Warm Handoff and Recovery Support Services (WARM)
Scope of Services and Deliverables

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About this document

This document is a portion of the Warm Handoff and Recovery Support Services (WARM) Notice of Funding Opportunity (NOFO). All application materials are available on the Illinois Regional Care Coordination Agency website via the Funding Opportunities page.

A. Description of Funding Opportunity

This Notice of Funding Opportunity (NOFO) sets forth the requirements for program applications to fund peer recovery support services delivered using a warm handoff model to individuals with opioid use disorder (OUD) or polysubstance use disorder who are experiencing a housing transition.

A.1. Authorizing Statutes or Regulations

Awardees are required to adhere to the requirements outlined in the following:

- Grant Accountability and Transparency Act (GATA), 30 ILCS 708
- Illinois Administrative Code, Government Contracts, Title 44, Part 7000
- Grantmaking, Procurement, and Property Management, and federal regulations under Grants and Agreements, 2 CFR 200
- The requirements and policies outlined in the Illinois Department of Human Services Division of Substance Use Prevention and Recovery (IDHS/SUPR) Contractual Policy Manual

A.2. Background

In 2013, 1,072 people in Illinois died of an opioid overdose.[1] In 2020, the number of fatal overdoses reached 2,000, and in 2021 and 2022, surpassed 3,000.[2] The opioid overdose epidemic has accelerated nationwide.[3] To hold companies responsible for their roles in the opioid crisis, the Illinois Attorney General has engaged in multiple investigations, lawsuits, and settlements with opioid manufacturers, distributors, and chain pharmacies. The funds from the settlements will support recovery in communities hardest hit by the opioid crisis and throughout the state.

The Illinois Office of Opioid Settlement Administration (OOSA) is the entity responsible for planning, administering, and managing 55% of the funds received from opioid settlements according to the Illinois Opioid Allocation Agreement and Executive Order 2022-19. The established processes ensure transparency and consideration of regional needs such as overdose rates, disparities created for specific populations, and resources to address opioid-related harms. The OOSA is housed within IDHS/SUPR.

About IDHS/SUPR

The mission of IDHS/SUPR is to provide a recovery-oriented system of care along the continuum of prevention, intervention, treatment, and recovery support where individuals with substance use disorder (SUD), those in recovery, and those at risk are valued and treated with dignity and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated. IDHS/SUPR is working to counteract systemic racism and inequity and to prioritize and maximize diversity throughout its service provision process. This work addresses existing institutionalized inequities, aims to create transformation, and operationalizes equity and racial and social justice. It also focuses on creating a culture of inclusivity for all, regardless of race, gender, religion, sexual orientation, or ability.

A.3. Need

The funds from the settlements will support prevention efforts in communities hardest hit by the opioid crisis and throughout the state. Fund distributions must be used equitably in service areas disproportionately affected by the opioid crisis as outlined in the Illinois Opioid Allocation Agreement, for example, areas with the following characteristics:

- High opioid fatality rates, including
  a) Counties other than Cook County with a crude rate of 1.8 or greater per 100,000 people and
  b) Zip codes within Cook County with more than 100 overdoses (fatal and nonfatal) within the most recent year included in the Illinois Opioid Data Dashboard
- Concentrated poverty, including
  a) Counties other than Cook County with a poverty rate greater than 12 percent and
  b) Zip codes within Cook County with a poverty rate greater than 12 percent, per the U.S. Census Bureau
- Concentrated firearm violence, including communities eligible for Reimagine Public Safety Act funding

- Other conditions that hinder the communities from reaching their full potential for health and well-being, including counties other than Cook with a crude nonfatal overdose rate of 4.0 or greater per 100,000 people, as listed in the Illinois Opioid Data Dashboard

Individuals with OUD experiencing homelessness or housing transitions have disparate rates of overdose death and challenges with maintaining continuity of care that may make it difficult to maintain treatment. For example,

- People with an opioid use disorder are at an increased risk of overdose death following discharge from a hospital setting.[4]
- Overdose is the leading cause of death for people exiting incarceration.[5]
- Individuals who receive medication-assisted recovery (MAR) services while incarcerated often fall through the cracks upon release for numerous reasons, such as unexpected early release, lack of transportation, lack of phone, lack of insurance, lack of photo identification, and low treatment engagement.[6]
- Overdose has been identified as a leading cause of death among people experiencing homelessness.[7] Most overdose deaths among people experiencing homelessness involve opioids and they are significantly more likely to die from an overdose death when compared to the general population.[8]
- Additionally, continuity of care can become complicated for individuals receiving shelter-based MAR services when they unexpectedly move into housing in the community.[9]

These risks highlight the need to link this population to evidence-based opioid overdose prevention strategies like Overdose Education and Naloxone Distribution and opioid use disorder treatment including Medication Assisted Recovery (MAR).

Peer engagement and warm handoffs have been shown to improve a variety of outcomes for person with OUD and polysubstance disorders. Peer-based teams can improve continuity of care across various transitions, including individuals treated in a hospital for an opioid overdose,[10] individuals receiving a first dose of buprenorphine during an emergency department visit,[11] and individuals beginning MAR in jails.[12] The National Association of Counties has determined the warm handoff, defined as "a transfer of care between service providers through face-to-face, phone, or video interaction in the presence of the person being helped,"[13] to be a best practice in responding to the opioid epidemic.

Despite the body of research indicating effectiveness, warm handoffs are not uniformly used in jails, prisons, homeless services, and hospitals. For example, a 2020 Illinois Public Health Institute study of opioid treatment services in Chicago revealed that hospitals studied over-relied on referrals, rather than warm handoffs, and that the wider opioid treatment system over-relied on informal partnerships, rather than cross-sector collaboration.[14]

A.4. Funding Source

The Office of the Illinois Attorney General has certified—and the Governor's Opioid Overdose Prevention and Recovery Steering Committee has approved—the use of up to $6 million over three years from the Illinois Opioid Remediation State Trust Fund (Fund) for Warm Handoff and Recovery Support Services for priority populations in accordance with the Illinois Opioid Allocation Agreement and the Fund allocation process. In April 2023, IDHS/SUPR awarded Advocates for Human Potential, Inc. (AHP) grant to serve as the Regional Care Coordination Agency (RCCA). The RCCA administers subawards with organizations providing prevention, intervention, treatment, and harm reduction services for people with SUDs in accordance with state-approved strategies.

The RCCA is now accepting applications to fund programs to provide Warm Handoff and Recovery Support Services (WARM). Applications will only be accepted through the online application available at the Illinois Regional Care Coordination Agency website via the Funding Opportunities page.

A.5. Scope of Services

WARM programs must provide peer recovery support services using a warm handoff model to individuals with OUD or polysubstance use disorder (including opioids), who are in housing transition, including:

- Pending or recent discharge from a jail, prison, hospital, or inpatient treatment.
- Transition within the justice system (e.g., monitored community release or completing probation or parole).
- Current homelessness or transition from homelessness into a housing setting.
- Exiting a recovery residence (e.g., peer-run recovery residence or recovery home).

Services shall be designed for a population disparately affected by the opioid crisis, and no person shall be denied service because of ongoing substance use or a return to use.

IDHS/SUPR has promoted two potential models for warm handoff initiatives, and these may be used to support the development of program service delivery models. Alternatives may be proposed.

- In co-located warm handoff services, peer recovery support specialists employed by an outside agency work within a setting such as a hospital, jail, or shelter, where they establish a relationship with individuals with OUD, engage them in SUD treatment, and provide ongoing recovery supports. An advantage of this model is that a single program can serve multiple sites, but staff coverage must be sufficient to ensure all discharges are accommodated, and privacy concerns must be addressed.
- In integrated warm handoff services, a jail, hospital, or shelter conducts Screening, Brief Intervention, and Referral to Treatment, hiring and training peer recovery support specialists to transition individuals who screen positive for OUD to community-based care.

IDHS/SUPR also developed workflows and a checklist for conducting warm hand-offs as part of its 2021 MAR toolkit that may be used to inform development of the program model. For example, best practices include:

- When warm handoffs to MAR are made, it is critical that key information, such as physical exam results and lab results, are communicated to the MAR provider.
- The person facilitating the warm handoff should offer harm reduction services, such as naloxone and information about preventing infectious disease.
- In addition to screening, counseling, and transmitting information, transportation to the initial meeting is a key element of warm handoffs.

The IDHS/SUPR toolkit focused on transitions from hospitals. However, the Substance Abuse and Mental Health Services Administration's (SAMHSA) toolkit on transition from jail or prison makes similar recommendations about warm handoffs, including the need for transportation and face-to-face introductions. However, transition from correctional settings may require earlier contact to address issues such as enrollment in health coverage.

Task 1. Fulfill Award Administration Requirements

The subrecipient must fulfill obligations outlined in section G. of the NOFO, Award Administration Information, including

(a) Organizational needs assessment,
(b) Implementation and sustainability plan development,
(c) Equity and racial justice plan development,
(d) Performance reporting,
(e) Fiscal reporting, and
(f) Participating in training and technical assistance (TTA).

Task 2. Coordination and Collaboration

The subrecipient must establish relationships, agreements and protocols to implement the model. Relationships should include, as aligned with the proposed model, the following:

a. One or more hospital, jail, prison, or provider of homelessness services; and
b. MAR providers, other community-based SUD treatment providers, homelessness Continuums of Care, providers of housing/homelessness services, overdose education and naloxone distribution programs, recovery community organizations (RCOs), and harm reduction groups.

The subrecipient must complete the following activities:

(a) Within 60 days, submit a coordination plan detailing the population of focus, including:
    a. demographic information and geographic area to be served,
    b. the existing or planned partnerships
    c. the warm handoff model (integrated, co-located, or an alternative approach),

d. the protocols to be established, including
    i. Transportation to an initial community-based MAR appointment and (if desired) accompany the individual to the initial appointment.
    ii. Data and information sharing that include the subrecipient providing results of recent examination, medical history, recent lab results, and other information pertinent to the initiation of community-based MAR. All information sharing must follow the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. Part 2.
    iii. Transportation and accompaniment to other clinical treatment for OUD, including mental health and/or SUD treatment, as indicated and desired by the individual.

(b) Within 90 days, submit the necessary memoranda of understanding (MOUs).

Subrecipients must also participate, when available, with local groups dedicated to substance use or homelessness. These may include regional coalitions facilitated by the RCCA, local ROSC councils (if any), and other relevant community coalitions. At a minimum, subrecipients must

(c) Actively participate in regional coalitions coordinated by the RCCA

Task 3. Outreach, Engagement, and Education

Subrecipients must, within 90 days, be prepared to conduct outreach, engagement, and education activities as follows:

(a) Within 60 days, hire at least 1 FTE staff member who is a CRSS or CPRS or working towards certification during their employment with the program;

(b) Within 90 days, initiate outreach activities to members of the priority population using motivational interventions designed to increase engagement in MAR and other clinical services; and

(c) Deliver the following outreach and engagement services for at least 12 months to program participants:
    a. Peer support services, including emotional support, promotion of drug-free leisure activities, and practical support with adjusting to new housing;
    b. Linkages to RCOs, harm reduction organizations and service providers in the community; and
    c. Linkages to needed community supports that promote self-sufficiency, including workforce agencies and childcare providers.

Task 4. Overdose Education and Naloxone Distribution (OEND) Services

Subrecipients must, within 90 days, be prepared to offer overdose education and naloxone kits to all program participants. Specifically, subrecipients must

(a) Enroll (if not currently enrolled) in the IDHS/SUPR Drug Overdose Prevention Program; and

(b) Offer naloxone kits and naloxone education to all individuals in transition contacted by the program, whether or not the individual is interested in engaging otherwise with treatment or recovery supports.

Task 5. Warm Handoff Services

Subrecipients must, within 90 days, be prepared to offer warm handoff services. This includes education, offering warm handoffs, and conducting warm handoff services in accordance with the program model to treatment and recovery support services. Subrecipients must

(a) Educate participants about treatment options, including
    a. MAR and its role in reducing risk of overdose, identifying options for MAR in the client's area including local OTPs offering methadone and prescribers offering buprenorphine;
    b. Other clinical treatment services
(b) Offer warm handoffs to MAR and other clinical treatment services, including mental health and/or SUD treatment; and
(c) Conduct warm handoffs to MAR and other clinical treatment services in accordance with model protocols.

Task 6. Housing Supports

Subrecipients must, within 90 days, initiate delivery of housing support services to participants. Specifically, subrecipients must

(a) Assist with obtaining housing, including, but not limited to
    a. Searching for housing;
    b. Applying for subsidized housing (e.g., filling out applications);
    c. Completing application for Coordinated Entry systems; and
    d. Assisting with moving in;
(b) Paying first month's rent or other associated move-in fees; and
(c) Providing "welcome home kits" of hygiene supplies, clothing, furniture, and other basic household items for people transitioning into housing.

A.6. Deliverables and Performance Measures

The following table details (a) the deliverables required according to the scope of services and (b) associated performance measures, standards, and potential metrics (subject to change) to be collected by task. Time periods refer to the days from the beginning of the period of performance. Standards for activities refer to percentages of those described in the project plan.

Deliverables		Performance Measures	Standards	Metrics
T1	**Award administration requirements**	(a) Complete organizational needs assessment survey	100%	Needs assessment survey completed (30 days after distribution)
		(b) Complete implementation and sustainability plan	100%	Implementation and sustainability plan created (45 days)

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Deliverables		Performance Measures	Standards	Metrics
				Sustainability plan update (submitted with final monthly reports)
		(c) Implement equity and racial justice plan	100%	Organizational assessment completed (90 days) Plan drafted (120 days) Plan finalized (160 days)
		(d) Report performance information	100%	Activities and services metrics reported (10th of each month, 10th following each quarter unless otherwise prescribed)
		(e) Report fiscal information	100%	Fiscal performance reported (10th of each month)
		(f) Participate in TTA	75%	# Monthly cohort meetings (initiated within 15 days) # TTA sessions attended (quarterly or as prescribed)
T2	**Coordination and Collaboration**	(a) Develop a coordination plan that reflects community and population needs	100%	Coordination plan developed (60 days)
		(b) Develop or maintain MOUs with partners	A minimum of 3	# MOUs or agreements created (90 days)
		(c) Attend RCCA coalition meetings	75%	# RCCA meetings attended (quarterly)
T3	**Outreach, Engagement, and Education**	(a) Hire at least 1 FTE peer staff member	100%	# FTE hired (60 days)
		(b) Initiate outreach services	100%	Services are available (90 days) # outreach contacts (by demographic)
		(c) Deliver ongoing outreach and engagement services to participates for 12 months	80% 50%	# encounters (by demographic) Retention rate at 12 months
T4	**OEND Services**	(a) Enroll in OEND	100%	Program enrollment completed
		(b) Offer naloxone kits and naloxone education	85%	% of participants offered kits # kits distributed

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Deliverables		Performance Measures	Standards	Metrics
T5	**Warm Handoff Services**	(a) Educate participants about treatment options	85%	# of individuals educated on treatment options (by type)
		(b) Offer warm handoffs	85%	# of individuals offered warm handoffs
		(c) Conduct warm handoffs	50%	% individuals receiving warm handoff to MAR (by type) % individuals receiving warm handoff to other clinical services (by type)
T6	**Housing Supports**	(a) Assist with obtaining housing	80%	# participants offered housing assistance
		(b) Provide financial assistance with initial rent or move-in expenses	50%	% of eligible individuals with housing within 30 days of transition
		(c) Provide "welcome home kits"	80%	# individuals receiving welcome home kits when moving into housing

[1] Illinois Opioid Data Dashboard.
[2] Ibid.
[3] State of Illinois Overdose Action Plan.
[4] King, C., Cook, R., Korthuis, P. T., Morris, C. D., & Englander, H. (2022). *Causes of Death in the 12 Months After Hospital Discharge Among Patients With Opioid Use Disorder.* Journal of addiction medicine, 16(4), 466–469.
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[14] Illinois Public Health Institute. (August 2020). *Responding to opioid overdoses and treating opioid use disorder: A landscape analysis of Chicago's west and south sides*.