Behavioral Health and Substance Use Disorder Plan 2024

Palm Beach County
Advisory Committee on
Behavioral Health, Substance Use
and Co-Occurring Disorders

It is time we … stopped focusing on brief episodes of biopsychosocial stabilization. It is time for national, state, and local initiatives to create recovery-oriented systems of care that can promote this model of sustained recovery management.

William L. White, MA
Recovery Management and Recovery Oriented Systems of Care: Scientific Rationale and Promising Approaches

ADVANCING A RESILIENCE AND RECOVERY ECOSYSTEM OF CARE

ONE INITIATIVE,
ONE INDICATOR AT A TIME

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I. Executive Summary

Palm Beach County, more specifically Delray Beach, had the reputation of being the Recovery Capitol of the Nation known for its vibrant recovery community and a safe, nurturing environment highly supportive of recovering individuals in the mid-2000's. Yet, at the time, there was also an identifiable underbelly that existed which propelled a proliferation of "pill mills" and opioid prescribing resulting in a rapid rise in opioid overdoses.

By 2017, Palm Beach County had the unfortunate distinction of being the epi-center of overdose deaths in the State of Florida, reaching a peak of 817 drug related deaths of which 626 were opioid deaths. News headlines and coverage also placed the County at the epi-center nationally of fraud and abuse in the treatment and recovery residence sector that preyed on vulnerable individuals in need of substance use disorder care and their families.

Important strides have been made since. Today, the State of Florida and the Nation look to Palm Beach County for its leadership in person-centered, recovery-oriented, and crisis care; leadership which began in 2017 when the Palm Beach County Board of County Commissioners (BCC) approved an Opioid Response Plan (ORP). The BCC also appointed a "Drug Czar", an ORP priority recommendation to lead the response efforts. The State Attorney's Office also aggressively took the fight to the treatment and recovery residence sector to overcome its abuses.

Critical to these efforts was setting a clear system of care path. A path that is more person-centered and recovery-oriented focused on improved long-term recovery outcomes and increased resiliency and rather than solely focused on the historic approach of acute- and crisis-centric care.

The BCC adopted substance use disorder, and behavioral health more broadly, as a strategic priority in 2019 with a major goal to establish a person-center, recovery-oriented system of care which has been renewed annually since. In November 2022, it approved the establishment of the Advisory Committee on Behavioral Health, Substance Use and Co-Occurring Disorders (BHSUCOD) and declared the BCC's expressed approval of a person-centered, recovery-oriented system of care. The BCC also approved the Behavioral Health and Substance Use Disorder Plan 2022 and its recommendations which were informed by community input and developed by a Steering Committee and its sub-committees operationalized in 2019.

The BHSUCOD is charged with enhancing the County's capacity and effectiveness in formulating behavioral health and substance use disorder policies as well as to offer recommendations regarding the County's provision of services to its citizens. It is also responsible for making recommendations on responding to the opioid epidemic, as provided in section 17.42 of the Florida Statutes (2022).

The Behavioral Health and Substance Use Disorder Plan 2024 details the number of initiatives and their outcomes that have been executed to achieve a true person-centered, recovery-oriented

system of care; an ecosystem of resilience and recovery that creates recovery-ready communities. Communities and care that will foster, not only hope, but create ready and easy access to person-centered, recovery-oriented care. It and subsequent Plan Updates are intended to maintain flexibility to address whatever needs that are forthcoming.

The 2024 Plan also details recommendations by the BHSUCOD's pursuant to its responsibilities related to section 17.42 of the Florida Statutes (2022). In doing so, the BHSUCOD remained mindful that the opioid settlement funds resulting from the Settlement Agreement entered into with the State of Florida were realized due to the malfeasance committed by certain entities within the pharmaceutical industry which resulted in untold loss, death and devastation wreaked upon individuals, families and communities.

The BHSUCOD affirms its position that one overdose death is one overdose death too many. It wishes to see continued reductions, which may never arrive at zero, but believe tracking overdose death rates should not be the singular outcome measure of the County's efforts success. Beyond this measure, the Advisory Committee supports the County's ongoing efforts to measure its initiatives through a recovery capital framework and its ability to capture resilience, health, well-being, social determinants of health and risk factors.

It is in this context that the BHSUCOD places the 2024 Plan recommendations' emphasis which are supported by the evidence developed by the County's own research; national research; and the direction set by the federal Domestic Policy Council, Office of National Drug Control Policy and Substance Abuse and Mental Health Services Direction. The Plan also emphasizes the need to focus, not only on individuals in crisis, but the nearly 37,000 total calls placed to 211 of Palm Beach and Treasure Coast for mental health and addiction assistance in calendar years 2022 and 2023 as well as individuals faced with mental illness and substance use disorder that do not require crisis care.

The BHSUCOD believes the Plan 2024 sets a sound course that will build a robust resilience and recovery ecosystem in Palm Beach County. An ecosystem, with its emphasis on social determinants of health, can prevent illness as well as intervene early in its cycle to avoid entrance into crisis care. The BHSUCOD also believes that the Plan 2024's recommendations fully fund the infrastructure and person-centered, recovery-oriented care necessary to create a near one hundred percent opportunity for individual's to successfully address their behavioral health and substance use disorder needs.

II. REVIEWING PROGRESS: ONE INITIATIVE, ONE INDICATOR AT A TIME

Significant strides have been made since the Palm Beach County Board of County Commissioners (BCC) adopted its plan, *Opioid Crisis - Palm Beach County's Response (ORP)*, in 2017 and subsequently identified behavioral health and substance use disorders as a strategic priority in 2019. The ORP pointed to the need to create a coordinated response through the designation of a primary entity responsible for the integration of all efforts relative to the epidemic.

The ORP also pointed to the need for leadership and guidance from an experienced veteran accustomed to working on solving substance use disorders --- in short, appointing a 'Drug Czar' for the County which the BCC accomplished in April 2018. Since, the appointee has led the Office of Behavioral Health and Substance Use Disorders (OBHSUD) established in the Community Services Department.

The OBHSUD supervises the planning, administration, and county contracting of behavioral health and substance use disorder services in Palm Beach County. It develops policies and manages various initiatives, programs, and funding strategies -- serving as liaison to communicate the County's efforts to the public; local, state, county and federal agencies; and the service provider community.

The OBHSUD is also responsible for facilitating the Palm Beach County Advisory Committee on Behavioral Health, Substance Use and Co-Occurring Disorders and its subcommittees as well as for the development of the Annual Plan Update submitted to the BCC. In this capacity, it has adopted a community wide approach which has been taken with many other valued partners and community members.

Traditionally, mental health services were rarely integrated with substance use disorder. According to reports published in the Journal of American Medical Association roughly 50% of individuals with severe mental disorders are affected by a substance use condition. (Robinson, L., 2018) The University of Chicago also found, in a patient-experience survey conducted across behavioral health provider groups and behavioral health consumer organizations, that 87% of patients of all ages who received mental health or substance use care from a provider felt they needed additional help from a substance use or mental health specialist. (Bowman Foundation, 2023).

Considering this context, the BCC expanded its focus to not only address the opioid epidemic but to include both behavioral health and substance use disorder when it identified such as a strategic priority in 2019, and maintained this priority to date. Also, in 2019 a Behavioral and Substance Use Disorder Cross-departmental team (CDT) of multiple department employees was established to address this priority. The team includes representatives from Youth Services, Employee

Assistance Program, Parks and Recreation, Victim Services, Fire Rescue, Medical Examiner's Office, Library, Cooperative Extension, Palm Tran and Community Services.

The CDT fosters leveraging of resources, talent and innovation across all departments. Integration of efforts assures increased access and stewardship of County resources. Chief amongst the BCC's aims is the establishment of a readily accessible, integrated and coordinated person-centered, recovery-oriented system of care (ROSC) for the purpose of improving long-term recovery outcomes and enhancing health and wellness.

The CDT recognizes that addressing behavioral and substance use disorders is a continuum of efforts starting with prevention and early intervention and continuing to treatment and long-term recovery through building of resilience. The CDT last presented to the BCC at a January 30, 2024 Workshop meeting during the County's Office of Management and Budget's (OFMB) budget and strategic planning cross-departmental team presentations. The team highlighted its broad range of services year including Youth Services free evidence-based and trauma-informed mental health services, Fire Rescue's Mobile Integrated Health teams, and, community education and public awareness events across all of the departments.

OFMB also presented the results of the County's 2023 community resident survey. The survey of 7,291 residents found that 52% said the county's response to substance use and behavioral disorders was fair or poor. Another 21% did not know enough to rate this question. Asked to rank County priorities, 62% said mental health, substance use and behavioral health support ranked a 4 or 5 on a scale of 5 in importance. (Palm Beach County, Resident Survey, 2023).

The ORP also pointed to the need to establish a steering committee to guide the County's efforts The CSD operationalized an Opioid Response Steering Committee in 2019. In 2021, the steering committee was officially renamed the ***Behavioral Health, Substance Use and Co-Occurring Disorder Steering Committee (BHSUCOD)*** in order to better align with the BCC's strategic priority. Steering Committee members volunteered endless hours and brought expertise and passion to approve *The Substance and Mental Disorders Plan Update, March 2022* (2022 Plan) at its March 2022 meeting.

Palm Beach County Advisory Committee on Behavioral Health, Substance Use and Co-Occurring Disorders Established

The 2022 Plan recommended the BCC enact an ordinance designating a lead entity granting it leadership, budget, planning and monitoring authority as an overarching high priority. In response, the BCC elected to approve Resolution No. R2022-1340 on November 1, 2022, instead of an ordinance. The Resolution established the Palm Beach County Advisory Committee on Behavioral Health, Substance Use and Co-Occurring Disorders (BHSUCOD) to enhance the County's capacity and effectiveness in formulating comprehensive, integrated, and effective behavioral health, substance use and co-occurring disorders prevention, treatment, support, and recovery policies, as well as to offer recommendations regarding the County's provision of

services to the citizens of Palm Beach County. (Palm Beach County Board of County Commissioners Agenda, November 1, 2022)

The Resolution also declared the BCC's expressed approval of a person-centered, recovery-oriented system of care focused on quality of care and long-term recovery outcome improvements. The BCC approved the 2022 Plan on November 15, 2022. It and this plan, *The Substance and Mental Disorders Plan Update, April 2024* (2024 Plan), developed by the BHSUCOD are intended to serve as a roadmap for Palm Beach County to bring to fruition an integrated and coordinated, person-centered, recovery-oriented system of care for anyone with a substance use, behavioral health and/or co-occurring disorder.

The BHSUCOD is comprised of nine at-large members and nine ex-officio members who are individuals with both lived and learned (professional experience) who represent a diverse cross-section of the community. This includes individuals who are parents who have lost their children to accidental overdose, impacted family members, people in recovery, formerly incarcerated individuals, clergy, peer support specialists, doctors, clinicians, first responders, providers, attorneys, law enforcement personnel as well as elected and government representatives. The Resolution outlined that the inaugural membership was to be comprised of the nine individuals who served as members on the BHSCOD Steering Committee at the time the Resolution was approved by the BCC and the three individuals who served as Ex Officio members of that Steering Committee.

BHSUCOD Membership

Public	Ex Officio (Designee)
Sharon Burns-Carter	Florida Department of Health PBC (Natalie Kenton)
Ariana Ciancio	PBC Fire Rescue (Chief Charles Coyle)
Lissa Franklin	PBC Health Care District (Belma Andric, MD)
William Freeman	PBC League of Cities (Hon. Angela Burns)
John Makris	PBC Sheriff's Office (Sandra Sisson)
Barbara Shafer	Palm Health Foundation (Patrick McNamara)
Brent Schillinger, MD	Southeast Florida Behavioral Health Network (Daniel Oria)
Rae Whitely (V. Ch.)	Southeast Florida Recovery Advocates (Maureen Kielian, Ch.)
Austin Wright	State Attorney's Office (Al Johnson)

The 2022 Plan adopted a Mission, Vision, Values and Beliefs statement to inform the County's work which is again affirmed by the BHSUCOD as follows:

A. **Mission:** To ensure access to individualized person-centered, recovery-oriented care and supports through integrated and coordinated services using a "no-wrong door" approach for all Palm Beach County residents in need.

B. **Vision:** To have a fully integrated and coordinated person-centered, recovery-oriented system of care that employs neutral care coordination and recovery as well as peer supports that focus on:

- Individual needs and assessment of each person holistically.
- Evaluation of personal resiliency and risk factors utilizing recovery capital indexing.
- Strength-based, accessible and available services to any person seeking improved outcomes for mental illness, substance use and/or co-occurring disorders.

C. **Values and Beliefs:** A person-centered, recovery-oriented system of care is non-judgmental, caring, trauma-informed and embraces the understanding that each individual's journey to recovery and wellness is unique. Additionally, a "no wrong-door" approach within a recovery oriented system of care:

- Places high value on collaboration and coordination among governmental and non-governmental organizations to provide appropriate levels of individualized care.
- Utilizes neutral care-coordination to screen and assess individuals and connect them to appropriate levels and types of care, remove barriers and provide follow-up and coordination of services as appropriate.
- Uses validated tools that assess needs, levels of care and recovery wellness.
- Values and respects individuals and meets them where they are, recognizing that substance use disorders and behavioral health disorders are brain-based, frequently intertwined and compromise decision-making abilities.
- Prioritizes individualized care based on need and considers client voice.
- Determines placement, supports and services based on assessments instead of based on a particular program's availability and/or for administrative convenience.
- Presents treatment and service options with appropriate and transparent disclosures related to risks that might be involved with either taking or not taking advantage of any given options, as well as provides information about the risk of not accepting any options for treatment or services.
- Supports and service options are trauma-informed, strength-based, individualized and supportive of long-term recovery.
- Recognizes that successful long-term recovery rests in a person-centric system that is inclusive, equitable, and community-based.
- Utilizes evidence-based practices to the maximum extent possible with a focus on recovery capital, improved recovery outcomes, adverse childhood experiences and trauma informed care.

Network of Recovery Community Centers and Organizations Expanded

In May 2023, the BCC approved a contract in the amount of 1.25 million dollars with the Palm Beach County Behavioral Health Coalition which operates as the fiscal agent for the county-wide Recovery Community Organization (RCO), the Recovery Community Hub of Palm Beach County, to expand the County's network of recovery community centers (RCC) and allied local RCOs. The Recovery Community Hub of Palm Beach County (Hub), Delray Beach opened in May 2021 and the Hub of Lake Worth Beach hosted a ribbon cutting ceremony and began services in September 2023.

The planned expansion includes establishing Hubs in Riviera Beach and Belle Glade with locally run RCO's and centers expected to be fully operational in fall 2024. Additionally, the expansion plans include the establishment of the aforementioned countywide RCO which facilitates the local RCO development process, provide ongoing technical and administrative assistance to the network, and conduct public awareness, training and education activities. To date, the countywide RCO is fully operational, sites have been leased with renovation and local RCO development activities are underway.

The network of RCOs and RCCs is a critical underpinning to achieving the BCC's goal of establishing a readily accessible, integrated and coordinated person-centered, recovery-oriented system of care. They are also consistent with the 2022 Plan's recommendation to implement recovery supports to ease transitions and continuity of care, remove barriers and improve long-term recovery outcomes.

In calendar year 2023, the Hubs in Delray Beach and Lake Worth Beach engaged a total of 3,016 individuals in their services. Nine hundred sixty five (965) individuals received peer support services; 1,200 individuals participated in education and training events; and, 291 in social events.

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, 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 their quality of life, self-esteem, and decrease their psychological distress. (Kelly, 2020)

The BCC approved a contract in May 2023 enabling the CSD to partner with Florida Atlantic University School of Social Work and Criminal Justice (FAU) to perform a program research evaluation of the County's existing RCOs and RCCs and organizational development processes for the new locations. The research evaluation is examining the long-term recovery outcomes of the participants who interface with the RCO/RCC by evaluating levels of engagement and recovery outcomes with a report expected to be completed in December 2024.

The School's research team is led by Dr. Heather Howard whose research focuses on community engagement as the basis for the data collection and analysis methods she utilizes. Her primary area of research is centered on trauma-informed care for women, particularly in substance use and health care from an empowerment lens. Howard also has over 25 years of clinical experience in social work in healthcare with clinical expertise in the treatment of grief and loss, trauma, and substance use disorders.

Comprehensive Opioid, Stimulant, and Substance Use Program Demonstrated Effective

FAU is also a research partner in Palm Beach County's Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) charged with its evaluation. COSSUP was the recipient of a 2023 National Association of Counties Achievement Award in the Criminal Justice and Public Safety Category. COSSUP is funded by a federal Department of Justice $1.2 million grant which as of October 1, 2023 entered into its fifth and final year. COSSUP was operationalized in October 2020 by contract with the Southeast Florida Behavioral Health Network (SEFBHN) and Rebel Recovery as the service provider which outreaches to reentry services, the courts, providers and the community as a means to engage program participants.

COSSUP's aim is to reduce overdose deaths, promote public safety, and support access to treatment and recovery services in the criminal justice system. COSSUP's primary focus is on achieving housing stability for criminal justice involvement individuals at high risk of overdose, given its key predictive value in achieving long-term recovery outcomes. It expedites recovery support services and provides housing vouchers, care coordination and flex fund support.

The aim of the evaluation is, through a recovery capital framework, to determine the impact of social capital, housing stability and a recovery-oriented system of care on individuals' outcomes of personal capital, rearrests and housing stability at 90 days for persons with justice

involvement and substance use histories. To date, the research team produced two reports: COSSUP Reports, 2021-22 and 2022-23. Two peer-reviewed articles were also published wherein CSD Office of Behavioral Health and Substance Use Disorder staff were co-authors. (See *"Now I Have My Own Key": The Impact of Housing Stability on Recovery and Recidivism Reduction Using a Recovery Capital Framework (*Howard, 2023).

> COSSAP has helped me enormously. Taken a huge weight off my shoulders and help me be able to figure things out and not be rushed into an environment where every dollar that I earn has to be paid towards rent. Helped me to save money and be able to figure out the next step in my life faster and better. Helped me be able to stay level headed.
>
> Bob, COSSUP participant, 2021

The research team found the COSSUP model was an effective strategy on building personal capital, housing stability, and recidivism reduction for justice-involved persons. In fact, of the 97 program participants only 14 experienced a rearrest (14 %). Of the 14 % (n = 14) that had a rearrest, 12 participants had a new charge whereas the others were based on technicalities (Howard, 2023).

The research team found recruiting recovery residences to participate in the Recovery Housing Provider Network proved difficult. This was true despite a 26 week resident housing voucher which met market rate and participant requirements that did not exceed Florida Association of Recovery Residences (FARR) certification standards or applicable federal law. FAU researchers indicated these realities and the project's findings bolstered the need to develop transitional housing capacity incorporating the project's programmatic interventions and affordable housing capacity given housing stability's predictive value in building recovery capital and improving long-term recovery outcomes.

In its storied history, the field of substance use disorder treatment has been unable to isolate certain interventions in an individual's care that would, with confidence, build recovery capital and create meaningful opportunities to achieve long-term recovery. The research team concluded the strong predictive relationships between identified recovery capital indicators and outcomes, including the reduction in criminal justice recidivism, have far reaching implications on how substance use disorder will be addressed in the future. Specifically, through operationalizing recovery capital and studying its relationships to outcomes, true person-centered, recovery-oriented care will not just be a theory, but can be provided through individualized recovery planning.

These findings are mirrored in research conducted by the University of Iowa, Carver College of Medicine. Its research team investigated whether participation in an addiction medicine clinic with active case management led to improvements in patients' recovery capital and whether there were associated changes in criminal activity and co-occurring methamphetamine or alcohol use. (Bormann, 2023).

The Recovery Research Institute at Harvard Medical School Teaching Hospital noted in its review of the study, *Recovery Capital Correlates With Less Methamphetamine Use and Crime in*

the Community, that individuals with greater recovery capital – the acquisition and/or use of available resources that can be accessed to support the initiation and maintenance of recovery from substance use disorder – report improved recovery outcomes over time.

The Institute noted the period following reentry post-incarceration is a vulnerable time for individuals with opioid and methamphetamine use disorder and is associated with higher likelihood of return to use and recidivism. The Institute also noted incarceration often systematically removes access to recovery capital, bolstering the importance of building recovery capital upon community reentry among formerly incarcerated people (Recovery Research Institute, 2023).

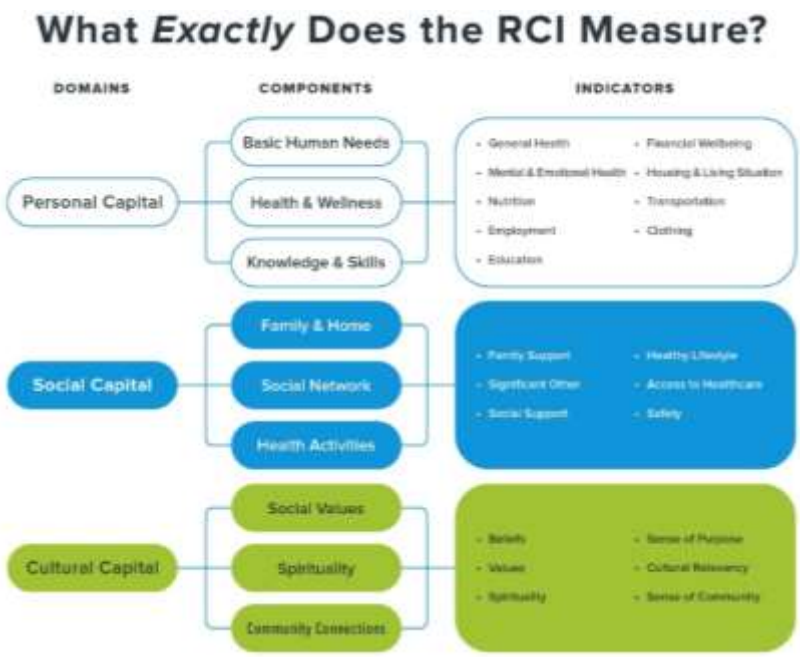
In the study, researchers found that recovery capital increased on average among formerly incarcerated people engaged in an addiction medicine clinic, and that increased recovery capital was associated with 60-75% reduced likelihood of alcohol and methamphetamine use and criminal. Reductions in methamphetamine use was particularly significant considering that there are currently no FDA approved medications for methamphetamine use disorder. (Bormann, 2023).

Recovery Capital: Integrating and Measuring Resilience and Risk

The measurement for assessing and enhancing recovery capital utilized by the FAU research team was the Recovery Capital Index (RCI) to support long-term recovery for justice-involved persons. The CSD deployed RCI in 2019 through its provider network which is key to measuring the system of care's success.

RCI is a peer-reviewed, validated assessment tool that accurately described the individual's current state of recovery. (Whitesock, 2018) Nationally, CSD has been at the forefront of deploying RCI and analyzing the data to inform its decision-making processes which has been memorialized in a Partner Story published in collaboration with Commonly Well, RCI's architect (Commonly Well, 2024)

The RCI provides a comprehensive picture of a person's whole well-being using an automated self-survey that allows for a personalized approach to care. RCI is person-centered and scientifically validated to reliably measure overall wellness regardless of treatment modality, recovery pathway, or substance of choice. It measures health and wellness using three domains (social, personal and cultural) and twenty-two components. The components provide a comprehensive baseline and, over time, allows for tracking of individual progress and tailored support as well as intervention effectiveness.



More than 4,600 RCI surveys have been completed by individuals served by CSD funded programs as of February 2024. There is a 95.3% survey completion rate (Commonly Well, 2024).

5 Indicators of Resilience	Avg.
Sense of Purpose	79.0
Beliefs	74.36
Safety	70.27
Healthy Lifestyle	70.06
Values	69.64

5 Indicators of Risk	Avg.
Financial Wellbeing	39.87
Employment	48.46
Housing/Living Situation	50.42
Transportation	53.75
Access to Healthcare	54.98

Domains	Avg.
Cultural Capital	71.73
Social Capital	62.96
Personal Capital	55.26
Total RCI	63.32

Overall, respondents are reporting low support in the workplace; insufficient housing and transportation; as well as low access to and high cost of health care. Commonly Well, through conducting a regression analysis, found Health and Wellness had the highest correlation to and impact on the overall RCI score followed by: Knowledge and Skills; Social Network; Healthy Activities and Environment; and, Basic Needs.

CSD's Financially Assisted Agencies (FAA) contracts with behavioral health providers that went into effect October 1, 2021 reflected the BCC's aim to establish of a person-centered, recovery-oriented system of care. Providers were required to follow specified guiding principles for such care and administer the RCI to clients with substance use and/or co-occurring disorders.

The RCI is required to inform the development a recovery plan for individuals with a substance use disorder or an individual with a mental disorder with a co-occurring substance use disorder prior to discharge. The recovery plan is to be person-centered, recovery-oriented; reflect the client's strengths, needs, and preferences. It is also to include a "warm-transfer" referral to a RCC and linkages to housing, employment, and/or recovery support services with client consent.

These newly initiated contracts pivoted away from successful discharge as an outcome measure and instead oriented measuring programmatic success toward clients being successfully transitioned to recovery support services. Specifically, whether clients are successfully transitioned to a RCC prior to discharge.

Clients are also expected to be linked successfully to housing, employment, and/or recovery support services. Further, there is an expectation that the clients' overall well-being will improve as indicated by whether their RCI score improved at least one point in the 3 domains from the baseline score at admission compared to the score at discharge.

Overall, Palm Beach County's initiatives are building recovery capital year over year. The highest year-over-year changes in the average scores for total RCI being recorded in 2022 with an increased score of 5.83 over the prior year.

Additionally, in March 2022, CSD contracted with FARR in the amount of 60 thousand dollars to launch a Recovery Capital Initiative which educates, trains and engages FARR certified recovery residences regarding the RCI. The Initiative also provides: education and training on Medication Assisted Treatment (MAT) and Medication Assisted Recovery (MAR) to these residences, owners and staff to broaden acceptance of MAT/MAR; and, helps develop best practices and compliance in following prescriptions for individuals utilizing MAT/MAR.

Palm Beach County has an interest in appropriately measuring long-term recovery outcomes in the recovery residence environment through the use of RCI. A major aim of the Initiative is to build recovery capital capacity within the County's FARR certified recovery residences. The intent is to foster an environment that maximizes a resident's opportunity to achieve long-term recovery through education, monitoring and measuring outcomes.

FARR currently has 103 housing providers certified statewide, representing 1,492 locations and 6,384 beds. Palm Beach County accounts for 51 of the statewide recovery residence programs (49.5 %), representing 635 locations (42.5 %) and 2,712 beds (42.5%). Housing stability is a key predictor of achieving long-term recovery outcomes. As such, Palm Beach County has a keen interest in ensuring that the County's certified recovery residences are rigorously screened and monitored to provide safe and stable housing environments. Thus, another aim of this initiative is to ensure FARR has sufficient capacity to also achieve housing stability for recovery residence residents utilizing the RCI.

Since October 1, 2023, FARR has conducted 24 onsite recovery residence assessments including education related to overdose prevention. MAT/MAR protocols have been conducted with administrators and staff to increase MAT bed capacity. FARR has also conducted seven trainings involving 16 recovery residences to review ROSC principles and implementing RCI.

Shaping a Healthier Palm Beach County: Assessing Community Wellness

Scan or text PBC to 844.926.6691

The CSD partnered with BeWell PBC and the Recovery Community Hub of Palm Beach County in September 2023 to launch the Help Shape a Healthier Palm Beach County campaign to coincide with National Recovery Month. The campaign aims to have county residents complete an anonymous wellness survey wellness survey in order to identify the strengths and needs of communities county-wide and is expected to conclude by September 2024, National Recovery Month.

The survey measures an individual's resilience capital which represents the internal and external resources someone can use to maintain a healthy lifestyle and overall well-being. The campaign's aim is to evaluate the community's strengths and needs in order to inform actions taken to improve the health and well-being of residents and communities.

Syringe Services: Improving Health and Saving Lives

In July 2019, the BCC was the first in Florida to enact an ordinance establishing a syringe access program after Gov. Ron DeSantis signed a bill a month earlier that gave permission to Florida counties wanting to create such a program. Palm Beach County contracted with Rebel Recovery as the first and only community-based syringe services program (SSP), Florida Access to Syringe and Health Services (FLASH) program which has been operating since April 2021.

The County's 2023 SSP Annual Report to the Florida Department of Health indicated that FLASH served 257 unduplicated clients during the reporting period, with 176 newly enrolled individuals. FLASH collected 136,220 used syringes and distributed 125,392 clean/unused syringes. In addition, 1,368 boxes of Narcan/Naloxone were distributed resulting in 232 reported overdose reversals (Palm Beach County Syringe Services Report, 2022).

FLASH also expanded to new locations in Riviera Beach and South Bay during the reporting period; areas of the County with high incidences of HIV and substance use.

FLASH's Wound Care Clinic served 40 unduplicated clients for services ranging from general health screenings to acute wound care as well as referrals to primary and specialty care when needed.

Managing Entity: Looking Up to Patients as the Guiding Star to Client-centric Care

SEFBHN is a critical partner in the County's efforts to address behavioral health and substance use disorders. SEFBHN is the managing entity for Palm Beach County contracted by the Florida Department of Children and Families (DCF) to administer and provide oversight of behavioral health services. Its aims align with those of the BCC with respect to orienting toward person-centered and recovery-oriented care. According to Ann Berner, SEFBHN CEO and President, SEFBHN has made it its mission to shift from a top-down view of the behavioral health system to a client-centric view that looks up to patients as the guiding star (Otero, M., 2023).

SEFBHN appropriates more than $70.3 million annually for community-based and residential treatment; acute care and community-based non-treatment services. Providers are required to employ principles of recovery including: choice, hope, trust, personal satisfaction, life-sustaining roles, interdependence, and community involvement.

Palm Beach County had four Baker Act receiving facilities as of 2022. SEFBHN added a fifth when it contracted with NeuroBehavioral Hospitals of the Palm Beaches (NBH) for inpatient services in West Palm Beach and Boynton Beach. The Boynton location includes voluntary admissions for people needing acute care (Otero, M., 2023).

The BCC approved a contract with SEFBHN effective October 1, 2020 wherein the managing entity partnered with the County to conduct a neutral care coordination pilot project to provide assessment, referral and care coordination services oriented toward individualized service plans unique to the individuals' needs and consideration of their choices with a care provider network comprised of treatment, social and recovery services as well as with the underpinnings of peer supports. In implementing neutral care coordination, the contract achieved an overarching high priority of the 2022 Plan Update 2022 and its aims to achieve cost-savings which will be reinvested in needed social, recovery support and prevention services.

In the second year of the contract, SEFBHN established the Expanding and Maximizing Better Access to Recovery and Resiliency through Care Coordination (EMBARCC) program. EMBARCC expanded the comprehensive neutral care coordination program to act as an initial and central point of contact for individuals seeking substance use disorder and mental health treatment services.

SEFBHN continued the project at the expiration of the County contract in September 2022. EMBARCC is described as playing a pivotal role in an overall transformation towards a recovery-oriented system of care by improving identification of behavioral health needs, maximizing coordination and linkage with needed services across health domains, and optimizing utilization of levels of care. This has been demonstrated to be cost-effective and maximizes the benefit to the individuals receiving services which is outlined in more detail on page 25 of this 2024 Plan.

Health Care District: Focus on Crisis and Trauma

In January 2019, the BCC approved an inter-local agreement with the Health Care District of Palm Beach County (HCD) to provide a revenue guarantee that would support the establishment of an addiction stabilization unit (ASU) on the campus of JFK North Hospital. An agreement between the BCC and JFK to provide financial assistance in the amount of $500,000 per year was later executed for this purpose.

The ASC is a unique public-private partnership designed to address the immediate and critical care of individuals experiencing medical emergencies due to opioid or other substance use disorders. The model, as originally designed, provided a central location with an emergency room component that allowed for lifesaving overdose intervention delivered within the ASU and a "warm hand off" to an adjacent outpatient clinic operated by the HCD where MAT and behavioral health services could be initiated or continued by a specialized, addiction-trained medical team.

Recognizing the success of the ASU in Palm Beach County, Governor Ron DeSantis in 2022 launched the Coordinated Opioid Recovery Network (CORE), modeled after the Palm Beach County program. The Governor's office described the program as the "first comprehensive solution to addiction recovery in the nation." In its inaugural year, CORE was rolled out in 12 Florida counties. Additional counties are now in various stages of implementing the statewide model (DeSantis, 2023).

The Florida Blue Foundation also highlighted this partnership with its 2023 Sapphire Award naming it the first-place program in recognition of the public health system's innovative outpatient addiction treatment model, which is now being replicated by the state in counties across Florida. (Health Care District, 2023)

For the period October 1, 2021 to February 18, 2024 the HCD reports serving 2,296 unique patients at the ASU and a total of 3,543 patient visits. Sixty eight percent (2,373) of which were walk-ins with the remainder largely being transported by local or county fire rescue departments. (Health Care District, ASU Data Report, February 18, 2024)

Fifteen percent of patients report coming to Florida for treatment. Of patients reporting having overdosed, 508 patients (60%) report having done so five or more times; 20% of which (256) report having overdosed ten or more times. Two hundred forty-two (242) patients reported carrying nasal Narcan spray and 73 patients report participating in a clean needle exchange. Seven percent of patients (251) reported a Baker Act history (Health Care District, 2024).

For the period October 1, 2021 to February 18, 2024, the HCD served 1,930 unique patients at its Lewis and Mangonia substance use disorder clinics. Sixty five percent (65%) are reported as homeless with 463 patients reporting they were street homeless. Additionally, more than two-

thirds of the patients are reported to be in need of care coordination for food (1,294), housing (1,258), and transportation (1,296). The HCD's housing and transportation care coordination needs are also identified in the Recovery Capital Index's highest risk factors. Housing ranked as the third highest risk factor and transportation was ranked fourth. (Health Care District Clinic Data Report, February 18, 2024).

Responding to community concerns regarding perceived deviations from the initial model that were primarily articulated in late 2023 and early 2024 at the BHSUCOD's ASU subcommittee and a recommendation by it to conduct an after action review, FAU clinical research team has been engaged as part of its existing contract with the County to produce a report that describes and documents the creation and the history of the ASC, the components of the applied health care model, and the implementation by the participating partners. It is anticipated the report will inform future decisions related to County funding for ASU operations and updates to the County's Behavioral Health Substance Use and Co-occurring Disorders Master plan.

In December 2023, the Health Care District unveiled the results of a feasibility study approved by its Board in June 2023. The District contracted with Initium Health of Denver, Colorado to conduct the study to present recommendations on the crisis care approach best suited for Palm Beach County. Initium recommended implementation of a Crisis Now Model (Initium, 2023).

Spearheaded by the National Association of State Mental Health Program Directors (NASMHPD), the model serves as a framework for communities to implement the National Guidelines. Initium stated there are a variety of ways to implement and operationalize the model's key programmatic components; someone to call; someone to respond; and, somewhere to go.

Initium utilized the NASMHPD Crisis Resource Need Calculator (Calculator) to provide an overview of the estimated cost reduction associated with transforming the existing crisis care system in Palm Beach County focused solely on emergency department and inpatient psychiatric services. Said services were estimated to cost $281 million while adoption of the Crisis Care model is estimated to cost $138 million.

Initium states the emergency department and inpatient psychiatric services scenario is a starting point for communities to estimate their cost reduction potential. It indicates by implementing the full continuum of Crisis Now services, Palm Beach County can build on its existing crisis services and realize significant savings (Initium, 2023). Initium, however, did not specify which entity (ies) (i.e. government, payors, private hospitals, etc.) would stand to realize these savings.

The Calculator enables consideration of the potential healthcare costs of scenarios such as adopting the Crisis Now model; using and expanding existing emergency departments and inpatients sites; and, adopting a modified behavioral health crisis care model. It is not designed for or intended to be used estimating a state or county's current total cost of behavioral health crisis care. Nor is it intended to specify cost savings and returns on investment for states or counties (National Association of State Mental Health Program Directors, Crisis).

Data to Action, Social Determinants of Health

To provide context to the number of individuals served by the HCD and SEFBHN funded providers noting the number of calls placed to 211 of Palm Beach and Treasure Coast (211) for mental health and addiction assistance is helpful. During the same HCD reporting period, October 1, 2021 to February 18, 2024, 211 reported 43,971 mental health and addiction calls. The calls were 211's second most requested category for the period which represents 24.1% of the total 182,807 calls received. (211 of Palm Beach and Treasure Coast, 2024)

In this context, the Florida Department of Health, Palm Beach County's (DOH) Overdose Data to Action (OD2A) grant from the Centers for Disease Control and Prevention (CDC) can be viewed. OD2A was renewed in 2023 and is a multi-year cooperative agreement to fund overdose surveillance and prevention programs. Overdose surveillance is conducted by DOH, while overdose prevention is mostly carried out through community partnerships. The goal of surveillance is to increase the foundational knowledge of the overdose and substance use epidemic in the County and to utilize local data to guide decision-making by putting overdose data to action to drive real, sustainable change.

Although more work remains to address historic concerns related to shared data, measurement, and outcomes, DOH's contributions have significantly aided in closing these identified data deficits. DOH's work provides important data to the County's decision-making processes which aids in achieving OD2A's aim of utilizing the data to drive real, sustainable change.

DOH releases monthly Syndromic Surveillance Reports and bi-annual and annual reports. The most recent annual report, *Overdose Data to Action (OD2A) Overdose Surveillance Annual Report Palm Beach County, FL, 2022*, was released in August 2023. These provide important detailed data analysis related to overdosed individuals' demographics, suspected drugs involved with and location of event, number of emergency room visits and discharge disposition (VanArsdale, W., 2023).

Critical to the BCC's goal of establishing a person-centered, recovery oriented ecosystem is the social determinants of health (SDOH) data DOH has contributed to the County's efforts of achieving this aim and its resilience and recovery orientation.

The CDC, Office of Disease Prevention and Health Promotion defines social determinants of health (SDOH) as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH is grouped into five domains: economic stability, education access and quality, health care access

and quality, neighborhood and built environment, and social and community context (Office of Disease Prevention and Health Promotion, Healthy People).

In this regard, DOH's 2022 Annual Report provides SDOH related to social and community context (i.e. marital status, emergency contact) as well as employment, health insurance and housing. People from all walks of life may be affected by substance use disorder but protective factors like social support helps maintain healthful behaviors. Experiencing and maintaining supportive and healthy relationships among family, friends, and romantic partners affect a person's emotional and mental health (Van Arsdale, W., 2023).

DOH found the percentage of individuals unemployed in 2022 was 43.8% higher than the percentage unemployed in the 2021 data sample. DOH cited a study of a large national cohort of people who lived with a disability, were unemployed, and/or were retired and were found to have a higher risk of overdose death compared to those who were employed.

DOH indicates such research demonstrates unemployment or retiring may lead to changes in routines, social connections, social support, and socioeconomic status—all social determinants of health. Additionally, people who use drugs often experience barriers to employment, including living in areas with few job opportunities, low educational attainment and lack of skills, poor access to transportation, and criminal history.

DOH found evidence of homelessness was present in 28.9% of the County's non-fatal overdose cases identified in the study. One in four suspected overdoses occurred among individuals that were currently experiencing homelessness. Additionally, DOH found that 22.5% of people who experienced an overdose had one associated address within the past year, but 77.5% had 2 or more associated addresses within the last year. Reasons for residential relocation are unknown.

In reporting on housing and homelessness DOH indicates housing instability can impact health outcomes and that studies show that experiencing housing instability or residential relocation can be linked to increased odds of experiencing violence, life-threatening health outcomes, high-risk health behaviors, decreased access to services, and criminal-legal system involvement. Furthermore, involvement in the criminal-legal system can restrict access to housing.

DOH found that the 2022 overdose data show that 40.2% of the sample are uninsured, 28.7% are privately insured, 15.6% receive Medicare, and 10.8% receive Medicaid. Since 2021, the number of uninsured people in the annual non-fatal overdose data sample has decreased by 15.2%, and the number with private insurance increased by 33.3%.

In reporting on health insurance, DOH indicates having health insurance is a strong indicator of a person's ability and willingness to access and stay in care. People who are uninsured, especially nonelderly adults and children, are less likely to have had a usual source of health care or a recent health care visit than people who are insured. SUD can be effectively managed as a chronic illness, similar to diabetes, when people have access not only to inpatient and outpatient treatment, but also to lifesaving MAT like buprenorphine, naltrexone, and methadone. Without insurance, these medications may not be affordable for most people (Van Arsdale, W., 2023).

White House Social Determinants of Health Playbook and Building a Recovery-Ready Nation

The White House Domestic Policy Council (DPC) released *The U.S. Playbook to Address Social Determinants of Health* (*Playbook*) in November 2023. The DPC drives the development and implementation of the President's domestic policy agenda in the White House and across the Federal government, ensuring that domestic policy decisions and programs are consistent with the President's stated goals, and are carried out for the American people (Office of Science and Technology Policy, Playbook, 2023).

The DPC emphasizes the fact that improving health and well-being across America requires addressing the social circumstances and related environmental hazards and exposures that impact health outcomes. An inability to meet these social needs puts individuals at higher risk for exacerbating health conditions such as heart disease, stroke, depression, cancer, and diabetes according to the DPC. Compounding the problem, unmet social needs can cause major disparities in health outcomes stratified by geography, race, ethnicity, age, income, disability status, sexual orientation and a number of other factors.

The DPC highlights evidence that suggests that interventions addressing social needs can improve health outcomes. For example, research has found that housing individuals with HIV who are experiencing homelessness increases survival with intact immunity by 21% after one year.

The *Playbook* lays out an initial set of structural actions federal agencies are undertaking to break down these silos and to support equitable health outcomes by improving the social circumstances of individuals and communities. The Playbook sets the stage for agencies and organizations to re-imagine new policies and actions around SDOH, both inside and outside of government.

The vision and coordinating actions outlined in the Playbook *creates a scaffolding upon which entities from all segments of society can build*. (emphasis added) These initial efforts are focused on individual and community-centered interventions with actions grouped into three pillars as follows:

- **Pillar 1:** *Expand Data Gathering and Sharing: Advance data collection and interoperability among health care, public health, social care services, and other data systems to better address SDOH with federal, state, local, tribal, and territorial support.*
- **Pillar 2: Support Flexible Funding for Social Needs:** *Identify how flexible use of funds could align investments across sectors to finance community infrastructure, offer grants to empower communities to address HRSNs, and encourage coordinated use of resources to improve health outcomes.*
- **Pillar 3: Support Backbone Organizations:** *Support the development of community backbone organizations and other community infrastructure to link health care systems to community service organizations.*

The DPC's aim is to accelerate innovation across sectors to develop practical solutions that equitably improve social circumstances and achieve better health outcomes. It declares it will

continue to champion advancements that foster individual and community engagement, enhance public health, improve well-being, and serve communities and calls upon all Americans to partner in these efforts and commit to investing in communities to strengthen the health of society (White House, Playbook, 2023).

Critically, the White House Office of National Drug Control Policy (ONDCP) in release of its 2022 National Drug Control Strategy (*Strategy*) emphasized recovery-oriented and harm reduction strategies in three of its seven drug control priorities as follows:

1. Expanding access to evidence-based treatment, particularly medication for opioid use disorder.
2. Advancing racial equity in our approach to drug policy.
3. Enhancing evidence-based harm reduction efforts.
4. Supporting evidence-based prevention efforts to reduce youth substance use.
5. Reducing the supply of illicit substances.
6. Advancing recovery-ready workplaces and expanding the addiction workforce.
7. Expanding access to recovery support services (ONDCP, Strategy, 2022).

ONDCP leads and coordinates the nation's drug policy so that it improves the health and lives of the American people. ONDCP is responsible for the development and implementation of the National Drug Control Strategy and Budget. ONDCP coordinates across 19 federal agencies and oversees a $41 billion budget as part of a whole-of-government approach to addressing addiction and the overdose epidemic (White House, ONDCP).

In outlining A Comprehensive Path Forward through its 2022 *Strategy*, ONDCP defines harm reduction as an approach that emphasizes working directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer flexible options for accessing substance use disorder treatment and other health care services. ONDCP emphasizes harm reduction is people-centered (ONDCP, Strategy, 2022).

Specifically, ONDCP's focus on harm reduction includes naloxone, drug test strips, and syringe services programs. Syringe services programs are community-based programs that can provide a range of services, including links to substance use disorder treatment; access to and disposal of sterile syringes and injection equipment; and vaccination, testing, and links to care and treatment for infectious diseases. Syringe services programs can be a critical intervention to reduce overdose deaths and communicable disease. Access to these proven, lifesaving interventions should not depend on where someone lives and instead should be available to all who need them.

The 2022 *Strategy* places great emphasis on Building a Recovery-Ready Nation. The four major dimensions of recovery prioritized in the *Strategy* are home, health, purpose, and community as defined by the federal Substance Abuse and Mental Health Administration. It reports Americans follow diverse trajectories from SUD to recovery or remission. In 2020, an estimated 29.2 million Americans perceived ever having a substance use problem. Of these, 21 million (72%) identified as in recovery or recovered from a substance use problem.

The *Strategy* also identifies a 2017 study which found that, among people who reported having resolved an alcohol or other drug program, the most common recovery supports included mutual aid groups (45%), treatment (28%), and emerging recovery support services (22%). ONDCP concludes reaching recovery is more important than the specific path taken to it.

The Strategy's goals to Build a Recovery-Ready Nation are:

1. Increase scientific understanding of recovery.
2. Foster adoption of more consistent certification and accreditation standards nationally.
3. Expand the peer recovery support services (PRSS) workforce and the organizational infrastructure that supports it.
4. Address stigma and misunderstanding, and
5. Eliminate barriers to safe and supportive housing, employment, and education for people in recovery. (ONDCP, Strategy, 2022).

President Biden, during his 2022 State of the Union address, stated, "If you're suffering from addiction, you should know you're not alone. I believe in recovery, and I celebrate the 23 million Americans in recovery… Now is our moment to meet and overcome the challenges of our time together. And we will" (Biden, J., 2022).

Community in Action

Granicus deploys digital and other communications strategies to better connect people with decision-makers. It defines community advocacy as "a strategic approach to influencing outcomes and driving change on behalf of the community. It involves representing the community's rights and needs to the level of government best able to respond." (Granicus, 2023). There is no greater example of community advocates in action and providing strong leadership to establish a recovery-oriented landscape than the Southeast Florida Recovery Advocates and Our2Moms.

These organizations, which represent persons in recovery, parents of loss, effected family members and other allies, were successful in advocating for the Palm Beach County Sheriff's Office to have their PBSO deputies and corrections officers not to carry Nalaxone (aka Narcan). Advocates held protests and candlelight vigils in January and April 2022 outside PBSO office in hopes of changing the policy requiring all law enforcement officers to carry Narcan.

In July 2022, advocates appeared before the BCC to advance their cause. The next month, PBSO announced a for all deputies and corrections officers to carry Narcan. The PBSO also announced it would conduct a three-year study on frequency and results of officers carrying Narcan to determine continued deployment (Palm Beach Post, 2022).

In late October 2022, the Palm Beach Post reported PBSO announced more than 2,000 sworn PBSO deputies and correction officers were armed with the nasal spray. The PBSO noted it obtained the doses from the Florida Department of Health's HEROS Program, or Helping Emergency Responders Obtain Support, at no cost to the agency (I Save FL, 2022). The HEROS program provides free naloxone to emergency response agencies.

Florida's Department of Children and Families also provides free Narcan to approved providers statewide through its I Save FL program. There are 23 approved providers in Palm Beach County who are regularly distributing Narcan, conducting Narcan trainings, and recording overdose reversals resulting from distributed Narcan (I Save FL, 2022).

At the forefront of care is Palm Beach County Fire Rescue, meeting the needs of patients and families when experiencing a substance or alcohol related medical emergency or a mental health emergency. To expand Fire Rescue's reach beyond the 911 scene, its Mobile Integrated Health Team supports patients and families after their 911 call through a specialized team of community paramedics and medical social workers. Florida's first, the Mobile Integrated Health Team serves as a bridge to both County and community resources to ensure warm transitions of care to address the unique needs of individuals.

Additionally, The School District of Palm Beach County reports all District operated schools carry Narcan in the school clinics. Narcan is made available in partnership with the Health Care District and the Department of Health. The School District will also be expanding this initiative with the School Police Department in the near future.

Leading the Way in Person-centered, Recovery-oriented Care

The 2017 Opioid Response Plan did not focus on recovery and person-centered, recovery-oriented care. While a relatively new concept in the 2000s and advanced by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in the substance use disorder field, the expectation was the structure of recovery-oriented systems of care (ROSC) would evolve at all levels of government.

William L. White's seminal monograph in ROSC, recovery management and ROSC addiction treatment literature, *Recovery Management and Recovery Oriented Systems of Care: Scientific Rationale and Promising Approaches*, has been advanced to help evolve this modality. The monograph comprehensively lays out the empirical support for moving to (ROSC).

White, Emeritus Senior Research Consultant at Chestnut Health Systems, is widely published in peer-reviewed journals and authored or co-authored more than 20 books as well as 400 articles, monographs, and research reports. His works, *Slaying the Dragon – The History of Addiction*

Treatment and Recovery in America and *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement*, enjoy wide critical acclaim (Chestnut, William White Papers).

The monograph provides a systematic review of the literature to support this transition; concrete strategies to make the vision of recovery-oriented service systems a reality; and, outlines the scientific conclusions and the systems-performance data supporting extension of the acute-care model of addiction treatment to a model of sustained recovery management.

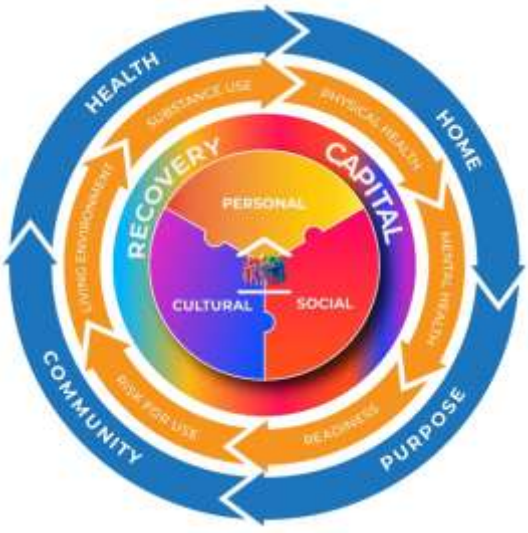
White issues a clarion call in the monograph, "It is time we proactively managed the prolonged course of addiction and recovery careers and stopped focusing on brief episodes of biopsychosocial stabilization. It is time for national, state, and local initiatives to create recovery-oriented systems of care that can promote this model of sustained recovery management within addiction treatment programs across the country."

> It is time we … stopped focusing on brief episodes of biopsychosocial stabilization. It is time for national, state, and local initiatives to create recovery-oriented systems of care that can promote this model of sustained recovery management.
>
> William L. White

Palm Beach County has responded to White's clarion call with, as noted earlier, the BCC's declaring its expressed approval of a person-centered, recovery-oriented system of care focused on quality of care and long-term recovery outcome improvements in the Resolution establishing the BHSUCOD.

All the County's collective and collaborative efforts, prior and since, have been directed at planning, developing and executing a comprehensive person-centered, recovery-oriented system of care. In 2023, the initial system model was modified to orient the County's efforts toward a Resilience and Recovery Ecosystem approach to Behavioral Health and Substance Use Disorder Care which has been adopted by the County. (See Appendix A)

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



The ecosystem model integrates American Society of Addiction Medicine's (ASAM) Third Edition criteria and its six dimensions. The ASAM Criteria is the most widely used and comprehensive set of standards for placement, continued service, and transfer of patients with addiction and co-occurring conditions. Many states across the country are using the ASAM Criteria as the foundation of their efforts to improve the addiction treatment system.

It should be noted ASAM recently released Fourth Edition criteria which were adopted subsequent to the County's current ecosystem modeling. The Fourth Edition criteria will be integrated into the ecosystem model in the near future.

ASAM Third Edition Dimensions	ASAM Fourth Edition Dimensions
1. Acute Intoxication and/or Withdrawal Potential 2. Biomedical Conditions and Complications 3. Emotional, Behavioral, or Cognitive Conditions and Complications 4. Readiness to Change 5. Relapse, Continued Use, or Continued Problem Potential 6. Recovery/Living Environment	1. Intoxication, Withdrawal, and Addiction Medications 2. Biomedical Conditions 3. Psychiatric and Cognitive Conditions 4. Substance Use-Related Risks 5. Recovery Environment Interactions 6. Person-centered Considerations

The Fourth Edition reorders the dimensions from the Third Edition. Readiness to change is now considered within each dimension, and the Third Edition Dimensions 5 and 6 were shifted to Dimensions 4 and 5, respectively, in the Fourth Edition. Important to the County's ecosystem model, the new Dimension 6: Person-Centered Considerations considers barriers to care *(including social determinants of health), patient preferences,* (emphasis added) and the need for motivational enhancement. (ASAM, ASAM Criteria)

The ecosystem also integrates the federal Substance Abuse and Mental Health Administration's (SAMHSA) for major dimensions of recovery: health, home, purpose and community (SAMHSA, Recovery). See Section III, Introduction to the Plan Update 2024, page 36 for additional details on SAMHSA's guidance related to ROSC and guiding principles.

The ecosystem at the Macro level is concerned 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. It makes accessible a network of services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve improved health, wellness, and quality of life.

The Meso level provides a 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.

The Micro level aims to increase an individual's 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.

In sum, the ecosystem model identifies the behavioral health and substance use disorder needs of the client population; improves client care with linkage efforts across all health domains; and, informs 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. It has also informed policy, planning, and programmatic decisions and is the lens through which funding opportunities are identified.

The ecosystem is consistent with achieving the process metrics related to the BCC's aims as follows: implement neutral care coordination; establish recovery community organizations and recovery community centers; broaden the reach of peer support services across the continuum; and, launch a Recovery Capital Instrument and train providers in its use.

It also remains consistent with the Palm Beach County 2019 Behavioral Health Needs Assessment (Assessment) recommendations which remains important guidance and include:

- Enhance "no wrong door policies and practices" and *development of a central assessment and care coordination system for the community.*
- Continue utilization of system-wide evidence-based practices including the *development of a true Recovery-Oriented System of Care (ROSC) and a comprehensive implementation of care coordination and wraparound services* (The Ronik-Radlauer Group., 2019*)*

The primary goals of the ecosystem 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.
- Reduce the use of crisis services.
- Maintain and utilize a comprehensive continuum of substance use disorder and/or mental health treatment services integrated with other social 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.

The Assessment's recommendation is to develop a central assessment and care coordination system is mirrored by the White House Domestic Policy Council's call to communities to establish a backbone organization and other infrastructure which will serve to link health care

systems to community service organizations (Office of Science and Technology Policy, Playbook, 2023).

The DPC's definition of a backbone organization and its responsibilities describes near perfectly the initiatives to establish neural care coordination such as the SEFBHN pilot program discussed earlier which the managing entity continues as EMBARCC. The DPC defines backbone organizations as entities that manage community-based partnerships formed across sectors such as health care, social services, public health, and economic development to improve the health and well-being of individuals and the community

The DPC states these organizations can serve as central coordinating hubs that connect individuals needing various services such as housing support, transportation, legal services, or nutrition support with relevant providers. At their best, these entities coordinate across service providers, integrate funding from multiple public and private sources to support operations and service delivery, leverage trusted relationships and members' existing assets, and foster community-based workforce development and training.

DPC cites one example of a specific type of backbone organization with a robust set of capabilities is a community care hub. These organizations centralize administrative functions and operational infrastructure for a network of community based organizations, including, but not limited to, payment operations and contractual agreements, management of referrals, service delivery fidelity and compliance, technology maintenance, information security, data collection, and reporting. (Office of Science and Technology Policy, Playbook, 2023).

Care coordination entities recommended by DPC and the Assessment are supported by the evidence. 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.

Usual Care 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 time 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 (Morgenstern, J., 2009).

Now the National Center for Advocacy and Recovery for Behavioral Health (NCAAR), its Work First New Jersey Substance Abuse and Behavioral Health Initiative (SAI/BHI) completed its 25th year of providing services in 2023. SAI/BHI provides comprehensive assessment, referral, care

coordination, and intensive case management services to General Assistance and Temporary Assistance for Needy Families recipients throughout the state (NCARR, Annual Report, 2023).

Over twenty-five years NCAAR reports having completed more than 217,000 referrals; more nearly 155,000 assessments; and nearly 100,000 individuals who entered treatment. SAI/BHI clients receive wrap around case management services, referrals to community-based resources, and assistance with medical appointments which allows individuals to thrive in a less intense level of care and stay in their communities.

In fiscal 2023, 5% of SAI/BHI clients were placed in residential treatment, including 2% residential withdrawal management, 1% short- term residential, 2% halfway house, and 1% long-term residential. The remaining 95% of SAI/BHI clients were referred and placed in outpatient treatment services, including 67% outpatient, 14% intensive outpatient, 6% partial care, and 7% in methadone maintenance (NCARR, Annual Report). It also reports its average cost per client per episode of care is $3,400 compared to the national average, which is between $14,000 and $23,000 (Wolff, S., 2018).

By any measure, NCAAR has been successful in developing an accountable behavioral health system to help reach the State's goals for quality care, accessibility, eliminating gaps in service, and moving clients cost-effectively along the continuum of care.

The County has worked diligently to implement neutral care coordination as noted earlier by its collaboration with the SEFBHN pilot program which the managing entity continues as EMBARCC. Before COVID halted efforts in 2020, the County also collaborated with SEFBHN on a contract that was executed to engage a consultant to assess the current and potential resources, and readiness to implement a neutral care coordination system that will include the use of a standardized level of care instrument and care coordination to navigate the system of public and private behavioral health and substance use disorder programs in Palm Beach County.

The consultant's work was to result in a plan and recommendations to implement the transition to a person-centered, recovery-centric and recovery-oriented system of care. The plan was to include independent and uniform assessment as well as care coordination for community-based behavioral health and substance use disorder programs. The County continues to collaborate with SEFBHN to achieve these aims and also collaborated with the HCD in early 2023 to discuss executing neutral care coordination in meetings facilitated by the Palm Health Foundation.

In 2021, the County established a working group to develop a comprehensive plan to establish neutral care coordination in Palm Beach County. The working group included professionals with significant experience operationalizing and working in a neutral care environment including Ariana Ciancio, Delray Beach Police Department Client Advocate and current Advisory Committee member. Previously, Ms. Ciancio served for seventeen years in multiple capacities with NCAAR's SAI/BHI program.

The Plan, *Establishing a Palm Beach County Neutral Care Coordination Entity and executing a person-centered, recovery-oriented system of care, July 2021*, outlined the goals of a Neutral Care Coordination Entity (NCCE) as follows:

- 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 Plan described the NCCE as 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.

The Plan also provides key programmatic elements as well as anticipated personnel and budget requirements. In July 2023, a Plan Executive Summary was also developed. (See Appendix B)

Much has been articulated regarding the County's efforts at *Leading the Way in Person-centered, Recovery-oriented Care*. Numerous bodies of planning documentation, research and programmatic evidence has been pointed to within Palm Beach County as well as nationally. To conclude, returning to White's Monograph and its summary of recommendations support the call for a transformation in the structure and service processes from a model of acute intervention to a broader model of sustained recovery management. These recommendations are worthy of further consideration as efforts to build a robust resilience and recovery ecosystem continue. (See Appendix C)

One Overdose Death is One Overdose Death Too Many

The BHSUCOD applauds the continued downward trend in overdose deaths in 2023. Given the devastation overdose deaths have on families, friends, and the community the BHSUCOD maintains the position that one overdose death is one overdose death too many.

The BHSUCOD wishes to see continued reductions, which may never arrive at zero, but believe tracking overdose death rates should not be the singular outcome measure of the County's efforts success. Beyond this measure, the BHSUCOD supports the County's ongoing efforts to measure its initiatives through a recovery capital framework and its ability to capture resilience, health, well-being, social determinants of health and risk factors.

In June 2023 the Gallup published findings in a report, *The Opioid Epidemic: How Wellbeing Can Help Bend the Curve*, which found high statewide wellbeing was linked to lower and slower-rising overdose rates. Additionally, career wellbeing stood out as key to curtailing drug overdose deaths. (Witters, D., 2023).

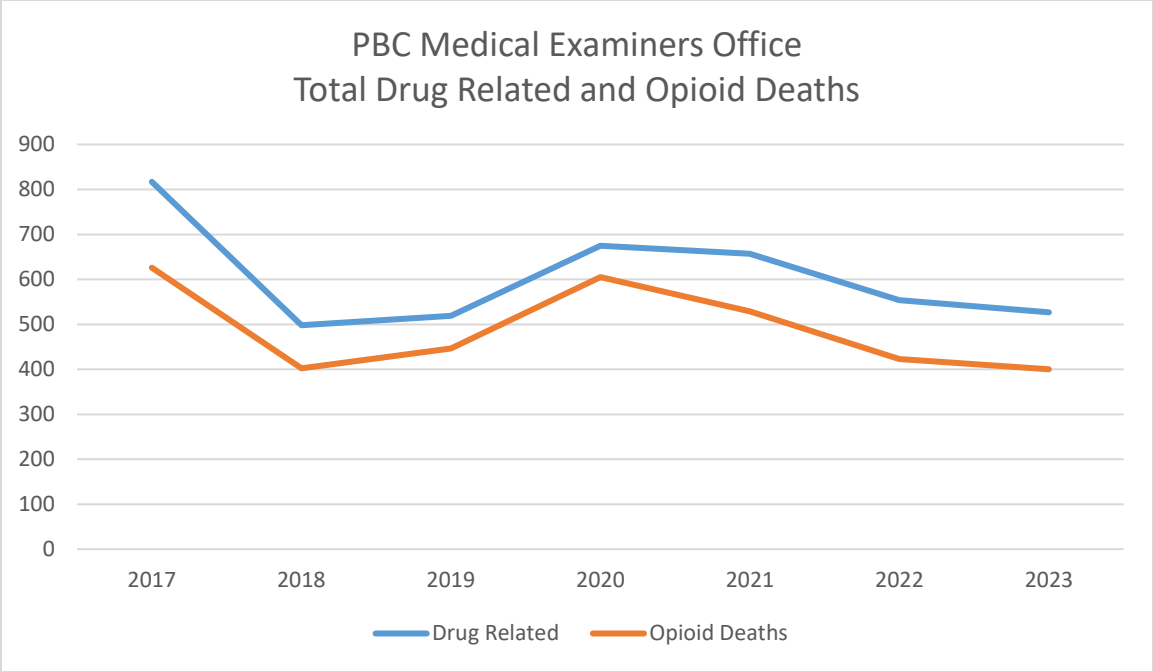
More specifically, that wellbeing was inversely related to drug overdose rates among states and the potential exists to mitigate the worsening opioid epidemic by expanding and elevating wellbeing. Gallup's analysis of the 2017 state ranks based on overall Well-Being Index scores showed that the highest-wellbeing states in 2017 had substantially lower average drug overdose rates in 2018 than what was found among the lowest-wellbeing states.

Furthermore, the rate of increase in the following two years also varied greatly, with the five lowest-wellbeing states in 2017 (West Virginia, Louisiana, Arkansas, Mississippi and Kentucky) increasing their already elevated overdose rates another 15.8 cases per 100,000 residents, on average -- compared with an increase of 5.3 cases per 100,000 among the five highest-wellbeing states (South Dakota, Vermont, Hawaii, Minnesota and North Dakota).

Gallup found high population wellbeing can serve an insulating function, whereby a cultural foundation exists that lowers the probability of per capita drug overdoses the following year. High drug overdose rates, in turn, reduce the probability of high population wellbeing the following year, but to a lesser extent.

Analyzing the data further, more specific to the five specific elements of wellbeing: career, community, social, physical, and financial wellbeing. All five are inversely related to the next year's drug overdose rate -- but the relationship with career wellbeing was strongest by far, outpacing social, financial, physical and community wellbeing (Witters, D., 2023)

Gallup also identified individual aspects of wellbeing that are critically important to understanding what increases or decreases drug overdose rates in states. These aspects of wellbeing referred to as warning signs by Gallup are worthy of further consideration as efforts to build a robust resilience and recovery ecosystem continue. (See Appendix D)



The Palm Beach County Medical Examiner's Office (MEO) reported 817 drug related deaths in 2017 of which 626 were opioid deaths and in 2018 recorded 498 drug related deaths of which 402 were opioid deaths; a 39 and 36% reduction respectively. The MEO reported 519 drug related deaths in 2019 of which 446 were opioid deaths and in 2020, amidst the COVID pandemic, recorded 675 drug related deaths of which 605 were opioid deaths; a 30 and 36% increase respectively from 2019 to 2020. (Palm Beach County Medical Examiner's Office, Annual Report 2022)

In 2021, the MEO reported 626 drug related deaths of which 524 were opioid deaths; a 7 and 14% decrease respectively from 2020 to 2021. In 2022, the MEO reported 554 drug related deaths of which 423 were opioid deaths; a 12 and 19% decrease respectively from 2021 to 2022. In 2023, the MEO reported 527 drug related deaths of which 400 were opioid deaths; a 5 and 5% decrease respectively from 2022 to 2023.

In its 2022 Annual Report the MEO reports fentanyl and its analogs (including acetyl fentanyl and fluorofentanyl) far exceeded the other opiates (such as heroin and oxycodone) in 2022. Most opioid deaths had multiple opioids contributing to the death, The MEO indicated the average age of accidental drug fatality victims was 43 years old and the victims were predominantly men (2.7:1). The MEO also indicated white individuals were 5.9 times more likely to die of an accidental drug overdose than those of Hispanic/Latino or Black/African American ancestry

The MEO reported 243 suicides in 2022 and 2021 and 172 in 2020. It reports the average annual number of suicides for the last ten years is 230. The male: female ratio for suicide victims in 2022 was 2.3:1. Most 2022 suicide victims were White (192), followed by Hispanic/Latino (29), Black or African American (16), and Asian (4) with the average age of a suicide victim was 54 years (Palm Beach County Medical Examiner's Office, Annual Report 2022)

The Florida Department of Health Palm Beach County's (DOH) 2022 Annual Surveillance Report reported on non-fatal overdoses and reviewed approximately 3,200 hospital medical records for suspected drug overdoses. Of those records reviewed, about half (number[n] =1611) met the criteria to be included in the sample of suspected non-fatal overdose (VanArsdale, W., 2023).

DOH identified sample characteristics. Of the 1,611 non-fatal overdoses cases included in the 2022 surveillance sample, 1,055 (65.5%) were among males and 556 (34.5%) were among females. This distribution is similar to that of prior years. Among females, 6 (1.1%) were pregnant at the time of overdose.

Of the suspected non-fatal overdoses 1,126 (69.9%) occurred among White non-Hispanic individuals. Overdoses among Hispanic individuals of any race accounted for 12.9% (n=208) of suspected non-fatal overdoses. Overdoses among Black non-Hispanic individuals accounted for 12.5% (n=202). The average age was 42 years with most overdoses occurring among adults aged 25 to 44 years and are overrepresented in the sample compared to their overall proportion in Palm Beach County. (VanArsdale, W., 2023).

While important progress has been made, the BHSUCOD continues to find systemic challenges so clearly identified in the 2019 Behavioral Health Needs Assessment remain. These include, amongst others:

- Fragmentation and disjointed care from multiple treatments, social and recovery support providers;
- Determinations of client treatment that are based on the services available at a particular provider, rather than on 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 treatments, social and recovery support providers serving one client; and
- On-going silos when it comes to client care (The Ronik-Radlauer Group, 2019).

III. PRIORITY AND OPIOID SETTLEMENT RECOMMENDATIONS

The Palm Beach County Advisory Committee on Behavioral Health, Substance Use and Co-Occurring Disorders (BHSUCOD) established by the BCC in November 2022 held its organizational meeting on January 12, 2023 at which it approved its operational guidelines manual. As noted earlier, the BHSUCOD was established to enhance the County's capacity and effectiveness in formulating comprehensive, integrated, and effective behavioral health, substance use and co-occurring disorders prevention, treatment, support, and recovery policies, as well as to offer recommendations regarding the County's provision of services to the citizens of Palm Beach County.

The BCC also declared, via Resolution R2022-1340, that:

- A Behavioral Health, Substance Use and Co-Occurring Disorder Steering Committee was established in 2019 consistent with the Opioid Response Plan, which was intended, in part, to satisfy the State's Opioid Settlement Clearing Trust Fund requirement for a Task Force to respond to the opioid epidemic pursuant to section 17.42 (4)(b), Florida Statutes (2022);
- The Response Plan was intended to satisfy the State's Opioid Settlement Clearing Trust Fund requirement for an opioid response abatement plan pursuant to section 17.42 (4)(c), Florida Statutes (2022)

Section 4 of Resolution R2022-1340 also outlined that the BHUSCOD shall have the following roles and responsibilities:

- Collect information related to substance use disorders in the County and provide that information to the BCC, along with recommendations on responding to the opioid epidemic, as provided in section 17.42, Florida Statutes (2022).
- Submit to the BCC by October 1 of each year the BHSUCOD Annual Report or Response Plan Update, which shall evaluate mechanisms for behavioral health and substance use disorder services and recommend any changes that may improve the quality, long-term recovery outcomes, and coordination of these services.
- If requested by the BCC, provide recommendations on positions the BCC may take on local, state and federal legislation.

In its update to members the Florida Association of Counties reported the suits against 11 corporate entities for their wrongful conduct in the opioid epidemic crisis went to trial in April 2022 and all the corporations involved settled in the pretrial phase. An allocation agreement was negotiated into three funds: the State Fund, Regional Fund, and City/County Fund which may only be used to abate or remedy the opioid epidemic. (Florida Association of Counties, The Opioid Settlement: Where are we now?).

State and subdivisions will receive more than $3.1B over the next 17 years. Over 18 annual distributions from the Regional and City/County funds, Palm Beach County is expected to realize nearly 122.5 million dollars. (See Appendix E) The states, counties, and cities also developed a thirteen-page list of programs that are illustrative of the types of programs that can be funded with settlement funds. (See Appendix F)

On March 22, 2022 the BCC approved participation in the Settlement Agreement and Release between the State of Florida and Endo (Florida Opioid Agreement and Statewide Response Agreement) and authorized the Mayor to execute the Subdivision Settlement and Participation Form. The County worked with the Palm Beach County League of Cities to secure inter-local agreements with Palm Beach County Municipalities that represent a more than 50% of municipalities' total population as required by the Florida Plan (Palm Beach County Board of County Commissioners Agenda. March 22, 2022).

Palm Beach County submitted its Florida Opioid Agreement and Statewide Response Agreement Qualified County Qualification Form to the State of Florida on April 12, 2022. In doing so the County certified:

- The County has a population of at least 300,000 and an opioid taskforce or other similar board, commission, council, or entity, including some existing sub-unit of the County's government responsible for substance abuse prevention, treatment, or recovery of which it is a member or it operates in connection with its municipalities or others on a local regional basis.
- The County has an abatement plan that has been adopted or utilized to respond to the opioid epidemic.
- The County was as of December 31, 2021, either providing or is contracting with others to provide substance use, prevention, recovery, and treatment services to its citizens.
- The County has entered an inter-local agreement with at least 50% of the Municipalities (by population) located within the County.

The BHSUCOD meets bi-monthly on the even numbered months of the calendar year. Members also lead eight (8) subcommittees that regularly engage and invite open participation of community members, stakeholders and other interested parties. The subcommittees are facilitated by the OBHSUD Program Evaluator and meet bi-monthly on the odd numbered months of the calendar year.

Florida Atlantic University School of Social Work and Criminal Justice (FAU) is also engaged as a research partner respective of the BHSUCOD and its subcommittees. FAU is conducting process and outcome evaluations for Plan Update, the BHSUCOD overseeing implementation and reporting on it, and initiatives of person-centered recovery-oriented systems of care.

In order to address re-occurring report findings and community concern about siloes between government, providers, and communities that create barriers to care, FAU surveyed the BHSUCOD utilizing the Wilder Collaboration Factors Inventory. The inventory is an assessment tool that helps provide an idea of how well interagency collaboration is doing in areas important to success. It identifies strengths and weaknesses of individual factors in an organization's collaboration and is used to provide an overall score of collaborative success.

The FAU research team used process and outcome evaluations for the BHSUCOD, Master Plan, and Initiatives of person centered recovery oriented systems of care. A thematic analysis was conducted and major themes were created based on interviews. Major themes consisted of barriers, programmatic and purpose.

The Wilder Inventory demonstrated that 80% of the responses were somewhat agree to strongly agree regarding collaboration as indicated by the inventory's indicators. Some of the indicators that received strongly agree responses were:

- The political and social climate seems to be "right" for starting a collaborative project like this one.
- I have a lot of respect for people involved in this collaboration.

- Everyone who is a member of our collaborative group wants this project to succeed

There were also areas identified for improvement including:

- Trying to solve problems through collaboration has been common in this community. It has been done a lot before.
- The organizations that belong to our collaborative group invest the right amount of time in our collaborative efforts.
- Communication among the people in this collaborative group happens both at formal meetings and in informal ways.

This 2024 Plan is intentionally substance agnostic and intended to serve as a roadmap for Palm Beach County to bring to fruition an integrated and coordinated, person-centered, recovery-oriented system of care for anyone with a substance use disorder, behavioral health disorder and/or co-occurring disorders.

The OBHSUD Program Evaluator facilitated processes for subcommittee participants to consider and review previously identified issues and strategies while also soliciting additional input as well as regularly surveyed subcommittee participants as to their familiarity with the 2022 Plan. They and OBHSUD staff considered and reviewed an analysis of feedback received at community forums, provider surveys and related needs assessments and studies.

The recommendations contained within align with the core strategies and approved uses identified in the Settlement Agreement. They also align with the BHSUCOD's overarching priority recommendations and comprise a roadmap for the 2024 Plan for achieving the BCC's articulated strategic priority to establish a person-centered, recovery-oriented system of care.

The BHSUCOD's comprehensive set of recommendations can be found on page 48 in Section IV, Proposed Theory of Action. The Committee developed recommendations after review of the 2022 Plan which served as the foundation for it its subsequent work in establishing the 2024 Plan's recommendations.

After review of the 2022 Plan, the BHSUCOD found of the 49 total recommendations (22.45 %) of the recommendation were completed; 67.35% of the recommendations are in progress; and, 10.20% of the recommendations have not yet started. Completed (C) recommendations are defined as recommendations accomplished since 2022. In progress (IP) recommendations have been initiated. And, not yet started (NYS) recommendations have not been initiated.

A discernible outcome of the collective work to date is the setting and execution of a vision to establish a readily accessible, integrated and coordinated recovery-oriented system of care that meets the needs of Palm Beach County residents. A rallying crying if you might that truly places an individual at the center of their care and delivers on an, to date, still illusive recovery-oriented system of care.

In sum, there have been some hard-won gains but the BHSUCOD recognizes how precarious this progress can be viewed by people and families affected by substance use and behavior disorders. Members are reminded day in and day out that its work is not complete.

BHSUCOD re-affirms the 2022 Plan recommendations while incorporating additional recommendations for the 2024 Plan Update. Its critical recommendations are as follows:

A. Overarching Priority Recommendations	
2022	**Status**
1. BCC enactment of ordinance designating lead entity granting it leadership, budget, planning and monitoring authority. 2. Advocate for policies and legislation which advance person-centered, recovery-oriented systems of care and essential services that meet individual's needs and are readily accessible and integrated. 3. Identify and provide sustainable resources (essential services) for individuals re-entering the community such as those provided through the Community Services Department's federal grant research project, Comprehensive Opioid, Stimulant, Substance Abuse Program (COSSAP). (Housing and peer support, care coordination, flex funds). 4. 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.	1. C 2. IP 3. IP 4. IP
2024	
1. Recommendation to BCC that the County lead and/or support comprehensive planning process between SEFBHN, HCD and other community partners to drive alignment, coordination, shared commitments, shared accountability, and clarify roles and responsibilities.	

B. Opioid Settlement Recommendations
2024
1. Provide sustainable resources (essential services) including housing, peer support, care coordination, and flex funds which mirrors the federal COSSUP program. 2. Housing should be focused on stable placement as well as affordability and should include transitional, recovery, supportive living and permanent opportunities for individuals with substance use and mental disorders. 3. Establish a Housing Trust and/or Revolving Loan Fund to support expanding housing opportunities for individuals with substance use and mental disorders. 4. Establish a non-conflicted neutral care coordination 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. 5. Expand Syringe Services Program capacity and opportunities. 6. Expand comprehensive recovery and treatment services, including MAT, for populations with substance use and co-occurring disorders demonstrating high need and prioritizing pregnant and parenting women. 7. Promote recovery-ready work environments and expand transportation and employment opportunities for individuals with SUD and co-occurring MH conditions. 8. Create public awareness campaigns that promote recovery-ready communities focused on improving mental as well as overall health and wellness in order to build resilience in individuals and communities. 9. Create and/or support community-based education or support services for families, youth, and adolescents at risk for SUD and any co-occurring MH conditions which builds resilience, recognizes adverse child experiences and is trauma-informed. 10. Expand County's MH/SUD research capacity and enhance its monitoring, surveillance, data collection, and evaluation capabilities.

C. Prevention and Education Priority Recommendations	
2022	**Status**
1. Educate the community regarding: o Impact of substance use on brain development. o Narcan deployment, safe storage / disposal of prescription drugs (i.e. pill drops and drug take back programs) o How to select providers, avoid unethical providers; and, navigate insurance coverage.	1. IP
2024	
1. Support integrated services in Palm Beach County schools. 2. Advocate for family trainings in and out of schools. 3. Education on Adverse Childhood Experiences (ACEs) the the need for trauma-informed care. 4. Support behavioral health technician's curriculum for high school students and promote MH and SUD professional internships.	

D. Public Policy Priority Recommendations	
2022	**Status**
1. Advocate for policies and legislation that improve standards of care including: integration of behavioral and primary health care;	1. IP 2. IP

adoption of standards of care that are person-centered and recovery-oriented aimed at improving long-term outcomes; and, requirements needed for provider licensure. 2. Advocate for Medicaid expansion.	
2024	
1. Recommendation to BCC that the County lead and/or support comprehensive planning process between the managing entity, Health Care District to drive alignment, coordination, shared commitments, shared accountability, and clarify roles and responsibilities. 2. Engage Palm Beach County policy makers by disseminating Plan and its recommendations. 3. Research, evaluate and recommend changes to federal law mandating 20 year sentence for individuals convicted of death or injury as a result distributing illicit drugs.	

E. Justice System and Public Safety Priority Recommendations	
2022	**Status**
1. Identify / develop alternative community placements in areas where there are few if any available. 2. Identify and provide sustainable resources (essential services) for individuals re-entering the community such as those provided through the Community Services Department's federal grant research project, Comprehensive Opioid, Stimulant, Substance Abuse Program (COSSAP). (Housing and peer support, care coordination, flex funds). 3. Advocate for the Palm Beach County Sheriff's Office to carry and use Narcan when responding to overdose calls.	1. IP 2. IP 3. C
2024	
1. Work with law enforcement and courts to intervene with offenders' misdemeanors earlier and provide treatment options. 2. Demonstrate results through efforts like COSSUP and MAPS. 3. Fund more peer-to-peer efforts in SUD, MI, justice and corrections.	

F. Treatment and Recovery Priority Recommendations	
2022	**Status**
1. Advocate for increased Medication Assisted Treatment (MAT) through mobile services which will help individuals who are without transportation and need the continuing support of MAT. 2. 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. 3. Develop communication protocols and Memoranda of Understanding (MOU) 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.	1. C 2. IP 3. IP
2024	
1. Advocate for options for MAT and evaluate efforts 2. Target efforts to address use disorder and pain to prescribers and support the medical community in peer education. 3. Integrate trauma-informed care.	

G. Essential Services Priority Recommendations	
2022	**Status**
1. Develop, identify, and maintain a real-time inventory (dashboard) of affordable, safe housing (recovery, supportive, transitional and permanent) for persons in recovery and other persons in recovery with diverse needs. (I.e. pregnant women, women with children, families, LGBTQ+, MAT, co-occurring). 2. Identify and disseminate resources to persons in recovery, providers and others related to technical and career training as well as employment services. 3. Establish an Ombudsman and processes to assist individuals removed from, or at risk of being removed, from their housing.	1. NYS 2. IP 3. NYS
2024	
1. Create an up to date list of recovery oriented care options in the County. 2. Implement a housing pilot program.	

3. Support permanent affordable and supportive housing. 4. Encourage medical providers to include social determinants of health in diagnosis.	

H. Evaluation and Monitoring Priority Recommendations	
2022	**Status**
1. Collaborate, coordinate, evaluate and disseminate with the Department of Health (O2DA) to obtain and share timely mental and/or substance disorder related data (i.e. RCI, overdose, Narcan deployment, mobile crisis, ER visits) from hospitals, fire rescue, law enforcement, Health Care District, Southeast Florida Behavioral Health Network and Medical Examiner's Office through a dashboard and other means. 2. Identify entities that are currently not reporting data and advocate for them to be required to do so. 3. Deploy RCI specifically with providers and more broadly in the community in order to collect data to determine success in achieving improvements in long-term recovery outcomes as well as overall community wellness.	1. IP 2. IP 3. C
2024	
1. Dashboard for shared data. 2. Evaluate number of MAT options available to individuals. 3. Maximize use of research and RCI data to improve the health and wellness of clients, program participants, policy makers, families, communities, and partners.	

I. Faith Based Priority Recommendations
2024
1. Engage faith leaders and organizations in the update of the Master Plan and support faith efforts to serve communities. 2. Deploy RCI specifically with faith-based entities in the community in order to collect data to determine success in achieving improvements in long-term recovery outcomes as well as overall community wellness. 3. Advocate funding for Pastor Associations to educate church leaders about recovery-centered resources including Hubs, trauma informed care and importance of destigmatizing substance use and behavioral disorders.

J. Addiction Stabilization Unit Recommendations
2024
1. In partnership with the Health Care District, contract with one emergency department to serve as an addiction stabilization unit and train fire rescue accordingly. 2. Connect emergency services to an outpatient facility and provide case management and social work assistance. 3. Complete an after action review to assess the use of the model and lessons learned.

IV. Foundational Plan Elements

Looking to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to inform the County's person-centered, recovery-oriented framework is beneficial. SAMHSA defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential (SAMHSA, Recovery).

SAMHSA reports 50.2 million American adults considered themselves to be in recovery from their substance use and/or mental health problems. With 2 in 3 adults who ever had a mental health problem considered themselves to be recovering or in recovery and 7 in 10 adults who ever had a substance use problem considered themselves to be recovering or in recovery.

SAMHSA finds recovery is characterized by continual growth and improvement in one's health and wellness and managing setbacks which are a natural part of life, resilience becomes a key component of recovery.

It outlines the Four Major Dimensions of Recovery as follows:

1. **Health** - Overcoming or managing one's disease(s) or symptoms - for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medication if one has an addiction problem- and for everyone in recovery making informed, healthy choices that support physical and emotional well-being.
2. **Home -** Having a stable and safe place to live.
3. **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.
4. **Community** - Having relationships and social networks that provide support, friendship, love, and hope.

SAMHSA also outlines the operational elements of a ROSC as:

- Collaborative decision-making
- Individualized and comprehensive services and supports
- Community-based services and supports
- Continuity of services and supports
- Multiple stakeholder involvement
- Recovery community / peer involvement
- Outcomes-driven
- Adequately and flexibly funded

> Recovery-oriented systems of care (ROSC) are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by severe substance use disorders. The system in ROSC is not a treatment agency, but a macro level organization of a community, a state or a nation.
>
> William L. White
> Author, Slaying the Dragon
> The History of Addiction Treatment and Recovery in America

Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence, to the greatest extent possible, by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. It is essential that the individual become an active partner with care providers in their own recovery process.

A. Development Process

The 2024 Plan has benefited from the collective wisdom and expertise of the BHSUCOD and subcommittee members as well as participants from all fields who met regularly to assess and update strategies and goals for it. Many of the contributors are themselves individuals with lived experience, parents of loss, and individuals who work or have worked in the fields of behavioral health and substance use disorders.

Also contributing to this plan were community champions, representatives from non-profit organizations and county agencies and analyses of community cafés, focus groups and input by participants of the County's fifth annual Facing the Crisis events held in September 2023.

The BHSUCOD subcommittees and OBHSUD staff began development of the Plan Update by assessing each of the strategies and objectives from the 2022 Plan.

The 2019 Behavioral Health Assessment (Assessment) was again considered and the following recommendations are affirmed:

- Develop a common language including the ***use of system-wide taxonomies***, data sharing and common outcome measurements.
- Enhance "no wrong door policies and practices" and ***development of a central assessment and care coordination system*** for the community.

- Continue utilization of system-wide evidence-based practices including the ***development of a true Recovery-Oriented System of Care (ROSC)*** and a comprehensive implementation of care coordination and wraparound services.
- Provide ***peer support in other systems*** beyond behavioral health and child welfare. (The Ronik-Radlauer Group., 2019)

Also noted was the fact that while progress has been made through assessing the BHSUCOD's collaborative efforts silos remain and opportunities to improve were identified as follows:

- Expanding efforts to educate the community about behavioral health to increase awareness and decrease stigma;
- Having providers, funders, and other stakeholders work together to address the behavioral health needs in Palm Beach County;
- Break down silos across sectors, populations, and communities;
- Examine outcomes, which is critical to an understanding of the effectiveness and efficacy of services provided; *and*
- Have funders of behavioral health services collaborate through the potential development of shared data and shared outcomes.

The BHSUCOD affirms the Assessment's recommendations that the CSD focus its funding allocations on the Support Services category to include: expanding care coordination to populations that are not considered "high utilizers", encourage wraparound case management for all populations and prioritize funding for individuals and families experiencing co-occurring psychiatric, substance use and other complex conditions.

Currently, there are eight (8) subcommittees designed to align with the BCC's strategic priorities within behavioral health and substance use disorders. The subcommittees are:

1. Prevention and Education
2. Treatment and Recovery
3. Public Policy
4. Justice System and Public Safety
5. Evaluation and Monitoring
6. Essential Services
7. Faith Based
8. Addiction Stabilization Unit

B. Infrastructure

Implementing and operationalizing an integrated, coordinated person-centered, recovery-oriented system of care requires a foundation (i.e., infrastructure) to be in place. This infrastructure must consist of:

- A continuum of care starting with prevention and including early intervention, treatment, and long-term recovery.
- Neutral care coordination.
- Utilization of valid tools to identify appropriate levels of care throughout the continuum.
- Provide for movement across and between levels of care as needed
- Be evaluated and monitored to ensure data are being collected, analyzed and used to inform outcomes, measure the impact and effectiveness of strategies and assess long-term recovery outcomes, and adjust strategies as necessary.

Client satisfaction and measures of wellness through recovery capital indexing also must be obtained to ensure that the focus remains on individualized needs. Accordingly, the system must be able to rely and capitalize on:

- Cross-agency cooperation and communication
- Person-centered individualized planning
- Outcomes as a measure of success, rather than measuring success by completion of treatment
- Funding that emphasizes and supports the development of community-based and accessible (in the broadest sense) resources

Barriers that affect engagement in treatment and recovery, such as premature medical facility discharges, must be continually identified and removed. Providers must recognize the importance of communicating with each other for shared clients and the necessity of collecting and using data to promote genuine and holistic individualized care. Recovery is a journey, regardless of substance used or pathway taken. Treatment is simply a step on the path to recovery that requires planning and individualization of recovery supports. This and building resilience are the key to success and will save lives as well as help reduce repeated cycling in and out of deep-end treatment.

C. **Neutral Care Coordination**

Neutral Care Coordination (NCC) is an essential building block for establishing this *system of care*. It is defined as 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.

Neutral Care Coordination 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.

Neutral care coordinators are not tied to any provider organization and are responsible for assessing and referring individuals based on identified need, rather than based on availability within a particular entity. It incorporates neutrality into "[c]are coordination … 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". This model is utilized for chronic medical conditions, so substance use disorders, which are chronic health conditions, should be handled in the same manner.

Utilizing an unaffiliated, external, neutral specialist as a care coordinator is the most effective and unbiased way to obtain a true person-centered, recovery-oriented system of care while at the same time contributing to the elimination of unnecessary and duplicative services and repetitive cycling into deep-end treatment without any differences in outcomes. Providing care based on need is expected to free up financial resources that can be invested into community-based care, which is imperative for client access.

Neutral Care Coordination embeds the idea that individuals in recovery do not need the added obstacle of navigating an unconnected set of supports on their own. As such, there must be shared responsibility and accountability across providers to ensure that individuals are seamlessly transferred from the care of one provider to the next in a way that supports the individual and facilitates connection to identified and necessary services and supports.

Neutral care-coordinators can fulfill this role and providers also can support these practices by facilitating warm transfers of their clients, creating an atmosphere of transparency before, during and after such transfers, and by keeping focused on patient needs, choices and outcomes. Regardless of where or when transfers of clients occur, the expectation must be that there is cooperation and communication between providers which takes place electronically, over the phone, face-to-face, or via video-chat.

D. Utilization of Valid Tools to Identify Appropriate Levels of Care

Measurements to assess and inform individualized needs should include but not be limited to the use of the following validated tools and strategies:

- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Depression and Suicide screenings
- American Society of Addiction Medicine (ASAM) criteria or Level of Care Utilization System (LOCUS) to determine appropriate levels of care
- Completion of the Adverse Childhood Experiences (ACEs) and resiliency questionnaire.
- Completion of the Recovery Capital Index (RCI)
- Use of Motivational Interviewing and trauma informed care.

Throughout an individual's journey of recovery, the neutral care coordinator should continually engage the client to assess if any additional supports or services are needed for recovery as well as to identify and help remove barriers that may make, stall or hinder progress while in recovery. Additionally, there should be regular check-ins to ensure services and supports continue to be effective and needed.

Recovery and peer supports are critical to individual recovery and serve as the underpinning of the system of care model described heretofore. RCOs and RCCs help individuals build relationships, increase their social capital, learn how to apply new or re-learned recreational skills in a sober environment and build confidence in their ability to remain in recovery long-term.

> Recovery Capital is the depth and breadth of internal and external resources that can be used by someone to begin and sustain wellness from addiction.
>
> (Granfield & Cloud, 1999).

Recovery capital is a concept that respects the entire presence and experience of a person. Most definitions of recovery capital — like the one below — shift the focus from the reasons one has an addiction to the components that promote recovery. "Whether we're in a state of addiction or in a state of recovery, we're still pulling from the same social, economic, and environmental components that promote or hinder wellbeing. Recovery, like life for someone not affected by addiction, is an ongoing dialogue with those components. We can best think of recovery capital as a specialized representation of wellbeing".

The RCI is a "scientifically validated survey instrument that provides a multidimensional measure of wellbeing. It effectively measures change regardless of treatment modality or intervention at individual and population levels. Care can be personalized, while individuals see success reinforced." The RCI has also been validated through research and is used to guide treatment and assess recovery.

E. Provision for Movement Across and Between Levels of Care

Anyone who enters the *system of care* should expect to be treated with dignity and in a culturally and linguistically respectful manner. Clients must be assessed holistically to ensure that they have access to what they require in terms of individually identified needs, including, but not limited to: housing, education and/or training for employment, mental health services, substance use treatment, community connections, safe spaces for peer connections, attention to physical health and access to nutritious food and safe water.

F. Evaluate and Monitor Data Collected and Analyze to Inform Outcomes

Required data must be valid, reliable, and timely. For providers that contract with CSD OBH-SUD, data are to be entered into the identified system in the manner called for and at the times required. Data are critical for determining if outcomes are improving and where focus may need

to be redirected or intensified. Data should be continually reviewed, shared with individuals and used for decision making. The RCI, a measure of recovery wellness, provides a unique opportunity to engage clients and when combined with motivational interviewing, has the advantage of helping clients hypothesize reasons and possible actions based on what they see from their own results and scores over time.

G. Contractual relationships

Contracts must focus on short and long-term outcomes, clearly define accountability, expected outputs and outcomes, and provide clear definitions of process metrics, anticipated outcomes measures and expectations of contractors. Contracts must require providers to communicate with each other, share data on common clients with client consent and ensure that each client's voice is heard.

Additionally, identical or substantially similar services should not be provided simultaneously to any individual, nor should any clients receiving services from more than one provider hear conflicting information from multiple providers. Further, clients should not be left to navigate through the system of care (providers, resources, etc.) on their own.

These kinds of tasks are for neutral care coordinators who should be working with individuals, identifying whether services are meeting needs and if not, re-referring and removing any barriers that will help ensure a true "no wrong door" approach. This includes co-occurring conditions and complex cases. Contractors must be held accountable fiscally and substantively. Reimbursements or payments are to be clearly supported by documentation according to contractual obligations.

Contracts in behavioral health and substance use disorders must be:

- Transparent on permitted spending and documentation for reimbursement
- Providers must have qualified staff who will work with clients that have complex issues
- Staff must have the capacity and ability to implement services and supports with fidelity
- Staff must be knowledgeable and able to implement effective practices
- Staff must utilize strategies premised on equity and multicultural awareness
- Staff must be able to tailor approaches and strategies on an individualized basis
- Staff must be able to establish short and long term goals with expected outcomes in individualized, person-centered plans
- Programs and services should routinely assess client satisfaction with both the provided services and the specific provider(s) and/or entity and
- Contractors should ensure clients experience smooth transitions with warm-hand-offs.

Client essential needs must be considered and planned for in a recovery-oriented manner. Additionally, when developing a budget utilizing a per-person, per-contact, or per-service as the defined "unit of cost" will not be sufficient. Instead, costs are to be based on quality of services, established recovery-oriented outcomes and quantifiable costs that are directly attributed to an individual and the actual services that were provided.

Services and supports should not only be available to those who can afford them or for individuals that are fortunate enough to get "scholar-shipped in". Implementing a person-centered, recovery-oriented system of care requires a focus on the person's needs and also the acceptance of each individual at the point in time when their individual journey to recovery begins.

VI. Proposed "Theory of Action" for getting to a coordinated person-centered, recovery-oriented system of care.

Beginning with the end in mind, this theory of action provides strategies and steps that will enable Palm Beach County, through neutral care-coordination and a coordinated network of public and private sector providers to realize its goal of implementing a person-centered recovery oriented system of care that is both integrated and coordinated across and between providers. A system that recognizes the importance of looking at individuals holistically and actualizes a "no wrong-door" approach through warm hand-offs and coordinated follow-up care that addresses essential needs and services that support long term recovery.

Typically, a Theory of Action describes how a project or a program is designed and set up. It articulates the mechanisms through which the activities are being delivered, e.g. through which actors (for example, NGOs, government or markets) and following which processes (for example, grants to NGOs disbursed from a challenge fund, provision of technical assistance, advocacy activities, or the establishment of partnerships). (Coffee) Additionally, within each of the following "buckets" the BHSUCOD subcommittees have identified a number of issues and strategies to address them which comprise the roadmap for this Strategic Plan.

A. Opioid Settlement

Palm Beach County has been harmed by misfeasance, nonfeasance and malfeasance committed by certain entities within the pharmaceutical industry which fueled an opioid epidemic and exacted a high price in overdose deaths as well as significant harm to families, friends and the Palm Beach County community at large. It is only fitting that the Settlement funds realized should be dedicated to effectuating the BCC's aims of establishing a person-centered, recovery-oriented system of care that promotes resilience and recovery. These funds should be appropriated in a targeted way to ensure this aim is achieved and adheres to the Plan Update's mission, vision and values, guiding principles as well as research and evidence.

Issues – Opioid Settlement	
1. Palm Beach County and its residents were harmed by acts of the pharmaceutical industry causing an opioid epidemic. 2. Ensure Settlement funds are appropriately leveraged to address these harms.	
Why	
1. Settlement funds can effectuate establishment of person-centered, recovery-oriented system of care.	
How (strategies)	
1. Provide sustainable resources (essential services) including housing, peer support, care coordination, and flex funds which mirrors the federal COSSUP program. 2. Housing should be focused on stable placement as well as affordability and should include transitional, recovery, supportive living and permanent opportunities for individuals with substance use and mental disorders. 3. Establish a Housing Trust and/or Revolving Loan Fund to support expanding housing opportunities for individuals with substance use and mental disorders. 4. Establish a non-conflicted neutral care coordination 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. 5. Expand Syringe Services Program capacity and opportunities. 6. Expand comprehensive recovery and treatment services, including MAT, for populations with substance use and co-occurring disorders demonstrating high need and prioritizing pregnant and parenting women. 7. Promote recovery-ready work environments and expand transportation and employment opportunities for individuals with SUD and co-occurring MH conditions.	

8. Create public awareness campaigns that promote recovery-ready communities focused on improving mental as well as overall health and wellness in order to build resilience in individuals and communities. 9. Create and/or support community-based education or support services for families, youth, and adolescents at risk for SUD and any co-occurring MH conditions which builds resilience, recognizes adverse child experiences and is trauma-informed. 10. Expand County's MH/SUD research capacity and enhance its monitoring, surveillance, data collection, and evaluation capabilities.	
Accountability	
1. Complete monitoring, surveillance and evaluation of initiatives related to Settlement funds. 2. Development tracking systems for essential services initiated through these Settlement funds. 3. Contracts and agreements established with Settlement funds shall integrate recovery capital indexing as well as other health and wellness measures.	

B. Prevention and Education

Evidence-based prevention programs can dramatically reduce rates of substance use and SUD. These programs can also be highly cost-effective. Rigorous evaluations have found many prevention programs are good long term economic investments, returning more to society than they cost. Evidence-based prevention interventions, especially those that focus on early childhood, do more than decrease drug use; they also reduce mental health problems and crime and promote academic motivation and achievement. Thus, these programs can have tremendous, long-term benefits for the children and families they serve, as well as for society as a whole. The Prevention and Education subcommittee's responsibilities are to include, but not be limited to, establishing prevention and harm-reduction activities and education for residents in schools and communities.

Issues – Prevention and Education	
1. Insufficient school-based prevention / education services or community engagement programs. 2. Prevention programs are utilized yet these interventions are often not tailored to specific target populations. 3. Data are not being used to assess community readiness. 4. Lack of training of emergency personnel, healthcare professionals, and pharmacists in person-centered, recovery-oriented system of care model and the benefits of recovery capital indexing. 5. Lack of community awareness related to supports available including law enforcement, prevention strategies and treatment options.	

Why	
1. Too many residents are overdosing or dying as a result of substance use disorders. 2. Tailored education, prevention and interventions will provide residents with a better understanding of warning signs of mental and substance use disorders.	
How (strategies)	
2022	**Status**
1. Develop prevention programs at different levels (individual, family, school, faith-based organizations) that are tailored to specific target population needs. 2. Develop, disseminate community readiness surveys and results to inform development of targeted interventions. 3. Create dashboard reporting on current trends and mapping by zip code. 4. Develop a Countywide Strategic Prevention Framework which targets specific community conditions to reduce opportunities for substance use and to enhance healthy lifestyle choices. 5. Educate the community regarding: o Impact of substance use on brain development. o Narcan deployment, safe storage / disposal of prescription drugs (i.e. pill drops and drug take back programs) o How to select providers, avoid unethical providers; and, navigate insurance coverage. 6. Train educators on early warning signs and symptoms of mental and substance use disorders and school nurses on evidence-based assessment screening tools. 7. Advocate for mental illness, substance use disorder and trauma training in schools of medicine and pharmacy; and with emergency room and healthcare professionals, first responders and pharmacists. 8. Develop a Good Samaritan Law public awareness campaign. 9. Establish a media committee responsible for developing a communications plan.	1. IP 2. IP 3. IP 4. C 5. IP 6. IP 7. IP 8. C 9. IP
2024	
1. Support integrated services in Palm Beach County schools. 2. Advocate for family trainings in and out of schools. 3. Education on Adverse Childhood Experiences (ACEs) and the need for trauma-informed care. 4. Provide various outlets for youth to express their behavioral health needs including the arts, exercise, parks, etc. 5. Emphasize the importance of coping and self-care plans in building resilience.	

6. Support behavioral health technicians' curriculum for high school students and promote MH and SUD professional internships.	
Accountability	
1. Track trainings and activities provided and detail type, target audience, number of participants, and outcomes achieved. 2. Track community readiness activities and detail assessments conducted, target community, and any outcomes achieved. 3. Track progress and completion of the Strategic Prevention Framework. 4. Track progress and completion of other prevention and education strategic objectives.	

C. Public Policy

Public policy seeks to define issues and implement strategies that will produce a measurable and positive result for the general public. It defines a problem, gathers evidence, identifies causes, reviews any current policies, and strategizes solutions that anticipate the social response. Careful consideration of benefits and costs are key factors in implementing a policy that will elicit a positive, measurable outcome. The Public Policy subcommittee's responsibilities are to include, but not be limited to, identifying, reviewing, and monitoring related public policies and legislation; and engaging, educating, and informing public officials, key strategic partners and constituency members in advancing sound public policy.

Issues – Public Policy	
1. Need for better alignment of behavioral health system of care entities to effectuate collaborative budgeting and planning and implementation of the Board's strategic aim to establish a person-centered, recovery-oriented system of care that is readily accessible and integrated. 2. There is no enforcement of the federal mental health parity law. 3. Mental and substance use disorder providers are currently regulated by the Department of Children and Families (DCF) which is regulatory inconsistent when these disorders are viewed as a primary health issue and should be moved from DCF to the Department of Health. 4.	
Why	
1. Mental Health Parity enforcement will allow County residents to have reliable access to a wide range of mental health, substance use and co-occurring disorder services; a choice of providers; and, be given recourse to effectively challenge caps on services.	

2. Consistent with the charge of the advisory committee as stated in the county resolution "to enhance the County's capacity and effectiveness in formulating comprehensive, integrated, and effective behavioral health, substance use and co-occurring disorders prevention, treatment, support, and recovery policies."	
How (strategies)	
2022	**Status**
1. BCC enactment of ordinance designating lead entity granting it leadership, budget, planning and monitoring authority. 2. Advocate for the reinstatement of statewide Drug Czar's Office and dedicated funding for it. 3. Advocate for policies and legislation which advance person-centered, recovery-oriented systems of care that are readily accessible and integrated. 4. Advocate for policies and legislation that improve standards of care including: integration of behavioral and primary health care; adoption of standards of care that are person-centered and recovery-oriented aimed at improving long-term outcomes; and, requirements needed for provider licensure. 5. Advocate for Medicaid expansion. 6. Educate the community on how to report non-compliance with parity laws. 7. Transfer regulatory responsibility for mental and substance use disorder services from Department of Children and Families to the Department of Health. 8. Advocate that the Florida Opioid Abatement Task Force have at least one physician and at least one representative from an organization that works with individuals with mental, substance use and/or co-occurring disorders and at least one person to represent parents of loss, individuals with lived experience, or individuals in recovery. 9. Develop spending plan for settlement funds that is strictly for funding mental health, substance use and co-occurring disorder services.	1. C 2. C 3. IP 4. IP 5. IP 6. IP 7. NYS 8. C 9. C
2024	
1. Recommendation to BCC that the County lead and/or support comprehensive planning process between the managing entity, Health Care District to drive alignment, coordination, shared commitments, shared accountability, and clarify roles and responsibilities. 2. Engage Palm Beach County policy makers by disseminating Plan and its recommendations. 3. Research, evaluate and recommend changes to federal law mandating 20 year sentence for individuals convicted of death or injury as a result distributing illicit drugs.	

Accountability	
1. Track progress and enactment of legislation: o Designating a County lead entity. o Making parity enforceable. o Placing Mental Health and Substance Use Disorders under the State Department of Health. o De-criminalizing fentanyl test strips. o Expanding Baker and Marchman Act. o Expanding housing inventory for persons in recovery. 2. Track progress of Florida Opioid Abatement Task Force recommended membership. 3. Track progress on Opioid Settlement Plan for funding mental health, substance use and co-occurring disorder services. 4. Track progress and completion of other public policy strategic objectives.	

D. Justice System and Public Safety

Individuals with mental and substance use disorders involved with the criminal justice system has enormous fiscal, health, and human costs and remain a challenge. It is well known, many offenders with mental and substance use disorders still do not receive treatment during incarceration. This is not only a disservice to the offenders and their families; it is a threat to public safety. Diverting these individuals away from jails and prisons and toward more appropriate and culturally competent community-based care must be an essential component of any strategies aimed eliminating unnecessary involvement in the criminal justice system.

Issues – Justice System and Public Safety	
1. Low utilization of drug- and related courts and lack of diversion services to decrease criminalization of substance use disorders and/or co-occurring disorders. 2. Individuals released from incarceration frequently do not remain engaged in services and often recidivate due to a lack of stable housing, support services and care coordination. 3. Law enforcement transport of individuals in mental health crisis.	
Why	
1. County correctional facilities and law enforcement personnel have become a de-facto system of care that is expensive, promotes inequity and does not promote recovery.	
How (strategies)	
2022	**Status**

1. Identify / develop alternative community placements in areas where there are few if any available. 2. Identify and provide sustainable resources (essential services) for individuals re-entering the community such as those provided through the Community Services Department's federal grant research project, Comprehensive Opioid, Stimulant, Substance Abuse Program (COSSAP). (Housing and peer support, care coordination, flex funds). 3. Develop plan to expand law enforcement partnerships and data access to increase ability to target over-prescribers. 4. Advocate for the Palm Beach County Sheriff's Office to carry and use Narcan when responding to overdose calls.	1. IP 2. IP 3. C 4. C
2024	
1. Work with law enforcement and courts to intervene with offenders' misdemeanors earlier and provide treatment options. 2. Demonstrate results through efforts like COSSUP and MAPS. 3. Fund more peer-to-peer efforts in SUD, MI, justice and corrections.	
Accountability	
1. Track diversion programs and maintain a system that will enable appropriate referrals, real-time availability and criteria for enrollment. 2. Track numbers of individuals who are enrolled in diversion programs and related outcomes. 3. Track progress and completion of other justice system and public safety strategic objectives.	

E. Treatment and Recovery

Individuals with mental and substance use disorders involved with the criminal justice system has enormous fiscal, health, and human costs and remain a challenge. It is well known, many offenders with mental and substance use disorders still do not receive treatment during incarceration. This is not only a disservice to the offenders and their families; it is a threat to public safety. Diverting these individuals away from jails and prisons and toward more appropriate and culturally competent community-based care must be an essential component of any strategies aimed eliminating unnecessary involvement in the criminal justice system. The Treatment and Recovery subcommittee's responsibilities are o include, but not be limited to, establishing a coordinated Recovery-Oriented System of Care (ROSC); integrated behavioral health; expanding Peer Recovery Support Services (e.g., Recovery Community Organization/Recovery Community Centers (RCO/RCCs); access to Medication-Assisted Treatment (MAT); and creating a neutral care coordination entity.

Issues – Treatment and Recovery	
1. On-going silos when it comes to client care and fragmentation/disjointed care from multiple treatment, social and recovery support providers. 2. Determinations of client treatment that are based on the services available at a particular provider, rather than on individualized needs; 3. Ineffective transitioning of clients from one level of care or one service provider to another. 4. Lack of timely sharing of needed treatment information among providers. 5. Lack of monitoring and follow-up to ensure client engagement. 6. Lack of accountability and agreed upon responsibilities among multiple treatment, social and recovery support providers serving one client. 7. Getting access to care at reasonably comparable reimbursement rates and overcoming hurdles such as a lack of transportation to get to a provider are barriers to getting help for behavioral health, substance use and/or co-occurring disorders. 8. Having the right type of treatment at the right time for clients is a barrier to obtaining the services and supports needed to get to recovery. 9. Insurance can often be a barrier to obtaining needed services and it can also restrict the number of days that services are able to be provided. 10. Lack of detoxification services for benzodiazepines. 11. There are insufficient recovery support services (i.e. housing, transportation) for persons discharged from the Addiction Stabilization Unit and provider settings. 12. Where and how individuals get to services and supports for care and treatment of behavioral health and/or substance use disorders is too frequently based on where and by whom they are screened and assessed for services, treatment, or care.	
Why	
1. A "no wrong-door" person-centered, recovery-oriented system of care approach will help identify and remove barriers (including access related barriers) and serve as a bridge between providers and needed recovery supports. 2. Without reasonable reimbursement rates, the few existing providers will not provide needed services and getting help will be more difficult, especially with provider shortages. 3. Access to properly trained providers who have availability is a critical prerequisite for clients seeking care that is person-centered and recovery oriented.	

4. Without sufficient coverage, many individuals are challenged to find providers that will work with them and/or have choices limited by the availability of providers who are able to work with a client and obtain a scholarship on their behalf. 5. PBC residents will be able to access individually identified services that are based on person-centered informed choice and individualized recovery plans	
How (strategies)	
2022	**Status**
1. 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 and remove barriers. 2. Reimburse virtual care at competitive rates and that are comparable to face-to-face rates in order to increase the number of potential clients that will be able to secure behavioral health services. 3. Advocate for increased Medication Assisted Treatment (MAT) through mobile services which will help individuals who are without transportation and need the continuing support of MAT. 4. Utilize medical detailing to educate physicians and emergency room personnel on MAT and Screening, Brief Intervention and Referral to Treatment (SBIRT). 5. Educate the community about MAT, including non-traditional partners and the faith-based community. 6. Educate providers on prescription monitoring. 7. Engage post-secondary institutions and other entities to recruit and educate students to become licensed and certified clinicians. 8. Identify and provide training opportunities in evidence-based, evidence-informed promising practices. 9. Identify and develop alternative funding sources for un- or under- insured individuals. 10. Engage and educate health insurers about mental, substance use and co-occurring disorders and co-occurring disorders which will involve community members in outreach efforts. 11. Engage the recovery community to recruit and educate persons with lived experience to become Certified Recovery Peer Specialist (CRPS). 12. Develop policies and trainings for neutral care coordination that will ensure essential skills related to the implementation of the County's system of care model.	1. IP 2. C 3. C 4. IP 5. IP 6. IP 7. IP 8. IP 9. IP 10. IP 11. IP 12. IP 13. IP 14. IP

13. Collaborate and coordinate across entities serving individuals with substance use disorders and/or co-occurring mental health and substance use disorders 14. Develop communication protocols and Memoranda of Understanding (MOU) 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.	
2024	
1. Advocate for options for MAT and evaluate efforts 2. Target efforts to address use disorder and pain to prescribers and support the medical community in peer education. 3. Integrate trauma-informed care.	
Accountability	
1. Develop and maintain resource that identifies programs that are available, criteria for acceptance into programs, types of services and how to access programs (i.e., referrals to whom and how to ensure referral is acted upon.) 2. Develop MOU related to data sharing across agencies. 3. Track number of individuals served by the ASU and related outcomes. 4. Track number of warm-handoffs through neutral care coordination and related outcomes. 5. Track status and implementation of neutral care coordination proposal. 6. Track progress and completion of other treatment and recovery strategic objectives.	

F. Essential Services

Essential Services (formerly Ancillary Services) more accurately reflects the critical nature of key long-term predictors of long-term recovery outcomes (i.e. housing stability, employment, strong family/society connection, altruism) to achieving the BCC's aim to establish a person-centered, recovery-oriented system of care that is readily accessible and integrated. These and other predictors are also referred to as social determinants of health which are conditions in the environments people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Social determinants have a major impact on health outcomes-especially for the most vulnerable populations and must be considered when providing person-centered, recovery-oriented care. Thus, when resources are available to overcome negative social determinants of health, they can have a significant impact on individual and population health outcomes. The Essential Services subcommittee's responsibilities are to include, but not be limited to, advancing social determinants of health such as food, housing, employment, education, access to medical care, and the collateral consequences of criminal justice involvement.

Issues – Essential Services	
1. Insufficient inventory of available, affordable, safe housing (recovery, supportive, transitional and permanent) for persons in recovery and other persons in recovery with diverse needs. (i.e. pregnant women, women with children, families, LGBTQ+, MAT, co-occurring) 2. Lack of awareness of existing career and job assistance programs.	
Why	
1. Sufficient inventory of safe, supportive, affordable, alcohol and drug-free housing and employment opportunities are key predictors of long-term recovery outcomes.	
How (strategies)	
2022	**Status**
1. Collaborate with Florida Association of Recovery Residences and the State Attorney Addiction and Recovery Task Force to oversee recovery residences and deploy Recovery Capital Indexing. 2. Collaborate with Oxford House to include its inventory in accounting of available, affordable, safe housing and substance-free living spaces. 3. Develop, identify, and maintain a real-time inventory (dashboard) of affordable, safe housing (recovery, supportive, transitional and permanent) for persons in recovery and other persons in recovery with diverse needs. (I.e. pregnant women, women with children, families, LGBTQ+, MAT, co-occurring). 4. Develop respite capacity lost because of Ted's Place closure to include housing first like options for those actively using. 5. Establish an Ombudsman and processes to assist individuals removed from, or at risk of being removed, from their housing. 6. Establish a recovery high school program. 7. Identify and disseminate resources to persons in recovery, providers and others related to technical and career training as well as employment services. 8. Educate the recovery community about existing and emerging public transportation services programs. 9. Conduct Americans with Disabilities Act (ADA) trainings.	1. IP 2. IP 3. NYS 4. IP 5. NYS 6. NYS 7. IP 8. IP 9. NYS
2024	
1. Create an up to date list of recovery oriented care options in the County. 2. Implement a housing pilot program.	

3. Support permanent affordable and supportive housing. 4. Encourage medical providers to include social determinants of health in diagnosis.	
Accountability	
1. Track progress and completion real-time inventory of available, affordable, safe housing homes. 2. Track progress and completion of career preparation and employment services resources made available for persons in recovery. 3. Track progress and completion of other essential services strategic objectives.	

G. Evaluation and Monitoring

Evaluation and monitoring are critical for assessing the range of interventions being implemented to mental and substance use disorders. It helps determine exactly when an intervention is on track and when changes may be needed. Evaluation and monitoring are also used to demonstrate that efforts have had a measurable impact on expected outcomes and have been implemented effectively. It is essential in helping managers, planners, implementers, and policy makers acquire the information needed to make informed policy and programmatic decisions; guide strategic planning; design and implement programs; and allocate resources. The Evaluation and Monitoring subcommittee's responsibilities are to include, but not be limited to, implementing a Recovery Capital instrument; measuring and tracking treatment outcomes across the care continuum using advanced analytics to establish evidence-based best practices; increasing Committee member participation in monitoring of publicly funded treatment and recovery programs and services.

Issues – Evaluation and Monitoring	
1. Numerous gaps and barriers still remain for obtaining data needed to see the trends and determine areas in which additional focus and attention. 2. Historic treatment outcome data (i.e. successful treatment discharge) is not a reliable measure related to the County's goal of improving long-term recovery outcomes and quality of care.	
Why	
1. Without data it is not possible to see patterns and trends and make data-informed decisions.	
How (strategies)	
2022	**Status**

1. Collaborate, coordinate, evaluate and disseminate with the Department of Health (O2DA) to obtain and share timely mental and/or substance disorder related data (i.e. RCI, overdose, Narcan deployment, mobile crisis, ER visits) from hospitals, fire rescue, law enforcement, Health Care District, Southeast Florida Behavioral Health Network and Medical Examiners Office through a dashboard and other means. 2. Identify entities that are currently not reporting data and advocate for them to be required to do so. 3. Deploy RCI specifically with providers and more broadly in the community in order to collect data to determine success in achieving improvements in long-term recovery outcomes as well as overall community wellness. 4. Utilize Overdose Mapping (High Intensity Drug Trafficking Areas (HIDTA)) data.	1. IP 2. IP 3. C 4. IP
2024	
1. Dashboard for shared data. 2. Evaluate number of MAT options available to individuals. 3. Maximize use of research and RCI data to improve the health and wellness of clients, program participants, policy makers, families, communities, and partners.	
Accountability	
1. Track progress and completion of data dashboard. 2. Track utilization of RCI surveys and the number of housing, education and employment opportunities that have been initiated and provided based on needs identified through the survey results. 3. Review and analyze data and prepare quarterly reports to the Advisory Committee which addresses data quality and additional data needs. 4. Track progress and completion of other evaluation and monitoring strategic objectives.	

H. Faith-based

Faith, spirituality and altruism play an important role in achieving long-term recovery outcomes. Faith and community leaders are often the first point of contact when individuals and families face substance use, mental and co-occurring disorders. The Faith-based subcommittee's responsibilities are to include, but not be limited to, advancing inter-faith understanding of mental illness and substance use disorder and the important role of faith communities in a recovery oriented system of care environment.

Issues – Faith-based	

1. Faith leaders have developed innovative strategies like Recovery Church to serve as a point of entry and support for substance use disorder and behavioral health.	
Why	
2. The faith-based community in Palm Beach County plays a pivotal role in community efforts as part of a ROSC.	
How (strategies)	
1. Engage faith leaders and organizations in the update of the Master Plan and support faith efforts to serve communities. 2. Deploy RCI specifically with faith-based entities in the community in order to collect data to determine success in achieving improvements in long-term recovery outcomes as well as overall community wellness. 3. 3. Advocate funding for Pastor Associations to educate church leaders about recovery-centered resources including Hubs, trauma informed care and importance of destigmatizing substance use and behavioral disorders.	
Accountability	
1. Track engagement of faith based leaders in subcommittees and the Advisory Committee. 2. Track utilization of RCI surveys competed through faith based entities.	

I. Addiction Stabilization Unit (ASU)

The ASU is a unique public-private partnership designed to address the immediate and critical care of individuals experiencing medical emergencies due to opioid or other substance use disorders. The model as originally designed, provided a central location with an emergency room component that allowed for lifesaving overdose intervention delivered within the ASC and a "warm hand off" to an adjacent outpatient clinic operated by Health Care District where medication for opioid disorder and other medication assisted treatments and behavioral health services could be initiated or continued by a specialized, addiction-trained medical team. The ASU subcommittee is responsible for working with the Palm Beach County Health Care District to review ASU patient care and related matters as well as make recommendations related to such when appropriate.

Issues – Addiction Stabilization Unit	
1. Evidence based practice indicates that specialized emergency services with a "warm hand off" are especially effective with overdose patients. 2. Connecting patients to an outpatient center avoids subsequent overdose and use patterns. 3. Community concern about fidelity to the ASU model as it was initially operationalized.	
Why	

1. Palm Beach County needs a model where fire and rescue agencies bypass the closest hospital to transport overdose patients to an emergency department that specializes in substance use disorder.	
How (strategies)	
2024	
1. In partnership with the Health Care District, contract with one emergency department to serve as an addiction stabilization unit and train fire rescue accordingly. 2. Connect emergency services to an outpatient facility and provide case management and social work assistance. 3. Complete an after action review to assess the use of the model and lessons learned.	
Accountability	
1. Track utilization of services each month. 2. Monitor use by social determinant of health status and follow up.	

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

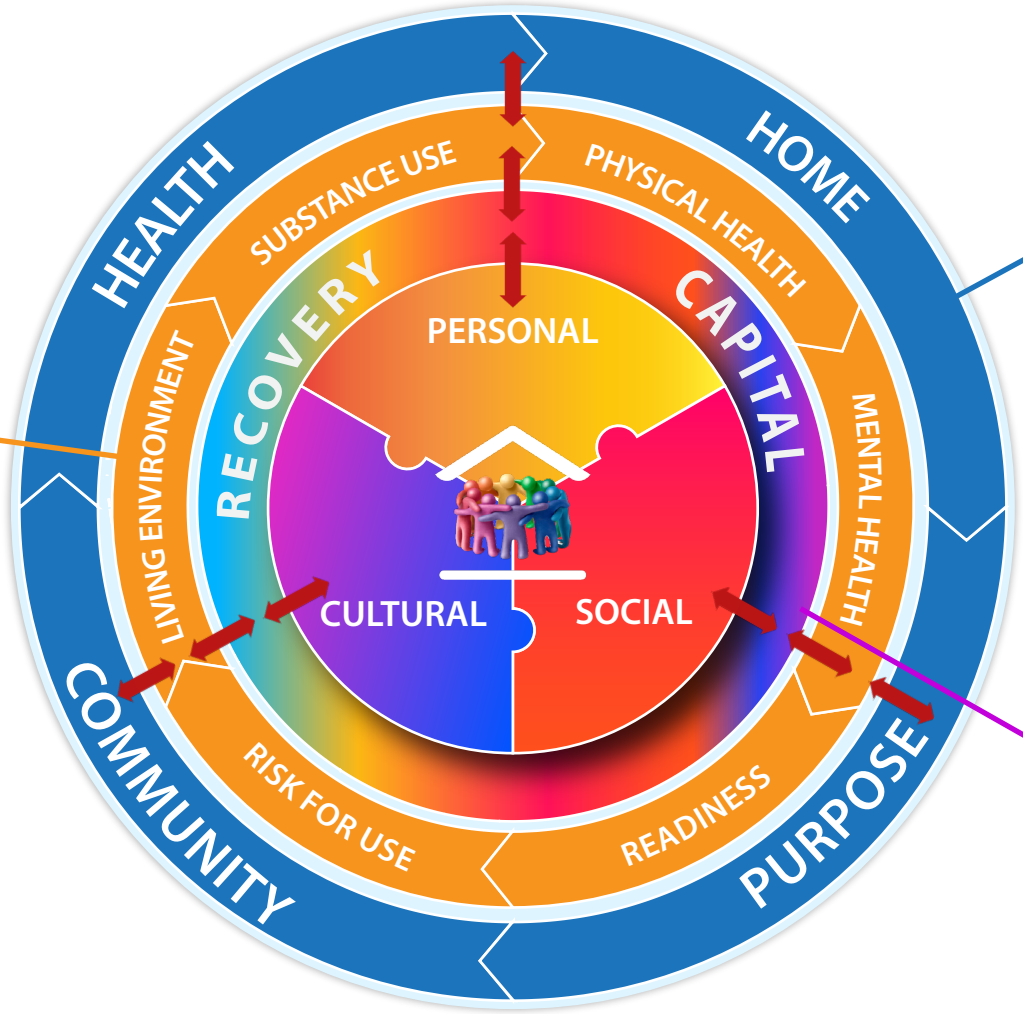
BIOMEDICAL CONDITIONS AND COMPLICATIONS
Exploring an individual's health history and curretn physical condition

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

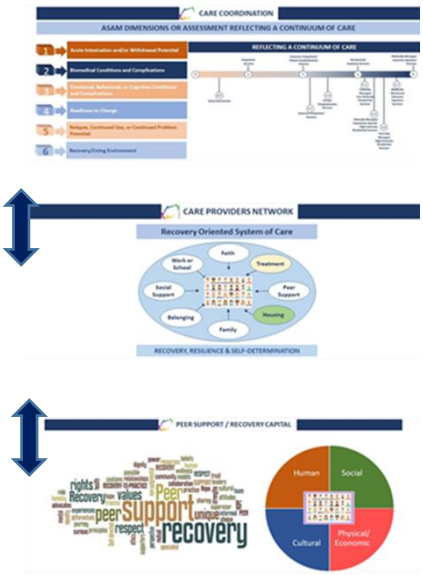
In July 2021, the Community Services Department (CSD) with the assistance of a team with expertise in neutrally coordinating and managing substance use disorder and mental health care completed a detailed proposal, "*Establishing a Palm Beach County Neutral Care Coordination Entity and executing a person-centered, 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.

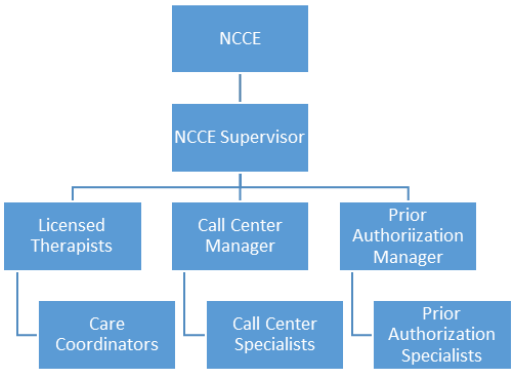
NCADD-NJ through its Work First New Jersey Substance Abuse and Behavioral Health Initiative has coordinated the substance use and behavioral health care of approximately 5,800 (unduplicated) individuals annually for the state's welfare to work population since 1998. It reports that in 2022, through validated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

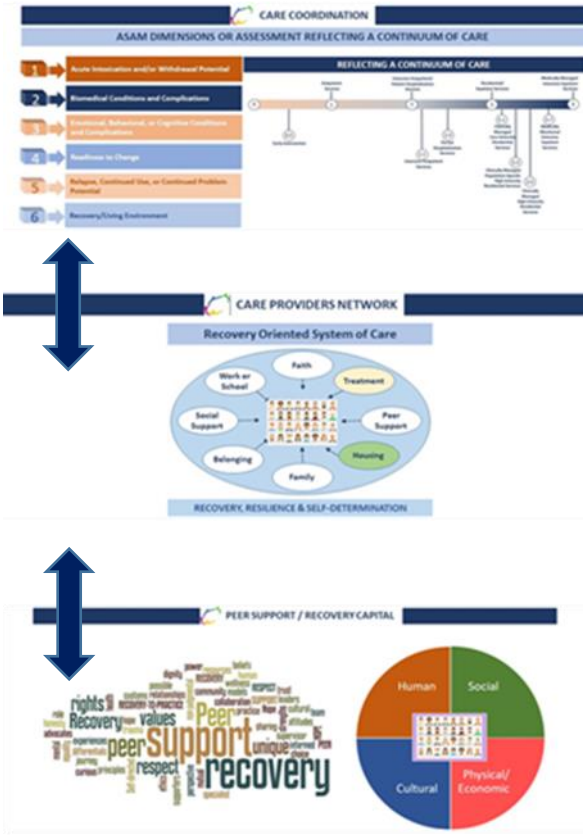
The BCC identified as an important goal the establishment of a readily accessible, integrated, person-centered and coordinated recovery-oriented system of care that commits to quality, evidence-based addiction and mental health services and integration of the Addiction Stabilization Facility.[1] Since,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

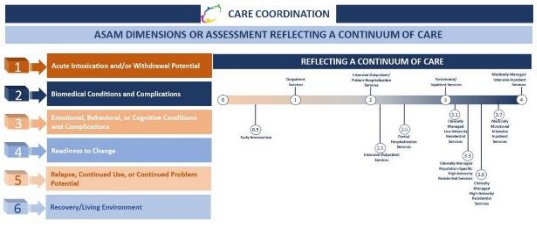
- Implement care coordination.
- Establish recovery community organizations and recovery community centers; broaden the reach of peer support services across the continuum.
- Launch a Recovery Capital Instrument and train providers in its use.
- Support the PBC Healthcare District's (HCD) efforts to 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.

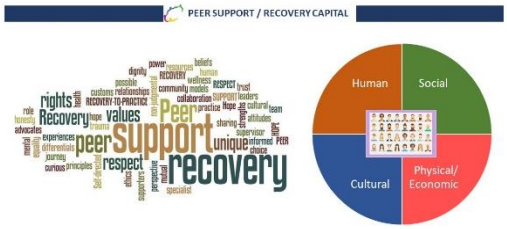
C. Project Description / Care Provider Network

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]

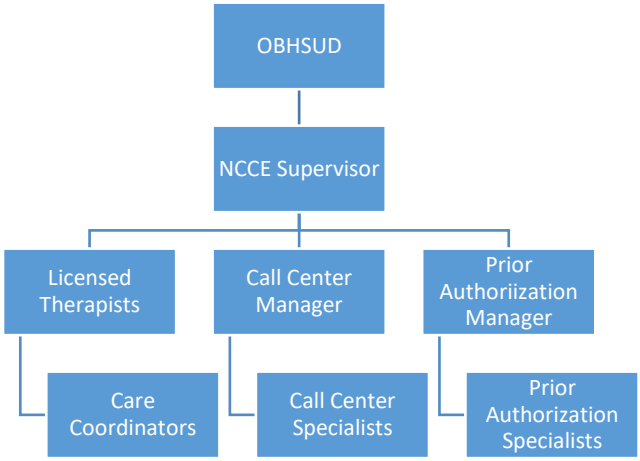
CSD's system of care model affords the unique ability to rapidly provide the exact recovery services called for and allow appropriate services to be maintained which will improve long-term recovery outcomes. A coordinated continuum of substance use disorder treatment and recovery services is also an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

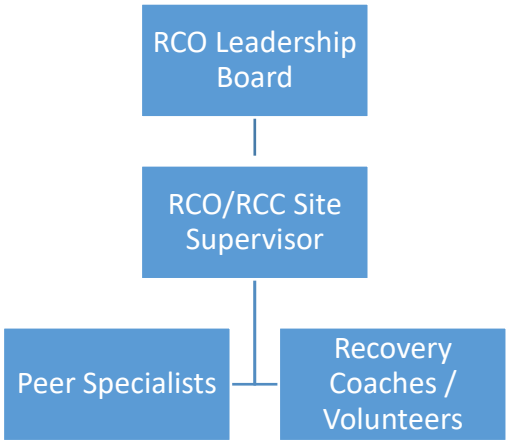
In addition, lastly, no individual shall be denied full access to, participation in and enjoyment of RCCs or RCOs services or activities, available or offered to others, due to the use of legitimately prescribed medications.

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.