2022 MISSOURI STRATEGIC PLAN

Overdose Prevention

Coming together to create a comprehensive, collective, realistic, 3-5-year strategic plan to address the opioid crisis and save lives across Missouri

November 29-30, 2022

Governor Office Building, Room 450
200 Madison Street, Jefferson City, MO 65101

huelife

What are we striving for?

What can we do, over the next five years, to unify and create sustainable collaborative partnerships across systems, local, state, and federal agencies, leveraging resources and data to increase equitable access to prevention, treatment, and recovery supportive services across the state in a combined effort to save lives across Missouri.

Two Day Agenda

DAY 1: Tuesday November 29		DAY 2: Wednesday November 30	
8:30am-12:00pm	**Morning Session** **Review Data:** Understand the realities surrounding prevention work and how the information will help inform community health **Practical Vision:** What do we want to see in place in three to five years as a result of our actions?	**8:30am - 12:00pm**	**Morning Session** **Strategies:** What innovative, substantial actions will deal with the underlying contradictions and move us toward our vision?
1:00pm–4:30	**Afternoon Session** **Contradictions:** What is blocking us from moving toward our vision?  	**1:00 - 4:30pm**	**Afternoon Session** **First Year Accomplishments:** What will our specific, measurable accomplishments be for the first year? **First Year Timeline and Assignments:** What is our timeline for the first-year accomplishments? What are implementation steps for the first-quarter accomplishments?

HUELIFE FACILITATORS:

Angie Asa-Lovstad David Ahles Karie Terhark Stephanie Ahles

Understanding the Data We Know

Data Review

Participants were provided with a packet of materials related to opioid misuse. Participants were asked to take a quick glance at the data and then to have a discussion at their tables. Participants discussed the data presented, and to then shared their own responses to the data. Individuals were invited to share additional data they were aware of, relevant to opioid misuse and overdose. Note that this was not an exhaustive look at all the data available. Each group was asked to record a few facts or essential information that the whole group would want to be mindful during the strategic planning process.

Participant Responses			

• Data needed
• There's a lag
• C/ME data for select # of counties
• MO student survey
• Neonatal syndrome data
• We have hospital discharge
• We have death certificates data MO residents or those who pass here
• We can't trace fentanyl I-ICDIO code
• 44/170 region
• 9 of 10 people w/SUD started before age 21!
• Black males
• Harm reduction data w/the story of why it is works
• Historic data to better tell story of overdose, deaths & racial disparity
	• SDOH
	  ○ Housing
	  ○ Education
	  ○ Employment
	  ○ Access to care (PCP, MH)
	  ○ Shortage of med.
	  ○ Family support system
	• Sexual orientation/identity/expression
	• Blood borne disease
	• Poly-substance use
	• History of OD-recurrence
	• Non-fatal OD
	• Naloxone dist.(location/amount)
	  ○ Avail. Trainers: people trained
	• Potency of what is taken
	• COVID rates (correlation)
	• STI rates
	• Overdose by drug type – more detail
		• <u>Important data to look at</u>
		• Missouri student survey
		• Prescription RX use going down – kids are practicing harm redux/replacing w/alcohol & Marijuana use
		• Regional data needs to be by zip code and accessible to better target outreach
		• Get a fuller data picture
		• Where naloxone is deployed vs utilized – hard but helpful – zip code level
		• Missouri student survey 6-12 grade
		• Data missing 19–29-year-olds
		  ○ *methods avail. But need $*
		  ○ Not in college
		• Pregnancy associated mortality
		• Prevention – <u>Primary</u>
		  ○ More risk / protective factor
			• Deaths & OD incidents w/ incarcerated
			• Veterans Administration -report opioid drug deaths and overdoses to Dept. of Defense
			• OD fatality reviews
			• Data on what youth use / don't have access
			• onechoiceprevention.org
			• Mandated reporting for SUD?For OD?
			• Impact of ACE's
			• Impact of Marijuana
			• Data of FTS
			• Data – pay off MH professionals (MO Low Tax – Low Service)
			• Why are we # 51?
			• <u>Want Data On:</u>
			• Percentage of people with access to Narcan that fatal overdosed (mortality prevention)

Participant Responses

- How comfortable are we in the data 2016-2021 9,960 OD deaths
- Toxicology results, centralized collection, testing &reporting, timely data based on testing
- Prevention in the # of deaths of younger persons not isolated to SUD (Pills) (School survey) (Prevention training)
- Why is there no separation of adult vs youth data
  - Trends for adults will be different vs youth
- Collaboration of vaping as gateway
- Was 2020 lower b/c of less outreach-based data being recorded

- # of treatment provides/facilities by county/region
- Narcan by EMS
- Correlation HIV/HEPC/SUB USE
- Correlation SDOH/SUB USE/OD
- Stats for non-fatal overdoses
- Population of top 10 counties
- Splitting up age Demographics 15-24 (15-18, 19-24)
- YTD data seizures seem low, what months were included in data
- How do our birth & death rates compare nationally
- Stats for populations connected to care
- Rural vs Urban outreach
- Need to see 2019 data – 1 yr. pre & post
- Access to care & client needs
- Meth totals – high rate of meth /opioid
- Naloxone use – data
- Supply driven epidemic
  Daily COVID data what about daily Opioid data

- Longitudinal data analysis
- Biggest impact of 25-44 (economic impact)
- 2017 – present – nearly 11,000 overdose reversals (could be so much worse)
- Huge increase in MOUD – reduced overdose
- Increased poly – substance use, and we don't have a great break down of that in data
- Connection between suicide vs OD – we don't know but more important for intervention
- More research on policy implications
- Jail data
- Maternal OD
- Expanded ER data
  - Non – fatal
  - Soft tissue infections
  - Unintentional vs med. Errors vs intentional
- Social vulnerability index (poverty, education., med access)
- Re-entry specific

- Was the client offered MAT during treatment?
- Drugs laced with fentanyl (outside of opioids)
- Types of data we know
  - SOR dashboard MIMH
  - MAT data (CIMOR)
  - SCOUT
  - ADAP – Access to MAT
  - Vulnerability assessment
- Wants
  - Zip code data (Drill down)
  - Social economic

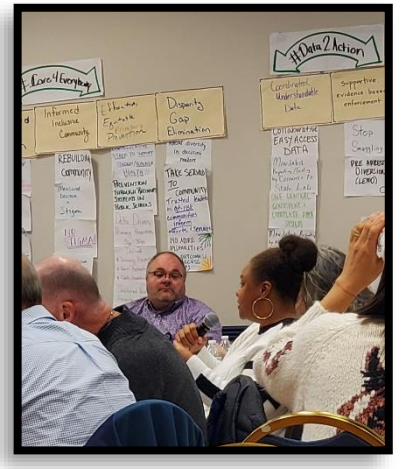
Over lay on fatal overdose by region (socio, sex, age)

- Need data on substance misuse, use before it gets critical
- Substance use disorder
  - Why the demand
  - How to address upstream
- Easy to just look at overdose deaths





What is Our Vision



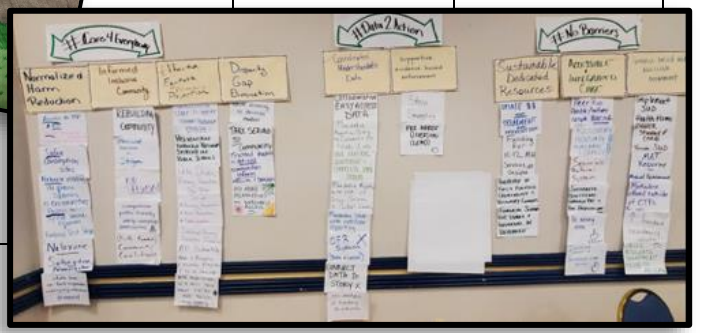
Our Practical Vision

Participants were asked to collaborate on the articulation of a collective vision, to imagine the future state of opioid misuse. What does the future hold for Missouri, related to opioid misuse? Everyone was asked to share their hopes and aspirations for this work to leverage that vision and energy to create a greater, more inclusive vision. The goal was to create a shared vision that looked beyond the horizon, a vision that is motivating and powerful, and yet realistic and attainable.

Our Workshop Question: **What do we want to see in place in 3-5 years as a result of our actions?**

#Care 4 Everybody				*#Data 2 Action*		*#No Barriers*		
Normalized Harm Reduction	**Informed Inclusive Community**	**Effective Equitable Primary Prevention**	**Disparity Gap Elimination**	**Coordinated Understandable Data**	**Supportive Evidence – based Enforcement**	**Sustainable Dedicated Resources**	**Accessible & Integrated Care**	**Evidence – based and Accessible Treatment**
As illustrated by	*As illustrated by*	*As illustrated by*	*As illustrated by*	*As illustrated by*	*As illustrated by*	*As illustrated by*	*As illustrated by*	*As illustrated by*

• Access to SSP & FTS (Safe Syringe Program – Fentanyl Test Strips)
• Safer consumption sites
• Naloxone vending in public spaces in communities
• Access to syringe service programs & fentanyl test strips
• Naloxone saturation and normalization
• State Law re: first responders carrying naloxone and using [Funded]
	• Rebuilding Community
	• Measured Decrease in Stigma
	• No Stigma
	• Comprehensive public friendly mktg. campaign (Data Focused)
	• (Fully Funded) Community Coalition
		• Comprehensive Staff to support student / teacher health
		• Prevention through recovery systems in public schools
		• Data driven primary prevention 5yo - 30yo
		• Defined:
		  ○ Primary prevention
		  ○ Harm reduction
		  ○ Death prevention
		• Sustained primary prevention funding
		• All schools have a prevention education program K-12 & University
		• Nontraditional settings talk about SUD/BH and refer (Churches, Pharmacies, City Council, etc.
			• Racial diversity in decision makers
			• Take services to community
			• Trusted leaders in at-risk communities inform efforts & services
			• No more disparities in outcomes / access
				• Collaborative easy access DATA
				• Mandated reporting / testing by coroners to state lab
				• One central consistent & complete data system
				• Mandated reporting by all LEA of drug seizures to central location
				• Mandate statewide overdose reporting
				• OFR system (state & local)
				• Connect data to story
				• ROI analysis of funding
					• Stop Smuggling
					• Pre-arrest division (LEAD)
						• Opiate $$ = treatment and prevention
						• Funding for K-12 MH services on sight
						• Increase of fully funded treatment & recovery centers
							• Peer run flexible /halfway respite housing
							• Recovery housing available locally (pretreatment respite continuum of housing)
							• Seamless referral system
							• Integrated health care through pre & post hospitalization
							• No wrong door
							• Increased access to Behavioral Health Services
								• Implement SUD health homes
								• Higher standard of care youth SUD
								• MAT required for Medicaid reimbursement
								• Methadone offered outside of OTP's
								• ^ funded residency slots
								• Jails integrate treatment prior to release



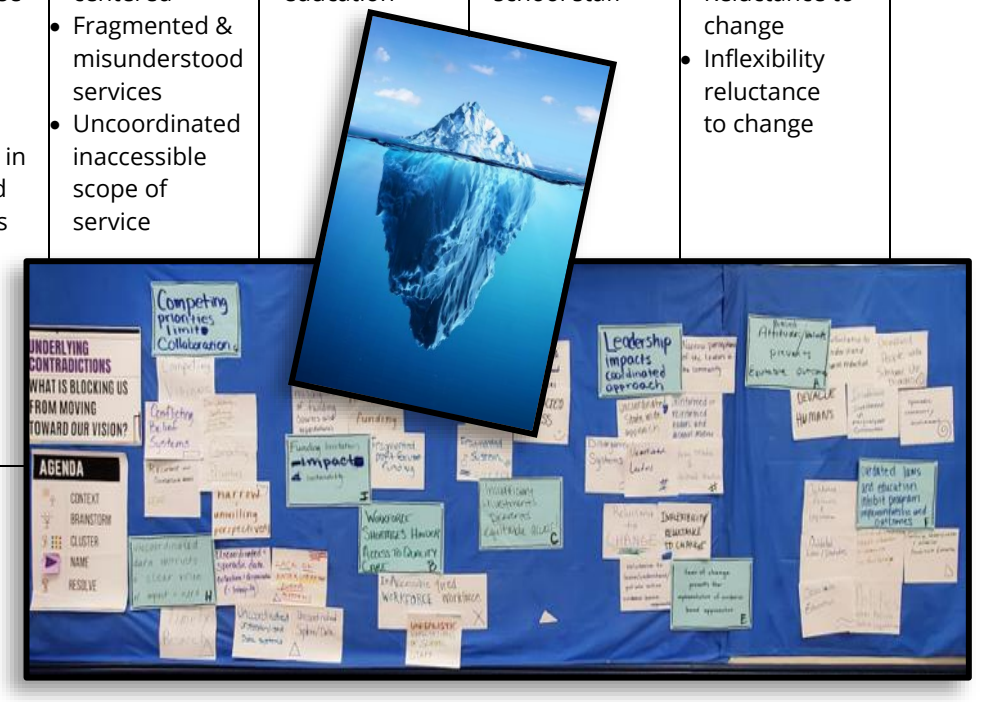
What is in Our Way

Our Underlying Contradictions

Based on the shared, practical, vision that the group created participants were asked to take a realistic look at *"why"* this vision isn't in place today. What is impeding our vision, our success? Participants were encouraged to look beyond the obvious, beyond the tip of the iceberg and to look below the surface at. The workshop pushed participants to think beyond the "lack of" and dig in to surface the root causes that are the true barriers to successfully achieving their vision.

Workshop Question: What is blocking us from moving towards our vision?

Competing Priorities Limit Collaboration	**Uncoordinated Data Obstructs a Clear Vision of Impact & Need**	**Funding Limitations Impact Sustainability**	**Leadership Impacts Coordinated Approach**	**Biased Attitudes/ Benefits Prevents Equitable Outcomes**	**Insufficient Investments Prevents Equitable Access**	**Updated Laws and Education Inhibits Program Implementation and Outcomes**	**Workforce Shortages Hinder Access to Quality Care**	**Fear of Change Prevents the Implementation of evidence – based approaches**
As illustrated by	*As illustrated by*	*As illustrated by*	*As illustrated by*	*As illustrated by*	*As illustrated by*	*As illustrated by*	*As illustrated by*	*As illustrated by*
• Competing visions • Conflicting belief systems • Reluctant and conflicting beliefs (fear) • Overwhelming conflicting priorities • Narrow & unwilling perspective(s)	• Uncoordinated & sporadic data collection & dissemination (& integrity) • Lack of interoperable data systems • Timely research • Uncoordinated unstandardized data systems • Uncoordinated system/data	• Fragmented profit – focused funding • Restrictive funding • Misalignment of funding sources and expenditures • Inflexible & narrow funding • Inflexible government funding requirements • Scarcity mentality (if you win, I lose)	• Narrow perceptions of the leader in the community • Uncoordinated statewide approach • Uniformed or misinformed leaders and decision makers • Disorganized systems • Unmotivated leaders • Divisive media & political practices	• Reluctance to understand harm reduction • Devalued people with substance use disorders • Devalue humans • Insufficient investments in marginalized communities • Sporadic community involvement	• Fragmented system • Restricted access • Inaccessible info – not person centered • Fragmented & misunderstood services • Uncoordinated inaccessible scope of service	• Outdated policies & legislation • Outdated laws/ statues • Obsolete education	• Inaccessible workforce • Tired workforce • Unrealistic expectations of school staff	• Reluctance to learn/ understand / put into action evidence – based • Reluctance to change • Inflexibility reluctance to change



What is Our Strategy?

Our Strategic Directions

In this workshop participants were asked to reflect on their shared, practical, vision and the blocks and barriers that were identified. If our vision is where we want to be in 3-5 years and we have identified *"why"* this vision isn't in place today, then the next task is to address these barriers and to leverage any opportunity that will move towards the vision. Participants were asked to brainstorm substantial actions. These were actions that would address these blocks, either by eliminating them or working to mitigate the impact on their vision or would put the vision in place and or address key opportunities.

Our Workshop Question: What two-year innovative, substantial actions will deal with our blocks, incorporate our commitment, and move us towards our vision?

Empowering for Change

Fund Communities

- Increase the number of community grant projects
- Funded community – driven initiatives
  - Communities that care
  - Community Coalitions
  - School prevention
- Replicate north STL initiative in other parts of state
- Expand peer-respite housing programs to other locations instate
- Initiative to increase the # of minority peers

Empower Diverse

- Prioritizing grass roots projects
- Develop mentoring programs for young black men within their communities
- Engage/Coordinate minority leadership in local listing sessions
- Events involving minority leaders including peers
- Plan to identify trusted local leaders for assessment of local needs & barriers

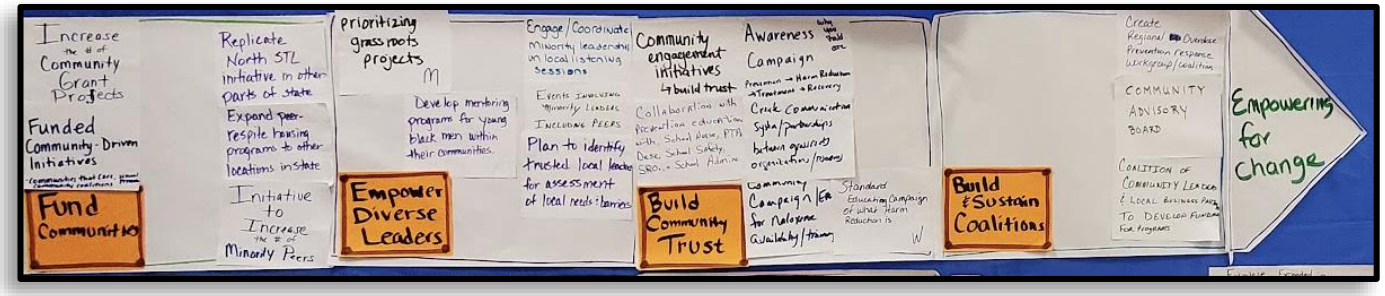
Build Community

- Community engagement initiatives build trust
- Collaboration with prevention education with school nurse, PTA, Dese, School Safety, SRO's, School Admin.
- Awareness Campaign
- Why you should care
- Prevention->Harm reduction->Treatment->recovery
- Community Campaign/E? for naloxone availability/training
- Standard education campaign of what harm reduction is.

Build & Sustain

- Create regional overdose prevention response workgroup/coalition
- Community advisory board
- Coalition of community leaders & local business partners to develop funding for programs

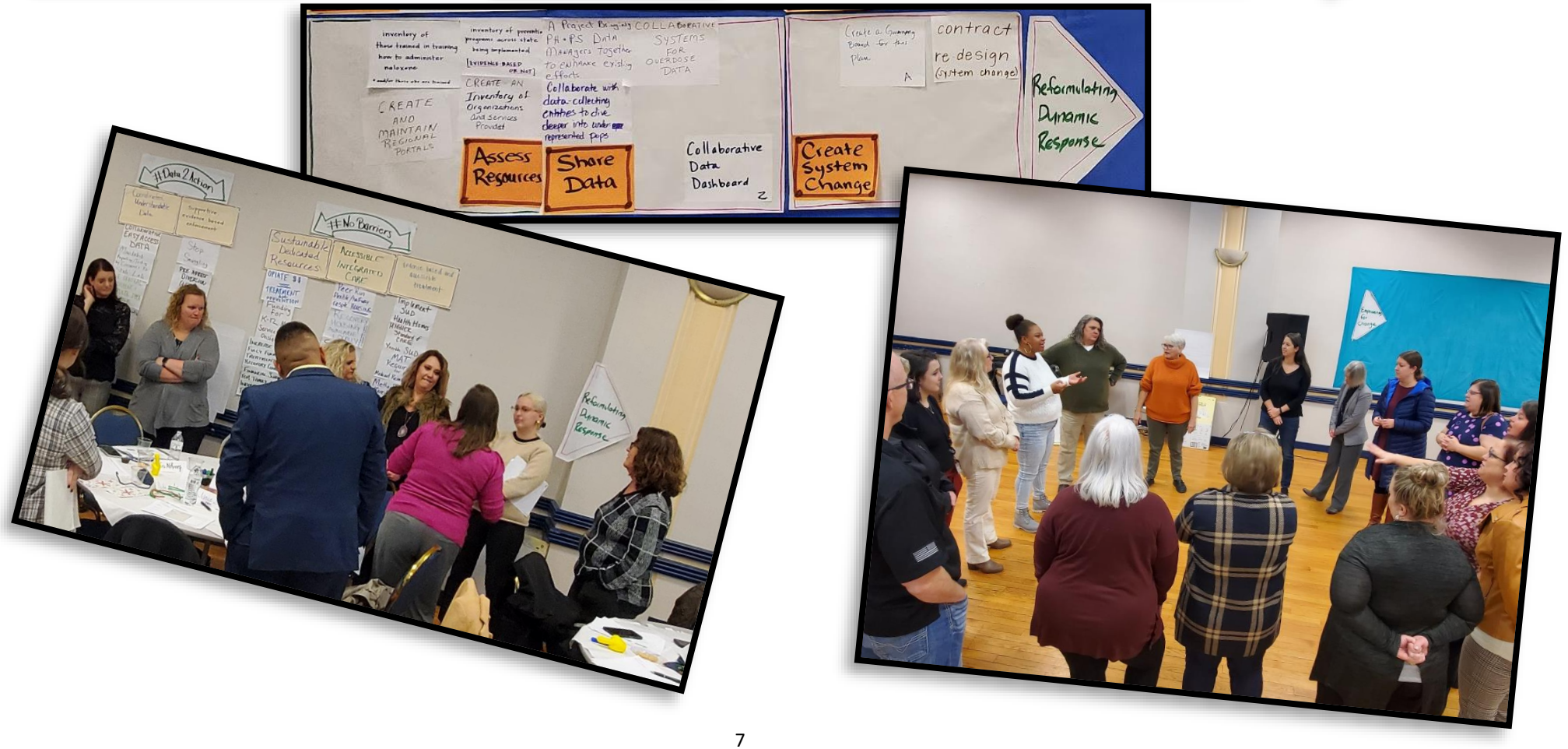
Empowering for Change



Reforming Dynamic Response

Assess Resources	Share Data	Create System
• Inventory of those trained in training how to administer naloxone ($ and /or those who are trained) • Create and maintain regional portals • Inventory of prevention programs across state being implemented [evidence based or not] • Create an inventory of organizations and services provided	• A project bringing PH & PS data managers together to enhance existing efforts • Collaborate with data-collecting entities to dive deeper into underrepresented pops. • Collaborative systems for overdose data • Collaborative data dashboard	• Create a governing board for this plan • Contract redesign (system change)

Reforming Dynamic Response



Prioritizing People

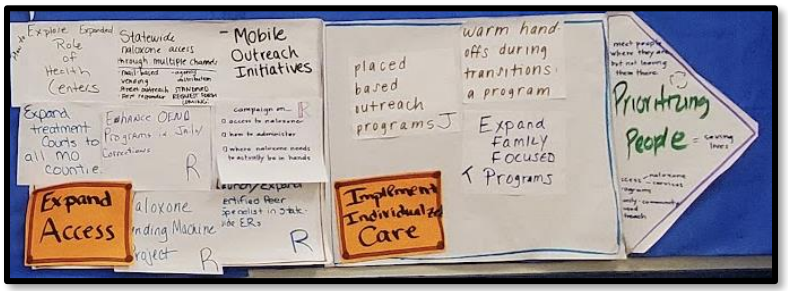
- Plan to explore expanded role of health centers
- Expand treatment courts to all MO counties
- Statewide naloxone access through multiple channels
  - Mail based, vending, street outreach, first responder, agency distribution, standard request form coming
- Enhanced OEND programs in jails/corrections
- Naloxone vending machine project
- Mobile outreach initiatives
- Research docket municipal courts
- Launch/expand certified peer specialists in statewide ER's

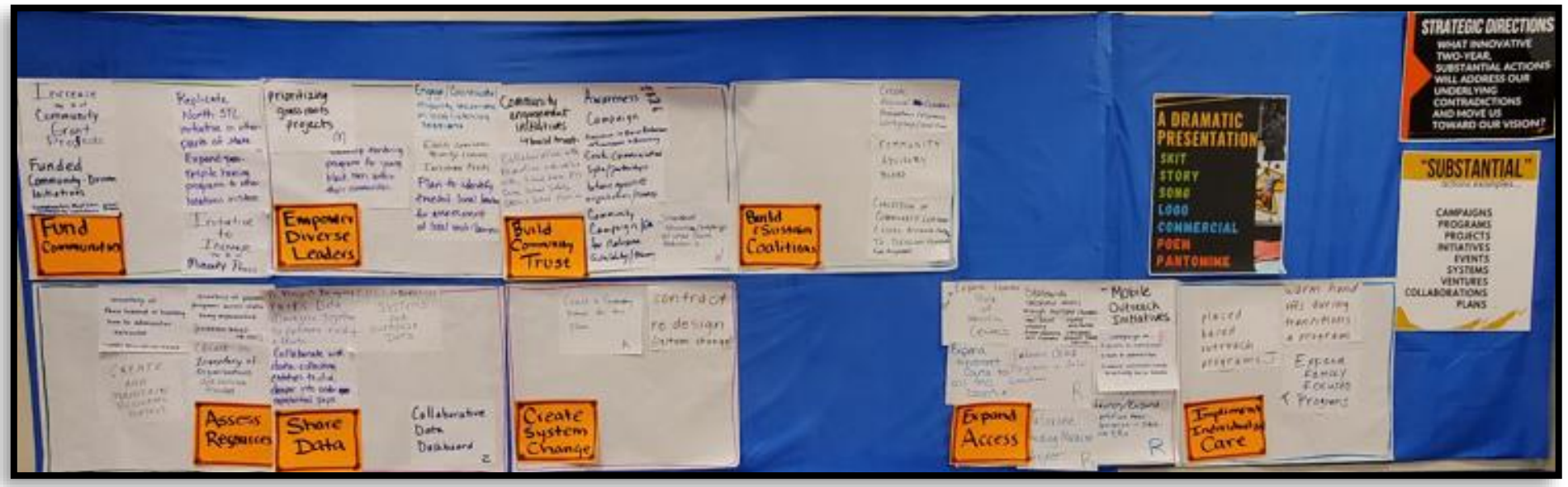
Expanded Assess

- Placed based outreach programs
- Warm hand offs during transitions – a program
- Expand family focused programs

Implement Individualized Care

Prioritizing People





What Can We Do?

Our Focused Implementation

In this workshop participants were tasked with creating an action plan. The goal here is to move the group from the reflective and analytic phase of planning to action. Participants were asked to focus on the strategic directions they had identified. The group reflected on this work and collaboratively identified the strengths, weaknesses, opportunities, and threats (SWOT) of each strategic direction. Once this analysis was completed the group worked to identify their first-year accomplishments, moving beyond what ***"could"*** be done to what ***"will"*** be done. Participants identified the specific, measurable, attainable, relevant and timebound (S.M.A.R.T.) actions that they will take in the next year, and over the next 90-days. These actions were then plotted on a timeline and individuals were assigned to specific tasks outlining the groups commitment to achieving their vision.

The Workshop Question: What are the specific, measurable accomplishments we can do in the first year?

Prioritizing People

Strengths	Weakness	Opportunities	Threats	2 -Year Success

• Empathy
• Group knowledge / resources
• Funding
• There is funding & models that can be replicated
• Regional hospital connections
• Lived experiences
• Commitment
• Passion and expertise
• Knowledge & subject experts
• Community already cares for community (regardless of funding)
	• Silo's
	• Stigma
	• Capacity
	• Workforce (lack)
	• Burnout
	• Secondary trauma
	• Funding restrictions on what can be purchased & timelines
	• Resource intensive
	• Community denial
	• Unintended ignorance
	• Moralized definition of health we know the answer – we don't listen - ask
	• Not meeting people where they are
	  ○ Physically
	  ○ Emotionally
	  ○ Socially
	  ○ In relationship w/ drug use
	  ○ Financially
		• Collaboration
		• Funding
		• Build up existing programs
		• Replicate successful programs
		• Epic
		• Expanded network/access
		• Wrap around person – centered services
		• Meet people where they are
		• Measured success / volume based
		• Current funds in state (+=6B)
		• Learn how to meet people where they are
		• Understand people's needs
			• Complacency
			• Close mindedness
			• Ego's
			• No centralized referral system … nowhere for warm hand off
			• Stable funding
			• Grant dependent
			• Moving target
			• Measuring success
			• Competition
			• Fear to admit things aren't working
			• Stigma
			• Competing priorities (time & money)
			• If they let you know their need & you can't provide it
				• Awareness & understanding of harm reduction
				• Easy access to Naloxone
				• Timely access to care w/in 3 days
				• People get what they want or need
				• Increase peer services / opportunities to be at the table
				• Expand EPICC / tx courts
				• Improved re-entry linkage w/services (jail / prison)
				• Immediate availability to Naloxone & F.T.S.
				• Expansion of family recovery programs
				• Additional housing units
				• Credentialed training i.e., CEU's for workforce

Empower for Change

Strengths	Weakness	Opportunities	Threats	2 -Year Success
• Commitment well rounded experience • Experience w/coalition building • Diverse group of perspectives focused on same outcome • Shared desire for coordination • Works within community • Existing prevention coalition/ centers infrastructure • Energized people willing to make change • Coalitions exist • PRC support available • Insight: first responders need to be at the table • Many groups doing great work • There are grass roots org doing great work • Community organizations present • Faith communities	• Lack of diversity • Limited funding not final decision makers • Historical division among groups • Old-school admin. • Competition for $ • No LPHA's here • Lacking effective strategies to connect w/first responders • Lack of coordination • Don't know what we don't know (or who) • Complacency after successful launch • Can be crisis driven & not sustained • Lack of trust of system • Lack of trust of professionals already in place • Coalitions don't communicate / collaborate / share resources • Lack of follow through • Time resources • Pre-determined champions for the community • Faith communities sometimes closed • Not enough collaboration -> (sustained funding, support, development) between admin. and grassroots. • Change takes time, long term time intensive commitment • Bureaucracy • Reluctance to change • People may gate keep resources	• Low barrier to entry • Expand scope of existing prevention infrastructure • Build on existing coalition work • Connections & relationships established • Leveraging existing relationships to inform targeted communities • Listen to peer community • Creative funding ideas / mechanisms • Develop civil operators • Increased knowledge in general community • Elevating voices of people who haven't been at the table • Catalyze new communities / members if communities • Faith communities more open / inclusive	• Sustained motivation / momentum • Current funding streams may dry up (fed stim, covid, relief) • Self-protection • Limited capacity – for participants • Stigma • Competing focus of coalitions • The next crisis • Slow funding for grass roots effort • Continued lack of trust in the system • Inconsistent programs coming in and out • People are tokenized • Absence of protected time and funding to sustain coalition work • Unpaid labor of volunteers /activists paying -> sustainability • Faith communities can be exclusive	• Well established & well-funded coalition -> led by diverse leaders • Uninform & supported state funding coalitions • Engagement of minority participation • Legislator w/lived experience • Awareness campaign • Visible minority leadership in all communities • Employ regional civil operators Missouri Guard • Coalitions that drive decision making at the state level • Peer respite recovery housing exists

Reforming Dynamic Response

Strengths	Weakness	Opportunities	Threats	2 -Year Success
• A lot diverse data some infrastructure exists • Legal knowledge • Trainers in Naloxone exist • Regional footprint • Funding does exist • State procurement knowledge • Big data exists • Data pockets • State procurement process • Opportunities • Diversify partnerships • Lots of programs / resources • Existing data sharing efforts	• Existing data not shared • Not enough #collab. • Silo systems (health, law enforcement, etc.) • No real time data (lags in ME) • Lack of data sharing agreements • Fear • Interpreting data only for their needs (not big picture) • Lack of data sharing / desire to share [i.e., This is mine] • Siloed government funding streams • No interoperability • Politics • Rigid contracting rules	• More collaboration • Data sharing • Overlay data/services/$ • ID people who are not at the table • Mandate representation • Develop system for real time data • Experience un - organized statewide imitative • Diversify partnerships • [once data all collected] … creation of job(s) to actually interpret the intersectional aspects of the data • Actionable (zip code) data • Better understanding of available data	• Insufficient state IT resources • Data (measurements, indicators) don't align/mesh • Incomplete data • Data not timely • Competition for resources • Personal agendas • Biased two edge swords • Funding ends • HIPAA/PPT liability • Burden on system, person, provider etc., etc., etc., data=burden • Blame game for neg. outcomes • Compassion fatigue • Disjointed planning • Subjective vs. objective definitions • Ownership (or feeling of) over the data • Misuse of data • Data integrity	• Identifying needs through collaborative data sharing • Real-time centralized data repository – and who is responsible for maintenance • Clearing house of resources & someone to maintain • Funding is where it is needed, and we know the outcomes of that funding • Inventory of current programming efforts -> evidenced based or not • Create / expand statewide drug dashboard to include PS & EMS OD data. • Creating statewide committee to oversee data – sharing initiative

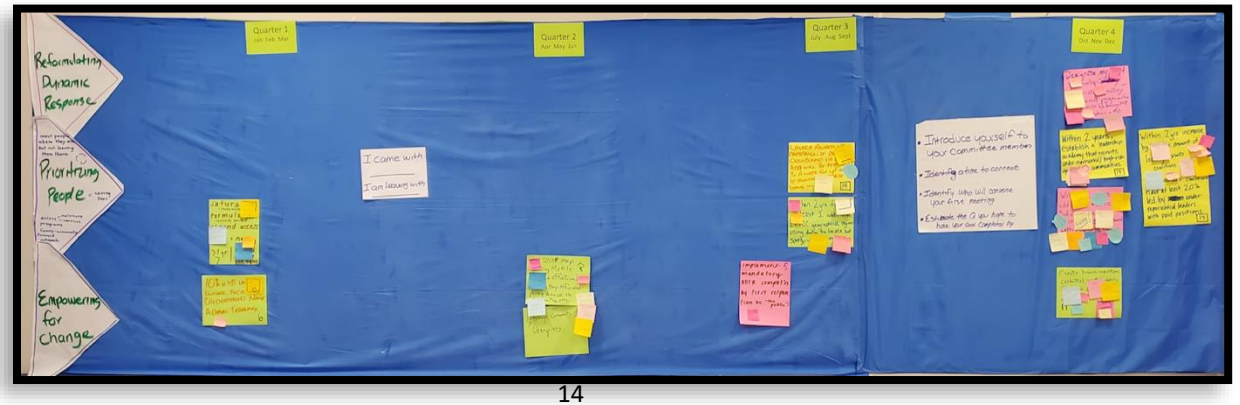
What Will We Do?

The Workshop Question: **What are the first-year assignments, timeline, and responsible parties?**

	Quarter 1 - 2023 Jan-Feb-Mar	Quarter 2 - 20223 Apr-May-Jun	Quarter 3 - 2024 July-Aug-Sept	Quarter 4 - 2023 Oct-Nov-Dec
Empowering for Change	• 10% of MO law enforcement. Receive credentialed nalox admin training *(Jenny Armbrusten, **Liz Conners)** -* **Complete** • Saturation (statewide) formula for (already exists) expand access trad & non-trad >1 year / yes inc., yes sus., yes equity (*Libby Brockman-Knight, Casey Johnson, Christine Smith, **Liz Conners**, Lauren Green, Jenny Armbrusten)*	• By 2024 map existing mobile outreach efforts and services they offer and publicly disseminate the service they offer through community champions. *(Casey Johnson, Cindy McDonnald, Sarah Crosley MOCPHE, Emily Hage, **Tara McKinney**, Christine Smith, Darla Belflower)*	• Within 2 years fund at least 2 additional EPICC geographical regions using data to locate hot spots with highest rates (*Kortney Gentner, Liz Conners, **Ralph Begay**, Libby Brockman-Knight, Sen. Holly Rehder)*	• Create harm reduction credential w/ MO credentialing board by January 2025 *(Darla Belflower, Rosie Anderson-Harper, Casey Johnsen, Marietta Hagan, **Lauren Green**, Neann Wedgeworth)*

	Quarter 1 - 2023 Jan-Feb-Mar	Quarter 2 - 20223 Apr-May-Jun	Quarter 3 - 2024 July-Aug-Sept	Quarter 4 - 2023 Oct-Nov-Dec
Reforming Dynamic Response			• Implement mandatory ODFR comput'n by first response. (can be "the public"). *(**Brenda Schell**)*	• Within 2 years add EMS & public safety data to existing DHSS dashboard with maintenance funding ***(Lynn**, Dave Mizell, Sara Crosley MOCPHE, Alicia Lensing, Liz Connors, Mindy Rustemeyer, Paul Boyd, Ryaki Deyton, Brenda Schell, Van Godsey, Marietta Hagan, Leighanna Bennett-DHSS)* • Designated agency 4 to develop a form to create inventory of current programs for SU service by January 2024 for demographics in MO *(Tara McKinney, Jenny Armbruster, **Susan Dupue**, Cindy McDannold, Laureen Green, Specific for college + higher ed efforts… Molly Lindner, Heather Harlan)*

	Quarter 1 - 2023 Jan-Feb-Mar	Quarter 2 - 20223 Apr-May-Jun	Quarter 3 - 2024 July-Aug-Sept	Quarter 4 - 2023 Oct-Nov-Dec
Prioritizing People			• Launch awareness campaign of overdose via Facebook ad will be featured 3x week for up to 6 months to those living in MO. *(**Mindy Rustemeyer**, Alicia Lensing, Molly Lindner)*	• Within 2 yrs. increase by 30% the amount of local grassroots coalitions *(Casey Johnson, Emily Hage, Liz Connors, **Jessica Howard,** Jenny Armbruster, Brenda Schell, Jonni Bryan* • For grassroots coalitions have at least 20% led by under-represented leaders with paid positions. (Within 2 years) AND Within 2 years establish a leadership academy that recruits under -represented / high risk groups from communities *(Scott O'Kelly, Jenny Armbruster, Jessica Howard, Emily Hage, Ralph Begay, Susan Depue)*



NOTE: SMARTIES goals were identified but not taken on as projects at this time.

Empowering for Change	Reforming Dynamic Response	Prioritizing People
• Obtain sustained funding for 1 peer respite recovery house in each district by January 2025 based on demographics most impacted by overdose • ID/compile/develop model for rural & urban communities as a guide to building local coalition – 6mo w/10 local coalitions brought up w/in next yr. • In spite homes in metro areas in year 1 w/intention to grow 6+ in next year • By December 2025, representation of the statewide overdose prevention coalition will accurately reflect the communities it serves by 25%	• Within 1 year, publish results of SIM mapping on a public website with mechanism to add additional efforts across continuum of care	• Within 2 years, create a career ladder with established trainings for peer specialists • Secure funding for 9 6 units (1 per region). Have partnerships & trainings IDed & set up w/in 1 yr. utilize new local coalitions to ensure equity. Provider ownership of units to sustain

"We believe prevention is better together and together, we are stronger!"

Thank you for your time and dedication to this work
Your HueLife facilitation team,

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