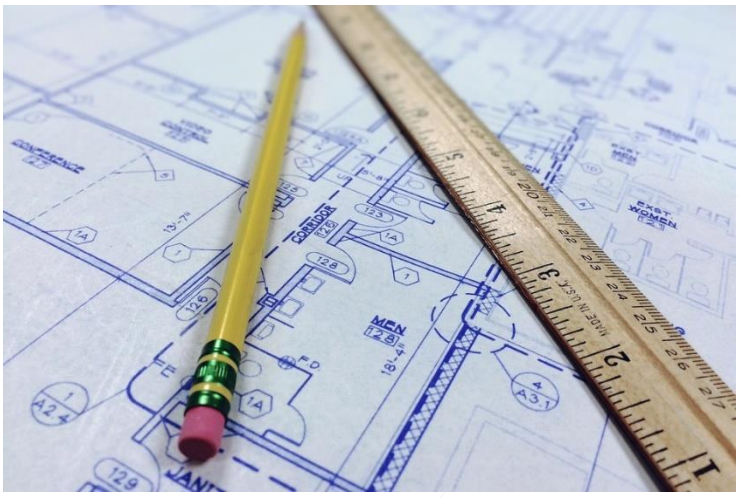
# Regional Blueprint for Action



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## Overview

The Adirondack Health Institute (AHI) Regional Blueprint for Action was developed to inform joint efforts of AHI and its eight-county consortium as they work together to address the opioid crisis in their region. Eight regional opioid crisis-related needs were prioritized for inclusion in this Regional Blueprint for Action.

1. Address Harm Reduction in Prevention, Treatment and Recovery
2. Create Awareness of Substance-Use Disorders through Community Engagement
3. Enhance Primary Prevention Strategies and Curriculum
4. Reduce Stigma Related to Substance-Use Disorders
5. Create Healthy Communities by Addressing Social Determinants of Health
6. Become a Trauma Engaged Region
7. Enable Substance-Use Disorder Treatment Innovation
8. Address Workforce Development Gaps for Providers

> Blueprint
> ***noun*** [C]
>
> **UK** /ˈbluː.prɪnt/ **US** /ˈbluː.prɪnt/
>
> An early plan or design that explains how something might be achieved.
> ***Cambridge Dictionary***

The AHI Regional Blueprint for Action is anchored in a mission statement and guiding principles developed by stakeholders from across the region. The Blueprint then presents the eight regional needs selected by those same stakeholders as "priority" needs.

## Regional Mission Statement

"Working together to collaborate, strategize and coordinate ways to enable healthy people, healthy communities and advance wellness"

## Regional Shared Values

Shared values across the region in terms of opioid and substance abuse are critical to achieving the Regional Mission Statement. Eleven statements were identified of stakeholders as the values that are critical to the success of a regional approach to addressing opioid- and substance- abuse prevention, recovery and treatment.

1. A sense of community is key.
2. Empower individuals.
3. In all things, be a helping hand.
4. Demonstrate empathy.
5. Acknowledge that language matters.
6. Show respect to all.
7. Create openness about trauma.
8. Show tolerance and acceptance.
9. Show kindness.
10. Recognize inherent worth and value life regardless of the circumstance.

11. From a health care perspective, understand that addiction is a chronic disease and is always a work in progress.

## Guiding Principles for Working Regionally to Address the Opioid Crisis

Eleven principles for working regionally were identified as key to helping individual organizations and counties throughout the region be effective and efficient in achieving the AHI Regional Blueprint for Success.

1. Leverage existing prevention, treatment and recovery programs in the region.
2. Focus funding on what is already being done so those programs can continue to make progress.
3. Be flexible and transparent about programs and funding.
4. Enable government and key stakeholders to accept the problems of substance-use disorders and the opioid crisis.
5. Adopt the mindset that partnerships are necessary to improve lives.
6. Create opportunities for cooperation among organizations and counties within a competitive environment.
7. Enable willingness and openness to share expertise.
8. Move out of silos and be the best the region can be.
9. Create sustainable practices, services and programs (ex: Peer coaching), recognizing that these are important for workforce development and retention in organizations that provide prevention, treatment and recovery services.
10. Acknowledge harm reduction as part of treatment.
11. Recognize that some people are unable or unwilling to stop using and accept that there will be individuals that choose to use substances and respect their rights.

## Success Factors for Working Regionally to Address the Opioid Crisis

Working across organizations and counties to tackle the Regional Priorities outlined in this document is dependent on various factors such as partnership and understanding of what is already happening in the Region. Twenty-one factors were identified by regional stakeholders as critical to the success of efforts to work regionally to address the opioid crisis.

1. Don't let a grant drive us to where we don't want to be.
2. Success of region rests on the success of organizations and their ability to provide comprehensive services, sometimes beyond what it is qualified to do.
3. Be aware of existing partnerships in the region.
4. Build clarity about who does what in the region in order to reduce confusion of what services exist and who provides them.
5. Have providers in the region share the burden to address the needs of the population.
6. Understand the range of comprehensive services to address duplication and create efficiency.
7. Have consistent information on services in the region and who provides them.
8. Be aware of programs and what jurisdictions they are offered in.
9. Be cognizant of the boundaries that exist on what providers can and can't do.
10. Identify barriers on why people and providers aren't able to provide other services.

11. Share eagerness to address needs of populations across counties, keeping in mind the boundaries that exist on what providers can and can't do.
12. Create complete and coordinated models and best practices to eliminate unnecessary competition (ex: Greater Rochester Initiative).
13. Determine what areas of expertise exist where in the region.
14. Map region to show where there are areas of expertise, what services are offered by which organizations and what pots of funding are supporting those services (who has what now).
15. Create transparency around funding and what services they are covering.
16. Understand funding restrictions and allowable funded service lines.
17. Incorporate supervisors and leaders as part of the collaboration process.
18. Make sure that Department of Community Services (DCS) is involved and in the room so that they know what is going on and can make more informed decisions about services and funding.
19. Create more of a shared responsibility when it comes to the issue of reimbursement rates and the responsibilities of funds across the continuum of healthcare, which includes payers.
20. Identify school-wide curriculum and funding models to support that curriculum that works for everyone consistently.
21. Leverage people that provide services well and not reinvent the wheel.

## Threshold Considerations for Working Regionally to Address the Opioid Crisis

Threshold Considerations are those which impact the region as a whole and, if not factored into any strategic or tactical planning, may inhibit the Region from achieving its mission and achieving the AHI Regional Priorities.

1. There is insufficient funding to create a system of sustainability (public vs. private funding).
2. There is confusion around funding sources and what services or programs they cover.
3. Inconsistent billing requirements across organizations where they are not always getting paid for the services they provide, which means those services can't be sustained (e.g. issues with rates and reimbursement policies).
4. There needs to be greater encouragement from New York State to move towards a Value Based Payment Medicaid Model.
5. Treatment and recovery are separate and hyper-confidential; this works against the concept of working regionally.
6. Existing competing regulations (HIPAA) and stigmatized laws, such as 42 CFR, which require individual levels of consent.
7. Information sharing barriers exists across organizations.
8. State requirements can impact organization's ability to be flexible to provide the appropriate service or share information (e.g. OASAS).
9. There is a lack of understanding and awareness of who can take advantage of federal regulations and waivers.
10. Organizations are not able to keep up with funding opportunities.

To assist in addressing some of the threshold considerations outlined above, a work group should be created to coordinate a conversation with grantors in the region so that stakeholders can connect on available funding and discuss the opioid- and substance-use challenges facing the region.

## Interdependence among Regional Priorities

The AHI Regional Priorities have varying levels of interdependence which must be taken into account when taking specific actions based on the blueprint. While each is based on their own objectives, stakeholders and indicators, there are existing interdependencies. Five interdependencies were identified by regional stakeholders as starting point for informing coordination actions.

1. Addressing harm reduction means looking at innovative ways to provide treatment and meet people where they are. Enabling treatment innovation in line with reducing harm.
2. Creating awareness through community engagement is directly linked with becoming a trauma engaged region because it requires community engagement around what trauma means.
3. Addressing workforce development gaps links to both community engagement and becoming a trauma engaged region because the workforce around programs and services must be part of those activities.
4. Addressing the Social Determinants of Health are tightly connected with primary prevention strategies, particularly when looking at underserved communities and education in k-12 schools.
5. Access to care is an important factor across all Regional Priorities because without that access, especially to underserved communities, those priorities can't be fully achieved.

| Regional Blueprint for Action<br>Regional Priority 1: *Address Harm Reduction in Prevention, Treatment and Recovery* | |
|---|---|
| **Objectives to Address Harm Reduction in Prevention, Treatment and Recovery** | |
| • Reduce the harms associated with opioid use<br>• Increase access to MAT (all forms of MAT)<br>• Increase access to Naloxone (Narcan)<br>• Naloxone given with every opioid prescription in the pharmacy to reduce risk, specifically to target population<br>• Provide education to reduce risks | • Increase health care engagement to target population because they often have fear or mistrust of providers based on how they've been treated in the past and are often not engaged at all with primary care or OB/GYN care<br>• Increase access to syringe exchange and address the need for more sites in all counties<br>• Improve coordination between primary care services and substance use providers |
| **Indicators of Success to Address Harm Reduction in Prevention, Treatment and Recovery** | |
| • Decreased prevalence of HIV and HEP C<br>• Increased number of people in HEP C treatment<br>• Reduced incarceration related to opioid use<br>• Decreased abscess/infection which decrease unnecessary ER visits | • Increased number of MAT providers<br>• Increased number of people in MAT treatment<br>• Decreased number of overdose deaths |
| **Key Stakeholders Required to Address Harm Reduction in Prevention, Treatment and Recovery** | |
| • Primary care providers<br>• People who use drugs<br>• Elected officials | • Family members of people who use drugs<br>• Treatment providers (substance-use and mental health)<br>• Law enforcement |
| **Critical Barriers in Addressing Harm Reduction in Prevention, Treatment and Recovery** | |
| • Lack of funding<br>• Social Determinants of Health<br>• Existing Federal/State regulations (e.g. methadone prescribing at the federal level | • Lack of access to on-demand counseling<br>• Stigma from community but also between people who use drugs<br>• Lack of ways to get mental health counseling beyond county clinics |
| **Key Resources to Address Harm Reduction in Prevention, Treatment and Recovery** | |
| • Funding for harm reduction activities and programs<br>• Advocacy for streamlining regulations<br>• Stability with providers | • Community support<br>• More/access to providers for medication and housing support (MAT/counseling) |
| **Target Populations in Addressing Harm Reduction in Prevention, Treatment and Recovery** | |
| • People who use opioids (prescription and non-prescription) | • People from eight regions covered within NYS |

| Regional Blueprint for Action<br>Regional Priority 1: *Address Harm Reduction in Prevention, Treatment and Recovery* | |
|---|---|
| **Regional Opportunities to Address Harm Reduction in Prevention, Treatment and Recovery** | |
| • Coordinate with coalitions in the area across eight counties | • Come together on any available state opioid grants<br>• Telehealth technologies |
| **Regional Challenges to Addressing Harm Reduction in Prevention, Treatment and Recovery** | |
| • Rural areas have existing limitations (e.g. transportation)<br>• Fear and mistrust of providers | • Existing stigmas of substance-use<br>• Need more data |
| **Recommended Actions for Addressing Harm Reduction in Prevention, Treatment and Recovery** | |
| • Create a workgroup across the region in order to talk about what harm reduction means to the region. This work group would come together to better understand the factors of harm reduction and could identify some actionable next steps once there is a shared understanding of what it means to this community. | |

| Regional Blueprint for Action<br>Regional Priority 2: *Create Awareness of Substance-Use Disorders through Community Engagement* | |
|---|---|
| **Objectives for Creating Awareness of Substance-Use Disorders through Community Engagement** | |
| • Community as a resource and source of support for the population (community for the community)<br>• Create education and awareness using resources available and already established assets<br>• Community as a resource for providers to help link patients with resources | • Create healthy outlets for risk taking<br>• Create transparency within the community and with the people served<br>• Reduce stigma around substance-use disorders |
| **Indicators of Success to Create Awareness of Substance-Use Disorders through Community Engagement** | |
| • Ongoing, sustainable participation and growing commitment in community activities<br>• More data on reduction in deaths and crime<br>• More data on increase utilization of services<br>• Normalization of conversations including language that is used and open conversations | • Greater attendance at events organized for the community<br>• Earlier interventions<br>• Culture shift and less stigma for families that is long-term |
| **Key Stakeholders Required to Address Awareness of Substance-Use Disorders through Community Engagement** | |
| • Town leadership and community leaders<br>• Big businesses<br>• Community agencies<br>• Higher education leaders | • Faith leaders<br>• Chamber of Commerce<br>• School administration and athletic leaders |
| **Critical Barriers in Creating Awareness of Substance-Use Disorders through Community Engagement** | |
| • Stigma around those in recovery, providers and community members<br>• Lack of increase in workforce<br>• Existing cultural norms and mindset around treatment and recovery; there is the idea that things should be “fast, fun and easy” | • Close-mindedness<br>• Funding support for activities<br>• Lack of transportation and center because of location and geography of rural areas<br>• A lot of people in isolation and shifting perceptions of social media |
| **Key Resources for Creating Awareness of Substance-Use Disorders through Community Engagement** | |
| • Duplicate "Mercy Care Friendship Volunteer" model<br>• Funding that is non-competitive and relevant | • Implement engagement coordinator in each region |
| **Target Populations in Creating Awareness of Substance-Use Disorders through Community Engagement** | |
| • Families of those who do and don’t have substance-use disorders<br>• Business community | • Youth<br>• Faith-based community organizations<br>• Schools |
| **Regional Opportunities to Create Awareness of Substance-Use Disorders through Community Engagement** | |
| • N/A | |

| Regional Blueprint for Action<br>Regional Priority 2*: Create Awareness of Substance-Use Disorders through Community Engagement* |
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| **Regional Challenges in Creating Awareness of Substance-Use Disorders through Community Engagement** |
| • N/A |
| **Recommended Actions to Create Awareness of Substance-Use Disorders through Community Engagement** |
| • Create workgroups at each coalition in the region to support each county. These workgroups would identify and start implementing community engagement strategies including use of language, discussions about existing stigma and how to combat it. |

## Regional Blueprint for Action
## Regional Priority 3: *Enhance Primary Prevention Strategies and Curriculum*

### Objectives to Enhance Primary Prevention Strategies and Curriculum

- Create knowledgeable, informed education programs that use evidence-based strategies
- Educate school age children and their families on preventative care
- Educate seniors by CBOs, health care providers and support services
- Bring in providers and familiarize them with evidence-based regionalized curriculum
- Reduce substance-use disorders in school-age population
- Increase senior medication safety
- Decrease senior substance-use disorders

### Indicators of Success to Enhance Primary Prevention Strategies and Curriculum

- Data supports positive change (e.g. Youth Risk Behavior Survey (YRBS))

### Key Stakeholders Required to Enhance Primary Prevention Strategies and Curriculum

- School staff including educators, administration, and superintendents
- Faith-based organizations
- Pediatricians, Family Practices, OB-GYN, Planned Parenthood
- County Health Departments
- Family health providers
- Joint Commission of Economic Opportunity (Community Action Coalition) JCEO
- Families
- Prevention organizations
- Behavioral health providers
- Women, Infants and Children (WIC) and Office for People with Developmental Disabilities
- Children's services
- NYS Office for the Aging

### Critical Barriers and Enablers in Enhancing Primary Prevention Strategies and Curriculum

| Barriers | Enablers |
|---|---|
| • No common core for prevention, primary care and primary prevention for SUD<br>• School bureaucracy, culture and indifference<br>• Families and sources of trauma (ACES)<br>• Lack of funding<br>• Lack of buy-in<br>• Lack of acknowledgement of importance of prevention<br>• Apathy by educators and families<br>• Lack of educator professional development for substance-use disorders and trauma engaged care<br>• Availability of opt-outs for educational opportunities<br>• Siloed school districts | • Professional development<br>• Common core curriculum (regional for school districts k-12)<br>• Culture of prevention recognition<br>• Funding available<br>• Engagement with school staff, family and stakeholders<br>• Empowering school nurses, physical education and health educators |

| Regional Blueprint for Action<br>Regional Priority 3: *Enhance Primary Prevention Strategies and Curriculum* | |
|---|---|
| **Key Resources for Enhancing Primary Prevention Strategies and Curriculum** | |
| • Funding to establish workgroup to design a curriculum for school districts that's relevant to the region | • Funding for school nurses, health and physical health professionals |
| **Target Populations in Enhancing Primary Prevention Strategies and Curriculum** | |
| • School age children (K-12) | • Seniors |
| **Regional Opportunities to Enhance Primary Prevention Strategies and Curriculum** | |
| • Regional curriculum collaborative | |
| **Regional Challenges in Enhancing Primary Prevention Strategies and Curriculum** | |
| • Connection between education and health because every school district is doing something different | |
| **Recommended Actions to Enhance Primary Prevention Strategies and Curriculum** | |
| • Conduct an evidence-based program established by a working group that sets out to design a regional curriculum that could be adopted by schools in the region. Part of this would be building a business case relative to other programs.<br>• Bring together individuals working on the youth health risk and work together on how to do that collectively to get a better understanding of the population level data to see if interventions initiatives make a difference. | |

| Regional Blueprint for Action<br>Regional Priority 4: *Reduce Stigma Related to Substance-Use Disorders* | |
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| **Objectives to Reduce Stigma Related to Substance-Use Disorders** | |
| • Hold community forums to engage in conversation and build off of what already is being done<br>• Engage with media outlets to highlight positive stories building hope for recovery using stigma free language | • Teach media contacts what type of language to use when talking about stories of substance use disorders<br>• Increase support for families<br>• Create a shared set of language<br>• Enable education for schools/law enforcement/providers including cultural competency |
| **Indicators of Success to Reduce Stigma Related to Substance-Use Disorders** | |
| • Increased involvement from law enforcement and elected officials<br>• Shift in media language<br>• Increased patient engagement in primary care | • Decreased complaints from clients about law enforcement, healthcare providers<br>• Improved health outcome<br>• Increased engagement in substance-use treatment |
| **Key Stakeholders Required to Reduce Stigma Related to Substance-Use Disorders** | |
| • Healthcare administrators<br>• Individuals who use drugs<br>• Faith-based leaders<br>• HR liaisons | • Specific media liaisons<br>• Individuals in recovery<br>• School administrators<br>• Families |
| **Critical Barriers in Reducing Stigma Related to Substance-Use Disorders** | |
| • Misinformation<br>• Existing apathy<br>• Mindset of “not my problem”<br>• Individual’s feeling of being “unworthy” | • Long held beliefs around substance-use<br>• Avoidance of confrontation for those who use improper terminology |
| **Key Resources for Reducing Stigma Related to Substance-Use Disorders** | |
| • Knowledge and regional expertise<br>• Open mindedness from key leaders<br>• Having a “Reducing Stigma” workgroup | • Educational tools<br>• Media attention |
| **Target Populations in Reducing Stigma Related to Substance-Use Disorders** | |
| • Medical providers, including pharmacists<br>• Law enforcement<br>• Family members<br>• Faith communities<br>• Employers/employees | • Media as an ally<br>• Elected officials<br>• Individuals who use drugs<br>• Schools<br>• Healthcare office staff |
| **Regional Opportunities to Reduce Stigma Related to Substance-Use Disorders** | |
| • Coalitions that comes together to help bring more people and opinions to the table<br>• Create media cooperation | • Build off existing successful models<br>• Come together on funding opportunities |

| Regional Blueprint for Action<br>Regional Priority 4: *Reduce Stigma Related to Substance-Use Disorders* |
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| **Regional Challenges in Reducing Stigma Related to Substance-Use Disorders** |
| • N/A |
| **Recommended Actions to Reduce Stigma Related to Substance-Use Disorders** |
| • Form a work group around reducing stigma in the region and conduct an evaluation on prevention funding and the return on investment in the region.<br>• Hold community forums across the region to talk about stigma and work with existing media outlets in the region to discuss language and what is harmful and what is not. |

## Regional Blueprint for Action
## Regional Priority 5: *Create Healthy Communities by Addressing Social Determinants of Health*

### Objectives to Create Healthy Communities by Addressing Social Determinants of Health

- Empower the public to take ownership of their health and make healthier choices
- Remove barriers to accessing healthcare services
- Create an environment for people to live, work and play in healthy communities
- Increase access to healthier food choices (ex: farmers market vouchers, meals on wheels)
- Increase regional transportation between counties so that people can access treatment, supportive services and criminal justice appointments
- Integration of substance-use and opioid-use disorder services in primary care

### Indicators of Success to Create Healthy Communities and Social Determinants of Health

- Increased affordable and livable housing
- Increases in access to care for all
- Increased access to childcare
- Increased supportive communities
- Increased health literacy information and materials to patients at a reading level they can meet so they can understand what they need to do
- Increased availability of public transportation
- Education attainment suitable for employment opportunities
- Reduction in food insecurity
- Reduction in the homelessness rate

### Key Stakeholders Required to Create Healthy Communities by Addressing Social Determinants of Health

- Providers of all types (ex: Women, Infant, Children's Program, transportation, housing, clinicians, Office for the Aging, Behavioral health, Primary and Preventative Care)
- Businesses/Employers
- Government officials
- Funders
- Law enforcement

### Critical Barriers in Creating Healthy Communities by Addressing Social Determinants of Health

- Lack of access to care (doctors are usually located in pockets of wealth)
- Lack of understanding of the population experiencing substance-use and opioid-use disorders
- Lack of funding
- Lack of access to health foods
- Lack of childcare
- Lack of funding
- Lack of community cohesion and support
- Punitive legal system (incarceration vs. treatment)
- Generational poverty and the cycle of poverty
- The system enables income disparities and doesn't promote advancement
- Social services system doesn't promote advancement
- Existing access to unhealthy choices
- Policy changes that are sometimes too stringent

| Regional Blueprint for Action<br>Regional Priority 5: *Create Healthy Communities by Addressing Social Determinants of Health* | |
|---|---|
| **Key Resources to Create Healthy Communities by Addressing Social Determinants of Health** | |
| • Policy change<br>• Community collaboration, support and resiliency<br>• Providers of all types | • Funding from the Department of Housing and Urban Development for sober living opportunities<br>• Employment opportunities |
| **Target Populations in Creating Healthy Communities by Addressing Social Determinants of Health** | |
| • Underserved populations in the areas of education, housing, health and transportation | |
| **Regional Opportunities to Create Healthy Communities by Addressing Social Determinants of Health** | |
| • ADK Wellness Connections | • Telehealth and virtual care |
| **Regional Challenges in Creating Healthy Communities by Addressing Social Determinants of Health** | |
| • Existing stigma surrounding substance-use disorders<br>• Lack of resources | • Geography creates challenges for transportation and ability to address social determinants<br>• Lack of workforce, jobs, funding and education around healthcare for substance-use disorders |
| **Recommended Actions to Create Healthy Communities by Addressing Social Determinants of Health** | |
| • Start to find funding for affordable and livable housing because there is a lack of sober living. Can be addressed by getting funding to renovate housing that can be used by those in treatment and recovery. Look to existing programs, like the MHAB Project, which renovated off-campus dormitories at Clinton County Community College into a multi-purpose rehabilitation campus | |

| Regional Blueprint for Action<br>Regional Priority 6: *Become a Trauma Engaged Region* | |
|---|---|
| **Objectives to Become a Trauma Engaged Region** | |
| • Create education and awareness around trauma and the impact it has | • Work across all sectors to understand trauma and its impact |
| **Indicators of Success to Become a Trauma Engaged Region** | |
| • Increased number of trained providers<br>• Shared understanding of what trauma means | • Improvement on social determinants of health indicators |
| **Key Stakeholders Required to Become a Trauma Engaged Region** | |
| • Policy makers<br>• Organizational leadership (ex: WIC) | • Insurance companies for buy-in<br>• Training organization champions |
| **Critical Barriers and Enablers in Becoming a Trauma Engaged Region** | |
| **Barriers** | **Enablers** |
| • Outdated mindset and stigmas<br>• Lack of shared understanding about what "trauma" means<br>• Lack of models that are evidence-based<br>• Fear of enabling | • Increased training on trauma<br>• More curriculum on trauma and tools to identify it<br>• Having data that is value added to what already exists on what we know about trauma |
| **Key Resources to Become a Trauma Engaged Region** | |
| • Shared model of implementation<br>• Common language around what "trauma" means | • Funding<br>• Buy-in from stakeholders and community |
| **Target Populations in Becoming a Trauma Engaged Region** | |
| • Service providers<br>• Healthcare organization staff | • Educators (K-12, day care, preschool)<br>• Law enforcement and criminal justice personnel<br>• County Social Services Providers |
| **Regional Opportunities to Become a Trauma Engaged Region** | |
| • Growing concept of being "trauma engaged"<br>• Regional training sessions<br>• Taking advantage of existing efforts like AHI's work around trauma informed care | • Sharing best practices<br>• Primary care screening (better understanding with patient's background)<br>• Law enforcement buy-in |
| **Regional Challenges in Becoming a Trauma Engaged Region** | |
| • Achieving consistent and practical application of concepts on trauma<br>• Existing social pressures | • Ensuring continued training and minimum level of understanding |
| **Recommended Actions to Become a Trauma Engaged Region** | |
| • Conduct an assessment to get a baseline of the community knowledge in order to understand the level of existing trauma informed training, education. This assessment would try to understand where people are at for the level of educational need for training. | |

| Regional Blueprint for Action<br>Regional Priority 7: *Enable Substance-Use Disorder Treatment Innovation* | |
|---|---|
| **Objectives to Enable Substance-Use Disorder Treatment Innovation** | |
| • In-person treatment intake with encounters within 24-48 hours<br>• Access to 1:1 counseling versus group counseling<br>• Counseling without commitment to abstinence<br>• Consistent care pathways for people discharged from the emergency department and/or incarceration | • Formal relationships between care providers to establish care pathways<br>• On demand treatment<br>• Increase range of patient-defined treatment options<br>• Access to non-traditional treatment models |
| **Indicators of Success to Enabling Substance-Use Disorder Treatment Innovation** | |
| • Established care pathways and information transfer<br>• Increased use of certified peers | • Increased availability of counseling options |
| **Key Stakeholders Required for Enabling Substance-Use Disorder Treatment Innovation** | |
| • Clinicians<br>• Correctional institutions<br>• Community<br>• Government agencies (Medicaid and Medicare) | • Health care state and county agencies<br>• Consumers<br>• Payers (insurers/3rd parties)<br>• Law Enforcement |
| **Critical Barriers and Enablers to Enabling Substance-Use Disorder Treatment Innovation** | |
| **Barriers** | **Enablers** |
| • Who owns and/or develops non-traditional models<br>• Funding from reimbursement rates and the availability of direct payment for non-traditional care<br>• Medical provider reluctance to treat substance-abuse<br>• Over regulated facility types<br>• Competing priorities and misaligned incentives | • Provider openness to MAT<br>• Some hospital and correctional facility openness to MAT collaboration<br>• Increased provider flexibility and willingness |
| **Key Resources to Enable Substance-Use Disorder Treatment Innovation** | |
| • OASAS<br>• Entity willing to develop counseling services and innovate in treatment | • Cooperative individuals working in the health care system |
| **Target Populations in Enabling Substance-Use Disorder Treatment Innovation** | |
| • People with problematic substance-use<br>• People not served by traditional treatment methods | • People in recovery |
| **Regional Opportunities to Enable Substance-Use Disorder Treatment Innovation** | |
| • N/A | |
| **Regional Challenges in Enabling Substance-Use Disorder Treatment Innovation** | |

| Regional Blueprint for Action<br>Regional Priority 7: *Enable Substance-Use Disorder Treatment Innovation* |
|---|
| • N/A |
| **Recommended Actions to Enable Substance-Use Disorder Treatment Innovation** |
| • Create a workgroup, working together with AHI, that documents existing treatment services and types in the region to understand what treatment services are being provided.<br>• Create a workgroup to review OASAS policies and come together to start understanding of the different interpretations of OASAS policies and the impact on patients and providers. |

| Regional Blueprint for Action<br>Regional Priority 8: *Address Workforce Development Gaps for Providers* | |
|---|---|
| **Objectives to Address Workforce Development Gaps for Providers** | |
| • Filling workforce gaps directly and collectively<br>• Conduct recruitment<br>• Create a recovery-minded work environment | • Retain, train and educate around priority needs (need to look a generational values)<br>• Create a pipeline for retention tools |
| **Indicators of Success to Address Workforce Development Gaps for Providers** | |
| • Increased retention rates<br>• Increased local training programs | • Reduced rates of open positions<br>• Recovery welcoming business community |
| **Key Stakeholders Required to Address Workforce Development Gaps for Providers** | |
| • Service providers<br>• Government health service agencies | • Employers<br>• Higher Education and training entities<br>• High school clinical educators (ex: BOCES) |
| **Critical Barriers and Enablers in Addressing Workforce Development Gaps for Providers** | |
| **Barriers** | **Enablers** |
| • Lack of program funding<br>• Lack of qualified professionals<br>• Lack of availability/cost of education/training opportunities<br>• Lack of creative solutions<br>• Lack of recruitment<br>• Lack of awareness/exposure<br>• Turnover and burnout<br>• 42 CFR laws<br>• Pay scale issues<br>• Loss of license for substance use<br>• Lack of access to aid for substance users to get education<br>• Regulations to hire people with a felony | • Increasing use of Telehealth<br>• Community colleges as a resource for education<br>• Providers enabling people to get back into the workforce<br>• New generational tolerance for those in treatment and recovery |
| **Key Resources to Address Workforce Development Gaps for Providers** | |
| • Training and educating providers<br>• Community partnerships<br>• Available educational experiences | • Funding resources and continued grant applications |
| **Target Populations in Addressing Workforce Development Gaps for Providers** | |
| • Provider workforce | • Employers |
| **Regional Opportunities to Address Workforce Development Gaps for Providers** | |
| • Shared services/staffing<br>• North Country Innovation Pilot<br>• Data sharing | • Telehealth<br>• Electronic Health Records solution<br>• Value Based Payment efforts |

| Regional Blueprint for Action<br>Regional Priority 8: *Address Workforce Development Gaps for Providers* | |
|---|---|
| **Regional Challenges in Addressing Workforce Development Gaps for Providers** | |
| • Lack of program funding<br>• Lack of qualified professionals<br>• Lack of availability/cost of education/training opportunities<br>• Lack of creative solutions<br>• Lack of recruitment<br>• Lack of awareness/exposure | • Turnover and burnout<br>• 42 CFR laws<br>• Pay scale issues<br>• Loss of license for substance use<br>• Lack of access to aid for substance users to get education<br>• Regulations to hire people with a felony |
| **Recommended Actions to Address Workforce Development Gaps for Providers** | |
| • Create a workgroup that will come together to identify internship opportunities for college students and determine which organizations would be willing to be part of an internship program.<br>• Design recruitment materials that can be used across the region. | |