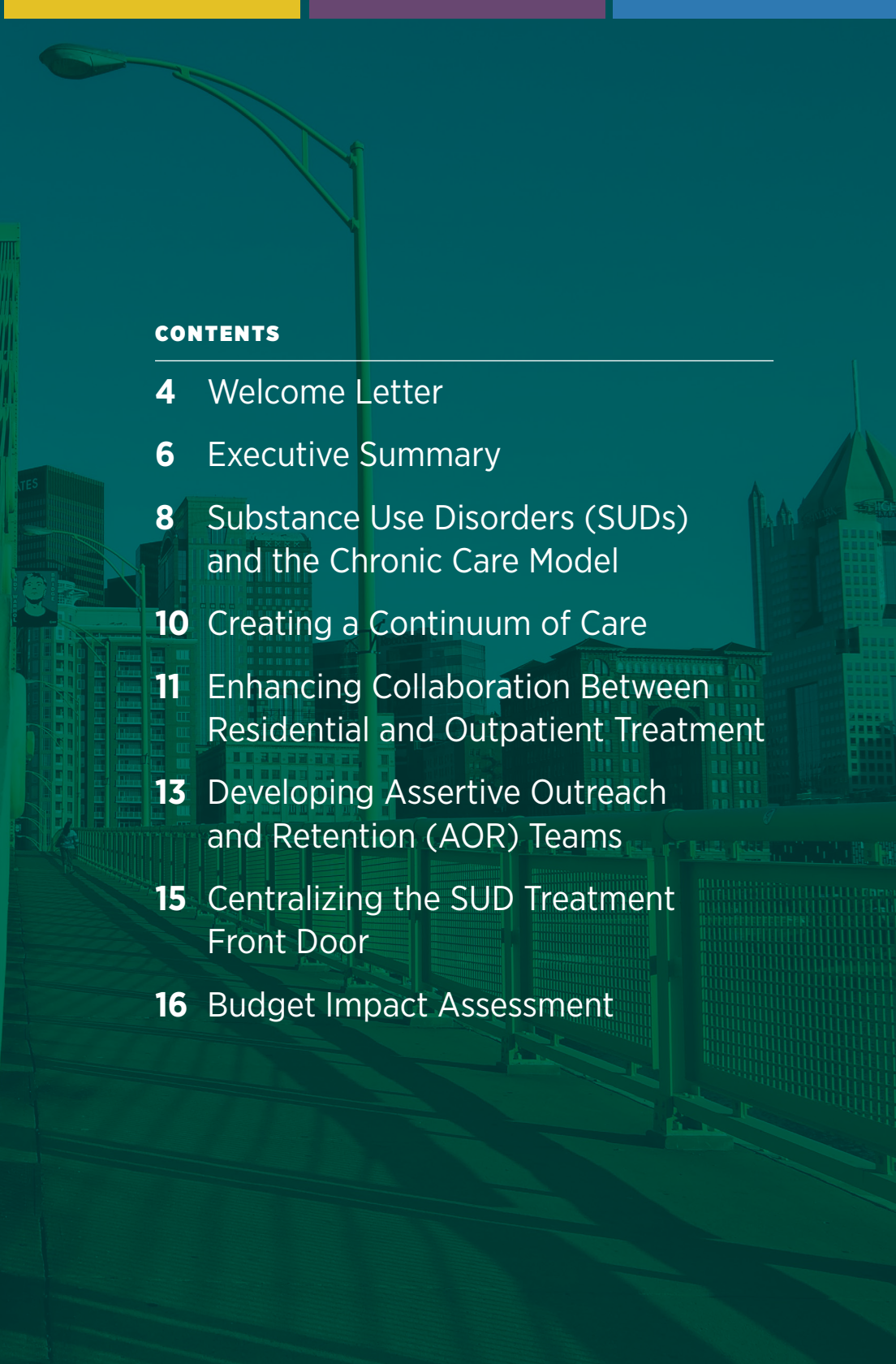
ALLEGHENY COUNTY DEPARTMENT OF HUMAN SERVICES

The Allegheny Recovery Partnership Plan: Building a Connected Drug and Alcohol Treatment System

September 2026



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Welcome Letter

Addiction is one of the most critical social issues facing our community and nation. In Allegheny County, we see its far-reaching effects in many of our systems—from child welfare to homelessness to criminal justice. National data underscore addiction's widespread prevalence: 25.7 million Americans aged 12 or older have an alcohol use disorder and 44.6 million have a substance use disorder, according to the 2025 National Survey of Drug Use and Health.[1]

Despite devoted efforts from healthcare professionals, researchers, and advocates, the pace of progress on reducing addiction's harm to individuals and society has been slower than anyone would like. In the past two decades no new medications—only reformulations of existing ones—have been approved for the treatment of alcohol or opioid use disorder, and there is still no FDA-approved medication for addiction to stimulants. A quarter-century after the opioid epidemic began to roil our community, it is difficult to point to policy victories commensurate with the scale of the challenge. Years after the medical community fought to shift the focus of addiction treatment from acute stabilization to chronic care, we have struggled to put these values into action.

25.7 million Americans over the age of 12 have an alcohol use disorder and 44.6 million have a substance use disorder

The Allegheny Recovery Partnership Plan addresses these challenges directly. Rather than treating the chronic condition of substance addiction with episodic care, we will create a system that functions as a true system: connecting people to care, anticipating and responding to setbacks, and enabling people to lead the full lives they've imagined. We will streamline access to services, strengthen our residential treatment options, and build a radically different outpatient system of care that stewards people's health for the long term.

Allegheny County is the best place in the country to pioneer this innovation. We will need strong partnerships with the community, healthcare providers, research institutions, foundations, and our clients. We'll work to earn trust through this transition, so the community understands our approach and hears from us on our progress.

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Addiction policy and response can sometimes hinge on big-picture philosophical debates, such as whether addiction is a disease or a choice. In our view, Stanford University psychologist Keith Humphreys had this one right: when someone asks whether addiction is a disease, they're really asking whether this person is worthy of compassion. We'll leave the debate for others, but compassion will always be a non-negotiable part of our approach.

And we aspire to more than compassion—as do the professionals, families, and individuals with substance use disorder who confront these issues every day. The policy changes outlined in the Allegheny Recovery Partnership Plan make us optimistic, to borrow a phrase from Harvard Medical School psychologist John F. Kelly, that we will create a system where people come to expect that recovery is "possible, likely, and sustainable."

Anything less would be a disservice to the community, our partners, and the resiliency of our neighbors in recovery.

— Alex Jutca, Interim Director
Allegheny County
Department of Human Services

Executive Summary

Chronic alcohol and drug use and addiction are major social challenges, taking the lives of hundreds of Allegheny County residents each year and affecting thousands of individuals and families in every part of the county. Substance use disorder (SUD) is a major driver of homelessness and crime and is associated with diminished employment and educational outcomes, among other negative outcomes.[2]

The Allegheny Recovery Partnership Plan is a groundbreaking, evidence-based strategy to support the long-term recovery of our neighbors, friends, and loved ones struggling with addiction. It aims to interrupt cycles of repeated hospitalizations, criminal justice involvement, and housing and employment challenges by establishing a coordinated countywide system that increases access to effective treatment and retains individuals with SUD in a continuum of care over time.

Under this model, we will pay providers for what matters: long-term recovery for our neighbors and families.

Most people with SUD require months or years of treatment to help them overcome the challenges associated with addiction to alcohol or other substances. While SUD is a chronic condition characterized by relapse, the current system behaves episodically, focusing on delivering services within a specific level of care rather than maximizing long-term engagement. Most current funding supports acute, mostly disconnected episodes of treatment that often provide only short-term benefit. As a result, clients are frequently lost to follow-up—during which no provider maintains responsibility for their care—and reappear in high-cost systems such as residential rehabilitation facilities, inpatient psychiatric hospitals, and jail.

Interrupting these cycles remains a significant policy challenge. Payment models are partially at fault: small performance incentives and narrow fee-for-service reimbursement do not afford providers the flexibility to invest in achieving clearly defined goals to support long-term recovery. In other words, while treatment providers understand the need to focus on a person's sustained recovery pathway, the system historically has not been set up to pay them for doing so. Because Allegheny County DHS administers the behavioral health system, we have the ability to change that. Under this model, we will pay providers for what matters: long-term recovery for our neighbors and families.

This plan will create a continuum of care where individuals can rapidly access services when needed, stay engaged in care, and effectively transfer across services without falling through the gaps that too often undermine progress today.

Specifically, we are undertaking three overlapping improvements to the SUD treatment system, including:

1. Enhancing SUD residential treatment (colloquially known as "rehab") through a series of new contracts with a select group of providers committed to increased coordination of care with outpatient treatment providers.

2. Creating and financing an assertive outreach and retention (AOR) intervention that will work with patients in the community to keep them engaged in care, re-engage individuals who have fallen through the gaps between services, and support those who are cycling through crisis levels of care (e.g., hospitals, emergency departments, jails, or residential levels of treatment).

3. Creating a unified front door to treatment to enhance coordination for individuals either seeking SUD treatment or transitioning across treatment episodes or services.

SUD Treatment in Allegheny County 2025

Clients Served:
12,700

Cost:
$99.6 million

When this system is fully implemented, someone with an SUD presenting in crisis at an emergency room, a treatment facility, or the county jail will begin a long-term partnership with their care team. Instead of being given recommendations to pursue treatment on their own, each client will have an assigned support person trained to help them stay engaged with treatment, find resources to stay on track, and check in regularly to ensure they are managing their condition and their life as best they can. While SUD and its social and individual costs can never be eradicated, this system will help more people lead more productive and fulfilling lives, strengthen their families and communities, and contribute to addressing the issues associated with substance use countywide.

Substance Use Disorders (SUDs) and the Chronic Care Model

People with SUDs can broadly be organized into two categories based on their need for treatment. About half can resolve their addiction through a low-touch, acute-care approach consisting of education (e.g., health literacy on the health risks associated with alcohol or other substances), mutual support programs such as Alcoholics Anonymous, treatment with a primary care physician, or self-directed changes to alcohol or drug use behaviors.[3] The other half, who have a moderate to severe SUD, need a long-term approach that may require multiple episodes of professionalized treatment, medication, and a range of recovery support services.

Most individuals who seek or need SUD treatment in Allegheny County have a chronic SUD requiring a chronic care management approach. Three in four people treated for SUD in Allegheny County during 2025 had received treatment in at least one prior year, and nearly half had received treatment in three or more prior years.

The SUD treatment system in the United States was designed and funded as an acute-care model, even though most individuals who need professionalized

About **40%** of those discharged from residential treatment **return within a year**

Nearly one in five individuals entering residential treatment have had **five or more prior** residential treatment episodes

More than two-thirds of admissions to residential treatment are **readmissions**

treatment require a chronic care approach.[4] It's as if the healthcare system treated patients with osteoporosis only by splinting broken bones, instead of providing therapies that improve bone density and allow fuller mobility.

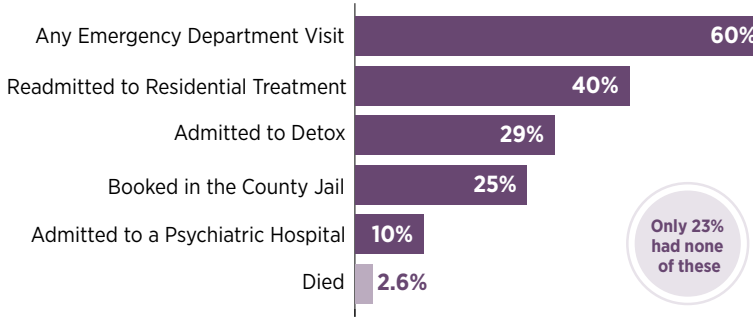
Today, Allegheny County provides an extensive range of SUD treatment programs, including dozens of residential treatment programs, outpatient services, medication-based services, recovery housing, peer-based services, and primary care services specializing in treating patients with SUD. Yet, despite this wide range of services, most providers offer only one or two interventions, and they tend to be disconnected from other SUD treatment providers.

As a result, most individuals who enter any SUD treatment services in Allegheny County either disengage before completing a single episode of care or do not access another level of care after completing one episode. The result of this disconnected system includes:

- Nearly 5,000 unique individuals receive publicly funded SUD residential services each year; however, 15% leave treatment within seven days.
  - About 40% of those discharged from residential treatment return within a year (most of them within six months), and nearly half leave without connecting to any follow-on care within 30 days. Two-thirds of admissions to residential treatment are readmissions, and nearly one in five individuals entering residential treatment have had five or more prior residential treatment episodes.
- About three in ten individuals are booked into the county jail or charged with a new offense within 12 months of leaving treatment; one in four individuals are jailed.

Three in Four Admissions are Followed by Crisis-System Contact

Share of ASAM 3.5 residential discharges (Jan 2018– Jun. 2025) with each event in the following 12 months



Source: ACDHS Data Warehouse (HealthChoices claims). ASAM 2.5 stays discharged Jan 2018–Jun 2025, each followed for 12 months (n=37.869 stays); stays built from full claim-line date spans, bridged at 14 days. ED visits from physical-health claims; detox=ASAM 3.7-WM/4-WM; psychiatric hospital = inpatient mental health; jail = ACJ booking; death = any cause.

Creating a Continuum of Care

The heart of the Allegheny Recovery Partnership Plan is ensuring all who need it have access to a continuum of care offering the right levels of support at different points in time to effectively manage SUD and recover long term. Through this plan, we will reduce the risk of individuals disengaging from care and experiencing crisis events such as an overdose, arrest, or hospitalization.

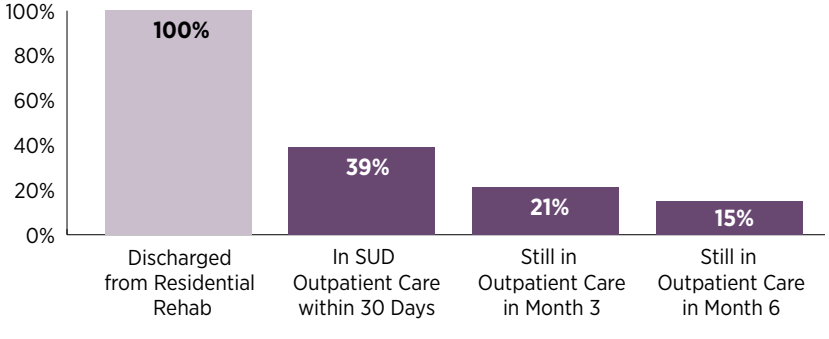
Evidence for this approach to care is strong:

- Individuals who remain engaged in a continuum of treatment and recovery supports achieve better outcomes, including significant and sustained reductions in alcohol and other substance use, improved quality of life and health, compared to those who disengage early from treatment.[5]
- One key component of ongoing care is medication-assisted treatment (MAT). Studies have shown that individuals with opioid use disorder (OUD) experience significant and sustained reductions in the use of heroin, fentanyl, or other opioids and a reduced risk of overdose if they can remain on MAT for three to five years, compared to those who disengage from MAT or never receive it.[6]

Underlying this approach is the well-established chronic care model used successfully for many years to improve outcomes for patients with conditions such as diabetes or high blood pressure. By improving collaboration between patients and their primary care practices, the system allows practitioners to tailor interventions to patients' readiness and capacities for self-managing their healthcare needs.

Fewer Than One in Seven People Stay Connected to Outpatient SUD Care through the Six Months After Rehab

Share of ASAM 3.5 discharges (Jan 2018–June 2025) with an SUD outpatient claim (D&A clinic, IOP, partial, methadone, buprenorphine, COE, or D&A case management) in each window



Source: ACDHS Data Warehouse (HealthChoices claims). ASAM 3.5 stays discharged Jan 2018–Jun 2025, each followed for 12 months (n=37,869 stays); stays built from full claim-line date spans, bridged at 14 days. Month 3 = days 61–90; month 6 = days 151–180; bars are the share of all discharges still on the connected path. Counting later connections and re-entries, 22% of discharges have an SUD outpatient claim in month 6. Pharmacy-filled MOUD without an outpatient claim does not count.

Enhancing Collaboration Between Residential and Outpatient Treatment

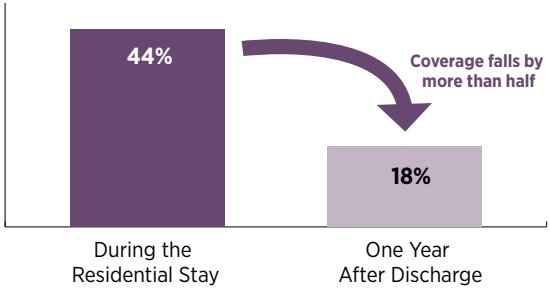
The first step in implementing the Allegheny Recovery Partnership Plan is issuing new contracts for residential care to a group of providers selected through a competitive process who will not only provide inpatient care to people in crisis but also ensure coordination across the continuum of care over time.

Through a re-procurement process, we are selecting a group of SUD residential programs that are willing to:

- Maintain Pennsylvania licensing standards for residential treatment, which follow American Society of Addiction Medicine (ASAM) criteria.
- Work with SUD outpatient providers to coordinate successful handoffs to services after individuals leave residential treatment, improving the rate of transfers between levels of care.
- Coordinate with housing programs and recovery houses to improve access to transitional housing programs for those experiencing homelessness at admission.
- Expand access to effective medications in residential treatment and coordinate care to help individuals stay on these medications in outpatient settings.
- Reduce cycling back to residential levels of care by referring individuals with multiple residential episodes of treatment to AOR teams (described next).
- Use continuous quality improvement (CQI) principles to improve retention and transfer rates.

Four in Five People are Off the Anti-Overdose Medication within a Year of Leaving Rehab

Share of opioid-diagnosed ASAM 3.5 residential episodes (admissions Jan 2018–May 2026) with active MOUD coverage



Source: ACDHS Data Warehouse claims and pharmacy fills through May 2026. MOUD = buprenorphine, methadone, or naltrexone coverage from pharmacy fills, MOUD spells, and methadone service claims. Medication filled on commercial insurance or cash is not observed, so both figures are floors.

Taken together, these commitments will allow for true coordination of care by increasing the likelihood that people with SUD will maintain control over their condition following discharge and by reducing the readmissions and other negative outcomes that are frequent features of the current system. The goal is that, when patients are discharged, they have a clear plan and connections to follow-up care and other supports that will enable them to build stability and security.

Outpatient programs, like the residential programs, will be asked to focus more on sustaining individuals in a continuum of care.

Expanding the SUD outpatient system is the other half of the continuum alongside modifications to the residential treatment model. Allegheny County has a robust outpatient care system, with dozens of programs throughout the county where most individuals with SUD receive their care. Settings include traditional treatment providers who offer group and individual counseling services and medications specific to SUD treatment, methadone programs, peer-based programs, case management services, and nontraditional services such as harm reduction programs or recovery community organizations. These outpatient programs, like the residential programs, will be asked to focus more on sustaining individuals in a continuum of care, such as improving coordination with residential programs, lowering barriers to accessing outpatient care, and expanding outreach.

Developing Assertive Outreach and Retention (AOR) Teams

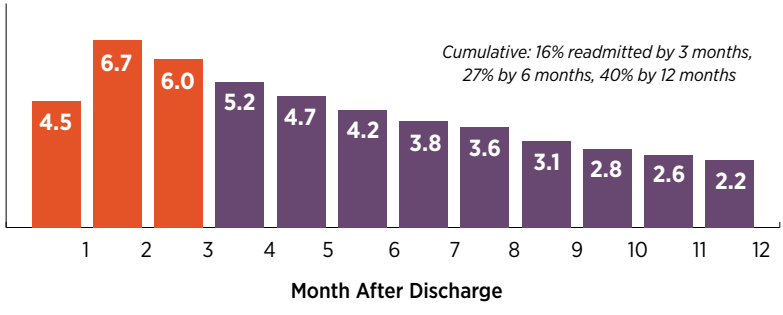
One of the most distinctive features of the Allegheny Recovery Partnership Plan will be the use of AOR teams to support people in outpatient care either following discharge from a residential program or when they are first identified as being at high risk of experiencing a serious medical event (e.g., overdose), readmission to a residential program or hospital, or incarceration.

The AOR approach is a community-based model of individually tailored assistance in which clients are connected with an outreach person, often a peer, who will proactively engage with them through the course of their lives to help them stay connected to treatment services, medical providers, and other essential resources.[7] Outreach staff will be trained to develop relationships with their clients that allow them to maintain connections with family members, employers, and other members of the client's support network and to help them access the supports and resources that best keep them engaged.

Allegheny County's AOR effort will be based on effective community-based models such as recovery management and checkups (RMC), behavioral coaching, and peer-based programs that have been shown to improve engagement in treatment among clients with SUD over longer periods of time. This includes people experiencing homelessness or other barriers to accessing traditional outpatient services.[8]

Returns to Rehab Peak in the Second and Third Month After Discharge — the Window Outreach Has to Cover

Of people not yet readmitted, the share readmitted to ASAM 3.5 in each month after discharge (%)



Source: ACDHS Data Warehouse (HealthChoices claims). ASAM 3.5 stays discharged Jan 2018–Jun 2025, each followed for 12 months (n=37,869 stays); stays built from full claim-line date spans, bridged at 14 days. Month 1 is lower than months 2–3 partly because returns within 14 days are treated as the same stay.

Outreach staff will be trained in techniques like motivational interviewing and ongoing collaborative monitoring of risk. They will use a detailed tracking protocol to help locate individuals in the community—even those who lack stable phone access or housing—and connect them to the services necessary to continue managing their condition. Recognizing the unique challenges inherent to addiction, staff will maintain monthly communication and case management even with clients who may continue to use alcohol and other substances or are not ready to enter SUD treatment. Maintaining these connections is critical to avoiding negative outcomes.[9]

Key steps to implement the AOR process will include:

- Creating a clinical protocol and a corresponding payment model for SUD outpatient treatment providers to effectively engage and retain individuals in the community, including working with those who have housing instability or need more time to learn how to reduce their use of alcohol or other substances.
- Developing an alternative payment model that provides agencies sufficient, flexible funding to work with individuals in the community, including dedicating the time to connect with them when they disengage or experience homelessness. DHS will create an alert system so that providers are aware when clients experience crises and can effectively reengage them to promote stability.
- Creating and applying a risk classification system for adjusting payment to SUD outpatient programs. Individuals with SUD will be classified as high, medium, or low risk based on two dimensions:
  - Risk of experiencing a crisis event (e.g., recent overdose, presenting to an emergency department, recent incarceration, or cycling through residential treatments).
  - Difficulty engaging in SUD outpatient care.

SUD outpatient treatment providers will receive higher payment for high-risk individuals and lower payment for low-risk individuals. These risk scores will not be used for any purpose other than ensuring that providers have the resources to treat people based on their needs, since some patients require more care than others. Strict protocols will be established to ensure that data access is limited to those who need it for purposes of providing or monitoring care.

Centralizing the SUD Treatment Front Door

Accessing behavioral health services can be complex and time-intensive, frequently requiring prospective clients to contact several providers to assess options and appointment availability. To improve clients' experience finding services and scheduling appointments, we will establish a streamlined patient intake process that will make it easier for all individuals seeking substance use services to be connected to the most effective care.

This will include a system for tracking care across multiple providers and modalities. Treatment providers will also be able to schedule appointments across programs to further help individuals successfully transition to other treatment interventions within the continuum of care.

When implemented, every new patient—whether they enter the system by contacting an individual treatment provider, through a hospital, or through law enforcement—will be immediately assessed and offered the most appropriate level of care and provider to maximize their chance of long-term success.

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The system will track appointment availability across treatment settings, reducing delays in finding treatment for those who need it.

A centralized system will make it easier for providers and AOR teams to see which patients are staying on course with their treatments and which require further engagement.

As with risk scoring, this system will be managed with strict rules for controlling access to private data, and information will be used only for managing patient care.

Budget Impact Assessment

The motivation for implementing the Allegheny Recovery Partnership Plan is to provide the best treatment system possible for people in Allegheny County. Modernizing the treatment system to reflect how recovery works in real people's lives would be a policy priority for Allegheny County even in a world without budget constraints. However, it is worth noting that at a time when funding for all forms of behavioral health treatment face increasing constraints, this program is designed to use currently available funds more efficiently and more effectively.

Allegheny County administered approximately $112 million in Medicaid funding in 2025; this does not include approximately $25 million in federal block grant dollars and other federal and state-specific funding for SUD services. The total amount of funding available in 2027 will be lower than in 2025 and 2026, due to reductions in Medicaid.

Implementing the steps outlined in this plan will enable more patients to be treated in settings that increase stability and reduce cycling through crisis levels of care.

Currently, nearly half of total SUD treatment dollars are spent on residential care. As noted above, a substantial portion of that funding pays for episodic care and repeat stays, with readmissions accounting for two-thirds of admissions, and many patients returning for ten or more stays. Notably, the costs of crisis care through emergency departments, hospitals, and jails and prisons for those with SUD are in addition to SUD treatment dollars.

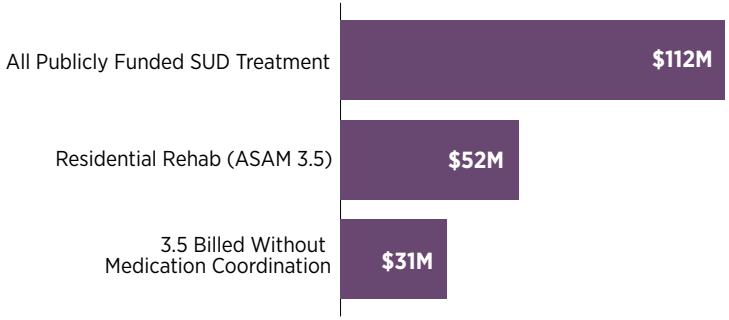
Implementing the steps outlined in this plan will enable more patients to be treated in settings that increase stability and reduce cycling through crisis levels of care. We will expand the availability of lower-cost step-down care for those with SUD who have housing instability but can be effectively served at a lower level of care, and recovery housing where people can continue outpatient care while living in a safe and supportive environment. Some of the savings from shifting to these less costly treatment settings will be redirected toward launching and managing AOR programs that will keep people engaged in treatment.

This program is expected to produce a more cost-effective and efficient system of care. By shifting emphasis from uncoordinated care and cycling through crisis services to ongoing coordinated care and wraparound services, we will retain more individuals in an effective continuum of care that offers the greatest promise for helping individuals manage their condition and their lives more effectively.

Ultimately, the measure of this program's success will not be in its financial impact but in its effectiveness at helping individuals achieve sustained recovery, and the benefits that this brings to their lives, their families, and their community. Managing limited resources with a focus on long-term outcomes will yield significant benefits for all of Allegheny County.

Nearly Half the SUD Treatment Dollar Buys Residential Rehab — Most of it Without Medication Coordination

Paid claims, calendar year 2025. The medication-coordinated rate costs only ~7% more per day.



Source: ACDHS Data Warehouse, AC_MH.UNIFIED_BH_OLAP, pull 2026-05-28. 2025 paid claims across OUS, AUD, and other-SUD primary cohorts.

We will retain more individuals in an effective continuum of care that offers the greatest promise for helping individuals manage their condition and their lives more effectively.

Endnotes

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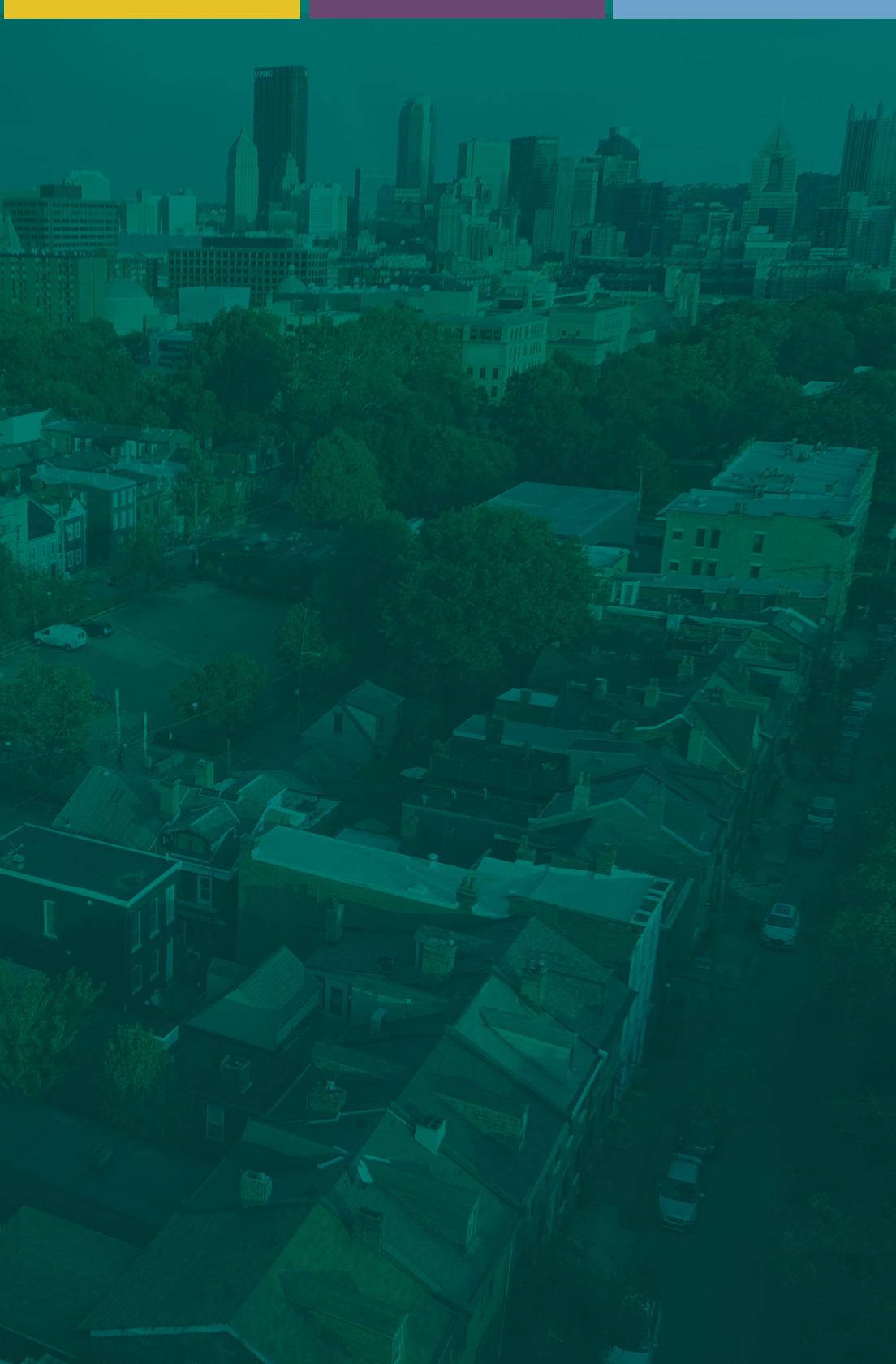

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