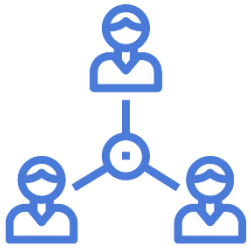

Metropolitan Indianapolis Addiction Referral Assessment and Plan 2020

MARION COUNTY PUBLIC HEALTH DEPARTMENT

Prevent. Promote. Protect.

MARION COUNTY PUBLIC HEALTH DEPARTMENT
Prevent. Promote. Protect.

3838 North Rural Street | Indianapolis, IN 46205 | PH 317-221-2000
www.marionhealth.org

July 16, 2020

Dear Metropolitan Indianapolis Substance Use Disorder and Recovery Service Organizations:
Many organizations form the service system supporting recovery from substance use disorder (SUD) in Marion County. The current system is complex and often uncoordinated, resulting in difficulties with navigation and access by consumers and their loved ones. Easily accessible and coordinated services for persons of all ages and cultures, tailored to the needs of the individual, and including multidirectional feedback between agencies is critical in optimizing success in long term recovery.

The Metropolitan Indianapolis Addiction Referral Assessment and Plan project culminated in this document to: (1) provide an in-depth assessment of the current landscape of care coordination between agencies supporting persons with SUD; (2) identify barriers to effective communication and referrals between agencies supporting persons with SUD; and (3) create a plan for practical short and long-term improvements to communication and referrals between these agencies.

Many agencies supporting persons with SUD in the Metropolitan Indianapolis area responded to our survey to inform and guide development of this plan. Still others participated in virtual interviews. Additionally, numerous individuals personally affected by SUD – either living with the condition or having a close friend or family member who is – participated in interviews. We are grateful for the commitment you demonstrated over the past several months to help with plan development.

While the Marion County Public Health Department facilitated creation of this plan, it belongs to you. You are asked to endorse this plan and to demonstrate a commitment to its implementation. Many of the recommendations must be implemented by you; however, the Marion County Public Health Department will support your implementation in a variety of ways. Soon, you will be contacted by the Marion County Public Health Department to evaluate next steps in creating implementation and evaluation plans. We look forward to growing this relationship with your agency, and to partnering with you to improve the health and quality of life of our residents.

If you have questions about this project, please contact Tammie L. Nelson, Epidemiology Manager and Marion County Overdose Data to Action Grant Coordinator at the Marion County Public Health Department. To contact her, call 317-221-3596 or send an email to TNelson@MarionHealth.org.

Regards,

Virginia A. Caine, MD
Director and Chief Medical Officer
Marion County Public Health Department

Tammie L. Nelson, MPH, CPH
Epidemiology Manager and Marion County
Overdose Data to Action (OD2A) Coordinator
Marion County Public Health Department

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I. Executive Summary

A. Purpose

The purpose of the Metropolitan Indianapolis Referral Assessment and Plan (RAP) project is to:

- assess the current landscape of substance use disorder (SUD) treatment and support delivery in Indianapolis and the surrounding metropolitan areas;
- identify barriers to effective communication and referrals between agencies supporting persons with substance use disorder (PWSUD); and
- recommend practical short and long-term improvements to communication and referrals between agencies supporting PWSUD.

B. Method

In order to gather data to inform the assessment and plan, the RAP Project team:

- developed a list of agencies, and contacts at those agencies, that provide treatment, recovery, and supportive services to PWSUD;
- created and distributed an online survey to those contacts;
- interviewed those survey respondents who indicated a willingness to participate in follow-up interviews to elaborate on responses in the online survey;
- developed a list of PWSUD and/or family members supporting PWSUD;
- contacted the PWSUD and asked for their participation in a telephone interview regarding their experience in getting treatment and support;
- conducted structured interviews with PWSUD and/or their family members who agreed to participate;
- interviewed representatives from known or suggested groups or systems supporting the initial or continuing referral of PWSUD to a treatment or recovery support agency.

The goal of the survey and interviews was to identify barriers or gaps in the effective coordination of the referral process. We found that organizations and PWSUD provided information about not just the referral process but also the initial entry into the treatment and recovery process, most of which impact the coordination of referrals as the treatment and support agencies assist the individual in navigating the continuum of addiction services.

C. Findings

An observation from all the data gathered from both organizations and PWSUD was that every organization with which we interacted was passionate about providing the best services possible to their clients and anxious to move forward in improving the coordination of referrals. Some of the recommendations made to improve the referral process are the responsibility of individual organizations, while others require cooperation and participation by an organized group of the organizations or the Marion

County Public Health Department. The project team believes there is a commitment by the SUD treatment and recovery support community to implement this plan.

From the data gathered, the RAP Project team found the following issues to be the most common barriers in coordinating effective and timely agency to agency referrals:

- There are several listings for providers of SUD treatment and recovery support services with varied levels of information. However, there is not currently a comprehensive online **directory of services** that is up to date and pertinent to coordination of care, or that has an online referral and follow-up functionality;
- Many agencies have built trusted relationships over time through trial and error and commonly make referrals to those they know and trust. Younger provider organizations or newer staff at those agencies may not have established those relationships. Neither generally has a way or forum to expand on, or to form, new **relationships** with new providers in the area or new contacts at established providers;
- There is no **universal referral form** that alleviates the need for the patient to repeatedly provide the same information;
- Selection of a referral target agency is hindered by the client's not having access to, or knowing about or how to use, available **transportation**;
- Referral to or access to services is limited or prevented by the client's **access to or limited payment options**;
- Referral to some services, particularly **housing**, is hindered by the availability of those services, i.e. quantity, at the time needed.

D. Proposed Improvement Plans

The proposals for improving upon the coordination of referrals are both short-term and long-term. They involve initiatives fostered by, sponsored by, or carried out by the Marion County Public Health Department in order to sustain the initiatives long-term. However, the cooperation and participation by each agency providing SUD treatment and recovery services in the greater Metropolitan Indianapolis area is essential for the greatest success. These proposals should not be seen as substitutes for current efforts by several agencies but as additive or expansive of those initiatives. The proposals are:

- **Directory of Services**:
  - Existing lists of service providers are currently in transition or process. 211 navigators have access to listings of treatment and service providers and are trained to make referrals into the system of care. Both 211 and treatmentconnection.com (OpenBeds) list providers. The Indiana Recovery Network's (IRN's) Recovery HUB links to provider information in various areas. These services are important in getting PWSUD initially into the treatment and recovery support continuum.

    Current services do not facilitate the referral process between or among agencies but are currently available as a starting point and are accessible by

the client as well as service organizations. PWSUD can also connect to a peer through IRN's Recovery HUB for help in finding a provider and ongoing support.

Education about these resources should be organized and delivered to providers across the spectrum of services needed by PWSUD.

- Longer term, a neutral government agency (e.g., Indiana Family and Social Services Administration, City of Indianapolis, Marion County Public Health Department) should procure an automated tool that provides not only a directory of services but facilitates referral services including the following elements:
  - A comprehensive searchable database that includes both treatment and non-treatment services such as, but not limited to, facilities for housing, recovery coaches and peers, and transportation. This would require no fee listings. The directory would need to be searchable by treatment or support services delivered, location, substance use being treated, and other factors relative to the needs of a client. Agency profiles are necessary and need to include factors such as, but not limited to, population served, population not served, payment type accepted, current availability of services;
  - A release of information (42 CFR Part 2, HIPAA, and Indiana State law compliant) and standard referral form (paper or electronic) with data capture of common information;
  - Feedback and communication including appointment scheduling and appointment resolution from the target agency to the referring agency;
  - Communication through email, text, or paper with the client about appointments and follow up;
  - Record retention in compliance with governing regulations and availability of records to the client;
  - Potential interface with electronic provider and client portals;
  - Business and technical support for developing agency profiles, delivering training and support for system usage and maintenance.

- **Relationship Building**
  - Regular, at least quarterly, meetings for agencies and organizations to introduce themselves, present information about their organization including their service offerings and profiles, and to network to build relationships and professional trust are needed.
    - Using the findings from this project of the most common agencies referred to or receiving referrals from, these conferences could target invitees, although should not be constrained by those results.

        - These meetings can be organized by agencies; however, to provide the widest exposure and sustainability, the Marion County Public Health Department should be involved in providing support and information where necessary.
    - At least annually, a regional provider conference should be held to allow for representatives from all types of provider organizations serving the SUD community to share and network. These conferences should include educational materials as well as direct contact information from the various providers. In addition, representatives from 211, treatmentconnection.com, a referral system if procured, Indiana Family and Social Service Administration's Department of Mental Health and Addiction Services, Division of Family Resources, Office of Medicaid Policy and Planning, Medicaid Managed Care Entities, Department of Child Services, Department of Corrections and local criminal justice systems should be included to address the breadth of services needed and available for PWSUD. This not only provides treatment and support agencies the opportunity to learn about State and local systems and services but also provides those agencies an opportunity to learn about the provider community and their needs and ideas to improve services.
    - Long term, the project proposes technical assistance to help organizations enhance their profiles so that referring agencies can better tell what populations they do or do not serve, including special populations (e.g., youth, LGBTQ, people with children).
- **Universal Referral Form**
    - Organization participants indicated in the survey and follow-up interviews that the lack of a universal referral form presents barriers to effective referral coordination. A standard referral form should be developed that includes the common information needed when a client is accepted as a referral. This form should be developed by a group of agency representatives and be compliant with privacy regulations covered by 42 CFR Part 2, HIPAA, and Indiana State law. The referral form should be an electronic form and would require the referring agency to scan the signed client authorization for release of information for electronic transmission, as appropriate.
    - Organizations should agree to and use the common referral form, once developed and approved.
    - If an automated referral system is used, it should incorporate the elements of this standard referral form.
- **Transportation**
    - While not directly tied to referral coordination, transportation is a barrier to referral if there is no way for a client to get to a referred facility. The project team recommends increased use of videoconferencing where the organization and PWSUD are able to participate. Out of necessity due to

COVID-19 restrictions, many organizations have already begun expanded use of these services.
    - Information about the availability of transportation services to PWSUD through, for example, 211 Lyft transportation, Medicaid covered transportation, and public transportation routes and usage, needs to be made available to providers to assist their clients. Informational training sessions should be created to disseminate information about currently available services. For agencies that have funding for transportation, any online profiles about their services need to be updated to include this information, including limitations.
    - Longer term, grant-funded organizations should include transportation costs in their requests and proposals.
- **Payment Options**
    - As with transportation, payment for services is indirectly tied to the referral process. In order to enhance the coordination of referrals, organizations need to clearly advertise and include in their online organizational profiles: 1) the methods of payments they accept; 2) if they use a sliding scale, what the determinants are; and 3) if there are limitations based on method of payment.
    - Initial contact staff need to be trained on and aware of the accepted methods of payment to assist either the PWSUD, family or friends, or referring agencies in making decisions about referral to the provider.
- **Housing**
    - The referral process is impacted by availability of recovery supportive living housing. There are not enough facilities/beds for the need; however, the scope of this project is limited to the referral process. Recovery supportive living housing listings on electronic directories must be comprehensive in terms of indicating the populations served, populations not served, availability, state certification level, and type(s) of psychiatric conditions, medications, and medication-assisted treatment accepted.

The data supporting these conclusions are presented in the Assessment section of this document.

II. Overview

A. Purpose of the Project

Within the metropolitan Indianapolis area, Marion and surrounding counties, there are many organizations supporting treatment and recovery from substance use disorder (SUD). The current system is complex and often uncoordinated, resulting in difficulties with navigation and access by consumers and their loved ones. Easily accessible and coordinated services for persons of all ages and cultures, tailored to the needs of the individual, including multi-directional feedback between agencies, is critical in optimizing success in long-term recovery.

The goals of the Metropolitan Indianapolis Addiction Referral Assessment and Plan (RAP) project, sponsored by the Marion County Public Health Department, were: (1) to conduct an in-depth assessment of the current landscape of care coordination between agencies supporting persons with SUD in the Indianapolis metropolitan area; (2) to identify barriers to effective communication and referrals between agencies supporting persons with SUD; and (3) to create a plan for practical short and long-term improvements to communication and referrals between these agencies.

RCR Technology Corporation was contracted to:

1) assess and analyze the current state of coordination and communication; this included identifying areas of consensus about weaknesses, opportunities, and improvements needed as well as identifying systems that exist locally or elsewhere which might be built upon or partnered with to improve effectiveness;
2) create a strategic plan to improve coordination, including the identification of more easily implemented 'low hanging fruit' or changes likely to bring the greatest return on investment; and
3) develop a plan for improvement that will have the endorsement, and a commitment to implement, from the organizations that participated in the project.

To complete the assessment, input was sought from, but not limited to, the types of organizations identified below:

Types of Organizations Receiving Survey		
Healthcare providers	Transportation services	Food assistance
Substance use treatment	Legal services	Crisis services
Mental health providers	Vocational and job readiness organizations	Childcare assistance
Emergency and public safety agencies	Employment supports	Schools and education systems
Recovery supportive shelters	Domestic violence supports	Faith-based initiatives

Short-term, long-term, and permanent housing entities	Homeless services	Recovery supportive recreation
Other supportive advocacy and outreach services	Law enforcement and criminal justice agencies	Public safety agencies

Grant funding for the project required completion by July 31, 2020, with endorsement of this document being the final deliverable. A set of activities to improve inter-agency communication and coordination to better serve persons living with, or in recovery from, SUD is included in Section IV, Plan Proposals. Additionally, we detail the methodology used in gathering and analyzing data in Section V, Methodology. This project included securing endorsement of the plan and its proposed activities by the organizations that will have to implement, assist in implementing, and support the proposed changes.

In order to include the perspective of those who are impacted by inefficiencies in coordination across agencies, input from persons with substance use disorder (PWSUD) was solicited through interviews of twenty-four (24) PWSUD or their close friends and family members. Seventy-nine (79) organizational staff from among sixty-one (61) organizations delivering treatment and recovery services or related services in and around Marion County, Indiana, participated in this project via survey completion and/or interview. Nearly half of survey respondents participated in either group or individual interviews to further elaborate on their survey responses.

B. Timeline

The duration of the RAP project, from contract execution to publication of this report, was approximately five months. Some of the key milestone activities are listed below:

Activity	**Associated Date(s)**
Project kickoff	February 20, 2020
Online surveys sent out	March 24, 2020
Online survey responses received	March 24, 2020 – April 15, 2020
PWSUD interviews conducted	April 8, 2020 – April 29, 2020
Organization elaboration interviews conducted	May 7, 2020 – June 10, 2020
Post-interview documentation phase*	June 2, 2020 – July 31, 2020
Project end	July 31, 2020

* *Includes review and feedback from participants*

C. Our Team

The following people participated in the RAP project. They served as consultants, subject matter experts, reviewers, and/or interviewers:

Our Sponsors:

Tammie L. Nelson, BS, MPH, CPH Epidemiology Manager and Marion County Overdose Data to Action Grant Coordinator, Health and Hospital Corporation of Marion County d/b/a Marion County Public Health Department	Tammie Nelson is an Epidemiology Manager at Marion County Public Health Department (MCPHD) where she manages a staff of epidemiologists and four overdose prevention grants exceeding $5 million. She oversees several projects for these grants, including the Metropolitan Indianapolis Addiction Referral Assessment and Plan and a collaborative research project linking disparate data sources to identify risk and protective factors for drug overdose. Nelson also sits on MCPHD's Public Health Emergency Preparedness Steering Committee and the Department of Homeland Security's regional BioWatch Steering Committee. Nelson's epidemiology practice focuses on overdose and violence prevention; communicable disease; emergency preparedness; needs assessments, strategic planning, and program evaluation; grant writing and review; and public health practice and research.
P. Joseph Gibson, MPH, PhD Director of Epidemiology, Health and Hospital Corporation of Marion County d/b/a Marion County Public Health Department	Dr. Gibson is an epidemiologist, data scientist, and informatics expert with private and public sector experience who has built decision support systems, developed expert teams, and identified critical factors and trends. He has extensive experience leading the organization and analysis of population health data, clinical data, claims and other administrative or operational data, and surveys. Regrettably, Dr. Gibson was unable to participate in the project after its initial stage due to responsibilities related to the COVID-19 pandemic.
Dean Babcock, LCSW, LCAC Consultant, Faculty Field Liaison, Indiana University School of Social Work; Consultant, Opioid Response Network	Dean Babcock has worked in the Indianapolis addiction and mental health community for about 30 years. He retired from a full-time position as Assistant Vice President at Eskenazi Hospital, responsible for the Midtown Community Mental Health Center. Throughout his career, he has participated in many projects including doing research for the National Institute on Drug Abuse. Currently, he is working for project Echo, and doing faculty work for the IU School of Social Work.

Our Partners:

Brandon George, BS Director, Indiana Addiction Issues Coalition	Brandon George is the Director of the Indiana Addiction Issues Coalition, a subsidiary of Mental Health American of Indiana. He comes from a treatment background and served as the CEO for Pro-Active Resources. He sits on Indiana Attorney General Curtis Hill's Drug Task Force and on boards for multiple organizations in the community. He is a keynote speaker throughout the state at multiple events on a wide range of topics. George has a Bachelor of Science degree in addiction counseling from Indiana Wesleyan University.
Jodi Miller Deputy Director, Indiana Addiction Issues Coalition	Jodi Miller is the Deputy Director of the Indiana Addiction Issues Coalition, a subsidiary of Mental Health America of Indiana. Her background came from working on the micro-level with an internship at Fairbanks Treatment Center and serving as women's coordinator at Fairbanks Supportive Living Program. Additionally, she has done work in the jail systems. Miller is a certified recovery coach and a certified health and wellness coach.
Sharon Dow, MS Senior Associate, The Bizzell Group	Sharon Dow is currently working with The Bizzell Group, a management consulting firm in Lanham, Maryland. She has worked in mental health and substance abuse since 1974 and through that time transitioned from mental health to alcoholism to drug abuse. She worked for the state of Maryland for 20 years as Chief of Policy and Planning. In 1994, Dow started managing a technical assistance contract funded by the Substance Abuse and Mental Health Services Administration. Her specialty is regulation and policy.
Natasha Cheatam Executive Director, Minority Recovery Collective Inc.	Natasha Cheatam is trained as a Certified Addictions Peer Recovery Coach (CAPRC I) and is certified as a Community Health Worker/Certified Recovery Specialist (CHW/CRS). She has dedicated herself to helping as many minorities as she can to find their own path to healing and recovery. She has been determined to help change the narrative surrounding addiction and mental illness in communities of color and other underserved groups.
Matt Heskett Recovery Consultant/Coach, Experience, Strength, Hope LLC; Recovery Coach, Pro-Active Resources	Matt has completed Certified Addiction Peer Recovery Coach (CAPRC) Training through Indiana Counselor's Association on Alcohol & Drug Abuse (ICAADA) and received *2018 Recovery Advocate of the Year* recognition through the Indiana Addiction Issues Coalition. Previously, at Fairbanks Treatment Center, he served as the Employer Services Coordinator, working to build relationships with referral sources, primarily employers, employee assistance programs, and other organizations within the community. Heskett has also worked within the community with such organizations as Indiana Addictions Issues Coalition, Overdose Lifeline, IU School of Medicine, and IU Fairbanks School of Public Health.

Our participating organizations that provided valuable input and review by responding to the online survey and/or by attending follow-up interviews:

*Note: Those who participated in follow-up interviews are indicated with **bold** font.*

Survey and Interview Respondents		
The 24 Group Inc. **Kim Manlove**	*Acadia Healthcare* Elaine Sullivan Dustin Thiels	*Adult and Child Health* **Lauran Canady**
Agape Behavioral Health and Addiction Counseling Services, Inc. Mary Beth Mahan	*Alcohol & Drug Treatment Program* Jennifer Parker	*Alpha Counseling Services, Inc.* Evey Gaither
Ascension St. Vincent Indianapolis **Daniel Waddle**	*Aspire Indiana Health* Trusa Grosso	*Beech Grove High School* Karen Matthews
Centerstone Amy Becher	*City of Indianapolis Office of Public Health and Safety, Albert G. and Sara I. Reuben Engagement Center* Dustin Hughbanks	*Coalition for Homelessness Intervention and Prevention (CHIP)* Danielle Bagg Wireman
Community Health Network **Melissa Davis, LCSW** Aimee Edmonds **Brooke Schaefer** (CHOICE Program)	*Cummins Behavioral Health Systems* Rebecca Bradford	*Damien Center* Ross Dorsey
Dove Recovery House for Women Sarah Owens	*Drug Free Marion County* **Michaelangelo McClendon**	*Eskenazi Health* **Philip Campbell** (Project POINT) **Jennifer Cianelli** (Sandra Eskenazi Mental Health Center) **Jon Ferguson** (Sandra Eskenazi Mental Health Center) Maria Howard (Sandra Eskenazi Mental Health Center) **Leila Mortazavi** (Integrated Behavioral Health Service)
Experience Strength and Hope, LLC Matthew Heskett	*Fairbanks Addiction Treatment and Recovery Center* John Adams (Supportive Living Program) **Robin Parsons** (Fairbanks Hospital)	*Franciscan Health* **Rachael Trimbur**
Grace Ministries, Inc. Greg Overby	*Hamilton Center, Inc.* **Stacey Totten**	*HealthNet, Inc.* Carrie F. Bonsack Lindsay Leonhard (Homeless Initiative Program)
Home with Hope Recovery Residence Dock Henry	*Hope Academy* **Rachelle Gardner**	*Horizon House, Inc.* Leslie V. Kelly Nicole Wesling
HVAF of Indiana, Inc. Bryan Dysert	*Indiana Family & Social Services Administration* **Tony Toomer**	*Indiana Minority Health Coalition* Tony Gillespie

Indiana Recovery Network **Heather Rodriguez**	*Indiana University Health* Leslie Hulvershorn, MD **Spencer Medcalf** **MacKenzie Sering, LCSW** (IU Health Methodist Addiction Treatment and Recovery Center)	*Indiana Youth Group (IYG)* Chris Paulsen
Indianapolis Intergroup Alcoholics Anonymous Alex Necker	*IUPUI Office of Health and Wellness Promotion* Danielle Wolfe	*Jane Pauley Community Health Center* Marc Hackett
The Landing Place, Inc. Linda Ostewig	*Landmark Recovery* Tobyn Linton	*Life Recovery Center* Eric L. Davis
Marion County Public Health Department **Debra Buckner**	*New Life Recovery Home* Annette Kreider	*Overdose Lifeline* **Justin K Phillips** **Kourtnaye Sturgeon**
Parents of Addicted Loved Ones (PAL) Andrea Boutselis	*Pathway to Recovery, Inc.* Sandy Jeffers	*Progress House* **Brian Foster** **Darrell Mitchell** **Eliot Severeid**
Public Advocates in Community Re-Entry, Inc. (PACE) **Rhiannon Edwards**	*Raphael Health Center* Claire Kammen	*Reach For Youth* Denise A. Senter, LMHC
Regenstrief Institute Debra Litzelman	*Salvation Army Harbor Light Center* Maj. K. Kendall Mathews	*Shalom Healthcare Center* Doris Graciano **Dominique Leveque** Shauna Miller
Shepherd Community Center **Andrew Green**	*Spero Health* **Mark Rappe**	*Summit Behavioral Healthcare* Erin Mooney
Tara Treatment Center Tina Snider	*Trusted Mentors* **Jeri Warner**	*Valley Mills Christian Church* Robin Paul
Veteran's Affairs Substance Use Disorder Recovery Program S. Earles, CARN, MA, LCAC	*Volunteers of America* Shannon Schumacher	*Wheeler Mission* Brandon Andrews **Lisa Hoffman**
Willow Treatment and Recovery Center, LLC Ashley S. English		

The individuals who participated in interviews to give us the perspective of people personally affected by SUD, including both PWSUD and close friends and family members, are identified in Appendix C. Some of the participants allowed their full name to be used; others chose to be identified by first name only, initials only, or with anonymized identifiers. Regardless of how they are identified their input was valuable and contributed to our findings and recommendations.

D. Acknowledgements and Appreciation

Without the invaluable assistance of Dean Babcock, this project would not have been possible. He was contracted by Marion County Public Health Department to be a

consultant to the project team. He provided expert guidance thanks to his decades of experience in the addiction and mental health community of Indianapolis.

We additionally thank Jodi Miller, Matt Heskett, Natasha Cheatam and Sharon Dow. This team led phone interviews with PWSUD. Miller, Dow, and Babcock also participated in follow-up interviews with survey respondents.

We also thank Brandon George who was instrumental in the early stages of the project by assisting in formulating the questions for the online survey and overall guidance throughout the process.

We also wish to express our appreciation for the organizations that participated in the surveys and follow-up interviews. This project took place during the early stages of the COVID-19 pandemic, a very difficult time for healthcare and related organizations. The project team was aware that often only a small percentage of individuals respond to a survey request. We received completed surveys from seventy-six (76) respondents out of 230, for a response rate of 33%. This is an excellent response rate, especially considering the online survey timeframe and onset of the COVID-19 pandemic. These organizations provided invaluable feedback and details, further evidence of their commitment to making improvements in the coordination of SUD treatment and recovery for the benefit of their clients.

Lastly, we could not have gathered complete data without the contribution of the people personally affected by SUD, including both PWSUD and their close friends and family members. These individuals volunteered to share their experiences while battling this disorder. The interviewees were very open about discussing personal and difficult times in their lives as well as the ongoing recovery process. Without bringing to the conversation those affected most directly by the delivery of services, we would not have a complete picture of how a lack of service coordination impacts outcomes. We extend our sincerest thanks for their participation.

III. Assessment

In this section, we discuss data that was captured through: an online survey of organizations delivering treatment and supportive services for PWSUD; survey follow up interviews; interviews with PWSUD and their close friends and family; and interviews with initiatives for finding and coordination of services.

A. Organization Survey and Elaboration Results

Survey results and data from follow-up interviews with organization representatives are detailed in Appendices A and B. Below are discussions on the most prevalent answers. This is not to discount any of the less common responses. Each response should be considered in looking at ways to improve service delivery, but initial focus is on the most commonly identified barriers.

1. Source and Target of Referrals

The top sources of referrals to surveyed organizations were family and friends, followed closely by governmental agencies or justice system entities and treatment organizations or related agencies that address SUD. Referrals for medical and mental health issues were the fourth through sixth most common referrals received by survey respondents.

Responses from Organization Interviews:

While the purpose of the project was to assess the coordination of referrals and services between agencies, organization interviews indicated that a number of agencies are the starting point for services. For those trying to assist PWSUD with getting them to the right service, there is an issue with finding the most appropriate entry point into care.

Several post-survey interviewees receive referrals from government and criminal justice entities. Some of these organizations serve young people and adolescents receiving referrals from the Department of Child Services. Still others directly serve persons with a history of incarceration. Many of these organizations have established relationships with the entities from which they receive referrals.

Targets of referrals from the survey respondents were to organizations that addressed mental health treatment, recovery/supportive living, medical treatment, recovery support and SUD treatment. In survey follow-up meetings, several agency representatives noted that mental health providers often do not address SUD even though it is common for these disorders to co-occur.

In order to be successful in recovery, recovery housing is often needed, along with the services of supportive living to enable PWSUD once they are discharged from a facility. Finding appropriate housing is especially difficult for those who have a history of being in the criminal justice system. Often, this housing has exclusion criteria related to criminal charges such as, but not limited to, misdemeanor versus felony, offense type, and violent versus non-violent crime. Recovery housing for sex offenders is virtually non-existent. Furthermore, services embedded in recovery supportive housing may be limited and may not include primary care, medical treatment, or mental health care. However, through partnerships, some organizations are starting to provide housing services.

Results of Written Survey Only

We were not able to elaborate on survey information with those respondents who could not participate in follow-up interviews; however, their responses are included in the survey statistics. We evaluated their responses by category to determine if there was any noticeable difference in their responses. The results, by source of and target for referrals, differed in the following ways.

Among organizations categorized broadly as supportive living, the majority of their referrals were from SUD treatment facilities followed, in equal percentage, by government agencies, justice system entities, and recovery/supportive housing agencies. The majority of referrals these organizations made were to mental health and recovery supportive housing facilities, followed by recovery support services and employment readiness services.

SUD treatment providers received a significant number of referrals from the criminal justice system. The referrals they made did not differ significantly from other organization types.

Medical treatment organizations often referred clients to services provided within their own organizations. Common sources of external referrals to medical providers were other medical treatment organizations, government agencies, recovery support services and family or friends of PWSUD; however, the overwhelming majority of entities to which they refer patients are mental health treatment organizations.

Those agencies dealing with homelessness most commonly received referrals from medical treatment facilities, mental health treatment facilities, and front-end access services, in equal percentages. Secondarily, they received referrals from first responders, the criminal justice system, and faith-based organizations. Front end access entities referring to these agencies showed the most variation from the general survey results. Agencies dealing with homelessness most commonly referred out for medical or mental health treatment. The most notable difference in referrals they made was that no organization indicated a referral to recovery support services as being common.

For those agencies not categorized as one of the types noted above (e.g. educational institutions, community organizations), the single largest source of referrals were from family or friends, followed distantly by recovery support services, government agencies, mental health treatment organizations, faith-based organizations, and SUD treatment organizations. The primary target of their referrals was recovery support services, followed by medical treatment organizations, mental health treatment organizations, and SUD treatment organizations.

2. Methods of Referral

Overwhelmingly, the most frequent method for receiving or sending referrals is via telephone call. This personal, albeit telephonic, interaction was stressed as necessary in interviews with organizations. The need to have a personal relationship with the organization to which a referral was being made was very important to organizational representatives. They expressed that referring a client out to an organization found on a website without knowing more about it could result in a negative experience for the individual. For example, one interviewee discussed having referred a pregnant woman to an organization that did not accept pregnant women, but this was not known until the client arrived at the facility. Another organization referred a person previously incarcerated for housing at an agency that

did not accept individuals coming out of the criminal justice system. Having personal connections with staff at a target agency also assists with feedback to assist the ongoing support of a client.

The second most common method of receiving referrals was via telephone contact from a PWSUD, or a close friend or family member, when seeking treatment. Based on follow-up interviews, this most commonly occurred when the individual was new to SUD treatment or recovery services, rather than as a next step in the process.

The third most common referral process involved verbally telling a client to contact a service provider. This process is the least successful, according to follow-up interviews.

Warm handoffs and emailing an agency were the fourth and fifth most common ways of making or receiving referrals that involved an agency-to-agency communication. Warm handoff was one of the most successful referral methods, but it's not always feasible or practical outside an organization.

Looking at survey results specific to those organizations not able to participate in follow-up interviews, we found that the most common method for making or receiving referrals was through a telephone call to the organization. Homelessness facilities indicated that, to an equal degree, the methods they employed most often were warm handoffs or verbally telling an individual of possible resources.

Some of the common methods of referral appear to be related to persons with whom the agency interacts, the lack of a common referral form, and the lack of current knowledge or relationship with other service providers.

3. Information Needed at Referral

The number one piece of information, other than basic client demographics, needed by agencies when receiving a referral is 'purpose or problem to be solved'. This information is essential to determine whether to accept a referral. For instance, an organization needs to know whether their agency provides the appropriate services to address the problem with which a client presents.

Depending on an organization's funding source, the second most important piece of information needed is healthcare coverage/payment information.

Other common elements include past medical history and referring agency information.

4. Barriers or Obstacles to Service Delivery Coordination

The three issues identified as the greatest barriers to the referral process included: lack of communication between service providers; timely accessibility of services (i.e., service was not available when needed); and lack of a formal referral process.

Lack of co-occurring services was a prominent issue indicated by supportive living providers who were unable to participate in follow-up interviews. Organizations dealing with homelessness indicated in the survey that limited knowledge about services offered and accessibility issues such as physical constraints (ADA compliance), criminal history, etc., were more common barriers for their clients than the average responses.

Referrals to service providers located in areas lacking access to public transportation, or where public transportation is available with limited times, routes, or multiple transfers, are sometimes not made

because the client does not have familiarity with public transportation or there is insufficient funding or contracts for ride services. One follow-up interviewee indicated that they had funding for gas cards but found that their clients did not have access to a vehicle. They switched to public transportation passes but found that some clients, people recently released from the criminal justice system for example, did not know how to use public transportation. One interviewee indicated they had ride service agreements in place, but that there were problems with where the client was coming from or time transportation was needed. Service cost is always a concern in treatment. The client not having coverage is an issue, but follow-up interviews revealed that greater access to services was provided by grants, enrollment in the Healthy Indiana Plan (HIP) or Medicaid programs, and the Recovery Works program. The expansion of SUD coverage by some commercial insurance, Medicare, and Medicaid helps, but does not eliminate, this barrier. The need for prior and continued authorization does not facilitate access.

5. Suggested Solutions

Solutions posited by survey respondents included: the need for a directory of services; online referrals with enough information; common referral forms; and a better understanding of privacy laws and regulations. Oddly, only five (5) organizations indicated that they commonly received referrals from, or sent referrals via, 211/OpenBeds. This was odd because 211/OpenBeds has a directory of services based on factors such as substance, location, and type(s) of services needed. In follow-up interviews, several people mentioned they needed an online directory, "Like OpenBeds, but better."

When asked to provide short-term and long-term suggestions, organizational respondents indicated:

Short term

- Better communication among service providers, including identified contact/point person and knowledgeable representative answering the telephone
- Better networking
- Better transportation to treatment services
- Increased access to services that are unavailable due to income or insurance
- Increased telehealth options
- An increase in housing resources
- Better follow-up of a client post-release from the facility

For those agencies unable to participate in follow-up interviews, the following were their best identified solutions for problems in the coordination of services among providers:

- Directory of available services
- Online referrals with comprehensive information

Long Term

- Better healthcare coverage, with access and service covered
- Revision of Federal and State regulations
- More facilities and beds
- Create interagency brochures, informational booklets, better information about services available
- Better transition process from inpatient to outpatient care, including post-release support

Federal and State regulation revisions included simpler documentation requirements, revision of Medicaid and Healthy Indiana Plan regulations to expand coverage and effective date of coverage, data integration across agencies, and privacy of records. This project proposes a better understanding of existing regulations but it is beyond our scope to look at revising those regulations.

The suggestion for provision of more facilities and beds is also beyond the scope of this project; however, this plan does provide a better understanding of this issue and proposes a process to know what is available.

B. PWSUD Interview Results

PWSUD and their close friends and family were interviewed for the project. In some instances, an individual was both a PWSUD and family member of a PWSUD.

From the perspective of close friends and family members, there are limited resources to assist in understanding and supporting the PWSUD in their family. In some instances, they went to other states, or came to Indiana from other states, seeking treatment.

There are limited services for adolescents and children, especially residential treatment services. Interviewees said they could have used a guide or support group that had been through the experience and could assist with gaining knowledge of what to do and expect. There is limited information about how to interact with, and what to expect from, a Crisis Intervention Team (CIT). A CIT is a law enforcement and mental health collaborative program designed to guide interactions with those living with mental illness.

Navigation through the process is difficult. Often, a family member assisting the PWSUD does not know how to navigate the process or the services network. One interviewee was told to call police when her brother was in crisis, but they could not help unless he was harming himself or others. She could take him to the hospital but there is no support or resources when he is not in crisis.

Families need assistance with being advocates for the PWSUD as well as themselves. Coaches or family support peers trained in facilitating the process would have made the path to recovery smoother.

One recommendation for how to improve the process for family members was a pairing process that matches attributes with PWSUD and family with sponsors/peers. Matching could take place on gender preference, gender identification, age, foreign language competency, race and ethnicity, and other characteristics in order to find a comfortable match between PWSUD (or family) and a peer.

Cultural barriers are obstacles for some clients in being successful in recovery. Interviewed PWSUD felt that the therapists and support resources with which they connect do not understand the culture in which the PWSUD lives.

PWSUD also voiced their observations that there seems to be a disconnect in the continuum of care model. Specifically, that treatment providers do not seem to know a lot about other service providers and recommendations for next steps.

A comprehensive directory of services and guides to assist PWSUD through the recovery process would have been helpful. A comprehensive directory of service would include information regarding

availability of services, what they treat, who they treat, services offered, location, contact information, and criteria for admission.

Interviews with PWSUD revealed that all had tried a variety of treatment services including detox, an intensive outpatient program (IOP), and residential services before being in recovery. However, the most important factor for their recovery was support, either in group settings or from a peer. Support was most successful when it involved others who were similarly situated, based primarily on age, as well as substance type and cultural factors.

Services which were needed, but not available in every situation, revolved around treating the patient as a whole including behavioral therapy, medication-assisted treatment (MAT), trauma therapy, mental health treatment, and therapy focusing on assistance with life skills. For some, structure and accountability facilitated reintegration into community living outside a treatment facility.

Factors preventing PWSUD from getting needed treatment were lack of services for their demographic, money, shame, transportation, service providers unclear about services offered, and lack of knowledge about what was available.

The treatment and recovery process was smoothed when PWSUD had their individual needs recognized and treated along with ongoing support from peers and support groups including, but not limited to, Alcoholics Anonymous (AA), Al Anon, and Narcotics Anonymous (NA). Co-located services are helpful for those in residential treatment facilities or housing. Having connections set up with the recovery community before an individual leaves a treatment facility is essential to long-term success.

Recommendations made by PWSUD to improve services included: a community-accessible database with various services listed; support that reflects their culture; and early contact with recovery support, ideally prior to discharge from inpatient treatment.

For someone just entering treatment, the recommendations were to, "Not give up, recognize you have a problem, persist in getting the treatment you need, and work the programs that are there to help you even if you don't agree with them as any progress is good."

C. Review of Initiatives

Part of assessing the coordination of services was looking at initiatives currently in progress in the Indianapolis metropolitan area and/or statewide, as well as systems that are active in other areas. Below is an assessment of these initiatives, as they relate to coordination of referrals, based on interviews with representatives from each.

Initiative	Assessment in Regard to Referral Coordination
2-1-1/Indiana 211	2-1-1 is a nationwide phone-based information and referral service with specific responses for the area code originating a call. Various options are available for the caller after entering their zip code. Legislation that went into effect on July 1, 2020 puts the Indiana 2-1-1 system under the auspices of the Indiana Family and Social Services Agency (FSSA). The process of integrating the service within the various divisions of FSSA has begun. The Division of Family Resources will be responsible for help with public assistance such as food, healthcare, and financial assistance. The Division of Mental Health and Addiction (DMHA) will be responsible for addiction service information and referral through 2-1-1. This integration process is expected to take up to a year.

	Currently, when a user calls 2-1-1, options for SUD include: (1) initially needing a ride to or from treatment via Lyft; or (2) speaking with a community navigator. Navigators are employees of the 2-1-1 contractor. These navigators are trained to identify needs and reasons for the call. For a call about SUD, the navigator can research, in real time, to find an appropriate facility based on information provided by the caller about substance, location, type of treatment sought, whether that facility is still operating, and if the organization is accepting referrals. Some navigators are specialized due to complexity of a subject area (like a co-occurring mental health condition). The navigator is to follow up with the caller to ensure the individual connected to the service. Indiana 211 is an online website connecting Hoosiers to health and human service agencies and resources in their local communities. Individuals can choose from various services, including *Mental Health & Addiction*. Selecting that option allows the individual to find a crisis hotline, drug or alcohol treatment, or an addiction support group. Once one of these subcategories is selected, a new window opens allowing a search for available resources. The individual uses the information on the organization's profile to connect to the service. 2-1-1 is currently funded, in part, by the Federal Emergency Management Agency to provide crisis intervention services, including addiction services, as part of the COVID-19 response. As part of this initiative, 2-1-1 will connect callers to the Indiana Recovery Network HUB and to recovery peers in their area, if the caller agrees. Crisis counselor applicants are now being screened by DMHA and, once hired, will be trained and available in July 2020. Grant funding is through September 2020 unless extended. 2-1-1 is not an initiative that connects agencies to agencies in the referral process but is a resource for finding services for an individual who is initially entering treatment. 2-1-1 can connect PWSUD and their close friends and family members to treatment and recovery services and to peers that can assist them on the road to treatment and recovery.
Indiana Recovery Network	Indiana Recovery Network (IRN) is a subsidiary of Mental Health America of Indiana (MHAI). At the IRN website, an individual can search for a recovery organization or fill out a short form to get connected with a peer who would be able to refer that individual to detox, treatment, transitional housing, recovery residences, recovery community organizations, recovery community centers, food pantries, and other services. IRN is currently partnering with Solutionize to validate and enter organizations/providers and their data into the Solutionize platforms. When an organization is added, increasing the number of providers in the system, it helps those providers to better collaborate with each other and to share best practices. It also allows peers and the public to find needed care. Peers can use the Solutionize TeamPatient application to organize clients' data and to keep them informed of referrals, appointments, and follow up activities (see more about TeamPatient below). IRN has created five Regional Recovery Hubs distributed geographically around the state. These Hubs aid in connecting individuals with mental health and substance use disorders to treatment and recovery supports through Certified Peer Recovery Coaches, Community Health Workers, and Certified Recovery Specialists. The IRN Hubs provide the option to connect to a peer. The peers do not limit support to giving information to PWSUD, but also provide a warm handoff for services and continue peer support for the individual. These peers are trained, and most certified, on how to access and route individuals to available resources. Peer supervisors meet biweekly to share information about services and best practices. Weekly, peer supervisors and peers meet to share information about services and experiences in their region to expand the knowledge of, and relationships with, treatment and support organizations. This initiative can help agencies identify organizations to which they could refer clients, and it can assist PWSUD to find services. There is no referral or feedback process within this initiative, but it does offer collaborative, non-client-specific communication.
INSTEP	INSTEP is a non-profit organization with the goal of furthering coordination, integration, and alignment of a community-wide response to SUD in the greater Indianapolis area. INSTEP works toward this mission by bringing together service providers, caregivers, people in recovery,

	community members, and related organizations. INSTEP tries to address such questions as, "Where do I go?"; "What do I do?"; and, "Where is the door?" as an individual with SUD tries to enter or navigate the treatment and recovery process. More than 70 organizations are members of INSTEP. These organizations come from several sectors including health care, law enforcement, government, education, business, and faith-based. This initiative is neither a treatment provider nor a referral group. Their aim is to enhance collaboration between organizations treating the same client population by sharing information and resources.
Know the Facts knowthefactsindiana.org	*Know the Facts* is a campaign re-launched by FSSA in 2020. Its goal is to reduce stigma around opioid and other substance use disorders that may prevent an individual from seeking treatment. Originally centered on opioid addiction as *Know the O Facts*, the campaign evolved to cover all facets of the drug epidemic and how it is affecting Indiana due to a rise in the use of methamphetamines and other substances. Campaign emphasis is on educating the public that SUD is a disease, there is treatment, and recovery is possible. Using television and radio spots, as well as outdoor and online advertising, the campaign highlights stories of Hoosiers who have gone through SUD and have overcome. The website is primarily educational; however, if a provider clicks on the link for treatment, they are directed to the Indiana Addiction Treatment Page. If they click on the link for Providers on that page, they are directed to the DMHA site with information about training and conferences. This initiative is not one that connects agencies to agencies in the referral process but is a resource from which PWSUD and their close friends and family can find treatment and recovery services.
TeamPatient	TeamPatient is a web-based application created by Solutionize, Inc. It is a cloud-based application, adhering to Amazon cloud-based application security, and is auditable as it stores a record of all activities. The application is mobile device-ready (a smartphone is needed) and phone data plans are not impacted with its use. This application allows clients (PWSUD) to be involved in the process of their own treatment and recovery. The client can choose to serve as administrator over their account, or they may select someone else to serve in this role on their behalf. The administrator determines who is allowed to enter and/or see data on their account. The goal of TeamPatient is to get everyone involved in the care process on the same page in order to produce better health outcomes. Working with IRN, Solutionize has created a second platform that is more provider-and peer-centric. There, the user can search for organizations by type, services offered, and location. In order to be included in the listing, organizations submit required profile information that is validated by IRN or their partners. If accepted, they are loaded into the system by IRN. RAP team members were provided a demonstration of the product and given the opportunity to ask questions about it. Solutionize expressed the belief that current issues with the referral flow for treatment and recovery can be resolved by a combination of both their platforms. The presenter stated that he envisions an individual getting started in the treatment and recovery process by searching for a provider, creating a profile in TeamPatient, and this profile (updated throughout the process) would serve as a basis for a referral form. The utilization of both platforms (IRN and TeamPatient) could, theoretically, allow for constant collaboration and a more seamless handoff between providers and better communication between providers and client – and all other stakeholders – throughout the process. Currently, the TeamPatient agency directory does not provide for direct referral between agencies, but it does provide a list of services for those agencies that are enrolled. TeamPatient is being used as a case management tool for referred clients by the peer community working with IRN Hubs.

Treatment Connection (OpenBeds)	Treatmentconnection.com is an OpenBeds portal that enables those seeking mental health and SUD treatment for themselves or others to: anonymously search for nearby providers who are accepting clients; evaluate the type of care needed; and submit confidential online referral inquiries to appropriate treatment providers vetted by the state of Indiana. It is important to note that because an organization does not appear on the list of service providers does not imply that the provider is deficient in quality services. It means only that the organization has not applied to participate in the listing. There is a yearly subscription fee for organizations wishing to join, and it varies by organization size. This fee is waived for non-profit organizations. Both OpenBeds and Treatmentconnection.com store provider information, but only as much as has been provided to them. Agencies are requested to update their availability data at least daily, and preferably twice per day. Periodic reviews are done to encourage agencies to keep their information up to date. When an organization wants to participate and be included in the database of providers, they contact DMHA. DMHA vets the agency with a high level investigation of licensing, performance, and regulatory issues. Treatmentconnection.com does have information about the availability of service openings, parameters of population served, and payment types; however, these profiles are not always complete or up to date. Very few respondents to the online survey or follow-up interviews indicated that they use the OpenBeds solution; and no one other than the DMHA representatives indicated that they knew the name had changed to Treatment Connect. While press releases were made at the time of the rollout and at least once since that time, the SUD treatment community did not seem to be knowledgeable of the offerings. Treatmentconnection.com could be useful for an agency looking for a service provider for one of their clients; however, the current listings for Marion County and the surrounding area do not appear to be comprehensive as many facilities and service organizations surveyed for this project do not participate and are not included. The subscription fee is a barrier to having more agencies listed on this resource.
Unite Us	Unite Us is a custom application built for the process of referring clients between providers. It is deployed in locales throughout thirty-five (35) states. Unite Us features include: ▪ Unite Us boasts a clean, simple user interface. ▪ Electronic referrals allow for tracking from a referral's inception to its resolution, including the selection of a resolution (outcome) type based on the referral area. These resolution types can be either of the standard or custom variety. ▪ Referrals may be accepted or rejected, and feedback is provided to the referrer as to client follow through and follow-up. ▪ Referrals to multiple agencies may be initiated simultaneously and, once an acceptance is entered, the other agency referrals are canceled. ▪ A referral cannot be sent without a client's signed consent. Various methods are available for procuring a client's consent but, in the end, the client is required to sign a hardcopy which is retained as a scanned image. ▪ Documents can be attached to a referral or to a client record. ▪ Communication with clients is allowed through their choice of text, email, or hardcopy. ▪ Unite Us interfaces with electronic medical record (EMR) systems. In theory, this can be bi-directional, but most health systems are not very receptive to the idea of pulling data INTO their internal systems. ▪ The product is based on roles and permissions. Each user is assigned a role that is maintained by participating organizations. ▪ To ensure that the database contains the most updated information, the system prompts participating organizations to update their profile. ▪ Reports can be generated to display various facets of auditing. For example, which organizations are only rejecting referrals or which organizations are not updating their profiles. ▪ Data is owned by the organization entering it and stored using Amazon Web Services. ▪ A client may request a copy of their record at any time.

	▪ Records are retained based on record retention laws in effect in the locality where the application is deployed. While Unite Us is designed to be an interagency referral and follow up tool, it is deployed with an integrated front end for the public in North Carolina. Based on information from NCCARE360, this integration with Unite Us: "Helps providers electronically connect those with identified needs to community resources and allows for feedback and follow up. This solution ensures accountability for services delivered, provides a 'no wrong door' approach, closes the loop on every referral made, and reports outcomes of that connection." The current inception to deployment time frame for Unite Us is 12-16 weeks. In order to ensure a solid coordination of services when setting up a state or locality, the process begins with a locally hired community engagement team which performs a landscape analysis in which they conduct interviews and review existing lists of organizations in the locality. This team then performs 'Influencer Sessions' with important players in that market in order to secure their buy-in. Unite Us maintains a local community advisory group for each deployment. Unite Us provides technical assistance to organizations in creating their organizational profiles. Ongoing technical assistance is also provided. Live and computer-based training is available as well. To participate in and get added to the system, an organization needs to register and fill out a form which is used in creating their profile. They must also sign a contract and a business associate agreement. This tool appears to provide a possible resolution for the issues of not having current information on a target referral agency and not receiving feedback on outcomes, including if the client showed up at the referred agency. It also seems to address the issues surrounding privacy laws and regulations.

D. Analysis

1. Scope of Services

This project examined coordination of services but also provides high level information on lack of adequate services based on interviews with PWSUD and organization surveys and interviews.

The metropolitan Indianapolis area has many services available for SUD treatment and recovery. Additionally, there are initiatives aimed at improving care coordination in a timely manner, including getting a client to the right service based on their substance, location, and history. However, it is often the case that a referral is not as successful as it could be because of incomplete or outdated information about the provider organization, lack of confidence in the referral due to unfamiliarity with the service provider, and lack of feedback from past referrals. There are underserved populations based on age, race, and background; and there are treatment protocols that lack enough availability for the population needing those services (e.g., transitional housing organizations and services). Getting PWSUD the appropriate assistance is sometimes hampered by insurance coverage limitations such as covered services, care time limits, or the need for prior authorization. Options for transportation to services are limited by availability and lack of knowledge about the available options. There are tools available in the area to assist with finding organizations for referrals, but not to facilitate the referral process or to provide feedback about the referral.

In the use of the available resources for locating service providers, there is a lack of confidence in the process (i.e., referring agencies are not familiar with the agency to which they are referring). Providers continue to deal with agencies that they know but then run into roadblocks based on availability or the referred to agency not accepting clients who have the social and/or SUD characteristics present (e.g., co-occurring mental health diagnosis, MAT, recently incarcerated).

2. Barriers to the Coordination of Services

The most common barriers to getting services to PWSUD from the organizational perspective are:

- lack of clarity regarding services provided;
- transportation;
- cost;
- poor communication between service providers;
- timely accessibility of services; and
- an informal referral process.

From the perspective of PWSUD, the biggest barriers were:

- appropriate services unavailable;
- cultural disparities between the PWSUD and the service provider community;
- lack of treatment options for adolescents;
- lack of enough appropriate residential services;
- lack of ongoing recovery support;
- lack of knowledge about available services; and
- readiness for change by the PWSUD.

More than one interviewee noted a lack of services and support for family members in understanding and navigating their loved one's SUD. A few individuals noted ongoing stigma and shaming associated with the need for treatment to overcome substance use as a concern in receiving those services.

3. Specific Barriers to Coordination of Referrals

Specific issues pertinent to coordination of services were:

- *Finding a provider*

  Some organizations and PWSUD report searching for services on the internet. Indiana 211 and treatmentconnection.com are available, but not commonly used by the parties interviewed. Provider searches on these sites result in high level information that is not always up to date and does not really identify what the organization is about (e.g., who they do/do not accept, how good they are at service delivery). Organizations were also confused regarding cost of participation. Those convinced they would need to pay to be listed questioned the return of their investment.

- *Lack of regular communication between service organizations*

  Organizations wanted to have regular contact with other providers to establish relationships and ascertain service quality. As much as possible, the need to have confidence in the target referral agency to meet the needs of the individual through relationship building should be resolved.

- *Lack of follow-up between referral agencies*

Agencies want to know if their referred clients showed up; if they received treatment; and when/where they were being discharged to. Most organizations did not have a current memorandum of understanding (MOU) or release of information process between agencies to facilitate this follow-up and exchange of information.

- *Repeated requests for information*

PWSUD were frustrated by having to repeatedly give the same information to organizations. There was no standardized sharing of information when referring a client to another agency.

- *Transportation to services, including recovery support*

Often, clients do not have access to private transportation. Public transportation is often not available or, if available, inconvenient to an unacceptable degree. Provided transportation is not timely and, often, is not financially feasible.

- *SUD services payment authorization and limitations*

While agencies receive referrals, many insurance policies, including Medicaid, require prior authorization. This includes time limits for specific services and treatment plans. Frustration was expressed that third-party payors do not treat SUD the same as they do other diseases or disorders, where a physician is trusted to authorize the treatment and plan.

- *Peer support*

According to survey respondents and interviewees, referrals to support/peer coaches are not used enough. Also according to survey respondents and interviewees, connecting a PWSUD to recovery support before they even leave an inpatient treatment facility would help reduce the incidence of relapse. Knowledge about connecting to peers is limited.

4. Successes

One consistent theme runs through the feedback we received – local agencies truly care about their client outcomes and are fierce in their determination that those outcomes are not hampered by barriers in obtaining appropriate treatment.

There are many providers and services available to assist PWSUD in the metropolitan Indianapolis area. Many organizations are trying to meet the needs of the SUD community and provide quality services. Some have taken steps to improve care coordination by creating and sharing common referral forms or reaching out and forming relationships with those agencies with which they interact regularly. The bringing together of organizations to share information where multiple agency contacts participated in joint interviews, or even in the individual organization interview, elicited ideas and provided information for them to move forward. All those with whom we spoke wanted to improve the process and work toward the best method to coordinate service delivery.

IV. Plan Proposals

In this section, plans for improving the coordination of referrals, based on evaluation of data from surveys and interviews of organizations, PWSUD, and their close friends and family, are proposed.

A. Short-term Solutions

When classifying solutions as short-term, we mean those that can be accomplished within a six (6) month period with no more than moderate expenditures. Some short-term and long-term initiatives overlap by type, but are differentiated based on extent or process.

Data gathered from surveys and interviews of organizations and PWSUD indicate that there should be:

- better communication among service providers;
- better transportation to treatment services;
- complete information regarding the cost of services, enabling more accurate referrals within financial constraints;
- better communication regarding availability of housing resources; and
- better follow-up, post-release, from various levels of care.

Additionally, participants suggested an increased availability of key components of care such as housing, expanded insurance coverage, and increased access to telehealth options. While these suggestions will take time to resolve, local SUD treatment and related service providers can work with the Marion County Public Health Department to begin taking steps towards implementation.

1. Directory of Services/Technology

Participating organizations want a directory of service providers distributed to agencies. While 2-1-1/Treatmentconnection.com (OpenBeds) is not a fix-all option and has been used only rarely to enhance coordination of the referral process, there is information and support available in this tool that could be useful immediately. An organization looking for a treatment facility or service for PWSUD can search 2-1-1/Treatmentconnection.com and follow up with providers that match the criteria being entered. The results are limited to those providers who have requested to be added to the directory and have been vetted to the extent that they do not have outstanding issues that affect quality of care. Providers complete a profile that includes contact information, type(s) of services provided, admission criteria, slot availability, and payment options. Experience has shown that these profiles are not always accurate and up to date. These limitations result in a lack of trust regarding the information posted and, therefore, the system is not used as often as it could be if it were more robust.

As currently configured, 2-1-1/Treatmentconnection.com does not resolve the need for feedback and follow-through between service providers. While use of the system to search for services is free, the cost of listing a provider is unclear, being based on organization size and type. Some providers who participated in the pilot are no longer listed on the site, and other providers are confused about the annual subscription cost. While this tool is helpful as an initial step in the location of treatment services and support, follow up with a listed agency is essential to ensure it meets the needs of the individual.

The FSSA DMHA sponsors Treatmentconnection.com. While there have been news releases concerning this service, there remains a lack of familiarity with it even within the SUD provider community. For instance, there was confusion about OpenBeds (now Treatmentconnection.com) related to target audience, cost, mechanism for posting organization information, updating information, quality of services offered, and feedback regarding service outcomes.

In order to expand familiarity of this option, DMHA should be encouraged to broadcast information about this option to PWSUD and SUD provider communities through targeted emails, social media, news releases in community and local newspapers and television, and interaction at treatment and recovery provider conferences and association meetings. It would also boost participation if all subscription fees were waived.

In addition to Treatmentconnection.com, PWSUD can get help with transportation to services that are not covered by many insurers by calling 2-1-1 and choosing the option for transportation. This service can be used while providers start to build funds into grant proposals for transportation.

These solutions will not solve the longer-term need for an automated directory and referral service which is widely subscribed to and provides the functionality the participants in this project indicated are needed, which was a system that:

- provides a searchable database of available services based on location and other parameters related to the needs of PWSUD;
- provides feedback to the agency making the referral;
- includes state certified active recovery coaches;
- includes halfway houses;
- provides real-time referrals;
- is up to date and accurate;
- is at least county-wide;
- allows agencies to request a referral;
- provides contact with a point person or designated contact at the agency; and
- provides a way to communicate with the client.

Another consideration to help in streamlining the referral process is sorting search results by the most common organizations to which an agency sends referrals. For example, if primary care organizations primarily refer to mental health organizations, then the top appearing agencies should be mental health agencies for a search conducted by a primary care entity. This would not rule out the display of other providers, especially if additional parameters were entered, but would expedite the search for users who do not have time to wade through uncommon results based on their most common referrals.

The IRN Hub provides information for clients seeking service and can connect them to a recovery coach or peer. Connecting to a peer through IRN Hub provides a solution not only for where to start but, when partnered with a peer, PWSUD receive continuing support and assistance in navigating the process. 2-1-1 is partnering with IRN Hub to refer callers to peers. This resource needs to be advertised more fully to PWSUD through local and regional news outlets, social media, and communication with service providers.

While the system described above meets the needs of participating organizations, it is not a product for use by PWSUD. One point made by organizations and PWSUD alike was that PWSUD often do not know where to start. Any system used by organizations should have a front-end access portal for PWSUD to use for help getting started in, and navigating, their recovery. 2-1-1/ Treatmentconnection.com provides screening tools to get PWSUD to an agency or service provider that will help them on the road to recovery but, as stated above, these services are not yet commonly used.

In order to provide such a system and sustain it over time, a neutral government agency (e.g., FSSA, City of Indianapolis, Marion County Public Health Department) should take the lead on securing a system that efficiently assesses patients' needs, provides for standard referral information, provides feedback and bi-directional communication about the patient/client, meets all privacy and security requirements (e.g., HIPAA, 42 CFR Part 2, and Indiana state law) allowing open communication between agencies and with the client, and provides for monitoring and follow-up based on outcomes. There may be other systems that meet these needs, but the one system reviewed by the project team that meets these goals in a simplified, easy to understand process was Unite Us. The Unite Us team employs and works with local providers to engage, train, and provide ongoing support for the process and system. The post-procurement time to implement the solution is 12-16 weeks.

2. Better Communication

Surveyed and interviewed organizations suggested the need for consistent documentation requirements for referrals, including a universal screening or assessment tool and a standardized referral form. A universal screening or assessment tool would be a longer-term initiative involving clinicians and working to improve upon existing best practice screening and assessment tools.

In the short-term, a standardized referral form or system that is accepted by SUD and related service providers in Marion County and the surrounding areas needs to be developed. At least two agencies have collaborated to develop such a form and are working to standardize the referral process. Using this form as a starting point, we suggest that a small work group be formed to refine a form that would be useful for all organizations. This form needs to consider privacy and security controls needed for electronically transmitting information and include the client's release of information authorization. The form must be compliant with HIPAA, 42 CFR Part 2, and Indiana state law.

Once developed, Marion County Public Health Department agrees to promote the standardized form to be used by all agencies to reduce the need for PWSUD to repeatedly give the same information. This form could be used to give feedback and updates on PWSUD to the referring agency. Agencies should agree to use this standard referral form, at least as a starting point, to be followed by any additional information and updates.

In addition to a universal referral form, organizations noted a need to streamline appointment scheduling. PWSUD need to be notified of their appointments in advance; be able to reach their appointment at the appointed time; and not have been scheduled for an appointment that is not appropriate. Having a universal referral process with feedback to the client and referring agency will alleviate this problem. Communication with the client about appointments and other pertinent information via email, text, and/or paper should be considered in choosing an automated referral tool.

3. Establishing Relationships and Training

Several organizational respondents identified a need for better communication between agencies, including face-to-face meetings, to learn about services offered and to establish confidence and trust between organizations. The forum for such meetings, as well as the jurisdiction to be invited, needs to be set with the goals of better and increased communication. For now, this solution is impacted by constraints caused by the COVID-19 pandemic. Depending on the track of re-openings in Marion County and throughout Indiana, these meetings could be held quarterly via videoconference or, when possible, face-to-face.

These conferences need to include a variety of providers that interact with each other with the opportunity for presentations by providers regarding their mission, referral process, and availability of services. These presentations should allow time for questions and answers. Providers should be encouraged to have brochures and handouts of current information about their service offerings, costs, payment types accepted, capacity, and contact persons.

Updated information from organizations such as Alcoholics Anonymous, Narcotics Anonymous, and Al Anon was specifically mentioned, along with the need to have information in languages other than English, particularly Spanish, for PWSUD and their close friends and family. Additionally, representatives from the criminal justice system should be invited to improve communication among service providers who can hear, and hopefully act upon, concerns regarding improved coordination between these entities and the service community. Providers can hear about release updates, access to parolees, and reporting by service agencies so that a parolee does not have to leave a facility or be transported to a meeting with a parole officer. The inclusion of state and local agencies covering addiction services, as well as other services needed by clients, should be planned as well.

In addition to organizations delivering information about their services, provider education on subjects like presumptive eligibility and insurance coverage, especially long-term post-detox, would be helpful to agencies participating in the conferences.

The cost of this initiative is minimal, especially if virtual. In-person meetings could be held at governmental offices, conference centers, or provider locations for a nominal fee. If limited to the metropolitan Indianapolis area, travel expense would not be much of a consideration.

The Marion County Public Health Department can assist with organizing these face-to-face meetings for providers. Alternatively, local organizations like those included in the review of initiatives (e.g., INSTEP or Indiana Recovery Network) can assist with event organization, but care needs to be taken to ensure that these events are regular and sustained long-term.

Invitations for agencies to participate need to be as broad as possible; however, if space and time are considerations, inviting agencies that most commonly interact in referrals would be ideal. The survey in this project indicated the most frequent organizational interaction by type and could be used as a starting point.

In order to make the referral process as smooth as possible, we propose technical assistance to help organizations enhance their profiles to ensure that referring agencies can tell what populations are or are not served, including special populations (e.g., youth, LGBTQ, people with children). In addition,

phone should be staffed by knowledgeable personnel. Initial contact staff should be trained to ensure that accurate and timely information about services and available openings is given to callers.

Staff proficient in languages other than English should be made available, if possible, and cultural competency training should be delivered to staff interacting with PWSUD, and their close friends and family, to ensure trust in the process. This may not be fully attainable in the short-term, but can be started. This requires that each agency commit to this initiative.

Additionally, training should be provided on what is available for referral processing, including 2-1-1/ Treatmentconnection.com, IRN Recovery Hubs, housing resources, payment resources, and transportation resources, should be delivered, or paired with, relationship building conferences in order for providers to understand what is available and how to access it.

B. Long-term Solutions and Funding

1. Training

Even though training is a short-term solution, it is important to recognize that training for organization leaders, staff, peers, and stakeholders must be institutionalized, ongoing, repeated and continuously funded. Behavioral health care organizations, traditionally, have not only relatively high staff turnover rates, but they are also frequently required to address an ever-evolving list of needs for the individuals they serve. Interviews with organizational members revealed a referral process that was often staff dependent and not part of the organization's policies and procedures. For example, if a key staff member who had developed relationships with key staff at other relevant agencies moved on, those contacts were lost and new staff had to re-develop relationships.

Other stakeholders, such as family members of SUD, also lamented that they did not have the education needed to support their loved ones during recovery; and they were not aware of the signs, symptoms and seriousness of addiction early enough to facilitate access to care in the initial stages of addiction. This may have resulted in individuals being sent to multiple treatment agencies with varying degrees of success. The following training recommendations can help to resolve the issues underlying remarks made by organizations and PWSUD when they described barriers to successful referrals.

Examples of Recommended Training
Screening and Brief Intervention to Treatment (SBIRT) – This standardized training for all navigators and individuals having initial contact with PWSUD would facilitate referral to the correct agency and save precious time, thereby reducing the incidence of individuals being incorrectly referred. Recommended audience: Navigators, public safety and first responders, case managers, certified peers, and medical personnel.
Family Education — It is a myth that most individuals seen in behavioral health organizations have 'burned all of their bridges' and no longer have the support of family and friends. In fact, most have supportive individuals in their lives, but those individuals do not have essential knowledge and experience to maximize the type of support they give. Family

education includes development of skills to reduce stigma, support other families with PWSUD, and strengthen inter and intra-family relationships. SUD and related organizations should be encouraged to have activities such as family nights, family education groups, recreational activities for family members, and other initiatives designed to support healthy family interaction. Partnerships with coalitions such as Drug Free Marion County, faith-based organizations, self-help groups, and other prevention initiatives could be beneficial. There should also be public service announcements to increase family awareness of the signs of addiction and how to seek help locally. Recommended audience: Organization staff, family members, and peers
Training in MAT—Medication Assisted Treatment (MAT) relies on 3 medications currently approved by the Food and Drug Administration for the treatment of opiate addiction: buprenorphine, methadone, and naltrexone. Stigma regarding the use of these medications remains, even in the recovery community and with other stakeholders such as criminal justice agencies, families, self-help groups, and some peers. It is crucial for everyone addressing the needs of individuals with opioid use disorder to understand this brain disease and how medication, dosed correctly and taken for as long as the individual needs it, is essential to recovery. Understanding which type of treatment is best suited to specific client needs reduces the 'wrong door' phenomenon, thereby reducing relapse and facilitating movement through the continuum of care. Recommended audience: physicians, nurses, organization directors, clinical supervisors, navigators, case managers, counselors, and peers

Funding – The cost of continued training is nominal, and may include the cost of a facility to host the training, curriculum development, and subject matter expert facilitators. Training curricula already exist in either online or in-person offerings, both of which can be customized for Marion County. Although these training needs were outside the scope of the RAP study, they are not exclusive to the organizations surveyed. It is possible that funding could be provided by FSSA technical assistance or block grants, outside consulting firms, or the Great Lakes Addiction Technology Transfer Center (ATTC). Access to training from ATTC is easily obtained through contact with that organization.

To maximize the benefit of training, Marion County Public Health Department could organize training sessions with multiple organizations in attendance. This not only ensures that the organizations learn the training objectives, but it is a way to facilitate organizational communication and cooperation.

The Marion County Public Health Department is hosting a free Opioid Safety and Alternatives Conference in November 2020, during which, a compressed SBIRT training will be offered. Additionally, Providers Clinical Support Systems (PCSS) offers free, on-demand, trainings on the topic of MAT.

2. Transportation

According to Family Voices of Indiana's medical transportation factsheet, Medicaid provides emergency and non-emergency transportation between Medicaid providers. This transportation is capped based on number of trips and distance. While there are mechanisms to expand the approved number of trips, transportation remains a significant problem for PWSUD, especially if they are traveling between non-Medicaid approved providers. Sometimes peers provide transportation for clients, but this is not always feasible and may not be the best solution, especially considering liability issues. A birds-eye view of all transportation funding sources is necessary, and all agencies should be made aware of options for the

individuals they serve. Access to transportation should be addressed in future grant applications, as well as program development and expansion plans. Assessment of individual transportation needs should be included in all systems initially contacted by individuals seeking care.

Funding – Medicaid; Indiana FSSA; United Way; grants; and private corporations

3. Third-Party Payors

Physicians and other diagnosticians have the expertise to determine the level of care required to treat SUD. This level of care not only includes type of care, but also the recommended length of treatment. That being said, some third-party payors require pre-authorization and certification of medical necessity, and do not take into account the progression of addiction and the relapses that sometimes occur, resulting in service caps. Every effort should be made to educate PWSUD and their loved ones regarding expectations of third-party payors. If an individual no longer has coverage due to unemployment, incarceration, or aging out of parental insurance, then steps should be immediately taken to ascertain if the individual is eligible for Medicaid. When this occurs, the client should receive services based on presumptive eligibility. This may require training navigators or case managers to assist individuals specifically with insurance questions.

In cases of incarceration, individuals can begin the process of getting Medicaid near the end of their sentence as part of the referral process for continuing, supportive care. In a hub and spoke model (see below), insurance verification and Medicaid eligibility should, ideally, be a confirmation service provided at the hub.

Participants in the survey follow-up discussions specifically noted the need for better funding for SUD treatment for children and better coverage of co-occurring mental health issues.

To the extent possible, Marion County Public Health Department or another neutral agency should convene a meeting with those insurers most commonly used, including Medicaid entities and managed care entities (MCEs). Providers, as well as at least one organization representing PWSUD, should be invited. The purpose of the meeting would be the reduction or elimination of barriers to treatment caused by prior authorization and served population constraints.

Funding – No cost, just labor intensive.

4. Improve Access to and Communication between Agencies

Organizations interviewed admitted that they do not always know where to turn to access services for the individuals they serve. A regional conference could be organized, remotely and/or in-person. The purpose of this conference would be to showcase participating organizations, clearly outlining target populations, available services, admission criteria, payment options, and key staff. The conference should be collaborative, not competitive. These conferences could be supplemented by quarterly meetings, facilitating discussions between organizations and reflecting changes that have occurred during the previous quarter. Meetings should have a standing agenda as well as presentation of a 'hot topic' so that participants could learn more about each other or a new, evidence-based practice. The 'hot topic' could be facilitated by a consultant, subject matter expert, or one of the participating organizations. It is important that these meetings be tightly organized and last no more than two hours

so that they are viewed as enhancing services. PWSUD should be invited to the regional conference, as well as quarterly meetings, as their involvement is crucial to person-centered care.

Every effort should be made to encourage MOUs and other agreements between agencies, designed to facilitate a common referral form and feedback related to client outcomes. The referral and feedback forms should incorporate HIPAA, 42 CFR Part 2, and Indiana state regulations, the results of which should be analyzed to improve client outcomes and improve communication between organizations. Referral forms also facilitate documentation regarding basic information, such as if the person showed up, was admitted, or received services, or was moved on to receive additional care.

Funding – Cost of space if the conference is held in-person and space cannot be obtained at no cost, or if funding is not already available in discretionary funds for education and or communication, could be borne by a minimal participant fee.

5. Expanded Use of Certified Peer Recovery Coaches

The value of connecting a PWSUD to a mentor with similar life experience cannot be understated. A peer recovery coach is an outreach worker, a motivator and cheerleader, a truth-teller, a planner, a problem solver, a resource broker, a monitor, a tour guide, an advocate, an educator, a community organizer, and a lifestyle consultant or guide. A peer recovery coach is not a sponsor, therapist, nurse, physician, or priest. Certified peer recovery coaches fill a void that is beyond the issues addressed by clinicians. Peer recovery coaches in emergency rooms are often able to interpret clinical jargon and assist individuals who realize that continued treatment would be beneficial. The recognition of shared experience breaks through the denial experienced by many individuals initiating a recovery journey. Peer recovery coaches within treatment programs and other support organizations (e.g., housing, job readiness programs, pre-release centers) can provide the support necessary to create new habits and allay fears. Peer recovery coaches should be trained to understand their role, not perpetuate stigma, and to support decisions regarding medication even if that was not their path. They should be paid for their work at a reimbursable rate commensurate with their certification. For organizations with less diverse staff, peer recovery coaches that can be matched to minority populations or special populations (e.g., pregnant women, those with criminal justice involvement, LGBTQ, etc.) can assist in addressing the issue of having 'someone who looks like me'.

Funding – Training to certify peer recovery coaches can be accessed through the same mechanism used for training clinical staff. Reimbursement rates will need to be addressed by the state and discussed with third party payors.

6. Centralized or Regional Referral System

When an individual identifies – or is identified by someone else – as needing assistance, the questions surrounding resources include: what type of assistance best meets the need; where is the assistance located; who will provide it; what does it cost; and when is it available. Currently, there are several systems that attempt to provide some of these answers but no single system is designed to provide all of them. Each agency asks their own set of questions. Recommended resources are often not near the individual needing services. Facilities have criteria that create barriers to care. Transportation is not available. Symptoms are not correctly identified. The referral is not appropriate for the identified problems. In short, PWSUD and those advocating for them feel confused.

A centralized or regional referral system that is designed to get individuals to the 'right door' would result in less fragmentation and alleviate the frequent complaint of not knowing where to start. When developing this system, it is crucial to have all stakeholders at the table during development, including treatment agencies, housing, vocational, criminal justice, family members, insurance (Medicaid and third-party payors) and, most importantly, peers. Marion County Public Health Department or another neutral government agency (e.g., Indiana FSSA, City of Indianapolis) needs to take the lead on securing a system that efficiently assesses a patient's needs, provides for standard referral information, provides feedback and bi-directional communication about the client, meets all privacy and security requirements (HIPAA, 42 CFR Part 2, Indiana state law) allowing open communication between agencies and with the client, and provides for monitoring and follow-up based on outcomes.

- ***Hub and Spoke Model*** – The Hub and Spoke model, successfully employed in Vermont and other small regions throughout the country, would enable Marion County to create a system that facilitates a 'right door' approach. Some models designate an agency as the hub, with other agencies being the spokes. The centralized (regional) agency would provide the most intensive services (e.g., detox, intensive outpatient treatment) with spokes providing MAT, housing, job readiness, and other relevant services. Hub organizations would be responsible for collecting relevant criteria information for the spokes, including insurance and other payment information, ensuring that referrals are routed to the most appropriate agency. The hub would be staffed by clinicians with SUD experience (i.e., physicians, nurses, counselors, social workers) and peers. PWSUD would not need to repeat information as they move through the system, although they may need to provide additional information to the various spokes.

  In the absence of designating a treatment agency as the hub, a hub could be created in Marion County that would collect all relevant information as previously stated, staffed by individuals trained in SBIRT, still insuring that PWSUD would not need to repeat information across spokes. If individuals experienced a relapse, or needed a different level of care or service, the hub would be contacted to facilitate referral. A decision needs to be made related to the best mechanism to access the hub, telephone or online. It would be best if both telephone and online are used; however, it is crucial that these mechanisms match each other so that barriers related to electronic access are not compounded.

  The IRN HUB, with referral to peers using the TeamPatient solution, is a form of Hub and Spoke with the peer managing clients' cases via the tool. This first requires that clients be connected to, and maintain the connection with, a peer for the process to be effective.

- ***Unite Us*** – Unite Us is a custom application built for the purpose of patient referrals. Referrals are facilitated for initial treatment, as well as between providers for subsequent levels of care or additional services. Features of Unite Us were detailed in the section on Review of Initiatives.

  While Unite Us is designed to be an interagency referral and follow up tool, it was deployed with an integrated, public-facing front-end in North Carolina (NCCARE360). This has allowed North Carolina to help providers electronically connect PWSUD to resources and referrals, while

allowing for feedback and follow up. It has also ensured accountability for delivered services, provided a 'no wrong door' approach, and provided feedback and outcomes of referrals made.

In order to ensure solid coordination of services, Unite Us set up for a jurisdiction begins with a local Community Engagement Team. This team performs a landscape analysis that includes interviews and a review of existing organizations. They also perform work with influencers in the jurisdiction to get buy-in. Unite Us maintains a local community advisory group for each deployment and provides technical assistance to organizations creating their profiles, as well as ongoing technical assistance. Live and computer-based training is also available. To participate, an organization needs to register by filling out a form that helps create their profile. They also execute a contract and business associate agreement. Unite Us current inception to deployment time frame is 12-16 weeks.

Unite Us appears to solve the problems of not having current information on a target referral agency; not receiving feedback on outcomes; and issues surrounding privacy laws and regulations.

Funding – Substance Abuse and Mental Health Services Administration block grants distributed through FSSA/DMHA; operational funds; or licensing fees from participating agencies

V. Methodology

A. Summary

For the initial stage of the project, the team strove to gather as much information as possible about the current referral process, what works well and what needs improvement, and what would be practical fixes. Data was gathered using multiple modes including:

- A standardized online survey was developed with both multiple-choice and open-ended responses. An email link for survey access was sent to 230 participants. This list of participants was developed by those partners and sponsors familiar with the Marion County area service landscape. The Marion County Public Health Department emailed the survey invitation. Multiple follow ups were done to the group to encourage participation. Appendix A includes survey questions, the email sent to organizations requesting completion, and survey results.
- Survey responses were distributed to all participants who responded to the survey. Those who had agreed to more in-depth conversations were scheduled for follow-up interviews.
- In-depth follow-up interviews with representatives from organizations that completed the online survey were conducted. The questions changed slightly after two rounds of organizational interviews due to the need for some clarity and better flow of the questions. Teleconferencing was utilized due to COVID-19 pandemic restrictions of limiting in-person interaction. A total of thirty (30) individuals from a variety of organizations were interviewed. Appendix B contains the PowerPoint slides from the interviews and the detailed write up of those conversations.
- Interviews were conducted with PWSUD and/or their close friends and family. Again, this interaction was limited to teleconferencing based on the COVID-19 pandemic. Additionally, because of those limitations, the interviewees were limited to those who were suggested by our partners rather than an in-person meeting with people who were willing to participate when gathered at a service facility.
- Interviews with representatives from current initiatives, electronic systems and groups that are trying to improve coordination in service delivery for PWSUD.

B. Standardized Survey

The team designed an online survey that was sent to various agencies and organizations. The goal of the survey was to gather baseline data about how those organizations make and receive referrals and to identify barriers to timely and effective referrals. We strongly encouraged organizations to have staff members with direct frontline experience in initiating and handling referrals to complete the surveys.

The team compiled a list of 230 individuals to be surveyed from roughly 170 different organizations. The list included a wide variety of organization types such as, but not limited to, those identified below:

Organizations to be Surveyed by Type		
Healthcare providers	Transportation services	Food assistance
Substance use treatment	Legal services	Crisis services
Mental health providers	Vocational and job readiness organizations	Childcare assistance
Emergency and public safety agencies	Employment supports	Schools and education systems
Recovery supportive shelters	Domestic violence supports	Faith-based initiatives
Short-term, long-term, and permanent housing entities	Homeless services	Recovery supportive recreation
Other supportive advocacy and outreach services	Law enforcement and criminal justice agencies	Public safety agencies

The survey was created in Microsoft (MS) Forms, a tool that allows you to easily create surveys, quizzes, and polls. It was distributed via a link in an email sent to the targeted individuals. The recipients would click the link to launch the survey. Many of the questions were of a multiple choice format, allowing respondents to select from a defined list of possible choices, including an option of 'Other' and allowing the respondent to enter a free-form response. Selecting from a defined list in this way allows for clearer statistical analysis of the data. Some questions were free text format. In addition to gathering general organization and contact information, the survey included the following questions:

Question	Format
What are the most common sources of referral to your organization?	Multi- select
What are the most common sources of referral from your organization?	Multi- select
How does your organization most commonly receive/send referrals?	Multi- select
When accepting referrals, other than name, age and contact information, what is the minimum information you must have?	Multi- select
What are the most common barriers in sending or receiving referrals to/from other agencies/organizations?	Multi- select
Are there any other common barriers in sending or receiving referrals that we missed in the previous questions?	Multi- select
What would enhance the referral process to your organization?	Multi- select
What three actionable short-term solutions/strategies would you recommend for overcoming the barriers you experience in sending or receiving referrals to and from other organizations?	Free Form

What three actionable longer-term solutions/strategies would you recommend for overcoming the barriers you experience in sending or receiving referrals to and from other organizations?	Free Form

From the survey requests, seventy-six (76) responses were received from individuals from a variety of organization types. The responses of each survey received were automatically stored by MS Forms and could be retrieved at any point and exported into Excel. See detailed results in Appendix A.

C. Survey Follow-up/Organization Elaboration Interviews

One of the questions asked as part of the online survey was whether the respondent would be willing to participate in a follow-up discussion session to expand on answers provided in the survey. Of the responses received for the online survey, a majority indicated a willingness to participate in interview sessions. The sessions were originally planned to be in person but, due to COVID-19 restrictions, all the sessions took place via videoconferencing.

The sessions were conducted by Sharon Dow, Dean Babcock, and Jodi Miller from the RAP team. Carol Key and Gary Lofgren took notes and set up the sessions. Although most online survey respondents indicated a willingness to participate, workload and other scheduling restrictions limited the number that actually participated in the sessions. The COVID-19 pandemic especially impacted this response. Interviews were conducted with thirty (30) respondents across a total of thirteen (13) sessions. Depending on the session, anywhere from 1-5 individuals participated at a time. The sessions were scheduled for either one or two hours, depending on the number of participants.

For consistency, each session consisted of five primary questions asked of each participant:

Survey Follow Up Interviews: Elaboration to the Online Survey:
1. We have your responses to the most common way you make and get referrals. What method has been most successful in ensuring the Person with Substance Use Disorder get the services they need? And to follow on that why, what made it most successful?
2. What has been the least successful referral method? Why and what made it unsuccessful? (included in May 7 and May 12, 2020 sessions only)
3→2. Is the referral method you most commonly use dependent on staff who are making the referral? Do staff have different contacts that make referral better?
3. Do you typically get feedback from other agencies to which you make referrals, and do you give feedback when receiving referrals? (included May 14, 2020 and after)
4. How would you rank barriers, i.e. what is the biggest impediment to coordinating services a client needs? Why is that the biggest impediment? Have you tried any mitigations? If so, what were they? How successful were they?
5. If you could identify one thing that you believe would make a significant improvement in referring people between agencies what would that be?
In addition to the primary questions, there were some additional questions covering: • population demographics; • wait time;

- 2-1-1/OpenBeds;, and
- Cost of/funding for services.

Although each session included the same primary questions to achieve a level of consistency, several of the primary questions naturally elicited free-form follow-up questions, depending on participants' answers. As the interviews took place, notes were taken by RCR personnel. After each session, the interview notes were completed and distributed internally to the team for review. See Appendix B for detailed notes on the follow-up interviews with survey respondent organizations.

D. PWSUD Interviews

When evaluating a process like that involved in referrals, it is instructive to gather data from different perspectives. Besides interviewing individuals from treatment providers and support organizations, a second perspective was obtained from people directly affected by SUD (PWSUD and their close friends and family members). These individuals experience first-hand both the good and the bad in the current referral process. As part of the RAP project, phone interviews were conducted with a number of PWSUD and their close friends and family members. First, a list of potential individuals recommended by Jodi Miller, Dean Babcock, Matt Heskett, and Natasha Cheatam was drawn up and the individuals contacted to see if they would be willing to participate. If the individuals agreed, their interviews were scheduled. In-person interviews were originally planned but, due to COVID-19 restrictions, all the sessions took place by phone. In total, twenty-four (24) interviews were conducted. Questions were asked by Dean Babcock, Matt Heskett, Jodi Miller, and Natasha Cheatam. Each session lasted approximately 45 minutes.

For consistency, each interview consisted of the same set of questions.

PWSUD Interview Questions
1. What services have you gotten and what services did you need and not get from the onset to now?
2. When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
3. When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
4. What things have made the process smoother
5. What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?
6. What do we need to know that we haven't already discussed?
7. What would you recommend for improving service delivery/coordination both now and long term?
8. What have you learned that you would recommend to someone going in?

As the interviews took place, notes were taken. After each session, interview notes were completed and distributed internally to the team for review. See Appendix C for the details of those interviews. While not promised in advance, a tangible incentive gift card was distributed to those who participated.

E. Review of Initiatives

The current issues in coordinating referrals and interaction between agencies are not new. There are several initiatives which have been developed to address the problems that impact coordination of care and the service delivery system. Each of these initiatives approaches the problems from different perspectives. Some are public facing, aimed directly at those seeking care, while others target the service delivery community. We reviewed the initiatives identified below.

1. TeamPatient

TeamPatient is a web-based application created by Solutionize, Inc. It is a patient-based collaboration network and allows everyone in a patient's care process (i.e., treatment providers, caregivers, family members and the patients themselves) to coordinate care in real-time and from their own perspective.

2. 2-1-1/Indiana 211

2-1-1/Indiana 211 is a nationwide phone-based information and referral service with specific responses for the area code from which a caller dials. Various options are available to the caller after he or she enters their zip code. In central Indiana, the options for substance use treatment include obtaining transportation to or from treatment via Lyft or speaking with a SUD community navigator. This service has recently (July 1, 2020) come under the auspices of FSSA and will, when completely rolled out, involve several social services departments administered by FSSA.

3. OpenBeds/Treatmentconnection.com

Treatmentconnection.com (OpenBeds) is a cloud-based platform that provides real-time treatment services availability, connection to social support services, evidence-based assessment tools, and therapy offerings. OpenBeds operates in multiple states. In Indiana, it operates as Treatmentconnection.com. It improves process efficiency through digital referrals and two-way provider communication, integrated notifications, and data aggregation and analytics. Treatmentconnection.com is a portal that enables those seeking mental health and SUD treatment for themselves or others to anonymously search for nearby providers, evaluate the type of care needed, and submit confidential online referral inquiries to appropriate treatment providers.

4. Know the Facts Indiana/knowthefactsindiana.org

Know the Facts is a campaign re-launched by FSSA in 2020 with the goal of reducing stigma around opioid and other substance use disorders that may prevent an individual from seeking treatment. Originally centered on opioid addiction as *Know the O Facts*, the campaign evolved to cover all facets of the drug epidemic and how it is affecting Indiana due to a rise in the use of methamphetamines and other substances, in addition to opioids. The main strategies are that opioid and other substance use disorders are a disease; there is treatment; and recovery is possible. Using television and radio spots,

as well as outdoor and online advertising, the campaign emphasizes stories of Hoosiers who have gone through SUD and have overcome.

5. Indiana Recovery Network

Indiana Recovery Network (IRN) is a subsidiary of Mental Health America of Indiana. RCR partners are principles at IRN and were able to provide information regarding the network. At the IRN website, an individual can search for a recovery organization or fill out a short form to be connected with a peer who is able to refer him or her to detox, treatment, transitional housing, recovery residences, recovery community organizations, recovery community centers, food pantries, and other services. Additionally, IRN has created five regional recovery hubs, distributed geographically around the state. These Hubs aid in connecting individuals with mental health and SUD to treatment and recovery through Certified Peer Recovery Coaches, Community Health Workers, and Certified Recovery Specialists.

6. INSTEP

Some members of the project team are members of INSTEP workgroups and provided information about the initiative. INSTEP is a coalition of organizations with a goal to coordinate, integrate and align a community-wide response to SUD in the greater Indianapolis area by bringing together SUD and related providers, caregivers, people in recovery, and members of the community. INSTEP tries to address questions related to entry into and navigation of treatment and recovery services. To accomplish their mission, they sponsor community education and focus groups. More than 70 organizations are members of INSTEP spanning several different sectors including health care, law enforcement, government, education, business, and faith-based organizations.

7. Unite Us

Developed seven years ago, the Unite Us system is an automated unifying infrastructure between health care entities and community-based organizations. It is currently implemented in 35 states. One of its main solutions is in North Carolina where it was activated in all 100 counties, with 1,150 participating organizations and 3,651 users (as of June 22, 2020). Some of the functionality included in the Unite Us system are:

- Electronic referrals and referral tracking from inception to resolution
- Notifications and alerts
- Integration with 211
- Outcome reporting capabilities

The Unite Us application includes not only technology, but locally hired business-oriented staff to assist in the set-up, implementation, roll out, and ongoing support of the system. Local advisory boards of providers and clients are set up and maintained for long-term maintenance and improvements.

Appendix A: Survey Information

MARION COUNTY PUBLIC HEALTH DEPARTMENT
Prevent. Promote. Protect.

The Metropolitan Indianapolis Addiction Referral Assessment and Plan (RAP) Survey

Based on the online survey for the Metropolitan Indianapolis Addiction Referral Assessment and Plan (RAP) project completed by 76 organization representatives, below are the answers chosen. The choice of more than one response results in more than 76 responses per question. The items below are sorted by highest to lowest percentage of overall answers. Where individuals answered Other, examples of some of those responses are included. The short term and long-term summaries at the end are not comprehensive but represent general areas. All responses will be considered when formulating plans for improving coordination of services.

1. What are the most common sources of referral to your organization?	**Number of responses**	**Percentage of responses**
Family/friends	35	47%
Government agencies	32	43%
Justice System entities	31	41%
Substance Use disorder treatment organizations	30	40%
Medical treatment organizations	29	39%
Mental health treatment organizations	26	35%
Recovery support services	16	21%
Recovery Housing/supportive living	14	19%
Educational institutions	12	16%
Front end access entities	12	16%
First Responders	12	16%

Other (e.g. self, homeless shelters)	12	16%
Faith Based organizations	10	13%
Employers referring employees	3	4%

2. What are the most common sources of referral from your organization?

Mental health treatment organizations	45	60%
Recovery Housing/supportive living	36	48%
Medical treatment organizations	34	45%
Recovery support services	32	43%
Substance Use disorder treatment organizations	31	41%
Government agencies	18	24%
Employment Readiness/Job Placement/Training	11	15%
Other (e.g. basic needs, food)	9	12%
Educational institutions	7	9%
Faith Based organizations	5	7%
Family/friends	5	7%
Employers referring employees	5	7%
Front end access entities	4	5%
Justice System entities	4	5%
First Responders	2	3%

3. How does your organization most commonly receive/send referrals?

Telephone call to agency/organization	46	61%
Telephone call from individual seeking treatment	33	44%

Orally tell the individual	32	43%
Warm handoff	27	36%
Email to organization	26	35%
Hand the individual a list of resources	21	28%
Formal referral given to the individual by an org	19	25%
Walk ins - self referral	17	23%
Walk ins from other organizations or within your org	13	17%
211/OpenBeds	5	7%
Online Scheduling	4	5%
Other (e.g. formal referral from Dr, Justice System)	4	5%

4. When accepting referrals, other than name, age and contact information, what is the minimum information you must have?

Purpose of referral or problem to be solved	50	67%
Healthcare coverage information	30	40%
Referring agency/agency contact information	26	35%
Past medical history	19	25%
Other Demographic data	16	21%
Location Address	16	21%
Diagnosis	14	19%
Other (e.g. homeless status, veteran status)	12	16%
Application/Interview	11	15%
No additional information	10	13%

5. What are the most common barriers in sending or receiving referrals to/from other agencies/organizations?

Individual transportation issues prevent follow through	41	55%
Cost of services	34	45%
Lack of communication between service providers	23	31%
Timely accessibility of services	23	31%
No formal referral process	20	27%
Unknown Insurance and billing practices	19	25%
Limited knowledge about services offered	18	24%
Lack of partnerships with referring organizations	16	21%
Lack of universal referral form/process	15	20%
Accessibility (Physical constraints, criminal history, etc.)	13	17%
Lack of co-occurring services	13	17%
Lack of knowledge about best manner for connecting individuals	12	16%
Notification that a referred client has connected	10	13%
Lack of knowledge of agency capacity	9	12%
Privacy concerns in referral process	6	8%
Child Care barriers	6	8%
Other (e.g. lack of warm handoffs, location, requirements for certain groups)	5	7%
Inconvenient hours of operation	4	5%
Cultural barriers	3	4%

Solutions/Comments: 1. What would enhance the referral process to your organization?		
Directory of services available	44	59%
Online referrals with enough information	40	53%
Common referral forms	24	32%
Better understanding of Privacy laws and regulations	10	13%

Below are recommendations received in the survey in addition to the above selected solutions. These are by no means all the suggestions but, instead, are the most commonly mentioned. We will elaborate on these and other suggestions in the follow-up sessions to help formulate practical steps for moving forward with plans for improved coordination.

Short-term improvement recommendations:

- Better communication among service providers including identified contact/point person and knowledgeable representatives answering telephones and better networking
- Better transportation to treatment services
- Increased access to services that are unavailable due to income or insurance and increased telehealth options
- Housing resources
- Better follow-up of the person post release from facility

Long-term improvement recommendations:

- Better healthcare coverage, access and service covered
- Revision of Federal and State Regulations
- More facilities/beds
- Create interagency brochures/informational booklets /better information about services available
- Better transition process from inpatient to outpatient care including post release support

The complete survey details may be seen by double clicking on the link below:

Survey Response Master.xlsx

Email distributing the survey results to those agencies choosing not to participate in follow-up interviews:

From: Tammie Nelson [TNelson@MarionHealth.org]
Sent: Wednesday, April 29, 2020 5:00 PM
To: Tammie Nelson
Cc: babdean@aol.com; Brandon George (bgeorge@mhai.net); Jodi Miller; Carol Key; Gary Lofgren
Subject: The Metropolitan Indianapolis Addiction Referral Assessment and Plan (RAP) – Survey Update

The Metropolitan Indianapolis Addiction Referral Assessment and Plan (RAP) – Survey Update

Thank you for participating in the survey to determine the current state of referrals and coordination of services for persons living with substance use disorder. This survey was just one part of the Metropolitan Indianapolis Addiction Referral Assessment and Plan (RAP) project undertaken by the Marion County Public Health Department, in conjunction with RCR Technology and partners.

We understand you chose not to participate in further discussions growing out of the survey; however, we do want to share with you the high-level results of the survey. We will also share with you the overall analysis of these results and the plan developed from the data gathered. This plan will be developed and distributed in the next few months.

Attached are the results of the individual survey questions ranked by most to least chosen answers. We had responses from 75 (seventy-five) agency or organization representatives. The respondent was able to choose more than one answer to most survey questions.

In addition to the survey of organizations we have interviewed 22 (twenty-two) persons living with substance use disorder about their experience in seeking and receiving the range of services they needed. Those interviews are being used in the overall assessment and plan for improving coordination of services. These individuals will also be asked to participate in follow-up sessions as appropriate.

Follow up information may be sent to you from RCR Technology staff, our partner in the RAP project. We want to make you aware of this so that you do not delete their follow-up messages or find them in your spam folder.

Again, thank you and please feel free to let us know if you have any further comments you feel would be helpful.

Sincerely,

Tammie

Tammie L. Nelson, MPH, CPH
Epidemiology Manager
Overdose Data to Action Grant Coordinator

Health & Hospital Corporation
Marion County Public Health Department
3901 Meadows Drive, H109
Indianapolis, IN 46205
O. (317) 221-3596
M. (317) 416-4104

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In your response, you chose to participate in further discussions growing out of the survey. We are in the planning process to schedule group discussions via virtual meetings. The purpose of these meetings is to share more fully the detail of answers and suggestions from the survey and to further elaborate on your processes. For example, why you do things the way you do, successes/drawbacks in your processes, elucidation and clarification of best practices and suggestions for communicating and instituting those practices. We want everyone to participate fully in these sessions. In order to schedule those group sessions, we need your input on the best time(s) to schedule the meetings.

Please respond to Carol Key at RCR Technology (ckey@rcrtechnology.com) indicating which day(s) of the week you are available Monday thru Friday with your availability for a couple of hours in the morning (**9-11 AM**) or afternoon (**2-4 PM**):

☐ Monday Morning ☐ Monday Afternoon

☐ Tuesday Morning ☐ Tuesday Afternoon

☐ Wednesday Morning ☐ Wednesday Afternoon

☐ Thursday Morning ☐ Thursday Afternoon

☐ Friday Morning ☐ Friday Afternoon

In the meantime, we want to share with you the high-level results of the survey. We will also share with you the overall analysis of these results and the plan developed from the data gathered. This plan will be developed and distributed in the next few months.

Attached you will find the high-level survey results of the individual survey questions ranked by most to least chosen answers. We had responses from 75 (seventy-five) agency or organization representatives. The respondent was able to choose more than one answer to most survey questions. Following completion of the analysis and plan development that documentation will be shared with the participants for review, final input and acceptance.

In addition to the survey of organizations we have interviewed 22 (twenty-two) persons living with substance use disorder about their experience in seeking and receiving the range of services they needed. Those interviews are being used in the overall assessment and plan for improving coordination of services. These individuals will also be asked to participate in follow-up sessions as appropriate.

Follow up information, including group scheduling, may be sent to you from RCR Technology staff, our partner in the RAP project. We want to make you aware of this so that you do not delete their follow-up messages or find them in your spam folder.

Again, thank you and please feel free to let us know if you have any questions.

Sincerely,

Tammie

Tammie L. Nelson, MPH, CPH
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Overdose Data to Action Grant Coordinator

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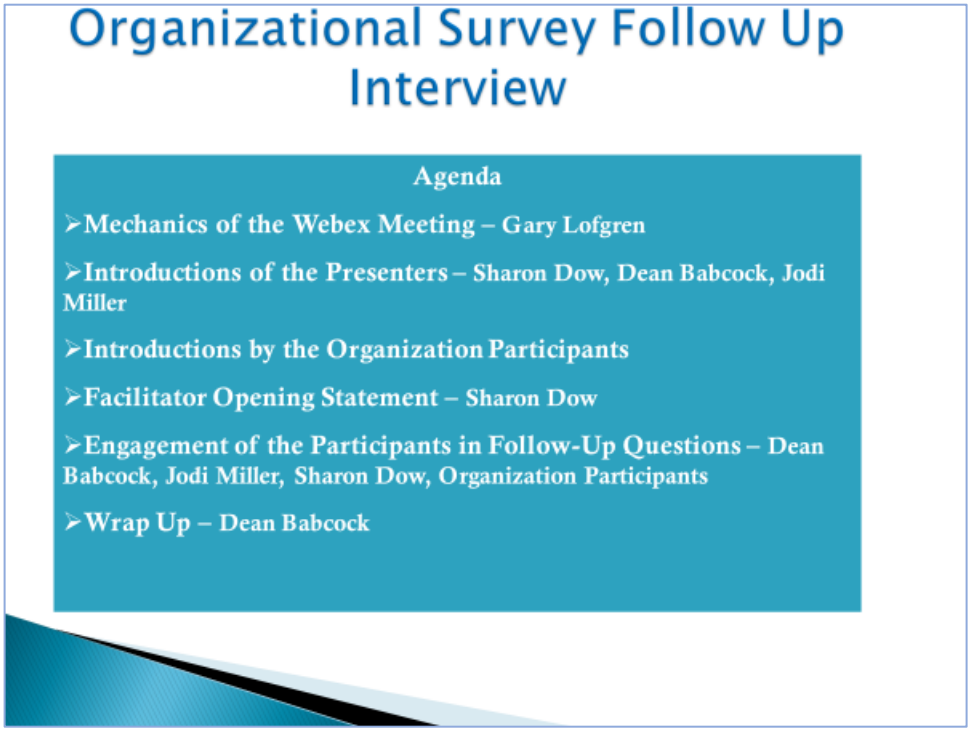
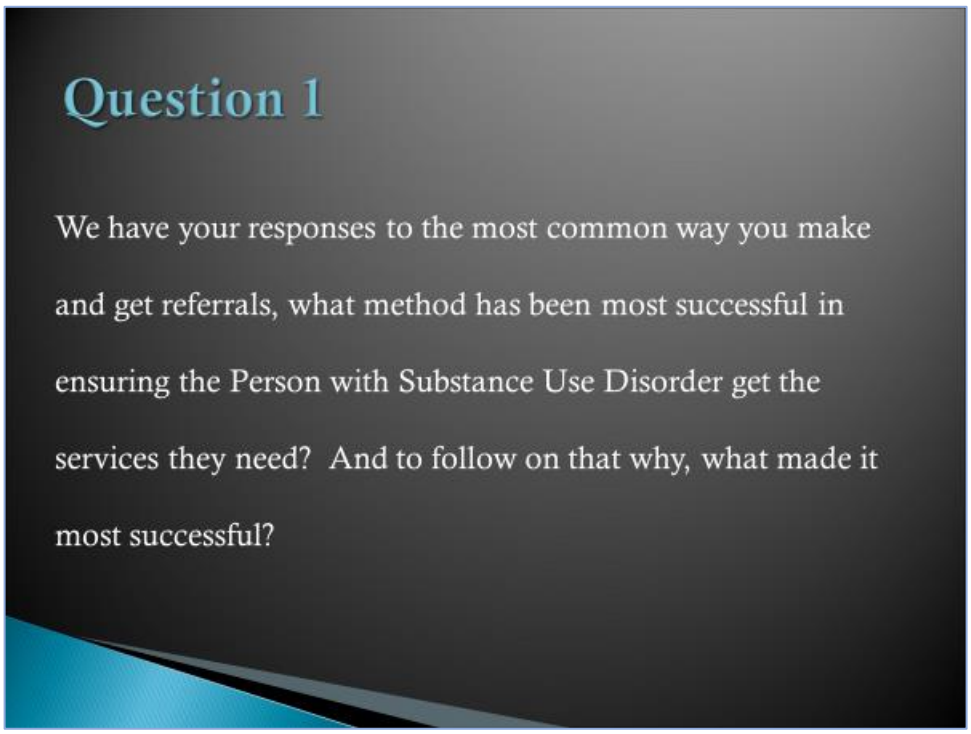
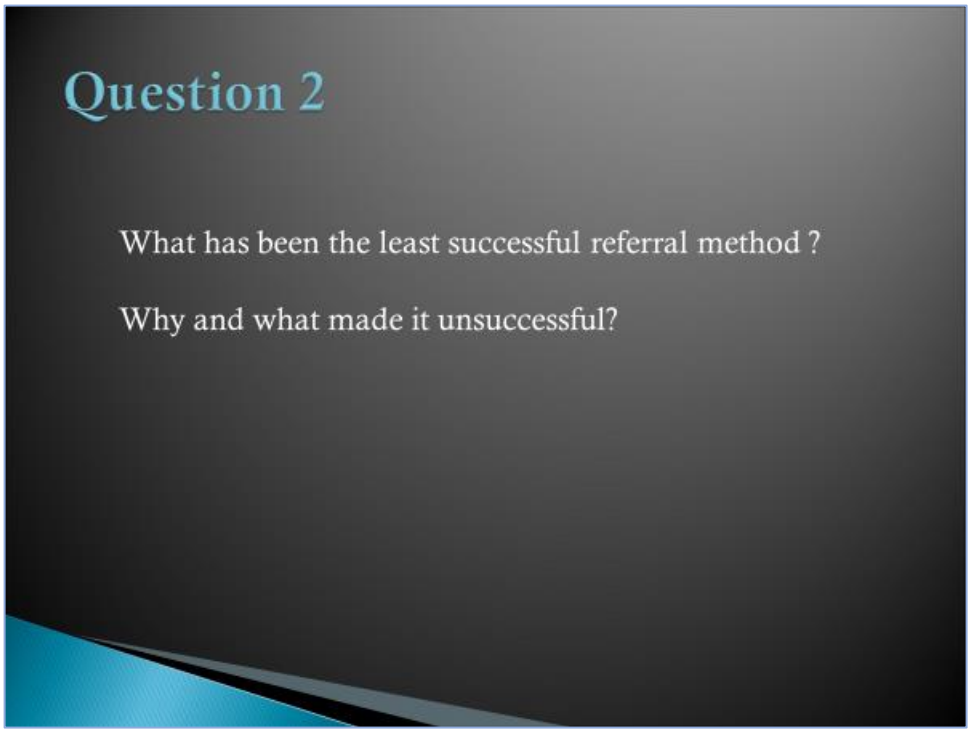
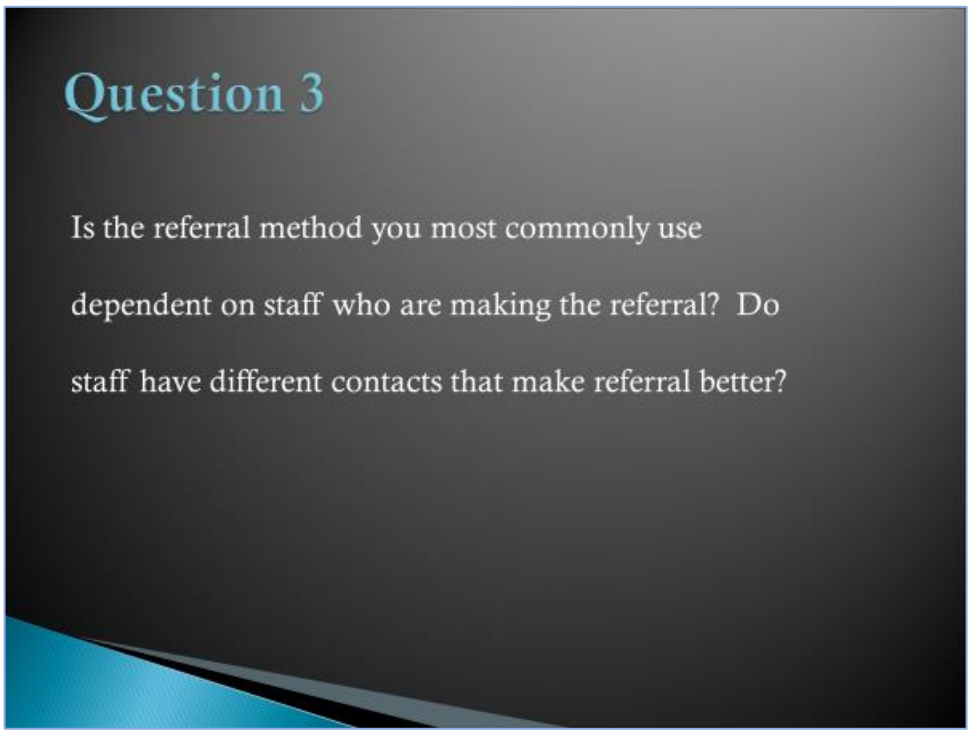
Appendix B: Organization Follow-Up Notes

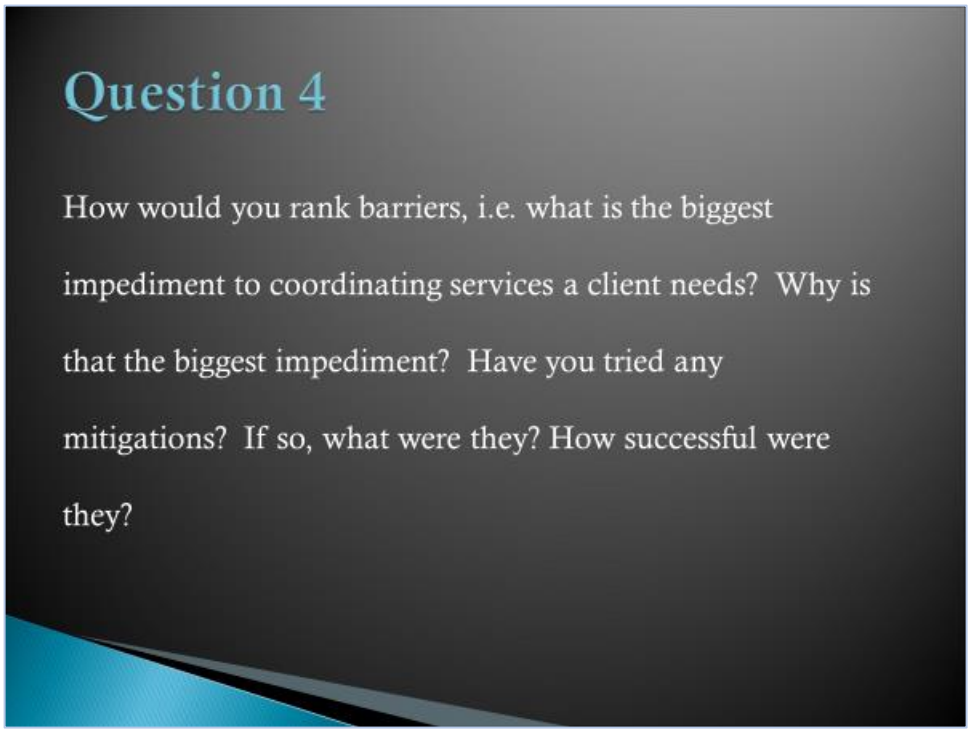
Slides Used in Interviews for May 7 and May 12, 2020:

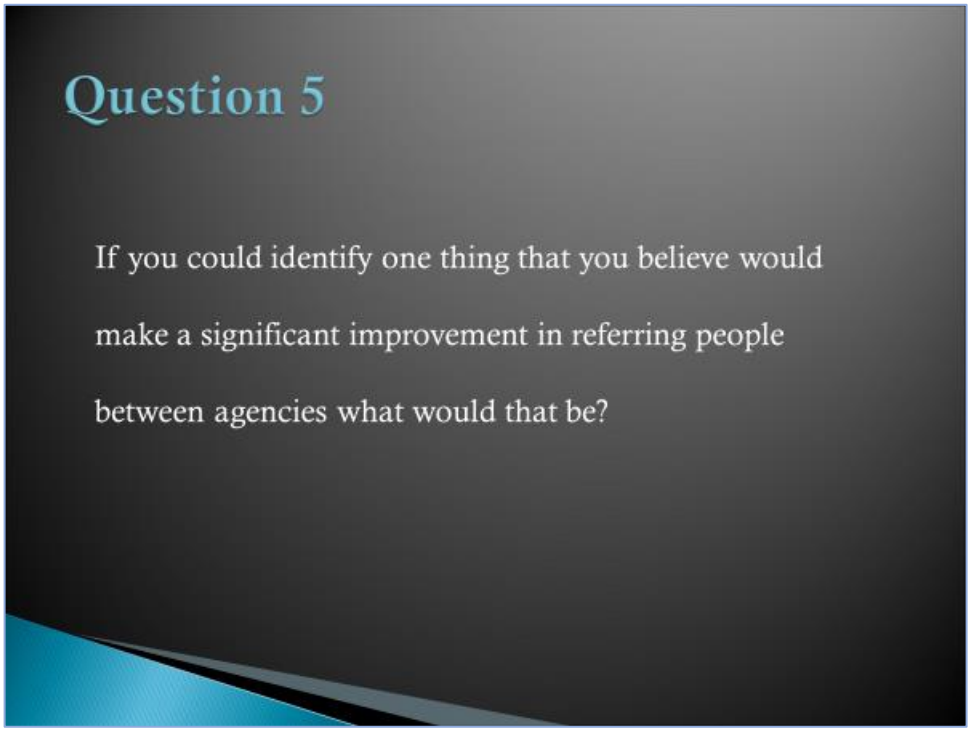


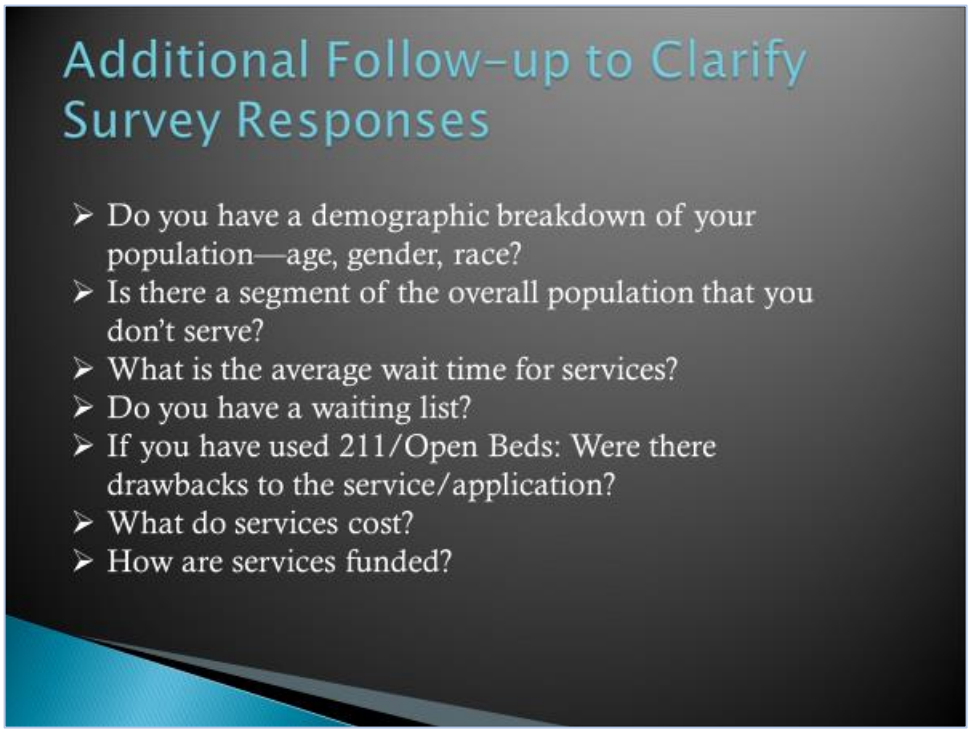

Question 1
We have your responses to the most common way you make and get referrals, what method has been most successful in ensuring the Person with Substance Use Disorder get the services they need? And to follow on that why, what made it most successful?

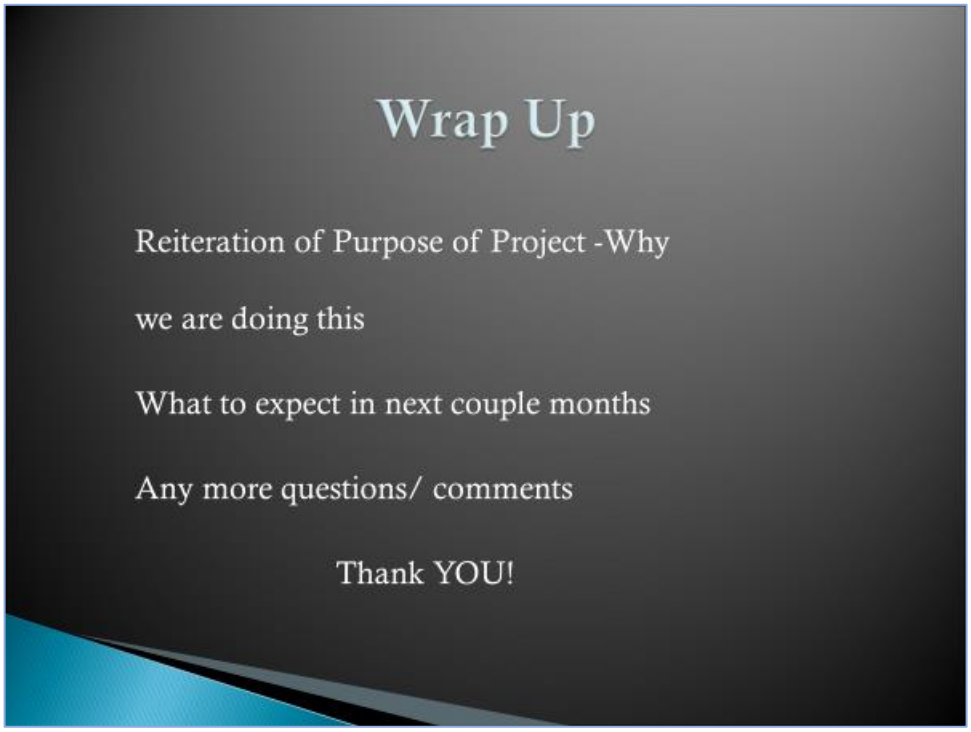

Question 2
What has been the least successful referral method ?
Why and what made it unsuccessful?


Question 3
Is the referral method you most commonly use dependent on staff who are making the referral? Do staff have different contacts that make referral better?

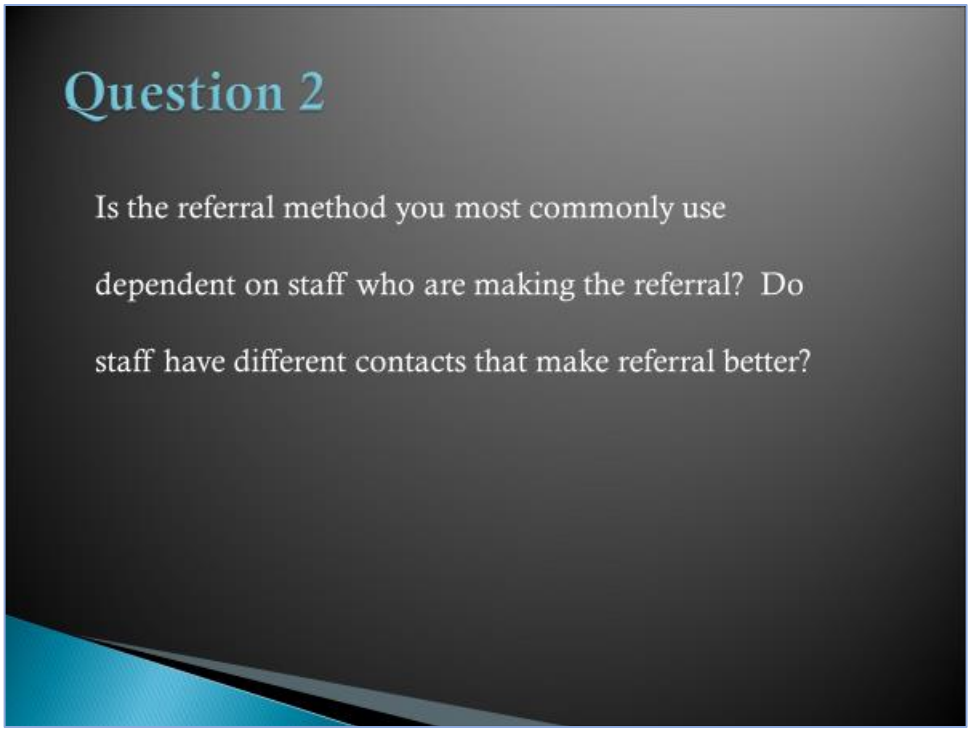

Question 4
How would you rank barriers, i.e. what is the biggest impediment to coordinating services a client needs? Why is that the biggest impediment? Have you tried any mitigations? If so, what were they? How successful were they?

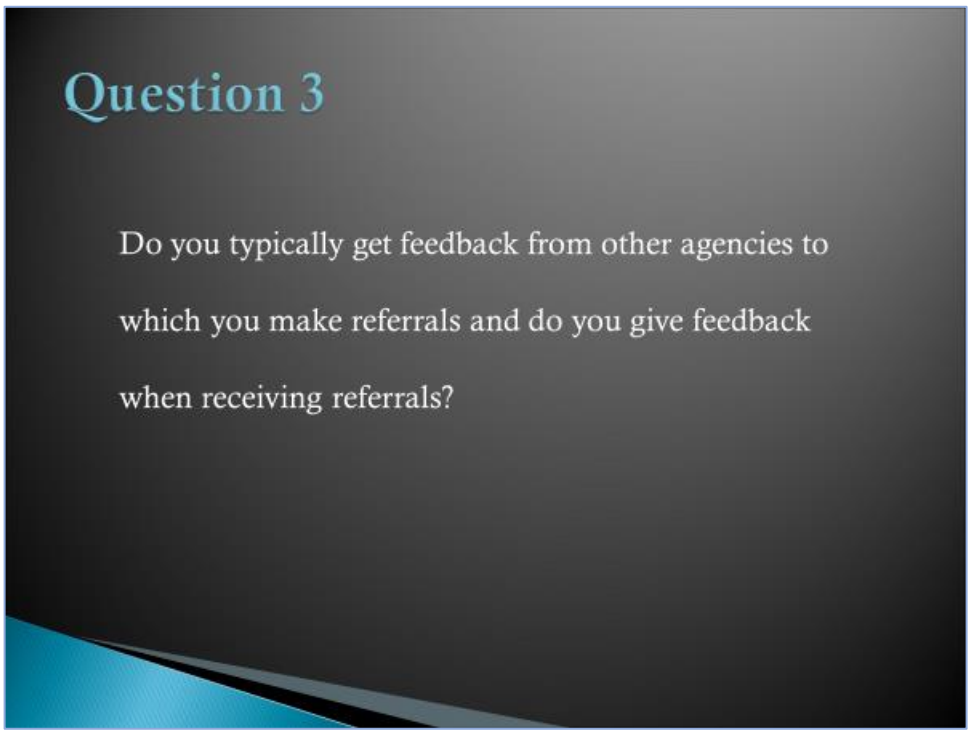

Question 5
If you could identify one thing that you believe would make a significant improvement in referring people between agencies what would that be?


Additional Follow-up to Clarify Survey Responses
Do you have a demographic breakdown of your population—age, gender, race?
Is there a segment of the overall population that you don't serve?
What is the average wait time for services?
Do you have a waiting list?
If you have used 211/Open Beds: Were there drawbacks to the service/application?
What do services cost?
How are services funded?



Questions 2 and 3 changed after the May 12. 2020 Interview session and were used in place of the above slides for questions 2 and 3 for the remaining interviews through June 10, 2020.





The Organizational follow-up notes are semi – transcriptional. They are not minutes of the meeting but reflect the conversational tone of the meetings.

SURVEY FOLLOW-UP INTERVIEW

Date: May 7, 2020

Participants/Organizations:

Robin Parsons, Clinical Director, Fairbanks Hospital

Kim Manlove, Co-Founder and Board Member, The 24 Group

Lisa Hoffman, Program Director, Wheeler Mission-Center for Women and Children

Darrell Mitchell, Executive Director, Aspire IN, Progress House

***Question 1*: We have your responses to the most common way you make and get referrals; what method has been most successful in ensuring the Person with Substance Use Disorder gets the services they need? And to follow on that why, what made it most successful?**

Responses:

Darrell: Case Manager (CM) liaisons who use various ways of connecting. Most businesses they partner with they connect by phone. Generally, they are connecting to the same individuals on a consistent basis.

The partnerships are varied. Some businesses they have MOUs or business contracts with, and some the CM is just using a list. They have established protocols with the other organizations. They have found this works better than a less formalized situation. They have found this works better.

Lisa: They have formalized agreement with a couple agencies. They are trying to form relationships with Probation Dept., different court systems around the state. Are becoming aware of the services available.

A CM goes to the jail for personal contacts. There are lot of letters sent, applications, information to them from the individual. A referral comes in over the phone, interview over the phone, mail out application. They are trying to get information out because their program is not that well known. They do have a waiting list but usually short wait. They are an 8 mos. program and there is usually someone vacating so spaces regularly available. They are in the process of expanding which will triple capacity.

Robin: They have MOUs and relationships with other service providers. They use marketing and advertising online. They have online inquiries resulting in online assessment and now have online admissions (change since Coronavirus social distancing). Before they did through online and phone call referrals. They have some using OpenBeds but barriers with this. They currently work closely with EAP specialists.

Kim: Marion County has a lot to offer but if you get too far north or south in the state availability of services drops off dramatically. He has been doing 12 Step meetings using Zoom meetings because of the situation but need to think about being able to deliver service to a broader group using teleconferencing after the social distancing guidelines are relaxed. Doing virtual outreach to incarcerated individuals.

Q: Have you considered or are you teaching Corrections people to assist with outreach?

Lisa: The services are already with some staff familiar with technology, but the cost is prohibitive currently-about $10 for 3 minutes to connect with the PWSUD. Lisa indicated that they communicate on a number of occasions with Jail personnel to get person on the phone to talk directly with them. She noted need for expanding Telehealth and educating their "guests" on using systems to communicate.

Robin: Their relationships with DMHA and DCS critical access points.

Lisa: Need for cooperation between the agencies in how they work to get people referred in. It was noted that with PSA/Stigma campaigns DMHA really empower what facilities doing.

Darrell: Telehealth provide a lot of people with services especially for orgs without a lot a staff to provide in person. His org has gone from 7 to 760 interactions per day with the addition of teleconferencing.

Question 2: **What has been the least successful referral method? Why and what made it unsuccessful?**

Responses:

Darrell: If no relationship established doesn't matter what the referral method is; email, phone, etc. Observed consistent theme, no relationship doesn't work.

Robin: Need to have relationship with a person at the other agency.

Recovery Network Association (RNA) was a self-organized group that met monthly at different member locations to share what they were doing and establish relationships. Now subsumed under Indiana Recovery Network and meetings suspended due to social distancing but still ongoing. Most people don't know this is available.

All: Same number of beds for women now as there were 20 years ago. Most people don't know what is available. There are new providers or people don't know what is available.

Kim discussed the role of the interventionist. Don't hear so much about an interventionist now. Need for engaging family, maybe some free center operating like EAPs. Need to give help to family even if the patient doesn't participate will help family. The family/family member/PWSUD will start to get help/get better. Most underutilized service. This is a gap.

Lisa: Agree on the whole family approach. As a residential recovery facility, they do include family.

Robin: She has not found OpenBeds to be as helpful as the original plan. It is not doing what it was originally intended to do. The 2-1-1 system is being overhauled currently by FSSA.

There are significant issues when patient has co-occurring conditions e.g. Mental Health, homelessness, SUD. Lot of facilities not able to assist with SUD because of mental health issues and housing facilities have same problems. Funding changes could assist with the treatment of patients with co-occurring problems – need holistic approach.

Question 3: **Is the referral method you most commonly use dependent on staff who are making the referral? Do staff have different contacts that make referral better?**

Responses:

Robin: Quality improves with having well trained staff who understand the disease. Have to have some of best people on the phone.

Darrell: Staff that are the most successful are those who know the agencies, have relationships and training.

Q: Is there a standard place they can get information about where to refer, what agencies offer?

Robin: They use their own list.

Q: Any staff that seem to be really, really good – are they used as mentors?

Robin: They do use shadowing as part of training.

Lisa: They pair new staff with more experienced staff as part of training.

Question 4: **How would you rank barriers, i.e. what is the biggest impediment to coordinating services a client needs? Why is that the biggest impediment? Have you tried mitigations? If so, what were they? How successful were they?**

Responses:

Robin: Micromanaging of treatment level of care/course of treatment by insurance or health coverage. Need to empower physicians and trust that they will not refer for care that is unreasonable. The overemphasis on not overtreating has led to undertreatment. Managed Care Entities are being penny wise and pound foolish. Not done in other treatment protocols. Stigma or lack of understanding could be playing a role. Lot of Utilization Reviews are done with medical personnel with specialties other than those related to SUD.

Darrell: Issues with capacity not on referral. Housing is changing to be ¾ and more long term.

Lisa: They are a no charge facility so funding not the issue for them. They are able to provide a lot of services in house. They work a lot with Adult and Child Mental Health, have primary care physician come in three times a week. They work a lot with jails, people on probation. They have been able to work with these organizations to get reporting done without people having to leave the facility and go to places where they are more vulnerable. The patient can't attend IOP/PHP and be in their program at the same time. They try to work with the requirements with Probation.

Transportation to their facility is a big problem especially as they have a lot of residents coming from outside Marion County. Some are homeless and don't have any relations that can help. People are released from jail at odd hours with no way to get to the facility. Tried Lyft but that did not work out, so they end up going to pick up people who have no other options.

Kim: Last couple decades have made significant strides in dealing with addiction as a medical condition. Still significant population view as a choice or criminal act.

Question 5: **If you could identify one thing that you believe would make a significant improvement in referring people between agencies what would that be?**

Responses:

<Jodi indicated RNA is still happening but suspended monthly get togethers for few months. There is also the Indiana Recovery Network website which has a grant from DMHA they are putting into place with 4 recovery hubs identified.>

Emergency Room Drs referral to the program should be all that is required. Need better referral from Dr. to SUD services.

Robin: found phenomenal respect among the agencies in Indiana. May not be able to help but everyone is trying.

Additional Information:

Responses:

Robin: Treat adolescents predominantly Caucasian. No Spanish speaking staff so limited in Hispanic services. About half and half male- female (?). Mostly from Marion but about equally Hamilton, Johnson, and Hendricks counties. They rarely have wait times but with current single bed occupancy they are at about 50% occupancy.

Based on their contracts they may get about 30-40% less than their set fee. They charge self payors 40% less. Because of the 1115 waiver in In. they are able to take Medicaid although a couple of the MCEs are not in their network. They take Medicare. They work with Community Mental Health to get people signed up for Presumptive Eligibility. Wide spectrum of reimbursement based on best available resources.

Darrell: Will send in information

Kim: Don't provide services but raise funds for adolescent and young adult treatment and recovery services. Fund raising activities have been curtailed this year

SURVEY FOLLOW-UP INTERVIEW

Date: May 12, 2020

Participants/Organizations:

Rachelle Gardner, COO, Hope Academy

Justin Phillips, Executive Director, Overdose Lifeline

Dominique Leveque, Nurse Practitioner MAT program; Social Worker; Referral Coordinator, respectively, Shalom Healthcare Center

Leila Mortazavi. Manager, Eskenazi Health Primary Care

***Question 1*: We have your responses to the most common way you make and get referrals; what method has been most successful in ensuring the Person with Substance Use Disorder gets the services they need? And to follow on that why, what made it most successful?**

Responses:

Rachelle: When making a referral understanding what the person needs. Trying to understand what all the provider can do for them. If don't know a place have to refer to who you know best. Important to make sure sending the patient to the right place when dealing with kids. You get children ready to go out then have to jump through hoops and don't get the services they need.

Dominique: Try to get to know someone in the organization. Feel like get more of personal touch. Only refer to people know and trust, have had some good experiences with. There is not a lot out there for children. Always a problem with mental health issues- becomes a barrier to getting them services. With the Covid-19 – no one meeting needs.

They have a social worker at their organization, but their staff is young and has little experience with Addiction services. Usually Dominique is the one making referrals, trying to find places for patients. She has taken more than 2 hours to try to get what she can from other people.

Q: Before Covid what ways did she use to find someone for a patient who needed services, how did she know what's out there?

Dominique: Previous experience. Have had to tell people how to get into places. Don't like to do this because takes away from people who need the service because they do have the condition that allows them admission to the service.

Q: How are you training staff?

Dominique: Hope when get back together will do inter-staff training and put together tutorials.

Justin: Nothing extra to add, boots on ground, grass roots effort – going to refer to people you know. There are a lot of people out there without the skills needed.

Q: How do you get to know them?

Justin: Try to have a conversation. She has her own knowledge about addiction and recovery treatment so asks questions to get under the top layer. Not everyone can read people, but she uses skills and knowledge she has. Determines if they are willing to use all the available resources to treat.

Question 2: **What has been the least successful referral method? Why and what made it unsuccessful?**

Responses:

Leila: Give phone number to people. Not very successful.

Justin: If she can call someone on behalf of the person and lay the groundwork most successful, warm handoff. Never puts someone in place she doesn't know. Depends on individual level of readiness also.

Rachelle: Lot of referrals just happen**.** People are given their phone number, don't have or take time to find out about the place. People just go from place to place. Become frustrated then lose their momentum.

Dominique: Send patient referrals but person doesn't show up or didn't bring the necessary papers they need even though they were told what those were. This is a problem.

Q: Do you do/have open houses – ever done at your agency or attended at other places?

Rachelle: Hope Academy has done but not necessarily large nor the norm.

Dominique: Yes, they do both. They had planned a major open house this summer but had to cancel. In the past the booth which deals with addiction services was not well attended. They are looking forward to visiting/seeing a lot of new facilities when able to be out again.

Justin: They have a small staff, so she has not had time to attend a lot. They don't serve clients directly in that way so have not had an open house.

Question 3: **Is the referral method you most commonly use dependent on staff who are making the referral? Do staff have different contacts that make referral better?**

Responses:

Justin: Mostly her doing this so. Not enough formalized experience to answer this question. She is going to look for people she knows or talk to someone she knows to have a conversation with.

Rachelle: She is so busy she has a list. Connections work both ways. When refer to somebody hopes the connection is made. The list comes from other departments or someone came to their door to say they were a new facility and what they do, or connection made in person, which is the best.

Justin: Made list of people who they will refer to. Not everyone is that deliberate. Thinks sometimes lists are made with no vetting. Too many anecdotal stories about people calling 800#s and ending up with problems – children worse and financially wrecked.

Q**:** How do you keep list current?

Dominique: Try to find places that accept Medicaid. This is hard – how to pay for it?

Q: Is it more difficult finding post treatment facilities/services?

Dominique: Social worker at their facility has a lot of resources for housing, transportation services. They have that covered. Recovery support- the world is changing so quickly hard to keep up with it. Part of the problem is the speed with which new facilities are coming on. Changing too quickly to keep up.

Leila: She thinks there are a lot of treatment services but referral for recovery is missing the mark. Need community housing.

Q: What do you do if most knowledgeable person decides to move to different position within org or outside org?

Dominique: Beg person to leave list of resources

Leila: Hope they have connected you with the referral

Rachelle: Make sure resources are shared with everyone in the organization

Justin: Institutional knowledge across the whole Agency

Question 4: **How would you rank barriers, i.e. what is the biggest impediment to coordinating services a client needs? Why is that the biggest impediment? Have you tried mitigations? If so, what were they? How successful were they?**

Responses:

Dominique: Problem delegating responsibility to other staff, so she needs to work on educating co-workers on what is available

Leila: Transportation, getting the person to the services is a big issue. Whole process for trying to get someone to the service. Peer coaches really have come in handy.

Justin: Insurance, method of payment. Transportation longer term but first have to get into treatment. If they don't have the right way to pay that is a barrier. Have to choose who will take coverage. Don't know what medications will be covered. Keep trying but have to settle for what don't really want sometimes.

Rachelle: Insurance, trying to find place that will take insurance especially for a young person. Have settle for what don't necessarily want. Fairbanks and Hope Academy splitting June 30 and Hope will open a new facility near University of Indianapolis – moving in in July and having August Open House.

Question 5: **If you could identify one thing that you believe would make a significant improvement in referring people between agencies what would that be?**

Responses:

Justin: Need to improve on people doing assessment. Send people to people who don't have any training in SUD. Need to treat like other diseases. If all use the same assessment tool, then when referred/transferred eliminate the time and frustration of asking the same questions again. Only people like people on the call doing the work.

Leila: Something like the IndianaRecoveryNetwork.org site only better. Way to leverage technology- this site linked her to the other agency website but didn't connect her to be able to make a referral. A start though. One step in lot of steps that need to happen.

{Jodi discussed the site; the plans and work being done by DMHA or under grants from DMHA}

Dominique: Noticed there were not a lot of updates on the site for services. She sent an email asking how she could get their services listed. Has not received a response. Somebody needs to be a clearing house. Don't think this site is there yet.

Justin: Don't need multiple sites, just one really good one.

Rachelle: A siloed approach exists to treatment. SUD service providers look at SUD in combination with Mental Health, but mental health providers do not look at SUD. Children ages 10-16 years, with mental health and SUD issues have SUD undetected until they are well into substance abuse by the time it is discovered. Someone is

talking to them about their behavior but not looking at the total picture. Schools have to address both. Schools are struggling, see this every day.

Leila: How do we educate/train our psychiatrists, behavioral health specialists to integrate looking at SUD into the workflow? Gets ignored because people don't feel comfortable.

Additional Information:

Responses:

Dominique: Most of the population they serve are white males followed by white females. They do not use gender or race as a tool. The youngest participants in their program is 21 years of age, no children. They have a grant to establish a mobile unit to visit communities to make services more accessible. They had planned to start this summer but not sure now.

Rachelle: Serve High School age up to 21 years. Tend to have more males than females although equaling out. Race is an issue. Usually Caucasian. In all communities across the county struggling with this. They are a free school and do not have a waiting list.

Q: Spanish speaking people – do they come to you or is this a challenge?

Leila: Centers in places with high Latino populations. SUD treatment centers tried to engage this population but not all staff is bilingual and not always an interpreter available, so this is a challenge. Not breaking down barriers to serve this community.

Leila: does not think enough being done to serve teens and pediatric ages at Eskenazi.

Q: Have they tried 2-1-1 and OpenBeds?

Leila: Used OpenBeds not 2-1-1.

Justin: State believe 211 and OpenBeds is a solution, but she was told by Hancock County Probation that they were not on the application because they would have had to pay a fee.

{Dean explained that during the pilot phase of OpenBeds the fee was waived/paid by State but not sure what cost is today. There is no charge for 211 and it is moving under the auspices of FSSA in July 2020}

Q: What are the costs/funding sources for your services?

Leila: Rates based on therapy visit. $300 to get in the door for assessment and plan. They take Medicaid and Medicare and have sliding scale for private pay. Grants help with most of meds.

Dominique: They are an FQHC and have grants. They take all insurance and have a sliding fee schedule. Most someone has to pay out of pocket is $75. All labs are $10 co-pay. They do Presumptive Eligibility when people come in to get on Medicaid.

Rachelle: They are free. Funded under the Department of Education.

Additional Comments:

Rachelle: Appreciate this project looking at adolescents and young people as they need additional attention.

SURVEY FOLLOW-UP INTERVIEW

Date: May 14, 2020

Participants/Organizations:

Philip Campbell, Project Coordinator, Project POINT, Eskenazi Health

Jennifer Cianelli, Clinical Supervisor of Mobile Crisis, Sandra Eskenazi Mental Health Center

Kourtnaye Sturgeon, Director of Education and Training, Overdose Lifeline

***Question 1*: We have your responses to the most common way you make and get referrals; what method has been most successful in ensuring the Person with Substance Use Disorder gets the services they need? And to follow on that why, what made it most successful?**

Responses:

Jennifer: She is with the Mobile Crisis unit, partner with Indianapolis Metropolitan Police Department (IMPD). They had a licensed clinician team up with a crisis police officer in each of the districts in Marion County. They do follow-up with anyone who presents and is subject to immediate detention. They see 3100-3500 people a year. They have found a warm handoff makes for the best success. They do follow-up before and after the patient's first appointment. The clinician does most of the linking up, but the visits are always as teams. They have 6 police officers involved in the program and they are also helping to educate the other police officers in the department. By warm handoff she means things like putting the individual in the car and driving them to the appointment. They have a grant that helps them integrate 7 peer recovery coaches into the process, but they can only see people with Opioid dependency. Most people they see have alcohol or methamphetamine substance use disorders.

Q: Do their peers have backgrounds in Opioid or MAT?

Jennifer- Not all. Their ages vary from 25-69 year of age. Try to match the peer with individual being referred, feel like good matches.

Philip: They work with the Emergency Department at Eskenazi. Do not take referrals from outside. They work specifically with Opioid use specialists. They do bedside follow-up to talk about recovery if the person is interested. They can start the person on MAT and link to Primary Care, get them partnered with the Mobile Crisis Unit, get them appointments set up for follow-up services. They check on the patients after release particularly if homeless. They are available am to 11:30pm Monday through Friday and have about 100 active patients a month.

They have opened a SUD clinic in the Emergency Dept. All nurse practitioners in the Emergency Dept. can prescribe Suboxone to carry the person over until their follow-up recovery appt. This practice/clinic has been hugely successful.

Q: What if they need to go outside the Emergency Department/Clinic?

Philip: They are able to make connections through primary care and Mobile Crisis Unit. Know patients can get taken care of. Everyone follows up in their department. They are able to provide transportation to services through bus cards, Lyft accounts. They contact patients to follow up before and after appointment and build relationships with them.

Kourtnaye: Long term support groups have those who lost loved ones. In the last 6 months or so been able to

add those with a surviving PWSUD. Very much word of mouth is how most people know about them.

Depending on where the person lives there is a short list of places to which they would refer someone. This is also telling the person about the other organization. Not a formal process. They work with 72 of the 92 counties.

Question 2: **Is the referral method you most commonly use dependent on staff who are making the referral? Do staff have different contacts that make referral better?**

Responses:

Jennifer: They are located in Adult Addictions Clinic. One of the clinicians walks the patient to the place they are going to do a warm handoff. So yes, makes a difference who is doing it.

Before Covid-19 they were working on getting established inside the jail so that they could interact before discharge.

Dependent on staff and their knowledge of the program.

Philip: Think fact that peers have personal experience - able to establish trust with patients helps. Lot of fear in patients, fear of arrest, already been arrested don't know what next- the peer is able to explain the process, who will call them etc.

Q: How do you get new people up to speed?

Jennifer: Lengthy onboarding process. Orientation, ride-alongs out in districts, day in Crisis Intervention Unit, time on Mental Health Recovery floor, utilize experienced clinicians to learn from as far as resources/services available. Peer Recovery coaches have their own contacts, networks and experience they draw from.

Kourtnaye: Their Executive Director has the most contacts. When someone comes in and needs referral, they connect to the Executive Director to reach out and try to get into particular ones, where to start, what kind of questions to ask.

They do not usually use peers but have done so for some school programs. (Jodi Miller will connect Kourtnaye up to a resource to assist with use of recovery peers)

Question 3: **Do you typically get feedback from other agencies to which you make referrals and do you give feedback when making referrals?**

Responses:

Jennifer: They can get feedback as long as there is a signed ROI. They work with PAIR court. Have about 20 clients typically in PAIR. The clients have mental health and/or SUD and have been convicted of misdemeanor or low-level felony. Work with them before sentencing and if they agree to the treatment plan/testing they can avoid serving a jail sentence. They do not currently work with Drug Court as it requires SUD only, not including/or. mental health disorder.

Philip: Majority of clients going to Sandra Eskenazi or Eskenazi Primary Care so they have access to Social Workers and Clinicians. Have to have ROI signed in Emergency Department. If send out to residential facility, many do not have an exit plan. Unless the patient signs up for IOP/PHP they are not followed up. Try to get ROI signed so they can work with the patient while in these facilities and upon release, so they don't end up back on the streets if homeless and/or using again.

They keep the ROIs internally. They have follow-up call lists to contact PWSUDs at least every 2 weeks during/after the patient presents. After three attempts to contact if they are unsuccessful, they consider the

patient as inactive on the contact list but will reactivate if the patient presents again or contacts them. The population they serve is about 70% poor and/or homeless. They have transient phones or may have no call minutes available or don't want to talk on the phone. His group was recently approved to send generic text messages. It has been pretty successful. It is most important for Project Point to have a consistent number to call. They do request an alternate number, often the patient's mother is the contact. They do communicate through MyChart which has proven complicated but they are working through it.

Kourtnaye: Do not get feedback. Might call a contact if really critical situation but otherwise do not contact.

Question 4: **How would you rank barriers, i.e. what is the biggest impediment to coordinating services a client needs? Why is that the biggest impediment? Have you tried mitigations? If so, what were they? How successful were they?**

Responses:

Philip: Change of employees has been a big thing, both turnover in staff and even shift change. Can get plan set up with a particular person in a facility but when the PWSUD ready to be discharged the new person you are working with doesn't know anything about it. As an example, may arrange a Lyft transport that the patient can use whenever they are ready but when they try to utilize the service no one knows anything about the order/arrangement. They have started using Sticky Notes in EPIC on the patient's chart.

They have to continually follow up with facilities and confirm information multiple times to prevent confusion/loss of services.

Q: How are barriers different working in the Emergency Department?

Philip: They have overdose patients more than walk-ins. They used to be only able to serve patients who OD'd and were given Narcan. In Sept 2019 changed to allow patients in withdrawal as well. They can serve anyone who shows up with anything related to Opioid Use Disorder in the Emergency Dept or if it comes up in routine treatment. When Covid-19 hit they had no one for an entire week in ER. He talked to 12 other ERs and they found same thing. Around April 1 they started seeing a few and now it has exploded. They are currently getting about 9 per day, mostly ODs but some in withdrawal. People were afraid to come to the hospital due to fear of Covid-19. When first shutdown may have had a lack of availability of drugs of choice but EMS was not seeing runs either.

Jennifer: Biggest barrier knowing the system, getting the patient connected up where they want to go, knowing all the ways orgs take referrals.

With Covid only certain ways organizations are taking referrals and limiting number of referrals accepting. Currently lot of webex or phone intake. All different modes of taking referrals.

Funding, insurance even ID are barriers. Added costs for ID in their grant, e.g. birth certificates can get expensive especially if have to get from out of state cost can be prohibitive.

Kourtnaye: From the parent side, when you call a provider, the questions are all different, how each will receive you is all different. First thing they want to know is insurance. Is patient someone they can help or do they need to go someplace else. Where to go? Very few parents know what to do, operating from point of fear. They leave a call to a provider feeling like they do not have a path to help their child.

From organization perspective, they are not calling to guide people to various services. Family members receive different information from various places in crisis situations.

Q: What about housing, education, job training or other services (outside mental health/addiction area)?

Jennifer: There are organizations that an individual is referred to that do good work in general but oftentimes the organization would call the individual one time and if the individual does not pick up, they go to the bottom of the list. Perhaps the individual has phone issues or they simply answer questions in a manner that doesn't qualify them for services where in reality they should be eligible. Important pieces of information are not accurately communicated to the service provider. Sometimes the client is simply in denial or doesn't want to admit what they need.

Philip: So many organizations change policies and accepted insurance or coverage on a regular basis. You think you have this down then things change and new rules, e.g. not using enough mgs to get into the facility. Have to help people answer/clarify questions, e.g. people who are sleeping on friend to friend couches should be considered homeless even though they may have "a place to stay" the night. In signing people up for Presumptive Eligibility, they may qualify for hospital time if homeless.

Q: Is there central resource to go to.

Philip: No. If have information about a provider, will get new person on phone who doesn't understand facility rules thoroughly and not person you have previously connected with.

Kourtnaye: Most often hear from people who were able to find help. They let her organization know when they are successful – big share moment.

Question 5: **If you could identify one thing that you believe would make a significant improvement in referring people between agencies what would that be?**

Responses:

Jennifer: Standard or universal ROIs or MOUs, some kind of document for people who come in for referral/services. Have people sign one document that allowed talking to each other instead of having to sign one for each entity. Like a universal permission form. Really impact treatment. Got to be a better way to remove barriers in a respectful way for confidentiality.

Philip: Need permission to openly text with patients with or without Permissions. Have to figure out way to make this happen. PWSUDs don't want to talk to you if they are high, scared or getting calls from bill collectors or warrants cause them to not accept phone calls. Need to know there is someone out there that can assist them or that cares about them.

Also need immediate HIP coverage, turned on immediately. Need put on right away. There are only a few places that will accept someone in HIP Presumptive Eligibility status. They use counselors that go through the patient's eligibility/help determine PE status.

Kourtnaye: If had a navigator type system to help get somebody into the process. Starting point for assisting family get help for underage PWSUD or help for the individual themselves. Like a clearinghouse – place to call to get patient from here to there. Need somewhere to help people get to the starting point.

Philip: Need some sort of larger scale recovery housing especially for couples. Really nothing out there currently for couples. Some facilities take people with children but that sometimes involves removing a child being cared for in a stable environment in order to get into recovery housing.

Many patients are on the sex offender registry and this prevents/limits housing options.

Additional Information:

Responses:

Jennifer: Not exactly sure of the demographic. They serve the most vulnerable communities. There is nobody they will not serve.

Philip: Majority of patients are white men age 25-44 years of age. 60% or higher. Then white women same age breakdown. The African American clients are generally in their 20s or 60s. In 2018 only 1-2 African Americans and in 2019, 6-15 a month. Older patients who had been using for years were suddenly overdosing. May say something about quality of product?

One in four of their patients is uninsured.

Q: How do peers track to demographics of patients?

Philip: Peers are all white. They have gone through a very long process to hire 3 new peers. Very few people of color applied. They look more for a personality. They are located in a high acuity area, 20 feet from trauma area. Large % of patients in holding area since arrestees needing medical treatment are brought to Eskenazi. It is important that the people considered have a long history in recovery, have a personality that can deal with diversity, emergency/intense situations. Their youngest peer is about 30 and oldest about 48.

Kourtnaye: Service for families who have lost a loved one to SUD but moving to provide education, trying to help get more resources for those in need of services. Do a lot with support groups. Ages generally 18-35 years of age, few over 45 years. 60-70% male, mostly Caucasian. Don't have specific race statistics. They do not charge for services. They provide educational programs usually in school systems but also health departments, coalitions, some DA o0ffices, lot of universities particularly in rural states. Raising education to prevention.

Jennifer: Have clinicians working primarily with adolescents, about 500.

Q: Is there a segment of the population you do not serve?

Kourtnaye: Not serving African American population very well at all.

Philip: Not specifically, take anyone who comes in through the Emergency Department. They have 1 Native American, 1 Asian American, very few Hispanic. They do not work with children. Thinks they probably present at Riley most often as attempted suicides.

Q: Have they tried 2-1-1 and OpenBeds?

Jennifer: Used 2-1-1- to find places. Don't use OpenBeds so much because there is a lot of Case Management to get into OpenBeds and their patients are in crisis and need to get them to someone who can get them into case management.

Q: What are the costs/funding sources for your services?

Philip: 4 Federal grants currently. Team is fully grant funded thinks through end of 2021. As a result, they do not charge for services. But about a year ago started moving records into the EPIC System in case they needed to start charging, first step in being able to bill for recovery. Because they are part of Marion County Health and Hospital Corp, they rely on the grant team.

He has no idea what the costs would be. They do not go outside the hospital although they try to assist with any questions /everything the patient might have questions about. Patients can call in or come in. If they had to go outside the office they would have to bill. That would also require remodel of program.

Kourtnaye: 1-3 years of funding. Constantly seeking grants. Young organization started in 2015. Spend lot of time on system rather than trying to gain more grants. Some revenue from Continuing Education fees but always need more money.

SURVEY FOLLOW-UP INTERVIEW

Date: May 19, 2020 am

Participants/Organizations:

Lauran Canady- Director of Clinic Based Services, Adult and Child Health

Melissa Davis- Program Manager, Outpatient Behavioral Health, Community Health Network

Mackenzie Sering- Manager of Clinical Programming for Methodist's Addiction Treatment and Recovery Center, IU Health Methodist Addiction Treatment and Recovery Center

Jon Ferguson- Manager, Sandra Eskenazi Mental Health

Daniel Waddle- Manager Behavioral Health, Ascension St. Vincent Indianapolis

***Question 1*: We have your responses to the most common way you make and get referrals; what method has been most successful in ensuring the Person with Substance Use Disorder gets the services they need? And to follow on that why, what made it most successful?**

Responses:

Jon*:* Being part of Eskenazi Health system has given support others do not have. They have access to Primary Care, large food pantry, housing sources, residential program. Have access to all these under same umbrella. Communication can still be a challenge but setting these communications up has been most helpful. Most successful ways of moving people back and forth between services – they have a system in place that is consistent and re-occurring. Over the years they have tried to find ways to improve the linkage, make even better. For example, sometimes meeting in person with obstetrics and addiction services. Weekly call to make sure clients don't get lost in the system, solve problems related to the linkage. If there is a barrier of transportation, they are able to work through this problem.

As far as outside partnerships, they have worked with Marion County Jail about pregnant women and get them services. They have great communication with people in the jail system. They have MOUs in place with guides and expectations spelling out what each party needs to be doing. Having point persons in place with regular contact can move quickly, 24-48 hours, and know how to talk to each other good. Ongoing communication including troubleshooting barriers and issues as they come up has helped be successful.

Melissa: They have centralized access and evaluations. Their relationships have helped have a centralized efficient referral system. The system has been helpful with patients not feeling line they get shuffled around. The centralized system makes the process more streamlined, get patients to the right place the first time. They use EPIC, VMR. They contact the patient and get the process started by getting basic information from the patient. They communicate directly with the vendor, evaluation center, placement for treatment after they get an electronic referral. If outside the EPIC system, they

still contact the referral through the access department and rout the patient appropriately.

Lauran: Have similar setup to Jon and Melissa. Internal integrated staff including primary care, mental health, addiction specialties to avoid losing patients in the shuffle. They have this staffing at all their locations. For external clients, they have centralized open walk-in model to assess. If not right agency, get the person to the right place. A weakness is making sure next step happens. Still working on this. Always aware lose clients when trying to connect somewhere else.

If they are the right fit, the patient has treatment but then needs housing, most times they refer to in-house team to get to services.

Danny: Not great in connecting with external resources. For the most part if come through door and would benefit from their services do good job. Not great communication to outside Most happens through access department if not great for them. A lot falls to individual counselors. They maintain lists but still primarily counselors work through their own lists.

Q: Is there a method by which counselors work through these lists that might be more successful than others? Really up to the individual counselor based on experience. Leaning on counselors, really up to the individual.

MacKenzie: Similar to Danny. One of only hospitals not connected to any community mental health system. Internal connections working pretty well. Falls to clinicians to make referrals. Trying to provide referrals if not take patient's insurance. Definitely lacking resources.

Jon: Important to keep it simple. How to get people into care as quickly and simply as possible. If client calls, they tell them to come on in and they will fit them in. Sometimes things still need to be worked out but still tell them to come on in. – get them connected to the services they need. They build a relationship, spend time with them. This goes a long way to getting people in treatment, better engagement in treatment.

Q: How would people in the community know about serviced?

Jon: Everyone different processes and processes change. Big barrier to delivering services. Trying to use social media. Website updated but they have one phone number for all services which connect you to a guide that gets you connected to where you need to be after a few questions. Finding ways to communicate with one contact.

Q: If point of contact is telephone instead of walk-ins, how do you train interviewers?

Jon: Important piece to the process. The interviewer needs to have enough general information to get the client to the right place.

How to create no wrong door approach? Trying to be able to get people to right place. Meet with them – want to get to provider of services even if come in wrong door.

Question 2: **Is the referral method you most commonly use dependent on staff who are making the referral? Do staff have different contacts that make referral better?**

Responses:

Jon: Yes, good in one respect. They often have staff who have been in the field for years and many have great resource lists. If know this staff, they are going to make use of their resources to get person to the right place. If the staff leave or is otherwise unavailable, then they don't have that resource. Important to build infrastructure apart from the individual staff rather than depending on people with long time experience.

Danny: Very tied to individual.

Lauran: Agree

Question 3: **Do you typically get feedback from other agencies to which you make referrals and do you give feedback when making referrals?**

Responses:

Lauran: Similar to previous question. Less history with connection has less feedback get and vice versa.

Q: Good idea to include as part of protocol? Absolutely yes- have a systematic referral structure across agencies.

Jon**:** Echo Lauran. Unfortunately, when get feedback lot of times because things have not gone well but this is good to help improve processes. Definitely something worth building into the process.

{Dean: 30 years ago, or so the Joint Commission on Hospital Accreditation required feedback but that in some ways has fallen by the wayside.}

Question 4: **How would you rank barriers, i.e. what is the biggest impediment to coordinating services a client needs? Why is that the biggest impediment? Have you tried mitigations? If so, what were they? How successful were they?**

Responses:

MacKenzie: Primarily it is timing, hopefully calling at the right time to get into service. Timing really important, having a way to figure out who has openings would reduce barriers.

General knowledge of experienced clinicians is lost when those clinicians leave. They do their best to try to have the information in a spreadsheet but changes constantly.

Danny: Barriers are payers, lack of EMR (electronic medical records), universal EMRs. They still document on paper. If there are EMRs they are not same others in area.

Timing- they have tried to have lists of resources on shared drives, systems to get on same page internally but everyone makes their own and providers come. All complicating factors.

Q: Have they tried to get to EMRs, what are the barriers?

They are a small department in a large entity. Their organization has two sets of EMRs, one for inpatient, one for outpatient. Every time they talk about everyone has a different idea about what part

goes where.

Lauran: Similar to everyone else- staff turnover in terms of what their contacts were, new orgs/ so many in the game, hard to figure out who does what, where the program is. With Covid 19 crisis they have been flooded with new clients and are not able to keep up. Trying to keep up with available resources. Constant change. Some of issue is trying to train staff on how to utilize things like 2-1-1.

Jon: Payer mix/coverage. Ton of money, way to access different. Different grants with different rules, who they apply to, what doesn't apply, Medicaid, Medicare, or commercial insurance. Real barrier when want to get connection to service but not covered.

Credentialing requirements for staff. LCSW who understands addiction really rare so orgs fighting for these people. They get a lot of clinicians right out of school. Marriage counselors are limited to who they can see. They navigate the coverage, but then not sure staff can see the patient. Need to open up who can see and work with clients. Want people experienced and well trained but there are barriers.

Melissa: Their staff who get reimbursed have limits on who they can see that have insurance. This is an ongoing barrier.

Cannibalizing staff is also an ongoing issue.

To get the client able to get all the services grants have hoops have to jump through. Benefit not measured. Need to meet the person where they are- means going to get them, analyze, connect to services needed, getting enough services in place to allow the client to use all treatment services they need.

Q: Does confidentiality get in the way – are there effective ways you have found to work with confidentiality rules?

Danny: Yes, but more than laws every agency has interpretation as to who they apply to.

MacKenzie: Totally agree. Interpretation but if patient doesn't sign all permissions then this gets in the way.

Lauran: Interpretation across agencies. Navigation for addiction services is more difficult than more complicated medical services/care. Much more than inpatient.

Melissa: Agree with everything said.

Q: Are staff just out of grad school coming with enough experience/knowledge?

Melissa: Partnership with local school to make sure get requirement for LCAC (Licensed Clinical Addiction Counselor) licensure. Had a gap here that is why they started the program.

Lauran: They connect people to internships, recruit internally If they can't do this or not a good fit then different issue.

Jon: internships great way to get experience, some start out not thinking this will be their life's work but end up loving it. Some experience and passion for the work important. Important to their process to hire and provide on the job training, support and supervision getting the staff to where they need to

be. Not enough candidates. Dual process is good.

Q: Do they use peer support?

Jon: They use peer supports from a new grant for Mobile pathways. Peers are awesome, partner with outpatient clinics. They go into community, provide support, tear down barriers to get the patient into and maintain services/treatment.

Lauran: Same. They have 2 and would love to have more. Essential part of their program.

Question 5: **If you could identify one thing that you believe would make a significant improvement in referring people between agencies what would that be?**

Responses:

Lauran: Centralized database, not like OpenBeds but, where you put in info and can connect to the patient's medical records, make referrals/connect to everyone. Make sure information to make connection, make sure patient shows up and do follow-up, troubleshoot if patient doesn't follow through. Something that connects all the dots, not dependent on a person.

Jon: Echo Lauran. What should it look like, how should it work? Should be able to input simple parameters to schedule handoffs. Would make jobs so much easier to get clients where they need to be.

Let clients have access to same kind of service – one place to get connected, put in information and a person calls them back with information about available services based on their need.

Danny: Universal EMR with access to referral information without fear of breaking the law and not getting paid. Like Open Beds only cleaner and better.

Melissa: Really is summary of what everyone mentioned. Ability to have warm handoffs, more freely share information.

MacKenzie: Exactly. More convenient, streamlined way to connect. Similar to OpenBeds but cleaner.

Q: Back in 90s a program called Target Cities. If organizations were going to be part of this, they had to have a centralized intake. Good initiatives but over time ran out of funding. How could something like this be funded, who would lead it – government, providers, private corporation with one provider giving input?

Jon: State's CARC (Comprehensive Addiction Recovery Centers) initiative just in beginning stages. Would have 1 phone number, 1 place to get resources. Talking about same things we are. That is concept that really need to be heading. Don't know who should pay for it.

Additional Information:

Responses:

Jon: They serve everyone. They partner with Riley Hospital for children. They have an Outpatient SUD program for preteens and teenagers. Their biggest demographic is age 20-55 pretty evenly split between Male-Female ratios. Opioid treatment has about 60% women and is kind of reversed for

Outpatient dual diagnosis program. As to race they are pretty close to even between Caucasian and African American. Not a lot of Hispanic clients- not sure why. Not a lot of Spanish speaking staff- may be a factor.

Dual diagnosis with mental health and addiction disorders, years of substance use and mental health issues, housing, transportation, and employment issues. Pretty complicated client.

MacKenzie: They serve anyone greater than 18 years both Male and Female. They don't serve youth and adolescents. Clients primarily 25-55 years of age more Caucasian than any other. Tend not to have a lot of Hispanic or Asian clients.

Lauran: They have a small adolescent program but tend to serve ages 20-55 years. Race is probably heavier African American than Caucasian. They have patients with very complex mental health diagnosis with Substance User Disorder long term. They are seeing an increase on the southern edge of Marion County with Burmese population- establishing a program. Hiring internal interpreter for that population.

Danny: Little difference in inpatient vs outpatient. Outpatient primarily Caucasian /African American in Northern Marion, Hamilton, and Boone counties. From child age 6 to seniors. Inpatient primarily Medicaid population. Outpatient IOP. PHP- Medicaid does not cover. Don't have IOP for Medicare. Mostly have third party payers not Federal or State assistance.

Melissa: Lot like Jon's. Fairly new partnership with Fairbanks to serve adolescent to adult. Look very similar to what Jon said.

Q: As to wait times:

Danny: No wait list for Inpatient walk-in. For PHP, IOP never more than 72 hours attributable to being M-F service. Few occasions for certain age groups may have a short wait list for IOP.

Lauran: Usually can get patients in in a couple days if not same day. No more than a week to get to the next level. IOP – have to wait for authorization. While waiting for authorization can start some interim treatment prior to the IOP authorization coming back.

Jon: No wait list. Get in same day or 2. Sometimes based on coverage but for most part day or two.

Q: Regarding 211/OpenBeds use

Melissa: OpenBeds used in Inpatient Unit. She is not personally involved so not sure about any drawbacks.

Jon: Like concept of OpenBeds. Barrier is it is really designed for inpatient options. If other types of services client need not as easy to keep updated and current. Not integrated with EPIC.

MacKenzie: Exactly what she was going to say.

Q: Regarding cost of services and funding

Danny: Inpatient per diem cost. Inpatient about @$8000, outpatient about $4000. Primarily funded through insurance plus charity care for under/uninsured. Inpatient covered by Medicaid. Some outpatient covered but not all.

Jon: Medicaid, Medicare, commercial insurance, and grants pay for services. Cost- there is what they bill but then contracts determine what they accept. Part of hospital services for billing. Some services are billed for hospital costs. IOP is billed to Medicaid, Medicare, commercial insurance. OTP clinic has weekly/ daily rate @ $130/week- includes all services. Compared to what people pay other places not bad. About 80% of their clients are covered by something. About three years ago @ 100% of their clients were self-pay. Wish all were paying weekly rate.

Lauran: Medicaid, Medicare, commercial insurance, DCS, grants. Don't have bundled OTP services so more individualized. Varies based on billed and what they take. More clients now covered than ever before. They have navigators at each location to connect clients to available coverage so minimum self-pay.

SURVEY FOLLOW-UP INTERVIEW

Date: May 19, 2020pm

Participants/Organizations:

Jeri Warner- Executive Director, Trusted Mentors

***Question 1*: We have your responses to the most common way you make and get referrals; what method has been most successful in ensuring the Person with Substance Use Disorder gets the services they need? And to follow on that why, what made it most successful?**

Responses:

Jeri*:* She is with Trusted Mentors. They train mentors to assist people stay out of prison. Many of their clients have addictions, mental health issues and need referrals. At Trusted Mentors everyone comes in through partnering agencies. When they started 16 years ago, they had ACES (Action Coalition to Ensure Stability). They have now about 20 partners who fill out a referral form and send to them to partner with a mentor.

Once someone falls back into addiction it can be a challenge to refer to services, not enough agencies, not close to where the person lives, don't have insurance. Usually most successful in knowing a connection, someone they can call.

The ACES (Action Coalition to Ensure Stability) project was a team of resource coordinators who made all connections. Came with money to help purchase services.

Case Mangers, Resource managers who care enough to follow through and get help most successful.

***Question 2:* Is the referral method you most commonly use dependent on staff who are making the referral? Do staff have different contacts that make referral better?**

Responses:

Jeri: Yes, and Yes. To build off what she has already said, not many options for their clients. One of the big problems is limited resources. If she loses staff, she may lose connections.

***Question 3:* Do you typically get feedback from other agencies to which you make referrals and do you give feedback when making referrals?**

Responses:

Jeri: When they receive a referral, they reply that they have received it and will follow-up. This is part of their process. Because they are matching mentors with adults, they go back to agency if think a good match, let them know they think will work. As they go along if problems come up go back to the referring agency. Go back to work with counselors to resolve with agency to support mentor. They communicate through email, phone calls, now Zoom meetings.

***Question 4:* How would you rank barriers, i.e. what is the biggest impediment to coordinating**

services a client needs? Why is that the biggest impediment? Have you tried mitigations? If so, what were they? How successful were they?

Responses:

Jeri: Right now, communication over Zoom. The current crisis has taught them need personal contact. All about building relationships. They do a lot of problem solving. Takes time to trust what/who might be a good resource. They emphasize the mentor is a friend, might be the only one they have, not a professional. They do not replace the Case Manager or Resource manager. They do not provide treatment resources. They do not want the mentor to be manipulated.

Biggest impediment is transportation. Lot of clients have limited data/minutes on their phones. Change phones a lot so lose track of the client.

Special difficulties for those coming out of prison like housing, access to affordable housing, housing unavailable for someone with a record. One of her staff has a list of places. More places are going to the boarding house model. Sex offenders are limited to where than can go. They have the most restrictions. Her group asks if there are any restrictions for the client but do not call out Sex Offender specifically.

Access to medication is often problem for those coming out of prison. They had the medication in prison but have problems with getting outside and may not follow through to continue.

Question 5: **If you could identify one thing that you believe would make a significant improvement in referring people between agencies what would that be?**

Responses:

Jeri: They do not have access to HMIS (Homelessness Management Information System) but in last two years it is a coordinated entry system for those in homeless prevention programs. Has proven helpful to mentors.

Not sure how program was created, how they work or who they take.

Tries to use 2-1-1. Try to assist /mentor clients know what questions they need to ask when they call a particular agency. Agencies come and go. She has gone through at least 3 systems in her tenure.

Additional Information:

Responses:

Jeri: As far as demographics served, they serve 18 up, about 30% of which are in their 50s. They do not serve anyone less than 18.

As to gender of their clients, sometimes dependent on mentors available. Varies from 60% female 40% male to vice versa. They have more females currently and most are white.

They do have a wait list and the time can be up to 3-4 months. They currently have a hold on it but is starting to open up again. They check back with the referring agency before they do a match for those on the wait list to make sure still need mentor.

They have used 2-1-1. They refer mentors/mentees to it when the client needs more help. A drawback is the person does not know what questions to ask. Not as perfect as anyone wants it to be because their problem

might not be faced. Ex-offenders would benefit from something like 2-1-1 specifically for ex-offenders but on the other hand would ex-offenders use it if they had to identify as an ex offender?

Also, they have documents from the Coalition for Homeless Intervention and Prevention which is updated annually and can be handed to the client.

They are funded through grants and corporate support. They are always chasing money. There is the Rx Initiative (**Rx** Abuse Leadership **Initiative Indiana?)** for Opioid use through Wellness Council with Indiana Chamber. If referral comes from business/employer more successful. Opportunities around business in terms of needing to work with business or Rx referrals. Also, employment is another big issue for their clients. Probably success can be attributed in part with employee's desire to maintain employment.

Last two months have changed things, completely different. They are working with second chance hiring for lot of their people.

SURVEY FOLLOW-UP INTERVIEW
Date: May 20, 2020 am
Participants/Organizations: Michaelangelo McClendon- Interim Executive Director, Drug Free Marion County
***Question 1*: We have your responses to the most common way you make and get referrals; what method has been most successful in ensuring the Person with Substance Use Disorder gets the services they need? And to follow on that why, what made it most successful?**
Responses: **Michaelangelo**: Build relationships with the person. Not easy to navigate through when need resource. Make sure person can succeed based on resource relationships. Go back and forth with these pieces. Q: How to create these relationships, how do you know who the players are? Website doesn't give starting point, all terms needed to start. There should be a clearinghouse, some resource, automated system. They get calls every day from people who think they should have information but sometimes have to put people in a holding pattern until they can do research. Some application would be helpful as more people relying on technology, something with latest information that can be updated
***Question 2:* Is the referral method you most commonly use dependent on staff who are making the referral? Do staff have different contacts that make referral better?**
Responses: **Michaelangelo:** Yes, depends on staff. They have an in-office database that assists people but not updated often enough. Some staff, especially those with background in recovery help. Lot of people not in recovery don't have the knowledge to navigate, to know what looking for. They do not use peer support. Best based on knowledge and experience. With experience they may know don't want to refer to a certain place or can assess what is best fit for the person. Small operation – 2 full time and 2 part time. To maintain/update database would need an additional full-time paid staff person.
***Question 3:* Do you typically get feedback from other agencies to which you make referrals and do you give feedback when making referrals?**
Responses: **Michaelangelo:** Do not receive feedback on treatment and recovery. They have gotten cards from places they refer people to. No emails or phone calls though. They do get some feedback from treatment referrals about the database that providers have to pay a fee to use.
***Question 4:* How would you rank barriers, i.e. what is the biggest impediment to coordinating services a client needs? Why is that the biggest impediment? Have you tried mitigations? If so, what were they? How successful were they?**
Responses:

Michaelangelo: If seeking SUD help, client may not know what kind of help they need, where they are in the addiction continuum. How do they know where to start? If they don't have insurance, they might not ever call. Another piece is they may have insurance but need people to help guide them through the process. Some are stuck in place, don't know what they need, looking for sense of direction based on what they need and where they are. Need an assessment tool which gives them a sense of control for when they are out of control. Like a decision tree with a few questions after which the answers given guide them to a service. An extremely simple decision tree would be very helpful. Start with an electronic assessment then move to a person that can get them to the right place.

Question 5: **If you could identify one thing that you believe would make a significant improvement in referring people between agencies what would that be?**

Responses:

Michaelangelo: Directory of services which help get the person where they need to be connected to an agency for those not tech savvy. Tech process allows someone or directs someone to services needed for addiction, assessment treatment and recovery. Pair with agency to help navigate the process. Need person to update the directory daily.

Additional Information:

Responses:

Michaelangelo: Elementary school age to adult population served. Serve all of Marion County. They do have a program where they focus in prevention for seniors However there are no programs here that have this specific treatment. They do not have many people from the Burmese population.

Have used 211 often when things come up for which they do not have the expertise, etc. They get calls from people in other counties and for people that have just moved to/planning to move to Marion County. Use 211 for this. Drawbacks are people have long waits. They try to people that they may have to wait but to call back. They try to connect to someone at the state or in their community.

They do not charge for their services but there are user fees for database access. They have grant monies.

SURVEY FOLLOW-UP INTERVIEW

Date: May 20, 2020pm

Participants/Organizations:

Heather Rodriguez- Manager, Indiana Recovery Network

Tony Toomer- Opioid Treatment Program Manager, Family & Social Services Administration

***Question 1*: We have your responses to the most common way you make and get referrals; what method has been most successful in ensuring the Person with Substance Use Disorder gets the services they need? And to follow on that why, what made it most successful?**

Responses:

Heather: Work on the macro level- don't provide direct services yet but hopefully opening up recovery services when open again. People visit website looking for services to navigate to. New thing on site to get to recovery coach. Connect with them – do a warm hand off to a person in the area, usually recovery services.

Expansion of services previously not available in lot of rural communities. Indiana has come a long way, but lot of places don't have recovery or addiction treatment services.

Tony: OTPs (Opioid Treatment Programs) – a lot are fighting stigma. Didn't see a lot of community referrals, mostly word of mouth. They are battling stigma to get the word out. Doing lot to get OTPs involved in community engagement. In rural areas require OTPs to do some kind of community engagement. Everyone was doing something different, giving different message. They worked with the Bizzell Group to do training and a campaign with the message going out consistently throughout the state. For OTPs, a warm hand off works best. Works out better than sending the patient somewhere or giving them a phone number. Need to establish a relationship.

***Question 2:* Is the referral method you most commonly use dependent on staff who are making the referral? Do staff have different contacts that make referral better?**

Responses:

Tony: Yes- don't know how to streamline process so that all staff have all information. Depends on which counselor using. The Program Directors doing the connections but how to get information disbursed to all counselors is problem.

Q: How to make this happen, get everyone on same page?

Tony: Have a database of resources. Depends on Program Director and services available in the area. Program manager to counselor is a problem. Get pushback from counselors- don't have enough time, etc. Somehow need to get from Program Director to counselors.

Heather: Mirror what Tony says. Don't normally engage with staff, peers. Usually dependent on staff

knowing what is available.

It continues to be a challenge on the IRN site to keep up. Talking to peers, identifying resources, making connections with resources in their and neighboring communities.

Question 3: **Do you typically get feedback from other agencies to which you make referrals and do you give feedback when making referrals?**

Responses:

Tony: Try to get feedback. Want to make sure the client got there, made an appointment, make sure sending to right place. Need to get out and get to know people. What they hear is negative communication. Giving feedback keeps lines of communication open. Most of what comes directly to him. With Covid19 having weekly calls with all OTPs. Talk about what going on in locale. All on phone at same time can learn from each other.

Heather: Doesn't usually hear a lot of feedback. Not had anybody follow up. She collects data and does not do direct services. No feedback is a good thing for her.

Q: How does the process work with the new peer recovery hubs?

Heather: In its infancy. Ideally flyers are distributed, and the person calls and speaks directly with peer support who provides them with a referral to what they need- detox, food banks, recovery needs, anything the person needs.

Tony: He has been in contact with Brandon George about talking to OTPs in communities. In process of putting together a partnership / collaboration. As soon as he gets set up will distribute to communities.

Question 4: **How would you rank barriers, i.e. what is the biggest impediment to coordinating services a client needs? Why is that the biggest impediment? Have you tried mitigations? If so, what were they? How successful were they?**

Responses:

Heather: Having served in community huge barrier is figuring out insurance needs, setting people up with insurance a challenge. Transportation is another big barrier. She works with lot of rural communities that do not have public transportation available.

Tony: OTPs just started accepting Medicaid. All non-profits so big step up. They have started having monthly calls with Medicaid and OTPs. A Q&A session to help them through the process.

Transportation is another big issue. Have had pushback from consumers and transportation providers. Historically they have been cash only.

When COVID 19 hit things really blew up – people have lost employment and don't have funds. Applied for Medicaid. They have found funds to help with transportation until on Medicaid. Not everyone can get Medicaid. OTPs required to refer to a Medicaid facility. If none available have to be able to refer to another clinic. If only one clinic and not a Medicaid provider then problem.

Question 5: **If you could identify one thing that you believe would make a significant improvement in referring people between agencies what would that be?**

Responses:

Heather: Lot of places in community don't have relationships/ partnerships with. In northwest Indiana she attended some sessions that were lunches. People from facilities in the area came to the luncheon, each attendee group introduced and informed about their organization- who they are, what they do. Staff needs to know resources available and this was a good way to learn.

Tony: Provide one stop shopping type of thing. One place everybody could go to get information. Advertise it, let people know about it. Nothing works better than things like lunch-and-learns, conferences, symposiums – let everyone come and talk. You always learn something. Community focus groups, ways to bring people together at every level, not just management but across the spectrum of staff and services.

Additional Information:

Responses:

Tony: Not reaching Latinx, rural people. Seeing more African Americans in clinics. Still have trouble reaching out to rural areas. Last time he checked they had a little over 10,600 people in clinics- pretty evenly divided Male-Female. They have started serving the transgender population.

They do not have wait time for OTPs, no wait lists. If someone needs to get in and meet criteria, they can get them in.'

211/OpenBeds- For OpenBeds it was supposed to be that anyone could call in and get to the services needed. The system opened to good reviews, They have revamped based on feedback and new site is www.treatmentconnections.com. You can search for open beds in real time. Now more user friendly. When first launched OpenBeds was only on the telephone through 211. There is not a charge for OpenBeds he thinks but would need to check.

Cost of OTP is $16.05 per day- cost per visit regardless of services you get.

Heather: Underserved population for recovery support services is the LGBTQAI+ and Latinx communities.

She is not familiar with any wait times. Covid 19 has presented challenges throughout the state.

She has heard of wait times with 211 or people unable to get through, etc. OpenBeds link is available on the IRN site. IRN site does not cost anything. It is free to join. They have a grant for funding through SAMHSA. They have an DSSA-DMHA grant for new initiative.

SURVEY FOLLOW-UP INTERVIEW

Date: May 27, 2020 am

Participants/Organizations:

Andrew Green- Executive Director, Shepherd Community Center Assistance

Stacey Totten- Manager of Recovery Services, Hamilton Center, Inc

***Question 1*: We have your responses to the most common way you make and get referrals; what method has been most successful in ensuring the Person with Substance Use Disorder gets the services they need? And to follow on that why, what made it most successful?**

Responses:

Andrew: Have found across the board that as far as referrals go relational component, warm handoff approach works best. If part of outreach, referring to other agencies, it is a matter of making connections with agencies and warm handoffs.

Just believe in this approach in how they do programs in general.

Q: How do you know who these people/agencies are to establish relationships?

Andrew: Sometimes community they have built relationships with others, sometimes referral from other connections with other organizations. In some cases, going out to find out what's out there.

Stacey: Find more successful for emails. They have developed standardized emails specific to the referral. Be it for recovery or the court system. And they have developed ones specific to the organization with which they have MOUs. They want to make where they have a point of contact for each organization. They send email then there is a person they make contact with. For Marion County office they keep a spreadsheet of each referring agency, was the client seen, when were they seen, communication back and forth to get release of information form. If the person does not show up, they get back to the referring agency with that information.

When she first started, she met with community partners and made sure process would work. She put herself out as a point of contact. Her organizations works in 10 counties now has outreach coordinator as a point of contact in each.

To keep up with available services try to attend as many coalition meetings as possible, be a part of coalitions, immerse self in these. She also follows closely what the state is doing.

***Question 2:* Is the referral method you most commonly use dependent on staff who are making the referral? Do staff have different contacts that make referral better?**

Responses:

Stacey: Yes, different staff have different contacts, but they are all trying to get out there and make more contacts.

In working with other agencies, some staff have better relationships than she does.

Andrew: Yes, it depends on staff but found that it is most effective if identify one person in the organization who is the contact and one person in the other organization who is the contact. Helps them crack whatever doors need to at the organization. Both sides of partnership identify a person who is going to make the

connection.

Question 3: Do you typically get feedback from other agencies to which you make referrals and do you give feedback when making referrals?

Responses:

Stacey: Agencies they refer to give feedback on the client -some better than others. Give information about what all the client has been referred for. They created their own referral form to be used by referring agency that asks about insurance coverage, what they are sending the person for, why they think they need the services Hamilton Ctr offers. They do their own intake and send back information to the referring agency. Some just want to know if the client showed up.

Really trying to start focusing on warm handoff. She has received her peer certification and tries to help navigate the client through the process with the peer experience.

Q: Moving people back and forth through email, how do you manage confidentiality?

Stacey: People sign releases. When they receive the initial referral, it goes to one person who sends to the appropriate site. This just has the person's name. No more PHI is shared until the client signs a release of information form. They do not communicate back to the referring agency until release signed.

Andrew: Much more informal process. Personal contact is source of feedback. Generic information like 'did they come', 'where are they now'.

Question 4: **How would you rank barriers, i.e. what is the biggest impediment to coordinating services a client needs? Why is that the biggest impediment? Have you tried mitigations? If so, what were they? How successful were they?**

Responses:

Andrew: Outside of some of normal barriers like access to transportation, community support and isolation which is now amplified and continues to be a big barrier. The neighbor (client) needs to know someone is journeying with them. Mitigation is building relationships like peer to peer and recovery connections in the community. For access to peers they have an Addictions Counselor on staff who has worked to connect a community person with getting certified as a peer.

Stacey: Transportation is the biggest barrier. They get referrals for people just coming out of criminal justice system, in re-entry process but the person can't get to them. Housing is an issue also. Without transportation and stable housing hard to get them and keep them engaged in recovery. They are able to give bus passes, but some people don't know how to use the bus system. Looking into grants that would allow for an Uber type ride assistance.

They reach out to different housing sources. Many counselors have relationships with housing providers. But these facilities are full or cannot rent to the client due to conviction. Not necessarily related to sex offender conviction. They have an MOU with PACE, refer to community partners but have those needing more help.

Question 5: **If you could identify one thing that you believe would make a significant improvement in referring people between agencies what would that be?**

Responses:

Andrew: There has been a conversation over the last year regarding universal referral system across Marion County or starting in Marion County and moving out from there. Hospital systems looking at purchasing a system to do referral across county. More organized and more directed than others. Not sure where resides now. May have neem too late, too slow in getting done. Hospital went ahead with their own systems.

Should be a referral system where the receiving organization would sign off, follow up and give feedback that the person came, got these services, what the outcome was. Information about if for example Shepherd Community Center is connected to these persons and here is where they are in process. Would need to work with HIPPA constraints. Thinks the initiative was with IUPUI/ CTSI. Troy Hege and Dr Sarah Wiehe were the sponsors/contacts. Not sure where that project stands. They were in the process of evaluating then COVID hit.

One of the pieces that they looked at was that they as an organization if they accepted a person would have a record of the neighbor's history of treatment and outcomes.

<Dean suggested this could be something like Client Track used for Homelessness support.>

Stacey: Going along with what Andrew said having a track when person referred and can easily be referred then have a history in an encrypted place. Organizations make a referral and then can have access to the information.

Communication piece – Just be able to communicate with community partners knowing what services they offer/ have available. How to have all parts moving smoothly so the patient gets moved easily. Need to know what the client needs to do warm handoff, knowing who the patient goes to.

Additional Information:

Responses:

Additional Follow up to Clarify:

Andrew: Large Hispanic population which has grown over last few years. Internally have not been able to provide services on Mental Health/Addiction side and seen this with external relationships as well.

Stacey: Pretty diverse population. They do record demographics, but she has not paid a lot of attention to it. Not as many Latino/Hispanic clients. Not sure why that is. They do provide bilingual services. Being downtown they have many ethnicities around, but Latino/Hispanics might be underserved. In discussions with others seems this population does not reach out as much.

They do not have many adolescents even though they have counselors in schools in Marion County. In Vigo County they have more.

Andrew: They do not have a wait list for their services. When they refer elsewhere, they do. Housing probably has most wait time.

Stacey: Currently no wait list. Hired on another person for the site. Added three new therapists. They encourage walk-ins for assessment. Only wait time could be if all therapists are busy then schedule an appointment for the next day. For referrals out for residential or housing always a wait time.

For funding:

Andrew: They are funded privately through donors and grants mostly from private foundations. They have over the years had government grants but those are not the main funding sources.

Stacey: Majority funding through Medicaid (MRO), extended services through HIP, and Recovery Works. Some funding through government or community funded grants.

211/Open Bed usage:

Andrew: Likes the 211 Centralized repositories of resources. Lack of follow up is significant challenge. Follow up and feedback the biggest drawback.

Stacey: Used OpenBeds for site referrals Used 211 but not as much as probably should have. The web version is currently under construction so...

Additional Comments:

Stacey: Would really like to thank us for this initiative and the follow up.

SURVEY FOLLOW-UP INTERVIEW

Date: May 27, 2020 pm

Participants/Organizations:

Mark Rappe- Sr. VP Business Development, Spero Health

Spencer Medcalfe- IU Health

Rhiannon Edwards- Executive Director, PACE, Inc.

***Question 1*: We have your responses to the most common way you make and get referrals; what method has been most successful in ensuring the Person with Substance Use Disorder gets the services they need? And to follow on that why, what made it most successful?**

Responses:

Rhiannon: For them what works best is having existing relationships with agencies helps navigate through process. Things change all the time. Having relationships, someone to talk to helps. People get frustrated and she feels like not serving appropriately unless can help navigate the process. Lot of the relationships they have are from working with each other for a while. Relationships seem to make a big difference. As far as keeping up with the constantly changing service landscape, honestly seem to work with the same agencies. Probably easier as she knows who can call and get results. They are a small agency and it is difficult to get out and meet new people/groups. Before referring to any place they are going to go out to the place and try to establish a relationship. Causes some disconnect with new places because of the feeling they are not responsive, goes both ways.

Spencer: Any time can do something with folks know it is super helpful. Not always possible in Marion County. He calls others tries to get information. Primarily they receive people through internal system so see EMRs. Simplest process or through known contact. Doing lot of referrals outside system. At that point, no real similar path. Setting someone up as an outpatient outside IU system is essentially providing contact information, hoping its right.

Mark: Lot of times receive patients downstream. Trying to make easy for discharge planners with information about their services. Having to be out constantly meeting orgs, making them aware of what they do, giving them confidence in what they do. Biggest piece is the handoff regardless of where the patient comes from. Getting as much information as possible about the patient, letting discharge know what insurance they take.

Transportation is a big challenge. They try to ping back to the referring agency about the schedule for when the patient is expected. And when the person arrives, they try to update the referrer with as much information about the referred patient as possible so they can reach out to patient and referring agency. Breakdowns can sometimes occur. At the end of the day it is about getting the patient in same day or withing 24 hours.

<Dean mentioned that he knows about their organization having attended an Open House there.>

***Question 2:* Is the referral method you most commonly use dependent on staff who are making the referral? Do staff have different contacts that make referral better?**

Responses:

Spencer: Staff working with the patient probably doesn't make a difference. Look mainly at the facility.

Sometimes can create barriers or communication breakdown but try to work past.

Rhiannon: All referrals happen in Recovery Dept (3-4 people). If one person makes a relationship with an agency, they introduce everyone to the agency. Who the individual staff is really doesn't matter, their relationship is with the agency.

Mark: Biggest challenge is more referrals in than out, referring out to a higher level of care if required. Consistency of discharge planners is a problem. There is a high level of turnover at discharge planner and case manager level. They sometimes see a drop of referrals from a certain org then find out the discharge planner they were dealing with has left. The referrals are frequently relationship driven.

For outbound referrals to detox unit there is always a shortage of beds.

Question 3: **Do you typically get feedback from other agencies to which you make referrals and do you give feedback when making referrals?**

Responses:

Spencer: Feedback when they make referrals. He doesn't give feedback unless super bad or super good. He tries to even out.

Rhiannon: Normally no feedback unless something happened. Depends on nature of relationship – they could be getting informal feedback from places where they are regular visitors. Not a lot of other feedback.

Mark: Don't give a lot of feedback because don't receive a lot back. They do internal review and ask themselves; 'How can they better the handoff, give the patient a better process?' 'How could we have done things differently?' and make improvements based on these. As they are rounding, they will get personal feedback such as "so and so doing well, etc.". Time is limited so they don't get out of facility often. Overall, probably lacking in this regard.

Question: Do you have facilities outside Indiana?

Mark: Yes, all but 4 are outside Indiana. The 4 in Indiana are in Muncie, Indianapolis, Greenwood and Jeffersonville.

Question: When someone sends a referral to them, do they give feedback to the referrer, actually make a connection, feedback given?

Rhiannon: They give feedback, but it is limited due in part to confidentiality perceptions. Sometimes there are perception of confidentiality constraints, but the conversation is never had to ensure. They have a release form, but the other place may have a different one. When making a referral need to know what's up, need to communicate about finances. After that it is more limited. Seems related on who is paying. Disconnect between agencies but all have same release. More could be done on collaboration.

When they send someone to a facility, they need information about when the person is going to be/is let out so they can do after care.

Spencer: Methodist IOP receives a large number of referrals from different places. They are not currently reaching out to let the facilities know the person showed up.

Question 4: **How would you rank barriers, i.e. what is the biggest impediment to coordinating services a client needs? Why is that the biggest impediment? Have you tried mitigations? If so, what were they? How successful were they?**

Responses:

Rhiannon: In the beginning of recovery process it is financial barriers, being able to pair up with someone who takes their insurance. In the long run more transportation that gets them to where they need to go without hours on the bus. Then about beds, available spots- inpatient, IOP etc. To mitigate they have tried building relationships with agencies. Hard with limited staff to be able to get to all and establish relationships.

Spencer: Relationships is a big one. Places with long-term relationships for recovery but not necessarily housing. Circumstance of where person living with non-supportive partner (maybe still using themselves) want to go to IOP.

They have established relationships with Medicaid and private insurances.

Transportation is an issue. They have purchased gas cards as a uniform way to provide transportation but not everyone has someone who can drive them, and they don't have a car.

Mark: Insuring a continuum of care difficult. Transportation is a big barrier. The patient has wrecked finances. Who is going to pay for services? Is the org in Medicaid or not? If they have commercial insurance lot of times the deductible is high.

Social determinants for example a spouse still using, etc. are barriers in continuation of care. If spouse is using, they try to get the patient to come to clinic as much as possible, assist the patient develop coping mechanisms.

First would be Social Determinants, second Transportation and third Insurance.

Question 5: **If you could identify one thing that you believe would make a significant improvement in referring people between agencies what would that be?**

Responses:

Spencer: Improved communication between agencies. What should this look like? Don't know. OpenBeds a beautiful system but not uniform, not accessible to all agencies, not mandatory.

Rhiannon: Piggyback off Spencer. Maybe one electronic place where you put in what client looking for. Make a referral electronically, then maybe follow with phone call when patient accepted, and development of a more personal relationship happens. They spend a lot of time calling with questions like 'Do you have a bed? Can you take them? Have a conversation about those with a record. If they could give this information up front electronically would save lots of hours on phone. System with parameters for what they take would be great, would save time.

Mark: They are about to sign up for OpenBeds. Good to have this. Don't know return on investment yet but going down this path. Something where moves patient from inpatient perspective and see what is out there. Needs links to accreditation information for the facility. Having an ability to communicate through email or instant message to see confirm would be good. Not sure if OpenBeds has this. If OpenBeds shows Medicaid providers can state pay for the application. Other states do this, make available to all treatment providers. They would get more orgs to sign up if did this.

Could the state provide finances for transportation for the first 30-60 days, from release to get to treatment, IOP. Sometimes people have a job, can't spend hours on public transportation trying to get to treatment. Maybe provide vouchers for something like Lyft for Medicaid beneficiaries.

Q: Should patients be able to access an electronic system, i.e. put in certain characteristics that will point them to the right place?

Rhiannon: Yes, but would depend on interface. Their patients not all that tech savvy. Would have to be very welcoming and user friendly. Don't want patients to become frustrated and stop using. If designed to be easy would work.

Additional Information:

Responses:

Demographics:

Rhiannon: Mainly African American males ages 25-45. This is the top demographic in any program, they serve. Age 18-25 present to their agency for other services but when trying to talk about mental health or addiction recovery they don't engage unless court order.

Spencer: They see more male than female. Large majority 25-44. All their patients are coming through the Emergency Dept. either walk-on or overdose. Doesn't matter what they present for as long as active patient can be referred to their services. They have presented to be a Recovery Works provider but do not yet.

Mark: Ages are 20-45 heavily Caucasian. About 50-50 male/female maybe a little more female but not appreciable. They don't serve Medicare population.

Wait time/lists:

Spencer: Methodist can get in within 24-48 hours depending on avenue of referral. Not had a waitlist in a while but at times they have.

Rhiannon: No wait time/list. If the person presents with an emergency, they are seen right away. If calling and not emergency, they wait until Monday when they do Orientation.

Mark: No wait time/list. Can get as soon as same day depending on time of day receive a call. Typically, they get people in in 24-48 hours.

211/Open Bed usage:

Rhiannon: They do not use these. They have used before. Probably in a unique category because serve people with criminal history and this factor is not screened for. She has looked at who is enrolled but it didn't make a good fit. Not enough services for their population. Couldn't make more than one referral for inpatient services so had to wait to see if would be accepted before looking for another place. Not updated often enough. Wastes time.

Spencer: Have used it in the past but not currently. Our population is mostly HIP 2.0ers; there weren't many options for them. Since then, we have already made established relationships so we don't need the service as much. Also, it wasn't updated often and slow response time.

Mark: Cost for facility so pay to play. For some health care providers there is no cost but not sure what level this is. There is a subscription service fee to get listed. Recommend state explore this, might be some obstacles to participation. Value of these in making outbound referrals get continuity of care or not enough folks willing to pay to get listed.

Receive more referrals than send out. Orgs like hospitals send them patients. Sounds like might not be enough options on OpenBeds when trying to send to orgs like his but now they are trying to figure out if it would be worth it to pay for it. He is trying to get the proposed cost to enroll reduced. He has a frame of reference from other states. Some places the service is completely free because the state pays for it. Paying a fee as part of professional licensing fee no better.

Funding:

Mark: They have partnerships with all MCOs in Indiana and take commercial insurance. Those paying themselves pay $300 month for first three months. This does not include medication.

Spencer: They are grant funded. There is no bill to the patient.

Rhiannon: They are free. Funded through grants, contracts. They do accept insurance. Nothing ever has a cost for the patient. They try to have unbudgeted funds for things that come up.

Question: Do they use Vivitrol?

Rhiannon: No, they do not

Mark: They do provide to a very small subset of their population, those pretty stable.

SURVEY FOLLOW-UP INTERVIEW

Date: May 29, 2020 am

Participants/Organizations:

Brooke Schaefer- Director, CHOICE

***Question 1*: We have your responses to the most common way you make and get referrals; what method has been most successful in ensuring the Person with Substance Use Disorder gets the services they need? And to follow on that why, what made it most successful?**

Responses:

Brooke: Feel like the number one thing people need is someone who cares for them; someone who is emotionally involved and can be their interpreter(advocate). Threatening, do it our way or get out attitude is very detrimental. Treating these women needs an interpreter (advocate). The Case Coordinator knows who to call, can make it happen. It is essential that there is someone who speaks their language. An example was a patient who was on the phone with a pharmacy and was treated very nasty. She (Brooke) called them and the tone completely changed. Patients need people who will not say No to their needs, just help them. Tough love needs to be little less tough and more love.

Q: When comes to Case Manager/Navigators do they ever talk about what of their strategies have been most successful?

Brooke: Most of their staff are Bachelor level. They do have a couple with Masters. They end up with extremely emotionally invested. They have a lot of emotional debt, not burned out. She is not sure why.

They don't keep patients indefinitely. Emotional engagement is a big part. Care Coordinators are "What are they going to say Yes to. Don't want to hear Nos". They are very out of the box, extremely resourceful in using their connections. Want to know what is the back-door phone number to get their patients in to the Doctor who need to see the patient, etc. They are problem solvers who think it is fun to figure out/overcome impossible barriers.

***Question 2:* Is the referral method you most commonly use dependent on staff who are making the referral? Do staff have different contacts that make referral better?**

Responses:

Brooke: They are a team. They have to set themselves up to be replaceable. Nobody gets to be the only one who does anything. Their work is bigger than their egos. About women and their babies and families. They communicate/work closely as a team sharing information.

***Question 3:* Do you typically get feedback from other agencies to which you make referrals and do you give feedback when making referrals?**

Responses:

Brooke: Because they are so friendly people who they are referring to give feedback. Feedback is very real, sometimes just need to vent.

They get women from all over the state. If there is a knew agency or agency, they don't know they are going to place a call to get information/communicate. They are tenacious. They will not be ignored or disrespected. If

the agency is too difficult to communicate with, then they do not refer there anymore. Don't have to be person's words but need enough information to help, have a return on investment.

Question 4: **How would you rank barriers, i.e. what is the biggest impediment to coordinating services a client needs? Why is that the biggest impediment? Have you tried mitigations? If so, what were they? How successful were they?**

Responses:

Brooke: People who are burnt out. People who don't want to be doing this job anymore but won't leave. Not judging burned out staff, sometimes have to do what you have to do but "you got to move' get out of our way. Can't let burn out affect patients. Women have uncanny ability to tell who cares about them and who doesn't. They are really good at it. Can tell if you don't care about them. Every time patient pointed out to her the patient has been right.

People make things too complicated because didn't care to make extra call because burned out.

More technical aspect is, they as a medical community, make things harder for the patient. As an example, she tried to help a patient apply for Food Stamps recently and could not get through the online application in an hour and a half. We ask people to do things that are really complicated. Lot of patients – if you had not done so much for them in the beginning, they would not have done it.

Question 5: **If you could identify one thing that you believe would make a significant improvement in referring people between agencies what would that be?**

Responses:

Brooke: They have found a friend in Kelly Smith at Anthem, a Medicaid Case Manager. She will take next step needed instead of giving out a telephone number for the person to call. Need more people like her. Caring Case Managers. Insurance providers need people in Case Management who care about the patient. When they see the patient has Anthem, they think "Great" they have a friend there. If the patient has both Community CHOICE program and Kelly at Anthem that is the best.

A year ago, would have said there was a need for housing. The Community Network foundation has been taking donations and finding financing and going to be building housing, some sort of semi-independent housing. Lot of patients can't get housing. Some have felonies, non-violent, but still can't get HUD housing for rest of their lives. Need to change what felonies are for SUD or change long-term effect of having felonies.

<Dean suggested that sometimes can get project-based HUD assistance. The project takes responsibility for screening for housing. Difficult but sometimes done.>

Brooke: incredible challenge of how felonies get in way of recovery. Need to be less punishing and more helping. Additionally, the stigma of being a "bad mom" affects recovery. If enough people tell you that you are a bad mom, you start to

Q: Could you tell us a little more about Community's housing initiative?

Brooke: Strong focus on treatment of people as if they have disease rather than character flaw. The head of their program is a big reason why they are where they are. Need to have a place to step down from inpatient treatment before going back in the neighborhood.

They have not broken ground yet but are close. Have the funding but COVID 19 has set them back couple

months. The Recovery house will have 15 beds/ units that will be where the woman and up to 2 children can live. They could not do this in rehab. Patients in CHOICE will have first dibs but not closed to public.

The patients can live there for up to 9 months or maybe little longer. They will have private rooms and baths and shared spaces like the kitchen. They will offer therapy and some assistance to get them ready to be independent, earn what they don't know to be successful. The facility location is confidential, but it will be near Community East hospital.

Q: Do you involve the receptionist in your patient's assessment?

Brooke: Yes, they have "best receptionist in the world". She learns things they need to know to help patient and comes to them with the information.

Additional Information:

Responses:

On demographics:

Brooke: As far as demographics, get the patient's in their twenties. Youngest 18 and oldest 46. Open to helping women younger but just haven't had any. Race is primarily Caucasian which is interesting in that Community East is in a predominantly African American community.

Their patients are from all sorts of financial situations but the majority (maybe 98%) are Medicaid recipients. They are embedded in primary care OB-GYN office. This cuts down on the stigma of SUD. In the waiting room no one knows who is there for SUD services. Patients can hide this even from their own families. Little bit better this way.

Q: Is reason primarily Caucasian population based on drug of choice?

Brooke: Opiates caught on faster with Caucasian population but started to see more African American right now. Dr Kim Kelly at Community has theory that there is a genetic difference, in the hook of the drug, that makes Caucasians like Opiates more.

They do not see a lot of alcohol use. They do not test for alcohol use as often so easier to hide. Feel like should look at this. Alcohol does long-term effect on outcomes is significantly awful. Feel could be ready to change on what is needed. If the patient shows up with alcohol addiction will figure it out.

Marijuana use is a constant challenge for them. Can get people to give up opiates but not marijuana.

On Wait list:

Brooke: No wait times. If it is the day for recovery going to get them in. By tomorrow they could be gone. They do 24X7 service. They can admit and get started on services anywhere, anytime, anyplace.

Regarding 211/OpenBeds:

Brooke: Awesome resource. Problem is that it gives the front door phone number and she needs the back-door phone number. Front door is hard to navigate. She understands they need to cast a wide net, just a starting point. They have to customize for their patients.

For funding:

Brooke: Primarily Medicaid, whatever the Medicaid rate is or costs. Know can't exist without breaking even but not she does not pay a lot of attention. Knows they get enough to stay open and sustainable. There was a project of over two years that looked at the mother-baby diad and found that their patients did significantly better than

those not in their program and saved the hospital more than $700,000.

They have been very lucky to get State of Indiana grants for their Legacy project coming in July which is completely grant funded. Patients will pay $50 participate in the program.

Community Health Network has a policy that they are not allowed to take a grant unless the staffing can be sustained once the grant stops. They are hiring a Nurse Navigator and Peer Recovery coach completely grant funded but Community will pay when grant ended.

Additional Comments:

Brooke: Excited about the project. Always happy to communicate. Thinks sometimes should be better communicators. Any way they can participate are happy to do so. How else to people learn about other agencies.

{Dean said Brooke might be interested in participating in an IU School of Medicine ECHO (Opioid Project extension for Community Healthcare Outcomes) program scheduled for June focused on pregnancy and SUDs. Kristen is the Project Coordinator.}

SURVEY FOLLOW-UP INTERVIEW

ate: June 1, 2020

Participants/Organizations:

Rachael Trimbur- Clinical Supervisor, Franciscan Health

***Question 1*: We have your responses to the most common way you make and get referrals; what method has been most successful in ensuring the Person with Substance Use Disorder gets the services they need? And to follow on that why, what made it most successful?**

Responses:

Rachael: Networking and having direct contact with agencies. Have direct referral source helps a lot – can do warm handoff. Like having a staff member who has admitting privileges or can walk you through the process. One example for her is that they work with a staff member at Fairbanks and have collaborated in creating a referral form that captures all the information needed. They send this to the Fairbanks staff, and he contacts the patient and gets them admitted. They only have with this one agency right now. They had offered to make one with other places but then COVID 19 hit and stopped for now. Intent is to collaborate with other agencies. Patients get lost in the process and need to assist them as much as possible.

Question: Fairbanks is the oldest treatment facility in Marion Count and there are some big places around a long time but how do you connect with newer providers?

Rachael: About once a month an agency will come in and do a presentation. And she tries to get out as much as possible. Usually the other provider contacts them as part of a marketing strategy.

Additional to answer above: They do have someone they connect with in Bloomington and Henryville now.

***Question 2:* Is the referral method you most commonly use dependent on staff who are making the referral? Do staff have different contacts that make referral better?**

Responses:

Rachael: Yes, to some degree if you have staff not as experienced with aspects. Also, about knowing people, networking, having a contact does make a difference. Also, if a physician calls or a nurse calls seem to get further with those referrals.

***Question 3:* Do you typically get feedback from other agencies to which you make referrals and do you give feedback when making referrals?**

Responses:

Rachael: If they get feedback, they are more likely to refer in the future. If the agency says they will give feedback, then don't then an issue. As far as giving feedback others can call her. She is usually available, usually knows what is going on, so she is the person giving feedback.

Q: Does the form developed with Fairbanks have a feedback section?

Rachael: No, don't believe so. Mostly used to ensure everything needed for services.

Question 4: **How would you rank barriers, i.e. what is the biggest impediment to coordinating services a client needs? Why is that the biggest impediment? Have you tried mitigations? If so, what were they? How successful were they?**

Responses:

Rachael: Has more to do with insurance, programs that won't allow MAT have treatment modalities, especially residential, more long-term treatment.

Patients change their minds – no follow through. Just don't have transportation, people losing insurance. Trying to get scheduled as close as possible to when the patient is seen. Some places have options for transportation.

Confidentiality laws also a barrier. Before reaching out to the other agency have patient sign release. Part of agreement with Fairbanks is release. Usually patient in her office she is calling and doing the form so usually sign while with her.

Question: What mitigations have you done for the problem with programs not allowing MAT?

Rachael: They have clinicians in the Emergency Department but not a Psychiatric Department. In emergency situations it is hard to get people to take patients at that moment. They have an abstinence-based program and say MAT at Physician's discretion. Finding a program to allow the patient to get off Suboxone is hard to find.

Question: Have they brought this to attention of State officials?

Rachael: No, they have not.

<Dean: Dynamics of storing medication has been a problem for residential facilities. There is a push to get all these facilities certified to be able to allow MAT. The facilities struggle with different storage security.>

Rachael: On the southside hard to keep up, find programs allowing MAT for residential longer than a couple of days.

Question 5: **If you could identify one thing that you believe would make a significant improvement in referring people between agencies what would that be?**

Responses:

Rachael: Set up some kind of collaboration between all providers to do something like this meeting on regular basis to discuss what they do, what insurances they take, what their services are, do they use MAT. She knows about OpenBeds but not a lot about it. Need a forum where people come together and keep current.

An electronic system, if kept current, up to date with online referral form standard for all agencies, that all have separate referral form now. With a common referral form, may need additional information but goes out to everyone.

They would love a peer recovery coach who gets with the client, takes where they need to go, hold their hand when needed. Someone who could be an in-person navigator, supportive and knowledgeable- help navigate them through the process.

Additional Information:

Responses:

On demographics:

Rachael: They have a wide variety of ages 19-60 years. Average in the late 20s-30s. Big portion of population is

Caucasian probably because of neighborhood. Split pretty equally Male and Female.

They are not well known for SUD. Started maybe a year or so ago. Need to get outside beyond community. They do not get a lot of DCS, probation referrals. Primarily from southside.

They are working with a Clinician to start a group for those under 18 who are mostly experiencing. If the patient needs more intensive help, they refer out. There are not a lot of places in this arena. She wishes they could do more.

On Wait list:

Rachael: There is no wait list. Everyone is scheduled upon referral. They get scheduled for Intake within couple days and with a Clinician or Doctor within a week. If the wait time is up to 48-72 hours, they lose probably 30-40%.

They have worked with Crisis and Inpatient teams to try to get prescriptions written for Suboxone for the wait period of up to 3 days. There is a lot of pushback based on lack of knowledge, maybe discrimination. The Medical Director is leaving. She was helpful in this. In process of trying to hire another Medial Director.

Regarding 211/OpenBeds:

Rachael: Not really used herself because they have a handful of places, they know can go to not tried to use.

For funding:

Rachael: They have a SAMHSA grant for MAT. Grants for uninsured and underinsured. They take all insurance, Medicaid and Medicare. People pay very little. They have charity care funding to cover costs. They do not turn anyone away. If someone gets a big bill, they bring in and it gets taken care of.

As to what happens when the grant funding is gone, they only have 2 people currently funded by a grant. Everyone else is insured.

SURVEY FOLLOW-UP INTERVIEW

Date: June 10, 2020

Participants/Organizations:

Debra Buckner- Director, Substance Use Outreach Services Program, Marion County Public Health Department

***Question 1*: We have your responses to the most common way you make and get referrals; what method has been most successful in ensuring the Person with Substance Use Disorder gets the services they need? And to follow on that why, what made it most successful?**

Responses:

Debra: Their partnerships help identify people in need. They have a lot of walk-ins. They do community presentations, have a lot of one on one interactions.

They get referrals from family members/loved ones or the person with substance use disorder themselves. People don't know where to go for treatment or have used all their money to pay for services in the past. Now they need to have resources identified for service and funding. They get funding for those who lack the ability to pay for services.

Effective partnerships with jails, shelters, halfway houses, and the community. People share their stories with them. They get referral information from patients and other orgs. They have built up relationships of trust with families and PWSUDs. Their most successful referrals are to Salvation Army Harbor Lights where they have a partnership. If the person meets the criteria, they try to identify the treatment and get them connected to Salvation Army Harbor Lights. Harbor Lights will try to find dollars for services.

The referral process involves calling Salvation Army, Harbor Lights while the client is there with them, get the client scheduled for an appointment. Then they follow-up to make sure the client gets to treatment, follows up to make sure the client is following the guidelines of the program and staying in treatment.

In working with Midtown mental health wait times are a problem. It is important the treatment is available when the person needs treatment.

They have just hired a couple navigators. They will help ensure clients stay connected in treatment.

Question: What is the actual function of the Navigators, who are they (background/role)?

All the navigators are trained. They just came on board 6-7 months ago. As they were implementing the program COVID 19 hit. They are not out in the community yet. They are currently looking at how to safeguard the navigators and the community in the post COVID 19 restriction environment. They will be continuously trained. The Epidemiology department will identify those who have overdosed. If the person is an overdosed PWSUD, the plan is to go out into the community to meet with the person

to work with them. If the overdose was a fatality the navigators will reach out to the family and those in their social group to provide prevention services.

The navigators are not peers. One is an ex-military male and one is female who is well known in the community relating to other services. They are looking for one additional person to take the lead. They are just in the process of putting the program together what the program will look like with the pandemic.

Question 2: **Is the referral method you most commonly use dependent on staff who are making the referral? Do staff have different contacts that make referral better?**

Responses:

Debra: Not always dependent on staff making referrals. All kinds of people make referrals to them.

Question: How do the navigators become aware of services, potential agencies to use when making referrals?

Debra: May have confused the discussion about the Navigators. The navigators are part of the Overdose to Data Action grant. They are strictly working with Opioid overdose clients. That is a different project than what her group does. It has not really begun yet, just getting started up.

For her group there are two case managers from the community with a host of resources and information sharing. They work with partners, doing lot of Naloxone presentations, sharing resources. They partner with PACE and have meetings and sharing of information.

Question 3: **Do you typically get feedback from other agencies to which you make referrals and do you give feedback when making referrals?**

Responses:

Debra: Yes, they get feedback from partnering agency. They follow the patient through the process at Salvation Army, Harbor Lights. The Case Management staff are in contact with Salvation Army, Harbor Lights to make sure patient following guidelines and they get feedback from the patients about their experience.

When they receive a referral, they give feedback.

Question: What services does Harbor Lights provide?

Debra: Detox, transitional living in which they a space with at least one other person, individual or group counseling, residential care. Once stabilized the patient goes out to seek employment. They provide all the resources a person needs to become independent when they leave the facility. They can stay up to 6 weeks at the facility. While Salvation Army Harbor Lights does not provide MAT, not sure if they can be receiving MAT and stay in the Harbor Lights facility. The type of substance (e.g. opioid, alcohol) does not affect admission into the facility/program.

Question 4: **How would you rank barriers, i.e. what is the biggest impediment to coordinating services a client needs? Why is that the biggest impediment? Have you tried**

mitigations? If so, what were they? How successful were they?

Responses:

Debra: Need to have a person identified to "walk with the client" through the process. Not everything in one central location. Planning to use navigators like peers or use peer person. They don't want to send people out and say go here or go there. The goal is to follow the client for a 6 months to a year period to make sure they get the treatment they need; have a real person to walk with them through the process.

This is the solution, but the problem is that the client falls through the cracks, orgs don't communicate well with each other sometimes- could do better on this. If client needs to go for whatever service need to make sure referred to the agency that is appropriate, make sure client gets there. As professionals should make sure that service needed is there. They make calls before sending anyone anywhere to make sure the service is available when the client gets there.

The way they know where to send someone is through the partnerships they have in the community. They keep a list and if don't know place pick up phone and call and ask specific questions about services. They sometimes do a physical visit to treatment orgs etc. They want to make sure the patient will be comfortable with the facility/ treatment. Make sure the staff is ok with their clients. Talking to clients who have had experience with a facility or organization about that experience is part of learning about the other agency.

Question 5: **If you could identify one thing that you believe would make a significant improvement in referring people between agencies what would that be?**

Responses:

Debra: 211 is a good start They have all the services listed. If there could be some kind of feedback to find out, touch base to find out will org do what they say. Like a report card for agencies. Need to see if they are doing a good job and if not, how can they make improvements. Need an evaluative component on the facility

Need services to meet the needs of some situations. A mother who needs SUD treatment is not going to go into treatment if nowhere to leave children. If a person can't keep their job if go into treatment, they are not going to go into Need to sit down and look at barriers want to attack for a client. What are challenges people have in accessing treatment.

Funding is always a problem.

Sometimes a plan is created but the client "just didn't want it enough". Need to go farther and find out why the client didn't "want it".

There are not enough services for young people, adolescents, children.

Additional Information:

Responses:

On demographics:

Debra: No age limit but for services but must be 13 years of age for STD testing. They provide services for both male and female. Currently their population served is about 30% African American, 30-35% Caucasian, 20% Hispanic, and remainder other. The average age is about 35 years.

On Wait list:

Debra: No wait list. Usually can get people into treatment in 1-2 days if weekend wait until Monday. They handle walk-ins and go into the community.

Regarding 211/OpenBeds:

Debra: Not used Open Beds. She is aware of it and thinks there is a fee now for using. They are contracted with Salvation Army so just have not had reason to use OpenBeds. If they are looking for a different facility, then she makes phone calls to places she knows or other people for a reference.

For funding:

Debra: Their services do not cost anything, except for Hepatitis testing which has a $20 flat fee. Funded through CDC and grants.

Appendix C: PWSUD Interview Notes

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 14, 2020 3pm
Participant/PWSUD or Family Member: Jillian W, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Before getting sober she had been to pretty much every treatment service in Indianapolis and other places as well. Dove Recovery House for Women was unlike any other therapy. She has normal IOP had weekly meetings with case manager, offer mandatory trauma therapy before and after active addiction. EMDR(?) therapy highly beneficial. First person she trusted and allowed her to open up to sponsor and cases manager. Dove House offered therapy, a living space, a lot of staff are in recovery, someone is there to assist 24 x 7. There are group meetings and classes on how to do a resumé, budget, a DCS representative came to talk about family/child relationships. The Dove House trauma therapy provides an outlet for things you hold on to that harm you. Not a cookie cutter program – not all are in same spot when they walk through the doors. They make sure everyone gets what they need. If one thing missing need more mental health resources for diagnosis and stabilization. May be true for a lot of people and places. Need to find the right resource that is available and affordable.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: Not a big fan of IOP for herself. All services are great but until the person is ready to apply the information does not help. Has to do with where the addict is. Needed for long term when leave facility: AA, Heroin Anonymous. If she had not been grounded herself, not sure would have been able to do long term if not have this after left place where everyone was sober. Utilized resources both short and long term at the Dove house.
Question 3: When you have tried to connect to services what are/were the

obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: Biggest lack is housing especially for women. There are wait lists everywhere. Expense of treatment. At Dove House everything was free but there was a 4 month wait list and plenty of people died because of lack of resources or while they were on the wait list.
Question 4: What things have made the process smoother?
Responses: Once you are in the door lot of resources. Mom did the footwork, family support getting her to the right place. 800 numbers with more information about resources
Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?
Responses: Assessments done everywhere. Asked about Family, traumatic events, criminal history, medical history (disease, diagnosis, psychological – depression etc.), insurance
Question 6: What do we need to know that we haven't already discussed?
Responses: Indiana done pretty good job, way more options today than 5-6 years ago. Until an addict hits their rock bottom services not going to succeed in or out of institutions/jail. Hers has been a 7-year battle. The precipitating event for her recovery was an overdose where she almost died and realizing she had lost her son to her parent's guardianship and may not get him back.
Question 7: What do we need to know that we haven't already discussed?
Responses: Need to be more ¾-house options. Dove House requires relapse prevention – help pay rent after leave in declining percentages for a period of time. Really helpful as some people don't have the background to handle. Still do drug screens as part of the integration into the community. Institutions are not the normal setting when people leave - need more follow up so that people can deal with post institutional setting where not everyone on same path.
Question 8: What have you learned that you would recommend to someone going

in?
Responses: Do what you are told, not fight it. Therapy very important piece, able to use 12 step programs as therapy. Dove House allowed children to be there on the weekend. Felt more like sisters and more like a home than a facility.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 8, 2020, 2:30pm
Participant/PWSUD or Family Member: Kourtnaye, Family Member
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Background – Her son's treatment, when initially looking for treatment, started in Indianapolis, with outpatient treatment (MAT). When his disease continued, he needed in-patient needed but couldn't get into one and went out of state. There he underwent recovery and family care. She felt she could only speak to outpatient experience in Indianapolis. As for the timeframe of all this, the original IOP was 7 years ago, the 1st inpatient out of state experience was 4 years ago. Experience in outpatient treatment (IOP) he received education about the disease and group therapy. He then received a referral to a MAT treatment provider, while in IOP (4 weeks total) then to the MAT provider who hooked him up with medication and therapy through their practice. The therapy was allowed to continue with the MAT without meeting his commitment to the therapy. He then had a setback. Then looking for in-patient. Family experience in IOP – there was one meeting with the provider, the son gave permission to speak to parents. This was a short meeting with not much education about disease and how important therapy was. After the first IOP, she reached out to large inpatient provider in Indianapolis but was told that he couldn't be admitted because he was actively using (heroin); he needed to go through detox first. And she was told that there were not many places in town for this. All in all they were not very helpful. A lot of such providers did not want to touch opioid or heroin individuals at that time. They did provide a referral to another MAT provider with good references. Her son did go to this provider and they did good job with counseling and therapy and spent 6 months on this plan. Family experience was that there were group meetings once a week for family members to learn (education group, taught about disease). This was helpful. But her son had 2nd setback and the disease progressed rapidly. He was ready for inpatient treatment. She reached out again to the large provider but was told there was no room at that time. There were not that many choices at that time for inpatient services so that is when they went out of state. That program had family education and recovery coaching for him and the family during transition.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: They could have benefited from coaching during the IOP. Either there was a lack of these services or not of good quality or seamlessly integrated in the IOP. Family-wise, the biggest gap was the lack of

informing/education. She contrasted this experience with that of her younger son who had juvenile diabetes where there was a lot of education.

Also, at that time there was a cold reaction from primary care physicians. They were not prepared to help and there was no follow-up. The family experiences trauma as well as the patient and these needs were not met.

Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?

Responses:

Obstacles – at that time, web searches for services didn't help much. There was no definitive authority. State websites only had listings but what was lacking was guidance and more (and trustworthy) information on support services.

Question 4: What things have made the process smoother?

Responses:

When you connect up with another person through a support group who has experienced this. With her son, he had much more enthusiasm when involved with this.

Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?

Responses:

She initially answered how she was referred: a friend recommended the first IOP, the IOP referred her to one doctor that some people have found success with.

She didn't recall any specific information asked for at referral.

Question 6: What do we need to know that we haven't already discussed?

Responses:

Concerning recovery services as an experience for the family, when as a parent she had a coach who was also in recovery themselves and was also a recovery coach for her son, this seemed to more rapidly paint a more realistic picture of the world as it is. She contrasted this to Al Anon just had parents sharing their own personal experiences. It would be helpful to parents today for a better understanding. Recommend this to improve services.

Question 7: What do we need to know that we haven't already discussed?

Responses:

See previous question. Also, navigator services would be helpful so a primary care physician can refer

their families to in order to smooth their path forward.
Question 8: What have you learned that you would recommend to someone going in?
Responses: Realize that there is indeed a role for the parents to play in loved one's recovery but it may not be intuitive on HOW to do this. Reach out to a variety of support groups and show them HOW to do this. They themselves need to heal because there's a lot of fear, trauma and stress. That concludes our interview questions. We would like to send you a thank you $20 gift card for participating. We have a few additional questions about that.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 8, 2020, 10am
Participant/PWSUD or Family Member: Michael Morales. PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: He has had 2 years of sobriety (after coming out of prison) and is currently at Progress House. He has been to others but likes Progress House because it provides a variety of services to straighten out one's life. They don't provide detox but do provide outpatient services and therapy in house, as well as medical treatment (they send you via Aspire to professional who can prescribe). Progress House is a great program because of the variety of services provided – he had nothing bad to say. Since they are now partnered with Aspire can offer more services in same place. His main personal difficulty was re-adjusting to life after prison. The structure provided at Progress House has helped him. The programs are tailored to one's individual needs.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: He needed re-integration services/resources/therapies at Progress House. Also, help with getting insurance and job placement, being provided on-site therapists. They are tackling everything all in the same place (getting you to AA, etc.)
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: Coordination and communication regarding his legal situation. Since he is coming out of prison (past legal stuff) associated with being on probation or parole. Also, finding employment (resources to help him find places to check out)
Question 4: What things have made the process smoother?
Responses: The structure and support provided at Progress House. They have many rules that they hold you accountable for, things like making your bed, showing up on time for work and appointments. This is

needed to help break patterns associated with addiction.

Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?

Responses:

To get into Progress House, there was a lengthy interview and 5 months total.

They asked personal things: name, criminal background, making sure there were no past sex or violent crimes, past experience with drugs/alcohol/depression, medical history; asked for birth certificate (help would have been provided to get one if not available). Consent needed to communicate with probation or parole, needed to sign, release of information on past medical records. Progress House is also very adamant that they will not hide or harbor you from the law.

Question 6: What do we need to know that we haven't already discussed?

Responses:

All covered already.

Re-iterated that Progress House is a unique program for unique situations that he's happy with. He did a lot of research. Other organizations (e.g. Jesus House, Salvation Army) he applied for or looked at did not offer as many services. Progress House provides a safe place to get his life back together. The baby steps he is able to take there will help when the program is over and he steps back into the world.

Elliot @ Progress House (and everyone there) helped him out a lot.

Question 7: What do we need to know that we haven't already discussed?

Responses:

Other places he tried or looked into didn't tackle underlying factors (e.g. PTSD, abuse in family); it is as if they "applied a Band-Aid and shoved you out the door". It would be positive for places to focus on these things

Job placement part really important also (you have to pay your bills and stay in the program). Job training would be useful (maybe via grants from labor unions to learn a trade). There are some grants available but how much is financially covered for the training depend on the severity of the crimes you have committed (e.g. former felon).

Question 8: What have you learned that you would recommend to someone going in?

Responses:

If you're not ready to commit to fixing your life, if you've truly not at the point where you've had enough, don't waste your time and money. Some people think they can do controlled use or drinking but end up dropping out of programs. Take it seriously.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 16, 2020 9am
Participant/PWSUD or Family Member: SS, Family Member
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: I have felt the need to see a therapist who represents me, a person of color. Knowledge of available therapy resources and resources outside therapy.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: Better gap services for those transitioning out of correctional facilities. As a sibling, I can't tell you all of the issues, but the first time my brother was released it was without meds. He was taken to Eskenazi yet had to wait a month to see a psychiatrist. Education on what to expect from CIT and what to do outside of crisis
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: My environment. Lack of cultural competence among providers. Not much available for those in between crisis and calm. I've been told too many times to call the police on my brother when he's in crisis. And when I have decided to call them for intervention from a CIT officer, I was told that unless my brother was actively harming himself or others, there wasn't much that could be done.
Question 4: What things have made the process smoother?
Responses: Within a school system (public). I advocated for my child and that made the transition smoother.
Question 5: What kinds of questions were you asked or information you were asked for in

getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?
Responses: Do you feel safe? What type of insurance? Where are you located? What health systems are you a part of?
Question 6: What do we need to know that we haven't already discussed?
Responses: What is being done to help the process of accessing mental health and substance use/recovery services for children outside of school and private pay?
Question 7: What do we need to know that we haven't already discussed?
Responses: Community has the most integrated system. Able to pull up full history. Wider integration across all systems. Education on how to support a loved one through seeking services The use of peers could be more integrated into healthcare systems
Question 8: What have you learned that you would recommend to someone going in?
Responses: Be patient and persistent. Find an advocate in an individual or org receiving services from. We need advocates we can depend on. Shelters should have more advocates and peer supports. Every organization serving the high-risk populations (especially the homeless) should have advocates.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 23, 2020 12PM
Participant/PWSUD or Family Member: JB, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: I've received mental health services.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: Mental health services from someone that looks like us (myself and my daughters).
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: Nothing.
Question 4: What things have made the process smoother?
Responses: N/A
Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?
Responses: What type of insurance? Reason for seeking services?
Question 6: What do we need to know that we haven't already discussed?
Responses:

N/A
Question 7: What do we need to know that we haven't already discussed?
Responses: N/A
Question 8: What have you learned that you would recommend to someone going in?
Responses: You have to be in control of your own life

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 23, 2020 12pm
Participant/PWSUD or Family Member: KB, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Looked for services here but ultimately went to rehab in Florida due to not being sure of services here and wanting to be completely removed from those influences.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: Would be better if physical fitness and nutrition were better highlighted and taught in recovery Counseling
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: Myself and my peers. Lack information on where to go and who to go to.
Question 4: What things have made the process smoother?
Responses: Having a peer navigator to walk through the process and follow through with decision to seek treatment.
Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?
Responses: What type of insurance? Where are you located?

When was the last time you used and how much?
Question 6: What do we need to know that we haven't already discussed?
Responses: N/A
Question 7: What do we need to know that we haven't already discussed?
Responses: N/A
Question 8: What have you learned that you would recommend to someone going in?
Responses: Don't wait, act on it immediately when you realize you have a problem.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 29, 2020 10AM
Participant/PWSUD or Family Member: RP, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Emergency care. I haven't been able to receive on going treatment.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: Need long-term treatment and solutions. I went to talk to a therapist once, and we identified some issues. He told me that he didn't know if he could treat me w/o meds. I wasn't scheduled for another appointment until a month out and I could be dead in a month. I need care when I need it, not when it's available.
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: Acceptable insurance
Question 4: What things have made the process smoother?
Responses: A better understanding of (education) or someone to explain to me what my benefits are and what is covered.
Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?
Responses**:** What type of insurance? Am I thinking of harming myself or someone else?

Do I feel safe at home?
Question 6: What do we need to know that we haven't already discussed?
Responses: There should be someone to intervene when we're in crisis. I don't want to have to go to the hospital every time. What if there were intervention people at fire stations and police stations (safe places) for those in crisis?
Question 7: What do we need to know that we haven't already discussed?
Responses: A more centralized approach from the beginning.
Question 8: What have you learned that you would recommend to someone going in?
Responses: Don't be ashamed. Shame will keep you from getting well. You're not the only one with issues. Be encouraged, it's not a big deal unless you don't get the help. It's a bigger deal to ignore than it is to attack it.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 20, 2020 12PM
Participant/PWSUD or Family Member: RH, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Inpatient rehab, residential rehab, and attended cocaine anonymous meetings. • Fairbanks • Project Hope • Safe Haven • Dove House Didn't receive enough mental health services.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: Education for my family on how to support me in recovery.
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: Money / insurance Availability of a therapist that looked like me
Question 4: What things have made the process smoother?
Responses: Educating and advocating for myself.
Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed-

medication, criminal history, insurance?
Responses: How are you paying? What type of insurance? Family (medical) history? When did you start using?
Question 6: What do we need to know that we haven't already discussed?
Responses: N/A
Question 7: What do we need to know that we haven't already discussed?
Responses: A community accessible database that includes all services and program available (and is kept up to date). Better communication between agencies.
Question 8: What have you learned that you would recommend to someone going in?
Responses: Be patient (not many things come immediately) and open minded (find a pathway of recovery that works for you).

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 15, 2020 1:00 pm
Participant/PWSUD or Family Member: Bryce Jones, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: At Dove House on of the best services offered was trauma therapy. Harbor Lights did not offer the same amount of help. Felt like she did not know what she was doing needed basic life skills, had no experience. Detox.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: Basically, same as @1. -help with life skills, guidance, education, personal health skills- not offered to everyone -better communication with facilities as to what she was looking for
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: -Needed $250 for assessment to get into detox at Harbor Lights -Dove House was free but lacked spaces -Recovery Works / court helped a lot after she moved into Harbor Light so it was free. Feels like should be offered to more people even if no felony.
Question 4: What things have made the process smoother?
Responses: -Family helped do research that she was not able to do herself. -Probation officer gave options on where and how to get into treatment facilities.

Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?
Responses**:** -insurance -family history -legal things going on/criminal history -medication -consent forms to contact others
Question 6: What do we need to know that we haven't already discussed?
Responses: Nothing she can think of
Question 7: What do we need to know that we haven't already discussed?
Responses: Availability of beds, better information about getting in. Harbor Lights – didn't know needed $250 to get in until there. Valle Vista – had to wait without admission 24 hours and then the next day before could get in. Not good communication internally in facilities. At Dove House felt like they just really wanted to help people.
Question 8: What have you learned that you would recommend to someone going in?
Responses: Just be prepared with all your information and history knowing what you are looking for -easier to answer questions. Have a backup plan.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 14, 2020 10:00 am
Participant/PWSUD or Family Member: Liz Schrier, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Community Corrections Steps to Success Dress for Success Outpatient treatment Non-profit orgs offer a lot of services- IOP/therapy- 1 on 1 or trauma-based therapy PACE helped with employment, DOC, Ivy Tech helped with Next Level Certification for Trades- one of the most helpful for employment Housing is the most difficult area to get help with- difficult for felons, re-entry. She is hoping non-profit will be helpful in finding housing (Dean recommended checking with Recovery Works- not sure they offer help with housing but doesn't hurt to ask.)
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: - housing -advocacy- stigma that comes with the territory. Being more vocal about willingness to accept that there is a problem. Letting people know that society is willing to help and that it is okay to ask for help.
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: -Lack of long-term help. Lot of programs are short term, discharge people with no long-term plan. Need at least 6 mos to a year of support. Sometimes looks like they just want to fill a bed. -Availability is sometimes a problem. Need more inpatient rehab and detox openings
Question 4: What things have made the process smoother?

Responses:

-211 line has been helpful with providing numbers and directories

-collected resources, did internet research for places available. She would call to get more information. Never had a bad experience with anyone she connected to.

It is easier with an agency helping to get connected instead of on your own. At least you feel like someone is trying to help instead of your just being a caseload or worse forgotten.

Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?

Responses**:**

-questions about identify

-any convictions

-history with substance abuse

-family

-Employment

-treatment services insurance - 9 out of 10 times she was using Recovery Works services

-medication

Question 6: What do we need to know that we haven't already discussed?

Responses:

None that she can think of

Question 7: What do we need to know that we haven't already discussed?

Responses:

-Reaching out to the PWSUD at least for a certain time period. Sometimes it is difficult to keep up with the individual's contact information but at least one organization has the change of address etc. Better communication between agencies. Follow up to see where that person is at in recovery.

-As a society be more kind and caring.

Question 8: What have you learned that you would recommend to someone going in?

Responses:

Don't give up- lots of "No s", no beds available, might not be able to get this job, lot of turn downs.

She tried a lot of agencies, programs. Sometimes timing is everything.

Don't be ashamed. You need to do what you need to do- keep trying.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 9, 2020 10:30 am
Participant/PWSUD or Family Member: Kim Manlove, Family Member
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: -in January 2001 learned 15-year-old son had a problem with drugs and alcohol. Never had any experience with treatment and recovery. They asked around/looked around and got him into outpatient treatment at Fairbanks. They had a lack of knowledge about available treatment. They were thinking that treatment locations were available "all over the place" Provider did not think very serious so put in outpatient treatment. They monitored their son and his interactions including drug testing. They did not realize how powerful addiction was. In June 2001 his son had a relapse and huffed computer duster which affected the electrical current to his heart while swimming at a friend's pool and drowned. He had a lack of knowledge about the services and language. There was not a lot of help for the parents at that time, considered an adult disease. He had family members, 2 uncles on one side of his family and an uncle and his wife on the other side who were alcoholics but it was swept under the rug, not talked about. His parents had stopped visiting one set of family members due to the problem with alcohol. His wife and himself started to become involved with two organizations: Partnership for rug Free America (NY) and Drug Free Marion County. They were calling on Congressional representatives etc. to put more focus on children and young adults. While all this was happening he was spiraling out of control and drinking and adding prescribed Xanax (for depression associated with his son's death and blaming himself) until he was found after a blackout He got treatment for his addiction)PHP, IOP, inpatient), When he was at the point of release he was assigned a sponsor. He then began speaking out, started speaking out.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: Had a lack of knowledge about the landscape. Not familiar with the needs and what was available.
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses:

-shame/ stigma

-lack of understanding of the continuum (probably everything done that could have been at that time)

-denial about how serious the problem was

Question 4: What things have made the process smoother?

Responses:

If there had been a way to have someone assigned to them kind of to demystify or navigate the process, not only to tell them what but why and how – lot better today with peers

-Need to continue to talk to other families going through same thing especially those farther down the road, people can tell you what the next weeks, months, years will be like.

Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?

Responses**:**

Usual things, like insurance, medical history, criminal history etc. but would have been good to ask questions when pairing with peers/sponsor questions related to attributes they could be most comfortable with (see question 7)

Question 6: What do we need to know that we haven't already discussed?

Responses:

No answer

Question 7: What do we need to know that we haven't already discussed?

Responses:

A pairing process that matches attributes with PWSUD and family with sponsors/peers including things like gender preference for peer, gender identification, age, gender, Foreign language competency, race and ethnicity to find a comfortable match between PWSUD (or family) and peer

Recruit more Hispanic and African American coaches

Provide opportunities for minority coaches

Figure out how to make peer recovery coach training more accessible especially for minority/underserved population

Question 8: What have you learned that you would recommend to someone going in?

Responses:

Best thing can do is treat the whole family not just the patient – make sure they know available services

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 9, 2020 2:00 pm
Participant/PWSUD or Family Member: MaryAnn, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Background – she and her family originated from another state. Her daughter had serious SUD issues and they traveled to different states (FL, MN, CT) for rehab. Every time she got out of rehab, she was recommended to boarding but finding something did not work out. The family ended up moving to Indianapolis so she could attend Hope Academy. She graduated Hope Academy after 2 years. But had a couple relapses during this time (one-nighters). Then she went into inpatient Fairbanks for adolescents, there a month. There, there was targeted private psychotherapy for addiction and related disorders. After inpatient at Fairbanks, she did outpatient at Fairbanks (IOP). After Fairbanks she's been doing did much better, switched therapists, saw psychiatrist in Indy (private practice). That psychiatrist was in charge of their meds. After Fairbanks inpatient she should done more therapies as she needs addiction therapy, related trauma, depression, anxiety, but she wanted to take a break and never started this. (It is on her list of things to do.) Needs When she graduated from Hope Academy, there was really a feeling of "Now what?", "Who's your sober group?"). This kind of support is very important.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: Family counseling/education. Maybe this was available but they were unaware of; to teach communication techniques for whole family, parenting techniques for impulsive kids, boundaries. A major difficulty is the lack of communication between parents and kids. Every wants to do better but don't know how, how to listen, reflect and respond. Need to make it easier for people to find these kinds of services.
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: Unknowns like when searching out services, no idea how to do this? Do you use the Internet? Do you ask 1000 people about who to go to for therapy? There seemed to be little direction. Insurance. Maybe insurance would pay for a couple weeks, that's it. It's an issue with many other people but they themselves didn't have that issue.

The stigma around SUD – specifically, people want services but people don't want to talk about it. No one wants to admit they have a PWSUD in the family. Hope Academy could have accepted many more kids but because of the stigma, many parents didn't take advantage of it.

Transportation: She wishes more places like Hope Academy had dorm space because parents getting their kids to school, classes or appointments are difficult. This is difficult if the parent works, or if it's simply far from where they live.

Question 4: What things have made the process smoother?

Responses:

Some ideas for what WOULD have made the process smoother (lack of these are actually barriers):

It would be helpful to have a basic central repository list with information about what services are out there (for SUD, include services for mental health, co-existing disorders, 12-step programs…) and what they treat, who treats, how, where to find it, names and numbers, and where to get referrals.

In moment of crisis (like during a relapse or an OD situation), people don't know what to do immediately at that moment of crisis. Do I call? Who do I call? Where should I go? Need something like "If this happens, do this…"

Family education is so important. A way to address this is helpful.

Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?

Responses**:**

Medications, previous diagnoses she got, treatments she already did, what was her drug of choice, other traumas or PTSD, has she hurt herself, was she willing to participate fully and stay in programs (like Fairbanks).

Insurance information also asked for. Many of the places would give an idea up front about how much insurance would cover and call back with details. Fairbanks paid for inpatient.

They asked what support they would pursue afterwards asked about.

Question 6: What do we need to know that we haven't already discussed?

Responses:

The different aspects of care always seem a little separate (therapies vs. physicians, etc.), they don't seem connected. If they could be better tied together more where they know each other better so when they leave one services, here would be given ideas about a good place to go next.

Question 7: What do we need to know that we haven't already discussed?

Responses:

Family education and communication (as expressed above)

Agencies know each other better (as expressed above)

Short-term/right now: What does the family do in the moment in an immediate crisis (as mentioned above).

This is where parents panic the most.

Question 8: What have you learned that you would recommend to someone going in?

Responses:

Recommendation: Jump on it a lot sooner and harder than is done normally. Minimize it. A lot of parents may get some help but not enough. Maybe only until insurance runs out. They may try to do things on their own (therapies, etc.) It's the additional steps following that falls apart.

It's important to remain involved in a more comprehensive plan for recovery and stick with it even if it seems separated. This needs to continue even after the child turns 18. Her daughter has been sober 2 years.

Persons with Substance Use Disorder (PWSUD) INTERVIEW

Date: April 16, 2020 4:30 pm

Participant/PWSUD or Family Member:

Howard Wilson, PWSUD

Question 1: What services have you gotten and what services did you need and not get from the onset to now?

Responses:

He recently tried cold turkey detox on his own (he spent his first 7 days in jail). Then he did substance abuse counseling with a substance abuse counselor. He also took classes for relapse prevention (the neuro biology behind addiction), and intensive outpatient classes.

Was there anything he did not get? First 7 days Marion county jail, detoxed there with no help.

Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?

Responses:

He went to AA and got a sponsor there and working the steps. He now sponsors people and that keeps him sober.

Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?

Responses:

Communication, or lack thereof, waiting for call-backs, more than anything

Transportation: At the beginning of his sobriety he didn't have license.

Question 4: What things have made the process smoother?
Responses: He got license back and he stays active in AA and is a firm believer in faith in God, living 12 steps daily is how he stays sober.
Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?
Responses**:** Probation officer referred him to counseling and classes. It was up to the counselor what he needed to do: for example, neurobiology study for relapse prevention. (how the brain works, how to know when your brain is trying to convince you to do wrong things). This was at Alan Parsely Counseling (Southport Road)
Question 6: What do we need to know that we haven't already discussed?
Responses: Get people into a detox center and into a program before they simply assume nothing is going to work.
Question 7: What do we need to know that we haven't already discussed?
Responses: Although every case is different, work the 12-step program.
Question 8: What have you learned that you would recommend to someone going in?
Responses: Don't give up, sobriety is not easy but it is important. He's now a city employee (compared to the life he had before he was sober) -- he didn't know he could accomplish that.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 7, 2020 4:30 pm
Participant/PWSUD or Family Member: Natalie, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Received Services: IOP (Intensive Outpatient Treatment) -3 to 4 times Residential Treatment Halfway house What she needed all along was residential treatment but she wasn't willing to do it until forced by her parents and employer
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: What she really needed was 24-hour surveillance – residential treatment but didn't get until she was at the point that she would get help
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: -money, no insurance when she went into residential care. Most people don't have the money and she did not but her parents did self-pay -guilt/shame- she felt so bad about her parent's paying she tried to detox at home but ended up in hospital after developed seizures -financial security- she couldn't pay her bills if she wasn't working -Employment/job security o- was fired from few jobs when informed her employer so she was afraid to tell her employer she had a problem and needed treatment
Question 4: What things have made the process smoother?
Responses: - Social worker to help her through finding help with making her have to worry less about bills so she could go into/stay in residential care without worrying about bills going unpaid

-Had supportive/active family members. Her mother made the phone calls to get her credit cards frozen with no additional interest so she could pay them. Visited bank with her but they were not helpful. After that her mother took it on herself to find out what could be done (no training in doing so)

-Employer support. Last employer understood and helped with the process

- she paid all her bills or got deferred payment plans and gave up her apt when went into residential care so she had less to worry about

Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?

Responses**:**

-what her vice was

-how often she was doing it

-Health history

-insurance

-employment

-ever been physically abused

-ever been arrested

-medications

Question 6: What do we need to know that we haven't already discussed?

Responses:

Didn't think of anything else

Question 7: What do we need to know that we haven't already discussed?

Responses:

A lot of treatment is based on insurance. She worked at Fairbanks for about 1 ½ years and noticed that people were leaving after the approved insurance time limit only to return again and again for treatment. People were recommended for residential treatment but insurance did not cover them so they did not go into residential treatment only to return again.

Question 8: What have you learned that you would recommend to someone going in?

Responses:

Keep an open mind – just because you don't think a particular course of treatment will be useful don't give up on it without trying.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 14, 2020 2:00 pm
Participant/PWSUD or Family Member: Melisa Cole, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Has received 18 mos of treatment and is 15 months into sober living Treatment received both inpatient and outpatient, IOP PHP Sober living, 12 step recovery, NA, AA, CA, Al-Anon Different events went to connect to recovery community – lot of 1-time events She cannot think of anything she needed but did not get.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: What she needed was: Needed all the services she got. Maybe help with finding a job would have been good as well as financial help- she had a lot of debt and was not good with money, legal debts, sober living debts
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: - financial issues paying for sober living -insurance paid for all her treatment so that was not a barrier for her -having no driver's license needed money for transportation
Question 4: What things have made the process smoother?
Responses: -the treatment facility offered all the care she needed. All tied together- helped set up further help, lot of information on 12 step, hosted meetings, introduced to other services -lot of people she connected with were /are in recovery, other events helped connect her to the right/other people in same situation

Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?
Responses**:** -did she have children -did she have a job
Question 6: What do we need to know that we haven't already discussed?
Responses: All fantastic questions. Most important thing is to be educated on treatment, personal recovery, treatments that lead to long term success.
Question 7: What do we need to know that we haven't already discussed?
Responses: Sometimes try to make as individual as possible but need to look at each person and make resources available even if not same treatment program.
Question 8: What have you learned that you would recommend to someone going in?
Responses: Do whatever you are asked to do, take suggestions that are given. Get as much treatment as possible. She only had one experience and it was really good.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 10, 2020 1:00 pm
Participant/PWSUD or Family Member: Michael, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: He was with Recovery Works and now has been living at Progress House 4 months (loves it). He has been sober 2 years (alcohol). Recovery Works helps find services, pays towards housing. There are clinical services, life skills, 1-on-1s, peer led classes, meditation groups. Was anything needed that he did not get? No. everything here is easy to access, even taking you to/from doctor appointments, even going to court on one's behalf. They've surpassed expectations.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: He was able to get of anger management sessions. There was nothing that he wanted or needed but couldn't get.
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: In a strange twist, getting services at Recovery Works was easy for people with felonies. He would like to see the same availability for non-felons. He's had no problems.
Question 4: What things have made the process smoother?
Responses: His experience at Recovery Works. Whenever he needed to do something (e.g. go to some appointment or session), they made sure he went. He never had to seek out anything on his own until about 2 years ago.
Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?

Responses**:**

Medical trauma, physical trauma, childhood trauma, mental health behavior, what his addiction was to, what services he's sought

Question 6: What do we need to know that we haven't already discussed?

Responses:

As indicated above, it would be really beneficial for those not part of the penal system to be offered the same opportunities as those in Recovery Works. They help with housing, medical costs.

He would like to see less pushing of one medicine over another. His concern was that often they use Narcan and let the individual just go on their way and they might not wake up next morning.

Question 7: What do we need to know that we haven't already discussed?

Responses:

Recovery Works is all he is familiar with. As of 3/1, he's been determined to be medically frail and is getting additional help for services via HIP. He believes that maybe a lot of people don't realize HIP is an option. They simply say to themselves, "I can't afford this treatment" and therefore don't start.

Recommended community outreach to the youth of today – to make impact on young community.

He did say that today, addicts are looked at in the public eye better than they were in the past. Addicts are people too. Once there were no resources; now there are more

Question 8: What have you learned that you would recommend to someone going in?

Responses:

He liked the saying "You have one mouth and two ears so close your mouth and open your ears".

He recommends that the individual be ready to change – they have to make that decision and can't take it lightly.

FYI, he has interest in becoming recovery coach. He was involved with gang violence.

He would like to see a synopsis of what conclusions we come to on this project.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 9, 2020 10:00 am
Participant/PWSUD or Family Member: LL, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Biggest need initially (barriers) – housing, once you go through detox, it was needing but hard to find due mainly because of a lack of income when trying to get sober after detox and being unemployed. Insurance often doesn't pay for. Some transitional housing will take you promise to get a job. The quality also of transitional housing, often facilities are not run well. He felt that there is not much done concerning housing during recovery. After detox you're on your own. Housing is crucial part of recovery because it provides for a safe environment.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: Mental health services are needed; he had lots of depression but no longer had insurance. Connection with insurance is needed; he felt he wasn't educated on process. Often one doesn't know where to start. Most wrap around services are needed (mental health and primary care, and insurance) because in that position you've often neglected a lot of things in your life.
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: Other than housing as mentioned earlier, transportation; it's impossible even to take a bus without money. Is housing or employment income a bigger barrier? It's a chicken or egg thing. You can't get a job if you're not presentable; you can't get housing without a job. Also insurance is a barrier – without almost impossible to get mental health services (prescriptions, etc.). In his experience, 80% of PWSUDs need mental health services.
Question 4: What things have made the process smoother?
Responses:

He ended up in jail. When he got out, he found the best resource to be the Internet for researching long-term programs. (Detox is only a short term solution and not for changing behaviors since you're back in same environment.)

He was lucky that he was able to stay at sister's until something became available.

Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?

Responses**:**

Most places asked the same kind of information – violent criminal history, any current court restrictions, asked for current IDs (which the individual may or may not have). Some places (e.g. Pathways to Recovery) didn't ask for any of that stuff (IDs, money).

He thinks Indianapolis has more resources but people don't know how to get connected.

Were consent forms to release information needed? Treatment facilities were; transitional housing places did not. Some places just wanted money.

Question 6: What do we need to know that we haven't already discussed?

Responses:

With so many people that he comes across, e.g. if guy living under bridge decides to get sober, there are not a lot of long-term programs to get their head cleared and get with wraparound services with no resources. Sometimes if they are lucky enough to find housing, that's all that they are able to take advantage of and they miss out on services for all their other needs.

Question 7: What do we need to know that we haven't already discussed?

Responses:

Recovery coaches in hospitals who try to connect. A lot of addicts need navigators to help early on to get through services (unless they go through an emergency room where they get a peer recovery coach). Some places have day services like Reuben Engagement Center who has case workers that help with housing. But even if they are placed in housing how to get connected to other services?

Social support services are essential to address removing barriers so they can focus on recovery.

Question 8: What have you learned that you would recommend to someone going in?

Responses:

Research the place you're thinking of going into (this may not be possible for some without phone or computer). Today (Coronavirus) you can't even go to the library.

Horizon House – it would be nice to have more places like that. They have a Recovery Café with people to help navigate.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 20, 2020 11:30 am
Participant/PWSUD or Family Member: James Clair, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Arrested 3.5 years ago (drugs and alcohol were involved). His public defender sat down with a social worker from Johnson County though whom he was granted a recovery work plan. His plea agreement stipulated that he needed to go a halfway house for 3 month. The grant allowed him to pay for an IOP at a halfway house where he went to daily meetings. He felt the IOP was beneficial but for ongoing sustainability he recommended 12 step meetings and getting a sponsor to help with that. With all these services, he has maintained his sobriety (although he knew of many people who didn't take this part as serious as he did and just gave it only lip service). The services more than adequate – he was more than ready. Earlier in his life he wasn't ready earlier.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: In the beginning, he needed the accountability and stability in a positive, structured environment that halfway houses bring. The IOP was good laying the groundwork, but he's gotten more out of 12 step programs. He really didn't know what else other than 12 step is available.
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: Only one he had was prosecution side. His public defender advocated for getting him into a halfway house. But the prosecution felt it was not going to be effective since he's tried it before and it didn't work. Luckily for him, the judge overruled. Transportation. The IOP was way downtown, and he had to ride his bike there – but did what he needed to do
Question 4: What things have made the process smoother?
Responses: Having the right connections, being surrounded by and building relationships with like-minded people

and staying connected with them. Spending so much time with them played a huge part. He was involved with Fairbanks as an adolescent – the seeds were planted there (previous to incarceration). It was key for him, that he knew where to go once he was ready. The meetings were crucial during his incarceration period. He looked forward to these meetings more than visits.
Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?
Responses**:** Criminal history, past and current drug/alcohol use (what, how much, how often), his financial situation, mental health questions (e.g. history of abuse in family)
Question 6: What do we need to know that we haven't already discussed?
Responses: Nothing that we haven't discussed already.
Question 7: What do we need to know that we haven't already discussed?
Responses: Continuing and even expanding youth education programs including prevention.
Question 8: What have you learned that you would recommend to someone going in?
Responses: Keep an open mind, close your mouth and open your ears. If you had, you wouldn't be in this situation. Do what you need to do – what do you have to lose?

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 10, 2020 10:00 am
Participant/PWSUD or Family Member: BM, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Had lots of tries. Had to be on board with it and took time to admit to himself. Went to AA with both his parents. That helped him. Took him going to jail at 18, introduced to court mandated IOP. Treatment with a therapist was mandated. He had weekly IOP with a therapist. Small group (6-7) all in same boat as you. Extremely helpful and personal. Comfortable with the therapist and relationship with the smaller group. He had an assessment done at Fairbanks but did not go through with it – he was recommended to continue before he got in trouble with law enforcement. When he was on probation went to AA meetings. 3-4 months in before stopped drinking. Moved to Colorado – he occasionally goes to meetings but staying sober and maintaining strength
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: Definitely IOP. IOP with therapist one of most important of anything. AA keeps grounded but doesn't talk a lot in those meetings but IOP felt more comfortable as mostly young people in his group If could have gotten more in touch with people who were younger would have felt more like he was not a unique case, other people going through same thing
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: Self- actually admitting that he was powerless over alcohol Not finances- his parents were able to support him both financially and parentally
Question 4: What things have made the process smoother?
Responses:

Not finances- his parents were able to support him both financially and parentally His support circle, People who hold him accountable not just tell him how good he is doing His parents His girlfriend Having a future path, something to work toward. In the year he was getting sober planned move to Colorado and a new life working in the music industry. Having a goal to look forward to so not thinking about drinking. He is still on probation so had to get approval for all this.
Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?
Responses**:** Insurance history, recent occurrences consent needed had to get approval from probation department, his therapist communicated with probation department, written reports about progress
Question 6: What do we need to know that we haven't already discussed?
Responses: Can't think of anything
Question 7: What do we need to know that we haven't already discussed?
Responses: -Try to find someone more able to relate to that person based on age -Huge issue is treatment vs incarceration, hope law enforcement takes this more into consideration. – get treatment instead of jail
Question 8: What have you learned that you would recommend to someone going in?
Responses: -Any actual genuine effort forward is good, moves you closer to recovery is good. -Going to AA- make it a common thing to attend, it is free, can go all day everyday if you want, can find lots of info about treatment, get a sponsor or at least someone to talk to. You don't necessarily need to work the steps but at least read and envision yourself doing them.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 17, 2020 1:00 pm
Participant/PWSUD or Family Member: FW, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Where she lived when she first needed treatment, there were no treatment services. Had to move a lot across states to get services. Went to FL, MN, Conn. Before coming to Indianapolis. Not a lot of IOP services for young people (adolescents). She had 60+ day residential treatment then back to school. No Sober living/after care provided.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: She needed inpatient care for more than 30 days, IOP, step down from inpatient especially from the treatment center back to her regular environs. Needed good transition after inpatient.
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: -Nothing for adolescents in the area she was / location -insurance was pretty good for her but she knows other people had problems -Age related issues for people less than 18 years old
Question 4: What things have made the process smoother?
Responses: - Getting in and maintaining recovery -all the people/lot of interventionist people to get help for her -IOP/Continued care / recovery meetings. Sometimes got lists to outside world, encourage her to get a sponsor -First three places her family dropped her at the airport. Then when she got treatment in Indianapolis in Sober HS / Family moved here to be with her
Question 5: What kinds of questions were you asked or information you were asked for in

getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?
Responses**:** -family history (runs in families, don't realize how much affects family) -insurance -what brought you here now? How is today different from previous times?
Question 6: What do we need to know that we haven't already discussed?
Responses: Don't think so
Question 7: What do we need to know that we haven't already discussed?
Responses: What happens after discharge, lot of anxiety about what resources afterwards – plan for therapy, recovery meetings A lot of younger people are struggling with this. People think just bad behavior in kids or kids acting out. There are not a lot of services. People forget how young people are. Helping younger people (a young as 10 or 11 years) would be good.
Question 8: What have you learned that you would recommend to someone going in?
Responses: Sometimes stuff takes time but people working in this have best intentions in mind. Trying to help you. Give people grace with that. Get connected to people in recovery as you transition out of treatment.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 15, 2020 11:00 am
Participant/PWSUD or Family Member: DP, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Three times at Fairbanks. Got everything he needed when needed- IOP, Detox, PHP, Supporting Living. Detox at Community North (Dr Kelly) – got MAT, 2 years now
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: Detox each time, each time little different last time went to IOP- MAT He developed knowledge over time, each time something different. Detox /IOP/ Partial Hospitalization/ Supportive living
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: 3rd or 4th time his insurance would not cover the drug with which he had problems so had to take Xanax so he tested positive for a drug that would be covered.
Question 4: What things have made the process smoother?
Responses: Family support Recovery contacts helped him get to the right place – felt like people rallied around him so he could cope, keep his head up and keep moving forward. Connecting with people in recovery that can connect him to resources he needs
Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?

Responses**:** Drug history -what using, when started, how long using Legal Problems? Abuse growing up What is living situation like now?
Question 6: What do we need to know that we haven't already discussed?
Responses: Nothing else he can think of
Question 7: What do we need to know that we haven't already discussed?
Responses: Having someone who has been in their place to talk to you not at you. Having these people when they are coming in to at least explain the process. These people who have been through the process could better explain, the person could relate and provide a better outlook on what's to come.
Question 8: What have you learned that you would recommend to someone going in?
Responses: Having someone who has been in their place to talk to you not at you. Having these people when they are coming in to at least explain the process. These people who have been through the process could better explain, the person could relate and provide a better outlook on what's to come.

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 14, 2020 4:00 pm
Participant/PWSUD or Family Member: WW, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: IOP and Detox services at Valle Vista/Fairbanks Didn't get real help needed until offered Medication Assisted Treatment (MAT) last time then help with getting connected with a sponsor, recovery unit. Before that he was just told to get a sponsor but no one offered to connect him to a sponsor before releasing him and he relapsed almost immediately.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: Medication for a full year Connection to a recovery unit No longer on medication but still need recovery connection
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: Himself – didn't follow through Medication treatment not offered Finances for a lot of people -he was lucky to have the funds/insurance Not getting engaged with recovery community
Question 4: What things have made the process smoother?
Responses: Connection to recovery community – going directly from treatment provider to sponsor when left treatment – someone to be available to him, anytime – contact with AA Treatment not meant to be forever but recovery is.
Question 5: What kinds of questions were you asked or information you were asked for in getting

or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?
Responses**:** What are you on, how much been using? Insurance Treatment history "What do you want?" Consent/release of information from family members, other providers Legal history – arrest history (pending or not) Family history with addiction Somebody safe to live with on release? Suicidal?
Question 6: What do we need to know that we haven't already discussed?
Responses: Don't think there is anything else
Question 7: What do we need to know that we haven't already discussed?
Responses: "Believe in the connections" Make connections before you leave treatment. He didn't know anything about this until his treatment at Community. Recovery resources need to come see the person before release. Connect the person to someone who will help them connect to recovery resources, where, who, how. Wish everyone at least tried to connect to recovery – make a direct connection. The only reason someone leaves Community without a connection is if they won't let them make the connection**.**
Question 8: What have you learned that you would recommend to someone going in?
Responses: Whole package- listening, following treatment plan, recovery community connection and MAT. Get it all. He tells people this is a lifetime situation. You don't go into treatment and then it is over**.**

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 17, 2020 1:00 pm
Participant/PWSUD or Family Member: JW, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Lives currently in Dove Recovery House for Women and works (but currently furloughed) She was in jail Madison Cnty and Hancock Cnty) first but referred to Dove (referred by Hancock County). This was a lifesaver for her – they have trauma therapy, AA, Al-Anon.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: She needed therapy, 1-on-1 time with case managers (gave advice on legal things she had to get done and financial obligations). She will be transitioning out at Dove soon because she's been there a year and will be able to continue there with after-care, will continue to attend groups.
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: For her therapy there were no barriers, only some staff changes, they had to switch around case managers. This was an adjustment (she and new case managers need to get to know each other again) Covid thing is a current barrier (meetings are now done on Zoom meetings but the connection is not always great.)
Question 4: What things have made the process smoother?
Responses: Director, staff at Dove are wonderful. They go to bat for you, like your family. This helps because she lost a lot of trust but they backed you up as long as you are making an effort.
Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?

Responses**:**

At the Madison county jail, they never heard of Dove House, would have been nice to know about it sooner up there. At Hancock county jail – because of her charges, she needed to provide information to determine that she met criteria for a heroin protocol program: they asked what her charges were (a level 6 felony needed, she had it), what was her drug of choice (heroin), how long was the substance abuse going on, had she ever had treatment, did she have any mental health disorders.

Question 6: What do we need to know that we haven't already discussed?

Responses:

One needs to be made more aware of options in your own county and surrounding counties for more opportunities.

Question 7: What do we need to know that we haven't already discussed?

Responses:

No response

Question 8: What have you learned that you would recommend to someone going in?

Responses:

Everything depends on the people themselves and how much they want to overcome their problems. Previous comment.

Make more facilities like Dove House in other places in the state

After care – there is a grant (Steps to Success), but grants need more funding

Transition help, more needed, as long as you are doing what you need to do

Persons with Substance Use Disorder (PWSUD) INTERVIEW
Date: April 16, 2020 3:00 pm
Participant/PWSUD or Family Member: MB, PWSUD
Question 1: What services have you gotten and what services did you need and not get from the onset to now?
Responses: Progress House He's taken advantage of many services in-house at Progress House: therapies, groups involving everything behavior-wise, 12-step programs, meetings, 1-on-1 sessions with counselors. Outside Progress House? Some people have gotten services but him not so much, other than going to outside alcohol meetings. If need needed medical care, he would go outside Progress House although they have an inside physician in-house.
Question 2: When you consider you or your loved one's/family member's overall recovery what services did you or your loved one/family need?
Responses: Services needed, not gotten –absolutely not. Everything he's needed, he's received (especially since Aspire came onboard). Employment help? They do that at Progress House. He joined "Back on My Feet" organization where members get together to exercise, they have financial workshops, help with employment He worked at a rent a car but (but furloughed due to covid). Longer-term, the need would be for affordable housing. Due to bad credit you don't get what you need for housing and not in a good location. Progress House has a "Next Step" sober living facility. Good for most people but not feasible for him due to transportation services needed. Clothes are hard to come by. Always an issue. You need money for them. Difficult when you have nothing. He used to be homeless, lived on Monument Circle. Horizon House? He's been there. It's a good program that helped him get a cane. But if you don't have a job you can't get storage space with them.
Question 3: When you have tried to connect to services what are/were the obstacles that have gotten in the way? What ere the barriers to getting services?
Responses: He may be an exception because in this city you don't go hungry, there are so many programs. You don't even have to look they hand it out. In 2018 was in Progress House, then relapsed and got kicked out, then got back in. He's been chronically

homeless. He had no clue of what to do. Then Progress House person came and took care of him.

If there were obstacles, it would be that a lot of these organizations that offer help have so much red tape and so many criteria to get in. You have to meet certain criteria or must be a vet or disabled. If not, you simply can't get in.

Question 4: What things have made the process smoother?

Responses:

People have come to him throughout this process. He has been extremely blessed. Without Progress House reaching out to him, he would not have been able to do this. Outreach helps.

Question 5: What kinds of questions were you asked or information you were asked for in getting or asking for a referral? Prompt with some examples if possible/needed- medication, criminal history, insurance?

Responses**:**

He didn't reach out to a lot of people. He would call agencies on the phone but can't recall conversations.

They always asked about money and insurance of course (his HIP had lapsed but got re-instated and also through work).

Question 6: What do we need to know that we haven't already discussed?

Responses:

We've covered all the bases. He assumes these organizations have criteria they need to follow that could be a barrier to some people but he has no particular experience with that.

Question 7: What do we need to know that we haven't already discussed?

Responses:

He doesn't have the experience to say. He's never reached out himself.

Question 8: What have you learned that you would recommend to someone going in?

Responses:

Most important: get a sponsor to help you get through the program and literature. Next, get involved in service work, community activities, etc. Getting involved has really saved him.

Take it one day at a time.

You need to want what people are offering to it to work.

Appendix D: Endorsing Organizations

It was the authors' intentions that this plan be owned and implemented by participating agencies. For this reason, each agency was asked to endorse and commit to the plan. The statement we asked participants to sign follows:

> I have reviewed the recommendations in the RAP Project document and I support the plan. Further, I agree to work with the Marion County Public Health Department and other participating agencies to support implementation of the recommendations in the plan to improve the referral processes between substance use disorder treatment and recovery organizations.

The 42 individuals from 39 agencies who made this commitment are listed below.

Organization	Name	Title
Adult and Child Mental Health	Lauran Canady	Director of Access Services
Alpha Counseling Services, Inc.	Evey Gaither	President
Ascension St. Vincent Stress Center Indianapolis	Sheila Mishler	Vice President
Aspire Indiana Health	Jody Horstman, PhD, HSPP	Chief Integration Officer
Community Behavioral Health	George Hurd	VP of Community Behavioral Health
Dove Recovery House for Women	Wendy Noe	Executive Director
Drug Free Marion County	Michaelangelo McClendon	Interim Executive Director
Drug Free Marion County	Kim Manlove	Member
Eskenazi Health	Lisa E. Harris, MD	CEO
Fairbanks Hospital	Robin Parsons	Clinical Director
Franciscan Health	Rachael Trimbur	Manager Psych OTPT Services
Gallahue Community Mental Health Center	George Hurd	CEO
Hamilton Center, Inc.	Stacey Totten	Manager of Recovery Services
HealthNet, Inc.	Ricardo A. Diaz	President and CEO
Hope Academy	Rachelle Gardner	Chief Operating Officer
Indiana Addiction Issues Coalition	Heather Rodriguez	Manager of Recovery Community Development
Indiana Addiction Issues Coalition	Matthew Heskett	Recovery Consultant
Indiana Family & Social Services Administration, Division of Mental Health & Addiction	Tony J. Toomer	Opioid Treatment Program Manager

Indiana Recovery Network	Heather Rodriguez	Manager
Indiana University	Debra Litzelman	Director of WeCare and CARE Programs
INSTEP	Wm Corley	President
Life Recovery Center	Eric Davis	Executive Director
Minority Recovery Collective Inc.	Natasha Cheatham	Director
New Life Recovery Home	Annette Kreider, MSW, LCSW	Director of Clinical Operations
Overdose Lifeline	Justin Phillips	Executive Director
Overdose Lifeline	Kourtnaye Sturgeon	Director of Education
Pathway to Recovery	Sandy Jeffers	Executive Director
ProActive Resources	Matthew Heskett	Recovery Consultant
Progress House	Darrell Mitchell	Executive Director
Progress House	Eliot Severeid	Re-Entry Coordinator
Public Advocates for Community reEntry, Inc.	Rhiannon Edwards	Executive Director
Raphael Health Center	Sherry Gray	CEO
Raphael Health Center	Rachael Ziegler	Psychologist
Raphael Health Center	Claire Kammen	Project Coordinator
Reach For Youth	Denise A. Senter, LMHC	Director of Mental Health and Clinical Services
Riley Hospital, Child & Adolescent Psychiatry Clinic, Dual Diagnosis Program	Leslie Huvershorn, MD	Director
Shalom Health Care Center	Dominique D. Leveque	Nurse Practitioner
Tara Treatment Center, Inc.	Jennifer Parker	Clinical Supervisor
Tara Treatment Center, Inc.	Tina Snider	Business Development Specialist
The 24 Group	Kim Manlove	Member
The Landing Place, Inc.	Linda Ostewig	Director
The Willow Center	Ashley S. English	Founder/CEO
Trusted Mentors	Jeri Warner	Executive Director
Volunteers of America Ohio & Indiana	Shannon Schumacher	Executive VP, Strategy, Innovation and Clinical Services
Wheeler Mission	Lisa Hoffman	Program Director
Wooded Glen Recovery Center	Erin Mooney	Director of Business Development