Allegheny County Department *of* Human Services

RFP Response Form

RFP for Case Management for Law Enforcement Assisted Diversion (LEAD)

PROPOSER INFORMATION

Proposer Name: Passages to Recovery, Inc.

Authorized Representative Name & Title: Carol L. Bender, Chief Operating Officer

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Website: https://www.passagestorecovery.org

Legal Status: ☐ For-Profit Corp. ☒ Nonprofit Corp. ☐Sole Proprietor ☐Partnership

Date Incorporated: 02/11/1976

Partners and/or Subcontractors included in this Proposal: N/A

How did you hear about this RFP? *Please be specific.* Allegheny County DHS Alert

Does your organization have a telecommunications device to accommodate individuals who are deaf or hard of hearing? ☐ Yes ☒ No

REQUIRED CONTACTS

	Name	Phone	Email
Chief Executive Officer	Carol A. Hertz	412-535-4310	chertz@passagestorecovery.org
Contract Processing Contact	Carol L. Bender	412-941-8401	cbender@passagestorecovery.org
Chief Information Officer	Geno Frattini	800-675-9396	geno@greendotactive.com
Chief Financial Officer	Kevin Boland	412-882-5382	kboland@donnelly-boland.com
MPER Contact*	Raymond Tokar	412-882-5383	rtokar@donnelly-boland.com

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** MPER is DHS's provider and contract management system. Please list an administrative contact to update and manage this system for your agency.*

BOARD INFORMATION

Provide a list of your board members as an attachment or in the space below.
Click here to enter text.

Board Chairperson Name & Title: Eric J. Sobczak, General Counsel

Board Chairperson Address: [redacted]

Board Chairperson Telephone: [redacted]

Board Chairperson Email: ejsobczak@cbs.com

REFERENCES

Provide the name, affiliation and contact information [include email address and telephone number] for three references who are able to address relevant experience with your organization.
Please do not use employees of the Allegheny County Department of Human Services as references.

Jennifer Belden-England
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Goodwill of Southwestern Pennsylvania
O: 412-632-1788
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Johnny Nguyen
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PROPOSAL INFORMATION

Date Submitted: 2/25/2022

RFP for Case Management for Law Enforcement Assisted Diversion (LEAD)

Amount Requested: $701,461.15

CERTIFICATION

Please check the following before submitting your Proposal, as applicable:

☒ I have read the standard County terms and conditions for County contracts and the requirements for DHS Cyber Security, EEOC/Non-Discrimination, HIPAA and Pennsylvania's Right-to-Know Law.

☒ By submitting this Proposal, I certify and represent to the County that all submitted materials are true and accurate, and that I have not offered, conferred or agreed to confer any pecuniary benefit or other thing of value for the receipt of special treatment, advantaged information, recipient's decision, opinion, recommendation, vote or any other exercise of discretion concerning this RFP.

Choose one:

☐ My Proposal contains information that is either a trade secret or confidential proprietary information and I have included a written statement signed by an authorized representative identifying those portions or parts of my Proposal and providing contact information.

OR

☒ My Proposal does not contain information that is either a trade secret or confidential proprietary information.

ATTACHMENTS

Please submit the following attachments with your Response Form. These can be found at http://www.alleghenycounty.us/dhs/solicitations.

- MWDBE and VOSB documents
- Allegheny County Vendor Creation Form
- Audited financial reports or other financial documentation for the last three years
- W-9
- At least one letter of support
- Job descriptions

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REQUIREMENTS

Please respond to the following. The maximum score a proposal can receive is 165 points. Your response to this section should not exceed 20 pages.

Organizational Experience (35 points possible)

1. Describe your organizational experience providing case management services to high-need individuals and/or communities with diverse identities.

Passages to Recovery, Inc. (*Passages*) has provided case management services to high-need individuals in Allegheny County for over 35 years. Formerly known as THE PROGRAM for Offenders, Inc., the organization was founded in 1974 to address the unmet needs of women incarcerated for low-level nonviolent crimes related to their efforts to cope with life challenges, such as poverty, trauma, unemployment, and behavioral health struggles, that are rooted in systemic inequities. The organization's successful outcomes at its work release facility for women and their preschool-aged children, opened in 1984, led to the opening of a second residential facility (now exclusively for men) in 1993 that combined work release with PA licensed intensive inpatient substance use disorder treatment. Currently, *Passages* contracts with Allegheny County to provide alternative housing services and substance use disorder treatment at two gender-responsive facilities, located in Pittsburgh and West Homestead, for individuals who meet the criteria for clinically managed high intensity residential drug and alcohol treatment services and who would otherwise be incarcerated in the Allegheny County Jail. In a typical year, these facilities serve approximately 250-300 clients and their families. Although most residential clients are justice-involved, *Passages* provides drug and alcohol treatment services to any eligible adult referred from the community, including self-referrals.

Passages provides comprehensive case management, as recommended in SAMSHA TIP No. 27. (2015), to address the unmet human service and behavioral health needs that have contributed to our clients' substance use. Case management is performed collaboratively with the client and includes assessment, planning, linkages, monitoring and advocacy. Needed services usually include housing, employment, physical and mental health services, and family support; they may also include peer recovery supports, legal assistance, basic needs assistance, and transportation. The individualized service plan is reviewed with the client weekly, revisited/revised periodically, and coordinated to avoid duplication of services. It is central to post-release planning and a warm hand-off at discharge that ensures clients will receive the services they need as they return to the community and move along the continuum of care.

Passages provides case management as a separate service, and not according to the "therapist-case manager" model, because our clients are so high-need. Many of our residential clients have been repeatedly caught up in the criminal legal system. Substance use disorder has significantly disrupted their motivation and choice. Systemic inequities have shaped their lives to such a degree that social determinants of health have affected their functional ability to engage in recovery. Our case managers must be skilled at building trust and engagement with individuals who have many barriers to accessing services and supports. This is especially true because our clients may have been offered and received services before, without lasting effect.

Despite the challenges, our experience with providing case management to such high-need individuals has been very positive. Although case management has never been evaluated as a separate component of service delivery at our residential facilities, third-party evaluations of our services as a whole have consistently found our programming to be a good match for our clients' needs. In our most recent Evaluation Report—dated January

2020 and available on request—our annual recidivism rate at six months post-release was estimated at 12.7%; among other favorable outcomes, nearly 80% of clients indicated that the progress they had made toward their goals met or exceeded their expectations.

Passages to Recovery serves people whose survival behaviors have been criminalized, and who will not be supported in changing those behaviors by the punishment, isolation and further marginalization they will endure if incarcerated. Our target population includes people with criminal histories and encompasses race and gender identity-based communities, and communities of people who face intersectional forms of stigma and oppression related to sexual orientation and socioeconomic status. We have historically specialized in providing alternative housing for incarcerated pregnant women, and were one of the first alternative housing providers to accommodate transgender women. We are taking bold steps, discussed below in Response #3, to correct the mistaken perceptions that our organization is part of the Jail, and that we only serve people who are incarcerated.

2. How does your organization approach building trust with the communities where you work? Provide at least one example of your past success in achieving a community's trust and at least one example of a lesson your organization learned while working to earn a community's trust. Attach at least one letter of support from an individual/organization from a community in which you've built trust.

The opioid epidemic has brought substance use disorder into the mainstream, but not into the light. *Passages to Recovery* operates in a complex environment where its clients are still demonized and feared, so we must gain the trust of the communities where we provide services to legitimize our presence and garner support. We approach building trust as a reciprocal process that takes time, effort, and the ability to identify and emphasize common interests rather than differences. The community must have grounds to believe that we have the competence and commitment to make the "right" decisions to protect our shared interests, even when we may not be pursuing the same priorities or incentives.

Building trust gets things done and is critical during periods of change, which stirs anxiety by disrupting old patterns, roles and boundaries. This became evident as our organization searched for a suitable site to relocate our women's residential facility, then located in Oakland, to a facility we could adapt for our reuse. Despite having ample support from state and local government and local foundations, we continually met with community resistance, lack of urgency, ambivalence, and other frustrating hurdles. It took almost four years to find the right site in a community willing to have us. The Borough of West Homestead, where our women's residential facility is now located, is a small community that was hit hard by the decline of the steel industry. Like many Mon Valley communities, it was also suffering from a dramatic escalation of opioid misuse. But it was not the prospect of having another treatment resource in the community that swayed local officials to endorse the project and rally the community around it. It was the prospect of economic development, coupled with reassurances that our project would not overwhelm local infrastructure or jeopardize public safety. We were comfortable framing the project in those terms because our project would accomplish those things; we could accomplish the community's priorities by accomplishing ours. This experience taught us that trust and collaboration must be grounded in an understanding what's important to others and a willingness to address their priorities along with our own.

Building trust with the recovery community in our region has also been crucial to the success of our Peer and Family Recovery Supports Program, which we piloted with a one-year grant from PA DDAP in 2020 and for which we have secured contractual agreements from CCBH, DHS, and private insurers. The peer supports program invests in and elevates members of the recovery community by hiring them because of their lived experience and supporting them with intensive training and supervision. Its processes are completely client-centered and help clients achieve tangible results. Recovery Specialists walk alongside their clients as they deal with the day-to-day messiness of recovery—which is anything but a continuum of getting better and better, even

after someone gets sober—in a way that therapists cannot. We learned, however, that our long history as a clinical treatment staple in the recovery community did not guarantee that individuals who could benefit from our peer support program would trust it, especially if they were not ready or willing to be in treatment. Every recovery journey is different. To earn the trust of the recovery community, our Certified Recovery Specialists (CRSs) need to find out what each client considers to be meaningful assistance. This requires intentional listening, humility, genuine interest, and time. In peer support, we have learned, the relationship is the intervention.

We built our Peer and Family Recovery Supports Program from nothing at the height of the pandemic, and welcomed our first client in July 2020. Despite COVID-19's impact on staffing availability and client engagement, we have built a robust referral network within the recovery community. In 2021, the program's three CRSs served a total of 208 clients (not including those who did not participate in the full continuum of services) across a service area that includes Allegheny, Butler, Washington, and Westmoreland counties. The average score on the Brief Assessment of Recovery Capital (BARC-10), an evidence-based tool that assesses quality of life for people in recovery, was 52 out of a possible 60. As a point of reference, evaluation of the BARC-10 measure has suggested that individuals who have a recovery capital score of 47 or higher are likely to reach or sustain a year or longer of recovery from substance use disorder. A Letter of Support from Robert D. Ashford, Executive Director of Unity Recovery and CEO and Founder of RecoveryLink™, is attached.

Because it has gained the trust of the recovery community, especially among some of its most marginalized members, the peer support program is also building trust across siloed local service lines. For example, the program is cultivating referral relationships with local systems such as Drug Court and Allegheny County Children Youth and Families. It has become an established resource at Intercept 2 (Initial Detention/Initial Court Hearings) of the Sequential Intercept Model in Magisterial District 05-2-02 in West View Borough, where a Certified Recovery Specialist is stationed every Wednesday so that the Court can make immediate referrals to our program. This option has proven to be so expedient that we are reaching out to expand the service to other interested district courts.

3. Describe your organization's understanding of Harm Reduction. Provide specifics on how your organization applies it to your current programs and interactions with program participants, and/or your commitment to doing so for LEAD Participants.

Passages to Recovery, Inc. (Passages) understands Harm Reduction in the context of substance use disorder as a social service that takes a non-binary, non-coercive "whole person care" approach to safeguarding and improving the health and wellbeing of individuals who use drugs, with a focus on promoting evidence-based methods for reducing associated health risks in the current moment. The defining feature of Harm Reduction is its focus on the prevention of further harm, and not on the prevention of substance use itself. Harm Reduction is typically described as promoting health in a way that "meets people where they are at," in the physical sense, and by accepting that not everyone is ready or able to stop their substance use at a given time. Harm Reduction emphasizes that people who have developed a substance use disorder have basic and human rights—including the autonomy to learn for themselves what works, and what doesn't, when maintaining their own safety—and deserve to be treated with dignity, compassion, and respect. There are no barriers to service provision, but providers must be prepared to reach out to the communities of people who have been subjected to years of implicit bias and stigma, judgments about the choices they have made, preexisting notions about what assistance they really need, and expectations about how they should behave. Harm Reduction is pragmatic in its goals and realistic about the process of behavioral change. It does not condone or enable drug use and does not exclude or dismiss abstinence-based treatment models as viable options.

Harm Reduction recognizes the complex sociocultural underpinnings of chaotic drug use. In many cases, people who have been historically denied opportunities and left out of systems of care like housing, healthcare, and family support turn to drugs simply so they can get through the day. Laws that criminalize what is, in effect, a coping mechanism have only created more anguish and made the drug use problem worse. Harm Reduction strategies and interventions that save lives are gaining more acceptance as the opioid crisis has become a full-blown public health emergency, but the ultimate Harm Reduction strategy would be the implementation of upstream changes that address inequities in policy, economic systems, and the social hierarchy.

Passages to Recovery (Passages) provides recovery-based services that focus on substance use while addressing contributing factors of trauma, mental health, and family systems. We apply Harm Reduction practices in our programs to the degree permitted by the terms of our licensure, contracts and applicable regulations. We share the view of the American Society of Addiction Medicine (ASAM) that addiction is a primary, chronic disease of the brain that has characteristic biological, psychological, social, and spiritual manifestations. ASAM's definition emphasizes that addiction is a serious, potentially fatal illness that is treatable, and that recovery—defined as improvement and potentially remission—is possible. We do not take this to mean that abstinence is the primary goal of treatment, but that services along the continuum of care should support people with substance use disorder wherever they are in their relationship with abstinence. We utilize Motivational Interviewing in all programs to draw out clients' ideas about change and emphasize their autonomy of choice. This provides the lens through which we identify and offer appropriate Harm Reduction measures in our programs:

--*Passages Pittsburgh* and *Passages West Homestead* provide clinically managed high-intensity inpatient services, commonly referred to as long-term rehab, for people who want to get and stay sober. This Level of Care is particularly helpful for individuals with co-occurring disorders and other life challenges that can be addressed in the client's service plan. Our residential clients receive HIV, Hepatitis C, and STI screening through our partnership with Central Outreach Wellness Center. They are supported with Medication Assisted Treatment, as prescribed. Overdose prevention practices are in place with and without Naloxone. For their own safety and the safety of other residents, clients cannot be admitted to or remain in our residential facilities if they have drugs in their possession or if they are intoxicated or high.

--*Passages Outpatient Clinic* provides outpatient drug and alcohol treatment at levels of intensity that match clients' assessed needs with scheduling flexibility, so they can still handle their daily responsibilities. We do not deny or discontinue outpatient treatment if a client continues or returns to use, as long as the client may still benefit from treatment at this Level of Care. Overdose prevention policies and practices are in place, as they are in our residential facilities. As Telehealth has become an available option and patterns of social interaction have been disrupted during the pandemic, we have also identified the need to address the impact of isolation and stress on the wellbeing of clients and staff. This has led to changes in office protocols and more emphasis on connections to Harm Reduction resources in the community.

--*Passages Peer and Family Recovery Supports* is a community-based program in which Certified Recovery Specialists with lived experience of recovery provide peer support to individuals at any stage of the recovery process. Like other peer-delivered recovery supports delivered by Recovery Community Organizations (RCOs), our program is reflexively centered around the initiation and maintenance of recovery but does not require sobriety. Services include overdose prevention and connections to Harm Reduction services such as syringe and needle exchange programs. Recovery Specialists meet clients where they are in every sense and accept that their clients' lives are their own to save. Based on our experience with this program, we would apply the same total commitment to Harm Reduction in our programming and interactions with LEAD participants.

We are continually working on developing self-awareness and strategies to avoid harming program participants in our interactions with them, especially because so many of our clients have experienced trauma and are quite vulnerable. Common discourse about addiction still reflects the long tradition of moralistically condemning individuals who use drugs—even within the recovery community, for instance, common expressions like "getting clean" have negative connotations for people who cannot or choose not to stay sober. We have become increasingly aware of the power of language at *Passages*, especially in light of our long association with the criminal legal system and the Allegheny County Jail. As discussed above in Response #1, our organization was founded to mitigate the systemic harm, stigma and shame inflicted on marginalized populations by mass incarceration policies. We have forged a long-term working relationship with the Allegheny County Jail, as it has always been our aim to address the damage the Jail could do. We have built trust with the Jail in much the same way that we build trust everywhere, by identifying ways in which we can support our co-stakeholders in achieving their goals without compromising ours. For example, we have helped the Jail avoid overcrowding and have addressed service gaps there, including shifting our service focus to provide residential drug and alcohol treatment services to eligible inmates at one of the most intensive levels of care available anywhere in the County. We have developed processes and procedures in our residential facilities that attempt to reconcile the approaches and priorities of corrections with those of treatment. This has not been a simple matter.

We remain committed to helping incarcerated and underserved men and women overcome their barriers to health and build better lives for themselves and their children. Now, because of the implementation of strategies to reduce the Jail population, the people we aim to serve are increasingly more likely to be out in the community. They need our services more than ever: substance use disorder drives the escalating need not only for criminal legal services, but for child welfare, homelessness, mental health, and even senior services. There is considerable overlap among the populations served by those systems, and our organization is well placed to provide services across them. But names are an incredibly important part of identity. Our clients have told us that they shrink from our organization's former name, which defined them by their past deeds as "offenders." We, too, have struggled with the harmful implications of calling our clients something that we don't want them to be. For this reason, we made the decision to change the legal name of our organization to *Passages to Recovery, Inc.* as of January 1, 2022. The challenges of the name change transition are significant but do not outweigh the benefits. The new name better reflects the services we provide, the positive impact we have in the community, and our commitment to our clients' health and wellbeing. We've reinforced that message with a new tagline—"*writing the next chapter of your life*"—which affirms our clients' dignity and autonomy.

4. LEAD is a national model being implemented locally across the country. What is your organizational experience implementing evidence-based programs, interventions and/or services to a model with high fidelity?

Virtually all services, programs, and interventions at *Passages to Recovery (Passages)* are evidence-based. This may be a regulatory requirement—e.g., PA DDAP requires that all clinical drug and alcohol treatment providers in the state follow the evidence-based ASAM Criteria—but we primarily rely on evidence-based models and approaches because they are more likely to produce the client outcomes we seek. Our services incorporate Motivational Interviewing, Motivational Enhancement Therapy, and Cognitive Behavioral Therapy, all evidence-based practices based on the well-validated Transtheoretical Model of Change. These specific techniques—as well as Medication Assisted Treatment, Harm Reduction, and Peer Recovery Supports—are often used in combination together and supplemented with Twelve Step meeting attendance, which is still a meaningful

form of peer support in the local recovery community even though studies evaluating Twelve Step groups and programs have not yet conclusively established their effectiveness.

Fidelity of implementation is important to us because it affects the quality of care. It ensures that our services are consistent, reliable, and based on what works. We need to know, and be able to show, how we accomplished our results so we can do it again. We ensure that we will implement evidence-based models with fidelity, first, by clarifying what a service, program or intervention entails: e.g., our clinicians follow a detailed Treatment Manual and use manualized curriculums, such as the Trauma Recovery and Empowerment Model (TREM), Hazelden's Living in Balance, and The Change Companies Interactive Journals in our treatment programs. Recovery Specialists use the evidence based My Ongoing Recovery Experience (MORE) curriculum. Second, we have tools and processes in place for checking charts and other documentation, so we can verify that all service protocols are being followed. Third, we reinforce expectations in supervision and training.

The larger the system in which a program operates, the more important it becomes to develop an agreed-upon core approach that pushes stakeholders to prioritize and go deep with a few intentional strategies that accommodate local desires and constraints while remaining faithful to the model that brought them together. For example, participants in our Peer and Family Recovery Supports Program remain eligible for services as long as they want them, whether they continue or return to use, are hospitalized, or are incarcerated. This is because all stakeholders—clients, referral partners, payers, providers, and the recovery community—while deeply invested in participants' progress through the continuum of care, also agree to the core principle that recovery is incremental and nonlinear. We have also found that the challenges to maintaining fidelity increase when entities from different systems are involved in program delivery, especially when their needs and priorities might appear to be at odds with the model. As discussed above in Response #3, we have experience in situations like this. We balance the tension between corrections and treatment in almost every detail of operations at our residential facilities. We have ensured program fidelity by meeting the Jail's requirements and, at the same time, remaining obsessively faithful to the fundamentals of our treatment model.

Case Manager Qualifications, Hiring and Retention (50 points possible)

5. Describe where LEAD will fit within the overall administrative structure of your organization and why you placed it there. Please attach draft job descriptions for a case manager and a case management supervisor that include the traits you will emphasize in hiring decisions. If you have already identified individuals within your organization to staff the LEAD pilot, include their names and a short description of their qualifications.

The LEAD pilot would be placed in the recently created Department of Community Services, which includes *Passages'* Outpatient Clinic and Peer and Family Recovery Supports Program. The Director of Community Services, who reports to the Chief Operating Officer, oversees existing programs and is charged with expanding our community service offerings and developing our community presence, so that *Passages* can serve individuals who might not otherwise know about or have access to our services. Our Peer and Family Recovery Support Program, which provides services that complement LEAD case management, has been an innovative success in both respects. The current Director—who designed and implemented that program, established its robust referral network, and developed an internal hire to take over supervision of the program before being promoted to the more senior role—will lead the implementation of the LEAD pilot and oversee the LEAD Case Management Supervisors.

We have identified individuals within our organization who would be a good fit to staff the LEAD pilot, but we have not yet discussed the opportunity with them. Draft job descriptions for Case Manager and Case Management Supervisor are attached. These job descriptions seek candidates who have wide knowledge and

experience in case management that is street-based, Participant-drive, long-term, adaptive, non-clinical and based in Harm Reduction. As the program expands, we might also consider having one or more dedicated specialists among the case managers—for example, a case manager who has deep experience in a complex area such as housing, who would serve their assigned Cohort and be a resource for the LEAD case management team.

6. Describe your organization's policies on and history of hiring individuals of color, individuals with varied educational backgrounds, and individuals with lived experience with the criminal-legal system, homelessness, substance use or other behavioral health needs. What is your plan to hire staff with these backgrounds and characteristics for LEAD?

Our organization has always been committed to providing culturally competent, evidence-based practices and programs through all lines of service and has made it a priority that the individuals we serve should see themselves reflected in the diversity of our staff. As part of our rebranding initiative, described above in Response #3, we have restated our vision, mission and core values. Equity Diversity and Inclusion (EDI) practices such hiring individuals of color, with varied educational backgrounds and with lived experience consistent with the experience of our clients, are critically important to operationalizing our reframed focus and purpose. We are examining patterns of diversity in our staff and modifying some of our policies and hiring strategies. We plan to hire an EDI Officer this year who will create and implement strategies to shift our mindsets, behaviors and organizational practices toward more equity and inclusion.

We have historically hired former clients and others with lived experience, subject only to clearance requirements and other applicable rules and regulations. To the extent possible, we have always emphasized experience over education. People of color have always been well-represented in our management structure and in our frontline. The racial makeup of all current staff (57 individuals) is 58% Black and 42% White. Seventy-five percent (75%) of Case Managers are Black; 67% of individuals in our higher-paying positions are White. We are now considering how our hiring and promotion practices might be reflecting the inequities embedded in the larger systems in which we operate. We are developing strategies to provide more employment opportunities for individuals who have diverse backgrounds and characteristics such as those targeted by LEAD.

In 2020, we partnered with Human Resources professionals at Donnelly Boland and Associates (DBA), a certified woman-owned business that performs our accounting and back-office functions. DBA utilizes technology that streamlines our recruitment and screening; this helps to eliminate "expediency bias" and gives *Passages* hiring managers time to focus less on a candidate's "fit" and more on the unique qualities that someone will bring to the organization. We are working with DBA on ways to diversify our recruitment network, tap non-traditional talent pools, evaluate our job postings for bias, and remove implicit bias from hiring processes. Our Training Specialist will work with the new EDI Officer to train staff as we implement changes to our policies and practices. We will also encourage existing staff members to obtain EDI certification as part of their professional development.

We will share these best practices with the Local Policy Coordinating Groups (LPCGs) and our operational partners as we develop the hiring process for LEAD. In addition to taking a thoughtful approach to the interview process—for example, having a diverse mix of interviewers on panels, framing hypothetical and behavioral interview questions so diverse clients can showcase their skills—we would ask stakeholders about their own EDI recruitment and hiring strategies. We would also ask all community stakeholders, including members of the Community Leadership Teams (CLTs), for their assistance in expanding the pool of applicants by promoting LEAD opportunities to individuals and organizations in their networks.

7. During the hiring process, how will you determine if a candidate has the ability and the cultural competence to work with LEAD Participants? After hire, how will you ensure LEAD staff respect, support, and serve Participants without discrimination and use of shaming techniques?

In our experience, the hiring process starts with the development of a job description that clearly describes expectations about *what* a candidate will do in the position (i.e., tasks or outputs) as well as expectations about the attitudes, beliefs, values, traits and motives that will shape *how* the candidate will perform. This will be an intrinsically thoughtful and time-consuming process, given the degree of collaboration involved in LEAD. In addition to coming to agreement on these specifications for the LEAD Case Manager and Supervisor positions, for example, the Cohort-level stakeholders must have a shared understanding of what they mean by terms like "cultural competence" and "harm reduction approach." Similarly, because the LEAD model relies on the exercise of discretion, it will be important for the County and Local Policy Coordinating Groups to clarify the limits of that discretion. But these steps will be critical to determining a candidate's ability and cultural competence to work with LEAD Participants. The job description is the basis for everything that comes next, from developing the job posting and interview format, to selecting the right candidates and managing their performance.

The best way to know whether candidates have what we're looking for is to ask them the right questions. We would add a short assessment to our job posting, in the form of a skills-based quiz or test, to screen candidates at the point of application and help us narrow the pool of candidates who will be invited to a first interview. Interview questions will be crafted to elicit authentic responses—specific as to what is being asked without suggesting a "right" answer. Based on the job description and in consultation with the LPCGs, we would develop different types of questions: skills-based and related to practical knowledge and experience; behavioral and related to aptitude, approach and soft skills; and hypothetical scenarios that give a glimpse into how a candidate would instinctively respond to on-the-job challenges. We would also share and discuss the job description with final candidates during the interview process, so they can fully understand what the job entails, ask us pertinent questions, and give complete responses.

Local Cohort stakeholders should also come to a shared understanding of how we'll know that Case Managers are providing services according to LEAD principles. Participant retention is the desired outcome of LEAD case management, and retention rates would also reliably indicate that Case Managers have built trusting relationships with Participants and are delivering services in a compassionate and culturally competent manner. In a one or two-year pilot with a ramping trajectory, however, we might also develop a working definition of a "successful referral" to the program that includes a degree of engagement beyond enrollment. We would also rely on feedback from the field, either unsolicited or collected through a respectful, transparent process. For example, Case Management Supervisors could develop a short set of simple questions for Participants, first responders and other local operational stakeholders about their experience with case management service delivery; share the results of these random contact surveys with Case Managers and follow up in supervision or with training.

8. How would you involve Cohort stakeholders in the case management hiring process? Provide an outline of when and how Cohort stakeholders would be a part of the process.

As the selected provider, we would drive a case management hiring process that involves Cohort stakeholders to some extent at every stage of hiring, as follows:

1. Work with the Local Policy Coordinating Groups (LPCGs) in each Cohort to determine whether the Cohort has specific needs that would affect the qualifications and desired characteristics of LEAD case management staff.
2. Develop and propose a combination and number of staff, including a plan for staggered implementation and deployment of all budgeted staff positions, for review by each LPCG. Discuss the scheduling preferences of local

law enforcement chiefs. The point at this stage is to identify and clarify aspects of implementation that will affect job descriptions and could be important to candidates as they consider employment with LEAD. Our preference would be initially to develop the same expectations of service delivery across all Cohorts, as that would afford more flexibility in deployment while we build out the case management program; we might propose this with the first case manager hires and accommodate differences in local needs as we add more staff during the pilot.
3. Finalize and propose job descriptions for LEAD Case Managers and Case Management Supervisors in each Cohort. Develop separate reference materials that briefly summarize the Cohort's shared understanding of the concepts and terms used in the job descriptions.
4. Post job openings with prescreening/assessment features. Ask members of the LPCGs, Community Leadership Teams (CLTs), and Operational Workgroups (OWGs) to expand the pool of qualified candidates by promoting the opportunities to organizations and individuals in their networks.
5. Invite Cohort stakeholders to participate in screening candidates for first interviews, and/or to be part of a workgroup that will review and provide feedback on the interview questions that we develop, and check references. We would prefer that first interviews would be conducted by *Passages*, although we could include a limited number of representatives from local stakeholder groups if they desire. The process would be transparent in either case, as we would regularly communicate our progress in hiring across the local governance structure.
6. Top candidates from first interviews would be invited for a second group interview with members of the OWG, the CLT, and the LPCG in each Cohort. Ideally, these interviews will take place on the same day or over successive days, with the same interviewers.
7. Interviewers will meet to make final hiring decisions.
8. We will extend offers to the selected candidates and report the results to local stakeholder groups.
We would expect that the hiring process would take place over a period of four to six weeks after approval of the job descriptions and implementation strategy.

9. Describe your plan to onboard and train LEAD staff.

Passages to Recovery (Passages) has formal onboarding processes (e.g., orientation paperwork and procedures, issuing of tools such as computers and email/mainframe access, tours of our facilities, reviews of our policies and operations, regulatory and contractually-required trainings, etc.) and informal processes in which supervisors and colleagues integrate the new hire with the organizational culture and temporarily share ownership of the new hire's experience (e.g., meet-and-greets, introductions to key contacts in the community, spending time with supervisors, shadowing other employees, and regular check-ins to find out how new hires feel overall and whether there is anything specific that they need). We would follow our usual internal onboarding procedures with LEAD Case Managers and Case Management Supervisors. Given how critical onboarding is to service delivery and employee retention, we want to accomplish it deliberately and without sacrificing quality for speed. This will be especially important with LEAD staff because the LEAD model may be new to them several key respects: LEAD creates new roles and boundaries for and among systems that do not usually work closely together; no single partner is "in charge;" and the goals of the program are achieved through authentic collaboration rather than service coordination. We have several strategies in mind to make onboarding for LEAD more efficient and effective:
1. Give priority to candidates who have street outreach experience, ties to the cohort communities, and lived experience.
2. Start to train during recruitment: e.g., refer first interview candidates to online materials from the LSB and ask them to be ready to discuss how LEAD principles would affect their practice.

3. Ask members of the CLTs to facilitate local introductions within their networks, especially if we are unable to find a qualified Case Manager with extensive ties to a Cohort community.
4. Set aside onboarding time during OWG meetings whenever a new person joins the group; this would give the partners a chance to connect in a work environment removed from referral settings.
5. Include new Case Managers in the planning of their own onboarding; they know where their comfort zone begins and ends.
6. Network and share best practices/experiences with Case Managers from the City of Pittsburgh LEAD Program pilot. Encourage new hires to seek out and learn from other established LEAD programs. Although it may not be feasible to make in-person connections, many recordings of workshops, panel discussions and conferences on LEAD and LEAD principles are readily available online—including a great deal of recorded material from the original LEAD program in Seattle and from many jurisdictions across the country. The recap of the CONNECT 2021 Pre-Arrest Diversion Summit includes recordings and further resources that, among other things, provide context for the implementation of LEAD in Allegheny County.
7. Hold regular Case Management Team meetings in which Case Managers share strategies for accessing resources, developing relationships, and presenting services to Participants in a way that is most agreeable to them.

In addition to ensuring that LEAD staff receive relevant trainings that our organization provides for all new hires—e.g., trainings on ethics and confidentiality, CPR, First Aid, overdose prevention, etc.— LEAD staff will participate in trainings provided by the LSB. The Director of Community Services will work with our organization's Training Coordinator to identify supplemental trainings on topics and issues related to LEAD principles; for Case Management Supervisors, for example, trainings that address the challenges of administering the operations of a field-based team or of supervising employees with lived experience.

10. Describe specific methods you will use to retain LEAD case managers. Provide your caseworker retention rates over the past three years and include an explanation of how you calculated the rate, commonly reported reasons for staff departures and any measures you have taken to improve retention.

The pandemic has changed work in ways that employers are just beginning to understand and address. Now more than ever, an employee's perceived bad experience at any stage of the employment relationship can lead to early departure and turnover. We are examining our hiring processes, our accountability structures, and our culture to identify areas where we can improve the employee experience across our organization. Our methods for implementing these improvements are outlined below in this response and will apply to LEAD Case Managers as well as to other staff. There are, however, specific retention challenges for LEAD Case Managers that we address separately in this Response, as follows:

From our experience in implementing our Peer and Family Recovery Supports Program, we know that there are personal risks associated with providing field-based services to individuals with high needs. These risks must be acknowledged and dealt with for everyone doing this kind of work, and especially for individuals with lived experience. We will continue to focus on this and other factors that contribute to return to use, burnout, secondary trauma, and turnover:

- Length of time in recovery. LEAD Case Management can be stressful and place Case Managers with lived experience in situations that could jeopardize their well-being. Although it's impossible to predict how long it takes to heal, we have observed that peer support staff who have been in recovery for less than 18 months are still quite vulnerable. We can't assume that even a seasoned street outreach worker is immune to these pressures, given the nonlinear nature of trauma and recovery. We must make sure that LEAD Case Managers are capable of

maintaining their own safety in the field, and provide them with ongoing support so they can. For example, a Supervisor (Case Management Supervisor, the Director of Community Services, or a Clinical Supervisor from another *Passages* program) should be available for immediate consultation during case management shifts. They must be able to determine when a Case Manager might need clinical assistance and facilitate their access to it. Scheduling should be flexible enough that it does not interfere with a Case Manager's treatment or recovery supports.

- Self-Care. One of the most important questions we ask candidates for any clinical or non-clinical position is what they do for self-care outside of work. Self-care can be any activity that supports well-being, but it must be part of a regular routine. Work-life imbalance is one of the primary contributors to burnout, especially for people whose passion for their work can become all-consuming.
- Isolation on the job. LEAD Case Managers work independently in the field and must be self-generating. They may feel alone, especially at the start of the pilot when they have not yet established trust with the community or with the other operational stakeholders. Like safety and self-care, these are topics for supervision; we will also ensure that there is a culture of teamwork among LEAD Case Managers, with ongoing internal communication and support. We would also inquire whether the LSB or another qualified entity could provide training on teambuilding for the OWG.

For the past three years we have had two full-time case manager positions at each of our residential facilities. The retention rate in this position for the last three years was 33% in 2019, 75% in 2020, and 75% in 2021. Retention rates were calculated using a formula (*Total # of Employees on 12/31/20XX - Total # of Employees Hired Between 1/1/20XX and 12/31/20XX = Total # of Employees Retained. Retention Rate = Total # of Employees Retained / Total # of Employees on 1/1/20XX)*. In other words, all of our four Case Manager positions were filled at the end of both 2020 and 2021. One Case Manager was hired during each of those years for a total of three retained Case Managers, which yields a retention rate of 75% (3/4 x 100). The retention rate was lower in 2019, primarily due to terminations rather than resignations. The most common reason that Case Managers have given when they've left voluntarily has been the rate of compensation, followed by lack of flexibility in scheduling and lack of opportunities for advancement within the organization. Like almost every nonprofit organization in the region, we have been challenged to recruit and retain staff. The voluntary annual turnover rate in the nonprofit sector far outpaced the all-industry average even before the pandemic, and "The Great Resignation" has caused historically high turnover rates. We recognize that there has been a societal shift in the way the workplace operates, and have taken the following measures to improve retention:

- Increased compensation. We consulted third-party salary studies last year as we prepared our rate-setting submission; these included a local salary comparison complied by the Bayer Center for Nonprofit Management and an internal salary comparison that gauged the level of variance in individual staff positions. (Residential security personnel, who are subject to the terms of a collective bargaining agreement, were not included in the study.) Almost every salary was out of line with market—significantly, in some cases. At the time, we couldn't afford to pay our staff what they could command in the market. Our revenue comes from treatment reimbursements and, to a lesser extent, alternative housing per diems, and our rates were comparatively quite low. Recently, however, we received rate increases that now allow us to offer competitive salaries, and to continue to provide generous benefits.
- Work-life balance. Scheduling in our Community Services has always been flexible, to accommodate the needs and preferences of clients. We are currently adapting our residential programs to ensure that they comply with the ASAM Criteria, which pose coverage challenges that, in fact, present opportunities for Case Managers who prefer a nontraditional schedule. Although the schedules of LEAD Case Managers will be dictated in large

part by the needs of local police precincts, we would advocate for schedules that would also permit Case Managers to have the flexibility they need.

- Reduced stress and increased opportunity. There has been a welcome uptick in applications for employment at our organization since we increased salaries. Our goal this year is to stabilize staffing, improve communication and transparency, and add clinical and non-clinical positions that will enhance services; reduce workloads overall; lessen crisis management; improve communication, supervision and performance management; and provide the time and resources for more professional development.

Service Delivery and Relationship Building (35 points possible)

11. Describe how you will ensure timely service delivery within the three pilot Cohorts, especially related to arriving on scene when officers call for service. Also include where case managers and case management supervisors will be in general and how they will be shared among the Cohorts.

We can ensure timely service delivery by requiring that LEAD Case Managers be physically stationed in their Cohort community during their shifts, and can quickly travel to a Participant's location in a vehicle that they own, or in a vehicle leased by *Passages*. Our deployment plan makes some assumptions and would be subject to change based on the needs, expectations, and processes of our operational partners:

- First, we are assuming that the full complement of six LEAD Case Managers will not be needed until later in the first year of the pilot, because of the time it will take to develop consensus around appropriate protocols and to fully establish LEAD in the stakeholder communities. We anticipate a staggered hiring process, with the assignment of one Case Manager in each Cohort community in Months 1-3, for a total of 3 Case Managers; the addition of a fourth Case Manager, who will be assigned to the Cohort community with the highest number of referrals, in Months 4-6; and the addition of a fifth Case Manager, assigned per the same criterion, in Months 7-9. There will be six LEAD Case Managers in Months 10-12, with three assigned to each Cohort community unless demand dictates a different pattern.
- Second, we are assuming that there will be times when someone other than the assigned Case Manager might need to step in—for example, in the event that a Case Manager is engaged with a LEAD Participant when an officer calls.
- Third, we are defining "timely service delivery" differently, depending on the type of referral. A timely response to a community referral would be within 24 hours. Timely arrival to perform an assessment after an officer's call for an arrest or social contact referral would be within 60 minutes. This is not the standard in other jurisdictions, but we are erring on the side of caution to start and may shorten the window if experience suggests it. This also depends on what's realistic and acceptable from the officers' point of view, whether we will be meeting officers at the site of the encounter or at the precinct station, and what else we can do to save time once we arrive. We will also need a protocol for dealing with unexpected delays.

With six Case Managers, it should be possible to ensure on-call coverage for referral response and to schedule less time-critical assessments, being visibly engaged in the community, providing long-term assistance to Participants, and working with collaborative stakeholders. Until then, we might address contingencies by utilizing the fourth or fifth Case Manager as a "floater," who would make the initial contact with a prompt warm hand-off to the Case Manager assigned to the Cohort. We would prefer, however, that the Case Management Supervisor would be the professional who temporarily steps in when an assigned Case Manager is unavailable. We acknowledge that we may be underestimating the level of activity we should expect in the first six months of the program; we know that in Seattle, for instance, LEAD received several times the projected number of referrals in

the first year. But in either case, LEAD has so many moving parts that we question whether we should place the "timely response" aspect of service delivery solely in the hands of the Case Management Supervisor or of leaving it to be worked out between the Case Managers and first responders in each Cohort. The Case Management Supervisor will develop schedules as part of program oversight; Case Managers and first responders will be in regular communication. But we've identified the need for one person whose job is to know in the moment where every member of the LEAD Case Management Team is during "on call" shifts in every Cohort, and to coordinate the Team's movements to ensure timely service delivery. This is why we are proposing the addition of an Administrative Assistant, whose time would be shared with our Outpatient Clinic, and who would perform this essential "dispatch" function for the LEAD Case Management Team. We believe that this will more smoothly coordinate deployment across service areas and increase Case Management Supervisors' capacity attend to and meet the support needs of LEAD Case Managers.

12. Describe how case managers will be supervised to ensure that quality services are being provided and that case managers have the support they need.

As noted above in Response #9, being a Case Manager in a LEAD program poses challenges even for seasoned social workers and counselors, including those who have extensive experience with chemical dependency and Harm Reduction. LEAD is an innovative, transformative model. No matter how committed they are to its principles, LEAD requires operational stakeholders to step outside the boundaries of their usual roles. Change is never comfortable. In addition to the retention issues identified and discussed above in Response #11, and which will require attention in supervision, we've identified several areas in which LEAD Case Managers will be challenged to unlearn old habits, rethink old attitudes, and develop new skills. They will need particular support from their supervisor in these areas in order to provide quality services:

- Making difficult decisions about how to allocate financial resources. LEAD is unique in that it gives Case Managers financial resources with which to apply the non-displacement principle. When Participants' needs are extensive, as they are likely to be in LEAD, Case Managers may need support in determining the appropriate level of assistance, as well as in developing the process for doing this. For example, these decisions could be made on a case-by-case basis, by developing general guidelines, by setting a predetermined limit on each Participants' share of available funds, or through some combination of these approaches. Case Managers may also need support in developing guidelines for providing tangible goods, perhaps by limiting these expenditures to items that Participants need for work, to be in treatment, or to be comfortable in temporary housing.
- Dealing with systemic barriers, such as the shortage of and limitations on affordable housing. Affordable, appropriately supportive housing may be in short supply in the Cohort communities, and LEAD participants may not be eligible for the housing that is available even if LEAD provides the necessary financial assistance. Supervisors should identify trainings and resources that would help Case Manager develop responsive strategies; they should also advocate for upstream solutions.
- Collaborating across adversarial relationships. LEAD's operational stakeholders have different priorities that have historically made them unlikely allies. It could be a challenge for Case Managers to develop a comfort level with law enforcement, in light of previous experience, and to determine the boundaries of their LEAD collaboration. For example, Case Managers may worry that people in the community may not trust them if they seem too close to local officers, or that people will think that LEAD is really a scheme to recruit informants. Issues related to building trust with first responders are discussed in more detail below in Response #13.
- Cultivating an open mind. LEAD stakeholders must find common ground in order to have an authentic collaboration. As they develop mutually acceptable protocols and deepen their working partnerships, they may begin to see each other's points of view in a fresh light. They may even find themselves advocating for solutions

that forward the goals of the collaboration but would have seemed unthinkable in the past. Case Management Supervisors can support Case Managers in learning when—and when not—to abandon a fixed position.

13. How will you approach building trust between case managers and first responders (e.g., police) within the Cohorts?

LEAD programs across the country have shared that eliciting the buy-in of line officers is one of their most significant challenges, even when LEAD has strong support from police leadership. Some skepticism on the part of officers is understandable, especially the "hard chargers." Harm Reduction seems antithetical to the job officers are sworn to uphold. LEAD asks them to refrain from arresting someone who appears to be committing a crime and refer them instead to a program that never makes them do or stop doing anything—including using drugs, hanging out on the street, or even committing another crime. Officers may already be defensive about their perceived role in perpetuating the systemic inequities that LEAD is designed to address, especially in communities where racial tensions run high. Officers might also see LEAD as affecting them personally and financially, especially if they think it is part of efforts to defund the police. And because the ideology of the Drug Wars has permeated every system, officers might resist LEAD even though it's plain to them that what they're doing isn't working. Our approach would be, first, to try to see LEAD the way a first responder might see it.

Second, we would look to the PCGs to devise policy-level strategies specifically designed to promote and incentivize officer buy-in: e.g., diversion-related pay and the inclusion of LEAD referrals and participation among the criteria considered for pay increases and promotions. The LPCGs should also carefully consider how officers are told about LEAD. Other jurisdictions report that LEAD can't simply be imposed from the top; officers need to understand what Harm Reduction is and have a say in how the program works. The LPCGs should develop processes for obtaining regular feedback from all operational stakeholders, not just police officers, and these processes must be open and transparent. Police officers need reasons to trust that LEAD is intended for their benefit as much as for the benefit of Participants, and that LEAD Case Managers are there to support good policing, not to undermine it. By the same token, we will expect to receive the same respect that we show officers.

Third, as discussed above in Response #2, building trust takes time. In the context of LEAD, trust will require regular reinforcement in different settings, such as in Operational Workgroup meetings, which officers should be encouraged to attend so they can participate in case conferences; in joint trainings for Case Managers and officers, where they can deepen their understanding of LEAD together; and in regular communication between Case Managers and officers that is frank and respectful. As discussed above in Response #12, LEAD Case Managers may also need internal support so they can accept and balance the dual aspect of their role to provide direct service and give police extra help on the street. Ongoing training and dialogue between line officers and case management staff will be essential, and make collaborative problem solving in work meetings easier and more effective. Mutual trust should develop along with our skill at collaborating. But because work groups are primarily task-focused, we will also need to develop mutually acceptable methods of communication and information sharing outside of those meetings.

14. Describe how you will create and maintain a strong relationship with Cohort community members. Include how you will work with the CLTs and the LEAD community engagement coordinator.

One of the many transformative aspects of LEAD, from our perspective, is the way in which it engages such a wide range of members from the community, including directly affected individuals and potential participants; impacted family, friends and neighbors; community leaders; faith leaders; local researchers; and local businesses. We engage these stakeholders to a more limited degree in our programming, to support the individuals we serve. But LEAD's community engagement processes and infrastructure are what make it a meaningful upstream

intervention. We look to CONNECT, and especially the LEAD Program Manager and Community Engagement Coordinator, to develop formal processes and practices for engaging the community early and often, creating space for equitable community input and trust building, inviting the community into leadership teams, aligning the program with community priorities, and soliciting and acting on community input. We are eager to participate in this aspect of LEAD. These are some of the ways in which we would create and maintain a strong relationship with Cohort community members:

- Our LEAD Case Managers will have the advantage of their constant presence in the Cohort communities. They will have many opportunities for informal engagement, to solicit feedback on LEAD, and to represent LEAD in the community. They may also interact with many community members who don't know about LEAD. By explaining what the program is, how it works, and the outcomes it's produced in so many other parts of the country, they can build grassroots support for LEAD here. This will increase community buy-in and trust, and ultimately improve program outcomes.
- Community members all have different motivations and may need reassurance that LEAD is addressing their specific concerns. Being actively involved in LEAD on a CLT presents a certain amount of risk. For example, it may be difficult for stakeholders who participate in LEAD primarily because it addresses systemic inequities to accept the way LEAD is presented as a public safety program, and to justify their involvement in LEAD to their own constituencies. Business owners who want LEAD in their community because cleaning up the streets brings more people to their doors may be dismayed when LEAD Participants don't change their ways overnight, and wonder whether their concerns are being heard. As the frontline face of LEAD, our Case Managers can reassure community members, every time we see them, that their priorities are being met.
- We can also provide data on what we're doing, and the difference that LEAD is making. We will be prepared to present reports to LEAD governance bodies, and to groups within and outside the Cohort communities. Our information can give communities that may be considering the LEAD program a basis on which to decide how they might implement it. This may be especially important here in Allegheny County, which is fragmented into so many municipalities, each organized a little differently and each attached to its own local identity. Field-based outreach and service delivery looks different in the suburbs, for example, than it might in urban centers or small towns. Our input could help potential stakeholders visualize what LEAD might actually look like in their communities.

15. Discuss your organization's interest in and capacity to expand beyond the initial LEAD pilot into other geographic areas of Allegheny County, including the challenges you anticipate.

Passages to Recovery is very interested in participating in expansion of LEAD beyond the initial pilot: either by expanding existing Cohorts to include adjacent communities, or by bringing LEAD to communities outside the pilot areas. This would allow us to engage more people for whom our clinical services are functionally inaccessible. We have the capacity to provide LEAD Case Management anywhere in the County, if the model is expanded with fidelity and appropriately resourced. The main question is whether potential expansion communities understand, want and need LEAD, and whether they have the will and capacity to implement a complex, long-term, community-wide collaboration on the scale of LEAD. Even if they do, however, there will be challenges to increasing the geographic area of an existing Cohort. For example, Penn Hills is adjacent to the East Cohort and, like those Cohort communities, has pockets of suburban poverty and many residents who have been displaced from low-income neighborhoods in the City of Pittsburgh. But it is also the second-largest municipality in Allegheny County, and its sheer size would present logistical barriers to timely deployment of Case Managers across the Cohort. LEAD could also be expanded to new Cohorts: for example, to the Mon Valley River

communities that are near but not within the City of Pittsburgh. However, the Mon Valley spans five counties and consists of a great many small municipalities. The regionalization of the area could make collaboration unwieldy.

In addition to the difficulty of maintaining communication, building relationships, and establishing trust among stakeholders when LEAD Cohorts expand or increase, an even more important factor to consider are the capacity constraints on social services in those communities, especially, but not exclusively, in the areas of housing and treatment. Expansion could help Participants who are geographically mobile to access services, but not those who face the transportation barriers so common in this region. More to the point, those services have to exist. Allegheny County is rich in resources, compared to many counties in Pennsylvania, but it also has one of the highest levels of need. Saying that we will connect more people to services, especially when they have historically been disconnected from them, increases strain on systems of care that are already struggling to meet the need. We are willing to do everything we can to mine existing resources for LEAD clients, but we can't have a positive impact on Participants' lives unless we can deliver something to them. We are already aware of the barriers we'll face—e.g., finding affordable housing for Participants who are ineligible for subsidized special housing but will never be well enough to work and pay rent; finding housing for active drug users; locating mental health and harm reduction services in suburban communities that need but typically don't welcome them, etc. We would hope that, by documenting the unmet need, we can give members of the PCG and other decision makers the data to build a case for systemic changes in the funding and the fair distribution of services.

Data Collection and Reporting (20 points possible)

16. Describe your data collection and reporting plan. Please include: a description of what data you plan to collect to ensure the quality of case management and service delivery to Participants; how data will be collected and entered; whether you propose to use DHS's CMIS, ClientPath, or a different data entry platform; and how you will share data with University of Pittsburgh evaluators and DHS.

Passages to Recovery will work with DHS and University of Pittsburgh evaluators to ensure that the data we collect during the pilot establishes proof of concept and gives stakeholders and funders a basis for determining whether expansion is feasible, and how valuable LEAD might be in potential Cohort communities. Our role would be to provide data showing the extent to which LEAD Case Management referrals have been adopted in a Cohort community, and whether Participants have made progress toward the goals they set with Case Managers. Performance indicators would show whether case managers meet the expectations of other operational partners, who the LEAD participants are, what they need, and whether those needs were addressed.

The specific data points suggested in the RFP fit into those general categories, and would be included in the data we collect, track and report: 1) Response time to officers when called to an encounter, 2) Number of individuals referred to LEAD, and referral source, 3) Number of individuals enrolled in LEAD (Participants), 4) Demographics of LEAD Participants, 5) Type of care and services provided to Participants; 6) Tangible goods provided to Participants, 7) Number and type of referrals to services for Participants, 8) Number and type of successful connections to services for Participants, 9) Number of case management appointments attended by Participants; 10) Number of Participants making progress toward self-identified goals, 11) Outcomes for Participants, including housing, income, criminal legal system interactions, health insurance membership and other identified outcomes; and 12) Detailed qualitative data on Participants' experiences with LEAD, including successes and barriers.

We interpret "tangible goods" to include financial assistance provided per the non-displacement principle, along with groceries and urgently-needed essential items that Case Managers purchase for Participants, and

coffee/meals provided during sessions and encounters in the community. We would add other data points as we customize our data collection tools, as indicated.

Passages to Recovery has an ongoing QSOA with RecoveryLink, ™ which has developed the only electronic records system specifically designed to meet the needs of community recovery services providers. RecoveryLink™ is accessible, HIPAA-compliant, and can easily generate program data and reports monthly, annually and in real time. Our Peer and Family Recovery Support staff has used this customizable platform to collect participant demographics and all relevant service-related information since the inception of the program, including data collection and performance measurement indicators required by the GPRA Modernization Act of 2010. Robert D. Ashford, the CEO and founder of RecoveryLink™ is Executive Director of Unity Recovery, a well-established RCO that provides recovery services throughout the state. We were introduced to Dr. Ashford by our Program Manager at PA DDAP during implementation our grant-funded peer recovery supports program pilot. Dr. Ashford and Adam Sledd, Recovery Support Services Director at Unity Recovery, have generously given their time to provide us with informal technical assistance. The behavioral health professionals in the Police Assisted Diversion Program pilot in Philadelphia use RecoveryLink. ™ Unless there is a compelling reason for us to do otherwise, we would prefer to use it in the LEAD pilot as well. Sharing data with DHS and University of Pittsburgh evaluators could easily be accomplished by obtaining additional RecoveryLink™ user licenses; these can be configured so that person-level, identifiable data can be shared with DHS.

LEAD Case Managers will enter and collect data in RecoveryLink™ (or another platform, such as ClientPath, if that is more beneficial for the overall operation of the program) on all reporting indicators during or immediately after each engagement with Participants. The LEAD Case Management Supervisor will oversee and monitor data collection, analyze the data and prepare reports. LEAD Case Managers will also be responsible for client-level data entry into other systems, as required.

17. Describe your strategy for balancing: 1) the need to share Participant information with law enforcement stakeholders and within OWG meetings and 2) the need to maintain Participant privacy and preserve Participant-case manager relationships.

The only requirements for participation in LEAD are completion of a psychosocial intake and the signing of a release of information. As Participants sign that release, Case Managers will make sure that Participants understand they are giving permission for relevant information about their case to be shared with operational stakeholders, and be told who those stakeholders are. Participants will know the limits of information sharing, and also its rationale. For example, police officers who encounter Participants in the community after enrollment may treat them differently if they know the Participant is engaged in the program. Information about the Participant can also be useful to prosecutors in the exercise of their discretion, and in their interactions with victims when deciding on the disposition of existing or future cases that may involve the Participant. However, LEAD Case Managers are also bound by all state and federal confidentiality laws associated with those with substance abuse and mental health diagnosis, particularly 42 CFR Part 2, which imposes stricter standards than HIPAA. This standard would apply to any inquiry outside of case conferencing during meetings of the OWG, including in encounters in the community with members of the operational group, which the Case Manager cannot answer in detail without the Participant's consent. It must also be made clear to all operational stakeholders that the information discussed at meetings is confidential and cannot be shared outside the group without the permission of the Participant, even when that might appear to be helpful. Participants must have grounds to trust the LEAD process.

In a larger sense, the integrity of the Case Manager's relationship with the Participant is the heart of LEAD. It is the intervention. The Case Manager must always demonstrate that the Participant's well-being is their

first priority, and that the Participant has the right to every consideration of privacy. There could be times when Participants divulge information to the Case Manager that would affect their status and safety in the community: for example, who they hang out with, who else was involved in an incident, who their dealer is, etc. Officers might like to have this information; it might even advance the goals of the program, to the extent that it could lead to social contact referrals. But our primary motivation should always be the health, welfare, respect and dignity of the Participant; this information cannot be disclosed without the Participant's prior consent.

Budget (10 points possible)

18. Provide a detailed, line-item budget that reflects a realistic estimate of the costs associate with implementing and sustaining your LEAD pilot for the first year. Be sure to include staff salaries and benefits, transportation expenses, training costs, IT equipment, administrative costs, and any other costs needed to provide LEAD case management services, including tangible goods to be provided to Participants.

Please see Attachment.

19. Provide a budget narrative that clearly explains and justifies all line items in the proposed line-item budget.

Please see Attachment.

Scenarios (15 points possible)

Please briefly describe how you would like your LEAD case managers to respond in the following scenarios.

20. You are a LEAD case manager. You arrive at an initial intake interview with an older White man who has been arrested ten times for public intoxication in the last year. He tells you he's pretty sure he won't have enough money for groceries or rent this month since he just lost his job, and that he keeps falling asleep on the bus home and missing his stop, which sometimes means he gets stranded far from home and must hitchhike or walk home. What would you do or say in response?

- My first priority during intake is to build rapport and relationship, and address emergent needs. This Participant seems most worried about whether he'll be able to meet his basic needs, so I will join him there. After asking a few questions to break the ice ("Where are you from originally?" "What kind of work do you do?"), and express care ("Can I get you a bottle of water?") I'd say, "I'm going to ask you some questions now, so I can see how I can help you. Is that okay?"
- It seems possible that this Participant has a pattern of holding his circumstances together for a while, and then spiraling downward due to his drinking. But I won't jump to any conclusions about how self-sufficient and well he is, or rush to cover his expenses so his problems don't get worse.
- I want to get his take on his own situation, but I'm also going to assess how urgent his situation is. This allows me to accomplish two things: do something meaningful for the Participant right away and reassure him that his situation isn't as hopeless as he may think. I'd start by:
- Asking when he last ate, how much food he has on hand. If he is food insecure, I'd offer to get him groceries for the next few days, help him access emergency food, and sign him up for the Food Bank.

- I'd ask him questions to find out, and help him see, what resources he has—he seems unclear about this—and how we can help him access cash assistance, unemployment benefits, or rental assistance. I'd ask if he would like assistance in discussing a payment arrangement with his landlord, or making a budget.
- I'd use MI techniques to assess where he is about his drinking. Instead of asking directly, I'd start a conversation about how he lost his job; what else is happening when he falls asleep on the bus; what triggered his consumption before his arrests. I'd ask if he'd like resources and referrals for substance abuse and offer them if he says he needs and wants them.
- I'd make sure he gets something tangible out of this interaction, and that he knows I've got his back.

21. You are a LEAD case manager. You are called by a police officer in from the East Cohort. She says she thinks the Black woman she's encountered would be a good fit for LEAD. When you arrive, the woman is angry at the officer because she isn't allowing her to leave and angry at you for asking her questions. What would you do or say in response?

I'd immediately assess the dynamic between the officer and woman. This situation needs to be de-escalated, and I need to start to build trust with the woman without alienating the officer. At the same time, I need to be mindful that this woman is reacting not just to what's happening now, but to a lifetime of systemic inequities and disparities associated with police. This is true whatever the officer's race is—although, if the officer is a white woman, she may have no idea of the impact intersectionality has had on the other woman; she may even think that the woman's behavior is out of line, given that she's doing her a favor by referring her to LEAD. So, while the woman is my first priority, I also need to address what's going on with the officer:

- After greeting the officer, I'd ask her to excuse me for a moment while I talk to the woman. I'd introduce myself, thank her for waiting for me, and explain what I do and why I'm there. I'd ask whether she's okay and offer her something to eat or drink—I always have a stash of bottled water, juice, fruit, and energy bars in my car—while I turn, with her permission, to talk briefly to the officer. I'd stay calm throughout and address the woman respectfully by her first name (e.g., "Miss ___").
- I want to find out how well the officer knows this woman and her circumstances. I'd want to know how often she's encountered the woman before, and why she called me now. I want the woman to hear all of that, and that the officer doesn't want to arrest her. She wants to help her avoiding ever being arrested again. This should only take a few minutes. I'm going to be listening for whether this is a true social contact referral, and not an attempt by the Officer to "widen the net" by referring someone who does not fit the criteria for eligibility for LEAD (i.e., may need help but would not be arrested or involved in the criminal legal system). If she is not eligible for LEAD, I'd refer her for services, if she wants them, with a warm handoff. I don't want her to have waited so long, and to have become so upset, for nothing.
- If she is LEAD eligible, I'd thank the officer, turn back to the woman, and tell her a little more about LEAD. I'd explain that I'll need to meet her to do an intake within 24 hours and make those arrangements if she accepts. If she doesn't, I'd give her my phone number and ask her to call me if she changes her mind.
- I'd offer her a ride home and, if she accepts, drive her there in my vehicle.
- I'd call the officer later, to debrief. That's when we'd talk about how we might have done things differently, and how we'll handle similar situations in the future.

22. You are a LEAD case manager. You get a call from a police officer who recently referred a young adult Participant to LEAD. This officer is concerned because the Participant is still using substances. In

your meetings with the Participant, they've indicated that they are not interested in abstinence, but they are making some progress toward their goals of obtaining long-term housing and stable income. What would you do or say in response?

This is a great chance for me to clear up confusion this Officer must have about LEAD, and especially about harm reduction. He may have called me because he's genuinely concerned about the Participant's wellbeing; because he feels like LEAD must not be working, if the Participant's still using; because he thinks I'm not doing my job; or perhaps all of the above. Here's how I'd address those concerns:

- I'd thank him for following up with me. I'd acknowledge him for paying attention and for caring about this Participant.
- I'd let him know that I meet with the Participant regularly, so I have a good idea of how he's doing. I'd say something like, "You know his problems didn't happen overnight, and they're going to be very hard for him to overcome. It's going to take time. In his case, any progress at all is a really good sign." Then I'd tell him, without being specific, that the Participant has set some goals and is moving toward them. My purpose here is to make the officer feel like he did a great thing when he referred this Participant to LEAD, and that his decision has led to the good things that are happening in this Participant's life.
- Then I'd try to educate the officer about Harm Reduction. Hopefully, he's had some training about it already, so I'd say something like, "___ may be young, but he's been through a lot. I never condone his drug use, but I accept that's what he might choose to do right now. That's up to him. What I can do is help him stay alive and out of trouble, and help him start to pick up the pieces of his life. Given where he's at, that would be a big win. He deserves a win, just like anybody else, whether he's using or not."
- Then I'd say, "It must be frustrating for you, not to know more about what happens to the people you refer to LEAD. I can see how you'd want to know, especially if you see them all the time when you're on patrol. Can you come to the Operational Workgroup meetings? They're every two weeks on __ at __ p.m. That's where we talk about cases. If that doesn't work with your schedule, give me a call whenever you have questions about the program in general or how someone you've referred is doing. I can't tell you everything that's going on with them unless I have permission, but I can give you a general idea. I think it's great that you're interested. I'm going to let ___ know that you were asking about him, and that you wanted to make sure he's okay."
- After I finished talking to the officer, I'd do just that: get in touch with the Participant to let him know that the Officer was asking about him. I'll tell him that I talked to the Officer and reassured him that the Participant was doing okay. I'll let him know that I wouldn't give the Officer more specific details unless I had the Participant's consent. That way he knows I'll never talk about him behind his back, especially not to the police.

Passages to Recovery, Inc. LEAD Case Management Program Budget

Personnel Services:				**Program Costs**
Salaries:	Hourly Rate		# of Staff	
LEAD Case Manager	$	21.88	6	$ 204,750.00
Case Management Supervisor	$	26.44	1.5	$ 82,500.00
Director of Community Services	$	31.25	0.25	$ 16,250.00
Administrative Assistant	$	18.00	0.5	$ 18,720.00
Benefits:				
LEAD Case Manager	26%			$ 53,235.00
Case Management Supervisor	26%			$ 21,450.00
Director of Community Services	26%			$ 4,225.00
Administrative Assistant	26%			$ 4,867.20
Total Personnel Services:				$ 405,997.20
Client Services:				
Transportation Assistance				$ 5,000.00
Client Financial Assistance				$ 75,000.00
Street Outreach				$ 25,000.00
Total Client Services:				$ 105,000.00
Supplies:				
Office Supplies				$ 4,950.00
Telephone				$ 8,640.00
Internet				$ 750.72
Computers				$ 11,700.00
Printers				$ 7,440.00
Total Supplies:				$ 33,480.72
Employee Travel:	Per Mile			
Mileage	$0.59			$ 20,000.00
Total Employee Travel:				$ 20,000.00
Other Costs:				
Rental Space				$ 36,344.04
Lease Vehicle				$ 6,000.00
Vehicle Maintenance/Insurance				$ 5,400.00
Staff Training				$ 9,000.00
Database and Tracking				$ 16,470.00
Indirect Costs (10%)				$ 63,769.20
Total Other Costs:				$ 136,983.23
Total Program Budget:				$ 701,461.15
GRANT AWARD				**800,000.00**
				$ 98,538.85

Passages to Recovery, Inc.
LEAD Case Management Program
Budget Narrative

The budget submitted with this proposal is our current realistic estimate of the costs associated with implementing and sustaining a LEAD pilot for the first year. The program design that this budget supports includes all program components described in the RFP, and requested in the Response Form, as well as other expenses that we anticipate and recommend. Because the design is subject to change, depending on negotiations with DHS and the needs and priorities of operational stakeholders, we submit this budget to demonstrate our thinking on how we would allocate program funds, generally; for example, we have allocated approximately 15% of our total budget toward client services, including financial assistance per the non-displacement principle, purchases to meet Participants' basic needs, and expenses associated with outreach and service delivery in the community. We have also allocated funds for supplies in amounts that seem reasonable now but may be inadequate during the pilot period, given global economic and political uncertainties. Similarly, we may discover that in the current hiring environment we will need to raise salaries in order to attract the right candidates. Rather than budget to the limit of funds available for this program, we have left a "cushion" of almost $100,000 so we can propose adjustments to one or more line items during negotiations, without taking those funds from another line. We realize that this approach is unorthodox but we believe it is correct, due to the complexity of LEAD and its collaborative demands.

Personnel Salaries: We have budgeted for 7 Full Time and 3 Partial Time personnel (i.e., full-time staff who will be hired during, but not at the beginning of, the pilot year): 6 Case Managers (Starting with 3 and hiring 1 additional staff member each quarter, depending on caseloads); 2 Full Time Supervisors (1 starting in the beginning and 1 joining in the middle of the program, comprising 1.5 FTEs), 1 Partial Time Administrative Assistant (50% of time spent on LEAD program, for 0.5 FTEs) and 1 Partial Time Director of Community Services (25% of time spent on LEAD program, for 0.25 FTEs).

Personnel Benefits: The fringe benefit rate amounts to 26%, which includes the following benefits: FICA (8%), Unemployment Compensation (3%), Health Insurance (13%), Dental and Vision (1%), and Life and Disability (1%). Our health insurance premiums are 100% employer paid for the employee, with reasonable premiums payable by the employee for spouse and family coverage.

Client Services: Several types of expenses are included in this line, all intended to provide financial and/or basic needs assistance: 1) The program will provide transportation assistance to clients to help individuals get to and from pro-social activities, including support meetings, drop-in centers, and other appointments, occasions and events that promote harm reduction. 2) The program will provide tangible assistance to Participants who urgently need essential items and have no funds with which to purchase them. 3) The program will have funds available so that Case Managers can more quickly place Participants in services such as housing, MAT, etc., that would otherwise require long wait times or when funding is not currently available—as is often the case with utility assistance programs that are seasonal and can be depleted before their projected conclusion dates. 4) The program will have funds available so that Case Managers can provide some benefit to Participants, and potential Participants, in the regular course of street

outreach. This would include funds for meals, non-alcoholic drinks, clothing, and prepaid cards if appropriate in the circumstances.

Supplies: Supplies include but are not limited to general office supplies, technology accessories, print materials, etc. Each of the 9 program employees will be provided with a cell phone and computer to be used in service delivery, and to facilitate communication with clients, first responders, collaborative stakeholders, across the agency, and for other work-related purposes. A dedicated leased printer will allow program staff easily and efficiently to produce program-related copies and documents. Internet service will be also provided to all program personnel.

Employee Travel: Employee travel up to approximately 33,900 miles will be reimbursed at the federal mileage rate. This will include travel to, from, and in connection with LEAD program activities. We will write a separate reimbursement policy for this program, which will align with federal guidelines for social service programs.

Other Costs: Program staff will spend a majority of their time out in the community. The program will, however, have a physical location in Swissvale, convenient to the Parkway, where staff members will have "hotel desks" and can complete administrative tasks and conduct meetings (Rental Space cost).

The program will also lease a vehicle to allow for circumstances in which staff are unable to transport Participants in their personal vehicle. With the leased vehicle, there will be maintenance/fuel and insurance costs.

The program will also provide staff trainings on program competencies and professional development. We have been unable to determine the specific trainings that will be provided in kind by the LSB, or the frequency with which they will be available. We assume that the LSB trainings will focus on the LEAD principles and their implementation. Until we have more information, we have allocated training dollars for trainings with complementary or supplementary content.

The program will maintain a database and tracking system through our existing contractual partnership with RecoveryLink™. This software package is uniquely suited to recovery community organizations and peer recovery support providers; it provides a suite of digital tools platform designed to improve recovery outcomes. RecoveryLink™ provides a HIPAA compliant, integrated recovery record platform that is compatible with many other systems. We use RecoveryLink™ in our Peer and Family Recovery Supports Program. We can lock in our current price per license, to avoid future increases, and can provide affordable licenses to personnel at DHS and CONNECT if needed.

Finally, the Indirect Costs calculation is based on the 10% de minimis amount, which includes standard expenses for back office administration, accounting, IT services, HR services, insurance, etc.

Passages to Recovery, Inc.
Draft Job Description
LEAD Case Manager

Overview of the LEAD Program

Law Enforcement Assisted Diversion (LEAD) is an inherently collaborative community-based public safety and order program that reduces police contacts and chronic criminal law violations. LEAD is a non-coercive program that diverts eligible individuals who have repeated encounters with law enforcement, and who are in extreme need due to poverty, mental health issues and/or substance use disorder, to long-term intensive case management instead of arrest and further involvement with the criminal justice system. LEAD gives law enforcement officers, who are the default responders for people struggling with unmet behavioral health needs, an option other than arrest in a moment of encounter. LEAD provides true public safety by addressing the underlying personal and systemic challenges that result in repeated arrest and incarceration. It provides equity-based solutions for individuals who have been historically overrepresented in the criminal justice system due to the racist criminalization of poverty and homelessness, as well as the "War on Drugs" which has disproportionately harmed communities of color. LEAD is a national model, guided and operated by an array of local stakeholders in the communities that implement it.

Job Summary

This field-based position is a critical component of the LEAD project, providing engagement and intensive case management services to individuals who have repeated contacts with law enforcement, who are suspected of committing specified low-level crimes in the moment of encounter, or are known to be at risk for arrest for these offenses in the near future. LEAD Case Management is based on non-negotiable principles that provide the essential framework to support Participants referred to the program: a harm reduction philosophy, a client-centered and driven approach, intensive case management, a non-displacement principle, peer outreach and counseling, a trauma-informed care perspective, specially-tailored interventions to address individual and community needs, and cultural competency. The LEAD Case Manager provides low barrier continuous long-term services to a case load of approximately 20-25 individuals. Set hours may include evening or after-hours shifts.

LEAD Case Managers provide Participant-tailored, long-term comprehensive case management services that are consistent with LEAD policies. In this position, your duties and responsibilities include but are not limited to:

Direct Service

- Be on-call during assigned shifts to take referrals from officers and dispatch quickly to referral locations within the Cohorts.
- Respond to and follow-up on social contact and community referrals in a timely manner, and according to processes determined in collaboration with the Operational Workgroup.
- Initiate engagement, obtain consent, and complete an initial screening with individuals referred by law enforcement, service providers, community members and authorized others.
- Assess Participants for immediate needs, as well as for housing status, substance use dependency, physical health, mental health, health insurance and other needs.

Passages to Recovery, Inc.
Draft Job Description
LEAD Case Manager

- Engage Participants in street level outreach, at their homes and in the community to establish an ongoing working relationship and offer services.
- Collaborate with Participants to develop, accomplish and periodically update an individualized service plan that addresses the Participant's basic needs, health care and insurance needs, substance use dependency, mental health, safety, and/or self-change.
- Connect Participants to Harm Reduction services for drug users, if indicated.
- Transport Participants as needed, including from police encounters and to/from case management meetings, treatment sessions, and appointments.
- Help Participants reach the goals they set in their individualized service plans (e.g., help them to access human services, navigate local resources, complete applications and forms, and accompany them to appointments)
- Help Participants access federal and state social programs including cash assistance, health insurance, food assistance, housing subsidies, energy and utilities subsidies and assistance, education and childcare assistance, and similar programs operated and administered in the nonprofit sector.
- Help Participants find and maintain housing.
- Help Participants with basic financial management, including creating a budget and taking them shopping.
- Advocate for Participants with other providers and within the criminal legal system, at court appearances and via written communication, in a manner that advances the LEAD core principles.
- Work closely with community providers to refer and place parents into services that also accommodate their children, wherever possible.
- Identify systemic barriers and potential solutions that address the needs of Participants, and share those observations with local stakeholders responsible for LEAD.

Administrative

- Develop and maintain Participant files according to LEAD, County and state requirements.
- Consistently utilize internal processes and procedures that facilitate communication and coordination within the LEAD Case Management Team.
- Utilize required database technology to support Participants in staying connected to their current service providers.

Partnership-Related

- Develop and maintain collaborative relationships with LEAD partners, including law enforcement officers, DHS and ACHD staff, LEAD program staff, other relevant providers, and other community stakeholders who can support Participants.
- Regularly communicate with other case managers working on similar diversion initiatives in the County and elsewhere, to share lessons learned and collaboratively develop best practices.
- Attend and participate in meetings of the Operational Work Group, the group in the LEAD governance structure that is responsible for day-to-day execution of LEAD operations in the Cohort(s) where they are working.

Passages to Recovery, Inc.
Draft Job Description
LEAD Case Manager

Must Haves for this Position:

- A commitment to social and racial justice.
- Experience building trust with, and a passion to serve, populations impacted by extreme poverty, behavioral health conditions including mental illness and substance use disorder, and who have had repeated encounters with the criminal legal system.
- Ability to create and maintain collaborative partnerships with police officers, other partners from the criminal legal system, and community and government stakeholders.
- A trauma-informed perspective, and believe in/practice a non-coercive, Harm Reduction, Participant-driven philosophy.
- Experience supporting and advocating for Participants within the criminal legal system, including at court appearances and in written communication.
- Street outreach experience providing services and resources to LEAD target populations.
- Experience working with groups of diverse individuals in respectful, equitable and inclusive ways.
- Capacity to work with participants in the long term with acceptance and patience.
- Ability to advocate, effectively communicate, solve problems and stay calm under pressure in high-stress situations.
- Regularly engage in self-care.
- Valid driver's license, good driving record, and a personal vehicle to travel between work locations and transport Participants.
- MUST HAVE TIES TO the North, South, or East Cohort areas, and be familiar with resources in those communities. Residence in or near the Cohort areas is preferred.
- LIVED EXPERIENCE with the criminal legal system, homelessness, substance use, and other behavioral health or human service needs is preferred.

Required Combinations of Education and Experience:

- A Bachelor's degree from an accredited college with a major in sociology, social welfare, social work, psychology, gerontology, anthropology, other related social sciences, criminal justice, theology, nursing, chemical dependency, counseling or education.
- A registered nurse, with 2 years' experience in public health.
- An Associate degree from an accredited college with a major in sociology, social welfare, social work, psychology, gerontology, anthropology, other related social sciences, criminal justice, theology, nursing, chemical dependency, counseling or education; and one year of direct client experience in a health or human service agency.
- A high school diploma or GED, and 12 semester credit hours in sociology, social welfare, psychology, gerontology, anthropology, or other social sciences, criminal justice, theology, chemical dependence, nursing, counseling or education; and two years of experience in public or private human services with one year of direct client contact.
- A high school diploma or GED, and five years of experience in public or private human services with two years of direct client contact.

Passage to Recovery, Inc.
LEAD Case Management Supervisor
Draft Job Description

Overview of the LEAD Program

Law Enforcement Assisted Diversion (LEAD) is an inherently collaborative community-based public safety and order program that reduces police contacts and chronic criminal law violations. LEAD is a non-coercive program that diverts eligible individuals who have repeated encounters with law enforcement, and who are in extreme need due to poverty, mental health issues and/or substance use disorder, to long-term intensive case management instead of arrest and further involvement with the criminal justice system. LEAD gives law enforcement officers, who are the default responders for people struggling with unmet behavioral health needs, an option other than arrest in a moment of encounter. LEAD provides true public safety by addressing the underlying personal and systemic challenges that result in repeated arrest and incarceration. It provides equity-based solutions for individuals who have been historically overrepresented in the criminal justice system due to the racist criminalization of poverty and homelessness, as well as the "War on Drugs" which has disproportionately harmed communities of color. LEAD is a national model, guided and operated by an array of local stakeholders in the communities that implement it.

Job Summary

This position is critical to the smooth functioning of the LEAD program and the effective allocation of services and resources to LEAD Participants. The Supervisor is responsible for day-to-day execution and delivery of services in the LEAD program, and oversees the work of LEAD Case Managers through regularly scheduled individual meetings, supervision, and consultation as needed when questions arise. The Supervisor ensures that LEAD Case Managers have the training and ability to follow the core principles of LEAD, by e.g., supervising their performance, occasionally accompanying Case Managers out in the community, monitoring their progress, reviewing/checking their documentation, and soliciting feedback from Participants and operational stakeholders. Above all, the Supervisor creates an environment of support in which LEAD Case Managers can best implement the strategies of the LEAD program and further the goals of the LEAD collaboration.

The LEAD Case Manager Supervisor provides support to ensure that Case Managers provide Participant-tailored, long-term comprehensive case management services that are consistent with LEAD policies and principles. In this position, your duties and responsibilities include but are not limited to:

Supervision

- Provide guidance and direct supervision to ensure that LEAD Case Managers are engaging clients through outreach and continuous assertive engagement strategies, trusting relationships, and individually tailored case management services.
- Use culturally-responsive, strengths-based resiliency practices to provide support for Case Managers with lived experience related to LEAD Participants and/or experiencing secondary trauma; help all LEAD staff manage stress, avoid burnout, and be successful in the workplace.

- Facilitate daily shift debriefs, as well as weekly individual supervision and monthly group supervision.
- Step in on a case, as needed, on a temporary basis.
- Facilitate conflict resolution between supervisees and other staff or partners.
- Provide creative solutions to remove situational roadblocks that LEAD Case Managers encounter.
- Develop and maintain channels of communication that keep the LEAD Case Management Team well-informed and aligned with the policies and decisions of the Operational Workgroup in the LEAD Cohorts.
- Model and ensure adherence to the LEAD core principles and the Patient Bill of Rights.

Administrative

- Develop and maintain all Participant files from all Case Managers, to ensure that they comply with LEAD, County, and state requirements.
- Develop and monitor schedules to ensure appropriate coverage across LEAD Cohort areas; identify, schedule and attend appropriate staff trainings, including trainings provided by the LEAD Support Bureau and/or its partners.
- Ensure that the program's discretionary financial resources are used appropriately; track their allocation and uses, and report on expenditures as the program's financial steward.
- Enter, track and share quantitative and qualitative data on all LEAD referrals and Participants with DHS and other partners, as required, via a live feed or other agreed-upon methods; prepare monthly service engagement reports; and work with DHS, the LEAD Program Director and evaluators from the University of Pittsburgh to create and refine data collection processes.
- Prepare and deliver presentations on program reports to LEAD governance bodies and community groups.

Partnership-Related

- Develop and maintain relationships with relevant providers and housing stakeholders, law enforcement officers, DHS and ACHD staff, LEAD program staff, and other community programs and organizations that can support Participants.
- Represent the LEAD program in the community, and to community stakeholders, using effective communication and strategic partnerships to best leverage the LEAD program's strengths and contribute to its success.
- Work with the Operational Workgroup to develop the hiring and performance management process for LEAD Case Managers; this may include screening, interviewing, participating in group hiring decisions, and/or providing feedback on those decisions.
- Review and interpret financial reports, and make service and programming recommendations, based on this information, to the Director of Community Services and LEAD operational and community partners.
- Support LEAD Case Managers during Operational Workgroup meetings, including the review and staffing of prospective referrals and active LEAD Participants, and of allocations of assistance pursuant to the non-displacement principle.

- Help the Operational Workgroup to define, develop, improve and implement LEAD policies and procedures.
- Identify gaps in and barriers to access to community resources and advocate for systemic change.

Must Haves for this Position:

- A firm belief in the core principles of LEAD and a demonstrated stance in support of Harm Reduction practices.
- A commitment to racial equity, inclusion and social justice.
- Supervision skills, including a culturally competent trauma-informed approach that recognizes the origins of personal decision-making patterns.
- Ability to inspire, motivate and manage others, including those with lived experience.
- Creativity and problem-solving skills.
- The demonstrated ability (e.g., open-minded, well-organized, adaptable, effective communicator, systemic and critical thinker) to create and maintain collaborative partnerships with police officers, other partners from the criminal legal system, and community and government stakeholders.
- Ability to make quick decisions through a Harm Reduction lens; ability to make wise and critical decisions that can provide balance and support, and improve workplace culture.
- Searching self-evaluation skills of themselves in the supervisory role.
- Valid driver's license, good driving record, and a personal vehicle to travel between work locations and occasionally transport Participants.
- Experience providing services to individuals with addiction from a Harm Reduction perspective.
- Experience with case management, homelessness, and co-occurring disorders.
- Ties in the North, South, or East Cohort areas and/or familiarity with resources in those communities is preferred.
- Past supervisory experience is preferred.

Required Combinations of Education and Experience:

- A Master's degree or above from an accredited college with a major in sociology, social welfare, social work, psychology, gerontology, anthropology, other related social sciences, criminal justice, theology, nursing, chemical dependency, counseling or education which includes a practicum in a health or human service agency.
- A Bachelor's degree with a major in sociology, social welfare, social work, psychology, gerontology, anthropology, other related social sciences, criminal justice, theology, nursing, chemical dependency, counseling or education, and two years of direct care experience in public or private health or human services.
- A registered nurse with three years of direct care experience in public or private health or human services.

RECOVERY LINK

Candice Crosgrove, Director
Outpatient and Community Services
Passages to Recovery, Inc.
1400 South Braddock Avenue, Suite 2
Pittsburgh, Pennsylvania 15218

02-22-2022

Dear Candice,

RecoveryLink offers recovery community organizations, peer recovery support providers, and enterprise health systems a suite of digital tools platform designed to improve outcomes through systems transformation. Our platform is built on our best-in-class electronic health record system, the RecoveryLink™ electronic recovery record, which offers integrated Telehealth/Telerecovery, a novel on platform staff supervision process, real time dashboard reporting, and monthly and quarterly reporting capability. Our platform is based on a recovery-oriented system of care and recovery management approach and is supported round-the-clock. RecoveryLink™ tools offer evidence-based recovery planning and recovery capital domains to promote long-term engagement and success.

RecoveryLink™ is integral to the services we provide at Unity Recovery, where I serve as Executive Director. Unity is a recovery community organization serving the Philadelphia community. We believe recovery is an individualized and dynamic process, and support those with mental health or substance use disorders, no matter the pathway they use. In 2016, Unity was just an idea; our whole-person approach has resounded so successfully within the recovery community that we served more than 400,000 individuals with recovery supports in 2020, at the height of the COVID-19 pandemic. Harm reduction is one of our core principles. We enthusiastically support programs that give officers an alternative to arrest when they encounter individuals who will only suffer more from additional involvement with the criminal legal system. We have productive relationships with many like-minded organizations, including the stakeholder partners in the Philadelphia Police-Assisted Diversion Program, which utilizes the RecoveryLink™ platform.

We are pleased that communities in Allegheny County are embracing the LEAD Program. I'm writing to express my support of Passages to Recovery's application to provide LEAD Case Management Services to the Cohort communities in the pilot. I became acquainted with Passages to Recovery in 2020, when Passages one of nine providers in the state selected by PA DDAP to pilot Peer and Family Recovery Supports, which were not widely known or readily available at the time in western Pennsylvania. Peer recovery supports work because they come from a place of connection and relationship, so it was a great challenge to start such a program during a pandemic. Passages dealt with those challenges and has done innovative outreach to establish the program and provide quality services that have earned the trust of the recovery community.

As we did during that time, RecoveryLink™ is willing to support Passages by sharing our experience and assisting with the integration of our platform as a tool to facilitate, manage and

RECOVERY LINK

report on service delivery. Our mission, goals and values align. We are confidence that Passages to Recovery has the ability to perform in accordance with the core principles of LEAD, and will provide high quality case management services to all participants referred by the LEAD stakeholders. We look forward to working with Passages on this worthy project.

Sincerely,

Robert D. Ashford, PhD, MSW
CEO and Founder