: Female 18-30 years old*

On a good note, suicides were reported down year over year by 32%. This alone though does not tell the complete tale of COVID's impact. One need only review Palm Health Foundation's COVID-19 Story Collection Project, wherein more than 900 community members told their very personal, and sometime heart-wrenching, stories of how coronavirus has affected their lives to get a true picture.

The systemic challenges remain and include, but are not limited to:

- Fragmented and disjointed care from multiple treatment, social and recovery support providers.
- Treating the client based upon the services available at a particular provider rather than based upon their individualized needs.
- Ineffective transitioning of clients from one level of care or one service provider to another.
- Lack of timely sharing of needed treatment information among providers.
- Lack of monitoring and follow-up to ensure client engagement.
- Lack of accountability and agreed upon responsibilities among multiple treatment, social and recovery support providers serving one client.

These challenges continue to force key stakeholders and others to analyze the system of care and to explore ways to improve long-term recovery outcomes and quality of care. In its wisdom, the Board of County Commissioners (BCC) identified the opioid epidemic, behavioral and substance use disorder as a high strategic priority in 2019.

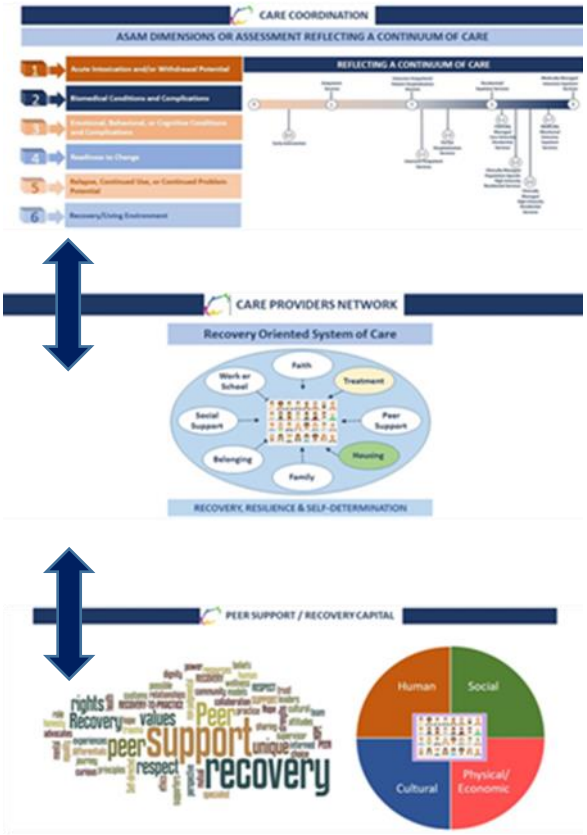
The BCC identified as an important goal the establishment of a readily accessible, integrated, person-centered and coordinated recovery-oriented system of care that commits to quality, evidence-based addiction and mental health services and integration of the Addiction Stabilization Facility.[1] Since, a cross-departmental team of key County staff, Department leads

[1] Hulick, J. Young, L. "Substance Use and Behavior Disorders Cross Departmental Team." Palm Beach County Board of County Commissioners Presentation. West Palm Beach, FL, November 16, 2019.

and resources has been utilized to plan and budget strategically as it aims to re-tool behavioral health care services for the residents of Palm Beach County.

B. Project Description

The Community Services Department developed a system of care model which is expected to truly deliver on and implement the person-centered, recovery-oriented system of care envisioned by the BCC which, to date, has been elusive. It is also expected to identify the behavioral health and substance use disorder needs of the client population; improve client care with linkage efforts across all health domains; and, inform public payers of appropriate level of care purchases resulting in anticipated cost-savings which will be reinvested to needed social, recovery support and prevention services.



The proposed system of care is consistent with achieving the process metrics related to the BCC goal above as follows:

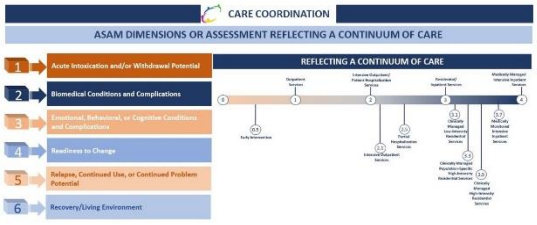
- Implement care coordination.
- Establish recovery community organizations and recovery community centers; broaden the reach of peer support services across the continuum.
- Launch a Recovery Capital Instrument and train providers in its use.
- Support the PBC Healthcare District's (HCD) efforts to have the Addiction Stabilization Facility (ASF) serve as the central point of intake/triage center for all overdose cases; and, integrate primary care and behavioral health services in partnership with the PBC Medical Society.

The system of care will also inform policy, planning, and programmatic decisions as well as be the lens through which funding opportunities are identified and applied for. A Neutral Care Coordination Entity (NCCE) will be central to the system. It will provide assessment, referral and care coordination services oriented toward individualized service plans unique to the individuals' needs and in consideration of their choices. It will also serve as prior authorizer and payer of certain care.

These services will be coordinated and provided within a Care Provider Network of treatment, social and recovery services. They will be also complemented by, as well as, with the underpinnings of peer supports, which are tied to recovery capital outcomes measuring and monitoring through recovery community organizations and allied recovery community centers.

The model affords the unique ability to rapidly provide the exact recovery services called for and allow appropriate services to be maintained which will improve long-term recovery outcomes. A coordinated continuum of substance use disorder treatment and recovery services is also an effective and a very good predictor to an individual achieving long-term recovery.

B. (1) Project Description / Neutral Care Coordination Entity



In a study published in the American Journal of Public Health, researchers tested the effectiveness of a long-term coordinated care strategy - intensive case management (ICM) - compared with usual care (UC) which was piloted by the National Council on Alcoholism and Drug Dependence-New Jersey (NCADD-NJ) and since has become the standard of care coordination for the state's welfare-to-work population.

UC is often referred to as the "screen and refer" model and was the standard of care in New Jersey at the time of the study. ICM is consistent with a chronic disease management strategy that augments current disconnected episodes of acute care with longer-term care strategies and cross-systems coordination that addresses other health and social needs and provides relapse monitoring and support during extended periods.

Researchers found ICM clients had significantly higher levels of substance abuse treatment initiation, engagement, and retention compared with UC clients. In some cases, ICM treatment attendance rates were double those of UC rates. Additionally, almost twice as many ICM clients were abstinent at the 15-month follow-up compared with UC clients.[2]

NCADD-NJ through its Work First New Jersey Substance Abuse and Behavioral Health Initiative has coordinated the substance use and behavioral health care of approximately 5,800 (unduplicated) individuals annually for the state's welfare to work population since 1998. It reports that in 2020, through validated appropriate level of care assessments, 89% of treatment placements were for outpatient care while 11% of placements were for inpatient care. It also reports its average cost per client per episode of care is $3400 compared to the national average of between $14,000 and $23,000.[3] This is one example of how a neutral entity responsible for assessing need and coordinating care can result in fewer high-intensity treatment and cost savings.

[2] Improving 24-Month Abstinence and Employment Outcomes for Substance-Dependent Women Receiving Temporary Assistance for Needy Families With Intensive Case Management Research and Practice | Peer Reviewed | Morgenstern et al. American Journal of Public Health | February 2009, Vol 99, No. 2 pp, 328 to 333.
[3] Wolff, S. Hightower. R. "Work First New Jersey Substance Abuse and Behavioral Health Initiative." Sober Homes Task Force presentation. West Palm Beach, FL, September 27, 2018.

The primary goals of the NCCE are to:

- Ensure uniform assessment of substance use and/or mental health severity throughout the client population in order to decrease fragmentation of treatment services among providers offering various levels of care.
- Maintain and utilize a comprehensive continuum of addiction and/or mental health treatment services integrated with other social, non-clinical and recovery support services.
- Provide the structure, process, and outcome measures necessary to meet care coordination goals and to streamline continuity, communication, and tracking of clients across providers and service settings.
- Accomplish the necessary underlying structure and processes needed to meet care coordination goals.

A NCCE module will be designed and developed to support on-going client engagement and enable services to be coordinated across the continuum of substance use disorder and mental health care. This care will be integrated with other social, non-clinical and recovery support services.

The NCCE will be a non-conflicted, neutral body, which serves as a single point of entry (SPOE) for referrals to providers as well as prior authorizer of and payer of certain care. Its core values are:

- Client choice and identified needs shall be the primary driver of service engagement and referral in a timely fashion. Clinical decisions shall be based on client need and obtaining best available care.
- Care coordination shall assist the client with a successful transition between assessments, initial placement, through a seamless movement along the continuum of care.
- Coordination services to include facilitation of communication among all professionals involved with the client and the community identified provider which most closely meets client's needs.
- Primary role is to eliminate barriers to achieve acceptance and admission to the appropriate level of care and facility in a timely manner.

Key elements to ensure NCCE services are client-centered and recovery-oriented include but are not limited to:

- Facilitate face-to-face or phone interview with the client and treatment provider when needed for admission review and acceptance. Utilization of an 800-phone line available 24/7 to link targeted individuals and the community-at-large to most appropriate resource to meet their needs.

- Facilitate completion of paperwork and other admission requirements in a timely manner (including release of information).
- Assist with provision of any evaluation reports needed (medical, psychiatric, dental, medication records, legal information, etc.).
- Identify any client barriers, facilitate scheduling of any necessary appointments (i.e., medical clearances, evaluations, etc.), and obtain reports as needed.
- Ensure medical needs are met in a timely manner to not delay engagement in treatment.
- Linkages to services (i.e., public assistance, social security, disability, legal services, pre-natal care, homeless services, medical care, self-help meetings/resources, HIV testing, counseling for domestic violence, trauma, recovery community centers, recovery community organizations and other community supports).
- Communicate with required collateral contacts involved with the client regarding assessment results, admissions, denials or delays for admissions, and case status as needed and with appropriate consents.
- Assist with potential barriers such as transportation to treatment and appointments.
- Monitor waiting lists for admission to treatment facilities and keep client and professionals informed via phone or email.
- Review consents for accuracy and forward as appropriate safeguarding client's privacy and confidentiality, as required by law.
- Maintain up-to-date records and ensure compliance with HIPAA and other legal requirements.
- Ensure on-going clinical case reviews occur with treatment providers to ensure targeted goals are being met and that placement and services continue to remain appropriate.
- Apply a cross-systems approach to case management by communicating with other agencies and advocating for the client to ensure client needs and goals are being met. Agencies may include public assistance, parole or probation officers, child protection services, etc.
- Track and report on outcomes measures.
- Participate and when needed, facilitate discharge and step-down planning conferences.

B. (1)(a) Intake and Assessment

Key Intake and Assessment components of the NCCE will include:

- An Immediate Need Profile (INP), in the form of a short questionnaire is to be completed as part of the intake process. The INP is to assess: acute intoxication and/or withdrawal potential; severe physical health problems; imminent danger or risk of future harm; inability to function in activities of daily living (ADL); dangerous living environment; any requirements by a 3rd party agency for the client to engage in a

treatment program within a specified time frame (i.e., court mandate – drug or family court).[4]

- Have access to Mobile Crisis Unit and/or emergency personnel if an involuntary treatment placement is required to ensure client does not engage in self-harm or harm to others or has an emergent medical need that requires transport to a hospital emergency room and/or receiving facility.
- A comprehensive assessment shall be completed independently by the client and provided to a separate staff member.

B. (1)(b) Referral to and Coordination of Treatment and Other Care Services

Referrals shall be based on Assessment results and appropriate level of care as determined by assessment to ensure client is recommended for the most clinically appropriate and least restrictive level of care. Referral is individualized and involves clients in decision-making. Other client-focused considerations include informed decision-making, strength-based recommendations and access to formal and informal supports and resources that will support treatment and recovery.

Neutral Care Coordinators' priority goals are to:

- Eliminate barriers.
- Develop Client individualized recovery plan (treatment, discharge, recovery supports and services, and an on-going recovery plan with provisions for peer supports and interventions as needed to help support and sustain recovery). Service planning across the continuum of care is to be discussed from the beginning, with pro-active steps taken from the outset to ensure client's future success.
- Prioritize client choice through transparent explanation of treatment options and recommendations based on screening and assessment so that Client makes informed choice and is involved in planning process (which optimizes successful treatment experiences and outcomes).
- Utilize Motivational Interviewing techniques.
- Present pros-cons of recommended treatment options and risks of treatment versus no treatment.
- Memorialize client decisions in writing through utilization of a Treatment and Recovery Plan Agreement.

[4] Here are some examples of INPs from other states (NJ, MO and CA).
NJ:https://www.state.nj.us/humanservices/dmhas/initiatives/managed/Immediate_Need_Profile.pdf
MO: http://18vtj92co9zb1qy8011oc0fw-wpengine.netdna-ssl.com/wp-content/uploads/The-ASAM-Criteria-Immediate-Need-Profile.pdf
CA (San Bernardino County): https://wp.sbcounty.gov/dbh/wp-content/uploads/2019/03/SUDRS027-Immediate-Need-Profile_FILLABLE-02.2019.pdf

- Obtain reciprocal releases signed by client to share information with the referring agency and collateral contacts.
- Treatment referral to appropriate level of care and intensity of services, based on ASAM criteria or LOCUS and results of DSM-5 diagnosis (if co-occurring)- with an immediate warm hand-off if possible. Contacts with providers are to be completed in client's presence and with resources as needed to get client to (transported to) treatment (i.e., if in-patient and client does not have transportation, then transportation should be set up as part of the care coordination along with finding an in-patient bed; if outpatient treatment is recommended and client lacks housing, transportation, these ancillary needs shall be met to remove barriers to treatment).
- Maintain client contact – outreach and manage (coordinate) integrated care through client engagement throughout the process.

B. (1)(c) Prior authorization and payer of certain care

Prior authorization shall be based on identified client need and most appropriate recommended level of service for a specified timeframe. The following are the goals of Prior Authorization:

- Care Coordination and Treatment Provider collaboration.
- Ensuring clinically appropriate treatment placement and movement along the continuum of care.
- Systematic and accurate payment structure designed to generate payment at the beginning of every month (optimally with a payment module integrated into the health information system).
- Accountability and compliance by the treatment provider community.
- Eliminate gaps in services.
- Ensure client eligibility and troubleshooting.

Continued service reviews ensure that appropriate services are delivered and that either anticipated progress is being made toward the established clinical goals or the treatment plan is adjusted accordingly. This review allows the Care Coordinator to obtain necessary clinical information to document the need for ongoing care.

Payment Authorization Process:

- Prior-Authorization for services are transmitted via secure web portal to the provider prior to delivery of services authorized for a designated length of stay and for a specific number of designated service units.
- Providers are responsible for submitting a written request via this portal for continuing services beyond the pre-authorized time and/or for more than the pre-authorized number of designated service units. All requests must be submitted with a clinical justification for continued services prior to the expiration of the pre-authorized time

and/or designated service units, for outpatient services, not less than five (5) business days before the initial time expires and for residential placement, not less than two (2) business days before the expiration of the preauthorization period. Once the clinical reasons for continued service are reviewed and as appropriate, have been approved, a new prior-authorization will be generated to the provider that will authorize a new service period and/or new number of service units, which will be eligible for reimbursement.

- All treatment services must be pre-authorized prior to clients receiving them.

Payment Authorization (PA)

An electronic system for prior-authorizations and payment authorizations will be developed in conjunction with the health information utilization system, which will verify delivery of services that are eligible for payment.

Treatment Providers would be responsible for entering clients' weekly attendance into a Payment Authorization module that would be developed and integrated into the Prior Authorization module in a secured web portal.

At the beginning of each month, the Payment Authorization Unit would be responsible for processing the invoices for the treatment providers for the prior month's pre-authorized treatment services. The Payment Authorization Unit reviews the attendance, along with the services that were pre-authorized for clients and authorizes payment (or reimbursement) accordingly.

The Payment Authorization Unit enters the approvals into the (Fiscal Agent's Management Information system) which then notifies the providers that their Payment Authorizations are ready). Following notice of approval, Providers may login to the secure web based portal and download their Payment Authorizations to submit with invoices for payment. Once providers have received their Payment Authorizations, they must submit their claims through the fiscal agent for payment.

B. (1)(d) Call Center

A NCCE Call Center will facilitate access to care for Palm Beach County residents with substance use disorder and mental illness challenges through a 24/7/365 telephonic single point of access. Call Center Specialists will be trained to field calls, provide resources, and conduct a brief screening.

The Specialist will schedule a complete substance use/mental health assessment with an NCCE Licensed Therapist for those residents identified as in need based on the initial screen. The assessment will be scheduled as soon as possible but no later than three business days from

initial contact. In emergencies, the specialist will triage callers to the most appropriate provider.

The Call Center will be staffed from 8:00AM – 5:00PM daily, Monday through Friday. The Center's second and third shifts along with weekend shifts will be staffed via a memorandum of understanding with Palm Beach County 211.

The Call Center Manager will oversee the monitoring of calls recorded through the Call Center operations and the completion of documentation audits for utilization management. The Manager will monitor compliance with quality standards, accreditation requirements, audit requirements, internal protocols and Palm Beach County 211's compliance with the memorandum of understanding.

Performance indicators pertaining to Call Center calls shall include but are not limited to professionalism, respect and courtesy, providing correct information, making sure the caller is aware of next steps or what next to expect, determining the correct call resolution status, and documenting the call properly, and following specific protocols for handling registration, providing community information and referrals.

Additionally, the Call Center Manager shall establish policy and procedures to seek feedback about residents' experience and satisfaction in their interactions with the Call Center. The Manager shall support and facilitate suggestions, feedback, and input into Quality Improvement activities, which may include, but not be limited to, using the following:

- Telephone surveys made to residents' services to inquire about their experience in speaking with Call Center Specialists.
- Mailed satisfaction surveys sent to residents inquiring about satisfaction and degree to which services helped residents.
- Targeted surveys to community organizations or system partners assessing their experience with the Call Center.
- Following up with residents regarding whether they are satisfied in the resolution of complaints.

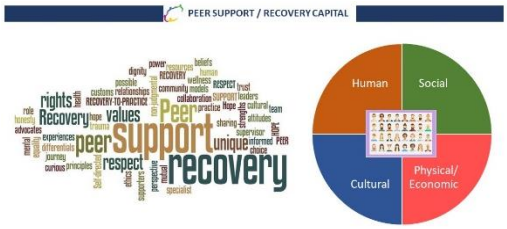
C. Project Description / Care Provider Network

The Care Provider Network (CPN) is a coordinated network of community based services and supports that will be person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve long-term recovery and improved health, wellness, and quality of life for those with or at risk of substance use disorders.

The CPN will require NCCE Care Coordinators to engage people and families in community support networks to ease their integration back into the community. The services and supports will be delivered in more traditional behavioral health and substance use disorder settings as well as less traditional non-clinical settings like Recovery Community Centers (RCC). RCCs provide services, adding a third tier to the 2 existing tiers of formal treatment and mutual help organizations.

The services and supports may include resources such as: recovery centers and activities; peer supports; mutual help groups; housing; transportation; education and vocational services; mental health and substance use disorder services; medical care, including HIV services; financial and budget counseling; legal and advocacy services; prevention for children and adolescents; and parenting and family services.

D. Project Description / Recovery Community Centers - Peer Support – Recovery Capital



Peer support services will be delivered by individuals through a network of Recovery Community Organizations (RCO) and allied Recovery Community Centers (RCC). Peers have common life experiences with the people they are serving and a unique capacity to help each other based on a shared affiliation and a deep understanding of this experience. Research has shown that peer support facilitates recovery and reduces health care costs. Peer support is often coupled with recovery support services which include access to evidence-based practices such as supported employment, education, and housing; assertive community treatment; illness management; and peer-operated services.

These services have been shown to: reduce expensive inpatient service use, reduce recurrent psychiatric hospitalizations, improve individuals' relationships with health care providers, better engage individuals in care, and significantly increase individuals' abilities to manage their symptoms and reduce their reliance on formal services while achieving positive recovery outcomes.

RCCs are intended to be recovery hubs facilitating "one-stop shopping" in the accrual of recovery capital and provide strong, recovery-specific, social support. They may include, but not be limited to, housing; transportation; education and vocational services; mental health/substance use disorder services and medical care linkages, including HIV services; financial and budget counseling; legal and advocacy services; prevention for children and adolescents; and parenting and family services.

RCCs have been found to be of particular help to those more vulnerable individuals beginning recovery from substance use disorder who have few resources and low recovery capital. That said, they offer value to many others in the early years of recovery stabilization and beyond. They have also been found to provide a unique function in helping participants build recovery

capital and thereby increase quality of life and self-esteem, and decrease psychological distress.[5]

The measures of success for the project will occur at the patient level using the Recovery Capital Index®, (RCI) secured through license and user agreement by Palm Beach County Community Services Department (CSD) and Southeast Florida Behavioral Health Network (SEFBHN) with the Index's developer, Face It TOGETHER (FIT). Additional outcome measures will also be explored, developed and integrated into the system of care.

RCI measures substance use disorder wellness using three domains (social, personal and cultural) and twenty-two components providing a comprehensive baseline and assessment of intervention effectiveness to allow for the tracking of client progress and tailored support. It is a peer-reviewed and validated assessment tool. The validation process verified the design of the RCI domains – personal, social, and cultural capital. Variables significantly related to substance use disorder wellness, based on the RCI, are primary substance use disorder, substance use disorder identification, employment, and income. The RCI accurately described the individual's current state of recovery and it was validated as a tool to measure substance use disorder wellness.[6]

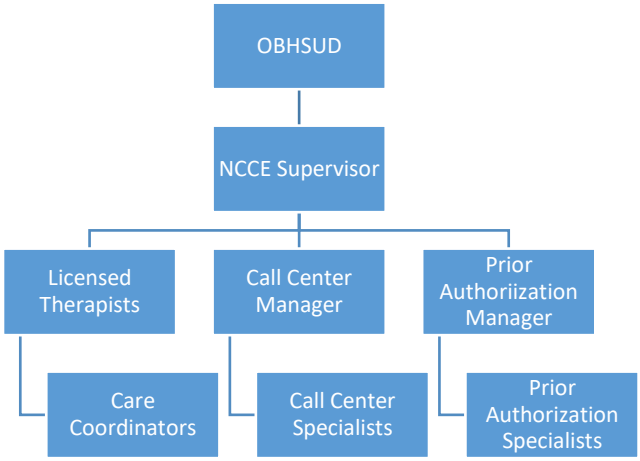
CSD's system of care model affords the unique ability to rapidly provide the exact recovery services called for and allow appropriate services to be maintained which will improve long-term recovery outcomes. A coordinated continuum of substance use disorder treatment and recovery services is also an effective and a very good predictor to an individual achieving long-term recovery.

[5]Occup. Ther. Int. 15(4): 205–220 (2008) Published online 9 October 2008 Effectiveness of a peer-support community in addiction recovery: participation as intervention, Boisvert, et. al.

[6] Validating a Survey for Addiction Wellness: The Recovery Capital Index | Peer Reviewed | Whitesock et al. S D Med. | 2018 May;71(5):202-212.

D. NCCE Project Personnel and Budget

A NCCE Supervisor will have administrative responsibility for the entity. The Supervisor must possess a Florida license as a licensed Clinical Social Worker, Licensed Mental Health Counselor, Marriage and Family Therapist or Psychologist.



The Supervisor will also be responsible for the supervision of a team of licensed therapists and the Call Center Manager. Therapists and the Call Center Manager will have to demonstrate evidence of working with substance use disorder and co-occurring disorders population and have prior supervisory experience. (See PBCHR Job Description #03969, PG 34 - Licensed Therapist Coordinator)

NCCE Licensed Therapists will have responsibility for conducting a mental health and substance use disorder clinical assessment. The Licensed Therapist must possess a Florida license as a licensed Clinical Social Worker, Licensed Mental Health Counselor, Marriage and Family Therapist or Psychologist.

Licensed Therapists will also be responsible for supervising care coordinators and serving as initial authorizers of certain care. They will have to demonstrate advanced training, knowledge and experience working with clients with substance use disorders and co-occurring disorders as well as be qualified to diagnose using the DSM-5, and identify appropriate levels of care using ASAM criteria, LOCUS and other evaluative instruments. (See PBCHR Job Description #03120, PG 32 – Licensed Therapist)

Care Coordinators will be responsible for conducting a comprehensive case management assessment that addresses multiple life domains and developing an Integrated Recovery Plan that is person-centered and respects client choice. Care Coordinators must possess a Bachelor's Degree from an accredited college or university with major course work in Social Work, Sociology or Psychology or related field.

Care Coordinators will also be responsible for monitoring progress of the treatment plan authorized by the Licensed Therapist and the Integrated Recovery Plan. They will also be linking clients to appropriate care and resources in the community as well as serving as ongoing authorizer's of payment for certain care. They will have to demonstrate evidence of working with substance use populations and knowledge in formal/informal community systems and resources. (See PBCHR Job Description #03057, PG 24 – Case Manager I)

A NCCE Prior Authorization Manager will have administrative responsibility for the Prior Authorization Unit and be responsible for planning, assigning and supervising the work of the

Prior Authorization Specialists. The Manager must possess a four (4) year college or university degree with major course work in Business or Public Administration or a related field.

The Manager will have to demonstrate experience in billing and payment processes preferably in a health care environment as well as staff supervision. They will also have to demonstrate evidence of a working knowledge of mental health and substance use disorder. (See PBCHR Job Description #00903, PG 17 – Data Processor II)

Prior Authorization Specialists will be responsible for processing of prior authorizations as well as interact directly with providers to assist them in billing and claims. They must have graduated from high school or any equivalent recognized certification and have one (1) year of data processing experience.

Specialists will also be responsible for gathering, compiling and preparing information to be entered into related reporting systems. Additionally, they will be responsible for inputting, reviewing and verifying data from a variety of source documents. (See PBCHR Job Description #00902, PG 12 – Data Processor I)

A NCCE Call Center Manager will have administrative responsibility for the Call Center and be responsible for planning, assigning and supervising the work of the Call Center Specialists. The Manager must possess an Associate Degree with major course work in Business or Public Administration or a related field.

The Manager will have to demonstrate experience in Call Center, Helpline operations or customer service related activities. They will also have to demonstrate evidence of a working knowledge of mental health and substance use disorder as well as formal/informal community systems and resources. (See PBCHR Job Description #09304, PG 29 – Customer Service Supervisor)

Call Center Specialists will be responsible for specialized contact with individuals seeking mental health and substance use disorder services through the Call Center. They are also responsible for answering inquiries and furnishing information to individuals by telephone or other means; scheduling assessments with Licensed Therapists; reviewing and processing related paperwork and preparing and reconciling reports.

Specialists will have to demonstrate evidence of a working knowledge of mental health and substance use disorders as well as formal/informal community systems and resources. They must possess an Associate Degree with coursework in Human Services or a related field and experience in Call Center, Helpline operations or customer service related activities. (See PBCHR Job Description #00447, PG 15 – Customer Service Specialist I or #03506, PG 19 – Case Manager Trainee).

Personnel Budget

Fully Staffed

A fully staffed NCCE would require the following personnel for the reasons stated below in the Budget Justification.

Title	Quantity	Salary	Total
Supervisor	1	$59,269	$59,269
Licensed Therapist	18	$56,305	$1,013,490
Care Coordinator	35	$45,853	$1,604,855
PA Manager	1	$38,311	$38,311
PA Specialist	9	$33,698	$303,282
Call Center Manager	1	$52,131	$52,131
Call Center Specialist	2	$36,393	$72,786
		Sub-total	$3,144,124
		Fringe (@ 30%/salary)	$943,237
		Total	$4,087,361

Budget Justification

The NCCE staff costs were calculated assuming 20,000 admissions (not unduplicated) to substance use disorder or mental health services annually. Staffing requirements are based on a five (5) day work week consisting of 7.5 hours per day, excluding a 30-minute lunch break. Proposed salaries include fringe benefits at a rate of 30% of stated salaries. Therapists, as explained above, will not only conduct assessments, but will also meet with case coordinators to assist and approve the individualized plans for clients.

Care Coordinators, as central figures to this model, carry significant responsibilities that include reviewing clinical services, obtaining consents, securing and appropriately sharing records with providers as needed, locating placements for identified services, identifying barriers and resolving them and following up with clients to ascertain client engagement and satisfaction with services.

Initial Prior Authorization and Client ASAM / Psychosocial Assessment (Licensed Therapist)

Each Therapist assesses five clients/day @ 1.5 hours per assessment and reserves 7.5 hours per week to meet with care coordinators to review, assist and approve individualized service plans developed by care coordinators and time for emergency evaluations.
7.5 hours X 4 days/week = 30 hours + 7.5 hours = 37.50 hours/week

37.5 hours X 47 weeks = 1762.50 total hours for Therapist to be available to conduct assessments and oversee development and approval of individualized care plans annually
Estimated required therapeutic hours for 20,000 clients X 1.5 hours per client = 30,000 therapeutic hours annually.

30,000 hours / 1762.50 hours per Therapist = 17.02 Licensed therapists rounded up to 18 so as not to create a backlog, lead to incomplete or rushed assessments, and to allow time for emergency assessments and to work with care coordinators to develop and oversee individualized care plans and conduct prior initial approval of certain care.

Clinical Service Review (CSR) and Ongoing Authorizations (Care Coordinator)

Each Coordinator would have three CSR's X 1 hour per CSR per episode for a total of 60,000 hours (20,000 clients x 3 CSRs) of CSR review.
Additionally, Care Coordinators will require on average, 4 to 5 hours per week for gathering and having documents executed and transferred to referral sources, supporting linkages with warm transfers and conducting follow-up with clients, updating individualized service plan updates and approving certain care.
60,000 hours / 1762.50 hours per year for Care Coordination = 34.04 Care Coordinators required to provide Care Coordination Services for 20,000 clients.

Authorization Payments (Prior Authorization Specialist)

Each Prior Authorization Specialist would process billing claims @ 15 minutes (.25) per claim. The number of claims equals 20,000 admissions x 3 CSRs for a total of 60,000 claims. 60,000 claims x .25 hours per claim equals 15,000 hours to process claims annually.

15,000 hours / 1762.50 per Prior Authorization Specialist = 8.5 Prior Authorization Specialist required.

Call Center (Call Center Specialist)

The NCCE Call Center staff costs were calculated based on data from PBC 211 calls in FY 2020 which amounted to 20,413 substance use disorder and mental health calls. The NCCE Call Center would field day shift calls or one-third of all calls equaling 6,804. Calls on average are 10 minutes long, which adds up to approximately six calls per hour. 6,804 calls / 6 calls per hour equals 1,134 hours to process calls annually, (approximately 45 calls per day) for the Call Center Specialist 329 days in 47 weeks (M-F)

1,134 hours / 1762.50 per Call Center Specialist = .64 FTE, which although rounded up would equal one (1) Call Center Specialist, however, to avoid a back-up of calls, account for illness, emergencies, etc., and allow for lunch, periodic breaks and reasonable need to obtain answers to questions that are not immediately available at the work station, two (2) specialists are needed.

Phased-in

A phased-in approach would reduce initial staffing levels and increase the number of therapists, care coordinators and PA Specialists over a three (3) to five (5) year period until the NCCE is fully staffed. Accordingly, the first year budget would be:

Title	Quantity	Salary	Total
Supervisor	1	$59,269	$59,269
Licensed Therapist	8	$56,305	$450,440
Care Coordinator	15	$45,853	$687,785
PA Manager	1	$38,311	$38,311
PA Specialist	5	$33,698	$168,490
Call Center Manager	1	$52,131	$52,131
Call Center Specialist	2	$36,393	$72,786
		Sub-total	$1,529,212
		Fringe (@ 30%/salary)	$458,764
		Total	$1,987,976

In year 2, two Licensed Therapists, five care coordinators and one PA Specialist would be hired; followed in year 3 by adding another two Licensed Therapists, five care coordinators and one PA specialist, bringing the annual totals for these positions and the overall budget expense to the following:

Year 2 (additional staff and associated fringe only):

Title	Quantity	Salary	Total
Licensed Therapist	2	$56,305	$112,610
Care Coordinator	5	$45,853	$229,265
PA Specialist	1	$33,698	$33,698
		Subtotal	$375,573
		Fringe @ 30%/salary	$112,672
		Total additional funding	$488,245
		Cumulative total:	2,101,596

Year 3: (additional staff and associated fringe only):

Title	Quantity	Salary	Total
Licensed Therapist	2	$56,305	$112,610
Care Coordinator	5	$45,853	$229,265
PA Specialist	1	$33,698	$33,698
		Subtotal	$375,573
		Fringe @ 30%/salary	$112,672
		Total additional funding	$488,245
		Cumulative total:	$2,964,466

Year 4: (additional staff and associated fringe only):

Title	Quantity	Salary	Total
Licensed Therapist	3	$56,305	$168,915
Care Coordinator	5	$45,853	$229,265
PA Specialist	1	$33,698	$33,698
		Subtotal	$431,878
		Fringe @ 30%/salary	$129,563
		Total additional funding	$561,441
		Cumulative total:	$3,525,907

Year 5: (additional staff and associated fringe only):

Title	Quantity	Salary	Total
Licensed Therapist	3	$56,305	$168,915
Care Coordinator	5	$45,853	$229,265
PA Specialist	1	$33,698	$33,698
		Subtotal	$431,878
		Fringe @ 30%/salary	$129,563
		Total additional funding	$561,441
		Cumulative total	$4,087,348

E. Recovery Community Center Objectives, Personnel and Budget

Palm Beach County currently has two RCCs operating in Delray Beach and West Palm Beach. As stated above, RCCs are intended to be recovery hubs facilitating "one-stop shopping" in the accrual of recovery capital and provide strong, recovery-specific, social support.

RCCs have been found to be of particular help to those more vulnerable individuals beginning recovery from substance use disorder who have few resources and low recovery capital. As such, it is the aim of CSD to establish a countywide network of RCCs and proposes to establish three additional (RCC) as well as allied recovery community organizations (RCO); and, to provide recovery peer support and other recovery capital services.

Objectives

The RCO/RCCs shall:

- Provide peer-to-peer recovery support services to promote sustained recovery and prevent recurrence of substance use disorder in a supportive substance-free environment but shall not provide any services that require a facility license. Substance-free environment shall be defined as one in which all RCO/RCC staff, volunteers and program participants agree to keep the Center free from substances at all times. Substances are defined to include alcohol, as well as illicit and illegal drugs and related paraphernalia.

- RCO/RCC's shall create a Recovery Center Board comprised, in majority part, of representatives from the local recovery community who shall also acknowledge and agree that the services and activities are member-inspired and premised on peer support. RCO/RCC services shall comport with SAMHSA's Recovery Oriented System of Care Principles; as well as Encompassing the Core Values of Keeping Recovery First; Participatory Process; Authenticity of Peers Helping Peers; Leadership Development; and Cultural Diversity and Inclusion and shall aim to:

    - Strengthen the linkage between treatment and recovery;
    - Increase support for sustained recovery within the community;
    - Support individuals in their recovery and provide them with a sense of hope;
    - Help prevent recurrence of substance use;
    - Provide recovery resources;
    - Provide a trauma informed community where individuals can achieve a full and satisfying life free of trauma and its consequences;
    - Improve life skills;
    - Provide a center for community-based leadership to grow and

develop; and,

- Lead to improved outcomes such as:
  - Improved recovery capital measurements;
  - Engagement and treatment;
  - Increased employment;
  - Increased enrollment education/vocational training;
  - Increased social connectedness; and
  - Reduced involvement in the criminal justice system.

Additionally, all services and activities shall be led and driven by the recovery community via the RCOs (i.e. individuals who have experienced addiction and recovery, either directly or indirectly as a family member or friend) and a Board comprised, in majority part, of representatives from the local recovery community as described above, which shall be created and responsive to community needs. RCC's shall allow individuals access to training, social, educational and recreational opportunities as well as information about substance use disorder treatment, recovery support services, and information about other community resources.

RCC programming may include, but not be limited to: services focused on wellness, nutrition and illness management, self-care, smoking cessation, stress management, financial management, literacy education, job and parenting skills, social events and recreational activities. Housing assistance such as finding sober living homes, apartments and roommates may also be provided as well as telephone support.

Furthermore, peer support services shall be provided by appropriately trained, certified and supervised individuals skilled in the constructs of recovery, peer support interventions and recovery capital. Peer support services shall be measured and monitored by use of Recovery Capital Index (RCI) and certified by The Council on Accreditation of Peer Recovery Support Services (CAPRSS).

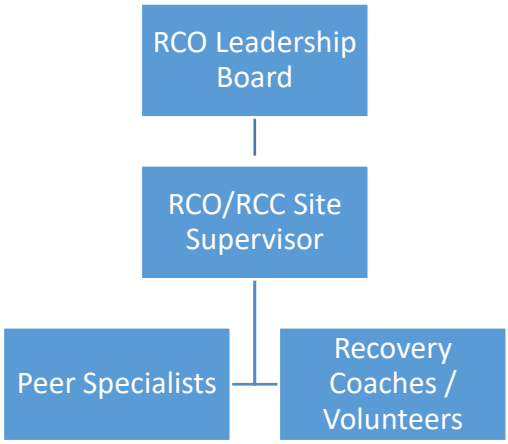
In addition, lastly, no individual shall be denied full access to, participation in and enjoyment of RCCs or RCOs services or activities, available or offered to others, due to the use of legitimately prescribed medications.

Personnel

Basic assumptions for personnel to staff the RCCs and RCO include having a talent pool with direct or indirect lived experience. Additionally, obtaining community and client input in terms of services and supports on community- specific levels that are made available through the RCCs/RCO is a critical component that will increase effectiveness and utilization. A recent research study shows how effective RCCs are for building social capital, engaging individuals throughout their recovery journey and provides a non-judgmental safe haven and most

critically, a sense of community (social capital).[7] Moreover, it is anticipated that connections and relationships will be built by the RCCs/RCOs with their local Addiction Stabilization Unit (ASU) so that peer outreach can begin as early as possible.

An RCO/RCC Site Supervisor will have administrative responsibility for the RCO/RCC. The person must possess a Bachelor's Degree in Social Work, Sociology, or a related field. It is preferred that the Supervisor be an individual with lived experience.



The Supervisor will also be responsible for the supervision of a team of peer specialists, recovery coaches and volunteers. They will have to demonstrate evidence of working with substance use disorder populations, knowledge in formal/informal community systems and resources as well as have supervisory experience. (See PBCHR Job Description #3010, PG 34 – Human Services Operations Supervisor)

Peer Specialists will be responsible for providing peer support services. They will also be responsible for linking individuals to appropriate care and resources in the community

Peer Specialists will have to demonstrate evidence of working with substance use populations. They must be a person with lived experience and possess a high school diploma or an equivalent recognized certification. Additionally, they must possess Florida Certified Recovery Support Specialist or obtain National Certified Peer Specialist certification. (See PBCHR Job Description #03250, PG 15 – Peer Specialist)

[7] Kelly, J. F., Stout, R. L., Jason, L. A., Fallah-Sohy, N., Hoffman, L. A., & Hoeppner, B. B. (2020). One-stop shopping for recovery: An investigation of participant characteristics and benefits derived From U.S. recovery community centers. Alcoholism: Clinical and Experimental Research, 44(3), 711-721. doi: doi.org/10.1111/acer.14281. (For summary of study, see, Recovery community centers: Is participation in these newer recovery support services associated with better functioning and quality of life? - Recovery Research Institute (recoveryanswers.org).)

Budget

Title	Quantity (Per Site)	Salary	Total (x 3 Sites)
Site Supervisor	1	$59,269	$177,807
Peer Specialists	3	$109,079	$327,237
	Sub-total	$168,348	$505,044
	Fringe (@ 30%/salary)	$50,504	$151,512
	Total Staff	$218,852	$656,556
Other Costs		**Cost**	**Total (x3 sites)**
Rent (Min. 2500 sf x 18 sq. ft.)		$45,000	$135,000
Utilities @ $500 mo.		$6,000	$18,000
Insurance		$4,000	$12,000
Supplies		$1,148	$3,444
	Total Other	$56,148	$168,444
	Total Project	$275,000	$825,000

Project Logic Model

Identified current situation in the community What needs to change?	***Outcome What will change? Who will the change impact?***	***Outcome/Indicator Projected # and % achieving each outcome What will the change look like?***	***Strategies to be implemented Identify the timeframe and scope of activities.***	***Resources List those available to conduct the identified strategies (Include partnerships)***	***Resources List those needed to conduct the identified strategies (Include partnerships)***	***Measurement Tools, processes, etc. How do you know what happened?***
Need/Planning	***Impact***	***Impact***	***Activities/Outputs***	***Inputs***	***Inputs***	***Accountability***
Services need to be coordinated and multiple providers serving the same clients need to communicate with each other with appropriate privacy and confidentiality consents.	Neutral care coordinators will assess clients and work with an approved individualized plan to coordinate services and members of individuals' care team members to implement individualized recovery-centric plans. Neutral care coordinators will consistently use screening tools to assess client needs and facilitate scheduling of evaluations by trained clinicians who will determine the most appropriate level of care, treatment goals, and develop a recovery plan to be implemented and coordinated by the neutral care coordinators. Individuals will be assessed holistically, including determining if clients have access to stable, secure housing; food;	Residents in Palm Beach County seeking treatment for behavioral health, substance use and/or co-occurring disorders will be able to access individualized need-based services and/or treatment (including clinical and non-clinical needs) with the assistance of a care-coordinator who will conduct an immediate needs screening, clinicians who will conduct holistic assessments. Care-coordinators will provide warm hand-offs to individually identified needed levels of care and help with navigation across systems beyond treatment and through recovery. PBC Residents in need of treatment, supports and services for behavioral health, substance use and/or co-occurring disorders will be able to access individually identified services that are based on person-centered informed choice recovery plans.	A neutral care coordination entity will be created which will serve as a single point of entry and also as authorizer and payer of certain care. Neutral care-coordinating entity will be created with sufficient personnel who will be responsible for initial screening, clinical assessments and case management. Train and employ a sufficient number of credentialed/ certified neutral care coordinators to work with clients with substance use and/or co-occurring substance use and mental health disorders. Develop a policy for neutral care coordination. Develop a policy for credentialing neutral care coordinators that involves required training and obtaining a certificate or credential.	Executed MOUs/MOAs demonstrating agreements to share information and data regarding shared clients, as well as agreements to collaborate on client care, development of individualized service plans as needed, and coordinate care and transitions across providers of services. SEFBHN, Managing Entity, Healthcare District, Non-profits involved in providing care and services, including, housing, mental health counseling, and other social service providing entities	TBD	Call center will track the number of calls and referrals, and where referrals are made. Client satisfaction surveys will be completed within 45 days of ending services for referred individuals. Care Coordinators will conduct outreach to clients monthly to facilitate engagement and keep documentation of client contacts in electronic record through CSD identified data system.

	water; employment and/or education/training that leads to self-sufficiency; and physical and mental well-being. LOCUS and/or ASAM criteria will be used to assess appropriate levels of care in the least restrictive appropriate setting, followed by as expeditious as possible referral or placement.		Develop or adopt an existing training for neutral care coordination that will ensure essential skills are taught and which will lead to a certificate or credential when completed.			

Identified current situation in the community What needs to change?	***Outcome What will change? Who will the change impact?***	***Outcome/Indicator Projected # and % achieving each outcome What will the change look like?***	***Strategies to be implemented Identify the timeframe and scope of activities.***	***Resources List those available to conduct the identified strategies (Include partnerships)***	***List those needed to conduct the identified strategies (Include partnerships)***	***Measurement Tools, processes, etc. How do you know what happened?***
Need/Planning	***Impact***	***Impact***	***Activities/Outputs***	***Inputs***	***Inputs***	***Accountability***
Various systems (providers, organizations serving individuals with substance use disorders, mental health disorders and co-occurring disorders) are operating in silos ("acting solely within their own spheres of influence") and not sharing critical client information with appropriate consents as needed, which leads to a smaller number of appropriate and individualized referrals. Impact is also on clients who are forced to navigate across systems on their own, which creates a barrier to obtaining treatment/services (i.e. an excuse not to get treatment and/or services).	Care coordination will facilitate communication across providers which will make it easier for clients to obtain appropriate levels of care for treatment and support through recovery.	Number of clients seeking treatment and recovery supports will increase by implementing care coordination.	Contractually mandate collaboration and coordination across entities serving individuals with substance use disorders and/or co-occurring mental health and substance use disorders. Develop communication protocols and Memoranda of Understanding (MOU) or Memoranda of Agreement (MOA) across provider and funding entities that will facilitate information sharing that allows for seamless transition of clients from one service or provider to another, based on individualized treatment and recovery plans, with appropriate warm hand-offs.	Neutral Care Coordination entity Increase usage of ASU through educating Emergency Department (ED) doctors & hospital staff (PB Med Society); SF Healthcare Finance Council	TBD	Number of ED and hospital staff reached through medical detailing each quarter. Number of clients that are referred to NCCE per quarter. Cost per client and per referral or linkage to service

Appendix C

Recovery Management and Recovery-oriented Systems of Care: Scientific Rationale and Promising Practices Summary of Findings

Recovery Management and Recovery-oriented Systems of care:
Scientific Rationale and Promising Practices
Chapter Fifteen
A Closing Reflection: Recovery, Science, and Systems Transformation

Summary of findings

Scientific research findings reviewed in this monograph support calls for a transformation in the structure and service processes in the United States from a model of acute intervention to a broader model of sustained recovery management. More specifically, the findings call for:

- Strengthening the infrastructure of addiction treatment to ensure sustained continuity of support and accountability to the individuals, families, and communities served by addiction treatment institutions;
- more proactive systems of identifying, engaging, and ensuring service access for individuals and families at the earliest possible stage of AOD-related problem development;
- individual, family, and community needs-assessment protocols that are comprehensive, strengths-based, and ongoing;
- the utilization of multidisciplinary and multi-agency service models for supporting long-term recovery for those individuals, families, and neighborhoods experiencing severe, complex, and enduring AOD problems;
- the reconstruction of the service relationship from an expert model to a partnership model involving a long-term recovery support alliance;
- expanding the service menu, with an emphasis on evidence-based and recovery-linked service practices;
- ensuring each client and family an adequate dose and duration of pre-treatment, in-treatment, and post-treatment clinical and recovery support services;
- exerting a greater influence on the post-treatment recovery environment by shortening the physical and cultural distance between the treatment institution and the natural environments of those served, and by intervening directly to increase family and community recovery capital;
- assertive linkage of clients and families to recovery mutual aid groups and other indigenous recovery support institutions;
- models of post-treatment monitoring (recovery check-ups for up to five years following discharge from primary treatment), ongoing stage-appropriate recovery education, sustained recovery coaching, and, when needed, early re-intervention; and
- the systematic and system-wide collection and reporting of long-term post-treatment recovery outcomes for all individuals and families admitted to addiction treatment.

White, M. (2008). Recovery management and recovery-oriented systems of care: scientific rationale and promising practices, pp. 131-132.

Appendix D

The Opioid Epidemic: How Wellbeing Can Help Bend the Curve; important warning signs for individuals who are at the highest risk of overdose

The Opioid Epidemic: How Wellbeing Can Help Bend the Curve

Individual aspects of wellbeing are also critically important to understanding what increases or decreases drug overdose rates in states. The following are the most important warning signs for individuals who are at the highest risk:

Career Wellbeing:

- Does not have a leader in their life who creates enthusiasm about the future
- Does not like what they do every day
- Does not routinely learn or do interesting things

Social Wellbeing:

- Does not have someone in their life who encourages good health
- Does not receive positive energy from friends and family

Financial Wellbeing:

- Is not satisfied with standard of living compared with the people around them

Physical Wellbeing (Physical Health/Pain):
Currently has or is being treated for asthma

- Currently has or is being treated for high cholesterol
- Disagrees that physical health is "near perfect"
- Has significant daily physical pain
- Has ever had a heart attack

Physical Wellbeing (Physical Energy/Activity):

- Healthcare provider has limited their exercise
- Has not felt active and productive in prior seven days
- Poor health has prevented normal activity two or more days in the past month

Physical Wellbeing (Mental Health):

- Does not feel good about physical appearance
- Has been clinically diagnosed with or is being treated for depression

Community Wellbeing:

- Is not proud of the community where they live

Witters, D., June 20, 2023. *The Opioid Epidemic: How Wellbeing Can Help Bend the Curve*, GALLUP, https://news.gallup.com/poll/507368/opioid-epidemic-wellbeing-help-bend-curve.aspx.

Appendix E

Palm Beach County City/County, Regional/Abatement funds Settlement Agreement funding projections.

City/County Funding Projections

City/County Fund Total Adjusted*	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Distributors	$ 7,325,179.15	$ 6,304,622.95	$ 8,513,747.86	$ 8,513,747.86	$ 8,513,747.86	$ 10,957,977.13	$ 12,893,184.96	$ 12,893,184.96	$ 12,893,184.96	$ 10,833,241.18
Janssen	$ 7,634,552.64	$ 4,961,182.23	$ 7,934,591.73	$ 8,858,798.32	$ 1,094,895.78	$ 1,656,698.63	$ 1,656,698.63	$ 2,117,462.37	$ 2,117,462.37	$ 2,117,462.37
Teva	$ 4,840,662.48	$ 3,180,209.33	$ 523,484.33	$ 523,484.33	$ 523,484.33	$ 855,574.95	$ 855,574.95	$ 855,574.95	$ 855,574.95	$ 855,574.95
CVS	$ 336,666.67	$ 2,811,666.67	$ 2,811,666.67	$ 2,811,666.67	$ 2,811,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67
Allergan	$ 718,636.36	$ 1,404,886.35	$ 1,404,886.35	$ 1,404,886.35	$ 1,404,886.35	$ 1,633,636.35	$ 1,633,636.35	$ 1,633,636.35	$ 1,633,636.35	$ 1,633,636.35
Walgreens	$ 486,666.67	$ 3,974,166.67	$ 3,974,166.67	$ 3,974,166.67	$ 3,974,166.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67
Walmart		$ 25,341,503.38								

Select your subdivision from drop list below.
If accessing via DropBox, use the"open in" at the top and select Excel, otherwise use the "download" option at the top. Open the file and select "Enable Editing".

**Subdivision	Percentage	Distributed December 2022	Distribute 2023	Distribute 2024	Distribute 2025	Distribute 2026	Distribute 2027	Distribute 2028	Distribute 2029	Distribute 2030	Distribute 2031
Palm Beach County	5.866649283905280%	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Distributors		$ 429,742.57	$ 369,870.12	$ 499,471.73	$ 499,471.73	$ 499,471.73	$ 642,866.09	$ 756,397.94	$ 756,397.94	$ 756,397.94	$ 635,548.27
Janssen		$ 447,892.43	$ 291,055.16	$ 465,494.67	$ 519,714.63	$ 64,233.70	$ 97,192.70	$ 97,192.70	$ 124,224.09	$ 124,224.09	$ 124,224.09
Teva		$ 283,984.69	$ 186,571.73	$ 30,710.99	$ 30,710.99	$ 30,710.99	$ 50,193.58	$ 50,193.58	$ 50,193.58	$ 50,193.58	$ 50,193.58
CVS		$ 19,751.05	$ 164,950.62	$ 164,950.62	$ 164,950.62	$ 164,950.62	$ 213,350.48	$ 213,350.48	$ 213,350.48	$ 213,350.48	$ 213,350.48
Allergan		$ 42,159.87	$ 82,419.76	$ 82,419.76	$ 82,419.76	$ 82,419.76	$ 95,839.72	$ 95,839.72	$ 95,839.72	$ 95,839.72	$ 95,839.72
Walgreens		$ 28,551.03	$ 233,150.42	$ 233,150.42	$ 233,150.42	$ 233,150.42	$ 301,350.22	$ 301,350.22	$ 301,350.22	$ 301,350.22	$ 301,350.22
Walmart		$ -	$ 1,486,697.13	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Yearly Distribution		$ 1,252,081.64	$ 2,814,714.93	$ 1,476,198.18	$ 1,530,418.14	$ 1,074,937.21	$ 1,400,792.78	$ 1,514,324.64	$ 1,541,356.03	$ 1,541,356.03	$ 1,420,506.35

***Amounts listed are projections until funding is received**

****Amounts listed include funds allocated from other subdivisions**

Year 11	Year 12	Year 13	Year 14	Year 15	Year 16	Year 17	Year 18
$ 10,833,241.18	$ 10,833,241.18	$ 10,833,241.18	$ 10,833,241.18	$ 10,833,241.18	$ 10,833,241.18	$ 10,833,241.18	
$ 855,574.95	$ 855,574.95	$ 2,626,725.00	$ 2,626,725.00	$ 2,626,725.00			
$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67	$ 3,636,666.67
$ 1,633,636.35							
$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67	$ 5,136,666.67

Distribute 2032	Distribute 2033	Distribute 2034	Distribute 2035	Distribute 2036	Distribute 2037	Distribute 2038	Distribute 2039	
Year 11	Year 12	Year 13	Year 14	Year 15	Year 16	Year 17	Year 18	
$ 635,548.27	$ 635,548.27	$ 635,548.27	$ 635,548.27	$ 635,548.27	$ 635,548.27	$ 635,548.27	$ -	
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
$ 50,193.58	$ 50,193.58	$ 154,100.74	$ 154,100.74	$ 154,100.74	$ -	$ -	$ -	
$ 213,350.48	$ 213,350.48	$ 213,350.48	$ 213,350.48	$ 213,350.48	$ 213,350.48	$ 213,350.48	$ 213,350.48	
$ 95,839.72	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
$ 301,350.22	$ 301,350.22	$ 301,350.22	$ 301,350.22	$ 301,350.22	$ 301,350.22	$ 301,350.22	$ 301,350.22	
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
$ 1,296,282.26	$ 1,200,442.55	$ 1,304,349.71	$ 1,304,349.71	$ 1,304,349.71	$ 1,150,248.96	$ 1,150,248.96	$ 514,700.70	$ 24,791,658.48

Regional/Abatement Funding Projections

Regional/Abatement Fund Total Adjusted *	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Distributors	$ 35,888,672.84	$ 25,642,141.47	$ 31,533,141.23	$ 31,533,141.23	$ 31,533,141.23	$ 29,281,272.34	$ 30,134,098.23	$ 30,134,098.23	$ 30,134,098.23	$ 24,603,346.68
Janssen	$ 24,164,159.36	$ 14,461,285.45	$ 21,914,631.93	$ 24,231,309.77	$ 4,769,794.08	$ 4,207,991.23	$ 3,679,492.32	$ 4,690,100.81	$ 4,990,745.56	$ 4,555,526.50
Teva	$ 15,182,370.73	$ 9,758,223.82	$ 2,673,623.82	$ 2,673,623.82	$ 2,673,623.82	$ 2,341,533.20	$ 2,046,341.55	$ 2,046,341.55	$ 2,046,341.55	$ 1,987,303.22
CVS	$ 6,457,777.78	$ 10,582,777.78	$ 10,582,777.78	$ 10,582,777.78	$ 10,582,777.78	$ 9,757,777.78	$ 8,535,555.56	$ 8,535,555.56	$ 8,535,555.56	$ 8,291,111.11
Allergan	$ 3,501,363.61	$ 4,645,113.60	$ 4,645,113.60	$ 4,645,113.60	$ 4,645,113.60	$ 4,416,363.60	$ 3,861,818.15	$ 3,861,818.15	$ 3,861,818.15	$ 3,750,909.06
Walgreens	$ 9,107,777.78	$ 14,920,277.78	$ 14,920,277.78	$ 14,920,277.78	$ 14,920,277.78	$ 13,757,777.78	$ 12,035,555.56	$ 12,035,555.56	$ 12,035,555.56	$ 11,691,111.11
Walmart	$ 75,154,824.84									

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Subdivision	Percentage	Distributed April 2023**	Distribute 2023	Distribute 2024	Distribute 2025	Distribute 2026	Distribute 2027	Distribute 2028	Distribute 2029	Distribute 2030	Distribute 2031
Palm Beach County	8.601594372052590%	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Distributors		$ 3,086,998.06	$ 2,205,633.00	$ 2,712,352.90	$ 2,712,352.90	$ 2,712,352.90	$ 2,518,656.27	$ 2,592,012.90	$ 2,592,012.90	$ 2,592,012.90	$ 2,116,280.08
Janssen		$ 2,078,502.97	$ 1,243,901.12	$ 1,885,007.75	$ 2,084,278.98	$ 410,278.34	$ 361,954.34	$ 316,495.00	$ 403,423.45	$ 429,283.69	$ 391,847.91
Teva		$ 1,305,925.95	$ 839,362.83	$ 229,974.28	$ 229,974.28	$ 229,974.28	$ 201,409.19	$ 176,018.00	$ 176,018.00	$ 176,018.00	$ 170,939.76
CVS		$ 555,471.85	$ 910,287.62	$ 910,287.62	$ 910,287.62	$ 910,287.62	$ 839,324.46	$ 734,193.87	$ 734,193.87	$ 734,193.87	$ 713,167.75
Allergan		$ 301,173.10	$ 399,553.83	$ 399,553.83	$ 399,553.83	$ 399,553.83	$ 379,877.68	$ 332,177.93	$ 332,177.93	$ 332,177.93	$ 322,637.98
Walgreens		$ 783,414.10	$ 1,283,381.77	$ 1,283,381.77	$ 1,283,381.77	$ 1,283,381.77	$ 1,183,388.24	$ 1,035,249.67	$ 1,035,249.67	$ 1,035,249.67	$ 1,005,621.96
Walmart		$ 6,464,513.18		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Yearly Distribution		$ 14,575,999.21	$ 6,882,120.16	$ 7,420,558.15	$ 7,619,829.38	$ 5,945,828.74	$ 5,484,610.18	$ 5,186,147.37	$ 5,273,075.81	$ 5,298,936.05	$ 4,720,495.44

*Amounts listed are projections until funding is received

Year 11	Year 12	Year 13	Year 14	Year 15	Year 16	Year 17	Year 18
$ 24,603,346.68	$ 24,603,346.68	$ 23,879,130.60	$ 23,879,130.60	$ 23,879,130.60	$ 21,706,482.36	$ 21,706,482.36	
$ 1,987,303.22	$ 1,987,303.22	$ 5,824,795.00	$ 5,824,795.00	$ 5,824,795.00			
$ 8,291,111.11	$ 8,291,111.11	$ 8,046,666.67	$ 8,046,666.67	$ 8,046,666.67	$ 7,313,333.33	$ 7,313,333.33	$ 7,313,333.33
$ 3,750,909.06							
$ 11,691,111.11	$ 11,691,111.11	$ 11,346,666.67	$ 11,346,666.67	$ 11,346,666.67	$ 10,313,333.33	$ 10,313,333.33	$ 10,313,333.33

Distribute 2032	Distribute 2033	Distribute 2034	Distribute 2035	Distribute 2036	Distribute 2037	Distribute 2038	Distribute 2039	
Year 11	**Year 12**	**Year 13**	**Year 14**	**Year 15**	**Year 16**	**Year 17**	**Year 18**	
$ 2,116,280.08	$ 2,116,280.08	$ 2,053,985.95	$ 2,053,985.95	$ 2,053,985.95	$ 1,867,103.57	$ 1,867,103.57	$ -	
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
$ 170,939.76	$ 170,939.76	$ 501,025.24	$ 501,025.24	$ 501,025.24	$ -	$ -	$ -	
$ 713,167.75	$ 713,167.75	$ 692,141.63	$ 692,141.63	$ 692,141.63	$ 629,063.27	$ 629,063.27	$ 629,063.27	
$ 322,637.98	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
$ 1,005,621.96	$ 1,005,621.96	$ 975,994.24	$ 975,994.24	$ 975,994.24	$ 887,111.10	$ 887,111.10	$ 887,111.10	
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
$ 4,328,647.53	$ 4,006,009.55	$ 4,223,147.06	$ 4,223,147.06	$ 4,223,147.06	$ 3,383,277.93	$ 3,383,277.93	$ 1,516,174.37	$ 97,694,428.99

Appendix F

Settlement Agreement Core Strategies and Allowable Uses

Schedule A

Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("**Core Strategies**")[, such that a minimum of __% of the [aggregate] state-level abatement distributions shall be spent on [one or more of] them annually].[1]

A. Naloxone or other FDA-approved drug to reverse opioid overdoses

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. Medication-Assisted Treatment ("MAT") Distribution and other opioid-related treatment

1. Increase distribution of MAT to non-Medicaid eligible or uninsured individuals;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

4. Treatment and Recovery Support Services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication with other support services.

C. Pregnant & Postpartum Women

1. Expand Screening, Brief Intervention, and Referral to Treatment ("SBIRT") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("OUD") and other Substance Use Disorder ("SUD")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

3. Provide comprehensive wrap-around services to individuals with Opioid Use Disorder (OUD) including housing, transportation, job placement/training, and childcare.

D. Expanding Treatment for Neonatal Abstinence Syndrome

1. Expand comprehensive evidence-based and recovery support for NAS babies;

2. Expand services for better continuum of care with infant-need dyad; and

3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

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[1] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the Term Sheet.

E. Expansion of Warm Hand-off Programs and Recovery Services

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;

2. Expand warm hand-off services to transition to recovery services;

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions. ;

4. Provide comprehensive wrap-around services to individuals in recovery including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. Treatment for Incarcerated Population

1. Provide evidence-based treatment and recovery support including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and

2. Increase funding for jails to provide treatment to inmates with OUD.

G. Prevention Programs

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools.;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. Expanding Syringe Service Programs

1. Provide comprehensive syringe services programs with more wrap-around services including linkage to OUD treatment, access to sterile syringes, and linkage to care and treatment of infectious diseases.

I. Evidence-based data collection and research analyzing the effectiveness of the abatement strategies within the State.

Schedule B

Approved Uses

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:[2]

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (MAT) approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Treatment of trauma for individuals with OUD (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

8. Training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD or mental health conditions, including but not limited to training,

[2] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the Term Sheet.

scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. [Intentionally Blank – to be cleaned up later for numbering]

13. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

14. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.

15. Development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in treatment for or recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved medication with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have – or at risk of developing – OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically-appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL-JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

    a. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);

    b. Active outreach strategies such as the Drug Abuse Response Team (DART) model;

    c. “Naloxone Plus” strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    d. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model;

    e. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

f. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions (CTI), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome (NAS), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.

6. Child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Enhanced family supports and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including but not limited to parent skills training.

10. Support for Children's Services – Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Fund medical provider education and outreach regarding best prescribing practices for opioids consistent with Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:

    a. Increase the number of prescribers using PDMPs;

    b. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

c. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increase electronic prescribing to prevent diversion or forgery.

8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Fund media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Fund community anti-drug coalitions that engage in drug prevention efforts.

6. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

7. Engage non-profits and faith-based communities as systems to support prevention.

8. Fund evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create of support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address

mental health needs in young people that (when not properly addressed) increase the risk of opioid or other drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, individuals at high risk of overdose, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities provide free naloxone to anyone in the community

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Provide training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Support screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in sections C, D, and H relating to first responders, support the following:

1. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitation, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local, or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services; to support training and technical assistance; or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to share reports, recommendations, or plans to spend opioid settlement funds; to show how opioid settlement funds have been spent; to report program or strategy outcomes; or to track, share, or visualize key opioid-related or health-related indicators and supports as identified through collaborative statewide, regional, local, or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection, and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g. Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

Appendix G

Language Dictionary

Language Dictionary: A Key to Common Terms and Their Definitions

The Language Dictionary is the beginning of an iterative process that will help shift language to being person-first, minimize and eventually eliminate stigma and serve as a resource for common terminology.

Addiction Stabilization Unit (ASU) – An addiction stabilization unit (or, addiction stabilization facility (ASF")) is a facility, such as the one located at JFK Hospital, where individuals who have been brought into the emergency department (ED) can be brought for observation following an overdose and where they can be assessed for further treatment, such as in-patient hospitalization, psychiatric evaluation that may lead to a voluntary or involuntary (Baker Act) psychiatric hospitalization, referral or placement in an in-patient detoxification program or referral for outpatient treatment.

Assessment – "An ongoing process used to determine the medical, psychological, and social needs of individuals with substance-related conditions and problems. It can take the form of biological assays (e.g., blood or urine samples), as well as clinical diagnostic interviewing and the completion of self-report measures to determine the presence of a substance use disorder or other psychiatric condition, and other symptoms and challenges with the ultimate goal of developing a fully informed and helpful treatment and recovery plan."[1]

Behavioral Health is "an umbrella term that refers to your overall wellbeing and how it is impacted by your behaviors"[2] While behavioral health and mental health tend to overlap, and many organizations substitute one term for the other, distinct differences do exist between the two. The U.S. Department of Health and Human Services defines mental health as a person's psychological, emotional, and social wellbeing. And while some mental health issues may be impacted by behavior, many mental health disorders have neurological or biological causes, meaning that simply changing a person's behavior may not cure them of that illness.[3]

Some examples of mental health disorders include:[4]

- Bipolar disorder.
- Schizophrenia.
- Depression.

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[1] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[2] https://www.projectknow.com/drug-addiction/behavioral-health/ (Extracted 12/22/2020).

[3] Grant, J.E., Potenza, M.N., Weinstein, A. & Gorelick, D.A. (2010). Introduction to Behavioral Addictions. *American Journal of Drug and Alcohol Abuse. 36(5), 233–241.* U.S. Department of Health and Human Services. (n.d.). *What Is Mental Health?* Bienvenu, O.J., Davydow, D.S. & Kendler, K.S. (2011). Psychiatric 'diseases' versus behavioral disorders and degree of genetic influence. *Psychological Medicine, 41(1), 33–40.*

[4] U.S. Department of Health and Human Services. (n.d.). *What Is Mental Health?* Bienvenu, O.J., Davydow, D.S. & Kendler, K.S. (2011). Psychiatric 'diseases' versus behavioral disorders and degree of genetic influence. *Psychological Medicine, 41(1), 33–40.*

- Generalized anxiety.
- Social anxiety.
- Attention-deficit/hyperactivity disorder (ADHD).

Examples of behavioral health disorders include:[5]

- Substance abuse disorders.
- Eating disorders.
- Behavioral addictions.

Care Coordination "involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient."[6]

Coaching is a way of interacting that builds confidence and competence in the person being coached. It is a style of communication that allows for empowerment and self-realization.

Cognitive Behavioral Therapy (CBT) "is a **psycho-social intervention that aims to improve mental health.** CBT focuses on challenging and changing unhelpful cognitive distortions (e.g. thoughts, beliefs, and attitudes) and behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems."[7] It is also defined as: "A prevalent type of talk therapy (psychotherapy) that involves working with a professional to increase awareness of inaccurate or negative thinking and behavior and to learn to implement new coping strategies."[8]

Co-occurring Disorders means having both a mental health and substance use disorder or, phrased differently, the "occurrence of two disorders or illnesses in the same person, also referred to as co-occurring conditions or sometimes dual diagnosis." [9]

Community-based Treatment and Services are those services and supports that occur in the person's community.

Damp Housing: Housing where tenants do not need to be "clean" when entering the program but are expected to be actively working on recovery from substance use problems.[10]

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[5] Id.

[6] https://www.ahrq.gov/ncepcr/care/coordination.html. (Extracted 12/22/2020).

[7] en.m.wikipedia.org/wiki/Cognitive_behavioral_therapy (Extracted 12/22/2020).

[8] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[9] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[10] https://www.heretohelp.bc.ca/visions/housing-and-homelessness-vol4/housing-glossary (Extracted 12/30/2020).

Deep End Treatment is residential, in-patient long term care.

Detoxification or detox "is the medical process focused on treating the physical effects of withdrawal from substance use and comfortably achieving metabolic stabilization; a prelude to longer-term treatment and recovery."[11]

Employment is an indicator for recovery wellness and research shows that it can be part time, full time or volunteer as long as it is fulfilling for the person engaged in the work activities.

Evidence-based Practices refers to "patient care informed through the integration of clinical expertise and best available clinical evidence from systematic research."[12]

Harm reduction "is a set of policies and practices intended to reduce the negative effects of drug and alcohol use. Harm reduction programs exist for several types of drugs, including opioids, alcohol, stimulants, Ecstasy, and marijuana. They range from needle exchange sites to managed alcohol programs to drug-testing kits at music festivals."[13]

Intensive Out-Patient Treatment is "time limited, intensive, non-residential clinical treatment that often involves participation in several hours of clinical services several days per week. It is a step below partial hospitalization in intensity."[14]

Intervention is "the act of interfering with the outcome or course especially of a condition or process (as to prevent harm or improve functioning)."[15]

Maintenance means the intentional use of MAT without a taper as a means of resolving a substance use disorder (e.g. methadone at scale for the past 60 years or so in the U.S.).

Mental Health "includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices."[16]

Moderation includes the non-problematic recreational use of drugs and/or alcohol (e.g. over 80% of Americans age 18 or older who have reported trying alcohol at some point in their life but do not meet the criteria for an Alcohol use disorder).

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[11] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[12] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[13] https://americanaddictioncenters.org/harm-reduction# (Extracted 12/29/2020).

[14] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[15] https://www.merriam-webster.com/dictionary/intervention (Extracted 12/23/2020).

[16] https://www.mentalhealth.gov/basics/what-is-mental-health (Extracted 12/23/2020).

Motivational Interviewing is a "clinical approach that helps people with mental health and substance use disorders and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health by helping them to explore and resolve ambivalence about changes. The approach upholds four principles: expressing empathy and avoiding arguing; developing discrepancy; rolling with resistance; and supporting self-efficacy (client's belief s/he can successfully make a change). This is non-directive approach to counseling that attempts to help patients resolve ambivalence about changing substance use and mobilize motivation and action toward healthier change."[17]

Neutral Care Coordination is services provided by a non-conflicted, neutral body functioning as a single point of entry for referrals to providers. Services include assessment, initial level of care determination, referral, care coordination across a continuum of clinical and non-clinical care, as well as prior authorization and payment of certain care. NCC values individualized care and individual choice in development of care plans. Individualized care plans are the primary drivers of care engagement and are aimed at achieving successful, seamless movement along a continuum of clinical care through non-clinical recovery support and social services to improve long-term recovery outcomes.

Peer Support can be volunteer or paid and "offer[s] valuable guidance and connection to individuals in recovery through the process of sharing their own experiences in recovery from substance use disorder."[18]

Prevention "is the act of stopping something or ensuring something does not happen."[19]

Recovery Capital Index™ (RCI) "is a holistic, person-centered metric that tracks wellness of the whole person."[20]

Recovery Capital encompasses "the resources (social, physical, human and cultural), which are necessary to begin and maintain recovery from substance use disorder."[21]

Recovery means the intentional non-use of mind-altering substances (i.e. drugs and alcohol) as a means of resolving a substance use disorder. It is worth noting that this includes prescribed use of MAT on a taper even if the particular MAT drug involved is abuse-able.

Recovery Community Center (RCC) "A center or hub that organizes recovery networks regionally and nationally to facilitate supportive relationships between individuals in recovery as well as family and friends of people in recovery. Centers may provide advocacy training, peer

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[17] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[18] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[19] https://www.yourdictionary.com/prevention (Extracted 12/23/2020).

[20] WeFaceItTogether.org

[21] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

support organization meetings, social activities, job linkage, and other community based services."[22]

Recovery Community Organization (RCO) "An independent, non-profit organization led and governed by representatives of local communities of individuals in recovery from a substance use disorder."[23]

Recovery-oriented System of Care (ROSC) is "a coordinated network of community based services that involve a strengths-based and personalized approach to recovery and increases in quality of life."[24]

Recovery Homes are "alcohol- and drug-free living facility for individuals recovering from alcohol or other drug use disorders that often serves as an interim living environment between detoxification experiences or residential treatment and mainstream society. Also known as Sober Houses, Sober Living Houses (SLHs), Sober Living Homes, or Sober Living Environments." [25]

Social Capital "is the effective functioning of social groups through interpersonal relationships, a shared sense of identity, a shared understanding, shared norms, shared values, trust, cooperation, and reciprocity. Social capital is a measure of the value of resources, both tangible (e.g., public spaces, private property) and intangible (e.g., actors, human capital, people), and the impact that these relationships have on the resources involved in each relationship, and on larger groups. It is generally seen as a form of capital that produces public goods for a common purpose."[26]

Substance Use Disorder is a "clinical term describing a syndrome consisting of a coherent set of signs and symptoms that cause significant distress and or impairment during the same 12-month period."[27]

Supported Employment "is founded on the belief that anyone can work if they are provided the right supports. Individuals who have not traditionally participated in competitive employment based upon their disability are the primary focus of Supported Employment. The expected outcome of Supported Employment is that individuals will maintain the appropriate level of employment (either full/part time) based upon their skills, interest and abilities."[28]

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[22] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[23] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[24] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[25] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[26] https://en.wikipedia.org/wiki/Social_capital (Extracted 12/23/2020).

[27] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[28] https://resourcecenter.org/services/manufacturing-services/employment-services/community-based-employment/supported-employment/ (Extracted 12/23/2020).

Treatment is the "management and care of a patient to combat a disease or disorder. Can take the form of medicines, procedures, or counseling and psychotherapy."[29]

Wet Housing is "housing where tenants are not expected to abstain from using alcohol and other drugs, and where entering a rehabilitation program is not a requirement. Tenants have access to recovery services and get to decide if and when they use these services. Wet housing programs follow a harm reduction philosophy."[30]

Wrap-around Services "is an intensive care coordination and management process focused on building a team comprised of formal (professionals) and informal (natural) supports."[31]

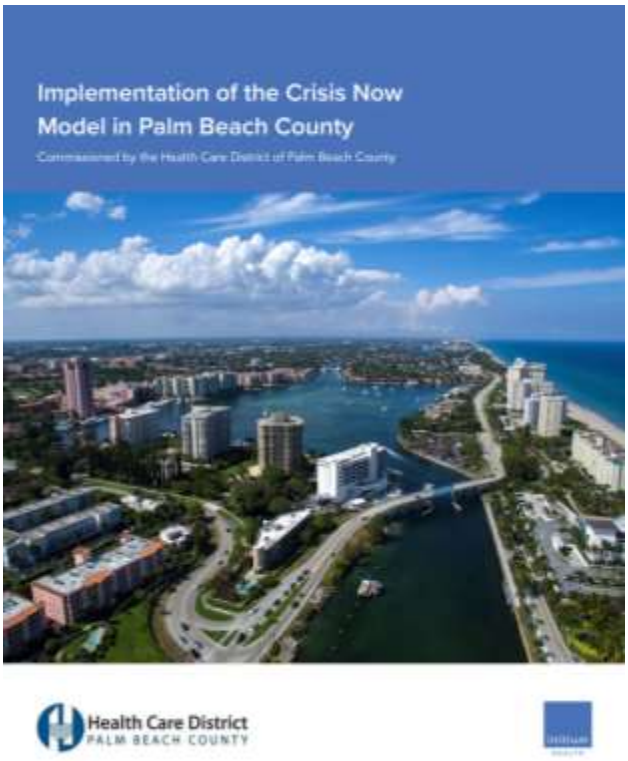
[29] https://www.recoveryanswers.org/addiction-ary/ (Extracted 12/23/2020).

[30] https://www.heretohelp.bc.ca/visions/housing-and-homelessness-vol4/housing-glossary (Extracted 12/30/2020).

[31] http://www.socflorida.com/documents/professionals/Wraparound%20in%20Florida%20White%20Paper.pdf.

Appendix H

Implementation of the Crisis Now Model in Palm Beach County
Commissioned by the Health Care District of Palm Beach County



Accessible at:

http://tiny.cc/HCDPBC_CrisisNow

SCAN ME

Appendix I

Palm Beach County Opioid Epidemic Timeline

PBC Opioid Epidemic Timeline

2017-2021

2017

- 817 Drug related deaths
- Opioid Response Plan

2018

- 498 Drug related deaths
- Office of Behavioral Health and Substance Use Disorder established

2019

- 519 Drug related deaths
- BCC sets Substance Use and Behavioral Health as a strategic priority
- Opioid Response Steering Committee established
- Behavior and Substance Use Disorder Cross Department Team established.
- Deployment of Recovery Capital Index
- Ordinance establishing syringe access program
- Interlocal agreement to establish ASU

2020

- 675 Drug related deaths
- Neutral Care Coordination Pilot
- PBC Comprehensive Opioid, Stimulant and Substance Use Program (COSSUP) established

2021

- 626 Drug Related deaths
- Recovery Community Hub in Delray Beach opened
- CSD contracts wit Financially Assisted Agencies for Mental Health
- Rebel Recovery FLASH program starts
- Working group on neutral care coordination established

PBC Opioid Epidemic Timeline

2022-2024

2022

- 554 drug related deaths
- BHSUD Plan published
- Advisory Committee on Behavioral Health, Substance Use and Co-Occurring Disorders established
- Opioid Settlement
- Contract with FARR to launch Recovery Capital Initiative
- SEFBHN establishes EMBARCC
- PBSO carries naloxone
- Florida establishes CORE network

2023

- 527 drug related deaths
- PBC Resident Survey
- BCC fully funds County-wide Recovery Community Organizations
- Lake Worth Beach Hub opens
- FAU contract for program evaluation and research
- NACo award for COSSUP
- Youth Mental Health Rally
- ~~SEFBHN contracts with~~ NeuroBehavioral Hospitals for inpatient services

2023 (cont.)

- Florida Blue Foundation Sapphire Award
- Health Care District Feasibility Study
- Two COSSUP research peer-reviewed journal articles published

2024

- BHSUD Plan Update
- After Action Review of ASU

Future

- Neutral Care Coordination launched
- Crisis Now implemented
- Wellness and Recovery Housing and Recovery Supports launched