# Matching the Functions of eTransX's Opioid Care Community system to the Recovery Oriented Systems of Care (ROSC)


This document matches the functions of eTransX's Opioid Care Community system to a checklist of desired outcomes associated with a Recovery Oriented Systems of Care (ROSC) model based on Ohio's Recovery is Beautiful® ROSC program. Specific ROSC functional categories supported by the Opioid Care Community system include:

**Assessment** – supports the development and use of online assessments including scoring to capture information in real time – such as SBIRT assessments, depression assessments, program surveys, personal needs assessments, Adverse Childhood Experience (ACE) assessments. Build your own assessments or use standardized assessments.

**Pathway** – supports the development and management of evidence-based personal success pathways – based on an individual's specific needs and circumstances. Can be used to develop personal pathways for prevention, harm reduction, treatment, or long-term recovery.

**Directory of Community Resources and Programs** – provides online directory of available resources and programs in the community or region that can be utilized to support prevention, harm reduction, treatment and recovery efforts. Allows community-based organizations (CBO) to log in to keep their information up to date in real time (such as available treatment beds or program openings).

**Referrals** – supports real-time, two-way referrals and service orders between organizations. Organizations receiving referrals/orders can respond in real time (e.g. "close the loop")

**Tracking** – captures client's and CBO's data in real time that can be tracked and reported in real time.

**Support teams** – set up support teams to work together with clients and share data securely

**Educate** – provides real time access to online educational materials or links to online educational materials. Can track if educational materials were viewed by clients and when.

The foundational information technology platform for the Opioid Care Community system:

- Is a hosted, cloud-based system that can be accessed through any Internet connection
- Utilizes an automated interface engine that can easily connect with other systems – to minimize duplicate data entry and support two-way data sharing between systems
- Is fully compliant with security and privacy standards such as HIPAA and 42CFR
- Supports multiple communications channels – web-based portals, two-way texting, live video visits, and secure email
- Utilizes a built-in rules engine to automate process workflows and trigger exception alerts

To learn more about how eTransX can help your community combat the opioid/substance abuse epidemic, please contact us at **(888) 221-4971** or visit us online at www.opioidcarecommunity.com

# Recovery-Oriented System of Care Self-Assessment

## ROSC STAKEHOLDER ASSESSMENT

| Please indicate to the degree to which you feel the following statements reflect the activities, values, and practices of your community. | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | OPIOID Care Community |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | Function to Use |
| **Domain: Focusing on Clients and Families** | | | | | | |
| 1. Service providers are trained regularly in recovery topics and resilience-based and trauma-informed assessments. | 1 | 2 | 3 | 4 | 5 | Educate |
| 2. Service providers offer specific services and programs for individuals with different cultures, life experiences, interests and specific needs. | 1 | 2 | 3 | 4 | 5 | Assess |
| 3. Every effort is made to involve family members (spouses, significant others, friends) and other natural supports (e.g., clergy, neighbors, landlords, coaches) in the planning of services – if so desired. | 1 | 2 | 3 | 4 | 5 | Support Team |
| 4. People in recovery can choose (and change, if desired) the therapist, psychiatrist, physician, or other providers from whom they receive services. | 1 | 2 | 3 | 4 | 5 | Directory |
| 5. People in recovery are given opportunities to discuss their spiritual needs and sexual preferences. | 1 | 2 | 3 | 4 | 5 | Assess |
| 6. Service providers listen to and follow choices and preferences of participants. | 1 | 2 | 3 | 4 | 5 | Pathway |
| 7. Progress toward goals (as defined by the person in recovery) is regularly monitored. | 1 | 2 | 3 | 4 | 5 | Track |
| 8. Barriers (e.g., childcare, transportation) are addressed for participants. | 1 | 2 | 3 | 4 | 5 | Pathway |
| 9. Multi-disciplinary teams (e.g., clinician, peer support, family members, other cross-system partners) work together with the goal of recovery. | 1 | 2 | 3 | 4 | 5 | Support Team |
| 10. Stage-appropriate services (e.g., detox before treatment, crisis services) are offered. | 1 | 2 | 3 | 4 | 5 | Pathway |
| 11. Flexibility in outpatient care is allowed. | 1 | 2 | 3 | 4 | 5 | Pathway |
| 12. Provide low-intensity care for those who would not benefit from high-intensity treatment at that time (e.g., outpatient vs. residential). | 1 | 2 | 3 | 4 | 5 | Pathway |
| 13. Age appropriate services are offered to children, adolescents, young adults, and seniors. | 1 | 2 | 3 | 4 | 5 | Pathway |
| **Domain: Ensuring Timely Access to Care** | | | | | | |
| 14. Individuals have timely access to the services and supports that are most helpful for them. | 1 | 2 | 3 | 4 | 5 | Directory |
| 15. Staff routinely assists individuals in the pursuit of education and employment. | 1 | 2 | 3 | 4 | 5 | Pathway |

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| 16. Partnerships exist for all ages in a variety of health care settings that will facilitate the use of evidenced-based behavioral health screenings, on-site assessments, early intervention and referral strategies, as well as wellness checks. | 1 | 2 | 3 | 4 | 5 | Support Team |
| 17. Co-occurring behavioral and physical health are addressed in integrated ways, including assertive referral to and coordination with primary care providers, with an aim to address co-occurring issues through integrated rather than consecutive care. | 1 | 2 | 3 | 4 | 5 | Referral |
| 18. Collaborations exist with childcare centers to promote early interventions to better meet children's emotional and behavioral needs. | 1 | 2 | 3 | 4 | 5 | Referral |
| 19. Connections with key community partners (e.g., housing and food shelters, halfway houses, church-based meal programs, community corrections facilities, recreation centers) exist for at-risk individuals. | 1 | 2 | 3 | 4 | 5 | Referral |
| 20. Partnerships exist with peer support recovery programs, recovery community organizations and other support groups. | 1 | 2 | 3 | 4 | 5 | Referral |
| 21. Partnerships exist with organizations that provide other resources (e.g., housing, childcare, employment services, transportation) that may benefit the individuals and families served. | 1 | 2 | 3 | 4 | 5 | Referral |
| 22. Partnerships and learning exchanges exist with first responders to help stabilize individuals by providing education on: mental health and substance abuse issues, common responses to trauma, and facilitation of referrals. | 1 | 2 | 3 | 4 | 5 | Educate |
| 23. Cross training and referrals with child and adult protective services are in place. | 1 | 2 | 3 | 4 | 5 | Referral |
| 24. A no-wrong-door policy exists in the community for children, adolescents, and adults to engage individuals at whatever point they enter the system and determine the most appropriate type and level of care at that time. | 1 | 2 | 3 | 4 | 5 | Direct/Refer |
| 25. Age-appropriate peers are used in community outreach and early engagement efforts. | 1 | 2 | 3 | 4 | 5 | Support Team |
| 26. Families, peer support staff, and volunteers are used in outreach efforts. | 1 | 2 | 3 | 4 | 5 | Support Team |
| 27. Interim services are available for people on waiting lists and/or who are not ready to commit to treatment. | 1 | 2 | 3 | 4 | 5 | Direct/Refer |
| 28. Assertive linkages exist during transitions using peer-based recovery support staff and volunteers through levels of care. | 1 | 2 | 3 | 4 | 5 | Referral |
| 29. Intake and engagement strategies use evidenced-based practices (e.g., motivational interviewing, contingency management and cognitive behavioral techniques). | 1 | 2 | 3 | 4 | 5 | Pathway |
| 30. Stages of change models are used in treatment (including motivational interviewing, and ensure that services provided are strength-based approaches that promote hope). | 1 | 2 | 3 | 4 | 5 | Pathway |
| **Domain: Promoting Healthy, Safe, and Drug-Free Communities** | | | | | | |
| 31. Helping people build connections with their neighborhoods and communities is a priority. | 1 | 2 | 3 | 4 | 5 | Direct/Refer |
| 32. The community receives education about mental illness and addictions. | 1 | 2 | 3 | 4 | 5 | Educate |
| 33. Persons in recovery are involved with facilitating trainings and education | 1 | 2 | 3 | 4 | 5 | Directory |

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| programs. | | | | | | |
| 34. Coordination exists to link people in recovery with other persons in recovery who can serve as role models or mentors. | 1 | 2 | 3 | 4 | 5 | Direct/Refer |
| 35. The community offers a variety of treatment options (e.g., individual, group, peer support, holistic healing, alternative treatment options, medical) that persons in recovery can access. | 1 | 2 | 3 | 4 | 5 | Directory |
| 36. The community offers opportunities to help people become involved in activities that give back to their community (e.g., volunteering, community services, neighborhood watch/clean up). | 1 | 2 | 3 | 4 | 5 | Directory |
| 37. Prevention, Treatment and Support services are available in the community. | 1 | 2 | 3 | 4 | 5 | Directory |
| *38.* Partnerships and learning exchanges exist with first responders and others in the community to provide education on mental health and substance abuse disorders, and common responses to trauma, facilitate referrals and alter them to types of situations you may be able to help them stabilize (e.g., Crisis Intervention Training, Mental Health First Aid). | 1 | 2 | 3 | 4 | 5 | Educate |
| **Domain: Prioritizing Accountable and Outcome-Driven Financing** | | | | | | |
| 39. People in recovery (service recipients) and their family members are actively involved in the evaluation of services and programs. | 1 | 2 | 3 | 4 | 5 | Assess |
| 40. Criteria for completing and exiting treatment are clearly defined and discussed with participants upon entry to services. | 1 | 2 | 3 | 4 | 5 | Educate |
| 41. The success of community-based screening processes is monitored regularly. | 1 | 2 | 3 | 4 | 5 | Track |
| 42. Indicators of initial treatment engagement (e.g., "no shows," frequency with which people come back for return appointments) are monitored regularly. | 1 | 2 | 3 | 4 | 5 | Track |
| 43. Focus groups and other formats (surveys) are used regularly to seek feedback about participant satisfaction and improvement strategies from adults, youth and families receiving services and supports. | 1 | 2 | 3 | 4 | 5 | Assess |
| 44. Behavioral health is included as a health indicator in the community. | 1 | 2 | 3 | 4 | 5 | Track |
| 45. Participants, alumni, and family members are engaged in the evaluation of continuing care. | 1 | 2 | 3 | 4 | 5 | Assess |
| 46. Evaluation procedures track the provision of research supported approaches to continuing support | 1 | 2 | 3 | 4 | 5 | Assess |
| 47. Quantitative and qualitative evaluation approaches are used to prevent barriers to program participation and satisfaction. | 1 | 2 | 3 | 4 | 5 | Track |
| 48. Leveraging of resources is used to enhance and promote prevention, treatment and recovery support services. | 1 | 2 | 3 | 4 | 5 | Directory |
| 49. Contracts are outcome-prioritized. | 1 | 2 | 3 | 4 | 5 | Track |
| 50. Outcomes are connected to community plan priorities. | 1 | 2 | 3 | 4 | 5 | Track |
| **Domain: Locally Managing Systems of Care** | | | | | | |
| 51. People in recovery work alongside providers to develop and provide new programs and services. | 1 | 2 | 3 | 4 | 5 | Assess |
| 52. Procedures are clear about the options for referrals to other programs and services if a provider cannot meet the needs of a participant. | 1 | 2 | 3 | 4 | 5 | Direct/Refer |

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| 53. Primary care and behavioral health follow-ups are integrated and coordinated. | 1 | 2 | 3 | 4 | 5 | Track |
| 54. The community ensures that age-appropriate, peer-run leisure activities are available. | 1 | 2 | 3 | 4 | 5 | Directory |
| 55. Safe, sober, and fulfilling activities are offered in the community. | 1 | 2 | 3 | 4 | 5 | Directory |
| 56. Partnerships exist with local businesses to increase opportunities for employment. | 1 | 2 | 3 | 4 | 5 | Direct/Refer |
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## Continuum of Care

| | Yes | No | |
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| 57. Prevention and wellness management services are available in the community. | Y | N | Directory |
| 58. People in recovery work alongside providers to develop and provide new programs and services. | Y | N | Assess |
| 59. Treatment services are available in the community, including outpatient, residential, partial hospitalization, and sub-acute detoxification. | Y | N | Direct/Refer |
| 60. Recovery supports are available in the community, including peer support, housing, and transportation. | Y | N | Direct/Refer |
| 61. Workforce programs and supports are available to help individuals get back to work. | Y | N | Direct/Refer |