

COOPERATIVE AGREEMENT TO BENEFIT HOMELESS INDIVIDUALS (CABHI)

PROGRAM OVERVIEW

Ohio Mental Health and Addiction Services (OhioMHAS) and its partners will implement the CABHI States-Ohio Housing and Recovery Initiative (OHRI) to address housing and service gaps for *veterans who experience homelessness, veterans who experience chronic homelessness and non-veterans who experience chronic homelessness and that experience severe and persistent mental illness and/or substance use disorders* in Cuyahoga, Franklin, Hamilton, Montgomery and Summit Counties. The intent of OHRI is to outreach, engage, and link to services and permanent housing utilizing screening tools and evidence based practices to end the cycle of homelessness for these individuals. Major partners include the Alcohol, Drug Addiction, and Mental Health (ADAMH) Boards and their providers, and the Ohio Housing and Homeless Collaborative (HHC). An expanded statewide infrastructure will promote adoption of these evidence based practices throughout Ohio, and adopt policies and strategies to sustain them over many years. Local and state staff will be trained in evidence based practices, and disseminate them statewide. Per the 2013 Point-In-Time Count, these five urban counties include 6,846 homeless persons of whom 12% (885) are veterans and 18% (1,233) are chronically homeless. These counties make up 56% of Ohio's total homelessness, 72% of veteran homelessness, and 68% of chronic homelessness.

In the five (5) OHRI counties, the ADAMH Boards indicated that about 25% of persons who are homeless are seriously and persistent mentally ill, as compare to all Ohioans of who about 6.6% reported mental health impairment in the Ohio Medicaid Assessment Survey. These ADAMH Boards also estimated that 26% of homeless persons have chronic SUD as compared to 7% of all Ohioans with alcohol abuse and 4% other drug dependences (Ohio SEOW/NSDUH data).

Each partner county will expand outreach services to chronic homeless veterans and non- veterans with mental illness and or substance use disorders. Eligible individuals will be identified through the continuum of care system, veteran’s administration and outreach and engagement. As this identified population is a priority population for most of the continuums, individuals will be prioritized for permanent housing and will be engaged with linkage to services, benefits and evidence based practices to enhance their housing retention and end the cycle of homelessness.

Ohio has projected to serve a total of 820 individuals over the three year grant period.

Ohio CABHI Program Projections of Individuals Served				
	Year 1	Year 2	Year 3	Totals
Cuyahoga	65	75	80	220
Franklin	50	70	80	200
Hamilton	40	60	70	170
Montgomery	30	45	50	125
Summit	20	35	50	105
Totals	205	285	330	820

1) SERVICE TARGETS

Proposed number of individuals to be served by subpopulations in the grant service area, and identification of disparate population.

Ohio Housing & Recovery Initiative CABHI States									
	Projected 3 Year Totals by County					Projected CABHI Clients Counts			
	Cuyahoga	Franklin	Hamilton	Montgomery	Summit	FY 1	FY2	FY3	Total
Race/Ethnicity									
Black or African American	148	130	97	46	36	116	159	181	457
American Indian or Alaska Native	0	0	0	0	0	0	0	0	0
Asian, or Pacific Islander	0	0	0	0	0	0	0	0	0
White	54	55	65	72	61	71	109	128	307
Hispanic/Latino(not including Salvadoran)	8	12	4	0	2	7	8	11	26
Salvadoran	0	0	0	0	0	0	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0	0	0	0	0	0	0
Two or more Races	10	3	4	7	6	11	9	10	30
Totals	220	200	170	125	105	205	285	330	820
Gender									
Female	102	59	56	50	33	81	110	110	300
Male	118	139	111	75	72	123	173	219	515
Transgender	0	2	3	0	0	1	2	1	5
Totals	220	200	170	125	105	205	285	330	820
Special Populations									
Veteran	12	85	13	5	21	34	49	55	138
Living in Poverty	220	200	170	125	105	205	285	330	820
By Sexual Orientation/Identity Status									
Lesbian	3	16	2	2	0	6	8	9	23
Gay	2	16	2	2	3	6	9	10	25
Bisexual	0	16	2	2	0	5	7	8	20

2) QUALITY IMPROVEMENT PLAN

A plan of how you will use your data for outcomes regarding race, ethnicity and LGBT status, including processes or programmatic adjustments to address identified issues, across the following domains:

- a. Data collection Activities
- b. Program services and activities development and implementation
- c. Data reporting, including access, use and outcomes measures

OhioMHAS has extensive experience collecting a variety of client data including, demographics, service data, staff and team assignments, outcomes, diagnoses, and medications. All data are entered into an integrated system. With 16 staff in the research office, OhioMHAS will be able to translate this experience into a project-specific data collection protocol that includes the collection of all required performance measures. The Department’s lessons of experience from previous and current SAMHSA funded grants has led to the development of an early notification system for GPRA six-month follow-up interviews to allow the needed data collection in a timely manner. These lessons will be applied to data collection and reporting requirements using the SAIS system to report GPRA requirements for this project.

OhioMHAS will implement the local and state level portions of the evaluation. OhioMHAS has extensive expertise in evaluation and research management for a wide variety of initiatives locally and nationally. Staff will assist in all aspects of evaluation design and implementation related to the project, including instrument design, Institutional Review Board protocols and reviews, data collection and processing, data analysis and will oversee the implementation of Quality Assurances as they relate to the data requirements of the evaluation. OhioMHAS will also provide training and technical assistance to field and data collection staff. Utilizing the vast array of state level resources across systems, including facilities, technology, equipment and expertise will allow the state to serve as a model for local communities of how to build capacity for evidence based practices.

Ohio will implement a comprehensive project evaluation to systematically assess the ongoing status of the program and to measure progress toward overall objectives. The process evaluation components of the evaluation plan will be used to make course adjustments to project activities. The evaluation team will design or modify instruments and processes to track progress, identify barriers and efforts to overcome barriers to achieving outcomes. The evaluators will provide annual progress reports. The state will report performance **annually** on performance measures through the project evaluation team. The following outcome and process research questions will be integrated into both the statewide and local evaluation data collection instruments and processes.

Outcome Research Questions:
What was the effect of the CABHI interventions on key outcome goals?
What factors were associated with outcomes, including race/ethnicity/sexual identity (sexual orientation/gender identity)?
How many people were assessed and permanently housed as a result of grant services? How many received Critical Time Intervention. Also, how many were enrolled in Medicaid and other mainstream programs as a result of the grant?
What program and contextual factors were associated with increased access to and enrollment in Medicaid and mainstream programs?

What was the effect of the permanent housing, recovery support, or treatment on key outcome goals?
Was the permanent housing and recovery support effective in maintaining the project outcomes at 6-month follow-up?

Process Research Questions:
How closely did implementation match the plan?
What types of changes were made to the originally proposed plan?
What types of changes were made to address behavioral health disparities, including the use of Enhanced National CLAS Standards?
What led to changes in the original plan?
Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?
What activities and actions taken by the Ohio Housing and Homeless Collaborative (HHC) helped improve the access to clinical and housing outcomes of sub awardees?
Are the targets and indicators linked and used to inform quality improvement activities for the state?
What efforts have been taken to overcome administrative and clinical barriers in enrolling individuals in Medicaid and mainstream programs?
What strategies were used to maintain fidelity to the evidence-based practice or intervention across providers over time?
How many individuals were reached through the program?
How has technology been used to improve the delivery of services and coordination of care for the population of focus?

Local performance measures: The local community partners will collect and report the following GPRA data **quarterly** throughout the five years of the grant program and in a final performance report.

Process Performance Measures
The total number of persons served as a result of implementing strategies identified in the grant.
The total number of persons who received CABHI services.
The percentage of housing referrals for persons which resulted in housing services being provided in the community.
The percentage of persons served that were satisfied with the cultural and linguistic appropriateness of the services provided.
The fidelity rate to CABHI grants standards of program providers (baseline, 18 months, and 36 months).

Outcome Performance Measures
The percentage of persons served that gained housing as a result of the grant.
The percentage of persons served that maintained housing for 6 months and 12 months.
The percentage of persons that increased their quality of life (housing, social connectedness, self-

sufficiency) as a result of grant services (measured every six months).
The percentage of persons served by housing or recovery specialists that secured housing.
The percentage of persons served that were enrolled in Medicaid.

Local data management: OhioMHAS has taken a proactive approach to data management with an integrated data system and core internal processes for maintaining high quality data. These principles will be applied to the data management component of the proposed project. Under the oversight of the OhioMHAS Project Director, the Quality Management Leader (Evaluation Lead) and the evaluation team will be responsible for monitoring all data collection and database management activities, conducting monthly database checks and quarterly analyses, and summarizing project findings for key stakeholders. The OhioMHAS Quality Management Leader will be responsible for reviewing and cleaning data prior to entry and entering additional data into locally maintained databases. GPRA data will be entered quarterly based on data collected from records and surveys and downloaded for review and analysis. Local data will also be entered, reviewed, and analyzed using this same timeframe. These local data will be stored on a dual backup network with computers protected by firewalls and project-specific passwords. Personal identifiers will be stored separately, with only an identification number assigned to participant data. All staff will complete the Health Insurance Portability and Accountability Act (HIPAA) training and sign a confidentiality statement clearly delineating protocols that must be followed in collecting and storing participant information. Strict attention will be paid to maintenance of confidentiality at all times. Only OhioMHAS Project and Quality Managers will have access to GPRA data. All data analyses, reports and professional publications will be at the aggregate, not individual level.

Local data analysis: Quarterly analyses will be conducted on the data to monitor progress, make necessary project adjustments, and communicate findings to key stakeholders. Analyses will focus on key performance measures including housing status, employment status, educational status, mental illness symptomology, functioning, crime and criminal justice involvement, access to services, retention in services, physical and mental health status, and social connectedness. Both descriptive and inferential analyses will be conducted. In particular, the evaluation will assess changes between intake and six-month follow-up on all measures and examine whether any demographic or clinical variables predict housing and treatment/support services participation. Other analytic aims will be determined in collaboration with the project management team.

Local performance assessment will include fidelity checks to ensure that the data collection plan is appropriately implemented. Fidelity checks will be conducted at baseline, 18 months, and 36 months to determine if any additional training and technical assistance may be required. Fidelity checks will be conducted by the evaluation team. The evaluation team will also conduct fidelity checks to ensure that all GPRA data is being collected consistently, timely and accurately. Volume of client and client demographics will be monitored by site on an ongoing basis to determine whether the number and composition of clients is consistent with project projections.

Continuous Quality Improvement: OhioMHAS has recent experience with continuous quality improvement (CQI) through its SAMHSA/CSAT Strengthening Treatment Access and Retention – State Implementation (STAR-SI) project. This project, funded from 2006 – 2010 used the NIATx Model of Process Improvement as a method for focusing on quality through process improvement. NIATx was developed at the University of Wisconsin-Madison with a focus on substance abuse treatment and has recently been applied to mental health service settings. During the course of the project, a total of 51 providers and boards were funded by OhioMHAS to participate. Through this process, OhioMHAS

diffused NIATx to other treatment providers. Subsequent Strengthening Treatment Access and Retention- State Implementation (STAR-SI) funding also assisted in diffusing the model to the field. In addition, OhioMHAS used NIATx tools and techniques internally with administrative-related change projects and began a pilot project in April 2011 with prevention providers. Given this demonstrated success with NIATx, MHA plans to use NIATx tools and technique for CQI with this project.

3) ADHERENCE TO THE CLAS STANDARDS

A plan for the development and implementation of policies and procedures to ensure adherence to the Enhanced Culturally and Linguistically Appropriate Services (CLAS) Standards and the provision of effective care and services that are responsive to:

1. Diverse cultural health beliefs and practices;
2. Preferred languages;
3. Health literacy and other communication needs of all sub-populations within the proposed geographic region.

Programmatic strategies will be implemented at the state and local level to ensure adherence to the CLAS Standards. At the state level, a Disparities and Cultural Competency (DACC) Advisory Committee will analyze outcome data and provide the CABHI Project Manager with recommendations for operationalizing CLAS Standards at the local level. The creation of DACC is one of four strategies identified in the OhioMHAS strategic plan to address health disparities. The DACC Advisory Committee is composed of partners representing the Asian, Hispanic/Latino, African, LGBTQ, American Indian and Alaskan Native, and African American communities. Each representative is a subject matter expert in cultural competence and functions in a leadership capacity in the following organizations:

- Ohio Department of Mental Health and Addiction Services
- Ohio Asian American Health Coalition
- Urban Minority Alcoholism & Drug Abuse Outreach Program (UMADAOP)
- Ohio Latino Affairs Commission
- Native American Indian Center of Central Ohio
- Multiethnic Advocates for Cultural Competence

This group will operate as a technical assistance collaborative with CABHI program staff to ensure that CQI and evaluation monitoring is assessed through a cultural and linguistic competence lens. To that end, the DACC Advisory Committee will work with CABHI Project Manager to accomplish the following strategies:

1. Improve cultural and linguistic competency
2. Improve health and behavioral healthcare outcomes for racial, ethnic, and underserved populations
3. Increase awareness of the significance of health disparities in behavioral health, their impact on the state, and the actions necessary to improve behavioral health outcomes for racial, ethnic, and underserved populations.

These strategies are based on the National Partnership for Action (NPA) 2011 National Stakeholder Strategy for Achieving Health Equity. The DACC Advisory Committee will make available a *Learning Series* to CABHI program staff through which event speakers will share experiences from the provider perspective and consumer voice on current efforts to reduce disparities at the local level. Speakers will discuss existing service gaps, emerging access barriers, and current strategies underway to achieve health equity. CABHI grantees will have the opportunity to interact with panelists and learn about Best and

Promising Practices as it relates to engagement, retention, and outcomes. These providers will also have access to regional Enhanced National CLAS Standards training which will include an overview on key concepts such as the State of Ohio Cultural Competence Definition (i.e., Cultural competence is a continuous learning process that builds knowledge, awareness, skills and capacity to identify, understand and respect the unique beliefs, values, customs, languages, abilities and traditions of all Ohioans in order to develop policies to promote effective programs and services.) and the Minority Health and Health Disparities Research and Education Act of 2000 (i.e., A population is a health disparity population if there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population.). Local areas will also have access to the OhioMHAS Resource Bank. The Resource Bank provides power point presentations, full journal articles, and resource lists on how to effectively develop and provide culturally and linguistically appropriate services across the various service populations in Ohio. All of these resources will be utilized as tools to improve access and quality of culturally and linguistically appropriate services.