Final Closeout Recovery Progress Report

Final Closeout Report is cumulative of all three (3) years of the program and is to be uploaded in eRA under Closeout in the Terms & Conditions Section. Please refer to the Grantee Reference Closeout attachment.

Grant Name: **BCOR -21** **RCSP-SN _____** **TCE-PTP ____**

Grantee: **Sandusky Artisans Cooperative**

Grant Number: **TI080772**

Reporting Period: 09/30/2018 - 09/29/2021 **Date Submitted: 12/10/2021**
Completed By: Gretchen Clark Hammond, Project Evaluator and Mary Supina, Project Director

Name of Institution awarded Grant:	Sandusky Artisans Cooperative
Project Name:	Building Strong Recovery Communities
CSAT Project Officer:	Enid Osborne, PhD

Project Director:	Mary Supina	LOE: 32%
Organization:	Sandusky Artisans Cooperative	
Address 1:	138 E. Market Street	
City, State, Zip:	Sandusky, OH 44879	
Phone:	419-621-9377	
E-mail:	marysupina1960@gmail.com	

Project/Peer Coord.	Stacie Hannon	LOE: 100%
Phone:	419-621-9377	
E-mail:	staciehannon02@yahoo.com	

Project Evaluator:	Gretchen Clark Hammond, PhD, MSW, LSW, LCDCIII, TTS
Institution:	Mighty Crow
Address 1:	11 W. Cooke Road
City, State, Zip:	Columbus, OH 43214
E-mail:	gretchen@mightycrow.com

I. CHANGES IN KEY PERSONNEL DURING 3-YEAR REPORTING PERIOD

Describe any new hires, critical vacancies, and changes in assignments of project staff.

A. New Key Staff Information:

Name:	Stacie Hannon	LOE: 100 %
Title:	Project Coordinator	
E-mail:	stacielynne02@yahoo.com	

B. Former Key Staff Information:

Name:	Bobbie Moore	LOE: 100 %
Title:	Project Coordinator	
E-mail:	bobbiejm827@gmail.com	

II. PROJECT INFORMATION NARRATIVE

*The following two (2) Sections apply to the key focus area of your grant. Respond **only** to the Section(s) that pertain(s) directly to your grant; **BCOR, TCE-PTP, or RCSP-SN** and that is/are aligned with your grant goals and objectives **as stated in your original application**.*

Peer Recovery Support Services (TCE-PTP and BCOR)

Narrative is to demonstrate the progress of your project towards reaching the primary Goals and Objectives **as stated in your original application**. Here are suggested areas to address:

a. Peer Staff (hiring, training, cultivating)
b. Peer delivery of Direct Services
c. Peer leadership development
d. Peer Trainings/Certifications
e. Organizational linkages, network development, and capacity building
f. Planning for project sustainability

The Sandusky Artisans Cooperative operates the Sandusky Artisans Recovery Community Center (SARCC) in Sandusky, Ohio (Erie County). SARCC was established in 1996 as a Peer-Driven, Peer-Supported, grassroots, non-profit organization with a focus on recovery support services. Services are delivered by Certified Peer Support Specialists. Everyone who works or volunteers at SARCC is a person in recovery.

SARCC is a Recovery Community Organization (RCO) dedicated to organizing and mobilizing peers in recovery, their families, friends, allies of the recovery movement, community organizations and networks that promote access to immediate treatment and the resources to long term recovery through peer to peer support services, education, the elimination of stigma and discrimination, the arts and to further the development of the rights and dignity of those in recovery.

The vision of SARCC is a world community where recovery from substance use and/or mental health challenges is viewed as public health issues, where there is universal access to prevention, treatment, and

recovery and the immediate resources and support to achieve goals of health and wellness, to lead a self-directed life, and reach the full potential that long-term recovery brings are available.

The "Artisans" part of SARCC is a focus on using art as a means of expression and healing. Joey Supina, SARCC's Executive Director worked as a professional artist prior to founding the organization. The use of art as a recovery support activity is a distinguishing feature of this RCO. Much of the center is adorned with colorful masks designed by persons in recovery. Recovery supports and recovery support services are the main focus of the organization, including hosting meetings for persons in recovery seven days a week including 12-step fellowship, National Alliance for the Mentally Ill (NAMI) meetings, SOLACE, and WHAM.

Peer counseling/mentoring is another service offered by SARCC. Persons in recovery who want to become Certified Peer Support Specialists can take this training through SARCC and oftentimes find employment as a peer through SARCC's many collaborations with local organizations. SARCC also offers numerous wellness services to its participants, as wellness is a vital part of one's recovery. Part of their commitment to wellness includes an annual summit, yoga and movement classes, health education, and a focus on self-care.

In October 2018, SARCC was awarded a BCOR grant through SAMHSA and launched the Building Strong Recovery Communities Project. The focus of this work is to increase access to recovery support services (RSS) and to positively impact those receiving services with substance use disorders. This project also focuses on raising the quality of RSS in the community and developing key partnerships within the community. This report provides an update on the work across all three years of grant funding.

Table 1 details the goals and objectives of this project and an update on progress toward achievement.

Table 1: Goals, Objectives, and Progress Summary	
Goals and Objectives	***Progress Summary***
Goal 1: Increase access to and the quality of RSS offered in Erie County and NW Ohio.	
Objective 1: Conduct quality improvement processes on a continuous basis.	Throughout the grant period, SARCC conducted weekly CQI meetings; these meetings continued throughout Y2 and Y3 during the pandemic. Additionally, the Project Evaluation team examine the concepts of "access" and "quality" of Recovery Support Services and analyzed the various points of access across RSS and the available metrics of quality for each RSS. The Evaluation team conducted a literature Review and a subsequent Issue Brief titled, "Substance Use Disorder Treatment and Recovery: Definition and Measurement of Access and Quality. ***The Literature Review will be included as an Appendix to the Grant Close-Out Report; the Issue Brief was Included as an Appendix to the Year Three Annual Report.***
Objective 2: Offer monthly educational and advocacy trainings for local professionals and people living in long-term recovery.	Trainings for people living in recovery occurred throughout the grant period. In Y1, trainings were held in-person; in Y2, training shifted to a virtual format, which continued throughout most of Y3. As vaccination rates increased and spread decreased, Sandusky Artisans was able to host events in a hybrid style, allowing for persons to attend in-person and to still attend virtually. Best Practice Events are discussed in the Evaluation Section, which include trainings provided to persons in long-term recovery.
Objective 3: Increase the number of Peer Recovery Supporters and Peer Guides at SARCC and other RCOs.	SARCC conducted Peer Support Certification trainings in Y1; once the pandemic started in Y2, the Ohio Dept. of Mental Health and Addiction Services postponed the in-person training and shifted the certification to a virtual format. SARCC continued to assist persons interested in obtaining Peer Supporter Certification in Y3. SARCC continued to hire

	Peer Supporters and work with partner organizations to place Peer Supporters as members of treatment teams, especially with the Ohio START program and with local specialty courts that address persons with substance use disorders.
Objective 4: Advocate for the elimination of stigma surrounding substance use disorders.	Advocacy, awareness, and vicinity continued, despite the pandemic. Joey and Mary Supina remained active on the many state-level boards and groups with which they are affiliated, including working directly with OMHAS, OCAAR, Ohio PRO, and various county mental health and recovery services boards, and courts. The Recovery Walk was able to occur in-person in September, which is one of the largest public events that address the elimination of stigma.
Goal 2: Integrate users of RSS with primary health care, oral health care, and behavioral health care.	
Objective 1: Execute an agreement with the Erie County Health Department (ECHD) to utilize their Federally Qualified Health Center (FQHC) as a medical, dental, and behavioral health home for users of RSS.	This agreement was in place at the time of SARCC's original application to SAMHSA. The partnership with ECHD remains strong even as this grant comes to an end.
Objective 2: Train ECHD's clinical and non-clinical staff on SUDs, RSSs, so they may refer their patients to SARCC's RSS when appropriate.	Much of this work occurred in Y1; as the partnership continues, SARCC provides ongoing training to ECHD and accepts referrals from ECHD.
Goal 3: Link people living in long-term recovery with vocational and educational opportunities so they may find gainful employment.	
Objective 1: Refer people in long-term recovery to Erie, Huron and Ottawa Vocational Education Program (EHOVE) for adults.	SARCC referred persons in recovery to EHOVE during all three years and worked to provide transportation assistance to those in need, as the distance to EHOVE is a barrier for some.

A. Peer Staff: Hiring, Training, Cultivating:

Providing Peer Support Certification Training and Supervisor Training was an area of focus in Y1. In May 2019, SARCC facilitated an **OhioMHAS Peer Support Training** facilitated by Joey and Mary Supina, who are both Certified Peer Supporters and certified as peer support training facilitators. The dates of the training were 05/04/2019, 05/05/2019, 05/11/2019, 05/12/2019, and 05/18/2019. There were 6 people in attendance at the training. On 10/04/2019, SARCC hosted an **OhioMHAS Peer Supporter Supervisor Training** and the facilitator was Jackie Dooley from the Peer Center of Columbus. 24 people attended the training. This work would have continued in Y2 and Y3 had the pandemic not occurred and the state suspended in-person training events. Instead of hosing the 40-hour in-person training, SARCC shifted its focus to providing continuing education opportunities to Certified Peer Support Specialists.

Growing the total number of Peer Recovery Supporters allowed SARCC to not only further its reach within the recovery community, but also with its partners who provide treatment services, healthcare services, and recovery housing services. If a partner is in need of this service, they know they can contact SARCC for help. To ensure that Peer Recovery Supporters understand the importance of their job and the importance of carrying forth the mission of SARCC, we provide them with training that includes positive organizational skills, team building, and networking.

SARCC plans to continue the growth of peer staff in the community and recognizes the important role it plays in helping interested persons pursue this certification. Therefore, SARCC provides a Help Center where people interested in becoming a Peer Supporter can use computers to take the required online courses through the e-based academy. SARCC staff also provide guidance with the application process. During Year Two, SARCC hired six new peers, one of which was for the Ohio START program while the other five were hired to work at SARCC. During Year Three, SARCC hired eight new peers, two of

which was for the Ohio START program while the other five were hired to work at SARCC. SARCC also hired one new Peer Support Supervisor.

This work was related to the following goals:

X	Increase access to and the quality of RSS offered in Erie County and NW Ohio.
	Integrate users of RSS with primary care, oral health care, and behavioral health care.
	Link people living in long-term recovery with vocational and educational opportunities so they may find gainful employment.

B. Peer Delivery of Direct Services:

SARCC Peers are engaged in working with many different organizations. Please see *Section D, Organizational Linkages* as well as the detail provided under *Section E, Sustainability Planning* for a list of the organizations that have contracted with SARCC for Peer Services. As an RCO, SARCC is peer-run, so services provided within the organization is also provided by peers.

This work was related to the following goals:

X	Increase access to and the quality of RSS offered in Erie County and NW Ohio.
	Integrate users of RSS with primary care, oral health care, and behavioral health care.
	Link people living in long-term recovery with vocational and educational opportunities so they may find gainful employment.

C. Peer Trainings/Certifications and Leadership Development:

SARCC proposed the following targets for the grant period: 7 events and 225 participants. By year, these targets were as follows:

- Y2019: 2 events; 50 participants
- Y2020: 3 events: 100 participants
- Y2021: 2 events: 75 participants

SARCC was very productive across the three years and maximized its grant award by providing **30** events (Trainings, Meetings, and Best Practice Events), reaching 887 participants. Details on the events and participants are provided in Tables 2 through 4.

Table 2: Trainings, Meetings, and Best Practice Events		
	Meetings (Y1)	
	Meeting Date	***Title***
1	4.25.2019	Wellness/Advocacy Symposium
2	5.22.2019	Camp Recovery
3	8.26.2019	Monday Connections
4	8.26.2019	Recovery Meditation
5	8.27.2019	Breaking the Chains
6	8.28.2019	Whole Health Action Management (WHAM)
7	8.30.2019	Friday Connections
8	8.30.2019	Concord Care WHAM
9	8.31.2019	Summers End Camp Recovery
10	9.9.2019	Just Move
11	9.14.2019	Annual Recovery Walk
	Total Meetings in Y1: 11	
	Trainings (Y1)	

	Training Date	***Title***
1	5.4.2019	Peer Support Training
2	6.27.2019	Understanding Compassion and Fatigue
3	6.28.2019	Organizational Wellness
4	7.11.2019	Narcan Training
5	7.18.2019	Working with Unique Populations
6	7.19.2019	Grief and Loss in the Workplace
7	8.15.2019	Ethics and Boundaries
8	8.16.2019	Faces and Voices – Our Stories have Power
	Total Trainings in Y1: 8	
	Total Events in Y1 (Meetings and Trainings Combined): 19	
	Best Practices Events (occurred after the transition from Meetings and Trainings in Y1)	
	Event Date	***Title***
1	2.19.2020	Addiction 101
2	5.12.2020	Connections 8 Dimensions of Wellness
3	6.4.2020	Virtual Wellness Symposium
4	6.23.2020	Ethics and Boundaries Training
5	9.26.2020	Recovery Walk
	Total Best Practice Events in Y2: 5	
	Best Practice Events Y3	
	Event Date	***Title***
1	12.3.2020	Trauma-Informed Care
2	2.3.2021	Ethics and Boundaries Training
3	4.28.2021	Human Trafficking
4	5.13.2021	Virtual Wellness Symposium
5	7.28.2021	Diversity Equity and Inclusion
6	7.29.2021	Non-violent De-escalation
	Total Best Practice Events in Y3: 6	

The SPARS Cumulative Frequency Report provides the following data as detailed in Table 3:

Table 3: Cumulative Frequency Report				
Event Type	Frequency Count	% of total frequency	Cumulative frequency count	Cumulative %
Meeting	335	37.7	335	37.7
TTC Event	465	52.42	800	90.19
Training	87	9.81	887	100.00

The SPARS Coverage Report provides the following data, as detailed in Table 4:

Table 4: Targets Achieved			
Period	Event Target	Events Completed	Event Coverage Rate
09/30/18 - 09/29/21	7	30	428.6%
	Participant Target	Post event forms completed	Participant coverage rate
	225	887	394.2%

This work was related to the following goals:

X	Increase access to and the quality of RSS offered in Erie County and NW Ohio.
	Integrate users of RSS with primary care, oral health care, and behavioral health care.
	Link people living in long-term recovery with vocational and educational opportunities so they may find gainful employment.

D. Organizational Linkages, Network Development, and Capacity Building:

Linkages

As discussed in this section, SARCC developed a strategic partnership with ECHD to ensure that persons in long-term recovery are connected to a health home. Additionally, this partnership provided a formal referral process from ECHD to SARCC. This process was replicated with Ohio START counties, local courts, and vocational service providers in an effort to create a "no wrong door approach" to helping people with substance use disorders gain access to care and needed services. The process is known as the SARCC Referral Program and includes the following components:

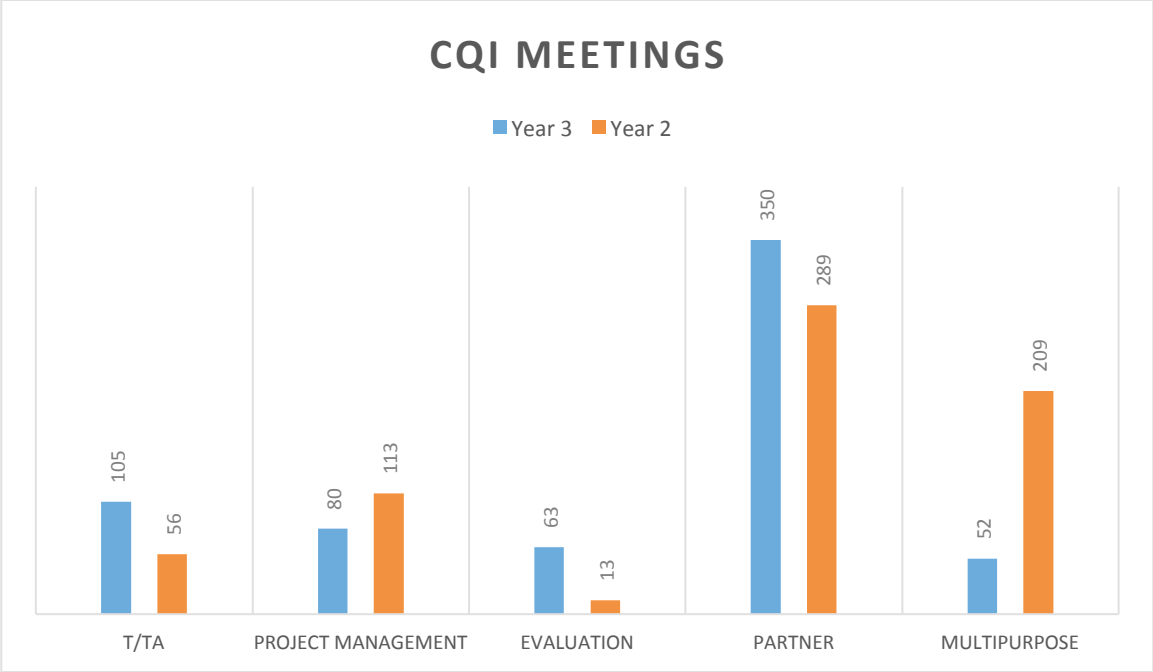
- ***Medical, Dental and Behavioral Health Partners***: Walk-ins to SARCC, residents at Becky's House sober living, and Ohio START clients (parents engaged in the child welfare system) can be promptly referred to the Erie County Health Department for medical or dental appointments, to the Erie County Detox Center for substance use disorders, and to Bayshore Counseling Services, Firelands Counseling and Recovery Services, and The LCADA Way for behavioral health assessments. SARCC can assist in transportation to scheduled appointments. It is worthwhile to note that the Erie County Health Department is also a Community Health Center and has seven service sites that allow it to serve persons across five counties. SARCC supports the work of the health department by assisting with the development of the Community Health Assessment (CHA), in addition to providing support to the health department for service referrals. The work of SARCC and ECHD is evidenced in the Community Health Improvement Plan and the strategies intended to reduce drug overdose deaths. Strategies where SARCC is directly involved include: (1) Increasing cross-sector collaboration and data=sharing, (2) Community response Planning, and (3) Recovery communities and Peer Supports.
- ***Vocational Services***: SARCC partnered with Sandusky Career Center, Townsend School, EHOVE Career Center, and Firelands BGSU to offer adult education assistance. Quarterly the schools and SARCC have a meeting to see how the collaboration is improving and updates within the programs. Clients are promptly referred to the school of their choice and given contact names and phone numbers/emails to begin the admission process.
- ***Community Resources and Social Services***: The "SARCC Referral Program" also assists clients in obtaining birth certificates, social security cards, and state ID's. SARCC collaborates with the Erie County Health Department for birth certificates, the Ohio BMV for state ID's, and the Social Security Office for social security cards.

These efforts are also connected to the development of SARCC's network and the overall network of care available to persons in recovery.

Network Development

SARCC utilizes a CQI process wherein all meetings by key SARCC staff are tracked in a spreadsheet system, which is then shared with the Project Evaluation team; *this tracking began in Y2 of the grant when the evaluation team was brought on board*. These meetings are then categorized as Project Management, Training, Technical Assistance, Evaluation, Partner, and Multipurpose. Staff participated in 650 meetings during Year 3 and 680 meetings in Y2, with the most common type of meeting being one focused on working with partners at the local and state level. Figure 1 provides the categorical breakdowns.

Fig. 1



In addition to providing trainings, Key Staff also participated in trainings to ensure that their skills continued to develop. These trainings included: Parent Peer Support Training, Wraparound, Compassion Fatigue, Trauma-Responsive Care for Trainers, Changing Recovery Language, Ohio START Training, and trainings hosted by Ohio MHAS.

Examples of these collaborations include:

Ohio START[1]: This program is a collaboration between the Public Children Services Association of Ohio (PCSAO), local public child welfare agencies, The Ohio State University College of Social Work, Case Family Programs, the Ohio Department of Mental Health and Addiction Services (OMHAS), and local organizations that provide treatment and recovery services. START stands for Sobriety, Treatment and Reducing Trauma. Erie County, the home of Sandusky Artisans, was part of a 17-county expansion of the original pilot project.

Sandusky Artisans provides Certified Peer Support Specialists for Ohio START, mentoring parents with substance use disorders who are seeking to resolve their cases with child welfare. Family peer mentorship is one of the innovative components of Ohio START. Sandusky Artisans, Erie County Job and Family Services, and The LCADA Way were the three local organizations who collaborated to bring Ohio START to Erie County[2].

Ottawa County HOPE Court[3]: The HOPE (Helping Our Parents Excel) Court is a Family Dependency Treatment Court for parents dealing with alcohol or drug addiction who have lost custody of their

[1] https://www.ohiocasa.org/start-program-expanded/

[2] https://sanduskyregister.com/news/27200/state-program-helps-reunify-local-families/

[3] http://ottawacountyjuvenilecourt.com/2019/03/ottawa-county-program-gives-imperfect-parents-hope/#:~:text=Parents%20who%20have%20lost%20custody,end%20objective%20of%20family%20reunification.

children in Ottawa County. The program involves a four-phase process with the end objective of family reunification. Sandusky Artisans provides Peer Support Services and linkages to recovery services for program participants.

Townsend Community School[4]: Townsend Community School is a dropout prevention and credit recovery high school designed to support students and their families during their journey through high school. All students in grades 9-12, up through the age of 21, are eligible to enroll at TCS whether they are credit deficient, or they simply prefer a non-traditional option. Recently, the local paper reported on this partnership and shared,

> On Tuesdays and Thursdays from 1-3 p.m., students living in the Sandusky area can now study at Sandusky Artisans Recovery Community Center. About 30 students and three instructors will use the space. Previously, students met with their instructors at the Sandusky Library for assignments. "It's just become too many students at the library. We've really appreciated the library being accommodating over the years, but it's best if (students) move to the Artisans. This will be a better situation for the students," Bartkowiak said.

Trauma-Responsive Community Coalition[5]: The Trauma-Responsive Community Coalition is a three-year project of the Erie County Family and Children First Council involving numerous organizations including first responders, police, schools, social service agencies, faith communities, civic organizations, mental health agencies businesses, and community members. Trauma-Responsive Care is based on universal precautions: everyone needs to feel safe, connected and in control, whether a trauma history is known or not. With Trauma-Responsive Care, everyone in an organization is responsible for making those they are with feel safe, connected, and in-control. This cultural shift is most likely to last if we help agency leaders understand the concepts of trauma-responsiveness and support these concepts being added to the policies and procedures of our local agencies. SARCC is one of the partners in this effort.

Community Networking: Large Scale

SARCC's visibility in the community continued, despite the pandemic. Community events like the Wellness Symposium occurred virtually this year on May 13, 2021. This half-day event focused on health, wellness, and recovery and was co-sponsored by SARCC, the Mental Health and Recovery Board of Erie and Ottawa County, and the Statewide Advocacy Network (SWAN). Speakers from around the Lake Erie region participated, as did numerous members from the community. The event was also held virtually in 2020 due to the onset of the pandemic. In 2019, this event was held in-person and drew over 100 participants.

Fortunately, the 8th Annual Recovery Walk was able to be held in person on 9.11.2021. The Sandusky Register[6] wrote:

> "A popular event support sobriety returns for an eighth straight year. Each year, the Recovery Walk represents one of the area's largest public outreach initiatives to raise awareness for a nationwide drug epidemic hitting home. It also aims to provide local treatment solutions."

Participants and supporters of the walk filled out signs that stated, "I walk for recovery because…." Signs could be carried by walkers or held by those cheering on the walkers. Anyone with a sign was also

[4] https://www.townsendcs.org/
[5] https://www.eriecounty.oh.gov/Trauma-ResponsiveCommunityCoalition.aspx
[6] https://sanduskyregister.com/news/333676/recovery-walk-returns-to-sandusky/

encouraged to post it on social media with #sarccrecovery. This activity was just one of many that the team at SARCC put into place to help build a sense of connection and belonging. After the walk, SARCC held a Grand Opening Ceremony for the newly renovated building. In 2020, the walk was held as a virtual event, allowing people to walk on their own and then post pictures of their participation. In 2019, the Recovery Walk was held on September 14th and drew over 500 people.

On September 23, 2021, SARCC hosted a large event aimed directly at prevention of substance use disorders in conjunction with Sandusky High School and the Ten Fifty-Eight Event Center. Nationally known speaker, Chris Herren[7], came and shared his message of recovery and the importance of changing the conversation on substance use. Chris often talks about "focusing on the FIRST day" and not the last day of someone's experience with drugs and alcohol. From his website:

> Chris Herren is a former professional basketball player, a voice on the topic of substance use prevention and a wellness advocate. Since 2009, Chris has spoken to over one million students, athletes and community members, sparking honest discussions on the topics of substance use disorder and wellness. A person in long-term recovery, Chris continues to share his story nationally with a renewed focus on prevention education and challenging audiences to rethink how we look at the disease of addiction – changing the focus from the last day to the first. As Chris says, "The focus oftentimes is on the worst day when it comes to speaking about addiction. We need to understand how this begins rather than how it ends. Prevention starts on the first day."

There were 834 students in attendance and 350 community members. Attendees remarked how impactful he was and how grateful they were to SARCC for bringing Chris to the community to speak.

Capacity Building

SARCC developed a support meeting called "Taking Back Ohio" intended to assist persons on Medication Assisted Treatment for opioid use disorders who were struggling to find support within other pathways of recovery. SARCC developed a curriculum for the group based on a positive peer approach. This curriculum has since been replicated across the state and is now used as a "multiple pathways" approach to helping people in recovery, not just persons using MAT. SARCC also renewed its status as a SWAN (State-wide Advocacy Network) grantee through the Ohio Department of Mental Health and Addiction Services.

This work in making referrals, building networks, and building capacity is related to all three goals:

X	Increase access to and the quality of RSS offered in Erie County and NW Ohio.
X	Integrate users of RSS with primary care, oral health care, and behavioral health care.
X	Link people living in long-term recovery with vocational and educational opportunities so they may find gainful employment.

[7] https://herrentalks.com/

III. SUCCESSES, CHALLENGES, and MODIFICATIONS (including COVID-19)

A. Describe project successes/challenges/modifications during the duration of the grant.

Year One Successes:

SARCC's first year with a BCOR grant was very successful. Events were presented efficiently and had high attendance rates. Recovery services held at SARCC consist of Taking Back Ohio, Mindful Mondays Connections Support Group, Just Move, Recovery Meditation, Yoga with a Twist, Friday Connections Support Group, SOLACE, Emotions Anonymous, Alcoholics Anonymous, Narcotics Anonymous, WHAM, Cocaine Anonymous, and Recovery Spiritual Service. Also held at SARCC is Townsend School System, Adult Parole Board, Citizen's Circle, and holiday special events. SARCC is a community center from its inception. It serves the WHOLE community, not just substance use disorders and mental health.

Collaborations were a second point of success in Year One. SARCC collaborated with the Erie and Ottawa Counties Job and Family Services, Children Service's Department, to form the Ohio START (Sobriety, Treatment and Reducing Trauma) Program. A family peer mentor works within Children Services Agency to assist mothers and fathers with a substance use disorder. The project started off slow and consisted of trainings, summits, and conferences. Both Erie and Ottawa County joined Ohio START in Cohort 2, which is the 2nd set of counties in Ohio implementing the program. Each county started with 2-4 families and is slowly increasing that number. SARCC has 2 Ohio START family peer mentors and 1 family peer mentor supervisor in the program. SARCC modified the interview and hiring process for family peer mentors because the eligibility guidelines were making it difficult to find hirable prospects.

Year Two and Three Successes:

The **first success** was related to the continued progress across all three of the project's goals and the corresponding objectives. Even with the challenges faced in year two related to the COVID-19 pandemic, SARCC was able to host its Best Practice events and surpass its targets. We are grateful for the ability to quickly strategize and utilize technology, as these factors allowed SARCC to continue to deliver Best Practice Events and other RSS.

The **second success** was the continued recognition of the importance of RSS in Erie County and the contiguous counties that often reach out to SARCC for Peer Support services and other RSS. The continued growth of Ohio START brings more work for Peers and more recognition of the importance of persons with lived experience as meaningful members of an intervention team, especially for parents in the child welfare system who are struggling with substance use disorders and mental health disorders. The same holds true for the local court systems at the adult and juvenile levels who are also recognizing the importance of Peer Support staff. The community overall continues to raise its awareness that while treatment is time limited, recovery supports are life long – including recovery housing, peer services, recovery-focused arts, recovery-centered vocational services, and life-skill development.

The **third success** was related to SARCC's building renovation and capital campaign. The capital campaign is focused on renovating the 113-year old building that houses the organization.

Renovations began in June 2020 and will result in a building that is accessible to persons with disabilities, including an elevator that will reach all three floors. There will be two additional rooms for larger groups and trainings and a new kitchen to support the many community events that SARCC hosts. These renovations were completed in the early summer of 2021. The result was a building that is accessible to

persons with disabilities, including an elevator that will reach all three floors. There are two additional rooms for larger groups and trainings and a new kitchen to support the many community events.

B. **Note changes in local conditions that may have affected continued project success, e.g., changes in economic situation, funding for services, political changes, changes in training departments/administrative participation, training methodologies, other environmental factors.**

The main challenge in Years Two and Three was the same one that impacted every grantee: the pandemic. This challenge forced SARCC to quickly pivot into the world of virtual meetings, a Virtual Recovery Walk, a Virtual Wellness Symposium, and online trainings. This transition was one that came quickly and SARCC rose to the occasion and continued to provide needed services. It is important to note that as with most public service programs, SARCC's work was impacted by the COVID-19 pandemic to some extent as the connections between persons in recovery were limited to online and virtual convenings. The physical location of SARCC where many people meet, gather, host events, etc. was closed due to safety at first, and then closed due to the large-scale renovations to the building. While it is difficult to know exactly how the response to COVID-19 affected SARCC and its outcomes, we can assume that we may have engaged with fewer individuals than originally intended for several months in 2020 while typical activities were temporarily reduced and modified. The large-scale community events like the Annual Recovery Walk and Camp Recovery were likely places where we saw fewer attendees than normal. These events are just not the same when done online as when they are conducted in person. Additionally, substance use, relapses, and overdose rates increased during this period and it was more difficult than usual to connect individuals with substance use treatment and recovery resources as various agencies shifted its programming in an effort to curb the spread of the virus. In response, SARCC and Ohio's RCOs had to develop more creative ways of keeping individuals engaged in support services.

IV. ALIGNMENT WITH DISPARITY IMPACT STATEMENT (DIS)

A. Determine if your overall demographics were in line with the projected DIS. Please comment and describe your findings as similarities or differences and explain.

The demographics of persons served were largely in line with expectations projected in the DIS. It is helpful to reference the demographic information of Erie County Ohio when examining the demographics of participants. Further details on the demographics of participants are provided in the following tables.

Table 5: Demographic Comparisons

Category	% In Erie County (2019)	% Participants in BCOR
Male	48.9%	33.03%
Female	51.1%	64.94%
White	86.7%	85%
Black or African American	8.9%	8%
American Indian and Alaska Native	0.4%	1%
Asian	0.8%	1%
Native Hawaiian and Other Pacific Islander	0.1%	1%
Hispanic or Latino	4.5%	4%

Table 6: Gender of Participants				
Gender	Frequency Count	% of Total Frequency	Cumulative Frequency Count	Cumulative %
Male	293	33.03	293	33.03
Female	576	64.94	869	97.97
Transgender	3	0.34	872	98.31
None of these	3	0.34	875	98.65
MISSING DATA	12	1.35	887	100.00

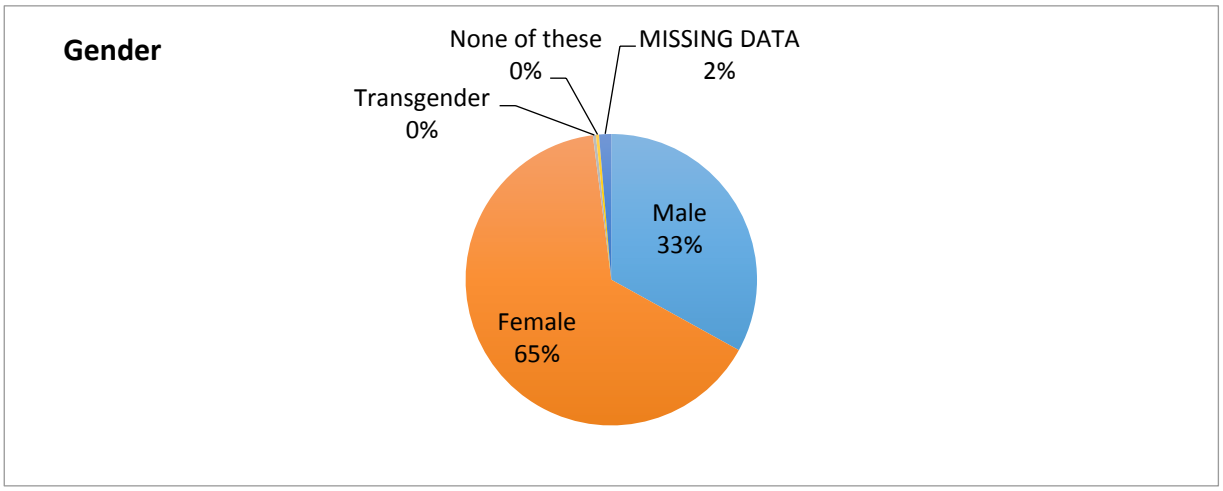


Fig. 2

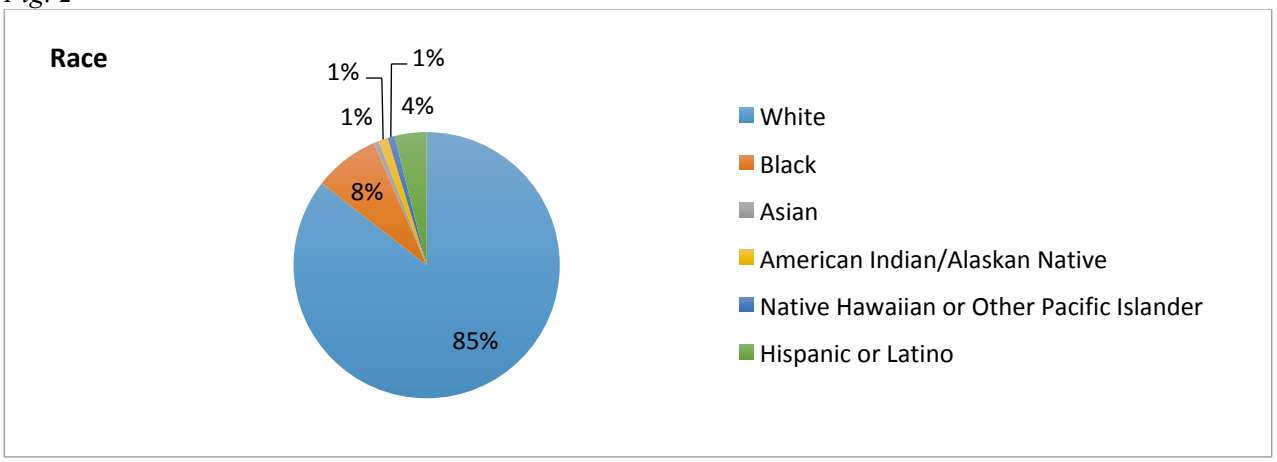


Fig. 3

Table 7: Race of Participants		
Race	Frequency Count	% of Total
White	775	85%
Black	72	8%
Asian	6	1%
American Indian/Alaskan Native	10	1%
Native Hawaiian or Other Pacific Islander	8	1%
Hispanic or Latino	35	4%

Table 8: Race and Ethnicity Combined				
Race/Ethnicity – including Multi-Race	Frequency Count	% of Total Frequency	Cumulative Frequency Count	Cumulative %
NH-American Indian Alaska Native	6	0.68	6	0.68
NH-Asian	5	0.57	11	1.25
NH-Black	67	7.63	78	8.88
NH-Native Hawaiian OPI	8	0.91	86	9.79
NH-White	753	85.76	839	95.56
Multi-Race	4	0.46	843	96.01
Hispanic	35	3.99	878	100.00

Table 9: Education of Participants		
Education	**Frequency Count**	**% of Total Frequency**
Less than high school	9	1.94
High school diploma or equivalent (GED)	102	21.94
Some college, but no degree	91	19.57
Associate's degree	66	14.19
Bachelor's degree	118	25.38
Master's degree	58	12.47
M.D. or D.O.	2	0.43
Other Doctoral degree or Equivalent	12	2.58
Other, specify	4	0.86
MISSING DATA	3	0.65

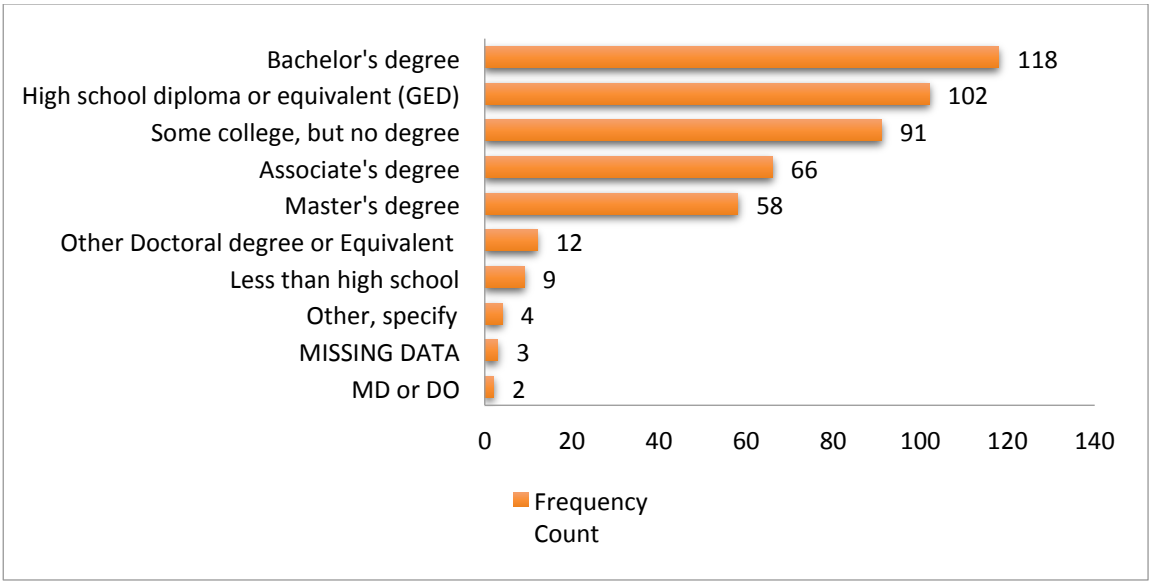


Fig. 4

C. **If there were noted increases or decreases in the populations originally reported in the DIS since the grant started, were any special efforts made to increase representation of groups that may have experienced health disparities?** Populations were as expected

overall. Efforts to increase representation occurred through community outreach, especially the large events either hosted by SARCC or done in collaboration with other community organizations. Hosting events virtually seemed to help with access to education by eliminating any transportation barriers or time barriers related to travel.

V. LESSONS LEARNED

Reflect over the 3-year grant period and share what have been some of the most meaningful experiences in terms of what the program has meant to the individuals and community (ies) served, what could have been done differently given other resources, and what has been the legacy.

SARCC sought BCOR funding to support its commitment to expanding access to and the quality of recovery support services. It took to heart the title of the funding to "Build Communities of Recovery" largely do to its commitment as a peer-run, peer-driven non-profit organization. SARCC has for over 25 years held the recovery vision, authenticity of voice, and accountability to the recovery community. SARCC has been and remains the place where individuals seeking recovery from substance use disorders and or mental health challenges have found assistance largely from Certified Peer Support Specialists. This grant further elevated the recognition of SARCC and its work in the community. During this funding period SARCC received the following awards and recognitions:

- 2019 Ohio Senate 133rd General Assembly Advocate of the Year Award recognizing Mary and Joey Supina
- 2019 Ohio Senate 133rd General Assembly Outstanding Achievement Award
- 2019 U.S. Senate Special Recognition Innovation & Critical Work Responding & Preventing Addiction in Ohio Award to Sandusky Artisans
- 2019 U.S. Senator Robert Portman Addiction Policy Forum Innovation Award to Joey & Mary Supina
- 2019 House of Representative 133rd General Assembly of Ohio commendation to Mary &
- Joey Supina
- Ohio County Behavioral Health Authorities Advocates of the Year Award Mary and Joey Supina
- 2019 House of Representative 133rd General Assembly of Ohio Special Recognition to Sandusky Artisans for Ohio Innovation Now Award

There are lessons learned with every project, which we are framing as successes and challenges.

The **first success** is related to the continued progress across all three of the project's goals and the corresponding objectives. Even with the challenges faced in years two and three related to the COVID-19 pandemic, SARCC was able to host its Best Practice events and surpass its targets. We are grateful for the ability to quickly strategize and utilize technology, as these factors allowed SARCC to continue to deliver Best Practice Events and other RSS. The key lessons learned here are in being flexible in how to still offer events, despite challenging circumstances, and to really focus on self care. This year was not an easy one, despite the release of vaccines and the hope that things would return to normal. It was taxing and at many times frightening, which takes a toll on the body, mind, and spirit.

The **second success** is the continued recognition of the importance of RSS in Erie County and the contiguous counties that often reach out to SARCC for Peer Support services and other RSS. The collaboration with partners outside of the behavioral health system creates an expansion in the understanding that recovery and wellness impacts everyone. Partnership with Townsend Community Schools is one example of how an RCO can create a space for others to learn and grow. The partnership

with Sandusky Schools to host a national speaker and share the message of prevention is another example of building bridges across systems and building that Community of Recovery, as the BCOR grants emphasize. The lesson learned here is the power of living recovery out loud and generating that visibility.

The **third success** is related to SARCC's building renovation and capital campaign. Renovations began in June 2020 and were completed in the late spring/early summer of 2021. The result was a building that is accessible to persons with disabilities, including an elevator that will reach all three floors. There are two additional rooms for larger groups and trainings and a new kitchen to support the many community events.

The **challenges** were largely a result of unforeseen circumstances related to the pandemic. The rapid shift from in-person interactions was the first challenge that we had to overcome. Staff and Peers quickly learned how to use virtual platforms to meet individually and in larger groups. Services at the SARCC building shifted to virtual, 12-step support and other recovery support meetings became online, and all events were held through Zoom and other platforms. It was exhausting to live through a stay-at-home order and an online world while trying to remain safe and health, yet SARCC was able to survive and thrive. We were still able to meet our grant objectives and be a source of support for so many people in recovery who were really struggling during this time of great isolation.

VI. EVALUATION

A. Describe GPRA intake and follow-up rates for the 3 years and any challenges experienced reaching your goals. Provide a brief explanation of how you went about overcoming challenges.

GPRA follow-up rates improved across the three years. Currently, the SPARS system does not have the capacity to calculate the follow-up rate for individual events, nor does it account for events that are very large and therefore exempt from the 30-day follow up requirement. In this section we provide a detailed breakdown of the meetings and trainings conducted in Y1 that were smaller than 100 people where the 30-day follow up was required, followed by the Best Practice events in Y2 and 3.

Table 10: Y1 Rates					
	Meetings (Y1)				
	Date	***Title***	***Post Event***	***Follow-up***	***Percentage***
1	4.25.2019	Wellness/Advocacy Symposium	Exempt – large event		
2	5.22.2019	Camp Recovery	Exempt – large event		
3	8.26.2019	Monday Connections	12	5	41.7%
4	8.26.2019	Recovery Meditation	3	2	66.7%
5	8.27.2019	Breaking the Chains	7	5	71.4%
6	8.28.2019	Whole Health Action Management (WHAM)	12	8	66.7%
7	8.30.2019	Friday Connections	12	8	66.7%
8	8.30.2019	Concord Care WHAM	5	0	0%
9	8.31.2019	Summers End Camp Recovery	Exempt – large event		
10	9.9.2019	Just Move	4	1	25%
11	9.14.2019	Annual Recovery Walk	Exempt – large event		
	Trainings (Y1)				
	Date	***Title***			
1	5.4.2019	Peer Support Training	6	6	100%
2	6.27.2019	Understanding Compassion and Fatigue	11	8	72.7%
3	6.28.2019	Organizational Wellness	11	7	63.6%

5	7.18.2019	Working with Unique Populations	12	10	83.3%
6	7.19.2019	Grief and Loss in the Workplace	10	7	70%
7	8.15.2019	Ethics and Boundaries	19	3	15.8%
8	8.16.2019	Faces and Voices – Our Stories have Power	8	2	25%

The average rate for the 30-day follow-up in Year One was 51.7%.

Table 11: Y2 Best Practice Rates				
Date	***Event Title***	***Post Event***	***30-day follow-up***	***Follow-up Percentage***
2.19.2020	Dr. Nicole Labor: Addiction 101	181	Exempt	N/A
5.12.2020	Connections: 8 Dimensions of Wellness	11	11	100%
6.4.2020	Virtual Wellness Symposium*	19*	5*	26%
6.23.2020	Ethics and Boundaries Training	25	21	84%
9.26.2020	Virtual Recovery Walk	79	Exempt	N/A

The average rate for follow-up for the non-exempt events was 90%; this rate drops to 70% when we add in the Virtual Wellness Symposium. The Virtual Symposium was a large event that should have been exempted from follow-up; however, at the time of the event, we had a different FPO who was uncertain about exemptions; therefore, we had 19 participants who were willing to complete the post-event survey and five participants who were willing to complete the follow-up. Normally, this event would be exempt because of its size. There were actually 75 people who participated from across the community.

Table 3 provides the breakdown by event and includes the average follow-up percentage, which was 81.87. The rate of completion ranged from 70.59% to 95.54%.

Table 12: Y3 Best Practice Rates			
Event	***Baseline Completed***	***Follow-Up Completed***	***Rate of Completion***
Trauma Informed Care	22	21	95.54%
Ethics and Boundaries	23	20	86.96%
Human Trafficking	34	24	70.59%
Diversity, Equity, and Inclusion	12	9	75%
Non-Violent De-escalation	16	13	81.25%

The average follow-up rate was 81.87%. The Virtual Wellness Symposium was one of the events that was open to the community and therefore, many participants did not consent to completing a baseline. There were 19 people who agreed to complete the baseline survey and 9 people who consented to completing a follow-up survey. Therefore, the rate of completion for follow-ups for this event was 47.36%. Again, this event was not targeted solely at Peer Supporters; rather, it was open to anyone in the community, which makes it more challenging to obtain consent from participants because they do not necessarily see themselves as being part of a project.

Satisfaction and Professional Benefit of Events

The majority (96.28%) of participants were either *Very Satisfied* (81.17%) or *Satisfied* (15.11%) with the events hosted by SARCC.

Table 13: Overall Quality				
How satisfied are you with the overall quality of this event?	Frequency Count	% of Total Frequency	Cumulative Frequency Count	Cumulative %
Very Satisfied	720	81.17	720	81.17
Satisfied	134	15.11	854	96.28
Neutral	17	1.92	871	98.20
Dissatisfied	1	0.11	872	98.31
Very Dissatisfied	5	0.56	877	98.87
MISSING DATA	10	1.13	887	100.00

In Year One, participants were asked to rate their level of agreement with the statement "I expect this training/meeting/TA to benefit my clients." The majority (93.13%) of participants either *Strongly Agreed* (78.91%) or *Agreed* (14.22%). In Years 2 and 3, this question was removed from the event survey and was changed to "I expect this event to benefit my professional development and/or practice. Again, the majority of participants (90.97%) either *Strongly Agreed* (69.68%) or *Agreed* (21.29%).

Table 14: Benefit to Clients				
I expect this training/meeting/TA to benefit my clients.	Frequency Count	% of Total Frequency	Cumulative Frequency Count	Cumulative %
Strongly Agree	333	78.91	333	78.91
Agree	60	14.22	393	93.13
Neutral	23	5.45	416	98.58
Strongly Disagree	4	0.95	420	99.53
MISSING DATA	2	0.47	422	100.00

In Year One, participants were posed several questions related to satisfaction, as detailed in Table 15.

Table 15: Satisfaction Measures Y1		
Questions	**% Responding**	**Average Score**
How satisfied are you with the overall quality of this meeting?	99.53%	1.23
How satisfied are you with the quality of the information/instructions from the meeting?	99.70%	1.24
How satisfied are you with the quality of the meeting materials?	99.29%	1.27
Overall, how satisfied are you with your meeting experience?	99.53%	1.23
Average Usefulness Score: 1.25 (Very Satisfied)		
Scoring Scale: 1: Very Satisfied; 2: Satisfied; 3: Neutral; 4: Dissatisfied; 5: Very Dissatisfied		

In Year One, participants were asked about the usefulness of trainings and meetings. There were three questions posed to 422 respondents, as detailed in Table 16.

Table 16: Usefulness Measures		
Questions	**% Responding**	**Average Score**
The material presented in this meeting will be useful to me in dealing with substance abuse.	99.29%	1.30
I expect to use this information gained from this meeting.	99.76%	1.28
How useful was the information you received?	96.45%	1.25
Average Usefulness Score: 1.28 (Very Useful)		
Scoring Scale: 1: Very Useful; 2: Useful; 3: Neutral; 4: Useless		

Recommendation of Event to Others

During Year One, 82.94% of participants *Strongly Agreed* that they would recommend the training or meeting to a colleague and 13.51% *Agreed* that they would recommend the training or event to a colleague; combined they represented 96.45% of total participants. In Years Two and Three the question changed to a "Yes or No" response regarding recommendation; 98.49% of participants indicated that they would recommend the event to a colleague.

Table 17: Recommendation of Training/Meetings

I would recommend this training/meeting/TA to a colleague.	Frequency Count	% of Total Frequency	Cumulative Frequency Count	Cumulative %
Strongly Agree	350	82.94	350	82.94
Agree	57	13.51	407	96.45
Neutral	9	2.13	416	98.58
Strongly Disagree	4	0.95	420	99.53
MISSING DATA	2	0.47	422	100.00

Table 18: Recommendation of Events

I would recommend this event to a colleague.	Frequency Count	% of Total Frequency	Cumulative Frequency Count	Cumulative %
No	2	0.43	2	0.43
Yes	456	98.06	458	98.49
MISSING DATA	7	1.51	465	100.00

B. Please note any evaluation topics that were under study and current results, if any.

Please see Appendix A Defining Access and Quality Literature Review. As stated earlier in this report, although "access" and "quality of care" have been explicitly defined and measured in healthcare, this information has been scarcely defined or applied to substance use disorder (SUD) treatment and recovery support services (RSS)—broadly defined here as non-clinical services that assist individuals to maintain long-term recovery from behavioral health disorders including SUD. The lack of clear definitions and measures for access to care and quality of care specific to SUD intervention across the spectrum of care can hinder program evaluation and continuous quality improvement efforts among providers and agencies providing SUD treatment and RSS (Pannella Winn & Paquette, 2016). More purposeful efforts to define and measure access to and quality of SUD care (including RSS) is required to provide evidence-based, effective services to facilitate recovery from substance use and improve individual and public health. The evaluation team conducted a literature review on access and quality of RSS and developed a detailed report (shared in this Grant Closeout Report) and an Issue Brief (shared with the Y3 Annual Report).

VII. GRANT BUDGET CHECK

A. Using the table below, please list: (1) your **actual grant year-to-date total expenditures in the first column**, (2) your **year-to-date grant budget as approved in the second column**, and (3) your **calculated variance in the third column**.

Variance is the difference between the actual year-to-date and budgeted expenditures divided by the budgeted year-to-date (YTD) expenditures. A negative variance means you are underspent; a positive variance means you are overspent.		
(1) Actual Expenditures YTD	***(2) Budget YTD***	***(3) Variance***
$249,664.03	YTD budget of $267,989.26	$18,325.23

B. If there is a variance of more than 15% (positive or negative) between budgeted and actual annual expenditures, briefly explain why and how you addressed the variance. N/A; the variance is not more than 15%; the remaining unexpended funds are 6.837%.

C. Did you expend 100% of grant funding for the 3 years? If not, why, and what amount of unexpended funds you requested for a NCE and how do you anticipate using those funds? N/A; SARCC did not request a NCE because it anticipated spending nearly all the funds.

VIII. SUCCESS STORY(IES) – *Please include any individual or group success story(ies) that you would like to share with SAMHSA. A signed Release of Information form is necessary.*

As stated in the Y3 Annual Report, Rather than an individual success story, we will share a success story related to the theme of "building communities of recovery." In the third and final year of this funding, SARCC fought through the obstacles of the COVID-19 pandemic and increased rates of drug overdoses and overdose deaths during the pandemic. Despite these very challenging circumstances, SARCC was able to provide recovery support services, conduct advocacy work, expand its reach into the community, and complete the renovations of its building and safely open its doors again. During a time when many organizations struggled or had to shudder, SARCC was able to thrive. The ability to thrive is largely connected to the mission of the organization and its steadfast commitment to the community.

These three years of grant funding allowed SARCC to truly build out the community of recovery in so many ways and there is growing momentum for the importance of recovery support services within Ohio. Both Joey and Mary Supina remain actively involved at the federal, state, and local level to advocate for access to recovery support services and for the quality of those services to be upheld.

Please see the Appendices for additional information.

- *Appendix A: Substance Use Disorder Treatment and Recovery: Definition and Measurement of Access and Quality. A Literature Review.*
- *Appendix B: SARCC Evaluation Plan*
- *Appendix C: SARCC Cumulative List of Events*

2021

Substance Use Disorder Treatment and Recovery: Definition and Measurement of Access and Quality

A LITERATURE REVIEW

Prepared for Sandusky Artisans by: Mighty Crow Media, LLC | www.mightycrow.com

Table of Contents

For questions about this report, please contact Rebecca McCloskey, Director of Evaluation at Mighty Crow, rebecca@mightycrow.com.

Substance Use Disorder Treatment and Recovery: Definition and Measurement of Access and Quality
A Literature Review

Defining Access

In healthcare, the term "access" generally refers to the ability to obtain physical and/or mental health care services that meet an individual's unique needs and preferences (Ralston et al., 2009). The Institute of Medicine (IOM)'s Committee on Monitoring Access to Personal Health Care Services defines access as "the timely use of personal health services to achieve the best possible outcomes" (Millman, 1993). Further, the United Nations Office of the High Commissioner for Human Rights (OHCHR)—in addition to declaring that the human right to health includes access to health care and health-related information—emphasizes that health care must be non-discriminatory and financially and physically accessible to all, particularly for those considered most vulnerable (e.g., children, older adults, those with disabilities) (OHCHR, 2008). Thus, healthcare access represents a layered concept that is often complicated and sometimes wholly prevented by various obstacles; so much so that much of the literature on access focuses on multi-level factors that prevent timely access to quality health and mental health care.

In the United States, health and access to healthcare are not universally perceived as human rights (Christopher & Caruso, 2015). This cultural belief shapes a significant barrier to healthcare access. While universal healthcare coverage can lead to an improvement in healthcare access and quality, access is not universal and is primarily tied to wealth and full-time employment (often for a minimum of 90 days or more). As a result, access is often more difficult for individuals with stigmatized identities, such as those recovering from substance use disorders (SUDs).

Access to care is multidimensional and individuals may be affected by facilitators or barriers across each dimension. Gulliford and colleagues (2002) examine access in terms of (1) service availability (whether or not there is an adequate supply of services to meet the need); (2) utilization of services and personal, financial, and organizational barriers (affordability, physical accessibility, and personal and cultural acceptability of services); (3) relevance and effectiveness (the right services and/or best possible outcomes of care); and (4) equity (ability to meet the needs of different population groups in terms of availability, utilization, and outcomes). The presence or absence of these factors facilitates or prevents access to appropriate, acceptability, and effective care in a timely fashion.

Taken from another perspective, Millman (1993) identifies the structural (e.g., availability of services; availability of transportation to services), financial (e.g., levels of insurance coverage; out-of-pocket fees), and personal (e.g., cultural beliefs, language, level of education, income) barriers that affect the degree to which individuals can acquire necessary health services and reminds that access can be facilitated, prevented, or limited for any and all individuals—whether they have health insurance or

not. Barriers affect the receipt of services; further, health-related outcomes and health equity are influenced by whether the care received was appropriate, effective, delivered by qualified providers, and accepted and acted upon by the patient (see Figure 1).

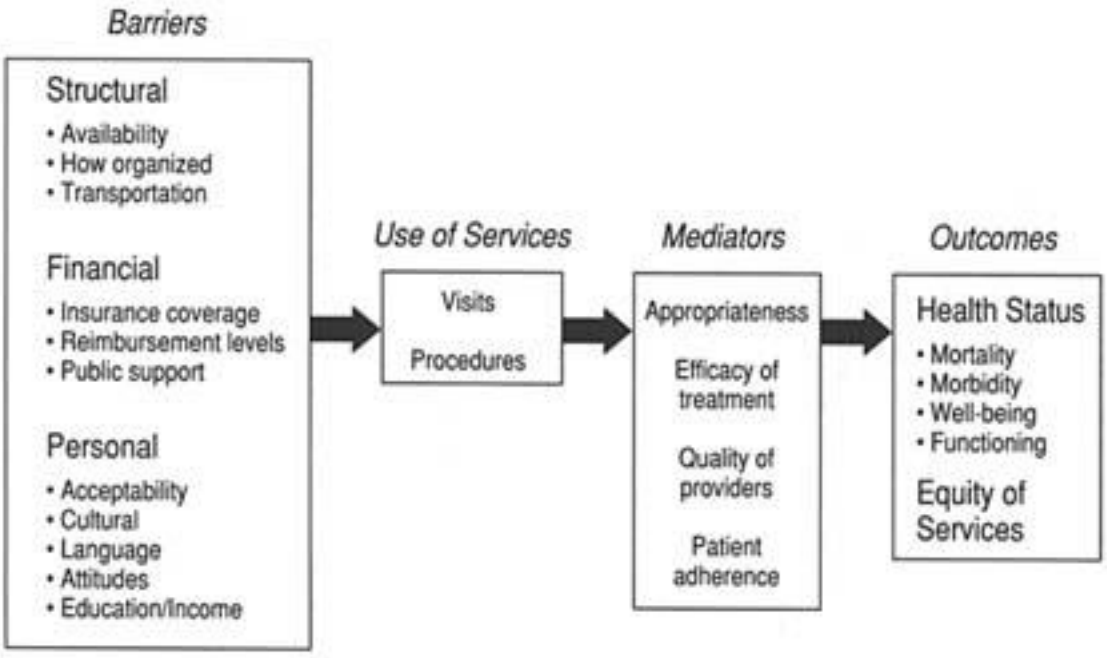


Figure 1. Model of access to personal health care

Barriers to Access for Individuals with SUD

Individuals with SUDs experience additional and unique barriers to healthcare access broadly, as well as barriers to SUD-specific treatment. Barriers to care can be categorized as personal, provider, and/or system related. In three studies (Neale et al., 2008; Ross et al., 2015; Wang et al., 2016) of over 2,600 patients with SUDs (in England and Canada), the most common personal barriers to accessing health care were mental health symptoms (e.g., anxiety, depression), drug side effects, feeling unwell, fear (of being mistreated, receiving a serious diagnosis, having children removed from one's care), concerns related to their children, and a lack of personal and economic resources (e.g., housing, transportation). Provider-related barriers included stigma and negative attitudes towards individuals with SUDs, lack of knowledge regarding mental health and SUDs, a rush to prescribe medication, and poor care. System-related barriers included complex paperwork, having too many appointments in different locations, long wait times, being rushed through appointments, high staff turnover, and poor communication between providers.

Barriers to accessing SUD-specific treatment overlap with the barriers to healthcare listed above. Costs associated with treatment, the convenience of treatment, societal stigma, and provider attitudes have all been identified as barriers to SUD treatment (Marchand et al., 2019). Additional personal barriers include beliefs that individuals should be strong enough to recover from SUD on their own, hoping the problem would resolve itself, and shame and embarrassment (Perron et al., 2009). Individuals with SUDs who were also experiencing homelessness reported barriers related to

transportation between shelters and treatment locations, childcare and related safety concerns, stigma, and limitations of available buprenorphine prescribers (Chatterjee et al., 2017). An additional access barrier relates to disparities created by racism and discrimination. Using Collaborative Psychiatric Epidemiology Surveys, Lo and Cheng (2011) found that non-Hispanic Whites were more likely than all other racial and ethnic minority groups to access a specialized treatment facility (e.g., inpatient, intensive outpatient, and/or other mental health care provided by professional staff trained in SUDs). All other racial groups were more likely to access non-specialty or primary care only (e.g., medical providers not specializing in SUD; religious leaders; self-help groups). Black Americans were the group least likely to report accessing either type of care for SUDs.

Recovery Support Services

As SUD treatment gradually shifts from an acute care to chronic disease management model that is recovery-oriented, the importance of recovery support services (RSS) receives more attention from service providers and potential funders. Recovery from SUD is a long-term process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential (SAMHSA, 2020). Thus, recovery cannot happen in isolation and requires a combination of internal (e.g., counseling, coping strategies) and external (e.g., community engagement; housing and employment stability) supports (Best & Lubman, 2012; Laudet & Humphreys, 2013; SAMHSA, 2020). RSS provide internal and external support individuals need to achieve and maintain long-term recovery from SUD. RSS often refer to non-clinical, peer-driven sources of support (Cousins et al., 2012). While not a substitute for substance use treatment, RSS, serves a primary role in helping individuals recover from SUDs. Examples of RSS include sober living homes, recovery high schools, self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), peer support programs, and social services that may assist with various types of temporary aid, housing, education, and employment.

Barriers to SUD treatment also exist for access to RSS. While recovery-oriented behavioral healthcare should promote "swift and uncomplicated entry" to support (SAMHSA, 2008, p. 12), RSS may include even more obstacles than SUD treatment. RSS are frequently excluded from the continuum of care and encounter funding instability resulting in limited accessibility of services (Pannella Winn & Paquette, 2016). Because sustainability challenges of RSS can contribute to the accessibility of services among people with SUD, ensuring that RSS is included in the continuum of SUD treatment and covering the full continuum of care under Medicaid is crucial for low-income populations (Bailey et al., 2021). In other words, leveraging Medicaid expansion and local policies to cover the full spectrum of RSS can enhance the accessibility and quality of RSS. Additionally, addressing inequalities and expanding the capacity of RSS in under-resourced communities can further enhance the inclusiveness of RSS.

It is also important to address the numerous environmental barriers (e.g., transportation barriers, unsafe neighborhoods) that hinder individuals from access (Dey et al., 2017). Improving the accessibility to various federal programs (e.g., childcare) that meet people's psychosocial needs can improve the utilization of RSS (Bailey et al., 2021). Clear definitions of RSS can also facilitate the service navigation process among people with SUD (Bassuk et al., 2016). Additionally, limited RSS may exist in some geographical locations. For example, recovery community organizations (RCOs)—nonprofit groups created by representatives of local communities in recovery—are primary providers of RSS, yet among the 88 counties in Ohio, only 10 of them have RCOs (OhioMHAS, 2021). RCOs and other providers may need support to apply for grants and seek other funding mechanisms to complement Medicaid-funded

RSS (Bailey et al., 2021). Moreover, clear and consistent definitions of each type of RSS (e.g., recovery housing, peer support) and education on the full spectrum of funding opportunities can enhance funding stability and accessibility of RSS (Pannella Winn & Paquette, 2016).

To further address the access disparity of RSS, a systematic review suggested that digital recovery support services (DRSS) might help improve the accessibility of RSS by minimizing the need for transportation. DRSS can also reduce the cost of delivery by providing RSS in publicly available, free online platforms, and smart phones (Ashford et al., 2020). There is a need for more rigorously designed studies and DRSS might not provide the same magnitude of support compared with in-person RSS, however, researchers suggested that DRSS played an important role in preventing relapses and enhancing recovery outcomes during the COVID-19 pandemic (Bergman et al., 2020). DRSS can also easily reach international audience while providing tailored services to specific groups (e.g., LGBTQ individuals) compared with in-person RSS. DRSS is highly attended among younger people (Ashford et al., 2019). However, like the limitation of other digital interventions, DRSS requires access to digital devices and reliable internet, which currently restricts its' application in some low-income neighborhoods and rural areas (Ashford et al., 2019).

Measuring Access

Healthcare and SUD treatment access have been assessed both quantitatively and qualitatively in the literature. In terms of survey data, study participants may be asked simple binary (e.g., yes/no) questions regarding whether they were able to access the healthcare they needed, whether it was accessed in a timely fashion, and whether they experienced barriers to access. Lo and Cheng (2011) asked individuals with a history of SUD where they accessed treatment (e.g., primary care or specialty SUD care), how many times they accessed each type of care, and which type of treatment was received first.

Most quantitative measures focus on barriers to healthcare access. The Group Health's annual Consumer Assessment of Healthcare Providers and Systems survey (CAHPS) asks patients (accessing care for any reason) to rate how much of a problem it was to access care, how often they received the help they needed in a timely fashion, the amount of time spent scheduling appointments, and the ease of accessing care (Ralston et al., 2009). When it comes to accessing care among individuals with SUDs, it is important to allow opportunities for identifying specific barriers; in response, interventions and policy changes can be developed that better facilitate access. Wang and colleagues (2016) asked over 2,400 Canadians who injected drugs if there was a time in the previous six months that they needed healthcare or social services but could not obtain them. If they responded in the affirmative, they were asked to identify which type(s) of care, service(s), or provider(s), they could not access from a variety of categories. Additionally, they collected data on individuals' mental health diagnoses and other characteristics (e.g., housing and food insecurity) and looked for associations between them and barriers to access. In another study, participants were asked if they experienced any barriers to help for their drug use. Those who said "yes" were then asked to choose as many barriers as were applicable to their situation from a list of 27 (Perron et al., 2009). Potential barriers included participants' personal beliefs, health status and symptoms, financial insecurity, lack of emotional and practical support, childcare needs, transportation, and addiction stigma.

Qualitative data gives context and depth to the quantitative data on reported barriers to care. Individuals' stories shed light on the complexity of needs, situations, and structures that create barriers to healthcare and substance use treatment, particularly for marginalized groups. Questions, such as, "What has been your experience of accessing care for your physical and/or mental health? How easy or difficult is it to get the care you need? What makes it easy or hard? What are the primary reasons for being unable to access the care you need? If you had the power to change how you access or receive healthcare and treatment related services and supports, what would you do?" have been used to gather in-depth information about personal, provider, and systemic barriers and facilitators to healthcare access and their weightiness (O'Donnell et al., 2016; Ross et al., 2015).

Resembling measures for treatment access, access to RSS have been primarily measured by the frequency of utilizing a particular type of RSS. Unfortunately, not all service providers systematically document the number of RSS accessed by clients because it is not always a requirement in data monitoring system (Cousins et al., 2012). Additionally, the lack of appropriate recovery measures, the amount of time, energy, and training needed to appropriate document RSS use and recovery outcomes further hinder the documentation of RSS among providers (Cousins et al., 2012). In addition to measuring the frequency of utilization, other studies shed light on the barriers to RSS accessibility, such as transportation barriers, cost of delivery, and limited availability of RSS in a certain geographic area. With the increasing prevalence of digital recovery support services (DRSS)—RSS delivered via technological platforms such as smartphone applications, websites, and social media—researchers are investigating the effectiveness of DRSS compared with in-person RSS (Ashford et al., 2019).

Defining Quality

Quality has been primarily defined by the fields of medicine and business and often emphasizes consumer perspectives. Because there has been so little written about quality in the context of addiction and recovery services specifically, we provide an overview of quality in terms of healthcare received. The IOM defines quality as the extent in which health care services "increase the likelihood of desired health outcomes and are consistent with current professional knowledge;" quality care should be safe, effective, timely, efficient, equitable, and patient-centered (Cleary & O'Kane, 2014). Quality, however, may be perceived differently by patients, healthcare staff, administrators, policymakers, and insurance providers. For patients, overall satisfaction with care may be the most important aspect of quality; for providers, it may be providing the recommended care according to current guidelines; for insurers, it may be whether the most cost-effective treatment was prescribed (Mosadeghrad, 2013). Thus, the definition of quality is largely influenced by the assessor.

Often, research focuses on quality from a patient perspective (AHRQ, 2015; Urbanoski & Inglis, 2019). Reports of patient satisfaction are generally equated with quality and represent a multifaceted concept consisting of patient experiences and perceptions of timely access to care, effective pain and symptom relief, patient-provider communication and relationship, provider expertise, receiving useful information from providers, comfort and the hospital environment, and expectations of care compared to actual care (Cimas et al., 2016; Grondahl et al., 2018). Cleary and O'Kane (2014) refer to these as process measures and account for whether a patient believe they received quality care. Process-focused measures may also track the kind of care and the number of people who received a certain type of care for their condition (AHRQ, 2015).

In addition to process measures, additional aspects of quality may include structural concepts (e.g., the physical space in which care was provided; personnel; healthcare policy) and outcomes (e.g., patient's health status and level of improvement after receiving care). This information can be gathered by patient report and/or through accessing administrative or medical records. Information collected directly from patients may be subject to reduced bias when compared to administrative or provider data which may be influenced by reimbursement incentives or desire to improve apparent performance (Cleary & O'Kane, 2014).

Quality of Recovery Support Services

As interventions for SUD shift from acute treatment towards the long-term management, being recovery-orientated is an important indicator of high-quality SUD treatment and support. A recovery-oriented system of care generally has the following features: provides person-centered and individualized treatment that is age and gender appropriate; engages family members and allies; strength-based; is locally available; offers services on a continuum (e.g., prevention, treatment); is evidence-based and outcomes-driven; and has a higher emphasis on collaboration than competition among providers (SAMHSA, 2008). To meet the needs of people with SUD, RSS must be flexible in nature, responsive and respectful to individuals' personal and cultural belief systems, attentive to diversity in its application, and aim to reduce disparities in care access and health outcomes (SAMHSA, 2020).

To ensure the quality of RSS, several states have standardized the training and certification of peer supporters and providers of other types of RSS. Workforce development plays a critical role in enhancing the quality of PRSS. Peer supporters differ from recovery allies who support people in recovery without personal lived experiences of SUD and/or mental illness (Eddie et al., 2019). The roles of peer supporters often vary from setting to setting, ranging from unpaid volunteer to paid clinical peer supporter (Jack et al., 2018), making it critical and challenging to define the responsibilities of peer supporters (Eddie et al., 2019). Other states focus more on establishing practice guidelines and standards for various types of RSS that allow efficient quality assessment of RSS (SAMHSA, 2008). In Ohio, the training and certification requirements for peer supports is currently being reviewed. However, peer supporters can gain certification via the completion of online courses, passing an exam and background check, and through previous work experience or additional in-person training.

Measuring Quality

Quality measurements (e.g., whether focused on structure, process, and/or outcomes) should be chosen based upon a study's research questions and what information is being sought (Cleary & O'Kane, 2014). Questionnaires may be targeted to address one or all elements previously described. If assessing whether health improvements were achieved, then outcomes focused measures may be most relevant. On the other hand, if patient perceptions of care are of interest, then process measures are preferred.

It is very common to assess patient satisfaction and quality using survey questions with Likert (5- or 7-point) scale responses. Patient perceptions are fairly simple to collect after a healthcare encounter, are cost-effective, and do not require accessing administrative and/or protected healthcare information (Haddad et al., 2000). Questions generally assess patients' experiences, opinions, and satisfaction with various domains of the care received, including the hospitality of the registration staff, wait time,

respect for dignity and privacy, staff expertise, staff communication, comfort, information provided, the types of treatment provided, and inclusion in decisions about one's care.

Although asking patients to rate their experiences is a generally accepted mode for measuring quality, it is important to note that many healthcare quality assessment tools have not been evaluated for reliability or validity (Cimas et al., 2016). This is even truer for tools focused on SUD treatment (Garnick et al., 2012). Therefore, it is vital to choose tools and questions that support the goals of the assessment (e.g., improving treatment and patient perceptions of quality of care) and are easy to understand for the population of interest (AHRQ, 2018). Additionally, when possible, validity testing—reviewing and editing questions with content area experts and individuals representing the targeted population—should be undertaken. Though not as commonly used to assess quality, qualitative methods (e.g., individual interviews, focus groups) can complement survey findings and can be used to garner detailed information about what means most to patients in terms of quality and recommendations for improving quality (Pope et al., 2002).

Measuring Quality for SUD Treatment

Much literature has pointed to the limitations in progress toward the development of universal tools to assess quality and quality improvement in SUD treatment (Garnick et al., 2012; Hepner et al., 2017; Pincus et al., 2011). Garnick and colleagues (2012) state that additional studies are needed to identify reliable and valid tools for measuring quality to make data-informed improvements to SUD care. As SUDs are considered chronic illnesses, this is especially necessary for better understanding process measures and their relationship to patient outcomes (e.g., quality of life, abstinence, addiction severity, arrests and incarceration, and cost-effectiveness of different treatments) in the short- and long-term. SUD treatment quality measures could further elucidate which interventions are best for which groups of people (e.g., women, adolescents, individuals who are incarcerated, etc.), and how quality relates to level of engagement in treatment, the intensity of treatment, the relationship between patient and providers, retention, and recovery supports. Further, the researchers suggest that the future of quality assessment in SUD treatment should be inclusive of assessing performance by level: client, system, facility, and community, and should examine the biological, behavioral, and environmental aspects of addiction.

The 2001 IOM's *Crossing the Quality Chasm: A New Health System for the 21st Century* report laid out a framework for healthcare quality improvement, but there has been limited leadership in applying it, particularly in the fields of mental health and SUD care (Pincus et al., 2011). Informed by this information, however, existing performance measures in mental health and addiction tend to revolve around the recommended quality indicator domains of safety, effectiveness, efficiency, accessibility, timeliness, equity, and patient-centeredness (Marchand et al., 2019; Urbanoski & Inglis, 2019). There is growing evidence that these quality domains overlap with patient satisfaction and perception of healthcare quality. For example, a survey of over 2,000 patients from the Veterans Health Administration who had a SUD diagnosis examined eight process-focused quality measures (e.g., treatment accessibility and initiation within 14 days, two or more engagements within 30 days, psychotherapy or psychosocial treatment) based on administrative data and patient perceptions of their care (Hepner et al., 2017). Results showed that the quality measures were significantly associated with patients' perceived improvement and suggested that patient reports are useful in assessing quality of SUD care received.

Notably, patient-centered care has also received a lot of attention in the literature. In a scoping review of 149 articles that defined and measured patient-centered care among individuals with SUDs, Marchand and colleagues (2019) explained that patient-centered care improves the quality of healthcare through its four primary values: (1) integrating a holistic and integrative approach; (2) honoring patients' unique needs, goals, cultures, and preferences, (3) sharing power and decision-making between patients and providers, and (4) enhancing the therapeutic alliance between patient and care providers. Additionally, outcome indicators commonly assessed in the literature: Days of substance use, severity of use, number of treatment visits, retention, adherence to care, physical and mental health, self-efficacy, interpersonal relationships, shame and stigma, housing, stress, employment, legal problems, behaviors, trauma symptoms, balanced client-provider power, perceived environmental safety, ownership in treatment decisions, decisional quality and comfort, and reduced confusion with healthcare correspond with quality and patient-centered care principles. Patient-centered care, then, can be used as an evidenced-based approach to assessing and improving the quality of SUD intervention.

As discussed earlier, person-centered care and recovery orientation are also important indicators of the quality of RSS (SAMHSA, 2008). To provide specific guidelines to peer recovery support services (PRSS), recovery community support programs identified 12 common indicators of quality for PRSS at their Annual Technical Assistance Conference in 2005. These indicators provide guidance for the quality assessment of RSS and are as follows: (1) The differences between PRSS and professional treatment as well as mutual aid groups are clearly defined. (2) PRSS are truly peer-led and peer-driven the actual programming. (3) The PRSS has established mechanisms for the recruitment and retention of diverse peer leaders. (4) The PRSS makes intentional effort to cultivate the leadership of peer leaders. (5) The PRSS comply with stated ethical guidelines. (5) The PRSS reflects peer and recovery values. (6) The PRSS establishes principles of self-care and procedures for addressing any relapse of peer leaders. (7) The PRSS is non-stigmatizing, inclusive, and strengths-based. (8) The PRSS offers culturally sensitive services. (9) The PRSS provides a broad range of service referrals regardless of types of services offered. (10) The PRSS has well-established, mutually beneficial relationships with community stakeholders. (11) The PRSS has plans and resources for program sustainability. (12) The PRSS has well-documented governance, fiscal, and risk management practices in place for RSS (SAMHSA, 2008).

Recent studies also measured and provided some initial evidence on the effectiveness of different types of PRSS. Reif and colleagues (2014) reviewed existing randomized control trials, quasi-experimental studies, and pre-post assessments on PRSS. The researchers concluded that there was a moderate level of evidence showing that participation in PRSS was associated with lower rates of relapse, higher rates of treatment retention, better social relationships, and improved quality of life. Other researchers found that participation in RSS resulted in lower Medicaid costs than those receiving SUD treatment but not RSS (Wickizer et al., 2009). One RCT demonstrated that those who received the one-on-one peer-delivered motivational intervention along with a referral list and written instructions had lower rates of using cocaine and opiate and higher rates of abstinence at six months than those who received referral list and written instructions only (Bernstein et al., 2005). Future studies need to investigate the contribution of various components of PRSS (e.g., emotional support, service navigation, motivational interviewing) to treatment outcomes (Reif et al., 2014). More, large sample studies with appropriate control groups and a consistent definition of recovery outcomes might further specify the effectiveness and cost-effectiveness of PRSS (Laudet & Humphreys, 2013). The systematic reviews

conducted by Bassuk and colleagues (2016) identified similar aforementioned positive effects of PRSS while highlighting important methodological limitations, such as small sample sizes and the heterogeneity of the sample in existing studies. A recent systematic review conducted by Eddie and colleagues (2019) also supported the potential effectiveness of PRSS and recovery support groups while acknowledging methodological limitations in the current studies.

Lastly, it is important to once again note the value of including qualitative data to understand and assess SUD quality of care. Patients' personal experiences allow for a broader and richer understanding of the way in which quality is perceived. Questions such as, "What is it like to be a client in this program? How effective do you think this program is? What do you perceive as strengths of the program? How could the program be improved?" can better define quality through participants' viewpoints and use this information for comparison and ultimate improvement to program objectives and outcomes (LaFave et al., 2008). In summary, study findings show that patient perceptions of healthcare and SUD care quality—collected both quantitatively and qualitatively—should not be underestimated and are increasingly used to assess and improve quality of care.

Conclusion

To summarize, improving the access to and quality of SUD care requires long-term systematic effort. Compared with general healthcare, unique sustainability challenges among SUD treatment facilities and RSS (e.g., funding instability, lack of adoption of evidence-based practice) can impact their accessibility and quality (Ashford et al., 2018). Based on qualitative interviews on professionals in the field of substance use care (e.g., therapists, policy makers), studies suggest that limited treatment capacity, lack of technological support, insufficient recovery support services (e.g., recovery housing), lack of collaboration within and across organizations, and increasing unethical practices in the field (e.g., patient brokering based on incentives) are major areas of improvement within the SUD service system (Ashford et al., 2018). Clear and consistent definitions of SUD services and the adoption of both qualitative and quantitative assessment methods can shed more light on multi-level systematic factors and guide the quality improvement process across the spectrum of SUD care.

References

Agency for Healthcare Research and Quality [AHRQ] (2018, November). *Key questions when choosing health care quality measures.* Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/talkingquality/measures/measure-questions.html

Agency for Healthcare Research and Quality [AHRQ] (2015, July). *Types of health care quality measures.* Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/talkingquality/measures/types.html

Ashford, R. D., Bergman, B. G., Kelly, J. F., & Curtis, B. (2020). Systematic review: Digital recovery support services used to support substance use disorder recovery. *Human Behavior and Emerging Technologies, 2*(1), 18-32. https://do.org/10.1002/hbe2.148

Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Systemic barriers in substance use disorder treatment: A prospective qualitative study of professionals in the field. *Drug and Alcohol Dependence, 189,* 62-69. https://doi.org/10.1016/j.drugalcdep.2018.04.033

Bailey, A., Hayes, K., Katch, H., & Solomon, J. (2021). Medicaid Is key to building a system of comprehensive substance use care for low-income people. https://www.cbpp.org/sites/default/files/3-18-21health.pdf

Bergman, B. G., & Kelly, J. F. (2020). Online digital recovery support services: An overview of the science and their potential to help individuals with substance use disorder during COVID-19 and beyond. *Journal of Substance Abuse Treatment*. https://www.doi.org/10.1016/j.jsat.2020.108152

Bernstein, J., Bernstein, E., Tassiopoulos, K., Heeren, T., Levenson, S., & Hingson, R. (2005). Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence*, *77*(1), 49-59. https://doi.org/10.1016/j.drugalcdep.2004.07.006

Best, D. W., & Lubman, D. I. (2012). The recovery paradigm: A model of hope and change for alcohol and drug addiction. *Australian Family Physician*, *41*(8), 593. http://actrecovery.co.uk/resources/201208Best.pdf

Chatterjee, A., Obando, A., Strickland, E., Nestler, A., Harrington-Levey, R., Williams, T., & LaCoursiere-Zucchero, T. (2017). Shelter-based opioid treatment: increasing access to addiction treatment in a family shelter. *American Journal of Public Health*, *107*(7), 1092-1094. https://doi.org/10.2105/AJPH.2017.303786

Christopher, A. S., & Caruso, D. (2015). Promoting health as a human right in the post-ACA United States. *AMA Journal of Ethics*, *17*(10), 958-965. https://journalofethics.ama-assn.org/article/promoting-health-human-right-post-aca-united-states/2015-10

Cimas, M., Ayala, A., García-Pérez, S., Sarria-Santamera, A., & Forjaz, M. J. (2016). The patient satisfaction questionnaire of EUprimecare project: measurement properties. *International Journal for Quality in Health Care*, *28*(3), 275-280. https://doi.org/10.1093/intqhc/mzw024

Cleary, P. D., & O'kane, M. E. (2014). *Evaluating the quality of health care. e-source*. Retrieved from http://www.esourceresearch.org/Portals/0/Uploads/Documents/Public/Cleary_FullChapter.pdf

Cousins, S. J., Antonini, V. P., & Rawson, R. A. (2012). Utilization, measurement, and funding of recovery supports and services. *Journal of Psychoactive Drugs, 44*(4), 325-333. https://doi.org/10.1080/02791072.2012.718924

Dey J., Fuller L., Lamont H. (2017). State and local policy levers for increasing treatment and recovery capacity to address the Opioid epidemic: Final report. https://aspe.hhs.gov/basic-report/state-and-local-policy-levers-increasing-treatment-and-recovery-capacity-address-opioid-epidemic-final-report

Eddie, D., Hoffman, L., Vilsaint, C., Abry, A., Bergman, B., Hoeppner, B., ... & Kelly, J. F. (2019). Lived experience in new models of care for substance use disorder: A systematic review of peer recovery support services and recovery coaching. *Frontiers in Psychology, 10,* 1052. https://doi.org/10.3389/fpsyg.2019.01052

Eisenberg, J. M., & Power, E. J. (2000). Transforming insurance coverage into quality health care: voltage drops from potential to delivered quality. *JAMA*, *284*(16), 2100-2107. https://doi.org/10.1001/jama.284.16.2100

Garnick, D. W., Horgan, C. M., Acevedo, A., McCorry, F., & Weisner, C. (2012). Performance measures for substance use disorders–what research is needed? *Addiction Science & Clinical Practice,7*(18) https://doi.org/10.1186/1940-0640-7-18

Grøndahl, V. A., Kirchhoff, J. W., Andersen, K. L., Sørby, L. A., Andreassen, H. M., Skaug, E. A., ... & Helgesen, A. K. (2018). Health care quality from the patients' perspective: a comparative study between an old and a new, high-tech hospital. *Journal of Multidisciplinary Healthcare*, *11*, 591. https://doi.org/10.2147/JMDH.S176630

Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002). What does' access to health care' mean? *Journal of Health Services Research & Policy*, *7*(3), 186-188. https://doi.org/10.1258/135581902760082517

Haddad, S., Potvin, L., Roberge, D., Pineault, R., & Remondin, M. (2000). Patient perception of quality following a visit to a doctor in a primary care unit. *Family Practice*, *17*(1), 21-29. https://doi.org/10.1093/fampra/17.1.21

Hepner, K. A., Paddock, S. M., Watkins, K. E., Ounpraseuth, S. T., Schrader, A. M., & Hudson, T. J. (2017). Association between quality measures and perceptions of care among patients with substance

use disorders. *Psychiatric Services*, *68*(11), 1150-1156. https://doi.org/10.1176/appi.ps.201600484

Hepner, K. A., Watkins, K. E., Farmer, C. M., Rubenstein, L., Pedersen, E. R., & Pincus, H. A. (2017). Quality of care measures for the management of unhealthy alcohol use. *Journal of Substance Abuse Treatment*, *76*, 11-17. https://doi.org/10.1016/j.jsat.2016.11.006

Jack, H. E., Oller, D., Kelly, J., Magidson, J. F., & Wakeman, S. E. (2018). Addressing substance use disorder in primary care: The role, integration, and impact of recovery coaches. *Substance Abuse, 39*(3), 307-314. https://doi.org/10.1080/08897077.2017.1389802

LaFave, L., Desportes, L., & McBride, C. (2008). Treatment outcomes and perceived benefits: a qualitative and quantitative assessment of a women's substance abuse treatment program. *Women & Therapy*, *32*(1), 51-68. https://doi.org/10.1080/02703140802384743

Laudet, A. B., & Humphreys, K. (2013). Promoting recovery in an evolving policy context: What do we know and what do we need to know about recovery support services? Journal of Substance Abuse Treatment, 45(1), 126-133. https://doi.org/10.1016/j.jsat.2013.01.009

Lo, C. C., & Cheng, T. C. (2011). Racial/ethnic differences in access to substance abuse treatment. *Journal of Health Care for the Poor and Underserved*, *22*(2), 621-637. http://doi.org/10.1353/hpu.2011.0054

Marchand, K., Beaumont, S., Westfall, J., MacDonald, S., Harrison, S., Marsh, D. C., ... & Oviedo-Joekes, E. (2019). Conceptualizing patient-centered care for substance use disorder treatment: findings from a systematic scoping review. *Substance Abuse Treatment, Prevention, and Policy*, *14*(1), 37. https://doi.org/10.1186/s13011-019-0227-0

Millman, M. (Ed.). (1993). *Access to health care in America*. National Academies Press. Retrieved from: http://www.nap.edu/catalog/2009.html

Mosadeghrad, A. M. (2013). Healthcare service quality: towards a broad definition. *International Journal of Health Care Quality Assurance*. https://doi.org/10.1108/09526861311311409

Neale, J., Tompkins, C., & Sheard, L. (2008). Barriers to accessing generic health and social care services: a qualitative study of injecting drug users. *Health & Social Care in the Community*, *16*(2), 147-154. https://doi.org/10.1111/j.1365-2524.2007.00739.x

O'Donnell, P., Tierney, E., O'Carroll, A., Nurse, D., & MacFarlane, A. (2016). Exploring levers and barriers to accessing primary care for marginalised groups and identifying their priorities for primary care provision: a participatory learning and action research study. *International Journal for Equity in Health*, *15*(1), 197. https://doi.org/10.1186/s12939-016-0487-5

OhioMHAS (2021). Peer Run Organizations. https://mha.ohio.gov/Health-Professionals/About-Mental-Health-and-Addiction-Treatment/Peer-Support/Peer-Run-Organizations

Pannella Winn, L., & Paquette, K. (2016). Bringing recovery housing to scale in Ohio: Lessons learned. Journal of dual diagnosis, 12(2), 163-174. https://doi.org/10.1080/15504263.2016.1173971

Perron, B. E., Mowbray, O. P., Glass, J. E., Delva, J., Vaughn, M. G., and Howard, M. O. (2009). Differences in service utilization and barriers among Blacks, Hispanics, and Whites with drug use disorders. *Substance Abuse Treatment, Prevention, and Policy,* 4(3). https://doi.org/10.1186/1747-597X-4-3

Phillips, C., Schulkind, J., O'Sullivan, M., Edelman, N., Smith, H. E., Verma, S., & Jones, C. J. (2020). Improving access to care for people who inject drugs: Qualitative evaluation of project ITTREAT—An integrated community hepatitis C service. *Journal of Viral Hepatitis*, *27*(2), 176-187. https://doi.org/10.1111/jvh.13214

Pincus, H. A., Spaeth-Rublee, B., & Watkins, K. E. (2011). The case for measuring quality in mental health and substance abuse care. *Health Affairs*, *30*(4), 730-736. https://doi.org/10.1377/hlthaff.2011.0268

Pope, C., Van Royen, P., & Baker, R. (2002). Qualitative methods in research on healthcare quality. *BMJ Quality & Safety*, *11*(2), 148-152. https://dx.doi.org/10.1136/qhc.11.2.148

Ralston, J. D., Martin, D. P., Anderson, M. L., Fishman, P. A., Conrad, D. A., Larson, E. B., & Grembowski, D. (2009). Group health cooperative's transformation toward patient-centered access. *Medical Care Research and Review*, *66*(6), 703-724. https://doi.org/10.1177%2F1077558709338486

Reif, S., Braude, L., Lyman, D. R., Dougherty, R. H., Daniels, A. S., Ghose, S. S., ... & Delphin-Rittmon, M. E. (2014). Peer recovery support for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services*, *65*(7), 853-861. https://doi.org/10.1176/appi.ps.201400047

Ross, L. E., Vigod, S., Wishart, J., Waese, M., Spence, J. D., Oliver, J., ... & Shields, R. (2015). Barriers and facilitators to primary care for people with mental health and/or substance use issues: a qualitative study. *BMC family practice*, *16*(1), 135. https://doi.org/10.1186/s12875-015-0353-3

Senarat, U., & Gunawardena, N. S. (2011). Development of an instrument to measure patient perception of the quality of nursing care and related hospital services at the National Hospital of Sri Lanka. *Asian Nursing Research*, *5*(2), 71-80. https://doi.org/10.1016/S1976-1317(11)60015-7

Substance Abuse and Mental Health Services Administration (SAMHSA). The Role of Recovery Support Services in Recovery-Oriented Systems of Care White Paper (2008). http://www.pacdaa.org/SiteCollectionDocuments/SAMHSA%20White%20Paper%20on%20The%20Role%20of%20Recovery%20Support%20Services.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2020, April 23). *Recovery and recovery support*. https://www.samhsa.gov/find-help/recovery

United Nations Office of the High Commissioner for Human Rights (OHCHR) (2008). *Fact Sheet No. 31, The Right to Health*, No. 31. Retrieved from: https://www.refworld.org/docid/48625a742.htm

Urbanoski, K., & Inglis, D. (2019). Performance measurement in mental health and addictions systems: A scoping review. *Journal of Studies on Alcohol and Drugs*, Supplement, (s18), 114-130. https://doi.org/10.15288/jsads.2019.s18.114

Wang, L., Panagiotoglou, D., Min, J. E., DeBeck, K., Milloy, M. J., Kerr, T., ... & Nosyk, B. (2016). Inability to access health and social services associated with mental health among people who inject drugs in a Canadian setting. *Drug and Alcohol Dependence*, 168, 22-29. https://doi.org/10.1016/j.drugalcdep.2016.08.631

Wickizer, T. M., Mancuso, D., Campbell, K., & Lucenko, B. (2009). Evaluation of the Washington state access to recovery project: Effects on Medicaid costs for working age disabled clients. *Journal of substance abuse treatment*, *37*(3), 240-246. https://doi.org/10.1016/j.jsat.2009.01.005

SARCC Evaluation Plan

Project Title: Building Strong Recovery Communities.
Evaluation Goal: Evaluate the SARCC Building Strong Recovery Communities project by assessing access to recovery support services and the impact those services have on persons with substance use disorders. Assess the quality of RSS in the community and assess the development of key partnerships for SARCC.

MIGHTY CROW

Project Goals

1	Increase access to and the quality of recovery support services (RSS).	**2**	Integrate users of RSS with primary, dental, and behavioral health services.	**3**	Link people in long-term recovery with vocational and educational opportunities so they may find gainful employment.

Evaluation Strategies:		
*Goal 1: Define **access**: number of RSS available; track time from referral to service receipt. Define **quality**: Determine quality measures for each identified RSS.*	*Goal 2: Define users as persons in early recovery; Define **integration** and track time from referral to receipt of service. Track types of services received.*	*Goal 3: Define **linkage**. Determine types of vocational and educational opportunities available in the area. Track utilization of those services. Determine how to track gainful employment.*

Evaluation Phases for Year Two and Year Three: October 1, 2019 through September 30, 2021

Information Gathering and Exploration → Develoop Initial Evaluation Plan → Finalize Evaluaiton Plan with Key Partners → Launch Evaluation → Collect Data → Analyze Data → Disseminate Findings

Inputs/Resources	
Stakeholders and Key Partners	Sandusky Artisans Recovery Community Center (Lead Organization; provider of RSS) Erie County Health Department (FQHC; treatment services provider; recovery housing operator) Mighty Crow: Project Evaluator

	Key Activities: Infrastructure Development	
☐	Collaboration Meetings	Meeting between project staff and project evaluator to provide input on the evaluation plan by reviewing existing data and current methods for collecting data. Determine other data elements to be collected and how those data will be storied.
☐	Defining Processes and Tracking System	**Project Staff will meet to define key terminology and processes:** *Define **access**: number of RSS available; track time from referral to service receipt.* *Define **quality**: Determine quality measures for each identified RSS.* *Define **integration** and track time from referral to receipt of service.* *Define **linkage**. Determine types of vocational and educational opportunities available in the area.* *Determine other key data points that should be captured as part of this project.*

	Key Activities: Evaluation	
☐	Initial Plan	Develop the initial plan for evaluation; gather feedback from Project Team and other key partners.
☐	Final Plan	Gather feedback on initial plan; ensure all instruments are selected and processes are defined. Prepare for first round of data collection on program participants.
☐	Data Collection and Analysis	Collect Data from Project Director (who is gathering data from project staff); analyze data and provide ongoing feedback to the Project Team. Develop protocols for conducting individual interviews.
☐	Prepare Reports	Prepare information for the Project Director to submit for federal reports.
☐	Dissemination of Findings	Work with the Project Team and Key Partners to disseminate findings at the local, state, and national level

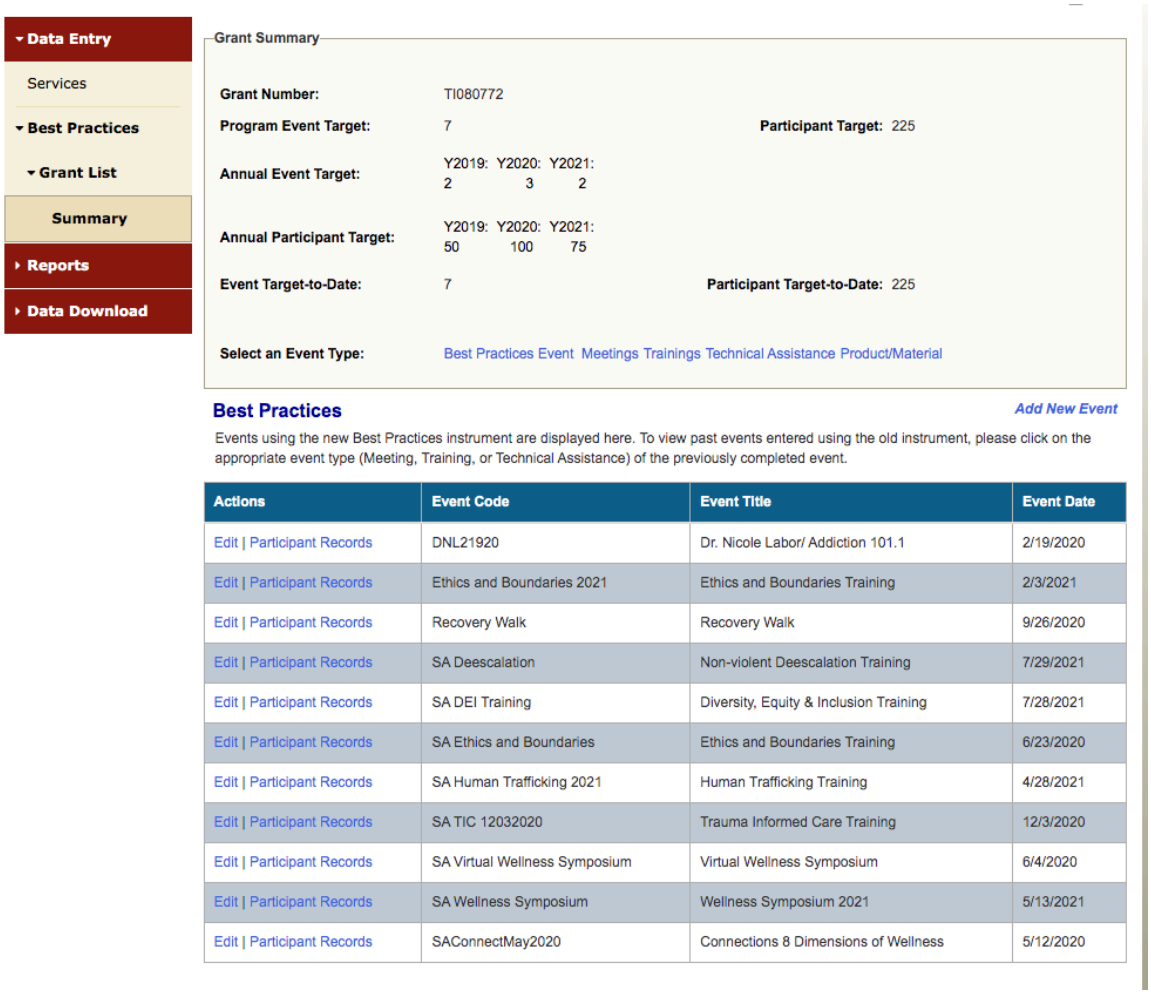
Goals and Objectives	Evaluator's Focus
Goal 1: Increase access to and quality of RSS offered in Erie County and Northwest Ohio	Define "access" and "quality" and determine how these variables will be measured and how data will be collected.
Objective A: Conduct quality improvement processes on a continuous basis.	Define what "quality improvement processes" mean and determine what they will focus on.
Objective B: Offer monthly educational and advocacy trainings for local professionals and people living in long-term recovery.	Track educational trainings offered including topic and persons in attendance. Ensure required surveys from SAMHSA are administered. Track advocacy trainings offered including topic and persons in attendance. Ensure required surveys from SAMHSA are administered.
Objective C: Increase the number of Peer Recovery Supporters and Peer Guides at SARCC and other RCOs.	Determine the baseline measure for total number of Peer Recovery Supporters and Peer Guides to track against an increase or decrease. Document strategies utilized to help increase the number of PRS and Peer Guides.
Objective D: Advocate for the elimination of stigma surrounding substance use disorders.	Define what SARCC means by "advocating for the elimination of stigma" and determine how to measure this objective. Assist SARCC with documenting the work they do as leaders in the community to help illustrate their advocacy.
Goal 2: Integrate users of RSS with primary, oral, and behavioral health care.	Determine how integration is defined and tracked.
Objective A: Execute an agreement with the Erie County Health Department (ECHD) to utilize their FQHC as a medical, dental, and behavioral health home for users of RSS.	Evaluate the utility and effectiveness of this partnership. Determine how SARCC will track service utilization.
Objective B: Training ECHD's clinical and non-clinical staff on SUDs and RSS so they may refer their FQHC patients to SARCC's RSS when appropriate.	Track educational trainings offered including topic and persons in attendance. Ensure required surveys from SAMHSA are administered. Determine how to track referrals from ECHD to SARCC.

Other Tasks for the Evaluation Team:

- Attend project meetings as requested by the Project Manager.
- Participate in conference calls with Federal Project Officer and TA provider.

Project Evaluator: Gretchen Clark Hammond, PhD, MSW, LSW, LCDCIII, TTS
Gretchen@mightycrow.com

Appendix C: Cumulative Events Across Three Years



- Data Entry
  - Services
  - Best Practices
    - Grant List
      - Summary
- Reports
- Data Download

Grant Summary

Grant Number:	TI080772		
Program Event Target:	7	**Participant Target:**	225
Annual Event Target:	Y2019: 2 Y2020: 3 Y2021: 2		
Annual Participant Target:	Y2019: 50 Y2020: 100 Y2021: 75		
Event Target-to-Date:	7	**Participant Target-to-Date:**	225
Select an Event Type:	Best Practices Event Meetings Trainings Technical Assistance Product/Material		

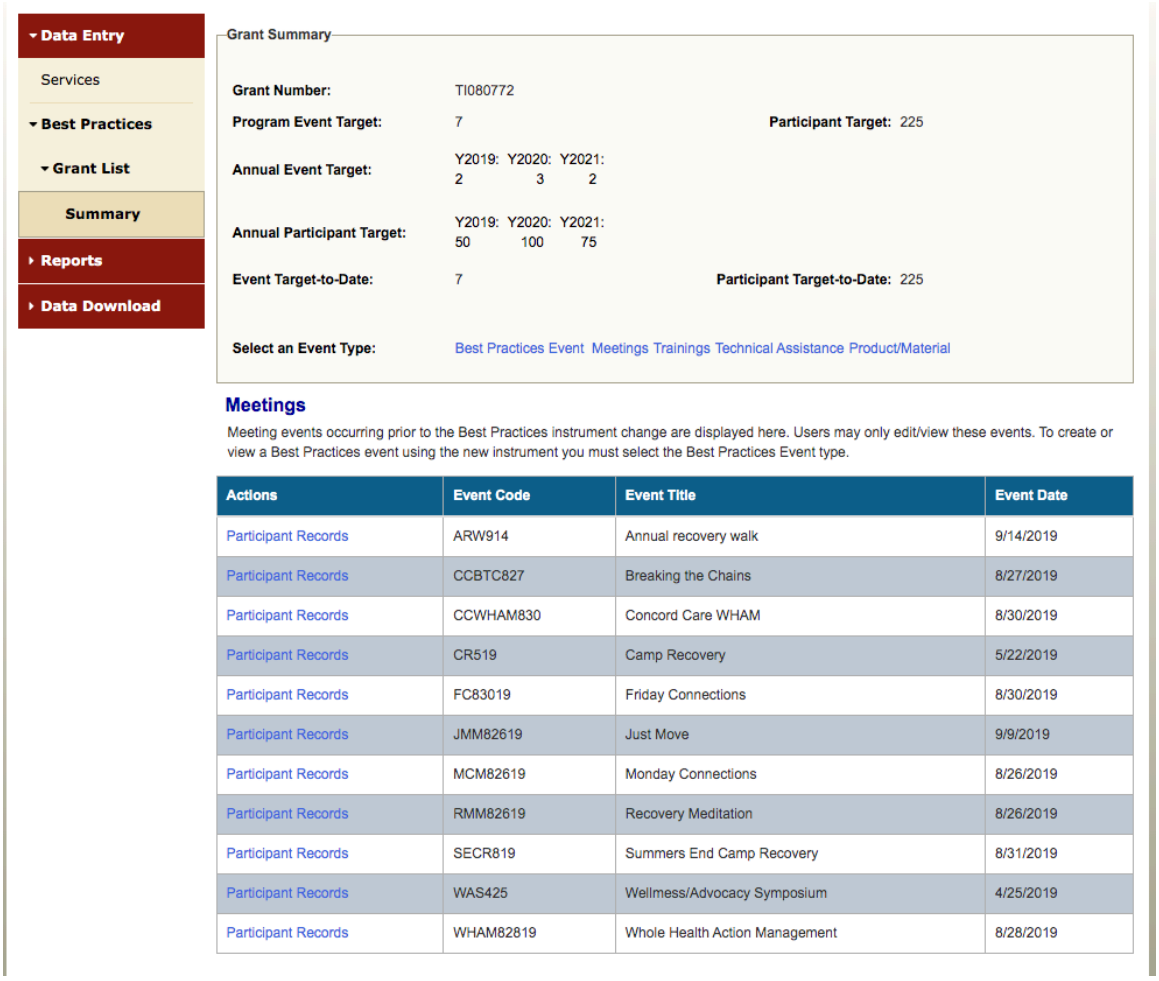
Best Practices *Add New Event*

Events using the new Best Practices instrument are displayed here. To view past events entered using the old instrument, please click on the appropriate event type (Meeting, Training, or Technical Assistance) of the previously completed event.

Actions	Event Code	Event Title	Event Date
Edit | Participant Records	DNL21920	Dr. Nicole Labor/ Addiction 101.1	2/19/2020
Edit | Participant Records	Ethics and Boundaries 2021	Ethics and Boundaries Training	2/3/2021
Edit | Participant Records	Recovery Walk	Recovery Walk	9/26/2020
Edit | Participant Records	SA Deescalation	Non-violent Deescalation Training	7/29/2021
Edit | Participant Records	SA DEI Training	Diversity, Equity & Inclusion Training	7/28/2021
Edit | Participant Records	SA Ethics and Boundaries	Ethics and Boundaries Training	6/23/2020
Edit | Participant Records	SA Human Trafficking 2021	Human Trafficking Training	4/28/2021
Edit | Participant Records	SA TIC 12032020	Trauma Informed Care Training	12/3/2020
Edit | Participant Records	SA Virtual Wellness Symposium	Virtual Wellness Symposium	6/4/2020
Edit | Participant Records	SA Wellness Symposium	Wellness Symposium 2021	5/13/2021
Edit | Participant Records	SAConnectMay2020	Connections 8 Dimensions of Wellness	5/12/2020

Event Title, Date, Type (New Instrument)

Event title	Event date	Event type	Frequency Count	Percent of Total Frequency
Non-violent Deescalation Training	29JUL2021	TTC Event	16	3.44
Diversity, Equity & Inclusion Training	28JUL2021	TTC Event	12	2.58
Wellness Symposium 2021	13MAY2021	TTC Event	43	9.25
Human Trafficking Training	28APR2021	TTC Event	34	7.31
Ethics and Boundaries Training	03FEB2021	TTC Event	23	4.95
Trauma Informed Care Training	03DEC2020	TTC Event	22	4.73
Recovery Walk	26SEP2020	TTC Event	79	16.99
Ethics and Boundaries Training	23JUN2020	TTC Event	25	5.38
Virtual Wellness Symposium	04JUN2020	TTC Event	19	4.09
Connections 8 Dimensions of Wellness	12MAY2020	TTC Event	11	2.37
Dr. Nicole Labor/ Addiction 101.1	19FEB2020	TTC Event	181	38.92


Data Entry
Services
Best Practices
Grant List
Summary
Reports
Data Download
Grant Summary
Grant Number: TI080772
Program Event Target: 7
Participant Target: 225
Annual Event Target: Y2019: 2 Y2020: 3 Y2021: 2
Annual Participant Target: Y2019: 50 Y2020: 100 Y2021: 75
Event Target-to-Date: 7
Participant Target-to-Date: 225
Select an Event Type: Best Practices Event Meetings Trainings Technical Assistance Product/Material
Meetings
Meeting events occurring prior to the Best Practices instrument change are displayed here. Users may only edit/view these events. To create or view a Best Practices event using the new instrument you must select the Best Practices Event type.
Actions
Event Code
Event Title
Event Date
Participant Records ARW914 Annual recovery walk 9/14/2019
Participant Records CCBTC827 Breaking the Chains 8/27/2019
Participant Records CCWHAM830 Concord Care WHAM 8/30/2019
Participant Records CR519 Camp Recovery 5/22/2019
Participant Records FC83019 Friday Connections 8/30/2019
Participant Records JMM82619 Just Move 9/9/2019
Participant Records MCM82619 Monday Connections 8/26/2019
Participant Records RMM82619 Recovery Meditation 8/26/2019
Participant Records SECR819 Summers End Camp Recovery 8/31/2019
Participant Records WAS425 Wellmess/Advocacy Symposium 4/25/2019
Participant Records WHAM82819 Whole Health Action Management 8/28/2019

Print

- Data Entry
  - Services
  - Best Practices
  - Grant List
    - Summary
- Reports
- Data Download

Grant Summary

Grant Number:	TI080772		
Program Event Target:	7	**Participant Target:**	225
Annual Event Target:	Y2019: 2 Y2020: 3 Y2021: 2		
Annual Participant Target:	Y2019: 50 Y2020: 100 Y2021: 75		
Event Target-to-Date:	7	**Participant Target-to-Date:**	225
Select an Event Type:	Best Practices Event Meetings Trainings Technical Assistance Product/Material		

Training

Training events occurring prior to the Best Practices instrument change are displayed here. Users may only edit/view these events. To create or view a Best Practices event using the new instrument you must select the Best Practices Event type.

Actions	Event Code	Event Title	Event Date
Participant Records	FVEB	Ethics and Boundaries	8/15/2019
Participant Records	FVGLW	Grief and Loss in the Workplace	7/19/2019
Participant Records	FVOSHP	Faces and Voices-Our Stories Have Power	8/16/2019
Participant Records	FVOW	Oragnizational Wellness	6/28/2019
Participant Records	FVUCF	Understanding Compassion and Fatigue	6/27/2019
Participant Records	FVWUP	Working with Unique Populations	7/18/2019
Participant Records	NALT71119	Narcan Training	7/11/2019
Participant Records	PRST519	Peer Support Training	5/4/2019

Event Topic, Date, Type (Old Instrument)

EventTitle	Event date	Event type	Frequency Count	Percent of Total Frequency
Annual recovery walk	14SEP2019	Meeting	81	19.19
Just Move	09SEP2019	Meeting	4	0.95
Summers End Camp Recovery	31AUG2019	Meeting	58	13.74
Concord Care WHAM	30AUG2019	Meeting	6	1.42
Friday Connections	30AUG2019	Meeting	12	2.84
Whole Health Action Management	28AUG2019	Meeting	12	2.84
Breaking the Chains	27AUG2019	Meeting	7	1.66
Monday Connections	26AUG2019	Meeting	12	2.84
Recovery Meditation	26AUG2019	Meeting	3	0.71
Faces and Voices-Our Stories Have Power	16AUG2019	Training	8	1.90
Ethics and Boundaries	15AUG2019	Training	19	4.50
Grief and Loss in the Workplace	19JUL2019	Training	10	2.37
Working with Unique Populations	18JUL2019	Training	12	2.84
Narcan Training	11JUL2019	Training	10	2.37
Oragnizational Wellness	28JUN2019	Training	11	2.61
Understanding Compassion and Fatigue	27JUN2019	Training	11	2.61
Camp Recovery	22MAY2019	Meeting	65	15.40
Peer Support Training	04MAY2019	Training	6	1.42
Wellmess/Advocacy Symposium	25APR2019	Meeting	75	17.77