SOLUTIONS TO HEROIN

A clinical playbook, a process for implementing the playbook, and the money to do it

PROJECT WHITE PAPER

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FINANCIAL TARGETS FOR EIGHT DEMONSTRATION PROJECTS

COMPONENT	*EACH PROJECT*	*TOTAL*	*SOURCE*
LENDING COMMITMENTS	$10,000,000	$80,000,000	FINANCIAL INSTITUTIONS
GRANT FUNDING FOR PROJECTS	$100,000	$800,000	PHILANTHROPIC AND LOCAL GOVERNMENT SOURCES
PROJECT IMPLEMENTATION COSTS	$500,000	$4,000,000	FINANCIAL INSTITUTIONS, PHILANTHROPIC, AND GOVERNMENT SOURCES
PROJECT DEVELOPMENT COSTS		$100,000	PHILANTHROPIC SOURCES
TOTAL	$10,600,000	$84,900,000	

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EXECUTIVE SUMMARY

The United States loses 175 people every day to overdose. Communities and healthcare systems are not responding to this epidemic fast enough. They have no way to fill gaps in local systems of care.

SOLUTIONS TO HEROIN fully addresses this situation. It consists of three elements: (1) a clinical playbook that sets standards for local systems of care; (2) a public-private partnership model to support investment in necessary infrastructure; and (3) a funding model that uses private-sector bank loans for startup capital.

This combination of program elements has the power to expedite formation of new treatment entities and build complete functional treatment systems in every community. The project utilizes Community Reinvestment Act and Small Business Administration funding to multiply the impact of government and philanthropic grants.

The project team proposes to demonstrate this model in eight communities, bringing $10.1 million in startup financing to each local treatment system. The funding will result in approximately $250 million in reimbursable healthcare services annually, which is equivalent to a full year of effective treatment for over 16,000 individuals. The eight demonstration projects will also produce over 1,000 new, livable wage jobs for paraprofessionals and 600 new professional jobs.

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SOLUTIONS TO HEROIN

PUBLIC PRIVATE PARTNERSHIPS: HOW EVERY REGION LEVELS UP

In the addiction treatment world, we know that the process of personal change is inherently difficult. Community change proved just as hard for the people and organizations working to upgrade and redevelop Cincinnati's urban core. In 2003, Cincinnati civic leaders committed to a new strategy. They organized a public-private partnership ("P3") called 3CDC to accelerate development. 3CDC was birthed with capital funding, development expertise, and leadership commitment. It weighed competing theories about how development should proceed, and took action. This work paid off. 3CDC changed the urban landscape and the experience of life for residents.

SOLUTIONS TO HEROIN uses the public-private partnership strategy to change the addiction treatment landscape. It delivers an improved experience of life for people affected by heroin and other opiates – actually, for anyone affected by any sort of addiction. It incorporates lessons learned in Northern Kentucky, where the community is implementing a fully integrated addiction treatment system centered in mainstream healthcare. The payoff is being measured in saved lives. Northern Kentucky is using a de facto P3 (comprised of the Heroin Impact Response Team, the Northern Kentucky Office of Drug Control Policy, county officials, St. Elizabeth Healthcare, treatment providers, funders, government agencies, and advocacy groups) to fill in treatment system gaps. The developers of SOLUTIONS TO HEROIN have been embedded within this effort for the past five years.

SOLUTIONS TO HEROIN is a two stage project. The first produces program materials and enrolls project partners. The second implements demonstration projects in eight communities across the US. Our goal is to show how communities can level up their efforts in a sustainable fashion. Another goal is to demonstrate how to systematically rescue people. To support the demonstration projects, SOLUTIONS TO HEROIN will organize local stakeholders, deliver program materials, provide technical assistance, help secure startup capital, and support local fundraising efforts.

Each demonstration project will customize and adapt the SOLUTIONS TO HEROIN clinical playbook to local conditions.

The process starts by conveninge three start-up working groups: a Leadership / Steering Committee – to develop a project charter and timeline, and set policy; a Governance / Legal / Administrative Committee – to research, outline and produce a legal entity that meets the requirements of local P3 law; and a Funding / Reimbursement / Finance Committee – to secure capital funding, and manage resources.

As the work proceeds, a number of other advisory groups and standing committees will take form. Examples include:

- Expert Advisory Group – local, national and international
- Treatment Protocols – to establish clinical methods
- Wraparound/ Case Management / Peer Support – to address identified barriers to recovery and support the social needs of clients (including strategies for daily living; safe, practical transportation; housing; recreation; family life; positive culture)
- Prevention – to develop evidence-based approaches that help community members flourish
- Data / Measurement / Quality Improvement – to inform and improve the service landscape
- Community / Education / Training – to educate the workforce and the public
- Multisystem Issues – to address intersections, conflicts, and barriers among behavioral health and other service systems, (criminal justice, workforce development, human services, foster care, etc.)

Reference: Woodard, C. (2016). How Cincinnati Salvaged the Nation's Most Dangerous Neighborhood. Retrieved February 10, 2017, from http://politi.co/1PwxY6S --pk--- 10/9/17

HOW THE P3 OPERATES

1. **Secures Funding Commitments**
    a. Banking System (Community Reinvestment Act, Small Business Administration)
    b. Philanthropic Sources
    c. Government Sources
    d. Managed Care Organization Commitments
2. **Issues Requests for Proposals**
    a. Specific Services
    b. Specific Populations
    c. Specific Timeframes
    d. Includes Startup Capital
3. **Directs Funding to Contractors**
    a. Recipients Are Combination Entities or Joint Ventures
        i. Capital Partner
            1. Helps Manage Startup Funds
            2. Assists with Business Model
            3. Factors A/R
        ii. Service Provider
            1. Delivers Services
            2. Reports Data
        iii. Quality Improvement Partner
            1. Reports to P3
            2. Reports to Service Provider
            3. Reports to Capital Partner
        iv. Technical Assistance Provider
            1. Certified by P3
            2. Advises Leadership
            3. Trains Staff
4. **Accelerates Grant Funding**
    a. Listens to Stakeholders and Persons Served
    b. Communicates Funding Priorities
    c. Provides Technical Assistance to Grant Applicants

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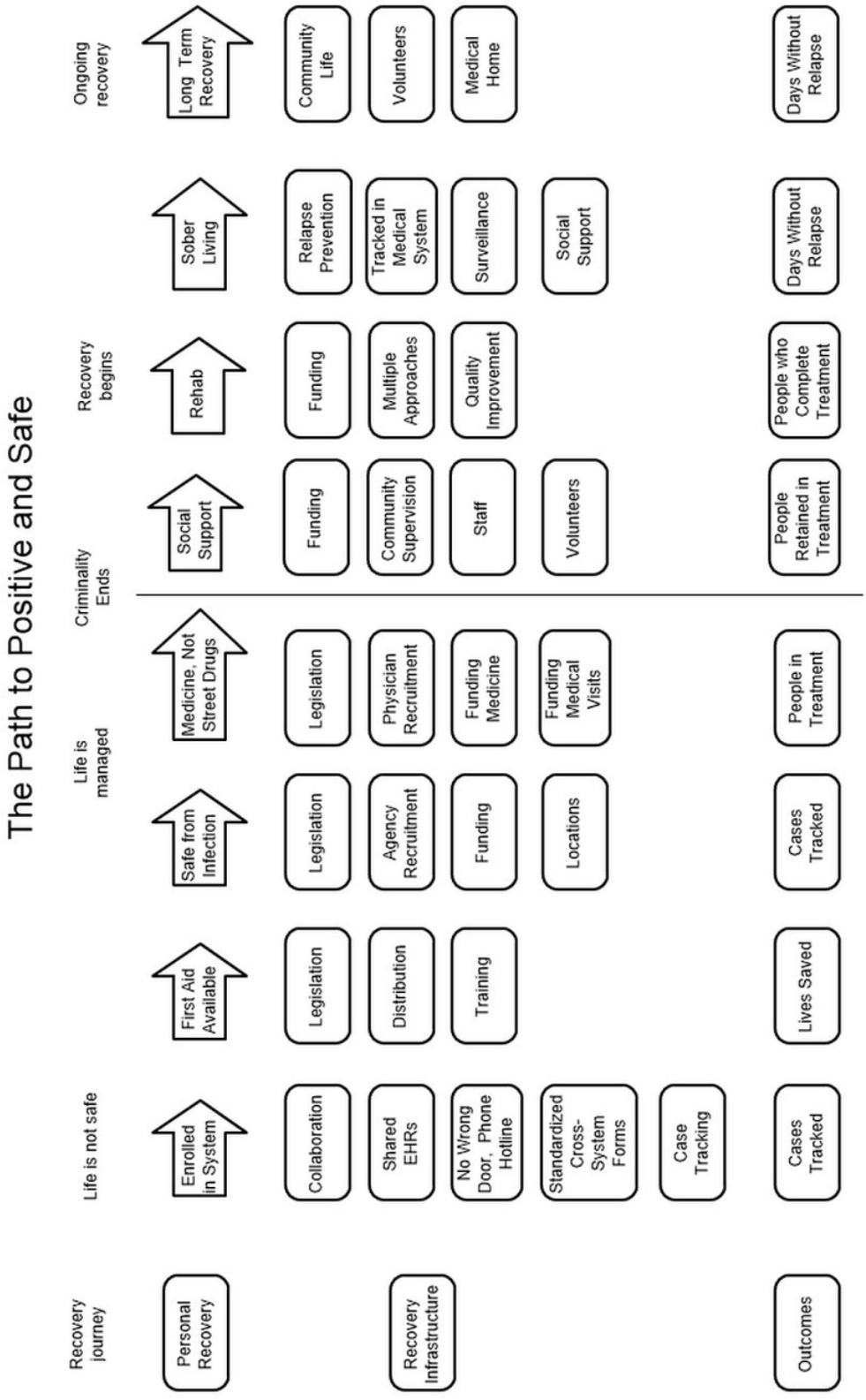
RECOVERY INFRASTRUCTURE MODEL



Source: Paul Komarek (2014). *SHARP Stop Heroin and Rescue People*

CLINICAL PLAYBOOK

The attached compilation of short documents is our clinical playbook. The content of these documents was developed in Northern Kentucky and reflects what is being implemented or developed in our region. They are the starting point of the work that each of the eight demonstration project will implement.

One document addresses the opiate crisis at the community level. Another addresses chronic pain management at the community level. The third document shows how hospital systems can address this crisis at every point of patient contact. The fourth is focused on primary and secondary prevention. The fifth concerns mental illness care at the community level.

This clinical playbook has been reviewed by over 100 clinicians and experts from across the United States.

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COMMUNITY STABILIZATION - HEROIN AND OPIATES

MINIMUM REQUIREMENTS

1. **Medication Assisted Treatment on demand** (methadone, Suboxone, Vivitrol, Naltrexone as appropriate) with behavioral therapy and support groups, available to be initiated 24/7
2. Enough trained and positioned doctors, nurse practitioners, with sufficient training to **initiate** treatment. Another group of doctors and teams to **continue** treatment
3. Buy-in from doctors, medical systems, insurance companies, pharmacies, and community organizations – schools, jails, halfway houses
4. Address every barrier that exists that hinders care presently
    a. No Medicaid or insurance reimbursement for methadone in the region
    b. Not enough Detox centers, day treatment, and residential with childcare
    c. Not enough doctors and nurse practitioners at points of entry.
5. Points of entry – anywhere – EMS, ER's, Urgent Cares, jail, primary care, appropriately trained community members.
6. For anyone who can't be stabilized, need detox/stabilization center available 24/7, no wait. Build medical-legal capacity for compulsory treatment on inpatient and outpatient basis.
7. Systematic approach to harm reduction: overdose, infection (syringe exchange), motor vehicles, etc.
8. Procedures and protocols universal for the region. Reference models – Integrated Dual Diagnosis Treatment (IDDT) and NY State Health and Recovery Plan (HARP) model

SYSTEM ENHANCEMENT

1. Create a cafeteria model for addiction care, with an HSA option that pays for services outside of standard Medicaid plans (e.g. methadone, transportation).
2. Participating institutions become Centers of Excellence.
3. Develop Accountable Care Organizations / Special Needs Plans around addiction, pain and mental health.
4. Develop leadership training, mentoring, and coaching at all levels of the system.
5. Build capacity for public policy advocacy

CASE MANAGEMENT

1. Integrated Team approach to case management
    a. Move from episodic model to integrated case-managed chronic care model
    b. Integrate today's collection of case management services into functional teams
    c. Create a regional multisystem case management leadership team
    d. The doctor's case coordinator convenes meetings of case managers from
        - Insurance
        - Medical system
        - Treatment
        - Social services
        - Jail services
        - Employment
        - Life coaches
        - Peer support workers
        - Natural support

e. Develop a consistent set of training programs for case managers at each system level
f. Manage case management through the Managed Care Organizations (MCOs) – funding, case coordination, approvals etc.

INTEGRATED SOCIAL SERVICES

1. Housing
2. Legal
3. Healthcare
4. Employment
5. Detox
6. Transportation
7. Childcare
8. Education
9. Care for pets

WRAPAROUND

1. Implement training programs for peer supports and community volunteers, including both initial training and ongoing training
2. Create a safe functional positive environment for people to stabilize.
3. Create a bridge between natural supports and institutional systems.
4. Akin to mentors, coaches, lay ministers – people who operate in nonclinical environments within the culture of the individuals but maintain healthy boundaries and have institutional connections.
5. The system provides a small stipend to cover incidental costs
6. Include safe community spaces, women's support groups, trauma support, recreation
7. Ombudsman and advocacy teams to help people facing barriers and structural issues
8. Assertive community treatment teams for high-risk populations
9. Multiple mutual support models – Women for Sobriety, SMART Recovery, and 12-Step
10. Specialized support groups for families, women, trauma survivors etc.

PEER SUPPORT

1. Basic community training for people who assist others in recovery
    a. Addiction science
    b. Myths and misconceptions
    c. Multiple approaches to support, from 12-step to cognitive approaches
    d. Career paths for peer workers
2. Link to formal Peer Support Certification Training

QUALITY IMPROVEMENT

1. Quality Improvement teams at each level of the system.
2. Data sharing between institutions.
3. Link quality improvement to professional development
4. Systematic approach to retaining people in service, with added surveillance as needed
5. Community oversight – address all health factors
6. Link with primary care, pain management, and mental health outcomes

PREVENTION TEAMS

1. Primary and secondary prevention

MANAGING QUALITY AT THE INTERSECTION OF PAIN MANAGEMENT, ADDICTION, MENTAL ILLNESS AND OUR COMMUNITY

MISSION STATEMENT

The physicians of our community will work together to serve and protect our patients and the community, while maintaining and respecting the patient-physician relationship.

OBJECTIVES

1. Address the health needs of the entire population in an integrated and holistic fashion.
2. Integrate chronic pain management, mental health care, and addiction care with the mainstream medical system.
3. Reduce stigma
4. Manage addiction and comorbid illness including mental illness
5. Reduce risk to the community, particularly risk of overdose, addiction, and drug diversion
6. Develop a wholly integrated continuum of care that eliminates service system fragmentation.
7. Build the workforce. Add peer support and case management throughout the medical system.
8. Develop community wraparound services. Utilize volunteers and natural supports.
9. Adopt commonsense protocols that address risk.
10. Create solutions that address the medical needs of higher risk populations.

WORK PROCESS

This process will be based on discussion among the practicing physicians, and supported with expert opinion, guidelines, evidence based-medicine and common sense input from patient, health care advocates and others.

CRITICAL CONCERNS

The following is an initial list of issues related to chronic pain, addiction and mental illness.

Increasing collaboration between primary care physicians, pain specialists, and mental health specialists (including therapists) to co-manage patients and provide effective, integrated care.

1. Educating the medical community and the larger community regarding chronic pain, addiction, and mental illness, with a special emphasis on reducing stigma.
2. Designing specific collaborative processes among physicians, medical systems, and regulatory bodies to manage high risk populations with comorbid issues such as pain and addiction, including those patients who have had past difficulty with controlled medication contracts.
3. Improving collaboration between physicians and insurance companies, particularly managed care organizations (MCOs).
4. Improving access to addiction medicine services, especially medical treatment to address our region's ongoing heroin epidemic.
5. Improving access to mental health care.

6. Reducing drug diversion.
7. Harm Reduction. Reducing accidental overdose and improving overdose outcomes by teaching family members how to properly respond using naloxone. Reducing infection risk by implementing syringe exchange programs and referring each person at risk of injection drug use to syringe exchange.
8. Making sure all patients get the best pain management that is both effective and the lowest risk.
9. Developing tools that combine population management approaches with patient-focused treatment.

HOSPITAL SYSTEM ADDICTION SERVICES PLAN

GENERAL

1. "No Wrong Door" approach to addiction treatment
2. Case finding - increase SBIRT (Screening, Brief Intervention, Referral to Treatment) throughout organization
3. A plan for each major point of entry to the system
    a. EMS Overdose Run
    b. Emergency Room
    c. Hospital Admissions
    d. Outpatient Primary Care
    e. Outpatient Specialty Care
    f. Pediatrics
    g. Outpatient Behavioral Health
    h. Detox
4. System Enhancements

A. EMS OVERDOSE RUN

1. Handoff to Emergency Room preferred
2. Follow-up visit for treatment program recruitment
3. Assess for mental health interventions
4. Build a Community Paramedicine service model

B. EMERGENCY ROOM

1. Screen all patients (SBIRT)
2. All ER doctors and nurses are trained to start Medication Assisted Treatment
3. A Transfer Team moves patients to next stage (outpatient or inpatient treatment)
4. Consultants assist with complicated patients
5. Enroll patients in Targeted Case Management service
6. Initial contact with Wraparound Service (orientation, social assessment, family education)
7. Dispense Naloxone
8. Infection Control Education - referral to syringe exchange

C. HOSPITAL ADMISSIONS

1. Screen all patients (SBIRT)
2. All doctors who admit, all Full Hospitalists and Third Hospitalists trained to administer Medication Assisted Treatment. (Suboxone, Naltrexone, Vivitrol).
3. Teams of addiction specialists round in the hospital.
4. Consultants assist hospitalists and addiction specialists
5. Address pain issues -- set up collaboration with Methadone Clinic. Address insurance issues around lack of Medicaid coverage for methadone
6. Enroll patients in Targeted Case Management service
7. Initial contact with Wraparound Service (orientation, social assessment, family education)
8. Dispense Naloxone
9. Infection Control Education - referral to syringe exchange

D. OUTPATIENT PRIMARY CARE

1. Screen all patients (SBIRT)
2. Rapid referral to outpatient specialist addiction clinic

3. Enroll patients in Targeted Case Management service
4. Initial contact with Wraparound Service (orientation, social assessment, family education)
5. Dispense Naloxone
6. Infection Control Education - referral to syringe exchange

E. OUTPATIENT SPECIALTY (NON ADDICTION)

1. Screen all patients and parents (SBIRT)
2. Refer to outpatient specialist addiction clinic - same day
3. Triage patient, begin medication treatment
4. Enroll patients in Targeted Case Management service
5. Initial contact with Wraparound Service (orientation, social assessment, family education)
6. Dispense Naloxone
7. Infection Control Education - referral to syringe exchange

F. PEDIATRICS

1. Screen all patients and parents (SBIRT)
2. Rapid referral to outpatient specialist addiction clinic
3. Enroll patients in Targeted Case Management service
4. Initial contact with Wraparound Service (orientation, social assessment, family education)
5. Dispense Naloxone
6. Infection Control Education - referral to syringe exchange

G. OUTPATIENT SPECIALTY (BEHAVIORAL HEALTH)

1. Psychosocial assessment
2. Triage patient
3. Begin medication treatment
4. Detox if necessary
    a. Ambulatory detox where appropriate
    b. Medical detox where appropriate
5. Provide mental health services
    a. Mental health assessment
    b. Screen for trauma
    c. Other diagnosis
6. Refer for medical assessment
    a. Hep C
    b. Immunizations
    c. Pain issues
7. Refer to specialist outpatient care if needed
8. Develop integrated treatment plan
9. Enroll patients in Targeted Case Management service
    a. Meet onsite and offsite
10. Use case management to inform and build consensus around care plans and recovery strategies
    a. Convene ongoing case management team meetings
    b. All case managers participate or provide reports
11. Initiate counseling
12. Initiate wraparound service
    a. Orientation
    b. Social assessment
    c. Family education

    d. Social supports
    e. Mutual support groups
    f. Housing
    g. Employment
    h. Legal
    i. Recreation
13. Initiate peer support
    a. Meet onsite
    b. Meet offsite
    c. Utilize peer support center
    d. Classes
    e. Life skills
14. Refer to methadone clinic if necessary
    a. Continue to case manage
    b. Develop plan to transition from methadone to Suboxone
    c. Integrate with other care
15. Dispense Naloxone
16. Infection Control Education - referral to syringe exchange

H. DETOX

1. Psychosocial assessment
2. Triage patient
3. Begin medication treatment
4. Refer for mental health assessment
    a. Screen for Trauma
    b. Other diagnosis
5. Refer for medical assessment
    a. Hep C
    b. Immunizations
    c. Pan issues
6. Refer to specialist outpatient care if needed
7. Develop integrated treatment plan
8. Enroll patients in Targeted Case Management service
    a. Meet onsite and offsite
9. Schedule ongoing case management team meetings
    a. All case managers participate or report in
    b. Use case management to inform and build consensus around care plans and recovery strategies
10. Initiate counseling
11. Initiate wraparound service
    a. Orientation
    b. Social assessment
    c. Family education
    d. Social supports
    e. Mutual support groups
    f. Housing
    g. Employment
    h. Legal
    i. Recreation
12. Initiate peer support

    a. Meet onsite
    b. Meet offsite
    c. Utilize peer support center
    d. Classes
    e. Life skills
13. Refer to methadone clinic if necessary
    a. Continue to case manage
    b. Develop plan to transition from methadone to Suboxone
    c. Integrate with other care
14. Dispense Naloxone
15. Infection Control Education - referral to syringe exchange

I. SYSTEM ENHANCEMENTS

1. Quality improvement
    a. Peer review
    b. Clinical supervision
    c. Outcomes reporting
2. Clinical management / tools
    a. EPIC
    b. Prescriptions for Naloxone
3. Community support
    a. Law enforcement
    b. Naloxone distribution
    c. Issue advocacy
    d. Support insurance coverage
    e. Shared outcomes
    f. Build service networks
4. Building infrastructure
    a. Crisis stabilization
    b. Stabilization center
    c. Residential Level of Care
5. Integrated Care
    a. Address chronic pain
    b. Build mental health service capacity
    c. Address social determinants of health

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PREVENTION AND EARLY INTERVENTION

To prevent substance use disorders and other behavioral health problems, we must look at health holistically. There are many factors that influence health. These include heredity, access to medical care, lifestyle, and environment. Communities can help people address these factors.

MISSION STATEMENT

The physicians of Northern Kentucky work together with community members to promote health in a holistic fashion throughout the population.

OBJECTIVES

1. Address the physical needs of the patient in the context of heredity, environment, and lifestyle.
2. Provide early screening and assessment for adversity in childhood, which is a precursor to many health/behavioral health concerns.
3. Provide screening and early referral for underage patients showing signs of alcohol or other drug use, cutting, suicide ideation, eating disorders, or other mental health concerns.
4. Provide screening and referral for adult patients showing signs of dependence of alcohol and other drugs.
5. Integrate family supports, social supports, and caregiver supports into care planning.
6. Manage chronic pain cautiously.
7. Engage with the community to promote optimal environments for children to grow; families to live; and persons to recover and prosper.

MENTAL HEALTH MANAGEMENT

There are many opportunities to improve mental health services for children and families, starting with programs to prevent and to address adverse childhood experiences. These include:

Peer Support. Increase opportunities to develop certified peer support specialists including access to education and development opportunities that introduce the concept and career path to people working toward recovery goals. Provide access to certified peer support training (youth, adult, family) and continuing education training opportunities to further develop the career path and support the individual. Increase opportunities for the employment of certified peer support specialists.

Employment is proven to help further recovery goals while it simultaneously helps families and communities achieve stability. Remove barriers that prevent individuals from achieving their recovery goals such as employment for those with felony convictions, safe and affordable housing for those living in recovery, and access to medical care that provides the medications they need for long term health and wellness.

Wraparound services, particularly those that include certified peer support specialists as part of the service delivery model, connect individuals with what they need. Increasing wraparound services and connecting individuals and families with multiple services is proven to generate the best outcomes, reduce the need for costlier services, and can prevent a continuous cycle of illness in a family.

ADDRESSING SOCIAL AND EMOTIONAL WELL-BEING

1. Provide training and materials for evidence based social and emotional/resiliency programs such as Core Life, a primary prevention program aimed at increasing resiliency and positive youth development for all

students. Developed in Northern Kentucky, Core Life is proving to reduce maladaptive behavior and also increase academic standing in reading. It covers 18 topics related to of character, healthy living, and drug prevention. Teachers ask to teach the program which engages parents and the community for the purpose of nurturing each student's healthy life choices and innate resiliency. For more information on this program, see: www.CoreLifeNKY.com.

2. Increase the number of counselors in schools to be consistent with recommended counselor-student ratio. Increased treatment services for adolescents with opioid addiction
3. Database of community-based resources by county for schools in need of intensive out-patient children's services for child and family
4. Stable funding for community drug prevention/support coalitions such as Hope4Boone County and coalitions without federal funding.
5. Family enrichment through jobs trainings for adults, exposure to cultural and arts events, development of reading skills, and development of new interests and hobbies.

INTERVENTIONS FOR THOSE AT HIGHEST RISK

Provide training to schools and/or direct services for early intervention/intensive counseling services for children/families at highest risk:

1. Psycho Educational Groups for Children with High Risk: This type of group is not funded by Medicaid but can be an inexpensive and effective tool for prevention. These groups can provide learning experiences for a targeted audience or the general population. We need to provide our citizens for tools for coping with stress, loss and other traumas so that they do not seek out substances of addiction, including opioids.
2. The Nurturing Program for Families in Recovery - This is a parent education program suitable for addicted parents in recovery and their partners in parenting. This may include extended family. The Nurturing Programs are evidenced–based programs recognized by National Registry of Evidenced-based Programs and Practices (NREPP), Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Juvenile Justice and Delinquency (OJJDP), Center for Substance Abuse Prevention (CSAP) and Child Welfare League of America (CWLA).There are 17 core sessions and additional sessions to address the needs of fathers. Each session is designed to be 90 minutes. We believe this program could be held in the community (schools and churches) to make it accessible and to reduce stigma.
3. S.E.L.F. (Safety/Emotions/Loss/Future). This is a group curriculum from The Sanctuary Institute. The Sanctuary Institute provides training and certification in becoming a Trauma informed Care agency. Research shows that trauma and loss lead to addictions. The group is designed to help people create safe places, deal with loss and emotions and envision a healthy future. The group is open ended so that anyone can join at any time. This maximizes availability and clients may come when they are able to do so and are not penalized. This group is suitable for adults and teens. Again any community setting would be appropriate so as to get the information and skills to the most people.

INTEGRATED CARE FOR MENTAL HEALTH

MINIMUM REQUIREMENTS

1. **Treatment on demand** with stabilization, assessment, medication, behavioral therapy, and community support, available to be initiated 24/7
2. Enough trained and positioned doctors, nurse practitioners, social workers, counselors, case managers, and peer support workers with sufficient training to **initiate** treatment. Another group of doctors and teams to **continue** treatment and maintain ongoing relationships with people requiring care.
3. Buy-in from doctors, medical systems, insurance companies, pharmacies, and community organizations – schools, jails, halfway houses
4. Address every barrier that exists that hinders care presently
    a. Not enough crisis stabilization centers, day treatment, and residential with childcare
    b. Not enough doctors and nurse practitioners at points of entry.
    c. Separation from mainstream healthcare and addiction care
5. Points of entry – anywhere – EMS, ER's, Urgent Cares, jail, primary care, appropriately trained community members.
6. For anyone who can't be stabilized at home, need stabilization center available 24/7, no wait. Build medical-legal capacity for compulsory treatment on inpatient and outpatient basis.
7. Systematically address suicide risk and risk of violence. Prioritize early stabilization and support to prevent loss of employment, housing, and social supports.
8. Utilize an integrated healthcare approach that is person-centered and strength-based, and includes family stabilization and support. Procedures and protocols universal for the region. Reference models – Integrated Dual Diagnosis Treatment (IDDT) and NY State Health and Recovery Plan (HARP) model

SYSTEM ENHANCEMENT

1. Develop Accountable Care Organizations / Special Needs Plans around addiction, pain and mental health. Create a cafeteria model or HSA that pays for services outside of standard Medicaid plans, including community wraparound services (e.g. employment, housing, family respite).
2. Participating institutions become Centers of Excellence.
3. Develop leadership training, mentoring, and coaching at all levels of the system.
4. Build capacity for public policy advocacy

CASE MANAGEMENT

1. Integrated Team approach to case management
    a. Move from episodic model to integrated case-managed chronic care model
    b. Integrate today's collection of case management services into functional teams
    c. Create a regional multisystem case management leadership team
    d. The doctor's case coordinator convenes meetings of case managers from
        - Insurance
        - Medical system
        - Treatment
        - Social services
        - Jail services
        - Employment
        - Peer support workers
        - Natural support
    e. Develop a consistent set of training programs for case managers at each system level

f. Manage case management through the MCOs – funding, case coordination, approvals etc.

INTEGRATED SOCIAL SERVICES

1. Housing
2. Legal
3. Healthcare
4. Employment, Transportation, Childcare
5. Education
6. Care for pets
7. Hotlines, Warmlines, Clubhouses

WRAPAROUND

1. Implement training programs for peer supports and community volunteers, including both initial training and ongoing training
2. Create a safe functional positive environment for people to stabilize.
3. Create a bridge between natural supports and institutional systems.
4. Akin to mentors, coaches, lay ministers – people who operate in nonclinical environments within the culture of the individuals but maintain healthy boundaries and have institutional connections.
5. The system provides a small stipend to cover incidental costs
6. Include safe community spaces, women's support groups, trauma support, recreation
7. Ombudsman and advocacy teams to help people facing barriers and structural issues
8. Assertive community treatment teams for high-risk populations
9. Multiple mutual support models
10. Specialized support groups for families, women, trauma survivors etc.

PEER SUPPORT

1. Basic community training for people who assist others in recovery
2. Link to formal Peer Support Certification Training

QUALITY IMPROVEMENT

1. Quality Improvement teams at each level of the system. Link quality improvement to professional development
2. Systematic approach to retaining people in service, with added surveillance as needed
3. Community oversight – address all health factors. Link with primary care, pain management, and addiction care outcomes. Data sharing between institutions.

COLLABORATION ACROSS SYSTEMS

1. Deploy mobile crisis teams to reduce involvement with criminal justice system.
2. Integrate court and jail practices and policies with medical needs of people served.

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NONCLINICAL ISSUES AND RECOVERY SUPPORTS

In 2013-2014, local volunteers conducted an informal survey of 304 local people who received addiction services. Dr. Perilou Goddard of Northern Kentucky University scored the surveys.

The top ten concerns for both men and women were:

1. Returning to environments associated with past drug use.
2. Worrying about letting other people down.
3. Coping with financial problems (such as trying to get out of debt, pay rent, pay child support).
4. Coping with life situations, such as when their car breaks down or they're laid off.
5. Figuring out how to structure time.
6. Overcoming other people's unrealistic expectations about recovery.
7. Dealing with frustration without using drugs.
8. Finding housing while having a felony conviction.
9. Needing transportation.
10. Dealing with others' misconceptions about treatment and recovery.

These are social issues, not biological or psychological issues. Struggling families work through these sorts of challenges every day. The most surprising feature of this list is that so many of these items are among the strengths and competencies of people who are moving away from drug use. There is no shortage of drivers, roommates, and sympathetic souls with coping skills among people in recovery (particularly among those somewhat further along) but society has done a poor job connecting these skills and competencies with people who might benefit.

COMMUNITY WRAPAROUND ACTIVITIES

Roommate arrangements

Recreation programs

Ridesharing

Job placement

Volunteer training

Friendly visitor programs

Church-hosted meals and activities

Homework assistance and tutoring

Book clubs

Restorative justice programs

Family mentoring

Prepaid legal services

Women's groups

Supervised family visitation

Caregiver support programs

Social clubs

Recreation center programs

Rapid diversion from court

Tax assistance

Nutrition education

Exercise, fitness, and yoga

Family movie night

Field trips

Housecleaning services