# OCHN Three-Year Substance Use Disorder Strategic Plan: 2024-27

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Oakland Community Health Network

Developmental Disabilities • Mental Health • Substance Recovery

## Section 1……

***A narrative identifying and prioritizing substance use disorder problems impacting the community with respect to Recovery-Oriented Systems of Care (ROSC) that includes prevention and treatment, as well as all other services necessary to support recovery. The narrative should include identification of related long-term and short-term consequences at the regional/community level. There should be evidence of an epidemiological profile in the prioritization of substance use disorder issues/problems.***

Oakland County (OC) is one of the largest counties in Michigan with a population of 1,269,431 (Footnote 1). The 908 square miles that Oakland County covers is situated just to the north of the City of Detroit and is bordered by Genesee, Lapeer, Livingston, Macomb, Washtenaw, and Wayne counties. The region is socially and economically diverse, containing within its boundary's major urban areas to its south and rural farmlands to its north.

Oakland County Substance Use Disorder (SUD) Access Center is in Pontiac, MI with a provider network located throughout the community as well as out of county to ensure timely access to treatment. The population served by Oakland Community Health Network (OCHN) is demographically like the greater Oakland County population. However, in Oakland County there is a higher proportion of Asian to Hispanic/Latino individuals. According to internal data collected from Oakland Community Health Network in 2022, 73% of the population served was Caucasian, 22% African American, 4.5% Hispanic/Latino, 0.3% Asian, and 0.4% Native American. 2.8% identified as Other Race and 0.3% as Bi or Multiracial (Footnote 2). In FY20, OCHN began to collect LGBTQIA+ information to better train our network and provide culturally appropriate services. Data pulled from OCHN's electronic medical record system, indicates that English represents the majority of language spoken by individuals seeking SUD services. The second largest language spoken was Spanish. The gender breakdown is comprised of 69% male and 31% female. Many persons served fall within the 26-59 year age range, similarly most of Oakland County's population falls within the same age range (Footnote 3). Twenty-eight percent of OCHN funded individuals in 2022 reported having 13 years or more of education, this is less than the 48.9% of the Oakland County population that reported having a bachelor's degree or higher (Footnote 4).

The population served by Oakland Community Health Network in 2022 was significantly more impoverished than the overall population of Oakland County. In 2022 60% percent of the individuals made less than $1,000 a year, with the majority falling well below the Federal poverty line (Footnote 5). The estimated individual per capita income of Oakland County was $49,012 (Footnote 6). Furthermore, more than half of publicly funded clients are unemployed, 69% in 2022 (Footnote 7). The number of individuals who are unemployed has been steadily increasing since 2019. The rate of unemployment during 2022 in Oakland County was 2.60%, which is lower than that of Michigan and the United States (Footnote 8). The gradual increase (11%) in the number of residents utilizing publicly funded SUD services facing unemployment is a sign of economic strife affecting this population since the last Strategic Plan in 2019 (Footnote 9).

From FY19 to FY22, there has been a significant decrease in the number of individuals served using heroin as their primary drug. Alcohol continues to be the major primary drug used amongst Oakland County persons served. The steadily increasing trend observed over the last three years indicates a sustained need for interventions aimed at improving treatment and expanding prevention efforts to further drive down the rate of serious use. Despite the legislative changes and

the approval of medical marijuana increasing social acceptance of the drug, the number of individuals using the substance has significantly decreased (Footnote 10).
The target population for SUD treatment includes individuals meeting American Society of Addiction Medicine (ASAM) criteria for Outpatient, Residential, or Medical Assisted Treatment. Oakland Community Health Network (OCHN) will continue to serve those who meet the income criteria, individuals with no insurance or are under-insured, have Medicaid or a Healthy Michigan Plan.

## Alcohol Use

In 2022, alcohol was the most widely reported primary substance used with 47% of individuals served for substance use treatment in Oakland County (Footnote 11). This mirrors the 2020 Annual TEDS Report findings that show in 2020 the national treatment admission rate was higher for primary alcohol abuse than for any illicit drugs. The primary alcohol admission rate was 162 per 100,000 population. (Footnote 12). OCHN individuals served reported a 14.6% increase in primary alcohol use between 2019 and 2022. A review of 2022 Oakland County individuals that named alcohol as the primary substance for which they sought services revealed that 62.7% of the clients initiated their alcohol use between the ages of 11-17, with the average age of initiation at 14 years old (Footnote 13). This early adoption of substance use can have severe consequences in terms of increased risky behaviors. Data from the 2021 Michigan Youth Risk Behavior Survey (MiYRBS) showed that 13.1% of the surveyed 11th graders have been in a car with an individual who had been drinking within the last 30 days. In addition, 1% reported having driven a car after drinking within the last 30 days (Footnote 14). In 2021 10.5% of alcohol involved crashes occurred amongst 16-20-year-old drivers in Oakland County (Footnote 15).
This pattern of risky behavior with alcohol use continues into adulthood with 2.8% of Oakland County adults surveyed during the 2010 Michigan Behavioral risk Factor Surveillance System reported driving after drinking too much in the last 30 days {2010 was the last year this specific information was collected in the survey} (Footnote 16). In 2021 81% of Oakland County alcohol crashes occurred amongst 25-64-year-old drivers. In addition, 2.9% of the 32,038 crashes in Oakland County occurred after the driver had been drinking; of those incidents 29.7% were fatal (Footnote 17).

## Heroin and Opioid Use

Since 2019 OCHN individuals have seen a slight decrease from 33.4% to 27.6% in 2022 of individuals reporting heroin as the primary substance for which they sought services. Additionally, there was a reported 28% decrease in reported primary use of all other opioids. Notably, for the first time, when heroin is combined with other opiates, (43%) this total is slightly less than reported use of alcohol (Footnote 18). Most persons served in 2022 reporting primary heroin are Caucasian (84.5%), make less than $1,000 annually (71%), and started using much later in life, majority age range 25+ years (35.8%) (Footnote 19). This drug has severe complications associated with its use, as continued use can lead to eventual overdose, hospitalization, or death. According to the 2020 Annual TEDS Report, (for drugs), the highest admissions ratios were for opiates (140 per 100,000 population aged 12 years and older) and methamphetamine/amphetamines (65 per 100,000 population aged 12 years and older). Heroin, alcohol, and methamphetamine/amphetamines were the most common primary illicit drugs used among admissions in all Census divisions (Footnote 20). Nationally, the rate of emergency room visits in 2011 due to heroin was 83 per 100,000 population, amongst 21-24-year-old. Three times that of the 266.1 per 100,000 population {2011 is the most current DAWN survey collected for ED data} (Footnote 21). These emergency room visits are most often related to an overdose event.

From 2020 to 2021 the rate of opioids overdose deaths in Oakland County has risen from 7.34 per 100,000 population to 16.93 per 100,000 population (Footnote 22). Additionally, long-term use of heroin puts users at risk for contraction of blood-borne illnesses, such as HIV and Hepatitis C. In the state of Michigan in 2021, history of injection drug use was reported in 78.0% of hepatitis C patients aged 18-39 years. Between 2010 and 2021 there has been a 45% increase in Michigan heroin substance use treatment admissions. From 2010 through 2020 heroin overdose deaths in Michigan have increased by 119%. Additionally, there were 129 cases of acute hepatitis C reported in Michigan in 2021 for a rate of 1.29 cases per 100,000 people. This is a decrease from rates reported in Michigan in 2020 (1.39), but still higher than the national acute HCV rate of 1.20 cases per 100,000 reported in 2018. The median age of acute hepatitis C cases was at least 8 years younger than that of other viral hepatitis infections and the only condition with a median age lower than that of the Michigan general population. Case follow-up and completion of epidemiological risk factors was completed for about 58% of acute hepatitis C cases in 2021. This is lower than previous years due to constraints on follow-up resources resulting from the COVID-19 pandemic response. Where data was available, injection drug use was reported by 58% of acute hepatitis C cases. Injection drug use continues to stand out as the predominant risk for acquiring HCV infection. The number of acute HCV cases in Michigan remained relatively stable from 2012 to 2014 but increased slightly in 2015 before nearly doubling in 2016, increasing rapidly in 2017, and decreasing from 2018 through 2021. A CDC/CSTE acute HCV case definition change in January 2016 is at least partially responsible for this sharp increase, along with the concurrent HAV outbreak resulting in an increased ordering of hepatitis panels and, in turn, increased HCV detection. In 2021 there were 310 deaths attributed to HCV in Michigan. Between 2015 and 2021, deaths due to chronic HCV decreased by 39%, likely resulting from the introduction of new medications that treat HCV infections, among other factors. (Footnote 23).

Within Oakland County there has been a 50% reduction in acute and chronic HCV cases reported over a three-year span. In 2016, there were 10 cases of acute hepatitis C reported with a rate of 0.80 cases per 100,000 people. This dropped to 5 reported acute HCV cases for a rate of 0.40 per 100,000 people in 2018. Chronic HCV cases decreased slightly from 1,039 cases with a rate of 83.63 per 100,000 people in 2016 to 1,022 cases with a rate of 81.71 per 100,000 people in 2018 (Footnote 24).

## Marijuana Use

In 2020, 3.1% of individuals served through OCHN funded providers reported marijuana as their primary drug of use. By comparison, 8.8% of all individuals served reporting primary marijuana use in 2017 (Footnote 25). This mirrors the 2020 TEDS Data Report that found the proportion of marijuana/hashish admissions aged 12 years and older steadily declined each year from 18.6 percent in 2010 to 9.8 percent in 2020 (Footnote 26). Secondary use of marijuana also showed a slight decline from 14.8% in 2017 to 10.1% in 2020 (Footnote 27). This reflects an overall decline in marijuana use as a primary substance. However, the steady percentage of individuals reporting secondary use may be an indication that more individuals continue use of the substance while using other drugs primarily. In 2022, amongst those served by OCHN's providers where marijuana was the primary diagnosis, the majority (33.7%) reported age of first use to be between the ages of 15-17 (Footnote 28). National Treatment Episode Data Set (TEDS) data supports this trend with 70.8% of clients reported initiating use at 17 years or younger in 2020 (Footnote 29). The percentage of Oakland County middle school students that reported trying marijuana before the age of 11 has declined to 0.4% between 2021-2022 from 0.6 % in 2019-2020. Conversely, 7th graders reporting use of marijuana within the last 30 days increased slightly to 1% in 2021-2022

from 0.9% in 2019-2020. Amongst 9th graders, reported use before age 13 declined to 2.5% in 2021-2022 from 2.9% in 2019-2020 and lifetime use dropped to 10.3% in 2021-2022 from 13.6% in 2019-2020. 11th graders reported use before age 13 declined from 3.2% in 2019-2020 to 2.6% in 2021-2022 and lifetime use dropped from 34.7% to 27.9%. Student perception of smoking marijuana once or twice a week "to be of moderate or great risk" declined from 60.5% amongst Oakland County 7th graders to 50.9% amongst 9th graders and 38.6% in 11th graders. This illustrates that although there has been an overall decrease in use amongst youth in Oakland County, there continues to be a decreased perception of risk and increased rate of use of marijuana with age. (Footnote 30)

**Demographic profile / Description of relationship-Prevention**

Prevention population of focus identified are the general public, youth (9-20) and parents, older siblings and relatives of youth and the 12 community sectors (outlined by the Community Anti-Drug Coalitions of America Institute, see attachment I) that comprise a community coalition. The Alliance, the umbrella of coalitions in Oakland County, was successful in increasing the coalition network by adding Brandon and South Lyon, which were added in the most recent contract cycle. We have been successful in having coalitions cover northeast, northwest, southeast, southwest, and central Oakland County (see attachment I). Geographically, the targeted populations include the public-school districts in the southeast quadrant (Hazel Park, Madison Heights, Oak Park, and Southfield), central and northern sections of the county (Pontiac, Holly, and Waterford). These areas tend to have lower socioeconomic populations, a high percentage of students who are eligible for free or reduced-price lunch and/or have high dropout rates when compared to the general Oakland County student population. A significant percentage of students in the southeastern quadrant are from families recently emigrated from the Middle East to Michigan or Hispanic and Latino families with limited English proficiency. An identified barrier in providing services to high-risk populations is access, usually occurring through the schools, is becoming more difficult to achieve due to an increased emphasis on academics and the safety of students.

**Description of System-Treatment**

The current system in place for treatment services supports a recovery oriented full continuum of care. Oakland Community Health Network (OCHN), the designated regional entity, intends on preserving the current system and expanding on the existing services over the next three years. There is a total of 13 providers; of the 13 providers, nine are outpatient level of care (including 3 providing medication-assisted treatment/MAT), spread throughout the entire county for ease of access. All outpatient providers are co-occurring capable, providing services to individuals with mental health and substance use disorders. All outpatient providers deliver enhanced outpatient services and intensive outpatient programming (IOP) to allow for more individualized treatment. There are currently Peer Recovery Coaches and Case Managers that provide services throughout the outpatient system. Three outpatient providers are well versed in servicing adolescents. There are three MAT providers, providing all medications for individuals diagnosed with an opioid use disorder. Two out of the three MAT providers also provide acupuncture, an evidenced based practice in the treatment of opioid use disorder. One state designated women's specialty outpatient provider delivers services to women meeting criteria. There are six withdrawal management providers to deliver services to individuals in need of sub-acute withdrawal management. Seven providers offer short term residential services, and one offers long term residential services. Two providers offer both domiciliary outpatient and intensive outpatient services. There is one outpatient women's specialty program (also offers IOP) and one women's specialty residential

program. All providers deliver services based on American Society of Addition Medicine (ASAM) patient placement criteria to ensure an appropriate level of care. Examples of additional evidenced based services include Motivational Interviewing, Stages of Change Model, Cognitive Behavioral Individual and Group Therapy, Family/Caregiver Intervention, Relapse Prevention Programming, Early Intervention, Case Management, Parenting Programs, Peer Support Service, Seeking Safety, MTREM, Moral Recognition Therapy and Beyond Trauma.

Due to the consistently high volume in opiate specific admissions over the past five years, the need to maintain and strengthen services addressing this population exists. In addition, data has indicated that some individuals with opioid use disorder do not respond well to traditional forms of treatment. Therefore, to address this identified gap, Sublocade was added to the array of medication assisted services. We will continue to closely monitor the effectiveness of medication-assisted treatment services and adjust based on data and outcomes. Ancillary services also include yoga, acupuncture, and meditation to further support those in recovery. Currently OCHN continues to offer Vivitrol for individuals diagnosed with an alcohol use disorder at multiple providers under our pilot program for the criminal justice population of individuals being released from prison.

The Substance Use team regularly meets with peer recovery coaches to discuss barriers and enhancements to therapeutic and ancillary services provided by Region 8. As a result of the feedback from the peer recovery coaches and recovery network, OCHN explored options to assist with transportation needs. We have continued partnerships with Freedom Road, Lyft, Uber, Logisticare, and Modivcare and will seek other resources and grants to further address the barriers to treatment. The provider network was also surveyed regarding gaps and barriers. As a result, we had an RFP for Recovery Housing Services and three recovery housing providers including specific housing for individuals enrolled in MAT. As a result of the Covid-19 pandemic, telehealth services are now offered across the network the individual's needs.

**Description of System- Prevention**

The Prevention Services funded by OCHN grants covers all the Center for Substance Abuse Prevention (CSAP) strategies, which are information dissemination, education, alternatives, problem ID & referral, community-based processes, and environmental. The current system in place for the delivery of community-based and environmental strategies is a coalition umbrella organization, the Alliance of Coalitions for Healthy Communities (ACHC). The Alliance is funded to foster, mentor, and assist in sustaining 21 local community prevention coalitions. The coalitions cover more than 55+ of the 61 Cities, Villages and Townships (CVTs) in Oakland County, with an agency goal of coalition presence in all the county's communities. Until all 61 CVTs are covered by Coalitions, OCHN considers this an identified gap. Community-based and environmental strategies are aimed at the data driven priority issues (under-age drinking, adult binge-drinking, non-medical use of prescriptions opiates/heroin use, youth marijuana use, underage youth tobacco access and tobacco use including electronic nicotine devises and vape products and increasing access to prevention services for older adults 55+) and target the general population in the area covered by the OCHN region. By their very nature, community and environmental strategies may affect all sectors of a community when successfully implemented. This includes youth, parents, educators, schools, community officials and policy makers, law enforcement, businesses, faith communities, hospitals and institutions of higher learning. The ACHC utilizes the evidenced-based framework of Communities Mobilizing for Action on Alcohol (CMCA) to address priority issues. The populations of focus for all other strategies are primarily high-risk youth and their parents. OCHN's Prevention Provider Network provides education, information dissemination, problem ID & referral services, and alternative services to schools and

communities throughout Oakland County addressing the priority areas identified by OCHN and MDHHS's strategic plan. The evidenced-based prevention programming used by OCHN prevention providers aimed for individuals include: Botvin Life Skills Training, Strengthening Families, Prime for Life, Guiding Good Choices, Positive Action, Opening Doors, Screen, Brief Intervention, Referral to Treatment (SBIRT), Mentoring and Tutoring services, Michigan Model for Health, Wellness Initiative for Senior Education (WISE), CATCH My Breath , INDEPTH, ReNewed, ReSolved, PEEPs and Best Practice for overdose, naloxone education and distribution. These programs, services, and activities are funded/delivered by The Alliance and through eleven additional licensed prevention agencies who deliver the educational, alternative strategies, and other CSAP strategies (Attachment I).

**Morbidity, mortality and prevalence of SUD problems in the PIHP region**

Addiction to tobacco, alcohol, and other drugs impact our population as a whole and is quantifiable in relation to deaths and illnesses. As a result, in 2021 Oakland County totaled 263 per 100,000 population in all drug overdose deaths and 32 alcohol involved traffic crash deaths. In 2021, 215 per 100,000 population died from opioid related deaths and in 2019, 156 opioid related hospitalizations occurred in Oakland County (Footnote 31). Consequently, addiction has an impact on morbidity by causing multiple illnesses and injuries each year. Adverse effects may occur from drug and alcohol abuse including Cardiac Crises, Respiratory Depression, Liver Cirrhosis, Nephropathy, Cardiac Pathology, Hepatitis, HIV, Tuberculosis, and Injury-associated Disability to name a few.

Morbidity and mortality may be prevalent in the first years of life. The effects may begin while a fetus is still in utero. Complications such as fetal distress, stillbirth, and low birth weight, or being born addicted because of maternal drug use during pregnancy may occur. In the teenage years, self-inflicted injuries and homicides became more common.

To address morbidity and mortality, all contracted women's specialty providers address issues related to infant and maternal health in addition to infant mortality. Non-women's specialty providers also address this issue when relevant. Currently OCHN sits on the Best Start for Babies and Local Leadership Group county-wide committee to address infant mortality in Oakland County. In addition, OCHN sits on the Mother Infant Health and Equity Collaborative and the Southeast Michigan Perinatal Quality Improvement Coalition to address maternal and infant death rates in Oakland County.

OCHN has addressed infant mortality by ensuring that substance use providers are coordinating services with OB/GYN Physicians. Women are screened by the Access Center as the priority population and referred to the appropriate level of care. The purpose of this is to decrease illnesses known to impact this population and improve a person's overall quality of life.

Morbidity and mortality may suddenly occur at any age regardless of the number of substances used or the length of use. Examples include vehicular accidents while impaired, overdose, death by overdose or brain damage from substance use. As mentioned above, juveniles in Oakland County hold two of the highest age groups where substances are first used. Oakland County has recognized the need to increase SUD services with juveniles. OCHN's Justice Department also works very closely with the Juvenile Drug Court to assist clients in this population to enter SUD treatment. Some of the areas in which OCHN's Justice Department works to assist at risk youth are as follows:

- Prosecutor's Office
    - Embedded clinical liaison who follows SBIRT (Screening, Brief Intervention, and Referral to Treatment

        - Completes S2BI or Youth Guide
        - If an 18 year (or older) still qualifies for the Juvenile Justice system, then an AUDIT / DAST are completed
        - Refer to Access for SUD Access Screenings as needed, otherwise provides community-based referrals
        - Follow-up meetings with family at various increments
- Juvenile Drug Court (JDC):
    - Determine eligibility for JDC (in the form of an Access Screening) – OCHN follows the Access Center's standard procedures as it relates to someone with third-party insurance
        - Community-based children: completed by the Access Center
        - Children detained in Children's Village: completed by the Justice Department
- Mental Health and Juvenile Justice Diversion (MHAJJD):
    - OCHN has had this grant since FY18 and utilizes the MAYSI-2 and Pediatric Symptom Checklist to determine any needs. This is not specific to SUD but the child as a whole
    - Based on those screening tools, a self-report and general conversation is conducted with the child and/or guardian. If SUD needs are identified, the child is referred to the Access Center (as appropriate) or other community-based services
    - Follow-up meetings with family at various increments

**Process used to determine the prioritized, consequences and intervening variables**

To determine and prioritize substance use disorder prevention, treatment, and recovery needs, OCHN utilizes the Strategic Prevention Framework (SPF), a prevention planning model developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). The first step of the process is completion of a formal needs assessment (NA) specific to Oakland County. The objective is to gather available resources and proven interventions to focus on identified problems; with the goal of effecting change at the population level and promoting positive behavioral health. Additional qualitative data was collected from focus groups that were formed. Three focus groups on substance use and misuse in prevention, treatment, and recovery were formed to assess levels of political will and community readiness. Following the guidelines of the SPF, OCHN formed a Community Epidemiological Workgroup (CEW) to collect available data on the consequences and consumption patterns that result from substance use in Oakland County based on the quantitative and qualitative data. The CEW assessed and analyzed the data to form problem statements and then determined probable intervening variables (driving forces) unique to Oakland County. From that information gathered, the CEW Workgroup identified priority areas to address within prevention, treatment, and recovery services. The eight identified priority areas rooted in data, community input, and group expertise are:

1. Increase effective media messaging to prevent substance misuse
2. Increase early prevention practices
3. Create collaborative outreach and treatment workgroups
4. Build systemic promising and best practice approaches
5. Support and address workforce retention and development
6. Increasing non-traditional education on prevention and treatment methods
7. Expanding access and implementation of harm reduction

8. Increasing support to address disparities related to substance misuse

As a final step in the process a Community Prevention Planning Collaborative (CPPC) was formed that included members of the CEW and other key community partners. The CPPC members identified root causes, local conditions/intervening variables, and possible solutions for each of the Strategic Directions identified in the State (MDHHS) Strategic Plan Guidelines. Strategic directions fell into three categories: prevention, treatment, and recovery, and included the following:

Prevention priority areas

- Reduce underage drinking
- Reduce prescription drug misuse, including a reduction in the misuse of opioids for non-medical purposes
- Reduce marijuana use among youth and young adults
- Reduce underage youth tobacco access and tobacco use including electronic nicotine devices and vape products
- Increase in access to prevention services for older adults age 55 and older

Treatment priority areas

- Expand behavioral health and primary care services for persons at-risk for and with mental health and substance use disorder
- Increase access to treatment and harm reduction for persons living with Opioid Use Disorder
- Increase in access to treatment for criminal justice involved population returning to communities
- Increase in access to trauma responsive services
- Reduce in the percentage of substance exposed birth/infants
- Increase in access to treatment services for older adults 55 and older

Recovery priority areas

- Enhance coordination of prevention, follow-up, and continuing care in the recovery process
- Expand treatment services to include ongoing support and multiple coordinated strategies to support recovery
- Increase in access to recovery services to promote life enhancing recovery and wellness for individuals and families

The CPPC members took the root causes, local conditions, the eight priority areas identified by the CEW Workgroup, and possible solutions for each of the state priority areas and organized the information into logic models to support the strategic planning process and identify solutions that address the root causes of substance use in Oakland County. The other priority issues outlined in our logic model were added from monitoring MiPHY data on gambling, monitoring ACCESS admission data with older adults in Oakland County, and participating in the Older Adult Wellbeing Workgroup. Please refer to Attachments I & II.

## Communicable Disease Services

OCHN will continue to adhere to Prevention Policy #2. Adherence to Level 1 training requirements for all staff in contact with clients will be monitored during the program review process. Providers will be encouraged to utilize the web-based program provided by Michigan Department of Community Health (MDCH). In addition, all clients receiving SUD services will receive TB tests upon entering residential treatment and those infected will be referred for medical services. Pregnant women are granted access to STD/Is, TB, Hepatitis and HIV testing. Screenings

for risk of HIV/AIDS, STD/Immunizations, TB and Hepatitis are conducted at both the SUD Access Center and provider sites. Information regarding risk is also provided. Available resources will continue to be given to individuals with high-risk behaviors via the SUD Access Center and provider sites. All documentation required in Prevention Policy #2 has been adhered to. Adherence to Prevention Policy #2 already occurs for individuals with co-occurring disorders that are screened by the SUD Access Center or receive treatment from a SUD provider.

## Section 2……

***A narrative, based on the epidemiological profile, identifying and explaining data- driven goals and objectives that can be quantified, monitored, and evaluated for progress (increase in access to SUD services, behavior change, quality improvement, and positive treatment outcomes, an increase in recovery support services, and improvement in wellness) over time.***

Based on the epidemiological profile described in section one of this report, the overall goals are to reduce substance use, increase sustained recovery, to protect the health, safety and improve the quality of life for all residents. It has been identified that there are gaps in sustained recovery with the targeted population. In 2022, 77% of OCHN individuals served have been through treatment more than once (Footnote 32). According to our data, 61% of individuals entering treatment successfully complete, 6.9 do not successfully complete, 28.4% drop out, and 3.7% were terminated by the facility (Footnote 33). Thirty percent of clients entering residential treatment discharge from the program prior to completion. (Footnote 34). SUD affects many aspects in life including employment, income, education, health, and overall quality of life. The objective to address this problem is to increase the use of recovery support services and increase clients' follow through to the next level of care. Due to the rise in alcohol and opiate specific admissions over the past five years as indicated in narrative one, the need to increase and strengthen services has been identified. Therefore, OCHN will expand upon and monitor its existing services to address alcohol and opiate addiction (for full description please see narrative one). This will provide an increased opportunity for sustained recovery and an improvement in the quality of life.

During the Fiscal Years of 2023 - 2027 objectives of OCHN are to implement the following: Increase the use of support services such as peer coaches, case managers, recovery housing and transportation, Increase the number of clients that continue to the next level of care, Add Sublocade to the array of medication assisted services for those with an opioid use disorder, Continue to review data specific to SUD via Power BI Dashboard to track and maintain information to review for effectiveness, quality assurance or the need for restructuring services, Continue ancillary services such as yoga and meditation to support recovery and Engage in an initiative to support the use of Narcan for all first responders in Oakland County.

Substance use disorders have a major impact on individuals, families, and communities. The effects of substance use disorders are collective, contributing to costly social, physical, mental, and public health problems. These problems include: Teenage pregnancy, Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), Other sexually transmitted diseases (STDs), Chronic health issues, Domestic violence, Child abuse, Car accidents, Aggressive behavior, Crime and Suicide. The spread of STDs is directly affected by social, economic, and behavioral factors. These factors cause barriers or gaps to STD prevention and treatment and, the willingness to seek care.

Social, economic, and behavioral factors that affect the spread of STDs include:

- Racial and ethnic disparities. Certain racial and ethnic groups correlate with other determinants of health status, such as poverty, limited access to health care, fewer attempts to get medical treatment, and living in communities with high rates of STDs.
- Access to high-quality health care is essential for early detection, treatment, and behavior-change counseling for STDs. Groups with the highest rates of STDs are often the same groups for who access to or use of health services is most limited.

With substance use comes a lowering of inhibitions bringing forward high risk behavior such as needle sharing unprotected sex, paying, and bartering for sex leading to the spread of STDs.

OCHN's goal is to continue to improve access to comprehensive and quality healthcare services. The Health Division has identified multiple health issues among the SUD population for many years. Recognizing missed opportunities to assess and educate clients about chronic health issues, risk reduction strategies, access to health care and activities to prevent illness was the motivation to address clients' overall health and well-being. OCHN ensures care coordination with the Primary Care Physicians (PCPs) for all services, as well as referrals made to the Health Department and Honor Health. Honor Community Health is a nonprofit, 501(c)(3) community health center providing comprehensive and integrated primary, behavioral health and dental care throughout Oakland County, Michigan. Honor Health is designated as a Federally Qualified Health Center by the Health Resources and Services Administration (HRSA).

Additionally, OCHN incorporated The RISE (Recovery, Information, Support and Education) Center, housed within the Resource and Crisis Center (RCC) in 2017, which connects individuals to free community resources, including dental, education, employment, housing, legal support, mental health services, and transportation. The center is open to the community to help maintain recovery and early intervention for anyone at risk of relapse. Services are provided by three skilled case managers. This team additionally assists individuals in applying for Medicaid, insurance needs, and linkage to a primary care physician. The Access Center utilizes the RISE center when meeting with individuals to assist the person served with applying for Medicaid/Health Michigan insurance and obtaining immediate resources that may be needed.

In August of 2017 OCHN created The Sober Support Unit (SSU), which is also housed at the RCC, as a first step toward long-term substance use treatment services. The unit is a sobering and monitoring program for people experiencing side effects of drug and alcohol misuse. It is an environment in which peers help a person feel as comfortable as possible until they are admitted into treatment. Symptoms are monitored, by following a specific set of criteria, and if the symptoms presented are outside the criteria, a referral for immediate medical attention occurs. Trained recovery coaches and Emergency Medical Technicians (EMT) are on staff twenty-four hours a day, seven days a week. People are transferred from the unit to individualized treatment within 24-hours of entrance. Data collected at the SSU in FY22 indicated that of the 1,717 individuals that entered the unit, 92% followed up with treatment. The average length of stay was between 1 day (52%) and 2 days (43%) respectively. There were a significantly higher number of males (76%) versus females (23%) and transgender individuals (0.4%) who presented on the unit. Half of the individuals presented with a primary alcohol use disorder (50%), followed by cocaine/crack (23%), and heroin (18%). Other opiates/synthetics only accounted for 4% of primary substances used. October saw the highest volume of people entering the unit, followed by August, and June/July (Footnote 35).

As we continue to understand the importance of addressing the issues that specifically affect women in recovery, OCHN continues to provide an array of women's specialty services. The SUD pregnant population is considered a high priority and screened within 24 hours by the Access

Center. Each pregnant individual is provided with pregnancy testing and clinical services and is linked to resources such as: Field Nursing, Nurturing Parent Program and Nurse Family Partnership. Each of these services provides support, education, self-sufficiency, and home visits. This team works in a collaborative effort to promote successful parenting.

## Section 3……

***A narrative illustrating goals, objectives, and strategies for coordinating services with public and private service delivery systems.***

**Prevention:**

OCHN established partnerships with the Oakland County Prosecutor's office by establishing the Community Liaison position. The Behavioral Health and Justice Liaison (Community Liaison) serves as an OCHN team member, who is embedded in the Oakland County Prosecutor's Office. The Behavioral Health and Justice Liaison utilizes Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach to provide case consultation, service and system coordination, and referrals/linkage to resources for children, adults, and families who are presented to the Prosecutor's Office with a potential legal charge and appear to benefit from mental health, substance use and/or co-occurring services. They advocate and assist to divert from formal adjudication and into appropriate intervention, whenever possible. They provide access screenings to arrange access to OCHN services.

Goals/Objectives

- Coordinate services, resources, and support between OCHN, Prosecutor's Office, Community Corrections, Oakland County Circuit Court, Children's Village, Provider Network, and other community partners
- Identify prevention and treatment needs of individuals and families in the community
- Provide crisis intervention services to individuals
- Integrate coordination of prevention, treatment and recovery services
- Increase access to screening and treatment services

OCHN established partnerships with twelve provider agencies providing prevention services in Oakland County. The following are the stakeholders and a description of the services provided.

America's Community Council (formally Arab American Chaldean Council) provides services to individuals residing in Oakland County. Their services delay and/or reduce the use of alcohol, tobacco, and other drugs with emphasis on the prevention of non-medical use of prescription drugs and marijuana in Arab/Chaldean youth and other high-risk populations in Southeast Oakland. This goal is achieved through implementation of Botvin Life Skills, Strengthening Families Program, and Problem Identification and Referral Services.

The Alliance of Coalitions for Healthy Communities assists in building and maintaining safe, healthy, drug-free communities in Oakland County utilizing the Strategic Prevention Framework (SPF) and Communities Mobilizing for Change on Alcohol (CMCA). Both evidence-based frameworks require community organizing to assess community norms that create, support, or offer resistance to goal attainment, building capacity by developing relationships with those motivated to change and who represent the diversity of Oakland County, assessing the variables that impact the identified priority problems and creating logic models and strategic work plans,

implementation of a multi-faceted plan, evaluation and modification based on outcomes. The Alliance addresses co-occurring mental health and substance use disorders with a focus on college age young adults aged 18-25 utilizing the Montana Institute Positive Community Norms Framework. The Alliance works within the framework to provide campus-based media campaigns and other strategies to address misperceptions about mental health issues and substance use as a means of mitigating anxiety, depression, and stress. The Alliance addresses underage drinking, underage binge drinking, prescription drug misuse and youth marijuana use by utilizing proven youth leadership trainings using the CADCA and Montana Institute frameworks. The Alliance equips urban youth, young adults, and key leaders in high-risk urban communities with information to develop and implement a culturally sensitive and appropriate campaigns aimed to reduce alcohol, marijuana, and non-medical use of prescription drugs and ENDS use as well as co-occurring mental health. Community-based process coalition building and collaboration with other relevant community-based organizations is utilized to accomplish this goal. The Alliance employs the Designated Youth Tobacco Use Representative to coordinate county-level efforts to increase tobacco retailer compliance of the Michigan Youth Access to Tobacco Law (YTA). This is accomplished through maintenance of the Oakland County's Master Retailer List, coordination of vendor education visits and non-Synar civilian visits, law enforcement, and formal Synar Compliance Check activity.

CARE of Southeastern Michigan implements INDEPTH and Botvin Life Skills Educational Programs in Hazel Park area schools to assist in the delay to initiation and/or reduce the likelihood of student drug use by assisting students in acquiring life skills, knowledge of the dangers of drug use, decision making skills, assertiveness training and social skills.

Catholic Charities of Southeast Michigan provides educational, alternative, and problem identification and referral strategies to families in Oakland County. Catholic Charities works to change knowledge and attitude about alcohol use among the Hispanic Community to reduce binge drinking and impaired driving, increase substance use knowledge and protective factors in Hispanic children and their parents through consistent support and guidance provided by mentors, prevent academic failure in Hispanic students through after-school tutoring to encourage academic success as a protective factor against substance use, instill protective factors in Hispanic children, increase positive parenting skills as a protective factor, and assist Hispanic parents with Limited English Proficiency with their children's academics through translation services in school-related activities. These outcomes are achieved through educational groups, mentoring, tutoring, screening, and referring families to services.

Easterseals MORC provides Prime for Life groups to at risk youth in Oakland County, specifically to individuals who identify as LGBTQIA+.

Holly Area Community Coalition's goal is to delay the initiation and reduce the likelihood of student drug use by assisting students in acquiring life skills in knowledge of the dangers of drug use, decision-making skills, assertiveness training and social skills peer resistance and refusal skills, relaxation skills as protective factors against substance use. This is achieved through their Botvin Life Skills Program, Above the Influence, ASSET Mentor, Safe Smart, and Successful Programs in the Holly Area.

Huron Valley Community Coalition provides Botvin Life Skills to increase knowledge of the dangers of drug use, decision making skills, assertiveness and social skills, peer resistance and refusal skills, relaxation skills as protective factors against substance use to students in the Huron Valley School District.

North Oakland Community Coalition provides the Botvin Life Skills Program to middle school students in the North Oakland, specifically Lake Orion School District. The Life Skills Program helps them reduce the use of alcohol, tobacco and other drugs with emphasis on the non-medical use of prescription drugs and the dangers of youth marijuana use the communities they serve.

Oakland County Health Division provides screening, brief intervention, and referral to treatment (SBIRT) services to individuals in the Health Divisions Clinics to assist with access to treatment in Oakland County. They provide Catch My Breath and the Michigan Model for Health Programs to students in Oakland County

Southeast Oakland Coalition provides Botvin Life Skills Program to students in the Ferndale School District to help assist in reducing the likelihood of student drug use by increasing life skills such as decision-making skills, relaxation and protective factors against substance use and misuse.

South Lyon Community Coalition implements the Botvin Life Skills Program and outreach services to students in the South Lyon School District.

Student Leadership Services, Inc. implements Botvin Life Skills, Prime for Life, Guiding Good Choices, and Students Leading Students Programs to help delay the onset and reduce the risk for use of alcohol, tobacco, and other drugs, including the non-skills among Oakland County middle school age youth.

Goals/Objectives

- To provide services in all the Center for Substance Use Prevention (CSAP) Strategies: education, information dissemination, alternatives, problem identification and referral, community-based process, and environmental.
- To provide prevention services across the lifespan of individuals in Oakland County based on data informed decision-making process.
- Coordinate prevention and treatment services including women specialty services in efforts to eliminate barriers in access to care.
- To continue to reduce the Retailer Violation Rate.
- Reduce stigma, increase protective factors, and increase perception of harm of substance use/misuse throughout Oakland County residents.
- Increase knowledge of prevention services in Oakland County.

## Treatment:

OCHN established partnerships with several entities to provide treatment and supportive recovery services. The following are the Stakeholders and a description of the collaborative relationships established with OCHN.

Honor Health (Federal Qualified Health Center) provides services to enhance and address the physical and behavioral health needs of individuals residing in Region 8. OCHN embedded a Peer recovery Coach on site to provide Project Assert Services which include screening, brief intervention, and referral to treatment (SBIRT) services to individuals identified by medical personnel as showing potential risk of substance misuse.
The Peer Recovery Coach provides education and information regarding substance misuse, facilitates calls to schedule appointments with Access for Withdrawal Management, Residential or Medication Assisted Treatment. Linkage to Substance Use Outpatient providers and Case Managers at the Recovery Information Support Education Center is also the role of the Prevention Specialist. OCHN understands, an individual's basic needs must be met to enhance their recovery experience.

Goals/Objectives

- To provide education
- To help identify treatment and prevention needs of individuals in the community
- Supportive services promoting a holistic approach to recovery
- Reduce barriers for screening and access to treatment services
- Increase knowledge of community-based recovery resources and linkage to a case manager
- Improve quality of life

Oakland County Jail (OCJ) and OCHN have established Medication Assisted Treatment (MAT) Services to individuals diagnosed with an Opioid Use Disorder during incarceration. Sacred Heart Wellness Center in coordination with Correct Care -OCJ conducts screenings to determine program eligibility. Counseling and Peer services are an adjunct to MAT. OCHN Access staff coordinates with Inmate Services Case Worker to determine level of care needs and admission to the program. OCHN will expand medication options and offer Sublocade to individuals enrolled in the program
If the individual was receiving services prior to incarceration, Access staff will coordinate with the existing Medication Assisted Treatment provider to ensure a seamless transition to jail MAT services. Prior to release. appointments are coordinated with all parties including the MAT provider to reduce the potential for reuse of substances and to monitor engagement in services post release. Follow up calls post release are included in the framework.

Goals/Objectives

- Provide MAT services to individuals diagnosed with an Opioid Use Disorder who otherwise would have experience withdrawal symptoms
- Overall expansion/availability of MAT services
- Continuation of treatment services for individuals involved in MAT prior to incarceration
- Provide therapeutic services to help support individuals in recovery during incarceration
- Provide Peer support to help build a positive relationship during incarceration and post release
- Improve outcomes for long term recovery and reduction in recidivism

OCHN is expanding Naloxone distribution and harm reduction efforts through two partnerships, Oakland County and the Alliance. OCHN established an interlocal agreement with Oakland County for the purchase of safe, sterile needles or syringes (supplies) for substance use disorder prevention and harm reduction efforts. The County is responsible for order, delivery, tracking of all supplies purchased, and data sharing. The Alliance implements the Save A Life Stations that

include naloxone kits, Deterra bags, Fentanyl Test Strips, Xylazine Test Strips, and harm reduction and treatment resources.

Goals/Objectives

- Expand access to implementation of harm reduction
- Increase non-traditional education on prevention and treatment methods
- Reduce opioid overdoses within Oakland County

OCHN will continue to explore the need to expand prevention services to include prevention efforts that address early intervention and older adult (age 55+) preventative services. OCHN is being intentional about establishing and strengthening these partnerships to expand prevention services.

OCHN also partners with Michigan Rehabilitation Services to identify vocational and employment. Michigan Rehabilitation Services (MRS) provides support for those with disabilities to prepare and obtain employment. To be eligible for services, the individual needs to have a physical or mental disability and this disability is a barrier to employment. A provider agency can make referrals for individuals served to MRS to assist in their employment goals. Once at MRS, a vocational counselor will help the individual develop a plan with goals on employment. The path to obtain employment may include assessments, classes on job/employment seeking skills, further treatment for physical or mental health needs, job and/or training placement etc. MRS also supports businesses who hire those with disabilities to help the employer maintain their employees.

Goals/Objectives:

- Establish gainful employment to meet the individual's basic needs
- Enhance employability and interviewing skills
- Offer vocational training and services to secure sustainable employment and income

OCHN continues to maintain relationships with employment partners that were established using the Individual Placement and Support Model. This program was effective 2021-2022 with the assistance of two Employment Specialist. The program provided employment and support to individuals diagnosed with an Opioid Use Disorder between the ages of 18-30.

An excellent addition to the services offered to people diagnosed with a substance use disorder is the Veterans Navigator. The Veterans Navigator works in the Access Center to address veteran's immediate needs, assists in coordinating treatment services and helping access benefits. The Navigator works closely with the State Veteran's Administration, in addition to the local Oakland County Veteran's Administration staff.

An extension of this role involves providing resources to family members of veterans, coordination and linkage to the RISE Center. The Navigator is also a liaison between OCHN and other Stakeholders. Participation in outreach events such as "Got Your Six" offers an opportunity to network and discuss/address issues specific to this population. OCHN is represented by the Veteran's Navigator at two Veteran Treatment courts at the district and circuit court levels. These courts are crucial to helping Veterans in need of treatment, with appropriate interventions thus deterring further criminal activity. Many of these Veterans qualify for VA and additional community behavioral health supports. These linkages have been crucial when the VA has not been a viable option for Veterans that are in crisis. To further OCHN's outreach efforts, the OCHN Veteran Navigator program also added the role of Veteran Peer Support Specialist to further assist in reaching Veterans and Military Families in Oakland County. Since the hiring of

the OCHN Veteran Peer Support Specialist, the Veteran Peer Support Specialist has successfully created and launched a Veteran Peer Support group that has reached multiple Veterans throughout Oakland County. This group is held in two locations at an OCHN partner agency.

Goals/Objectives:

- To educate and provide information about Substance Use Prevention & Treatment Services
- To advocate for Veterans and coordinate treatment services with Access and Providers
- Recommend services and discuss barriers with the Substance Use Team to help build capacity to meet the needs of Veterans and their families

As a result of feedback about transportation needs from individuals in the recovery community and providers OCHN coordinates with Freedom Road to help bridge the gap. Oakland Community Health Network has liaisons to coordinate transportation needs with Freedom Road. Freedom Road is an agency that provides reimbursement through a voucher program. Reimbursement is provided to the individual enrolled in services or family/friends who provide transportation for the individual. Services are based on insurance, income and area of residency. Providers have also established relationships with Uber, Lyft, LogistiCare and Modivcare. These services are coordinated by the Case Manager or Peer Recovery Coach. SOR funds are utilized to assist individuals enrolled in medication assisted treatment to meet transportation needs.

Under SOR funding, OCHN is currently in conversations with a local area hospital to implement Project Assert into their Emergency Department. Peer recovery coaches will coordinate with the medical staff to screen, coordinate and provide linkage to treatment and recovery services

Goals/Objective:

- To provide immediate screening, linkage, and coordination for admission to substance use disorder services
- To increase access to treatment services for individuals admitted to the emergency room
- To provide information and resources about treatment and recovery supports in the community
- To increase outcomes for engagement in long term recovery

OCHN partners with Oakland County Community Corrections. An OCHN contracted provider facilitates Seeking Safety gender specific groups to individuals enrolled in the Step Forward Program. Step Forward is an alternative to incarceration program that offers case management, therapeutic groups, and other wrap around services.

Goals/Objectives:

- To address gender specific needs related to traumatic experiences
- To educate individuals about post-traumatic stress disorder and other experiences that may have caused trauma in their lives and the impact on mental health/substance use
- To teach positive coping skills and identify safe spaces and relationships

Oakland Community Health Network has a variety of committees that address the behavioral health, treatment and recovery needs of individuals served. A representative from the Substance Use Service Network Team participates on the following committees: Quality Improvement Committee, Best Practices Committee, Outcome Improvement Committee, ODIN (Electronic Health Record) SUD User Group, Psychiatric Quarterly, Operations Management Team, Improving Practices Leadership Team, Internal Utilization Management Committee, Sentinel Event Review Committee, Peer Advisory Committee, Health Care Integration Committee and Department of Human Services Team Decision Making Team.

The WSS Coordinator attends Team Decision Making (TDM) meetings as a Community Representative. During these meetings, the goal is to assist the parent with resources to help maintain and/or regain custody of their child(ren). The Community Representative explains resources available for SUD and MH services within the OCHN Provider Network along with providing education on SUD to the entire TDM team which includes but not limited to the family, their supports if requested, the CPS worker and supervisor, the TDM facilitator, lawyer for children and/or parent, School representatives, Foster Care worker/Supervisor, etc. Additionally, another staff member of the SUD Team is a member of the TDM Steering Committee.

OCHN has a very active Health Care Integration Committee. The Nurse Case Managers, OCHN's Clinical and SUD team, providers and individuals receiving services meet monthly. The goal of the committee is to ensure care coordination within systems, address the comorbid needs of individuals and support sustained recovery and stability.

The above committees include clinicians, psychiatrists, quality management professionals, and administrative staff from provider agencies, hospitals, Medicaid health plans and persons served. The goals for coordinating with community agencies are to assess the needs of the population, evaluate current programs, identify gaps in services and expand programming. The following are community stakeholder committees that the Substance Use Service Network Team is presently represented on or collaborates with to improve services in our community:

- Oakland County Best Start for Babies Committee
- Oakland County Elderly Isolation Task Force
- Oakland County Fetal and Infant Mortality Review Committee
- Oakland County Homeless Healthcare Collaboration
- Oakland County Hospital Discharge Task Force
- Oakland County Juvenile and Adult Treatment Courts
- Oakland County Community Corrections
- PIHP Substance Use Directors Workgroup
- Community Corrections Advisory Board
- Treatment Provider Collaborative
- Prevention Provider Collaborative
- Medical Services Advisory Group
- Veteran Services
- Recovery Community
- Freedom Road
- Faith based stakeholders
- Department of Human Services
- Community Volunteers
- Residents of Oakland County
- Oakland County Commissioners
- American House Older Adult Living Community
- Law Enforcement Agencies
- Michigan Department of Corrections
- Oakland Livingston Human Service Agency
- Veteran Treatment Court
- Oakland County Homeless Veterans Task Force

- Oakland Suicide Prevention Task Force
- American Legion
- Welcome Missionary Baptist Church

The Substance Service Network Team regularly meets with Peer Coaches to discuss what works for those engaged in sustained recovery. The Peer Coaches identified several things that support the recovery process as well as some things that hinder the process. These include the following: The need for recovery housing and employment resources, Affordable housing, Offering several pathways to recovery and community support groups, Person centered planning meeting individuals where they are in their recovery journey, Provide a clubhouse setting where people can go and encourage one another, Assistance with obtaining financial assistance from Department of Human Service

The OCHN Recovery, Information Support and Education (RISE) Center provides assistance with the needs noted above. Case managers are available to meet with individuals, assist with applications for housing, DHS benefits and linkage to a Federal Qualified Health Clinic. Case Managers also conduct follow-up calls to ensure engagement in the resources provided.

OCHN will be partnering with a Recovery Community Organization for individuals to socialize and engage in activities and other support to enhance their recovery journey.

OCHN has a long-standing relationship with various community organizations. There has been close collaboration with both the public and private sectors of the community. Presentations on services in the community include hospitals, town hall meetings, churches and formal organizations. Throughout Fiscal Years 2024-2027 it is the goal of OCHN to uphold the following:

- Continue to as an organization that collaborates with partners and advocate to improve the quality of life for the people we serve.
- Continue Community Outreach
- Continue to explore funding to expand services
- Advocate for and continue to provide services to the offender population

While maintaining the above goals the objective will be to achieve the following:

- Increase education to the public about substance use disorders
- Increase information to the community about access to SUD services
- Continue to provide opportunities for input from Stakeholders, Providers, and individuals in the recovery community to help drive services, programming and the like
- Provide education and resources for harm reduction

While maintaining the above goals the objective will be to achieve the following:

- Increase education to the public about substance use disorders
- Increase information to the community about access to SUD services
- Identify and remove gaps and barriers to treatment
- Reduce stigmatism
- Reduce homelessness
- Establish Promising Practices
- Improve quality of life
- Improve outcomes

**Recovery:**

Goals/Objectives:

- Supportive services promoting a holistic approach to recovery
- Increase knowledge of community-based recovery resources and linkage to a case manager
- Improve quality of life

Goals/Objectives

- Onboard a new Recovery Community Organization
- Increase access and hold community events for recovery services to promote life enhancing recovery and wellness for individuals and families.
- Develop effective media messaging surrounding recovery messaging
- Develop a plan to increase community engagement in the recovery community and reduce stigma

OCHN has identified a need to increase recovery-oriented services and as a result, has issued a Request for Proposal seeking to add a Recovery Community Organization to the system of care. The intention of the RCO will be to support recovery efforts by providing recovery-oriented activities, support, and programming. The location of the Recovery Community Organization will take into consideration location and transportation access for individuals who will be utilizing these services. This will assist in our goal of increasing community engagement and creating a space to promote recovery efforts and assist in reducing stigma. The intention with the RCO will be to normalize recovery in a way that supports all pathways. This will be done through holding community events for those in recovery along with the families of those in recovery.

Through grant funding, OCHN will work to increase media messaging to support recovery efforts in a way that is meaningful and takes into consideration the feedback from the needs assessment. Media messaging with also be utilize to promote and educate on community resources and events occurring throughout Oakland County.

Goals/Objectives:

- Research the need to expand recovery support services including peer specialists, recovery housing, recovery cafes, recovery-friendly workplaces, recovery high schools, collegiate recovery programs, and family caregiving.

To further address housing concerns during an individual's recovery effort, OCHN contracts with 10 recovery homes to provide a recovery friendly environment. These current contracts reside with Turning Point who has capacity of 22 male and 12 female beds, Sacred Heart Rehabilitation Center, with capacity for 6 male beds, and Milford Counseling, with capacity for 59 male beds. To ensure that we can accommodate the continued need for housing supports, OCHN will be submitting a Request for Proposal for additional recovery housing to support continued recovery efforts and ensure adequate capacity to meet the needs within the county. OCHN will continue to explore the need to expand recovery support services through hosting regular townhall meetings where stakeholders can provide input, analyze data collected from provider post-discharge surveys, OCHN created surveys, and GPRA outcomes.

## Section 4……

***A summary of key decision-making processes and findings undertaken by the SUD Policy Oversight Board or other regional advisory or oversight board.***

Oakland Community Health Network (OCHN) and Oakland County entered into an inter-local agreement in 2014 outlining the Oakland County Board of Commissioners (BOC) involvement in the Oversight Policy Board (OPB). The agreement allows the BOC to appoint two commissioners to the OPB. OCHN utilized the technical advisory to develop by-laws and in determining the general make-up of the board. The OPB consists of 12 board members and currently eleven seats are filled with one vacancy. The current OPB is represented by the following community members; County Commissioners; OCHN Board Member (liaison between OPB and full board); Faith Based Community; Recovery Community; Veterans Services (currently vacant); Department of Human Services; Treatment Community; Prevention Community and General Public.
Since the inception of the OPB, the board has continued to weigh in on key decision making as it relates to SUD services and funds spent. Activities the OPB members are involved in include but are not limited to the following.

- Review and comment on all prevention and treatment site review findings
- Invitation to take part in the RFP process including selection of the awarded contracts
- Review and approval of strategic/annual action plans
- Comment and support on key legislative issues
- Review and approval of the budget process
- Review of Pilot Projects
- Review of how PA2 funds are utilized.

The OPB also weighs in on current issues that present themselves and impact individuals with substance use disorders by providing guidance, support and advocacy.

The OCHN Veterans Navigator's mission is to help veterans and their families navigate state, federal, and community resources, including disabilities, employment, housing, Re-entry, substance use disorders, transportation, and other resources. Services are available to all veterans regardless or discharge status, veterans who do not meet service eligibility due to time-in-service, veterans who are not eligible for Veterans Administration (VA) services, and Veterans who do not wish to seek traditional support paths.

OCHN is represented by the Veteran's Navigator at two Veteran Treatment courts at the district and circuit court levels. These courts are crucial to helping Veterans in need of treatment, with appropriate interventions thus deterring further criminal activity. Many of these Veterans qualify for VA and additional community behavioral health supports. These linkages have been crucial when the VA has not been a viable option for Veterans that are in crisis.

The Veteran's Navigator works to ensure the building of community partnerships and collaborations to best service Oakland County veterans. The Veteran's Navigator partners with the VA in the efforts of identifying and registering previously unidentified Veterans. This connectivity ensures individuals who qualify for VA services are able to receive health care, mental health services, substance abuse services, housing and compensation. In 2019, OCHN

created a Veteran's Task Force which brings together Veteran's, family members of Veteran's, substance abuse treatment providers, core provider agencies, OCHN SUD Oversight Policy Board Members, the Oakland County Veteran's Affairs office and other community partners to discuss challenges and solutions that Veteran's in Oakland County face when attempting to obtain services.

Since the inception of the OCHN Veteran Navigator program, about 1,000 Veterans and Military families have been screened and connected to various resources, benefits and organizations in the Tri County Region. Close to 2,500 Veterans and Military families have been connected to resources and benefits since OCHN and partner agencies created the Oakland County Veteran Resource Fairs. To further OCHN's outreach efforts, the OCHN Veteran Navigator program also added the role of Veteran Peer Support Specialist to further assist in reaching Veterans and Military Families in Oakland County. Since the hiring of the OCHN Veteran Peer Support Specialist, the Veteran Peer Support Specialist has successfully created and launched a Veteran Peer Support group that has reached multiple Veterans throughout Oakland County. This group is held in two locations at an OCHN partner agency.

**Opioid Settlement Funds**

Michigan anticipates it will receive over $1.45 billion from opioid settlements which will be divided between local subdivisions and the State of Michigan. The opioid settlement funds that the State receives will be directed to the Michigan Opioid Healing and Recovery Fund (MCL 12.253) created by the Legislature in 2022 at which time it also created the Opioid Advisory Commission (MCL 4.1851) to make recommendations for use of the State's opioid settlement funds.

PIHPs will not for the most part be direct recipients of opioid settlement funds. We will nonetheless continue to be guided by the values we share with the Opioid Advisory Commission (OAC) like advancing health equity, reducing stigma and cross-system collaboration, and we fully endorse the OAC's recommendation in its 2023 Annual Report that opioid settlement funds be applied to best practice strategies for SUD prevention, treatment, harm reduction and recovery, and in particular to strategies with otherwise limited fund streams, e.g., jail-based services which currently can't be funded by Medicaid. MSHN will continue to collaborate with the OAC, MAC, and other statewide and local stakeholders, including the local subdivisions in our regions involved directly in the receipt and deployment of opioid settlement funds.

## Section 5……

***A narrative complete with a detailed logic model for selecting and implementing evidence-based programs, policies, and practices for implementing a recovery-oriented system of care that includes prevention, treatment, and recovery services as well as all other services in your array necessary to support recovery. The logic model approach should include common risk and protective factors contributing to substance use and mental health disorders and its consequences, as well as opportunities for recovery.***

**Prevention Narrative**

The Prevention Logic Model was built around the State Strategic Plan Priority Areas which are reduce underage drinking, reduce prescription drug misuse, including a reduction in the misuse of opioids for non-medical purposes, reduce marijuana use among youth and young adults, reduce underage youth tobacco access and tobacco use including electronic nicotine devices and vape products, and increase access to prevention services for older adults 55 and older. Data is shown to support why these are identified as primary problems, especially within Oakland County. Intervening variables were identified for each area of focus or overall goal. The intervening variables ranged from accessibility, family and community norms, perception of risk, and risk factors to name a few. Objectives were determined for reducing underage drinking, reducing prescription drug misuse of opioids for non-medical purposes, reducing marijuana use among youth and young adults, reducing underage youth tobacco access and tobacco use including electronic nicotine devices, increasing access to prevention services for older adults. OCHN's contracted providers are trained in and deliver a variety of evidence-based methods and practices to support prevention of substance use disorders. Some of those practices are: Botvin Life Skills, Prime for Life, Guiding Good Choices, Strengthening Families, Michigan Model for Health, CATCH My Breath, INDEPTH, Campaigns such as, 21 to Buy, Not Supply and Parents Who Host, Wellness Initiative for Senior Education (WISE), Narcan vending machines distribution and education and collaborating with community organizations on policy changes

**Treatment Narrative**

The OCHN SUD Treatment Logic Model was built around the State Strategic Plan Priority Areas which are to expand behavioral health and primary health services for persons at-risk for, and with, mental health (MH) and substance use disorder (SUD), increase access to treatment and harm reduction for persons living with an Opioid Use Disorder, increase access to treatment for the criminal justice involved population returning to the community, increase access to trauma responsive services, reduce the percentage of substance exposed infants at birth, and increase access to treatment services for older adults 55 and older. Data is shown to support why these are identified as primary problems, specifically within Oakland County. Intervening variables were identified for each area of focus or overall goal. The intervening variables included societal culture and expectations, lack of support within the workforce, access and affordability to resources/support/treatment, lack of community collaboration, social barriers and stigma, lack of services including prenatal, and trauma informed, and current laws and policies that perpetuate the identified priority areas.

Objectives were determined for addressing the priority areas by utilizing our current contracted providers, community resources, and identifying areas for expansion to further address these needs. The objectives identified include but are not limited to advocacy at both the local and state level, increasing awareness of our current services network, addressing stigma through media campaigns, increase interdisciplinary collaboration, publish an RFP for recovery housing and explore the need to incorporate Women's Specialty Service specific recovery housing, implement a sustainability plan for SOR funded services, host work groups with community partners, assist workforce issues with trauma responsive services/resources, increase Crisis Intervention Training (CIT) with the Sheriff's Department, and provide education and resources for pre and post-natal care. OCHN's contracted providers are trained in and deliver a variety of evidence-based methods and practices to support the treatment of substance use disorders. Some

of those practices are: Expanding Project Assert to local hospital systems and FQHC sites, Facilitating partnerships between our treatment and prevention providers to attend Legislative Lobby Days, Implementing zero Suicide philosophy within our service network, Increasing training for trauma informed EBPs among clinical staff within the network, Expanding Opioid and Stimulant Use Health Homes to offer WSS, Providing evidenced-based education on comprehensive sex education strategies across the lifespan, Expanding MAT services to provide treatment for Alcohol Use Disorder, Increase ancillary services such as yoga and meditation to support recovery. Research the addition of Vivitrol to the array of medication assisted services for alcohol use disorders, Expand Women Specialty Services to MAT providers, Implement new administrative efficiencies to increase ease of access to services and to assist in workforce retention, Maintain diversity, equity and inclusion efforts within OCHN and the provider network

## Recovery Narrative

The OCHN SUD Recovery Logic Model was built around the State Strategic Plan Priority Areas which are to enhance coordination of prevention, follow-up, and continuing care in the recovery process, expand treatment services to include ongoing support and multiple coordinated strategies to support recovery, and increase access to recovery services to promote life enhancing recovery and wellness for individuals and their families. Data is shown to support why these are identified as primary problems, specifically within Oakland County. Intervening variables were identified for each area of focus or overall goal. The intervening variables include funding structure limitations, stigma, staffing challenges, barrier to support including limited awareness, familial impact of addiction, and service accessibility and awareness.

Objectives were determined for addressing the priority areas by utilizing our current contracted providers, community resources, and identifying areas for expansion to further address these needs. The objectives identified include but are not limited to increasing media messaging, onboarding a contracted provider for a Recovery Community Organization (RCO), implement a process to increase provider administrative efficacy, develop implementation plans for any needed recovery supports, continued analysis for staffing needs, increase in utilization of ancillary services, increase interdisciplinary collaboration, increase training on EBPs within our current treatment network, continuation of RCO community engagement, and increase services accessibility and awareness. OCHN's contracted providers are trained in and deliver a variety of evidence-based methods and practices to support the treatment of substance use disorders. Some of those practices are: Expanding Project Assert to local hospital systems and FQHC sites, Collaboration with Oakland County Schools, Recovery Friendly Workplace (RFW), and Individual Placement Services (IPS), Explore need for additional recovery support services such as Peer Specialists, recovery housing, recovery cafes, collegiate recovery programs, family recovery supports, and recovery high schools, Increase in utilization of ancillary support, Increase access and hold community events for recovery services to promote life enhancing recovery and wellness for individuals and families and Develop effective media messaging surrounding recovery messaging

## Section 6……

***Provision of an allocation plan, derived from input of the SUD Policy Oversight Board or other regional advisory or oversight board for funding a recovery-oriented system of care that includes prevention, treatment and recovery, as well as all other services in your array, necessary to support recovery in identified communities of greatest need consistent with a data-driven, needs-based approach and evidence-based practices.***

## Commitment to Prevention

OCHN ensures that we allocate a minimum of 20% of funds to prevention but, and we typically exceed that 20%. Due to the identified need for increased prevention services to ensure there are coalitions and/or programming throughout Oakland County, OCHN utilizes PA2 funds as well as requesting additional block grant funds (when available) to fulfill the needs of this large county. OCHN continues current State and SAMHSA prevention initiatives including the promotion of the social determinants of health and prevention prepared communities. The balance of Community Block Grant funding is devoted to evidenced-based prevention programs aimed at high-risk individuals, all of which incorporate health promotion as a protective factor to delay/prevent the use of substances.

Environmental Change and Community-based Process Strategy activities continue to be an area of improvement for OCHN. Some of the environmental change activities that are currently implemented are around the work OCHN does with the Designated Youth Tobacco Use Representative (DYTUR) to reduce the sales to minors and increase tobacco retailer compliance of the Michigan Youth Access to Tobacco Law (YTA). The DYTUR provides training and technical assistance to coalitions to facilitate vendor education visits and tobacco/nicotine related issues. Vendor education visits and information regarding the YTA are communicated with tobacco retailers in Oakland County annually. The Alliance works with local college universities in Oakland County to promote the Positive Norms Campaign. Various members of the coalitions attend regional and local workgroups, such as Michigan Coalition to Reduce Underage Drinking (MCRUD) where they learn of policy changes and how they can help. The OCHN Prevention Coordinator helps keep the Prevention Provider Network up to date on any legislative, policy, and regulation changes. Some of the community-based process activities implemented are through The Alliance and Oakland County Health Division which provides technical assistance to coalitions and community partners around drug take back days, prevention strategies and initiatives, and the priority areas of reducing alcohol, tobacco, and other drugs in Oakland County. Partnerships have been formed with law enforcement, schools, businesses, and other stakeholders to collaborate on addressing substance misuse in Oakland County. Although there are environmental change and community-based strategy activities that OCHN implements, there is more that OCHN can do in this area. OCHN will continue to work to implement activities in these areas.

The collaboration with primary care occurs at the community coalition level as local physicians may serve on the board or a representative from a local hospital may attend meetings or volunteer. In addition, OCHN began providing Screening Brief Intervention and Referral to Treatment (SBIRT) in a local federally qualified health center (FQHC), HONOR Health, to prevent the onset of a substance use disorder when an individual shows signs of misuse. The SBIRT prevention specialist works with medical staff to identify individuals who are at risk as well as assists individuals with connecting to treatment if the need is identified. This position

became vacant in 2022, however, will resume at Honor Health under Project Assert in June 2023. Additionally, OCHN has worked tirelessly to bring Project Assert to the hospitals in Oakland County. OCHN will continue to pursue this in by continually reaching out to hospitals. Further collaboration with primary care exists within OCHN. There is a very active Health Integration Project that the SUD Service Network Team has been incorporated in since the merger. SUD data was embedded in the Relias tool developed to mine the Care Connect 360 data. Complex case management nurses utilize the data to identify individuals who have high level physical health and substance use needs and work with Medicaid Health Plans to coordinate care.

Collaboration with tribal entities continues to be somewhat problematic because none presently exist in Oakland County. Native Americans who wish to identify with a tribal community and reside in Oakland County (.3% according to the 2022 census) affiliate with the Southeast Michigan Indians, an entity in neighboring Macomb County. Information on how to access services was sent to Southeast Michigan Indians and OCHN will continue to review census data to determine if there is a higher percentage of Native Americans in Oakland County and if any tribal entities have been established in Oakland County and coordinate to ensure services are identified and available.

Workforce development for both prevention and treatment will remain a priority for OCHN through continuation of in-house provider trainings, making available national and state webinars, and encouraging attendance at the Annual Co-Occurring State Conference. OCHN will continue to support and work with Oakland County's strong SUD provider network and coalition presence to ensure services are evidenced based and meeting the needs of people served. During FY23, OCHN also allotted providers with $25,000 under Covid Supplemental Blockgrant dollars, to be specially used for training needs for staff at their organization.

Allocation of funds – implement a full continuum of research and evidence-based care

OCHN considers capacity and access to care of the utmost priority. OCHN currently allocates funding to support a full continuum of care. The current OCHN substance use provider panel and array of services allows for services to be provided throughout the County and focuses on evidenced based services. To increase positive outcomes and ensure evidence-based programs are delivered with fidelity, OCHN is moving to outcome based contracting and service models rather than the traditional fee for services contracts. This allows for OCHN to better monitor and assist providers in delivering services that best meet the needs of people served. It also allows providers to work towards stretch goals centered around people's care and outcomes in order to obtain incentives. Residential service models have been implemented in the network and the SUD Department expects MAT services models to be implemented in FY23. All other OCHN service contracts are outcome based and showing improvement in services and access to services since the contracts changed, evidence that moving to outcome-based contracting ensures better care and service delivery. Any additional services or providers will be expanded over the next three years.

Currently, OCHN matches funding at approximately 20% per year, exceeding the match requirement in order to meet the needs of the community. The OPB is informed and provides input into how OCHN expends funds for substance use disorder services. It is difficult to determine a specific allocation plan as funding varies, however, supports the following method:

Allocate funding to avoid wait lists, Dedicate funding to emerging issues, Provide an increase in both prevention and treatment services when an emerging issue is causing an overwhelming impact on the community (e.g. Opiates), Dedicate local funds to services not covered by other State and Federal fund sources, Dedicate funds to pilot programs and evidenced based practices and Dedicate funds to the continued development of a ROSC

**Evidence of the intent to maintain the provider panel (identified deficits and strategies)**

In order to better understand and have full knowledge of the problems in Oakland County, OCHN utilizes the data within our electronic health record (which includes BH TEDS data) to monitor service needs and obtain a clear understanding of current trends, demand for services and capacity to fill the demands within the region. This applies to both priority populations as well as all others in need of substance use disorder treatment. OCHN responds to trends by increasing services offered through the procurement process and /or developing pilot projects to respond to immediate needs for services.

Based on current data, alcohol use disorders remain significant and an area in which services should be targeted. The data shows that treatment admissions for alcohol use disorders almost mirror those of opiate use disorders and are the top two reasons for admission to treatment. Services for alcohol use disorders are available but, data shows the need for additional services to meet increased need. One area in which there is a significant gap is in our local jail. OCHN has monitored jail data since the inception of the jail MAT program and found over 1,500 people in jail with alcohol use disorders. In addition, a law was passed in 2019 requiring courts to evaluate all individuals convicted of DUI 3rd for medication assisted treatment. The Oakland County Circuit Court noted about 400 DUI 3rd cases per year on average. While not all people will enter the public system, this statistic indicates the need to expand programming. Currently there is no programming in the jail to address alcohol use disorders. Due to the Covid-19 pandemic, efforts to address alcohol use disorders in jail were paused. OCHN is also working with a local outpatient provider to pilot the delivery of treatment and medication for alcohol use disorders for those individuals coming out of prison or those who are referred by Oakland County Community Corrections for DUI 3rd offenses. OCHN will continue the goal in our Strategic Plan of implementing MAT services for alcohol use disorders in the jail setting.

Services for opiate use disorders are extremely robust due to assistance from the federal SOR grant in addition to traditional treatment services. Services include transportation, jail-based services (including medication assisted treatment in the jail) and evidence-based prevention services/Narcan training. During FY23, OCHN worked with its contracted prevention provider to supply funding for Save-a-Life boxes. Initial deployment started with 30 boxes being strategically placed around Oakland County. Each Save-a-Life box contains Narcan, Fentanyl testing strips, Xylazine testing strips and prescription medication disposal kits.

Oakland County is fortunate to have several prevention and treatment providers who are committed to assisting the residents of Oakland County in living healthier, happier lives. OCHN and its contracted providers have a long history of working together to identify gaps in services and ways to improve. A current need is withdrawal management, residential services and partial hospitalization for adolescents. Although the historical need for this is very low, likely due to the solid prevention, outpatient and intensive outpatient services offered, there is still a need. OCHN is in pursuit of an adolescent provider to meet this gap and a Request for Proposal for each level

of care will be released around September 2023. Until OCHN can find an adolescent residential provider, a single case agreement will be sought when the need arises.
While OCHN has significantly increased the utilization of peers, case management and other recovery supports, this is also an area in which there needs to be an increase in the utilization of services to support recovery. Moving to outcome based contracting and establishing benchmarks for utilization of said services will address this issue. In terms of peer services, another identified gap is the addition of peers in hospitals. OCHN is continuing attempts to work with hospitals to allow the evidence-based intervention, Project Assert, to be embedded in emergency rooms. Currently, Project Assert will begin at HONOR Health, a FQHC and verbal agreements have occurred with McLaren Clarkston to embed a peer in their ED.
As mentioned above there is only .3% representative of tribal communities in Oakland County. OCHN will continue to refer to Southeast Michigan Indians, an entity that provides SUD services for Native Americans if a person prefers. Native Americans can also access any services offered by OCHN as all providers deliver services in a culturally competent manner. If the percentage of tribal communities increases, a focus group will be developed to receive input on how services can be tailored to address the needs for people identifying as Native American.

**Evidence of intent to ensure that priority populations are served first**

OCHN and its provider network work closely together and treatment is offered within 24 hours for residential treatment and withdrawal management, within in 72 hours or less (on most occasions and dependent on person's preferred provider) for MAT, and within 14 days for everyone. The addition of the SSU and the extreme dedication of providers allowed this to occur. OCHN has not had to place people on a waitlist due to funding constraints or capacity issues. This occurs because of the ability to utilize PA2 funds if block grant is not available and intense utilization review and management to ensure services are based on ASAM criteria, individualized, and medically necessary. This way people receive all the services they need.
OCHN has policies and procedures to ensure priority populations are served timely and interim services are provided when needed. Policies for priority populations and interim services are listed below.

***Policy: Priorities for admission into Treatment***

Each program will give preference for admission into treatment services to clients, regardless of level of care, in the following order:
1. Pregnant injecting Drug Users (IDUs)
2. Pregnant substance abusers
3. IDUs
4. A parent whose child has been removed from the home under the Child Protection Laws of this state or is in danger of being removed from the home under the Child Protection Laws of this state because of the parent's substance abuse
5. Individuals under supervision of the Michigan Department of Corrections
6. All others

A. Programs will inquire, at the time of request for appointment, if prospective client is pregnant or a current IDU (within past month)
B. Answers to these questions must be documented on Pre-Admission Form and become a part of each client record

C. Admission Timelines for Pregnant Women
a. Pregnant women must be admitted to the treatment program within 24 hours. If the program has a waiting list the client must be referred to the SUD Access Center. The SUD Access Center will attempt to locate a treatment program that can enroll the client immediately.
b. If pregnant client cannot be admitted within 24 hours into a program, client will be placed on the SUD Access Center - pregnant women waiting list and the SUD Access Center will provide Interim Services within 48 hours
c. No pregnant client should be put on a waiting list at the program level
If the program cannot admit Injecting Drug (IDU) clients on their waiting list within 120 days, the program must notify the Regional Entity staff. (It should be noted that waitlist requirements do not apply to Medicaid recipients as this is not allowable. The above is in reference to block grant requirements)

***Policy: Interim Services***

The SUD Access Center will provide federally mandated Interim Services to:
1) IDUs within 48 hours who cannot be admitted into treatment within 14 days
2) Pregnant women within 48 hours who cannot be admitted into treatment immediately
3) Parent At-Risk of Losing Children

***Interim Services minimally consist of the following:***

1) IDUs
a) Counseling and education about HIV and Hepatitis
b) Completion of TB screening history
c) Risks of needle-sharing
d) Risks of transmission of HIV and other STDs to sexual partners and infants
e) Steps that can be taken to ensure that HIV transmission does not occur
f) Referral for HIV and TB services if necessary
2) Pregnant Women
a) Services listed above
b) Counseling on effects of alcohol, tobacco and other drug use on the fetus
c) Referral for prenatal care
3) Parent At-Risk of Losing Children
A) Early intervention clinical services referral that will begin within 48 business hours
The SUD Access Center will provide Interim Services for all eligible clients who are assessed by the SUD Access Center. The SUD Access Center will also provide interim services for pregnant women and IDU clients who present at provider programs who cannot provide the service and cannot admit the client to treatment within the above federal admission requirement.

**Evidence that there is a problem /services plan consists of evidence-based services**

The provision of evidence-based treatment is of the utmost importance to OCHN. The move to outcome-based contracts and the purchase of specific evidenced based programming will further allow OCHN to not only ensure evidence-based practices are delivered with fidelity but work towards goals that enhance a person's success in recovery. For example, as the new contract and service model is being built for MAT Services, benchmarks are being developed related to providing Contingency Management and increasing the use of peers.
A comprehensive needs assessment to determine priority problems resulting from the use of

substances, as well as geographic "hot spots" was carried out in spring of 2023. The Strategic Prevention Framework (SPF) process was implemented with the formation of a Community Epidemiological Workgroup (CEW) and a Community Strategic Prevention Planning Workgroup (CSPPC). The CEW established priority problems from the data as well as the intervening variables. The CSPPC researched and determined the evidenced-based programs designed to impact the intervening variables. All prevention programs, services and activities meet the guidelines outlined in the "Guidance Document: Selecting, Planning and Implementing Evidence-Based Interventions for the Prevention of Substance Use Disorders"
The identified priority issues included:

- Increase effective media messaging to prevent substance misuse.
- Increase early prevention practices.
- Create collaborative outreach and treatment workgroups.
- Build systemic promising and best practice approaches.
- Workforce retention and development.
- Increasing non-traditional education on prevention and treatment methods.
- Expanding access and implementation of harm reduction.
- Increasing support to address disparities related to substance misuse.

## Trauma informed system of care

All SUD contracted providers are trained in trauma informed system of care. Providers have developed agency wide plans to be trauma informed and agency plans are monitored annually by the SUD department. Technical assistance is provided when requested and some providers have chosen to apply to SAMHA for further technical assistance.

A. Trauma Informed Care **(Attachment)**
   1. There must be evidence that the provider is delivering Trauma Informed Services.
   2. All staff must receive training in the principles and practices providing Trauma Informed Services.
   3. Individuals who are providing Trauma Informed Evidence Based Practices and clinical interventions must have the proper credentials (if applicable to the model being practiced.
   4. Providers are expected to follow the guidelines provided in the SAMHSA TIP 57 Trauma Informed Care in Behavioral Health Services

## Section 7……

***An implementation plan that describes how key prevention, treatment, and recovery services, as well as all other services necessary to support recovery, will be implemented and a three (3) year timeline that identifies persons or entities responsible for the completion of strategies and completion dates.***

## Year 1

**Prevention**

- Continue the Community Epidemiological Workgroup (CEW) and Community Prevention Planning Collaborative (CPPC) on an ongoing basis while intentionally recruiting members within the community to participate
  - Responsible Parties: OCHN SUD Team and OCHN Communications Department

- Expand Overdose Education Naloxone Distribution (OEND) efforts throughout the county by expanding access and implementation of harm reduction
    - Responsible Parties: OCHN SUD Team and The Alliance of Coalitions for Healthy Communities
- Strengthen partnerships and collaborations within Oakland County to build capacity
    - Responsible Parties: OCHN Leadership, OCHN SUD Team, SUD Prevention and Treatment Provider Network
- Increase effective media messaging to prevent substance misuse
    - Responsible Parties: OCHN SUD Team and OCHN Communications Department
- Effectively communicate prevention efforts to help connect and integrate prevention, treatment, and recovery efforts within Oakland County by having more of a presence at community events
    - Responsible Parties: OCHN SUD Team, OCHN Leadership, and OCHN Communications Department
- Strengthen Tobacco Prevention and Cessation efforts
    - Responsible Parties: OCHN SUD Team and SUD Provider Network

**Treatment**

- Increase the number of individuals that continue to the next level of care by converting SUD services to performance-based contracts
    - Example: Service models for MAT, then we move to OPC
    - Responsible Parties: OCHN SUD Team and OCHN Contracts Departments
- Improve the analysis of data specific to SUD via Power BI Dashboards to track outcomes
    - Responsible Parties: OCHN SUD Team and OCHN IT Department
- Continue to support healthcare integration and review outcomes of Opioid Health/SUD Home; determine if RFP network wide is needed
    - Responsible Parties: OCHN SUD Team
- Continue to advocate for the implementation of Project Assert in local emergency rooms
    - Responsible Parties: OCHN SUD Team
- Expand capacity for adolescent withdrawal management and residential treatment
    - Responsible Parties: OCHN SUD Team
- Evaluate and identify administrative inefficiencies to increase ease of access to services and to assist in workforce retention
    - Example: Change in audit practice, ODIN review and changes of processes
    - Responsible Parties: OCHN SUD Team and SUD Contracted Provider Network
- Develop sustainability plans for services funded by SOR grants
    - Responsible Parties: OCHN SUD Team
- Continue to support workforce development and retention within the SUD Network
    - Example: Training funds dispersed to providers, working with MDHHS on loosening credential requirements for SUD professionals
    - Responsible Parties: OCHN SUD Team
- Improve SDOH for individuals receiving services through OCHN
    - Example: housing financial support program under CSUGS

    - Responsible Parties: OCHN SUD Team and Community Partners
- Further integrate SUD into OCHN processes and move all Treatment contracts to follow the Mental Health contract structure
    - Responsible Parties: OCHN SUD Team and OCHN Contract Department

**Recovery**

- Onboard a new Recovery Community Organization
    - Responsible Parties: OCHN SUD Team
- Develop effective media messaging surrounding recovery messaging
    - Responsible Parties: OCHN Communication Team
- Develop a plan to increase community engagement in the recovery community and reduce stigma
    - Responsible Parties: OCHN SUD Team, OCHN Communications Team, RCO

## Year 2

**Prevention**

- Increase early prevention practices and expand prevention services
    - Responsible Parties: OCHN SUD Team and Provider Network
- Build systemic promising and best practices approaches by increasing non-traditional education of prevention methods
    - Responsible Parties: OCHN SUD Team
- Increase awareness of prevention programming
    - Responsible Parties: OCHN SUD Team, OCHN Leadership, and OCHN Communications Department
- Support workforce retention and development of prevention providers
    - Responsible Parties: OCHN SUD Team and OCHN Leadership
- Continue to strengthen partnerships and collaborations
    - Responsible Parties: OCHN SUD Team and OCHN Leadership
- Continue to strengthen and expand OEND efforts
    - Responsible Parties: OCHN SUD Team and The Alliance of Coalitions for Healthy Communities
- Create and finalize sustainability plan for SOR and ARPA funding
    - Responsible Parties: OCHN SUD Team

**Treatment**

- Increase ancillary services such as yoga and meditation to support recovery.
    - Responsible Parties: OCHN SUD Team and OCHN Contracted Providers
- Research the addition of Vivitrol to the array of medication assisted services for alcohol use disorders
    - Responsible Parties: OCHN SUD Team
- Research a pilot-based MAT program for treatment of Alcohol Use Disorders in the jail
    - Responsible Parties: OCHN SUD Team
- Continue diversity, equity and inclusion efforts within OCHN and the provider network
    - Responsible Parties: OCHN SUD Team and OCHN DEI Workgroup
- Expand Women Specialty Services to MAT providers

    - Responsible Parties: OCHN SUD Team and OCHN Contracted Providers
- Improve OCHN's identity and affiliation branding. Reinforce OCHN's position as the organization responsible for providing services to persons living with an intellectual or developmental disability, mental illness, or substance use disorder in Oakland County.
    - Responsible Parties: OCHN Communications Department
- Create collaborative outreach and treatment workgroups.
    - Responsible Parties: OCHN SUD Team
- Implement new administrative efficiencies to increase ease of access to services and to assist in workforce retention
    - Responsible Parties: OCHN SUD Team and OCHN IT

**Recovery**

- Increase access and hold community events for recovery services to promote life enhancing recovery and wellness for individuals and families.
    - Responsible Parties: OCHN SUD Team and RCO
- Research the need to expand recovery support services including peer specialists, recovery housing recovery cafes, recovery-friendly workplaces, recovery high schools, collegiate recovery programs, and family caregiving.
    - Responsible Parties: OCHN SUD Team and RCO

## Year 3

**Prevention**

- Integrate prevention, treatment, and recovery services and have services on a continuum of care providing services across the lifespan
    - Responsible Parties: OCHN SUD Team and SUD Provider Network
- Review successes/barriers of prevention work**;** use to prepare for next strategic plan
    - Responsible Parties: OCHN SUD Team, OCHN Leadership, OCHN Oversight Policy Board, CEW and CPPC workgroups.
- Implement sustainability plan for services funded by SOR and ARPA grants
    - Responsible Parties: OCHN SUD Team and Provider Network

**Treatment**

- Implement Vivitrol for alcohol use disorders into current MAT Services
    - Responsible Parties: OCHN SUD Team
- Implement a Jail MAT program for alcohol use disorders
    - Responsible Parties: OCHN SUD Team
- Create New Strategic Plan
    - Responsible Parties: OCHN SUD Team
- Implement sustainability plan for services funded by SOR grants
    - Responsible Parties: OCHN SUD Team
- Maintain diversity, equity and inclusion efforts within OCHN and the provider network
    - Responsible Parties: OCHN SUD Team and OCHN DEI Workgroup
- Implement plan to reduce stigma
    - Responsible Parties: OCHN SUD Team and OCHN Communications

**Recovery**

- Implement plans for any needed recovery support services
    - Responsible Parties: OCHN SUD Team and RCO
- Continue to evaluate sustainability plan for services funded under grants
    - Responsible Parties: OCHN SUD Team

## Section 8……

***An evaluation plan that identifies baseline, process and outcome data for implementing a ROSC that includes prevention, treatment, and recovery services as well as all other services necessary to support recovery, including process and procedures for conducting the evaluation. The evaluation plan should describe how the identified issues/problems, strategic plan, and evaluation data will be used for making adjustments in the implementation of a ROSC***

Each Prevention Provider is expected to have an outcome evaluation tool and process evaluation tool. The Provider Network has processes in place for issuing the evaluation tools with participants of services. The OCHN SUD Prevention Coordinator reviews the outcome and process evaluation tools with each provider during the programmatic review audit, which occurs annually. Each provider is scored on compliance with the contract requirements and recommendations for updates are discussed during this time of review. Each Prevention Provider participates in an observational site visit and a programmatic review audit. The scoring for the site visit and programmatic review are shared with the provider and they are issued a letter of their compliance with the contract requirements or a letter detailing the areas where they are out of compliance and were placed on a Performance Improvement Plan. Monthly reports are reviewed monthly by OCHN SUD Team and progress with outputs is monitored. Each provider submits an end of year report of outcomes, outputs, and results from the surveys. The identified issues/problems, strategic plan, and evaluation data will be reviewed annually to monitor progress with goals and assess any changes that need to be made in implementation. OCHN SUD Department has made the decision to convene the Community Epidemiological Workgroup and Community Prevention Planning Collaborative Workgroup on an ongoing basis, which will help in the assessing of goals, progress, and any recommended changes in implementation activities.

**For prevention services:** The evaluation plan must include the completion of proposed outcomes, as well as capture the percentage of evidence-based programs. These indicators must be addressed in each region as part of overall statewide efforts. The evaluation plan for prevention services (as outlined in Attachment I) includes a variety of levels:

- Evidence Based Practices (EBP): 100% of prevention services meet the guidelines outlined in the "Guidance Document: Selecting, Planning and Implementing Evidence-Based Interventions for the Prevention of Substance Use Disorders" and are monitored for program fidelity in an annual program review as well as a site visit
- All prevention providers are required to report outputs on a monthly basis and this is used to track and verify outputs entered into MPDS
- All prevention providers are required to report immediate outcomes of programming at end-of-year to the OCHN
- All prevention service providers are required to document both outcome and process evaluation during an annual review by the Prevention Coordinator
- Michigan Prevention Data System (MPDS) is utilized to monitor service delivery area via zip code, target population reach, and provider performance in terms of outputs

- Population level data for the OCHN region is monitored bi-annually using the data indicators and data bases indicated in Attachment I (The Michigan Profile for Healthy Youth (MiPHY), National Survey on Drug Use and Health (NSDUH) for sub state regions, annual Synar Inspection results and the ACHC Parent Survey)
- The Pre/Post Tests of the evidence-based educational groups are reviewed annually. Providers who provide Botvin Life Skills send their results to be scored by OCHN internally. Pre and Post tests of the Botvin Life Skills, Prime for Life, Guiding Good Choices, Strengthening Families, Catch My Breath, INDEPTH, and all other evidence-based programs are reviewed by OCHN SUD Team.
- Prevention Providers conduct process and outcome evaluations and submit the results to OCHN annually in an end of year report.
- A coalition assessment is conducted annually at the site visit and is scored as the site visit observation.
- All evaluation tools and scoring, audits, and observational site visits are stored on OCHN's shared drive database system.

1. **For preventing youth access to tobacco:** The evaluation plan must include tools that measure outcomes which include indicators for reducing tobacco sales to minors (Synar compliance). Youth access to tobacco is monitored through the SYNAR inspection process on an annual basis as mandated by the federal government and also through the following:

- US Food and Drug Administration website: Weekly Digest Bulletin identifies vendors selling to minors by FDA inspectors and repeat offender receiving warning letters
- Reports from local law enforcement and community coalitions to the Designated Youth Tobacco Representative (DYTUR) of vendors cited or observed selling to minors
- Examination of the sell patterns by vendor location, type of vendor, history of selling, and vendor and inspector characteristics for more effective targeting of vendors for education. Please refer to Attachment I.

## Evaluation Plan-treatment and other recovery services

| Domain | Measure (s)/Baseline & Outcome Data | Evaluation Mechanism(s) |
|---|---|---|
| Health and Safety | Sentinel Events | ODIN/OCHN data reporting system |
| Administration: Use of Public Funds | On-time reporting | MDCH reporting |
| | Withdrawal management subsequent services | ODIN/OCHN data system reporting |
| | Outpatient continuation | ODIN/OCHN data system reporting |
| | Funds spent of services | ODIN/OCHN data system reporting |
| | Funds spent on integrated programs | ODIN/OCHN data system reporting |
| | Funds spent on recovery supports | ODIN/OCHN data system reporting |
| Treatment Penetration Rates for Selected Populations | Youth and Young Adults (12-17 years-of-age) | ODIN/OCHN data system reporting |
| | Women of Childbearing Age | ODIN/OCHN data system reporting |
| | African American | ODIN/OCHN data system reporting |
| | Hispanic | ODIN/OCHN data system reporting |
| | Native American | ODIN/OCHN data system reporting |

| | | |
|---|---|---|
| | Persons with Opioid Dependence/Addiction | ODIN/OCHN data system reporting |

## Women's Specialty Services

OCHN works diligently to meet the Maintenance of Effort (MOE) funding requirements for Women's Specialty Services (WSS) and has been successful for many years. Services such as case management and peer support have been an integral part of our outpatient WSS services since the movement to a recovery-oriented system of care was implemented. OCHN contracts with two providers for outpatient and residential women's specialty services.

The residential program is Sacred Heart Clearview and the outpatient programs are Oakland Family Services PRISM Program (OFS PRISM) (offering both outpatient and IOP). Individuals are screened through the SUD Access Center prior to authorization for admission to residential treatment. OFS understands the federal definition for WSS funding and admits people according to the federal definition. OCHN reviews and authorizes all WSS admissions. In addition, there are several providers throughout the OCHN network that provide gender responsive programming.

The WSS Coordinator conducts site reviews and ensures providers are adhering to OCHN WSS policies in addition to the state policy. The SUD Access Supervisor and the Contract Manager work closely together so there are no gaps in services or monitoring.

Monitoring the designated WSS providers is taken very seriously. Records are reviewed to ensure compliance during WSS Program reviews. Sacred Heart Clearview, and OFS PRISM have separate allocations for women's specialty services. All services provided within the designated programs are reimbursed from the Women's Specialty allocation. During the screening process, SUD Access Center staff ensures that only women meeting the criteria receive services from a stated designated WSS provider.

OCHN has a WSS policy that is in the provider treatment contract developed from the MDHHS Treatment Policy #12 for Women's Specialty Services. Listed below are the core requirements listed in the policy.

Core Values of treatment and coordination of care will include: Family Centered Approach, Family involvement in the process, Building on Natural and Community Supports, Strength Based Planning, Unconditional Care, Team Approach Across, Ensuring Safety, Gender/Age/Culturally Responsive Treatment, Self Sufficiency, Education and Work Focus, Belief in Growth, Learning and Recovery and Outcome Oriented.

**Provider Requirements and Procedure**

OCHN WSS Treatment Providers will maintain fundamental principles as the foundation for integrating women specific SUD treatment services and non-gender specific services, while focusing on the effective and comprehensive treatment of women and their families.

**Program Structure**

- Treatment must be centered around the role women have in society
- A relational model, based on the psychological growth of women shall be the foundation for recovery
- A collaborative philosophy, driven by the woman and her family shall be used
- A model of empowerment is utilized in treatment and recovery planning
- Employment is recommended as an important component in recovery and serves as an important therapeutic tool
- A multi-system approach that is culturally aware shall be employed in the recovery process

**Treatment**

Programs that are designed to offer and meet women specific treatment needs shall include the following criteria: Accessibility, Assessment, Psychological Development, Abuse/Violence/Trauma, Family Orientation, Mental Health Issues, Physical Health Issues, Legal Issues, Sexuality/Intimacy/Exploitation, Survival Skill and Continuing Care/Recovery Support. Other recovery support services may also be provided as a part of WSS including ancillary and case management services.

OCHN has identified the importance of this priority population and will continue to make efforts towards a seamless transition. OCHN will continue to contract with the existing WSS providers and is committed to ensuring the MOE requirement continues to be met once fully integrated. It is OCHN goal to continue to increase engagement in WSS for those that meet criteria. The ability to provide effective WSS is also evaluated through the data captured by ODIN our EHR. ODIN captures data related to pregnancy, women of childbearing years and women with children and their follow through with services in the Insight Data System. This is used to determine the additional services that need to be offered to ensure positive outcomes.

All programs have begun to implement hybrid programs and/or increase face to face services FY 22.

Sacred Heart - Clearview provides individualized inpatient care to expecting Mothers and Children up to the age of 9 while the mothers receive withdrawal management and residential services. Treatment is trauma informed; gender specific with Seeking Safety Curriculum. Pregnant women attend Henry Ford program, Hopeful Hearts via zoom monthly. Pregnant women learn about NICU, labor and delivery, social workers, lactation consultants, early on education and other resources for mothers and babies. The program helps educate and helps the clients and professionals understand babies' goal and development milestones through their delivery and infancy stage. Children are provided referrals as needed through St. Clair County Infant Mental Health and Clearview works with local schools to ensure education continues while in treatment. At Clearview, Full-time peer recovery coach has contact with clients upon treatment entry, during treatment, and following up after discharge. Sacred Heart Clearview reaches across providers to obtain housing needs and continue to seek housing opportunities for pregnant women and women with children.

Oakland Family Services PRISM program continues to offer WSS OP/IOP services with the ability to offer Enhanced Women's Services. With the addition of Enhanced Services, OFS has hired a Community Outreach Specialist who has been working on creating relationships in the community to increase referrals and education regarding WSS and by doing so decrease stigma related. PRISM Children receive effective and meaningful therapeutic interventions as all mothers entering services with the PRISM program are screened during the intake process. Mothers who require early childhood services for their child(ren) are referred to different programs based on needs. Early On and Parents as Teachers are both early childhood programs offered at Oakland Family Services. Mothers who have a child(ren) between the ages of 0-3 years old are provided materials to Oakland Family Services Before Three to Succeed Program. Pregnant and parenting women are encouraged to complete the Ages and Stages Questionnaire to help identify any delays displayed by their child(ren). Mothers who need educational services for their child(ren) are referred to the Children's Learning Center/GSRP and the Early Learning Communities. Mothers who have treatment concerns for their youth/adolescent child(ren) may be referred to the Oakland Family Services program Specialized Services for Youth or the OFS Day One Program.

The PRISM Program continues to assess the appropriateness of hybrid vs telehealth services or a combination of both based on client's needs. Clients can move to an in-person full-time, remote (once the intake assessment is completed) or a combination of the two based on a variety of factors and or needs of the client. The PRISM program has hired an Outreach Worker and is working to hire a Case Manager position at the beginning of FY 22-23 to aid in better serving the clients in PRISM during the next FY.

Our providers utilize evidence-based programs and curriculum-based programs such as: Seeking Safety, Beyond Trauma, Nurturing Parent and Motivational interviewing.

OCHN has supported WSS providers to increase training in EBP. 2-3 staff at OFS were sponsored by OCHN to attend Beyond Trauma. OFS and Sacred Heart Staff were sponsored by OCHN to attend the Women in SUD series presented by NAADAC. OCHN continues to increase EBP and education in WSS by continuing to offer trainings related to PPD/PPA, Beyond Trauma, MI, Seeking Safety, etc.

OCHN understands a high proportion of the WSS population have experienced trauma and in response, the trainings stated above have increased to address perinatal mood disorders, Beyond Trauma Curriculum and the WSS Coordinator will continue going into the community to provide education on WSS and create relationships. Also, they sit as a Community Partner for Team Decision Making meetings with MDHSS to reduce stigma and help facilitate non bias and empathic referrals for SUD/MH services as needed.

OCHN has increased community outreach on WSS to help increase admissions. There was a decrease in enrollments from 2021 to 2022, however once presentations began, referrals doubled for the year. The WSS Brochures and Flyers were updated along with a presentation developed on WSS for the community. The WSS Coordinator presented on WSS to local hospitals and healthcare providers in the community such as Corewell Health East (Formerly Beaumont Troy), Trinity Health (formerly St Joe's), Henry Ford Bloomfield, OCHN Community Workshops and Best Start for Babies Workgroup. The WSS Coordinator also participates in Team Decision Making Meetings to provide information on WSS and help with referrals/transitions.

WSSs were presented in the community as well at various events. At the OCHN Annual Recovery Celebration in September, Individuals and their children were invited and attended to celebrate the hope and encourage family partnership. The first annual Community Baby Shower was held June 2023 to support pregnant and parenting women in WSS programs and the Community. Over 20 vendors attended to provide education and resources such as doula services, vaccines, nutrition, smoking cessation, education programs etc to participants. 4 speakers presented on safe sleep, breastfeeding, nutrition and doula services. Through generous donations, 9 raffle items were given out that included a car seat, diapers, clothes, nursing items, bathing items, pack n play, etc. Over 25 families attended. On average, vendors were able to speak with 15 families to provide screenings and/or answer questions and were able to provide services and/or referrals for 3 families.

**Opioid addiction and Intravenous Drug Use (IDU)**

OCHN continually monitors and researches treatment data and utilizes this information to address the region's needs. OCHN has been paying specific attention to the trends in opiate related use. The data reflects the trend in opiate prescription use that eventually graduates to intravenous drug use if left un-treated. This trend occurs largely with the young adult age group. Therefore, OCHN ensures that an emphasis is placed on prevention programming geared toward children and adolescents. OCHN contracts with a total of 13 providers. Of the 13 providers, there are 10 Outpatient sites, spread throughout the entire county for ease of access. OCHN has been

researching alternative services that serve as best practice in the aid of SUD treatment. As a result of the growing heroin use problem Sublocade was added to the service array as a treatment in FY 2023. It should be noted that all outpatient providers can provide services to individuals with opioid dependence. However, of the 13 providers Oakland County has three Medication Assisted Treatment (MAT) Programs, all of which provide Suboxone, Subutex, Vivitrol and Sublocade in addition to methadone.

A total of 2,972 individuals served by OCHN's providers presented with an opiate use disorder in FY22.[1] Of that total population, 382 identified their race as African American, or 12.85%. According to the US Census Data for 2022, there were a total of 176,451 African Americans living in Oakland County, Michigan[2]. African Americans accounted for 13.9% of the total population of Oakland County (1,269,431). Of this population, only 0.023% were served by OCHN's providers for their opiate use disorder. Of the 2,972 individuals served with an opiate use disorder in FY22, 148 identified as having Hispanic/Latino ethnicity, or 4.97%. There was a total of 59,663 Hispanic/Latinos living in Oakland County in 2022. Hispanic/Latinos accounted for 4.7% of the total population of Oakland County (1,269,431). Of this population, only 0.0248% were served by OCHN's providers for their opiate use disorder. This illustrates that OCHN needs to improve outreach efforts specifically aimed at targeting these groups to promote positive treatment outcomes and reduce the stigma associated with misuse. OCHN plans to do this by doing the following:

- Hosting the annual Minority Mental Health Awareness event and have a variety of speakers talk about diversity, equity, and inclusion
- A direct mailing list scheduled to go out that target's specific locations relevant to minority populations
- A peer has been hired to conduct Project Assert within one of the FQHC's Honor Community Health
- OCHN started the DEI (Diversity, Equity, Inclusion) workgroup to discuss disparities seen between different groups.
- The SUD team is always seeking to join community workgroups that focus on diversity

Specific to the opiate use population served by OCHN in FY 22, males comprised the largest percentage (64.97%), with females at (35%).[3] In comparison, males comprised the largest percentage (60.1%), with females at (39.9%) in FY 19. Of all the contracted providers, Therapeutics in Pontiac had the highest number of admissions at 228 and discharges at 81 with an average length of stay at 185.4 days. This was followed by Sacred Heart Madison Heights had 172 admissions, highest discharges (100) and with an average length of stay of 83.57 days.[4] In Comparison, FY 19 MAT providers, Sacred Heart-Madison Heights had the highest number of admissions at 352 and discharges (307), with an average length of stay of 248.77 days. This was followed by Meridian with 302 admissions and 282 discharges and an average length of stay of 375.68 days.

Evidence shows that alternative services such as acupuncture, yoga and meditation assist in the recovery process. OCHN has incorporated these ancillary services into the treatment milieu, focusing on the individuals with opiate addiction that have struggled with previous therapeutic interventions (e.g. withdrawal management, residential, outpatient interventions that accompany methadone). All three MAT providers have peer recovery coaches on staff and the goal is to continue to expand in this direction. In addition to MAT, OCHN also utilizes withdrawal

management and residential treatment for individuals that may not meet criteria for opiate replacement therapy.

OCHN has expanded OUD services in the community by expanding MAT services within the Jail, adding Ambulatory Withdrawal Management at one provider and onboarding 5 providers to offer Opiate Health Home (OHH) Services and Substance Use Disorder Health Home (SUDHH) Services.

Beginning FY 22, Sacred Heart began to offer Ambulatory Withdrawal Management Services. This least restrictive and cost- effective level of care is being offered to individuals who meet criteria. The enhanced program is designed for those individuals diagnosed with a mild to moderate Opioid Use Disorder with the goal of treating the level of withdrawal severity in a safe and comfortable setting. Intensive Outpatient or Outpatient services are continued in conjunction of ambulatory withdrawal management services.

OCHN has partnered with the Oakland County Jail to screen incarcerated individuals upon entry into jail for an opiate use disorder. Eligible individuals are offered to either continue the opiate use treatment they are currently on, if any, or are initiation on a medication assisted treatment medication. In addition to medication, individuals enrolled in the program receive individual and group therapy, case management, medication reviews, and peer recovery coach services. Individuals interested in continuing their opiate use disorder treatment at one of the three providers through OCHN are scheduled for an outpatient appointment post-release.

OCHN has implemented Opioid Health Home (OHH) and Substance Use Disorder Health Homes (SUDHH) to assist those with OUD to coordinate care for all needs. The OHH/SUDHH is a model of care that provides care management and care coordination services to individuals with a current opioid use disorder in addition to a physical health, behavioral, or social need. Focusing on patient centered care, individuals will also benefit from healthy lifestyle interventions. For the OHH, you must have Medicaid and a resident of Oakland County to be eligible for services. Whereas the SUDHH, services those who are underinsured or have no insurance OCHN has 5 providers that work directly with the SUDHH and OHH. Currently, there are 6 individuals enrolled into the SUDHH, and 148 individuals enrolled into the OHH. Individual served feedback to the providers referencing the Health Homes: “This is such a great service to have, it’s like having my own personal assistant to help me in my day-to-day life.” Since receiving OHH services, I feel so connected and I’ve met some personal goals I’ve been working toward. I look forward to more appointments.” “Managing my health has always been a task for me. Now that I’ve been meeting weekly with my recovery coach, she keeps me on track and encourages me to keep going.”

Starting FY 22 Meridian Health Services began a Family Treatment Program to address the family members' needs. The goal of the Family Treatment Program is to help family members develop coping strategies, develop a support network, learn self-care, gain resources and identify the differences between enabling and support.

OCHN has a policy in place for treating priority populations such as individuals engaging in IDU. They are offered an appointment for screening within 24 hours. If medication assisted treatment is recommended, an appointment is scheduled during the screening process. The appointment with the MAT provider takes place within two business days and often the same day. This policy has been reviewed and approved by MDCH during previous site visits and ensures all federal requirements are met.

As will all other components of this plan, OCHN will continue the positive and expand upon it as needed. All current policies and practices in place will continue through FY25. As services and/or policies need to be expanded OCHN will do so by utilizing trends and evidenced-based practices.

## Section 9……

***Evidence of a process and procedure for ensuring that policies, programs, and practices will be conducted in a culturally competent and equitable manner.***

Currently all prevention and treatment providers are required contractually to have a written cultural competency plan/policy in place that includes the requirements of the MDCH Contract Providers are asked to demonstrate compliance at the Annual Program Reviews.
OCHN supports a number of initiatives including training to ensure a culturally competent service delivery system. This includes outreach to and inclusion of underserved population such as persons who are deaf. OCHN currently has contractual services arrangements with the Arab American/Chaldean Council.
Cultural Competence is defined as a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among and between groups. All Prevention and Treatment Providers are expected to adhere to the following:

- The commitment to diversity will be institutionalized and articulated in policies and procedures and strategic plan of each treatment and prevention provider.
- OCHN will require all of its funded SUD providers to develop a written cultural competency plan that includes a minimum of three training hours, in diversity and competency training.
- Each service provider will ensure that their management and staff undergo regular, formal training in diversity and competency.
- Each service provider will develop a written strategy to recruit, retain and promote diverse, culturally competent administrative, managerial, clinical and support staff who are trained and qualified to address specific needs of the diverse racial and ethnic communities and persons served.
- Each service provider will review and adjust its policies and procedures to ensure that they reflect their commitment to diversity and competency, including areas such as intake, treatment planning and discharge planning and client satisfaction.
- Every service provider will ensure that all written materials are fully accessible to all clients served, such as forms, rules and regulations and consents for disclosure of information (releases) and bibliotherapeutic materials.

After creating a five-year Cultural Competency, Diversity, and Inclusion workplan in 2017 to advance diversity throughout the agency, our network of providers, individuals served, and community; OCHN conducted a Diversity, Equity, and Inclusion (DEI) Organizational Assessment in 2020 to help continue drive our DEI initiatives. From this assessment, annual plans were developed with standards, goals, objectives, and measurements; along with an OCHN goal to accomplish 75% of all DEI objectives within that annual plan.
In addition to continuing our internal I.D.E.A. (inclusion, diversity, equity, and accessibility) committee among OCHN staff, OCHN created a network-wide Diversity Committee to implement trainings, influence policy and procedure, and ensure all services provided are culturally sensitive, diverse, and inclusive. Funding is sustained through OCHN's Training Department for evidence and research-based trainings, and to ensure presenters require proper training, instruction, and certification. Having proper and adequate training to create a comprehensive curriculum will help to better equip our staff and network by increasing knowledge about the individuals we serve from

different backgrounds, such as socioeconomic, gender, religious, racial, ethnic, and sexual orientation. In the behavioral healthcare field, DEI training can help to be more empathetic toward the individuals that we serve and increase the inclusion of marginalized communities into healthcare services, ultimately decreasing health disparities.

Short-term goals include sustaining and maintaining the internal committee and network-wide collaborative of individuals from key providers within OCHN's network to share best practices, assess and evaluate current DEI initiatives within the network and their own agencies. Long-term goals include hiring a full-time staff dedicated to DEI to work closely with OCHN's DEI Officer; updating and maintaining policies, and procedures to ensure diversity, equity, and inclusion principles are engrained throughout; and maintaining both in-person and online trainings on DEI principles, including implicit bias and microaggressions. The internal OCHN I.D.E.A Committee, comprised of OCHN staff at all levels, is currently conducting the second organizational diversity assessment, and looking internally at OCHN policies, procedures, staff, and hiring practices. During fiscal year 2023, OCHN participated in the CMHA Cultural Competency Learning Collaborative, where we explored how to take DEI at OCHN to the next level using organizational change models.

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**ATTACHMENT I**

## Prevention Logic Model and Other Details for Prevention Services

Provider Acronyms: ACC- Arab American and Chaldean Council; ACHC- Alliance of Coalitions for Healthy Communities; CARE- Care of Southeastern Michigan; CCSEM- Catholic Charity of Southeast Michigan; HACC- Holly Area Community Coalition; HVCC- Huron Valley Community Coalition, NOCC- North Oakland Community Coalition; OCHD- Oakland County Health Division; SEOC- Southeast Oakland Coalition, SLCC- South Lyon Community Coalition, SLS- Student Leadership Services; OC-Oakland County.

| Overall Goal | Consequence (Primary Problem) | Intervening Variables | Objective | Activity/Immediate Outcome | Long-Term Outcome | Provider/ County |
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| Alcohol Use<br><br>To reduce underage drinking and UD binge drinking | Underage drinking (UD) and UD binge drinking in OC while trending downward in the last 5 yrs. remains unacceptably high<br>Data: MiPHY, past 30-day use:<br>2017-2018 7th = 1%<br>9th = 12.3%<br>11th = 29.2%<br>O.C. = 20%<br>2019-2020 7th= 1.1%<br>9th = 8.6%<br>11th= 24.4%<br>O.C. =16%<br>2021-2022 7th= 1%<br>9th= 6%<br>11th= 18%<br>O.C. = 11%<br>Data: MiPHY, past 30 days binge drinking:<br>2017-2018 7th= 0.6%<br>9th = 6%<br>11th= 19% | **Easy social access (accessibility)**<br>Impact of COVID-19<br><br>1.Older friends and relatives may supply alcohol to youth<br>2.High concentration of liquor stores, especially in economically disadvantaged areas<br>3. Parents/adults not monitoring alcohol in homes- Lack of adult supervision<br>4. Ease of buying alcohol throughout county in many stores | - Increase parent awareness of consequences of UD hosting<br><br>- Increase young adult awareness of penalties for furnishing alcohol to minors<br><br>-Bolster parental skills/ confidence around monitoring and being a positive support for their child | Parents who Host, implemented by 21 community coalitions covering 55+ of the 62 CVT's in OC)/ parent awareness of legal penalties for hosting<br><br>Awareness campaign "21 to Buy – Not Supply" / decrease in students reporting obtain alcohol from older sibling or young adult x 21 community coalitions* | Reduction in <u>past 30-day use</u> by 1%<br><br>Increased perception of disapproval by 1% | Oakland ACC, ACHC, CARE, CCSEM, HACC, HVCC, NOCC, OCHD, SEOC, SLCC, SLS |
| | | **Mental Health** (emotional/Life Stressors)<br>-Lack or positive coping skills, stress and boredom for rural communities, high drop out rates, family conflict, etc. | Increase likelihood of success in school<br><br>Educate youth on positive coping skills | 1.Mentoring program for 20 Hispanic youth<br>2.Tutoring program for 150 Hispanic youth<br>3.Provide problem ID, parent education and referral to needed services to 100 families of chronically truant/tardy students<br>4. Botvin Life Skills, Prime for Life, Strengthening Families, Positive Action, Guiding Good Choices, increase fidelity of implementation of MMH, Mental Health Navigators | Return to/stay in school | Oakland |

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| | O.C. = 12%<br>2019-2020 7th= 0.6%<br>9th= 5%<br>11th= 16%<br>O.C. = 10%<br>2021-2022 7th= 0.4%<br>9th= 3%<br>11th= 12%<br>O.C. = 7%<br>Data: MiPHY, perception of moderate/great risk/harm<br>2017-2018 7th= 70%<br>9th= 68%<br>11th= 71%<br>O.C. = 69%<br>2019-2020 7th= 66%<br>9th= 66%<br>11th= 68%<br>O.C. = 67%<br>2021-2022 7th= 64%<br>9th= 67%<br>11th= 70%<br>O.C. = 68% | **Perception of risk/harm**<br>-Schools do not have the time/resources to provide alcohol education to students, parents not informed and do not provide education to youth, lack of education around risks associated with alcohol use, including legal consequences, developmental factors, health risks, peer pressure, media promotes high risk use without showing the consequences | Increase perception of risk associated w/ UD and BD<br><br>Increase life skills | Provide:<br>70 series- LST in elementary and MS;<br>3 series- Safe, Smart<br><br>&Successful in MS;<br><br>2 series- Above the Influence in MS<br>1 series- Prime for Life in MS/HS<br><br>Provide information dissemination to families and communities of risks, harm, information, and resources | Increase <u>perception of risk/harm by 1%</u> | Oakland |
| | | **Family and community norms that support use**<br>• Stigma associated with alcohol misuse<br>• Not wanting to admit youth drinking is an issue in home<br>• Lake Area promotes party environment seasonally<br><br>Family<br>• Communication about drug use<br>• Individuals prone to addiction; family/genetic component<br>• | Increase parental communication about UD/ATOD use/abstinence.<br>Increase social supports, social connectedness<br>- Increase family cohesiveness and communication | 4 series- *Love &Logic*<br>*3 series- Guiding Good Choices*<br>2 series- *NCTI Cognitive Behavioral Change*<br>1 series- *Positive Action Family Program*<br><br>Provide 1 series of Strengthening Families Program to families of Arab and Hispanic students; provide 4 series of Love & Logic to Hispanic families; provide 3 series of Guiding Good Choices<br>Communities Mobilizing for Change on Alcohol, Communities that Care, Enhanced Enforcement of Laws Prohibiting Sales to Minors<br><br>Coalition activity examples: Advocate for ordinances, policies, | <u>Increase in perceived risk of use; perception of disapproval by 1%</u><br><br>Increase in <u>social connectedness</u> and families talking to students about drugs by 1% | Oakland |

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| | | | | practices that discourage youth use. "Student Athlete Project" (change school code); "Safe Homes"; Non-alcohol family events like "Band Jam", Movie Nights, Teen Expo, Youth Dialogue Day, Youth Action Boards sponsored activities; social norming campaigns* | | |

| Overall Goal | Consequence (Primary Problem) | Intervening Variables | Objective | Activity/Immediate Outcome | Long-Term Outcome | Provider/ County |
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| To reduce prescription drug abuse, including opiates | The nonmedical use of Rx drugs by teens and young adults in OC | Low perception of risk/harm @ NMPUD<br>-Lack of education or understanding of addiction, perceived safe because prescribe by doctor, lack of | Increase perception of risk of NMPUD | Provide:<br>70 series- LST in elementary and MS;<br>3 series- Safe, Smart &Successful in MS;<br>2 series- Above the Influence in MS | Increase in perceived risk of use by 1% | Oakland ACC, ACHC, CARE, CCSEM, HACC, HVCC, |

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| and other drugs | Data: MiPHY: students reporting past 30-day NMUPD Rx Painkillers<br>**2017-2018**<br>7th = 3%<br>9th=5%<br>11th= 8%<br>O.C. = 6%<br>**2019-2020**<br>7th=4.1%<br>9th= 4.3%<br>11th= 6.4%<br>O.C. = 5%<br>**2021-2022**<br>7th=4%<br>9th= 3.4%<br>11th= 3.4%<br><br>Any use of cocaine | knowledge of risks, social acceptance of use | | 1 series- Prime for Life in MS/HS<br><br>Provide information dissemination of information and risk of harm to families and communities.<br><br>Media Awareness | | NOCC, OCHD, SEOC, SLCC, SLS |
| | | Availability/<br>Easy access<br>Youth have had increased easy access | Increase parent awareness of NMPUD by youth | Increase monitoring of Rx drugs in home; use of lock boxes | Decrease the past 30-day use of NMUPD and NMUPD painkillers by 1% | Oakland ACHC, OCHD |
| | | | | Increase Rx drug "Take Back" days | | |
| | | | | Implement CADCA Challenge Tool Kit | | |
| | | | | "Do Your Part- Be the Solution" campaign x 21 community coalitions* | | |

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| | 2016-2017 7th= 10.1%<br>2017-2018 7th= 8.3%<br>2018-2019 7th= 8.8%<br>2019-2020 7th= 7.3%<br>2021-2022 7th = 6.8%<br><br>No data available for OC for OTC misuse | Family and community norms associated with NMUPD | -Increase positive parenting skills and family communication<br><br>-Increase family, community and cultural norms that discourage Rx and OTC drug use<br><br>Increase and expand Naloxone Education & Distribution and Save A Life Stations | Provide:<br>70 series- LST<br>1 series- Prime for Life<br>4 series- Love &Logic<br>3 series- Guiding Good Choices<br>2 series- NCTI Cognitive Behavioral Change<br>1 series- Positive Action Family Program<br><br>-Implement CADCA Challenge Tool Kit to educate sectors of community and advocate for policy change @ NMPUD utilizing CMCA framework<br>-"Do Your Part- Be the Solution" campaign x 21 community coalitions*<br>-Provide presentations on the risks to students, parents, and the community by way of information dissemination<br>-Promote awareness and availability of Naloxone through community education and reduced stigma by providing at least 20 community presentations and boxes. Increase Save a Life Stations | Increase social support/ connectedness by 1%<br><br>-Make an impact in the culture norms that creates increase in perception of harm by 1% | ACHC, SLS, CCSEM, ACC, CARE, HACC, HVCC, SEOC, NOCC, SLCC |

| Overall Goal | Consequence (Primary Problem) | Intervening Variables | Objective | Activity/Immediate Outcome | Long-Term Outcome | Provider/ County |
|---|---|---|---|---|---|---|
| To reduce youth access to tobacco | Annual Synar Compliance Rates<br>FY 2019=100<br>FY 2020=91.6<br>FY 2021= 77%<br>FY 2022= 70%<br><br>MiPHY OC students smoked cigarettes during past 30 days<br>2021-2022<br>7th = 0.2%<br>9th = 0.5%<br>11th = 1%<br><br>Data: MiPHY Electronic Vape Products in last 30 days<br>2017-2018 7th = 6%<br>9th= 23%<br>11th= 36%<br>2019-2020 7th = 3%<br>9th= 13%<br>11th= 25%<br>2021-2022 7th = 3.5%<br>9th= 8%<br>11th= 16% | Retail access | Decrease access to tobacco products by minors by educating retailers on YTA | Provide 800 (to all vendors) tobacco vendor education visits by local community coalitions and local law enforcement/ retailers check ID (target those most likely to sell based on history and type of outlet)<br><br>Provide technical assistance (DYTUR) to a minimum of 30 offending (FDA or Synar) tobacco retailers to train employees to comply with YTA | Maintain more than 80% on Annual Synar Compliance rate<br><br>-Have less than 2.0 of retailers willing to sell to minors in Annual Synar Inspections | Oakland<br><br>ACHC |
| | | Family and community norms that accept childhood exposure to 2ndhand smoke, tobacco, and nicotine products | Decrease student exposure to 2ndhand smoke, tobacco, and nicotine products | -Provide technical assistance to Tobacco Free Oakland County -(TFOC)/ to assist in updating school policies on tobacco & 2ndhand smoke, educate parents & students on dangers of 2nd hand smoke, hookah, snuff and other emerging tobacco products, participate in efforts to establish policies and ordinances that limit exposure to 2ndhand smoke, tobacco, and nicotine products<br><br>-Catch My Breath, INDEPTH, Botvin Life Skills, Prime for Life | Increase in perception of disapproval/ attitude by 1% | Oakland ACHC |
| | | Low perception of risk | Provide education to students, parents, retailers, and | -Conduct compliance checks for tobacco | Increase perception of risk and decrease the number of | Oakland |

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| | | | community of risks of electronic vape products | and electronic vapor products<br><br>-Provide a minimum of:<br>3 Tobacco and ENDS prevention education presentation on risks of use | students who used vape products in last 30 days by 1% | |

| Overall Goal | Consequence (Primary Problem) | Intervening Variables | Objective | Activity/Immediate Outcome | Long-Term Outcome | Provider/ County |
|---|---|---|---|---|---|---|
| To reduce marijuana use. | The use of marijuana by young people in OC while trending downward, remains high<br><br>Data:<br>MIPHY- Past 30-day use of marijuana in OC<br>**2017-2018**<br>7th = 1.3%<br>9th = 11%<br>11th= 25.1%<br>**2019-2020**<br>7th = 1%<br>9th = 8%<br>11th= 21.3%<br>**2021-2022**<br>7th = 1%<br>9th = 6%<br>11th= 16% | Family and social norms tolerating use; Easy Access<br><br>Low perception of risk | Educate parents and students on the dangers of marijuana use in terms of addiction potential and academic/ workplace success<br><br>Increase students' low perception of risk associated w/ marijuana use acquire life skills | 21 community coalitions will implement the public awareness campaign *Clear the Smoke* in 55+ of the 62 CVT's in OC<br><br>Help with the public awareness campaign Mobilizing Michigan-Protecting Our Kids from Marijuana<br><br>Provide:<br>4 series- Love &Logic<br>3 series- Guiding Good Choices<br>1 series- SFP<br>1 series- Prime for Life/ Prime for Life 420<br>2 series- NCTI Cognitive Behavioral Change<br>1 series- Positive Action Family Program<br>70 series- LST in elementary and MS;<br>3 series- Safe, Smart &Successful in MS;<br>2 series- Above the Influence in MS | Decrease the past 30-day use and increase perception of risk by 1%. | Oakland ACC, ACHC, CARE, CCSEM,<br><br>HACC, HVCC, NOCC, OCHD, SEOC, SLCC, SLS |

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| | | | | Policy changes- collaborate with other community partners to restrict where and how retailers are able to market, laws around billboard density, changes to school board policies to allow mental health support including counseling sessions for youth<br><br>Collaborate to increase access to mental health supports for youth to address coping and stressors | | |

| Overall Goal | Consequence (Primary Problem) | Intervening Variables | Objective | Activity/Immediate Outcome | Long-Term Outcome | Provider/ County |
|---|---|---|---|---|---|---|
| Older Adults Build capacity in OC and increase access to prevention and treatment services for older adults age 55 and older | FY 22 Admissions in OC:<br><br>Alcohol most widely reported 202 (53%)<br><br>Heroin 89 (23%)<br><br>Other Opiates/synthetics 17 (4.45%)<br><br>Oakland County Health Department, Michigan 2021, Top 10 causes of Death in OC: Heart disease, cancer, Covid-19, Unintentional injuries, stroke, chronic lower respiratory disease, Alzheimer's | **Impact of COVID-19 and health disparities** among the older adult population<br><br>**Mental Health** -Isolation and lack of community, lack of coping skills, stigma around seeking help, fixed income stressors<br><br>**Lack of knowledge related to** | Collaborate to build services in community<br><br>Increase partnerships and community collaborations<br><br>Increase evidence based programming and outreach to community<br><br>Implement solutions to address social determinants of health needs by partnering with other organizations to support implementation. | Conduct a needs assessment within OC identifying providers and capacity for prevention and treatment services<br><br>Assess current service system for SUD and work to enhance<br><br>Monitor data of COVID-19 impact on older adults and continue to address disparities<br><br>Participate and have representation from OC on the Adult Wellbeing Workgroup spearheaded by the State<br><br>Implement WISE Program, Mental Health First Aid and other similar supports for adults caring | Reduction in health disparities and substance use admissions by 1% and expand services to reach older adults | Oakland |

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| | Disease, Diabetes mellitus, Kidney Disease, chronic liver disease and cirrhosis. | **pain medication** | | for/interacting with older adults, increase medical pathways/gateway education for both patients and medical staff, support and encourage wraparound services to help remove barriers to prevent services | | |

| Overall Goal | Consequence (Primary Problem) | Intervening Variables | Objective | Activity/Immediate Outcome | Long-Term Outcome | Provider/ County |
|---|---|---|---|---|---|---|
| To reduce youth gambling by Increasing gambling disorder awareness and the risks associated with **it** | While gambling among students has fluctuated over the past 6 years, it remains high.<br><br>Data: MiPHY-Past 30-day use<br>**2017-2018**<br>9th=16.2%<br>11th=16.3%<br>**2019-2020**<br>9th= 13.4%<br>11th= 15.3%<br>**2021-2022**<br>9th= 13.2%<br>11th= 14.3%<br><br>73.2% of pathological gamblers have alcohol use disorder, 38.1 had a drug use disorder, 49.6% had a mood disorder, 60.8% had personality disorder and 15-20% attempted suicide (NESARC) | Lack of supervision with increase internet screen time<br><br>Co-occurring Disorders<br><br>Low perception of risk | To build capacity to address the need in OC.<br><br>Raise awareness<br><br>Educate parents, students, and communities on risks of gambling | Continue to monitor data and access need. Have Prevention Coordinator and some providers trained in evidence-based curriculums/best practices.<br><br>Create a Media Campaign<br><br>Disseminate prevention information | Decrease the past 30-day use in gambling by 1% | Oakland |

## Identify Prevention Providers/Coalitions (by county) to implement the regional plan described in the Logic Model.

| County | Provider Name | City Where Located |
|---|---|---|
| Oakland | **Alliance of Coalitions for Healthy Communities (ACHC)** | Pontiac; Coverage Area= Oakland County |
| | Birmingham Bloomfield Community Coalition | Birmingham Public Schools and Bloomfield Hills School Districts which include municipalities of Beverly Hills, Bingham Farms, Birmingham, Bloomfield Hills, Bloomfield Township, Franklin and portions of Orchard Lake, Southfield, Troy, and West Bloomfield |
| | Brandon Prevention Coalition | Ortonville and Brandon |
| | Clarkston Coalition for Youth | Clarkston, Independence Twp., and part of Springfield Twp. |
| | Clawson Community Coalition | Clawson |
| | Greater Farmington/Farmington Hills Community Coalition | Farmington/Farmington Hills |
| | Greater West Bloomfield Community Coalition for Youth | West Bloomfield Twp., Keego Harbor, Orchard Lake, and Sylvan Lake |
| | Hazel Park Community Coalition | Hazel Park |
| | Holly Area Community Coalition | Holly Area School District which includes the Village of Holly, Holly Twp., Davisburg, Rose Twp., Groveland Twp., Springfield Township, and parts of White Lake |
| | Huron Valley Community Coalition | Huron Valley School District which includes Commerce, Highland, Milford, and White Lake |
| | Madison Heights Community Family Coalition | Madison Heights |
| | North Oakland Community Coalition | Lake Orion and Oxford |
| | Novi Community Coalition | Novi, parts of Northville, Walled Lake, and South Lyon |
| | Prevention Pontiac Coalition | Pontiac School District |
| | Rochester/Auburn Hills Community Coalition | Rochester, Rochester Hills, Auburn Hills and Oakland Twp. |
| | Royal Oak Community Coalition | Royal Oak |
| | South Lyon Community Coalition | South Lyon, Lyon Township, and New Hudson |
| | Southeast Community Coalition | Ferndale School District, Ferndale, Pleasant Ridge, Royal Oak Twp., and Oak Park |
| | Southfield Community Anti-Drug Coalition | Southfield |
| | Tri-Community Coalition | Oak Park and Berkley School Districts, Huntington Woods, Berkley, Oak Park |
| | Troy Community Coalition | Troy |
| | Waterford Coalition for Youth | Waterford Twp. |

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| | Youth Advisory Council of Commerce/ Walled Lake | Commerce, Walled Lake, Wixom, and Wolverine Lake |
| Oakland | **Arab American Chaldean Council** | Southfield, Hazel Park |
| Oakland | **Catholic Charities of Southeast MI Hispanic Outreach Services** | Pontiac |
| Oakland | **CARE of Southeastern Michigan** | Hazel Park and Oak Park |
| | **Easterseals MORC** | Auburn Hills, Southfield, Pontiac |
| Oakland | **Holly Area Community Coalition** | Holly |
| | **Huron Valley Community Coalition** | Huron Valley School District |
| Oakland | **Oakland County Health Division Health Education Unit** | Pontiac, Auburn Hills, Troy |
| Oakland | **North Oakland Community Coalition** | Lake Orion and Oxford |
| | **Southeast Oakland Coalition** | Ferndale School District |
| | **South Lyon Community Coalition** | South Lyon School District |
| Oakland | **Student Leadership Services** | Waterford, Auburn Hills |

## 12 Community Sectors Outlined in the Community Anti-Drug Coalitions of America Institute

•Youth (persons <= 18 years of age) • Parents • Business community • Media • Schools • Youth-serving organizations • Law enforcement agencies • Religious or fraternal organizations • Civic and volunteer groups • Healthcare professionals • State, local or tribal agencies with expertise in the field of substance abuse • Other organizations involved in reducing substance abuse

## Quadrant Sections of Oakland County

**Northwest**: Holly Area Community Coalition and Brandon Community Coalition.
**Northeast**: Clarkston Coalition for Youth, North Oakland Community Coalition, and Rochester/Auburn Hills Community Coalition, and Waterford Coalition for Youth.
**Southwest**: Greater Farmington Coalition, Huron Valley Community Coalition, Youth Advisory Council of Commerce/Walled Lake, Novi Community Coalition, and South Lyon Community Coalition.
**Southeast**: Prevention Pontiac Coalition, Birmingham Area Coalition, Clawson Coalition, Greater West Bloomfield Coalition for Youth, Hazel Park Coalition, Madison Heights Coalition, Royal Oak Coalition, Southfield Coalition, Tri-Community Coalition, and Troy Coalition.

**Check (*) the Key Stakeholders involved in prevention services in the region, by county, based on the following sectors. Add columns for counties, as needed:**

| Key Stakeholder | County: OAKLAND |
|---|---|
| **Health care professionals** | * |
| **Schools** | * |
| **Law Enforcement** | * |
| **State, local, and/or tribal government agencies** | * |
| **Business community** | * |
| **Mental health agencies** | |
| **Parents** | * |
| **Media** | * |
| **Youth** | * |
| **Youth-serving organizations** | * |
| **Faith community or fraternal organizations** | * |
| **Fraternal organizations/civic or volunteer groups** | * |
| **Military/Veteran groups or organizations** | * |
| **Treatment Providers** | * |
| **University & Research Institutions** | * |
| **Gambling- Financial Institutions** | |
| **Older Adults- Groups and organizations** | * |
| **Synar Key Stakeholders**** | * |

**Community coalitions, local law enforcement including the Sheriff's Department, youth, and retailer groups

**If key stakeholders are missing, provide a timeline with key activities and dates to assure their involvement:**

| Stakeholder Missing | County | Key Activities to Engage | Date | Who's Responsible |
|---|---|---|---|---|
| Mental Health agencies | Oakland | Continue to work to integrate mental health and substance use prevention efforts for children, youth, young adults, adults, and older adults. Continue to expand services | October 2023-September 2026 | SUD Prevention Coordinator (PC) and SUD Team |
| Early Intervention Prevention | Oakland | Expand services to include early intervention and lifespan ages. Access, | October 2023-September 2026 | SUD Team |

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| | | gather, monitor data, and prepare plan to move forward | | |

**List the Federal Strategies (specific) to be addressed in the region, based on the Logic Model provided above:**

Alternative: tutoring and mentoring activities, youth/adult leadership activities, ATOD-free family activities

Community-based: coalition building and facilitating, community coalition activities involved in assessment, planning, technical assistance, and advocacy for prevention services

Educational: classroom and other group education prevention programs

Environmental: all community coalition activities targeted at environmental change to decrease likelihood of ATOD use and all Synar-related activities

Information Dissemination: accompanies all funded activities

Problem Identification and Referral intervenes with truant students and their families, school liaison services.

**List the Evidence-Based Programs to be implemented in the region:**

Above the Influence
Botvin's Life Skills Training
CADCA Challenge Tool Kit
CATCH My Breath
Communities Mobilizing for Change on Alcohol (CMCA)
Guiding Good Choices
INDEPTH
Love & Logic
Michigan Model for Health
NTCI Cognitive Behavior Change and Positive Action for Families
Opening Doors
Positive Action Family Program
Prime for Life
Safe, Smart, and Successful
School Liaison Services for LEP families
Synar Compliance Checks
Strengthening Families Program
Tutoring and Mentoring Services
WISE Program

**List the Service Populations (specific based on CSAP Priority Populations) to receive services in the region, based on the Logic Model provided above:**

| ***High Risk*** | ***Non-High Risk*** |
|---|---|
| 04 Children of substance abusers | 31 Students |
| 05 Delinquent youth (chronically truant) | 33 Parents and families |
| 06 Economically disadvantaged | 34 LGBTQA |
| 13 Homeless or runaway youth | 36 Business and industry |
| 16 People using substances | 38 Coalitions |
| 24 School dropouts | 45 General population |
| | 32 Older Adults |
| | 30 Youth/minors |
| | 17 People with disabilities |
| | 18 People with mental health problems |
| | 19 Physically/emotionally abused |
| | 42 SUD prevention/treatment professionals |

**Outcomes: The following pre-populated outcomes are to be addressed statewide. In the table below, identify your baseline measure (what the data says now). Identify the data source, and your goal to reach for intermediate and long-term. If your region has identified additional priority problems to be addressed, add the information to the table below where noted.**

| Indicator | Baseline Measure *(As of 7/1/2023)* | Data Source/ Date of Report | Intermediate Outcome Measure *(By 9/30/2021)* | Intended Long-Term Outcome Measure *(By 9/30/2026)* |
|---|---|---|---|---|
| **Past 30-day alcohol use-Youth (age 12-17)** | **HS = 18%<br>MS = 6%** | **MiPHY 2021-2022** | **HS = 16%<br>MS = 5%** | **HS = 15%<br>MS = 4%** |
| **Past 30-day alcohol use- Young Adult (age 18-25)** | **50.1 %** | **NSDUH's Sub state Region Report 2021** | **50 %** | **49%** |
| **Past 30-day alcohol use- Adult (age 26 and older)** | **51.9 %** | **NSDUH's Sub state Region Report 2021** | **51.5 %** | **51 %** |

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| **Past 30-day binge alcohol use- Youth (age 12-17)** | **3.8** % | **NSDUH's Sub state Region Report 2021** | **3.5 %** | **3** % |
| **Past 30-day binge alcohol use- Young Adult (age 18-25)** | **29.2 %** | **NSDUH's Sub state Region Report 2021** | **29.1** | **29** |
| **Past 30-day binge alcohol use- Adult (age 26 and older)** | **22.4 %** | **NSDUH's Sub state Region Report 2021** | **22.2** | **22** |
| **Past 30 Day NMUPD Rx Painkiller** | **7th grade = 4% 11th grade=3.4%** | **MiPHY 2021-2022** | **7th = 3.5 % 11th = 3.2 %** | **7th = 3 % 11th = 3 %** |
| **Tobacco retailer compliance rate** | **70%** | **Annual Synar Inspection 2022** | **Average since 2020 76.2%** | **80% or above** |
| **Past 30-day use of marijuana in OC 7th & 11 graders** | **7th = 1** % **11th = 16** % | **MIPHY 2021-2022 (Past 30-day use of marijuana)** | **7th = 0.7 % 11th = 15** % | **7th = 0.5** % **11th = 14 %** |

| Primary Problem | Intervening Variables | Strategies | Immediate Outcomes | Intermediate Outcomes | Long-term Outcomes | County |
|---|---|---|---|---|---|---|
| Expand Behavioral health and Primary care services for persons at-risk for, and with, mental health (MH) and substance use disorder (SUD). | 1. Societal culture and expectations<br>a. Historical mistreatment leading to mistrust in the medical community.<br>b. Shifting away from an "Us vs. Them" mindset<br>c. Media perpetuates what trauma may look like, which often does not align with lived experience.<br>2. Lack of support for workforce<br>a. High cost of trainings<br>3. Factors reducing quality of mental health.<br>a. Overlooking mental health in favor of other health concerns.<br>b. Stigma<br>c. Self-medication, coping mechanisms<br>d. Pandemic-exposed disparities and lack | 1. Public awareness campaigns<br>a. Perception campaigns to address stigma.<br>2. Health service accessibility and navigation<br>a. Increase understanding of when and from whom to access services.<br>b. Community Health Worker integration<br>c. Mental Health Navigator integration in schools<br>3. Collaboration<br>a. Interdisciplinary collaboration and resource management | 1. Increase awareness through community impact campaigns.<br>a. To decrease stigma around MH and SUD<br>b. Increase promotion of trauma-informed messaging for children, adolescents, families, and special populations<br>2. Increase awareness of multiple pathways to recovery and the availability of services in Oakland County.<br>3. Improve the analysis of data specific to SUD via PowerBI.<br>4. Continue advocacy for the implementation of Project ASSERT in | 1. Increased admissions to treatment and transitions to level of care (LOC).<br>2. Expand capacity for additional services, including:<br>a. Publishing an RFP for adolescent withdrawal management and residential treatment<br>b. Researching a pilot-based Jail-medication assisted treatment (MAT) program for treatment of Alcohol Use Disorder (AUD)<br>i. Research the addition of Vivitrol | 1. Increase in access to behavioral health services for individuals with mental and substance use health needs.<br>2. Integration of SUD into OCHN processes through the integration of all treatment contracts to follow the mental health contract structure.<br>3. Increased resource/ service density in needed locations based on demographics.<br>4. Implementation of new services:<br>a. Implement Vivitrol for AUD into current outpatient MAT services. | Oakland |

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| | of wraparound services<br>e. Employment stigma with justice involved individuals.<br>f. Media portrayal of people using substances.<br>4. Access, affordability, and availability of support/ resources/ and treatment.<br>a. Challenges locating and reaching out to providers.<br>b. Lack of resources for youth, insufficiency of assessment and diagnostic services, and workforce shortages<br>c. Disparities in affordability, lack of sustainable funding for treatment. | | local hospitals and FQHC systems.<br>5. Increase interdisciplinary collaboration and resource management to help decrease barriers to accessing treatment.<br>a. Increase training for provider network on evidence-based practices (EBPs) and co-occurring treatment practices. | to the array of MAT services for AUD.<br>c. Publish and RFP for residential and recovery housing services.<br>i. Research the addition of Women's Specialty Service (WSS) specific recovery housing.<br>3. Increase locations where screenings like Project ASSERT are offered throughout the community.<br>4. Increase admissions for OHH/ SUDHH.<br>5. Investigate new administrative efficiencies to | b. Implement Jail-MAT program for AUD.<br>5. Expand Project ASSERT to 1 hospital systems or FQHC sites.<br>6. Increase in community partnerships for those at risk.<br>a. Oakland University, law enforcement, court systems, Families Against Narcotics, and prevention partners, and homeless shelters. | |

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| | | | | increase ease of access to services and in workforce retention. | | |
| Increase access to treatment and harm reduction for persons living with Opiate Use Disorder | 1. Infrastructure and regulation<br>a. Rising healthcare costs<br>b. Inadequate treatment infrastructure (lack of capacity and capability)<br>2. Lack of collaboration<br>a. Singular agency providing harm reduction services in the county.<br>b. Grant funding restrictions | 1. Financial resource allocation<br>a. Support use of opioid settlement funds<br>b. State Opioid Response (SOR) grant.<br>2. Community education, marketing, and awareness of harm reduction.<br>a. Educate the community on what harm reduction is and the goals of harm reduction services.<br>b. Educate community on current harm reduction efforts through OCHN's community partners. | 1. Develop sustainability plan for services funded through SOR.<br>a. Reduce transportation barriers to treatment for MAT and Stimulant Use Disorder (StUD) individuals.<br>2. Timely communication around the consequences of illicit substances (e.g., xylazine).<br>3. Save A Life box expansion throughout rural areas in Oakland County.<br>4. Research effective/ best practice messaging to increase support for harm reduction services. | 1. Implement sustainability plan for SOR funded services, if necessary.<br>2. Data collection and analysis of current harm reduction services and barriers to treatment.<br>3. Include harm reduction resources in willing partnering service facilities.<br>4. Expand community education about OUD treatment and recovery through media messaging, community workshop promotion, etc.<br>5. Evaluate effectiveness of, and provide technical assistance | 1. Decrease in overdose and death rates<br>2. Increase in communities that allow for harm reduction services<br>3. Advocate for the expansion of allowable eligibility and SUD service reimbursement.<br>a. Increasing Block Grant funding to cover uninsured or underinsured individuals to receive necessary MAT medication.<br>b. Continued advocacy for Medicaid eligibility expansion. | Oakland |

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| | | i. Increase awareness of free Narcan training<br>ii. Narcan, fentanyl test strips, xylazine test strips, and condoms in harm reduction kits.<br>3. Expand use of harm reduction innovative solutions and tools.<br>a. Adding Contingency Management as an incentive program for contracted MAT clinics.<br>b. Analyze policies related to workforce retention and reimbursement of services. | 5. Implement service model for MAT providers.<br>6. Explore workplace policies to support retention within OCHN and its partnering organizations. | regarding, service implementation across MAT clinics.<br>6. Increase funding and staff for harm reduction through peer coaches and ancillary service utilization.<br>a. Expansion of WSS to MAT providers. | | |
| Increase in access to treatment | 1. Social barriers and stigma<br>a. Criminal Justice versus mental | 1. Facilitating collaboration, increasing | 1. Identifying gaps in communication and collaboration | 1. Facilitating new partnerships or | 1. Implementation of community events to | Oakland |

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| for the criminal justice involved population returning to communities. | health perspective of the "problem."<br>b. Misunderstandings and fears surrounding mental health.<br>2. Communication and awareness<br>a. Poor coordination between parties inside and outside the system.<br>b. Lack of awareness of publicly funded resources.<br>3. Access to services<br>a. Access to mental health treatment and services.<br>b. Staff shortages in health and support services. | communication, and expanding education<br>a. Greater connection among treatment, prevention, and recovery.<br>b. Increased collaboration with law enforcement, including a space for airing frustrations and sharing recovery success stories.<br>c. Educate funders and policymakers to increase funding to support transition infrastructure.<br>2. Financial and logistic support<br>a. Increase the ability to hire more staff to manage appropriate caseloads. | between stakeholders.<br>2. Increase OCHN SUD team representation at community events.<br>3. Analyze efficacy of provider information and requests through ODIN and external processes. | collaborative workgroups.<br>a. Increase collaboration between judicial systems and treatment providers.<br>b. Increase collaboration between prevention, treatment, and recovery providers.<br>c. Analyze the need for a SUD community workgroup, including individuals served.<br>2. Increase education of professionals throughout Oakland County.<br>a. CIT training for co-responders and first responders. | strengthen partnerships across Oakland County and education regarding current services.<br>a. i.e., SUD townhalls or Call to Solidarity<br>2. Assist persons served in self-advocating through the creation of an advocacy toolkit. | |

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| | | b. Paperwork reduction. | | b. Community education campaign for medical and non-contracted providers on treatment of justice-involved individuals.<br>3. Facilitating partnerships between treatment and prevention providers to attend Legislative Lobby Days. | | |
| Increase in access to trauma responsive services. | 1. Stigma<br>a. Need for increased education on trauma across service professionals.<br>b. Providers may be judgmental, preventing individuals served from disclosing substance use, especially during pregnancy. | 1. Increased support of workforce providing trauma responsive resources and services.<br>a. Increase diversity and representation of providers who serve communities and how they analyze and respond to | 1. Marketing of educational opportunities and culturally competent and inclusive training provided by OCHN.<br>a. To non-contracted providers<br>b. SUD service network<br>2. Media campaigns about the importance of | 1. Increase attendance at community workshops and other OCHN provided training.<br>2. Increased reports from provider network on EBP trauma-informed trainings attended.<br>3. Support contracted providers | 1. Increase referrals from non-contracted providers<br>2. Analysis of individuals served perception of trauma-responsive care through annual evaluation.<br>3. Increase in number of clinicians trained | Oakland |

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| | c. Professionals in the field may not want to admit that they also need trauma-informed services.<br>2. Lack of access to trauma-informed services<br>a. High turnover of professionals.<br>b. Lack of culturally competent providers to increase feelings of safety for individuals receiving services. | individuals with Social Determinants of Health (SDOH) needs.<br>b. Increase education to medical providers in the specific needs of WSS, or other special populations, and its intersection with SUD.<br>2. Provide support for treatment professionals seeking services.<br>3. Increase OCHN and SUD providers involvement in utilizing community-based resources in treatment.<br>4. Zero Suicide philosophy implementation. | everyone seeking mental health treatment.<br>3. Continued involvement in TDMs by Women's Specialty Coordinator to advocate for WSS utilization as a prevention activity.<br>4. Increase utilization of ancillary services (e.g., yoga, meditation)<br>5. Analysis of suicide prevention and crisis care in the SUD provider network. | implementing trauma-responsive workforce retention policies.<br>4. Analysis of utilization of ancillary services.<br>5. Explore the analysis of referrals to treatment from TDMs.<br>6. Creation of protocol and training requirements of the clinical pathway in SUD service network. | in trauma informed EBPs<br>4. Implementation of Zero Suicide philosophy/ Clinical pathway protocol.<br>5. Implement analysis of SDOH needs being addressed in treatment planning process. | |
| Reduce in the percentage | 1. Laws and Policies<br>a. State law promotes | 1. Policy change<br>a. Advocate for state-level | 1. Initiate collaboration between WSS | 1. Increase collaboration with prevention | 1. Encourage attendance of WSS partners to | Oakland |

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| of substance exposed infants at birth. | abstinence-only sexual education.<br>b. State law creates unfunded mandate to school districts to provide sexual education and health education.<br>c. Former policies of removing infants from parents using substances have been changed to encourage family stability.<br>2. Lack of access to prenatal care for those who are using and/or in treatment utilization rates for Women's Specialty Services.<br>a. Barriers with transportation—unreliable, cost of ride-sharing options.<br>b. Pregnant people may lack knowledge of available resources.<br>c. Waitlist to see provider in some areas. | policy changes related to comprehensive sex education and health in schools.<br>2. Increase resources and funding to support initiatives and programs.<br>a. Increase partnerships between WSS and prevention providers.<br>b. Encourage schools have funded positions at the district level to support available services within the school.<br>3. Increase marketing, and knowledge, of SUD and sex education, including resource availability.<br>a. Provide education on the effects of | community providers and prevention providers.<br>2. Increase marketing and education campaigns in non-traditional spaces.<br>a. I.e., hair salons, PTA meetings, hospitals, non-contracted OBGYN facilities. | partners to advocate for WSS and sex education policy reform.<br>2. Expand WSS provider network through new service provision. | attend Legislative Lobby Days.<br>2. Expansion of OHH and SUDHH to WSS population.<br>3. Increase WSS admissions<br>4. See a decrease in babies' substance-exposed at birth. | |

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|---|---|---|---|---|---|---|
| | 3. Stigma<br>a. According to the CDC in 2019, approximately 40% of pregnancies in the United States are unplanned and may have used substances without realizing they were pregnant. They may fear judgement for disclosing this information.[1]<br>4. Misinformation on substance use and pregnancy.<br>a. Some healthcare providers and social workers are not up to date with current policy and call CPS right away when a baby is born exposed to substances.<br>b. People may believe marijuana is safe to use during pregnancy and do not report it to providers. | substance use on prenatal development.<br>b. Provide evidence-based education on comprehensive sex education across the lifespan.<br>c. Educate providers on referral resources to support individuals. | | | | |

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|---|---|---|---|---|---|---|
| | c. Certain cultures may not view using certain types of substances during pregnancy as a problem. | | | | | |
| Increase in access to treatment services for older adults 55 and older. | 1. Advocate for change in healthcare practices.<br>a. Overprescribing<br>b. Failure to appropriately screen older adults for risk of addition and need for services.<br>c. Current screening tools may not accurately capture levels of drug use.<br>d. Not communicating risk of medications with patients.<br>2. Barriers to accessing treatment.<br>a. Lack of access to reliable transportation.<br>b. Cost of ride-sharing transportation. | 1. Increase OCHN community analysis of barriers for older adults in Oakland County to accessing services.<br>a. Assess healthcare provider barriers to delivery of services.<br>b. Assess treatment needs in Oakland County.<br>2. Increase partnerships and collaborations with community-based organizations, such as:<br>a. Departments of Education within hospital systems. | 1. Investigate barriers and potential solutions for older adults accessing services.<br>a. Initiate a workgroup specific to older adults to analyze potential gaps in knowledge related to SUD risk and barriers to accessing services.<br>b. Analyze current network to determine if additional services are needed and current utilization rates. | 1. Initiate interdisciplinary and community collaboration.<br>a. Hospital systems<br>b. Senior Reach Collaborative<br>c. YMCA programs for older adults<br>d. Library programs<br>e. Older adult care facilities<br>2. Implement a plan to target barriers to treatment for older adults.<br>a. i.e., increase funding for transportation services specific to the older adult population, if necessary. | 1. Increase in admissions to programs by older adults | Oakland |

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|---|---|---|---|---|---|---|
| | c. Providers may not know where to refer people.<br>3. Stigma<br>a. Difficulty disclosing information about substance use with medical professional.<br>b. Difficulty admitting that they need help.<br>4. Lack of patient knowledge and education.<br>a. Risks of drug interactions, including alcohol.<br>b. Risk of addiction with prescription medication. | b. Senior Reach Collaborative<br>c. Local universities and college programs<br>3. Increased education about older adult substance use.<br>a. Risks of drug interactions, including alcohol.<br>b. Risk of addiction with prescription medication. | 2. Create marketing material to distribute at non-traditional locations (i.e., hospitals, YMCA, AAA, libraries, older adult care facilities) for older adults to:<br>a. Become aware of service provisions available.<br>b. Get education on dangers of medication interactions with illicit substances.<br>c. Destigmatizing SUD in older adults. | 3. Increase referrals to treatment from non-contracted providers. | | |

| Primary Problem | Intervening Variables | Strategies | Immediate Outcomes | Intermediate Outcomes | Long-term Outcomes | County |
|---|---|---|---|---|---|---|
| Enhance coordination of prevention, follow-up, and continuing care in the recovery process. | 5. Historical conflict with partnerships and feeling protective of intellectual property and programming.<br>6. Funding structure limitations<br>a. Competitive grants<br>b. Reporting requirements<br>7. Stigma<br>a. Lack of understanding of SUD.<br>b. Shame (e.g., a person feeling like a failure because they relapsed).<br>i. Shame and judgements existing within the different recovery communities. | 4. Increase education surrounding relapse as part of the recovery process.<br>5. Educate on other modalities that exist outside of 12-step recovery (CBT programs, Buddhist programs, SMART recovery, etc.)<br>6. Educate and promote varying modalities beyond group settings (Al-Anon), such as individual counseling and support services.<br>a. Focus on change of the whole person, not just treating the problem. | 6. Increase media messaging surrounding the recovery process and available community support.<br>a. Relapse as part of the recovery process.<br>b. Harm reduction as it intersects with recovery.<br>7. Onboard contracted provider for Recovery Community Organization (RCO).<br>a. Marketing of RCO through outreach and events. | 6. Explore need for additional recovery support services, such as:<br>a. Peer specialists<br>b. Recovery Housing<br>c. Recovery cafes<br>d. Recovery high schools<br>e. Collegiate recovery programs<br>f. Family recovery support<br>7. Analysis of need for additional recovery support services, such as:<br>a. Townhall where stakeholders can share ideas.<br>b. Data from provider post-discharge surveys | 1. Increase in transition to lower LOC services from higher LOC<br>a. Increase in utilization of ancillary support.<br>b. Increase in utilization of group community support.<br>2. Develop implementation plans for any needed recovery support services. | Oakland |

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|---|---|---|---|---|---|---|
| | | | | c. OCHN-created survey.<br>d. GPRA outcomes | | |
| Expand treatment services to include ongoing support and multiple coordinated strategies to support recovery. | 3. Staffing and volunteer challenges<br>a. Staff desire for private practice<br>i. Higher compensation<br>b. Staff and volunteers burn out.<br>c. Impact of insufficient funding on staffing.<br>4. Funding constraints<br>a. Consistency in funding streams.<br>b. Funding restrictions affecting program choice and innovation.<br>5. Interorganizational cooperation and integration<br>a. Need for increased cooperation between organizations.<br>b. Overcoming the siloed understanding and efforts. | 4. Optimize financial support.<br>5. Analysis of administrative efficiency.<br>6. Exploration of efficacy of care coordination processes between LOCs. | 7. Analyze efficacy of provider information and requests through ODIN and external processes.<br>8. Increase interdisciplinary collaboration and resource management to help decrease barriers to accessing treatment.<br>a. Increase training for provider network on evidence-based practices (EBPs) and co-occurring treatment practices.<br>b. Implement coordination of care process improvements, if necessary. | 7. Implement process to increase provider administrative efficacy.<br>8. Advocate for the expansion of allowable eligibility and SUD service reimbursement.<br>a. Increasing Block Grant funding to cover uninsured or underinsured individuals.<br>b. Continue advocacy for Medicaid eligibility expansion. | 4. Continued analysis of provider information requests and staff needs.<br>5. Continued advocacy for expansion of allowable SUD service reimbursement. | Oakland |

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|---|---|---|---|---|---|---|
| Increase in access to recovery services to promote life enhancing recovery and wellness for individuals and their families. | 4. Familial impact of addiction<br>a. Addiction impacts the entire family, not only the individual experiencing SUD.<br>b. Addiction can affect communication and create harm within familial relationships.<br>c. Strained family relationships.<br>5. Barriers to support<br>a. Limited awareness of available resources.<br>b. Families are not able to access supports before their loved one enters treatment.<br>c. Costs associated with recovery services.<br>6. Stigma and fear<br>a. Familial shame about substance use/ addiction<br>b. Fear of repercussions (CPS, legal, etc.) if | 3. Increase awareness of:<br>a. Available resources for families outside of treatment programs (Al-Anon, and Friends and Family for SMART Recovery available at any time).<br>b. Education on how substance use impacts families.<br>4. Community engagement<br>a. Engage school systems and parent associations to know what role they can play in recovery and the services available. | 4. Implement media campaigns and education on recovery services available to Oakland County residents.<br>a. Stigma reduction campaign.<br>5. Increase outreach of RCO through community engagement.<br>a. Community-based recovery events. | 4. Explore additional RCO engagement efforts, such as:<br>a. Collaboration with Oakland County Schools<br>b. Recovery Friendly Workplace (RFW)<br>c. Individual Placement Services (IPS) | 3. Continuation of RCO community engagement. | Oakland |

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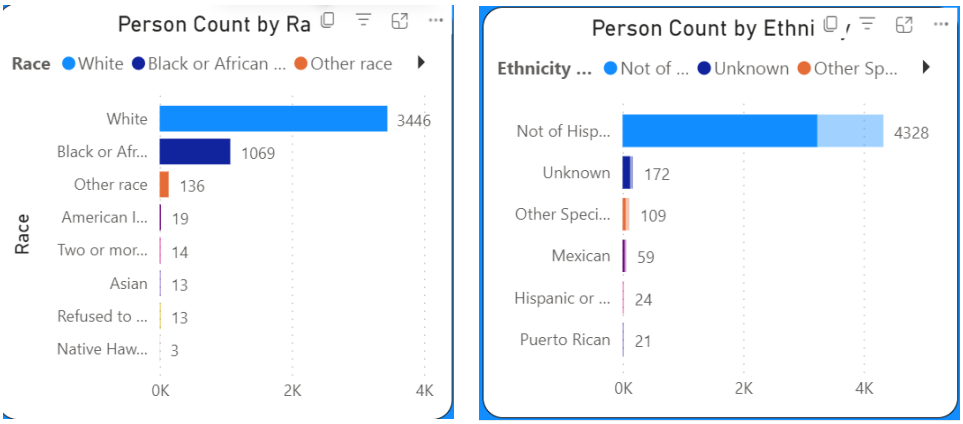
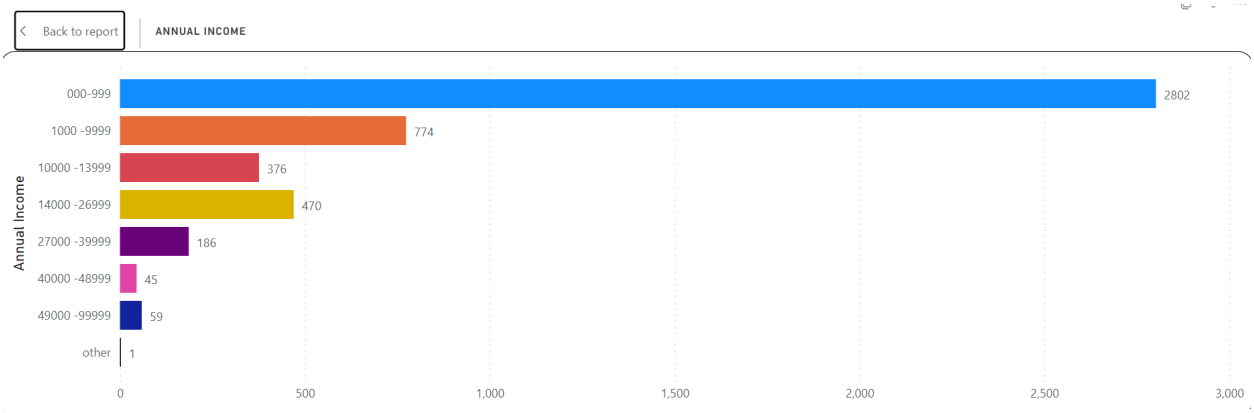
|---|---|---|---|---|---|---|
| | it is known that family members are using.<br>7. Service accessibility and awareness<br>a. Difficulty in accessing multiple pathways to services.<br>b. Use of technology to enhance service delivery.<br>c. Need for human connection in post-COVID era.<br>d. Raising awareness of available services. | b. Workplace education for employers so people can feel safe seeking help. | | | | |

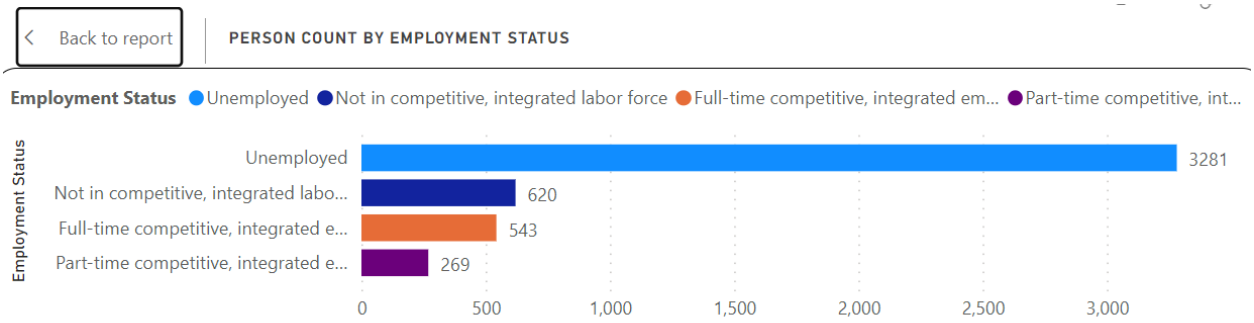
## Footnote 2




## Footnote 5



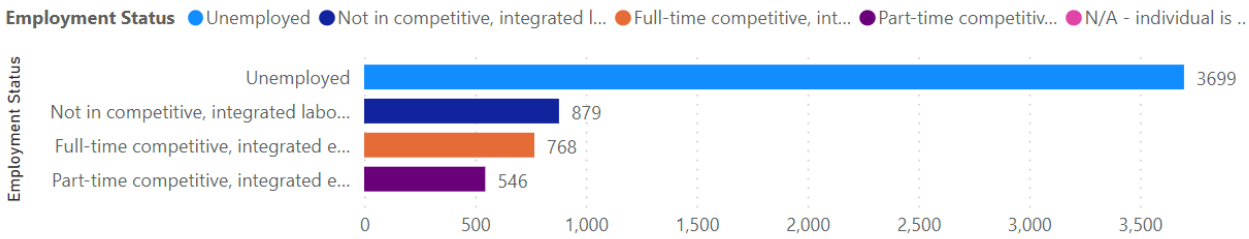

## Footnote 7




| Employment Status | Count of Person Count |
|---|---|
| Unemployed | 3281 |
| Not in competitive, integrated labor force | 620 |
| Full-time competitive, integrated employment | 543 |
| Part-time competitive, integrated employment | 269 |

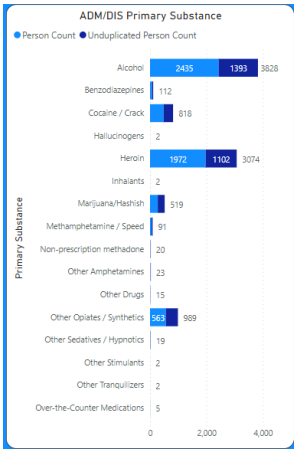
## Footnote 9

Back to report | PERSON COUNT BY EMPLOYMENT STATUS

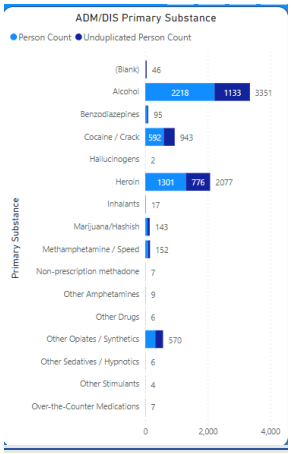



| Employment Status | Count of Person Count |
|---|---|
| Unemployed | 3699 |
| Not in competitive, integrated labor force | 879 |
| Full-time competitive, integrated employment | 768 |
| Part-time competitive, integrated employment | 546 |
| N/A - individual is under 16 years of age | 10 |

## Footnote 10

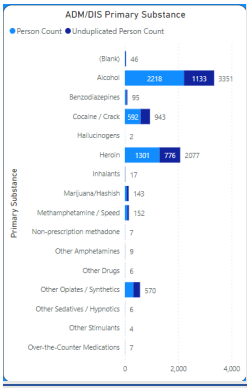



FY 2019

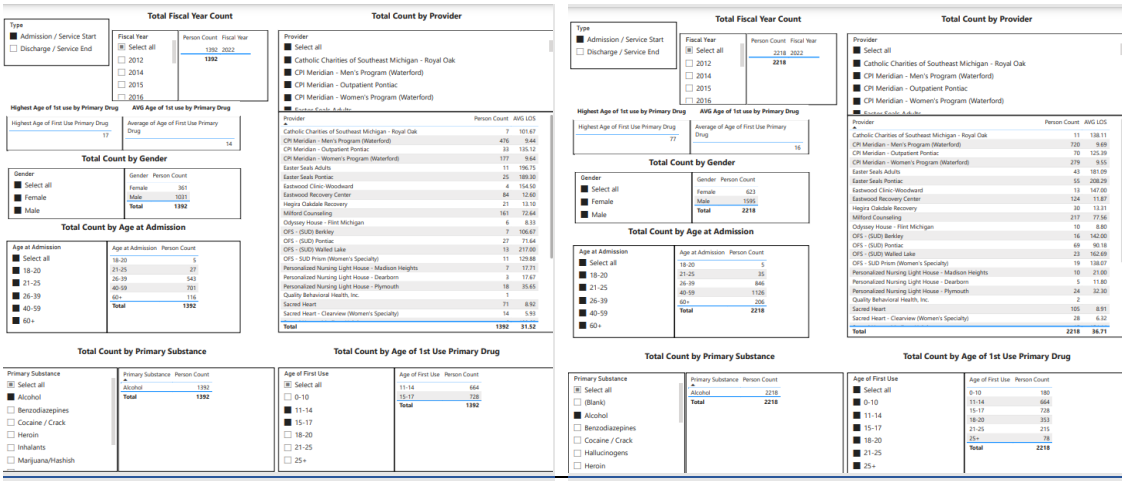



FY 2022

## Footnote 11



## Footnote 13

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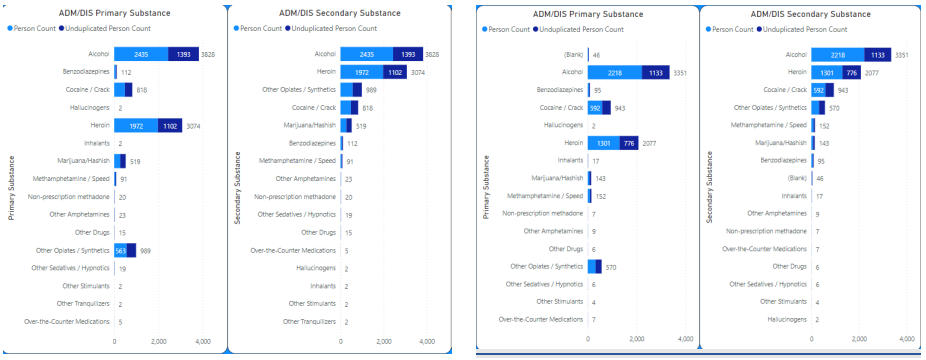
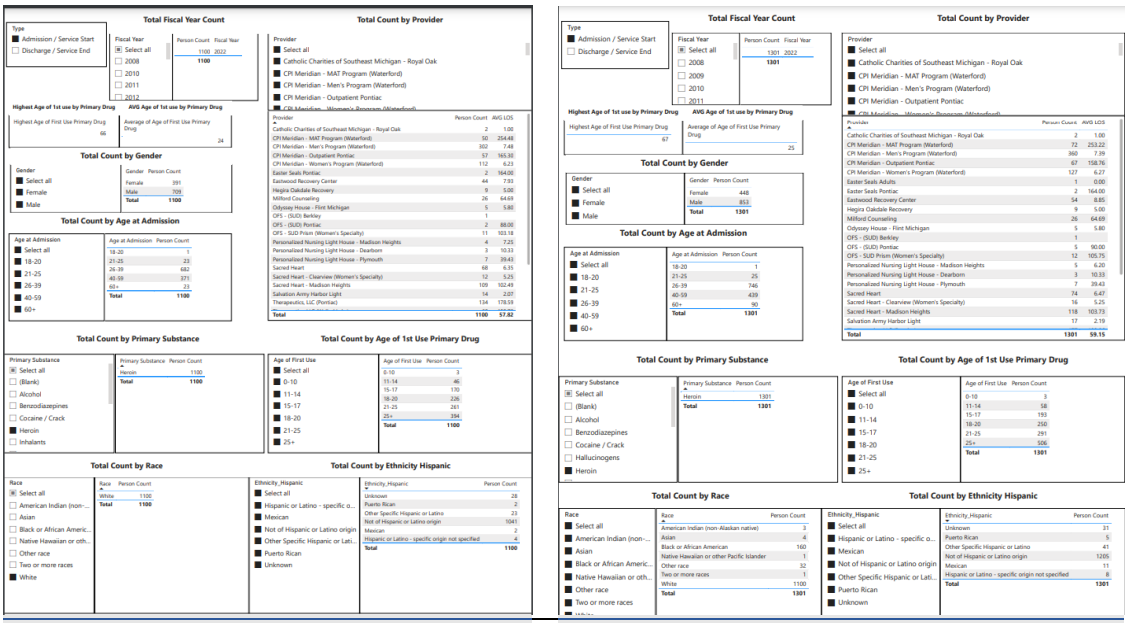



**FY 2019** **FY 2022**

## Footnote 19



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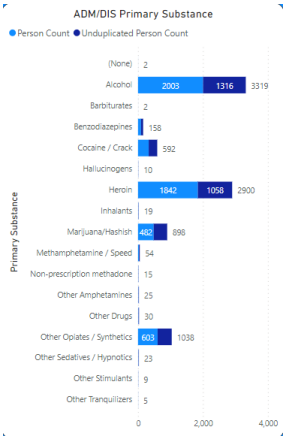
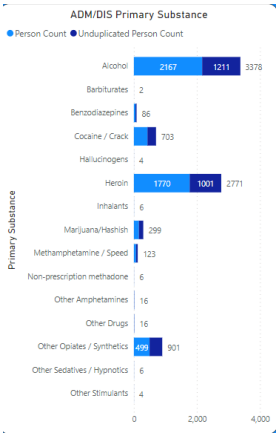
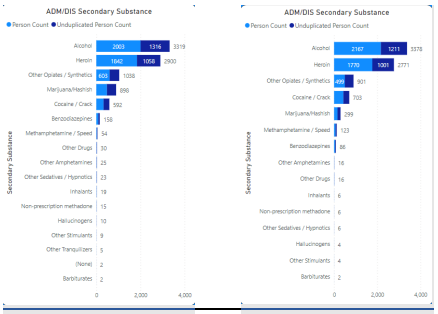



**FY 2017**




**FY 2020**

## Footnote 27

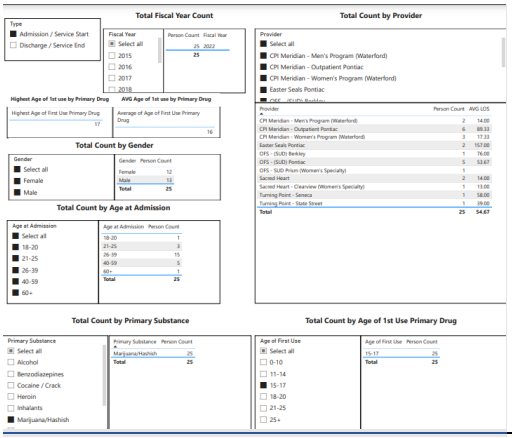


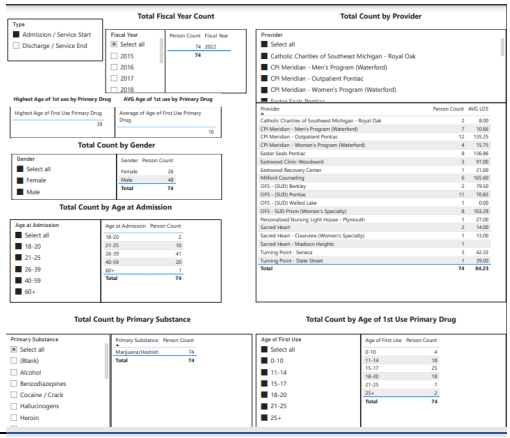

**FY 2017**



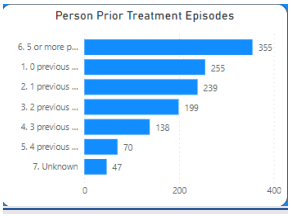

**FY 2020**

## Footnote 28



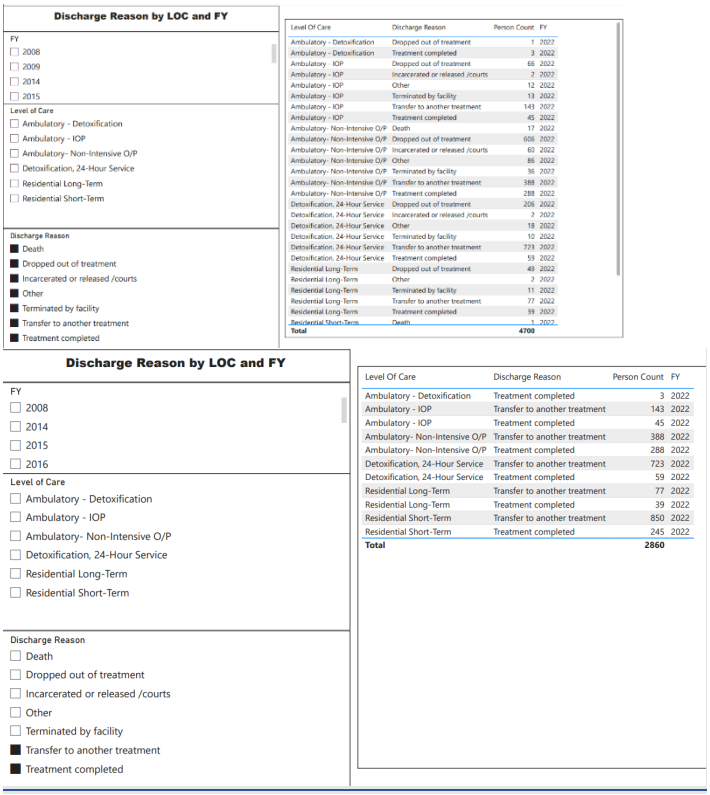



## Footnote 32




**FY 2022**

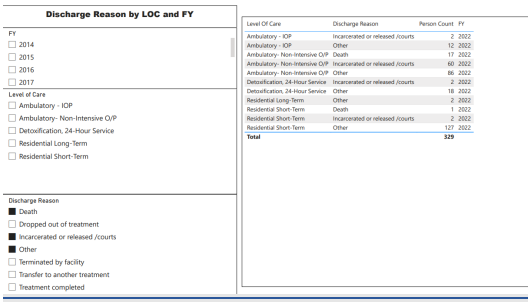
## Footnote 33



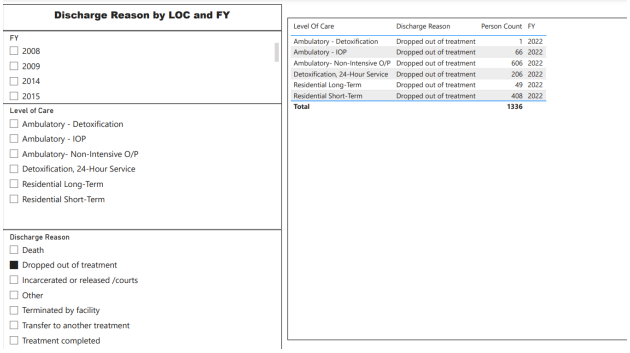




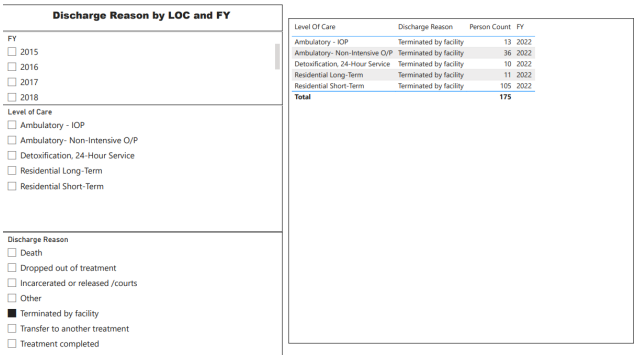
**Successfully completed treatment**




**Did not successfully complete treatment**




## Dropped out of treatment

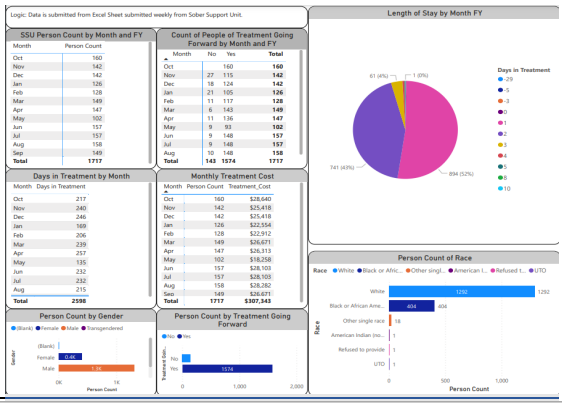


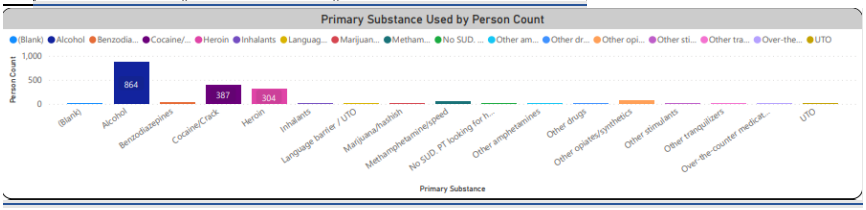

## Terminated by the facility

## Footnote 34

| Provider Name | # Persons Discharged | # Persons AMA | % Person | Fiscal Year | Quarter |
|---|---|---|---|---|---|
| CPI-Meridian | 289 | 81 | 28.03% | 2022 | Q4 |
| CPI-Meridian | 279 | 87 | 31.18% | 2022 | Q3 |
| CPI-Meridian | 272 | 74 | 27.21% | 2022 | Q2 |
| CPI-Meridian | 270 | 70 | 25.93% | 2022 | Q1 |
| Eastwood | 61 | 12 | 19.67% | 2022 | Q1 |
| SH-RES | 56 | 19 | 33.93% | 2022 | Q2 |
| Turning Point | 55 | 25 | 45.45% | 2022 | Q2 |
| Turning Point | 50 | 19 | 38.00% | 2022 | Q3 |
| SH-RES | 48 | 19 | 39.58% | 2022 | Q4 |
| SH-RES | 46 | 18 | 39.13% | 2022 | Q3 |
| Turning Point | 42 | 11 | 26.19% | 2022 | Q1 |
| Eastwood | 41 | 8 | 19.51% | 2022 | Q2 |
| SH-RES | 38 | 14 | 36.84% | 2022 | Q1 |
| Eastwood | 35 | 8 | 22.86% | 2022 | Q3 |
| Turning Point | 35 | 8 | 22.86% | 2022 | Q4 |
| Eastwood | 24 | 6 | 25.00% | 2022 | Q4 |
| Hegira | 13 | 3 | 23.08% | 2022 | Q1 |
| Hegira | 12 | 2 | 16.67% | 2022 | Q3 |
| PNLH | 12 | 6 | 50.00% | 2022 | Q4 |
| PNLH | 9 | 3 | 33.33% | 2022 | Q1 |
| PNLH | 8 | 3 | 37.50% | 2022 | Q3 |
| Hegira | 7 | 3 | 42.86% | 2022 | Q2 |
| Hegira | 6 | 3 | 50.00% | 2022 | Q4 |
| PNLH | 4 | 2 | 50.00% | 2022 | Q2 |
| SAHL | 4 | 1 | 25.00% | 2022 | Q4 |
| SAHL | 2 | 2 | 100.00% | 2022 | Q1 |
| SAHL | 2 | 2 | 100.00% | 2022 | Q2 |
| SAHL | 1 | 1 | 100.00% | 2022 | Q3 |
| | 1721 | 510 | | | |
| Applied filters:fiscal_year is 2022 | | | | | |

## Footnote 35


Logic: Data is submitted from Excel Sheet submitted weekly from Sober Support Unit.
SSU Person Count by Month and FY
Count of People of Treatment Going Forward by Month and FY
Length of Stay by Month FY
Days in Treatment by Month
Monthly Treatment Cost
Person Count of Race
Person Count by Gender
Person Count by Treatment Going Forward


Primary Substance Used by Person Count
(Blank)
Alcohol
Benzodiazepines
Cocaine/Crack
Heroin
Inhalants
Language barrier / UTO
Marijuana/hashish
Methamphetamine/speed
No SUD, PT looking for h...
Other amphetamines
Other drugs
Other opiates/synthetics
Other stimulants
Other tranquilizers
Over-the-counter medicat...
UTO
Person Count
Primary Substance