



State Fiscal Year 2015 Analysis Community Collaborative Resources

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Pursuant to the Mid-Biennium Review (House Bill 483), the Ohio Department of Mental Health and Addiction Services (OhioMHAS) implemented the Community Collaborative Resources (CCR) program, which set forth \$20.1 million dollars for investments in addiction and mental health recovery supports with emphases upon crisis and housing. The funds were to be used in State Fiscal Year (SFY) 2015. This investment prioritized funding projects that fill gaps in the continuum of care established by boards of alcohol, drug addiction and mental health services (ADAMHS) under division (A) (11) of section 340.03 of the Ohio Revised Code. Projects were identified in consultation with and implemented by ADAMHS boards except in areas for which the Director of OhioMHAS identified unmet needs. Within the SFY 2015 reporting period, there were no specialized projects and all funds were granted to ADAMHS boards.

Projects were encouraged to include some of the following elements:

- Collaboration
- Innovation
- Sustainability
- Efforts to reduce administrative costs and move funds into direct services
- Stakeholder support beyond traditional behavioral health partners
- Efforts to maintain local capacity, especially meeting needs for crisis and housing
- Concepts that can be evaluated and meet the expectations set forth in the legislation

CCR projects were awarded to local boards as part of the 2015 Community Plans. The CCR funds brought additional resources to the areas of housing, crisis care, treatment and program development. Table 1 demonstrates the SFY 2015 totals by area of focus.

Agency and Community Investments

Through CCR funds, several agencies were able to expand their treatment capacity. One provider in the Southwest region reported hiring eight new employees. Several agencies that received CCR funds reported hiring additional clinicians and expanding their hours. As a result, the programs reported that wait lists were reduced and clients were seen more quickly. Additionally, CCR funds enabled some crisis teams to assess and admit clients during evening hours, thereby stabilizing clinician hours and expanding access to care.

The CCR funds were successfully utilized by county boards to increase the field's resources. Trainings helped to maintain qualified clinicians, inform providers on the needs of the client base and increase public awareness of underserved populations within the mental health and addictions fields. One population of interest within the Southeast region was expectant mothers. A series of trainings, presentations and community discussions supplied residents with valuable information regarding the importance of prenatal care. Other trainings

Table 1. CCR Service Totals, SFY 2015

Area	Indicator	SFY 2015 Total
Assessment	Number of new assessments	16,176
Crisis	New crisis beds purchased	210
Crisis	Units of crisis intervention provided	1,270
Crisis	Persons linked to services	470
Employment	Number of new jobs obtained by clients	187
Housing	Total served in subsidized housing	480
Housing	Number of housing vouchers funded	528
Program Expansion	Number of new units contracted, expanded or built	43
Program Expansion	Number of staff increases	23
Program Expansion	Number of new policy changes	154
Program Expansion	Number of people trained	547
Treatment	Number of clients served	15,411
Treatment	Number of bed days funded	1,899
Treatment	Total served in MAT	574
Treatment	Number of new referrals to services	1233
Treatment	Total served through residential treatment programs	601

included the person-centered Recovery Oriented Systems of Care (ROSC) training series, which was adopted by the majority of boards. ROSC trainings helped to engage individuals in their own recovery process. Similarly, cognitive enhancement trainings established in the Northwest region helped to expand peer supports and community resources aimed toward treatment, recovery and wellness. Attendance and public interest have been high, with one region reporting an expected audience of 135 people for the ROSC trainings. As a result of the outreach, participation in peer coaching and cognitive enhancement programming also increased within the past year, with several groups reporting positive responses from clients.

Similarly, medication assisted treatment (MAT) expansion and the related trainings led to several new partnerships and collaborations within Ohio. The MAT trainings have helped to develop a positive relationship between the ADAMHS boards and local health departments. Training and evaluation partnerships were established between state universities and providers. In addition, the trainings have increased the number of Ohio physicians with an interest in MAT.

The newly established programs have increased capacity to meet direct care service needs, while improving practitioner and program-level cultural competence. An agency within the Heartland region reportedly added a translator to their staff, thereby improving client satisfaction and engagement with the treatment process. Other programs have completed similar expansions, such as legal resources.

Treatment and Care Coordination

CCR funds also helped to increase alcohol and other drug (AoD) residential and detoxification treatment within several regions of the state. A number of these programs reported hiring new treatment staff with CCR funds. By increasing volunteer and paid treatment staff, the CCR funds helped to expand treatment to additional populations, reduce wait times, and increase client satisfaction and engagement. However, one project leader reported difficulty increasing awareness of AoD issues within their community.

Mental health treatment has been difficult to access within several of Ohio's rural and Appalachian counties. In an effort to address this issue, a multi-county program within the Southeast region provided in-home supportive services to 79 individuals recently released from inpatient psychiatric facilities. The program demonstrated success, with 90 percent of clients remaining in the community for at least 30 days without a re-admission. At 90 days, the rate remained somewhat stable, at 87 percent. The Southeast region also added a transportation program, increasing access to state hospitals. The success of these programs may point to home health care as a viable option for individuals within rural areas.

CCR promoted collaboration between county boards in an effort to eliminate barriers which currently exist within treatment. As a result of their efforts, partnerships arose between boards, providers, schools and peer support groups. Several counties utilized CCR funds to develop collaborative projects which provided treatment to specialized populations. Within the area of care coordination, prenatal care developed as a focus of several Appalachian and rural counties. County recovery centers and providers worked to provide screenings, referrals and case management efforts for women with addictions needs. Funds were also used to assist expectant mothers with expenses. Several successful treatment cases were reported. With the help of one AoD program, one woman abstained from using illicit drugs during her pregnancy, 5 women did not use illicit drugs between arrival to treatment and child birth, and 5 babies were born drug-free.

The CCR funds have also led to several expansions within detoxification and residential treatment. One provider reported, "We have been able to serve double the amount of people at this point in the fiscal year than we have been able to serve in previous years in AoD residential and detox services, with the increased CCR resources. We anticipate the number to be triple our past few years by the end of the fiscal year. This has felt good to the provider and to the community!" The number of detox programs has increased, and several project leaders reported an increase in number served. In addition, CCR funds have helped to address the opiate issue at the policy level. Within the Central region, the residential treatment centers are directly linked with drug courts to provide MAT to those in need. In addition, project leaders are currently working with drug courts to refine a special docket regarding opiate-related offenses.

Despite the recent expansions, several project leaders recognized existing barriers to treatment. Transportation is still seen as an obstacle, particularly within the Appalachian region. In addition, boards which include several counties often had difficulty coordinating programs, possibly due to staffing issues. Rural counties also reported difficulty hiring AoD-licensed staff and training facilitators.

Criminal Justice

Through the development of programs which focus upon the integration of individuals with criminal justice backgrounds, the CCR funds reportedly helped to reduce emergency services within the Southeast region. These programs maintained a wide range of services, including assessment, counseling, intensive outpatient and employment assistance. Some programs focused their efforts upon very specific underserved populations, including individuals not eligible for insurance.

CCR recipients suggested that collaboration between the drug courts and county boards may be related to increased AoD treatment success rates. Improvements in care coordination have reportedly reduced recidivism rates among individuals with criminal backgrounds. Licking County reported that 91 percent of offenders receiving services from the linkage and re-entry program had no new involvement with the criminal justice system.

Crisis

The CCR funds were used to provide alternatives to state hospital placement and reduce mental health crisis costs within the state. Crisis funds were used to treat individuals in mental health or substance abuse crisis and return them to a stable living environment, at the lowest possible level of care. In addition to expanding the number of available crisis beds within several counties within Ohio and conversely decreasing state hospital use, CCR funds linked additional clients in need of crisis care to services.

Project managers within the realm of crisis care reported increases within billable hours and access to psychiatric care. Providers also reported increased productivity, and a recognition among staff of the urgency when treating patients in crisis. The funds were particularly useful within counties with smaller populations. The development of crisis hotlines within rural and Appalachian counties resulted in a total of 13,484 connections with clients in crisis.

Employment

Several employment programs were begun or maintained with CCR funds. Programs reported collaborating with local employers and employment agencies. These programs also helped to increase public awareness of mental health issues and helped local employers understand behavioral health needs. Existing programs also added new staff, including employment specialists. A supported employment program within the Southeast region reported helping 25 clients maintain employment past 90 days. One provider from Clermont County shared a success story:

“In November 2014, a gentleman presented for intake. He reported staying at the local homeless shelter, had no vehicle, and had a family he needed to raise. He was receiving limited assistance. We were able to help him locate work in January 2015 in his chosen profession. During this time, he has been able to save up and gain stable housing and public assistance, has maintained his sobriety, and is only a few weeks shy of reaching 90 days of continued employment. He reports his employer is satisfied with his performance and he is working on gaining stable transportation. Per his treatment agency of choice, this client has been successful with treatment and has graduated from his groups. He has been able to maintain stability with medication assisted treatment since his graduation in March.”

While several programs established supporters within the community, clients were often difficult to maintain due to recidivism to prison, relapse in treatment, or not following up after the initial assessment. Staffing and funding issues were also common. Finally, one agency described the majority of client positions as temporary or seasonal work.

Housing

Recipients of CCR funds focused their efforts upon several different underserved populations within their region, particularly within the area of housing. Housing and residential treatment programs were designed and successfully implemented within each region of the state. CCR funds housed individuals with severe mental illness (SMI) and severe and persistent mental illness (SPMI). Several regions reported an increased need for community residences and housing facilities. Programs included a wide range of populations including transition age youth, children in crisis, criminal justice and individuals with dual diagnoses. Funds fostered collaboration between boards, providing housing services for 480 individuals in need. Within the Southwest region, the housing projects fostered a positive relationship between the regional boards and the city of Springfield, which provided additional funds. CCR housing projects also provided contracts with several new landlords and providers including the Metropolitan Housing Authority and expanded bed availability. Finally, several programs have reportedly begun building new facilities or expanding their current physical capacity. For example, a residential program located in the Central region reported serving seven additional individuals with special needs as a result of their program development efforts. Housing programs reported increasing both volunteer and paid staff capacity, with two programs seeking expansions in the area of recovery coaching. Despite these efforts, several counties reported a growing need for both temporary and stable housing, with high program costs. In addition, one program reported potential clients moving between locked facilities rather than to the community.

Recognizing a community's need for a particular service may not result in immediate success at the program level. Despite reports of increased need for housing programs throughout the state, a newly expanded housing facility reported having available units well after opening their doors. It is possible that local care coordinators and case managers are unaware of the program's expansion. In addition, recidivism to jail from housing facilities was reported as a common trend.

Medication Assisted Treatment

MAT programs were a focus of regional projects funded by CCR. As a result of the funds, several MAT programs reported an increase in clients, and new programs were developed during SFY 2015. Specifically, in an effort to educate the public of the dangers of opioid misuse and save lives from opioid overdose, several Project DAWN (Deaths Avoided with Naloxone) sites were implemented within Ohio. By the end of SFY 2015, 21 new Project DAWN sites were expected to be completed, resulting in increased MAT coverage across the state. Additional trainings regarding MAT best practices have also helped to improve quality of care. Finally, CCR recipients reported that Medicaid expansion increased the number of clients treated via MAT programs.

MAT programs within the Northeast region reported developing partnerships with area drug courts, jails and adult probation departments. Several programs have reported staff increases, including new physicians with training specific to successful MAT. One program within the Northwest region increased psychiatric care for individuals struggling with opiate addiction. Outpatient MAT programs were also added within the Northwest region, through hospitals and local providers.

All of these developments have increased awareness among providers, helping to identify potential MAT candidates and promote appropriate procedures for MAT. As a result of the jail and probation programs, nurses are currently able to administer medication to inmates prior to their release, and treatment continues when individuals are released into the community.

CCR funds were often used to expand MAT toward underserved populations. Within the Northwest region, CCR funds were used to reduce treatment costs for the homeless or uninsured. Within Tuscarawas and Carroll counties, the jail-based reentry coordinator described successful treatment of the first client to receive MAT through the program. "He received his first injection while incarcerated and has done well since. He was granted early release by the court and transitioned to the newly developed Recovery House in the community. He is engaged in ongoing treatment, will work to gain employment in the future." In addition, the client's family noticed changes in his behavior as a result of treatment.

Despite these accomplishments, respondents often reported difficulties specific to MAT program development. Several respondents reported low client volume. The number of clients served by each program within the past year has varied by program, treatment type and region. Medicaid funding seems to have impacted the volume of clients served by various MAT programs throughout the state. A participant reported the diverse effects of Medicaid expansion by saying, "With Medicaid expansion there has been an increase in the number of persons with opiate addiction served under the medication assisted treatment project. However, the number of persons served for MAT from these project funds has been drastically reduced from the original projections. In total, the number of persons served has increased from the prior year (Medicaid and non-Medicaid)."

Some programs also reported a delay in the development process due to funding or staffing issues. Other MAT programs reported difficulties in developing treatment plans or models conducive to treatment of their specific population. In addition to policy changes, media promotion and increased public awareness of specific MAT methods may have also been factors. A provider explains, "Promotion of Suboxone® has caused an inordinate number of requests for the medication. Their acceptance for Vivitrol® is somewhat diminished when they discover it completely counters the high they get from opiates. Lack of detox resources makes successful completions difficult given a user's withdrawal symptoms three days into abstinence."

At the clinical level, MAT programs have reported difficulties accessing and maintaining clients. Staff turnover and the lack of available qualified staff were common issues. Several respondents reported staff changes and contracting issues as barriers to continuous treatment. Some programs reported difficulty identifying and retaining qualified physicians due to financial or logistical concerns. Respondents also reported problems identifying potential candidates for MAT. Others reported that individuals appropriate for MAT and opiate programming were often difficult to reach or engage within treatment, and attrition was common. Transportation and other access issues were also mentioned. Respondents reported losing clients within a short period of time, often due to recidivism to jail. Finally, some AoD providers reported difficulty establishing contracts with providers.

Summary

CCR'S collaboration efforts attempted to bridge the treatment gap for Ohio residents in need of quality mental health, crisis care and residential treatment. Collaboration between boards, providers and state agencies has helped to provide resources to previously underserved populations. Specifically, CCR funds have successfully expanded the fields of crisis care, housing and employment. In addition, several programs supported by CCR funds reported an increased interest in recovery coaching and peer support programming, and produced additional volunteers. New collaborations between the criminal justice, addictions and mental health fields have improved care coordination efforts for individuals struggling with community reentry. Project DAWN and other related interventions have increased both the number and impact of MAT programs throughout the state. Finally, the funds were used to develop AoD and mental health training programs for physicians and clinicians throughout Ohio, thereby improving the quality of care.

One area where barriers still exist may be at the policy level. A board member describes this gap by saying, "Since losing our contract with Mercy Hospital Clermont, the Clermont Board has been interested in having a contract with another hospital to assure access to hospitalization for those clients who have no means to pay for a local hospital or have issues with hospitalization at Summit, or for when access to Summit is difficult. We have talked with other Cincinnati hospitals but were unable to arrange a contractual relationship with them. We thought that by combining with other boards, we would be able to reach agreement with University, but that did not occur." Client retention was a problem for several treatment programs, particularly in the areas of corrections and crisis. Several CCR projects reported difficulty acquiring or maintaining clients, possibly due to transportation.

CCR project leaders often reported staffing concerns. While recovery coaching programs have helped to expand peer support, CCR recipients often reported difficulty finding and maintaining qualified clinicians, including social workers, psychologists and physicians. The staffing issues were most often due to logistical concerns. One regional MAT program described a difficulty maintaining qualified physicians due to travel time.

While the CCR projects reported several improvements and expansions in treatment, some unforeseen setbacks either delayed program starting dates or decreased treatment capacity. While the majority of respondents reported no necessary project revisions or rejections, several newly developing projects reported unexpected financial barriers. A respondent attempting to increase housing capacity reported that program costs were higher than expected. This issue had a direct effect upon program development, and sustainability beyond the funding period. Personnel issues were also reported by upcoming programs. Respondents often reported that a single fiscal year was not long enough to design and implement the proposed programs. As a result, these projects often displayed no data for the first two to three quarters of SFY 2015.

The majority of CCR projects maintained their original goals and objectives throughout the project span. Approximately 6 percent of the projects requested a change in their original intent. Three projects were modified after the proposed use of CCR funds, such as additional projects or staff members, was deemed unnecessary. Boards also requested changes due to transportation, regional differences between chain agencies, and physical distance between providers. One program recognized a need for additional detox beds during their initial program development.

Throughout the tenure of CCR, technical assistance requests were low, and generally related to the re-direction of funds. One crisis program identified the need for a crisis liaison. They suggested that the liaison would help to navigate the layers of administration for crisis providers, and create a memorandum of understanding between the hospitals and crisis programs. In addition, a peer-support program requested additional process training regarding future changes to Medicaid. Finally, a provider requested a procedural document including suggestions for engaging clients who leave treatment and return to the community.

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